Experience, Quality and Safety Committee

Thu 03 June 2021, 10:00 - 13:00

Teams

Agenda

10:00 - 10:00
0 min

1. PRELIMINARY MATTERS

EQS_Agenda_03Jun21 amended.pdf (2 pages)

1.1. Welcome and apologies

1.2. Declarations of interest

1.3. Minutes of the previous meeting held on 15 April 2021 (for approval)

EQS_Item_1.3_ Unconfirmed Minutes 15 April 2021.pdf (13 pages)

1.4. Matters arising from previous minutes

1.5. Committee Action Log

EQS_Item_1.5_EQS Action Log_3July_2021.pdf (4 pages)

10:00 - 10:00
0 min

2. ITEMS FOR APPROVAL/RATIFICATION/DECISION

There are no items for inclusion in this section

10:00 - 10:00
0 min

3. ITEMS FOR DISCUSSION

3.1. Clinical Quality Framework, Implementation Plan Update

EQS_Item_3.1_CQF implementation plan April 2021.pdf (9 pages)

3.2. Service Group, Quality Governance Reporting

3.2.1. Mental Health

DEFERRED

3.2.2. Women and Children's

EQS_Item_3.2b_Quality Governance Framework for WC services.pdf (9 pages)
EQS_Item_3.2bi_Appendix 1- Women and Children's Quality Governance framework.pdf (2 pages)

3.3. Maternity Services Assurance Framework and Improvement Plan

EQS_Item_3.3_Maternity Assurance and Improvement plan.pdf (7 pages)

3.4. Approach to Assessing Harm from Covid-19

Oral

3.5. Approach to Learning Update

EQS_Item_3.5_Approach to Learning Update2.pdf (6 pages)

3.6. Serious Incidents and Concerns Report

EQS_Item_3.6_Concerns Paper 03062021.pdf (24 pages)
EQS_Item_3.6ai_Appendix 1 - Doctrina Spring 2021.pdf (4 pages)
EQS_Item_3.6ib_Appendix 1a - Doctrina Spring 2021 - Cymraeg.pdf (4 pages)

3.7. Inspections and Regulation Report

EQS_Item_3.7_Regulatory Inspections Report.pdf (5 pages)
EQS_Item_3.7a_Appendix 1 - 210429 Llandrindod hospital Clywedog Report.pdf (11 pages)
EQS_Item_3.7b_Appendix 2 - WAST review 2021 - Terms of Reference - FINAL.pdf.pdf (3 pages)
EQS_Item_3.7c_Appendix 3 - HSCRRR Dashboard 07052021.pdf (1 pages)

3.8. Infection Prevention and Control Report

EQS_Item_3.8_IPC Update_Draft.pdf (10 pages)

3.9. Medical Appraisal and Revalidation Briefing Report

EQS_Item_3.9_Medical Revalidation Progress Report 2019-2020 EQS 3 June 2021.pdf (5 pages)
EQS_Item_3.9a_Appendix 1 Revalidation Progress Report (RPR) 2019-20.pdf (24 pages)
EQS_Item_3.9b_Appendix 2 Revalidation Support Unit Powys Report.pdf (11 pages)

3.10. Clinical Audit Programme Report

EQS_Item_3.10_Clinical Audit Report EQS.pdf (13 pages)

3.11. Safeguarding during Covid

EQS_Item_3.11 Safeguarding during Covid-19.pdf (6 pages)
EQS_ITem_3.11ii_Appendiix 1_ PTHB_2021-38 _Safeguarding during COVID-19_Final Internal Audit Report.pdf (22 pages)
EQS_Item_3.11ii_Appendix 2.pdf (2 pages)

10:00 - 10:00
0 min

4. ITEMS FOR INFORMATION

4.1. WHSSC Quality and Patient Safety Committee, Meeting held 11 May 2021, Chairs Report

EQS-Item_4.1_QPS Chair's Report - May 21.pdf (7 pages)

10:00 - 10:00
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:

15 July 2021 at 10:00

POWYS TEACHING HEALTH BOARD
EXPERIENCE, QUALITY & SAFETY COMMITTEE

3 JUNE 2021,
10.00 – 12.15
TO BE HELD VIRTUALLY VIA MICROSOFT TEAMS

AGENDA			
Item	**Title**	**Attached /Oral**	**Presenter**
1	**PRELIMINARY MATTERS**		
1.1	Welcome and Apologies	Oral	Chair
1.2	Declarations of Interest	Oral	All
1.3	Minutes of the previous meeting held on 15 April (for approval)	Attached	Chair
1.4	Matters Arising from Previous Meetings	Oral	Chair
1.5	Committee Action Log	Attached	Chair
2	**ITEMS FOR APPROVAL/RATIFICATION/DECISION**		
	There are no items for inclusion in this section		
3	**ITEMS FOR DISCUSSION**		
3.1	Clinical Quality Framework, Implementation Plan Update	Attached	Director of Nursing and Midwifery & Clinical Directors
3.2	Service Group, Quality Governance Reporting: a) Mental Health b) Women and Children's	DEFERRED Attached	Director of Primary, Community Care and Mental Health
3.3	Maternity Services Assurance Framework & Improvement Plan	Attached	Director of Nursing and Midwifery
3.4	Approach to Assessing Harm from COVID-19	Oral	Medical Director
3.5	Approach to Learning Update	Attached	Medical Director
3.6	Serious Incidents and Concerns Report	Attached	Director of Nursing and Midwifery
3.7	Inspections and Regulation Report	Attached	Director of Nursing and Midwifery
3.8	Infection Prevention and Control Report	Attached	Director of Nursing and Midwifery
3.9	Medical Revalidation Progress Report 2019/2020	Attached	Medical Director
3.10	Clinical Audit Programme Report	Attached	Medical Director
3.11	Safeguarding during Covid	Attached	Director of Nursing and Midwifery

4	**ITEMS FOR INFORMATION**		
4.1	WHSSC Quality & Patient Safety Committee, Meeting held 11 May 2021, Chairs Report		
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: • 15 July 2021 at 10.00		

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

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

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

In addition, the Board will publish a summary of 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 15 APRIL 2021 VIA MICROSOFT TEAMS

Present:

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

In Attendance:

Carol Shillabeer	Chief Executive
Alison Davies	Director of Nursing and Midwifery
Julie Rowles	Director of Workforce, OD and Support Services
Stuart Bourne	Director of Public Health
Jamie Marchant	Director of Primary, Community Care and Mental Health
Kate Wright	Medical Director
Rani Mallison	Board Secretary
Katie Blackburn	Community Health Council
Jason Crowl	Assistant Director of Community Services Group
Marie Davies	Deputy Director of Nursing
Kate Evans	Women and Children Risk Governance Lead
Joy Garfitt	Assistant Director for Mental Health Services
Clare Lines	Assistant Director Commissioning Development
Rebecca Collier	Relationship Manager, Healthcare Inspectorate Wales
Sara Utley	Audit Wales

Observers:

Rhobert Lewis	Independent Member
Ronnie Alexander	Independent Member -

Apologies for absence:

Pete Hopgood	Director of Finance and IT
Wayne Tannahill	Head of Estates and Property
Kate Evans	Women and Children's Risk Governance Lead

Committee Support:
Elizabeth Patterson Corporate Governance Manager
Shania Jones Committee Secretary

EQS/21/01	**WELCOME AND APOLOGIES FOR ABSENCE** The Committee Chair welcomed Members and attendees to the meeting, and CONFIRMED there was a quorum present. Apologies for absence were NOTED as recorded above.
EQS/21/02	**DECLARATIONS OF INTERESTS** No interests were declared.
EQS/21/03	**UNCONFIRMED MINUTES OF THE EXPERIENCE, QUALITY AND SAFETY COMMITTEE MEETING HELD ON 15 APRIL 2021** The minutes of the previous meeting held on 4 February 2021 were AGREED as being a true and accurate record.
EQS/21/04	**MATTERS ARISING FROM PREVIOUS MEETINGS** It was confirmed that Board and Committee governance arrangements would be discussed at a Board Development session on 27 April 2021 where the remit of each committee would be considered to ensure best arrangements are in place. The Director of Primary, Community Care and Mental Health advised in respect of overdue recommendations in the Health Inspectorate Wales tracker, an update was included within the meeting papers. The Director of Nursing and Midwifery confirmed that the improvement plan for the Maternity Assurance Framework would be brought back to Committee at its next meeting. **Action: Director of Nursing and Midwifery**
EQS/21/05	**COMMITTEE ACTION LOG** The Committee received the action log and NOTED the updates as provided within the paper.

ITEMS FOR APPROVAL/RATIFICATION/DECISION	
EQS/21/06	**MENTAL HEALTH SERVICES: AGE APPROPRIATE BEDS** The Director of Primary, Community Care and Mental Health presented the report which had been previously been presented to the Executive Committee in February 2021. The paper outlined arrangements for the 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. It was noted that the Tier 4 CAMHS inpatient service was commissioned directly by Welsh Government and provided by Cwm Taf UHB and Betsi Cadwalader UHB. The Committee was advised that at present, all inpatient treatment (Tier 4) for children and young people living in Powys was 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 was via an assessment undertaken face to face by the Regional Service and there were frequently occasions when a young person requires a Tier 4 in patient service which is not immediately available. This was often due to lack of available beds, or due to delays in the regional service assessing the patient. The Director of Primary, Community Care and Mental Health advised that for this client group, there were few other options available to PTHB, other than creating its own short-term admissions facility. Therefore, the paper which had been supported by the Executive Committee, proposed 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 being to manage clinical risk, maximising the opportunity to proactively prepare and then accommodate if needed, rather than respond in an emergency and be ill equipped. It was noted that, in terms of children below this age, referrals for inpatient provision were very rare, and the existing pathway into paediatric wards at DGH's would continue. It was noted that, following support from the Committee (in addition to the approval of Executive Committee), the service would commence 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.

	Is it clear that the clinical and therapeutic expertise, and capacity to help, can be provided at short notice and 24/7? The Director of Primary, Community Care and Mental Health explained that the proposals set out arrangements for a short-term emergency situation whilst arrangements were put in place to assess and arrange for longer term requirements. The Assistant Director for Mental Health Services confirmed all staff on Velindre Ward had undertaken Safeguarding Training and the arrangements were intended to last for less than 72 hours whilst a Tier 4 bed was found by CAHMS. *Is this a response to regulatory inspections on children and young people?* The Director of Primary, Community Care and Mental Health confirmed that it was a response to the need and welcomed regulatory inspections. This was a pragmatic outcome and is in the best interests of Powys patients. Additionally, the Women and Children Risk Governance Lead explained there was guidance provided regarding the transition of 16-17 year olds who can to elect to be treated in an adult, paediatric ward or young persons environment. *This is not just a Powys problem, why is there such a national problem with the CAMHS service?* The Director of Primary, Community Care and Mental Health explained that it is a complex issue, the critical mass for specialist skills to support these children is an issue. It is not just a Wales-wide issue but a UK issue, with an increasing demand for specialist treatment and support for children in crisis. Work was currently being undertaken by WHSSC within Wales to understand what is needed for this service within Wales. *Has there been an increased referral rate due to the lockdown?* The Director of Primary, Community Care and Mental Health noted that once children re-engage into society through schools and other contacts an increase in need for mental health support will be identified. The emotional health and wellbeing of all ages who have been through the lockdown will be an ongoing issue. Mental Health services are preparing to understand and assess what can be done.

	It was confirmed that the Mental Health Services Group had met respective performance measures during the pandemic. *Is the organisation monitoring the number of children and young people who present with self-harm?* The Director of Nursing and Midwifery confirmed that this was being monitored and that a spike in admissions had not been seen to date. The Committee DISCUSSED and APPROVED the approved Age Appropriate Beds, which had been previously supported by the Executive Committee. *Frances Gerrard joined the meeting.*
EQS/21/07	**MENTAL HEALTH ACT HOSPITAL MANAGERS POWER OF DISCHARGE GROUP TERMS OF REFERENCE AND OPERATING ARRANGEMENTS** The Board Secretary presented the paper which highlighted the revised terms of reference for the Hospital Managers Power Discharge Group which reports into the Experience, Quality and Safety Committee. The Board had previously agreed this as a sub-committee of the Board. The purpose of the group would be to provide assurance on operation of the delegated functions and section 23 of the Mental Health Act. The membership of the sub-group was made up of hospital managers and was chaired by an Independent Member of the Board, who sits on the Experience, Quality and Safety Committee. *Is the understanding correct that it has a slightly larger remit than the previous group?* The Board Secretary advised the remit would remain the same. The Terms of Reference had been expanded in order to provide more clarity on the role of the group rather than the remit. The Committee DISCUSSED and APPROVED the Mental Health Act Hospital Managers Power of Discharge Group Terms of Reference and Operating Arrangements. *Carol Shillabeer joined the meeting.*
	ITEMS FOR DISCUSSION
EQS/21/08	**SERIOUS INCIDENTS AND CONCERNS REPORT** The Director of Nursing and Midwifery presented the Committee with a paper which provided 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. The Committee received an update Following on from the issue of a Special Report by the Public Service Ombudsman for Wales in October 2020. The Committee was advised that 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 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 was no evidence from the fact-finding work that the issues arising in this case were the result of either structural or resourcing issues. There was no evidence in the review that the issues that arose were the direct result of lack of training or inappropriate training. Likewise, there was 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 was 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. The Committee was informed of work underway 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

	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 It was noted that the recommendations arising from implementation of the audit and assurance plan will be reported to Committee. The Committee welcomed this work. The Committee was pleased to note that the first Learning from Experience Group was held within the Health Board in March 2021, chaired by the Director of Clinical Strategy. This had provided the opportunity to triangulate quality related issues and how to maximise learning across the Health Board. During January and February 2021 the Health Board had received 22 formal concerns. There was no specific theme to the concerns which largely related to communication, care and treatment across a range of services and access. A thematic Public Services Ombudsman for Wales report had been published accompanied with an offer of training which the Health Board have accepted. Education and training opportunities had been developed within the last quarter with root cause analysis training been delivered to staff. It was a noted that Serious Incidents Performance in Wales was now overseen by the Delivery Unit and work had commenced on revising the Serious Incidents Framework. This would help the organisation learn from colleagues across Wales best practice for Serious Incident investigating and reporting.

	During the period of January 2021 to February 2021, there were eight serious incidents reported, no particular themes or trends within the service groups had been identified. There had been less than five 'No Surprises' notifications made to Welsh Government during the period of February 2021 to March 2021. There had been less than five Coroner's inquiries and less than Public Service Ombudsman for Wales inquires. The Health Board are complaint with any of the recommendations made by the Public Service Ombudsman. *In respect of the way in which this data triangulates, is it possible to explore how this information can be presented in a simpler format for members of the public?* The Director of Nursing and Midwifery confirmed that the recently formed Learning from Experience group were working on improvements to triangulation of data. The organisation was working on improving data presentation and it was hoped that the imminent implementation of Once for Wales would improve the situation. It was hoped that capacity could be built for data analysis. *The commissioned service complaints which are made directly to the Health Board, seem very low. Does the Health Board know how many complaints were received by the Provider Health Board themselves?* The Director of Nursing and Midwifery noted that in respect of commissioned service complaints, the Health Board was aware of complainants which came forward to the PTHB to act on their behalf. The Health Board regularly met with Commissioned Providers and were always looking to improve the accuracy and integrity of the data which, it is acknowledged, does vary. *The Socioeconomic Duty was introduced on 31 March 2021 and the Quality Impact Assessment, is there a way to triangulate the concerns, complaints and the issues raised in context of equality and Socioeconomic Duty?* The Director of Nursing and Midwifery agreed that this could be examined but noted that whilst there could be benefits there may be limitations in terms of size and representativeness. The Chief Executive observed the progress made over the last eighteen months noting further progress was necessary

	but that the establishment of the Learning and Experience Group would assist the ongoing process. The Committee DISCUSSED and NOTED the Serious Incidents and Concerns Report.
EQS/21/09	**REGULATORY INSPECTIONS REPORT** The Director of Nursing and Midwifery presented the report noting that the Health Inspectorate Wales (HIW) had advised of their intention to restart the NHS quality check programme during mid-February 2021. An all-Wales report had been received on mass vaccinations which supported the Health Board's own clinical approach to mass vaccination. HIW had undertaken a remote Quality Check of Ddyfi Valley Health and the report raised one improvement action. A response would be submitted within the required three months of inspection. HIW had informed the Health Board of its intention of conducting further quality checks of Clywedog Ward, Llandrindod Wells Memorial Hospital and Felindre Ward, Bronllys Hospital. The findings would be reported on publication of the report. *The first phase of HIW's Maternity Review examined quality and safety. What would be the focus in Phase 2?* Rebecca Collier, HIW, explained that Phase 2 would concentrate on community services and support. The Chief Executive advised that feedback on Phase 1 findings had been requested previously and asked if HIW could follow this up. The Committee DISCUSSED and NOTED the Regulatory Inspections Report.
EQS/21/10	**CLINICAL QUALITY FRAMEWORK, IMPLEMENTATION PLAN UPDATE** The Director of Nursing and Midwifery presented the report highlighting the progress made in implementing the Health Board's Clinical Quality Framework Implementation Framework. The Implementation plan followed on from an internal review of arrangements in relation to Clinical Quality Governance and was a three-year plan developed during 2020-2023. 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. Five goals were outlined, each with a lead Director. Progress had been made although the pandemic had meant progress had been variable. The Executive Committee would now review each goal to ensure that they remain appropriate post pandemic. The revised programme would be brought to the next Committee meeting. **Action: Director of Nursing and Midwifery** *The Independent Member (University) noted the organisation had an excellent workforce that was thinly spread in terms of quality initiatives and offered medical students to assist with projects for up to six weeks at a time.* This offer was welcomed by the Medical Director who noted that over the last year much improvement had taken place and the challenge was to evidence this. *In regard to Patient Experience, moving forward what should the Health Board expect over the next year?* The Director of Nursing and Midwifery noted there were a range of approaches for patient experience across the organisation. The intention is to take a more strategic approach. There are a number of electronic solutions used in terms of patient experience in other areas which would be considered by the Executive Committee. The Committee DISCUSSED and NOTED the Clinical Quality Framework, Implementation Plan Update.
EQS/21/11	**COMMUNITY SERVICES: APPROACH TO CLINICAL QUALITY** The Director of Primary, Community Care and Mental Health introduced the paper which highlighted the approach taken in Community Services Group to quality and patient safety. It was noted that in the previous organisational structure was locality based, the re-alignment that took place two years ago moved to service groups. The largest service group is under the Director of Primary, Community Care and Mental Health and is a complex group covering community beds, student nurses, elective care and endoscopy amongst others. The Assistant Director of Community Services Group further explained that the service group was new which had required the redesign of reporting frameworks.

	What difference should be seen in 12 months' time, in terms of the impact of the new structure? The Assistant Director of Community Services Group explained that the old locality structure had not been as integrated as it could have been. The redesign was horizontal and vertical, and was looking to ensure that there was diversity within the approach of therapies, nursing and medicine. The intention was to see an improvement in patient feedback with monitoring undertaken within the Directorate and through the Quality Governance Group. The Committee DISUCSSED and NOTED the Community Services: Approach to Clinical Quality.
EQS/21/12	**COMMISSIONING ASSURANCE: SATH** The Director of Nursing and Midwifery introduced the report which was presented by the Assistant Director Commissioning Development. The report highlighted the organisations that, within the Commissioning Assurance framework, were at level four and above, or are within special measures. This included Shrewsbury and Telford Hospitals NHS Trust, Cwm Taf Morgannwg University Hospital's maternity services and Wye Valley NHS Trust which remain at level 4 however, the issues are wide spread. Attention was drawn to a Shrewsbury and Telford Hospitals NHS Trust (SaTH) which had received an unannounced inspection in January 2021 as a result of the Care Quality Commission being alerted to concerns regarding anaesthetic cover. This resulted in a further Section 31 Notice, imposing conditions on SaTH relating to the admission of children and young people who may have learning disabilities or challenging behaviours. The paper outlined the actions taken in response to the Section 31 Notice which included an intention to avoid admissions from this cohort to the Shrewsbury and Telford Hospitals by using the age appropriate bed in Bronllys for patients aged 16-17 or using an arrangement with Wrexham Maelor Hospital for younger patients. The Committee was advised that the organisation was monitoring weekly the action SaTH was taking in response to the Section 31 Notice and it was noted that SaTH was in an improvement alliance with University Hospital Birmingham.

	Is the Health Board taking the opportunity to review what services are available locally to support children with behavioural and mental health problems? The Committee expressed its ongoing concern at the quality of services provided at SaTH and requested that a board-level discussion be arranged to discuss these concerns further with all board members. **ACTION: The Board Secretary to arrange for a board-level discussion relating to SaTH** The Committee DISCUSSED and NOTED the Commissioning Assurance Report.
EQS/21/13	**APPROACH TO ASSESSING HARM FROM COVID-19** The Committee NOTED an update from the Medical Director in respect of the approach to assessing harm From COVID-19.
ITEMS FOR INFORMATION	
EQS/21/15	**UPDATE ON IMPLEMENTATION OF ONCE FOR WALES COMPLAINTS MANAGEMENT SYSTEM** The Committee NOTED the paper.
EQS/21/16	**WHSSC QUALITY & PATIENT SAFETY COMMITTEE MINUTES** The Committee NOTED the paper.
EQS/21/17	**AUDIT WALES QUALITY GOVERNANCE REVIEW, TERMS OF REFERENCE** The Committee NOTED the paper.
EQS/21/18	**WELSH GOVERNMENT WRITTEN STATEMENT: THE HEALTH AND SOCIAL CARE (QUALITY AND ENGAGEMENT) (WALES) ACT 2020 – UPDATE ON IMPLEMENTATION** The Committee NOTED the paper.
OTHER MATTERS	
EQS/21/19	**ITEMS TO BE BROUGHT TO THE ATTENTION OF THE BOARD AND OTHER COMMITTEES** There are no items for inclusion in this section
EQS/21/20	**ANY OTHER URGENT BUSINESS** No urgent business.

	The Committee Chair thanked all members.
EQS/21/21	**DATE OF THE NEXT MEETING** 03 June 2021 at 10:00, Microsoft Teams

Key:

Completed
Not yet due
Due
Overdue
Transferred

EXPERIENCE, QUALITY & SAFETY COMMITTEE

ACTION LOG

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

Minute	Meeting Date	Action	Responsible	Progress Position	Completed
Transferred from Board or other Committee Meetings					
Transferred from Board Meeting: PTHB/20/148 Socioeconomic Duty for Wales	31 March 2021	An update be presented to the Experience, Quality and Safety (EQS) Committee on the health boards response to the impact of the pandemic on the domestic abuse agenda, mental health agenda, children and young people agenda	Director of Nursing and Midwifery	03/06/21: Safeguarding update included on the agenda	
Transferred from Audit, Risk & Assurance Committee 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		Update to be scheduled for June 2021
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	Director of Primary, Community Care and Mental Health	15/04/21: Update included on the agenda	

		particular those relating to 2018 and 2019.			
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	03 Dec 2020 It is proposed that an update on Research and Development is built into the Committee's workplan for 2021/22 16 April 2020 The Committee agreed that in light of COVID-19, this action would be deferred to Q3, 2020/21 (priority 2).	
EQS/19/22	4 June 2019	HIW/CIW Joint Inspection: Community Mental Health – The Hazels (Llandrindod Wells) – where 'The Hazels' building sits in the asset refurbishment programme will be	Assistant Director of Estates and Property	28 January 2021 Programme Business Case for Llandrindod (£11M+) was submitted to Welsh Government in December 2020, currently awaiting endorsement and this includes a funding	

		confirmed at the next meeting		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).	
EQS/21/04 Matters Arising	15 April 2021	Improvement for Maternity Assurance Framework be brought back to EQS	Director of Nursing and Midwifery	03/06/21: Maternity Services update included on the agenda	

EQS/21/10 Clinical Quality Framework	15 April 2021	Revised Clinical Quality Framework Programme be brought to EQS	Director of Nursing and Midwifery	03/06/21: Clinical Quality Framework update included on the agenda	
EQS/21/12 Commissioning Assurance	15 April 2021	An update on SaTH be provided to Board Development	Board Secretary	03/06/21: Transferred to Board action log for 10th June 2021 meeting	
IC_EQS/21/06 Complex Concerns & SIs	15 April 2021	A final brief on the PSOW report be provided to EQS (In-Committee)	Director of Nursing and Midwifery		

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 3.1

EXPERIENCE QUALITY & SAFETY COMMITTEE	**Date of Meeting: 3 June 2021**
Subject:	**PTHB Clinical Quality Framework Update**
Approved and Presented by:	Alison Davies, Director of Nursing & Midwifery
Prepared by:	Alison Davies, Director of Nursing & Midwifery Kate Wright, Medical Director Claire Madsen, Director of Therapies & Health Sciences Stuart Bourne, Director of Public Health Julie Rowles, Director of Workforce and Organisational Development
Other Committees and meetings considered at:	Quality Governance Group, 17 May 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 March 2021. The Clinical Quality Framework contributes to the Organisational Development Strategic Framework.

RECOMMENDATION(S):

The Executive Committee is asked to DISCUSS the content of this report.

Approval/Ratification/Decision	Discussion	Information
☒	✓	☒

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

EXECUTIVE SUMMARY:

The 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.

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. The last update to Quality Governance Group was in March 2021.

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.

2.2 The overall implementation of the Clinical Quality Framework Implementation Plan has been adversely affected since the emergence of the Covid19 pandemic, however, progress has been made and/or maintained in most of the goals but has slowed during April 2021.

2.3 Following papers presented and discussion at the Experience Quality and Safety Committee and Executive Committee in April 2021, it was agreed that Directors would review the reprioritise activities within the goals they lead and provide a revised plan for consideration at Quality Governance Group. Once agreed, the revised priorities will be scheduled for delivery during 2021-2022.

2.4 It is anticipated that the results of the individual Director led reviews and the generation of revised priorities are reported to the Quality Governance Group on 6 July 2021, along with specific agenda items related to Goal 1c: patient experience and Goal 5: intelligence.

2.5 The RAG ratings previously reported upon in March 2021 are unchanged and included in **appendix 1** for reference. Progress made in implementing existing priorities during April 2021 is captured in **appendix 2**.

NEXT STEPS:

It is anticipated that revised and re-prioritised activities for each of the goals within the Clinical Quality Implementation Plan will be presented to the Quality Governance Group in July 2021 and subsequently to the following Experience Quality and Safety Committee.

Appendix 1

The table below provides an 'at a glance' summary of status in relation to each of the activities up until April 2021. There have been no changes to RAG ratings since the last report to QGG in March 2021.

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 April 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		

Appendix 2: 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

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. This policy has been updated to reflect recent guidance from the Public Health Ombudsman's office and is due to be considered by the Board at the end of May 2021. It will require further revision as the policy will also be required to take account of the new serious incident framework being launched 14 June 2021, as described further in this paper.

Training for complaints and concerns management was held at the end of April 2021, with good attendance across the health board.

Improvements in concerns performance has been evidenced the last quarter of 2020/21, and this continues during the first quarter 2021/22.

An interim structure is being progressed to manage concerns, with two additional posts out to advert to strengthen the team during the next six months, whilst an agreed structure is put in place.

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

Plans to introduce a 'swarm' model in relation to incidents of in-patient falls and pressure damage to strengthen the timeliness and robustness of investigation and learning are in progress.

There is a shift to focus on serious incidents during quarter 1 of 2021/22 to ensure investigations are robust and complete, and to close outstanding historical cases that remain open. The organisations performance in relation to serious incident

management is scrutinised by the Chief Executive Officer and by the Experience Quality and Safety Committee.

Quality governance arrangements within the service groups continue to strengthen with appointments to supporting roles and articulation of the systems and processes used to support the broader quality governance agenda.

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 Director for Strategy and value-based health care is now in post, and value-based care is an emerging principle in all areas of transformation. Securing secondary care provision for expertise to help review practice and guidance is being explored.

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

A draft paper has been developed aimed at the health board procuring an electronic service user feedback system, as part of the Once for Wales national approach. The paper is scheduled for the Inaugural Investments Benefits Group 19th May 2021 and thereafter the Executive Committee.

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

The Organisational Development Framework is currently under review

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

The opportunity to continue developing and enabling clinical leaders is being reviewed as part of the organisational development framework

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

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)

Plans to implement the Once for Wales Concerns Management System have progressed at pace locally with support from the programme delivery lead. The national team have indicated advised this work has been delayed and the system has a 'go live' date of June 2021.

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 3.2b

EXPERIENCE, QUALITY AND SAFETY COMMITTEE	**Date of Meeting: 3rd June 2021**
Subject:	**Women and Children's Service Group – Quality Governance Framework 2020-2021**
Approved and Presented by:	Jamie Marchant Executive Director of Primary Care, Community and Mental Health Services Alison Davies Executive Director of Nursing & Midwifery
Prepared by:	Louise Turner, Assistant Director for Women and Children's Services
Other Committees and meetings considered at:	Quality Governance Group – 20th May 2021 W&C Senior Clinical Leadership meeting – 27th May 2021

PURPOSE:
The purpose of this paper is to provide an update on refinement of the Women and Children's Services Group Quality Governance framework for 2021/22
RECOMMENDATION(S):
The Experience, Quality & Safety Committee is asked to: NOTE and DISCUSS the Women and Children's Services Group Quality Governance Framework 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 Women and Children's Services Quality Governance framework was developed and implemented during 2020 based on the PTHB Clinical Quality Framework. A prioritisation plan has supported the implementation and embedment of the Women and Children's Quality Governance framework alongside the unpresented pressures on the Senior Leadership Team, Heads of Service and Operational Leads managing immediate COVID 19 responses, service redeployment and contributions to mass vaccination.

There have also been some gaps which has led to fragility within key leadership and governance posts These postholders play a key role in ensuring s effective quality and safety governance. This fragility has had some impact on timely review of DATIX, outstanding historical DATIX, completion of quality and safety reports, overdue complaints and incidents response rates all of which is now on a journey of improvement with quality and safety monthly tracker showing improvement in regards to timeliness. The Women and Children's governance quarterly report is being developed to provide detail around trends for incidents, concerns and evidence of sharing the learning.

The Quality Governance framework describes the arrangements in the Women and Children's Services and the intended progress for 2021.

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 Women and Children's Services Group was formed in February 2020 following the commencement of the Assistant Director for Women and Children's services, from a previous North locality structure and underwent a period of transition which was concluded in January 2020. The Women and Children's service group continued to maintain and further developed the focus on quality governance through the 2020 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 the Women and Children's Quality Governance framework is part of its commitment to recovery and renewal.

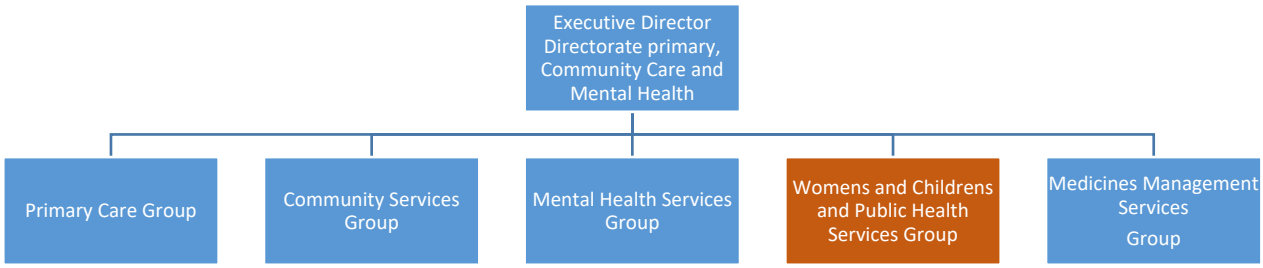
This paper outlines the priorities for 2021/22 which aims to provide a focus in line with the Health Boards strategic quality priorities.

The Women and Children's Quality Governance framework focussed on delivery and compliments as set out in the PTHB Board Assurance Framework.

Women and Children's Services Group

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

Diagram 1: Directorate Structure



The Women and Children's Services Group have 214 staff, of which 169.01 are FTE posts from a wide range of professional groups including:

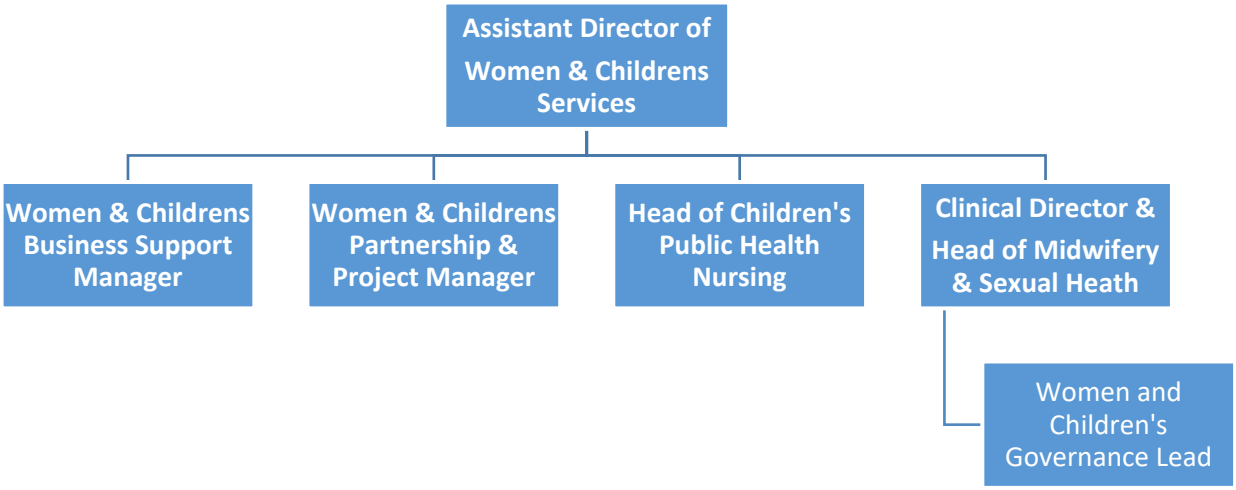
- Midwives
- Health Visitors
- School Nurses
- Community Children's Nursing Incl. Neurodevelopment & Continuing Care
- Medicine
- Nursing
- Paediatric Therapies
- Health Sciences
- Administrative
- Leadership

With a budget of £7.696m for 2020/21 for the Women and Children's Service delivers a unique portfolio of services in a way which is different to other Health Boards in Wales in that it manages Community Paediatrics, Neurodevelopmental, community children's nursing and Paediatric therapy services alongside Midwife Led, Health Visiting and School Nurse services which would usually be placed in different directorates, for example:

- Planned care including Community Paediatric Triage, Neurodevelopmental services outpatients, Serial Casting and Paediatric Speech and Language services,
- Planned care and Unscheduled care flow through Maternity services
- Maternity Diagnostic ultrasound, and radiography
- Planned care to meet the Healthy Child wales programme standards
- School Based Immunisation programme
- Powys provided Sexual Health services and links with DGH level 3 sexual Health
- Powys Pelvic Health and developing Women's Health Endometriosis service

The Women and Children's Service is therefore a complex service group with a broad range of services with children, young people and family 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

Women and Children's Quality Governance Framework

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 Women and Children's Services Group Quality Governance framework has been shared widely within the Group via established team meetings, from ward to senior management team since introduction in September 2020. The structure provides clarity on the arrangements for:

- Women and Children's People's Experience forum
- Women and Children's Process for Serious Incidents Oversight and Concerns
- Women and Children's Clinical Audit Improvement and Audit Plan
- Women and Children's Policy and Guideline Group
- Monthly Senior Leadership Performance Monitoring
- Women and Children's Risk Register
- 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
- Escalation and reporting in line with NHS Outcomes Framework
- Scrutiny and learning

Women and Children's Quality Governance Framework principles	Progress for 2020 and priorities for 2021
Women and Children's Quality Governance Framework approved by Women and Children's Senior Clinical Leadership September 24th 2020 (**appendix 1**). To assist with the implementation of the Quality Governance Framework, the following targeted forums were established to progress improvement in the following areas;	
Women and Children's monthly Incident Oversight was established to review and monitor Women and Childrens incident reporting to include SIs, CYSUR, Risk Register, Datix, Review reporting processes and mechanisms to ensure accurate data entries and responses. The monthly meeting has provided a platform to identify trends, areas that may need improvement and address through formal action planning. Each service brings a shared learning example to the Monthly W&C Senior Clinical Leadership meeting to cascade learning across all services. A tracker for supporting actions has been set up to enable a focus on 2021 to ensure recommendations from SI's, concerns responses are progressed in the relevant services	The Women and Children's team value the weekly tracking and monthly meetings with the Quality and Safety team to review SI's, Concerns and Complaints from Quality and Safety team which is reviewed by W&C Senior Leadership team to prioritise and progress responses. The Quality and Safety information will used to evidence the shared learning and outcomes from the themes and trends for incidents and concerns
Women and Children's Policies & Procedures was established to oversee the Development of Policies, Procedures, Guidelines, Standard Operating Procedures (SOP) (where required) relating to working practices across Women and Childrens Services	The monthly Policies and Procedures is managing the risk of progressing outstanding Policies, guidelines and developing relevant SOPs where required.
During 2020, Women and Children's service group have established a proactive Women and Children's People's Experience forum align to the PTHB Patient Experience Steering group. The W&C forum is ensuring client's experience is at the centre of everything we do and aspires to capture and monitor people's experience	The Women and Children's People's experience forum has enhanced the quality and content of the quarterly Patient Experience reports and the monthly

through Powys and commissioned services. The group is providing assurance that the 'service user' voice is heard and actively used to inform service improvement".	shared learning examples are cascaded across the services.
In April 2020, a monthly Perinatal & Child Death Review with the objectives of the group to Monitor and review perinatal & child deaths for Powys resident on a monthly rather than annual basis in collaboration with the relevant commissioned services such as DGH Obstetric services, DGH Paediatric services and All Wales Paediatric Network. The monthly meetings have ensured focused data, intelligence and analysis, to understand the quality and standards of care provided and commissioned by Powys Teaching Health Board.	The work of the monthly Powys Perinatal & Child Death Review will be presented to the Annual Powys Perinatal & Child Death Review on the 18th May to share the data analysis, themes and trends and inform learning from the monthly reviews. The W&C Bereavement forum is supporting improved pathways, family support and staff bereavement training.
Healthy Child Wales Programme Oversight Meeting was set up in September to Review and monitor Powys Teaching Health Board's (PTHB) compliance with the HCWP, through locally produced audit reports as well as from Welsh Government quarterly reports.	Priorities for 2020-2021 have focused on - Improving quality assurance measures for Newborn screening with error rates - Improving WPAS recording of Newborn Initial Examination with further assurance planned on the use of WCCIS
Women and Children's Service Clinical Audit Plan and Clinical Audit Improvement Plan outlines the Women and Children's commitment to continuous improvement through clinical audit and service improvement	During 2020, W&C Audit group increased its activity and effectiveness with 6 Audit presentations provided at the W&C Winter Audit presentation and further 4 audits scheduled to be reported in the Summer meeting on 2nd June 2021 namely Referrals into Physiotherapy for early intervention for premature babies, Audit

	of ASD within CAMHS Annual Audit and Child Protection Medicals in Powys
Women and Children's have two key HealthCare Inspectorate Wales reports to progress recommendation for relevant services; - HIW National Maternity report - HIW Review of Health Care services for Youth People The Maternity assurance with the progress of HIW and RCOG and RCM recommendations is being monitored through the Powys Maternity Improvement plan which continues to be presented through Experience, Quality and Safety committee.	The progress with Powys improvements for both HIW reports and the ongoing RCOG and RCM recommendations are being monitored through as a standard agenda item for the monthly Women and Children's Senior Clinical Leadership meeting
Women and Children's have a defined W&C Health & Safety forum to monitor and review health & safety concerns across Women and Childrens Services. The forum is aligned to the Corporate Health and Safety priorities and ensure communication with action plans to facilitate improvement	The Women and Children's Health and Safety forum continued ot meeting on a Bi-monthly basis with specific areas of focus including compliance with COVID19 Environmental Risk Assessments, Fire Safety Compliance and Emotional Wellbeing support to staff / impact of COVID19 working to meet during 2020.

The Structure will be evaluated during 2021 and a report generated to the Quality Governance Committee reflecting findings, recommendations and lessons learned.

Women and Childrens Governance Framework

All Team Agendas to Include:

- Concerns / Complaints
- Datix
- Risk Register
- Patient Experience
- Audit

Quality Governance Group

(QGG)

Jamie Marchant

(DPCCMH)

Senior Clinical Leadership (SCL)

4th Thursday every month 9.30 – 11.00

Individual Teams & Services

Chair: Service Lead

Incident Oversight Groups

- SIs
- CYSUR
- Risk Register
- Datix

3rd Wednesday Every Month

9.00 – 10.30

Chair: Assistant Director Women and Childrens Services

Audit

1st Wednesday Every Month

12.30 – 1.30

Chair: Clinical Director/ Head of Midwifery & Sexual Health

Policies

&

Procedures

3rd Monday Every Month

13.00 – 14.30

Chair: W&C Risk & Governance Lead

Child Death Review Meetings

1st/2nd Tuesday Every Month

(1 Hour)

Chair: Clinical Director/ Head of Midwifery & Sexual Health

Patient

Experience

Forum

2nd Wednesday Every Month

Chair: TBC

Health &

Safety

Quarterly

Chair: Assistant Head of Midwifery & Sexual Health

Individual Teams & Services

Quality Governance Group (QGG)

Jamie Marchant (DPCCMH)

Senior Clinical Leadership (SCL)

HoM / AHoM

HoM / AHoM

Medical Lead

Midwifery Management Meeting

Chair: Rotational

Tuesdays Every Week

Joint Shire Meetings

Monthly

Chair: Assistant Head of Midwifery

Team Meetings

Monthly

Chair: Band 7 Midwife

Clinical Incident/Supervision

Monthly

Chair: Clinical Supervisor of Midwives/ Risk & Governance Lead

Sexual Health Team Meetings

Senior Managers Public Health Nursing & Paediatrics

Ass Head Childrens Nursing

Ass Head of Children's Public Health Nursing……

Team Leader (TL)

Team Leader (TL)

Continence

LD / ND

CCN

HV

SN

Consultants

Medical Secretaries

Weekly

Chair: Childrens Patient Services Manager

Child Health

2nd Wednesday Every Month

Chair: W&C Business Support Manager

Physio & OT

Monthly

Joint & Individual Service Meetings

Chair:

Head of Physio and 14+ Service

Speech & Language (SaLT)

Fortnightly (Mainly Tuesdays)

Chair: Head of SaLT

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda Item 3.3

EXPERIENCE, QUALITY SAFETY COMMITTEE	**Date of Meeting: 3 June 2021**
Subject:	**Maternity Services Update**
Approved by:	Alison Davies, Executive Director of Nursing and Midwifery
Prepared and presented by:	Julie Richards, Head of Midwifery and Sexual Health Clare Lines, Assistant Director for Transformation
Other Committees and meetings considered at:	None

PURPOSE:
The purpose of this paper is to provide assurance to the Experience Quality Safety Committee (EQS) including the progress of the Powys Maternity Improvement Plan, the scheduling of a Powys Maternity and Neonatal Performance Board by Welsh Government, development of an assurance committee in SaTH, and reference to the work underway within the maternity and neonatal workstream of the South Powys Programme Board.
RECOMMENDATION:
The EQS Committee is asked to DISCUSS and NOTE the report.

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

THE PAPER IS ALIGNED TO THE DELIVERY OF THE FOLLOWING STRATEGIC OBJECTIVES AND HEALTH AND CARE STANDARDS:		
Strategic Objectives:	Focus on Wellbeing	✓
	Provide Early Help and Support	✓
	Tackle the Big Four	✓
	Enable Joined up Care	
	Develop Workforce Futures	
	Promote Innovative Environments	
	Put Digital First	
	Transforming in Partnership	
Health and Care Standards:	Staying Healthy	✓
	Safe Care	✓
	Effective Care	✓
	Dignified Care	✓
	Timely Care	✓
	Individual Care	✓
	Staff and Resources	✓
	Governance, Leadership & Accountability	✓

EXECUTIVE SUMMARY:

The paper updates to the Committee in relation to the development of the Powys Maternity Improvement Plan and Maternity Assurance Framework including commissioned services; the development of all Wales Maternity and Neonatal Assurance tool; responses to the first Ockenden Report; the Welsh Government Maternity and Neonatal Performance Board which has been scheduled for Powys Teaching Health Board for the 14th July 2021 and reference to the South Powys Programme Maternity and Neonatal Workstream.

DETAILED BACKGROUND AND ASSESSMENT:

1. All Wales Assurance tool & Welsh Government's Maternity and Neonatal Performance Board

1.1 Following the publication of the Ockenden Report and the assurance framework developed by NHS England and Improvement (NHSEI), the all Wales Maternity and Neonatal Network has developed a Welsh assurance tool. This tool has been developed to support providers to assess their current position against the 5 themes of the Maternity Vision for Maternity Services in Wales incorporating recommendations from other key reports and audits.

1.2 The tool is integrated and brings together recommendations made by Healthcare Inspectorate Wales, national maternity, Ockenden immediate and essential actions, RCOG & RCM recommendations following the review of Cwm Taf Morgannwg University Health Board and MBRRACE recommendations against the 5 themes of the Maternity Vision for Maternity services in Wales, as well as

recommendations from other key reports and audits.

1.3 A Powys Maternity Improvement Plan has been drafted following a self-assessment in relation to the National Report for Healthcare Inspectorate Wales (HIW) recommendations for maternity services (March 2021) and learning from other sources.

1.4 The all Wales assurance tool is currently being ratified in readiness to support the Welsh Government's Maternity and Neonatal Performance Board. Once the assurance tool has been approved for use on an all Wales basis, the Powys Maternity Improvement plan will be finalised and shared at a future EQS committee. The Powys Maternity Improvement Plan has been aligned to the PTHB Health and Care Strategy using the key messages from national reports including the experiences of women and their families who have suffered loss.

1.5 The Powys Maternity and Neonatal Performance Board is scheduled for July 2021 and is an annual event chaired by the Chief Nursing Officer for Wales, designed to hold providers to account for its delivery of services in the preceding year.

2. **Shrewsbury and Telford Hospital NHS Trust, Ockenden Report**

2.1 The first Ockenden Report published on the 10th December, 2020, entitled "*Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust*", contained local actions which were specific requirements for SaTH, together with immediate and essential actions for all NHS providers.

2.2 An NHS England and Improvement (NHSEI) letter on the 14th December, 2020, set out the requirement for all Trusts to receive the report at public meetings. An assurance statement also had to be completed. NHS Trusts in England have submitted reports to the NHSEI regions and it is understood that these are being risk assessed. PTHB will provide a separate internal assessment when these have been collated.

2.3 SaTH has established a committee with an independent chair, to drive forward actions arising from the report. The Ockenden Report Assurance Committee (ORAC) meets monthly in public. PTHB is represented through the Director of Nursing and Midwifery. The Powys Community Health Council is also represented. The purpose of the Committee is to obtain and provide assurance in relation to the delivery, evidence, sustainability and impact of the implementation of the actions arising from the Ockenden report.

3. Provider assurance

3.1 In terms of assurance and oversight, internally, we continue to refine the service group governance arrangements and the PTHB Maternity Assurance Framework continues to develop, which assists the health board in understanding, and influencing, the quality and safety of the services provided to the women of Powys by neighbouring commissioned NHS organisations.

3.2 The Maternity Assurance Framework along with regular position

reports, are provided to the Quality Governance Group and the Experience Quality and Safety Committee, both in the public domain and in-committee to help protect personally identifiable information.

3.3 The Women and Children's Quality Governance Framework has been shared at the Quality Governance Group (20th May 2021) and Experience, Quality and Safety Committee (4th June 2021). The Women and Children's Governance Framework has a key focus on shared learning and outcomes, strengthened by the peoples experience forum, with a co-production approach to ensure strong user engagement.

3.4 As a result of the HIW National Maternity Healthcare Inspection report, the Powys directly managed maternity service is focusing on the following priority areas, which will be included within the overall Powys Improvement Plan:

3.4.1 Sustainable workforce including staff wellbeing: The support and sustainability of the Powys midwifery workforce has been the key priority with maternity services being maintained as an essential service during the Pandemic. The peer review of the Clinical Supervision Model for Midwifery (May 2021) highlighted the value of the model in supporting the workforce over the last 12 months and the positive impact this support has had on staff wellbeing. The midwifery streamlining with 1.8wte newly qualified midwives will be supportive to the sustainability of the midwifery workforce which does face the ongoing impact of maternity leave and a number of retirements scheduled over the next 5 years. Powys midwifery update training continues to use the PROMPT methodology which includes the importance of respectful team working to build a supportive work culture. A number of MDT opportunities have been identified through the Health Board meetings to build on the Ockenden Report recommendations on the importance of teams training together not simply staying in their professional corners.

3.4.2 Full implementation of Continuity of Care: The Future Vision for Maternity Care highlighted the need for continuity throughout low risk and complex care, with shared decision making and collaborative working across specialities. As part of the full implementation of Continuity of Care scheduled for June 2021 Powys Maternity services is linking with relevant health boards to ensure that each individual team is establishing a dedicated Obstetrician linked to each community team to ensure consistency with medical engagement for women with additional needs for pregnancies requiring obstetric input. Locally Powys and SaTH are jointly developing an agreed pathway for managing complex pregnancy, to ensure clarity for women who require input from obstetricians and who need to e be referred; which conditions this would include; and expectations around communication between services. The specific pathways drawn up, in terms of referral processes and communication, will ensure coherence with the maternity work through the South Powys

Programme. PTHB is working to ensure a common pathway will be replicated across the interface with all of the commissioned services.

3.4.3 Digital Maternity Cymru – electronic record / database: Currently the maternity system relies on paper based individual hand-held records with assimilation of records onto electronic systems which vary between health boards. The recording of data is different in every health board even though women regularly move between health boards to access care. The HIW National Report for Maternity services recommended that a single digital system is needed and this system should be an all wales system which incorporates the individual woman's record. An outline project proposal has been written and presented to the NHS Wales Health Collaborative Executive Group. The outline project proposal ensures a collaboratively agreed way forward with key stakeholders including Welsh Government (OCNO and Digital Transformation Programme), NWIS/ Digital Healthcare Wales, Health Boards (CEOs, digital teams, maternity teams) and the Maternity and Neonatal Network together with a fully assessed funding framework

3.4.4 Healthier lifestyles / support worker role: As part of the Building a Healthier Wales Prevention and Early Years Fund, Powys has been able to introduce a First 1000 days/Healthy Lifestyles Support Worker role to Maternity and Health Visiting services. COVID-19 has presented a challenge to the project resulting in adaptations being made to how the service is delivered. All face-to-face options were not possible in 2020/21 and therefore the service has adapted to use virtual technology for delivery of Foodwise in Pregnancy and smoking cessation support either via Teams or by phone. The physical activity part of the project has been delayed but plans are now in place to progress the "buggy walk" element of the programme. The programme in 2021/22 will play a key role in the support and engagement with Powys families and a full evaluation of the programme is scheduled for March 2022.

3.4.5 Birth Centre Environments: The Welshpool Birth Pool installation and refurbishment of the birth room is scheduled for June 2021 following a key recommendation in HIW review for Powys Maternity services. The Powys Maternity Improvement Plan includes a focus on profiling the birth options through Powys Birth Centre services and will further promote the availability of waterbirth options. HIW highlighted the need for modernisation of Llanidloes and Knighton Birth Centre environments and plans are currently in development to present to the Health Board Capital Control Group. The increase access to waterbirth and improved birth centre environments enhance the possibility of normal birth / decreased intervention.

4.Maternity and Neonatal Pathways

4.1 As reported to the EQS Committee a Maternity and Neonatal Workstream is in place under the South Powys Programme chaired by the PTHB Director of Nursing and Midwifery, involving clinicians from PTHB, Aneurin Bevan University Health Board (ABUHB) and CTMUHB. The right timing for a future strategic change in pathway will be subject to PTHB Board approval based on assurances about quality, safety, patient experience and governance and an assessment of readiness including factors such as capacity and capability

4.2 The outcome of the South Wales Programme was approved by PTHB in February 2014 and the other South Wales Health Boards and WAST following extensive public consultation. This approved a five-site model for consultant led emergency medicine, maternity, neonatal and inpatient children's care. Prince Charles Hospital in Merthyr Tydfil was recognised as being of strategic importance offering the nearest DGH for the majority of the South Powys population.

4.3 The accelerated opening of the Grange University Hospital was needed as part of ABUHB's response to the COVID winter of 2020/2021. This required an accelerated system change with PCH becoming the closest DGH with consultant led emergency services for the majority of South Powys. Health Boards worked together to ensure this change was completed by 17th November, 2020, in relation to consultant led Emergency Department Services and emergency admissions. However, work in relation to the consultant led maternity and neonatal pathways for South Powys is being undertaken in a different timescale as CTMUHB's maternity services are in special measures. South Powys access to the obstetric and neonatal care within ABUHB is being maintained until a decision is taken by the Board of PTHB about the timing for a strategic change in pathway as described above.

4.4 A further update about the independent oversight arrangements of maternity and neonatal services at CTMUHB was provided by the Minister for Health and Social Services on the 22nd March 2021. Whilst there has been neonatal expertise as part of the Independent Maternity Overight Panel's (IMSOP) work in relation to the Clinical Review Programme and within the Quality Assurance Panel, there is now also neonatal expertise within the full Panel.

4.5 The Independent Maternity Services Oversight Panel (IMSOP) provides independent oversight arrangements of maternity and neonatal services at CTMUHB. This is timely given that the neonatal reviews are underway and it will be important to ensure that as the learning emerges it is fed into the wider improvement programme. Alongside this the panel will also begin a deep dive to take stock of the current neonatal service and its improvement plan to provide assurance that services are safe, effective, well led and importantly integrated with the maternity service to provide a seamless service for women and babies. This should help inform improvements CTMUHB is making on their journey to provide exemplar maternity and neonatal services. When the Panel last reported in September 2020, it

concluded that the health board had done remarkably well to maintain the focus and momentum of its Maternity and Neonatal Improvement Programme (MNIP) during the first wave of the COVID-19 pandemic. In the circumstances which have prevailed over the past twelve months and the last six months in particular, the Panel has advised that the current pace of progress is entirely understandable in their view. The Panel has identified the key areas of focus to regain momentum over the coming months and have determined that September would be an appropriate time to next provide a full report on progress.

Next Steps

- The ongoing self-assessment and the outcome of the Welsh Government Maternity and Neonatal Performance Board will further inform the development of the Powys Maternity Improvement Plan.

- Maintain oversight and escalation of commissioned services through Powys Maternity and Neonatal Matters Group and PTHB Commissioning Assurance Framework (CAF), to continue to strengthen data gathering and intelligence reporting to provide assurance and be confident about the quality and safety of services for the Powys population.

- As previously presented to the Experience, Quality and Safety committee we will continue with monitoring quality, safety and sustainability of maternity services around Powys' border using our Strategic Change Situation Report and Fragile Services Log, alongside our monitoring of commissioned services compliance to national standards particularly for consultant-led/obstetric care, to ensure strategic oversight of service providers.

- To provide the EQS Committee with future updates following the approval of the all Wales Maternity Assurance framework which is intended to provide public assurance and help to improve services for patients and their families.

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 3.5

Experience, Quality and Safety Committee	**Date of Meeting: 3rd June 2021**
Subject :	Approach to Learning Update
Approved and Presented by:	Kate Wright, Medical Director
Prepared by:	Kate Wright, Medical Director
Other Committees and meetings considered at:	

PURPOSE:
The purpose of this paper is to describe our approach to building upon our learning culture throughout Powys Teaching Health Board.
RECOMMENDATION(S):
The Committee is asked to NOTE the contents of the report.

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:

The Francis report highlighted the importance of transparency, openness and of a learning culture within health organisations and much has since been achieved in developing these. Powys Teaching Health Board already has a strong learning culture. It is a complex organisation with its many small teams spread over a large geographical area interfacing with many other Health Boards. Whilst this can bring challenges to learning and sharing of information, it also brings opportunities.

Below the principles, culture, mechanisms and opportunities for developing shared learning are described.

DETAILED BACKGROUND AND ASSESSMENT:

Shared learning

A lot of important learning happens informally in teams who naturally adapt to changing contexts. This happens through everyday working practices. People notice that what they are doing no longer seems to generate the

desired impact and start to adjust what they do, sometimes without even being aware of it.

Allowing space for people to reflect is important and should be part of the routine and discipline of how people work together and make adjustments in real time. Important changes in practice should be captured, audited and shared in departmental Multi-Disciplinary Teams (MDT) governance meetings before being shared with the wider organisation. Each of PTHB major service groups has a regular MDT meeting where learning is shared. Primary care practitioners hold regular educational meetings where important topics are discussed and information is shared.

Leaders should bear witness to people's experiences. This requires us to create spaces that are safe enough for people to share their experiences without feeling at risk of negative consequences.

Organisational Learning

Learning from Experience Group

The Learning from Experience group was established in Powys THB in spring 2021. This provides a forum for the clinical executives to discuss quality issues, and consider how the organisation can continuously learn. Experience tells us that serious issues in healthcare can in retrospect appear to cross a number of governance areas by teams unable to see the bigger picture outside their own silos. The Learning group enables us to triangulate different sources of data on quality and safety issues. Learning will then be shared and will help provide assurance and inform the strategic direction of the organisation around areas for learning on issues of quality and safety.

Examples of topics discussed
-Learning from mortality reviews
-Learning from incidents and concerns
-Triangulation of Powys practice with findings of national clinical audits
-Pharmacy

Sharing and cascading of important Learning

Following each Learning from Experience Group, a learning bulletin will summarise important learning and will be cascaded throughout Powys Teaching Health Board. Significant learning will be shared. A summary will be provided for Quality Governance Group.

The three main areas (Women and Children, Community and Mental Health) hold regular quality meetings. Important learning should be fed into the Learning Group and Quality Governance Group to facilitate organisational learning and to provide assurance.

There are many other sources of rich learning in Powys:

Local information and feedback

- Staff feedback – departmental CPD/governance meetings
- Staff surveys
- SI and concern meetings and investigation reports
- Mortality reviews
- Local and national audits
- Learning from nosocomial incidents
- Information sharing at Cluster leads, Local Medical Committee, DMT and CPD days

National and regional forums

- All Wales Medical Directors/Nurse Directors/CMO/CNO feedback
- Networks – e.g. Cancer, trauma
- Mid Wales Clinical Advisory Group
- Quality discussions with commissioned services
- HEIW

There is open discussion in these forums. This not only facilitates peer review and benchmarking but allows important shared learning both within Powys Teaching Health Board and with other Health Boards.

The Research, Innovation and Improvement Hub

The RIIH helps to share information and cascade learning. For example 'bite size' short productions are planned to deliver important information in an accessible and easily digestible manner.

Health and Care Academy

This will provide further opportunity to cascade learning and to embed our learning from events into training and practice.

Facilitating a culture of learning

We should encourage a culture of rapid cycle investigation and learning. Whilst process for investigation is important in providing structure and consistency, it should not be arduous or protracted and should not delay or prevent timely action and real time learning and ownership.

We should promote and encourage incident reporting. The Once for Wales Concerns Management system will bring new opportunities. Feedback is vital in achieving engagement with incident reporting and this should be a key goal for our leadership teams.

Most importantly we should focus on our positives.

Not only will that boost morale, wellbeing and motivation, but it will inform us of what we should be doing more of, and of practices that should be embedded and developed.

NEXT STEPS:

To develop the learning bulletin – this will be published following the next Learning from experience group.

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** ***Please provide supporting narrative for any adverse, differential or positive impact that may arise from a decision being taken***
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				Statement *Please provide supporting narrative for any risks identified that may occur if a decision is taken*
	None	Low	Moderate	High	
Clinical	x				
Financial	x				
Corporate	x				
Operational	x				
Reputational	x				

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 3.6

EXPERIENCE, QUALITY AND SAFETY COMMITTEE	**Date of Meeting: 3 June 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 19 May 2021

PURPOSE:

The purpose of this report is to provide the Experience, Quality and Safety Committee with a summary of patient experience and concerns, including complaints, serious incidents and claims for the period 1 April 2020 to 31 March 2021.

Recommendation(s):

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

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

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

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

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

DETAILED BACKGROUND AND ASSESSMENT:

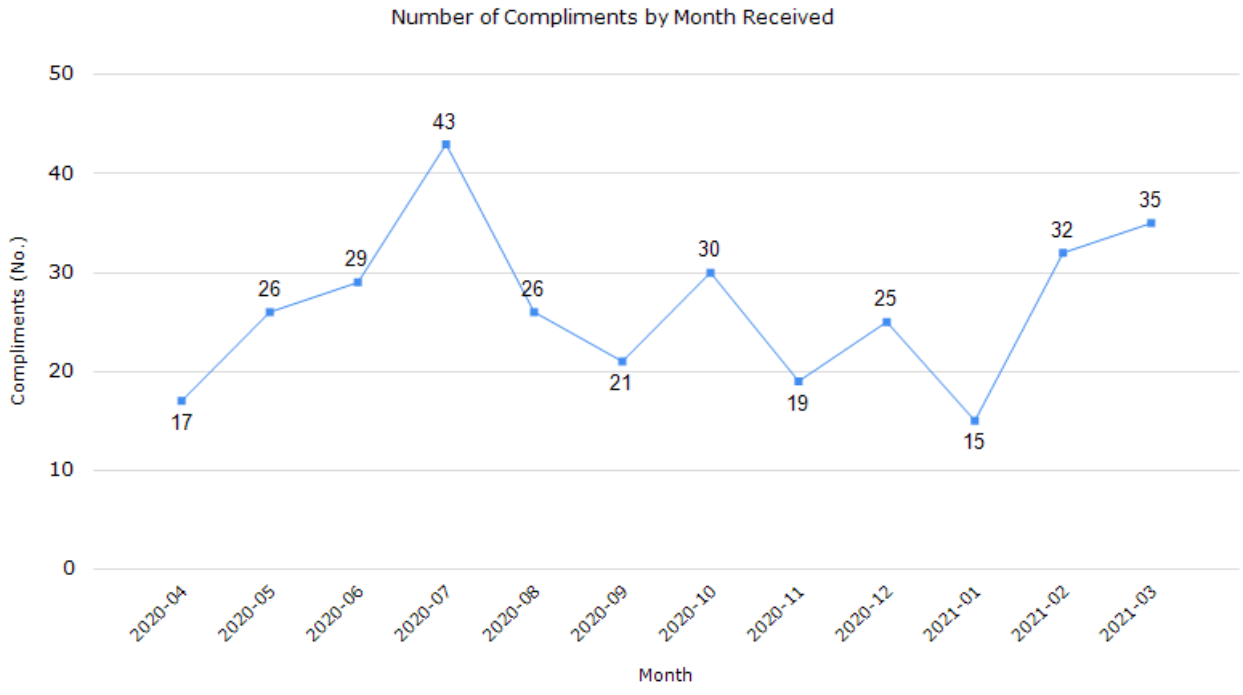
This paper provides a summary of patient experience and concerns, including complaints, patient safety incidents, including serious incidents and claims for the period 1 April 2020 to 31 March 2021. It attempts to portray an overall picture, including trends, over the last financial year to assist discussion 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, the handover of the new system having taken place 7 May 2021.

- **Compliments**

Between 01 April to 31 March 2021, a total of 318 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. In year, audiology compliments accounted for 128 of the 318 reported, this reflects their proactive activity to ensure compliments are recorded. Other specialities ranged from 1 – 50, the latter number have no speciality recorded.

Graph 1 – Total number of compliments received between 01 April 2020 to 31 March 2021



Source: Datix (PALS)

The compliments for the year 2020-2021 consist of expressions of thanks for services, care and treatment provided and small gifts. Since the last report, the examples continue to reflect the recognition of staff assisting patients in the community during the pandemic, for example,

the swift provision of replacement hearing aids, tubing, and batteries, and repair of hearing aids, describing the services as excellent, supportive, residents feeling valued and very appreciative of the prompt services provided. During March compliments for the continence service demonstrated the difference their support made to the quality of people's lives, particularly, the end of life and enabling people to be cared for at home. Mass vaccination compliments reflected the effective roll out of the programme and podiatry patients were very appreciative of the services provided.

1.2 Patient Experience

Service areas continue to report patient experience activity and at the recent Patient Experience Steering Group meeting it was agreed questions will be developed to assist services in presenting their information through the 4-quadrant approach, a reminder below, which describes a range of methods that is used to gather feedback and gain a balanced view of patient experience.

"Real Time"	**"Retrospective"**
Short surveys used to obtain views on key patient experience indicators whilst patients, carers and service users are in our care (such as in hospital) or very shortly afterwards (such as on discharge or immediately after an out-patient appointment).	Surveys post discharge or any clinical encounter in any setting to gain in depth feedback of service user experience. They can also incorporate quality of life measures and Patient Reported Outcome/Experience Measures (PROM/PREM)
"Proactive/Reactive"	**"Balancing"**
Provide opportunities for all service users/families/carers to provide feedback. Includes feedback cards, permanent and temporary online surveys and emerging methods such as text, QR codes and social media.	Concerns and complaints Compliments Clinical Incidents Patient stories Patient groups Third party surveys such as Community Health Councils and voluntary organisations

In developing our strategic approach to patient experience that is person, rather than service or organisation specific, we are focussing on what action services take in response to patient feedback, thus demonstrating improvements and changes put in place and how the patient experience has changed as a result.

A draft paper has been developed for consideration by the Executive Committee regards the Service User Feedback System, procured through the Once for Wales Concerns Management System National Team. The aim to seek support and agreement to funding the system for use within Powys to gather real time feedback from Powys residents regardless of where they access healthcare services. The paper is scheduled for the first meeting of the new Investment Benefits Group scheduled June 2021.

Putting Things Right

- **Putting Things Right Audit and Assurance Plan**

The agreed annual programme is in place and recommendations arising from implementation of the audit and assurance plan will be reported to the Experience Quality & Safety Committee, the first quarter due July 2021.

- **Putting Things Right Policy**

The policy on 'Putting Things Right' and Management of Concerns was recently reviewed to comply with Section 38 of the Public Services Ombudsman (Wales) Act 2019. In November 2020, the Public Services Ombudsman for Wales (hereafter the 'Ombudsman') wrote to Chief Executives reminding them that the Public Services Ombudsman (Wales) Act 2019 (hereafter, the 'Act') received Royal Assent in July 2019. Although the COVID-19 pandemic had limited its application during 2020, health boards and NHS Trusts were now being engaged by the Ombudsman to take forward the powers.

The Ombudsman Complaints Standard Authority, working with health boards and NHS Trusts, have focussed on complaints handling standards taking account of good practice and have introduced guidance to provide additional support to public service bodies. This is in the form of training to enhance complaints handling and guidance including:

- Complaint Handling Processes – Statement of Principles;
- Concerns and Complaints Policy for Public Services Providers in Wales; and,
- Guidance for Public Service Providers on Implementing the Concerns and Complaints Policy.

The Ombudsman also requested receipt of quarterly complaints data from public service bodies which they considered gave fresh insight into the way in which public bodies recorded and handled complaints and provided for a fresh context to their complaints data. The health board has submitted their quarter 1,2, 3 and 4 data for 2020-2021 to the Ombudsman.

Section 38 of the Act requires public bodies to reflect on their own practices and procedures, comply with the stated guidance and consider how they ensure that all complaints are captured appropriately. In accordance with the Act the health board is required to provide the Ombudsman with a copy of their complaints handling procedure within six months of the date of their request, the response due 31 May 2021. The policy review has involved looking at the materials provided through the Complaints Standards Authority and additions made to the policy reflect the Ombudsman's model policy.

The main additions include:

- Strengthening the expectations section to provide greater clarity on what complainants can expect from the health board when they raise a complaint.
- The ways in which a complainant can express their concerns.
- Accessibility and publicising the complaints process.
- When the complaints process does not apply.
- Dealing with concerns.

- Reference to the Duty of Quality, Health and Social Care (Quality and Engagement) (Wales) Act 2020.
- Strengthening the proportionate and appropriate investigation section.
- Public Services Ombudsman for Wales information.
- Resources.
- Strengthening management of cross border concerns.
- Learning from Concerns.
- Audit Programme Cycle.

A paper enclosing the reviewed policy was received by the Executive Committee on 5 May 2021, and subject to some minor changes the policy is due to be presented to the Board on the 26 May 2021.

The opportunity to look at the guidance provided by the Ombudsman has highlighted the need to provide staff with a procedure on managing complaints to ensure the procedural aspects within the current Policy are simplified and explained in more detail for our staff. The Head of the Complaints Standard Authority has agreed the health board's use of their model policy and guidance for development into a charter for the people of Powys to understand our commitment to them in listening, acting and learning from their complaints and a detailed procedure for our staff. This work has commenced and will be shared once complete.

Further review of the policy will also be required to take account of the new serious incident framework being launched 14 June 2021, as described further in this paper.

1.3.3 Learning

Opportunities continue to share lessons and promote wider learning. Most recently the quarterly newsletter of Welsh Risk Pool's learning Advisory Panel issued in May via Powys Announcements, at **appendix 1 and 1a.** This focuses on learning implemented by health bodies for 262 new redress or clinical negligence cases, across Wales. The newsletter reports an increase of 47 cases, compared to the last quarter and no cases submitted to review, related to COVID-19.

Key messages include:

- Trends – Clinical negligence cases and redress claims by type of incident
- The case of the missing drill bit
- Intrapartum Fetal Surveillance Standards and PROMPT Training
- The case of the baby's injured eye
- Cuts, grazes, scrapes and stabs
- The case of the broken glass Ampoule
- Venous Thrombo-embolism review
- The case of the inadequate prophylaxis

1.3.4. 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

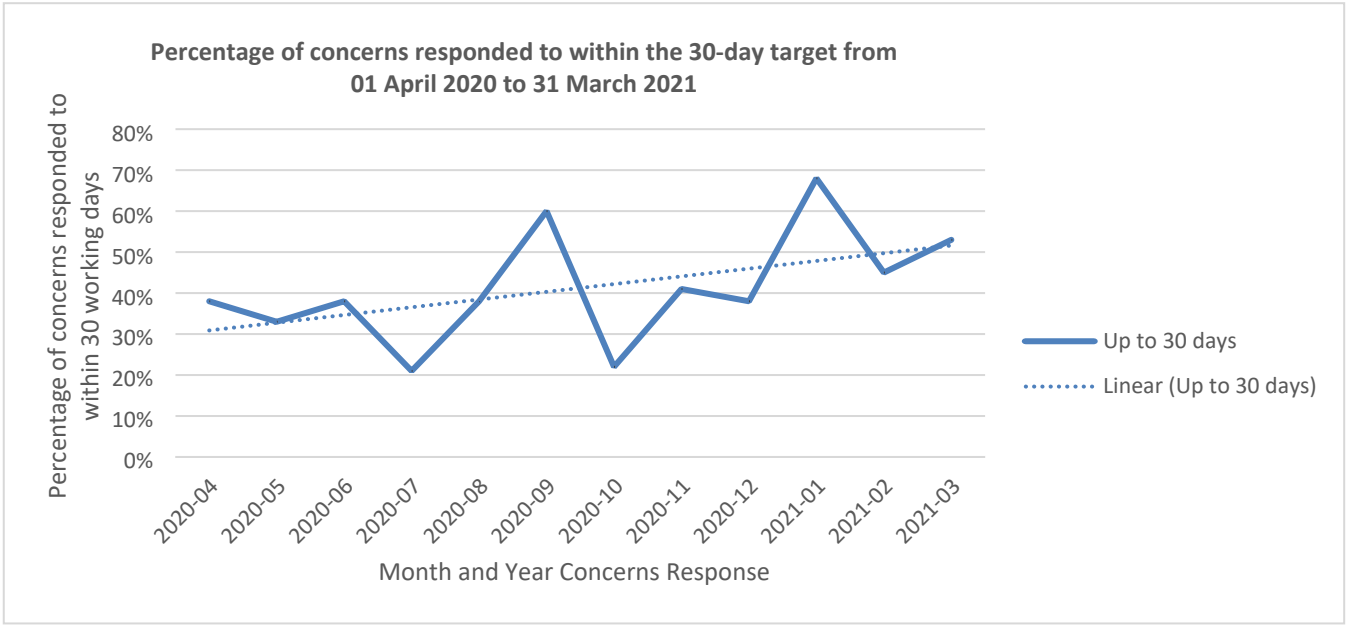
concerns, informal and formal, are required to be acknowledged within two working days. Our internal target for the acknowledgement of informal concerns is 100%. During the period of 01 April 2020 to 31 March 2021 the health board achieved 95% of this target, out of two concerns reported in May 2020, one concern was 1 day late. April 2021, 100% achieved.

During the same period 01 April 2020 to 31 March 2021, the health board achieved 90% in acknowledging formal concerns, with the months of April 20 and June 2020 and March 2021 achieving 100%. In April 2021, 96% achieved with 1/27 concerns received out of target.

The health board set an internal target of 90% of informal concerns to be responded to by the next working day. From 01 April 2021 to 31 March 2021, the health board achieved 73% successfully managed within the expected timeframe, with 75% for April 2021.

During 01 April 2020 and 31 March 2021, the health board received 218 formal concerns. The top 3 subject areas relating to access to services, attitude of staff and treatment and intervention 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.

Graph 2: Percentage of concerns responded to within the 30-working days from 01 April 2020 to 31 March 2021



Data Source: IFOR

Concerns relating to the Mass Vaccination Programme has reduced over past weeks, with an average of <5 being received each week. A total of 91 concerns recorded since January 2021 to date. Work continues with the Mass Vaccination Team, who are managing the concerns on a daily basis. Work is progressing to plot concerns by socioeconomic group, data for the year 1 April 2020 to 31 March 2021 is currently being looked at. This will be reported in future iterations of this paper.

As a result of a request made during the last Committee, work has commenced to explore the relationship of **concerns and socio-economic group** for the financial year 2020-2021. Postcodes have been identified for a total of 200 available addresses.

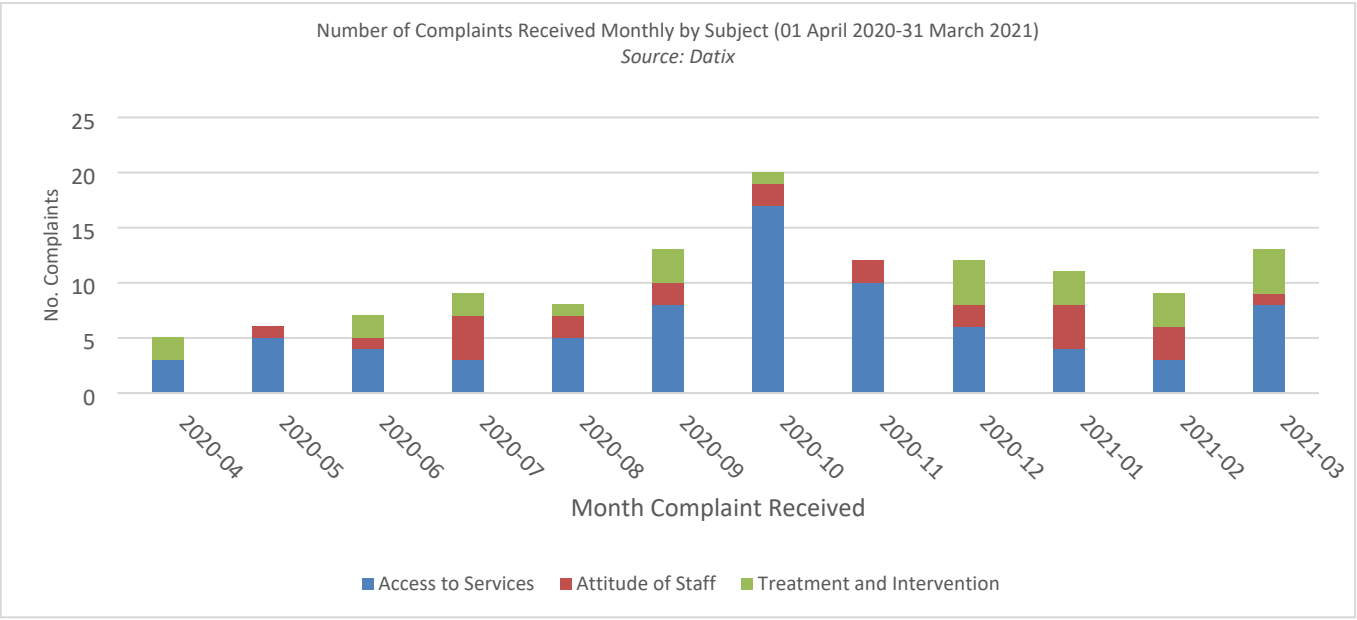
Themes and Trends since 01 April 2020

The following data, sourced via Datix for the period 01 April 2020 to 31 March 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 (n35), Community Hospitals (n23), Commissioned Services (n23), Women & Children's Services (n15) and Allied Health Professionals (n10). It is important to note that complaints for other areas are very small numbers.

The main reasons for complaints are categorised below. With access to services the main area of concern (n76) and attitude of staff (n24) and treatment and intervention (n25) attracting similar numbers of concerns. Access to services spans the range of provided services and commissioned services. Attitude of staff reflects mostly provided services with <5 related to commissioned services 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.

Learning from concerns will be reported through service group reporting.

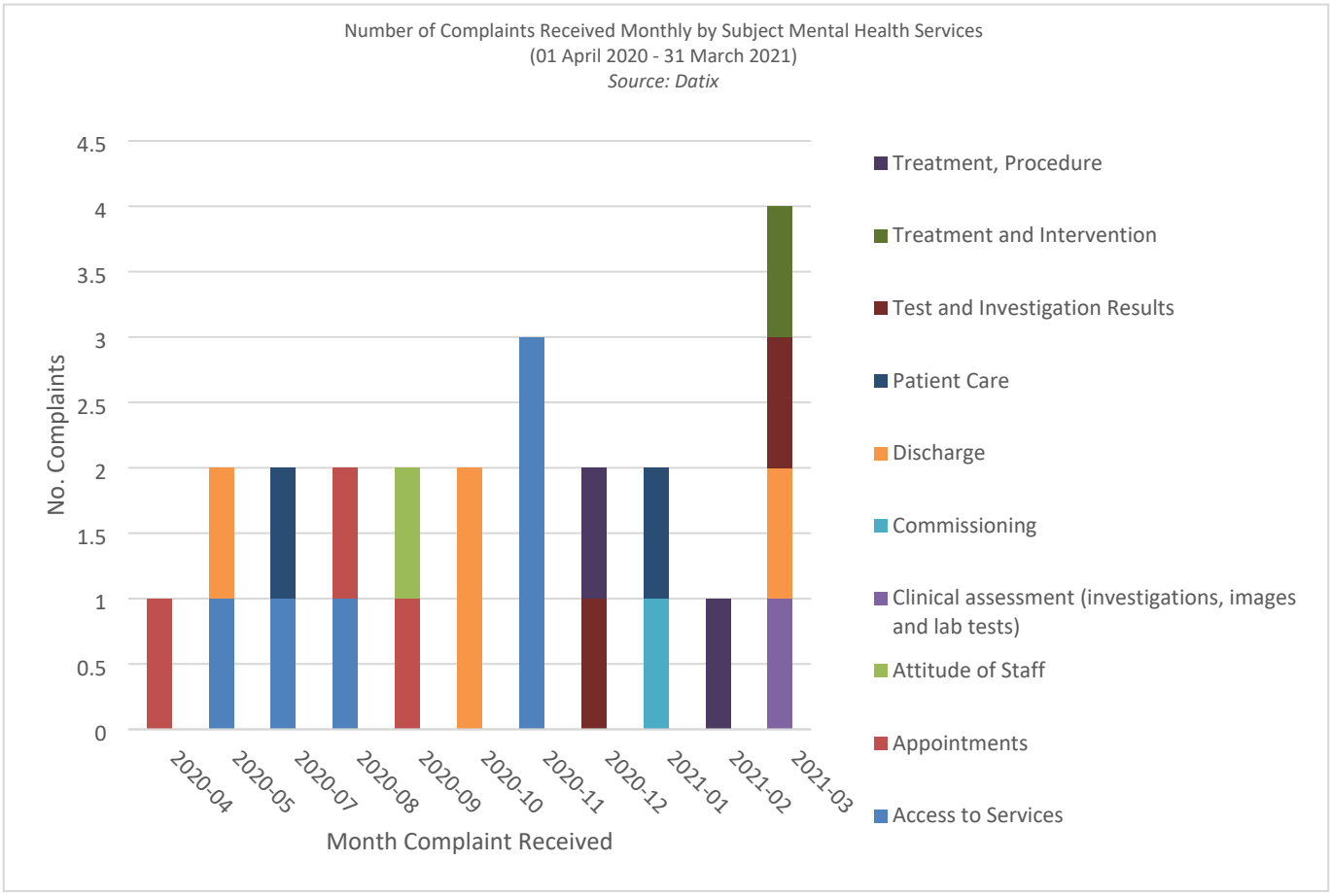
Graph 3: Number of complaints received monthly by subject (01 April 2020-31 March 2021)



- **Mental Health Services**

01 April 2020 to 31 March 2021, the table below illustrates the number and type of complaints 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.

Graph 4: Number of complaints received monthly for Mental Health Services subject (01 April 2020-31 March 2021)



Learning

Concerns are shared with team members to promote wider learning for improvement.

- Triaging and Managing the Referral Process
  Any triage system ideally has a single point of access. It is beneficial to have a consistent approach across Powys – same triage process, same outcome. We therefore need to look at research, what is done elsewhere in the United Kingdom and see what works. A successful triage system also involves having the resources in place to meet the outcome or to be able to respond flexibly.

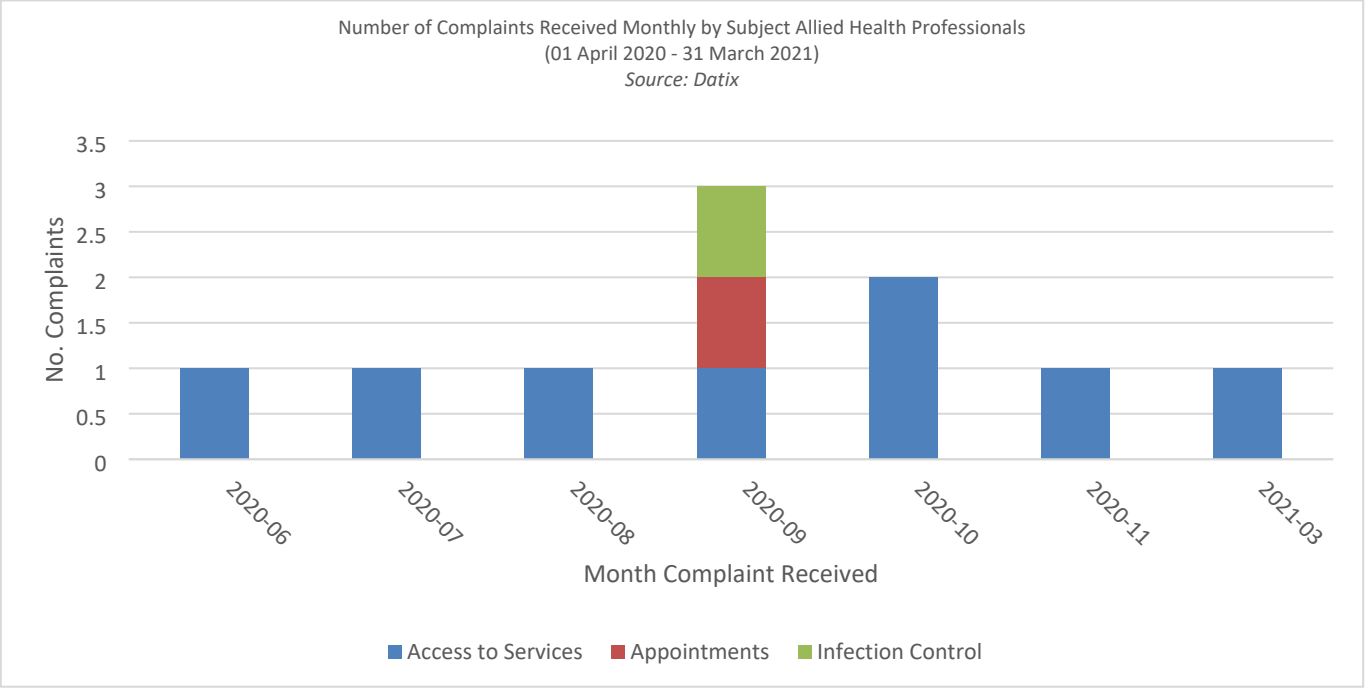
- Care and Treatment Plan Audit Work
  To add to the Care and Treatment Audit Plan the importance of the use of positive, respectful, non-judgemental language with regard to patients with dementia and to monitor the progress made on this.

- Safe Discharge
  Reflect on Discharge Arrangements for Non-Attendees
  Part 2 Discharge Letters – make clear patient rights under Part 3

- **Services provided by Allied Health Professionals**

Concerns related to services provided by allied health professionals remain less in number (n10), 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 2020-31 March 2021)



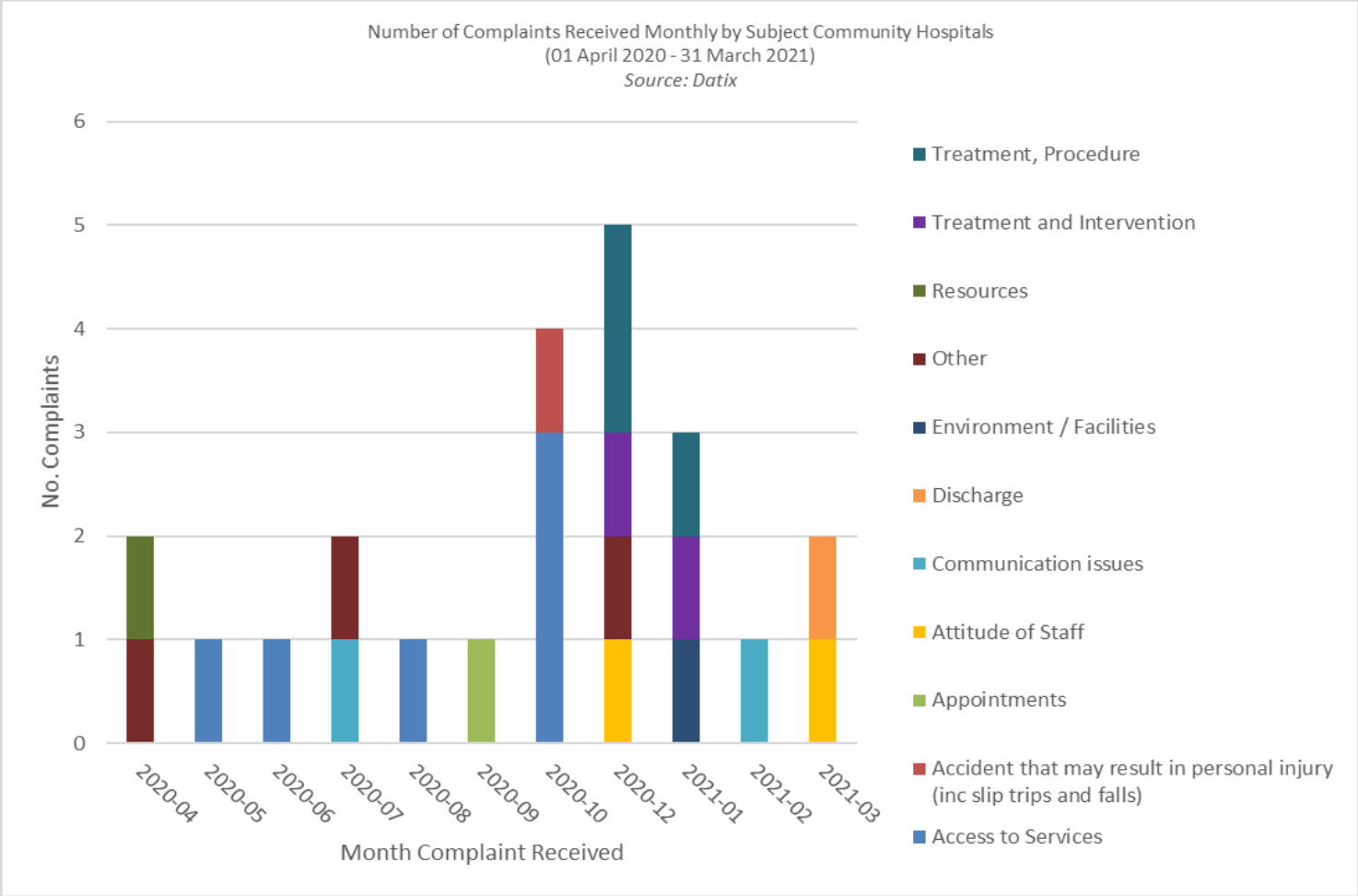
Learning

- Improve the messages to the public following discharge and the allocation of care packages.
- Strengthen linking with Social Services on what is available to share with the patients.
- Need to review the general appliance leaflet given to patients to ensure they understand the process if allocated equipment starts to rub and they can contact the relevant service.

- **Community Hospital concerns**

Concerns (n23) 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 2020-31 March 2021)



Learning Identified

- All concerns procedures are followed and a more robust concerns investigation process has been implemented, including the duty of candour to relatives/next of kin and lasting power of attorney.

- Communications have been strengthened and include monthly Ward Manager meetings and regular ward huddles where guidance and learning is shared.

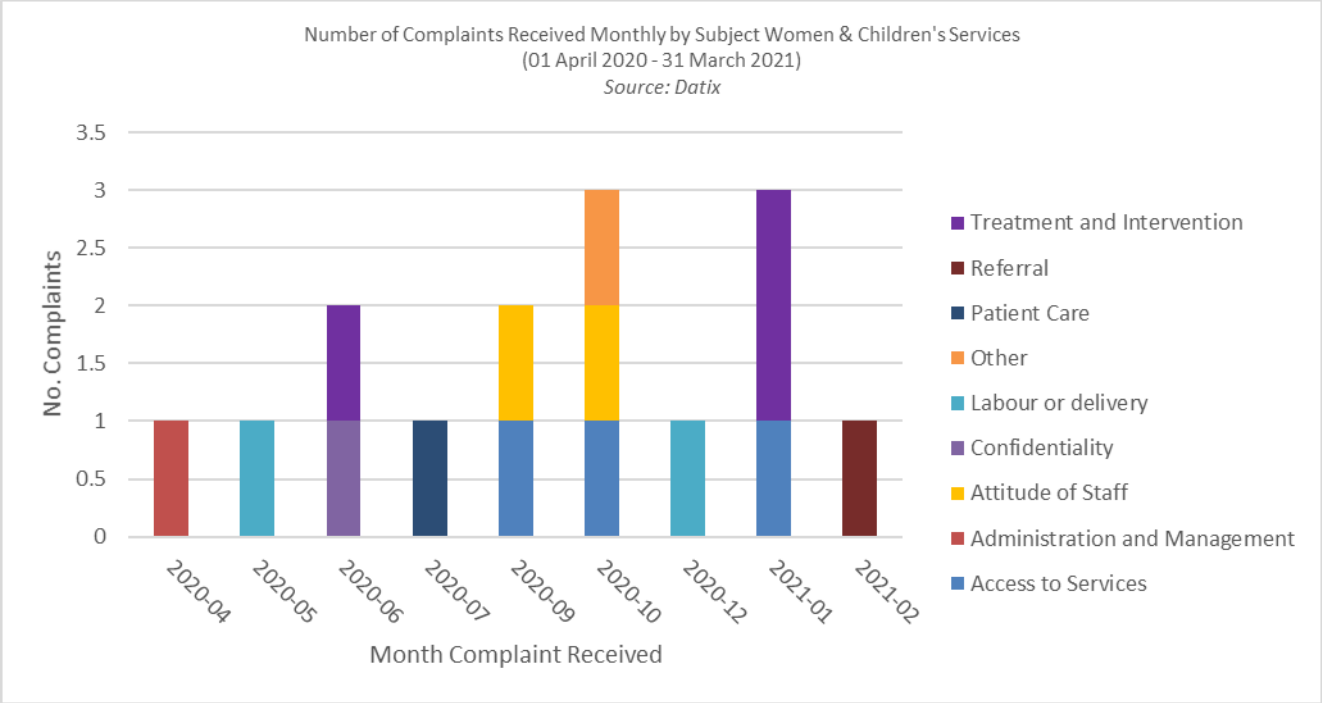
- A multidisciplinary approach is adopted where appropriate on concerns and particularly on a current case with a patient's relative. Professionals meetings are undertaken as appropriate for concerns.

- Learning from a recent District Nurse case has included support from the Community Services Manager and professionally via the Head of Nursing and a planned case review with all stakeholders including General Practitioner, Social Services and Care Agency, to ensure a robust action plan is completed.

- **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 2020-31 March 2021)



In terms of **learning and improvement**, communication was identified as an area for improvement, ensuring that information and messaging to clients is shared in a way that they understand.

- A Women & Children's shared learning template has been developed for each service to present the learning from a concern at the Women & Children's People's Experience forum. Recent examples have included improvements made by the Paediatric Speech and Language team on using virtual social platforms to cascade information and engage with families. The shared learning template from a Pelvic Health concern has also been widely shared in the Pelvic Development group, Midwifery, Health Visiting and Adult Physiotherapy teams.

- Women & Children's services have implemented the concept of women's stories at service meeting as such maternity stories are shared at monthly group supervision. The birth stories share feedback from Women and clinical incident reviews. Clinical discussions from a midwifery concern have include the need for Birth discussions paperwork to include recording of the consideration of a family situation/childcare arrangement for birth discussions.

- Women & Children's Senior leadership meeting bring shared learning examples to the monthly meeting which has also included learning from commissioning experiences for Powys Families especially children with complex needs.

- The annual Perinatal and Children learning event shared the progress of the Women & Children's Bereavement forum to ensure shared bereavement support with Powys services and the relevant specialist teams. Clinical cases were shared at the event including examples of end of life pathways for Children and their families.

- The themes from concerns are informing the Women & Children's Clinical Audit Improvement plan such as a review of a concern on delayed access to Women's Health Physio has highlighted significant increase in Women's Health Physio referrals since the changes have been made for Midwifery and Health Visiting referral form.

- A Women & Children's tracker for supporting actions has been set up to enable a focus on 2021 to ensure recommendations from serious incidents and concerns responses are progressed in the relevant services.

- **Commissioned service complaints**

The number of complaints received directly by the health board about commissioned services for the period 01 April 2020-31 March 2021 (n23) 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

Learning shared from reported concerns includes:

- Importance of accurate documentation in nursing records
- Poor discharge planning and need to ensure timely arrangements to support effective discharge and communication to family members
- Need for effective pain management post-surgery, patients recover at different rates post-operatively and it is not always possible to predict how much pain a person may be in

Informal concerns

A compliment was received from one service user with regards the management of an informal dental concern:

"Thank you so much for the below details and for getting me into a new surgery which I am really looking forward to hearing from (as much as one can from a dentist). In addition, I would like to thank you for your handling of my situation. You did it so professionally, politely, and efficiently. I could not have asked for more."

Education and Training re: Putting Things Right

The heath board have taken the opportunity to access training provided by the Complaints Standard Authority, Public Services Ombudsman for Wales. This has been delivered to staff across the health board and Practice Managers (General Practice) in primary care. Two days of training on Complaints Handling and Investigation Skills were provided on Wednesday 28th April, 19 staff participating, and Friday 30th April 2021, 20 staff participating. The days were interactive, very well received and prompted discussion and questions.

The new system under the Once for Wales Content Management System was released to the health board 7 May 2021, its implementation delayed due to issues at National level. A training programme has been put in place ensuring training is available to staff for a two-week period prior to going 'live' and a rolling programme of training thereafter with drop in surgeries for any issues twice weekly.

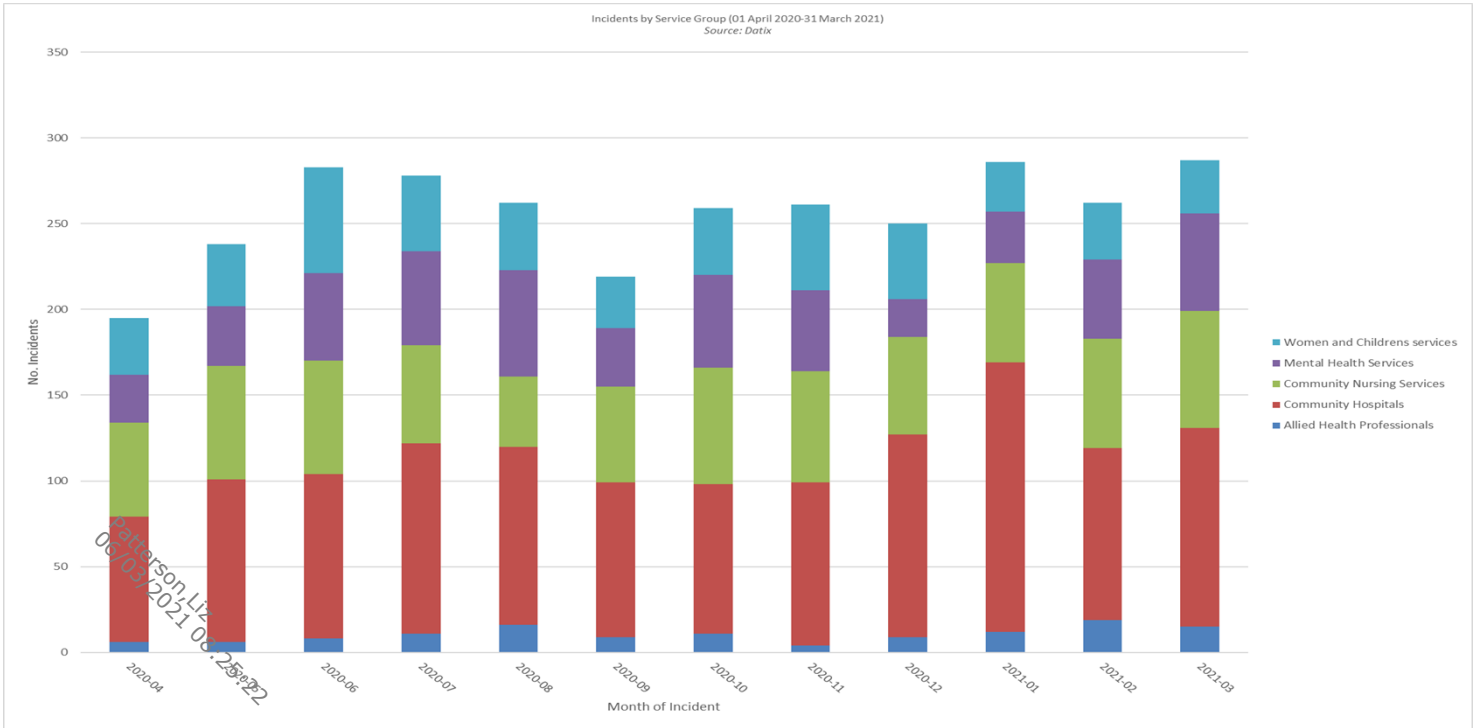
2. Incident Reporting

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

The following graph shows the incidents reported (n3080) by the main service groups (graph 11) for the period 01 April 2020-31 March 2021, with Community Hospitals (n1242), Community Nursing Services (n721), Mental Health Services (n521), Women & Children's Services (n470) and Allied Health Professionals (n126) displayed.

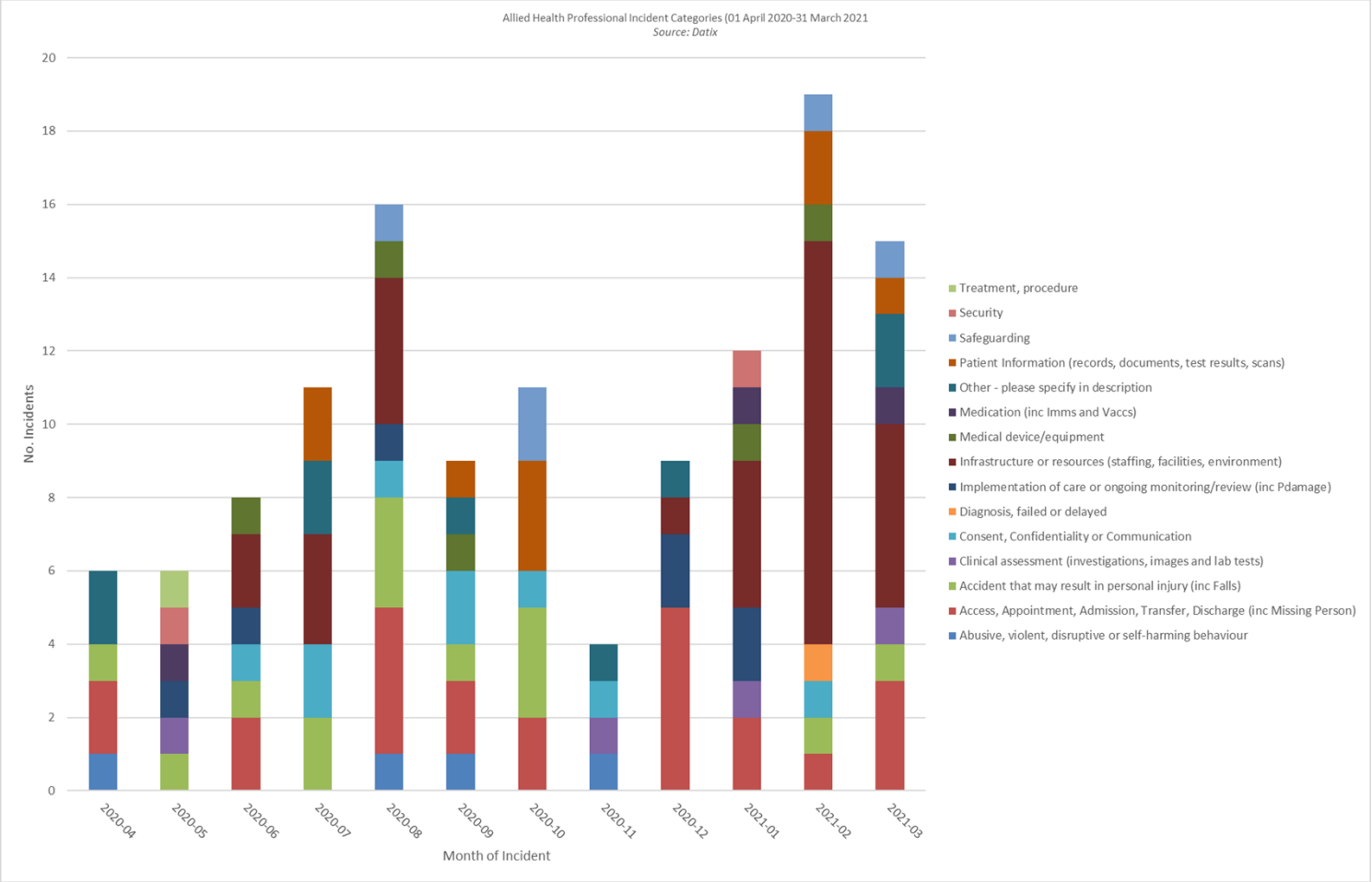
Graph 8: Incidents reported by Service Group 01 April 2020-31 March 2021



2.2 Services provided by Allied Health Professionals

The reported incidents (n126) related to services provided by Allied Health Professionals covers a wide range of services. The main categories remain the same as previously reported, relating to the infrastructure and resources (n30) (staffing, facilities and environment) and access, appointment and admission (n23).

Graph 9: Allied Health Professionals Incident Categories 01 April 2020 – 31 March 2021



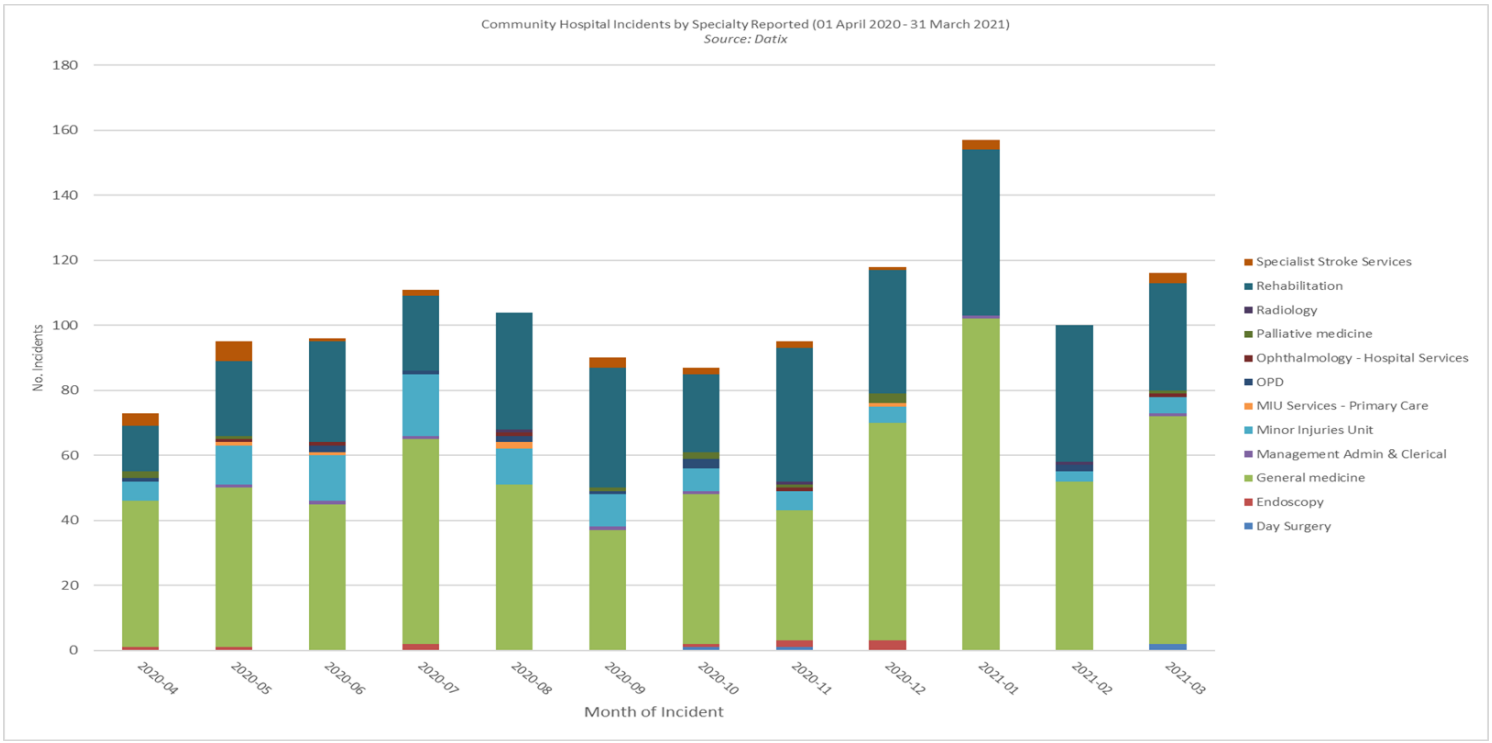
The lessons below reflect examples throughout the last year to date:

- Staff to continue to escalate any concerns regarding the use of Personal Protective Equipment (PPE). Reiteration of importance of wearing PPE.
- Better tracking of specialist equipment needed when moving across sites for storage.
- Better communication with other departments when generator testing taking place. Staff walk around the site to notify all departments, including critical areas and X-ray both before and after testing.
- Poor discharge highlighted to the discharge coordinator.
- Support given to staff prior to completion of the Multiagency Referral Form via the phone.
- Liaison with dietetics team in District General Hospital with the aim of improving discharge and handover to prevent delayed discharges.
- Ensure that letters sent out are proof read thoroughly before dispatch.

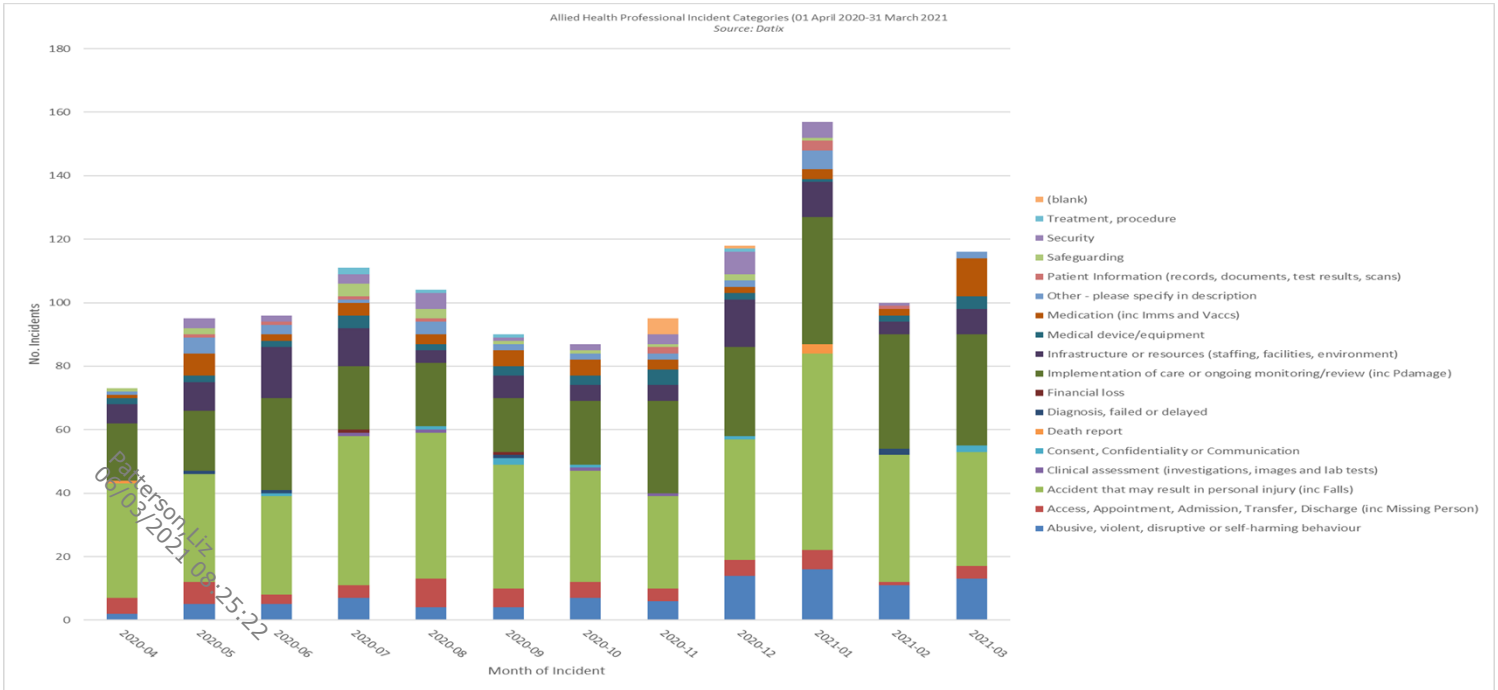
2.3 Community Hospital

Incidents (n1242) covers a range of areas, some allied health professional incidents included. The categories reported span clinical and non-clinical activities. The highest categories remain the same as previously reported, including abuse, violent disruptive behaviour (n94), access, appointments, admissions, transfer, discharge (n59), accident that may result in personal injury (including falls) (N 473), implementation of care or ongoing monitoring/ review (including pressure damage) (n311) and Infrastructure or resources (including staffing, facilities, environment) (n102).

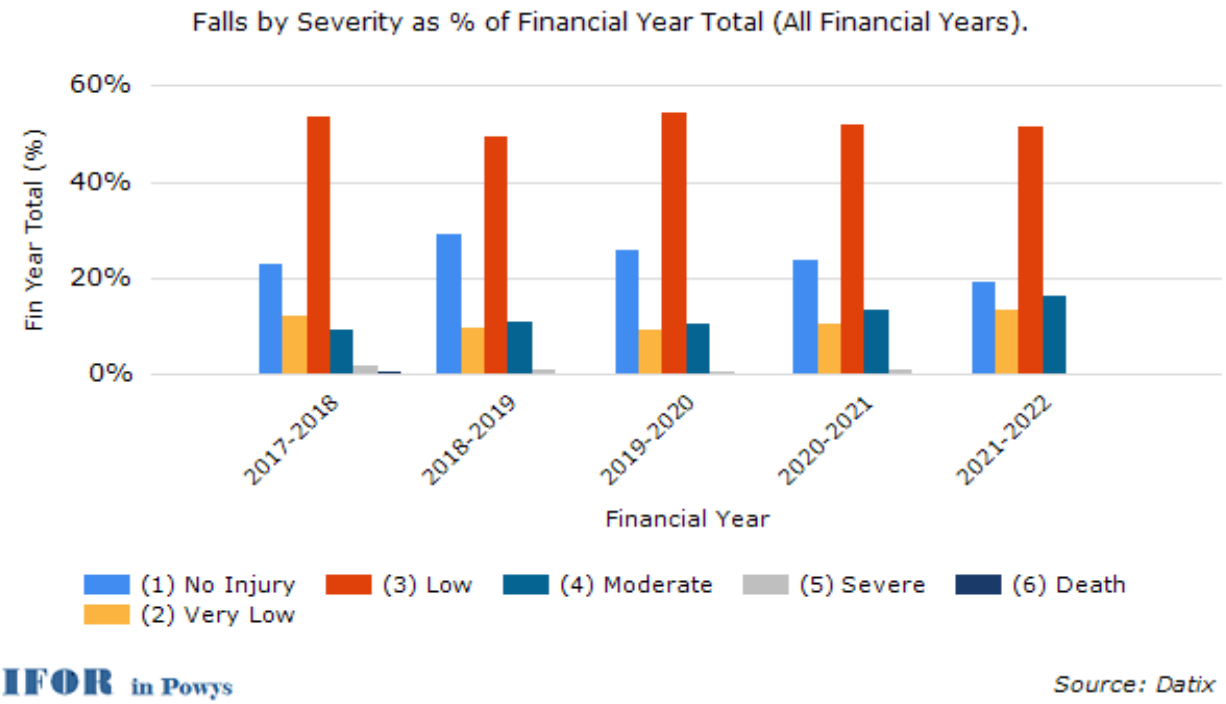
Graph 10: Community Hospital Incidents reported 01 April 2020 – 31 March 2021



Graph 11: Community Hospital Incident Categories 01 April 2020 – 31 March 2021



Since 2017 to date, the data shows the majority of falls result in no injury and low harm, the latter indicating no injury, although occasionally a small abrasion or bruising noted.



IFOR in Powys

Source: Datix

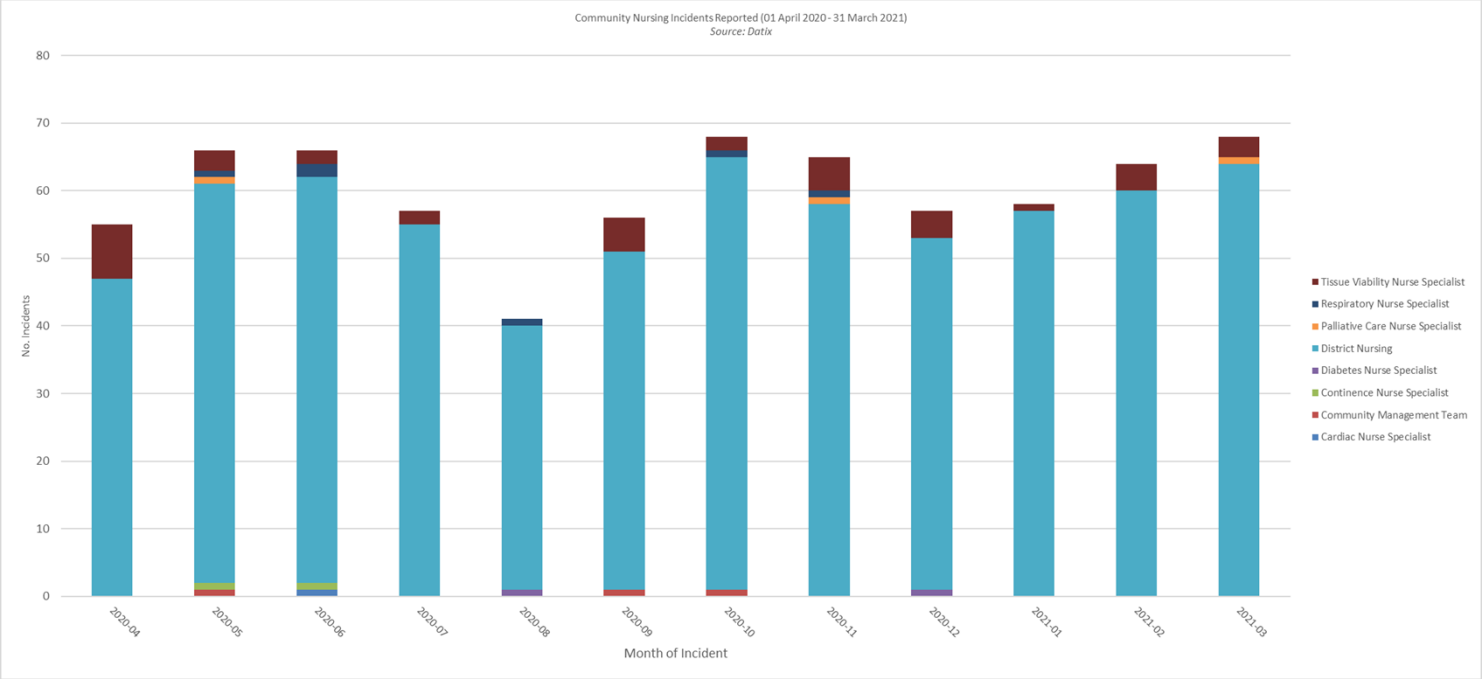
The lessons below reflect examples reported in year:

- Continue to follow policy and procedure and seek advice/review when needed.
- Staff to continue to assess all patient for risk of falls and commence care plan to mitigate against risk. To ensure that patients receive the right level of care for their needs and are nursed in high visibility bays if possible.
- Staff to continue to consider the impact of cognitive impairment when supporting patients will all Activities of Daily Living.
- To continue to work with the Care Transfer Coordinator/Welsh Ambulance Services NHS Trust and ward team to ensure patients are transferred safely who are likely to be COVID positive.
- Continue to monitor and rule out infection when there are changes in behaviour.
- Staff to continue to assess all patients skin condition on admission.
- Staff to ensure weight is reviewed when updating care plan. Staff to ensure patient is referred to dietician if there is significant weight loss.
- Staff to be reminded of the importance of contacting family re: pressure damage or documenting rationale if this is not done.

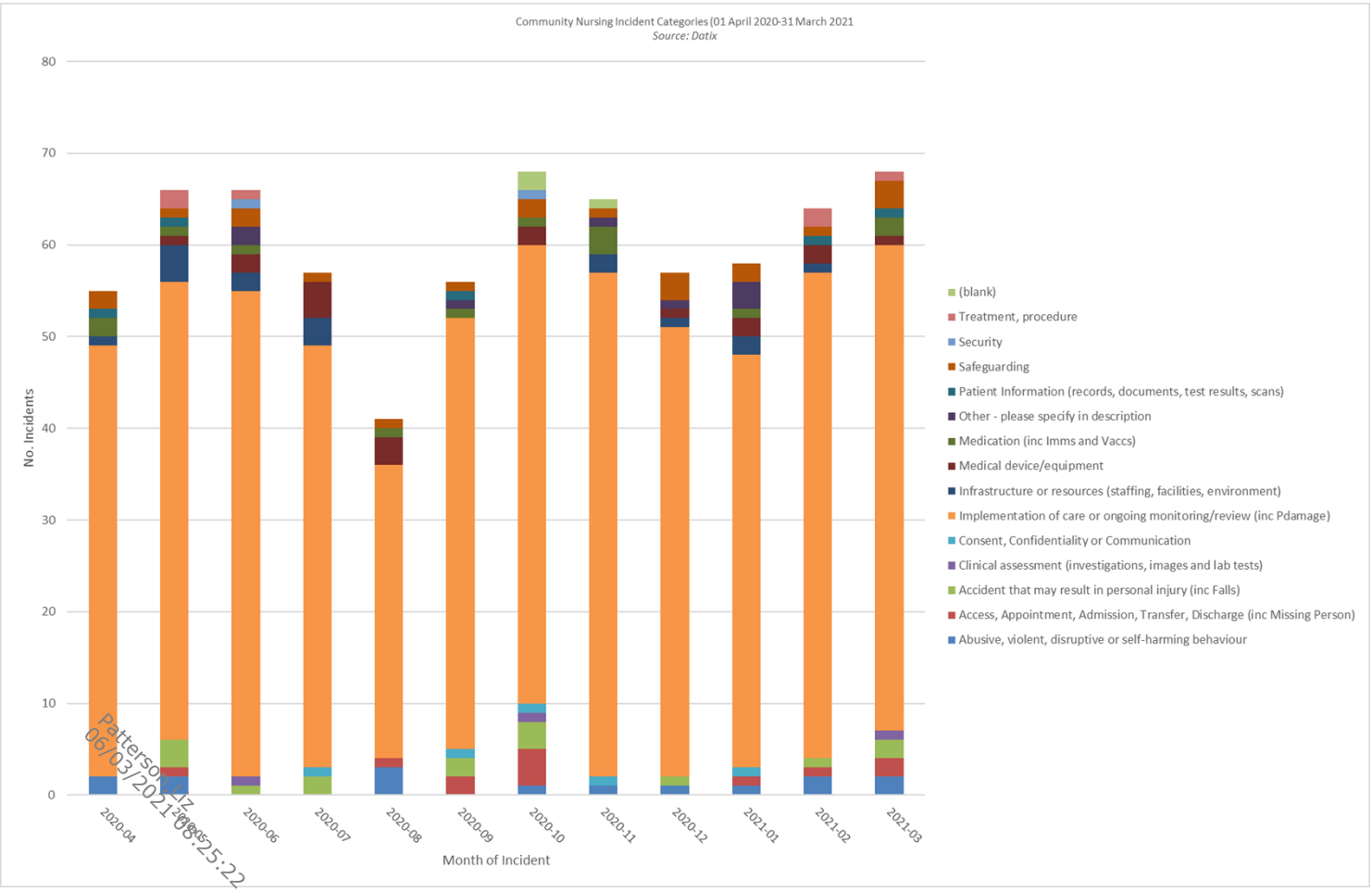
2.4 Community Nursing

Incidents reported cover nurse specialities and district nursing (n721). The highest number of incident types reported are implementation of care or ongoing monitoring/ review (including pressure damage) (n580), of which 314 are pressure damage are reported pressure damage, various grading.

Graph 12: Community Nursing Incidents reported 01 April 2020 – 31 March 2021



Graph 13: Community Nursing Incident Categories 01 April 2020 – 31 March 2021



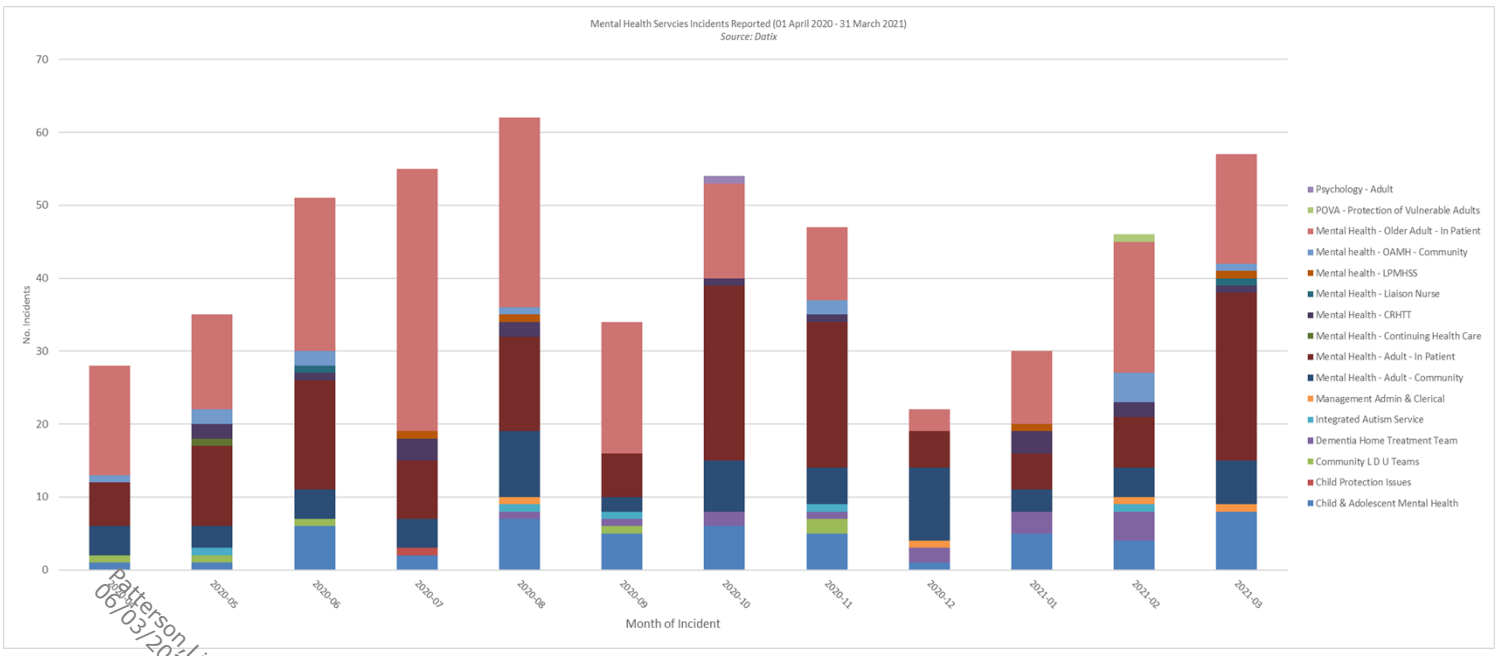
The lessons below reflect examples reported in year:

- Continue minimum 3 monthly review of pressure areas or more frequent based on clinical judgement.
- Importance of maintaining standards of documentation.
- Patient autonomy prevents best practice. Documentation needs to be accurate and contemporaneous.
- Always follow the training on violence and aggression and adhere to it.
- Always be aware of venerable patients and the procedure to follow to report concerns.
- Importance of effective communication between care settings.
- Awareness of risk of needle stick injury when performing venepuncture and measures to take to minimise risk.
- The need to be clear and concise with what is the ask of relatives and confirms their understanding. Consideration by professional of what is expected of relatives and confirmation that this is understood and agreed to.
- To prevent loss of equipment, staff, use a plastic box to carry equipment into houses during pandemic rather than loosely carrying equipment.

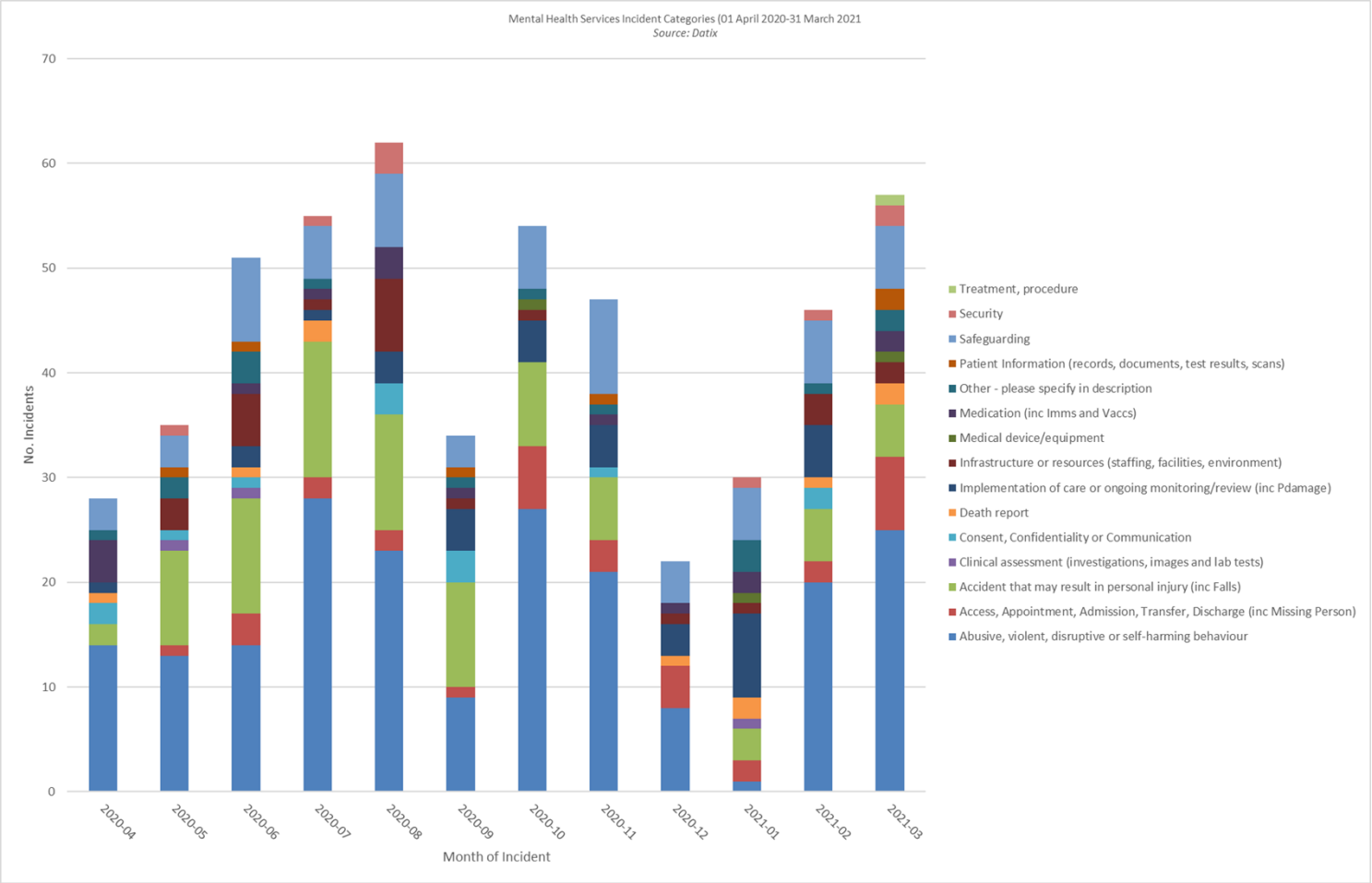
2.5 Mental Health Services

Incidents are representative of a range of mental health services, the majority of incidents reported in Mental Health – Older Adult Inpatient (n198), Mental Health – Adult Inpatient (n143), Mental Health – Adult Community (n61) and Child & Adolescent Mental Health (n51). The main incident categories as previously reported being abusive, violent, disruptive or self-harming behaviour (n203), accident that may result in personal injury (including falls) (n83) and safeguarding (n65).

Graph 14: Mental Health Service Incidents reported 01 April 2020 – 31 March 2021



Graph 15: Mental Health Services Incident Categories 01 April 2020 – 31 March 2021



The lessons below reflect examples reported in year:

- Vigilance re. patient moods and behaviours and make themselves and everyone safe.
- Staff need to remember to keep themselves safe at all interventions.
- staff to be more aware of patient moving at night and possibly utilise falls alarm.
- The importance of staff using the translation service for patients.
- Consider patients' physical health as they deteriorate mentally.
- Any admissions/ transfers from the general hospitals should have a telephone conversation between Consultants to agree the transfer is appropriate for the patients' needs.
- Staff to be aware of the need of reviewing observation levels on a daily basis and to use appropriate interventions early enough.
- Importance of reporting safeguarding concerns.
- Staff are aware of the need to closely observe all patients even if they are not subject to 1:1 observation.
- Staff to ensure that all unnecessary equipment is stored away and risk assess the ones being required to stay in view.

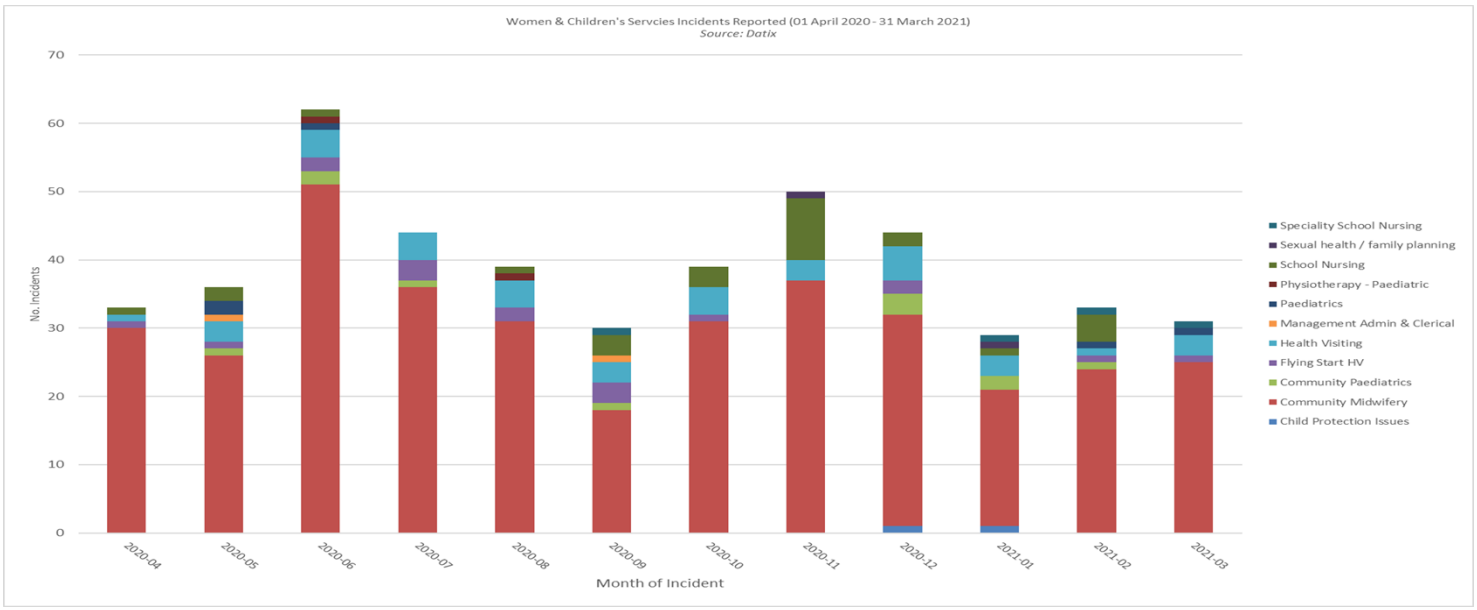
2.6 Women and Children's Services

Incidents are focussed as per previous report more in Community Midwifery (n360) reflecting the service model in place, with Health Visiting (n38) and School Nursing (n27) the next two

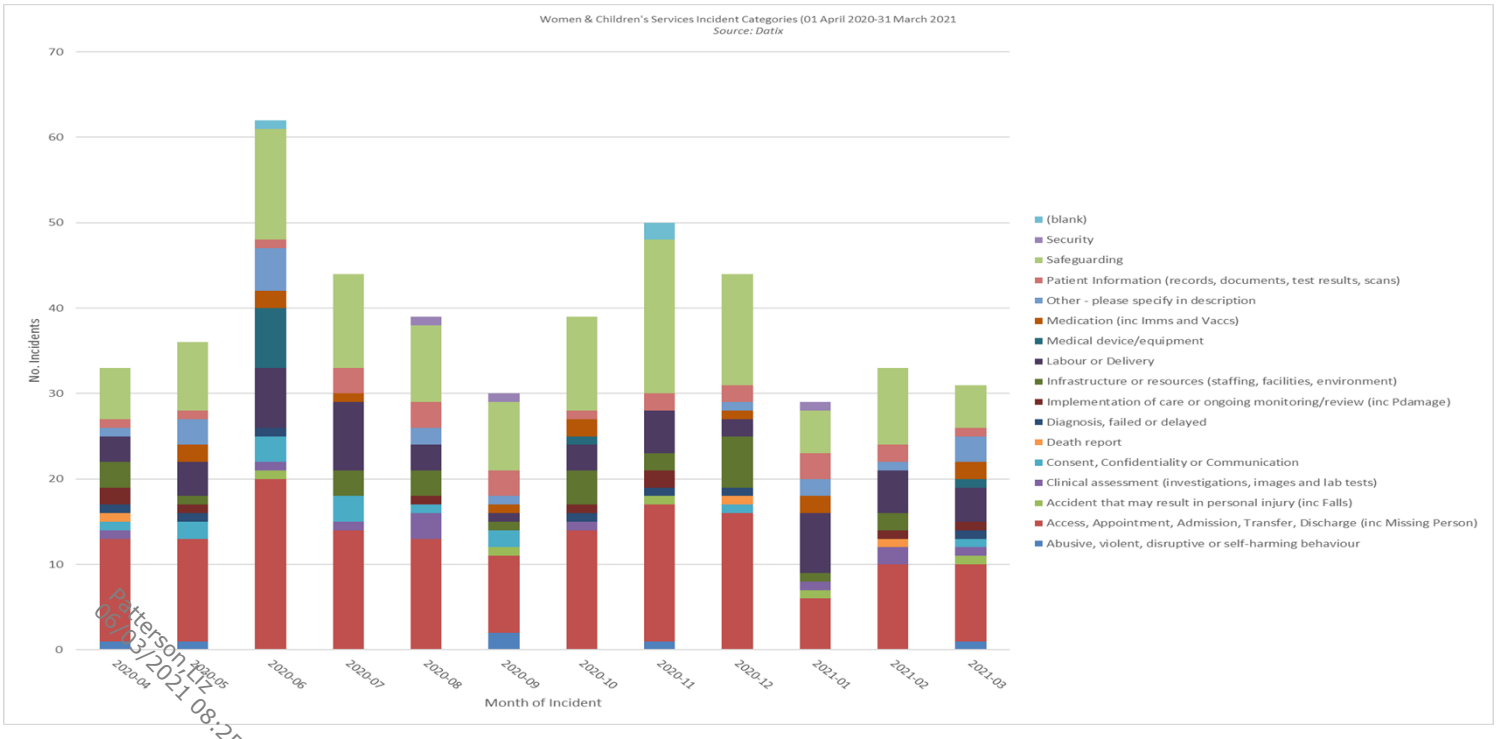
main areas of reporting. The main types of categories reported are Access, Appointment, Admission, Transfer, Discharge (n151), safeguarding (n116), labour / delivery (n52), infrastructure or resources (staffing, facilities, environment) (n26) and Patient Information (records, documents, test results, scans) (n23).

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 – 31 March 2021



Graph 17: Women & Children's Services Incident Categories 01 April 2020 – 31 March 2021



The lessons below reflect examples reported in year:

- Information shared with District General Hospital who has reported to the consultant obstetrician importance of maintaining records to provide effective care.
- To ensure that named midwife informs health board sonographers when a woman has sadly had a miscarriage.
- Personal Protective Equipment needs to be available for all staff participating in training situations where close contact is required.
- Staff members must raise concerns should they feel their health and wellbeing is at risk.
- A temperature of 38°C or more is abnormal and the cause should be evaluated (emergency action). A full assessment, including physical examination, should be undertaken (NICE Guidance). All midwives aware to transfer baby directly to District General Hospital paediatrician for review.
- To ensure routine enquiry is completed by midwives.
- The importance of communication and ensuring that the information shared is correct.

3. 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 period of 01 April 2020 to 31 March 2021 the health board reported 35 serious incidents to Welsh Government/ Delivery Unit. As previously identified related to slips, trips and falls, unexpected death, reaction to medication, discharge, test results and infection control.

- **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 April 2020 to 31 March 2021, the health board have reported 21 to Welsh Government. These included for example issues related to diagnosis, communication, acting on test results and referral processes.

A new national NHS Wales serious incident framework is being launched 14 June 2021, a workshop preceding this held 20 May 2021. Historical systems for reporting 'serious incidents' will now be replaced by a more holistic approach to incident reporting. Consisting of two phases, phase 1 will relate to the reporting of individual incidents which have occurred during NHS funded healthcare and tend to result in significantly harmful outcomes. Policy guidance and supporting documents to enable organisations to prepare for policy go-live on 14 June 2021 will be issued the 7 June 2021.

Phase 2 is to instigate a shift from national reporting of individual incidents, to thematic reporting of certain incident types. A workshop is being held 5 July to start looking at the assessment for Phase 2. The next few months will see this work begin and the aim to be fully in place by April 2022.

The main changes to the policy and process are:

- Phase 1 primarily relates to individual reporting of incidents mainly linked to harmful outcomes.
- Greater local accountability for deciding what needs to be reported using guiding principles and definitions.
- Greater emphasis on proportionate investigations, linking with Medical Examiners and mortality reviews where applicable.
- A new more concise list of incidents that need to be reported on an individual basis.
- Standing back up the pre-existing pressure damage reporting process.
- A new process for retrospectively reporting unexpected deaths in the community of patients known to Mental Health and Learning Disabilities Services.
- Nationally report within 7 working days.
- At the point of notification, suggest identifying anticipated investigation timescales – 60, 90, 120 days and what kind of proportionate investigation is intended.
- Change to the closure process with accountability for these sitting with Health Boards/Trusts.
- Learning outcomes will be reported to the Delivery Unit for collation of national learning, identification and management of risk.
- Learning from Events reports will be used aligning with existing processes used by the Welsh Risk Pool Services to learn from redress and compensation claims.

The new framework is being shared with staff across the health board to ensure they are sighted and engaged in the developing work and changes put in place.

- **Inquests**

During the period of 01 April 2020 to 31 March 2021 there have been 15 HM Coroner Enquiries opened, the majority relating to mental health services. No lessons to share from inquests held to date.

4. 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 April 2020 to 31 March 2021, the health board have received 7 PSOW enquiries, and responded to 7 of the recommendations made by the PSOW, with a further 8 enquiries notified by the PSOW that are not being investigated.

The agreement with the PSOW to extend the timescale to finalise an outstanding Standard Operating Procedure due to the complexity involved, remains extant. In learning from concerns reported to the Ombudsman, the health board is finalising a medical pathway for women accessing maternity services whose care spans both midwifery-led services and Consultant-led care.

5. Claims

Powys Teaching Health Board has a small claims portfolio; there are currently 15 open which are inclusive of clinical negligence and personal injury claims. 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.

6. Patient Safety Solutions

Performance for all Health Boards and Trust in Wales can be found at **http://www.patientsafety.wales.nhs.uk/safety-solutions-compliance-data** Compliance with one overdue 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, will be reported in Quarter 1 2021/22.

One new notice has been received:

PSA012 / April 2021 Deterioration due to rapid offload of pleural effusion fluid from chest drains – to be completed by 1 July 2021

Doctrina

Doctrina meaning learning
Edition 2
Spring 2021

The quarterly newsletter of the Welsh Risk Pool's Learning Advisory Panel (LAP)

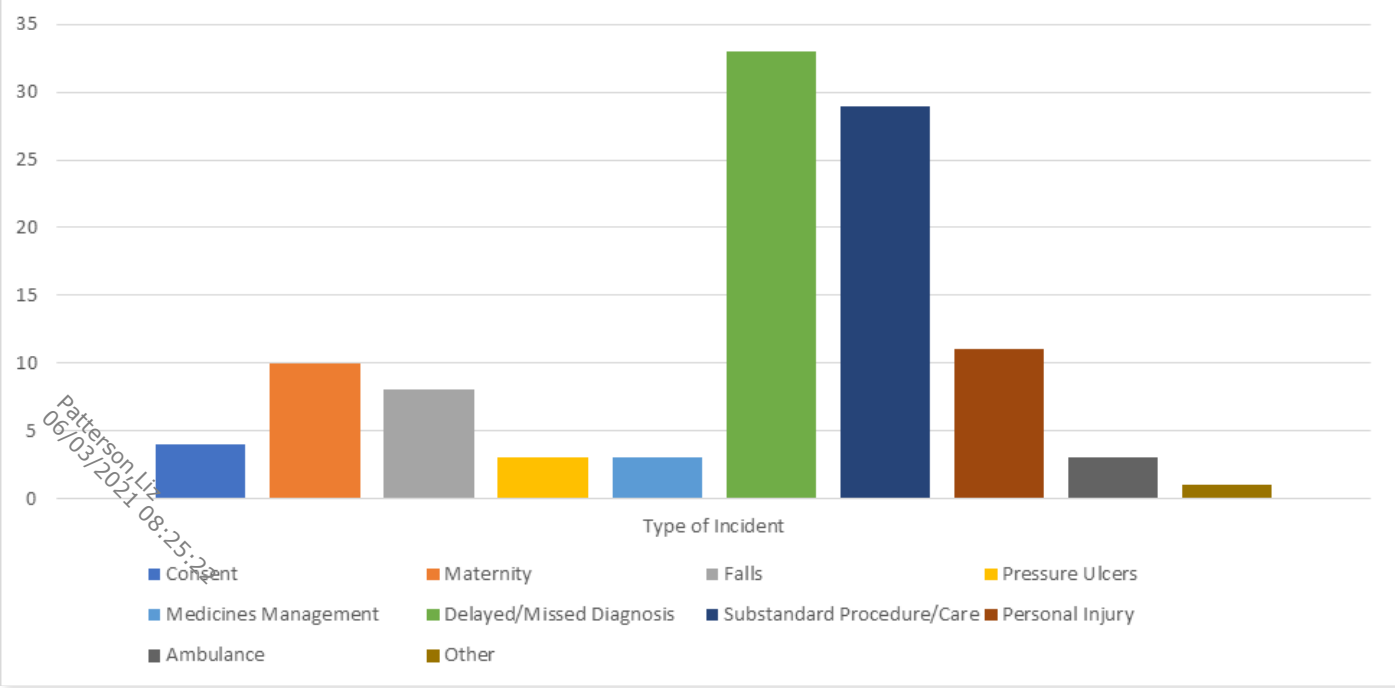
Trends

During the last quarter, the LAP has reviewed the learning implemented by health bodies, for 262 new redress or clinical negligence cases, across Wales. This is an increase of 47 cases, compared to the last quarter. We have not yet had any cases submitted to review, which are related to COVID-19.

The last year has been unprecedented, yet the teams across Wales have continued to submit the learning required by the Welsh Risk Pool, which is a demonstration of the considerable amount of hard work which they have done and continue to do.

The graph below, gives a summary of the type of incident and learning which has been reviewed by the LAP this quarter. As expected and consistent with previous quarters, the largest number of cases are related to missed or delayed diagnoses. The number of cases related to falls or pressure ulcers remains low, which reflects the considerable amount of work which health bodies have done in relation to these topics.

A Graph To Show The Percentage Of Clinical Negligence And Redress Claims Reviewed By The Learning Advisory Panel For The Quarter To April 2021:



The Case of the Missing Drill Bit

A 15-year-old female was the victim of a serious assault, during which, she suffered a fracture jaw which required surgical repair.

The surgery was successful and she initially made a good recovery post-operatively, however, x-rays undertaken in the following weeks identified a fragment of the surgical drill bit, within her jaw. It was in a location where it would not be easily retrievable and so the decision was made to leave it in situ due to the risk of damaging other vital structures.

Five years later, she suffered from an infected molar tooth which required extraction. During extraction of the tooth, the surgeon was able to visualise the drill bit fragment and thus removed it.

This incident demonstrates a failure of checking procedures within theatre. The health body in question have revised their policy for checking consumables pre, during and post operatively and reinforced the procedure with staff. Drill bits are now single use and checked after each procedure as part of the theatre checking procedures.

This case highlights the importance of the correct completion of theatre checklists.

Intrapartum Fetal Surveillance Standards and PROMPT Training

PROMPT (PRactical Obstetric Multi-Professional Training) Wales training has been mandated in NHS Wales maternity services since 2019 with most maternity units running training monthly. Evidence demonstrates improvements in safety and clinical outcomes and associated litigation when all maternity staff participate in training. Health Boards agreed to the standard of over 95% compliance for midwives, obstetric doctors and obstetric anaesthetists annually. Training was paused from late March 2020 due to COVID-19 but resumed with a COVID-secure programme from September. Whilst recognising the challenges of providing PROMPT training in the current situation, the WRP will be measuring compliance against the PROMPT Wales Standards on 31/8/21.

The All Wales Intrapartum Fetal Surveillance Standards (2018) stipulates that all professionals providing intrapartum care attend six hours of teaching annually. Given the evidence that inappropriate fetal heart monitoring contributes to poor outcomes and associated litigation, the WRP would expect compliance for this training to be 95%, as for the PROMPT training.

The Case of the Baby's Injured Eye

A 31-year-old female was in her first pregnancy and under consultant led care. A plan had been made for induction of labour when gestation was 40+3 weeks. She was admitted to the Labour Ward for the artificial rupture of membranes and commencement of a Syntocinon infusion.

Early the following morning, she was assessed as being fully dilated and active pushing commenced. After two hours of unproductive pushing, she was reviewed by a registrar and a plan made for trial of forceps in theatre. The baby was noted as being caput (swelling of the scalp caused by prolonged pressure during delivery).

Forceps were applied and a live male infant was born shortly thereafter. He was noted as having forceps marks to his forehead and behind his right ear. It was later identified that he had suffered a scratch to his right cornea due to incorrect placement of the forceps as his head had not been rotated into the correct position. The extent of any long-term harm to his eye is still under consideration.

As a result of this case, the operative delivery proforma was amended to include a section on head rotation and an area for comments to ensure appropriate recording of instrumental deliveries.

Cuts, Grazes, Scrapes and Stabs

We continue to see a steady flow of cases where staff have injured themselves on sharp objects like needles or glass ampoules or blunt objects like doors or chairs. We cannot stress enough, the need to follow training and procedures when dealing with sharp objects and to use equipment appropriate for the task, in order to reduce the risk of personal injury or harm.

The Case of the Broken Glass Ampoule

A senior nurse was removing the top from a medication glass ampoule without the use of a rubber snapper. The jagged edge of the bottom of the ampoule, lacerated her right index finger and she sustained a tendon injury which required surgical correction. The injury took twelve weeks to heal.

It was unclear whether the individual had been shown how to correctly open an ampoule with a rubber snapper.

As a result of this case, the health body have ensured that rubber snappers have been added to procurement and audit forms, for all wards. New training has been implemented and feedback from the case shared with staff.

Venous Thrombo-embolism Review

The LAP has identified an increase in the number of clinical negligence and redress cases relating to venous thrombo-embolisms (VTE) in hospitalised patients. Given that all acutely unwell patients are at a higher risk of developing a VTE, there is concern that due to the high number of hospital admissions of patients acutely unwell with Covid-19, there will be increasing numbers of VTE related cases presenting to the Panel This concern has been reinforced by data submitted to Welsh Government on the Hospital Acquired Thrombosis (HAT), quarterly returns.

The Welsh Risk Pool Safety and Learning Team will be undertaking a review of Health Board VTE policies together with their clinical application. In particular, this will focus on the completion and type of risk assessment on admission, together with the provision of prophylaxis.

The Case of the Inadequate Prophylaxis

A 45-year-old female presented to the Minor Injury Unit having injured her ankle whilst surfing. She had a medical history of pulmonary embolism and a deep vein thrombosis (DVT).

X-rays confirmed the presence of a fractured lateral malleolus. A below the knee non-weightbearing cast was applied and she was discharged home with Aspirin. Three weeks later, she was diagnosed with a DVT and is now on long-term anticoagulation therapy.

It was concluded that there was a failure to act on her long-term medical history and that LWMH (Low Weight Molecular Heparin) should have been prescribed prophylactically. If it had, on balance, she would not have suffered from the DVT.

As a consequence of this case, staff were reminded of the local thromboprophylaxis policy and the use of risk assessments and care plans is being monitored and audited.

Contact us

If you have any questions about the Learning Advisory Panel or would like to participate in one, please contact the Safety and Learning Team via email at welsh.riskpool@wales.nhs.uk.

Doctrina

Doctrina sy'n golygu dysgu
Rhyfin 2
Gwanwyn 2021

Cylchlythyr chwarterol Panel Cynghori ar Ddysgu (y Panel) Cronfa Risg Cymru

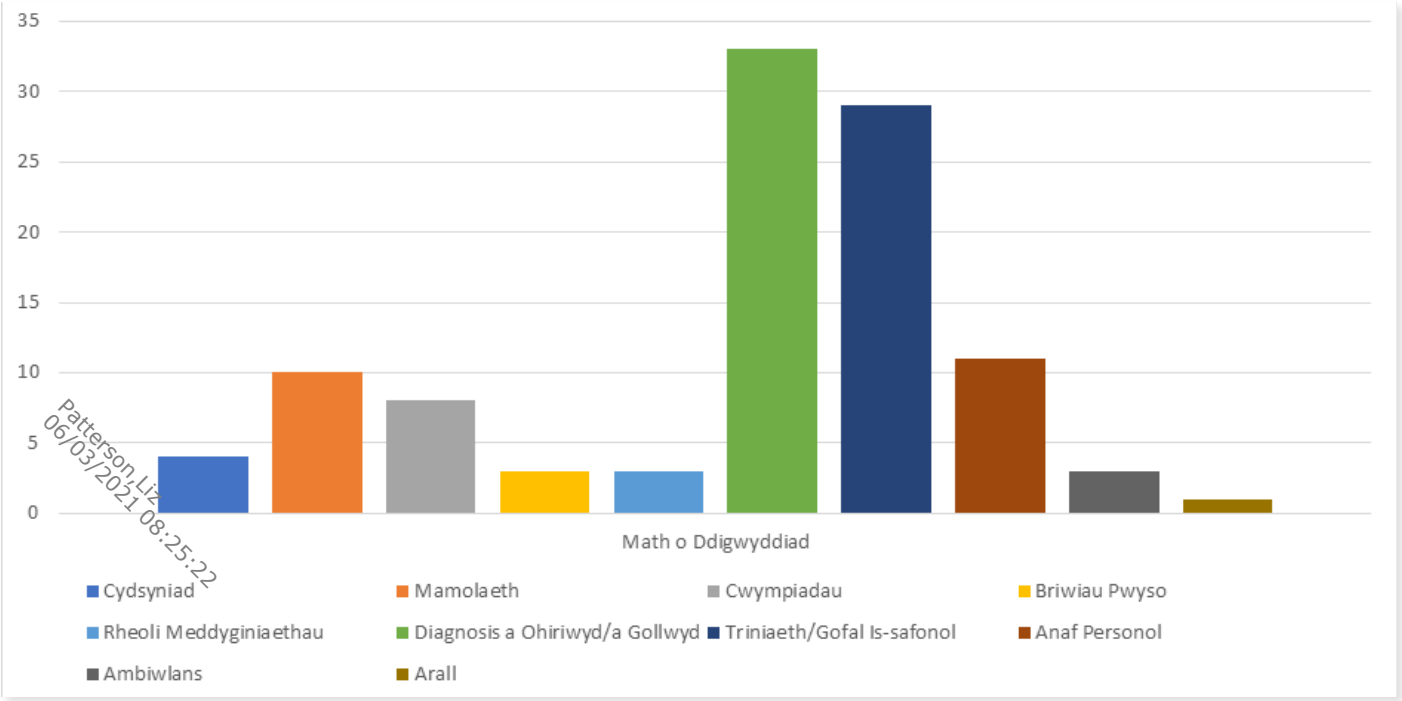
Tueddiadau

Yn ystod y chwarter diwethaf, mae'r Panel wedi adolygu'r dysgu a weithredwyd gan fyrddau iechyd am 262 achos newydd o wneud iawn neu o esgeuluster clinigol ledled Cymru. Mae hyn yn gynnydd o 47 achos, o'i gymharu â'r chwarter diwethaf. Hyd yn hyn, nid ydym wedi cyflwyno unrhyw achosion sy'n gysylltiedig â COVID-19 i'w hadolygu.

Bu'r flwyddyn ddiwethaf yn un ddigynsail, ac eto mae'r timau ledled Cymru wedi parhau i gyflwyno'r dysgu sy'n ofynnol gan Gronfa Risg Cymru, sy'n dangos yr holl waith caled y maent wedi'i wneud ac yn parhau i'w wneud.

Mae'r graff isod yn rhoi crynodeb o'r math o ddigwyddiad a dysgu a adolygwyd gan y Panel y chwarter hwn. Yn ôl y disgwyl, ac yn gyson â chwarteri blaenorol, mae'r nifer fwyaf o achosion yn gysylltiedig â diagnosis a gollwyd neu a ohiriwyd. Mae nifer yr achosion sy'n gysylltiedig â chwympo neu friwiau pwyso yn parhau i fod yn isel, sy'n adlewyrchu'r gwaith sylweddol y mae cyrff iechyd wedi'i wneud mewn perthynas â'r pynciau hyn.

Graff i ddangos canran y ceisiadau esgeuluster clinigol a gwneud iawn a adolygwyd gan y Panel Cynghori ar Ddysgu ar gyfer y chwarter hyd Ebrill 2021:



Achos y Darn Blaen Coll o'r Dril

Dioddefodd merch 15 oed ymosodiad difrifol ac yn ystod yr ymosodiad torrodd ei gên ac roedd angen triniaeth lawfeddygol arni.

Roedd y llawdriniaeth yn llwyddiannus ac i ddechrau roedd yn gwella'n dda ar ôl y llawdriniaeth, fodd bynnag, nododd pelydrau-X a gynhaliwyd yn ystod yr wythnosau canlynol fod darn blaen y dril llawfeddygol yn ei gên. Roedd mewn lleoliad lle na fyddai'n hawdd ei adfer ac felly gwnaed y penderfyniad i'w adael yn ei le oherwydd y risg o niweidio strwythurau hanfodol eraill.

Bum mlynedd yn ddiweddarach, roedd ganddi gilddant heintiedig yr oedd angen ei dynnu. Wrth dynnu'r dant, roedd y llawfeddyg yn medru gweld darn blaen y dril ac felly tynnodd ef.

Mae'r digwyddiad hwn yn dangos methiant gweithdrefnau gwirio yn y theatr. Mae'r corff iechyd dan sylw wedi diwygio ei bolisi ar gyfer gwirio nwyddau traul cyn, yn ystod ac ar ôl llawdriniaeth ac mae wedi atgyfnerthu'r weithdrefn gyda staff. Bellach, mae darnau blaen driliau yn cael eu defnyddio unwaith ac maent yn cael eu gwirio ar ôl pob triniaeth fel rhan o'r gweithdrefnau gwirio theatrau.

Mae'r achos hwn yn tynnu sylw at bwysigrwydd cwblhau rhestrau gwirio theatrau yn gywir.

Safonau Cadw Golwg ar y Ffetws yn ystod Genedigaeth a Hyfforddiant PROMPT

Mae hyfforddiant PROMPT (Hyfforddiant Amlbroffesiynol Obstetrig Ymarferol) Cymru wedi'i fandadu yng ngwasanaeth mamolaeth GIG Cymru er 2019 ac mae mwyafrif yr unedau mamolaeth yn cynnal hyfforddiant yn fisol. Mae tystiolaeth yn dangos gwelliannau mewn diogelwch a chanlyniadau clinigol ac ymgyfreitha cysylltiedig pan fydd yr holl staff mamolaeth yn cymryd rhan mewn hyfforddiant. Cytunodd byrddau iechyd i'r safon o gydymffurfiaeth o dros 95% ar gyfer bydwragedd, meddygon obstetreg ac anesthetyddion obstetreg yn flynyddol. Cafodd hyfforddiant ei oedi o ddiwedd mis Mawrth 2020 oherwydd COVID-19 ond ailddechreuodd gyda rhaglen ddiogel o ran COVID-19 o fis Medi. Wrth gydnabod yr heriau o ddarparu hyfforddiant PROMPT yn y sefyllfa bresennol, bydd Cronfa Risg Cymru yn mesur cydymffurfiad yn erbyn Safonau PROMPT Cymru ar 31/8/21.

Mae Safonau Cymru ar gyfer Cadw Golwg ar y Ffetws yn ystod Genedigaeth (2018) yn nodi bod yr holl weithwyr proffesiynol sy'n darparu gofal yn ystod genedigaeth yn mynychu 6 awr o addysgu bob blwyddyn. O ystyried y dystiolaeth bod monitro amhriodol o galon y ffetws yn cyfrannu at ganlyniadau gwael ac ymgyfreitha cysylltiedig, byddai Cronfa Risg Cymru yn disgwyl i gydymffurfiad â'r hyfforddiant hwn fod yn 95%, fel ar gyfer yr hyfforddiant PROMPT.

Achos y Babi ag Anaf i'w Lygad

Roedd menyw 31 oed yn feichiog am y tro cyntaf ac yn cael gofal dan arweiniad ymgynghorydd. Gwnaed cynllun ar gyfer prysuro'r geni ar ôl 40+3 wythnos o feichiogrwydd. Fe'i derbyniwyd i'r Ward Esgor ar gyfer rhwygo pilenni yn artiffisial a chychwyn trwytho Syntocinon.

Yn gynnar y bore canlynol, aseswyd ei bod wedi ymledu'n llawn a dechreuodd ar y gwthio. Ar ôl dwy awr o wthio anghynhyrchiol, cafodd ei hadolygu gan gofrestrydd a gwnaed cynllun ar gyfer treialu gefeiliau yn y theatr. Nodwyd bod y babi yn 'caput' (chwyddo i groen y pen a achosir gan bwysau am gyfnod estynedig yn ystod y geni).

Defnyddiwyd gefeiliau a ganwyd baban gwryw byw yn fuan wedi hynny. Nodwyd bod ganddo farciau gefeiliau ar ei dalcen a thu ôl i'w glust dde. Nodwyd yn ddiweddarach ei fod wedi dioddef crafiad i'w gornbilen dde oherwydd bod y gefeiliau wedi'u gosod yn anghywir gan nad oedd ei ben wedi'i droi i'r safle cywir. Mae faint o niwed tymor hir sydd i'w lygad yn dal i gael ei ystyried.

O ganlyniad i'r achos hwn, diwygiwyd y profforma esgor trwy lawdriniaeth i gynnwys adran ar droi pen ac adran ar gyfer sylwadau i sicrhau bod genedigaethau gydag offeryn yn cael eu cofnodi'n briodol.

Briwiau, Crafiadau a Gwaniadau

Rydym yn parhau i weld llif cyson o achosion lle mae staff wedi anafu eu hunain ar wrthrychau miniog megis nodwyddau neu ampylau gwydr neu wrthrychau nad ydynt yn finiog megis drysau neu gadeiriau. Ni allwn orbwysleisio yr angen i ddilyn hyfforddiant a gweithdrefnau wrth ddelio â gwrthrychau miniog a defnyddio offer sy'n briodol ar gyfer y dasg, er mwyn lleihau'r risg o anaf personol neu niwed.

Achos yr Ampwl Gwydr a oedd wedi Torri

Roedd uwch nyrs yn tynnu caead ampwl meddyginiaeth gwydr heb ddefnyddio torrwr rwber. Rhwygodd ymyl garw gwaelod yr ampwl ei bys blaen dde a chafodd anaf i'r tendon yr oedd angen cywiriad llawfeddygol arno. Cymerodd yr anaf ddeuddeg wythnos i wella.

Nid oedd yn glir a ddangoswyd i'r unigolyn sut i agor ampwl gyda thorrwr rwber yn gywir.

O ganlyniad i'r achos hwn, mae'r corff iechyd wedi sicrhau bod torwyr rwber wedi'u hychwanegu at ffurflenni caffael ac archwilio, a hynny ar gyfer pob ward. Mae hyfforddiant newydd wedi'i gyflwyno a rhannwyd adborth o'r achos gyda'r staff.

Adolygiad o Thrombo-emboleddau Gwythiennol

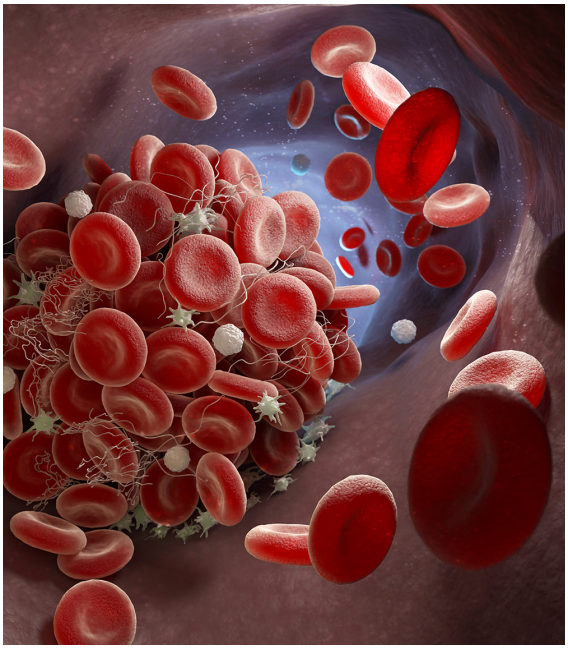
Mae'r Panel wedi nodi cynnydd yn nifer yr achosion esgeuluster clinigol a gwneud iawn yn ymwneud â thrombo-emboleddau gwythiennol (VTE) mewn cleifion yn yr ysbyty. O ystyried bod gan bob claf sy'n ddifrifol wael risg uwch o ddatblygu VTE, mae pryder, oherwydd y nifer uchel o dderbyniadau i'r ysbyty sy'n ddifrifol wael gyda COVID-19, y bydd nifer cynyddol o achosion sy'n gysylltiedig â VTE yn cael eu cyflwyno i'r Panel. Atgyfnerthwyd y pryder hwn gan ddata a gyflwynwyd i Lywodraeth Cymru ar ffurflenni chwarterol Thrombosis a gafwyd yn yr Ysbyty (HAT).

Bydd Tîm Diogelwch a Dysgu Cronfa Risg Cymru yn cynnal adolygiad o bolisïau VTE y Bwrdd Iechyd ynghyd â'u cymhwysiad clinigol. Yn benodol, bydd hyn yn canolbwyntio ar gwblhau asesiad risg a'r math o asesiad risg a gynhelir wrth dderbyn cleifion, ynghyd â darparu proffylacsis.

Achos y Proffylacsis Annigonol

Daeth dynes 45 oed i'r Uned Mân Anafiadau ar ôl anafu ei phigwrn wrth syrffio. Roedd ganddi hanes meddygol o emboledd ysgyfeiniol a thrombosis gwythiennau dwfn (DVT).

Cadarnhaodd pelydrau-X bresenoldeb gordan ochrol a oedd wedi torri. Gosodwyd cast nad yw'n dal pwysau dan y pen-glin a chafodd ei rhyddhau gartref gydag asbrin. Dair wythnos yn ddiweddarach, cafodd ddiagnosis o DVT ac mae bellach ar therapi gwrthgeulo tymor hir.



Daethpwyd i'r casgliad y methwyd â gweithredu ar ei hanes meddygol tymor hir ac y dylai LWMH (Heparin Moleciwlaidd Pwysau Isel) fod wedi'i ragnodi'n broffylactig. Ar ôl pwyso a mesur, ni fyddai wedi dioddef o DVT pe bai wedi'i ragnodi.

O ganlyniad i'r achos hwn, atgoffwyd staff o'r polisi thromboproffylacsis lleol ac mae'r defnydd o asesiadau risg a chynlluniau gofal yn cael ei fonitro a'i archwilio.

Cysylltwch â ni

Os oes gennych unrhyw gwestiynau am y Panel Cynghori ar Ddysgu neu os hoffech gymryd rhan, cysylltwch â'r Tîm Diogelwch a Dysgu trwy anfon e-bost at welsh.riskpool@wales.nhs.uk.

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 3.7

EXPERIENCE, QUALITY & SAFETY COMMITTEE	**Date of Meeting: 3 June 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 19 May 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 content 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:

Recent Healthcare Inspectorate Wales (HIW) activity has seen the publication of one Tier 1 Quality Check report in April 2021, highlighting two areas for improvement. A scheduled Tier 1 inspection of a mental health ward was cancelled on two occasions, a new date awaited.

The health board have contributed to the 'Welsh Ambulance Service Trust - Local Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover'.

HIW have invited the health board to identify key representatives to participate in the professional engagement element of the 'National Review of Mental Health Crisis Prevention in the Community'.

A dashboard overview of the current position is provided, relating to the implementation of actions in response to recommendations from the Health and Social Care Regulators.

DETAILED BACKGROUND AND ASSESSMENT:

<u>Health Inspectorate Wales Inspections</u>

<u>Tier 1 Quality Checks</u>

On the 23 March 2021 Healthcare Inspectorate Wales (HIW) undertook a remote Quality Check of Clywedog Ward, Llandrindod Wells Memorial

Hospital as part of its assurance work, the final report was published 29 April 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. Two improvements were identified:

- The health board must provide HIW with assurance as to how the site can best meet the needs of these patient groups [functional and organic] in both the short term and longer term, specifically if the use of bays in accommodating patients with organic and functional needs fully promotes patient wellbeing and dignity.
- The health board is advised to review and update its environmental / COVID-19 related risk assessment(s).

The health board are required to provide updates on the improvement plan on outstanding actions within three months of the Quality Check taking place.

The findings can be reviewed at the following link or in **appendix 1.** 20210429Llandrindodhospitalen.pdf (hiw.org.uk)

A Quality Check of Felindre Ward, Bronllys Hospital was scheduled for the 30 March 2021. A letter was received 24 March 2021 indicating postponement, and the Quality Check rescheduled for the 27 April 2021. A second letter was received 26 April 2021 indicating due to unforeseen circumstances cancellation of the rescheduled Quality Check. At present, no future date has been offered/provided by HIW.

As indicated in the previous paper, areas where improvement plans are required, an update is required by HIW within 3 months of the inspection date. To date no feedback has been received for the updated improvement plan submitted for Tawe Ward, Ystradgynlais Hospital.

<u>Welsh Ambulance Service Trust - Local Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover</u>

Correspondence was received by the Chief Executive Officer on the 1 April 2021 relating to the 'Welsh Ambulance Service Trust - Local Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover'. It was recognised that Powys Teaching Health Board have no Emergency Departments located within their area, and therefore there was no requirement for Powys to complete a self-assessment. HIW extended an offer for any contribution the health board wished to make to the review, either by letter or through discussion with the review team, to be confirmed by the 20 April 2021. The Terms of Reference for the review are available, **appendix 2,** and set out HIW's commitment to

undertaking a local review of the service during 2020-2021. The review will conclude in July 2021 with the publication of a report.

The Executive Director of Primary Community Care and Mental Health Services, provided feedback on the heath board's interactions with Welsh Ambulance Services NHS Trust to inform the review.

Further information can be found at Local Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover | Healthcare Inspectorate Wales (hiw.org.uk)

National Review of Mental Health Crisis Prevention in the Community

As previously mentioned the National Review of Mental Health Crisis Prevention in the Community had commenced. A letter received by the Chief Executive Officer on the 23 April 2021 set out two key areas for professional engagement considered critical to the national review:

- A professional survey, for staff providing services to share their experiences with HIW anonymously; and,
- Interviews with senior health board staff and service representatives.

The health board have been invited to identify key representatives with whom HIW can engage within primary care services and community based mental health services for adults; details of which were to be provided by the 5 May 2021. Further information on the review can be found at National Review of Mental Health Crisis Prevention in the Community | Healthcare Inspectorate Wales (hiw.org.uk)

Health and Social Care Regulatory Reports: Recommendations and Tracker

The overview of the current position relating to the implementation of recommendations following HIW inspections, and any made by Care Inspectorate Wales, is at **appendix 3**. Validation of the tracker continues to ensure a current position on progress against all recommendations is captured.

The following table (1) sets out the inspections where all actions have been completed since the previous reporting period. These have been removed from the tracker.

Table 1: Inspections with actions completed

2017/18	171803	Mental Health Service Inspection (Ystradgynlais Hospital)
2018/19	181901	Ionising Radiation Regulations and Follow Up Inspection (Brecon and Llandrindod Hospitals)
2018/19	181902	General practice Inspection (Presteigne Medical Practice)
2019/20	192001	Joint Community Mental Health Team Inspection - The Hazels, Llandrindod
2019/20	192003	Unannounced Mental Health Service Inspection (Clywedog Ward, Llandrindod)
2020/21 CIW	20045	Tier 1 Quality Check: Tawe Ward, Ystradgynlais Hospital Inspection report on Cottage View, Knighton

Inspections added to the tracker since the last report, featured in Table (2) below, support ongoing monitoring and assurance on actions as they are implemented:

Table 2: Inspections added to the tracker

2019/20	192009	HIW Review of Healthcare Services for Young People
2021/22	212201	HIW National Maternity Improvement Plan 2021 Priorities
2021/22	212202	Tier 1 Quality Check Clywedog Ward, Llandrindod Wells

Community Health Council

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

Environmental Health Services

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

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Quality Check Summary

Clywedog ward, Llandrindod Wells Memorial Hospital

Activity date: 23 March 2021

Publication date: 29 April 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:

Communications Manager
Healthcare Inspectorate Wales
Welsh Government
Rhydycar Business Park
Merthyr Tydfil
CF48 1UZ

Or via

Phone: 0300 062 8163

Email: hiw@gov.wales

Website: www.hiw.org.uk

Digital ISBN 978-1-80195-332-0

Findings Record

Our Approach

Healthcare Inspectorate Wales (HIW) undertook a remote quality check of Clywedog ward, Llandrindod War Memorial Hospital as part of its programme of assurance work. The ward provides care to older adults with organic and functional care needs. It has a capacity of ten beds, although this was reduced to nine throughout the pandemic due to the need to retain one room as an isolation facility.

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 Service Manager and the Deputy Ward Manager on 23 March 2021 who provided us with information and evidence about their setting. We used the following key lines of enquiry:

- How are you ensuring that the environment is safe and suitable for the needs of patients at this time? What changes, if any, have been made to the physical environment, ward routines and patients' access to leave as a result of COVID-19?
- How is the risk of infection assessed and managed to keep patients, visitors and staff safe?
- Considering the impact of COVID-19, how are you discharging your duty of care against the Mental Health Act and how are patients' rights being safeguarded?
- How are you ensuring that there are sufficient numbers of appropriately trained staff to meet patients' needs, with access to wider mental health professionals where needed?

Environment

During the quality check, we considered how the service has designed and managed the environment of care to keep it as safe as possible for patients, staff and visitors. We reviewed recent risk assessments, incident reviews and use of restraint and seclusion. We also questioned the setting on the changes they have made to make sure patients continue to receive the care and treatment according to their needs.

The following positive evidence was received:

We were told that patients are encouraged to use the day room at the start of each morning in order to help provide patients with a daily routine. The ward also had access to several other communal areas, including a TV area, a secure garden and a dining room, which could be used as a breakout room if needed.

We found that restrictions to visiting caused by the pandemic had been difficult for both patients and their relatives. However, we were told that visiting with purpose had been permitted, in line with the latest Chief Nursing Officer for Wales guidelines. This had been achieved through creating a visitor booking system, ensuring that all visitors are symptom checked and are supplied with appropriate personal protective equipment (PPE) before they enter the designated visitor meeting space. We were also told that relatives were provided with daily updates at the peak of the pandemic, in order to provide additional reassurance at a time when visiting was further restricted.

We found there to be an overall low number of incidents reported at the site, which included no incidences of restraint within the last three months. The site placed an emphasis on verbal de-escalation techniques, distraction techniques and through providing meaningful activities for patients. It was positive to hear that thorough patient histories are taken, with the involvement of relatives, at the point of admission in order to establish a patient's preferred routine and to help staff to understand any triggers.

We found that there was a single bedroom which had been fitted with anti-ligature fixtures and fittings. This was supported by a comprehensive anti-ligature risk assessment, however, the health board must ensure that this is reviewed on an annual basis.

We found that multi-disciplinary team (MDT) meetings had continued throughout the pandemic and that these were held virtually, wherever possible. This ensured that patient care and treatment needs could continue to be met.

We noted that a recent deprivation of liberty safeguarding (DoLS[1]) application had also been undertaken by virtual means, with the involvement of relatives and the patient as far as

[1] The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. The safeguards aim to make sure that people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom

possible. This means that patients' rights are protected by ensuring that best interest's assessments[2] are undertaken in a timely manner.

Ward management told us that ward routines had overall remained stable throughout the pandemic, with patients still receiving the required levels of direct patient care and having access to activities. Staff told us that, due to COVID-19 restrictions, access to some services (e.g. hairdressing) had paused and that, whilst was difficult for some patients, staff were hopeful that these services would soon resume.

We found that access to wider health professionals had continued wherever possible, but that there had been occasional difficulties in receiving on-site visits from all services. We acknowledge that the pandemic will have impacted the ability of some services to engage on-site, however, the health board is advised to monitor and review this to ensure that care and well-being needs are met.

The following areas for improvement were identified:

We found that the ward provides care for older adults with organic[3] and functional care needs. This means that, at times, care for these two distinct groups of older people may lead to challenging behaviours or frustration between patients. This is compounded by the use of two and three bed bays, rather than single patient rooms.

Management explained to us how they are able to work with patients in order to successfully de-escalate or mitigate any challenging behaviours or frustrations. Despite this and, as identified in our previous inspection report (2019), the health board must provide HIW with assurance as to how the site can best meet the needs of these patient groups in both the short term and longer term, specifically if the use of bays in accommodating patients with organic and functional needs fully promotes patient wellbeing and dignity.

Infection prevention and control

During the quality check, we considered how the service has responded to the challenges presented by COVID-19. We considered how well the service manages and controls the risk of infection to help keep patients, visitors and staff safe. We reviewed infection control policies, infection rates and risk assessments. We reviewed key systems including the use of personal protective equipment (PPE).

The following evidence was received:

We found that the site had remained COVID free until the end of 2020 when a COVID-19 outbreak occurred. However, we confirmed that an investigation by the health board was

[2] The purpose of a best interests assessment is to decide whether a deprivation of liberty is happening or may happen, and if it is whether this is in the best interests of the person affected.
[3] This may include conditions such as dementia or Alzheimer's disease

underway, including a root cause analysis, in an effort to determine the cause and to aid any learning.

Despite this, ward management confirmed that there had been good support from the IPC link-nurse throughout the pandemic in order to review and maintain local IPC arrangements. We also saw evidence to show that positively-scored IPC audits had been undertaken by ward management since the outbreak, with the outcomes reported to the health board through an appropriate governance mechanism.

We were told that up-to-date information related to IPC is regularly communicated verbally to staff and that staff were encouraged to use the intranet for policies and sources of support. Information was also disseminated through daily ward rounds and at regular team meetings.

We confirmed that staff had received donning and doffing training in order to be able to correctly apply and dispose of PPE. Staff also confirmed that stocks of PPE and other supplies, such as hand gel, was in plentiful supply.

We saw evidence to confirm that COVID-19 related updates had been communicated to visiting professionals and relatives. This included use of a booking system to control the number of visitors on-site, as well as posters and stickers to remind staff and visitors of the need to maintain good IPC practice (e.g. hand hygiene and social distancing).

It was positive to hear that service had recognised the difficulties faced by patients with cognitive impairments in understanding and retaining new IPC habits, such as social distancing, and perceived trip hazards associated with placing stickers on the floor. Staff told us that posters and stickers had been carefully positioned around the ward to maintain visibility and that patients had been gently supported to help them understand. Staff told us that overall patients had responding positively to these changes.

We found that the ward had taken additional steps to help prevent the transmission of COVID-19, this included working with the health board estates department to limit the cross-over of domestic staff entering the ward. Also, access points had been limited, including the use thoroughfares leading onto and off the ward in an effort to reduce unnecessary footfall.

The following areas for improvement were identified:

We were told that all patients will be tested for COVID-19 prior to their admission, unless an urgent admission is required. In this case, the patient would undergo a period of isolation in a single bedroom that had been re-designated for this purpose until a negative COVID-19 test result is received. However, we found that this had not always been possible due to the presentation of the patient (e.g. a wandering patient).

Whilst we found that the COVID-19 related environmental risk assessment had identified this risk, there was a lack of documented mitigation identified within the assessment to control

and reduce this risk. The health board is advised to review and update the risk assessment.

Governance

As part of this standard, HIW considered how the setting ensures there are sufficient numbers of appropriately trained staff to meet patients' needs, with access to wider mental health professionals where needed.

We also questioned the setting about how, in light of the impact of COVID-19, they are continuing to discharge their duty of care against the Mental Health Act and safeguarding patients' rights.

The following positive evidence was received:

The service manager spoke highly of the committed, team approach that all staff have demonstrated throughout the pandemic in an effort to ensure that patients care and well-being needs were met. It was also positive to note that the need for visible ward management was emphasised, particularly throughout the pandemic, when staff and patient anxieties can be heightened.

Ward management described how they ensure that there are sufficient numbers and an appropriate skill mix of staff in order to meet patient needs. This included taking into account safe nurse staffing levels, existing skill mix, on-going patient risk assessments and other factors, such as newly admitted patients, who may require increased observations.

We confirmed that there was an appropriate process in place to escalate any staffing concerns and we found that staff were familiar with how to escalate concerns at both a ward and health board level.

We found that staff sickness and leave associated with the pandemic had impacted staffing on the ward. However, staff were able to describe the support and oversight they had received from the health board in managing these situations, such as access to additional bank or agency staff. It was positive to note that emphasis was placed on using a small pool of bank staff, which helped with patient familiarity and IPC purposes.

We found that all staff had completed at COVID-19 workforce risk assessment. It was also emphasised to us that staff could contact ward or service management at any time should they require any additional support.

We were provided with the mandatory training statistics and found mixed levels of compliance in some areas. However, we acknowledge that these training areas had been affected by COVID-19 due to the lack of face-to-face training options. We were told that that these areas would be prioritised as and when they become available.

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: Llandrindod Wells Memorial Hospital

Ward: Clywedog Ward

Date of activity: 23 March 2021

The table below includes improvements identified during the Tier 1 Quality Check, where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Please note, all actions are expected to be complete within three months of the Quality Check and the final version of the Improvement Plan is to be submitted via Objective Connect once complete.

Reference Number	Improvement needed	Standard/ Regulation	Service Action	Responsible Officer	Timescale
1	The health board must provide HIW with assurance as to how the site can best meet the needs of these patient groups [functional and organic] in both the short term and longer term, specifically if the use of bays in accommodating patients with organic and functional needs fully promotes patient wellbeing and dignity.	**Standard 12 Environment** **Regulation 26/ 40**	Due to the Covid-19 pandemic, engagement on new models of inpatient services has been suspended. The mental health service will follow national guidance around the option of progressing this work until such time as it becomes possible to fully consult in a face to face manner with our communities, to consider the best way forward. Risks to service users are identified, assessed, managed,	**Assistant Director Mental Health/ Learning Disabilities**	Workshop with stakeholders in the autumn of 2021 to produce bed configuration options including the potential for separating clinical needs for

			recorded and reviewed on an individual basis through the WARRN assessment. Necessary action is taken as quickly as possible to mitigate risks and safeguard the wellbeing of each individual patient. Care and Treatment Plan (CTP) Audit will identify the effectiveness of this. Wherever possible, we seek to separate patients with functional and organic needs from sharing accommodation within the same bay.		the benefit of patient care. **31st October 2021** CTP Audit is annual next due: **December - January 2022**
2	The health board is advised to review and update its environmental / COVID-19 related risk assessment(s).	**Standard 7 Safe and Clinically Effective care Regulation 15** **Standard 13 Infection Prevention and Control (IPC) and Decontamination Regulation 9, 15** **Standard 22 Managing Risk and Health and Safety**	The Risk Assessment has been reviewed and updated 12.04.2021 Next review of the Environmental Risk Assessment will become due on October 12th 2021 or sooner if any changes prompt this.	**Service Manager/ Head of Operational Services**	**Completed**

		Regulation 9, 19, 26			

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

Name: Ruth Derrick, Head of Nursing, Quality and Safety, Mental Health

Date: April 12th 2021

Welsh Ambulance Service Trust - Local Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover

Terms of Reference

Why are we doing this work?

It is clear that the Covid-19 pandemic has introduced unique and unprecedented pressures on the healthcare system, however, it is Healthcare Inspectorate Wales' (HIW) continued commitment and goal to check that people in Wales are receiving good quality care, which is provided safely and effectively, in line with recognised standards.

As part of our annual reviews programme, we committed to undertake a local review of the WAST during 2020-21.

Scope and Methodology

A range of information sources indicate that ambulance waiting times outside hospital Emergency Departments can be excessive, particularly when the healthcare system is under pressure. These information sources include Welsh Government ambulance monthly performance indicators, Serious Incident notifications to Welsh Government, intelligence held by WAST, media reports, and discussions between HIW and senior staff within both WAST, and Health Boards. In addition, delays in the handover process with Emergency Departments resulting in reduced ambulance availability, were highlighted during HIW's local review of WAST during 2019/20. The previous review explored how the risks to patients' health, safety and well-being were being managed, whilst they were waiting for an ambulance. A copy of this report can be found here.

In response to the issues outlined above, this local review will consider the impact of ambulance waits outside of Emergency Departments on patient safety, privacy, dignity

and overall experience. The COVID-19 pandemic has introduced unique and unprecedented pressures on the healthcare system; in view of this, the review will consider patient experiences over the past 12 months in order to understand what impact the Covid-19 pandemic has had on this issue.

We will also consider whether there is local and regional variation across Wales and highlight any good practice we identify. This will include exploring the following:

- The procedures in place between each hospital emergency department and WAST for accepting patients from ambulances into the care of health board staff
- The overall experience of patients whilst waiting in an ambulance to include their safety and any impact on their wellbeing
- How patient dignity is maintained and needs are met, to include nutritional, hydration and toilet needs whilst waiting in an ambulance
- The impact of the delays on ambulance staff.

To assess the areas detailed above, the review will include analysis of relevant guidelines and standard operating procedures, as well as other information such as clinical incidents relating to handover. We will also collate the views of patients through surveys to understand their experience whilst waiting in an ambulance. We will engage with Health Boards, WAST and Community Health Councils to seek their support in obtaining patient views. We will also undertake a number of interviews with ambulance and emergency department staff and senior managers within WAST and Health Boards. We will also be making a staff survey available to allow all staff to share their views and experiences with us. HIW aims to complete all fieldwork remotely as a result of the COVID-19 pandemic.

Timescales

The table below includes estimated timescales for the review:

Activity	Timescales
Fieldwork planning and document review	March 2021
Fieldwork	April – May 2021
Report Publication	July 2021

Analysis and reporting

Throughout the review fieldwork phase, the review team will give immediate feedback if any issues arise which represent an immediate risk to patient safety.

The review will conclude with the publication of a report that will set out the key themes and recommendations identified from our work. Any information provided by staff during the fieldwork will not be directly attributed to them in the report. Also, a summary of anonymised survey results will be included within the report.

The Trust (and health boards where applicable), will be provided with a copy of the draft report to comment on factual accuracy and each will receive a copy of the final report prior to its publication.

If areas for improvement are identified, the Trust and Health Boards may be required to complete an improvement plan, which details how the services will address the findings set out in the report. Following review, any improvement plan will be published on HIW's website alongside the report.

Personal data

This review forms part of HIW's 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. This terms of reference sets out our intended approach to the review.

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.

Appendix 3-DASHBOARD OF IMPLEMENTATION OF HEALTH AND SOCIAL CARE REGULATORY REPORT RECOMMENDATIONS

Ref	Ref	Inspection Title	Recommendations Made	Recommendations Complete	Recommendations Overdue (agreed timescale)	Overdue Recommendation Revised Timescale	Recommendations Not Yet Due
2017/18	171808	Mental Health Service Inspection (Clywedog Ward, Llandrindod)	9	8		1	
	TOTAL		9	8		1	
2019/20	192003	Unannounced Mental Health Service Inspection (Clywedog Ward, Llandrindod)	23	20		3	
	192004	Unannounced Twymyn Ward, Machynlleth Community Hospital & Graham Davies Ward, Llanidloes Hospital Inspection	20	19	1		
	192006	Unannounced Hospital Inspection: Llewellyn Ward, Bronllys Hospital	13	12	1		
	192007	Birth Centres (Free Standing Midwifery Led Unit) Across Powys	9	6	3		
	192008	NHS Mental Health Service Inspection (Unannounced): Felindre Ward, Bronllys Hospital	23	21	1	1	
	192009	HIW Review of Healthcare Services for Young People	37 (5/37 N/A PTHB – x3 hospices/ x2Welsh Government)	31	1		
	TOTAL		125	109	7	4	
2020/21	202150	Tier 1 Quality Check: Maldwyn Ward, Welshpool Hospital	2		2		
	TOTAL		2		2		
2021/22	212201	HIW National Maternity Improvement Plan 2021 Priorities	25	3	7		15
	212202	Tier 1 Quality Check Clywedog Ward, Llandrindod Wells	2	1			1
	TOTAL		27	4	7		16
	GRAND TOTAL		163	121	16	5	16

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda Item: 3.8

EXPERIENCE, QUALITY & SAFETY COMMITTEE	**Date of Meeting: 3rd June 2021**
Subject :	**Infection, Prevention and Control Update**
Approved and Presented by:	Alison Davies – Director of Nursing and Midwifery
Prepared by:	Jennie Leleux - Senior Nurse for Infection Prevention & Control Marie Davies – Deputy Director of Nursing
Other Committees and meetings considered at:	Information contained in this report has been presented at the Infection Control Group, Gold Group and at Quality Governance Group.

PURPOSE:

This paper provides a summary of the work undertaken by the Infection, Prevention and Control (IP&C) Group, both within an existing action plan programme and in response to Covid 19.

RECOMMENDATION(S):

The Experience, Quality and Safety Committee is asked to:

- Receive the paper as an update to the current work activity being undertaken by the Infection Prevention and Control Group
- Receive an update on the plan to undertake an Authorized Engineer Decontamination review
- Plan to receive the Annual Report for Infection, Prevention and Control in August 2021 and quarterly updates following this.

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 Infection Prevention & Control (IPC) Group meets on a quarterly basis. Representatives of all departments across the Health Board attend, and there are a number of sub-groups which manage specific elements of infection, prevention and control to include decontamination, anti-microbial resistance and environmental cleanliness. It offers the opportunity to share the progress made across PTHB on IPC related-issues.

This paper provides an overview of the topics covered and the latest position within PTHB both discussed within the Infection, Prevention and Control Group and achievements since the last meeting. A draft annual report will be considered in the Infection, Prevention and Control Group in June, and will be shared at the next Experience, Quality and Safety meeting in August 2021.

DETAILED BACKGROUND AND ASSESSMENT:

1. Infection, Prevention and Control (IPC) Workplan

Workplans for both 2020/21 and 2021/22 have been developed by the team. Several actions on the 2020/21 workplan have been carried over to the new financial year due to COVID19 requirements and team capacity. The team has made a great deal of progress in a short period of time during Quarters 3 and 4, and the 2021-22 action plan is due to be signed off in the next IPC Group.

The team is currently recruiting to vacancies for a Band 7 Infection Control Specialist Practitioner and a Band 3 Administrator.

Actions are grouped within the workplan to include service provision, policy and procedures, systems & processes, the environment and training and education.

A number of uncompleted actions relate to Antimicrobial Resistance (AMR). An AMR sub-group was developed in 2020 with strong leadership and work programme. The pharmacy team is currently heavily involved with COVID19 Mass Vaccinations which has impacted on the progression of AMR objectives. It is planned that this will recommence with vigour once COVID19 pressures ease.

2. IPC Group Subgroups

2.1 Antimicrobial Resistance

The high level of national scrutiny has reduced during the pandemic and it is anticipated this will renew during the recovery period. The subgroup is planning to re-focus and invigorate their workplan as COVID19 allows. A national recommendation was made to issue Chronic Obstructive Pulmonary Disease (COPD) Rescue Packs for patients who might be vulnerable to winter infections. These contained broad-spectrum antibiotics which slightly diverges from the desire of the AMR Group to reduce broad-spectrum antibiotic usage but it was noted that use of these in Powys was exceptionally low.

2.2 Environmental Cleanliness and Operational Guidance

The subgroup received assurance that high standards of environmental cleanliness are maintained through the outcomes of regular cleanliness audits. An Environmental Cleanliness Dashboard is established and presented to the IPC Group.

During COVID19, the importance of maintaining clean environments has reached a higher level of awareness and understanding amongst stakeholders; and the profile of the service provided by domestic staff has generated a stronger interest, particularly from clinical teams. In return, the ability to provide timely data on cleaning performance has been vital to supporting the fight against COVID19.

To further support cleaning processes and to take account of Welsh Government guidance, Environmental Cleanliness Operating Procedures have been developed and approved by the IPC Group which details cleaning operations, taking account of the requirements for COVID19, and in preparing for any future pandemic scenarios. The procedures are aligned with other PTHB policies and procedures including the newly developed COVID 19 IPC Policies.

The existing "Post Outbreak Enhanced Cleaning Procedure" has been captured within the Environmental Cleanliness Operating Procedures to align processes and enable clear advice for the various cleaning requirements.

A paper was prepared for consideration at GOLD regarding the health board's position and resource requirements to meet compliance with the NHS Wales COVID Cleaning Standards.

2.2 Water Safety and Ventilation

2.21 Legionella/Water

The Estates team has a proactive sampling regime that aims to identify and resolve water quality issues along with a management system. New risk assessments have been completed for all buildings, including all recently acquired or leased premises due to the needs of the COVID19 pandemic.

There is an ongoing Pseudomonas sampling requirement at Welshpool Renal Unit which is being managed by Estates and Facilities teams, and monitored by the IPC team, Microbiologist and Water Safety Group. Estates have well established subgroups within all these disciplines, which feeds into the respective main IPC groups.

2.22 Ventilation and other Key Estates Works

The Estates team have completed, and led on several projects which have made significant improvements to the infection prevention and control standards across the Powys Teaching Health Board. Project planning, design and inception have all been supported by the IPC team, ensuring compliance with relevant technical guidance and recommendations to create safer environments across PTHB. The following refurbishment works have been completed:

- Llandrindod Wells Endoscopy AHU
- Installation of mechanical ventilation within specified ward areas for Covid 19 (Llandrindod, Brecon Main Hospital and Dentistry, Welshpool and Glan Irfon Dentistry)
- Social distancing measures to allow staff to return safely to the work environment across all sites
- Creation of the main Bronllys PPE store, and several other satellite PPE across PTHB
- Installation of vinyl flooring and U-PVC cladding to non-clinical areas to allow the recommencement of vital services across PTHB
- Upgraded shower facilities across PTHB
- Creation of a Hot Clinic

2020/21 brought the challenges of a global pandemic which strengthened the collaborative working between the Estates teams, IPC team and Shared Services, this being crucial to NHS successful response to the pandemic. All guidance and updates were reviewed by all, with estates improvements being

implemented quickly to help contribute towards the national control effort, this included:

- COVID 19 specific ventilation at Llandrindod, Welshpool & Brecon including Glan Irfon & Brecon Dentistry
- Conversion of premises into mass vaccination and testing centres including the installation of all infrastructures as required
- Car park management system where required including lighting to accommodate the extra traffic flow and safeguard visitors and staff
- Installation of COVID 19 signage, screens
- Installation of additional bed curtains and rails, and wash facilities to ensure adherence to COVID19 19 ward/bed layouts

2.3 Decontamination

2.31 Strategic Decontamination Group

The group has maintained oversight of a range of decontamination equipment during the very challenging period when services and site inspections were stepped back to deal with the pandemic.

The role of Decontamination Authorised Person has been successfully appointed. This role will strengthen the environmental and engineering aspects related to decontamination equipment ensuring the clinical teams have access to advice and support when needed. The Group oversaw a review of the list of equipment in use in Powys, and supported a number of site audits by shared services when these recommenced.

Community Dental Services benefitted from the installation of improved ventilation and decommissioning of obsolete bench top sterilisers.

A site visit to Llandrindod Endoscopic Decontamination system was undertaken in February 2021 and this demonstrated improvements in the services delivered. Learning from incidents from other NHS organisations included an incident involving a minor spillage of peracetic acid, and this led to a review of strategies and systems for dealing with this sort of spillage.

Looking ahead the Group will be contributing to a number of routine quality assurance site visits and will be developing a revised delivery plan for 2021/22.

2.31 Authorising Engineer for Decontamination (AE(D)) Report

As part of the role of AE(D), and in accordance with the guidance set out in Welsh Health Technical Memorandum 00, it is a requirement for the Authorising Engineer to produce an annual audit and subsequent report (WHTM 00 Best practice guidance for healthcare engineering paragraph 3.15). The subsequent report will be submitted to the Executive Board Decontamination Lead, expected in during the summer 2021.

Healthcare organisations have a duty of care to patients, their workforce and the public. This is to ensure that a safe and appropriate environment for healthcare is provided, which is a requirement identified in a wide range of legislation applicable to Health Boards. The AE (D) will report on findings, compare progression in alignment with recommended practise and systems for decontaminating medical devices instigated within PTHB and the other Health Boards/Trusts within NHS Wales.

The AE(D) will be linking with the Decontamination Operational Lead, an IPC representative, Estates and Facilities representative, Sterile Services Department Management, Community Dental representatives and the Endoscopy Service Lead to undertake this review. The audit will measure:

- Decontamination Built Environments – structure/resilience and compliance, ancillary service provision
- Equipment Used for Decontamination of medical devices – operational management, compliance and current conditions
- Service and Validation Protocols for decontamination equipment
- Compliance to Governance Framework and effectiveness of systems – APD, Microbiologist support, Training pathways etc
- Compliance to WG strategies – JAG accreditation, audits and needs/community dental strategies/reaction to WHC's.
- Action Plans Developed and risk outstanding identified in each survey discipline – continual improvement.
- Short/Medium/Long term plans identified for service, equipment and decontamination service, to include any prospective capital plans to meet changing service needs.
- Any other issues that maybe a perceived risk within the organisation and subsequently the patients treated within.

2.3.2 Since 2014, NHS Wales multi-disciplinary peer review groups have carried out surveys at individual healthcare organisations to identify the effectiveness of decontamination for flexible endoscopes and non-lumen probes; sterile services and infrastructure; and instruments used in community dental services. Each organisation is made aware of its survey findings with suggestions for improvement and at national strategy level. Each organisation is asked to develop an action plan with specific timescales that responded to the survey findings and visits to health boards are planned to review progress to discuss the action plans implemented, obstacles encountered, and next steps. The visiting team will include representation from Welsh Government, Shared Services and an independent Operational Decontamination Lead. Powys is scheduled to be visited during October 2021.

2.4 Nosocomial Group

The Nosocomial Group oversees the investigation of all positive cases of COVID19 in patients and staff. Nationally agreed templates are completed

for each case and reviewed through scrutiny panels. All investigations will have been through the scrutiny process by the end of May 2021.

The learning through this approach is being drawn together and a report will be available by July 2021 to provide a summary of the approach taken and lessons learnt. A national framework to support this work has been developed, and along with health boards and Trust in Wales, PTHB will work with Welsh Government and the Delivery Unit to implement this.

2.41 Patient investigations

The patient scrutiny panel is chaired by the Professional Head of Nursing for Community Services. As of the end of April 2021 all patient investigation toolkits have been completed. There have been 8 patient scrutiny panels held, with 63% of investigations reviewed. The remaining investigations will be completed by the end of May 2021. A process for validating the outcomes of the panel will be developed and aligned to the All Wales arrangements within the national framework.

2.42 Staff investigations

The staff investigation toolkit has been developed on an All Wales basis. Minor adjustments have been made locally in order to gain more information whist conducting the investigation. All additions were agreed by the health board's Nosocomial Investigations Group.

The Chair of the Staff Scrutiny Panel is the Assistant Director: Health & Safety and Support Services. There was a delay in reviewing possible staff transmission due to the non-completion of the staff investigation toolkits. However, this process has been streamlined; the toolkit is now available on the intranet and a link provided within ESR for managers to complete with staff.

As of the end of April 2021 there were less than 5 staff toolkit investigations outstanding of those staff cases identified as needing investigation. Staff who did not work within the health board for at least 14 days prior to being tested and therefore would not be classed as having a nosocomial infection were excluded. There has been to date 6 staff scrutiny panels held with 75% of investigations reviewed. The remaining investigations are scheduled for review by the end of May 2021.

From June 2021, any toolkits, both patient and staff will be scheduled for presentation at the following month's scrutiny panel. The panels will also be aligned so any learning from a given outbreak can be shared across panels.

3 IPC Annual Report

The 2020-21 Infection Prevention and Control Annual Report is currently being drafted and will be reviewed by the IPC Group in June 2021. Key performance measures are detailed below for ease of reference.

3.1 Health Acquired Infections

Key performance metrics for Health-Care Acquired Infections (HCAI) are shown below. Due to the nature of services in Powys this is not benchmarked with other services in Wales.

3.11 C. difficile

- 7 reportable C. difficile cases were reported in 2020/21 in PTHB inpatient wards, with 6 being Hospital-Onset, Hospital-associated, and one case being within 48 hours of admission.
- This compares to 6 reportable cases in 2019/20, with 6 HOHA and 2 within 48 hours of admission.
- GP samples show a marked decrease this financial year, with only 4 positive cases, versus 15 in 2019/20. This may suggest that fewer samples have been sent due to the perceived reduction in access to surgeries during the pandemic.

3.12 Gram negative bacteria Blood Stream Infections

- There were less than 5 blood stream infections (BSIs) caused by each *Escherichia coli*, *Klebsiella Pneumoniae, Pseudomonas aeruginosa* during the last year.
- Although individually this does not appear to be a great increase year on year, in total, Gram-negative bacteria caused 7 BSIs compared to only 4 in 2019/20.
- From April 2021 all BSIs will have a post-infection review to identify any learning and improvement required.
- Gram-negative bacteria are a cause for concern as they are becoming increasingly resistant to antibiotics, making them much harder to treat.
- A number of patients will be diagnosed in A&E and therefore may have been identified by GP practices but will not show on our patient record system.

4.13 Staphylococcus aureus BSIs

- There were no MRSA or MSSA BSIs recorded on ICNet in PTHB in 2020/21.
- However, there was 1 community-acquired MRSA BSI**,** diagnosed in Shrewsbury and Telford Hospital. A Serious Incident Review was undertaken to grenade learning and improvement where needed.

4.2 COVID19 Update and Outbreaks

4.21 PTHB sites:
In Quarter 3 and 4, there were a number of outbreaks, predominantly on the in-patient units and to a lesser degree, in community teams. All were deemed significant incidents and allocated Investigating Officers to undertake detailed investigations.

4.22 Care Homes:
During this time period there have also been a number of outbreaks in care homes. The Senior Nurse for IPC for Care Homes has undertaken visits alongside Environmental Health Officers to advise and support. Themes in care homes are similar to those identified in hospital premises. It is acknowledged that the pandemic has led to improved collaborative working with residential/care homes and the council.

4.3 PPE/IPC training and Fit testing

Initially, COVID19 and PPE training was delivered face to face, and the expectation was that clinical staff would cascade to their teams, areas or departments. A significant amount of training was delivered in the earlier part of the pandemic. This training was delivered by Infection Prevention and Control (IPC), with assistance from other members of the nursing team.

As the pandemic progressed, training moved onto MS Teams and was delivered virtually, with all staff expected to attend. This also enabled attendance to be recorded. The number of sessions given between 25th March 2020 and 25th October 2020 was 152, with 1200 members of staff recorded as attending.

No training was given during Quarter 3 but since then, regular sessions have been offered. 6 sessions were delivered during Quarter 4, with 110 participants from a range of departments across PTHB.

Fit testing was also offered across PTHB and to care home/domiciliary care staff. 284 members of staff from providers external to PTHB were fit tested in Quarter 1 and 2.

Since February 2021, responsibility for the fit testing programme has moved from IPC to Health & Safety, and a new programme for PTHB staff is being formulated in preparation for forthcoming months.

4.4 Policies and Procedures

The following policies and Standard Operating Procedures (SOP) were developed and approved:

- The Environmental Cleanliness Standard Operating Procedure (SOP)

- The Resuscitation Policy has been clarified and updated, in line with the Resuscitation Council UK's recommendations on chest compressions requiring Aerosol Generating Procedures and use of PPE.
- 7.2.1 SARS-CoV-2 (COVID19) Infection Prevention & Control Policy.
- 7.2.2 SARS-CoV-2 (COVID19) Infection Prevention & Control Policy Part d – Visiting arrangements for inpatient units. Updated document providing more clarity
- 7.2.3 SARS-CoV-2 (COVID19) Infection Prevention & Control Policy Part C – Managing Outbreaks
- 7.2.4 Mental Health Infection Prevention Control During COVID19 Policy
- The Patient Testing SOP has been approved.
- Further policies, SOPs and Action Cards are in development.

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 3.9

EXPERIENCE, QUALITY AND SAFETY COMMITTEE	**Date of Meeting: 3 June 2021**
Subject :	**Medical Revalidation Progress Report 2019/2020**
Approved and Presented by:	Dr Kate Wright, PTHB Medical Director/Responsible Officer
Prepared by:	Dr Jeremy Tuck, PTHB Assistant Medical Director and Deputy Responsible Officer
Other Committees and meetings considered at:	Executive Committee

PURPOSE:

The purpose of this report is to provide the Experience, Quality and Safety Committee with the Powys Teaching Health Board Medical Revalidation and Appraisal Annual Report 2019/2020.

RECOMMENDATION(S):

It is recommended that the Experience Quality and Safety Committee notes the developments made in the Responsible Officer's area over the reporting period. However, while progress has been made, not all of the important actions from the previous review have been achieved.

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:

Doctors who wish to practise medicine in the UK must hold registration with the General Medical Council, with a license to practise. To maintain a license, doctors must demonstrate, through a 5 year cycle of appraisal and revalidation, that they are fit to practise. This is achieved by reflecting on learning and identifying development needs, discussing significant events, complaints and compliments, engaging in audit and quality improvement and undertaking patient and colleague feedback exercises. This report summarises the arrangements in place and presents the 2019/2020 report and return to Welsh Government.

DETAILED BACKGROUND AND ASSESSMENT:

Duties of Doctors

"Good Medical Practice" (General Medical Council (GMC), 2013) describes the duties of all doctors registered with the GMC and provides the framework for annual professional appraisal, revalidation and other supporting guidance. Doctors are personally accountable for their professional practice and must always be prepared to justify their decisions and actions. "Good Medical Practice" has four domains, each encompassing further detailed guidance:

1. Knowledge, skills and performance
2. Safety and quality
3. Communication, partnership and teamwork

4. Maintaining trust

In accordance with the General Medical Council (License to Practise and Revalidation Regulations) 2012, Powys Teaching Health Board is a Designated Body for doctors with a "prescribed connection". As such, the Health Board is required to submit an annual report to the Quality and Revalidation Team of Health Education and Improvement Wales and Welsh Government.

With reference to appraisal and revalidation, GMC guidance for the employers of doctors includes that employers should have established:

- Responsible Officer arrangements, with the Responsible Officer supported by the systems required to enable to Responsible Officer role to be discharged
- An up to date appraisal system which reflects the "Good Medical Practice" requirements for doctors
- Clinical governance systems which provide doctors with the supporting information they require for annual appraisal and revalidation (including patient feedback)
- Systems and policies for identifying and responding to concerns about doctors
- Robust links with other organisations where doctors may be employed or working in other capacities, so that information about clinical practice (and any concerns) can be shared between Responsible Officers

The attached Revalidation and Appraisal Report 2019/2020 (Appendix 1) is designed to enable Designated Bodies in Wales to report relevant figures relating to these responsibilities for 2019/2020, including appraisal arrangements. The report was submitted as required, by deadline, to Health Education and Improvement Wales. The reports are analysed by the Revalidation Support Unit (RSU), on behalf of the Wales Revalidation Delivery Board (WRDB) and will be reported to the WRDB. At present, Powys Teaching Health Board has received no detailed feedback concerning its report for 2019/2020. This is not surprising considering that the appraisal system has been interrupted twice due to the COVID Pandemic and is only now getting back up to full pace.

Points to Note from the 2019/2020 report

The progress towards meeting the performance questions for 2019/2020 is Red assessment; 2, Amber 15, Green 12. 2018/2019 performance was Red 2, Amber 14, Green 13.

In 2019/2020, the red progress was against lay involvement in the process. The re-instigation of the Powys Teaching Health Board Medical Appraisal and Revalidation Advisory Group will offer an opportunity for enabling lay involvement in the process. The second Red assessment concerns the ability to analyse constraints to practice. It is felt that there is sufficient scope for Doctors to bring constraint issues into Powys Teaching Health Board either by the Local Medical Committee, the Cluster Leads or by direct communication with the Medical Director/Assistant Medical Director. For hospital doctors, the route would be via clinical directors or direct to the Medical Director/Assistant Medical Director. To that end, it is felt that the issues are being addressed. What is lacking at present is tracking and triangulation of the the entirety of the constraint's narrative within Powys Teaching Health Board.

In broad terms, the amber progress assessments are due constraints on developing sufficiently robust processes to monitor progress. This requires administrative support for the appraisal and RO function.

Work to address the outstanding performance issues has been put into the RO plan for 2020/2021.

The annual report for 2019/2020 and the RO Plans for 2020/2021 are attached - see **Appendix 1**.

Revalidation Support Unit Advisory Visit to PTHB.

On 25 March 2019, Powys Teaching Health Board was visited by the Revalidation Support Unit to undertake a peer review of the RO function. The visiting team noted that the Powys performance in terms of managing appraisal and revalidation was above the all Wales average. The visit recommended that an SOP was put in place to ensure Whole Practice Appraisal was undertaken. The visit report also recommended that Powys Teaching Health Board appoint appraisal leads and recruit additional appraisers for secondary care. The visit also recommended that lay representation be enabled in the Powys Teaching Health Board revalidation and appraisal process.

The complete report is at **Appendix 2**.

NEXT STEPS:

To continue to develop and refine the Responsible Officer arrangements in Powys Teaching Health Board so that all doctors on the Powys Teaching Health Board Designated Body list are considered for revalidation in a timely manner, with a recommendation submitted by the Responsible Officer by GMC due deadline, without exception.

Priorities will be: to audit the Whole Practice Appraisal component to ensure that those doctors who have multiple elements to their job plans have each element discussed during appraisal and; to identify resourcing to support the

administrative process and appraisal lead role in support of the Responsible Officer function.

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REVALIDATION PROGRESS REPORT (RPR) 2019-20

1.1 Name of designated body:	Powys Teaching	**Last Year's RPR report:**
Name of Responsible Officer:	Dr Catherine Mary Woodward	
Type of organisation:	Teaching Health Board	2018-2019 Revalidation Progress
Name of person completing this report:	Dr Catherine Mary Woodward//Dr Jeremy Tuck	
Job title of person completing this report:	Interim Responsible Officer//Assistant Medical Director	

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Part 1 - Appraisal Figures

1.2 Appraisal Completion Figures as of the 31.03.20

IMPORTANT: ONLY DOCTORS WITH WHOM THE DESIGNATED BODY HAS A PRESCRIBED CONNECTION SHOULD BE INCLUDED IN THIS SECTION. EACH DOCTOR SHOULD BE INCLUDED IN ONLY ONE CATEGORY	Number of prescribed connections	No of doctors exempt from appraisal due to extenuating circumstances	No of completed appraisals (summary agreed)
General practitioners	112	0	108
Consultants (including honorary contract holders)	17	0	15
Staff grade, associate specialist, specialty doctor (including hospital practitioners, clinical assistants who do not have a prescribed connection elsewhere)	3	0	4
Doctors with practising privileges (for independent healthcare providers only); all doctors with practising privileges who have a prescribed connection should be included in this section, irrespective of their grade)	0	0	0
Temporary or short-term contract holders (including trust doctors, locums for service, clinical research fellows, trainees not on national training schemes, doctors with fixed-term employment contracts)	0	0	0
Other (Including some management/leadership roles, research, civil service, other employed or contracted doctors, doctors in wholly independent practice, etc.)	2	0	1
Trainees doctor on national postgraduate training scheme (for Deaneries only)	0	0	0

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Part 2 – Quality Assurance of Processes

Please include a copy of the DBs Revalidation Action Plan or equivalent as an appendix to this report

The Action Plan from the PTHB Revalidation Quality Review Visit (February 2019) is provided in Section 3.1

2.1 Revalidation Processes. What level of assurance does the DB have:		
2.1.1 That there are sufficient support structures in place to support the RO and revalidation team?		Level of Assurance (RAG): **AMBER**
Reason for assessment / evidence:	Areas for development / Action plan:	Progress against last year's action plan
The capacity of the PTHB revalidation team has increased since the 2018/19 report, with the appointment and training of the PTHB AMD/Deputy RO. The Deputy RO now performs an initial review of appraisal portfolios, as part of the overall "revalidation ready" assessment, before consideration by the MD/RO. The Deputy RO also leads on monitoring MARS and ORBIT in order, for example, to identify doctors who might be having difficulties in meeting their revalidation obligations. The PA to the MD/RO continues to provide some administrative support (for example, paperwork management; some interface with MARS). While the current team is able to meet obligations to PTHB doctors and to HEIW and the GMC, further ongoing assurance and improvement would require the appointment of a Revalidation Support Officer	• To reconsider the establishment of a (part-time) Revalidation Support Officer function, to enable ongoing audit of practice and to release the AMD/Deputy RO to complete additional strategic/developmental work	The main progress was in developing the role of the AMD/Deputy RO in supporting the appraisal and revalidation systems. The MD also further developed the proposal for a Revalidation Support Officer, but this was not supported by the PTHB Executive Committee at the time
2.1.2 That revalidation recommendation decisions are made timely and in line with GMC RO regulations?		Level of Assurance (RAG): **GREEN**
Reason for assessment / evidence:	Areas for development / Action plan:	Progress against last year's action plan
No known external issues or concerns The MD/RO personally reviews the appraisal portfolios of each of the doctors with a prescribed	• To consider access permission of the AMD/Deputy RO to the GMC Connect portal • To explore and apply examples of good practice from other HBs	Appointment of AMD/Deputy RO Initial RO training undertaken by AMD AMD/Deputy RO fully integrated within the Wales RO and appraiser networks

connection to PTHB, prior to recommendation. The appointment of the AMD/Deputy RO provided additional capacity to streamline, manage and prioritise the appraisal portfolios, prior to consideration and recommendation to the GMC, by the MD/RO. Other arrangements are also in place to ensure that revalidation recommendations are always made in a timely manner (i.e. active management of the "Under Notice" list). In addition, a programme of work has been established to review the current position of each doctor brought "Under Notice" under the COVID arrangements, to determine whether their portfolio is potentially "revalidation ready", prior to the RO recommendation (despite some relatively long lead-in times); and if not, to agree and support necessary "next steps" with each doctor, on a case by case basis. This work is being completed partly in an attempt to avoid a potential spike in numbers coming through later in 2021	• To establish arrangements to ensure continuity of business processes following commencement in post of the new PTHB MD/RO in early 2021 (including handover arrangements) • To audit local practice (subject to capacity)	

2.1.3 That revalidation deferrals decisions are made and managed appropriately?		Level of Assurance (RAG): **GREEN**
Reason for assessment / evidence:	Areas for development / Action plan:	Progress against last year's action plan
No known external issues or concerns See above (2.1.2) The MD/RO personally reviews the appraisal portfolios of each of the doctors with a prescribed connection to PTHB, prior to recommendation to the GMC (including for any deferral recommendations). The MD/RO liaises with the individual doctor, the GMC liaison adviser and RSU/HEIW as indicated/required, with the support	• To consider access permission for the AMD/Deputy RO to the GMC Connect portal • To explore any benchmarking intelligence in relation to practice and outcomes relating to deferral recommendations in Wales • To establish arrangements to ensure continuity of business processes following commencement in post of the new PTHB MD/RO in early 2021 (including handover arrangements) • To audit local practice (subject to capacity)	Appointment of AMD/Deputy RO Initial RO training undertaken by AMD AMD/Deputy RO fully integrated within the RO and appraiser networks

of the Deputy RO. Recommendations for deferral are discussed and agreed with individual doctors. Doctors are informed following (any type of revalidation) recommendation to the GMC. Practice is also shared through the RO network			
2.1.4 That there are processes in place for reviewing WPA in the context of appraisal and revalidation?		Level of Assurance (RAG):	**AMBER**
Reason for assessment / evidence:	Areas for development / Action plan:	Progress against last year's action plan	
Use of existing systems to appropriately explore, review and document WPA, including MARS. WPA captured on standard PTHB documentation. The MD/RO personally reviews the quality of the evidence provided in relation to WPA. (There are historic examples of RO intervention in situations where the WPA evidence was deemed to be requiring improvement). Following review during 2018/19, evidence in relation to WPA was assessed by the MD 2019/20; however, this remains a work in progress	• To complete the audit of local practice • To re-establish the PTHB Medical Appraisal and Revalidation Advisory Group (currently stood down) to provide oversight and assurance • To explore and apply examples of good practice from other HBs	Evidence in relation to WPA was assessed by the MD during 2019/20 Appraisers document WPA on MARS pro-forma for all doctors	
2.1.5 That the RO role can be covered in the event of unplanned absence?		Level of Assurance (RAG):	**GREEN**
Reason for assessment / evidence:	Areas for development / Action plan:	Progress against last year's action plan	
The appointment of the AMD/Deputy RO provided additional capacity to streamline, manage and prioritise appraisal portfolios, prior to consideration and recommendation by the MD/RO. The appointment has also provided enhanced continuity for the process, including during any absence of the MD/RO. Other arrangements are also in place to ensure that revalidation recommendations are always made	• To consider access permission for the AMD/Deputy RO to the GMC Connect portal • To establish arrangements to ensure continuity of business processes following commencement in post of the new PTHB MD/RO in early 2021 (including handover arrangements)	Appointment of AMD/Deputy RO Initial RO training undertaken by AMD AMD/Deputy RO fully integrated within the RO and appraiser networks	

in a timely manner (i.e. active management of the PTHB "Under Notice" list)		
2.1.6 That revalidation processes are reviewed for effectiveness and quality; and that key issues arising from reviews and quality improvement activity are progressed?		Level of Assurance (RAG): **AMBER**
Reason for assessment / evidence:	Areas for development / Action plan:	Progress against last year's action plan
See above (2.1.1) – routine audit of revalidation practice undermined to some extent by lack of capacity to complete such reviews In terms of wider QI activity, the AMD/Deputy RO is completing work to highlight and share good practice from primary care clinical audit. The AMD/Deputy RO leads the Continuing Education Group, which also identifies opportunities to share and learn from good practice	• To re-establish the PTHB Medical Appraisal and Revalidation Advisory Group (currently stood down) to provide oversight and assurance • To fully implement the action plan agreed following the Revalidation Quality Review Visit (February 2019) • To complete the programme of work in relation to primary care clinical audit	There is evidence of improved liaison with PTHB appraisers since the previous return
2.1.7 That all revalidation processes consider equality, diversity and inclusivity issues and are fair and non-discriminatory?		Level of Assurance (RAG): **GREEN**
Reason for assessment / evidence:	Areas for development / Action plan:	Progress against last year's action plan
No known external issues or concerns E&D training remains part of PTHB mandatory training	• To define good practice in this area and to audit local practice (subject to capacity)	No specific action was recorded in the 2018/19 report

2.1.8 That the DB takes into consideration public and patient views regarding revalidation processes?		Level of Assurance (RAG): **AMBER**
Reason for assessment / evidence:	Areas for development / Action plan:	Progress against last year's action plan
While there is no current involvement of patients or the public in these local processes, there are no known local issues or concerns which have been raised by patients or the public	• To re-establish the PTHB Medical Appraisal and Revalidation Advisory Group (currently stood down) to provide oversight and assurance (potentially including wider and lay membership) • To establish good practice on this issue in other Welsh HBs	Due consideration was given and a possible candidate was identified. However, COVID then stalled any further progress
2.1.9 That the DB engages with national activity relating to revalidation, e.g. RAIG and RO meetings and QA events?		Level of Assurance (RAG): **GREEN**
Reason for assessment / evidence:	Areas for development / Action plan:	Progress against last year's action plan
PTHB MD/RO attends all Wales RO Network meetings. RAIG meetings delegated to AMD/Deputy RO. AMD/Deputy RO also supported the RSU on an assurance visit to BCUHB	• To establish arrangements to ensure continuity of existing arrangements following commencement in post of the new PTHB MD/RO in early 2021 (including handover arrangements)	AMD/Deputy RO appointed
2.1.10 That thresholds applied for revalidation recommendations are in line with those of other DBs?		Level of Assurance (RAG): **GREEN**
Reason for assessment / evidence:	Areas for development / Action plan:	Progress against last year's action plan
The MD/RO follows GMC guidelines and processes and liaises with the GMC Liaison Officer when specific issues arise Sharing of practice via Wales RO Network No known benchmarking issues. No concerns raised by GMC	• To consider raising via Wales RO network, to establish the basis for comparison	Communication with ROs outside Wales continues (examples are available)

2.2: Underpinning systems: appraisal. What level of assurance does the DB have:		
2.2.1 That there is sufficient support for doctors to enable them to be appraised? Including number of available appraisers, information about appraisal, support with MARS, access to relevant data		Level of Assurance (RAG): **AMBER**
Reason for assessment / evidence:	Areas for development / Action plan:	Progress against last year's action plan
All doctors with a prescribed connection to PTHB can raise any issues directly with the MD/RO or AMD/Deputy RO. Excellent relationship established with appraisal coordinator for primary care (currently 4 appraisers), with routine briefings. Any issues are predominantly case-specific (not systematic). There remains a case to establish a PTHB appraisal lead for secondary care (currently 7 appraisers), including to work with the primary care coordinator	• To identify a PTHB appraisal lead • To improve support and development opportunities for local appraisers • To support more doctors (primary and secondary care) in becoming an appraiser	No further progress
2.2.2 That there is a robust induction process for doctors including appraisal and revalidation guidance for the organisation?		Level of Assurance (RAG): **AMBER**
Reason for assessment / evidence:	Areas for development / Action plan:	Progress against last year's action plan
New doctors are included in the wider PTHB induction process for all new staff There are in-year examples of additional measures for medical staff - the AMD/Deputy RO inducted a new health board employed GP into their new role, encompassing appraisal and revalidation; and provided bespoke advice and support regarding appraisal and revalidation for a newly appointed secondary care doctor	• To update the induction policy to include a routine meeting for all new and substantively appointed PTHB medical staff with the MD/RO or AMD/Dep RO (to encompass appraisal and revalidation)	Some progress made regarding induction; however, PTHB policy requires update

2.2.3 That all doctors requiring appraisal are appraised when they should be?		Level of Assurance (RAG): **AMBER**
Reason for assessment / evidence:	Areas for development / Action plan:	Progress against last year's action plan
All AQ change requests are considered by the MD/RO or the AMD/Deputy RO. No known current MARS alerts regarding missed appraisals (Note: current exercise in hand to review potential "Revalidation Ready" position of all PTHB "Under Notice" doctors)	• To review (and if required, improve) the alert system for missed appraisals	Revalidation Support Officer: proposal developed by MD, but not supported by PTHB Executive Committee at the time (see 2.1.1)
2.2.4 That reasons for non-completion are documented, and non-engagement is managed appropriately?		Level of Assurance (RAG): **GREEN**
Reason for assessment / evidence:	Areas for development / Action plan:	Progress against last year's action plan
MD/RO personally reviews all portfolios for revalidation and records position using standard PTHB template developed for this purpose (which also supports tracking). Reasons for non-completion and/or non-engagement are recorded, with follow-up action led by the RO/MD, on a case by case basis As at 10/12/20, the GMC revalidation portal for PTHB was recording one case where there had been failure to engage during 2019 (This had been a complex case, fully discussed with the GMC, involving a medical practitioner who was largely working abroad, but returning to the UK for extremely short periods of time, simply in order to complete appraisal. Case also shared via RO Network)	• To keep the case for a Revalidation Support Officer under review	Revalidation Support Officer: proposal developed by MD, but not supported by PTHB Executive Committee at the time (see 2.1.1)

2.2.5 That appraisers are fit for purpose, appropriately trained and up to date?		Level of Assurance (RAG): **AMBER**
Reason for assessment / evidence:	Areas for development / Action plan:	Progress against last year's action plan
Appraisers are trained and attend continuation training, in line with all-Wales policy and practice	• To identify an appraisal lead (see 2.2.1) (e.g. to provide additional mentorship to the appraiser cohort; and to track and audit compliance on a range of measures)	PTHB appraisal lead not yet identified
2.2.6 That appraisers are supported and managed in their role, and are performing the role appropriately?		Level of Assurance (RAG): **AMBER**
Reason for assessment / evidence:	Areas for development / Action plan:	Progress against last year's action plan
Appraisers are supported by MD/RO and AMD/Deputy RO as required. No known concerns. Routine assurance measures not fully established due to the lack of an appraisal lead for secondary care doctors	• To identify an appraisal lead (see 2.2.1) (e.g. to provide additional mentorship to the appraiser cohort; and to track and audit compliance on a range of measures)	PTHB appraisal lead not yet identified
2.2.7 That appraisal outputs (summary and PDP) meet agreed standards?		Level of Assurance (RAG): **GREEN**
Reason for assessment / evidence:	Areas for development / Action plan:	Progress against last year's action plan
The MD/RO reviews all appraisal summaries prior to revalidation recommendation to the GMC	• To identify an appraisal lead (e.g. to establish routine local audit of appraisal summaries as part of QA) • To re-establish the PTHB Medical Appraisal and Revalidation Advisory Group (currently stood down) to provide oversight and assurance	AMD/Deputy RO appointed and now actively involved in the appraisal processes

2.2.8 That appraisal and its outputs are having a positive impact on individuals and on the organisation?		Level of Assurance (RAG): **AMBER**
Reason for assessment / evidence:	Areas for development / Action plan:	Progress against last year's action plan
Historically, appraisals have provided evidence of both individual reflection on QA activity; and that appraisal is a valued process for some individuals. The profile of the appraisal process was raised through assurance reports to PTHB Board EQ&S subcommittee (There is currently work in hand to improve the integration of primary care clinical audit activity within the wider programme of clinical audit activity within the HB)	• To review and improve the impact of appraisal and its outputs on clinical quality in the organisation, through the PTHB Clinical Effectiveness Committee	PTHB appraisal lead not yet identified
2.3: Underpinning systems: governance. What level of assurance does the DB have:		
2.3.1 That appropriate checks, including regarding their appraisal status and any outstanding concerns, are carried out prior to establishing a connection with a doctor?		Level of Assurance (RAG): **GREEN**
Reason for assessment / evidence:	Areas for development / Action plan:	Progress against last year's action plan
To be in line with GMC guidance, doctors need to declare any restrictions on their practice during the initial application processes. Checks are completed by the medical lead within the PTHB Workforce and OD Team; any concerns are raised with the MD/AMD. The TRAX system encompasses advice to doctors that a job offer is conditional to all checks concerning licensing, revalidation and appraisal being completed. This includes approaching the current RO for confirmation that the doctor is in good standing with their current Designated Body. (In this	• To continue with current processes	Communication with ROs continues (including outside Wales; examples available)

general context, the MD also personally reviews all applications for inclusion on the Powys MPL)		
2.3.2 That the DBs GMC Connect list is up to date (in terms of both joiners and leavers), and cross-checked against your staff records and / or the MPL?	Level of Assurance (RAG):	**GREEN**
Reason for assessment / evidence:	Areas for development / Action plan:	Progress against last year's action plan
MD/RO advised about all doctors newly joining the HB as employees. GMC Connect list kept under routine review with follow-up with individual doctors by the MD/RO, as indicated (e.g. for doctors who have retired)	• To consider and implement an audit of practice processes in relation to new joiner GPs, to explore establishment of prescribed connections with PTHB	No specific action was recorded in the 2018/19 report
2.3.3 That where concerns arise about doctors with whom you have a prescribed connection, these are managed and inform the revalidation recommendation appropriately?	Level of Assurance (RAG):	**AMBER**
Reason for assessment / evidence:	Areas for development / Action plan:	Progress against last year's action plan
MD/RO should be informed of any concerns in relation to medical practitioners through the routine PTHB Q&S processes (including for doctors with a prescribed connection). The wider management of concerns is through the relevant PTHB policy	• To re-establish the PTHB Medical Appraisal and Revalidation Advisory Group (currently stood down) to provide oversight and assurance (e.g. PTHB Quality and Safety officer is a member of this group)	No specific action was recorded in the 2018/19 report
2.3.4 That should concerns arise during the appraisal process, these will be shared and managed appropriately?	Level of Assurance (RAG):	**AMBER**
Reason for assessment / evidence:	Areas for development / Action plan:	Progress against last year's action plan
Appraisers should be handling concerns which emerge during the appraisal process in line with national policy and their training. The MD/RO	• To identify an appraisal lead to provide additional assurance on this issue, through routine assessment/audit of appraisal outputs	There is evidence of improved liaison with PTHB appraisers since the previous return

personally reviews all appraisal portfolios at the point of recommendation for revalidation		
2.3.5 That should concerns arise about a doctor who works for the DB but does not have a prescribed connection with the DB, or no longer has a prescribed connection with the DB, this information is shared appropriately between organisations?	Level of Assurance (RAG):	**GREEN**
Reason for assessment / evidence:	Areas for development / Action plan:	Progress against last year's action plan
The MD/RO leads contact with other DBs and other organisations if necessary, having been notified of a concern	• No specific action indicated at this time	No specific action was recorded in the 2018/19 report
2.3.6 That governance information is consistently available relating to all doctors, including for example those who work within the DB for a short period of time?	Level of Assurance (RAG):	**AMBER**
Reason for assessment / evidence:	Areas for development / Action plan:	Progress against last year's action plan
Concerns would be notified to the RO/DB via a range of potential sources; there was an example of this working in practice for a locum doctor working in PTHB, during 2019/20 (including that dialogue was established with another RO). Numbers are relatively low and can be managed directly by the MD/RO and AMD/Deputy RO on a case by case basis	• To re-establish the PTHB Medical Appraisal and Revalidation Advisory Group (currently stood down) to provide oversight and assurance	MD/RO continues to liaise with other ROs
2.3.7 That governance data is shared appropriately with those making revalidation recommendations – including for example information about complaints and incidents, and feedback from patients?	Level of Assurance (RAG):	**GREEN**
Reason for assessment / evidence:	Areas for development / Action plan:	Progress against last year's action plan
Appraisal information is reviewed personally by the PTHB MD/RO at the point of recommendation	• To re-establish the PTHB Medical Appraisal and Revalidation Advisory Group (currently	No specific action was recorded in the 2018/19 report

to the GMC. The PTHB RO contacts the DB RO as indicated if concerns/incidents arise in relation to doctors without a prescribed link to PTHB. Also in this context and as referenced above, following review during 2018/19, evidence in relation to WPA was assessed by the PTHB MD during 2019/20	stood down) to provide oversight and assurance	
2.3.8 That the DB encourages lay involvement in quality assurance processes to provide independent scrutiny and challenge?		Level of Assurance (RAG): **RED**
Reason for assessment / evidence:	Areas for development / Action plan:	Progress against last year's action plan
At present, there is no lay involvement in QA processes relating to revalidation	• To re-establish the PTHB Medical Appraisal and Revalidation Advisory Group (currently stood down) to provide oversight and assurance (potentially including wider and lay membership)	Due consideration was given and a possible candidate was identified. However, COVID then stalled any further progress
2.3.9 That the organisation's Board is appropriately engaged in / informed about governance and revalidation processes?		Level of Assurance (RAG): **AMBER**
Reason for assessment / evidence:	Areas for development / Action plan:	Progress against last year's action plan
Historically, PTHB Board has been briefed on revalidation via the MD reports to the Board's EQ&S subcommittee. The ToR of the EQ&S subcommittee also encompass clinical governance	• To re-establish the previous PTHB Board reporting arrangements on revalidation	There was no Board level briefing report on revalidation during 2019/20

2.3.10 That doctors' constraints identified at appraisal are reported to the Board for consideration i.e. to be included in risk register if appropriate?		Level of Assurance (RAG): **RED**
Reason for assessment / evidence:	Areas for development / Action plan:	Progress against last year's action plan
Constraints narratives are reviewed as part of the review of appraisal portfolios at revalidation. Local GPs also have pathways into the HB to express any concerns regarding constraints, including at the LMC and the HB cluster leads meetings (MD in attendance at both). (HEIW produces a consolidated report on constraints from primary and secondary care, although this is not broken down into DB specific data)	• To consider and progress an analysis of local constraints (if capacity allows)	No further progress
2.3.11 That governance processes are having a positive impact, and informing revalidation appropriately?		Level of Assurance (RAG): **AMBER**
Reason for assessment / evidence:	Areas for development / Action plan:	Progress against last year's action plan
As discussed – PTHB has a relatively low number of doctors with a prescribed connection. The MD/RO personally reviews the appraisal portfolios at the point of recommendation. Wider work has been completed in relation to WPA. There are no known concerns or incidents associated with the revalidation process in-year	• To re-establish the PTHB Medical Appraisal and Revalidation Advisory Group (currently stood down) to provide oversight and assurance • To fully implement the action plan agreed following the Revalidation Quality Review Visit (Feb 2019) • To apply the learning from the review of WPA • To develop metrics regarding the process and outcome of the revalidation process for local reporting to Board • To complete the programme of work in relation to primary care clinical audit	AMD/Deputy RO appointed, but governance processes not yet reviewed

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Covid-19 Pandemic: Preparation for 2020-21 Revalidation Data

Q1. Do you have plans in place to process the revalidation recommendations for doctors that have had approved missed appraisals as a result of the Covid-19 pandemic?

Please Provide Comments:

Yes.

At the request of the PTHB Interim RO, the AMD/Deputy RO is screening the portfolios of all doctors with a prescribed connection to PTHB who are currently "Under Notice" of revalidation, to explore current readiness (including doctors with approved missed appraisals). Doctors who are potentially "Revalidation Ready" will then be considered by the RO, prior to recommendation to the GMC. Doctors "Under Notice" who emerge as not being potentially ready for RO consideration (or who have been deemed by the RO as not yet suitable for recommendation) will be contacted and receive further advice and support from the MD/RO or AMD/Deputy RO as necessary. The relatively long lead-in times currently in hand for this programme of work mean that it should be completed in line with revalidation dates.

Q2. Do you have sufficient capacity to undertake the additional revalidation recommendations that will need to be made in 2021 as a result of the suspension of revalidation?

Please Provide Comments:

Yes.

See above. This work is being undertaken partly to manage the "Under Notice" forward activity profile created by the revalidation arrangements established in response to COVID. Further, the number of doctors with a prescribed link to PTHB is relatively low, in both absolute and relative terms.

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Part 3 – Quality Visits, Internal Quality Assurance and Other Projects

3.1 Progress against Quality Visit Actions

3.1.1 Designated Body Action Plan and Comments (1ST and 2nd year progress to be completed by DB) Date of Visit: 21/2/2019

Action	By Whom	Timescale	1st Year Progress	2nd Year Progress
Develop SOP to monitor whole practice appraisal	Jane Parry	Not stated	Review remained in progress; findings reported to MD	2nd year still in progress
Support revalidation decision making:	Wyn Parry	3 months		
(i) Input of Deputy RO (post training)	Jeremy Tuck		Completed	2nd year still in progress
(ii) Consider introduction of lay representation	Not stated		Not completed	
Identify/recruit lead appraiser for secondary care	Mark McIntyre/ Wyn Parry	3 months	Not completed	2nd year still in progress
Identify more secondary care appraisers	Mark McIntyre/ Wyn Parry	6 months	Not completed	2nd year still in progress
Identify SPA time for appraisers by job plan review	Clinical Directors	6 months	Completed	2nd year still in progress
Develop information/guidance on appraisal and revalidation for new medical appointees to PTHB	Wyn Parry/Mark McIntyre	6 months	Not completed	2nd year still in progress

3.2 Internal Quality Assurance exercises (IQA)			
3.2.Have you undertaken an internal quality assurance exercise?	Yes	Date of last exercise	Commenced 2018/19; reported to MD during 2019/20

Please provide details of the sample size and parameters that are used	Please proved details of the resources used i.e. RSU calibration video, scoring criteria, sample summaries etc.	Please provide brief details of the outcome of the quality assurance exercise
This was a review of Whole Practice Appraisal arrangements in PTHB. The review encompassed all doctors with a prescribed link to PTHB, as well as some doctors with prescribed links to other organisations - but who were providing care to PTHB patients at the time	Resources used included, but were not limited to: PTHB officer time, IT resources, appraisal summaries and contractual information	A number of issues were identified in relation to the assessment and reporting of whole (clinical) practice, as part of WPA. The exercise remains a "work in progress"

3.2.2 Please provide a copy of the most recent Internal Quality Assurance outcomes with your RPR return (if applicable).			
3.3 Other Revalidation or Appraisal Projects			
3.3.1 Have you have recently completed or currently undertaking a project?	Yes	Date of last project	Commenced November 2020

Project 1. Please provide details of the project.	Project 2. Please provide details of the project.	Project 3. Please provide details of the project.
As summarised earlier in the return (e.g. "Question 1" above). In summary: a review/initial screen of all doctors currently "Under Notice" of revalidation		

3.3.2 Please provide a copy of your project report with your RPR return

Review currently in progress; however, there is no current intention to produce a "stand alone" report

Llywodraeth Cymru
Welsh Government

GIG CYMRU NHS WALES
Addysg a Gwella Iechyd Cymru (AaGIC)
Health Education and Improvement Wales (HEIW)

Part 4 – DB Statement of Compliance

Llywodraeth Cymru
Welsh Government

GIG CYMRU NHS WALES
Addysg a Gwella Iechyd Cymru (AaGIC)
Health Education and Improvement Wales (HEIW)

4.1 Completed report authorised by Responsible Officer

Name	Signature	Date.
Dr Catherine Mary Woodward PTHB Interim Responsible Officer GMC 3085499		05/01/2021

4.2 Board statement of compliance

Signed on behalf of the designated body (Chief executive or chairman, or executive if no board exists)

Name	Role	Signature	Date.
Mrs Carol Shillabeer	Chief Executive Officer PTHB		13/01/2021

I can confirm that:
The organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013)
We are satisfied with the level of assurance we have about these systems and processes, both now and throughout the year, and the way in which they support and inform revalidation
We are satisfied with the organisation's progress in terms of revalidation, and that there is a clear plan in place to guide further quality improvements

Or: we have concerns about any of the above, as described below:

Revalidation Quality Review Report

Designated Body Visited: Powys Teaching Health Board

Date of Quality Review Visit: 21 February 2019

Location: PTHB HQ, Glasbury House, Bronllys Hospital, LD3 0LS

Visiting Team:
Dr Chris Price – Chair, Deputy Director, Revalidation Support Unit
Dr Alastair Roeves, Responsible Officer, ABMU Health Board
Wynne Evans, Lay Representative
Sharon Penhale, Revalidation Manager, ABMU Health Board
Andrea Gwilliam, Business Manager, Velindre NHS Trust
Sian Parker-Hornsey, Revalidation and Quality Manager, Revalidation Support Unit
Katie Leighton, Revalidation and Quality Senior Manager, Revalidation Support Unit

Context

Type/sector of DB	NHS Health Board
Chief Executive	Carol Shillabeer
Responsible Officer / Medical Director	Wyn Parry
Assistant Medical Director and Deputy RO	(not present at review)
Deputy Director of Workforce	Mark McIntyre
Medical Workforce Manager	Nikki Smith

Other Representatives met during the visit:
Appraisees x 1
Appraisers x 4

Appraisal completion figures for the period (Source RPR):

Appraisal Completion Figures				
	Number of Prescribed connections (on 31 Mar 18)	**No of doctors exempt from appraisal due to extenuating circs (on 31 Mar 18)**	**No of completed appraisals (summary agreed)**	**% of completed appraisals *(including exceptions)***
General practitioners	*116*	*2*	*111*	*96%*
Consultants (including honorary contract holders)	*15*	*0*	*13*	*87%*
Staff grade, associate specialist, specialty doctor (including hospital practitioners, clinical assistants who do not have a prescribed connection elsewhere)	5	0	3	60%
Temporary or short-term contract holders (including trust doctors, locums for service, clinical research fellows, trainees not on national training schemes, doctors with fixed-term employment contracts)	*0*	*0*	*0*	0
Other (including some management/leadership roles, research, civil service, other employed or contracted doctors, doctors in wholly independent practice, etc)	0	0	0	0
TOTAL	**136**	**2**	**127**	**93%**

Designated Body Revalidation recommendations for the period (Source RPR):

1.3 Revalidation Recommendations							
Recommendations which were due between 3 December 2012 and 31 March 2018 but were not completed on time		***7 days and under*** 0	***1-3 weeks*** 0	***Over 3 weeks*** 0			
Number of recommendations to be split by year (Year 1: December 2012 – 31st March 2015. Year 2: 1st April 2013 – 31st March 2014. Year 3: 1st April 2014 – 31st March 2015)	**2012/13**	**2013/14**	**2014/15**	**2015/16**	**2016/17**	**2017/18**	**Total**

Number of total approved recommendations	0	27	61	44	3	9	144
Number of approved positive recommendations	0	25	53	40	1	9	128
Number of approved requests for deferral (insufficient evidence to support a recommendation)	0	2	8	4	2	0	16
Number of approved requests for deferral (participating in an ongoing process)	0	0	0	0	0	0	0
Number of approved notifications of failure to engage	0	0	0	0	0	0	0
Total Deferral rate – 11%							

All Wales revalidation rates:

Deferral due to IE – 12%
Deferral due to ongoing process – 1%
Non engagement – 0%
Total Deferral rate: 13%

Regional Quality Assurance Analysis (2016/17 exercise) ***(Source RQA analysis)***

Powys Primary Care
Average summary score – 93%*
All Wales average summary score – 87%

Powys Secondary Care
Average summary score – 100%**
All Wales average summary score – 55%

*Only two Primary Care summaries scored
**Only one Secondary Care summary scored

No. of Powys Appraisers attended RQA event –

Two Powys Appraisers attended 2018 event.

Supporting documents provided to the visiting team prior to the visit are listed in Appendix 1.

Outcome & General Overview

Powys Teaching Health Board are a relatively small NHS designated body enabling the senior management team to closely monitor appraisal and revalidation activity among doctors with a connection. The Revalidation team currently consists of the Responsible Officer (RO) who has been in post approximately 6 months and his PA, although an Assistant Medical Director/Deputy RO has been recently appointed and is due to undertake training imminently. The RO has previous experience of being a RO at the DVLA for 5 years. The majority of doctors working within the Health Board are Primary Care based with a small number of consultants and staff grade doctors.

The review team thanked the Health Board for their hospitality and noted the friendly and welcoming atmosphere within the organisation. The review team were encouraged by the meetings held and felt that there were no significant issues to be addressed in relation to appraisal and revalidation processes.

Areas of Good Practice

1. Appraisal rates are above average for Wales and the Board are keen to maintain this
2. Appraisees and Appraisers seem generally happy in their roles within the Health Board
3. Small number of doctors enables close monitoring of doctors progress towards revalidation and clinical governance
4. CPD for doctors fully supported by Health Board and Primary Care tutors funded to provide monthly CPD meetings and RO directly involved in providing previous session
5. Appointment of Assistant Medical Director/Deputy RO

Areas for Development

1. Formal structures should be developed for revalidation decision making, all being done by RO represents a risk
2. A standard operating procedure should be developed for identifying and monitoring whole practice appraisal requirements being included in appraisal

3. A lead Appraiser is needed in Secondary Care to ensure appraisers meet on a regular basis (minimum every 6 months), facilitate ongoing training in the role and provide support outside of the governance structure
4. Appraisers of all grades should have SPA identified to undertake appraisals
5. Additional Secondary Care Appraisers need to be identified as doctors are now having to go outside the Health Board to secure an Appraiser
6. Formalising lay/patient input into the revalidation process, possibly as part of an RO Advisory Group would be beneficial
7. A revalidation action plan should be developed and implemented as per previous Revalidation Progress Report return
8. New starters to the Health Board would benefit from revalidation and appraisal guidance being including within their induction

Quality Standard Areas	Summary Notes
1. Resources and structures to support appraisal	
Engagement with appraisal (RPR 2.2.1, 2.2.2, 2.2.3)	Appraisal rates are high, above average for Wales, and the HB should be proud of this achievement. PA to RO monitors doctor's engagement with appraisal, following up on those overdue. As a relatively small HB this is manageable. Appraisal due dates also flag within the ESR system.
Appraiser selection and training (RPR 2.2.4, 2.2.5)	Primary Care – Appraisers have to apply via a formal recruitment process including interview and role play scenarios. Successful applicants then undertake Appraiser training followed by a probation period in which they are supported by their Appraisal Co-ordinator. Secondary Care – Appraisers volunteered for the role but there was not a formal recruitment process. Appraisers attended Appraiser training provided by the RSU and of those spoken to during the review they had attended a Regional Appraiser Conference as further training in the role. All Appraisers present agreed that there is a need for an Appraisal Lead role in Secondary Care to support and provide guidance.
Appraiser support and management (RPR 2.2.5)	The RO has an open door policy in terms of Appraisers approaching him for advice. Ongoing training for Appraisers is not something provided by the HB, although they are in support of Appraisers attending educational events. Primary Care – Appraisers are managed and supported by their Appraisal Co-ordinator and the RSU. Appraisers indicated that this support was sufficient. Appraisers felt able to adapt to changes such as revalidation being introduced.

Quality Standard Areas	Summary Notes
	Secondary Care - There is not currently a management structure for Secondary Care Appraisers apart from the RO. The HB have started to draft a job description for an Appraisal Lead role and will be looking to recruit in the future. Secondary Care Appraisers highlighted that they would benefit from having an Appraisal Lead which is separate to the governance system. Also allowing time for Appraisers to get together and discuss issues would be very useful. Appraisers mentioned a case they were aware of in which a Staff grade doctor had been told to undertake the role of Appraiser within their current SPA time and was not allocated anything additional. Appraisers highlighted that if a specialty only has one Appraiser it can become a burden as all colleagues within that specialty request only them as an Appraiser.
Appraisal management structures	Appraisal management structures are minimal within the HB, as there are a relatively small number of doctors the PA to the RO monitors appraisal engagement.
Supporting information (RPR 2.1.4) **Provision of info** **GMC standards**	The HB provides funding and time for CPD and this would also include that for revalidation requirements. Further information provided in 'Supporting Doctors in the DB' section. The RO checks all doctors job plans to ensure their appraisal covers whole scope of practice. If information from all roles is not included in appraisal the RO would follow this up and contact other places of work to get clinical governance assurances. The HB would benefit from formalising a process for ensuring whole practice appraisal is taking place.
Appraisal outputs (RPR 2.2.6) **Quality** **Using data**	The HB's scores at the recent Regional Quality Assurance event run by RSU highlighted above average scores for the summaries reviewed from Powys. However it should be noted that only a very small percentage of those from the HB were reviewed. The HB acknowledged that quality can always be improved. Primary Care – Appraisers felt supported by having regular feedback on their appraisal summary outputs from their Appraisal Co-ordinator, leading to improved quality. During regular Appraiser group meetings issues are discussed to gain consensus and share learning.

Quality Standard Areas	Summary Notes
	Secondary Care – Appraisers highlighted a need for support structure. Some were aware of being able to gain access to feedback from doctors they had appraised on MARS.
Benefits of appraisal (RPR 2.2.7)	
2. Resources and structures to support revalidation	
Supporting doctors in the DB **E.g. induction** **CPD, Appraisal** **Provision of data**	Doctors within the HB have the full support of the RO and Board to undertake CPD, barriers such as funding or time to undertake CPD are not seen as an issue. Within Primary Care CPD tutors are funded to provide monthly educational meetings, one of which the RO has personally delivered previously. This is of great benefit to doctors within the HB. The HB are very keen to maintain their high appraisal rates and the senior management team felt there were no issues for doctors finding appraisers. However Secondary Care doctors during their feedback session did not agree and felt there was a need for more Secondary Care Appraisers within the HB to ensure there was a sufficient pool. The appraisee who attended the review session highlighted that appraisal within Powys HB had been what he thought appraisal should be, he had experienced a varied quality of appraisal within other HBs. There is a need for more Appraisers to be available within certain specialties, some doctors have had to use Appraisers outside Powys HB. It would be beneficial to include guidance on revalidation and appraisal within new starters' induction. The HB have been supportive in terms of appraisal and as far as he was aware colleagues had not experienced any issues with revalidation or collating the elements required. Time is allocated for CPD and clinical data is available to doctors if they know what they want.
Structures to support revalidation (RPR 2.1.1, 2.1.5)	Revalidation team within the HB is small, consisting of RO and PA to RO. The previous RO had identified the need for a Revalidation Support Officer but it is felt this is not a current priority.

Quality Standard Areas	Summary Notes
	An Assistant Medical Director has recently been appointed who will be taking on the role of Deputy RO, this will provide further revalidation support and cover in the event of RO absence. Patient complaints are discussed at Board meetings. The Chief Executive and RO see all complaints, this is another advantage of having a relatively small HB, and it enables senior management to maintain an overview of all issues. Previously a clinical concern that arose had been documented and discussed at appraisal which is reassuring for the HB. It was suggested by the review team that it may be beneficial to include a lay representative in other areas of the revalidation or quality assurance processes. The creation of an RO advisory group may be helpful for the RO to support decision making, making those decisions independently of any other colleagues is a risk. The RO does plan to make changes in terms of education within the HB and hopefully have more trainees. Revalidation support may then sit within the education team.
Revalidation recommendations (RPR 2.1.2, 2.1.3, 2.1.8)	The RO personally reviews all summaries and supporting documents for doctors due for revalidation. He makes the decision himself, so far nearly all have been straight forward. One recommendation required the RO to seek further advice from other ROs, the GMC ELA and the RSU. The RO is mindful to discuss difficult decisions with other knowledgeable colleagues as a sense check. If a case for making a second deferral recommendation for a doctor were to come up the RO would seek further guidance on this from the RSU and/or the GMC ELA, as this is not something he has done before and would want to make the right decision for the doctor.
Deferrals (RPR 2.1.3)	Deferral decisions have been made but usually this is not required as doctors seem to engage well with appraisal. A second deferral decision has not been required within the HB to date.
QM (RPR 2.1.6)	The HB's previous RPR indicates that a revalidation action plan will be produced, this has not been actioned by the HB yet but now an Assistant Medical Director has been appointed this will be revisited.

Quality Standard Areas	Summary Notes
National support / consistency (RPR 2.1.8) **Is support meeting needs?**	The RO attends RO Support Network meetings and has attended RO training. RO Support Network meetings are seen as very useful in terms of discussing how others deal with out of the ordinary cases, the RO takes this on board as there may be a need for this knowledge in the future. Quality assuring RO decisions is hard to do, the RO suggested that one way to approach this would be to undertake a benchmarking exercise with other ROs.
Benefits of revalidation	The benefits of revalidation include encouraging doctors to reflect and it probably does reassure the public. The best outcome has been getting doctors to look at and think about what they've done.
3. Governance	
Link with HR processes (RPR 2.3.1, 2.3.2, 2.3.3, 2.3.5, 2.3.6, 2.3.7) **Recruitment & pre-employment** **Performance management, dealing with concerns**	New joiners to the HB provide previous appraisal summaries and information is sought from the previous RO. The RO would also utilise the GMC ELA if required for further information. The RO has not had to 'push' on information yet as no doctors have left since being in post. He would liaise with the next RO if this was required. The RO would be aware of any clinical governance issues as he is the HB lead for this area. The HB maintains files for all doctors which contain any relevant information, and these files are reviewed prior to making a revalidation recommendation. The Medical Workforce team also pick up relevant information and inform RO to ensure all parties are aware.
MPL (RPR 2.3.2)	
Locums (RPR 2.3.6)	Powys HB do use locums and regularly are in contact with other relevant ROs to share information, concerns have been previously raised by Powys which the doctors own RO was not aware of. There have been previous cases within the HB regarding overseas doctors returning to undertake appraisal, this can sometimes lead to the RO seeking advice from other ROs, RSU and GMC ELA regarding revalidation recommendations as it is not a straight forward decision. These scenarios are taken on a case by case basis.

Quality Standard Areas	Summary Notes
Board (RPR 2.3.8)	The Board have a role in strongly supporting CPD activity for all their doctors. The Board has an insight into appraisal and revalidation as an independent member of the Board also sits on the Safety and Quality committee which discusses such issues.

Designated Body Action Plan and Comments (to be completed by designated body and returned to Katie Leighton on katie.leighton@wales.nhs.uk by **25th March 2019**

Designated Body General Comments: We are satisfied with the content and accuracy of the report and are grateful to the review team for pointers to further enhance PTHB's support for revalidation.			
Action Plan completed by: Mr Wyn Parry, Medical Director			
ACTION	**INDIVIDUAL**	**TIMESCALE**	**OUTCOME MEASURE**
Develop SOP to monitor whole practice appraisal	Jane Parry Library Services Manager	In process	Production of written protocol
Support revalidation decision making: -input of deputy RO (post training) -consider introduction of lay representation	Wyn Parry -Dr Jeremy Tuck (assistant MD) -discuss with PTHB as part of wider recruitment of lay members	 In process 3 months	 Completion of training Dependent on PTHB response
Identify/ recruit lead appraiser for secondary care	Mark McIntyre/ Wyn Parry	Role advert drafted. 3 months	Identification of individual; support for training
Identify more secondary care appraisers	Mark McIntyre/ Wyn Parry	6 months	Identification, training and support. Identification may follow more easily from joint mentoring course in Sept 2019
Identify SPA time for appraisers by job plan review	Clinical directors	6 months	Job plan reflects SPA activity
Develop information/ guidance on appraisal and revalidation for new medical appointees to PTHB	Wyn Parry/ Mark McIntyre	6 months	Production of appropriate material within induction presentation.

Appendix 1

Supporting Documents provided to visiting team by designated body prior to visit:

- Revalidation Structure
- WOD_Item_3.3_Medical Revalidation and Appraisal Annual Report for 2017 (003).pdf

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 3.10

EXPERIENCE, QUALITY AND SAFETY COMMITTEE	**Date of Meeting: 3 June 2021**
Subject:	**Final update of the 2020/21 Clinical Audit Plan**
Approved and Presented by:	Kate Wright, Medical Director
Prepared by:	Howard Cooper, Safety & Quality Improvement Manager
Other Committees and meetings considered at:	Quality Governance Group

PURPOSE:

The purpose of this paper is to inform the Experience, Quality and Safety Committee of the final position of the 2020/21 Clinical Audit plan.

RECOMMENDATION(S):

The Experience, Quality and Safety Committee is asked to receive and discuss this report.

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

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

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

	5. Timely Care	✓
	6. Individual Care	✓
	7. Staff and Resources	✓
	8. Governance, Leadership & Accountability	✓

EXECUTIVE SUMMARY:

This report provides the **final position in relation to the** 2020/21 Clinical Audit plan. Whilst much was achieved and key priority audits were undertaken, the workforce and clinical constraints brought about by the pandemic have led to some audits not being completed. These are detailed below along with summaries of completed audits by specialty.

DETAILED BACKGROUND AND ASSESSMENT:

Background

This report provides an update on the final position at the end of the 2020/21 Clinical Audit Programme. The Directors and Service Leads have asked for the Committee to receive this update to the Clinical Audit plan.

The 2020/21 Clinical Audit plan updated with the final status of each audit is listed in Appendix A. Where audits were not completed these have been reviewed and risk assessed by specialty leads. These will be reviewed again as part of ongoing audit review for 2021/22.

The programme of audits for 2021/22 was presented in December and is proceeding as planned.

Audits reporting their findings this period

Radiology

The Radiology service completed the suite of seven audits that are required for their service re-validation process. The audits were reported and discussed at the Radiation Protection Committee on 15 December 2020. The following actions were agreed.

- The audit template will be reviewed and amended to create a uniform template for the audits across Powys.
- The Radiation Protection Supervisors (RPS) will form a group to meet regularly and plan the audit timetable.
- The RPS will set up a uniform Quality Assurance program.
- A monthly Radiography Imaging Optimisation Team (RIOT) has been set up to audit performance based on procedure outcomes.

Speech and Language Therapy

The Adult Speech and Language Therapy team conducted an audit of the on-line patient record system that they had adopted to allow for greater flexibility of staff assignments in response to the Covid 19 pandemic. The

main issues identified concerning the system was the failure to record the language preference of the client in accordance with the Welsh Language (Wales) Measures 2011. It is planned to address this issue in future updates of the Welsh Community Care Information System (WCCIS).

In terms of clinician actions, the main areas for improvement identified by the audit were the need to use the 24-hour (military time) style of recording time, the need to include an impressions diagnosis in the notes, and the need to counter sign any entries made by support workers or student staff.

Podiatry
The podiatry staff have completed their documentation audit however analysis of the results will not be available until late May 2021.

Community Dental Service
The Community Dental Service reported the completion of their annual programme of WHTM01-05 audits on the decontamination of surgical instruments and also of their radiography grading audits. Both audit programmes reported excellent results.

Corporate Nursing Team
The Corporate Nursing Team reports the completion of the Fundamentals of Care Audit, the Pressure Ulcer Prevention Audit and the Compliance with the Serious Incident Policy Audit. Results of the audits will be available by the end of May.

Women and Childrens Service
The Women and Childrens Service report that the Epilepsy 12 and the Child Protection Medicals in Powys audits have been completed and that the audit reports will be completed by the end of May.

Mental Health
The Mental Health service reported on the Care and Treatment Plan (CTP) Audit. 102 patient files were examined. 84% of patients had an up to date risk assessment with 81% having a CTP that had been reviewed in the last 12 months. For 76% of the patients there was a clear record of their current medication regime. The findings were reported and review of the patients who did not meet the standard indicated that in most cases it was because they had been discharged from the caseload. The Clinical Lead was able to identify areas that need more attention or staff that need more support.

The Infection Prevention and Control (IPC) audit was also completed and the results reported to the IPC committee. As a result of the audit, quarterly IPC improvement meetings with the three service leads were introduced to allow for the better exchange of information and issue reporting.

Pain and Fatigue Management Service (PFMS)
The PFMS conducted an audit of the treatment of lower back pain against NICE standards (NICE Guideline NG59). The service was compliant with 93%

of the applicable standards. A plan was put in place to address areas not fully compliant and this included the amendment of assessment paperwork to include relevant section for diagnosis review and screening and to ensure that NICE guidance was embedded into referral pathway for interventions.

The Committee is asked to note the completion of these audits.

Organisational structure developments with regard to audit
During the second half of 2020 the Women and Childrens Service began to hold monthly audit and improvement meetings over Microsoft Teams. These have proved very popular with staff as they have allowed for potentially dispersed teams to share audit findings and provide mutual support.

Inspired by these meetings, the Community Services Group have organised their own series of meetings. In their first meeting in April, radiology audits, Occupational Therapy notes audits, the documentation of best interest decisions for those unable to give consent and patients experience of having an endoscopy were amongst the topics discussed.

Changes to the local 2020/21 Clinical Audit plan

The Directors and Service Leads request that the Committee approves the following changes to the 2020/21 Clinical Audit plan. Not all of the audits for this period were completed as a result of resource and staffing constraints during the pandemic. These have been reviewed and risk assessed by the teams and will be revisited as we move forwards.

Service Area	Name of Audit	Change requested	Reason for change	Risks involved	Proposed new date of audit
Safeguarding	Safeguarding Supervision Audit	Delay of Audit to the 2021/22 programme	New process to be introduced which will reduce relevance of audit of previous system	None considered significant	September 2021
Corporate Nursing Team	Falls Audit	Delay of Audit to the 2021/22 programme	Insufficient capacity to complete audit at this time.	None considered significant.	September 2021
Podiatry	Taxonomy (Patient risk category assignment) audit.	Delay of Audit to the 2021/22 programme.	the audit will be of more value if done after the implementation of new codes onto the WPAS system.	None considered significant.	September 2021
Clinical Musculoskeletal Assessment and Treatment Service	Referral management audit	Removal from programme	The service was unable to complete these audits due to service changes forced by the pandemic	None considered significant.	

Women & Childrens Service	WAST Transfer Audit.	Delay of Audit to the 2021/22 programme.	Insufficient capacity to complete audit at this time.	None considered significant.	September 2021
Women & Childrens Service	Recording of Antenatal Alcohol Exposure.	Delay of Audit to the 2021/22 programme.	Insufficient capacity to complete audit at this time.	None considered significant.	September 2021
Community Nursing	Audit of the Care of patients fed *via* naso-gastric tubes.	Removal from programme due to being no longer required.	Audit proposed as a result of the decision to admit future patients to Powys with NGTs. However, no patients in this category have actually been admitted and are unlikely to be in the future as the pandemic recedes.	None considered significant.	-
Community Dentistry	Patient experience questionnaires	Removal from programme	The service was unable to complete these audits due to service changes forced by the pandemic	None considered significant.	
Community Dentistry	Notes Audits	Removal from programme	The service was unable to complete these audits due to service changes forced by the pandemic.	None considered significant.	
Specialist Nursing Parkinson's	Parkinson's care audit.	Removal from programme	The service was unable to complete these audits due to service changes forced by the pandemic.	None considered significant.	
Mental Health	NICE guidance on Dementia	Removal from programme	Insufficient capacity to complete audit at this time.	None considered significant.	
Mental Health	Clozapine and physical health audit	Removal from programme	Insufficient capacity to complete audit at this time.	None considered significant.	
Mental Health	Audit of prescription charts against BNF standards	Removal from programme	Insufficient capacity to complete audit at this time.	None considered significant.	
Mental Health	Mental Health Act Documentation	Removal from programme	Insufficient capacity to complete audit at this time.	None considered significant.	
Mental Health	ECGs undertaken on Older Adult Mental Health	Removal from programme	Insufficient capacity to complete audit at this time.	None considered significant.	

	in-patient units				

Appendix A

Clinical Audit Plan 2020/21

Primary, Community & Mental Health Care Services Directorate				
Community Nursing				
Driver	**Audit Title**	**Start Date**	**Lead**	**Final Status**
National Audit Programme	Pulmonary Rehabilitation	April 2020	CSM South	COMPLETED BUT NOT YET REPORTED
National Audit Programme	Cardiac Rehabilitation Audit	Ongoing database	AD Community Services	COMPLETED BUT NOT YET REPORTED
Serious Incident Learning	DNACPR Audit	June 2020	Head of Nursing	July 2020 COMPLETED
Serious Incident Learning	NEWS Chart use Audit	June 2020	Head of Nursing	July 2020 COMPLETED
Changes to existing policy or practice	Care of patients fed *via* naso-gastric tubes	Q3 2020	Head of Nursing	Q4 2020 NO LONGER REQUIRED
Mental Health				
Driver	**Audit Title**	**Start Date**	**Lead**	**Final Status**
Service Improvement required	Clozapine and physical health audit	January 2020	Dr Sadid	*Q4 2020/21* STOOD DOWN

Service Improvement required	Audit of prescription charts against BNF standards	March 2020	Clinical Director Mental Health and Learning Disabilities	*Q4 2020/21* **STOOD DOWN**
Changes to existing policy or practice	Mental Health Act Documentation	March 2020	Clinical Director Mental Health and Learning Disabilities	*Q4 2020/21* **STOOD DOWN**
Changes to existing policy or practice	ECGs undertaken on Older Adult Mental Health in-patient units	May 2020	Advanced Nurse Practitioner	*Q4 2020/21* **STOOD DOWN**
Serious Incident Learning	Care and Treatment Plan (CTP) audit	February 2020	Senior Manager, Adult Mental Health Montgomeryshire	*Q4 2020/21* **COMPLETED**
Service Improvement required	Tawe Ward CTP audit	January 2020	Ward Manager	*Q4 2020/21* **COMPLETED**
National Audit (Non-Programme)	Tawe Ward IPC audit	August 2020	Ward Manager	*Q4 2020/21* **COMPLETED**
Service Improvement required	NICE Guideline Dementia Ystradgynlais Older Adult CMHT	January 2020	Community Mental Health Nurse	*Q4 2020/21* **STOOD DOWN**
Dentistry				
Driver	**Audit Title**	**Start Date**	**Lead**	**Final Status**
National Audit (Non-Programme)	WHTM01-05	April 2020	senior Dental Therapist	*Q4 2020/21* **COMPLETED**
National Audit (Non-Programme)	Patient Experience Questionnaire (CDS)	May 2020	Dentist	*Q4 2020/21* **STOOD DOWN**
National Audit (Non-Programme)	Patient Experience Questionnaire (Oral Surgery)	March 2020	Dental Nurse Oral Surgery Team Lead	*Q4 2020/21*

				STOOD DOWN
Service improvement required	Radiography grading	Continuous yearly run chart	Dental Director	Continuous yearly run chart COMPLETED
Service improvement required	Hand Hygiene	April 2020 and October 2020	Senior Dental Therapist	*Q4 2020/21* STOOD DOWN
Service improvement required	Clinical record keeping	November 2020	Dentist	*Q4 2020/21* STOOD DOWN
Service improvement required	Clinical record keeping (special care)	March 2020	Specialist in Special Care	*Q4 2020/21* STOOD DOWN
Primary Care				
Driver	**Audit Title**	**Start Date**	**Lead**	**Final Status**
National Audit Programme	National Diabetes Core Audit	To be determined nationally	Remote audit of GP computer system	COMPLETED BUT NOT YET REPORTED
Service improvement required	Patient Safety Programme	September 2019	Prescribing lead within each practice	Stood down by Welsh Government
Service improvement required	Reducing Stroke risk through improved management of AF in primary care clusters	September 2019	Lead GP	Stood down by Welsh Government
Service improvement required	Multidisciplinary Antimicrobial Stewardship Urinary Tract Infection (UTI)	September 2019	Antibiotic lead	Stood down by Welsh Government

Service improvement required	Diabetes Gateway	April 2020	Diabetes lead	Stood down by Welsh Government
Women's and Children's Service				
Driver	**Audit Title**	**Start Date**	**Lead**	**Final Status**
National Audit Programme	National Maternity and Perinatal Audit	To be determined nationally	Head of Midwifery	To be determined nationally
National Audit Programme	National Audit of Seizures and Epilepsies in Children and Young People	To be determined nationally	Consultant Community Paediatrician	COMPLETED
Child Protection Quality Standards (UK)	Child Protection Medicals in Powys	Q4 2020/21	Consultant Community Paediatrician	Q4 2020/21 COMPLETED
FOI request re FASD	Recording of Antenatal Alcohol Exposure on Adoption Medical Reports	Q4 2020/21	Consultant Community Paediatrician	Q4 2020/21 DELAYED TO 21/22
Changes to existing policy or practice	WAST Transfer Audit.	Q3 2020/21	Head of Midwifery	Q4 2020/21 DELAYED TO 21/22
Changes to existing policy or practice	Birth Trauma Service Audit.	Q3 2020/21	Head of Midwifery	Q4 2020/21 COMPLETED
Service improvement required	Paediatric Triage Audit.	Q3 2020/21	Head of Midwifery	Q4 2020/21 COMPLETED

Therapies and Health Sciences Directorate				
Driver	**Audit Title**	**Start Date**	**Lead**	**Final Status**
National Audit Programme	National Diabetes Foot Care Audit	To be determined nationally	Head of Podiatry	**Stood down by Welsh Government**
National Audit Programme	All Wales Audiology Audit	To be determined nationally	Head of Audiology	**Stood down by Welsh Government**
National Audit Programme	Stroke Audit (SSNAP)	Ongoing	Professional Head Physiotherapy	Ongoing **COMPLETED**
Change to policy or procedure	Consent taking and initial assessment process.	Q3 2020	Pain Management Service	Q3 2020 **COMPLETED**
Service improvement required	OT Documentation	April 2020	Head of Therapies	Sep-20 **COMPLETED**
Service improvement required	Documentation audit	September 2020	Head of Podiatry	March 21 **COMPLETED**
Service improvement required	Taxonomy audit	December 2020	Head of Podiatry	Mar-21 **DELAYED TO 21/22**
Service improvement required	NICE Audit Low Back Pain	December 2020	Clinical Specialist Physiotherapist	Mar-21 **COMPLETED**
Service improvement required	Clinical Notes audit - Pain and Fatigue service	November 2020	Clinical Specialist Physiotherapist	2021 **COMPLETED**
Service improvement required	Parkinson's Care	2021	PD UK	2021 **STOOD DOWN**
Service improvement required	SLT notes	2020 - 2x yearly	Head Adult Speech & Language	2021 **COMPLETED**

Audit for re-accreditation	Radiography: Non-medical referrers audit	September 2020	Team Lead/ Supt Radiographer	Oct-20 **COMPLETED**
Audit for re-accreditation	Compliance with Standard operating procedures (SOP's)	September 2020	Team Lead/ Supt Radiographer	Oct-20 **COMPLETED**
Audit for re-accreditation	Compliance with gonad protection standards	September 2020	Team Lead/ Supt Radiographer	Oct 20 **COMPLETED**
Audit for re-accreditation	Reject analysis	September 2020	Team Lead/ Supt Radiographer	Oct 20 **COMPLETED**
Audit for re-accreditation	Recording of date of last menstrual period	September 2020	Team Lead/ Supt Radiographer	Oct 20 **COMPLETED**
Audit for re-accreditation	Correct use of radiographic markers	September 2020	Team Lead/ Supt Radiographer	Oct 20 **COMPLETED**
Audit for re-accreditation	Radiographer commenting audit	September 2020	Team Lead / Supt Radiographer	Oct 20 **COMPLETED**
Service improvement required	Physiotherapy Notes	TBC	Professional Head Physiotherapy	March 21 **COMPLETED**
Service improvement required	CMATS- referral management	TBC	**DoTH Sponsor** Professional Head Physiotherapy	March 21 **STOOD DOWN**
Nursing Directorate				
Driver	**Audit Title**	**Start Date**	**Lead**	**Final Status**
Serious Incident Learning	Falls Audit	Q3 2020	Assistant Director of Nursing	End Q4 2020 **DELAYED TO 21/22**
Service improvement required	Fundamentals of nursing care	Q4 2020	Assistant Director Quality & Safety	Q1 2021 **COMPLETED**

Serious Incident Learning	Pressure Ulcer Prevention	Q3 2020	Assistant Director Quality & Safety	End Q4 2020 **COMPLETED**
Serious Incident Learning	Compliance with the serious incident policy	Q4 2020	Assistant Director Quality & Safety	End Q4 2020 **COMPLETED**
Safeguarding				
Driver	**Audit Title**	**Start Date**	**Lead**	**Final Status**
Service improvement required	Safeguarding Maturity Matrix	July 2020	Assistant Director Safeguarding	Sep-20 **COMPLETED**
Service improvement required	Safeguarding Supervision Audit	December 2020	Senior Nurse Safeguarding	Feb-21 **DELAYED TO 21/22**

Audit Driver Key:

	Driver
	Welsh Government National Audit Programme
	Other National Audits
	Audits performed for accreditation schemes
	Local Audits for service improvement
	Local Audits following change to policy or procedure
	Local Audits in response to a Serious Incident
	Other

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 3.11

EXPERIENCE, QUALITY & SAFETY COMMITTEE	**Date of Meeting: 3rd June 2021**
Subject :	**Safeguarding during covid-19: Violence Against Women Domestic Abuse and Sexual Violence**
Approved and Presented by:	Alison Davies**,** Director of Nursing and Midwifery
Prepared by:	Jayne Wheeler Sexton Assistant Director of Safeguarding and Public Protection
Other Committees and meetings considered at:	The information within this report has been shared at the Health Board's Safeguarding and Public Protection Group and the internal audit discussed at Audit Committee.

PURPOSE:
Further to previous recent reports, the purpose of this paper is to provide an update in regards to Violence Against Women Domestic Abuse and Sexual Violence (VAWDASV) and to share the outcome of the internal audit regarding safeguarding during covid.
RECOMMENDATION(S):
The Experience, Quality and Safety Committee is asked to note the report for information and discussion.

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 Covid-19 pandemic has had a profound impact on the way health care services have been delivered over the past year. The stay at home guidance during the height of the first lockdown limited and re-shaped the usual contact with patients, carers and professionals, all of which may have impacted upon the Health Board's ability to recognise an adult or child at risk.

The Health Board was subject to an internal audit into safeguarding during covid19, with the final report received in May 2021. The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with 'Safeguarding During COVID-19' is reasonable assurance, with 2 areas of substantial assurance and 3 of reasonable assurance, resulting in 1 medium and 1 low priority recommendation.

Legislation that drives the Health Boards 'safeguarding agenda' did not change, this included the Violence against Women, Domestic Abuse, Sexual Violence (Wales) Act 2015, which required a national, regional and local response in order to safeguard victims and their families.

The Health Board has worked closely with partner agencies to respond to VAWDASV. There was initially an increase in operational VAWDASV meetings to enable a proactive response to the emerging crisis and the development of a regional pathway to support practitioner navigate advice and support for victims, later, in preparation for the recovery phase partners contributed to the 2021/22 VAWDAVS Regional Priorities.

The Experience Quality and Safety Committee can take assurance that the focus on safeguarding, public protection and VAWDASV has been maintained throughout the pandemic, albeit an exceptional period whereby the circumstances and effects on families, communities and society as a whole are unprecedented, likely to evolve over time and have far reaching effects across generations.

DETAILED BACKGROUND AND ASSESSMENT:

1. Background

1.1 Throughout the Covid-19 pandemic, safeguarding and public protection has remained a key priority for the Health Board, this has been demonstrated by the safeguarding team not being redeployed as part of the Health Board's response to the pandemic.

1.2 The Health Board was subject to an internal audit into safeguarding during covid19, with the final report received in May 2021 **(appendix 1).** The objective of the audit, undertaken by NHS Wales Shared Services Partnership Audit and Assurance Services, was to review Health Board arrangements for the safeguarding of children and vulnerable adults during the COVID-19 pandemic. The internal audit assessed the adequacy and effectiveness of the internal controls in operation. The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with 'Safeguarding During COVID-19' is reasonable assurance, with 2 areas of substantial assurance and 3 of reasonable assurance, resulting in 1 medium and 1 low priority recommendation.

1.3 Legislation that drives the Health Boards 'Safeguarding agenda' did not change, this included the Violence against Women, Domestic Abuse, Sexual Violence (Wales) Act 2015 which required a national, regional and local response in order to safeguard victims and their families. VAWDASV stands for Violence against Women, Domestic Abuse and Sexual Violence.

1.4 Home Office Statistics (2020) identify that 1 in 4 women and 1 in 6 men are victims of some form of VAWDASV. The Act sits alongside the Social Services and Well-Being (Wales) Act 2014 which provides a legal framework for transforming social services and improving the well-being of adults and children who need care and support, and the Well-being of Future Generations (Wales) Act 2015, which requires public bodies to think about what actions and activities are required to improve the well-being of current and future generations.

2. The impact of the Covid-19 pandemic on Violence Against Women Domestic Abuse and Sexual Violence

2.1 2The pandemic has affected us all, however the social, economic and health impact of Covid-19 have not been distributed equally across our population. Covid-19 has interacted with existing health inequalities putting

certain communities and individuals at higher risk. This is also the case for violence and adverse childhood experiences.

2.2 National and international data measuring the impact of Covid-19 on violence tells us; women, children, older people, people from black and minority ethnic communities, people with disabilities and those who are socially isolated and/or vulnerable are at a higher risk of victimisation and have been disproportionally affected. Key Findings and Overall Trends of VAWDASV are listed in **appendix 2.**

3. National and Regional Response to VAWDASV

3.1 In Wales, the VAWDASV (Wales) Act 2015 places a duty on all public services, including Health Boards, to focus on the prevention of VAWDASV, as well as the protection of survivors and support for all those affected. All public services must ensure that they implement strategies to reduce VAWDASV at all levels of the prevention spectrum. Welsh Government made available Capital Grants to support Wales' response to the increased demands on services as a result of Covid-19. During July 2020 Welsh Government launched its National Communications Campaign on the importance of reporting any suspected domestic abuse including abuse or neglect during the Covid-19 pandemic. The campaign used webpages, animation and social and digital media platforms.

3.2 Within Mid and West Wales there are two groups dedicated to VAWDASV; a Strategic Group and a Delivery Group consisting of membership from all four Local Authorities, both Health Boards and Dyfed Powys Police, along with a number of other key agencies including specialised VAWDASV charities and organizations. Throughout the height of the pandemic the Regional VAWDASV Delivery Group met monthly which assisted in agencies coming together to support a regional, coordinated response to VAWDASV. The VAWDASV Regional Advisor coordinated successful applications from across the regional partnership.

3.3 During April and May 2020 Dyfed Powys Police recorded a 39% drop in calls about domestic abuse. The 3rd sector, Domestic Abuse Services and SARC referrals all reported a drop-in contact with victims ranging from 60 to 80%. While the statistics did not show an increase in reports of domestic abuse in the wake of Covid-19, it was anticipated that the actual instances of domestic abuse were likely to have increased. By June 2020 the number of domestic abuse incidents reported to Dyfed Powys Police were slowly returning to pre-pandemic levels, by January 2021 Domestic Abuse providers reported referrals rates at the same level as previous the year for adult and children outreach support. The second Covid-19 lockdown did not impact on reports like in the first wave, however local support agencies report the abuse that is being presented appears to be more complex and requiring specialist support.

3.4 In recognition that addressing the abusive behaviours of perpetrators is fundamental in keeping victims and children safe**,** the Strategic Partners of the Mid and West Wales Regional VAWDASV Partnership agreed to fund the current

Regional Perpetrator Programme throughout 2021/22, this will enable analyse of the need and demand on a regional basis and inform options for future arrangements for commissioning such a provision. Nationally this is being recognised as an excellent piece of work and other regions are interested to see how it evaluates.

3.5 Child to Parent Abuse has increased within the region. Work is ongoing with Dyfed Powys Police on a specific pilot to support the identification of CPA and referral pathways into safeguarding. This is being evaluated with support from a Welsh Government masters student project. A Regional CPA Policy is in development.

4. PTHB response and update to VAWDASV

4.1 Safeguarding and public protection remained a key priority for PTHB throughout the uncertain and unprecedented past 12 months. It is important that all health practitioners are aware of the potential impact of social isolation, home working and school closures on all children, young people and adults at risk of all forms of VAWDASV. This has been supported by:

- Production of a guide to safeguarding processes during the Covid-19 pandemic, the guidance reiterated that safeguarding people remains everyone's responsibility
- newsletters relating to VAWDASV, reminding staff, when safe to do so, to make every contact count and apply a low threshold for asking about domestic abuse, and to consider colleagues, friends, relatives and neighbours who might be victims of abuse.
- A link for Virtual Agent Chat Bot Pilot - an advice, guidance and sign posting tool hosted by Powys County Council has been added to PTHB internet site.
- Mass vaccine sites have been supplied with information packs on VAWDASV to support practitioners should they have a disclosure of abuse when vaccinating.
- Delivery of Group 2 Ask and Act training using the Teams platform. This has produced its own challenges, specifically looking at measures to support staff during the training and afterwards. For this reason, the numbers attending the training has been limited and there are two trainers at each session. Staff are advised not to undertake the training at home if they are not comfortable to do so. Overall evaluations of the training are positive and indicate that the competencies of the training were met for the majority of staff. The evaluations indicate the training has reached to all parts of the Health Board in the breadth of practitioners attending the course. Training Compliance has gradually improved during 2020/21, we are on track to comply with VAWDASV National Training Framework for Group 2 Ask and Act training by 2023.
- Specific domestic abuse risk assessment training for Health Visitors and Midwives is due to take place in June 2021.
- The Violence Prevention unit of Dyfed Powys Police presented at the PTHB Safeguarding Strategic Group to strengthen links and explore data sharing to support the development of a Powys vulnerability map.

In summary, the Experience Quality and Safety Committee can take assurance that the focus on safeguarding, public protection and VAWDASV has been maintained throughout the pandemic, albeit an exceptional period whereby the circumstances and effects on families, communities and society as a whole are unprecedented, likely to evolve over time and have far reaching effects across generations.

NEXT STEPS:

The recommendation made in the safeguarding during covid-19 internal audit report, will be addressed.

PTHB will continue to engage, debate and influence at a national, regional and local level ensuring the VAWDASV agenda moves forward. It is imperative that Wales commits to an evidence-based programme of primary, secondary and tertiary prevention and provides the necessary resources for its implementation and monitoring.

PTHB Safeguarding Team will continue to deliver against the VAWDASV Training Strategy and progress the Health Board to achieve Group 1 and 2 training compliance. The team will also continue to support staff with complex safeguarding concerns and with the reporting process.

Safeguarding during COVID-19

Internal Audit Report

2020/21

Powys Teaching Health Board

NHS Wales Shared Services Partnership

Audit and Assurance Services

CONTENTS Page

Review reference:	PTHB-2021-38
Report status:	Final
Fieldwork commencement:	09 April 2021
Fieldwork completion:	05 May 2021
Draft report clearance meeting:	11 May 2021
Draft report issued:	11 May 2021
Management response received:	18 May 2021
Final report issued:	20 May 2021
Auditors	Helen Higgs, Head of Internal Audit Osian Lloyd, Deputy Head of Internal Audit Mair Evans, Principal Auditor
Executive sign off	Alison Davies, Executive Director of Nursing and Midwifery
Distribution	Jayne Wheeler-Sexton, Assistant Director of Nursing - Safeguarding Raquel Bennett – Senior Nurse Safeguarding
Committee	Audit, Risk and Assurance Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors.

ACKNOWLEDGEMENT

NHS Wales Audit & Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Please note:

This audit report has been prepared for internal use only. Audit & Assurance Services reports are prepared, in accordance with the Service Strategy and Terms of Reference, approved by the Audit Committee.

Audit reports are prepared by the staff of the NHS Wales Shared Services Partnership – Audit and Assurance Services, and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of Powys Teaching Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

1. Introduction and Background

Powys Teaching Health Board (the 'health board') recognises its statutory duty to safeguard adults and children at risk and to promote their wellbeing. It is required to comply with Standard 2.7 of the Health and Care Standards, 'Safeguarding Children and Safeguarding Adults at Risk', including adhering to Social Services and Well-being (Wales) Act.

An adult at risk, is an adult who:

- is experiencing or is at risk of abuse or neglect,
- has needs for care and support (whether or not the authority is meeting any of those needs), and
- as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

A child at risk, is a child who:

- is experiencing or is at risk of abuse or neglect or other kinds of harm, and
- has needs for care and support (whether or not the local authority is meeting those care needs)

Through working in partnership with other statutory agencies, professionals, the third sector and wider community the heath board aims to meet its obligations in relation to safeguarding and protecting children and adults at risk of harm. The health board requires that all employees recognise that they have a responsibility to ensure that any child or adult, who may be at risk of harm, coming into contact with the health board, whether directly or indirectly, is safeguarded and protected from that harm.

2. Scope and Objectives

The internal audit assessed the adequacy and effectiveness of the internal controls in operation. Any weaknesses were brought to the attention of management and advice issued on how particular problems may be resolved and control improved to minimise future occurrence.

During 2019/20, we undertook a safeguarding review which focused on employment arrangements and allegations, following the Healthcare Inspectorate Wales (HIW) January 2019 report into Abertawe Bro Morgannwg University Health Board's handling of the employment and allegations made against Mr W. The health board received a reasonable assurance opinion.

The overall objective of this audit is to review health board arrangements for the safeguarding of children and vulnerable adults during the COVID-19 pandemic. The health board and its contracted services are required to

promote and protect the welfare and safety of children and adults at risk by conforming to legislation and guidance. This review considered the requirements of Standard 2.7 when determining if the health board has discharged its statutory requirements. The specific objectives to be reviewed are:

- to ensure that key policies and procedures conform to legislation and guidance – including suitable Disclosure and Barring Service (DBS) controls for staff and volunteers;
- to confirm that multi-agency co-operation is in place and in accordance with the Social Services and Well-being (Wales) Act;
- to determine if staff have received adequate training in relation to the protection of children and adults at risk, including the sharing of good practice;
- to ensure arrangements are in place to manage safeguarding issues, allegations and concerns raised;
- to ensure adequate governance arrangements exist, with clear strategy, risk management and leadership in place.

The impact of the COVID-19 pandemic was taken into consideration in our assessment of the appropriateness of the arrangements in place. We are aware that the restrictions placed on individuals to remain in their homes and the additional stresses of employment, social isolation, no school etc., could have a detrimental effect. Children, young people and adults are at an increased risk of abuse which may be undetected with catastrophic outcomes.

3. Associated Risks

The risks considered in the review are as follows:

- non-compliance with Standard 2.7, 'Safeguarding Children and Safeguarding Adults at Risk' and applicable legislation, guidance and policy;
- insufficient communication and co-operation with interested parties and organisations;
- a lack of training and development of staff to ensure effective working;
- lack of clear lines of accountability for safeguarding from the Board through to front line staff;
- risk of injury and death to vulnerable patients and staff, due to insufficient procedures, resources and training;
- safeguarding concerns and issues raised are not investigated appropriately; and
- inappropriate / insufficient governance and accountability arrangements without a clear channel of communication to the Board.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

We are required to provide an opinion as to the adequacy and effectiveness of the system of internal control under review. The opinion is based on the work performed as set out in the scope and objectives within this report. An overall assurance rating is provided describing the effectiveness of the system of internal control in place to manage the identified risks associated with the objectives covered in this review.

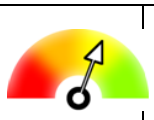
The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with 'Safeguarding During COVID-19' is **Reasonable assurance**.

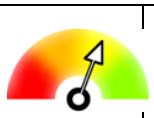
RATING	INDICATOR	DEFINITION
Reasonable Assurance		The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to **moderate impact on residual risk** exposure until resolved.

The overall level of assurance that can be assigned to a review is dependent on the severity of the findings as applied against the specific review objectives and should therefore be considered in that context.

5. Assurance Summary

The summary of assurance given against the individual objectives is described in the table below:

					
1	Policies, Guidance and procedures				✓
2	Multi-Agency relationships				✓
3	Staff training			✓	

					
4	Management of safeguarding referrals, allegations of abuse and complaints / concerns			✓	
5	Governance arrangements			✓	

** The above ratings are not necessarily given equal weighting when generating the audit opinion.*

Design of Systems/Controls

The findings from the review have not highlighted any issues that are classified as a weakness in the system control/design for 'Safeguarding During COVID-19'.

Operation of System/Controls

The findings from the review has highlighted two issues that are classified as a weakness in the operation of the designed system/control for 'Safeguarding During COVID-19'.

6. Summary of Audit Findings

The COVID-19 pandemic had a profound impact on the way health care services were being delivered. The stay at home guidance during the height of the first lockdown limited and re-shaped the usual contact with patients, carers and other professionals, all of which impacted upon the health board's ability to recognise an adult or child at risk. The health board issued a guide to Safeguarding processes during the COVID-19 pandemic which reiterated that safeguarding people remains everyone's responsibility and remained a key priority during this uncertain and unprecedented time. This was also demonstrated through the Safeguarding Team not being redeployed as part of the health board's response to the pandemic.

There has been a concentrated focus by the health board to strengthen its policies, procedures and guidance documents, in line with the development of the new National Safeguarding Procedures which came in to force in April 2020. In addition to the guide to Safeguarding processes during the COVID-19 pandemic, the Safeguarding Team also issued monthly safeguarding briefings and newsletters to staff. The health board continued to demonstrate a strong a commitment to partnership working including

through representation and contribution to the work of various multi-agency forums, including a number of weekly meetings set up to support local partners during the COVID-19 Pandemic.

Due to COVID-19 the Safeguarding team had to reconsider how to enable staff to achieve the training and competencies required. A decision was taken by the Strategic (Gold) Group within hierarchy of command established during the initial phase of the pandemic, that staff were required to complete a minimum level of training, recognising the risk that staff will not be trained to the level required for their permanent position. In order to mitigate this risk, the health board recognised the need to continue to provide safeguarding supervision to staff to support the training. The health board has continued to produce training material to give practitioners and staff a flexible, blended approach to learning, although improvements are needed in the compliance rates for certain modules.

The review identified that appropriate governance arrangements and clear lines of accountability exist for safeguarding. From discussions with senior health board staff and review of Board and Committee papers, it is evident that Safeguarding remained a key priority during this uncertain and unprecedented time. The Safeguarding Team have remained available to support an employee when they have a duty to report an adult or child at risk. The health board's Safeguarding Team monitors the numbers of referrals submitted for reporting purposes, although we noted an issue with the parameters used to generate the report. In addition, we analysed child and adult safeguarding incidents raised during 2020/21 and identified that an improvement is needed in respect of the monitoring arrangements to ensure referral forms are completed and submitted to the Local authority within 24 hours of a verbal report being raised.

7. Detailed Audit Findings

Objective 1: Safeguarding policies and procedures are in place and are consistent with the Safeguarding Strategic Plan and were maintained during COVID-19.

The Safeguarding policies and procedures are accessible to staff on the health board's intranet site, presented under national, regional and local policy headings. There is also a brief overview / introduction of each health board policy on the intranet page for the benefit of staff. The description of roles and responsibilities remain aligned across four key documents identified in respect of this audit: the NHS Safeguarding Maturity Matrix, Safeguarding Policy, Managing Allegations of Abuse or Neglect Made against Professionals & Members of Staff and the Safeguarding Supervision Protocol.

Additionally, the health board's Annual Safeguarding Report 2019-20 states that it has provided feedback at each consultation phase during the development of the new National Safeguarding Procedures. The Procedures were launched in November 2019 and came in to force in April 2020. The health board has contributed to consultations on regional and national policies through the safeguarding board and that there has been a concentrated focus by the health board to strengthen its policies, procedures and guidance documents.

The health board issued a guide to Safeguarding processes during the COVID-19 pandemic. This recognised that health care services are being delivered differently which is limiting and re-shaping the usual contact with patients, carers and other professionals, all of which had an impact upon the health board's ability to recognise an adult or child at risk. It reiterated that safeguarding people remains everyone's responsibility and remains a key priority during this uncertain and unprecedented time. This was demonstrated through the Safeguarding Team not being redeployed in the health board's response to the pandemic and in Board presentations, monthly safeguarding briefings and newsletters to staff and meetings.

We did not raise any findings in respect of this objective.

Objective 2: Effective multi-agency working relationships exist during COVID-19 to ensure a holistic approach to the investigation of safeguarding cases.

The protection and safeguarding of vulnerable adults and children rely on multi agency working and effective information sharing, working together to improve services and outcomes for all. The health board has continued to demonstrate a strong commitment to partnership working including through representation and contribution to the work of the Mid and West Wales Safeguarding Board (MAWWSB - also known as Cysur / Cwmpas), the Regional Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV) Strategy Group, and the Powys Local Safeguarding Operational Group (PLOG) for Adults and Children. This is in addition to the National NHS Wales Safeguarding Network and health board's own Committee structure and requires members of the health board's Safeguarding Team to attend a significant amount of meetings. Minutes and action notes are produced for each multi-agency meeting, including Professional Strategy meetings.

The Safeguarding Team continued to work with multi agency colleagues locally, regionally and nationally to safeguard people at risk of all types of abuse. The team took part and contributed to a number of meetings set up

to support during the COVID-19 Pandemic, including weekly Mid and West Wales Safeguarding Board Partners, weekly meeting with local partners including the Local Authority and the Police, the homeless cell coordination meeting and the monthly Mid and West Wales VAWDASV Operational Group. A multi-agency meeting to support children's homes response to COVID-19 also met weekly.

We did not raise any findings in respect of this objective.

Objective 3: Staff have received adequate training in relation to the protection of children and adults at risk during COVID-19.

Due to COVID-19 the Safeguarding team had to reconsider how to enable staff to achieve the training and competencies required. The health board cancelled all face to face training in March 2020, and staff were required to complete online training. Current employees, those being deployed and all new starters were required to complete, as a minimum, the Safeguarding People module which covers Safeguarding Adults and Children Level 1 and the Group 1 VAWDASV module. This decision was taken by the Strategic (Gold) Group within hierarchy of command established during the initial phase of the pandemic, recognising the risk that staff will not be trained to the level required for their permanent position.

The health board has continued to produce training material to give practitioners and staff a flexible, blended approach to learning, including developing You Tube training slides, newsletters and safeguarding briefings. By June 2020, the Safeguarding Team delivered training via Microsoft Teams and this was followed by the introduction of an additional training platform called Modular learning to assist in gaining the evidence that is required to achieve the competencies for level 3 safeguarding. The Competency Training Passport has also been updated and re launched via Newsletters and Powys Announcements. The health board also recognised that to support the training and mitigate any risks to good quality safeguarding, supervision is an essential component in keeping people safe and has provided safeguarding supervision to staff via MS Teams and telephone contact.

The health board has monitored the staff training compliance rates regularly. The table below illustrates the position improving between 2019-20 and 2020-21. The training modules which require improvement are highlighted in red below and include Level 3 Adults and Children, Level 4 Children and VAWDSV Level 2. In quarter 4 of 2020-21, the Safeguarding Team introduced a more detailed analysis of compliance rates so that they could identify the services areas requiring support to improve.

Training / Period	Quarter 4 2019/20	Quarter 1 2020/21	Quarter 2 2020/21	Quarter 3 2020/21	Quarter 4 2020/21
Adults Level 1	57%	83%	83%	84%	85%
Adults Level 2	37%	86%	85%	86%	86%
Adults Level 3 *		25%	25%	28%	34%
Adults Level 4 *		75%	80%	100%	100%
Children Level 1	72%	84%	84%	86%	86%
Children Level 2	62%	87%	86%	88%	88%
Children Level 3 *	45%	55%	54%	57%	65%
Children Level 4 *		37.50%	50%	62.50%	75%
VAWDSV Level 1		82%	83%	84%	82%
VAWDSV Level 2 **		18%	33%	44%	57%

** We were advised level 3 & 4 Safeguarding Adults and Children can take 12 months to complete.*
*** We were informed that in 2018/19 the Welsh Government set health boards 5 years to achieve compliance. We have been advised that the health board is on track to achieve this.*

Refer to finding 1 in Appendix A

Objective 4: Arrangements for managing safeguarding referrals, allegations of abuse against staff members and complaints / concerns relating to children, young people and adults at risk are robust and compliant with polices in place during COVID-19.

In line with objective 2 above, we were informed that during the height of the pandemic weekly multi-agency catch up meetings took place with the health board (senior safeguarding nurse), Police, Children's Services and Education typically in attendance. These meetings provided an opportunity to share updates, intelligence and best practice, challenge and raise issues or concerns regarding practice, learn from each other and a forum for support.

The health board has a policy for managing allegations of abuse or neglect made against professionals or members of staff and in 2020 introduced a mechanism for recording allegations of abuse or neglect against staff within adult care homes and children's homes. The table below illustrates the number of cases open and closed within the calendar year. Professional strategy meetings continued via MS Teams which was supported by a senior nurse from safeguarding team.

Practitioner Concerns	No. Cases Opened	No. Cases Closed	Still Active
PTHB Staff 2019	6	6	0
PTHB Staff 2020	6	6	0
PTHB Staff 2021 (up to April)	3	1	2
Children Care Homes 2020	15	15	0
Children Care Homes 2021 (Up to April)	7	4	3
Adult Care Homes 2020	1	1	0
Adult Care Homes 2021 (Up to April)	2	1	1

The Safeguarding Team have remained available to support an employee when they have a duty to report an adult or child at risk. All safeguarding reports must be made by practitioners when an Adult or Child at risk is identified. The report needs to be made by phone in the first instance to the Local Authority and then a multi-agency referral form (MARF) must be completed and sent to the Local Authority within 24 hours. The practitioner is also required to complete a record on the Datix incident reporting system.

The health board's Safeguarding Team monitors the numbers of referrals submitted for reporting purposes. Practitioners are expected to inform the safeguarding team if they are unhappy with the management of cases. We were informed that the quality of MARFs was audited for 6 months and found they were of a good standard in the main. The audit has now been merged with the data collection tool used to complete data collection for the Strategic Safeguarding Group.

During the course of our review of referrals we noted that there was an inconsistency in two reports provided to us for audit. After further investigation with the health board's Safeguarding Team it was determined that the parameters used to report on the number of safeguarding referrals raised had been incorrectly set. One of the key parameters for extracting the data (date of MARF referral) had been set on a non-mandatory field and if this was not populated on Datix then the referral would not form part of the report. Whilst the reports generated for reporting purposes were under recording referrals made, the underlying actual referral cases were being managed and reported to the local authority. The under reporting of safeguarding referrals and is set out in the table below. The revised reporting parameters will be set on the incident date going forward to ensure that all the relevant data is collated.

Multi Agency Referral Forms	Original DATIX Report		Revised Report		Difference	
	Child MARF Raised	Adult MARF Raised	Child MARF Raised	Adult MARF Raised	Child MARF Raised	Adult MARF Raised
Apr-20	6	4	9	5	**3**	**1**
May-20	10	2	12	5	**2**	**3**
Jun-20	7	6	15	7	**8**	**1**
Jul-20	9	5	15	8	**6**	**3**
Aug-20	13	3	19	4	**6**	**1**
Sep-20	10	4	11	5	**1**	**1**
Oct-20	19	7	19	7	**0**	**0**
Nov-20	23	4	26	6	**3**	**2**
Dec-20	15	12	14	11	**-1**	**-1**
Jan-21	12	5	15	7	**3**	**2**
Feb-21	13	10	12	13	**-1***	**3**
Mar-21	15	8	13	8	**-2***	**0**
Total	152	70	180	86	**28**	**16**

**Our expectation would be all the results would show a positive position (under reporting due to a field left blank so not collated into the report), however December 2020, February and March 2021 showed a negative figure. The explanation provided to us was that DATIX is a live system so data can be overwritten.*

It is worth noting the number of referrals remained relatively stable during quarter one, with a slight rise seen during quarter two, followed by a spike during quarter three. The change in referral rate can possibly be attributed to the changes in how practitioners engaged with individuals during the first lockdown. Whilst we concur there are robust arrangements in place including around policies, procedures and guidance, quality assurance checks over referral forms and training and supervision, there is no mechanism in place currently to demonstrate with any accuracy that MARFs are completed and sent by health board practitioners to the Local Authority within 24 hours of a verbal report being raised. We were also informed by the Safeguarding Team that no concerns have been raised regarding the timeliness of written reports to the Local Authority through the various methods of interaction with partners, as detailed under the multi-agency objective above. We understand that the Safeguarding Team will take this forward to address as part of the migration to the new "Once for Wales Concerns Management" system.

Refer to finding 2 in Appendix A

Objective 5: Appropriate governance arrangements and clear lines of accountability exist for safeguarding, from front line staff (including redeployments and volunteers) through to the Board, providing clarity in respect of roles and responsibilities during COVID-19.

The health board's governance arrangements for safeguarding remains consistent with that set out during our 2019/20 safeguarding review. The Chief Executive is responsible for providing overall assurance to the Board on the effectiveness and quality of the safeguarding arrangements within the health board. This is devolved to the Director of Nursing who is responsible for ensuring robust safeguarding systems and processes are in place in order that the health board can discharge its organisational responsibilities. The Assistant Director of Nursing for Safeguarding assumes day to day responsibility for safeguarding, which includes managing the Safeguarding Team. Roles and responsibilities are also defined for Heads of Service / Operational Managers, Senior Safeguarding Nurses and Workforce Business Partners. The health board's Vice Chair is the designated lead Independent Member for children's and young people's services with responsibility for providing oversight and scrutiny of the broader safeguarding agenda.

Assurance is provided to Board members via the Executive Committee and where applicable, via other relevant Committees such as the Experience, Quality and Safety (EQS) Committee. The health board's Safeguarding Strategic Group meets quarterly, acting as a forum '*for sharing learning, disseminating changes in legislation, policy and guidance, monitoring compliance with safeguarding mandatory training and sharing information from external meetings.'* The Safeguarding Strategic Group reports directly to the Quality Governance Group, a sub-group of the Executive Committee. A Safeguarding Operational Group is also in place which provides assurance to the Safeguarding Strategic Group.

From discussions with senior health board staff and review of Board and Committee papers, it is evident that Safeguarding remained a key priority during this uncertain and unprecedented time. This was reiterated through the Safeguarding Team not being redeployed in the health board's response to the pandemic. There have been a number of presentations and papers to Executives and Board Members during the pandemic, including safeguarding updates provided at a Board Development session, EQS, Executive Committee (including Strategic Gold Group established during the initial phase of the pandemic) and to Welsh Government. In addition, as noted above, the health board issued a guide to Safeguarding processes during the COVID-19 pandemic and issued monthly safeguarding briefings and newsletters to staff.

We did not raise any findings in respect of this objective.

8. Summary of Recommendations

The audit findings, recommendations are detailed in Appendix A together with the management action plan and implementation timetable.

A summary of these recommendations by priority is outlined in the table below.

Priority	High	Medium	Low	Total
Number of recommendations	**0**	**1**	**1**	**2**

Finding 1 Safeguarding Training (Operation)	Risk
We recognise that the health board has made a significant improvement from 2019-20 in relation to providing staff training and that the health board however there is still need for improvement in particular in Level 3 Training for Safeguarding Adults and Children, Level 4 Children and VAWASDV Level 2. We also recognise that the health board is providing more detailed analysis of the lower performance training modules so that assistance can be provided to improve the compliance rates.	Failure to demonstrate that staff have received the appropriate safeguarding training resulting in harm to children or vulnerable adults, reputational damage and financial loss to the health board.
Recommendation 1	**Priority level**
The health board should ensure that compliance rates for safeguarding statutory and mandatory training is at an acceptable level for all relevant modules across all directorates so that the target rates can be achieved and maintained.	**Low**
Management Response 1	**Responsible Officer / Deadline**
Recommendation accepted. There is a safeguarding training plan in place with a rolling programme of training packages available to professionals. PTHB will continue to produce Safeguarding Newsletters to support professionals with their independent learning. PTHB will continue to be represented at the Regional Safeguarding Training Group and share multi agency training opportunities with PTHB professionals. Safeguarding training compliance reports will continue to be presented and monitored at the Operational and Strategic Safeguarding Group.	Alison Davies Executive Director of Nursing and Midwifery Immediate and ongoing

Finding 2 Multi-Agency Referral Monitoring (Operation)	Risk
The health board's Safeguarding Team monitors the numbers of referrals submitted for reporting purposes. During the course of the review we noted an issue in relation to the parameters used to generate the report of safeguarding referrals. The issue with running the report from Datix was that the date of MARF referral field set as a parameter was not a mandatory field and if staff neglected to complete the field the case was not collated into the report. On further analysis we identified numerous instances where the date that the MARF (Multi-Agency Referral Form) had been referred to the Local Authority had been left blank and several instances where this date was prior to the incident. The impact of this error was the under reporting of safeguarding referrals. The revised reporting parameters will be set on the incident date going forward to ensure that all the relevant data is collated. In addition, there is no mechanism in place currently to demonstrate with any accuracy that MARFs are completed and sent by health board practitioners to the Local Authority within 24 hours of a verbal report being raised. We were also informed by the Safeguarding Team that concerns regarding the timeliness of reports to the Local Authority have not been raised through the various methods of interaction with partners, as detailed under the multi-agency objective above. We understand that the Safeguarding Team will take this forward to address as part of the migration to the new "Once for Wales Concerns Management" system.	Failure to take timely and appropriate action in response to a safeguarding referral, an allegation of abuse, or reported complaint/concern potentially resulting in harm to children or vulnerable adults. Incorrect information reported or inability to demonstrate that key reporting indicators have been met within the health board for decision making purposes and which could cause reputational damage.
Recommendation 2	**Priority level**
The health board remind staff of the importance of the requirement to complete and send the multi-agency referral form to the Local Authority within 24 hours of a verbal report to the Local Authority and complete a Datix incident form accurately. In addition, we recommend that the Safeguarding Team puts a formal mechanism in place monitor the timeliness of MARF submissions and address any underlying issues identified.	**Medium**

Management Response 2	Responsible Officer / Deadline
Recommendation accepted.	Alison Davies Executive Director of Nursing and Midwifery
PTHB Safeguarding team will undertake an audit of Multi Agency Referral Forms following a verbal report to the Local Authority.	One month
The introduction of the Once for Wales Safeguarding Module will be set with mandatory fields when completing a Safeguarding Report.	Once for Wales Safeguarding Module due to be introduced July 2021

Audit Assurance Ratings

 **Substantial Assurance** - The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.

 **Reasonable Assurance** - The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to **moderate impact on residual risk** exposure until resolved.

 **Limited Assurance -** The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

 **No Assurance** - The Board has **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Action is required to address the whole control framework in this area with **high impact on residual risk** exposure until resolved

Prioritisation of Recommendations

In order to assist management in using our reports, we categorise our recommendations according to their level of priority as follows.

Priority Level	Explanation	Management action
High	Poor key control design OR widespread non-compliance with key controls. PLUS Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in control design OR limited non-compliance with established controls. PLUS Some risk to achievement of a system objective.	Within One Month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. These are generally issues of good practice for management consideration.	Within Three Months*

* Unless a more appropriate timescale is identified/agreed at the assignment

Confidentiality

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The health board shall apply any relevant exemptions which may exist under the Act. If, following consultation with the Head of Internal Audit this report or any part thereof is disclosed, management shall ensure that any disclaimer which NHS Wales Audit & Assurance Services has included or may subsequently wish to include in the information is reproduced in full in any copies disclosed.

Audit

The audit was undertaken using a risk-based auditing methodology. An evaluation was undertaken in relation to priority areas established after discussion and agreement with the health board. Following interviews with relevant personnel and a review of key documents, files and computer data, an evaluation was made against applicable policies procedures and regulatory requirements and guidance as appropriate.

Internal control, no matter how well designed and operated, can provide only reasonable and not absolute assurance regarding the achievement of an organisation's objectives. The likelihood of achievement is affected by limitations inherent in all internal control systems. These include the possibility of poor judgement in decision-making, human error, control processes being deliberately circumvented by employees and others, management overriding controls and the occurrence of unforeseeable circumstances.

Where a control objective has not been achieved, or where it is viewed that improvements to the current internal control systems can be attained, recommendations have been made that if implemented, should ensure that the control objectives are realised/ strengthened in future.

A basic aim is to provide proactive advice, identifying good practice and any systems weaknesses for management consideration.

Responsibilities

Responsibilities of management and internal auditors:

It is management's responsibility to develop and maintain sound systems of risk management, internal control and governance and for the prevention and detection of irregularities and fraud. Internal audit work should not be seen as a substitute for management's responsibilities for the design and operation of these systems.

We plan our work so that we have a reasonable expectation of detecting significant control weaknesses and, if detected, we may carry out additional work directed towards identification of fraud or other irregularities. However, internal audit procedures alone, even when carried out with due professional care, cannot ensure fraud will be detected. The organisation's Local Counter Fraud Officer should provide support for these processes.

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Appendix 2:

Key Findings and Overall Trends of VAWDASV

Key Findings and Overall Trends

Overall police recorded crime in Wales had decreased during the Covid -19 pandemic in conjunction with the same period in 2019 (March 2020-Jan 2021)

All VAWDASV helplines have seen a considerable increase in contacts during the pandemic, the concerns being shared by callers are reported as increased in complexity and severity. There has been an increase the number of self-referrals and a decrease in the number of agency referrals, suggesting the burden of demand had shifted from the public to the voluntary sector.

Violence against women domestic abuse and sexual violence

A&E data shows a decrease of 3% looking at the 3 month rolling average compared to the same period last year for own home domestic assault, with the exception of the month of December where there was an increase of 14% in attendances, this was predominately in the 25 to 34 year olds.

Overall repots to the police for sexual violence incidents have decreased during the pandemic. However, reports are now starting to increase and returning to pre Covid-19 levels.

In the first 3 months from Jan 2021 A&E attendance for domestic assault has increased in the younger age categories (18- 24 years)

Of all A&E attendances related to domestic abuse 70% are from the lower 2 socio economic groups.

Similarly, domestic abuse related calls to the police reduced, while calls to the Live Fear Free helpline (WG funded VAWDASV helpline) increased by 41%. Evidence suggests victims are presenting with more complex issues, with victims less able to access support from friends, family, or services.

Welsh Womens Aid received three times the number of webchat contacts since the beginning of lockdown compared to pre-lockdown figures, there was a 54% increase of contacts from survivors experiencing abuse who disclosed they had children.

Lockdown conditions have exacerbated and further isolated older people in abusive relationships with spouses, family or carers. Hourglass, a UK national charity tackling harm and abuse of older people, noted a 34% increase in calls to their helpline since the start of lockdown.

Karen Ingala Smith, the founder of Counting Dead Women, a pioneering project that records the killing of women by men in the UK, identified at least 16 killings between 23 March and 12 April, including those of children, she reported; "the number of women killed by men over the first three weeks of lockdown was the highest it's been for 11 years and is double that of an average 21 days over the last 10 years"

At the start of lockdown, the Forced Marriage helpline experienced a 355% increase in calls, a 347% increase in emails and a 34% increase in contacts from pregnant woman. Victim self-referring represented 42% of the demand compared to 25% in 2019/20.

Reports to the Revenge Pornography Helpline doubled during lockdown when compared to the same period last year.

Data from the UK-wide domestic abuse charity RESPECT demonstrated that there was an initial decrease in both call and email demand for their male perpetrator service for men concerned about their own violent behaviours (February-March 2020). However, compared to the same period in 2019, there was a 61% increase in telephone demand, this further increased to 70% in May.

Furthermore, data on the demand for the RESPECT men's domestic abuse victim support service showed that compared to the same period the previous year, there was an increase in calls by 68% in April and 71% in May and 86% and 66% respectively for support via email.

Violence against children and young people

Throughout the pandemic there has been an overall decrease of 32% in the number of children reported missing, and an overall decrease in serious youth violence offences.

In some parts of Wales there has been an increase in children using Xanax (short acting tranquiliser), which have been linked to an increase in violence and sexual abuse.

County Lines groups have continued to be active in Wales and are responsible for supplying the majority of Class A drugs (heroin and crack cocaine).

The NSPCC reported a sharp rise in contacts regarding concerns for the impact of domestic abuse on children and young people. During the 8 weeks following the first lockdown, 1,500 reports were made regarding domestic abuse, and in 40% of the contacts the caller reported the domestic abuse happening for at least six months

There has been an increase in the volume of demand to Childline, with over 500 counselling sessions provided to children concerned about domestic abuse.

The findings of a UK-wide survey identified an increase in Child/Adolescent to parent violence (C/APV) during the Covid-19 pandemic. Within families with a history of C/APV a 70% increase in the number of violent incidences was reported. 92% of the adult victims were female, and 72% of the children were male, highlighting high levels of son-to-mother violence. The age of the children and young people ranged from 6 to 22 years, (average age of 13-14 years). Reasons for increases in C/APV identified include; confinement and coerced proximity, changes in structure and routine, fear and anxiety and lack of access to support. Parents raised concerns for the risks to other children in the household, with greater exposure to the violence, and in many cases resulting in the violence being directed towards them.

Reporting Committee	**Quality Patient Safety Committee**
Chaired by	**Emrys Elias**
Lead Executive Director	**Director of Nursing & Quality**
Date of Meeting	**23 March 2021**

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

1. Commissioning Assurance Framework

Members received an update regarding the review of the Quality Assurance Framework which has been renamed the Commissioning Assurance Framework and will be supported by the following suite of documents:

- Risk Management Framework;
- Performance Framework;
- Escalation Process; and
- Patient Engagement & Experience Framework.

The Commissioning Assurance Framework was circulated to Joint Committee on 16 February 2021 as an appendix to the 2021-22 Integrated Commissioning Plan. Further work is on-going to finalise the appendices.

2. Caswell Clinic Feedback from SUI

The committee received a presentation for Swansea Bay University Health Board following an untoward serious incident that occurred on the unit. They were reassured by the robustness of the investigation and asked that any lessons learnt would be shared wider amongst the network.

3. Risk Management

Members were reminded of the changes to the way in which risk is monitored and scored across the organisation and would be more aligned to the risk management process within Health Boards. It was proposed that a new Risk Register would be created for the new financial year and that this would be presented at the next meeting. There was agreement that there were long standing fragilities within the system before and this had been compounded by the COVID-19 pandemic. A workshop was being held on 11 May 2021 to discuss the deliverability of the ICP and to establish key principles regarding equity of access to services.

4. 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**

It was noted that the collaborative working between the thoracic surgery services in SBUHB and CVUHB had resulted in patients moving across to receive their surgery in a different centre where the waiting time is shorter. The BMT service in CVUHB had recently received notification that they had received JACIE accreditation. Non-recurrent funding had been used to support the plastic surgery service in SBUHB to allow them to run more theatre sessions. A formal impact of investment report would be available in May 2021.

- **Cardiac**

The TAVI service in SBUHB had reduced to level 2 of the WHSSC escalation process. Further work was ongoing regarding a regional approach to subclavian access.

- **Mental Health & Vulnerable Groups**

An update of the complex mental health patient was provided to the committee. The increase in Eating disorder referrals was also noted and the committee were updated of the ongoing work led by Welsh Government to review the pathway. An update was provided on the two CAMHS inpatient units and the review undertaken by the NCCU Quality Assurance Improvement Service would be available for the next meeting.

- **Women & Children's**

It was reported the Women & Children's Team had been subject to review by Internal Audit and had received an audit opinion of Substantial Assurance. An engagement plan was in the process of being put in place with the BAHA and Cochlear service around Cochlear services so that a final decision as to lead provider can be made. The committee were updated regarding the ongoing work around neonatal transport service and were reassured that the Joint Committee would be considering the issue at an Extraordinary meeting in early April 2021. Members raised concerns about the harm to the personal development and wellbeing of the 55 patients waiting for Cleft Lip and Palate treatment given their young age. Members were assured that the SBUHB Cleft Lip and Palate team were assessing the children regularly and were treating in highest priority order. A full update was requested for the next meeting.

- **Neurosciences**

Access to Mechanical Thrombectomy for stroke patients remained the main concern noted within the report. Work was underway with CVUHB to develop a thrombectomy service within University Hospital Wales and that it was hoped significant progress would be made over the next 6 months. All Health Boards and the Stroke Network were aware of the issues regarding access to Mechanical Thrombectomy. Members wished the Joint Committee to be made aware of the concerns.

5. Services in Escalation Report

Members received and considered a report proposing changes to the reporting of services in escalation to reflect the performance monitoring expectation in light of COVID-19. It was acknowledged that the Minister for Health & Social Services had made a decision to suspend the monitoring of RTTs. As a result it was proposed and supported that those service in escalation as a result of breach of RTT would be temporarily removed and monitored to be monitored through the recovery plans with the providers. The remaining services in escalation are attached to this report. It should be noted that the movement of arrows down is an improving picture and an arrow upward a rise in the escalation level. This is further expanded in the revised escalation proves which will be considered at the next meeting.

6. Other Reports Received

Members received reports on the following:

- **CQC/HIW Summary Update**
- **WHSSC Policy Group**
- **Concerns and SUI report**

7. Items for information

Members received a number of documents for information only which members need to be aware of:

- Chair's Report and Escalation Summary to Joint Committee 09 March 2021
- Quality & Patient Safety Committee Annual Cycle of Business
- Health Board QPS Leads Contacts
- DOLS Replacement Arrangements
- Welsh Risk Pool Learning and Advisory Panel Newsletter

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
Matters referred to other Committees
None
Confirmed Minutes for the QPS meetings are available on request

Date of next scheduled meeting:	08 June 2021

Services in Escalation

Date of Escalation	Service	Provider	Level of Escalation	Reason for Escalation	Current Position	Movement from last month
April 2015 Escalated to Stage 3 December 2018	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. Performance meeting suspended as a result of COVID-19. SLA meeting to recommence this month to discuss recovery plans.	
April 2015	Cardiac Surgery	SBUHB	2	• Failure to deliver the Referral to Treatment times targets	Only emergency surgery being undertaken. Performance meeting suspended as a result of COVID-19. SLA meeting to recommence this month to discuss recovery plans.	
March 2017	Thoracic Surgery	SBUHB & CVUHB	2	• Failure to maintain cancer targets/capacity to meet patient need	Emergency and Elective work only being undertaken in Cardiff for the south Wales region. Performance meeting suspended as a result of COVID-19. SLA meeting to recommence this month to discuss recovery plans.	

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 3. Lipomata with atypical features on US/MRI that have been discussed at MDT. GMOSS: Outreach clinics into Wales suspended. Phone appts in place. Surgery able to continue.	
February 2018	Plastic Surgery (South Wales)	SBUHB	2	• Failure to achieve maximum waiting times target	No provider update on whether any surgery is going ahead during COVID-19 although it is understood that all non-essential surgery has been cancelled. Performance meeting suspended as a result of COVID-19. SLA meeting to recommence this month to discuss recovery plans.	
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-19. SLA meeting to recommence this month to discuss recovery plans.	

	North Wales Adolescent Service (NWAS)	BCUHB	3	• 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	Paper taken to CDG Board in April resulting in a reduction in escalation of service. Interim solution to medical workforce with non-medical clinical lead appointed supported by Consultants from Community Teams. Unit back operating at full commissioned capacity with fully recruited nurse establishment. This has led to sustained reduction in out of area placements. Introduction of central MH CAMHS bed management system to be introduced from this month to monitor patient flow and use of surge beds.	
December 2017	Paediatric Intensive Care	CVUHB	2	• Inadequate level of staffing to support the service	No further update on PICU during COVID-19.	
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	• C&VUHB were able to treat all patients who required both urgent and routine surgery within 26 weeks by the end of March.