Experience, Quality and Safety Committee

Thu 03 December 2020, 13:30 - 15:30

Teams Meeting

Agenda

13:30 - 13:30
0 min

1. PRELIMINARY MATTERS

EQS_Agenda_3 DEC 2020_Final.pdf (2 pages)

1.1. Welcome and apologies

1.2. Declarations of interest

1.3. Minutes of the previous meetings held on 1 October 2020 and 6 November 2020 for approval

EQS_Item_1.3a_01_October_2020 Unconfirmed Minutes.pdf (16 pages)
EQS_Item_1.3b_06_November_2020 Unconfirmed Minutes_.pdf (7 pages)

1.4. Matters arising from previous minutes

1.5. Committee Action Log

EQS_Item_1.5_EQS Action Log_03_December_2020.pdf (2 pages)

13:30 - 13:30
0 min

2. ITEMS FOR APPROVAL/RATIFICATION/DECISION

13:30 - 13:30
0 min

3. ITEMS FOR DISCUSSION

3.1. Clinical Quality Framework Implementation Plan Update

EQS_Item_3.1_EQS Clinical Quality Framework Dec 2020.pdf (10 pages)

3.2. Serious Incidents And Concerns Report

EQS_Item_3.2_Final Concerns_SIs 23112020.pdf (15 pages)
EQS_Item_3.2a_Appendix 1 - DU correspondence to NHS Wales regarding CoRSEL.pdf (2 pages)
EQS_Item_3.2b_Appendix 2 - NHS inPatient outpatient commissioning survey 2019 v3.pdf (18 pages)
EQS_Item_3.2c_Appendix 3 - Impact and Reach Report 2020 final.pdf (31 pages)

3.3. Special Report issued by the Public Services Ombudsman for Wales

EQS_Item_3.3_PSOW Report.pdf (5 pages)
EQS_Item_3.3a_Appendix_1_ENC - Final Public Interest Report.pdf (16 pages)
EQS_Item_3.3b_Appendix_2_PSOW CEO response letter special report -Laura Collins_Redacted.pdf (2 pages)

3.4. Inspections and External Bodies Report, including Action Tracking

EQS_Item_3.4_Regulatory Inspections Report (V2) 23112020.pdf (5 pages)
EQS_Item_3.4a_Appendix 1 - HIW Tracker Report - Dashboard.pdf (1 pages)
EQS_Item_3.4b_Appendix 2 - HIW Tracker Report - Revised Deadlines.pdf (3 pages)
EQS_Item_3.4c_Appendix 3 - AGIC Adroddiad Blynyddol 2019-2020.pdf (75 pages)
EQS_Item_3.4d_Appendix 4 - Final Report - Tawe Ward.pdf (10 pages)
EQS_Item_3.4e_Appendix 5 - Final Report - Bryn Heulog Ward.pdf (9 pages)
EQS_Item_3.4f_Appendix 6 - Final Report - Maldwyn Ward.pdf (10 pages)
EQs_Item_3.4g_Appendix 7 - Final Report - Epynt Ward.pdf (7 pages)

3.5. Infection Prevention and Control Report

EQS_Item_3.5_Experience Quality and Safety Committee_IPC Update.pdf (12 pages)

3.6. Maternity Services Assurance Framework

EQS_Item_3.6_Maternity service assurance.pdf (7 pages)

3.7. Commissioning Arrangements Update

EQS_Item_3.7_CAF Escalation Report and SaTH Update 2020.pdf (10 pages)

3.8. Clinical Audit Programme

3.8.1. Update against the 2020-21 Clinical Audit Plan

EQS_Item_3.8a_Clinical Audit Programme Plan Update Report November 2020.pdf (13 pages)

3.8.2. Progress against the Clinical Audit Improvement Plan

EQS_Item_3.8b_Clinical Audit Improvement Plan Update Paper November 20.pdf (10 pages)

3.8.3. Proposed Clinical Audit Plan 2021/22

EQS_Item_3.8c_Clinical Audit Programme 2021-2022 Paper November 2020.pdf (9 pages)

3.9. Annual Data Quality Report

EQS_Item_3.9_Annual Data Quality Report Cover Paper.pdf (4 pages)
EQS_Item_3.9a_Annual Data Quality Report Final Amended.pdf (24 pages)

3.10. Once for Wales Complaints Management System, Programme Update

EQS_Item_3.10_OFWCMS update 3rd Dec 2020.pdf (5 pages)

13:30 - 13:30
0 min

4. ITEMS FOR INFORMATION

4.1. Review of Committee Programme of Business

EQS_Item_4.1_EQS_Committee_Work Programme_2020-21_Nov20_RM.pdf (6 pages)

13:30 - 13:30
0 min

5. OTHER MATTERS

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

5.1.1. Any other urgent business

5.1.2. Date of next meeting:

Thursday 4 February 2021, 10am.

POWYS TEACHING HEALTH BOARD
EXPERIENCE, QUALITY & SAFETY COMMITTEE

3 DECEMBER 2020,
13.30PM – 3.30PM
TO BE HELD VIRTUALLY VIA MICROSOFT TEAMS

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

AGENDA			
Item	**Title**	**Attached /Oral**	**Presenter**
1	**PRELIMINARY MATTERS**		
1.1	Welcome and Apologies	Oral	Chair
1.2	Declarations of Interest	Oral	All
1.3	Minutes of the previous meetings held for approval: a) 01 October 2020 b) 06 November 2020	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	Clinical Quality Framework Implementation Plan Update	Attached	Director of Nursing & Midwifery
3.2	Serious Incidents and Concerns Report	Attached	Director of Nursing & Midwifery
3.3	Special Report issued by the Public Services Ombudsman for Wales	Attached	Director of Nursing & Midwifery
3.4	Inspections and External Bodies Report, including Action Tracking	Attached	Director of Nursing & Midwifery
3.5	Infection Prevention and Control Report	Attached	Director of Nursing & Midwifery
3.6	Maternity Services Assurance Framework	Attached	Director of Nursing & Midwifery
3.7	Commissioning Arrangements Update	Attached	Assistant Director of Commissioning
3.8	Clinical Audit Programme: a) Update against the 2020/21 Clinical Audit Plan b) Progress against the Clinical Audit Improvement Plan c) Proposed Clinical Audit Plan 2021/22	Attached	Medical Director
3.9	Annual Data Quality Report	Attached	Director of Finance & IT

3.10	Once For Wales Complaints Management System, Programme Update	Attached	Director of Finance & IT
4	**ITEMS FOR INFORMATION**		
4.1	Review of Committee Programme of Business	Attached	Board Secretary
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: • 4 February 2021 from 10:00 – 13:00 via Microsoft Teams.		

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 its committee meetings virtually by electronic means as opposed to in a physical location, for the foreseeable future. This will unfortunately mean that members of the public will not be able attend in person. The Board has taken this decision in the best interests of protecting the public, our staff and Board members.

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

In addition, the Board will publish a summary of 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 1 OCTOBER 2020 VIA MICROSOFT TEAMS

Present:

Melanie Davies	Vice-Chair (Committee Chair)
Trish Buchan	Independent Member (Committee Vice-Chair)
Frances Gerrard	Independent Member
Susan Newport	Independent member

In Attendance:

Alison Davies	Executive Director of Nursing and Midwifery
Carol Shillabeer	Chief Executive
Claire Madsen	Director of Therapies and Health Sciences
Clare Lines	Assistant Director Commissioning Development
Elaine Matthews	Audit Wales
Jamie Marchant	Executive Director of Primary, Community & Mental Health
Jayne WheelerSexton	Assistant Director of Nursing Safeguarding
Julie Rowles	Director of Workforce, OD and Support Services
Paul Buss	Medical Director
Rani Mallison	Board Secretary
Rebecca Collier	Relationship Manager, Health Inspectorate Wales
Wendy Morgan	Assistant Director of Quality and Safety

Apologies for absence:
None

Committee Support:

Holly McLellan	Senior Administrator/Personal Assistant to Board Secretary

EQS/20/58	**WELCOME AND APOLOGIES FOR ABSENCE** The Committee Chair welcomed Members and attendees to the meeting, and CONFIRMED there was a quorum present.
EQS/20/59	**DECLARATIONS OF INTERESTS** No interests were declared.
EQS/20/60	**UNCONFIRMED MINUTES OF THE EXPERIENCE, QUALITY AND SAFETY COMMITTEE MEETING HELD ON 30 July 2020** The minutes of the previous meeting held on 30 July 2020 were AGREED as being a true and accurate record.
EQS/20/61	**MATTERS ARISING FROM PREVIOUS MEETINGS** No matters arising were declared.
EQS/20/62	**COMMITTEE ACTION LOG** The Committee received the action log and the following updates were provided. The Board Secretary noted that all actions positions are as reported, none are due in the immediate future. The Board Secretary raised that all actions had been deferred due to COVID-19 and identified as not for immediate action however issues around estates have been identified. The Committee Chair raised that moving forward a revision of the action log would be beneficial. The Committee Vice Chair raised that EQS/19/89 infection control of visiting clinicians should be prioritized for follow-up. The Assistant Director of Quality and Safety responded EQS/19/89 was being followed up on by the Quality and Safety team. The Medical Director confirmed their support in resolving EQS/19/89.
ITEMS FOR APPROVAL/RATIFICATION/DECISION	
EQS/20/63	*There are no items for inclusion in this section.*
ITEMS FOR DISCUSSION	
EQS/20/64	**SAFEGUARDING** **a) ANNUAL REPORT 2019-20**

	The Assistant Director of Nursing Safeguarding presented the previously circulated paper which provided an overview of the PTHB Safeguarding Annual Report 2019/20 to the Experience, Quality and Safety Committee. The Assistant Director of Nursing Safeguarding advised that the Annual Safeguarding Report outlined the key areas of development and achievement which have supported PTHB to meet its statutory responsibilities in safeguarding the people of Powys during 2019/20. Additionally, areas for improvement and recommendations for further development in the forthcoming year are highlighted. The Committee Vice-Chair acknowledged that compliance was improving and queried what level of assurance could be taken that as an organisation PTHB was fulfilling its responsivities. The Assistant Director of Nursing Safeguarding responded that significant work had been undertaken to ensure the terms of reference displayed how PTHB was meeting statutory responsibilities. Over the next 12 months a good level of assurance would be provided. The Committee Vice-Chair thanked the Assistant Director of Nursing Safeguarding and asked for confirmation that PTHB would be in a stronger position next year. The Assistant Director of Nursing Safeguarding responded noting that the current position is strong however identified the presentation as the key issue. Progress was being made to make it more robust and to highlight gaps. The Committee Chair noted that the focus had been more robust since the appointment of the Assistant Director of Nursing Safeguarding. The Committee Chair raised the importance of improving the visibility of safeguarding and assurance. The Committee Chair offered to discuss with the Executive Director of Nursing and Midwifery and return findings to the Experience, Quality and Safety Committee. **Acton: Committee Chair and Executive Director of Nursing and Midwifery.** The Committee Chair queried the Independent Members on if they felt they had been receiving enough information.

	The Committee Vice Chair responded that the IMs do receive enough information and the Clinical Quality Framework would provide a full circle view. The Committee NOTED and DISSCUSSED the paper and thanked the Assistant Director of Nursing Safeguarding. **b) EXPERIENCE STORY** The Assistant Director of Nursing Safeguarding presented the previously circulated experience story which captured a conversational interview with a looked after child performed by a Childrens Nurse who wanted to establish the effects of COVID-19 on a looked after children. The Assistant Director of Nursing Safeguarding advised that there were 246 Powys looked after children spread across 10 Children's Homes. 155 are from Powys the others are brought into Powys. The Assistant Director of Nursing Safeguarding also noted that the PTHB expressed pride for the contribution made by the Looked After Child and Care Workers. The Committee Chair noted that the experience story demonstrated resilience, maturity and how the pandemic had changed our society. The Executive Director of Nursing and Midwifery raised that effects on children was one of the categories of harm from COVID-19. It was beneficial that there had been opportunity to look at the wider issues in relation to COVID-19 such as the experience story. The Director of Therapies and Health Sciences queried whether it would have been possible to use the experience story as part of the publicity campaign. The Committee Chair queried if a follow-up could be had to find out how the young person was and if they would be interested in sharing their up to date views. The Committee Vice-Chair noted that it was important to keep the young person's wellbeing the priority. It should be considered if a higher profile would be appropriate. The Assistant Director of Nursing Safeguarding responded that the young person was well and kept in touch with the Children's Nurse. The

	young person had given consent for their story to be part of a newsletter. The Assistant Director of Nursing Safeguarding would make contact through the appropriate channels to confirm whether the young person would be willing to talk to PTHB again. **Action: The Assistant Director of Nursing Safeguarding.** The Executive Director of Primary, Community & Mental Health commended the Experience Story as having been very powerful. The Medical Director noted that the sentiments of the Experience Story are unlikely to be isolated. Mental health of young people should be taken into account, key areas include how safe exercise could be used to help with individuals mental health. The Committee Vice Chair raised that similar sentiments were identified in the Farmers Meeting and queried whether work could be undertaken through charitable funds. The Chief Executive responded that this is scheduled to be discussed in board development in December. The Chief Executive offered to circulate information gathered by the World Health Organisation on COVID-19 impacts on mental health. Mental health would also feature in Board's response to the winter protection plan. The Committee thanked the Assistant Director of Nursing Safeguarding and NOTED the Experience Story.
EQS/20/65	**COMMISSIONING ASSURANCE REPORT** The Assistant Director Commissioning Development presented the previously circulated paper which highlighted to the Experience, Quality and Safety Committee any providers in Special Measures or scored as Level 4 under the PTHB Commissioning Assurance Framework. It also provided an update in relation to Shrewsbury and Telford Hospitals NHS Trust and other key issues. The Assistant Director Commissioning Development advised that the report highlighted providers in Special Measures or scored as Level 4 at the July 2020 PTHB Internal Commissioning Assurance Meeting (ICAM), which

	was then considered at the Delivery and Performance Meeting on the 20th August and 15th September 2020 at the Quality and Governance Group. There has been an issue with the synchronisation of meetings, so this report also contains information received after those dates. There are: • 4 providers with services in Special Measures • 1 provider at Level 4 The report provides an update on a number of serious matters, particularly: • Shrewsbury and Telford Hospitals NHS Trust (SaTH) • Accelerated system change affecting South Powys • and the deteriorating position in relation to referral to treatment times (RTT) times. The Assistant Director Commissioning Development raised that Worcestershire had come out of special measures since the report was submitted. The final version of the risk-based plan would be brought forward and would need to interfacing with the improvement plan within SaTH. The Assistant Director Commissioning Development noted concerns that a lower peak would be would be more difficult to manage. The situation had deteriorated since the report was submitted. The Assistant Director Commissioning Development raised it would be important to differentiate between risk stratification and harm review. The Committee Chair thanked the Assistant Director Commissioning Development for a clear report. Susan Newport queried the staffing arrangements if field hospitals were used. The Assistant Director Commissioning Development responded that staffing arrangements was a key point taken to Welsh Government. Staffing and maintaining community services would help people stay out of hospital. The Assistant Director Commissioning Development apologised for not being able to provide a solution and noted these are NHS wide problems. An advantage in PTHB would be to keep primary and community care strong. Frances Gerrard noted there was little option other than field hospitals however a staffing logistics system would need to be developed. Frances Gerrard raised that without

	extra capacity PTHB would not be able to provide some services during winter 2020. The Director of Workforce, OD and Support Services responded that there was no evidence that the Grange University Hospital was drawing staff from PTHB. PTHB had a temporary staffing unit to fill roles when staff were off sick. If a department was running understaffed it was escalated through appropriate channels. The Chair queried if anything further could be done to provide assurance. The Assistant Director Commissioning Development responded that there is assurance in midwifery. The adversity of COVID-19 had provided opportunities such as repatriation of services and good practice had been noted. There was a significant amount of risk in managed PTHB commissioned services such as growing waiting times, risks are being identified. The Committee Chair queried if it would be necessary to escalate to Board. The Chief Executive responded that it had been escalated to Board and it would be entirely appropriate for further discussion to be had at Board Development, and by a committee to ensure people are seen appropriately and in the right time frames. Detailed scenarios were being constructed on winter pressures. On wider specialties where pre COVID-19 pressure existed new solutions would need to be developed. PTHB could use this as an opportunity for improvement. The Medical Director raised that 'choose wisely' would be a good basis for a value programme in Powys. The Committee DISSCUSSED the commissioning assurance report.
EQS/20/66	**SERIOUS INCIDENTS AND CONCERNS REPORT** The Executive Director of Nursing and Midwifery presented the previously circulated paper which provided the Experience, Quality and Safety Committee with a summary of patient experience and concerns, including complaints, patient safety incidents and claims for July 2020. The report also outlines serious incidents reported to Welsh Government and Her Majesty's Coroner's enquiries that have been received by the health board.

	The Executive Director of Nursing and Midwifery advised that the data depicted within the report is taken from the Datix system, unless otherwise specified, and is correct at the time it was taken from the system. The data quality and confidence are subject to limitations of the current Datix system, which is subject to change as part of the Once for Wales Concerns Management System initiative, currently due for implementation by April 2021. The Committee Vice Chair raised that in incident reporting, the Datix system is fundamental to our understanding of concerns raised on the front line. Incorrect completion of Datix is concerning as there had been a number of initiatives to improve correct documentation. The Committee Vice Chair queried what new tactics had been developed to improve to improve completion of Datix. The Board Secretary responded that the committee had received briefings on the Once for Wales concerns management systems. The implementation of a planned approach would be instrumental in shaping a cultural shift moving forward. The Director of Workforce, OD and Support Services noted there was a full programme infrastructure to initiate the cultural elements improvement. The Director of Workforce, OD and Support Services raised that there was policy work to be discussed and picked up outside of Experience, Quality and Safety Committee. **Action: The Director of Workforce, OD and Support Services.** The Committee Chair raised that the Experience, Quality and Safety Committee would need to be sighted on the policy work. Frances Gerrard queried if Datix was to be superseded with a newer system. The Board Secretary responded that it would be a new system for the same provider as Datix. Frances Gerrard raised that Datix had had a bad track record which created significant resistance. The Executive Director responded that there had been issues on how Datix had been configured and reconfigured by PTHB therefore PTHB must take responsibility where the problem has been self-caused. The quality of PTHB data goes into

	make better quality decisions meaning this upgrade would be an important opportunity. The Committee Chair thanked the Executive Director of Nursing and Midwifery for the paper which the Committee NOTED and DISSCUSSED.
EQS/20/67	**INSPECTIONS AND EXTERNAL BODIES REPORT** The Assistant Director of Quality and Safety presented the previously circulated paper which provided the Experience, Quality & Safety Committee with an update on the most recent Regulatory Inspections undertaken and any planned inspections the health board has been notified of. The Assistant Director of Quality and Safety advised that PTHB is constantly striving to continue to make improvements in response to recommendations made following such inspections and ensure any learning is shared widely. The monitoring and management of the Health Inspectorate Wales (HIW) electronic tracking tool, previously implemented by the Clinical Governance Team, has recently been handed over to the Quality and Safety Team, who will maintain the tracker, and develop means to close completed improvement plans with HIW. The Committee Vice Chair noted improvement in the environmental health inspections of hospital kitchens. The Committee Vice Chair queried on the Health Inspectorate Wales (HIW) tracker were all inspections being tracked or just HIW. The Assistant Director of Quality and Safety responded that work is being undertaken to ensure all inspections are picked up on. A more robust overall tracker would be required going forward. The Committee Chair thanked the Assistant Director of Quality and Safety and the Committee NOTED and DISSCUSSED the paper.
EQS/20/68	**MENTAL HEALTH ACT COMPLIANCE & POWERS OF DISCHARGE REPORT** The Executive Director of Primary, Community & Mental Health presented the previously circulated paper which provided the committee with assurance that Powys

	Teaching Health Board is compliant with the legal duties under the Mental Health Act 1983 (MHA). Referencing the most recent quarterly management information and activity data in relation to the Hospital Managers' scheme of delegated duties under the MHA including amendments (section 23), the report demonstrates the activity undertaken regarding admissions and other related arrangements. This report is not to be considered as a performance report as the data and activity cannot be viewed in that way. This report summarises the activities pertaining to the use of Mental Health Act within Powys Teaching Health Board services in the reporting period and summarises the compliance with the Act accordingly. The Executive Director of Primary, Community & Mental Health advised that the report provides assurance in respect of the work that has been undertaken during the reporting period that those functions of the Mental Health Act 1983 (the Act), which have been delegated to officers and staff under the policy for Hospital Managers' Scheme of Delegation are being carried out correctly and that the wider operation of the Act across the Health Board area is operating within the legislative framework. The Committee Chair noted, in the last paper results from interviews showed 3/6 patients said they were not provided with advocacy. The Committee Chair queried if the report could include a section on advocacy and if patients were aware of it. Frances Gerrard queried the deaths of detained patients. The Executive Director of Primary, Community & Mental Health responded that there was one death which was being investigated as a Serious Untoward Incident currently, the patient would not be identified for patient confidentiality reasons. The Executive Director of Primary, Community & Mental Health offered to provide further information in an Experience, Quality and Safety In-Committee meeting.

	The Committee Chair thanked the Executive Director of Primary, Community & Mental Health for the paper and the Committee NOTED the contents of the report.
EQS/20/69	**STAFF WELL-BEING AND ENGAGEMENT REPORT** The Director of Workforce, OD and Support Services presented the previously circulated paper which provided the Experience, Quality and Safety Committee an update on staff well-being and engagement. The Director of Workforce, OD and Support Services advised the wellbeing and engagement of staff is a key strategic priority for PTHB and has been an integral part of the IMTP for a number of years. Immediately prior to COVID-19 emerging as a significant risk, PTHB were externally assessed against the Corporate Health standards and successfully maintained its Gold level status. The report provides an update on actions taken by the health board in response to the new and emerging issues created by COVID-19 and the support provided to staff during the past 6 months. The Committee Chair thanked and congratulated the Director of Workforce, OD and Support Services for a comprehensive report and for upkeeping statutory and mandatory training. The director of workforce, OD and Support Services responded that in keeping up to date on Personal Appraisal and Development Reviews (PADRs) it is hoped PTHB will be able to respond quickly and proactively to staff needs. The Committee Vice Chair noted the paper was easy to understand and focused. The Committee NOTED and DISCUSSED the paper.
EQS/20/70	**INFORMATION GOVERNANCE QUALITY REPORT** The Board Secretary presented the previously circulated paper which provided the Experience, Quality and Safety group with assurance on the quality of key information governance aspects.

	The Board Secretary advised that the paper had been developed to provide an assessment against key information governance (IG) quality indicators. The Committee Vice Chair queried if information sharing protocols in key areas such as safeguarding were in place. The Board Secretary responded that an overview could be brought forward however normally they are taken forward on a risk-based basis. The Committee Vice Chair queried if information sharing protocols would be in place between organisations. The Board Secretary responded that the Wales Information Sharing protocol covers elements of this. The Chief Executive raised the duty to cooperate and share information to the benefit of patients. Where information was shared even with no agreed protocol in place it can be justified where there was an overriding benefit to the patient. Information sharing in situations where safeguarding was a concern had been brought to the attention of PTHB. The Committee Vice Chair requested assurance that staff were aware of the possibility of information sharing without protocol. The Chief Executive responded that it was part of the professional registrant code of conduct. The Board Secretary raised that each breach is assessed on severity and any action necessary is taken forward. The Committee Chair thanked the Board Secretary for the paper and the Committee NOTED the content.
EQS/20/71	**THE PUBLIC SERVICES OMBUDSMAN FOR WALES ANNUAL REPORT AND ACCOUNTS 2019/2020** The Assistant Director of Quality and Safety presented the previously circulated report which provided the Experience, Quality and Safety Committee with an overview of the Public Services Ombudsman for Wales Annual Letter for 2019/2020.

	The Assistant Director of Quality and Safety advised that the Public Services Ombudsman of Wales had requested by the 30 November outcomes on the following actions: • Presentation of the Annual Letter to the Board to assist Board Members in their scrutiny of the Board's performance. • Work with the PSOW Improvement Officer and Complaints Standards colleagues to improve complaint handling practices and standardise complaints data recording. • Inform the PSOW of the outcome of the Health Board's considerations and proposed actions within the Annual Letter. The Committee Chair noted there will be a drop-in concerns once the continuing health care conditions go through the system. The Committee Chair queried where PTHB stood in an all wales position. The Assistant Director of Quality and Safety responded that this was detailed in the paper. The Committee Vice Chair raised that feedback from complaints often defines staff attitude as a key factor. The Committee Vice Chair queried if training could be established to we help staff to deal with complaints. The Committee Chair responded that many complaints can be managed right at the start of the process. The Committee Chair thanked the Assistant Director of Quality and Safety and the Committee NOTED the content of the paper.
EQS/20/72	**MORTALITY REPORTING** The Medical Director presented the previously circulated paper which provided an update to Experience, Quality & Safety Committee on the mortality review process implemented across the Health Board together with actions that were being taken to show improvement. The Medical Director advised that the PTHB approach to case review had been developed with the aim of ensuring a standardised format and process. This would ensure higher quality, more consistent reviews, and a robust process for escalation and dissemination of learning. The learning from

	mortality case review would be used to drive service improvement and offer assurance to patients, stakeholders and the Board that the causes and contributory factors of all deaths had been considered and appropriately responded to. The Committee Vice Chair queried if this was cross Powys of just in Brecon and, if perinatal deaths were longer term or just recent perinatal deaths being considered. The Medical director responded that the process was being taken one step at a time. Many instances are subject to legal or other issues. Early next year there would be a clear picture of all deaths across PTHB sites. The Medical Director noted that at that stage Medical Examiners would then be liaised with to coordinate learning. The Committee Vice Chair queried what special arrangements in place with other perinatal providers that are under investigation. The Medical Director responded that this would require raising to Board. PTHB would require a special arrangement when it comes to perinatal deaths. Susan Newport queried whether the higher numbers of sepsis are due to transfer of very ill patients. The Medical Director responded that there had not been sufficient data yet to ascertained that. A positive culture would need to be developed of learning on how to identify sepsis. The Committee Chair thanked the Medical Director and the Committee NOTED and DISCUSSED the paper.
EQS/20/73	**CLINICAL AUDIT REPORT** The Medical Director presented the previously circulated paper which informed the Experience, Quality and Safety Committee regarding the progress of the 2020/21 Clinical Audit plan and request permission for changes to the annual audit plan. The Medical Director advised the report provided a current position in relation to the 2020/21 Clinical Audit plan. As the Clinical Audit plan is a Board-owned document, the Directors and Service Leads requested that the Experience,

	Quality and Safety Committee acknowledge that new arrangements were being developed to link the future audit programme more closely to professional development through medical and nursing revalidation and organisational risk and to give approval for the proposed changes to the plan requested in this report. The Committee Chair raised that the committee was asked to note the changes in the audit structure. The Committee APPROVED the proposed changes to the annual audit plan.
ITEMS FOR INFORMATION	
EQS/20/74	**REVIEW OF COMMITTEE PROGRAMME OF BUSINESS** The Board Secretary presented the previously circulated paper which provided the Experience, Quality & Safety Committee with the 2020/21 workplan, as at September 2020. The Board Secretary advised the 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. The Committee NOTED the work plan.
EQS/20/75	**PUTTING THINGS RIGHT CLAIMS AND COMPENSATION ANNUAL REPORT 2019- 2020 (FINAL)** The Executive Director of Nursing and Midwifery presented the previously circulated paper which provided the Experience, Quality and Safety Committee with information on the progress and performance of Powys Teaching Local Health Board in their management of concerns during

	2019-2020. This report includes compensation claims management. The Executive Director of Nursing and Midwifery advised that the report was prepared in line with 'The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011', of which Regulation 51 provided that a responsible body must have prepared an annual report. The report was published in support of PTHB's Annual Quality Statement. The Committee NOTED the paper for information.
OTHER MATTERS	
EQS/20/76	**ITEMS TO BE BROUGHT TO THE ATTENTION OF THE BOARD AND OTHER COMMITTEES** The Committee Chair raised the issues of treatment times noting it would be brought to other committees.
EQS/20/77	**ANY OTHER URGENT BUSINESS** No urgent business. The Committee Chair thanked all members.
EQS/20/78	**DATE OF THE NEXT MEETING** 6 November 2020, Microsoft Teams.

POWYS TEACHING HEALTH BOARD
EXPERIENCE, QUALITY & SAFETY COMMITTEE

UNCONFIRMED

MINUTES OF THE MEETING HELD ON THURSDAY 6 NOVEMBER 2020 VIA MICROSOFT TEAMS

Present:

Melanie Davies	Vice-Chair (Committee Chair)
Trish Buchan	Independent Member (Committee Vice-Chair)
Frances Gerrard	Independent Member
Susan Newport	Independent Member

In Attendance:

Alison Davies	Director of Nursing and Midwifery
Carol Shillabeer	Chief Executive
Clare Lines	Assistant Director Commissioning Development
Hayley Thomas	Director of Planning and Performance
Rani Mallison	Board Secretary

Apologies for absence:
None

Committee Support:

Holly McLellan	Senior Administrator/Personal Assistant to Board Secretary

EQS/20/79	**WELCOME AND APOLOGIES FOR ABSENCE** The Committee Chair welcomed Members and attendees to the meeting, and CONFIRMED there was a quorum present.
EQS/20/80	**DECLARATIONS OF INTERESTS** No interests were declared.
ITEMS FOR APPROVAL/RATIFICATION/DECISION	
EQS/20/81	**South Powys Pathways Programme** The Chief Executive and Assistant Director Commissioning Development presented the previously circulated paper which provided and update on the South Powys Pathways Programme, following the announcement of the accelerated opening of The Grange University Hospital in Aneurin Bevan University Health Board. The Chief Executive advised that the paper provided updated information in relation to risk management and readiness. It also confirms the PTHB assumptions about expected Powys patient flows (in Phase 1) following the accelerated opening of The Grange University Hospital (GUH). The Chief Executive handed over to the Assistant Director Commissioning Development who advised that before the COVID-19 pandemic Powys Teaching Health Board (PTHB) had established a South Powys Pathways Programme Board. Chaired by the CEO, involving the Welsh Ambulance Service NHS Trust (WAST), Cwm Taf Morgannwg University Health Board (CTMUHB) and Aneurin Bevan University Health Board (ABUHB). The Programme Board had been convened to prepare for changes: anticipated under the South Wales Programme; in response to the opening of GUH in Spring 2021; and under the Powys Health and Care Strategy. The winter of 2020/21 will be extremely difficult due to the COVID 19 pandemic. This year has been one of unprecedented challenge for all and civil contingency arrangements remain in place. GUH is key to ABUHB's COVID winter response and approval was given on the 27th August 2020 to bring forward the GUH opening to the 17th November, 2020. Responding to the early opening of the Grange was identified as a key strategic priority for the whole board of PTHB. Following the announcement PTHB amended the

	scope and phasing of its Programme Board to focus, in Phase 1, on the changes needed in a compressed timescale to emergency and urgent care flows. Following public consultation five health boards and WAST had approved, in 2014, recommendations in relation to the future configuration of consultant-led maternity and neonatal care, inpatient children's services and emergency medicine (A&E) for South Wales and South Powys. Under this Prince Charles Hospital (PCH) in Merthyr Tydfil was recognised as being of strategic importance for South Powys offering the nearest District General Hospital (DGH) for the majority of the South Powys population. The opening of GUH results in changes to Nevill Hall Hospital (NHH) DGH in Abergavenny which becomes a "Local General Hospital". Whilst it will continue to provide a range of outpatient, diagnostic, admission and day case surgical services for South Powys patients it will no longer be the closest DGH with a Consultant led Emergency Department and for emergency admission (including paediatrics). In summary, the assumptions and expected patient flows for PTHB are: • There should be alignment with the outcomes of the South Wales Programme • "Time critical" journeys by WAST (usually "Reds" and "Amber 1s") will be to the closest District General Hospital (DGH) with an Emergency Department (ED). For most of South Powys this will be Prince Charles Hospital (PCH). • PCH is also the closest DGH for most South Powys WAST calls classified as "Amber 2s, 3s and Greens" (helping to ensure ambulances are away from Powys for the least time possible). • Once the changes at NHH in Abergavenny take place, the closest DGH ED for the majority of patients who are "walk-ins" from South Powys will be PCH. • PCH will be the main DGH ED and hospital for paediatric emergency flows for most of South Powys. • Powys GPs may refer adults, fitting the clinical criteria, in hours, to the NHH MAU. • Powys patients will use the PTHB Minor Injury Units (MIUs) where appropriate

	PTHB will work closely with CTMUHB to accelerate movement of patients back to Powys from the PCH ED and wards. The Assistant Director Commissioning Development noted that a risk-based approach had been utilised working on a compressed time scale. To mitigate risk, detailed work had been done around patient flows. A key aim was to reduce the need for emergency department admissions. In a meeting on the morning of 6 November 2020 the Executive Director of CTMUHB agreed that this aim was reflected in the CTMUHB quarter 3 and 4 plans. The Chief Executive thanked the Assistant Director of Commissioning Development and raised that PTHB needed a clear position on readiness. PTHB must be confident that its preparation is of the highest standard prior to the opening of the Grange University Hospital. Hayley Thomas raised that ABUHB were undertaking daily meetings of preparation work. No issues were escalated from the meeting on the morning of 6 November 2020. The final meeting would take place on 12 November 2020. The Chief Executive raised that one risk had not been managed, the outcome of the fire break would factor into the level of risk and other current factors were predicted to also have a positive effect. The risk would be left at its current level and not pre-emptively reduced. The Committee Chair agreed on the current approach to the risk. The risk would be escalated to Board and the committee should be sighted on it. Susan Newport acknowledged the work that has been undertaken and queried the availability of air ambulances considering winter weather conditions. The Chief Executive responded that there was a heightened awareness of issues with the Heads of the Valleys and Brecon Beacons roads. Comments have been made in stakeholder management. There have been few issues, the Welsh Ambulance Service had given clear and positive responses on how they would work through any problems. Powys County Council would aim to keep main routes and those of known at risk patients open. Welsh Ambulance had a good level of awareness from travel agencies on weather conditions and open routes. The Committee Vice-Chair commended work undertaken and queried if the investment in Prince Charles Hospital

	was sufficient and timely to assist with the current influx. The Chief Executive responded that there had been a capital investment from the South Wales Programme which was progressing. The accelerated opening of the Grange University Hospital has been the biggest challenge and is receiving further investment now. CTMUHB has faced changes that didn't come to fruition such as an expectation of a different bed base. Additional investment to Prince Charles Hospital has been undertaken if we translate investment to bed capacity expansion. The Committee Vice-Chair queried how risk would be mitigated in terms of repatriation of patients from high Covid-19 areas. The Chief Executive responded that people are already being tested and needs met appropriately. PTHB intends to introduce Near Patient Testing which would be swifter as soon as is possible. The Committee Vice-Chair queried whether communications should be extended and enhanced for vulnerable people. Were there any plans to strengthen patient feedback? Do PTHB partners have an appropriate understanding of the level of change for patients? The Chief Executive responded that PTHB was mindful of individuals who do not use digital media which lead to actioning information being distributed via mail drop as well as social media. The Chief Executive commended Adrian Osbourne, Assistant Director of Communication and Engagement, for his work in supporting this. PTHB were envisaging that voluntary organisations would help to discharge messages and pick up concerns moving forward. Patient experience would be discussed weekly. The Assistant Director of Commissioning Development added that easy read versions of information were produced and sent to all supported living providers. Individuals with a written care plan would be assessed to ensure their plan was adjusted accordingly. The Chief Executive raised that the Clinical Summit PTHB had hosted and developed had been valuable and it was agreed no matter where a patient came from they would receive treatment. It was important to ensure any administrative issues were dealt with behind the scenes. CTMUHB had taken this on and had been supportive and keen to develop working relationships.

	The Director of Planning and Performance raised that the Community Health Council through check and challenge had also helped to get information into the community. Frequent users had received a targeted approach to asses which individuals would be impacted upon by the change, front line staff in particular were reinforcing at every opportunity. The Assistant Director of Commissioning Development noted that in every case where an individual was an emergency admission PTHB would ensure care plans were in place and reviews were done to ensure patients did not require emergency admissions. The Committee Chair queried the clinical impact of the South Powys Pathways Programme on maternity and time scales. In what ways would the Crickhowell pathway be affected. The Director of Nursing and Midwifery responded that as part of the work stream there was a Senior Representative from Cwm Taf and Aneurin Bevan, this provided scope for a more informed plan. A date is to be identified for continuity of care. Work would be undertaken alongside the Director of Midwifery from Cwm Taf and with engagement from Ian Sop to form a constructive agenda. The Chief Executive raised that it would be necessary to be clear on where Crickhowell would flow to. The Assistant Director of Commissioning Development responded that approximately 20% of the activity that previously went through Nevill Hall MIU will still flow through where the patient is an adult and fits the appropriate predetermined parameters. In terms of clinical impact there would be a meeting with appropriate counterparts from other Health Boards as well as weekly meetings in the immediate period after the opening of the Grange University Hospital to touch base. In the South Cluster, once the immediate safety aspect was dealt with both sides felt positive regarding the new relations with Cwm Taf. The Chief Executive thanked the Committee Chair and queried whether the Committee felt assured that the focus and conclusion could be endorsed. The Committee Chair responded that key matters had been addressed and the pathway work provided good assurance. The Committee Chair noted that the known risk was around capacity and Covid-19. The Chief Executive thanked the planning team and raised that additional actions would be added going forward.

	The Chief Executive noted an update was scheduled to be presented to Board on 25 November 2020. The Committee NOTED the report and ENDORSED the progression of the South Powys Pathways Programme.
ITEMS FOR DISCUSSION	
EQS/20/82	There are no items for inclusion in this section.
ITEMS FOR INFORMATION	
EQS/20/83	There are no items for inclusion in this section.
OTHER MATTERS	
EQS/20/84	**ITEMS TO BE BROUGHT TO THE ATTENTION OF THE BOARD AND OTHER COMMITTEES** There are no items for inclusion in this section.
EQS/20/85	**ANY OTHER URGENT BUSINESS** No urgent business. The Committee Chair thanked all members.
EQS/20/86	**DATE OF THE NEXT MEETING** 3 December 2020, 13:30 – 16:30 via Microsoft Teams.

Key:

Completed
Not yet due
Due
Overdue
Transferred

EXPERIENCE, QUALITY & SAFETY COMMITTEE

ACTION LOG 2020/21

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Minute	Meeting Date	Action	Responsible	Progress Position	Completed
Arising from Meetings of the Experience, Quality & Safety Committee (2019/20)					
EQS/19/89	4 February 2020	Information regarding how PTHB receive assurance that visiting clinicians are compliant with training will be circulated with Committee Members.	Assistant Director of Quality & Safety	1 October 2020 It was confirmed that the Quality and Safety team are following up on this action. The Medical director confirmed their support in resolving the action. 16 April 2020 The Committee agreed that in light of COVID-19, this action would be deferred to Q4, 2020/21 (priority 3).	

EQS/19/76	3 December 2019	The Research and Development and Innovation Update report was requested to be strengthened and taken forward in conjunction with the Clinical Quality Framework.	Medical Director	03 Dec 2020 It is proposed that an updated on Research and Development is built into the Committee's workplan for 2020/21 16 April 2020 The Committee agreed that in light of COVID-19, this action would be deferred to Q3, 2020/21 (priority 2).	
EQS/19/22	4 June 2019	HIW/CIW Joint Inspection: Community Mental Health – The Hazels (Llandrindod Wells) – where 'The Hazels' building sits in the asset refurbishment programme will be confirmed at the next meeting	Assistant Director of Estates and Property	03 Dec 2020 An update on this item will be provided to the Committee in February 2021. 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).	

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 3.1

EXPERIENCE QUALITY & SAFETY COMMITTEE	**Date of Meeting: 3 Dec 20**
Subject:	**Progress on implementing the PTHB Clinical Quality Framework Implementation Plan, 2020-23**
Approved and Presented by:	Alison Davies, Director of Nursing & Midwifery
Prepared by:	Alison Davies, Director of Nursing & Midwifery Claire Madsen, Director of Therapies & Health Sciences Stuart Bourne, Director of Public Health Julie Rowles, Director of Workforce and Organisational Development Paul Buss, Medical Director
Other Committees and meetings considered at:	Quality Governance Committee

PURPOSE:

The purpose of this report is to present progress made on implementing the PTHB Clinical Quality Framework Implementation Plan, 2020-23, and to identify the need for revised timescales for some elements of the framework where progress has been adversely affected as a consequence of the COVID9 pandemic, resulting in activities scheduled for completion in year 1 deferred into year 2, along with the potential for a small number of year 2 priorities deferred into year 3.

RECOMMENDATION(S):

The Experience Quality and Safety Committee is asked to:
Discuss the contents of this report and note the requirement for revised timescales for some elements of the implementing the Clinical Quality Framework.

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

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

EXECUTIVE SUMMARY:

The PTHB Integrated Medium Term Plan 2020-2023 identifies quality as a core component of the health boards strategic direction. The Clinical Quality Framework consists of 5 goals and the progress related to each is led and coordinated by a Director.

Whilst implementation has been adversely affected as a result of the demands of the COVID19 pandemic, gains have been made in implementing actions in each of the goals. The revised national patient experience strategy, currently delayed but expected in 2021, will assist in shaping this agenda locally, along with the continued focus within service groups on strengthening quality governance arrangements, including a focus on patient experience.

The implementation of the Clinical Quality Framework remains a priority for Board and at every level within the health board. Should the cautious optimism offered by the possibly of mass vaccination become a reality and result in a more favourable environment in 2021, it is envisaged that progress in implementing the Clinical Quality Framework will be expedited.

DETAILED BACKGROUND AND ASSESSMENT:

1 Introduction and Background

The PTHB Integrated Medium Term Plan 2020-2023 identifies quality as a core component of the health boards strategic direction and, following an internal review of arrangements in relation to clinical quality governance, a Clinical Quality Framework was developed to further improve and assure the quality of clinical services during the next three years (2020 to 2023). The framework is centred on 5 goals and focuses on:

- Organisational culture - encompassing honesty and openness
- Clinical leadership
- The improvement methodology in place in the organisation
- Clinical quality intelligence and performance reporting

The framework identifies the need for a diverse range of strategic, operational and logistical interventions across a number of functions with the aim of embedding robust quality governance within the health board. The implementation plan was presented to, and approved by the Experience Quality and Safety Committee in June 2020.

2. Assessment

2.1 The development and endorsement of the Clinical Quality Framework Implementation Plan set out the health board's ambition to progress with the actions required to achieve the 5 goals as agreed, with a lead Director identified for each of the goals. Whilst quarter 1 of 2020-2021 was dominated by the emergence of COVID19, the remainder of the year has been focused on understanding and wherever possible, mitigating the 4 harms resulting from the pandemic, in all aspects related to the population of Powys. The way in which the health board has approached this period is clearly detailed in the quarter 2 3 and 4 planning arrangement, submitted to Welsh Government and through regular reporting to Board and its Committees.

2.2 Whilst overall implementation of the Clinical Quality Framework Implementation Plan has been adversely affected as a result of the COVID19 pandemic, gains have been made in implementing actions in each of the goals. A simple traffic light system is used in the table below to demonstrate the current status of each of the activities scheduled to take place in year 1. The majority of the actions are identified as amber, with some progress having been made. Whilst it is recognised goal 1c related to patient experience is categorised as no progress, it is acknowledged that this area is co-dependent on a number of other external factors, including the availability of a revised national patient experience strategy, currently delayed but expected in 2021, and the establishment of a Once for Wales patient experience module. Both will assist in shaping this agenda locally, along with the continued focus within service groups on strengthening quality governance arrangements, including a focus on patient experience.

The table below provides an 'at a glance' summary of status in relation to each of the activities identified for year 1, the narrative in **appendix 1** provides more context in terms of the assessment of progress as displayed below:

Table 1: at a glance status of year 1 clinical quality framework activity

Goal	Status
GOAL 1a. SAFETY	
Implement the revised Putting Things Right policy	
Implement the five key improvement actions relating to Serious Incident management	
GOAL 1b. EFFECTIVENESS	
Implement the improvement plan for clinical audit	
GOAL 1c. EXPERIENCE	
Refresh the PTHB Patient Experience Framework	
Review arrangements for learning from patient experience in all clinical services	
GOAL 2: Organisational culture	
Consider aligning Values and Behaviours Framework to compassionate leadership	
Consider deployment arrangements including roles/accountabilities of Executive Directors/teams	
Evaluate the current culture of the organisation	
Ensure a multidisciplinary approach to clinical risk assessment and management	
GOAL 3: clinical Leadership	
Visible Clinical Executive Director leadership in the roll-out of the Clinical Quality Framework	
Consider assigning a named PTHB clinical lead to specific quality governance areas	
GOAL 4: Improvement methodology	
Using a prioritised and risk-based approach, define and deliver a programme of clinical quality improvement projects	
GOAL 5: Intelligence	
Review and develop performance monitoring arrangements for clinical services; aligning to work undertaken on Commissioning Assurance Framework(s)	

2.3 Whilst some of the developments identified within the Clinical Quality Framework are not being progressed as speedily as originally expected, existing systems and processes, along with increased levels of support and scrutiny, particularly related to goals 1a, are in place to mitigate risk.

2.4 The implementation of the Clinical Quality Framework remains a priority for Board and at every level within the health board, the re-emergence of COVID19, the wider response required in relation to prevent and respond including mass vaccination, the focus on continued provision of essential services along with supporting staff resilience and wellbeing, all impact on the opportunity to strategically develop, redesign, establish and consolidate new opportunities. Should the cautious optimism offered by the possibly of mass vaccination become a reality and result in a more favourable environment in 2021, it is envisaged that progress in implementing the Clinical Quality Framework will be expedited.

NEXT STEPS:

Focus on implementing the Clinical Quality Framework plan will continue. A revised schedule for implementation is likely to be required given the continuing adverse effects of the pandemic, with activities scheduled for completion in year 1 deferred into year 2, along with the potential for a small number of year 2 priorities deferred into year 3.

Appendix 1: Progress Report: implementing the Clinical Quality Framework

GOAL 1: Implement the core model for clinical quality: safety, effectiveness and experience
1a. SAFETY Implement the revised Putting Things Right policy

The Innovation and Improvement Team are leading a programme of improvement looking at the approach to concerns, incidents, serious incidents and learning to deliver effective and sustainable change. This work will be supported by the findings of an independent review, being undertaken following the receipt of a Special Report issued by the Public Services Ombudsman for Wales, due to report in December 2020, which will generate recommendations to assist the health board in targeting resource to support compliance.

A revised Putting Things Right (PTR) policy was published in November 2019 and provides a comprehensive overview of the requirements for compliance. During 2020, the following assurance processes have been undertaken in relation to compliance with the policy:

- Monthly reporting to Board committees related to concerns and serious incident response times
- Focussed improvement work on serious incidents
- Planned Internal Audit during December 2020
- Welsh Risk Pool audit related to claims management
- A rolling annual programme of audit is being developed to generate internal assurance related to each of the aspects of the policy, which is scheduled to commence early 2021
- Baseline assessment and improvement related to incident reporting, including quality and management, with refreshed focus on training and revised guidance on reporting, managing and closing incidents.

Once the review of incidents is completed, the group will become a ground level learning group feeding into the strategic learning group being led by the Medical Director.

Supplemented by a series of specialist study days for the concerns team, the Putting Things Right training programme consisted of two days and focussed on the management of concerns, customer care, investigation of concerns and redress and was delivered between September -December 2019. An education and training programme is currently under development, including external provision of

investigation training, bespoke training for the Public Service Ombudsman for Wales and an internal programme.

GOAL 1: Implement the core model for clinical quality: safety, effectiveness and experience
1a. SAFETY Implement the five key improvement actions relating to Serious Incident management

The serious incident policy was published in July 2020. The focus on review, closure, learning and improvement related to the of historic, open serious incidents, is nearing completion. The status of all serious incidents currently reported by the health board (those that originated in the last 60 days as well as those that are historic), has been ratified with Welsh Government. Each of the incidents has a trajectory for completion, set by the service lead and performance managed.

In relation to serious incident investigation, Investigating Officers have been designated, to include Heads of Service and Governance Leads within service groups, and will be trained by an external agency. A threshold audit for incident reporting is being considered by the incident reporting group and will from part of the annual audit programme.

Patient Safety Alerts /Notices are received from a variety of sources, namely serious incidents reported to Welsh Government, Ombudsman and Coroners' reports, and patient safety alerts issued by NHS England which are reviewed to ensure they meet the needs of the NHS Wales, in addition to any other relevant information from local, national and international sources.

Work is required to review and refresh the systems and supporting processes, and approve the existing draft policy and procedure. An education/ awareness programme to support staff in their response to alerts is required. The safety alerts module currently used in Datix will features as part of the awaited new Once for Wales Content Management System, but no date is available with regards its implementation. A review of systems and processes will be triggered at this time to ensure improvements put in place remain appropriate.

GOAL 1: Implement the core model for clinical quality: safety, effectiveness and experience
1b**. EFFECTIVENESS**: Implement the improvement plan for clinical audit

Work is underway to build upon the clinical audits that have been undertaken in 2019/2020. The plan for clinical audit is tiered in nature, ranging from collating clinical audits undertaken by professionals as part of professional revalidation requirements, identifying team-based audits at a local level and any audits undertaken in relation to issues related to organisational risk. In addition, reporting those national audits undertaken in our commissioned services will form part of the overall systematic approach to try and identify early indicators of risk and to adopt adequate clinical or organisational responses. An update in relation to the new structure and approach to clinical audit in PTHB will be presented in early 2021.

GOAL 1: Implement the core model for clinical quality: safety, effectiveness and experience
1c. **EXPERIENCE** • Refresh the PTHB Patient Experience Framework • Review arrangements for learning from patient experience in all clinical services

A refreshed patient experience group is established and a task and finish group set up to revise the health board's patient experience strategy to include review of arrangements within service groups. New developments include a commitment to set up an Allied Health Professional's learning group, learning from mental health services where there is an established approach. Priority has been given to enabling and using patient stories including stories from complaints and incidents, along with stories to support learning about equality.

GOAL 2: Optimise organisational culture, to enable high quality clinical care (linked to Organisational Development Framework)

Nationally, HEIW are leading the adoption of Professor Michael West's Compassionate and Collective Leadership model, which has been evidenced to directly link to improved patient outcomes. HEIW are currently in consultation to finalise the NHS Wales Compassionate Leadership Principles. The goal will be to adopt and embed this approach within teams so that a collective responsibility for compassionate leadership is evident, both between staff and towards patients. Activity to include:

- Provide leadership development opportunities in line with the PTHB leadership development framework that can be accessed at all levels. This includes an approach to leadership succession and talent management
- Evaluate the current culture of the organisation. The health Board is preparing for the National Staff Survey which will enable the Health Board to consider its current culture and identify areas for improvement. The Health Board has undertaken two recent staff surveys and is utilising the outcome of these surveys to ensure that learning can be utilised to improve organisational culture.
- Consider aligning Values and Behaviours Framework to compassionate leadership
- Roll out the national approach to Healthy Working Relationships and the Respect and Resolution Policy
- Consider deployment arrangements including roles/accountabilities of Executive Directors/teams
- Review the resources available to support clinical quality improvement
- Ensure a multidisciplinary approach to clinical risk assessment and management
- Phase two realignment plans are being developed with relevant Directors. These include the Finance Directorate Structure, Performance and Planning Structure and the Professional Structure for Therapies and Health Science

GOAL 3: Develop excellent clinical leadership, to enable high quality clinical care

Visible Clinical Executive Director leadership in the roll-out of the Clinical Quality Framework has been established by the three clinical directors taking responsibility for different areas. Each Director needs to consider if they will name a clinical lead to be responsible for the different areas in their remit. A named lead for clinical outcome measures has been identified and the Assistant Director of Therapies and Health Sciences will be clinical lead for point of care testing and medical devices.

GOAL 4: Implement a defined programme of improvement methodology, to enable high quality clinical care
Using a prioritised and risk-based approach, define and deliver a programme of clinical quality improvement projects

A strategic approach to linking quality improvement to our governance intelligence via a learning committee will be one method that links our future responses to significant risk (identified through mortality reviews, medical examiner feedback, clinical audit, etc). Examples would include identifying educational needs around (for example) sepsis, deterioration or ceilings of care or issues related to patient

experience identified through clinical note-reviews. In relation to selecting the right response to the clinical issue identified our quality improvement team will meet and discuss in the Learning Committee the educational and quality improvement approaches that are necessary to address any specific clinical risks.

GOAL 5: Develop excellent information and intelligence systems, to enable high quality clinical care
Review and develop performance monitoring arrangements for clinical services; aligning to work undertaken on Commissioning Assurance Framework(s)

The Strategic Commissioning Framework sets out the health board's arrangements for ensuring that commissioning is undertaken in a "holistic" way - where there is an integrated understanding of safety, quality, effectiveness, equity, access, cost and the patient experience. Further, the Commissioning Assurance Framework seeks to ensure a safer more holistic and robust understanding of the services currently commissioned with a rules based approach to escalation.

An internal provider CAF report is under development, currently centred on maternity services. This has been used at internal commissioning assurance meetings already. The degree to which this can be adopted more widely, and the policy framework that would cover is currently subject to further discussion.

Agenda item: 3.2

EXPERIENCE, QUALITY & SAFETY COMMITTEE	Date of meeting: 03 December 2020
Subject:	**CONCERNS (COMPLAINTS, CLAIMS AND PATIENT SAFETY INCIDENTS)**
Approved and Presented by:	Alison Davies, Executive Director of Nursing & Midwifery
Prepared by:	Wendy Morgan, Assistant Director Quality & Safety Rebecca Membury, Senior Manager Putting Things Right
Other Committees and meetings considered at:	Quality Governance Group – 11 November 2020

PURPOSE:

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

Recommendation(S):

The Experience, Quality & Safety Committee are asked to discuss and note the contents of this report.

Approval/Ratification/Decision	Discussion	Information
✘	✓	✘

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

EXECUTIVE SUMMARY:

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

DETAILED BACKGROUND AND ASSESSMENT:

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

1. Management of Compliments and Concerns

1.1 Once for Wales Concerns Management System

The Once for Wales Concerns Management System is hosted by the Welsh Risk Pool, supported by Welsh Government and will provide an integrated functionality to support a range of essential patient safety & experience functions. The preparation for the introduction of the Once for Wales Concerns Management System within the health board is overseen by a Programme Board led by the Executive Director of Finance. The new system aims to offer a fresh approach to the capture and use of information for patient and staff safety across NHS Wales.

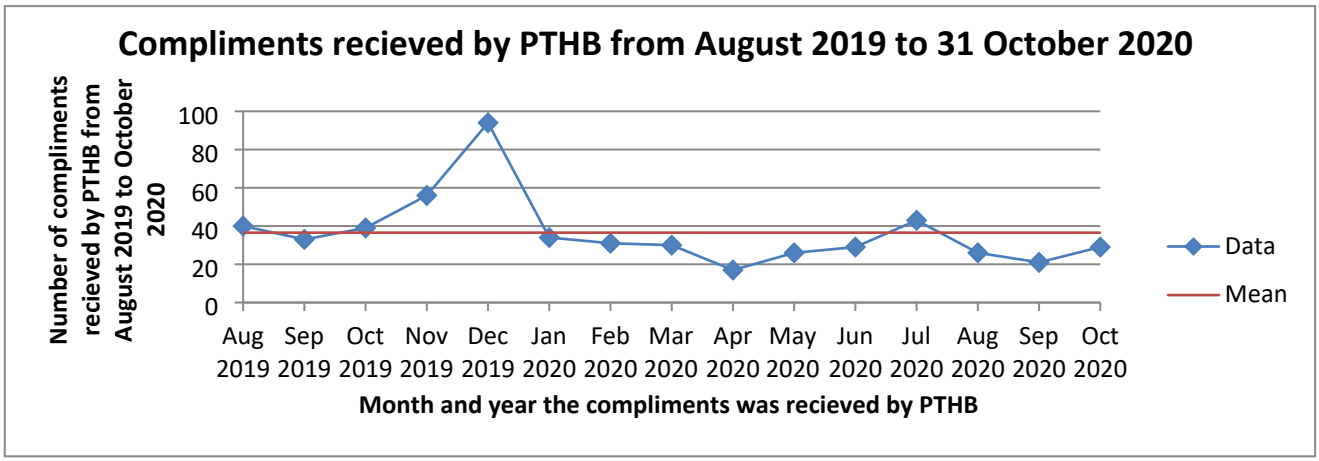
A number of work streams have been setup to help identify how best to implement the new functionalities, which can be adapted and developed to meet the needs of organisations. More detailed information can be sourced through Board and Committee papers related to the health board's digital priorities.

1.2 Compliments

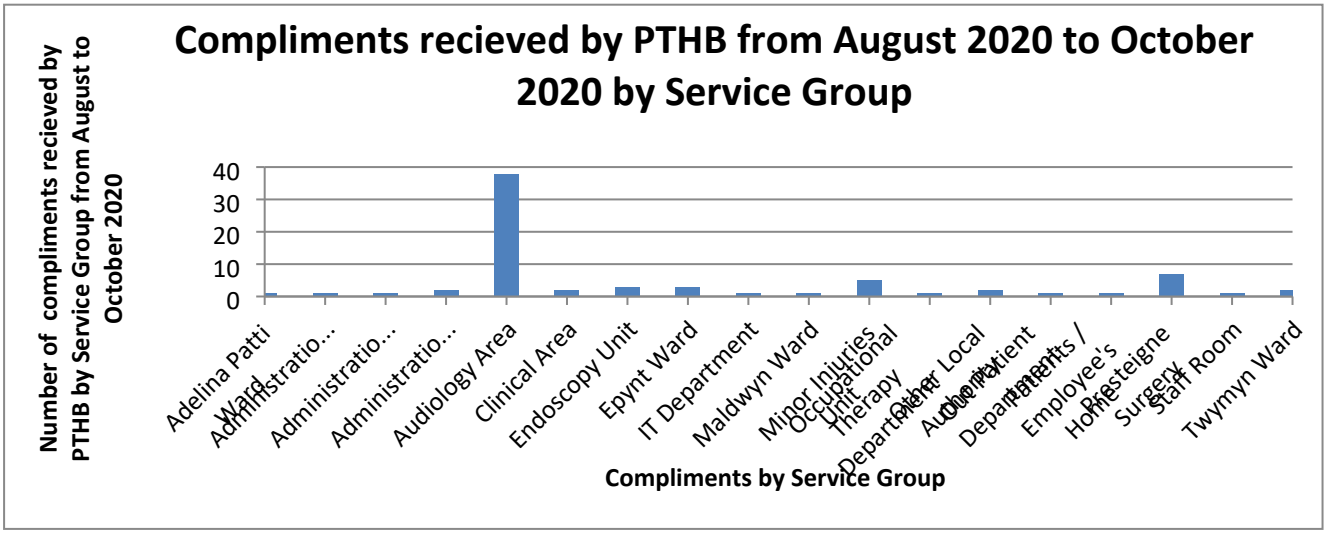
During the period of 01 August 2019 to 31 October 2020, 707 compliments were received by the health board from patients and relatives. These consisted of a combination of cards, and small tokens such as chocolates, expressing thanks and appreciation for kindness, compassionate care and support provided.

During the period of 01 August 2020 to 31 October 2020, the health board received 76 compliments with the Audiology Department still having the highest number of compliments recorded for this time period. The graph below illustrates a reduction in compliments during August to October 2020, this may be in relation to the changes in accessibility and delivery of services or decreased formal reporting of the receipt of compliments.

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



Graph 2: Compliments by Service Group during the period of 01 August 2020 to 31 October 2020



1.3 Complaints

Informal concerns, often termed 'on the spot' concerns usually relate to issues which can be resolved quickly. All concerns, informal and formal, are required to be acknowledged within two working days. Our internal target for the acknowledgement of informal concerns is 100%. During the period of 01 August 2020 to 31 October 2020 the health board achieved 100% of this target. During the same period, the health board achieved 85.3% target in acknowledging formal concerns. Dedicated administration support is continuing to assist improvements in this area.

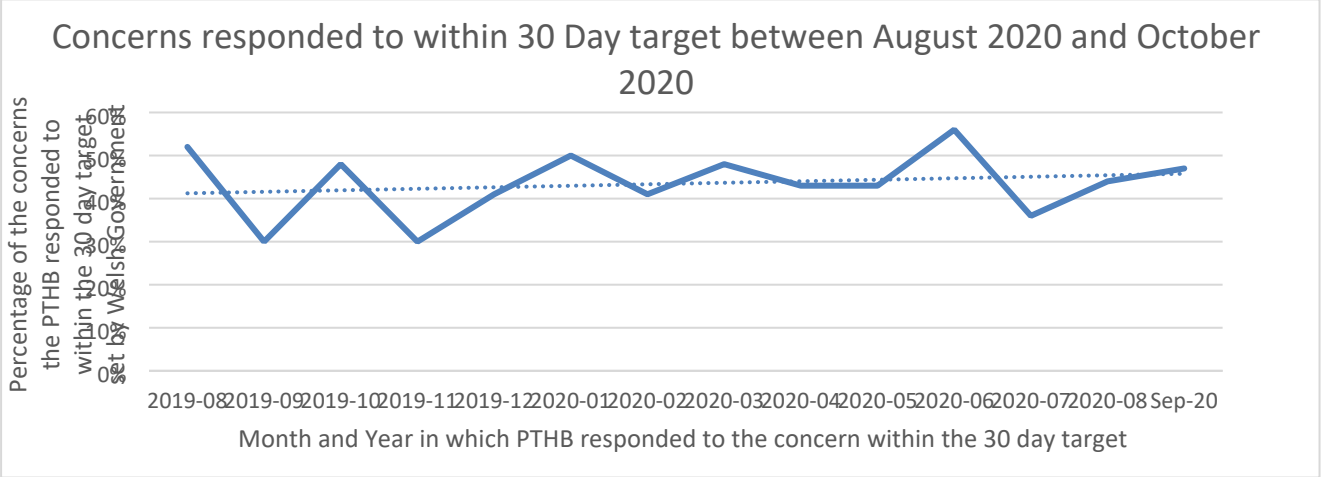
The health board set an internal target of 90% of informal concerns to be responded to within the new Welsh Risk Pool Services and Welsh Government target of 2 working days. From 01 August 2020 to 31 October 2020 the health board received 6 informal concerns, none of which escalated to a formal concern, as issues were addressed immediately, with a satisfactory outcome. From review of the same period of 2019, there is has been a reduction in the number of informal concerns to the health board. This may, in part, be as a result of the changing way in which

services are provided. Increased senior nurse presence in ward areas assists in gaining assurance in relation to the standard of care and treatment being provided.

During 01 August 2020 to 31 October 2020, the health board received 66 formal concerns, the main issue raised related to access to services, including inability to access the Primary Care, in particular, difficulty arranging appointments in a timely manner with the General Practitioner and Dental Teams resulting from the COVID19 restrictions that are in place. The restrictions have meant that General Practice are utilising a triage system before offering face to face appointments and where possible, using digital platforms to consult. In respect of the dental services, the number of appointments that can be offered has reduced which has impacted on the availability of the service for Powys residents.

During this period, the health board responded to 51.5% of formal concerns within the 30-working day target, this is an improvement on previous months and maintains the improvement trajectory but remains below the expected 75% target.

Graph 3 – Percentage of concerns responded to within the 30-day target from August 2019 to 30 September 2020



Data Source: IFOR

An internal review is underway in relation to the way in which the organisation approaches the main aspects of Putting Things Right. Led by the Deputy Director of Nursing, the review will help identify areas of good practice and areas for development. The review is likely to be complete mid December 2020, which will coincide with the more focussed independent review underway in response to the Public Service Ombudsman for Wales special report, subject of a paper included in the agenda for this Experience Quality and Safety Committee meeting. The subsequent programme of improvement required will be supported by the Innovation and Improvement Team.

1.3.1 Concerns raised about Commissioned Services

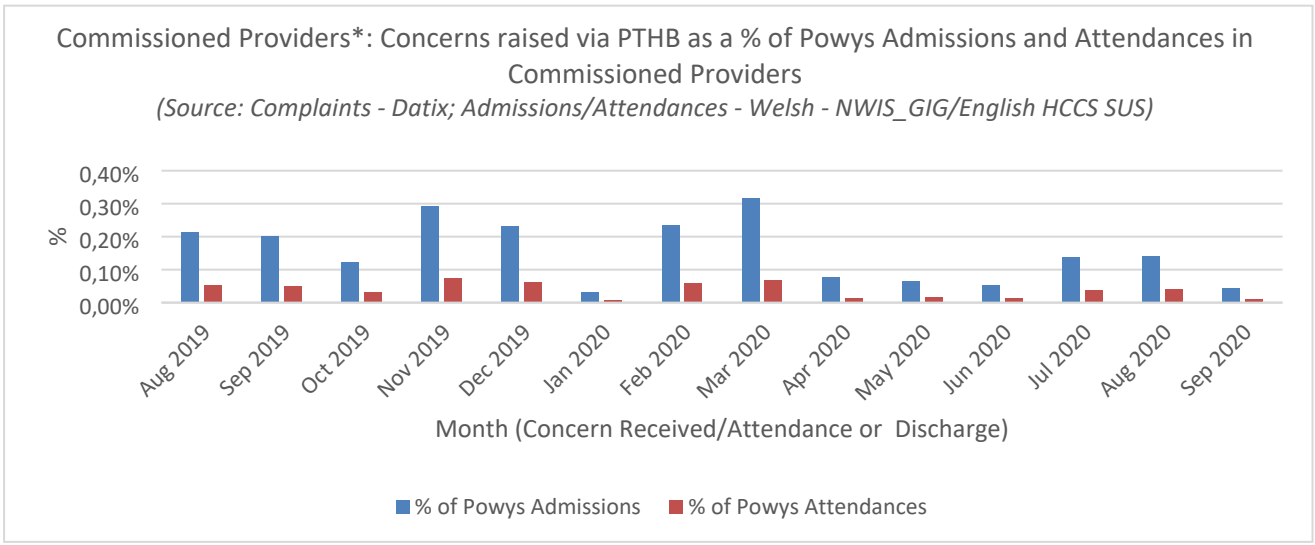
The data presented below is based on the information held by the health board, and whilst a condition within the long-term agreements made with commissioned services, there may be variance in the numbers of complaints made by residents of Powys, and the data shared with the health board, particularly as patients may

liaise directly with the commissioned provider. Sharing of this data continues to be a focus in the regular quality commissioning meetings held with commissioned service providers.

During Quarter 2 of 2020/2021 the health board received notification of 7 concerns relating to commissioned services from differing sources, from review there are no themes or trends identified during this period. From analysis of one year's period from 01 August 2019 to 30 September 2020 it can be seen from the graph below the number of concerns raised during the same period in 2019 are comparable. There is a decline in concerns being raised via the health board during the months

The data in the charts below has been captured and analysed on the basis that the patient admissions/attendances are used as a monthly denominator to give a context to the number/proportion of complaints. It is to be noted that there is no suggestion that complaints in a particular month were made by patients who attended or were admitted in that particular month.

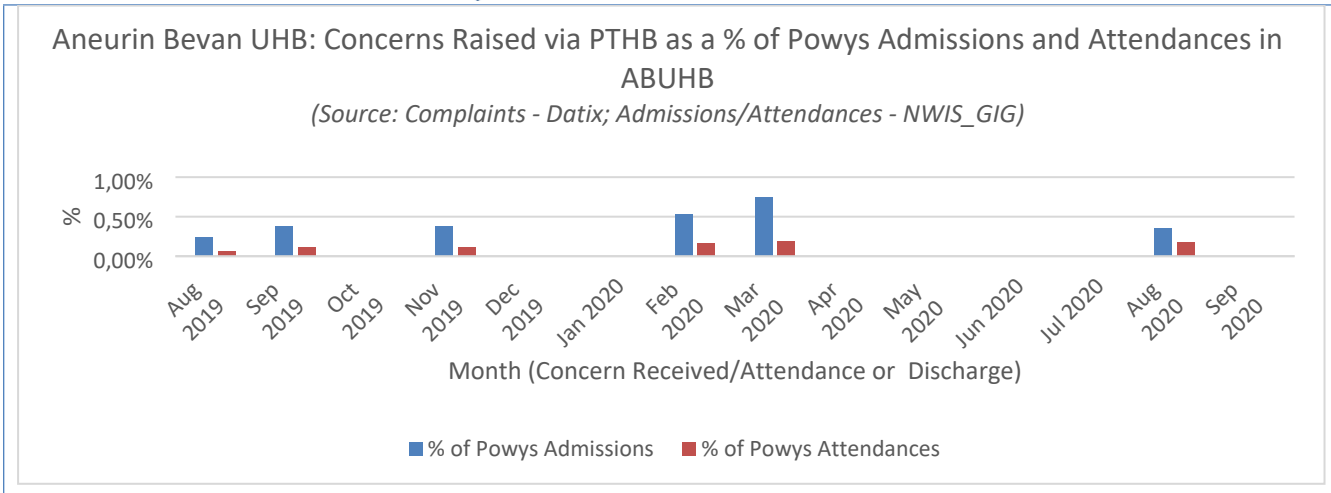
Graph 4: Concerns raised via Powys Teaching Health Board all Commissioned Services providers



Where concerns are raised in relation to commissioned services, the small numbers do not readily enable meaningful identification of themes or trends, however, when triangulated data and intelligence from other sources, an overall perspective of the quality of services proved can be asserted, therefore whilst concerns are presented specifically in this report, the health board's view is also informed by data collected as part of the commissioning assurance framework process.

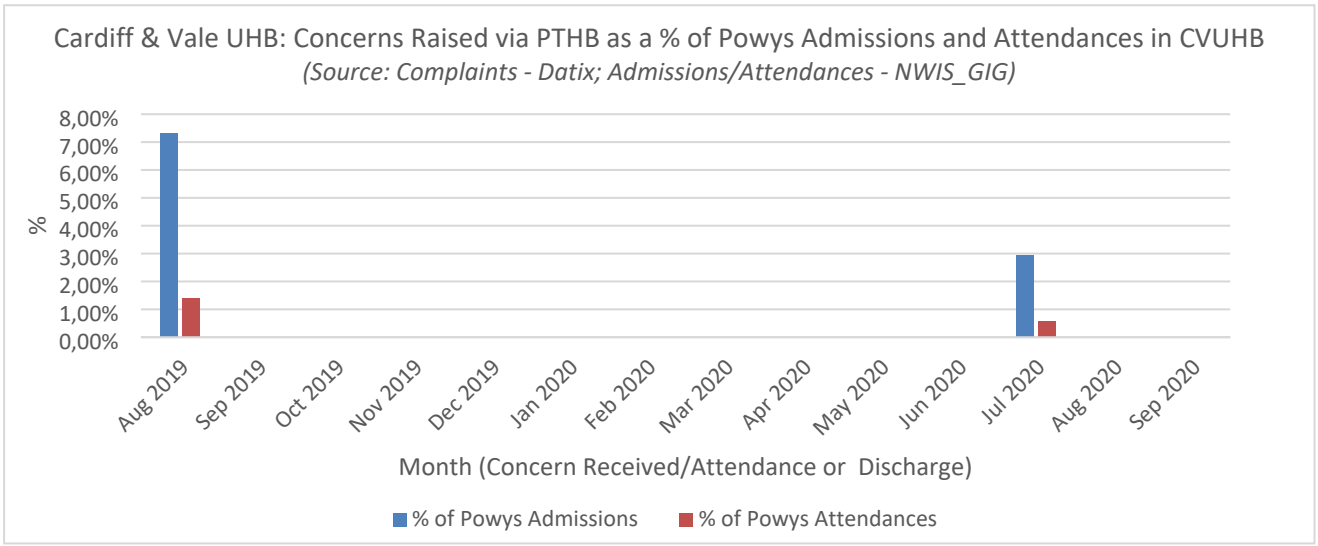
It is noted that from 01 August 2019 to 30 September 2020 no concerns were received in relation to services provided by the following -, University Hospitals Birmingham NHS Foundation Trust, Velindre University NHS Trust, Public Health Wales and Welsh Ambulance Service Trust.

Graph 5 Concerns received about commissioned services from Aneurin Bevan University Health Board (ABUHB)



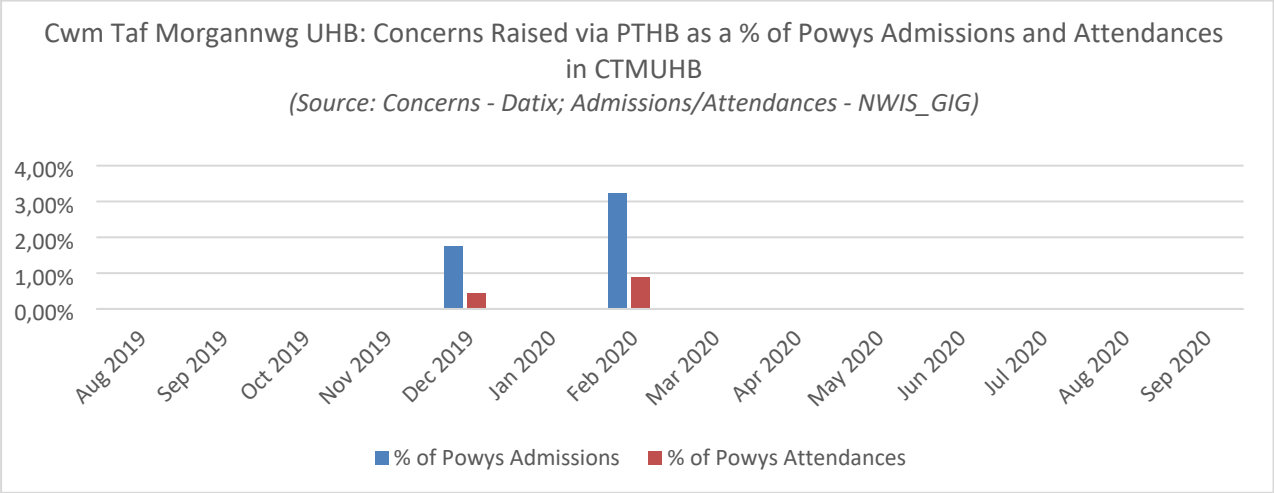
From for the period of August 2020 there have been less than 5 concerns raised about this provide, this is in trend for the same period for the previous year. Overall the concerns for this commissioned provider remains low. This could be in part related to the Covid19 where services were suspended but on the whole the number of concerns raised in relation to ABUHB are small.

Graph 6: Concerns received re commissioned services from Cardiff & Vale University Health Board



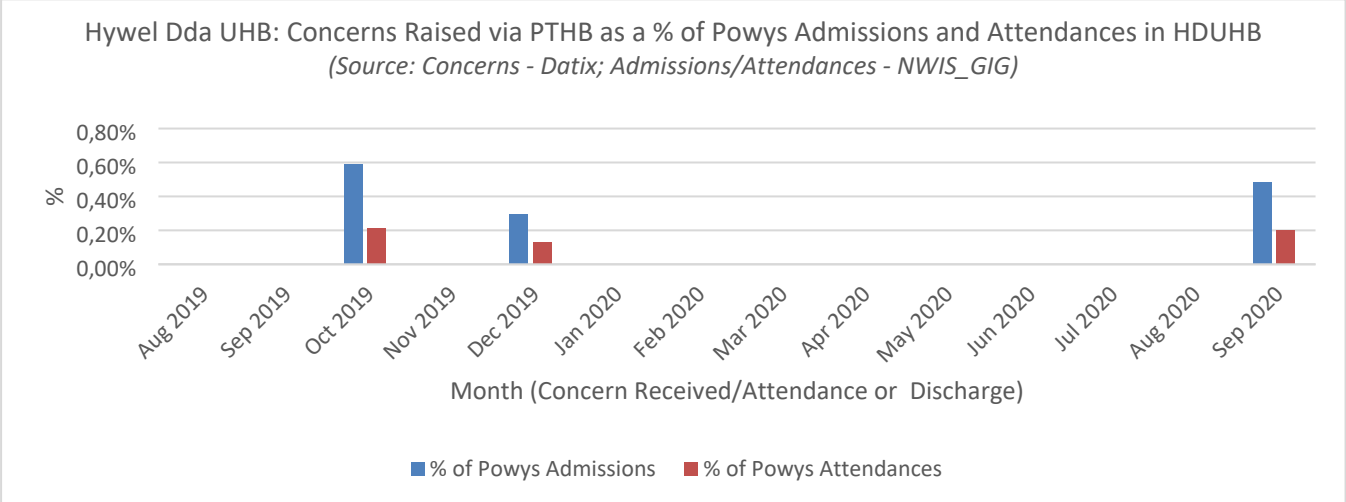
It can be noted that for a period of 10 months, there were no concerns raised via Powys Teaching Health Board about Cardiff and Vale University Health Board, on the whole the concerns numbers are low with less than 5 concerns being raised from July 2020 to September 2020.

Graph 7 Concerns received about commissioned services from Cwm Taf Morgannwg University Health Board



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

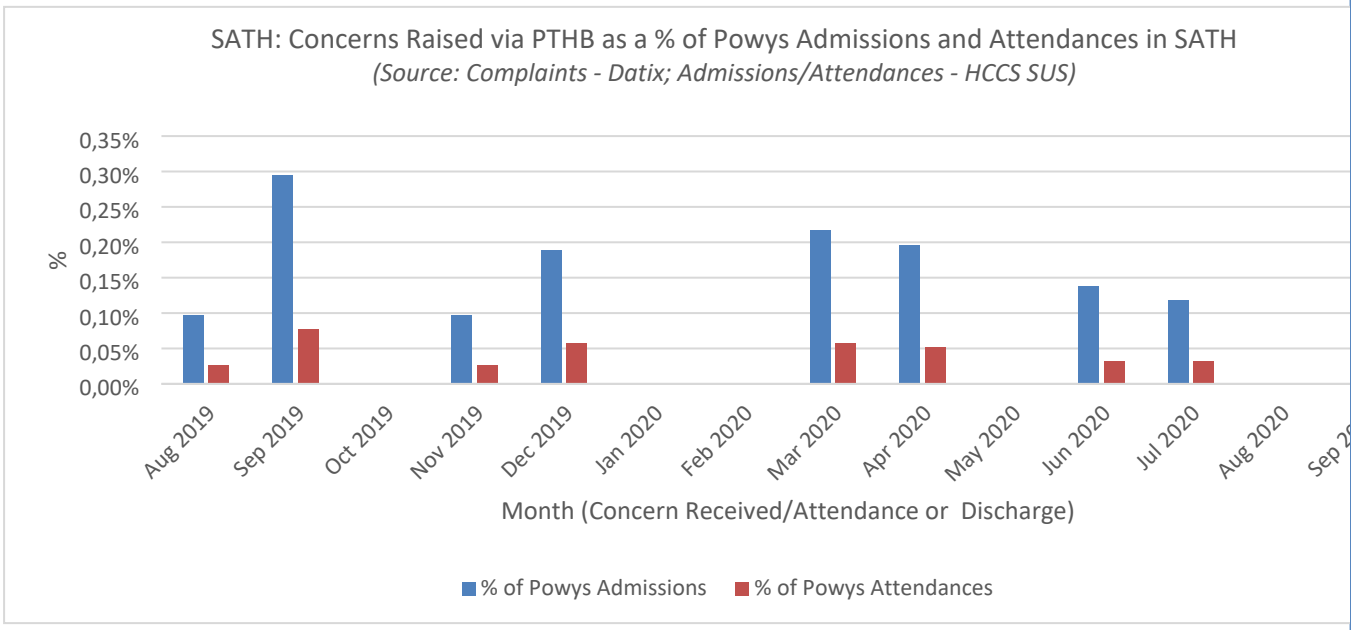
Graph 8 Concerns received about commissioned services from Hywel Dda UHB



In relation to the concerns received about commissioned services from Hywel Dda University Health Board, the numbers are below five for the period of 01 July 2019 and 31 July 2020. It was noted on review, there were no concerns raised between July 2019 to October 2019 and there have been no concerns raised since December 2019 to September 2020 less than 5 concerns have been raised.

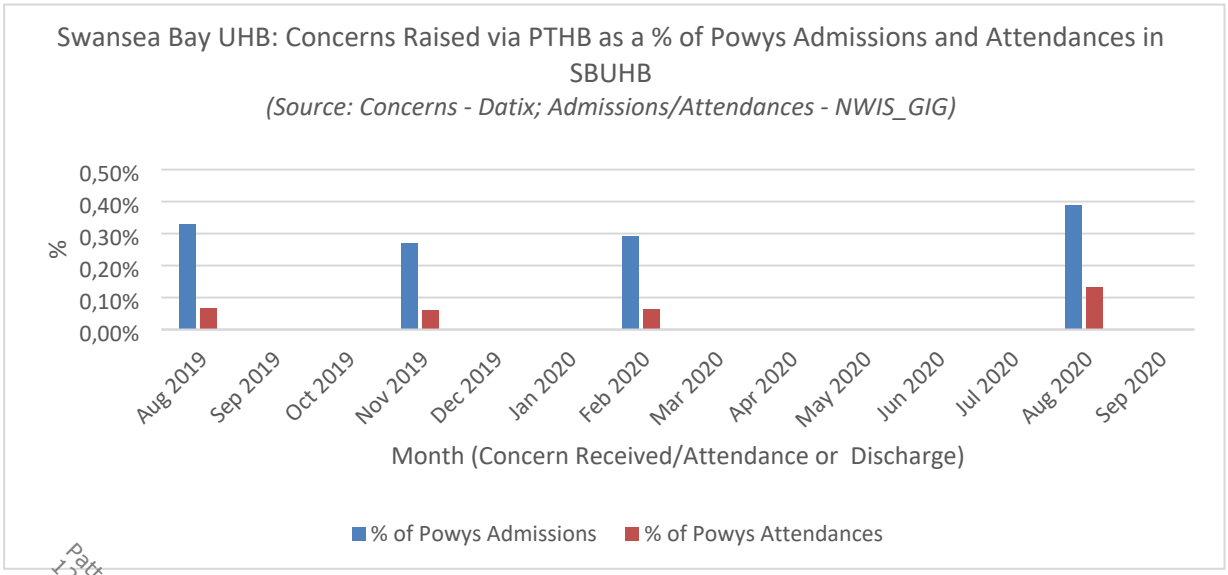
Between the period of 01 July 2019 to 30 September 2020, there have been less than five concerns raised via PTHB about Robert Jones & Agnes Hunt NHS Trust commissioned provider.

Graph 9: Concerns raised via PTHB about Shrewsbury and Telford (SaTH) NHS Trust from 01 July 2019 to 31 July 2020



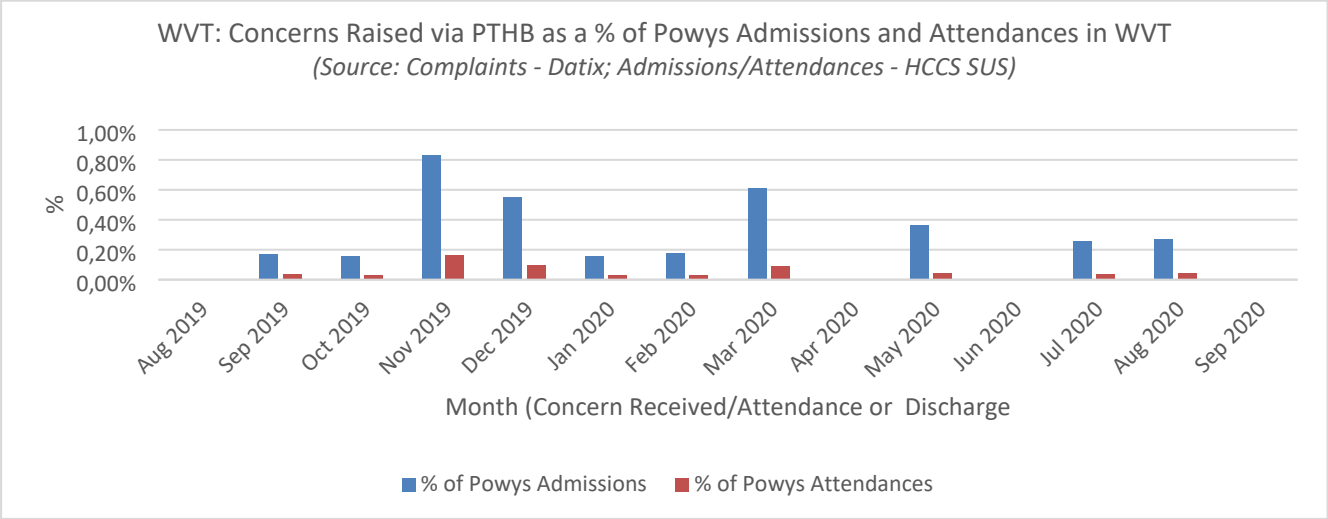
In relation to the concerns received in relation to Shrewsbury and Telford (SaTH) NHS Trust, across the period of 01 July 2019 to 31 July 2020 the number were noted to peak in September 2019 but since this time the number of concerns the health board are aware of has declined. In reviewing the 12 concerns raised by Powys Residents about SaTH there are no identified themes or trends in relation to these concerns. During the period of August 2020 and September 2020 there have been no concerns raised which is why the graph above does not reflect these months as there was no data to capture.

Graph 10: Concerns received about commissioned services from Swansea Bay UHB



From analysis of the data, the health board has received less than 5 concerns about Swansea Bay University Health Board from 01 July 2019 to 30 September 2020.

Graph 11: Concerns raised via PTHB about Wye Valley Trust during 01 July 2019 to 31 August 2020



From review of the data in the above graph, it can be noted that there are peaks when the health board received an increased number of concerns about WVT, from analysis there were no identified themes or trends in relation to the concerns raised. It will be noted that from the period of 01 August 2020 to September 2020 there have been less than 5 concerns raised.

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

1.4 Learning and improving from concerns, patient experience and incidents

This is a key focus for the health board. Reports on learning are presented to the quarterly Patient Experience Steering Group meetings as well as individual learning through wards and departments, newsletters, and 'you said, we did' boards. The Medical Director's proposal in relation to development of a health board wide learning group is gaining pace and a regular section within Powys Announcements has been secured to share learning in relation to COVID19, this will support early learning being collated and made available via the Delivery Unit, related to in-hospital transmission of Covid-19 (CoRSEL) (**appendix 1**).

Identifying local and shared organisational learning opportunities is a critical part of the improvement process. This enables us to target relevant areas, systems and processes for improvement and to prevent the reoccurrence of similar (or more serious) incidents occurring in the future. To develop a culture of learning, the system must contain and recover from errors as quickly as possible focusing on what needs to change and being alert to the possibilities of learning and continuous improvement. Recent examples of improvement include:

- Following a concern raised regarding a delay in referral to physiotherapy services, the team made improvements to the appointment booking process. Correspondence is now to be sent to patients if no response is received to the

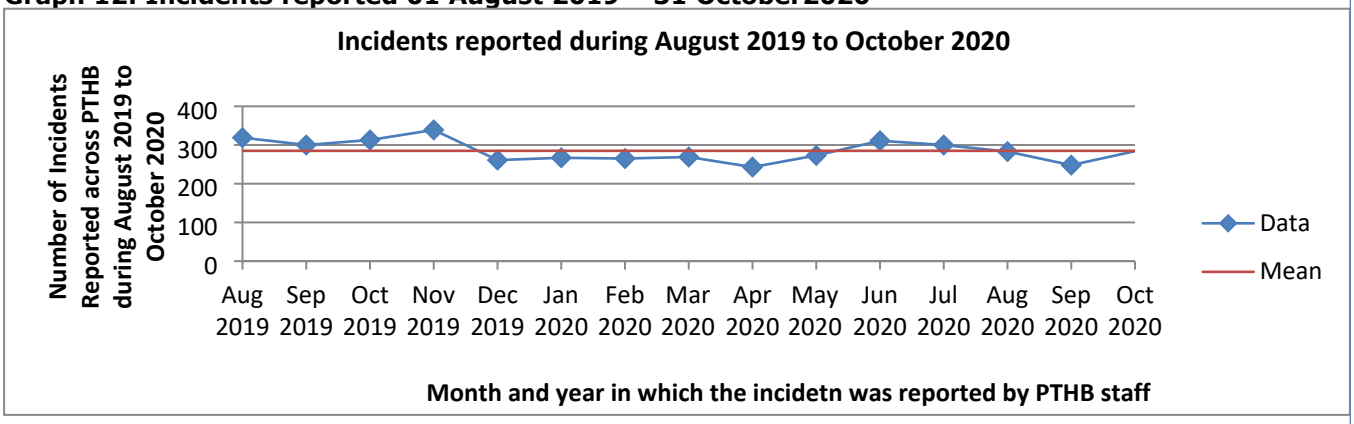
partial booking letter/invitation, prior to the patient being removed from the waiting list.

- The Community Services advised that by way of learning and looking at the 'so what' from an incident that occurred relating to pressure damage experienced by a person receiving care, the community nursing team have made far more explicit how and when to contact the team in between scheduled visits. This is something that is often verbally communicated to families but often isn't documented, this improvement to the care plans for patients will support communication.
- Mental health services identified the need to review their policy related to the contract made at commencement of an episode of care following a concern raised by the parent of a young person who arrived late for an appointment
- The Quality & Safety Commissioning Lead has completed a survey of Powys residents attending the Royal Wolverhampton NHS Trust (RWT) outpatient department for the period April 2018 to December 2019. Overall the survey found the 85% of the people that responded felt their overall experience was good, the findings are detailed in **appendix 2.** RWT are scheduled to provide feedback at the end of November following discussion of the findings of the questionnaire.

2. Incident Reporting by Service Group

During the period 01 August 2020 to 31 October 2020, there have been 815 reported incidents (graph 12), which is reflective of the average number reported (see graph 13 below).

Graph 12: Incidents reported 01 August 2019 – 31 October2020

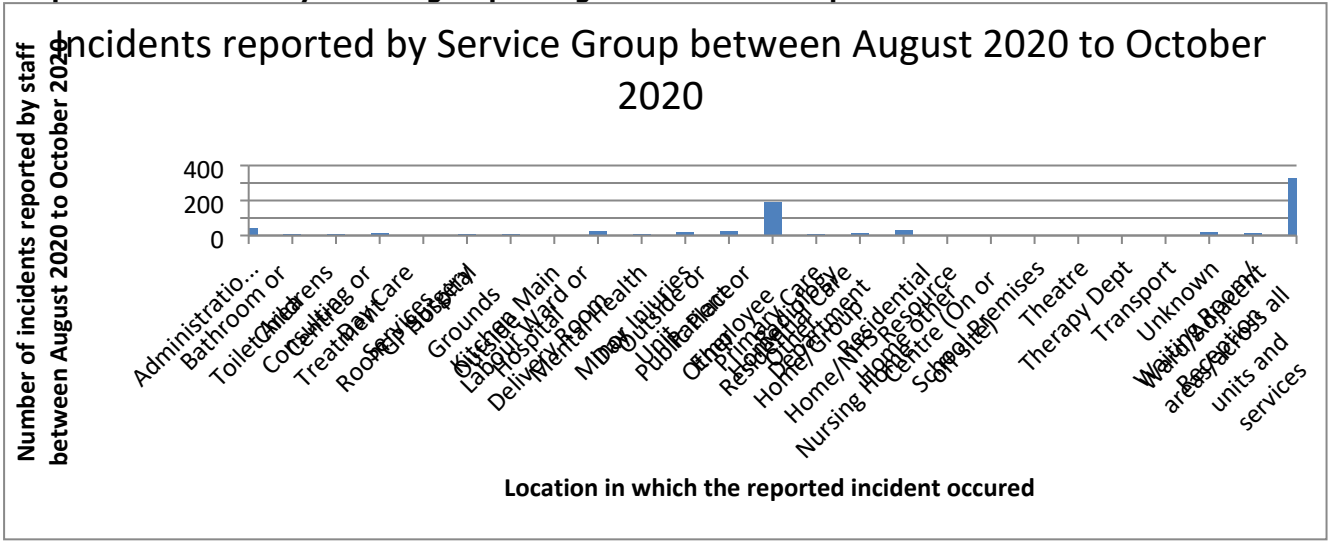


It is noted over the last year there is variation in the number of incidents reported month on month, the range 213-339, and average of 283 incidents per month. A total of 3,963 incidents reported for the whole year, a reduction is noted in the month of April 2020, which may reflect the reduced activity and low bed occupancy as a result of Covid-19. A decline in reporting since June 2020 is noted, and the incidents are lower than this time last year, possibly related to changes to service delivery as a result of the COVID19 pandemic. This decline is being reviewed for any identifiable trends or themes being identified as a result of the decline.

Incidents increased between May – July 2020, with a decrease in reporting during August and September 2020 but from review this has increased again during

October 2020. There are a number of factors that may affect reporting rates, including lower bed occupancy during this period. It is noted that there is an increase in incidents being reported being linked to the patient's home, the increase could be due to greater awareness, increased reporting and strengthened nurse leadership via the Head of Nursing, who will monitor for themes or trends. Tawe Ward, is also an area for higher levels of reporting.

Graph 13: Incidents by service group 1 August 2020 to 30 September 2020

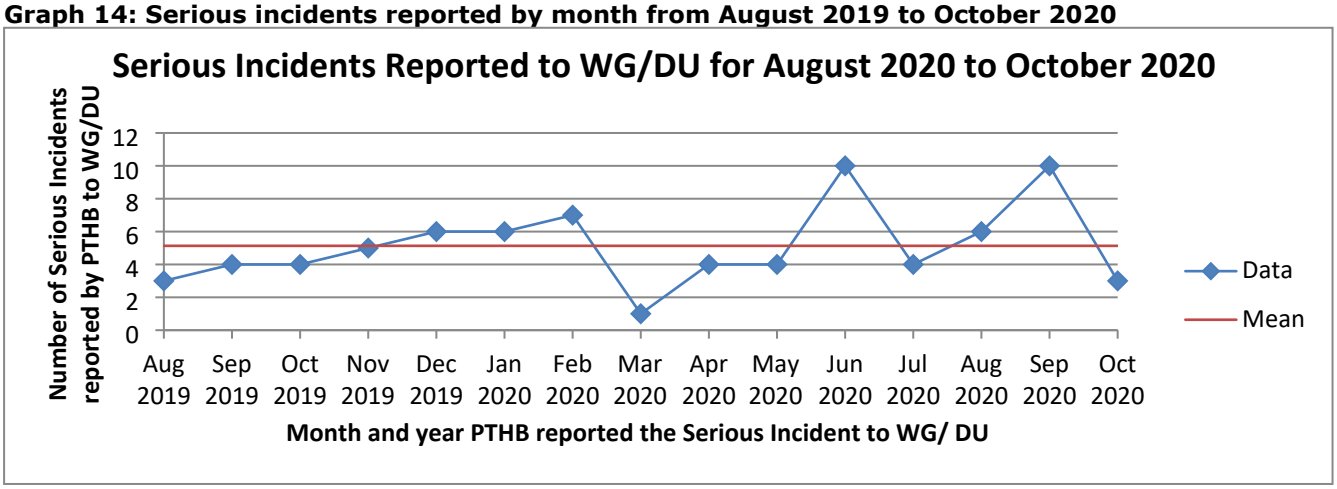


2.1 Serious incidents

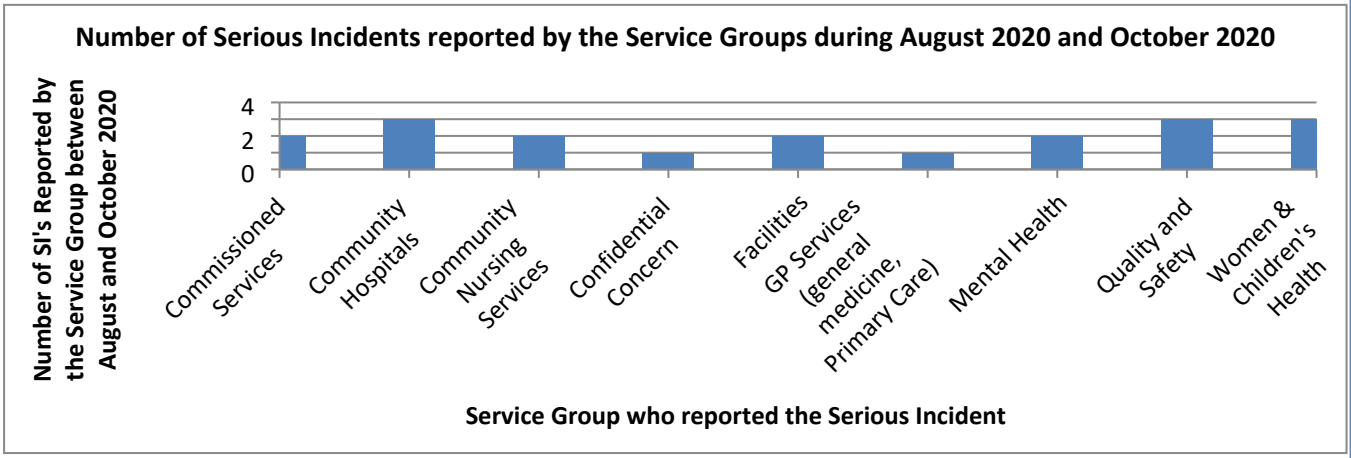
A serious incident is defined as an incident that occurred during the provision of NHS funded healthcare. All serious incidents were reported to Welsh Government until the 01 October 2020. All serious incidents reported post 01 October 2020 are now to be reported to the Delivery Unit, the health board is required to provide the Delivery Unit with an assurance that a robust investigation for a serious incident has been completed and learning identified within 60 working days. Welsh Government have recently issued a list of open serious incidents pre-1 October and actions are being progressed across the heath board to ensure learning is captured and shared. The development of a serious incident tracker for open actions has taken place and this will be developed further over the coming weeks to ensure closure of open actions timely, lessons are learnt and shared and assurance on actions taken in place.

During the period of 01 August 2020 to 31 October 2020 the health board reported 19 serious incidents to Welsh Government. The decrease in reporting during August and September 2020 can be noted in the graph below, however from review of the same period for 2019, there is an increase reporting during this time. From review of the October 2020 data there is decrease in reporting of SI's this could be attributed to the second wave of COVID19 but further review any analysis of this data will be undertaken and reported in the next meeting for assurance.

Graph 14: Serious incidents reported by month from August 2019 to October 2020



Graph 15: Serious Incidents by Service Group from 01 August 2020 to 31 October 2020



3. No surprises notifications

Welsh Government are notified of sensitive issues via a process known as 'no surprises' these are closed automatically within 3 working days. Between 01 August 2020 and 31 October 2020, the health board have made 9 reports to Welsh Government. As noted in the previous paper, from 01 August 2020, Welsh Government have agreed to accept a no surprises report in relation to a serious incident that has occurred in commissioned services which is why there is an increase of reporting. This will provide an added level of oversight and scrutiny in relation to the experience of the people of Powys in receipt of care from other providers.

4. Inquests

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

The HM Coroner is currently considering alternative means by which to undertake inquests and from August and until 31 October 2020, it is noted the position has not changed since the previous paper with dates are now being listed with the caveat of significant delays likely to exceed the 6 months' timescale detailed in the Coroners Rules 2009.

5. **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 the Public Services Ombudsman (PSOW). The PSOW determines whether to pursue a full investigation, with the authority to impose sanctions on the health board by way of financial compensation to the complainant. In addition, there PSOW can issue a Public Interest Report and reports issued under Section 16 or Section 21. During the period of 01 August 2020 and 31 October 2020, the health board have received less than 5 PSOW enquiries.

In October 2020, the health board received a Special Report issued under s28 of the Public Services Ombudsman (Wales) Act 2019 following a complaint made by Mrs A against Powys Teaching Health Board. Please see the specific report on this matter included in this meeting of the Experience Quality & Safety Committee.

6. **Claims**

Powys Teaching Health Board has a small claims portfolio; there are currently 15 open which are inclusive of clinical negligence and personal injury claims. During 2019-2020 the health board were managing 11 clinical negligence claims with an additional 8 potential clinical negligence cases that could progress following the initial disclosure of the medical records to the claimant's solicitors. The claims pending remain with the health board until NWSSP Legal and Risk Services are formally instructed. The health board currently have less than 5 personal injury cases being managed by NWSSP Legal and Risk Services. From review of the claims for the health board there have been no identified themes and trends.

NWSSP Legal and Risk Services have completed and impact and reach report to give an update on the services they provide. A copy of the report is attached for your information. (**Appendix 3**).

7. **Patient Safety Solutions**

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

Action has been taken to progress compliance with the three open patient safety solutions indicated as non-compliant.

PSN 034: Supporting the introduction of the National Safety Standards for Invasive Procedures – updated from theatres received and a further update on the current compliance position awaited.

The following two patient safety notices are currently being prepared for reporting compliance or non-applicable status to Patient Safety Wales.

- PSN 051 Depleted batteries in intraosseous injectors
- PSN 052 Risk of death and severe harm from ingesting superabsorbent polymer gel granule

NEXT STEPS:

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

GIG CYMRU NHS WALES | Delivery Unit Uned Gyflawni

To: Executive Nurse Directors
Assistant Directors and Heads of Quality & Patient Safety
Quality & Patient Safety Teams

26 October 2020

Dear Colleagues

Sharing early learning related to in-hospital transmission of Covid-19 (CoRSEL)

Further to the correspondence from Welsh Government on 6 August 2020, as well as recent discussions with Executive Directors via our six monthly quality & safety meetings, we are writing to all Health Boards and Trusts in Wales to promote CoRSEL, the pilot system for Covid-19 Rapid Sharing of Early Learning.

Why do we need a new system for sharing early learning?
Whilst there are many local and national systems for sharing learning from investigations and reviews, sometimes it can take weeks or months for investigations to be completed. However, some of the most important learning can occur within hours or days of an incident or event. It's therefore important that NHS organisations can quickly and easily share that learning with each other, so other organisations can take steps to make local improvements where necessary.

Additionally, not all learning is related to incidents, outbreaks or events – learning can come from near misses, and of course from good ideas or practices that staff want to share. However there aren't always national mechanisms for sharing this kind of learning.

In establishing CoRSEL, we heard from NHS staff that while early learning was being shared through personal and professional networks, sometimes the messages took too long to get to the right part of the organisation to make effective and systemic changes. We wanted to set up a one-stop system that NHS organisations could use to rapidly share their early learning about in-hospital staff or patient transmission of Covid-19, whether from incidents, events, outbreaks, near misses and/or good practices.

Currently the scope of CoRSEL is limited to in-hospital transmission while the system becomes established, but may be expanded in the future if organisations find it a useful mechanism for sharing learning.

How can I share my organisation's learning through CoRSEL?
The original proposal for CoRSEL involved NHS staff sharing their learning points directly into a dedicated database. Feedback received to date has been that this is not the preferred mechanism for NHS organisations.

We are therefore changing the process to ask HBs/Trusts to share early learning through the following mechanisms:

- Where early learning relates to a Serious Incident which will be notified to the DU, early learning can be shared using the existing updated National SI reporting form (v4.0).
- For all other early learning (i.e. not associated with an SI), the attached form can be used and emailed to PatientSafety.Wales@wales.nhs.uk.

The purpose of having a form to share learning is to provide organisations with reference points for the information needed for sharing, and to support the audit trail. This system is not subject to performance management and learning shared via CoRSEL will not be used for this purpose.

What will happen with learning my organisation shares via CoRSEL?
The DU will log learning points into the SharePoint database to act as a central repository of learning shared through this process.

Learning points will be reviewed by an oversight group which includes membership from the DU, Welsh Government, Public Health Wales, and Improvement Cymru. Anonymised learning messages will be disseminated back to NHS organisations via the DU's existing communications network for Patient Safety Alerts and Notices. Individual organisations receiving those learning messages can then decide if they need to make any local changes as a result.

We have a great opportunity to help each other by sharing early learning in relation to Covid-19, However CoRSEL can only be successful if Health Boards and Trusts in Wales share their learning through this system.

We look forward to the support of all Health Boards and Trusts across Wales in sharing early learning related to Covid-19 through CoRSEL. Please don't hesitate to get in touch with any questions or concerns.

Yours sincerely,

Quality & Safety Team
NHS Wales Delivery Unit
PatientSafety.Wales@wales.nhs.uk

NHS IN-PATIENT & OUTPATIENT COMMISSIONING SURVEY 2019

QUALITY & SAFETY UNIT

COMMISSIONED SERVICES

THE ROYAL WOLVERHAMPTON NHS TRUST

07/10/2020

SURVEY BACKGROUND

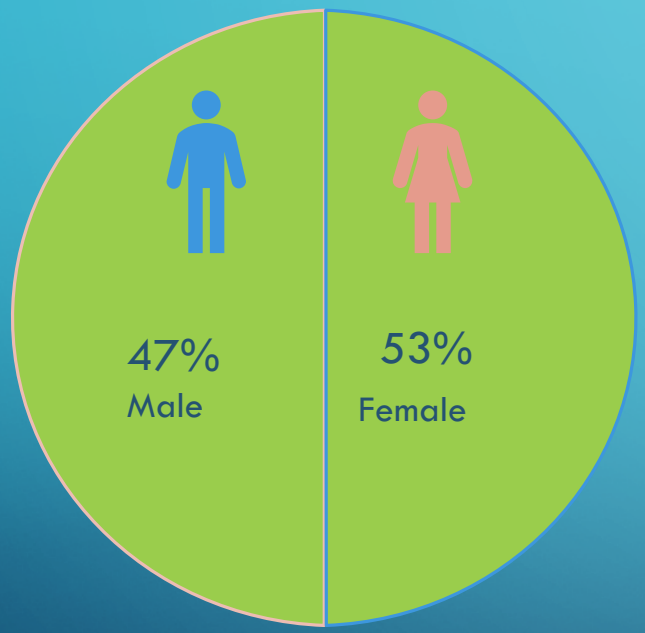
May 2017: Wolverhampton provided Neurology services for Powys patients due to an unplanned withdrawal of this service provided by Shrewsbury & Telford NHS Trust.

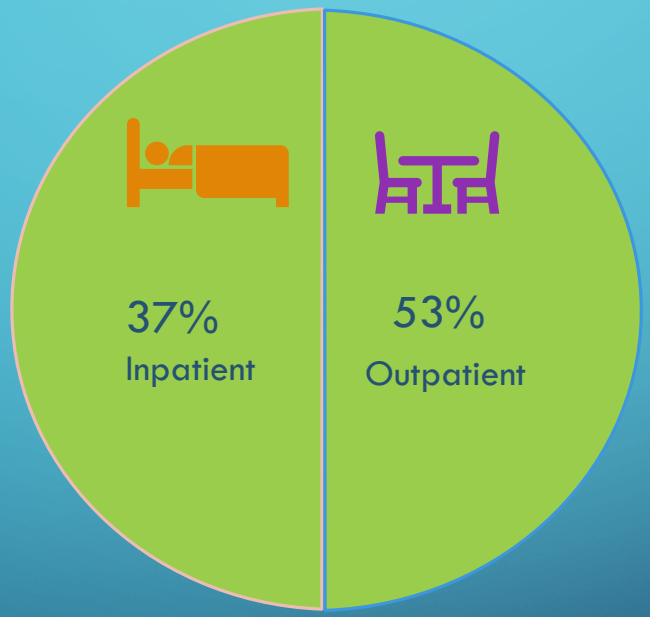
A Long Term Agreement was signed & agreed in May 2017. The services commissioned was across all specialities, inpatient, outpatient, diagnostic, therapy, mental health & critical care with the exemption of Maternity & Emergency (core services). All services provided are elective and planned.

343 Powys residents received care at The Royal Wolverhampton NHS Trust during the period of April 2018-December 2019	**7.5%** Out of 343 Patients 7.5 % no longer lived in Powys	**3.5%** Out of 343, 3.5% were Identified as deceased	**89%** Patient Satisfaction Questionnaire posted	**27%** Of the 89%, 27% questionnaire's were completed and returned.

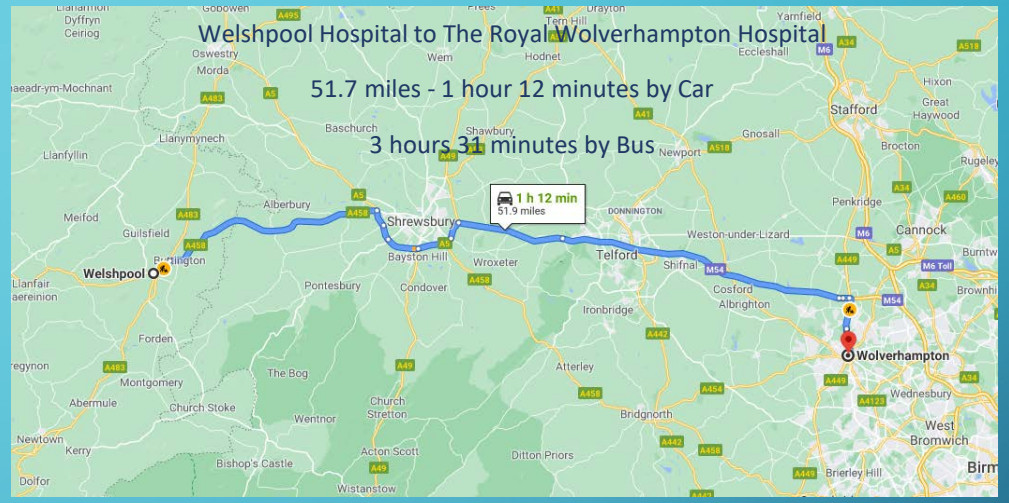
DEMOGRAPHICS

343 Powys residents received care at The Royal Wolverhampton Hospital during the period of April 2018/ December 2019





POPULATION



Information from Google Maps

- 26% of Powys residents are aged 65 or over compared to England 18%
- The population of North Powys is currently 63,271, the main centres of population include Newtown (11319), Welshpool (6668), Llanidloes (2804) and Machynlleth (2213)
- These areas have many challenges with rural communities, some areas of high deprivation and an ageing population. There are transport challenges with long distances to the nearest District General Hospitals .
- One of the main issues raised by Powys residents reflects on the change of travelling time, the bus or train route are not direct and require some transfers.

QUESTIONNAIRE

1. Questionnaire was based on the Health Care Standards:

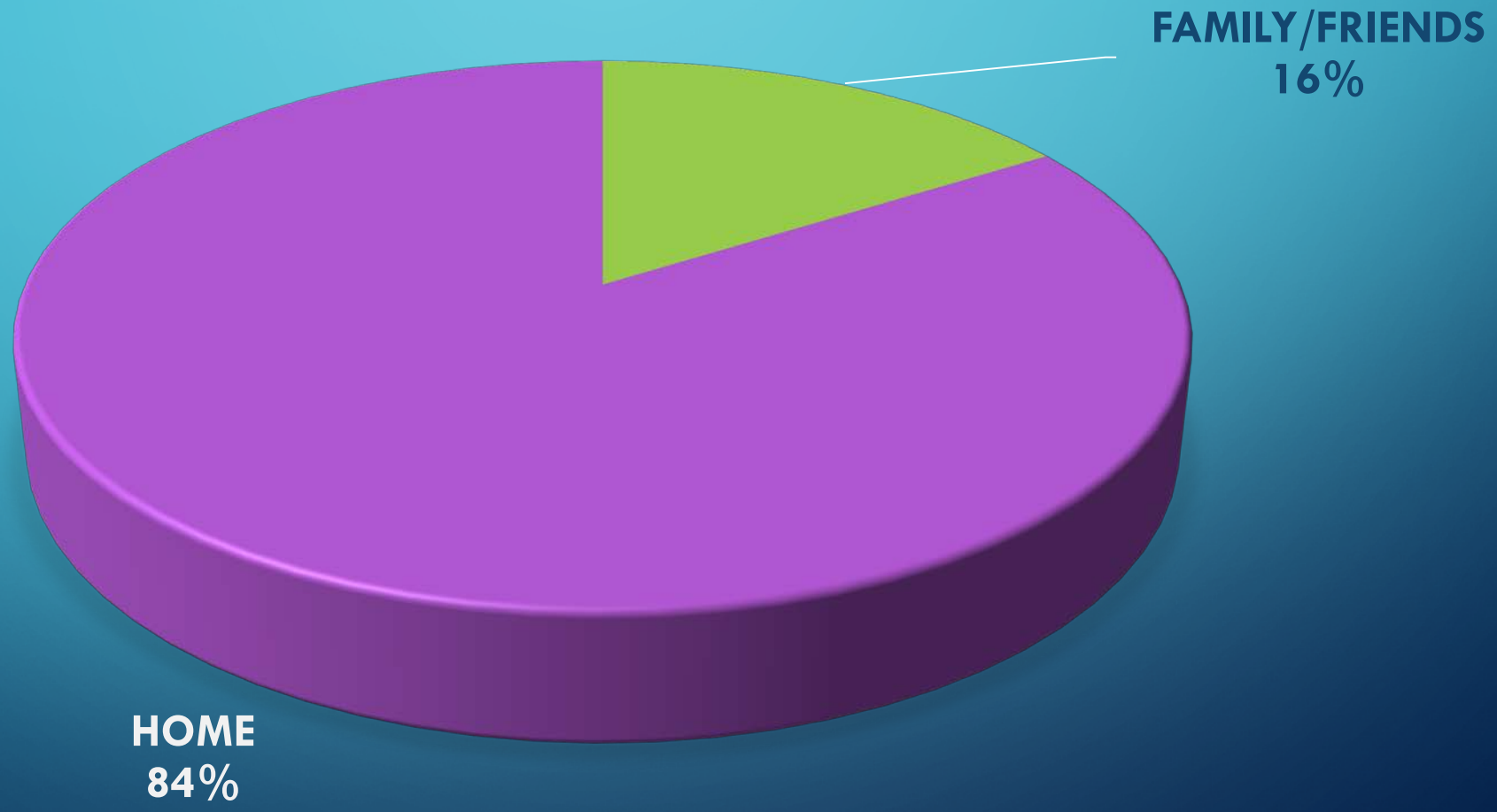
- Theme 2: Safe Care
- Theme 3: Effective Care
- Theme 4: Dignified Care
- Theme 5: Timely Care
- Theme 6: Individualised Care
- Theme 7: Workforce

2. The Questionnaires did not have any patient demographics entered.

3. Each patient was allocated a specific number, the aim was to listen to the patient experience, and any urgent issues arising, to take action.

DISCHARGE OUTCOME

Q21. WHERE WERE YOU DISCHARGED TO WHEN YOU LEFT THE HOSPITAL? PLEASE SPECIFY



Patterson, Liz
12/01/2020 12:33:19

THEME 2: SAFE CARE

- 2.4 Infection Prevention & Control

Q3	In your opinion was the environment Clean	Yes	No
		99%	1%

- 2.5 Nutrition & Hydration

Q7	Where you offered a choice of food at meal times?	Yes	No	N/A
		31%	4%	65%
Q8	How would you rate the hospital Food?	Good	Fair	Poor
		84%	15%	1%
Q9	Did you get enough support from staff to eat your meals?	Yes	No	N/A
		20%	0%	80%
Q10	During your time in hospital, did you get enough to drink?	Yes	No	N/A
		38%	4%	58%

- 2.6 Medicine Management

Q16	During your visit were you in any pain?	Yes	No	N/A
		15%	85%	0%
Q17	Do you think the staff did everything they could to help control the pain?	Yes	No	N/A
		15%	0%	85%

THEME 3: EFFECTIVE CARE

- 3.1 Safe & Clinical Effective Care

Q22	After leaving the hospital, did you get enough support from health or social care professionals to help you recover & manage your condition?	Yes	No	N/A
		66%	6%	28%
Q28	After being discharged was the care and support you expected, available when you needed it?	Yes	No	N/A
		28%	6%	66%

- 3.2 Communicating Effectively

Q11	When you had important Questions to ask the Medical Staff, did you get the anwers that you could understand?	Yes	No	Sometimes
		95%	3%	2%
Q12	When you had important Questions to ask a Nurse, did you get the anwers that you could understand?	Yes	No	N/A
		79%	4%	17%
Q26	Did the doctors or nurses give your family, friends or carers all the information they needed to help care for you?	Yes	No	N/A
		52%	20%	28%
Q27	did the hospital staff tell you who to contact if you were worried about your condition or treatment after you left the hospital?	Yes	No	N/A
		73%	20%	7%

- 3.4 Information Governance

Q14	Were you given enough information about your condition or treatment?	Yes	No	Sometimes
		83%	12%	5%
Q24	Before you left the hospital were you given any written or printed information about what you should or should not do after leaving hospital?	Yes	No	N/A
		56%	16%	28%
Q25	Where you given clear written or printed information about your medicines on discharge?	Yes	No	N/A
		83%	2%	15%

THEME 4: DIGNIFIED CARE

- 4.1 Dignified Care

Q4	While visiting the hospital, did you ever share a sleeping area, with patients of the opposite sex?	Yes	No	N/A
		4%	93%	3%
Q5	Did they move you to another ward during the night?	Yes	No	N/A
		5%	64%	31%
Q6	Did you get enough support from staff to maintain your personal hygeine?	Yes	No	N/A
		32%	1%	67%
Q15	Where you given enough Privacy during your visit?	Yes	No	N/A
		95%	1%	4%
Q29	Overall did you feel you were treated with respect?	Yes	No	N/A
		99%	1%	0%

THEME 5: TIMELY CARE

- 5.1 Timely Access

Q2	From the time that you arrived at the hospital, did you have to wait a long time to be seen?	Yes	No	N/A
		10%	90%	0%

THEME 6: INDIVIDUAL CARE

- 6.1 Planning & Independence

Q13	Were you involved as much as you wanted to be in the decisions about your care?	Yes	No	N/A
		80%	8%	12%
Q19	Did you feel you were involved in decisions about your discharge from the hospital?	Yes	Fair	Poor
		69%	5%	26%
Q20	Were you given enough notice about when you were going to be discharged?	Yes	No	N/A
		72%	1%	27%

THEME 7: STAFF & RESOURCES

- 7.1 Workforce

Q18	If you needed attention, were you able to get a member of staff to help you within a resonable time?	Yes	No	N/A
		60%	4%	36%

Q30: OVERALL EXPERIENCE RATE

PATIENT FEEDBACK

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

I was referred from RSH. How different, I can't Praise the surgeon & Staff for their time & Care

Water Jug always available and fresh.

This has to be the best hospital within 70 miles for people living in Mid-Wales!

I have also used the A&E at Newcross and I could not fault them in anyway.

Extremely professional at all times, but always time to stop and have a chat.

Dr Raglan is an outstanding consultant, nothing is too much trouble for him! He deserves a pay rise!

Everyone at the diabetic clinic is superb

My experience was a positive one, I have just been disappointed with my follow up.

The best hospital within 100 miles for me would not go any where else, I have been in several wards and they were all the same quality

I thank all the staff on B14 for their patience & information, they knew how upset I was (far away), so good at informing me clearly as husband's wellbeing. Very professional & compassionate conduct.

Kept Well Informed

Even though I had to travel it was worth it from specialist down to cleaners & Porters I was so impressed.

Dr Newman & all staff are wonderful, we are extremely lucky to have them

Dealt with Speed on arrival in A&E

Don't stop the service outstanding care

A BIG Thank You!

Following a car crash, they were very fast & efficient. If I ever need to go to a hospital again, Wolverhampton is the place for me

Considering the pressure these professionals work under, I have nothing but admiration for the way they carry out their duties. I was listened to, this is a Rare attribute. These comments do not apply to management.

Radiology team, kind & caring

As an inpatient the NHS was outstanding for my Op and Recovery

Mrs Matey at RWT & Team the care I received was excellent

Don't want to go anywhere else, felt **SAFE**

Cleanliness & food excellent

They care for the families, & that is very reassuring

I please keep this place it is an asset.

I have never been seen before my appointment Great!

There is nothing better to heal you than having somebody who listens, & They do!

PATIENT FEEDBACK

Very busy & parking poor

Had a scan May 2019 and as of February 2020 still waiting for the results, GP practice still waiting for results!

Had my hip done which was a great experience however a long way to travel for a Follow up appointment.

Neurological appt had to share room with stroke patients, I was not sure if I was in the right place, signage is poor.

I was moved at 12 midnight, however not before asking & explaining why, They were desperate for beds, I did find it difficult to fall asleep again, handy I had a good book!

As a young girl I would like to be asked before a male nurse tries to help me on the loo as I have Asperger's. However once I explained they sent for a female.

Consultant American, had limited geographical knowledge of Welshpool & access.

X4 appointments each 130 miles! Not sure what can be done! Care was good

Was taken for an x-ray from the ward, waiting area very cold, x-ray staff asked for another blanket, apparently they do not hold a stock of blankets. However the staff were very efficient and caring.

Clinics run late, but we were always told why.

2 ½ hours travel by train, catering poor for an outpatient appointment

A good Café would be helpful, too small, Catering offer poor, had I known this I would have brought a lunch box!

Clean but run down

Stressful trip, bus, train & Taxi.

140 mile round trip!

IMMEDIATE ACTION

- **Had a scan May 2019 and as of February 2020 still waiting for the results, GP practice still waiting for results!**
- PTHB Q&S unit contacted RWT and requested to fax scan results to GP practice, GP practice contacted to confirm scan results received and requested to contact patient.
- **As a young girl I would like to be asked before a male nurse tries to help me on the loo as I have Asperger's. However once I explained they sent for a female.**
- PTHB Q&S Unit raised at RWT Clinical Quality Review Meeting, agreed to raise with unit sister and raise awareness with ward staff.
- **Neurological appt had to share room with stroke patients, I was not sure if I was in the right place, signage is poor.**
- RWT agreed to look into the signage.
- **Was taken for an x-ray from the ward, waiting area very cold, x-ray staff asked for another blanket, apparently they do not hold a stock of blankets. However the staff were very efficient and caring.**
- PTHB Q&S Unit raised at RWT Clinical Quality Review Meeting, will contact the radiology dept.

LONG TERM ACTION

- Scan result had been faxed December 2019 – 7 months period for the GP to receive the scan. PTHB Q&S Unit requested RWT to review their pathways and ensure all scans related to PTHB residents are not delayed.
- A good Café would be helpful, too small, Catering offer poor
- Travel distance

CONCLUSION

February 2020 the Care Quality Commission rated The Royal Wolverhampton Hospital services overall as Good. Caring services was rated as Outstanding as staff always treated patients with compassion and kindness, with respect and dignity and their was a team work culture & Involvement relationship with families. This was reflected within Powys residents feedback, an elderly relative who was not able to visit her poorly husband every day due to the distance was always reassured by phone, the nurses were seen as good and clear at informing, never judgemental, very professional and compassionate. The patients found they were listened to and empowered to make decisions about their care.

Distance is an issue for two reasons, they had to add another hour to their travel by car and if they travelled by train they had to transfer and get a taxi. However the travelling was overcome by the experience they received, they were always made welcome, the professionalism and caring. To date we have not had a concern related to the distance and travelling time.

CONT. CONCLUSION

Few patients found the catering poor, the Café is a normal size, it is at the entrance of the hospital, there is some hot food available, but no big meals. My personal experience has been good, not excellent, however they cater for vegetarians, vegans and gluten free. I believe if the appointment clarified the catering facilities available at RWT, when inviting patients to an appointment, this would allow patients to prepare their own lunch box and reduce disappointments.

Environment – some areas identified as tired/run down, this has been identified within the Clinical Quality Commissioning report, the trust has submitted and implemented an action plan. 99% patients found the hospital was clean, to date PTHB has not reported any Clostridium Difficile or sepsis patients from this trust.

Clinics run late – Few patients highlighted that sometimes clinics run late, however, they were always informed and given a reason, communication has been raised throughout as good within outpatient and the wards

RECOMMENDATION

Overall feedback has been very positive, although we need to be aware that some areas score low, such as, 31% patients stated they were given a choice of food, however 65% patients stated it was not applicable as they had an outpatient appointment. PTHB were aware of the patients travelling distance, however the experience, care, safety and outcome has compensated for the travelling inconvenience. The overall experience as a commissioner has been excellent, any issues are acted upon immediately, good leadership. It is very satisfying to receive positive feedback and know that Powys residents receive safe care and are treated with privacy 95% & Dignity 99%. Reference travelling distance, the GP's will give the patient a choice of where they would like to have their appointment in general, unfortunately neurological services the options are limited.

- Continue monitoring patient experience (PTHB)
- Monitor incidents & complaints (PTHB)
- Inform patients prior appointments, reference catering facilities. (RWT)

GIG CYMRU NHS WALES

Partneriaeth Cydwasanaethau
Gwasanaethau Cyfreithiol a Risg

Shared Services Partnership
Legal and Risk Services

Impact and Reach Report

NWSSP Legal and Risk Services including the Welsh Risk Pool

Contents

Introduction

Welcome to our 'Impact and Reach' report, we hope that this is helpful to your understanding of our work in Legal and Risk Services, for you, our NHS partners and customers.

Anne-Louise Ferguson MBE

Mark Harris

This report provides an overview of our work, not only in clinical negligence but also across our growing portfolio encompassing personal injury, employment, regulatory and commercial, property law, complex patients, safety and learning together with our comprehensive legal advice service to the NHS in Wales. We plan to issue this report twice a year, to share information about the impact of an ever-changing legal and healthcare environment on your local services, financial position and patient and staff experience.

We would welcome your views on the format and content of this report, to ensure that it is timely, helpful to your understanding of our services, and informative for action you may need to take in response to local and national issues.

Anne-Louise Ferguson MBE, retired from the role of Director of Legal and Risk Services at the end of March 2020 after 24 years of outstanding leadership and service. We would like to pay tribute to her commitment and that of her team for their efforts in improving outcomes and reducing the burden of harm on the NHS in Wales.

Mark Harris has been appointed to the role of Director of Legal and Risk Services. Mark was previously Deputy Director of Legal and Risk Services and took up his new post on 1 April 2020.

Who we are

Legal and Risk Services is a division of the NHS Wales Shared Services Partnership (NWSSP) and acts for NHS bodies in Wales, employing specialist lawyers to provide tailored, high quality, cost effective legal services and advice. Welsh Risk Pool (WRP) is part of Legal and Risk Services and manages the reimbursement arrangements for claims and engages with NHS bodies to ensure that lessons are learned.

We work with the health service to provide integrated legal risk management advice, to identify areas of concern, achieve improvement and share good practice.

Our key purpose is:

- to provide a comprehensive in-house legal and risk service to NHS Wales that is recognised as approachable, responsive and reliable; and
- to support health bodies in learning lessons from things that go wrong.

We employ 65 qualified lawyers, supported by 45 administrative, secretarial, and paralegal and trainee solicitor staff, across 14 teams.

The Welsh Risk Pool employs six substantive staff supported by 20 sessional and secondment staff managing the claims reimbursement process, feedback on lessons learned, promoting improved practice and delivering the quality and safety improvement programmes. The team provides support and training across NHS Wales to Board Members, clinicians, claims managers and administrators.

In recent years, we have grown our corporate legal services such as employment, property, regulatory, commercial and procurement law. The remit and breadth of the work undertaken by our Complex Patient Team has also grown significantly.

Ever changing operating environment

2020 will be another year of significant change for clinical negligence litigation. The introduction of a long debated fixed recoverable costs scheme for lower value clinical negligence claims may finally happen, leading to a reduction in costs that the NHS pays to Claimant's solicitors. We are part of the working group of interested parties which culminated in the proposals set out in the publication of the Civil Justice Council Report in October 2019. We are told that the Department of Health and Social Care will proceed to a further public consultation. However, following the disappointingly modest change in the personal injury discount rate (PIDR) last year, from -0.75% to -0.25%, it is difficult to speculate on potential savings at this stage.

We have introduced the Early Reporting Scheme across Wales requiring potential claims in respect of brain injuries suffered at birth to be reported to us within 30 days of the event. We hope this will result in earlier payments to families where the brain injury is proven to have been caused by negligent treatment and, the securing of evidence at an early stage to assist the defence of those cases which are defensible.

We will continue to fight dishonestly exaggerated claims against the NHS and pursue proven dishonest claimants through the legal system to ensure the imposition of both financial and custodial penalties wherever possible. The WRP committee has formally approved the use of surveillance in appropriate cases.

The **Health and Social Care (Quality & Engagement) Wales Bill** is set to become law this summer. It will implement an organisational Duty of Candour. This obligation will require Health Bodies to be open and honest with patients and families when things go wrong to promote a culture of openness and improve quality of care. The "candour" procedure will be set out in new Regulations and accompanying guidance, which we understand will fit in neatly with the present arrangements for openness and transparency under the NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011. There will be a requirement that the Health Bodies report annually on when the duty has come into effect and the steps that have been taken to prevent any future occurrence.

In addition, it will create a new national body which will represent the interests of both health and social care services in Wales, replacing the Community Health Councils. It is hoped that this new body will strengthen the voice of service users, making sure they are listened to and to continue to support them when making a complaint about their care. **The Public Services Ombudsman (Wales) Act 2019** became law on 22 May 2019.The Act gives the Public Services Ombudsman for Wales ("PSOW") extended powers in a number of areas relevant to Health Bodies such as the ability to accept oral complaints, to investigate private medical treatment in cases where there is a NHS/private care pathway and, the ability to undertake own initiative investigations. This is arguably the most significant change to the PSOW powers.

Legal and Risk Services are pleased to be assisting the PSOW Network in liaising with the PSOW regarding the new powers.

Clinical Negligence

Our Clinical Negligence teams provide advice and guidance to all NHS Wales organisations. Every NHS organisation has a named contact or Team Leader for clinical negligence:

Liz Dawson
Betsi Cadwaladr University Health Board and Welsh Ambulance Services NHS Trust
Sarah Watt
Cardiff & Vale University Health Board and Velindre NHS Trust
Vanessa Llewellyn
Cwm Taf Morgannwg University Health Board and Public Health Wales
Fiona Webber
Swansea Bay University Health Board
Alison Walcot
Aneurin Bevan University Health Board
Anne Sparkes
Hywel Dda University Health Board and Powys Teaching Health Board
Mark Harris
Public Health Wales


Liz Dawson


Sarah Watt


Vanessa Llewellyn


Fiona Webber


Alison Walcot


Anne Sparkes

The team defend all clinical negligence claims made against the NHS in Wales. Our aim is to ensure in every case that the outcome is fair and reasonable to the patient and to the NHS and its staff.

Where claims are justified we aim for early settlement. Claims are managed proactively and robustly to ensure a fair and equitable settlement. However, where unjustified claims are made, these are robustly defended, to a trial if necessary.

We investigate claims as quickly as possible. We meet with clinical and other staff and obtain expert evidence as appropriate. Due to our unique relationship with our clients we are able to provide unparalleled support to members of staff who are witnesses in claims.

An increasing number of claims made against the NHS Wales are worth in excess of £1million. These claims are often very complex and require management by our highly

skilled solicitors. We have extensive experience in managing such high value claims. We have a specialist costs team which monitors all claims for costs, advising throughout the team to ensure Claimant solicitors' costs are robustly managed. Significant costs savings are regularly made.

Some cases require the early involvement of the legal team, which can have a marked impact on the overall costs in a case and the approach taken in relation to admissions made. A key area where this early involvement has benefits is in relation to maternity cases where there may be life-changing impact to a baby's health. We have introduced the Early Reporting Scheme which requires organisations to notify the Legal & Risk Team of specified cases within 30 days. This enables us to allocate an experienced lawyer to support organisations in ensuring that the investigative process being undertaken locally is as effective as possible.

The law governing clinical negligence litigation is complex and constantly changing. We pride ourselves on keeping our clients up to date with significant legal changes. Members of the clinical negligence team give regular talks to a wide variety of staff groups across the NHS in Wales.

General Medical Practice Indemnity (GMPI)

The Scheme for GMPI went live on 1 April 2019. GMPI is a discretionary state-backed scheme providing indemnity for providers of GP services in Wales for compensation arising from clinical negligence claims relating to the care, diagnosis and treatment of a patient following incidents on or after 1 April 2019. NWSSP Legal and Risk Services have been commissioned by Welsh Government to operate the scheme.

We have established a GMPI FAQs section on our website to reflect the actual queries received since the scheme went live on 1 April 2019. A copy was sent to all GP practices and GPs on the medical performers list in Wales. Queries have been received from Health Boards, practices and individual GP staff. Queries come to the team via the GMPI telephone helpline or dedicated GMPI e-mail address.

You can find these along with our detailed guidance note on GMPI on our website here: http://www.nwssp.wales.nhs.uk/general-medical-practice-indemnity.

Our GMPI team offers practices guidance in dealing with concerns raised via the Putting Things Right scheme and we have supported a number of practices with complex complaints received relating to treatment provided post 1 April 2019. The team also benefit from the "in-house" assistance of the NWSSP newly appointed Medical Director, Professor Malcolm Lewis, who is an experienced GP and medico legal expert and supports the team by providing a clinical perspective on complaints and claims, which fall within the scope of the GMPI scheme.

The team have attended GP Practice Manager meetings and various Health Board CPD events across Wales throughout 2019-20 providing workshops, newsletters and practical guidance regarding the new scheme including when and how to report a claim post 1 April 2019. These sessions have been well received and this proactive and collaborative approach has enabled GP staff to better understand the role of Legal and Risk and the interface between Legal and Risk and the continuing role of the medical defence organisations. The team attends the claims manager network to provide Health Board staff with an update on the scheme. The team plan to provide workshops to GP Practices on managing Putting Things Right complaints in 2020-21.

The current caseload consists of the following:

- 1,393 GMPI communications i.e. general queries
- 929 patient concerns or complain notifications
- 23 potential clinical negligence claims notified
- 2 letters of claim received (not yet quantifiable)

Two letters of claim were received before the yearend date and have a 'Possible' status in terms of likely settlement. These have been classified as contingent liabilities rather than provisions at the 31 March 2020 and have a combined quantum value of approximately £96k. If you are interested in hearing more about the GMPI scheme, then please contact the team via email GMPI@wales.nhs.uk.

Welsh Risk Pool

Jonathan Webb

The Welsh Risk Pool (WRP) forms part of our Legal and Risk Services Division. The WRP has responsibility for reimbursement of claims handled under NHS Indemnity over £25,000 and reimbursement of all claims handled under the GMPI Scheme (the £25,000 threshold does not apply to GMPI matters). The cases reimbursed mainly relate to clinical negligence and personal injury matters, although the scope of the WRP includes buildings and, in exceptional circumstances, equipment.

The role of the Welsh Risk Pool was expanded in 2018 to include responsibility for the appropriate reimbursement of permitted costs and damages arising from Redress cases. Redress cases, introduced in 2011 through the 'Putting Things Right' arrangements, deal with matters where there is a qualifying liability arising from complaints and healthcare reported incidents. Effective use of the Redress process has a direct impact on the litigation costs for each organisation, with average savings of over £30k in claimants' costs.

It is essential to have effective processes for ensuring that NHS Wales learns from events to limit the risk of recurrence and improve the quality and safety for both patients and staff, and the WRP oversees the Learning from Events process for Claims, Complaints and Redress Cases.

In addition to reviewing events that have occurred, our clinical assessors and safety & learning team undertake a range of proactive clinical assessments in sectors which are high-risk for litigation, as well as assessing the arrangements for the management of concerns and learning from events.

NWSSP has responsibility for the administration of the WRP including the management of the Welsh Risk Pool Budget. In line with standing orders, the NWSSP has resolved to establish a sub-committee to be known as the Welsh Risk Pool Committee (WRPC). The WRPC is a sub-committee of the NWSSP Committee and has no executive powers, other than those specifically delegated in the Terms of Reference. The WRPC has its membership and Terms of Reference updated to reflect the additional responsibilities relating to GMPI.

The WRPC comprises of representation from senior NHS professionals from Trusts, Local Health Boards, Legal and Risk Services and the Welsh Government, and the

Chair is Margaret Foster, Chair of the NWSSP. The WRPC has met 6 times during 2019-20:

- May 2019
- September 2019
- January 2020
- July 2019
- November 2019
- March 2020

Improving Learning from events

The WRP has during 2019 implemented a revised process to bring the scrutiny of learning in relation to all claims and redress cases much earlier in the process than previously.

From reviews of 2017 and 2018 claim cases, it was clear that learning reports are frequently only commenced at the point that they need to be submitted as part of the reimbursement process. This is despite the index events occurring a number of years prior to the reimbursement request and therefore there is a loss of opportunity in implementing action and improvements to reduce the risk of a reoccurrence.

The aim therefore is to alter the point when scrutiny of learning takes place from the point when reimbursement is requested from the WRP to a defined period (60 working days) from when the decision to settle a claim is reached.

Our research conducted on a sample of just over 250 claim cases shows that by bringing forward the scrutiny of learning in this way will mean that action plans are produced and implemented an average of 18 months earlier than previously. Pilots of the revised process were implemented in 4 claims teams across Wales which showed that there is a need to introduce a sense of urgency and important to this issue in order to gain the support of the clinical teams but that the alternative process provides the opportunity for local governance of learning plans.

Fig 1. Outlines the former process for scrutiny of learning from claims – with learning plans submitted at the point of reimbursement:

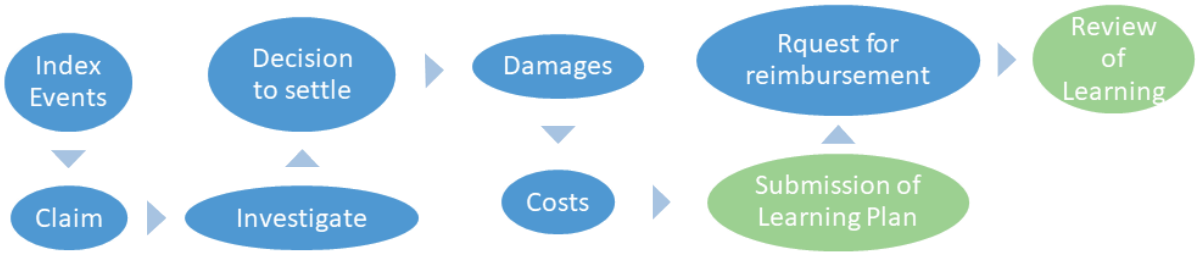
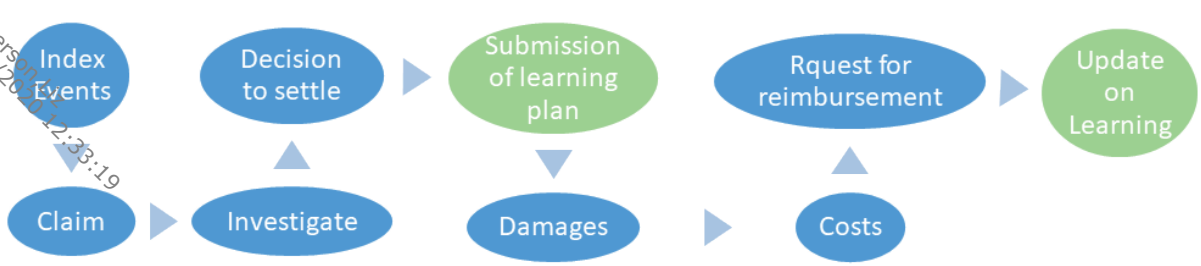


Fig 2. Highlights the opportunity to introduce earlier scrutiny of learning at the point of a decision to settle a case:



Casual Factor Analysis

It is clear that careful analysis of the circumstances of a claim provides an opportunity to establish the themes and trends, and to ensure that priority is given to actions addresses the identified issues. The Welsh Risk Pool analyses the risk data held within claim records to determine common findings.

- **Generic Causal Factors**
  Research into the claims and redress case records identifies three generic causal factors and this enables organisations to align their improvement work to these issues.
  Communication Issues: Failures and errors in communication between healthcare professionals, teams and services. Issues in communication with patients and their carers
  Documentation Issues: Errors and failings in record keeping capture of pertinent clinical information to aid decision making and loss of information.
  Escalation issues: Issues relating to failures to escalate care to senior clinical staff or alternative specialty staff.

- **Thematic Analysis**
  Through the review of causal factors, lessons learned and actions implemented in relation to cases across NHS Wales, the Welsh Risk Pool is in a unique position to be able to identify specific areas where improvement in clinical and organisational practice is needed.

  Maternity Services – CTG analysis and Human Factors
  The Welsh Risk Pool budget continues to experience pressure from a dominance of claim values related to care within maternity services and the analysis of these cases demonstrate a clear trend of communication issues which have ultimately led to the circumstances in which a claim arose. The analysis, recording and action taken in relation to Cardio Toco Graph (CTG) reviews is an area which needs additional focus and the WRP has established an improvement programme to further build on previous work in this area. Communication issues when obstetric complications and emergencies occur remain a theme from claims, but the work of the PROMPT Wales programme in enhancing human factor awareness among clinical groups has already been identified in safety attitude and preparedness reviews as having a positive effect.

  Access to Regional Services
  An increasing area of focus from claims and redress cases during the last year relates to delays in referrals to, and acceptance by, regional specialist services, including neurosurgery and vascular services. The WRP will work with specialist services and central commissioning bodies to identify potential areas for improvement and monitoring.

  Radiological Investigations
  Delays and errors in interpreting radiological investigations has been a theme in claims and redress cases for some years and this is mirrored in other areas of UK healthcare. The national review of radiology services undertaken by the WRP in 2018-19 has highlighted that all organisations have discrepancy review processes, which monitor and reflect on errors in interpretation of images. Case reviews demonstrate that there is limited sharing of learning from these discrepancy processes – both locally within organisations and more widely across NHS Wales, and more needs to be done in this area. Additionally, with an increase in the

outsourcing of radiology reporting, organisations need to ensure that effective monitoring and oversight is in place.

Delays in acting upon unexpected and incidental findings on radiological reports is a stubbornly common theme, especially when the finding relates to a clinical specialty that did not request the investigation. The WRP national review of radiology services highlighted that a national electronic solution to ensure that findings were both communicated and acted upon was needed and would be welcomed by clinical teams. However, until an electronic solution is available, organisations need to invest in processes to avoid the delay or failure to act on an important finding.

The WRP will be undertaking a follow-up review from its national review and seeking updates on the actions taken by organisations.

Consent to Examination & Treatment

Cases involving allegations of a failure to adequately provide appropriate information on the risks, benefits and alternatives of procedures are increasing and the claims experience is that claimants are including these allegations in matters which may have a further issue or allegations – such as complications.

Building on the national work led by Welsh Government, the WRP has established a national team to drive the consent agenda across all services.

An unfortunately common finding is that information shared with patients is deemed inadequate during the investigation of a claim, but the information already available to clinicians via the EIDO Consent Information Download Centre would have presented a robust opportunity to defend the claim. The WRP has funded the EIDO system for a number of years and use of the information leaflets is very high. However, some clinical areas continue to use alternative forms of consent information. The WRP Committee has determined that during 2020-21 a requirement will be implemented, where claims are unlikely to be reimbursed unless the EIDO patient information leaflets are utilised.

Continuing Professional Development is being rolled out by the WRP - to aid the understanding and practical application of the principles of Consent to Examination & Treatment amongst healthcare professionals who participate in the consenting processes. This will be presented via a range of e-learning, workshops, webinars and conferences.

Pressure Ulcer Causal Factors

Despite almost all health bodies having organisation-wide strategies to address pressure damage, the frequency of such cases continues to be stubbornly high and many such cases, where the damage is deemed to have been avoidable, are resolved as redress cases or claims.

Having rolled out specialised Scrutiny Panel Training to over 170 Matrons and Ward Managers through one health board, the Welsh Risk Pool has been able to provide assurance in relation to the effectiveness of the case scrutiny process.

The Welsh Risk Pool also analysed over 160 serious incident, pressure damage cases and established a series of direct and indirect causal factors, which contributed to the occurrence of these events. This found that issues were commonly linked to failures in basic nursing care – rather than a need for complex

solutions.

The development of a Casual Factor table, which can be uploaded onto the Datix system, enables organisations to map their pressure ulcer prevention strategies to the causal factors that are identified as occurring in the organisation as a whole or more locally at ward or department level.

Implementing effective learning lessons from Redress Cases

The transfer of responsibility for reimbursement of redress cases moved from Welsh Government to Welsh Risk Pool on 1st April 2019 and a period of transition has been established to support health bodies during the change.

A key driver for this change was the need to implement scrutiny of the learning from each case – in a similar way that is undertaken for negligence claims, and move the redress process from a purely financial reimbursement model.

To provide support to health bodies during the period of transition, WRP Safety and Learning Advisors have been deployed to assist organisations to analyse redress case investigation findings and to link learning and improvement actions to these.

- **Progress to date**
  Over 591 redress cases have been scrutinised since the transfer of responsibility for reimbursement and learning assurance has been confirmed in the majority of these cases. Claims teams have broadly welcomed the process for the provision of structured learning information. They are able to encourage clinical teams and departments to provide the required information and implement actions plans.

  Review of the learning from redress cases has also undergone a significant change, with the creation of a peer-review panel. Formed of junior leadership clinicians from around Wales, the peer-review group shares the learning from all redress cases and makes recommendations to the Welsh Risk Pool Committee about whether the learning information is suitable and sufficient.

- **Streamlining the submission of information**
  As part of the roll out of a new Once for Wales Concerns Management System (the replacement for current Datix systems), a portal system will be introduced which enables information about a case to be shared with the Welsh Risk Pool team and scrutiny of learning to be even swifter. This will reduce the burden on both local teams and the WRP Operations Team and free up more time to focus on learning from cases.

  The majority of redress cases are managed locally within a health body, with limited involved of the Legal and Risk Service. This a proportionate approach to dealing with cases, whilst there remains a need to ensure governance about how the financial values of a case are reached and that these offer value for money for NHS Wales.

  The introduction of the requirement for health bodies to produce a Case Management Report provides the opportunity for local governance teams to review how the quantum (damages and other costs associated with a case) has been determined. This will provide an effective local scrutiny tool and facilitate all-Wales sharing of case management data between redress teams.

Safety & Learning Programes

Analysis of the rich data available to the Welsh Risk Pool provides an insight into the types of claim, which are occurring. It is clear that the most expensive claims are those relating to maternity services, and a common incidental finding in a claim case relates to an issue with the consent-to-examination & treatment process.

The Welsh Risk Pool is supporting organisations in addressing these themes through its Safety & Learning Programmes.

PROMPT WALES

A national WRP team, leads the implementation and operation of PROMPT Wales in all maternity services across Wales.

This team develops national tools & resources, delivers train-the-trainer sessions and quality assures local training.

PROMPT Wales building on the well-established international PROMPT (PRactical Obstetric Multi-Professional Training) programme of human factors and situational awareness scenarios, which prepare clinical teams to recognise and deal with obstetric emergencies.

The introduction of PROMPT Wales is supported by Welsh Government and national standards for organisations to meet have been established and distributed via Welsh Health Circular WHC/2019/022. These will be reviewed during 2020-21 by the Welsh Risk Pool.

During 2019-20, the WRP, supported by colleagues from Powys Teaching Health Board, has developed and rolled out a Community PROMPT Wales package – specifically focussed at midwives delivering care in the community or midwifery-led units. PROMPT has been introduced into maternity services across the world and the implementation by the WRP within NHS Wales has been recognised by the PROMPT Maternity Foundation as achieving rapid and consistent adoption and roll-out. The implementation process has also been recognised by the Obstetrics & Gynaecology Society.

As part of data collection processes to measure the positive impact of PROMPT Wales, early results of from staff safety attitude surveys demonstrates that participation in PROMPT Wales training enhances the confidence of all grades and specialties of healthcare professionals who may respond to an obstetric emergency. Working with the Maternity & Neonatal Network, the Welsh Risk Pool aims to support the introduction of a national data measures for maternity services during 2020-21, which will strengthen the measurement of the impact of PROMPT Wales within all NHS Wales organisations.

CONSENT TO EXAMINATION & TREATMENT

The All-Wales Consent to Examination Treatment National Team has been formed by the WRP and has drawn together various national strands of work in this topic.

The WRP provides the EIDO Healthcare Download Centre of Consent Patient

Information Leaflets for all organisations in NHS Wales. These are already widely used throughout all organisations and arrangements for the development of new leaflets are in place to support the growing number of alternative procedures and pathways.

During 2019-20, the development and adoption of Wales-specific consent information related to the use of surgical mesh for stress-related incontinence was coordinated by the WRP – ensuring that NHS Wales has appropriate information available for use by clinicians across all organisations in respect of this UK-wide issue.

The digitisation of the consent to examination & treatment process is a workstream for the WRP during 2020-22. The existing contractual arrangements with the provider of the leaflet download centre facilitate the development and roll out of a digital platform for sharing information, capturing patient queries, identifying patient-specific risks and recording consent.

Building on the All-Wales Policy, published via Welsh Health Circular WHC/2017/036, The WRP will be undertaking a national review of Consent to Examination & Treatment through all NHS Wales organisations during 2020-21 - aimed at assisting organisations to establish local improvement plans and identify national themes and trends.

A national clinical group for Consent to Examination & Treatment will be re-focussed during 2020-21 – helping organisations to recognise and understand the consent themes associated with their own claims and redress cases and determining national approaches to achieve consistency.

The support for learning and enhancing undertaking of the consent process by all healthcare professionals who participate in obtaining and recording consent is a key aim for the national team. A series of roadshows, webimars and conference-style learning sessions are planned for 2020-21, alongside the provision of a Wales-specific e-learning package on consent-to-treatment which is awarded CPD points by key royal colleges.

Once for Wales Case Management System

The Once for Wales Concerns Management System (OFWCMS) Programme Board has been established to support implementation during 2019-22. During 2019-20, the Programme Executive sponsor was Claire Bevan, former Executive Director for Quality and Nursing Welsh Ambulance Service NHS Trust.

The preferred provider following a tender exercise is RLDatix Ltd. Considerable work has already been completed to produce a system that meets the needs of NHS Wales now and in the future.

The new system will operate differently from the existing systems and the aim is to improve how data is captured and stored to strengthen the consistency in reporting across organisations and on a NHS Wales basis. The system also offered additional functionality including a case management process for Redress cases in NHS Wales, dedicated safeguarding referrals and management system and a process for recording and monitoring Deprivations of Liberty Safeguards.

An added area of strength will be how it facilitates the capture, escalation and presentation of risks, both as Risk Registers and Assurance Frameworks. The Board Secretary group are engaged in supporting common terminology and systems to enable this. The new system will also be able to support primary care services including community optometrists, dental practices and GP practices.

A small number of early adopters have been identified: Hywel Dda UHB, Swansea Bay UHB and Velindre University NHS Trust. Other NHS organisations will have the opportunity to be involved in piloting and trialling new functions that were not previously available on older systems.

All organisations will need to have a structured plan place on how they will support the system and business change 'roll out' and a single point of contact has been identified between the programme team and every organisation to ensure that effective communications are in place. Regular updates will also be provided through the Director's of Nursing forum, the Board Secretaries group and the National Quality & Safety Forum.

The rollout was originally planned over two financial years. However, to align with the introduction of a revised Serious Incident Framework, Welsh Government are currently working with the programme team to accelerate the introduction of the complaints and incidents functionalities.

Maria Stolzenberg leads the Programme Team, and a dedicated email address has been established at OnceForWales.CMS@wales.nhs.uk

Wider remit of our team

Commercial, Regulatory and Procurement Team

Our Commercial, Regulatory and Procurement Team have an exceptional number of years of experience in dealing with a vast array of legal disputes, overseeing the procurement process and advising on procedural fairness throughout NHS Wales.

The team advises health bodies throughout Wales on all manner of issues, both contentious and non-contentious, which includes Commercial (contractual arrangements) and public law matters (judicial reviews). We also help the NHS understand the complexities of the maze of regulation that exists.
Below is a non-exhaustive list of some of the topics that we are able to advise on:

- Commercial contracts
- Procurement law (Advice on regulations and procedure)
- Procurement documentation (Advice on drafting Invitations To Tender (ITT), Pre-Qualification Questionnaires (PQQ) and specification)
- Procurement challenges
- Outsourcing treatment and services
- Intellectual Property
- Regulatory law
- Public contract law (General Medical Services/General Dental Services Contracts)
- Public/Private partnership (National Cancer Service)
- Judicial Review
- Commercial Litigation

- Residency disputes
- Disputes between public authorities regarding funding
- Dispute resolution
- Policy drafting
- Construction
- Criminal
- Civil Fraud
- Injunctions
- Defamation
- TUPE
- Information law (Data Protection and FOI issues).
- Debt collection
- International law (Memoranda Of Understanding & Service Level Agreements with foreign governments).

Personal Injury Team

The Personal Injury (PI) team is headed by Andrew Hynes and deals with personal injury claims across all of the Health Boards. The claims dealt with can range from relatively low value slip and trip claims to more complex matters such as mesothelioma and incidents resulting in permanent injuries.

The team provides advice in the following fields:

- Employers and Public liability
- Work related stress
- Bullying and harassment
- Violence & Aggression
- Industrial disease, including
- Asbestos
- Hearing loss
- Object and person manual handling
- Repetitive strain injury
- Defective equipment
- Infection Control
- Slip and trip cases

The PI team work well together to deliver an excellent service to our clients, including a bi-annual education day. This day allows colleagues from across NHS Wales the chance to update and refresh their legal knowledge and provides an opportunity to network. Guest speakers including Barristers have also kindly provided talks on a range of subjects and exciting mock trials.

The team also provides valuable analysis of trends as well as focusing upon learning lessons and giving practical risk management advice in areas that have been identified as vulnerable. Prevention is better than cure.

The team has also become involved in a range of projects; most recently being the NHS Anti-Violence Collaborative titled "Obligatory Responses to Violence in Healthcare", which we are working towards publishing as a Welsh Health Circular. It is recognised that NHS staff (Hospital, Ambulance, Community and Primary Care) are among those most likely to face violence and abuse during the course of their employment and there is a strong public interest in prosecuting those who verbally and physically assault NHS staff deliberately.

To address this the NHS Wales Anti Violence Collaborative (AVC) has been established which has representation from NHS Wales, the Police, CPS, Welsh Government and Unions.

Some of the aims of the Collaborative are as follows:

1. To improve the reporting of violent incidents;
2. To strengthen the investigation and prosecution process, by improving the quality and timeliness of shared information; and
3. To improve victim and witness care and confidence.

Information regarding the NHS Wales Anti Violence Collaborative can be found via our Communications Toolkit. http://www.nwssp.wales.nhs.uk/communications-toolkit.

Complex Patient (Court of Protection)

Our Complex Patient team is led by Gavin Knox; a specialist team which is comfortable dealing with highly complex and sensitive clinical situations where a patient's life or liberty might be at stake. Early intervention will often improve outcomes for patients. This may be by helping ensure Health Board staff are acting in the best interests of the patient, or by resolving disputes that can in themselves cause distress to the individual.

- **Mental Capacity Act and Best Interests for Children** - there is a growing need for NHS staff to understand and implement the principles and provisions of the Mental Capacity Act. Our team offers a rapid and reasoned response to any capacity or best interests related query. By engaging early with clinicians, patients and families, we can usually assist in resolving disputes or ethical dilemmas and avoid the need for applications to be made to Court. The same applies to disputes about medical treatment or end of life decisions for children.

- **Deprivation of Liberty** - The full impact of the Supreme Court decision in Cheshire West, that redefined what amounted to a deprivation of liberty, is still being realised with enormous impact on NHS resources. We help Health Boards avoid unlawful deprivations and provide representation in the Court of Protection when a patient appeals against their detention.

- **End of Life Decision Making (adults and children)** - There are no more important decisions than those relating to the end of life. We are regularly instructed where disputes arise between clinicians and patients or their family about what treatment can lawfully be given.

- **Mental Health** - We help staff navigate the legislation and the difficult conflicts and interfaces with the Mental Capacity Act and Deprivation of Liberty.

- **Court of Protection & High Court Applications** - Not all issues can be resolved locally and ultimately some decisions need to be made by a Court. Often these can be highly contentious, complex, and emotive cases with the health, liberty or life of a vulnerable adult or child in the balance. We have extensive experience of making applications to both the Court of Protection and the High Court, each with their own particular rules and procedures. We offer a service that aims to resolve disputes quickly and sensitively to preserve therapeutic relationships with patients or families.

- **Inquests** – the team has overseen the whole inquest service in recent years, focussing on those that raise complex Human Rights issues such as suicides, deaths

in prison or Mental Health detention, gross negligence, or systemic Health Board failings. Demand is such that plans are being developed for a separate team to deal with all inquests.

All NHS Wales organisations are aware of how to contact this team out of hours for urgent advice.

Employment Team

Our Employment Team is led by Daniela Mahapatra. Since its inception in 2012, the team has acted for Health Boards and Trusts in a wide and diverse range of Employment Tribunal and County Court cases. The team has also had the privilege of advising on high level strategic policy issues.

The team can help with all types of claims in the Employment Tribunal including, but not limited to:

- Unfair dismissal (conduct and capability)
- Various types of discrimination (disability, sexual orientation, race, age, gender etc)
- Unlawful deduction of wages
- Holiday pay
- Whistleblowing
- Pension
- Agency worker rights
- Doctor disciplinary cases

The team can also help with the following non-contentious issues:

- Interpretation of policies and procedures on an All Wales level
- Issues arising out of the employment relationship (including advising on grievances and disciplinary hearings) including termination of employment
- Family friendly policies (i.e. Shared Parental Leave regime)
- Clinician banding appeals
- Severance packages and drafting settlement agreements.
- The Transfer of Undertaking (Protection of Employment) Regulations 2006
- Voluntary Early Release Schemes and queries
- Doctor disciplinary issues
- All Wales matters in association with the Welsh Government
- Employment status
- Consultations and Redundancies
- Union Recognition
- Restructures

As well as helping clients to manage cases when things go wrong, the team also works with clients to train Workforce teams and line managers to reduce the risk of claims. Employment law is constantly evolving.

Our Employment team can offer a wide range of educational talks and seminars that can be delivered at our fully equipped premises. We are also able to tailor quarter, half or full day packages at a location to suit our client. Recent topics include:

- Training on the Upholding Professional Standards Policy
- Disciplinary investigations training
- Employment updates

- TUPE training
- Dignity at Work
- Whistleblowing

Property Team

Our property team provides advice across the NHS Wales estate, delivering a quality service at competitive rates. The team has extensive knowledge and experience in commercial property and of the NHS Wales estate. The team works closely with NWSSP Specialist Estates team and undertakes a range of work, which encompasses:

- Leasehold acquisition of offices on behalf of NHS Trusts and Health Boards;
- Lease re-gears, including varying principal lease terms and break dates, as well as general management work (licences to alter etc) in support of tenant works;
- Freehold sales of surplus commercial and residential properties, including provisions to protect future development rights of adjacent land retained by NHS Wales;
- Freehold acquisitions in connection with large-scale developments by NHS Trusts and Health Boards; and
- General, one-off property queries on sundry matters, including in the primary care field.

Our Response to COVID-19

All staff in the health & social care sector are working incredibly hard to increase capacity and to provide care to patients in these very challenging circumstances. It is important that indemnity concerns do not become a barrier to effective care arrangements and the development of alternative delivery models to support patient needs.

The NWSSP Legal & Risk Service has established a hub of experienced lawyers to provide advice on legal issues arising from the Coronavirus pandemic. This is co-ordinated by Senior Solicitor Sarah Watt and enquiries should be emailed in the first instance to Sarah.Watt@Wales.nhs.uk.

The Welsh Risk Pool Operations Team is able to provide advice on indemnity arrangements. The main WRP is of course closed but voicemails will be picked up. Anyone who has an indemnity query should address it in the first instance to the Head of Safety & Learning, Jonathan Webb, via email Jonathan.Webb@wales.nhs.uk or telephone 07850 521999.

Learning more about our work

We publish newsletters that contain valuable recent case studies reflecting our casework and the NHS in Wales. These newsletters help promote good practice and safeguard the wellbeing and care of patients and staff. They illustrate the impact of the work we do to deliver positive outcomes for the NHS in Wales.

You can access our regular newsletters on our intranet pages here.

Key Messages for NHS Wales Health Bodies

We hope that the information contained in this report assists each organisation to focus quality and safety activities towards reducing the risk of harm and associated litigation.

Each organisation is asked to consider the areas of focus which are relevant to their own claims and redress case experience and develop improvement plans.

The Welsh Risk Pool Operations Team can assist in compiling a summary of claims for each organisation. The scope of these case summaries is currently limited due to the restrictions of the database currently used to store information, but as the new systems are implemented, the extent of claims and redress summaries will be further enhanced. If organisations would like to discuss the potential use of WRP data, please contact the team via email welsh.riskpool@wales.nhs.uk.

Some key messages for organisations to note include:

- **Early Reporting Policy**
  For organisations which provide maternity services, ensure that appropriate staff are familiar with the requirements of the Early Reporting Policy, introduced in October 2019 – requiring organisations to notify Legal & Risk Services of specified cases. This is an important policy and reimbursement by the Welsh Risk Pool is dependent on compliance with the notification requirements, which are aimed at enhancing investigations and reducing litigation costs.
- **Learning from Events & Case Management processes**
  All organisations are encouraged to review their corporate and local approach to learning from claims, complaints and redress cases – focussing on identifying lessons learned and monitoring / tracking actions agreed. Additionally, organisations should ensure that processes in place for case management, particularly redress cases, is efficient and complies with the PTR requirements.
  The WRP will be undertaking a new style of WRP Assessments during 2020-21, focussed on ensuring processes are compliant with PTR requirements and encourage learning. The outcomes from these assessments will be included in the overall matrix of the risk share agreement.
- **Radiology**
  Organisations which undertake radiological investigations are asked to note the findings of the previous review undertaken into this topic and ensure that improvement plans are in place. The WRP will undertake a further, focussed review during 2020-21.
- **Consent to Examination & Treatment**
  All organisations are encouraged to ensure that their local policies are compliant with the all-Wales Policy on Consent to Examination & Treatment (WHC/2017/036) and to ensure that where an EIDO Consent Patient Information Leaflet is published it is utilised. The WRP will publish a Risk Management Alert during 2020-21 - with organisations required to demonstrate compliance with a range of requirements aimed at reducing the litigation profile for this topic.
- **Regional Specialist Services**
  Providers and organisations accessing regional specialist services are encouraged to consider the arrangements for referrals and acceptance of patients into these services, with a process of risk-assessing patients who are waiting to determine clinical priority. The WRP has identified a growing trend of claims and redress cases arising from delays associated with some regional services and will work with partner organisations to identify improvements.

Welsh Risk Pool Finances

Estimated Resource Requirement

The complexity and uncertainty of underlying liabilities has long been recognised as the timeframe extends and because of changes in the Personal Injury Discount Rate (PIDR).

In February 2017, the Lord Chancellor announced a change in the PIDR from a positive 2.5% to a minus 0.75%. This PIDR change has led to a significant increase in the value of individual settlements and in particular to the amount attributable to future losses with lump sum compensation payments.

In addition, the solicitor time required on open cases has increased the average value of damages and costs are rising, as medicine and care costs have become more advanced and complex.

The most significant element of expenditure relates to clinical negligence matters that include the annual costs of claims settle using a periodical payment order (PPO) and/ or lump sum payment order.

The Welsh Government provides the NWSSP with two distinct funding stream in respect of the WRP:

i. **Departmental Expenditure Limit** (the DEL) to meet in year costs associated with settled claims arising within Health Boards and Trusts e.g. a lump sum or periodic payment order.
ii. **Annually Managed Expenditure** (the AME) to meet the costs of accounting for the long term liabilities of claims i.e. the provision for the future costs of claims.

In the event that the annual revenue allocation from the Welsh Government is not sufficient to meet the value of the forecast in year expenditure i.e. the DEL, then the service bears the risk of any variation from the estimate and he excess will be subject to an agreed risk sharing agreement with the NHS Wales member organisations.

The DEL resource cover required by the WRP can be broadly summarised as follows:

- Reimbursements to member NHS Wales organisations in respect settled claims.
- Movement on the WRP claims creditor (where a claim has been settled by an NHS body but the payment was not made by the WRP before the yearend).
- Payments made in respect of WRP managed claims i.e. a former Health Authority claim.
- Payments made in respect of claims settled using a Periodic Payment Order.

Forecasting when claims will settle, and for what value, changes frequently as claims mature and more evidence becomes available. These forecasts are calculated on a case-by-case basis through the application of professional judgment from NWSSP Legal and Risk solicitors. The also take into account the monthly returns of expenditure received from the individual NHS organisations.

Increasingly claimants are asking for more to be put into the lump sum part of their damages and less to be paid by way of periodical payments (PPOs). This emerging trend is linked to the change in PIDR rates in 2017 and has not been reversed by the announcement made by the Lord Chancellor in July 2019 to changes the PIDR from minus 0.75% to minus 0.25%. Quite often, this does not become apparent until the settlement meeting, late in the overall process. The impact is in respect of the timing

of cash flows and the level of payments made within the financial year (the DEL) and not on the overall value of the claims (the AME) which is payable over a longer period of time and include in the provision of the WRP.

The cost of clinical negligence is expected to rise in each of the next three years. Most of this additional cost relates to the change in PIDR. Consequently, invoking the risk-sharing agreement is the 'most likely' scenario for members of the WRP.

The risk-sharing model

The risk-sharing model was reviewed by the Welsh Risk Pool Committee and was revised as recently as 2016/17. Made up of five key areas, the model calculates a weighted risk sharing percentage per NHS organisation as follows:

	Area	Weighting
A	Hospital and Community Health Services and Prescribing Allocation	30%
B	Claims History	20%
C	New claims passed to Legal and Risk Services for Litigation	10%
D	Claims potentially affecting next years' spend: i. cases with estimated cash flows within a year ii. Periodic payment orders	25%
E	Management of concerns and learning from events.	15%

The model:

- Weights various contributory factors in order to provide a balanced and equitable system,
- Is transparent and auditable in its application,
- Accounts for the percentage of the allocation that is utilised before any in year settlements,
- Provides reward for managing Putting Things Right effectively,
- Can be updated every year to reflect recent activity and progress,
- Does not rely heavily on past events,
- Provides emphasis on activity and behaviours of the last year,
- Allows the inclusion of NHS Trusts that impact on the allocation usage but which were ignored in historic formula,
- Has systems and databases in place, which can easily manipulate and analyse information in a timely manner to derive the formula for future years.

Expenditure 2019/20

The indicative forecast revenue that was included in the NWSSP 2019-2022 IMTP is summarised below:

	2019/20 £M	2020/21 £M	2021/22 £M
Core allocation	75.000	75.000	75.000
PIDR funding (HMT)	31.500	32.800	33.400
Risk Sharing agreement income	3.701	6.900	8.700
Total	110.201	114.700	117.100

The 2019/20 allocation for the 2019/20 financial year was therefore anticipated to be £106.5M for clinical negligence and personal injury claims. £75M related to the

core allocation and £31.5M related to the impact of the change in the personal injury discount rate (PIDR) estimate, and the balance of £3.7M met from the risk sharing agreement.
At Month 4, an adjustment of approximately £4M was applied to take account of the announcement on 15 July 2019 by the Lord Chancellor to change the PIDR applicable to future losses within lump sum compensation payments, from minus 0.75% to minus 0.25%.

At Month 6, the DEL forecast was updated to a most likely scenario of approximately £110M. Assuming the funding from HM Treasury was reduced in line with the PIDR adjustment (£30M to £26M) then the net income requirement from the Risk Sharing Agreement rose from £3.701 to £9M.

At Month 7, the DEL forecast was revised to a most likely scenario of approximately £116.378M. The net income requirements from the Risk Sharing Agreement had therefore risen from £9M to £15.378M.

Following discussion with the WRPC and Directors of Finance group in November, Legal and Risk carried out a detailed case review on all those cases anticipated to settle in either the final quarter of 2019/20 or first quarter of 2020/21. Consequently, at Month 8 the DEL forecast was revised to a most likely scenario of approximately £110.851M. The net income requirement from the Risk Sharing Agreement being estimated at £9.851M.

There was little movement during Months 9 and 10 with a most likely scenario of £110.718M. The most likely net income requirement from the Risk Sharing Agreement was adjusted to £9.718M.

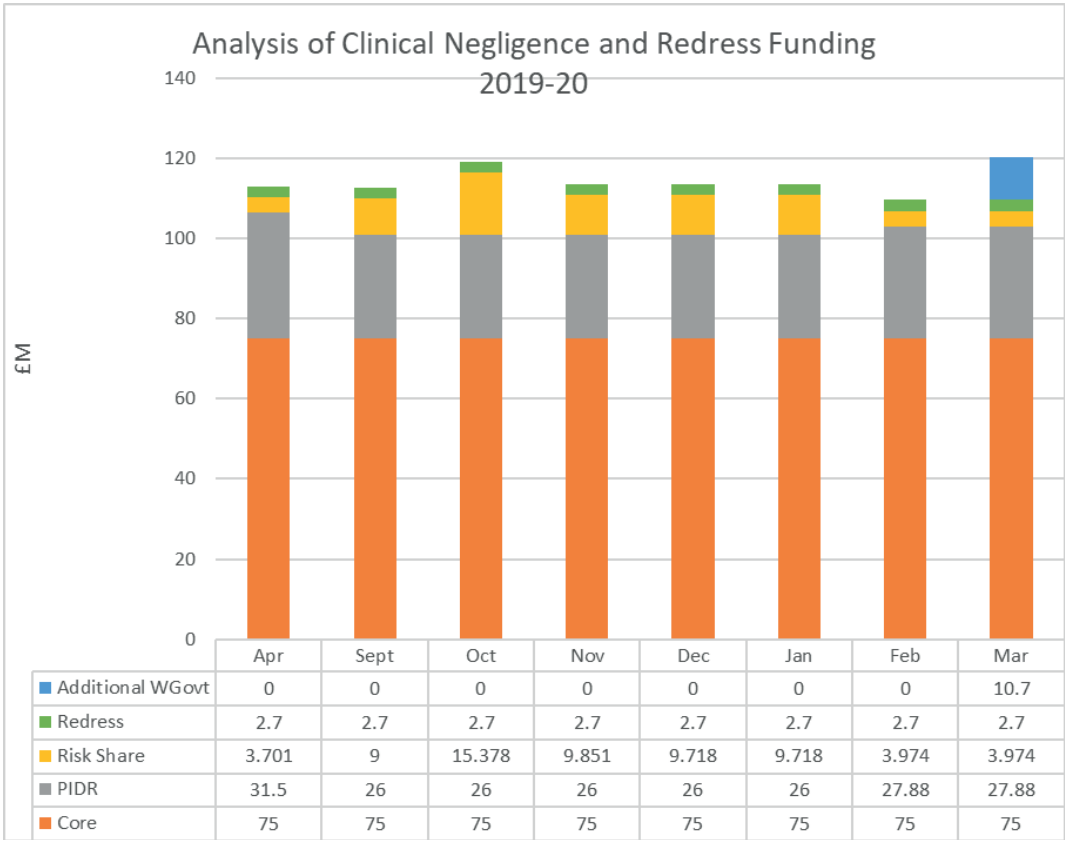
During February 2020, the Welsh Government was able to secure an additional £1.88M funding from HM Treasury as a contribution to the impact of PIDR. This and further changes to the timing and value of settlements resulted in a revised DEL forecast of £106.854M.

The Welsh Government agreed with Directors of Finance that the net income requirement from the Risk Sharing Agreement would be £3.974M to facilitate year end planning. A summary of the Risk Sharing agreement by organisation is set out in Appendix 1.

Any residual movements on the DEL forecast were managed between NWSSP and the Welsh Government, subject to available funding. This amounted to an additional £10.7M for two cases that settled late in March 2020. Welsh Government will apply a resource adjustment to Health Boards annual revenue allocation to recover the funding and will invoice the Trusts for their proportion.

By 31 March 2020, the total funding for 2019/20 was as follows:-

Funding Streams	**£M**
Welsh Government Core	**75.000**
PIDR Tranche 1	**26.000**
PIDR Tranche 2	**1.880**
NHS Wales Risk Sharing Agreement	**3.974**
Welsh Government Additional Funding	**10.700**
Subtotal before Redress	**117.554**
Welsh Government Redress	**2.700**
Total Funding	**120.254**



	Apr	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Additional WGovt	0	0	0	0	0	0	0	10.7
Redress	2.7	2.7	2.7	2.7	2.7	2.7	2.7	2.7
Risk Share	3.701	9	15.378	9.851	9.718	9.718	3.974	3.974
PIDR	31.5	26	26	26	26	26	27.88	27.88
Core	75	75	75	75	75	75	75	75

Resource utilised during 2019/20

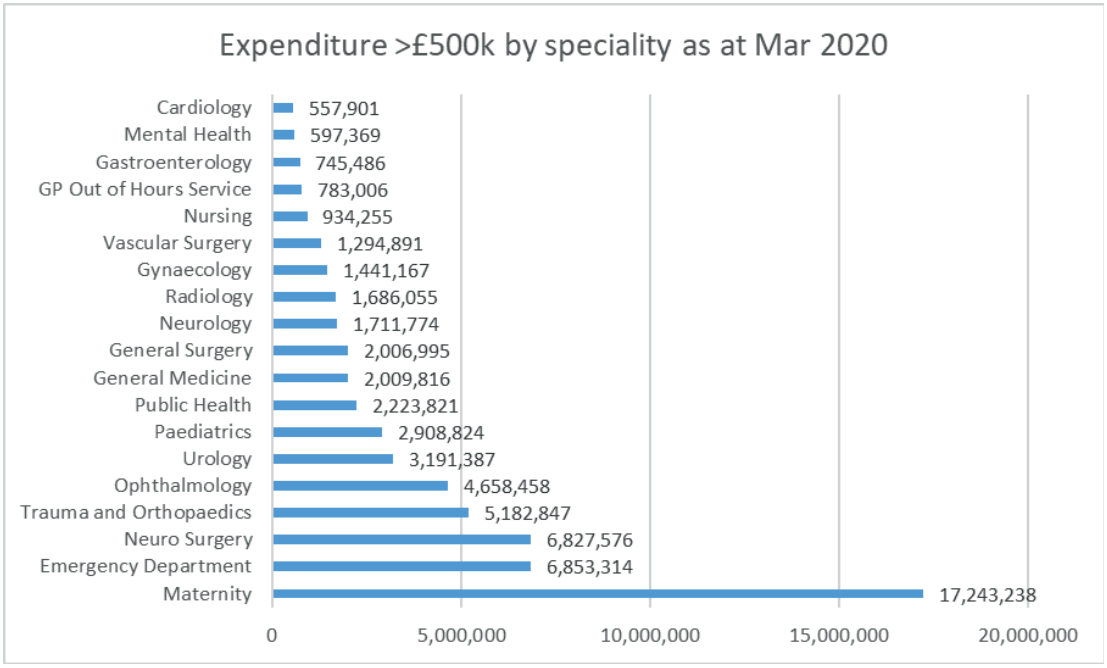
The total DEL expenditure amounted to £120.197M (including Redress) and a detailed breakdown is provided below:

Expenditure type	**Position as at 2018/19 £M**	**Position as at 2019/20 £M**
Claims reimbursed & WRP Managed Expenditure	102.994	**68.036**
Periodical Payments made to date	12.054	**13.972**
Redress Reimbursements	1.671	**1.431**
EIDO – Patient consent	0.062	**0.238**
Movement on Claims Creditor	(4.369)	**36.520**
Year to date expenditure	**112.412**	**120.197**

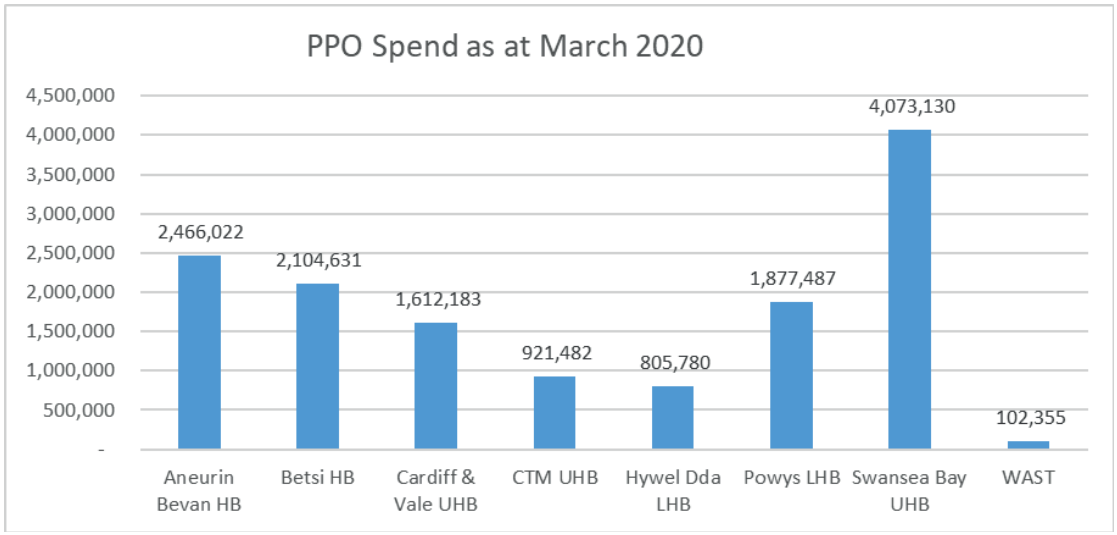
The increase in the movement on the claims creditor compared to last year can be explained by an unusually high number of high value cases settling in February and March. Health Boards and Trusts have not yet had the opportunity to seek reimbursement for these cases from the WRP.

Similarly, the decrease in claims reimbursements compared to last year relates to the same timing issues as the claims creditor. These cases have either not yet been submitted by Health Boards and Trusts to the WRP team for consideration or not yet been approved for reimbursement via WRP committee.

A summary breakdown of the reimbursement expenditure (£68.036M by speciality (specialties with spend >£500k) is below:



A breakdown of PPO expenditure as at end of March 2020 (£13.972M) by organisation is summarised below:



Provisions

Total provisions have risen to £1,133.965M in 2019/20, an increase of £52.524M compared to a £18.227M increase in provisions in 2018/19.

	Closing Provision 2018/19 £M	Closing Provision 2019/20 £M	Movement £M
Probable or certain	658.925	692.902	33.977
Structured Settlements/PPOs	422.516	441.063	18.547
	1,081.441	1,133.965	52.524

The effect of the Personal Injury Discount Rate change in March 2017 reached a plateau in 2018/19 after two financial years of significant increases in provisions. The subsequent change in August 2019 from -0.75% to -0.25% has had minimal effect compared to the previous change in 2017, when rates moved from a 2.5% positive rate to a negative -0.75%.

The movement on PPO's can be analysed as follows:-

	2018/19 £M	2019/20 £M
Opening balance	369.466	422.516
New PPOs	65.119	32.011
PPOs removed	-2.179	-6.840
Application of discount rates and RPI	-9.89	-6.624
	422.516	**441.063**

Total case numbers have reduced (1,793 at the start of the year compared to 1,674 on 31 March 2020) although probable and certain cases have remained relatively constant - a slight increase from 667 at the end of 2018/19 to 670 cases at the end of 2019/20.

As the 2017 PIDR effect has been fully provided for in claims valuations for the past two years, the increase in the provision mostly relates to the increasing value of claims for other reasons. An analysis of increasing claims values has been previously reported in the context of increasing annual spend, but the following also applies to the provisions elements:-

- Claimants are living longer due to advances in medical treatments with longer life expectancies which increase settlement values
- Cases are becoming more complex, with more treatment options for claimants, more multiple defendant cases and subsequently more expert contribution across multiple fields.
- General inflationary factors affecting large purchases e.g., house purchases, adaptations and carer's wages factored into the initial claims values.

Analysis of ongoing claims

	2018/19 No of Cases	£M	2019/20 No of Cases	£M
Probable	123	103.387	130	73.335
Certain	544	555.538	540	619.567
TOTAL	667	658.925	670	692.902
Contingent Liabilities	1,126		1,004	
TOTAL	1,793		1,674	
AVERAGE VALUE PER CLAIM	0.987		1.034	

The above table shows a reduction in the number of cases categorised as being contingent. The reduction is limited to contingent liabilities rather than provisions, i.e. remote and possible cases rather than probable and certain cases.

The average value of a claim for Probable & Certain cases has increased from £987K to £1.034M from 2018/19 to 2019/20. Provision values remain high, with the very high value cases becoming more expensive over the past few years due to a number of factors including:-

- Impact of the PIDR change in 2016/17
- Increasing complexity of high value cases
- Cases litigated at court involve far more work
- Increasing life longevity of claimants

A breakdown per Health Board and Trust for open claims including remote contingent and contingent liabilities is provided in Appendix 2.

Looking ahead to 2020/21

The allocation for 2020/21 has not yet been confirmed, but the table below reflects the figures in the approved NWSSP IMTP 2020-2023. These figures have also been shared with the NHS organisations party to the Risk Sharing agreement for planning purposes. The current forecast shows a resource requirement of £121M for 2020/21 and includes an assumption the Risk Sharing Agreement will be invoked, this is included in Appendix 3 by organisation.

The table below shows £13.78M relating to core claims growth to be re-charged to NHS Wales in 2020/21. The impact from the Personal Injury Discount Rate (PIDR) is estimated to be £32M and these assumptions are based on the current core WG allocation of £75M. Consistent with prior years neither Treasury nor WG will cover any movement above the annual £75M core allocation that does not relate to PIDR change (i.e. relating to general growth in claims costs).

	2020/21 £M	2021/22 £M	2022/23 £M
Core WGovt Allocation	75.000	75.000	75.000
PIDR impact – Separately funded	32.170	31.450	31.980
Risk Sharing Agreement (Core claims growth)	13.780	11.768	13.250
Total DEL forecast	**120.95**	**118.218**	**120.23**

Professional influence savings

During 2019/20, Legal and Risk has reported professional influence savings of £79.3M compared to £66.1M in 2018/19.

The table below provides an overview of the professional influence savings recorded for 2019/20 and reflects significant achievements in reducing the final settlements from that of the claimant's initial estimate.

Savings	£M
Claims above £100k	69.6
Claims less than £100k	4.64
Savings in relation to costs	1.8
Repudiated claims	3.1
Miscellaneous	0.2
Total	**79.3**

Note:
The final position for the Welsh Risk Pool annual accounts as at 31 March 2020 will be audited by the Wales Audit Office. These accounts are then consolidated into the annual accounts of Velindre University NHS Trust and published.

Appendix 1

Revised Risk Sharing Agreement 2019-20

	Total	Total	HSCS Allocation	Claims History	PTR	Cash flow< 1 year	PPO	Lessons learnt	**Share of £3.974**	Share of £3.701M Original Estimate
	2018/19	2019/20	A	B	C	Di	Dii	E	**£M**	£M
Aneurin Bevan	17.34%	17.04%	5.69%	2.49%	2.01%	3.49%	2.20%	1.16%	**0.677**	0.631
Betsi Cadwaladr	18.37%	18.44%	6.68%	3.39%	1.51%	3.12%	1.60%	2.14%	**0.733**	0.682
Cardiff & Vale	16.38%	15.32%	4.18%	4.59%	1.83%	2.33%	1.17%	1.22%	**0.609**	0.567
Cwm Taf Morgannwg	10.84%	11.97%	4.53%	1.63%	0.96%	2.85%	0.67%	1.33%	**0.476**	0.443
Hywel Dda	9.85%	10.72%	3.76%	1.66%	1.28%	1.82%	0.63%	1.57%	**0.426**	0.397
Powys	6.51%	5.86%	1.36%	0.72%	0.14%	0.60%	0.54%	2.50%	**0.233**	0.217
Public Health Wales	1.26%	1.20%	0.00%	0.19%	0.05%	0.04%	0.00%	0.92%	**0.048**	0.044
Swansea Bay	16.37%	16.09%	3.80%	4.64%	2.05%	0.75%	3.11%	1.74%	**0.639**	0.595
Velindre	1.10%	1.13%	0.00%	0.08%	0.00%	0.00%	0.00%	1.05%	**0.045**	0.042
Welsh Ambulance Service	1.98%	2.23%	0.00%	0.61%	0.18%	0.00%	0.08%	1.36%	**0.089**	0.083
	100.00%	100.00%	30.00%	20.00%	10.00%	15.00%	10.00%	15.00%	**3.974**	3.701

Appendix 2 -

Analysis of caseload activity for clinical negligence matters by Health Board & Trust at February 2020

2019/20	SBU	BCU	AB	CTM	HD	C&V	Powys	WAST	Velindre	PHW	Grand Total
Opening Month 1	360	342	318	215	265	239	13	27	4	10	**1793**
Closing Mth 12	311	318	297	229	212	246	12	29	7	13	1674
Movement	**-49**	**-24**	**-21**	**14**	**-53**	**7**	**-1**	**2**	**3**	**3**	**119**
Total opened 2019/2020	75	107	89	76	41	109	5	13	3	6	**524**
Total closed 2019/2020	-124	-131	-110	-62	-94	-102	-6	-11	0	-3	**-643**

2018/19	ABMU	BCU	AB	CTM	HD	C&V	Powys	WAST	Velindre	PHW	Grand Total
Opening Month 1	423	397	331	255	297	286	16	22	8	13	2048
Closing Month 12	360	342	318	215	265	239	13	27	4	10	1793
Movement	**-63**	**-55**	**-13**	**-40**	**-32**	**-47**	**-3**	**5**	**-4**	**-3**	**-255**
Total opened 2018/2019	104	67	83	37	55	74	3	8	2	3	436
Total closed 2018/2019	-167	-122	-96	-77	-87	-121	-6	-3	-6	-6	-691

Appendix 3

Forecast Risk Sharing Agreement by organisation

	RSA 2020/21	2020/21 April £	2021/22 £	2022/23 £
ANEURIN BEVAN	**17.04%**	2,348,310	2,005,582	2,257,983
SWANSEA BAY	**16.09%**	2,217,476	1,893,843	2,132,183
BETSI CADWALADR	**18.44%**	2,540,430	2,169,662	2,442,714
CARDIFF & VALE	**15.32%**	2,110,872	1,802,796	2,029,679
CWM TAF MORGANNWG	**11.97%**	1,648,925	1,408,270	1,585,500
HYWEL DDA	**10.72%**	1,477,117	1,261,537	1,420,301
POWYS	**5.86%**	806,778	689,031	775,746
PHW	**1.20%**	165,925	141,709	159,543
VELINDRE	**1.13%**	156,217	133,418	150,208
WAST	**2.23%**	306,950	262,152	295,143
TOTAL	**100.00%**	**13,779,000**	**11,768,000**	**13,249,000**

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 3.3

EXPERIENCE, QUALITY & SAFETY COMMITTEE	**Date of Meeting: 03 December 2020**
Subject:	**Special Report Issued by the Public Services Ombudsman for Wales**
Approved and Presented by:	Alison Davies, Director of Nursing & Midwifery
Prepared by:	Alison Davies, Director of Nursing & Midwifery
Other Committees and meetings considered at:	None

PURPOSE:

The purpose of this report is to present the Special Report issued under s28 of the Public Services Ombudsman (Wales) Act 2019 following a complaint made by Mrs A against Powys Teaching Health Board; and to articulate the health boards response.

Recommendation(S):

The Experience, Quality & Safety Committee are asked to discuss and note the contents of this report.

Approval/Ratification/Decision	Discussion	Information
✖	✓	✖

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

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

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

EXECUTIVE SUMMARY:

In October 2020, the health board received a Special Report issued under s28 of the Public Services Ombudsman (Wales) Act 2019 following a complaint made by Mrs A against Powys Teaching Health Board.

The Public Service Ombudsman made two recommendation within the special report, including the provision of a further apology to Mrs A and within 2 months of the final report, the Health Board's CEO personally respond to the Ombudsman, having undertaken a review of its complaints handling team and its ability and capacity to deal with complaints under the PTR regime in an effective and timely way. This review should consider not only capacity but whether additional training on the PTR requirements should be undertaken.

The Public Services Ombudsman for Wales will be informed of the outcome of the independent review and the recommendations of both reviews will inform the programme of improvement required, which will be supported by the Innovation and Improvement Team.

DETAILED BACKGROUND AND ASSESSMENT:

1. Background

The Public Services Ombudsman for Wales is independent and has legal powers to investigate complaints about public services and independent care providers in Wales. Additionally, the PSOW can investigate complaints that members of local government bodies have broken their authority's code of conduct.

1.1 In October 2020, the health board received a Special Report issued under s28 of the Public Services Ombudsman (Wales) Act 2019 following a complaint made by Mrs A against Powys Teaching Health Board. The report is provided in **appendix 1.**

1.2 Under the provisions of the Act, pursuant to section 6, the PSOW is able to take any action deemed appropriate to resolve a complaint as an alternative to investigating it. This can include agreeing with a relevant body that it will take certain actions within a stipulated time. Where the PSOW is not satisfied that the relevant body has carried out the actions it explicitly agreed to undertake within the time stipulated, a special report may be issued.

1.3 As Accountable Officer, the Chief Executive is required to ensure compliance with the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011. The facts determined by the findings of the review in respect of the below point (iv.) will be considered by the Chief Executive in order that a response can be prepared for the PSOW and any action taken forward as deemed necessary.

1.4 Mrs A had complained to Powys Teaching Health Board ("the Health Board") and a second local health board in July 2019 concerning the care and treatment that had been provided to her mother. The Health Board was the lead relevant body for the purposes of the investigation in accordance with the statutory regime for dealing with healthcare related complaints (Putting Things Right – "PTR").

1.5 "Mrs A" complained to the Ombudsman in January 2020. She outlined why she was dissatisfied with the care and treatment provided to her mother and she asked the Ombudsman to investigate the Health Board's handling of her complaint as it had not provided her with a complaint response, despite her chasing up the lack of response. In accordance with his powers, the Ombudsman resolved the complaint (as an alternative to investigation) on the basis of the Health Board's agreement to the following 2 actions; it would provide Mrs A with a written apology and a complaint response by 14 February 2020. Being dissatisfied that the Health Board had not complied with either of the 2 recommendations within the timescales agreed, the Ombudsman invoked his powers under section 28 of the Act to issue a Special Report. This is critical of the Health Board's handling of Mrs A's complaint and its failure to implement the recommendations that it had expressly agreed to.

1.6 Within the special report received in October 2020, the Ombudsman made two further recommendations: (a) Issue a written apology to Mrs A's for the way in which it has handled her complaint. (b) Within 2 months of the final report, the Health Board's CEO personally respond to the Ombudsman, having undertaken a review of its complaints handling team and its ability and capacity to deal with complaints under the PTR regime in an effective and timely way. This review should consider not only capacity but whether additional training on the PTR requirements should be undertaken.

2. **Assessment**

2.1 The health board has accepted the report (**appendix 2**).

2.2 The report makes stark reading and is the first of its kind, clearly expresses the failure of the health board to comply with the recommendation made by the PSOW and comments on the potential factors that have resulted in this position, including reference to the basis for action or non-action by health board Officers. The report acknowledges there can be complexity when more than one health board is involved in concerns management, however, asserts that as the health board had agreed to coordinate the response on behalf of other stakeholders, it failed to do so and remains accountable.

2.3 In terms of the second recommendation made by the PSOW, the health board has commissioned an independent review of the ability and capacity of the health board's complaints handling team to deal with complaints under the Putting Things Right (PTR) regime in an effective and timely way. Terms of reference are included in appendix 2. This should include identifying whether additional training on the PTR requirements should be undertaken. The review will compliment and supplement work already undertaken to inform the clinical quality implementation framework an is required to report within 8 weeks.

2.4 The PSOW is entitled to publicise the Special Report and supply a copy of the published report or any part of it to any person who requires it. The report was placed on the PSOW website on 30 October 2020, and a press release issued about its publication. EN https://www.ombudsman.wales/reports/powys-teaching-health-board-202001997/CY https://www.ombwdsmon.cymru/reports/bwrdd-iechyd-addysgu-powys-202001997/. A copy of the report will also have been sent by the PSOW to relevant AMs/MP and to the Welsh Government.

2.5 The health board placed a prominent notice, as required, and a link to the full text of the Special Report, on its website and confirmed this has been completed to the PSOW: EN: https://pthb.nhs.wales/news/health-board-news/special-report-issued-under-s28-of-the-public-services-ombudsman-wales-act-2019-following-a-complaint-made-by-mrs-a-against-powys-teaching-health-board/ CY: https://biap.gig.cymru/newyddion/newyddion-y-bwrdd-iechyd/adroddiad-arbennig-a-gyhoeddwyd-o-dan-adran-s28-y-ddeddf-ombwdsmon-gwasanaethau-cyhoeddus-cymru-2019-yn-deillyn-cwyn-a-wnaed-gan-mrs-a-yn-erbyn-bwrdd-iechyd-addysgu-powys/

2.6 A further letter of apology has been sent to Mrs A.

2.7 An internal review is underway in relation to the way in which the organisation approaches the main aspects of Putting Things Right. Led by the Deputy Director of Nursing, the review will help identify areas of good practice and areas for development. The review is likely to be completed mid December 2020, which will coincide with the more focussed independent review underway in response to the Public Service Ombudsman for Wales special report. The subsequent programme of improvement required will be supported by the Innovation and Improvement Team.

NEXT STEPS:

The Public Services Ombudsman for Wales will be informed of the outcome of the independent review and the recommendations of both reviews will inform the programme of improvement required, which will be supported by the Innovation and Improvement Team.

Special Report issued under s28 of the Public Services Ombudsman (Wales) Act 2019 following a complaint made by Mrs A against Powys Teaching Health Board

A report by the
Public Services Ombudsman for Wales
Case: 202001997

Contents	Page

Introduction

This report is issued under section 28 of the Public Services Ombudsman (Wales) Act 2019 ("the Act").

In accordance with the provisions of the Act, the report has been anonymised so that, as far as possible, any details which might cause individuals to be identified have been amended or omitted. The report therefore refers to the complainant as Mrs A and to members of staff of Powys Teaching Health Board by their post designation.

Summary

Mrs A had complained to Powys Teaching Health Board ("the Health Board") and a second local health board in July 2019 concerning the care and treatment that had been provided to her mother. The Health Board was the lead relevant body for the purposes of the investigation in accordance with the statutory regime for dealing with healthcare related complaints (commonly known as Putting Things Right – "PTR"). Mrs A complained to the Ombudsman in January 2020. She outlined why she was dissatisfied with the care and treatment provided to her mother and she asked the Ombudsman to investigate the Health Board's handling of her complaint as it had not provided her with a complaint response, despite her chasing up the lack of response. In accordance with his powers, the Ombudsman resolved the complaint (as an alternative to investigation) on the basis of the Health Board's agreement to the following 2 actions; it would provide Mrs A with a written apology and a complaint response by 14 February 2020.

Being dissatisfied that the Health Board had not complied with either of the 2 recommendations within the timescales agreed, the Ombudsman invoked his powers under section 28 of the Act to issue a Special Report. This was critical of the Health Board's handling of Mrs A's complaint and its failure to implement the recommendations that it had expressly agreed to.

The Ombudsman made 2 further recommendations to the Health Board:

(a) To issue a written apology to Mrs A's for the way in which it has handled her complaint.

(b) Within 2 months of the final report, that the Health Board's CEO personally responds to the Ombudsman, having undertaken a review of its complaints handling team and its ability and capacity to deal with complaints under the PTR regime in an effective and timely way. This review should consider not only capacity but whether additional training on the PTR requirements should be undertaken.

My Jurisdiction

1. Under the provisions of the Act, pursuant to section 6, I am able to take any action I consider appropriate to resolve a complaint as an alternative to investigating it. This can include agreeing with a relevant body that it will take certain actions within a stipulated time. Where I am not satisfied that the relevant body has carried out the actions it explicitly agreed to undertake within the time stipulated, I may issue a special report.

The Background

2. Mrs A complained to me about Powys Teaching Health Board ("the Health Board") on 23 January 2020. In her complaint to me, Mrs A explained that on 29 July **2019** she had complained to both the Health Board and another local health board ("the Second Health Board") about the care and treatment her late mother had been afforded. That complaint had been submitted to be dealt with in accordance with the NHS Redress Concerns, Complaints and Redress Arrangements (Wales) Regulations 2011 (commonly referred to as "Putting Things Right" – "PTR").

3. Under PTR, when a person makes a complaint that involves the actions of more than one responsible body, the first and second body must co-operate for the purposes of co-ordinating the handling and consideration of the complaint and ensuing that the complainant receives co-ordinated responses. There is a duty on the bodies to seek to agree which will take the lead and communicate with the complainant.[1]

4. Under PTR, unless it is considered that a "qualifying liability" may exist as a result of possible harm to the patient (when different rules apply), all reasonable attempts should be made by the relevant body to provide a complaint response within 30 working days of receiving it. If unable to do so, the relevant body should inform the complainant of the reasons why it cannot do so and send the complaint response "as soon as reasonably practicable and within six months". PTR does go on to say that in

[1] PTR Regulations 17 (3) and (4)

"exceptional circumstances" where a relevant body cannot adhere to the 6-month period, the complainant must be informed of the reasons for the delay and when a response might be expected. [2]

5. Following receipt of Mrs A's complaint, a Casework Officer from my Complaints Advice Team ("the CO") contacted the Health Board to discuss the complaint. A representative of the Complaints Team ("the Officer") confirmed via email, on 5 February **2020**, that the Health Board had received Mrs A's complaint and an investigation into her concerns had already commenced. The Officer said that as most of the issues needed to be addressed by the Health Board, it had taken the lead in complaint handling, with additional information being sought from the Second Health Board. The Officer said that a delay had occurred due to the number of people that the Health Board needed to contact in order to inform its complaint response. The Officer said that the deadline for receipt of the final comments from clinicians was 7 February. Once received, the Health Board would be in a position to provide Mrs A with a complaint response. It was envisaged that Mrs A would receive the complaint response no later than 14 February; this would allow the Health Board time to go through its quality checking process and for the complaint response to be signed off by the Chief Executive Officer ("CEO"). The Officer offered Mrs A an apology for the delay.

6. In light of the information provided by the Health Board, by way of early settlement of Mrs A's complaint (in accordance with my powers set out in paragraph 1), the CO considered that the actions proposed by the Health Board were sufficient to resolve Mrs A's complaint. The early settlement letters were sent on 10 February and outlined the Health Board's intention to; apologise to Mrs A for the delay in responding to her complaint and to issue a complaint response by 14 February. The Officer acknowledged safe receipt on 13 February.

Implementing the Recommendations

7. On 2 March Mrs A contacted the CO to say that she had not received any correspondence from the Health Board. Mrs A sought advice on how best to proceed.

[2] PTR Regulations 24 (3) (4) and (5).

8. On 3 March the CO contacted the Officer and the Assistant Director, Quality and Safety ("the Assistant Director") enquiring if the complaint response had been sent to Mrs A. Receipt of the email was acknowledged by the Assistant Director, who said that she would speak to the Complaints Team the following day. The CO responded to inform that the Ombudsman would have to consider issuing a Special Report due to the Health Board's non-compliance.

9. On 5 March the Assistant Director emailed the CO and said that additional information had been requested and had subsequently been received (that day). The Assistant Director envisaged that the complaint response would be completed and "signed off" by 13 March and Mrs A would receive it no later than 16 March. The Assistant Director asked that an apology be provided to Mrs A for the delay. The CO updated Mrs A.

10. On 7 April the Officer emailed the CO and apologised for the continuing delay in providing Mrs A with a complaint response. She said that the Health Board was still waiting on a key clinician to address the concern raised. The Officer said that the complaint response would be provided urgently but no timescales could be given due to the position that all health boards were currently in (due to the impact of the COVID-19 pandemic). Again, the Officer asked that an apology be provided to Mrs A for the continued delay.

11. The following day, the CO emailed the Officer and said that the matter would be placed on hold until July. In the meantime, if a complaint response was sent to Mrs A, the CO asked that the Ombudsman be informed. The CO updated Mrs A.

12. On 16 June the Officer wrote to the CO to inform her that the Health Board had all the information required in order to finalise the complaint response. The complaint response was going through the quality checking process and, as soon as the CEO had signed it, an update would be provided. Coincidentally, Mrs A contacted the CO for an update on the same day. She was informed of the Health Board's position.

13. The CO contacted the Officer on 6 July for an update. On 7 July the Officer informed her that the complaint response was being approved by the Second Health Board in respect of its findings and the Health Board had chased it for a response.

14. The CO emailed the Officer again on 27 July requesting an update.

15. Mrs A informed the CO on 28 July that she intended to escalate matters if she did not receive the complaint response within 10 days. The CO informed Mrs A that she was continuing to liaise with the Health Board.

16. On 30 July the Officer responded to the CO's email of 27 July. She said that the complaint response was still with the Second Health Board as its comments were being approved by one of its Consultants.

17. On 4 August an Assistant Investigation Manager from my Investigation Team discussed the complaint with the Concerns Manager at the Second Health Board. The Concerns Manager said that the comments on the complaint response had been sent to the Health Board on 15 June. The Concerns Manager said that as there appeared to be a breach of duty of care in relation to an aspect of the complaint concerning the actions of the Second Health Board, the Health Board had requested that it deal with that matter separately and progress the issue through its own redress process. The Concerns Manager said that it was in the process of doing this. As far as the Concerns Manager was aware, there was nothing for the Second Health Board to "sign off" as it was taking matters forward separately. The Concerns Manager said that the Second Health Board had not updated Mrs A as it had not been sure whether the Health Board would be undertaking that task.

18. The CO contacted the Officer and the Assistant Director on 5 August and notified them of the discussions held with the Second Health Board. She expressed her dissatisfaction that neither Mrs A nor the Ombudsman had been updated. The CO asked that a meaningful update be provided to Mrs A and asked for clarification as to whether what the Second Health Board said was factually correct and, if so, why the Health Board's internal systems were noting that information was still awaited. The CO's

email was first met with an automated response indicating that the Officer was on leave. Later that day the Assistant Director replied to say that she would need to ask staff for an update before responding.

19. Mrs A was updated with the above information by the CO on 7 August.

20. Mrs A contacted the CO on 17 August to say that she still hadn't received a complaint response from the Health Board. Mrs A intended to write to both her late mother's MP and the Health Board's CEO asking for an update on the status of her complaint (which she subsequently did).

21. On 18 August the CO wrote to both the Officer and the Assistant Director asking for a further update. A response was received from the Officer who said that there had been some confusion. Whilst the Health Board was the lead for the purposes of the complaint response, it said that it could not make any admission in respect of a breach of duty of care on behalf of the Second Health Board. The Officer said that when the Second Health Board advised that it would address the queries posed by the Health Board, it had been assumed that it would present the complaint to its own Redress Panel and update Mrs A itself. The Officer apologised that this had not happened. She said she planned to liaise with the Second Health Board as a matter of urgency.

22. On 28 August Mrs A received an email from the Officer expressing her sincere apologies that she had not received any communication from the Health Board about her complaint. She said that there appeared to be a misunderstanding as to who would remain in contact with Mrs A to keep her appraised of the progress of the complaint response. Mrs A was informed that the complaint response was going through the quality checking process and the Officer would endeavour to ensure that the complaint response was sent as a matter of priority.

23. On 14 September an Investigation Officer from my Investigation Team contacted the Officer to seek a further update. On 30 September the Officer responded and said that the complaint response had been reviewed and clarification had needed to be sought from a clinician on a few outstanding points. The comments were still awaited, and an anticipated timescale for receipt could not be provided. The Officer updated Mrs A directly that day.

24. On 2 October Mrs A was informed by the Officer that the outstanding comments had been received and consequently the complaint response could be finalised. As the CEO's office was closed at the time of correspondence, the Officer said that a further update would be provided to Mrs A on 5 October. As agreed, Mrs A was informed on 5 October that the complaint response would be sent via email by close of business on 12 October. Mrs A received a complaint response on 12 October.

The Health Board's comments on a draft of this report

25. The Health Board said that it took the nature of this report extremely seriously and apologised unreservedly for the failings identified. The Health Board confirmed that it accepted my recommendations and would ensure their implementation.

26. As a consequence of this report, the Health Board informed me that a fact-finding assessment would be undertaken in relation to events set out above; the key members of staff (referred to within this report) would have the opportunity to contribute to the process.

27. The Health Board said that it is a commissioner of services from a range of providers across Wales and England and this complex situation often impacted on managing complaints across multiple organisations. It was keen to access support (including from my office) in relation to the preparation of complaint responses as soon as possible.

Analysis and Conclusions

28. The Health Board's proposed action was agreed by the CO, on my behalf, as an early resolution and this was formalised in a letter from the CO on 5 February (see paragraph 6), however, the Health Board failed to comply within the timescales stipulated.

29. It is evident that the Health Board was in no position to fulfil the agreement that it entered into with my office in February. The correspondence received from the Health Board prior to the early settlement being agreed implied that the complaint response was almost complete (or at least in the latter stages of drafting). It was in fact the Health Board that

signalled that it could provide a resolution to Mrs A's complaint within a short timeframe and the original short timeframe was not one proposed or indeed imposed on it by my office. The timeframe regularly used by my office in entering settlements such as here, is within one month. However, it is open to a public body to propose and agree to a lesser time, as happened here.

30. I have monitored the impact that the COVID-19 pandemic has had on key public services and have been sensitive to the pressures upon them, particularly health boards.[3] However, the failure of the Health Board to initially comply with the agreement pre-dates the full effect of the pandemic as its response was due in mid-February. At the start of March, the Health Board led me to believe that all the necessary information had been obtained in order for the complaint response to be drafted and that it would be completed and sent to Mrs A within 7 working days, however, a response did not materialise. When it became apparent in April (when pressures on public services were rising), that the complaint response was not near completion (despite the assurances given in March), my CO offered the Health Board a reprieve until July. This was in line with the position I had taken as explained above. It was the Health Board that re-established contact in June to inform my CO that the complaint response was complete and going through quality assurance.

31. More recently, the Health Board indicated that the actions of the Second Health Board were impacting on its ability to comply with its agreement. I suspect that there has been some confusion around how to conclude the joint investigation as PTR is not prescriptive on the issue and these types of investigations are not commonplace. Nevertheless, what PTR is clear on, is that the Health Board, having agreed to be the lead body, is responsible for keeping the complainant informed. It has distinctly failed in that responsibility from the events set out above. Until the very latter stages of the investigation, it has been left to my CO to keep Mrs A updated. That was the Health Board's responsibility as my office's formal involvement at that stage was complete when the settlement was agreed in February. It is evident that there has been poor communication between the two Health Boards with my office having to act as the "the middleman" in August, in an attempt to ascertain the reasons for the stalemate that

[3] https://www.ombudsman.wales/blog/2020/04/28/covid-19-update-3/

occurred. Mrs A was once again informed on 28 August that all the information had been received from the Second Health Board, the issues had been resolved and the complaint response was going through quality assurance. Nevertheless, once again, it was identified that further information was needed, and it took a further 6 weeks for the complaint response to make its way to Mrs A.

32. At the point that Mrs A received her complaint response, compliance was 7 months (very nearly 8 months) overdue. Mrs A waited 14 months, in total, for a response to her concerns. I accept that a complaint response within 30 days could pose a challenge for an NHS body properly investigating a complaint, especially when the investigation involves two local health boards, however, a period of 14 months (even taking into account the pressures on health bodies as a result of Covid-19) is a significant and unacceptable delay. The delay also potentially compromises my office if Mrs A is unhappy with the long-awaited complaint response she has now received; it is more difficult for my staff to meaningfully investigate historical matters. It is why the Act sets a starting point of generally expecting complaints to reach me within 12 months of events.

33. I consider that the information received from the Health Board has been misleading, the updates provided by the Health Board have done nothing but raise Mrs A's expectations that a resolution to her complaint was forthcoming. This is not in keeping with the spirit of PTR; Mrs A has not had her concern dealt with efficiently and openly.

34. It is disappointing that Mrs A waited 13 months to have any meaningful update from the Health Board regarding the status of her complaint. The Health Board said that there was some confusion about which body should have been providing her with updates. The duty imposed via PTR on communication is clear, as I set out above. There needs to be an agreement as to which body will take the lead and communicate with the complainant; in this instance it is the Health Board. In addition to the obligations set out within PTR, the Health Board is the subject of Mrs A's complaint, it expressly agreed to provide her with both a complaint response and apology in its communications with my office, therefore I would have expected it to have directly updated Mrs A periodically after the date for compliance had passed and offer an apology for the continued delay.

I am pleased to note that towards the end of August, the Health Board endeavoured to keep Mrs A updated on the status of her complaint. However, overall, I consider that the Health Board's liaison with Mrs A showed her a lack of respect and courtesy.

35. The events giving rise to me issuing this report give me significant cause for concern about the Health Board's management of its complaint handling function and also its candour. The Health Board expressly agreed to undertake 2 actions. As a consequence of its promise, I did not undertake an investigation into its complaint handling. A resolution under section 6(1) of the Act is just as important as formal recommendations made following a full investigation. It has since provided this office with a number of updates as to the status of the complaint response, but unfortunately the Officer's responses have at best been overly optimistic and at worst disingenuous and misleading. I consider it unacceptable for a major public body to fail to take prompt and effective actions to ensure that agreed recommendations are implemented, and to fail to live up to what are, in effect, binding promises to me as Ombudsman. This is only the second time that I have had reason to invoke my powers to issue a special report against an NHS body for failing to implement agreed actions. It is the first such report under section 28 of the Public Services Ombudsman (Wales) Act 2019 against any public body.

36. I am aware from my office's communications with Mrs A throughout these events that Mrs A was losing confidence in the Health Board's ability to respond to her complaint openly and appropriately. This is not surprising in the circumstances.

37. Also, in view of the confusion in relation to shared responsibilities for the joint investigation of complaints and concerns under the PTR scheme, I am sharing this Report with the Welsh Government.

Further Recommendations

38. I expect and **recommend** that the Health Board:

a) Issue a written apology to Mrs A's for the way in which it has handled her complaint.

b) I further require that the Health Board's CEO personally responds to me, **within 2 months** of this report, having undertaken a review of its complaints handling team and its ability and capacity to deal with complaints under the PTR regime in an effective and timely way. This review should consider not only officer capacity but whether additional training on the PTR requirements should be undertaken.

39. I am pleased to note that in commenting on the draft of this report **Powys Teaching Health Board** has agreed to implement these recommendations.

Nick Bennett 22 October 2020
Ombudsman

Public Services Ombudsman for Wales
1 Ffordd yr Hen Gae
Pencoed
CF35 5LJ

Tel: 01656 641150
Fax: 01656 641199
Email: ask@ombudsman-wales.org.uk
Follow us on Twitter: @OmbudsmanWales

Vivienne Harpwood, Cadeirydd / Chair
Ffon / Phone: 01874 712502
E-bost / Email: Vivienne.Harpwood@wales.nhs.uk

Carol Shillabeer, Y Prif Weithredwr / Chief Executive
Ffon / Phone: 01874 712659
E-bost / Email: carol.shillabeer2@wales.nhs.uk

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

29 October 2020

Your ref: 202001997/LC/LS

Public Services Ombudsman for Wales
1 Fford Yr Hen Gae
Pencoed
Cardiff
CF35 5LJ

Sent by email only to: Laura.Collins@ombudsman-wales.org.uk

Dear Ombudsman

Complaint made to the Ombudsman by [redacted]

Thank you for your letter of 22nd October 2020, in which you provide your definitive special report, issued under the Public Services Ombudsman (Wales) Act 2019. I note that this has been issued under embargo until 30th October 2020.

The health board fully accepts your findings and the recommendations set within. I am sorry that on this occasion the health board has failed to meet the standards that our patients and their families have a right to expect. I confirm that the health board has issued an unreserved apology to [redacted] for the way in which her complaint has been handled.

I have commissioned an independent review of our Putting Things Right process to ensure that swift improvements are made. This will also enable me to respond to you, as required by 31 December 2020, with regard to the ability and capacity of the complaints handling team to deal with complaints in an effective and timely way. I attach the terms of reference for this review for your information at this stage.

As required in your most recent letter, I confirm that a prominent notice has been prepared for publication on the health board's website on 30th October 2020, along with your full report.

Yours sincerely

Carol Shillabeer
Chief Executive

cc. Alison Davies, Executive Director of Nursing & Midwifery

Enc.

Agenda item: 3.4

Experience, Quality & Safety Committee	**Date of Meeting: 03 December 2020**
Subject:	**Regulatory Inspections Report**
Approved and Presented by:	Alison Davies, Director of Nursing & Midwifery
Prepared by:	Helen Kendrick, Quality and Safety Manager
Other Committees and meetings considered at:	Quality Governance Group 11 November 2020

PURPOSE:

The purpose of this report is to articulate the receipt and outcomes of regulatory inspections that have occurred during this reporting period, to share the HIW tracker and note the change to completion dates for a small proportion of the actions.

RECOMMENDATION(S):

The Quality Governance Group are asked to DISCUSS the contents of this report and note the revised deadlines for recommendations, as outlined in **Appendix 2**.

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

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

EXECUTIVE SUMMARY:

The health board is constantly striving to continue to make improvements in response to recommendations made following such inspections and ensure any learning is widely shared.

The health board has been in receipt of 3 Tier 1 inspections which consist of completion of self-assessment followed by a discussion between HIW and Ward Manager on the inspection date. Each of the reports has been positive, with a low number of improvements required.

An overview of the current position relating to the implementation of recommendations following HIW inspections is provided, whilst there have been some delays in updating progress against recommendations, the tracker is contemporaneous.

Reference to the HIW annual report is included in this report.

DETAILED BACKGROUND AND ASSESSMENT:

Health Inspectorate Wales Inspections

Tier 1 Quality Checks

The Group has previously been notified of the new methodology and inspection approach Health Inspectorate Wales are implementing to enable 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 is the 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

The health board has been in receipt of 4 Tier 1 inspections to date.

Tier 1 Quality Check of NHS Mental Health
30 September 2020 – Tawe Ward, Ystradgynlais Hospital
The quality check focused on four key areas: COVID-19 arrangements, environment, infection prevention and control and governance. Whilst there were no areas identified as requiring immediate assurance HIW made two recommendations in relation to environment and governance:

- Review the completed ligature risk assessment on the ward and carry out remedial work identified.
- Some mandatory training had lapsed during Covid-19 and it was advised the health board ensure all staff have completed training in all mandatory areas.

The Final Report was published by Health Inspectorate Wales on 28 October 2020 and can be accessed via the following link and in Appendix 4:

https://hiw.org.uk/sites/default/files/2020-10/20201028TaweWardEN.pdf

Further action is required at 3 months post inspection, to provide an update on actions that remain outstanding at that time.

Tier 1 Quality Check of General Hospital
15 October 2020 – Bryn Heulog Ward, Newtown Hospital
The quality check focused on four key areas: COVID-19 arrangements, environment, infection prevention and control and governance. The health board has been in receipt of the Findings Report to which it has responded within the timescales set out by HIW.

The health board is pleased to report a positive inspection with no improvements identified.

The Final Report was published by Health Inspectorate Wales on 12 November 2020 and can be accessed via the following link and in Appendix 5:

https://hiw.org.uk/sites/default/files/2020-11/20201112BrynheulogWardNewtownHospitalEn.pdf

15 October 2020 – Maldwyn Ward, Welshpool Hospital
The quality check focussed on four key areas: Covid-19 arrangements, environment, infection prevention and control, and governance. Additional evidence was requested post-inspection and provided 21 October requesting the infection prevention and control policy and audit activity undertaken on the ward particularly relating to the environment and Infection prevention and control.

Overall a positive visit with some improvements identified linked to environment and governance, namely storage on the ward.

The Final Report was published by Health Inspectorate Wales on 12 November 2020 and can be accessed via the following link and in Appendix 6:

https://hiw.org.uk/sites/default/files/2020-11/20201112welshpoolhospitalen.pdf

Further action is required at 3 months post inspection, to provide an update on actions that remain outstanding at that time.

21 October 2020 – Epynt Ward, Brecon Hospital
The quality check focused on four key areas: COVID-19 arrangements, environment, infection prevention and control and governance. The health board has been in receipt of the Findings Report to which it has responded within the timescales set out by HIW.

The health board is pleased to report a positive inspection with no improvements identified.

The Final Report was published by Health Inspectorate Wales on 18 November 2020 and can be accessed via the following link in Appendix 7:

https://hiw.org.uk/sites/default/files/2020-11/20201118BreconWarMemorialHospitalcy.pdf

Review of Healthcare Services for Young People
HIW wrote to the health board on 11 September 2020 in relation to the published review "How are healthcare services meeting the needs of young people?" HIW requested information and assurance around the actions the health board has implemented, is currently taking, or planning to take to address the issues raised in the review. The health board has submitted this information to HIW and awaits a response.

The review can be viewed at the following link:
HIW publishes review of healthcare services for young people | Healthcare Inspectorate Wales

Online Maternity National Review of Women and their Families

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

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

Health Inspectorate Wales Recommendations and Tracker

This section of the report provides an overview of the current position relating to the implementation of recommendations following HIW inspections. Validation of the tracker continues by the Quality & Safety Team to ensure a current position on progress against all recommendations is captured. Following COVID, there have been some delays in updating progress against recommendations.

Appendix 1 provides a dashboard view of the current position. Recommendations made through Tier 1 Quality Checks, Review of Services for Young People and The National Maternity Review will be added to this monitoring process as soon as HIW have approved the improvement plans submitted by the health board and the final reports are published.

Appendix 2 presents the revised deadlines for approval for the group as previously referenced in the Recommendations section.

HIW Annual Report

The HIW Annual Report 2019-2020 was published the 22 October - see Appendix 3. A summary of Powys Teaching Health Board related activity can be found on pages 54-56. The report is also available at https://hiw.org.uk/annual-report-2019-2020

Care Inspectorate Wales (CIW)

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

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

Community Health Council

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

APPENDIX 1 – DASHBOARD OF IMPLEMENTATION OF HIW RECOMMENDATIONS

HIW RECOMMENDATIONS							
Ref	**Inspection Title**	**Recommendations Made**	**Recommendations Complete**	**Recommendations Overdue (agreed timescale)**	**Overdue Recommendation Revised Timescale**	**Recommendations Not Yet Due**	**All recommendations implemented**
			2017/18				
171803	Mental Health Service Inspection (Ystradgynlais Hospital)	12	11	1	0	0	*
171808	Mental Health Service Inspection (Clywedog Ward, Llandrindod)	5	4	1	0	0	*
TOTAL		**17**	**15**	**2**	**0**	**0**	
			2018/19				
181901	Ionising Radiation Regulations and Follow Up Inspection (Brecon and Llandrindod Hospitals)	9	9	0	0	0	*
181902	General practice Inspection (Presteigne Medical Practice)	13	13	0	0	0	*
181903	Joint HIW & CIW National Review of Mental Health Services Inspection visit to (announced): Welshpool Community Mental Health Team	17	17	0	0	0	*
TOTAL		**39**	**39**	**0**	**0**	**0**	
			2019/20				
192001	Joint Community Mental Health Team Inspection - The Hazels, Llandrindod	8	7	1	0	0	*
192003	Unannounced Mental Health Service Inspection (Clywedog Ward, Llandrindod)	19	15	4	0	0	*
192004	Unannounced Twymyn Ward, Machynlleth Community Hospital & Graham Davies Ward, Llanidloes Hospital Inspection	20	6	14	0	0	*
192006	Unannounced Hospital Inspection: Llewellyn Ward, Bronllys Hospital	13	9	4	0	0	*
192007	Birth Centres (Free Standing Midwifery Led Unit) Across Powys	2	2	0	0	0	*
192008	NHS Mental Health Service Inspection (Unannounced): Felindre Ward, Bronllys Hospital	24	7	17	0	0	*
TOTAL		**86**	**46**	**40**	**0**	**0**	
GRAND TOTAL		**142**	**100**	**42**	**0**	**0**	

Appendix 2 – HIW Recommendations with Revised Deadlines for Approval

HIW Inspections undertaken in 2017/18					
Recommendations with Revised Deadlines for Approval					
Audit Title	**Recommendation Overdue**	**Original Agreed date for Implementation**	**Variance**	**Revised date for Implementation**	**Responsible Director**
Mental Health Service Inspection: Clywedog Ward, Llandrindod Wells Hospital	PTHB must develop and implement processes, protocols and formal service level agreements in order to provide the designated physical, medical health coverage required for patients on the ward.	28 February 2017	49 Months	31 March 2021	Director of Primary, Community and Mental Health Services

HIW Inspections undertaken in 2019/20					
Recommendations with Revised Deadlines for Approval					
Audit Title	**Recommendation Overdue**	**Original Agreed date for Implementation**	**Variance**	**Revised date for Implementation**	**Responsible Director**
Joint Community Mental Health Team Inspection - The Hazels, Llandrindod	The service should consider whether the current structure of the CMHT promotes effective team working and integration between the health board and local authority, including the allocation of duty work.	30 June 2019	21 Months	31 March 2021	Director of Primary, Community and Mental Health Services
Joint Community Mental Health Team Inspection - The Hazels, Llandrindod	The local authority must continue to explore ways to recruit social workers into the CMHT on a permanent basis	31 May 2019	22 Months	31 March 2021	Director of Primary, Community and Mental Health Services
Unannounced Mental Health Service Inspection: Clywedog Ward, Llandrindod Wells Hospital	The health board must provide additional storage space on the ward.	31 July 2020	8 Months	31 March 2021	Director of Primary, Community and Mental Health Services
Unannounced Mental Health Service Inspection: Clywedog Ward, Llandrindod Wells Hospital	The health board must develop and implement processes, protocols and formal service level agreements, to provide physical and medical health support for patients on the ward.	30 November 2019	16 Months	31 March 2021	Director of Primary, Community and Mental Health Services

HIW Inspections undertaken in 2019/20					
Recommendations with Revised Deadlines for Approval					
Audit Title	**Recommendation Overdue**	**Original Agreed date for Implementation**	**Variance**	**Revised date for Implementation**	**Responsible Director**
Unannounced Hospital Inspection: Llewellyn Ward, Bronllys Hospital	The health board must ensure that patient information is made available in Welsh.	29 February 2020	13 Months	31 March 2021	Director for Therapies & Health Sciences
Unannounced Hospital Inspection: Llewellyn Ward, Bronllys Hospital	The health board must produce a policy to support patient self-administration of medication	31 March 2020	9 Months	31 December 2020	Director of Primary, Community and Mental Health Services

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Arolygiaeth Gofal Iechyd Cymru
Adroddiad Blynyddol 2019-2020

Arolygiaeth Gofal Iechyd Cymru (AGIC) yw arolygiaeth a rheoleiddiwr annibynnol gofal iechyd yng Nghymru

Ein diben
Gwneud yn siŵr bod pobl yng Nghymru yn derbyn gofal iechyd o ansawdd da.

Ein gwerthoedd
Rydym yn rhoi cleifion wrth wraidd yr hyn a wnawn.

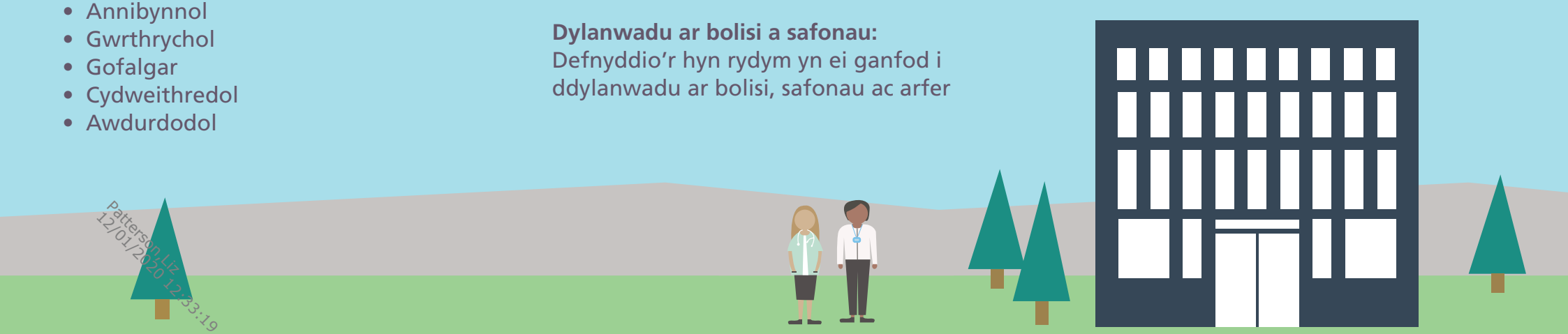
Rydym yn:
- Annibynnol
- Gwrthrychol
- Gofalgar
- Cydweithredol
- Awdurdodol

Ein blaenoriaethau
Drwy ein gwaith, ein nod yw:

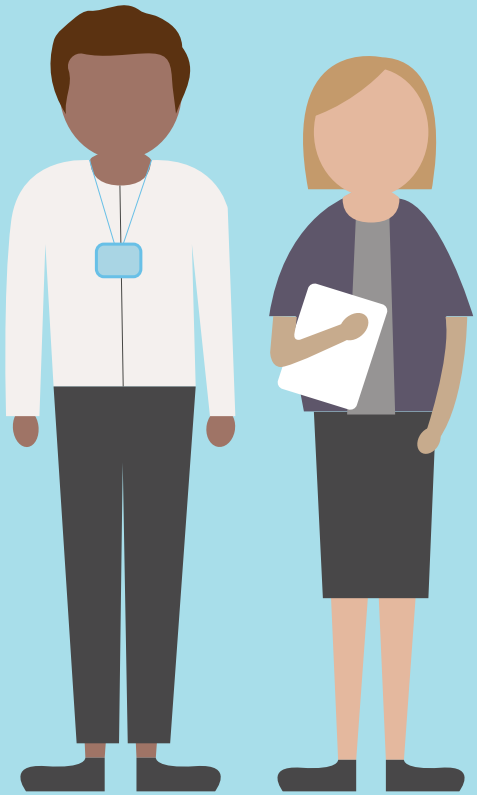
Darparu sicrwydd:
Cynnig barn annibynnol ar ansawdd y gofal.

Hybu gwelliant:
Annog gwelliant drwy lunio adroddiadau a rhannu arfer da

Dylanwadu ar bolisi a safonau:
Defnyddio'r hyn rydym yn ei ganfod i ddylanwadu ar bolisi, safonau ac arfer



Cynnwys



Rhagair

Mae'n bleser gennyf gyflwyno ein Hadroddiad Blynyddol ar gyfer 2019-2020. Wrth ei ysgrifennu bu'n rhaid i wasanaethau iechyd a gofal ledled Cymru ateb heriau pandemig byd-eang Covid-19. Yn sgil y sefyllfa sydd ohoni rhoddwyd pwysau unigryw, nas gwelwyd o'r blaen, ar y system a fydd yn parhau dros y gaeaf. Mae gwasanaethau wedi gorfod addasu, newid ac ehangu er mwyn ymdopi â'r pwysau a rhaid canmol yr ymateb a welwyd ledled Cymru.

Mae'r adroddiad hwn yn cwmpasu'r cyfnod rhwng 1 Ebrill 2019 a 31 Mawrth 2020 felly dim ond effeithio ar gyfran fechan o'n rhaglen arolygu arferol a wnaeth cyfyngiadau'r pandemig a chwblhawyd y rhan fwyaf o'n gwaith ar amser.

Wrth gwblhau ail flwyddyn ein strategaeth tair blynedd, sef 'Gwneud Gwahaniaeth', rydym wedi adeiladu ar sail gadarn er mwyn cyflawni ein nod o annog gwelliannau mewn gofal iechyd drwy wneud y gwaith cywir ar yr amser cywir yn y lle cywir, gan sicrhau bod yr hyn a wnawn yn cael ei gyfleu'n dda ac yn gwneud gwahaniaeth.

Bu modd inni adeiladu capasiti ein sefydliad yn sgil yr adnoddau newydd a gafwyd, gan gynyddu ein gweithgarwch craidd o fewn y GIG a'n gallu i gyflawni amrywiaeth o weithgareddau mewn ymateb i'r wybodaeth a ddaeth i law yn ystod y flwyddyn. Hefyd gwnaethom gynnal mwy o adolygiadau cenedlaethol a lleol a chydweithio'n fwy ag Arolygiaeth Gofal Cymru.

Rhaid crybwyll ein hymateb i'r wybodaeth a gawsom am fethiannau ym Mwrdd Iechyd Prifysgol Cwm Taf Morgannwg yn ymwneud â phrosesau llywodraethu cadarn a gwasanaethau mamolaeth. Cynhaliwyd adolygiad brys o'r trefniadau llywodraethu ar y cyd ag Archwilio Cymru lle tynnwyd sylw at nifer o broblemau a gwendidau sylfaenol, gan wneud nifer o argymhellion ar gyfer gwella. Gwnaethom hefyd ddechrau cynnal adolygiad cenedlaethol o wasanaethau mamolaeth ledled Cymru a gyhoeddir yn ddiweddarach yn 2020.

Yn 2018 herodd yr Adolygiad Seneddol o Iechyd a Gofal Cymdeithasol arolygiaethau i ystyried ein dull o arolygu systemau gofal integredig cymhleth. Dynododd Adolygiad o Ofal Integredig - Canolbwyntio ar Gwympiadau ddull arolygu newydd ar gyfer AGIC, gan weithio gydag amrywiaeth o bartneriaid i ystyried effeithiolrwydd system ofal sy'n cynnwys gwasanaethau iechyd a gofal cymdeithasol, yn ogystal â'r sector preifat, y sector annibynnol a'r sector gwirfoddol.

Ar y cyfan gwelsom fod y cleifion yn cael gofal iechyd o safon uchel yn ystod ein harolygiadau. Fodd bynnag, rhaid nodi rhai themâu a gododd dro ar ôl tro yn ystod ein gwaith, y mae'n rhaid mynd i'r afael â nhw.

Roedd y broses o reoli meddyginiaethau a'u storio'n ddiogel yn dal yn broblem ar rai wardiau ac mewn meddygfeydd. Hefyd, ni chyrhaeddir safonau atal a rheoli heintiau bob amser ac ni chaiff cyfarpar dadebru ei gynnal a'i gadw ar adegau. Mewn meddygfeydd nodwyd na chaiff gwiriadau gan y Gwasanaeth Datgelu a Gwahardd (DBS) eu cynnal bob amser a gellid gwella'r broses o gadw cofnodion imiwneiddio staff mewn ambell achos. Hefyd, nododd cleifion eu bod yn ei chael hi'n anodd trefnu apwyntiad i weld meddyg.

Roedd canfyddiadau ein harolygiadau deintyddol yn gadarnhaol iawn ar y cyfan. Fodd bynnag, gwnaethom nodi amrywiaeth o welliannau ym maes atal a rheoli heintiau a sicrhau bod trefniadau addas ar waith i ddiogelu'r cleifion a'r staff mewn argyfwng meddygol. Cawsom sicrwydd amserol ond mae'n rhwystredig bod llawer o'r materion roedd angen ymdrin â nhw'n syth yr un peth â'r rhai a godwyd yn 2018-19.

Roedd y gwaith o gynnal a chadw ac adnewyddu wardiau yn fater a gododd mewn llawer o'n harolygiadau iechyd meddwl ac roedd ansawdd cynlluniau gofal yn amrywio'n sylweddol.

Fel sefydliad rydym wedi cymryd camau cadarn i ddatblygu, cael mwy o effaith, ymyrryd lle na chaiff safonau eu cyrraedd, bod yn fwy gweladwy a gwneud y gwaith gorau posibl. Mae hyn oll yn rhoi sylfaen gadarn inni adeiladu, addasu a chyflawni ein gwaith pwysig o dan amodau heriol ac unigryw pandemig byd-eang.

Os oes gennych unrhyw gwestiynau, sylwadau, syniadau neu adborth ar ein gwaith, cofiwch gysylltu â ni – byddem wrth ein bodd yn clywed gennych.

Alun Jones
Prif Weithredwr Dros Dro Arolygiaeth Gofal Iechyd Cymru

Ffigurau AGIC yn 2019-2020

Eleni gwnaethom gynnal 205 o arolygiadau, gan gynnwys arolygiadau dilynol o ysbytai, deintyddion, meddygfeydd, darparwyr iechyd meddwl, gofal iechyd annibynnol a lleoliadau sy'n defnyddio ymbelydredd ïoneiddio.

Ysbytai

- 6 arolygiad dilynol
- 3869 o holiaduron cleifion
- 31 o arolygiadau o ysbytai cyffredinol
- 915 o holiaduron staff
- 1 arolygiad llawfeddygol
- 23 o lythyrau Sicrwydd Uniongyrchol ar gyfer ysbytai'r GIG

Meddygfeydd

- 25 o arolygiadau o feddygfeydd
- 816 o holiaduron cleifion
- 15 llythyr Sicrwydd Uniongyrchol

Arolygiadau o dan y Rheoliadau Ymbelydredd Ïoneiddio (Cysylltiad Meddygol)

- 3 arolygiad IR(ME)R
- 93 o holiaduron cleifion

Deintyddol

- 68 o arolygiadau deintyddol, yn cynnwys 5 arolygiad dilynol
- 2019 o holiaduron cleifion
- 14 o hysbysiadau diffyg cydymffurfio
- 1 llythyr Sicrwydd Uniongyrchol

Gofal Iechyd Annibynnol

- 7 arolygiad o glinigau annibynnol
- 4 o hysbysiadau diffyg cydymffurfio
- 508 o holiaduron cleifion
- 27 o arolygiadau o wasanaethau laser
- 7 arolygiad o ysbytai annibynnol

Ffigurau AGIC yn 2019-2020

Iechyd meddwl

- 66 o holiaduron cleifion gan dimau iechyd meddwl cymunedol (TIMC)
- 958 o ymweliadau SOAD
- 8 llythyr Sicrwydd Uniongyrchol neu hysbysiad diffyg cydymffurfio
- 3 arolygiad o dimau iechyd meddwl cymunedol
- 28 o arolygiadau o sefydliadau'r GIG a rhai annibynnol
- 1017 o geisiadau am SOAD

Gweithgarwch Cofrestru

Gwasanaethau Gofal Iechyd Annibynnol

- 26 o Gofrestriadau Newydd
- 16 o Achosion o Amrywio Amodau Cofrestru AGIC
- 17 o Achosion o Newid Rheolwr
- 7 Achos o Ganslo Cofrestriad (Darparwr) AGIC
- 17 o Achosion o Ganslo Cofrestriad (Rheolwr) AGIC
- 10 Achos o Newid yr Unigolyn Cyfrifol

Practisau Deintyddol Preifat

- 2 o Achosion o Amrywio Amodau Cofrestru AGIC
- 20 o Achosion o Ganslo Cofrestriad (Rheolwr) AGIC
- 25 o Achosion o Newid Rheolwr
- 22 o Gofrestriadau Newydd
- 6 Achos o Newid yr Unigolyn Cyfrifol
- 6 Achos o Ganslo Cofrestriad (Darparwr) AGIC

Ffigurau AGIC yn 2019-2020

Gorfodi – Gofal Iechyd Annibynnol

- Cael gwybod am wasanaethau nad oeddent wedi cofrestru o bosibl – 14
- O'r rhain roedd angen i 9 gofrestru
- Gwasanaethau a oedd yn peri pryder[1] – 4
- Gweithredu Sifil[2] – 4

Cyfathrebu ac ymgysylltu

- Mynychu 6 chynhadledd neu ddigwyddiad mawr
- 484,700 o argraffiadau Twitter (cynnydd o fwy na 300%)
- Lansio tudalennau Facebook AGIC
- 319,631 o sesiynau ar ein gwefan (cynnydd o 14%)
- Cynyddodd nifer y tanysgrifwyr i'n cylchlythyr o 946 i 4339

Adolygiadau cenedlaethol a lleol

- Dechreuwyd 2 adolygiad cenedlaethol newydd
- Dechreuwyd 2 adolygiad lleol
- Cyhoeddwyd 2 adolygiad

Gofal iechyd troseddwyr

- 17 o adolygiadau o farwolaethau yn y ddalfa

Pryderon

- 367 o bryderon gan y cyhoedd a staff
- 15 ohonynt yn rhai 'risg uchel'

[1] Bydd gwasanaeth yn peri pryder pan fo'n parhau i beidio â chydymffurfio a chaiff ei fonitro

[2] Dim ond yn erbyn gwasanaethau sydd wedi cofrestru ag AGIC y gellir cymryd camau gweithredu sifil a gall hyn gynnwys amrywio neu osod amodau cofrestru, atal cofrestriad neu geisio canslo cofrestriad ar fyrder.

Barn y Cleifion

Fel rhan o'r broses arolygu rydym yn gofyn i gleifion a fyddent yn hoffi sôn am eu gofal drwy gwblhau holiadur.

Y llynedd cawsom 3869 o holiaduron cleifion wedi'u cwblhau; roedd hyn 763 yn fwy na chyfanswm nifer yr ymatebion a gafwyd y flwyddyn flaenorol.

Gwnaethom hefyd wahodd staff mewn ysbytai a hosbisau i gwblhau holiadur, a chawsom 915 o holiaduron wedi'u cwblhau gan y cyflogeion; roedd hyn 588 yn fwy na chyfanswm nifer yr ymatebion a gafwyd y flwyddyn flaenorol. Mae'r cynnydd mawr hwn yn bennaf oherwydd yr adolygiad cenedlaethol o wasanaethau, lle cafodd yr holiadur staff ei hyrwyddo'n sylweddol.

Beth a ddywedodd cleifion wrthym?

Yn gyffredinol, dywedodd y cleifion wrthym eu bod yn fodlon ar y gofal roeddent yn ei gael. Rydym wedi gwahanu'r ffigurau i ddangos canlyniadau'r arolwg cleifion yn 2019-2020 yn ôl y math o leoliad.

Sgôr gyffredinol

Roedd canran y cleifion a nododd fod eu gofal yn dda, yn dda iawn neu'n ardderchog yn amrywio o ryw 90% i 100% ym mhob lleoliad:

- rhoddodd 88% o'r cleifion sgôr o 8 allan o 10 neu'n uwch i ysbytai
- nododd 99% o gleifion deintyddfeydd fod eu deintydd yn dda, yn dda iawn neu'n ardderchog. Hon oedd y sgôr a gafwyd y llynedd hefyd
- nododd 94% o gleifion meddygfeydd fod eu profiad yn dda, yn dda iawn neu'n ardderchog. Mae'r sgôr hon 6% yn uwch na'r llynedd
- nododd 97% o gleifion a gafodd weithdrefn ymbelydredd ïoneiddio fel rhan o driniaeth ddiagnostig fod eu profiad yn dda, yn dda iawn neu'n ardderchog. Hon oedd y sgôr a gafwyd y llynedd hefyd
- nododd 100% o gleifion gwasanaethau laser fod eu profiad yn dda, yn dda iawn neu'n ardderchog. Mae'r sgôr hon 2% yn uwch na'r llynedd.

Glendid

Gwnaethom hefyd ofyn i'r cleifion sgorio glendid a thaclusrwydd cyfleusterau.

- dywedodd 97% o gleifion ysbytai fod y ward yn lân a dywedodd 96% ei bod yn daclus
- dywedodd 96% o gleifion deintyddfeydd fod y lleoliad yn lân iawn a dywedodd 4% arall ei fod yn weddol lân
- dywedodd 86% o gleifion meddygfeydd fod yr amgylchedd yn lân iawn a dywedodd 13% arall ei fod yn weddol lân
- cytunodd 97% o gleifion clinigau annibynnol fod yr amgylchedd yn lân a dywedodd 98% ei fod yn daclus.

Barn y Cleifion

Gofal ag Urddas

Mae hyn yn cynnwys hawliau dynol sylfaenol urddas, preifatrwydd a dewis ar sail gwybodaeth i gleifion.

- dywedodd 97% o gleifion ysbytai fod y staff bob amser yn gwrtais, yn garedig ac yn sensitif
- dywedodd 82% o gleifion ysbytai fod y staff yn eu cynorthwyo mewn ffordd sensitif fel eu bod yn gallu mynd i'r toiled
- cytunodd 94% o gleifion ysbytai fod y staff yn ymateb pan fyddent yn seinio'r larwm
- roedd 99% o gleifion meddygfeydd o'r farn bod y staff yn eu trin ag urddas a pharch.

Cyfathrebu'n Effeithiol

Mae hyn yn cynnwys y ffordd mae cleifion yn cyfathrebu â staff a'r ffordd mae staff yn cyfathrebu â chleifion.

- dywedodd 81% o gleifion ysbytai eu bod yn gallu cyfathrebu yn eu dewis iaith
- cytunodd 86% o gleifion ysbytai fod y staff wedi siarad â nhw am eu cyflyrau meddygol ac wedi eu helpu i'w deall
- dywedodd 92% o gleifion ysbytai eu bod o'r farn bod y staff bob amser yn gwrando arnynt
- dywedodd 94% o gleifion meddygfeydd eu bod yn gallu cyfathrebu yn eu dewis iaith

- dywedodd 96% o gleifion deintyddfeydd eu bod yn gallu cyfathrebu yn eu dewis iaith
- dywedodd 85% o gleifion TIMC eu bod o'r farn bod y staff yn gwrando arnynt yn astud
- credai 80% o gleifion TIMC fod gan y staff ddigon o amser i drafod eu hanghenion.

Opsiynau triniaeth

Gwnaethom ofyn i'r cleifion pa mor dda y cafodd triniaethau eu hegluro wrthynt, a'u dealltwriaeth o'r broses a'r rhan y gwnaethant ei chwarae ynddi.

- dywedodd 97% o gleifion meddygfeydd fod pethau bob amser yn cael eu hegluro wrthynt mewn ffordd roeddent yn ei deall a dywedodd 95% eu bod yn teimlo'n rhan o benderfyniadau am eu gofal
- dywedodd 95% o gleifion deintyddfeydd fod opsiynau triniaeth wedi'u hegluro wrthynt yn llawn a dywedodd 96% eu bod yn teimlo'n rhan o benderfyniadau am eu triniaeth
- dywedodd 96% o gleifion IR(ME)R eu bod yn teimlo'n rhan o benderfyniadau am eu triniaeth a dywedodd 96% eu bod wedi cael digon o wybodaeth i ddeall risgiau'r driniaeth
- dywedodd 99% o gleifion triniaethau laser / Golau Pwls Dwys (IPL) eu bod yn teimlo'n rhan o benderfyniadau a dywedodd 99% eu bod wedi cael digon o wybodaeth i ddeall risgiau'r driniaeth.

Cost triniaeth

Ar gyfer triniaeth nad yw am ddim o dan y GIG.

- dywedodd 97% o gleifion deintyddfeydd fod cost y driniaeth yn glir
- dywedodd 99% o gleifion gwasanaethau laser fod cost y driniaeth yn glir.

Mynediad

Gwnaethom ofyn am hwylustod y broses o drefnu apwyntiad.

- dywedodd 97% o gleifion deintyddfeydd ei bod hi'n weddol hawdd neu'n hawdd iawn i drefnu apwyntiad
- dywedodd 76% o gleifion meddygfeydd ei bod hi'n weddol hawdd neu'n hawdd iawn i drefnu apwyntiad.

Gofal y tu allan i oriau

O ran yr ymwybyddiaeth o wasanaethau y tu allan i oriau.

- dywedodd 77% o gleifion deintyddfeydd eu bod yn gwybod sut i gael gafael ar y gwasanaeth y tu allan i oriau
- dywedodd 82% o gleifion meddygfeydd eu bod yn gwybod sut i gael gafael ar y gwasanaeth y tu allan i oriau.

Ein Gwaith

Darparu sicrwydd

Darparwn farn annibynnol am ansawdd gofal drwy arolygu amrywiaeth o leoliadau'r GIG yng Nghymru sy'n cynnwys ysbytai, meddygfeydd, deintyddfeydd, unedau iechyd meddwl a thimau iechyd meddwl cymunedol.

Yn y sector annibynnol rydym yn rheoleiddio ac yn arolygu lleoliadau gofal iechyd drwy gofrestru amrywiaeth o ddarparwyr a monitro eu cydymffurfiaeth; mae'r lleoliadau hyn yn cynnwys clinigau ac ysbytai annibynnol, deintyddion, unedau iechyd meddwl, hosbisau a gwasanaethau laser mewn salonau harddwch.

Mae gennym gyfrifoldeb penodol mewn perthynas â diogelu hawliau cleifion agored i niwed a gedwir o dan y Ddeddf Galluedd Meddyliol a Threfniadau Diogelu wrth Amddifadu o Ryddid.

Wrth i'r flwyddyn ariannol hon dynnu at ei therfyn, gwnaethom ddechrau ar y gwaith o gyflwyno dull mwy systematig o ddilyn hynt canfyddiadau ein harolygiadau a'n hadolygiadau, a adlewyrchir yn ein hadroddiad blynyddol nesaf.

Mae ein rhaglen waith yn sicrhau ein bod yn bodloni ein gofynion statudol ac yn adolygu unrhyw bryderon a godir drwy amrywiaeth o ffynonellau gwybodaeth. Mae ein Pwyllgor Risg ac Uwchgyfeirio yn asesu'r dystiolaeth a'r wybodaeth sydd ar gael bob mis, ac yn pennu ein rhaglen o arolygiadau arferol ac ymatebol.

Mae proses debyg ar waith yn ein Bwrdd Llywio Adolygiadau sy'n blaenoriaethu ac yn cynllunio adolygiadau cenedlaethol a lleol, gan graffu ar hynt adolygiadau drwy gydol y flwyddyn.

Safonau Perfformiad

Mae ein safonau gwasanaeth yn amlwg iawn.

- Lle bo angen Sicrwydd Uniongyrchol yn dilyn arolygiad y GIG, caiff llythyrau eu hanfon at Brif Weithredwr y sefydliad o fewn 2 ddiwrnod
- Lle bo angen gweithredu ar frys yn dilyn arolygiad yn y sector annibynnol, caiff y gwasanaeth hysbysiad diffyg cydymffurfio o fewn 2 ddiwrnod
- Rydym yn anelu at gyhoeddi pob adroddiad 3 mis wedi arolygiad fel y nodir yn ein polisi cyhoeddi.

Yn 2019-2020 gwnaethom gyhoeddi 96% o'n hadroddiadau o fewn tri mis i'r arolygiad. Adroddwyd ar 98% o'r materion a oedd yn peri pryder uniongyrchol o fewn 2 ddiwrnod.

Perfformiad

Blwyddyn	Deuddydd wedi'i fodloni	Deuddydd wedi'i fethu	Tri mis wedi'i fodloni	Tri mis wedi'i fethu
2019-2020	98%	2%	96%	4%
2018-2019	94%	6%	92%	8%
2017-2018	100%	0%	92%	8%
2016-2017	91%	9%	82%	18%
2015-2016	71%	29%	75%	25%

Ein Gwaith

Hybu gwelliant

Mae ein trefniadau llywodraethu yn ein galluogi i nodi pa sectorau, lleoliadau a themâu i'w blaenoriaethu fel rhan o'n gweithgarwch arolygu ac adolygu. Mae ein map a geirfa llywodraethu yn manylu ar ein proses graffu fewnol.

Mae llawer o'n hadroddiadau yn cynnwys argymhellion sy'n ceisio sicrhau gwelliannau yn ansawdd gwasanaethau gofal iechyd ac rydym wedi cyflwyno dull mwy systematig o ddilyn hynt canfyddiadau eleni.

Dylanwadu ar bolisïau a safonau

Drwy ein gweithgareddau, gwelwn sut mae deddfwriaeth, polisïau a safonau yn gweithio'n ymarferol. Achubwn ar y cyfle i rannu ein canfyddiadau o'r safbwynt unigryw hwn drwy ymgyngoriadau, tystiolaeth i Bwyllgor Senedd Cymru, ac yn uniongyrchol â swyddogion polisi Llywodraeth Cymru a llunwyr polisi mewn cyrff proffesiynol, arolygiaethau, rheoleiddwyr neu gyrff llywodraethol eraill.

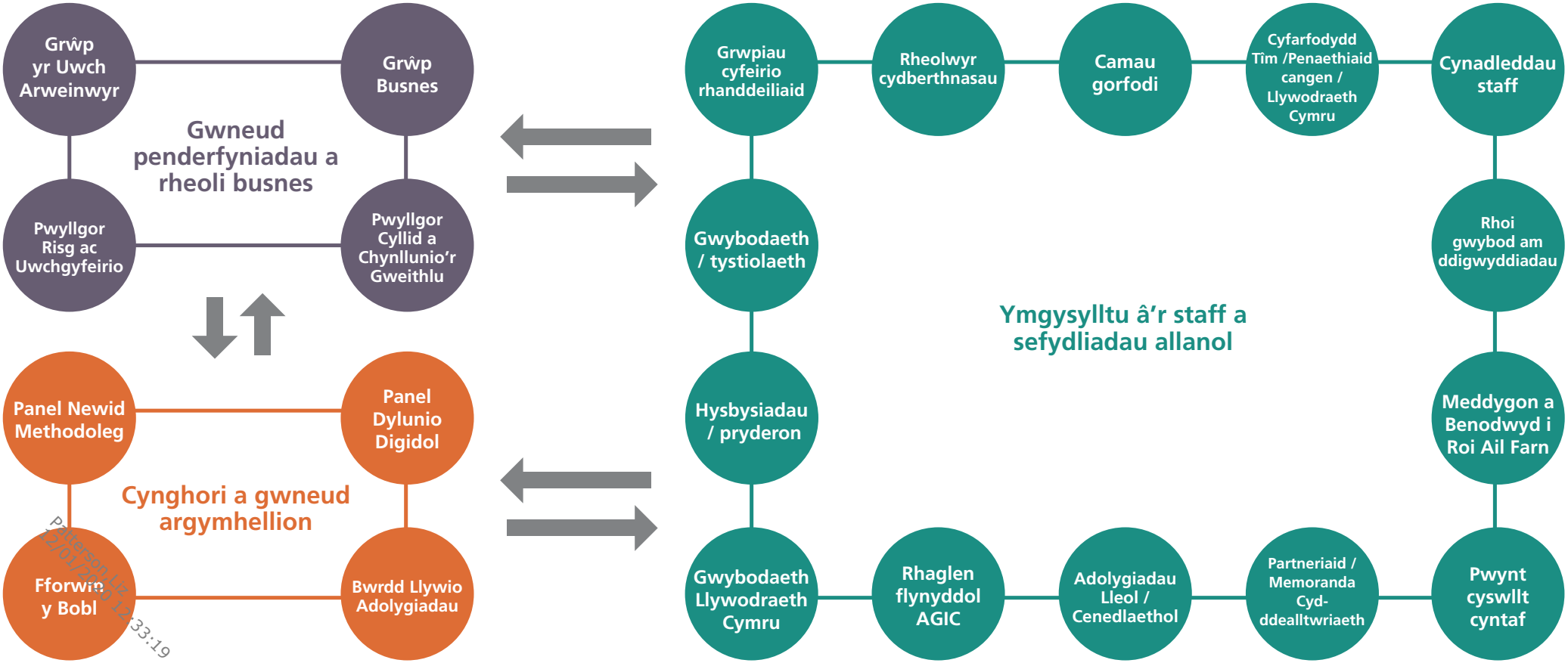
Gwnaethom gymryd rhan mewn 10 ymgynghoriad a gynhaliwyd gan sefydliadau allanol y llynedd a hynny mewn perthynas ag amrywiaeth o faterion sy'n effeithio ar ein gwaith neu sy'n ymwneud â'n gwaith. Ymhlith y rhain roedd Senedd Cymru (Cynulliad Cenedlaethol Cymru gynt), GIG Cymru, Cymdeithas Feddygol Prydain (BMA), y Cyngor Deintyddol Cyffredinol (GDC), Llywodraeth Cymru a'r Cyngor Meddygol Cyffredinol (GMC).

Yn 2019-20 gwnaethom ymddangos gerbron y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon bedair gwaith, gan gynnwys:

- Tystiolaeth ysgrifenedig a llafar ar Iechyd Meddwl yng nghyd-destun Plismona a Dalfa'r Heddlu ym mis Ebrill 2019
- Tystiolaeth ysgrifenedig a llafar mewn sesiwn dystiolaeth ar y cyd ag AGC ar Fil Iechyd a Gofal Cymdeithasol (Ansawdd ac Ymgysylltu) (Cymru) ym mis Medi 2019
- Tystiolaeth ysgrifenedig a llafar mewn sesiwn dystiolaeth ar y cyd ag AGC ac Arolygiaeth Carchardai Ei Mawrhydi ar Darparu gofal iechyd a gofal cymdeithasol ar yr ystâd carchardai i oedolion ym mis Hydref 2019
- Cyflwyno ein hadroddiad annibynnol ar y cyd ag Archwilio Cymru, sef Adolygiad ar y cyd o drefniadau llywodraethu ansawdd Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg mewn sesiwn friffio ffeithiol ym mis Ionawr 2020.

Map Llywodraethu AGIC

Mae 'Geirfa Llywodraethu AGIC' ar dudalen 73.



Gweithio gydag Eraill

Mae rhannu gwybodaeth yn effeithiol rhwng sefydliadau yn hollbwysig wrth asesu ansawdd y gofal iechyd a ddarperir ledled Cymru. Yn ystod 2019-20 gwnaethom gynnal dwy uwchgynhadledd gofal iechyd gan ddwyn ynghyd gyrff archwilio, arolygu, rheoleiddio a gwella allanol er mwyn rhannu gwybodaeth am sefydliadau'r GIG. Cytunwyd ar y themâu a wnaeth ddeillio o'r trafodaethau hyn ac fe'u rhannwyd â Llywodraeth Cymru a'u bwydo i mewn i drafodaethau uwchgyfeirio ac ymyrryd GIG Cymru.

Drwy'r trefniadau cydweithio a ddatblygwyd ar y cyd â'r Cynghorau Iechyd Cymuned, bu modd i'n Hadolygiad Cenedlaethol o Wasanaethau Mamolaeth ddatblygu arolwg cynhwysol ac effeithiol, a gwblhawyd gan fwy na 3,000 o famau yng Nghymru. Dim ond drwy gydweithio ar y dylunio, a dosbarthu'r arolwg ymhlith y cyhoedd, y bu modd gwneud hyn.

Rydym wedi parhau i weithio'n agos gydag Arolygiaeth Gofal Cymru (AGC), Swyddfa Archwilio Cymru ac Estyn ar feysydd o gyd-ddiddordeb drwy gydol y flwyddyn, gan gynnwys adolygiadau ar y cyd. Yn 2019-20 gwnaethom ddechrau helpu AGC i gynnal ei Hadolygiad o Blant Anabl, drwy gynnal cyfweliadau ag arweinwyr gofal iechyd strategol a gweithredol; byddwn yn parhau i gefnogi'r adolygiad hwn drwy gydol 2020. Drwy gyd-bresenoldeb Arolygu Cymru yn Sioe Frenhinol Cymru, rydym yn ymgysylltu â'r cyhoedd ac yn darparu gwybodaeth am ganfyddiadau ein hadolygiadau.

Rhown ein barn yn ystod prosesau ymgynghori a chraffu polisïau a deddfwriaeth newydd a datblygol, gan gynnwys Bil Iechyd a Gofal Cymdeithasol (Ansawdd ac Ymgysylltu) (Cymru) a gyflwynwyd ym mis Mehefin 2019. Rhoddodd AGIC, ar y cyd ag AGC, dystiolaeth i'r Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon ym mis Medi 2019.

Yn ystod 2019 gwnaethom weithio gydag AGC, Estyn, Arolygiaeth Prawf Ei Mawrhydi ac Arolygiaeth Cwnstabliaeth a Gwasanaethau Tân ac Achub Ei Mawrhydi i ddatblygu fframwaith arolygu a oedd yn edrych ar drefniadau amddiffyn plant. Y pynciau a gwmpaswyd gan yr Arolygiad ar y Cyd o Drefniadau Amddiffyn Plant (JICPA) oedd camfanteisio ar blant (yn rhywiol ac yn droseddol) a masnachu plant.

Ym mis Rhagfyr 2019 cynhaliwyd arolygiad peilot yn ardal Casnewydd i brofi'r fframwaith hwn gyda'r pum arolygiaeth ar y safle; y tro cyntaf i hyn gael ei wneud yng Nghymru. Cafodd crynodeb o'r canfyddiadau, Edrych ar sut yr ydym yn cadw plant a phobl ifanc yn ddiogel yng Nghasnewydd, ei gyhoeddi ar ein gwefan ym mis Medi 2020.

Gohiriwyd arolygiad peilot arall oherwydd pandemig Covid-19, ond mae grŵp gweithredol JICPA wedi parhau i gyfarfod gyda'r nod o gynnal rhaglen waith yn y dyfodol.

Ym mis Mawrth 2020 gwnaethom gyfrannu at ddarpariaethau yn y Deddf y Coronafeirws 2020, gan gynnwys newidiadau dros dro i leoliadau iechyd meddwl a'r gwasanaeth Meddyg a Benodwyd i Roi Ail Farn (SOAD) yng Nghymru.

Cynnydd yn erbyn ein Cynllun Strategol 2018-21

Sicrhau bod ein gwaith yn cael yr effaith orau bosibl er mwyn cefnogi'r gwaith o wella gofal iechyd

Mae AGIC yn rhoi pwyslais cryf ar ddefnyddio gwybodaeth i ddatblygu ei rhaglen waith. Drwy wneud y gwaith cywir ar yr amser cywir yn y lle cywir, gall AGIC gyflawni elfen allweddol o'i rôl, sef annog gwelliannau mewn gofal iechyd.

Dros y flwyddyn ddiwethaf, rydym wedi parhau i ganolbwyntio ar ddefnyddio gwybodaeth ac wedi atgyfnerthu trefniadau llywodraethu er mwyn sicrhau ein bod yn cael yr effaith fwyaf bosibl drwy wneud penderfyniadau gwybodus am y gwaith a wnawn. Mae ein Grŵp Llywio Adolygiadau newydd wedi ein galluogi i ystyried amrywiaeth o wybodaeth wrth benderfynu pa thema neu wasanaeth gofal iechyd i'w (h)adolygu ar lefel genedlaethol. Mae wedi ein galluogi i gadw llygad ar y gwaith o ddatblygu a chyflawni rhaglen o adolygiadau lleol a chenedlaethol a wnaeth ehangu yn 2019 yn sgil penodi mwy o arolygwyr ar ddiwedd 2018. Rhaid crybwyll y gwaith o gwblhau 26 o arolygiadau i gefnogi cam cyntaf ein hadolygiad cenedlaethol o wasanaethau mamolaeth fel rhan o'r rhaglen hon. Caiff adroddiad yn nodi canfyddiadau'r cam hwn ei gyhoeddi ym mis Tachwedd 2020.

Rydym wedi parhau i gydweithio â sefydliadau partner allweddol gan sicrhau ein bod yn gallu cael gafael ar wybodaeth hollbwysig i gyflawni ein swyddogaethau ni ein hunain, a rhai'r partneriaid hynny, a'i rhannu. Lle bo hynny o fudd i bawb, rydym hefyd wedi gweithio gyda'n partneriaid i gyflawni arolygiadau neu adolygiadau penodol. Gwnaethom weithio gydag Arolygiaeth Gofal Cymru ar ein rhaglen o arolygiadau o Dimau Iechyd Meddwl Cymunedol, a chafodd AGC ei chynnwys hefyd yn ein hadolygiad cenedlaethol o ofal integredig - canolbwyntio ar gwympiadau. Gwnaethom weithio gydag Archwilio Cymru i gynnal adolygiad ar y cyd o drefniadau llywodraethu ansawdd Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg. Fel rhan o'n hadolygiad cenedlaethol o wasanaethau mamolaeth, gwnaethom hefyd gydweithio â Chynghorau Iechyd Cymuned i ddylunio a dosbarthu arolwg a gwblhawyd gan fwy na 3,000 o famau

Fel rhan o'n strategaeth tair blynedd, a lansiwyd ym mis Mehefin 2018, gwnaeth AGIC ymrwymo i wneud gwaith i ystyried y ffordd fwyaf effeithiol ac effeithlon o rannu ei chanfyddiadau fel eu bod yn hawdd eu deall. Mae'r gwaith hwn wedi dechrau, ac wedi mynd rhagddo fel rhan o flwyddyn arolygu 2020-21, wrth i AGIC ystyried ffyrdd amgen o gyflawni ei rôl yn ystod pandemig COVID-19.

Cynnydd yn erbyn ein Cynllun Strategol 2018-21

Cymryd camau lle na chaiff safonau eu cyflawni

Mae gallu AGIC i gymryd camau amserol pan na chaiff safonau eu bodloni yn dibynnu ar nifer o ffactorau. Mae'r ffactorau hyn yn cynnwys natur y fframweithiau cyfreithiol sy'n diffinio ein pwerau, ansawdd ac amseroldeb ein gwaith, y ffordd rydym yn ymgysylltu â sefydliadau gofal iechyd a'r ffordd rydym yn uwchgyfeirio materion.

Rydym wedi datblygu proses gynllunio sy'n ein galluogi i ystyried amrywiaeth o wybodaeth wrth lunio ein rhaglen flynyddol o arolygiadau ac adolygiadau. Defnyddir ein rhwydwaith o reolwyr cydberthnasau byrddau iechyd, risgiau hysbys i ddiogelwch cleifion, a'r angen i ymchwilio ymhellach i unrhyw heriau penodol sy'n wynebu'r system iechyd yn genedlaethol. Ar gyfer rhai mathau o wasanaethau, yn enwedig yn y sector annibynnol lle ceir llai o oruchwyliaeth yn gyffredinol, os o gwbl, drwy brosesau diogelwch a sicrwydd y GIG, mae AGIC wedi sefydlu rheolau ynghylch pa mor aml y cynhelir ymweliadau arolygu.

Mae'r gwaith o ddatblygu cynlluniau blynyddol yn gofyn i ni fonitro ein dulliau gweithredu yn barhaus, gan eu haddasu neu greu rhai newydd fel y bo angen. Mae gennym drefniadau i flaenoriaethu a rheoli'r gwaith hwn, ac rydym wedi datblygu ein gallu ac adnoddau yn y maes hwn dros y blynyddoedd diwethaf.

Mae amrywiaeth o amgylchiadau lle gallwn gymryd camau gorfodi fel rheoleiddiwr gwasanaethau gofal iechyd annibynnol yng Nghymru. Er y gall ymddangos bod pob achos gorfodi yn unigryw, mae'n bwysig ein bod yn cymryd camau rheoleiddio cymesur, cyson ac effeithiol. Dros y flwyddyn ddiwethaf rydym wedi bod yn gweithio'n galed i symleiddio ein prosesau yn y maes hwn, ac rydym hefyd wedi cyflwyno gwybodaeth fanylach am berfformiad er mwyn ein galluogi i sicrhau ein bod yn cymryd camau amserol lle cawn wybod am wasanaethau nad ydynt wedi cofrestru. Rydym hefyd wedi parhau i gymryd camau gorfodi fel y bo angen o ganlyniad i faterion a nodwyd gennym mewn arolygiadau. Caiff y camau gorfodi rydym wedi'u cymryd yn ystod y cyfnod hwn eu crynhoi ar dudalen 35.

Mae dilyn hynt canfyddiadau arolygiadau yn elfen allweddol arall o'n hymrwymiad i weithredu lle na chaiff safonau eu cyrraedd. Dros y flwyddyn ddiwethaf rydym wedi datblygu trefniadau newydd sy'n sicrhau bod amrywiaeth o weithgareddau dilynol yn cael eu hystyried ar ddiwedd pob arolygiad. Rhoddir y trefniadau hyn ar waith yn ystod blwyddyn arolygu 2020/21.

Rydym yn parhau i atgyfnerthu'r ffordd rydym yn cyfathrebu â darpar ddarparwyr gofal iechyd annibynnol a darparwyr presennol. Yn 2019-20 gwnaethom wella'r canllawiau sydd ar gael i ddarpar gofrestrwyr, gan gynnwys egluro'r hyn sy'n ddisgwyliedig ganddynt. Mae'r gwaith hwn yn sylweddol a bydd yn parhau i mewn i 2020-21.

Yn y sector annibynnol mae ein pwerau cyfreithiol yn ein helpu i sicrhau bod gwasanaethau perthnasol yn cofrestru â ni ac yn cydymffurfio â'r rheoliadau. Rydym yn parhau i ymgysylltu â Llywodraeth Cymru ar gwmpas ein pwerau ac unrhyw gyfyngiadau sy'n gysylltiedig â deddfwriaeth gyfredol. Yn y GIG, rydym wedi cyfrannu at ddatblygu Bil drafft Iechyd a Gofal Cymdeithasol (Ansawdd ac Ymgysylltu) (Cymru), gan gynnwys darparu tystiolaeth ysgrifenedig ac ymddangos gerbron sesiwn dystiolaeth y Pwyllgor.

Cynnydd yn erbyn ein Cynllun Strategol 2018-21

Bod yn fwy gweladwy

Er mwyn cyflawni ein nod strategol, mae angen i ni wella dealltwriaeth y cyhoedd a gweithwyr proffesiynol o'n gwaith, a'u hymgysylltiad ag ef.

Yn ystod y flwyddyn rydym wedi llwyddo i ddod yn fwy gweladwy fel sefydliad. Yn 2018, roedd ychydig dros chwarter y bobl yng Nghymru yn ymwybodol o'r arolygiaeth[3]. Yn 2019, roedd wedi cynyddu i ychydig o dan 40 y cant[4]. Rydym wedi cyflawni hyn drwy wneud sawl darn o waith.

Rydym wedi treialu dull creadigol newydd o gyflwyno ein canfyddiadau er mwyn eu gwneud yn fwy hygyrch a diddorol. Yn ein Hadolygiad Cenedlaethol o Ofal Integredig: Canolbwyntio ar Gwympiadau, gwnaethom gyflwyno animeiddiadau ac enghreifftiau o lwybrau gofal delfrydol a chamweithredol, yn seiliedig ar ein canfyddiadau. Y nod oedd ceisio egluro'n well brofiad unigolion o atal a thrin cwympiadau a helpu gweithwyr gofal iechyd proffesiynol a'r cyhoedd i ddeall sut beth yw gofal da. Cafwyd adborth cadarnhaol ar y dull hwn o weithredu ac mae'n sail gadarn i rannu canfyddiadau adolygiadau o systemau gofal cymhleth yn y dyfodol.

Rydym wedi datblygu strategaeth ar gyfer y cyfryngau cymdeithasol sydd, ar y cyd ag adnoddau digidol eraill, wedi ein helpu i gynnwys y cyhoedd a gweithwyr proffesiynol yn ein gwaith yn fwy. Yn arbennig, fel rhan o'n Hadolygiad Cenedlaethol o Wasanaethau Mamolaeth, gwnaethom weithio'n agos gyda'r Cynghorau Iechyd Cymuned a rhanddeiliaid eraill ledled Cymru i greu arolwg cleifion a staff ar-lein. Hyrwyddwyd yr arolwg ar ein tudalen Facebook newydd yn bennaf a thrwy ein gwaith i ymgysylltu â sefydliadau lleol er mwyn helpu i godi proffil ein gwaith mewn cymunedau. O ganlyniad i hyn, rhannodd dros 3,300 o gleifion a 600 o aelodau o staff eu barn am wasanaethau mamolaeth yng Nghymru. Bellach, mae arolygon ar-lein yn fater o drefn mewn arolygiadau, ochr yn ochr â dulliau mwy traddodiadol, gan alluogi pobl i wneud sylwadau a rhoi adborth mewn cynifer o ffyrdd â phosibl.

O ganlyniad i'n strategaeth mae ein presenoldeb ar-lein wedi tyfu'n sylweddol dros y flwyddyn ddiwethaf, gyda nifer ein dilynwyr ar y cyfryngau cymdeithasol yn cynyddu'n sylweddol, ynghyd â nifer yr ymweliadau â'n gwefan a'r niferoedd sydd wedi tanysgrifio i'n cylchlythyr.

Rydym wedi parhau i adeiladu ar ein henw da a pha mor weladwy ydym drwy fynd i gynadleddau a seminarau allweddol i rannu ein canfyddiadau a'r gwersi sy'n deillio o'n gwaith. Yn ystod Sioe Frenhinol Cymru yn 2019, cymerodd 368 o bobl ran yn ein harolwg am waith a chanfyddiadau AGIC, a gwnaethom siarad â dros 480 o aelodau'r cyhoedd am eu profiadau gofal iechyd. Hefyd, defnyddiwyd cynadleddau Conffederasiwn GIG Cymru a Gwelliant Cymru i gyflwyno ein canfyddiadau i weithwyr gofal iechyd proffesiynol er mwyn annog gwelliant.

Rydym hefyd wedi meithrin cydberthynas gryfach ag Addysg a Gwella Iechyd Cymru a chyrff proffesiynol eraill er mwyn gwella dealltwriaeth o'n rôl a'n diben, a sut y gallwn gydweithio i gefnogi gwelliant.

Mae ein Huwchgynadleddau Gofal yn parhau i chwarae rôl hollbwysig wrth rannu gwybodaeth a chynrychioli barn gyfunol y rhai sy'n craffu ar ofal iechyd ledled Cymru.

[3] Omnibws Cymru, Beaufort Research Ltd - Medi 2018

[4] Omnibws Cymru, Beaufort Research Ltd - Medi 2019

Cynnydd yn erbyn ein Cynllun Strategol 2018-21

Datblygu ein pobl a'n sefydliad i wneud y gwaith gorau posibl

Ased gorau AGIC yw ei phobl.

Yn ystod y flwyddyn ddiwethaf, rydym wedi datblygu ymhellach fel sefydliad. Mae ein harolwg staff diweddaraf yn dangos gwelliant ym mhob maes, gyda'r sefydliad yn cyflawni ei ganlyniadau gorau erioed o ran ymgysylltu â'i staff, rheoli newid a sicrhau bod gennym yr hyn sydd ei angen i wneud ein gwaith.

Dros y flwyddyn ddiwethaf mae'r sefydliad wedi newid yn sylweddol, o ran adeiladu capasiti i gynyddu ein gweithgarwch craidd o fewn y GIG a thrwy gyflwyno systemau TGCh newydd sy'n diogelu gwybodaeth yn well ac wedi ein gwneud yn fwy effeithlon. Er hyn, yn yr arolwg staff mwyaf diweddar, rydym wedi parhau i gael adborth cadarnhaol ar reoli'r broses newid a galluogi pobl i wneud eu gwaith yn effeithiol.

Wrth recriwtio arolygwyr newydd aethom ati i adnewyddu a gwella ein proses sefydlu er mwyn sicrhau bod staff newydd yn effeithiol yn eu rolau mor gyflym â phosibl. O ganlyniad i hyn, gwnaethom lwyddo i gyflawni mwy o arolygiadau yn ystod y flwyddyn a gweithio ar adolygiadau cenedlaethol a lleol newydd.

Mae ein gwelliannau digidol, gan gynnwys arolygiadau di-bapur a thaliadau ar-lein, bellach yn rhan gwbl integredig o'n prosesau busnes ac rydym wedi symud i gam adeiladu system rheoli gwybodaeth a data newydd y sefydliad, sef prosiect a fu'n flaenoriaeth drwy gydol y flwyddyn.

Drwy roi mwy o bwyslais ar ddysgu a datblygu, rydym wedi cymryd camau breision tuag at ddod yn sefydliad dysgu. Mewn arolwg staff diweddar, nododd y rhan fwyaf o bobl eu bod o'r farn eu bod yn gallu achub ar y cyfleoedd dysgu a datblygu iawn pan fo angen, a bod gweithgareddau y maent wedi eu cwblhau dros y flwyddyn ddiwethaf wedi helpu i wella eu perfformiad.

Rydym hefyd wedi adolygu'r ffordd rydym yn defnyddio adolygwyr lleyg gwirfoddol, gan greu sail gadarn i gyflwyno rhwydwaith newydd o Arbenigwyr drwy Brofiad ac Adolygwyr Profiad Cleifion a fydd yn gwella'r broses o gofnodi llais y claf yn ystod arolygiadau.

Adolygiadau Cenedlaethol a Lleol

Mae AGIC yn cynnal adolygiadau cenedlaethol sy'n ei galluogi i archwilio'r modd y darperir gwasanaethau ledled Cymru. Rydym hefyd yn cynnal adolygiadau lleol o faterion a all fod yn benodol i un sefydliad neu ranbarth arbennig.

Awgrymiadau ar gyfer Adolygiadau

Mae sawl ffactor yn ein helpu i benderfynu pryd a ble y dylid cynnal adolygiad cenedlaethol neu leol, gan gynnwys gwybodaeth gan reoleiddwyr neu arolygiaethau eraill, a gwybodaeth a nodir pan godir pryderon neu pan wneir cwynion. Drwy ffurflen awgrymu pwnc adolygiad ar ein gwefan, rydym yn annog pobl i rannu eu barn am yr hyn y dylem edrych arno.

Caiff yr holl awgrymiadau sy'n dod i law eu hadolygu gan ein Bwrdd Llywio Adolygiadau. Mae'r grŵp hwn yn ymchwilio i'r pynciau a awgrymir, ac yn eu trafod a'u blaenoriaethu, gan wneud argymhellion ar gyfer unrhyw waith pellach y gallem ei wneud. Ein Pwyllgor Risg ac Uwchgyfeirio, sy'n ystyried blaenoriaethau ac adnoddau AGIC, sy'n gwneud y penderfyniad terfynol am droi awgrym yn adolygiad.

Adolygiad Cenedlaethol o Wasanaethau Mamolaeth

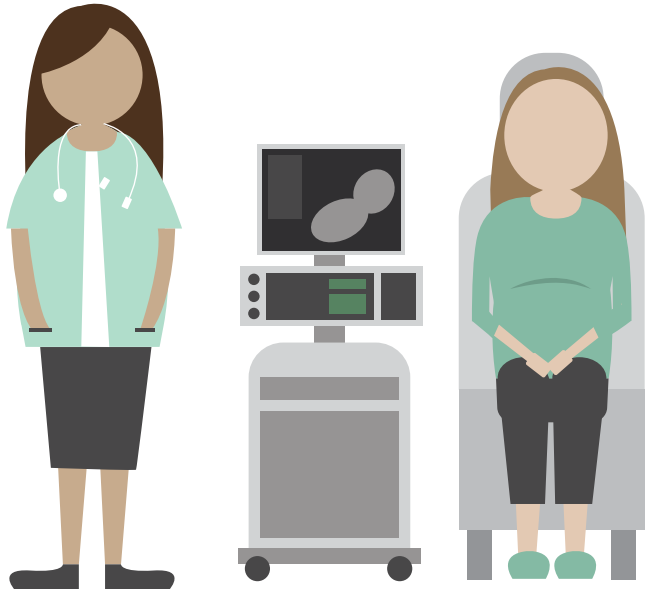
Gwnaethom benderfynu cynnal yr adolygiad hwn oherwydd y pryderon a godwyd ynghylch pwysau o fewn gwasanaethau mamolaeth yng Nghymru, a'r materion a nodwyd yn ystod ein harolygiad o wasanaethau mamolaeth yn Ysbyty Brenhinol Morgannwg yn hen Fwrdd Iechyd Prifysgol Cwm Taf ym mis Hydref 2018.

Mae'r adolygiad ar ddau gam ac yn edrych ar brofiadau menywod, eu partneriaid a'u teuluoedd, a'r graddau y mae byrddau iechyd yn darparu gwasanaethau mamolaeth diogel ac effeithiol. Mae hefyd yn anelu at alluogi byrddau iechyd i adnabod cryfderau eu gwasanaethau mamolaeth, ynghyd â meysydd lle mae angen gwella.

Roedd cam un yn cynnwys 15 o arolygiadau dirybudd o unedau mamolaeth ysbytai, 11 o unedau geni mamolaeth cartrefol, cyfweliadau â thimau gweithredol, bwrw golwg dros ddogfennau llywodraethu, ac arolygon helaeth gyda'r cyhoedd a staff gwasanaethau mamolaeth. Mae canfyddiadau'r arolygiadau hyn wedi cael eu cyhoeddi ar ein gwefan a chaiff adroddiad cam un yr adolygiad ei gyhoeddi ym mis Tachwedd 2020.

Roedd enghreifftiau o arferion da a nodedig ym mhob bwrdd iechyd. Fodd bynnag, roedd ansawdd y gofal a'r driniaeth yn amrywio rhywfaint ac roedd angen tynnu sylw at nifer o faterion, gan gynnwys archwilio cyfarpar, cynnal archwiliadau, dysgu a threfniadau atal a rheoli heintiau.

Bydd cam dau yn dechrau ym mis Hydref 2020, gan gynnwys ymweliadau â gwasanaethau cymunedol, megis gofal cynenedigol ac ôl-enedigol.



Adolygiad Cenedlaethol o Wasanaethau Atal Argyfyngau Iechyd Meddwl

Yn ystod 2019-20 gwnaethom ddechrau pennu cwmpas adolygiad cenedlaethol o wasanaethau atal argyfyngau iechyd meddwl ledled Cymru. Nododd ein gwaith blaenorol, gan gynnwys ein Hadolygiad o Dimau Iechyd Meddwl Cymunedol a'n Hadolygiad o Wasanaethau Camddefnyddio Sylweddau, fod angen gwella'r broses o reoli pobl sy'n wynebu argyfwng a sicrhau eu bod yn gallu cael gafael ar wasanaethau mewn modd amserol.

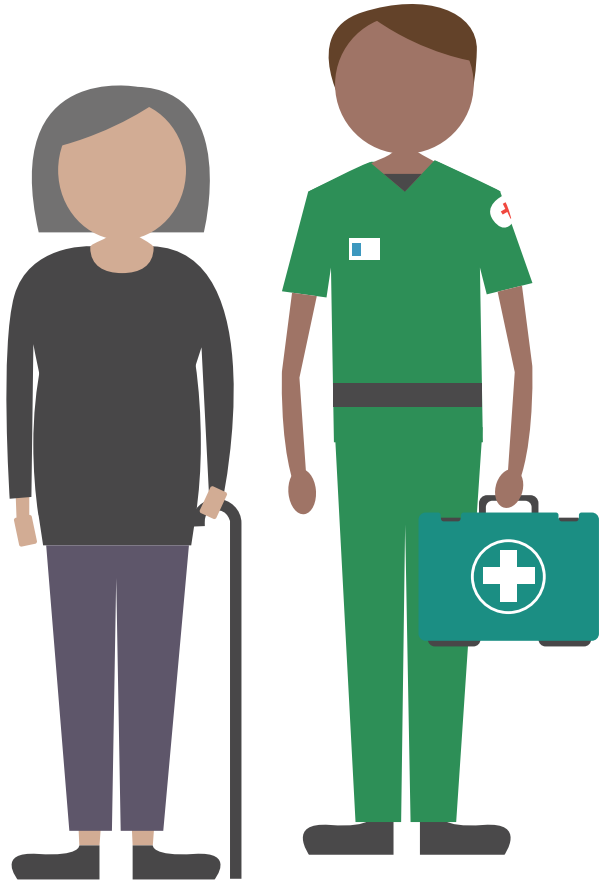
Dechreuodd yr adolygiad ar ddechrau 2020 a bydd yn mynd rhagddo drwy'r flwyddyn, gan ddod i ben yn ystod gwanwyn 2021. Byddwn yn adolygu ein canfyddiadau blaenorol, ynghyd ag unrhyw wybodaeth arall sydd ar gael inni, a'r gwaith sy'n cael ei wneud ym maes argyfyngau iechyd meddwl gan sefydliadau eraill yng Nghymru. Ein nod yw nodi unrhyw themâu, tueddiadau neu bryderon sydd wedi dod i'r amlwg yn genedlaethol, a nodi arferion da wrth gefnogi pobl, er mwyn helpu i atal argyfwng iechyd meddwl.

Adolygiad o Ofal Integredig: Canolbwyntio ar Gwympiadau

Ym mis Medi 2019, gwnaethom gyhoeddi ein hadolygiad cenedlaethol o'r llwybr gofal integredig ar gyfer cwympiadau ymysg pobl dros 65 oed yng Nghymru: Adolygiad o Ofal Integredig – Canolbwyntio ar Gwympiadau. Mae cwympo yn broblem gyffredin i bobl hŷn, gydag un o bob tri pherson dros 65 oed yn debygol o gwympo bob blwyddyn.

Roedd hwn yn adolygiad arloesol lle nodwyd enghreifftiau o lwybrau delfrydol a chamweithredol. Gwnaethom gynhyrchu cyfres o fideos wedi'u hanimeiddio i esbonio profiad unigolion o'r llwybr cwympiadau yn well.

Gwnaethom wyth argymhelliad allweddol a thynnwyd sylw at yr hyn y gallai staff sy'n gweithio gyda phobl hŷn sy'n wynebu risg o gwympo, yn ogystal â rheolwyr iechyd a gofal cymdeithasol, ei ddysgu. Gwnaethom argymell y dylid llunio Fframwaith Cwympiadau Cenedlaethol i Gymru, er mwyn safoni'r dull o atal, trin ac ailalluogi pobl hŷn sy'n wynebu'r risg o gwympo neu sydd wedi cwympo'n barod. Gwnaethom hefyd argymell y dylai pob bwrdd iechyd weithio'n agos gydag awdurdodau lleol yn ei ardal i lunio llwybr lleol ar gyfer cwympiadau a all fod yn hyblyg i anghenion yr unigolyn, ac sydd hefyd yn gyson â fframwaith cenedlaethol.



Adolygiadau Lleol

Adolygiad ar y cyd o drefniadau llywodraethu ansawdd Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg

Ym mis Ebrill 2019, cyhoeddodd Coleg Brenhinol yr Obstetryddion a'r Gynaecolegwyr a Choleg Brenhinol y Bydwragedd adolygiad hynod feirniadol o wasanaethau mamolaeth yn hen Fwrdd Iechyd Prifysgol Cwm Taf. Nododd yr adolygiad hwn nifer o bryderon difrifol a methiannau mewn gwasanaethau.

Yn rhannol mewn ymateb i'r adroddiad hwn, yn ogystal â'n pryderon ni'n hunain am systemau llywodraethu a rheoli risg, aed ati i gynnal adolygiad ar y cyd brys o drefniadau llywodraethu gydag Archwilio Cymru.

Cynhaliwyd yr Adolygiad ar y Cyd o Drefniadau Llywodraethu Ansawdd Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg yn ystod haf 2019 ac fe'i cyhoeddwyd ym mis Tachwedd 2019. Tynnodd sylw at nifer o faterion a gwendidau sylfaenol yn nhrefniadau llywodraethu ansawdd y bwrdd iechyd a nodwyd 14 o argymhellion ar gyfer gwella, yr ymhelaethir arnynt ar dudalennau 46 - 47.

Cafodd canfyddiadau'r adolygiad ar y cyd eu derbyn yn llawn gan y bwrdd iechyd. Er ein bod wedi ein calonogi gan ymateb y bwrdd iechyd i argymhellion yr adolygiad, ni ddylid tanamcangyfrif yr heriau a wynebir i wella trefniadau llywodraethu ansawdd a diogelwch cleifion, a bydd yn gofyn am ymrwymiad a ffocws parhaus gan y bwrdd iechyd.

Mae hefyd yn bwysig bod Llywodraeth Cymru yn ystyried y materion a godir yn yr adroddiad hwn, ynghyd ag unrhyw wersi ehangach mewn perthynas â'r ffordd y gall gael sicrwydd ynghylch cadernid trefniadau llywodraethu ansawdd o fewn cyrff eraill y GIG.

Public Health Wales

Ym mis Tachwedd 2019, dechreuodd AGIC adolygu Bron Brawf Cymru, sef rhaglen sgrinio'r fron y GIG a ddarperir gan Iechyd Cyhoeddus Cymru (ICC).

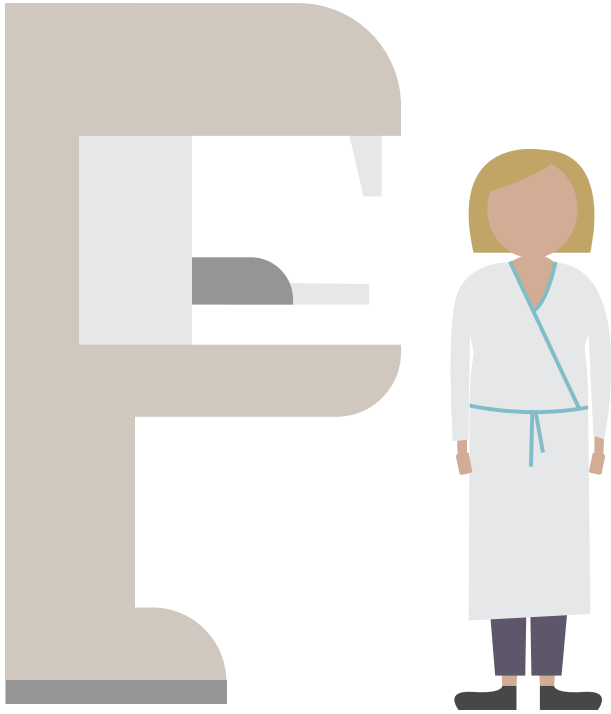
Diben yr adolygiad oedd edrych i weld a yw'r broses o sgrinio'r fron yn cael ei rheoli'n amserol ar gyfer menywod sy'n cael canlyniad mamogram abnormal.

Gwnaethom siarad â staff ym mhencadlys ICC, a staff mewn canolfannau sgrinio'r fron rhanbarthol yng Nghaerdydd, Llandudno ac Abertawe.

Defnyddiwyd arolwg i gasglu barn menywod a ailalwyd i glinig asesu ac a gafodd canlyniad anfalaen (ni nodwyd canser) wedyn.

Roedd yn galonogol iawn nodi bod menywod wedi cael profiad ardderchog ar y cyfan. Fodd bynnag, nododd ein hadolygiad rai heriau o ran y gweithlu rhanbarthol ledled Cymru sy'n effeithio ar amseroldeb y gofal a gaiff menywod. Hefyd, roedd staff Bron Brawf Cymru yn ofalgar, yn ymroddedig ac yn ymrwymedig i ddarparu'r gwasanaeth gorau posibl i fenywod.

Cyhoeddwyd ein hadroddiad ym mis Hydref 2020.



Adolygiadau Lleol

Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru

Fel rhan o raglen AGIC o adolygiadau lleol a'r pryderon parhaus ledled Cymru ynghylch amseroedd aros am ambiwlans, gwnaethom ddechrau adolygiad lleol o Ymddiriedolaeth Gwasanaethau Ambiwlans Cymru ym mis Tachwedd 2019. Ystyriodd yr adolygiad sut y caiff y risgiau i iechyd, diogelwch a lles cleifion eu rheoli tra byddant yn aros am ambiwlans.

Nod yr adolygiad oedd asesu'n benodol sut roedd cleifion yn cael eu rheoli gan dair Canolfan Cyswllt Clinigol y Gwasanaeth Meddygol Brys pan ddaw cais am ambiwlans i law, hyd at yr adeg pan fydd yr ambiwlans yn cyrraedd y claf. Ystyriodd yr adolygiad hefyd sut y caiff y staff sy'n gweithio yn y Canolfannau Cyswllt Clinigol eu cefnogi a'u hyfforddi i ymgymryd â'u rolau, a'r adnoddau sydd ar gael i'w cefnogi i wneud hynny.

Ar y cyfan, nododd ein hadolygiad fod prosesau ar waith sy'n anelu at ddarparu gofal diogel ac effeithiol i gleifion. Fodd bynnag, gwnaethom nodi materion a oedd yn cael effaith negyddol ar allu'r gwasanaeth i ymateb i'r galw. Hefyd, roedd gennym bryderon am swyddi gwag, a'r cyfleoedd hyfforddi a datblygu, a chefnogaeth, a oedd ar gael i'r staff i'w galluogi i gyflawni eu rolau mewn ffordd effeithiol a phriodol.

Cyhoeddwyd ein hadroddiad ym mis Medi 2020.

Canfyddiaddau Arolygiadau

Ysbytai'r GIG

Yn 2019-20 gwnaethom arolygu 38 o ysbytai ledled Cymru, gan gynnwys tri ysbyty cymunedol. Ystyriodd pob arolygiad sut roedd y gwasanaeth yn cyrraedd y Safonau Iechyd a Gofal mewn tri maes: ansawdd profiad y claf; darparu gofal diogel ac effeithiol; ac ansawdd rheolaeth ac arweinyddiaeth.

Parhaodd y cleifion i ganmol ymroddiad, caredigrwydd a thosturi'r staff yn ein holl arolygiadau. Er bod y lleoliadau yn brysur iawn, daeth bron pob un o'n harolygiadau i'r casgliad bod y cleifion yn cael eu trin ag urddas a pharch, ym mron pob agwedd ar eu gofal. Gwelsom sawl enghraifft o waith tîm amlddisgyblaethol da, sy'n cyfrannu at brofiad y cleifion, a hefyd systemau trin a rhyddhau cleifion effeithlon.

"Staff gwych. Bwyd blasus iawn. Mae'r staff bob amser yn barod i'ch helpu." – Claf ym mwrdd iechyd Caerdydd a'r Fro

Mae arweinyddiaeth ar lefel ward a gwasanaeth yn hollbwysig i'r gwaith o ddarparu gofal effeithiol i'r cleifion. Nododd y rhan helaeth o'n harolygiadau fod y rheolwyr yn gefnogol a bod yr arweinwyr yn effeithiol. Fodd bynnag, nid oedd hyn yn wir bob amser ac, ar nifer bach o adegau, dywedodd y staff wrthym fod angen i'r diwylliant arwain wella er mwyn eu helpu i gyflawni eu rolau. Mae neilltuo amser i'r staff nyrsio gwblhau hyfforddiant ac arfarniadau hefyd yn broblem o hyd. Mae'n hanfodol bod buddiannau tymor hwy arweinyddiaeth dda a hyfforddiant parhaus yn cael eu cydnabod yn llawn ym mhob lleoliad.

"Rwy'n fodlon iawn ac yn ddiolchgar i reolwr fy ward am yr holl gymorth y mae'n ei roi i mi ac aelodau eraill y timau. Mae yma i'n cefnogi yn ystod materion proffesiynol a phersonol. Mae bob amser yn mynd yr ail filltir i gefnogi'r staff." – Aelod o staff ym mwrdd iechyd Hywel Dda

Gwnaethom arolygu pedair adran achosion brys fel rhan o'n rhaglen arolygu, a oedd yn cynnwys dau ymweliad dilynol i sicrhau yr aed i'r afael ag argymhellion ymweliadau blaenorol. Nododd yr holl arolygiadau hyn fod y cleifion yn gorfod aros amser hir a'i bod hi'n anodd cael gofal amserol. Mae lefelau staffio a nifer y cleifion mewn adrannau brys yn ffactorau amlwg wrth geisio cadw'r ddysgl yn wastad o ran yr hyn y gall y gwasanaeth ei gyflawni a'r galw sydd amdano. Fodd bynnag, mae ein gwaith yn tynnu sylw cynyddol at yr angen i wella llif cleifion drwy ysbytai er mwyn lleihau'r pwysau ar adrannau brys.

"Weithiau rwy'n mynd gartref yn fy nagrau oherwydd y pwysau sydd arna i am na alla i wneud popeth sydd ei angen. Mae cleifion ym mhob twll a chornel ac mae sawl un yn gorfod aros yng nghefn yr ambiwlans y tu allan" – Aelod o staff ym mwrdd iechyd Bae Abertawe

"Weithiau fe fydda i'n teimlo na alla i ofalu am y cleifion mewn ffordd effeithlon na diwallu eu hanghenion nhw, oherwydd y pwysau cynyddol sydd ar yr adran achosion brys" – Aelod o staff ym mwrdd iechyd Bae Abertawe

Canfyddiaddau Arolygiadau

Archwiliwn lendid a hylendid pob ward ac ardal a arolygwn ac anaml y nodir unrhyw broblemau. Fodd bynnag, yn wahanol iawn i flynyddoedd blaenorol, nodwyd, er mawr siom, amgylcheddau budur, llawn llwch, mewn tri arolygiad, lle nad oedd amserlenni glanhau yn cael eu cwblhau'n rheolaidd. Hefyd nodwyd dirywiad ar un safle penodol. Gwnaethom arolygu adran achosion brys yn 2017, gan nodi pa mor lân oedd y safle a chafodd y staff cadw tŷ eu canmol. Fodd bynnag, mewn arolygiad newydd o'r un safle yn 2020, gwelwyd baw, haenau mawr o lwch a chyfarpar nad oedd yn cael ei lanhau rhwng cleifion. Uwchgyfeiriwyd ein pryderon at y bwrdd iechyd ac roeddem yn fodlon ar y camau a gymerwyd i unioni'r sefyllfa. Rhaid cadw wardiau yn lân er mwyn atal a rheoli heintiau a gall hyn beri risg fawr i gleifion.

Arolygwyd unedau pediatrig mewn tri arolygiad. Lluniwyd holiaduron cleifion newydd er mwyn casglu barn plant a phobl ifanc ar y safleoedd hyn. Gwelsom enghreifftiau rhagorol o'r defnydd o therapyddion chwarae i helpu'r plant drwy driniaethau, ac roedd cynlluniau chwarae unigol ar gyfer y cleifion hynny a oedd yn mynd i fod ar y ward am gyfnod estynedig. Fodd bynnag, mewn dau arolygiad, nodwyd nad oedd cynllun y ward yn ei gwneud hi'n hawdd sicrhau preifatrwydd ac urddas yr holl gleifion. Un enghraifft o hyn oedd cleifion a rhieni yn gorfod cerdded drwy ardaloedd gwely ar wahân bechgyn a merched i fynd i'r ardd. Gwnaethom argymell gwelliannau i'r cynllun a chafodd y rhain eu cynnwys mewn gwaith buddsoddi yn yr uned a oedd i ddod.

"Rwy'n mwynhau chwarae gemau o amgylch y bwrdd" – Claf ym mwrdd iechyd Hywel Dda

"Roedd yr holl staff yma yn wych. Nid oedd fy mab wedi bod yn yr ysbyty o'r blaen ac roedd yn brofiad brawychus i bawb. Roeddent yn rhoi tawelwch meddwl, yn barod iawn i helpu ac yn garedig, gan wneud cyfnod anodd cymaint yn haws" – Gofalwr claf ym mwrdd iechyd Hywel Dda

Pan ystyriodd yr arolygwyr pa mor dda y cafodd ein hargymhellion blaenorol eu rhoi ar waith, roeddem yn falch i weld bod y rhan fwyaf wedi cael eu rhoi ar waith a'u bod yn cael eu cynnal. Fodd bynnag, roedd ambell un yn dal i fod yn weddill ac, er mawr siom, rydym yn dal i weld yr un materion yn codi mewn llawer o'n harolygiadau, yn enwedig o ran rheoli meddyginiaethau a'u storio'n ddiogel. Enghraifft o hyn yw hylifau IV a chyffuriau a reolir a adewir mewn ardaloedd agored, heb eu cadw dan glo.

Roedd archwiliadau annigonol a lefel wael o gynnal a chadw cyfarpar dadebru hefyd yn thema gyffredin. Disgwyliwn i'r byrddau iechyd rannu canfyddiadau ein harolygiadau â wardiau ac ysbytai eraill fel y gallant ddysgu gwersi, a gweld a oes angen i safleoedd eraill wneud gwelliannau tebyg. Mae angen cyflwyno systemau mwy effeithiol er mwyn sicrhau bod hyn yn cael ei wneud yn gadarn.

Canfyddiaddau Arolygiadau

Meddygfeydd

Eleni gwnaethom gynnal 25 o arolygiadau o feddygfeydd o fewn y saith bwrdd iechyd yng Nghymru. Ystyriodd pob arolygiad sut roedd y feddygfa yn cyrraedd y safonau iechyd a gofal.

Nodwyd bod y cleifion yn cael eu trin mewn ffordd urddasol, ac roedd y staff yn barchus, yn gwrtais ac yn broffesiynol. Gwelsom amgylchedd croesawgar yn y rhan fwyaf o'r meddygfeydd, gyda safonau uchel o lendid yn y saith bwrdd iechyd. Yn ystod yr arolygiadau, gwelsom dystiolaeth o arweinyddiaeth effeithiol gyda thimau rheoli cynhwysol a chydlynol ar waith. Yn gyffredinol, dywedodd y cleifion wrthym eu bod yn fodlon ar y gofal roeddent yn ei gael.

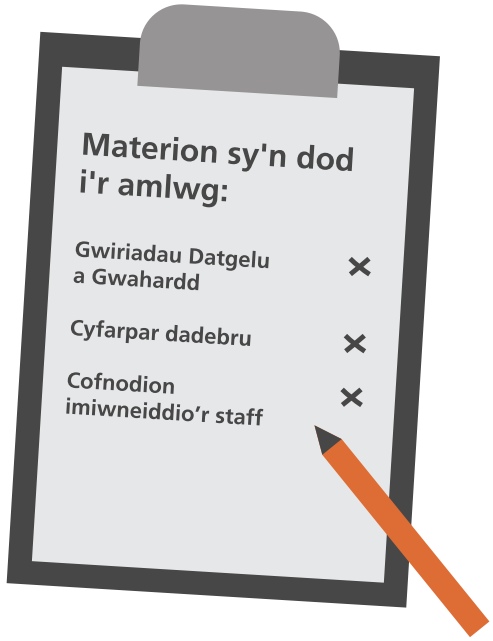
Fodd bynnag, yn 2019-20 parhawyd i weld problemau yn trefnu apwyntiadau i weld gweithiwr gofal iechyd proffesiynol. Dywedodd y cleifion wrthym am systemau trefnu apwyntiadau dros y ffôn gwael, bod angen aros amser hir i weld meddyg a bod oriau agor meddygfeydd yn fyr - awgrymodd llawer o'r cleifion y dylid cynnig apwyntiadau min nos neu ar benwythnosau.

Eleni gwnaethom gyflwyno 15 o Lythyrau Sicrwydd Uniongyrchol; roedd hyn bron deirgwaith yn fwy na blynyddoedd blaenorol. Mae hyn yn golygu ein bod wedi ysgrifennu at y feddygfa yn union wedi'r arolygiad gan nodi bod angen cymryd camau unioni ar frys er mwyn cadw'r cleifion yn ddiogel.

Roedd angen gwneud gwelliannau ar unwaith mewn wyth meddygfa a hynny'n ymwneud â chyflogi staff a gwiriadau'r Gwasanaeth Datgelu a Gwahardd (DBS). Gwiriadau cofnodion troseddol yw'r rhain y mae'r rhan fwyaf o gyflogwyr yn eu cynnal ar staff newydd. Nodwyd nad oedd y gwiriadau hyn wedi'u cynnal ar gyfer pob aelod presennol o'r staff, neu nid oedd modd dod o hyd i gofnodion. Rhaid cynnal gwiriadau DBS ar gyfer pob aelod o staff sy'n gweithio mewn gofal iechyd, ar lefelau gwahanol, ac maent yn rhan hanfodol o sicrhau diogelwch cleifion.

"Staff hyfryd. Meddygon gwych. Ry'n ni mor ffodus bod gennym ni feddygon teulu mor dda ac nad oes angen dibynnu ar locwm pan fo'r wlad yn ei chael hi'n anodd recriwtio a chadw meddygon" – Claf ym mwrdd iechyd Hywel Dda

"Staff gwych sy'n barod eu cymwynas bob amser. Tîm ardderchog, gofalgar" – Claf ym mwrdd iechyd Powys



Canfyddiaddau Arolygiadau

Nodwyd bod angen gwneud gwelliannau ar unwaith mewn perthynas â chynnal a chadw cyfarpar dadebru mewn pedair meddygfa. Gwelsom hen gyfarpar neu gyfarpar nad oedd wedi'i galibradu, ac nid oedd y cyfarpar dadebru yn cael ei archwilio bob amser. Mae angen y cyfarpar hwn rhag ofn y bydd argyfwng yn ymwneud â chlaf a rhaid ei archwilio er mwyn sicrhau ei fod yn gweithio bob amser.

Roedd hefyd angen gwneud gwelliannau ar unwaith i gynnal cofnodion imiwneiddio'r staff, yn enwedig Hepatitis B, ar bum safle. Dylai meddygfeydd allu darparu tystiolaeth bod pob aelod o'u staff wedi'u diogelu'n ddigonol rhag y feirws.

"Mae'r gofal a roddir yn y feddygfa hon bob amser wedi bod yn wych. Ond mae cyfyngiadau'r apwyntiad 5 munud; yr anawsterau wrth gynnal cysondeb o ran gweld yr un meddyg, a'r pryder ynghylch y gallu i gael apwyntiad oll yn golygu bod yr hyn a arferai fod yn wasanaeth cadarn a oedd yn rhoi tawelwch meddwl, dan fygythiad" – Claf ym mwrdd iechyd Hywel Dda

Nodwyd bod gan y rhan fwyaf o'r meddygfeydd brosesau cadw cofnodion cadarn ar gyfer cofnodion eu cleifion. Fodd bynnag, nodwyd nad oedd gan rai meddygfeydd system glir ar waith i reoli atgyfeiriadau. Er enghraifft, roedd un feddygfa na allai gadarnhau a oedd atgyfeiriadau cleifion yn cael eu hanfon i'r adran gywir, neu a oeddent wedi'u prosesu mewn ffordd amserol.

O gymharu â blynyddoedd blaenorol, roedd gwelliant cyffredinol o ran y wybodaeth a oedd ar gael i'r cleifion yn ardaloedd aros y meddygfeydd. Roedd taflenni a phosteri ar gael i'r cleifion ar aros yn iach, a gwybodaeth am anhwylderau cyffredin. Hefyd, roedd gwelliant clir o ran arddangos gwybodaeth am sut i gwyno a phroses Gweithio i Wella GIG Cymru.

"Mae'n anodd cysylltu dros y ffôn. Efallai nad oes digon o linellau" – Claf ym mwrdd iechyd Caerdydd a'r Fro

Canfyddiaddau Arolygiadau

Deintyddfeydd

Yn 2019-20 gwnaethom barhau i weithio gyda'n hadolygwyr cymheiriaid deintyddfeydd i sicrhau bod cleifion yn cael gofal a thriniaeth ddeintyddol yn unol â chanllawiau proffesiynol a deddfwriaeth berthnasol, gan gynnwys y Safonau Iechyd a Gofal a Rheoliadau Deintyddiaeth Breifat (Cymru) 2017.

Gwnaethom arolygu 68 o ddeintyddfeydd cyffredinol, a oedd yn cynnwys pum ymweliad dilynol i sicrhau yr aed i'r afael ag argymhellion ymweliadau blaenorol.

Roedd gan y rhan fwyaf o'r deintyddfeydd gyfleusterau pwrpasol i lanhau a sterileiddio (dihalogi) cyfarpar deintyddol fel yr argymhellir yng nghanllawiau Memorandwm Technegol Iechyd Cymru (WHTM) 01-05. Fodd bynnag, nododd ein hadolygwyr cymheiriaid amrywiaeth o welliannau yn ymwneud ag atal a rheoli heintiau yn ystod yr arolygiadau. Y materion mwyaf cyffredin a godwyd oedd prosesau archwilio a phrofi awtoclafau anghyson, tystiolaeth nad oedd yr hyfforddiant gofynnol ar atal a rheoli heintiau ar gael, a'r angen i gynnal archwiliadau rheolaidd o drefniadau rheoli heintiau. Rhaid i ddeintyddfeydd fonitro ac asesu eu cydymffurfiaeth â gweithdrefnau atal a rheoli heintiau arfer orau yn rheolaidd er mwyn cynnal safonau.

Er inni gael sicrwydd amserol wedyn, mae'n rhwystredig bod llawer o'r materion roedd angen ymdrin â nhw'n syth yr un peth â'r rhai a godwyd yn 2018-19. Mae'n bwysig bod deintyddfeydd a byrddau iechyd yn sicrhau bod unrhyw beth a ddysgir yn sgil canfyddiadau ac adroddiadau ein harolygiadau yn cael ei roi ar waith mewn ffordd gadarn a'i rannu'n effeithiol.

Hefyd, rhaid rhoi trefniadau mwy effeithiol a rhagweithiol ar waith i fonitro rheoliadau perthnasol a safonau proffesiynol, a sicrhau y cydymffurfir â nhw.

Canfyddiadau

Gwnaethom arolygu deintyddfeydd ym mhob bwrdd iechyd yng Nghymru, heblaw am Bowys, ac roedd y canfyddiadau'n dda ar y cyfan. Roedd y staff yn deall eu rolau a'u cyfrifoldebau ac roedd yn amlwg eu bod yn gweithio'n galed, ac yn ymrwymedig i sicrhau bod y cleifion yn cael gwasanaeth o ansawdd da o dan eu gofal.

Roedd sylwadau'r cleifion yn ystod ein harolygiadau bron bob amser yn gadarnhaol, a nodwyd bod gan y rhan fwyaf o'r deintyddfeydd bellach brosesau sefydledig ar waith i ymgysylltu â'r cleifion i gael adborth ar y gwasanaeth a ddarperir. Fodd bynnag, cynghorwn ddeintyddfeydd yn rheolaidd i arddangos canlyniadau holiaduron neu arolygon a hysbysu cleifion o'r camau a gymerwyd mewn ymateb i'w hadborth er mwyn gwella'r gwasanaeth a ddarperir. Mae hyn yn galluogi'r cleifion i ddeall sut mae eu barn wedi llywio'r gwasanaeth a ddarperir.

Roedd gan y rhan fwyaf o'r deintyddfeydd gyfleusterau pwrpasol i lanhau a sterileiddio (dihalogi) cyfarpar deintyddol fel yr argymhellir yng nghanllawiau Memorandwm Technegol Iechyd Cymru (WHTM) 01-05. Fodd bynnag, nododd ein hadolygwyr cymheiriaid amrywiaeth o welliannau yn ystod yr arolygiadau, ac mae angen i'r deintyddfeydd sicrhau eu bod yn monitro ac yn asesu eu cydymffurfiaeth â gweithdrefnau atal a rheoli heintiau arfer orau yn rheolaidd.

Canfyddiaddau Arolygiadau

Mae'r trefniadau a'r prosesau sydd ar waith i hybu a sicrhau lles a diogelwch y staff, y plant a'r oedolion yn gadarn, a nodwyd arferion da yn y maes hwn yn rheolaidd. Mae sicrhau bod y staff yn ymwybodol o'u cyfrifoldebau o dan Weithdrefnau Diogelu 2019 newydd Cymru, ac yn eu deall, yn faes a ystyrir gan ein harolygwyr yn y dyfodol.

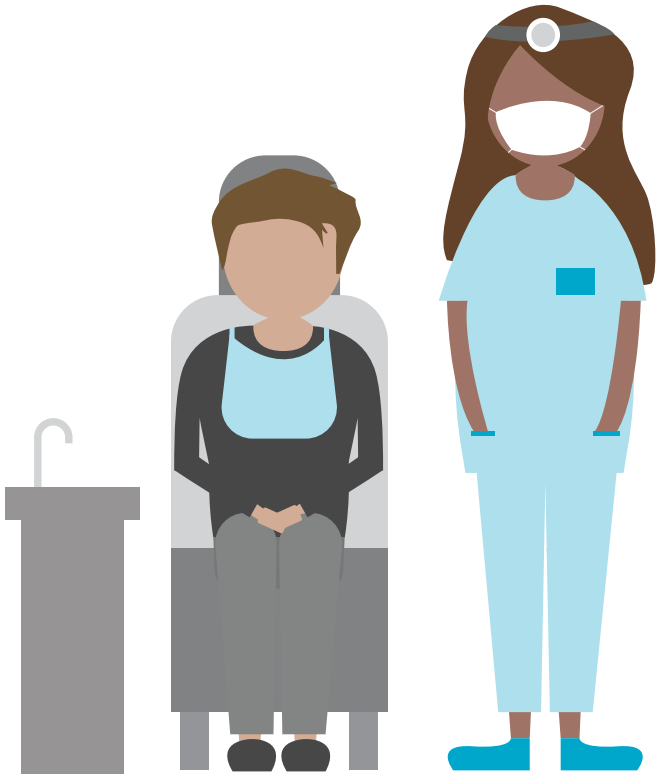
"Roedd y staff yn garedig ac yn ofalgar iawn. Mae'r staff hefyd yn gyfeillgar iawn ac yn cynnig y cyngor gorau i ddiogelu fy neintgig a'm dannedd bob amser. Practis deintyddol gwych ar y cyfan." – Claf ym mwrdd iechyd Bae Abertawe

Roedd cofnodion cleifion yn amrywio o ran ansawdd. Roedd rhai o'r deintyddfeydd yn cadw cofnodion cleifion ardderchog a oedd yn glir, yn ddealladwy ac yn cynnwys yr holl wybodaeth berthnasol am drafodaethau a gynhaliwyd ynglŷn ag opsiynau triniaeth, costau, risgiau, buddiannau a sut y gofynnwyd am gydsyniad cleifion. Fodd bynnag, safon wael o ran cadw cofnodion oedd y mater a godwyd fwyaf mewn Llythyrau Sicrwydd Uniongyrchol a hysbysiadau diffyg cydymffurfio. Mae'n hanfodol bod deintyddfeydd yn defnyddio archwiliadau ac adolygiadau cymheiriaid i helpu i sicrhau bod cofnodion cleifion yn gywir ac yn gynhwysfawr.

Ar y cyfan roedd y staff yn cael eu cefnogi yn eu rolau drwy drefniadau rheoli a llywodraethu da, a gallent achub ar y cyfleoedd hyfforddi a datblygu proffesiynol parhaus priodol er mwyn cyflawni eu rolau a'u cyfrifoldebau. Bydd ein harolygwyr yn parhau i ddisgwyl i weithwyr deintyddol proffesiynol allu dangos eu bod yn cydymffurfio â'u rhwymedigaethau proffesiynol eu hunain.

Un o'r materion mwyaf arwyddocaol a gododd yn ein harolygiadau oedd y ffaith nad oedd trefniadau addas ar waith i ddiogelu cleifion a staff mewn argyfwng meddygol. Rhaid i ddeintyddfeydd sicrhau bod cyffuriau brys a chyfarpar dadebru ar gael yn unol â chanllawiau'r Cyngor Dadebru, a bod archwiliadau wedi'u dogfennu yn cael eu cynnal bob wythnos i sicrhau eu bod yn gyfredol ac yn ddiogel i'w defnyddio.

"Yn fy marn i, hwn yw'r practis deintyddol gorau rwyf erioed wedi ei ddefnyddio. Allwn i ddim meddwl am unrhyw ffyrdd o wella'r gwasanaeth." – Claf ym mwrdd iechyd Betsi Cadwaladr



Canfyddiaddau Arolygiadau

Iechyd Meddwl ac Anableddau Dysgu

Yn 2019-20 cynhaliodd AGIC 13 o arolygiadau o ysbytai'r GIG, gan gynnwys uned Gwasanaethau Iechyd Meddwl Plant a'r Glasoed (CAMHS), uned diogelwch canolig, gwasanaeth anableddau dysgu, Uned Gofal Dwys Seiciatrig (PICU) a gwasanaethau gofal i'r henoed. Arolygom tri thimau iechyd meddwl cymunedol mewn rhannau gwahanol o Gymru.

O ran arolygiadau gofal iechyd annibynnol, gwnaethom gynnal 15 o ymweliadau, gan gynnwys un ysbyty anableddau dysgu, unedau diogelwch canolig ac uned CAMHS. Ymwelwyd â'r un uned CAMHS ddwywaith ac ymwelwyd â'r un darparwr annibynnol ddwywaith. Fel rhan o'r ymweliadau hyn mae AGIC yn parhau i fonitro'r defnydd o'r Ddeddf Iechyd Meddwl, y Ddeddf Galluedd Meddyliol, gan gynnwys Trefniadau Diogelu wrth Amddifadu o Ryddid (DoLS), a Mesur Iechyd Meddwl (Cymru) 2010.

Canfyddiadau

Nododd AGIC sawl maes cadarnhaol yn ystod ei gwaith. Roedd y staff yn rhyngweithio ac yn ymgysylltu â'r cleifion mewn modd parchus a gwelwyd gwaith tîm da gyda staff ymroddedig a llawn cymhelliant. Hefyd roedd y cleifion yn cael amrywiaeth dda o therapïau a gweithgareddau, ac roedd rhai enghreifftiau da o gynlluniau gofal a thriniaeth.

Mewn ambell achos roedd yn amlwg bod y Byrddau Iechyd a'r Darparwyr Annibynnol wedi cyflwyno sawl newid yn dilyn arolygiadau blaenorol, ac wedi rhoi modelau gofal lleiaf cyfyngol ar waith. Hefyd gwelsom dystiolaeth o rai trefniadau llywodraethu effeithiol a oedd yn cael effaith gadarnhaol ar y gofal a oedd yn cael ei ddarparu.

Fodd bynnag, gwnaeth AGIC nifer sylweddol o argymhellion i fyrddau iechyd unigol, ynghyd â nodi gofynion gwella ar gyfer darparwyr gofal annibynnol cofrestredig. Gwnaethom barhau i nodi amrywiaeth o fethiannau wrth gynnal a chadw ac adnewyddu wardiau ac, mewn rhai achosion, roedd hyn yn cael effaith andwyol ar ofal, preifatrwydd, urddas a diogelwch y cleifion. Roedd hen gynllun rhai amgylcheddau clinigol hefyd yn cael effaith ar breifatrwydd ac urddas y cleifion.

Canfyddiadau Arolygiadau

Gwelsom amrywiaeth o sgyrsiau yn digwydd a oedd yn amrywio'n sylweddol rhwng y staff, a rhwng y staff a'r cleifion, ac yn anffodus nid oedd rhai yn briodol. Cafwyd un enghraifft lle roedd aelod presennol o'r staff yn cyflwyno'r ysbyty i gyflogai newydd, lle dywedodd y byddai'r cleifion yn y carchar oni bai am y Ddeddf Iechyd Meddwl. Ymhlith y problemau mawr eraill a nodwyd roedd y canlynol: morâl gwael ymhlith y staff nyrsio a gofal, problemau yn monitro iechyd corfforol, a systemau larwm personol annigonol wrth alw staff o wardiau eraill.

Roedd ansawdd y cynlluniau gofal yn amrywio'n sylweddol. Mewn rhai achosion ni allem ddod o hyd i gynllun gofal i fynd i'r afael â risgiau sylweddol i'r claf a nodwyd; roedd hyn yn destun pryder mawr o ran diogelu cleifion agored i niwed. Hefyd, ni roddwyd hyfforddiant mewn sawl maes allweddol i'r staff, gan gynnwys y canlynol: y Ddeddf Iechyd Meddwl, y Ddeddf Galluedd Meddyliol, rheoli risg, arsylwi ar y cleifion, anhwylderau bwyta, anawsterau dysgu gan gynnwys awtistiaeth ac anhwylder diffyg canolbwyntio a gorfywiogrwydd (ADHD), ac amrywiaeth o hyfforddiant gorfodol. Hefyd nid oedd y Byrddau Iechyd yn rhannu'r hyn a ddysgwyd o arolygiadau.

Yn ystod y flwyddyn nodwyd unwaith eto broblemau sylweddol mewn perthynas â rheoli meddyginiaethau mewn ffordd effeithiol. Ymhlith y problemau roedd y canlynol:

- gwallau cyfrif stoc
- llofnodion tystion ar goll yn y llyfr Cyffuriau a Reolir
- rhesymau dros roi meddyginiaeth PRN (pro re nata / yn ôl y gofyn) ddim yn cael eu cofnodi bob amser

- hen wybodaeth ar ddyddiadau pigiadau depo
- rhwymynnau a ddifrodwyd gan ddŵr
- oergelloedd a droriau lle cadwyd meddyginiaeth ddim yn cael eu cloi
- diffyg system gadarn gyda'r fferyllfa ar gyfer archebu a danfon meddyginiaeth frys
- diffyg proses i sicrhau y cymerir camau i fynd i'r afael â thymereddau anfoddhaol ar gyfer oergelloedd meddyginiaeth ar unwaith
- diffyg manylion cleifion ar Gofnodion Rhoi Meddyginiaeth
- trefniadau annigonol ar waith i ddychwelyd neu waredu meddyginiaeth nad oes ei hangen yn brydlon
- meddyginiaeth a ragnodir ddim yn cael ei hawdurdodi gan y dystysgrif cydsynio i driniaeth gyfatebol
- cypyrddau cyffuriau a reolir ddim yn cael eu defnyddio i storio eitemau amhriodol.

Hefyd, nid oedd polisïau a oedd yn berthnasol i ddefnyddio ystafelloedd meddyginiaeth ac ystafelloedd clinig bob amser yn gyfredol ac ni allai'r staff gael gafael arnynt bob amser.

Rhan allweddol o'r ymweliadau iechyd meddwl y mae AGIC yn eu cynnal yw cyflawni ei chyfrifoldebau i fonitro Deddf Iechyd Meddwl 1983 ar ran Gweinidogion Cymru sydd â dyletswyddau penodol y mae'n ofynnol iddynt eu cyflawni o dan y gyfraith. Mae AGIC yn cyhoeddi adroddiad manylach ar wahân ar ganfyddiadau'r ymweliadau hyn, sy'n cynnwys adran ar y ffordd y caiff y Ddeddf ei gweithredu. Mae'r adroddiad yn ystyried sut mae byrddau iechyd unigol a darparwyr cofrestredig annibynnol yn cyflawni eu dyletswyddau fel bod y Ddeddf yn cael ei gweinyddu'n gyfreithlon ac yn briodol ledled Cymru.

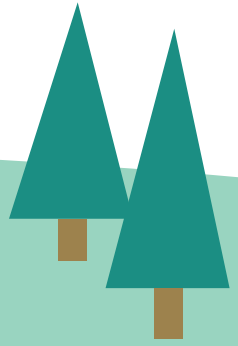
Fel rhan o'n rôl i fonitro'r defnydd o'r Ddeddf Iechyd Meddwl gwnaethom barhau i nodi llawer o arferion da wrth weithredu a dogfennu'r Ddeddf ac roedd yn amlwg bod lefel dda o lywodraethu ac archwilio ar waith. Yn y rhan helaeth o achosion, roedd dogfennaeth gyfreithiol i gadw cleifion o dan y Ddeddf Iechyd Meddwl yn bodloni gofynion y ddeddfwriaeth, ac roedd cofnodion cynhwysfawr ar gyfer gweinyddu'r Ddeddf.

Roedd cofnodion y cleifion yn nodi eu bod wedi cael eu hysbysu am eu hawliau yn unol ag Adran 132 o'r Ddeddf. Dangosodd cofnodion fod apeliadau yn erbyn cadw cleifion wedi'u cynnal o fewn yr amserlenni gofynnol a rhoddwyd meddyginiaeth i'r cleifion yn unol ag Adran 58 o'r Ddeddf. O ran Cydsynio i Driniaeth, roedd tystysgrifau triniaeth yn cael eu cadw gyda'r Siart Cofnod Rhoi Meddyginiaeth gyfatebol. Roedd hyn yn golygu bod y staff a oedd yn rhoi'r feddyginiaeth yn gallu cyfeirio at y dystysgrif er mwyn sicrhau bod y feddyginiaeth wedi'i rhagnodi o dan ddarpariaethau cydsynio i driniaeth Adran 58 o'r Ddeddf Iechyd Meddwl.

Canfyddiaddau Arolygiadau

Fodd bynnag, gwnaethom nodi rhai problemau wrth weinyddu'r Ddeddf gan gynnwys:

- Dylai gweinyddwr y Ddeddf Iechyd Meddwl ystyried gwella'r lefelau o gyfathrebu â thimau allanol, er enghraifft er mwyn sicrhau bod y cleifion yn cael eu Tribiwnlysoedd Adolygu Iechyd Meddwl a gwrandawiadau rheolwyr yn unol â'r amserlenni a ganiateir gan y Ddeddf
- Mae angen gwella'r broses dderbyn yn sylweddol, yn enwedig o ran priodoldeb cadw cleifion - nid oedd y papurau i gadw cleifion yn yr ysbyty wedi'u cwblhau'n gywir i gyd
- Mewn un enghraifft, nid oedd ffurflen CO2[5] wedi cael ei chwblhau ar gyfer un o'r cleifion ar ôl iddo gael ei drosglwyddo i'r ysbyty. Roedd hyn yn golygu nad oedd tystiolaeth i gadarnhau bod y claf wedi cydsynio i gael ei drosglwyddo nac i'r driniaeth a gafodd yn ehangach
- Mewn ymweliad arall, pan gafodd pob set o ddogfennau statudol ei hadolygu, nid oedd cofnod o asesiad clinigydd cyfrifol y claf o alluedd y claf i gydsynio i driniaeth. Hefyd, nid oedd cofnod i ddangos bod triniaethau'n cael eu hadolygu'n rheolaidd
- Mewn un enghraifft, roedd tystysgrif cydsynio i driniaeth un claf yn fwy na thair blwydd oed ac nid oedd tystiolaeth i ddangos ei bod wedi cael ei hadolygu
- Mewn ambell achos, nid oedd arwydd clir wedi'i osod ar dystysgrifau cydsynio i driniaeth nad oeddent yn awdurdodi triniaeth mwyach er mwyn dangos i'r staff nad oeddent yn ddilys mwyach
- Nid oedd arwydd clir wedi'i osod ar ffurflenni awdurdodi Absenoldeb Adran 17 nad oeddent yn awdurdodi absenoldeb mwyach er mwyn dangos i'r staff nad oeddent yn ddilys mwyach
- Staff annigonol yn yr adran Deddf Iechyd Meddwl
- Diffyg papurau cadw yng nghofnodion cyfredol cleifion.



[5] Mae ffurflen CO2 yn dynodi bod y claf wedi cydsynio i'r cynllun triniaeth

Canfyddiaddau Arolygiadau

Gofal Iechyd Annibynnol

Mae ein harolygiadau o leoliadau gofal iechyd annibynnol, heblaw iechyd meddwl, yn ceisio sicrhau bod gwasanaethau yn cydymffurfio â Deddf Safonau Gofal 2000, gofynion Rheoliadau Gofal Iechyd Annibynnol (Cymru) 2011 a chadarnhau sut mae gwasanaethau'n cyrraedd y Safonau Gofynnol Cenedlaethol ar gyfer Gwasanaethau Gofal Iechyd Annibynnol yng Nghymru. Anelwn at arolygu'r gwasanaethau hyn bob tair blynedd o leiaf, ond gallwn gynnal ymweliadau mwy rheolaidd os oes angen o ganlyniad i wybodaeth a ddaw i law neu newid gwasanaeth.

Canfyddiadau

Ysbytai Annibynnol

Cafwyd canfyddiadau cadarnhaol yn dilyn ein harolygiadau o saith ysbyty annibynnol eleni ac ni nodwyd unrhyw faterion o ran diogelwch cleifion lle roedd angen gweithredu ar unwaith. O ganlyniad ni fu angen cyflwyno unrhyw hysbysiadau diffyg cydymffurfio.

Roedd systemau rheolaeth ac arweinyddiaeth cryf a gweladwy ar waith yn ein holl arolygiadau, ac mae'n parhau i fod yn faes lle prin y gwneir argymhellion. Ar y cyfan, gwelsom brosesau a gweithdrefnau clir i helpu i ddarparu gofal diogel ac effeithiol. Dywedodd y cleifion wrthym eu bod yn hapus â'r profiad a'r gwasanaeth roeddent wedi'u cael a chwblhawyd cofnodion y cleifion i safon uchel yn gyffredinol.

Fodd bynnag, gwnaethom nodi rhai problemau o ran dogfennaeth ac asesu risgiau. Roedd enghreifftiau lle roedd angen gwella dogfennaeth cyn asesu drwy ei gwneud yn fanylach, gan gynnwys cofnodi gwybyddiaeth, diogelu ac unrhyw gredoau crefyddol. Roedd angen i rai asesiadau risg fod yn fwy cadarn ac roedd angen ychwanegu manylion penodol am gleifion atynt o bryd i'w gilydd. Rhaid cwblhau a / neu adolygu pob asesiad risg ar adeg derbyn claf, a'i storio gyda nodiadau'r claf.

Atgoffwyd lleoliadau hefyd i sicrhau bod eu staff yn cwblhau'r holl hyfforddiant gorfodol a bod cofnodion cyfredol o hyn yn cael eu cadw gan y lleoliad.

Er bod systemau atal a rheoli heintiau yn dda ar y cyfan, roedd yn faes lle gwnaethom amrywiaeth o argymhellion. Yn eu plith roedd cynnal a chadw amgylcheddau'n briodol fel bod modd eu glanhau'n effeithiol, er enghraifft trwsio arwynebau sydd â darnau bach ar goll, sy'n rhydu neu sy'n fandyllog. Mae angen ystyried niferoedd a lleoliadau sinciau golchi dwylo a biniau gwastraff clinigol, ac atgoffa'r staff i ddilyn y canllawiau golchi dwylo, a rhaid i leoliadau newid neu ddefnyddio llenni untro os oes angen.

"Staff gofalgar a pharod eu cymwynas sy'n darparu gofal gwych" - Claf Ysbyty Annibynnol

Canfyddiaddau Arolygiadau

Clinigau Annibynnol a gwasanaethau sy'n darparu 'technegau rhagnodedig'

Sefydliadau lle caiff gwasanaethau eu darparu gan ymarferwyr meddygol preifat, heb fod gwelyau dros nos yno, yw clinigau annibynnol.

Gwasanaethau, megis IVF (ffrwythloni in vitro), terfynu beichiogrwydd, ac enwaedu, yw 'technegau rhagnodedig' a ddarperir gan leoliadau sydd wedi cofrestru â ni fel ysbyty annibynnol. Mae hyn hefyd yn cynnwys ysbytai deintyddol sy'n darparu triniaeth o dan anaesthesia cyffredinol.

Gwnaethom gynnal saith arolygiad eleni a pharhawyd i weld lefelau uchel o foddhad cleifion ar gyfer clinigau annibynnol a gwasanaethau ledled Cymru. Roedd yn braf gweld na nodwyd unrhyw faterion o ran diogelwch cleifion lle roedd angen gweithredu ar unwaith ac, o ganlyniad, nid oedd angen inni gyflwyno unrhyw hysbysiadau diffyg cydymffurfio.

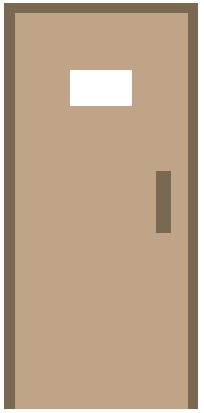
Ym mhob arolygiad clinigol, gwelsom amgylcheddau glân a oedd yn cael eu cynnal a'u cadw'n dda, ac roedd trefniadau ar waith i sicrhau bod gofal a thriniaeth yn cael eu darparu i gleifion mewn ffordd ddiogel ac effeithiol.

Fodd bynnag, gwnaethom nodi nifer bach o achosion o dorri rheoliadau. Rhaid i ddarparwyr cofrestredig sicrhau bod gwiriadau DBS yn cael eu cynnal i lefel briodol a bod hyfforddiant staff gorfodol yn cael ei gwblhau gyda chofnodion cyfredol. Hefyd, rhaid i'r unigolyn cyfrifol gynnal ymweliadau bob chwe mis o leiaf, gan lunio adroddiad ar ymddygiad y gwasanaeth yn dilyn yr ymweliad.

Ymhlith yr argymhellion ar gyfer gwella roedd sicrhau bod cofnodion cleifion yn cael eu cadw i safon uchel, yn enwedig trefniadaeth cofnodion, pa mor hawdd ydynt i'w deall, a gweithdrefnau gwrthlofnodi; gwella argaeledd deunydd hybu iechyd; a rhaid arddangos y canlyniadau ac unrhyw newidiadau a wnaed yn dilyn adborth cleifion lle gallant eu gweld.

Nodwyd y defnydd o hebryngwyr yn fater unwaith eto. Rhaid i ddarparwyr cofrestredig gymryd camau ystyrlon i sicrhau bod cynnig hebryngwyr a defnyddio hebryngwyr yn cael eu cofnodi.

O ran gwasanaethau sy'n darparu technegau rhagnodedig, roedd adborth y cleifion yn gadarnhaol ym mhob arolygiad, ac roedd y lleoliadau yn lân ac yn daclus, gyda threfniadau atal a rheoli heintiau addas ar waith. Fodd bynnag, gwnaethom nodi achos o dorri rheoliadau mewn un lleoliad lle na chadwyd cofnodion y cleifion yn unol â'r safonau proffesiynol.



Canfyddiaddau Arolygiadau

Laserau Dosbarth 3b/4 a Goleuni Pwls Dwys (IPL)

Eleni gwnaethom gynnal 27 o arolygiadau o'r lleoliadau hyn o gymharu â 15 y flwyddyn flaenorol. Ar y cyfan nodwyd bod y cleifion yn cael gofal diogel ac effeithiol gan y staff a oedd yn meddu ar y sgiliau a'r wybodaeth briodol i'w trin.

Yn gyffredinol, cawsom y sicrwydd canlynol:

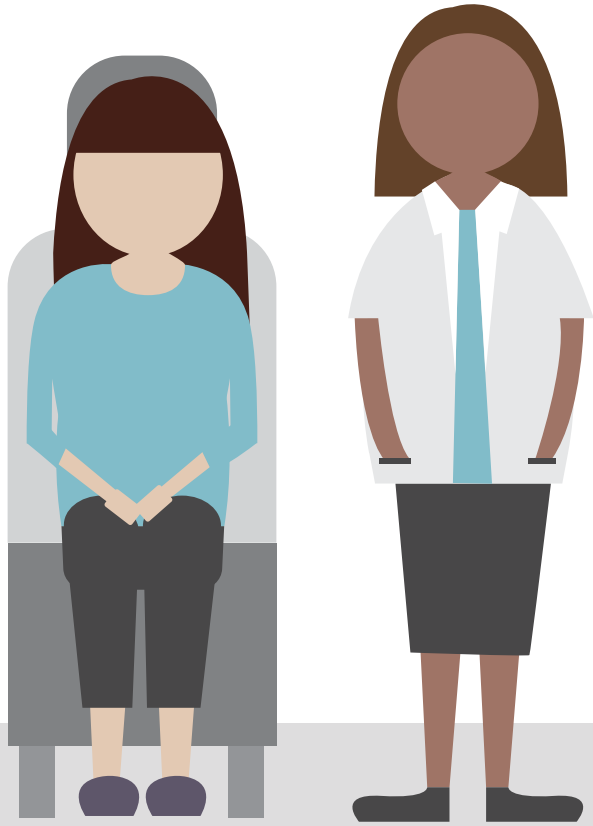
- Cafwyd cydsyniad ar sail gwybodaeth am fod y cleifion yn cael y wybodaeth gywir am eu triniaeth mewn ffyrdd y gallent eu deall
- Roedd nodiadau a chofnodion y cleifion yn cael eu cadw i safon dda i ddangos bod y cleifion yn cael gofal unigoledig
- Roedd y peiriannau laser ac IPL a oedd yn cael eu defnyddio gan y lleoliadau i ddarparu triniaethau wedi cael eu gwasanaethu a'u calibradu er mwyn sicrhau eu bod yn gweithio'n ddiogel ac yn ôl y disgwyl.

Nodwyd bod mwy o leoliadau yn defnyddio'r cyfryngau cymdeithasol fel ffordd o gasglu adborth gan y cleifion.

Rhaid i'r lleoliadau hefyd sicrhau eu bod yn casglu adborth y cleifion hynny sydd leiaf tebygol o roi adborth ar-lein.

Nodwyd rhai gwelliannau cyffredin yn unol â chanllawiau proffesiynol a safonau roedd angen i'r lleoliadau eu gwneud. Roedd y rhain yn cynnwys:

- Rhagofalon tân gwell, megis profion larwm tân wedi'u dogfennu bob wythnos a chwblhau asesiadau risg tân rheolaidd
- Archwilio pecynnau cymorth cyntaf yn amlach er mwyn sicrhau bod y dyddiadau ar y cynnwys yn iawn a bod y cynnwys yn ddiogel i'w ddefnyddio
- Dogfennu amserlenni glanhau i ddangos bod trefniadau rheoli heintiau yn cael eu dilyn
- Sicrhau bod y staff yn cael hyfforddiant diogelu priodol i hybu ac amddiffyn lles a diogelwch plant ac oedolion agored i niwed
- Cael ymarferydd meddygol arbenigol i lunio protocolau cyfredol ar gyfer triniaethau meddygol sy'n nodi'r gweithdrefnau i'w dilyn i sicrhau bod triniaeth yn cael ei darparu'n ddiogel.



Canfyddiaddau Arolygiadau

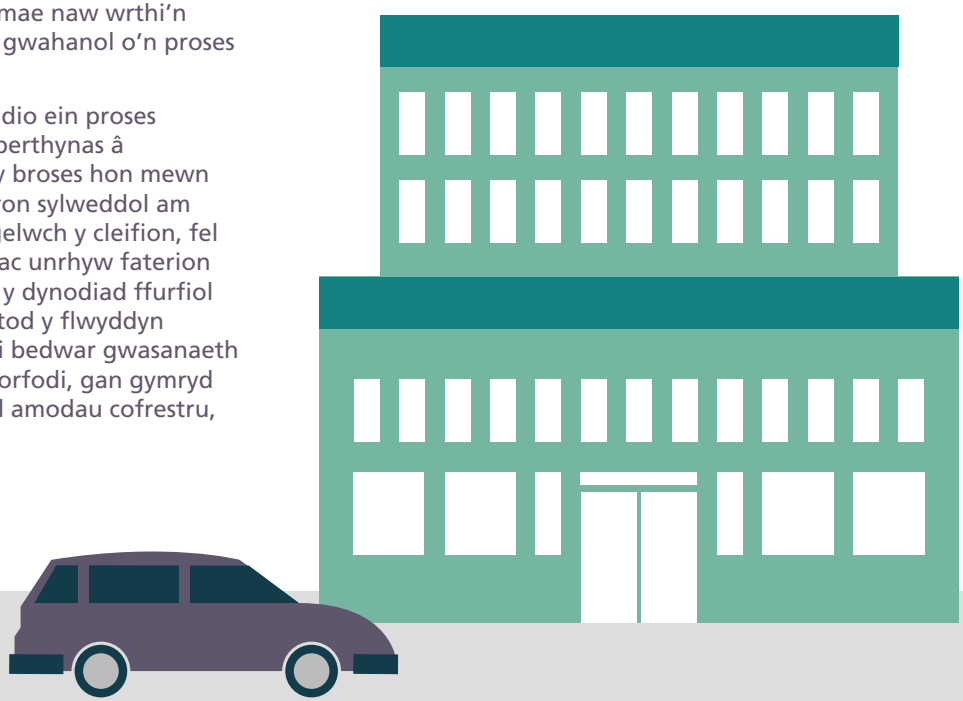
Er bod nifer yr hysbysiadau diffyg cydymffurfio a gyflwynwyd gennym eleni yn fach, nodwyd, fel mewn blynyddoedd blaenorol, fod angen i leoliadau fod yn fwy rhagweithiol o hyd i sicrhau eu bod yn cydymffurfio â'r rheoliadau a'u hamodau cofrestru ag AGIC. Yn arbennig:

- Rhaid i ddogfennau allweddol fel y Canllaw i Gleifion a'r Datganiad o Ddiben gynnwys yr holl wybodaeth berthnasol a chael eu hadolygu'n rheolaidd
- Rhaid i bolisïau fod yn fanwl ac amlinellu'r trefniadau perthnasol sydd ar waith i sicrhau bod y staff yn ymwybodol o'u rolau a'u cyfrifoldebau
- Rhaid cynnal gwiriadau cefndir ar aelodau o'r staff er mwyn sicrhau eu bod yn addas i weithio yn y lleoliad er mwyn helpu i ddiogelu'r cleifion rhag cael eu cam-drin
- Rhaid i'r rheolau lleol ar sut i ddefnyddio'r peiriant laser neu IPL yn ddiogel gael eu hadolygu bob blwyddyn o leiaf gan arbenigwr laser neu IPL perthnasol.

Gorfodi

Rydym wedi parhau i weithredu lle rydym wedi cael gwybod am ddarparwyr anghofrestredig, gan gymryd y camau angenrheidiol i weld a oes angen iddynt gofrestru, a'u tywys drwy'r broses honno. Lle rydym wedi nodi darparwyr nad ydynt wedi cydweithredu, rydym wedi cymryd camau cryfach ac, yn achos un darparwr penodol, gwnaethom ddechrau ymchwiliad troseddol. Yn ystod y flwyddyn ddiwethaf, nodwyd 14 o ddarparwyr nad oeddent wedi cofrestru o bosibl, ac mae naw wrthi'n cofrestru, gyda'r gweddill ar gamau gwahanol o'n proses orfodi.

Rydym hefyd wedi parhau i ddefnyddio ein proses Gwasanaeth sy'n Peri Pryder mewn perthynas â gwasanaethau cofrestredig. Dilynir y broses hon mewn achosion lle rydym wedi nodi pryderon sylweddol am wasanaethau a all effeithio ar ddiogelwch y cleifion, fel rheol yn deillio o ymweliad arolygu ac unrhyw faterion diffyg cydymffurfio dilynol. Rhoddir y dynodiad ffurfiol hwn i wasanaeth o ganlyniad. Yn ystod y flwyddyn ddiwethaf, rhoddwyd y statws hwn i bedwar gwasanaeth ac fe'u rheolwyd yn unol â'n proses orfodi, gan gymryd camau gweithredu sifil, megis gosod amodau cofrestru, mewn ymateb.



Canfyddiaddau Arolygiadau

Rheoliadau Ymbelydredd Ïoneiddio (Cysylltiad Meddygol)

Y Rheoliadau Ymbelydredd Ïoneiddio (Amlygiad Meddygol)

AGIC sy'n gyfrifol am fonitro cydymffurfiaeth yn erbyn Rheoliadau Ymbelydredd Ïoneiddio (Cysylltiad Meddygol) 2017. Bwriedir i'r rheoliadau amddiffyn pobl rhag peryglon sy'n gysylltiedig ag ymbelydredd ïoneiddio. Mae ein gwaith arolygu yn edrych i weld a yw gwasanaethau'n cydymffurfio â'r Rheoliadau Ymbelydredd Ïoneiddio (Cysylltiad Meddygol) ynghyd â ph'un a gaiff gofal a thriniaeth eu darparu yn unol â Safonau Iechyd a Gofal Llywodraeth Cymru.

Yn ystod 2019-20 cwblhaodd AGIC dri arolygiad IR(ME)R, sy'n is nag arfer oherwydd anawsterau gweithredol ddiwedd mis Chwefror a dechrau pandemig y Coronafeirws ym mis Mawrth 2020. O dan yr amgylchiadau hyn hefyd, dim ond dau o'r tri math o gysylltiad meddygol a ystyriwyd (radiotherapi a delweddu diagnostig) - nid edrychwyd ar feddygaeth niwclear eleni.

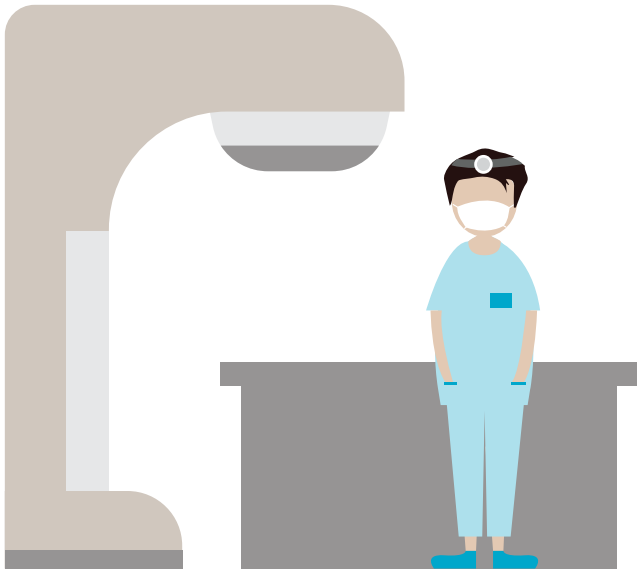
Canfyddiadau

Yn ystod ein harolygiadau gwnaethom ofyn i'r cleifion raddio eu profiad; ar y cyfan dywedodd y cleifion wrthym eu bod yn fodlon iawn ar y gwasanaeth roeddent wedi'i gael. Yn ein harolygiad o'r adran radiotherapi yng Nghanolfan Ganser Felindre roedd sylwadau'r cleifion yn gadarnhaol ar y cyfan wrth iddynt ganmol y staff yno.

Roedd cydymffurfiaeth gyffredinol â'r rheoliadau yn dda, gyda pholisïau a gweithdrefnau ysgrifenedig sy'n ofynnol o dan IR(MER)2017 ar gael ac yn gyfredol. Dangosodd trafodaethau â'r staff fod ymwybyddiaeth o'u cyfrifoldebau yn unol ag IR(ME)R hefyd yn dda, ar y cyfan. Roedd hefyd yn gadarnhaol gweld bod uwch-aelodau o'r staff yn croesawu ein harolygiad ac yn dangos parodrwydd i wneud gwelliannau o ganlyniad i'n canfyddiadau.

Roedd hanner yr argymhellion ar gyfer gwella a wnaed gennym yn ymwneud â phrofiadau'r cleifion. Nodwyd y gallai'r gwasanaethau y gwnaethom ymweld â nhw wneud mwy i roi gwell gwybodaeth i'r cleifion am y meysydd canlynol:

- Argaeledd gwasanaethau Cymraeg a hyrwyddo'r Cynnig Rhagweithiol
- Amseroedd aros
- Â phwy y dylid cysylltu os bydd ganddynt unrhyw gwestiynau yn dilyn eu harchwiliad / triniaeth
- Sut i godi pryder am y gwasanaeth a gafwyd a sut y gall y Cyngor Iechyd Cymuned eu helpu i wneud hynny.



[6] Mae 'Cynnig Rhagweithiol' yn golygu darparu gwasanaeth yn Gymraeg heb i neb orfod gofyn amdano. Dylai'r Gymraeg fod yr un mor weladwy â'r Saesneg

Canfyddiaddau Arolygiadau

Roedd yr argymhellion a wnaed o ran gofal diogel ac arweinyddiaeth / rheolaeth yn benodol i'r safle a arolygwyd gennym, heb fod unrhyw themâu yn codi. Yr unig eithriad oedd yr angen i sicrhau bod pob cysylltiad meddygol ac anfeddygol wedi'i gyfiawnhau ac y gellir nodi'r ymarferydd unigol sy'n cyfiawnhau pob cysylltiad. Mae hyn yn broblem benodol gyda gwasanaethau y tu allan i oriau a ddarperir drwy drefniant contract Cymru gyfan allanol. Mae'r contract hwn yn darparu gwasanaeth adroddiadau radioleg sy'n cynnwys, mewn rhai achosion, gyfiawnhad y tu allan i oriau o archwiliadau penodedig a gwerthusiadau clinigol cysylltiedig. Mae hwn yn fater sy'n berthnasol i Gymru gyfan felly mae angen i bob bwrdd iechyd sicrhau yr eir i'r afael ag ef.

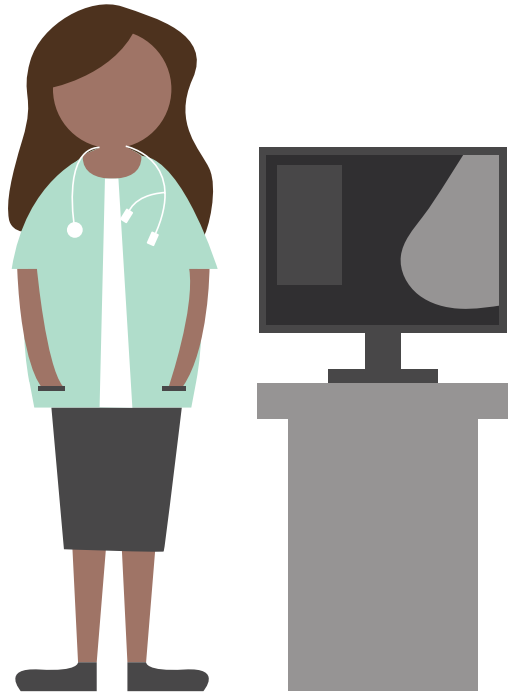
Er nad oedd unrhyw themâu yn deillio o'r argymhellion eu hunain, roedd thema glir yn y camau gweithredu a gynigiwyd gan y gwasanaethau mewn ymateb i'n hargymhellion. Yr ymateb cyffredin oedd gwneud mwy o waith archwilio a llywodraethu er mwyn sicrhau bod y gwasanaeth yn gallu nodi'r materion hyn eu hunain, heb orfod dibynnu ar arolygiad gan y rheoleiddiwr i nodi meysydd o ddiffyg cydymffurfio. Nodwyd yr angen i wella'r broses lywodraethu a'r broses o oruchwylio cydymffurfiaeth ag IR(ME)R fel mater allweddol yn ein rhaglen arolygu yn 2018-19. Byddem yn annog pob bwrdd iechyd ac ymddiriedolaeth i barhau i ganolbwyntio ar hyn, a dysgu o'i gilydd.

Ar gais Llywodraeth y DU, cynhaliodd tîm rhyngwladol o uwch-arbenigwyr diogelwch adolygiad cymheiriaid o'r Gwasanaeth Adolygiadau Rheoleiddiol Integredig (IRRS) rhwng 14 a 25 Hydref 2019. Diben yr adolygiad hwn oedd gwerthuso fframwaith rheoleiddio'r DU ar gyfer diogelwch niwclear ac ymbelydredd yn erbyn safonau diogelwch IAEA. Hwn oedd y pedwerydd adolygiad o IRRS i'w gynnal yn y DU ers i raglen IRRS ddechrau yn 2006, a'r adolygiad llawn cyntaf i edrych ar ddiogelwch niwclear ac ymbelydredd. Fel rhan o'r elfen diogelwch ymbelydredd, ystyriwyd y defnydd o ymbelydredd ïoneiddio am resymau meddygol am y tro cyntaf.

Cymerodd AGIC ran lawn yn yr adolygiad hwn, ar y cam hunanasesu cychwynnol ac wrth gael ei chyfweld gan y tîm adolygu yn ystod yr adolygiad ei hun. Ar y cyfan, roedd y tîm adolygu yn fodlon ar y trefniadau oedd ar waith i fonitro cydymffurfiaeth ag IR(ME)R ac ni wnaeth unrhyw argymhellion ynghylch ein methodoleg arolygu. Fodd bynnag, gwnaeth argymell y dylai pob reoleiddiwr IR(ME)R yn y DU gynnal arolygiadau rheolaidd. Bydd hyn yn golygu cynnal mwy o arolygiadau bob blwyddyn wrth i ni geisio cyflawni'r rhaglen arolygu ganlynol:

- Caiff gwasanaethau radiotherapi eu harolygu bob pedair blynedd
- Caiff cyfleusterau meddygaeth niwclear eu harolygu bob chwe blynedd
- Caiff ysbytai â gwasanaethau delweddu diagnostig eu harolygu bob 10 mlynedd.

Ar y cyfan, roedd adolygiad IRRS yn brofiad dysgu gwerthfawr i reoleiddwyr y DU a wnaeth ein galluogi i nodi gwelliannau sydd eu hangen i'n polisïau a'n gweithdrefnau ni ein hunain. Mae hefyd wedi creu cydberthynas llawer agosach rhwng pedwar rheoleiddiwr y DU ac wedi creu dull o rannu gwersi ac ymarfer ledled y DU.



Canfyddiaddau Arolygiadau

Gofal Iechyd Troseddwyr

Mae'n ofynnol i'r Ombwdsmon Carchardai a Phrofiannaeth ymchwilio i bob marwolaeth sy'n digwydd mewn carchar. Mae AGIC yn cyfrannu at yr ymchwiliadau hyn drwy gynnal adolygiad clinigol o bob marwolaeth mewn carchar neu Sefydliad Cymeradwy yng Nghymru. Caiff y trefniant hwn ei ddiffinio mewn Memorandwm Cyd-ddealltwriaeth rhwng yr Ombwdsmon ac AGIC.

Mae ein hadolygiadau o farwolaethau yn y ddalfa yn archwilio ac yn gwerthuso systemau, prosesau ac ansawdd gwasanaethau gofal iechyd a ddarperir i garcharorion yn ystod eu hamser mewn carchar neu Sefydliad Cymeradwy, a hynny mewn ffordd feirniadol.

Yn 2019-20, cafodd AGIC ei chomisiynu i gynnal 14 o adolygiadau o farwolaethau clinigol yn y ddalfa ar ran yr Ombwdsmon Carchardai a Phrofiannaeth. Roedd hanner y rhain yn CEM Parc ym Mhen-y-bont ar Ogwr. CEM Abertawe oedd â'r nifer lleiaf o farwolaethau yn y ddalfa, gyda dim ond un achos.

Unwaith eto eleni, daeth ein hadolygiadau o farwolaethau yn y ddalfa i'r casgliad cyffredinol bod y gofal a gaiff carcharorion yng Nghymru yn cyfateb i'r hyn a fyddai'n ddisgwyliedig yn y gymuned. Ym mhob un o'n hadolygiadau, gwnaethom nodi gwelliannau ac arferion da.

Nodwyd bod atgyfeiriadau at arbenigeddau yn cael eu gwneud mewn modd amserol ac effeithlon ar y cyfan. Hefyd, rheolwyd meddyginiaeth y carcharorion a chynhaliwyd adolygiadau rheolaidd ohoni mewn modd boddhaol.

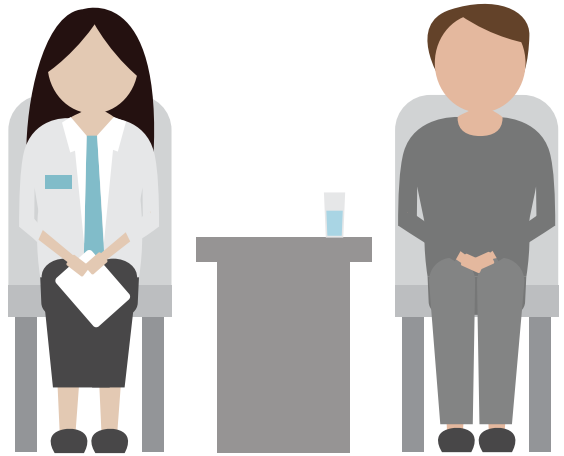
Nodwyd bod angen gwneud gwelliannau yn ein hadolygiadau hefyd. Er enghraifft, nodwyd bod angen gwella arferion archwilio clinigol. Dylai archwiliadau clinigol fod yn rhan annatod o reoli ansawdd gwasanaethau gofal iechyd carchardai, gan eu bod yn hyrwyddo canlyniadau cadarnhaol ac yn diogelu cleifion yn fwy.

Hefyd, nodwyd bod angen gwella gwasanaethau iechyd meddwl / dementia yn ein hadolygiadau o farwolaethau yn y ddalfa. Argymhellwyd y dylai carcharorion â dementia gael gofal iechyd meddwl arbenigol lleol mewn modd amserol.

Arolygiadau o Garchardai

Arolygiaeth Carchardai Ei Mawrhydi sy'n cynnal arolygiadau o garchardai yng Nghymru. Mae Memorandwm Cyd-ddealltwriaeth ar waith rhwng yr Arolygiaeth ac AGIC, a chawn ein gwahodd i fynychu ei harolygiadau o garchardai yng Nghymru. Mae'r dulliau hyn o weithredu yn ein galluogi i rannu'r hyn a ddysgwn o adolygiadau clinigol o farwolaethau yn y ddalfa a hefyd ystyried y ffordd y caiff gofal iechyd carchardai ei lywodraethu.

Yn ystod 2019-20, gwnaethom fynychu dau o arolygiadau'r Arolygiaeth yn CEM Parc ger Pen-y-bont ar Ogwr. Roedd yr arolygiadau ar gyfer y boblogaeth o garcharorion sy'n oedolion, a'r sefydliad troseddwyr ifanc a leolir yn CEM Parc.



Canfyddiaddau Arolygiadau

Nododd yr adroddiadau arolygu yr arferion da canlynol:

- Cynhaliwyd prosesau sgrinio iechyd cychwynnol yn brydlon ac yn effeithiol wrth dderbyn, gan atgyfeirio'n briodol at wasanaethau eraill pan fo angen. Cynigiwyd gwasanaeth sgrinio eilaidd yn rheolaidd, ac roedd y cyfraddau derbyn a chofnodi wedi gwella dros y 12 mis diwethaf
- Roedd y carchar yn hybu iechyd mewn modd cydlynol. Roedd y tîm gofal iechyd yn defnyddio calendr o ddigwyddiadau i adlewyrchu rhaglenni cenedlaethol, ac roedd gwybodaeth hybu iechyd i'w gweld ym mhob rhan o'r carchar
- Roedd uned byw â chymorth arbenigol ar gyfer y carcharorion hynny ag anawsterau dysgu, a oedd yn darparu lefel ardderchog o ofal a chymorth
- Roedd presenoldeb dwy nyrs ddynodedig ar yr uned i blant yn sicrhau parhad gofal effeithiol ac yn helpu i feithrin cydberthnasau gofalgar y gellid ymddiried ynddynt â'r plant.

Nododd yr arolygiad hefyd rai meysydd i'w gwella yn enwedig yn y meysydd canlynol:

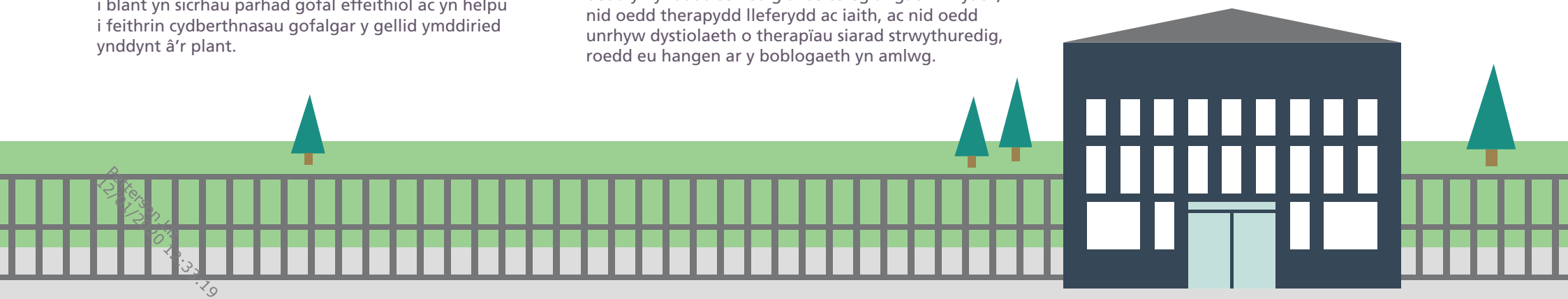
- Roedd y galw am wasanaethau iechyd meddwl yn uchel ac nid oedd y gwasanaethau a oedd ar gael yn bodloni'r galw. Er bod y cymorth a oedd ar gael ar gyfer problemau ysgafn i gymedrol wedi gwella, nid oedd yr amrywiaeth o ymyriadau arbenigol na chymorth i garcharorion ag anghenion mwy cymhleth yn ddigonol, ac roedd gormod o garcharorion yn aros gormod o amser am wasanaethau a fodolai eisoes
- Dim ond unwaith yr wythnos y gallai carcharorion agored i niwed mewn un uned weld deintydd, a allai fod wedi arwain at oedi cyn cael gofal brys
- Nid oedd gwasanaethau iechyd meddwl plant a'r glasoed yn darparu amrywiaeth addas o asesiadau, triniaethau nac ymyriadau ar gyfer plant Parc. Nid oedd ymyriadau seiliedig ar seicoleg ar gael mwyach, nid oedd therapydd lleferydd ac iaith, ac nid oedd unrhyw dystiolaeth o therapïau siarad strwythuredig, roedd eu hangen ar y boblogaeth yn amlwg.

Gwasanaethau Troseddwyr Ifanc

Rydym yn parhau i weithio mewn partneriaeth ag Arolygiaeth Prawf Ei Mawrhydi wrth adolygu'r gofal iechyd a ddarperir o fewn Gwasanaethau Troseddwyr Ifanc. Mae'r adolygiadau manwl hyn hefyd yn cynnwys amrywiaeth o asiantaethau partner eraill gan gynnwys Estyn ac Arolygiaeth Gofal Cymru.

Ym mis Chwefror 2020 cymerodd AGIC ran mewn arolygiad o Wasanaethau Troseddwyr Ifanc Caerdydd, lle gwerthuswyd y gwasanaethau gofal iechyd a'r hyn a ddarperir i'r bobl ifanc.

Disgwylir cyhoeddi'r adroddiad llawn ddiwedd mis Gorffennaf a bydd ar gael ar wefan Arolygiaeth Prawf EM.



Byrddau Iechyd Lleol ac Ymddiriedolaethau'r GIG

BIP Aneurin Bevan

Yn gyffredinol, gwelsom fod y staff yn darparu gofal diogel ac effeithiol, ac yn trin y cleifion ag urddas a pharch. Roedd y rhan fwyaf o'r cleifion y gwnaethom siarad â nhw yn hapus â'r gofal roeddent yn ei gael. Roeddem yn falch o weld tystiolaeth o waith amlddisgyblaethol effeithiol yn yr arolygiadau, yn enwedig yn ystod ein harolygiadau o ysbytai.

Un o'r prif heriau sy'n wynebu'r bwrdd iechyd, a gafodd ei chydnabod yn Adroddiad Blynyddol y llynedd, yw rhannu gwersi rhwng gwasanaethau, a nodi materion tebyg yn ein harolygiadau. Er ei bod hi'n braf gweld llawer o enghreifftiau o arferion da, mae'n siomedig nad yw'n ymddangos eu bod yn cael eu rhannu a'u rhoi ar waith o fewn y bwrdd iechyd cyfan. Enghraifft o hyn yw ein harolygiadau Iechyd Meddwl, lle nodwyd bod y Ddeddf Iechyd Meddwl yn cael ei gweithredu'n dda yn yr Ysbyty Sirol, ond roedd yn cael ei gweithredu'n wael yn Ysbyty Cwrt Maindiff. Gwnaethom hefyd godi'r mater hwn mewn arolygiad tebyg ym mis Tachwedd 2018. Hefyd, rydym eisoes wedi codi pryderon am ansawdd y gwaith o gadw cofnodion mewn lleoliadau, ac roedd yn siomedig nodi bod nifer o welliannau yn ofynnol yn y maes hwn mewn nifer o wasanaethau.

Roedd canfyddiadau ein harolygiadau o feddygfeydd yn gadarnhaol ar y cyfan. Roedd y rhan fwyaf o'r cleifion y gwnaethom siarad â nhw yn hapus â'r gofal roeddent yn ei gael, a gwelsom y staff yn trin y cleifion ag urddas a pharch. Roedd y meddygfeydd yn ymwybodol o'u cyfrifoldebau o ran hyrwyddo hawliau'r bobl a sicrhau bod y gwasanaethau yn hygyrch i bob claf, ac roedd pob meddygfa yn cael ei rheoli'n dda. Fodd bynnag, bu angen cyflwyno dau lythyr Sicrwydd Uniongyrchol yn dilyn dau o'r arolygiadau hyn, gyda'r ddau yn ymwneud ag archwilio cyfarpar brys. Yn dilyn hyn cawsom sicrwydd digonol gan y bwrdd iechyd ynghylch y materion hyn.

Gwnaethom arolygu tri ysbyty fel rhan o'n Hadolygiad Cenedlaethol o Wasanaethau Mamolaeth. Gwelsom ryngweithio proffesiynol a charedig rhwng y staff a'r cleifion, ac roedd gofal yn cael ei ddarparu mewn ffordd urddasol. Roedd y rhan fwyaf o'r cleifion y gwnaethom siarad â nhw yn gadarnhaol am y gofal roeddent yn ei gael. Roedd yn braf gweld prosesau da ar waith ar gyfer rheoli digwyddiadau clinigol, sy'n enghraifft dda o rannu arferion da rhwng safleoedd. Roedd Bydwragedd Arbenigol wedi'u penodi gan y tri ysbyty, a gwelsom dystiolaeth o waith tîm amlddisgyblaethol da. Fodd bynnag, nodwyd bod angen gwella prosesau atal a rheoli heintiau mewn dau arolygiad. Cyflwynwyd llythyr Sicrwydd Uniongyrchol yn dilyn un arolygiad a oedd yn ymwneud â diogelwch y babanod ar y ward; archwilio cyfarpar brys; a monitro tymereddau oergelloedd cyffuriau. Yn dilyn hyn cawsom sicrwydd digonol gan y bwrdd iechyd ynghylch y materion hyn.

BIP Aneurin Bevan

Gwnaethom arolygu dau o leoliadau Iechyd Meddwl y GIG yn 2019-20. Roedd yn braf gweld tystiolaeth o waith tîm da rhwng y staff a chlywed y cleifion yn siarad yn gadarnhaol am y gofal roeddent yn ei gael. Roedd pwyslais penodol ar ofal unigoledig, ac roedd cysylltiadau cryf rhwng y ddau leoliad a'r gymuned leol. Hefyd, roedd prosesau sefydledig ar waith i sicrhau bod y staff yn diogelu plant ac oedolion agored i niwed. Yn anffodus, roedd angen gwella'r ffordd roedd meddyginiaethau yn cael eu rheoli er mwyn sicrhau eu bod yn cael eu cadw ar y tymheredd cywir, a oedd yn rhywbeth a nodwyd wrth arolygu un o'r ysbytai hefyd.

Gwnaethom arolygu 13 o ddeintyddfeydd yn 2019-20. Roedd yn braf nodi eu bod yn casglu barn y cleifion ac yn gweithredu arno, ac roedd tystiolaeth o reolaeth ac arweinyddiaeth dda. Fodd bynnag, yn achos dros hanner ein harolygiadau, nodwyd bod angen gwella safonau cadw cofnodion clinigol, sy'n arbennig o siomedig am fod y maes hwn wedi'i nodi'n thema roedd angen ei gwella yn Adroddiad Blynyddol 2018-19.

Byddwn yn olrhain cydymffurfiaeth â'n hargymhellion yn ystod 2020-21 er mwyn sicrhau bod y gwersi yn cael eu rhannu, ac y gweithredir ar yr argymhellion.

BIP Aneurin Bevan

Ysbytai

- ✓ Ar y cyfan nodwyd gofal diogel ac effeithiol
- ✓ Roedd y staff yn trin y cleifion ag urddas a pharch
- ✓ Dywedodd y rhan fwyaf o'r cleifion eu bod yn hapus â'r gofal a gawsant
- ✓ Tystiolaeth dda o waith tîm amlddisgyblaethol
- ✓ Lefelau da o breifatrwydd ar gyfer y cleifion ar y wardiau
- × Problemau o ran mesurau atal a rheoli heintiau
- × Archwilio cyfarpar brys
- × Cadw cofnodion
- × Rheoli meddyginiaethau

Iechyd meddwl

- ✓ Staff ymroddedig a llawn cymhelliant
- ✓ Y cleifion yn canmol y gofal
- ✓ Gwaith tîm da
- ✓ Gofal unigoledig da
- × Rheoli meddyginiaethau
- × Gweithredu'r Ddeddf Iechyd Meddwl
- × Problemau o ran dysgu ar y cyd a chyflawni ymrwymiadau yn dilyn canlyniadau arolygiadau

Meddygfeydd

- ✓ Ar y cyfan nodwyd gofal diogel ac effeithiol
- ✓ Roedd y staff yn trin y cleifion ag urddas a pharch
- ✓ Mynediad da i wybodaeth am y cleifion
- ✓ Meddygfeydd yn cael eu rheoli'n dda
- ✓ Cyfathrebu da rhwng y staff
- × Polisïau a gwybodaeth am hebryngwyr
- × Cofnodion hyfforddiant y staff
- × Cadw cofnodion
- × Archwilio cyfarpar dadebru brys

Deintyddfeydd

- ✓ Casglwyd adborth gan y cleifion yn rheolaidd, a gweithredwyd arno
- ✓ Ar y cyfan roedd y deintyddfeydd yn lân ac mewn cyflwr da
- ✓ Tystiolaeth o reolaeth ac arweinyddiaeth dda
- × Dyfeisiau a chyfarpar meddygol
- × Storio gwastraff a'i gadw'n ddiogel
- × Safon cadw cofnodion clinigol

Byrddau Iechyd Lleol ac Ymddiriedolaethau'r GIG

BIP Betsi Cadwaladr

Ar y cyfan, bu'r arolygiadau o'r bwrdd iechyd yn 2019-20 yn gadarnhaol. Nodwyd gofal unigoledig ac urddasol yn cael ei ddarparu gan y staff yn y lleoliadau a arolygwyd. Fodd bynnag, roedd yn bryderus bod rhai o'r materion a godwyd y flwyddyn flaenorol yn dal i fod yn amlwg.

Un o'r prif heriau a welwyd yn yr Adrannau Brys a arolygwyd oedd llif y cleifion i mewn i wasanaethau priodol yn yr ysbytai. Cafodd hyn effaith andwyol ar y gwaith o redeg yr adrannau a chyflawni targed Llywodraeth Cymru ar gyfer amseroedd aros.

Yn y chwe meddygfa a arolygwyd yn ystod 2019-20, roedd yn bryderus gweld cynifer o broblemau'n ymwneud â gofal diogel ac effeithiol a llywodraethu ac arweinyddiaeth. Fodd bynnag, nododd y cleifion yn gyffredinol fod y staff yn eu trin ag urddas a pharch.

Cyflwynwyd dau hysbysiad diffyg cydymffurfio o ganlyniad i'r wyth arolygiad o ddeintyddfeydd a gynhaliwyd. Fodd bynnag, nid oedd angen nodi unrhyw welliannau ar gyfer dwy o'r deintyddfeydd yr ymwelwyd â nhw, a oedd yn braf i'w weld.

Roedd hefyd yn braf gweld tystiolaeth o ofal effeithiol a oedd yn canolbwyntio ar yr unigolyn a gwaith cynllunio cyfannol yn ein harolygiadau o ysbytai, lleoliadau iechyd meddwl a TIMC. Roedd hefyd yn galonogol gweld na fu angen cyflwyno llythyr Sicrwydd Uniongyrchol yn sgil unrhyw un o'r arolygiadau iechyd meddwl.

Roedd prosesau cynllunio a dogfennu gofal o safon dda yn yr arolygiadau o ysbytai, lleoliadau iechyd meddwl a TIMC, ond gwnaethom argymell bod angen cryfhau'r system ar gyfer dysgu gwersi o archwiliadau, pryderon a digwyddiadau. Roedd y canfyddiadau hyn hefyd yn amlwg yn yr arolygiadau a gynhaliwyd yn 2018-19.

Ar y cyfan, ym mhob arolygiad, roedd y staff yn gadarnhaol iawn am y meysydd roeddent yn gweithio ynddynt, ond roedd angen gwneud gwelliannau er mwyn atgyfnerthu trefniadau hyfforddi a chadw staff.

Yn ystod 2019-20, gwnaethom arolygu holl unedau geni acíwt a chymunedol un bwrdd iechyd o fewn gwasanaethau mamolaeth. Roedd yn braf gweld gwelliannau o fewn yr arolygiadau mamolaeth acíwt ac roedd yn amlwg bod gwersi yn cael eu rhannu, ac roedd cyfathrebu gwych rhwng y gwasanaethau acíwt. Fodd bynnag, roedd yn bryderus nodi bod problemau'n ymwneud â'r tair safon gofal iechyd yn y tair uned geni gymunedol. Er gwaethaf y materion hyn, roedd yr adborth a gafwyd gan y menywod a oedd yn defnyddio'r unedau yn gadarnhaol iawn ynghylch eu gofal a'u profiadau.

Gan fod y bwrdd iechyd yn parhau i fod mewn mesurau arbennig, mae'n hanfodol parhau i wneud gwelliannau a rhannu argymhellion, a sicrhau na chollir momentwm.

BIP Betsi Cadwaladr

Ysbytai

- ✓ Tystiolaeth dda o ofal sy'n canolbwyntio ar yr unigolyn ac ymgysylltu gan staff
- ✓ Gwelwyd gofal diogel ac effeithiol ym mhob arolygiad
- ✓ Roedd trefniadau da ar waith o fewn mamolaeth i roi cymorth profedigaeth a chymorth iechyd meddwl amenedigol i'r menywod a'u teuluoedd
- × Cydymffurfiaeth wael o ran atal a rheoli heintiau mewn rhai meysydd
- × Dysgu o archwiliadau, cwynion a digwyddiadau
- × Llywodraethu ac arweinyddiaeth gyffredinol o fewn yr unedau geni cymunedol

Iechyd meddwl

- ✓ Adborth cadarnhaol gan ddefnyddwyr gwasanaeth ynghylch ymgysylltu'r staff a chynllunio a darparu gofal sy'n canolbwyntio ar yr unigolyn
- ✓ Prosesau archwilio, adrodd ac uwchgyfeirio clinigol da ym maes Gofal TIMC
- ✓ Trefniadau llywodraethu sefydledig sy'n darparu gofal diogel a chlinigol effeithiol
- × Gwybodaeth yn cael ei rhoi i'r cleifion
- × Rheoli meddyginiaethau mewn ffordd ddiogel ac effeithiol
- × Asesu risgiau pwyntiau clymu
- × Hyfforddi, recriwtio a chadw staff

Meddygfeydd

- ✓ Cleifion yn cael eu trin ag urddas a pharch a'u cynnwys yn eu gofal
- ✓ Tystiolaeth dda o gadw cofnodion mewn ffordd gadarn
- ✓ Staff yn hapus yn eu gwaith ym mhob arolygiad
- × Angen gwella mesurau atal a rheoli heintiau
- × Angen adolygu cofnodion y staff er mwyn sicrhau bod cydymffurfiaeth yn cael ei dogfennu'n glir, megis DBS, imiwneiddio a hyfforddiant
- × Caiff cyfarfodydd diogelu eu cynnal a'u dogfennu'n rheolaidd, a dysgir gwersi ohonynt

Deintyddfeydd

- ✓ Dulliau da ar gyfer casglu adborth y cleifion ac ymateb iddo
- ✓ Amrywiaeth addas o ddeunydd hybu iechyd a hylendid y geg
- ✓ Hyfforddiant priodol ar ddiogelu plant ac oedolion
- × Ehangu'r defnydd o archwiliadau clinigol, yn enwedig rhoi'r gorau i smygu a rhagnodi gwrthficrobaidd
- × Angen gwella mesurau atal a rheoli heintiau
- × Gosod biniau cyfarpar miniog ar y waliau

Byrddau Iechyd Lleol ac Ymddiriedolaethau'r GIG

BIP Caerdydd a'r Fro

Ar y cyfan, roedd canfyddiadau ein harolygiadau o fewn y bwrdd iechyd yn gadarnhaol. Lle roedd angen gwella, mae pob bwrdd clinigol wedi ymateb mewn modd adeiladol, ac wedi ymgysylltu'n dda. Ym mhob arolygiad, bu rhyngweithio da iawn rhwng y staff a'r timau arolygu, a bu ymgysylltiad parhaus timau arwain y bwrdd iechyd yn gadarnhaol hefyd.

Ar y cyfan, roedd y cleifion yn gadarnhaol iawn am y gofal, y driniaeth a'r gwasanaethau a ddarparwyd gan y bwrdd iechyd. Hefyd, rhoddodd y staff adborth cadarnhaol am y gefnogaeth a'r arweinyddiaeth a ddarparwyd gan uwch-reolwyr adrannol a bwrdd iechyd. Roedd arferion gwaith tîm amlddisgyblaethol effeithiol ar waith, a nodwyd eu bod yn gadarnhaol ac yn alluogol.

Gwnaethom ymweld â phedwar ysbyty ac arolygu saith adran, ac arolygwyd gwasanaethau mamolaeth yn Ysbyty Athrofaol Cymru fel rhan o'n Hadolygiad Cenedlaethol o Wasanaethau Mamolaeth. Ar y cyfan, gwelsom enghreifftiau o ryngweithio proffesiynol a thrugarog rhwng y staff a'r cleifion. Nododd pob arolygiad fod urddas a phreifatrwydd y cleifion yn cael eu cynnal gan y staff, ac roedd y staff yn ceisio darparu gofal diogel ac effeithiol.

Mae'r bwrdd iechyd yn ystyried yn gyson fod craffu allanol a mewnol yn ffordd gadarnhaol o ddysgu a gwella'n barhaus. Bu'n amlwg bod y bwrdd iechyd wedi rhannu gwersi yn y rhan fwyaf o feysydd. Roedd yn braf nodi i arolygiad dilynol AGIC o'r Uned Asesu a'r Uned Frys ddangos gwelliant sylweddol mewn sawl maes yn dilyn y materion a godwyd yn arolygiad y llynedd.

Ni fu modd inni gynnal ein harolygiad TIMC yn ardal gogledd-orllewin Caerdydd, a hynny oherwydd pandemig Covid-19. Datgelodd ein harolygiad o uned iechyd meddwl Hafan y Coed fod nifer o broblemau a oedd yn cael effaith negyddol ar brofiad y cleifion, ac a all effeithio ar eu diogelwch. Nodwyd nifer o'r materion a godwyd gan AGIC yn ystod arolygiad 2019 eto eleni.

Rhaid i'r bwrdd iechyd fyfyrio ar ei asesiad ei hun o'r trefniadau a oedd ar waith yn dilyn arolygiad y llynedd o Hafan y Coed, a pham na chymerwyd mwy o gamau mewn perthynas â'r cynllun gweithredu, gan arwain at godi'r un materion unwaith eto eleni.

Ar y cyfan, yn ein tri arolygiad o feddygfeydd, gwelsom fod y staff yn darparu gofal diogel ac effeithiol i'r cleifion. Roedd safon dda o gadw cofnodion ar y cyfan, ac roedd pob meddygfa yn cael ei harwain yn dda, gyda rhyngweithio tîm a staff da. Nodwyd rhai meysydd i'w gwella, yn enwedig o ran diweddaru polisïau a gweithdrefnau, ac roedd gwiriadau gan y Gwasanaeth Datgelu a Gwahardd (DBS) yn broblem mewn rhai meddygfeydd.

Gwnaethom gynnal 15 o arolygiadau o ddeintyddfeydd eleni, a nodwyd bod y staff yn canolbwyntio ar ddarparu gofal diogel ac effeithiol i'r cleifion, ac ar y cyfan roedd y cleifion yn hapus â'r gofal roeddent yn ei gael. Roedd prosesau rheoli da ar waith yn gyffredinol o fewn y gwasanaethau. Fodd bynnag, nodwyd bod angen gwneud rhai gwelliannau o ran y ddogfennaeth yng nghofnodion y cleifion, gweithgarwch archwilio clinigol, ac o ran archwilio, storio a lleoli cyfarpar brys.

BIP Caerdydd a'r Fro

Ysbytai

- ✓ Ar y cyfan roedd pob arolygiad yn gadarnhaol, a nodwyd gofal diogel ac effeithiol
- ✓ Nodwyd profiadau cadarnhaol gan y cleifion ym mhob arolygiad
- ✓ Roedd tystiolaeth dda o waith amlddisgyblaethol ym mhob arolygiad
- ✓ Roedd arweinyddiaeth a rheolaeth dda ym mhob arolygiad
- × Archwiliwyd cyfarpar dadebru mewn dwy adran
- × Roedd cyfleusterau diheintio dwylo ar gael ym mhob ardal glinigol
- × Cynhaliwyd adolygiadau datblygu blynyddol personol yn amserol
- × Cydymffurfiwyd â hyfforddiant gorfodol yn amserol

Iechyd meddwl

- ✓ Roedd timau o staff ymroddedig a oedd yn ymrwymedig i ddarparu gofal o'r safon uchaf
- ✓ Roedd rhyngweithio ac ymgysylltu da rhwng y staff a'r cleifion, ac roedd y cleifion yn cael eu trin ag urddas a pharch
- ✓ Roedd cofnodion y cleifion yn cael eu cadw i safon dda
- ✓ Roedd arweinyddiaeth dda ar y ddwy ward, gydag adborth cadarnhaol gan y staff a'r cleifion
- × Nid oedd tystysgrifau cydsynio i driniaeth na statws cyfreithiol y cleifion bob amser ar gael yn eu siartiau cyffuriau
- × Roedd y cleifion yn aml yn 'cysgu allan' o'u ward ddynodedig, ar wardiau eraill
- × Cydymffurfiaeth wael o ran hyfforddiant staff
- × Mynediad priodol i ardd Hafan y Coed i'r cleifion

Meddygfeydd

- ✓ Ar y cyfan roedd pob arolygiad yn gadarnhaol, a nodwyd gofal diogel ac effeithiol
- ✓ Adborth da gan y cleifion
- ✓ Safle glân ac mewn cyflwr da
- ✓ Proses rheoli meddyginiaethau dda
- × Gwiriadau'r Gwasanaeth Datgelu a Gwahardd
- × Gwelliannau i bolisïau a gweithdrefnau
- × Cael mynediad amserol i apwyntiadau

Deintyddfeydd

- ✓ Ar y cyfan, roedd y cleifion yn fodlon ar y gwasanaeth a gafwyd
- ✓ Roedd gan bob deintyddfa staff a oedd wedi'u hyfforddi'n briodol ym maes dadebru
- ✓ Proses sefydlu staff dda
- ✓ Cydymffurfiaeth dda ag arfarniadau blynyddol staff
- × Gweithgarwch archwilio clinigol a'r defnydd o adolygiadau cymheiriaid
- × Amlder archwiliadau a storio neu leoli cyfarpar brys
- × Dogfennaeth cofnodion clinigol
- × Storio gwastraff a'i gadw'n ddiogel

Byrddau Iechyd Lleol ac Ymddiriedolaethau'r GIG

BIP Cwm Taf Morgannwg

Bu hon yn flwyddyn heriol iawn i'r bwrdd iechyd, un a ddechreuodd drwy gyhoeddi'r adroddiad ar wasanaethau mamolaeth ym Mwrdd Iechyd Prifysgol Cwm Taf gan Goleg Brenhinol yr Obstetryddion a'r Gynaecolegwyr a Choleg Brenhinol y Bydwragedd, lle nodwyd nifer o bryderon difrifol a methiannau gwasanaeth. Yn sgil canfyddiadau'r adroddiad mamolaeth, rhoddwyd y gwasanaethau hyn o dan Fesurau Arbennig, a chafodd statws cyffredinol y bwrdd iechyd ei uwchgyfeirio i Ymyriad wedi'i Dargedu hefyd.

Yn rhannol mewn ymateb i'r adroddiad hwn, yn ogystal â'n pryderon ni'n hunain am systemau llywodraethu a rheoli risg, aed ati i gynnal adolygiad ar y cyd o drefniadau llywodraethu gydag Archwilio Cymru. Tynnodd yr adolygiad hwn sylw at nifer o ddiffygion sylfaenol yn nhrefniadau llywodraethu ansawdd y bwrdd iechyd. Roeddem yn ofni bod y gwendidau hyn yn peryglu gallu'r bwrdd iechyd i nodi ac ymateb i broblemau a all godi o ran ansawdd a diogelwch gofal y cleifion, a hynny mewn ffordd ddigonol. Hefyd, nodwyd bod angen mynd ati ar frys i wneud gwelliannau er mwyn atgyfnerthu trefniadau presennol, strwythurau sefydliadol a rolau, yn ogystal â mynd i'r afael â nifer o faterion yn ymwneud â diwylliant y bwrdd iechyd. Yn arbennig, teimlwyd bod angen atgyfnerthu ac ehangu trefniadau arwain o ran ansawdd gofal a diogelwch y cleifion o fewn y bwrdd iechyd, a bod bylchau mewn trefniadau llywodraethu allweddol o ran rheoli a nodi risg, a darparu gwybodaeth i gefnogi gwaith craffu effeithiol gan y bwrdd a'i bwyllgorau.

Derbyniodd y bwrdd iechyd y canfyddiadau hyn yn llawn ac mae wedi llunio ymateb cadarnhaol i'r argymhellion. Yr hyn sy'n bwysig nawr yw bod y bwrdd iechyd yn parhau i wneud cynnydd o ran gwella. Ni ddylid tanamcangyfrif yr heriau a wynebir i wella trefniadau llywodraethu ansawdd a diogelwch cleifion, a bydd yn gofyn am ymrwymiad a ffocws parhaus gan y bwrdd iechyd.

O ran ein gweithgarwch arolygu ein hunain yn ystod y flwyddyn, rydym wedi nodi rhai gwelliannau o gymharu â rhaglen waith y llynedd. Y llynedd, nododd ein hadroddiad blynyddol fod pryderon am ddiffyg dysgu sefydliadol o arolygiadau blaenorol, yn enwedig ym maes gwasanaethau iechyd meddwl. Eleni mae ein harolygiadau o wasanaethau iechyd meddwl wedi dangos bod sawl un o'r materion a nodwyd yn flaenorol wedi eu datrys, neu maent wrthi'n cael eu datrys. Mae'n amlwg bod y staff yn ymrwymedig i ddarparu'r gofal gorau posibl. Serch hynny, nododd dau o'n tri arolygiad faterion Sicrwydd Uniongyrchol, a'r mwyaf difrifol o'r rhain oedd pryderon am ofal diogel a rhoi gwybod am ddigwyddiadau.

BIP Cwm Taf Morgannwg

O ran ein harolygiadau o ysbytai eleni, roedd y rhain i gyd yn canolbwyntio ar wasanaethau mamolaeth, yn unol â'n Hadolygiad Cenedlaethol ehangach o Wasanaethau Mamolaeth. Fel y cyfryw, gwnaethom arolygu pob uned mamolaeth yn y bwrdd iechyd. Ar y cyfan nododd ein harolygiadau fod menywod yn teimlo'n gadarnhaol am eu gofal a'u profiad o ddefnyddio gwasanaethau mamolaeth drwyddi draw. Hefyd, nodwyd, ar y cyfan, fod y staff yn rhyngweithio'n gadarnhaol ac roedd tystiolaeth o arweinyddiaeth gref ym maes bydwreigiaeth. Mae'r rhain i gyd yn elfennau cadarnhaol ac yn dystiolaeth o'r gwaith mae'r bwrdd iechyd wedi'i wneud mewn perthynas â gwasanaethau mamolaeth. Fodd bynnag, nodwyd hefyd nifer o faterion Sicrwydd Uniongyrchol yn ein harolygiadau mamolaeth, gyda sawl un o'r rhain yn debyg ar bob safle. Er i lawer o'r materion hyn hefyd gael eu nodi ledled Cymru, mae'n glir serch hynny fod cryn dipyn o waith i'w wneud o hyd i sicrhau bod safonau'n gyson o fewn gwasanaethau mamolaeth y bwrdd iechyd.

Nodwyd materion diffyg cydymffurfio mewn un arolygiad IR(ME)R y llynedd. Felly, roedd yn gadarnhaol nodi na chodwyd unrhyw faterion o bwys yn arolygiadau eleni, gyda chydymffurfiaeth dda i'w gweld yn erbyn y rheoliadau. Mae'n bwysig bod y gwelliannau hyn yn parhau.

Byddwn yn parhau i fonitro'r bwrdd iechyd yn agos ac yn olrhain ei gynnydd yn erbyn argymhellion yr adolygiad ar y cyd yn 2020-21.

BIP Cwm Taf Morgannwg

Ysbytai

- ✓ Roedd y menywod a'u teuluoedd yn gadarnhaol am eu gofal a'u triniaeth
- ✓ Gwelsom ryngweithio proffesiynol a charedig rhwng y staff a'r cleifion, a gwelsom fod gofal yn cael ei ddarparu mewn ffordd urddasol
- ✓ Roedd trefniadau ar waith i roi cymorth profedigaeth a chymorth amenedigol i'r menywod a'u teuluoedd
- ✓ Roedd y staff yn gadarnhaol ar y cyfan am y gefnogaeth roeddent yn ei chael gan eu rheolwyr a gwelsom arweinyddiaeth gref ym maes bydwreigiaeth
- × Archwilio cyfarpar dadebru brys
- × Rheoli meddyginiaethau, gan gynnwys storio cyffuriau'n ddiogel
- × Atgyfnerthu mesurau er mwyn sicrhau bod y risg o herwgydio babanod yn cael ei lliniaru
- × Diogelwch cofnodion y cleifion
- × Rhagnodi meddyginiaeth i ysgogi'r cyfnod esgor

Iechyd meddwl

- ✓ Gwelsom fod y staff yn rhyngweithio ac yn ymgysylltu â'r cleifion yn barchus
- ✓ Roedd rhai o'r cyfleusterau mewn cyflwr da ac yn creu amgylchedd gofal pleserus
- ✓ Staff yn ymrwymedig i ddarparu gofal urddasol
- ✓ Amrywiaeth o fentrau gofal dementia
- × Dogfennaeth glinigol a systemau rheoli risg gwael
- × Profiad a chymysgedd sgiliau'r staff, ynghyd â lefelau staffio
- × Rheoli meddyginiaethau, gan gynnwys storio cyffuriau'n ddiogel
- × Cyfraddau cydymffurfiaeth â hyfforddiant gorfodol
- × Ymgorffori archwiliadau clinigol
- × Methu â dogfennu, cofnodi nac adrodd ar ddigwyddiadau'n ddigonol

BIP Cwm Taf Morgannwg

Meddygfeydd

- ✓ Enghreifftiau cadarnhaol a chyfeillgar o ryngweithio rhwng y staff a'r cleifion
- ✓ Amgylcheddau glân a thaclus
- ✓ Tystiolaeth o dimau cryf, ac ymrwymiad i wneud gwelliannau
- × Angen atgyfnerthu trefniadau o ran cadw cofrestr o statws imiwneiddio ac imiwnedd hepatitis B pob aelod o'r staff clinigol
- × Atgyfnerthu trefniadau gwirio staff wrth recriwtio staff newydd
- × Sicrhau bod cwynion yn cael eu cofnodi a'u hasesu'n briodol, gan gynnwys dangos y camau a gymerwyd o ganlyniad iddynt
- × Gwella gwefannau er mwyn sicrhau eu bod yn adlewyrchu'r gwasanaethau a gynigir

Deintyddfeydd

- ✓ Dywedodd y cleifion wrthym eu bod yn hapus â'r gwasanaeth roeddent yn ei gael
- ✓ Gallai'r cleifion roi adborth i'r gwasanaeth mewn ffyrdd priodol
- ✓ Roedd gwybodaeth ar gael i'r cleifion yn hawdd o fewn y gwasanaethau
- × Angen gwella cofnodion clinigol, gan gynnwys cyngor ar yfed alcohol a smygu, hanes meddygol, ailalw a chofnodi BPE

Rheoliadau Ymbelydredd Ïoneiddio (Cysylltiad Meddygol)

- ✓ Roedd cydymffurfiaeth â Rheoliadau IR(ME)R 2017 yn dda
- ✓ Roedd yr adran yn cael ei rheoli'n dda ac roedd sylwadau gan y staff yn dangos eu bod yn teimlo eu bod yn cael cefnogaeth gan uwch-aelodau o'r staff
- ✓ Roedd yr adborth a gafwyd gan y cleifion yn nodi eu bod yn fodlon iawn ar y gwasanaethau a ddarperir yn yr adran
- ✓ Roedd uwch-aelodau o'r staff yn croesawu ein harolygiad ac yn dangos parodrwydd i wneud gwelliannau o ganlyniad i'r arolygiad
- × Sicrhau bod cleifion yn cael gwybodaeth fel mater o drefn am y risgiau a'r buddiannau sy'n gysylltiedig â'u harchwiliadau
- × Sicrhau bod y staff yn cynnal gwiriadau adnabod cleifion ac yn holi ynghylch statws beichiogrwydd yn rheolaidd cyn i gleifion ddod i gysylltiad ag ymbelydredd ïoneiddio
- × Sicrhau bod staff sy'n siarad Cymraeg yn gweithio yn yr adran er mwyn helpu i ddarparu'r 'Cynnig Rhagweithiol'[7]

[7] Mae 'Cynnig Rhagweithiol' yn golygu darparu gwasanaeth yn Gymraeg heb i neb orfod gofyn amdano. Dylai'r Gymraeg fod yr un mor weladwy â'r Saesneg

Byrddau Iechyd Lleol ac Ymddiriedolaethau'r GIG

BIP Hywel Dda

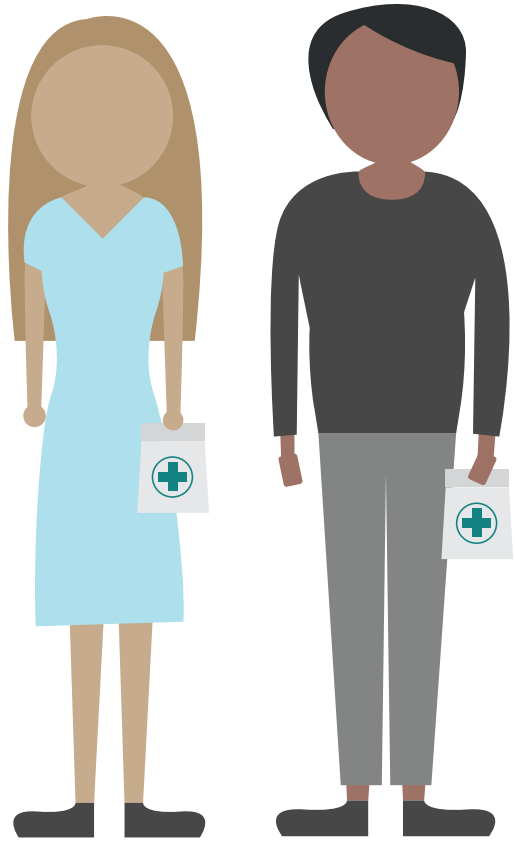
Ar y cyfan, roedd y cleifion yn gadarnhaol iawn am y gofal, y driniaeth a'r gwasanaethau a ddarparwyd gan Fwrdd Iechyd Prifysgol Hywel Dda. Rhoddodd y staff adborth cadarnhaol am y gefnogaeth a'r arweinyddiaeth a ddarparwyd gan uwch-reolwyr ward ac ysbyty. Nodwyd bod arferion gwaith amlddisgyblaethol effeithiol hefyd yn gadarnhaol ac yn alluogol.

Yn anffodus, unwaith eto eleni, nodwyd themâu a godwyd mewn adroddiadau blynyddol blaenorol sy'n parhau i beri problemau i'r bwrdd iechyd. Yn arbennig nodwyd rheoli meddyginiaethau unwaith eto fel maes i'w wella.

Gwnaethom ymweld â chwe ysbyty ac arolygu deg ward. Cynhaliwyd tri arolygiad mewn ysbytai fel rhan o'n Hadolygiad Cenedlaethol o Wasanaethau Mamolaeth. Ar y cyfan, nododd ein harolygiadau fod menywod yn teimlo'n gadarnhaol am eu profiad o ddefnyddio gwasanaethau mamolaeth drwyddi draw. Gwelsom enghreifftiau o ryngweithio proffesiynol a thrugarog rhwng y staff a'r cleifion. Yn ystod ein harolygiadau o wasanaethau mamolaeth gwelsom dystiolaeth o arweinyddiaeth effeithiol. Fodd bynnag, nodwyd hefyd nifer o faterion Sicrwydd Uniongyrchol yn ein harolygiadau mamolaeth, gyda sawl un o'r rhain yn debyg ar bob safle. Nodwyd rhai o'r materion hyn ledled Cymru hefyd. Cydnabyddir, fodd bynnag, fod gwaith i'w wneud i sicrhau bod safonau'n gyson o fewn gwasanaethau mamolaeth y bwrdd iechyd.

Gwnaethom gynnal un arolygiad anableddau dysgu ac un arolygiad iechyd meddwl. Roedd yn braf nodi na chyflwynwyd unrhyw lythyrau Sicrwydd Uniongyrchol. Yn y ddau arolygiad, nodwyd bod y gofal, y cymorth a'r driniaeth yn cael eu darparu mewn modd urddasol a pharchus.

Hefyd cynhaliodd AGIC arolygiad o Dîm Iechyd Meddwl Cymunedol yn Llanelli. Gwelsom fod ansawdd y gofal a'r ymgysylltu yn dda ar y cyfan, a bod defnyddwyr y gwasanaeth yn gadarnhaol ar y cyfan am y cymorth a gawsant. Gwelwyd bod dull amlddisgyblaethol ar waith ar gyfer asesu, cynllunio gofal ac adolygu, a bod defnyddwyr y gwasanaeth a'u teuluoedd yn cael eu cynnwys yn y broses, lle roedd hynny'n briodol. Yn ystod yr arolygiad, tynnwyd sylw at bryderon ynghylch gwiriadau'r Gwasanaeth Datgelu a Gwahardd (DBS) ac agweddau ar y gwaith o reoli meddyginiaeth. Ymdriniwyd â'n pryderon o dan ein proses Sicrwydd Uniongyrchol.



BIP Hywel Dda

Ar y cyfan, yn ein pedwar arolygiad o feddygfeydd, gwelsom eu bod yn canolbwyntio ar ddarparu gofal diogel ac effeithiol i'r cleifion. Nodwyd bod y cofnodion yn cael eu cadw i safon dda. Gwnaethom nodi rhai meysydd i'w gwella, yn enwedig mewn perthynas ag arferion adnoddau dynol. Yn benodol, nodwyd nad oedd gwiriadau'r Gwasanaeth Datgelu a Gwahardd (DBS) yn cael eu cynnal mewn modd cadarn a chynhwysfawr.

Yn ein harolygiadau o ddeintyddfeydd, nodwyd eu bod yn darparu gofal diogel ac effeithiol i'w cleifion ar y cyfan, a hynny mewn modd proffesiynol ac ymroddedig. Ar y cyfan, roedd y cleifion yn gadarnhaol iawn am y gwasanaethau a ddarparwyd. Nodwyd rhai meysydd i'w gwella, a oedd yn cynnwys hyfforddiant gorfodol ar gyfer y staff a phrosesau recriwtio cadarn.

Yn ystod ein holl arolygiadau a'n cyswllt â'r bwrdd iechyd, mae'n bwysig nodi y bu'r gydberthynas yn gadarnhaol ac yn alluogol. Dangoswyd hyn yn ein rhyngweithio â staff y wardiau a'r uwch-dîm gweithredol. Lle tynnwyd sylw at argymhellion / Sicrwydd Uniongyrchol, mae'r Bwrdd Iechyd wedi ceisio datrys unrhyw faterion cyn gynted â phosibl. Rhaid canmol Bwrdd Iechyd Prifysgol Hywel Dda am ei ddull o wella safonau gofal a diogelwch cleifion. Mae'r bwrdd iechyd wedi datblygu diwylliant o fod yn agored ac yn dryloyw, a rhaid canmol ei uwch-swyddogion gweithredol am ddilyn y trywydd hwn.

BIP Hywel Dda

Ysbytai

- ✓ Roedd y staff yn ymrwymedig i ddarparu gofal o ansawdd uchel i gleifion
- ✓ Gwelsom ryngweithio proffesiynol a charedig rhwng y staff a'r cleifion, ac roedd gofal yn cael ei ddarparu mewn ffordd urddasol
- ✓ Gwaith tîm amlddisgyblaethol da
- ✓ Ar y cyfan, roedd y staff yn gadarnhaol am y gefnogaeth roeddent yn ei chael gan eu rheolwyr
- × Rheoli meddyginiaethau, gan gynnwys storio cyffuriau'n ddiogel
- × Archwilio cyfarpar dadebru brys
- × Cydymffurfiaeth y staff â hyfforddiant statudol a gorfodol
- × Dogfennaeth, gan gynnwys asesiadau risg
- × Arferion hylendid a rheoli heintiau

Iechyd meddwl

- ✓ Roedd amrywiaeth dda o therapïau a gweithgareddau yn cael ei darparu i'r cleifion
- ✓ Gwaith tîm da a staff sy'n llawn cymhelliant
- ✓ Hybu gofal sy'n canolbwyntio ar y claf i'w helpu i wella
- ✓ Cynlluniau gofal unigoledig manwl
- ✓ Darpariaeth dda y tu allan i oriau, a gweinyddu'r Ddeddf Iechyd Meddwl yn ein harolygiad TIMC
- × Capasiti ei wasanaeth iechyd meddwl i gleifion mewnol sy'n oedolion
- × Trefniadau archwilio a llywodraethu
- × Y wybodaeth a'r llenyddiaeth a ddarperir ar y wardiau ar gyfer y cleifion
- × Cydymffurfiaeth y staff â hyfforddiant statudol a gorfodol
- × Gwella'r gwaith o reoli meddyginiaethau, gan gynnwys storio cyffuriau'n ddiogel yn ein harolygiad TIMC
- × Gwiriadau DBS heb eu cwblhau'n ddigonol yn ein harolygiad TIMC

BIP Hywel Dda

Iechyd Meddwl Cymunedol

Gwnaethom arolygu Tîm Iechyd Meddwl Cymunedol Llanelli

- ✓ Ymgysylltiad defnyddwyr y gwasanaeth a'r gofalwyr
- ✓ Gwaith amlddisgyblaethol a chysylltiadau ag asiantaethau eraill
- ✓ Darpariaeth y tu allan i oriau
- ✓ Gweinyddu'r Ddeddf Iechyd Meddwl
- × Rheoli meddyginiaethau, gan gynnwys storio cyffuriau'n ddiogel
- × Gwiriadau DBS ar staff
- × Amseroedd aros seicoleg
- × Hyfforddiant ar y Ddeddf Gwasanaethau Cymdeithasol a Llesiant ar gyfer staff y bwrdd iechyd

Meddygfeydd

- ✓ Roedd y cleifion yn cael eu trin ag urddas a pharch
- ✓ Cofnodion o safon dda
- ✓ Amrywiaeth dda o wybodaeth a mentrau hybu iechyd
- ✓ Cefnogaeth gan yr uwch-reolwyr
- × Cwblhau gwiriadau'r Gwasanaeth Datgelu a Gwahardd
- × Darparu mwy o wybodaeth ddwyieithog
- × Rheoli meddyginiaethau, gan gynnwys storio cyffuriau'n ddiogel
- × Cydymffurfiaeth â hyfforddiant statudol a gorfodol

Deintyddfeydd

- ✓ Deintyddfeydd yn cael eu cynnal i safon uchel
- ✓ Roedd trefniadau ar waith ar gyfer atal a rheoli heintiau
- ✓ Rhoddwyd digon o wybodaeth i'r cleifion er mwyn eu helpu i wneud penderfyniad ar sail gwybodaeth ynglŷn â'u triniaeth
- ✓ Roedd y cleifion yn gallu rhoi adborth ar y gofal a'r driniaeth a gawsant
- × Gwella'r broses o roi canllawiau 'Delivering Better Oral Health' ar waith a sicrhau y caiff tystiolaeth ei chofnodi yng nghofnodion y cleifion.
- × Sicrhau bod cofnodion cleifion clinigol yn cael eu cynnal yn unol â safon broffesiynol y cytunwyd arni
- × Cydymffurfiaeth â hyfforddiant statudol a gorfodol

Byrddau Iechyd Lleol ac Ymddiriedolaethau'r GIG

Bwrdd Iechyd Addysgu Powys

Ar y cyfan, bu'r arolygiadau yn 2019-20 yn gadarnhaol ar y cyfan. Nodwyd bod gofal urddasol, a oedd yn canolbwyntio ar yr unigolyn, yn cael ei ddarparu gan staff ymrwymedig ym mhob arolygiad, fel y gwelwyd yn ystod arolygiadau 2018-19.

Gwnaethom arolygu un feddygfa yn 2019-20 lle nododd y cleifion yn gyffredinol eu bod yn cael eu trin ag urddas a pharch gan y tîm yno. Gwelsom dystiolaeth o waith tîm da ymhlith staff y feddygfa. Roedd angen gwneud gwelliannau er mwyn sicrhau bod cofnodion cyflogaeth y staff yn gyfredol, gan gynnwys gwiriadau cyn cyflogi a gwybodaeth am hyfforddiant. Roedd angen rhaglen o archwiliadau clinigol er mwyn sicrhau bod y feddygfa yn adolygu ei gweithgareddau'n rheolaidd.

Roedd yn braf gweld tystiolaeth o waith amlddisgyblaethol effeithiol yn ein harolygiadau o ysbytai, lleoliadau iechyd meddwl a TIMC. Yn arbennig, roedd lefel yr integreiddio rhwng iechyd a gofal cymdeithasol o fewn y TIMC yn gadarnhaol iawn, o gymharu ag arolygiad TIMC yn y bwrdd iechyd y flwyddyn flaenorol. Roedd hefyd yn gadarnhaol nodi gwelliannau yn amseroedd aros y cleifion ar gyfer gwasanaethau seicoleg o fewn y TIMC.

Hefyd, nodwyd bod y gwaith o gynllunio a dogfennu gofal yn dda, gyda'r rhan fwyaf o'r cofnodion y gwnaethom edrych arnynt wedi'u cwblhau'n fanwl ac yn canolbwyntio ar yr unigolyn. Fodd bynnag, nodwyd meysydd i'w gwella gyda rhai agweddau ar ddogfennaeth y Ddeddf Iechyd Meddwl mewn nifer o leoliadau. Mae hwn yn faes lle cafwyd canfyddiadau tebyg yn ein harolygiad TIMC yn 2018-19.

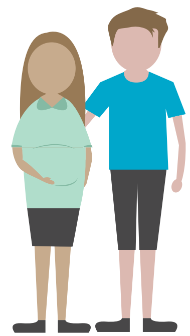
Yn ein harolygiadau o ysbytai, lleoliadau iechyd meddwl a TIMC nodwyd bod prosesau llywodraethu ac archwilio cefnogol ar waith. Fodd bynnag, roedd rhai meysydd lle gellid gwella hyn, megis sicrhau bod polisïau a gweithdrefnau yn cael eu hadolygu'n amserol, a sicrhau bod y staff yn cael y wybodaeth fwyaf priodol a chyfredol i'w cefnogi yn eu gwaith. Roedd hefyd yn siomedig nodi, mewn un arolygiad iechyd meddwl, i welliannau a nodwyd yn ystod arolygiad 2017 gael eu nodi eto yn yr arolygiad hwn.

Ar y cyfan, nododd y staff fod amgylchedd gwaith tîm da ac roeddent yn teimlo eu bod yn cael eu cefnogi gan eu rheolwyr a'u cydweithwyr. Gwelsom fod y bwrdd iechyd yn dal i'w chael hi'n anodd llenwi rhai swyddi gwag. Fodd bynnag, roedd y bwrdd iechyd yn hysbysebu er mwyn denu ymgeiswyr i'r rolau hyn. Er gwaethaf yr anawsterau hyn, nodwyd bod lefelau staffio priodol ym mhob lleoliad i helpu i ddarparu gofal o safon dda.

Er inni weld gwaith cynllunio effeithiol ar gyfer rhyddhau cleifion ym mhob lleoliad, nodwyd y gallai fod oedi wrth ryddhau cleifion o'r ysbyty am fod prinder lleoliadau gofal cymdeithasol a/neu ymgysylltiad â gofal cymdeithasol.

Roedd yn siomedig nodi nifer o faterion yn ymwneud ag ystadau mewn amrywiaeth o wasanaethau yn y bwrdd iechyd, yr oedd angen mynd i'r afael â nhw er mwyn sicrhau bod gan y cleifion amgylchedd diogel. Rhaid hefyd ystyried cynllun rhai wardiau iechyd meddwl. Nodwyd bod ystafelloedd â dau unigolyn ynddynt a chyfleusterau ystafell ymolchi a oedd yn cael eu rhannu yn cael effaith negyddol ar allu'r staff i ddarparu gofal urddasol.

Gwnaethom arolygu chwe uned canolfan geni yn y bwrdd iechyd, ac er inni nodi eu bod yn gadarnhaol ar y cyfan, roedd rhai anghysondebau yn y broses a ddefnyddir i gael y wraig feichiog o bwll geni mewn argyfwng. Hefyd, nid oedd rhywfaint o'r cyfarpar cynorthwyol a ddefnyddir mewn argyfwng o'r fath ar gael ym mhob uned. O ganlyniad i hyn, cyflwynwyd llythyr sicrwydd uniongyrchol i'r bwrdd iechyd er mwyn iddo gymryd camau adferol ar frys. Cawsom sicrwydd yn sgil y camau a gymerwyd.



BIA Powys

Ysbytai

- ✓ Roedd y cleifion yn derbyn gofal urddasol a pharchus gan staff ymrwymedig
- ✓ Gwaith tîm amlddisgyblaethol
- ✓ Nodi'r cleifion hynny sydd angen cymorth ychwanegol gyda'u hanghenion h.y. cynllun pili pala a nodi'r rhai sydd angen cymorth i fwyta ac yfed
- ✓ Ar y cyfan, ceir prosesau llywodraethu, archwilio ac adolygu clinigol da
- ✓ Archwilio cyfarpar brys
- × Materion amgylcheddol
- × Defnydd cyson o adnodd asesu poen
- × Gallu'r bwrdd iechyd i lenwi swyddi gwag
- × Cwblhau meysydd mewn dogfennaeth Deddf Iechyd Meddwl
- × Effaith diffyg darpariaeth gofal cymdeithasol ar gynllunio i ryddhau cleifion
- × Yr angen i sicrhau bod polisïau a gweithdrefnau yn cael eu hadolygu'n rheolaidd a'u diweddaru

Meddygfeydd

- ✓ Cleifion yn cael eu trin ag urddas a pharch
- ✓ Amgylchedd cefnogol, lle mae'r tîm yn cydweithio'n dda
- ✓ Cleifion yn gwbl ymwybodol o'r rhesymau dros feddyginiaeth a ragnodwyd
- ✓ Amgylchedd clinigol glân a thaclus
- × Yr angen i roi rhaglen o archwiliadau clinigol ac archwiliadau ansawdd ar waith
- × Cofnodion personél y staff i gael eu cynnal a'u cadw'n briodol, gan gynnwys gwybodaeth am gyflogaeth a hyfforddiant
- × Cyfathrebu'n ffurfiol â'r staff, gan gynnwys cyfarfodydd tîm a chyfarfodydd staff clinigol i ledaenu gwybodaeth yn briodol

BIA Powys

Iechyd meddwl

- ✓ Roedd y cleifion yn derbyn gofal urddasol ac unigol, gan gynnwys cynlluniau gofal, gan staff ymrwymedig
- ✓ Gwaith tîm amlddisgyblaethol ym mhob gwasanaeth, a lefel dda o waith integredig yn y TIMC
- ✓ Defnyddio technegau tynnu sylw, yn hytrach nag atal yn gorfforol yn yr ysbyty
- ✓ Er nad oedd yn wir am y ddwy ward ysbyty, gwelsom enghreifftiau o arfer nodedig y gellid ei rhannu (defnyddio cyngor cleifion a dogfen 'Dyma fi')
- ✓ Proses amserol ar gyfer sgrinio atgyfeiriadau newydd o fewn y TIMC
- ✓ Lleihad sylweddol mewn amseroedd aros ar gyfer gwasanaethau seicoleg o fewn y TIMC (o ddwy flynedd i ddau neu dri mis)

- × Cynllun rhai wardiau ysbyty, gyda rhai o'r cleifion yn rhannu ystafelloedd ac ystafelloedd ymolchi, yn cael effaith ar allu'r staff i ddarparu gofal urddasol bob amser
- × Cyfranogiad ac argaeledd darparwyr gofal cymdeithasol yn effeithio ar drefniadau rhyddhau cleifion
- × Angen adolygu polisïau a gweithdrefnau am fod llawer wedi dyddio
- × Gallu'r bwrdd iechyd i lenwi swyddi gwag
- × Amgylchedd ysbyty Bronllys
- × Problemau mawr gyda'r system TG a ddefnyddiwyd ar gyfer cofnodion y cleifion, gan arwain at atal y staff rhag cael gafael ar gofnodion yn amserol (cyflwynwyd SU ar gyfer hyn)
- × Cywirdeb dogfennaeth y Ddeddf Iechyd Meddwl a'i chwblhau
- × Rhai trefniadau ar gyfer ymdrin ag argyfyngau mewn perthynas â'r cleifion yn y TIMC, megis argaeledd meddygon Adran 12, argaeledd gwelyau cleifion mewnol lleol, a chludiant amserol a diogel ar gyfer y cleifion i'r ysbyty
- × Amrywiaeth o hyfforddiant arbenigol i'r staff a chydymffurfiaeth â hyfforddiant gorfodol o fewn y TIMC

Byrddau Iechyd Lleol ac Ymddiriedolaethau'r GIG

BIP Bae Abertawe

Yn gyffredinol, ym mhob lleoliad, roedd y cleifion yn gadarnhaol iawn am eu gofal a'u triniaeth. Roedd grŵp proffesiynol o staff yn trin y cleifion ag urddas a pharch. Roedd y staff yn rhoi gwybod i'r cleifion am eu gofal yn gyson, gan eu galluogi i wneud dewisiadau ar sail gwybodaeth.

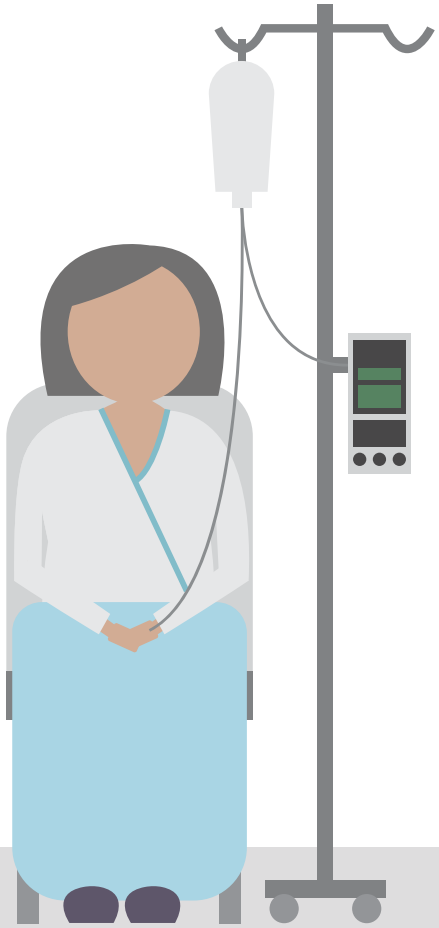
Gwelsom waith tîm da ym mhob lleoliad, ac awydd i ddysgu o weithgarwch arolygu a gwneud gwelliannau. Fodd bynnag, mae angen atgyfnerthu trefniadau llywodraethu er mwyn hybu dysgu rhwng lleoliadau.

Mewn rhai lleoliadau, gwnaethom siarad ag aelodau o'r staff a oedd yn teimlo nad oeddent yn cael eu cefnogi wrth godi pryderon ac yn dilyn digwyddiadau clinigol. Yn ogystal â hyn, dywedwyd nad oedd digon o bresenoldeb uwch aelodau o'r staff na staff gweithredol mewn ardaloedd gweithredol.

Mae'r bwrdd iechyd wedi cymryd camau cadarnhaol sylweddol o ran ei wiriadau cyn cyflogi ar ôl adolygiad Kris Wade. Mae gweithgor wedi cael ei sefydlu i sicrhau cydymffurfiaeth ym mhob lleoliad yn y bwrdd iechyd, gyda rhaglen barhaus o fonitro ac archwilio

Gwnaethom arolygu dwy uned famolaeth ym mwrdd iechyd Bae Abertawe fel rhan o'n hadolygiad cenedlaethol o wasanaethau mamolaeth ledled Cymru. Roedd y rhain yn ysbytai Singleton a Chastell-nedd Port Talbot. Ar y cyfan, roedd y ddau arolygiad yn gadarnhaol. Roedd yr adborth gan y cleifion yn gadarnhaol iawn ac yn canmol y gofal, y driniaeth a'r cymorth a oedd yn cael eu rhoi gan y staff.

Yn fwyaf diweddar, mewn arolygiad o Adran Achosion Brys ac Uned Asesu Meddygol Acíwt yn Ysbyty Treforys a gynhaliwyd cyn Covid-19, tynnwyd sylw at bryderon sylweddol mewn nifer o feysydd. Nodwyd nifer o faterion Sicrwydd Uniongyrchol mewn perthynas â rheoli a rhoi meddyginiaeth, cynnal a chadw cyfarpar dadebru, atal a rheoli heintiau ac amseroedd asesu ar gyfer cleifion sy'n cyrraedd mewn ambiwlans. Bydd AGIC yn parhau i fonitro cynnydd y bwrdd iechyd wrth ddelio â'r materion hyn. Mae'r manylion llawn wedi'u cyhoeddi yn yr adroddiad ar gyfer Adran Achosion Brys ac Uned Asesu Treforys ar ein gwefan.



BIP Bae Abertawe

Ysbytai

- ✓ Proses ddiogel a chadarn ar gyfer rheoli meddyginiaethau ar bob ward a arolygwyd
- ✓ Roedd y ddogfennaeth o safon uchel iawn
- ✓ Roedd y cyfarpar yn y ganolfan eni yn cael ei wirio'n rheolaidd ac yn gyson er mwyn cynnal safonau
- ✓ Gwelsom ryngweithio proffesiynol a charedig rhwng y staff a'r cleifion, a gofal yn cael ei ddarparu mewn ffordd urddasol
- ✓ Dangosodd staff yr Adran Achosion Brys a'r Uned Asesu Meddygol Acíwt ymrwymiad i ddysgu o'r arolygiad a gwneud gwelliannau fel y bo'n briodol
- × Archwilio'r trefniadau archwilio er mwyn sicrhau cysondeb a hyrwyddo rhannu a dysgu
- × Dylai pob claf gael ei ryddhau mewn modd amserol
- × Bod y rotâu staffio'n cael eu hadolygu er mwyn sicrhau bod y lefelau staffio'n ddiogel ac yn effeithiol i ddiwallu anghenion y gwasanaeth
- × Roedd y cleifion yn aros yn nhair ardal aros yr Adran Achosion Brys am gyfnodau hir iawn, gyda rhai yn aros am hyd at 15 i 20 awr
- × Nid oedd anghenion maeth a hydradu'r cleifion yn cael eu diwallu'n gyson yn yr Adran Achosion Brys

Iechyd meddwl

- ✓ Gwelsom dîm ymroddedig o staff a oedd yn ymrwymedig i ddarparu gofal o safon uchel i'r cleifion. Gwelsom fod y staff yn dangos parch wrth ryngweithio â'r cleifion drwy gydol yr arolygiad
- ✓ Roedd y staff yn dangos parch wrth ryngweithio ac ymgysylltu â'r cleifion
- ✓ Roedd amrywiaeth dda o therapïau a gweithgareddau yn cael ei darparu i'r cleifion
- × Mae'n rhaid i'r bwrdd iechyd adolygu ei ddarpariaeth iechyd meddwl er mwyn sicrhau bod yr amgylchedd gofal yn cael ei ddatblygu i adlewyrchu'r ffordd y caiff gofal iechyd meddwl ei ddarparu ar hyn o bryd ac yn y dyfodol.
- × Yr amgylchedd gofal, er mwyn i'r staff reoli diogelwch y wardiau
- × Cynllun yr ystafelloedd clinig a'r ffordd y caiff meddyginiaeth ei storio
- × Y broses o gadw cofnodion a chwblhau dogfennaeth glinigol

BIP Bae Abertawe

Meddygfeydd

- ✓ Trefniadau ar gyfer rheoli atgyfeiriadau cleifion
- ✓ Adolygu clinigol gan gymheiriaid a chymorth
- ✓ Roedd y practis yn treialu dulliau newydd o rannu gwybodaeth a gofal iechyd ataliol gan ddefnyddio ap i'r cleifion.
- ✓ Amrywiaeth dda o wasanaethau ar gael i gleifion, gan gynnwys gwybodaeth am hybu iechyd, yn ogystal â chlinigau rheolaidd ar gyfer cyflyrau parhaus
- ✓ Cynlluniau parhau busnes a chynlluniau argyfwng cynhwysfawr ar waith.
- × Sefydlu clinigau rheoli clefydau cronig
- × Rhai agweddau ar gadw cofnodion cleifion.
- × Ni allai'r practis ddarparu tystiolaeth o imiwnedd rhag Hepatitis B ar gyfer pob aelod o'r staff clinigol. Gwelsom gofnodion ar gyfer rhai aelodau o'r staff, ond nid pob un
- × Roedd cyfarpar monitro pwysedd gwaed, taldra a phwysau yn cael ei gadw y tu ôl i ddesg y dderbynfa ac nid oedd hyn yn cynnal cyfrinachedd y cleifion.
- × Nid oedd rhai aelodau o'r staff yn gwybod ble roedd y diffibriliwr ac nid oedd y cyfarpar dadebru yn cynnwys mwgwd bag-falf er mwyn helpu cleifion i anadlu.
- × Nid oedd meddyginiaeth yn cael ei storio'n ddiogel bob amser

Deintyddol

- ✓ Roedd y staff yn cael eu cefnogi ac roeddent wedi cael yr hyfforddiant angenrheidiol i gyflawni eu rolau'n effeithlon
- ✓ Roedd yr amgylchedd yn darparu cyfleusterau clinigol gydag offer digonol a oedd mewn cyflwr da ac yn edrych yn lân ac yn daclus
- ✓ Lefelau da iawn o foddhad cleifion
- ✓ Roedd y wybodaeth gywir yn cael ei rhoi i'r cleifion er mwyn iddynt wneud penderfyniadau ar sail gwybodaeth am eu triniaeth
- ✓ Roedd asesiadau risg cynhwysfawr ar waith er mwyn sicrhau bod y safle a'r cyfleusterau clinigol yn addas at y diben
- ✓ Roedd yr aelodau o'r staff clinigol wedi'u cofrestru i ymarfer â'r Cyngor Deintyddol Cyffredinol ac roeddent wedi derbyn yr hyfforddiant angenrheidiol ar gyfer eu rolau a'u cyfrifoldebau
- × Cofnodi gwybodaeth ychwanegol yn nodiadau'r cleifion, er enghraifft hanes meddygol parhaus
- × Mae'n rhaid i'r practis sicrhau bod cyffuriau a chyfarpar brys yn cael eu gwirio'n wythnosol
- × Mae'n rhaid i'r practis sicrhau bod padiau pediatrig addas ar gael yn y pecyn argyfwng
- × Mae angen i'r bwrdd iechyd gael gwared ar y cyfarpar a ddatgomisiynwyd
- × Mae angen i'r cofnodion clinigol gynnwys cydsynio parhaus

Ymddiriedolaethau – Iechyd Cyhoeddus Cymru, Ymddiriedolaeth GIG Felindre, Ymddiriedolaeth Gwasanaeth Ambiwlans Cymru

Public Health Wales

Gwnaethom gynnal arolwg o Iechyd Cyhoeddus Cymru er mwyn asesu'r ffordd y mae Bron Brawf Cymru yn sicrhau y caiff y broses o sgrinio'r fron ei rheoli'n amserol ar gyfer menywod sy'n cael canlyniad mamogram abnormal.

Drwy gydol yr adolygiad, roedd y sefydliad yn agored ac yn barod i helpu. Roedd hyn yn cynnwys rhoi amrywiaeth o wybodaeth i AGIC, a helpu i hwyluso'r broses o ddosbarthu arolwg i gasglu safbwyntiau ac adborth gan fenywod.

Anfonwyd yr arolwg at bob menyw a ailalwyd i glinig asesu i gael profion ac ymchwiliadau pellach o fis Hydref tan fis Rhagfyr 2019, ac a gafodd ganlyniad anfalaen, h.y. ni nodwyd canser. Roedd canlyniadau'r arolwg yn gadarnhaol iawn, gyda'r rhan fwyaf o'r menywod yn dweud bod eu profiad yn ardderchog. Hefyd, cawsom lawer o sylwadau gan fenywod yn canmol proffesiynoldeb a natur ofalgar y staff.

Ymddiriedolaeth GIG Felindre

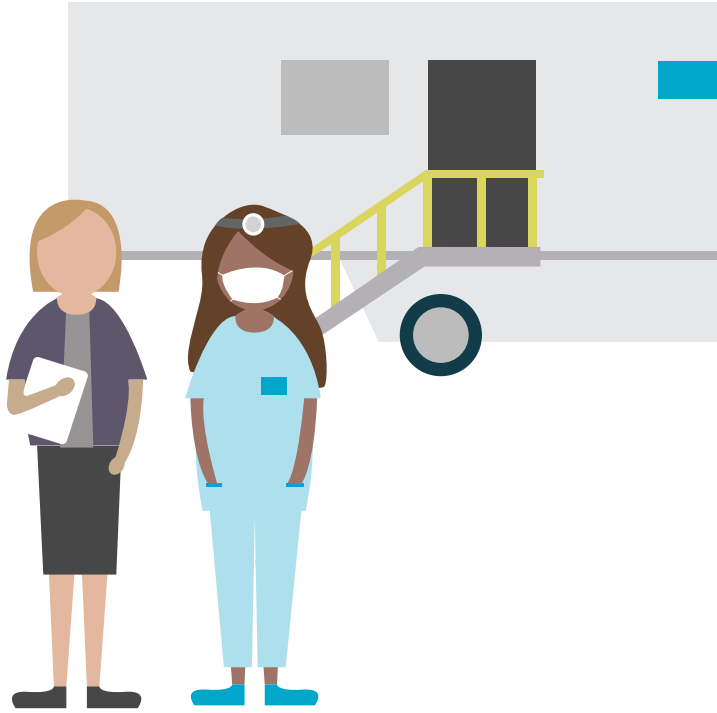
Mae Felindre yn parhau i fod yn sefydliad cymharol fach sy'n cynnig triniaeth canser arbenigol ac yn gartref i Wasanaeth Gwaed Cymru. Drwy ein trafodaethau a'n cyfarfodydd arferol, bydd cleifion yn dweud yn gyson eu bod yn cael eu trin yn dda iawn gan y staff yn Felindre.

Gwelwyd bod trefniadau digonol ar waith yn Felindre i hybu diogelwch a llesiant y cleifion pan arolygodd AGIC yr adran radiotherapi. Hefyd, dim ond nifer bach o ddigwyddiadau difrifol a nodir ganddo ac ni roddwyd gwybod i AGIC am bryderon gan y cyhoedd ynglŷn â'r gwasanaethau a ddarperir.

Mae'r prif heriau i Felindre yn ymwneud â'r amgylchedd a'r seilwaith. Mae'r ymddiriedolaeth yn y broses o osod system TGCh newydd yn lle'r hen un, cynllunio ac adeiladu canolfan ganser newydd yng Nghaerdydd, a symleiddio ei gwasanaethau canser er mwyn iddynt fod yn fwy integredig a chanolbwyntio'n fwy ar fodel gofal yn y cartref. Er y bydd hyn yn fuddiol dros ben i'r cleifion pan fydd wedi'i gwblhau, mae angen cynnal y gofal a roddir i'r cleifion yn ystod y cyfnod pontio hwn.

Mae Felindre'n ei chael hi'n anodd ymdopi â galw mawr iawn am ei wasanaethau. Mae amseroedd aros a mynediad amserol i wasanaethau yn her. Eir i'r afael â hyn drwy osod peiriannau radiotherapi newydd yn lle'r rhai hŷn a chynyddu capasiti'r gweithlu.

Hefyd, nododd AGIC fod angen i Felindre sicrhau bod mwy o aelodau Cymraeg o staff ar gael a chyfathrebu'n effeithiol â'r cleifion am achosion o oedi a'r gweithdrefnau cwyno. Derbyniodd Felindre yr argymhellion hyn ar gyfer gwella ac mae wedi cymryd camau i sicrhau ei fod yn bodloni disgwyliadau'r 'Cynnig Rhagweithiol' ac yn rhoi'r wybodaeth ddiweddaraf am unrhyw newidiadau i amseroedd aros.



Ymddiriedolaethau – Iechyd Cyhoeddus Cymru, Ymddiriedolaeth GIG Felindre, Ymddiriedolaeth Gwasanaeth Ambiwlans Cymru

Ymddiriedolaeth Gwasanaethau Ambiwlans Cymru (WAST)

Drwy gydol 2019-2020, roedd WAST yn wynebu problemau difrifol yn ymwneud ag oedi wrth drosglwyddo cleifion ac amseroedd aros yn y gymuned. Yn ystod misoedd cyntaf y gaeaf, roedd perfformiad yn arbennig o wael mewn perthynas ag amseroedd ymateb. Fodd bynnag, mae hyn yn rhannol o ganlyniad i nifer cynyddol o alwadau coch blaenoriaeth uchel, a hefyd amseroedd aros hwy i ambiwlansys y tu allan i adrannau achosion brys. Ceir oedi'n aml cyn trosglwyddo cleifion rhwng ambiwlansys a staff yr ysbyty, ac mae'r gyfran o gleifion a gaiff eu trosglwyddo o fewn 15 munud wedi bod yn lleihau drwy gydol 2019-2020. Nid yw hyn yn rhywbeth y gall WAST ei ddatrys ar ei phen ei hun, a rhaid iddi weithio gyda'r byrddau iechyd i fynd i'r afael â'r mater.

Er mai problem system gyfan yw hon, gall WAST weithredu ar hyn i raddau. Mae Llywodraeth Cymru yn ymwybodol o'r broblem hon, ac mae'n ceisio gweithio'n agosach gyda'r ysbytai a'r byrddau iechyd sy'n perfformio waethaf i'w datrys. Mae'n ymddangos bod hyn yn cael rhywfaint o effaith, gan fod gwelliant mewn perfformiad unwaith eto ar ddiwedd gaeaf 2020.

Rhoddwyd mesurau brys ar waith mewn gwahanol safleoedd ledled Cymru, gyda rhai yn derbyn cleifion i'r coridorau ac eraill yn defnyddio adeiladu dros dro ar safleoedd ysbytai. Mae hyn wedi helpu i leddfu'r pwysau ar wasanaethau ambiwlans, ond mae AGIC wedi codi pryderon ynglŷn â'r gofal a roddir i'r cleifion yn y coridorau ac wedi rhoi heriau i'r byrddau iechyd ar gyfer rhoi'r arferion hyn ar waith.

Eleni, mae AGIC wedi bod yn cynnal adolygiad o drefniadau rheoli cleifion WAST, gyda ffocws ar y prosesau ar gyfer rheoli galwadau yn ei Chanolfannau Cyswllt Clinigol. Mae rhagor o wybodaeth am yr adolygiad hwn i'w gweld ar dudalen 21.

Ein Hadnoddau

Ein pobl

Mae'r tabl isod yn dangos nifer y swyddi llawn amser neu ran-amser ym mhob tîm o fewn AGIC yn ystod 2019-2020.

Tîm	Swyddi llawn amser
Uwch-swyddogion Gweithredol	4
Arolygu, Rheoleiddio a Phryderon	36
Gwybodaeth, Partneriaeth a Methodoleg	14
Strategaeth, Polisi a Chyfathrebu	5
Cyngor clinigol (gan gynnwys gwasanaeth SOAD)	4
Cymorth busnes	18
Cyfanswm	**81**

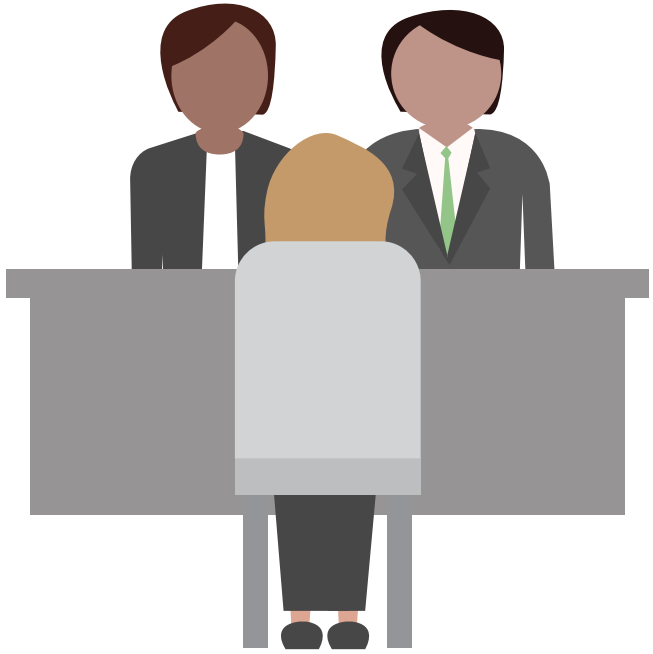
Yn dilyn ymgyrch recriwtio lwyddiannus a lansiwyd tua diwedd 2018, gwnaethom groesawu 10 aelod newydd o staff i'n tîm arolygiadau ac adolygiadau yn 2019. Roedd hyn yn flaenoriaeth allweddol i ni er mwyn meithrin gallu sefydliadol ar draws ein swyddogaethau craidd.

Rydym hefyd wedi recriwtio i feysydd allweddol eraill yn y sefydliad, gan gynnwys atgyfnerthu ein tîm Cyngor Clinigol, gan gynyddu cyfanswm y swyddi o fewn AGIC i 81.

Rydym yn dibynnu ar gyfraniad adolygwyr cymheiriaid a lleyg er mwyn helpu i gyflawni ein rhaglen arolygu ac adolygu. Gweithwyr iechyd proffesiynol sy'n defnyddio eu gwybodaeth a'u harbenigedd i sicrhau bod ein gwaith yn seiliedig ar arfer a phrofiad cyfredol yw adolygwyr cymheiriaid. Mae adolygwyr lleyg gwirfoddol yn cyflawni rôl bwysig wrth helpu i gryfhau llais y cleifion yn y ffordd y caiff gwasanaethau iechyd eu hadolygu.

Ar hyn o bryd mae gennym banel o fwy na 250 o adolygwyr cymheiriaid, ar ôl cynnal nifer o ymarferion recriwtio yn ystod 2019-2020, er mwyn ateb y galw yn sgil ein rhaglen gynyddol o arolygiadau ac adolygiadau cenedlaethol. Roedd hyn yn cynnwys Adolygwr Cymheiriaid Meddygon Teulu Arweiniol, nifer o Adolygwyr Cymheiriaid Meddygon Teulu, Adolygwyr Cymheiriaid Bydwragedd ac Adolygwyr Cymheiriaid Obstetryddion Ymgynghorol.

Gwnaethom hefyd gynnal gwerthusiad o'n rôl adolygwr lleyg gwirfoddol, yn unol â'r ymrwymiad yn ein Cynllun Gweithredol, ac rydym wedi penderfynu cyflwyno dwy rôl gyflogedig yn ei lle – Adolygwr Profiadau Cleifion ac Arbenigwr drwy Brofiad. Mae hyn yn tynnu sylw at y pwys a roddwn ar asesu profiad y claf drwy siarad â chleifion a'u gwahodd i lenwi holiaduron ar ein harolygiadau.



Ein Hadnoddau

Cyllid

Mae'r tabl canlynol yn dangos sut y gwnaethom ddefnyddio ein hadnoddau ariannol yn y flwyddyn ariannol ddiwethaf er mwyn cyflawni Cynllun Gweithredol 2019-2020.

	£000au
Cyfanswm Cyllideb AGIC	**4529**
Gwariant	
Costau staff	3912
Teithio a Chynhaliaeth	102
Dysgu a Datblygu	26
Costau nad ydynt yn ymwneud â staff	103
Cyfieithu	84
Costau adolygu	637
Costau TGCh cyfalaf	157
Cyfanswm gwariant (a)	**5021**
Incwm	
Gofal Iechyd Annibynnol	251
Cofrestru deintyddfeydd preifat	239
Ffioedd cyfreithiol	11
Cyfanswm incwm (b)	**500**
Cyfanswm Gwariant Net (a-b)	**4521**

Matrics Ymrwymiadau

Yn y tabl isod nodir amcanion AGIC ar gyfer 2019-2020 ynghyd â manylion ynghylch sut y gwnaeth gyflawni'r amcan.

Yr hyn a ddywedom	Mesurwyd drwy	Canlyniad
Amcan 1 Prosesu ceisiadau i gofrestru, neu newidiadau i gofrestriadau, mewn modd amserol Sicrhau bod pob ymgeisydd yn gallu dangos ei fod yn bodloni'r rheoliadau perthnasol a'r safonau gofynnol.	Penderfynu ar geisiadau i gofrestru o fewn 12 wythnos o'r cais llawn a chyflawn	Yn ystod 2019-2020, gwnaethom gwblhau: Gwasanaethau Gofal Iechyd Annibynnol • 26 o Gofrestriadau Newydd • 17 o Newidiadau i Reolwyr Cofrestredig • 10 Newid i Unigolion Cyfrifol • 16 o Amrywiadau i Amodau Cofrestru AGIC Practisau Deintyddol Preifat • 22 o Gofrestriadau Newydd • 25 o Newidiadau i Reolwyr Cofrestredig • 6 Newid i Unigolion Cyfrifol • 2 Amrywiad i Amodau Cofrestru AGIC

Matrics Ymrwymiadau

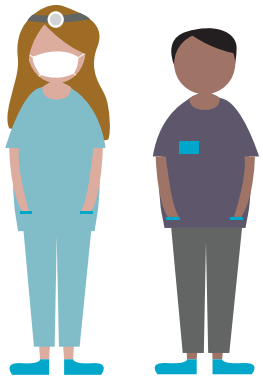
Yr hyn a ddywedom	Mesurwyd drwy	Canlyniad
Amcan 2 Cynnal rhaglen o ymweliadau â darparwyr yr amheuir nad ydynt wedi'u cofrestru • Yn ôl yr angen Darparu rhaglen o arolygiadau mewn lleoliadau annibynnol • Tua 27 ar gyfer laserau • Tua 19 ar gyfer lleoliadau nad oes ganddynt laser, ac eithrio iechyd meddwl	• Nifer yr ymweliadau a gynhaliwyd • Nifer yr arolygiadau a gynhaliwyd • Nifer yr adroddiadau a gyhoeddwyd 3 mis ar ôl yr arolygiad	Gwnaethom gynnal un ymweliad dirybudd â darparwr a oedd dan amheuaeth o fod yn anghofrestredig Gwnaethom gynnal 27 o arolygiadau o wasanaethau sy'n rhoi triniaethau laser neu IPL Gwnaethom gynnal 14 o arolygiadau o wasanaethau annibynnol (heb gynnwys laser/IPL ac iechyd meddwl). Roedd hyn ychydig yn is na'r bwriad am fod arolygiadau wedi cael eu canslo ym mis Mawrth 2020 oherwydd y coronafeirws ac oherwydd dadgofrestriadau yn ystod y flwyddyn.

Matrics Ymrwymiadau

Yr hyn a ddywedom	Mesurwyd drwy	Canlyniad
Amcan 3 Sicrhau yr ymdrinnir â phryderon a hysbysiadau Rheoliad 30/31 mewn modd amserol a phroffesiynol	• Nifer y pryderon a ddaw i law • Nifer yr hysbysiadau Rheoliad 30/31 a ddaw i law • Dadansoddi'r ffynhonnell a gweithredu	Yn ystod 2019-2020, cawsom 367 o bryderon gan y cyhoedd neu staff. O'r rhain, roedd 229 yn ymwneud â lleoliadau neu wasanaethau'r GIG ac roedd 131 yn ymwneud â gwasanaethau gofal iechyd annibynnol sydd wedi cofrestru ag AGIC. Hefyd cawsom 7 pryder yn ymwneud â darparwyr anghofrestredig neu leoliadau nad oes angen iddynt gofrestru ag AGIC. Caiff yr holl bryderon eu hadolygu bob wythnos ac maent yn llywio penderfyniadau ynghylch ein gweithgareddau a'n blaenoriaethau arolygu. Mae'n ofynnol i ddarparwyr gofal iechyd annibynnol ein hysbysu o ddigwyddiadau o bwys a datblygiadau yn eu gwasanaeth. Parheir i ymdrin â'r hysbysiadau Rheoliad 30/31 hyn yn unol â'n proses ac ymdrinnir â nhw'n effeithiol. Cawsom gyfanswm o 1,157 o hysbysiadau Rheoliad 30/31. Roedd y rhain yn cynnwys: • Marwolaeth mewn Hosbis – 597 • Marwolaeth heb gynnwys Hosbis – 10 • Absenoldeb heb awdurdod – 137 • Anafiadau difrifol – 280 • Honiad o gamymddwyn yn erbyn aelod o staff – 120 • Achos o glefyd heintus – 2 • Trefniadau Diogelu wrth Amddifadu o Ryddid (DoLS) – 11

Matrics Ymrwymiadau

Yr hyn a ddywedom	Mesurwyd drwy	Canlyniad
Amcan 4 Cynnal rhaglen arolygu eang yn y GIG wedi'i llywio gan wybodaeth ac asesiad o'r risg gan gynnwys tua • 31 o arolygiadau ysbytai cyffredinol • 36 o arolygiadau o feddygfeydd • 75 o arolygiadau o ddeintyddfeydd • 5 arolygiad Rheoliadau Ymbelydredd Ïoneiddio (Cysylltiad Meddygol) • 6 arolygiad o wasanaethau llawfeddygol • O'r arolygiadau hyn, mae 23 yn cynnwys elfen o weithredu dilynol o arolygiadau a gynhaliwyd yn flaenorol	• Nifer yr arolygiadau a gynhaliwyd	Gwnaethom gynnal 150 o arolygiadau • Ysbytai – 38 • Unedau iechyd meddwl y GIG - 13 • TIMC – 3 • Meddygfeydd – 25 • Deintyddfeydd – 68 • Rheoliadau Ymbelydredd Ïoneiddio (Cysylltiad Meddygol) – 3 • Llawfeddygol – 1 (wedi ei gynnwys yn y ffigurau arolygu ysbytai uchod) • Dilynol – 13 (wedi eu cynnwys yn y ffigurau uchod)



Matrics Ymrwymiadau

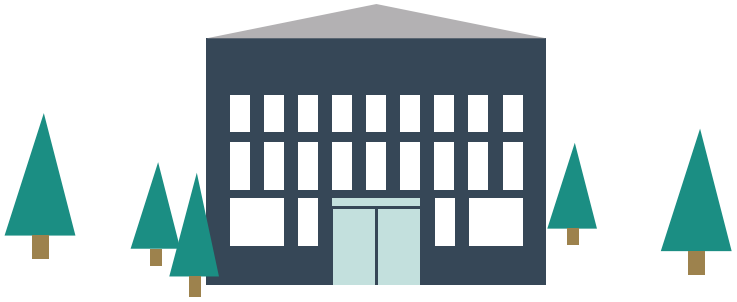
Yr hyn a ddywedom	Mesurwyd drwy	Canlyniad
Amcan 5 Parhau â'n rhaglen o adolygiadau thematig cenedlaethol gan gynnwys: • Adolygiad Cenedlaethol o Ofal Argyfwng mewn Iechyd Meddwl • Adolygiad Cenedlaethol o Wasanaethau Mamolaeth • Adolygiad Cenedlaethol o Lwybrau Gofal i'r Henoed yng Nghymru: Canolbwyntio ar Gwympiadau • Adolygiad Cenedlaethol o Atal a Hyrwyddo • Annibyniaeth ar gyfer Oedolion Hŷn (dros 65 oed) sy'n Byw yn y Gymuned. • Adolygiad Lleol – Bron Brawf Cymru, Iechyd Cyhoeddus Cymru • Adolygiad Lleol – Trefniadau Rheoli Cleifion mewn Canolfannau Cyswllt Clinigol – Ymddiriedolaeth Gwasanaethau Ambiwlans Cymru	• Cyhoeddi cylch gorchwyl pob prosiect • Cyhoeddi adroddiadau ysbytai unigol ac, ar gyfer adolygiadau lleol a chenedlaethol, adroddiadau terfynol	Yn ystod y flwyddyn gwnaethom gyhoeddi: • Adolygiad o Ofal Integredig: Canolbwyntio ar Gwympiadau Gwnaethom ddechrau gweithio ar ddau Adolygiad Cenedlaethol: Adolygiad Cenedlaethol o Wasanaethau Mamolaeth, Cam Un – arolygwyd 15 o ysbytai a 10 uned geni, a chyhoeddwyd pob adroddiad. Caiff adroddiad cenedlaethol ar gam un ei gyhoeddi yn ystod hydref 2020. Adolygiad Cenedlaethol o Ofal Argyfwng mewn Iechyd Meddwl, Cam Un. Cyhoeddir adroddiad ar Gam Un yn ystod gaeaf 2020/21. Gwnaethom ddechrau gweithio ar ddau Adolygiad Lleol: Adolygiad Lleol o'r ffordd y caiff prosesau sgrinio'r fron eu rheoli'n amserol ar gyfer menywod sy'n cael canlyniad mamogram abnormal, o fewn Bron Brawf Cymru. Adolygiad Lleol o'r trefniadau rheoli cleifion mewn Canolfannau Cyswllt Clinigol yn Ymddiriedolaeth Gwasanaethau Ambiwlans Cymru (WAST).

Matrics Ymrwymiadau

Yr hyn a ddywedom	Mesurwyd drwy	Canlyniad
Amcan 6 Cynnal adolygiad lefel uchel o holl gyrff y GIG drwy • Ddatblygu'r swyddogaeth Rheoli Perthynas ymhellach • Llunio Datganiad Blynyddol ar gyfer pob Bwrdd Iechyd ac Ymddiriedolaeth y GIG	Cyhoeddi datganiadau blynyddol byrddau iechyd ac ymddiriedolaethau'r GIG	Cyflwynwyd canfyddiadau blynyddol 2019-2020 yng nghyfarfodydd y bwrdd a diwrnodau datblygu'r bwrdd ar gyfer Byrddau Iechyd ac Ymddiriedolaethau'r GIG gan Reolwyr Cydberthnasau. Wrth lunio'r crynodebau o'r byrddau iechyd yn yr adroddiad blynyddol, gwnaeth Rheolwyr Cydberthnasau ystyried: • canfyddiadau o'n rhaglen arolygu ac adolygu ar gyfer 19-20 • gwybodaeth a gasglwyd drwy fod yn bresennol mewn nifer o gyfarfodydd allweddol byrddau iechyd, megis cyfarfodydd Ansawdd a Diogelwch a chyfarfodydd un i un â phersonél allweddol byrddau iechyd • pryderon a ddaeth i law drwy ein proses pryderon • cyfarfodydd â sefydliadau partner allanol megis Archwilio Cymru a Chynghorau Iechyd Cymuned.
Amcan 7 Cynnal rhaglen o arolygiadau mewn lleoliadau iechyd meddwl annibynnol a'r GIG, gan gynnwys tua • 15 o unedau iechyd meddwl y GIG • 14 o unedau iechyd meddwl annibynnol • Arolygiadau o Unedau Iechyd Meddwl yn cynnwys adolygu'r ffordd y caiff y Ddeddf Iechyd Meddwl ei chymhwyso • 7 arolygiad o Dimau Iechyd Meddwl Cymunedol	• Nifer yr arolygiadau a gynhaliwyd	Gwnaethom gynnal 28 o arolygiadau o Unedau Iechyd Meddwl ac Anableddau Dysgu: • 13 o unedau iechyd meddwl y GIG • 14 o unedau iechyd meddwl annibynnol • 1 uned anableddau dysgu annibynnol Gwnaethom gynnal saith arolygiad o Dimau Iechyd Meddwl Cymunedol.

Matrics Ymrwymiadau

Yr hyn a ddywedom	Mesurwyd drwy	Canlyniad
Amcan 8 Darparu Gwasanaeth Meddyg a Benodwyd i Roi Ail Farn (SOAD) ar gyfer tua 1000 o geisiadau SOAD	• Dangosyddion Perfformiad Allweddol	Cawsom 1017 o geisiadau am SOAD a chynhaliwyd 958 o ymweliadau SOAD.
Amcan 9 Cyhoeddi adroddiadau o bob un o'n harolygiadau ac adolygu gweithgarwch yn unol â'n safonau perfformiad.	• Cyhoeddi adroddiadau • Amserlen Gyhoeddi • Cyhoeddi perfformiad AGIC yn erbyn targedau	Ym mis Tachwedd 2019 gwnaethom lunio Polisi Cyhoeddi newydd yn amlinellu ein dull o gyhoeddi adroddiadau arolygu ac adolygiadau. Caiff dyddiadau cyhoeddi ein holl adroddiadau arolygu arferol eu rhoi ar ein gwefan 10 wythnos ymlaen llaw. Mae'r amserlen gyhoeddi ar gael yma: www.agic.org.uk/amserlen-gyhoeddi



Matrics Ymrwymiadau

Yr hyn a ddywedom	Mesurwyd drwy	Canlyniad
Amcan 10 Rhannu ein canfyddiadau a'n hargymhellion yn rhagweithiol â rhanddeiliaid, darparwyr gwasanaethau a'r cyhoedd er mwyn dylanwadu ar welliannau yn y maes gofal iechyd, a'u hysgogi. Yn arbennig mewn cysylltiad â'r canlynol: • Arolygiadau o Ysbytai • Meddygfeydd • Deintyddfeydd • Adroddiad Monitro Blynyddol ar y Ddeddf Iechyd Meddwl • Trefniadau Diogelu wrth Amddifadu o Ryddid (DoLS) • Rheoliadau Ymbelydredd Ïoneiddio (Cysylltiad Meddygol) • Laserau • Adroddiad Blynyddol AGIC	Cyhoeddi a rhannu ein canfyddiadau mewn nifer o ffyrdd gan gynnwys: • Cynnal digwyddiadau dysgu • Dosbarthu bwletinau dysgu • Dosbarthu astudiaethau achos o arfer da • Gwella cynnwys y wefan • Eu cynnwys yn ein cylchlythyr misol i randdeiliaid	Rydym yn cynnal gweithdai rheolaidd gyda Chynghorau Iechyd Cymuned ac uwchgynadleddau chwarterol gyda'r GIG a'r sector gofal iechyd annibynnol Ym mis Mawrth 2020, gwnaethom gyhoeddi ein cylchlythyr chwarterol cyntaf i adolygwyr cymheiriaid Ar ôl cyhoeddi ein Hadolygiad o Gwympiadau, a oedd yn cynnwys cyfres o lwybrau gwahanol, gwnaethom gynnal dau ddigwyddiad dysgu gyda rhanddeiliaid Rydym wedi cefnogi gwelliannau i'n gwefan yn 2019–2020 gan gynnwys: • Confensiwn enwi cyson ar gyfer yr holl adroddiadau a gyhoeddir ar ein gwefan • Gwybodaeth gofrestru a darparwyr cofrestredig • Gwybodaeth SOAD wedi'i diweddaru • Ymestyn ein hamserlen gyhoeddi i gynnwys dyddiadau cyhoeddi 10 wythnos ymlaen llaw. Rydym yn rhannu dolenni i'r holl adroddiadau a gyhoeddir â 4339 o danysgrifwyr bob mis yn ein cylchlythyr i randdeiliaid.
Amcan 11 Parhau â'n gwaith arolygu ar y cyd ag asiantaethau'r DU • Tua 16 o adolygiadau marwolaeth yn y ddalfa gyda'r Ombwdsmon Carchardai a Phrofiannaeth • Hyd at 3 adolygiad ar y cyd â gwasanaeth Carchardai EM a gwasanaeth Prawf EM	• Nifer yr arolygiadau a gynhaliwyd	Gwnaethom gynnal 14 o ymchwiliadau i farwolaethau yn y ddalfa. Gwnaethom gynnal 3 arolygiad ar y cyd â gwasanaeth Carchardai EM a gwasanaeth Prawf EM.

Matrics Ymrwymiadau

Yr hyn a ddywedom	Mesurwyd drwy	Canlyniad
		Gwnaethom gynnal adolygiad ar y cyd o drefniadau llywodraethu a rheoli risg Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg ochr yn ochr ag Archwilio Cymru. Gwnaethom gymryd rhan mewn proses arolygu ar y cyd, gyda sefydliadau partner fel Arolygiaeth Gofal Cymru (AGC), Arolygiaeth Cwnstabliaeth a Gwasanaethau Tân ac Achub Ei Mawrhydi (HMICFRS), Arolygiaeth Prawf Ei Mawrhydi (HMIP) ac Estyn. Gwnaed hyn fel Arolygiad ar y Cyd o Drefniadau Amddiffyn Plant (JICPA) ym mis Rhagfyr 2019. Arolygiad o Fwrdd Iechyd Prifysgol Aneurin Bevan oedd hwn.
Amcan 12 Parhau â'n gwaith ar y cyd ag asiantaethau eraill y DU ac asiantaethau rhyngwladol ar arolygu ar y cyd a dylanwadu ar arferion gorau	• Cymryd rhan mewn gwaith ar y cyd • Atgyfnerthu canfyddiadau allweddol a themâu sy'n dod i'r amlwg ar wasanaethau ieuenctid a welwyd gan aelodau Arolygu Cymru.	Er na wnaethom waith penodol ar y cyd mewn perthynas â gwasanaethau ieuenctid, rydym yn bwriadu gwneud gwaith dilynol ar ein hadolygiad o wasanaethau gofal iechyd i bobl ifanc (a gyhoeddwyd ym mis Mawrth 2019) drwy ofyn am ymateb wedi'i ddiweddaru i'n hargymhellion. Gwnaethom weithio gydag AGC ar yr Adolygiad Cenedlaethol o Atal a Hyrwyddo Annibyniaeth ar gyfer Oedolion Hŷn (dros 65 oed) sy'n Byw yn y Gymuned. Cyhoeddwyd yr adroddiadau unigol hyn yn ystod 2019 a 2020. Gwnaethom weithio gydag AGC ar y ddogfen Trefniadau Diogelu rhag Colli Rhyddid – Adroddiad Monitro Blynyddol ar gyfer Gofal Cymdeithasol a Iechyd 2018-19. Cyhoeddwyd yr adroddiad hwn ym mis Awst 2020.

Geirfa Llywodraethu AGIC

Gwneud penderfyniadau a rheoli busnes

Grŵp yr Uwch Arweinwyr

Mae'r Grŵp hwn yn goruchwylio trefniadau llywodraethu corfforaethol AGIC a hwn yw'r corff sy'n gwneud penderfyniadau gweithredol ar ein cyfer.

Grŵp Busnes

Mae'r Grŵp Busnes yn monitro gweithgarwch ym mhob rhan o AGIC, ac wedyn caiff y wybodaeth hon ei rhaeadru i'r staff yn syth ar ôl y cyfarfod.

Pwyllgor Cyllid a Chynllunio'r Gweithlu

Mae'r Pwyllgor hwn yn ystyried ceisiadau gan yr holl staff am adnoddau / hyfforddiant / cynadleddau. Mae'r Pwyllgor yn ystyried y ceisiadau hyn, gan edrych i weld faint o gyllideb sydd ar gael a pha mor berthnasol ydynt i rôl yr unigolyn/tîm.

Pwyllgor Risg ac Uwchgyfeirio

Y Pwyllgor hwn yw'r grŵp sy'n cymryd camau i sicrhau y caiff rhaglen AGIC o weithgareddau ei chyflawni cystal â phosibl, ac yn uwchgyfeirio unrhyw argymhellion / penderfyniadau sy'n gofyn am newid proses at Grŵp yr Uwch Arweinwyr.

Cynghori a gwneud argymhellion

Panel Newid Methodoleg

Prif rôl y Panel hwn yw creu methodoleg newydd, newid adnoddau/gweithlyfrau sydd eisoes yn bodoli a datblygu canllawiau / gwybodaeth ategol.

Panel Dylunio Digidol

Mae'r Panel hwn yn trafod ac yn cymeradwyo/gwrthod/ gohirio unrhyw ddogfennau gofynion busnes newydd, dogfennau ffurfweddu / manylebau gweithredol a dogfennau Bwrdd Cynghori ar Newid sydd wedi cael eu cyflwyno. Mae hefyd yn cadw golwg ar hynt ceisiadau cyfredol am newidiadau ac yn blaenoriaethu'n unol â hynny.

Fforwm y Bobl

Prif dasgau'r Fforwm yw trafod materion yn ymwneud â'r staff, datblygu a rheoli camau gweithredu, a chynnig cyswllt rhwng y staff a Grŵp yr Uwch Arweinwyr.

Bwrdd Llywio Adolygiadau

Prif rôl y Bwrdd yw monitro'r ffordd y caiff adolygiadau cyfredol eu cyflawni, ystyried cynigion a gwneud argymhellion ar gyfer ymchwiliadau pellach gan AGIC, gan gynnwys adolygiadau cenedlaethol a lleol.

Geirfa Llywodraethu AGIC

Ymgysylltu â'r staff a sefydliadau allanol

Grwpiau Cyfeirio Rhanddeiliaid

Mae'r grwpiau hyn yn dwyn cynrychiolwyr o'r sector ynghyd i'n herio mewn ffordd adeiladol ynglŷn â'n gwaith ym meysydd meddygon teulu, deintyddfeydd ac iechyd meddwl.

Rheolwyr cydberthnasau

Rheolwyr cydberthnasau yw'r pwynt cyswllt cyntaf i staff HIW a byrddau / ymddiriedolaethau iechyd. Maent hefyd yn arwain y gwaith o bennu'r gweithgarwch arolygu a sicrwydd o fewn pob bwrdd iechyd penodol.

Cyfarfodydd pryderon / hysbysiadau

Y nod yw monitro / uwchgyfeirio unrhyw bryderon neu hysbysiadau y mae angen gweithredu arnynt. Y prif weithgarwch yw creu methodoleg newydd, newid adnoddau/gweithlyfrau sydd eisoes yn bodoli yn ôl y gofyn a datblygu canllawiau / gwybodaeth ategol i bob defnyddiwr.

Cyfarfodydd Penaethiaid Cangen

Y nod yw gwella arferion gwaith a gwybodaeth rhannu ar draws pob maes o AGIC.

Cyfarfodydd Tîm

Mae pob tîm yn cynnal cyfarfodydd rheolaidd sydd fel arfer yn dilyn y cyfarfod Grŵp yr Uwch Arweinwyr i alluogi Pennaeth y Gangen i ddiweddaru staff ar unrhyw gamau sy'n codi o'r cyfarfod.

Fforwm y Bobl

Prif dasgau'r Fforwm yw trafod materion yn ymwneud â'r staff, datblygu a rheoli camau gweithredu, a chynnig cyswllt rhwng y staff a Grŵp yr Uwch Arweinwyr. Caiff unrhyw newidiadau sy'n effeithio ar yr holl staff eu trafod yn y Fforwm yn gyntaf, er mwyn sicrhau bod y dull yn gadarn (e.e. cynllun dysgu a datblygu blynyddol, unrhyw newidiadau TGCh, diweddariadau i ddogfennau proses).

Cynadleddau Staff

Caiff cynadleddau staff eu cynnal yn ôl yr angen, ddwywaith y flwyddyn fel arfer. Mae'n ofynnol i bob aelod o'r staff fynychu'r rhain er mwyn rhoi sylw i faterion sy'n ymwneud ag AGIC drwyddi draw.

Cyfarfodydd grwpiau Addysg a Gwasanaethau Cyhoeddus

Y prif nod yw rhoi'r wybodaeth ddiweddaraf am weithgareddau ym mhob un o feysydd y Grwpiau Addysg a Gwasanaethau Cyhoeddus a rhannu negeseuon allweddol. Mae ein Prif Weithredwr yn cynrychioli AGIC.

Gellir darparu'r cyhoeddiad hwn a gwybodaeth arall gan AGIC mewn fformatau neu ieithoedd amgen ar gais. Bydd oedi byr wrth i ieithoedd a fformatau eraill gael eu cynhyrchu pan ofynnir amdanynt i ddiwallu anghenion unigol. Cysylltwch â ni am gymorth.

Bydd copïau o'r holl adroddiadau, pan gânt eu cyhoeddi, ar gael ar ein gwefan neu drwy gysylltu â ni:

Yn ysgrifenedig:

Rheolwr Cyfathrebu
Arolygiaeth Gofal Iechyd Cymru
Llywodraeth Cymru
Parc Busnes Rhydycar
Merthyr Tudful
CF48 1UZ

Neu

Ffôn: **0300 062 8163**
E-bost: **hiw@gov.wales**
Gwefan: **www.agic.org.uk**

Mae'r ddogfen hon hefyd ar gael yn Saesneg.
This document is also available in English

 WG40229 Digital ISBN 978 1 80082 314 3

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Quality Check Summary

Tawe Ward, Ystradgynlais Hospital

Activity date: 30 September 2020

Publication date: 28 October 2020

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

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

In writing:

Communications Manager
Healthcare Inspectorate Wales
Welsh Government
Rhydycar Business Park
Merthyr Tydfil
CF48 1UZ

Or via

Phone: 0300 062 8163

Email: hiw@gov.wales

Website: www.hiw.org.uk

Digital ISBN 978-1-80082-401-0

Findings Record

Our Approach

Healthcare Inspectorate Wales (HIW) undertook a remote quality check of Tawe ward, Ystradgynlais Hospital, as part of its programme of assurance work.

HIW's quality checks form part of a new tiered approach to assurance and are one of a number of ways in which it examines how healthcare services are meeting the Health and Care Standards 2015 (and other relevant regulations). Feedback is made available to service representatives at the end of the quality check, in a way which supports learning, development and improvement at both operational and strategic levels.

Quality checks capture a snapshot of the standards of care within healthcare settings. This quality check focussed on four key areas: COVID-19 arrangements; environment; infection prevention and control; and governance. More information on our approach to inspections can be found here.

We spoke to the ward manager and the deputy ward manger on 30 September 2020, who provided us with information and evidence about their setting. We used the following key lines of enquiry:

- How are you ensuring that the environment is safe and suitable for the needs of patients at this time? What changes, if any, have been made to the physical environment, ward routines and patients' access to leave as a result of COVID-19?
- How is the risk of infection assessed and managed to keep patients, visitors and staff safe?
- Considering the impact of COVID-19, how are you discharging your duty of care against the Mental Health Act and how are patients' rights being safeguarded?
- How are you ensuring that there are sufficient numbers of appropriately trained staff to meet patients' needs, with access to wider mental health professionals where needed?

COVID-19 arrangements

During the quality check, we considered how the service has responded to the challenges presented by COVID-19; what changes they have made to ensure they can continue to provide a safe, effective and person centred service. We reviewed key policies, including the use of personal protective equipment (PPE).

The following positive evidence was received:

We saw evidence to show that the service has conducted necessary risk assessments and updated relevant policies and procedures to meet the additional demands stemming from the COVID-19 pandemic.

We were told that training specific to COVID-19 had been delivered to all staff by the health board. We saw evidence of this training in the form of power-point slides.

We were told that no confirmed cases of COVID-19, or any other infectious diseases, have been reported within the patient or staff group.

We were told that cleaning schedules have been increased and the use of personal protective equipment (PPE) has been optimised with adequate stocks sourced at the outset, and the Ward manager told us that they were confident that adequate stocks would be available going forward.

We saw evidence to show that an infection control audit had been completed recently.

We were told that patients and staff have been receiving regular COVID-19 updates and that written information relating to the management of COVID-19 has been made available to staff, patients and visitors. Regular communication has ensured everyone has up to date advice and guidance on COVID-19.

No areas for improvement were identified.

Environment

During the quality check, we considered how the service has designed and managed the environment of care to keep it as safe as possible for patients, staff and visitors. We reviewed recent risk assessments, incident reviews and use of restraint and seclusion. We also questioned the setting on the changes they have made to make sure patients continue to receive care and treatment according to their needs.

The following positive evidence was received:

We were told that changes have been made to the environment as a result of COVID-19. These include the setting aside of a designated room where patients could be isolated should they test positive for COVID-19. Cleaning schedules have been amended to enable more frequent cleaning of all patient and staff areas.

We were told that visiting was suspended initially but has since been re-introduced on the basis of one visitor for an hour in the morning and one visitor for an hour in the afternoon, utilising a designated room which is cleaned after each visit. Telephones and tablet devices have been made available in order for patients to maintain contact with family and friends.

We were told that multi-disciplinary team meetings involving external professionals have continued and that all reviews scheduled under the Mental Health Act 1983, have been undertaken within prescribed timeframes. Face to face meetings were suspended at the outset of the pandemic, with telephone and video calls used to ensure patients continue to have access to external professional services, including advocacy. Some face to face visits have recently resumed with adherence to social distancing guidelines.

We were reassured from the documents submitted, and from discussions with the ward manager and deputy, that any patient or staff diagnosed with an infectious disease would be managed appropriately.

We saw records of incidents and use of restraint for the months of July, August and September 2020. Records reflect the nature of the incidents and actions taken. The ward manager explained that the incidents were not directly linked to changes in ward routines as a result of COVID-19, but were reflective of the general care needs of the patient group.

We were told that an environmental risk assessment, looking specifically at social distancing arrangements, was undertaken on 18 September 2020. However, the report was not yet available.

We were told that patients are supported to engage in activities on the ward using a computer system which is cleaned in-between each use. Events such as VE Day have also been celebrated, in a socially distanced manner.

The following areas for improvement were identified:

We saw evidence to show that a ligature risk assessment had been carried out on the ward, which highlighted a number of areas that required attention. However, the only control set in place to minimise the risk to patients was to ensure good staffing levels. To further mitigate against the risk of harm to patients, the health board must review the ligature risk assessment and carry out the remedial work identified.

Infection prevention and control

During the quality check, we considered how well the service manages and controls the risk of infection to help keep patients, visitors and staff safe. We reviewed infection control policies, infection rates and risk assessments.

The following positive evidence was received:

We saw evidence to show that there are policies and procedures in place for the prevention and control of infection. These have been amended to reflect the management of COVID-19. The policies and procedures are reviewed and updated regularly. We were told that patients, relatives and staff are informed of any updates.

We were told that staff greet all visitors to the ward and ask relevant screening questions and take the visitor's temperature before allowing them entry to the ward. All visitors are required to wear a face mask and are reminded of the need to maintain social distance.

Regular audits are undertaken to assess and manage the risk of infection. The most recent infection control audit was undertaken on 17 June 2020. A copy of the report was presented with the service's self-assessment document.

We were told that there are systems and procedures in place to identify any staff or patient who may be at risk of developing, or display symptoms of COVID-19. We were told that risk assessments have been completed for all staff and, depending on the risk level, the organisation will determine whether or not the staff member needs to isolate.

We were told that a larger room was currently being used as a day room so that patients are able to effectively social distance whilst still interacting with each other. All shared bedrooms have been re-configured to ensure that there is adequate space to enable social distancing to take place.

No areas for improvement were identified.

Governance

As part of this standard, HIW considered how the setting ensures there are sufficient numbers of appropriately trained staff to meet patients' needs, with access to wider mental health professionals where needed.

We also questioned the setting about how, in light of the impact of COVID-19, they are continuing to discharge their duty of care against the Mental Health Act and safeguarding patients' rights.

The following positive evidence was received:

The ward manager told us that they are well supported by their line manager and that there was good communication across the health board. This is enhanced by regular updates through the Powys Announcements communication system, which ensures that staff feel supported and are provided with the most recent guidance. The health board's Mental Health and Learning

Disabilities Directorate has developed a series of infographics to help staff understand essential information with the aim of reducing anxiety through straight forward, accessible information.

We were told by the ward manager that staff sickness levels had been comparatively low over the past three months. This was reflected in the supporting documentation provided. We were also told that there was only one staff vacancy on the ward. There had been some use of agency and bank staff but this has been minimal as some staff members had been re-deployed on to the ward from Brecon hospital. The ward manager confirmed that the re-deployed staff had settled in well to their new working environment on Tawe ward. The ward manager confirmed that all staff had access to occupational health support which includes counselling.

The service can accommodate up to eight patients. There were five patients accommodated at the time of the quality check. We were told that patient dependency levels is assessed regularly and additional staff rostered to cover any increase in demand and that there were no issues in securing more staff.

We were told that staff training is on-going with use of in-house facilities and e-learning. We were told that staff support and supervision takes place informally, on a day to day basis. More formal, documented support is provided to staff through the annual appraisal process. However, the ward manager informed us that this had lapsed during the height of the pandemic, and that they were taking steps to ensure that all staff received an annual appraisal in the near future.

We were told that Mental Health Act reviews, and other contact with external professionals, to include advocacy, has continued through phone calls and video conferencing. The service has been responsive to the lifting of restrictions put in place due to COVID-19 through reviewing risk assessments, and allowing more on site visits to take place, making use of the family room, which undergoes a deep clean after each visit.

Patient day leave had been stopped in order to reduce the risk of cross-infection. Long term leave, where appropriate, is managed on an individual case-by-case basis, for example, if a patient is detained on the ward under Section 3 of the Mental Health Act 1983, and requires leave with view to discharge, then it would likely be granted. If a patient on long term leave is required to return to hospital then they would have to be admitted to the isolation room initially, and await a COVID-19 test and negative result before being able to use the rest of the ward facilities.

The following areas for improvement were identified:

We were told that some elements of mandatory training had lapsed during the pandemic due to the unavailability of suitable training sessions. This was reflected in the training matrix provided. The health board must ensure that all staff have completed training in all mandatory subjects.

What next?

Where we have identified improvements during our check, which require the service to take action, these are detailed in the improvement plan below.

Where an improvement plan is required, it should:

- Clearly state how the findings identified will be addressed
- 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
- Ensure required evidence against stated actions is provided to HIW within three months of the Quality Check.

As a result of the findings from this quality check, 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.

Improvement plan

Setting: Ystradgynlais Hospital

Ward: Tawe

Date of activity: 30 September 2020

The table below includes improvements identified during the Tier 1 Quality Check, where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.
Please note, all actions are expected to be complete within three months of the Quality Check and the final version of the Improvement Plan is to be submitted via Objective Connect once complete.

Reference Number	Improvement needed	Standard/ Regulation	Service Action	Responsible Officer	Timescale
1	To further mitigate against the risk of harm to patients, the health board must review the ligature risk assessment and carry out the remedial work identified.	2.1 Managing Risk and Promoting Health and Safety	1. HON to undertake on site review of ligature risks with Service Manager; Ward Manager and Estates Team 2. HON and Estates to identify remedial works and seek funding source 3. Ward manager and Service Manager to ensure actions to mitigate risks are in place	Head of Nursing Quality & Safety	Risk Review: November 6th 2020 Completion of works: March 31st 2021

2	The health board must ensure that all staff have completed training in all mandatory subjects.	7.1 Workforce	1. Service Manager to support Ward Manager to undertake a full audit of all mandatory training and implement individual achievement plans through supervision process with each staff member 2. Where there are difficulties with access to specific training programmes, these should be escalated to HON	Service Manager Ward Manager	December 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.

Name: Ruth Derrick Head of Nursing, Quality & Safety Mental Health

Date: October 16th 2020

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Quality Check Summary

Brynheulog Ward, Newtown Hospital

Activity date: 15 October 2020

Publication date: 12 November 2020

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

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

In writing:

Communications Manager
Healthcare Inspectorate Wales
Welsh Government
Rhydycar Business Park
Merthyr Tydfil
CF48 1UZ

Or via

Phone: 0300 062 8163

Email: hiw@gov.wales

Website: www.hiw.org.uk

Digital ISBN 978-1-80082-460-7

Findings Record

Our Approach

Healthcare Inspectorate Wales (HIW) undertook a remote quality check of Brynheulog Ward, Newtown Hospital as part of its programme of assurance work. Brynheulog ward was a 14 bed stroke rehabilitation ward. The ward was described as the stroke rehabilitation ward for North Powys and patients were transferred there from a wide range of district general hospitals. Medical cover was provided through a shared agreement between two local GP practices.

HIW's quality checks form part of a new tiered approach to assurance and are one of a number of ways in which it examines how healthcare services are meeting the Health and Care Standards 2015 (and other relevant regulations). Feedback is made available to service representatives at the end of the quality check, in a way which supports learning, development and improvement at both operational and strategic levels.

Quality checks capture a snapshot of the standards of care within healthcare settings. This quality check focussed on four key areas: COVID-19 arrangements; environment; infection prevention and control; and governance. More information on our approach to inspections can be found here.

We spoke to the Senior Sister on 15 October 2020 who provided us with information and evidence about their setting, the Community Services Manager for Mid Powys was also in attendance. We used the following key lines of enquiry:

- How do you ensure that there are sufficient numbers of appropriately trained staff on the ward to provide safe and effective care?
- How do you ensure that the risk of infection is assessed and managed to keep patients, visitors and staff safe?
- How do you ensure that the ward environment is safe and protects patients from harm, and how do you ensure that patient dignity is maintained?

COVID-19 arrangements

During the quality check, we considered how the service has responded to the challenges presented by COVID-19; what changes they have made to ensure they can continue to provide a safe, effective and person centred service. We reviewed key policies, including the use of personal protective equipment (PPE).

The following positive evidence was received:

A number of changes to the ward environment were described, these included ensuring the distance between beds allowed for safe social distancing. Regular huddles were introduced to inform staff of changes to COVID-19 guidance. Additionally, all changes were recorded on a wipe board in the staff room. We were told that if there were any suspected cases of COVID-19, the ward would become a red zone, with full PPE and visors worn, until the result of the test was received. Additionally, management would be informed and any planned visits would be cancelled.

Staff encouraged families and patients to maintain contact with each other, through using computer to computer calls, smart phones and the portable telephone. Patients and families booked slots to use the equipment. If the patient was considered to be end of life, families were allowed to visit in a side ward. The process that the families followed was described, to maintain staff, patient and family safety. Families were also involved, by virtual means, as well as patients, in the multi-disciplinary team discussions of the patient care plans.

We were provided with evidence of a number of policies and procedures specific to COVID-19, including Infection, Prevention and Control (IPC) guidance and risk assessments. We were told that there were sufficient supplies of PPE for staff and patients. Staff had received training on the correct donning and doffing of PPE and fit testing of masks. There were very few aerosol generating procedures in the ward, apart from cardiopulmonary resuscitation[1]. The fit tested masks were kept next to the resuscitation trolley, with staff names clearly marked, for ease of use during an emergency. There were also posters on the wall, which were regularly changed when updated, with advice on PPE. In line with guidance, community admissions to the ward were tested for COVID-19 on admission.

We were told that there had been an outbreak of COVID-19 on the ward, in May 2020, at the height of the pandemic, when several members of staff and patients had contracted COVID-19. We saw the evidence on how the outbreak was managed, documented and the actions taken, both within the ward and throughout the hospital. This included deep cleaning of the ward, and additional training for staff, including how to deal with staff, patient and relatives anxiety. This evidence also described a root cause analysis, which included the potential causes for the outbreak. There were no healthcare acquired infections at the time of the quality check.

Additionally, we were told that whilst staff had access to online training, face to face training sessions had been limited during the pandemic. Where training could be completed by electronic learning, training time had been allocated to staff. We saw evidence that the majority of mandatory training was over 80 percent. However, the face to face training, such as resuscitation and fire safety was under 75 percent. We were told that there had been issues with basic life support training, which had been escalated to the training department.

[1] A medical procedure involving repeated cycles of compression of the chest and artificial respiration, performed to maintain blood circulation and oxygenation in a person who has suffered cardiac arrest.

The fire safety training had been arranged for late October. As a result of the steps taken by the service, this area has not been identified as a formal area for improvement, but the health board is advised to be vigilant of this matter.

We saw evidence of the COVID 19 awareness update, which included the current guidance and summary of principles. Additionally, we were provided with a copy of the COVID-19 Prevention and Response Plan. This was a joint plan with Powys County Council and led by the Chief Executives of the organisations and the Director of Public Health and Public Protection.

No improvements were identified.

Environment

During the quality check, we considered how the service has designed and managed the environment of care to keep it as safe as possible for patients, staff and visitors. We reviewed recent risk assessments, incident reviews and any pressure or tissue damage which has occurred. We also questioned the setting on the changes they have made to make sure patients continue to receive care and treatment according to their needs.

The following positive evidence was received:

We were told that the ward had a multi-disciplinary focus with weekly goal setting meetings and weekly multi-disciplinary team meetings. Due to the nature of strokes, patients had varying levels of cognitive impairment. The length of stay of the patients could be considered higher than normal due to the need for complex discharge planning and varying degrees of discharge care destinations.

Patient dignity was maintained at all times through a number of methods, which included drawing curtains, when necessary, with do not enter signs on the curtains. We were told that this was part of the ward ethos. The ward team also believed they needed to be aware of respecting the patients and ensuring confidentiality, as the staff, as well as the patients, were all members of the local community. "This is Me"[2] documents were used for dementia patients and stroke patients with cognitive problems to aid respect and dignity. The Butterfly[3] scheme was also used where appropriate and this was identified via a magnetic symbol on the patient flow board. A number of other methods to maintain patient dignity were also described such as encouraging staff training on dignified care and in ensuring appropriate care planning for patients who are unable to maintain their own dignity.

---

[2] 'This is me' is a leaflet produced by the Alzheimer's Society to help hospital staff better understand the needs of people with dementia. The leaflet provides professionals with information about a person with dementia to help enhance the care and support they receive whilst in an unfamiliar environment.

[3] The Butterfly Scheme provides a system of hospital care for people living with dementia or who simply find that their memory isn't as reliable as it used to be.

The process used to investigate instances of patient falls and pressure damage was described. This included using alarm mats, where patients regularly stepped out of bed and were at risk of falling. The ward used the All Wales Multifactorial Assessment, a falls prevention tool, to ensure patients were being supported with their basic fall prevention needs.

When patients were admitted, we were told that their skin was checked, the patient was given the appropriate mattress and they were put on skin bundles, as necessary. The patient was then checked on a regular basis, depending on the risk. The patient was also given a leaflet to raise awareness of the need to keep moving. Staff received additional training on pressure area management from the tissue viability team. Where there had been instances of pressure damage, the causes were investigated and the care plan updated. Photographs of the pressure damage were also sent to the tissue viability team, for them to view the damage remotely and comment as necessary.

We saw evidence of the Quality Checks in Health Care, this tool was used to undertake observational quality checks on those receiving healthcare in any care setting within Wales. This then provided evidence of ongoing and continuous improvement at the point of care, quality assurance, demonstrated good practice and innovative solutions. We also saw the action plan that listed how the findings would be achieved and to gain ongoing assurance this was implemented.

No improvements were identified.

Infection prevention and control

During the quality check, we considered how well the service manages and controls the risk of infection to help keep patients, visitors and staff safe. We reviewed infection control policies, infection rates and risk assessments.

The following positive evidence was received:

We saw evidence of good hand hygiene and bare below the elbow audit scores. We also saw evidence of the planned review that was undertaken by the senior nurse for IPC. The purpose of the visit was to review current practice, discuss measures where the ward areas could be zoned and to provide clear guidance of the PPE that was required in each area. The visit also provided staff with an opportunity to ask questions on any concerns that they had in relation to infection control measures. The walk around identified zones in line with infection prevention guidance. Due to the geography of the ward it was not possible to segregate red and amber zones, each room was identified using zoning posters and staff were aware of infection control guidance.

We were told that the majority of staff had completed aseptic non touch technique (ANTT)[4] training. The ward adopted the ANTT principles and link nurses assessed team compliance in practical learning sessions. Knowledge was evidenced through written and practical assessments. We were told of the IPC policy which gave advice and guidance on all aspects of IPC and a lead nurse to support and ensure compliance. The link nurse for infection control met regularly with the ward team and cascaded relevant updates and learning back to their areas. Two registered nurses led on this on the ward, with the support of the ward sister. Additionally, the ward sister had also completed the ANTT assessor training.

No improvements were identified.

Governance

As part of this standard, HIW explored whether management arrangements ensure that there are sufficient numbers of appropriately trained staff on the ward to provide safe and effective care.

We reviewed staffing and patient levels, staff training and absences, management structures, ward functions and capacity, incidents and a variety of policies (such as escalation).

The following positive evidence was received:

We were told of the process undertaken by the ward to ensure that staffing levels maintained the safety and effective care of the patients. The process started eight weeks in advance of the shift and had various checkpoints that required approval and agreement, to ensure there were sufficient staff working on the ward. The senior sister stressed the importance of knowing the staff and who was available. There had not been any instances where minimum staffing levels, as required by the Nurse Staffing Levels (Wales) Act 2016[5], had not been met. Staff were aware of the need to report on DATIX, the system used to record incidents, when the required levels were breached. There was a 'Know how we are doing board' located on the ward that included information on agreed and actual staffing numbers per shift.

We were provided with evidence that showed that the ward was up to establishment with qualified staff.

The self-assessment provided, stated that there was visible leadership on the ward assuring appropriate staff were in place. There was an open and honest culture and staff would escalate any issues that arose. We were told that leading by example was important, as was knowing your staff as individuals, as well as employees. They would then feel they could approach

[4] ANTT is a method used to prevent contamination of wounds and other susceptible sites by ensuring that only sterile objects and fluids come into the contact with these sites and that the risk of contamination is minimised.
[5] https://www.legislation.gov.uk/anaw/2016/5/enacted

management with any problems or issues. Ward meetings were held regularly and staff who were on sickness absence were contacted, by the ward, regularly by telephone or by virtual methods, in addition to human resource contact.

The evidence provided showed that there was only 53 percent compliance with the performance appraisal and development reviews (PADR)[6]. We were also provided with evidence of the plan in place to ensure full compliance by the end of November 2020. HIW would expect these to be completed as agreed and would see ensuring compliance with completion rates for future PADR's to be a priority for the health board.

We were also told that staff received a 90-day review to monitor development of staff and to promote good knowledge-based care. Any areas highlighted for development were actioned and a plan made to source education.

No improvements were identified.

What next?

Where we have identified improvements during our check, which require the service to take action, these are detailed in the improvement plan below.

Where an improvement plan is required, it should:

- Clearly state how the findings identified will be addressed
- 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
- Ensure required evidence against stated actions is provided to HIW within three months of the Quality Check.

As a result of the findings from this quality check, 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.

[6] Undertaken to ensure that staff development was enhanced and opportunities created in relation to professional development, leadership and clinical skills.

Improvement plan

Setting: Newtown Hospital

Ward: Brynheulog Ward

Date of activity: 15 October 2020

The table below includes improvements identified during the Tier 1 Quality Check, where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.
Please note, all actions are expected to be complete within three months of the Quality Check and the final version of the Improvement Plan is to be submitted via Objective Connect once complete.

Reference Number	Improvement needed	Standard/ Regulation	Service Action	Responsible Officer	Timescale
1	No Improvements identified.				

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.

Name: Lesley Sanders Community Services Manager

Date: 26th October 2020

Patterson Liz
12/01/2020 12:33:19

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Quality Check Summary

Welshpool Hospital: Maldwyn Ward

Activity date: 15 October 2020

Publication date: 12 November 2020

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

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

In writing:

Communications Manager
Healthcare Inspectorate Wales
Welsh Government
Rhydycar Business Park
Merthyr Tydfil
CF48 1UZ

Or via

Phone: 0300 062 8163

Email: hiw@gov.wales

Website: www.hiw.org.uk

Digital ISBN 978-1-80082-462-1

WG41024

Findings Record

Our Approach

Healthcare Inspectorate Wales (HIW) undertook a remote quality check of the Maldwyn Ward at Welshpool Hospital within Powys Teaching Health Board as part of its programme of assurance work. Maldwyn Ward is a 21 bed unit and provides general medical, rehabilitation and palliative care services.

HIW's quality checks form part of a new tiered approach to assurance and are one of a number of ways in which it examines how healthcare services are meeting the Health and Care Standards 2015 (and other relevant regulations). Feedback is made available to service representatives at the end of the quality check, in a way which supports learning, development and improvement at both operational and strategic levels.

Quality checks capture a snapshot of the standards of care within healthcare settings. This quality check focussed on four key areas: COVID-19 arrangements; environment; infection prevention and control; and governance. More information on our approach to inspections can be found here.

We spoke to the ward manager on 15 October 2020 who provided us with information and evidence about their setting. We used the following key lines of enquiry:

- How do you ensure that there are sufficient numbers of appropriately trained staff on the ward to provide safe and effective care?
- How do you ensure that the risk of infection is assessed and managed to keep patients, visitors and staff safe?
- How do you ensure that the ward environment is safe and protects patients from harm, and how do you ensure that patient dignity is maintained?

COVID-19 arrangements

During the quality check, we considered how the service has responded to the challenges presented by COVID-19; what changes they have made to ensure they can continue to provide a safe, effective and person centred service. We reviewed key policies, including the use of personal protective equipment (PPE).

We were provided with a range of guidance materials that the ward had been following since the outbreak of COVID-19 to help protect patients and staff. This included national guidance for healthcare settings as well as localised guidance issued by Powys Teaching Health Board.

The following positive evidence was received:

We saw evidence of a recent COVID-19 risk assessment undertaken at the ward that outlined the range of measures in place to help mitigate cross-infection of staff and patients during the pandemic. The ward environment was modified in consultation with the senior nurse for infection prevention and control at the health board; red, amber and green zones were implemented to help safely separate and manage patients according to their COVID-19 status, as well as to help reduce thoroughfare throughout the ward. The number of beds available on the ward was reduced from 21 to 17 to comply with national guidance to ensure the space between patient beds allowed for safe social distancing.

The ward manager spoke about the new arrangements in place to support the well-being of staff during COVID-19. The location of the staff room was moved to ensure staff members could adhere to social distancing guidelines. The new staff room has been informally labelled a 'well-being hub', where any donations from the local community such as coffee and food are stored and are available for staff during their breaks. We were told that all staff have completed a personal COVID-19 risk assessment with their manager to help protect and manage those staff identified as being at a higher risk of experiencing more serious symptoms if they contract COVID-19.

The ward manager confirmed that there had not been any incidents of shortages of Personal Protective Equipment (PPE) being available for staff to wear since the onset of COVID-19. Weekly stock checks of PPE are undertaken by ward staff each Wednesday and stock is replenished from a centralised hub managed by the health board.

No improvements were identified.

Environment

During the quality check, we considered how the service has designed and managed the environment of care to keep it as safe as possible for patients, staff and visitors. We reviewed recent risk assessments, incident reviews and any pressure or tissue damage which has occurred. We also questioned the setting on the changes they have made to make sure patients continue to receive care and treatment according to their needs.

The following positive evidence was received:

The ward manager confirmed that the red, amber and green zones set up to help keep patients and staff safe during COVID-19 has worked well. We were informed that posters are displayed throughout the ward to remind staff of the different levels and types of PPE required for each zone. The main entrance to the ward is no longer accessible to help reduce thoroughfare throughout the ward; staff and any visitors now access the ward from the garden.

Evidence provided included a picture of signs that are placed on closed curtains around patient beds on the ward, to remind staff to ask and make themselves known before entering. This is to help protect the privacy and dignity of patients.

The ward manager discussed the measures in place to help protect the rights of patients, especially those with dementia and other cognitive impairments. A dementia champion has been assigned for the ward and staff have undertaken training on the Butterfly Scheme[1] to help understand the needs of such patients, to allow them to provide more effective and appropriate care and support.

We were told that patients were able to stay in contact with their families and friends electronically during lockdown and the restriction to visiting arrangements. Visits are being slowly re-introduced with a booking system in place. Additionally, visitors are educated and informed about how to wear the required PPE appropriately by staff and escorted directly to the patient.

The ward manager described how the needs of patients are met by involving patients and their families in care planning assessments, daily ward rounds and weekly multidisciplinary team (MDT) meetings. 'This is me'[2] documentation is used on the ward to record personal details and describe the needs of patients with dementia and those with cognitive impairments to help focus their care.

We saw evidence of a Quality Checks in Health Care report completed by a senior nurse in August 2020, which checked whether care on the ward was being provided in line with relevant standards and in a safe and compassionate way. We noted that the nurse found areas of good practice and we saw that all identified improvements had been actioned in a timely way.

We were told that the risk to patients of pressure or tissue damage is discussed during the weekly MDT meeting. We received data that showed the number of incidents of pressure ulcers on the ward had remained consistently low over the last 36 months.

The following areas for improvement were identified:

The ward manager told us that the large day room on the ward was currently not accessible to patients due to equipment being stored in there as a result of a lack of other storage options. We noted that this issue was also picked up in the observational quality check undertaken in August 2020. The nurse also reported that equipment was being stored in one

[1] The Butterfly Scheme provides a system of hospital care for people living with dementia or who simply find that their memory isn't as reliable as it used to be.

[2] 'This is me' is a leaflet produced by the Alzheimer's Society to help hospital staff better understand the needs of people with dementia. The leaflet provides professionals with information about a person with dementia to help enhance the care and support they receive whilst in an unfamiliar environment

of the bathrooms on the ward.

This meant that patients are unable to participate in group activities within the day room and rehabilitation activities are being carried out at the bedside. Due to the potential impact this may have on the recovery of patients, we recommend the health board reviews these arrangements to help reduce the impact on patients.

We were told that patients have weekly risk assessments to help monitor and prevent the risk of falls. However, following review of the evidence provided, we identified a recent spike in the amount of falls and a corresponding increase in the 12 month moving average. We recommend that the health board reflects on potential reasons behind this increase and provides assurance to HIW of the actions that will be taken to address this issue going forward.

Infection prevention and control

During the quality check, we considered how well the service manages and controls the risk of infection to help keep patients, visitors and staff safe. We reviewed infection control policies, infection rates and risk assessments.

The following positive evidence was received:

We spoke to the ward manager about the arrangements in place to help stop the transmission of COVID-19 throughout the ward, via patient admissions and throughout the wider community when patients are discharged. Patients are either tested for COVID-19 before being transferred onto the ward or undergo a test upon arrival. In both instances patients are kept isolated from other patients on the ward in one of five separate rooms until the test results are received. The patient is then moved to the required zone. We saw evidence of a COVID-19 transfer checklist that is completed by staff on the ward ahead of any patient discharge. The checklist aims to improve communication and provide clarity about the COVID-19 status of each patient to community services, to ensure the patient is handled safely and appropriately.

The ward manager confirmed that all staff received COVID-19 awareness training and training on how to safely don and doff PPE at the beginning of the onset of COVID-19. Staff members were required to demonstrate their understanding and competency in relation to the safe use of PPE to the ward manager following the training. We were told that refresher PPE training is being organised for all staff shortly as a reminder for staff ahead of any anticipated second wave of COVID-19. We received evidence of a PPE audit undertaken in August 2020 to monitor the safe use of PPE and saw that no issues were identified.

We were told that a resource folder is being maintained at the ward to keep staff updated with any announcements or changes to local arrangements relating to COVID-19. Monthly team meetings were replaced with daily staff huddles during the height of COVID-19 to ensure

information was cascaded down to staff and ensure they were kept up to date with the rapidly changing landscape.

We were provided with evidence of a number of policies and procedures specific to COVID-19, including infection prevention and control (IPC) guidance, and audit activities undertaken on the ward to monitor compliance with these requirements and help identify improvements. IPC highlight reports are completed at a ward level quarterly and submitted to the health board to be discussed during health board group meetings to share learning across all sites. More frequent checks carried out on the ward include monthly hand hygiene and cleaning audits and we saw that no issues had been identified during recent audits.

We saw evidence that very few incidents of healthcare acquired infections had occurred at Welshpool Hospital during the 2020-21 financial year.

No improvements were identified.

Governance

As part of this standard, HIW explored whether management arrangements ensure that there are sufficient numbers of appropriately trained staff on the ward to provide safe and effective care.

We reviewed staffing and patient levels, staff training and absences, management structures, ward functions and capacity, incidents and a variety of policies (such as escalation).

The following positive evidence was received:

The ward manager spoke about the arrangements in place to help ensure that there is the right skill mix and numbers of staff on the ward during each shift. HealthRoster is used as an electronic tool to manage staff rotas, staff working preferences and absence management. Analysis was undertaken in line with the Nurse Staffing Levels (Wales) Act 2016[3] to determine an appropriate number of staff needed to provide care to patients that meets their needs. Emergency requests for additional resources are escalated and filled from the temporary staffing unit at the health board or via agency staff.

We were told that a 'Know how we are doing' board was displayed on the ward that showed the required staffing numbers and the actual staffing numbers per shift. Staff are encouraged to report any 'shifts of concern' when staffing issues arise that may potentially impact on the level of care provided to patients. Encouragingly, we were told that only three shifts of concerns had been reported in the last six months.

The ward manager spoke about the managerial support provided to staff to support them in

[3] https://www.legislation.gov.uk/anaw/2016/5/enacted

their roles. This included regular catch ups and the completion of annual Performance Appraisal and Development Reviews (PADR) to discuss objectives and to help identify any learning requirements. We saw evidence that 63% of staff had received their annual PADR and saw that dates had been arranged in the coming months for the completion of those outstanding. HIW would expect these to be completed as agreed and would see ensuring compliance with completion rates for future PADRs to be a priority for the health board.

We were told that staff are provided with time to complete their training requirements alongside their day to day responsibilities. We saw evidence that compliance with mandatory and statutory training was high amongst staff working on the ward. Staff are encouraged to upskill wherever possible, but such training can only be undertaken once staff have completed their mandatory and statutory training.

The following areas for improvement were identified:

During our discussion with the ward manager we spoke about whether staff were being provided with opportunities for clinical supervision. Only a small number of staff are currently receiving clinical supervision and HIW would expect such opportunities to be encouraged further to increase staff participation to help their development with the aim to improving patient care.

What next?

Where we have identified improvements during our check, which require the service to take action, these are detailed in the improvement plan below.

Where an improvement plan is required, it should:

- Clearly state how the findings identified will be addressed
- 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
- Ensure required evidence against stated actions is provided to HIW within three months of the Quality Check.

As a result of the findings from this quality check, 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.

Improvement plan

Setting: Welshpool Hospital

Ward: Maldwyn Ward

Date of activity: 15 October 2020

The table below includes improvements identified during the Tier 1 Quality Check, where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Please note, all actions are expected to be complete within three months of the Quality Check and the final version of the Improvement Plan is to be submitted via Objective Connect once complete.

Reference Number	Improvement needed	Standard/ Regulation	Service Action	Responsible Officer	Timescale
1	The health board must review the issue of equipment being stored in the day room and bathroom on the ward to help reduce any potential impact on the recovery of patients.	Health and Care Standards 2015 Standard 6.1	Due to Covid-19, the dayroom is currently being used for staff welfare, huddles, donning and doffing of PPE etc. Patients are able to access the dayroom outside of these times, with a current limit of 2 patients at a time to comply with social distancing requirements. As soon as able the dayroom will return to its normal function. Access to the physiotherapy gym is still utilised for 1:1 activity. It is recognised that there is a lack of	Zoe Clent - Community service manager	Anticipated 4 months 1 month

			storage on the ward for large manual handling equipment and as such the hoist equipment is currently stored in the bathroom. The deputy ward sister will request that the works department visit the ward and undertake a review of opportunities to create appropriate storage area for the hoists. If a patient requests a bath then the equipment is currently moved out to facilitate this.		
2	The health board must investigate the increase in the amount of falls over the last 12 months and provide HIW with assurance of the actions that will be taken to address the issue going forward.	Health and Care Standards 2015 Standard 2.3	There are some fall monitoring aids in use on the ward. It was agreed that contact would be made with relevant companies to explore the availability of alternative and additional aids to meet patient's needs. There will be a review of the DATIX reports that involve patients falls. The purpose of this will be to identify any learning, common themes and to review the recording and collation of the number of falls. In addition, this will be added to the falls working group development work, led by the Innovations department.	Zoe Clent – Community service manager	1 month 2 months

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.

Name: Zoë Clent

Date: 03 November 2020

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Quality Check Summary

Brecon War Memorial Hospital

Activity date: **21 October 2020**

Publication date: 18 November 2020

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

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

In writing:

Communications Manager
Healthcare Inspectorate Wales
Welsh Government
Rhydycar Business Park
Merthyr Tydfil
CF48 1UZ

Or via

Phone: 0300 062 8163

Email: hiw@gov.wales

Website: www.hiw.org.uk

Digital ISBN 978-1-80082-495-9

WG41024

Findings Record

Our Approach

Healthcare Inspectorate Wales (HIW) undertook a remote quality check of Epynt Ward, Brecon War Memorial Hospital as part of its programme of assurance work.

HIW's quality checks form part of a new tiered approach to assurance and are one of a number of ways in which it examines how healthcare services are meeting the Health and Care Standards 2015 (and other relevant regulations). Feedback is made available to service representatives at the end of the quality check, in a way which supports learning, development and improvement at both operational and strategic levels.

Quality checks capture a snapshot of the standards of care within healthcare settings. This quality check focussed on four key areas: COVID-19 arrangements; environment; infection prevention and control; and governance. More information on our approach to inspections can be found here.

We spoke to the Ward Sister on 21 October 2020 who provided us with information and evidence about their setting. We used the following key lines of enquiry:

- How do you ensure that there are sufficient numbers of appropriately trained staff on the ward to provide safe and effective care?
- How do you ensure that the risk of infection is assessed and managed to keep patients, visitors and staff safe?
- How do you ensure that the ward environment is safe and protects patients from harm, and how do you ensure that patient dignity is maintained?

COVID-19 arrangements

During the quality check, we considered how the service has responded to the challenges presented by COVID-19; what changes they have made to ensure they can continue to provide a safe, effective and person centred service. We reviewed key policies, including the use of personal protective equipment (PPE).

The following positive evidence was received:

We found that the ward had conducted the necessary risk assessment audits and developed relevant procedures to meet the additional demands stemming from the COVID-19 pandemic.

We saw that the ward had completed additional risk assessments for air ventilation and social distancing with control measures put in place. We were told that Epynt ward is a 15 bedded ward. All rooms are single, apart from one double bay room which enables prompt isolation of patients who become symptomatic. We were also told that patients can use the large dining room by maintaining social distancing. Patients can also access the secure garden from the day room. This enables patients to safely socialise on the ward and not having to remain in their rooms.

We found that the usual patient visiting arrangements to the ward had been suspended during the pandemic, in line with Public Health Wales guidelines. However, a process for visiting had been introduced for end of life patients and any patients with cognitive impairment. We also saw that the ward had a visiting plan in place, along with relevant questionnaires for visitors to complete prior to entering the ward environment.

We were told that the ward had sufficient stocks of personal protective equipment (PPE) sourced and stock levels were monitored on a weekly basis. A new dedicated PPE store room had been put in place to enable prompt access to PPE. In addition, the ward had been split into zones with clear instructions displaying which PPE should be worn in each zone.

We were told that mobile phones and tablets were provided for patients who were unable to receive face-to-face visitors due to the suspended visiting arrangements, and that staff had taken the time to assist patients in contacting their friends and relatives.

No improvements were identified.

Environment

During the quality check, we considered how the service has designed and managed the environment of care to keep it as safe as possible for patients, staff and visitors. We reviewed recent risk assessments, incident reviews and any pressure or tissue damage which has occurred. We also questioned the setting on the changes they have made to make sure patients continue to receive care and treatment according to their needs.

The following positive evidence was received:

We noted that various environmental risk assessment audits had been completed at a ward level with control measures put in place. The Ward Sister told us that they actively monitor the ward environment on a daily basis.

We were told that patients' dignity is fully protected by the appropriate use of privacy windows on each door of the single rooms and that privacy curtains are also available in the double bay.

We were informed that the ward identifies where patients have no support network for undertaking tasks such as laundering their clothes. Arrangements are put in place for this to be done locally.

We were told that staff complete an 'intentional rounding' checklist for all patients throughout the day. The 'intentional rounding' checklist involves a proactive check on each patient to ensure they have everything they need, and staff are more visible to patients which provides assurance.

The ward also makes use of the 'Butterfly[1]' scheme and the 'This is me[2]' document for any patients who have cognitive problems which helps staff to treat patients with dignity and respect.

A range of audits are undertaken to support patient safety on the ward, which include audits on falls and pressure and tissue damage. We reviewed a sample of these and found that, overall, positive scores had been achieved.

No improvements were identified.

Infection prevention and control

During the quality check, we considered how well the service manages and controls the risk of infection to help keep patients, visitors and staff safe. We reviewed infection control policies, infection rates and risk assessments.

The following positive evidence was received:

The Ward Sister told us that they undertake regular audits of infection control, hand hygiene and general ward cleanliness.

The ward has a dedicated Infection Prevention and Control link nurse who maintains regular contact with the ward to ensure all staff are kept up to date with any changes in guidance or practice.

We saw that, during the COVID-19 pandemic, specific COVID-19 guidance for infection prevention and control in healthcare settings was in place, with clear procedures for staff to follow. We also noted that the Health Board has signed up to the National Infection Prevention and Control manual which is available electronically.

[1] The Butterfly Scheme provides a system of hospital care for people living with dementia or who simply find that their memory isn't as reliable as it used to be.

[2] 'This is me' is a leaflet produced by the Alzheimer's Society to help hospital staff better understand the needs of people with dementia. The leaflet provides professionals with information about a person with dementia to help enhance the care and support they receive whilst in an unfamiliar environment.

We were told that all staff had received infection control training. Staff had access to 'donning and doffing' PPE training online. The Ward Sister also confirmed that the ward practices 'bare below the elbow' in line with the infection control policy.

No improvements were identified.

Governance

As part of this standard, HIW explored whether management arrangements ensure that there are sufficient numbers of appropriately trained staff on the ward to provide safe and effective care.

We reviewed staffing and patient levels, staff training and absences, management structures, ward functions and capacity, incidents and a variety of policies (such as escalation).

The following positive evidence was received:

We found that the Ward Sister had suitable procedures for ensuring that staffing levels are appropriate and are increased when required, for example an increase in dependency levels on the ward or staff absence. We were told that there is a 'Know how we are doing board' located on the ward which displays the required and actual staffing numbers per shift.

We were provided with data on sickness rates which appeared to be low and stable. The Ward Sister told us that they encourages a supportive culture and operates an open door policy.

We were provided with mandatory training statistics for the team and found a high rate of compliance in all areas. The Ward Sister confirmed that study time is allocated for staff development and any identified specific training is provided in-house.

We were also provided with information relating to staff appraisals and noted that a high number of staff had received an annual appraisal. Where some staff are due to receive an annual appraisal, the Ward Sister confirmed that arrangements are in place for these to be undertaken in a timely manner.

No improvements were identified.

What next?

Where we have identified improvements during our check, which require the service to take action, these are detailed in the improvement plan below.

Where an improvement plan is required, it should:

- Clearly state how the findings identified will be addressed
- 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
- Ensure required evidence against stated actions is provided to HIW within three months of the Quality Check.

As a result of the findings from this quality check, 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.

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 3.5

Experience, Quality and Safety Committee	**Date of Meeting: 3 December 2020**
Subject :	**Infection Prevention and Control Update**
Approved and Presented by:	Alison Davies – Director of Nursing and Midwifery
Prepared by:	Marie Davies – Deputy Director of Nursing Wendy Morgan – Assistant Director, Quality and Safety
Other Committees and meetings considered at:	Quality Governance Group 11th November 2020

PURPOSE:

This paper provides a summary of the work undertaken by the Infection, Prevention and Control (IP&C) team, both within an existing action plan programme and in response to Covid 19.
The approach going forward is outlined which includes a refreshed approach to the delivery work programme, meeting structures and expansion of the IP&C team.
Throughout November and December, the newly appointed Senior Nurses for IP&C for PTHB will be reviewing the audits already in place across the Health Board and the findings of this used to develop an IP&C assurance framework.

RECOMMENDATION(S):

The Experience, Quality and Safety Committee is asked to:

1. Note the work being undertaken both by the IP&C team and operational teams to delivery safe, effective care
2. Discuss the planned approach to explore existing audit arrangements for IP&C within Powys Teaching Health Board and identify any gaps.
3. Discuss and support the plan to develop an assurance framework for IP&C that will support the work being undertaken by the Clinical Quality Framework

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

DETAILED BACKGROUND AND ASSESSMENT:

1. Background

The NHS in Wales is committed to zero tolerance of preventable healthcare associated infections (HCAIs).

NHS organisations in Wales have made significant improvements in reducing HCAIs in recent years, including Meticillin resistant Staphylococcus aureus (MRSA) bloodstream infections and infections caused by Clostridium difficile; however, as the **Code of Practice for the Prevention and Control of Healthcare Associated Infections 2014** states "*more can and must be done to protect service users and achieve world class standards of service user safety*".

Effective infection prevention and control needs to be everybody's business and must be integral to everyday healthcare practice, and based on the best available evidence.

The Code of Practice sets out the minimum necessary infection prevention and control (IP&C) arrangements for NHS healthcare providers in Wales. The nine elements are set out as standards for achievement, and are expected to be met in full across the range of healthcare services that they provide.

Compliance with these standards should be evident to service users, visitors, staff and to the Welsh Government including Healthcare Inspectorate Wales.

These standards are also reflected in the Health and Care Standards Section 2.4 Infection, Prevention and Control (IPC) and Decontamination.

Developments and work undertaken since March 2020

Since March 2020 there have been a number of key areas which have impacted on the work programme of infection, prevention and control. These include:

- Coronavirus Pandemic
- The Senior Nurse for Infection Prevention & Control moved to a new role outside of the health board in May 2020, a new substantive appointment has been made but not due to start until 16 November 2020.
- An interim Senior Nurse for Infection Prevention & Control was appointed during the intervening period, supported by an experienced ward nurse on secondment.
- The IP&C portfolio transferred to the Assistant Director Quality & Safety, as an interim measure, from June 2020 until September 2020, in the absence of the Assistant Director of Nursing.
- Pace in the following key areas of work continued to be progressed:
  - Participation of the Senior Nurse for IP&C in Covid-19 related working groups
  - Rolling programme of IP&C education and training including Personal Protective Equipment (PPE), Covid-19 awareness, fit mask testing, IP&C Level 1 & 2 training
  - Recording of training/ competencies on the electronic staff record (ESR) to ensure accurate data available
  - Fit mask testing across the health board, in care homes and some primary care

provision
  - The Link Worker Policy was also developed and approved
- The Infection Prevention and Control Committee met on two occasions, June & September 2020. Under the leadership of the Director of Nursing and Midwifery the focus of this group has been refocussed, sub groups redefined and new leadership. There has also been a focus on commissioned services including operational services, domiciliary care, closed settings and primary care. Revised terms of reference for the main group and subgroups have been developed and approved. An update on the work of the IP&C Group is further outlined in section 2.2.
- Aseptic Non-Touch Technique (ANTT) training/ compliance has been progressed. In July 2020 assessor training was procured and a programme of training provided for staff. Related work to record competencies on ESR has been established. An update on training is provided in section 4.

2. Infection Control and Prevention Arrangements in Powys

2.1 The Infection, Prevention and Control Team

From the 16th of November the IP&C dedicated team is in place.

The team consists of two 8a posts, both Senior Nurses for IP&C; where one post is focused on PHTB directly provided services and the other for the wider provision of services in enhanced settings, primarily in primary care and care homes.

The team is further supported by a Band 6 IP&C Nurse Specialist. This post is currently being covered by an experienced ward nurse on secondment, whilst the substantive holder is supporting Test, Track and Protect.

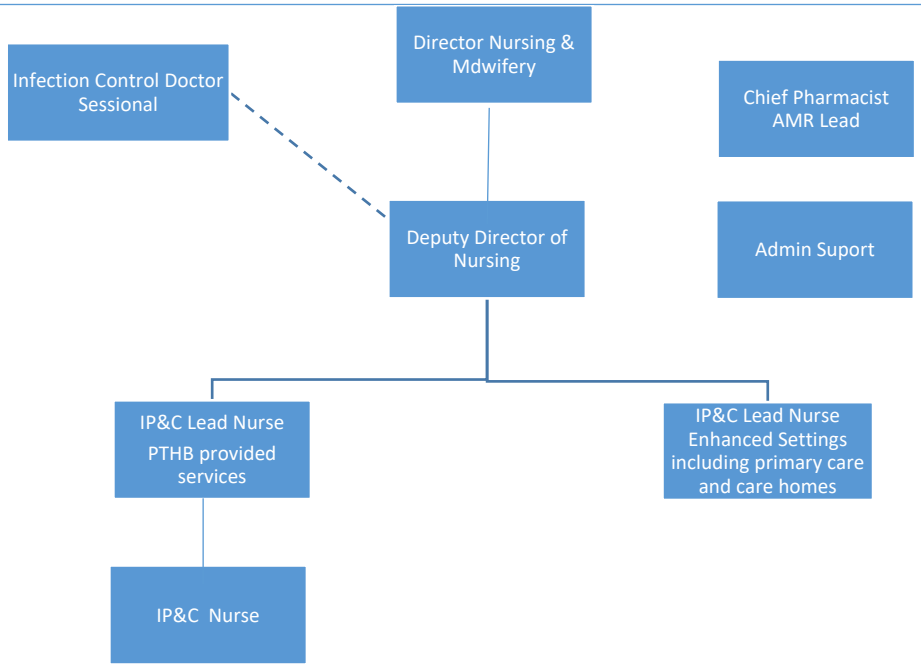
The team is also supported through three sessions of microbiologist support, the Infection Control Doctor, through a service level agreement with Public Health Wales. The current postholder has worked with PTHB since 2017 and is readily available for advice and support. Going forward this support will extend to attendance of key meetings and events.

Administration support is provided from the wider Nursing Directorate team.

Senior Nurse oversight is provided by the Deputy Director of Nursing on behalf of the Executive Director of Nursing and Midwifery who is the executive lead for IP&C.

This and the wider team directly contributing to the function of IP&C is shown diagrammatically in figure 1.

Figure 1: Infection, Prevention and Control Team



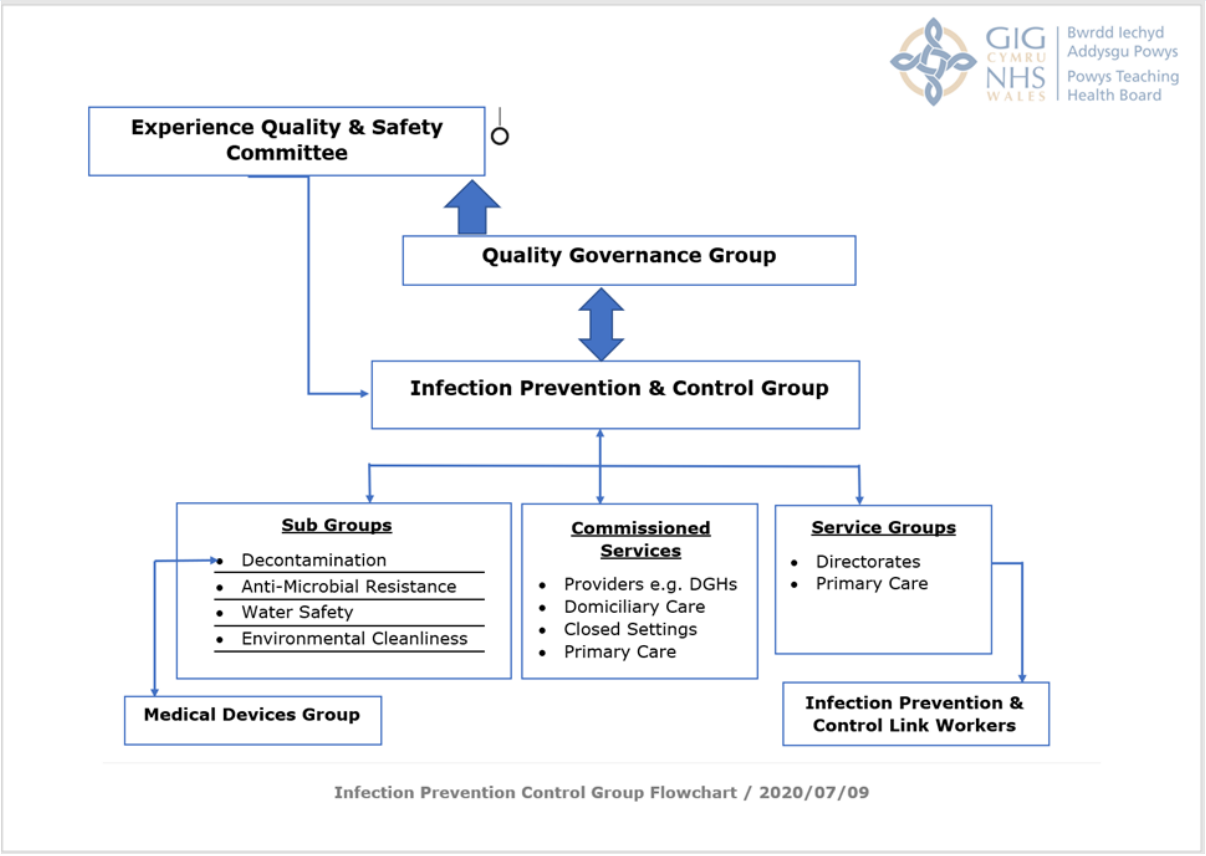
2.2 Governance arrangements for Infection, Prevention and Control Group and associated sub groups.

The Infection, Prevention and Control Group is held quarterly and is chaired by the Director of Nursing and Midwifery. The Terms of Reference have recently been reviewed and updated (Appendix 1).

There are four subgroups reporting to the main group to include; decontamination, Anti-Microbial Resistance, water safety and ventilation and environmental cleanliness. From November the environmental cleanliness group will be expanded to include any requirements of Covid 19 operational guidance. The health board currently has an action plan for IP&C and this is attached as appendix 2.

The governance of the group is outlined in figure 2.

Figure 2: Governance arrangements for Infection, Prevention and Control Group



2.3 Infection Prevention and Control Link Workers

Since January PTHB has established a diverse network of Link Workers across all operational areas. The role is generic and includes both clinical and non-clinical staff. Responsibilities are set out in a Standard Operating Procedure (SOP) with the aim of establishing networks to monitor standards and improve the care of the service. The link workers are a key resource to operational areas in sharing best practice, learning from adverse events and in monitoring safe, evidence-based practice.

3. Summary of updates from the meeting held on the 26th of September 2020

includes:

3.1 Anti-Microbial Resistance – chaired by Jacqui Seaton, Chief Pharmacist and Lead for AMR

A meeting was being held the following week. There was a considerable amount of work to be achieved and an improvement plan was being developed. Terms of reference were shared for this new group and it was noted that Jacqui was developing a five-year strategy. A baseline audit was also being undertaken.

3.2 Water Safety and Ventilation – chaired by Steve Watkins, Estate Manager

The COVID-19 Ventilation Project was noted to be starting in Brecon on the 28th September. The project will expand to Welshpool and Llandrindod Wells and completion scheduled for early 2021. The team are currently looking at phase 2 which includes dental suites and Aerosol Generating Rooms.

Improvements were being made to shower facilities and it was noted that the

work has been designed and tendered. In terms of assurance both Health and Safety Executive improvement notices have been lifted and the new risk assessments were being undertaken across the county.

The issue of adequate ventilation and use of portable fans was discussed, and as a result of the discussion a paper was submitted through Gold. It was agreed that fans should not be used in clinical areas but may be used in non-clinical areas with appropriate risk assessment. Representatives from estates, health and safety and nursing are now working with staff side to develop the guidance for staff to implement this.

3.3 Decontamination – chaired by Jason Crowl, Assistant Director (Community Services Group)

This is an established group with a defined action plan and an update provided against the defined actions within this.

3.4 Environmental Cleanliness – chaired by Duncan Crawley, Quality Improvement Manager

At the beginning of Covid 19 there were noted to be issues regarding hand gels. This risk had now been addressed.

Cleaning audits were continuing and a dashboard was noted to be in development. It was noted that although there was some variability around cleanliness scores the overall standard was high. It was felt some of the variability was as a result of different approaches by those auditing. A review is being undertaken in relation to this and training provided were required. Going forward this group will also include review of operational guidance relating to Covid 19.

4. IP&C Training and Competencies

4.1 Level 1&2

IP&C training is mandatory for all staff, the level depending on the role of the worker. All staff should be trained at level 1, and defined roles such as clinicians should have level 2 training.

To help to improve compliance IP&C Link Workers have been asked to support Managers / Team Leaders in encouraging staff to complete this on-line training. Compliance is improving and is now exceeding the expected 85% compliance level Figure 3.

Figure 3: IP&C Level 1 and 2 training compliance

	IP&C Level 1	**IP&C Level 2**
March 2020	82.14%	80.30%
August 2020	85.6%	85.65%

4.2 Personal Protective Equipment use E-Training & Competencies

The correct use of PPE has never been more important. Every employee is required to have working knowledge of the selection, use, removal and disposal of PPE as this is vital in maintaining staff and patient safety.

This will not only reduce the risk of spread of COVID19 but other transferable infections including Clostridium Difficile (C-Diff), Noro Virus and Escherichia Coli

(E-Coli).

PPE training is delivered via Skype by the IP&C nursing team, and the competency assessment completed at department level. Both elements are recorded on ESR.

There has been a marked increase in the staff who have completed their competency assessment since August 2020, and this offer has been extended to care homes, primary care and independent services.

4.3 Aseptic Non-Touch Technique (ANTT) Competencies

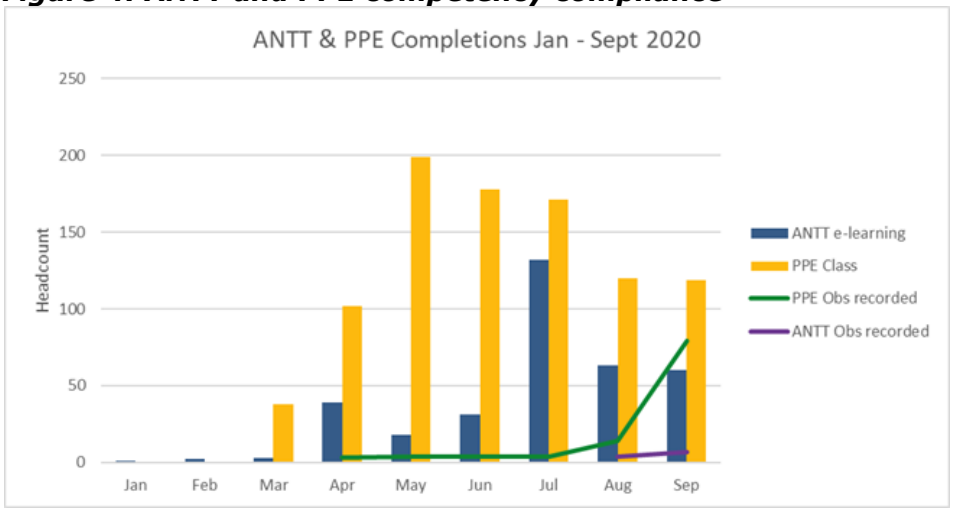
The Senior Nurse for Infection Prevention and Control provides local leadership for ANTT.

PTHB policy is that the training and a competency assessment is mandatory every three years for all staff who completed procedures requiring this skill.

ANTT on-line training is now a prerequisite for all clinical skills training where ANTT procedures are required. There is an increase in numbers of staff completing this training since March 2020 and since August in line with the training of ANTT assessors the competency assessments are beginning to be completed.

The IP&C team are currently working with the Head of Clinical Education to develop the approach with the new post of Clinical Skills Trainer.

Figure 4: ANTT and PPE competency compliance



4.4 Fit Testing

The need for FFP3 masks to be worn is identified through clinical risk assessment legislated, under the Health and Safety at Work Act 1974.

The mask is used to protect against respiratory borne pathogens and is required for all aerosol generating procedures when caring for patients that are, or suspected of being, Covid 19 positive.

There are two different methods of Fit Testing: Qualitative and Quantitative.

Qualitative testing is currently undertaken in the PTHB. This involves the wearer's subjective assessment of any leakage through the face seal region by detecting the introduction of bitter- or sweet-tasting aerosol as a test agent. The risk associated with this method include subjectivity of testing, staff ability to taste the solution, allergy to the solution and or cannot tolerate the testing hood for testing process.

The most effective testing is that of a quantitative method. This is a measure of how well a particular face piece seals against a person's face. It is expressed as a ratio of the concentration of challenge aerosol outside a respirator to the concentration of aerosol that leaks into the respirator through the face seal.

PTHB have recently purchased two machines that uses a Quantitative Fit Testing method called PortaCount. This is a mechanical device which produces direct numerical results called a Fit Factor. There is a higher pass rate, consistency and reliability associated with the method. An additional benefit is that it will no longer use a reagent which will allow more staff to be fit tested. Once the machines have been received a training package will be developed and delivered for the existing fit testers.

5. Incidence of infection for the Powys population

The incidence of infection remains low compared to All Wales rates. This is shown in Figures 5 and 6 respectively.

Figure 5: Powys incidence of infection

POWYS	April	May	June	July	Aug	Sept
C. difficile	2	1	0	0	0	1
E. coli bacteraemia	0	2	0	0	0	0
Gram negative bacteraemia	1	2	1	0	0	0
Klebsiella sp bacteraemia	1	0	0	0	0	0
MRSA bacteraemia	0	0	0	0	0	0
MSSA bacteraemia	0	0	0	0	1	0
P. aeruginosa bacteraemia	0	0	1	0	0	0
S. aureus bacteraemia	0	0	0	0	1	0

Figure 6: All Wales incidence of infection

ALL WALES	April	May	June	July	Aug	Sept
C. difficile	58	76	83	76	104	101
E. coli bacteraemia	118	143	158	209	179	185
Gram negative bacteraemia	169	198	216	270	267	243
Klebsiella sp bacteraemia	40	42	45	45	69	47
MRSA bacteraemia	4	3	4	4	4	2
MSSA bacteraemia	52	49	55	63	71	57
P. aeruginosa bacteraemia	11	13	13	16	19	11
S. aureus bacteraemia	56	52	59	67	75	59

The IP&C Team have been working with the Quality and Safety Commissioning Lead to gain more oversight in relation to IP&C issues and incidents in

commissioned services. This is currently being scoped and will be included in quarterly updates to the IP&C Group going forward.

6. Covid – 19 Related Issues

6.1 Nosocomial Infection

In September a draft protocol and toolkits were shared across Wales. The purpose of these tools was to identify and then investigate any incidence of nosocomial infection.

This is summarised below;

- Identify, report and review/investigate staff incidents of suspected workplace acquired COVID-19 consistently across organisations, and in accordance with existing incident reporting policies and procedures.
- Confirm the responsibilities of staff and managers to report suspected workplace acquired COVID-19, and ensure an integrated approach between the management of COVID-19 staff absence/sickness and staff safety incidents.
- Confirm the requirement for organisations to identify incidents that are reportable to the Health and Safety Executive (HSE) in accordance with RIDDOR requirements.
- Identify and share learning.

Further work is being undertaken and it is envisaged that an All Wales group will be established called The Nosocomial Transmissions Group (NTG), jointly chaired by the Deputy Chief Medical Officer and the Chief Nursing Officer.

Several pieces of draft guidance have been shared with the Directors of Nursing across Wales for their comments. This includes protocols and roles and responsibilities.

Locally we have identified 32 staff cases, where the employee may have contracted Covid 19 whilst working. These cases have been reported to RIDDOR, and a further 30 identified which are going through a defined assessment process.

Similarly, patients who may have Covid through nosocomial transmission are being identified and will be investigated through a similar process.

This work is being progressed through a newly developed Nosocomial Group, chaired by the Deputy Director of Nursing. This has representation from Medicine, Therapies, Health and Safety, Quality and Safety, and Workforce and Organisational Development. The group will report to the IP&C Group as a task and finish group.

6.2 Practical Guidance

The importance of responding to new guidance issued through the Covid 19 period has been essential. This has included a defined Covid 19 Policy Group, held on a two weekly basis to change policies and standard operating procedures in relation to new guidance.

The IP&C team are closely involved with this work. In response to new guidance and in supporting operational teams this has resulted in defined outputs including:

- Action cards to outline the procedure for checks on patients using services including no longer requiring a temperature to be taken (Appendix 3).
- The development of guidance on the use of fans in the clinical and non-clinical areas
- Use of masks in public corridors where a 2m social distance cannot be achieved.

The IP&C team will continue to work with operational services to support best evidence and new guidance into practice.

The IP&C team are also working in conjunction with the Social Distancing Group to ensure coherent and joint communications to staff around Covid 19 precautions.

6.3 Offer to Care Homes

In November the previous Interim Senior Nurse for IP&C commenced a substantive post to support primary care and care home services within a wider Enhanced Care provision. This will include:

- Develop working relationships/links with PHW, EH, AMR lead PTHB, HARP team and Local Authority to support, and not duplicate, or provide conflicting advice, and share good practice with care homes.
- Develop IP&C Link worker group for care homes
- Offer PPE on line training for suggestions for future issues or queries
- Support ANTT development and competencies
- Support access to on line training for ANTT Level 1 & level 2 IP&C
- To support/encourage hand hygiene audits to improve practice
- To support policy development in line with All Wales guidance for IP&C
- To have regular IP&C virtual meetings with care home managers to share learning
- Provide information to the care homes
- Provide data feedback
- Provide IP&C advice and retain record of when and what advice given.
- Feedback on incidence
- Support and virtual care home forums organised by the Local Authority
- Support the implementation of the Guidance Care Homes action plan

The health board offer to care homes is currently being developed and forms part of the commitment made in the Care Home Action Plan. The IP&C team are working closely with Community Services to ensure joint working on this approach.

7. Audit and Assurance Framework

Infection, Prevention and Control is everyone's business. The requirement for adhering to IP&C guidance is set out as a standard statement in job descriptions.

The fundamental standards for IP&C arrangements in health are outlined in the Code of Practice discussed earlier and then translated into regulatory requirements. The Code applies to all NHS healthcare organisations (Health Boards and Trusts) in Wales and to all services provided in both primary and secondary care. For those organisations that

do not provide in-patient services, the relevant sections of the Code apply. In addition, NHS healthcare organisations must ensure that when they contract or commission services the requirements of this Code are reflected clearly within contracts and commissioning arrangements.

Throughout November and December, the newly appointed Senior Nurses for IP&C for PTHB will be reviewing the audits already in place across the Health Board, and assess to what extent these provide assurance using the requirements under section 2.4 'Infection, Prevention and Control (IPC) and Decontamination' of the Health and Care Standards. Once this is complete the wider IP&C team will be using this evidence to develop an assurance framework using the standards as headings and there will be an ability to 'score' levels of assurance. The initial drafts for the audit standard requirements are attached as Appendix 4 and the assurance framework as Appendix 5 for information only. The team already has many thoughts and ideas how the service could be improved. These will be captured and further developed during a team development session in November.

8. Summary and Recommendation

This paper provides a summary of the work undertaken by the Infection, Prevention and Control (IP&C) team, both within an existing action plan programme and in response to Covid 19.

Since March, under the executive leadership of the Director of Nursing and Midwifery, the approach to IP&C has evolved. As substantive post holders move into their roles in November there is further opportunity to develop this. Throughout November and December, the newly appointed Senior Nurses for IP&C for PTHB will be reviewing the audits already in place across the Health Board and develop an assurance framework, revitalising the action plan associated with IP&C. The team work already in place is essential in ensuring the ongoing programme for IP&C in Powys.

Covid 19 will be a particular challenge for 2020-21 and associated work programmes to support vaccination programmes are ongoing and supported by the IP&C team.

NEXT STEPS:

Following review and approval by the Quality Governance Group the approach to reviewing the audit programme was strengthened to take account of what audits are already in place across the health board.

Ongoing work outlined in the action plan and planned activities will continue to be reported and overseen by the Infection, Prevention and Control Group under the executive leadership of the Director of Nursing and Midwifery.

Appendices:
1: IP&C Group Terms of Reference - July 2020
2: IP&C Action Plan – September 2020
3: IP&C Action Cards
4: IP&C Draft Audit Tool

5: IP&C Draft Assurance Framework


Appendix 1_IP&C Group Terms of Refer


Appendix 2_ IPC and Decontamination Acti


Appendix 3_IP&C_Action Cards.


Appendix 4_Infection Prevention and Contr


Appendix 5_IPC Assurance Framework

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda Item 3.6

Experience Quality Safety Committee	**3 December 2020**
Subject:	**Maternity Assurance Paper**
Approved and Presented by:	Presented by Alison Davies, Executive Director of Nursing and Midwifery
Prepared by:	Julie Richards, Head of Midwifery and Sexual Health Clare Lines, Assistant Director Commissioning Development
Other Committees and meetings considered at:	Women and Children's Senior Clinical Leadership Team (29th October 2020) Midwifery Management and Leadership Governance meeting – (3rd November 2020) Quality Governance Group (QGG) – (11th November 2020)

PURPOSE:

The purpose of this paper is to provide the Experience Quality Safety Committee with an updated position in relation to the Maternity Assurance Framework on the ongoing emerging areas in relation to maternity services.

RECOMMENDATION:

The Experience, Quality and Safety Committee is asked to NOTE the reports and the consideration of our directly provided midwifery services and the ongoing focus of our commissioner role (in relation to the quality, safety and sustainability of maternity services around the borders of Powys).

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

THE PAPER IS ALIGNED TO THE DELIVERY OF THE FOLLOWING STRATEGIC OBJECTIVES AND HEALTH AND CARE STANDARDS:		
Strategic Objectives:	Focus on Wellbeing	✓
	Provide Early Help and Support	✓
	Tackle the Big Four	✓
	Enable Joined up Care	
	Develop Workforce Futures	
	Promote Innovative Environments	
	Put Digital First	
	Transforming in Partnership	
Health and Care Standards:	Staying Healthy	✓
	Safe Care	✓
	Effective Care	✓
	Dignified Care	✓
	Timely Care	✓
	Individual Care	✓
	Staff and Resources	✓
	Governance, Leadership & Accountability	✓

EXECUTIVE SUMMARY:

Since the updated paper and presentations for maternity services to the Experience, Quality and Safety Committee (December 2019 and July 2020), there continues to be a number of emerging reports and unfolding positions in relation to maternity services provided by commissioned services.

They broadly relate to:

- Assurance work (maternity services within the overall assurance framework)
- The implementation of the South Wales Programme and Aneurin Bevan University Health Board's (ABUHB) Clinical Futures Programme
- Cwm Taf Morgannwg University Health Board position
- Shrewsbury and Telford NHS Trust (SaTH)
- Secretary of State investigation (SaTH)
- Wye Valley NHS Trust (WVT)
- National Healthcare Inspectorate Wales (HIW) report for Maternity services due to be published on 19th November 2020
- Phase 2 Healthcare Inspectorate Wales (HIW) report for Maternity services
- 2020 Welsh Government Maternity performance board scheduled for Spring 2021

DETAILED BACKGROUND AND ASSESSMENT:

Maternity Assurance Framework

The Maternity Assurance Framework within the Commissioning Assurance Framework (CAF) has been operational since September 2019 and reviewed on a monthly basis. It considers both provided and commissioned maternity services. The design of the Maternity CAF was implemented following the outcome & recommendations of the Welsh Government initiated RCOG/RCM review of Maternity Services - at the time provided by the former CTUHB. The CAF seeks to identify and escalate emerging patterns of poor performance and risk using five domains: patient experience, quality, safety, access, activity, finance, governance and strategic change.

The MAF provides a thematic view across key providers with a continuous process, including "credible soft intelligence". There is a continued clinical engagement with commissioned services to support the generation of reliable intelligence and understanding of internal governance mechanisms so that the level of risk can be appropriately assessed.

The Maternity Assurance Framework continues to develop and mature, providing quantitative data and a descriptor of events as additional context. Some of the datasets remain unavailable and the specificity of data an element for consideration, along with proportionality, at times the lack of context and the effect of small numbers hinders analysis. An all Wales Maternity system would enhance the timeliness and validity of the data to enable comparative data analysis and enhanced the assurance framework.

National HIW Review of Maternity services

Healthcare Inspectorate Wales's national maternity review, published on the 19th November 2020, illustrates the national picture of the quality and safety of NHS maternity services across Wales. This work is intended to provide public assurance and help to improve services for women and their families. In summary,

"HIW overall view is that those working within maternity services across Wales are extremely committed and dedicated to providing the best standard of care to women and their families. It is clear that the various professionals working in maternity services take great pride in what they do, strive to ensure that the journey through the pregnancy pathway is a positive experience as possible. HIW believe that the quality is good and that maternity services in general are delivered in a safe and effective way"

There are a number of key recommendations for Health Boards to consider from the themes that emerge from a programme of unannounced inspections of maternity units across Wales. The focus has been on the care provided in

obstetric maternity units up to the point of discharge plus some aspects of antenatal care provided in the community. The Health Board will be attending the Welsh Government and Maternity and Neonatal Network learning event in December to consider the national recommendations for local services and able to provide further update on the proposed improvements for future EQS Committee.

It has been confirmed with HIW that further work will be undertaken as part of the next phase to review antenatal and postnatal services across Wales. HIW have confirmed their intention to listen to the accounts of women, their partners and families to gain further insight, understand their experience and have already shared some user feedback which Powys has undertaken local service improvement around.

During this phase, HIW will undertake a selection of inspections based on phase I, in order to determine completion or progress of actions in line with recommendations made during inspection. The immediate assurance actions for Powys Maternity services were completed by June 2020 and the Powys HIW Maternity Improvement plan has been reviewed and updated in October 2020.

Welsh Government Maternity Performance Board 2020

Welsh Government has notified Health Boards in regards to the revised arrangements due to COVID19 for forthcoming Welsh Government Maternity Performance Boards, scheduled for early 2021. A table top exercise during November 2020 is planned by Welsh Government to review the Welsh Government National statistics for maternal and child health. The Health Board has highlighted the ongoing challenges that this data presents in terms of the need for inclusion of non-Welsh data as part of the maternity and birth statistics, Wales publications, which at this stage, omit any baby born outside Wales, even if the mother resides in Wales. Additionally, all data is lost when initial assessments are undertaken in a different health board to that of birth, or where the assessment cannot be matched to a birth record. The Health Board has raised the need for consistency in maternity data definitions and datasets. This is recognised within the Maternity and Neonatal Network workplan, although unfortunately, progress has been delayed as a result of the pandemic and we look forward to the opportunity to support the development of an All Wales maternity dashboard.

Preparation is underway for the forthcoming Maternity Performance Board. The Powys presentation will be developed around the following areas;

- Progress on highlighted areas from autumn 2019 review
- Key performance data
- Additional data in regards to workforce and incident reporting
- Serious incident reviews and improvements made
- Safety and training
- Engagement with women and families

- Clinical supervision for midwives key performance indicators

Powys Provided services

During the last 6 months, the Quality Governance framework within women and children's services has been strengthened through the development of a number of forums including establishment of the following;

- W&C Incident and Concerns Oversight Group which is focusing on the Maternity serious incident reports and progression of improvement plans generated from findings and based on learning.

- W&C People Experience Forum which is reporting into the established Powys Maternity and Parent Voices Partnership (PMVP) and is improving the quality of the patient experience reports. A recent all Wales Community Health Council (CHC) survey has been considered by the PMVP and within the Midwifery Management and Leadership meeting to consider the themes from families experiencing maternity services during COVID19. The CHC report has been explored through weekly midwifery group supervision to ensure Powys midwives are cited on women and families experience to influence the support Powys maternity services can offer families.

- W&C Policies and Procedures Group which is ensuring robust evidence policy and guidelines development.

- W&C Audit Forum which is undertaken quarterly. Audit learning events contribute to the Health Board Audit Improvement plan

- W&C Safeguarding Development Plan which is strengthening the safeguarding capacity, competency and improving compliance with safeguarding standards

Shrewsbury and Telford Hospital Maternity Services

Shrewsbury and Telford Hospitals NHS Trust (SATH) is in special measures and overall maternity services require improvement.

SaTH has been at CEO led escalation within PTHB's processes. Reports to Board Committees have explained the work undertaken through CEO level meetings, the Commissioning Assurance Framework, including the development of a Maternity Assurance Framework. An "Improvement Alliance" with the University Hospitals Birmingham NHS Foundation Trust (UHB) has been established. A new Chair of the Board of SaTH has been appointed from UHB and "Committees in Common" established.

Governance and assurance processes are being strengthened as follows:

- Maternity assurance will be provided via the Quality & Safety

Assurance Committee (QSAC).
- A Maternity Transformation Plan is in place.
- Compliance with reporting requirements in relation to the Perinatal Mortality Review Tool (PMRT).
- External Advisory Group established
- Continued liaison with the Secretary of State's Independent Review chaired by Donna Ockenden, which is due to fully report in 2021
- Active Maternity Voices Partnership.
- Positive midwife to birth ratio and Birthrate Plus assessment completed

South Wales Programme Implementation and ABUHB's Clinical Futures Programme

Before the COVID-19 pandemic PTHB had established a South Powys Pathways Programme Board involving WAST, CTMUHB and ABUHB. The Programme Board had been convened to prepare for changes to Powys patient flows anticipated under the South Wales Programme (SWP); in response to the opening of the Grange University (GUH) Hospital, originally planned for Spring 2021; and under the Powys Health and Care Strategy.

This year has been one of unprecedented challenge for all and civil contingency arrangements remain in place. GUH is key to ABUHB's COVID winter response and approval was given on the 27th August 2020 to bring forward the opening to mid-November, 2020.

PTHB has established a separate maternity workstream under the South Powys Pathways Programme, chaired by the Executive Director of Nursing and Midwifery which is working to a longer timescale in terms of strategic changes to patient pathways.

In terms of ABUHB's Clinical Futures Programme, which has now been accelerated in terms of the transition period for the scheduled move for obstetrics services to the Grange in November 2020, Powys maternity services have undertaken mitigating work to track the activity, service readiness assessment and consider long term impacts plans to move obstetric services to the new Grange services.

The South Powys Pathways Maternity Workstream has commenced as part of Phase 2 of the South Powys Programme Board to support the changes under the South Wales Programme planned for 2021/2022. The workstream has the workstream plan (which will be approved by and form part of the South Powys Pathways Programme Plan chaired by the CEO) which will cover the key governance, quality, safety, workforce, information, IT, financial and assurance arrangements which need to be in place to ensure a smooth transition to the use of Obstetric services at Prince Charles Hospital Merthyr in line with the outcome of the South Wales Programme. The workstream will consider the services which can be repatriated to Powys such as Early Pregnancy Assessment and new ways of working to help ensure services are provided closer to home where possible.

Cwm Taf Morgannwg University Health Board (CTMUHB) update

Cwm Taf Morgannwg maternity services remain in special measures with Welsh Government (WG) and Wales Audit Office (WAO) targeted intervention, based on the findings of a Royal College of Obstetricians and Gynaecologists and Royal College of Midwives report which identified:

(i) serious failings in maternity services;
(ii) a number of significant concerns around staffing and processes;
(iii) the underlying culture in maternity services which have compromised care.

The independent oversight group report publishes quarterly reports which highlight that the foundations for improvement are largely in place. Powys Executive Director of Nursing and Midwifery or Head of Midwifery representation at the Cwm Taf Morgannwg Improvement Board has been insightful to consider the improvements. 12 of the RCOR / RCM requirements have now been signed off and the Health Minister recognised in September 2020 that good progress continues to be made.

Next Steps

Our aim is to continue to ensure that women, their partners and babies have a positive experience whether in Powys or across our borders.

- To maintain oversight and escalation of commissioned services through PTHB Commissioning Assurance Framework (CAF), to continue to strengthen data gathering and intelligence reporting to provide assurance and be confident about the quality and safety of services for the Powys population.
- As previously presented to the Experience, Quality and Safety Committee we will continue with monitoring quality, safety and sustainability of maternity services around Powys' border using our Strategic Change Situation Report and Fragile Services Log, alongside our monitoring of commissioned services compliance to national standards particularly for consultant-led/obstetric care, to ensure strategic oversight of service providers.
- To provide Committee a future update on any actions required resulting from the HIW phase 1 report.

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

AGENDA ITEM: 3.7

EXPERIENCE, QUALITY AND SAFETY COMMITTEE	**DATE OF MEETING: 3 December 2020**
Subject:	**COMMISSIONING ESCALATION REPORT AND SATH UPDATE**
Approved and Presented by:	Assistant Director Commissioning Development
Prepared by:	Assistant Director Commissioning Development
Other Committees and meetings considered at:	Scores were considered on the 21st October 2020 at the Internal Commissioning Assurance Meeting. The report also contains information received after that date. (A verbal update of key issues was provided to the Delivery and Performance Meeting on the 22nd October 2020.)

PURPOSE:
The purpose of this paper is to highlight to the Experience, Quality and Safety Committee any providers in Special Measures or scored as Level 4 under the PTHB Commissioning Assurance Framework. It also provides an update in relation to Shrewsbury and Telford Hospitals NHS Trust.
RECOMMENDATION(S):
It is recommended that the Experience, Quality and Safety Committee DISCUSSES this Commissioning Escalation Report.

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

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

EXECUTIVE SUMMARY:

This report highlights providers in Special Measures or scored as Level 4 following the 21st October 2020 PTHB Internal Commissioning Assurance Meeting (ICAM). There are:

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

The report provides an update in relation to Shrewsbury and Telford Hospitals NHS Trust (SaTH).

DETAILED BACKGROUND AND ASSESSMENT:

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

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

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

Formal inspection reports for the NHS organisations commissioned are available on the websites of Health Inspection Wales (HIW) and the Care Quality Commission (CQC). PTHB attempts to draw from providers' existing

Board reports, plans, returns to Government and nationally mandated information wherever possible.

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

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

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

Since July, PTHB has been working to incrementally restore the CAF although there remain significant limitations and it is not possible to score all of the domains. (For example, the block financial arrangements do not reflect budgets and the financial schedules in Long term Agreements set in February prior to COVID escalating in the UK.)

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

As reported to the Delivery and Performance Group on the 22nd October 2020, whilst routine services are being restored the size of waiting lists and waiting times are deteriorating across the NHS. Whilst the Access domain can be scored red it will not be possible to apply the PTHB CAF escalation process in the usual way to providers. Work is underway on solutions, including some whole system and regional collaboration.

Special Measures

Provider	Quality & Safety			Patient Experience			Access			Finance (Cost & Activity)	Change in Level Status	Governance & Strategic Change
Shrewsbury & Telford Hospital NHS Trust	Aug 2020	Sept 2020	Oct 2020	Aug 2020 (Powys Specific)	Sept 2020 – Data not available	Oct 2020	Aug 2020	Sept 2020	Oct 2020	No Score – Block Agreement	↔	Not Rated
Betsi Cadwaladr University Health Board	Aug 2020	Sept 2020	Oct 2020	Aug 2020	Sept 2020 – Data not available	Oct 2020 – Data not available	Aug 2020	Sept 2020	Oct 2020	No Score – Block Agreement	↔	Not Rated
Cwm Taf Morgannwg University Health Board	Aug 2020	Sept 2020	Oct 2020	Aug 2020	Sept 2020	Oct 2020 – Insuf info	Aug 2020	Sept 2020	Oct 2020	No Score – Block Agreement	↔	Not Rated

Level 4

Provider	Quality & Safety			Patient Experience			Access			Finance (Cost & Activity)	Change in Level Status	Governance & Strategic Change
Wye Valley NHS Trust	Aug 2020	Sept 2020	Oct 2020	Aug 2020	Sept 2020	Oct 2020 – Insuf info	Aug 2020	Sept 2020	Oct 2020	No Score – Block Agreement	↔	Not Rated

Shrewsbury and Telford Hospitals NHS Trust (SATH)

As previously reported the Care Quality Commission (CQC) carried out a further unannounced inspection of SaTH on the 9th and 10th of June. This resulted in a letter, known as a Section 31 Notice, imposing further conditions on its regulated activity. The full reports can be accessed through the links below:

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

The focused inspection showed that the position had deteriorated:

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

The CQCs findings included concerns in relation to the management of:

- Pressure area care
- Falls
- Nursing documentation
- Learning from previous incidents

- Mental Capacity Act and Deprivation of Liberty Safeguards
- End of life care
- the oversight of audits and the improvement of outcomes
- the culture

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

Whilst PTHB is not the main commissioner of SaTH, its DGH services are strategically important to the highly rural population in North Powys. The next nearest DGH is also part of an organisation within special measures.

SaTH has been at CEO led escalation within PTHB's processes. Reports to Board Committees have explained the work undertaken through CEO level meetings, the Commissioning Assurance Framework, including the development of a Maternity Assurance Framework. It has been explained that PTHB liaised with key stakeholders in England to help secure a way forward for SaTH aimed at ensuring improved quality and safety of services**.**

An "Improvement Alliance" with the University Hospitals Birmingham NHS Foundation Trust (UHB) has been established, as SaTH was not in a position to improve the quality and safety of its services without further support. A new Chair of the Board of SaTH has been appointed from UHB and "Committees in Common" established.

SATH SUMMARY TIMELINE	
November 2018	The Trust is placed in special measures by NHS Improvement.
29th November 2018	The CQC tells the Trust it must: • Ensure sufficient and suitably qualified and trained staff are available to care for and protect people from the risk of harm. • Keep all environments safe for use. • Review and improve midwifery staffing levels to meet the needs of women and keep women and babies safe. • Take account of the report from the Royal College of Obstetricians and Gynaecologists' review of current practice in maternity services and formulate action plans to improve the service. • Review the processes around escalating women who are at high risk so that women who present at the midwifery led unit or day assessment unit receive a medical review without delay. • Review its policy on reduced foetal movements so there is a clear and defined pathway for midwives and sonographers to follow. • Ensure complaints are addressed within the timescale laid down by the trust's complaints policy. • Doctors covering out of hours must have the capability and confidence to review patients at the end of life, including prescribing. • All records must be safely and securely stored. • The trust must improve the rates of administering antibiotics within an hour of identifying patients with suspected sepsis. • Best practice must be followed when preparing, administering and storing medicines.

15th April 2019	CQC focused inspection to review concerns relating to the Emergency Department PRH.
15th April 2019	CQC focused inspection to review concerns relating to the Emergency Department RSH.
16th April 2019	Unannounced focused inspection of the midwife led unit at Royal Shrewsbury Hospital
18th April 2019	CQC issues Section 31 Notice notably concerning children in Emergency Department.
2nd August 2019	Findings of the April Emergency Department CQC inspections published.
12th November 2019	CQC inspection
November 2019	Further letter issued by the CQC
6th December, 2019	The CQC publish a quality report following an unannounced focused inspection of the midwife led unit at Royal Shrewsbury Hospital on the 16th April, 2019.
17th February 2020	CQC unannounced focused inspections of Emergency Departments at RSH and PRH
8th April 2020	The CQC publishes the findings of the inspection which took place between the 12th November 2019 to 10th January 2020. (The reports in relation to the quality visits on the 17th February are also published.) The overall trust quality rating is "inadequate". The safe, effective, responsive and well led key questions were all rated as inadequate. The caring key question went down to requires improvement. Royal Shrewsbury Hospital was rated requires improvement. The Princess Royal Hospital was rated as inadequate.
9th and 10th June 2020	CQC unannounced inspection
18th June, 2020	The Trust received a further Section 31 Notice

Update: As well as a new chair from UHB a new Director of Nursing has been appointed. There is also an improvement team in place to support the Trust's Quality Improvement Plan (QIP) and co-ordinated by an Improvement Director.

The Trust's critical objective is the improvement of patient experience, which is dependent on the quality of care and safety at the Trust. There is a renewed focus on the quality of clinical care; governance and culture. In October the Improvement Alliance focused on getting to know the trust and accessing evidence of the quality of care being delivered.

A revised Board Assessment Framework (BAF) has been put in place to help ensure that the Trust's strategic directives are being met and risks managed appropriately.

In terms of the QIP in response to the CQC findings, by the 16th October 87% of the actions had been completed (351 of 402.) However, it is being refocused into key themes:

- ***How we reduce harm from avoidable falls***
- ***Pressure ulcers and medication errors***
- ***How we recognise and respond to our most acutely unwell patients***

- ***How we support our most vulnerable groups***

There is also a realignment of the plan to focus on sustainable improvement across the organisation as part of a wider "Getting to Good" improvement plan.

An integrated performance report is in place spanning quality, operational performance, workforce, finance, risk and estates. An extract of the key exceptions reported to the SaTH Board in November is below.

	Measure	Target Month	Actual Month	Bench marking	Trend	Kitemark	Comment
Safe	Serious Incident Reporting		7				
	Never Events	0	0				
	VTE Risk Assessments	95.0%	96.2%				National returns not collected since Dec-19. Locally collected and monitored
	Falls per 1000 bed days	6.60	4.61				Awaiting updates from Patient Safetly Measuresument Unit (PSMU) for benchmarking data
	Hospital Acquired Pressure Ulcers (Cat 2 Confirmed)	12	11				Target based on 20% reduction of 19/20 monthly average
	MSSA Bacteraemia infections		2				Target to be confirmed
	E.coli Bacteraemia Infections		6				Target to be confirmed
	C Diff Infection Cases	3	1				
Effective	HSMR	96.42	90.79**	(Aug-20)			
	Readmission Rate (28 days)		9.8%**	(Aug-20)			Target to be confirmed
	Ambulance Handover (over 60 mins)		205				Target to be confirmed
	Super Stranded		44				Target to be confirmed
	Average LOS (Adult Emergency)		6.35				Target to be confirmed
	Agency Staffing	£1,173k	£2,633k		-		
Caring	Friends and Family Test: % Recommended by Patients - A&E	85.0%	92.4%				National returns not collected since Mar-20. Trust commenced local collection May 20
	% of Complaints which were upheld	19%	7.5%				
	A&E Left Without Being Seen	5.00%	2.5%				
	Maternity - Emergency C Sections	<10%	13.5%	(Jun-20)			
	Mixed Sex Accommodation Breaches - Confirmed	0	25				National reporting on MSA breaches has been paused due to COVID19 impact
Responsive	RTT Performance	92.0%	55.0%	(Aug-20)			
	Waiting Times - Diagnostic Waits	99.0%	41.4%	(Aug-20)			
	A&E 4 Hour Performance	95.0%	76.2%	(Sep-20)			
	RTT - 52 Week Breaches	0	598	(Aug-20)			
	Cancer Waiting Times - 62 Day	85.0%	81.8%	(Aug-20)			
Well Led	Retention rate exc. Junior Drs		89.3%				Target to be confirmed
	Sickness	4.0%	4.2%	(May-20)			
	PDP Completion	90.0%	85.3%				
	Financial surplus/deficit	£0k	£0k		-		Target to be confirmed
	CIP Target		£628k	N/A			Target to be confirmed, YTD live and carry in
	Capital Programme Delivery		£702k	N/A	-		Target to be confirmed, expenditure in month
	Staff FFT						Last available data Q2 19/20

The Phase 3 Recovery Plan and Winter Protection Plan are being implemented in response to a difficult COVID winter. SaTH is to provide PTHB with a weekly report on recovery progress.

There has been a deteriorating picture in relation to waiting times. Routine outpatient appointments are being restored but are being affected by social distancing and infection control factors. Patients who are now waiting more than 52 weeks for treatment are being seen based on clinical priority and waiting times. SaTH is working with system partners on solutions. For example, an arrangement is being developed where orthopaedic patients are being operated on within Robert Jones Agnes Hunt but by SaTH surgeons. A virtual fracture clinic

is also being implemented to reduce the number of hospital visits needed, resulting in some patients requiring no face to face follow-up.

In terms of diagnostics there is a backlog for CT and MRI scans (this was exacerbated by an outbreak within the PRH Radiology Department in September). Two mobile MRI scanners have been secured and a mobile CT scanner.

The endoscopy recovery work is behind planned levels. The limiting factors have been swabbing capacity and patient compliance with pre-procedure isolation.

Work is underway to improve cancer performance including the continued use of private sector capacity in the Nuffield.

The Trust is reviewing its policies, processes, assessment, intervention and assurance in relation to falls. A "falls lead" is attending wards. Workforce has provided assurance that the wards experiencing falls have satisfactory staffing. The Board has been informed that the number of falls within SaTH are currently within normal variation.

A quality and performance improvement programme has begun supported by the Emergency Care Intensive Support Team.

All Clinical Directors are in place and a clinical leadership development programme is underway.

In terms of assurance the following statement was recorded in the November 2020 SaTH Board:

The Committee wish to assure members of the Board that:

- There continues to be good progress against the CQC action plan targets. There is a key focus required on embedding actions. There remain concerns about the management of deteriorating patients as inpatients with a recent Serious Incident
- The plan for winter is very well constructed but the implications on quality and safety of care require considerable attention

In terms of maternity services:

- The arrangements for maternity assurance are being revised. The Maternity Assurance Committee (MAC) will no longer meet and assurance will be provided via the Quality & Safety Assurance Committee (QSAC).
- A Maternity Transformation Plan is in place.
- There has been compliance with reporting requirements in relation to the Perinatal Mortality Review Tool (PMRT).
- There is a risk to compliance with the Clinical Negligence Scheme for Trusts (CNST) in relation to maternity services, as there are occasions when co-

ordination is not supernumerary. There was also one occasion when 1:1 care was not achieved during labour.

- There is an External Advisory Group in relation to Maternity Services and continued liaison with the Independent Review chaired by Donna Ockenden.
- There is an active Maternity Voices Partnership.
- The midwife to birth ration is positive at 1:26.
- Work in relation to the Birthrate plus assessment has been completed in order to develop an updated midwifery workforce action plan.
- Further assurance will be sought in relation the organisation’s emergency C section rate.
- The assurance statement provided to the SaTH Board is below:

The Committee wish to assure members of the Board that:

- Given the upcoming changes in the Trust assurance committee structure this was the last meeting of the MAC. Assurances are to be provided going forward through QSAC or directly to the main board.
- The Care Group Medical Director advised that whilst anaesthetic cover for the maternity unit was not currently in line with RCA guidance, it is partly mitigated by cover being in place from experienced staff grade anaesthetists. Scheduled care (SC) who are responsible for this cover continue to actively recruit and have recently appointed a new anaesthetic CD who is focusing on this issue.
- All action plans included in the MIP have shown an improved status in month with the exception of the Early notification scheme which has remained static, the Midwifery staffing audit and CNST which have declined slightly. This plan summarises progress on 14 separate action plans. The status of the 452 actions as at September were classified as following: Embedded 6, Complete 157, On track 231, Off track 32 Not yet started 11 and 15 have been paused due to Covid. In October the care group is focusing on moving actions to an embedded status and reducing the off track items further.
- Compliance with PMRT and Early notification scheme reporting requirements was met
- 100% recommendations from the FFT
- Continuity of Carer teams implemented and making positive impact – 9% women booked onto pathway. National target is 35% by March 2021 and further work is in hand to achieve this.
- The Clinical dashboard was reviewed and main areas for noting are:
    - An increase in births overall during August (an increase of 16 on Consultant Unit and 11 on the Wrekin Midwife Led Unit).
    - Overall a YTD decreasing birth rate (In line with national trend)
    - Breast feeding rates Initiation rates remain above the national average (at or above 72% YTD; 72.7% for August) however breast feeding at discharge from hospital remains at just below national average at 59.4%.
    - Bookings have continued to increase slightly with a more significant increase from July to August (increase of 37).
    - Decreased CO recording (in line with pandemic recommendations)
    - Smoking rate at birth is continuing to drop (from 14.7 in July to 11.5% in August), this has reduced despite the pandemic.

In terms of the CQC rating the overall score is that the maternity service requires improvement. However, the Section 31 Notice, requiring weekly reporting to regulators, has been lifted.

PTHB will continue to work with key stakeholders to develop a risk reduction plan including the development of clinically appropriate services in Powys where possible. The North Powys Programme is pivotal development in this context. Key actions built into the PTHB Quarter 3 and 4 plan and Winter Protection Plan should

help to reduce emergency activity and admission, thus relieving some of the pressure on SaTH.

However, for PTHB this has been a particularly challenging time in relation to commissioned services as it is managing significant cumulative risks notably SaTH, accelerated changes to emergency pathways in South Powys and deteriorating waiting times for routine interventions against the background of winter pressures, the COVID-19 pandemic and preparation for EU exit. The intense focus which has been needed on the South Powys emergency flows issue has temporarily reduced the PTHB capacity to focus on SaTH.

Aneurin Bevan University Health Board and Cwm Taf University Health Board

A full and separate paper was submitted to the Experience, Quality and Safety Committee which was endorsed on the 6th November, 2020, in relation to the accelerated changes needed to emergency flows in South Powys.

Conclusion

There are three providers in special measures and one at Level 4. Work has been continuing to reinstate the CAF, but it is not possible to score all the domains or apply the escalation process in the usual way.

This has been a particularly challenging period in terms of commissioned services and cumulative significant risks are being managed by PTHB. Notably these include SaTH, accelerated changes to emergency pathways in South Powys and deteriorating waiting times for routine interventions against the background of winter pressures, the COVID-19 pandemic and preparation for EU exit.

Whilst the Improvement Alliance between SaTH and the University Hospital Birmingham is at an early stage, there is already some evidence that it is driving forward improved governance arrangements focusing on the quality and safety of services.

NEXT STEPS:

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

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 3.8a

Experience, Quality and Safety Committee	**Date of Meeting: 3 December 2020**
Subject :	**Update of the 2020/21 Clinical Audit Plan**
Approved and Presented by:	Paul Buss, Medical Director
Prepared by:	Howard Cooper, Safety & Quality Improvement Manager
Other Committees and meetings considered at:	Executive Committee

PURPOSE:

The purpose of this paper is to inform the Experience, Quality and Safety Committee regarding the progress of the 2020/21 Clinical Audit plan.

RECOMMENDATION(S):

The Experience, Quality and Safety Committee is asked to RECEIVE and APPROVE this report.

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

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

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

	5. Timely Care	✓
	6. Individual Care	✓
	7. Staff and Resources	✓
	8. Governance, Leadership & Accountability	✓

EXECUTIVE SUMMARY:

This report provides a **current position in relation to the** 2020/21 Clinical Audit plan.

DETAILED BACKGROUND AND ASSESSMENT:

Background

This report provides an update on the position of the 2020/21 Clinical Audit Programme. The Directors and Service Leads have asked for the committee to receive this update to the Clinical Audit plan.

The original 2020/21 Clinical Audit plan is listed in **Appendix A**.

Audits reporting their findings this period.

Women and Children's Service

Paediatric Physiotherapy Record Keeping Audit

The Paediatric and 14+ Learning Disability and Mental Health Physiotherapy service conducted an audit of their case note recording. The audit looked at five aspects of care: Documentation, Subjective assessment, Assessment data and analysis, Treatment planning & implementation and Evaluation & discharge. Standards used were those of the Chartered Society of Physiotherapy.

Notes scoring as 85 and above (out of a possible 100) against the standards were considered as of good quality, those scoring between 70 and 84 were considered acceptable but with scope for improvement whilst those scoring 69 and below were considered unacceptably poor.

This was the second time the Physiotherapy audit had taken place so results could be compared to the previous year. Results show the percentage of notes examined falling into each category.

	2019	2020
Good Quality	67%	81%
Acceptable but with room for improvement	33%	19%
Unacceptably poor	0%	0%

Learning
Analysis of the results didn't identify any particular parts of the documentation that were systemically poorly completed so the improvement action was to issue staff with a checklist which they could refer to whilst completing documentation with the aim that it would prompt completion of any missing aspects.

Community Paediatric Triage Audit

The Community Paediatric Triage team meets weekly to discuss referrals to ensure that the client is directed to the clinician most able to address their needs whilst also achieving the "no wrong door" philosophy that all referrals received get a positive decision, and are not left unresolved in the system. The criteria used came from Standard 1 of the RCPCH's guidance *Facing the Future: Standards for Children with Ongoing Health Needs.*

The audit findings were that 30% of referrals were accepted onto the caseloads of Powys paediatricians whilst 49% were referred onto either commissioned paediatric services or other healthcare professionals. The remainder were returned to the referrer with advice that a referral to a specialist service was not required.

Learning
The audit considered that all referrals had been appropriately triaged and the service had been successful in achieving standardisation and equity between all areas of Powys.

Audit of Children on Vacant Caseloads

A vacant caseload occurs when a patient is accepted for treatment but then due to staff illness, retirement or job change a situation arises where there is no named clinician responsible for the continued care of the patient.

A specialist practitioner children's nurse undertook an audit in North Powys and discovered there were 53 children on the vacant caseload who had not received a paediatrician's review since the retirement of the substantive consultant paediatrician in 2018.

These children and their families were then followed up by the auditor to assess whether they had continuing unmet needs.

25 reported that they no longer required to see a paediatrician or other clinician,
8 were referred to the care of other clinicians and did not require a further appointment with a paediatrician,
11 had moved out of Powys,
6 were still requiring an appointment with a Powys paediatrician,
2 had transferred to an adult service,
1 was transferred to the care of a South Powys consultant paediatrician.

Learning
The audit showed that an active review of the needs of clients on the caseload resulted in clients being signposted to an appropriate team rather than waiting to be seen by a paediatrician. In all 88% of the caseload was discharged with the consent of the families and clients concerned. The six children still on the caseload could then be prioritised to be seen.

Therapies and Health Sciences

Occupational Therapy Adult, Paediatric and 14+ Learning Disability and Mental Health Service Record Keeping Audit

For the Occupation Therapy audit this was the first time the audit had been completed. Standards used were those of the Occupational Therapy "Standard 7" benchmark. 76 sets of notes were examined.

Results show the percentage of notes examined falling into each category.

	2020
Good Quality	51%
Acceptable but with room for improvement	24%
Unacceptably poor	25%

Learning

In contrast to the Physiotherapy audit a number of aspects were identified as requiring improvement for the majority of staff. These included improving the recording of consent and to introduce the systematic use of the SOAP approach (Subjective, Objective, Assessment, Planning) to record keeping. A Teams workshop is to be arranged to share the audit outcome and the improvement actions will be incorporated into the PADR review process for the staff members concerned. The audit will be repeated in 2021.

Speech and Language Service

Audit of the use of on-line notes

The Speech and Language Service audited their use of on-line notes, a new process that they had adopted in response to the Covid 19 epidemic.

Learning

Overall results were good though some minor issues were identified concerning;

Recording time in the 24 hour clock format,
Recording of patient consent,
The counter signing of SALTA (assistant therapist) entries.

Planned introductions to the WCCIS (Welsh Community Care Information) System will help resolve the majority of these issues and the audit will be repeated once the changes to WCCIS have been introduced.

Pain and Fatigue Management Service

Consent and Assessment Audit

The Pain and Fatigue Management Service undertook an audit of their consent taking and initial assessment process in support a service improvement initiative.

The results of the audit showed that a good standard of note keeping was reached but that improvements could be made in the recording of the clients presenting condition and in the recording of the dates and times of therapies.

Learning
As an action the admission documentation and the format of the notes was redesigned to improve the capture of the initial assessment process, and to better document the time and date of each entry in the notes.

Nursing Directorate Corporate Team

Safeguarding Maturity Matrix Audit.

The service in Powys was evaluated against the five safeguarding standards that have been agreed under a "Once for Wales" approach. Each standard is scored out of maximum of five points. The five standards cover Governance, Safety, Adverse Childhood Experiences, and lastly, Learning and Partnership working.

Powys THB scored four out of five for each of the standards with the exception of identifying children at risk of Adverse Childhood Experiences where the organisation scored a three.

Learning
An action plan has been developed to improve the maturity of the Powys service in each of the five areas including the introduction of a formal process for quality assuring Multi-Agency Referral Forms (MARFs) and ensuring better use of the Child Sexual Exploitation Risk Questionnaire (CSERQ) process.

Changes to the National Clinical Audit Programme

The three Primary Care audits originally planned for this period, which were linked to the Quality Assurance & Improvement Framework, have been stood down by Welsh Government to free capacity during the Covid 19 epidemic.

Summary
The Directors and Service Leads have **no** requests for any changes to the 2020/21 Clinical Audit plan at this time.

The committee is therefore asked to note and approve the completion of the audits reported in this paper.

RECOMMENDATIONS:

The Experience, Quality and Safety Committee is asked to approve this paper.

Appendix A

Clinical Audit Plan 2020/21

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

Service Improvement required	Audit of prescription charts against BNF standards	March 2020	Clinical Director Mental Health and Learning Disabilities	
Changes to existing policy or practice	Mental Health Act Documentation	March 2020	Clinical Director Mental Health and Learning Disabilities	
Changes to existing policy or practice	ECGs undertaken on Older Adult Mental Health in-patient units	May 2020	Advanced Nurse Practitioner	
Serious Incident Learning	Care and Treatment Plan (CTP) audit	February 2020	Senior Manager, Adult Mental Health Montgomeryshire	
Service Improvement required	Tawe Ward CTP audit	January 2020	Ward Manager	
National Audit (Non-Programme)	Tawe Ward IPC audit	August 2020	Ward Manager	
Changes to existing policy or practice	Tawe Ward Prescription audit	January 2020	Ward Manager	
Service Improvement required	NICE Guideline Dementia Ystradgynlais Older Adult CMHT	January 2020	Community Mental Health Nurse	
Serious Incident Learning	Audit of the Joint Working Protocol between adult substance misuse services and adult mental health services.	January 2020	Service Manager - Adult Mental Health (North Powys)	

Dentistry				
Driver	Audit Title	Start Date	Lead	End Date
National Audit (Non-Programme)	WHTM01-05	April 2020	senior Dental Therapist	July 2020
National Audit (Non-Programme)	Patient Experience Questionnaire (CDS)	May 2020	Dentist	August 2020
National Audit (Non-Programme)	Patient Experience Questionnaire (Oral Surgery)	March 2020	Dental Nurse Oral Surgery Team Lead	June 2020
Service improvement required	Radiography grading	Continuous yearly run chart	Dental Director	Continuous yearly run chart
Service improvement required	Hand Hygiene	April 2020 and October 2020	Senior Dental Therapist	May 2020 and November 2020
Service improvement required	Clinical record keeping	November 2020	Dentist	March 2021
Service improvement required	Clinical record keeping (special care)	March 2020	Specialist in Special Care	March 2021

Medicines Management Team				
Driver	**Audit Title**	**Start Date**	**Lead**	**End Date**
▪ New Chief Pharmacist now in post. ▪ Support in place to enable the development of a half year clinical audit plan in place to be implemented from 1st October for the remaining 6 months. ▪ Quality Improvement to work with Chief Pharmacist and MMT to develop a QI plan which will identify key areas for improvement and Clinical Audit going forward.				
Primary Care				
Driver	**Audit Title**	**Start Date**	**Lead**	**End Date**
National Audit Programme	National Diabetes Core Audit	To be determined nationally	Remote audit of GP computer system	To be determined nationally
Service improvement required	Patient Safety Programme	September 2019	Prescribing lead within each practice	September 2020
Service improvement required	Reducing Stroke risk through improved management of AF in primary care clusters	September 2019	Lead GP	September 2020
Service improvement required	Multidisciplinary Antimicrobial Stewardship Urinary Tract Infection (UTI)	September 2019	Antibiotic lead	September 2020
Service improvement required	Diabetes Gateway	April 2020	Diabetes lead	December 2020
Women's and Children's Service				

Driver	Audit Title	Start Date	Lead	End Date
National Audit Programme	National Maternity and Perinatal Audit	To be determined nationally	Head of Midwifery	To be determined nationally
National Audit Programme	National Audit of Seizures and Epilepsies in Children and Young People	To be determined nationally	Consultant Community Paediatrician	To be determined nationally
Child Protection Quality Standards (UK)	Child Protection Medicals in Powys	TBC	Consultant Community Paediatrician	TBC
FOI request re FASD	Recording of Antenatal Alcohol Exposure on Adoption Medical Reports	TBC	Consultant Community Paediatrician	TBC
Therapies and Health Sciences Directorate				
Driver	**Audit Title**	**Start Date**	**Lead**	**End Date**
National Audit Programme	National Diabetes Foot Care Audit	To be determined nationally	Head of Podiatry	To be determined nationally
National Audit Programme	All Wales Audiology Audit	To be determined nationally	Head of Audiology	To be determined nationally
National Audit Programme	Stroke Audit (SSNAP)	Ongoing	Professional Head Physiotherapy	Ongoing
Service improvement required	OT Documentation	April 2020	Head of Therapies	September 2020

Service improvement required	Documentation audit	September 2020	Head of Podiatry	March 2021
Service improvement required	Taxonomy audit	December 2020	Head of Podiatry	March 2021
Service improvement required	NICE Audit Low Back Pain	December 2020	Clinical Specialist Physiotherapist	March 2021
Service improvement required	Clinical Notes audit - Pain and Fatigue service	November 2020	Clinical Specialist Physiotherapist	2021
Service improvement required	Parkinson's Care	2021	PD UK	2021
Service improvement required	SLT notes	2020 – 2 x yearly	Head Adult Speech & Language	2021
Audit for re-accreditation	Radiography: Non-medical referrers audit	September 2020	Team Lead/ Supt Radiographer	October 2020
Audit for re-accreditation	Compliance with Standard operating procedures (SOP's)	September 2020	Team Lead/ Supt Radiographer	October 2020
Audit for re-accreditation	Compliance with gonad protection standards	September 2020	Team Lead/ Supt Radiographer	October 2020
Audit for re-accreditation	Reject analysis	September 2020	Team Lead/ Supt Radiographer	October 2020
Audit for re-accreditation	Recording of date of last menstrual period	September 2020	Team Lead/ Supt Radiographer	October 2020
Audit for re-accreditation	Correct use of radiographic markers	September 2020	Team Lead/ Supt Radiographer	October 2020
Audit for re-accreditation	Radiographer commenting audit	September 2020	Team Lead / Supt Radiographer	October 2020
Service improvement required	Physiotherapy Notes	TBC	Professional Head Physiotherapy	March 2021

Service improvement required	CMATS- referral management	TBC	**DoTH Sponsor** Professional Head Physiotherapy	March 2021
Nursing Directorate				
Driver	**Audit Title**	**Start Date**	**Lead**	**End Date**
Serious Incident Learning	Falls Audit	Q3 2020	Assistant Director of Nursing	End Q4 2020
Service improvement required	Fundamentals of nursing care	Q4 2020	Assistant Director Quality & Safety	Q1 2021
Serious Incident Learning	Pressure Ulcer Prevention	Q3 2020	Assistant Director Quality & Safety	End Q4 2020
Serious Incident Learning	Compliance with the serious incident policy	Q4 2020	Assistant Director Quality & Safety	End Q4 2020
Safeguarding				
Driver	**Audit Title**	**Start Date**	**Lead**	**End Date**
Service improvement required	Safeguarding Maturity Matrix	July 2020	Assistant Director Safeguarding	September 2020
Service improvement required	Safeguarding Supervision Audit	December 2020	Senior Nurse Safeguarding	February 2021

Audit Driver Key:

	Driver
	Welsh Government National Audit Programme
	Other National Audits
	Audits performed for accreditation schemes
	Local Audits for service improvement
	Local Audits following change to policy or procedure
	Local Audits in response to a Serious Incident
	Other

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 3.8b

Experience, Quality and Safety Committee	**Date of Meeting: 3 December 2020**
Subject :	**Clinical Audit Improvement Plan**
Approved and Presented by:	Paul Buss, Medical Director
Prepared by:	Howard Cooper, Safety & Quality Improvement manager
Other Committees and meetings considered at:	Executive Committee

PURPOSE:

The purpose of this paper is to provide the Experience, Quality and Safety Committee with an update regarding progress against the Clinical Audit Improvement Plan

RECOMMENDATION(S):

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

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

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

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

	4. Dignified Care	✓
	5. Timely Care	✓
	6. Individual Care	✓
	7. Staff and Resources	✓
	8. Governance, Leadership & Accountability	✓

EXECUTIVE SUMMARY:

This paper is to provide an update on actions set out in the Clinical Audit Improvement Plan 2018-2020.

DETAILED BACKGROUND AND ASSESSMENT:

Background

Following the February 2018 rating of limited assurance given by the Internal Audit team in their review of Clinical Audit in Powys the then Medical Director, Dr Catherine Woodward, produced the Clinical Audit Improvement Plan 2018-20. This improvement plan was approved by the Executive Committee in July of 2018.

The improvement actions outlined in the plan fell into four main categories

- Support of staff to undertake clinical audit
- Strengthening of the governance framework around clinical audit
- Investigating the potential of electronic monitoring of clinical audit
- Strengthening the approach of clinical audit with respect to commissioned services

Support of staff to undertake clinical audit

Improvement actions have been completed at both the individual and service levels. Training in clinical audit has been provided to individuals and teams and resources place on the PTHB intranet for staff to draw on. The increased use of video conferencing during the Covid epidemic has proved beneficial in that it has facilitated short but more frequent discussions on quality issues amongst staff. The Director of Nursing and the Director of Therapies and Health sciences are also supporting staff by agreeing to directly sponsor one audit a year.

Status

Actions 1, 6, 7, 10, 11, 12, 13 and 19 are now complete. Narrative around the completion of these actions is given in Appendix A. No further actions remain for this section but it is requested that Executive Directors continue to encourage the frequent and regular discussion of quality issues amongst their teams.

Strengthening of the governance framework around clinical audit

Clinical Audit has been put on a more formal footing by the adoption of the annual Clinical Audit Programme as a Board level document. The initial programme and any subsequent changes are therefore reviewed and approved by the Experience Quality and Safety Committee. The initial Clinical Audit Programme for 2020-21 was received and approved by the Experience Quality and Safety Committee in June this year and

two subsequent update reports outlining progress against the plan, and lessons learned by the organisation, have been produced.

Status
Actions 2, 3, 8, 9 and 18 are now complete**.**

Remaining Actions:
Action 17. Clinical Audit to be reported as part of Directorate review process.
This action is currently suspended due to pressures resulting from the Covid epidemic.

Action 5. Integrate clinical audit into a wider programme of quality improvement and service development.
This is a wide and ongoing body of work whose ambitions are described in the Clinical Effectiveness and Quality Improvement Strategy that was presented recently at the Quality Governance Group.

Actions 4 and 16 Communication.
There has already been significant engagement by staff with clinical audit but as is the nature of communication there is always scope for more activity in future.

Investigating the potential of electronic monitoring of clinical audit
A number of options were investigated to evaluate the potential for the electronic monitoring of progress against the clinical audit programme. In England, the Audit Management and Tracking (AMaT) system is gaining increasing use. AMaT is a commercial software suite that is able to link into both NICE guidance databases and the host organisation email system to allow both the dissemination and receipt of audit material. It could also be used to support medicine management activities and Internal Audit tracking. Cwm Taf University Health Board is the only Welsh health organisation currently to run the system. Licencing costs for the system are around £25,000 per year and at Cwm Taf there is a Band 5 administrator dedicated to the support of the system.

Status
Action 20 is now completed. The Committee may wish to consider this system in future development plans.

Strengthening the approach of clinical audit with respect to commissioned services
Two actions, 14 and 15, in this section looked at strengthening the approach to clinical audit which occurs in our commissioned services. This is both in local services provided by the General Practitioner community and in out-of-county DGH based services.

Status
Arguably the most challenging part of the improvement plan work is underway in both these areas. The challenge is particularly acute with regard to utilising audit information for out of county providers as we lack the local clinical resource who would be able to fully interrogate the audit findings.

The Committee may wish to discuss how our approach to using the audit data from out of county providers could be strengthened.

A copy of the Clinical Audit Improvement Plan that sets out progress to date can be found at **Appendix A**.

RECOMMENDATIONS:

- It is requested that the Experience, Quality and Safety Committee approves the report.

PTHB Clinical Audit Programme

2020 / 21

Updated 23rd June 2020

REF	ACTIVITIES (BOLD ARE ON HIGH LEVEL PLAN)	RESPONSIBLE LEAD	Management Lead	Deadline	BRAG STATUS	Update
1	**Ensure identify the lead officer with responsibility for clinical audit and development of the programme and ensure that this is fully reflected in their job description**	Medical Director	Safety & Quality Improvement Manager	31-Mar-20		Confirmed that the Strategic lead is MD and it's in the MD portfolio. Confirm that the management lead is HC and it is in his JD
2	**Develop the Clinical Audit Programme Plan**	Assistant Director I&I	Assistant Director I&I	30-Apr-20		Agreed at QGG & EQ&S
3	**In line with the Clinical Quality Framework, agree the governance arrangements for the annual clinical audit cycle**	Assistant Director I&I	Assistant Director I&I	31-May-20		Dates and process agreed with Board Sec
4	**Following approval of the Clinical Audit Programme at QGG and EQ&S, launch the clinical audit programme through a targeted communication to all key staff**	Assistant Director I&I	Assistant Director I&I	30-Apr 21		Planning of formal launch underway
5	**Integrate clinical audit into a wider programme of quality improvement and service development;**	Assistant Director I&I	Assistant Director I&I	30-Jun-2020 Revised to 31-Jul-2021		Clinical Effectiveness and Quality Improvement Strategy drafted. Implementation plan

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

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

	Define/develop role of PTHB primary care in supporting national primary care clinical audits	Medical Director	Assistant Medical Director	30-Jun-21		
15	To review National Clinical Audits as they would apply to PTHB commissioned services where and support PTHB Commissioning Team in interpreting/addressing any actions required.	Assistant Director I&I	Safety & Quality Improvement Manager	30-Apr-21		This was undertaken for the current clinical audit plan and will be further developed for future plans
16	Raise the profile of the clinical audit programme (both national and local projects) in PTHB through a programme of communication and engagement with staff and service users.	Assistant Director I&I	Safety & Quality Improvement Manager	30-Apr-21		Linked to 4 above
17	Clinical audit activity to be consistently reported as part of Directorate review processes	Board Secretary		30-Jun-21		Review of performance against clinical audit is part of the Directorate Performance Review process. These were stood down during Covid19. There are plans to reinstated these.
18	Develop a SOP to support the PTHB response (including actions) to all national clinical audits, whether in PTHB provided or commissioned NHS services	Assistant Director I&I	Safety & Quality Improvement Manager	30-Jun-2020 revised to 31-Jul-2020		
19	To complete a clinical audit training needs	Assistant	Safety &	30-Jun-2020		

	assessment for PTHB staff and develop the training offer to meet these defined needs	Director I&I	Quality Improvement Manager	revised to 31-Aug-2020		
20	Explore QA Tracking for the electronic monitoring of clinical audit	Assistant Director I&I	Assistant Director I&I	30-Jun-2020 revised to 31-Aug-2020		

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

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

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 3.8c

Experience, Quality and Safety Committee	**Date of Meeting: 3 December 2020**
Subject :	**2021 – 2022 Clinical Audit Programme**
Approved and Presented by:	Paul Buss Medical Director
Prepared by:	Amanda Edwards Assistant Director Innovation & Improvement
Other Committees and meetings considered at:	Executive Committee

PURPOSE:

The purpose of this paper is to seek approval for the proposed 2021-2022 Clinical Audit Programme.

RECOMMENDATION(S):

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

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

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

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

	5. Timely Care	✓
	6. Individual Care	✓
	7. Staff and Resources	✓
	8. Governance, Leadership & Accountability	✓

EXECUTIVE SUMMARY:

The paper presents the PTHB clinical audit programme for 2021-2022. It is proposed that there should be three tiers of locally undertaken clinical audits, plus a fourth tier which looks at the results achieved by out of county healthcare providers in National Clinical Audits.

Tier 1 will be the National Clinical Audits and Outcome Reviews as mandated by Welsh Government, Tier 2 will be Organisational Audits selected by senior clinical staff within the Health Board and designed to support the organisational ambitions of the Health Board to provide safe, effective and timely care. Tier 3 will be Individual Audits which are performed by members of staff wishing to undertake a local quality improvement project using clinical audit methodology.

In addition to the three tiers of audit on Powys-based activity, Tier 4 will look at audits undertaken by external Health Boards and Trusts whose services are commissioned by Powys THB. This work on commissioned services will be taken forward as a separate workstream.

DETAILED BACKGROUND AND ASSESSMENT:

Background

Clinical audit is the review of the care that is provided to our patients and clients. The care is benchmarked against a previously agreed set of standards and improvement actions planned should the care provided fall short of those standards.

For 2021-2022 Clinical Audits that are undertaken within Powys will fall into three tiers.

Tier 1
Tier 1 will be those National Clinical Audits and Outcome Reviews that are mandated by Welsh Government and which are based on the programme developed by the Healthcare Quality Improvement Partnership, a Department of Health funded, but independent body, managed by the UK Medical and Nursing Royal Colleges.

Tier 2.
Tier 2 will be clinical audits put forward by the senior clinical managers who represent all of the services delivered in Powys. These audits will have been identified as those whose completion is of the greatest importance. The audits will have been selected on the basis that they are responding to Serious Incidents, risks or an identified need for service improvement. The programme will be added to, with the consent of the Committee, as and when further priorities are identified during the year.

Tier 3.
Tier 3 will be audits that are of lesser importance to the mainstream issues facing the organisation but are none the less valuable, as they give staff experience in using audit methodology as well as encouraging a culture of continuous improvement. By continuing to promote the participation of staff in grass roots audits we encourage the development of services that are already good to be taken to a level of excellent.

Tier 4.
Work is currently underway around the processes for studying the performance of commissioned, out of county, healthcare providers who partake in the National Clinical Audit and Outcome Review programme. This work will be the subject of a future paper.

This paper outlines those audits currently identified for Tier 2 and Tier 3 of the audit programme. Tier 1 audits will be added after the National Clinical Audit and Outcome Review programme is ratified by Welsh Government in April 2021.

A copy of the Clinical Audit Programme Plan can be found at **Appendix A**.

RECOMMENDATIONS:

- The Experience, Quality and Safety Committee considers and approves the submission of the Programme.

Appendix A

Draft Clinical Audit Plan 2021/22

Primary, Community & Mental Health Care Services				
Community Nursing				
Driver	**Audit Title**	**Start Date**	**Lead**	**End Date**
Tier 2 – Identified risk	Completion of Admission Assessment Documents (re-audit of 2021 audit)	Quarter 2 2021	*Emma McGowan*	Quarter 4 2021
Tier 2 – Identified risk	Patient Identification Audit	Rolling Monthly audit	*Senior Nursing Staff*	Rolling Monthly audit
Tier 2 – Identified risk	Completion of DNACPR audit	Rolling Monthly audit	*Senior Nursing Staff*	Rolling Monthly audit
Tier 2 – Identified risk	Completion of NEWS chart audit	Rolling Monthly audit	*Senior Nursing Staff*	Rolling Monthly audit
Tier 2 – Identified risk	Observation of Hand Hygiene Practice audit	Rolling Monthly audit	*Senior Nursing Staff*	Rolling Monthly audit
Tier 2 – Identified risk	Compliance with the use of Personal Protective Equipment (PPE) audit	Rolling Monthly audit	*Senior Nursing Staff*	Rolling Monthly audit
Mental Health				
Driver	**Audit Title**	**Start Date**	**Lead**	**End Date**

	Mental Health audits to be added at a later date after the completion of the 2020-21 programme			
Dentistry				
Driver	**Audit Title**	**Start Date**	**Lead**	**End Date**
Tier 2- Audit for accreditation scheme	WHTM01-05 (equipment decontamination) audit	*Quarter 3 2021*	Dental staff	*Quarter 3 2021*
Medicines Management Team				
Driver	**Audit Title**	**Start Date**	**Lead**	**End Date**
Tier 2 – Identified risk	Safe Storage of medicines audit	*Quarter 3 2021*	*Medicines Management Staff*	*Quarter 4 2021*
Tier 2 Service Improvement	Audit of authorisation process for staff to use Patient Group Directions	*Quarter 3 2021*	*Medicines Management Staff*	*Quarter 4 2021*
Tier 2 Service Improvement	Record keeping regarding the use of Patient Group Directions	*Quarter 3 2021*	*Medicines Management Staff*	*Quarter 4 2021*
Tier 2 Service Improvement	Use of Patient Group Directions across the health Board	*Quarter 3 2021*	*Medicines Management Staff*	*Quarter 4 2021*
Tier 2 – Identified risk	Audit of the use of Standard Operating Procedures with regards to Controlled Drugs	*Quarter 3 2021*	*Medicines Management Staff*	*Quarter 4 2021*

Tier 2 – Identified risk	Controlled Drugs Register Audit	*Quarter 3 2021*	*Medicines Management Staff*	*Quarter 4 2021*
Primary Care				
Driver	**Audit Title**	**Start Date**	**Lead**	**End Date**
	Primary Care Audits are currently suspended due to the Covid 19 epidemic and will be re-instated at the direction of Welsh Government.			
Women's and Children's Service				
Driver	**Audit Title**	**Start Date**	**Lead**	**End Date**
Tier 2 – Local Audit following change of policy/process	Using TOMS to measure virtual therapy practices	*Quarter 1 2021*	Head of Children's SLT service	*Quarter 3 2021*
Tier 2 - Audits in response to a Serious Incident	CYSUR Action Plan (5) and (6)	*Quarter 1 2021*	Assistant Head of Children's Public Health Nursing - Health Visiting and School Nursing & Assistant Head of Midwifery & Sexual Health Services	*Quarter 3 2021*
Tier 3 – Local Audit for service evaluation	Evaluation of Midwife & Health Visitor Led Contraception pilot.	*Quarter 1 2021*	Sexual Health Clinical Lead	*Quarter 3 2021*
Tier 3 – Local Audit for service evaluation	Evaluate management of referrals to Sexual Health Services via All Wales Test & Post platform	*Quarter 1 2021*	Sexual Health Clinical Lead	*Quarter 3 2021*
Tier 3- Audit suggested by FOI request	Recording of Antenatal Alcohol Exposure on Adoption Medical Reports	*Quarter 1 2021*	Consultant Community Paediatrician	*Quarter 3 2021*
Therapies and Health Sciences				

Driver	Audit Title	Start Date	Lead	End Date
Tier 2 Service Improvement	Notes Audit (re-audit of 2020 audit)	*Quarter 3 2021*	Occupational Therapy staff	*Quarter 3 2021*
Tier 2 Service Improvement	Notes Audit	*Quarter 3 2021*	Podiatry staff	*Quarter 3 2021*
Tier 2 Service Improvement	Notes Audit (re-audit of 2020 audit)	*Quarter 3 2021*	Physiotherapy staff	*Quarter 3 2021*
Tier 2 Service Improvement	Notes Audit	*Quarter 3 2021*	Speech and Language staff	*Quarter 3 2021*
Tier 2 Service Improvement	CMATS Osteo arthritis Knee Audit based on NICE guidance.	*Quarter 3 2021*	Physiotherapy staff	*Quarter 4 2021*
Tier 2 Service Improvement	Taxonomy Audit	*Quarter 3 2021*	Podiatry staff	*Quarter 4 2021*
Tier 2- Audit for accreditation scheme	Non-medical referrers audit	*Quarter 3 2021*	Radiography staff	*Quarter 3 2021*
Tier 2- Audit for accreditation scheme	Compliance with Standard operating procedures	*Quarter 3 2021*	Radiography staff	*Quarter 3 2021*
Tier 2- Audit for accreditation scheme	Compliance with gonad protection standards	*Quarter 3 2021*	Radiography staff	*Quarter 3 2021*
Tier 2- Audit for accreditation scheme	Reject analysis	*Quarter 3 2021*	Radiography staff	*Quarter 3 2021*
Tier 2- Audit for accreditation scheme	Recording of date of last menstrual period	*Quarter 3 2021*	Radiography staff	*Quarter 3 2021*
Tier 2- Audit for accreditation scheme	Correct use of radiographic markers	*Quarter 3 2021*	Radiography staff	*Quarter 3 2021*
Tier 2- Audit for accreditation scheme	Radiographer commenting audit	*Quarter 3 2021*	Radiography staff	*Quarter 3 2021*
Tier 2 Service Improvement	Number and appropriateness of referrals received into department	*Quarter 3 2021*	Audiology staff	*Quarter 4 2021*

Tier 2 – Identified risk	Waiting times/compliance with targets	*Quarter 3 2021*	Audiology staff	*Quarter 4 2021*
Tier 2 Service Improvement	Outcome measures for hearing aid users	*Quarter 3 2021*	Audiology staff	*Quarter 4 2021*
Tier 2 – Identified risk	Daily calibration checks on equipment	*Quarter 3 2021*	Audiology staff	*Quarter 4 2021*
Tier 2 Service Improvement	Spasticity against National Standards	*Quarter 3 2021*	Physiotherapy staff	*Quarter 4 2021*
Tier 2 Service Improvement	Number of hearing aids lost by patients	*Quarter 3 2021*	Audiology staff	*Quarter 4 2021*
Tier 3 – Local Audit following change of policy/process	Number of tinnitus referrals into Audiology versus into ENT.	*Quarter 3 2021*	Audiology staff	*Quarter 4 2021*

Nursing Directorate				
Driver	**Audit Title**	**Start Date**	**Lead**	**End Date**
	Corporate audits to be added at a later date after the completion of the 2020-21 programme			

Safeguarding				
Driver	**Audit Title**	**Start Date**	**Lead**	**End Date**
Tier 2 Service Improvement	Safeguarding Maturity Matrix audit	*Quarter 3 2021*	Head of Safeguarding	*Quarter 3 2021*
Tier 2 Service Improvement	Safeguarding Supervision audit	*Quarter 4 2021*	Head of Safeguarding	*Quarter 4 2021*

Audit Driver Key:

	Driver
	Welsh Government National Audit Programme
	Other National Audits
	Audits performed for accreditation schemes
	Local Audits for service improvement
	Local Audits following change to policy or procedure
	Local Audits in response to a Serious Incident/Identified Risk
	Service Evaluation
	Other

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 3.9

Experience, Quality & Safety Committee	**3 December 2020**
Subject :	**Annual Data Quality Report 2019/20**
Approved and Presented by:	Director of Finance, IT and Informatics
Prepared by:	Head of Information
Other Committees and meetings considered at:	Quality Governance Group

PURPOSE:
The purpose of this paper is to present the findings from the Annual Data Quality Report 2019/20.
RECOMMENDATION(S):
The Committee is asked to accept the report which will be published nationally.

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

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

EXECUTIVE SUMMARY:

The Annual Data Quality report (**Appendix A**) describes the achievements made during 2019/2020 by the Information Department against the national targets for data quality and submission to NHS Wales Informatics Service (NWIS) for statutory reporting of mandated datasets.

The report looks at compliance and accuracy of clinical coding, along with additional work that has taken place during the financial year, to improve data quality in other areas within the gift of the Information Department.

The specification of the report has been agreed nationally by the Information Quality Improvement Initiative (IQII).

DETAILED BACKGROUND AND ASSESSMENT:

Performance Monitoring

NWIS provide all Health Boards with the tools to monitor their data validity and consistency for mandated datasets. Standards are set for key data items and the expectation is that these standards will be met. Performance within Powys is categorised as 'good' and if a standard is not met there is understanding and plans nationally and locally, to ensure the issues are rectified. Non-compliance affects two areas.

- Treatment Function Codes - National
- Changes to coding for Opticians and local GP look up codes – Local

Key Highlights

- **Clinical Coding**
  Powys THB have exceeded the national target of 95% coded within one month maintaining 100% compliance for the full twelve months. The national audit result for accuracy has seen an increase in our achievement of 2.15% from 2018/19 to 2019/20. The all Wales target is 90% with PTHB achieving 95.9%

- **Intelligent Tracking**
  Intelligent Tracking is well established within PTHB with Podiatry and Dietetic Services outstanding.

- **WCCIS**
  The development of data quality reports for information captured has allowed targeted improvement areas with Health Care Professionals to ensure correct procedures for data capture are used.

- **WPAS**
  PTHB have been instrumental in driving changes to the capture of data within Welsh Patient Administrative System (WPAS) for maternity services. Data that was sourced from three systems are now held within WPAS allowing for improved data quality and the decommissioning of a legacy system that was historically manually populated within the Finance Department.

NEXT STEPS:

Improving data quality is a high priority within Powys THB and we aim to raise the profile throughout the organisation and establish a forum to formulate Service Improvement plans.

Information leads continue to engage with the national Data Set Change Notification Group (DSCN), IQII group and the Welsh Informatics Service Board (WISB) to ensure changes to standards are processed in line with best practice and PTHB are able to influence and understand the change.

Additional outcomes introduced:

- Recording of virtual activity e.g. Video Consultations
- Cardiac Waiting Times

- Bed management, developing a patient flow dashboard for bed management at ward level for ward staff and managers
- Welsh Nursing Care Record (WNCR),
- SCP submission
- Moving to real-time recording of WPAS data. Following new data requirements for reporting of activity due to the pandemic monthly reports have changed to weekly and therefore require more timely updating from an operational perspective
- Responsive to the ongoing requirements to capture data in relation to Covid 19
- Social distancing has meant new and sustainable ways of delivering training, and this is now delivered via MS Teams.

Powys Teaching Health Board

2019/20 Annual Data Quality Report

Final

Author: Head of Information

Introduction

The Annual Data Quality report describes the achievements made by the Information Department against the national targets for data quality submission to NHS Wales Informatics Service for statutory reporting of Admitted Patient Care, Emergency Department, Outpatient Activity and Outpatient Referral datasets. The report looks at compliance and accuracy of clinical coding along with additional work that has taken place during 2019/20 to improve data quality in other areas that are in the gift of the Information Department. This is in line with the requirements of the ministerial letter (EH/ML/007/08) which mandated that all NHS Trusts and Health Boards provide an annual data quality report to the board.

The specification of this report has been agreed by the Information Quality Improvement Initiative (IQII) group. This group was formed following the release of WHC (2015) 027. This is a national programme charged with driving through improvements in data quality and to aid the development and publication of policies and programmes that will help raise the profile of data quality and better inform all staff who have a role in its improvement.

Governance

The Experience Quality and Safety Committee extends to the full range of the Health Board's 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 role of the Committee is to provide accurate, evidence based (where possible) and timely advice to the Board and its committees in respect of the development of the following matters, consistent with the Board's overall strategic direction.

- Population health and wellbeing;
- Citizen experience
- Quality and Safety of directly provided and commissioned services;
- Staff Wellbeing and Experience; and
- Health and Safety

The Experience Quality and Safety Committee seek assurance on the effectiveness of processes and systems to safeguard information and associated governance arrangements.

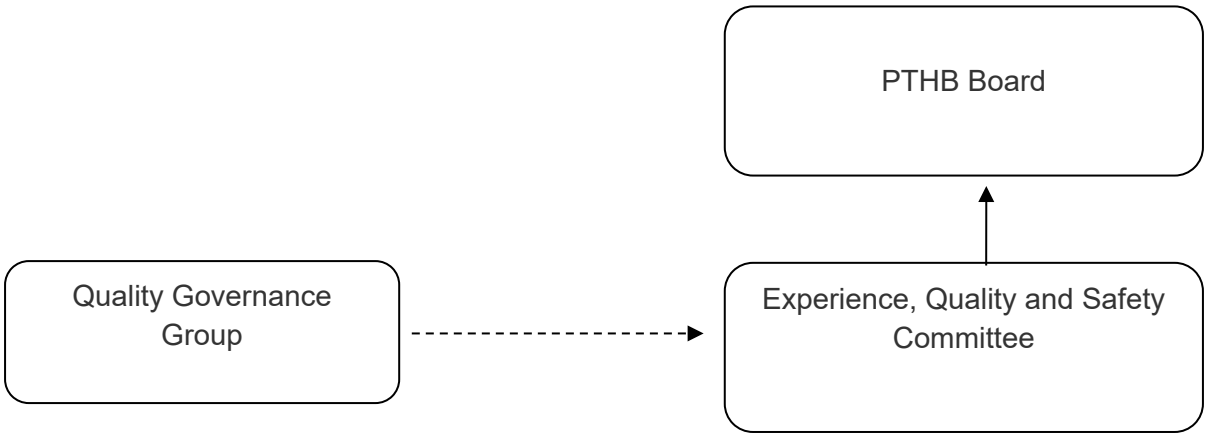
Advice is provided to the Board in relation to the strategic direction of partner organisations including the all Wales Informatics Service (NWIS).

Assurance is provided to the Board for any relevant requirements and standards determined for the NHS in Wales.

As per Powys Teaching Health Board's (PTHB) Scheme of Reservation and Delegation approved by the Board, delegates responsibility for Data Quality to the Director of Finance, Information Technology (IT) and Informatics.

As part of the governance structure the Annual Data Quality report is presented to the Quality Governance Group by the Director of Finance, IT and Informatics for acceptance before submission to the Experience, Quality and Safety Committee.

Information Governance Organisational Chart



Performance and Monitoring

Data quality standards exist to ensure that nationally submitted data is monitored and improved so it can be used for secondary uses. The following data quality standards are mandated within NHS Wales.

Standards Applicable to Powys THB

- Admitted Patient Care (APC) Data Validity Standards
- Admitted Patient Care (APC) Data Consistency Standards
- Outpatient Activity Data Validity Standards
- Outpatient Activity Data Consistency Standards
- Outpatient Referral (OPR) Data Validity Standards
- Emergency Department Data Set (EDDS) Data Validity Standards
- Emergency Department Data Set (EDDS) Data Consistency Standards

Standards Not Applicable to Powys THB

- Critical Care Data Validity Standards
- Critical Care Data Consistency Standards

The tables below indicate Powys THBs annual achievements for the last three financial years against those compared to the rest of Wales. Within the tables, ticks indicate the target has been met and where the target has not been met, the actual performance is indicated.

The term 'data validity' refers to whether the submitted data has been provided in the agreed format and, where applicable, whether it is populated with a nationally-agreed value.

The term 'data consistency' refers to whether related data items within the same data set are consistent with one another. For example, a record that

indicates a male patient has given birth should be considered inconsistent and would require investigation.

There are two main areas of concern that are affecting Powys THBs ability to meet both the data validity and data consistency targets.

- Treatment Function Codes
- Changes required for local look up codes for GP and Opticians

Treatment Function Codes

Treatment Function is the specialty under which the patient has been treated and there has been long-standing confusion surrounding the definitions and use of specialty codes.

As part of an ongoing programme to review and update definitions and codes associated with specialties a Data Set Change Notification [DSCN 2014/08 (AMD)] has been issued stating that all Health Boards must have implemented the new Treatment Function Codes by 31 March 2017. The Information Department has worked closely with the NHS Wales Informatics Service (NWIS) National Welsh Patient Administration System (WPAS) team to ensure that the codes required for Powys THB have been verified and checked. Unfortunately, due to a number of pressures experienced by the National WPAS team they have been unable to update the reference tables within the Powys THB's deployment of WPAS. It is estimated by the national WPAS team that this may take 18 months to complete for the whole of Wales unfortunately due to other pressures there is no planned date and it does not feature on their IMTP. As this work has been delayed the Information Department would need to undertake a re-evaluation of its codes should the national team be in a position to re-instate this work.

The data items that are affected by the omission of the revised treatment function codes are

- Main Specialty (consultant)
- Specialty of Treatment
- Treatment Function Code

Changes to coding of Opticians and local GP look up codes

The Information team are working closely with the National WPAS team to resolve local issues over the recording of opticians to ensure that the Patient Administration System can capture and identify the Health Care Professional rather than a dummy code being used. Work is also ongoing to update local reference data to align with national reference codes for current GP Practitioners, unfortunately due to other pressures within the Information team this work has not been prioritised. However, it is having minimal impact on the overall data quality of national return.

The data items that are affected by the issues shown above are

- Consultant code
- Referrer code
- Referrer Code vs Source of Referral: Outpatients

The following tables show the comparison of 2017/18, 2018/19 and 2019/20 against the All Wales achievement of national targets.

Admitted Patient Care (APC) data Validity

Data Item	Data Validity Standard	All Welsh Providers			Powys Teaching LHB		
		2017/18	2018/19	2019/20	2017/18	2018/19	2019/20
APC submission received by the 17th	-	-	-	-	✓	✓	✓
Number of Records Loaded	-	1136169	1173980	1165417	4781	4813	4830
Administrative Category	98%	✓	✓	✓	✓	✓	✓
Admission Date	98%	✓	✓	✓	✓	✓	✓
Admission Method	98%	✓	✓	✓	✓	✓	✓
Consultant Code	98%	96.30%	96.0%	96.4%	92.40%	88.1%	79.4%
Date of Birth	98%	✓	✓	✓	✓	✓	✓
Decision to Admit Date	98%	✓	✓	✓	✓	✓	✓
Discharge Date	98%	✓	✓	✓	✓	✓	✓
Discharge Destination	98%	✓	✓	✓	✓	✓	97.3%
Discharge Method	98%	✓	✓	✓	✓	✓	✓
Episode Start Date	98%	✓	✓	✓	✓	✓	✓
Ethnic Group	98%	✓		✓	✓	✓	✓
HRG Code	95%	✓	✓		✓	✓	
Intended Management	98%	✓	✓	✓	✓	✓	✓
Last Episode in Spell Indicator	98%	✓	✓	✓	✓	✓	✓
Legal Status	98%	✓	✓	✓	✓	✓	✓
Local Health Board of Residence	95%	✓	✓	✓	✓		✓
Main Specialty (consultant)	98%	✓	✓	✓	66.00%	72.6%	76.1%

NHS Number	95%	✓	✓	✓	✓	✓	✓
NHS Number Status Indicator	95%	✓	✓	✓	✓	✓	✓
NHS Number Valid & Traced	95%	✓	✓	✓	✓	✓	✓
Patient Classification	95%	✓	✓	✓	✓	✓	✓
Postcode	98%	✓	✓	✓	✓	✓	✓
Principal Diagnosis	95%	94.40%	✓	94.1%	✓	✓	✓
Principal Procedure Code	95%	✓	✓	✓	✓	✓	✓
Principal Procedure Date	95%	✓	✓	✓	✓	✓	✓
Referrer Code	98%	✓	✓	93.1%	96.50%	97.2%	97.0%
Registered GP Practice Code	98%	✓	✓	✓	✓	✓	✓
Sex	98%	✓	✓	✓	✓	✓	✓
Site Code (of Treatment)	98%	✓	✓	✓	✓	✓	✓
Source of Admission	98%	✓	✓	✓	✓	✓	✓
Specialty of Treatment Code	98%	✓	✓	✓	73.60%	73.8%	75.1%
Waiting List Date	98%			✓			✓

Admitted Patient Care Data Consistency

Data Item	Data consistency Standard	All Welsh Providers			Powys Teaching LHB		
		2017/18	2018/19	2019/20	2017/18	2018/19	2019/20
Admission Date vs. Date of Birth	98%	✓	✓	✓	✓	✓	✓
Admission Method vs. Intended Management	98%	✓	✓	✓	✓	✓	✓
Admission Method vs. Patient Classification	95%	✓	✓	✓	✓	✓	✓
Admission Method vs. Source of Admission *	98%	✓	✓	✓	✓	✓	✓
Decision to Admit Date vs. Admission Date	98%	n/a	✓	✓	n/a	✓	✓
Decision to Admit Date vs. Waiting List Date	98%	n/a	84.4%	83.3%	n/a	✓	✓
Discharge Method vs. Discharge Date & Date of Birth [i.e. Age] *	98%	n/a	n/a	n/a	n/a	n/a	n/a
Discharge Method vs. Discharge Destination *	98%	✓	✓	✓	✓	✓	✓
Discharge Method vs. Specialty (of Treatment)	98%	86.20%	85.0%	83.7%	n/a	n/a	✓
Episode End Date vs. Admission Date	98%	✓	✓	✓	✓	✓	✓
Episode End Date vs. Discharge Date	98%	✓	✓	✓	✓	✓	✓
Episode End Date vs. Date of Birth	98%	✓	✓	✓	✓	✓	✓
Episode End Date vs. Episode Start Date	98%	✓	✓	✓	✓	✓	✓
Episode Start Date vs. Admission Date	98%	✓	✓	✓	✓	✓	✓
Episode Start Date vs. Discharge Date	98%	✓	✓	✓	✓	✓	✓

Episode Start Date vs. Date of Birth	98%	✓	✓	✓	✓	✓	✓
HRG Code vs. Sex	95%	n/a	n/a	n/a	n/a	n/a	n/a
Last Episode in Spell vs. Episode End Date & Discharge Date	98%	✓	✓	✓	✓	✓	✓
Legal Status vs. Specialty (of Treatment)***	98%	85.70%	✓	✓	✓	✓	✓
Patient Classification vs. Discharge Date & Admission Date [i.e. Length of Stay]	95%	✓	✓	✓	✓	✓	✓
Postcode vs. Local Health Board of Residence	95%	✓	✓	✓	✓	✓	✓
Primary Diagnosis Code vs. Admission Date & Birth Date [i.e. Age]	95%	✓	93.1%	✓	n/a	n/a	n/a
Primary Diagnosis Code vs. Sex	95%	✓	✓	✓	✓	✓	✓
Primary Procedure Code vs. Sex	95%	✓	✓	✓	✓	✓	✓
Primary Procedure Date vs. Episode Start Date & Episode End Date	95%	✓	✓	✓	✓	✓	✓
Referrer Code vs. Referring Organisation Code	98%	✓	✓	✓	✓	✓	✓
Specialty (of Treatment) vs. Sex*	98%	n/a	✓	✓	n/a	✓	✓
Waiting List Date vs. Admission Date	98%	n/a	✓	✓	n/a	✓	✓
Waiting List Date vs. Admission Method	98%	n/a	✓	✓	n/a	✓	✓

Outpatient Data Validity Report

Data Item	Data Validity Standard	All Welsh Providers			Powys Teaching LHB		
		2016/17	2017/18	2018/19	2016/17	2017/18	2018/19
OP submission received by the 20th	-	-	-	-	✓	✓	✓
Number of Records Loaded	-	4124629	3951988	4103621	48276	53309	51111
Administrative Category	98%	✓	✓	✓	✓	✓	✓
Attended or Did Not Attend	98%	✓	✓	✓	✓	✓	✓
Attendance Category	98%	✓	✓	✓	✓	✓	✓
Clinical Referral Date	98%	✓	✓	✓	✓	✓	✓
Code of Registered GP Practice	98%	✓	✓	✓	✓	✓	✓
Consultant Code	98%	90.40%	90.70%	91.0%	93.70%	93.40%	94.1%
Date of Birth	98%	✓	✓	✓	✓	✓	✓
Date of Patient Referral	98%	97.90%	✓	✓	✓	✓	✓
Location Type Code	98%	✓	✓	✓	✓	✓	✓
Main Specialty (Consultant)	95%	✓	✓	✓	92.00%	93.10%	92.4%
Medical Staff Type Seeing Patient	98%	✓	✓	✓	✓	✓	✓

NHS Number	98%	✓	✓	✓	✓	✓	✓
NHS Number Status Indicator	95%	✓	✓	✓	✓	✓	✓
NHS Number Valid & Traced	95%	✓	✓	✓	✓	✓	✓
Organisation Code (LHB Area of Residence)	95%	✓	✓	✓	✓	✓	✓
Outcome of Attendance	95%	✓	✓	✓	✓	✓	✓
Postcode of Usual Address††	98%	✓	✓	✓	✓	✓	✓
Primary Procedure Code†	98%	✓	✓	✓	✓	✓	✓
Priority Type (New Patients)	95%	✓	✓	✓	✓	✓	✓
Referrer Code	98%	96.10%	96.00%	96.0%	96.80%	97.00%	96.4%
Referring Organisation Code	98%	94.80%	97.60%	✓	✓	✓	✓
Sex	98%	✓	✓	✓	✓	✓	✓
Site Code (of Treatment)	98%	✓	✓	✓	✓	✓	✓
Source of Referral: Outpatients	98%	✓	✓	✓	✓	✓	✓
Treatment Function Code	98%	96.20%	✓	✓	94.30%	95.90%	95.7%

Latest available data

Outpatient Data Consistency Report

Data Item	Data Consistency Standard	All Welsh Providers			Powys Teaching LHB		
		2016/17	2017/18	2018/19	2016/18	2017/19	2018/19
Number of Records Loaded	-	4124629	3951988	4103621	48276	53309	51111
Clinical Referral Date vs Attendance Date	98%	✓	✓	✓	✓	✓	✓
Date of Birth vs Attendance Date	98%	✓	✓	✓	✓	✓	✓
Date Of Patient Referral vs Attendance Date	98%	✓	✓	✓	✓	✓	✓
Date of Birth vs Clinical Referral Date	98%	✓	✓	✓	✓	✓	✓
Date of Patient Referral vs Clinical Referral Date	98%	✓	✓	✓	✓	✓	✓
Date of Birth vs Date of Patient Referral	98%	✓	✓	✓	✓	✓	✓
Attendance Category vs Priority Type (New Patients)	98%	✓	✓	✓	✓	✓	✓

Location Type Code vs Site Code (of Treatment)	98%	✓	✓	✓	✓	✓	✓
Postcode of Usual Address vs Organisation Code (LHB Area of Residence)	95%	✓	✓	✓	✓	✓	✓
Primary Procedure Code (OPCS) vs Sex	95%	✓	✓	✓	✓	✓	✓
Referrer Code vs Referring Organisation Code	98%	✓	✓	✓	✓	✓	✓
Referrer Code vs Source of Referral: Outpatients	98%	93.50%	94.10%	94.6%	94.70%	94.20%	96.4%
Source of Referral: Outpatients vs Referring Organisation Code	98%	97.40%	97.80%	96.6%	✓	✓	✓

Latest available data

Outpatient Referral (OPR) Data Validity Report

Data Item	Data Validity Standard	All Welsh Providers			Powys LHB		
		2017/18	2018/19	2019/20	2017/18	2018/19	2019/20
OPR submission received by the 14th	-	-	-	-	✓	✓	✓
Number of Records Loaded	-	1283713	1356413	1340320	21293	21590	23408
Administrative Category	98%	✓	✓	✓	✓	✓	✓
Date of Birth	98%	✓	✓	✓	✓	✓	✓
Date of Patient Referral	98%	✓	✓	✓	✓	✓	✓
GP Practice Code	98%	✓	✓	✓	✓	✓	✓
Local Health Board of Residence	95%	✓	✓	✓	✓	✓	✓
Main Specialty (consultant)	98%	✓	✓	✓	97	96.4	96.3

NHS Number	95%	✓	✓	✓	✓	✓	✓
NHS Number Status Indicator	95%	✓	✓	✓	✓	✓	✓
NHS Number Valid & Traced	95%	✓	✓	✓	✓	✓	✓
Postcode of Usual Address†	98%	✓	✓	✓	✓	✓	✓
Referrer Code	98%	91.6	93.1	88.8	96.7	94.9	87.9
Referring Organisation Code	98%	97.4	97.9	✓	93.1	95.2	91.4
Referrer Priority Type	98%	✓	✓	✓	✓	✓	✓
Sex	98%	✓	✓	✓	✓	✓	✓
Source of Referral: Outpatients	98%	✓	✓	✓	✓	✓	✓

Emergency Department Data Set (EDDS) Data Consistency Report

Data Item	Data Validity Standard	All Wales			Breconshire War Memorial Hospital			Llandrindod Wells Hospital			Victoria Memorial Hospital			Ystradgynlais Community Hospital		
		17/18	18/19	19/20	17/18	18/19	19/20	17/18	18/19	19/20	17/18	18/19	19/20	17/18	18/19	19/20
Number of Records Loaded		216132	217582	210263	9213	9260	9062	7690	7788	7138	5512	5795	5305	2716	2532	2351
Treatment End Date vs. Treatment End Time	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Administrative Arrival Date/Time vs. Administrative End Date/Time	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Treatment End Date/Time vs. Administrative End Date/Time	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Administrative Arrival Date/Time vs. Treatment End Date/Time	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Attendance Group vs. Outcome of Attendance	98%	✓	0.0	0.0	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	0.0	n/a	n/a	n/a
Birth Date vs. Admin Arrival Date	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Birth Date vs. Admin End Date	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Birth Date vs. Health Event Date	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Birth Date vs. Treatment End Date	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Health Event Date/Time vs. Administrative Arrival Date/Time	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Health Event Date/Time vs. Administrative End Date/Time	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Health Event Date/Time vs. Treatment End Date/Time	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Activity at Time of Injury vs. Road User	98%	81.4	81.1	79.9	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Activity at Time of Injury vs. Sports Activity	98%	81.2	✓	84.9	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Attendance Group vs. Activity at Time of Injury	98%	✓	✓	✓	✓	96.7	96.0	✓	97.7	97.7	✓	✓	✓	✓	✓	✓
Attendance Group vs. Injury Location Type	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Attendance Group vs. Mechanism of Injury	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Attendance Group vs. Road User	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Attendance Group vs. Sport Activity	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Arrival Mode vs. Ambulance Incident Number	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Attendance Category vs. Alcohol Indicator	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Attendance Category vs. Appropriateness of Attendance	98%	✓	✓	✓	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Attendance Category vs. Arrival Mode	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Attendance Category vs. Triage Category	98%	81.5	84.3	91.0	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Postcode vs. Organisation Code (LHB of Residence)*	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Referrer Code vs. Referring Organisation Code	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Emergency Department Data Set (EDDS) Data Validity Report

Data Item	Data Validity Standard	All Wales			Breconshire War Memorial Hospital			Llandrindod Wells Hospital			Victoria Memorial Hospital			Ystradgynlais Community Hospital		
		17/18	18/19	19/20	17/18	18/19	19/20	17/18	18/19	19/20	17/18	18/19	19/20	17/18	18/19	19/20

EDDS submission received by the 10th	-	-	-	-	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Activity at Time of Injury	98%	✓	✓	✓	✓	✓	97.1	✓	✓	96.8	✓	✓	95.2	✓	✓	95.2
Alcohol Indicator	98%	✓	✓	96.9	✓	✓	95.0	✓	✓	94.7	✓	✓	94.4	✓	✓	94.6
Appropriateness of Attendance	98%	84	84.0	81.8	0	0.0	0.0	0	0.0	0.0	0	0.0	0.0	0	0.0	0.0
Arrival Mode	98%	✓	✓	✓	✓	✓	96.5	✓	✓	95.6	✓	✓	95.6	✓	✓	95.5
Attendance Category	98%	✓	✓	96.9	✓	✓	95.0	✓	✓	94.7	✓	✓	94.4	✓	✓	94.6
Attendance Group	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Birth Date	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Ethnic Group	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
GP Practice Code	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Health Event Date	98%	78	78.9	79.2	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Health Event Time	98%	60	59.1	59.6	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Injury Location Type	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mechanism of Injury	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
NHS Number	95%	95	94.0	93.7	✓	✓	✓	✓	✓	✓	✓	✓	94.8	✓	✓	✓
NHS Number Status Indicator	95%	✓	✓	✓	✓	✓	✓	✓	✓	94.7	✓	✓	94.4	✓	✓	94.6
NHS Number Valid & Traced	95%	94	92.8	87.8	✓	✓	84.2	✓	✓	84.9	✓	✓	79.7	✓	✓	78.7
Organisation Code (Local Health Board of Residence)	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Outcome of Attendance	98%	✓	✓	96.9	✓	✓	95.0	✓	✓	94.7	✓	✓	94.4	✓	✓	94.6
Postcode of Usual Address†	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Referrer Code	98%	97	95.1	93.4	✓	✓	87.6	✓	95.7	✓	97.2	✓	97.5	97.2	94.7	✓
Referring Organisation Code	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Road User	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Sex	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Source of Service Request	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Sport Activity	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Treatment End Date	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Treatment End Time	98%	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Triage Category	98%	✓	✓	96.6	97.7	✓	94.1	✓	✓	94.6	81.2	✓	94.3	✓	✓	94.6

Clinical Coding

Powys THB is mandated to clinically code the Finished Consultant Episodes (FCEs) for every patient admitted to a hospital within Powys. Powys THB is required to accurately code information relating to all diagnoses and

procedures relevant to each individual episode of care experienced by a patient.

Welsh Health Boards and Velindre Trust are monitored against two national performance measures:

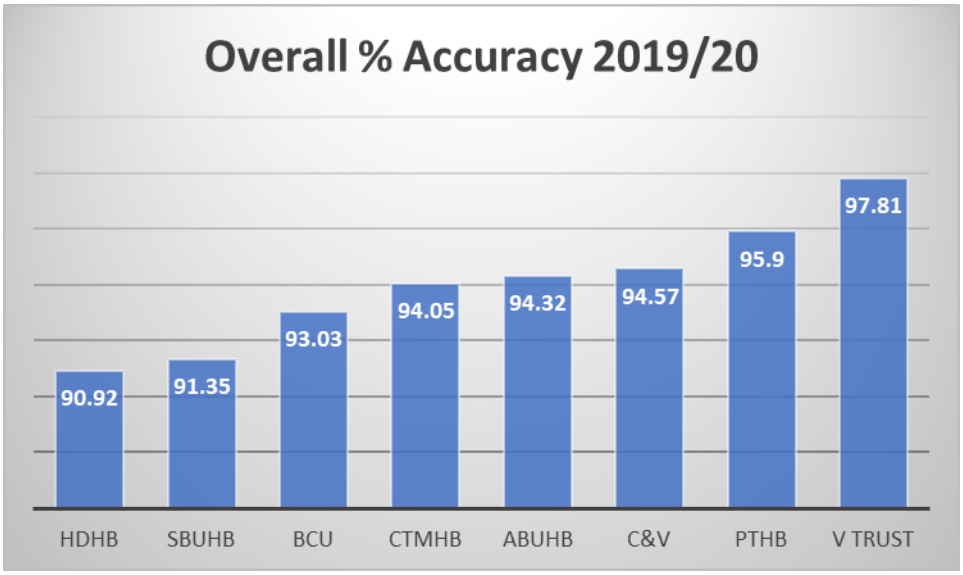
- Completeness at 95% of all FCEs to be coded within 30 days of the episode end date
- Display an annual improvement in the percentage of clinical coding accuracy attained in the NWIS national clinical coding accuracy audit programme.

Completeness

PTHB Clinical Coders consistently achieve 100% completeness each month, this high standard of completeness has been achieved since April 2016.

Accuracy

Due to boundary changes it is not possible to make yearly comparisons with all Health Boards, however the graph below shows the overall accuracy for the financial year 2019/20 showing that against other organisations PTHB are one of the best within Wales.



Source: NWIS Information Standards & Business Analysis Health Board Clinical Coding Audits 2019/20

Findings from the 2019/20 NHS Wales Informatics Service audit showed that clinical coders within the Information Department achieved above the recommended accuracy in all four categories:

	Target	Achieved	Achieved	Achieved
		2017/18	2018/19	2019/20
Primary Diagnosis	≥90%	93.50%	93.50%	91.00%
Secondary Diagnosis	≥80%	92.29%	92.38%	95.67%
Primary Procedure	≥90%	96.05%	96.75%	99.40%
Secondary Procedure	≥80%	94.48%	95.50%	97.36%

Source: NWIS Information Standards & Business Analysis PTHB Clinical Coding Audits

The overall accuracy percentage for Powys THB was 95.90% this figure marks an increase of 2.15% from the previous years Accuracy Measure score of 93.75%.

The reduction in accuracy for Primary Diagnosis code can be attributed to the following

Error Type	Specific Error Key	Number of Errors	Percentage of FCEs with Error
Coder Error	PD3 PRIMARY DIAGNOSIS INCORRECT AT THREE CHARACTER LEVEL	2	1.00%
	PD4 PRIMARY DIAGNOSIS INCORRECT AT FOUR CHARACTER LEVEL	2	1.00%
	PDIS PRIMARY DIAGNOSIS INCORRECTLY SEQUENCED	5	2.50%
Non-Coder Error	PDI INFORMATION AVAILABLE AT THE TIME OF AUDIT NOT AVAILABLE AT THE TIME OF CODING	1	0.50%
	PDC PRIMARY DIAGNOSIS CODED TO CLINICIAN SPECIFICATION	7	3.50%
Documentation Issues	PDD PRIMARY DIAGNOSIS DOCUMENTATION ISSUE	1	.50%

Review of the Year

Clinical Coding

Following the introduction in April 2017 of the national outcomes framework target of clinical coding completeness of 95% within one month the target has been met and exceeded. For the twelve months the percentage achieved has been 100% each month. The team have faced a number of challenges over the 12 months but have been responsive to change and continue to work to a very high standard.

Clinical coding within Powys remains high with Powys being one of the highest performers for completeness and accuracy within Wales.

In September 2019 the Head of Information and the Senior Clinical coder had the opportunity to witness cataract surgery undertaken at Brecon Hospital in order to understand the challenges faced by our visiting consultants with completing the information that coders required in order to code activity. This led to discussions nationally to ensure that only minimum was required thus saving the clinician valuable time but still allowing coders to capture all information required to meet national standards.

As part of the national outcomes framework for 2020/21 there is no longer a requirement to meet 95% completeness, however the Information Department will continue to monitor itself against this as a local performance target to ensure that standards do not slip.

National Submissions

APC, OPA, OPR and EDDS submission Pre-validation checks that have been established prior to the submission of national data allows the Information Department the opportunity to go back to the service to correct any issues at source before being nationally submitted. All submissions to NWIS were submitted as per the mandated timetable.

Intelligent Tracking

The Information Department has led on a project to introduce Intelligent Tracking of case notes within the organisation. This has allowed the organisation to identify the location of active general casenotes. The system went live on 1 August 2018. The Information Department have been working closely with operational staff and validation reports have been developed to allow managers and staff to view and make any necessary changes. The validation reports have full drill down to patient record levels to allow staff the opportunity to correct any error. Below is an example of a validation report for Intelligence Tracking.

Phase 1 saw the implementation of intelligence tracking of general casenotes which included Outpatients, Daycases and Inpatients for active notes. The full functionality of intelligent tracking has been rolled out to all service users although the function called 'tag it' which allows staff to electronically tag a set of notes that they require to be with a specific clinic at a given time has not been utilised. This has been taken forward by the organisations Records Manager.

Phase 2 commenced in June 2019 to incorporate Mental Health casenotes. This has been completed ensuring that the majority of all active notes are tracked within PTHB. Following the completion of this work the Information Department conducted refresher training to all staff.

To date the majority of Therapy Services, use Intelligent Tracking with the exception of Podiatry and Dietetic Services. Although planned to be incorporated within the whole programme of work, this coincided with a change of Head of Service and the onset of the pandemic. It is the intention of the department to re-commence this work.

Intelligence tracking reports have been further developed to improve the accuracy regarding where patient notes are being stored.

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

IFOR in Powys
Intelligence Focused Online Reporting

Intelligence Tracking Summary
Non Mental Health

	Count
Number of current tagged casenotes	19
Number of current tagged casenotes against the same user as sent to	2
Number of temporary casenotes	28
Number of casenotes being held, not currently in filing library	8832
Number of casenotes not in deceased store, but have a death date	554
Number of casenotes in deceased store, but don't have a death date	1
Number of patients with multiple casenotes/volumes per type & base location. Exc Archived.	2576
Archived Library location but not Archived Library holder, latest transaction	4
Deceased Library location but not Deceased Library holder, latest transaction	0
Filing Library location but not Filing Library holder, latest transaction	428
DGH location but not DGH holder, latest transaction	0
Active casenotes recorded outside of All Sites Volume	0
Latest transaction, sent to filing library, not received within 14 days.	105
Latest transaction not received within 14 days. Excluding filing library	249
Number of casenotes currently at DGH	10
New patients that have been registered that should not contain any casenote volumes	136

Mental Health

Through routine validation by the information department it was identified that there were data capture errors within the legal status table and the admission record within the Patient Administration system. There were issues with the administration of WPAS in regards to legal status. Work commenced and has finalised with the service to include all legal statuses within the designated area of WPAS. This was done through training and awareness sessions. Work continues within the service to validate their waiting lists ensuring all data captured is valid.

Validation procedures have been established by the Information Department that are used on a monthly and weekly basis.

Welsh Community Care Information System

With the implementation of the Welsh Community Care Information System (WCCIS) the Information Department has been instrumental in the development of data quality reports. The reports are used by the implementation team to improve the quality of data captured.

Below is an example of one of the many validation reports that has been created to inform users of validation errors that requires investigation and amending.

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

IFOR in Powys Intelligence Focused Online Reporting

WCCIS Data Quality Summary Dashboard for Health Visiting Generic & Flying Start (2018-2019)

Validation Check	Count
Referrals which have no Contacts (Form or Casenotes) Recorded	0
Patients With Multiple Open Referals to Health Visiting and/or Flying Start	22
Referrals which are owned by another Service	1
Multiple Instances of the 1-6 Week (Family & Child) Forms on the Same Referral	740
Multiple Instances of the Same Form (Not Including 1-6 Weeks Forms) on the Same Referral	1688
Child Forms on People Over the Age of 5	90
Parental Forms on People Under the Age of 15	404
Flying Start Active Referrals on patients who do not have a Flying Start Postcode	125
Health Visiting Active Referrals on patients who have a Flying Start Postcode	70
Contacts Classed as Flying Start on Generic Health Visiting Referrals	381
Contacts Classed as Generic Health Visiting on Flying Start Referrals	146
Children Open to Health Visiting Generic and/or Flying Start Without Parent Relationship	119
Parents Open to Health Visiting Generic and/or Flying Start Without Child Relationship	150
Health Visiting Generic and/or Flying Start Owned Forms On Another Services Referral	14
Health Visiting Generic and/or Flying Start Owned Activity On Another Services Referral	13

Maternity Data

The information department has been working closely and continues to with the maternity service to resolve data conflicts in relation to the % reduction of smoking during pregnancy indicator. Data was sourced from three different sources; WPAS Maternity module, Rosetta (a locally developed system managed by the Finance Directorate) and the Maternity Indicators Dataset, held by NWIS for out of county births.

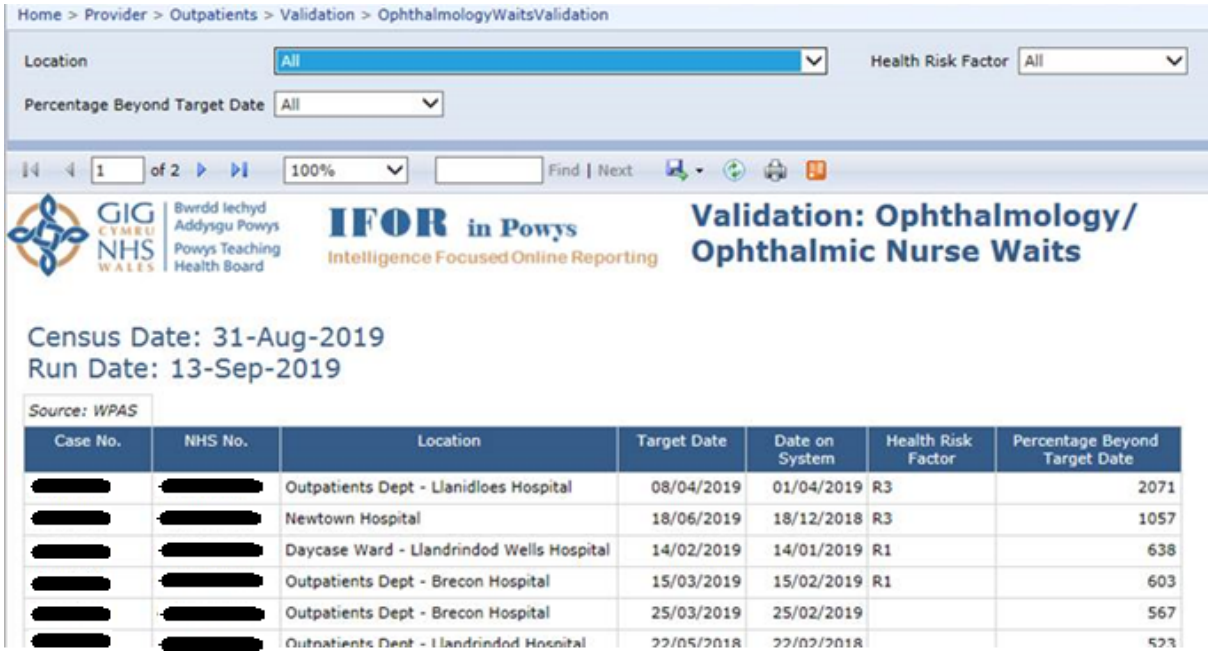
Change requests made to the national change advisory board were accepted and implemented. This has resolved the issues that staff were experiencing with dual reporting and sourcing data from multiple systems. PTHB were the driving force to the changes within the national system that has seen improvements throughout all Health Boards.

As part of this work Rosetta has now been decommissioned and is no longer used. This has had a positive impact on the midwives who no longer had to record information on paper for it to be entered into Rosetta and also for the Finance Department who then had to transpose the data into the system.

Ophthalmology Validation Reports

Validation reports have been developed for patient services to work through the patients waiting more than 100% past their target date as identified by the Eye Care Measures report this work continues.

The table below is an example of the validation report which allows patient services staff to drill through into the patient detail.


Home > Provider > Outpatients > Validation > OphthalmologyWaitsValidation

Location: All | Health Risk Factor: All

Percentage Beyond Target Date: All

1 of 2 | 100% | Find | Next

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

IFOR in Powys
Intelligence Focused Online Reporting

Validation: Ophthalmology/ Ophthalmic Nurse Waits

Census Date: 31-Aug-2019
Run Date: 13-Sep-2019

Source: WPAS

Case No.	NHS No.	Location	Target Date	Date on System	Health Risk Factor	Percentage Beyond Target Date
[redacted]	[redacted]	Outpatients Dept - Llanidloes Hospital	08/04/2019	01/04/2019	R3	2071
[redacted]	[redacted]	Newtown Hospital	18/06/2019	18/12/2018	R3	1057
[redacted]	[redacted]	Daycase Ward - Llandrindod Wells Hospital	14/02/2019	14/01/2019	R1	638
[redacted]	[redacted]	Outpatients Dept - Brecon Hospital	15/03/2019	15/02/2019	R1	603
[redacted]	[redacted]	Outpatients Dept - Brecon Hospital	25/03/2019	25/02/2019		567
[redacted]	[redacted]	Outpatients Dept - Llandrindod Hospital	22/05/2018	22/02/2018		523

Specialist Nurses

Following the release of a DSCN work commenced to ensure that specialist nursing activity was captured within national OPA data set. Significant work was undertaken to allow this data to be captured and has given the organisation greater recognition of outpatient activity, this is now used for planning and demand and capacity work.

Application Standards

In March 2020 the information department took application ownership of two further national systems Welsh Clinical Portal (WCP) and Welsh Clinical Communications Gateway (WCCG), work then commenced to ensure that they align to the same standards adopted for WPAS ensuring that there is governance and a full audit trail of users. The applications are fully supported by the applications team and there are strong links to the national development teams ensuring that any updates are fully tested and released appropriately.

Master Patient Index (MPI)

The information department have now gained access to the MPI this has allowed the department further assistance with resolving issues with duplicate and potential duplicates within WPAS.

Improvement Plan

Improving data quality is a high priority within the Information Department, although there is no dedicated lead for this all Information Staff. In order to raise the profile throughout the organisation further work needs to be undertaken to establish a forum at which issues can be discussed and action plans can be developed. This will give the Information Department a platform from which they can get support from the organisation to improve data quality.

Following the implementation of Intelligence tracking the Information Department will continue to work closely with service leads identifying areas of concern and establishing best practice.

The Head of Information and Lead Information Analyst continue to work closely and support the work of the national Data Set Change Notification Group (DSCN), IQII group and the Welsh Informatics Service Board (WISB) to ensure that any changes to standards have been through the correct processes and that PTHB are able to influence and understand change.

The following list shows the areas of work that have commenced within WPAS and will be continued to be worked on in 2020/21

- Recording of virtual activity e.g. Video Consultations
- Cardiac Waiting Times
- Bed management, developing a patient flow dashboard for bed management at ward level for ward staff and managers
- Welsh Nursing Care Record (WNCR),
- SCP submission
- Moving to real-time recording of WPAS data. Following new data requirements for reporting of activity due to the pandemic monthly reports have changed to weekly and therefore require more timely updating from an operational perspective
- Responsive to the ongoing requirements to capture data in relation to Covid 19

Following a change to working routines and the urgent requirement to meet changing needs for data collection and reporting it has not been possible to continue with the face to face drop in sessions that had been put in place to support users of WPAS. The information Department will be re-establishing drop in sessions for users adhering to new social distancing rules and embracing new technology such as MSTeams. Training events have also been revised so that staff do not have to travel to various hospital locations to meet in person. Training now takes place using MSTeams and has proved successful.

Targets

Identified within the directorate plan is the maintenance of clinical coding completeness and accuracy and the clinical coding team along with the wider information department will work hard to achieve this.

Although there are no specific targets the information department are committed to improving data quality with continued interaction between service users and managers.

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 3.10

Experience, Quality & Safety Committee	**Date of Meeting: 3 December 2020**
Subject :	**Progress report for the implementation of the Once for Wales Concerns Management System**
Approved and Presented by:	Director of Finance and IT Services
Prepared by:	Digital Project Manager
Other Committees and meetings considered at:	Quality Governance Group

PURPOSE:

The purpose of this report is to provide a status update for the implementation of the Once for Wales Concerns Management System (OFWCMS).

RECOMMENDATION(S):

The Experience, Quality & Safety Committee are asked to:

a) Note and approve the current position
b) Note the current risks that arise at this stage of the project
c) Review and approve/inform the 4 action areas

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

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

EXECUTIVE SUMMARY:

To support the implementation of the Once for Wales Concerns Management electronic tool, work has commenced to move the 3 workstreams, previously suggested as Systems, Processes and Safety into two areas for consistency with the national programme;

1. Technical Workstream
2. Functional Workstream

The above will support the 20+ workstreams and contribute to the overall delivery plan.

With the workstreams spreading over 2 phases, establishing processes, governance, ICT technology and developing effective functionality within the RLDatix system and adopting a cultural change will be crucial to the effectiveness of the Programme.

Phase 1 will see many modules integrated into the new system with a go live date of 1 April 2021. Local leads will be integral in ensuring representation at network meetings and reporting back to the project board to ensure the new functionalities are adapted and developed to meet the needs of PTHB.

DETAILED BACKGROUND AND ASSESSMENT:

Work progressed:

Incident Module Access

A user input mapping exercise has been carried out the past few weeks to identify which users will require access to the Incident's module. Deadline for submission was the 30th October which we were able to achieve. For those services who have not responded to the request, users will be added after the system has gone live.

Mortality Module

The module was due to go live on the 1st October with 2 wards at Brecon Hospital, however with the national DPIA still under review, this has caused a delay with the pilot. To note this is not a local issue.

Accredited Practitioner

An RLDatix practitioner was accredited at the end of October to support the programme. This will help support best practice when discussing an approach to the various workstreams.

Project Boards

Engagement progressing with executive leads to support two areas (previously 3);

1. Technical Workstream
2. Functional Workstream

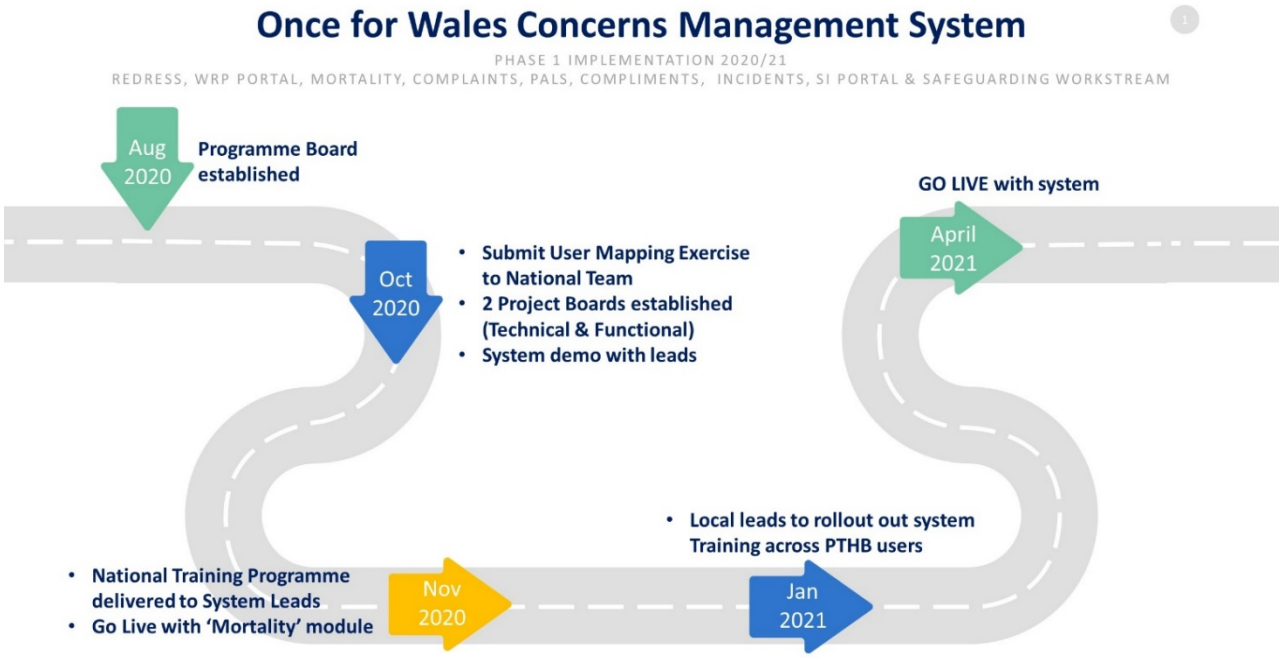
The safety & culture won't form an individual workstream but support the organisation with cultural change pre and post go live.

Terms of reference have been drafted for the project boards and monthly meetings scheduled.

Timelines

A new national Project Manager has been appointed and health boards are currently awaiting an update to what workstreams will be contained in phase 1 and what will be delivered in phase 2. Each workstream will identify a workplan and align to the National Programme where possible.

A high-level roadmap identifies the milestones over the next 6 months:



Identified Risks

The initial risks have been identified below and will now be assessed and rated using the Health Board methodology and reported to the Risk and Assurance group.

No	Risk description	Severity	Mitigation
1	Automation of patient details to avoid manual error in system		Link to EPI. Work with NWIS and IT - National risk
2	Insufficient resource available for current and new programme		Ensure fields are locked down to manage consistency of data input
3	Resistance to change culture using a new single system		Staff awareness, training sessions, communications
4	Legacy system infrastructure failure (Datix)		Ensure resource to maintain systems & work with national lead to see how others are approaching this
5	Not being able to complete within timeframe set - current system and new system. Conflicting priorities		Project plan in place & workstreams identified

Key Actions and Areas of Focus

1. Governance Structure

A structure has been developed to formulise reporting requirements and accountability for the overall programme. Note recommendation for consideration and approval at next OFWCMS Board. See **Appendix A**.

2. National groups

A review of the national groups has been completed and included as **Appendix B**. Recommended future membership will be agreed at the next OFWCMS Board.

3. Readiness Assessment

A readiness assessment has been completed as **Appendix C** to support the new system implementation to inform the implementation action plan.

4. Policies

To support a safety culture, a review of existing and any additional policies and standard operating procedures (SOPs) has taken place covering the functional and technical workstreams. See **Appendix D.**

Supporting documents

Appendix A Governance Structure	Paper 1 - Governance structure.
Appendix B National groups	Paper 2 - OFWCMS National Group Repre
Appendix C Readiness Assessment	Paper 3 - OFWCMS Powys Readiness Che
Appendix D Policies	Paper 4 - Policies received v2.docx

NEXT STEPS:

- Establish task & finish groups
- Engage with workstream leads to identify and ensure tasks are detailed within the project plan and resource is appropriately identified to support implementation.
- Communicate via the Teams Channel
- Project leads to provide Highlight reports for the bi-monthly programme Board
- National programme Board participation
- Standardise reporting and escalation process from Programme Board to Health Board Committees.

EXPERIENCE, QUALITY & SAFETY COMMITTEE
PROGRAMME OF BUSINESS 2020-21

The scope of the Experience, Quality & Safety Committee extends to the full range of PTHB responsibilities. This encompasses all areas of experience, quality and safety relating to the workforce, patients, carers and service users, within directly provided services and commissioned services. The Committee embraces the Health and Care Standards as the Framework in which it fulfil its purpose

This Annual Programme of Business has been developed with reference to:

- the Committee's Terms of Reference as agreed by the Board;
- the Board's Assurance Framework;
- key risks identified through the Corporate Risk Register, Commissioning Assurance Framework; and Operational Risk Registers.
- audit and regulatory reports identifying weaknesses in internal control (following consideration by the Audit, Risk and Assurance Committee);
- key statutory, national and best practice requirements and reporting arrangements.

In May 2020, the Board agreed its governance arrangements during the COVID-19 Pandemic. It was agreed that Formal meetings of the Board's Committees would have a shortened, concise agenda focussing on essential matters only and will be held virtually to ensure compliance with social distancing guidance.

MATTER TO BE CONSIDERED BY COMMITTEE	EXEC LEAD	SCHEDULED COMMITTEE DATES 2020-21					
		16 April	04 June	02/30 July	01 Oct	03 Dec	04 Feb
Annual Reports							
Putting Things Right Annual Report	DNM			✓			
Public Services Ombudsman Annual Report	DNM			✓			
Annual Report of the Accountable Officer for Controlled Drugs	MD				✓		✓
Safeguarding Annual Report	DNM				✓		
Annual Report of the Caldicott Guardian	MD						✓
Annual Data Quality Report	DF&IT					✓	
Annual Quality Statement	DNM			✓			
Quality & Safety Assurance Reports							
Clinical Quality Framework Implementation Plan	DNM			✓		✓	
Organisational Quality Governance Actions - Update	BS		✓				✓
Clinical Audit Programme	MD		✓	✓			
Clinical Audit Report	MD				✓		
Quality Performance Report (Provided and Commissioned Services)	DNM				✓	✓	✓

MATTER TO BE CONSIDERED BY COMMITTEE	EXEC LEAD	SCHEDULED COMMITTEE DATES 2020-21					
		16 April	04 June	02/30 July	01 Oct	03 Dec	04 Feb
Serious Incidents and Concerns Report	DNM		✓	✓	✓	✓	✓
Inspections and External Bodies Report	DNM			✓	✓	✓	✓
Mortality Reporting	MD			✓	✓		✓
Mental Health Act Compliance & Powers of Discharge	DPCCMH				✓		✓
HIW Action Tracking	DNM / BS				✓	✓	✓
Information Governance Quality Report	BS				✓		✓
Staff Well-being and Engagement Update (including Staff Survey)	DWOD	✓			✓		✓
Quality Improvement Programme	MD					✓	✓
Infection Prevention & Control Report	DNM		✓			✓	
Safeguarding Report	DNM		✓				✓
Estates Compliance Update	DPP	✓ Moved to P&R Committee					
Health and Safety Update	DWOD			✓			✓
Welsh Language Standards Update	DTHS						✓

MATTER TO BE CONSIDERED BY COMMITTEE	EXEC LEAD	SCHEDULED COMMITTEE DATES 2020-21					
		16 April	04 June	02/30 July	01 Oct	03 Dec	04 Feb
Audit and Regulatory Reports		As and when identified					
Additional reports Scheduled as an Organisational Priority/Strategic Risk							
Maternity Services Assurance Framework	DNM					✓	
Commissioning Arrangements: Shrewsbury & Telford Hospitals NHS Trust	ADCD		✓	✓	✓	✓	✓
Once for Wales Complaints Management System (DATIX) Implementation Update	DF&IT			✓			✓
Refreshed Patient Experience Framework	DNM						✓
Refreshed Values and Behaviours Framework	DWOD						✓
Quality & Engagement (Wales) Act	BS			✓			✓
Coronavirus (COVID-19): • Overview • Non-COVID Activity • Staffing of Clinical Response Model • PPE Arrangements • Ethical Framework • Clinical Decision Making	CEO & Directors	✓					
Risk Assessment: Transmission of COVID-19 in the workplace			✓				
Support to Care Homes during COVID-19			✓				

MATTER TO BE CONSIDERED BY COMMITTEE	EXEC LEAD	SCHEDULED COMMITTEE DATES 2020-21					
		16 April	04 June	02/30 July	01 Oct	03 Dec	04 Feb
Use of PPE for CPR procedures during COVID-19	MD			✓			
Committee Governance Reports							
Committee Risk Register	BS				✓	✓	✓
Policies Delegated From the Board for Review and Approval	BS	**As and when identified**					
Review of Committee Programme of Business	BS			✓	✓	✓	✓
Committee Requirements as set out in Standing Orders							
Development of Committee Annual Programme Business	BS						✓
Annual Review of Committee Terms of Reference 2021-22	BS						✓
Annual Self-assessment of Committee effectiveness 2021-22	BS						✓
The Committee will meet in a closed session to discuss any matters deemed of a confidential and/or sensitive nature, including where reports include patient identifiable information							

KEY:

CEO:	Chief Executive
DPP:	Director of Planning and Performance
DF&IT:	Director of Finance and IT
DPCCMH:	Director of Primary, Community Care and Mental Health
MD:	Medical Director
DoN:	Director of Nursing
DoTHS:	Director of Therapies and Health Sciences
DWOD:	Director of Workforce & OD
DPH:	Director of Public Health
BS:	Board Secretary
ADC&E:	Associate Director of Capital & Estates
ADCD:	Assistant Director of Commissioning Development