Patient Experience, Quality & Safety Committee

Tue 23 January 2024, 09:30 - 12:30

Agenda

09:30 - 09:30
0 min

1. PRELIMINARY MATTERS

PEQS_ Agenda_23 Jan 24.pdf (2 pages)

1.1. Welcome and Apologies

1.2. Declarations of Interest

1.3. Minutes from the previous meeting held on the 24 October 2023 for approval

PEQS_1.3_unconfirmed Minutes 2023-10-24.pdf (17 pages)

1.4. Patient Experience, Quality and Safety Committee Action Log

PEQS_1.4_Action Log Jan24.pdf (2 pages)

09:30 - 09:30
0 min

2. ITEMS FOR ASSURANCE

2.1. Integrated Quality Report

Attached *Director of Nursing and Midwifery*

PEQS_2.1 Integrated Quality Report.pdf (12 pages)
PEQS_2.1a_03636 Brecon Hospital- Full Report.pdf (45 pages)
PEQS_2.1b_Llais Presentation to PESG.pdf (15 pages)
PEQS_2.1c_Pavo Powys Third Sector Report.pdf (4 pages)

2.2. Mental Health Deep Dive from a Quality and Safety Perspective (actions PEQS/22/51, PEQS IC/22/73 and PEQS/23/42)

Attached *Director of Nursing and Midwifery/Director of Operations, Community Care and Mental Health*

PEQS_2.2_MH Q&S Review Cover.pdf (4 pages)

2.3. MH Power of Discharge Six Monthly Report including MH compliance with legislation

Attached *Director of Operations, Community Care and Mental Health*

PEQS_2.3_MHA Compliance Report Oct 22 to Sep 23.pdf (12 pages)

2.4. Joint Inspection on Child Protection Arrangements - Including Update on Level 3 Safeguarding Training PEQS/23/23b

Oral *Director of Nursing and Midwifery*

2.5. Cancer Improvement Plan

Attached *Medical Director*

PEQS_2.5_Powys Cancer Improvement Plan.pdf (6 pages)

PEQS_2.5a_Annex 1 Cancer Improvement Plan 2023-26.pdf (9 pages)

2.6. Annual Report of Accountable Officer for Controlled Drugs

Attached *Medical Director*

PEQS_2.6_Controlled Drugs Accountable Officer Annual Report.pdf (13 pages)

2.7. WHSSC Quality and Safety Committee Chairs Report October 2023

Attached *Director of Nursing and Midwifery*

PEQS_2.7_4.4.5 Quality Patient Safety Committee Chairs Report.pdf (12 pages)

09:30 - 09:30
0 min

3. ITEMS FOR APPROVAL

There are no items for approval.

09:30 - 09:30
0 min

4. ITEMS FOR DISCUSSION

4.1. Annual Assessment of Committee Effectiveness

Attached *Director of Corporate Governance*

PEQs_4.1_ committee effectiveness Jan 2024.pdf (18 pages)

4.2. Review of Terms of Reference

Attached *Director of Corporate Governance*

PEQS_4.2a_Committee_ToR Review.pdf (11 pages)

09:30 - 09:30
0 min

5. ESCALATED ITEMS

5.1. Infection Prevention and Control Improvement Plan Progress Report (contained within the Integrated Quality Report)

Information *Director of Nursing and Midwifery*

5.1.1.

09:30 - 09:30
0 min

6. ITEMS FOR INFORMATION

6.1. Incident Management Final Internal Audit Report

Information

PEQS_6.1_PTHB-2324-05 Incident Management Final Audit Report.pdf (20 pages)

09:30 - 09:30
0 min

7. OTHER MATTERS

7.1. Committee Risk Register

Oral *Director of Corporate Governance*

7.2. Committee Work Programme

Attached *Director of Corporate Governance*

PEQS_7.2_Work programme 2023-24.pdf (1 pages)

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

Oral *Chair*

7.4. Any Other Urgent Business

Oral *Chair*

7.5. Confidential Items

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

7.6. Date of the next meeting: 16 April 2024

7.7. Suicide Review Report (November 2023)

7.8. Mental Health Deep Dive from a Quality and Safety Perspective

POWYS TEACHING HEALTH BOARD
PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE

TUESDAY 23 JANUARY 2024
09:30 – 13:00
VIA MICROSOFT TEAMS

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

AGENDA				
Time	**Item**	**Title**	**Attached/Oral**	**Presenter**
	1	**PRELIMINARY MATTERS**		
09:30	1.1	Welcome and Apologies	Oral	Chair
	1.2	Declarations of Interest	Oral	All
	1.3	Minutes from the previous Meeting 24 October 2023	Attached	Chair
09.35	1.4	Committee Action Log	Attached	Chair
	2	**ITEMS FOR ASSURANCE**		
9.40	2.1	Integrated Quality Report	Attached	Director of Nursing and Midwifery
10.35	2.2	Mental Health Deep Dive from a quality and safety perspective (actions PEQS/22/51, PEQS IC/22/73 and PEQS/23/42)	Attached	Director of Nursing and Midwifery/Director of Operations, Community Care and Mental Health
10.40	2.3	MH Power of Discharge Six Monthly Report including MH compliance with legislation	Attached	Director of Operations, Community Care and Mental Health
10.50	2.4	Joint Inspection on Child Protection Arrangements • Including Update on Level 3 Safeguarding Training PEQS/23/23b	Oral	Director of Nursing and Midwifery
10.55	**COMFORT BREAK (15 minutes)**			
11.10	2.5	Cancer Improvement Plan	Attached	Medical Director
11.25	2.6	Annual Report of Accountable Officer for Controlled Drugs	Attached	Medical Director
11.35	2.7	WHSSC Quality and Safety Committee Chairs Report October 2023	Attached	Director of Nursing and Midwifery
	3	**ITEMS FOR APPROVAL**		
There are no items for approval.				
	4	**ITEMS FOR DISCUSSION**		
11.40	4.1	Annual Assessment of Committee Effectiveness	Attached	Director of Corporate Governance

12.00	4.2	Review of Terms of Reference	Attached	Director of Corporate Governance
	5	**ESCALATED ITEMS**		
	5.1	Infection Prevention and Control Improvement Plan progress report (contained within the Integrated Quality Report)	-	Director of Nursing and Midwifery
	6	**ITEMS FOR INFORMATION**		
	6.1	Incident Management Final Internal Audit Report		
	7	**OTHER MATTERS**		
12.10	7.1	Committee Risk Register	Oral	Director of Corporate Governance
	7.2	Committee Work Programme	Attached	Director of Corporate Governance
	7.3	Items to be Brought to the Attention of the Board and/or Other Committees	Oral	Chair
	7.4	Any Other Urgent Business	Oral	Chair
	7.5	Date of the next meeting: 16 April 2024		
7.6 The Chair, with advice from the Director of Corporate Governance, has determined that the following items include confidential or commercially sensitive information which is not in the public interest to discuss in an open meeting at this time. The Board is asked to take this advice into account when considering the following motion to exclude the public from this part of the meeting: <u>Motion under Section 1(2) Public Bodies (Admission to Meetings) Act 1960</u> ***"Representatives of the press and other members of the public shall be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest"***				
12.15	7.7	Suicide Review Report (November 2023)	Attached	Director of Operations, Community Care and Mental Health
12.30	7.8	Mental Health Deep Dive from a Quality and Safety Perspective	Presentation	Director of Nursing and Midwifery

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

MINUTES OF THE MEETING HELD ON TUESDAY 24 OCTOBER 2023 VIA MICROSOFT TEAMS

Present:

Kirsty Williams	Vice-Chair (Committee Chair)
Jennifer Owen Adams	Independent Member
Simon Wright	Independent Member
Ian Phillips	Independent Member

In Attendance:

Claire Roche	Director of Nursing and Midwifery
Claire Madsen	Director of Therapies and Health Sciences
Debra Wood-Lawson	Director of Workforce and OD (from 10.30)
Zoe Ashman	Assistant Director of Quality and Safety
Helen Bushell	Director of Corporate Governance
Marie Davies	Deputy Director Nursing (from 11.00)
Lucie Cornish	Assistant Director of Therapies and Health Sciences (for Item 2.7)
Louisa Kerr	Head of Mental Health Operations
Jacquie Seaton	Chief Pharmacist (for Item 2.1)
Kelle Rees	Service Manager Community Mental Health (for Item 2.5)

Observing:

Carl Cooper	Chair PTHB
Sonia Thomas	Llais
Sarah Diskin	Llais (from 10.30)

Apologies for absence:

Hayley Thomas	Interim Chief Executive
Kate Wright	Medical Director
Joy Garfitt	Interim Director Operations, Community Care and Mental Health
Pete Hopgood	Director of Finance, Information and IT
Amanda Edwards	Assistant Director – Innovation and Improvement

Committee Support:

Liz Patterson	Interim Head of Corporate Governance

PEQS/23/35	**WELCOME AND APOLOGIES FOR ABSENCE** The Committee Chair welcomed Members to the meeting and shared the sad news that Independent Member Mark Tayor had passed away noting that Mark was a diligent and effective Member of the Committee and a dedicated and valued Member of the Board. Apologies for absence were noted as recorded above.
PEQS/23/36	**DECLARATIONS OF INTERESTS** No interests were declared in addition to those already declared in the published register.
PEQS/23/37	**MINUTES OF THE EXPERIENCE, QUALITY AND SAFETY COMMITTEE MEETING HELD ON 04 JULY 2023 (FOR APPROVAL)** The minutes of the previous meeting held 04 July 2023 were AGREED as a true and accurate record.
PEQS/23/38	**PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE ACTION LOG** The Director of Corporate Governance presented the action log noting that six actions had been completed, four were on track, and three were classified as 'at risk' as whilst work was on-going, they had not met their original deadlines. These included: • A deep dive into Mental Health – an item on the agenda was included to clarify exactly what Committee expected in relation to this action with the requested report now scheduled for the February 2024 meeting; • Losses and Special Payments – the Director of Nursing and Midwifery requested this be deferred to February 2024; and • Annual Safeguarding Report - the Director of Nursing and Midwifery requested this be deferred to February 2024 The reason for the delay in relation to the Mental Health action was queried. The Director of Corporate Governance advised that there had been changes in Executive Lead on this item and there had been a misunderstanding of what was required by the Committee in relation to this action. The inclusion of the item later in the agenda would help clarify the request, with a substantive item scheduled for the next meeting of the Committee.

	The change of date requests were APPROVED.
ITEMS FOR ASSURANCE	
PEQS/23/39	**MEDICINE MANAGEMENT ANNUAL REPORT** The Chief Pharmacist presented the report which provided an update on the Medicines Management/Pharmacy Team activities undertaken between April 2022 and September 2023. The report provided information on the Health Board's Medicines Management/Pharmacy arrangements, provided an update on progress, outlined key challenges and areas of concern, and provided information regarding plans for the next 12 months. *Page 12 of the report states 'work initiated to ensure non-medical prescribing is driven by service need rather than personal development desires'. To what extent will this impact on retention and/or development of staff?* The Chief Pharmacist advised that priority would be given to training staff in areas of organisational need rather than providing training for staff which was not then used in their current role. There was no budget for training staff on areas not needed by the organisation. *Page 14 of the report states 'funding was approved for a Band 5 post (fixed term), we have been unable to recruit'. Could this be made a permanent post to make it more attractive?* The Chief Pharmacist confirmed the fixed term nature of the post was due to funding constraints. *Page 15 of the report states that the Health Board does not have an Antimicrobial Stewardship Pharmacist. Is this gap due to funding issues?* The Chief Pharmacist confirmed this was again due to funding constraints. *Page 15 of the report states 'the current level of support to Mental Health Services is inadequate and does not meet the needs of the population of Powys'. What is being done to address this?*

	The Chief Pharmacist advised that this was both a funding issue and an issue of attracting staff to Powys. Support was provided via a 0.2 FTE (Full Time Equivalent) from Aneurin Bevan UHB, but this did not provide hands on support in the Mental Health wards or Community Services. There is an opportunity for funding a Perinatal Mental Health Pharmacist in the short term and the potential for an existing Pharmacist to be offered Mental Health training both of which are being explored. An update on Pharmacy support to Mental Health Services will be provided in the next Medicines Management report. **Action: Chief Pharmacist** *The report mentions efficiencies to be achieved in the management of pharmacy stores. How will this be achieved?* The Chief Pharmacist advised the intention was to move to a centralised store operating out of Bronllys to reduce the number of items being delivered to the wrong site or getting lost, and to increase the ability to manage ordering and monitor usage between sites. The centralised store will start with orders for sip feeds and wound care products and then expand into other areas. *Page 13 of the report notes plans for the Ministry of Defence (MoD) to move to using NHS prescriptions. What implication will this have for the Medicines Management Team?* The Chief Pharmacist advised that the current prescription service providers for the MoD have withdrawn and the Health Board has been asked to provide this service with funding for a 1 FTE post provided to support the change. *To what extent will the change to Electronic Prescribing and Medicines Administration (EPMA) help alleviate staffing issues?* The Chief Pharmacist advised this Welsh Government supported scheme would primarily be of benefit to patient safety and in addition will save staff time. Initially this will be implemented in ward areas and then will move to outpatients. This will require a considerable amount of staff training and a change in way of working for clinical colleagues. There is a challenge in relation to the IT infrastructure which requires attention. An update on EPMA will be provided in the next Medicines Management report. **Action: Chief Pharmacist**

	One of the key financial pressures of the Health Board relates to Primary Care Prescribing which is overspending. Whilst some of this is known to be related to global supply chain issues and increases in the cost of drugs, is it feasible that this budget will get back on track? The Chief Pharmacist advised there were problems related to obtaining drugs at drug tariff prices where it was necessary to move to price concessions. In some instances, the drugs did not go back to the original drug tariff price. The impact of this has cost an additional £600k so far this year. In addition, new drugs are being developed in areas such as diabetes care which are expensive. The NICE guidance that is produced for the new drugs needs summarising and the formulary needs to be kept up to date to outline which drugs should be used in the first instance. A new Pharmacist and new Pharmacist technician have been appointed who will work in this area. The Chair congratulated the team on receiving an Innovation and Best Practice Award for the development of their Medicines Intervention Reporting and Monitoring Tool. The Chair advised that the Chair's Report to Board would reference the constraints highlighted during item and the risks they pose, and that she would work with the Medical Director, Chief Pharmacist and Director of Corporate Governance to ensure the actions were reported back to Committee in a timely manner. **Action: Chair, Medical Director, Chief Pharmacist and Director of Corporate Governance** The Committee RECEIVED the Medicines Management Assurance Report April 2022 – September 2023 taking ASSURANCE on the actions taken and progress made. The Chief Pharmacist left the meeting.
PEQS/23/40	**INTEGRATED QUALITY REPORT TO INCLUDE:** • **PSOW ANNUAL REPORT 2022/23**

	• **INFECTION PREVENTION AND CONTROL PLAN PROGRESS** The Director of Nursing and Midwifery presented the report and drew attention to the following areas: • Work assessing potential nosocomial cases of Covid-19 has been completed ahead of schedule with no cases of harm or death identified. The national Interim Learning Report was provided with the Final Learning Report anticipated Spring/Summer 2024. The learning identified locally will be shared via the Infection Prevention and Control group to ensure learning is embedded throughout the organisation. • The target of compliance of response to concerns within 30 days continues to be met with a challenge of maintaining this target. The themes and trends relating to concerns for provided and commissioned services were outlined. • There have been eight Duty of Candour cases triggered in Q1 and Q2 of which four have been closed with no harm identified and four remain under investigation. • The Public Services Ombudsman for Wales (PSOW) Final Report 2022/23 had been received. A relatively high number of concerns had been forwarded to the PSOW. This had been expected as a series of long overdue concerns had been closed, triggering the opportunity to complain to the PSOW. Now the backlog has cleared it is expected this figure will fall. • The number of pressure ulcer incidents was provided and the processes in place to manage this was outlined. • The Patient Experience system continues to evolve with the implementation of District Nurse feedback arrangements. • The Infection Prevention and Control Improvement Plan developed in response to matters raised at Executive Committee and PEQS In-Committee in July 2023 was shared with Committee. Of the 24 actions identified, six had been completed and 18 were on-track with none behind schedule. *It is disappointing that the Health Board were unable to attend the Safe Care Collaborative meeting in September given the importance of safety to the organisation.* The Director of Nursing and Midwifery provided assurance that this had been a hard decision but with a small team in

	Powys it had not been possible to release staff for a 2-3 day event. However, the Director of Nursing and Midwifery and Medical Director had attended the Executive session on Day 2 and Improvement Cymru are invited to attend the Health Boards local Safe Care improvement meetings. *The PSOW report mentions that resources remain an issue in relation to complaints and concerns. What action will be taken to address this?* The Assistant Director of Quality and Safety advised that this report related to a period when the team had resourcing issues which have since been addressed. It was confirmed this was no longer a problem. *Why are pressure ulcer incidents most commonly recorded as Category 2 rather than being identified and treated earlier?* The Assistant Director of Quality and Safety advised that the second graph in the report demonstrated that around half of the pressure ulcers inherited (from patients transferred from other care settings or directly from home) are Category 2. A Tissue Viability Nurse is supporting the correct reporting of pressure ulcers to ensure those that are inherited are recorded as such and it is expected that this will be completed by the end of the year. *Could the breakdown between pressure ulcer incident graph be disaggregated between those inherited and those acquired in our setting?* The Director of Nursing and Midwifery undertook to strengthen the Integrated Quality Report in respect of pressure ulcer incidents. **Action: Director of Nursing and Midwifery** *In relation to patient feedback from the District Nursing team can assurance be given that positive as well as negative feedback is shared with Board?* The Assistant Director of Quality and Safety advised that both positive and negative feedback is shared via patient stories to Board.

	Can the Committee be assured that the District Nursing team are advised that their patient feedback has been shared with Board Members? The Director of Nursing and Midwifery undertook to provide this feedback personally. *In relation to the Welsh Risk Pool (WRP) Assessment of the Putting Things Right process Limited Assurance Report, can assurance be given that the necessary improvements are being made?* The Director of Nursing and Midwifery advised that the fieldwork for this report had been undertaken some time ago when the organisation was in the process of addressing a number of issues. The Director of Nursing and Midwifery would welcome a follow up report by the WRP in the role of critical friend. *The Infection Prevention and Control action plan refers to a Decontamination Policy which at 9 years old appear out of date. Should this policy be subject to urgent review?* The Assistant Director of Quality and Safety advised that since this report had been prepared the Decontamination Policy had been reviewed. *Information contained within the report highlights that some patients are unable to afford to travel to appointments. How is this information shared with partners to inform wider policy development?* The Director of Nursing and Midwifery confirmed this information was shared with Executive Committee and should also be shared at the Regional Partnership Board. It is also possible to provide this information in feedback to Welsh Government on themes of complaints. The Assistant Director of Quality and Safety advised that in the first instance many complainants require signposting to navigate complex pathways of care and increasingly the complaints team are undertaking advocacy. For example, patients are being asked to attend Velindre Cancer Centre in Cardiff four times a week. The complaints team have requested that Velindre look at patient postcodes when arranging appointments.

	Could the Integrated Quality Report include examples of themes of advocacy in the next report? The Director of Nursing and Midwifery confirmed that this would be considered. **Action: Director of Nursing and Midwifery** The Llais representative joined the meeting. The Committee: • RECEIVED the report and took ASSURANCE that Quality and Safety is appropriately monitored and reported and that continued actions are in place to further develop quality and safety monitoring and reporting.
PEQS/23/41	**MATERNITY SERVICES** The Director of Nursing and Midwifery presented the report which provided the Committee with the first six monthly update on progress in maternity service following local de-escalation, and drew attention to the following areas: • the Maternity Governance Framework to support continuous improvement was shared; • arrangements for service user feedback from women and families including specific surveys for antenatal appointments, partners and for when women are transferred in labour to a District General Hospital; • two experiences of transfer during labour had been positive, and one had resulted in a concern from which learning had been identified; and • quarterly learning events are held with all staff. *Is the Maternity Neonatal Champion able to have a say on neonatal matters despite PTHB not offering neonatal care including feeing into the configuration of maternity services along the M4 corridor which some south Powys mums and babies may use?* The Director of Nursing and Midwifery advised that the Health Board have a midwife who is the Maternity Neonatal Safety Champion. This includes working with the national team and, as Powys does not have a neonatal unit, liaising with respective colleagues in neighbouring health boards. In addition, the Head of Midwifery attends the peer group with equal status and the Director of Nursing and Midwifery attends the Maternity Neonatal Safety Board.

	Will the experience of the maternity team during escalation be shared as a staff story in this Committee or Workforce and Culture Committee? The Director of Nursing and Midwifery confirmed that this would be shared in the Workforce and Culture Committee. The Committee took ASSURANCE that the Maternity Services improvement actions are being delivered to plan. The Deputy Director of Nursing joined the meeting
PEQS/23/42	**MENTAL HEALTH SERVICES PRESENTATION (Action PEQS/22/51)** The Head of Mental Health Operations presented a slide outlining potential areas for a deep dive in the February 2024 Committee meeting. These included: • Current demand, challenges and opportunities • Recent and planned service developments • Patient experience and co-production • Accelerated Sustainable Transformation Update • Mental Health progress against dementia standards • Systems and Outcomes developments • Quality and Safety – case study work for learning and development • Suicide and Self harm prevention and postvention The Director of Nursing and Midwifery outlined the importance of clarity of purpose and the avoidance of duplication. The Executive Committee had requested a deep dive into recent quality and safety issues in Mental Health Services and this could be included in the next Integrated Quality Report. The Chair outlined the importance of focussing the request on quality and safety rather than straying into delivery and performance which is the remit of a different Committee. The Assistant Director of Quality and Safety outlined that the team worked with all services when managing incidents. A Welsh Risk Pool assessment was in progress for Q3/Q4 audit of incident management in Mental Health Services and Women's and Childrens Services. It was agreed that the Director of Nursing and Midwifery would meet with the Head of Mental Health Operations to

	ascertain how to present the information requested as part of the Integrated Quality Report. **Action: Director of Nursing and Midwifery and Head of Mental Health Operations** The Service Manager Community Mental Health joined the meeting
PEQS/23/43	**111p2 – 12-week review** The Service Manager for Community Mental Health gave a presentation on the 12 week review of the 111press2 noting the service had gone live in May 2023 initially with a 12hr/day service moving to 24/7 in June 2023. Local care is provided via a national number giving parity of care to mental as well a physical health. The service is provided out of two sites in Powys with the advantage if one site is having technical issues the other site can provide cover. The service is able to signpost users to self-care or make specialist referrals to mental health services as appropriate. It is designed to enable a single assessment to be made so users do not have to repeat their story to different professionals. Activity information was shared, and it was confirmed that the Health Board were one of four Health Boards meeting all targets. Service development plans were shared but it was noted the 24/7 service was currently funded by Welsh Government and discussions regarding ongoing funding would be needed. The service had recently moved from the Transformation Programme to Business as Usual. *How can the Health Board assess whether the right balance of resource is in place between 111p2 and other parts of Mental Health services?* The Head of Mental Health Operations advised that there was a need for part of this programme to remain within the Transformation Programme to ensure that users are treated appropriately in Powys given there is no Accident and Emergency centre in county. *Can 111p2 be accessed from outside Wales?* The Head of Mental Health Operations confirmed the service provided in Powys could be accessed by users

	outside Powys, but clarity would be sought on access from outside Wales. **Action: Head of Mental Health Operations** *Have colleagues in primary care seen a reduction in calls relating to Mental Health from the introduction of this service?* The Head of Mental Health Operations advised that a full analysis was required. However, a reduction in primary care appointments had been observed. The number of calls to 111p2 was approximately double what had been expected. *Patient feedback would be welcomed along with outcomes such as suicide prevention. Have other services such as the police seen a positive impact from the introduction of this service?* The Head of Mental Health Operations confirmed that Dyfed Powys Police had signed up to Right Time, Right Place, Right Person and were supportive of local arrangements. The Committee welcomed the presentation and looked forward to receiving further updates as the service becomes embedded. The Director of Nursing and Midwifery, and the Service Manager for Community Mental Health left the meeting
PEQS/23/44	**IMPLEMENTATION OF WELSH GOVERNMENT GUIDANCE ON TRANSITION AND HANDOVER FROM CHIILDREN'S TO ADULT'S HEALTH SERVICES** The Deputy Director of Nursing presented the report which provided 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 published in 2022 for implementation from 2024/25. An Annual Report on transition will be published but it was suggested that the implementation of the guidance is shared with Committee in the Integrated Performance Report.

	Page 3 of the report outlines that very few services have transition plans. What plans are in place to address this? The Deputy Director of Nursing confirmed that there was a mixed picture across individual areas and there is no Health Board standard. The implementation plan will enable standardised plans to be used across all health services. However, the guidance is specifically for health and there are instances where young people who will be transitioning into adult services are not known to health services. This guidance does not apply to colleagues in social care. Work is ongoing in the Regional Partnership Board (RPB) to help align approaches across all services. The Assistant Director of Therapies and Health Sciences confirmed that a standardised version of a handover plan has been produced for those areas that do not already have appropriate handover arrangements. This includes a Rising 16 Review to help prepare ahead of transition. This will be tested via an audit process. *When will the audits take place?* The Assistant Director of Therapies and Health Sciences advised that the audit work programme was under development and the initial audit would test for readiness against the guidance after which there would be a rolling programme of audit on a six monthly basis. *To what extent should Members be concerned that the guidance on transition of young people to adult services only applies to health organisations despite young people receiving services from partner organisations?* The Assistant Director of Therapies and Health Sciences advised that the Live Well Programme within the RPB have a Transitions Partnership which was working in this area, however, this service suffered from redeployment during the covid-19 pandemic. Live Well and Start Well are now working jointly on transitions and are looking to redefine the programme. The Committee: • RECEIVED the progress report NOTING the progress to date in Implementation of Welsh Government guidance on Transition and Handover from Children's to Adults health services.

	• Took ASSURANCE that the Health Board has an effective system in place to implement the guidance. • AGREED that further updates on Transitions would be included within the Integrated Quality Report
PEQS/23/45	**MEDICAL DEVICES AND POINT OF CARE TESTING ANNUAL REPORT** The Assistant Director of Therapies and Health Sciences presented the report which provided an overview of the Medical Devices and Point of Care Testing Service and its ambitions for 2023 – 2024. The report set out how the service has performed during 2022-2023, highlighted key achievements and reviewed of the challenges and risks. *Are inflationary pressures being seen in relation to costs of this service?* The Assistant Director of Therapies and Health Sciences confirmed that there is not a large flow of equipment, and inflationary pressures had not been raised as an issue, however, maintenance costs were under discussion. *In relation to new devices for point of care testing, are there processes in place to ensure this is undertaken appropriately?* The Assistant Director of Therapies and Health Sciences confirmed that the appointment of the Point of Care Testing Co-ordinator would provide expertise in this area. *What action will be taken to address concerns regarding the timeliness of the transfer of point of care testing information into systems which may mean information is not visible to colleagues via the Welsh Clinical Portal?* The Assistant Director of Therapies and Health Sciences advised that the Health Board are part of an all Wales Point of Care Testing contract but have to date been unable to get the system working in Powys. This will be a primary area of focus for the newly appointed Point of Care Testing Co-ordinator. Attention was drawn to the funding for this post which was via Six Goals Funding from Welsh Government. The Health Board are also reliant on supervision for this post from a neighbouring Health Board and are in discussion with Aneurin Bevan UHB to provide this support as the Health Board do not have an in-house laboratory service.

	The Committee: • REVIEWED the attached report and accepted it as an accurate overview of the service. • Took ASSURANCE that the Medical Devices and Point of Care Testing requirements have been fulfilled. The Assistant Director of Therapies and Health Sciences left the meeting
ITEMS FOR APPROVAL	
PEQS/23/46	**STATEMENT OF COMMITMENT TO INFECTION PREVENTION AND CONTROL**
	The Assistant Director of Quality and Safety presented the report which proposed a Board level statement on Infection Prevention and Control. Committee Members requested that the wording of the statement be strengthened to stress the importance of prevention. The amended statement reads: *"Powys Teaching Health Board recognise the significant impact and harm Healthcare Associated Infections (HCAIs) have on service users, carers, and staff. Effective infection prevention and control is the responsibility of all our people and integral across all our services. Where infections occur, we will learn and take action to improve. We therefore commit to preventing HCAIs and meeting the standards, as set out in the Code of Practice for the Prevention and Control of Healthcare Associated Infections".* The Committee: • APPROVED the proposed Board level statement as part of the requirements under the Code of Practice for the Prevention and Control of Healthcare Associated Infections.
ITEMS FOR DISCUSSION	
PEQS/23/47	There were no items for discussion.

ESCALATED ITEMS	
PEQS/23/48	**INFECTION PREVENTION AND CONTROL (covered within the Integrated Quality Report)** This item will be included in the Chair's Report to the Board.
ITEMS FOR INFORMATION	
PEQS/23/49	**CLINICAL AUDIT INTERNAL AUDIT** The Audit, Risk and Assurance Committee (ARAC) receive all Internal Audit reports and monitor implementation of recommendations. ARAC share the outcome of Internal Audit Reports with Committees of the Board for information purposes.
OTHER MATTERS	
PEQS/23/50	**COMMITTEE WORK PROGRAMME** The Director of Corporate Governance presented the Committee Work Programme for information.
PEQS/23/51	**ITEMS TO BE BROUGHT TO THE ATTENTION OF THE BOARD AND/OR OTHER COMMITTEES** The Chair noted that this report would refer to risks associated with the constraint of resource in the Pharmacy and Medicines Management team.
PEQS/23/52	**ANY OTHER URGENT BUSINESS** There was no other urgent business.
PEQS/23/53	**DATE OF THE NEXT MEETING** 23 JANUARY 2024, via Microsoft Teams.
PEQS/23/54	**CONFIDENTIAL ITEM** The following motion was passed: ***Representatives of the press and other members of the public shall be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.***

PRESENT:

Kirsty Williams	(Chair)
Jennifer Owen Adams	(Independent Member)
Simon Wright	(Independent Member)
Ian Philips	(Independent Member)

IN ATTENDANCE:

Claire Madson	(Director of Therapies and Health Sciences)
Helen Bushell	(Director of Corporate Governance)
Marie Davies	(Deputy Director of Nursing)
Zoe Ashman	(Assistant Director of Quality and Safety)
Liz Patterson	(Interim Head of Corporate Governance)

APOLOGIES FOR ABSENCE:

Mark Taylor	(Independent Member)
Joy Garfitt	(Interim Director Operations, Community Care and Mental Health)
Pete Hopgood	(Director of Finance, Information and IT)
Claire Roche	(Director of Nursing and Midwifery)
Kate Wright	(Medical Director)
Debra Wood Lawson	(Director of Workforce and OD)
Hayley Thomas	(Chief executive Officer)

PEQS IC/23/55	**MINUTES OF THE IN-COMMITTEE MEETING HELD ON 4 JULY 2023** The minutes of the previous In-Committee meeting held 04 JULY 2023 were AGREED as a true and accurate record.

Liz Patterson								
RAG Status:								
At risk	Red - action date passed or revised date needed							
On track	Yellow - action on target to be completed by agreed/revised date							
Completed	Green - action complete							
No longer needed	Blue - action to be removed and/or replaced by new action							
Transferred	Grey - Transferred to another group							
Patient Experience, Quality and Safety Committee								
Meeting Date	**Item Reference**	**Lead**	**Meeting Item Title**	**Details of Action**	**Update on Progress**	**Original target date**	**Revised Target Date**	**RAG status**
OPEN ACTIONS FOR REVIEW								
24/10/2023	PEQS/23/40a	DON	Integrated Quality Report	IPR to include a disaggreation of inherited and acquired pressure sore incidents	**23-01-24 update -** request to provide this to April 2024 meeting **23-01-24 update -**This work is on-going to ensure that data is correct. It is anticipated this will be included in the IQR at in April 24	Jan-24	Apr-24	At risk
24/10/2023	PEQS/23/43	Head of MH Operations	111p2	Confirmation of ability to access 111p2 for Welsh patients from England	**23-01-24 update -** an oral update will be given to the meeting**.**	Jan-24		At risk
04/07/2023	PEQS/23/23a	DNM	Annual Safeguarding Report	The method of sharing information with the Committee relating to the number of cases and backlogs in the system to be reviewed	**24.10.2023 update -** A position paper regarding the Mental Capacity Act and Deprivation of Liberty Safeguards is in preparation for Executive Committee at the end of November. Change of date requested **23.01.24 update:** paper now going to Executive Committee late January. Change of date requested to April 2024	Oct-23	Apr-24	At risk
23-Feb-23	PEQS/22/84b	DNM	Child Practice Review	Child Practice Review to be brought back to Committee	**24.10.2023 update** - Date remains to be confirmed**.** **25.04.23 update** - Added to work programme for Jan 2024, review due to be completed and report received in November **23.01.24 update** Report expected February 2024, publish date is out of the health boards control. report will be shared with committee and reported at the following meeting following being published	Jan-24	April 2024 TBC	At risk
OPEN ACTIONS - IN PROGRESS BUT NOT YET DUE								
24/10/2023	PEQS/23/39a	MD	Medicine Management Annual Report	Update on Pharmacy Support to Mental Health Services to be included in the next Medicines Management Report	**23.01.24 update** - action on track	Oct-24		On track
24/10/2023	PEQS/23/39b	MD	Medicine Management Annual Report	Update on Electronic Prescribing to be included in the next Medicines Management Report	**23.01.24 update** - action on track	Oct-24		On track
ACTIONS RECOMMENDED FOR CLOSURE (MEETING 23 JANUARY 2024)								
24-Oct-23	PEQs and WC/23/	DGP	Speaking Up Safely Draft Self-Assessment	Appoint a Speaking Up Safely Champion. The Board will look at the role and expectations of Board Champions to enable Champions to understand their role.	**20.02.24 update** - transferred to Board action log			Transferred
24/10/2023	PEQS/23/39c	MD/DCG	Medicine Management Annual Report	Chair's Report to Board to reference constraints affecting Pharamcy services	**20.02.24 update** - reported to Board in November 2023			Completed
24/10/2023	PEQS/23/40b	DON	Integrated Quality Report	IPR to include examples of themes of advocacy	**23-01-24 update -** engagement session with Llais scheduled for the 19 January 2024	Jan-24		Completed
24/10/2023	PEQS/23/42	DON/Head of MH Operations	Mental Health Services Presentation	Mental Health Services deep dive - as part of IQR	**23-01-24 update -** Deep dive undertaken. Presented to Executives. Summary paper PEQs 23 Jan 24	Jan-24		Completed

25-Apr-23	PEQS/23/05	DNM	Duty of Candour and Quality	The Duty of Candour and Quality Implementation Plan to be shared with Committee	**04.07.23 update** - Director of Nursing advised that the implementation plan had not been shared by July 2023 but would be updated and circulated after the July meeting **23.01.24 update:** an oral update to be given to the meeting	Jul-23	Oct-23	Completed
31-Jan-23	ARA/22/109	DNM	LOSSES AND SPECIAL PAYMENTS UPDATE REPORT (transferred from Audit Committee)	Trends and lessons learnt from rebutting negligence claims to be included in the Integrated Quality Report to the Patient Experience, Quality and Safety Committee	**25.04.23 update** - Action has been reviewed and given the low number of claims, data could become individually identifiable. DNM to reconsider how to achieve the action and report back. Change of date . **24.10.23 Update -** Change of date requested **23.01.24 update -** due to low numbers of negligence claims within the Health Board it would be inappropriate to use the IQR as a reporting mechanism. Dependent on the volumes of claims, bespoke reports will be completed and presented.	Oct-23	Jan-24	Completed
13/09/2022 and 24 Nov 2022	PEQS/22/51 and PEQS IC/22/73	DOCC&MH	Mental Health Services	A further report on Mental Health Services to be brought to the December 2022 Committee meeting	**24.10.2023 update -** The October agenda contains an item for the Committee to confirm what is required to be presented at the Jan 2024 meeting. Change of date requested **23.01.24 update -** a report on the deep dive Mental Health is included in the January agenda	Dec-22	Jan-24	Completed
23-Feb-23	PEQS/22/81	DCG	National Commissioning Functions Review	The Report of the National Commissioning Functions Review be brought back to Committee at the appropriate time	**24.10.2023 update** - Date remains to be confirmed**.** **25.04.23 update** - Added to work programme for Jan 2024, Board had a discussion on 12/10/24. **23.01.23 update:** This has been considered at Board Development sessions	Jan-24		Completed
25-Apr-23	PEQS/23/05	DNM	Integrated Quality Report	Integrated Quality Report to be strengthened in terms of themes and trends relating to behaviours resulting in harm	**04.07.23 update** - DoNM is currently liaising with DoTHs (with current responsibility for Health and Safety) to review non-patient safety incidents, themes and trends **23.01.24 update:** Annual Report on Health and Safety has been completed and will be submitted to Board shortly. Key to this is where H&S reports through to Board sub-commitees	Jul-23	Oct-23	Completed

Agenda item: 2.1

Patient Experience and Quality Commitee	**10 January 2024**
Subject:	**Integrated Quality Report**
Approved and Presented by:	Claire Roche, Executive Director of Nursing & Midwifery
Presented by	Claire Roche, Executive Director of Nursing & Midwifery
Prepared by:	Zoe Ashman, Assistant Director Quality & Safety
Other Committees and meetings considered at:	Executive Committee 10 January 2024

PURPOSE:

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

RECOMMENDATION(S):

The Patient Experience and Quality Committee are asked to:

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

Approval/Ratification/Decision[i]	Discussion	Information
✖	✓	✓

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

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

DETAILED BACKGROUND AND ASSESSMENT:

1 Background

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

2 Specific matters for consideration by this meeting (Assessment)

2.1 Quality & Engagement Act (2023) Implementation

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

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

2.2 Once for Wales Content Management System (RLDatix)

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

PTHB pilot of the risk module commenced in September 2023 within the Nursing Directorate (supported by the Director of Corporate Governance). Training has taken place to support roll out across service groups in a staged approach. Taking the opportunity to pilot the module ensures PTHB can use a digital platform to manage risks across the health board, ensuring a more robust structure for risk management visible on one platform.

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

2.3 Supporting learning and improvement

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

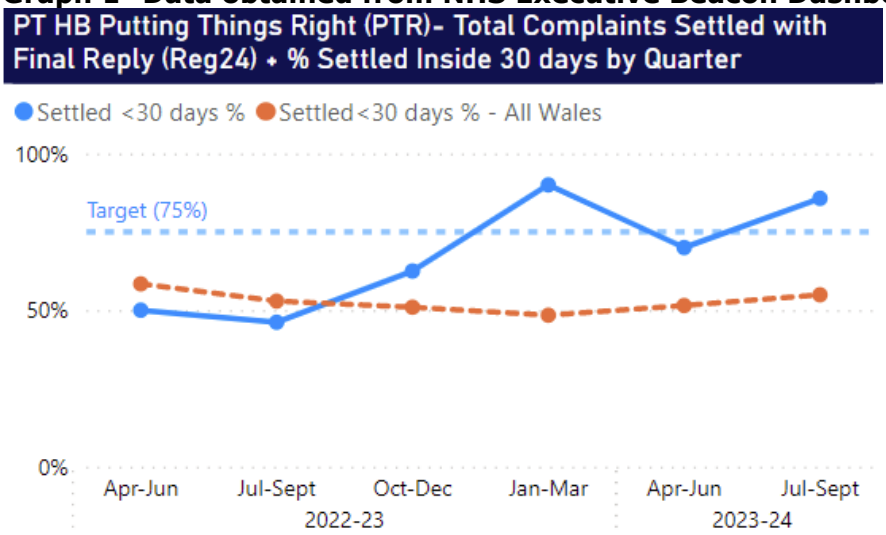
The team have supported learning events to discuss incidents that have occurred with common themes and crossover of learning. The learning events have been well attended by key individuals within the services to further strengthen the actions for improvement that are required. It is envisaged that these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

2.4 Putting Things Right – Concerns

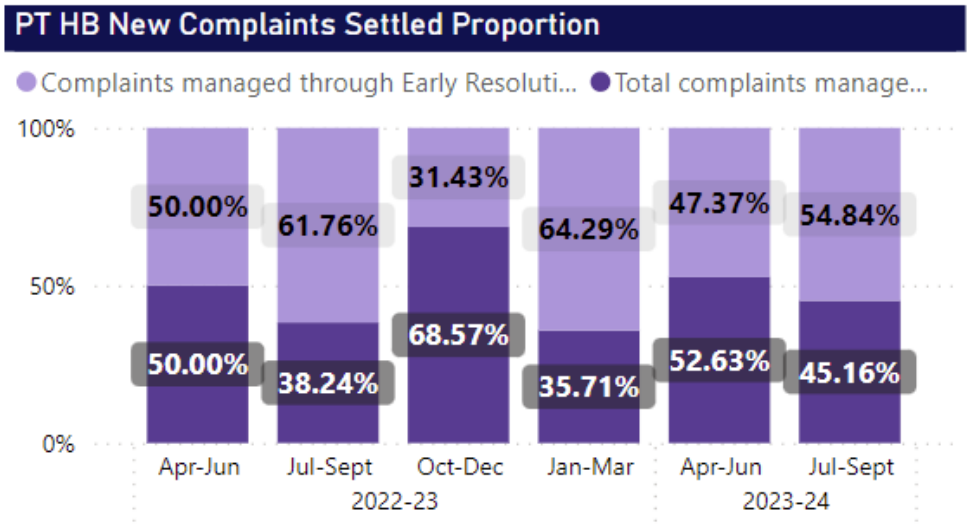
The management of concerns compliance within 30 working days has been stable during Q1-Q3 with reported compliance nationally of 76.47% which is an improvement to the same period during 2022-23 of 57.65%. Continued focus is maintained to ensure concerns are managed in a timely manner with the appropriate investigation and response.

Graph 1 highlights the Powys quarterly compliance (blue line) against the national position (Orange line), Whilst Graph 2 notes the percentage of concerns managed as early resolution (light purple) and formally (Dark purple).

Graph 1- Data obtained from NHS Executive Beacon Dashboard



Graph 2- Data obtained from NHS Executive Beacon Dashboard



Themes from concerns (provider) –

- Communication with families.
- Clarity of pathway of care.
- Decision making regarding pathways of care.

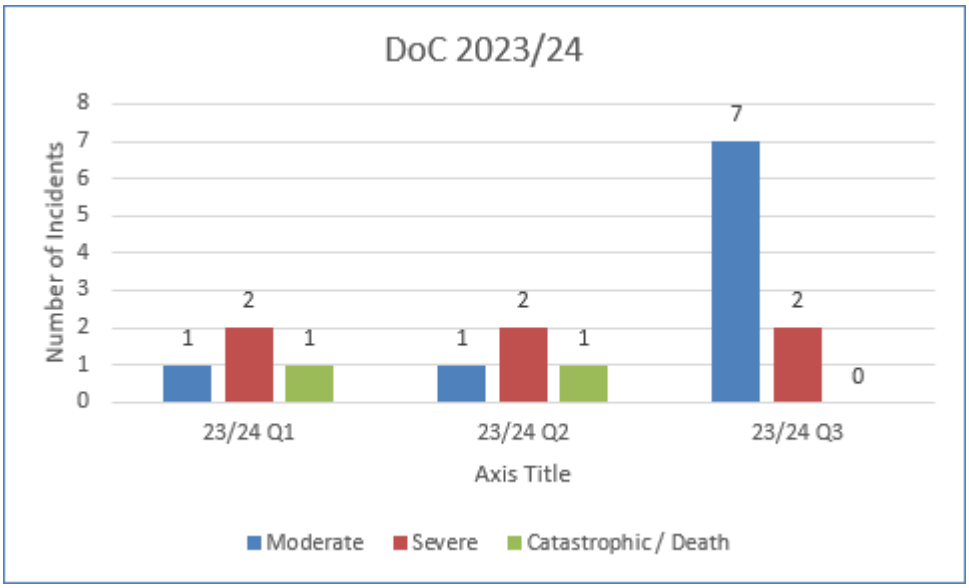
Themes from concerns (commissioning) –

- Waiting time for gynaecology procedures at SaTH
- Attending appointments when results not available.
- Request to move care from one health board to another.

Themes from enquiries –

- Unable to access dental care following closure of previous practice.
- Misuse of visitors' car park at BWMH.
- Availability of epilepsy equipment in Powys.
- Delay in receiving covid boosters.

Duty of Candour
Duty of Candour cases have increased during Q3 as anticipated, as this is a new process for teams the impact of training, confidence and awareness has impacted the numbers reported. To note no cases have been referred for Redress, therefor no harm has been identified.



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

Clinical Negligence
6 Open files

General Medicine Practice Indemnity (GMPI) Claims
4 Open cases

2.5 Public Service Ombudsman for Wales (PSOW)

Q1 & Q2 has been received from PSOW as noted below:

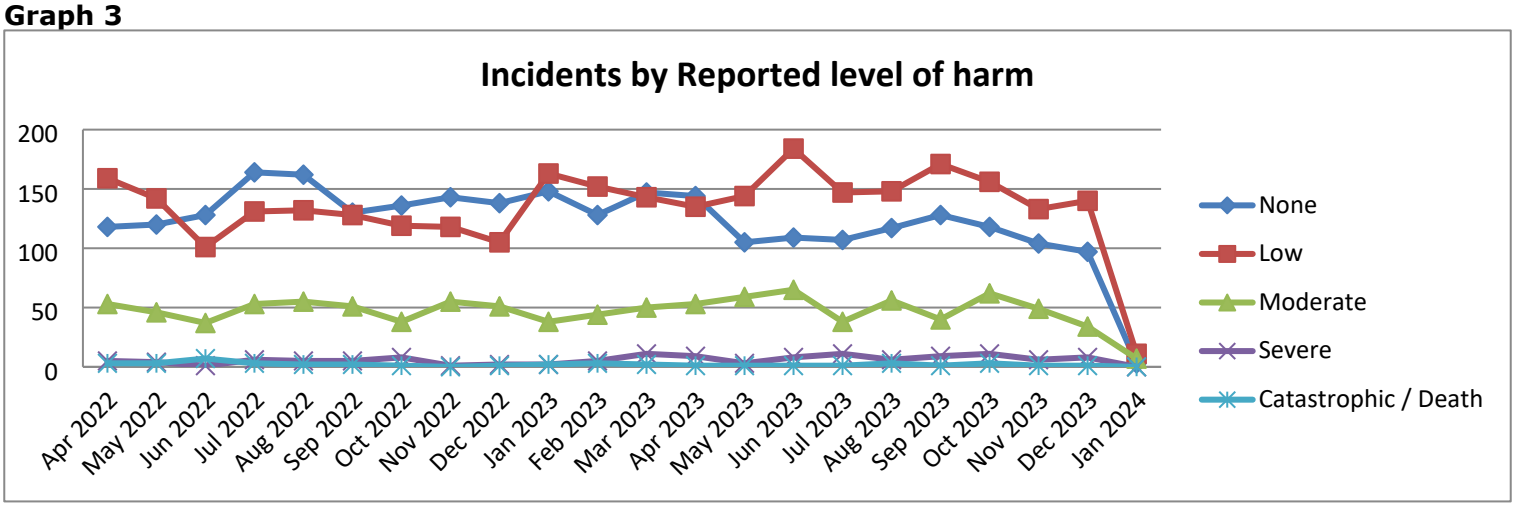
Time period	Decision not to investigate	Premature	Matter out of Jurisdiction	Upheld	Not upheld	Total
Q1	5	1	1	0	0	7
Q2	1	1	3	1	1	7

Number of referrals to PSOW have reduced in comparison to 2022/23 data, noting that of the 14 cases noted above only 2 have been investigated with 1 of those upheld. The case upheld was a historical case from 2021.

2.6 Incident Management

The number of patient safety incidents (**Graph 3**) reported is stable and appropriate with most incidents reported within the Low and No Harm classification.

Graph 3



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

- Implementation of Incident Management Framework, which provides clarity of process and expectations along with templates to support timely investigations.
- Weekly reporting to Heads of Service, Assistant Director and Executive Directors highlighting incidents that remain open/overdue.
- Weekly meetings with service governance leads.
- Additional training sessions to support timely incident management.
- Production of dashboards within Datix for all services.
- Additional resource to support the management of Pressure Ulcer incidents as noted to committee within the more detailed narrative provided October 2023. A further focus will be provided to Committee regarding management of Pressure Ulcers during Q2 2024/25. This will include a disaggregation of inherited and acquired pressure sore incidents as committed to in a previous Committee. This work is on-going to ensure that data is correct.

The management of incidents is an organisational issue that will require continued support from all service leads and senior teams to address. Ensuring that themes and trends for learning are realised and shared. The recent deep dive into incident management in Mental Health has demonstrated how rigour can be applied to all service groups across Powys.

2.10 Early Warning Notifications (previously No surprises notifications)

3 Early Warning Notifications have been submitted during Q3 2023/24.

2.11 Nationally Reportable Incidents

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

Number open	Number open in time	Number open overdue	Number awaiting final approval
14	7	5	2

The themes for learning and improvement include:

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

3. Patient Experience

3.1 CIVICA

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

The numbers of responses within CIVICA are low, this will be addressed with the implementation of text notifications (during Q4) and prompts to patients following admission or attendance to share their feedback. Development of the volunteer role will further support completion as the volunteers will be able to support in patients and those attending outpatients appointments with completion of the questionnaire with the use of an IPad.

Your NHS Experience is available for all patients that have accessed healthcare. **Graph 3** demonstrates the feedback available as a percentage of all respondents. Further analysis is required of the narrative 'free text' option to understand what has impacted both positively and negatively to support ongoing learning and service improvement. **Graph 4** is a wordle of the most used words within the 'free text' system.

Graph 3 – Source CIVICA

Question:	Survey	2022 Nov	2023 Jan	2023 Feb	2023 Mar	2023 Apr	2023 May	2023 Jun	2023 Jul	2023 Aug	2023 Sept	2023 Oct	2023 Nov	2023 Dec	Benchmark
2. Did you feel that you were listened to?	Your NHS Wales	100	100	100	100	63	100	100	81	-	71	80	100	100	85
3. Were you able to speak in Welsh to staff if you needed to?	Your NHS Wales Experience	0	-	-	-	100	-	-	-	-	-	0	-	25	85
4. From the time you realised you needed to use this service, was the time you waited:	Your NHS Wales Experience	75	100	-	75	75	50	100	63	-	63	35	100	50	85
5. Did you feel well cared for?	Your NHS Wales Experience	100	100	100	100	60	88	100	75	-	67	75	75	100	85
6. If you asked for assistance, did you get it when you needed it?	Your NHS Wales Experience	100	100	-	100	50	100	100	75	-	75	67	-	100	85
7. Did you feel you understood what was happening in your care?	Your NHS Wales Experience	100	100	100	100	65	100	100	92	-	75	90	-	100	85
8. Were things explained to you in a way that you could understand?	Your NHS Wales Experience	100	100	100	100	80	100	100	92	-	79	90	-	100	85
9. Were you involved as much as you wanted to be in decisions about your care?	Your NHS Wales Experience	100	100	100	100	75	100	75	75	-	67	80	-	100	85
10. How would you rate your experience 1-10	Your NHS Wales	100	100	100	100	64	60	100	70	-	68	62	-	100	85
Overall:		86	100	100	97	69	85	97	77	-	70	71	92	87	

Graph 4 – Source CIVICA **Photo 1**

During the Patient Experience Steering Group 20 November 2023, services shared their successes, areas for learning along with ongoing priorities, a sample of those are shared below:

Service Successes

- The patient's council led by PAVO has produced meaningful change for the patients on Felindre Ward at Bronllys.
- Collection of service user feedback has enhanced team morale and development of services.
- Civica PREMS questionnaire automated process
- Patient Experience Boards available in all clinical areas (MIU example: **Photo 1**)
- 100% of patients with urgent dental needs are offered urgent dental appointments via the dental helpline. Since April 2023, 781 patients have been allocated to dentists within Powys from the PTHB dental waiting list.

Opportunities for Learning

- The WIFI accessibility on all wards requires upgrading and improvement.
- Integration of Civica survey results into continual service improvement cycle.
- Promotion of the Primary & Community Care Academy (P&CCA) and engagement with wider teams, collaboratives, and cluster to promote the support offered from the P&CCA and further understand training requirements.
- The roll out of the Accelerated Cluster Development (ACD) programme demonstrates the need for multi-professions collaborative working to build local service provision for patients.
- Neurodevelopment Service – Electronic screeners available for schools to accelerate process and reduce paper traffic and risks associated with this.

Ongoing priorities

- Analysis of feedback data and free text to further understand what matters to patients, their families, and carers.

- Improvements to inpatient length of stay- deep dive session taken place in November 2023, specific wards with enhanced length of stay patients supported by a bed census audit to determine root causes of long bed waits.
- School Nursing - Review the way parental consent is gained by School Nursing for immunisations. Currently, preparing for E-Consent Jan 2024.

3.2 Patient Stories

The development of a library of patient stories to support learning and improvement is a priority for Q4 2023/24 and Q1 2024/25 to positively inform team meetings, Board and Sub-Committees. As there is currently no resources to support the production of patient stories, the Assistant Director of Quality & Safety has purchased equipment to digitally record stories for sharing as required.

4. Infection Prevention and Control (IP&C)

4.1 IP&C improvement plan is progressing at pace, with progress noted below:

Summary Delivery vs Plan		
Delivery against Plan	**RAG Status Definition**	**%**
% of activities which are complete	The action has been completed and there is a record of evidence to support it's completion.	60%
% of progress being made	Progress is good and the action is likely to be achieved within timescale.	19%
% of activities which are late or confirmed as being late	Work is significantly behind schedule and no progress has been made/or progress has been made but the timescale has not been achieved.	2%
% of activities on track	Progress being made and is on track and will be completed on timescale.	19%

- **29 actions have been completed.**
- **8** on track and will be completed within the timescales provided.
- **9** progress is good and is likely to be achieved.
- **1** where no progress has been made, relates to the availability of policies in different formats i.e., Welsh language. This will be addressed during Q4.

Areas of improvement realised to date:

- **IP&C will feature as part of the corporate induction monthly from February 2024**
- A Board level statement outlining its collective responsibility towards the prevention of Healthcare Associated Infections has been agreed and endorsed at PEQS.
- PHW dashboards on Tier1 surveillance organisms, now aligns with PTHB internal data, at present, providing a true reflection of infection data in Powys.
- Epidemiology support gained from PHW, with assigned epidemiologists to support Powys, as and when needed.
- New policies developed, implemented, and shared across the organisation.

Priorities for Q4:

- Review of IP&C structure, capacity, and resilience, including providing support to Primary Care.
- Continue discussion with commissioning colleagues regarding processing of Microbiology samples through Welsh laboratories.
- Support Pharmacy colleagues with a business case to support an Antimicrobial Stewardship Pharmacist.
- Currently scoping an electronic system for recording and monitoring of audits, including ward accreditation.
- Internal audit of IP&C.

5. Health and Social Care Inspections Regulatory Recommendations

5.1 Health Inspectorate Wales Inspections

There have been three inspections since the last reporting period.

- Epynt & Y Bannau Wards, Brecon War Memorial Hospital; 25 - 27 September 2023(final report **Appendix 1**).
- Graham Davies Ward, Llanidloes Hospital; 9-11 October 2023 (Report not published)
- Brynheulog Ward, Newtown; 21-22 November 2023 (Report not published)

Over the past 9 months 6 community Hospital wards have been inspected by HIW, triangulation of all report's findings will be completed and presented to Patient Experience & Quality Committee in April 2024.

5.2 Joint Inspection of Child Protection Arrangements (JICPA)

Health Inspectorate Wales, in partnership with Care Inspectorate Wales (CIW), His Majesty's Inspectorate of Constabulary, Fire & Rescue Services (MNICFRS). And Estyn undertook a system wide inspection of child protection arrangements in Powys during Quarter 3. We have received the draft report and subsequently responded as requested and the final report is due for publication imminently. Once published, the Health Board will jointly produce an Action Plan to address any recommendations for improvement with Powys County Council, Dyfed Powys Police and the Education sector.

This will be a key agenda item for the next Patent Experience and Quality Committee.

6. Llais

Engagement events held in two localities:

- Welshpool & Montgomery
- Ystradgynlais

Key findings noted in **Appendix 2**.

An engagement session is planned between the health board and Llais colleagues on 19 January 2024, to test ways to socialise and embed the feedback from the locality deep dive engagement events held by Llais. This model when finalised will be rolled out across Wales.

7. PAVO

Feedback was shared during the Patient Experience Steering Group (20/11/23) from the multiple touch points facilitated and supported by PAVO; **Appendix 3**.

8. Environmental Health Services

Environmental services carried out an inspection of Bronllys Hospital catering facility on 28 October 2023 which resulted in a hygiene rating of 1. Immediate action was taken to resolve the issues identified and re-inspection was carried out on 28 November 2023 and a hygiene rating of 5 was rewarded. Robust actions are in place to monitor compliance across all catering facilities within PTHB. The executive and Delivery and Performance Committees have had specific agenda items for assurance in relation to these issues.

9. KEY MATTERS FOR BOARD/COMMITTEE

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

Appendix 1: HIW Inspection Report, Epynt & Y Bannau wards, Brecon War Memorial Hospital	 03636 - Brecon Hospital - Full Report
Appendix 2: Llais Engagement feedback	 Llais Presentation to PESG 20Nov23.pd
Appendix 3: PAVO Engagement feedback	 PAVO Powys Third Sector Report - Patie

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

IMPACT ASSESSMENT					
Equality Act 2010, Protected Characteristics:					
	No impact	**Adverse**	**Differential**	**Positive**	**Statement** ***Please provide supporting narrative for any adverse, differential or positive impact that may arise from a decision being taken***
Age	√				
Disability	√				
Gender reassignment	√				
Pregnancy and maternity	√				
Race	√				
Religion/ Belief	√				
Sex	√				
Sexual Orientation	√				
Marriage and civil partnership	√				
Welsh Language	√				
Risk Assessment:					
	Level of risk identified				**Statement** Reputational risk if no improved compliance with Welsh Government performance for management of concerns.
	None	**Low**	**Moderate**	**High**	
Clinical	√				
Financial	√				
Corporate	√				
Operational	√				
Reputational			√		

/

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Hospital Inspection Report (Unannounced)

Epynt and Y Bannau Wards, Brecon War Memorial Hospital, Powys Teaching Health Board

Inspection date: 26 and 27 September 2023

Publication date: 28 December 2023

This publication and other HIW information can be provided in alternative formats or languages on request. There will be a short delay as alternative languages and formats are produced when requested to meet individual needs. Please contact us for assistance.

Copies of all reports, when published, will be available on our website or by contacting us:

In writing:

Communications Manager

Healthcare Inspectorate Wales
Welsh Government

Rhydycar Business Park

Merthyr Tydfil

CF48 1UZ

Or via

Phone: 0300 062 8163

Email: hiw@gov.wales
Website: www.hiw.org.uk

Digital ISBN

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

Our purpose

To check that healthcare services are provided in a way which maximises the health and wellbeing of people

Our values

We place people at the heart of what we do. We are:

- Independent – we are impartial, deciding what work we do and where we do it
- Objective - we are reasoned, fair and evidence driven
- Decisive - we make clear judgements and take action to improve poor standards and highlight the good practice we find
- Inclusive - we value and encourage equality and diversity through our work
- Proportionate - we are agile and we carry out our work where it matters most

Our goal

To be a trusted voice which influences and drives improvement in healthcare

Our priorities

- We will focus on the quality of healthcare provided to people and communities as they access, use and move between services.
- We will adapt our approach to ensure we are responsive to emerging risks to patient safety
- We will work collaboratively to drive system and service improvement within healthcare
- We will support and develop our workforce to enable them, and the organisation, to deliver our priorities.

Contents

1. What we did

Full details on how we inspect the NHS and regulate independent healthcare providers in Wales can be found on our website.

Healthcare Inspectorate Wales (HIW) completed an unannounced inspection at Brecon War Memorial Hospital, Powys Teaching Health Board on 26 and 27 September 2023. The following hospital wards were reviewed during this inspection:

- Epynt ward – 15 beds – GP and Consultant led - providing specialist rehabilitation services and is the stroke rehabilitation centre for south Powys
- Y Bannau ward – 15 beds – GP led - providing general medical and palliative care services.

During the inspection we invited patients or their carers to complete a questionnaire to tell us about their experience of using the service. We also invited staff to complete a questionnaire to tell us their views on working for the service. A total of four questionnaires were completed by patients or their carers on Epynt ward and six on Y Bannau ward. Six questionnaires were completed by staff working on Epynt ward and seven by staff working on Y Bannau ward. Feedback and some of the comments we received appear throughout the report.

Where present, quotes in this publication may have been translated from their original language.

Our team, for the inspection comprised of three HIW Healthcare Inspectors, four clinical peer reviewers and one patient experience reviewer (who spent time speaking with patients on both wards). The inspection was led by a HIW Senior Healthcare Inspector.

Note the inspection findings relate to the point in time that the inspection was undertaken.

This (full) report is designed for the setting and describes all findings relating to the provision of high quality, safe and reliable care that is centred on individual patients.

A summary version of the report, which is designed for members of the public can be found on our website

2. Summary of inspection

Quality of Patient Experience

Overall summary:
We found the quality of patient experience to be good on both wards. Patients and their relatives spoken with during the inspection expressed satisfaction with the care and treatment received. Patients told us that staff were kind and caring. We observed good interactions between staff and patients, with staff supporting patients in a dignified and respectful manner. We saw staff attending to patients in a calm and reassuring manner. However, we found some aspects of the environment on both wards that required improvement.

This is what we recommend the service can improve:

- Provide information on how to raise a concern or make a complaint and replace the information relating to the Community Health Council with information relating to Llais
- Refurbish the palliative care facilities on both wards to make them less clinical in appearance and more comfortable for patients and relatives
- Develop the outside garden space for use by patients and visitors on Y Bannau ward
- Repair the emergency call bell on Y Bannau ward and the call bell in the bathroom on Epynt ward
- Provide additional aids to support individuals with dementia e.g clocks, calendars etc
- Provide additional stroke rehabilitation chairs on Epynt ward
- Explore the use of alternative areas for storage on both wards and the charging of medical equipment on Epynt ward.

This is what the service did well:

- Good interactions between staff and patients
- Food provision.

Delivery of Safe and Effective Care

Overall summary:

We found the provision of care on both wards to be generally safe and effective and the staff team were committed to providing patients with compassionate, safe and effective care. However, we found that improvement was required in relation to aspects of infection control, medication management and record keeping.

Suitable equipment was available and being used to help prevent patients developing pressure sores and to prevent patient falls. The wards were clean and tidy, and arrangements were in place to reduce cross infection. There were formal medication management processes in place.

Patient care needs had been assessed by staff and staff monitored patients to promote their wellbeing and safety.

This is what we recommend the service can improve:

- Some aspects of medication management
- Some aspects of infection prevention and control
- Some aspects of record keeping and auditing of care documentation
- Review the timings of MDT meetings to ensure that GPs are able to attend
- Ensure that the DOLS process is robust and in line with the pathway.

This is what the service did well:

- Provision of person-centred care
- Risk management
- Multidisciplinary working.

Quality of Management and Leadership

Overall summary:
We found good management and leadership on both wards, with staff commenting positively on the support that they received from the management team. However, we found that improvement was needed around staff supervision and some elements of staff training.

Staff members told us that they were generally happy in their work and that an open and supportive culture existed.

This is what we recommend the service can improve:

- Some aspects of staff training to include mandatory training, sepsis and Duty of Candour training
- Move to electronic records management system
- Ensure that regular staff meetings are conducted on Y Bannau ward
- Ensure that staff have regular appraisals
- Ensure that staff are aware of how to access policies and procedures on the intranet.

This is what the service did well:

- Good support and oversight by ward managers

- Good auditing and reporting processes.

Details of the concerns for patient's safety and the immediate improvements and remedial action required are provided in Appendix B.

3. What we found

Quality of Patient Experience

Patient Feedback

During the inspection we used paper and online questionnaires to obtain views and feedback from patients and carers. A total of four questionnaires were completed by patients or their carers on Epynt ward and six on Y Bannau ward.

Comments from patients accommodated on Epynt ward included the following:

> *"Thumbs up for the staff."*
>
> *"Staff outstanding at all levels."*
>
> *"Staff have encouraged me to be as independent as I can."*

Comments from patients accommodated on Y Bannau ward included the following:

> *"Every single person involved in running this hospital from cleaning staff to nursing have been kind, respectful, helpful and need that respect back. They work under stress most days due to staff shortage. Keep giving them the pay they deserve."*
>
> *"Staff are lovely."*
>
> *"The care couldn't be better."*

We asked what could be done to improve the service. Comments included the following:

> *"Mostly good, but there are lots of staff changes."*
>
> *"Trying to get appropriate healthcare to go home is proving difficult."*

Person Centred

Health promotion
Health related information and pamphlets were available in various parts of the wards, many of which were bilingual. However, there were many empty leaflet racks on both wards, and these should be removed if no longer required.

The heath board should remove the empty leaflet racks if no longer required.

We saw good interactions between staff and patients with staff attending to patient needs in a discreet and professional manner.

We saw staff spending time with patients and encouraging and supporting them to do things for themselves thus maintaining or regaining their independence.

We saw a variety of equipment on both wards to help patients to mobilise and to encourage independence. However, we were told that there were not enough specialist stroke chairs on Epynt ward to meet patient demand.

The health board must ensure that there are enough specialist stroke chairs on Epynt ward.

Dignified and respectful care
We found that patients were treated with dignity, respect and compassion by the staff team and patients and their relatives were full of praise for the staff.

We observed staff being kind and respectful to patients. We saw staff making efforts to protect patient privacy and dignity when providing assistance with personal care needs. Patients confirmed that staff were kind and sensitive when carrying out care.

We saw that staff were making an effort to ensure that patients were clean and that their clothing was changed regularly.

Patients told us that they were happy with the way that staff maintained their privacy and we saw curtains being drawn around patients when personal care was being given.

There were designated palliative care suites on both wards. These provided a valuable resource for patients requiring end of life care. However, both suites required refurbishment in order to make them less clinical in appearance and more comfortable for patients and their relatives. We also suggested that the garden area adjacent to Y Bannau ward be made more accessible to patients and their visitors and in particular those patients in receipt of palliative care.

The health board should consider refurbishing the palliative care facilities on both wards to make them less clinical in appearance and more comfortable for patients and relatives.

The health board should consider ways of making the garden area adjacent to Y Bannau ward more accessible to patients and their relatives.

Individualised care

The quality of assessment and care planning was generally good, and we found that care was being planned and delivered in discussion with patients and in a way that identified and met individual needs and wishes.

There were good multi-disciplinary discussions taking place during the board round around patients' needs. However, we were told that GPs were not always able to attend some of the multidisciplinary team meetings due to other work commitments.

The health board should review the timings of MDT meetings to ensure that GPs are able to attend.

We found that patients' wishes with regards resuscitation in the event of collapse were being discussed with the patients and their nominated family representatives and that Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) documentation was being completed where needed. However, we noted that both the DNACPR and escalation of treatment forms had red borders which could lead to confusion, and we recommend that these be reviewed.

The health board should look at ways to distinguish between the DNACPR and escalation of treatment forms to avoid confusion.

Timely

Timely care

Patients on both wards were attended to promptly when they needed assistance. Staff were seen to anticipate patients' needs through general observation. This enabled them to attend to patients in a timely way. However, we were told that the emergency call bell on Y Bannau ward was not working. This had been reported to the maintenance department and an alternative, temporary system of alerting staff to an emergency put in place. We also found that a call bell in one of the bathrooms on Epynt ward was not working.

The health board must repair the emergency call bell on Y Bannau ward and the call bell within one of the bathrooms on Epynt ward without further delay.

There were good multidisciplinary discharge planning processes in place with support provided by the discharge co-ordinator. There was a robust process in place to track patients on the wards who were awaiting discharge. However, the supporting documentation was not always reflective of the process and the decisions made. In addition, some patients were being accommodated for longer than was needed due to delays in social worker assessments or the availability of suitable community care packages.

The health board must ensure that the discharge planning documentation is reflective of the process undertaken and the decisions made.

The health board must continue to engage with the local authority with a view to improving the availability of suitable social care provision in order to facilitate timely patient discharge.

Equitable

Communication and language
Throughout the inspection, we saw staff on both wards communicating with patients and their relatives in a calm and dignified manner. Patients were referred to according to their preferred names. Staff were seen communicating with patients in an encouraging and inclusive manner.

Patients told us that staff on the wards were mostly English speaking with some able to speak a few Welsh words and phrases. We were also told that Welsh language training was available, but staff uptake was low. Translation services were available and Welsh speaking staff from other areas of the hospital could be called upon to assist if needed. However, there was no directory of available Welsh speaking staff to assist in this process.

The health board must continue with efforts to encourage staff to learn Welsh and consider drawing up a directory of Welsh speakers that could be called upon for assistance if required.

There was no hearing loop equipment on either ward, and we suggest that such equipment be made available in order to assist in communicating with patients and visitors who may be hard of hearing.

The health board should consider providing hearing loop equipment on both wards.

Rights and Equality
We saw staff on both wards being kind and respectful to patients and patients spoken with confirmed that staff were kind and sensitive when carrying out care.

Patients told us that staff were always polite and listened, both to them and to their friends and family.

We found that care was being provided in a way to promote and protect patients' rights.

Staff were aware of the need for patients and family to meet in private and were willing to accommodate this by utilising unused bedrooms.

We found staff knowledge and application of Deprivation of Liberty Safeguards (DoLS) and Mental Capacity Act to be variable.

The health board must ensure that staff are provided with further training relating to DoLS and Mental Capacity.

Staff were aware of which patients were subjected to DoLS and this was reflected in the documentation we reviewed. However, we found one example on Epynt ward where a DoLS authorisation had lapsed.

The health board must ensure that staff adhere to the DoLS process and monitor timeframes to ensure that re-assessments are undertaken in a timely way.

Delivery of Safe and Effective Care

Safe

Risk management
We found that the delivery of care was generally safe and effective on both wards, where patients' care, and providing support to their relatives/carers, were the main priorities for the staff.

There were comprehensive policies and procedures in place to support the safe and effective delivery of care. These were based on current clinical guidelines and were being reviewed on a regular basis.

General and more specific risk assessments were being undertaken on a regular basis to reduce the risk of harm to patients, staff, and visitors. However, we found that falls risk assessments were not being reviewed regularly.

The health board must ensure that falls risk assessments are regularly reviewed.

Infection, prevention, control and decontamination
There were generally good housekeeping arrangements in place on both wards. The communal areas and rooms we looked at were clean and generally tidy.

However, we saw that medical equipment and some supplies of PPE were being stored within corridor areas on both wards increasing the risk of cross infection. Some medical equipment was also being charged on the corridor on Epynt ward. We also saw that portable suction machines were being stored on the floor in the corridor on Epynt ward. Not only does this increase the risk of trips and falls, but it also increases the risk of cross infection.

The health board must ensure that equipment is appropriately stored to reduce the risk of falls and cross infection.

We found that the flooring within most areas of Epynt ward had become detached from the walls. Not only was this unsightly but it also made it difficult to keep clean and increases the risk of cross infection.

The health board must take steps to repair the flooring on Epynt ward.

We saw that there was a good supply of personal protective equipment available to help prevent the spread of infection. However, we found that plastic aprons were

being draped on handrails within the corridor on Y Bannau ward. Consequently, some of the aprons had fallen on to the floor thus increasing the risk of cross infection.

The health board must ensure that all items of PPE are appropriately stored.

Hand washing and drying facilities were available. We also saw hand sanitising stations strategically placed around the ward.

There was a comprehensive infection control policy in place supported by comprehensive cleaning schedules. However, we found that staff on Y Bannau ward were not cleaning the blood pressure monitoring equipment between patients.

The health board must ensure that staff clean the blood pressure monitoring equipment between patients.

Regular audits were being undertaken to ensure that staff were adhering to the policy and good practice principles. We suggest that outcomes of such audits be displayed for patients, visitors and staff to see.

The health board should display the outcome of audits on the wards for patients, visitors and staff to see.

Safeguarding of children and adults
Patients told us that they felt safe on the wards. There were written safeguarding policies and procedures in place. Both ward managers were knowledgeable about the practical application of these policies and procedures.

We were told that there were no active safeguarding issues on the wards at the time of the inspection.

Blood management
There was a blood transfusion policy in place. However, we found that this was due for review in 2020.

The health bord must review and update the blood transfusion policy.

We were told that blood transfusions were not undertaken on a regular basis on either ward. However, we were told that staff involved in blood transfusion and the management of blood products attended training and undertook regular competency assessments. Staff spoken with had a good understanding of the procedures to be followed.

Staff told us that any issues encountered during the transfusion process would be reported on Datix. However, staff were unaware of the Serious Hazard of Transfusion (SHOT) reporting process.

The health board must ensure that all staff involved in the transfusion of blood and blood related products are aware of the SHOT reporting process.

Management of medical devices and equipment
Both wards had a range of medical equipment available, and records showed that the equipment was maintained appropriately.

Medicines Management
There was a comprehensive medication management policy in place and medicines management arrangements were seen to be generally safe, effective, and well organised on both wards.

We were told that there was good support from the pharmacist and pharmacy technician who attended the wards three times a week.

We observed staff administering medication on both wards and looked at a sample of medication administration records and found the process to be generally well managed. However, patient weights were not routinely recorded on the medication administration charts and there was a lack of consistency in the way staff were recording medication administration with patients' evaluation of care notes.

The health board must ensure that staff record patients' weight on the medication administration charts.

The health board must ensure that staff consistently record medication administration with patients' evaluation of care notes.

Both wards shared a medication storage fridge located on Y Bannau ward due to issues with the room temperature on Epynt ward. We noted that the fridge was left unlocked, when staff were not present, on a number of occasions during the inspection. However, the room within which the fridge was located was always locked.

The health board must ensure that the medication storage fridge is locked when staff are not in attendance.

There was evidence of pain assessments taking place with nurses, when administering medication, asking patients if they needed any pain relief. However, we found inconsistencies in the pain scoring documentation.

The health board must ensure that pain scores are recorded consistent and accurately.

Effective

Effective Care

There was evidence of very good multi-disciplinary working between the nursing and medical staff on both wards.

From our discussions with staff and examination of patient care documentation, we found that patients were receiving generally safe and clinically effective care.

The multi-disciplinary healthcare team provided patients with individualised care according to their assessed needs. There were processes in place on both wards for referring changes in patients' needs to other professionals such as the tissue viability specialist nurse, dietician, occupational therapists, and physiotherapists.

We found that pressure area and skin integrity risk assessment were updated regularly and that referrals to the tissue viability specialist nurse made as required. However, we found that, on Epynt ward, records of referrals to the tissue viability nurses, and other professionals were not detailed.

The health board must ensure that referrals to other professionals are accurately recorded within patient care notes.

National Early Warning Score (NEWS) system was reflected in the assessment and care planning process, with evidence of full screening and assessment on admission and regular reviews at weekly intervals. However, we found two examples on Y Bannau ward where NEWS scores had been wrongly calculated.

The health board must ensure that NEWS assessments are undertaken in a consistent way and that scores are accurately recorded.

Staff were aware of the Sepsis pathway and care bundle and could describe how they would manage a patient with suspected or confirmed Sepsis. However, there was no evidence of staff having undertaken Sepsis training nor did they have access to guidance relating to the Sepsis pathway.

The health board must ensure that staff receive training on the management of patients with Sepsis and that they have access to guidance relating to the sepsis pathway.

Nutrition and hydration

We found the provision of food and drink to be very good with patients' eating and drinking needs assessed on admission. However, we found that re-assessments were not always undertaken in a timely way.

The health board must ensure that nutrition and hydration assessments are reviewed regularly.

We found an effective system to cater for individual patient needs with good communication between care and catering staff on both wards.

Patients had access to fluids with water jugs available by the bedside.

Staff were seen helping patients to eat and drink. We observed lunchtime meals being served on both wards and saw staff assisting patients in a calm, unhurried and dignified way allowing patients sufficient time to chew and swallow food. We also saw staff providing encouragement and support to patients to eat independently.

All the meals are freshly cooked on site daily and looked well-presented and appetising. Patients told us that the food was very good.

Patient records

The quality of the patients' records we looked on both wards variable. We were told that that documentation audits were undertaken annually as part of fundamentals of care / health and care standards audit. There was some evidence of records audits, but they were limited in scope e.g., DoLS.

The health board should set a process in place for regularly auditing care records to ensure consistency, accuracy and legibility.

We found that records were being maintained in both electronic and paper formats, and that there was some disjoin between medical notes, nursing notes, documents kept at the bottom of patients' beds and those records maintained electronically. This made finding relevant information difficult. Some medical notes lacked chronology and, in some cases, were illegible. Some medical notes were not signed and dated.

The health board should review how records are maintained and, if possible, move to an entirely electronic system.

Efficient

Efficient

We saw staff striving to provide patients with efficient care.

There was a mix of patients receiving care on the ward which included patients with mental health care needs due to dementia, patients with high physical care needs and patients assessed as suitable for discharge and awaiting suitable care home placement or community care package. Staff were aware of and responsive to the varying needs of patients.

Quality of Management and Leadership

Staff feedback

Staff on both wards were generally happy with the working environment and the support provided to them.

We asked what could be done to improve the service. Comments included the following:

> *"On Y Bannau, the nurse call system has broken down over recent weeks. A temporary solution is in place however the ward no longer has an emergency call bell. This potentially places patients and staff at risk in event of an emergency."*
>
> *"Currently there is no Chapel of rest. This can be quite distressing should family chose to see their loved ones. I am told the senior management are addressing the problem but what actions are planned have not been communicated. Maybe the Health Board need to consider a service level agreement with a local undertaker enabling the deceased to be collected and taken directly to the Undertakers."*
>
> *"Need further training on Trac and ESR. Need a formal band 7 induction programme."*
>
> *"Crib sheet, or training around external services for discharge planning."*

The health board must give due consideration to the above staff comments and take steps to address the issues highlighted.

Leadership

Governance and Leadership
There was a clear structure in place to support the governance and management arrangements on both wards.

We found that there were well defined systems and processes in place to ensure a focus on continuously improving the services. This was, in part, achieved through a rolling programme of audit and an established governance structure which enabled nominated members of staff to meet regularly to discuss clinical outcomes associated with the delivery of patient care.

During discussions with staff, we were told that there were good informal, day to day staff supervision and support processes in place on both wards. However, staff appraisal completion rates, although improving, were variable across both wards.

The health board must ensure that all staff receive an appraisal at least once every twelve months.

There was good communication, information sharing and mutual support between both ward managers.

There was also evidence of good day to day communication between the ward managers and staff. Staff meetings were taking place on a regular basis on Epynt ward whilst they had lapsed somewhat on Y Bannau ward.

The health board must ensure that staff meetings take place on a regular basis on Y Bannau ward and that minutes are shared with those staff members who are unable to attend.

Workforce

Skilled and Enabled Workforce

There was a formal staff recruitment process in place.

We looked at a sample of staff records on both wards and found that the appropriate procedures had been followed when recruiting staff and that relevant recruitment checks had been undertaken prior to the commencement of employment.

Staff on both wards were expected to complete training in subjects such as fire safety, infection control, Mental Capacity Act, Deprivation of Liberty Safeguards, Health & Safety and Safeguarding as well as service specific training. However, the staff training information provided showed mandatory training completion rates to be variable across both wards.

The heath board must ensure that staff complete all aspects of mandatory training.

Culture

People engagement, feedback and learning

We spoke with several staff members on both wards and found them to be friendly, approachable, and committed to delivering a high standard of care to patients, and staff told us that they generally work well together.

We were told by staff that the number of complaints received about the service was very low.

There was very little information on the wards to inform patients and visitors on how to make a complaint and one poster contained reference to the now dissolved Community Health Council.

The health board must display information on the wards on how to make a complaint and ensure that reference to the Community Health Council is replaced with details of Llais, which is the new national, independent body set up by the Welsh Government to give the people of Wales **a say in how they receive their health and social care services.**

We found that not all staff we spoke with were aware of their responsibilities under the Duty of Candour regulations with some staff telling us that they had undertaken e-learning with others telling us that they had not received any training on the subject.

The health board must ensure that staff are aware of their responsibilities under Duty of Candour and that they receive appropriate training on the subject.

Information

Information governance and digital technology

There was a formal information governance framework in place and staff were aware of their responsibilities in respect of accurate record keeping and maintenance of confidentiality.

Health board policies and procedures were kept on the intranet. However, not all the staff members spoken with knew how to access the policies and procedures.

The health board must ensure that all staff know how to access policies and procedures on the intranet.

Learning, improvement and research

Quality improvement activities

Regular audits were being undertaken on both wards in order to monitor and improve the quality of care provided.

Whole system approach

Partnership working and development

We were told that the ward was well supported by other professionals such as the local GPs, pharmacists, physiotherapists and dieticians.

4. Next steps

Where we have identified improvements and immediate concerns during our inspection which require the service to take action, these are detailed in the following ways within the appendices of this report (where these apply):

- Appendix A: Includes a summary of any concerns regarding patient safety which were escalated and resolved during the inspection
- Appendix B: Includes any immediate concerns regarding patient safety where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking
- Appendix C: Includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

The improvement plans should:

- Clearly state how the findings identified will be addressed
- Ensure actions taken in response to the issues identified are specific, measurable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed
- Ensure required evidence against stated actions is provided to HIW within three months of the inspection.

As a result of the findings from this inspection the service should:

- Ensure that findings are not systemic across other areas within the wider organisation
- Provide HIW with updates where actions remain outstanding and/or in progress, to confirm when these have been addressed.

The improvement plan, once agreed, will be published on HIW's website.

Appendix A – Summary of concerns resolved during the inspection

The table below summarises the concerns identified and escalated during our inspection. Due to the impact/potential impact on patient care and treatment these concerns needed to be addressed straight away, during the inspection.

Immediate concerns Identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
No immediate issues were identified and escalated during this inspection.			

Appendix B - Immediate improvement plan

Service: Epynt and Y Bannau Wards, Brecon Hospital

Date of inspection: 26 and 27 September 2023

The table below includes where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking.

Risk/finding/issue	Improvement needed	Service action	Responsible officer	Timescale
No immediate concerns about patient safety were identified during this inspection.				

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

Service representative:

Name (print):

Job role:

Date:

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Appendix C - Improvement plan

Service: Epynt and Y Bannau Wards, Brecon Hospital

Date of inspection: 26 and 27 September 2023

The table below includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Risk/finding/issue	Improvement needed	Service action	Responsible officer	Timescale
We found a number of leaflet racks on both wards.	The heath board should remove the empty leaflet racks if no longer required.	• Ward Managers to illicit what racks are required and either remove the surplus ones or use them.	Ward Managers	Completed November 2023
We found that both palliative care suites required refurbishment to make them less clinical in appearance and more comfortable for patients and their relatives.	The health board should consider refurbishing the palliative care facilities on both wards to make them less clinical in appearance and more comfortable for patients and relatives.	• To request redecoration through estates maintenance team to improve the appearance of the area and make it feel warmer & less clinical. • Some further equipment will be required fridge, microwave, pictures etc) consideration through charitable funds or League of	Ward Manager Community Services Manager (CSM)	December 2023

		Friends funding. Ward sister to compile a list with costs.		
The garden area adjacent to Y Bannau was not accessible to patients and their visitors and in particular those patients in receipt of palliative care.	The health board should consider ways of making the garden area adjacent to Y Bannau ward more accessible to patients and their relatives.	• Ward manager and CSM are reviewing a plan to improve this area. • Staff member has been appointed to oversee processes and applications for funding.	Ward manager and CSM will escalate through Community services group (CSG) operational meeting.	3-month review and monthly thereafter. Initial update expected February 2024.
We were told that GPs were not always able to attend some of the multidisciplinary team meetings due to other work commitments.	The health board should review the timings of MDT meetings to ensure that GPs are able to attend.	• Request made to GP practices to review attendance. • GP feedback and input into care is included at all MDT.	Community services manager to report via exception through CSG quality and safety meeting.	Monthly reporting from December 2023.
We noted that both the DNACPR and escalation of treatment forms had red borders which could lead to confusion, and we recommend that these be reviewed.	The health board should look at ways to distinguish between the DNACPR and escalation of treatment forms to avoid confusion.	• This is under review at an all-Wales level. • Staff reminded to be aware of which form is being reviewed. • Untoward incidents to be reported via Datix.	Escalation by exception reporting by CSM through CSG Quality and safety meeting.	Monthly reporting from December 2023

The emergency call bell on Y Bannau ward and a call bell in one of the bathrooms on Epynt ward was not working.	The health board must repair the emergency call bell on Y Bannau ward and the call bell within one of the bathrooms on Epynt ward without further delay.	• This was escalated at the time the fault was discovered. • A temporary system was deployed to mitigate the risks. • This has since been repaired and is currently working. • Persistent issues to be escalated and inserted onto risk register. • Continued monitoring and escalation must be in place.	Ward Managers/CSM's Exceptions to be reported through operational and Q&S group reports by CSM.	Completed October 2023
Documentation relating to patient discharge was not always reflective of the process and the decisions made. In addition, some patients were being accommodated for longer than was needed due to delays in social worker assessments or the availability of suitable community care packages.	The health board must ensure that the discharge planning documentation is reflective of the process undertaken and the decisions made. The health board must continue to engage with the local authority with a view to improving the availability	• The health board has twice weekly decision control group (DCG) meeting where the LA are represented by senior team members and concerns are escalated and communicated.	Escalation through weekly ward flow meetings for DCG. Assistant Director CSG and HoN CSG	Completed November 2023

	of suitable social care provision to facilitate timely patient discharge.	• The health board will liaise with ward nursing teams to ensure discharge documentation evidences the patient pathway and discharge processes.		
Staff Welsh language training uptake was poor and there was no directory of available Welsh speaking staff to assist in communicating with patients who chose to speak in Welsh.	The health board must continue with efforts to encourage staff to learn Welsh and consider drawing up a directory of Welsh speakers that could be called upon for assistance if required.	• The importance of Welsh language is maintained through all meetings. • Staff encouraged to make the active offer. • Staff encouraged to undertake Welsh language training. • Rosters and Uniforms reflect Welsh speaking staff, and we try where possible to ensure we have one member of staff who is Welsh speaking.	Reporting through CSG Patient Experience and Quality Group meeting and Patient Experience Steering Group (PSEG) Audited annually via fundamentals of care. Ward manager/CSM	Tri Annual review. Completed November 2023

There was no hearing loop equipment on either ward to assist in communicating with patients and visitors who may be hard of hearing.	The health board should consider providing hearing loop equipment on both wards.	• Hearing loops are available on all wards – staff made aware of the location and how to use.	Ward manager	Completed September 2023
We found staff knowledge and application of Deprivation of Liberty Safeguards (DoLS) and Mental Capacity Act to be variable.	The health board must ensure that staff are provided with further training relating to DoLS and Mental Capacity.	• Staff encouraged to complete and update DoLS training. • Safeguarding team have offered bespoke training to the ward team to improve the application of this knowledge. • Wards to achieve 85% training compliance by March 2024.	Ward manager to update CSM at monthly 1:1 regarding compliance with training. CSM to provide update in CSG Patient Experience & Quality Group meeting bi-monthly.	Completed November 2023 Training compliance target March 2024
We found an example on Epynt ward where a DoLS authorisation had lapsed.	The health board must ensure that staff adhere to the DoLS process and monitor timeframes to ensure that re-assessments are undertaken in a timely way.	• Oversight of expiry dates of DoLs required. • Question added to the monthly DoLs audit for inpatient wards.	Ward Manager CSM	Completed September 2023

		• Care plans implemented for all patients under DoLs which will provide all the details for improved monitoring of the process, including the date of the DoLs application, the date the DoLs is approved and the expiry date. The RP visit date is also included. • The care plan will be reviewed weekly alongside all other aspects of planned care. • Ward sister will add to the agenda for the next ward meeting in November.		
Falls risk assessments were not being reviewed regularly.	The health board must ensure that falls risk assessments are regularly reviewed.	• Biweekly review of Welsh Nursing Clinical Record (WNCR) in place.	Ward Manager CSM Head of Nursing	Completed November 2023

		• Nursing team reminded of the importance of reviews, weekly, as per policy or if there is a change in patient condition. • Recorded in ward meeting minutes and disseminated to all ward leaders at the relevant team meeting.	Escalation through CSG Patient Experience & Quality Group meeting by exception reporting.	
Medical equipment and some supplies of PPE were being stored within corridor areas on both wards increasing the risk of cross infection. Some medical equipment was also being charged on the corridor on Epynt ward. Portable suction machines were being stored on the floor in the corridor on Epynt ward. Not only does this increase the risk of trips and falls, but it also increases the risk of cross infection.	The health board must ensure that equipment is appropriately stored to reduce the risk of falls and cross infection.	• This was immediately resolved, following delivery of the items. • Central storage under review for all areas by the organisation. • Portable suction concern resolved on day of visit. • CSM to undertake spot checks on subsequent visits.	Ward Manager CSM	Completed November 2023

The flooring within most areas of Epynt ward had become detached form the walls. Not only was this unsightly but it also made it difficult to keep clean and increases the risk of cross infection.	The health board must take steps to repair the flooring on Epynt ward.	• This will form part of the improvement works being managed and coordinated by one individual within the community services group. • Escalated through operational and estates working groups.	CSM Head of Nursing Assistant Director.	March 2024
Plastic aprons were being draped on handrails within the corridor on Y Bannau ward and some of the aprons had fallen on to the floor thus increasing the risk of cross infection.	The health board must ensure that all items of PPE are appropriately stored.	• Alternative dispensers being sourced.	Ward Manager Escalation through CSM if not able to rectify.	January 2024
Staff on Y Bannau ward were not cleaning the blood pressure monitoring equipment between patients.	The health board must ensure that staff clean the blood pressure monitoring equipment between patients.	• All staff have been reminded of our responsibility for cleaning equipment through our team and ward level meetings. • Cleaning schedule updated and frequent Audits in place by IP&C	Ward Manager	Completed October 2023

Outcomes of audits were not displayed on the wards for patients, visitors, and staff to see.	The health board should display the outcome of audits on the wards for patients, visitors, and staff to see.	• Audit display boards are now in place. • Monthly audits to be published. • Spot checks by CSM and HoN during visits.	Ward Manager CSM HoN	Completed November 2023
The blood transfusion policy in place was due for review in 2020.	The health bord must review and update the blood transfusion policy.	• Blood transfusion policies have been updated and published. • Training needs analysis undertaken for blood transfusion delivery. • Ward to achieve 85% compliance by April 2024	Ward manager CSM Exception reporting through CSG Patient Experience & Quality Group meeting.	Policy update completed November 2023 Training compliance April 2024
Staff were unaware of the Serious Hazard of Transfusion (SHOT) reporting process.	The health board must ensure that all staff involved in the transfusion of blood and blood related products are aware of the SHOT reporting process.	• Training needs analysis undertaken for blood transfusion delivery. • Ward to achieve 85% compliance by April 2024	Ward manager CSM Exception reporting through CSG Patient Experience & Quality Group meeting and	April 2024

			Health & Safety Group.	
Patient weights were not routinely recorded on the medication administration charts.	The health board must ensure that staff record patients' weight on the medication administration charts.	• Weights are undertaken on admission and at regular intervals. • Staff reminded to document on medication charts to ensure that medications requiring weight calculation can be prescribed safely. • Added to ward meeting and shared with all staff. • Spot checks to be undertaken by senior management team visits. • Omissions to be added to datix and reported through medicines management team.	Ward manager CSM Exception reporting through CSG Patient Experience & Quality Group meeting and Health & Safety Group.	Completed November 2023

		• Monthly analysis of medication errors to be conducted.		
There was a lack of consistency in the way staff were recording medication administration with patients' evaluation of care notes.	The health board must ensure that staff consistently record medication administration with patients' evaluation of care notes.	• Evaluation of care records review to be undertaken by ward manager on WNCR • Ward manager to ensure that team are aware of the best practice approach in relating care implementation to documentation.	Ward manager CSM Exception reporting through CSG Patient Experience & Quality Group meeting and Health & Safety Group.	Completed November 2023
The medication fridge was left unlocked, when staff were not present, on a number of occasions during the inspection.	The health board must ensure that the medication storage fridge is locked when staff are not in attendance.	• Staff reminded immediately during the visit, and this has been reiterated during a team meeting. • Spots checks to take place during SMT visits.	Escalation via exception reporting through CSG Patient Experience & Quality Group meeting and CSM 1:1 with HoN	Completed September 2023
We found inconsistencies in the pain scoring documentation.	The health board must ensure that pain scores are recorded consistent and accurately.	• Pain scoring is now undertaken on WNCR.	Ward Manager HoN	Completed November 2023

		• Relevant actions are documented in the delivery of care update to include efficacy of analgesia. • HoN to undertake random spot check of pain scoring on WNCR monthly and use as a mechanism for shared learning.	Exception reporting through CSG Patient Experience & Quality Group meeting	
We found that documentation relating to referrals to the tissue viability nurses, and other professionals was not detailed.	The health board must ensure that referrals to other professionals are accurately recorded within patient care notes.	• Review of referral processes to be undertaken and forward moving plan disseminated to ensure detailed referrals are accurately documented.	CSM to undertake a review of referral systems and report to HoN by March 2024.	Completed October 2023
We found two examples on Y Bannau ward where National Early Warning Scores (NEWS) had been wrongly calculated.	The health board must ensure that NEWS assessments are undertaken in a consistent way and that scores are accurately recorded.	• Training needs analysis undertaken and opportunity for additional education has been identified.	Ward Manager HoN Exception reporting through CSG Patient Experience &	Completed November 2023

		• Clinical education team building a program of education. • Education provided to teams at ward level in a bespoke session in November 2023. • Opportunities for feedback and education to be taken during clinical visits by CSM and HoN	Quality Group meeting	
There was no evidence of staff having undertaken Sepsis training nor did they have access to guidance relating to the Sepsis pathway. Mills,Belinda 23/01/2024 16:55:35	The health board must ensure that staff receive training on the management of patients with Sepsis and that they have access to guidance relating to the sepsis pathway.	• The current training on ESR is out of date and requires updating. • To source a training provider. • CSM undertaking TNA due by 9th November clinical education will establish a timeline for implementation. • Sepsis Policy available to all staff via Sharepoint	CSM HON Education Department	Policy availability Completed November 2023 Training completion April 2024

We found that nutritional assessments were not always reviewed in a timely way.	The health board must ensure that nutrition and hydration assessments are reviewed regularly.	• Nutritional assessments are now being tracked through WNCR. • Relevant care planning has not been available since transition to WASSP. • Dietetics working with HoN and wards to develop bespoke care planning. • Teams reminded of the importance of regular reviews.	Ward Manager HoN Exception reporting through CSG Patient Experience & Quality Group meeting	Completed October 2023 Bespoke Care planning May 2024
The quality of the patients' records we looked on both wards variable and there was no evidence of regular documentation audits taking place.	The health board should set a process in place for regularly auditing care records to ensure consistency, accuracy, and legibility.	• CSM to develop existing documentation audit tool and trial with 5 sets of medical records (written and electronic) in November. • Focus on the quality of written documentation. • Ward sister will add to the agenda for the next	Ward Managers CSM Monitored through 1:1's and escalated as appropriate via exception reporting within CSG Patient Experience &	Documentation Audit completed November 2023

		ward meeting in November	Quality Group meeting.	
There was some disjoin between medical notes, nursing notes, documents kept at the bottom of patients' beds and those records maintained electronically. This made finding relevant information difficult. Some medical notes lacked chronology and, in some cases, were illegible. Some medical notes were not signed and dated.	The health board should review how records are maintained and, if possible, move to an entirely electronic system.	• As multiple platforms for documentation are not just an issue within PTHB but across Wales, this has been added to the risk register.	CSM	Completed October 2023
Staff, in response to the HIW questionnaire, made suggestions as to how the service could be improved.	The health board must give due consideration to the staff comments and take steps to address the issues highlighted.	• The feedback from staff will be taken through the PESQ for broader learning and consideration in line with transformation, enabling ownership at local level.	HoN	Completed October 2023
Staff appraisal completion rates, although improving, were variable across both wards.	The health board must ensure that all staff receive an appraisal at least once every twelve months.	• Ward sisters reminded of the requirement to	Ward Managers CSM's	February 2024

		improve compliance with PADR rates. • PADR compliance to me monitored through BI system and reported through CSG Q&S process. • Encouraged to plan time effectively with improvements required month on month. • CSM to be responsible for ensuring progression within teams of responsibility. • 85% compliance to be achieved by February 2024.		
Staff meetings were not taking place on a regular basis on lapsed Y Bannau ward.	The health board must ensure that staff meetings take place on a regular basis on Y Bannau ward and that minutes are shared with those staff members who are unable to attend.	• Ward meetings to be reinstated and held on a monthly basis. • Minutes to be recorded and shared with CSM.	Ward Managers	Completed November 2023

The staff training information provided showed mandatory training completion rates to be variable across both wards.	The heath board must ensure that staff complete all aspects of mandatory training.	• ILS/BLS booked as far as dates are available. • Dementia/Falls/Paul Ridd to be added to mandatory training for wards. • Staff being managed who have consistently and persistent low % of compliance. • Training is reviewed monthly by ward Manager and CSM and exceptions are reported through Quality and safety group.	Ward Manager CSM	Completed November 2023
There was very little information on the wards to inform patients and visitors on how to make a complaint and one poster contained reference to the now dissolved Community Health Council.	The health board must display information on the wards on how to make a complaint and ensure that reference to the Community Health Council is replaced with details of Llais, which is the new national, independent body set up by the Welsh Government to give the people of Wales a say in how they receive their health and social care services.	• Boards to be installed in all ward areas. • To consider using an existing space on temporary basis.	Corporate Services Q&S Team CSM	Completed September 2023

Not all staff were aware of their responsibilities under the Duty of Candour regulations.	The health board must ensure that staff are aware of their responsibilities under Duty of Candour and that they receive appropriate training on the subject.	• Ward sisters to undertake the appropriate training and encourage all qualified staff to undertake. • Ward sisters to monitor the numbers of staff trained through the PADR and staff development process. • Ward sister will add to the agenda for the next ward meeting in November. • Information printed and laminated in both ward areas.	Ward Managers	Completed October 2023
Not all the staff knew how to access the policies and procedures.	The health board must ensure that all staff know how to access policies and procedures on the intranet.	• All staff made aware of the health board intranet pages where policies can be accessed.	Ward Manager	Completed September 2023

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

Service representative

Name (print): Linzi Shone

Job role: Professional Head of Nursing

Date: 5/12/2023

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Llais What We are Doing and What We've Heard

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Andrea Blayney

Deputy Regional Director

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Presenting today

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- Regionally – **based on Regional Partnership Board footprint**

- Locally – **using the 13-locality approach based around Powys' largest towns and their surrounding areas**

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How we are working in Powys

- Ongoing engagement through local community events to raise awareness of Llais and to gather feedback (eg summer shows, community wellbeing events, community cafes)
- Surveys (online and paper)
- Collect patient experience stories
- Access to premises to engage with service users where they are receiving care
- Focus our engagement on one locality for a month for a ‘Deep Dive’

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Focused Engagement in Welshpool & Montgomery Locality

- ‘Deep Dive’ was piloted in Welshpool & Montgomery Locality in June
- Ystradgynlais Locality in September and Builth Wells & Llanwrtyd Wells Locality in November
- Reach out to organisations and groups working in the area
- Raising awareness
- Finding ways to engage with people of all ages and with different interests

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- Posters and flyers to Town & Community Councils
- Poster and leaflet drop in Welshpool, Montgomery and surrounding villages
- Article to local press
- Powys Talking Newspaper recorded a short broadcast for their listeners
- Face-to face engagement in 15 venues/groups – Carers Groups, Leisure Centre, Arthritis Support Group, Dementia Meeting Centre, Breastfeeding Support Group, High School, Ponthafren Craft Group & Gardening Group, Llandrinio Pop-up Market, Carnival, Youth Club, Visually Impaired Club, Veterans Hub, Montgomery Town Hall Market

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Focused Engagement in Welshpool & Montgomery Locality

KEY THEMES

- GP Services – Some people expressed positive comments about their experiences. Outweighed by challenges people face – difficulty obtaining appointments (long waits for telephone appointments), inability to obtain face-to-face appointments, problems getting through on phone, lack of GPs, inconsistent care when not seeing same GP.

- Unpaid Carers – concerns about mental health of carers, need for respite, feeling uncomfortable asking family or friends for help, lack of awareness about existing support services eg Credu, poor communication between different health/care workers/services causing carers to constantly chase actions, concerns about financial difficulties. Suggestion for liaison officer who could assist carers with follow-up actions.

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What We Heard in Welshpool & Montgomery Locality

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What We Heard in Welshpool & Montgomery Locality

- Need for more paid carers – difficulties finding carers even when willing to pay privately, difficulties getting packages of care set up.

- Challenges in Children's Services – issues with attending appointments for children with complex medical needs (eg blood tests cannot be done locally), concerns about transition from paediatric to adult services, difficulties obtaining assessments for ADHD or Autism.

- Mental Health Services – general perception of lack of mental health services in Powys, concerns about availability of mental health workers. Positive comments about Ponthafren but need for better promotion and funding for it.

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What We Heard in Welshpool & Montgomery Locality

- Dementia Services – positive feedback about Dementia Meeting Centre ("lifeline", peer support), carers expressed need for private discussions without person with dementia present, issues with lack of progress in arranging care packages, lack of follow-up from social services.
- Services for Visually Impaired – concerns about need to travel out of county for eye consultations and diabetic eye screening appointments.
- Veterans/Ex-Armed Forces Personnel – need for all GP practices to become accredited Veteran Friendly, challenges in the recording of veteran status, issues with timely transfer of medical records for individuals leaving the Forces.
- Dentists – some people had obtained dental appointments fairly easily, some attending out-of-county, cost of private dental care unaffordable.

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- Discussions with Young People – Need to use variety of means to get information to young people, need better awareness of mental health services available, more teachers trained in mental health first aid. Since COVID, young people do not want to be seeking support online.

- Young Carers – Many young people don't realise they are young carers and don't know about support available. Needs to be better information sharing when transitioning from primary to secondary school for children known to be young carers.

- In discussions, young people expressed satisfaction with services.

- Discussion with Irish Travellers – positive comments about local services, discussions about long waits for orthopaedic surgery, not knowing length of wait for diagnostic tests, past experiences affected the way that people felt about Shrewsbury Hospital. Spoke about need for healthcare providers to have a better understanding of the culture of travellers and importance of family, especially if someone in hospital receiving end of life care.

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What We Heard in Welshpool & Montgomery Locality

Focused Engagement in Ystradgynlais Locality

- Posters and flyers to Town & Community Councils
- Face-to face engagement on 6 dates throughout the month
- Coelbren Coffee Morning; The Hub at Abercrave Post Office and Café; Cymru versus Arthritis Support Group; Coelbren OAP Club; Ystradgynlais Warm Hub; Ystradgynlais Welfare Hall; Ystradgynlais Friends Tea Bar; Ystradgynlais Hospital; Ystradgynlais Volunteer Centre; Community Café; Ystradgynlais Library; Pengorof Surgery; Tesco; Ystradgynlais Youth Club

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KEY THEMES

- GP Services – Mixed feedback. Several people praised Ystradgynlais Practice for pleasant staff, ease of appointments and care provided. Seven Sisters Medical Practice received compliments with people commenting that they were seen quickly.
  Issues – not wishing to explain to receptionist reason for call, length of wait for call back, difficulty getting through on phone, lack of available appointment when do get through, appointment system difficult for older people, concerns about prescribing medication over the phone without seeing patient.

- Dentistry – Mix of satisfaction and frustration with dental care locally. Complaints about long waiting lists, appointment cancellations and limited availability NHS dentists, private dental care costly.

- Ystradgynlais Hospital – Appreciation for all the services provided at the hospital with praise for MIU, IBS nurse service, Audiology, caring and supportive during COVID.

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What We Heard in Ystradgynlais Locality

What We Heard in Ystradgynlais Locality

- Ystradgynlais Hospital – Concerns about under-utilisation. Day hospital closure seen as having significant negative impact on community and calls for it to be re-opened.
- Long waiting times for planned care – people quoted 5-8 year waits. Some people had resorted to private healthcare.
- Praise for ambulance crews but concerns about queuing outside ED leading to inadequate coverage in Powys.
- Elderly Care – Positive experiences with day centres and hospice services. Concerns about availability of social workers for older people, need for more community-based care options, better support needed for people living with dementia, reluctance of older people to complain about services.
- Distance to Services – Difficulties in accessing health care due to distance and transport issues.

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- Pharmacy Services – difficulties experienced with supply of some medicines, community pharmacy not providing expected service, difficulty finding pharmacy open on a Sunday.

- Discussions with Young People – spoke about positive experiences of various services. Doctors and nurses spoke directly to them in a way they could understand. Limited knowledge of ChatHealth.

What We Heard in Ystradgynlais Locality

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Happy to answer questions

Contact me:

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Thank You

Patient Experience Steering Group - Monday 20th November 23

	PAVO Patient Experience Steering Group Report November 2023
Paper submitted by	Clair Swales - CEO
Purpose of Paper	Information gathered via engagement with Powys population to inform Patient Experience Steering Group and other relevant partnership groups
Action/Decision required	For information/action
Acronyms and abbreviations	PAVO - Powys Association of Voluntary Organisations ; PTHB - Powys Teaching Health Board; ACD - Accelerated Cluster Development (Primary Care) ARFID - Avoidant Restrictive Food Intake Disorder

Felindre Ward Patients Council

PAVO Mental Health Participation Officer - Emma Cullingford attends and supports the facilitation of Patient's Council on Felindre Ward, Bronllys Hospital. The Ward Manager is present, listens and addresses concerns raised.

Issues Raised in the meeting held in October

Issue	Detail	Action to date
WiFi on the ward	Poor connections, not strong enough to use for streaming services	Report to PTHB Executive
No psychologist on the ward	No counselling / therapy offered	Discussed in Engage to Change
Information available to inpatients	Information available for patients on different mental health conditions	Rebecca Stringer (ward manager) sourcing leaflets

Access to learning hub	Patients having access to learning hub and online / distance learning courses to upskill during time on ward	
Creative activities	Increase artwork activities for patients on the ward	Art project proposal being drafted with Celf O Gwmpus
Exercise facilities	Lack of exercise facilities on the ward	Discussions of potential outside gym
Roof repairs	Concerned about disruption to patients during roof repairs	

Older People

Andrew Davies, PAVO Health & Wellbeing Participation Officer has been carrying out engagement across Powys with Older People to listen to their concerns. Older People representatives have now been recruited from all 13 localities.

Concerns raised are reported to the relevant department or lead officer. They are also reported to the Older People's Forum meeting where Senior Officers from PCC & PTHB are present.

Issue	**Detail**	**Action to date**
Access to GP appointments	Waiting over a month for GP appointments, Telephone call answering waiting times , some waiting over 40 minutes for calls to be answers and a number of calls being cut off The issues has been reported in Knighton, Brecon, Llanfyllin & Montgomery	Reported to Primary Care Development via 3 ACD meetings
Transport to health appointments	Public Transport timetables and stops are not conducive to many who rely on public transport especially those in rural areas - Knighton	
Covid Vaccination access	Transport and accessibility barriers Distance to travel Not available in the local community	Raised with Mererid Bowley (PTHB – Director) and a response received Local provision has been provided for the elderly and frail
Breast Screening (Knighton)	Not had access to the mobile breast screening unit for over 3 years	Response from PTHB - no suitable accommodation to site the mobile screening unit
Access to Allied Health Services	Access to services like physio can be patchy - Newtown	

Issues reported via the **Community Connector Service**

Issue	Detail	Action to date
Non-emergency patient transport	The notice period for Non-emergency patient transport has increased from 48-72 hours. Weekend hospital appointments - no (free) transport to access them	

Powys Junior Start Well Board

Lucy Taylor, Children & Young People's Wellbeing Officer supports Powys Junior Start Well Board to ensure their voices are heard. Issues reported in the July & October meeting are as follows;

Issue	Detail	Action to date
GP's	Some have a lack of understanding & reluctance to refer to specialist services for Mental Health support Comments such as 'it's just your age' were reported	Reported to RPB Start Well - going to facilitate a meeting with ACD leads & Start Well Board reps
Referral pathway to Mental Health support	Easier & quicker referral pathways are required to mental health/ emotional support services for young people. More support to be provided whilst waiting for a service.	To be raised with MH Partnership
Length of time to get a ADHD or ASD diagnosis	Covid had an impact on referral waiting times. Long delays persist. GP's are not great at recognising the symptoms.	
Medical appointments	Young people would like more choice when they can have a medical appointment	
No funding for support related to ARFID	ARFID support trailed in PTHB but no funding to continue delivering this support at present	To be raised with MH partnership

Community Transport Network facilitated by Claire Sterry, PAVO

Organisation	Issue	Detail	Action to date
Builth Wells Community Support - BWCS	Covid Vaccination access Not able to change appointments Age is a priority for vaccination in Glan Irfon	Coordination - service users not being able to accessing Glan Irfon when there is a need BWCS are not allowed to change appointment time unless the patient is present - resulting in them making up to 4 journeys per day to Bronllys Request that health/disabilities are included in the priority list	Raised with Mererid Bowley (PTHB – Director) and a response received. Local provision has been priorities for the elderly and frail

Emerging concerns

This section highlights emerging and ongoing concerns relating to third sector delivery that is likely to have a knock on consequence to statutory partners and the patient experience.

Issue	Detail	Action to date
Dementia Matters in Powys service delivery	Funding issues are likely to impact the operational delivery of the Dementia Meeting Centres. Outcomes include possible closure of services. This would likely result in a number of people living with dementia and their carers without support, or looking to statutory services for support.	A range of discussions have taken place with PTHB , PCC and the RPB but current funding constraints are problematic. PAVO continues to offer DMIP support.
Care and Repair adaptations service	Referrals for small adaptations have increased 30% since April 23 to date. This is resulting in Care & Repair facing a substantial funding shortfall of £67K. A funding shortfall would result in a prioritisation system being put in place to ensure continued provision for urgent and the highest risk works only. This will leave clients with needs that are not being met.	A range of discussions have taken place with PTHB & PCC. The initial shortfall was £152K but this is anticipated to be been reduced by a £35K top up from WG & £50,000 from PCC Housing top up (Verbally agreed, awaiting written confirmation)

Reported compiled by the Health, Wellbeing & Partnership Team - PAVO
20th November 2023

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 2.2

Patient Experience and Quality Committee	**Date of Meeting: 23 January 2024**
Subject :	Mental Health Quality and Safety Review
Approved and Presented by:	Claire Roche: Director Nursing and Midwifery Kate Wright: Medical Director Joy Garfitt: Interim Director of Operations, Community and Mental Health
Prepared by:	Head of Quality and Safety Assistant Director of Nursing (Q&S) Assistant Director Mental Health Head of Nursing, Mental Health
Other Committees and meetings considered at:	Executive Committee 17 January 2024

PURPOSE:

To provide the Patient Experience and Quality Committee with the outcome of a quality and safety review in Mental Health Services.

RECOMMENDATION(S):

The Patient Experience and Quality Committee is asked to:

- **NOTE** that an Incident Management Quality and Safety review has been undertaken in Mental Health Services.
- Take **ASSURANCE** that an improvement plan is being developed, which will be received and monitored by the Executive Committee, and an update will be provided to this Committee at its next meeting in April 2024.

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

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

		✓

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

EXECUTIVE SUMMARY:

The Chief Executive Officer commissioned a review into the quality and safety governance arrangements in mental health services. This request was informed by a number of nationally reportable incidents in the service and in response to a number of outstanding actions from the Patient Experience, Quality and Safety (PEQS) Committee.

The review is the first in a series of planned reviews that will take place across the organisation to support our ongoing learning and improvement.

The review has been co-ordinated and led by the Head of Quality and Safety, supported by the Assistant Director of Nursing (Quality and Safety) and in partnership with the Assistant Director Mental Health and the Head of Nursing, Mental Health.

The process for the review involved a deep dive into a number of incidents reported in the DATIX system as well as visits to wards and discussions with key members of the mental health team.

The findings of the review were presented to the Executive Committee on the 17 January 2024.

DETAILED BACKGROUND AND ASSESSMENT:

A Review of 50 incidents in the Datix system (Sept'22-Oct'23) was reviewed. This included 25 OPEN incidents and 25 CLOSED incidents. These were randomly selected from across all services areas/teams in Mental Health. It is important to note that although randomly selected, within the OPEN incidents, 5 were noted to be categorised as Severe / Catastrophic and therefore these were targeted for review.

Reporting arrangements for Nationally Reportable Incidents in line with the Incident Management Framework were reviewed, taking account the infrastructure for incident review, monitoring, taking actions and learning.

The review identified some key gaps with the management of incidents and Nationally Reportable incidents, in addition to identifying some additional opportunities for improvement.

The review provided the opportunity for learning to improve the quality and safety governance arrangements in the service.

Whilst the review was focussed specifically on mental health services, any improvement plan must include a review and assessment of the quality governance arrangements in the Health Board to support a robust floor to Board reporting.

It must be noted that this review was confined to a specific time frame and was an initial review to gain an understanding of the quality and safety arrangements in the Mental Health Service. It is not a full-scale service review and therefore will have limitations in its findings.

The findings of the review were presented to the Executive Team on the 17 January. The Executive team welcomed the review and agreed the next steps set out below.

NEXT STEPS:

- Mental Health Quality and Safety Improvement plan to be developed by the Mental Health Team, supported by the Quality and Safety team. This needs to be a Continuous Improvement Plan that addresses the key findings of the review and any emerging improvements (in line with a Quality Management System).
- The Improvement plan will be monitored by the Executive team and progress will be reported to the Patient Experience and Quality Committee.
- Proposed infra-structure for Quality and Safety Governance to be brought to the Executive Committee for agreement and approval (no later than the 21 February 2024).

- Patient Experience and Quality Committee to be informed of the review, its reporting to the Executive Committee and the next steps proposed.

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 2.3

PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE	**Date of Meeting: 23 January 2024**
Subject:	**Mental Health Act Compliance Report for the 12 month period :** **1 October to 31 December 2023 (Q3)** **1 January to 31 March 2023 (Q4)** **1 April to 30 June 2023 (Q1)** **1 July to 30 September 2023 (Q2)**
Approved and Presented by:	Joy Garfitt, Executive Director of Operations / Director of Community and Mental Health
Prepared by:	Melissa Brooks, Mental Health Act Administrator
Other Committees and meetings considered at:	
References	*Monitoring the Mental Health* 2018/19 (2020). **www.cqc.org.uk/mhareport** *Mental Health, Learning Disability Hospitals and Mental Health Act Monitoring Annual Report* 2018/19 (2020)Healthcare Inspectorate Wales **www.hiw.org**

PURPOSE:

The purpose of this paper is to assure the committee that Powys Teaching Health Board is compliant with the legal duties under the Mental Health Act 1983 (MHA).
RECOMMENDATION(S):
That the committee **RECEIVES** the report and takes **ASSURANCE** that the performance of the service in relation to the administration of the Mental Health Act 1983 has been compliant with legislation.

Approval	Discussion	Information
	✓	

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

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

EXECUTIVE SUMMARY:

This report seeks to provide assurance that the services delivered and Mental Health Act requirements discharged by the Mental Health and Learning Disabilities service group during the reporting period are compliant with the Mental Health Act (1983, as amended 2007).

This includes functions of the Mental Health Act which have been delegated to officers and staff under the policy for Hospital Managers' Scheme of Delegation are being carried out correctly and that the wider operation of the Act across the Health Board area is operating within the legislative framework.

DETAILED BACKGROUND AND ASSESSMENT:

Hospital Managers must ensure that patients are detained only as the Mental Health Act 1983 (amended 2007) allows; that their care and treatment fully complies with it, and that patients are fully informed of and supported in exercising their statutory rights. Hospital Managers must also ensure that a patient's case is managed in line with other legislation which may have an impact, including the Human Rights Act 1998, Mental Capacity Act 2005 and Mental Health (Wales) Measure 2010.

Due to the population size of Powys, where there are low numbers to report, the *less than five* descriptive has been used to protect patient identity.

Mental Health Act, 1983 - Data Collection and Exception Reporting

i) Detention under Section 5 – (Doctor and Nurse Holding Powers)

Section 5 of the MHA relates to patients who are already in hospital where the admission has been voluntary. At a point following this admission, (known as an informal admission), the patient may present with a worsening of symptoms or their risk factors increased. This includes when a patient expresses the desire to leave the hospital or lacks capacity to consent to admission or treatment.

On these occasions, Mental Health professionals have the power to detain the patient for short periods while further medical opinion and an approved mental health practitioner assessment is sought. During this period, treatment cannot be made compulsory, nor may a patient appeal against the short holding power.

Section 5(4) is used by mental health and learning disability nurses in mental health in-patient settings for up to 6 hours to allow for a further assessment to take place.

Section 5(2) is used by doctors in both mental health and general hospital settings to detain an in-patient for up to 72 hours to allow for a mental health act assessment to take place.

The table below summarises the uses of the Mental Health Act (1983) during the 12-month period and the comparison to the same period last year:

	2022 /2023 (12 months)	2023 / 2024 (12 months)
Sec 5 (4)	**3**	**6**
Sec 5 (2)	**16**	**18**

The use of both Section 5(4) and Section 5(2) powers has increased over the last two years and the service will continue to monitor the use of s5(2) powers closely during 2023/24.

ii) Section 2 – Admission for Assessment

This section authorises the compulsory admission of a patient to hospital for assessment, or for assessment followed by medical treatment for up to 28 days. At the end of this period, the patient either reverts to an informal status remaining in hospital, is discharged home or the section 2 is converted to section 3 (if thresholds of the Mental Health Act are met and treatment is required).

Section 2 was used on 98 occasions during this 12-month period. The majority of patients reverted to voluntary status following this period of detention under the Act. For the same period last year, section 2 was used on a total of 88 occasions.

Once again, it is likely that the aftermath of the Covid 19 pandemic continues to have a direct impact on the number of patients detained on a section 2. This may be due to higher than usual presentations of mental distress, and the effect of patients isolating and Mental Health services becoming aware of a citizen's deteriorating mental health when it has reached a crisis point.

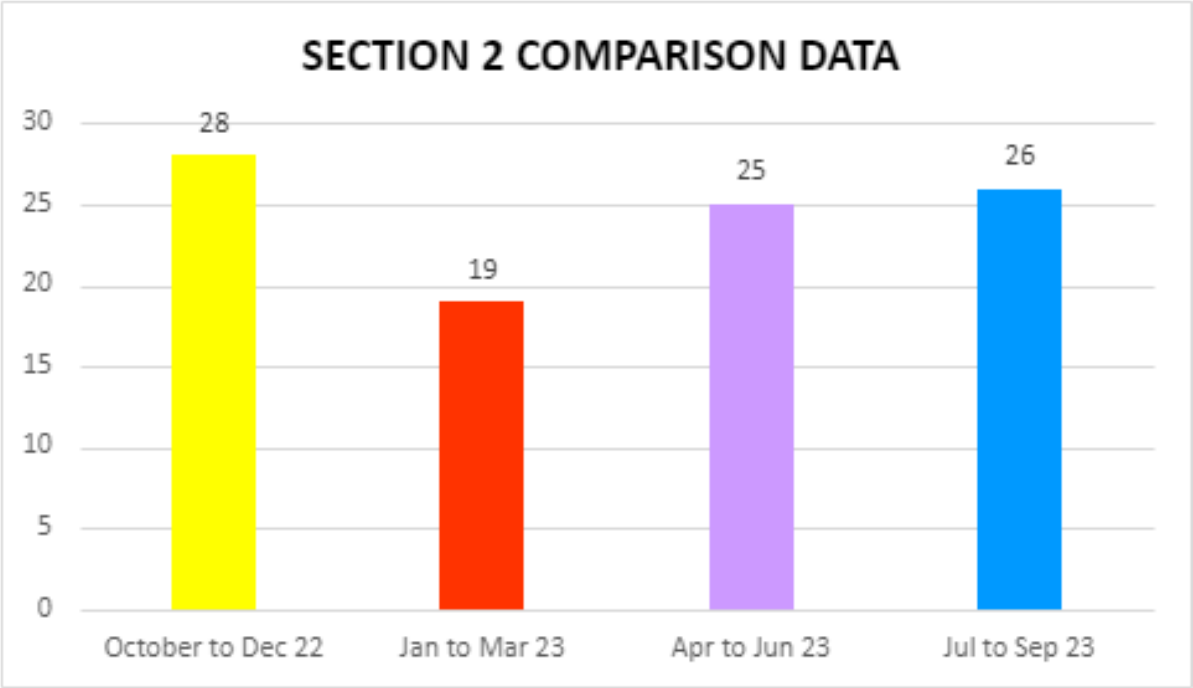


Table 1: Use of Section 2 over the last 12-month period

iii) Section 3 – Admission for Treatment

This section provides for the compulsory admission of a patient to hospital for treatment for mental disorder. The detention can last for an initial period of six months.

During this 12-month period section 3 was used on 43 occasions.
For the same period last year, section 3 was used on a total of 30 occasions. One explanation for this increase may be again linked to COVID pandemic and the social issues arising including reduced services, financial difficulties etc.

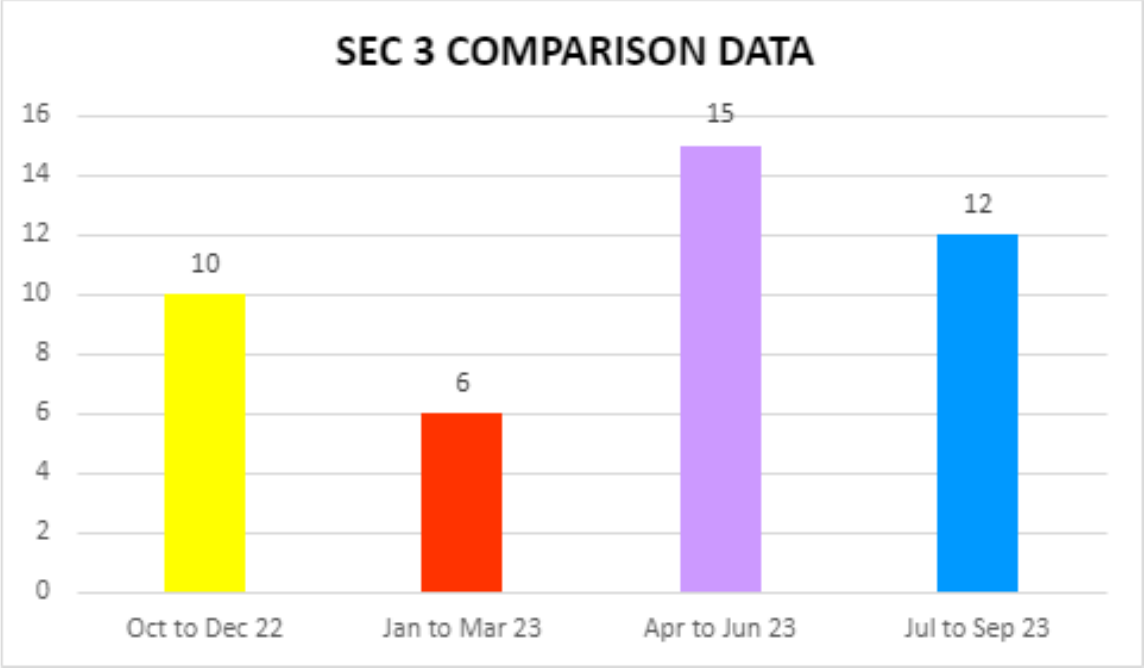


Table 2: Use of Section 3 over the last 12 month period

iv) Section 4 – Emergency Admission for Assessment

The use of Section 4 powers of the Mental Health Act 1983 is to enable an admission for assessment to take place in cases of urgent necessity, where this power is applied, one s12(2) Doctor can make a medical recommendation to detain a patient for up to 72 hours.

An alternative section is preferred (if at all possible) as best practice would involve two medical opinions. Section 4 (up to 72 hours holding power) should only be used to avoid an unacceptable delay and as such is infrequently used. If it is likely that the patient requires detention past 72 hours, a new Mental Health Act assessment must be undertaken (with two Doctors). This section is specifically examined by Mental Health Act Managers when it is applied. Section 4 was used 9 times during this 12-month period. For the same period last year, section 4 was used on a total of less than 5 occasions. Rationale for use of Section 4 is multi-faceted and can be expressed in terms of availability of Section 12 approved Doctors and the acuity of symptoms resented in the individuals being assessed requiring hospital admission being expedited using Section 4 preventing any delay in access to treatment.

v) Section 17A – Community Treatment Order (CTO)

This section provides a framework to treat and safely manage eligible patients who had been detained in hospital for treatment, to be treated in the community whilst still being subject to powers under the Act. Rather than the patient remaining in hospital for the continuation of treatment, a CTO supports the patient to live in the community and is therefore a less restrictive treatment option.

A CTO can only be used for a patient who has already been detained in hospital (under a section 3) and there will be conditions that the patient must comply with regarding their treatment within the community. If the patient does not adhere to the conditions of the CTO, they can be recalled to hospital for up to 72 hours to enable an assessment of their mental health. CTO's are used for patients who have serious mental illness and have experienced admission to hospital under the Act. It is likely that they would need the support of a CTO to accept treatment that will help them to remain well outside of a hospital setting.

In PTHB, there were 9 community treatment orders (CTO) in place as at 30th September 2023. CTO activity during the 12-month period 1 October 2022 to 30 September 2023 includes 3 new CTO's; 3 patients were recalls/revocations and 5 discharged from the CTO. One patient was discharged from their CTO by the Mental Health Review Tribunal. By comparison on 30th September 2022 there were 16 community treatment orders in place.

vi) Police Powers to Remove a Person to a Place of Safety under Section 136

This section empowers a Police Officer to remove a person from a public place to a place of safety, if it is considered that the person is suffering from mental disorder and is in immediate need of care or control. Although the police station can be used as a designated place of safety, all the assessments that took place under this section of the Act were carried out in a health-based place of safety (POS), which is the preferred practice.

Section 136 was used on twenty occasions during the twelve-month period 1 October 2022 to 30 September 2023. During the reporting period over half of those assessed resulted in the admission or further detention of the person. The number of assessments undertaken under s136 powers, was a little lower than in the previous 12-month period when it was used on a total of twenty two occasions (over the last five years an average of twenty three s136 assessments undertaken per year), however all assessments referred and conducted were appropriate.

A multi-disciplinary sub-committee of the Mental Health Planning & Development Partnership is reviewing the use of s136 powers and meets regularly to discuss cases and identify areas for improvement and learning.

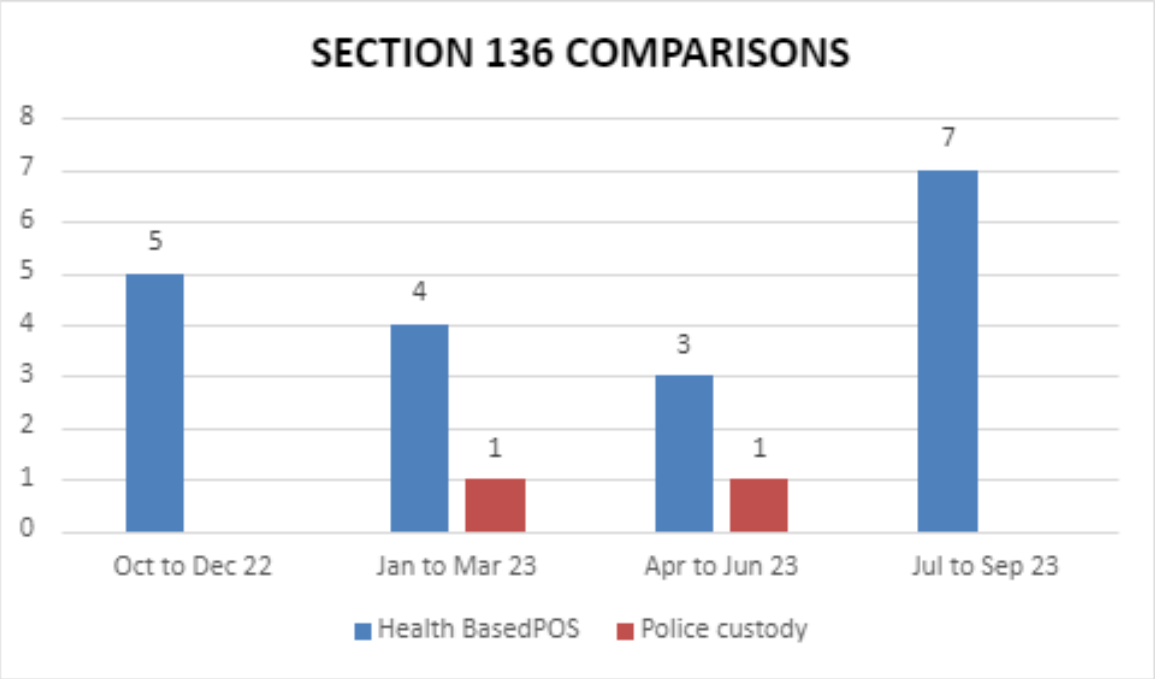


Table 3: **Location of completed Section 136 assessments highlights that police cells were used on two occasions as a place of safety during the period.**

vii) Scrutiny of Documents

Hospital managers must ensure that Mental Health Act admission documents are received and scrutinised correctly by formally delegated officers. Section 15 of the Act provides for certain admission documents, (which if found to be incorrect or defective) must be rectified within fourteen days of the patient's admission. Rectification or correction is mainly concerned with inaccurate recording (e.g., spelling of a patient's name) and it cannot be used to enable a fundamentally defective application to be retrospectively validated. For example, a spelling error on a document, if corrected ensures the detention remains valid.

For this 12-month period there were ten rectifications which is the same as the previous year. Error types are spelling errors in patient's names, omission of a patient's middle name, incorrect order of patient's Christian name and middle name and incomplete address of Approved Mental Health Professional. There was one fundamentally defective detention where the patient was detained following recall of a Community Treatment Order and remained on the ward informally. In the absence of the regular Responsible Clinician during a weekend, a covering Approved Clinician detained the patient under the Mental Health Act as he was not aware of the recalled CTO. All sections discharged and patient re-detained within the framework of the Mental Health Act.

Errors found that were required to be rectified within the fourteen days statutory time limits under section 15 of the Act were:

Rectifications		**Number of Errors**
Quarter 3	1 Oct to 31 Dec 22	**Four occasions**
Quarter 4	1 Jan to 31 Mar 23	**None**
Quarter 1	1 Apr to 30 Jun 23	**One**
Quarter 2	1 Jul to 30 Sep 23	**Three**
Fundamentally Defective Detentions		
Quarter 3	1 Oct to 31 Dec 22	**None**
Quarter 4	1 Jan to 31 Mar 23	**None**
Quarter 1	1 Apr to 30 Jun 23	**One (noted above)**
Quarter 2	1 Jul to 30 Sep 23	**None**

viii) Deaths of detained patients

During the period there was one death of a patient who was subject to detention under the Mental Health Act 1983. The patient became physically unwell and passed away on Felindre. A further patient/service user passed away whilst on a CTO and living in the community.

ix) Application for Discharge to Hospital Managers and Mental Health Review Tribunal (MHRT)

During the 12-month reporting period reporting period, 26 applications/ referrals were made to the MHRT:

- Two patients were discharged

Sixteen Hospital Managers Hearings were held during the period. By comparison there were 14 Hospital Managers Hearings for the same period in the previous year.

All patients attending hearings are entitled to be accompanied by an Independent Mental Health Advocate (IMHA) and are provided with information about this service to have representation. In this quarter, IMHAs attended two of the hearings, largely due to the nature of the hearings. The Mental Health services continue to encourage patients to accept the support of an IMHA and there is ongoing work to address the poor uptake of commissioned advocacy services. We have recently started to collect data in respect of advocacy and attendance at formal reviews. This will be evidenced in next years' report. Further, this is reviewed by the quarterly Powers of Discharge Committee which is satisfied those patients are being made aware of their rights and have sufficient information to appoint an advocate if they want one.

Hospital Managers Power of Discharge Committee

Meetings for the above committee made up of the Hospital Managers and Independent Members were held during the year and quarterly performance was reported, scrutinised and discussed. Attached are the minutes of the meetings held within the period.

Healthcare Inspectorate Wales (HIW) Visits to Mental Health & Learning Disabilities Units

During the reporting period there was two visits by HIW. The first visit was to Tawe ward in January 2023 and the second was to Bryntirion CMHT in March 2023. No urgent recommendations were made by HIW in relation to the Mental Health Act Administration.

From the Tawe action plan the health board were asked to ensure that the Mental Health Act office undertake regular audit activity of the records to ensure that records are well maintained, fully completed and easy to navigate. An SBAR is being formulated to support adding resource to the MHA office as currently this work is undertaken by a lone administrator.

RECOMMENDATION:

That the committee **RECEIVES** the report and takes **ASSURANCE** that the performance of the service in relation to the administration of the Mental Health Act 1983 has been compliant with legislation.

Appendix

KEY TO MENTAL HEALTH ACT SECTIONS

Part 2 – Compulsory Admission to Hospital or Guardianship

- Section 5(4) Nurses Holding Power (up to 6 hours)
- Section 5(2) Doctors Holding Power (up to 72 hours)
- Section 4 Emergency Admission for Assessment (up to 72 hours)
- Section 2 Admission for Assessment (up to 28 days)
- Section 3 Admission for Treatment (6 months, renewable)
- Section 7 Application for Guardianship (6 months, renewable)
- Section 17A Community Treatment Order (6 months, renewable)

Part 3 - Patients Concerned with Criminal Proceedings or Under Sentence

- Section 35 Remand for reports (28 days, maximum 12 weeks)
- Section 36 Remand for treatment (28 days, maximum 12 weeks)
- Section 38 Interim Hospital Order (Initial 12 weeks, maximum 1 year)
- Section 47/49 Transfer of sentenced prisoner to hospital
- Section 48/49 Transfer of un-sentenced prisoner to hospital
- Section 37 Hospital or Guardianship Order (6 months, renewable)
- Section 37/41 Hospital Order with restriction (Indefinite period)
- Section 45A Hospital Direction and Limitation Direction
- CPI 5 Criminal Procedure (Insanity) & Unfitness to Plead (Indefinite period)

Part 10 – Miscellaneous and Supplementary

- Section 135(1) Warrant to enter and remove (up to 24 hours)
- Section 135(2) Warrant to enter and take or retake (up to 24 hours)
- Section 136 Removal to a place of safety (up to 24 hours).

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 2.5

PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE	**Date of Meeting: 23 January 2024**
Subject:	**Powys Cancer Improvement Plan**
Approved and presented by:	Medical Director
Prepared by:	Assistant Director Transformation and Value Transformation Programme Manager
Other Committees and meetings considered at:	The mapping of cancer services against the nine priorities in the Cancer Improvement Plan for NHS Wales has been a key area of work for the Cancer Transformation Programme Board. The Cancer Improvement Plan 2023-26 has been approved by the Executive Committee.

PURPOSE:

The purpose of this paper is to provide ASSURANCE to the Patient Experience, Quality and Safety Committee that the Cancer Improvement Plan 2023 – 2026 is in place for Powys Teaching Health Board.

RECOMMENDATION(S):

The Committee is asked to:

- Take **ASSURANCE** to the patient Experience, Quality and Safety Committee that the Cancer Improvement Plan 2023 – 2026 is in place for Powys Teaching Health Board.

Approval/Ratification/Decision[1]	Discussion	Information
✓		

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

EXECUTIVE SUMMARY:

A priority in the PTHB Integrated Plan 2023 – 2026 and Year One Delivery Plan 2023 – 2024 is to *Deliver Cancer Improvement (in line with NHS Wales Cancer Improvement Plan)* with two milestones:

- Map, benchmark and agree actions for nine themes Q1; implementation Q2 – 4, Review Q4 and plan next year
- Single Cancer plan for Powys agreed Q1-Q2

The Cancer Improvement Plan for NHS Wales 2023-2026 was published in January 2023. The plan aims to improve cancer patient outcomes and enhance patient experience. It focuses on preventing cancer, diagnosing it earlier and faster,

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

treating patients with the most effective treatments and supporting them and their carers through and beyond their cancer pathway.

The plan identifies nine themes for '*focus and action*' which are summarised below:

1. Stopping people getting cancer (Cancer Prevention)
2. Identifying a cancer as early as possible (Early Diagnosis)
3. Identifying that a person has cancer more quickly (Faster Diagnosis)
4. Improving waiting times for treatment for cancer (Elective Care Recovery)
5. Improving cancer care and timeliness through policy (Compliance with the Single Cancer Pathway/ National Optimal Pathways)
6. Treating cancer effectively (Effective Treatments)
7. Improving care for those whose cancer cannot be cured (Palliative and End of Life Care)
8. Supporting cancer patients and making services better (Improving Patient Experience)
9. Working together to make services better (Key System Wide Enablers)

Annex 1 is the proposed Cancer Plan following mapping of all the work currently underway against the nine themes to identify gaps and any further actions required. The mapping showed significant work already underway against the nine themes and that appropriate actions had been included in the integrated plan and were underway. It should be noted that the performance of diagnostic and treatment services remains a significant concern across Health Boards. That is monitored through cancer tracking and harm review processes and working closely with the commissioning team.

DETAILED BACKGROUND AND ASSESSMENT:

Powys Teaching Health Board does not provide Cancer services in the same way as other health boards. The health board constantly collaborates with five other regions across England and Wales – including linking with Cancer Centres in the Shrewsbury, Telford and Wrekin system for the North Powys population; with Wye Valley NHS Trust and Cheltenham and Gloucester for the mid Powys population; with Velindre for the South Powys population; and with Swansea Health Board NHS Trust for the South West Powys population and North West of Powys (via Hywel Dda University Health Board).

The health board on the whole commissions secondary diagnostic and treatment services from district general hospitals and cancer centres. The three main screening services are commissioned by Public Health Wales. Specialised cancer services for children and adults are commissioned through the Welsh Health Specialised Services Committee from providers in England and Wales. Within

Powys wellbeing and prevention services are provided locally; primary care is provided including Faecal Immunochemical Testing (which was rolled out through the Renewal programme). Some diagnostic work is undertaken, predominantly in south Powys, through inreach (low complexity inreach surgical specialties also include general surgery and gynaecology). The Community Services Group does not have a multi-disciplinary cancer team. Palliative care spans services both within Powys and out of county. Third sector provision includes Macmillan, St David's Foundation, St Michael's Hospice and Severn Hospice. Macmillan has funded work on the Improving Cancer Journey programme. There is also other third sector support available to the people of Powys such as Lingen Davies which is developing information, advice and prehabilitation. Bodies such as the Bracken Trust are also part of the third sector provision.

A clinical lead for cancer is in place for Powys. Work currently underway through the cancer programme (following the successful completion of the roll out of FIT testing) includes the implementation of Transnasal Endoscopy where funding was secured from the Moondance Cancer Initiative; ensuring access to Rapid Diagnostic Centres for the population of Powys in collaboration with other health boards; finalising the development of a Business Intelligence tool to help alert the Commissioning team to potential difficulties in external pathways; piloting an approach to cancer tracking in Powys as a provider; and piloting an approach to considering the harm reviews involving Powys patients diagnosed and treated in other organisations. In addition the Wales Cancer Network has led work on optimal pathways which are complex in the Powys context spanning England and Wales.

An "Improving the Cancer Journey" (ICJ) partnership with Macmillan Cancer Support has been in place embedding holistic needs assessments and co-production of care plans and signposting to support which can be provided closer to home.

The Powys Cancer Improvement Plan has been drafted following discussions with a range of PTHB teams and services and external partners and identifies key actions and milestones to be achieved in 2023-24 aligned to the nine themes in the Cancer Improvement Plan for Wales, together with some outline and indicative priorities for 2024-26. The plan includes:

- PTHB annual/integrated plan priorities
- Other PTHB services / activities
- Improving the Cancer Journey Programme phase 2
- External organisation services / activity
- Powys Regional Partnership Board priorities

NEXT STEPS:

- Implementation of the Powys Cancer Improvement Plan 2023.
- Discussion is underway to finalise how progress against the plan will most effectively be monitored and reported across the service groups responsible for its delivery.
- Actions and milestones will be reported annually and reported via the Executive Committee. Areas related to patient safety and quality will be reported to the Patient Experience, Quality and Safety Committee.

Cancer Prevention

Strategic Objective	Strategic Priority	Executive Lead	National Cancer Plan Priority	Key Action	Ref	Key Milestones	Delivery Area	Delivery Quarter 2023-24				Outline Priority 2024-25	Indicative Priority 2025-26
								Q1	Q2	Q3	Q4		
Tackling the Big Four	Cancer	MD and exec leads for delivery areas	1.Stopping people getting cancer (Cancer Prevention)	Delivery of health-board-led population level health improvement programmes	1.1	Healthy Child Wales Programme	Women & Children's Service	x	x	x	x		
					1.2	Expand the offer of the Just B smoking prevention programme to targeted secondary schools in conjunction with Public Health Wales	Public Health Wales			x	x		
					1.3	Continue to work in partnership to improve awareness of and access to NHS Stop Smoking Service	Powys Public Health Team	x	x	x	x		
					1.4	Delivery of Whole System Approach to Healthy Weights programme		x	x	x	x		
					1.5	Healthy Schools and Healthy Pre-Schools Scheme (‘Bach a Iach’)		x	x	x	x		
					1.6	Smoking cessation, including Help me Quit, encouraging and promoting the pharmacy stop smoking service		x	x	x	x		
					1.7	Increasing physical activity and healthy eating		x	x	x	x		
					1.8	HPV immunisation programme	Women & Children's Service	x	x	x	x		
				Public Health Wales national awareness campaigns	1.9	Help Me Quit	Public Health Wales	x	x	x	x		
					1.10	HPV vaccine benefit campaign		x	x	x	x		
					1.11	New Public Health Guidance on Vaping/E-cigarettes for Schools and Colleges			x	x	x		
					1.12	Public Health Wales is proposing that an Incident Response Group (IRG) is established to investigate the rapid increase in reports of young people vaping and propose a response			x	x	x		
				Genetic Services	1.13	Genetic Services (WHSSC)	WHSSC	x	x	x	x		
				Chronic Disease Management	1.14	Management of chronic disease registers in primary care	Primary Care	x	x	x	x		
				Wellbeing in the workplace	1.15	PTHB Health and Safety role as employers e.g. asbestos, smoking, alcohol policies	PTHB	x	x	x	x		
				Start Well	1.16	Support children and young people and families to achieve and maintain healthy, active lives	Powys Regional Partnership Board	x	x	x	x		
				Live Well	1.17	Develop prevention and community co-ordination so that people in Powys have their care and support needs met, including carers		x	x	x	x		
					1.18	Address the health and care inequalities facing people in Powys through targeted interventions		x	x	x	x		
				Local Authority Initiatives	1.19	Trading Standards tackling illegal tobacco	Powys County Council	x	x	x	x		
					1.20	Schools engaging in Healthy Schools programme, and delivering health and wellbeing element of new curriculum		x	x	x	x		
					1.21	Youth services delivering C-Card		x	x	x	x		
					1.22	Commissioned leisure services		x	x	x	x		
				Preventative approach	1.23	Making Every Contact Count (MECC)	Patient facing staff	x	x	x	x		
					1.24	There is a strategic commitment to supporting activities that reduce the incidence of cancer through wider work to improve health and well-being	Powys Regional Partnership Board	x	x	x	x		
					1.25	Reducing alcohol and substance misuse	Powys Area Planning Board	x	x	x	x		
					1.26	Next steps in embedding preventative approaches and addressing inequalities	Transformation & Value					x	
				Third Sector Support	1.27	National Cancer Charity Campaigns	Third Sector	x	x	x	x		
					1.28	Information, signposting and/or support to encourage healthy behaviours from third sector eg Mind, Kaleidoscope, Parkrun		x	x	x	x		
					1.29	Information and awareness raising provided by Lingen Davies ‘Cancer Champions’		x	x	x	x		

PTHB annual/integrated plan priority
Other PTHB services / activity
Improving the Cancer Journey Programme
External organisation services / activity
Powys Regional Partnership Board priority

Early Diagnosis

Tackling the Big Four	Cancer	MD and exec leads for delivery areas	2.Identifying cancer as early as possible (Early Diagnosis)	Implementation of Dermatology	2.1	Phase 2 (South Powys) recruitment, implementation, Phase 3 (North Powys), Phase 4 (Mid Powys)	Transformation & Value	x	x	x	x		
				Public Health Wales National Screening Programmes	2.2	Bowel Screening Wales	Public Health Wales	x	x	x	x		
					2.3	Breast Test Wales		x	x	x	x		
					2.4	Cervical screening Wales		x	x	x	x		
					2.5	Welsh Government are working with Public Health Wales to explore options on the approach for a national Lung Health Checks/targeted lung cancer screening programme						x	
				Patient Information & Experience	2.6	Patient education / information for symptoms / vague symptoms in primary care	Primary Care	x	x	x	x		
					2.7	Mid and north Powys general practices piloting a patient app which includes the 'NHS Symptom Checker'		x	x	x	x		
					2.8	Universal app for Wales	Wales Cancer Network					x	
					2.9	Supports the sharing of information on symptoms of cancer and encouraging those with concerns to engage with primary care through community events and collaboration with the Lingen Davies Cancer Fund Powys initiative	Improving the Cancer Journey			x	x		
					2.10	Allied Health Professional Cancer Lead to be included in the ICJ Programme to develop access to prehabilitation for people living with cancer in Powys				x	x		
					2.11	PAVO Health Promotion Facilitators supporting health promotion campaigns in general practices	Third Sector	x	x	x	x		
				General Practice	2.12	Cancer & End of Life Newsletter distributed to General Practices provides information and updates quarterly	Medical Directorate	x	x	x	x		
					2.13	PLT sessions and information for Primary Care provided by PTHB Cancer Clinical Lead for Cancer Transformation, as required	Transformation & Value	x	x	x	x		
					2.14	Improve pre-work undertaken in Primary Care ahead of attendance at outpatient appointment to avoid delays in prognosis	Primary Care	x	x	x	x		
				Diagnostics	2.15	Symptomatic FIT testing in primary care in place	Primary Care	x	x	x	x		
					2.16	Barrett's surveillance	Planned Care	x	x	x	x		
				Delivery of key initiatives to improve access	2.17	Pilot the use of capsule sponge testing	Transformation & Value		x	x	x		
				Outpatients	2.18	Capturing of incidental findings in outpatient clinics	Planned Care	x	x	x	x		

PTHB annual/integrated plan priority
Other PTHB services / activity
Improving the Cancer Journey Programme
External organisation services / activity
Powys Regional Partnership Board priority

Faster Diagnosis

Strategic Objective	Strategic Priority	Executive Lead	National Cancer Plan Priority	Key Action	Ref	Key Milestones	Delivery Area	Delivery Quarter 2023-24				Outline Priority 2024-25	Indicative Priority 2025-26
								Q1	Q2	Q3	Q4		
Tackling the Big Four	Cancer	MD and exec leads for delivery areas	3.Identifying that a person has cancer more quickly (Faster Diagnosis)	Rapid Diagnostic Centres	3.1	Review solution in place for access for Mid Powys patients	Transformation & Value	x	x				
					3.2	PTHB secured funding from Cancer Research Wales to scope the potential to provide a Rapid Diagnostic Clinic service in PTHB, the project commenced in January 2023 with recommendations due June 2023		x					
					3.3	Consideration of research project and identification of access for mid Powys patients in partnership with Wales Cancer Network and providers		x	x				
					3.4	Taking forward the approved approach, based on the outcome of research findings, to ensure access to Rapid Diagnostic Clinics for a highly rural population.						x	
				Delivery of Key Initiatives to improve access	3.5	Implementation of Transnasal endoscopy	Transformation & Value			x	x		
					3.6	Embedding the use of Transnasal Endoscopy across Powys including North Powys						x	x
				Ministerial Priority	3.7	Commissioning team to work closely with secondary care providers to ensure there are improvements in waiting times for cancer diagnosis.	Performance & Commissioning	x	x	x	x		
					3.8	Commissioning team to review variation of SCP performance across secondary care providers						x	
					3.9	Data analysis to increase understanding of the patient flows for the three ministerial priority cancer pathways - Lower Gastrointestinal, Gynaecology and Urology for Powys residents	Transformation & Value			x	x		
				Harm Review Approach	3.10	Harm Review approach and process finalised and implemented	Quality & Safety	x	x	x	x		
				Cancer Tracking (Powys Provider)	3.11	Set up Cancer tracking pilot approach within PTHB as a provider	Planned Care	x	x	x			
					3.12	Evaluation and approval for the way forward					x		
					3.13	Review of PTHB provider diagnostic services	Quality & Safety			x	x		
				Specialist Services	3.14	Specialist services commissioned via WHSSC	Performance & Commissioning	x	x	x	x		
				Primary Care	3.15	Identification from dentists and optometrists during routine appointments	Primary Care	x	x	x	x		
				Quality Statements & Pathways	3.16	Work with the Wales Cancer Network on optimal pathways and quality statement	Transformation & Value					x	
					3.17	A Programme of renewal for Urology pathways across the region which will support and link to national pathway work	Mid Wales Joint Committee	x	x	x	x		

PTHB annual/integrated plan priority
Other PTHB services / activity
Improving the Cancer Journey Programme
External organisation services / activity
Powys Regional Partnership Board priority

Elective Care Recovery

Strategic Objective	Strategic Priority	Executive Lead	National Cancer Plan Priority	Key Action	Ref	Key Milestones	Delivery Area	Delivery Quarter 2023-24				Outline Priority 2024-25	Indicative Priority 2025-26
								Q1	Q2	Q3	Q4		
Tackling the Big Four	Cancer	MD and exec leads for delivery areas	4.Improving waiting times for treatment for cancer (Elective Care Recovery)	Powys Provider	4.1	Improve communications with Consultants around administrative process for managing patients with suspicion of cancer	Planned Care	x	x	x	x		
					4.2	Improve liaison with Health Boards and Trusts where patients cancer care spans across multiple organisations			x	x	x		
					4.3	Review of design of tracker cards used in PTHB with visiting Consultants to ensure meaningful options to enable correct recording on cancer tracker				x			
					4.4	Supporting patients to wait well & developing model for care co-ordination – models need to be developed, alignment with PPP work and coordination of existing pathways.				x	x		
				Strategic Commissioning	4.5	Reduction in backlog of patients waiting over 62 days to enable delivery of 75% of patients starting their first definitive Cancer treatment 62 days prior to point of suspicion	Performance & Commissioning	x	x	x	x		
					4.6	Implement the agreed national Cancer pathways within the national target – demonstrating annual improvement toward achieving target by March 2026		x	x	x	x		
					4.7	Commissioning team to work closely with secondary care providers to ensure there are improvements in waiting times for cancer treatments, including use of Business Intelligence tool identify patients having long waits on SCP		x	x	x	x		
				Effective Pathways	4.8	Wales Cancer Network regional working to review effectiveness of Suspected Cancer Pathways	Wales Cancer Network	x	x	x	x		

PTHB annual/integrated plan priority
Other PTHB services / activity
Improving the Cancer Journey Programme
External organisation services / activity
Powys Regional Partnership Board priority

Compliance with SCP & NOP

Strategic Objective	Strategic Priority	Executive Lead	National Cancer Plan Priority	Key Action	Ref	Key Milestones	Delivery Area	Delivery Quarter 2023-24				Outline Priority 2024-25	Indicative Priority 2025-26
								Q1	Q2	Q3	Q4		
Tackling the Big Four	Cancer	MD and exec leads for delivery areas	5.Improving cancer care and timeliness through policy (Compliance with the Single Cancer Pathway/ National Optimal Pathways)	Cancer Tracking	5.1	Set up Cancer tracking pilot approach within PTHB as a provider	Planned Care	x	x	x			
					5.2	Evaluation and approval for the way forward					x		
					5.3	Embedding a cancer tracking approach appropriate to the circumstances of Powys, following the outcome of the pilot						x	
					5.4	Review SOPs and action plan for SCP compliance and processes for Powys as a provider			x	x			
					5.5	Use of SCP education package (produced by WCN) for Patient Services Team					x	x	
				Quality statement and Pathways	5.6	Work with the Wales Cancer Network on optimal pathways and quality statement	Transformation & Value	x	x	x	x		
					5.7	Driving improvements in key cancer pathways learning from the mapping of optimal pathways, learning from harm reviews, outcomes and patient experience.						x	
					5.8	Working with the Wales Cancer Network to identify stage at diagnosis in national dashboards						x	
				Strategic Commissioning	5.9	Commissioning Team discussions with secondary care providers on performance for commissioned services including SCP compliance	Performance & Commissioning	x	x	x	x		
				Patient Experience	5.10	Learning from patient experiences including CPES action plan	National/PTHB teams		x	x	x		
					5.11	Person centred care and prehabilitation are both included in the National Optimal Pathways. Both are included in the ICJ Programmes aims and objectives	Improving the Cancer Journey			x	x		

PTHB annual/integrated plan priority
Other PTHB services / activity
Improving the Cancer Journey Programme
External organisation services / activity
Powys Regional Partnership Board priority

Effective Treatments

Strategic Objective	Strategic Priority	Executive Lead	National Cancer Plan Priority	Key Action	Ref	Key Milestones	Delivery Area	Delivery Quarter 2023-24				Outline Priority 2024-25	Indicative Priority 2025-26
								Q1	Q2	Q3	Q4		
Tackling the Big Four	Cancer	MD and exec leads for delivery areas	6.Treating cancer effectively (Effective Treatments)	Radiotherapy and Chemotherapy Pathways	6.1	Establish the new Chemotherapy Day Unit at Bronglais General Hospital. Review radiotherapy and chemotherapy pathways to identify opportunities for increasing provision and access across Mid Wales and identify improvements to handovers	Mid Wales Joint Committee	x	x	x	x		
					6.2	ABUHB radiotherapy business case supported by PTHB	ABUHB	x	x	x	x		
				Specialist Services	6.3	Specialist services commissioned via WHSSC	Performance & Commissioning	x	x	x	x		
				Acute Oncology Services	6.4	Access to Acute Oncology Services for Powys residents	Performance & Commissioning	x	x	x	x		
					6.5	South East Wales Acute Oncology Service developments		x	x	x	x		
				Value Based Approaches	6.6	The ICJ will be a platform through which to develop understanding of value-based approaches	Improving the Cancer Journey			x	x		
				Person centred care	6.7	Review of cancer treatment alert cards	Wales Cancer Network			x	x		
					6.8	Review of national treatment helplines				x	x		
				Value Based Approach	6.9	Working with the Cancer Clinical Network to improve information about outcomes, patient experience and comparative costs	Transformation & Value					x	
					6.10	Working with the Cancer Clinical Network to assess improvements to outcomes, patient experience and comparative costs							x

PTHB annual/integrated plan priority
Other PTHB services / activity
Improving the Cancer Journey Programme
External organisation services / activity
Powys Regional Partnership Board priority

Palliative Care and EOL Care

Strategic Objective	Strategic Priority	Executive Lead	National Cancer Plan Priority	Key Action	Ref	Key Milestones	Delivery Area	Delivery Quarter 2023-24				Outline Priority 2024-25	Indicative Priority 2025-26
								Q1	Q2	Q3	Q4		
Tackling the Big Four	Cancer	MD and exec leads for delivery areas	6.Treating cancer effectively (Effective Treatments)	Radiotherapy and Chemotherapy Pathways	6.1	Establish the new Chemotherapy Day Unit at Bronglais General Hospital. Review radiotherapy and chemotherapy pathways to identify opportunities for increasing provision and access across Mid Wales and identify improvements to handovers	Mid Wales Joint Committee	x	x	x	x		
					6.2	ABUHB radiotherapy business case supported by PTHB	ABUHB	x	x	x	x		
				Specialist Services	6.3	Specialist services commissioned via WHSSC	Performance & Commissioning	x	x	x	x		
				Acute Oncology Services	6.4	Access to Acute Oncology Services for Powys residents	Performance & Commissioning	x	x	x	x		
					6.5	South East Wales Acute Oncology Service developments		x	x	x	x		
				Value Based Approaches	6.6	The ICJ will be a platform through which to develop understanding of value-based approaches	Improving the Cancer Journey			x	x		
				Person centred care	6.7	Review of cancer treatment alert cards	Wales Cancer Network			x	x		
					6.8	Review of national treatment helplines				x	x		
				Value Based Approach	6.9	Working with the Cancer Clinical Network to improve information about outcomes, patient experience and comparative costs	Transformation & Value					x	
					6.10	Working with the Cancer Clinical Network to assess improvements to outcomes, patient experience and comparative costs							x

PTHB annual/integrated plan priority
Other PTHB services / activity
Improving the Cancer Journey Programme
External organisation services / activity
Powys Regional Partnership Board priority

Improving Patient Experience

Tackling the Big Four	Cancer	MD and exec leads for delivery areas	8.Supporting cancer patients and making services better (Improving Patient Experience)	Patient Information	8.1	ICJ provides a package of information around the following ten themes: - Pre diagnosis, diagnosis, prognosis. - Coordination of care - Emotional support - Patient voice & choice - Carers rights & voice - Practical Support - Relationships & communication - Transport & travel - Education and information - Advance care planning / EOL	Improving the Cancer Journey	x	x	x	x		
				Patient Support	8.2	The Journeying Together Forum consisting of those with lived experience and carers is integral to the ICJ Programme. The fundamental essence of the "what matters" conversations is to assess people's needs to identify resources, locally where possible, to meet those needs, and co-produce a written care plan. This includes a universal offer of benefits advice	Improving the Cancer Journey	x	x	x	x		
					8.3	Through increased collaboration, the ICJ supports services in Powys to better understand the provision of support for people living with cancer in Powys, therefore increasing the ability to meet a person's needs				x	x		
					8.4	Support provided by third sector organisations including Bracken Trust, Lingen Davies, Credu, PAVO	Third Sector	x	x	x	x		
					8.5	Use of the Macmillan Toolkit in Primary Care to improve quality of care provided to people with cancer	Primary Care	x	x	x	x		
				Prehabilitation	8.6	ICJ development of Prehabilitation Service, prehabilitation improves patient resilience and tolerance to treatments, improving clinical outcomes	Improving the Cancer Journey			x	x		
				Patient Experience	8.7	Learning from patient experiences including CPES action plan	Specialist Palliative Care Team		x	x	x		
				Workforce Approaches	8.8	Review palliative care to identify opportunities for simplifying models through shared workforce approaches	Mid Wales Joint Committee	x	x	x	x		
					8.9	Scoping of Cancer Navigator / Cancer Nurse Specialists role	Improving the Cancer Journey			x	x		
				Integrated Community Services	8.10	In line with the Accelerated Sustainable Model strengthen the web of integrated community services for people with cancer	Transformation & Value					x	
					8.11	Develop Community based care – providing complex care closer to home for people in Powys	Regional Partnership Board	x	x	x	x		

PTHB annual/integrated plan priority
Other PTHB services / activity
Improving the Cancer Journey Programme
External organisation services / activity
Powys Regional Partnership Board priority

Enablers

Tackling the Big Four	Cancer	MD and exec leads for delivery areas	9.Working together to make services better (Key System Wide Enablers)	Workforce	9.1	Role of PAVO Health Promotion Facilitators	PAVO	x	x	x	x		
					9.2	Education for workforce development - fundamentals for palliative care for clinical staff and education for unregistered staff	Specialist Palliative Care Team	x	x	x	x		
					9.3	Phase 2 of the ICJ Programme will reflect on shared patient experiences and the Cancer Patient Experience Survey results to identify gaps in care and explore the need for local cancer specialist nurses, cancer pathway co-ordinators/champions and other roles	Improving the Cancer Journey			x	x		
				Information & Intelligence	9.4	Cancer Patient Experience Survey Action Plan	National/PTHB teams		x	x	x		
					9.5	PLT sessions / Webinars / GP collaboratives inputs and updates (e.g. for FIT, RDCs) as required	Transformation & Value	x	x	x	x		
					9.6	Information sharing with Primary Care		x	x	x	x		
					9.7	Use of Cancer Business Intelligence tool	Performance & Commissioning	x	x	x	x		
					9.8	Access to patient information and advice signposted by third sector organisations including Bracken Trust, Lingen Davies, Age Cymru, Care and Repair	Third Sector	x	x	x	x		
					9.9	The patient experience and results from 'What matters' conversations will provide information and intelligence on the needs of people living with cancer in Powys	Improving the Cancer Journey			x	x		
					9.10	Referral for 'What matters' conversations including signposting for advice e.g. welfare, benefits		x	x	x	x		
					9.11	Powys Cancer Partnership Group	Medical Directorate	x	x	x	x		
					9.12	Improving Cancer Journey Strategic Partnership	Powys County Council	x	x	x	x		
					9.13	Assist meetings		x	x	x	x		
					9.14	All Wales Groups facilitated by Wales Cancer Network	Wales Cancer Network	x	x	x	x		
				Research & Innovation	9.15	Roll out of new diagnostic techniques – Capsule sponge testing / TNE	Transformation & Value	x	x	x	x		
					9.16	Development of End of Life Care support / provision in Community Hospitals through charitable funds	nd of Life & Palliative Care Workstrea	x	x	x	x		
					9.17	Health and Care Academy	WOD	x	x	x	x		
					9.18	Development of radiotherapy at Nevill Hall, new building at Velindre	Performance & Commissioning	x	x	x	x		
					9.19	Digital aspect	Digital Transformation	x	x	x	x		
					9.20	RPB Capital Care Programme	Powys County Council	x	x	x	x		

PTHB annual/integrated plan priority
Other PTHB services / activity
Improving the Cancer Journey Programme
External organisation services / activity
Powys Regional Partnership Board priority

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 2.6

PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE	**Date of meeting 23 January 2024**
Subject:	Controlled Drugs Accountable Officer Annual Update October 2022 – September 2023
Approved by:	Kate Wright, Executive Medical Director
Prepared and presented by:	Jacqui Seaton, Chief Pharmacist & Controlled Drugs Accountable Officer
Other meetings considered at:	Controlled Drugs Local Intelligence Network (January 2024)

PURPOSE:

To provide the Patient Experience, Quality and Safety Committee with the Controlled Drugs Accountable Officer's (CDAO) Annual Update for October 2022-September 2023. The report provides:

- Background information about the legislation relating to CD governance
- Details of the responsibilities of the CDAO
- Information about the Controlled Drugs Local Intelligence Network including:
  - Membership and attendance
  - Incident/occurrence reports
- Details of arrangements for:
  - CD declarations/self-assessments and baseline assessments
  - CD Authorised Witnesses (for CD destructions)
  - Standard Operating Procedures (SOPs)
  - Education and training
  - Monitoring CD prescribing
- Details of the plans for the year ahead.

RECOMMENDATION(S):

The Committee is asked to:

- **RECEIVE** the report recognising the progress that has been made during the last 12 months;
- Take **ASSURANCE** that an annual report is in place and that systems exist to capture, record and report the information;
- **NOTE** that there is still considerable work to be done to strengthen governance arrangements across the Health Board and through collaborative working with partners.

Decision/Assurance	Discussion	Information
✓		✓

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

Controlled Drugs Accountable Officer Annual Update
October 2022 – September 2023

1. Introduction

In January 2000, Dr Harold Shipman was convicted of 15 murders. The Public Inquiry that followed revealed that he had secretly diverted large quantities of controlled drugs (CDs) and used them to murder more than 200 people over a period of around 25 years. Harold Shipman remains the biggest serial killer in UK history.

The Shipman Inquiry published six reports between January 2002 and January 2005. The Fourth Report, published in 2004, was concerned with the overall management and use of CDs. Following the publication of this report, the UK Government strengthened the arrangements for the governance of CDs.

CDs are controlled under Home Office legislation: The Misuse of Drugs Act 1971. The main purpose of the Act is to prevent the misuse of CDs (referred to as Class A, B or C). Access to CDs for healthcare purposes is regulated under the Misuse of Drugs Regulations 2001. These Regulations divide CDs into Schedules 1-5, according to the level of control required.

The Controlled Drugs (Supervision of Management and Use) (Wales) Regulations 2008 came into force on 9th January 2009. These Regulations relate to arrangements that support the safe management and use of controlled drugs in Wales. Under the regulations, designated bodies (i.e. Health Boards, NHS Trusts, Welsh Ambulance Services NHS Trust and Welsh independent hospitals) are required to appoint an appropriate person to the role of Controlled Drugs Accountable Officer (CDAO). This role is held by the Chief Pharmacist in Powys.

Healthcare Inspectorate Wales (HIW) maintains and publishes an online register of CDAOs across Wales. The health board is mandated to have a CDAO in place at all times and to notify HIW's Chief Executive of both the nomination and removal of a CDAO.

2. Summary of the responsibilities of the health board's CDAO

The health board's CDAO is responsible for:

- Ensuring that the health board and any body or person acting on behalf of, or providing services under arrangements made with the health board:
  - Complies with the misuse of drugs legislation.

- Has appropriate arrangements for securing the safe management and use of CDs.
- Has adequate and up-to-date standard operating procedures (SOPs) in place.
- Has adequate destruction and disposal arrangements for CDs,
- Establishes and operates appropriate arrangements for monitoring/auditing the use and management of CDs including:
    - Monitoring and analysing NHS and private prescribing of CDs.
    - Developing incident reporting systems for untoward incidents involving CDs
    - Establishing systems to alert the CDAO of any complaints/concerns involving CDs.
    - Analysing and responding to untoward incidents involving CDs.
- Provides access to appropriate training to support the safe and secure management of CDs.
- Establishing the CD Local Intelligence Network (CDLIN)
- Assessing and investigating concerns and taking appropriate action as necessary
- Maintaining a record of concerns regarding relevant individuals
- Requesting periodic declarations and self-assessments from general medical practitioners on the health board's medical performers list.
- Carrying out periodic inspections of premises, not subject to inspection by HIW, CSSIW or GPhC, used in connection with the management or use of CDs.

3. **Powys Controlled Drugs Local Intelligence Network (CDLIN)**

The Regulations require the health board's CDAO to establish a local intelligence network (CDLIN) for sharing information relating to the management and use of CDs.

Members of the CDLIN have a duty to cooperate with other CDLIN members in identifying cases where action may be appropriate.

The Regulations specify that the CDLIN must include (although it need not be limited to) the following types of bodies, as appropriate: a Local Health Board, an NHS Trust, HIW, CSSIW, Counter Fraud, a regulatory body, a police force, a local authority

Powys CDLIN membership includes:
- PTHB Controlled Drug Accountable Officer (Chair)
- PTHB Medical Director/Deputy Medical Director
- PTHB Head of Primary Care Medicines Management
- PTHB Senior Pharmacy Technician Primary Care
- PTHB Head of Community Services Medicines Management
- PTHB Senior Pharmacy Technician Community Services
- Dyfed-Powys Police

- NHS Counter Fraud officer
- Healthcare Inspectorate Wales (HIW)
- Welsh Ambulance Services NHS Trust (WAST)
- Care and Social Service Inspectorate Wales (CSSIW)
- General Pharmaceutical Council (GPhC)
- Local Authority Representative
- Shropshire Doctors OOH provider (Shropdoc)
- Ministry of Defense (MOD)
- Drug and alcohol service (Kaleidoscope)
- Representatives from Powys provider hospitals (Nevill Hall and Bronglais)

The CDLIN meets quarterly. Between October 2022 and September 2023 the CDLIN met 4 times: October 2022, January 2023, April 2023 and July 2023

CDLIN attendance rates (Oct 22-Sept 23)

Organisation	CDLIN attendance rate
PTHB	100%
NHS Counter Fraud	100%
GPhC	75%
Bronglais Hospital	75%
MOD	75%
Nevill Hall Hospital	50%
Shropdoc	50%
Powys County Council	50%
Kaleidoscope	50%
Dyfed-Powys Police	50%
HIW	25%
WAST	25%
Other areas	25% (National CD LIN Lead)

4. CD incident reports/Quarterly Occurrence Reports

CDAOs reporting to the CDLIN are required to ensure that their organisation has robust systems in place to enable concerns relating to CDs to be raised, logged, and investigated as appropriate.

PTHB has developed a CD incident reporting template and a generic email address to support submission of CD incident reports to the CDAO – Powys.CDAO@wales.nhs.uk. This template is used in addition to the Once for Wales Incident Reporting System (Datix) to ensure that the CDAO receives the required level of detail for all CD incidents.

The CDLIN receives Occurrence Reports from designated bodies:

- Powys Teaching Health Board
- Welsh Ambulance Service

The CDLIN also receives update reports from Dyfed-Powys Police, Ministry of Defence, GPhC, Shropshire Doctors Co-Operative (Shropdoc) and Kaleidoscope

Number of incident reports received from designated bodies:

Designated body	Number of incidents reported Oct 21 – Sept 22	Number of incidents reported Oct 22 – Sept 23
Powys Teaching Health Board	20	27
Welsh Ambulance Service	4	3

Summary of key CD incident themes:

PTHB	Welsh Ambulance Service
• Balance discrepancy • Damaged/spilled CDs • Administration of date expired CDs • Administration error (e.g. wrong drug) • Safe custody breach • Lost or stollen CDs/CD Prescriptions • Prescribing error/query	• Accidental loss of CD during dose preparation • Unaccounted for CDs

The CD LIN requests assurance that all incidents have been fully investigated, brought to a satisfactory conclusion and that learning has been cascaded appropriately.

Over the last 12 months work has been undertaken to ensure more robust mapping of CD incidents, allowing identification of common themes as well as identifying areas that are experiencing multiple CD incidents and those that are not reporting incidents at all. This work is helping identify areas requiring targeted interventions and allowing enhanced surveillance to be implemented where necessary.

In addition to incident reports submitted by services that PTHB is directly responsible for providing, the health board receives details of a small number of CD incidents reported by:

- Community Pharmacies (10 incident reports received from 7 pharmacies)
- Care Homes (3 incident reports received from 3 care homes)
- GP practices (2 incident reports received from 2 GP practices)

- Dyfed-Powys Police

These are followed up with the service providers and reported to the CD LIN as appropriate.

5. CD Standard Operating Procedures (SOPs)

CD SOPs are detailed written instructions that aim to achieve uniformity in the way that CDs are managed across the organisation. They are live documents that are kept under constant review.

Benefits of CD SOPs include:

- Clarity for staff on what is expected of them
- Practical guidance to support the safe and secure management and use of CDs.
- Improved CD governance by ensuring that consistent safe and legal processes are in place.

The Health Board is required to have SOPs covering every applicable aspect of the CD journey. The list below provides details of the health board's current SOPs relating to CDs:

- Ordering of stock and named patient controlled drugs
- Receipt and storage of controlled drugs
- Prescribing of controlled drugs
- Administration of controlled drugs
- Controlled Drugs record keeping
- Controlled drugs stock checks
- Destruction of controlled drugs (SOP for authorised witnesses)
- Collection of medication (including controlled drugs) from community pharmacies.
- Management of concerns or incidents relating to controlled drugs

The safe and secure management of CDs is also covered in the health board's Medicines Policy.

Local SOPs are informed by the NICE baseline assessment tool and also by relevant national guidance (e.g. NICE guidance (NG46): Controlled drugs: safe use and management; Patient safety notice (PSN 055) on the safe storage of medicines).

6. Self-assessment and controlled drug declarations.

Healthcare organisations providing clinical services, and relevant social care organisations, are required to complete a periodic declaration (at least every 2 years) on whether they, or their organisation, keep stocks of controlled drugs and whether

there are any special circumstances that might explain any seemingly unusual patterns of prescribing or supply.

The CDAO is responsible for asking primary care clinicians, on the health board's Performers List, to complete a CD declaration/self-assessment. All Powys GP Practices completed practice level declarations /self assessments during the time period relevant to this annual report. The submitted declaration/self assessment forms are now being used to prioritise practices for inspection over the next 12 months. The NICE baseline assessment tool is being used to develop a local inspection visit template.

7. CD destruction/Authorised witnesses

Thirteen members of the Medicines Management Team are currently trained to witness the destruction of controlled drugs. These individuals are known as Authorised Witnesses.

All Authorised Witnesses are subject to a professional code of conduct and/or have undergone a DBS check in the last 12 months.

Internal processes have been strengthened to ensure that Authorised Witnesses are made available promptly, ideally within 28 days of the request being received, to witness the destruction of CDs, to avoid the unnecessary build-up of expired or unwanted stock.

All destructions are carried out under the guidance of a standard operating procedure.

Time period	Number of requests received to witness the destruction of CDs (% by area)
October 2020 – September 2021	41 (56% hospital, 34% pharmacy, 5% GP, 5% dentist)
October 2021 – September 2022	69 (63.8% hospital, 27.5% pharmacy, 7.2%GP, 1.5% dentist)
October 2022 – September 2023	88 (61.3% hospital, 18.2% pharmacy, 12.5% GP, 8% dentist)

The percentage of requested destructions waiting more than 28 days from the date that the request was received, to the date that the Authorised Witness attended, continues to decline (59% (Oct 20 – Sept 21), 32% (Oct 21 – Sept 22), 22% (Oct 22 – Sept 23)).

8. Education and training resources

The Health Board's CDAO attended the 'Controlled Drugs Accountable Officer online course' provided by Sancus Solutions during 2021 and completed an online refresher course during 2023.

As part of the Medicines Management Incentive Scheme 2023/24, the health board has continued to commission and provide primary care clinicians with access to a PrescQIPP e-learning course - 'reducing opioid prescribing in chronic pain'. The course provides tools and information required to tackle the growth in opioid use and to improve outcomes for patients with chronic non-cancer pain. The Medicines Management Team is monitoring practice level uptake and completion of the course.

In November 2022, the All Wales Therapeutics and Toxicology Centre published two new guidelines:

- All Wales Analgesic Stewardship Guidance – aimed at improving patient outcomes, reducing analgesic-related harm and ensuring cost-effective use of analgesics to provide optimal pain management.
- All Wales Pharmacological Management of Pain Guidance – supporting prescribers to make the best choice when using medicines for pain management.

Both guidelines have been actively promoted to clinicians during the last 12 months.

Clinicians and patients continue to be signposted to Opioids Aware which provides access to resources covering:

- Best professional practice
- Understanding pain and medicines for pain
- Clinical use of opioids
- A structured approach to opioid prescribing
- Opioids and addiction
    - Information for patients
    - About pain for patients
    - Thinking about opioid treatment
    - Taking opioids for pain

Patient stories remain a powerful tool and continue to be used to highlight the dangers associated with pain management. Faye's Story continues to be used with both clinicians and patients.

9. Monitoring CD Prescribing

The health board's Medicines Management Team routinely monitors CD prescribing.

The PTHB Medicines Management Team identified problems with two national opioid key performance indicators (Opioid burden (DDD per 1,000 patients) and High strength opioid prescribing (DDD per 1,000 patients) and as a consequence, the

national team has suspended both indicators until the identified errors have been corrected.

Local monitoring includes:

- CD key performance indicators:
  - Opioid patches (percentage of all opioid prescribing)
  - Hypnotics and anxiolytics (ADQ per 1,000 patients)
  - Gabapentin and pregabalin (DDD per 1,000 patients)
  - Tramadol (DDD per 1,000 patients)
- Monitoring for excessive/inappropriate prescribing (e.g. prescribing in excess of 30 days' supply at any one time).
- Monitoring increases and decreases in prescribing of CD chemical substances.

These monitoring reports are used to inform the work of the Medicines Management Team and quarterly updates are provided to the CDLIN.

GP practices are provided with monthly reports showing their performance against key performance indicators and providing details of excessive and/or potentially inappropriate prescribing that they need to address. Although most practices respond to queries raised on behalf of the CDAO efficiently, a small number of practices remain challenging to engage.

10. Plans for the year ahead

To ensure patient safety and maintain public confidence, it is vital that the safe management of controlled drugs and the work of the CDAO and CDLIN remains high on the health board's agenda.

Priorities for the year ahead include:
Continue to raise awareness: Ensure that there is widespread awareness of the identity and roles/responsibilities of the CDAO across the health board and geography of Powys. Ensure that the risks associated with CDs are understood and that staff are aware of their responsibilities around CD governance and incident reporting.

Continue to learn from incidents and proactively share learning.

Declarations/Self-assessments: Now that CD declarations and self-assessments have been received from practices, practice visits will be undertaken to address any issues identified. Declarations and self-assessments will be requested from each and every clinician on the health board's Performers List over the next 12 months.

Strengthen governance arrangements: Ensure that good governance around controlled drugs is embedded into everyday practice. Areas to be prioritised include processes to ensure that:

- all CD incidents are reported to the CDAO within 24 hours.
- all clinical areas have robust auditable processes in place to control access to CDs.
- balance checks are carried out routinely at a frequency that is fit for the purpose of the service.
- prescribing data is further scrutinised to identify excessive and/or inappropriate CD prescribing (expanding scrutiny beyond Schedule 2 and 3 CDs)

Develop additional SOPs: Two new SOPs will be developed covering:

- CD Monitoring
- Denaturing of Schedule 3 and 4(Part 1) controlled drugs at ward level in the absence of an Authorised Witness.

Increase CD incident reporting by community pharmacy contractors: There are 23 community pharmacies located across the geography of Powys. Between October 2022 and September 2023, 10 incidents were reported by 7 community pharmacies. Six of the incidents were reported by Boots pharmacies and one was reported by Lloyds pharmacy. To ensure that we can understand why incidents are happening in community pharmacy and to ensure that learning can be shared with contractors to help prevent similar incidents, we need to encourage all contractors to actively report. To maintain a focus on CD incident reporting in community pharmacy, CD incident reports have been included in the 'contract assurance framework' (CAF).

Engage with GP practices to:

- **Increase CD incident reporting:** There are 16 GP practices in Powys. Between October 2022 – September 2023, only two CD incident reports were received from GP practices. To enhance our understanding of the nature of CD incidents that occur in primary care and to support learning, we need to encourage all practices to report CD related incidents. To maintain a focus on CD incident reporting in primary care, a recommendation will be made to include CD incident reports in the medicines management section of the primary care 'contract assurance framework' (CAF).
- **Ensure prompt responses to queries raised by the CDAO**. The Medicines Management Team routinely monitors primary care CD prescribing data to identify excessive and potentially inappropriate prescribing. A minority of practices do not currently engage as required. This will be addressed over the next 12 months.

Increase CD incident reporting by care homes and continue to strengthen governance arrangements in care homes: CD incident reporting by care homes is

currently very low. As the health board strengthens collaboration with care homes and the local authority, work will be undertaken to promote the benefits of incident reporting and encourage all homes to actively report incidents relating to medicines, including CDs.

Improver understanding of influences behind the increase in schedule II CD prescribing. Primary care prescription items for Schedule II CDs have grown by around 4.5% annually for the last two years. To help ensure that prescribing is appropriate, and that patient safety is not being compromised, we aim to understand the rationale behind this growth during the next 12 months. National guidelines will continue to be promoted to help ensure safe and appropriate prescribing. Work will be undertaken with the health board's pain management team to guide and support deprescribing where necessary and appropriate.

Support and inform the development of the national CD prescribing monitoring dashboard. Over the next 12 months a member of the Medicines Management Team will collaborate with other health board controlled drugs leads to inform the development of a national dashboard. It is hoped that the national dashboard will provide benchmarking data as well as reducing the burden associated with local monitoring that is currently being undertaken by the team.

11. Conclusion

Over the last 12 months the health board has continued to strengthen the governance arrangements around controlled drugs. The CDLIN has continued to meet quarterly and has received regular occurrence reports from designated bodies. Significant progress has been made to increase the efficiency of witnessing the destruction of date expired and unwanted CDs. CD monitoring arrangements have been enhanced and strengthened and GP practices have continued to receive monthly reports which includes a number of CD key performance indicators and details of excessive and inappropriate prescribing that they need to address. Educational materials have been made available to primary care clinicians, along with guidelines to support appropriate prescribing of controlled drugs.

It is recognised that there is still a lot of work to be done, particularly to encourage primary care contractors and care homes to report CD incidents to help us understand incident themes and to allow learning to be shared to enhance the safe and secure management of controlled drugs and improve patient safety.

The national work associated with the development of the CD dashboard is a significant step forward and will allow health boards to collaborate more closely on CD governance and to share learning across a national footprint.

Over the next 12 months the CDAO, in collaboration with the CDLIN will build on the achievements made to date to further strengthen the arrangements for the safe and secure management of controlled drugs across the geography of Powys.

Reporting Committee	**Quality Patient Safety Committee (QPSC)**
Chaired by	**Carolyn Donoghue**
Lead Executive Director	**Director of Nursing & Quality**
Date of Meeting	**23rd October 2023**

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

As the morning had been taken up with the Quality Patient Safety Development Day there was no presentation or Patient Story at this meeting. The Chair welcomed two new members to the committee representing Cardiff & Vale University Health Board and the Deputy Regional Director for Llais.

1.0 COMMISSIONING TEAM AND NETWORK UPDATES

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

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

- **Cancer & Blood**

It was noted that no new risks for the portfolio had been added to the Risk Register since the last report.

- Members noted the improved traction on the performance issues within the All Wales Lymphoma Panel (AWLP) service and following the submission of a final report by the service, it is likely a recommendation will be made to reduce the level of escalation level by the next meeting.
- The Harm Review being undertaken on the North Wales (NW) plastics service remains outstanding. No timescales for completion were presented to the committee and members asked for further clarity.
- Whilst the Burns South Wales (SW) remains in Escalation Level 3 the capital case has been approved by Welsh Government and it is anticipated that the interim staffing arrangements can be sustained until the new build is complete.
- A Neuro Endocrine Tumour Stakeholder meeting was organised by Cardiff & Vale University health Board on the 17th October 2023.

- **Neurosciences**

Members noted that one new risk scoring above 15, relating to staffing levels within Neuro-rehabilitation at CVUHB, had been added since the last report was received. The committee was informed that due to quality issues with current provider commencement of Designated Provider process for the South Wales Deep Brain Simulation (DBS) service has been initiated. A letter has been sent to Llais informing them of the position.

- **Cardiac**

No new risks for the Cardiac portfolio had been added to the Risk Register since the last report. Members noted the updates against the two services, which currently remained in escalation at level 2.

- **Women & Children**

Members were concerned that there were five service areas with risks scoring 15 and above and that two new risks scoring above 15, both relating to Neonatal at CVUHB, had been added since the last report was received.

There are five service areas with high risks and in Escalation Level 3 are noted as follows and further detail and actions can be found in the summary of services in escalation, which is attached to the report.

- Paediatric Intensive Care (CVUHB)
- Paediatric Surgery (CVUHB)
- Neonatal Intensive Care (CVUHB)
- Paediatric Cardiac Surgery (UHBNHSFT)
- Wales Fertility Institute (WFI) (SBUHB)

The committee were informed that an extraordinary Exec to Exec meeting with CVUHB was due to take place later that day to consider the areas of concern and agree a way forward. It has been proposed that all three will be brought into a single Escalation process with joint Exec Leads to provide additional support. It was also noted that Paediatric Surgery is not meeting contract volumes but ministerial measures are being met. A recommendation will be considered at the November Joint Committee for the escalation objectives to remain that Paediatric Surgery achieves contract volumes.

It was noted that the SBUHB assurance report was not submitted to HFEA on time. A further WHSSC escalation meeting is scheduled for the 27th October 2023, and the worst case scenario will be to source a new provider.

- **Mental Health & Vulnerable Groups**

One new risk has been added to the risk register regarding the magna security locks in the North Wales CAMHS unit. Assurance was received that this was being closely monitored and a meeting with the provider had identified the need for a capital bid to fund the necessary remedial works. A number of incidents had

been reported to WHSSC following that meeting and it was agreed that these would be further escalated to the BCUHB DoN for urgent consideration.

Members received an update regarding progress on the development of a Children and Young People's Gender Identity Service led through the NHS England transformation programme.

Members noted that there are a number of safeguarding concerns at an NHSE Eating Disorder provider and these have been escalated to NHSE for discussion and investigation. The relevant safeguarding teams are aware and the care coordinators from the Health Boards have been asked to review the individual patients. A more detailed report was to be received at the next meeting.

The new Eating Disorder unit in Tŷ Glyn Ebwy Hospital, Hillside, Ebbw Vale is due to be opened by the Deputy Minister for Health on the 9th November 2023. This will allow for repatriation of out of area placements and reduce the risk identified with one of the current independent providers.

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

Members received an update of the quality issues for services relating to the Intestinal Failure Commissioning Team Portfolio and noted that no new risks for the portfolio had been added to the Risk Register since the last report.

2.0 OTHER REPORTS RECEIVED

Members received reports on the following:

- **Services in Escalation Summary**

A copy of each of the services in escalation is attached to the report at ***Appendix 1***

- **CRAF Risk Assurance Framework**
- **Care Quality Commission (CQC)/ Health Inspectorate Wales (HIW) Summary Update**
- **Incident and Concerns Report**
- **Report from the WHSSC Policy Group**.

3.0 ITEMS FOR INFORMATION:

Members received a number of documents for information only:

- Chair's Report and Escalation Summary to Joint Committee September 2023
- Welsh Health Circular: Speaking up Safely Framework
- QPSC Distribution List; and
- QPSC Forward Work Plan.

4.0 ANY OTHER BUSINESS

It was noted that there had been a Development Day for QPS members and Quality Leads from the Health Boards that morning. The theme of the session

was to consider the impact of the Duty of Quality Act in terms of future reporting and monitoring of commissioned services. It had been well attended and a report will be presented at the next meeting.	
Key risks and issues/matters of concern and any mitigating actions Key risks are highlighted in the narrative above. Members expressed concerns regarding the number of services that were in escalation in the Women & Childrens portfolio and asked that these were escalated for the attention of the Joint Committee.	
Summary of services in Escalation • Attached (***Appendix 1***)	
Matters requiring Committee level consideration and/or approval • None	
Matters referred to other Committees As above.	
Confirmed minutes for the meeting are available upon request	
Date of Next Scheduled Meeting	5 December 2023

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

Date of Escalation Meetings: 27/09/22, 01/12/2022, 03/03/2023, 03/05/2023
Date Last Reviewed by Quality & Patient Safety Committee: 16/08/23

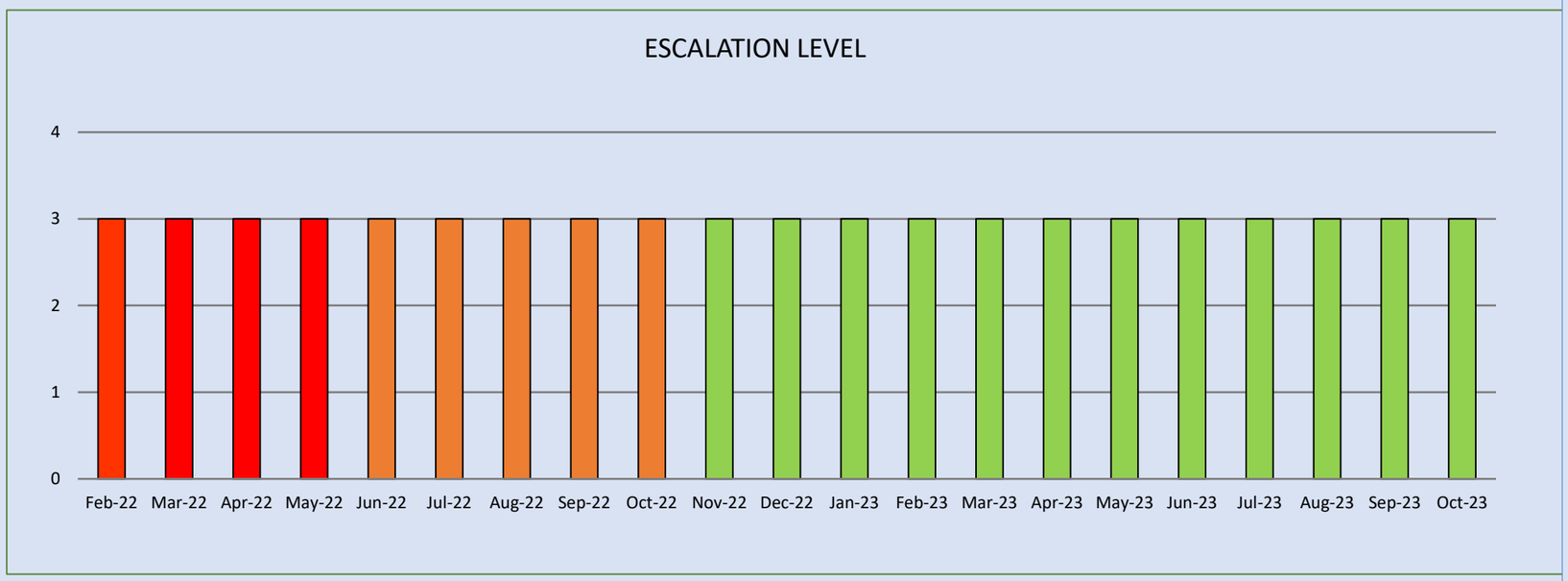
Service in Escalation: Burns

Current Escalation Level 3

Escalation Trend Level

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

Escalation Trajectory:



Escalation History:

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

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

Background Information:

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

Actions:

Action	Lead	Action Due Date	Completion Date
To escalate and liaise with SBUHB at CEO and MD level with regard to the immediate actions needed to provide continued access to burns care for patients in Wales and the Network.	MD/ CEO		Completed
To work with NHS England south west commissioners and the SWW Burns Network to support clear pathways and ensure continued access to burns care for patients in Wales and the Network.	MD/Exec Lead WHSSC		Completed
To monitor the SBUHB action plan through formal escalation meetings.	MD/ Exec Lead WHSSC		Ongoing
The peer review report was received by WHSSC and discussed at the Burns Network meeting on the 16th December 21. The interim mitigations are still in place at present.	Senior Planner		Completed

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

Issues/Risks:

- **July 2023 The Welsh Government Infrastructure Investment Board considered the burns case on June 22nd the outcome is not confirmed as yet.**
- **October 2023: the capital case has been approved by Welsh Government. Timeline tbc.**

Appendix 1

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

Date of Escalation Meetings: 26/04/23, 23/05/23, 20/06/2023, 26/07/23, 12/09/23 & 10/10/23
Date Last Reviewed by Quality & Patient Safety Committee: 16/08/23

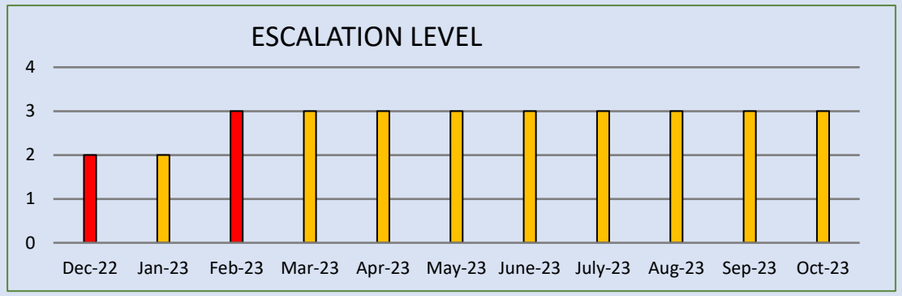
Service in Escalation: Paediatric Surgery

Current Escalation Level 3

Escalation Trend Level

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

Escalation Trajectory:



Escalation History:

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

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

Background Information:

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

WHSSC assurance and confidence level in developments:

Medium – Action plan developed and positive progress made in designing a number of new pilot schemes and securing additional capacity, some delays in implementation. The current financial pressures and savings plans requested by WG have resulted in the Health Board re-profiling the trajectories and unlikely to meet contract volumes for the remainder of the financial year.

Actions:

Action	WHSSC Lead	Action Due Date	Completion Date
Monthly escalation meetings with CVUHB to review progress against the improvement plan.	Senior Planning Manager	Monthly	
Action plan to be monitored through the monthly escalation meetings and when data shows improvement consideration will be given to de-escalation.	Senior Planning Manager	Monthly	
Requested revised trajectories to be issued to WHSSC by the end of June 2023.	Senior Planning Manager	30 June 2023	Completed 20/06/23
Further reprofiling of waiting times being undertaken by the HB in line with meeting contract volumes by December 2023.	Senior Planning Manager	August 2023	Completed 06/10/23
Special Executive to Executive meeting scheduled with provider.	Director of Planning & Performance	23 October 2023	

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

Appendix 1

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

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

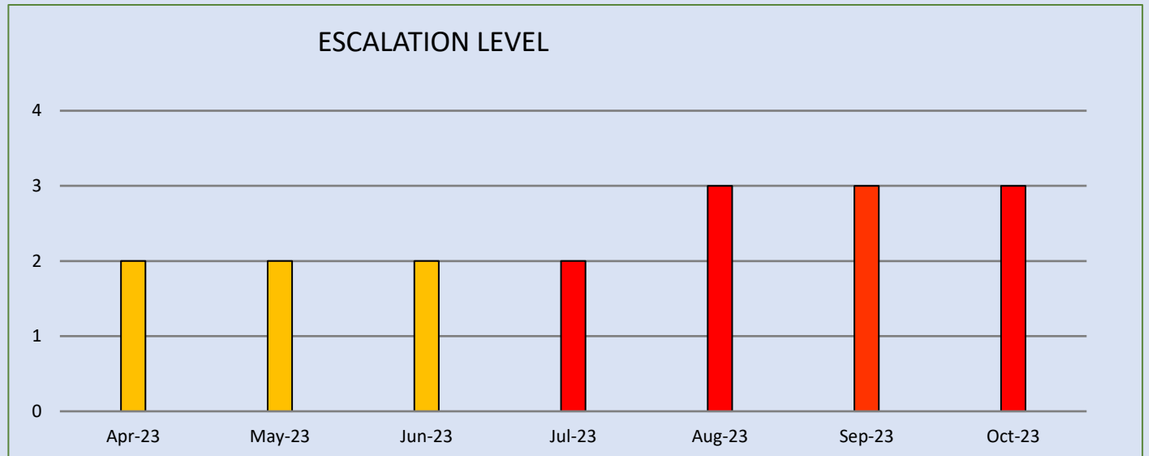
Service in Escalation: Paediatric Intensive Care

Current Escalation Level 3

Escalation Trend Level

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

Escalation Trajectory:



Escalation History:

Date	Escalation Level

Rationale for Escalation Status :
Following concerns regarding bed availability due to workforce shortages, refusal rates and pressure sore incidents the service was escalated to level 2. There was limited progress over a 3 month period against the objectives therefore the decision was taken to further escalate to level 3.

Background Information:

There is a risk that a Paediatric intensive care bed, in the Children's Hospital for Wales, will not be available when required due to constraints within the service. There is a consequence that Paediatric patients requiring intensive care will be cared for in, inappropriate areas where the necessary skills or equipment is not available or the patient being transferred out of Wales. The availability of a bed and staffing constraints have been brought to the attention of WHSSC through various routes including HiW and the daily SITREP.

WHSSC assurance and confidence level in developments:

Low – HB have submitted draft action plan, a final version has been requested. The escalation is predominantly linked to workforce and the lead in time for mitigations is medium term, in particular the recruitment of International Nurses. New streamliners have begun in the HB and although supernumerary at present and will not directly fill PIC vacancies it will support the wider workforce challenges across the Children's Hospital.

Actions:

Action	WHSSC Lead	Action Due Date	Completion Date
Requested demand and capacity plan from HB to develop sustainable contracting framework for PIC and HD	Senior Planning Manager	31 October 2023	
Requested action plan to be developed against the escalation objectives.	Senior Planning Manager	31 October 2023	
Requested sight of the Pressure Sore report presented to the HB Quality and Patients Safety Committee.	Senior Planning Manager	31 October 2023	
Special Executive to Executive meeting scheduled with provider	Director of Planning	23 October 2023	

Issues/Risks:

Appendix 1

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

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

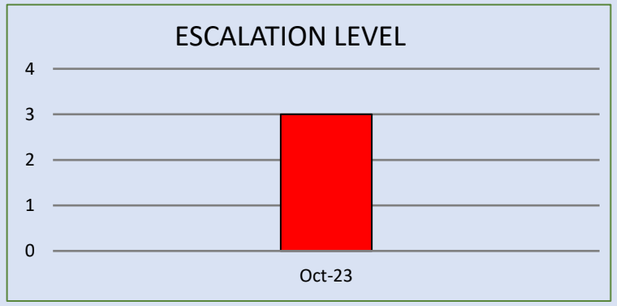
Service in Escalation: Neonatal Intensive Care Unit

Current Escalation Level 3

Escalation Trend Level

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

Escalation Trajectory:



Escalation History:

Date	Escalation Level
September 2023	3

Rationale for Escalation Status :

High levels of cot closures reported across all three levels of care, blood stream infection rates and progress implementing the new cot configuration.

Background Information:

There are currently two risks on the CRAF relating to Neonatal services at Cardiff and Vale UHB, lack of cot availability due to workforce and the service being a negative outlier status for blood stream infections, on the National Neonatal Audit Programme (NNAP). Limited progress has also been made against implementing the workforce required to support the cot configuration.

WHSSC assurance and confidence level in developments:

The service were only notified of escalation in late September therefore at the time of writing the report the objectives have not yet been set.

Actions:

Action	WHSSC Lead	Action Due Date	Completion Date
Develop agreed objectives for escalation	Planning Manager	31 October 2023	
Health Board to develop detailed action plan against the agreed objectives	Planning Manager	14 November 2023	
Special Executive to Executive meeting scheduled with provider	Director of Planning	23 October 2023	

Issues/Risks:

Appendix 1

Executive Director Lead: Iolo Doull
Commissioning Lead: Dominique Gray-Williams
Commissioning Team: Women and Children

Date of Escalation Meetings: 07/08/23
Date Last Reviewed by Quality & Patient Safety Committee: 16/08/23

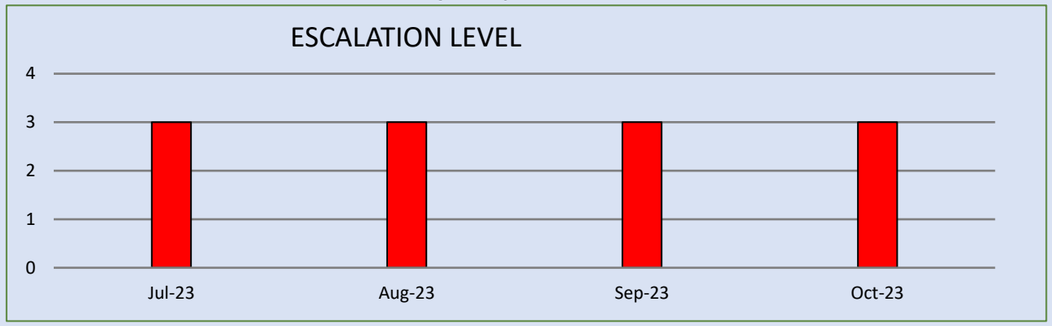
Service in Escalation: Wales Fertility Institute

Current Escalation Level 3

Escalation Trend Level

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

Escalation Trajectory:



Escalation History:

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

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

Background Information:
A number of concerns regarding the safety and quality of service had been raised through different routes, including HFEA re-inspection report January 2023, WHSSC quality and assurance meetings and WFI IPFR requests regarding Wales Fertility Institute leading to the escalation of the service.
There is a risk the Wales Fertility Institute (WFI) in Neath & Port Talbot Hospital is not providing a safe and effective service due to 7 major concerns identified during a relicensing inspection by HFEA in January 2023. There is a consequence that families who have treatment at this centre are not receiving the quality of care expected from the service and in turn impacting outcomes.

WHSSC assurance and confidence level in developments:

Medium – The Health Board have instigated regular Gold Command and operational service improvement meeting with positive progress made in addressing HFEA concerns. The Action plan has been agreed and progress has been made with regards to WHSSC data submissions, however, the service need to ensure time is given both internally and to WHSSC to allow for review and consideration of documentation.
The service are due to submit a progress report to the HFEA by the 18th October. HFEA re-inspection is due to take place in January 2024.

Actions:

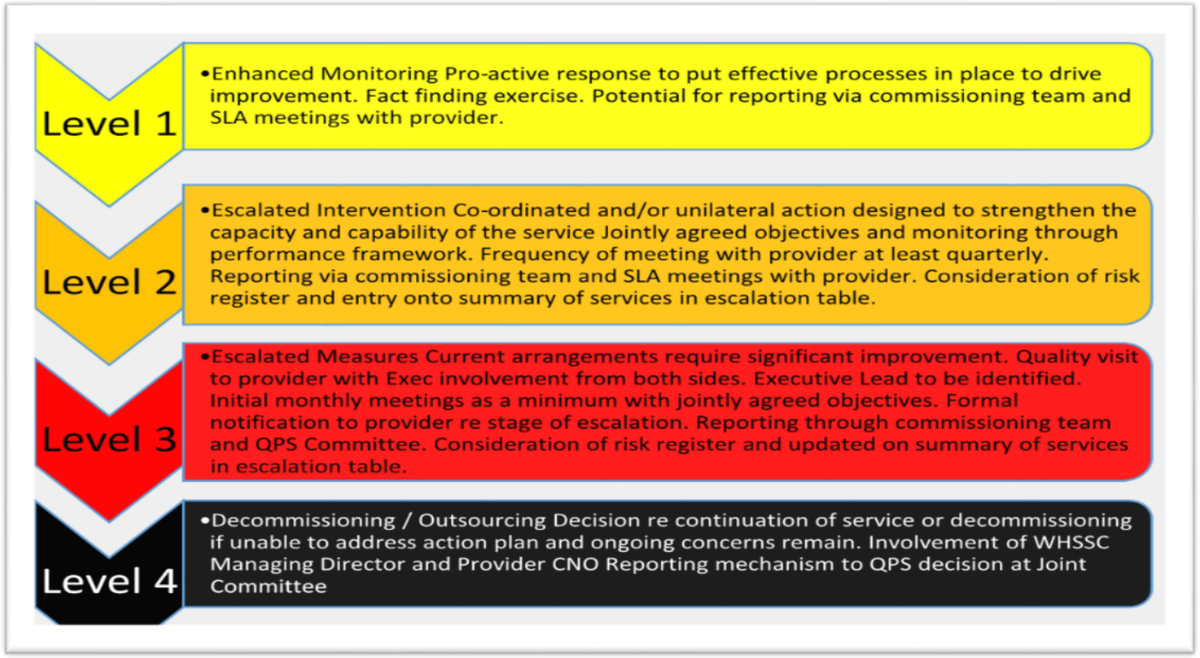
Action	Lead	Action Due Date	Completion Date
Initial escalation planning meeting Exec to Exec	Assistant Specialised Planner	7th August 2023	7th August 2023
Monthly escalation meeting to review progress against Action Plan Escalation meeting 19th September 2023	Assistant Specialised Planner	Monthly	Ongoing
Quality visit	Assistant Specialised Planner	14th November 2023	
SMART Action plan from WFI, action plan has been requested in order that it can be agreed with WHSSC colleagues	Assistant Specialised Planner/ Service Manager	7th August 2023	7th August 2023
SMART Action plan reviewed and agreed	Service Manager	19th September 2023	19th September 2023

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

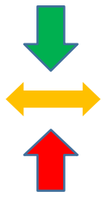
Appendix 1

Level 1 ENHANCED MONITORING	Any quality or performance concern will be reviewed by the Commissioning Team. Enhanced monitoring is a pro-active response to put effective processes in place to drive improvement. It is an initial fact finding exercise which should ideally be led by the provider and closely monitored and reviewed by the commissioning team. The enquiry will lead to one of the following possible outcomes: • No further action is required routine monitoring will continue. The concern which raised the indication for inquiry will be logged and referred to during the routine monitoring process to ensure this has not developed any further. • Continued intervention is required at level 1 and a review date agreed. • Escalation to Level 2 if further intervention is required There is the potential for reporting via commissioning team report to Quality Patient Safety Committee and through SLA meetings with provider
Level 2 ESCALATED INTERVENTION	Escalated intervention will be initiated if Level I Enhanced Monitoring identifies the need for further investigation/intervention. There should be a Co-ordinated and/or unilateral action designed to strengthen the capacity and capability of the service. At this stage there should be jointly agreed objectives between the provider and commissioner and monitored through the relevant commissioning team. Frequency of meeting with provider should be at least quarterly and possible interventions will include • Provider performance meetings • Triangulation of data with other quality indicators • Advice from external advisors • Monitoring of any action plans A risk assessment should be undertaken, and logged on the Commissioning Team Risk Register. Where appropriate the risk will be included on the WHSSC Risk Management Framework. Reporting is via commissioning team report to Quality Patient Safety Committee report and SLA meetings with provider. The investigation will lead to on to the following possible outcomes: • Action plan and monitoring are completed within the allocated timeframe, evidence of progress and assurance the concern has been addressed. De-escalation to Level 1 for ongoing monitoring. • If the action plan is not adhered to and further concerns are raised by the Commissioning team or by the provider team or further concerns are identified it may be necessary to move to Level 3 Escalated Measures
Level 3 ESCALATED MEASURES	Where there is evidence that the Action Plan developed following Level 2 has failed to meet the required outcomes or a serious concern is identified a service will be placed in escalated Level 3. At this stage the quality of the service requires significant action/improvement and will require Executive input. In addition to routine reporting through QPS a formal paper will be considered by the WHSSC Corporate Directors Group (CDG) and an Executive Lead nominated. Formal notification will be sent to the provider re the Level of escalation and a request made for an Executive lead from the provider to be identified. An initial meeting will be set up as soon as possible dependant on the severity of the concern. Meetings should take place at least monthly thereafter or more frequently if determined necessary with jointly agreed objectives. Provider representation will depend on the nature of the issue but the meetings should ideally comprise of the following personnel as a minimum: • Chair (WHSSC Executive Lead) • Associate Medical Director - Commissioning Team • Senior Planning Lead – Commissioning Team • WHSSC Head of Quality • Executive Lead from provider Health Board/Trust • Clinical representative from provider Health Board/Trust • Management representative from provider Health Board/Trust An agreed agenda should be shared prior to the meeting with a request for evidence as necessary. At the conclusion of the meeting a clear timeline for agreed actions will be identified for future monitoring and confirmed in writing if appropriate. Reporting will be through commissioning team to QPS Committee. Consideration of entry on the risk register and summary of services in escalation table for Chairs report to Joint Committee. Consideration to involve and have a discussion with Welsh Government may be considered appropriate at this stage. If there is ongoing concern relating patient care and safety with no clear progress then further escalation will be required to Level 4. On the other hand if progress is made through the escalation Level 3 evidence of this should be presented to CDG/QPS and a formal decision made with the provider to de-escalate to Level 2.
Level 4 DECOMISSIONING/OUTSOURCING	Where services have been unable to meet specific targets or demonstrate evidence of improvement a number of actions need to be considered at this stage. This stage will require notification and involvement of the WHSSC Managing Director and CEO from the provider organisation. Both Quality Patient Safety Committee and Joint Committee should be cited on the level of escalation. The following areas will need to be considered and the most appropriate sanction applied to help resolve the issue: 1. De-commissioning of the service 2. Outsourcing from an alternative provider. This may be permanent or temporary 3. Contractual realignment to take into account the potential need to maintain and agree an alternative provider. Involvement with Welsh Government and the Community Health Council is critical at this stage as often there are political drivers and levers that need to be considered and articulated as part of the decision making. Moving in and out of escalation and between Levels In addition to the Levels described above the process has introduced a traffic light guide within each level. The purpose of this is to help demonstrate the direction of travel within the level. It sets out an approach to help identify progress within the level and lays out the steps required for movement either upwards (escalation) or downwards (de-escalation) through the level. At every stage a red, amber or green colour will be applied to the level to illustrate whether more or less intervention is in place. Red being a higher level of intervention moving down to green. It will also help determine the easing of the escalated measures described and inform movement within the stages of escalation. As the evidence and understanding of the risks from a provider and commissioner become evident decisions can be made to reduce the level of intervention or there may be a need to reintroduce intervention should conditions worsen and trigger the re-introduction of measures if progress is unacceptable. In this way organisations will be able to understand what is being asked of them, progress will be easily identified and it will help avoid any confusion. It will also help in the reporting to provide assurance that action is being taken to meet the agreed timescales.

Appendix 1



SERVICES IN ESCALATION

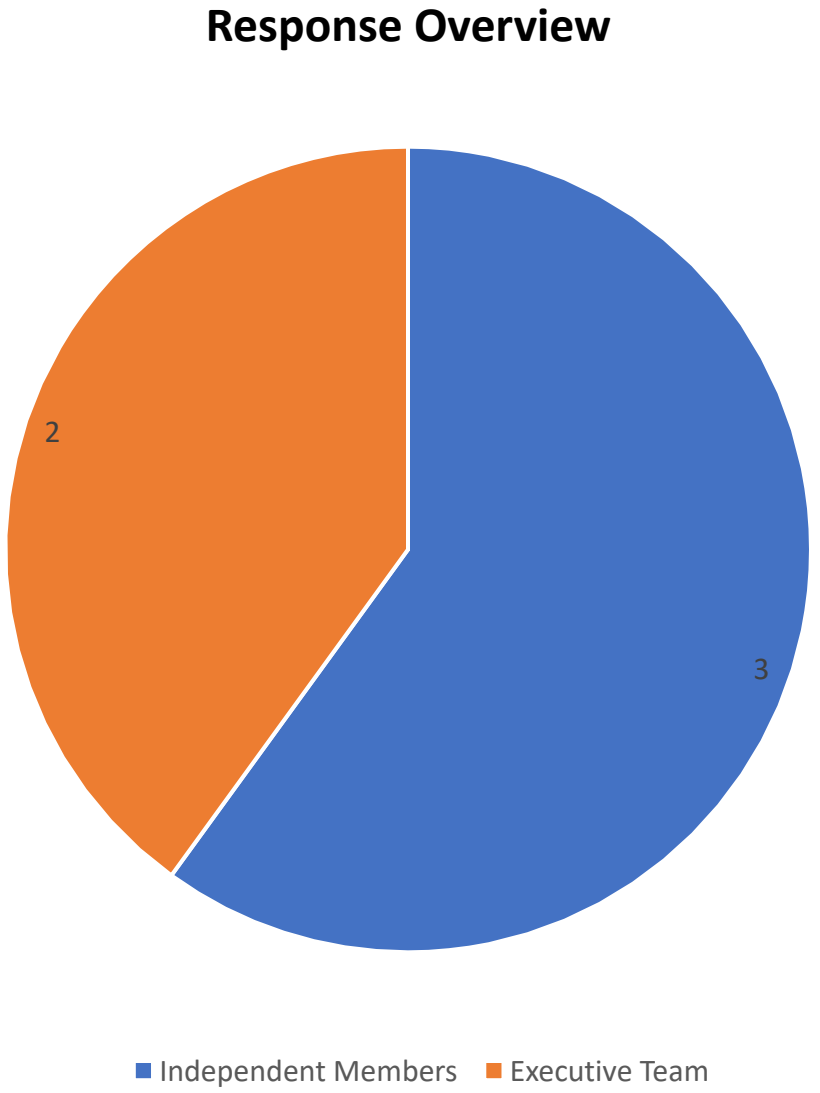


Level of escalation reducing / improving position

Level of escalation unchanged from previous report/month

Subject:	Committee Effectiveness – Patient Experience, Quality and Safety Committee
Approved and Presented by:	Director of Corporate Governance/Board Secretary
Author:	Director of Corporate Governance/Board Secretary
Purpose:	This presentation provides a summary of the responses received to the Committee Effectiveness questionnaire (PEQS); and is provided to stimulate discussion within the Committee to support the identification of what works well, learning and actions for improvement.
Recommendations:	The Committee is asked to: • **DISCUSS** the summary of the Committee Effectiveness survey and **PROPOSE** any areas for action/improvement.
Executive Summary:	Each Committee of the Board is required to assess its effectiveness at the end of each year and to report its views to the Board on how governance arrangements might be improved. This is a key principle of good corporate governance which demonstrates a committee's understanding of its remit and oversight responsibility and a culture of continuous improvement. The approach for 2023/24 contained a questionnaire and then discussion at the Committee meeting. The Committee effectiveness questionnaire focuses on the critical themes of: (i) composition and establishment, (ii) effective functioning, and (iii) assurance.

Response Overview



Mills Belinda
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Section 2 – Composition and Establishment

Overview of ratings

Question	Lowest score	Highest score	Score as % of maximum
The Committee understand its role	3	4	95%
The Committee annual work plan covers all the relevant areas in terms of reference.	3	4	90%
The Committee has the membership, authority and resources to perform its role effectively.	3	4	95%
The right people attend meetings of the Committee to enable it to fulfil its role effectively.	4	4	100%
Committee members have the collective skills & experience needed to fulfil the terms of reference and to advise & assure the Board.	3	4	95%

Section 3 – Effective Functioning

Overview of ratings – Effective Functioning

Question	Lowest score	Highest score	Score as % of maximum
Meeting arrangements (frequency, time allocation) allow members individually and collectively to contribute to effective scrutiny and challenge.	3	4	95%
Committee meetings are conducted in a business- like manner and managed effectively with issues getting the time & attention proportionate to importance.	4	4	100%
Committee papers are of good quality and provide sufficient information (detail, presentation, timeliness) to enable the committee to fulfil its role.	3	4	80%
There is good monitoring of matters arising & agreed actions to support the Committee in its role.	3	4	95%

Overview of ratings – Effective Functioning

Question	Lowest score	Highest score	Score as % of maximum
The Committee is briefed on urgent/emerging issues (policy, performance or new legal/regulatory obligations) in a timely and appropriate way.	4	4	100%
The Committee environment is one in which members can provide supportive but critical challenge on key/sensitive issues.	4	4	100%
Reports to the Board cover all key issues discussed at Committee. The Board takes due regard of the Committee's views (i.e. recommendations, issues escalated, sharing of good practice).	3	4	95%
In meetings, we listen to and respect each other's views.	4	4	100%

Effective Functioning – Comments

- We have discussed that more detail on incidents and quality and safety concerns could be brought through from service groups.
- Briefer papers with more focus on trends and key areas of concern or good practice in some instances would help to highlight important areas
- Additional reading time would be welcome.

Section 4 – Assurance

Overview of ratings – Assurance

Question	Lowest score	Highest score	Score as % of maximum
The Committee receives sufficient and timely reports and advice on key issues that clearly set out the analysis of the situation, the risks and the assurance the Committee can take in order to enable it to discharge its responsibilities.	3	4	90%
The Committee receives timely reports on the work of external regulatory and inspection bodies and other independent sources of assurance.	3	4	95%
The Committee receives regular and sufficient evidence that the organisation is learning and improving.	3	4	85%
Performance reporting is at an appropriate level to enable the Committee to identify areas where it requires further assurance.	3	4	80%
The Committee receives the assurance it needs to fulfil its role effectively.	3	4	90%

Section 5 – General Comments

Comments - what areas are going well?

- Meetings run well
- Meeting terms of reference
- We get through the business
- Processes and quality of papers
- Clarity of papers with good executive summaries
- Open and safe space for challenge and discussion of quality concerns
- Bringing in Assistant Directors to tell their story has been valuable and effective
- Meeting culture, proportionate scrutiny and challenge, is progressive, aims high.
- Great chairing
- Well chaired and open dialogue of meetings
- High quality papers, we are able to conduct our business well
- Papers are generally good quality
- Everyone has an opportunity to make their points
- Briefings provided where required
-

Comments – What could be Improved?

- Better evidence of learning and outcomes (when we are able to produce this data)
- Improve information and data on patient experience
- Breadth and depth of PEQS remit/scope is huge. How do we know we're focussing on the right 'stuff' at the right time ? We probably are but how assured are we about that?
- Given the huge range of PEQS remit, what's the process for how we prioritise our business items? We've started to be explicit about how our role aligns with/overlaps with other Board sub committees - that's great
- Earlier release of papers

Comments – What training/other development activity would support the Committee in its role?

- Consider outlining committee purpose and function to wider staff groups at induction - would help develop improved floor to board reporting and to demonstrate the focus on quality
- Consider how key outcomes of discussion could be fed back to staff and service groups
- More info / review of our patient/citizen/user data systems - and how robust/inclusive/fit for purpose are they? How do they inform our decisions/recommendations...e.g. " you said...., we did....“ - can we see our golden thread linking patient voice to Board decisions?

Comments – What areas should the Committee focus on in the future (incl. areas to be looked at more or less frequently)?

- Duty of Quality
- Areas of focus should be led by key trends or concerns highlighted from incidents/concerns/ new system challenges and from trends identified by external bodies
- Deep dive into Primary Care?
    - What are our citizens saying about Primary Care ? Is it working for them? Are there any myths we can bust to help our citizens engage better/have an even better experience with Primary Care? Are there two/three 'new things' we could do 'shift the dial '?
- Would like to see more focus on primary care
- Access to dental services

- Would like to see the ASM (Accelerated Sustainable Model) being more prominent in our work and how are we planning to capture the patient experience of any new/different approaches
- 'Visioning' what great/high quality patient experience looks like in 2030 (or a suitable longer-term funding/strategy cycle.)

Any Other Comments

- PEQS is a very professional committee which does its job really well.

Next Steps

Next Steps

Actions	Timescale
1. Share content of the Effectiveness questionnaire with Committee	23 January 2024
2. Receive feedback from the Committee, discuss any actions / improvements	23 January 2024
3. Develop action plan, in partnership with Committee Chair, for Committee oversight based on Committee survey and contributions	Next Committee meeting (April 2024)
4. Committee feedback and key actions will be incorporated into summary report with other Committees' feedback and shared with the Board	By end March 2024
5. Committee forward plan for 2024/25 is in development and will form part of the April Committee meeting (reviewed at each meeting)	Next Committee meeting (April 2024)
6. PTHB Chairs Forum will continue to develop an overarching role in committee focus areas and work plans	Ongoing

Note to Committee:

These terms of reference are the existing terms of reference in place, comments are requested from the Committee as to any changes that are relevant to recommend to the Board as part of our annual review of arrangements.

Patient Experience, Quality and Safety Committee

Terms of Reference & Operating Arrangements

September 2021

1. INTRODUCTION

1.1 Section 2 of the Standing Orders of the Powys Teaching Health Board (referred to throughout this document as 'PTHB', the Board' or the 'Health Board') provides that:

"*The Board may and, where directed by the Welsh Government must, appoint Committees of the Health Board either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of its business extends equally to the work carried out on its behalf by committees*".

1.2 The Health Board has established a committee to be known as the **Patient Experience, Quality and Safety Committee** (referred to throughout this document as 'the Committee'). The Terms of Reference and operating arrangements set by the Board in respect of this committee are provided below.

2. PURPOSE

2.1 The scope of the Committee extends to the full range of PTHB responsibilities. This encompasses all areas of patient experience, quality and safety relating to patients, carers and service users, within directly provided services and commissioned services. The Committee will embrace the Health and Care Standards as the Framework in which it will fulfil its purpose:

- Staying Healthy
- Safe Care
- Effective Care
- Dignified Care
- Timely Care
- Individual Care
- Staff and Resources

2.1 ADVICE

The Committee will provide accurate, evidence based (where possible) and timely advice to the Board and its committees in respect of the development of the following matters, consistent with the Board's overall strategic direction

- Citizen Experience; and
- Quality and Safety of directly provided and commissioned services.

2.2 ASSURANCE

In respect of the achievement of the Boards' strategic aims, objectives and priorities, the Committee will seek assurances on:

a. The robustness of the Board's Clinical Quality Framework;
b. the experience of patients, citizens and carers ensuring continuous learning;
c. the provision of high quality, safe and effective healthcare within directly provided and commissioned services;
d. the effectiveness of arrangements in place to support Improvement and Innovation and
e. compliance with mental health legislation, including the Mental Health Act 1983 (amended 2007) and the Mental Capacity Act 2005.

3 DELEGATED POWERS AND AUTHORITY

3.1 With regard to the powers delegated to it by the Board, the Committee will:

A. Seek assurance that the Health Board's **Clinical Quality Framework** remains appropriate, is aligned to the National Quality Framework, and is embedded in practice.

B. Seek assurance that arrangements for capturing the **experience of patients, citizens and carers** are sufficient, effective and robust, including:

- the delivery of the Patient Experience Plan; and
- the implementation of Putting Things Right regulations (to include patient safety incidents, complaints, compliments, clinical negligence claims and inquests) reporting trends, with particular emphasis on ensuring that lessons are learned.

C. Seek assurance that arrangements for **the provision of high quality, safe and effective healthcare** are sufficient, effective and robust, including:

- the systems and processes in place to ensure efficient, effective, timely, dignified and safe delivery of directly provided services;
- the commissioning assurance arrangements in place to ensure efficient, effective, timely, dignified and safe delivery of commissioned services;
- the arrangements in place to undertake, review and act on clinical audit activity which responds to national and local priorities;

- the recommendations made by internal and external review bodies, ensuring where appropriate, that action is taken in response;
- the arrangements in place to ensure that there are robust infection, prevention and control measures in place in all settings;
- the development of the board's Annual Quality Statement and Annual Quality Priorities; and
- performance against key quality focussed performance indicators and metrics.

D. Seek assurance on the arrangements in place to support **Improvement and Innovation**, including:
   - an overview of the research and development activity within the organisation;
   - alignment with the national objectives published by Health And Care Research Wales (HCRW);
   - an overview of the quality improvement activity within the organisation.

E. Seek assurance that arrangements for **compliance with mental health legislation** are sufficient, effective and robust, including:
   - the Mental Health Act 1983 Code of Practice for Wales and associated regulations;
   - the Mental Capacity Act 2005 Code of Practice and associated regulations;
   - the Mental Capacity Act 2005 Deprivation of Liberty Safeguards Code of Practice and associated regulations; and
   - the Mental Health Measure (Wales) 2010.

3.2 The Committee will consider and recommend to the Board for approval those policies reserved for the Board and delegated to this Committee for review, in-line with the Board's Policy Management Framework and Scheme of Delegation and Reservation of Powers.

3.3 The Committee will seek assurances on the management of strategic risks delegated to the Committee by the Board, via the Corporate Risk Register.

Authority

3.4 The Committee is authorised by the Board to investigate or have investigated any activity within its terms of reference. In doing so, the Committee shall have the right to inspect any books, records or documents of the Health Board relevant to the Committee's remit and ensuring patient/client and staff confidentiality, as appropriate.

The Committee may seek any relevant information from any:

- employee (and all employees are directed to cooperate with any reasonable request made by the Committee); and
- any other committee, sub committee or group set up by the Board to assist it in the delivery of its functions.

3.5 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary (subject to the Board's procurement, budgetary and any other applicable standing requirements).

Access

3.6 The Head of Internal Audit shall have unrestricted and confidential access to the Chair of the Committee.

3.7 The Chair of the Committee shall have reasonable access to Executive Directors and other relevant senior staff.

Sub Committees

3.8 The Committee may, subject to the approval of the Board, establish sub committees or task and finish groups to carry out on its behalf specific aspects of Committee business.

3.9 The Committee has established a sub-committee, named the **Mental Health Act Power of Discharge Group.** The purpose of this group is to review and monitor how the operation of the delegated functions under Section 23 of the Mental Health Act 1983 are being exercised. This group will report through to the Patient Experience, Quality & Safety Committee providing assurance in-line with its agreed Terms of Reference.

Committee Programme of Work

3.10 Each year the Board will determine the Committee's priorities for its annual programme of work, based on the Board's Assurance Framework and Corporate Risk Register. This approach will ensure that the Committee's focus is directed to the areas of greatest

assurance needs. This will therefore mean that these Terms of Reference are provided as a framework for the Committee's annual programme of work and is not an exhaustive list for full coverage. This approach recognises that the Committee's programme of work will be dynamic and flexible to meet the needs of the Board throughout the year.

4 MEMBERSHIP

Members

4.1 Membership will comprise:

Chair	Vice Chair of the Board
Vice Chair	Independent member of the Board
Members	Independent member of the Board x3
	The Committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise.

Attendees

4.2 In attendance: The following Executive Directors of the Board will be regular attendees:

- Director of Nursing and Midwifery (Officer Lead)
- Director of Therapies and Health Sciences
- Medical Director
- Director of Public Health
- Director of Primary, Community Care and Mental Health

4.3 By invitation:
The Committee Chair extends an invitation to the PTHB Chair and Chief Executive to attend committee meetings.

The Committee Chair will extend invitations to attend committee meetings, dependent upon the nature of business, to the following:

- other Executive Directors not listed above;
- other Senior Managers and
- other officials from within or outside the organisation to attend all or part of a meeting to assist it with its discussions on any particular matter.

Secretariat

4.4 The Office of the Board Secretary will provide secretariat services to the Committee.

Member Appointments

4.5 The membership of the Committee shall be determined by the Board, based on the recommendation of the Chair of PTHB - taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government.

4.6 Members shall be appointed to hold office for a period of one year at a time, up to a maximum of their term of office. During this time a member may resign or be removed by the Board.

4.7 Terms and conditions of appointment, (including any remuneration and reimbursement) in respect of co-opted independent external members are determined by the Board, based upon the recommendation of the Chair of PTHB.

Support to Committee Members

4.8 The Board Secretary, on behalf of the Committee Chair, shall:

- arrange the provision of advice and support to committee members on any aspect related to the conduct of their role; and
- ensure the provision of a programme of development for committee members as part of the Board's overall Development Programme.

5 COMMITTEE MEETINGS

Quorum

5.1 At least **three** members must be present to ensure the quorum of the Committee, one of whom should be the Committee Chair or Vice Chair.

5.2 Where members are unable to attend a meeting and there is a likelihood that the Committee will not be quorate, the Chair can invite another independent member of the board to become a temporary member of the Committee.

Frequency of Meetings

5.3 The Chair of the Committee shall determine the timing and frequency of meetings, which shall be held no less than **bi-monthly**, and in line with the Health Board's annual plan of Board Business.

5.4 The Chair of the Committee may call additional meetings if urgent business is required to be taken forward between scheduled meetings.

Openness and Transparency

5.5 Section 3.1 of PTHB Standings Orders confirms the Board's commitment to openness and transparency in the conduct of all its business and extends equally to the work carried out on its behalf by Committees. The Board requires, wherever possible, meetings to be held in public. The Committee will:

- hold meetings in public, other than where a matter is required to be discussed in private (see point 5.6);
- issue an annual programme of meetings (including timings and venues) and its annual programme of business;
- publish agendas and papers on the Health Board's website in advance of meetings;
- ensure the provision of agendas and minutes in English and Welsh and upon request in accessible formats, such as Braille, large print, and easy read; and
- through PTHB's website, promote information on how attendees can notify the Health Board of any access needs sufficiently in advance of a proposed meeting, e.g., interpretation or translation arrangements, in accordance with legislative requirements such as the Equality Act 2010 and Welsh Language Standards 2018.

Withdrawal of individuals in attendance

5.6 There may be circumstances where it would not be in the public interest to discuss a matter in public, e.g., business that relates to a confidential matter. In such cases the Chair (advised by the Board Secretary where appropriate) shall schedule these issues accordingly and require that any observers withdraw from the meeting. In doing so, the Committee shall resolve:

That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960 (c.67).

In these circumstances, when the Committee is not meeting in public session it shall operate in private session, formally reporting any decisions taken to the next meeting of the Committee in public session.

6. RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

6.1 Although the Board has delegated authority to the Committee for the exercise of certain functions (as set out within these terms of reference), the Board retains overall responsibility and accountability for all matters relating to performance and resources.

The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.

6.2 The Committee will work closely with the Board's other committees, joint and sub committees and groups to provide advice and assurance to the Board through the:

- joint planning and co-ordination of Board and Committee business;
- sharing of appropriate information; and
- applicable escalation of concerns.

in doing so, this contributes to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.

6.3 The Committee shall embed the Health Board's agreed Values and Behaviours, as set out in the Board's Values and Behaviours Framework, through the conduct of its business.

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

- report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes verbal updates on activity, and the submission of Committee minutes and written reports;
- bring to the Board's specific attention any significant matters under consideration by the Committee;
- ensure appropriate escalation arrangements are in place to alert the Chair of PTHB, Chief Executive or Chairs of other relevant committees/groups of any urgent/critical matters

that may affect the operation and/or reputation of the Health Board.

7.2 The Board may also require the Committee Chair to report upon the Committee's activities at public meetings, e.g., Annual General Meeting, or to community partners and other stakeholders, where this is considered appropriate, e.g., where the committee's assurance role relates to a joint or shared responsibility.

7.3 The Board Secretary shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation including that of further committees established.

7.4 The Committee shall provide a written annual report to the Board on its activities. The report will also record the results of the Committee's self-assessment and evaluation.

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

8.1 The requirements for the conduct of business as set out in PTHB's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum
- Issue of Committee papers

9. CHAIR'S ACTION ON URGENT MATTERS

9.1 There may, occasionally, be circumstances where decisions which would normally be made by the Committee need to be taken between scheduled meetings, and it is not practicable to call a meeting of the Committee. In these circumstances, the Chair of the Committee, supported by the Board Secretary as appropriate, may deal with the matter on behalf of the Committee - after first consulting with at least two other Independent Members of the Committee. The Board Secretary must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.

9.2 Chair's action may not be taken where the Chair has a personal or business interest in the urgent matter requiring a decision.

10. REVIEW

10.1 These Terms of Reference shall be reviewed annually by the Committee. The Committee Chair will report any changes to the Board for ratification.

Incident Management
Final Internal Audit Report

January 2024

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-2324-05
Report status:	Final
Fieldwork commencement:	18th October 2023
Fieldwork completion:	1st December 2023
Debrief meeting:	8th December 2023
Draft report issued:	15th December 2023
Management response received:	29th December 2023
Final report issued:	3rd January 2024
Auditors:	Ian Virgill – Head of Internal Audit Andrea Calise – Audit Manager
Executive sign-off:	Claire Roche - Director of Nursing and Midwifery
Distribution:	Zoe Ashman – Assistant Director of Quality and Safety Heidi Sinclair – Head of Quality and Safety
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 the audit was to review the arrangements in place within the Health Board for the identification, recording, investigation, and management of incidents. The review also focused on the Health Board's ability to learn from incidents and take action to improve processes whilst sharing best practice across the Health Board.

Overview

We have issued reasonable assurance on this area.

The matters requiring management attention include:

- The Health Board's Incident Management Framework (June 2023) adopts the latest national guidance for managing incidents.
- Further engagement is required between the Quality and safety Team and Service Areas to better coordinate and further implement the incident management training programme.
- The Mental Health Service Area are dealing with a significant backlog of open incidents which have been dealt with and just awaiting finalisation/closure within Datix.
- Further work is required to ensure that lessons learnt from incidents are being monitored and actioned.
- Improvements required to ensure Nationally Reportable Incidents are reported within the required timescales.

Report Opinion

		Trend
Reasonable 	Some matters require management attention in control design or compliance. Low to moderate impact on residual risk exposure until resolved.	 Incident Management (PTHB-2223-06)

Assurance summary[1]

Objectives		Assurance
1	Incident management policies and procedures	Reasonable
2	Incident identification, recording and responsiveness.	Limited
3	Incident monitoring and reporting	Reasonable
4	Incident lessons learnt	Reasonable
5	External incident reporting (Nationally reportable incidents)	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	Incident reporting training	1&2	Operation	Medium
3	Incident reporting and management timeliness	2&3	Operation	High
4	Monitoring of actions arising from incident investigations	4	Operation	Medium
5	Nationally Reportable Incidents timeliness	5	Operation	Medium

1. Introduction

1.1 The review of 'Incident Management' was completed in line with the Powys Teaching Health Board's (the 'Health Board') 2023/24 Internal Audit Plan.

1.2 All NHS organisations are accountable for the quality and safety of care provided to their respective populations. They must report all incidents of patient harm and near misses locally through their local risk management systems. This includes incidents across the whole patient pathway. They should be investigated appropriately and proportionately with actions taken accordingly, in line with PTR requirements.

1.3 The Health Board is subject to the Duties within the Health and Social Care (Quality and Engagement) (Wales) Act 2020. The Duty of Candour focusses on the need to be open with patients, families and carers when things go wrong, building on the requirements already set out in Putting Things Right.

1.4 The Health Board has a revised Incident Management Framework in place which was approved in July 2023. Implementation of the Framework will further support the timely and robust management of incidents.

1.5 The Health Board's Serious Incident Policy Reporting, Investigating and Assurance Processes (PEP 004) underlines the procedures essential for the management of serious incidents in line with the Regulations as it applies to staff who have a responsibility to report and manage these serious incidents. "This policy sets out clear guidance on the management of serious incidents from the point of notification to closure of the related investigation, ensuring lessons have been learnt and shared, and assurance provided".

1.6 We previously carried out a review of Incident Management as part of the 2022/23 Internal Audit plan. The final report was issued in March 2023 with an overall rating of Reasonable Assurance. The 22/23 review focused on processes within the Community Services Group, the current review has focused on Women and Children Services and Mental Health Services.

1.7 The Executive Director of Nursing is the executive Lead for the review.

1.8 The potential risks considered during this audit are as follows:

- Non-compliance with relevant legislation;
- Patient harm or poor patient experience;
- Financial loss; and
- Reputational damage with decreased public confidence.

2. Detailed Audit Findings

Objective 1: The Health Board has incident management policies and procedures in place that are up to date and have been communicated to all staff and are readily available.

2.1 National incident reporting in NHS Wales underwent major changes from 14 June 2021 with the publishing of Phase 1 of the National Patient Safety Incident Reporting Policy by the Welsh Government. The NHS Wales National Incident Reporting Policy Implementation Guidance Document (Phase 1) was coordinated and produced by the NHS Wales Delivery Unit for use by all NHS Wales Organisations, supporting how NHS Wales responsible bodies will implement the Welsh Government's National Incident Reporting Policy.

2.2 In May 2023, the NHS Wales Executive published a revised National Incident Policy and Guidance document. Through the updated version of the Policy, the NHS Wales Executive has developed further on the initial aims (June 2021 policy) continuing to promote collaborative work between NHS Wales organisations and other key stakeholders in delivering a new system for collecting and analyzing incident data.

2.3 The Health Board's SharePoint site has a Quality and safety section which includes Health Board, Welsh Government and the Delivery Unit's policy, guidance documents, training updates, forms and templates. Our previous internal audit of the Health Board's incident management arrangements (see paragraph 1.6) made a recommendation relating to the number of incident management policies and procedures requiring review and update. We can confirm that the Quality and Safety Team has implemented this recommendation by combining all policies and procedures into one overarching Incident Management Framework ('the Framework') which was published in June 2023.

2.4 Our review of the Framework, which is available to all staff via the Quality and Safety section of the Health Board's intranet (SharePoint), confirms that the document aligns with the latest NHS Wales Executive national policy and Delivery Unit guidance on the management and reporting of incidents. We did note however, that there is one area of the National guidance which is not clearly set out within the Framework. **(Matters Arising 1 – Low Priority)**

2.5 As part of the scope for the audit, we considered the incident management arrangements locally for two Service Areas:

- Women and Children;
- Mental Health.

We met with governance and clinical leads for both areas and sighted various documentation (Standard Operating Procedure (SOP), flowcharts, policies and procedures) which confirmed alignment with the overarching Framework.

2.6 The Quality and Safety Team, supported by the Safety Systems and Information Coordinator deliver incident reporting and management training seminars twice monthly. These sessions are open to all staff who wish to attend and can register via the "Datix Training" section on the Quality and Safety page on the intranet (SharePoint).

2.7 As per paragraph 2.14, analysis of the incident data and findings from our sample testing of incidents logged on Datix system identified a high number of instances where staff have misclassified the levels of harm. Discussions with the Quality and Safety Team and with the respective governance leads from both sampled service areas confirmed that these are long standing issues which have been known to the Health Board and actions are being taken to ensure that there is a coherent and consistent understanding amongst staff of how to assess level of harm. As per paragraph 2.6, there is a training programme in place for new and existing users. In addition to this, as part of the Incident Management Framework implementation, the Q&S team will be reviewing the RCA framework and its implementation in line with the Patient Safety Incident Response Framework (PSIRF, NHS England). **(Matters Arising 2 – Medium Priority)**

2.8 The Quality and Safety Team are also in the process of reviewing training and support provided to teams in the event of a patient safety incident, to include walk-through of the incident, statement writing, support with Coroner's Court and debrief following this.

Conclusion:

2.9 The Health Board has developed a comprehensive Incident Management Framework (June 2023) which aligns to WG policy and NHS Wales Executive guidance. The Framework is supported by a plethora of SOPs, templates and guidance procedures all of which are accessible via the intranet. The Health Board needs to continue to progress with its Datix training programme to ensure compliance with the Framework and accurate use of Datix. We have provided **Reasonable Assurance** for this objective.

Objective 2: Incidents are identified and responded to in a timely manner and to the required standard in accordance with the relevant legislation.

2.10 In line with national guidance, the Health Board has implemented the "Once for Wales Concerns Management System" and records all patient safety incidents via the Datix module. To inform the review, we were provided with read only access to the incident database relating to the two sampled service areas; Mental Health and Women and Children.

2.11 It is the responsibility of the staff in the service where the incident occurred to notify of its occurrence via Datix and adequately complete the incident form with the relevant information. Incidents are managed at the service level and key staff have been identified within service areas to handle incident reporting. The Quality and Safety team provide continued support to embed robust assurance processes and learning from incidents.

2.12 Managers assign the investigators who are notified via a link within the email sent to them. The form is then changed to 'make safe'. Focused reviews of incidents are then undertaken by scrutiny panels. It is also stated how long the management actions will take in days. Recommendations, lessons learnt, and date completed are also entered on the form.

2.13 When initially logged on Datix incidents are assessed by the reporter (staff logging the incident) as either: no harm; low harm; moderate harm; severe harm; or

death. Investigations into reported incidents are managed by the governance team within each of the service areas and overseen by the Quality & Safety Team. Depending on the level of harm, staff are allocated responsibility for managing and investigating the incident case. For example, a low harm case is managed by operational management, while significant cases, whilst still being investigated within the service areas, will also involve the Quality and Safety team.

2.14 As per the scope of the audit, we performed an analysis of the Datix database for the two sampled areas. The dataset focused on incidents that had occurred between 1st April 2023 and 15th November 2023 with a "closed" status. The analysis considered the timeliness of incident initial reporting, management response, investigation and closure. Several observations were made:

- Whilst all incidents reviewed were in the "Low/No Harm" category, stages within the incident reporting and management process fell behind expected and established timelines. **(Matters Arising 3 – High Priority)**
- The reporter's assessment on the level of harm is often re-graded following management review/investigation. **(See Matters Arising 2)**
- Within the Women and Children Service Area, a large proportion of low/no harm incidents is being directed to the Women and Children Risk and governance Lead for "Management Review/Make Safe". As per paragraph 2.13, these incidents should be assigned to operational management. The disproportionate assignment of incident caseloads is a likely cause of the Women and Children Service Area falling behind incident reporting and management expected and established timelines. **(See Matters Arising 3**)
- Mental Health Service Area is currently dealing with a significant backlog of open incidents, the majority of which has a low/no harm impact and need to be closed. The Quality and Safety Team are undertaking regular training to address this issue (See paragraph 2.7)

2.15 In addition to the analysis of the Datix system we also selected a random sample of 20 closed incidents from across the two samples areas (10 each). Records and documentation stored to Datix confirmed the following:

- Assignment of responsible individuals for undertaking Management reviews/investigations;
- Evidence of near immediate "make-safe" actions taking place in all cases;
- Evidence of lessons learnt and action plans being in place (where investigations had been completed).

Conclusion:

2.16 Our data analysis demonstrates that key stages within the incident reporting and management process are currently falling behind the expected and established timelines. In particular for the Mental Health Service area, which is also dealing with a significant backlog of open and overdue incidents. We have provided **Limited Assurance** for this objective.

Objective 3: Incidents are reported, monitored and discussed at appropriate forums within the Health Board and are escalated where required to provide the required assurance.

2.17 The Safety Systems and Information Co-ordinator produces incident reports that are presented at various groups and committees, along with a dashboard report from the business intelligence section of Datix. Dashboards are developed manipulating data to meet the needs of specific service areas.

2.18 We can confirm that the data dashboards are readily available to all staff and are fully customisable at the request of the Safety systems and Information Co-ordinator. We also note that the Head of Quality and Safety monitors all open and overdue incidents across the Health Board and sends weekly emails to operational and senior management of the relevant Service Areas to promote timely closure and actioning of open incidents.

2.19 The Health Board's Integrated Quality Report (IQR), which is presented to the Executive Committee and to the Patient Experience, Quality and Safety Committee includes a serious incidents and concerns section. The reports for April, July and October 2023 were reviewed, the relevant areas of the report pertaining to the audit included:

- Reports on the current position of open NRI;
- Report on patient and non-patient safety per non, low, moderate, severe, Catastrophic & death level of harm;
- Highest reported incident themes: Pressure or moisture damage being the highest followed by trip, slip or fall; and
- Tabular presentation of new incidents, make safes, incident under investigation and those awaiting closure.

2.20 The Professional Nursing and Midwifery Oversight Group, which meets monthly and reports into the Patient Experience, Quality and Safety Committee, is a forum that provides assurance on Nursing Quality and Safety. Each Service Area provides a Quality Assurance Report on a number of themes, one of which is incident management. A review of the Quality Assurance Reports submitted in September, October and November 2023 confirmed that the following data is produced:

- Number of Nationally Reportable Incidents in the period;
- Update on serious patient safety/Duty of Candour incidents;
- Trends of incidents being submitted (year view);
- Breakdown of the categories of incidents submitted in period; and
- Breakdown of "Open Incidents" with an update as to where the service area is at ensuring completion.

2.21 We also reviewed the governance arrangements in place for the sampled Service Areas and can confirm that there are appropriate structures and reporting arrangements in place to discuss and escalate incidents (where applicable). We did note that there is limited scrutiny of the Datix data (open/overdue incidents

awaiting action, incident reporting and management performance). **(See Matter Arising 3)**

Conclusion:

2.22 The Health Board has a structure in place that provides effective mechanisms for incident reporting from a Service Area level up to the Quality and Safety Team and up to the Patient Experience, Quality and Safety Committee and the Board. Whilst the regularity of the current monitoring arrangements allows for the prompt escalation of incidents, further work is required to ensure that incident reporting and management data from Datix is routinely visible to operational management. We have provided **Reasonable Assurance** for this objective.

Objective 4: There is clear evidence of action being taken and lessons being learned and shared across the Health Board to minimise future occurrence where deficits are identified.

2.23 The Incident reporting form on Datix has a section where lessons learnt are to be documented. Depending on the level of harm and type of incident, the completion of the lessons learnt section might not be applicable. We selected a random sample of 20 recently completed investigations (10 from each Service Area) and can confirm that for all completed investigations in our sample, the lessons learnt had been captured. However, the action plan section within Datix was not completed and there was limited information available to confirm whether the actions had been completed. **(Matters Arising 4 – Medium Priority)**

2.24 Listening and learning events regularly take place within the Mental Health and Women and Children service areas. We saw that key themes and trends from high profile incidents are discussed and lessons learned with best practice guidance shared amongst staff in attendance.

2.25 The Quality and Safety Team produce quarterly newsletters providing information such as staff incident related training dates, key patient safety learning and actions, urgent safety briefings and safety alerts. Majority of the information is added to the Quality and Safety Section of the Intranet (SharePoint)

Conclusion:

2.26 Lessons learnt are documented on Datix and shared via a number of means at the Health Board level from reports presented at the PEQS to the learning newsletters and 7-minute briefs. Methodical sharing has been evidenced at the operational level within both Mental Health and Women and Children Service Areas. However, we have found that there is a lack of documentation to support the monitoring of action plans arising from incident investigations. We have provided **Reasonable Assurance** for this objective.

Objective 5: Relevant incidents, including nationally reportable incidents, are reported in a timely manner in accordance with national reporting requirements.

2.27 Nationally Reportable Incidents (NRI) are required to have a rapid meeting. This is held by those 'not' directly involved in the incident. All NRI's have an executive lead allocated to the incident who chairs the rapid meeting.

2.28 Once an incident is recognised as an NRI, an NRI notification is completed and sent to the Concerns Team, the concerns team subsequently cascades this to the right person. The NRI is then submitted to the Delivery Unit by either the Lead Clinician, Quality & Safety or the Ward sister. This is proof checked by the Executive Director of Nursing and Midwifery.

2.29 The Delivery Unit generates a dashboard of how many NRI the Health Board has reported, analysed across months, severity and location. The purpose of this reporting is to ensure good governance both on the part of the Delivery Unit, responsible for the national reporting process, and individual organisational governance responsibilities in complying with the published policies and guidance.

2.30 Performance in relation to Nationally reportable incidents from each Service Area are reported monthly to the Professional Nursing and Midwifery Oversight Group, to the Patient Experience, Quality and Safety Committee and to the Executive Team/Board. A review of the governance documentation for November 23 confirmed the there are currently 19 NRI's with an open status. Of the total, 7 relate to Mental Health Service area and 1 relates to Women and Children.

2.31 We performed a review of the NRI's with an open status as at November 2023 and can confirm that the Health Board has experienced delays in reporting 3 of the 8 NRI's that related to Mental Health Service and Women and Children. The reason for the delay in submission were noted within the Datix system and were reviewed and approved by the Executive Director of Nursing and Midwifery. All incidents remain open and have agreed "finalisation by" dates by NHS Wales Executive. A review of the monthly reporting confirms that updates on the progress of open/overdue NRI's are being provided to the PNMOG. **(Matters Arising 5 – Medium Priority)**

Conclusion:

2.32 The findings from our sample testing (incidents and Nationally Reportable Incidents) together with findings from our data analysis of the Datix system suggest that further work is required to ensure that incidents and Nationally Reportable incidents are reported in a timelier manner. The Health Board is aware of this and regular updates on incident management progress are being shared with Senior Management through the governance structure. We acknowledge that the Health Board has recently implemented a revised Incident Management Framework in July 2023 and that it will take time to fully implement and embed improvements to incident reporting processes. **Reasonable Assurance** against this objective.

Appendix A: Management Action Plan

Matter Arising 1: Incident Management Framework (Design)	**Impact**
In May 2023 the NHS Wales Executive published a revised National Incident policy and guidance document. Our review of the Health Board's Incident Management Framework found that it aligns to WG, NHS Wales Executive national policies and DU guidance. However, we did note that there is an area within the DU guidance that is not clear within the Health Board's Incident Management Framework (July 2023) - "Setting out the reporting lines into relevant committees and the Board". The NHS Wales National Incident Reporting & Management Policy sets out the requirement for clear and demonstrable lines of reporting across all parts of the organisation, including through relevant Committees of the Board. Although our review of the monitoring and reporting of incidents has identified that the Board and relevant committees are sighted on this information, the Incident Management Framework does not make reference to how reporting will take place.	Potential risk of: • Non-compliance with the most relevant legislation.

Recommendations		**Priority**
1	The Incident Management framework should be reviewed and updated so that it includes the incident management governance arrangements, specifically demonstrating the clear lines of reporting across all parts of the organisation, including through to the relevant Committees of the Board.	**Low**

Agreed Management Action		**Target Date**	**Responsible Officer**
1	Update the Incident Management Framework to reflect the Health Board governance arrangements for the management of Nationally Reportable Incidents.	February 2024	Head of Quality & Safety

Mills,Belinda
23/01/2024 16:55:35

Matter Arising 2: Incident Management Training (Operation)	**Impact**
Our data analysis of the Datix system noted that for a significant number of incidents (that had been closed and thus were subject to management review/investigation), the level of harm was incorrectly assessed by staff reporting the incidents. Our findings concluded that between April 2023 and November 2023 the following number of incidents were regraded: • Women and Children – 35 incidents of a total of 141 – 25%. • Mental Health – 65 incidents of a total of 104 – 63%. We note that following management review/investigation the above incidents were graded to low/no harm. We reviewed a random sample of incidents which were regraded and can confirm that the rational for changing the level of harm was justified and thus the incidents fell into the low/no risk category. Discussion of the above findings with senior management from both service areas confirmed a general consensus that this is a training issue.	Potential risk of: • Non-compliance relevant incident reporting and management requirements.

Recommendations		**Priority**
2	A training needs analysis be undertaken to ensure that staff understand the incident reporting process and are effectively assessing the level of harm caused. Senior management from service areas should engage and coordinate any identified training requirements with the Quality and Safety Team.	**Medium**

Agreed Management Action		**Target Date**	**Responsible Officer**
2	Governance leads for service groups to complete a training needs analysis to highlight staff members that have not completed Datix Incident Management training.	March 2024	Governance Leads:

Mills, Belinda 23/01/2024 16:55:35

Matter Arising 3: Incident reporting and management timeliness (Operation)	Impact
We performed an analysis of the Datix database for the two sampled areas. The dataset and range was limited to incidents that had occurred within the current financial year to date (1st April 2023 to 15th November 2023 and with a "closed" status. The analysis considered the timeliness of incident initial reporting, management response, investigation and closure. To note that within this period, there were no closed incidents, which following management review/investigation, were assessed as having a level of harm which was moderate or above.	Potential risk of: • Non-compliance with relevant legislation. • Patient harm or poor patient experience. • Reputational damage with decreased public confidence.

Women and Children Service Area (Between 1st April 23 and 15th November 23 – total of 141 incidents closed) Indicators	**Expected and established timelines**	**Low/No Harm** (Average days taken by Health Board)	**Notes**
Average days to report incident within Datix from incident occurrence	Within 1 day	**8 days**	Note 1
Average days for incident to be at Management review stage (Make it Safe plus)	Within 2 days	**18 days**	Note 2
Average days for investigation to complete	Within 24 days	**18 days**	Within timescales
Average days for incident to be closed (overall cycle)	Within 29 days	**22 days**	Within timescales

Note 1: Midwiferies Cynefin and Midwifery Dylife the worst performers taking on average 18 and 13 days respectively to report Datix incidents from the incident date.

Note 2 Further analysis found that within the Women and Children Service Area, a large proportion of low/no harm incidents is being directed to the Women and Children Risk and governance Lead for "Management Review/Make Safe". As per paragraph 2.13, these incidents should be assigned to operational management.

This disproportionate caseload assignment is a likely cause of the Service Area falling behind the above expected and established timelines.

Mental Health Service Area (Between 1st April 23 and 15th November 23 – total of 104 incidents closed) Indicators	**Indicative Timescales**	**Low/No Harm**	**Notes**
Average days to report incident within Datix from incident occurrence	Within 1 day	**3 days**	Note 3
Average days for incident to be at Management review stage (Make it Safe plus)	Within 2 days	**16 days**	Note 4
Average days for investigation to complete	Within 24 days	**21 days**	Within timescales
Average days for incident to be closed (overall cycle)	Within 29 days	**37 days**	As per note 4

Note 3: 20 incidents took on average 6 days to be reported and the likely cause for skewing this indicator.

Note 4: Discussions with the Head of Nursing – Quality and Safety and with the Lead Clinician – Quality and Safety confirmed that the Service Area has and continues to deal with operational pressures and capacity challenges which are having a knock-on effect on other processes such as the timely management and closure of incidents within Datix. As at the 15th November 2023, there were 179 open incidents within Datix for Mental Health Service area of which:

- *2 incidents had been reviewed and investigated and were awaiting closure;*
- *175 incidents were at Management Review stage. Of the total, 134 had elapsed the 29 days overall turnaround time and were considered "overdue". Discussions with the leads confirmed that the majority of these incidents had been reviewed and were of low/No harm and needed closing.*
- *2 incidents were under investigation.*

Similar incident reporting and management issues were also identified as part of last year's internal audit review (see paragraph 1.6) which focused on Community Service Groups.

Open and overdue incidents are also discussed at the Professional Nursing and Midwifery Oversight Group (PNMOG), which meets monthly and is chaired by the Executive Director of Nursing and Midwifery and attended by Service Area leads and the Quality and Safety Team. A review of the PNMOG which met in November, confirmed that the Health Board is aware of the current levels of open/overdue incidents and as of September 2023, the Datix notification system has been amended so that staff with allocated open/overdue incidents are notified. The Quality and Safety Team have been tracking the trends of open incidents and have noted a significant improvement in October 2023 with a 157% increase in incident owners investigating and closing incidents.		
Recommendations		**Priority**
3	Senior management within Service Areas should ensure that: • Incidents are processed within the expected timeframes as stated in the policy and framework, or within a reasonable timeframe. A review is undertaken of the key parts of the process where significant delays are occurring with a view to understanding any reasons behind the delay and revising or refining approaches to help reduce these delays. • The current reporting capabilities of the Datix system and the weekly monitoring efforts by the Quality and Safety Team are being exploited. • Datix reports of open/overdue incidents, incident reporting and management performance be shared and discussed within the governance structures of the Service areas.	**High**
Agreed Management Action	**Target Date**	**Responsible Officer**
3 Services to provide an action plan for improvement to support how they intend to manage overdue incidents along with timely management of new incidents in line with the Incident Management Framework.	March 2024	Respective Heads of Nursing and Midwifery

Matter Arising 4: Monitoring of Actions from Lessons Learnt (Operation)	**Impact**
The lessons learnt section on the incident reporting form on Datix is usually completed and is documented based on the uniqueness in learning of the reported event. Depending on the type of incident, the completion of the lessons learnt section might not be applicable. Evidence from reviewing the Directorate of Nursing and Midwifery and Health Board reports, shows synopsis in the identification of lessons learnt. Listening and learning events regularly take place within the Mental Health and Women and Children service areas. We saw that key themes and trends from high profile incidents were being discussed with lessons learned and best practice guidance being shared amongst staff in attendance. However, we noted that there is currently no form of monitoring (on one system/ database) of the lessons learnt over time and actions which have been undertaken operationally to minimise future occurrence where these deficits are identified. This issue was also identified as part of last year's incident management audit.	Potential risk of: • Non-compliance with relevant legislation. • Patient harm or poor patient experience. • Reputational damage with decreased public confidence.

Recommendations		**Priority**
4	Management is advised to have a system where lessons learnt (and mitigating actions) are collated, especially those that have been seen as a recurring theme across the Health Board and monitored to help mitigate/avoid/minimise further occurrence.	**Medium**

Agreed Management Action		**Target Date**	**Responsible Officer**
4	Services to review systems in place to monitor lessons learned to support appropriate triangulation and improvement.	May 2024	Respective Heads of Nursing/Midwifery

Mills,Belinda 23/01/2024 16:55:35

Matter Arising 5: Nationally Reportable Incidents (Operation)	**Impact**
The Quality and Safety Team reports on status of open Nationally Reportable Incidents on a monthly basis to the Professional Nursing and Midwifery Oversight Group. We reviewed the latest NRI report presented to the Group in (November-23) and can confirm that progress of NRI's is being monitored with actions agreed to ensure that the stages for reporting NRI's are being undertaken. As at November 2023 there were 19 NRI's with an open status for which 7 related to Mental Health Service area and 1 related to the Women and Children Service area. Further investigations of the Datix system confirmed that 3 of the open NRI's that related to the Mental Health Service area had not been reported to the NHS Wales Executive in a timely manner. We also noted that one of the open NRI's for Mental Health Service Area (ref:3944), which occurred in April 2022, is yet to be reported to the NHS Wales Executive. The Quality and Safety Team and the Management from Mental Health service area are currently in the process of retrospectively reporting the incident to the NHS Wales Executive. We acknowledge that the issues above relate to incidents that had occurred prior to the implementation of the Incident Management Framework (June 2023) and that the recently established PNMOG, which is attended by the executive Director of Nursing and Midwifery, will continue to monitor open NRI and their submissions on a monthly basis.	Potential risk of: • Non-compliance with relevant legislation. • Patient harm or poor patient experience. • Reputational damage with decreased public confidence.

Recommendations		**Priority**
5	Arrangements be put in place to ensure that Nationally Reportable Incidents are reported to the NHS Wales Executive in line with the required timescales set out in the National Policy on Patient Safety Incident Reporting & Management (March 23).	**Medium**

Mills, Belinda 23/01/2024 16:55:35

Agreed Management Action		Target Date	Responsible Officer
5	Monitoring of arrangements in place to ensure incidents are reported in a timely manner to the NHS executive. Monthly reporting to Executive Committee to ensure executive oversight.	January 2024	Assistant Director of Quality & Safety

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.

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Patient Experience Quality and Safety Committee 2023-24

Theme	Item Title	April 25/04/2023	July 04/07/2023	October 24/10/2023	January 23/01/2024	Comments
Governance	Minutes of previous meeting	✓	✓	✓	✓	
Governance	Declaration of Interests	✓	✓	✓	✓	
Governance	Action Log	✓	✓	✓	✓	
Governance	Committee Risk Register	✓	✓	☒	✓	
Governance	Annual Work Programme	✓				
Governance	Work Programme (updated through year)		✓	✓	✓	
Governance	Annual Assessment of Committee Effectiveness	✓		x	✓	
Governance	Committee Annual Report	✓				Scheduled for April 2024
Governance	Review of Terms of Reference			☒	✓	
Performance	Integrated Quality Report	✓	✓	✓	✓	
Performance	Maternity and Midwifery			✓		
MH Compliance	MH Power of Discharge Annual Report including MH compliance with legislation		✓		✓	
Clincial Audit	Annual Programme				☒	Scheduled for April 2024
	Progress Report		✓			
Audit	Potential Report giving sight of IA and EA reports, actions and management responses (ARAC retain responsbility for monitoring)			✓		
Clinical Quality	Clinical Quality Framework					Will form part of 24/25 work programme
Medicines Management	Annual Report of Accountable Officer for Controlled Drugs				✓	
Medicines Management	Medicines Management Annual Report		☒	✓		
Safeguarding	Safeguarding Annual Report		✓	☒		
	Children's Services					Will form part of 24/25 work programme
Improvement and Innovation	Overview of research and development activity					Will form part of 24/25 work programme
	Alignment with national objectives published within Health and Care Research Wales					Will form part of 24/25 work programme
	An overview of the quality improvement activity within the organisation					Will form part of 24/25 work programme
Infection Prevention and Control	IPC Assurance Report		✓			
	IPC progress/focus				✓	
Patient Experience	Patient Experience approach / outline - within IQR		✓			
Other reports/Action log requests	PEQS/22/51 Presentation on MH Services in public session		✓		✓	
	Report on National Commissioning Functions Review					Has formed part of Board Development discussions
	111 press 2 - 12 week review		☒	✓		
	Child Practice Review outcome (when completed)					Published date expected early February 2024
	Individual Patient Funding requests					On March 2024 Board agenda
Additional Items:	Implementation of WG guidance on transition and handover from Children's to Adult's Mental Health Services			✓		
	Statement of Commitment to Infection Prevention and Control			✓		
	PSOW Annual Letter (within Integrated Quality Report)			✓		
	Cancer Improvement				✓	
	Annual Report Medical Devices and Point of Care Testing			✓		
	Update on Level 3 Safeguarding Training PEQS/23/23b				✓	
	Outcome of Joint Inspection of Child Protection Agencies				✓	
Key						
Date to be confirmed						
Item to be confirmed						
Item deferred						
Item brought forward						
Going to Board						
Due to Committee						
Find Exec Cttee date						
Added to draft agenda						