Comisiynu Gwasanaethau Iechyd Arbenigol Cymru

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

CYLCHLYTHYR

4ydd Argraffia, Gwanwyn/ Haf 2023

Dyma'r 4ydd rhifyn o'r cylchlythyr Ansawdd gan dîm Gwasanaethau Iechyd Arbenigol Cymru yng Nghymru. Ein cynllun yw cyhoeddi'r rhain bob chwarter i ategu adroddiadau a data a ddarparwyd eisoes drwy wahanol fforymau i Fyrddau Iechyd Cymru.

Mae hwn yn rhoi trosolwg o rywfaint o'r gwaith yr ydym yn ymwneud ag ef, ac yn cyflwyno rhai o'r uchafbwyntiau o safbwynt comisiynu. Darperir gwasanaethau a gomisiynir gan PGIAC yng Nghymru ac yn Lloegr; bydd hwn yn rhoi cipolwg ar ein gwaith yn unig. Rhoddwyd caniatâd ar gyfer y cynnwys sydd wedi'i gynnwys.

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

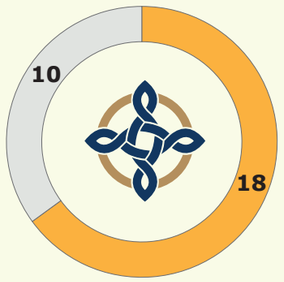
Cynnwys

PGIAC - Cylchlythyr 4ydd Edition, Argraffiad, Gwanwyn/ Haf 2023

Adrodd

Nid yw PGIAC yn ymchwilio i ddigwyddiadau ond mae'n gyfrifol am gefnogi'r ymchwiliadau i'r rhain ochr yn ochr â monitro ac adrodd i'r Byrddau Iechyd. Mae PGIAC yn gyfrifol am sicrhau bod gwasanaethau diogel yn cael eu darparu a sicrhau bod gan dueddiadau neu themâu sy'n codi o bryderon gynlluniau gweithredu sy'n cael eu cwblhau ac sy'n cefnogi dysgu. Mae PGIAC yn hwyluso monitro parhaus gwasanaethau a gomisiynir ac yn gweithio gyda darparwyr pan fydd materion yn codi.

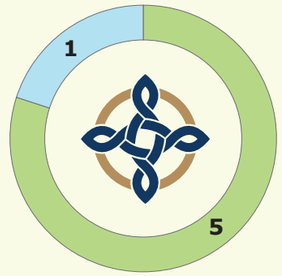
Rhwng y cyfnodau o fis Ionawr i fis Mehefin 2023, cofnodwyd ***18*** Digwyddiad Diogelwch Cleifion a ***10*** Hysbysiad Rhybudd Cynnar.



10
Hysbysiadau Rhybudd Cynnar

18
Digwyddiadau

Rhwng y cyfnodau o fis Ionawr i fis Mehefin 2023, cofnodwyd ***5*** Digwyddiad Diogelwch Cleifion a ***1*** Hysbysiad Rhybudd Cynnar.



1
Hysbysiadau Rhybudd Cynnar

5
Digwyddiadau

Pryderon

Digwyddiadau

Gweithio i Wella

Cwynion

Gall pryderon a godir gyda PGIAC gynnwys ymateb uniongyrchol gan y sefydliad neu gynnwys ymateb ar y cyd â'r Bwrdd Iechyd sy'n comisiynu neu efallai y bydd angen i PGIAC ofyn i'r Bwrdd Iechyd ymateb yn uniongyrchol.

GIG CYMRU NHS WALES

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

Diweddariad gan y Tîm Gofal Cleifion IPFR (Ceisiadau Cyllido Cleifion Unigol)

Mae'r Tîm Gofal Cleifion yn derbyn ac yn rheoli ceisiadau cyllido cleifion unigol am ofal iechyd sydd y tu allan i'r ystod gytunedig o wasanaethau.

Trosolwg o Geisiadau Cyllido Cleifion Unigol a broseswyd yn Chwarter 4 2022-23 a Chwarter 1 2023-24:

	Nifer y Ceisiadau a drafodwyd fel Camau Gweithredu Cadeiryddion	Nifer y Ceisiadau a drafodwyd gan Banel IPFR Cymru Gyfan
Ionawr 2023	7	9
Chwefror 2023	2	12
Mawrth 2023	1	12
Ebrill2023	0	14
Mai 2023	8	12
Mehefin 2023	7	11

Diwrnod Clefydau Prin - 28ain Chwefror 2023

Ar Ddiwrnod Clefydau Prin, dadorchuddiwyd Ap newydd gan y Gweinidog Iechyd a Gwasanaethau Cymdeithasol, Eluned Morgan. Datblygwyd yr ap Gofal ac Ymateb yng Nghymru gan Science & Engineering Applications Ltd, mewn cydweithrediad ag amrywiol grwpiau cleifion a'r GIG, gyda chyllid gan Lywodraeth Cymru i gefnogi'r broses o wneud penderfyniadau clinigol mewn achosion o argyfwng a sefyllfaoedd eraill sy'n hanfodol o ran amser.

Ar hyn o bryd mae Llywodraeth Cymru yn gweithredu Cynllun Gweithredu Clefydau Prin Cymru, ac yn ariannu Clinig SWAN (Syndrome Without a Name) cyntaf y DU, sydd wedi'i leoli yn Ysbyty Athrofaol Cymru, yng Nghaerdydd.

Care and Respond

Cliciwch ar y llun i fynd â chi i wefan Care and Respond.

Sganiwch y cod QR/ cliciwch arno i fynd â chi i Gynllun Gweithredu Clefydau Prin Cymru 2022-2026.

Dyfeisiau Meddygol Uned Peirianneg Adsefydlu Bae Abertawe (MPCE)/ Gwasanaeth Aelodau Artiffisial a Chyfarpar (ALAS)

Yn ddiweddar, cyhoeddwyd erthygl yn Scope, sef cylchgrawn aelodau'r Sefydliad Ffiseg a Pheirianneg mewn Meddygaeth (IPEM) gan Uned Peirianneg Adsefydlu Bae Abertawe.

Mae'r erthygl yn adlewyrchu'r dull yn Abertawe o gyflawni cydymffurfiaeth Rheoliadau Dyfeisiau Meddygol (MDR) drwy weithredu systemau rheoli ansawdd o fewn gwasanaethau unigol (gan gynnwys Gwasanaeth Aelodau Artiffisial a Chyfarpar (ALAS), a chyfeiriad a chydlynu drwy 'Grŵp Sicrwydd MDR' ledled y Bwrdd Iechyd.

Cyfeirir hefyd at waith Grŵp MDR Addysg a Gwella Iechyd Cymru (AaGIC), yn ogystal â sut mae Abertawe wedi cydweithio'n ddiweddar â Bwrdd Iechyd Prifysgol Betsi Cadwaladr (BIPBC) ynghylch 'Parodrwydd ar gyfer MDR' a manteision cydweithredu ar draws Byrddau Iechyd (h.y. rhannu gwybodaeth arbenigol, ffyrdd effeithlon o weithio, dulliau cyd-alinio) i leihau'r risgiau corfforaethol a gweithredol, gan gynnwys gwasanaethau a gomisiynwyd.

Sganiwch y cod QR/ cliciwch arno i fynd â chi i rifyn yr Haf o Scope sy'n cynnwys yr erthygl ardderchog hon (tudalen 32)!

QuicDNA

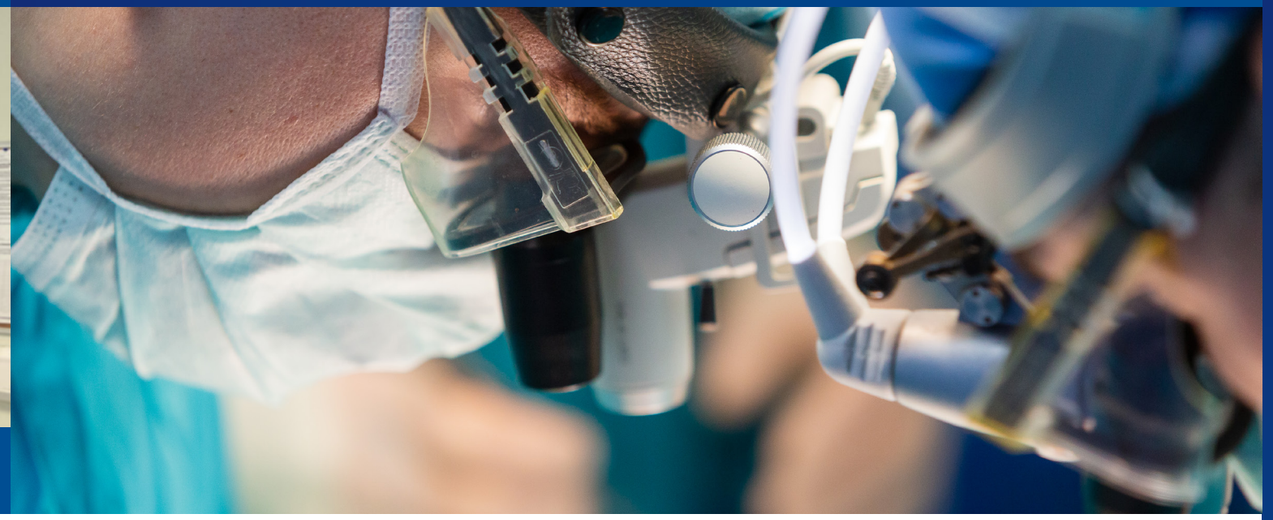
O'r chwith i'r dde: Charles Janczewski, Dr Magda Meissner, Eluned Morgan MS, Sian Morgan

Mae QuicDNA yn dreial clinigol a fydd yn gwerthuso buddion prawf biopsi hylif arloesol mewn pobl sydd ag amheuaeth o ganser yr ysgyfaint. Bydd y treial yn edrych ar sut y gallai defnyddio'r prawf biopsi hylif yn gynharach yn y broses ddiagnostig wella a chyflymu'r diagnosis, lleihau'r amser rhwng diagnosis a thriniaeth, ac yn y pen draw hysbysu sut y gellir defnyddio'r dechnoleg ar gyfer mathau eraill o ganser.

Ymwelodd y Gweinidog Iechyd a Gwasanaethau Cymdeithasol, Eluned Morgan AS, â'r Sefydliad Geneteg Feddygol yn Ysbyty Athrofaol Cymru i ddysgu mwy am lansiad treial clinigol QuicDNA.

Cyflwynwyd QuicDNA gan Sian Morgan yn y Digwyddiad Addysg Thorasig a gynhaliwyd gan Rwydwaith Canser Cymru ar 19 Mai. Yn y dyfodol, mae gan QuicDNA y potensial i ddarparu dull syml, hygyrch a dibynadwy o ymchwilio i ganserau amheuir, sgrinio cleifion canser asymptomatig a monitro llai ymledol ar gyfer dychweliad canser.

Trawsblaniad Rhoddwyr Byw



Mae Dr Doruk Elker, Arweinydd Clinigol Trawsblannu wedi rhannu llwyddiant gwych Rhaglen Trawsblannu Rhoddwyr Arennau Byw (LKD).

Cwblhawyd 41 trawsblaniad rhoddwyr arennau byw ym mlwyddyn ariannol 2021/22 a dyma'r nifer uchaf o drawsblaniadau rhoddwyr byw y mae'r tîm wedi'u gwneud yng Nghaerdydd mewn degawd! Yn ogystal, cwblhawyd 5 neffrectomi rhoddwr byw, ac roedd pedwar ohonynt yn rhoddwyr anhunanol heb eu cyfeirio. Cafodd dau o blant eu trawsblannu ym Mryste ar ôl i'r rhoddwyr a'r derbynnydd gael eu datblygu yng Nghaerdydd. Anogir y tîm y bydd y gweithgaredd cryf hwn yn parhau gan fod 14 trawsblaniad LKD eisoes wedi'u bwcio tan ganol mis Gorffennaf gyda llawer mwy yn y camau cynllunio.

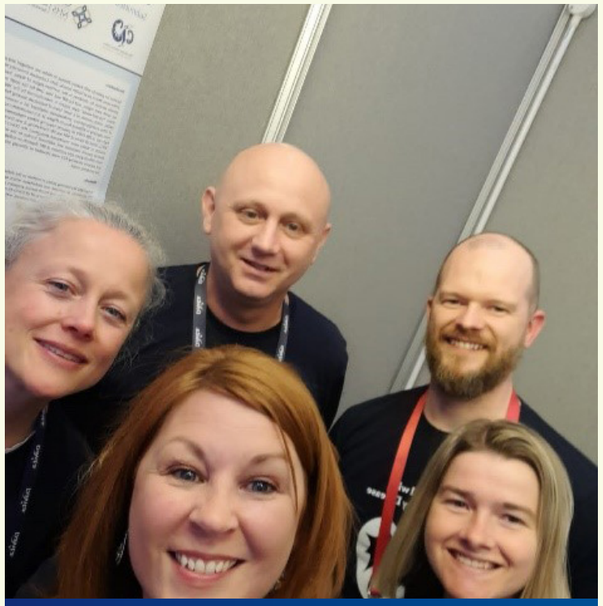
> "Llongyfarchiadau i'r tîm Rhoddwyr Byw a'r tîm trawsblannu ehangach am eu hymroddiad a'u hymrwymiad i wneud i hyn ddigwydd i'r cleifion a'u teuluoedd."
>
> Rydym hefyd yn diolch i'n cydweithwyr Neffroleg am addysgu cleifion clefyd cronig yn yr arennau (CKD) a'u teuluoedd am fanteision rhoi arennau byw a'u cyfeirio mewn modd amserol. Adlewyrchir hyn yn adroddiad diweddaraf Gwaed a Thrawsblaniadau'r GIG (NHSBT) sy'n dangos mai Uned Trawsblannu Caerdydd sydd â'r gyfradd uchaf o drawsblaniadau arennau rhoddwyr byw rhagataliol yn y DU."
>
> **Dr Elker**

Cyflawniad anhygoel, rydym yn siŵr y byddwch yn cytuno!

Cynhadledd UK Kidney

Roedd Rhwydwaith Arennau Cymru yn un o'r nifer o stondinau arddangos a gynrychiolir yn nigwyddiad 'UK Kidney Week' (UKKW) Cymdeithas Arennau'r DU sy'n ddigwyddiad blynyddol a'r digwyddiad Cynhadledd fwyaf yn y DU ar gyfer Gweithwyr Proffesiynol Arennau. Cynhaliwyd digwyddiad 2023 yn ICC Casnewydd ar 5 - 7 Mehefin.

Dyma'r tro cyntaf i'r digwyddiad cenedlaethol hwn gael ei gynnal yng Nghymru a gallodd nifer o arweinwyr clinigol y Rhwydwaith Arennau Cymru (WKN) hyrwyddo'r gwaith rhagorol sy'n digwydd ar draws ein cenedl, o Drawsblannu i Therapïau Cartref, Seilwaith Digidol i archwiliadau Gweithlu. Arweiniodd hyn, ochr yn ochr â Phrif araith Gweinidog Iechyd a Gofal Cymdeithasol Cymru, lle canmolwyd WKN yn fawr, at nifer o gynrychiolwyr yn ymweld â stondin arddangosfa'r Rhwydwaith yn ystod y digwyddiad.



O'r chwith i'r dde: Sarah McMillan, AnnMarie Pritchard, Richard Davies, Jonathan Matthews, Jennifer Holmes

Mae ein rhwydwaith arennau wedi'i adeiladu ar ansawdd, arfer gorau, technoleg ac arloesedd, gan osod cleifion wrth wraidd popeth a wneir gennym.

Rhwydwaith Arennau Cymru
Welsh Kidney Network

Diwrnod Rhyngwladol y Nyrsys a Diwrnod Rhyngwladol y Fydwraig

Roedd timau Gofal ac Ansawdd Cleifion PGIAC yn arddangos trugareddau o'r gorffennol i ddathlu Diwrnod Rhyngwladol y Nyrsys a Diwrnod Rhyngwladol y Fydwraig. Diolch yn fawr iawn i Theresa Williams o'r Tîm Gofal Cleifion am bobi cacennau bach a chacennau cri!

Canolfan Walton

Mae Canolfan Walton wedi lansio proses chwe cham, sef 'The Six WALTON Steps' sy'n tynnu sylw at eu gweledigaeth o Daith Cleifion a Theuluoedd rhagorol. Trwy adborth, maent wedi datblygu gweledigaeth ar y cyd ar gyfer y profiad delfrydol i gleifion a'u teuluoedd yng Nghanolfan Walton ac wedi cynnwys mentrau fel therapi anifeiliaid anwes ar draws yr Ymddiriedolaeth, sesiynau cerddoriaeth ac wyau Pasg a ddarperir gan yr uwch dîm nyrsio ar Sul y Pasg.

Dyletswydd Ansawdd

Mae'r Ddyletswydd Ansawdd yn rhan o Ddeddf Iechyd a Gofal Cymdeithasol (Ansawdd ac Ymgysylltu) (Cymru) 2020 ac mae PGIAC yn dangos sut maent yn bodloni'r Ddeddf:

Sganiwch y cod QR/ cliciwch arno i fynd â chi i Ganllawiau Statudol y Ddyletswydd Ansawdd 2023 a Safonau Ansawdd 2023.

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

PGIAC - Cylchlythyr 4ydd Edition, Argraffiad, Gwanwyn/ Haf 2023

Rhaglen Trawsblannu Gwaed a Mêr Esgyrn De Cymru (SWBMT)

Roedd Dydd Gŵyl Dewi 2023 yn nodi 40 mlynedd ers y trawsblaniad bôn-gelloedd cyntaf a berfformiwyd yng Nghymru ar 1af Mawrth 1983.

Cynhaliwyd digwyddiad dathlu ar 24 Mehefin i anrhydeddu Dr Jack Whittaker a ddechreuodd y rhaglen drawsblannu, yn ogystal â sefydlwyr allweddol eraill.

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

Ymgyrch Strôc FAST

Cynhaliwyd ymgyrch ymwybyddiaeth ddiwedd mis Ebrill ac roedd yn cynnwys y teledu, fideo ar alw, hysbysebu ar y radio a chyfryngau cymdeithasol, yn ogystal â darllediadau yn y cyfryngau yng Nghymru. Nod yr ymgyrch oedd codi ymwybyddiaeth o arwyddion strôc a chynyddu gwybodaeth am strôc fel argyfwng meddygol.

Strôc yw'r pedwerydd prif achos marwolaeth yn y DU a'r achos unigol mwyaf o anabledd cymhleth. Dangoswyd bod mwy o ymwybyddiaeth o'r acronym FAST yn arwain at gleifion yn gofyn am gymorth prydlon ar gyfer symptomau strôc. Mae triniaeth gynnar nid yn unig yn achub bywydau ond yn arwain at fwy o siawns o wellhad.

Digwyddiad Addysg Thorasig

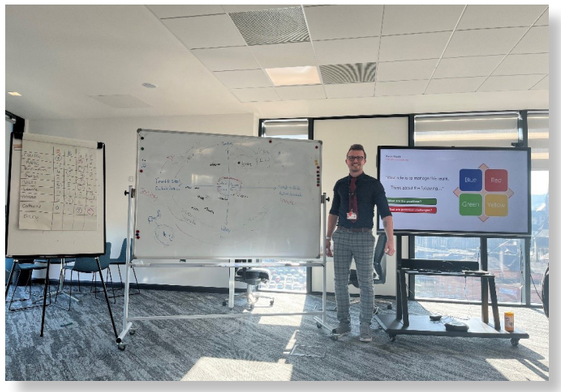
Cynhaliodd Rhwydwaith Canser Cymru Ddigwyddiad Addysg Blynyddol Grŵp Oncoleg Thorasig Cymru ddydd Gwener 19 Mai a mynychodd ystod eang o aelodau'r tîm amlddisgyblaethol (MDT). Ymhlith y pynciau a gyflwynwyd oedd Sgrinio Canser yr Ysgyfaint, Echdoriad Is-labedol, Roboteg a Genomeg.

Diolch yn fawr iawn i Rhiannon Parker, Rheolwr Digwyddiadau Rhwydwaith Canser Cymru am ddarparu'r lluniau!

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

Diwrnod Datblygu Tîm Gofal ac Ansawdd Cleifion

Mynychodd Timau Gofal Cleifion ac Ansawdd PGIAC Ddiwrnod Datblygu Tîm ym mis Chwefror mewn cydweithrediad â Thrafnidiaeth Cymru (TrC). Roedd Mark Hector, Rheolwr Hyfforddi a Datblygu TrC yn Hwylusydd ardderchog yn yr Offeryn Jigsaw Discovery ac mae'r Tîm yn edrych ymlaen at gyfleoedd i gydweithio yn y dyfodol!

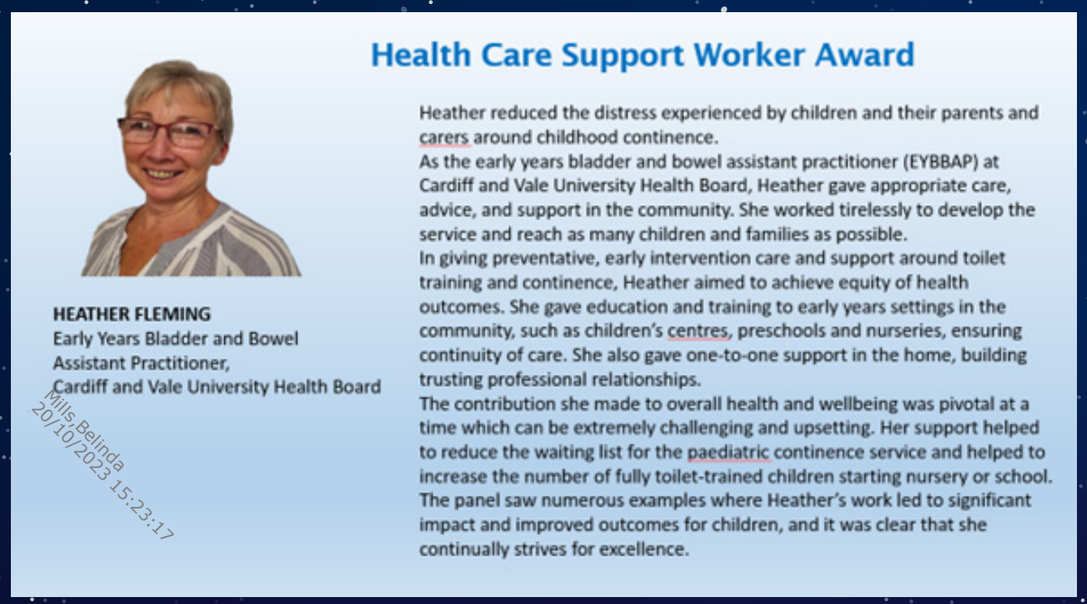


Gwobrau RCN 2023

O'r Dde i'r Chwith: Krysta Hallewell, Emma King, Debra Davies, Kate Eden, Leanne Amos, Jason Mohammad, Vicki Dawson-John, Kirsty John

Cynhaliwyd gwobrau'r Coleg Nyrsio Brenhinol blynyddol ar 29 Mehefin yn Neuadd y Ddinas, Caerdydd. Mae PGIAC yn noddi'r wobr Gweithiwr Cymorth Gofal Iechyd (HCSW) ac mae nifer o staff PGIAC yn mynychu'r seremoni wobrwyo ynghyd â Kate Eden (Cadeirydd). Mae'r wobr yn agored i unrhyw Weithiwr Cymorth Gofal Iechyd sy'n cael gwaith wedi'i ddirprwyo'n uniongyrchol gan Nyrs Gofrestredig, Bydwraig neu Ymwelydd Iechyd mewn unrhyw leoliad, sydd wedi dangos ymrwymiad i ddarparu safonau uchel o ofal nyrsio a bydwreigiaeth.

Llongyfarchiadau mawr i'r enillydd, Heather Fleming, a hefyd i'r ail, 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.

PGIAC - Cylchlythyr 4ydd Edition, Argraffiad, Gwanwyn/ Haf 2023

Newyddion Cyflym o'r Timau Comisiynu

Iechyd Meddwl a Grwpiau Agored i Niwed

Strategaeth iechyd meddwl 5 mlynedd parhaus. Adolygiad o'r gwasanaethau presennol a datblygiad pellach o'r rhain ar y gweill.

Menywod a Phlant

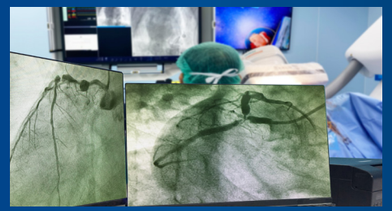
Diwrnod Gwella ac Arloesi'r Gwasanaeth IVF yn cael ei gynllunio ar hyn o bryd.

Niwrowyddorau a chyflyrau hirdymor

Strategaeth Cymru gyfan i wella canlyniadau a phrofiad cleifion sy'n cael adsefydlu arbenigol ar y gweill.

Canser a'r Gwaed

Diwrnodau Gwella ac Arloesi'r Gwasanaeth Thorasig, Anhwylder Gwaedu Etifeddol ac Imiwnoleg yn cael eu cynllunio ar hyn o bryd.



Cardiaidd

Gwerthusiad a chamau gweithredu yn cael eu datblygu o ddatblygiadau gwasanaeth fel dangosfyrddau ar gyfer adrodd ar ymarfer clinigol.

Methiant y Coluddyn

Gwaith parhaus yn cael ei wneud gyda'r tîm comisiynu Methiant y Coluddyn a ffurfiwyd yn ddiweddar ac o ganlyniad i'r adolygiad Methiant y Coluddyn a'r Diwrnod Gwella Gwasanaeth ac Arloesi.

Gwasanaethau Arbenigol

Strategaeth ar y gweill.

GIG CYMRU NHS WALES

Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru

Welsh Health Specialised Services Committee

Cydnabod Digwyddiadau Sylweddol a Diolchiadau

Cyhoeddwyd stori newyddion rhagorol – Mae Gwasanaeth Glasoed Gogledd Cymru (NWAS) wedi derbyn Nod Barcud!

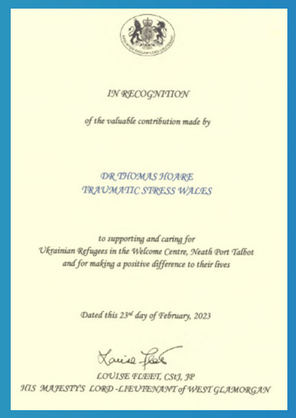
Gellir cyflawni'r Nod Barcud Safonau Cyfranogiad Cenedlaethol, a ddyfernir gan bobl ifanc, ar gyfer sefydliadau sy'n profi eu bod yn cyflawni yn erbyn y Safonau Cenedlaethol.

Sganiwch y cod QR/cliciwch arno i fynd â chi i'r stori newyddion!

Cafodd Dr Thomas Hoare gydnabyddiaeth gan yr Arglwydd Raglaw o Orllewin Morgannwg a Penny Nurse, Rheolwr Prosiect Straen Trawmatig Cymru.

"Llongyfarchiadau i Tom - mae hyn yn haeddiannol iawn a dylech fod yn falch IAWN."

Mae'r holl dîm yma yn PGIAC yn cytuno!



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

Dolenni defnyddiol

Cylchlythyr Clefyd Cynhenid y Galon Oedolion (ACHD)

Mae fersiynau Gaeaf a Gwanwyn o'r Cylchlythyr ACHD ar gael yma:

Cliciwch ar y PDF i agor y ddogfen.

Cylchlythyr Cynllun Gweithlu Nyrsio AaGIC

Mae AaGIC yn cynhyrchu Cylchlythyr chwarterol Cynllun Gweithlu ac mae rhifyn y Gwanwyn bellach ar gael.

Sganiwch y cod QR/ cliciwch arno i fynd â chi i'r cylchlythyr.

Cylchgrawn Mesothelioma UK

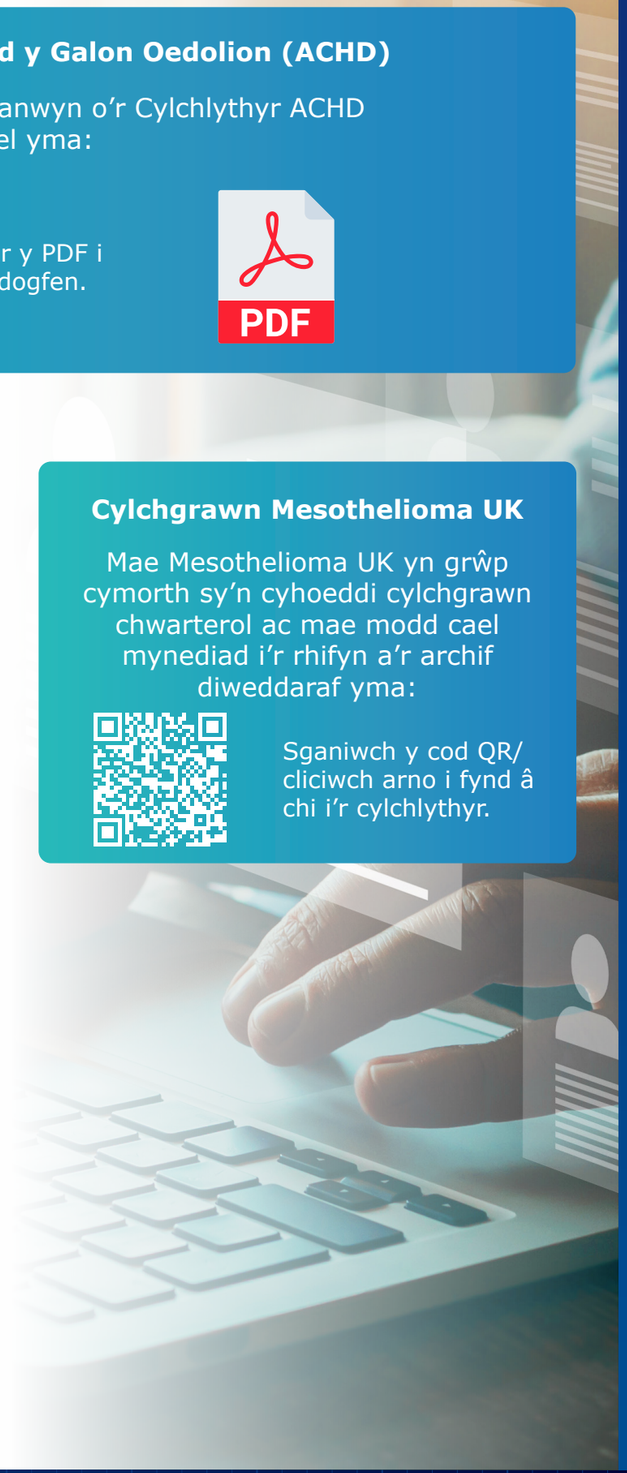
Mae Mesothelioma UK yn grŵp cymorth sy'n cyhoeddi cylchgrawn chwarterol ac mae modd cael mynediad i'r rhifyn a'r archif diweddaraf yma:

Sganiwch y cod QR/ cliciwch arno i fynd â chi i'r cylchlythyr.

Cylchlythyr Rhwydwaith Iechyd Meddwl Amenedigol

Mae cylchlythyr Rhwydwaith Iechyd Meddwl Amenedigol Ebrill ar gael yma:

Sganiwch y cod QR/ cliciwch arno i fynd â chi i'r cylchlythyr.



Comisiynu Gwasanaethau
Iechyd Arbenigol Cymru

CYLCHLYTHYR

Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru
Welsh Health Specialised Services Committee

Whssc.nhs.wales

Gwanwyn/Haf 2023

Ar gyfer ymholiadau neu fanylion am unrhyw agwedd o fewn y Cylchlythyr hwn, cysylltwch ag **Adele Roberts,** Pennaeth Diogelwch Cleifion ac Ansawdd neu **Leanne Amos**, Swyddog Cymorth Gweinyddu Ansawdd.

E-bost: Adele.Roberts@wales.nhs.uk / Leanne.Amos@wales.nhs.uk

Cynlluniwyd gan Gyfathrebu Partneriaeth Cydwasanaethau GIG Cymru

Interim Learning Report

National Nosocomial COVID-19 Programme

March 2023

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Bwrdd Iechyd Prifysgol Cardiff and Vale University Health Board

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Bwrdd Iechyd Prifysgol Bae Abertawe Swansea Bay University Health Board

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Bwrdd Iechyd Addysgu Powys Powys Teaching Health Board

Ymddiriedolaeth GIG Prifysgol Felindre Velindre University NHS Trust

Contents

The glossary of terms in section 8.2 provides more information on some of the terms used.

1. Introduction

The National Nosocomial COVID-19 Programme (NNCP) wishes to extend its sincere condolences to those who lost loved ones after acquiring COVID-19 in healthcare settings. It has without a doubt been an extremely difficult time for many families, carers and staff alike and the impact cannot be underestimated.

The purpose of the Interim Learning Report is to outline the early learning that has emerged as a result of the nosocomial investigations and the wider programme of work.

It is important to recognise that the programme is not a nationally led investigation into nosocomial (hospital-acquired) COVID-19 in Wales, nor does it seek to detract from the role of the UK COVID-19 Inquiry. The NNCP has been established to support NHS Wales organisations undertake their duty to investigate patient safety incidents in a proportionate way - whilst reflecting the complexities of COVID-19 which caused unusually high numbers of incidents.

2. Background

In response to the pandemic, NHS Wales rapidly adapted and altered its operational focus to minimise the harmful impact of COVID-19 as far as possible, at a time of high levels of uncertainty and anxiety. It is widely acknowledged that NHS staff worked tirelessly through the most challenging period in the history of the NHS to maintain high standards of clinical care and minimise risk to patients. Despite best efforts, the requirement for the NHS to shift operational focus to respond to the pandemic severely disrupted routine healthcare activity.

On an international level, COVID-19 was a new and unpredictable infection of which little was known, beyond the fact it posed a serious threat to global population health. Whilst infection prevention and control (IP&C) measures are routine practice for the NHS, the spread of COVID-19 in healthcare settings proved challenging, particularly at times when community prevalence was high, and hospitals had significantly high levels of patient complexity, demand and occupancy.

The scale of the pandemic meant that, despite being in a healthcare environment, patients in hospitals and other in-patient settings inevitably faced an increased risk of contracting nosocomial COVID-19. Whilst Health Care Acquired Infections (HCAIs) - now including COVID-19 - are a recognised risk in healthcare settings, learning and developing our understanding of how to investigate such matters of patient safety is important to help inform IP&C design and implementation.

3. What is the National Nosocomial COVID-19 Programme?

The NNCP was established in April 2022 to support NHS Wales organisations to conduct proportionate investigations into patient safety incidents of nosocomial COVID-19, which occurred between March 2020 and April 2022. It is a collective membership of all NHS organisations across Wales, working together to implement as consistent an approach as feasible, to investigate nosocomial patient safety incidents.

Beyond the commitment by NHS Wales to investigate and answer as many questions as possible, the programme also provides a timely opportunity to consider how NHS Wales manages and undertakes patient safety investigations; particularly how service users, families and carers are supported and engaged in the process.

All NHS Wales organisations have a duty to manage and proportionately investigate patient safety incidents in line with the NHS Wales The Duty of Candour Procedure (Wales) Regulations 2023 (the Regulations).

Patient safety incidents are any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS-funded care. HCAIs, including COVID-19, will in certain circumstances be considered a patient safety incident, depending on how and when the infection was acquired.

To assist NHS organisations investigating patient safety incidents of nosocomial COVID-19, a National Framework for the *Management of Patient Safety Incidents following Nosocomial Transmission of COVID-19* was developed, to ensure as consistent an approach as feasible was followed and investigations were done once and done well. To date, the framework has supported NHS Wales organisations to assess and investigate over 5,000 cases of nosocomial COVID-19 where they met the definition of a patient safety incident.

Acknowledging the impact of COVID-19 on service users, families, carers and NHS Wales staff, the programme has adopted a learning approach that seeks not to place blame but maximise the opportunity for learning and improvement.

4. How has learning been identified?

As organisations work hard to progress the completion of their patient safety investigations at pace, learning is identified through various quantitative and qualitative methods including investigation findings, the experiences of people (service users, families, carers and NHS Wales staff), incidental findings, and through collaboration with internal and external partners. Learning has also emerged through organisational scrutiny panels, which are conducted independently of investigations.

Combined learning from across organisations is collated into national themes to further support the identification of areas for improvement in the quality and safety of services, enhancing provision and people experience.

Learning sources include:

- Set-up of the programme including preparatory work
- Test sample audit and subsequent impact assessment
- Investigations
- People's experiences (Service users, families, carers and NHS staff)
- Wider feedback and stakeholder engagement

Acknowledging that listening to and learning from people's experiences is integral to learning for the programme, a *Capturing Experience Through the National Nosocomial COVID-19 Programme* plan has been developed to further support and enhance people's voices in the process, particularly during the second year of the programme.

5. What are the learning themes so far?

The below sections identify the learning themes which have emerged through the first year of the programme and have been categorised as follows:

People's experiences

- Bereavement support and care-after-death services
- Supporting the service user during the investigation process
- Visiting restrictions

Patient safety incidents and concerns

- Application of the programme outside of NHS Wales organisations (including care homes)
- Identification, reporting and investigation of Health Care Acquired Infections (HCAIs) as a patient safety incident
- Application of Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) decisions

National infection prevention and control guidance

- Roll out of guidance
- Outbreak management

5.1 People's experiences

5.1.1 Bereavement support and care-after-death services
Access to high-quality bereavement and care-after-death support services can be extremely helpful in managing grief. When the NNCP programme was established, consideration was made about how service users - particularly the bereaved - would be supported. It has been identified that there is a differentiation in pathways for signposting, referring and accessing bereavement support services across NHS organisations. Some NHS Wales organisations did not have dedicated services that offered support following a bereavement.

To help reduce variation in accessing bereavement support, a *National Framework for the Delivery of Bereavement Care* was launched in 2021. The framework highlighted the need for a consistent and equitable approach across Wales for accessing bereavement support. This has resulted in organisations now having a dedicated bereavement support service.

NHS Wales recognised that support should be available for all families contacted as part of the programme and worked collaboratively with Health Boards and Trusts to ensure bereavement support arrangements were in place for bereaved families when contacted. Learning has identified that this came too late for some families connected with the programme, and that the bereavement process for some families has been adversely impacted.

Good practice
The Development of the *National Framework for the Delivery of Bereavement Care* launched in 2021 has assisted in setting a standard of expectation to be implemented within all organisations for the provision of a bereavement support service. Organisations have worked hard to implement this requirement.

Key learning
Bereavement support services should be proactively made available to all families, particularly for those where there may be a link with an associated patient safety incident.

Families should be proactively signposted to information about bereavement services at the earliest opportunity.

5.1.2 Supporting service users during an investigation process

Navigating and understanding the concerns process and knowing who to contact when people have a question is sometimes the difference between understanding and trusting the process, or dissatisfaction and lack of trust. In equal measure, listening to the experience of service users, families and carers is a fundamental principle of good concerns management, and key to ensuring learning opportunities are maximised.

Through contacting patients and their families impacted by the patient safety investigations, feedback emerged that patients and families found it confusing knowing how and who to contact to discuss a concern or seek clarification on the progress of their case.

To improve this experience, organisations established a dedicated five-day single point of access for service users, families and carers, when managing a concern.

Good practice
To ensure this principle was facilitated for service users, families and carers, a set of minimum standards were established by the NNCP for how services should engage the public. The provision supports a coordinated approach to handling queries about nosocomial COVID-19, with ease of access to address additional queries or broader concerns regarding nosocomial COVID-19.

Key learning
Every service user, family and carer should have timely access to a dedicated and easy-to-access single point of contact to provide feedback, and raise questions, concerns or queries. This is particularly key for patients and families involved in the concerns process.

Supporting information should be available and easily accessible to assist families in understanding the sometimes-complicated language linked to the concerns process.

5.1.3 Visiting restrictions

Visitors play an important part in a patient's recovery, with evidence continually highlighting the role visitors have on positive outcomes such as shorter stays and faster recovery times for patients. It is recognised that families and carers are often best placed to observe deterioration and identify a loved one's needs.

Visiting restrictions can be a tool used in response to infectious outbreaks in healthcare settings. Restrictions during COVID-19 were introduced to help reduce transmission from community settings into hospital environments, and particularly to minimise the risk for vulnerable patient groups.

The programme identified, through service user, family and carer feedback, that visiting restrictions had many adverse effects on the physical and mental health of patients - especially those in the vulnerable groups that the restrictions were intended to safeguard, many of whom were not able to fully understand the decisions made. The limited alternative opportunities for making contact and communicating with loved ones, also negatively impacted the experience for many other service users, families and carers.

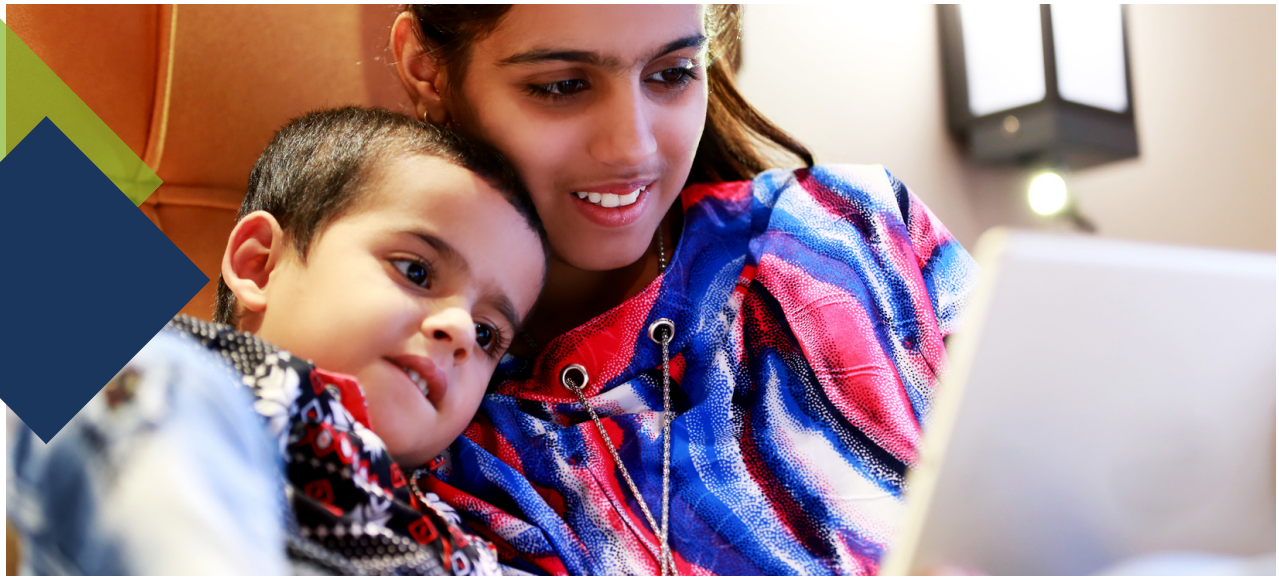
Investigations highlighted that families often relied on clinical teams and ward staff to connect with their loved ones. Whilst this communication in the main has been highlighted as positive, there are instances where communication was below the expected standards, especially the inability to make contact during busy periods.

Good practice
Organisations developed many innovative ways to minimise the impact of the visiting restrictions. These included examples such as virtual visiting via tablet devices, outdoor visiting and utilising ward-based patient support teams to bridge the gap.

Volunteers also played a key role in bridging the gap, particularly later in the pandemic. Many organisations have continued to strengthen these services and enhanced staff training.

Key learning
All services and wards should have named dedicated patient support teams and volunteers to support service users, families and carers who may be finding it difficult to visit a loved one in hospital.

Future visiting guidance should pay particular reference to the role carers have as an important part of a patient's care team.



5.2 Patient safety incidents and concerns

5.2.1 Patient safety incidents outside of NHS Wales hospitals

Patients often receive NHS-funded care in other settings, for example, their own homes, care homes, and facilities outside of Wales. Whilst NHS Wales organisations, under the duty of candour, have a responsibility to ensure any patient safety incidents that occur to their local population are reported to them, the requirement to undertake investigations can alter.

In applying the *National Framework for the Management of Patient Safety Incidents Following Nosocomial Transmission of COVID-19*, it has been identified that how the Regulations are applied in different parts of the health and social care system, as well as other sectors such as independent providers (private and public service), is variable and confusing.

Learning has identified that whilst the Regulations require an investigation for concerns relating to the transmission of COVID-19 during NHS-funded healthcare, there are a number of differences when care has been provided by a non-NHS organisation. For example, who undertakes the investigation, how the investigation is progressed, the requirement to compensate and how NHS Wales organisations who fund the care are notified.

The programme identified that the Regulations create variability and inequity for service users, families and carers who receive NHS-funded healthcare via another provider when a concern is raised. On this basis of the Regulations, the current programme does not extend to investigating all instances of nosocomial COVID-19 which occurred through an independent provider setting under NHS-funded care, including care homes.

Evidence from the experience of service users, families and carers connected to the programme to date, suggests they are not routinely informed of these differences.

Good practice
The learning from applying the *National Framework for the Management of Patient Safety Incidents following Nosocomial Transmission of COVID-19* has been shared with social care colleagues. A good practice guide is being developed for non-NHS support services in other sectors to apply a more consistent and standardised approach to concerns in social care and care home settings.

Key learning
All policies and procedures relating to the management of patient safety incidents which occur during NHS-funded care should set expectations of the standards required across all care settings to minimise confusion for service users, families and carers who may be receiving care across multiple complex care pathways.

5.2.2 Identification, reporting and investigation of Health Care Acquired Infections (HCAIs) as a patient safety incident

Learning from patient safety incidents is an important element to improve quality of care, and continually learn how to minimise the impact of HCAIs and the impact on patients.

Beyond the management of nosocomial COVID-19 as a patient safety incident, learning has identified that current arrangements within NHS Wales for the identification, reporting and investigation of all HCAIs that meet the definition of a patient safety incident are variable.

The programme also identified inconsistent approaches to the management and reporting of HCAIs across Wales and variations in the methodology used to investigate such incidents. It has also been established that the use of surveillance definitions in NHS Wales does not automatically indicate that a patient safety incident has occurred.

Good practice
As a result of this learning, the National Policy on patient safety incident reporting has been updated to reflect new national reporting requirements for HCAIs, including the reporting of nosocomial COVID-19.

Key learning
All health-acquired infections need to be assessed against the requirement to report as a patient safety incident, in line with national incident policy, and a proportionate patient safety investigation needs to be initiated.

5.2.3 The application of Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) decisions

DNACPR is designed to protect people from unnecessary suffering by receiving resuscitation that they do not want, that will not work, or where the harm outweighs the benefits. It is a key enabler in the promotion of a dignified death.

A common theme in the concerns raised by families and carers during the early part of the programme was the application of DNACPR decisions for patients who acquired COVID-19. Some of the themes in the concerns related to a view that there was a 'blanket approach' to applying the decision when somebody was diagnosed with COVID-19, and a lack of knowledge or consultation in the process of applying the decision.

Findings from investigations and other sources such as the Medical Examiners Service and mortality reviews have identified that there was a:

- Need to improve the description of patient's co-morbidities and their impact on the reason for a DNACPR being enacted
- Need to improve communication, especially around the rationale for DNACPR implementation and discussions with patients, families and carers
- Need to improve documentation related to discussions with patients, families and carers
- Need to improve the DNACPR document, particularly whether a decision should be reviewed if a patient's condition improves

Whilst a DNACPR decision does not strictly require consent from a next of kin or carer before application, unless the patient lacks capacity, learning from the investigations has recognised the importance of such communication, and the impact the management of this sensitive subject can have when managed well, and in these instances, not so well.

The analysis did not identify evidence or trends that DNACPR decisions had been placed inappropriately, or not in keeping with the current All Wales DNACPR Policy.

Good practice
There is an NHS Wales Strategic Advance & Future Care Planning group that includes representatives from NHS organisations. The group has agreed to strengthen the section in the policy relating to appropriate and timely communication with patients and families. This is seen as an important step to support clinicians to move beyond the formal process of DNACPR, providing helpful guidance and support in how, when and with whom to communicate to ensure understanding, and minimise upset.

Key learning
Service users, families and carers place great value on good communication around the DNACPR process and need to be involved as much as possible in the decision-making process.

Continued development and roll-out of an electronic advanced care planning document, is also seen as key to improvements which would support clinicians during the process and alleviate some of the potential issues around DNACPR documentation and broader communication.

5.3 Infection Prevention and Control

5.3.1 Roll out of guidance

National policy and guidance on IP&C are essential elements in supporting healthcare organisations to develop and implement local strategies which help to reduce the risk of infections. In response to the pandemic, the UK infection prevention and control guidance was co-produced across the UK's four nations and was published by the UK Health Security Agency (previously Public Health England).

Due to the need to respond rapidly to the significant population health risk that COVID-19 posed, guidance updates were published frequently, at short notice and often out of normal business hours. The rapid increase in the prevalence of COVID-19 and the high demand on health and social care, in addition to the emergence of new evidence, made it necessary to update guidance on an almost weekly basis, sometimes more frequently.

NHS Wales staff experience has shown that the frequency in which the guidance was updated, created challenges for already stretched IP&C teams, who are responsible for leading the necessary changes for all HCAIs across often large and complex organisations. Naturally, it can take time to assess and disseminate guidance which requires organisations to make significant adjustments to care delivery. For example, changes to care pathways, guidance on PPE (personal protective equipment), and testing processes.

The expectation that guidance should be implemented immediately, once published, was a significant challenge during the pandemic, particularly given the level of resources required to ensure training, communication and application across large workforce numbers and settings. It is worth noting that IP&C workforces responsible for COVID-19, also retained existing duties relating to other IP&C issues which continued throughout the pandemic. The implementation impacted staff who worked shifts and or were off sick, making it difficult to keep pace with changes in guidance that related to their practice.

Whilst acknowledging updates to IP&C policy are critical, the NHS in Wales should consider how updates are distributed and communicated when an evidence base is rapidly evolving in a future major incident scenario.

Good practice
Organisations developed extraordinary systems to respond to the rapid increase in the prevalence of COVID-19 and the high demand on health and social care. In addition, due to the emergence of new evidence, they also had systems in place to respond at pace to updating the necessary guidance on an almost weekly basis.

Key learning
NHS Wales organisations are encouraged to continue exploring and implementing digital communication methods that support timely and engaging communication with colleagues on updates to guidance.

5.3.2 Outbreak management

Testing can be an important mechanism in the identification and prevention of infectious diseases, including COVID-19. Access to appropriate testing and the timely turnaround of test results are crucial to mitigating and preventing the onward spread of infectious diseases.

Increased demand for COVID-19 testing during the pandemic posed a significant challenge to the existing testing infrastructure, which still had to manage routine provisions such as blood tests for in-patients. Demand exceeding capacity and the inability to test rapidly for COVID-19 during periods of 2020, meant that testing was somewhat ineffective as a mechanism for reducing infections, until the supply of consumables met demand and testing capacity increased.

Due to the testing capacity challenges early in the pandemic, service users were discharged into other care settings or their own homes without the ability to rapidly test for COVID-19. This was in line with national guidance at the time, which did not advise that negative tests were required before transfer/admission into residential settings.

Further UK guidance, especially early in the pandemic, actively encouraged the discharge of patients from hospitals into care home settings, to free up hospital capacity in order to manage the anticipated demand for services.

Whilst a testing strategy produced by Welsh Government was launched on 15th July 2020, significant challenges in applying the policy existed due to limited access to the volume of consumable items required to undertake tests, and laboratory capacity to manage the extreme demand. Additional capacity beyond the existing infrastructure was achieved with the launch of the lighthouse laboratory (IP5), towards the end of August 2020, this meant it became easier and quicker to test patients and staff for COVID-19.

As well as testing, isolation plays an important part in preventing and controlling the spread of infections, especially in healthcare settings. Timely testing, along with the ability to isolate suspected or positive patients can aid in preventing onward transmission. It is important to note that isolation is one of several control measures and must be used in conjunction with other measures to be effective.

It should also be noted that isolation for infection purposes brings additional risks to service users with other care needs, particularly for older and vulnerable people, such as falls. Decisions to isolate patients for infectious purposes, even when isolation is available, should be considered in a holistic risk-balanced way that does not introduce the risk of additional harm.

An aged estate and limited isolation facilities (such as access to single rooms) meant that patients were often unable to be isolated in single rooms, and co-horting was established to maintain operational flow through hospitals during extreme demand. The inability to isolate patients often meant that, in an attempt to reduce spread of infections, service users were subjected to multiple ward movements.

In line with UK guidance, the introduction of designated care pathways, which tried to prevent onward transmission (as far as reasonably practicable), played a significant part in multiple ward movements - especially in older estates.

Experience from families and carers found that they were often not informed of these movements, which resulted in additional communication difficulties when seeking updates.

Good practice

Organisations rapidly implemented increased point-of-care testing (POCT) to support clinical care delivery and assist in more timely diagnosis and clinical decision-making. This supported improved daily epidemic control by reducing patient movements and achieving early detection for treatment plans to be put in place which assisted in the safe timely transfer and discharge of patients into alternative care settings where necessary.

Key learning

Policies and procedures should reflect mechanisms that result in limiting the number of patient moves, ensuring patients are in the right place at the right time.

Where patients are moved, families should receive proactive and timely communication on the location and rationale for the move.

6. Looking forward

The NNCP will be working with NHS Wales organisations to further share and embed learning in the second year of the programme.

In addition to progressing the learning on the subjects listed in this report, the programme will continue to identify and explore new and emerging topics. The below list represents topics which are currently emerging and will be reported upon further in the final report:

- Staff experience to help further inform learning themes
- Service user experience of the NNCP to date
- Healthcare environments (estates and ventilation in relation to IP&C)
- Consideration of safeguarding in the emergency response to COVID-19
- Discharge planning

7. Closing remarks

Thank you to the NHS Wales staff who are delivering the programme, and for the valuable feedback from service users, families and carers, through whom we are identifying many areas for improvement. The wealth of positive feedback and areas of good practice are equally as valuable in demonstrating positions we should continue to take and develop.

Some of the content in this report may be upsetting for many. However, it is imperative that this programme offers transparent insights that will lead to meaningful change. Please be conscious of NHS Wales staff, service users, families and carers who are involved in this programme when discussing findings.

The extent of the work that still lies ahead should not be underestimated. The NNCP will continue to identify learning in the second year of the programme, with a view to sharing findings in Spring 2024.

8. Additional information

8.1 Accessing support

People involved in the programme are encouraged to reach out to their designated Health Board/Trust contact if they feel like they need a conversation about some of the findings. Mental health and wellbeing support can be accessed 24/7 via the CALL Mental Health Listening Line, call 0800132737 or text “help” to 81066.

A number of organisations that provide bereavement support can be found on the Health Education and Improvement Wales website.

Access to mental health and wellbeing support for NHS Wales staff is available through wellbeing services and occupational health in each Health Board/Trust in the first instance. Additional mental health and wellbeing support can be accessed through the CALL Mental Health Listening Line.

Media requests should be directed via the typical channels.

Aneurin Bevan University Health Board	Call: 0300 373 0652 Email: abb.covidinvestigationteam@wales.nhs.uk
Betsi Cadwaladr University Health Board	Call: 03000 846992 Email: BCU.HCAICovid19@wales.nhs.uk
Cwm Taf Morgannwg University Health Board	Call: 01443 443084 Email: CTM.NosocomialCV19@wales.nhs.uk
Cardiff and Vale University Health Board	Call: 02921 836407 Email: Cav.Covidsupport@wales.nhs.uk
Hywel Dda University Health Board	Call: 0300 303 8322 Email: covidenquiries.hdd@wales.nhs.uk
Swansea Bay University Health Board	Call: 01639 684440 Email: SBU.NosocomialReviewTeam@wales.nhs.uk
Powys Teaching Health Board	Call: 01874 442918 Email: PTHBNosocomialReviewTeam@wales.nhs.uk
Velindre University NHS Trust	Call: 02920 196161 Email: HandlingConcernsVelindre@wales.nhs.uk

8.2 Glossary of terms

Co-horting	Defines groups of people with shared characteristics from health data being placed together where demand exceeds capacity. In the context of this report, co-horting relates to suspected COVID-19 diagnosis and other health related issues.
Concern	A concern is any patient safety incident, or any expression of dissatisfaction raised by a member of the public and can be verbal or written.
Consumable items	Goods used by individuals and businesses that must be replaced regularly such as needles / swabs etc. In the context of this report, 'consumables' refers to items used for COVID-19 testing.
DNACPR	This refers to a specific process of discussion and documentation NOT to initiate future CPR (Cardio-Pulmonary Resuscitation) in the event of a future cardiac arrest and natural and anticipated dying event. A DNACPR decision does not have repercussions on any other element of treatment and care.
Independent providers	Services delivered by organisations that are not NHS Health Board/ Trust services. Examples include independent care providers such as care homes, local authority social services, charities and Third Sector organisations.
Nosocomial infections	Nosocomial infections, also referred to as 'healthcare-associated infections' (HAI), are infection(s) caught during the process of receiving health care, and where that infection was not present during the time of a person's admission to hospital or healthcare setting. They may occur in different areas of healthcare delivery, such as in hospitals, long-term care facilities, and ambulatory settings. The infection may also appear after discharge from a healthcare setting but are attributed to the time a person was in contact with the healthcare setting.
Patient safety incident	An unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS-funded care.
PPE (Personal protective equipment)	Protective face coverings, clothing, helmets, goggles, or other garments, designed to protect the wearer from injury or infection.
Service users	Anybody using NHS Wales healthcare funded services.
Surveillance definitions	Surveillance of Health Care Acquired Infections refers to the monitoring and reporting of these events. Surveillance definitions are used to categorise these events as part of investigations.

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda Item: 2.3

Patient Experience, Quality and Safety Committee	**24 October 2023**
Subject:	**Maternity Assurance Paper (Escalation)**
Approved by:	Claire Roche, Executive Director of Nursing and Midwifery
Prepared and presented by:	Prepared by: Shelly Higgins, Interim Head of Midwifery and Sexual Health Presented by: Claire Roche, Executive Director of Nursing and Midwifery
Other Committees and meetings considered at:	Maternity leadership and management meeting and Women's and Children's Senior Management Team meeting Executive Committee: 11 October 2023

PURPOSE:

The purpose of this paper is to provide the Patient Experience, Quality and Safety Committee with an update on the maternity service progress following de-escalation in Powys Teaching Health Board.

RECOMMENDATION:

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

- Take ASSURANCE that the Maternity Services improvement actions are being delivered to plan;

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

THE PAPER IS ALIGNED TO THE DELIVERY OF THE FOLLOWING STRATEGIC OBJECTIVES AND HEALTH AND CARE STANDARDS:

Strategic Objectives:	Focus on Wellbeing	✓
	Provide Early Help and Support	✓
	Tackle the Big Four	✓
	Enable Joined up Care	
	Develop Workforce Futures	
	Promote Innovative Environments	
	Put Digital First	
	Transforming in Partnership	

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

Health and Care Standards:	Staying Healthy	✓
	Safe Care	✓
	Effective Care	✓
	Dignified Care	✓
	Timely Care	✓
	Individual Care	✓
	Staff and Resources	✓
	Governance, Leadership & Accountability	✓

EXECUTIVE SUMMARY:

The purpose of this paper is to provide the Executive Committee with an update on progress following de-escalation in maternity services in Powys.

The paper focuses on the Powys Provider maternity service continuous improvement plan and the progress made against previously escalated areas.

DETAILED BACKGROUND AND ASSESSMENT:

The maternity service returned to business as usual in March 2023 following a period of escalation from June 2022. Local escalation had been enacted in response to the following:

Identification of three Nationally Reportable Incidents (NRIs) between February and May 2022

Findings from a local review of governance in the Midwifery Service that highlighted improvements were required in the review of maternity transfers (particularly intra-partum), review of incidents and the undertaking of root cause analysis (RCA) investigations.

Concerns around the use of the Perinatal Institute's Gap/Grow programme.

Local escalation resulted in increased monitoring for quality/ safety and assurance purposes. Business as usual governance arrangements are in place and include:

- Governance - Oversight and scrutiny of Incidents/Concerns and the subsequent learning and actions.
- Perinatal Institute GAP/GROW programme.
- A continuous improvement plan.

Governance - Oversight and scrutiny of Incidents/Concerns and associated action and learning

Maternity National Reportable Incidents (NRI's)

There has been one new NRI reported in the period since the last report (March 2023). This is currently being investigated. There is one further NRI currently in the assurance processes.

The maternity service aims for a joint review approach with commissioned services for cases where care has been provided outside of Powys and ensure this ask is made of the commissioned services where necessary as per the Maternity Assurance Framework.

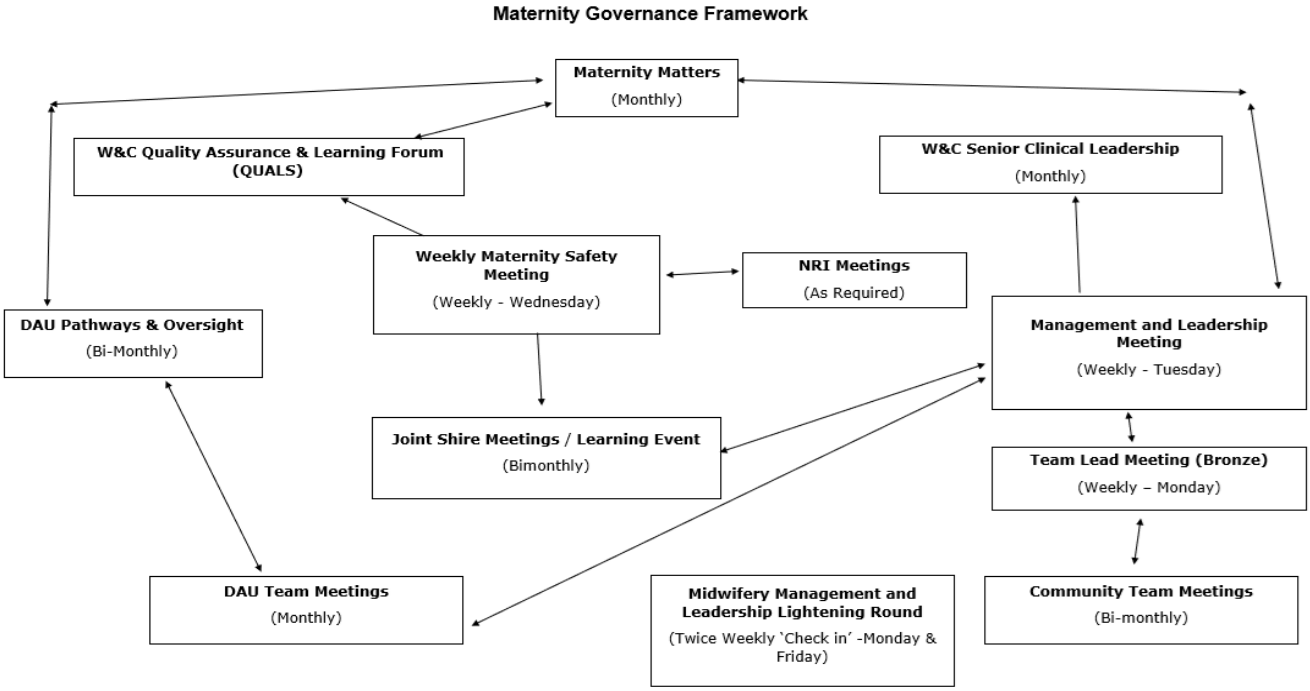
Maternity service oversight

There are several mechanisms in place to ensure oversight of maternity services including:

- Leadership and management team 'check-in' meetings on a Monday and Friday which enable responsiveness to any issues around operational escalation and incidents.
- Weekly safety meeting, with the purpose of:
    - Monitoring key data for maternity services including escalation, births, and Clinical Information Sharing (CIS) cases.
    - Reviewing the weekly incident tracker and to confirm all Datix submissions from the previous week.
    - Confirming the method of investigation/review for cases including SBAR, Timeline, RCA/NRI.
    - Reviewing progress of incident reviews through review of data obtained from Datix that day.
    - Managing the progress of RCA reports for NRI's and escalate any issues.
    - Ensuring concerns are dealt with in a timely manner.
    - Discussing themes and trends related to incidents and concerns.
    - Monitoring peripartum transfer data
    - Considering any items for escalation (for example, threshold for an NRI as described below)
    - Discussing any family feedback received related to incidents.
- Weekly Team Leader meeting (bronze) for escalation to the leadership and management team and dissemination to clinical staff of significant information.
- Review of the maternity improvement plan as a standard agenda item for week 1 of the monthly leadership and management meetings.
- Review of the outcome/action plan tracker as a standard agenda item for week 2 of the monthly leadership and management meetings.
- Monthly Women and Children's Quality Assurance and Learning forum where the Quality & Safety paper is shared. This offers the opportunity to review themes and trends within W&CH for incidents, concerns, patient experience, and audit.
- Day Assessment Unit (DAU) Pathway/Oversight Meeting to support monitoring of the ultrasound provision through maternity services.
- Monthly Maternity Matters meeting chaired by the Executive Director of Nursing, which has an established cycle of business for updating and reporting including a quarterly assurance report.

Patient safety huddles are convened with Quality and Safety input when required as per the Maternity Assurance Framework.

The table below shows an updated governance and assurance framework for maternity following de-escalation in March 2023.



Learning from service users and feedback

Service user feedback is obtained through CIVICA which was launched in maternity services from May 2023. Prior to this feedback was regularly gained through use of MS Forms surveys. Automatic texting of surveys at specific points in the maternity journey has commenced in August 2023 for women who receive all care in Powys. QR codes are available in all cases. There are 4 surveys in use with an additional one for partners and a separate MS Form for feedback on transfers.
Feedback is also gained on the provision of antenatal education and through submission of compliments to the service. These have been very positive.
All women who transfer from Powys in the peripartum period are also directly contacted and proactively asked to feedback on their experiences. Since March we have had feedback from three families following receipt of the letter from maternity services offering them the opportunity to share their experience. Two of those shared positive feedback about the service and one was to share a concern informally, which has been fed back to the staff involved. This mechanism for feedback has been valuable to gain first-hand information from Powys residents who decide to birth in one of the birth centres or at home.

There have been no formal concerns since March 2023. There have been 1 enquiry and one early resolution concerns since March 2023.

Closing the loop and feedback to staff

A mechanism of feedback for the wider maternity team is achieved through quarterly learning events and through group clinical supervision/incident review meetings, 'weekly brief', newsletters and email. There have been two learning events to date which have

focussed on feedback from NRI's, other incidents as well as including external speakers focussing on staff well-being and psychological safety.

- **Perinatal Institute (PI) GAP/GROW Compliance**

One of the key drivers for the implementation of local escalation arrangements was the identification of incidents that highlighted specific actions for Growth Assessment Protocol (GAP) and Gestation Related Optimum Weight (GROW) compliance for the detection of Small for Gestational Age (SGA) babies. There is sustained work in relation to GAP/GROW including:

- The Perinatal Institute (PI) have now released a new GROW calculator online that enables every midwife and midwife sonographer to input either symphysis fundal height, or estimated fetal weight measurements. The calculator works out if the growth/weight is within normal parameters and had reduced the need to use set squares and rulers to define reduced growth. It is hoped this will reduce the margin of error for assessing when further assessment is required.
- The local fetal growth guideline is being updated to match this change in practice.
- The service is still aiming to introduce GROW 2.0, a fully digital way of utilising the GAP/GROW system. This is currently with the information governance and cyber security.
- Babies that are born with undiagnosed SGA, $<10^{th}$ centile are reported to the PI using the GAP score system. A database for tracking locally is in use and a datix is completed for each case.
- When 30 cases have been added to the reporting system, the PI generates a GAP-Score report with themes and taxonomies relating to SGA included. The GAP-Score is an integral part of the GAP programme & is an electronic audit tool which aims to assist the reviewing of clinical care in the 'missed case' of fetal growth restriction. The care is reviewed in a standardised way, examining potential factors which may have improved the referral rate for suspicion & detection of fetal growth restriction.
- Following the last presentation of the report at Maternity Matters, the main taxonomies have been further investigated and aligned to the SGA database.
- Annual mandatory training days include a session on GAP/GROW and now includes use of the GROW calculator. A real-life anonymised case based on one of the NRI's is being used as part of the training in this 12-monthy training cycle.
- The Perinatal Institute continue to attend Maternity Matters on a quarterly basis to enable further monitoring of themes and trends. The Governance Lead Sonographer for DAU also presents image audit findings at future meetings for completeness.

Maternity Improvement Plan

The Maternity continuous improvement plan is in place and a progress report against the improvement plan is monitored via maternity matters. There are four key components of the plan:

- Quality and Safety

- Leadership and Culture
- Clinical Excellence
- Finance and Workforce

Work has progressed against several actions including:

- Progress with maternity guidelines
- Development of a training needs analysis
- RCA training for staff
- Commencement of audit cycle of reporting for 2023/24
- Robust management of CIS cases
- Band 7 team lead development support
- A focus on staff wellbeing including signing of the RCM Caring for You action plan

Future work will focus on:

- Workforce review against the most recent Birth Rate Plus report
- Progressing a dashboard (links with national recommendations of MATNEO report)
- Development of an equality and diversity action plan
- Re-establishing the maternity and parent voices partnership
- Digital Maternity Cymru
- Quality improvement work including commencement of single point telephone triage to reduce variation in care.

A copy of the plan can be found in Background Papers provided to the Committee at Appendix A.

MATNEO Safety Support Programme

The maternity and neonatal safety support programme commenced in Q3 of 2022. The report of the discovery phase was published in July 2023. The key focus has been on:

- Work culture
- Leadership
- Learning
- Workforce and clinical outcome measures

A gap analysis is currently being undertaken to understand the all-Wales improvement priorities. There are 59 report priority areas and 124 improvement actions. The gap analysis is enabling cross referencing to the existing improvement plan. The MATNEO programme is currently in a transition phase prior to commencing phase 2, which is anticipated to begin in 2024.

Next Steps

- The Committee be assured that the business-as-usual mechanisms have continued and are embedded into the structure of the midwifery services
- The business-as-usual mechanisms include the Monthly Maternity Matters meeting, chaired by the Executive Director of Nursing and Midwifery.
- Six monthly Maternity Services Assurance Reports will continue to be provided to the Executive Committee and the Patient Experience, Quality and Safety Committee.

ACTION / ACTIVITY	Additional detail	Outcome expected	RESPONSIBILTY Person	START DATE	PROJECTED COMPL DATE	COMPL DATE	COMPL BY (staff)	BRAG STATUS	Progress	Evidence and location stored	
Systems for reporting NRI/concerns/Incidents/Learning to be strengthened (Directly from Exec paper for escalation) links to 1.16 of WG MAT/NEO Assessment, Assurance & exception reporting tool - CTM/Ockenden/HIW	1. Clear reporting and escalation mechanisms to include management of concerns & complaints. 2. Link with Rachel (datix) to set up a dashboard for monitoring of concerns	Updated Governance process within senior team and understanding of roles and responsibilities	W&C Governance Lead	Oct-22	Mar-23	Mar-23	leadership and management team		Underway. Revised trigger list and instructions for Datix sent out. Drop in Datix sessions for all staff 3x weekly ongoing. Concerns come straight from concerns team to R&G lead. Shared email address is in place - but needs to be sorted for entire management team have access too - this will be used as the mechanism for feeding concerns/complaints into maternity Logged on weekly tracker which is reviewed on a Wednesday Any actions to be added to QUALS/Outcomes tracker flowchart to be finalised by NR and KE additional drop downs for datix reporting still to be explored/considered MARCH - tracker/dashboards now in place		
Learning events to embed recommendations of National Reportable Incidents.		Learning events in place through whole Powys maternity team meetings. clinical incident review meetings linked with supervision - to be monthly dissemination from Team Leads	W&C Governance Lead	Jan-23	Apr-23	Apr-23	leadership and management team		1st learning event 11-1-23 dates booked for 2023 for whole team meetings (shire) clinical incident review meetings in place - dated to be added to a poster for the year and disseminated to all staff Learning events set for remainder of 2023. ACTION COMPLETE	Joint Shire Minutes 11.01.2023.docx CLINICAL & GROUP SUPERV	
Update of policies & procedures with current risk assessment. (Directly from Exec paper for escalation)	Guideline tracker to be reviewed at monthly maternity guidelines group	To have guidelines within maternity service up to date	Consultant Midwife & CSfM	Oct-22	ongoing		leadership and management team		23 needed – phased priority list for completion compiled. Monthly review meeting in place. Further policy team to be developed in January 23. MARCH - guidelines/policies is on risk register - monthly meetings continue - progress is being made APRIL - Exploring option for bank staff to support progression with guidelines. continued progression being made internally with guidelines. monthly meetings continue. MAY - Continues as per April JUNE - Continues as per May AUGUST - Continues to be a focus and reduction in out of date policies. SEPT - Continues as above 10 out of date or required	TEAMS w&c Guidelines tracker can be reviewed. minutes noted for maternity and W&C	
Monthly Leadership review to ensure traction of policy updates	Guidelines to be prioritised by order of importance	To have guidelines within maternity service up to date	Consultant Midwife & CSfM	Oct-22	ongoing	BAU - August 2023	leadership and management team		established materntiy Guidelines Group - review tracker on TEAMS and update accordingly. ToR of the group and membership due for review Feb 23. Guideline development session planned for Jan 23 to support staff to write guidelines. APRIL - links with above MAY - As above JUNE - As abover per May AUGUST - Staff supporting progress. Reduction in out of date policies. established and consistent process in place - agreed BAU processes now as monitored through other mechanisms	TEAMS w&c guideline tracker, minutes of guidelines meetings for maternity and W&C, consistent progress evident. meetings with DoN for final sign off	
Future audit plan for 2023 to be agreed.	Contribute Maternity Audit Plans for W&C overarching plan		Consultant Midwife	Dec-22	Dec-22	Dec-22	consultant midwife		Audit plan submitted Dec 2022. Audits progressed in 2023: transfer audit - presented at audit, data shared with midwives and poster for public Record keeping aufit completed and shared BFI audit DAI/Routine enquiry audit completed Pool evacuation audit in progress.	Completed and submitted to W&C for approval https://nhswales365.sharepoint.com/:w:/s/POW_Women_and_children/EUDB8OlStEdFjjZOYtNPfVsB2uUh64ci9NJT8fdDMprwQw copy saved to improvement plan folder	
Ensure robust process and monitoring for leadership and management team meetings	1. Agenda template to be reviewed/refreshed for leadership and management team meetings 2. ToR to be reviewed and refreshed to ensure membership and reporting expectations are clear 3. same to be put in place for Monday B7 Team Lead meetings		HoM	Jan-23	Mar-23	May-23	leadership and management team		weekly management meetings in place weekly B7 meetings in place maternity governance framework in place Awaiting sign off of Band 7 ToR and management meeting ToR - expected by end of March 23 APRIL - Management ToR approved 4-4-23 Band 7 TOR resent out for comments 24/4/23 and approved at weekly Band 7 meeting	weekly safety meeting ToR - https://nhswales365.sharepoint.com/:w:/r/sites/POW_W&C_Mat/_layouts/15/Doc.aspx?sourcedoc=%7BF67B8ADB-8965-4A0F-84D2-EF9394799C29%7D&file=Weekly%20Safety%20Meeting%20TOR%20Final%20March%202023.doc&action=default&mobileredirect=true&DefaultItemOpen=1 https://nhswales365.sharepoint.com/:w:/r/sites/POW_W&C_Mat/_layouts/15/Doc.aspx?sourcedoc=%7B0A225C6B-05DA-42EC-81D0-EEEDCC8CBB0F%7D&file=Maternity%20Governance%20Framework.docx&action=default&mobileredirect=true	

Weekly Safety Meetings to continue in relation to incident management. (Directly from Exec Paper for escalation)	1. Standard agenda/checklist to be developed to support review of tracker 2. ToR for group including core membership to be devised 3.Tracker to be used to feed into fortnightly Maternity Escalation meetings	To have assurance of processes and embedding of learning within the maternity service	W&C Governance Lead	Oc-22	will be ongoing in BAU	ongoing - BAU	leadership and management team		Jan 23 -meetings occuring weekly and tracker updated. Process to be further enhanced with ToR and clear agenda for Wed am meeting	https://nhswales365.sharepoint.com/:x:/r/sites/POW_W&C_Mat/_layouts/15/Doc.aspx?sourcedoc=%7BB98C3B18-4D28-44CA-BEE4-C6E2F03E7D9B%7D&file=Maternity%20Weekly%20Escalation%20Tracker%20v1.xlsx&wdLOR=c09CDB241-352E-4E8A-95FC-737448A96954&action=default&mobileredirect=true	
RCA training to be undertaken by all relevant roles (Directly from Exec paper for escalation)		Relevant staff have received RCA training and understand process	W&C Governance Lead	Oct-22	Dec-23		All senior midwives		RCA training completed by leadership team and Midwives ongoing. KATE - Need updated list of who has been trained please and expected dates for B7 - add dates to 'everything'database. March date was cancelled - SPB and FFW were due to attend. Awaiting further dates from Q&S team. - date in June Review training planned with KE and Team Leads 31-3-23 Update 23/5/23 Band 7 meeting it was highlighted that all Band 7's who had not attended needed to do so and	RCA Training 2023	
Management of Clinical Information Sharing (CIS) cases	Guideline to be developed to ensure clear process for assessment and management of CIS cases	Robust process in place to manage complex cases in Powys	Consultant Midwife	Aug-22	Oct-22	Oct-22	consultant midwife		The CIS database is reviewed at weekly Safety meeting which is attended by leadership team. Forward plan for audit fo CIS Guideline by focussed reords review.	CIS database and CIS guideline MAT079 in place on sharepoint	
Management of CIS Cases and risk review (Directly from Exec paper for escalation)	1. Establish process for review of CIS cases on a weekly basis to identify cases for escalation and ongoing monitoring 2. Ensure CIS database is maintained to support monitoring of outcomes	To ensure clear understanding of complex cases and monitor cases for escalation	Cconsultant midwife and CSfM	Jul-22	established process by Nov 22	Nov 22 now BAU	Consultant midwife and CSfM		Complete as established process for monitoring cases. Weekly safety meeting review CIS . Guideline ratified.	weekly safety tracker. CIS database Guideline MAT079 published on sharepoint	MAT 079 Informed Choice, Personalised Care and The Care of Women Making Choice Outside of Recommended Guidelines.docx
Peer-to-peer audit review of CIS cases (Directly from Exec paper for escalation)	1. Process to be set up for ongoing review of cases 2. Audit template to be devised for staff 3. To be noted on 23/24 audit programme 4. To be reported on during 23/24	1. To ensure peer review and learning from CIS cases 2. To Ensure embedding of process around management of CIS cases	Consultant Midwife	Apr-23	Apr-23	Apr-23	CSfM - now BAU in record keeping audit		post Feb 23 - to be strengthened in record keeping audit process from April 23 - this is a peer review process led by supervisor Apr 23 - All CIS parts added to the record keeping database - will report as part of 23/24 record keeping notes report write up Sept 2023 - a focussed audit will take place of CIS cases against the guideline to ensure a good sample are	record keeping audit	
Day Assessment Unit review (Directly from Exec paper for escalation)	1. Review against original service specification 2. understand activity - capacity and demand	To have clear understanding of the demand and capacity of DAU service in Powys and requirement to sustain and develop the service	AHoM - SPB	Mar-23	Mar-24		Consultant midwife and AHoM		Jan 23 - this has not commenced - no capacity in current service ?support to be obtained externally feb 23 - SPB will start to lead this work in March MAY - On hold due to Senior Management capacity. Director of Nursing aware. JUNE - Likely to be on consultant midwife workplan once in post SEPT - Consultant Midwife due to commence september 2023. Is on work plan.Meeting arranged with DAU teams and radiology teams to support detail required		
Migration from Standalone Database Gap and Grow to RLdatix systems (Directly from Exec paper for escalation)	1. To determine what local need is from datix 2. To meet with Q&S team to establish what can be achieved and agree timeframes for migration	To have clear mechanism for monitoring themes and trends from incidents	W&C Governance Lead	TBC	Feb-23	Mar-23	W&C Governance Lead		Initial meetings held with Datix team to scope work. Follow up planned for end Jan23 cannot be provided in the level of detail that is required - meeting held with datix team and AD Q&S - Jan 23 dashboard will be in place in datix for summary data such as open cases		
To achieve de-escalation within maternity services and return to a business-as-usual operative status.		service returns to BAU	HoM	Mar-23	Mar-23	Mar-23	HoM		BAU approved following Exec Committee 17-3-23.	Final DRAFT Exec Paper De Escalation March 2023 -.docx (sharepoint.com)	

ACTION/ACTIVITY	Additional detail	How will outcomes be achieved?	RESPONSIBILTY Person	START DATE	PROJECTED COMPL DATE	COMPL DATE	COMPL BY (staff)	BRAG STATUS	Progress	Evidence and location stored
Training Needs Analysis to be undertaken for maternity service (Directly from Exec paper for escalation)	1. Overall training requirements for the service ensuring it also reflects any requirements as a result of reviews/incidents/concerns	TNA will be completed, which will be reviewed on an annual basis	SPB/CSFM/Facilitator	Jan-23	Apr-23	Aug-23	AHoM		Jan 23 - Draft TNA devised - will require completion Ongoing through senior leadership meetings and workforce meetings. Refresh agreements with DGH partners for skills refreshers e.g., Cannulation Currently there is no PDM in place and there is concern that we will not be able to complete currently 2/5/23 In progress of Draft being ready for comments JUNE - No further update however cannulation training is underway. AUGUST - Initial consultation comments to be followed up and actioned. SEPT - SPB sent to W&C - linked in W&C plan. Next step to review againt prior to 24/25 calendar year.	https://nhswales365.sharepoint.com/:w:/s/POW_W&C_Mat_Templates/EXoYXHzBxI9Eq_8f_gKdGrsBWCsH8_WPM83bkxqCSlBLRw?e=Phn7U2
Ensure Band 7 workforce able to confidently and competently perform role (Directly from Exec paper for escalation) - links to 3.10 of WG MAT/NEO Assessment, Assurance & exception reporting tool - CTM/Ockenden	1. Continuation of work in progress - link with WoD to ascertain finalised programme and planned sessions 2. Programme plan for core components of Band 7 role to be finalised - to include sickness management, recruitment, datix, RCA training etc 3. Clarity on expectation of the Band role and decision on the %management time	1. links with WoD 2. finalised programme available for review aim for annual programme thereafter to include senior Band 6 staff	AHoM	Apr-23	Dec-23		Leadership and Management team		Started training sessions held with OD team October and November 2022. To define and ensure outcomes of development course are captured in evaluation at end of course feb 23 - meeting set up with Rhys and Ross to discuss ongoing development programme. MARCH – meeting has taken place with OD, requirements discussed, plans in place to broaden to leadership team as a whole unit rather than purely Band 7 development. Includes planned use of climate surveys, internal managers programme, compassionate leadership development and supporting psychological safety. Planned to commence in May 2023. band 7 induction programme to be finalised MAY - SPB linking with JB to pull together induction programme for team leads. SPB linking with Rhys for content for scheduled development days June and July. Allocated Management time of 7.5 hours a week JUNE - Date set to review induction programme and Team Lead day set for October 2023. AUGUST - KE will remind all at the next Bronze meeting. Sept - Leadership days scheduled with WoD October 2023 - programme agredd - components around compassionate leadership, processes, climate surveys. Dates set into 2024	Saved to Maternity Templates - programmes for the leadership days
Workforce Planning- to include consideration of Birth Rate Plus, And Specialist Midwifery Roles eg Fetal surveillance Midwife, Digital Midwife (Directly from Exec paper for escalation) Links to 1.11, 3.9, 5.6 & 5.16 of WG MAT/NEO Assessment, Assurance & exception reporting tool - Ockenden/HIW	1. Service to consider SBAR development of required staffing structure to be able to meet requirements for recommendations of reports such as Ockenden/HIW and RCM/RCOG/CTMUHB		HoM	Apr-23	Dec-23		Leadership and Management team		Digital Midwife post currently being job matched. Further work on individual team establishments to be commenced December 22. Understanding wte against actual budget. Benchmark workforce requirements against maternity review action plan and agreed mandatory requirements MARCH – meetings held with finance to understand budget against Birth Rate Plus, follow up meetings planned in April 2023. Leadership team day scheduled to review team structures against caseloads. Digital midwife post received 2 years funding, currently in Trac/recruitment process. Digital post now appointed with start date 5/6/23. Secondment for their role replacement within DAU has gone out as expression of interest. MAY - Final All Wales birth Rate plus report due in June JUNE - Final report received by EDoN - will need overarching workforce paper to be developed. Finance reviews continue AUGUST - NIL further progression. Sept - workforce plannign trainign completed, SBAR in draft regarding urgent staffing requirements. Capacity challenging to dedicate to this work at present.	
Map of caseload demand / boundaries and capacity review. (Directly from Exec paper for escalation)	1. Review of caseload numbers by area and midwife to establish if team sizes and number of staff is sufficient to meet needs of the service 2. Mechanism to be put in place to be reviewed on a monthly basis as part of leadership and management meeting through reporting by Band 7's		CSfM SPB	Apr-23	Sep-23	Sep-23	Leadership and Management team		Work commencing with teams as of November 22 to include Allocate rostering and current working patterns. Ongoing meetings with Heads of Midwifery within Wales for peer support and to share practice. to review in April MARCH – meeting held for leadership team to begin review of caseload demand/capacity and to review team structures. Follow up planned for April. Plan to build team structure by WTE against average caseload to 'futureproof' service Further work undertaken 16th May 2023 by senior team reviewing caseloads, reviewing maternity leave and sickness. Work continues in this domain as larger workforce piece of work MAY - Work continuing under Workforce Transformation stream.	

Ensure the maternity workforce is supported in relation to health and well-being	1. Identify ongoing package for health and well-being for staff 2. Review and refresh the caring for you action plan 3. date to be set to review the Caring for You Charter with the RCM	committee to pull together caring for you action plan	RCM Committee and senior team	Feb-23	May-23	ongoing	RCM H&S Rep and senior team		Shire 11-1-23 - session with WoD/OH - cancelled - OH sickness rebooked for May 23 To aim for signing of charter at May shire Caring for you campaign charter signed at May shire meeting with RCM representatives present. Apr 23 - booked for May learning event JUNE- Charter signed at May learning event. Group has met in June to discuss priorities on action plan - reviewed monthly at management meeting	
Ensure a whole service approach to the maternity improvement plan	1.Utilise team meetings (shire) to feedback on progress of the improvement plan 2. Dissemination via Band 7 route progress with the plan		HoM	Feb-23	Jul-23	ongoing	senior team		MARCH - B7 Team leads now part of weekly leadership meetings - OTL minimum to attend. plan to agenda for Q2 learning event to provide update	
Ensure a service where equality and dviersity are a priority including: development of a local action plan to consider actions required to support the work around anti-racism, also to include wider equality and diversity issues and Welsh Language work	Theraplau a Gwyddorau Iechyd - Safonau Proffesiynol / Therapies and Health Science - Professional Standards - Anti-racist-Action-Plan-PTHB-2022-24.pdf - All Documents (sharepoint.com)	action plan drafted and then completion of action plan	AHoM (KE)	Jul-23	May-24		Risk and Governance Lead and Perinatal champion		JUNE 23 - Evie attending RCM event in July around E&D AUGUST - Meeting scheduled for September. SEPT - ED to link with diverse Cymru regarding cultural competency.	

ACTION / ACTIVITY	Additional detail	How will outcomes be achieved?	RESPONSIBILTY Person	START DATE	PROJECTED COMPL DATE	COMPL DATE	COMPL BY (staff)	BRAG STATUS	Progress	Evidence and location stored
Digital Maternity Cymru Implementation (links to DMC project plan) (Directly from Exec paper for escalation)	Implementation of digital maternity record	Completion and implementation of digital record	HoM	Q4 22/23	5 year project - 2028	BAU	HoM		Project board meeting next 3-2-23 - chaired by AD Digital Transfromation - Links to separate DMC project plan. Jan-23 update - programme has had ministerial sign off by WG - awaiting next steps for local implementation MARCH – Digital midwife post in Trac/Recruitment process. Expected to be in post from June 2023. APRIL - Interviews scheduled for 25-4-23 MAY - Post appointed to commenced 05.06.23 JUNE - Post in place - workplan underway. Lead and HoM sitting on national groups. Local Business plan will be needed for continued funding beyond 2025 - picked up through DMC Powys programme Board sept - Move to BAU on this plan as DMC is being managed through DMC Powys programme Board separately.	All DMC records stored on W&C Sharepoint
Digital Maternity Cymru Implementation (links to DMC project plan)	Appointment of digital midwife	Recruitment of digital midwife into post	HoM	Q4 22/23	5-year project	Jun-23	HoM		Jan-23 - awaiting confirmation from WG for funding stream - whether programme or HB led recruitment and posts. JD/PS back from job evaluation APRIL - Digital post interviews scheduled for 25-4-23 MAY - Post appointed to commenced 05.06.23 JUNE - Senior lead maternity informaticist in post. DMC workstream picked up in above action.	All DMC records stored on W&C Sharepoint
Data systems / quality and collection and Dashboard build (Directly from Exec pape for escalation) - links with 1.4 of WG MAT/NEO Assessment, Assurance & exception reporting tool - CTM/Ockenden	Ability to have a local dashboard which provides data for review for population rather than just local activity	Interactive dashboards that capture key KPI's	HoM	Oct-22	will link with DMC so up to 5 years		Leadership and Management Team		Will King convening session. Maternity Champion appointed too. Discovery programme and ongoing engagement with team to develop key performance indicators across Wales MARCH – contribution made to requirements for IPR. This work will also be picked up through the DMC work nationally. APRIL - Details submitted locally for 'ask' of dashboards internally. National DMC work is looking at national KPI's MAY - As above JUNE - Meeting to conveine with information Senior Team Public Health consultant Digital Midwife and Mat Neo Champion. AUGUST - Meeting scheduled for 22nd August with Information performance team and Public Health Consultant. SEPT - Meeting going to take place with CTM. ED & LJ leading.	
Ensure ongoing mechanism for Perinatal Institute reporting and monitoring to assess themese and trends in small for gestational age babies (Linked to Exec paper for escalation)	1. SBAR to be drafted to provide detail on GAP 2.0 requirement to seek organisational commitment		CSfM - SPB	Oct-22	Mar-23	Jun-23	AHoM		Meeting convened for November 2022 to present last quarter data report and improvements with pathway	standard agenda item on a quartlerly basis through maternity matters image audit reviews to take place and summary paper for maternity matters from USS Governance lead Apr 23 - GROW 2.0 paperwork to be sent to IG to progress
Continue to monitor database for Gap & Grow Pathway in collaboration with Perinatal Institute reporting. (Linked to Exec paper for escalation)	1. PI will attend Maternity Matters quarterly to provide update GAP Score report	To ensure understanding of SGA rate, available data, taxonomies and mechanism for ongoing monitoring	CSfM - SPB	Jul-22	Nov-22	now BAU	AHoM		completed - await decision as BAU	G&G database stored on Maty Templates
Implement GROW 2.0 within PTHB maternity service	To ensure as robust a way as possible of recording fetal growth	link with PI and local IG team to implement	AHoM (SPB)	Apr-23	Oct-23		AHoM		June - docs have been reviewed by IG team and cyber security - queries returned to PI. Currently out of materntiy hands, progressing through process. AUGUST - Meeting took place in July with the PI and IG cyber security. Action to be taken forward by PI & IG Teams.	
Commencement of Maternity & Neonatal Safety Improvement plan.	Will require outcome from MATNEOSSP report		HoM	expected March 2023			Leadership and Management Team		March - report draft received - comments returned and awaiting final report - now expected 28th April Delayed report - expected June 2023 AUGUST - Report received. JUNE - Report expected 10-7-23 SEPT - October Maternity Matters will review Powys Action Plan/Gap	

Work to be developed with Powys Safeguarding Team to ensure mandatory training requirements are met within Maternity Team.	To aim to increase compliance with safeguarding supervision		Lead midwife SG	Mar-23	Sep-23	Sep-23	Lead midwife for safeguarding		MARCH - Lead Midwife SG attends management meeting monthly to update on compliance against passport and supervision. also discusssed at weekly team leads meeting JUNE - SG midwife attends monthly management meeting - compliance shared - reviewed monthly SEPT - move to BAU, SG midwife comes monthyl to Leadership and Management meeting to share progress with supervision and passports. significant improvements made and regularly reviewed	Documents saved on Sharepoint
Re-establish the Maternity Parent Voice Partnership to ensure external scrutiny and service user input/consideration - links to 2.2 WG MAT/NEO Assessment, Assurance & exception reporting tool - Ockenden			consultant midwife	Sep-23	Mar-24				post vacant (Consultant Midwife) MARCH - MAT/NEO champion making links with MPVP chair to seek user input MAY - Poster ciruclated to Social Media for interest for MPVP	
Develop 'triage; system for call taking day and night to support staff to be able to do clinical work and to support TOIL	to include standardised 'triage pack' for all staff to ensure standardisation across the service in how hone calls are managed	by development of SOP relating to managing calls to the maternity service	MAT/NEO champion and Consultant Midwife	May-23	Oct-23		Perinatal Champion		meeting set up with Improvement Cymru in June to do workshop for staff thoughts Started develoment of Maternity Development Triage AUGUST - Documents due to go out for consultation with a view to implementing end of October.	
Review of equipment/kit lists to ensure staff are carrying correct equipment including neonatal resuscitation kit as per Resus Council Guidelines		Review of lists and ordering of any additional equipment or risk assessment if not ordered	MAT/NEO champion and AHoM (SPB)	Jun-23	Oct-23		AHoM and perinatal champion		ED exploring i-gels. SPB linking with Howard Cooper. SEPT - SPB needs to change kit list to reflect. Using for adults and Neonates. Will be using from OCT 2023.	
Implement use of neonatal SATS monitors for NIPE in Powys to align with national recommendation	1. Procurement of neonatal SATS monitors 2. development of local guideline for NIPE process to include SATS	1 x SAT monitor per team and associated guideline	MAT/NEO champion and AHoM (SPB)	Jun-23	Oct-23		AHoM and perinatal champion		Options being explored for procurement. AUGUST - Likely to be supported through tiny tickers EDOF process currently being followed. SEPT - EDOF form completed for SATs monitors. Needs to be incorporated into NIPE Guideline.	

ACTION/ACTIVITY	Additional detail	How will outcomes be achieved?	RESPONSIBILTY Person	START DATE	PROJECTED COMPL DATE	COMPL DATE	COMPL BY (staff)	BRAG STATUS	Progress	Evidence and location stored
Review of Maternity budgets	To understand current financial position, WTE establishment and to support future workforce planning	Meet with finance team, review current structure	HoM	Jan-23	Mar-23				initial meeting planned for 24-1-23 MARCH - Meeting also took place in march - updated against current establishment links now to caseload and team structures work. follow up meeting planned for April 2023 to try and realign budgets APRIL - WG have received all HB BRP reports and a meeting will convene about next steps. Current picture is slightly over established if aligned with 'option 1' and about right against 'option 2'. workforce in place now balanced and agreed with finance with all posts listed. work to be done to see if posts can be streamlined and to ensure resource is in the right place. JUNE - BRP received by EDoN - will need overarching workforce paper for requirements for the future - senior team completing training in workforce planning.	
Review establishments and current vacancies within Maternity department.	To review and refresh workforce structure and ensure clear understanding of current vacancies		HoM	Jan-23	Mar-23				Jan 23 - organisation structure reviewed for current status MARCH - Current structure now reflected - need further work to establish against birth rate plus and to seek agreement for 'table 2' of the BRP report MAY - Final BRP Report expected in June	https://nhswales365.sharepoint.com/:w:/r/sites/POW_W&C_Mat/_layouts/15/Doc.aspx?sourcedoc=%7B52CCB88B-C327-42AA-AB96-501E3FF2F52A%7D&file=Powys%20Teaching%20Health%20Board%20Maternity%20Services%20Staff%20Structure%20-%20Jan%202023.docx&action=default&mobileredirect=true

No.	Priority	Action	Nature	Timescale	Status	Responsible	Resource Needed	PTHB position
1	1.1 Ensure Executive Board members and senior leaders are visible to, and have visibility of, maternity and neonatal services	A. Ensure maternity and neonatal services are a standing agenda item at all Health Board Quality and Safety Meetings. a. Ensuring discussion of themes, learning and action resulting from reported incidents, b. and review of the standardised perinatal quality surveillance dashboard.	Perinatal	Short term		Health boards	Minimal resource	Mat Matters - need to clarify reporting on through HB
		B. All Health Boards to appoint a Director of Midwifery to manage the strategic delivery of maternity services locally.	Maternity	Medium term		Health boards	Resource needed	
		C. Implement quarterly standardised leadership walk-arounds.	Perinatal	Short term		Health boards	Minimal resource	senior team visibility
		D. All Health Boards to appoint and resource Obstetric and Neonatal Consultant Safety Leaders and a neonatal senior nurse to sit at a senior level within the organisation on Quality and Safety Boards and committees to create a floor-to-board link and ensure quad representation.	Perinatal	Short term		Health boards	Resource needed	Does this need consideration from maternity perspective in PTHB?
	1.2 Ensure leadership and culture are optimised to improve maternity and neonatal teamworking	E. Ensure staff in recognised leadership roles have access to leadership training which includes content on culture and the principles of high performing teams and that resourcing for higher/additional qualifications is supported.	Perinatal	Medium term		Health boards, NHS Executive, HEIW	Minimal resource	leadership and culture action 3
		F. Ensure structures and ways of working, including co-location, which enable midwifery, obstetric and neonatal leads to regularly meet, share, and learn together.	Perinatal	Medium term		Health boards, NHS Executive	Minimal resource	
	1.3 Develop a National Improvement Collaborative for Maternity and Neonatal Services in Wales	G. Ensure improvement-related recommendations from MatNeoSSP Discovery Phase are subject to a test, scale and spread methodology across NHS Wales.	Perinatal	Long term	In progress	NHS Executive	Resource needed	NA - Led by others
	2.1 Develop a workforce strategy for NHS Wales maternity & neonatal services 2.2 Adherence to national workforce standards from BAPM, RCOG & RCM to deliver optimal care	A. National workforce planning to establish safe standards of care for midwifery, obstetric and neonatal workforce (to include recruitment, retention and training). Strategy to ensure: a. Minimum staffing levels include locally calculated uplift, representative of the three previous years' data, for all absences including sickness, mandatory training, study leave annual leave and maternity leave. b. NICUs (neonatal intensive care unit) have direct clinical care provision of 12-hour consultant cover over 7 days. c. Maternity units have enough staff to facilitate a consultant ward round every 12 hours. d. Allied Health Professional roles are embedded within services in line with national standards. e. Facilitation of new models of medical care (e.g., Physician's Associates, ANNPs on Tier 2 and nurse consultant roles). f. Facilitation of clear career progression for non-qualified and qualified workforce.	Perinatal	Medium term	In progress	Health boards, NHS Executive, HEIW	Resource needed	birth rate plus and workforce plan
		B. Ensure the Maternity & Neonatal Network is structured to deliver its defined responsibilities under the NHS Executive Mandate and resourced adequately with Medical and AHP leads including a lead Pharmacist.	Perinatal	Medium term		NHS Executive	Resource needed	NA - Led by others
		C. Annual review of workforce collated as part of Maternity and Neonatal Network workforce review.	Perinatal	Short term	In progress	NHS Executive	Minimal resource	NA - Led by others
		D. Health Boards to undertake annual working patterns survey to explore inefficiencies and use results to review system waste and ensure prudent deployment of all roles, e.g., ensuring sufficient administrative staff.	Perinatal	Short term		Health boards, HEIW	Minimal resource	Finance and workforce action 3 leadership and culture action 4&5
		E. All NICUs to have a Clinical Director/Lead or equivalent post with a minimum of two funded sessions to deliver against recommendations.	Neonatal	Short term		Health boards	Resource needed	NICU related
		F. All Maternity Units to have a Clinical Director with sessional allocation in line with RCOG recommendations.	Maternity	Short term		Health boards	Resource needed	

		G. All Health Boards must allocate adequate SPA time for consultants. This allocation should aim to adhere to the accepted standard of 7:3 DCC (Direct Clinical Care): SPA, with additional time allocated for specific extra lead roles undertaken (e.g., governance, data, Perinatal Mortality Review Tool).	Perinatal	Short term		Health boards	Resource needed	
	2.3 Local workforce planning and team structures ensure sufficient capacity and prudent use of skills for high quality care	H. All NICUs should have a data manager with consideration of data management input for SCUs.	Neonatal	Medium term		Health boards	Resource needed	NICU related
		I. NHS Wales to ensure provision of psychological support, within each maternity department and neonatal unit for all maternity and neonatal staff.	Perinatal	Short term		Health boards, WHSSC	Resource needed	Locally via learning events, supervision sessions and team meetings
		J. Inform future workforce strategies and workforce planning by maximising standardised exit interview uptake, reporting and taking action to address themes both locally and at national level.	Perinatal	Short term		Health boards, HEIW	Minimal resource	
		K. All maternity & neonatal services to embed Psychological Safety and the principles of a Just Culture embedded as cultural norms.	Perinatal	Long term		Health boards, NHS Executive, HEIW	Minimal resource	Locally via learning events, supervision sessions and team meetings
		L. All maternity and neonatal units should appoint a Freedom to Speak Up Champion.	Perinatal	Short term	In progress	Health boards	Minimal resource	
2	2.4 Prioritise the wellbeing and safety of staff and patients through team culture and support mechanisms	M. All maternity and neonatal units should implement an annual validated psychological safety survey e.g., SCORE, SAFE, with results shared, discussed and acted on at local team, unit, Health Board and national levels.	Perinatal	Short term	In progress	Health boards, NHS Executive	Minimal resource	culture climate surveys completed July 2023 - results now availbale - to link with WoD for next steps
		~~A. Define national training/competency requirements and standards for each role within the maternity & neonatal workforce~~ Which includes but is not limited to adherence to mandatory training in: a. Equality & Diversity b. FiCare (see 7J) c. Human Factors d. Lactation & Loss (see 13G) e. Leadership (see 1E) f. Multiprofessional Simulation g. Neonatal Life Support h. Patient Safety (see 11FF) i. Perinatal mental health (see 5L) j. Quality Improvement (see 12A & 12H) k. Situational Awareness (see 11P) l. Team Working (including communication) (see 11P) Which addresses current deficits in relation to: m. Enhanced Maternal Care (see 11S) n. Incident Investigation (see 11FF) o. Radiology (see 12K) Which creates a:	Perinatal	Medium term	In progress	Health boards, HEIW, WRP	Minimal resource	Equality and diversity training - to be included with the cultural competencies action plan
	3.1 Develop a national maternity and neonatal workforce training	B. Establish local training plans in each organisation to ensure that every member of the maternity and neonatal workforce has allocated time, capacity and opportunity to meet all nationally and locally defined training needs.	Perinatal	Medium term		Health boards	Resource needed	TNA drafted - leadership and culture action 2

	strategy. 3.2 Deliver national strategy through local training plans. 3.3 Ensure training, competence and qualification records are complete and reportable. 3.4 Ensure sufficient service capacity and opportunity for all members of maternity and neonatal workforce to be able to fulfil all training and development requirements.	C. Ensure adequate administrative support is in place to maintain records of all staff training, competencies, and qualifications. These should be held centrally with in the Health Boards, reportable and reviewed at least annually for all staff.	Perinatal	Medium term		Health boards	Resource needed	consider admin support as part of workforce review
3		D. Ensure that all additional personal and professional training needs are recorded using local appraisal processes.	Perinatal	Short term	In progress	Health boards	Minimal resource	PADR discussion and locally held database demonstrating compliance with training
	4.1 Establish & deliver a Maternity and Neonatal research strategy for Wales to improve both short term neonatal and longer term child and adult outcomes	A. Develop an NHS Wales Maternity & Neonatal Research Strategy which: a. Is led by a centrally funded maternity & neonatal academic lead for Wales in a central facility. b. Establishes research partnerships within Wales and internationally. c. Accesses current data repositories within Wales. d. Ensures primary data is available in a timely manner to drive high quality care.	Perinatal	Long term		Welsh Government	Resource needed	NA - Led by others
		B. Expand opportunities for Maternity and Neonatal Trainees in Wales to undertake research and higher degrees.	Perinatal	Medium term		HEIW	Resource needed	NA - Led by others
4		C. Ensure that members of the perinatal team who wish to be active researchers have support from their Clinical Leads/Directors with consideration of recognised research time in their job plans.	Perinatal	Short term		Health boards	Resource needed	
	5.1 Every woman to be as well as possible for, and during, pregnancy and supported to give children the best start in life	A. Resource and maintain clear service pathways between maternity services, Public Health Wales and primary care to support women to: a. Achieve and maintain a healthy weight, b. Access smoking cessation support services, before, during and after pregnancy.	Maternity	Medium term		Health boards, PHW	Resource needed	
		B. All Health Boards to a. co-produce communications tailored for ethnic minority women in their communities, b. ensure rapid access to advice if women from an ethnic minority background are concerned about their health, c. and ensure all staff have a lower threshold to review, admit and consider multidisciplinary escalation in women from an ethnic minority background.	Maternity	Short term		Health boards	Minimal resource	
		C. Ethnicity must be accurately recorded at booking and data used to monitor outcomes for women of different ethnic origins.	Maternity	Short term	In progress	Health boards, NHS Executive	Minimal resource	To be included in the cultural competencies action plan
		D. All Health Boards to implement use of the 'Healthier Together' website, or similar product, to provide advice and information translated into many languages.	Maternity	Medium term		Health boards	Resource needed	To be included in the cultural com

		E. All women with limited English language skills should be provided with a co-produced, maternity access card to advise them on how/where to attend an obstetric unit in case of a concern.	Maternity	Short term		Health boards	Minimal resource	
		F. All Health Boards to invest in portable visual interpreting systems (functionality similar, but not limited to, those provided by Language Line). These should be accessible 24 hours a day so that they can be used in clinic, theatres, and neonatal units.	Perinatal	Short term		Health boards	Resource needed	To be included in the cultural competencies and DMC action plan
		G. Maternity Voices Partnerships in each Health Board should consider becoming Maternity and Neonatal Voices Partnerships to reflect the common goals of both services.	Perinatal	Short term		Health boards	Minimal resource	maternity and parent voices partnership in place in PTHB
		H. Each Health Board should engage with their local Maternity Voices Partnership volunteers to create points of contact in harder to reach communities.	Perinatal	Short term		Health boards	Minimal resource	
		I. Each Health Board to establish paid Chair & Deputy Chair Maternity Voices Partnership positions to embed co-production of services.	Perinatal	Short term		Health boards	Resource needed	
		J. Establish an All Wales Maternity and Neonatal Service User Framework Group to ensure the voices of women and families are central to national co-production of services	Perinatal	Medium term	In progress	NHS Executive	Minimal resource	NA - Led by others
	5.2 Review access to maternity care for all women, regardless of ethnicity, geography or socio-economic status or other protected characteristic.	K. Consideration should be given to NHS Wales procurement of digital tools to assist in accurate risk assessment for adverse pregnancy outcome in early pregnancy.	Maternity	Long term		NHS Executive, Welsh Government	Resource needed	NA - Led by others
5	5.3 Prioritise women's mental health in all areas of contact antenatally and postnatally	L. All Health Boards to embed the Wales perinatal mental health programme and ensure all staff are trained, (see 3A) feel competent to ask about mental health and recognise importance of recording PNMH data including medication use.	Maternity	Medium term		NHS Executive, Health boards	Resource needed	staff trained
	6.1 Ensure all Health Boards embed The All-Wales Midwifery Led Care Guidance into practice	A. Gather place of birth data as defined in Section16 of the 'Auditable Standards' in the All-Wales Midwifery Led Care Guidelines. a. Benchmark data with 2011 Birthplace Study results. b. Analyse findings to identify variation/risks and use data to inform quality improvement activity and implementation of sustainable practice changes.	Maternity	Medium term		NHS Executive, Health boards	Minimal resource	
	6.2 Develop mandated standards for Midwifery led units in Wales	B. Benchmark Freestanding and Alongside Midwifery Units in Wales against the Midwifery Unit Network published standards. C. Analyse findings to: a. Support development of NHS Wales Midwifery Led Unit Standards. b. Identify variation/risks and use data to inform quality improvement activity.	Maternity	Medium term		NHS Executive	Minimal resource	NA - Led by others
6	6.3 Implement standardised informed decision-making aids across Wales	D. Agree and implement standardised decision-making aids to support women and families in making informed choices. e.g. BRAN (Choosing Wisely) or BAPM Enhancing Shared Decision Making Framework.	Perinatal	Medium term		NHS Executive, Health boards	Minimal resource	use BRAIN in practice

		A. Develop a standardised mechanism for multidisciplinary maternity & neonatal teams to review ATAIN (Avoiding Term Admissions into Neonatal) rates. B. Establish and ensure ongoing thematic analysis of ATAIN C. Share findings/learning nationally and use data to inform quality improvement activity and implementation of sustainable practice changes. e.g., where upstream (antenatal) contributory factors have been identified engage with Public Health Wales and other stakeholders (i.e., smoking/obesity to ensure equitable care).	Perinatal	Medium term		NHS Executive, Health boards	Minimal resource	
		D. Ensure adequate facilities and support provision for wider family members, e.g., playrooms and additional support for siblings.	Neonatal	Short term		Health boards	Resource needed	
		E. Expand Neonatal Outreach services across NHS Wales to enable earlier discharge from neonatal units, Transitional Care, and postnatal wards. This should: a. Be available 7 days a week, b. Include access to Allied Health Professional Services. F. Include the ability to support short-term nasogastric tube feeding in the community for preterm infants.	Neonatal	Medium term	In progress	Health boards, WHSSC	Resource needed	
	7.1 Families to be supported and enabled to stay together (where possible) when their baby requires support, investigation, or treatment	G. Where possible transcutaneous bilirubinometers to be used in the community alongside awareness of challenges for diagnosis of jaundice in ethnic minority babies. Explore introduction of home phototherapy.	Perinatal	Short term	In progress	Health boards	Resource needed	in place
	should be accessible to all families during their stay in an NHS Wales neonatal unit with seamless links to community maternity mental health services as appropriate	H. Nationally review funding and provision of psychology service ensuring it is in line with national UK guidance. I. Use review findings to share national learning, refine/create services and establish referral links to community maternity mental health services as appropriate.	Neonatal	Medium term		Health boards, WHSSC	Resource needed	
		J. FiCare resources to be allocated and training to be facilitated for all units.	Neonatal	Short term	In progress / Bright spot	Health Boards, NHS Executive	Minimal resource	NICU related
	7.3 FiCare to be fully embedded in practice in all NHS Wales Neonatal Units	K. All Neonatal Units to demonstrate >80% compliance with FiCare passport, and where not achieved, submit Board report describing barriers and action being taken to address on a 6 monthly basis.	Neonatal	Medium term		Health boards	Minimal resource	NICU related
	7.4 All Neonatal Units to adhere to Bliss Baby Charter Standards	L. All Neonatal Units to achieve Bliss Baby Charter accreditation. a. Resource and workforce capacity should be explicitly allocated to support achieving and maintaining accreditation.	Neonatal	Long term	In progress	Health boards	Resource needed	NICU related
	7.5 Embed a standardised family feedback process for NHS Wales	M. Agree and embed a standardised Maternity and Neonatal Feedback mechanism into NHS Wales services, during and following service use including Transitional Care. a. Ensure inclusion of feedback question/s about parental opinion on safety of care experienced. b. Ensure simplicity of process, communication materials to promote to families and information/training for staff, c. Make results available to parents, families, staff and senior leaders.	Perinatal	Long term		NHS Executive, Health boards	Minimal resource	

		A. All neonatal units to employ at least one funded infant feeding lead post, who will work closely with the Health Board Strategic Infant Feeding Lead (as mandated in All Wales Breastfeeding 5 Year Action Plan 2019) to promote good breastfeeding practice.clxxvi a. High activity level units to consider employing 2 WTE Infant Feeding Leads.	Neonatal	Short term	In progress	Health boards	Resource needed	NICU related
		B. NHS Wales to adopt the UNICEF Baby Friendly Initiative as a breastfeeding good practice accreditation. a. Resource and staff capacity should be explicitly allocated to support achieving and maintaining accreditation.	Perinatal	Medium term	In progress	Health boards	Minimal resource	
	8.1 Ensure opportunities for breastfeeding are optimised for all women to improve breastfeeding rates across Wales 8.2 Ensure early access to breast milk and sustaining numbers of both preterm and term babies receiving breast milk during their entire stay 8.3 Ensure NHS Wales has an infant feeding educated workforce 8.4 Ensure monitoring and evaluation of process and outcome indicators for successful breastfeeding	C. All neonatal units to record expressed breastmilk volumes, as defined in the All-Wales Enteral Feeding Pathway for Preterm Infants. a. Report compliance with the pathway quarterly. D. Share findings/learning nationally and use data to inform quality improvement activity and implementation of sustainable practice changes, or reinforce action already being taken.	Neonatal	Short term		Health boards, NHS Executive	Minimal resource	
		E. All units alongside their Infant Feeding Leads to develop unit-level plans to maximise early colostrum and early breast pump use in line with national guidance (BAPM MBM Toolkit). a. Ensure pathways and staff education on facilitation and recording of skin-to-skin rates. b. Ensure availability of breast pumps at each cot side. c. Monthly local monitoring of plan implementation. F. Share findings/learning nationally and use data to inform quality improvement activity and implementation of sustainable practice changes, or reinforce action already being taken.	Neonatal	Short term		Health boards	Resource needed	
8	8.5 Ensure equitable access to donor milk and options to donate milk across NHS Wales	G. Develop Milk Bank access for all women across Wales.	Perinatal	Long term	In progress	PHW, Health boards	Resource needed	
		A. Implement Neonatal Transitional Care UK standards. a. Consider a single national data recording system to provide monitoring data and commissioning information. b. Ensure Transitional Care Service in all units is commissioned alongside all other neonatal services c. Ensure that all Neonatal Transitional Care standards are embedded by ensuring services are commissioned and. sustainably staffed to BAPM standards, including a designated nurse lead (band 7); a ratio of nursing/nursery staff to babies of 1:4; and all babies to have a named paediatric or neonatal consultant.	Perinatal	Medium term	In progress	Health boards, NHS Executive	Resource needed	NICU related
9	9.1 Develop Transitional Care in all maternity units, aligned with national BAPM standards	B. Each baby to have clinical input at the same level of seniority as babies receiving special care on a Neonatal Unit.	Neonatal	Medium term		Health boards	Resource needed	NICU related
		A. Establish an agreed method of understanding the continuity of care that women in Wales currently receive. a. Use that method to collect baseline continuity of carer data b. Establish improvement plans where required.	Maternity	Medium term		Health boards	Resource needed	
	10.1 Review models of midwifery care to optimise continuity	B. Health Boards to review community midwifery service provision to ensure that women see: a. No more than 2 midwives antenatally and postnatally, b. their named midwife for postnatal discharge.	Maternity	Medium term		Health boards	Resource needed	
10	10.2 Maximise continual risk assessment throughout pregnancy to ensure women birth in their place of choice	C. Health Boards to implement All Wales Midwifery-Led Care Guideline (6th Edition) guidance to ensure all women have the choice to birth in a Midwifery Led setting.	Maternity	Short term	In progress	Health boards	Minimal resource	in place

		A. Implement standard advice and pathways to support each Health Board, emergency service and clinician to provide optimal care for women experiencing acute pregnancy problems.	Maternity	Medium term		Health boards, WAST	Resource needed	
		B. Ensure that standardised clinical advice is made available to women and their families: a. Using Plain English principles b. Available via the most accessible channels c. Easily available at times of critical need d. Translated into multiple languages.	Maternity	Medium term		Health boards, NHS Executive	Minimal resource	
		C. Review information being given via 111 web pages and ensure: a. Alignment with the standard advice b. Published using Plain English principles c. Available in multiple languages.	Maternity	Medium term		WAST	Resource needed	NA - Led by others
		D. Establish telephone advice resources, based on the standard advice, and embed their use throughout NHS Wales maternity services.	Maternity	Medium term		Health boards, WAST	Resource needed	PTHB local maternity triage work
	11.1 Develop and implement standardised advice for management of women with acute problems in pregnancy	E. Create permanent midwifery posts within Welsh Ambulance Services Trust (WAST) to: a. Establish an expert link with maternity and neonatal services for clinical advice, information and partnership working, b. Provide expert input into development of a national 'Labour Line' telephone service. c. Provide expert input into consideration of a national 'Triage Line' telephone service. d. Provide specialist input into internal WAST training, paramedic undergraduate and post graduate education.	Perinatal	Medium term		Health boards, WAST	Resource needed	
	11.2 Implement a standard approach to the detection of the sick or deteriorating woman in line with NICE guidance (NG133)	F. Develop an All-Wales Maternity Early Warning Score (MEWS) Chart and implement in every healthcare setting in Wales where a pregnant woman could receive care.	Maternity	Medium term	In progress	NHS Executive	Minimal resource	NA - Led by others
		G. Establish a Maternal Medicine Network for South Wales, ensuring: a. Leadership from an obstetric physician, b. Senior midwifery coordination, c. Specialist advice from an obstetrician trained in maternal medicine.	Maternity	Medium term		NHS Executive	Resource needed	NA - Led by others
		H. Develop and maintain a service level agreement (or equivalent) between NHS Wales services in North Wales with the Liverpool Maternal Medicine Centre.	Maternity	Medium term		Health boards	Resource needed	
	11.3 Establish maternal medicine network access across NHS Wales	I. NHS Wales to consider if a Maternal Medicine Centre could/should be shared between Health Boards.	Maternity	Long term		NHS Executive	Resource needed	NA - Led by others

		J. Refresh the NHS Wales Safer Pregnancy Campaign incorporating actions from Saving Babies' Lives Care Bundle version 3. This will require funding/implementation of: - a. Smoking cessation support readily available in all Health Boards. b. An improvement programme to ensure standardisation of carbon monoxide monitoring. c. Training to support provision of: a. Sufficient sonography services b. Uterine artery dopplers at 20 weeks c. Transvaginal cervical length in preterm birth clinics (NICE Guidance NG25) d. Computerised CTG (Cardiotocograph) to be made available in all units for women with reduced fetal movement or early onset fetal growth restriction. e. Preterm birth prevention clinics established in each Health Board.	Maternity	Medium term		Health boards, NHS Executive, HEIW	Resource needed	
		K. All Health Boards to review existing complement of specialist midwives and ensure there are posts to cover diabetes and preterm birth	Maternity	Medium term		Health boards	Resource needed	consider in workforce review
		L. All Health Boards to implement Placental Growth Factor (PLGF) testing for women with suspected pre-eclampsia (NICE guidance NG133).	Maternity	Short term	Bright spot	Health boards, NHS Executive	Resource needed	N/A
		M. All Health Boards* to establish multiple pregnancy clinics with a specialist midwife, obstetrician, and sonographer as core staff (NICE guidance NG137). *Powys to consider specialist midwife to link with neighbouring clinics.	Maternity	Medium term		Health boards	Resource needed	
		N. National guidance that is not followed should be reported by each Health Board to the NHS Executive Maternity and Neonatal Network	Maternity	Short term		Health boards	Minimal resource	
	11.4 Embed national guidance (NICE, RCOG, All Wales guidance) relating to pregnancy and birth across NHS Wales.	O. NHS Wales to undertake a review of the effectiveness of GAP/GROW compared to alternative models for detecting small for gestational age babies.	Maternity	Long term		NHS Executive	Minimal resource	NA - Led by others
		P. All Cardio Tocograph/Intermittent Auscultation training to consider using Each Baby Counts + Learn & Support toolkits and ensure inclusion of content relating to: a. Situational awareness, b. team working (including communication), c. and escalation (See 3A)	Maternity	Medium term	In progress	Health boards, NHS Executive, WRP	Minimal resource	
		Q. In suspected pre-term labour, all Health Boards to ensure all women have access to the most accurate preterm birth tests including: a. ultrasound machines to perform transvaginal cervical length, b. and quantitative fetal fibronectin.	Maternity	Medium term		Health boards, HEIW	Resource needed	
		R. In suspected pre-term labour, all Health Boards to ensure obstetricians are trained to perform transvaginal cervical length scans. (see 3A).	Maternity	Medium term		Health boards, HEIW	Resource needed	
	11.5 Minimise variation in intrapartum care in line with NICE guidance.	S. Enhanced maternal care training to be provided for enough midwives to ensure an appropriately qualified midwife on every shift in obstetric units. (See 3A). (E.g., PROMPT CiPP course)	Maternity	Medium term		Health boards, HEIW, WRP	Minimal resource	

		T. Ensure all obese postnatal women can access the primary care obesity prevention programme (in development as of April 2023).	Maternity	Medium term		Health boards, PHW	Minimal resource	
		U. Ensure all postnatal women who have had gestational diabetes receive advice relating to: a. postnatal testing b. yearly HBA1C c. lifestyle modification to reduce development of type 2 diabetes and associated complications	Maternity	Medium term		Health boards, NHS Executive, Primary Care	Resource needed	
		a. lifestyle modification	Maternity	Short term		Executive, Primary	Resource needed	
	11.6 Ensure evidence-based care and advice given to postnatal women on modifiable risks	W. Ensure all postnatal women who had a preterm birth under 34 weeks have an appointment with a specialist obstetrician to discuss implications for future pregnancies.	Maternity	Medium term		Health boards	Resource needed	
	11.7 Develop and launch data dashboards which enable monitoring and benchmarking of clinical activity and outcomes	X. NHS Wales to agree the content and output of a national standardised data dashboard which enables benchmarking against the NHS England Maternity Services and National Maternity and Perinatal Audit data sets.	Perinatal	Medium term	In progress	NHS Executive, DHCW	Minimal resource	NA - Led by others
		Y. Health Boards to collaborate and develop local dashboards, to include the standardised perinatal quality surveillance dashboard to enable real time activity/outcome measurement and monitoring to support local improvements. a. A standardised perinatal quality surveillance dashboard would incorporate the following: • Clinical outcomes including stillbirths, neonatal deaths, HIE, ATAIN, SBLCBv2 progress and compliance.	Perinatal	Short term		Health boards, NHS Executive	Minimal resource	Sept 23 - 1st local stakeholder meeting agreed to commence further work. Meeting with CTM to understand measures,
	11.8 Ensure standardised approach to maternal and neonatal safety assurance and measurement throughout NHS Wales	Z. NHS Wales to implement annual assurance safety metrics which are aligned with safety actions elsewhere in the UK, including consideration of incentivisation.	Perinatal	Medium term		NHS Executive, WRP	Minimal resource	NA - Led by others
	11.9 Optimise and standardise maternity & neonatal governance systems across Health Boards	AA. Develop and implement NHS Wales Maternity and Neonatal Trigger Tools to guide standardisation of event/incident reporting.	Perinatal	Short term		NHS Executive	Minimal resource	NA - Led by others
		BB. Appoint national Maternity and Neonatal Safety Leads to support national learning and ensure implementation of learning from incidents.	Perinatal	Short term		NHS Executive	Resource needed	NA - Led by others
		CC. Align NHS Wales Datix fields with agreed national Trigger Tools and analyse data at Health Board and national level to identify themes and guide continual improvement.	Perinatal	Short term		NHS Executive, Health boards	Minimal resource	
		DD. NHS Wales to develop and implement a standardised maternity & neonatal adverse event review process (E.g., NHS Scotland Perinatal Adverse Event Review Process).	Perinatal	Short term	In progress	NHS Executive, Health boards	Minimal resource	

		EE. All maternity and neonatal units to have robust governance team structure, with accountability and line management to the DoM and CDs. The team should include: - e. a designated senior midwife/nurse and medical consultant leads for governance: f. with protected time allocated for fulfilling their roles including external review for PMRT, g. sufficient administrative support, h. and equitable allocation across both maternity and neonatal services.	Perinatal	Medium term		Health boards	Resource needed	
		FF. All incident investigators to be fully trained and competent to undertake their roles, to include consideration of training in: a. Systems Engineering Initiative for Patient Safety (SEIPS) b. Patient Safety Investigation Response Framework (PSIRF). (See 3A)	Perinatal	Medium term		Health boards, HEIW	Resource needed	RCA trained and Q&S action 9
	11.10 Ensure local and national review of maternity & neonatal incidents to facilitate thematic analysis, learning and improvement 11.11 Ensure Executive Boards are aware of maternity & neonatal metrics, outcomes, safety and governance issues	GG. All Health Boards to ensure recorded justification and decision making to support any local deviation from nationally agreed protocols/guidance/best practice.	Perinatal	Short term		Health boards	Minimal resource	caveat and cover sheets in place where necessary
11	11.12 Ensure all cases of maternal death, term intrapartum stillbirth, early neonatal death>37 weeks and hypoxic ischaemic encephalopathy (HIE) are reviewed by a fully trained independent investigation team	HH. NHS Wales to develop or commission a system for external independent review for all cases of: a. Maternal death, b. Term intrapartum stillbirth, c. Early neonatal death>37 weeks, d. Hypoxic ischaemic encephalopathy (HIE).	Perinatal	Medium term		Health boards, NHS Executive	Resource needed	
		A. Ensure that perinatal quality improvement is embedded and sustained as a cultural and behavioural norm throughout NHS Wales. Supporting implementation of: a. Local improvement activities in each unit and Health Board b. National improvement activities such as perinatal optimisation PeriPrem Cymru and MatNeoSSP Improvement Collaborative.	Perinatal	Short term	In progress	NHS Executive, Health boards	Minimal resource	Sept 23 - Fundamentals of improvement training for leadership team and specialist midwives - with plan to roll out to rest of workforce
		B. Ensure all instances where babies were not born in the right place (e.g., <32 weeks) are subject to robust local and national review (including babies born prehospital under care of the Welsh Ambulance Services Trust).	Perinatal	Short term		Health boards, NHS Executive, WAST	Minimal resource	
		C. All Health Boards to establish and sustain mechanisms for maternity and neonatal teams to work together across service boundaries, to: a. Create strong working relationships and strong communication pathways, b. Support changes in service development c. maximise multidisciplinary learning e.g., Sim training, d. Optimise clinical outcomes. (In line with national guidance)	Perinatal	Short term	In progress	Health boards	Minimal resource	
		D. NHS Wales to implement the NHS Wales Probiotics Guideline	Neonatal	Short term	In progress	NHS Executive, Health boards	Minimal resource	

		E. Develop and implement an NHS Wales robust definition and process for review of all infections in babies on neonatal units. a. Health Boards to constantly record and monitor local instances. F. Report and publish infection rates nationally every 6 months. G. Consider use of established QI process for neonatal infection e.g., Vermont Oxford Network (VON)	Neonatal	Medium term		Health boards, NHS Executive	Minimal resource	
		H. Ensure neonatal teams embed national guidance on specialist neonatal respiratory care for babies born preterm.	Neonatal	Medium term		Health boards	Minimal resource	
	12.1 Optimise Maternity & Neonatal Outcomes	I. All NHS Wales maternity and neonatal units to ensure that a designated Quality Improvement Midwife/Nurse and senior consultant, with: a. The skills/competence to lead quality improvement activity in their unit. b. Time allocated to act as their unit's Quality Improvement Lead.	Perinatal	Short term		Health boards	Resource needed	
		J. All neonatal units to have a plan and to be allocated capacity to have early developmental intervention and to undertake developmental assessment at two years, using AHP input.	Neonatal	Medium term		Health boards	Resource needed	
	12.2 Ensure Services are equitable for babies across Wales	K. Undertake a national review of care pathways for babies with bilious vomiting to enable close partnership working between surgical NICU's, transport services and all service providers to: a. Reduce unnecessary transfers b. Minimise mother-baby separation c. Consider drive-through options	Neonatal	Medium term		NHS Executive	Resource needed	NA - Led by others
12	12.3 Improve the pathway for babies presenting with bilious vomiting	L. Develop a system of radiology support for neonatal units with no out of hours radiology services to reduce delays in access to surgical review and upper GI contrast study.	Neonatal	Medium term	In progress	NHS Executive, WHSSC	Resource needed	NA - Led by others
		A. NHS Wales to explore commissioning options for perinatal pathology outside Wales to reduce waiting time for post-mortem results.	Perinatal	Medium term	Complete	WHSSC	Minimal resource	NA - Led by others
	13.1 Minimise variation in bereavement care for all families who lose a baby, regardless of gestation or age	B. NHS Wales to fully implement all five pathways within The National Bereavement Care Pathway (NBCP).	Perinatal	Long term	In progress	Health boards, NHS Executive, Welsh Government	Resource needed	
		C. Provide equitable bereavement care across Wales and services to ensure that all bereaved women receive care and advice from a Bereavement Midwife.	Perinatal	Medium term		Health boards	Resource needed	
		D. Each Health Board to establish and sustain a Rainbow Clinic model which provides: a. Standardised debriefs for bereaved families, b. Specialist obstetric and midwifery care for women in future pregnancies to reduce risk of recurrent loss.	Maternity	Short term		Health boards	Resource needed	
	13.2 All maternity and neonatal units to ensure specialist bereavement posts are created/sustained within workforce	E. Health Boards to review the caseload of all Bereavement Midwife posts to ensure appropriate use of skills, and plan for delivery of sustainable bereavement services in line with NBCP requirements.	Maternity	Short term		Health boards	Minimal resource	

	plans	F. Health Boards to ensure each Neonatal unit has a named Bereavement Lead, with	Neonatal	Short term		Health boards	Resource needed	
13	13.3 Create national and local implementation plans to embed the BAPM Lactation and Loss	G. Establish funding/resources, pathways, information and training to enable all Health Boards to embed the BAPM Lactation and Loss Framework for Practice.	Perinatal	Medium term		Health boards, NHS Executive	Minimal resource	
14	14.1 Ensure resourcing for maternity services is transparent, and an alternative funding model urgently considered 14.2 Establish a care and funding model which fairly and adequately compensates Health Boards for delivering high quality care to all woman, whilst supporting personalisation, safety, and choice	A. Ensure that funding/resources follow the woman and her baby as far as possible, to a. Ensure women's choices are funded, b. Support organisations to work in close partnership to deliver services.	Maternity	Long term	In progress	NHS Executive	Minimal resource	NA - Led by others
		B. Incentivise the delivery of high quality and efficient care for all women, regardless of where they live or their health needs (also see 11Z).	Maternity	Medium term		Welsh Government, WRP	Resource needed	NA - Led by others
	15.1 Ensure there is joined up review of all perinatal services and that neonatal services encompass care from cot to community 15.2 Ensure efficient use of cot capacity across Wales 15.3 Ensure efficient flow of babies to their local hospitals or back home with their families 15.4 Ensure babies are born in the right place where possible 15.5 Ensure SCU teams are skilled in managing repatriated babies from NICUs 15.6 Maintain emergency care skills and confidence for all neonatal clinical staff, particularly those working in SCUs	A. Planning for neonatal services (such as reviews of flow and capacity) should be coordinated jointly with maternity services.	Neonatal	Medium term	In progress	WHSSC	Minimal resource	NA - Led by others
		B. Transitional Care and Outreach services must be included where there is any review of maternity and/or neonatal services.	Perinatal	Long term		NHS Executive, WHSSC	Minimal resource	NA - Led by others
		C. Strategic planning and commissioning of maternity and neonatal services (from Cot to Community) should be coordinated jointly with commissioners and the NHS Executive and include representation from all members of the perinatal team.	Perinatal	Medium term		NHS Executive, WHSSC	Resource needed	NA - Led by others
		D. Undertake central review of the BAPM recommendations regarding NICUs admitting < 100 VLBW babies or carrying out <2000 intensive care days to develop plans to amalgamate NICUs to increase throughput or change designation.	Neonatal	Medium term		WHSSC	Resource needed	NA - Led by others
		E. Establish a system to electronically capture data relating to transfers and failed transfers of women and babies, in utero and ex-utero in both maternity and neonatal settings.	Perinatal	Medium term		NHS Executive, WHSSC	Resource needed	NA - Led by others
		F. Develop and implement a tool for monthly monitoring of each NHS Wales neonatal unit's non-special care days (coded HRG 3-5 on Badgernet). a. All units to share and discuss results regionally and nationally to identify improvements and share learning, e.g., barriers to delayed discharge, outreach support, Transitional Care facilities.	Neonatal	Medium term		Health boards, NHS Executive	Minimal resource	
15		G. Establish and fund ongoing rotational experience for permanent medical staff from SCUs to NICUs.	Neonatal	Long term		HEIW, Health boards	Resource needed	
		A. Establish NHS All Wales guidance and toolkit to enable review of all clinical incidents related to transfers.	Neonatal	Medium term		NHS Executive	Minimal resource	NA - Led by others
		B. Maximise the ability of families to travel with their baby.	Neonatal	Medium term		CHANTS, NWTS	Minimal resource	NA - Led by others
16	16.1 Ensure compliance with all national neonatal transport guidance 16.2 Ensure 24/7 equitable transport service provision across Wales	C. Establish a Transport Service single point of contact for clinical advice and cot/maternal bed location. a. To include teleconferencing, call handling, and call recording functionality.	Perinatal	Medium term	In progress (South Wales)	NHS Executive, CHANTS, NWTS	Minimal resource	NA - Led by others

Powys Teaching Health Board
111 Press 2 - Mental Health

PEQS

24th October 2023
Item 2.5

The Journey so far…….

National 111p2 service

Mental Health 111 Press Option 2 (MH111#2) was proposed as the model to deliver some of the ‘Beyond the Call’ recommendations in 2021 with Welsh Government providing funding to deliver, what they termed, a national ‘jump forward’ in 24/7 mental health care in Wales within 2 years.

The MH111#2 program began in April 2022, built on the Health Board implementation of a national model jointly coordinated by the NCCU and NHS Wales 111 Program.

Ministerial launch June 2023.

Beyond the call

PTHB Pilot

Consultation

Implementation

PTHB Go live, May 10th

24/7 June 23

National Ministerial Launch

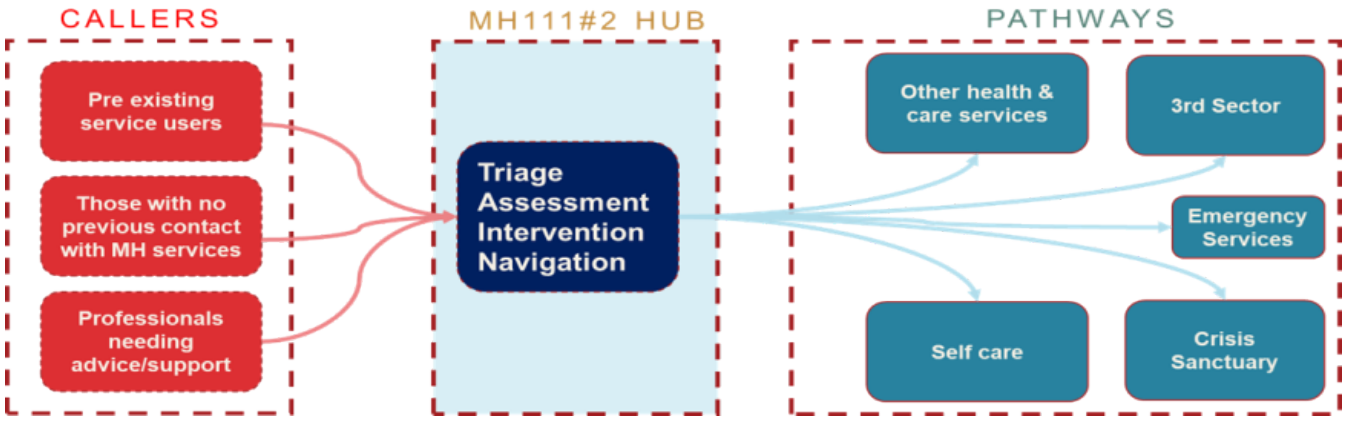
Peer review & Evaluation

Aims & Objectives of 111#2

- Provide local care through a national number (111)
- Improve the callers experience and outcomes.
- Provide early intervention for mental ill health issues.
- Provide navigation to local appropriate services/non statutory support for welfare issues.
- Provide information and options for self-care and support.
- Reduce the demand on ED/GP/Police/WAST/MH crisis services.
- Make seamless referrals to specialist mental health services if necessary.
- Provide advice for other agencies such as GP/WAST/Police

MH 111#2-Model & Principles

- Model is driven by locally based compassionate MH interventionists focused on the callers needs
- Model will require no referral
- Model should be unlimited by callers age, location in Wales, or day of the week, or time of day



No wrong front door	If a person contacts MH111#2, an inclusive response should be received whereby no person is turned away. The caller should be assisted with their current presentation and arrangements made for further/different support, if required.
Put expertise at the front door	Ensure the person answering the call is able to effectively triage, signpost, provide brief intervention and escalate if required.
Do as much as possible during the initial phone call	A meaningful conversation which allows the caller to describe their current situation and receive a validating response, which may include problem solving, brief interventions, signposting to other services, making an appointment for a crisis assessment or urgent appointment.
No need for multiple assessments	There should be an understanding of the person who completes the assessment being a trusted assessor and so referrals made to other services should not result in another assessment.
Local Knowledge	The person answering the call should be aware of local services, how they operate and how they can be contacted. This knowledge should allow them to provide support to the person that is tailored to their need and local area. This includes 3d sector, social care and NHS services

The current PTHB 111# 2 service

- Fully operational 24/7 MH triage service
- Professionals line (WAST, Police and GP's)
- Two office sites North and South
- 7 x Band 5 Wellbeing practitioners - substantive staff, full compliment
- 1 x Band 5 Service coordinator (administrative) in post
- 4 x Band 6 Senior MH practitioner staff in post substantive & Agency. (Substantive funded posts 3 WTE)
- 1 x Band 7 Team Lead In post
- 1 x Band 8 service manager in post
- Continued engagement with secondary and primary care MH, GP's, Social care, Police, WAST, Third sector partners and service users

Demand and Capacity

Data May - September 2023 extracted from Web-Ex cross referencing Ifor reporting

- 1285 calls answered and triaged (May 23 – September 23)
- Calls appear equally distributed across North, Mid and South Powys
- Averaging 15 calls a day
- Sundays have the highest call volume
- 6pm peak call time
- Age range of callers - 11yrs to 95yrs
- Call duration averaging 00:11:16
- 57% callers Active to MH, 20% closed to MH and 23% no MH history
- Average caller is Male 44 – 65 age range
- 60% of calls result in F & G outcome – Listening, self help, advise, signposting and connection to Third sector

Performance data reportable to WG:

- **Patient Outcome** - SUD's scores – 100% of expected target
- **Activity** - Calls currently answered within 00:01:05 seconds
- **Impact** - Onward Referral 9% Cat A Emergency May to date

* PTHB 1 of 4 HB currently meeting WG targets as per table

		2023-2024	2024-2025
Demand	Number of calls per Health Board per month	• No target	• No target
Activity	Time to answer call	• 85% of calls answered within 2 minutes	• 90% of calls answered within 1 minute
Patient Outcome	Subjective User Distress Level	• 85% of callers to have distress level at the end of the call no higher than that recorded at the start of the call.	• 95% of callers to have distress level at the end of the call no higher than that recorded at the start of the call.
Impact	Onward referral	• Less than 20% of calls to be directed to Emergency Department or 999	• Less than 10% of calls to be directed to Emergency Department or 999

Governance, Leadership & Accountability

- Review of Datix from 111#2 start up
- Focus on Datix training for MH Directorate
- MH Directorate Learning & Development group led by Quality Governance lead
- National Peer review completed Oct 23
- ASM Transformation program board presentation – September 23
- PEQS report & presentation Oct 2023
- Patient experience steering group

Service Development

- Welsh Language
- **Band 6 provision to allow 24/7 service – Finance discussions**
- Sanctuary & 4-hour response
- IT infrastructure
- Cat A onwards referral
- Pathways review
- Single point of access?
- User experience feedback and coproduction

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

111 # Team feedback

"My overriding impression is that many of the people who have utilised 111p2 have been both extremely grateful & complimentary of the fast, easy access to support, advice & onward referral to relevant services for their mental health & emotional wellbeing needs"

"Having the team across two bases within the county has worked in our favour in my opinion with regards to recruitment, I think we have a good team at the moment with a good knowledge base between us and I feel we all work well as a team"

"Considering the service has been running for 4 months, they have been very successful in providing a much-needed service to those in need in Powys, especially being such a rural area with no other 24/7 mental health service available"

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

AGENDA ITEM: 2.6

Patient Experience, Quality and Safety Committee	**Date of Meeting: 24 October 2023**
Subject:	**Implementation of Welsh Government guidance on Transition and Handover from children to adult's health services**
Approved and Presented by:	Claire Roche, Executive Director of Nursing and Midwifery Claire Madsen, Executive Director of Therapies and Health Science
Prepared by:	Lucie Cornish, Assistant Director, Therapies and Health Science Marie Davies, Deputy Director of Nursing and Midwifery
Other Committees and meetings considered at:	Executive Committee - 11 October 2023 who endorsed the report to the Patient Experience, Quality and Safety Committee.

PURPOSE:

The purpose of this paper is to provide an update and assurance on work being undertaken to implement the Welsh Government guidance on transition of Children and Young People to adult health services.

RECOMMENDATION(S):

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

- **RECEIVE** the progress report **NOTING** the progress to date in Implementation of Welsh Government guidance on Transition and Handover from children's to adult's health services.
- Take **ASSURANCE** that the Health Board has an effective system in place to implement the guidance.

Approval	Discussion	Information
	√	

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

EXECUTIVE SUMMARY:

In February 2022, the Welsh Government published a guidance document on transition and handover from children to adult health services. Following a two-year implementation period, Health Services will be expected to report compliance with the guidance to Welsh Government.

An implementation task and finish group has been established in Powys Teaching Health Board under the leadership of the Assistant Director of Therapies and Health Science and Deputy Director of Nursing who have co-chair responsibility for the group.

This paper details progress to date, challenges, risks**,** and recommendations for implementation. The Patient Experience, Quality and Safety (PEQS) Committee are asked to acknowledge the summary of progress to date, challenges and risks, and to discuss and approve the recommendations for reporting within the organisation.

DETAILED BACKGROUND AND ASSESSMENT:

Background

In February 2022, the Welsh Government published a guidance document **Transition and handover from children to adult health services | GOV.WALES**

This details the steps that health services in Wales must take to meet the 2016 NICE (National Institute for Clinical Excellence) Guidance on Transition.

Overview | Transition from children to adults' services for young people using health or social care services | Guidance | NICE.

A baseline for the Powys population served by the guidance and a gap analysis against the guidance have been carried out. This identified the following:

- The population aged 12-17 for Powys in 2022 was 8,795.
- For this population 1,480 contacts were seen in 2022 as reported on WPAS (Welsh Patient Administration System) (to November 22), this equated to 1,108 unique young persons.
- Therefore, 12.5% of the total population aged 12-17 were known to 1 or more Powys service and 3.1% (276) of the 12-17 Powys population were open to 2 or more services at the time of the data extraction.

The full gap analysis summary is detailed at the following link **Transition Slides Gap Analysis updated.pptx.** In brief, the gap analysis reviewed existing processes, completion of Transition and Handover Plans, the allocation of Transition Key Workers and existing monitoring mechanisms as defined in the guidance. The findings indicated that very few services currently have Transition and Handover Plans in place and no services have a process to identify and allocate Transition Key Workers. Monitoring arrangements either are not in place or are not consistent or co-ordinated. Transition is discussed within children's services on an individual patient basis however this is not co-ordinated as an MDT (Multi-Disciplinary Team) approach and the engagement of adult services in transition planning is limited.

Progress against Welsh Government Requirements

Powys Teaching Health Board progress against the requirements defined in the Welsh Government guidance is detailed below.

1. ***Health Boards and Trusts should have a clear accountability and delivery mechanism in place for ensuring implementation of the***

transition and handover guidance across all healthcare settings, which reports to the Board.

A Task and Finish Group was initiated in July 2022 and is in place for implementation of the Transition and Handover guidance with associated Terms of Reference. This group led the baseline population assessment and gap analysis. Resources have been developed to support staff awareness of the guidance, these will be made available within a 'Tool Kit' on a dedicated Transition site within the Womens and Children service group SharePoint site.

Progress during the implementation phase (until February 2024) is reported to the Patient Experience, Quality and Safety (PEQS) Committee as a standalone item initially followed by inclusion in the Integrated Quality Report. During the implementation phase, any issues for escalation to the Executive Committee outside of the reporting cycle will be raised through the Transition and Handover Task and Finish Group to the Executive Leads, the Executive Director of Nursing and Midwifery**,** and the Executive Director of Therapies and Health Science, by the Transition and Handover Senior Leads.

The Transition and Handover Task and Finish Group will remain in place until February 2024 when it is anticipated 'business as usual' arrangement will be in place. For details**,** please see Standard 5. In the autumn, the group will change its Terms of Reference to support oversight of assurance from activities within the Service Groups and act as a peer support to resolve challenges and risks, escalating through the governance structure any areas of concern.

2. There is a designated a Transition and Handover Senior Lead with accountability for ensuring implementation and quality of the transition and handover guidance across all primary, secondary, tertiary and community services.

Following Clinical Executive Director discussion, the role of Transition and Handover Senior Lead for the implementation period was designated jointly to the Deputy Director of Nursing and Assistant Director of Therapies and Health Science.

It is recommended that following the implementation period the senior lead role will transfer to the responsibility of the Womens and Children service group, this has been discussed with the Assistant Director of the Womens and Children service group who is supportive. It is also recommended that there is a nominated lead from the Community Services Group and Mental Health and Learning Disabilities Service Group to support ongoing collaborative working into adult and mental health and learning disability services. Service group representatives within the Task and Finish Group are

in agreement with this recommendation and it has formed part of presentations to service group Senior Management Teams.

3. Every child and young person transferring from children to adult services should have a documented Transition and Handover Plan (THP), or equivalent.

Following review of the gap analysis, the Task and Finish Group have proposed use of the Transition and Handover Plan, included in the WG Guidance documentation, is adopted as a standardised plan for all children and young people receiving healthcare in PTHB services. The plan has been successfully piloted for use by the Learning Disabilities team.

Where other Transition planning documents are already in use within service areas, teams will continue to use these following a local assessment to ensure they remain fit for purpose and meet the requirements of the WG guidance.

The Transition and Handover plan document is included in a 'Tool Kit,' available for services, hosted on a dedicated and openly accessible 'Transition' site within the Womens and Children service group SharePoint site.

4. Transition and Handover Named Workers are identified and appointed from the NHS Body's children's or adult services to support the transition and handover of healthcare for every child and young person.

The Transition and Handover Named Worker provides a key role in co-ordinating and promoting continuity and integration of the child or young person's healthcare. It has been agreed that the worker should be identified and based in the child or young person's existing care team and will be involved in the child / young person's transition and handover process and follow up for six months after the handover of care. This will be monitored through service group arrangements as detailed in Standard 5.

5. Monitoring arrangements are in place in the Health Board in relation to quality, effectiveness, patient satisfaction and activity for Transition and Handover.

All Service Group Senior Management Teams will have received a presentation from members of the Task and Finish group by the end of October 2023. This will detail the requirements of the guidance, overview of the gap analysis and resources available to enable service groups to appropriately embed the requirements into existing monitoring and reporting arrangements. There is an acknowledgement that this will differ for each

service group, any issues and risks identified will be escalated to the Task and Finish group during the implementation period.

Following conclusion of the implementation period in February 2024, it is proposed that reporting to PEQS committee occurs on an annual basis through the Integrated Quality Report, with a 6 monthly interim report. Following the stand down of the Task and Finish group, Service Groups will be responsible for providing assurance relating to compliance with the guidance to the Transition and Handover leads as business-as-usual governance and assurance activity.

6. Health Boards and Trusts should have a mechanism to capture the child and young person/family/carer impression of the transition and handover process after 6 months and 12 months to help inform future service provision. In addition, a mechanism is in place to capture how many people have made a representation under Putting Things Right.

A national Patient Reported Experience Measure (PREM) to meet the requirements of the guidance is in discussion through the national CIVICA Leads group in which the PTHB Transition and Handover Task and Finish Group have representation through the Quality and Safety Team. An interim PREM is currently being considered for local use through CIVICA whilst a national approach is considered.

Existing Service Group and Quality and Safety team arrangements will enable capture of Putting Things Right data.

The Live Well Regional Partnership Board Transition Project and Start Well Nyth/Nest project have been engaged in joint discussions regarding future workshop planning to enable feedback about service user experience and co-production of transition and handover resources and service models.

Barriers to progress

The gap analysis has identified a current lack of standardised approach to Transition and Handover planning across the Health Board. Implementation of the guidance will require a more joined up approach across services. Challenges to this will include workforce capacity constraints, current limitations in use of digital systems, and existing referral pathways. However, ultimately the clarity provided by the guidance will support operational change to patient centred, integrated and more efficient delivery. Audit will be required to be undertaken at service group and organisational level to assess ongoing progress, the Task and Finish Group will make recommendations for frequency and structure of this.

NEXT STEPS:
The Task and Finish Group to continue to deliver implementation of the guidance in PTHB and plan to transfer the arrangements into business-as-usual activities from February 2024. From 2024-25 this will include an annual report.

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

IMPACT ASSESSMENT

Equality Act 2010, Protected Characteristics:

	No impact	Adverse	Differential	Positive	Statement
Age				x	**Statement** The Transition and Handover national guidance supports the seamless support of care from children's to adults' services
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
	None	Low	Moderate	High	From 2024/25 the Health Board will be required to publish an annual report which outlines the arrangements and activities in relation to Transition and Handover.
Clinical	x				

Financial	x				
Corporate		x			
Operational		x			
Reputational		x			

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda Item 2.7

Patient Experience, Quality & Safety Committee	**24 October 2023**
Subject:	**Medical Devices and Point of Care Testing Annual Report 2022 - 2023**
Approved and presented by:	Claire Madsen, Executive Director for Therapies and Health Sciences
Prepared by:	Lucie Cornish, Assistant Director for Therapies and Health Sciences Helen Kendrick, Medical Devices and Point of Care Testing Coordinator Catherine Quarrell, Service Development Manager
Other Committees and meetings considered at:	Executive Committee – 4 October who discussed the report in detail and endorsed it to the Patient Experience, Quality & Safety Committee.

PURPOSE:

This paper has been prepared for assurance and approval. It 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.

RECOMMENDATION(S):

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

- **REVIEW** the attached report and accept this as an accurate overview of the service.
- Take **ASSURANCE** that the medical devices and Point of Care Testing requirements have been fulfilled.

Approval/Ratification/Decision	**Discussion**	**Information**
	x	

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 and Accountability	✓

POWYS TEACHING HEALTH BOARD
MEDICAL DEVICES AND POINT OF CARE TESTING
ANNUAL REPORT
1st April 2022 - 31st March 2023

Contents

Background

Powys Teaching Health Boards (PTHB) Medical Devices and Point of Care Testing Service ensures practicable steps are taken to make sure all risks associated with the acquisition, management and use of medical devices are minimised to protect and safeguard the interest of service users, carers, and staff. Medical Devices and equipment represent a substantial health board asset and have a significant impact on patient care.

Whilst the term "medical devices" covers a broad range of products and can be defined as instrument, apparatus, appliance, material, or healthcare product, (except medicines) used for, or by a patient or service user. The associated consumables are not the responsibility of the Medical Device and Point of Care Testing Team, and this sits within the service groups.

Powys Teaching Health Board must ensure that the medical devices and equipment meet appropriate standards of safety, quality, and performance, complying with all the relevant directives set out by the Medicines and Healthcare Products Regulatory Agency (MHRA). It is the responsibility of the organisation and all employees to contribute to the provision of safe and secure use of all medical devices for service users, carers, and staff.

Introduction

This Annual Report describes the Health Board's Medical Devices and Point of Care Testing activities undertaken, for the financial year commencing the 1st of April 2022 to 31st of March 2023.

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

Governance Arrangements

Medical Device and Point of Care Testing Team

The overall responsibility for Medical Devices and Point of Care Testing rests with the Chief Executive.

The Chief Executive has delegated the responsibility and leadership for Medical Devices and Point of Care Testing to the Director of Therapies and Health Sciences, who has delegated it to the Assistant Director of Therapies and Health Sciences.

This role is supported by a full-time Medical Devices and Point of Care Testing Service Manager and a part-time Senior Administrator. The Medical Devices and Point of Care Testing Service Manager takes responsibility for ensuring that PTHB is compliant with all aspects of Medical Device and Point of Care Testing management. The Medical Devices and Point of Care Testing Service Manager works in collaboration with internal and external service leads, Welsh Government, other NHS organisations and external multiagency partners, to help facilitate a comprehensive integrated approach across the organisation. Governance and reporting framework for Point of Care Testing requires strengthening to enable development in this area. The team does not currently have any clinical, technical, or scientific qualifications or expertise. There are plans in place to recruit a Point of Care Testing Coordinator (PoCT) before the end of December 2023. This post, in conjunction with a formal arrangement from a neighbouring health board, will offer a much-needed Governance and Assurance framework to support the development of Point of Care Testing in Powys.

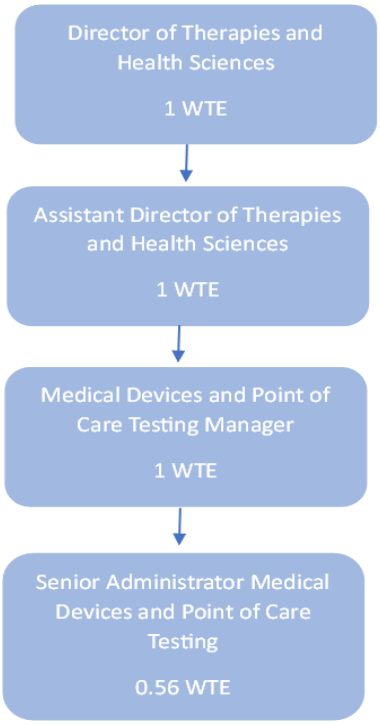


Diagram 1 – Medical Devices and Point of Care Testing Management Structure

Medical Equipment and Devices Internal Audit, October 2021

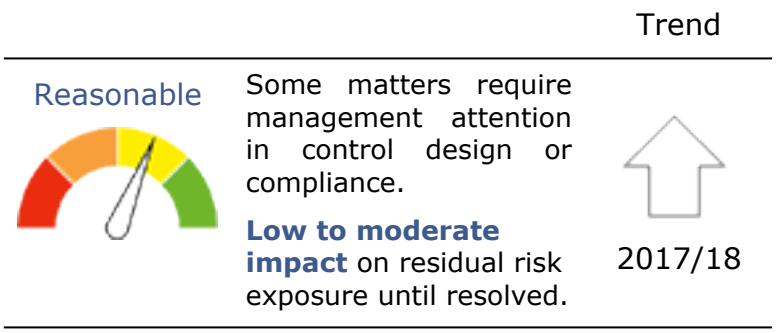


Image 1 - Medical Equipment and Devices Internal Audit, October 2021 Report Classification

An Internal Audit was carried out in July 2021 with the final report being issued in October 2021. The overall rating of Reasonable Assurance was awarded, a significant improvement on previous audits. Reasonable Assurance reflects the fact that a policy and procedures are in place, but improvements are required in several areas to ensure that controls are being consistently complied with. The key matters requiring management attention have been outlined in an action plan and regularly reviewed and updated through the Medical Device and Point of Care Testing Group. Compliance against the recommendations is also formally reported through internal audit monitoring processes led by the Corporate Governance Team. Significant improvements have been made against the recommendations, with several fully completed, however, the speed of progress against the remaining recommendations has been limited by capacity. Outstanding actions continue to be closely monitored and full details of these can be referenced in Appendix A.

Recommendation Area	Status
Purchase of New Equipment	**Complete**
Inventory Records	**Complete**
Loaned Equipment	**Complete**
Storage of Medical Equipment Devices & Equipment	**Complete**
Staff Training	**Elements outstanding**
Contract Monitoring	**Elements outstanding**
Point of Care Testing	**Elements outstanding**

Table 1 - Medical Equipment and Devices Internal Audit, October 2021 Summary of Recommendation Areas

Risk Assessment and Management

The Medical Devices and Point of Care Service risk registers are reviewed and updated monthly, and those risks (over 12) go into the Therapies & Health Sciences directorate risk register. During the timeframe for this report the team had 3 risks (over 12) on the overarching risk register.

The risks currently identified on the Therapies & Health Sciences directorate risk register include:

- Point of Care Testing Quality Assurance and Governance
- Equipment Maintenance - contract monitoring, key performance indicators, staff training
- Acquisition of medical devices – procurement practices, preferred equipment list, review, and digitisation of EDOF process (Equipment and Device Ordering Form)

Incidents

Incidents are reported into the Medical Device and Point of Care Testing Group where key themes and trends are also identified. The Medical Device

and Point of Care Testing Manager is automatically informed of any related incidents.

During this reporting period, there have been a total of 43 incidents reported. These fall into subcategories as listed below:

Category	Quantity
Failure of Medical Device	14
Other	9
Medical Device User Error	8
Accidental Damage/Loss	7
Lack of Availability of Medical Device	3
Damaged Packaging	1
Poorly Maintained Device	1

Table 2 – Incidents Reported by Category (*Data Source: Datix*)

Analysis of these figures does not show any trends or themes of concern relating to specific equipment type or service.

Medical Devices Audit

The Medical Devices Audit was relaunched in February 2022 transferring from a manual version into Microsoft Forms. The audit covers key areas of medical device management. For example, maintenance; asset tracking; storage; training; infection control and decontamination. Adopting the MS Forms method has resulted in much greater uptake by services. Audit outcomes are reported and monitored through the Medical Device and Point of Care Testing Group. The Medical Device and Point of Care Testing Team provide support to teams who identify through their audit process that improvements are required. Further improvements are being implemented to support services with increasing their uptake further. This includes setting specific months for audit completion.

Medical Device Training

The Management of Medical Devices policy requires operational managers to ensure that staff are suitably trained and competent to use all medical devices and equipment depending on their role, and to document evidence of training taking place which must be recorded on Electronic Staff Record (ESR).

The Medical Equipment and Devices Internal Audit, October 2021 gave Limited Assurance in terms of staff training and therefore for staff that are expected to operate and use medical devices. A matrix of training requirements and supporting SBAR is being developed to ensure that the requirements of the audit are achieved. Through development of the matrix, gaps in training have been identified. Collaborative work between Medical Devices and Clinical Education has identified what actions are required to ensure significant improvements are made in this area.

It is anticipated that a robust model will be implemented for high-risk items by end of 2023/2024. This will be dependent on resource and capacity, but once embedded the model will be rolled out across all service areas and devices.

Medical Devices Regulations (MDR)

Following the United Kingdom's departure from the European Union, the updated Medical Devices Regulations are expected to be issued Summer 2024. The Medical Devices and PoCT Manager and clinical representation attend a Health Education and Improvement Wales (HEIW) led MDR group which has been tasked with reviewing information and assessing Health Board readiness for the change in regulations which will have legal implications on organisations. Based on readiness assessments to date, the Health Board has reasonable assurance it will be able to fulfil the requirements of any new regulations produced by the Medicines and Healthcare products Regulatory Agency (MHRA). An All-Wales Collaborative has been proposed to review requirements and develop Quality Management Systems on a once for Wales basis, the Assistant Director of Therapies & Health Science is engaged in these discussions.

An update previously provided to the Patient Experience, Quality and Safety Committee is included for information in Appendix B.

Partnership Working

Medical Devices Replacement Programme

The Medical Devices Replacement Programme is regularly discussed at the Medical Devices and Point of Care Testing Group. The Health Board is fully engaged in the National Imaging Replacement Programme. Internal discussions have commenced with those services with high value equipment with an action plan under development to enable long term planning for replacements. It is recognised that more work is needed in this area with the relevant service areas. The Medical Device and Point of Care Testing Manager has close links with Capital Control Group to ensure any opportunity for funding is secured and allocated through a fair prioritisation process. Before equipment requests for Capital Funding are presented to the Capital Control Group, they go through the Capital Funding Prioritisation Group where a formal evaluation process takes place. Prioritisation in this way supports the Capital Control Group in allocating funding accordingly.

Clinical Education

The Medical Devices and Point of Care Testing Service Manager and representatives from the Clinical Education Team meet monthly. This relationship is key to developing a robust training programme for all staff expected to operate medical devices and equipment and has been the foundation for the training matrix and progress made to date, as referenced previously.

Community Equipment Contract

The Medical Devices and Point of Care Testing Service Manager is working closely with the Head of Therapies and the Strategic Commissioning Manager in Powys County Council to identify medical devices which are suitable for distribution via the Community Equipment Service. This will ensure that the Health Board is assured that those items are serviced and maintained as required. These relationships continue to strengthen enabling improved assurance process, reporting on activity and compliance into the Medical Device and Point of Care Testing Group on a quarterly basis.

Environment & Sustainability

The Medical Device and Point of Care Testing and the Environment and Sustainability Team work very closely. Collaboratively, improvements have been put in place to support the acquisition and disposal of medical devices ensuring environment and sustainability factors are always considered. The Health Board is part of an all-Wales contract with an on-line auction company. This company collects and disposes of equipment that is no longer required by the Health Board. A total of 42 items were disposed of through this process of which 10 were recycled and 32 were sold on. This generates substantial income for the Health Board with a total of £3,890 during 2022/2023. Please note this total includes non-medical equipment. This process not only provides some income generation for the Health Board but also ensures items are disposed of in a responsible way. The Medical Device and Point of Care Testing Manager is certified Carbon literate, along with other members of the Therapies and Health Science Directorate.

Assurance

Medical Device Alerts

Collaborative working between the Quality and Safety Team, Medical Device and Point of Care Testing Team along with Service Groups has seen vast improvements in the way the Health Board manages and responds to Medical Device Alerts. Implementation of this new process enables prompt engagement with key stakeholders to ensure action is taken as quickly as possible. Compliance against the alerts is reported through the Medical Device and Point of Care Testing Group. Process have also been strengthened between the Health Board and NHS Wales Shared Services Partnership (NWSSP) Procurement, this supports the way in which alerts are managed and provides additional assurance that any impacted products are identified, and appropriate action taken.

There were 16 alerts received into the Health Board during this reporting period.

Number of alerts received	Number not Applicable to PTHB	Number Closed	Number with actions outstanding
16	3	13	0

Table 3 - Medical Device Alerts received within the reporting period.

Complaints & Patient Feedback

The service is pleased to report there are very little in terms of complaints reported in relation to medical devices and point of care testing. However, the Medical Devices Team has listened and taken on board comments made regarding disposal methods for walking aids. A collaborative approach, both internally and externally with neighbouring health boards, has enabled the development of an improved process. Once formally approved, the change will enable patients to return walking aids to their local hospital, regardless of where they were issued. This is not currently permitted. The change will also see the implementation of a re-issuing process, rather than current process of disposal of the equipment. Not only will this process offer a far more convenient option for Powys residents, but also ensures the Health Board is acting responsibly in relation to environment and sustainability factors. Whilst these items are generally low value items, the financial benefits to re-issuing such equipment will be significant.

Lessons & Good Practice

Medical Devices and Point of Care Service Group receives quarterly reports from all service areas, which are reviewed and used to formulate lessons learnt and good practice for sharing across the Health Board. An example of good practice has been shared by the Outpatients Team. They have developed Standard Operating Procedures of all the Point of Testing Devices they use within the department. This is something that was not in place previously. These documents support those staff expected to use the devices and strengthens governance processes associated with Point of Care Testing.

Medical Devices and Point of Care Testing Section on PTHB Staff Intranet

Work has been undertaken to ensure that all relevant documentation and guidance has been uploaded to the SharePoint site. This allows staff ease of access to documents, procedures and other useful and up to date information. Limited capacity within the team has unfortunately meant there is still work to do in this area. For example, the uploading of medical device User Manuals.

Indemnity Forms

An indemnity form and Standard Operating Procedure has been developed following an audit recommendation regarding temporary loan of medical equipment to patients for use at home. This will provide assurance that the equipment is safe for use and that the person using it understands how to operate it and is aware of how to obtain any items that need to be replaced. This process supports both staff and patients by reducing any potential risks that are associated with the use of medical devices at home.

Freedom of Information Requests

During 2022/2023 there were 6 Freedom of Information requests made with regards to Medical Devices. Of these 2 breached the timeframe for replies and the responsibility for the breach did not lie with the Medical Devices Team.

Month of Request	Request Subject	Requestor Type	Time taken (days)
Jul-22	Details of Medical Device Team	Individual	24
Jul-22	Replacement of Patient Trolleys	Company	24
Sep-22	Process for Renewal of Pacemakers	Individual	8
Nov-22	Total Number of Devices per Hospital	Individual	14
Feb-23	Types, Models, Quantity & Dept of Immunoassay Analysers	Company	13
Mar-23	Surgical Robotic Systems & Procedures	Individual	15

Table 4 – Freedom of Information requests made during 2023/2023 (*Data Source: FOI Team)*

Medical Devices and Point of Care Testing Priorities 2023/24

Point of Care Testing Coordinator

There are plans in place to recruit a Point of Care Testing Coordinator (PoCT) before the end of December 2023. This post, in conjunction with a formal arrangement from a neighbouring health board, will offer a much-needed Governance and Assurance framework to support the development of Point of Care Testing in Powys. Powys residents will benefit through improved patient experience, a more equitable service and in some cases, earlier diagnosis. It is expected that this post will be a registered Biomedical Scientist.

Business Continuity

A Business Impact Assessment has been undertaken and the service is compliant with the Health Boards requirements. There are ongoing challenges with out of hours provision due to the current capacity of the Team. A review of this plan will be undertaken before the end of December 2024 in line with the Health Boards Business Continuity process.

Information Communication and Technology (ICT)

The digitisation of the Medical Devices and Point of Care Testing processes, where appropriate will be carried out in 2024.

e-Quip Asset Management System

e-Quip Asset Management System is used by the Health Board to manage medical devices. Following a lengthy project implementation phase which commenced prior to COVID-19, transfer into Business as Usual took place in December 2022. Robust processes have been implemented to support the success of the system. It is essential that service groups adhere to these processes and ensure they are compliant with all elements of medical devices and point of care testing management. Validation exercises will be

undertaken, in conjunction with services to ensure processes continue to be embedded.

All Wales Point of Care Testing System (WPOCT)

The Health Board is included in an All-Wales contract for a Point of Care Testing solution that enables test results to be transferred electronically from networked Point of care testing devices to Welsh Clinical Portal. Whilst the Health Board contributes financially on annual basis for the solution, it has not been possible to fully implement the system across the Health Board. It is anticipated the appointment of the Point of Care Testing Co-ordinator will enable progress in this area. Patients will benefit in terms of patient experience because of access to results in a timelier manner, and greater efficiency of staff time.

Equipment acquired through planning for COVID-19

Planning for COVID-19 included acquisition of many items of medical devices and equipment, through local and national procurement processes. To store these items a unit was leased in a central location within Powys. Many of the items have been issued across the health board. Of the items that remain, the largest quantity is beds. A replacement programme is required to distribute the beds across the health board, replacing those beds that are older and nearing the end of their expected lifecycle. The lease on the unit will be expiring in November 2023, by which all equipment will have been relocated.

Contracts

Contract monitoring is a key aspect of Medical Device and Point of Care Testing management. Contracts can include all-Wales purchasing contracts through which the Health Board benefits from reduced costs and maintenance contracts for maintenance and repair of equipment. As of 1st of April 2022, the main maintenance contract for medical devices was awarded to a new provider. The contract covers many general medical devices, excluding specialist items such as beds, hoists, dental and x-ray equipment for example. Year one of the contract has identified some issues, which have been raised with the provider and NWSSP Procurement and worked through collaboratively. These issues include unexcepted costs associated with wasted visits and user damage which are being for which options have been identified to reduce and/or totally remove them.

Improved engagement and input from support services including finance and procurement has enabled improved processes. However, limited capacity within the Medical Device and Point of Care Testing team continues to impact on the ability to robustly monitor contracts.

PTHB Preceptorship Study Day

The Medical Device and Point of Care Service Manager will be engaging with the PTHB Preceptorship Study Day to promote awareness of medical device and point of care testing management. This engagement will be invaluable in ensuring users of equipment are aware of their responsibilities, ensuring both patient and staff safety is not compromised.

Appendix A – Medical Equipment and Devices Internal Audit, October 2021 - Progress Against Outstanding Actions

Matter Arising 1 - Purchase of New Equipment (Operating effectiveness)	Status
• A process should be developed to ensure that the Preferred Equipment list is maintained and kept up to date by adding and removing items as necessary. • The EDOF form should include a field to confirm that NWSSP have been involved in the purchase, or an explanation as to why not. • The Medical Devices team should ensure that all EDOF's are fully completed prior to processing.	**Complete**
Matter Arising 2 - Inventory Records (Operating effectiveness)	**Status**
Management should consider alternative methods of populating the e-Quip system in addition to the current process of requesting information from ward or departmental staff. These could include: • Using item data from maintenance schedules to populate the e-Quip system, then forwarding e-Quip Inventory records to each site for verification. • Nominated e-Quip 'champions' at each site with access to input data directly to the e-Quip system. • Undertaking site visits. • Sending out e-Quip inventory reports to each site on a half yearly basis for updating. • Identify additional staff resources on a temporary basis to help populate the e-Quip system.	**Complete**
Matter Arising 3 - Loaned Equipment (Operating effectiveness)	**Status**
All staff should be reminded of the requirement to ensure indemnity forms signed by the patient are completed for all items loaned to patients.	**Complete**

Matter Arising 4 - Storage of Medical Equipment Devices & Equipment (Operating effectiveness)	Status
Management at the Llanidloes Hospital should be asked to review their storage areas within the Graham Davies Ward at Llanidloes Hospital with a view to providing a single, secure storage facility for medical devices and equipment. A general reminder should be issued to all sites within the Health Board of the requirement to ensure that all medical devices and equipment are stored in a safe, secure location when not in use.	**Complete**

Matter Arising 5 - Staff Training (Operating effectiveness)	Status
The Local Responsible Officers at each ward / department should ensure that all training received by staff in respect of medical devices and equipment is recorded in ESR. The manufacturer's instructions for all medical devices and equipment should be scanned and stored together electronically in accordance with the requirements of the Policy for the Management of Medical Devices and Equipment. This may be achieved by developing a central repository for manufacturer’s instructions that is accessed via the Medical Devices pages of the intranet, rather than being done by individual wards and departments.	**Progress is being made against this recommendation.** It is anticipated that a robust model will be implemented for high-risk items by end of 2023/2024. This will be dependent on resource and capacity, but once embedded the model will be rolled out across all service areas and devices.

Matter Arising 6 - Contract Monitoring (Control design)	Status
The Health Board should introduce suitable monitoring arrangements for all contracts associated with the provision and maintenance of medical devices and equipment. This should include the development of key performance indicators (KPI's) and targets for each contract. These could for example include: • Actual expenditure against expected expenditure / annual contract value • The number / percentage of medical devices and equipment serviced each month / quarter (PPM Contracts)	**Progress is being made against this recommendation.** Improved processes have positively impacted on contract monitoring, identifying cost savings and opportunities to strengthen processes. Limitations within the medical devices team continue to be a

• Quality - the number of staff and patient complaints received, number resolved / unresolved, time taken to resolve. • Call out response times (for responsive, unplanned maintenance) Performance should preferably be monitored on a regular basis and reported to the Medical Devices Group.	barrier to continuous improvement against this recommendation.
Matter Arising 7 - Point of Care Testing (Operating effectiveness)	**Status**
7.1) Staff and independent contractors across the HB responsible for undertaking POCT should be reminded to ensure that all Internal Quality Control (IQC) checks and External Quality Assessments (EQA's) are recorded in accordance with the requirements of the Management of Point of Care Testing Policy. 7.2) Staff and independent contractors across the HB responsible for the management of medical devices and equipment and undertaking POCT should be reminded of the requirement to periodically complete the Medical Devices Audit Form, in accordance with the Management of Point of Care Testing Policy and the Management of Medical Devices and Equipment Policy. The Management of POCT policy should be updated to include an indicative timescale for undertaking self-audits and completing the Medical Devices Audit Form. A link to the Medical Devices Audit Form should also be added to the Management of Medical Devices and Equipment Policy. 7.3) A Standard Operating Procedure (SOP) should be drawn up for all medical devices and equipment used in POCT, in accordance with the Management of Point of Care Testing Policy.	**Progress is being made against this recommendation.** There are plans in place to recruit a Point of Care Testing Coordinator (PoCT) before the end of December 2023. This role will support progress against the Internal Audit Recommendations

Appendix B - Medical Device Regulations (MDR) Update

Background

As a consequence of Brexit, the Medicines and Healthcare products Regulatory Agency (MHRA) has had to develop new Medical Device Regulations. In May 2017, the new Medical Device Regulations were published. The date of application for the new regulations was originally May 2020, however, timescales were impacted upon following a delay due to COVID-19. Further delays have followed, with the MHRA now advising they have extended the standstill period for the new regulations and are now aiming to bring them in to force by July 2024.

An all-Wales group, including representatives from Powys Teaching Health Board (PTHB), has been set up to ensure compliance with new Regulations. The MHRA has organised focus groups to work on the planned new regulations. Dates for the focus groups have yet to be released.

What do the Regulations mean for PTHB?

The main impact of the regulations for the Health Board are within therapy services and include Physiotherapy, Occupational Therapy, Podiatry, Audiology and Orthotic Services, particularly in relation to device modifications.

The Health Board does not have an in-house Medical Engineering Service and Central Sterile Services Department (CSSD), these are currently outsourced to Avensys Ltd and Cwm Taf Morgannwg University Health Board respectively.

PTHB's position is different from other health boards in Wales in that there are no manufacturing laboratories producing devices/appliances for patients. The Health Board does not employ any technicians who would fill that role. The manufacture of appliances, insoles and similar devices is undertaken by an external provider, Dacey's, under an all-Wales contract.

The devices made by clinicians in PTHB are, therefore, custom-made using materials supplied by external suppliers, specifically for that purpose. However, there are ongoing discussions as to whether this constitutes in-house manufacturing. The outcome of these discussions is important as it will determine whether the health board is required to put a Quality Management System in place and what expertise are required to support this. There is work taking place on an All-Wales basis, exploring a collaborative approach to support the implementation of the Medical Device Regulations and therefore Quality Management Systems, where required.

A recent communication from MHRA (May 2023) has now confirmed that they have laid legislation before Parliament, subject to approval, which will ensure that all medical devices, including custom made devices that were compliant with EU MDR previously, will be covered until 30 June 2030.

Compliance

All suppliers who provide PTHB with devices and materials for the manufacture of custom-made devices have been questioned to determine their compliance with regulations including ISO 9001, ISO 13485 or CE marked. All were found to be fully compliant. The table below provides this detail.

Service	Relevant Activity	ISO 13485 status	ISO 9001 status	Notes/other
Occupational Therapy	The purchase of products that are onward supplied to the patient are procured from approved suppliers. All materials that may come into direct contact with the patient are procured from CE approved suppliers.			Confirmation of compliance received from suppliers. However, products can change according to new prices / properties. All purchases made via Oracle.
Physiotherapy	The purchase of products that are onward supplied to the patient are procured from approved suppliers. All materials that may come into direct contact with the patient are procured from CE approved suppliers.			Confirmation of compliance received from suppliers e.g.Benecast, Delta-Cast, Scotchcast. All purchases made via Oracle.

Prosthetics	N/A			
Maxillo-facial	N/A			
Podiatry	The purchase of products that are onward supplied to the patient are procured from approved suppliers. All materials that may come into direct contact with the patient are procured from CE approved suppliers. The Podiatry Department maintains a system to assess the approved status of suppliers who should be CE or ISO approved.			Confirmation of compliance received from suppliers e.g., Benecast, Scotchcast, X-Line. All purchases made via Oracle.
Rehabilitation Engineering	N/A			
Medical Physics	N/A			
Clinical Engineering	Provided by Avensys Ltd.	Certified (May 2022 – May 2025)	Certified (May 2022 – May 2025)	Certificates provided as evidence
Software as Medical Device	Seeking further clarification on requirements.			

Orthotics	Provided by Dacey Ltd	Certified (May 2021 – May 2024)		Certificates provided as evidence.
Audiology	Hearing equipment supplied by Minerva UK. Ear moulds manufactured from Otoform silicone manufactured by Dreve. Ear moulds manufactured from Detax silicone.	Certified (May 2022 – May 2025) Certified (Oct 2022 – May 2024) Certified (May 2022 –June 2023)	Certified (May 2022 – May 2025) Certified (Oct 2022 – Oct 2025)	All earpieces are manufactured in the UK and tested to EN352-2 standards. Dreve Otoform products only consist of approved silicone polymers according to ISO 9001 and ISO 13485. Detax products conform to MDR QM Certificate and EG-Certification 93/42/EEC
CSSD	Sterile Service provision	Certified (Jan 2022 – May 2024)	Certified (Jan 2022 – May 2024)	Certificate GB22/969347 provided as evidence

In summary, the health board has reasonable assurance it will be able to fulfil the requirements of any new regulations produced by the MHRA. PTHB does not have any manufacturing laboratories and all contracted supplier and materials are compliant with regulation. National discussions as to what constitutes in-house manufacturing will determine whether the health board is required to put a Quality Management System in place and what expertise are required to support this. There is work taking place on an All-Wales basis, exploring a collaborative approach to support the implementation of the Medical Device Regulations and therefore Quality Management Systems,

where required. A further update will be provided once appropriate action has been agreed and, where appropriate, progressed.

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item:

Patient Experience, Quality and Safety Committee	**Date of Meeting: 24th October 2023**
Subject:	**A Board level statement outlining its collective responsibility for minimising the risks of infection within PTHB**
Approved and presented by:	Claire Roche, Executive Director of Nursing & Midwifery
Prepared by:	Gareth Thomas, Consultant Nurse Infection Prevention and Control
Other Committees and meetings considered at:	Executive Committee - 11th October 2023 who endorsed the report to the Patient Experience, Quality and Safety Committee.

PURPOSE:

To present a statement for **APPROVAL** to the PEQS Committee outlining the Board's collective responsibility for the reduction of Healthcare Association Infections, under the Welsh Government Code of Practice for the Prevention of Healthcare Associated Infections, and as part of the organisations Infection Prevention and Control Improvement plan.

RECOMMENDATION(S):

The PEQS Committee is asked to:

- **APPROVE** the proposed Board level statement as part of the requirements under the Code of Practice for the Prevention and Control of Healthcare Associated Infections

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	x
	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	✓

SBAR

Situation

The Welsh Government Code of Practice for the Prevention and Control of Healthcare Associated Infections sets out the minimum necessary infection prevention and control (IP&C) arrangements for NHS healthcare providers in Wales. The nine elements represent standards that organisations will be expected to meet in full across the range of healthcare services that they provide. Compliance with these standards should be evident to service users, visitors, staff and to the Welsh Government including Healthcare Inspectorate Wales.

As part of *Standard 1: "Appropriate organisational structures and management systems for IPC must be in place"*, there is a requirement for 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 statement to this extent does not currently exist within PTHB. Therefore, a brief statement outlining this commitment under the Code of Practice has been prepared for discussion and approval:

"Powys Teaching Health Board recognise the significant impact and harm Healthcare Associated Infections (HCAIs) have on service users, carers, and staff. The Health Board commits to preventing HCAIs. Where these occur, we will learn and take action to improve. Effective infection prevention and control is the responsibility of all our people and integral across all our services. We therefore commit to the standards, as set out in the Code of Practice for the Prevention and Control of Healthcare Associated Infections".

Clinical Audit
Final Internal Audit Report

September 2023

Powys Teaching Health Board

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

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

Contents

Review reference:	PTHB-2324-14
Report status:	Final
Fieldwork commencement:	15 June 2023
Fieldwork completion:	6 September 2023
Draft report issued:	11 September 2023
Management response received:	26 September 2023
Final report issued:	26 September 2023
Auditors:	Ian Virgil, Head of Internal Audit Jayne Gibbon, Audit Manager Geoffrey Woolley, Principal Auditor
Executive sign-off:	Kate Wright, Executive Medical Director
Distribution:	Howard Cooper, Safety & Quality Improvement Manager
Committee:	Audit Risk & Assurance Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

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

Executive Summary

Purpose

The overall objective of this audit was to review the adequacy of the systems and controls in place for the planning, delivery and reporting of Clinical Audit work.

Overview

We have issued substantial assurance on this area.

The Health Board has an approved Annual Clinical Audit Plan in place, there is appropriate guidance available to staff and there are experienced staff in place to plan, coordinate and undertake the clinical audits.

The matters requiring management attention include:

- Enhancing the reports submitted to the Patient Experience, Quality and Safety (PEQS) Committee to reflect outcomes or feedback on the audits that have been completed.
- Ensuring completed clinical audit files can be accessed.

Other recommendations / advisory points are within the detail of the report.

Report Opinion

Reasonable

Few matters require attention and are compliance or advisory in nature.

Low impact on residual risk exposure.

Assurance summary[1]

Objectives		Assurance
1	Appropriate guidance is in place.	Substantial
2	An approved annual Clinical Audit Plan is in place.	Substantial
3	Appropriate resources are in place.	Reasonable
4	Progress and outcomes is reported and monitored.	Reasonable

[1]The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
2	Delivery of the Health Board's Clinical Audit Programme.	3	Operation	Medium
3	Clinical Audit Committee Reports.	4	Design	Medium
5	Access to completed clinical audit files.	4	Design	Medium

1. Introduction

1.1 Our review of Clinical Audit was completed in line with the 2023/24 Internal Audit Plan for Powys Teaching Health Board (the 'Health Board').

1.2 The Healthcare Quality Improvement Partnership (HQIP) defines clinical audit as a "quality improvement cycle that involves measurement of the effectiveness of healthcare against agreed and proven standards for high quality, and taking action to bring practice in line with these standards so as to improve the quality of care and health outcomes."

1.3 Its purpose is to engage all healthcare professionals in systematic evaluation of their clinical practice against standards and to support and encourage improvement in the quality of treatment and care. Additionally, it provides information for patients and the public on the quality of specific healthcare services being provided locally and nationally.

1.4 Each year the Health Board produces a Clinical Audit plan that sets out the national audits from the National Clinical Audit and Outcome Review Plan (NCAORP) in which they must participate and also the local audits that are to be undertaken. These Clinical Audit outcomes are an integral part of the Health Board's processes for improvement and assurance.

1.5 The Executive lead for this review is the Medical Director.

1.6 The associated risks for the audit are:

- Resource capacity prohibits the completion of the Clinical Audit Plan;
- Clinical issues materialise if risks are not identified due to ineffective monitoring and governance arrangements; and
- Patient harm due to healthcare not meeting quality standards.

2. Detailed Audit Findings

Objective 1: There is appropriate guidance in place for the undertaking of clinical audit within the Health Board.

2.1 A Clinical Audit page is maintained on the Health Board's Intranet which is accessible to all staff and includes relevant, clear and helpful guidance.

2.2 The page identifies the Safety & Quality Improvement Manager as the relevant contact for any further help or advice, and who is also able to provide training to the clinical areas where necessary.

2.3 Within the operational service areas, we have been advised by the Clinical Audit leads that there are sufficient experienced staff who are able to provide helpful advice and information to other staff that are considering undertaking clinical audits.

2.4 However, a small number of minor improvements to the Clinical Audit page on the Intranet were identified (Matter Arising 1)

Conclusion:

2.5 There is appropriate guidance in place for the undertaking of clinical audit within the Health Board, although a small number of minor improvements to the Intranet page were identified. We have provided Substantial Assurance for this objective.

Objective 2: There is an approved annual Clinical Audit Plan in place.

2.6 A 2023-2024 Clinical Audit Programme was presented to the Patient Experience, Quality and Safety (PEQS) Committee on 23 February 2023, where the PEQS Committee noted and approved its content.

2.7 Prior to this, the 2023-2024 Clinical Audit Programme had previously been considered at the Executive Committee on 8 February 2023 and it was also subsequently presented at the Audit, Risk and Assurance Committee on 21 July 2023.

2.8 Coordination of development of the 2023-2024 Clinical Audit Programme is undertaken by the Safety & Quality Improvement Manager as follows:

- The 2023-2024 clinical audit planning cycle began in October 2022 when the service area leads were initially alerted that a clinical audit plan would be required.
- Following a period of development and discussion within the service areas, their respective local clinical audit plans were submitted to the Safety & Quality Improvement Manager by 19 January 2023.
- These were reviewed for any obvious issues and were then consolidated into an overall Health Board Clinical Audit Programme which was reviewed by the Medical Director prior to consideration by the Executive Committee and the PEQS Committee.

2.9 Within the service areas, potential audits are submitted to the services clinical audit leads for consideration and approval for the service area clinical audit plan. The individual plans will then be forwarded to the Safety & Quality Improvement Manager for consideration/inclusion in the Health Board's annual clinical audit plan.

Conclusion:

2.10 The Health Board has an annual Clinical Audit Plan in place which has been formally and appropriately approved by the Health Board. We have provided Substantial Assurance for this objective.

Objective 3: There are appropriate resources in place for Clinical Audit.

2.11 The Health Board has a dedicated officer in place who is responsible for co-ordination and consolidation of the Health Board's 2023-2024 Clinical Audit Programme.

2.12 This officer is supported by Clinical Audit leads in each of the operational service areas who consider what clinical audits should be undertaken and the resources available to do this and then monitor progress on delivery of their clinical audit programme.

2.13 We have been advised by the Clinical Audit leads in the operational areas tested that they have sufficient experienced staff to plan, coordinate and undertake clinical audits, although this may be more challenging for some clinical areas than others.

2.14 However, the completion report for the 2022-23 Clinical Audit Programme indicates that only 66% of the planned audits were fully completed and, of the remaining audits, 16% were still ongoing at the year-end, 15% were postponed to the following year and 3% did not proceed. (Matter arising 2)

Conclusion:

2.15 While there are resources in place to deliver the annual clinical audit plan, this may be more challenging for some clinical areas than others and only 66% of the planned clinical audits for 2022-23 were fully completed by the year end. We have provided Reasonable Assurance for this objective.

Objective 4: Progress against delivery of the Clinical Audit Plan, and the outcomes from completed audits is reported and effectively monitored at appropriate forums.

2.16 The Patient Experience, Quality and Safety (PEQS) Committee's annual work plan includes time set aside for consideration of the Clinical Audit Programme.

2.17 The Closure report for the 2022-2023 Clinical Audit Programme was presented to the PEQS Committee on 4 July 2023. The information was generally well laid out and clearly presented, although there was nothing included in the report on the outcomes or feedback on the audits that had been completed. (Matter Arising 3)

2.18 An update on progress on delivery of the 2023-2024 Clinical Audit Programme was also presented to the PEQS Committee on 4 July 2023. Again, the information was generally well laid out and clearly presented. However, many of the audits are scheduled for completion towards the end of the year and so it may be beneficial if some could be reprioritised to avoid so many requiring completion at the same time and risk them not all being completed which, as noted under objective 3, was the case in 2022-23. (Matter Arising 4)

2.19 Feedback outcomes from clinical audits are disseminated within local service areas and also, where appropriate, to wider Heath Board groups. Furthermore, any risks identified will be managed in accordance with the Health Board's Risk Management Framework.

2.20 However, for one service area tested, while we were informed that monitoring of clinical audits take place, examples of any update/closure reports could not be

provided due to changes in post holder and files being stored on legacy systems that predates the new Intranet 'host' SharePoint. (Matter Arising 5)

Conclusion:

2.21 Progress against delivery of the Clinical Audit Plan and the outcomes from completed audits is generally reported and effectively monitored at appropriate forums. However, a number of enhancements regarding the information contained in the reports have been identified. We have provided Reasonable Assurance for this objective.

Appendix A: Management Action Plan

Matter Arising 1: Clinical Audit Intranet page. (Operation)	**Impact**
A Clinical Audit page is maintained on the Intranet which is accessible to all staff and includes the following guidance: • What is Clinical Audit. • A guide to Clinical Audit. • Audit Top 10 tips. • The difference between Clinical Audit, Research and Quality Improvement. The information included is relevant, clear and helpful and identifies the Safety & Quality Improvement Manager as the relevant contact for any further help or advice, who is also able to provide training to the clinical areas where necessary. However, a small number of improvements to the Intranet page were identified: • The Intranet page makes reference to the annual report on the previous year's plan but a copy had not been uploaded to the intranet page.' • Whilst the Intranet page identifies who is responsible for Clinical Audit in the respective clinical areas, we noted that some of the contact details are out of date.	The Clinical Audit information available to staff is not fully complete and up to date.

Recommendations		**Priority**
1	Management should ensure that the Clinical Audit page on the Intranet is reviewed and updated to reflect the issues identified above.	**Low**

Agreed Management Action	**Target Date**	**Responsible Officer**
1 Agreed. The requested changes to the web site have been made.	**Completed**	**Safety and Quality Improvement Manager**

Matter Arising 2: Delivery of the Health Board's Clinical Audit Programme. (Operation)			**Impact**
The completion report for the 2022-23 Clinical Audit Programme states that only 66% of the planned audits were fully completed and, of the remaining audits, 16% were still ongoing at the year end, 15% were postponed to the following year and 3% did not proceed.			Beneficial clinical improvements may not be identified and implemented.
Recommendations			**Priority**
2	The Health Board should ensure that sufficient resources are available for clinical audits so that the annual Clinical Audit Programme is fully delivered.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
2	The agreed management plan will be shared with colleagues from the operational services to ensure that prioritisation of audits is understood.	Q3 2023/24	**Medical Director/operational and clinical executives**

Matter Arising 3: Clinical Audit Committee Reports. (Design)	**Impact**
The Closure report for the 2022-2023 Clinical Audit Programme was presented to the Patient Experience, Quality and Safety (PEQS) Committee on 4 July 2023. The information provided was generally well laid out and clearly presented. However, there was nothing included in the report on the outcomes or feedback on the audits that had been completed. The paper that went to the Committee in July 2022 for approval of the 2022-2023 Programme stated that progress against the plan would be reported to PEQS. It also stated that the reporting would highlight: • Action to be taken as a result of audits undertaken; and • How learning is shared and sustainable safety improvements made as a result. These highlights were not included in the 2022-23 Closure report. We do not note that the progress report that went to the November 22 Committee provided a more detailed update, including highlights of the outcomes from completed national and local audits.	Inadequate reporting and monitoring of clinical audits at appropriate forums.

Recommendations		**Priority**
3	Management should consider updating future closure reports presented to the Patient Experience, Quality and Safety (PEQS) Committee to include outcomes and feedback on completed audits.	**Medium**

Agreed Management Action		**Target Date**	**Responsible Officer**
3	The Medical Directorate will ligase with the Chair of the Patient Experience Quality and safety Committee to agree the level of detail required in any future Closure report.	March 2024	**Medical Director/operational and clinical executives**

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

Matter Arising 4: Timing of audits in the 2023-2024 Clinical Audit Programme. (Design)			**Impact**
An update on progress on delivery of the 2023-2024 Clinical Audit Programme was presented to the Patient Experience, Quality and Safety (PEQS) Committee on 4 July 2023 where it was noted that many of the audits are scheduled for completion around the same time towards the end of the year.			There may be difficulty delivering the 2023-2024 Clinical Audit Programme.
Recommendations			**Priority**
4	The timing of audits within the 2023-2024 Clinical Audit Programme should be reviewed as it may be beneficial if some of the audits could be reprioritised to avoid so many requiring completion at the same time and risk them not all being completed which, as noted under Matter Arising 2, was the case in 2022-23.		**Low**
Agreed Management Action		**Target Date**	**Responsible Officer**
4	The agreed management plan will be shared with colleagues from the operational services to outline the benefits of a Clinical Audit Program that is better distributed across the months.	Q3 2023/24	**Medical Director/operational and clinical executives**

Matter Arising 5: Access to completed clinical audit files. (Design)			**Impact**
For one service area tested, while we were informed that clinical audits take place, examples of audit update/closure reports could not be provided due to changes in post holder and files being stored on legacy systems that predate SharePoint. We have been informed that 'SharePoint' is now being used in this clinical area which will prevent future problems.			Inability to access and refer to previous clinical audit files.
Recommendations			**Priority**
5	Management should advise all staff undertaking clinical audits that all clinical audit files should be stored in a way that allows them to be easily accessed and referred to.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
5	The agreed management plan will be shared with colleagues from the operational services to ensure that they recognise the importance of good document management.	Q3 2023/24	**Medical Director/operational and clinical executives**

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**Unsatisfactory assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

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

NHS Wales Shared Services Partnership
4-5 Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ

Website: Audit & Assurance Services - NHS Wales Shared Services Partnership

Patient Experience Quality and Safety Committee 2023-24

Theme	Item Title	Item Required	Duration (mins)	Role of Committee	Reason / Rationale	Onward Journey to Board (Y/N)	Exec Lead	April 25/04/2023	July 04/07/2023	October 24/10/2023	January 23/01/2024
Governance	Minutes of previous meeting	Y		Approval		N	DCG	✓	✓	✓	✓
Governance	Declaration of Interests			Compliance			DCG	✓	✓	✓	✓
Governance	Action Log			Approval			DCG	✓	✓	✓	✓
Governance	Committee Risk Register			Assurance				✓	✓	☒	✓
Governance	Annual Work Programme		15	Recommendation to Board		Y	DCG	✓			
Governance	Work Programme (updated through year)		5	Review		N	DCG		✓	✓	✓
Governance	Annual Assessment of Committee Effectiveness		25	Review		Y	DCG	✓		x	?
Governance	Committee Annual Report		10	Recommendation to Board		Y	DCG	✓			?
Governance	Review of Terms of Reference			Recommendation to Board		Y	DCG			☒	✓
Performance	Integrated Quality Report			Assurance		?	DoNM	✓	✓	✓	✓
Performance	Maternity and Midwifery			Assurance		N	DoNM			✓	
MH Compliance	MH Power of Discharge Annual Report including MH compliance with legislation			Assurance		N	D Ops		✓		✓
Clincial Audit	Annual Programme			Assurance		N	MD				✓
	Progress Report			Assurance		N	MD		✓		
Audit	Potential Report giving sight of IA and EA reports, actions and management responses (ARAC retain responsbility for monitoring)			Assurance		N	DCG			✓	
Clinical Quality	Clinical Quality Framework			Assurance		N	MD/DoNM/DoTHS				
Medicines Management	Annual Report of Accountable Officer for Controlled Drugs			Assurance		N	MD				✓
	Medicines Management Annual Report			Assurance		N	MD		☒	✓	
Safeguarding	Safeguarding Annual Report			Assurance		Y	DoNM		✓	☒	
	Children's Services			Assurance		N	DoNM				
Improvement and Innovation	Overview of research and development activity			Assurance		N	MD				
	Alignment with national objectives published within Health and Care Research Wales			Assurance		N					
	An overview of the quality improvement activity within the organisation			Assurance		N	DoNM				
	More on Learning Organisation work			Assurance		N	MD				
Infection Prevention and Control	IPC Assurance Report			Assurance		Y	DoNM		✓		
	IPC progress/focus			Assurance		N	DoNM				✓
Patient Experience	Patient Experience approach / outline - within IQR			Assurance		Y	DoNM		✓		
Other reports/Action log requests	PEQS/22/51 Presentation on MH Services in public session			Assurance		N	D Ops		✓		
	Report on National Commissioning Functions Review			Assurance		N	DPP&C				
	111 press 2 - 12 week review			Assurance		N	D Ops		☒	✓	
	Child Practice Review outcome (when completed)			Assurance		N	DoNM				
	Individual Patient Funding requests					N	DoNM				
Additional Items:	Implementation of WG guidance on transition and handover from Children's to Adult's Mental Health Services			Assurance		?	DoNM			✓	
	Statement of Commitment to Infection Prevention and Control					?	DoNM			✓	
	PSOW Annual Letter (within Integrated Quality Report)									✓	
	Cancer Improvement			Assurance			MD				✓
	Annual Report Medical Devices and Point of Care Testing			Assurance			DoTHS			✓	