Experience, Quality and Safety Committee

Thu 15 April 2021, 14:30 - 16:15

Teams

Agenda

14:30 - 14:30
0 min

1. PRELIMINARY MATTERS

EQS_Agenda_15Apr21_Final.pdf (2 pages)

1.1. Welcome and Apologies

1.2. Declarations of Interest

1.3. Minutes of the Previous Meeting held on 4 February 2021, for approval

EQS_Item_1.3_Minutes_Uncomfirmed_04-02-21.pdf (12 pages)

1.4. Matters Arising from Previous Minutes

1.5. Committee Action Log

EQS_Item_1.5_EQS Action Log_15 April_2021.pdf (4 pages)

14:30 - 14:30
0 min

2. ITEMS FOR APPROVAL/RATIFICATION/DECISION

There are no items for inclusion in this section

2.1. Mental Health Services: Age Appropriate Beds

EQS_Item_2.1_Age appropriate bed report.pdf (7 pages)

2.2. Mental Health Act Hospital Managers Power of Discharge Group Terms of Reference and Operating Arrangements

EQS_Item_2.2_PoD Group ToR_April21.pdf (3 pages)
EQS_Item_2.2a_PoD_Group_TermsofReference_ March20_Draft.pdf (5 pages)

14:30 - 14:30
0 min

3. ITEMS FOR DISCUSSION

3.1. Serious Incidents and Concerns Report

EQS_Item_3.1_EQS ConcernsSUIs Paper 01042021.pdf (21 pages)
EQS_Item_3.1a_Appendix 1&2 - PtR audit programme cycle.pdf (4 pages)
EQS_Item_3.1b_Appendix 3 - At-Your-Service-A-Good-Practice-Guide.pdf (18 pages)
EQS_Item_3.1c_Appendix 4 - List of Subjects for Concerns.pdf (1 pages)

3.2. Regulatory Inspections Report

EQS_Item_3.2_Regulatory Inspections Report FINAL 01042021.pdf (6 pages)

EQS_Item_3.2a_Appendix 1- 20200112DyfiValleyHealthEN.pdf (8 pages)
EQS_Item_3.2b_Appendix 2 - HIW to PTHB - HIW Work update.pdf (2 pages)
EQS_Item_3.2c_Appendix 3 - 20200120MentalHealthCrisisPreventionReview-TermsofReference-en.pdf (5 pages)
EQS_Item_3.2d_Appendix 4 - 210308 Updated Youth Review - PTHB - Action Plan March 2021.pdf (26 pages)
EQS_Item_3.2d_Appendix 5 - 210324 QGG - H&SC Regulatory Report Dashboard 15032021.pdf (2 pages)
EQS_Item_3.2e_Appendix 6 - CIW Inspection Report Improvement Actions Cottage View.pdf (8 pages)

3.3. Clinical Quality Framework, Implementation Plan Update

EQS_Item_3.3_CQF implemenatation plan March 20201 (002).pdf (13 pages)

3.4. Community Services: Approach to Clinical Quality

EQS_Item_3.4_CSG Quality and Patient Safety Structure EQPS Cover Paper April 2021 jm.pdf (6 pages)

3.5. Commissioning Assurance: SATH

To Follow

3.6. Approach to Assessing Harm from COVID-19

14:30 - 14:30
0 min

4. ITEMS FOR INFORMATION

4.1. Update on Implementation of Once for Wales Complaints Management System

EQS_Item_4.1_OfWCMS EQS Committee update.pdf (8 pages)

4.2. WHSSC Quality & Patient Safety Committee Minutes

EQS_Item_4.2_QPS Chair's Report and Escalation Table January 2021.pdf (11 pages)

4.3. Audit Wales Quality Governance Review, Terms of Reference

EQS_Item_4.3_Appendix 1 Quality Governance Project Brief_v2.pdf (9 pages)

4.4. Welsh Government Written Statement: The Health and Social Care (Quality and Engagement) (Wales) Act 202- update on implementation

EQS_Item_4.4_Written Statement_ The Health and Socia...ementation (24 March 2021) _ GOV.pdf (3 pages)

14:30 - 14:30
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:

3 June 2021 at 10:00AM via Teams

POWYS TEACHING HEALTH BOARD
EXPERIENCE, QUALITY & SAFETY COMMITTEE

15 APRIL 2021,
14.30 – 16.15
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 meeting held on 04 February 2021 (for approval)	Attached	Chair
1.4	Matters Arising from Previous Meetings	Oral	Chair
1.5	Committee Action Log	Attached	Chair
2	**ITEMS FOR APPROVAL/RATIFICATION/DECISION**		
2.1	Mental Health Services: Age Appropriate Beds	Attached	Executive Director of Primary, Community Care and Mental Health
2.2	Mental Health Act Hospital Managers Power of Discharge Group Terms of Reference and Operating Arrangements	Attached	Board Secretary
3	**ITEMS FOR DISCUSSION**		
3.1	Serious Incidents and Concerns Report	Attached	Executive Director of Nursing & Midwifery
3.2	Regulatory Inspections Report	Attached	
3.3	Clinical Quality Framework, Implementation Plan Update	Attached	
3.4	Community Services: Approach to Clinical Quality	Attached	Executive Director of Primary, Community Care and Mental Health
3.5	Commissioning Assurance: SATH	Attached	Assistant Director of Commissioning Development
3.6	Approach to assessing Harm from COVID-19	Oral	Executive Medical Director

4	**ITEMS FOR INFORMATION ONLY**		
4.1	Update on Implementation of Once for Wales Complaints Management System		
4.2	WHSSC Quality & Patient Safety Committee Minutes		
4.3	Audit Wales Quality Governance Review, Terms of Reference		
4.4	Welsh Government Written Statement: The Health and Social Care (Quality and Engagement) (Wales) Act 2020 – update on implementation		
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: • 03 June 2021 at 10.00 AM		

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

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

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

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

POWYS TEACHING HEALTH BOARD
EXPERIENCE, QUALITY & SAFETY COMMITTEE

UNCONFIRMED

MINUTES OF THE MEETING HELD ON THURSDAY 4 FEBRUARY 2021 VIA MICROSOFT TEAMS

Present:

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

In Attendance:

Carol Shillabeer	Chief Executive
Stuart Bourne	Director of Public Health
Lucie Cornish	Assistant Director of Therapies and Health Science
Alison Davies	Director of Nursing and Midwifery
Marie Davies	Deputy Director of Nursing
Clare Lines	Assistant Director of Commissioning Development
Claire Madsen	Director of Therapies and Health Sciences
Rani Mallison	Board Secretary
Jamie Marchant	Director of Primary, Community Care and Mental Health services
Julie Richards	Head of Midwifery and Sexual Health
Julie Rowles	Director of Workforce, OD and Support Services
Jeremy Tuck	Assistant Medical Director
Geoffrey Davies	Community Health Council
Elaine Matthews	Audit Wales

Apologies for absence:

Paul Buss	Medical Director
Susan Newport	Independent Member

Committee Support:

Elizabeth Patterson	Corporate Governance Manager
Shania Jones	Committee Secretary

EQS/20/99	**WELCOME AND APOLOGIES FOR ABSENCE** The Committee Chair welcomed Members and attendees to the meeting, and CONFIRMED there was a quorum present. Apologies for absence were NOTED as recorded above. The Committee Chair explained that the Health Board continued to work through an unprecedented time and so business as usual is not as was. The Board has taken a decision to ensure its committees have short meetings with concise agendas focussing on the essential matters during this time. The Board will be holding a development session in February, focussed on planning for recovery and to explore the priorities for the year ahead – there is no doubt that there will need to be further re-prioritisation of focus and resource as we move forward. The Committee itself will need to be mindful of the importance of taking a balanced view as to where its focus is in the coming months, recognising there is work to be done in improving quality governance arrangements whilst also ensuring the organisation has capacity to enable ongoing response to the pandemic and recover thereof.
EQS/20/100	**DECLARATIONS OF INTERESTS** No interests were declared.
EQS/20/101	**UNCONFIRMED MINUTES OF THE EXPERIENCE, QUALITY AND SAFETY COMMITTEE MEETING HELD ON 3 DECEMBER 2020** The minutes of the previous meeting held on 3 DECEMBER 2020 were AGREED as being a true and accurate record.

EQS/20/102	**MATTERS ARISING FROM PREVIOUS MEETINGS** No matters arising were declared.
EQS/20/103	**COMMITTEE ACTION LOG** The Committee received the action log and the following updates were provided. ARA/20/82 – Transferred from Audit, Risk and Assurance Committee. Internal Audit Report: Fire Safety (Limited Assurance). A follow-up report to be presented to the Experience, Quality and Safety Committee. EQS 19/22 – The Hazels (Community Mental Health) Llandrindod Wells – application to reconfigure/refurbish submitted to Welsh Government as part of the Llandrindod Hospital Programme Business Case. £50k discretionary capital allocated for immediate repairs subject to Board approval.
ITEMS FOR APPROVAL/RATIFICATION/DECISION	
EQS/20/104	There are no items for inclusion in this section
ITEMS FOR DISCUSSION	
EQS/20/105	**SERIOUS INCIDENTS AND CONCERNS REPORT** The Director of Nursing and Midwifery presented report noting that the Audiology Department had recorded the highest number of compliments which was a result of the proactive approach to gaining patient experience feedback. This approach would be taken forward to the Patient Experience Group as an example of good practice. Patient experience will be particularly important as part of the renewal planning post COVID-19, to help inform service delivery. It was noted that a national All Wales Patient Experience system had been recently launched. It was noted that whilst performance regarding acknowledgement of complaints were within the Welsh Government target, improvement was needed to maximise the health board's response. The performance for responding to formal complaints fluctuates but is well below the target and requires improvement. Significant work was being undertaken to target the areas in need of most improvement for example, the management of concerns, whilst it is anticipated that the outcome of the

	independent and internal reviews will identify further areas for improvement. In respect of the data provided related to Commissioned Services, please note that the concerns raised during the month indicated do not necessarily correlate to the month of attendance or admission that the concern realties to. It was noted by the Director of Nursing and Midwifery that graph 12 'Incidents reported 01 November 2019 – 31 December 2020' demonstrated a steady trend and variation may correlate to changes in service delivery as a result of the pandemic. In relation to Patient Safety Solutions, compliance is being assured in two and as a result of recent appointments into the senior theatres team, progress is expected in complying with the remaining notice. *The report is reflective and transparent; however, it appears that the organisation may be vulnerable to delays in investigations which could lead to external criticism.* The organisation is working intensively to address this and has committed resources to enable a full understanding of the position, supported by transparency of reporting. *In regards to Graph 13, it was noted that there was high number of concerns raised by the service group for Women and Children. Can more information be provided as to what is happening there?* The Director of Nursing and Midwifery explained that this graph illustrated the pattern of reporting by service groups over a period of time and reporting was encouraged to enable learning to take place. The quantity of reports is one of the indicators to consider. Women and Children's Service Group hold regular meetings to scrutinise their patterns or reporting, including the type and volume of incidents. The Delivery Unit intend to publish pan Wales reporting which may assist in benchmarking with others, bearing in mind the comparability of services. *Should Committee be concerned regarding areas that are not reporting concerns?* Service group incident reporting was encouraged but the reason for areas that are not reporting as many incidents could be due to the area being less a clinically focused area. Therefore, it may be more helpful to see the local

	trends within the service group over time rather than as a direct comparison. *Are any compliments collected online? Focusing more on how are individual's treated under normal circumstances? For example, how have people responded online to the Vaccination programme. Might this be a more accessible way for the public to engage?* The Chief Executive advised work is being undertaken to collect the feedback received by the Powys Teaching Health Board either via social media or through letters to the Health Board. A public Q&A session was held in order to gain more feedback from patients and families. It was important to understand what had been said regarding the Vaccination programme and the Health Board itself. In regard to the Vaccination Programme, the feedback has been overwhelmingly positive, there had been areas of improvements identified which had been very small and focused. The Director of Therapies and Health Sciences advised that the All Wales patient group had tested a real time feedback IT system. There was an opportunity for a Powys Teaching Health Board to consider adopting this system, however, there would be a cost implication and a Business Case would be submitted and will be brought back to the committee at a later date as a business case. *In the section of the report 'Incident Reporting by the Service Groups', can there be an explanation on what the incidents cover in future papers?* The Director of Nursing and Midwifery agreed to include a definition of incidents in future papers. *Are patients and families informed of delays in respect of inquests and concerns?* The Director of Nursing and Midwifery explained that the HM Coroner's Office keeps in contact with families, where the Coroner is involved. The delay is a Wales wide issue. However, concerns, there is a need for significant improvement in the way contact is maintained with families where a concern or serious incident is identified, this is a key aspect of the improvement work and will be further assisted by the deployment scoping that is currently underway, which will help clarify roles and responsibilities.

	The committee DISCUSSED and NOTED the Serious Incidents and Concerns Report.
EQS/20/106	**INSPECTIONS AND EXTERNAL BODIES REPORT** The Director of Nursing and Midwifery presented the report informing Committee of the outcome of regulatory inspections that had taken place during this period and outlining the progress of the actions that were taken forward as part of the inspection process against the Health Inspectorate Wales (HIW) tracker. *It would be helpful to have a generic tracker than a HIW tracker for the recommendations. It would be helpful to know the Public Service Ombudsman and the CIW work is going ahead.* The Director of Nursing and Midwifery clarified that the tracker does include all recommendations and the tracker's title needs to be amended to reflect this. *There are 26 overdue recommendations. Can further information be provided in respect of these, in particular those relating to 2018 and 2019.* This information will be brought to the next Committee. **Action: Director of Primary Care Community & Mental Health** The Director of Primary, Community Care and Mental Health services provided additional information regarding the outstanding actions. A number of actions relate to estates however, this does not necessarily mean that estates were the issue. In addition, these actions have been risk assessed and may be considered to be of lower priority when set against requirements in relation to the pandemic. The committee DISCUSSED and NOTED the Inspections and External Bodies Report.
EQS/20/107	**MORTALITY REPORTING** The Assistant Medical Director presented the Mortality Report on behalf of the Medical Director outlining the changes that had been made to strengthen the mortality review process. Prior to these changes there was a good practice of stage one reviews being undertaken. Stage two reviews had not

	been systematised therefore, the Medical Director initiated an action in order to begin the process. *Has plans to review infections as part of a national programme begun?* The Assistant Medical Director informed the committee that the meeting to discuss the nosocomial tool was rescheduled. *Is nosocomial toolkit is fit for purpose?* The Assistant Medical Director explained that there has been no opportunity to test it, but will give detailed feedback once testing has begun. *Will the Datix Mortality Module be taken up with the new appointed Medical Examiner (ME)?* The Assistant Medical Director explained that the current system had been paused. It would be helpful to have an All Wales reporting system for transparency and a level of equity. The delayed arrival of the ME hindered the ability to move forward on the mortality review process. However, the foundations had been set in order to start the process and to demonstrate that the review process has been taken seriously. The committee DISCUSSED and NOTED the Mortality Report.
EQS/20/108	**SAFEGUARDING UPDATE** The Director of Nursing and Midwifery presented the safeguarding update. The report gave the committee assurance concerning the way in which safeguarding and public protection had been handled during the COVID-19 pandemic. The Director of Nursing and Midwifery advised that safeguarding had remained a key priority throughout the COVID-19 pandemic. The report included examples of developments of progress made regarding how matters were addressed within Powys, and advised of the next steps that to be taken for improvements surrounding the safeguarding agenda. *In terms of the Child Protection Medicals, is the out of hours support provided by Cwm Taf Morgannwg University Health Board available across Powys or just within the South Powys?*

	The Assistant Director of Commissioning Development explained that the arrangement with Cwm Taf is for South Powys. *The 'Looked After Children' health assessment in Children's homes, is currently being done remotely. Will face-to-face assessments resume as the vaccine is distributed?* The Director of Nursing and Midwifery confirmed that as guidance changes, the assessments that require face-to-face assessments will resume provided it is safe to do so. *There had been an increase in referrals to Child Protection and an increase in Domestic Violence during the COVID-19 pandemic. Will the service have the capacity and capability to meet the new challenges it is facing?* The Director of Nursing and Midwifery explained that there was concern for children and families in this prolonged period of lockdown. This is wider than safeguarding and the service will work closely with local authority partners to ensure current arrangements meet the need or consider any changes to services that may be required. *Are Shropdoc, who provide out of hours service for clinical matters, aware of these changes in the location of Child Protection Medicals in South Powys? Can assurance be given that the doctors who are working with Shropdoc know how to access the appropriate services? Do Shropdoc practitioners receive Level 3 updates?* The Assistant Director of Commissioning Development explained that direct contact was made with Shropdoc to provide them of all details related to the changes with weekly telephone conferences arranged to discuss matters of mutual concern. All doctors who are working with Shropdoc that provides care for Powys are required to be on the Welsh performance list, which provides a large amount of information and experience. The committee DISCUSSED and NOTED the Safeguarding Update.
EQS/20/109	**COVID-19 INCIDENT MANAGEMENT UPDATE REPORT**

	The Director of Public Health presented the paper which highlighted the appropriate operation and effectiveness of the local outbreak management response in regards to the COVID-19 pandemic. The report provided the committee assurance that the outbreak management was well organised and managed. The Communicable Disease Outbreak Plan for Wales (2020), was the approved plan by the Welsh Government, NHS Wales and the Directors for Public Protection for dealing with an outbreak and the immediate response. The plan was followed closely and focused on 'how incident response was handled and organised within Powys'. This was related to hospitals outbreaks during the pandemic and further guidance had been recently published. An addendum was added in the last six months concerning the management of outbreaks in a hospital setting. There are two Incident Management Team (IMTs) structures which are interlinked with an overarching multi-agency Incident Management Team, that includes colleagues from Police, local authority and Public Health Wales, and includes cross border colleagues where necessary. IMT reports twice weekly to the Health Board's prevention and response group with escalated decisions taken to Gold Group. Reports are given to the Welsh Government which detail incidents, cases and control measures that are underway. *Are there particular members of the team which have particular influence and expertise in different areas? How does that impact on a particular team?* The Director of Public Health explained that it is a rare skillset, on an All Wales level therefore, not a lot of people had the particular skills which is required and it has been more difficult in the PTHB team to access specialist skills when required. However, as the team has gained experience they have been able to apply this learning. *When are test samples being analysed regarding the new variant? Is there any further intelligence regarding that?*

	The Director of Public Health explained that not all samples are analysed but of those that are a high percentage are testing positive for the new variant. The committee DISCUSSED and NOTED the Covid-19 Incident Management Update Report. *Julie Richards joined the meeting.*
EQS/20/110	**MATERNITY SERVICES PRIORITIES** The Head of Midwifery and Sexual Health presented the report highlighting the findings and recommendations from the Ockenden Report of Maternity services published in December 2020, which aligned to the Health Inspectorate Wales (HIW) National Report for Maternity Services published January 2021. The purpose of the report was to provide an overview of the themes and messages that emerged, which informed key priorities to develop Powys' Maternity Services Improvement Plan and the Assurance Framework for Commissioned Services. *The Chair requested consideration that a patient story be included on the Committee Work Programme.* **Action: Board Secretary** *In regards to complaints received by women who had experienced difficult births in the past. Can assurance be given that issues that could be avoided, will not happen again? What is in place to provide assurance to current parents and historical parents that the Health Board has taken the issues raised in the HIW tracker and the Ockendon Report seriously?* The Head of Midwifery and Sexual Health advised that the Powys Maternity and Partners Voices partnership had been established. Cases that had been identified with issues were provided with support and feedback on improvements made. Additionally, the Health Board will continue to publish information on a regular basis to evidence improvements made. It is the intention of the 2021 improvement plan to bring all recommendations in to a central plan. *Given the circumstances, can a time frame be provided as to when this Maternity Assurance Framework will be brought through the committee?*

	The Director of Primary, Community Care and Mental Health services reinforced the importance of the Maternity Assurance Framework therefore, the aim would be to bring this issue back to the EQ&S Committee as soon as possible. The committee DISCUSSED and NOTED the Maternity Service Priorities paper.
EQS/20/111	**CAF ESCALATION REPORT & SATH UPDATE** The Assistant Director of Commissioning Development presented the CAF Escalation Report and SaTH Update advising that the report highlighted the providers that are currently in Special Measures or scored a level four following January 2021 Powys Teaching Health Board Internal Commissioning Assurance Meeting (ICAM). *This was unprecedented and it is important to consider the position as a Health Board. Could this fundamentally change the way care will be provided in the future?* The Chief Executive agreed and welcomed the sense of moving towards recovery and renewal. The pandemic should be considered as an opportunity to investigate as a Health Board what challenges had been presented and what innovative responses had been made. The next stage of the pandemic would be to understand the future implications of COVID-19 and support clinicians and managers to prepare to tackle the various harms caused by the pandemic *With regards to the renal transplant waiting list was there a conversation between the commissioning team and WHSSC regarding waiting times?* The Assistant Director of Commissioning Development confirmed that this issue was being monitored on a monthly basis. The committee DISCUSSED and NOTED the CAF Escalation Report & SaTH Update.
	ITEMS FOR INFORMATION
EQS/20/112	There are no items for inclusion in this section

OTHER MATTERS	
EQS/20/113	**ITEMS TO BE BROUGHT TO THE ATTENTION OF THE BOARD AND OTHER COMMITTEES** There are no items for inclusion in this section
EQS/20/114	**ANY OTHER URGENT BUSINESS** No urgent business. The Committee Chair thanked all members.
EQS/20/115	**DATE OF THE NEXT MEETING** 15 April 2021, Via Microsoft Teams

Key:

Completed
Not yet due
Due
Overdue
Transferred

EXPERIENCE, QUALITY & SAFETY COMMITTEE

ACTION LOG 2020/21/22

GIG CYMRU NHS WALES
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 (2020/21)					
EQS/20/106 Inspections report – action tracking	February 2021	Further information to be provided in respect of the 26 overdue recommendations, in particular those relating to 2018 and 2019.	Director of Primary, Community Care and Mental Health		
ARA/20/82	3 November 2020	Internal Audit Report: Fire Safety (Limited Assurance). A follow-up report to be presented to the Experience, Quality and Safety Committee.	Board Secretary / Director of Workforce & OD and Support Services	Action transferred to the Experience, Quality & Safety Committee Action Log, as requested by ARA Committee (November 2020)	Update to be scheduled for June 2021
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 & Medical Director	1 October 2020 It was confirmed that the Quality and Safety team are following up on this action. The Medical director confirmed his support in resolving the action.	

EQS/19/76	3 December 2019	The Research and Development and Innovation Update report was requested to be strengthened and taken forward in conjunction with the Clinical Quality Framework.	Medical Director	<u>03 Dec 2020</u> It is proposed that an update on Research and Development is built into the Committee's workplan for 2021/22 <u>16 April 2020</u> The Committee agreed that in light of COVID-19, this action would be deferred to Q3, 2020/21 (priority 2).	

EQS/19/22	4 June 2019	HIW/CIW Joint Inspection: Community Mental Health – The Hazels (Llandrindod Wells) – where 'The Hazels' building sits in the asset refurbishment programme will be confirmed at the next meeting	Assistant Director of Estates and Property	<u>28 January 2021</u> Programme Business Case for Llandrindod (£11M+) was submitted to Welsh Government in December 2020, currently awaiting endorsement and this includes a funding allowance for The Hazels block reconfiguration / refurbishment. Additionally, £50K has been included in the discretionary capital programme for 2021/2022 for more immediate remedial repairs, subject to Board approval. <u>03 Dec 2020</u> An update on this item will be provided to the Committee in February 2021. <u>16 April 2020</u> It was confirmed that due to pressure on the Estates Department as a result of	

				COVID-19, this item would be deferred to Q3, 2020/21 (Priority 3).	

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 2.1

Experience, Quality & Safety Committee	**Date of Meeting: 15 April 2021**
Subject:	**Age Appropriate Beds (for young people aged 16-17 years)**
Approved and Presented by:	Alison Davies, Executive Director of Nursing and Jamie Marchant, Executive Director Primary Care, Community and Mental Health Services
Prepared by:	Joy Garfitt Assistant, Director Mental Health Services and Samantha Shore Head of Young People and Early Intervention
Other Committees and meetings considered at:	Executive Committee, 10th February 2021

PURPOSE:

The purpose of this paper is requesting the Committee's support of the decision of the Executive Committee for the provision of an age appropriate bed for young people aged 16-17 years during a mental health crisis in Powys, in the short term, where all other options are exhausted.

RECOMMENDATION(S):

The Committee is asked to:
SUPPORT the Executive Committee provision of care for young people aged 16-17 years during a mental health crisis in Powys, in the short term, where all other options are exhausted at Felindre Ward, Bronllys.

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:

Background

The Tier 4 CAMHS inpatient service is commissioned directly by Welsh Government and provided by Cwm Taf UHB and Betsi Cadwalader UHB. At present, all inpatient treatment (Tier 4) for children and young people living in Powys is provided either at Ty Lydiard, Princess of Wales Hospital in Bridgend or the North Wales Adolescent Service (NWAS) situated in Abergele.

Access to this service is via an assessment undertaken face to face by the Regional Service and there are frequently occasions when a young person requires a Tier 4 in patient service which is not immediately available. This is often due to lack of available beds, or due to delays in the regional service assessing the patient.

Within the last two years a number of Powys young people have experienced delays of up to 4 days prior to the regional service assessing or admitting the young person, leaving the patient managed within Emergency Department cubicles at a DGH for an unacceptable amount of time. Additionally, private sector in-patient beds can also incur a delay for assessment and decision on admission, which leaves Powys young people with no appropriate short-term treatment option, other than at ED units within local DGH's. This results in an increase in clinical risk at a time when a child or young person is arguably most vulnerable, with issues of unsuitable environment, ill equipped staff and busy emergency situations not always conducive to the optimisation of safe and effective care to children and young people suffering from mental health crisis.

For this client group, there are few other options available to PTHB, other than creating our own short-term admissions facility. Therefore, this paper proposes that the opportunity to provide a short-term service at Felindre Ward (Bronllys) for young people aged 16 to 17 years of age, where all other options have been exhausted. The aim is to manage clinical risk, maximising the opportunity to proactively prepare and the accommodate if needed, rather than respond in an emergency and be ill equipped. In terms of children below this age, referrals for inpatient provision are very rare, and the existing pathway into paediatric wards at DGH's will continue.

DETAILED BACKGROUND AND ASSESSMENT:

Situation:

The current Mental Health pathway for emergency admissions for children and young people (including those aged 16-17 years) is via presentation and assessment at Powys' neighbouring DGH Emergency departments.

It is extremely rare for a child younger than 16 years to require inpatient treatment. However, we are now experiencing more regular need for 16-17-year olds who are presenting in significant mental health crisis (which is frequently induced by illicit drug consumption). Since December 2019 the Powys Mental Health service has been required to facilitate the transfer of young people aged 16-17 to Felindre Ward on four occasions, due to lack of any other timely or safe inpatient provision available anywhere within Wales or Herefordshire / Shropshire.

At these times, and due to a complete lack of any other safe alternative provision (other than DGH Emergency Departments), the Powys Mental Health Services has provided a temporary "age appropriate care environment" for a young person aged 16 and 17 years old at Felindre Ward, Bronllys and then reported this as a Serious Incident to Welsh Government.

Within other Welsh Health Boards, (including those with a Tier 4 Service within their footprint) this same issue is experienced and has led to the development of age appropriate care environments for 16-17-year olds within their Adult Acute inpatient units. The Assistant Director for Mental Health has sought to commission access to these beds for Powys young people (without success), since our partner Health Boards have found that demand for this provision is high within their areas, leaving no surplus capacity for Powys young people.

Proposal – an age appropriate care environment for Powys.

Given the lack of alternative short-term provision for young people aged 16-17 who are awaiting a Tier 4 CAMHS bed, the Mental Health service established a working group comprised of Psychiatrists and Mental Health Practitioners from all disciplines to develop a Powys solution for a short-term appropriate bed for our young people.

The attached policy proposes that an "age appropriate care environment" for 16-17-year olds is provided on Felindre adult mental health ward at Bronllys Hospital. The CAMHS age appropriate care environment will only be used by those who cannot be supported in a less restrictive community setting. The use of the age appropriate care environment is considered the last resort for the treatment of the young person when all other possible alternatives are assessed as presenting a greater risk to the young person, and only for a period of up to seven days prior to transfer to a regional Tier 4 bed.

Children under the age of 16;

Young people under the age of 16 requiring mental health inpatient admission will continue be cared for on the paediatric ward in the relevant District General Hospital until they have been assessed by the Tier 4 inpatient unit gatekeeper. This in itself is not an ideal solution, however, at present there is no other appropriate alternative available and the Powys Mental Health Service continues to work with other Health Boards and Welsh Government to identify this service gap.

Admission to the age appropriate care environment;

For admissions within normal operational hours, the specialist CAMHS practitioner and CAMHS consultant will arrange the admission directly into Felindre ward. Outside of core operational hours, a 16-17-year-old requiring a Mental Health bed, will be assessed at a neighbouring DGH and transferred directly to Felindre Ward.

The CAMHS consultant will advise the Felindre Psychiatrist of the ongoing medical management and retain Responsible Clinician responsibility. All the young people (under the age of 18) admitted onto the ward will be nursed on a minimum of one to one basis and utilise close nursing observation in order to prevent inadvertent or unnecessary risk from:

- Adults who display disturbed behaviours
- Exposure to illicit substances
- Sexually inappropriate behaviours by adult patients
- Harm to self

When possible, it will be appropriate for the young person to mix with the general ward population (depending on their mental state, risk profile, and acuity levels of other patients on the ward). However, such decisions will always be informed by risk assessment, balanced against the potential risks to the young person and discussion between the Nurse in Charge, Adult Consultant, CAMHS Consultant and CAMHS team leader. Following admission, the Specialist CAMHS team will assess the young person daily to ascertain the need for a continued inpatient stay and to follow up the process to transfer the young person to Tier 4 services.

Maintaining family involvement;

Felindre Ward can provide appropriate provision for family visits, including those involving other children and younger siblings. However, during Covid times we will inform the family of any changes to visiting. Young people will continue be offered advocacy support from the Mental Health Advocacy service.

Environment of care;

The environment of care at Felindre Ward has been examined and is appropriate for meeting the short term needs of 16-17-year olds requiring an inpatient admission. Where absolutely necessary, Felindre ward can provide a segregated area, with a single sleeping area, lounge and bathroom facility where the young person can be cared for away from the adult patient group.

However, this will require the use of the s136 suite and will impact upon other patients should a s136 assessment be required at the same time. In the longer term, some adaptions to Felindre Ward will be required to create a combined Extra Care area / age appropriate bed which can be separated from the main ward (without impacting upon the s136 suite). However, most other Welsh Health Boards identify a bed within the main ward for 16-17-year-old patients for short term admissions**.**

Safeguarding

It is the responsibility of CAMHS and Felindre ward staff to keep the young person as safe as possible whilst they are being nursed on the adult ward. Prior

to the admission the ward manager in discussion with CAMHS staff will consider the needs of the both adult patients and younger people on Felindre ward

All Felindre staff would have participated in Level 3 child safeguarding training and the safeguarding team will be informed of the admission via datix
Training for Felindre staff will be every three months on a continuous rolling programme so this will capture any new staff

The Felindre team will be trained in;

- Awareness of the best practice in relation into the nursing management of 16- and 17-year olds
- Overview of problems and disorders in young people
- Childrens Act and other legalities including consent
- Rights and responsibilities
- Safeguarding.
- CAMHS will deliver bespoke training package to Felindre staff on a rolling programme.

Financial Implication

Young people admitted to the age appropriate care environment will be nursed on a minimum of 1:1 basis, depending on individual patient acuity. Naturally, this is likely to require the allocation of additional staff through Bank/Agency above the Felindre Ward establishment (depending on occupancy levels and adult patient acuity). However, this will be cost neutral as PTHB already funds any 1:1 nursing while a young person experiencing a mental health crisis is cared for with a DGH emergency department.

NEXT STEPS:

Following the approval by the Executive Committee, the service has commenced the delivery of the Operational Policy and formally provide short term inpatient admissions to 16-17-year olds who are waiting for assessment or admission into a Tier 4 regional CAMHS bed.

The following Impact Assessment must be completed for all reports requesting Approval, Ratification or Decision, in-line with the Health Board's Equality Impact Assessment Policy (HR075):

IMPACT ASSESSMENT					
Equality Act 2010, Protected Characteristics:					
	No impact	**Adverse**	**Differential**	**Positive**	
Age				x	
Disability				x	
Gender reassignment				x	
Pregnancy and maternity	x				
Race	x				
Religion/ Belief	x				
Sex	x				
Sexual Orientation	x				
Marriage and civil partnership	x				
Welsh Language	x				
Risk Assessment:					
	Level of risk identified				
	None	**Low**	**Moderate**	**High**	
Clinical			x		
Financial			x		
Corporate		x			
Operational			x		
Reputational		x			

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 2.2

EXPERIENCE, QUALITY & SAFETY COMMITTEE	**DATE OF MEETING: 15 April 2021**
Subject:	**Mental Health Act Hospital Managers Power of Discharge Group Terms of Reference and Operating Arrangements**
Approved and Presented by:	Rani Mallison, Board Secretary
Prepared by:	Rani Mallison, Board Secretary
Other Committees and meetings considered at:	Developed in liaison with Director of Primary, Community Care and Mental Health

PURPOSE:

The purpose of this paper is to request approval of revised Terms of Reference and Operating Arrangements for the Mental Health Act Power of Discharge Group, as sub-Group of the Experience, Quality & Safety Committee.

RECOMMENDATION(S):

The Committee is asked to DISCUSS and APPROVE revised Terms of Reference and Operating Arrangements for the Mental Health Act Power of Discharge Group, as sub-Group of the Experience, Quality & Safety Committee.

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 March 2019, the Board approved a revised committee structure and in doing so established the Experience, Quality and Safety Committee. The scope of the Experience, Quality & 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.

Further, the Board approved that a Hospital Managers Powers of Discharge sub-committee, which previously reported to the Mental Health and Learning Disabilities Committee (stood down in March 2019), would remain in operation under existing Terms of Reference (attached at **Annex A**) and report through to the Experience Quality and Safety Committee. The purpose of this sub-committee was to review and monitor how the operation of the delegated functions under Section 23 of the Mental Health Act 1983 were being exercised. At this time, the Board noted that the Terms of Reference and Operating Arrangements for this sub-committee required review and would be brought forward further consideration.

The Terms of Reference and Operating Arrangements have now been reviewed, led by the Board Secretary and Executive Director of Primary, Community Care and Mental Health, and are attached for the Committee's consideration and approval.

It should be noted that a change of name is proposed in revising the Terms of Reference to give clarity on its alignment with the requirements of the Mental Health Act and also to remove committee from its title given that its membership is predominantly made up of Hospital Managers and not Board

level Independent Members (as all other board level committees). The proposed Terms of Reference and Operating Arrangements are attached at **Annex B** for the Committee's consideration.	
ANNEX A	 PoD_Committee_Ter msofReference_ Octol
ANNEX B	 EQS_Item_2.2a_PoD_ Group_TermsofRefere

MENTAL HEALTH ACT
HOSPITAL MANAGERS
POWER OF DISCHARGE GROUP

Terms of Reference and Operating Arrangements

April 2021

1. INTRODUCTION

Powys Teaching Health Board (PTHB) is required under the Mental Health Act (MHA) Code of Practice (para 37.8) to develop a scheme of delegation for the duties identified by the MHA legislation. PTHB has taken a decision to delegate the power of discharge under the MHA to the 'Power of Discharge Group'.

The Power of Discharge Group (PODG) is a Sub-Group of the PTHB Experience, Quality & Safety Committee which is directly accountable to the PTHB Board. The Chair of the PODG must be a member of the Experience, Quality & Safety Committee and will for assurance purposes make regular reports to the Experience, Quality & Safety Committee on the work of the PODG.

The PODG will comprise MHA Hospital Managers who have been independently appointed. The MHA Hospital Managers sit as panels of three or more in order to exercise their power of discharge as detailed in the MHA Code of Practice. The decisions made by the panels are binding and therefore are not required to be ratified by the Experience, Quality & Safety Committee or by the Health Board. However, the procedures and behaviours adopted by the panel are subject to scrutiny and as such the MHA Hospital Managers are accountable to the Board via the Experience, Quality & Safety Committee.

2. REQUIREMENTS OF THE MHA

The primary purpose of the 1983 Act is to ensure that compulsory measures can be taken, where necessary and justified, to ensure that people who suffer from a mental disorder get the care and treatment they need. Because these provisions place people under compulsion (for example to receive treatment) the 1983 Act also contains a number of safeguards. These include, for example, a right to apply for discharge to the MHA Hospital Managers. MHA Hospital Managers have a central role in operating the provisions of the Act and as detailed above the Health Board has made the decision to delegate this responsibility to the PODG, and assurance will be provided to the Board through monitoring by the Experience, Quality & Safety Committee.

3. PURPOSE OF THE POWER OF DISCHARGE SUB-COMMITTEE

3.1 The purpose of the PODG is to:

- Consider all relevant issues for MHA Hospital Managers to undertake their role in accordance with PTHB and legislative requirements.
- Receive activity monitoring reports on the use of the Mental Health Act.
- Ensure that discharge panels are acting in a fair and reasonable manner and exercised lawfully.
- Consider updates regarding recommendations made during panel hearings.
- Discuss and agree training for MHA Hospital Managers.
- Receive professional advice to support the discharge of the MHA Hospital Manager Role.
- Provide a forum for consideration of any matter impacting on the decision making for discharge of patients detained under the Mental Health Act.
- Receive development/discussion sessions to improve overall knowledge of services.

3.2 The PODG will, in respect of its provision of advice to the Experience, Quality & Safety Committee, comment specifically upon:

- Processes in place to support discharge panels.
- Advise on issues arising from discharge panels and appeals of an unusual or contentious nature.
- Discuss any impact of legislative changes on role of MHA Hospital Managers.
- Highlight any impact of service changes on the ability to undertake the MHA Hospital Manager role effectively.

3.3 To achieve this, the Experience, Quality & Safety Committee shall provide assurance to the Board that:

- MHA Hospital Managers are effectively equipped and trained to undertake their role.
- PTHB provides appropriate support to ensure the Discharge Panels operate effectively.
- PTHB is aware of the impact of any legislative or service changes impacting on the Discharge panel's considerations and recommendations.

4. PODG MEMBERSHIP

4.1 The membership of the PODG is as follows: -

Chair	Independent Member (who must be a member of the Experience, Quality & Safety Committee)
Members	All of the Mental Health Act Managers appointed by PTHB
By invitation	The Committee Chair may invite: any other PTHB officials and/or any others from within or outside the organisation

The invitees may be asked to attend all or part of a meeting to assist it with its discussions on any particular matter.

4.2 Secretariat

The secretariat for the PODG will be via the Mental Health Act Administration Team.

4.3 Member Appointments

The membership of the Committee shall be determined by the Experience, Quality & Safety Committee, based on the recommendation of the PODG Chair and the membership of the PODG will be reviewed annually.

5. SUPPORT TO THE PODG

The PODG will receive support from the Mental Health Act Administration Department.

6. PODG MEETINGS

6.1 Quorum

A Quorum of a third of the whole number, including the Independent Member of the Health Board as Chair of the PODG.

6.2 Frequency of Meetings

Meetings shall be held no less than quarterly or more frequently if deemed necessary by the chair of the PODG.

7. RELATIONSHIP & ACCOUNTABILITIES OF THE PODG

The PODG is directly accountable to the Health Board for its performance in exercising the functions set out in these terms of reference. The accountability is achieved by the appointment of a PODG chair who must be included in the membership of the Experience, Quality & Safety Committee. Accountability will also be achieved by the submission of the minutes of all PODG meetings to the Experience, Quality & Safety Committee acting on behalf of the Board. The Experience, Quality & Safety Committee will also provide assurance reports to the Board, which will include information relating to its monitoring role of the PODG.

8. REPORTING AND ASSURANCE ARRANGEMENTS

The PODG Chair shall:

- report formally, regularly and on a timely basis to the Experience, Quality & Safety Committee on the PODG's activities. This includes verbal updates on activity and the submission of committee minutes and written reports throughout the year;

- bring to the Experience, Quality & Safety Committee's Chair specific attention any significant matters needing their consideration.

- ensure appropriate escalation arrangements are in place to alert the PTHB Chair, Vice Chair, Chief Executive (Accountable Officer) or Chairs of other relevant committees of any urgent/critical matters that may affect the operation and/or reputation of the PTHB.

9. REVIEW

9.1 These PODG terms of reference shall be reviewed annually by the Experience, Quality & Safety Committee.

Agenda item: 3.1

EXPERIENCE, QUALITY & SAFETY COMMITTEE	Date of Meeting: 15 April 2021
Subject:	**CONCERNS (COMPLAINTS, CLAIMS AND PATIENT SAFETY INCIDENTS)**
Approved and Presented by:	Alison Davies, Director of Nursing & Midwifery
Prepared by:	Wendy Morgan, Assistant Director Quality & Safety
Other Committees and meetings considered at:	Quality Governance Group 24th March 2021

PURPOSE:

The purpose of this report is to provide the Experience, Quality & Safety Committee with a summary position on patient experience and concerns, including complaints, patient safety incidents, serious incidents and claims for the period 1 April 2020 to 28 February 2021.

Recommendation(S):

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

Approval/Ratification/Decision	Discussion	Information
✖	✓	✖

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

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

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

DETAILED BACKGROUND AND ASSESSMENT:

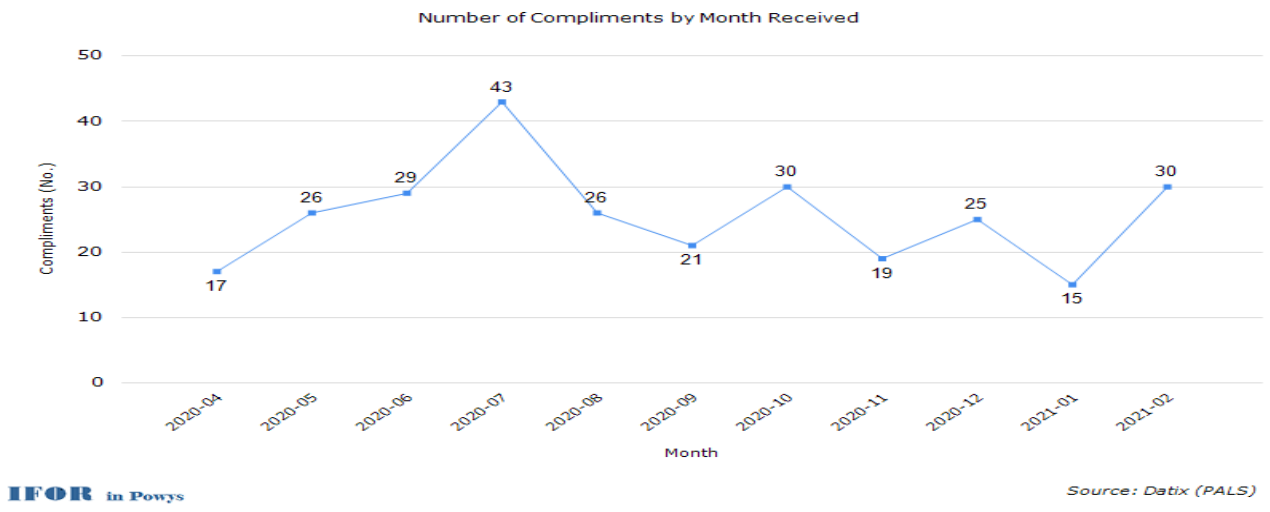
This paper provides a summary of patient experience and concerns, including complaints, patient safety incidents, serious incidents and claims for the period 1 April 2020 to 28 February 2021. It attempts to portray an overall picture, including trends, over the last financial year to assist discussion and identify areas where further emphasis is required. The contents of this paper should assist in triangulation with other sources including national audit, mortality review, research, clinical guidelines and professional standards.

The data depicted within this report is taken from the Datix system, unless otherwise specified, data quality and confidence are subject to limitations of the current Datix system, which is scheduled to be replaced as the Once for Wales Concerns Management System, commencing April 2021.

1.1 Compliments

Between 01 April to 28 February 2021, a total of 281 compliments have been received by the health board from patients, relatives, carers and other health services in the health board. These consisted of a combination of cards, letters, donations, gifts and verbal compliments.

Graph 1 – Total number of compliments received between 01 April 2020 to 28 February 2021



Examples include recognition of staff who have assisted patients in the community during the pandemic, for example, the swift provision of replacement hearing aids, tubing, and batteries, describing the services as prompt, efficient and caring. These comments have continued into January and February 2021.

The health board has received compliments since mass vaccination services commenced, particularly focusing on the welcome and efficiency of the services in

place with both staff and volunteers praised, received via social media, by email to the Concerns/ Patient Experience Team and directly to the Powys Mass Vaccination Team, which are not all captured in the numbers above, given the various channels they are received through.

1.2 Patient Experience

There are a numebr of individual approaches across services provided by the health board to capture patient experience, along with work undertaken to gather the exprience of Powys residents who use services commsioned from other health boards and trusts. Developing a strategic approach to patient experience that is person, rather than service or organisation specific, is a priority for the health board as exressed in the Clinical Quality Framework Plan. Its progression has been adversly affected by the need to respond to the pandemic but reamins an ambition during 2021-2022.

Alongside, but not dependent upon the Once for Wales Concerns Management System, work is progressing to enable a unified approach to patient experience which enables electronic patient feedback through surveys on a web browser platform. Potential benefits of using an electronic system include a consistent approach to capturing patient experience feedback from Powys residents regardless of where they access services, the variety of ways to feedback, direct feed of information in 'real time' enabling a prompt response if required, along with bespoke localised surveys. The procurement and use of a system to better capture patient experience will be considered by the Executive Team during quarter 1.

1.3 Putting Things Right

1.3.1 Putting Things Right Audit and Assurance Plan

Following on from the issue of a Special Report by the Public Service Ombudsman for Wales in October 2020, an independent review was undertaken regarding the ability and capacity of the health board's complaints handling team to deal with complaints under Putting Things Right (PTR) in an effective and timely way, including whether additional training on PTR requirements should be undertaken.

The final report, received in Febraury 2021, utilised the National Health Service Wales (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 (The Regulations), the PTHB Statement and Policy in respect of "Listening, Acting and Learning – Putting Things Right and Management of Concerns" which embodies the regulations, along with copies of correspondence and case notes (redacted) held by the health board in respect of the complaint and it's handling. Interviews with key individuals were recorded and transcribed.

The findings of the review confirmed that the way in which the health board managed Mrs A's complaint was poorly managed. Although there were resourcing challenges over this period, they were identified and dealt with as they arose and there is no evidence from the fact-finding work that the issues arising in this case were the result of either structural or resourcing issues. Although cross

organisational concerns are not in the majority, neither are they rare. Although some clarification in respect of what the co-ordinating role looks like and what should it entail may be of help in handling these cases, the evidence suggests that this would not have impacted on the progress of this case.

There is no evidence in the review that the issues that arose were the direct result of lack of training or inappropriate training. Likewise, there is no evidence to suggest that lack of training at manager level outside of the concerns team contributed to any delay or confusion in this case. Generally, there is felt to be a reasonable training offer in respect of Putting Things Right and concerns handling in the health board and across Wales and this is in the process of being updated. To ensure that the Putting Things Right Policy is fully effective there is a need to understand not only the All Wales policy context, but also the local service structures and accountabilities, and in this case, any specific issues that working within the health board's context might pose. This type of training has been provided in the past but a combination of temporary resourcing issues and more recently covid 19 pandemic, means it is an area that needs to be picked up and refreshed. PART B of the report was submitted in line with the agreed Terms of Reference.

The health board is eager to establish an audit system that supports generation of assurance in relation to the implementation of health boards policy on Putting Things Right, which is underpinned by a series of Regulations and Standards as well as additional considerations written in legislation that have been introduced since the publication of the policy in 2019. The policy commits that a minimum 10% sample of concerns will be subject to monthly audit to ensure compliance with the Regulations, however, since the policy has been approved, there are additional requirements that the health board is required to provide assurance against. Additionally, the preparation undertaken to inform the audit and assurance plan identified that the spread and depth of the of regulations and standards means that a monthly 10% sample is a significant demand on time and resources and therefore likely unachievable and the monthly cycle does not allow sufficient time for the translation and implementation of learning and actions before the next monthly audit commences – it is therefore not a preferable option.

An agreed annual programme is provided in **appendix 1,** which the policy is currently being updated to reflect. The programme is based on the core requirements of Putting Things Right and are noted in **appendix 2**. The audit programme proposal is structured on a rolling annual basis.

The implementation of the audit and assurance plan is predicated on the following factors:

- Establishment and consolidation of the quality and safety function with service groups, achieving greater clarity and separation between the service response and corporate assurance.
- The roles and responsibilities of the central Putting Things Right team clarified and aligned to the core skill set needed to meet the need, with capacity to accommodate the audit and assurance programme

- Little or no outstanding concerns, serious incidents and incidents, enabling robust and timely response where issues arise
- Introduction of the Once for Wales Content Management System (OFWCMS)
- A programme of continuous learning to support the development of knowledge, skills and expertise

The recommendations arising from implementation of the audit and assurance plan will be reported to the Quality Governance Group and subsequently the Experience Quality & Safety Committee.

1.3.2. Learning

The health board's first 'Learning from Experience Group', chaired by the Director of Clinical Strategy, took place in March 2021. The group creates the opportunity to discuss and triangulate quality issues, and how the organisation can maximise learning. The importance of the data quality available and the ability to analyse it effectively, to improve timely decision making was noted, along with the need to consolidate site based multi-disciplinary learning and the possibility of holding a Powys Quality and Safety learning event in the Autumn, were all key aspects of the meeting. This group should be well positioned to provide assurance and inform the strategic direction from learning on issues of quality and safety.

The learning from experience group will identify system wide learning, and will be informed by the service groups quality and safety arrangements, along with lessons learned within commissioned services. Examples of recent learning are included in remaining sections of this report.

Opportunities to share lessons and promote wider learning have also been taken during the year, through the Patient Experience Steering Group and Powys announcements.

1.3.3 Concerns (complaints) Summary Position

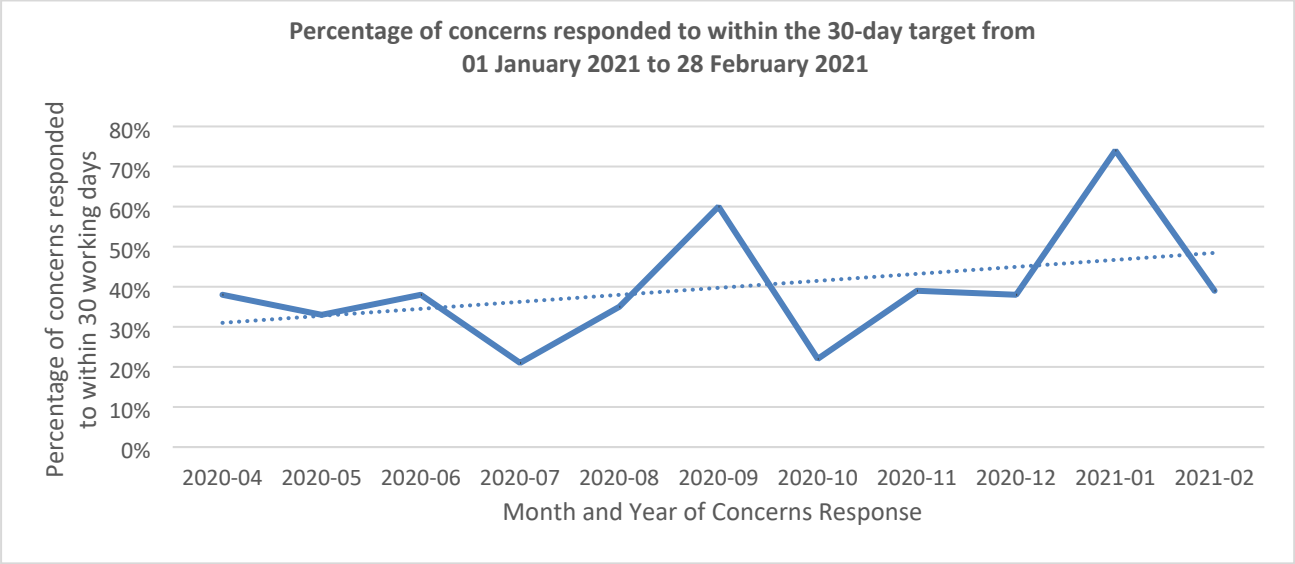
Informal concerns, often termed 'on the spot' concerns, usually relate to relatively easy to address issues which can be resolved quickly and ideally by the next working day. All concerns, informal and formal, are required to be acknowledged within two working days. Our internal target for the acknowledgement of informal concerns is 100%. During the period of 01 January 2021 to 28 February 2021 the health board achieved 100% of this target. During the same period, the health board achieved 90% (↑ from 85.3%) in acknowledging formal concerns.

The health board set an internal target of 90% of informal concerns to be responded to by the next working day. From 01 January 2021 and 28 February 2021, the health board received <5 informal concerns, these were successfully managed within the expected timeframe.

During 01 January 2021 and 28 February 2021, the health board received 22 formal concerns. The main issues relating to communication, care and treatment across

a range of services, but no specific themes evident. The graph below shows the month on month compliance with the 30-working day target, recognising this does vary, there is an upward trend demonstrated. During quarter 3, the health boards response within 30 working days equated to 69.4%, a steady improvement from 28.2% in the previous 12 months and 50% in the previous period. The target is 75% and the al Wales average 71.9%.

Graph 2: Percentage of concerns responded to within the 30-working days from 01 January 2021 to 28 February 2021



Data Source: IFOR

Since the Mass Vaccination Programme commenced in December 2020 for the period 01 January 2021 and 28 February 2021, 41 enquiries have been made regards access to vaccination. Working with the Mass Vaccination Team, 37 of these were resolved with actions ongoing relating to the further 4 received

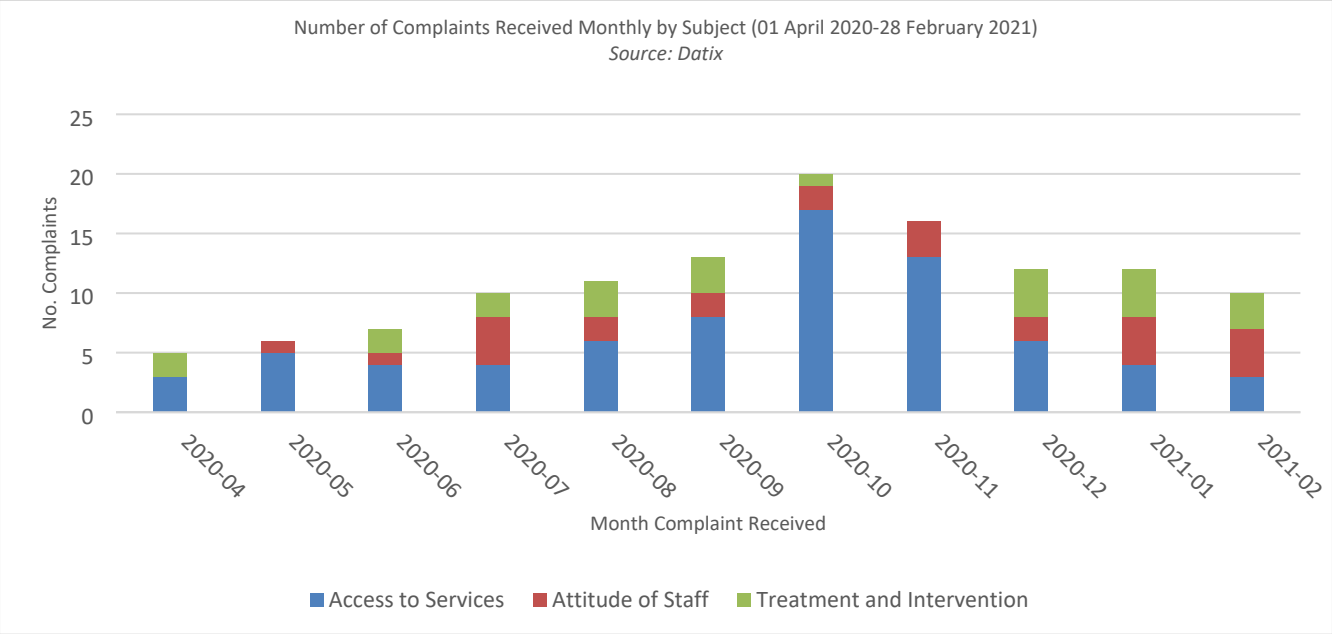
A recent Public Services Ombudsman for Wales Thematic Report – At Your Service: A Good Practice Guide included at **appendix 3**, focuses on good practice and describes good practice as one that has been proven to work well and produce good results, also occurring when an officer does more than expected to ensure a positive outcome. Training provided by the PSOW officers is scheduled within the health board during April 2021.

Themes and Trends since 01 April 2020

The following data, sourced via Datix for the period 01 April 2020 to 28 February 2021, shows the number of complaints received monthly for service groups who have attracted the highest numbers since 01 April 2020. They are Mental Health (n29), Community Hospitals (n21), Commissioned Services (n19), Women & Children's Services (n15) and Allied Health Professionals (n9). It is important to note that complaints are received for other areas, but these are very small numbers.

The main reasons for complaints are categorised below. With access to services the main area of concern (n73) and attitude of staff (n25) and treatment and intervention (n24) attracting similar numbers of concerns. Access to services spans the range of provided services and commissioned services. Attitude of staff reflects provided services only and treatment and intervention mainly reference provided services. It is important to note that the commissioned services complaints represent those that are raised directly with Powys Teaching Health Board, and are potentially a proportion of complaints made about commissioned services

Graph 3: Number of complaints received monthly by subject (01 April 2020-28 February 2021)



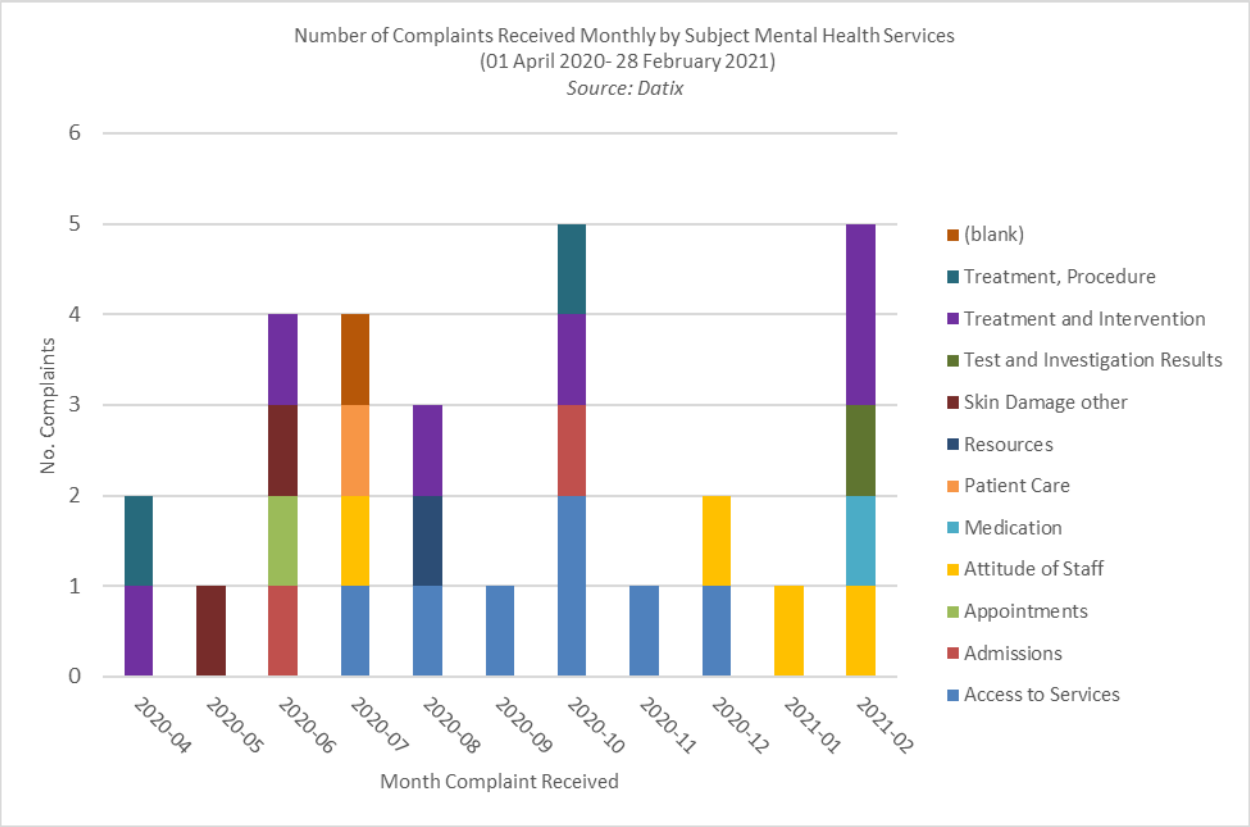
- **Mental Health Services**

During quarter 4, mental health services developed a more proactive approach to managing complaints, namely through early contact with people who raise concerns to understand better the issues being raised and to ensure immediate action is taken where possible to put improvements in place and share learning. As a result of these actions they have been able to resolve three concerns at a local level. Further actions to improve responses to concerns has seen the introduction of a rota for undertaking investigations which has been positive to date, ensuring all staff have the opportunity to complete investigations maintaining their skills and competences and assists in balancing workload. The Service is also working to create a database of learning to promote sharing of lessons on a wider basis.

The table below illustrates the number and type of complaint received by mental health services, by month over the last financial year, appreciating that the way

in which services were provided changed early on as a result of the pandemic. provision

Graph 4: Number of complaints received monthly for Mental Health Services subject (01 April 2020-28 February 2021)



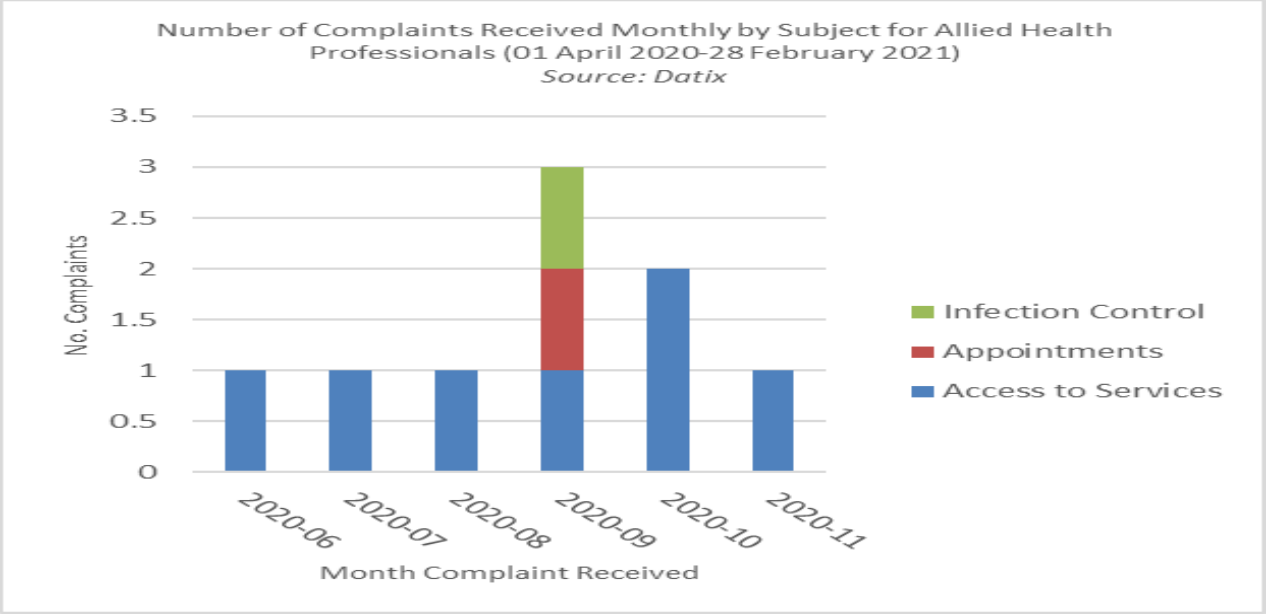
Examples of **learning and improvements** in response to concerns from the Mental Health Services include:

- Providing greater clarity of discharge s and re-referral arrangements under the Mental Health Measure (Wales) 2010
- Ensuring that practitioners identify early warning signs (EWS) where these are known in patient plans around risk/safety
- Throughout February and March 2021, Mental Health Partnership Participation Officers have supported an individual representative to hold 'Self Injury Awareness' sessions with mental health and minor injury unit staff. The sessions provide opportunity for the staff to learn from an expert by experience. The sessions are focused on immersing staff in the patient perspective and honesty about self-injury without judgement. Overall, feedback has been positive, noting a marked difference between the mental health awareness of the different staff groups. In light of this, the Suicide and Self-Harm Prevention Coordinator will be looking into the need for mental health training / trauma informed training to help support our minor injury unit staff.

- **Services provided by Allied Health Professionals**

Concerns related to services provided by allied health professionals are less in number (n9), the main area of concern is access to services in podiatry and physiotherapy services. No trends are noted due to such small numbers.

Graph 5: Number of complaints received monthly for Allied Health Professionals by subject (01 April 2020-28 February 2021)



Learning has resulted in

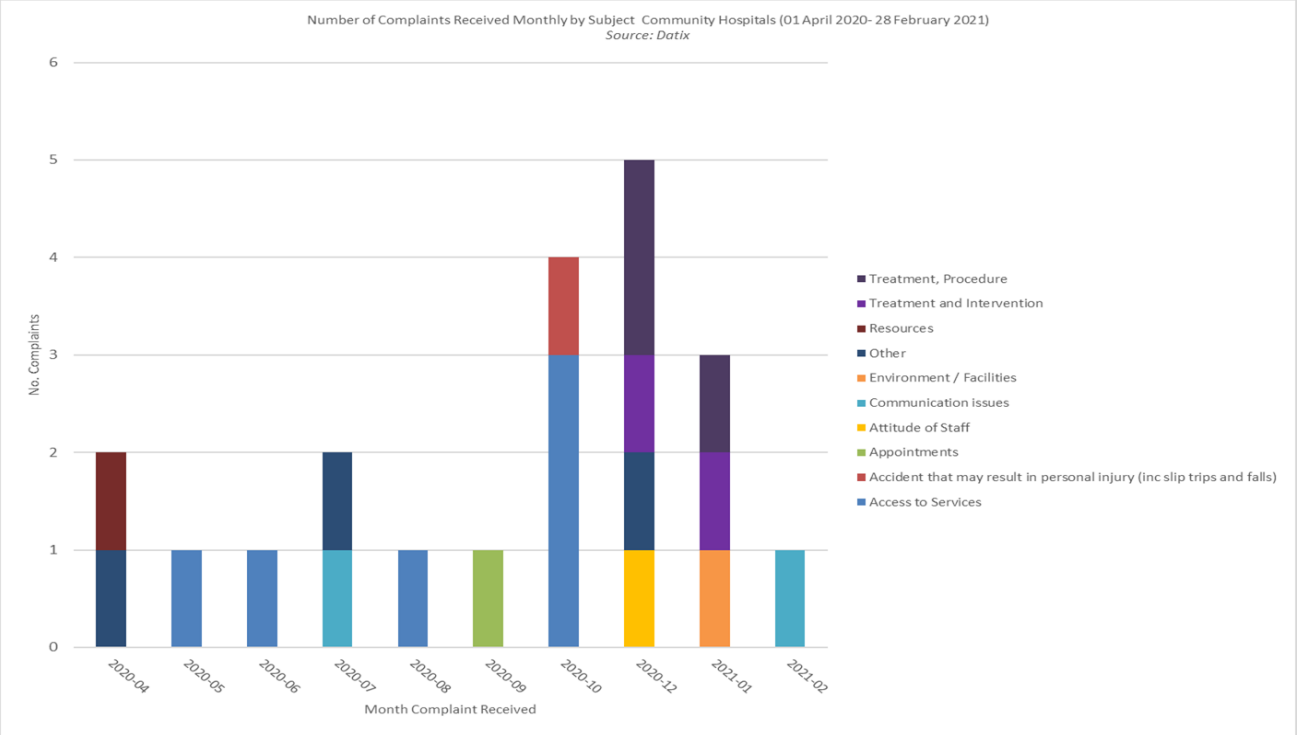
- Amendments made to the self-referrals process and review of website content. The service is in the process of implementing an e-referral form for MSK.
- Concerns raised regards access to podiatry services and furniture in a local Medical Practice. A refurbishment plan has been agreed and the works are being costed.
- Refresher personal protective equipment (PPE) training with all Heads of service ensure compliance and support spot checks within the service.

Community Hospital concerns

The Community Services Group and other service groups, will increasingly report their specific quality and safety related matters contemporaneously, enabling this report to better reflect the organisational themes, trends and learning. Concerns within the service groups are varied and occur across most of the community hospital sites, in general relate to ward and inpatient areas.

Graph 6: Number and type of complaints received monthly for Community Hospitals by month (01

April 2020-28 February 2021)



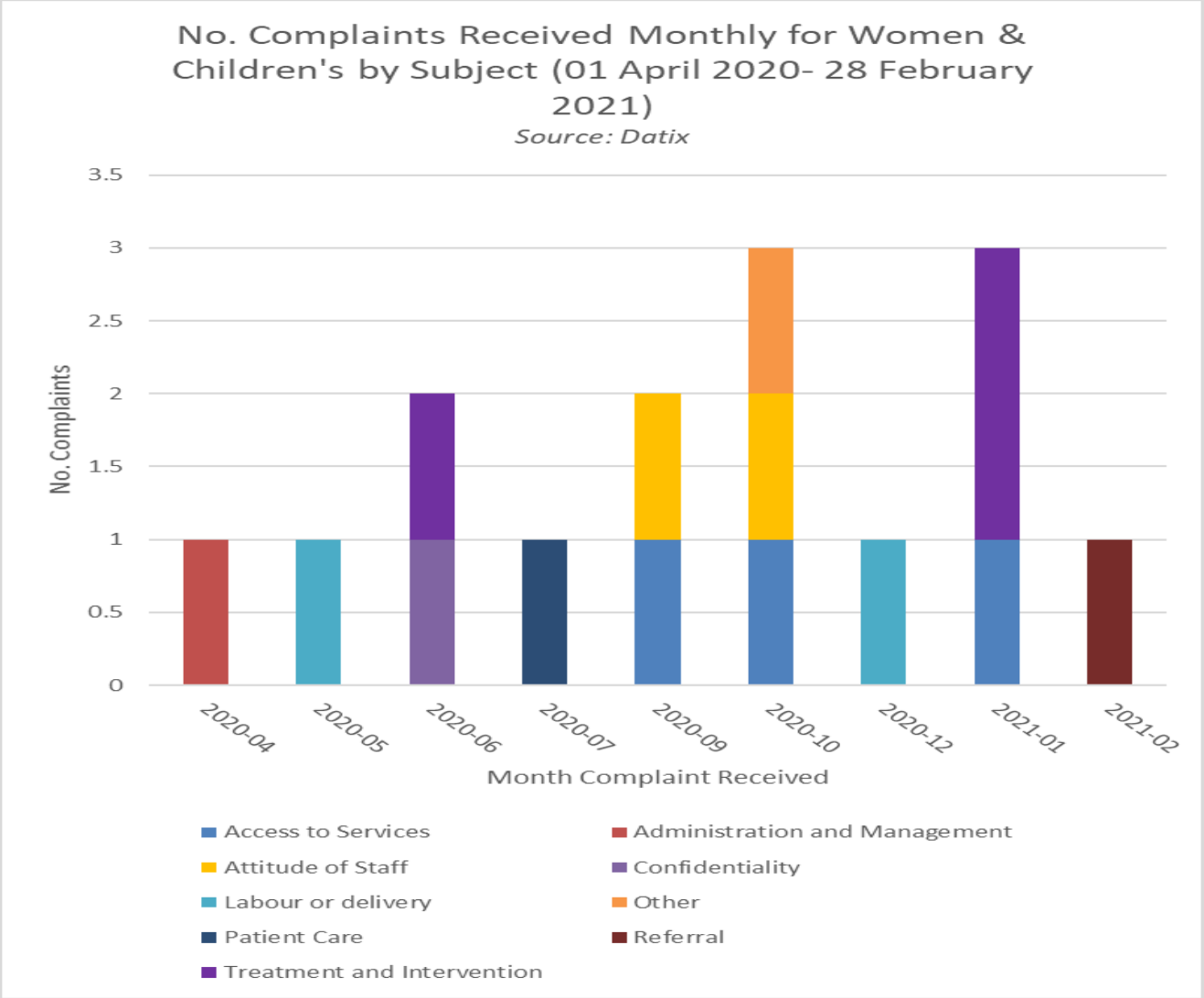
Learning includes:

- Improved arrangements based on good communication with families relating to the care and treatment provided to patients, including those living out of area
- Minor Injury Units have revised leaflets and posters explaining how people are assessed and prioritised on attendance, which will help initiate and inform discussion
- Refreshed communication and explanation with patients and families where the need to take and use photographs exits, including clear processes in gaining consent.

Women & Children's Services

There has been a total of 15 concerns in year, the main categories of concern relate to treatment and intervention and access to services.

Graph 7: Number and type of complaints received monthly for Women & Children's Services by subject (01 April 2020-28 February 2021)



In terms of **learning and improvement**, development of clinical pathways between the health board and commissioned providers for pregnant women with chronic medical conditions, has been a key focus.

- **Commissioned service complaints**

The number of complaints received directly by the health board about commissioned services for the period 01 April 2020-28 February 2021 is small in number (n16) and relate to the following providers:

- Aneurin Bevan University Health Board
- Abertawe Bro Morgannwg University Health Board
- Birmingham University Hospitals
- Cardiff & Vale University Health Board
- Hywel Dda University Health Board
- Shrewsbury & Telford NHS Trust
- Wye Valley NHS Trust

1.3.3 Education and Training re. putting Things Right

In January and February 2021, root cause analysis training was provided to a group of 10 senior service group managers. This consisted of two days exploring root cause analysis training, and a half day focussing on workforce relations management linked to investigation of concerns and incidents.

Two webinars took place, the 18th February 2021 (36 staff participated) and 4th March 2021, the topics "Writing Witness Statements and What to Expect When Attending Court" provided and supported by NHS Wales Shared Services Legal & Risk Services, a solicitor answering questions following pre-recorded webinars. The short sessions (40 minutes) provided popular, feedback is currently being collated and will be reported in the next update.

The Public Service Ombudsman for Wales is offering training on the management of concerns and their investigation. Two days training has been offered and dates have been confirmed for week commencing 26 April 2021. This will form the next available training for staff to access.

As part of the implementation of RLDatix systems under the auspice of the Once for Wales Content Management System, training is taking place for the Datix Administrators in March 2021 and wider roll out of training from 12 April 2021 as the first modules go live.

2. Incident Reporting

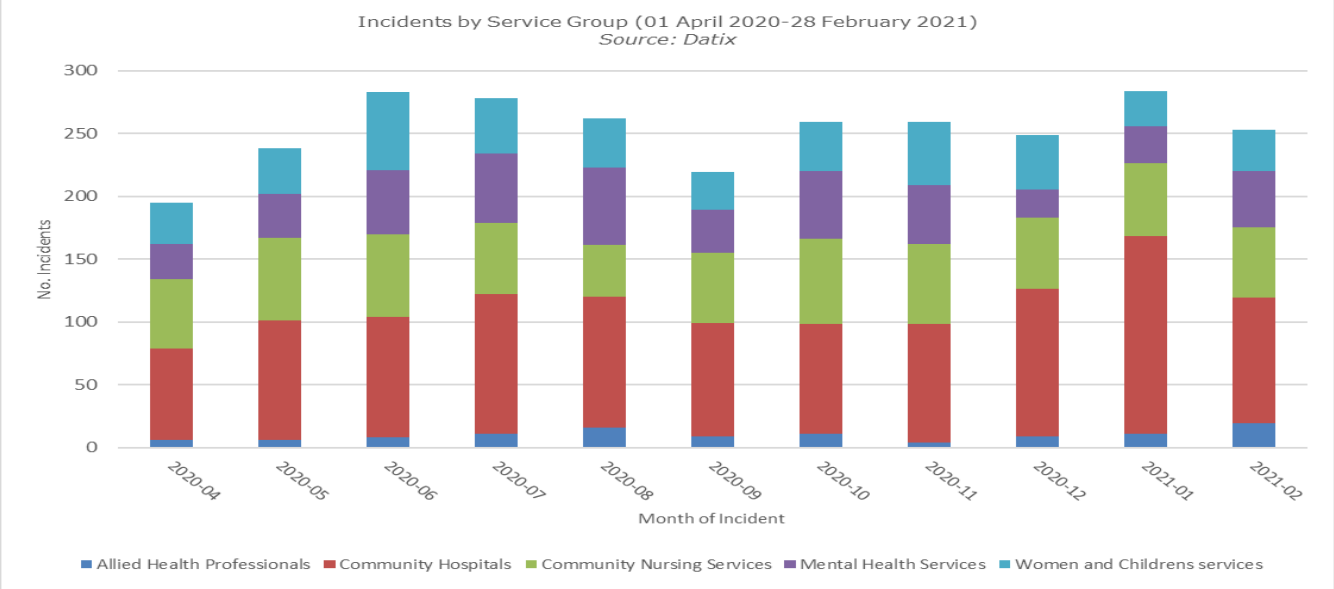
An incident is defined as an event that occurs in relation to NHS-funded services and care resulting in unexpected or avoidable death, harm or injury to patient, carer, staff or visitor.

2.1 Incident Reporting

Incidents are categorised by the subjects they relate to, and these have been defined at a national level and reported on quarterly to the Welsh Risk Pool Services. There are 31 categories which also includes a category 'other', see **appendix 4** for full listing.

The following graph shows the incidents reported (n2779) by the main service groups (graph 11) for the period 01 April 2020-28 February 2021, with Community Hospitals (n1124), Community Nursing Services (n644), Mental Health Services (n463), Women & Children's Services (n438) and Allied Health Professionals (n110) displayed. The range 189-275 incidents reported per month, the average number per month 243 incidents.

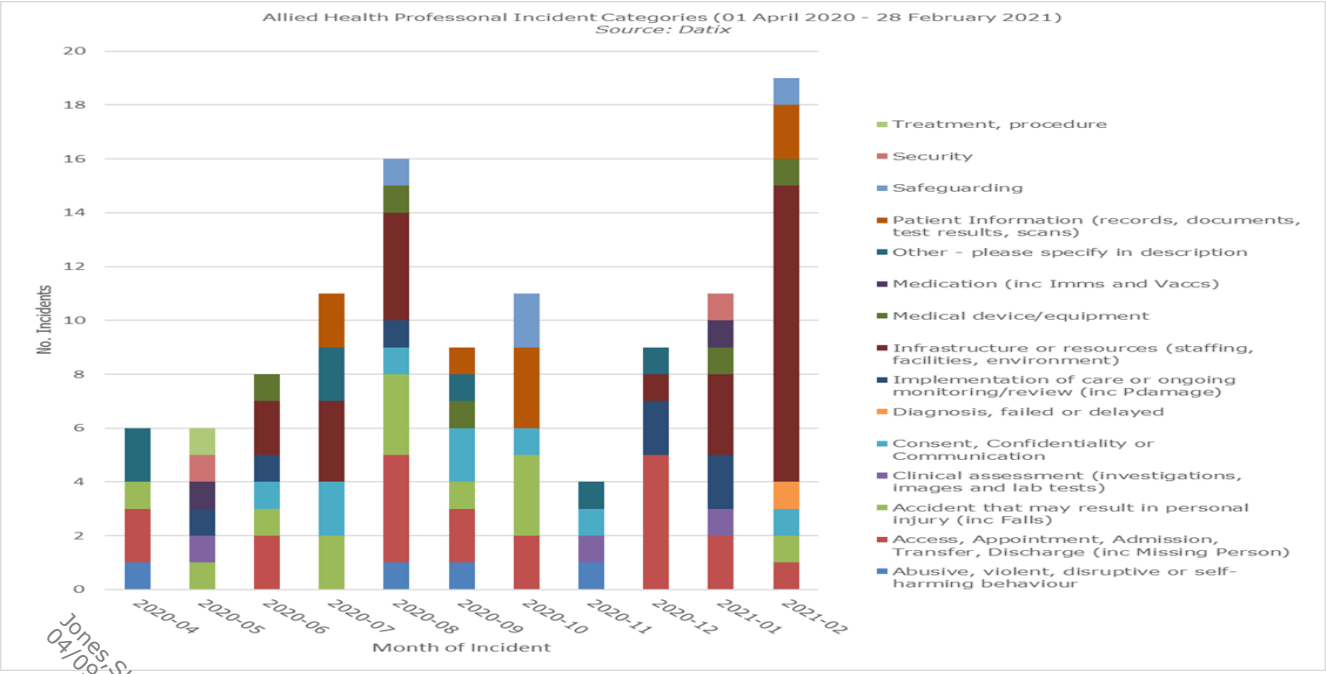
Graph 8: Incidents reported by Service Group 01 April 2020-28 February 2021



2.2 Services provided by Allied Health Professionals

The reported incidents (n110) related to services provided by Allied Health Professionals covers a wide range of services, as does the type of incidents reported including administration, ophthalmology and specialist nursing. Further work is required to understand the reporting within these categories. The main categories relating to the infrastructure and resources (n24) (staffing, facilities and environment) and access, appointment and admission (n20). The increase in February is as a result of the outage of the WCCIS system which has been discussed as a risk rather than an incident.

Graph 9: Allied Health Professionals Incident Categories 01 April 2020 – 28 February 2021

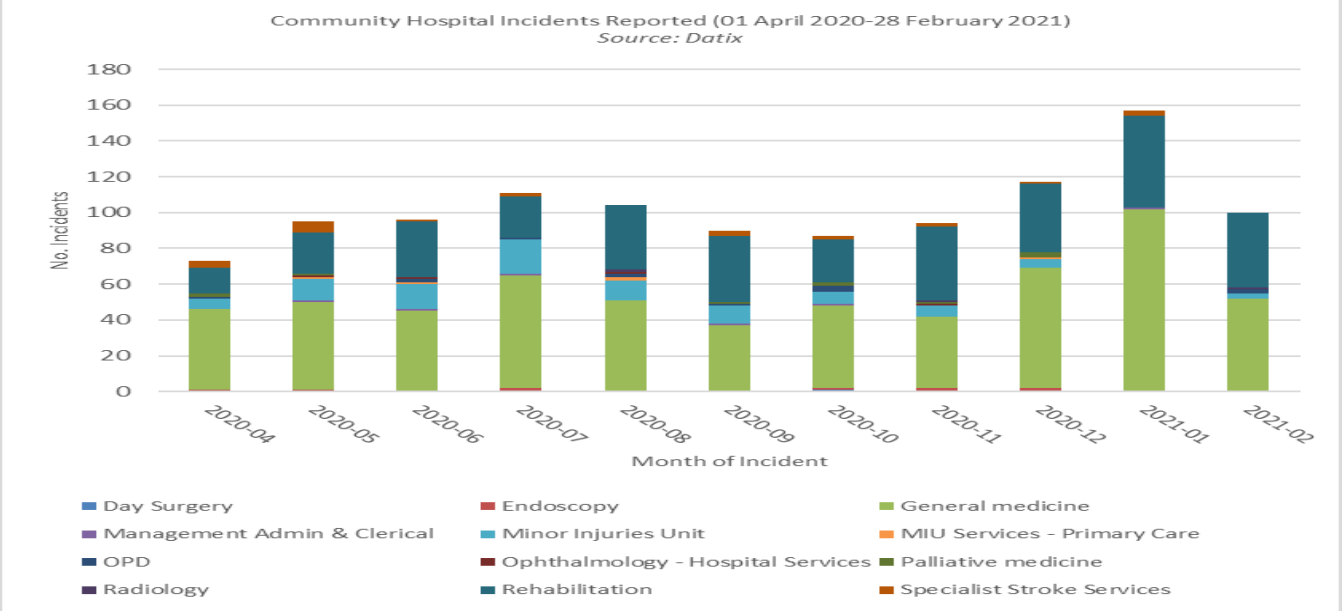


2.3 Community Hospital

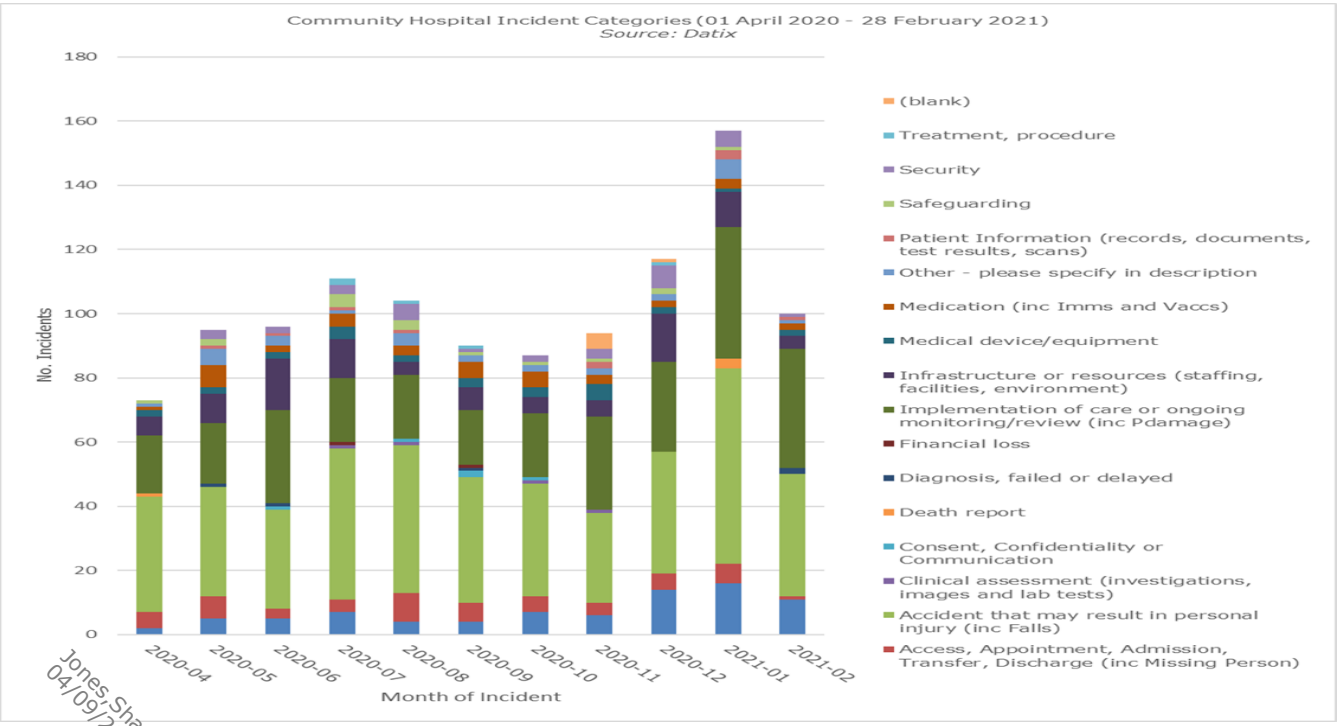
Incidents (n1124) covers a range of areas, some allied health professional incidents

included. The categories reported span clinical and non-clinical activities. The highest categories including abuse, violent disruptive behaviour (n81), access, appointments, admissions, transfer, discharge (n55), accident that may result in personal injury (including falls) (N 433), implementation of care or ongoing monitoring/ review (including pressure damage) (n278) and Infrastructure or resources (including staffing, facilities, environment) (n 94).

Graph 10: Community Hospital Incidents reported 01 April 2020 – 28 February 2021



Graph 11: Community Hospital Incident Categories 01 April 2020 – 28 February 2021



The lessons below reflect examples throughout the last year to date:

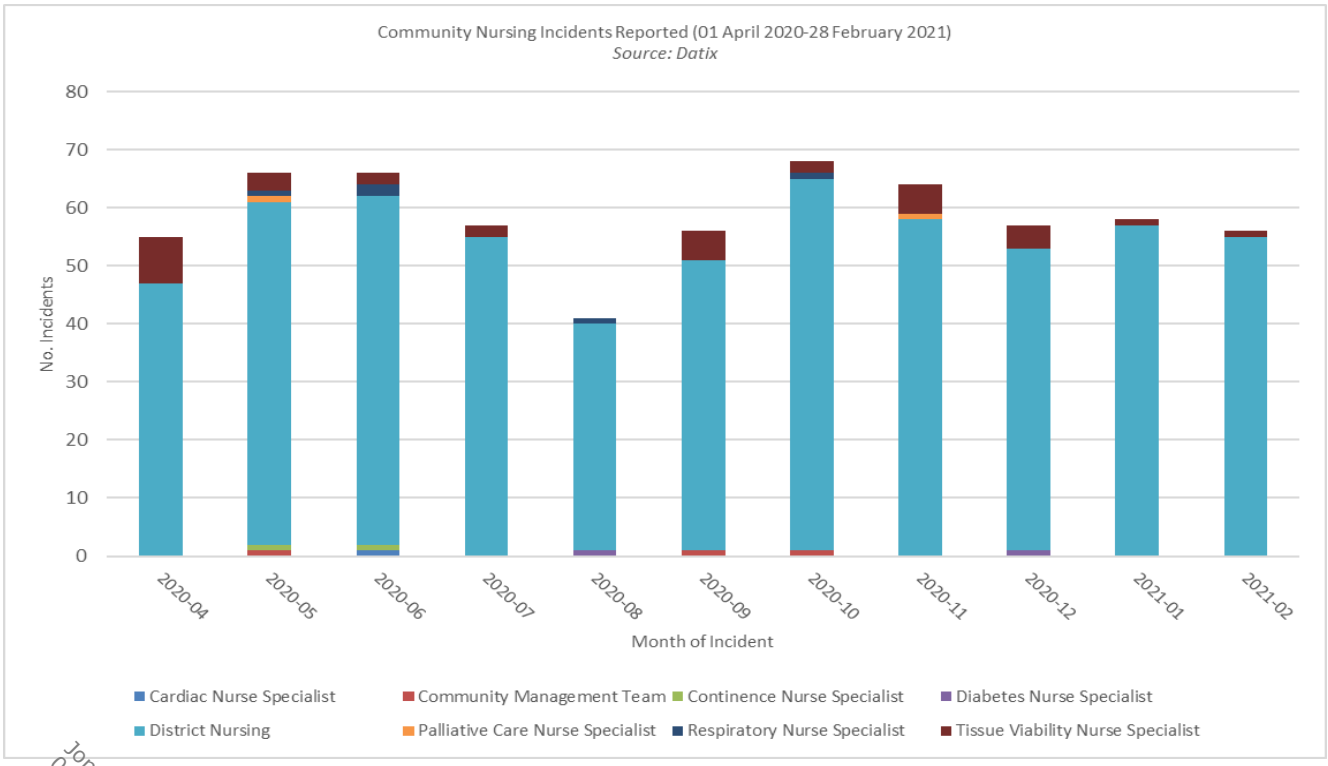
- Ensure bed pumps are closely checked and in place to avoid accidents

- Escalate any 'near misses' with medication
- Awareness of Information Governance Policies and Procedures
- All staff must wear identification badges and produce them when asked
- Continue to review skill mix according to patient acuity
- Follow safeguarding procedures and always consider if a child is at risk
- Ring the Estates department to adjust heating for the wards
- Need for care and precision when handling/copying/filling patients notes
- Copies of all notes to be sent to other professionals involved in assessment
- Adherence to all aspects of social distancing including the staff room, this includes staggered lunches, eating elsewhere and going for a walk.
- Always maintain appropriate checks to ensure integrity of cold chain
- All staff are aware of how to enter new Controlled Drugs coming on to a ward
- All staff aware of the risks of aggression physically and continue to document any issues and refer back to the mental health team for advice and support if required. To ensure a safe environment if a patient becomes aggressive and to step back from a situation.

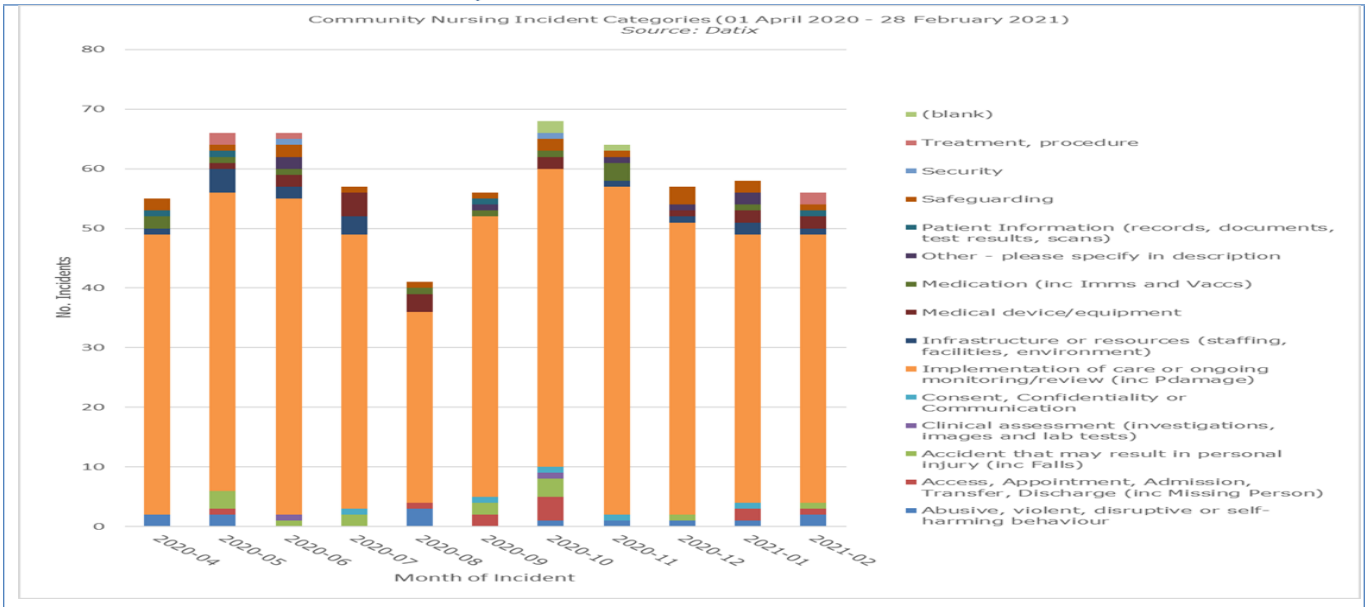
2.4 Community Nursing

Incidents reported cover nurse specialities and district nursing (n644). The highest number of incident types reported are implementation of care or ongoing monitoring/ review (including pressure damage) (n519), of which 389 are pressure damage are reported pressure damage, various grading.

Graph 12: Community Nursing Incidents reported 01 April 2020 – 28 February 2021



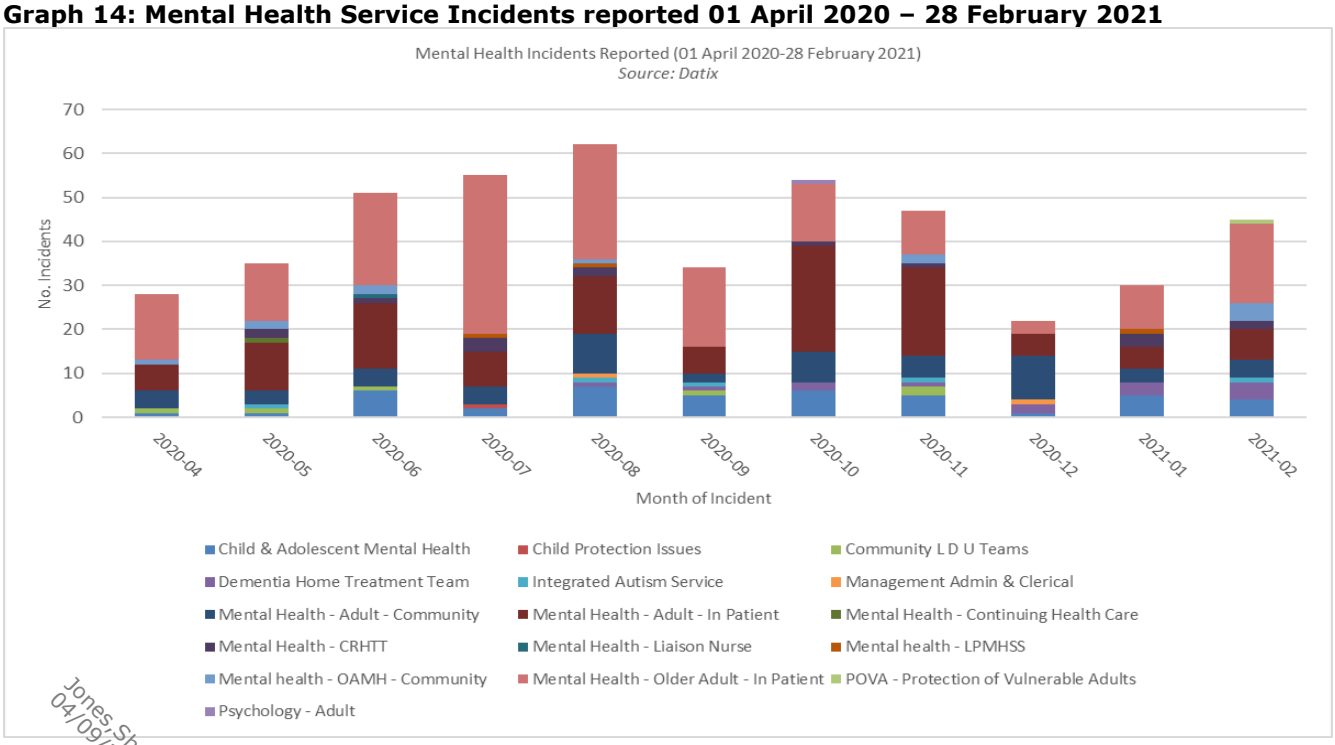
Graph 13: Community Nursing Incident Categories 01 April 2020 – 28 February 2021



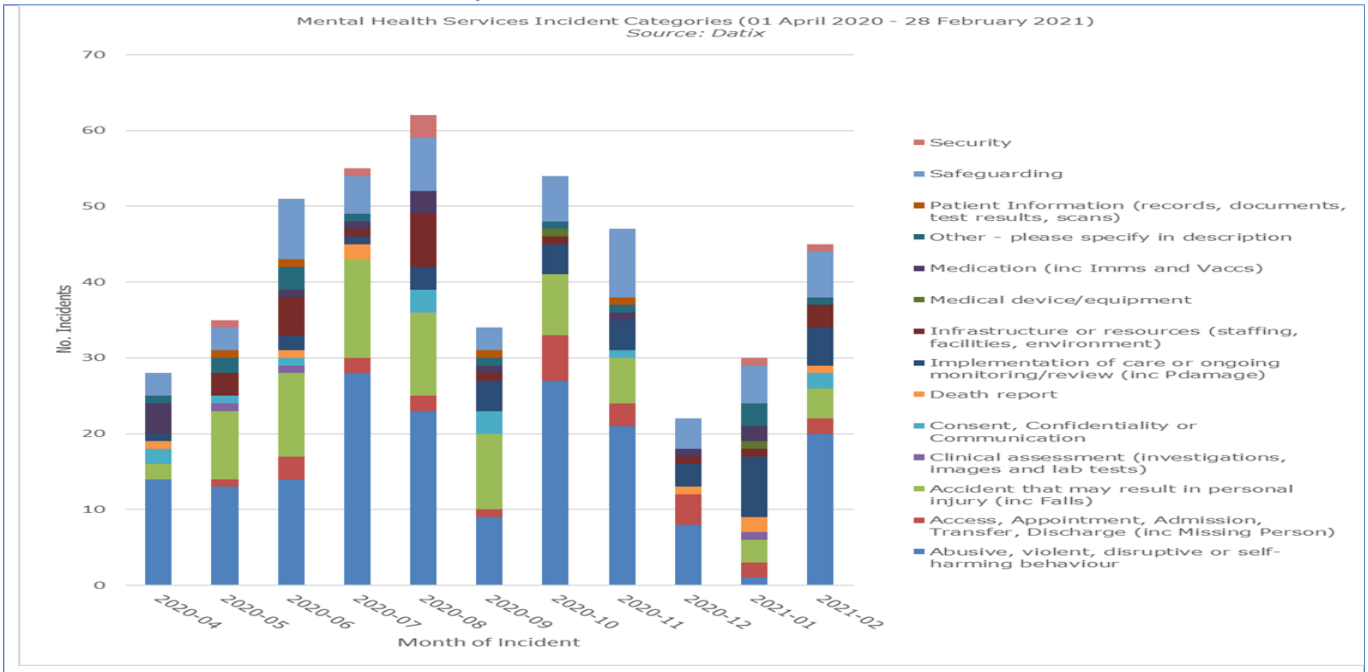
2.5 Mental Health Services

Incidents are representative of a range of mental health services, the majority of incidents reported in Mental Health – Older Adult Inpatient (n183), Mental Health – Adult Inpatient (n120), Mental Health – Adult Community (n55) and Child & Adolescent Mental Health (n43). The main incident categories being abusive, violent, disruptive or self-harming behaviour (n178), accident that may result in personal injury (including falls) (n77) and safeguarding (n59).

Graph 14: Mental Health Service Incidents reported 01 April 2020 – 28 February 2021



Graph 15: Mental Health Services Incident Categories 01 April 2020 – 28 February 2021

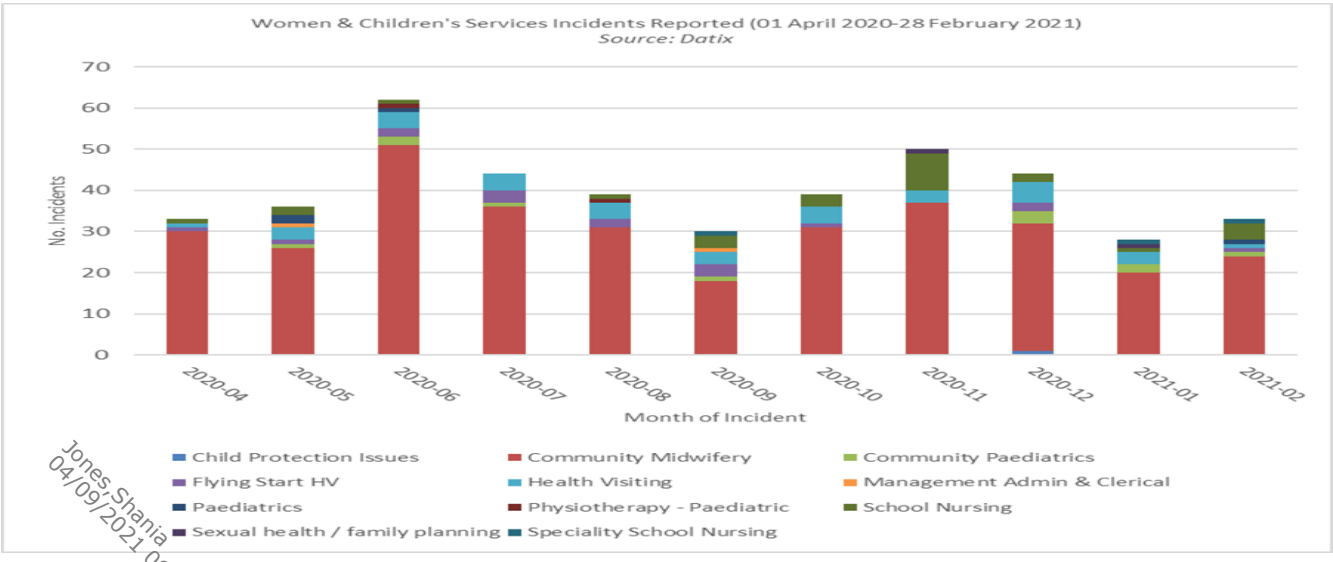


2.6 Women and Children's Services

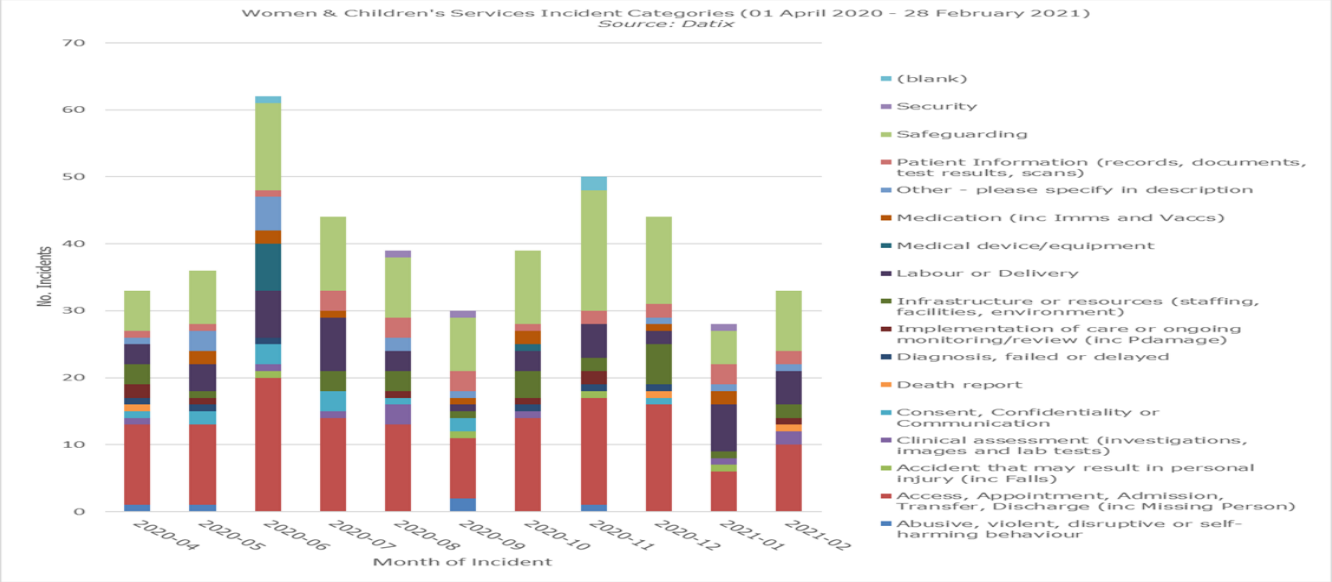
Incidents are focussed more in Community Midwifery (n335) reflecting the service model in place, with Health Visiting (n35) and School Nursing (n27) the next two main areas of reporting. The main types of categories reported are Access, Appointment, Admission, Transfer, Discharge (n142), safeguarding (n111), labour / delivery (n48), infrastructure or resources (staffing, facilities, environment) (n26) and Patient Information (records, documents, test results, scans) (n22).

The main reporting area is related to transfers, recognising Powys as providing midwifery led care, the transfers relate to either pain relief or for obstetric opinion when there are delays or concerns during labour and delivery, and other issue that is not as expected.

Graph 16: Women & Children's Service Incidents reported 01 April 2020 – 28 February 2021



Graph 17: Women & Children's Services Incident Categories 01 April 2020 – 28 February 2021



In terms of learning, considerable work on ensuring policies and procedures are current has been achieved, along with development of clinical pathways for pregnant women with chronic medical conditions and a focus on the uptake of safeguarding supervision.

2.7 Serious incidents

A serious incident is defined as an incident that occurred during the provision of NHS funded healthcare. Serious Incidents are now reported to the Delivery Unit arm of Welsh Government, who have taken over the serious incident reporting process. Work has also commenced on the revision of the serious incident framework to ensure appropriate reporting of serious incidents and to maximize learning opportunities from incidents reported.

During the Covid-19 pandemic period Welsh Government provided guidance on the application of Putting Things Right, reissued again in January 2021, and this included guidance on reporting and investigating serious incidents, resulting in only the following categories to be reported:

- all never events
- in patient suicides
- maternal deaths
- neonatal deaths
- homicides
- incidents of high impact / likely to happen again including child related deaths (for local decision)

During the period of 01 January 2021 to 28 February 2021 the health board reported 8 serious incidents to the Delivery Unit. No themes or trends identified and related to slips, trips and falls, unexpected death, reaction to medication, discharge, test results and infection control.

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 January 2021 to 28 February 2021, the health board have made less than 5 reports to Welsh Government, these included (not exclusively) issues related to mass vaccination and Women & Children's Services. As part of the serious incident framework review Welsh Government are also reviewing how commissioned services related incidents are reported. Previously reported as no surprises, there is work progressing to report key issues and lessons learnt. Further information will follow.

4. Inquests

During the period of 01 January 2021 to 28 February 2021 there have been less than 5 HM Coroner Enquiries opened. As a result of the Covid19 pandemic, HM Coroner Courts have been advised to 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 December 2020, it is noted that 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 January 2021 to 28 February 2021, the health board have received less than 5 PSOW enquiries, and responded to two of the recommendations made by the PSOW. The agreement with the PSOW to extend the timescale to finalise an outstanding Standard Operating Procedure due to the complexity involved, remains extant.

6. Claims

Powys Teaching Health Board has a small claims portfolio; there are currently 16 open which are inclusive of clinical negligence and personal injury claims with one case transferring from a potential claim during quarter 3, with NWSSP Legal and Risk Services instructed to act on behalf of the health board. 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.

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 Locally, action has been taken to progress compliance with the one open patient safety solution indicated as non-compliant (PSN 034): Supporting the introduction of the National Safety Standards for Invasive Procedures – action is progressing to support compliance, the appointment of new senior nurse roles in theatres and outpatients departments will support completion of this work. Quarter 1 2021/22 will report further compliance.

Compliance regarding 4 patient safety notices has been reported to Patient Safety Wales:

- PSN 051 Depleted batteries in intraosseous injectors – not applicable to Powys Teaching Health Board
- PSN 052 Risk of death and severe harm from ingesting superabsorbent polymer gel granule – Compliant
- PSN 053 Risk of harm to babies and children from coin/ button batteries in hearing aids and other hearing devices – Compliant
- PSN 054 Risk of death from unintended administration of sodium nitrite – Compliant

T**wo new notices** have been received:

- PSN 055 The Safe Storage of Medicines: Cupboards – action required by 30th September 2021(notice replaces PSN 030 issued in 2016)
- PSN 056 Foreign body aspiration during intubation, advanced airway management or ventilation- action required by 1 July 2021

NEXT STEPS:

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

Appendix 1: audit programme cycle

Area		Activity	Delivery timeframe for internal activity				
			Q1	Q2	Q3	Q4	External Audit (EA)
Process compliance A combination of open and closed cases in a set period of time may be required for a 10% sample.	Standard concerns (all concerns excluding categories below)	random sample audit					
	Staff concerns	random sample audit of specific category					
	Children and Adults at Risk	random sample audit of specific category (Or 10 unique if 10% < 10)					
	Serious Concerns	random sample audit of specific category (Or 10 unique if 10% < 10)					
	Never Events	random sample audit of specific category (Or 10 unique if 10% < 10)					
	Management of Redress Cases	random sample audit of specific category (Or 10 unique if 10% < 10)				(EA)	Yes - Annual
	Claims Management	random sample audit of specific category (Or 10 unique if 10% < 10)				(EA)	Yes – Annual (25%/25 unique)
	Commissioned services concerns	random sample audit of specific category (Or 10 unique if 10% < 10)					
	Cross Border concerns	10% random sample audit of specific category (Or 10 unique if 10% < 10)					
	Multi-agency concerns	10% random sample audit of specific category (Or 10 unique if 10% < 10)					
Listening & Learning	Complainant experience	Ongoing feedback monitoring					
		High level review of monitoring /red flags and learning					
		10% random sample deep dive audit					
	Organisational learning	Combined audit and review activity					
Duty of Candour	Duty of Candour	10% random sample audit					

Appendix 2: core requirements

Table 1: Core Requirements					
Audit area	**Regulation**	**Standard**	**Activity**	**Responsibility**	**Timeframe**
Concerns responses / Process compliance for: Standard concerns; Concerns about Children and Adults at Risk; Serious Concerns and Never Events	Regulation 23 and 24 All concerns must be managed and investigated in the most appropriate, efficient and effective way as outlined in Regulation 23. Welsh NHS bodies should note in particular Regulation 23(1)(i) which states that where the concern notified includes an allegation that harm has or may have been caused it must consider: the likelihood of any qualifying liability arising; the duty to consider Redress in accordance with Regulation 25; and where appropriate, consider the additional requirements set out in Part 6 of the Regulations. Records – Reg 50	To ensure NHS Bodies have an effective process for managing concerns raised by patients and staff in accordance with the NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 which complements and supports the existing processes for the management of clinical negligence claims	Live tracking (for detail see Appendix 0) and system to alert when timeframes have been breached Quarterly audit of 10% random sample. Audit to cover: Compliance with timeframes/ GDPR/ process as stipulated in the Policy / accurate grading / proportionality/ appropriate escalation / open timely accurate communication (to complainant and staff) / complaint support/ storage / retention/ records / accuracy and current record keeping / report and output quality… Children and adults at risk / serious concerns / never events - 10% random sample (or a minimum of 10 unique if greater than 10%) at quarter 1 and 3. (NB these may be captured in the random sample also, but twice yearly audit questions will be asked of a 10% sample of these specific areas)	Concerns Team responsible for tracking and quarterly audit covering random sample across all services. IF it is found through theme and trend monitoring that specific services are non-compliant a service specific focussed audit to be conducted by Service lead	Live tracking Quarterly 10% sample audit aggregated to annual reporting 10% sample from concerns related specifically to Children and adults at risk / serious concerns / never events at quarter 1 and 3.
Management of Redress Cases	Regulations 25 to 33 cover the arrangements that apply when Redress is to be considered by a Welsh NHS body. Regulations 34 to 48 allow for Redress to be considered also in relation to care commissioned from NHS providers in other parts of the UK.	To ensure an effective process for managing legal claims for financial compensation brought under the Civil Procedure Rules by patients and staff and that the conditions for the operation of the delegated authority for settlement of claims to a limit of £1 million are met by Responsible Bodies managing such claims. These are defined as 'compensation claims' and include concerns involving a qualifying liability in tort resolved by the settlement of damages to a maximum of £25,000 under Redress in addition to concerns and claims for negligence exceeding £25,000 and formal claims for negligence below £25,000 resolved in accordance with the relevant Pre-Action Protocols and Civil Procedure Rules.	Q2 10% random sample (Or 10 unique if 10% < 10) (internal) to assess: •Compliance with/adherence to Regulations The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) (Amendment) Regulations 2011 •Consideration has been given to whether there is a qualifying liability in tort for any concern under investigation •Where it is indicated that there is a qualifying liability in tort there is a consideration of redress. •A redress SBAR has been completed	Q2 – responsible officer = Q&S Team Annual = NWSSP Shared Services Internal Audit Service	Internal light touch audit to occur Quarter 2 Annual external audit

			•A Redress Panel is in place, chaired by the Director of Nursing. •Redress is offered/made where appropriate. •The quantity of redress in each of the 4 types: A formal apology; Remedial action; Investigation and explanation; Financial compensation •All records are accurate and up to date Annual/at year end 25% or 25 of all redress activity (whichever is the fewer number)		
Claims management and adherence to WRPS Reimbursement Procedure	Standard 22-Managing Risk and Health and Safety and Standard 23	In order to comply with the requirement of the WRPS Claims Management Standard– as detailed in the Claims management procedure, the audit will ascertain the accuracy of reports, costs, compensation claims and, further to ascertain that claims/refunds and dealt with in accordance with the Welsh Risk Pool Reimbursement Scheme.	Q2 10% random sample (internal) (Or 10 unique if 10% < 10) Annual/at year end 25% or 25 of all claims (whichever is the fewer number) which have been through the WRPS Reimbursement Process.	Q2– responsible officer = Q&S Team Annual = NWSSP Shared Services Internal Audit Service	Internal at 6 months / Q2 Annual external
Listening and Learning from feedback and events	Standard 6.3 See Appendix 1 for key questions to be considered	To ensure good organisational learning from all events (including concerns (incidents, complaints, claims under redress) compensation claims, claims reviews etc) with high level commitment to the objective and the process adopted.	6 monthly audit/ review will look for evidence that demonstrates: •How the health board is responding to user experience to improve services •Feedback is captured, published and acted upon in a way that provides an ongoing and continuous view of performance and demonstrates learning and improvement •Action plans are uploaded onto Datix and are implemented as planned •Learning from complaints informs service development and improvement • lessons learnt shared to improve services provided and prevent recurrence. • Key safety and practice issues have been identified through investigations and these have been shared and acted on appropriately. •There is a process for observing trends, themes and recurrent lessons highlighting these for action. •Themes from concerns and lessons learnt are shared	Concerns Team	Internal report at 6 months and annual report for both internal use and submission to WG
Duty of Candour	Health and Social Care (Quality and Engagement) (Wales) Act 2020. Part 3, See Appendix 2 for details	Audit will look for evidence that demonstrates: •Compliance with duties/requirements set out in Health and Social Care (Quality and Engagement) (Wales) Act 2020 Part 3 •Duty of Candour has been applied in instances where more than minimal harm has occurred where health care was a	6 monthly - 10% random sample internally assessed for compliance At year end an annual report is required for submission to WG	Concerns Team	Internal report at 6 months and annual report for both internal use and submission to WG

		factor– I.e. was the person informed and apologised to within an appropriate timeframe and through appropriate means? •Records are accurate and up to date			
Raising Concerns by staff		See Appendix 1	Audit mid-year and Annual review	Concerns Team	Audit mid-year and Annual review
Complainant experience	Regulation 3	A person should: Be able to notify their concern through a single point of entry / Have their concern dealt with efficiently and openly / Have their concern investigated properly and appropriately / Have their expectations and involvement in the process established early on/ Be treated with respect and courtesy / Be given advice on the availability of assistance to pursue their concern, and where they may obtain it / Have a named contact throughout the handling of the concern and know how to contact that person / If an investigation reveals that there is a qualifying liability, the Welsh NHS body must give consideration to the application of the Redress arrangements / Receive a timely and appropriate response to their concern and be kept informed if there is a delay / Be informed of the outcome of the investigation / Be assured that appropriate action has been taken as a result of raising their concern and lessons learnt / Have their concern managed and investigated in line with guidance issued by Welsh Ministers	*Policy currently states random 10% sample monthly - "This will involve contact with complainants to understand how they feel the health board have handled their concern. Seeking their views on the process from raising a concern through to receiving a response, taking account of what was good, what was not so good and what we can do differently to provide complainants with a positive overall experience".* This is not achievable and would recommend a feedback mechanism implemented to monitor and capture this ongoing with a high level review quarterly to identify red flags and learning. Twice yearly audit / deep dive.	Concerns Team	Ongoing feedback mechanism Quarterly high level review of feedback to identify learning and red flags. Twice yearly deep dive / audit
Commissioned services /Cross Border or multi-agency concerns/ complaints	Part 7 of the Regulations, cover cross-border application of Redress	Regulation 17 covers concerns which involve or may involve more than one Responsible Body. Regulations 18 to 21 deal with concerns notified to a Local Health Board about the services provided by a primary care provider under a contract or arrangements with that Health Board. Regulation 19 prescribes the action to be taken by a Health Board when it receives notification of a concern about a primary care provider from a patient or his or her representative. Regulation 20 prescribes the action to be taken by a Health Board when a primary care provider notifies a concern in respect of which he or she is the subject of concern and requests that it be investigated by the Health Board. Regulation 21 sets out how Health Boards must communicate decisions made under Regulations 19 and 20. Part 7 of the Regulations need to be taken into account with regards to managing cross border concerns/ commissioned concerns	6 monthly at quarters 1 and 3 10% random sample of specific category of concern		Internal assurance conducted at quarters 1 and 3 aggregated to annual report for both internal use and submission to WG

EQ&S Committee
15 April 2021
Agenda Item: 3.1
Appendix 3

Ombwdsmon
Ombudsman
OMBWDSMON GWASANAETHAU CYHOEDDUS CYMRU
PUBLIC SERVICES OMBUDSMAN FOR WALES

Thematic Report

At Your Service:

A Good Practice Guide

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Appendix 14

www.ombudsman.wales

communications@ombudsman-wales.org.uk

@OmbudsmanWales

This report is laid before the National Assembly for Wales under paragraph 15 of Schedule 1 of the Public Services Ombudsman (Wales) Act 2019

Foreword

When the Public Services Ombudsman (Wales) Act 2019 came into force in July 2019, I did not expect its inaugural year to include the worst public health crisis the world has seen since the Spanish Flu pandemic in 1918. Like many other organisations in Wales, and across the world, I had a plan for the year. In my case, part of my plan included using the new powers within the 2019 Act to drive up the standards of complaint handling and improve public service delivery - using my new Complaints Standards powers and undertaking my first "own initiative" investigation.

Instead, the country was put into lockdown and everyone was sent home to stay safe. Some of those people had the opportunity to work at home, some were furloughed, and sadly, many people have lost their jobs, which has resulted in a greater dependence on public sector services. As the virus continued to spread, more people became unwell - and the country became more fearful. Yet, despite this fear and, in many cases, risk, officers in Welsh public services have continued to serve the people of Wales and ensure that, at a time when the nation needed them most, public services were available, supporting us and keeping us safe, whether that was by providing hospital care, social services support or welfare checks.

As devastating as the global pandemic has been, it has forced the Senedd and public services in Wales to think about services and their delivery. It has encouraged us to "think outside the box" and re-evaluate approaches to long-standing problems. It has also encouraged multi-departmental and multi-agency working. This can only be a positive outcome for the citizens of Wales.

The inevitable repercussions of COVID-19 will be felt by Wales, and the rest of the world, for many years and as budgets are tightened and demands for services increase, it is more important than ever that public service delivery is effective and provides value for money. The time is right for me to broaden my Improvement Agenda to share not only lessons to be learned when things have gone wrong, but also good practice identified in my casework.

Of course, dealing with complaints as I do, my casework often provides examples of what can go wrong. It is particularly pleasing to find examples of good practice in the cases that come to me, and I am keen to make sure that I share these positive examples, too.

This is the fifth thematic report I have published during my time as the Public Services Ombudsman for Wales. Unlike my previous thematic reports (such as 'out of hours' care in Welsh hospitals, hospital discharge arrangements, the lessons that can be learned from poor complaint handling by all sectors of public service in Wales, and poor records management) which have focused on service failures, this report seeks to showcase good practice throughout public services in Wales. Previous thematic reports have been well received and have resulted in changes to public service delivery. I hope that this report will be met with the same appetite for continuous and meaningful improvement.

Finally, I would like to commend and pass on my gratitude to all the key and essential workers throughout Wales who have worked tirelessly, in such difficult circumstances, to look after us and keep us safe.

Nick Bennett
Public Services Ombudsman for Wales

Introduction

The responsibilities and role of the Ombudsman

As the Public Services Ombudsman for Wales, I have legal powers to examine complaints about public services. I also investigate complaints that members of local government bodies have breached their authority's Code of Conduct. I have a team of people to help me consider and investigate complaints. My service is independent of all government bodies, impartial and free of charge.

I also have further powers to drive systemic improvement of public services through investigations on my own initiative and to set complaints standards for public bodies in Wales.

Introduction

Public Services in Wales

Public Services in Wales are provided by national and local government, either directly through public service organisations, or by financing the provision of services by private companies or third sector organisations.

In 2019, there were approximately 3.1 million people living in Wales.[1] All residents will have used some form of public services, or their lives will have been impacted by them, at one point or another - whether that was through health care, education, housing or highways, to name but a few. As the population continues to grow and people continue to live longer, and unemployment, low wages or financial difficulties increase, dependence upon public services is inevitably going to rise. This means that, now more than ever, organisations need to ensure that they get the most for their money, and that the services they provide are sustainable and provide value.

Value for money is defined as the most advantageous combination of cost, quality, and sustainability to meet the users' requirements. It does not necessarily equate to the cheapest product or service; rather, it reflects the term "do it once, do it right".[2] Valuable resources are wasted every year as a result of poor quality products and services, resulting in additional and often unnecessary costs as things need to be put right or replaced, or actions need to be repeated. This can result in a complaint, adding the costs of investigating and remedying the complaint. Service failure and poor quality services can also have significant human cost in harm, distress or inconvenience caused.

[1] https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/bulletins/annualmidyearpopulationestimates/mid2019estimates

[2] Helen Tau 'au Filisi

Introduction

What is good practice?

A good practice is one that has been proven to work well and produce good results. It may also occur when an officer does more than expected to ensure a positive outcome.

Information about good practice is available to all public services from organisations such as the National Institute for Health and Care Excellence,[3] Audit Wales[4] and my own office.[5]

Even when good practice has been followed, there may be occasions when the desired outcome has not been achieved. However, following good practice guidelines and adopting good practice reduces the risk of adverse incident or dissatisfaction. Good practice in service delivery and in complaints handling should not only secure good services but should also reduce and resolve complaints, as well as making it less likely that any complaint will be upheld.

The effect of COVID-19

At the time of writing, the world is in the grip of the COVID-19 pandemic. The impact on public services has been substantial, as organisations have had to move away from their usual work practices and try new, often innovative and more efficient, methods of working. Many organisations have worked together to provide joined-up services, and new and fresh ideas have been tested, many with success.

It is important that we take note of those new ideas and share the learning to support other public services in providing efficient and effective services for the people of Wales.

[3] https://www.nice.org.uk/guidance
[4] https://www.audit.wales
[5] https://www.ombudsman.wales/guidance-policies

Analysis

Sharing Good Pracitce

In order to secure the success of any service or business, it is important to identify good practice and share it throughout that organisation. This applies equally to public services. There are 22 Local Authorities, 9 Health Boards/Trusts and a large number of other public services which fall within my jurisdiction. Whilst there are many differences between these organisations, even between those providing similar services, it is important to recognise that many of their fundamental values and strategic aims are often the same, particularly in relation to matters such as record keeping and complaint handling. This allows us, as a public service provider and through our role reviewing other public services, to share information about the successes of others as well as any lessons that may have been learned, to support the provision of first-class public services.

The benefits of sharing good practice

- It allows for improvements to be made to a service using tried and tested processes. This should reduce the amount of work that may have to be redone and result in positive changes to productivity and efficiency in a shorter space of time.
- It creates a culture of learning and provides a safe environment for creative and innovative ideas. This, in turn, increases efficiency, competence, and confidence in both the process and the officers who administer them.
- It identifies and addresses gaps in knowledge, allowing organisations to share information with the right people at the right time to ensure maximum impact without overwhelming staff. Consequently, training and support can be targeted, resulting in better decision making.
- It encourages the development of a sector knowledge base by turning personal knowledge into corporate/sector knowledge and reduces an organisation's or a sector's dependence upon specific individuals.
- It extends the benefits of local sharing of information to the wider sector, allowing for the development of a supportive organisational/sectoral community.

Analysis

Analysis of Individual Case Examples

The examples below all relate to complaints that were raised prior to the COVID-19 pandemic. However, these examples have been chosen because, in my view, they will remain relevant in a post COVID-19 world. I have not referred to every body or sector in my examples because much of the good practice identified may be adapted and used in any public sector setting.

It should also be noted that this report focusses on the good practice identified in these examples, and many of the complaints were upheld for other reasons.

Full details of the cases mentioned appear in the Appendix.

Early Resolution

In this section, I refer to complaints made by Mr A.

I always welcome any action taken by an organisation to resolve a complaint as early as possible. Often complaints relate to matters such as refuse collection or keeping access roads clear, which can often be easily remedied. In the case of **Mr A**, the Local Authority undertook prompt action to resolve the complaint about overgrown weeds affecting an access lane. In my opinion, by undertaking this work at an early stage and committing to further works, the complaint was fully addressed, and further investigation was not necessary. Consequently, public money and time were saved as there was no requirement for investigation, and no possible redress implications.

Good practice point: Prompt and effective action to put things right.

Care and Treatment

In this section, I refer to complaints made by Mrs D, Mr E, Ms H and Mrs N.

It can be an extremely difficult and stressful time when either you or a loved one requires some form of care and treatment. It is important that the recipient of that care and treatment is treated with respect, dignity and fairness at all times. A failure to do this can have a detrimental impact on the relationship between the patient (and their family) and the service provider, and, sadly, once that faith in a service is lost, it is very difficult to regain. Therefore, it is important for a service to ensure that a comprehensive assessment is completed (**Mrs D**) and timely interventions are undertaken (**Mr E**). This also means that a holistic person-centred approach can be taken to someone's care and action can be taken to avoid unnecessary pain and injury (**Ms H** and **Mrs N**). This, in turn, should maintain confidence in the service and not only result in better service provision but also reduce upheld complaints.

Good practice point: Comprehensive assessment, focus on individual needs and timely action.

Analysis

Planning

In this section, I refer to complaints made by Mr S.

Good care planning allows for a holistic person-centred approach to meeting a person's needs. Additionally, it allows the care recipient to stay as independent as possible and have as much control over life decisions as possible, which promotes independence, dignity and respect. Care planning should reflect the needs of the recipient and how those needs will be met. In the case of **Mr S**, there was evidence of collaborative working with **Mr S** and external agencies which allowed for a person-centred plan that focused on the specific issues causing him difficulty.

Good practice point: Collaboration with external agencies or other departments to meet the service user's specific needs.

Communication

In this section, I refer to complaints made by Mrs U, Mr T and Mrs W.

Many of the complaints that reach my office relate to poor communication, whether that is a failure to share information, a failure to ensure that information has been understood, or a failure to listen to the complainant. Communication is key in any relationship and failure to provide explanations can often leave a person feeling suspicious and apprehensive. Ultimately, this will have a negative impact on the relationship between the parties and may become a barrier to progressing care, support, or complaint handling. In some instances, a single point of contact may be useful as it allows for a professional relationship of trust to build between the body and the recipient/complainant.

Communicating bad news to someone is always difficult, and it is good practice to ensure that you have an appropriate officer/clinician available who can answer any questions and ensure appropriate support mechanisms are in place before providing that information (**Mrs U**).

Equally, when communicating information to a patient, it is important to ensure that the language used is suitable, and that any treatment plans and decisions are fully explained (**Mr T**). Leaflets/factsheets are an example of good communication. They are an easy way to provide comprehensive information to a person in an easy to manage, takeaway format. In the case of **Mrs W**, it was noted in her records that she was provided with a leaflet that included comprehensive information about caring for the injury at home, physiotherapy exercises and pain relief. Therefore, the clinicians could feel confident that she had been discharged with all the information she required to hand.

Good practice point: Effective communication, clear explanations, informative answers to questions from patients or relatives and written information to take away.

Analysis

Complaint Handling

In this section, I refer to complaints made by Mrs Y and Mr Z.

It is always disappointing to see complaints about the administration of complaint handling. In my view, these complaints should not occur and are a significant waste of resource. Complaints about complaint handling often fall into two categories:

- Delay
- Failure to answer the complaint

Whilst I would always expect a complaint to be resolved within the specified timeframe, I accept that it is not always possible, especially if it is a complex matter or there are other extenuating circumstances. In these cases it is really important that the complainant is made aware of any delays, the reasons for those delays, and any new deadlines. I would also expect to see appropriate apologies (**Mrs Y**). After all, the delay is rarely the fault of the complainant.

An important factor in complaint handling is listening. Often the fundamental issue is that the complainant does not feel that s/he has been listened to, heard and understood. This can often lead to a long and protracted relationship, potentially hostile, with the complainant which is costly and fails to benefit either party. When responding to complaints, it is important to answer the issues and questions that have been raised (**Mr Z**) rather than merely recount the chronology of events.

Good practice point: Understand the complaint, provide regular updates, and make sure any apology is meaningful.

Multi-disciplinary Teamwork

In this section, I refer to complaints made by Mrs AA and Mrs BB.

Multi-disciplinary teamwork is encouraged because it allows for collaboration and a variety of perspectives when treating a patient. This often results in a holistic approach to the care and consequently an effective and more positive outcome for the care recipient (**Mrs AA**). It is also an efficient use of resources (**Mrs BB**) and it fosters learning and a supportive working environment.

Good practice point: Coordinate multi-disciplinary inputs to care and treatment, complaint handling and engaging with the Ombudsman.

Analysis

Record Keeping

In this section I refer to complaints made by Mrs DD.

Record keeping is an essential part of public services. It is why so many sectors and organisations (e.g. General Medical Council and Social Care Wales) have included it within their codes of practice. Contemporaneous, accurate and comprehensive records are not only fundamental in ensuring that you have an up-to-date picture of your client's needs, they are also crucial in complaint handling. Written records should be succinct and include all relevant information. Assessments, charts and reviews should be completed as directed as they often influence any care and treatment decisions (**Mrs DD**) and may prevent further injury or illness occurring to the recipient.

Good practice point: Accurate and timely recording of treatment, care and observations.

Multi-disciplinary Teamwork

Good complaints governance is central to good quality service provision, good complaints handling and learning from complaints. To support good complaints governance, one of my early actions as Ombudsman was to establish the role of Investigation and Improvement Officer within my office. A small number of these officers work with bodies in my jurisdiction to provide support with complaint handling and complaints governance. I was pleased to see the positive responses my officers received. As a result of their interventions, the following improvements were made:

- Hywel Dda University Health Board and Swansea Bay University Health Board included information about the Ombudsman's service and good complaint handling in its annual development training programmes.
- Other bodies in jurisdiction, such as Conwy County Borough Council, took proactive steps to be clear about the differences between a complaint and service request, to ensure that matters are dealt with appropriately.
- Ceredigion County Council adopted the model complaints handling process to replace its own.
- Betsi Cadwaladr University Health Board made efficiency improvements to improve response times and took a proactive approach to learning by using both internal information and information from the Community Health Council to identify themes and trends.

Since July 2019, and the introduction of my Complaints Standards role, I have been able to provide additional investigation and complaint handling support to public services in my jurisdiction. This has been achieved through the provision of training and through the collation of data to identify organisational and sectoral trends. It has been encouraging to see that Local Authorities have fully engaged in the training offered, which includes complaint handling and investigation skills, as well as soft skills, such as time management, listening, managing expectations and communication skills. I am also pleased to note that its success has led to additional training and refresher sessions being requested to ensure that these important skills can be developed and maintained throughout the organisations. I intend to offer these training packages to Health Boards during 2021, and I am pleased to say that they too have welcomed the prospect of such training for their officers.

Good practice point: Regular senior review of complaints data and complaint handling performance, and high-level commitment to resolving and learning from complaints.

Analysis

Complaints governance in shared and collaborative services

I welcome the fact that public bodies are collaborating and working jointly with the aim of providing streamlined and cost-effective services to the public. However, when failings occur in these collaborative or shared services it is important that members of the public have the same access to justice as they would for a service provided directly. Cases coming to me suggest that collaborative arrangements can blur the lines of accountability, making it difficult for service users to know to whom they should complain. In these shared and collaborative services, I expect:

- Clear arrangements for complaint handling in any contract or agreement with partner organisations
- Any such arrangements to be consistent with any statutory complaints process (e.g. Putting Things Right /Children's Social Services complaints) and should otherwise follow the Model Complaints & Concerns Policy
- Clear arrangements for how disputes between the public body and the provider are dealt with, to ensure they do not impact upon the process for responding to the complainant.
- It to be clear which a party is responsible for responding to a complaint
- The organisation responsible for responding to a complaint to ensure that the complainant is informed of their right to complain to my office
- Staff within all organisations know what the arrangements are and what their role is in carrying them out
- The public body with overall responsibility for the service to be informed about all complaints and monitors the outcomes of complaints
- Elected councillors or independent board members to understand complaint mechanisms so that they can respond to queries from the public.

Good practice point: Clear responsibility for complaints agreed and communicated to service users, regular senior review (by all organisations party to the collaborative arrangements) of complaints data and complaint handling performance.

Conclusions

The benefits of good practice are clear. By sharing this practice throughout public services, and being open to the work practices of other organisations and sectors, organisations and staff have the opportunity to see what has been successfully tried and tested and what can be adapted to meet the specific local aims and needs. This in turn allows an organisation to develop and continuously improve its services.

Sharing good practice can only benefit an organisation, as productivity and output are more efficient, timely, and provide better value for money. Organisations will also find additional benefits as they see an increase in the confidence officers and service users have in the services provided, as well as a reduction in complaints that are upheld. Additionally, making all contact with the customer/patient a positive experience will reduce the time and cost of having to reissue or repeat information or meet the cost of putting things right.

Consideration of wider good practice is also important as it demonstrates commitment to organisational learning and progression. Good practice can be used to drive changes to service delivery, policies and processes. It enables an organisation to move away from simply taking a reactive and preventative approach when things go wrong.

Recommendations

As someone reviewing a range of public services, I am in a privileged position because I can see and share good practice ideas - not only between organisations but between sectors. When making my recommendations to individual organisations, I consider that it is also important that I promote good practice and, whenever possible, share learning with the bodies in my jurisdiction.

The Ombudsman's Commitment to sharing good practice

I am committed to identifying and promoting good practice in public services in Wales. I will:

1. Publish a Good Practice Casebook and introduce case examples, as they arise in my casework, in the new "Our Findings" section of the Ombudsman's website.

2. Promote good practice through the work of my Complaints Standards team.

3. Identify good practice in my reports, where appropriate.

Recommendations

I recommend that:

1. Public services focus on identifying and extending good practice in their organisations, with actions at strategic and operational levels.

2. Organisations make good practice and information sharing a standard agenda item in departmental/team meetings.

3. Public services consider incorporating information from the Ombudsman's casebooks/"Our Findings" into training for service delivery and complaints handling staff.

4. Public services take up the offer of complaints handling training from my Complaints Standards team.

5. Consideration is given to the creation of a portal for cross-sector sharing of good practice.[6]

[6] The Public Services Ombudsman for Wales will seek to take this forward with public bodies and other oversight bodies in Wales

Appendix

Case Studies

Examples of Early Resolution

Mr A complained about the condition of the access lane to his property. On consideration, it was noted that, prior to Mr A making a complaint to my office, his Local Authority had responded to Mr A's concerns and had undertaken a number of actions to resolve the complaint that fully met or exceeded its statutory and policy obligations.

Mr B complained about the decision to amend the provision of disability care services to his son without consultation. Consideration of the complaint found that the Health Board took responsibility for the care of Mr B's son following receipt of information from a Regulator that the care provider was unsuitable. It was also noted that the care options were shared with Mr B and that he was invited to express a preference for the care provided.

Ms C complained that she had not been informed of the Local Authority's decision to arrange a care package for her that would require her to make a financial contribution. Ms C cancelled the care package and disputed liability for any incurred fees. The Local Authority accepted early on that it was at fault and waived the fees. It also agreed to address the communication concerns raised by Ms C.

Examples of Good Care and Treatment

Mrs D complained about the care and treatment her daughter received from Mental Health Services. The investigation found that the assessments undertaken by both the Psychiatrist and the Community Psychiatric Nurse were comprehensive and included all relevant information to aid diagnosis and inform the treatment plan.

Mrs E complained about the treatment her husband, Mr E, received for his complex medical needs. The investigation found that while in the Emergency Department, Mr E was fully assessed and diagnosed with sepsis. Urgent interventions were undertaken without delay and a multi-disciplinary approach was taken to his care and treatment.

Mr F complained that the decision to discharge his father, Mr G, from hospital resulted in a delay in diagnosis. The investigation found that the investigations and assessments undertaken when Mr G initially attended the hospital had been comprehensive and the decision to undertake a CT scan at that stage was an example of excellent practice.

Ms H complained about the care and treatment her mother, Mrs I, received. The investigation found that Mrs I had a detailed assessment, which allowed for a clear understanding of her medical and social needs, and regular senior medical reviews. The investigation also found a high level of attention to detail for the planned nursing care and its execution, particularly in respect of nutrition, hydration and pressure sore avoidance.

Appendix

Mrs J complained about a delay in diagnosis. The investigation found examples of thorough assessment, prompt referrals to relevant health professionals and sensitive and conscientious care throughout.

Mrs K complained about the care and treatment she received. The investigation found that the standard of care provided by the surgical team had been prompt, of a high standard and very thorough. It also found that the treatment had been provided in a timely manner.

Ms L complained about the care and treatment her father, Mr M, received. The investigation found that Mr M was regularly reviewed, along with his treatment plan and medication.

Mrs N complained about the care and treatment she received during surgery. The investigation found that Mrs N was provided with appropriate information prior to consenting to the treatment and that the communication with her throughout was of a high standard. The investigation also found that the standard of care provided was an example of best practice, as the anaesthetic team quickly recognised the potential for injury and attempted to minimise it as well as seeking multi-disciplinary advice. Mrs N was extensively monitored, and the records of the events were contemporaneous, legible and of a high standard.

Mrs P complained about the care and treatment her husband received. The investigation found that Mr P's care and treatment plan was comprehensive and reviewed daily by nurses, which allowed for Mr P's complex needs to be managed and interventions to be made without delay. The investigation also found robust nursing records which evidenced the high level of nursing care provided to Mr P, as well as a multi-disciplinary approach to his care.

Mrs Q complained about the care and treatment her father, Mr R, received. The investigation found that clinicians implemented treatment while waiting for a formal diagnosis, to prevent any delay.

Examples of Good Care Planning

Mr S complained about the care and treatment he received. The investigation found that the clinical team focused on Mr S's complex individual health needs and there was good communication and collaborative working between internal departments and external support agencies. The investigation also found that the care and treatment plan focused on the specific issues causing Mr S difficulties and that the content was agreed with Mr S.

Appendix

Examples of Good Communication

Mrs T complained about the care and treatment of her husband, Mr T. The investigation found that the patient management plan was exemplary. The letter written to Mr T fully explained the investigations to be undertaken and the reason for them. The letter also explained the next steps in the process.

Mrs U complained about the care her mother, Mrs V received. The investigation found that it was good practice for the senior member of staff to inform patients, such as Mrs V, of bad news about their diagnoses. It was also good practice to ensure that Mrs V was supported at the time by a member of her family and a staff nurse. The investigation also found comprehensive physiotherapy records which demonstrated that Mrs V's needs and requirements had been carefully respected.

Mrs W complained about the care and treatment she received for an injury. The investigation found that Mrs W was provided with a leaflet which included comprehensive information about caring for the injury at home, physiotherapy exercises and pain relief.

Miss X complained about the care and treatment she received. The investigation found that the surgeon provided Miss X with a full de-brief following surgery.

Examples of Good Complaint Handling

Mrs Y complained about the way in which the Local Authority handled her complaint. The investigation found that Mrs Y was provided with regular updates during the complaints process, including the details of any delays, and appropriate apologies.

Mr Z complained about the care and treatment his wife, Mrs Z, received. The investigation found that the complaint response included a detailed and clear account of events and answers to all of the issues and concerns raised by Mr Z.

Appendix

Examples of Multi-disciplinary Teamwork

Miss AA complained about the care and treatment she received. The investigation found that a significant infection was managed through the correct and timely decision of the orthopaedic and bacteriology teams to work together.

Mrs BB complained about the care and treatment she received. The investigation found that the Radiographer modified a diagnostic test to suit Mrs BB's needs. This resulted in a more appropriate test being undertaken to achieve the images the Clinician required.

Examples of Good Record Keeping

Mrs CC complained about the care and treatment she received. The investigation found that her records were thorough, contemporaneous and well written.

Mrs DD complained about the care and treatment her father, Mr EE, received. The investigation found that the nursing care provided to Mr EE was clearly documented. The records also showed that appropriate risk assessments were undertaken and regularly reviewed.

Ombwdsmon
Ombudsman

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PUBLIC SERVICES OMBUDSMAN FOR WALES

Appendix 6

List of subjects for categorising concerns.

Complaints by SUBJECT **How many new complaints received by the organisation during the quarter were in relation to the following subjects:** **(Only the Principal subject should be submitted)**		Access (to services)
		Accident / falls
		Admissions
		Appointments
		Attitude / behaviour
		Assault
		Post death issues
		Catering
		Cleanliness
		Clinical treatment / assessment
		Communication issues (including language)
		Concerns handling
		Confidentiality
		Consent
		Discharge issues
		Equality
		Equipment
		Environment / facilities
		Infection control
		Medication
		Monitoring / observation issues
		Nutrition / hydration issues
		Patient care
		Personal property / finance
		Privacy / dignity
		Referrals
		Record keeping
		Resources
		Skin damage
		Test and investigation results
		Other

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 3.2

EXPERIENCE, QUALITY & SAFETY COMMITTEE	**Date of Meeting: 15th April 2021**
Subject:	**Regulatory Inspections Report**
Approved and Presented by:	Alison Davies, Director of Nursing & Midwifery
Prepared by:	Wendy Morgan, Assistant Director Quality & Safety Susannah Jermyn, Service Development Officer
Other Committees and meetings considered at:	Quality Governance Group 24th March 2021

PURPOSE:

The purpose of this report is to articulate the receipt and outcomes of regulatory inspections that have occurred during this reporting period and to share the Health and Social Care Regulatory Reports dashboard.

RECOMMENDATION(S):

The Experience, Quality & Safety Committee is asked to DISCUSS 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:

Healthcare Inspectorate Wales (HIW) approach to inspections has also included General Practices in recent months, the Ddyfi Valley Health visit report is positive highlights one area for improvement.

Updated action plans have been provided to HIW for health board inpatient areas, one confirmed acceptable to date, with one decision awaited. HIW have now restarted their quality checks schedule, with two visits scheduled for the heath board in coming weeks.

A self-assessment, along with priority setting for development and improvement in respect of phase 1 of the National Review of Maternity Services has been submitted to HIW for consideration and will be shared when accepted.

A dashboard overview of the current position is provided, relating to the implementation of actions in response to recommendations from health and social care regulators.

DETAILED BACKGROUND AND ASSESSMENT:

Health Inspectorate Wales Inspections

On the 25th January 2021, HIW wrote to the Chief Executive Officer and Chair of the health board, see **appendix 1**, indicating their intention to restart the NHS quality check programme during mid-February 2021. HIW indicated their interest in the delivery of Wales' vaccination strategy and in particular the arrangements for providing this service in a safe and effective manner. The approach to gaining assurance on this service is being developed, along with the proposed approach and timing for any activity.

HIW also referenced their intention to seek the views of health bodies on the Quality Checks undertaken to determine whether they should be a standard assurance tool alongside their full inspection approach. Working is progressing to formalise HIW's 'Service of Concern' process for the NHS which is aimed at ensuring transparency of their approach where standards are repeatedly not being met or where they find significant failings in the quality of care. Their National Review of Mental Health Crisis Prevention in the Community has started, the terms of reference can be found at the following link or in **appendix 2** **https://hiw.org.uk/sites/default/files/2021-01/20200120MentalHealthCrisisPreventionReview-TermsofReference-en.pdf**
The HIW review team will engage with the health board in the coming months as this review progresses.

1. Tier 1 Quality Checks

On the 9th December 2020, Healthcare Inspectorate Wales (HIW) undertook a remote Quality Check of Ddyfi Valley Health as part of its programme of assurance work, the report published on the 12th January 2021. The focus of the remote check was on three key areas; infection prevention and control, governance (specifically around staffing) and the environment of care. One improvement was identified: *'The practice should compile a training skills matrix for all staff, to ensure there is sufficient oversight of training in IPC (and other areas) at a practice wide level'.* The findings can be reviewed at the following link or in **appendix 3**. **https://hiw.org.uk/dyfi-valley-health** Compliance with the improvement plan will be monitored by the Primary Care Team as part of the clinical quality governance monitoring and assurance processes of General Medical Practices.

2. Forthcoming Quality Checks

On 9th March 2021, HIW wrote to the Chief Executive Officer providing notification of their intention to conduct a Quality Check of Clywedog Ward,

Llandrindod Wells Memorial Hospital on the 23rd March 2021. The findings will be reported on publication of their report.

On the 16th March 2021, HIW wrote to the Chief Executive Officer providing notification of their intention to conduct a Quality Check of Felindre Ward, Bronllys Hospital on the 27th April 2021. The findings will be reported on publication of their report.

3. Progress reporting to HIW

For areas where improvement plans are required, an update is required by HIW within 3 months of the inspection date. The health board submitted an updated improvement plan for Tawe Ward, Ystradgynlais Hospital on 11th 2020 December and is awaiting a response from HIW.

An updated improvement plan was also provided for Maldwyn Ward, Welshpool Hospital on the 26th January 2021, and a response received 11th February 2021 confirming HIW's conclusion that the plan provided sufficient assurance. The updated improvement plan is not published but it used to inform any future inspections or assurance activity.

4. National Review of Maternity Services

The Committee have been previously updated on the publication of the National Review of Maternity Services undertaken by Health Inspectorate Wales. Phase 1 of the national review commenced in June 2019 through to the summer, 2020 and the phase one report was published in November 2020.

Work commenced on phase 2 of the review, but due to the COVID-19 pandemic, in January 2021, HIW decided to delay phase two for a period of 6 months.

The phase 1 review explores the quality and safety of maternity services in Wales. The decision to undertake this review was based on a number of concerns relating to the pressures around maternity services in Wales, including the concerns in Cwm Taf Morgannwg University Health Board. Phase one of the national review explored the experiences of women, their partners and families, and the extent to which health boards across Wales provided safe and effective maternity services, and understood the strengths and areas for improvement within their maternity services.

From June 2019 to January 2020 HIW carried out a programme of unannounced inspections of maternity services across Wales. A further

programme of announced inspections within free standing birthing units was also undertaken. A national public survey was also carried out in support of phase one of the review. The survey asked people with recent experience of maternity services to share those experiences and their views of maternity services.

In December 2020, Powys Teaching Health Board participated in a HIW hosted learning event, contributing to the all Wales discussion related to the 32 recommendations from the review and subsequently, local workshops were held to consider the opportunity for improvement in Powys and work to be undertaken on a national level. A Health Board self-assessment has been completed using the prepopulated template and submitted to HIW in line with the requirements. The health board is required to HIW's provide a progress report on improvements to HIW in early 2022 and internal quarterly reviews have been established to oversee this work locally.

5. Review of Healthcare Services for Young People

The Committee have been previously informed of 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 submitted this information to HIW and awaits a response.

As part of the health board's internal assurance arrangements, ongoing progress in achieving recommendations is monitored. The updated action plan in **appendix 4** shows some progress in completed actions from 25 to 26 with a further 6 progressing; there are 5 actions not applicable to the health board, because the actions are related to hospices and Welsh Government. As a reminder, the review can be viewed at the following link: HIW publishes review of healthcare services for young people | Healthcare Inspectorate Wales

6. Health and Social Care Regulatory Reports: Recommendations and Tracker

This section of the report provides an overview of the current position relating to the implementation of recommendations following HIW and any made by Care Inspectorate Wales (CIW). Validation of the tracker continues with an electronic solution being sought to maximise the currency and accuracy of the tracking system. **Appendix 5** provides a dashboard view of the current position.

7. Care Inspectorate Wales (CIW)

The paper in **appendix 6** provides an update on the CIW inspection improvement actions for Cottage View, following the inspection visit in March 2020.

8. Community Health Council

There have been no recent visits by the Community Health Council Community Health Council, although there have been a number of reports received related to peoples experience of accessing health care during the covid19 pandemic. The reports have been disseminated to services to support learning as they have become available.

9. Environmental Health Services

There have been no recent visits by the Environmental Health Services.

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Quality Check Summary

Setting Name: Dyfi Valley Health

Activity date: **9 December 2020**

Publication date: 12 January 2021

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:

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Website: www.hiw.org.uk

Digital ISBN 978-1-80082-711-0

WG41462

Findings Record

Our Approach

Healthcare Inspectorate Wales (HIW) undertook a remote quality check of Dyfi Valley Health as part of its programme of assurance work.

Dyfi Valley Health provides general practitioner (GP) services to the population of North Powys (Machynlleth and surrounding areas). The practice proides a number of clinics for the management of chronic diseases such as asthma and diabetes and offer a wide range of other medical services including antenatal and postnatal care, minor surgery, minor injuries, childhood vaccinations and well-person check-ups

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 are a snapshot of the standards of care within healthcare settings. They are conducted entirely offsite and focus on three key areas; infection prevention and control, governance (specifically around staffing) and the environment of care. The work explores arrangements put in place to protect staff and patients from COVID 19, enabling us provide fast and supportive improvement advice on the safe operation of services during the pandemic. More information on our approach to inspections can be found here.

We spoke to the Practice Manager on 9 December 2020 who provided us with information and evidence about their setting. We used the following key lines of enquiry:

- How has the practice and the services it provides, adapted during this period of COVID-19? What is the practice road map for returning to pre-COVID-19 levels of services?
- How effectively are you able to access wider primary care professionals and other services such as mental health teams, secondary care and out of hours currently?
- What changes have you implemented in light of COVID-19 to ensure infection prevention and control standards are maintained?
- How are you ensuring that patients (including vulnerable/at risk groups) are able to access services appropriately and safely? In your answer please refer to both the practice environment and processes to enable patients to access appointments.

Environment

During the quality check, we considered how the service has responded to the challenges presented by COVID-19. We questioned the practice on how they are making sure all patients have safe and appropriate access to services.

The following positive evidence was received:

The practice told us that an early decision was taken to close public access to the practice in an effort to protect staff and patients. However, they continued to place an emphasis on managing patient expectations and ensuring access to services. These included:

- Ensuring clear communication through bi-lingual signage on the exterior of the premises and an updated website. There was a marked increase in the number of patients signing up to the practice text messaging service as a result
- Installation of video door bells at the entrance to the building and at the dispensing window in order to maintain some level of face-to-face contact
- Continued use of post boxes for patients to drop off prescription requests or samples
- Providing a shelter on the outside of the premises for patients who were required to queue or who arrived by foot.

We found that the practice had trialled and implemented systems which enabled the practice to undertake virtual and remote consultations. The practice manager told us that this had worked well for a number of patients due to the ability to send and receive images and messages through the platform. For older and vulnerable patients, or those with sensitive issues, the practice told us that patients could still call to speak to a member of the practice staff who would triage their call as appropriate.

We looked at the process the practice had in place for the triage of patients. We reviewed a draft call handling guide, which covered a range of conditions, with nominated individuals and a clear timeframe in which to respond. Given that this was a draft document, we would advise the practice to adopt a final triage protocol and policy once approved, ensuring that all staff then receive an appropriate level of training for their role.

For patients who were required to attend an appointment inside the practice, we were told that a number of other measures had been introduced to support staff and patient safety. These included:

- Ensuring all patients and visitors were temperature checked at the entrance to the building and were provided with Personal Protective Equipment (PPE), where necessary

- Ensuring that Test, Trace and Protect details were taken via a QR[1] code, on mobile phone devices, or manually upon entry
- Implementing a one-way system with appropriate floor marking and signage
- Closure of waiting rooms and toilet facilities (unless required)
- Designating two clinical rooms with direct access from the outside of the premises, allowing non-COVID patients to be seen without the need to pass through the main building
- Designating an external repurposed area of the practice into a 'hot hub' for patients who may be displaying suspected COVID-19 symptoms to be seen safely and separately to other areas of the practice. We confirmed that this area contained no unnecessary equipment. Appointments were managed in a way so that clinicians were able to leave at the end of day, without the need to re-enter the practice.

The practice told us that a limited number of clinic activities and services, such as cervical screening, were suspended as a result of the pandemic. These suspended services have now been re-introduced. We found that the practice had adapted the delivery of other clinics, such as prescribing B12 to be taken orally rather than through an injection at the practice. However, the practice emphasised that there was no blanket approach to the delivery of care and that patients would be asked to attend in-person, as determined by clinical need.

The practice told us that they had good links with the district nursing team, which had enabled the practice to maintain effective links with patients within the community. It was positive to note that the practice took part in a daily General Practitioner (GP)-led call with the district nursing team. Specialists, such as palliative care at home services, were invited where required, to discuss the needs of patients within the community.

No improvements were identified.

Infection prevention and control

During this process, we reviewed infection control policies, cleaning schedules and staff training. We also questioned the setting about how the changes they have introduced to make sure appropriate infection control standard are maintained. We reviewed key systems including the use of PPE.

The following positive evidence was received:

We found that the practice followed an Infection Prevention and Control (IPC) procedure and a Pandemic Policy, both of which had been recently reviewed and tailored to meet the needs

[1] QR Code is a two-dimensional version of the barcode, typically made up of black and white pixel patterns.

of the practice. We saw evidence to show that this procedure had been read and understood by all staff, including emails between staff identifying IPC and pandemic related updates.

We were told that all staff had access to appropriate PPE and that the pressures on obtaining PPE had eased throughout the pandemic. The practice policy outlined to staff how to don and doff PPE correctly and the practice manager confirmed that all staff had received demonstrations from the GP partner.

We saw evidence of recent risk assessments for a range of areas within the practice, including clinical areas, which focused on limiting the transmission of COVID-19. We also saw evidence that some audit activity had been undertaken by the practice manager and had been communicated to all staff. However, the practice is advised to consider adopting a more formal tool when undertaking audit activity in order to effectively monitor and evidence outcomes.

We saw confirmation that formal IPC training had been undertaken by a number of staff, including GP's, nursing and cleaning staff, and the practice manager confirmed that IPC training was mandatory for staff. However, IPC training records were not immediately available for us to view.

It was positive to note that a dedicated cleaner was employed by the practice and that they had undertaken training provided by the health board specific to their role. We saw that regular cleaning schedules had been maintained, including enhanced cleaning throughout the pandemic.

The following areas for improvement were identified:

The practice should compile a training skills matrix for all staff, to ensure there is sufficient oversight of training in IPC (and other areas) at a practice wide level.

Governance

As part of this standard, HIW reviewed policies and procedures for future pandemic emergencies. We also questioned the setting about how they have adapted their service in light of the COVID-19 pandemic, how they are interfacing with wider primary care professionals and their risk management processes.

The following positive evidence was received:

The practice formed part of the North Powys Primary Care Cluster[2], in which we found evidence of supportive cluster working arrangements. The practice manager told us that the cluster met on at least a monthly basis, but had met more frequently throughout the pandemic

[2] A Cluster is a grouping of GPs working with other health and care professionals to plan and provide services locally.

in order to support staff and patient care.

In support of individual staff safety and wellbeing, we saw that the All-Wales COVID-19 Risk Assessment had been completed by staff in order to assess their personal circumstances in relation to the pandemic. The practice had also undertaken an additional risk assessment of the working environment, in order to further support staff and the management.

We were told that there had been a number of staff on leave throughout the pandemic due to issues of sickness or childcare. However, we found that all staff had now returned to work and that arrangements had been made for staff to work from home wherever possible.

It was expressed clearly to us that staff were beginning to feel the psychological effects of the pandemic, such as tiredness and fatigue. We were told that this had been heightened due to an increased demand on the services provided by the practice and other issues, such as difficulty in making referrals into various secondary care systems. The practice should continue to engage with the Health Board to ensure that staff well-being is fully supported.

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: Dyfi Valley Health

Date of activity: 9 December 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 practice should compile a training skills matrix for all staff, to ensure there is sufficient oversight of training in IPC (and other areas) at a practice wide level.	7.1 Health and Care Standards	Noted and will be actioned	LC – PM	By end February 21
2					
3					
4					

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: Lucy Cockram Date: 16 December 2020

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

Chief Executive and Chair
Powys Teaching Health Board
Via Email: *Carol.shillabeer2@wales.nhs.uk*

25 January 2021

Dear Carol and Vivienne

HIW work programme update

I am keen to continue with the 'no surprises' approach that we have operated during the pandemic, providing transparency around our planned work so that you can get in touch about any challenges you face as result.

I wrote to you in December to let you know that HIW would not commence any new, routine Quality Checks or Inspections in the NHS until at least the end of January due to the significant pressures that NHS services faced over that period. We have continued to discharge our functions through our concerns, intelligence and relationship management function, however, it is our intention to restart our routine quality check programme in the NHS in mid-February.

As ever, we are carefully considering what our programme of work will look like from February, taking risk into account. As you might expect, we will be taking an interest in the delivery of Wales' vaccination strategy and in particular the arrangements for providing this critical service in a safe and effective manner. We are currently refining our approach to gaining assurance on this service; I will write to you again shortly to update you on our proposed approach and the timing for any activity.

I would also like to make you aware that we intend to seek your views on the effectiveness of our Quality Checks as we consider whether they should become a standard assurance tool we use alongside our full inspection approach. We are also working to formalise our 'Service of Concern' process for the NHS, aligned with our approach in independent healthcare sector. This is intended to ensure transparency of our approach where standards are repeatedly not being met or where we find

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significant failings in the quality of care. I will provide more detail on this proposal over the coming months and would very much like to meet to listen to your views.

Finally I wanted to let you know that our National Review of Mental Health Crisis Prevention in the Community has started and we have published a terms of reference on our website. Our review team will engage with your organisation in the coming months as this review progresses.

Should you wish discuss anything with me directly then please do not hesitate to get in touch.

Yours sincerely

Alun Jones
Interim Chief Executive
Healthcare Inspectorate Wales
Cc.
Chair: Vivienne.Harpwood@wales.nhs.uk
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Gwirio bod pobl yng Nghymru yn derbyn gofal da

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Healthcare Inspectorate Wales

National Review of Mental Health Crisis Prevention in the Community 2020-21

Terms of reference

At the time of undertaking this national review, health and care services across Wales have had to rise to meet the challenges of a global pandemic, Covid-19. This has introduced unique and unprecedented pressures on the system that will continue through the winter months. The review will be conscious of how services have adapted and changed to cope with these pressures.

Background

In its Operational Plan 2019-2020[1], Healthcare Inspectorate Wales (HIW) committed to a programme of national reviews which included crisis in mental health. The decision to undertake this review was based on a number of concerns relating to people's ability to access timely care, to prevent them reaching a crisis with their mental health.

HIW previously identified that initial access to mental health services is an area that requires improvement. Our Joint Thematic Review of Community Mental Health Teams national report 2019[2], highlighted a lack of knowledge for some primary care professionals, with the range of referral services available for people suffering with mental health issues.

Our review on Substance Misuse services in 2018[3] identified significant challenges around holistic working within mental health services. Issues were identified with long waiting lists after referral to mental health services, and staff at substance misuse services highlighted concerns that referral processes were sometimes overly complicated and inconsistent. In addition, it was recommended that improved co-ordination between substance misuse services and mental health teams was required in some areas of Wales.

[1] https://hiw.org.uk/sites/default/files/2019-06/190412operationalplan1920en.pdf
[2] https://hiw.org.uk/sites/default/files/2019-06/190207joint-thematic-review-community-mental-health-en.pdf This review was undertaken jointly with Care Inspectorate Wales
[3] https://hiw.org.uk/sites/default/files/2019-06/180725smen.pdf

The Mental Health (Wales) Measure 2010[4] made provision for the expansion and strengthening of mental health services at the primary care level. The GP is often the first point of contact for people with mental health concerns, and the care which they provide in local settings helps to normalise mental health issues. However, it is important to note that third sector organisations may also be a first point of contact for some people, although currently they cannot refer people directly in to NHS primary care services.

Welsh Government published the National Model for Local Primary Mental Health Support Services[5] in August 2011. The aim of these services is to improve access and patient outcomes for mental health care within primary care settings. In addition, the Together for Mental Health Delivery Plan 2019-2022[6] highlights a number of priorities, which includes improved access to preventative measures and early intervention to promote recovery. The Mental Health Crisis Care Concordat[7], published by the Welsh Government and its partners in 2015 highlights a shared statement of commitment to improving mental health services in primary care, and is endorsed by senior leaders from organisations who are most involved in responding to those in mental health crisis.

Consideration of work by other organisations

Since we decided to undertake this review, Welsh Government has commissioned other streams of work, which includes the following:

- The NHS National Collaborative Commissioning Unit (NHSNCCU) which is carrying out the Mental Health Urgent Care Access and Conveyance Review; due for completion in 2021
- The NHS Delivery Unit is undertaking an All Wales Psychiatric Liaison and Crisis Care Review 2020-21, and its work will be work carried out within each health board in Wales.

Understanding the planned and ongoing work by other stakeholders and partners within mental health crisis services has been a key consideration in shaping the focus of our national review. This is to ensure our work can add value to what is or is not known in this area, and not to duplicate any ongoing or planned work in the area of urgent care or crisis within mental health.

[4] https://www.legislation.gov.uk/mwa/2010/7/contents
[5] http://www.wales.nhs.uk/sitesplus/documents/863/Mental%20Health%20Measure%20-%20Primary%20Care%20Model.pdf
[6] https://gov.wales/sites/default/files/publications/2020-01/together-for-mental-health-delivery-plan-2019-to-2022.pdf
[7] https://gov.wales/sites/default/files/publications/2019-03/mental-health-crisis-care-concordat.pdf

Scope and methodology

Our research, stakeholder and third sector engagement has helped inform the main question which our review will seek to answer. That being:

- Is mental health crisis being prevented in the community through timely and appropriate care?

Throughout the review we will explore:

- The experiences of people accessing care and treatment

It will also explore how services available within the community of each health board across Wales:

- Provide safe and effective services to help prevent mental health crisis
- Understand the strengths and areas for improvement to help prevent mental health crisis

The review will focus on support provided by GP and other NHS services across Wales to prevent mental health crisis, and what third sector organisations do to support this. We will listen to the accounts of people, their partners and families to gain their opinion of the services they receive to help manage their mental health condition and prevent crisis. We will also explore how well services work together to provide holistic care. The national review will collect evidence in a number of ways over the next year.

The review will also aim to explore evidence of good practice and areas for improvement from our previous reviews and routine and reactive inspection work within mental health services, and that of partners, stakeholders, and third sector services.

Phase 1

Phase 1 will consider the evidence and any themes that emerge from a programme of work to explore primary care mental health services across Wales. The focus will be on the care and support available for patients within primary, community and third sector organisations.

This work will include:

- Interaction with the NHSNCCU, NHS Delivery Unit and Care Inspectorate Wales
- Review of relevant inspections or reviews undertaken by HIW in the last 36 months
- National public and professional surveys
- Interviews with health board and GP representatives

We will launch a national public survey, developed with input from Community Health Council Wales, and other relevant stakeholders. The aim is to gather the experiences of individuals who have accessed mental health care or support across Wales.

Professional survey(s) will also be launched to capture the views of staff working within relevant community settings and other services that support people with their mental health.

These surveys will also be published on our website and shared with health care providers as applicable.

Phase 2

This will be informed by the work undertaken during Phase 1 and will intend to include:

- Interviews or focus groups with GP and community services staff
- Interviews or focus groups with third sector organisations in Wales
- Focus groups with service users

Following completion of the national review, we will publish a report in 2021.

Working with other organisations

We will seek to collaborate with a range of stakeholders, including the Community Health Councils and third sector organisations, in order to engage with people using mental health services, their partners and families, to understand their experiences of mental health services across Wales.

We will liaise with these stakeholders at key intervals throughout the review, to share plans and ensure any joint working opportunities are explored to avoid unnecessary duplication of efforts and to share findings following completion of fieldwork.

Planning

We have established a mental health stakeholder reference group to inform the review. They will provide support and advice to our internal project board as required on the day to day implementation of the review.

Timescales

Scoping and research for the review commenced during 2019. The development of the review continued through 2020 with implementation set for the end of the year and continuing in to 2021. Analysing of the findings will be undertaken during the spring of 2021 with a report published during the autumn.

The methodology of the review may be amended during the review, to adhere to Welsh Government and Public Health Wales guidance on the Covid-19 pandemic, this may affect timescales of the review.

Analysis and reporting

The review will conclude with the publication of a national report in the summer of 2021. The final report will highlight key themes and recommendations identified throughout our review. The report may make recommendations for health care providers, other stakeholders and Welsh Government to consider and take action.

If any urgent concerns are identified, these will be raised promptly with health boards, service providers or Welsh Government.

Publication and engagement

Any highlight reports will be published on our website and a communication strategy will be developed to enhance exposure.

A dedicated webpage for the mental health crisis prevention review will be developed on our website, with updates on the key findings from the review. We will also use a number of communications tools and channels to raise awareness of how people can take part in the national survey and engagement activities. Following the publication of the final national report, follow-up, engagement and learning events will be considered.

Personal data

This review forms part of our work to provide independent assurance on the quality and safety of healthcare services in Wales. The Health and Social Care (Community Health and Standards) Act 2003 (Part II, Chapter 4) gives HIW the power to carry out inspections, reviews and investigations of the NHS or services provided for the NHS.

Where we process personal data, this is in accordance with data protection legislation, including the Data Protection Act 2018 and the General Data Protection Regulations. Further information is set out in HIW's privacy notice which can be found on our website https://hiw.org.uk/privacy-policy.

Number of Actions	Number of Completed Actions	Number of Amber Actions	Number of actions with no progress
37	**26**	**6**	**5 Not Applicable to PTHB** **X3 hospice / x2 Welsh Government**

Ref	Recommendation	Setting action	Timeframe	Responsible person	Action Status *(Complete/In Progress/Not Actioned)*
1	Health boards and service providers must ensure environments protect the safety and wellbeing of young people. There must be robust systems in place to monitor risks within the environment and ensure maintenance work is conducted in a timely way.	Reviewed October 2020 and assessed as **complete** based on the following evidence: • Powys Teaching Health Board (PTHB) has no in-patient CAMHS areas More broadly: • Environmental risk assessments for children's centre sites have been reviewed and updated in line with Covid guidance	Complete October 2020		Complete

2	Health boards and service providers must ensure there is clear communication with young people to help them understand their treatment.	Reviewed October 2020 and assessed as **complete** based on the following evidence: • PTHB has no in-patient CAMHS areas However, more broadly: : • PTHB uses child friendly information where available • As a broader point, all children's teams have accessed person centred training and are using this approach in multi-agency meetings • Children's Community Nursing (CCN) team use child centred resources (books, video) to support communication. • Services are using the Attend Anywhere platform for virtual clinics, which allows children and young people visual access to practitioners	Complete October 2020		Complete

3	Welsh Government, health boards and service providers need to improve the communication with, and information available for, young people and their families at the point of referral.	Reviewed October 2020 and assessed as **complete** based on the following evidence: • Powys CAMHS operates a duty system in which all new referrals are dealt within day of referral and when signposting is indicated, family are consulted and informed of action. • Single point of entry for all paediatric referrals (community paediatrician, General paediatricians, children's continence, learning disability) these are discussed weekly and where unmet needs are identified and action is taken immediately to ensure that there is timely communication to address concerns or issues. • Single point of entry for all Neurodevelopmental referrals, families always included in response to referrer	Complete October 2020		Complete

		• All teams have bilingual information leaflets with links to national advice websites as appropriate			
4	Welsh Government needs to consider the capacity within CAMHS services across Wales to ensure this meets the needs of young people, including those who are high risk.	Reviewed October 2020 and assessed as **'in progress'** based on the following evidence: • Powys CAMHS is a combined service Primary and secondary with incorporated CITT and crisis provision. We have service level agreements with neighbouring health boards as there is no A+E provision in Powys • The team consistently meet national targets for assessment and intervention • Powys CAMHS works 9-5 hours generally with scope to provide some out of hour pre -arranged CITT provision but no out of hours Crisis provision planned or unscheduled			In progress

		Reviewed March 2021 – there are currently no capacity issues within CAMHS and therefore our we are able to deploy our CITT provision as and when it is required. **Action required:** • Due to lack of CAMHS capacity, children and young people with neurodevelopmental diagnosis and high level anxieties or behaviours which challenge, have difficulty accessing appropriate services in a timely manner. Plan being developed March 2021 – Childrens Neurodevelopment do not currently sit within CAMHS	April 2021	Assistant Director for Mental Health/assistant Director for Women and Children	
5	Welsh Government and health boards need to review the waiting times for CAMHS services, ensure there are timely referrals to other organisations to support young people and	Reviewed October 2020 and assessed as **in progress** based on the following evidence: • For those young people who do not meet the criteria for Primary care and Specialist CAMHS, PTHB is working			In progress

	how young people can access support at times of crisis.	very closely with partner organisations to provide a multiagency panel who will signpost those young people to more appropriate support providers • Powys CAMHS are consistently working within National Targets • Powys CAMHS operates duty service 9-5 where any young person or family member currently open to the service can contact at times of crisis. • Powys CAMHS does not currently operate a crisis service outside of these times **Action required:** • ND waits for assessment have increased due to Covid 19 which is impacting on the Referral to Treatment Time. Plan being developed. • Support services for post diagnosis ASD and ADHD are scarce and relies on	December 2020 December 2020	Assistant Director for Women and Children and Assistant Director for Mental Health	

		universal / tier one services which lack the capacity. Plan being developed		Assistant Director for Women and Children and Assistant Director for Mental Health	
6	Health boards and service providers must ensure there is clear information for young people on advocacy services and flexibility to enable young people to meet with advocacy services at a time of their choice.	Reviewed October 2020 and assessed as **complete** based on the following evidence: • PTHB commissions independent advocacy through a contract with Tros Gynnol Cymru • This contract is monitored on a quarterly basis and support has continued through the pandemic • Information is displayed within waiting areas • Children and Young people who are placed in residential placements and jointly funded with health and the local authority have access to advocacy if required	Complete October 2020		Complete

7	Health boards and services providers must ensure young people know how to raise a concern.	Reviewed October 2020 and assessed as **complete** based on the following evidence: • Easy read version of raising a concern is available and displayed in waiting areas	Complete October 2020		Complete
8	Health boards and service providers must ensure that: • Patient records, care planning and statutory mental health documentation are comprehensive, accurate and completed in a timely manner • Emergency clinical items, including ligature cutters can be located without delay • Staff have sufficient knowledge on how to support and monitor patients before,	Reviewed October 2020 and assessed as **in progress** based on the following evidence: • PTHB has no in-patient CAMHS areas More broadly: • Use of WCCIS has facilitated staff to maintain timely records and remote access has ensured timely completion • However, the process of documentation audits within CAMHS needs formalising **Action required:** CAMHS to develop an audit tool based on specific CAMHS	December 2020	ead of CAMHS and Young People	complete

	during and after mealtimes Any restraint must be carefully considered, risk assessed and monitored, with the involvement of the young person to ensure their safety, rights and dignity are protected as much as possible.	standards and introduce regular documentation audit A joint meeting was held between education and PTHB following restraint consultation to agree how to implement and model positive behaviour planning across settings.			
9	Health boards and service providers must ensure CAMHS staff have up-to-date safeguarding training.	Reviewed October 2020 and assessed as **complete** based on the following evidence: • PTHB has no in-patient CAMHS areas • Regular Safeguarding supervision and mandatory / statutory training is in place for all practitioners • During 1-1 supervision and in team meeting's staff will be reminded of their mandatory training responsibility to ensue that they have up to date safeguarding training.	Complete October 2020		Complete

		• Audit will continue to ensure compliance.			
10	Welsh Government, health boards and service providers must consider how issues around workforce within CAMHS units can be addressed to ensure young people receive care from the right staff with the rights skills to meet their needs.	Reviewed October 2020 and assessed as **complete** based on the following evidence: • PTHB has no in-patient CAMHS areas • Powys CAMHS and Young Person's service is divided into Primary care, specialist CAMHS with support from a clinical Nurse Specialist in Youth Justice, Specialist practitioner in eating disorders and early intervention. • All these services are supported with a multi-disciplinary team by two part time CAMHS consultants, two psychologists, a CBT practitioner and a part time specialist psychologist in parenting. This therefore means that staff can be deployed from each of these	Complete October 2020		Complete

		areas to support the young persons individual needs. • PTHB CAMHS does not experience any recruitment difficulties			
11	Health boards must ensure that children and young people can consistently be treated within designated areas.	Reviewed October 2020 and assessed as **in progress** based on the following evidence: • PTHB has 2 dedicated Children's Centres, one in Brecon and one in Newtown where most children are treated • The community hospitals also hold children's outpatients which are child friendly areas but are not designated children's areas • MIUs have a child friendly treatment room but not waiting areas **Action required:** • Post Covid19, PTHB will scope outpatient and MIU	April 2021	Head of Children's Public Health	In progress

		waiting areas with the aim of creating a child friendly waiting area.		Nursing and Paediatric services/Unscheduled Care manager/Scheduled care manager	
12	Health boards must ensure young people consistently receive timely care and treatment within emergency departments and for emergency invasive procedures.	Reviewed October 2020 and assessed as **complete** based on the following evidence: • PTHB has no paediatric in-patient beds or A/E services • Children do attend local Minor Injury Units (MIU) within PTHB, although children under 1 must attend a District General Hospital	Complete October 2020		Complete
13	Health boards must ensure that young people know how they can raise concerns about their care within hospitals.	Reviewed October 2020 and assessed as **complete** based on the following evidence: • PTHB has no paediatric in-patient beds • An easy read version of how to raise a concern is displayed in waiting areas	Complete October 2020		Complete

14	Health boards must ensure that paediatric risk and pain assessment documentation is comprehensive and completed in a timely manner.	Reviewed October 2020 and assessed as **complete** based on the following evidence: • The Whaley and Wong (faces) paediatric pain assessment is used by the community children's nursing team • The community children's nursing team uses the all Wales paediatric pain tool for paediatric palliative care cases. • Appropriate risk assessments in place	Complete October 2020		Complete
15	Health boards must ensure that staff working who may work with children and young people have up-to-date safeguarding training.	Reviewed October 2020 and assessed as **complete** based on the following evidence: • There is a Regional Safeguarding Training Strategy in place.	Complete October 2020		Completed- Compliance monitored via Safeguarding Group

		• PTHB have adopted the NHS Wales Safeguarding Networks Training Strategy which a member of the Safeguarding Team contributed to. • Level 1 Safeguarding People and level 2 Safeguarding children and adult training is compliant with the relevant Intercollegiate Documents (national e-learning package via ESR). • A programme of Level 3 Safeguarding Children and Adult training is available via a rolling training programme. • Microsoft Teams training commenced June 2020. • Modular Training approach developed to give professionals more flexibility and fit blended learning. • Safeguarding Training competency passport in place for level 3 and 4 safeguarding training, this is aligned to the			

		adults ICD 2018 and the Childrens ICD 2019. • Zip folders of relevant learning material sent to training attendees post training. • Mental Capacity Act training is mandatory and ESR will be updated Sept/oct 2020. • Child Exploitation – module will be available by Oct 2020. • VAWDASV Group 1 and group 2 aligned to relevant staff, rolling training programme in place. • Learning and Development via monthly Safeguarding themed Newsletters and 7BM. • ACEs incorporated into training packs. • Improved monitoring process for completed safeguarding competency passports. • Safeguarding Training Compliance analysed via Safeguarding Strategic and			

		Operational groups every quarter.			
16	Health boards must ensure there are sufficient numbers of staff with the right skills to meet the needs of children and young people.	Reviewed October 2020 and assessed as **complete** based on the following evidence: • PTHB has no paediatric in-patient beds or ED department • Community staff have good access to a wide range of training, appropriate to meet the needs of children with complex conditions. • PTHB CCN team has a training plan which is being reviewed on an All Wales basis by a sub group of the All Wales Children and Young People Senior Nurse Forum. • The aim of the review is to ensure that teams across wales share expertise and training. • Some of the specialist training requires staff to travel	Complete October 2020		Complete

		across the border into England. • No current vacancies in CCN team			
17	Service providers must ensure they have comprehensive and up-to-date environmental risk assessments and address any actions highlighted.	N/A To be completed by hospices			
18	Service providers must ensure there are arrangements to support communication needs of children, young people and their families, including facilities to support people who use hearing aids.	N/A To be completed by hospices			
19	Welsh Government needs to assess any unmet demand for palliative care services to ensure children and young people across Wales get the care they need.	N/A To be completed by Welsh Government .			

20	Service providers need to be mindful of how they ensure young people and their families are made aware of how to raise a concern about their care.	N/A To be completed by hospices			
21	Welsh Government and health boards must ensure there are clear transition pathways and policies in place for each service area. Where possible, there should be consistency in approaches to transition in line with national guidelines.	Reviewed October 2020 and assessed as **complete** based on the following evidence: • PTHB has a transition pathway which is aligned to the draft WG guidance (awaiting final version) and transition meetings are held biannually. • Continuing Care transitions are improving and recent transfers of care from the CCN team to adult CHC have been positive for the young people	Complete October 2020		Complete
22	Health boards must ensure there are robust systems to monitor transition policies and pathways across healthcare services to	Reviewed October 2020 and assessed as **in progress** based on the following evidence: • In relation to transitions for complex care, adult and children teams are currently			In progress

	ensure approaches are effective.	working together to ensure operating procedures around transition are aligned. The process of transition is being incorporated into the Adult Continuing Health Care (CHC) Standard Operating Procedures **Action required:** • Completion of Adult CHC Standard Operating Procedures	December 2020	Senior Nurse for CHC	
23	Welsh Government and health boards must ensure there are sufficient resources and capacity to support effective and timely transition.	Reviewed October 2020 and assessed as **in progress** based on the following evidence: • PTHB is still awaiting the final WG 'Transition and Handover guidance' where the HB is expecting their responsibilities to be outlined. **Action required:**			In progress

		• PTHB will review WG 'Transition and Handover guidance' when available and action accordingly	TBC	Assistant Head of Children's Nursing	
24	Health boards must ensure a named key worker to coordinate transition is identified promptly and consider how to best support transition, including considering designated roles.	Reviewed October 2020 and assessed as **complete** based on the following evidence: • As part of PTHB's transition pathway, the appropriate adult service is identified when the child is aged 14 and then at 16 a specific adult key worker is identified	Complete October 2020		Complete
25	Health boards must ensure they have a formal systems for involving young people in the design and delivery of transition processes and learn from their experiences.	Reviewed October 2020 and assessed as **in progress** based on the following evidence: • PTHB are engaged with Powys County Council (PCC) to review the experience of transition for young people on a multi-agency basis. This has been suspended during the Covid19 pandemic **Action required:**			In progress

		• The HB will re-engage with PCC when this work is re-commenced	April 2021	Assistant Head of Children's Nursing	
26	Health boards must ensure young people are involved in the planning and transition process and are provided with adequate support to enable them to adjust.	Reviewed October 2020 and assessed as **complete** based on the following evidence: • PTHB have adopted the person centred care approach to ensure the wishes and feelings of young people are captured as part of their transition plans.	Complete October 2020		Complete
27	Health boards must ensure there is sufficient time to allow for effective transition and planning starts as early as possible.	Reviewed October 2020 and assessed as **complete** based on the following evidence: • In PTHB the transition process commences at 14 which provides sufficient time to allow for effective transition	Complete October 2020		Complete
28	Health boards need review the practices where transition starts later, particularly for services where this starts after the age of 16 and align with national guidelines.	Reviewed October 2020 and assessed as **complete** based on the following evidence: • This is particularly relevant to young people with a mental health disorder as this may	Complete October 2020		Complete

		not manifest itself until later adolescence. • PTHB have an early intervention practitioner in CAMHS that links in and jointly works with the adult early intervention team to support those adolescents aged between 14 -25 who need transition between CAMHS and adult services			
29	Welsh Government and health boards need to ensure there are appropriate transition pathways and support for young people with complex health needs and life-limiting conditions.	Reviewed October 2020 and assessed as **complete** based on the following evidence: • PTHB has a clearly defined pathway for transition of young people with complex health needs and life-limiting condition.	Complete October 2020		Complete
30	Health boards must ensure there are consistent and robust systems identify young people who will need to transition and support for attending appointments in adult services.	Reviewed October 2020 and assessed as **complete** based on the following evidence: • PTHB meets with PCC quarterly to identify young people who will need additional support for	Complete October 2020		Complete

		transition which includes consideration of support for adult appointments. • PTHB also commissions joint child/adult clinics for those young people transitioning eg Diabetes			
31	Health boards must ensure that adult services make every effort to engage with young people and communicate with other involved agencies, to ensure they can successfully transition.	Reviewed October 2020 and assessed as **complete** based on the following evidence: • As part of the transition pathway, PTHB has a robust system to ensure it engages with young people and communicates with other agencies, to ensure a successful transition	Complete October 2020		Complete
32	Welsh Government and health boards need to review the differences between service models and thresholds between child and adult healthcare services and consider how young people can continue	Reviewed October 2020 and assessed as **complete** based on the following evidence: • The transfer of care for children with complex needs within Powys is clearly outlined and this includes the move from children's	Complete October 2020		Complete

	to receive holistic care and support into adulthood.	continuing care to adult Continuing Health Care. • Young people who access their specialist health care out of county are transitioned back to their GP in county, or to the appropriate adult service out of county. • Action to confirm health care pathways for specific conditions needs to be confirmed in line with the HB service level agreement.			
33	Health boards must ensure that parents and carers are sufficiently involved in transition planning.	Reviewed October 2020 and assessed as **complete** based on the following evidence: • Parents/carers are invited to all Person Centred planning meetings for transition • In the case of a young person who has capacity, they can decide if they want their parents/carers present	Complete October 2020		Complete
34	Health boards must ensure there is clarity across services about how all	Reviewed October 2020 and assessed as **complete** based on the following evidence:	Complete October 2020		Complete

	young people aged 16 and 17 should be appropriately treated, including how they will ensure staff have the right skills to care for them.	• PTHB has no inpatient paediatric ward and no acute wards • Within community services, all 16 and 17 years olds are treated by children's nursing or community paediatricians, who have the appropriate skills			
35	Welsh Government needs to ensure there is clear guidance about how young people under 18 years of age, should be treated when needing care for physical health needs.	N/A To be completed by Welsh Government .			
36	Welsh Government and health boards must review the practice and frequency of placing young people on non-designated adult mental health wards.	Reviewed October 2020 and assessed as **in progress** based on the following evidence: • PTHB are in the process of designating an age appropriate bed on an acute AMI ward. **Action required:**	October 2020	Assistant Director MHLD	Complete

		• Complete and implement plans			
37	Welsh Government needs to consider the reporting and monitoring of underage admissions on adult (non-mental health) hospital wards to ensure there is oversight on this issue across Wales.	Welsh Government action			Complete

DASHBOARD OF IMPLEMENTATION OF HEALTH AND SOCIAL CARE REGULATORY REPORT RECOMMENDATIONS

HEALTH AND SOCIAL CARE REGULATORY REPORT 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 HIW	Mental Health Service Inspection (Ystradgynlais Hospital)	25	25	0	0	0	√
171808 HIW	Mental Health Service Inspection (Clywedog Ward, Llandrindod)	9	9	0	0	0	√
TOTAL		**34**	**34**				√
			2018/19				
181901 HIW	Ionising Radiation Regulations and Follow Up Inspection (Brecon and Llandrindod Hospitals)	9	9	0	0	0	√
181902 HIW	General practice Inspection (Presteigne Medical Practice)	13	13	0	0	0	√
181903 HIW	Joint HIW & CIW National Review of Mental Health Services Inspection visit to (announced): Welshpool Community Mental Health Team	25	25	0	0	0	√
TOTAL		**47**	**47**	**0**	**0**	**0**	√
			2019/20				
192001 HIW	Joint Community Mental Health Team Inspection - The Hazels, Llandrindod	19	19	0	0	0	√
192003 HIW	Unannounced Mental Health Service Inspection (Clywedog Ward, Llandrindod)	23	20	0	3	0	×
192004 HIW	Unannounced Twymyn Ward, Machynlleth Community Hospital & Graham Davies Ward, Llanidloes Hospital Inspection	20	19	1	0	0	×
192006 HIW	Unannounced Hospital Inspection: Llewellyn Ward, Bronllys Hospital	13	12	1	0	0	×
192007 HIW	Birth Centres (Free Standing Midwifery Led Unit) Across Powys	9	6	3	0	0	×
192008 HIW	NHS Mental Health Service Inspection (Unannounced): Felindre Ward, Bronllys Hospital	23	21	0	1	1	×
HIW	The National Review of Services for Young People	32 (5/37 N/A PTHB – x3 hospices/ x2Welsh Government)	26	2	1	3	×
CIW	Inspection Report on Cottage View, Knighton	3 areas of non-compliance	0	0	8 notifications submitted to date to support compliance and work ongoing	0	×
TOTAL		**139**	**123**	**7**	**5**	**4**	
			2020/2021				
20045 HIW	Tier 1 Quality Check: Tawe Ward, Ystradgynlais Hospital	2	1		1	0	×
20050 HIW	Tier 1 Quality Check: Maldwyn Ward, Welshpool Hospital	2	0	2	0	0	×

TOTAL	**4**	**1**	**2**	**0**	**0**	
GRAND TOTAL	**193**	**179**	**7**	**6**	**1**	

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item:

Management Report	**Date of Meeting 24th March 2021**
Subject :	Care Inspectorate Wales (CIW) Inspection Report Improvement Actions Cottage View
Approved and Presented by:	Jason Crowl, Assistant Director Community Services
Prepared by:	Jason Crowl, Assistant Director Community Services
Other Committees and meetings considered at:	N/A

PURPOSE:
The purpose of this paper is to provide an update on the CIW inspection improvement actions for Cottage View following the inspection visit in March 2020.
RECOMMENDATION(S):
Note and accept the actions taken to date.

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

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

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:

Cottage View is a care home managed by the Health Board and is regulated under The Regulation and Inspection of Social Care (Wales) Act 2016. Unlike the NHS which generally delivers governance through policy and professional standards, care homes achieve good governance through adherence to regulation.

Regulation covers all aspects of service delivery and care homes are inspected on a regular basis by Care Inspectorate Wales (CIW).

Three Non-Compliance Notices were issued in 2020 relating to failure to meet the regulations associated primarily with governance and management of the service. This paper outlines the actions taken to meet the regulatory requirements.

The CIW inspection and the Guidance for Providers and Responsible Individuals are referenced below.

DETAILED BACKGROUND AND ASSESSMENT:

Introduction

Cottage View Care Home is located in the town of Knighton in Powys and provides care and support for up to ten people. The registered provider is Powys Teaching Health Board who have appointed Jason Crowl as the responsible individual (RI) to oversee the operation of the service. The Registered manager Chris Creamer has day-to-day responsibility and is registered with Social Care Wales (SCW). The care home has 10 single rooms and has residents on a commissioned and private funded bases.

Summary of our findings

CIW undertook an assessment in March 2020 as a follow up to their primary report in 2019.

During the assessment residents told CIW that they are happy living at Cottage View. Residents confirmed they can make choices that affect their lives or have someone who can support them with this. They can do things they are interested in and are supported by staff who know them well and treat them with kindness and respect. Improvements are made to the service based on people's comments and views, they feel listened to by the manager and staff.

However, the leadership and management of the service needed improvement to ensure it is run in accordance with the legal requirements.

There were three areas of non-compliance with the regulations noted during the inspection and has directed the ongoing improvement work at the home.

Leadership and Management	Our Ref: NONCO-00009451-TBWT
Non-compliance identified at this inspection	
Timescale for completion	**31/07/20**
Description of non-compliance/Action to be taken	**Regulation number**
The service provider does not notify the service regulator of events in line with the legal requirements.	
Evidence	
The registered person is not compliant with regulation 60 This is because the provider does not inform CIW of events as required in the regulations. The evidence includes: The service was registered under RISCA on 8 May 2019. CIW have not received any online notifications since this date. The manager informed CIW on 17 March 2020 that they had previously been made aware by CIW that they were no longer receiving paper copies of the notifications and these must be submitted on line. They said this was escalated to senior management but not actioned. CIW are not receiving information about the service as required by law and which could impact on the health and well-being of people using the service. The service is not operating within the legal requirements of their registration.	

Management Update

To date there have been 8 notifications submitted in line with the regulations from 30/10/2020
These include:

List of Notifications

	Notification Transaction Record	Sub Category	Status
+	OTRAN-00109276-CPKK	Event which prevents or could prevent the continued delivery of the service safely to people using the service	Accepted
+	OTRAN-00103023-JGMP	DoLS request sent to a supervisory body	Completed
+	OTRAN-00103019-LTFF	Reopening following temporary closure due to COVID-19	Completed
+	OTRAN-00099122-NCCY	Death of a person using the service	Completed
+	OTRAN-00097671-WMMW	Outbreak of an infectious disease at the service	Completed
+	OTRAN-00095819-KLXN	Outbreak of an infectious disease at the service	Completed
+	OTRAN-00095818-LLNY	Temporary closure due to COVID-19	Completed
+	OTRAN-00095730-BCTM	Outbreak of an infectious disease at the service	Completed

1 10

Add Notifications

RI visit review visit undertaken 26th November 2020 and booked again 25th February 2021

Leadership and Management	Our Ref: NONCO-00009452-HTVT
Non-compliance identified at this inspection	
Timescale for completion	**31/07/20**
Description of non-compliance/Action to be taken	**Regulation number**
There are no clear arrangements for the oversight and governance of the service.	
Evidence	
The registered person is not compliant with regulation 6 This is because the service provider has not ensured the service is provided with sufficient care, competence and skill to meet the requirements of the regulations. The evidence: The Responsible Individual has not carried out visits to the service at least once every three months in line with the legal requirements. There is no system in place to make sure key documents including the complaints policy, statement of purpose and guide to the service are kept up to date and contain information in line with the legal requirements. CIW are not notified of key events that impact on individuals or the delivery of the service. Key documentation including the statement of purpose, guide to the service and complaints policy do not refer to the correct regulations under which the service is registered. The service is not meeting the requirements of the regulations which could impact on the service people receive.	

Management Update

To date there have been 8 notifications submitted in line with the regulations from 30/10/2020.

RI role has commenced and is registered with CIW.

Care Home
Observation of Care T

RI visit review visit undertaken 26th November 2020 and booked again 25th February 2021

Care Home Policy List.docx

Statement of purpose has been revised to include correct legislation and outlines the management structure.

2021 Cottage View Statement of Purpose

Leadership and Management	Our Ref: NONCO-00009454-TTFV
Non-compliance identified at this inspection	
Timescale for completion	**31/07/20**
Description of non-compliance/Action to be taken	**Regulation number**
The provider has failed to ensure the person designated as responsible individual has carried out their role effectively.	
Evidence	
The registered person is not compliant with regulation 9 (2) (a), (3) (a), (b), (4) (b) (c) (5) (a) (b) This is because the provider has failed to ensure the Responsible Individual has carried out their duties effectively. The evidence: The SOP, guide to the service and complaints policy do not contain information required in the regulations. They do not refer to the legislation that the service is registered under. Notifications of significant events are not reported to CIW in line with the regulations. The Responsible Individual has not carried out visits to the care home at least once every three months in line with the legal requirements. We were made aware on 1 April 2020 that the person nominated as Responsible Individual was currently absent from the role. CIW had not been informed of this in line with the legal requirements. The above demonstrates a lack of understanding of the requirements of the regulations under which the service is registered.	

Management Update

Statement of purpose has been revised to include correct legislation and outlines the management structure and reference to the correct legislative framework

To date there have been 8 notifications submitted in line with the regulations from 30/10/2020

RI visit review visit undertaken 26th November 2020 and booked again 25th February 2021

RI role has commenced and is registered with CIW

Reference Material

CIW Inspection 17th March 2020.

CIW Inspection 17th March 2020.pdf

Regulations relating to Cottage View are referenced below

guidance-for-providers-and-responsible-in

RECOMMENDATIONS:

Note and accept the actions taken to date.

The following Impact Assessment must be completed for all reports requesting Approval, Ratification or Decision, in-line with the Health Board's Equality Impact Assessment Policy (HR075):

IMPACT ASSESSMENT
Equality Act 2010, Protected Characteristics:

	No impact	Adverse	Differential	Positive	Statement
Age				x	***Please provide supporting narrative for any adverse, differential or positive impact that may arise from a decision being taken***
Disability				x	
Gender reassignment				x	
Pregnancy and maternity				x	
Race				x	
Religion/ Belief				x	
Sex				x	
Sexual Orientation				x	
Marriage and civil partnership				x	
Welsh Language				x	

Risk Assessment:

	Level of risk identified				
	None	Low	Moderate	High	This risk assessment is based on service being provided
Clinical				x	
Financial		x			
Corporate			x		
Operational				x	
Reputational				x	

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 3.3

Experience, Quality and Safety Committee	**Date of Meeting: 15 April 2021**
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 Kate Wright, Medical Director
Other Committees and meetings considered at:	Quality Governance Group, March 2021

PURPOSE:

The purpose of this report is to present progress made on implementing the health board's Clinical Quality Framework Implementation Plan, 2020-2023, since the last report in November 2020. The Clinical Quality Framework contributes to the Organisational Development Strategic Framework.

RECOMMENDATION(S):

The Experience Quality and Safety Committee is asked to:

1. DISCUSS the contents of this report, note the impact of the covid 19 pandemic on some areas and progress in others.
2. NOTE the intention of the Executive Committee to review the prioritisation of actions scheduled for 2021-2022 to ensure the focus reflects developments and learning during the last 12 months

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 and along with the Organisational Development Strategic Framework, which focusses on improving the effectiveness of the health board and to support the alignment, delivery and improvement approach across all areas.

Since Febraury 2020, the Covid19 pandemic has essentially dominated the focus of health boards and NHS Trusts in Wales, England, and beyond, with widely acknowledged adverse impact on the population's access to health care, along with the potential for ill effects on the wellbeing of staff.

Whilst overall implementation of the Clinical Quality Framework Implementation Plan has been adversely affected throughout the year as a result of the COVID19 pandemic, progress has been made and/or maintained in most of the goals.

An 'at a glance' summary of status in relation to each of the activities identified for year 1, year 2's scheduled activities have been highlighted in red. The Executive Committee plan to review the prioritisation of actions scheduled for 2021-2022 to ensure the focus reflects developments and learning during the last 12 months.

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 implementation plan was presented to, and approved by the Experience Quality and Safety Committee in June 2020 and a report detailing its status was presented during November 2020. The Clinical Quality Framework contributes to the Organisational Development Strategic Framework, the role of which is to focus on improving the effectiveness of the health board and to support the alignment, delivery and improvement approach across all areas.

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. The opportunity to progress has been predicated on the capacity and capacity of the workforce at every level within the health board, in the context of managing the Powys response to the covid19 pandemic.

2.2 Since Febraury 2020, the Covid19 pandemic has essentially dominated the focus of health boards and NHS Trusts in Wales, England, and beyond, with widely acknowledged adverse impact on the population's access to health care, along with the potential for ill effects on the wellbeing of staff. The 4 harms related to covid19, used to help shape and inform the NHS Wales response, recognises the limitations faced by health boards in this context. During quarters 3 and 4 of 2020 – 2021, the opportunity and challenge presented by mass vaccination emerged, Powys Teaching Health Board's success in protecting the population has been made possible through redeployment of a significant proportion of the workforce at all levels, to ensure safe, timely access to vaccination. This was a proportionate, planned and measured response, which mitigated some of the opportunity to pursue other priorities.

2.3 Whilst overall implementation of the Clinical Quality Framework Implementation Plan has been adversely affected throughout the year as a result of the COVID19 pandemic, progress has been made and/or maintained in most of the goals. The traffic light system in the table below was introduced into reporting in November 2020 and is updated, with a key as explanation of the rating, demonstrating the current status of each of the activities.

The table below provides an 'at a glance' summary of status in relation to each of the activities identified for year 1, year 2's activities have been highlighted in red, however, the intention of the Executive Committee is to review the prioritisation of actions scheduled for 2021-2022 to ensure the focus reflects developments and learning during the last 12 months, hence there may be a change in future focus and reporting. The narrative in **appendix 1** provides more context in terms of the assessment of progress as displayed below:

RAG key

No progress made	
Progress made but slower than anticipated	
Progress satisfactory	
Completed	

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

Goal	Status Nov 2020	Status Mar 2021
GOAL 1a. SAFETY Director of Nursing & Midwifery		
Implement the revised Putting Things Right policy		
Implement the five key improvement actions relating to Serious Incident management		
Develop and implement a revised approach to organisational learning		
Assess systems of communication and support that enable staff to raise concerns		
Review & revise system for safety alerts/notices		
GOAL 1b. EFFECTIVENESS Medical Director		
Implement the improvement plan for clinical audit		
Review & develop organisation approach to implementation of national clinical guidelines		
Accelerate Value-based Healthcare Programme in the organisation		
Review approach to Health and Care Standards		
GOAL 1c. EXPERIENCE Director of Therapies & Health Sciences		

Refresh the PTHB Patient Experience Framework		
Review arrangements for learning from patient experience in all clinical services		
Consider alignment of resources for Patient Experience to enable intelligence gathered to inform clinical care and Board decisions		
GOAL 2: Organisational culture Director of Workforce & Organisational Development		
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		
Design/implement an organisational and staff development programme to embed Clinical Quality Framework		
Review Terms of Reference of relevant committees to reflect Framework		
Review the resources available to support clinical quality improvement		
GOAL 3: clinical Leadership Director of Therapies & Health Sciences		
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		
Design and implement an approach to develop and sustain clinical leadership across the health board		
Review/improve clinical leadership in design, review and action from performance/intelligence on clinical services		
GOAL 4: Improvement methodology Medical Director		
Using a prioritised and risk-based approach, define and deliver a programme of clinical quality improvement projects		
Agree and adopt an approach to clinical quality improvement, including the methodology, knowledge and skills		
Develop a training programme to enable staff have improvement knowledge and skills		

Review and develop the resources available to lead and support clinical quality improvement across the organisation		
GOAL 5: Intelligence Director of Public Health		
Review and develop performance monitoring arrangements for clinical services; aligning to work undertaken on Commissioning Assurance Framework(s)		
Review and develop ward/department and service-level dashboards		
Develop arrangements for the clinical validation/interpretation of the core datasets relating to clinical services, including the use and interpretation of data in providing assurance		
Develop/integrate a valid and robust organisational benchmarking approach, using national/international comparators where available		

2.4 Whilst some elements expected in year 1 have not been progressed having bene adversely affected as a result of the second wave of the pandemic, others have essentially been expedited. As the second year of implementation proceeds, those elements well established will be further consolidated and outstanding actions will be integrated into the year 2 plan.

NEXT STEPS:

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 renewal and recovery, along with supporting staff resilience and wellbeing, all impact on the opportunity to strategically develop, redesign, establish and consolidate new arrangements. The intention of the Executive Committee is to review the prioritisation of actions scheduled for 2021-2022 to ensure the focus reflects developments and learning during the last 12 months. A further report will be presented in June 2021.

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 work initiated by the Innovation and Improvement Team has been progressed as part of an internal review, led by the Deputy Director of Nursing, due to report imminently. This work will enhance and triangulate the findings of an independent review, undertaken following the receipt of a Special Report issued by the Public Services Ombudsman for Wales and will ensure that the focus of improvements implemented by the health board results in real and sustained change and increased compliance.

In terms of compliance, the requirements around Putting Things Right are laid out in the health board's policy and are underpinned by a series of Regulations and Standards as well as additional considerations written in legislation that have been introduced since the publication of the policy in 2019. The policy commits that a minimum 10% sample of concerns will be subject to monthly audit to ensure compliance with the Regulations, however, since the policy has been approved, there are additional requirements that the health board is required to provide assurance against.

An annual programme has been developed based on the core requirements of Putting Things Right. The audit programme is structured on a rolling annual basis and it is recommended that a baseline exercise is conducted across certain elements to establish areas in need of immediate action and enable the application of learning. The implementation of the audit and assurance plan is predicated on the following factors:

- Establishment and consolidation of the quality and safety function with service groups, achieving greater clarity and separation between the service response and corporate assurance.
- Using the results of the internal and independent review, the roles and responsibilities of the central Putting Things Right team clarified and aligned to the core skill set needed to meet the need, with capacity to accommodate the audit and assurance programme
- Little or no outstanding concerns, serious incidents and incidents, enabling robust and timely response where issues arise
- Introduction of the OFWCMS

- A programme of continuous learning to support the development of knowledge, skills and expertise

The recommendations arising from implementation of the audit and assurance plan will be reported to Quality Governance Group and subsequently the Experience Quality & Safety Committee.

A training programme is emerging and implementation commenced. During quarter 4, root cause analysis training was provided to a group of senior leaders and managers, width the aim of reasserting 'what good looks like' in terms of professional inquiry, investigation and analysis. Live webinar training provided by NHS Wales Shared Services Legal & Risk Services, generated good attendance and engagement. Training from the Public Service Ombudsman for Wales is also being explored.

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 focus on developing an effective and efficient response to serious incident management is becoming embedded, with robust arrangements within each of the service groups, enabling multi-disciplinary review and shared learning. The advent of a learning group, chaired by the Medical Director, scheduled to meet in March 2021, will assist in maximising the sharing of learning. Plans to introduce a 'swarm' model in relation to incidents of in-patient falls and pressure damage, will help strengthen the timeliness and robustness of investigation and learning. The organisations performance in relation to serious incident management is scrutinised by the Chief Executive Officer weekly and by the Experience Quality and Safety Committee.

Quality governance arrangements within the service groups have strengthened over quarter 3 and 4, Women and children's arrangements have consolidated as reported to the Experience Quality and Safety Committee. Continued development of the approach in Mental Health and Learning Disability Services has been approved by the Executive Committee in March 2021 and arrangements within the Community Servcie Group are being presented to the Quality Governance Group in March 2021, for immediate implementation.

The core model for clinical quality in commissioned services is captured via commissioning assurance frameworks and the infrastructure that supports regular

quality focussed scrutiny with providers, intelligence gathering, examination of Board papers and other sources, enabling triangulation and well informed levels of assurance.

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

The plan for clinical audit has been implemented on and progress reported to the Experience Quality and safety Committee during December 2020.

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

Whilst the patient experience group was temporarily deferred during the second wave of coronavirus during quarters 3 and 4, work is underway to explore the opportunity to procure a patient experience system enabling collation of an electronic patient feedback through surveys on a web browser platform. This approach may enable a consistent approach to capturing patient experience feedback from Powys residents regardless of where they access services which is essential, given the variety of health care providers commissioned to provide care and treatment for the population of Powys. An options appraisal will be provided to the Executive Committee for consideration. The revised national patient experience strategy, remains delayed but is expected during 2021.

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

The covid19 pandemic has seen the emergence of natural leaders and leadership across the health board, with individuals and teams more than meeting the challenge, looking for innovative solutions and working outside of traditional boundaries to achieve best outcomes. This has highlighted the opportunities for further enabling and development. In light of this, the Organisational Development Strategic Framework is due for discussion at executive level with the aim of reviewing and refreshing the way forward.

The health board's Values and Behaviours Framework has been aligned to the principles of compassionate leadership, and in conjunction with the 2020 staff survey results which were positive showing a similar high engagement index score to 2018, provide a good basis to move ahead with, balancing the need for renewal and recovery with the wellbeing and resilience of the workforce.

In terms of a multidisciplinary approach to clinical risk assessment and management, the pandemic has necessitated the development of new and different ways of assessment and service provision, including virtual assessment and diagnosis, at times, leading to innovative service provision. The need for multidisciplinary risk assessment has never been more evident, including close working alongside primary care, public health, microbiology and local authority colleagues. The health boards approach to harm review is reported to Equality Experience and Safety Committee.

Multi-disciplinary risk assessment has been a fundamental factor across all provided services including in caring for people at home who might previously have been cared for in hospital, covid related incident management, hospital admission, transfers and discharge. Other examples include involving WAST as key partners in planning for women choosing to birth at home and General Practices to ensure that the most vulnerable populations have ready access to primary health care.

As the 4 harms from covid are realised, multi-disciplinary risk assessment will continue in relation to prioritising and managing the populations health needs, especially where treatment has been delayed or inaccessible during the pandemic. New service models including the North Powys development and progressing 'The Big 4' will be informed by multi-disciplinary clinical risk assessment.

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

The last year has been exceptionally challenging and has tested the health board's capability and capacity to clinically lead, including within its own provided services as well as with providers commissioned to care for the population of Powys. A range of new clinical leadership positions have been established to lead the way, and clinical leadership has been encouraged at all levels within the health board, including maximising the ability for all to work at the top of their licence, the clinical executive team, including deputy and assistant posts have been secured and established. An Assistant Director Development programme is one means by which this approach will be supported. This has increased senior visibility as well as spot, support and enable individuals in clinical areas. Examples include the approach to serious incident investigation and learning, enabling individuals to work to their strengths through deployed roles to meet new need, initiating new practices to care for people at home who would traditionally be admitted to hospital,

strengthening teams enabling far greater external reach and partnership work, for example, with care homes and the Local Authority.

Two Heads of Nursing and Midwifery were success in achieving a place on the prestigious Kings Fund leadership development course, nominated by the Chief Nursing Officer for Wales. Unfortunately, the course did not proceed as a result of the pandemic, and the individuals have been offered an alternative development opportunity with HEIW. The attainment of a digital scholarship by a senior nurse, along with successful completion and publication of research and good practice have all been achieved by the nursing and midwifery workforce during 2020-2021. Normally an achievement in its own right, each of the examples above demonstrates exceptional clinical leadership during a pandemic.

A revised professional nursing structure has been established to maximise the opportunities for nurses, midwives and members of the nursing family, to influence and shape the health boards strategic direction, along with benefitting from the engagement of senior professional leaders externally. The development of a quarterly nursing and midwifery leaders' event and a twice-yearly professional nursing and midwifery forum, aim to engage as many individuals and teams across Powys as possible, to maximise the opportunity for clinical leadership, raise awareness of quality and assurance related matters, share new ideas and good practice, enjoy robust discussion and help support future succession planning.

Work to strengthen professional leadership within therapies is almost complete, ensuring that there is a clear line of accountability from Board to front line services which is simple and clearly understood by all.

The health boards approach to ensuring strong clinical leadership is further supported by a review of the deployment arrangements within the health board. The results of this work will help ensure clarity of role and responsibilities, maximising the capacity and capability of individuals and teams.

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

A paper presented to the Quality Governance Group in November 2020 set out the health board's understanding and planned approach to clinical effectiveness and quality improvement. Development of the Clinical Effectiveness and Quality Improvement Strategy has been further delayed as a result of the second wave of

the pandemic, however it remains a priority for the health board during 2021-2022.

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)

Quality information, data, analysis and intelligence is absolutely key to making well based decisions in relation to strategy, policy and intervention. Gaol 5 recognises the need for development in this area. The requirement for oversight, scrutiny and responsiveness generated by the pandemic has increased the organisation's capability is designing, implementing and interpreting data and information generated via dashboards. Along with the added value experienced as a result of increased joint data analyst resource with Powys County Council to specifically identify and utilise information and intelligence in preventing and responding to covid, valuable exposure and experience has been gained to help support the health board's broader ambition.

Plans to implement the Once for Wales Concerns Management System have progressed at pace during December 2020, with support from the programme delivery lead. Individual meetings were conducted with the point of contacts for the individual workstreams. Areas of focus were established which formed an action plan to allow the health board to review any gaps; these mainly being updates to current policies, creation of SOPs, cleansing of complaints and claims and closure of old incidents.

The national team have indicated that 7 modules will be available as part of phase 1 for implementation from April 2021 but with the discretion and readiness of each health board. These 7 modules consist of incidents & feedback, complaints, PALS and compliments, claims, redress, safeguarding, and inquests. Focus is now on developing a training plan, commence engagement and communication so staff are informed and start to use the new concerns management system from mid-April 2021. This work is reported through to Executive Committee and the Experience Quality and Safety Committee.

Whilst the commissioning assurance framework approach is well developed for commissioned services and provided maternity services, the development of an internal provider commissioning assurance framework continues to be explored and is subject to further consideration in the next Quality Governance Group. has There is also an opportunity to develop a similar approach to care home quality, which is currently supported using a joint dataset with Powys County Council and

a standalone health board quality dashboard. This work will recommence when the section 33 care home meetings are recommenced.

In relation to 'Standardisation of nursing core risk assessment documents (WHC/2019/026)' the Chief Nursing Officer has further extended the compliance date to 31 May 2021. This further extension and timetable review acknowledge the ongoing pressures on services and the effect on frontline staff capacity to fully adopt the new tools or use digital formats of the core tools. The core adult nursing assessment tools has been fully adopted in paper format with the health board, with the intention of fully digitalising to maximise the use of information in the provision of high-quality care.

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 3.4

Experience, Quality and Safety Committee	**Date of Meeting: 15 April 2021**
Subject :	**Community Services Group – Quality Governance and Patient Safety Structure 2021**
Approved and Presented by:	Jamie Marchant, Executive Director Primary Care, Community and Mental Health Alison Davies Executive Director of Nursing & Midwifery
Prepared by:	Jason Crowl Assistant Director Community Services
Other Committees and meetings considered at:	Community Services Group Senior Management Meeting 11th March 2021 Quality Governance Group 24th March 2021

PURPOSE:

The purpose of this paper is to provide an update on refinement of the Community Services Group Quality Governance and Patient Safety Structure for 2021/22.

RECOMMENDATION(S):

The Experience, Quality and Safety Committee is asked to:
NOTE and DISCUSS the Community Services Group Quality Governance and Patient Structure for 2021/22

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 Community Services Group – Quality Governance and Patient Safety Structure, originally planned for 2020 and delayed due to the pandemic has been prepared as part of the final phase of realignment of localities into a single service group.

The structure describes the arrangements in the CSG, supports the implementation of the Clinical Quality Framework Implementation Plan and supports operationalisation of the Board Assurance Framework.

DETAILED BACKGROUND AND ASSESSMENT:

Background

Powys Teaching Health Board aims to deliver the highest quality clinical services to its local population - as signalled through the Powys Health and Care Strategy ("A Healthy, Caring Powys") and the health board's Integrated Medium-Term Plan and annual planning processes.

More specifically, "Quality and Citizen Experience" is an organisational priority, as signalled through the PTHB IMTP for 2019-22; the PTHB Annual Plan 2020-2021 encompasses this priority within the health board's overall wellbeing objective of "Fully Joined Up Care".

Linked to this, PTHB delivery priorities for 2020-2021 include (but are not limited to) an improvement plan for the management of serious incidents and clinical audit.

The PTHB Clinical Quality Framework has been developed to further improve and assure the quality of clinical services provided by PTHB, during the next three years (2020 to 2023) and has been previously reported upon to the Quality Governance Group.

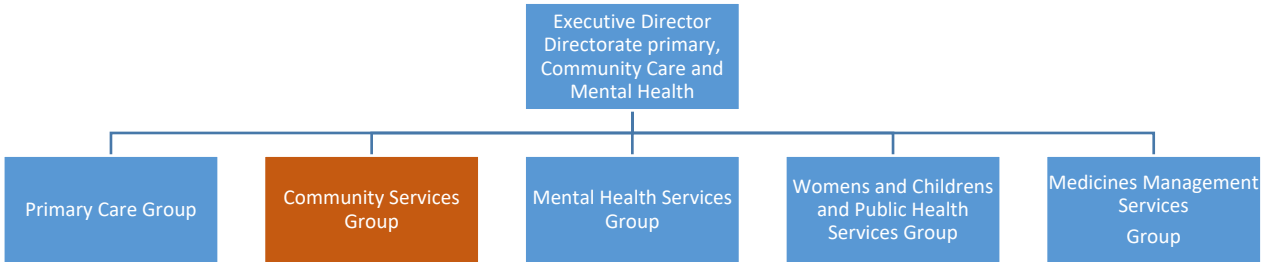
The Community Services Group was formed in Autumn 2019 following the commencement of the Assistant Director Community Services, from a previous locality structure and underwent a period of transition which was concluded in January 2020. The Group immediately went into a period of service change associated with meeting the needs of the Global Pandemic and instigated a modified quality governance arrangement in line with the Health Boards own COVID 19 response arrangements.

As the Group emerges from a challenging winter and second wave of COVID 19 it has finalised its Quality Governance and Patients Safety Structure as part of its commitment to recovery and renewal. This paper outlines the proposed approach for 2021/22 which aims to provide a focus in line with the Health Boards strategic quality priorities.

The CSG Quality Governance and Patient Safety Structure is focussed on delivery and compliments the PTHB Board Assurance Framework.

Community Services Group
The Community Services Group is one of five Service Groups within the Directorate of Primary and Community Care.

Diagram 1: Directorate Structure



The Community Services Group (CSG) has 970 staff for 768 FTE posts from a wide range of professional groups including:

- Medicine
- Nursing
- Therapies
- Health Sciences

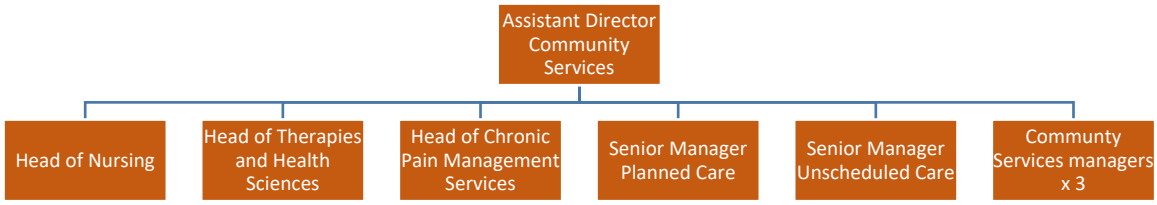
- Administrative
- Leadership

With a budget of £37,157,478 the CSG delivers a unique portfolio of services in a way which is different to other Health Boards in Wales in that it manages general community nursing and therapy services alongside services which would usually be placed in different directorates, for example:

- Unscheduled care flow hub and minor injuries services,
- Planned care including outpatients, elective surgery and endoscopy,
- Diagnostic ultrasound, and radiography

The CSG is therefore a complex service group with a broad range of services with over 100,000 patient contacts a year across the outpatient, inpatient, therapy and health sciences, clinics, community, continuing health care, planned and unscheduled care.

Diagram 2: Group Leadership Team



PTHB Clinical Quality Framework

The Clinical Quality Framework Implementation Plan was introduced to the PTHB Board Meeting on the 29th January 2020 describing the outline, scope and ambition of the plan. Further updates were received by the Quality Governance Group as the framework developed. The specific purpose of the PTHB Clinical Quality Framework is to realise a vision of:

Systematic, clinically-led, continuous and sustained, year-on-year improvement in the quality of clinical care provided by Powys Teaching Health Board.

In this context and through its approach, the framework encompasses fundamental pre-determinants of the delivery of high-quality clinical care, including:

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

The Framework is structured around five organisational goals (below) and (linked) improvement actions to determine good quality care in PTHB clinical services, during the period 2020-2023.

Organisational Goals

- GOAL 1 Implement the Darzi model for clinical quality, encompassing safety, effectiveness and patient experience
- GOAL 2 Optimise organisational culture, to enable high quality clinical care
- GOAL 3 Develop excellent clinical leadership, to enable high quality clinical care
- GOAL 4 Implement a defined programme of improvement methodology, to enable high quality clinical care
- GOAL 5 Develop excellent information and intelligence systems, to enable high quality clinical care

Community Services Group Quality Governance and Patient Safety Structure (QGPSS)

The Group has designed its structure with the support of the Director of Nursing and Midwifery, and by sharing best practice across the Directorate, aligning with the Clinical Quality Framework to help achieve the following outcomes:

- People who receive care, their families and the people who provide it, can identify where change is needed and take action to shape change
- Culture and practice that promotes and facilitates continuous improvement by listening and learning
- Underpinning the delivery of safe, effective, efficient, equitable, timely and person-centred care
- Help to consolidate an honest, just and open culture, and actively support the duty of candour
- Increase the level of assurance for all stakeholders through its implementation, with the aim of increasing public trust and confidence
- Articulate the expectations of the Board in relation to quality and patient safety
- Better inform and shape the Health Board's Annual Quality Statement by ensuring the work of established quality improvement working groups, demonstrate a learning and quality improvement focus
- Improve the opportunity for the provision of safe care through clear lines of communication and reporting from ward to Board and Board to ward
- Support clarity in roles, responsibilities and lines of reporting

The structure provides clarity on the arrangements for:

- Generation of learning and improvement in the pursuit of high quality service provision to the population of Powys
- Roles and responsibilities of managers and leaders

- File access for safe storage and access of relevant documentation
- Escalation and reporting in line with NHS Outcomes Framework
- Scrutiny and learning
- Quality and Patient Experience Meetings Terms of Reference and Agenda
- Group Management Process for Serious Incidents and Concerns
- Group Clinical Audit Plan
- Group Clinical Audit Improvement Plan
- Performance Monitoring
- Risk Register

The Community Services Group Quality Governance and Patient Structure will be shared widely within the Group via established team meetings, from ward to senior management team in preparation for introduction on 1st April 2021

The structure will be evaluated over a 6-month period and a report generated to the Quality Governance Group reflecting findings, recommendations and lessons learned.

RECOMMENDATIONS:

The Experience, Quality and Safety Committee is asked to:

NOTE and DISCUSS the Community Services Group Quality Governance and Patient Structure for 2021/22.

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 4.1

Experience Quality and Safety Committee	**Date of Meeting: 15 April 2021**
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:	Executive Committee

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 EQS Committee is asked to:

a) Note the current position and areas progressed.
b) Note the date the system will go live
c) Note the current risks that arise at this stage of the project.

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

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

Strategic Objectives:	1. Focus on Wellbeing	✖
	2. Provide Early Help and Support	✖
	3. Tackle the Big Four	✖
	4. Enable Joined up Care	✖
	5. Develop Workforce Futures	✖

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

EXECUTIVE SUMMARY:

To support the implementation of the Once for Wales Concerns Management electronic tool, work progressed at pace December with support from the programme delivery lead. Individual meetings were conducted with the point of contacts for the individual workstreams. Areas of focus were established which formed an action plan to allow the health board to review any gaps; these mainly being updates to current policies, creation of SOPs, cleansing of complaints and claims and closure of old incidents.

The national team have indicated that 6 modules will be available as part of phase 1 for implementation from 8 April 2021 but with the discretion and readiness of each health board. These 6 modules consist of:

1. Incidents & Feedback
2. Complaints
3. Suggestions, Enquiries & Compliments (previously PALS)
4. Claims
5. Redress Case Management
6. Inquest Case Management

Learning for Mortality was due to go live in Phase 1, however, with the Medical Examiner Office for Wales now up and running and are currently using their own iteration of RL Datix Cloud solution. This means stage 1 and stage 2 developed in the sandpit environment needs revising.

In addition, Safeguarding has been delayed until 1 July 2021 as there remains a requirement to work with Local Authorities across Wales to finalise configuration of the transmission of cases and develop an electronic referral process.

With Phase 1 of the system being available nationally from 8 April 2021, a decision has been made by senior management to go live in Powys from next month. The first 3 weeks will involve rolling out an intense training programme so staff have the correct knowledge to record on the new system from the 4th May 2021.

DETAILED BACKGROUND AND ASSESSMENT:

Over the past few months the following work has progressed:

Data Protection Impact Assessment

The national DPIA (v11) has been finalised and approved by the Welsh Information Governance Board (WIGB), however will be reviewed and updated in accordance with the project progression via Information Governance Managers Advisory Group (IGMAG) and any changes fed back to the local programme board. Any Risks identified within the DPIA (both local and national) will be added to the local programme risk register and updated with local actions/mitigations.

Relationship between NWSSP (Velindre) as the contracting authority with Civica with Call-Off contract in place for HBs/Trust is covered on pages 9 & 10 of the DPIA. National Memorandum of Understanding current in development that will cover the processing and sharing of information between NWSSP and Health Boards/Trusts.

National Information Governance Breach Management Guidance

National work is near completion in developing Information Governance Breach Reporting Guidance. In conjunction with this, work is progressing with the Incident Reporting and Management Workstream lead with the aim to incorporate changes to the incident management form which will enable those recording incidents to highlight key IG points which in turn will assist IG leads in scoring incidents to determine if reportable to the Information Commissioners Office and ensuring GDPR compliance in meeting the 72-hour requirement. Updates on progress with this will be provided to the local Programme Board.

Task and Finish Groups Established

Task and finish groups were established in December, led by the Functional Lead and Project Manager to formalise individual action plans. Project manager continues to engage with local workstream leads and the national team to ensure feedback is provided on the individual modules when required.

Locations and Services

A locations and service hierarchy spreadsheet was submitted last year and updated in December reflecting changes to the top tier in our structure to make names more consistent with what is in ESR.

Migration Plan

A migration plan has been drafted which looks at maintenance of the legacy system as it is currently sitting on an old server which needs moving to a new IT server and moving data through different stages as the modules go live in the new system from:

1. Fully accessible read/write legacy system
2. Read-only legacy system
3. Archived legacy data

There is also an ongoing task of ensuring old incidents and complaints are closed down before go live and a final decision on what will be migrated to the new reporting system.

National Readiness Report

A readiness report was submitted at the end of December which provided our implementation plan and a draft training and communications plan. An updated version can be located in **Appendix A**.

Workstreams

Where workstreams have commenced, local leads have been identified to represent Powys at national meetings and give feedback on the RL Datix sandpit platform.

Areas Requiring Attention

In order to prepare for a "go live" date across the health board, the following approach was approved at the March exec committee:

Training Plan with timelines

With the majority of modules being back-end, training will predominately be for staff within the quality and safety team.

The Incidents and Feedback module will require a greater Powys wide roll out. Staff will need to know how to report an incident and managers will need to know how to review/ assess incidents.

The Datix administrators have attended training sessions on the individual modules this month and are now in a position to start preparing training to staff from 12th April 2021. In addition, national user guides will be provided, pre-recorded video tutorials via Teams and drop in virtual clinics.

The timelines for going live and modules which will be available can be seen below:

PHASE 1 Implementation	Date Planned Available Nationally	Date Staff will have Access
COMPLAINTS	8 April 2021	4 May 2021
CLAIMS	8 April 2021	4 May 2021
INCIDENTS & FEEDBACK	8 April 2021	4 May 2021
INQUEST CASE MANAGEMENT	8 April 2021	4 May 2021
SUGGESTIONS, ENQUIRIES & COMPLIMENTS (prev. PALS)	8 April 2021	4 May 2021
REDRESS CASE MANAGEMENT	8 April 2021	4 May 2021
SAFEGUARDING	1 July 2021	1 July 2021
LEARNING FROM MORTALITY	TBC	TBC

Communications plan with timelines

The communications plan is incorporated in the Readiness report (**Appendix A**) which has been approved by the Engagement & Communications team. Powys Announcements commenced this month and will continue weekly up until go-live.

A page has been developed on the intranet which contains a list of Q&As. Training dates, user guides and pre-recorded videos on the individual models, which will inform and support staff will be available early April.

Policies and Procedures

Existing policies and procedures are being reviewed and updated where 'Datix' will be replaced with 'Once for Wales Reporting system'. Any gaps identified locally will be developed to address this and replaced on the intranet.

Existing Datix System

Managers have recently received reports on open cases and have been asked to close down old incidents so only the most relevant and required files are migrated to the new system. From the 4th May staff will be expected to use the new reporting system and after 3 months Datix will become a read only legacy system.

Migration Plan

A local decision has been made to migrate open incidents internally rather than use national support. This will work as a training aid for the **Safety Systems & Information Co-ordinators**.

Combo-linking

A decision was not made if we should as a health board incorporate combo-linking for locations/services. It might be something we require and incorporate once we go live.

Embedding a Culture of Safety

To ensure staff have the correct level of training and knowledge to use the new system correctly, it is important that the following is embedded across the organisation:

- Workforce and Development have been approached and have agreed to incorporate the new system as part of the corporate induction of new staff.
- Before staff are given access to the system, there will be an expectation that they attend a training session or go through the pre-recorded training videos which will be uploaded onto the Intranet.
- Ensure staff add an incident onto the new system within 48 hours instead of up to 3 months.

Patient Experience System (Civica)

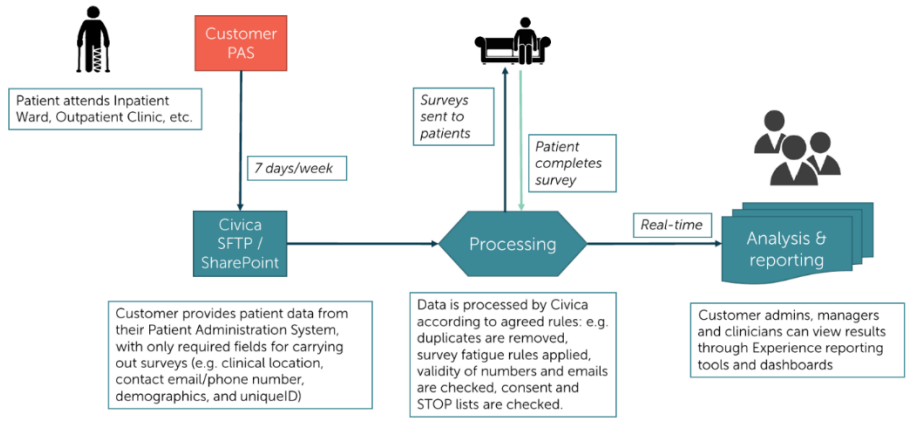
Separate to the Once for Wales Concerns Management System, the Patient Experience system procured through Civica is an optional system which can collate electronic patient feedback through surveys on a web browser platform.

Benefits include:

- Consistent approach to capturing patient experience feedback from Powys residents regardless of where they access services (currently manually issuing surveys to residents who have accessed provider and commissioned services)
- Provides a variety of ways to feedback
- A direct feed of information in 'real time'
- Engages operational teams

- 'Real time' feedback enables prompt action to be taken if any safety risks identified
- Provides a lens at different levels of the health board and services
- Feedback available in various formats and accessible formats
- The system provides a degree of autonomy as well as being able to set up some local surveys so not tied into what the provider produces.

Typical workflow – survey distribution and completion



The annual cost of the system is £19,200.00+VAT per year with no initial setup costs. This is for the core system, survey design tool and data analysis functionality. The VAT will be recovered and NWSSP will cross-charge £19,200 to the organisation in October each year to cover the annual licence from 1st Dec to 30th Nov.

The contract also provides optional extras:

1) 10 x tablets (or multiples of 10) with cases and software for £3,920+VAT per year. The purchase of tablets can be discontinued with notice prior to the commencement of the next annual period (tablets do not need to be purchased for the full period of the contract).
2) The automation of sending out emails containing survey links has an annual fee with unlimited use at £2,000.00+VAT plus a transactional cost of 1p per email or just 1p transaction cost if the organisation does this itself. Alternatively, emails can be sent from the NHS servers at no cost.

The Once for Wales Concerns Management Team can facilitate demonstrations and pilots of the system to assist organisations in determining how the Service User Feedback system might assist in strengthening quality and governance.

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.

Delivery Function	Risk	Control Measure	Risk Rating
Functional & Technical	Resistance to change	Powys Announcements to inform staff. Intranet page with training materials and drop in sessions.	6
Functional & Technical	Current system and new system and not being able to go live from 1 April 21.	Programme management approach with exec involvement and senior project leadership.	6
Functional	National delay going live with the Mortality Module due to the ME process	Liaising with the national team on progress and next steps. National risk.	6
Technical	Upgrade legacy system as sitting on an out of date server and risk of Infrastructure failure	Bi-monthly meetings with local authority to ensure server is updated. If system fails, informed that data is backed up.	12
Technical	Automation of patient details	To avoid manual error in system, requirement that patient details will link to the master patient index. National risk.	8
Functional	Insufficient resource available to rollout the modules and the ongoing resources needed to support all users.	Training materials will be provided by the national workstream leads and available on the Intranet. Staff org wide training only required for Incident & Feedback module	6
Technical	Lack of mandatory drop-down boxes to allow for the incident to be matched to a location.	Additional functionality requested as an enhancement and expected to be active on the system by the end of June 2021. As an interim, need to ensure location is always added by the administrator.	8
Technical	Accurate staff details contained within new system and linked to ESR	Ensure accurate information is provided to the national team to support reporting arrangements	6

Additional risks identified through the national DPIA have been provided in **Appendix B**.

Recommendations Approved by Executive Committee

1. Support from service leads to adapt local policies and procedures and ensure revised versions are on the intranet by 30th April 2021
2. Ensure we embed a culture of safety and learning
3. Staff are released to attend training during April
4. Note that a Business Case is being completed for consideration by Executive Committee re the purchase of the patient experience Civica system.

Supporting documents

Appendix A Updated Readiness Report	 210303 OfWCMS Org Readiness Report upc
Appendix B Risks associated from the National DPIA	 210305 National DPIA Risk Register.pdf

GIG CYMRU NHS WALES | Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru (PGIAC) | Welsh Health Specialised Services Committee (WHSSC)

Reporting Committee	**Quality Patient Safety Committee**
Chaired by	**Emrys Elias**
Lead Executive Director	**Director of Nursing & Quality**
Date of Meeting	**19 January 2021**

Summary of key matters considered by the Committee and any related decisions made

1. Patient Story/video

The Committee received a patient video regarding a young amputee who had received paediatric blades and the positive impact it had on their life.

2. Renal Network

The Renal network had received confirmation from the Chief Nursing Officer that dialysis nurses were classed as highly skilled, specialist nurses and therefore should not be redeployed during the COVID pandemic to ensure the continuation of a safe service to patients. It was also noted that a local Renal Charity PPF, had been nominated for an award for "Providing Calm, Accurate and Consistent Messaging about COVID-19 to Kidney Dialysis Patients in Wales".

3. Commissioning Team updates

Reports from each of the Commissioning teams were received and taken by exception. Members noted the information presented in the reports and a summary of the services in escalation is attached to this report. The key points for each service are summarised below:

- **Cancer and Blood**

Members were informed that thoracic surgery provision for lung cancer patients in mid and south west was an ongoing concern with differential waiting lists between south Wales' providers compared to NHS England providers. As a result weekly meetings involving thoracic surgeons and service managers from both SBUHB and CVUHB had been put in place to review the patient tracker with the group including the ability to cross refer patients between the two centres, depending on capacity and the urgency of treatment.

- **Cardiac**

Members received an updated position regarding cardiac surgery services. It was noted that the plans described in previous reports for the outsourcing of cardiac surgery to Royal Stoke University Hospital had been put on hold due to the significant increase in COVID-19 cases and Tier four lockdown restrictions implemented by Welsh Government. Discussions would recommence subject to

an improvement in the COVID -19 situation and risk assurance being received from both C&VUHB and Royal Stoke University Hospital.

- **Mental Health & Vulnerable Groups**

The Committee received an update on the progress made by SBUHB in respect of the Mother & Baby Unit at Tonna Hospital which was on track to open in April 2021 as planned. Discussions were also ongoing with NHS England regarding another facility in the Chester / Wirral area for North & Mid Wales residents and noted the pathway for Powys patient's pathway would be to either Tonna Hospital or into the north Wales facility.

An update was received regarding the ongoing issues with the high cost complex mental health patient previously reported. It was hoped that transfer to the WEMHS service would take place in February.

Members were updated on the ongoing work and involvement of NCCU Quality Assurance Improvement Service (QAIS) re Tier 4 CAMHS Services.

- **Neurosciences**

Members noted the de-escalation of the Specialised Neurorehabilitation service at Neath Port Talbot Hospital (NPTH), Swansea Bay UHB.

- **Women & Children's**

Members were made aware of service risks associated with Paediatric Surgery. It was noted the Board of CHCs had written to WHSSC expressing concern over the length of the waiting list. Assurance was received that CVUHB waiting list position was improving but there were still some patients waiting >52 weeks and the WHSS Team continued to work closely with CVUHB to support them.

It was reported KP reported that WHSSC was embarking on a key strategic priority in the Integrated Commissioning Plan 2021/22 to develop an All Wales Paediatric Strategy including the Children's Hospital for Wales.

It was noted that the interim 24-hour Neonatal Transport service for south and mid Wales was now in place and would continue to run until the work to finalise the Lead Provider Service Model was completed.

4. Significant COVID-19 related issues not covered in Commissioning Team updates

It was reported that University Hospitals Birmingham NHS Foundation Trust had suspended all elective capacity until further notice as a result of the COVID-19 pandemic and that the WHSS Team was monitoring the situation for any impact on WHSSC commissioned services.

5. Other Reports received

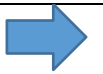
Members received reports on the following:

• **WHSSC Action Plan arising from HIW & WAO Review of Quality Governance at CTMUHB** • **CQC/HIW Summary Update** • **WHSSC Policy Group Report** • **Concerns and SUI Report** • **Risk Management Update** Risk management workshop 28 January, feedback to next meeting
Key risks and issues/matters of concern and any mitigating actions
Summary of services in Escalation (Appendix 1 attached)
Matters requiring Committee level consideration and/or approval Identification of Lead Provider for 24hr Neonatal Transport Service
Matters referred to other Committees Complex mental Health Case update to In-Committee Joint Committee

Date of next scheduled meeting:	23 March 2021

Summary of Services in Escalation

Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru (PGIAC)
Welsh Health Specialised Services Committee (WHSSC)

Date of Escalation	Service	Provider	Level of Escala-	Reason for Escalation	Current Position	Movement from last month
April 2015 Escalated to Stage 3 December 2018 October 2020	Cardiac Surgery	CVUHB	3	• Failure to deliver and maintain the Referral to Treatment times targets	Emergency and elective work being undertaken where possible for the south Wales region. Formal performance meetings halted due to COVID however a monthly meeting with C&VUHB has been confirmed for the 20th January 2021	
April 2015 October 7, 2020 2020	Cardiac Surgery	SBUHB	2	• Failure to deliver the Referral to Treatment times targets	Emergency surgery and elective been undertaken. Current formal performance meetings temporarily halted due to Covid 19 but regular monthly meeting planned to restart in January. Dates for meetings are in the process of being finalised with the operational team.	
March 2018	Sarcoma (South Wales)	SBUHB	2	• Risks to service quality and sustainability	Priority work being undertaken: 1. Biopsy Proven Sarcoma 2. Diagnostic biopsies for high	

					risk lesions. 3. Lipomata with atypical features on US/MRI that have been discussed at MDT	
February 2018 October 2020	Plastic Surgery (South Wales)	SBUHB	2	• Failure to achieve maximum waiting times target	Emergency surgery only being undertaken within the HB. No further update on plan for waiting times Current monitoring against RTT temporarily halted due to Covid 19	
November 2017	All Wales Lymphoma Panel	CVUHB & SBUHB	2	• Failure to achieve quality indicators (in particular, turnaround times)	No provider update on service being delivered during Covid.	

	North Wales Adolescent Service (NWAS)	BCUHB	2	• Medical workforce and shortages and operational capacity • Lack of access to other Health Board provision including Paediatrics and Adult Mental Health. Number of Out-of-Area admissions	WHSSC met with LHB in October to discuss issues relating to gap analysis and new service specification. Sustainability of current interim model at risk due to gaps in community consultant workforce. Possible network arrangements with English providers to be explored further and recruitment to inpatient Consultant post to be revisited. In addition relocation of the service onto a main hospital site has also been raised with LHB to consider as strategic issue.	

March 2018 Sept 2020	Ty Llidiard	CTMUHB	3	• Unexpected Patient death and frequent SUIs revealed patient safety concerns due to environmental shortfalls and poor governance • SUI 11th September 2020	Medical Emergency Response Team implemented Nov 20. Escalation meetings held 12th Nov, Dec 8th QAIS working with unit as part of review. Workshop to discuss gap analysis and model re Service Specification to be held 20th January. SBAR received from Health Board to recommence the use of Seren Ward. Approved by CDGB on the 18th Dec. Health Board informed. Draft investigation report received 8/12/20	
19 February 2016	Neurosurgery	C&VUHB	2	• Failure to maintain <36 week Referral to Treatment target	Emergency and limited urgent elective (tumour) work being undertaken. A number of patients will be waiting in excess of 52 weeks for surgery at the end of June. Current monitoring against RTT temporarily halted due to Covid 19	

27 Nov 2019	ALAC/AAC	CVUHB	2	• Increase in waiting times, failure to deliver Referral to Treatment target within 26 weeks and failure to provide timely waiting list and activity reports.	The phase 1 AAC Review report was presented to the December Management Group. There were a number of follow up questions raised, which will be discussed at the January meeting. A Performance Assurance meeting WAS to be held in January 2021, where de-escalation from Stage 2 of the escalation process will be reviewed	
June 2017	Paediatric Surgery	CVUHB	2	• Failure to maintain <36 weeks Referral to Treatment times	Only emergency/ life threatening / urgent surgery is taking place, so the number of patients waiting over 36 weeks is increasing – 200 reported at the end of July. Virtual clinical reviews of patients are being undertaken. Current monitoring against RTT temporarily halted due to Covid 19	

				• Inadequate level of staffing to support the service	No further update on PICU during Covid.	

September2019	Cochlear Implant Service	South Wales	4	• Quality and Patient Safety concerns from C&V Cochlear Implant team, from the patients who were immediately transferred to the service in Cardiff following the loss of audiology support from the Bridgend service.	• C&VUHB were able to treat all patients who required both urgent and routine surgery within 26 weeks by the end of March. • Transfer of services to C&V going ahead awaiting feedback from CHC	
February 2020	TAVI	SBUHB	3	• Quality and Patient Safety concerns due to the lack of assurance provided to the WHSS team regarding the actions taken by the HB to address 4 Serious Incidents relating to vascular complications.	• Action plan in place. Following approval at CDG planned access via subclavian route re commenced. Escalation meeting Jan 12th 21	

July 2020	Thoracic Surgery	SBUHB	3	• Failure to maintain cancer targets and undertake elective surgery cases	• Concerns raised around the monitoring of Thoracic patients during Covid period and lack of surgical activity	
September 2020	FACTS	CTMUHB	3	• Workforce issue	• 2 CQV's held in Dec. Critical appointment of Clinical Lead (Consultant Psychiatrist) on locum basis. Provider has submitted workforce overview (budget and actual) for review. Recruitment of Senior Psychologist (8c) is underway. Interim solution to address Psychology supervision in place. Provider preparing a performance improvement plan for next meeting on 25th January.	

Reference: March 2021

Date issued: 1794A2019-20

Review of Quality Governance Arrangements

Background

1 The Auditor General has included an examination of quality governance arrangements in his programme of performance audit work at relevant NHS bodies. The review forms part of the programme of work that he will undertake to satisfy himself that NHS bodies have proper arrangements to secure the efficient, effective and economical use of resources, as required by Section 61 of the Public Audit Wales Act 2004. The Auditor General's powers under section 145A of the Government of Wales Act 1998 are also relevant to this review.

2 We had originally planned to begin our reviews of quality governance during the early part of 2020, but the onset of the pandemic meant that we needed to pause the planned work. That pause has allowed us to adjust both our scope and approach to fit within the context of COVID-19. This briefing note sets out our intended approach to the review.

3 Where we process personal data, this is in accordance with data protection legislation, including the Data Protection Act 2018 and the General Data Protection Regulation. Further information is set out in our fair processing notice attached at Appendix 1. We ask that you share this project brief with officers, independent members/non-executive directors and any other staff that we will be interviewing or meeting with as part of this work. This will help to ensure they understand the purpose of our review and how we will use the information we collect.

Why are we doing this work

4 Quality should be at the 'heart' of all aspects of healthcare and 'putting quality and safety' above all else is one of the core values underpinning the NHS in Wales. Poor quality care can be costly in terms of harm, waste and variation.

5 The drive to improve quality has been reinforced in successive health and social care strategies and policies over the last two decades. In June 2020, the Health and Social Care (Quality and Engagement) (Wales) Act became law. The Act will strengthen the duty to secure system-wide quality improvements, as well as placing a duty of candour on NHS bodies, requiring them to be open and honest when things go wrong to enable learning. The Act indicates that quality includes but is not limited to the effectiveness and safety of health services and the experience of service users.

6 Quality and safety must run through all aspects of service planning and provision and be explicit within NHS bodies integrated medium-term plans. NHS bodies are expected to monitor quality and safety at board level and throughout the entirety of services, partnerships and care settings but our annual Structured Assessment work across Wales has pointed to various challenges. These challenges include the need to improve the flows of assurance around quality and safety, the oversight of clinical audit and the tracking of regulation and inspection findings and recommendations.

7 Given this context, it is important that NHS boards, the public and key stakeholders are assured that quality governance arrangements are effective and that NHS bodies are maintaining an adequate focus on quality in responding to the pandemic. The current NHS Wales planning framework reflects the need to consider the direct and indirect harm associated with COVID-19. It is important that NHS bodies ensure their quality governance arrangements support good organisational oversight of these harms as part of their wider approach to ensuring safe and effective services.

8 Our review will examine both the operational and corporate approach to quality governance, looking at issues such as organisational culture and behaviours, strategy, structures and processes, information flows and reporting. It will draw on the methodology that was used in the 2019 joint review of quality governance arrangements at Cwm Taf Morgannwg University Health Board. It will form part of a wider programme of work aimed at getting a better understanding of quality governance arrangements across NHS Wales.

Audit approach

9 The review will seek to address the following question: **Do the organisation's governance arrangements support delivery of high-quality, safe, and effective services**? **Exhibit 1** sets out the key lines of enquiry we will consider.

Exhibit 1: key lines of enquiry

Do the organisation's governance arrangements support delivery of high-quality, safe and effective services?
1. Does quality drive the organisational strategy? a. Are quality and patient safety priorities clearly defined, documented and periodically reviewed? b. Are COVID and non-COVID risks to quality and patient safety identified and documented along with mitigation to eliminate or reduce their impact?

Do the organisation's governance arrangements support delivery of high-quality, safe and effective services?

2. Does the organisation promote a quality and patient-safety-focused culture?
   a. Is the organisation actively participating in quality improvement initiatives?
   b. Do organisational values and behaviours support a quality and patient-safety-focused culture?
   c. Does the organisation take steps to listen to patients and staff and involve them in monitoring service change/improvement?
   d. Is there a strong culture of learning lessons from patient and staff feedback or concerns?
   e. Is quality and patient safety an integral part of workforce management processes?

3. Do organisational structures and processes support delivery of high-quality, safe and effective services?
   a. Are there clear lines of accountability for quality and patient safety across the organisational structure i.e. 'floor to Board'?
   b. Are there effective corporate and operational controls to support delivery of high-quality and safe services?
   c. Is there enough resource and expertise to support and improve quality governance arrangements?

4. Do corporate and operational arrangements for performance monitoring and reporting provide an adequate focus on quality and patient safety?
   a. Does the organisation have comprehensive and timely information for monitoring and reporting on quality and patient safety?
   b. Is the organisation examining the direct and indirect harms known to result from COVID?
   c. Does quality and patient safety receive effective coverage at both corporate and operational management meetings?
   d. Does the Board and its committees receive information about quality and patient safety to support effective scrutiny and assurance?

10 In addition to reviewing corporate level quality governance arrangements for commissioned and provided services, we plan to test the 'floor to board' perspective. To test the floor to board perspective, we will focus on the general medical, rehabilitation and palliative care wards within the Community Services Group. We discussed the details and practical arrangements for testing the floor to board arrangements, along with our proposed methodology (**Exhibit 2**), with the Health Board at a set-up meeting on 4th March 2021.

Exhibit 2: proposed methodology

Methodology	Activity
Document review	Our review will include, but is not limited to, relevant organisational strategies for quality and safety, board, committee and sub-committee papers, executive and operational management team papers related to quality and safety, relevant policies/procedures, risk registers, performance reports or quality dashboards and patient experience reports. Where documents are not publicly available, we will request these from the Health Board to provide evidence against our lines of enquiry. We may use evidence from other agencies, such as the NHS Internal Audit and Assurance Service and Healthcare Inspectorate Wales.
Interviews with staff and board members	We will arrange virtual interviews with relevant individuals, including board members, executive directors, and corporate and operational staff. The interviews will cover broad themes, such as quality and safety priorities, organisational culture, roles, and responsibilities, monitoring and reporting performance, quality improvement activity and sharing learning and lessons.
Community Services Group data collection form	We will ask the Community Services Group to complete a data collection form that seeks information on aspects of the Group's quality governance arrangements.
Corporate data collection form	We will ask the Health Board to complete a data collection form that seeks information about the level and type of corporate resource available to support and improve quality governance arrangements.

Methodology	Activity
Staff survey	We will invite operational staff working in the hospitals to take part in our online attitude survey about quality and patient safety arrangements within the organisation or their area of work.
Observations	We will draw on observations at the Experience, Quality and Safety Committee within the review period. We also aim to observe at least one relevant meeting of the Quality Governance Group and other Community Services Group meetings with a quality and safety focus.

11 Auditors will work remotely to carry out the audit given our on-site work remains suspended in accordance with COVID legislative requirements and our desire to ensure our work does not impede the Health Board's continuing response to the pandemic. We will work with the lead executive director for the audit to agree the timing and focus of interviews with operational staff and board members, and the information required to support our work. Interviews will be undertaken virtually via telephone, MS Teams or Skype.

12 We have engaged with Healthcare Inspectorate Wales (HIW) to inform the scope and audit approach for this work, building on the learning from our 2019 joint review of quality governance at Cwm Taf Morgannwg University Health Board. While the work described in this document is not being conducted as a formal joint review, we will continue to work closely with HIW to ensure relevant information is shared and to prevent any duplication of activity. HIW relationship managers may join us at interviews and attend our internal meetings to discuss audit findings.

Timing of the work

13 The indicative timescales for the key stages of the audit work are shown in **Exhibit 3**. Where appropriate, we will give interim feedback if issues of concern arise during our work.

14 We will keep our delivery arrangements and the timescales under close review and adjust them to avoid unnecessary burden on the Health Board at a time when it is still responding to the COVID-19 pandemic. We accept that these factors may impair the ability of Health Board to respond in a timely way to requests for information and interviews.

Exhibit 3: indicative timescales for the work

Key stage	Timing
Set up	March 2021
Evidence gathering	April to May 2021
Draft report	June 2021
Final report	July 2021

Reporting our findings

15 We will prepare a report for the Health Board setting out local findings and any recommendations arising from the work. In line with the Audit Wales arrangements for public reporting, we will publish the report on our website once it has been formally considered by the relevant Board committee.

16 We may summarise the findings from our local work at NHS bodies in a national publication which may then be laid before the Senedd in line with the Auditor General's powers set out in Section 145A of the Government of Wales Act 1998.

Audit Wales Contacts

17 The project team and their contact details are set out in **Exhibit 4**.

Exhibit 4: project team

Name	Contact details
Elaine Matthews Audit Lead	Elaine.Matthews@audit.wales 07748 181678
Gabrielle Smith Audit Lead	Gabrielle.Smith@audit.wales 02920 320608
David Thomas Audit Director	Dave.Thomas@audit.wales 07798 503064

Appendix 1 – Fair processing notice

This privacy notice tells you about how the Auditor General for Wales (and the Wales Audit Office on his behalf) processes personal data provided by you in connection with our quality governance review of NHS Trusts and Health Boards in Wales.

Who we are: The Auditor General for Wales' work includes examining how public bodies manage and spend public money, and the Wales Audit Office provides the staff and resources to enable him to carry out his work.

Data Protection Officer (DPO): Our DPO is Martin Peters, who can be contacted by telephone on 029 2032 0500 or by email at: infoofficer@audit.wales.

The relevant laws: We process your personal data in accordance with data protection legislation, including the Data Protection Act 2018 (DPA) and the General Data Protection Regulation (GDPR). Our lawful basis for processing is powers and duties under legislation, including the Public Audit (Wales) Acts 2004 and 2013, Government of Wales Acts 1998 and 2006, Local Government (Wales) Measure 2009 and Well-being of Future Generations (Wales) Act 2015.

Purposes for processing: We are collecting opinions and information to help us carry out our quality governance review at health bodies. Some of this information may be about identifiable individuals, which would make it personal information, even though the purpose of our work is not in itself to collect information about identifiable individuals. The information collected (including anonymised quotes) will be used for this review and may also be used in our wider statutory audit work.

Who will see this data? The Auditor General and the WAO audit team will have access to the information you provide. We may share some information with senior management at the audited bodies involved, and our published report may include some information. We may share some data with other public service review bodies, such as HIW, where the law permits this. The Auditor General may present a report to the Senedd.

How long we keep the data? We will keep your data for six years (or 25 years if it is included in a published report).

Our rights: The Auditor General has rights to information, explanation and assistance under paragraph 17 of schedule 8 Government of Wales Act 2006 and/or section 52 Public Audit (Wales) Act 2004 and/or section 26 of the Local Government (Wales) Measure 2009. It may be a criminal offence, punishable by a fine, for a person to fail to provide information.

Your rights: You have rights to ask for a copy of the current personal information held about you and to object to data processing that causes unwarranted and substantial damage and distress.

To obtain a copy of the personal information we hold about you or discuss any objections or concerns, please write to: The Information Officer, Wales Audit Office, 24 Cathedral Road, Cardiff, CF11 9LJ or email infoofficer@audit.wales. You can also contact our Data Protection Officer at this address.

The ICO: To obtain further information about data protection law or to complain about how we are handling your personal data, you may contact the Information Commissioner at: Information Commissioner's Office, Wycliffe House, Water Lane, Wilmslow, Cheshire, SK9 5AF, or by email at casework@ico.gsi.gov.uk or by telephone 01625 545745.

Llywodraeth Cymru
Welsh Government

CABINET STATEMENT

Written Statement: The Health and Social Care (Quality and Engagement) (Wales) Act 2020 – Update on implementation

Vaughan Gething MS, Minister for Health and Social Services

First published: 24 March 2021

Last updated: 24 March 2021

The Health and Social Care (Quality and Engagement) (Wales) Bill was passed by the Senedd just over one year ago.

My hope, when the Act received Royal Assent in June 2020, was that it could be implemented within two years. However, this last year has been an incredibly difficult time for us all; potentially no more so than for those who plan, deliver and rely on our health and social care services. What we have experienced has been truly unparalleled and at times, may have felt all-consuming.

Today, looking forward, I wish to share this Government's aspirations to implement the Act in full by April 2023. We recognise the immediate years ahead will present further challenges and we may be subject to some ongoing constraints but we remain committed to doing all we can to engage and involve stakeholders in making these important changes.

There is one element of the Act, I hope, will come to fruition this calendar year: the making of Regulations to enable the appointment of statutory Vice Chairs of NHS Trusts – improving their governance and decision-making processes, bringing them in to line with Local Health Boards.

Beyond this, our aim will be to commence the re-focussed duty of quality on NHS bodies (Local Health Boards, NHS Trusts and Special Health Authorities) at the same time as the new duty of candour – which will also apply to primary care providers – from April 2023. This will enable a more transitional and joined-up approach to their introduction. It will afford greater scope to co-ordinate stakeholder involvement in the co-production of statutory guidance and preparation of Regulations, as well as the design and delivery of training for NHS staff. Importantly, it will allow additional time for NHS bodies (and primary care, in respect of candour) to streamline plans and implement changes to their existing policies and procedures, to ensure compliance with the duties from that date.

I can also confirm our intentions to review the Health and Care Standards, alongside development of statutory guidance on the duty of quality; to make adjustments to existing Putting Things Right (NHS complaints) Regulations and guidance, to align these with and support the new duty of candour; and to place a similar duty of candour on independent healthcare providers, using existing powers under the Care Standards Act 2000 – something welcomed by the sector – bringing them in to line with NHS bodies and providers of regulated social care.

With regards to establishment of the Citizen Voice Body for Health and Social Care, foremost, I acknowledge that it has been over five years since we first discussed the creation of such a body. I recognise this has, at times, been unsettling for the staff and members of Community Health Councils (CHCs) but want to give assurance of this Government's intention that the new Body should be established and operational by April 2023, with CHC staff and volunteer members engaged in and fully supported to manage the transition.

Since the Health and Social Care (Quality and Engagement) (Wales) Bill was passed we have seen the publication of The Independent Medicines and Medical Devices Safety Review, chaired by Baroness Julia Cumberlege. In response to the recommendation within that report for the establishment of a Patient Safety Commissioner, I have asked my officials to use some of this additional time to explore the role the Citizen Voice Body, with its consent, could play in meeting this

health and social care; promoting closer integration of health and social care services; and investing in services that promote continuous engagement with the public in these matters.

This critically important work is being taken forward by the Minister for Mental Health, Wellbeing and Welsh Language, jointly with the Deputy Minister for Health and Social Services. They recently met with representatives of the Board of CHCs to hear about the activities of Community Health Councils and to understand how CHC staff and volunteer members have adapted to provide vital support for patients by working effectively with health boards throughout the pandemic. The CHC Board members also expressed their enthusiasm to share the CHCs' collective experience and knowledge in shaping and making a success of this new, independent Body that will be a key enabler for engagement with people, in a multitude of ways, in all parts of Wales.

The Citizen Voice Body will be at the heart of conversation with the Welsh public, working together with NHS bodies and local authorities, and alongside other public, independent and volunteer organisations to strengthen the voice of citizens. It will be essential for all partners to establish close working relationships and I anticipate the new Body will prove an excellent source of advice when it comes to determining what matters to people in relation to health and social care.

I want to emphasise this Government's commitment to engaging with stakeholders and citizens to inform and guide our work in implementing the Act. Together we can create the culture and understanding needed, all round, to meet the duties of quality and candour and to ensure the Citizen Voice Body becomes embedded within the health and social care landscape, working well with its partners, representing the views of the public.

Collectively, the measures within the Act will help us to work beyond the difficulties of this last year and move further towards the integration and sustainability aspirations set out in A Healthier Wales; driving improvements in health and social care, and crucially, leading to better outcomes that matter most to the people of Wales.