Patient Experience, Quality & Safety Committee

Tue 24 October 2023, 09:30 - 12:30

Agenda

09:30 - 09:30
0 min

1. PRELIMINARY MATTERS

PEQS_ Agenda_24 Oct2023.pdf (2 pages)

1.1. Welcome and Apologies

Oral *Chair*

1.2. Declarations of Interest

Oral *Chair*

1.3. Minutes from the previous meeting held on the 4 July 2023 for approval

Attached *Chair*

PEQS_1.3_unconfirmed Minutes 2023-07-04.pdf (14 pages)

1.4. Patient Experience, Quality and Safety Committee Action Log

Attached *Chair*

PEQS_1.4_Action Log 2023-24.pdf (2 pages)

09:30 - 09:30
0 min

2. ITEMS FOR ASSURANCE

2.1. Medicines Management Annual Report

Attached *Medical Director*

PEQS_2.1_Medicines Management Assurance Report Ap22-Sept23.pdf (20 pages)

2.2. Integrated Quality Report to include:

Attached *Director of Nursing and Midwifery*

PEQS_2.2_Integrated Quality Paper September2023.pdf (13 pages)
PEQS_2.2a_App1_WRP Concerns Assessment.pdf (38 pages)
PEQS_2.2b_App2 PTHB - ENG - 22-23 Annual Letter PSOW.pdf (8 pages)
PEQS_2.2c_App3_IPC improvment plan Sept 2023.pdf (5 pages)
PEQS_2.2di_QPSC July 2023.pdf (5 pages)
PEQS_2.2dii_QPSC July 2023 Appendix1.pdf (10 pages)
PEQS_2.2diii_QPSC Sept 2023.pdf (7 pages)
PEQS_2.2div_QPSC Sept 2023 Appendix1.pdf (8 pages)
PEQS_2.2dv_WHSSC Newsletter Spring Summer 2023.pdf (10 pages)
PEQS_2.2dvi_CGIAC Cylchlythyr Gwanwyn Haf 2023.pdf (10 pages)
PEQS_2.2e_App 5 National Nosocomial Programme Interim Learning Report.pdf (16 pages)

2.3. Maternity Services

Attached *Director of Nursing and Midwifery*

PEQS_2.3_Maternity Assurance Paper October 2023.pdf (6 pages)

PEQS_2.3ai_Maternity Improvement Action Plan Quality & Safety.pdf (2 pages)
PEQS_2.3aii_Maternity Improvement Action Plan Leadership & Culture.pdf (2 pages)
PEQS_2.3aiii_Maternity Improvement Action Plan Clincial Excellence.pdf (2 pages)
PEQS_2.3aiv_Maternity Improvement Action Plan Finance and Workforce.pdf (1 pages)
PEQS_2.3av_Maternity Improvement Action Plan MATNEO.pdf (12 pages)

2.4. Mental Health Services Presentation (Action PEQS/22/51)

Presentation *Director of Operations, Community Care and MH*

2.5. 111p2 – 12-week review

Attached *Director of Operations, Community Care and MH*

PEQS_2.5_111 Press#2 PEQS Presentation Oct23_.pdf (9 pages)

2.6. Implementation of Welsh Government guidance on Transition and Handover from Children's to Adult's Health Services

Attached *Director of Nursing and Midwifery*

PEQS_2.6_WG Transition Guidance Implementation Update Sept 23.pdf (8 pages)

2.7. Medical Devices and Point of Care Testing Annual Report

Attached *Director of Therapies and Health Sciences*

PEQS_2.7_Medical Devices and Point of Care Testing AR 2022-23.pdf (21 pages)

09:30 - 09:30
0 min

3. ITEMS FOR APPROVAL

3.1. Statement of Commitment to Infection Prevention and Control

Attached *Director of Nursing and Midwifery*

PEQS_3.1_IPC Board Level Statement.pdf (3 pages)

09:30 - 09:30
0 min

4. ITEMS FOR DISCUSSION

09:30 - 09:30
0 min

5. ESCALATED ITEMS

5.1. Infection Prevention and Control (covered within the Integrated Quality Report)

Oral *Director of Nursing and Midwifery*

09:30 - 09:30
0 min

6. ITEMS FOR INFORMATION

6.1. Clinical Audit Internal Audit

Attached *Medical Director*

PEQS_6.1_PTHB-2324-12 Clinical Audit Final Internal Audit Report.pdf (14 pages)

09:30 - 09:30
0 min

7. OTHERS MATTERS

7.1. Committee Work Programme

Attached *Director of Corporate Governance*

PEQS_7.1_2023-24 PEQS work plan.pdf (1 pages)

7.2. Items to be Brought to the Attention of the Board and/or Other Committees

Oral *Chair*

7.3. Any Other Urgent Business

Oral *Chair*

7.4. Date of the next meeting: 11 January 2024

7.5. Confidential Items

Representatives of the press and other members of the public shall be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interes

7.6. Welcome and Apologies

Chair

7.7. Declarations of Interest

Chair

7.8. Minutes of the In-Committee meeting held on 4 July 2023

7.9. Close

POWYS TEACHING HEALTH BOARD
PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE

TUESDAY 24 OCTOBER 2023
09:30 – 12:30
VIA MICROSOFT TEAMS

AGENDA				
Time	**Item**	**Title**	**Attached/Oral**	**Presenter**
	1	**PRELIMINARY MATTERS**		
09:30	1.1	Welcome and Apologies	Oral	Chair
	1.2	Declarations of Interest	Oral	All
	1.3	Minutes from the previous Meeting 4 July 2023	Attached	Chair
09.35	1.4	Committee Action Log	Attached	Chair
	2	**ITEMS FOR ASSURANCE**		
09.40	2.1	Medicines Management Annual Report	Attached	Medical Director
10.00	2.2	Integrated Quality Report to include: • PSOW Annual Report 2022/23 • Infection Prevention and Control Plan Progress	Attached	Director of Nursing and Midwifery
10.45	2.3	Maternity Services	Attached	Director of Nursing and Midwifery
11.00	**COMFORT BREAK**			
11.15	2.4	Mental Health Services Presentation (Action PEQS/22/51)	Presentation	Director of Operations, Community Care and MH
11.25	2.5	111p2 – 12-week review	Attached	Director of Operations, Community Care and MH
11.40	2.6	Implementation of Welsh Government guidance on Transition and Handover from Children's to Adult's Health Services	Attached	Director of Nursing and Midwifery
11.55	2.7	Medical Devices and Point of Care Testing Annual Report	Attached	Director of Therapies and Health Sciences
	3	**ITEMS FOR APPROVAL**		
12.05	3.1	Statement of Commitment to Infection Prevention and Control	Attached	Director of Nursing and Midwifery
	4	**ITEMS FOR DISCUSSION**		
There are no items for inclusion within this section				

	5	**ESCALATED ITEMS**		
12.10	5.1	Infection Prevention and Control (covered within the Integrated Quality Report)	Oral	Director of Nursing and Midwifery
	6	**ITEMS FOR INFORMATION**		
12.15	6.1	Clinical Audit Internal Audit	Attached	Medical Director
	7	**OTHER MATTERS**		
12.20	7.1	Committee Work Programme	Attached	Director of Corporate Governance
	7.2	Items to be Brought to the Attention of the Board and/or Other Committees	Oral	Chair
	7.3	Any Other Urgent Business	Oral	Chair
	7.4	Date of the next meeting: 11 January 2024		

7.5 The Chair, with advice from the Director of Corporate Governance, has determined that the following items include confidential or commercially sensitive information which is not in the public interest to discuss in an open meeting at this time. The Board is asked to take this advice into account when considering the following motion to exclude the public from this part of the meeting:

Motion under Section 1(2) Public Bodies (Admission to Meetings) Act 1960

"Representatives of the press and other members of the public shall be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest"

12.25	7.6	Welcome and Apologies	Oral	Chair
	7.7	Declarations of Interest	Oral	Chair
	7.8	Minutes of the In-Committee meeting held on 4 July 2023	Attached	Chair
12.30	7.9	Close		

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.

Meetings are currently held virtually, should you wish to observe a virtual meeting of a committee, please contact the Director of Corporate Governance at PowysDirectorate.CorporateGovernance@wales.nhs.uk at least 24 hours in advance of the meeting in order that your request can be considered on an individual basis.

Papers for the meeting are made available on the website in advance and a copy of the minutes are uploaded to the website once agreed at the following meeting.

POWYS TEACHING HEALTH BOARD
PATIENT EXPERIENCE, QUALITY & SAFETY COMMITTEE
UNCONFIRMED

MINUTES OF THE MEETING HELD ON TUESDAY 4 JULY 2023 VIA MICROSOFT TEAMS

Present:

Kirsty Williams	Vice-Chair (Committee Chair)
Jennifer Owen Adams	Independent Member
Mark Taylor	Independent Member
Simon Wright	Independent Member

In Attendance:

Claire Roche	Director of Nursing and Midwifery
Kate Wright	Medical Director
Claire Madsen	Director of Therapies and Health Sciences
Hayley Thomas	Interim Chief Executive
Debra Wood-Lawson	Director of Workforce and OD
Zoe Ashman	Assistant Director of Quality and Safety
Amanda Edwards	Assistant Director – Innovation and Improvement
Helen Bushell	Director of Corporate Governance
Louise Turner	Assistant Director Women's and Children's (for item 2.2)
Louisa Kerr	Head of Mental Health Operations (for item 2.2)
Jayne Wheeler Sexton	Assistant Director for Safeguarding and Public Protection (for item 2.4)

Observing:

Bethan Hopkins	Audit Wales
Jayne Gibbon	Internal Audit
Rebecca Jewell	Health Inspectorate Wales
Katie Blackburn	Llais

Apologies for absence:

Ian Phillips	Independent Member
Joy Garfitt	Interim Director Operations, Community Care and Mental Health

Committee Support:

Liz Patterson	Interim Head of Corporate Governance

PEQS/23/16	**WELCOME AND APOLOGIES FOR ABSENCE** The Committee Chair welcomed Members to the meeting. Apologies for absence were noted as recorded above.
PEQS/23/17	**DECLARATIONS OF INTERESTS** No interests were declared in addition to those already declared in the published register.
PEQS/23/18	**MINUTES OF THE EXPERIENCE, QUALITY AND SAFETY COMMITTEE MEETING HELD ON 25 APRIL 2023 (FOR APPROVAL)** The minutes of the previous meeting held 25 April 2023 were AGREED as a true and accurate record.
PEQS/23/19	**PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE ACTION LOG** The Action Log recorded updates with the following update provided during the meeting: PEQS/23/05 – The Director of Nursing and Midwifery advised that the Duty of Quality and Candour action plan had not been shared to date but would be updated and circulated to Members. The Committee RECEIVED the updates on the action log.
	ITEMS FOR ASSURANCE
PEQS/23/20	**INTEGRATED QUALITY REPORT** The Director of Nursing and Midwifery presented the report and drew attention to the following areas: • The final meeting of the Quality and Engagement Act (2023) Implementation Board had been held. The Health Board will now report to Welsh Government via the Quality Performance and Delivery meetings. The Duty of Candour had been triggered three times during April/May 2023; • An update on the Safe Care Collaborative, a partnership between NHS Wales Health boards and Trusts, Improvement Cymru and the Institute for Health Care Improvement to encourage and support health boards to improve their quality and safety of care. The Health Board attended a collaborative event in June 2023 and a follow up was planned for July 2023 to strengthen the quality improvement journey;

	• The report contains additional information regard Patient Experience for example the use of feedback forms and community hospital audits, undertaken by a team led by the Head of Nursing where subjects including medicine management, paperwork and patient views were examined. The Director of Therapies and Health Sciences advised that new regulations around health care appliances would not affect the Health Board as devices were not made, only adjusted locally. The systems and processes had been reviewed and were in line with regulations. Digital devices might be affected and advice from Information Governance was being sought. *Independent Members sought assurance by asking the following questions:* *The development of a safe care collaborative is welcomed, will it be able to provide a longitudinal picture?* The Director of Nursing and Midwifery advised that the safe care collaborative was a national venture led by Improvement Cymru where information can be shared in real time. It is a sharing community which will leave a legacy. The Health Board are involved with two projects, one in Ystradgynlais with Swansea Bay UHB on sepsis and one in Aberystwyth with Hywel Dda UHB on admission avoidance. *What is outcome of the concerns validation report?* The Director of Nursing and Midwifery advised that the substantial assurance outcome meant that independent verification had been received that the Health Board were reporting correctly on concerns. It had been necessary to undertake national validation due to previous issues matching data between Welsh Government and the Public Services Ombudsman for Wales. *Is the reduction in incidents thought to be because people are more aware of what is an incident or because people are choosing not to report incidents?* The Director of Nursing and Midwifery advised that since staff have attended root cause analysis training there has been an increased confidence to assess incidence at the correct level where prior to training incidents had initially been reported at a higher level than they were found to be.

	There is volatility within the nationally reportable incidents but the length of time these incidents are open has decreased. *Page 7 of the report notes pressure or moisture damage as the highest reported incident theme. What percentage of the incidents do these comprise and is the trend increasing or decreasing?* The Director of Nursing and Midwifery noted this was a key area of avoidable harm. When the panel reviews the incidents to ensure they are recorded at the correct level it is also confirmed if pressure damage was evident when the patient was admitted. The Assistant Director of Quality and Safety advised that comparable data nationally would be sought. The next Integrated Performance Report would be enhanced with the inclusion of number of cases closed, the split between avoidable and unavoidable harm and benchmarking with peers for length of stay. The Medical Director cautioned that looking at trends was challenging as numbers were small therefore long term trends should be examined. *Pressure damage has been an issue at least for the last six years. Is the health board improving? Is it possible to stop pressure damage occurring? Given pressure and moisture damage had the highest reported incidence during Q4 could long term trends be included in the next report?* The Assistant Director of Quality and Safety undertook to include further information in the next Integrated Quality Report. **Action: Assistant Director of Quality and Safety** *Now the CIVICA patient experience system is in place how is all the patient experience received by the Health Board captured and where is it reviewed?* The Director of Nursing and Midwifery explained there is a Patient Experience Steering Group (PESG) which she chairs, and which is the forum for capturing all patient experience. This umbrella group allows good practice to be shared along with the early identification of themes, and if these are localised or organisation wide. The information considered at the PESG also includes that held locally on 'How are we doing' boards.

	The Regional Director, Llais explained that the Health Board and Llais teams met locally and Llais will be considering how patient experience influences services in the longer term. *This is the first meeting of the Committee which covers Duty of Candour reporting with three triggers reported. The Health Board will be required to do an annual report. Will the Integrated Quality Report regularly report on the number of times the Duty of Candour is triggered? What feedback has been received from staff on the new arrangements?* The Director of Nursing and Midwifery advised that new arrangements had made little practical difference as the Health Board had previously spoken to families when incidences had occurred. When the Duty of Candour is triggered staff are supported, and Incident Review Panel is convened with an Investigation Officer appointed. The Investigation Officer is the point of contact with the family and the member of staff. This can be a stressful time for staff, and it is important to cultivate a culture of learning rather than blame. The Assistant Director of Quality and Safety advised that implementation had gone to plan partly due to the long lead in time and also as the teams were already using the Datix reporting system. The biggest challenge is the initial conversations where it is acknowledged something has gone wrong and an investigation is necessary. Local teams need to be enabled to own the process. Colleagues in England have 12 years of experience of this system and locally teams are embracing this. The Director of Nursing and Midwifery noted a joint meeting of Workforce and Culture Committee and Patient Experience, Quality and Safety Committee was planned in terms of triangulating the experience of patients and staff. **Action: Director of Corporate Governance.** The Patient Experience and Quality Committee took assurance that Quality and Safety was appropriately monitored and reported and that actions are in place to further develop quality and safety monitoring and reporting.

PEQS/23/21	**MENTAL HEALTH POWER OF DISCHARGE ANNUAL REPORT INCLUDING MENTAL HEALTH COMPLIANCE WITH LEGISLATION** The Head of Mental Health Operations presented the report and drew attention to the following areas: • a decrease in the number of times Section 5 detentions were used from the previous year; • a small decrease in the number of times a patient was admitted for assessment on the previous year (which had been higher than previously, thought to be linked to the Covid-19 pandemic); • emergency admissions for assessment remained low at less than five patients; • there were 15 Community Treatment orders in place compared to 11 in the previous year; • Section 136 (Police powers to remove a person to a place of safety) were used 22 times compared to 19 times in 2021/22 with a five year average of 27 times; • Scrutiny of documents for errors found in three of the four quarters errors were found on less than five occasions with the fourth quarter recording no errors. One fundamentally defective detention was recorded over the year; • Two deaths were recorded of patients who were subject to detention under the Mental Health Act 1983 which will be subject to the Serious Incident Process; and • 15 Hospital Manager Hearings were held with 24 applications resulting in one patient discharge. *Given the improving trends outlined within the report it appears the effects of Covid-19 are beginning to recede. However, this seems to be at odds with what is reported in the media. Does the data reflect the population in Powys?* The Head of Mental Health Operations advised that this report related to acute patients and the wider community needs reflected what is happening nationally within the specific local demographic. Covid-19 had impacted on services with an increase in cases which is now decreasing, however, cases have increased in complexity. The Director of Corporate Governance advised that the minutes of the Power of Discharge Committee were not

	appended to the report. The compliance report provides assurance for Committee Members and the minutes would be available on request. *There have been media reports in England that the Police will only attend patients with mental health issues if the public are in danger. Is this likely to be replicated in Wales?* The Chair advised that Dyfed Powys Police had expressed an intention to work with Health Boards on suicide prevention and dementia. The Committee NOTED the contents of the report and took assurance that the performance of the service in relation to the administration of the Mental Health Act 1983 had been compliant with legislation.
PEQS/23/22	**CLINICAL AUDIT PROGRESS REPORT** The Medical Director presented the Closure Report of the 2022-2023 Clinical Audit Programme and update on progress for Q1 2023-2024 noting that the majority of audits were complete with most of those planned taking place. Capacity reasons meant some audits had been rolled over to the following year and some audits had not taken place. These audits had been risk assessed. For 2023/24 Quarter 1 seven audits had been planned of which five had been completed. The two audits not completed were in endoscopy where the lead endoscopist role was vacant. *The Pressure Damage Audit has been rolled forward from Q4 2002 and is due for completion in Q4 2024. Given the discussion earlier on pressure damage should this be given higher priority? In addition, Infection Prevention and Control Audits have been rolled forward and are due in Q3. Should these also be given a higher priority? What is the mechanism for providing assurance to Board members on audit outcomes?* The Medical Director acknowledged that reporting on the audit programme was skewed towards the end of the year. It would be necessary to bring reporting on some audits forward and the service groups needed to prioritise their most pressing audits. Clinical audits are owned by service groups and if an audit is not showing what is required it will

	be repeated. Learning Groups were in place to enable feedback and learning. *At present Board Members only receive confirmation that an audit has been completed. It would be helpful to see any actions taken as a result of an audit.* The Chair advised that she had observed a meeting of the Learning Group and it may be possible for other Committee Members to observe a meeting of the Learning Group. *What is the relationship between risk and audit. How are clinical audits informed by service level risk?* The Medical Director understood it was an informal mechanism but undertook to check the position. The Director of Corporate Governance advised that the Risk and Assurance Group would be reincorporated in September and would be an appropriate place to explore this relationship. The Assistant Director – Innovation and Improvement confirmed the links were discussed in service teams but a more formal discussion at Risk and Assurance Group would be welcome. *If an audit is not taking place due to capacity issues, is that a risk to the service?* The Medical Director advised that services are asked to make a judgement on their audits which are risk assessed. Capacity is an issue; however, the Health Board does undertake many clinical audits for a small organisation. Some of the proposed clinical audits would more properly be described as ward level activity, however, they have remained on the list to ensure they do not get lost. The Committee: • NOTED the end of year clinical audit programme position (see also appendix A); and • Took ASSURANCE on quarter one progress against the 2023/24 programme.
PEQS/23/23	**ANNUAL SAFEGUARDING REPORT** The Assistant Director for Safeguarding and Public Protection presented the 2022-23 Safeguarding and Public

	Protection Annual Report and drew attention to the following matters: • the Safeguarding team had recently won an award for their work done promoting Safer Sleep in mid and west Wales; • a Senior Practitioner for mental capacity had recently been appointed funded by Welsh Government; • a working group had been set up to reflect and learn from Operation Jasmine; • a significant amount of work had taken place relating to children and adults who are at risk and are not brought to appointments; and • looking forward to 2023/24 it was acknowledged the safeguarding arena was expanding and the Child Practice Review would be completed from which learning would take place. *What is the 'uncertainty around LPS' referred to in the look ahead section?* The Chair advised that Liberty Protection Standards (LPS) had been designed to replace the Deprivation of Liberty Standards (DoLS). However, national implementation had stopped, and Welsh Government were looking at what options might be available for Wales. *The Committee have previously had sight of the number of cases in the system and backlogs. Will this be made available again?* The Director of Nursing and Midwifery confirmed that the Safeguarding Group receive this information and the method of sharing with the Committee will be reviewed. **Action: Director of Nursing and Midwifery** *There has been a 51% increase in safeguarding adult reports from 2021/22 (p30 of the report). What has caused this and what impact is this having on the capacity of the team?* The Assistant Director for Safeguarding and Public Protection agreed the increase appeared dramatic but should be seen in the context of reduced safeguarding adult reports during covid. There had been an increase in safeguarding activity across all areas with increased activity in the safeguarding hub. This increased visibility may be resulting in the increased activity.

Why are the levels of compliance with safeguarding adults training around 46% against a target of 85%?

The Assistant Director for Safeguarding and Public Protection advised that staff were asked to do a safeguarding passport which they are reporting is difficult to follow. The competencies have been reviewed and staff have fed back that this is easier to follow.

The improvement plan was welcomed. What is being done to prevent the neglect of children?

The Assistant Director for Safeguarding and Public Protection advised that at risk children are most commonly reported as being neglected as this covers other forms of abuse. The Covid-19 pandemic had an impact on the visibility of safeguarding within communities as visits to the home, paused during the pandemic, are important when identifying children at risk. The current cost of living crisis is also an issue. However, staff are encouraged to be vigilant, curious and identify signs at an early stage.

The Chief Executive drew attention to the wealth of activity outlined in the Safeguarding Report noting the excellent progress that had been made with the Safeguarding Hub. Much of the work is done in partnership with Mid and West Wales around the preventative agenda and sharing good practice.

A recent Learning and Skills Scrutiny Committee at the Council reported a huge increase in homeschooled children. Education settings are often a good place to identify children at risk. What action is being taken to ensure the welfare of children who are not seen?

The Assistant Director for Safeguarding and Public Protection advised there is a robust policy for children and adults who are not brought to appointments. The matter of home schooled children will be raised in the Powys Local Operations Group. The Safeguarding Team have a good relationship with the local authority Safeguarding Team.

The Director of Nursing and Midwifery highlighted the difficulty of not knowing about the children who do not attend school, but the midwifery and health visiting service do know of children born or brought into the county. The Midwifery Team transition children to the Health Visiting

	Team. It is crucial that Health Visitors are able to get to know the children in the family home. However, there is a national shortage of Health Visitors and Community Nurses, and the team are working with the Head of Children's Services to mitigate this risk. The Chair requested that confirmation be provided regarding where DoLS data is available to Members for assurance and that a checkpoint be provided later in the year on progress on Level 3 Safeguarding training. **Action: Director of Nursing and Midwifery** The Committee: • RECEIVED the Annual Safeguarding Report 2022/23 and took ASSURANCE the Health Board are delivering their statutory requirements.
PEQS/23/24	**WHSSC QUALITY AND SAFETY COMMITTEE REPORT – APRIL 2023** The Director of Nursing and Midwifery presented the report highlighting the following 5 services in escalation level 3 or above: • Ty Llidiard – reduced from 4 to 3; • Paediatric Surgery at Cardiff and Vale UHB escalated to level 3 There had been no changes in escalation levels in the other services. The Chair advised that she had pressed for escalation of paediatric services to ensure that Welsh Government target for paediatric waits is now met. It was noted that the nature of the specialist services provided meant that numbers of patients accessing the services was low. The Committee requested that WHSSC updates include the number of patients accessing services from each Health Board and the impact of the escalations on Powys patients.
	ITEMS FOR DISCUSSION
PEQS/23/25	There were no items for discussion.

ESCALATED ITEMS	
PEQS/23/26	There were no items for escalation.
ITEMS FOR INFORMATION	
PEQS/23/27	There were no items for information.
OTHER MATTERS	
PEQS/23/28	**COMMITTEE RISK REGISTER** The Director of Corporate Governance presented the Risk Register for risks associated with this Committee outlining that risk had been considered at Board Development where it was expected the risk would be replaced by split risks covering commissioned and provided care. The Committee: • CONSIDERED the corporate risks within the committee's remit, • DISCUSSED any relevant issues; and • took ASSURANCE that risks were being managed in line with the Risk Management Framework.
PEQS/23/29	**COMMITTEE WORK PROGRAMME** The Director of Corporate Governance advised that the Committee Work Programmes had been presented to the May meeting of Board. It was confirmed that the 12 week review of 111 press 2 had been deferred to the October Committee meeting as there had been a delay in launching the system which had meant the 12 week review could not be undertaken. The Medical Director confirmed the items highlighted in yellow related to research, development and innovation. Dates would be discussed with the Chair and Director of Corporate Governance and the work programme populated.
PEQS/23/30	**ITEMS TO BE BROUGHT TO THE ATTENTION OF THE BOARD AND/OR OTHER COMMITTEES** There were no items from the Patient Experience, Quality and Safety Committee to bring to the attention of Board.
PEQS/23/31	**ANY OTHER URGENT BUSINESS** There was no other urgent business.
PEQS/23/32	**DATE OF THE NEXT MEETING**

	4 July 2023, via Microsoft Teams.
PEQS/23/33	**CONFIDENTIAL ITEM** The following motion was passed: ***Representatives of the press and other members of the public shall be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.***

PRESENT:

Kirsty Williams	(Chair)
Mark Taylor	(Independent Member)
Jennifer Owen Adams	(Independent Member)
Simon Wright	(Independent Member)

IN ATTENDANCE:

Claire Roche	(Director of Nursing and Midwifery)
Claire Madson	(Director of Therapies and Health Sciences)
Kate Wright	(Medical Director)
Debra Wood Lawson	(Director of Workforce and OD)
Helen Bushell	(Director of Corporate Governance)
Gareth Thomas	(Consultant Nurse - Infection Prevention and Control)
Amanda Edwards	(Assistant Director – Innovation and Improvement)
Zoe Ashman	(Assistant Director of Quality and Safety)
Liz Patterson	(Interim Head of Corporate Governance)

OBSERVING:

Jayne Gibbon	(Internal Audit)

APOLOGIES FOR ABSENCE:

Ian Phillips	(Independent Member)
Joy Garfitt	(Interim Director Operations, Community Care and Mental Health)

PEQS IC/23/34	**INFECTION PREVENTION AND CONTROL** Rationale for item being held in private: Information remained confidential at this stage but would be released at a later date.

	The Director of Nursing and Midwifery presented the report. It was AGREED this item would be brought to the attention of Board In-Committee and a further paper would be brought to the next meeting of the Patient Experience, Quality and Safety Committee, in public session.

Liz Patterson								
RAG Status:								
At risk	Red - action date passed or revised date needed							
On track	Yellow - action on target to be completed by agreed/revised date							
Completed	Green - action complete							
No longer needed	Blue - action to be removed and/or replaced by new action							
Transferred	Grey - Transferred to another group							
Patient Experience, Quality and Safety Committee								
Meeting Date	**Item Reference**	**Lead**	**Meeting Item Title**	**Details of Action**	**Update on Progress**	**Original target date**	**Revised Target Date**	**RAG status**
OPEN ACTIONS FOR REVIEW								
13/09/2022 and 24 Nov 2022	PEQS/22/51 and PEQS IC/22/73	DOCC&MH	Mental Health Services	A further report on Mental Health Services to be brought to the December 2022 Committee meeting	**24.10.2023 update -** The October agenda contains an item for the Committee to confirm what is required to be presented at the February 2024 meeting. Change of date requested	Dec-22	Feb-24	At risk
31-Jan-23	ARA/22/109	DNM	LOSSES AND SPECIAL PAYMENTS UPDATE REPORT (transferred from Audit Committee)	Trends and lessons learnt from rebutting negligence claims to be included in the Integrated Quality Report to the Patient Experience, Quality and Safety Committee	**25.04.23 update** - Action has been reviewed and given the low number of claims, data could become individually identifiable. DNM to reconsider how to achieve the action and report back. Change of date requested	Oct-23	Feb-24	At risk
04/07/2023	PEQS/23/23a	DNW	Annual Safeguarding Report	The method of sharing information with the Committee relating to the number of cases and backlogs in the system to be reviewed	**24.10.2023 update -** A position paper regarding the Mental Capacity Act and Deprivation of Liberty Safeguards is in preparation for Executive Committee at the end of November. Change of date requested	Oct-23	Feb-24	At risk
OPEN ACTIONS - IN PROGRESS BUT NOT YET DUE								
23-Feb-23	PEQS/22/81	DCG	National Commissioning Functions Review	The Report of the National Commissioning Functions Review be brought back to Committee at the appropriate time	**24.10.2023 update** - Date remains to be confirmed. **25.04.23 update** - Added to work programme for Feb 2024, Board had a discussion on 12/10/24.	Feb-24		On track
23-Feb-23	PEQS/22/84b	DNM	Child Practice Review	Child Practice Review to be brought back to Committee	**24.10.2023 update** - Date remains to be confirmed. **25.04.23 update** - Added to work programme for Feb 2024, review due to be completed and report received in November	Feb-24		On track
25-Apr-23	PEQS/23/05	DNM	Integrated Quality Report	Integrated Quality Report to be strengthened in terms of themes and trends relating to behaviours resulting in harm	**04.07.23 update** - DoNM is currently liaising with DoTHs (with current responsibility for Health and Safety) to review non-patient safety incidents, themes and trends	Jul-23	Oct-23	On track
25-Apr-23	PEQS/23/05	DNM	Duty of Candour and Quality	The Duty of Candour and Quality Implementation Plan to be shared with Committee	**04.07.23 update** - Director of Nursing advised that the implementation plan had not been shared by July 2023 but would be updated and circulated after the July meeting	Jul-23	Oct-23	On track
ACTIONS RECOMMENDED FOR CLOSURE (MEETING 24 OCTOBER 2023)								
25-Apr-23	PEQS/23/05	DNM	Integrated Quality Report	Integrated Quality Report to be strengthened in tems of Incident Management	**04.07.23 update** - a revised incident management framework has been drafted and is currently out to consultation. This will be reported on in greater detail at the October PEQS. **24.10.23 update** - update to be provided as part of the Integrated Quality Report during the meeting	Jul-23	Oct-23	Completed

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04/07/2023	PEQS/23/20b	DCG	Integrated Quality Report	A joint meeting of Workforce and Culture Committee and Patient Exeperience, Quality and Safety Committee to be arranged to triangulate experience of patients and staff	**25.04.23 update** -The joint meeting has been arranged for 24 October 2023	Oct-23		Completed
24-Nov-22	PEQS/22/59	MD	Clinical Audit Progress and Learning	Revise the Terms and Reference of the Learning Group to reflect changes in reporting of National Audits	**25.04.23 update** - The Terms of Reference have been revised and will be considered for approval at the next Learning Development Meeting . **10.10.23** Update TOR were agreed at the LFEG meeting 11 May 2023.	Jul-23		Completed
04/07/2023	PEQS/23/20a	DNM	Integrated Quality Report	Integrated Quality Report to include long term trends in relation to pressure and moisture damage	**24.10.2023 update** - The Integrated Quality Report includes this information	Oct-23		Completed
23-Feb-23	PEQS/22/82	DOCC&MH	Mental Health Services 111 press 2 project	The 12 week review into NHS 111press2 to be brought to Committee	**24.10.2023 update** - On PEQS agenda for October 2023 meeting	Oct-23		Completed
04/07/2023	PEQS/23/23b	DNW	Annual Safeguarding Report	Information to be provided to Members of where DoLS data is available and a checkpoint be provided later in the year on progress on Level 3 safeguarding training	**24.10.2023 update** - The position paper regarding the Mental Capacity Act and Deprivation of Liberty Safeguards paper will cover the DoLS data. Update on Level 3 Safeguarding training – cleanse of ESR completed. Safeguarding Adults and Children Level 3 passports updated and in use. Compliance continues to be monitored 3 monthly via the Safeguarding Strategic Group and Safeguarding Operational Group. Monthly email reminders sent to staff completing Level 3 training that their passports must be completed within 6 months of attending the training. Update on L3 training scheduled for February agenda	Oct-23		Completed

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 2.1

PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE	**24 October 2023**
Subject :	Medicines Management Assurance Report (April 2022-September 2023)
Approved and Presented by:	Kate Wright, Medical Director
Prepared by:	Jacqui Seaton, Chief Pharmacist
Other Committees and meetings considered at:	

PURPOSE:

The Medicines Management Assurance Report aims to provide an update on the Medicines Management/Pharmacy Team activities undertaken between April 2022 and September 2023. It is intended to inform the Board of the health board's Medicines Management/Pharmacy arrangements, provide an update on progress, outline key challenges/areas of concern and provide information about plans for the next 12 months.

RECOMMENDATION(S):

The Patient Experience, Quality and Safety Committee is requested to RECEIVE the Medicines Management Assurance Report April 2022 – September 2023 taking ASSURANCE on the actions taken and progress made.

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:

This report outlines the scope of the work undertaken by the Medicines Management Team (MMT), highlights the progress made between April 2022 and September 2023, raises awareness of the challenges and discusses the plans for the next 12 months.

DETAILED BACKGROUND AND ASSESSMENT:

Background

The health board's Medicines Management and Pharmacy Services are managed and directed by the Chief Pharmacist. The role of the Chief Pharmacist is a statutory role, responsible for strengthening the governance of pharmacy services and ensuring that they are run safely and effectively.

Medicines are the most common therapeutic intervention and the second highest area of NHS spending after staffing costs. Used correctly, medicines prevent, treat or manage many illnesses or conditions. However, medicines also have the potential to cause harm. Between 5-10 per cent of all hospital admissions are medicines related, two-thirds of medicines-related hospital admissions are preventable and 30-50 per cent of medicines prescribed for long-term conditions are not taken as intended.

Medicines are associated with a high degree of clinical and financial risk. The health board's medicines management work therefore plays a vital role in improving health outcomes and ensuring the most efficient use of NHS resource. The budget managed by the Chief Pharmacist is ~10% (~£40 million) of the health board's overall financial allocation.

The MMT ensures safe, legal, evidence-based, clinically-effective and cost-effective prescribing, safe and secure storage, supply and use of medicines within the resources available.

The MMT is responsible for ensuring that services and pathways in which medicines are used deliver cost-effective use of resources, reduce risks associated with medicines, improve patient outcomes and experience with medicines.

Although the term 'medicines management' is still used, the team is focussed on medicines optimisation. This is a person-centred approach to safe and effective medicines use, to ensure that people obtain the best possible outcomes from their medicines. The concept is often summarised as 'right medicine, right patient, right time'. Effective medicines optimisation contributes to:

- The improved health of individuals and the population as a whole
- Improved patient care and satisfaction
- Making the best use of available resources
- Making better use of professional skills
- The delivery of clinical governance

Medicines management is one of the golden threads that run between all sectors of care, whether in prevention or treatment. The MMT links and collaborates with multiple stakeholders – acute hospitals, mental health providers, GP practices, community pharmacies, social care providers, local authorities, care homes and other care providers – seeking to ensure a seamless journey for patients moving between different care providers.

Key documents that inform the work of the MMT:

- Pharmacy: Delivering a Healthier Wales
- HEIW Strategic Pharmacy Workforce Plan
- Independent review of clinical pharmacy services at NHS hospitals in Wales
- Six Goals for Urgent and Emergency Care
- Transforming and modernising planned care and reducing waiting lists in Wales
- Duty of Quality Statutory Guidance 2023

Workforce

The health board has a small MMT (~ 33 WTE) made up of pharmacists (~12 WTE), pre-foundation pharmacists (1 WTE), pharmacy technicians (~12 WTE), a pre-registration pharmacy technician (1 WTE), Assistant Technical

Officers (ATOs) (2.8 WTE), administrators (2 WTE) , Medicines Management Nurses (0.9 WTE), a data analyst (1 WTE) and a project manager (1 WTE). Pharmacists and pharmacy technicians are registered professionals, regulated by the General Pharmaceutical Council. The team is sub-divided into 3 key teams:

- Community Services
- Primary Care
- Commissioned Services and high-cost drugs

Collaborative working across these teams is essential to ensure the most appropriate use of NHS resources and the best possible outcomes for the population that we serve.

Recruitment of suitably experienced pharmacy professionals is a significant challenge for the NHS in general, but it is particularly challenging for PTHB due to our expensive rural geography. The introduction of the Assistant Technical Officer (ATO) role to the team during 2021/22 has proved to be a huge success, allowing delegation of appropriate tasks from pharmacists to technicians and from technicians to ATOs, relieving some of the pressure presented by the recruitment challenge.

Areas supported by the team

The team provides medicines management support and advice to health and social care right across the 2,000 square miles geography of Powys: e.g. community nursing teams (e.g. district nurses, school nurses), community hospitals (x 10), specialist teams (e.g. dietetics, tissue viability, school nurses, Occupational Health, immunisations and vaccinations), GP practices (x 16 + branch surgeries), community pharmacies (x 23), care homes (x 41), women and children's services, mental health services, domiciliary care providers, dental practices, patients, carers, members of the public etc.

Functions of the Medicines Management Team

The intention of the list below is to provide the committee with a brief summary of the scope of the work undertaken by the team, the list is not intended to be exhaustive.

- **Medicines optimisation –** improve the health of the population by optimising the use of medicines through: promoting the safe, evidence-based and cost-effective use of medicines, providing up to date, unbiased information about medicines, treatments and care pathways, supporting practitioners and patients to make the best use of medicines, minimising the harm caused by medicines, developing local guidelines and care pathways to optimise the management of chronic conditions, collaborating with providers of acute care and other healthcare providers to support these aims.
- **Medicines Safety –** Medicines Safety Officer, Serious Incident Investigations, Datix, national alert management/assurance processes, shared learning
- **Medicines guideline/policy development and review**

- **Clinical pharmacy and safe and secure management of medicines services** to community hospitals and other community services (wards, outpatient departments, specialist services (e.g. tissue viability, respiratory physiology), minor injuries, theatres, dental, maternity, therapies etc).
- **Contract/SLA management** – Community Pharmacy Contract; Dispensing Doctors Contract, Quality Controller (Medical Gases Pipeline Systems); Primary Care SLAs, external provider Health Board SLAs.
- **Legal requirements and governance –**Controlled Drugs Accountable Officer, Antimicrobial Stewardship, Patient Group Directions, Shared Care Agreements, Safe and Secure handling of medicines and controlled stationery.
- **Controlled Drugs –** The Chief Pharmacist is the health board's Controlled Drugs Accountable Officer and Chair of the Local Intelligence Network. This is a statutory role with responsibility for the safe and secure management of controlled drugs across the health economy.
- **Primary care –** Medicines Management Incentive Scheme, Decision Support Software, practice visits (annual), Dispensing Services Quality Scheme, medicines related enhanced services management, outline consent applications, input into the contract assurance framework (CAF)
- **Community Pharmacy** – Pharmaceutical Needs Assessment, new contract applications, enhanced service development, contract management, monitoring and review (including community pharmacy contract assurance framework (CAF)), annual contract visits.
- **Commissioned Services** – development of medicines management quality standards for inclusion in provider contracts, high-cost drugs management (including Blueteq), homecare, policy development, assurance around compliance with local and national guidance/policy, attendance at provider Drug and Therapeutics Committees.
- **Formulary management** – Formulary Management Group, formulary review and development (i.e. INFORM, MicroGuide), NICE/AWMSG compliance (National Treatment Fund (NTF)), low value medicines, horizon scanning.
- **Robust and transparent medicines decision making processes** – Area Prescribing Group (APG); Individual Patient Funding Requests (IPFR) panel.
- **Provision of medicines information services**
- **Sustainable medicines management –** e.g. tackling medicines waste, reducing carbon footprint (e.g. inhalers and medical gases).
- **Medical Gases –** Medical Gases Governance Group (chaired by Chief Pharmacist), ensuring access to training, appointment of QC for Medical gas pipeline system.
- **Financial Management** – budget management (the Chief Pharmacist is responsible for the management of ~10% of the health board's total financial allocation), Value-Based Healthcare (e.g. reducing costs by improving patient outcomes through medicines optimisation), development and delivery of the annual medicines value plans.

- **Immunisation and Vaccination –** supporting national immunisation programmes (e.g. COVID-19, influenza). Supporting the mass vaccination centres, outreach clinics, community and hospital nursing teams. Supporting cold chain management (e.g. maintaining central fridge log, provision of data loggers, arranging annual fridge calibration, supporting cold chain breach investigations).
- **Pharmacy Stores –** logistics and centralised management of vaccines, wound care products, sip feeds, emergency boxes etc.
- **Data analysis** – CASPA, SPIRA (national key performance indicators, controlled drugs, antimicrobials, low priority prescribing, primary care benchmarking dashboard, biosimilar efficiencies, medicines safety dashboard, decarbonisation dashboard), monitoring uptake of flu vaccination, community pharmacy contract monitoring (i.e. service provision), PTHB provider services monitoring (in-patient wards, outpatient clinics, WP10(HP)), secondary care spend (including high-cost drug spend).
- **Audit –** development and delivery of the annual audit plan.
- **Training and education** – pre-foundation pharmacists, pre-registration pharmacy technicians, post-foundation pharmacists, continuing professional development, nurse induction.
- **Non- medical prescribing** – Collaboration with service leads to identify priority areas for NMPs. Liaison with HEIs and HEIW, recruitment to training places, scope of practice monitoring, prescribing monitoring, peer discussion group.
- **Patient centred care** – shared decision making, patient support materials
- **Medicines management support to care homes and domiciliary care**
- **Technology –** Providing expert medicines management input into national digital transformation programmes including Electronic Prescribing and Medicines Administration (EPMA) and Electronic Prescription Service (EPS). Supporting Medicines Transcribing and E-Discharge (MTeD) and working with the national team to identify and develop medicines management tools that empower patients and support disease management and patient independence. Primary care decision support software, PTHB Intervention recording and monitoring tool (award winning).
- **Website –** one stop shop for medicines information.
- **Patient and Public Engagement –** collaboration with Citizen Voice Body (CVB).

Key achievements April 2022 – September 2023

The list below details some of the progress and achievements made since April 2022:

- Continued support to the COVID-19 response
    - Senior Pharmacy Technician seconded to manage pharmacy stores (fixed term contract until March 2024)

    - Vaccine logistics and safe and secure handling of the vaccines strengthened. Robust Standard Operating Procedures (SOPs) in place.
    - MMT leading clinical triage and coordination of access to COVID therapies (nMABs/antivirals).
    - PGD/PSD development and review
- Public Health
    - Pathway to support improved access to influenza antivirals established
    - Opportunity to roll out of Blood-borne virus (BBV) testing in community pharmacies being explored
- Pharmacy Stores
    - Senior Pharmacy Technician with responsibility for Stores has completed training on 'The role of the responsible person' (approved by the MHRA and including 'good distribution practice' (GDP)).
    - Plans in place to expand pharmacy stored to deliver efficiencies.
- Electronic Prescribing and Medicines Administration (EPMA)
    - Chief Pharmacist identified as strategic lead for the pharmacy aspect of this high priority programme.
    - Senior pharmacist and senior pharmacy technician recruited to support implementation across PTHB.
    - Implementation on in-patient wards (including mental health) agreed for phase 1 implementation (by March 2025).
    - Steering Group and Programme Board established.
- Primary Care
    - Prescribing priorities developed and distributed to practices
    - Medicines Management Incentive Scheme aligned with prescribing priorities
    - QAIF medicines related harm domain indicators identified, promoted to primary care and actively monitored. (template developed to support monitoring)
    - Routine monthly monitoring and sharing of primary care prescribing data (e.g. national KPIs, low priority indicators, antimicrobial prescribing indicators, controlled drugs prescribing data).
    - Strategic approach to medicines management support to primary care further developed.
    - Medicines Management Service Level Agreements strengthened (e.g. Llanfyllin).
    - Increased medicines management input into medicines related primary care enhanced services (e.g. DOAC, drug monitoring)
    - Quarterly Medicines Management input into the primary care Contract Assurance Framework (CAF) now established.
    - Lead technician identified to manage primary care decision support software (ScriptSwitch / OptimiseRx).
    - Head of Primary Care Medicines Management attending annual practice meetings with the Primary Care Team and Medical Director.

    - Chief Pharmacist engaging with OpenPrescribing.net to explore the possibility of including Welsh primary care prescribing data in this valuable benchmarking tool.
- Formulary Management Group in place and meeting regularly to ensure that the formulary is seen as a valuable resource, supporting clinicians in both primary care and community services.
- Medicines Management Dietitian – post currently out to advert. This post will help support appropriate prescribing of nutritional products in primary care and community services.
- Medicines Management Nurse – second medicines management nurse recruited.
- Pharmaceutical Services
    - PTHB Pharmaceutical Needs Assessment (PNA) in place and frequently reviewed to ensure that it accurately reflects pharmaceutical service provision across the county.
    - Community pharmacy CAF developed.
    - Contract monitoring reinstated (previously suspended during COVID-19)
    - Contract management being strengthened – procedure for the management of community pharmacy contractual breaches drafted and awaiting approval.
    - Contractor delivery of Clinical Community Pharmacy Service (CCFS) monitored monthly, performance report provided to contractors and barriers to delivery explored with contractors.
    - Pharmacist independent prescribers are in place in five community pharmacies (Llanidloes, Llanwrtyd Wells, Hay-on-Wye, Talgarth and Lower Cwmtwrch), actively prescribing and helping alleviate pressure on primary care. Prescribing activity monitored on a monthly basis.
    - Robust management of the community pharmacy contract budget in place.
    - Regular meetings between PTHB and Community Pharmacy Wales (CPW) in place.
    - Health board website strengthened to provide health care professionals, carers, citizens etc with details of opening hours and services provided by community pharmacies across Powys.
    - Community pharmacy contractors supporting access to medicines that may be required urgently (e.g. vancomycin for C. diff, end of life medicines).
    - 3.7% Increase in delivery of influenza vaccines in community pharmacy during 2022/23 compared to 2021/22 (6990 doses vs 6741 doses).
- Controlled Drugs
    - Controlled Drugs Local Intelligence Network (CDLIN) continues to meet quarterly.
    - Relationship with partner organisations further strengthened. National CDLIN Lead now routinely attending Powys CD LIN meetings.

    - Controlled Drugs Accountable Officer's annual report submitted.
    - Controlled drug incident log established and plans in place to map incidents to support easy identification of trends.
    - Pool of controlled drugs authorised witnesses increased (to support CD destruction).
    - Routine monitoring of CD prescribing in primary care in place to identify excessive and potentially inappropriate prescribing.
    - CD declarations received from all practices and being used to prioritise practice visits.
    - Controlled drugs cupboards installed in all health board dental clinics to ensure that midazolam can be stored in compliance with regulations.
    - Application submitted to the Home Office for domestic controlled drugs licences for each of the health board's off-site dental clinics to ensure compliance with the regulations.
- Antimicrobial Stewardship
    - Antimicrobial Stewardship (AMS) Group continues to meet quarterly.
    - Improvement plan in place, regularly reviewed and standing agenda item for the AMS Group.
    - Quarterly AMS Group highlight reports submitted to the Infection Prevention and Control Group.
    - Letter sent to GP practices by Chief Pharmacist and Consultant Nurse for Infection Prevention and Control to primary care (July 2023) regarding antimicrobial prescribing and post infection review of Clostridioides infections (CDI) (see challenges)
    - MMT supporting CDI root cause analysis.
    - Primary care antimicrobial prescribing KPIs monitored quarterly and shared with antimicrobial stewardship group and Infection Prevention and Control (IPC) Group (also shared with GP practices on a monthly basis, along with other primary care KPIs).
    - MicroGuide launched and promoted to clinicians (primary care and community services), uptake being monitored.
    - Audit of primary care '4C antimicrobial' (co-amoxiclav, cephalosporins, fluoroquinolones and clindamycin) prescribing undertaken.
    - Discussions initiated regarding strengthening the role of the Infection Prevention Control Doctor/Microbiologist support commissioned by the health board.
    - Discussions initiated regarding access to microbiologist advice across the county.
- Self administration of medicines
    - Self administration of medicines whilst in hospital helps to reduce the risk of deconditioning. It helps to improve understanding of medicines, promotes independence and autonomy and prepares patients' for discharge. Self-administration has been piloted on one health board site, lessons have been learned and plans are in place to ensure that appropriate patients are able to self-administer on all health board sites.

- Medical gases
    - Medical Gases Governance Group, chaired by the Chief Pharmacist, continues to meet quarterly.
    - Chief Pharmacist representing all Chief Pharmacists on the 'National Pharmacy Medical Gases Governance Group'.
    - MMT actively involved in multidisciplinary medical gases audits across all health board sites. Plans in place to initiate second round of visits over the next 12 months.
    - Risk register for medical gases in place
    - Options appraisal on the potential decommissioning of the Vacuum Insulated Evaporators (VIEs) from three health board sites in final stages of development.
    - Completion of the BOC Medical gases e-learning courses, commissioned for Designated Nursing Officers (DNOs), monitored and reported to Community Services Managers quarterly. 21 DNOs' have completed and passed every module, 7 DNOs' still have modules to complete and pass.
    - Access to free national Medical Gases Training being pursued. This will allow access to medical gases training by all appropriate staff. The Health & Safety at Work Regulations and HTM02-01 require the health board to provide this training (online and practical elements).
    - Quality Controller for Medical Gases Pipeline Systems in place under an approved SLA with NWSSP (IP5).
    - Work ongoing to strengthen governance and provide robust oversight of the home oxygen budget.
    - Medical gases cylinder amnesty undertaken. Work is underway to review the cylinder requirements across the Health Board.
    - Governance issues associated with liquid nitrogen identified and addressed
- Financial Management/Value based medicine
    - Live medicines value plan in place, covering primary care, community services and commissioned services/high cost drugs.
    - Senior members of the MMT regularly meeting to review progress against medicines value plan targets.
    - All members of the MMT actively encouraged to submit medicines value ideas – 'Ideas spreadsheet' in place.
    - Chief Pharmacist entwined in the Value Based Health Care agenda, driving value-based prescribing and optimal prescribing for higher health gain.
    - Regular meetings in place with finance to improve budget understanding and monitoring.
    - Invoice approval processes continue to be strengthened.
- Training and development
    - The team has continued to support the training and development of pre-foundation pharmacists, pre-registration pharmacy technicians and post-foundation pharmacists.
    - All team members have completed Dementia Friends training.

    - Compliance with mandatory training is monitored regularly and a significant improvement in compliance with training requirements has been seen.
- Medicines storage
    - PSN 055 audits being repeated (medicines storage in wards, outpatients, minor injuries units, theatres, maternity etc).
    - Data loggers and routine temperature monitoring in place in all medicines storage areas (cold and ambient storage).
    - Process in place to adjust expiry dates of medicines requiring ambient temperature storage where temperature breaches are identified (i.e. exposure to temperature > 25^{0}C). Validated correction factors are applied.
- Medicines Safety
    - Medicines Safety Officer (MSO) in place and working to strengthen the role.
    - Plans being developed to monitor medicines safety KPIs following national plans to decommission the national medicines safety dashboard.
    - Significant work undertaken to ensure that the health board has robust systems in place to provide assurance that all patients admitted to PTHB hospital sites have documented venous thromboembolism risk assessments and, where necessary, have access to appropriate treatments.
    - The MMT continues to provide quarterly updates on a number of medicines safety indicators for the PTHB Integrated Performance Report including:
        - Number of women of childbearing age prescribed valproate as a percentage of all women of childbearing age.
        - Number of people age ≥ 65 years prescribed an antipsychotic
        - Total antibacterial items per 1,000 STAR-PU
        - Opioid average daily quantity (ADQ) per 1,000 patients
    - Priority medicines safety areas identified – antimicrobial stewardship and opioid prescribing.
    - National medicines alerts management standard operating procedure in place
- Medicines Management Incident Reporting and Learning:
    - Medicines intervention reporting and monitoring tool, developed by one of our clinical pharmacists, is now recognised as an award winning tool. The tool was a finalist in the NHS Wales awards in 2022 and recently received an Innovation and Best Practice Award. The tool is in routine use in all health board sites and also in care homes. The tool continues to be used to identify areas where guidelines are required. The tool has significantly increased intervention reporting and learning. There is considerable national interest in the tool and potential for its use to be cascaded across NHS Wales and potentially wider.
- Care Homes/Domiciliary Care

    - Medicines Management support to Care Homes and Domiciliary Care continues to be strengthened – pharmacy technician in post. This has strengthened relationships with the local authority and with care home providers.
    - Draft PCC/PTHB Medicines Policy developed.
- Patient Group Directions
    - Patient Group Direction Governance Group continues to meet quarterly.
    - Governance processes reviewed and strengthened.
    - Single process for developing and reviewing patient group directions in place.
    - Database of PGDs established and workplan prioritised around the database.
    - Dedicated section of health board's website established for PGDs to ensure that clinical teams always have access to the most up to date version.
    - Training in place for staff who develop/review PGDs and for those who work to PGDs
- Non-Medical Prescribing (NMP)
    - Work initiated to ensure that NMP development is driven by service need, rather than personal development desires.
    - Work undertaken to identify location of all NMPs and their prescribing status. Register of NMPs developed.
    - Barriers to prescribing by inactive NMPs being explored.
    - Work ongoing to ensure that all health board employed NMPs have an up-to-date scope of practice and that non-medical prescribing is included in their job description.
    - Monitoring of prescribing by NMPs initiated.
- Medicines Management support to the Individual Patient Funding Request (IPFR) panel maintained
- Commissioned services
    - New senior pharmacist and senior pharmacy technician in post
    - Understanding of high-cost drug spend strengthened, although this is limited by the quality of the information provided to the health board by providers.
    - 'Commissioning for Quality in Medicines Management' document, outlining PTHB's expectations of providers, developed and embedded in provider contracts for 2023/24.
    - Relationship with PTHB's commissioning team strengthened.
    - Chief Pharmacist continuing to lead the national work on Blueteq implementation. This is now supported by a national mandate to implement the system.
        - DPIA being developed by national Information Governance leads. Once in place pilots can begin.
    - National Treatment Fund (NTF) compliance database maintained.
    - Actively working with providers to switch patients to biosimilar medicines (e.g. ranibizumab).

    - Shared care agreements (supporting access to care closer to home) – plans in place to support adoption of appropriate NHS England Regional Medicines Optimisation Committee (RMOC) shared care agreements. Collaborative working with acute providers, PTHB clinicians, the LMC and primary care clinicians continues. Barriers to primary care clinicians supporting shared care continue to be explored.
- Decision making processes
    - Area Prescribing Group (APG) established and meeting quarterly. This is now the health board's key medicines decision making group.
    - Sub-groups of the APG include Medicines Safety Group, Formulary Management Group, the PGD Governance Group and the Antimicrobial Stewardship Group
- Policies/Guidelines/Procedures
    - Register of policies, guidelines and procedures established.
        - Review planned to remove documents that are no longer required and prioritise those that require review.
    - Medicines Policy published (live document, subject to frequent updates)
    - Discretionary Medicines Policy approved by the APG June 2023.
    - Clinical guidelines on Weight Adjusted dosing of oral paracetamol in adults approved by APG April 2023.
    - Covert administration policy in final draft – to be approved October 2023
    - Clinical guideline on injectable iron in final draft – to be approved October 2023
    - Unlicensed Medicines Policy in development.
- Website
    - Medicines Management pages continue to be developed, aiming to make them a one-stop shop for clinicians, patients and members of the public.
- Ministry of Defence (MOD) – plans in place for the MOD to move to NHS prescriptions, to improve access to pharmaceutical services for MOD personnel. WG has asked PTHB to lead this work for Wales (working collaboratively with the MOD). Work is ongoing.
- Green agenda – work has been undertaken to highlight the environmental impact associated with metered dose inhalers, nitrous oxide and medicines waste. The percentage of inhalers prescribed as Dry Powder or Soft Mist Inhalers (DPIs or SMIs) has increased by 22.5% since 2021 (31.96% vs 26.09%). Our carbon footprint (CO_2Kg) has also declined by 24.3% over this period.

Although the progress and achievements may look extensive, it is recognised that there is still considerable work to be done before the Chief Pharmacist is assured, and therefore able to assure the executive team, that medicines are managed in line with relevant legislation and regulations, and that national and professional guidance on medicines governance are followed across the organisation.

Challenges

1. **COVID 19:**

   COVID-19 continues to challenge the MMT due to the ongoing requirement to support the vaccination programme and the additional challenge of ensuring that some of the most vulnerable citizens in our population have access to COVID therapies (if they receive a positive diagnosis).

   The programme is supported by a senior pharmacy technician (seconded until March 2024) and although funding was approved for a band 5 post (fixed term), we have been unable to recruit. Without additional support, the MMT will not be able to meet the demands of the service. To support vaccine logistics, the pharmacy stores need to be staffed Monday-Friday, current resource will not allow this. COVID therapies are having a significant, but unpredictable impact on the MMT. Members of the MMT were previously redeployed to support COVID work, however this model is no longer sustainable due to the pressure of clinical duties presented by their substantive posts. Additional support is required to ensure that the MMT can meet the needs of the service. Work is underway to identify a solution.

2. **Cold chain management**

   Cold chain management across the health board has been highlighted as an area of concern. Despite access to training and sharing learning, cold chain incidents continue to be reported due to failed compliance with cold chain standards.

   Following a number of cold chain breaches, the school nursing team in Brecon and the health board's Occupational Health Team requested that the MMT managed their vaccines in the central pharmacy store. This was possible during the summer months, however the central store does not have capacity to accommodate the school nursing and occupational health vaccines, nor the workforce capacity to manage the logistics of these vaccines during the autumn/winter period.

   Central pharmacy stores management of all school nursing and occupational health vaccines would significantly strengthen governance arrangements and provide assurance around the safe and secure management of vaccines. However, without additional resource (capacity to store and workforce to manage logistics), this is not possible.

3. **Medicines transport between Nevil Hall Hospital and PTHB sites**.

   Challenges have been identified with maintaining medicines at the required temperature (cold and ambient) during the transportation process. A temporary solution has been implemented and work is being undertaken to identify a solution at pace.

4. **Antimicrobial stewardship**

PTHB is not on track to meet the 25% antimicrobial prescribing reduction target (against 2013/14 baseline) for primary care by March 2024. In 2022/23, PTHB achieved an overall 8.5% total reduction against the 2013/14 baseline which is far short of the 22.5% reduction target set for the year 2022/23. The increase in scarlet fever, invasive group A strep infection, and respiratory infection in the winter of 2022 was detrimental to prescribing targets and antimicrobial stewardship.

Antimicrobial items per 1,000 STAR-PUs: Between Q4 2021/22 and Q4 2022/23 PTHB saw the second highest growth in overall antimicrobial prescribing in Wales (26.23%, range across HBs = 16.5% to 26.65%)

4C, broad spectrum antimicrobials (items per 1,000 patients): Only two health boards saw an increase in 4C use between Q4 2021/22 and Q4 2022/23 – ABUHB and PTHB. PTHB saw the highest growth (2.3%) and again, this is a significant concern considering that PTHB has the highest level of 4C antimicrobial prescribing in Wales and is 75% above the national target.

A 4C antimicrobial prescribing audit has been undertaken by the MMT. The results will be fully analysed over the coming weeks.

PTHB remains the only health board that does not have a dedicated antimicrobial stewardship pharmacist. A dedicated antimicrobial stewardship pharmacist is required to strengthen our governance arrangements. This resource will be used to ensure that robust guidelines/policies are in place, to support education and training and to provide regular monitoring and oversight of antimicrobial prescribing across community services and primary care.

5. Medicines management support to mental health services

PTHB has four mental health wards, three are Older People's Mental Health Wards (OPMH) - Crug (Brecon), Tawe (Ystradgynlais) and Clewedog (Llandrindod). The Fan Gorau (Newtown) and Ty Cloc (Bronllys), the Hazels (Llandrindod) units provide community mental health services. In addition there is an acute assessment unit, Felindre ward at Bronllys hospital.

PTHB currently has access to 0.2 WTE Band 8A pharmacist to support Felindre Ward and query answering - commissioned via an SLA with ABUHB. There is a clear inequity in medicines management support to mental health services when compared to the support provided to services linked to physical health conditions.

The current level of support to mental health services is inadequate and does not meet the needs of the population of PTHB. We are currently unable to provide assurance about effective, prudent and safe use of medicines throughout the service. Investment in dedicated mental health pharmacy support, which is integrated into the MMT is essential.

NEXT STEPS:

Over the next 12 months, the MMT will build on the progress made to date. Work will be undertaken with the executive team, the wider health board and partner organisations to address each of the challenges outlined above.

Medicines Management work plans and medicines value plans for 2023/24 have been developed. These are being proactively implemented and regularly monitored and reviewed. The health board recognises the opportunities associated with prescribing, both in terms of the potential to improve patient outcomes through medicines optimisation and through the medicines value programme.

In light of the workforce and financial challenges, the MMT will continue to review the skill mix across the team and ensure tasks are undertaken by the most appropriate team member. Delegation will be used where possible to release clinical time to focus on direct patient care and strategic medicines management services. Development of unregistered staff will be maximised and pharmacy technicians will be upskilled. HEIW funding (e.g. training posts) and remote working opportunities will also be maximised.

The implementation of Electronic Prescribing and Medicines Administration (EPMA) is a ministerial, and therefore a health board priority. It is one aspect of the national Digital Transformation Programme. It is a significant work programme for the health board that involved close collaboration between pharmacy, digital, nursing, medical and finance teams. Implementation will see a complete change to the way that our health board clinical teams work, whilst bringing considerable benefits, including releasing nursing time to focus on direct patient care, and improving patient safety. Our Digital Lead Pharmacist will work closely with local and national EPMA Teams and members of the MMT to work towards successful implementation of EPMA on all health board in-patient wards.

Another aspect of the national Digital Transformation Programme is the implementation of Electronic Prescription Services (EPS) in primary care. The MMT will work with the national EPS Implementation Advisory Group to facilitate implementation across Powys. The national plan is to start rolling out EPS during Q3 2023/24, although it is not anticipated that all pharmacy suppliers will be ready to support EPS until 2025. The MMT will support the prioritisation of implementation sites (i.e. GP practices and community pharmacies).

Action plans will be developed, and work initiated to implement the goals and recommendations outlined in Pharmacy: Delivering and Healthier Wales and the Welsh Government recommendations following the Independent review of clinical pharmacy services at NHS hospitals.

The MMT will work closely with HEIW to help address the workforce challenge and support the implementation of the Strategic Pharmacy Workforce Plan.

The MMT will continue to play a part in responding to the climate emergency and align with Welsh Ministers' ambition for the public sector to be collectively net zero by 2030. Our focus over the next 12 months will be on reducing medicines waste, ensuring that more environmentally friendly inhalers are used and decommissioning nitrous oxide manifolds.

In collaboration with the Tissue Viability Team and Nursing Directorate, a wound care formulary will be developed over the next 12 months. A clear process map for accessing wound care products will also be developed and, if possible, the routes of access will be simplified. A robust understanding of spend on wound care products will be acquired and opportunities for efficiencies will be identified and exploited.

The ability to offer appropriate patients the ability to self-administer their medicines whilst admitted to PTHB in-patient wards will be extended to all sites. This will reduce the impact of deconditioning whilst in hospital.

The MMT plans to initiate the process of applying for a Wholesale Distribution Authorisation (WDA) to support the distribution of medicines outside the legal entity of the health board (e.g. to GP practices and community pharmacies). The benefits of having this ability were seen during the COVID-19 pandemic. A national consultation is currently seeking views on extending the ability to move COVID-19 and influenza vaccines between premises at the end of the supply chain, by providers operating under NHS arrangements that do not hold WDAs. If approved, our ability to move COVID-19 and influenza vaccines will remain in place until 1st April 2026. The exemption will not however apply to any other medicines.

Subject to capacity to store, and workforce to support, plans are in place to expand the central pharmacy store (Bronllys) to improve efficiency across the health board (e.g. sip feeds, wound care, vaccines)

The MMT will work to improve the health board's performance against each and every medicine related national key performance indicator (KPI). We look beyond performance in Wales and compare our performance to that of English CCGs, and where we believe that the Welsh national targets are not ambitious enough, we will strive to work towards the more ambitious English targets.

Regular prescribing data will continue to be provided to primary care so that each and every practice will be able to see their performance against KPIs and how they compare to other practices.

Work will be undertaken with data analysts to obtain clinical data that can be used to enhance discussions around prescribing data (e.g. practice level data on % of patients treated to blood pressure, HbA1c, cholesterol etc targets; hospital admissions data).

SLA and contract management will continue to be strengthened. Robust performance management arrangements will be strengthened with increased collaboration and feedback to providers.

Work will continue with providers to ensure that the health board is provided with adequate data to allow high-cost drug spend to be robustly scrutinised and, where appropriate, challenged. This will be supported by the implementation of Blueteq.

As soon as a national DPIA is approved for Blueteq, this will be adopted by the health board and the Blueteq system will be implemented and used by appropriate PTHB provider services (e.g. ophthalmology, weight management) and English providers. This will significantly improve our financial and clinical governance around high cost drugs.

Work to ensure that the health board's formulary provides clear guidance that supports prescribers will continue at pace.

The Chief Pharmacist and the wider MMT will work closely with the Medical Gases Governance Group to strengthen the management and governance of medical gases across the health board and in the community. Ordering processes for medical gases for health board sites will be strengthened to ensure clinical oversight.

The MMT will continue to work closely with medical, nursing and therapies leads to develop a strategy for non-medical prescribing. Applications to train as non-medical prescribers are currently led by personal interest rather than service needs.

The MMT will work closely with the Primary Care Team to review the varied models of medicines management support/funding that are in place across the health board. Our ambition is to have a standardised model as soon as possible.

The medicines management pages of the health board's website will be further developed and populated to ensure that it is an easy to use and helpful website which is accessible to patients, members of the public and clinicians.

The medicines management audit programme will be actively progressed. Areas of focus include antimicrobial stewardship, medicines storage, Patient Group Directions (PGDs),medical gases and controlled drugs.

The Chief Pharmacist will work with the Assistant Director for Quality and Safety to improve the quality of medicines related incident reporting and encourage increased reporting to support learning across the organisation.

The MMT will spend time working with clinical teams across the organisation to get a better understanding of the medicines management challenges faced on a day-to-day basis. This will increase awareness of the challenges, improve collaborative working and ensure that clinical teams are supported with medicines management issues.

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: 2.2

Patient Experience, Quality & Safety Committee	**24 October 2023**
Subject:	**Integrated Quality Report**
Approved and Presented by:	Claire Roche, Executive Director of Nursing & Midwifery
Prepared by:	Zoe Ashman, Assistant Director Quality & Safety
Other Committees and meetings considered at:	Executive Committee - 11 October 2023

PURPOSE:

The purpose of this report is to provide the Patient Experience and Quality Committee with an overview of the Quality & Safety agenda across the Health Board.

RECOMMENDATION(S):

The Patient Experience, Quality and Safety Committee are asked to:

- **RECEIVE** the report and take **ASSURANCE** that Quality and Safety is appropriately monitored and reported and that continued actions are in place to further develop quality and safety monitoring and reporting.

Approval/Ratification/Decision[i]	**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	✓

ACRONYMS	
PTUHB	Powys Teaching Health Board
NRI	Nationally Reportable Incidents
PTR	Putting Things Right
PSOW	Public Service Ombudsman Wales
PCC	Powys County Council
HM Coroner	Her Majesty's Coroner
PREM's	Patient Reported Experience measures
PROM's	Patient Reported Outcome Measures
GMPI	General Medicine Practice Indemnity
WRP	Welsh Risk Pool

DETAILED BACKGROUND AND ASSESSMENT:

1 Background

The purpose of this report is to provide the Patient Experience and Quality Committee with an update on the quality and safety agenda for Powys Teaching Health Board (PTHB).

2 Specific matters for consideration by this meeting (Assessment)

2.1 Quality & Engagement Act (2023) Implementation

The Health and Social Care (Quality and Engagement) (Wales) Act ('the Act') became law on 1 June 2020 and full implementation commenced on 1 April 2023.

Implementation Group is in place to monitor compliance and ensure the implementation plan is realised.

2.2 Once for Wales Content Management System (RLDatix)

The implementation of the Once for Wales Content Management System (OFWCMS) is complete.

PTHB have agreed to pilot the risk module which is the final module planned for implementation. Taking the opportunity to pilot the module ensures PTHB can use a digital platform to manage risks across the health board, ensuring a more robust structure for risk management visible on one platform. The pilot has commenced within the Nursing Directorate in September 2023 with plans to roll out to all services in a managed and staged approach.

The Incident Management Framework (IMF) has been ratified and rolled out during Q2 with continued focus during Q3 to support further training for teams to investigate and close incidents. The training will continue to build on the training provided during 2022/23.

Data dashboards are available and in use for teams across the health board to further support the management of incidents in a timely and proportionate manner.

2.3 Supporting learning and improvement

The Learning Group is supported by all Clinical Directors and their teams. This forum is a key enabler to the reporting and monitoring process further supported by the implementation of the Incident Management Framework.

The team have supported learning events to discuss incidents that have occurred with common themes and crossover of learning. The learning events have been well attended by key individuals within the services to further strengthen the actions for improvement that are required. It is envisaged that these events will ensure that teams develop a safe culture to learn, improve and celebrate their successes.

2.4 Safe Care Collaborative

The Safe Care Collaborative is part of the Safe Care Partnership, which is a collaboration between NHS Wales health boards and trusts, Improvement Cymru and the Institute for Healthcare Improvement (IHI).

The partnership's aim is to coach and support health boards and trusts to improve the quality and safety of care across their systems. The Safe Care Collaborative creates a learning system where organisations test and measure practice innovations and share their experiences to accelerate learning and widespread implementation of best practices for safe care. It brings together teams, coaches, executives, and senior leaders for safety from across all the health boards and trusts in Wales to focus on a common aim.

The Health Board representatives did not attend this event in September 2023 due to conflicting challenges associated with the financial position of the NHS in Wales and operational demands. However, the Executive Director of Nursing and Midwifery and the Medical Director did attend a closed Executive session virtually on day 2 of the event. Future events will be virtual and PTHB will continue to engage in this collaborative. Improvement Cymru colleagues have been invited into our local SafeCare collaborative meetings. The team focussed on the completion of L2 Quality Impact Assessments required by Welsh Government to support the cost saving projects.

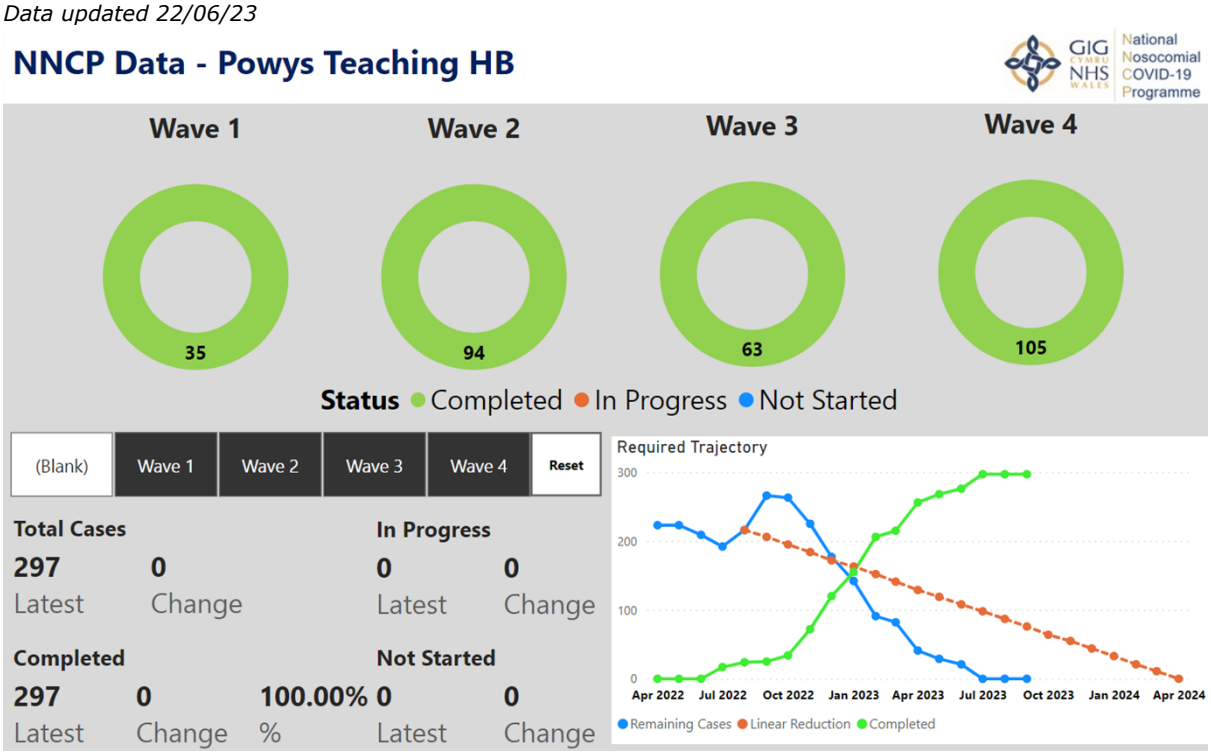
2.5 National Nosocomial Framework

In March 2021, the Framework into the 'Management of patient safety incidents following nosocomial transmission of COVID-19' was published. Any hospital acquired infection, including COVID-19, is considered a patient safety incident and therefore the provisions of the Putting Things Right Regulations (PTR) apply.

To date, the Health Board has not received any concerns from families or patients affected by nosocomial transmission of Covid-19. No identified cases where severe harm or death have occurred have been identified thus far and therefore, duty of candour conversations with patients and/or families have not been required.

The programme completed all cases during July 2023 and will be providing information to the national team for an end of programme report regarding learning.

Data updated 22/06/23



Learning identified within the Nosocomial Framework specifically for Powys includes:

- With the restrictions to visiting and flow numbers of nosocomial cases were low, Health Board had an advantage of planned admissions following strict guidance.
- Clear tracking of patients i.e., location of bed on ward, would have been helpful to identify learning during outbreaks.
- Increased visibility of IP&C team and presence in clinical areas to provide support to teams could have been improved
- Outbreak meetings could have been better structured and communicated more effectively The Learning from outbreaks did not always effectively inform care planning or future actions.
- Training has been provided by the nosocomial team to support ward managers and team leads to manage incidents associated with Nosocomial infections.

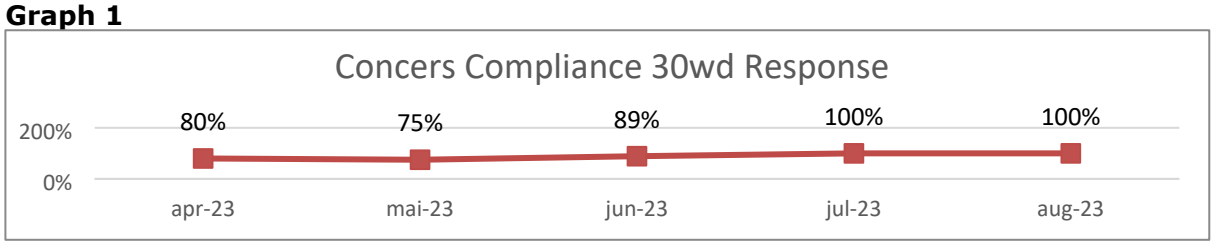
National learning has been identified and shared within the Interim Learning Report **(Appendix 5).**

2.6 Putting Things Right – Concerns

The management of concerns continues to improve with the target of 75% compliance to responses within 30 working days being realised. Continued focus is maintained to ensure concerns are managed in a timely manner with the appropriate investigation and response.

With the use of the CIVICA patient Experience system, feedback is obtained from those that have raised a concern which have since been closed to assess their satisfaction with how their concern has been handled. An overwhelming response was received with over 79% very happy with the process, standard of communication and engagement with the team.

Graph 1



Themes from concerns (provider)

- MIU attendances and further treatment required at DGHs.
- Neurodevelopment services ongoing theme around providing timely letters regarding children's diagnosis.

Themes concerns (commissioning)

- Lack of choice of location for treatment.
- Length of Orthopaedic waiting lists.
- Funding for transport to SaTH and WVT
- Patients' requirement to travel to commissioning Trusts to collect medication which that cannot be prescribe by a local GP.
- Concerns that Powys do not receive equitable care.

Duty of Candour
During Q1 & Q2 there have been 8 duty of candour cases. 4 have been closed with no harm and 4 investigations are ongoing.

Claims, Redress & Clinical Negligence Position
Redress
6 open cases being managed.
100% compliance with re-imbursement recovery.

Clinical Negligence
9 Open files

General Medicine Practice Indemnity (GMPI) Claims
3 Open cases

Welsh Risk Pool (WRP) Assessment of the Putting Things Right processes
The WRP undertakes assessments of member organisations' policies, procedures, and practice as part of its oversight duties – with the aim of gathering assurance on local processes for the WRP committee and Welsh Government, whilst also providing recommendations to support organisations in continuous improvement within this area.

The WRP Assessment process provides a framework for the analysis of an organisation's compliance with the WRP Reimbursement Procedures, the requirements of the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 and other national policies & procedures related to the Putting Things Right sector.

The period used for assessment related to policies and procedures in force and matters opened, under investigation, or closed between 1st January 2022 to 31st March 2022.

The review team recognised that significant improvements had been made since the period reflected in the review and subsequently greater assurance would be obtained within future assessments. Full report **Appendix 2**.

2.7 Public Service Ombudsman for Wales (PSOW)

The Health Board position for 2022/23 with complaints escalated to the PSOW is noted in **table 1** as shared with committee in July 2023 report. PSOW has since published their annual report which provides further detail and highlights 16% of all PTHB concerns were referred to PSOW in 2022/23. Reports to committee during 2022/23 highlighted this increased referral rate to PSOW and recognised the association with previously poorly managed concerns with significant lengthy response times which have contributed to this increase in referrals.

Despite the high ratio of referrals to PSOW no concerns were upheld by PSOW during 2022/23:
Table 1

	Population	Complaints Received	Complaints Received per 1000 residents (adjusted)	Complaints Closed	Within 30 days %	Referred to PSOW	Referred %	PSOW Cases Closed	PSOW Intervened %	Early resolution %	PSOW Upheld%
PTHB	132,447	134	1.01	146	43.84%	23	15.75%	23	21.74%	17.39%	0.00%
Wales	3,138,631	18,901	6.02	17,724	75.89%	926	5.22%	918	29.85%	18.95%	9.59%

PSOW have requested that all Health Boards consider the following actions to support a response to their recommendations within the report, which include:

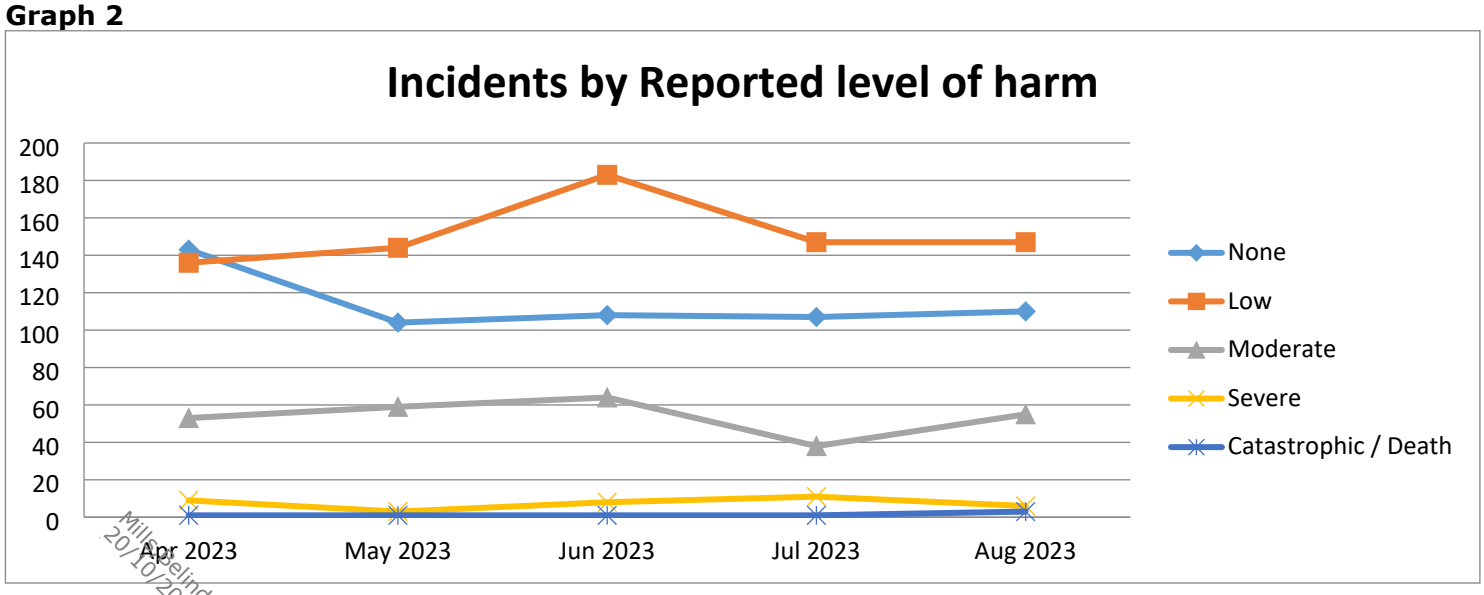
- Review of resources available to the concerns team.
- Review arrangements for accurately compiling complaints data.
- Consider whether the option to provide staff investigating concerns with independent medical advice, is considered on a case by case basis.
- Reflect upon the lessons highlighted in the report when scrutinising performance on concerns handling.
- Ensure that lessons learned from PSOW's findings and recommendations are included in the Health Board annual report on the Duty of Candour and Quality.

2.8 Incident Management

The number of patient safety incidents (**Graph 2**) reported is stable and appropriate with most incidents reported within the Low and No Harm classification.

It must also be recognised that the number of moderate harm incidents has reduced which may be attributed to the increased education and training regarding the classification of harm and incident management.

Graph 2



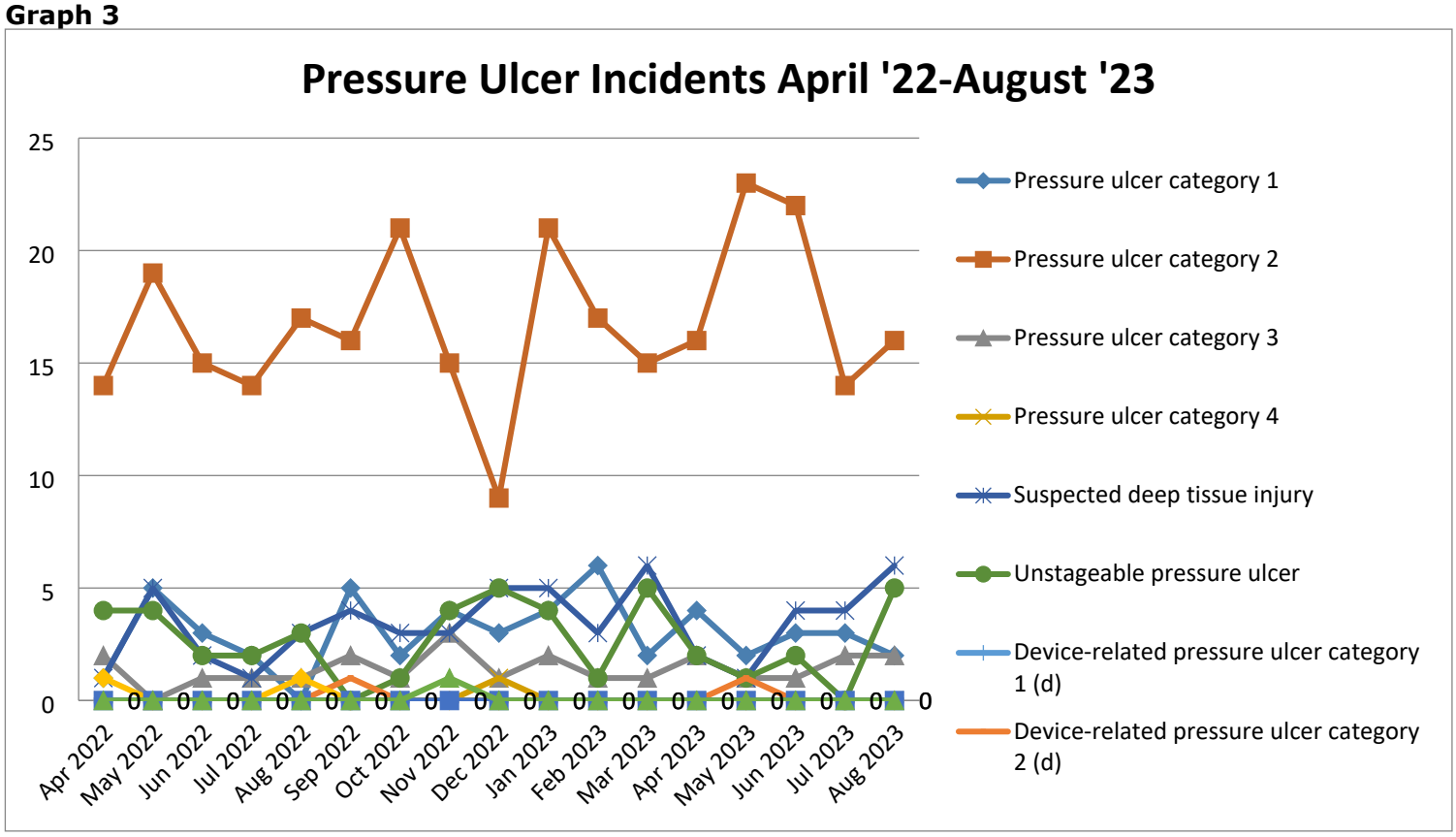
Significant challenge continues with the timely management and closure of incidents by services, actions to further support closure of incidents is being taken to ensure during Q3 & Q4 incidents will be closed at pace, these include:

- Implementation of Incident Management Framework, which provides clarity of process and expectations along with templates to support timely investigations.
- Weekly reporting to Heads of Service, Assistant Director and Executive Directors highlighting incidents that remain open/overdue.
- Weekly meetings with service governance leads.
- Additional training sessions to support timely incident management.
- Production of dashboards within Datix for all services.
- Additional resource to support the management of Pressure Ulcer incidents.

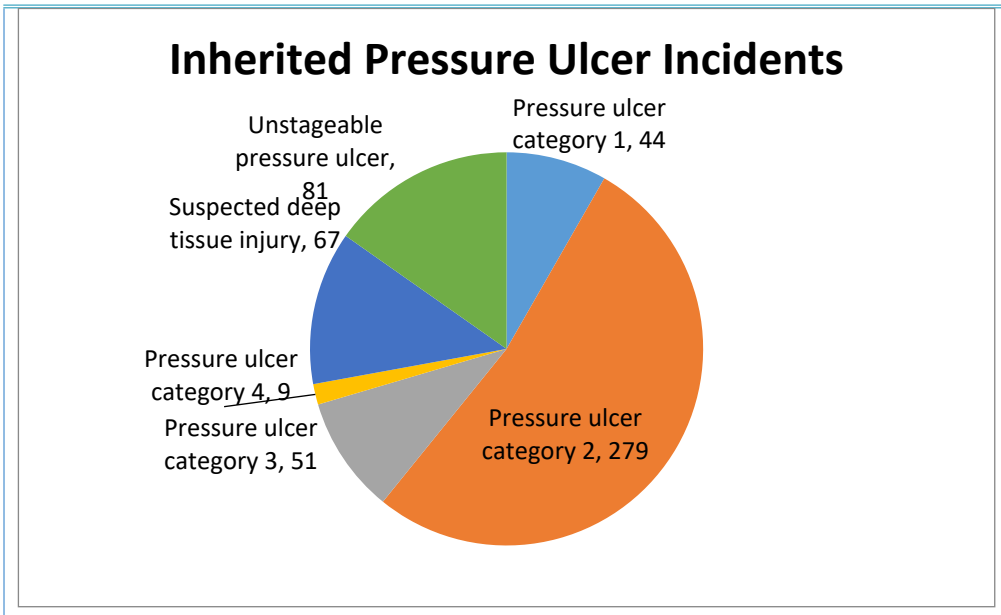
2.9 Pressure Ulcer (PU) Incidents

Pressure Ulcers incidents are the highest reported incidents for the health board, a number of which are inherited from care in other locations i.e. home, another HB/Trust orCare home. **Graph 3** demonstrates all PU incidents reported from April 2022 – end August 2023 along with **Graph 4** demonstrating the inherited PU incidents for the same period.

Graph 3



Graph 4



Several processes are in place to appropriately manage, learn and improve the care of patients with pressure ulcers, which include:

- Twice monthly pressure ulcer scrutiny panels attended by the Multidisciplinary team (MDT).
- Additional resource to support the management of overdue PU incidents along with support for further learning and improvements for teams.
- Sharing learning and incidents of inherited PU with commissioned organisations or origin.

2.10 Early Warning Notifications (previously No surprises notifications)

3 Early Warning Notifications have been submitted during Q2 2023/24.

2.11 Nationally Reportable Incidents

The current position for open Nationally Reportable Incidents (NRI's) is reported in the table below.

Reported period	Number open in time	Number open overdue	Number awaiting final approval	Closed
Q1 & Q2	**14**	**7**	**2**	**5**

The themes for learning and improvement include:

- Standards of record keeping
- Consent to treatment
- Ensure appropriate patients are treated in community hospital settings.
- Enhanced care requirements
- Clinical Guidelines not followed or not present.
- Complex pathway of care

3. Patient Experience- CIVICA

CIVICA patient experience system continues to evolve and become established across teams with 35 questionnaires available for use.

Key achievements in Q2:

- Implementation of District Nursing feedback process.
- Commence audit visits across community hospitals with the inclusion of feedback from patients, Next of Kin (NOK) and carers.
- Age-appropriate feedback mechanisms are in place for young people withing PTHB

Key priorities in Q3:

- Roll out of questionnaires on a monthly 'push notification' to those that have received commissioned care (not achieved in Q2).
- Implementation of 'How we are doing boards' within clinical areas.

Examples of feedback received by patients and service users has been captured below:

- 'My District Nurses are always kind, caring and compassionate'
- 'The care my family received whilst my mother was at her end of life was exemplary, I felt the nurses, cleaners, support staff, doctors and everyone we met really cared about what mattered for my mum and us as a family'
- 'I am really not able to afford to travel for my appointments miles from my home, can't I have care in my local hospital or GP practice?'

4. Infection Prevention and Control (IP&C)

4.1 A paper was presented to the Executive Committee in June 2023, and a subsequent PEQS in-committee meeting with Independent Members. This resulted in the approval of an organisational wide IP&C improvement plan **(Appendix 3)** aligned to the minimum standards set out within the 2014 Code of Practice for the Prevention and Control of Healthcare Associated Infections. The improvement plan will be led by the Consultant Nurse for IP&C in collaboration with all services and departments across the health board, thus ensuring IP&C is everyone's business, owned and understood by all.

Progress of Improvement Plan

- Total number of actions: 24
- Completed actions: 6
- On trac to complete: 18
- Behind schedule: 0

Areas of improvement realised to date:

- Establishment and inaugural meetings of the IP&C improvement collaborative on 13 July 2023, representation from all service areas was achieved.

- A rolling IP&C annual audit programme has been implemented; good progress has been noted with completion of all areas bar 1 completed. Similar themes identified – in terms of the state of our estate and the work required to upgrade.
- Development and implementation of a SOP for the management of microbiology results to ensure a robust and consistent approach.
- Implementation of 3 new policies and update of 2 policies
- Joint site visits with IP&C & Works & Estates (W&E) to address priority key issues, that are likely to impact Infection Control across PTHB; completed at the end of August.
- Increased visibility from the IP&C team across the organisation.
- Recruitment of experienced retired Assistant Director of Nursing (IPC) into bank post to support the improvement programme.
- Ongoing work to review c.difficile cases from 2021/2022 to identify learning and cases from Wye Valley from the first 6 months of 2023/24.
- Establishment of relationships with Shrewsbury & Telford and Wye Valley IP&C teams, which has resulted in greater information sharing and organisational learning**.**

5. Health and Social Care Inspections Regulatory Recommendations

5.1 Health Inspectorate Wales Inspections

There have been no new HIW inspections during this current reporting period.

5.1 Health and Social Care Regulatory Reports

2 actions remain outstanding 2017-2020. Updates against these are provided below:

HIW Review of Healthcare Services for Young People	Health boards must ensure that children and young people can consistently be treated within designated areas.	Discussion on adult OPD environment with scheduled care managers held, consideration given to move some OPD clinics to children's centres- currently being reviewed re capacity and staffing.
HIW Review of Healthcare Services for Young People	Health boards must ensure there are robust systems to monitor transition policies and pathways across healthcare services to ensure approaches are effective.	Benchmarking against "let me flourish" report 2021 is being undertaken by the Startwell Complex Needs workstream in addition to this being progressed through PTHB transition guidance group

6. Medical Devices & Point of Care Testing

The Medical Device and Point of Care Testing Annual Report 2022-2023 was presented to Executive Committee on 4 October 2023. The report provides an overview of the Medical Devices and Point of Care Testing Service, its background to the organisation and its ambitions for 2023 – 2024. The report sets out how the service has performed over the past year, with highlights of the key achievements and a review of the challenges and risks. The report highlights the significant improvements that continue to be made, in particular, against the NWSSP Internal Audit Recommendations. There is also acknowledgement there remains some areas where improvements are required, and identifies what challenges are faced when endeavouring to progress.

The report covers the following activities that PTHB has undertaken during this period, to make improvements to the Health Board's Medical Devices and Point of Care Testing Service provision:

- Governance Arrangements
- Risk Assessment and Management
- Partnership Working
- Environment and Sustainability
- Assurance
- Key Priorities for April 2023 to March 2024

The Report can be located at agenda item 2.7 on the agenda.

7. KEY MATTERS FOR BOARD/COMMITTEE

Timely management of incidents is required to ensure appropriate action is taken.
ACTION taken: Managers and those responsible for managing incidents have been provided with RCA training to manage incidents effectively and in a timely manner. Implementation of the Incident Management Framework will further support the timely and robust management of incidents.

Appendix 1: WRP Assessment Report	
Appendix 2: PSOW Annual Report 2022/23	
Appendix 3: IP&C Improvement Plan	
Appendix 4: WHSSC Quality & Patient Safety Chairs Report July and September 2023	
Appendix 5: Nosocomial Programme Interim Learning report	
Annual Report Medical devices and point of care testing – agenda item 2.7.	

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	√				
Disability	√				
Gender reassignment	√				
Pregnancy and maternity	√				
Race	√				
Religion/ Belief	√				
Sex	√				
Sexual Orientation	√				
Marriage and civil partnership	√				
Welsh Language	√				
Risk Assessment:					
	Level of risk identified				**Statement**
	None	**Low**	**Moderate**	**High**	
Clinical	√				Reputational risk if no improved compliance with Welsh Government performance for management of concerns.
Financial	√				
Corporate	√				
Operational	√				
Reputational			√		

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Cronfa Risg Cymru
Shared Services Partnership
Welsh Risk Pool Services

Welsh Risk Pool Concerns Assessment

A Report by the Welsh Risk Pool (WRP) Safety and Learning Team

Powys University Health Board

Final Report August 2023

Mills, Belinda 20/10/2023 15:29:17

Gwella Diogelwch Cleifion Trwy Ddysgu
Improving Patient Safety Through Learning

WRP Assessments

A Report by the WRP Safety and Learning Team

August 2023

About this Report

This report is intended to support health bodies within NHS Wales to continuously improve the operation of its Putting Things Right processes and provide assurance in relation to current policies, procedures, and practice.

This report provides findings for the health body following a review conducted by an independent assessment team. It has previously been circulated for comments and factual accuracy considerations.

The report identifies a number of recommendations. Each organisation has been asked to develop an action plan which addresses the findings and supports the prioritisation of improvement activity in this area. A copy of the organisation's action plan is included in the final report to enable tracking of information and to support future reviews.

In addition to the report, the health body has been provided with a summary of the fieldwork analysis of the matters scrutinised. This enables the organisation to consider the comments in the context of the information that the reviewers analysed.

Assessment Visits	November 2022 - March 2023
Draft Findings shared	June 2023
Action Plans Received	July 2023
Final Report Published	August 2023

Version
Powys Teaching Health Board WRP Concerns Assessment Report VFinal1

WRP Concerns Assessment

A Report by the WRP Safety and Learning Team

August 2023

CONTENTS

1.0 Outline of Review

1.1 The WRP undertakes assessments of member organisations' policies, procedures, and practice as part of its oversight duties – with the aim of gathering assurance on local processes for the WRP Committee and Welsh Government, and to provide recommendations to support organisations in continuous improvement in this area.

1.2 The WRP Assessment is used by the WRP Committee when determining members' contributions to the fund as part of the risk sharing agreement. For the 2022-23 programme of assessments, the outputs will be advisory in nature and will not affect the individual contributions already established for the 2023-24 financial year.

1.3 The WRP Assessment process provides a framework for the analysis of an organisation's compliance with the WRP Reimbursement Procedures, the requirements of the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 and other national policies & procedures related to the Putting Things Right sector.

1.4 The review involves analysis of individual case management against both legal requirements and policy criteria. It also examines compliance with the application of the Once for Wales Concerns Management System workflows and essential data fields.

1.5 The review further facilitates analysis of the efficacy of the Learning from Events process within the organisation and examines how a health body shares and implements good practice between organisations.

1.6 The methodology for assessment has evolved during the last few years in line with national policies. The approach is focussed on peer-review, with senior leaders within the Putting Things Right sector in other organisations joining staff from the WRP in conducting the assessment. Specialist advisors in legal specialists, join the assessment team as required. This approach is considered to promote sharing of best practice and enable the assessment team to recognise the application of the areas for assessment in operational practice.

1.7 For each area for assessment, the Assessment Team consider the available evidence and report assurance to the organisation using the NHS Wales Internal Audit Assurance Framework. Details of the framework are shown in Appendix 1.

2.0 Scope of Review

2.1 The review considers a number of areas for assessment, each focussed on a different aspect of the Putting Things Right process.

- Management of Concerns (Incidents)
- Management of Concerns (Complaints & Enquiries)
- Redress Case Management
- Claims Case Management
- Learning from Events
- WRP Reimbursement Process

2.2 The period used for the assessment related to policies and procedures in force and matters opened, under investigation, or closed between 1st January 2022 to 31st March 2022. This period was selected and agreed with senior leaders from the Putting Things Right sector, as it is considered that cases would be sufficiently progressed from the initial report and commencement of investigations to facilitate a thorough review. This period was selected for all organisations to allow a fair comparison between organisations where the outputs of the assessment are used as part of the risk sharing agreement. Where an organisation had not commenced live use of the Once for Wales Concerns Management System during the intended period, the first three months of live use of the system was selected as an alternative period.

2.3 The clinical specialities selected as an area for focus in organisations which provide acute care were chosen as they represent the greatest proportion of the litigation profile across NHS Wales. The clinical specialties selected for the focus of the assessment in acute organisations were:

- Maternity Services
- Emergency Department Care
- Orthopaedics

3.0 Assessment Team

3.1 The WRP Assessments are conducted by a small group of specialist practitioners who are drawn from the Putting Things Right sector.

3.2 The Coordinator for each Assessment is a member of the WRP team, with the Chair of the Assessment Team drawn from a member of the Heads of Patient Experience Safety & Learning Network – providing realistic advice on the practicalities in achieving the standards in practice.

3.3 To ensure compliance with the legislation, a lawyer from the Legal & Risk Service is included in the Assessment Team and this colleague focusses on compliance with redress case handling and legal compliance in relation to claims.

3.4 As the assessment process focusses greatly on the use of the Datix Cymru system, a member of the Once for Wales Concerns Management System central team is included in the Assessment Team.

3.4 The Assessment Sponsor coordinates the formation of fieldwork teams and oversees any queries which arise, along with signing off the Assessment Report.

3.5 The Assessment Team for this review was:

Sponsor: Jonathan Webb, Head of Safety & Learning
Welsh Risk Pool

Field Work: Kath Clarke, Assistant Director of Patient Safety
Health Board

Gemma Cooper, Senior Solicitor
Legal & Risk Services

Christine Buckland, Safety & Learning Advisor
Once for Wales Concerns Management System Team

Eleri Wright, Safety & Learning Advisor
Welsh Risk Pool

4.0 Review Findings

4.1 Management of Concerns (Incidents)

4.1.1 The Assessment Team noted that there were 1452 incidents reported in the period 1st January to 31st March 2022.

4.1.2 In considering the application of policy, the Assessment Team found that there was good evidence of clear incident management processes, including nationally reportable incident management, within the health board. There is a health board Incident Management Policy in place which provides a structured approach and covers the requirements as set out in the PTR guidance. This had been introduced after the period for which the assessment took place and was included as it represents current health board practice. The Assessment Team were assured that over the last few months and since the appointment of a new Assistant Director of Quality &Safety there have been significant improvements in the management of concerns, claims and incidents.

4.1.3 The Assessment Team scrutinised the detail of nineteen incident records within the Datix Cymru system, which related to the period being assessed. The Team noted that for the majority of records reviewed, the contributory factors framework has only been completed with the “no” box being ticked. Those reviewed did not have an investigation report uploaded to Datix with feedback to the reporter comprising of mainly a “thank you for reporting” message. Whilst reviewing the records the Assessment Team found that several documents were password protected and despite being given different options of what the password could be the Team were unable to review sufficient documents. However, following discussion with the Assistant Director of Quality &Safety it was confirmed that passwords are not now used to save documents onto the Datix Cymru System and going forward this situation will not reoccur.

4.1.4 It is important that incidents are reported and graded correctly in order to facilitate appropriate safety measures to be implemented. The Assessment Team noted that in some incidents, the reporter had graded the record correctly as no harm but at the post investigation stage, the record had been upgraded despite there being no evidence of harm having been caused. In one particular

incident it was reported as catastrophic with it being downgraded to severe but no investigation or explanation provided. This places significant questions on the reliability and validity of the incident records covering the period of the assessment. A random sample of more recent incidents were reviewed by the Assessment Team and these were found to have been graded more appropriately and evidence being attached. This provides stronger assurance of current processes within the health board.

4.1.5 The Assessment Team were not assured that unexpected deaths of a patient open to Mental Health Services are managed consistently to the same process. Furthermore, the Team were not assured that incidents that occur to patients whilst receiving care cross border are dealt with consistently. The Assessment Team would recommend that the Investigation section be completed for accurate reporting purposes.

Management of Concerns (Incidents)		
LIMITED ASSURANCE		The organisation can take **limited assurance** that arrangements to secure governance, risk management and internal control in relation to the Putting Things Right areas of assessment are suitably planned and applied effectively. More significant matters require management attention with moderate impact on residual risk exposure until resolved.
The Assessment Team were more assured about current incident management practices and oversight within the health board and would anticipate any re-assessment would result in a greater level of assurance being secured.		

4.2 Management of Concerns (Complaint and Enquiries)

4.2.1 The Assessment Team noted that there were 42 complaints reported in the period 1st January 2022 to 31st March 2023.

4.2.2 The Assessment Team reviewed the current policy in place which was issued in June 2021. The Policy was approved by the Executive Committee and the Board which is a suitable forum for this purpose.

4.2.3 The Assessors noted that the health board has made significant changes to processes and procedures since February 2022 and there is now a clear structure in place to manage concerns including complaints and enquiries. In considering the records from the review period, there did not appear to be a consistent approach to the management of concerns cases.

4.2.4 The Assessment Team scrutinised the detail of five complaint records within the Datix Cymru System and found that there were inconsistencies in the application of the Putting Things Right Regulations with responses being sent to complainants not in line with the requirements. The Assessment Team also noted that the application of the Regulations in terms of consent was also inconsistent with lack of evidence recorded as to how decisions to disclose information were reached.

4.2.5 The Putting Things Right Regulations require qualifying liability to be considered and referenced in the letters of response even in concerns where there is no allegation of harm. The Assessment Team noted responses sent without reference to qualifying liability.

4.2.6 The Assistant Director of Quality & Safety explained that significant changes have been made within the Concerns Team - with staff roles being reviewed and developed to better suit the complexity of care within the health board. A Patient Advice & Liaison Service (PALS) structure is also being considered. The Assistant Director of Quality & Safety is also now reviewing all concerns to ensure they are dealt with consistently and investigated in line with the Putting Things Right Regulations.

Management of Concerns (Complaints & Enquiries)		
REASONABLE ASSURANCE		The organisation can take **reasonable assurance** that arrangements to secure governance, risk management and internal control in relation to the Putting Things Right areas of assessment are suitably planned and applied effectively. Some matters require management attention in control design or compliance with low to moderate impact on residual risk exposure until resolved.
Whilst the Assessment Team found inconsistencies within the Complaints & Enquiries records relating to the period of the review, the revised concerns management approach is being retrospectively applied to older records, which is reassuring. The Assessment Team consider that a re-assessment would likely result in finding of substantial assurance.		

4.3 Redress Case Management

4.3.1 At the outset, the Assessors noted that the health board has made significant changes to processes and procedures since February 2022. Notwithstanding that, it was important that the review was undertaken from the review period, January-March 2022 as this is the same period for all organisations that are subject to the WRP Assessment process.

4.3.2 The Assessment Team scrutinised the detail of seven redress records within the Datix Cymru system. It was noted that it was unfortunately difficult to follow the cases, particularly insofar as the documentation saved to Datix was concerned. This appeared to have, on some files, been uploaded retrospectively and out of chronological order. Some documents were password protected and the password was not available. However, following the changes to processes described above, this practice has now been stopped. Regulation 26 and 33 responses were not easily identifiable and were sometimes attached to emails and sometimes missing altogether. Hard copies were provided to the Team but it was not clear what versions of the documents had been sent.

4.3.3 From the review period there did not appear to be a consistent or evidenced approach to the management of redress cases. However, this has now changed with draft interim responses making admissions being checked by the Team and the file then being handed over for further work under the Redress part of the Regulations.

4.3.4 It is important that responses are sent out in a timely manner to ensure compliance with the Regulations. The Assessment Team noted that delays were evident on a number of the files reviewed, sometimes significantly so. A number of the files reviewed involved incidences of treatment many years ago (2017-2020, for the review period as above Jan-Mar 2022). In some cases there was ultimately non-compliance by the patient/complainant or family and this is possibly due, in part at least, to the delays and lapse of time from index treatment. Some of the cases reviewed involved complexities – being maternity or commissioned care cases (1 of those reviewed). However, others appeared

more straightforward (e.g., pressure ulcer) and it was more difficult to see why there were such delays on those.

4.3.5 The Assessors noted that the information in the Redress section of Datix Cymru was not always accurate, insofar as the position on breach of duty and causation not being noted or updated correctly.

4.3.6 As above, following discussion with the Assistant Director of Quality & Safety however, it appears that processes are now very different from January to March 2022. It seems that there are good processes for involvement of the Assistant Director of Quality & Safety and the Redress Manager in reviewing any draft Regulation 26 responses where admissions are to be made.

4.3.7 The Assessment Team noted clear evidence of support from Legal and Risk Services with formal referrals. The Assessors discussed the availability of a Legal and Risk Drop In Clinic for Investigators, which may assist with ownership and education from the Services. The Redress Manager is also more recently being empowered to make more decisions on the Redress cases, insofar as referrals to Legal and Risk and instructing experts, and the Assessors were assured that the Assistant Director of Quality & Safety, the Redress Panel and Executives were retaining oversight of the overall decision making around liability and offers.

4.3.8 The Assessment Team would advise the health board to consider the timing of consideration as to value of concerns and whether it exceeds £25,000 as this should be done at the outset to provide a clear structure for the investigation and the level of response to be sent to the complainant.

4.3.9 The Assessors would also recommend ensuing there is a clear process in place for the management of cases involving commissioned care in line with the Putting Things Right Regulations.

Redress Case Management		
REASONABLE ASSURANCE		The organisation can take **reasonable assurance** that arrangements to secure governance, risk management and internal control in relation to the Putting Things Right areas of assessment are suitably planned and applied effectively. Some matters require management attention in control design or compliance with low to moderate impact on residual risk exposure until resolved.
Whilst the Assessment Team found inconsistencies within the Redress records relating to the period of the review, the revised concerns management approach is being retrospectively applied to older records, which is reassuring. The Assessment Team consider that a re-assessment would likely result in finding of substantial assurance.		

4.4 Claims Case Management

4.4.1 The Assessment Team noted that there were 4 claims opened in the period from 1st January 2022 to 31st March 2022.

4.4.2 There was good evidence of clear claims management processes in place for both Clinical Negligence and Personal Injury Claims however following discussion, the Assessment Team recommended that a Standard Operating Procedure would be beneficial especially for new staff and this was something the Team agreed would be considered.

4.4.3 The Assessment Team were assured that there was a Claims Policy in place and had been reviewed, ratified and approved by the Board and was due to be reviewed later this year.

4.4.4 Training for staff is in place but on an ad hoc basis as and when requested by the services through the organisation.

4.4.5 The Assessment Team were assured that Claims are discussed regularly with the Executive Team and any significant cases or issues are discussed and highlighted to the team.

4.4.6 The Assessment Team were assured to see evidence of close working relationships with the services throughout the organisation. The Assistant Director of Quality & Safety explained that the reporting structure had recently changed and provided assurance that all Services are advised and updated with their claims on a regular basis and at key stages within the process. Weekly meetings with the Services used to be in place but given the nature of claims and the number they deal with it is now done on an ad hoc basis. Six monthly progress reports are provided to the Executive Committee with minutes then submitted to the Board highlighting key issues and any settlement information.

4.4.7 Executives are sited on all claims and are shared with relevant Heads of Nursing when they are confirmed as progressing on the Datix Cymru System and local governance leads are also sited. The Governance Leads review and investigate the claims and make contact with relevant colleagues rather than the claims team making direct contact as they appreciate it can be daunting to be contacted in such circumstances.

4.4.8 There is a clear process in place for the application of Standing Financial Instructions with timely authorisation for admissions and settlement of matters. Timely instructions are provided from senior colleagues as they are already sited on the claims, they are able to provide authority efficiently agreeing proposed ways forward as advised by Legal and Risk. The Assessors noted this as good practice and assists in building close working relationships with the Services.

4.4.9 The Oracle system is used to process payments which can prove a lengthy process with payments taking up to fourteen days to be approved and paid. The Assessors would recommend that the process and system for processing payment requests is reviewed as delayed payments can have significant financial consequences.

4.4.10 The Assessment Team scrutinised the detail of four claims records within the Datix Cymru System and noted there is evidence of good file management. Progress notes is used to update cases and documents are uploaded to the system allowing cases to be reviewed efficiently and current stages of claim reviewed appropriately. This allows the Team to provide accurate reports and information to Executive Teams and Service areas. The Assessors also noted a timely and efficient claims process with confirmed cases being sent to Legal and Risk Services on the same day as receipt of the Letter of Claim on most occasions.

4.4.11 The Assessment Team noted that the Access to Health Records Department deal with disclosure matters on behalf of the Claims Team. The Claims Team are advised of all potential claims and they are opened and tracked on the Datix Cymry System. An internal consent form is used to ensure only relevant documents are released which the Assessment Team believed to be good practice. Information Governance colleagues review the documents and ensure the process is followed accordingly. The Assessment Team would recommend that a Standard Operating Procedure is developed to assist new staff and to document the process appropriately.

Claims Case Management		
SUBSTANTIAL ASSURANCE		The organisation can take **substantial assurance** that arrangements to secure governance, risk management and internal control in relation to the Putting Things Right areas of assessment are suitably planned and applied effectively. Few matters require attention and are compliance or advisory in nature with low impact on residual risk exposure.

4.5 Lessons Learned

4.5.1 The health board explained that a Learning Group has recently been established to discuss themes and trends from complaints, incidents and claims. Cases are also discussed at the Redress Panel where actions from lessons learnt are taken forward by key staff. This was evidence of regular good practice ensuring relevant staff are made aware of claims and action taken as a result of issues raised.

4.5.2 The Claims Team draft the Learning from Events Reports (LFER) and sometimes complete the issues and actions sections for the Services to sign and take accountability for. The Assistant Director of Quality & Safety as well as the Heads of Nursing and the Governance Leads review the LFERs and agree the learning which assured the Assessment Team that learning from concerns is a priority to the health board.

4.5.3 The Assessment Team were advised about the processes being established to ensure learning is considered at an early stage in cases which trigger the new Duty of Candour in Wales.

Lessons Learned		
SUBSTANTIAL ASSURANCE		The organisation can take **substantial assurance** that arrangements to secure governance, risk management and internal control in relation to the Putting Things Right areas of assessment are suitably planned and applied effectively. Few matters require attention and are compliance or advisory in nature with low impact on residual risk exposure.

4.6 Reimbursement Process

4.6.1 The Assessment Team were assured that there is an effective process for monitoring WRP submission deadlines. Cases are tracked on Datix Cymru to ensure deadlines are not missed. Cases have also recently been reviewed and updated with regards to the finance section which has enabled cost schedules to be pulled directly from the system. The WRP section on the Datix Cymru system is fully utilised to ensure effective tracking of cases and deadline dates.

4.6.2 The Assessment Team considered the information available from the WRP records in relation to matters presented for reimbursement. The required checklists were fully completed and there had been no cases rejected or issues with calculations from schedules of loss.

4.6.3 The Assessors were assured that the system was working effectively as no requests for extensions have recently been made by the team and the information submitted was accurate, complete, and up to date.

Reimbursement Process		
SUBSTANTIAL ASSURANCE		The organisation can take **substantial assurance** that arrangements to secure governance, risk management and internal control in relation to the Putting Things Right areas of assessment are suitably planned and applied effectively. Few matters require attention and are compliance or advisory in nature with low impact on residual risk exposure.

5.0 Main Themes

5.1 Good evidence of clear incident management structure now in place, replacing ineffective arrangements previously established.

5.2 Good communication links between corporate services and divisional services, with excellent records of requests and responses and escalation procedures where required.

5.3 Effective communication channels with the Executive Team to maintain awareness and provide escalation where necessary.

5.4 Good Claims management structure in place and this would be further enhanced by the introduced documented SOP to sustain the high quality of information seen.

5.5 Regular and close working relationship with health board Finance teams, which ensures that WRP and Welsh Government periodic returns align to the case records held corporately.

5.6 Areas of Good Practice

The Assessment Team found excellent current practice within the Claims and Redress function of Datix Cymru with the use of the WRP sections utilised fully to ensure submission dates are met and cases tracked efficiently and effectively. This demonstrates particularly positive improvement on the previous system in place for Redress cases.

6.0 Assurance Summary

Management of Concerns (Incidents)	LIMITED ASSURANCE	
Management of Concerns (Complaints & Enquiries)	REASONABLE ASSURANCE	
Redress Case Management	REASONABLE ASSURANCE	
Claims Case Management	SUBSTANTIAL ASSURANCE	
Learning from Events	SUBSTANTIAL ASSURANCE	
WRP Reimbursement Process	SUBSTANTIAL ASSURANCE	

NOTES

The Assessment Team found that there had been considerable changes to practice and processes within the department responsible for the oversight of these functions since the period being reviewed, and that it is considered likely that future re-assessments would result in substantial assurance being attained.

7.0 Recommendations

R1 PTHB should ensure that investigation outcomes for incidents are recorded accurately on Datix Cymru, with a validation / audit process established to ensure this is monitored.

R2 PTHB should introduce a KPI for incident reporting, regularly reviewing and scrutinising cases to ensure that records are closed efficiently and that all investigation outcomes are completed on the system.

R3 PTHB should ensure decisions in terms of consent in respect of concerns are clearly recorded on Datix Cymru.

R4 PTHB should ensure responses include consideration of qualifying liability, where appropriate, and that this is recorded clearly within the system.

R5 PTHB should map out the process for the transition of an incident and a complaint into a redress case and consider introducing an SOP to support practice in these areas.

R6 PTHB should ensure responses to concerns are uploaded to Datix Cymru in a timely manner and are clearly identifiable on the system, with no secondary password applied to documents held.

R7 PTHB should consider the timing of the process for the consideration of the value of a concern (and whether it is likely to exceed £25,000), as this should be done at the outset.

R8 PTHB to ensure there is a clear process in place for the management of cases involving commissioned care in line with PTR.

R9 PTHB should consider development of an SOP for claims management to build on the good process seen and ensure consistency in operational practice and sustained procedures. This would be seen as presenting the good practice currently in place as a model approach for Wales.

R10 PTHB should review its processes for managing financial payments in claims and concerns as any delays could have financial consequences.

8.0 Health Body Action Plan

Powys Teaching Health Board has developed an action which addresses the recommendations made in this report. The action plan was received by the Welsh Risk Pool on 24th July 2023.

ACTION PLAN FOR IMPROVEMENT	
Reference	**WRP Assessment Report Recommendations**
Directorate	**Quality & Safety**
Lead Officer for Action Plan	**Assistant Director Quality & Safety**
Date action plan commenced	**06 July 2023**

Recommendation	**Risk rating**	**Action needed**	**Progress & Evidence**	**Monitoring Arrangements** (State HB group where progress is reported)	**By who**	**Deadline date for completion** (Use traffic light system to indicate status) **& insert date of completion**
1. PTHB should ensure that investigation outcomes for incidents are recorded accurately on Datix Cymru, with a validation / audit process established to ensure this is monitored.		Within the amended Incident Management Framework Policy, the Assistant Director of Quality & Safety and the Head of Quality & Safety, are responsible for closure down incidents categorised as severe or above.	Audits will be completed as suggested by the National Teams	Monthly reporting to the Professional Nursing and Midwifery Assurance Group	Head of Quality and Safety	20/07/2023

Recommendation	Risk rating	Action needed	Progress & Evidence	Monitoring Arrangements (State HB group where progress is reported)	By who	Deadline date for completion (Use traffic light system to indicate status) & insert date of completion
		Anything below severe, is closed by team leads. Those named as an investigator, under Powys Processes are unable to close the incidents down. The Head of Quality & Safety will report monthly to the Professional Nursing and Midwifery Assurance Group the attached audit.				
2. PTHB should introduce a KPI for incident reporting, regularly reviewing and scrutinising cases to ensure that records are closed efficiently and that all investigation outcomes are completed on the system.		Dashboards in place to monitor entries of incidents.	Dashboards in place Reporting within directorate Quality Structures	PEQS & Directorate Quality Meetings	Head of Quality and Safety	20/07/2023

Recommendation	Risk rating	Action needed	Progress & Evidence	Monitoring Arrangements (State HB group where progress is reported)	By who	Deadline date for completion (Use traffic light system to indicate status) & insert date of completion
3. PTHB should ensure decisions in terms of consent in respect of concerns are clearly recorded on Datix Cymru.		Fields within RLDatix regarding consent receipt, or why a written consent is not required. The Datix Administrator will create dashboards for the HoQ&S for monthly assurance reporting	Monthly reports	Monthly reporting to the Professional Nursing and Midwifery Assurance Group	Head of Quality and Safety	Ongoing
4. PTHB should ensure responses include consideration of qualifying liability, where appropriate, and that this is recorded clearly within the system.		Amendments to the standard template response which ensures QI is address. In addition, within RL Datix system, when a response has gone for final sign-off, staff are prompted to complete the mandatory investigation	Mandatory fields and insert reg 24 and reg 26 response template.	Redress Panel	Head of Quality and Safety	20/07/2023

Recommendation	Risk rating	Action needed	Progress & Evidence	Monitoring Arrangements (State HB group where progress is reported)	By who	Deadline date for completion (Use traffic light system to indicate status) & insert date of completion
		outcome tab to complete the lessons learnt.				
5. PTHB should map out the process for the transition of an incident and a complaint into a redress case and consider introducing an SOP to support practice in these areas.		Complete process map	Planning and mapping commenced	When guidance changes	Head of Quality and Safety	30/07/2023
6. PTHB should ensure responses to concerns are uploaded to Datix Cymru in a timely manner and are clearly identifiable on the system, with no secondary password applied to documents held.		All documentation regarding a concern is saved to RLDatix We no longer password protect documents since 2022	This will be audited by WRP in 12 months.	This will be monitored through weekly progress reports to the HoQ&S and the Assistant Director of Quality	Complaints & PSOW Case Coordinator and Head of Quality and Safety	20/07/2023

Recommendation	Risk rating	Action needed	Progress & Evidence	Monitoring Arrangements (State HB group where progress is reported)	By who	Deadline date for completion (Use traffic light system to indicate status) & insert date of completion
7. PTHB should consider the timing of the process for the consideration of the value of a concern (and whether it is likely to exceed £25,000), as this should be done at the outset.		Consideration will be given during the whole concern process regarding value >£25k to ensure early referral to L&R	SOP to support process	In line with guidance changes	Head of Quality and Safety and Redress, Compensation Claims and Inquest Case Co-ordinator	01/04/2022
8. PTHB to ensure there is a clear process in place for the management of cases involving commissioned care in line with PTR.		Clear process in place since April 2022	Commissioning meetings	Annual in line with commissioning contracting	Complaints & PSOW Case Coordinator and Head of Quality and Safety	01/04/2022

Recommendation	Risk rating	Action needed	Progress & Evidence	Monitoring Arrangements (State HB group where progress is reported)	By who	Deadline date for completion (Use traffic light system to indicate status) & insert date of completion
9. PTHB should consider development of an SOP for claims management to build on the good process seen and ensure consistency in operational practice and sustained procedures. This would be seen as presenting the good practice currently in place as a model approach for Wales.		Draft SOP to reflect practice	1st draft of SOP completed	Periodic review of the SOP or as and when national guidance changes.	Head of Quality and Safety and Redress, Compensation Claims and Inquest Case Co-ordinator	14/07/2023
10. PTHB should review its processes for managing financial payments in claims and concerns as any delays could have financial consequences.		A review is underway, pending findings.	Draft SOP to be reviewed and sent for consultation.	Financial monitoring	Head of Quality and Safety and Redress, Compensation Claims and Inquest Case Co-ordinator	30/09/2023

Status of action:

GREEN	Complete
AMBER	In progress
RED	Missed deadline for completion - escalate

Appendix 1

NHS Wales Assurance Framework

The WRP Assessment Programme utilises the NHS Wales Internal Audit Framework for Assurance:

SUBSTANTIAL ASSURANCE		The organisation can take **substantial assurance** that arrangements to secure governance, risk management and internal control in relation to the Putting Things Right areas of assessment are suitably planned and applied effectively. Few matters require attention and are compliance or advisory in nature with low impact on residual risk exposure.
REASONABLE ASSURANCE		The organisation can take **reasonable assurance** that arrangements to secure governance, risk management and internal control in relation to the Putting Things Right areas of assessment are suitably planned 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 organisation can take **limited assurance** that arrangements to secure governance, risk management and internal control in relation to the Putting Things Right areas of assessment are suitably planned and applied effectively. More significant matters require management attention with moderate impact on residual risk exposure until resolved.
NO ASSURANCE		The organisation has **no assurance** that arrangements to secure governance, risk management and internal control in relation to the Putting Things Right areas of assessment are suitably planned and applied effectively. Action is required to address the whole control framework in this area with high impact on residual risk exposure until resolved.

Appendix 2

WRP Concerns Assessment – Areas for Assessment

The WRP Assessment Programme uses a series of Areas for Assessment to guide the Assessment Team in the aspects and criteria to be examined. These cover the areas of activity which directly impact on matters which may cause a request for reimbursement from the WRP.

The Areas for Assessment provide a framework for the Assessment Team to gather information, evidence and collate data to support the identification of findings and the establishment of recommendations.

Assessment Criterion

AREA FOR ASSESSMENT	
A	Management of Concerns (Incidents)
B	Management of Concerns (Complaint and Enquiries)
C	Redress Case Management
D	Claims Case Management
E	Lessons Learned
F	Reimbursement Process

Area for Assessment A: Management of Concerns (Incidents)	
A1-01	Is the timescale between index events and incident reporting reasonable?
A1-02	Did the incident have an initial review, where appropriate?
A1-03	Is the timescale between reporting and initial review, where appropriate, reasonable?
A1-04	Did the incident have a management review completed, where appropriate?
A1-05	Did the incident have a proportionate investigation completed, where appropriate
A1-06	Is the timescale between reporting and investigations reasonable?
A1-07	Have all the essential data fields been completed correctly on Datix Cymru?
A1-08	Was the incident record closed within 30 days? Where this is not possible, is there information to explain the reason for any delays or actions being taken?
A1-09	Was the incident reportable as a Nationally Reportable Incident? Was the timeliness of any notifications reasonable?
A1-10	Was the there a consideration whether the incident met the requirements for a Qualifying Liabilty?

Policy and Procedure	
A2-01	Is there a policy or procedure in place for Incident Management within the Health Body? Is it in date? Is there a review date? How is it reviewed/ratified?
A2-02	Does the policy or procedure cover the requirements as set out in PTR guidance and associated national policy?

Information, Reporting & Governance Arrangements	
A3-01	Are there effective governance arrangements for the management of incidents?
A3-02	Is there a screening process in place for monitoring accuracy of information submitted in incident reports? Is it timely?
A3-03	How are incidents reported within the Health Body and to what meetings or committees are they reported? Are they reported at Board level or Sub-Committee? Are these arrangements proportionate?
A3-04	Is there training in place for staff for reporting incidents?
A3-05	Is there training in place for staff for investigating incidents?

Area for Assessment B: Management of Concerns (Complaint and Enquiries)	
B1-01	Is the complaint record complete? Is all correspondence, advice and supporting information available for review?
B1-02	Does the complaint investigation consider all relevant points raised in the complaint received?
B1-03	Does the complaint response comply with the content requirement as set out within the guidance?
B1-04	Did the concern conclude with the final response? If not why? How was the concern resolved if not with the final response?
B1-05	Are the essential data fields in Datix Cymru completed accurately and up to date?
B1-06	Has a response been prepared for every concern notified and investigated?
B1-07	Has a report been provided to the person notifying the concern within 30 days
B1-08	Where it has not been possible to provide the report within 30 days, has the person notifying the concern been advised within 30 working days, and an explanation provided, and proposed timescale agreed?
B1-09	Where a complaint is dealt with 'on the spot' / via early resolution, is this recorded appropriately? Is the timescale for early resolution matters recorded accurately and is it appropriate?
B1-10	How many concerns were answered within the 30 day period?

Area for Assessment B:	
Policy and Procedure	
B2-01	Is there a policy or procedure in place for Complaint Management within the Health Board? Is it in date? Is there a review date? How is it reviewed/ratified?

Information, Reporting & Governance Arrangements	
B3-01	What are the governance arrangements for the management of complaints and enquiries?
B3-02	How are complaints reported and monitored within the Health Body and to what meetings/Committees are they reported? Are they reported at Board level or Sub-Committee?
B3-03	Is there a training package in place for staff for complaints handling?

Area for Assessment C: Redress Case Management	
C1-01	Is there an appropriate process for determining when a matter should be handled by Redress specialists? Is there a clear process for transition from incident teams and complaints teams?
C1-02	Is the redress record complete? Is all correspondence, advice and supporting information available for review?
C1-03	Has an interim report (Reg 26 letter) for the concern reviewed and investigated been prepared where the Health Body considers there may be a Qualifying Liabillity?
C1-04	Has the interim report been provided to the person notifying the concern within 30 days?
C1-05	Does the response letter comply with the content requirement set out in the Regulations & associated Guidance? E.g., explaining QL, advice re Solicitors, addresses all concerns raised etc
C1-06	Has a Reg 24 response been prepared for the concern reviewed which has been investigated and in respect of which the Responsible Body considers there is no QL in tort?
C1-07	Has a Reg 24 been prepared for the concern which has been investigated and in respect of which the Health Board considers the claim to be over £25,000 in value?
C1-08	Has a Reg 24 letter been provided to the person notifying the concern within 30 days?
C1-09	Where it has not been possible to provide the Reg 24 letter within 30 days, has the person notifying the concern been advised within 30 working days, with an explanation provided and proposed timescale agreed?

C1-10	Does the Reg 24 letter comply with the requirements as set out in the guidance? Eg no reference to BOD and QL if considered over £25,000 and advice re Solicitors etc?
C1-11	In circumstances where a Reg 26 interim response was provided, have independent experts been instructed? Has this been done in line with the requirements in the Regulations (ie jointly) and appropriately?
C1-12	Has a Regulation 33 report been sent for every concern reviewed and investigated in respect of which the Responsible Body has not sent a Regulation 24 response?
C1-13	Has the Regulation 33 report been provided within a maximum of 12 months of the concern being notified to it?
C1-14	Does the Regulation 33 Response comply with the requirements of the Guidance? Eg clearly sets out the basis for the final decision as to QL and the offer made.
C1-15	Where financial compensation has been paid, has an appropriate contract been entered into between the recipient of the financial compensation and the Organisation?
C1-16	Has Legal and Risk Advice been requested? Was this request proportionate?
C1-17	Who authorised QL and on what basis? Was this appropriate?
C1-18	Have all essential data fields been completed correctly within the case management record?
C1-19	How many LFER's submitted in relevant period?
C1-20	How many requests for reimbursement submitted to WRP?
C1-21	What is the performance for WRP submission deadlines?
C1-22	How may extensions were requested for submission to WRP?
C1-23	How many cases were approved at the first Learning Advisory Panel?

Policy and Procedure	
C2-01	Is there a policy or procedure in place for Redress Case Management within the Health Body? Is it in date? Is there a review date? How is it reviewed/ratified?
C2-02	Is there a clear process for the application of Standing Financial Instructions and authorisation of admissions & settlement of matters?

C2-03	Is there a process in place to review admission/denial decisions?

Area for Assessment C: Redress Case Management	
Information, Reporting & Governance Arrangements	
C3-01	What are the governance arrangements for the management of redress cases?
C3-02	How are they reported within the Health Board and to what meetings/Committees are they reported? Are they reported at Board level or Sub-Committee?
C3-03	Is there a training package in place for staff?
C3-04	There is a system for learning lessons from events including concerns (incidents, complaints, claims under redress) compensation claims, claims reviews etc which are used to improve services

Area for Assessment D:	
Claims Case Management	
D1-01	Is there an effective process for receiving and processing requests for disclosure of medical records in matters where a claim is being considered against the health body?
D1-02	Where disclosure of records is requested, is there a process to ensure appropriate release of information is managed and redaction of relevant information undertaken as required?
D1-03	Is there an effective process for the oversight of disclosure of information in matters where a claim is being considered against the health body?
D1-04	Is there a clear process for referral of relevant matters to Legal & Risk? Is the referral to Legal & Risk being utilised? Is the timescale for referral of claims to Legal & Risk appropriate?
D1-05	Is there a clear process for receipt of advice in a matter and analysis of requests for instructions? Are the timescales for receiving advice and providing instructions appropriate and proportionate?

Area for Assessment D:	
Policy and Procedure	
D2-01	Is there a policy or procedure in place for Claims Case Management within the Health Board? Is it in date? Is there a review date? How is it reviewed/ratified?
D2-02	Is there a clear process for the application of Standing Financial Instructions and authorisation of admissions & settlement of matters?

Area for Assessment D:	
Information, Reporting & Governance Arrangements	
D3-01	What are the governance arrangements for the management of claims cases?
D3-02	How are they reported within the Health Board and to what meetings/Committees are they reported?
D3-03	Are they reported at Board level or Sub-Committee?
D3-04	Is there a training package in place for staff responsible for managing claims?

Area for Assessment E:	
Lessons Learned	
E1-01	Does the Health Body have in place a defined and formalised process or procedure through which it sets out its objectives and demonstrates practically how it learns lessons from events?
E1-02	Is there a clear process relating to the approval of Learning from Events Reports prior to submission to WRP
E1-03	Is there an assurance process relating to lessons learned from the Operational level to Board level? E.g. Flowchart, Terms of Reference for meetings, Reports?
E1-04	What proportion of LFER reports were submitted in accordance with the WRP Reimbursement Procedures? E.g. timeless, completeness, extension requirements?
E1-05	What proportion of LFER reports were approved by the Learning Advisory Panel?

Area for Assessment F:	
Reimbursement Process	
F1-01	Does the Health Body have in place a defined and formalised process or procedure through which it sets out its objectives and provides assurance for the accounting of losses & special payments which are subject to WRP Reimbursement?
F1-02	Does the Health Body have a process for tracking and ensuring submission to WRP for reimbursement? E.g. timeliness?
F1-03	Does the Health Body have a process for identifying and submitting post-closure reimbursement requests in a timely manner?

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Date: 17 August 2023

Carl Cooper
Powys Teaching Health Board
By Email only: carl.cooper@wales.nhs.uk

Annual Letter 2022/23

Dear Carl

I am pleased to provide you with the Annual letter (2022/23) for Powys Teaching Health Board which deals with complaints relating to maladministration and service failure, and the actions being taken to improve public services.

This letter coincides with my Annual Report – "A year of change – a year of challenge" – a sentiment which will no doubt resonate with public bodies across Wales. My office has seen another increase in the number of people asking for our help – up 3% overall compared to the previous year, and my office now receives double the number of cases we received a decade ago.

Last year, I met with public bodies across Wales last year – speaking about our casework, our recommendations, and our proactive powers. The current climate will continue to provide challenges for public services, but I am grateful for positive and productive way which Health Boards communicate with my office.

926 complaints were referred to us regarding Health Boards last year – an increase of 21% compared to the previous year. During this period, we intervened in (upheld, settled or resolved at an early stage) 30% of Health Board complaints - a similar proportion to previous years.

Supporting improvement of public services

Our *Groundhog Day 2: An opportunity for cultural change in complaint handling?* report issued in June, highlighted the complaint handling failings we identified in cases involving health boards across Wales during the preceding 12 months.

Our recommendations to the Health Board were aimed at ensuring that, as the new Duties of Candour & Quality are introduced within your organisation, that the opportunity for a cultural change is taken - to promote openness and candour with service users and ensure there is systemic learning when things have gone wrong.

I trust that, in line with our recommendations to the Health Board, the report has or will soon be considered by your Quality & Patient Safety Committee and it will:

- review the resources available to your complaints team
- review arrangements for accurately compiling complaints data
- consider whether the option to provide staff investigating complaints with independent medical advice, is considered on a case by case basis
- reflect upon the lessons highlighted in this report when scrutinising their performance on complaint handling
- ensure that lessons learned from the PSOW's findings and recommendations are included in their Health Board's annual report on the Duty of Candour and Quality.

Despite the challenges of last year, we have pushed forward with our proactive improvement work and launched a new Service Quality process to ensure we deliver the standards we expect.

Last year, we also began work on our second wider Own Initiative investigation – this time looking into carers assessments within Local Authorities. This investigation will take place throughout the coming year, and we look forward to sharing our findings.

The Complaints Standards Authority (CSA) continued its work with public bodies in Wales last year, with more than 50 public bodies now operating our model policy. We've also now provided more than 400 training sessions since we started in September 2020.

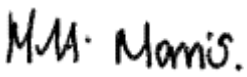
We continued our work to publish complaints statistics into a second year, with data now published twice a year and we included information about Health Boards for the first time in 22/23. This data allows us to see information with greater context – for example, last year 16% of Powys Teaching Health Board's complaints were referred to PSOW – the highest proportion of any Health Board.

I would encourage Powys Teaching Health Board, to use this data to better understand your performance on complaints.

Further to this letter can I ask that Powys Teaching Health Board takes the following actions:

- Present my Annual Letter to the Board at the next available opportunity and notify me of when these meetings will take place.
- Update my office on how the Health Board has complied with the recommendations in our report: *Groundhog Day 2: an opportunity for cultural change?* by **1 December 2023**.
- Continue to engage with our Complaints Standards work, accessing training for your staff, fully implementing the model policy, and providing complaints data.
- Inform me of the outcome of the Council's considerations and proposed actions on the above matters at your earliest opportunity.

Yours sincerely,



Michelle Morris
Public Services Ombudsman

cc. Hayley Thomas, Chief Executive, Powys Teaching Health Board.
By Email only: Hayley.Thomas@wales.nhs.uk

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Factsheet

Appendix A - Complaints Received

Health Board	Complaints Received	Received per 1000 residents
Aneurin Bevan University Health Board	166	0.28
Betsi Cadwaladr University Health Board	225	0.33
Cardiff and Vale University Health Board	137	0.28
Cwm Taf Morgannwg University Health Board	134	0.30
Hywel Dda University Health Board	104	0.27
Powys Teaching Health Board	23	0.17
Swansea Bay University Health Board	137	0.36
Total	926	0.30

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Appendix B - Received by Subject

Powys Teaching Health Board	Complaints Received	% share
Ambulance Services	0	0%
Appointments/admissions/discharge and transfer procedures	0	0%
Clinical treatment in hospital	10	43%
Clinical treatment outside hospital*	4	17%
Complaints Handling	4	17%
Confidentiality	0	0%
Continuing care	0	0%
COVID19	0	0%
De-registration	0	0%
Disclosure of personal information / data loss	0	0%
Funding	0	0%
Medical records/standards of record-keeping	0	0%
Medication> Prescription dispensing	0	0%
Mental Health	3	13%
NHS Independent Provider	0	0%
Non-medical services	0	0%
Nosocomial COVID	0	0%
Other	0	0%
Out Of Hours	0	0%
Parking (including enforcement and bailiffs)	0	0%
Patient list issues	0	0%
Poor/No communication or failure to provide information	0	0%
Prisoner Care	0	0%
Referral to Treatment Time	1	4%
Rudeness/inconsiderate behaviour/staff attitude	0	0%
Total	**23**	

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Appendix C - Complaint Outcomes
(* denotes intervention)

Powys Teaching Health Board		% Share
Out of Jurisdiction	5	22%
Premature	1	4%
Other cases closed after initial consideration	12	52%
Early Resolution/ voluntary settlement*	5	22%
Discontinued	0	0%
Other Reports - Not Upheld	0	0%
Other Reports Upheld*	0	0%
Public Interest Reports*	0	0%
Special Interest Reports*	0	0%
Total	**23**	

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Appendix D - Cases with PSOW Intervention

	No. of Interventions	No. of Closures	% Of Interventions
Aneurin Bevan University Health Board	48	160	30%
Betsi Cadwaladr University Health Board	80	231	35%
Cardiff and Vale University Health Board	30	129	23%
Cwm Taf Morgannwg University Health Board	37	141	26%
Hywel Dda University Health Board	41	100	41%
Powys Teaching Health Board	5	23	22%
Swansea Bay University Health Board	33	134	25%
Total	**274**	**918**	30%

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Information Sheet

Appendix A shows the number of complaints received by PSOW for all Health Boards in 2022/23. These complaints are contextualised by the number of people each health board reportedly serves.

Appendix B shows the categorisation of each complaint received, and what proportion of received complaints represents for the Health Board.

Appendix C shows outcomes of the complaints which PSOW closed for the Health Board in 2022/23. This table shows both the volume, and the proportion that each outcome represents for the Health Board.

Appendix D shows Intervention Rates for all Heath Boards in 2022/23. An intervention is categorised by either an upheld complaint (either public interest or non-public interest), an early resolution, or a voluntary settlement.

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Code of Practice Standard No	Code of Practice Header	Link to Duty of Quality	Recommendation No	Recommendation	Action Required	Current Position (Where applicable)	Target Date	Revised Target Date	Target Achieved Date	Action Lead (Initials)	RABG Rating	Desired Outcomes	Evidence
Standard 1	Appropriate organisational structures and management systems for IPC must be in place	Quality Assurance & Quality Planning	1	A Board level statement outlining its collective responsibility for minimising the risks of infection and the general means by which it prevents and controls such risks	A Board level statement outlining its collective responsibility for minimising the risks of infection and the general means by which it prevents and controls such risks	Absence of a Board level statement	31.10.2023			CR		A Board level statement outlining its collective responsibility for minimising the risk of infection and the general means by which it prevents and controls such risks	Statement to be presented and approved at PEQS Committee in October 2023
			1.1	The mechanisms by which the Board intends to ensure that adequate resources are available to secure the effective IPC of HCAIs.	A skilled IP&C structure	A junior IP&C operational team	1. 15.06.2023 2. Ongoing 3. 01.10.2023			GT/ZA/DWL/MM		1. Recruitment of IP&C specialist at pace to support with skills and expertise on IP&C improvement plan 2. Upskill IP&C team, to include exploring the opportunity of shadowing days within an acute trust, which will build on experience. 3. Upskill of team utilising IPS portfolio competency framework	1. 01.06.2023 - WOD support, vacancy advertised and fast tracked through bank. LW started with team on 15.08.2023 2. AS to spend time with ABHB from 08.08.2023 for 3/7 for decontamination
						0.6 WTE Band 6 IP&C Nurse contract due to end in Jul 2023	08.06.2023			GT		Extension of FTC from Jul 2023 to March 2024	WOD support on 31.05.2023. Contract extension requested 08.06.2023
						PTHB does not currently have a dedicated antimicrobial pharmacist	01.01.2024			JS		Appropriate resource to drive forward the AMR agenda and reduce inappropriate prescribing and improve antimicrobial stewardship	GT to work with JS to input into business case for AMR Pharmacist; as PIRs are identifying anitbiotic prescribing as a signficant issue, which is contributing to HCAI's
						PTHB does not currently receive any epidemiology support from PHW	01.10.2023			GT		Epidemiology support via PHW to look back at previous outbreaks, including COVID-19, to see if any lessons can be learnt for future planning	
						No process for standardising how microbiology results are dealt with by the IP&C team in PTHB	12.06.2023		11.07.2023	GT		A consistent approach to the actioning of results via ICNET and other sources across the PTHB IP&C team	Development and implementation of a SOP for the results process to be implemented from 11.07.2023
						0.6 WTE Band 6 IP&C Nurse who is due to go on Maternity leave in September & unable to undertake clinical visits	01.09.2023		04/08/2023	GT		Internal advertisement of band 5/6 IPC post to ensure continued compliment of staff	Advert paused whilst IP&C improvement plan is ongoing
			1.2	Clear governance framework and reporting mechanisms, to provide assurance, including regular reporting into various committees	A review of the current assurance framework and reporting structures	A quarterly IP&C group, a separate decontamination group with ad-hoc/limited reporting into the PEQS committee	12.07.2023		12.07.2023	GT/ZA/CR		A combined IP&C & Decontamination Committee, with AMR reporting. Following this regular reporting into the PEQS committee to provide assurance on IP&C, Decontamination & AMR (where appropriate)	Reformatted meeting scheduled to be held on 12.07.2023
					An electronic system for IP&C audits, which provides assurance of IP&C measures, including hand hygiene	Currently paper IP&C audits are conducted with limited reporting or escalation of failures	12.06.2023			GT/CA		Development of an electronic application, which will provide audit data at a glance	Digital system created with PTHB analytics colleagues and ready for trial from 12.06.2023 26.06.2023 - following PNMOG to be trialled on one ward (AP, Ystrad)
					An appropriate governance framework	Currently there is no annual programme of work for the IP&C team	13.06.2023		13.06.2023	GT/AS		A robust rolling annual IPC programme of work and IPC strategy implemented across PTHB, which is also linked to the Health & Care strategy & IMTP for PTHB. This will enable ward to board and board to ward assurance.	An annual rolling audit programme created, developed and implemented (which is linked to the IPS audit framework) from 13.06.2023
			1.3	Staff, volunteers, contractors, and other persons whose normal duties are directly or indirectly concerned with service user care receive suitable and sufficient training, information and supervision on	A campaign across PTHB to promote IP&C standards, policies and procedures "Clean, Safe, Care"	IP&C standards, policies, procedures and protocols across the HB are not in place that make clear the expectations on staff across PTHB	01.10.2023			IP&C Team		A "Clean, Safe, Care" campaign, with an event North & South to reiterate and refresh standards, policies, procedures and protocols required to ensure robust IP&C standards across PTHB	
					Improve offering of IP&C training sessions across PTHB	Currently no training/teaching sessions are offered on IP&C unless requested	01.10.2023			IP&C		Regular IP&C training/teaching sessions available for all staff groups across PTHB outside of ESR mandatory and statutory requirements	

Code of Practice Standard No	Code of Practice Header	Link to Duty of Quality	Recommendation No	Recommendation	Action Required	Current Position (Where applicable)	Target Date	Revised Target Date	Target Achieved Date	Action Lead (Initials)	RABG Rating	Desired Outcomes	Evidence
				training, information and supervision on the measures required for IPC	Increase organisational compliance with IPC mandatory training	All staff are required to undertake mandatory Level 1 IPC training (& level 2 for clinical staff) via ESR. Organisational compliance with IPC training is currently 83%, with the lowest group at 60% (Medical & Dental)	31.12.2023			All		Increase compliance on IP&C mandatory and statutory training across PTHB	
			1.4	Responsibility for IPC including antimicrobial stewardship is effectively devolved to all professional groups in an NHS Wales organisation and clinical specialities, clinical and non-clinical directorates, and all similar groups	Improvement of IP&C audits at a ward/departmental level	Limited IP&C audits being carried out with variable reporting	01.09.2023			Ward Managers/CSM/HoN		Regular reporting and monitoring of standards via an electronic system that shows immediately departmental audit performance with key IPC indicators/measures. This will ensure consistency of standards across PTHB	
					Improvement in hand hygiene audits at ward/departmental level	Variable & ad-hoc reporting via the H&CS system	30.06.2023			Ward Managers/CSM/HoN			
					Consistent cleaning schedules across PTHB	Differing cleaning schedules utilised across different wards/departments, therefore not providing consistency	01.09.2023			Ward Managers/CSM/HoN			
Standard 2	The physical environment should be maintained and cleaned to a standard that facilitates IPC and minimises the risk of infection	Quality Control	2	There are policies for the environment that make provision for liaison between the members of the IPCT and the persons with overall responsibility for estates and facilities management	Development/implementation of a policy on pest control	Currently there is no pest control policy within PTHB	01.10.2023			Support Services/JM		The development and implementation of a policy for pest control across PTHB	07.08.2023 - AD for Support Services confirmed they will undertake work on a pest control policy ASAP
					An updated policy on the management of laundry for used and infected linen	The current policy is out of date and requires updating	18.07.2023		18.07.2023	AQ		An up to date policy on the management of laundry for used and infected linen linked to current evidence base	18.07.2023 - an updated policy completed
			2.1	All parts of the premises in which it provides healthcare are suitable for the purpose, kept clean and maintained in good physical repair and condition	A priority list of key areas that require upgrading/works as part of W&Ecapital programme of work	Due to the age of estates some clinical environments require significant improvements/upgrades. Currently some ward areas present an infection control risk due to suboptimal flooring, for example	31.08.2023		31.08.2023	W&E & IPC		1. A priority list of key areas for upgrade/improvement works 2. An annual update programme of works	Joint visits planned: 01.08.2023 – Llandridnod Wells Hospital 04.08.2023 – Ystradgynlais Community Hospital 15.08.2023 – Montgomeryshire County Infirmary & Llanidloes 16.08.2023 – Bronllys Hospital 17.08.2023 – Brecon War Memorial Hospital
			2.2	There are effective arrangements for the appropriate decontamination of instruments and other equipment	Organisational decontamination policy, which outlines roles, responsibilities, and details of decontamination requirements against current Health Technical Memorandum (WHTM 01-01)	Organisational decontamination policy is currently 9 years out of date . This policy also makes reference to other policies that do not exist	31.08.2023			IP&C		A decontamination policy that is up to date and relevant to current WHTM 01-01 standards, thereby ensuring appropriate decontamination arrangements and standards for staff across PTHB	
			2.3	Uniform and dress code policies ensure that clothing worn by staff when carrying out their duties is clean and fit for purpose	All staff are aware of and adhere to the 'All Wales NHS Dress Code' including requirements of BBE	PTHB, as other Health Boards & Trusts in Wales follow the 'All Wales NHS Dress Code'. However, there is currently an increase in staff non-compliant with BBE in clinical areas, which does not allow for effective hand decontamination.	30.09.2023			All		At a national level the current All-Wales NHS dress code is undergoing a review with an updated version expected in 2023. The updated national policy will assist in outlining the expectations to staff to achieve compliance with the policy across PTHB.	09.08.2023 - following All Wales lead IPC meeting; it was discussed that the updated policy will be published in September
			2.4	The supply and provision of linen and laundry reflect Health Service Guidance (HSG) (95)18 Hospital Laundry Arrangements for Used and Infected Linen	Linked to action 2	Linked to action 2	18.07.2023		18.07.2023	AQ		All staff are compliant and understand their obligations under the HSG (95) 18 guidance, via a PTHB safe management of linen policy.	18.07.2023 - an updated policy completed
			2.5		Functional macerators and availbility of timely repairs with an appropriate service level agreement, if appropriate		31.10.2023			W&E		Macerators within PTHB are in good working order and timely access to repairs/maintenance is available	Escalated via EDoN on 18.07.2023
					Accurate recording of HCAIs via the DATIX system, and accurate recording of HCAIs to the public via PHW dashboards. Accurate recording of outbreaks and associated outbreak control meetings.	Limited incident recording of HCAIs on the DATIX system.	01.10.2023			All		All HCAI incidents are reported and recorded via the DATIX system A dedicated IP&C page on PTHB website, where IP&C information is publicly available	

Code of Practice Standard No	Code of Practice Header	Link to Duty of Quality	Recommendation No	Recommendation	Action Required	Current Position (Where applicable)	Target Date	Revised Target Date	Target Achieved Date	Action Lead (Initials)	RABG Rating	Desired Outcomes	Evidence
Standard 3	Suitable and accurate information on infections must be made available to service users, their visitors, and the public.	Quality Assurance	3	Explanations of incident/outbreak management; and publication of accurate, useful, and relevant information and data relating to HCAIs in an open and transparent manner.			[illegible]			All			
					Retrospective review of HCAI cases, including c.diff cases to ensure appropriate organisational learning	There are a number of c.diff cases back to 2021 which have not had a PIR/RCA (21 cases)	01.09.2023	01.10.2023		IPC/Pharmacy		Review of c.difficle cases to ensure lessons learnt, including areas of good practice	07.06.2023 - Notes requested for 21 cases to start case reviews. 07.07.2023 - Antimicrobial prescribing reviewed by pharmacy colleagues 21.08.2023 - revised target date due to Wye Valley results; which will need
					Retrospective reporting & updating of HCAI's via the DATIX system	Limited incident recording of HCAIs on the DATIX system. Limited outbreak control meetings and publication of HCAIs via an annual report and the public facing PEQ&S committee	01.09.2023	01.10.2023		IP&C		All HCAI incidents are reported and managed via the DATIX system which will enable trend and analysis of HCAI's and organisational learning	IP&C team to commence retrospective reporting following completion of casereviews as identifed in above action 21.08.2023 - revised target date due to Wye Valley results; which will need including in look back exercise
			3.1	The roles and responsibilities of individuals such as carers, relatives, and advocates in IPC, to support them when visiting service users	Information available to relatives and the public on HCAI information at the point of entry	Limited information on infection control, including responsibilities of visitors and their requirements to keep service users safe across PTHB	01.12.2023			Ward/Department Managers/HoN/IP &C		Up to date IP&C information at the point of entry for visitors, including appropriate signage and leaflets	11.08.2023 - information provided on IP&C inputs for a "How we are doing" notice board that will be displayed at ward entrances
			3.2	General principles on IPC and key aspects of the organisation's policy on IPC, which considers the communication needs of the service user	Availability of policies, which consider the needs of the service user i.e., different formats available including Welsh language	Currently policies are only available in a standard format, and not available in Welsh, for example	Ongoing					Policies to consider the communication needs of patients	PTHB organisational wide issue
			3.3	Reporting failures of hygiene and cleanliness	Self-assessments to be monitored by the IP&C team	Cleanliness audits are currently self-assessed by facilities	01.12.2023			IP&C		A process whereby validation audits are conducted by IP&C and the reporting/recording of failures in hygiene and cleanliness	
			3.4	Explanations of incident/outbreak management; and publication of accurate, useful, and relevant information and data relating to HCAIs in an open and transparent manner.	Ensure reporting of positive samples processed in Wye Valley laboratories are included in local reporting (c.diff)	Currently these are not reported as they do not meet the PHW surveillance definition due to different testing criteria (not double testing)	01.04.2023		01.04.2023	GT		Local reporting of c.difficile infections from Wye Valley, despite not meeting the PHW definition, as patients are being treated and managed in-line with c.diff pathway	Argreement to include figures within PTHB internal reporting numbers if patient is actively treated for c.difficile, following discussion with IP Doctor & AD. SBUBH currently do this due to testing platforms
Standard 4	Suitable, timely and accurate information on infections must be provided to any person concerned with providing further support or nursing/medical care when a service user is moved from one organisation to another or within the same organisation.	Quality Assurance	4	Accurate information is communicated in an appropriate and confidential manner	IP&C to inform daily ward information that is distributed to ensure accurate and up-to-date information on IP&C across the organisation	Currently daily ward information that is sent out is not informed by IP&C	30.06.2023		27.06.2023	IP&C/Operations		Accurate and up-to-date information on infections across PTHB to enable the safe flow of patients	22.06.2023 - IP&C to input into IP&C questions on referral form and to attend daily 14:30 patient transfer/flow meeting. 27.06.2023 - IP&C attended first flow meeting and have regular invites. Referral form updated with pertinent IP&C questions
					A robust reporting process from Shrewsbury and Telford laboratories, where samples have been sent from a PTHB site (including primary care)	Paper copies of results being posted with ad-hoc email alerts (due to a failure in the system). Only setup to be alerted of c.difficile and MRSA bacteraemia, no other Infections or Tier 1 targets	Ongoing		14.04.2024	GT/ZA/CM		A robust reporting process into the IP&C team to ensure the robust and effective management of infections	Meeting with SaTH colleagues on 14.04.2023, which has resulted in an email process being established. GT will continue to monitor and quality assure with SaTH colleagues. A look back exercise has taken place back to 2021 29.06.2023 - continue to monitor twice daily emails and QA with SaTH
					A robust reporting process from Wye Valley laboratories	Currently not all results are displaying on ICNET	01.07.2023			IP&C team		A robust reporting process into the IP&C team and ensuring that all organisms are available to view via ICNET	07.06.2023 - Communication with PHW & Baxter regarding results process 08.06.2023 - Confirmation from PHW that all results should display on ICNET - confirmed with Baxter & this is now taking place following system upgrade 08.08.2023 - Following a meeting with Wye Valley IPC colleagues; it was identified that results are not appearing as they should via ICNET - this has been escalated with the Pathology IT team at Wye Valley and

Code of Practice Standard No	Code of Practice Header	Link to Duty of Quality	Recommendation No	Recommendation	Action Required	Current Position (Where applicable)	Target Date	Revised Target Date	Target Achieved Date	Action Lead (Initials)	RABG Rating	Desired Outcomes	Evidence
					A robust process whereby ward staff are informing IP&C of any suspected infectious patient in order that the appropriate advice canbe given, or where testing for COVID i.e. via LFT has taken place and returned a positive result	The IP&C team are not always sighted in a timely manner to prevent onward transmission and support with advice and management of patients	01.10.2023			IP&C, Ward/Department Managers/HoN		A robust ward to IP&C reporting mechanism when infections/period of increase incidence are suspected	
Standard 5	All staff employed to provide care in all settings are fully engaged in the process of IPC.	Quality Control	5	IPC, as it relates to their role, is included in the job descriptions, and included in the induction programme and staff updates of all employees (including volunteers)	Delivery of IP&C expectations and standards at corporate induction	All staff are required to undertake mandatory Level 1 IPC training (& level 2 for clinical staff) via ESR. Outside of this, training is not delivered by the IPAC team unless requested.	01.01.2024			IP&C, WOD		IP&C training to form part of corporate induction, which will re-enforce the message that IPC is everyone's business	
			5.1	Where staff undertake procedures, which require skills such as, for example, aseptic technique, staff are trained and demonstrate competency before being allowed to undertake these procedures independently; and Staff are aware of their responsibilities with regards to vaccine preventable diseases and how they can protect themselves and service users.	Improve the number of staff across the organisation who have: 1. been assessed as an ANTT assessor 2. undertaken training in ANTT prior to undertaking clinical procedures	Currently the team are progressing toward ANTT Bronze accreditation across some service/areas departments	31.03.2024			IP&C/Ward Managers/Department Managers		Increase in compliance with ANTT training and increase in the number of clinical ANTT assessors, to include at a minimum Ward/Department Managers	
					An up to date ANTT policy to support the skills element	The current policy is out of date	04.08.2023		03.08.2023	GW		Align to current All Wales policy, which has recently been updated in 2023	03.08.2023 - policy updated and live for colleagues across PTHB
Standard 6	Adequate isolation facilities are provided to support effective IPC.	Quality Control	6	An NHS Wales body should ensure that it is able to provide, or secure the provision of, adequate isolation precautions and facilities, as appropriate, sufficient to prevent or minimise the spread of infection	Appropriate isolation facilities to minimise the risk the spread and onward transmission of infection	Whilst some in-patient areas have appropriate isolation facilities there is limited isolation facilities in other ward areas (***although this is not unique to PTHB***). Whilst access to single rooms is limited, should patients need cohorting, current facilities make this difficult, as some ward areas have solid wood doors, with no viewing windows, which means that doors are required to be left open for patient safety reasons	Ongoing			IP&C/W&E		The provision of appropriate isolation facilities as part of capital planning/programme of works, as ward areas are upgraded/updated.	Will pick up as part of visits planned with W&E (although recognising limitiations)
Standard 7	Policies on IPC must be in place and made readily accessible to all staff.	Quality Improvement & Quality Control	7	An NHS Wales body must, in relation to preventing and controlling the risks of HCAIs, have in place the appropriate core policies	A policy on standard infection control precautions	Currently there is no policy in place	04.08.2023		04.08.2023	AS		Minimum policy set as outlined in the Code, which are up-to-date and in-line with current evidence, including regular reviews, as new evidence emerges.	04.08.2023 - Standard infection control policy completed distributed for comments (to be approved at next IPC group in October) 21.08.2023 -D&V policy completed and distrbiuted for comments (to be approved at next IPC group in October) 22.08.2023 - c.difficile policy completed and distributed for comments (to be approved at the next IPC group in October)
					An up to date policy of the management of clostriodies difficile	Current policy was due for review in 2020	30.08.2023		22.08.2023	GT			
					A policy on Multi-Drug Resistant Organisms (MDRO)	Currently there is no policy in place	N/A			IP&C	Management of Clinically Significant Anti-Microbial Resistant Organisms policy is currently in draft and due to replace MDRO policy (await publication)		
					A policy on spongiform encephalopathies	Currently there is no policy in place	01.09.2023	01.10.2023		AS/GT			
					An updated policy on the management of Diarrhoea and/or Vomiting Outbreaks	Current policy references another Health Board/Trust	21.08.2023		21.08.2023	GT			

Code of Practice Standard No	Code of Practice Header	Link to Duty of Quality	Recommendation No	Recommendation	Action Required	Current Position (Where applicable)	Target Date	Revised Target Date	Target Achieved Date	Action Lead (Initials)	RABG Rating	Desired Outcomes	Evidence
					An outbreak and incident management including closure of wards, departments, and premises to new admissions (including presumed or confirmed viral gastroenteritis)	Currently there is no policy on place	01.09.2023			GT			
Standard 8	So far as is reasonably practicable, staff are free of and is protected from exposure to infections that can be acquired or transmitted at work.	Quality Planning & Control	8	Occupational health policies on the prevention and management of communicable infections in staff are in place	Policies on the prevention and management of communicable infections in staff	Currently there is no policy available to staff for communicable infections	01.09.2023	30.09.2023		EB		An up to date and available policy, which is accessible to staff across PTHB	04.09.2023 - EB chase with HH in OH
Standard 9	All staff are suitably trained and educated in IPC associated with the provision of healthcare.	Quality Control and Quality Improvement	9	The principles and practice of IPC are included in induction and training programmes for all new staff	IPC training is available and delivered at induction, including corporate induction for all new staff members within PTHB	Currently staff are required to undertake mandatory level 1 (& 2 training for clinical staff) via ESR. Outside of this no other IP&C training is provided, unless requested	01.04.2024			IP&C Team		The principles and practice of IPC to be included as part of corporate induction, when a new member of staff starts, highlighting that IPC is everyone's business within PTHB.	
			9.1	There is appropriate ongoing education for existing staff (including support staff, volunteers, agency/locum staff and staff employed by contractors), which should			01.04.2024			GT		A detailed IP&C education strategy, which goes beyond the requirements of solely undertaking training via ESR.	
			9.2	There is a record of training and updates for all staff; and the responsibilities of each member of staff for IPC are reflected in their job description and in any personal development plan or appraisal	Requirements of IP&C to be discussed at PADR	IP&C (and mandatory and statutory training) does not currently feature as part of PADR requirement	01.04.2024			WOD		The importance of compliance with IP&C mandatory and statutory training to be discussed within PADRs	

Name	Role

RABG	Progress/indicator RAG status
R	Work is significantly behind schedule and no progress has been made, and/or Progress has been made but the timescale has not been achieved.
A	Progress is being made, progress is good and the action is likely to be achieved within timescale. Or the action has been completed but evidence is required to demonstrate achievement.
B	Progress being made and is on track and will be completed on timescale
G	The action has been completed and there is a record of evidence to support its completion.

WHSSC Joint Committee
18 July 2023
Agenda Item: 4.9.5

Reporting Committee	**Quality Patient Safety Committee (QPSC)**
Chaired by	**Ceri Phillips**
Lead Executive Director	**Director of Nursing & Quality**
Date of Meeting	**14 June 2023**

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

1.0 IMMUNOLOGY PATIENT STORY

Members received an informative patient story on the benefits of self-administering subcutaneous immunoglobulin infusions at home. The patient story highlighted the positive impact that the Immunology Services had made to the patient's quality of life.

2.0 WELSH KIDNEY NETWORK (WKN)

Members received a report outlining the current Quality Patient Safety (QPS) issues within the services that are commissioned by the Welsh Kidney Network (WKN) across Wales.

Members noted that the risk register for the WKN had been reviewed and discussed in the WKN QPS meeting on 2 May 2023 and the WKN Board meeting on 31 May 2023. It was noted that there were 13 items on the current WKN risk register. One risk related to COVID-19 had recently closed.

Members noted the updates to the Renal Funding risk and the limited outpatient dialysis capacity risk in Swansea and it was highlighted that these risks remain on the Corporate Risk Assurance Framework (CRAF).

3.0 COMMISSIONING TEAM AND NETWORK 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 and updates regarding services in escalation are attached in the table at the end of the report.

- **Cancer & Blood**

The main issue to note was the traction on the performance issues within the all Wales Lymphoma Panel service. The Escalation meetings were closely monitoring progress against the action plan. Arrangements were being put in

place to look at the sustainability of the service model and clinical leadership as part of the WHSSC planning work.

The North Wales Plastic Surgery service remains an area of concern. WHSSC is contributing to the Welsh Government escalation arrangements and officers continue to attend the local Task and Finish Group as an advisor. The Harm review is underway and there is traction with the operational issues within the context of the wider issues within BCUHB.

South Wales Plastic Surgery - It was noted that Plastic Surgery waiting times continue to breach the Ministerial measures waiting times for treatment at Swansea Bay UHB and this remains a concern for WHSSC, with escalation levels being reviewed.

Workforce issues within the Neuro Endocrine Tumour Service (NETS) have been addressed with the support of a visiting consultant with NET expertise to oversee the delivery of the service. A full review of the service with stakeholders is planned in June 2023 with the aim of finding a sustainable solution going forward.

- **Neurosciences**

There were no changes in risks since the last update, with no red risks in the portfolio and no services are in escalation.

- **Cardiac**

Within the Cardiac surgery services, there have been significant improvements in both South Wales services. No new risks for the portfolio have been added to the Risk Register since the last report.

Members noted that SBUHB and CVUHB Cardiac Services have been de-escalated from level 3 to level 2 following the improvements put in place. The services will continue to be monitored through their action plans. The Cardiff service was recently de-escalated to Level 2 in May 2023 and will be reviewed in 6 months for assurance that the improvement actions have been fully embedded.

- **Fertility Service South Wales**

Members noted that a number of concerns had been raised following a relicensing inspection by the Human Fertilisation and Embryology Authority (HFEA) of the Women's Fertility Institute (WFI) in Neath Port Talbot Hospital, which was undertaken in January 2023. A new risk has been added to the CRAF and the escalation level is being reviewed.

- **Paediatric Surgery**

The service remains in Escalation Level 3 and the Risk remains on the CRAF. Members noted the issues in relation to the waiting list and the actions in place to improve the situation. It was noted that CVUHB have provided assurance that

they will meet the contract volumes and they have committed to producing a revised demand and capacity plan and waiting times trajectory.

Waiting times have decreased and the service is meeting the Ministerial measures for waiting times. However, because this relates to children WHSSC have set an objective for further significant reduction over the next year. Outsourcing arrangements to NHS England and the private sector will remain in place to support this.

- **Paediatric Intensive Care Unit (PICU)**

The Paediatric Intensive Care service remains in escalation Level 2 due to concerns regarding capacity, staffing levels, quality and contract monitoring. In line with the WHSSC Escalation Framework clear objectives have been set for improvement and an action plan was received in June 2023. Members advised they were unable to be assured on the pressure damage report from the Health Board as this had been shared in summary by letter. The DoN undertook to write to the UHB to request the full report. An update will be provided at the next QPSC meeting.

- **Neonatal Cot Availability in South Wales**

The Neonatal Cots Reconfiguration recommendations were approved by the Joint Committee in March 2023 and members noted that the investment as agreed in this year's ICP had been released which should stabilise the position and see the reduction in risk over the next year.

- **Mental Health & Vulnerable Groups**

Members noted that there were currently two Mental Health services in escalation. Ty Llidiard remains at Escalation Level 3 and FACTS is currently in escalation Level 2.

The committee received an update regarding the Gender Development Service (GIDS) for Children and Young People. NHS England have published an update on their progress towards improving and expanding services for children and young people experiencing gender incongruence and gender dysphoria and it is anticipated that the early stages of service provision at the Southern Hub will begin in autumn this year (2023) – with the Northern Hub mobilising by April 2024.

The Cass Review published a journal entry detailing the research programme and made some recommendations with regard to Hormone Therapy for Children.

- **Intestinal Failure (IF) – Home Parenteral Nutrition**

Members noted the report highlighting the new risk related to sustainability and delivery of the service due to workforce issues. Alternative options were being explored and outsourcing to a service in Bristol is being considered.

4.0 OTHER REPORTS RECEIVED

Members received reports on the following:

4.1 Services in Escalation Summary

Members noted the content of the report and the new format template. The new format of the report aims to provide an escalation trajectory to capture both the historical picture and movement within the escalation level. Members noted the three services in escalation level 3 and above and the updates:

- Ty Llidiard had been lowered to escalation level 3 from 4 in December 2022,
- Paediatric Surgery C&VUHB had been escalated to level 3 in March2023,
- Burns service in SBUHB remains in Escalation level 3.

Members provided very positive comments on the report and found it very helpful providing an overall snapshot with the narrative for the detail. A copy of each of the services in escalation is attached to the report ***Appendix 1***

4.2 WHSSC Committee Effectiveness Survey Results

Members received a report providing feedback from the Annual Committee Effectiveness Self-Assessment 2022-2023.

4.3 CRAF Risk Assurance Framework

Members received a report outlining WHSSC's current risks scoring 15 or above on the commissioning teams and directorate risk registers. Members noted the updates in red.

4.4 Care Quality Commission (CQC)/ Health Inspectorate Wales (HIW) Summary Update

A briefing on Healthcare Inspectorate Wales (HIW) and Care Quality Commission (CQC) reports published during the period April to June 2023 was presented to the committee.

4.5 Incident and Concerns report

Members received a report outlining the incidents and concerns reported to WHSSC and the actions taken for assurance. A request was made to include an in-depth review of the women and children's incidents. This was following queries raised by members as to whether there were any themes linked to these concerns.

Members noted the content of the report.

5.0 ITEMS FOR INFORMATION:

Members received a number of documents for information only:

- Chair's Report and Escalation Summary to Joint Committee 16 May 2023

• WHC/2003/017 National Policy on Patient Safety Incident Reporting • QPSC Distribution List; and • QPSC Forward Work Plan.
Key risks and issues/matters of concern and any mitigating actions Key risks are highlighted in the narrative above.
Summary of services in Escalation • Attached (***Appendix 1***)
Matters requiring Committee level consideration and/or approval • N/A
Matters referred to other Committees As above.
Confirmed minutes for the meeting are available upon request

Date of Next Scheduled Meeting	16 August 2023 at 14.00hrs

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

Executive Director Lead: Nicola Johnson
Commissioning Lead: Luke Archard
Commissioning Team: Cancer and Blood

Date of Escalation Meetings: 27/09/22, 01/12/2022, 03/03/2023, 03/05/2023
Date Last Reviewed by Quality & Patient Safety Committee: 18/04/2023

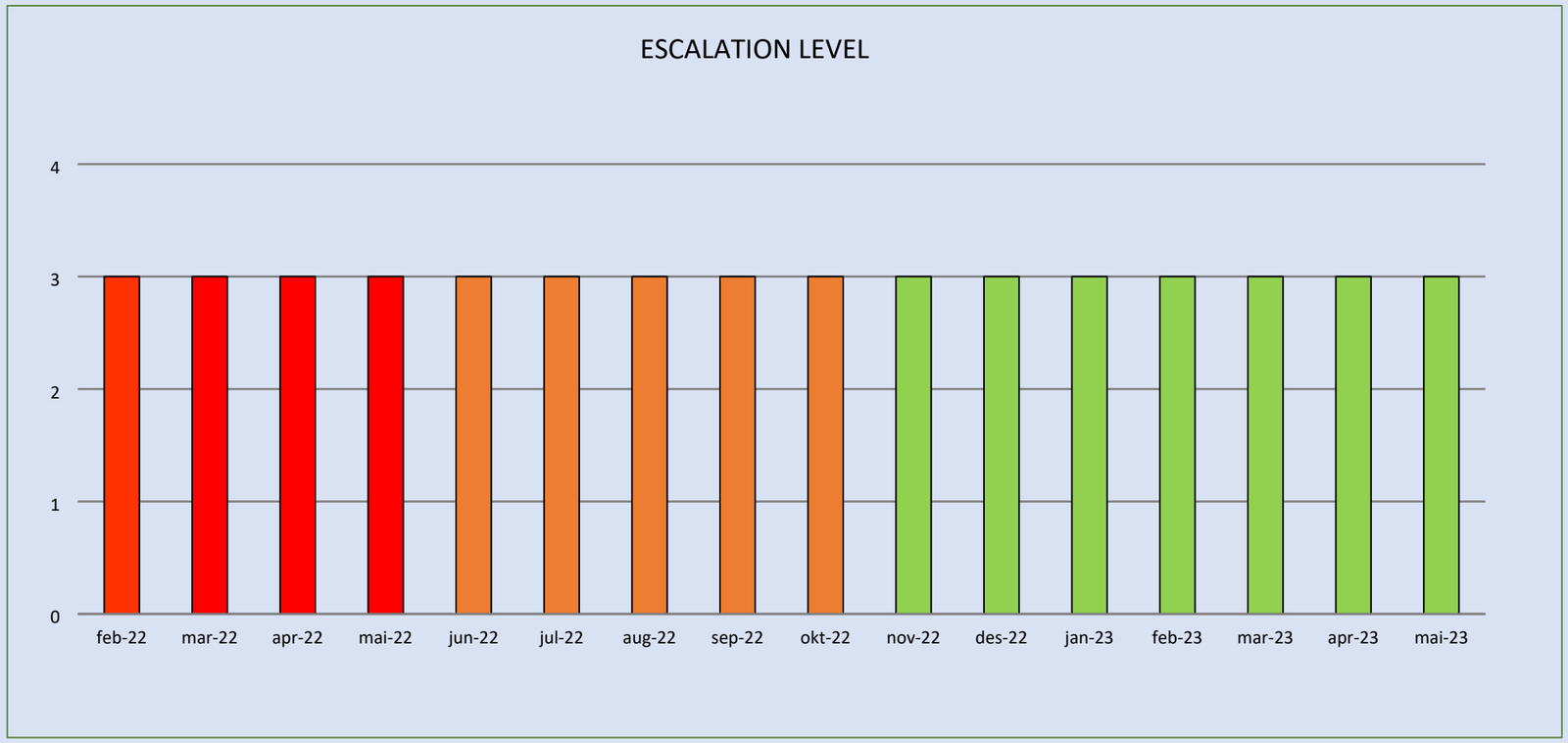
Service in Escalation: Burns

Current Escalation Level 3

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↔ May 2023
↔	Escalation remains the same	
↑	Escalation level escalated	

Escalation Trajectory:



Escalation History:

Date	Escalation Level
November 2021 – South West Burns Network escalation	**4**
February 2022 – WHSSC escalation	**3**
August 2022 – WHSSC escalation	**3**
September 2022 – WHSSC escalation	**3**
December 2022 – WHSSC escalation	**3**

Rationale for Escalation Status :
Remains at level 3.
The current timeline for completion of the capital works to enable relocation of burns ITU to general ITU at Morriston Hospital is the end of 2023.
The capital case remains on target with the planned timeline.

Background Information:

At the time of initial escalation, the burns service at SBUHB was unable to provide major burns level care due to staffing issues in burns ITU. An interim model was put in place allowing the service to reopen in February 2022. The current escalation concerns the progress of the capital case for the long term solution and sustainability of the interim model.

Actions:

Action	Lead	Action Due Date	Completion Date
To escalate and liaise with SBUHB at CEO and MD level with regard to the immediate actions needed to provide continued access to burns care for patients in Wales and the Network.	MD/ CEO		Completed
To work with NHS England south west commissioners and the SWW Burns Network to support clear pathways and ensure continued access to burns care for patients in Wales and the Network.	MD/Exec Lead WHSSC		Completed
To monitor the SBUHB action plan through formal escalation meetings.	MD/ Exec Lead WHSSC		Ongoing
The peer review report was received by WHSSC and discussed at the Burns Network meeting on the 16th December 21. The interim mitigations are still in place at present.	Senior Planner		Completed
SBUHB are to provide a plan based on the recent peer review by the end of January 22.	Senior Planner		Completed
A series of monitoring meetings are being put in place and LA to ask SBUHB if they are confident as to whether 2 beds meets their requirements. The unit has reopened with reduced capacity, i.e. 2 ITU beds instead of 3. Full capacity will return in the longer term. WHSSC has responsibility for monitoring implementation rather than the burns network. It was agreed that the risk score could be reduced to 9 (3 x 3) and considered for further reduction when assurance as to whether the service considered the reduced capacity to be sufficient for their needs.	Senior Planner WHSSC/ Service Manager SBUHB		Completed
Interim arrangements to sustain burns service are in place while the business case is developed to collocate burns intensive care with the general intensive care unit. Interim arrangements appear to have taken effect. Risk may be reduced once escalation meetings can be confirmed.	Senior Manager/ Senior Planner WHSSC	Ongoing	
WHSSC to look at the business continuity plan in the event of potential loss of staff.	Senior Planner WHSSC	Ongoing	
Since the last escalation meeting, there has been a degree of delay relating to the process of Welsh Government scrutiny of the case which will go their Investment in Infrastructure Board on 22nd July. It had been hoped that the works would commence in May. There may therefore be a 2 month or so departure from original timelines. At the SLA with Swansea on Monday of this week, it was confirmed that this message had been conveyed to the staff supporting the interim rota arrangements (one of the concerns has been to ensure the resilience of this rota which in turn is felt to depend in part on there being demonstrable progress with the business case so they can see the finish line).	Senior Team SBUHB/ Senior Planner WHSSC	Ongoing	

Issues/Risks:

Executive Director Lead: Nicola Johnson
Commissioning Lead: Emma King
Commissioning Team: Mental Health & Vulnerable Groups

Date of Escalation Meetings: 12/07/21, 10/08/21, 14/09/21, 12/10/21, 09/11/21, 14/12/21, 11/01/22, 08/02/22, 08/03/22, 12/04/22, 03/05/22, 14/06/22, 20/07/22, 09/08/22, 13/09/22, 14/10/22, 05/12/22, 10/01/23, 12/06/23
Date Last Reviewed by Quality & Patient Safety Committee: 18/04/2023

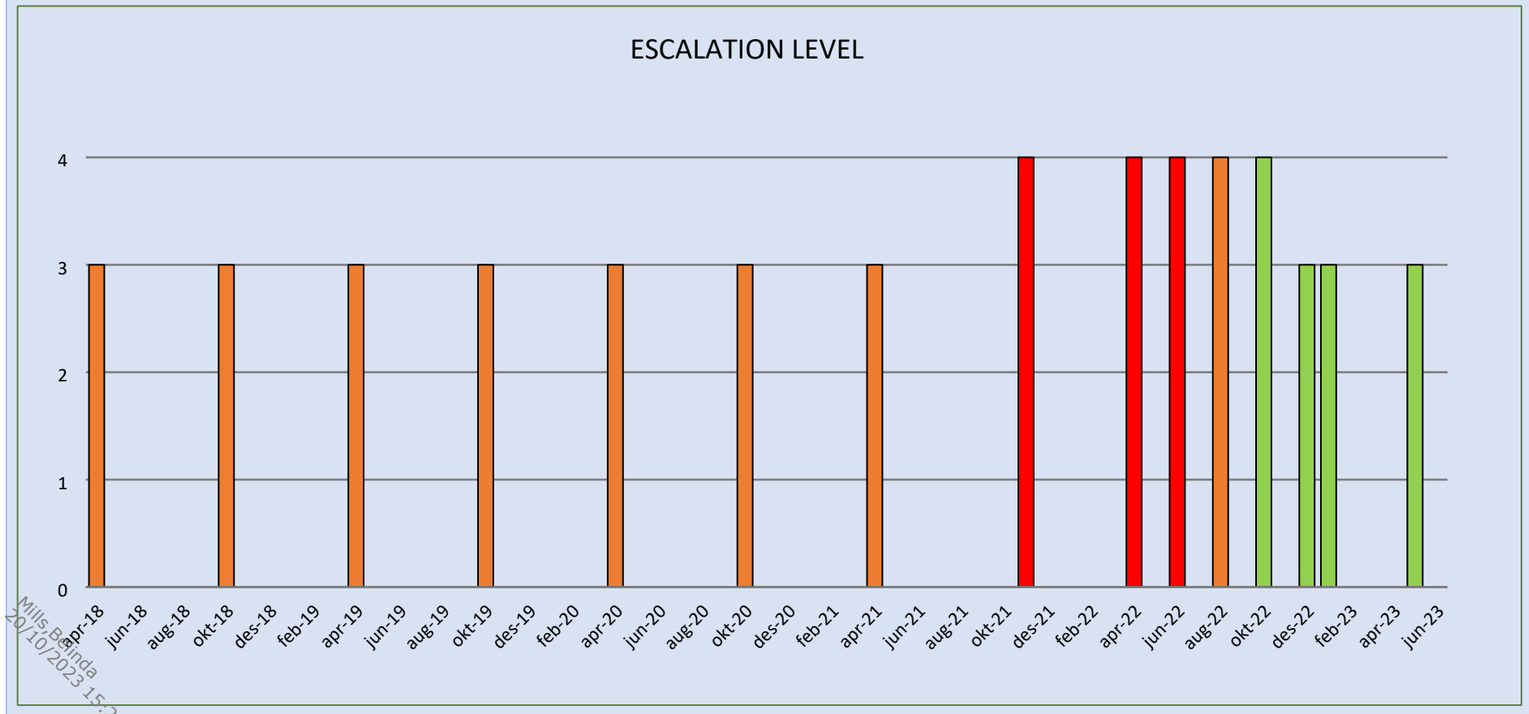
Service in Escalation: Ty Llidiard

Current Escalation Level 3

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↔ May 2023
↔	Escalation remains the same	
↑	Escalation level escalated	

Escalation Trajectory:



Escalation History:

Date	Escalation Level
Mar 2018 – WHSSC escalation	3
Sept 2020 - WHSSC escalation	3
Nov 2021 - WHSSC escalation	Escalation level increased to level 4
December 2022 - WHSSC escalation	De-escalated to level 3

Rationale for Escalation Status :
De-escalated to level 3.

Background Information:

March 2018 - Unexpected Patient death and frequent SUI's revealed patient safety concerns due to environmental shortfalls and poor governance.
September 2020 - SUI reported to Welsh Government.
September 2022 - Recruitment plan underway with all vacancies out to advert; interview dates arranged.
December 2022 - This service has been de-escalated to Level 3 as agreed by CDGB on 14th December.

Actions:

Action	Lead	Action Due Date	Completion Date
Escalation meetings held monthly, however these have been escalated to Executive level discussions following the report on a visit from NCCU into the unit.	Senior Planner		Completed March 22
Service specification action plan agreed.	Senior Planner		Completed March 22
Implementation of Medical Emergency Response SOP by CTM took place on 03/05/22.	Senior Planner		Completed May 22
Recruitment of all staff to be in place.	Senior Planner / Service Leads		Completed
Estates issues being addressed and meeting to map these and plan a timeline.	Senior Planner / Service Manager	Ongoing	
Executive lead for CTMUHB leading on the current escalation and development plan alongside WHSSC Executive lead with regular updates in between Escalation meetings.	Senior Planner	Ongoing	
NCCU CAMHS review to provide the driver for the CAMHS work stream of the mental health strategy.	Senior Planning Manager		Completed
Reviewed service specification.	Senior Planning Manager		Completed
Monitor training status of the staff by QAIS.	Shane Mills		Completed
Submission of a discussion papers followed by a business plan for Clinical Director Dr Krishna Menon for a Physician Associate.	Dr Krishna Menon		Completed
Confirm funding arrangements on staffing position for Nursing, Therapies, Medical Staff and Service Business Manager.	Director of Finance		Completed
Action plan developed following QAIS review conducted in March 2022 and managed under escalation process.	NCCU Director	March 2023	
Review of patient referrals admissions refusals and outcomes from March 2022 being undertaken.	NCCU Director and Team	April 2023	Ongoing

Issues/Risks:
This is a significant risk and is captured on WHSSC CRAF ref: MH/21/02 There is a risk that tier 4 providers for CAMHS cannot meet the service specification due to environmental and workforce issues, with a consequence that children could abscond/come to harm.

July 21- The commissioning team reviewed the risk scores and agreed to lower the target score from 12 to 8 as it was originally scored too high
April 22 – Score to remain as it is subject to impact of completed actions
June 22 – Risk remains at current level as risk of absconding is still prevalent
December 22 – Service de-escalated to Level 3 however work continues to consider referral processes and assessments
May 23 - There has been no change to the Ty Llidiard escalation status and no meetings have been held pending a report from NCCU next meeting planned for June 12 2023.

Executive Director Lead: Nicola Johnson
Commissioning Lead: Richard Palmer
Commissioning Team: Cardiac

Date of Escalation Meetings: 01/06/22, 20/07/22, 21/11/22, 05/04/23
Date Last Reviewed by Quality & Patient Safety Committee: 18/04/23

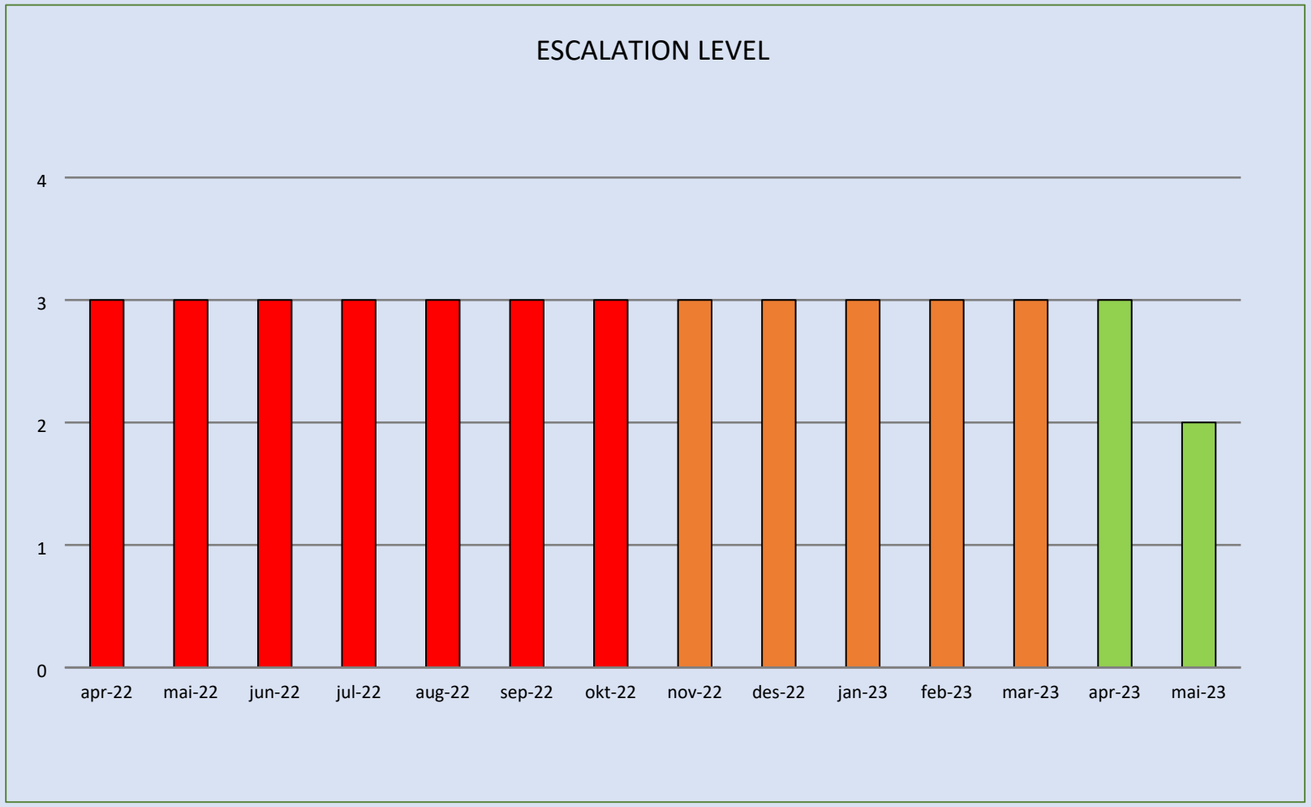
Service in Escalation: Cardiac CVUHB

Current Escalation Level
2

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↓ May 2023
↔	Escalation remains the same	
↑	Escalation level escalated	

Escalation Trajectory:



Escalation History:

Date	Escalation Level
April 2022– WHSSC escalation	**3**
June 2022– WHSSC escalation	**3**
November 2022– WHSSC escalation	**3**
May 2023 – WHSSC escalation	**2**

Rationale for Escalation Status :

Following an escalation meeting on 5 April 2023, the escalation status of the Cardiff and Vale Cardiac Surgery service was considered by the Cardiac Commission Team, which recommended a reduction to Level 2. When considering the service's escalation status, the Cardiac Commissioning Team found that:

- The majority of the actions contained in the GIRFT/HEIW action plan were complete and that there had been evident progress towards the delivery of the GIRFT indicators
- Those actions that remained outstanding were subject to a number of interdependencies that may delay delivery
- The requested HEIW report had been received, and the Cardiac Surgery service had shared detail of progress against the report's recommendations and follow-up visits via Level 3 escalation meetings

- There had been had been improved engagement from the Health Board senior team in respect of escalation issues.

Background Information:

Owing to the failure of Cardiff and Vale University Health Board to…

1. Implement the outcomes of the GIRFT review (June 2021), for which no appropriate SMART action plan has been shared with WHSSC
2. Communicate and address (via a SMART action plan) the additional issues recently identified by HEIW, arising from the concerns with the cardiac surgical service raised by trainees

…there is a risk that people waiting for Cardiac Surgery delivered by Cardiff and Vale University Health Board may receive suboptimal or delayed treatment, and that WHSSC will be unable to effectively monitor.

The following controls have thus been put in place:

- Instituting of regular (every 6 weeks) Stage 3 escalation meetings with Cardiff and Vale University Health Board – with monitoring to be taken forward via regular Cardiac Services Risk, Assurance and Recovery meetings following de-escalation to Level 2, and with a formal review planned for October 2023.
- HEIW report and action plan shared with WHSSC and discussed in escalation meetings.
- Development of SMART action plan to take forward the recommendations of the GIRFT review, shared with WHSSC at escalation meetings to enable the monitoring of progress and identification of any required remedial actions.

WHSSC assurance and confidence level in developments:

Medium – Although the service has been de-escalated and commended both for the improvements made and the engagement of the senior team since the service was escalated to Level 3 in April 2022, further de-escalation will depend on the delivery of a number of interdependent actions, including the repatriation of the Cardiac Surgery service from UHL to UHW and additional

Actions:

Action	Lead	Action Due Date	Completion Date
De-escalate service to Stage 2 of the WHSSC escalation process	Director of Planning		Completed
Utilise regular bi-monthly Cardiac Services Risk, Assurance and Recovery meetings to oversee escalation process	Senior Planning Manager		Completed
Receive a SMART action plan from the service that addresses the recommendations contained in the GIRFT report.	Senior Planning Manager	In progress - chased 10/06/22	Completed
Receive HEIW report concerning issues with the cardiac surgical service raised by trainees.	Senior Planning Manager		Completed
Monitor implementation of the SMART action plan at escalation meetings.	Senior Planning Manager	In progress	
Development of de-escalation criteria based on recommendations in GIRFT report and action plan.	Associate Medical Director		Completed

recruitment. Although appropriate planning has been undertaken and progress will be monitored, any delay in the interdependent actions will see consideration of further de-escalation similarly delayed.	

Issues/Risks:
June 2022 – Service escalated to Stage 3 of the WHSSC escalation process in April 2022 owing to continuing concerns with engagement; agreed at the 28 June 2022 Cardiac Commissioning Team meeting that the escalation constituted a risk (as opposed to an issue) owing to concern that the failure to implement GIRFT/HEIW recommendations will impact on patients, but that the accompanying narrative should be revised to clarify the precise concerns; escalation meeting held on 01 June 2022, at which an apparently extant action plan was discussed, but not subsequently shared.
July 2022 – Action plan now shared with WHSSC. Second escalation meeting held on 20 July 2022 at which – mindful of the long-term nature of many of the HB's objectives – progress was noted. Agreed that WHSSC would refer to both the GIRFT report and the action plan in order to develop de-escalation criteria in time for the next escalation meeting (September). No change to risk score.
August 2022 – Draft de-escalation criteria shared with Health Board in readiness for discussion at September escalation meeting. No change to risk level.
September 2022 – The de-escalation criteria was discussed with the Health Board in the September escalation meeting. It was agreed in the meeting that the Health Board would provide a formal response in regards to the proposed de-escalation criteria. No change to the risk score.
October 2022 - Health Board had not yet provided formal response to proposed de-escalation criteria. Planned October escalation meeting had been rescheduled to Monday 21 November owing to Health Board availability; Health Board had submitted updated action plan in lieu of meeting. No change to risk score.
November 2022 – Further progress was noted at November escalation meeting; de-escalation criteria discussed – agreed that focus would be on evidencing positive trajectory, assisted by cardiac surgery dashboard; risk score unchanged.
December 2022 – No escalation meetings since the last CRAF review. Risk/escalation level unchanged.
January 2023 – No escalation meetings since the last CRAF review. Risk/escalation level unchanged.
February 2023 – No escalation meetings since the last CRAF review. Risk/escalation level unchanged.
March 2023 – No escalation meetings since the last CRAF review. Risk level remains unchanged; next meeting scheduled for 5 April 2023.
May 2023 – Following the de-escalation of the service (from Level 3 to 2 in May 2023) and the subsequent review of the risk by the Commissioning Team, the risk score has been reduced to 9. Regular monitoring will continue through the Cardiac Risk, Assurance and Recovery meetings. The Health Boards position will be formally be reviewed in six months' time following an assessment of progress against the actions as outlined in the de-escalation letter.

Executive Director Lead: Nicola Johnson
Commissioning Lead: Kimberley Meringolo
Commissioning Team: Women and Children

Date of Escalation Meetings: 26/04/23, 23/05/23
Date Last Reviewed by Quality & Patient Safety Committee: 18/04/2023

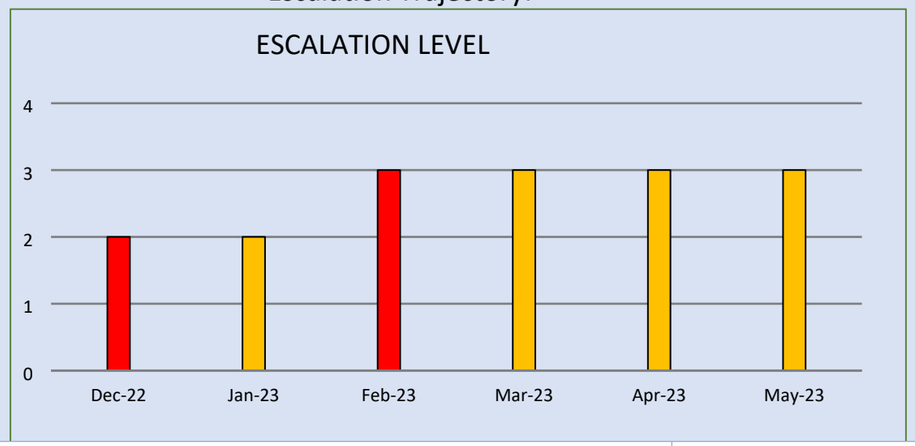
Service in Escalation: Paediatric Surgery

Current Escalation Level 3

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↔ May 2023
↔	Escalation remains the same	
↑	Escalation level escalated	

Escalation Trajectory:



Escalation History:

Date	Escalation Level
March 2023 – WHSSC escalation	**3**

Rationale for Escalation Status :
As a result of the service failing to engage fully with WHSSC regarding the weekly submission of contract delivery and waiting time profiles, it was agreed that the C&VUHB Paediatric Surgery service should be further escalated from Level 1 to Level 3 of the WHSSC Escalation Framework.

Background Information:

There is a risk that Paediatric patients waiting for surgery in the Children's Hospital of Wales are waiting in excess of 36 weeks due to COVID-19. The consequence is the condition of the patient could worsen and that the current infrastructure is insufficient to meet the backlog.
• Recovery plan trajectories have reflected a nominal improvement on the waiting list position, and clarity is required on zero waits > 104 weeks,
• The current plan does not deliver contracted volumes,
• Timely assurance on delivery against the baseline for future recovery, via weekly reports, as opposed to monthly reporting suggested by the UHB.

WHSSC assurance and confidence level in developments:

Medium – Action plan developed and positive progress made in implementing a number of new pilot schemes and securing additional capacity. Currently it is premature to consider the de-escalation of the service as these pilot schemes need to roll out and additional lists undertaken to measure success against the waiting list position. Commitment to re-cast trajectories in light of action plan with ultimate aim to meet contracted volumes.

Actions:

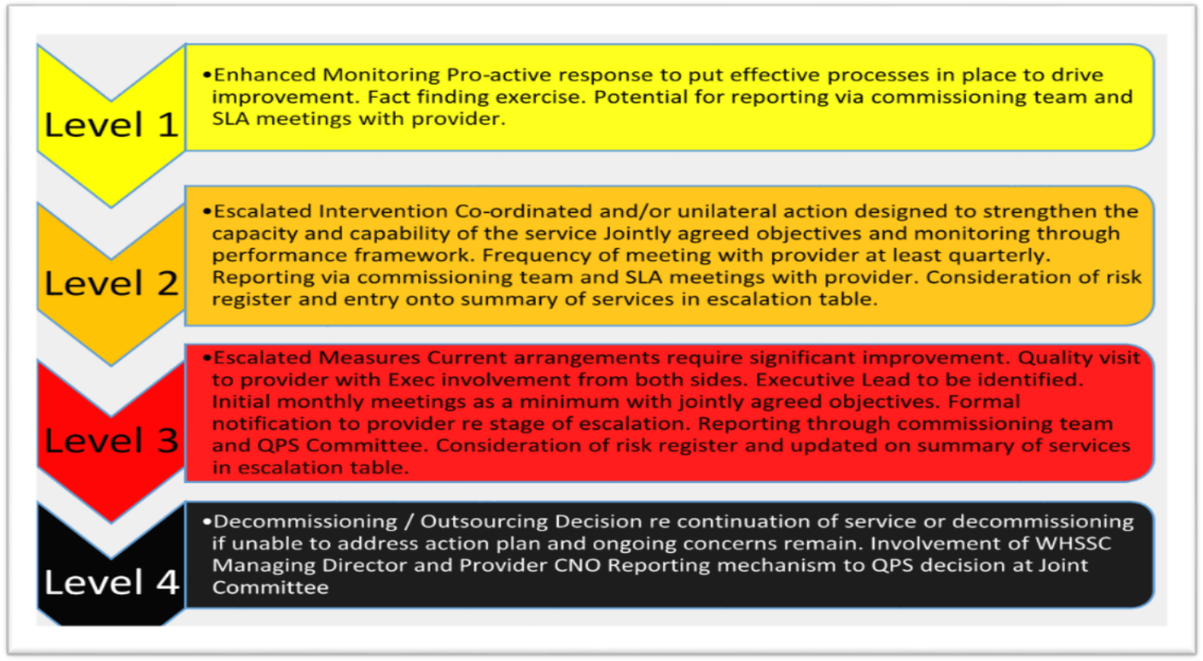
Action	Lead	Action Due Date	Completion Date
To establish monthly escalation meetings with CVUHB to review progress against the improvement plan.	Senior Planning Manager	Monthly	
Action plan to be monitored through the monthly escalation meetings and when data shows improvement consideration will be given to de-escalation.	Senior Planning Manager	Monthly	
Requested revised trajectories to be issued to WHSSC by the end of June 2023.	Senior Planning Manager	30 June 2023	

Issues/Risks:
April 2023 – Action plan presented by HB and actions agreed to progress in time for next meeting.

May 2023 – a number of actions within the action plan are in progress, action at meeting to update trajectories in time for the July meeting in order to allow measurement of improvement.

Level 1 ENHANCED MONITORING	Any quality or performance concern will be reviewed by the Commissioning Team. Enhanced monitoring is a pro-active response to put effective processes in place to drive improvement. It is an initial fact finding exercise which should ideally be led by the provider and closely monitored and reviewed by the commissioning team. The enquiry will lead to one of the following possible outcomes: • No further action is required routine monitoring will continue. The concern which raised the indication for inquiry will be logged and referred to during the routine monitoring process to ensure this has not developed any further. • Continued intervention is required at level 1 and a review date agreed. • Escalation to Level 2 if further intervention is required There is the potential for reporting via commissioning team report to Quality Patient Safety Committee and through SLA meetings with provider
Level 2 ESCALATED INTERVENTION	Escalated intervention will be initiated if Level I Enhanced Monitoring identifies the need for further investigation/intervention. There should be a Co-ordinated and/or unilateral action designed to strengthen the capacity and capability of the service. At this stage there should be jointly agreed objectives between the provider and commissioner and monitored through the relevant commissioning team. Frequency of meeting with provider should be at least quarterly and possible interventions will include • Provider performance meetings • Triangulation of data with other quality indicators • Advice from external advisors • Monitoring of any action plans A risk assessment should be undertaken, and logged on the Commissioning Team Risk Register. Where appropriate the risk will be included on the WHSSC Risk Management Framework. Reporting is via commissioning team report to Quality Patient Safety Committee report and SLA meetings with provider. The investigation will lead to on to the following possible outcomes: • Action plan and monitoring are completed within the allocated timeframe, evidence of progress and assurance the concern has been addressed. De-escalation to Level 1 for ongoing monitoring. • If the action plan is not adhered to and further concerns are raised by the Commissioning team or by the provider team or further concerns are identified it may be necessary to move to Level 3 Escalated Measures
Level 3 ESCALATED MEASURES	Where there is evidence that the Action Plan developed following Level 2 has failed to meet the required outcomes or a serious concern is identified a service will be placed in escalated Level 3. At this stage the quality of the service requires significant action/improvement and will require Executive input. In addition to routine reporting through QPS a formal paper will be considered by the WHSSC Corporate Directors Group (CDG) and an Executive Lead nominated. Formal notification will be sent to the provider re the Level of escalation and a request made for an Executive lead from the provider to be identified. An initial meeting will be set up as soon as possible dependant on the severity of the concern. Meetings should take place at least monthly thereafter or more frequently if determined necessary with jointly agreed objectives. Provider representation will depend on the nature of the issue but the meetings should ideally comprise of the following personnel as a minimum: • Chair (WHSSC Executive Lead) • Associate Medical Director - Commissioning Team • Senior Planning Lead – Commissioning Team • WHSSC Head of Quality • Executive Lead from provider Health Board/Trust • Clinical representative from provider Health Board/Trust • Management representative from provider Health Board/Trust An agreed agenda should be shared prior to the meeting with a request for evidence as necessary. At the conclusion of the meeting a clear timeline for agreed actions will be identified for future monitoring and confirmed in writing if appropriate. Reporting will be through commissioning team to QPS Committee. Consideration of entry on the risk register and summary of services in escalation table for Chairs report to Joint Committee. Consideration to involve and have a discussion with Welsh Government may be considered appropriate at this stage. If there is ongoing concern relating patient care and safety with no clear progress then further escalation will be required to Level 4. On the other hand if progress is made through the escalation Level 3 evidence of this should be presented to CDG/QPS and a formal decision made with the provider to de-escalate to Level 2.

Level 4 DECOMISSIONING/OUTSOURCING	Where services have been unable to meet specific targets or demonstrate evidence of improvement a number of actions need to be considered at this stage. This stage will require notification and involvement of the WHSSC Managing Director and CEO from the provider organisation. Both Quality Patient Safety Committee and Joint Committee should be cited on the level of escalation. The following areas will need to be considered and the most appropriate sanction applied to help resolve the issue: 1. De-commissioning of the service 2. Outsourcing from an alternative provider. This may be permanent or temporary 3. Contractual realignment to take into account the potential need to maintain and agree an alternative provider. Involvement with Welsh Government and the Community Health Council is critical at this stage as often there are political drivers and levers that need to be considered and articulated as part of the decision making. Moving in and out of escalation and between Levels In addition to the Levels described above the process has introduced a traffic light guide within each level. The purpose of this is to help demonstrate the direction of travel within the level. It sets out an approach to help identify progress within the level and lays out the steps required for movement either upwards (escalation) or downwards (de-escalation) through the level. At every stage a red, amber or green colour will be applied to the level to illustrate whether more or less intervention is in place. Red being a higher level of intervention moving down to green. It will also help determine the easing of the escalated measures described and inform movement within the stages of escalation. As the evidence and understanding of the risks from a provider and commissioner become evident decisions can be made to reduce the level of intervention or there may be a need to reintroduce intervention should conditions worsen and trigger the re-introduction of measures if progress is unacceptable. In this way organisations will be able to understand what is being asked of them, progress will be easily identified and it will help avoid any confusion. It will also help in the reporting to provide assurance that action is being taken to meet the agreed timescales.



SERVICES IN ESCALATION

Level of escalation reducing / improving position

Level of escalation unchanged from previous report/month

WHSSC Joint Committee
19 September 2023
Agenda Item 4.8.5

Reporting Committee	**Quality Patient Safety Committee (QPSC)**
Chaired by	**Kate Eden**
Lead Executive Director	**Director of Nursing & Quality**
Date of Meeting	**16 August 2023**

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

- **WHEELCAIR SERVICES DEEP DIVE PRESENTATION AND PATIENT STORY**

A presentation outlining the functions of the Posture and Mobility service and the services it provides for children, young people and adults who require long term wheelchair use was received. Members noted the actions in place to reduce the current waiting times of over 52 weeks to zero by December 2023. The increased waiting times were a direct result of the COVID Pandemic and the backlog created due to the service being closed during that period.

Members received an informative patient story about a young girl, Ellen, who presented to the service initially with extremely complex issues and no experience of independent movement having never rolled, crawled or operated a wheelchair by herself. Despite this, Ellen was insistent on trying a powered wheelchair to gain more independence in her everyday life. Members noted the challenges Ellen faced due to her presentation, posture and dyskinesia and how the services used innovative thinking to overcome the issues by adapting a wheelchair to suit her posture and using the Drive Deck Platform to assess the best way she could drive it independently.

The presentation;

- Explored Referral to Treatment Time (RTT) between 2019/2022 and 2022/2023 and the first quarter of 2023/2024; and
- Explained the actions that were being taken to help reduce waiting lists.

QPSC noted;

- The Welsh Government RTT performance measures,
- Trajectories for 2023/2023,
- Key Performance Indicators; and
- Quality standards.

The challenges and achievements across the three centres were highlighted.

2.0 WELSH KIDNEY NETWORK (WKN) PRESENTATION

Members received a presentation outlining the impact of kidney disease and treatment options for patients with advanced kidney failure. Members noted the significant commitment required for patients undergoing Haemodialysis in the Dialysis Unit and the work that the WKN had undertaken to increase the uptake of home therapy using value based healthcare to improve access for patients as well as employing welfare benefits officers to assist patients in navigating the benefits system to access available financial assistance.

Members also noted the main role of the WKN as the commissioner for all adult kidney specialised services in Wales. The presentation explained the structure and role of WKN and highlighted the current commissioning responsibilities as;

- Haemodialysis (HD),
- Home HD,
- Peritoneal dialysis,
- Transplantation,
- Vascular access

3.0 WELSH KIDNEY NETOWRK REPORT

Members received a report outlining the current Quality and Patient Safety issues within the services that are commissioned by the Welsh Kidney Network (WKN) across Wales.

Members noted that the risk register for the WKN had been reviewed and discussed in the WKN QPS meeting on 5 July 2023 and WKN Board meeting on 3 August 2023. There were 11 items on the current WKN risk register. One risk related the pressure on the Transplant Follow up Service had been closed.

Members noted that the Network Manager post would be advertised shortly which should decrease the current staffing risk and the updates to the limited outpatient dialysis capacity risk in Swansea which should be resolved once the new units open.

The Patient Story attached as an appendix to the report provided an account of a renal patients experience with the services following two failed transplants and how the team supported them to carry out self-care dialysis at home despite initial anxieties.

4.0 COMMISSIONING TEAM AND NETWORK 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 and updates regarding services in escalation are attached in the tables at the end of the report.

- **Cancer & Blood**

The main issue to note was the improved traction on the performance issues within the All Wales Lymphoma Panel service. The Escalation meetings continue to monitor progress against the action plan. It is anticipated that during the next escalation meeting in September 2023 there will be a recommendation to reduce the level of escalation due to the good work being undertaken.

North Wales Plastic Surgery service remains an area of concern and WHSSC continue to work with the Welsh Government escalation arrangements. WHSSC continue to attend the Task and Finish Group as an advisor and members noted that the Harm review is progressing. Members noted that as part of the harm review patients had been categorised and prioritised and those categorised as urgent have already been seen.

South Wales Plastic Surgery - It was noted that Plastic Surgery waiting times continue to breach maximum waiting times for treatment at Swansea Bay UHB and this remained a concern for WHSSC. The service remains in escalation Level 2 with a delivery plan in place.

- **Neurosciences**

Members noted that two new risks scoring above 15, both relating to Deep Brain Stimulation commissioned from North Bristol NHS Trust, had been added since the last report. A progress meeting has been scheduled for 21 September 2023 and a further update will be provided at the next QPSC meeting.

- **Cardiac**

Members noted the updates against the two services which currently remained in escalation level 2; Cardiff and Vale UHB (CVUHB) Cardiac Surgery Service;

- The planned repatriation of Cardiothoracic Surgery to UHW, initially scheduled for September 2023, is likely to be delayed and the actions that had been paused pending the relocation have been discussed with the HB at the July Cardiac Service Risk, Recovery and Assurance meeting.
- A formal escalation review is scheduled to take place in October 2023 when the outstanding actions will be discussed.

Swansea Bay UHB (SBUHB) Cardiac Surgery Service;

- Escalation monitoring continues to take place via bi-monthly meetings,
- SBUHB continue to make excellent progress against the action plan and the team will be considering the potential for further de-escalation at the next meeting in October 2023 subject to the National Adult Cardiac Surgery Audit Report (NACSA 2023).

- **Women & Children**

Members noted the five service areas with risks scoring 15 and above;

  - Paediatric Intensive Care,
  - Paediatric Surgery,
  - Neonatal,
  - Paediatric Cardiac Surgery; and
  - Wales Fertility Institute (WFI) – IVF.

- Mitigating actions are in place for each of the services with Paediatric Surgery, Paediatric Intensive Care and the Wales Fertility Institute all being managed through the WHSSC escalation process.

- **Fertility Service South Wales**

Members noted that a number of concerns had been raised following a relicensing inspection by the Human Fertilisation and Embryology Authority (HFEA) of the Women's Fertility Institute (WFI) in Neath Port Talbot Hospital, which was undertaken in January 2023. The first escalation meeting is due to be scheduled and further feedback will be shared subsequently.

- **Paediatric Surgery**

The service remains in Escalation Level 3 and the Risk remains on the CRAF. Members noted the issues in relation to the waiting list and the actions in place to improve the situation. It was noted that CVUHB have provided assurance that they will meet the contract volumes by December 2023 and they have provided a revised demand and capacity plan and waiting times trajectory and this is being monitored on a weekly basis. Members expressed their continued concern in relation to Paediatric Surgery waiting times and requested further assurance.

Overall waiting times have decreased to meet the Ministerial waiting time of 104 weeks. However, because this relates to children WHSSC have requested further significant reduction to 52 weeks over the next year. Outsourcing arrangements to NHS England and the private sector will remain in place to support this.

- **Paediatric Intensive Care Unit (PICU)**

The Paediatric Intensive Care service remains in escalation Level 2 due to concerns regarding capacity, staffing levels, quality and contract monitoring. In line with the WHSSC Escalation Framework clear objectives have been set for improvement and an action plan was received on 1 June 2023. Further investigations into pressure damage sustained on the unit are on-going. WHSSC have written to CVUHB requesting further assurance regarding the concerns raised into the pressure damage incidents. A response from the Executive Nurse Director (END) has been received advising that the Executive team in CVUHB had been sighted on the full report which is due to be presented to the HB Quality, Patient, Safety and Experience (QPSE) Committee on 26 September 2023. The full assurance report with relevant actions will then be shared with WHSSC and submitted to WHSSC QPSC in October 2023.

Health Inspectorate Wales has written to the Chief Executive Officer (CEO) of CVUHB after a whistle blowing letter outlining concerns relating to the Paediatric Critical Care Unit (PICCU). Members noted the response provided by the Executive Director of Nursing confirming that detailed analysis was being undertaken and highlighting the significant pressures the services are currently experiencing. Once that analysis has been completed the results will be shared with QPSC.

- **Mental Health & Vulnerable Groups**

Members noted that there was currently only one Mental Health service in escalation. Ty Llidiard has been de-escalated to Level 2 and FACTS has been de-escalated completely. Ty Llidiard in particular had made excellent progress over the last 12 months.

The committee received an update regarding the rise in Eating Disorder (ED) adult placements, many of them being placed out of area. A review with the Clinical Gate Keepers is taking place to understand the rationale for the significant increase over the last six months. A Deep Dive into ED services will be brought back to QPS for further discussion.

WHSSC continue to participate in the Children and Young People's Gender Identity Service transformation programme and NHS England (NHSE) have prepared letters to issue jointly from NHSE and NHS Wales to all those on the waiting list relevant by age. These will be available bilingually.

Members noted that the First Minister made a visit to the Mother and Baby Unit in Tonna in July which received positive feedback.

- **Intestinal Failure (IF) – Home Parenteral Nutrition**

Members noted the improved position concerning the risk related to sustainability and delivery of the IF service in CVUHB due to workforce issues. The HB remain committed to providing this services.

4.0 OTHER REPORTS RECEIVED

Members received reports on the following:

Services in Escalation Summary

Members noted the content of the report and the new format template. The new format of the report aims to provide an escalation trajectory to capture both the historical picture and movement within the escalation level. Members noted the three services in escalation level 3 and above and the updates:

- Ty Llidiard had been lowered to escalation level 2 in July 2023,
- Paediatric Surgery C&VUHB remains in escalation level 3 since March2023,
- Wales Fertility Institute (WFI) – IVF has been escalated to Level 3.

Members provided very positive comments on the report and found it very helpful providing an overall snapshot with the narrative for the detail. A copy of each of the services in escalation is attached to the report at ***Appendix 1***

4.2 CRAF Risk Assurance Framework
Members received a report outlining WHSSC's current risks scoring 15 or above on the commissioning teams and directorate risk registers. Members noted the updates in red.

4.3 Care Quality Commission (CQC)/ Health Inspectorate Wales (HIW) Summary Update
A briefing on Healthcare Inspectorate Wales (HIW) and Care Quality Commission (CQC) reports published during the period June to July 2023 was presented to the committee.

4.4 Incident and Concerns Report
Members received a report outlining the incidents and concerns reported to WHSSC and the actions taken for assurance. Members noted the 8 new incidents that had been reported since the last update and the actions taken in line with the governance process within the relevant HBs.

An in-depth review of the women and children's incidents was included. Members noted the additional detail following the Deep Dive into Women and Children's services outlined within the report, as requested by members during the last QPSC meeting for further assurance. No themes or issues were identified.

A public report has been issued from the Ombudsman looking at how complaints are handled and the recommendations will be considered at the QPSC Development Day to ensure it ties into the Duty of Candour and Quality going forward.

Members noted the content of the report.

4.5 Report from the WHSSC Policy Group
A report outlining the summary of activity of the Policy Group was received and members noted the 40 policies currently in development across the services. The Policy Group also reports this to Management Group for further assurance.

4.6 Quarterly Newsletter
The WHSSC Quarterly Newsletter in Welsh and English versions was received and members noted the work outlined within the paper. The newsletters are attached as ***Appendix 2.***

4.0 ITEMS FOR INFORMATION:

Members received a number of documents for information only:

- Chair's Report and Escalation Summary to Joint Committee 18 July 2023,

- Welsh Health Circulars on Research Matters and Withdrawal of WHC Annual Quality Standards,
- QPSC Distribution List; and
- QPSC Forward Work Plan.

Key risks and issues/matters of concern and any mitigating actions

Key risks are highlighted in the narrative above. Members continued to express their concern over Paediatric Surgery waiting times and requested more information in relation to the waiting times trajectories. Further assurance was requested on pressure sores in CVUHB Paediatric Intensive Care Unit.

Members also wanted to highlight the inspiring patient story received and the comprehensive update received on the work of ALAC. In addition a very informative presentation from the WKN was provided.

Carolyn Donoghue new Independent Member (IM) for WHSSC has been appointed as the new WHSSC QPSC Chair.

Summary of services in Escalation

- Attached (***Appendix 1***)

Matters requiring Committee level consideration and/or approval

- Quality Newsletter English and Welsh (***Appendix 2 & 3***)

Matters referred to other Committees

As above.

Confirmed minutes for the meeting are available upon request

Date of Next Scheduled Meeting	24 October 2023 at 10.00hrs

Executive Director Lead: Nicola Johnson
Commissioning Lead: Luke Archard
Commissioning Team: Cancer and Blood

Date of Escalation Meetings: 27/09/22, 01/12/2022, 03/03/2023, 03/05/2023
Date Last Reviewed by Quality & Patient Safety Committee: 14/06/2023

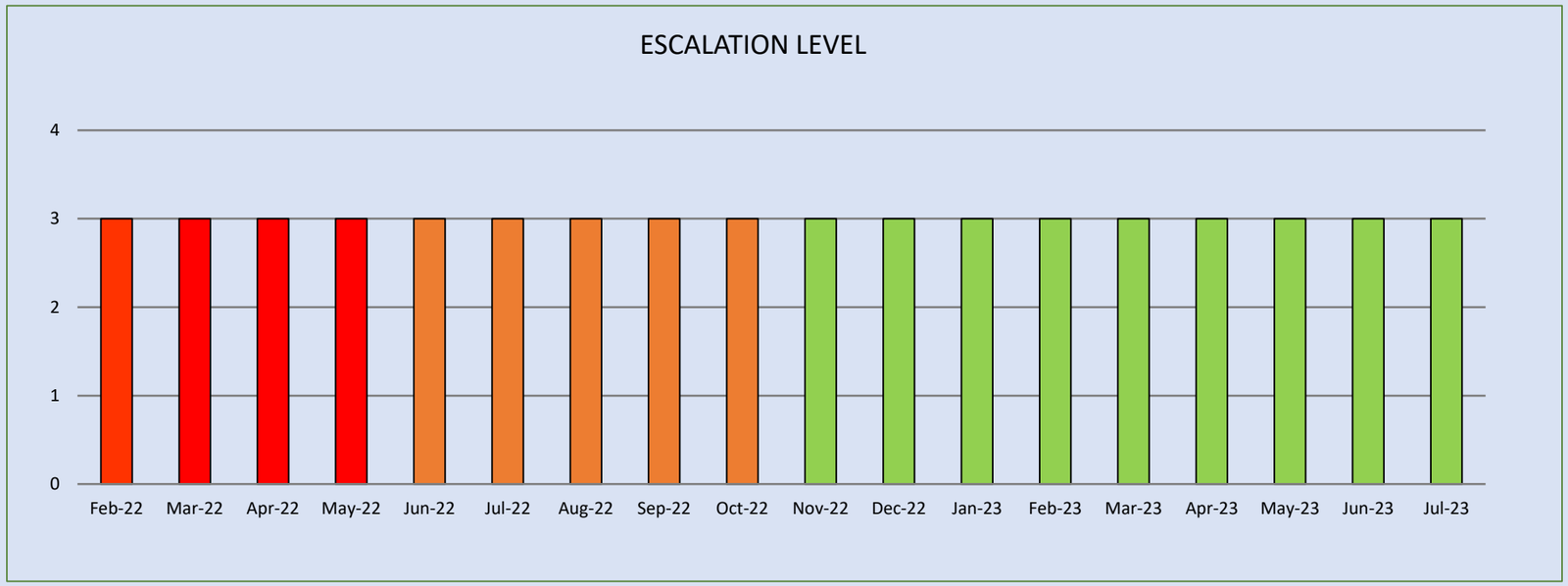
Service in Escalation: Burns

Current Escalation Level 3

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↔ July 2023
↔	Escalation remains the same	
↑	Escalation level escalated	

Escalation Trajectory:



Escalation History:

Date	Escalation Level
November 2021 – South West Burns Network escalation	**4**
February 2022 – WHSSC escalation	**3**
August 2022 – WHSSC escalation	**3**
September 2022 – WHSSC escalation	**3**
December 2022 – WHSSC escalation	**3**

Rationale for Escalation Status :
Remains at level 3.
The current timeline for completion of the capital works to enable relocation of burns ITU to general ITU at Morriston Hospital is the end of 2023.
The capital case may be delayed to the initial intended timeline as the case goes through the scrutiny process.

Background Information:

At the time of initial escalation, the burns service at SBUHB was unable to provide major burns level care due to staffing issues in burns ITU. An interim model was put in place allowing the service to reopen in February 2022. The current escalation concerns the progress of the capital case for the long term solution and sustainability of the interim model.

Actions:

Action	Lead	Action Due Date	Completion Date
To escalate and liaise with SBUHB at CEO and MD level with regard to the immediate actions needed to provide continued access to burns care for patients in Wales and the Network.	MD/ CEO		Completed
To work with NHS England south west commissioners and the SWW Burns Network to support clear pathways and ensure continued access to burns care for patients in Wales and the Network.	MD/Exec Lead WHSSC		Completed

To monitor the SBUHB action plan through formal escalation meetings.	MD/ Exec Lead WHSSC		Ongoing
The peer review report was received by WHSSC and discussed at the Burns Network meeting on the 16th December 21. The interim mitigations are still in place at present.	Senior Planner		Completed
SBUHB are to provide a plan based on the recent peer review by the end of January 22.	Senior Planner		Completed
A series of monitoring meetings are being put in place and LA to ask SBUHB if they are confident as to whether 2 beds meets their requirements. The unit has reopened with reduced capacity, i.e. 2 ITU beds instead of 3. Full capacity will return in the longer term. WHSSC has responsibility for monitoring implementation rather than the burns network. It was agreed that the risk score could be reduced to 9 (3 x 3) and considered for further reduction when assurance as to whether the service considered the reduced capacity to be sufficient for their needs.	Senior Planner WHSSC/ Service Manager SBUHB		Completed
Interim arrangements to sustain burns service are in place while the business case is developed to collocate burns intensive care with the general intensive care unit. Interim arrangements appear to have taken effect. Risk may be reduced once escalation meetings can be confirmed.	Senior Manager/ Senior Planner WHSSC	Ongoing	
WHSSC to look at the business continuity plan in the event of potential loss of staff.	Senior Planner WHSSC	Ongoing	
Since the last escalation meeting, there has been a degree of delay relating to the process of Welsh Government scrutiny of the case which went to their Investment in Infrastructure Board on 22nd June; it had been hoped that the works would commence in May. There may, therefore, be a 2 month or so departure from original timelines. At the SLA with Swansea on 5th June, it was confirmed that this message had been conveyed to the staff supporting the interim rota arrangements (one of the concerns has been to ensure the resilience of this rota which in turn is felt to depend in part on there being demonstrable progress with the business case so they can see the finish line).	Senior Team SBUHB/ Senior Planner WHSSC	Ongoing	

Issues/Risks:

- **July 2023 The Welsh Government Infrastructure Investment Board considered the burns case on June 22 2023 the outcome is not confirmed as yet.**
- **There may be delay to the initial intended timeline as the case goes through the scrutiny process. Once the outcome of the WG process is known, the timeline can be confirmed.**

Executive Director Lead: David Roberts
Commissioning Lead: Emma King
Commissioning Team: Mental Health & Vulnerable Groups

Date of Escalation Meetings: 12/07/21, 10/08/21, 14/09/21, 12/10/21, 09/11/21, 14/12/21, 11/01/22, 08/02/22, 08/03/22, 12/04/22, 03/05/22, 14/06/22, 20/07/22, 09/08/22, 13/09/22, 14/10/22, 05/12/22, 10/01/23, 12/06/23
Date Last Reviewed by Quality & Patient Safety Committee: 14/06/2023

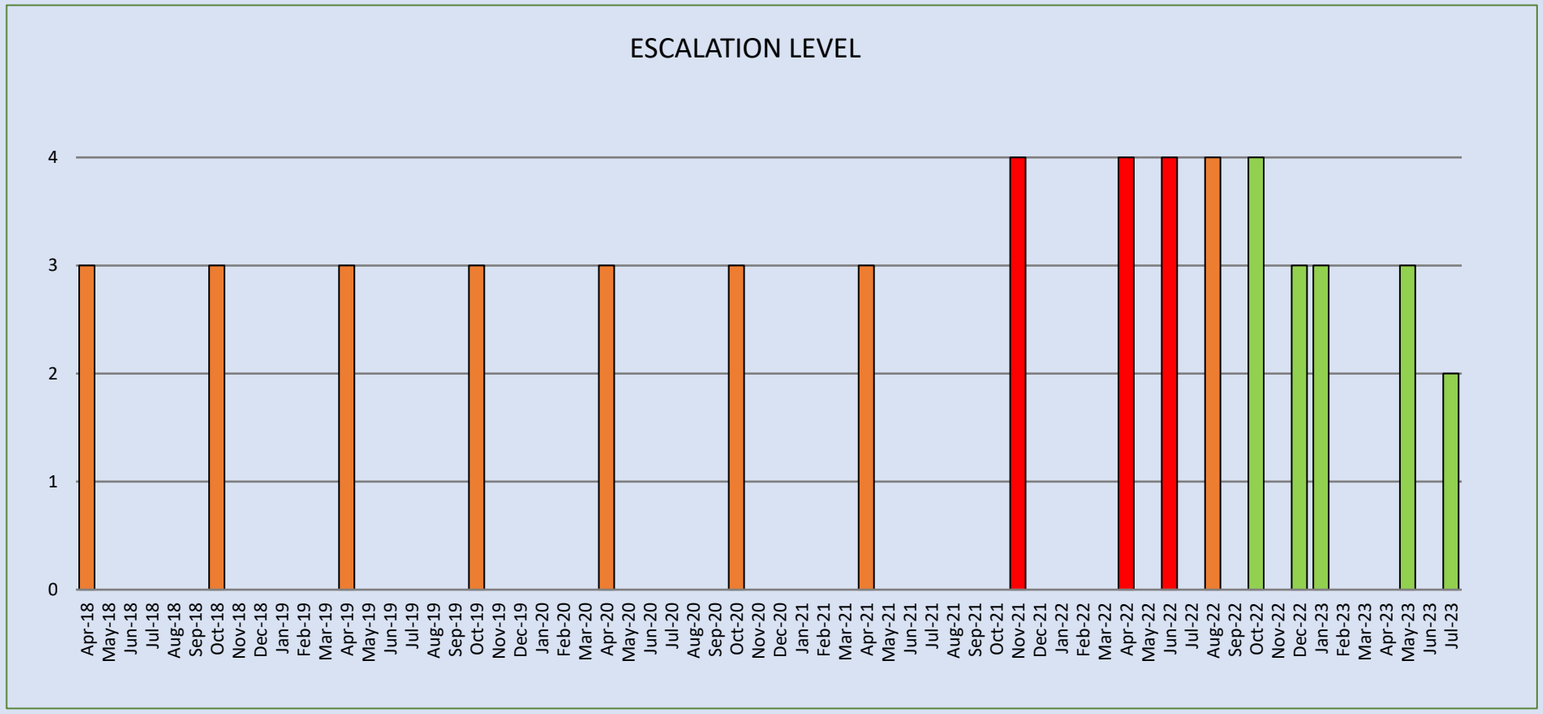
Service in Escalation: Ty Llidiard

Current Escalation Level 2

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↓ July 2023
↔	Escalation remains the same	
↑	Escalation level escalated	

Escalation Trajectory:



Escalation History:

Date	Escalation Level
Mar 2018 – WHSSC escalation	3
Sept 2020 - WHSSC escalation	3
Nov 2021 - WHSSC escalation	Escalation level increased to level 4
December 2022 - WHSSC escalation	De-escalated to level 3
July 2023 - WHSSC escalation	De-escalated to level 2

Rationale for Escalation Status :
De-escalated to level 2.

Background Information:

March 2018 - Unexpected Patient death and frequent SUI's revealed patient safety concerns due to environmental shortfalls and poor governance.
September 2020 - SUI reported to Welsh Government.
September 2022 - Recruitment plan underway with all vacancies out to advert; interview dates arranged.
December 2022 - This service has been de-escalated to Level 3 as agreed by CDGB on 14th December.
July 2023 – The Service has been de-escalated to Level 2 in June 2023

Actions:

Action	Lead	Action Due Date	Completion Date
Escalation meetings held monthly, however these have been escalated to Executive level discussions following the report on a visit from NCCU into the unit.	Senior Planner		Completed March 22
Service specification action plan agreed.	Senior Planner		Completed March 22
Implementation of Medical Emergency Response SOP by CTM took place on 03/05/22.	Senior Planner		Completed May 22
Recruitment of all staff to be in place.	Senior Planner / Service Leads		Completed
Estates issues being addressed and meeting to map these and plan a timeline.	Senior Planner / Service Manager	Ongoing	
Executive lead for CTMUHB leading on the current escalation and development plan alongside WHSSC Executive lead with regular updates in between Escalation meetings.	Senior Planner	Ongoing	
NCCU CAMHS review to provide the driver for the CAMHS work stream of the mental health strategy.	Senior Planning Manager		Completed
Reviewed service specification.	Senior Planning Manager		Completed
Monitor training status of the staff by QAIS.	Shane Mills		Completed
Submission of a discussion papers followed by a business plan for Clinical Director Dr Krishna Menon for a Physician Associate.	Dr Krishna Menon		Completed
Confirm funding arrangements on staffing position for Nursing, Therapies, Medical Staff and Service Business Manager.	Director of Finance		Completed
Action plan developed following QAIS review conducted in March 2022 and managed under escalation process.	NCCU Director	March 2023	Actions outstanding to be completed by Sept 23
Review of patient referrals admissions refusals and outcomes from March 2022 being undertaken.	NCCU Director and Team	April 2023	Completed June 23

Issues/Risks:
This is a significant risk and is captured on WHSSC CRAF ref: MH/21/02 There is a risk that tier 4 providers for CAMHS cannot meet the service specification due to environmental and workforce issues, with a consequence that children could abscond/come to harm.
July 21- The commissioning team reviewed the risk scores and agreed to lower the target score from 12 to 8 as it was originally scored too high
April 22 – Score to remain as it is subject to impact of completed actions
June 22 – Risk remains at current level as risk of absconding is still prevalent
December 22 – Service de-escalated to Level 3 however work continues to consider referral processes and assessments
May 23 - There has been no change to the Ty Llidiard escalation status and no meetings have been held pending a report from NCCU next meeting planned for June 12th.
July 23 – Report received from NCCU and resulted in de-escalation Level 2 in June 2023. 6 Actions outstanding to be completed by September 2023. Further escalation meeting scheduled for 7th August 2023.

Executive Director Lead: Nicola Johnson
Commissioning Lead: Kimberley Meringolo
Commissioning Team: Women and Children

Date of Escalation Meetings: 26/04/23, 23/05/23, 20/06/2023 & 26/07/23
Date Last Reviewed by Quality & Patient Safety Committee: 14/06/2023

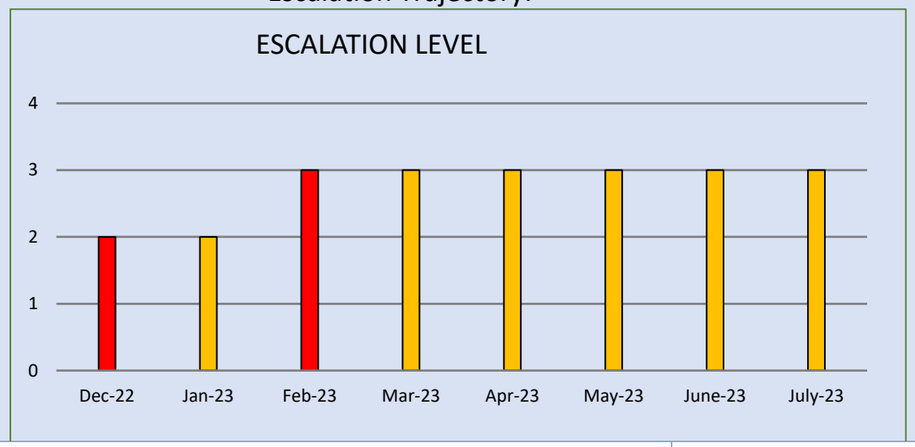
Service in Escalation: Paediatric Surgery

Current Escalation Level 3

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↔ July 2023
↔	Escalation remains the same	
↑	Escalation level escalated	

Escalation Trajectory:



Escalation History:

Date	Escalation Level
March 2023 – WHSSC escalation	**3**

Rationale for Escalation Status :
As a result of the service failing to engage fully with WHSSC regarding the weekly submission of contract delivery and waiting time profiles, it was agreed that the C&VUHB Paediatric Surgery service should be further escalated from Level 1 to Level 3 of the WHSSC Escalation Framework.

Background Information:

There is a risk that Paediatric patients waiting for surgery in the Children's Hospital of Wales are waiting in excess of 36 weeks due to COVID-19. The consequence is the condition of the patient could worsen and that the current infrastructure is insufficient to meet the backlog.
• Original recovery plan trajectories have reflected a nominal improvement on the waiting list position, and clarity is required on zero waits > 104 weeks,
• The original plan does not deliver contracted volume,
• Timely assurance on delivery against the baseline for future recovery, via weekly reports, as opposed to monthly reporting suggested by the UHB.

WHSSC assurance and confidence level in developments:

Medium – Action plan developed and positive progress made in implementing a number of new pilot schemes and securing additional capacity. Service is on-track to meet contracted volumes by December 2023. Reprofiling the waiting times projections is being undertaken by the HB for sharing in August.

Actions:

Action	WHSSC Lead	Action Due Date	Completion Date
Monthly escalation meetings with CVUHB to review progress against the improvement plan.	Senior Planning Manager	Monthly	
Action plan to be monitored through the monthly escalation meetings and when data shows improvement consideration will be given to de-escalation.	Senior Planning Manager	Monthly	
Requested revised trajectories to be issued to WHSSC by the end of June 2023.	Senior Planning Manager	30 June 2023	Completed 20/06/23
Further reprofiling of waiting times being undertaken by the HB in line with meeting contract volumes by December 2023.	Senior Planning Manager	August 2023	

Issues/Risks:
April 2023 – Action plan presented by HB and actions agreed to progress in time for next meeting.
May 2023 – a number of actions within the action plan are in progress, action at meeting to update trajectories in time for the July meeting in order to allow measurement of improvement.

Executive Director Lead: Nicola Johnson
Commissioning Lead: Kimberley Meringolo
Commissioning Team: Women and Children

Date of Escalation Meetings:
Date Last Reviewed by Quality & Patient Safety Committee:

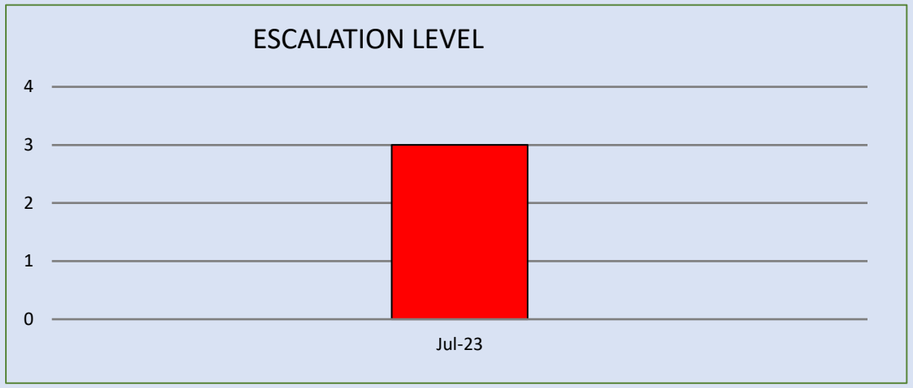
Service in Escalation: Wales Fertility Institute

Current Escalation Level 3

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	
↔	Escalation remains the same	
↑	Escalation level escalated	

Escalation Trajectory:



Escalation History:

Date	Escalation Level
July 2023 – WHSSC escalation	**3**

Rationale for Escalation Status :
Concerns from a number of routes with regards to the service including the WHSSC contract monitoring data submission; adherence to WHSSC policies and HFEA performance outcomes below National average.

Background Information:
A number of concerns regarding the safety and quality of service had been raised through different routes, including HFEA re-inspection report January 2023, WHSSC quality and assurance meetings and WFI IPFR requests regarding Wales Fertility Institute leading to the escalation of the service.

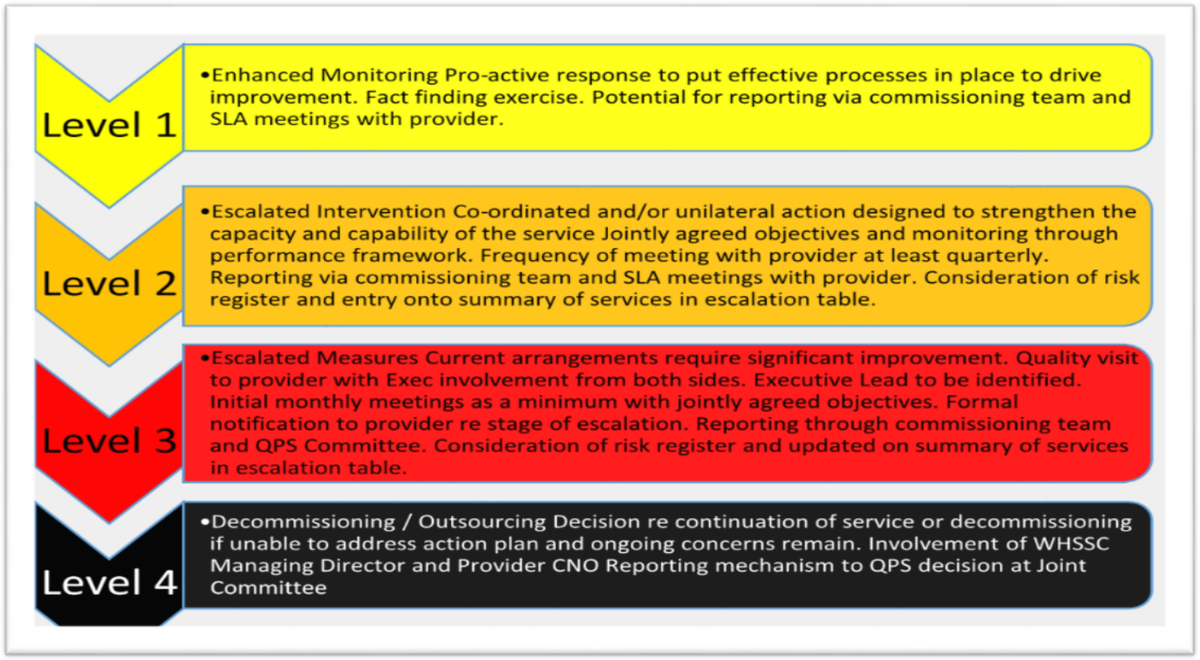
Actions:

Action	Lead	Action Due Date	Completion Date
Initial escalation planning meeting Exec to exec	Assistant Specialised Planner	7th August 2023	
Monthly escalation meeting	Assistant Specialised Planner	Monthly	
Quality visit	Assistant Specialised Planner	September 2023	
SMART Action plan from WFI, action plan has been requested in order that it can be agreed with WHSSC colleagues	Assistant Specialised Planner/ Service Manager	7th August 2023	

Issues/Risks: There is a risk the Wales Fertility Institute (WFI) in Neath & Port Talbot Hospital is not providing a safe and effective service due to 7 major concerns identified during a relicensing inspection by HFEA in January 2023. There is a consequence that families who have treatment at this centre are not receiving the quality of care expected from the service and in turn impacting outcomes.

Level 1 ENHANCED MONITORING	Any quality or performance concern will be reviewed by the Commissioning Team. Enhanced monitoring is a pro-active response to put effective processes in place to drive improvement. It is an initial fact finding exercise which should ideally be led by the provider and closely monitored and reviewed by the commissioning team. The enquiry will lead to one of the following possible outcomes: • No further action is required routine monitoring will continue. The concern which raised the indication for inquiry will be logged and referred to during the routine monitoring process to ensure this has not developed any further. • Continued intervention is required at level 1 and a review date agreed. • Escalation to Level 2 if further intervention is required There is the potential for reporting via commissioning team report to Quality Patient Safety Committee and through SLA meetings with provider
Level 2 ESCALATED INTERVENTION	Escalated intervention will be initiated if Level I Enhanced Monitoring identifies the need for further investigation/intervention. There should be a Co-ordinated and/or unilateral action designed to strengthen the capacity and capability of the service. At this stage there should be jointly agreed objectives between the provider and commissioner and monitored through the relevant commissioning team. Frequency of meeting with provider should be at least quarterly and possible interventions will include • Provider performance meetings • Triangulation of data with other quality indicators • Advice from external advisors • Monitoring of any action plans A risk assessment should be undertaken, and logged on the Commissioning Team Risk Register. Where appropriate the risk will be included on the WHSSC Risk Management Framework. Reporting is via commissioning team report to Quality Patient Safety Committee report and SLA meetings with provider. The investigation will lead to on to the following possible outcomes: • Action plan and monitoring are completed within the allocated timeframe, evidence of progress and assurance the concern has been addressed. De-escalation to Level 1 for ongoing monitoring. • If the action plan is not adhered to and further concerns are raised by the Commissioning team or by the provider team or further concerns are identified it may be necessary to move to Level 3 Escalated Measures
Level 3 ESCALATED MEASURES	Where there is evidence that the Action Plan developed following Level 2 has failed to meet the required outcomes or a serious concern is identified a service will be placed in escalated Level 3. At this stage the quality of the service requires significant action/improvement and will require Executive input. In addition to routine reporting through QPS a formal paper will be considered by the WHSSC Corporate Directors Group (CDG) and an Executive Lead nominated. Formal notification will be sent to the provider re the Level of escalation and a request made for an Executive lead from the provider to be identified. An initial meeting will be set up as soon as possible dependant on the severity of the concern. Meetings should take place at least monthly thereafter or more frequently if determined necessary with jointly agreed objectives. Provider representation will depend on the nature of the issue but the meetings should ideally comprise of the following personnel as a minimum: • Chair (WHSSC Executive Lead) • Associate Medical Director - Commissioning Team • Senior Planning Lead – Commissioning Team • WHSSC Head of Quality • Executive Lead from provider Health Board/Trust • Clinical representative from provider Health Board/Trust • Management representative from provider Health Board/Trust An agreed agenda should be shared prior to the meeting with a request for evidence as necessary. At the conclusion of the meeting a clear timeline for agreed actions will be identified for future monitoring and confirmed in writing if appropriate. Reporting will be through commissioning team to QPS Committee. Consideration of entry on the risk register and summary of services in escalation table for Chairs report to Joint Committee. Consideration to involve and have a discussion with Welsh Government may be considered appropriate at this stage. If there is ongoing concern relating patient care and safety with no clear progress then further escalation will be required to Level 4. On the other hand if progress is made through the escalation Level 3 evidence of this should be presented to CDG/QPS and a formal decision made with the provider to de-escalate to Level 2.

Level 4 DECOMISSIONING/OUTSOURCING	Where services have been unable to meet specific targets or demonstrate evidence of improvement a number of actions need to be considered at this stage. This stage will require notification and involvement of the WHSSC Managing Director and CEO from the provider organisation. Both Quality Patient Safety Committee and Joint Committee should be cited on the level of escalation. The following areas will need to be considered and the most appropriate sanction applied to help resolve the issue: 1. De-commissioning of the service 2. Outsourcing from an alternative provider. This may be permanent or temporary 3. Contractual realignment to take into account the potential need to maintain and agree an alternative provider. Involvement with Welsh Government and the Community Health Council is critical at this stage as often there are political drivers and levers that need to be considered and articulated as part of the decision making. Moving in and out of escalation and between Levels In addition to the Levels described above the process has introduced a traffic light guide within each level. The purpose of this is to help demonstrate the direction of travel within the level. It sets out an approach to help identify progress within the level and lays out the steps required for movement either upwards (escalation) or downwards (de-escalation) through the level. At every stage a red, amber or green colour will be applied to the level to illustrate whether more or less intervention is in place. Red being a higher level of intervention moving down to green. It will also help determine the easing of the escalated measures described and inform movement within the stages of escalation. As the evidence and understanding of the risks from a provider and commissioner become evident decisions can be made to reduce the level of intervention or there may be a need to reintroduce intervention should conditions worsen and trigger the re-introduction of measures if progress is unacceptable. In this way organisations will be able to understand what is being asked of them, progress will be easily identified and it will help avoid any confusion. It will also help in the reporting to provide assurance that action is being taken to meet the agreed timescales.



SERVICES IN ESCALATION

Level of escalation reducing / improving position

Level of escalation unchanged from previous report/month

Welsh Health Specialised Services Commissioning

NEWSLETTER

4th Edition, Spring/ Summer 2023

GIG CYMRU NHS WALES
Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru
Welsh Health Specialised Services Committee

This is the 4th edition of the Quality newsletter from the Welsh Health Specialised Services team in Wales. Our plan is for these to be published on a quarterly basis to supplement reports and data already provided through different forums into Welsh Health Boards.

This gives an overview of some of the work we are involved with, and presents some of the highlights from a commissioning perspective. The services commissioned from WHSSC are provided both in Wales and in England; this will only provide a snapshot of our work. Permission has been provided for the content included.

This Newsltter is available in Welsh on request.
Mae'r Cylchlythyr hwn ar gael yn Gymraeg ar gais.

GIG CYMRU NHS WALES
Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru
Welsh Health Specialised Services Committee

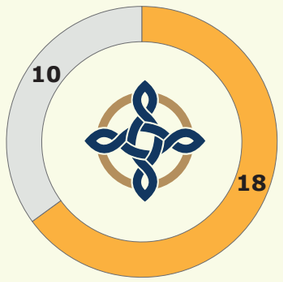
Contents

WHSSC - Newsletter *4th Edition, Spring/ Summer 2023*

Reporting

WHSSC do not investigate incidents but are responsible for supporting the investigations into these alongside the monitoring and reporting to the Health Boards. WHSSC are responsible for ensuring the delivery of safe services and ensure that trends or themes arising from concerns have actions plans which are completed and support learning. WHSSC facilitates the continued monitoring of commissioned services and work with providers when issues arise.

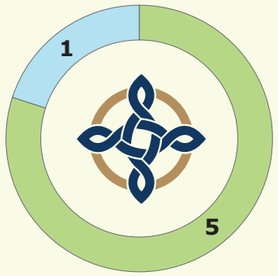
Between the periods of January to June 2023, there were ***18*** Patient Safety Incidents and ***10*** Early Warning Notifications logged.



10
Early Warning Notifications

18
Incidents

Between the periods of January to June 2023, there were ***5*** Patient Safety Incidents and ***1*** Early Warning Notifications logged.



1
Early Warning Notifications

5
Incidents

Concerns

Incidents

Putting Things Right

Complaints

Concerns raised with WHSSC may involve a direct response from the organisation or involve a joint response with the commissioning Health Board or WHSSC may need to ask the Health Board to respond directly.

GIG CYMRU NHS WALES

GIG CYMRU NHS WALES
Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru
Welsh Health Specialised Services Committee

Update from the Patient Care Team IPFR (Individual Patient Funding Request)

The Patient Care Team receives and manages individual patient funding requests for healthcare that falls outside of agreed range of services.

An overview of IPFRs processed in Quarter 4 2022-23 and Quarter 1 2023-24:

	Number of Requests discussed as Chairs Actions	Number of Requests discussed by All Wales IPRF Panel
January 2023	7	9
February 2023	2	12
March 2023	1	12
April 2023	0	14
May 2023	8	12
June 2023	7	11

Rare Disease Day - 28th February 2023

On Rare Disease Day, a new App was unveiled by Health and Social Services Minister Eluned Morgan. The Care and Respond app has been developed in Wales by Science & Engineering Applications Ltd, in collaboration with various patient groups and the NHS, with Welsh Government funding to support clinical decision making in cases of emergency and other time critical situations.

The Welsh Government is currently implementing the Wales Rare Diseases Action Plan, and funding the UK's first SWAN (Syndrome Without a Name) Clinic, based at the University Hospital of Wales, in Cardiff.

Care and Respond

Click the picture to be taken to the Care and Respond website.

Scan the QR code/ click on it to be taken to the Wales Rare Diseases Action Plan 2022-2026.

Medical Devices Swansea Bay's Rehabilitation Engineering Unit (MPCE)/Artificial Limb and Appliance Service (ALAS)

Swansea Bay's Rehabilitation Engineering Unit (MPCE) recently had an article published in Scope, the member magazine of the Institute of Physics and Engineering in Medicine (IPEM).

The article reflects the approach in Swansea to achieving Medical Devices Regulations compliance through implementation of quality management systems within individual services (including Swansea's Artificial Limb and Appliance Service), and direction and coordination through the Health Board wide 'MDR Assurance Group'.

The work of the Health Education and Improvement Wales (HEIW) MDR Group is also referenced, plus how Swansea has recently collaborated with BCUHB regarding 'MDR Preparedness' and the benefits of cross-Health Board collaboration (i.e. sharing of specialist knowledge, efficient ways of working, aligned approaches) to reduce the corporate and operational risks, including of commissioned services.

Scan the QR code/ click on it to be taken to the Summer edition of Scope which features this excellent article (page 32)!

QuicDNA

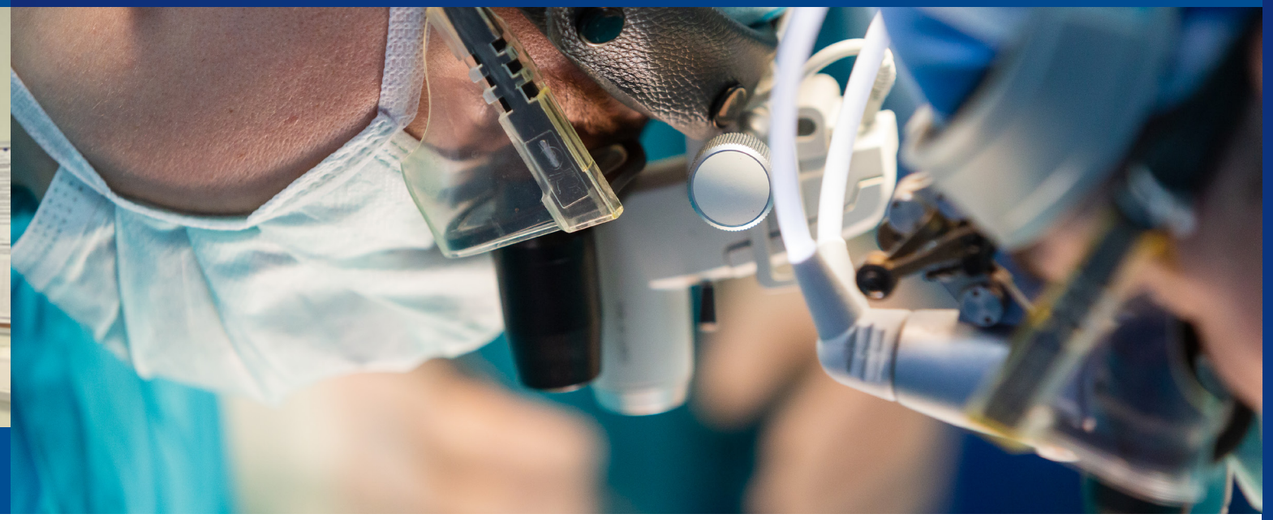
From left to right: Charles Janczewski, Dr Magda Meissner, Eluned Morgan MS, Sian Morgan

QuicDNA is a clinical trial that will evaluate the benefits of an innovative liquid biopsy test in people with suspected lung cancer. The trial will look at how the use of the liquid biopsy test earlier in the diagnostic process could improve and speed up diagnosis, reduce the time between diagnosis and treatment, and eventually inform how the technology can be used for other types of cancer.

The Minister for Health and Social Services Eluned Morgan MS visited the Institute of Medical Genetics at University Hospital of Wales to learn more about the launch of the QuicDNA clinical trial.

QuicDNA was presented by Sian Morgan at the Thoracic Education Event hosted by Wales Cancer Network on 19th May. In the future, QuicDNA has the potential to provide a simple, accessible and reliable means of investigating suspected cancer, screen asymptomatic cancer patients and less invasive monitoring for cancer recurrence.

Living Donor Transplant



Dr Doruk Elker, Clinical Lead for Transplantation has shared the fantastic success of the Living Kidney Donor (LKD) Transplant Program.

41 living kidney donor transplants were completed in the 2021/22 financial year and is the highest number of living donor transplants the team have done in Cardiff in a decade! In addition, 5 living donor nephrectomies were completed, of which four were non-directed altruistic donors. Two children were transplanted in Bristol after the donor and recipient work-ups were completed in Cardiff. The team are encouraged that this strong activity will continue as there are 14 LKD transplants already booked until mid-July with many more in the planning stages.

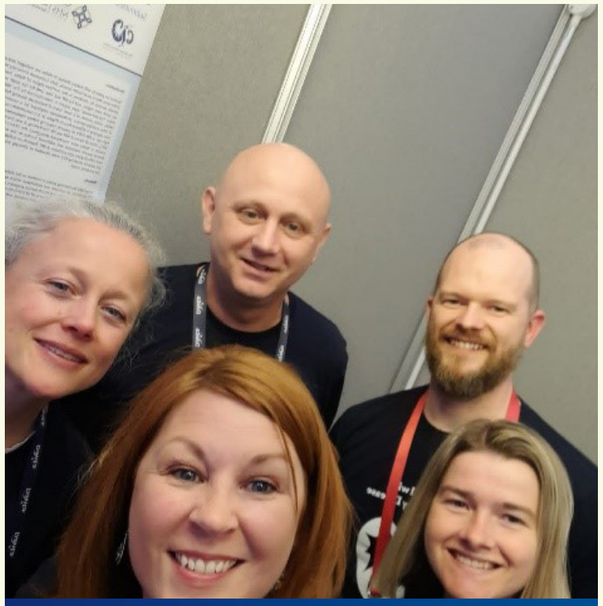
> “Congratulations to the Live Donor team and the wider transplant team for their dedication and commitment to make this happen for the patients and their families.”
>
> We also thank our Nephrology colleagues for educating CKD patients and their families about the benefits of living kidney donation and referring them in a timely fashion. This is reflected in the latest NHSBT report which demonstrates that Cardiff Transplant Unit has the highest rate of pre-emptive living donor kidney transplants in the UK.”
>
> **Dr Elker**

An amazing achievement, we are sure you will agree!

UK Kidney Conference

The Welsh Kidney Network were one of the many exhibition stands represented at the UK Kidney Association's 'UK Kidney Week' (UKKW) event which is an annual occurrence and the largest UK Conference event for Kidney Professionals. 2023's event was hosted at the ICC Newport on the 5th-7th June.

This was the first time that this national event had been hosted in Wales and a number of the WKN's clinical leads were able to promote the excellent work going on across our nation, from Transplantation to Home Therapies, Digital infrastructure to Workforce audits. This, alongside the Welsh Minister for Health and Social Care services' Key Note speech in which the WKN were highly commended, led to a number of delegates visiting the Network's exhibition stand during the event.



From left to right: Sarah McMillan, AnnMarie Pritchard, Richard Davies, Jonathan Matthews, Jennifer Holmes

Our Kidney Network is built on quality, best practice, technology and innovation, placing patients at the heart of everything we do.

Rhwydwaith Arennau Cymru
Welsh Kidney Network

WHSSC - Newsletter *4th Edition, Spring/ Summer 2023*

International Nurses Day and International Day of the Midwife

WHSSC Patient Care and Quality Teams displayed memorabilia to celebrate International Nurses Day and International Day of the Midwife collectively. A massive thank you to Theresa Williams of the Patient Care Team for baking cupcakes and Welsh cakes!

The Walton Centre

The Walton Centre have launched a six stage process The 'Six WALTON Steps' highlighting their vision of an excellent Patient and Family Journey. Through feedback, they have developed a shared vision for the ideal patient and family experience at The Walton Centre and included initiatives such as pet therapy across the trust, music sessions and Easter eggs delivered by the senior nursing team on Easter Sunday.

Duty of Quality

The Duty of Quality forms part of The Health and Social Care (Quality and Engagement) (Wales) Act 2020 and WHSSC demonstrate how they are meeting the Act:

Domains of Quality (**STEEEP**)
Framework to assess quality and guide improvement.

- Safe
- Timely
- Effective
- Efficient
- Equitable
- Person- centred

Evidencing the Duty of Quality

- Make use of existing performance, outcome and delivery indicators and measures where possible
- Patient and staff experience, information and stories
- Reports from inspectorate and licensing bodies
- Consideration of national clinical audits, reports, inquiries

Reporting to support Annual Quality Report

- Bimonthly QPS Chairs Report to Joint Committee
- Summary of Services in Escalation Trajectory
- Quarterly bilingual Quality newsletter
- Six monthly Innovation & Improvement Report
- QPS & WHSSC Annual Report
- Integrated Commissioning Plan (ICP)
- Incorporate STEEEP into all reporting templates
- Quarterly report to QPS to monitor progress

Scan the QR code/ click on it to be taken to The Duty of Quality Statutory Guidance 2023 and Quality Standards 2023.

WHSSC - Newsletter *4th Edition, Spring/ Summer 2023*

South Wales Blood and Marrow Transplant (SWBMT) Programme

St David's Day 2023 marked the 40th anniversary of the first stem cell transplant performed in Wales on 1st March 1983.

A celebratory event was held on 24th June to honour Dr Jack Whittaker who started the transplant programme, as well as other key founding members.

Dathlu 40 mlynedd: 1983-2023
Celebrating 40 years: 1983-2023
TGMDC SWBMT 40

FAST Stroke Campaign

Awareness campaign ran at the end of April and included TV, video on demand, radio and social media advertising, as well as coverage in the Welsh media. The campaign aimed to raise awareness of the signs of stroke and increase knowledge of stroke as a medical emergency.

Stroke is the fourth single leading cause of death in the UK and the single largest cause of complex disability. Increased awareness of the FAST acronym has been shown to lead to patients seeking prompt help for stroke symptoms. Early treatment not only saves lives but results in a greater chance of a better recovery.

Thoracic Education Event

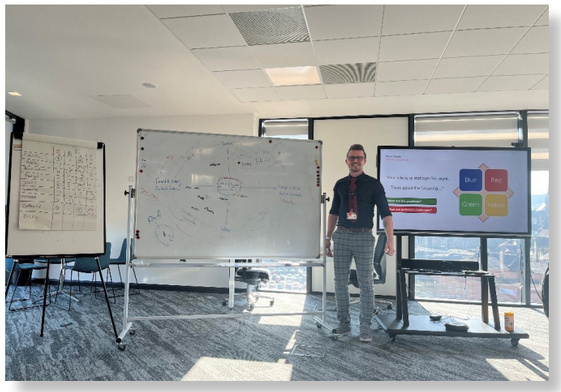
The Wales Cancer Network held the Annual Welsh Thoracic Oncology Group Education Event on Friday 19th May and was attended by a wide range of MDT members. Among the topics presented were Lung Cancer Screening, Sublobar Resections, Robotics and Genomics.

A big thank you to Rhiannon Parker, Events Manager for The Wales Cancer Network for providing the pictures!

GIG CYMRU NHS WALES | Rhwydwaith Canser Cymru | Wales Cancer Network

Patient Care and Quality Team Development Day

WHSSC Patient Care and Quality Teams attended a Team Development Day in February in collaboration with Transport for Wales (TfW). Mark Hector, Training and Development Manager at TfW was an excellent Facilitator in the Jigsaw Discovery Tool and the Team look forward to future collaboration opportunities!

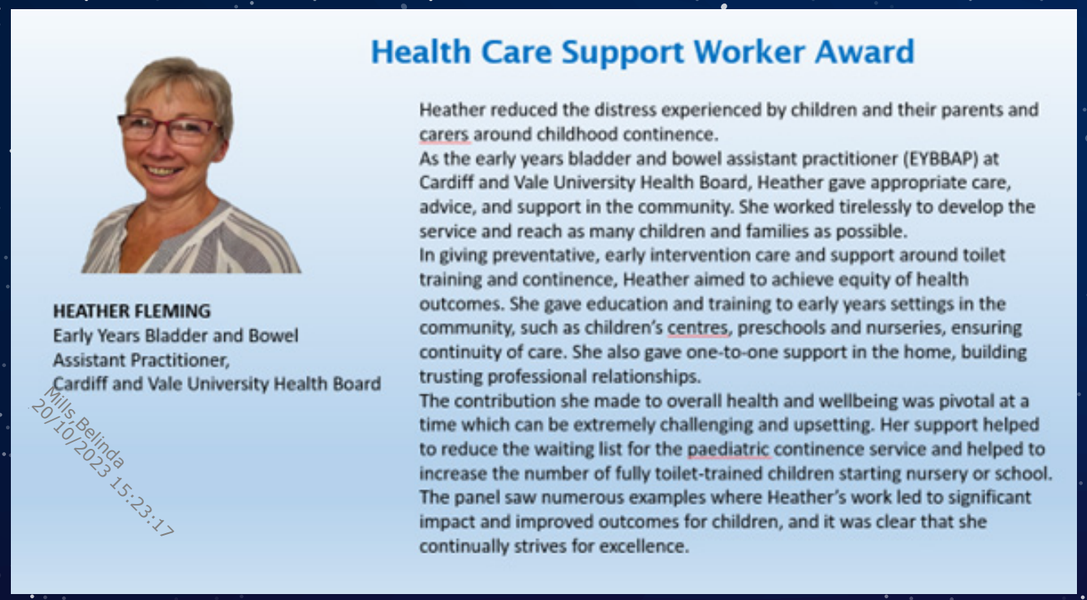


RCN Awards 2023

From left to right: Krysta Hallewell, Emma King, Debra Davies, Kate Eden, Leanne Amos, Jason Mohammad, Vicki Dawson-John, Kirsty John

The annual Royal College of Nursing awards took place on 29th June at City Hall, Cardiff. WHSSC sponsors the Health Care Support Worker (HCSW) award and a number of WHSSC staff attend the award ceremony along with Kate Eden (Chair). The award is open to any Health Care Support Worker who is delegated work directly by a Registered Nurse, Midwife or Health Visitor in any setting, who has demonstrated commitment to providing high standards of nursing and midwifery care.

A huge congratulations to the winner, Heather Fleming, and also to the runner-up, Kelly Brown!



Health Care Support Worker Award

HEATHER FLEMING
Early Years Bladder and Bowel Assistant Practitioner,
Cardiff and Vale University Health Board

Mills Belinda 20/10/2023 15:23:17

Heather reduced the distress experienced by children and their parents and carers around childhood continence.
As the early years bladder and bowel assistant practitioner (EYBBAP) at Cardiff and Vale University Health Board, Heather gave appropriate care, advice, and support in the community. She worked tirelessly to develop the service and reach as many children and families as possible.
In giving preventative, early intervention care and support around toilet training and continence, Heather aimed to achieve equity of health outcomes. She gave education and training to early years settings in the community, such as children's centres, preschools and nurseries, ensuring continuity of care. She also gave one-to-one support in the home, building trusting professional relationships.
The contribution she made to overall health and wellbeing was pivotal at a time which can be extremely challenging and upsetting. Her support helped to reduce the waiting list for the paediatric continence service and helped to increase the number of fully toilet-trained children starting nursery or school.
The panel saw numerous examples where Heather's work led to significant impact and improved outcomes for children, and it was clear that she continually strives for excellence.

Quick Round up of Commissioning Teams

Mental Health and Vulnerable Groups

5 year Mental health strategy ongoing. Review of current services and further development of these underway.

Women and Children's

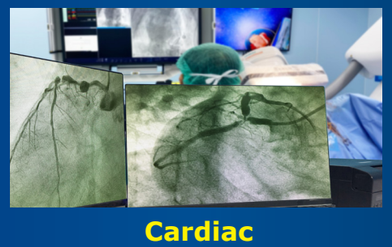
IVF Service Improvement and Innovation Day currently being planned.

Neurosciences and long term condition

All Wales strategy to improve outcomes and experience of patients receiving specialised rehabilitation is underway.

Cancer and Blood

Thoracic, Inherited Bleeding Disorder and Immunology Service Improvement and Innovation Days are currently being planned.



Cardiac

Evaluation and actions being taken forward from service developments such as dashboards for clinical practice reporting.

Intestinal Failure

Ongoing work being undertaken with the recently formed IF commissioning team and as a result of the IF review and Service Improvement and Innovation Day.

Specialised Services

Strategy is underway.

GIG CYMRU NHS WALES

Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru

Welsh Health Specialised Services Committee

Recognition of Significant Events and Thank you's

"

An excellent news story was published - The North Wales Adolescent Service (NWAS) has been awarded a Kitemark!

The National Participation Standards Kitemark, which is awarded by youngsters, is achievable for organisations who prove they are achieving against the National Standards.

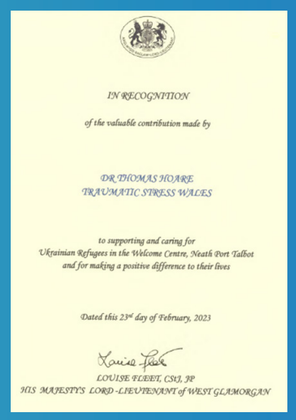
Scan the QR code/click on it to be taken to the news story!

"

Dr Thomas Hoare received recognition from the Lord Lieutenant of West Glamorgan and Penny Nurse, Project Manager for Traumatic Stress Wales said

"Congratulations Tom – this is well deserved and you should be VERY proud."

The entire team here at WHSSC agree!



IN RECOGNITION

of the valuable contribution made by

DR THOMAS HOARE
TRAUMATIC STRESS WALES

to supporting and caring for
Ukrainian Refugees in the Welcome Centre, Neath Port Talbot
and for making a positive difference to their lives

Dated this 23rd day of February, 2023

LOUISE FUDET, CSO, JP
HIS MAJESTY'S LORD-LIEUTENANT of WEST GLAMORGAN

Mills Belinda 20116 2023.15:23:17

WHSSC - Newsletter *4th Edition, Spring/ Summer 2023*

Useful Links

Adult Congenital Heart Disease (ACHD) Newsletter

The Winter and Spring versions of the ACHD Newsletter are available here:

PDF

Click the PDF to open the document.

PDF

HEIW Nursing Workforce Plan Newsletter

HEIW produce a quarterly Workforce Plan Newsletter and the Spring edition is now available.

Scan the QR code/ click on it to be taken to the newsletter.

Mesothelioma UK Magazine

Mesothelioma UK are a support group who publish a quarterly magazine and the latest edition and archive can be accessed here:

Scan the QR code/ click on it to be taken to the newsletter.

Perinatal Mental Health Network Newsletter

The April Perinatal Mental Health Network Newsletter is available here:

Scan the QR code/ click on it to be taken to the newsletter.

GIG CYMRU NHS WALES | Partneriaeth Cydwasanaethau Shared Services Partnership

Welsh Health Services Specialised Commissioning

NEWSLETTER

GIG CYMRU NHS WALES | Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru
Welsh Health Specialised Services Committee

Whssc.nhs.wales

Spring/Summer 2023

For queries or detail on any aspect within this Newsletter, contact **Adele Roberts,** Head of Patient Safety and Quality, or **Leanne Amos**, Quality Administration Support Officer.

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