Patient experience, Quality and Safety Committee

Tue 30 July 2024, 09:30 - 12:30

Agenda

09:30 - 09:30
0 min

1. PRELIMINARY MATTERS

PEQS_ Agenda_30JUL24 FINAL.pdf (2 pages)

1.1. Welcome and Apologies

1.2. Declarations of Interest

1.3. Minutes from the previous meeting held on the 16 April 2024 for approval

PEQS_1.3_unconfirmed PEQS Minutes 2024-04-16.pdf (15 pages)

1.4. Patient Experience, Quality and Safety Committee Action Log

PEQS_1.3_Action Log July 2024.pdf (2 pages)

1.5. Patient Story

09:30 - 09:30
0 min

2. ESCALATED ITEMS

2.1. Infection Prevention and Control - Annual Report

PEQS_2.1_IPC report cover.pdf (7 pages)
PEQS_2.1a_IPC Annual Report 23-24.pdf (25 pages)

2.2. Mental Health Services Escalation Assurance Report

To follow

PEQS_2.2_MH cover.pdf (7 pages)

09:30 - 09:30
0 min

3. ITEMS FOR ASSURANCE

3.1. Integrated Quality Report Quarter 1

PEQS_3.1_Integrated Quality Q1 report July 2024.pdf (14 pages)
PEQS_3.1a_ App A HIW Thematic Review.pdf (8 pages)
PEQS_3.1b Appendix B Maternity Feedback poster.pdf (11 pages)

3.2. Care Inspectorate Wales Report - Cottage View, Knighton

PEQS_3.2_Cottage View CIW Report Cover Paper.pdf (6 pages)
PEQS_3.2a_CIW Inspection Report Cottage View.pdf (10 pages)

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3.3. Health Inspectorate Wales - DNACPR Review

PEQS_3.3a_Healthcare Inspectorate Wales - DNACPR Review.pdf (46 pages)

09:30 - 09:30
0 min

4. CONSENT AGENDA

4.1. Mental Health Power of Discharge Annual Report - including Mental Health compliance with legislation

PEQS_4.1_MHA Compliance Report Apr 23 to Mar 24.pdf (10 pages)

09:30 - 09:30
0 min

5. ITEMS FOR APPROVAL

There are no items for approval

09:30 - 09:30
0 min

6. ITEMS FOR DISCUSSION

There are no items for discussion

09:30 - 09:30
0 min

7. ITEMS FOR INFORMATION

7.1. Internal Audit Reports

PEQS_7a_CHC FNC Final Internal Audit Report.pdf (20 pages)
PEQS_7b_Patient Experience Final Internal Audit Report.pdf (12 pages)

7.2. WHSSC Quality Patient Safety Committee Chairs Report February 2024

PEQS_7c_Quality Patient Safety Committee Chairs Report.pdf (16 pages)

09:30 - 09:30
0 min

8. OTHER MATTERS

8.1. Committee Risk Register

PEQS_8.1_Committee Risk Report.pdf (3 pages)
PEQS_Item_8.1_Appendix A_Committee Risk Register_July24.pdf (12 pages)

8.2. Committee Work Programme

PEQS_8.2_Work Programme July 2024.pdf (1 pages)

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

PEQS_Item_8.3_ Escalated Items.pdf (4 pages)

8.4. Any Other Urgent Business

8.5. Date of the Next Meeting: 5 September 2024

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8.6. Close

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POWYS TEACHING HEALTH BOARD
PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE

TUESDAY 30 JULY 2024
09:30 – 12:30
VIA MICROSOFT TEAMS

AGENDA				
Time	**Item**	**Title**	**Attached/Oral**	**Presenter**
	1	**PRELIMINARY MATTERS**		
09:30	1.1	Welcome and Apologies	Verbal	Chair
	1.2	Declarations of Interest	Verbal	All
	1.3	Minutes from the previous Meeting held on 16 April 2024	Attached	Chair
	1.4	Committee Action Log	Attached	Chair
10.15	1.5	Patient story (nb to be taken after item 2.2)	Verbal	Executive Director of Nursing, Quality, Women and Family Health
	2	**ESCALATED ITEMS**		
09.40	2.1	Infection Prevention and Control – Annual Report	Attached	Executive Director of Nursing, Quality, Women and Family Health
09.55	2.2	Mental Health Services Escalation assurance report	Attached	Executive Director of Nursing, Quality, Women and Family Health
	3	**ITEMS FOR ASSURANCE**		
10.30	3.1	Integrated Quality Report – Quarter 1	Attached	Executive Director of Nursing, Quality, Women and Family Health
10.50	3.2	Care Inspectorate Wales Report Cottage View, Knighton	Attached	Executive Director of Allied Health Professions, Health Sciences and Digital
11.00	**COMFORT BREAK (15 minutes)**			
11.15	3.3	Health Inspectorate Wales – DNACPR Review	Attached	Medical Director
	4	**CONSENT AGENDA**		
10.25	4.1	Mental Health Power of Discharge Annual Report including Mental Health compliance with legislation	Attached	Executive Director of Primary Care, Community and Mental Health
	5	**ITEMS FOR APPROVAL**		
		There are no items for approval		
	6	**ITEMS FOR DISCUSSION**		

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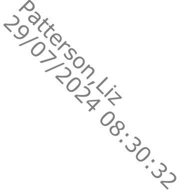
		There are no items for discussion		
	7	**ITEMS FOR INFORMATION**		
		Internal Audit Reports: – Continuing Health Care – Patient Experience WHSSC Quality Patient Safety Committee Chairs Report		
	8	**OTHER MATTERS**		
12.20	8.1	Committee Risk Register	Attached	Director of Corporate Governance
	8.2	Committee Work Programme	Attached	Director of Corporate Governance
	8.3	Items to be Brought to the Attention of the Board and/or Other Committees • Review of Escalated Items	Verbal	Chair
	8.4	Any Other Urgent Business	Verbal	Chair
	8.5	Committee feedback	Verbal	Chair
	8.6	Date of the next meeting: • PEQS 5 September 2024 • Joint PEQS and Workforce and Culture 10 October 2024 • PEQS 7 November 2024 – in person, venue tbc		
12.30		Close		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POWYS TEACHING HEALTH BOARD
PATIENT EXPERIENCE, QUALITY & SAFETY COMMITTEE

UNCONFIRMED

MINUTES OF THE MEETING HELD ON TUESDAY 16 APRIL 2024 VIA MICROSOFT TEAMS

Present:

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

In Attendance:

Claire Roche (CR)	Director of Nursing and Midwifery
Kate Wright (KW)	Medical Director
Pete Hopgood (PH)	Director of Finance, Information and IT
Hayley Thomas (HT)	Chief Executive
Zoe Ashman (ZA)	Assistant Director of Quality and Safety
Jason Crowl (JC)	Assistant Director Health and Safety and Support Services
Helen Bushell (HB)	Director of Corporate Governance
Amanda Edwards (AE)	Assistant Director – Innovations and Improvement

Observing:

Carl Cooper (CC)	Chair PTHB
Ian Virgil (IV)	Internal Audit
Daisy Dee (DD)	Health Inspectorate Wales

Apologies for absence:

Joy Garfitt	Interim Director Operations, Community Care and Mental Health
Claire Madsen	Director of Therapies and Health Sciences
Mererid Bowley	Director of Public Health
Debra Wood Lawson	Director of Workforce and OD
Sonia Thomas	Llais

Committee Support:

Liz Patterson	Interim Head of Corporate Governance

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PEQS/24/01	**WELCOME AND APOLOGIES FOR ABSENCE** KWi welcomed all to the meeting. Apologies for absence were noted as recorded above.
PEQS/24/02	**DECLARATIONS OF INTERESTS** No interests were declared in addition to those already declared in the published register.
PEQS/24/03	**MINUTES OF THE EXPERIENCE, QUALITY AND SAFETY COMMITTEE MEETING HELD ON 23 JANUARY 2024** The minutes of the previous meeting held 23 January 2023 were AGREED as a true and accurate record subject to the inclusion of the rationale for items to be held In-Committee.
PEQS/24/04	**PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE ACTION LOG** KWi presented the action log noting that there were two completed actions, three actions not yet due and four actions which were given the following oral updates: • **PEQS/23/40 The disaggregation of inherited and acquired pressure sore incident** – CR advised this work had been delayed due to significant absences in the Community Services Group, but this would be picked up and included in the Integrated Quality Report. Action to remain open. • **PEQS/23/23a -The Mental Capacity Act and the backlogs in the system** – CR advised a paper was considered at Executive Committee with an action to discuss at the Joint Leadership Team (JLT) with Powys County Council. A workshop has taken place with operational leads where actions and solutions were identified to improve the response to the Mental Capacity Act. The implementation of these solutions will be fed back to JLT and to this Committee. Action to remain open. • **PEQS/23/12 – process of off listing patients and number of patients affected under GP Behavioural Contracts** – PH advised that liaison had taken place with Llais, and an update would be circulated to the Committee. Action to be closed on receipt of information. • **PEQS/23/63 – Safeguarding training implementation** – CR advised that this information was contained within the cover paper for the Joint Inspection of Child Protection arrangements. Action

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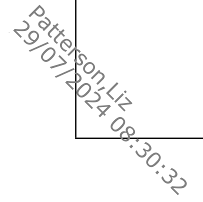
	Closed. The updates to the Action Log were NOTED.
ITEMS FOR ASSURANCE	

PEQS/24/05	**INTEGRATED QUALITY REPORT:**
	CR presented the report and drew attention to the following areas:-
	• All implementation actions are complete for the Duty of Candour;
	• Four actions remain outstanding for the implementation of the Duty of Quality which are due for completion by June 2024;
	• A full update on the implementation of the Duty of Quality and Candour will be provided in the first Annual Report;
	• Compliance with the 30 day response time for Putting Things Right (PTR) has increased from 27% two years ago, to 57% last year and 81% this year;
	• The proportion of complaints settled by early resolution is showing a gradual increase from around half to two thirds over the last nine months;
	• The number of Duty of Candour cases is increasing as colleagues become familiar with the new duty;
	• The Infection Prevention and Control (IPC) action plan is nearing conclusion, and all actions are on track for completion;
	• A summary of outstanding Health Inspectorate Wales actions is provided showing six actions overdue, four actions with revised timescales and eight actions not yet due, and
	• There are two key matters for Board highlighted:
	  o The resource to support patient experience, and
	  o Timely management of incidents
	
	Independent Members asked the following questions for assurance:
	
	All six overdue HIW actions involve the local authority. Is the local authority engaging in partnership on these matters?
	
	DF confirmed that whilst there were six overdue actions when the report was compiled, since then these six actions have been addressed. ZA advised that any updates to the tracker are quality assured before they are reported as complete.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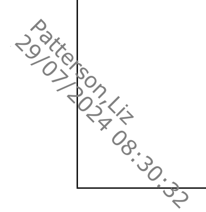
	The report includes some welcome improvements in a number of areas. Will it be possible to maintain and improve further on the position? CR expressed confidence the improvements would be sustained given the trajectory had been over two years. That there is no longer a backlog of outstanding complaints gives further confidence the position can be maintained. *Now that the necessary kit has been purchased to record patient stories, will these be shared with Board and Committee to demonstrate the Health Board is a learning organisation?* CR advised that in the absence of a dedicated Patient Experience team, the team were seeking to resolve this across the organisation with the intention of working in a matrix style to maximise the benefits of the resources available. *Is it possible to test how the successful the learning environment is?* CR advised that the newly approved Integrated Quality and Performance Framework, which includes local escalation arrangements, and the establishment of an Integrated Quality and Performance Group should enable reporting which will demonstrate the success of the learning environment. It is expected that this will take approximately two years to reach maturity. KW added that the Learning Group was maturing, and additional information could be shared with Committee on the themes and methods of sharing learning. Clinical audits also play a role in demonstrating learning, and finally, a reduction in the number of incidents received can demonstrate learning. *The sustained improvement is welcomed, and the work undertaken to reach this position is noted. The report notes significant challenge continues with the timely management of incidents. What actions are being taken to address this?* ZA advised that improvements in the management of incidents have been more complex as a new system was implemented last October. At this point there were over 2,000 open incidents, these have been reduced to approximately 1,000 open incidents with around 150 incidents occurring each month. Incident reporting has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been impacted by the Duty of Candour, but the team are improving at a sustainable pace. The highest risk cases have been reviewed and staff have been trained on incident management. The improvement trajectory around incidents could be shared with Committee.

Action: Assistant Director of Quality and Safety

How is the patient experience data captured in the Civica system being used to inform learning and commissioning?

ZA advised that responses via the Civica system from a commissioned care perspective had increased over the last 4-5 months from around 150/month to 270/month. Overwhelmingly positive feedback had been received relating to care provided by the Wye Valley NHS Trust, but further detail shows that after care provided in the community was good too. As this information is shared teams become more proactive in seeking feedback which has led to an increase in patient experience data. The intention is to share this feedback with GP practices where much of the care takes place.

Is there capacity within the team to service the level of patient experience data that is now available?

ZA advised that it would be necessary to scope the requirements in relation to the duty of quality, duty of candour and reporting requirements of the Integrated Quality and Performance Report.

On Graph 6 (feedback on Your NHS Experience), why are the last two months showing mostly red performance?

ZA advised that some of this performance is likely to always be red, for example 'were you able to speak Welsh to staff' is likely to be red for care provided in England, however, there were particularly low numbers of responses in February and March which may skew the figures. A fuller report on this information can be provided to the next meeting.

Action: Assistant Director of Quality and Safety / Director of Nursing, Quality, Women and Family Health

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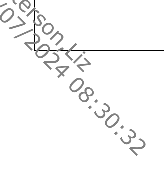

	The information presented on Living Well is welcomed. Could a similar focus on other services be provided in future reports? ZA confirmed a similar highlight on other services would be included in future reports. **Action: Assistant Director of Quality and Safety / Director of Nursing, Quality, Women and Family Health** *How will the effectiveness of the Quality and Engagement Act Implementation be monitored?* CR noted that there is a cultural element to many of the indicators and the confidence to identify a duty of candour case is one which can indicate effective implementation of the Quality and Engagement Act. *In relation to the Health Inspectorate Wales reports what is the difference between an amber and red classification?* CR confirmed that an amber classification meant a timescales had been revised, whereas a red classification meant the action was overdue. *Can the number of Nationally Reportable Incidents (NRIs) be confirmed?* ZA confirmed that the number of NRIs was 18. This was likely to be lower in the next report as a number of cases were awaiting quality assurance before sign off. The Committee: • RECEIVED 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.
PEQS/24/06	**MENTAL HEALTH QUALITY AND SAFETY REVIEW** CR introduced the report in response to some of the actions on the Action Log and in relation to Chief Executive's request for a deep dive into Mental Health incident management, outlining some of the actions taken since the previous meeting of this Committee. Attention was drawn to the following matters: • an audit of the clinical systems had been undertaken - this identified a number of gaps requiring

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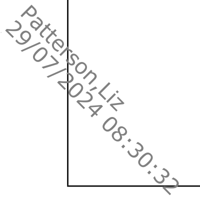
	triangulation of the ongoing work being progressed through incident management, • the Integrated Quality and Performance framework has been updated to include a proposed internal escalation framework, • local Mental Health services have been placed into a period of escalation; at level 2A, and • an escalation oversight meeting has been created. DF advised the team had been supported with operational oversight and resources to deliver the actions. The team were making good progress. KW advised that the team had experienced difficulties with staff absence and one of the Assistant Medical Directors was assisting with ensuring polices were up to date which provided additional capacity. HT noted that the learning from local escalation of maternity services had informed the internal escalation framework, including in relation to de-escalation. The Executive Team have provided wrap around support for the service to aid improvement. The letter from the regulator was received after local escalation had been implemented and the relationship with the regulator will be key. Independent Members asked the following questions for assurance: *How are the staff within a service supported when the service is put into escalation? Is there shared experience from maternity services that can be used to support colleagues in mental health?* CR confirmed that for any improvement to be successful, staff need to feel psychologically safe and can speak up. Having this support is extremely important and has been a priority in moving forward with this process. The senior Mental Health team are putting together a variety of different forums to support the staff on the ground, including multiple meetings and walk arounds. The Executive Management team are providing support to Senior Managers on a team and individual basis. In addition, there is ongoing dialogue with the Midwifery team who have previously experienced escalation. *What happens after de-escalation, will the Health Board be in a similar situation in another 12 months' time? Is there something more radical that needs to be done to prevent further occurrence of this situation?*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	HT confirmed the need for a safe service with the current model; that the nature of the demand, the clinical presentation and acuity of patients had changed substantially. This has happened across the whole system. Actions need to be taken to address the current situation, and sustainability conversations are needed as part of the Accelerated Sustainable Model; these will involve staff working within the service and will need to fit into the regional and national model for mental health. DD (Health Inspectorate Wales representative) noted the HIW had written to the Health Board regarding a cluster of concerns. A follow up meeting has been scheduled to determine next steps and timescales. *What arrangements have been made for stakeholder engagement with service users and other key partners. How is reassurance going to be provided to users and key stakeholders in relation to this escalation.* CR advised an engagement plan is to be developed, this will include all stakeholders and Llais and will use existing engagement arrangements including the Mental Health Patient Experience Forum. Board will be appraised via the Committee Chair's report. *How will improvement be measured, and does the service have sufficient capacity to make the necessary improvements and attend to service transformation under the Accelerated Service Model?* CR confirmed a continuous improvement plan has been devised, which has been divided into two parts – part A and part B. Part A looks at the improvements required to be in a recovery position, looking at the key indicators that led to the decision of escalation; Part B is linked to the medium-longer term transformation of the service. HT reported that steps have been taken to deal with the immediate issues which had taken considerable resource. There are ongoing conversations with the Executive team regarding protecting the capacity for this work to be undertaken. There is a need to engage with the current teams on transformation and change, to identify efficiencies and be an effective as possible. KWi noted this Committee will receive formal progress updates for the duration of the escalation period for Mental Health Services.

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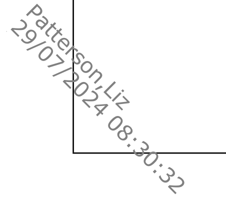
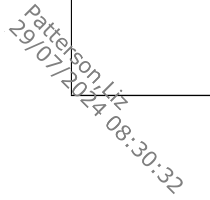


	The Committee: 1. **NOTED** the actions that have been taken since 23 January 2024 2. **NOTED** the escalated status of Mental Health Services to Level 2a (in line with the newly approved escalation framework within the Integrated Quality and Performance Framework IQPF) **3.** Took **ASSURANCE** of the plans in place to monitor progress in mental health services to ensure effective oversight, assurance and improvement.
PEQS/24/07	**CLINICAL AUDIT ANNUAL PROGRAMME** KW presented the Clinical Audit Plan and drew attention to • a continual aim of strengthening the plan; • improved triangulation of concerns and incidents; • more focus on areas of new practice and new policies; • reviewed the plans to avoid repeated audits on areas where assurance has been provided; • will participate in national clinical audits when the programme has been clarified; • received a 'substantial' Internal Audit on the clinical audit plan with 'reasonable' for capacity. The team has worked with clinical teams with an aim to ascertain the capacity gap; and • Mental Health audit plan has been strengthened focused; it is expected this will evolve as the service works through a period of escalation. IV (Internal Audit) confirmed the position in respect of Internal Audit and welcomed that the recommendations regarding capacity were being addressed. HT observed that audits varied in terms of resource required and that examination of the experience of teams audited this year may assist in mapping future capacity requirements. *When will the information on Primary Care Group GP Services (p18 of the report) be available?* KW advised the dates and themes of the GP services audits are to be added to the plan. **Action: Medical Director** The Committee RECEIVED and APPROVED the clinical audit plan 2024-2025.



PEQS/24/08	**JOINT INSPECTION ON CHILD PROTECTION ARRANGEMENTS (JICPA) ACTION PLAN** CR presented the report, providing an overview of the improvements allocated to the Health Board, the actions required, by when and by whom and how these actions have been Red Amber Green (RAG) rated. These actions will be reviewed internally through the Safeguarding Strategy Group and the arrangements for monitoring the multi-agency improvement plan will be taken through the partnership arrangements that are currently in place. Independent Members asked the following questions for assurance: *Can you give an insight into the challenges when identifying the levels of training appropriate to members staff.* The Health Board had already identified this as a key area for improvement and had agreed a series of actions to take and monitor through the Strategic Safeguarding Group. The recommendations of JIPCA added to this. The training requirements have been identified with the team and workforce colleagues. It has been necessary to ensure that staff are released for training and there is capacity within the safeguarding team to be able to provide the training. Now there is a full complement of staff supporting the safeguarding team, there is confidence the necessary mechanisms are in place to increase the training. *Is Improvement 3 (…children in Powys frequently require access to health care and services across borders…) an IT or a commissioning team issue?* CR advised this recommendation came from information and intelligence that was gleaned from the staff survey. This is one of the key areas that staff reported as being problematic. Firstly, there is a need to collaborate with the teams to fully understand the issue to inform the next phase of the improvement plan. It was noted that there is further work is ongoing, the progress against the action plan will be reported quarterly to the Safeguarding Strategic Group, the Executive Committee and to this Committee.

	Action: Director of Nursing, Quality, Women and Family Health The Committee: 1. **NOTED** the Joint Inspection of Child Protection Arrangements (JICPA) report and findings. 2. **NOTED** the improvements identified for PTHB and took **ASSURANCE** from the arrangements for monitoring progress. 3. **NOTED** the arrangements for monitoring the multi-agency whole system improvement plan.
PEQS/24/09	**CHILD PRACTICE REVIEW** CR presented the report drawing attention to the recent publication of the Child Practice Review (CPR) relating to the sad death of a young person that was a Powys resident. The report does not go into detail but describes the work done to date, and how the findings of the Child Practice Review will continue to inform the improvements and actions to be undertaken by the Health Board. Attention was drawn to following matters: • the action plan will be owned by Mid and West Wales Safeguarding Board; • the action plan will not be made public; and • the Health Board will ensure that, in line with the Duty of Quality and Candour, the actions within the organisations responsibility are undertaken. Independent Members asked the following questions for assurance: *What is the gap in professional curiosity that this report highlights? What has been done to address this, should that gap exist?* CR advised that safeguarding was a highly complex area and whilst professional curiosity was required it was necessary to remember that human factors are at play in the way caseloads are managed and how day to day events are presented to professionals. Many factors will impact on a clinicians assessment, but some factors may not be seen by the clinician. KW noted professional curiosity was critical and this was a welcome reminder of this. *The report says that an annual audit plan of the Children Not Brought policy was carried out in December. What was*

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	the outcome of that? From previous experience children who are not brought and children who are not visible are a common theme in Child Practice Reviews. CR advised that the outcome of the Audit would be shared with Members. *What mechanisms can be strengthened to ensure that the voice of the child is heard when dealing with complex cases?* CR advised much of work has been done to ensure that for Children Looked After, that the young person's social and care plan is owned by them in partnership with health providers and social workers as part of the care coordination team. It is good practice to be able to demonstrate that the voice of the child is front and centre to their care plan. For a very young child the Parenting Charter and the voice of the parent is very important. The outcome of the Was Not Brought Audit in December 2023 is to be circulated to the Committee. **ACTION: Director of Nursing, Quality, Women and Family Health** A report is to be provided to a future meeting of the Committee focusing on the work being undertaken, and the mechanisms in place to ensure that the voices of the children and young people are being heard. **ACTION: Director of Nursing, Quality, Women and Family Health** The Committee: 1. **NOTED** the recommendations within the Concise Practice Review for PTHB, 2. **NOTED** the reviews and improvements undertaken to date., 3. **NOTED** the internal process to implement and monitor the PTHB Specific Practice Review Learning within the Safeguarding Practice Improvement Group which reports to the Strategic Safeguarding Group, and 4. **NOTED** the expected date for the Mid and West Wales Safeguarding Board CPR Multi Agency Action Plan to be shared with Safeguarding Board members.
ITEMS FOR APPROVAL	
PEQS/24/10	**COMMITTEE ANNUAL REPORT**

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	The Chair introduced the report which summarises the 2023-24 key areas of business and activity. Independent Members asked the following questions for assurance: *Given there is a theme about sustainability, is there something specific about considering areas that have got high vacancy and high agency use because of the impact that that has on the quality and sustainability of services. Is this something to consider going forward?* KWi advised the matter will be considered in the future work programme, and the Terms of Reference for the Committee could potentially be updated. **ACTION Director of Corporate Governance** The Committee: • **CONSIDERED** the Patient Experience, Quality and Safety Committee Annual Report for 2023/24 summarising the key areas of business activity undertaken; and • **RECOMMENDED** the report to the Board for the 22 May 2024 meeting.
PEQS/24/11	**COMMITTEE ANNUAL WORK PROGRAMME** HB confirmed the work programme will follow at the next meeting. HB advised the information received from the Terms of Reference and the Committee Effectiveness review is being collated, the Board will then receive an overview of this information which will be brought back to this Committee for consideration.
ITEMS FOR DISCUSSION	
There were no items for discussion	
ESCALATED ITEMS	
PEQS/24/12	**INFECTION PREVENTION AND CONTROL (IPC) IMPROVEMENT PLAN PROGRESS REPORT (CONTAINED WITHIN THE INTEGRATED QUALITY REPORT)** KWi noted this had been considered as part of the Integrated Quality Report and details would be included in her Chair's Report to the Board. Independent Members asked the following questions for assurance: *How does a matter get to be de-escalated?*

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	HB advised that the IPC Annual report will be brought to the next Committee meeting; this will allow this Committee to consider the escalation status, and if there is further work to be done or if the matter can be de-escalated to business as usual.
ITEMS FOR INFORMATION	
PEQS/24/13	The following Internal Audit Reports were shared for information: • Annual Internal Audit Plan (2024/25) • Board Committee Effectiveness (2023/24) • Infection Prevention and Control
OTHER MATTERS	
PEQS/24/14	**COMMITTEE RISK REGISTER** HB introduced the Risk Register noting that Risk 3 relates to the potential for poor quality care, which this is a live risk across the organisation. IP raised concerns about the lack of a single Integrated record of care. Staff are having to use multiple systems, both paper and electronic, which is a significant risk to the continuity and the quality of care as the information needed to effectively treat the patient does not appear in one place. This has an impact on quality and raises the profile of Digital First as an enabler. The Committee: • **CONSIDERED** the corporate risks within the committee's remit, and • • took **ASSURANCE** that risks are being managed in line with the Risk Management Framework.
PEQS/24/15	**ITEMS TO BE BROUGHT TO THE ATTENTION OF THE BOARD AND/OR OTHER COMMITTEES** The Committee will bring to the attention of Board the local escalation of Mental Health Services and will update Board on Infection Prevention and Control.
PEQS/24/16	**ANY OTHER URGENT BUSINESS** There was no other urgent business.
PEQS/24/17	**DATE OF THE NEXT MEETING** To be confirmed, via Microsoft Teams.

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PEQS/24/18	**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:

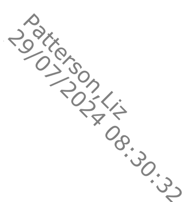
Claire Roche (Director of Nursing and Midwifery)
Pete Hopgood (Director of Finance, Information and IT)
Kate Wright (Medical Director)
Hayley Thomas (Chief Executive Officer)
Helen Bushell (Director of Corporate Governance)
Liz Patterson (Interim Head of Corporate Governance)

APOLOGIES FOR ABSENCE:

Joy Garfitt (Interim Director Operations, Community Care and Mental Health)
Claire Madson (Director of Therapies and Health Sciences)

PEQS IC/24/19	**DECLARATIONS OF INTEREST** There were no declarations of interest
PEQS IC/24/20	**MINUTES OF THE IN-COMMITTEE MEETING HELD ON 23 JANUARY 2024** The minutes of the In-Committee meeting held on 23 January 2024 were approved as a correct record subject to correcting the date of the next meeting.

DRAFT



Liz Patterson

RAG Status:

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

RAG	Description
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	Executive Director of Nursing, Quality, Women and Family Health	Integrated Quality Report	IQR 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. **16.04.24 update** - update to be provided in the meeting **30.07.24 update** - action rolled forwards to Novemebr (Q2) report, date change requested	Jan-24	Nov-24	At risk
16/04/2024	PEQS/24/05a	AD Quality and Safety	Integrated Quality Report	The improvement trajectory around incidents to be shared with Committee	**30.07.24 update** - trajectory to be shared via email, date change requested (due to staff absence)	Jul-24	Sep-24	At risk
16/04/2024	PEQS/24/05b	AD Quality and Safety / DNQWFH	Integrated Quality Report	A fuller report on Your NHS Experience to be shared with Committee	**30.07.24 update** - trajectory to be shared via email, date change requested (due to staff absence)	Jul-24	Nov-24	At risk
16/04/2024	PEQS/24/05c	AD Quality and Safety / DNQWFH	Integrated Quality Report	The Integrated Quality Report to include highlights on other services (such as provided in the April 2024 report on the Powys Living Well Service)	**30.07.24 update** - trajectory to be shared via email, date change requested (due to staff absence)	Jul-24	Nov-24	At risk
16/04/2024	PEQS/24/09a	DNQWFH	Child Practice Review	The Was Not Brought Audit December 2023 to be shared with Committee	**30.07.24 update** - update will be provided in the meeting	Jul-24		On track
OPEN ACTIONS - IN PROGRESS BUT NOT YET DUE								
23/01/2024	PEQS/23/58	Executive Director of Allied Health Professions, Health Sciences and Digital	First Point of Care Testing Coordinator	Update on draft staus report evidencing or otherwise the need for the First Point of Care Testing Coordinator role	**16.04.24 update -** action on track **30.07.24 update** - action on track for November meeting	Oct-24		On track
24/10/2023	PEQS/23/39a	Executive Medical Director	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 **16.04.24 update** - action on track	Oct-24		On track
24/10/2023	PEQS/23/39b	Executive Medical Director	Medicine Management Annual Report	Update on Electronic Prescribing to be included in the next Medicines Management Report	**23.01.24 update** - action on track **16.04.24 update** - action on track **30.07.24 update** - action on track for November meeting	Oct-24		On track
16/04/2024	PEQS/24/08	DNQWFH	Joint Inspection on Child Protection Arrangements Action Plan	Progress against action plan to be reported to Committee	**30.07.24 update** - action on track for November meeting	Nov-24		On track

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16/04/2024	PEQS/24/09b	DNQWFH	Child Practice Review	A report on the work undertaken to ensure the voices of children and young people are being heard	**30.07.24 update** - action on track for November meeting	Nov-24		On track
16/04/2024	PEQS/24/07	MD	Clincial Audit Annual Programme	Information on Primary Care Group GP services added to the Clinical Audit Programme	**30.07.24 update** - work continues in this area, audits are generally added in October each year. Further update will follow into the November meeting	Nov-24		On track
16/04/2024	PEQS/24/10	DCG	Committee Annual Report	Consider including on the work programme an item on areas with high vacancy/high agency use in relation to the quality and sustainability of services	**30.07.24 update** - discussion planned with Chair and lead executive to explore and determine work programme	Jan-25		On track
ACTIONS RECOMMENDED FOR CLOSURE (MEETING 30 July 2024)								

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Agenda item: 2.1

Patient Experience, Quality and Safety Committee	**Date: 30 July 2024**
Subject:	**An update on the Infection Prevention & Control (IP&C) Improvement Plan at the end of year one, objectives for year two, and the 2023/24 annual report**.
Approved and presented by:	Claire Roche, Executive Director of Nursing, Quality, Women and Family Health Marie Davies, Deputy Director Nursing
Prepared by:	Gareth Thomas – Consultant Nurse Infection Prevention & Control
Other Committees and meetings considered at:	Executive Committee - 17 July 2024 who endorsed the report to the Committee.

PURPOSE:

The purpose of this paper is to present the Committee with an end of year report on the Infection Prevention and Control improvement plan, outline the objectives for year two and provide the 2023/24 Annual Report.

RECOMMENDATION(S):

The Committee is asked to:

- **RECEIVE** and **DISCUSS** the Infection Prevention and Control improvement plan at the end of year one (2023/24) taking **ASSURANCE** in progress against plan;
- **NOTE** the objectives set for year two and the contents of the 2023/24 Annual Report.

Approve/Take Assurance	**Discuss**	**Note**
Y	Y	Y

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:		
1. Focus on Wellbeing	Y	
2. Provide Early Help and Support	N	
3. Tackle the Big Four	N	
4. Enable Joined up Care	N	
5. Develop Workforce Futures	N	
6. Promote Innovative Environments	N	
7. Put Digital First	N	

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8. Transforming in Partnership	N	

EXECUTIVE SUMMARY:
To provide a comprehensive update on the status of the Infection Prevention and Control improvement plan at the end of year one, highlighting the substantial work accomplished over the past year. This follows submission and approval of the improvement plan in June 2023, which was subsequently endorsed by the Patient, Experience, Quality and Safety Committee (PEQS).

DETAILED BACKGROUND AND ASSESSMENT:

A paper was presented to the Executive Committee in June 2023, and a subsequent in-committee meeting with the Independent Members, which resulted in the approval of an organisational wide IP&C improvement plan, to ensure PTHB meets the minimum standards, as required under the 2014 Code of Practice for the Prevention and Control of Healthcare Associated Infections which would be led by the IP&C team, with collaboration from services and departments, to ensure IP&C is everyone's business and is owned by all.

Following the completion of year one, a significant amount of work has been undertaken across the organisation on the IP&C improvement plan. The Executive Committee are asked to note the key highlights over the past year and note the progress that has ensued. The improvement plan is currently 86% completed. The outstanding actions of the improvement plan will be realised in year two.

There are 24 overall recommendations within the IPC improvement plan; within these recommendations there are 47 associated actions:

- **41** actions have been completed.
- **1** is on track and will be completed within the timescales provided.
- **5** where progress is being made, progress is good and is likely to be achieved.
- **0** where no progress has been made.

A percentage summary of the overall delivery plan is presented below;

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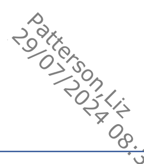
Summary Delivery vs Plan		
Delivery against Plan	**RAG Status Definition**	**%**
% of activities which are complete	The action has been completed and there is a record of evidence to support it's completion.	86%
% of progress being made	Progress is good and the action is likely to be achieved within timescale.	2%
% 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	0%
% of activities on track	Progress being made and is on track and will be completed on timescale.	12%

Some key achievements to note from the improvement plan:

- A Board level statement outlining its collective responsibility towards the prevention of Healthcare Associated Infections
- PHW dashboards on Tier1 surveillance organisms, now aligns with PTHB internal data, at present, providing a true reflection of infection data in Powys.
- The Health Board has continued to maintain a record of zero cases of MRSA bacteraemia since 2013/14.
- Internal audit during Q4 provided reasonable assurance overall, with a proportion of areas gaining substantial assurance.
- The IP&C team has responded effectively and efficiently, overcoming the challenges and increased workload, as a result of the IP&C improvement plan
- The team have successfully implemented and maintained several crucial policies, processes, and standard operating procedures across the organisation, enhancing awareness, understanding and safety for both staff and patients.
- Relationships across the Health Board have significantly improved as awareness and understanding of the IP&C team's roles and responsibilities have become more widely recognised.
- Compliance for mandatory and statutory IP&C training levels one and two have continued to increase over the year, currently exceeding 85%.



The six recommendations within the improvement plan that are on track and will carry over into year two are:

Recommendation	Progress
Implementation of an electronic auditing system	A system has been identified, progressed through the appropriate channels, and is expected to be implemented early in Q2.
Dedicated support and capacity in antimicrobial stewardship	Recruitment is in progress and anticipated to be completed early in Q2. This role will support the IPC team by strengthening antimicrobial stewardship and enhancing the post infection review process
IPC team capacity	A fixed term to permanent band 7 position has been filled, and recruitment for a band 6 position is underway, expected to be realised in Q2
Policies	Policies pertaining to multi-drug resistant organisms and communicable disease in staff: these policies are actively being developed and likely to be finalised in Q2
ANTT compliance/training	Ongoing work with Head of Nursing for CSG and Clinical Education – likely to be realised in Q3

Year two objectives:

During year two of the improvement plan, the focus will be on consolidating and building on upon the successes of the first year. The detailed objectives, as outlined in the appendices, include:

1. Minimise the risk of avoidable HCAI's to patient and embed a culture of zero-tolerance to HCAIs (Healthcare Associated Infections) across Powys Teaching Health Board.
2. Focus on the reduction of Clostridioides difficile infections across the Health Board, with the aim of a 10% reduction on the 2023/24 rates.
3. Improve staff training, education and compliance rates with Infection Prevention and Control mandatory and statutory training and practices, maintaining rates >85%
4. Ensure robust and judicious antimicrobial prescribing, recognising the global health threat this presents.
5. Improve, standardise, and sustain the standard of cleanliness across the organisation and explore the opportunities to utilise new and evolving technologies for environmental cleaning and decontamination, such as HPV and UV
6. Maintain an up-to-date suite of Infection Prevention and Control guidance and policies for staff across the organisation.
7. Ensure the consistent management of acute infections and sepsis across Powys Teaching Health Board in-line with new NICE guidance.

8. Bring the citizen voice to infection prevention and control, to improve experience and outcomes for patients.
9. Implement an electronic auditing system to enhance consistency, facilitate comparisons and improve governance and reporting on IP&C (Infection Prevention and Control) measures.

Key highlights from the Annual Report related to infection rates:

- The Health Board observed twenty-five cases of Clostridioides Difficile (increase of nine on the previous FY). Majority of cases (n.20) being Community Onset cases.
- The Health Board observed two E.coli bacteraemia's (increase of one on the previous FY year)
- The Health Board observed one case of MSSA bacteraemia (increase of one on the previous FY year)
- The Health Board continues to report zero cases of MRSA bacteraemia (last reported in 2013-14)

Wales has historically had the highest rates of CDI of all the UK nations and the proportion of non-inpatient cases has not reduced for a decade. Between April 2022-March 2023 CDI figures were greater than in any year within the last 10 years. A similar picture is seen in Powys, with a higher proportion of community acquired cases (non-inpatient) than that of in-patient cases (20 and 5 respectively as at the end of 2023/24). As part of the Health Board's process for reviewing cases of CDI, each case undergoes a thorough post infection review (PIR). This review combines the expertise of colleagues across the organisation. There is strong engagement from colleagues across the organisation in the completion of post infection reviews, including from Primary Care; this provides valuable insights into CDI acquisition.

Learning from Clostridiodies post infection reviews:

- Antimicrobial prescribing within primary care in Powys is recognised as a concern, particularly the prescribing of the 4C antimicrobials (Powys Teaching Health Board has the highest prescribing of 4C antimicrobials in Wales). CDIs associated with antimicrobial prescribing are used to highlight the risks and to share learning.
- Some General Practices continue to prescribe Metronidazole as first line treatment for CDI. This has highlighted that clinicians are not routinely referring to MicroGuide to guide treatment choices, which is now widely promoted across the organisation and included in CDI letters to primary care.
- Powys Teaching Health Board residents, as part of Whole Genome Sequencing (WGS) have been identified as part of a larger cluster outbreak associated with a larger Health Board in Wales.

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- Environmental cleanliness within inpatient areas, especially near patient equipment has been identified on multiple Infection Prevention and Control audits to be sub-standard.

Actions to address learning:

- Antimicrobial stewardship improvement plan in place including the development of a business case to support the recruitment of an Antimicrobial Stewardship Pharmacist.
- Primary care prescribing data is monitored on a monthly basis; General Practices are provided with monthly key performance indicator reports which include a number of antimicrobial KPIs; prescribing data is routinely discussed during General Practice visits; where prescribing concerns are identified, targeted discussions take place; MicroGuide is regularly promoted to all clinicians and compliance with MicroGuide is monitored.
- 4C antimicrobial prescribing audit undertaken in primary care during 2023/24. This will be repeated during 2024/25.
- The Antimicrobial Stewardship Group has a standing agenda item on primary care antimicrobial prescribing.
- CDIs associated with antimicrobial prescribing are used to highlight the risks and to share learning with clinicians.
- Equipment cleanliness discussed with Head of Nursing within Clinical Service Group, and subsequent assurance mechanisms put into place for regular compliance reporting.
- Infection Prevention and Control to provide targeted education sessions on CDI to staff across the organisation, including opportunistic teaching whilst undertaking site visits.
- 'Back to Basics' cleaning campaign undertaken during Q3 2023/24 with the support of Gamma Healthcare colleagues.

It is anticipated that the year two objectives as outlined above will lead to a reduction in CDI rates in the coming year.

NEXT STEPS:
The Committee is asked to acknowledge the significant work and progress made on Infection Prevention and Control across the Health Board. Efforts towards achieving the year two objectives, informed by the lessons learned from year one, are already underway. Further updates will be provided to the committee, as per the Committee work programme, as progress continues.

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IMPACT ASSESSMENT – NOT REQUIRED FOR THIS REPORT					
This section must be completed for all strategic organisational decisions including approval of health board policies.					
QUALITY:					
	No impact	Negative	Positive	Both	A Quality Impact Assessment must be undertaken for all reports requesting approval, ratification or decision in line with health board Duty of Quality processes (under development). In this space you should provide supporting narrative to explain the potential adverse and positive impacts that may arise from a decision being taken, and the steps being taken to mitigate adverse impacts. Where required, the full Quality Impact Assessment should be available as a supporting document to inform the decision making process.
Safe					
Timely					
Effective					
Efficient					
Equitable					
Person Centred					
Workforce					
Leadership					
Culture					
Information					
Learn, Improve, Research					
Whole Systems Approach					
EQUALITY:					
	No impact	Negative	Positive	Both	An Equality Impact Assessment must be undertaken for all reports requesting approval, ratification or decision in line with health board Equality Impact Assessment policies and procedures (CGP009). In this space you should provide supporting narrative to explain the potential adverse and positive impacts that may arise from a decision being taken, and the steps being taken to mitigate adverse impacts. Where required, the full Equality Impact Assessment should be available as a supporting document to inform the decision making process.
Age					
Disability					
Gender reassignment					
Marriage / civil partnership					
Pregnancy / maternity					
Race					
Religion or Belief					
Gender					
Sexual Orientation					
Welsh Language					
Socio-economic status					
Social exclusion					
Carers					
RISK ASSESSMENT:					
	Level of risk identified				A Risk Assessment should be undertaken for all reports requesting approval, ratification or decision in line with health board Risk Management Framework CGP005. In this space you should briefly describe the key risks and the steps being taken to manage them, and also how these risks relate to the Board's stated Risk Appetite.
	Very Low (0-3)	Low (4-8)	Moderate (9-12)	High (15-25)	
Clinical					
Financial					
Corporate					
Operational					
Reputational					

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Powys Teaching Health Board

Infection Prevention and Control Annual Report 2023/24

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Foreword

As we reflect on 2023-24, this annual report not only showcases our achievements but also sets the scene for our future direction in Infection Prevention and Control.

This was a pivotal year for Infection Prevention and Control services across Powys Teaching Health Board, as the team worked collaboratively with colleagues across the organisation to advance our improvement plan, which was incorporated into the Health Boards Integrated Medium Term Plan.

The plan, aligned with the 2014 Code of Practice for the reduction of healthcare associated infections, emphasises our commitment to the duty of quality and demonstrates how robust infection prevention and control measures can significantly enhance patient care.

The progress we have made in 2023-24 lays a strong foundation for continued improvement as we progress into year two of the improvement plan. In compiling this annual report, I would like to thank colleagues across Powys Teaching Health Board for their continued support and efforts in driving improvements in Infection Prevention and Control.

Claire Roche

Executive Director of Nursing, Quality, Women and Family Health

Executive Summary

- Key policies have been operationalised across the Health Board, in accordance with the Welsh Government's Code of Practice for the Prevention and Control of Healthcare Associated Infections
- A Board level statement approved and ratified at the Patient Experience, Quality and Safety (PEQS) committee outlining its collective responsibility to the reduction of Healthcare Associated Infections within Powys Teaching Health Board
- The Health Board observed twenty-five cases of Clostridioides Difficile (⬆ of nine on the previous year). Majority of cases (**n.20**) being Community Onset cases.
- The Health Board observed two E.coli bacteraemia's (⬆ of one on the previous year)
- The Health Board observed one case of MSSA bacteraemia (⬆ of one on the previous year)
- The Health Board continues to report zero cases of MRSA bacteraemia (*last reported in 2013-14*)
- A two-year Infection Prevention and Control Improvement Plan was implemented in Q2 of 2023-24 and forms part of the Health Boards Integrated Medium Term Plan (IMTP).
- Internal audit during Q4 provided reasonable assurance overall, with a proportion of areas gaining substantial assurance.

1. Introduction

This Infection Prevention and Control annual report for the year ending 2023/24 provides a comprehensive overview of Powys Teaching Health Board's efforts in maintaining a robust system to safeguard against infections. Healthcare Associated Infections (HCAIs) can cause significant harm to patients and the cost to organisations, patients and families can be incalculable and considerable.

Powys Teaching Health Board is dedicated to fostering public trust in the services it provides, with rigorous Infection Prevention and Control measures being fundamental to this commitment, both in our role as a provider and a commissioner. The Health Board maintains a zero-tolerance stance towards Healthcare Associated Infections (HCAIs) and is committed to learning from any occurrence to drive improvements that enhance patient care and safety across the Health Board. Robust Infection Prevention and Control standards, and the process by which they are implemented across an organisation can be seen as a key quality indicator, and the Duty of Quality, as part of the Health and Social Care (Quality and Engagement) (Wales) Act 2020, which came into being in April 2023 puts a duty on organisations to ensure safe and effective services.

Throughout the year, the Infection Prevention and Control (IP&C) team, together with colleagues across the Health Board have worked tirelessly to implement the recommendations of the Health Boards Infection Prevention and Control Improvement Plan. The plan is underpinned by the standards as set out in the 2014 Code of Practice for the reduction of Healthcare Associated Infections.

This annual report is prepared in accordance with the requirements under the Code of Practice for the Reduction of Healthcare Associated Infections, which outlines the requirement for an annual report.

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Key Achievements

There have been a several notable achievements in 2023/24/, some of which are highlighted below:

- The Health Board has continued to maintain a record of zero cases of MRSA bacteraemia since 2013/14.
- The IP&C team has responded effectively and efficiently, overcoming the challenges and increased workload, as a result of the IP&C improvement plan
- The team have successfully implemented and maintained several crucial policies, processes, and standard operating procedures across the organisation, enhancing awareness, understanding and safety for both staff and patients.
- Relationships across the Health Board have significantly improved as awareness and understanding of the IP&C team's roles and responsibilities have become more widely recognised.
- Compliance for mandatory and statutory IP&C training levels one and two have continued to increase over the year, currently exceeding 85%.

Key Challenges

Several key challenges were identified during 2023/24 and are expected to persist as we move into 2024/25:

- The IP&C team assumed responsibility for decontamination across the Health Board in July 2023, managing this additional portfolio within existing roles despite significant demands on time and resources.
- Given the limited capacity of the team, their ability to engage in proactive work, which could mitigate reactive challenges is constrained. Specialist IP&C support for primary care, such as GP surgeries, is not routinely available due to resource limitations, even though these contractors are required to adhere to Powys Teaching Health Board policies and procedures.
- Maintaining effective IP&C standards poses a challenge within an increasingly ageing estate portfolio.
- The absence of a specialised Antimicrobial Stewardship Pharmacist to provide expertise and support, particularly during post infection reviews.
- The lack of electronic auditing system requires teams to manually input data into spreadsheets/documents, making comparisons and thematic analysis extremely challenging and time consuming, against the backdrop of limited resources.

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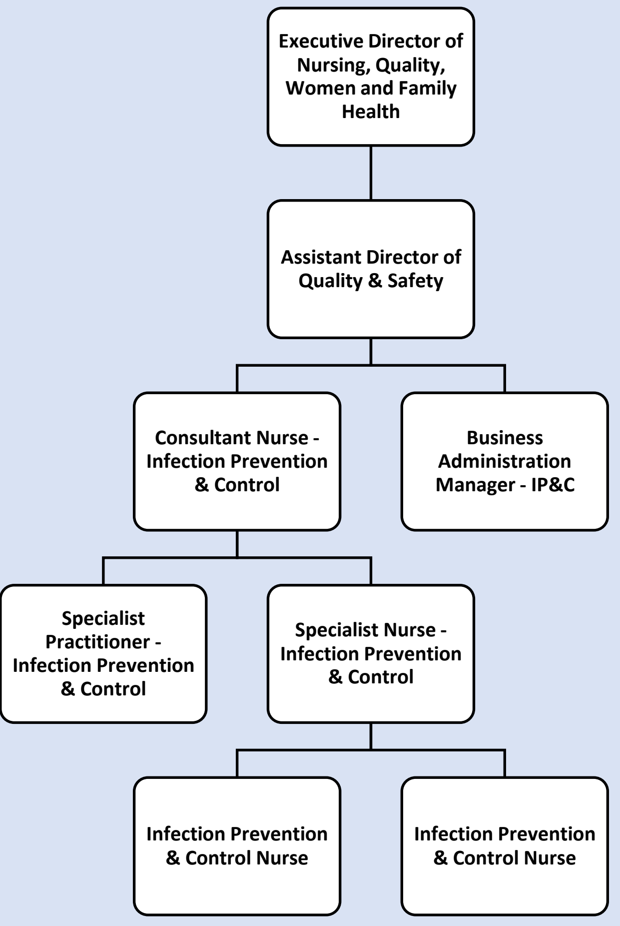
2. Infection Prevention and Control Structure

Infection Prevention and Control sits within the Quality and Safety function, with the Executive Director of Nursing, Quality, Women and Family Health holding delegated responsibility for Infection Prevention and Control and Decontamination across Powys Teaching Health Board.

The current organisational structure of the Infection Prevention and Control team is illustrated below:



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3. Primary responsibilities of the Infection Prevention and Control team

The Infection Prevention and Control team consists of Nurses and Allied Health Professionals, with expertise and support from an Infection Control Doctor/Consultant Microbiologist, with the team providing support which spans the whole of the Health Board.

The team are responsible for:

- Providing expert advice, guidance and support to all services and departments within Powys Teaching Health Board
- Surveillance, audit, and management of Healthcare Associated Infections across the Health Board.
- Education, training, and support across the organisation to provide safe environments of care for our patient population.
- Ensuring policies, process and procedures are up-to-date and in-line with best practice and current clinical standards and guidelines.

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4. IPC Reporting structure

Infection Prevention and Control activities are reported within the Health Board, firstly to the quarterly Infection Prevention & Control Committee which is chaired by the Executive Director of Nursing, Quality, Women and Family Health. Onward reporting to the Patient Experience, Quality and Safety (PEQS) Committee and to the Board.

5. Groups

The Infection Prevention & Control team actively participate and are members of various groups and committees across Powys Teaching Health Board, as detailed below. The expertise of the IP&C team significantly contributes to enhancing patient safety across the Health Board.

Group	Meeting Frequency
Antimicrobial Stewardship Group	Quarterly
Water Safety Group	Quarterly
Ventilation Safety Group	Quarterly
Prevention and Response Oversight Group	Monthly
Waste & Recycling User Group	Quarterly
Linen User Group	Quarterly
Environmental & Sustainability Group	Quarterly
Medical Devices/PoC Testing Group	Quarterly
Health & Safety Group Meeting	Quarterly
All-Wales Healthcare Associated Infection Delivery Board	Quarterly
All-Wales Decontamination Group	Quarterly
Womens & Children Health & Safety Group	Quarterly
Ultrasound Governance Group	Quarterly
Decontamination Safety Group*	Commencing bi-annually from June 2024

6. IPC improvement plan

In May 2023, the IP&C team conducted a comprehensive GAP analysis of Infection Prevention and Control services across the Health Board, leading to the development of an organisational improvement plan. The plan was evaluated against the nine standards, as set out in the 2014 Code of Practice for the Prevention and Control of Healthcare Associated Infections, and subsequently reviewed and approved by the Patient Experience, Quality & Safety Committee (PEQS).

To ensure the actions required were prioritised it was integrated into the Health Boards Medium Term Plan (IMTP) for 2023-2026. In affirming its commitment to the zero-tolerance stance on Healthcare Associated Infections, the Board approved a statement outlining its collective responsibility to the reduction of Healthcare Associated Infections and improvements in Infection Prevention and Control standards across Powys Teaching Health Board, which was presented and approved at the Patient Experience, Quality and Safety (PEQS) Committee during Q3 2023/24.

A considerable amount of work has been undertaken by the Infection Prevention and Control team in conjunction with colleagues across the Health Board to achieving the requirements of the plan. Actions that will be prioritised in year 2 of the improvement plan include:

- Policy for the prevention and management of communicable infections in staff (Occupational Health Team to lead)
- The availability of an electronic auditing system, which will support improved compliance with standards and consistency along with providing at a glance assurance. This will provide an additional benefit to better utilise the limited resource within the IP&C team.
- Dedicated Antimicrobial Stewardship Pharmacist

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7. Policies/procedures/standard operating procedures

The implementation of the Infection Prevention and Control improvement plan resulted in the addition of several policies, which have been operationalised across the Health Board. These policies are outlined in the table below:

Policy/Standard Operating Procedure Title	Issue Date
IPC 003 The Management of Clostridioides Difficile (formerly Clostridium Difficile)	November 2023
IPC 048 Standard Infection Prevention and Control Precautions (SICPs) Policy	November 2023
IPC 050 Policy for Animals and Pets Visiting PTHB Premises	February 2024
IPC 051 Policy for the Safe Use of Medical Sharps	February 2024
IPC 052 Policy for the checking, replacement and auditing of mattresses, trolleys, and cushions	February 2024
IPC 047 Policy for the Management of Suspected or Confirmed Infectious D&V in Community & MH Wards	November 2023
IPC 036 All Wales Aseptic Non-Touch Technique Policy (ANTT)	August 2023

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8. Rates of Healthcare Associated Infections (Welsh Government Reduction Targets)

Annual reduction targets for Healthcare Associated Infections and Antimicrobial Prescribing are set by Welsh Government. However, due to the relative size of Powys Teaching Health Board, and the patient population, in comparison to other Health Boards within Wales, we consistently fall below these targets and are not benchmarked against other Health Boards, specifically from an Infection Prevention and Control perspective. Year two of the Infection Prevention and Control improvement plan will explore internal reduction targets.

8.1 Clostridioides Difficile (CDI)

The Health Board has observed an increase in CDI cases in 2023-24. Rates of CDI for 2023/24 were twenty-five, marking an increase of nine cases compared to the same period in 2022/23. Wales has historically had the highest rates of CDI of all the UK nations and the proportion of non-inpatient cases has not reduced for a decade. Between April 2022-March 2023 CDI figures were greater than in any year within the last 10 years. A similar picture is seen in Powys, with a higher proportion of community acquired cases (non-inpatient) than that of in-patient cases (20 and 5 respectively as at the end of 2023/24). An overview of the rates of CDI can be seen in the graph below:

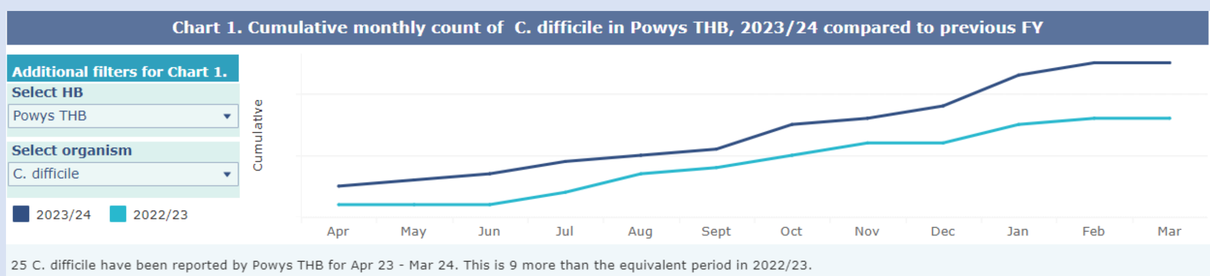

Table 2. Monthly count and rate of C. difficile in Powys THB, 2023/24

	Total count	CO* count	HO** count	% HO***	Total rate per 1,000 hospital ..	Total rate per 100,000 popula..
2023/24	**25**	**20**	**5**	**20%**	**19.47**	**18.67**
April 2023	5	4	1	20%	46.30	45.56
May 2023	1	1	0	0%	9.80	8.82
June 2023	1	1	0	0%	8.93	9.11
July 2023	2	2	0	0%	17.39	17.64
August 2023	1	0	1	100%	8.77	8.82
September 2023	1	1	0	0%	10.42	9.11
October 2023	4	4	0	0%	36.70	35.27
November 2023	1	1	0	0%	9.09	9.11
December 2023	2	2	0	0%	16.26	17.64
January 2024	5	2	3	60%	42.02	44.09
February 2024	2	2	0	0%	22.73	18.85
March 2024	0	0	0	0%	0.00	0.00

Source: Public Health Wales

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As part of the Health Board's process for reviewing cases of CDI, each case undergoes a thorough post infection review (PIR). This review combines the expertise of colleagues across the organisation. There is strong engagement from colleagues across the organisation in the completion of post infection reviews, including from Primary Care; this provides valuable insights into CDI acquisition.

Learning from Clostridiodies post infection reviews:

- Antimicrobial prescribing within primary care in Powys is recognised as a concern, particularly the prescribing of the 4C antimicrobials (Powys Teaching Health Board has the highest prescribing of 4C antimicrobials in Wales). CDIs associated with antimicrobial prescribing are used to highlight the risks and to share learning.
- Some General Practices continue to prescribe Metronidazole as first line treatment for CDI. This has highlighted that clinicians are not routinely referring to MicroGuide to guide treatment choices, which is now widely promoted across the organisation and included in CDI letters to primary care.
- Powys Teaching Health Board residents, as part of Whole Genome Sequencing (WGS) have been identified as part of a larger cluster outbreak associated with a larger Health Board in Wales.
- Environmental cleanliness within inpatient areas, especially near patient equipment has been identified on multiple Infection Prevention and Control audits to be sub-standard.

Actions to address learning:

- Antimicrobial stewardship improvement plan in place including the development of a business case to support the recruitment of an Antimicrobial Stewardship Pharmacist.
- Primary care prescribing data is monitored on a monthly basis; General Practices are provided with monthly key performance indicator reports which include a number of antimicrobial KPIs; prescribing data is routinely discussed during General Practice visits; where prescribing concerns are identified, targeted discussions take place; MicroGuide is regularly promoted to all clinicians and compliance with MicroGuide is monitored.
- 4C antimicrobial prescribing audit undertaken in primary care during 2023/24. This will be repeated during 2024/25.
- The Antimicrobial Stewardship Group has a standing agenda item on primary care antimicrobial prescribing.
- CDIs associated with antimicrobial prescribing are used to highlight the risks and to share learning with clinicians.
- Equipment cleanliness discussed with Head of Nursing within Clinical Service Group, and subsequent assurance mechanisms put into place for regular compliance reporting.

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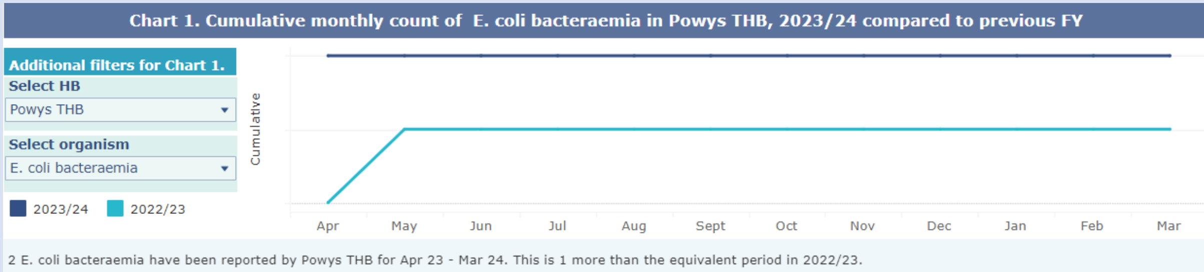
- Infection Prevention and Control to provide targeted education sessions on CDI to staff across the organisation, including opportunistic teaching whilst undertaking site visits.
- 'Back to Basics' cleaning campaign undertaken during Q3 with the support of Gamma Healthcare colleagues.

8.2 Gram negative blood stream infections (E.coli, klebsiella and pseudomonas aeruginosa)

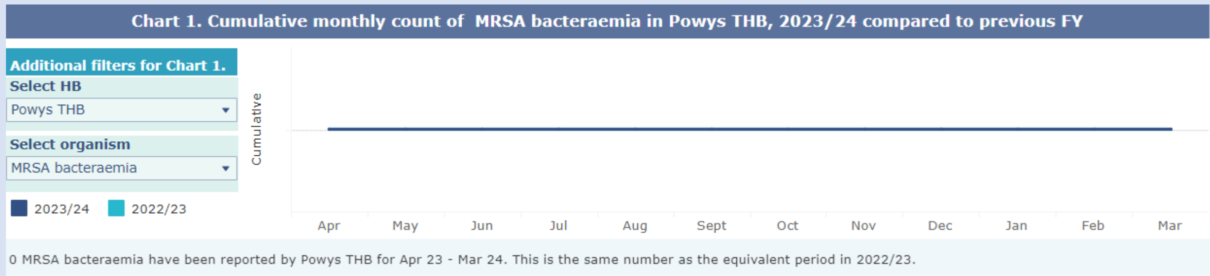
The Health Board observed two cases of gram-negative bacteraemia (E.coli), which is one more than the equivalent period in 2022/23.



Source: Public Health Wales

8.3 Methicillin-resistant Staphylococcus aureus Bacteraemia (MRSA)

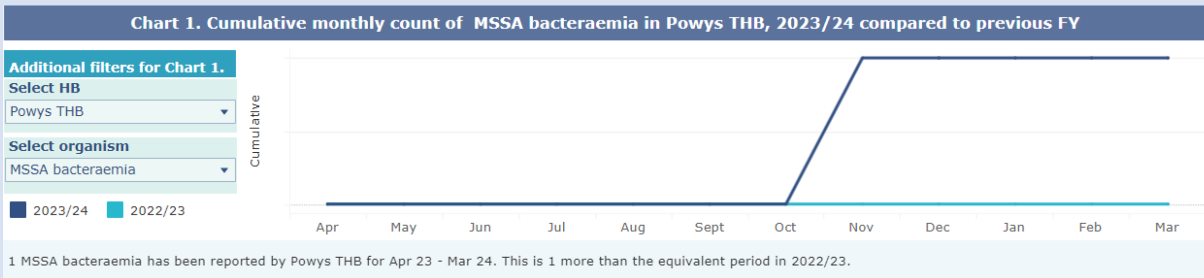
The Health Board has continued to observe zero cases of MRSA bacteraemia, with the last case of MRSA bacteraemia reported in 2013-14.



Source: Public Health Wales

8.4 Methicillin-Sensitive Staphylococcus aureus Bacteraemia (MSSA)

The Health Board has observed one case of MSSA bacteraemia, which is an increase of one on the previous year.



Source: Public Health Wales

8.5 Acute Respiratory Infections (including COVID-19)

COVID-19

Despite the return to business as usual, COVID-19 outbreaks continued to impact services, with several outbreaks reported during Q1 2023/24. In response to a persistent increase in community prevalence of COVID-19 the Health Board introduced a period of mandatory mask wearing in all patient facing areas from September 2023 – February 2024 to protect patients, staff and visitors. This measure aligned with the World Health Organisation (WHO) recommendation that universal mask wearing should be undertaken in healthcare organisations when periods of high community transmission rates are observed. No COVID-19 outbreaks were observed during Q3 or Q4 (winter period), and where cases were identified these were sporadic and no onward transmission was observed. The graph below illustrates the weekly number of COVID-19 cases:

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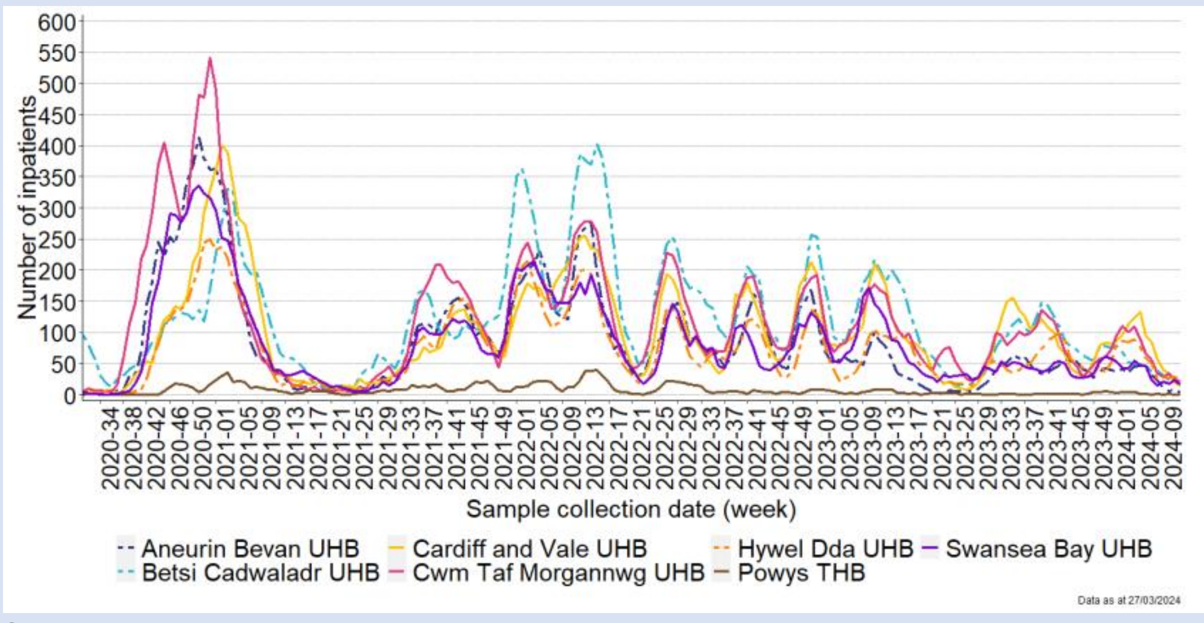
Weekly number of confirmed COVID-19 inpatients in all Hospitals, by Health Board:



Source: Public Health Wales

Influenza

The Health Board observed an Influenza A outbreak, which resulted in the closure of a ward in March 2024. An outbreak review meeting was convened to identify areas of learning and good practice. Several learning outcomes were identified which included:

- Not isolating patients in a timely manner.
- Cross-site communication when transferring patients.

The learning identified continues to be taken forward by the Infection Prevention and Control team through simulated education sessions.

8.6 Norovirus

Norovirus outbreaks occurred later in the year within Powys Teaching Health Board compared to other Health Boards/Trusts within Wales. Several incidents of norovirus occurred across our inpatient areas from late February to early March 2024, totalling three outbreaks due to Norovirus. Prompt outbreak review meetings were convened in all cases to identify crucial lessons and to safeguard patients and staff whilst trying to prevent as far as reasonably practicable any further onward transmission.

9. Infection Prevention and Control Audits

A comprehensive series of audits were conducted throughout the Health Board, following the criteria as set out in the Infection Prevention Society (IPS) audit tool, which is evidence based and utilised UK wide. Following these audits a number of notable practices and improvements were identified which is outlined below:

Notable practice:

- Welcoming and engaged staff, at all levels within the Health Board with Infection Prevention and Control audits.
- Willingness of staff to engage with education and training
- Pockets of exemplary practice with hand hygiene
- Patients and visitors actively encouraged to participate in robust hand hygiene standards.
- Robust supplies of Personal Protective Equipment (PPE) on all wards/departments
- Visible data on Infection Prevention and Control at the entrance to ward areas

Areas for improvement:

- Compliance with the All-Wales uniform policy
- Appropriate use of glove wearing
- Age of estates, which can indirectly influence Infection Prevention and Control standards.
- Improper storage of cleaning chemicals
- Mattress checking and replacement processes.
- Compliance with sharps safety i.e., sharps boxes not always labelled appropriately.

Considerable progress has been made in the areas identified for improvement by colleagues across the Health Board, and numerous initiatives have been implemented to address these standards, including:

- A policy for the checking and replacement of mattresses, to raise awareness, standards and bring consistency to the process across the Health Board
- Training, the standardisation of cleaning chemicals and posters, with further training by the provider of the chemicals to take place in April and May 2024.
- The development of a sharps policy to enhance standards, best practice, and compliance with legal requirements throughout the Health Board.
- A collaborative visit to all in-patient premises with Works and Estates colleagues to identify and address minor works requirements.
- A national campaign on appropriate glove usage is being conducted later in 2024.

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10. Environmental Cleanliness

The Support Services Department is primarily responsible for maintaining hygiene and cleanliness standards across the Powys Teaching Health Board environment, encompassing clinical, nonclinical, and public spaces, as well as any additional facilities acquired by the Health Board for healthcare purposes. Relevant department staff also carry out additional cleaning duties where they are responsible for cleaning specific equipment.

The importance of maintaining clean environments is recognised, especially in areas identified as requiring a critical level of cleanliness, such as Theatres, Birth Centres, Dentistry, and Podiatry. The level of risk in each area determines the required standards of cleanliness, with higher-risk areas needing more frequent cleaning and auditing. This approach is guided by the National Standards for Cleaning in NHS Wales, last revised in October 2009, and the National Standards for Cleaning in Wales – Addendum Key Standards for Environmental Cleanliness Revision 2.0, December 2021.

The Health Board's Environmental Cleanliness Standards Operating Procedure is developed to inform correct processes for assuring high cleanliness standards. This Procedure applies to all Health Board sites and to all employees of the Health Board who undertake cleaning procedures as part of their duties. This includes general scheduled and reactive cleaning activities undertaken by the Support Services, Nursing, and Estates Departments, as well as cleaning duties undertaken by clinical staff.

The Environmental Cleanliness Standards Operating Procedure is supported by 20 newly revised method statements covering primary cleaning tasks, enabling tasks to be carried out to consistently high standards.

The aim is for cleaning staff to be rostered to meet the frequency of scheduled cleaning tasks. However, this has been challenging over the last six months due to staff roster reviews and tight financial controls, leading to occasions where there hasn't been enough staff to fully meet demands and necessitating prioritisation of cleaning to higher risk areas. This challenge also impacts the number of audits that supervisors can undertake to check cleaning standards due to the need to assist with cleaning duties when staffing is low.

The IP&C team communicates closely with local cleaning teams to inform them of any specific recommendations or requests regarding the need for additional unscheduled cleans due to infectious outbreaks in an area.

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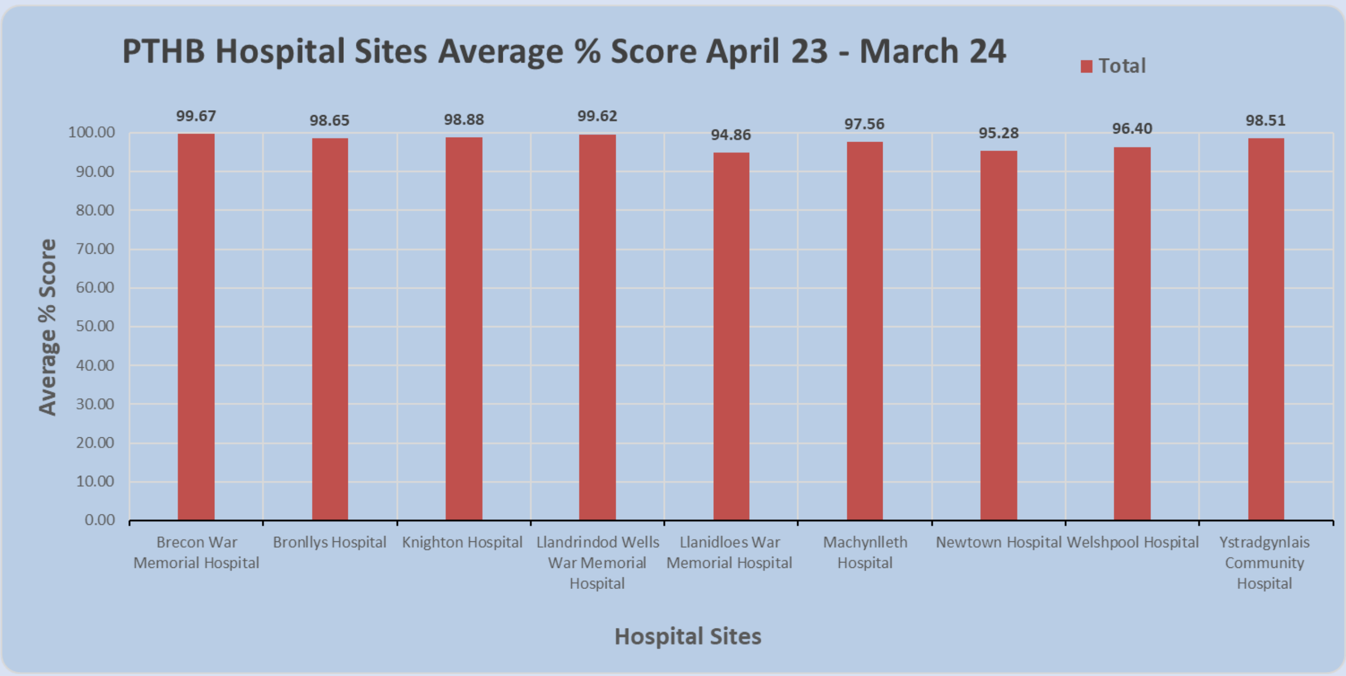
Given the importance of maintaining cleanliness standards, the Support Services Senior Management Team provides monthly assurance reports on several key performance areas, including:

- Monthly average cleaning scores by risk level and area.
- Number of cleaning audits completed by risk level and area.
- Number of failing elements by element type by site and area risk level.

Additionally, any area may be drilled into to support clinical investigations.

Support Services intend to transition from their current cleanliness monitoring software



MiCAD to another named Synbiotix in Q1 2024/25. This is noted to be an improvement due to its capability to provide more meaningful reporting and performance dashboards for benchmarking, as well as representing a financial saving.

During the last period, there have been several improvements to support cleaning activities, including:

- Removing vacuum cleaners in clinical areas and replacing them with a dry mopping system. The new system is currently under review for further improvement.

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- Designing a poster named "What clean do I mean" to support joint understanding across departments of cleaning types and intensity.
- Switching to a primary cleaning detergent disinfection solution of equal effectiveness but on a compliant procurement contract.

New National Standards for Environmental Cleanliness are expected in 2024/25. Powys Teaching Health Board has played a significant role in this national work to develop these new standards, as it did in the previous Addendum for the existing standards of 2009.

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11. Internal Audit

As part of our ongoing commitment to improvement, the team participated in an internal audit as a component of the Health Boards annual internal audit programme. This evaluation specifically aimed to examine the protocols and measures in place across the IP&C portfolio, with a particular emphasis on the management of CDI and the Infection Prevention and Control improvement plan.

Conducted in the fourth quarter of 2023/24, the audit provided a reasonable level of assurance overall, with substantial assurance gained in several key areas including the management of CDI within the organisation and the effective oversight and reporting of the IP&C improvement plan. An outline of the internal audit is provided below, with full audit provided in the appendix:

Report Opinion

Reasonable	Some matters require management attention in control design or compliance. Low to moderate impact on residual risk exposure until resolved.

Assurance summary[1]

	Objectives	Assurance
1	Monitoring and reporting of the IPC Improvement Plan	Substantial
2	Clostridioides Difficile policies and procedures	Reasonable
3	Guidance and training	Reasonable
4	Incident reporting and monitoring of Clostridioides Difficile	Substantial
5	Reporting on Clostridioides Difficile performance	Substantial

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

A small number of management actions, as identified within the internal audit have been fully implemented, with the sole exception being the updated terms of reference for the Infection Prevention and Control Group, which was ratified at the group in May 2024.

12. Decontamination

In August 2023, the Infection Prevention and Control team assumed operational responsibility for Decontamination across the Health Board. The team have been working diligently since then to establish strong oversight and monitoring frameworks, during a JAG audit in March 2024 auditors praising the IP&C team for the substantial support and visibility they bring to the service.

Efforts have been focused on addressing the key issues identified in 2023-24 annual Institute of Healthcare Engineering and Estate Management (IHEEM) audit conducted by NHS Wales Shared Services Partnership (NWSSP). Many long-standing actions now being addressed, with the intense support provided by the Specialist Practitioner in Infection Prevention and Control.

Moving into 2024-25, the team is committed to continuing its efforts to:

- Refresh the Health Boards decontamination safety group, which will take place bi-annually from June 2024. This group will report to the quarterly Infection Prevention and Control group, chaired by the Executive Director of Nursing, Quality, Women and Family Health.
- Strengthen partnerships with commissioned providers, who deliver decontamination/sterile services to Powys Teaching Health Board.
- Work with Primary care colleagues, including Community Dental Services to further strengthen frameworks.
- Continue to ensure robust process for decontamination of re-usable medical devices are in place, including ultrasound machines.
- Ensure a structured annual audit programme across the Health Board, which will include an audit of commissioned service providers.
- Ensure robust contingency plans are in place for decontamination services across Powys Teaching Health Board
- Ratify and approve a small number of key policies, related to decontamination at the Infection Prevention and Control group in May 2024.

13. Commissioning Arrangements

Powys Teaching Health Board commissions care within Wales, and across the border in England. Over the past year the team have successfully established strong relationships with counterparts in England, engaging in regular meetings, including attending post infection reviews, where Powys patients have been impacted. This collaboration provides assurance to the Health Board that the probable cause of the HCAI has been explored and any lessons learned is adopted by the commissioning organisation. As we move into 2024/25, we will continue to strengthen the relationships and the reporting learning outcomes via the Infection Prevention and Control Committee.

The commissioning of laboratory services across the border in England has presented challenges in the timely notification of results, as they do not link into the ICNET clinical surveillance database that is utilised Wales-wide. This has led to communication gaps to the Infection Prevention and Control team, which has on occasions impacted the prompt management actions from the team. A further impact has been discrepancies between internal and external dashboards, creating inconsistencies in data reporting, which has been recognised within the Health Boards Infection Prevention and Control improvement plan. Efforts are actively underway to rectify the issue, with one of the laboratories successfully integrated into the ICNET system, to support results being available as they are authorised and reported. Further measures are currently under way with a second laboratory, it is hoped that this will imminently be able to feed through the ICNET system. These steps are part of a broader strategy to enhance coordination and streamline the flow of information via one source, ensuring more accurate any synchronised data.

14. Antimicrobial Stewardship

Antimicrobial resistance (AMR) has been identified as one of the most pressing global challenges. The World Health Organisation (WHO) has declared it as one of the top 10 global public health threats along with the UK Government acknowledging the issue on the national risk register.

AMR arises when the organi1sms that cause infection evolve ways to survive treatment. Once standard treatments are ineffective, it is easier for infections to persist and spread.

Although resistance occurs naturally, the inappropriate use of antimicrobials in both human and animal medicine, in plants and crops and unintentional exposure, for example through environmental contamination and food, is rapidly accelerating the pace at which it develops and spreads.

The NHS has a key role to play in tackling AMR and all NHS organisations are required to support the implementation of antimicrobial stewardship interventions.

The importance and value of embedding antimicrobial stewardship pharmacists in antimicrobial teams is well recognised, however Powys Teaching Health Board (PTHB) is the only health board in Wales that does not have at least one such pharmacist in post. A business case has been written and is currently being considered by the health board. Although PTHB has the second lowest prescribing of antimicrobials in Wales (antimicrobial items per 1,000 STAR-PUs), our prescribing is considerably higher than that seen across the border in England, demonstrating scope for improvement.

However, our prescribing of the 4C antimicrobials (co-amoxiclav, cephalosporins, fluoroquinolones and clindamycin) (i.e. the antimicrobials that are most commonly associated with Health Care Associated Infections (HCAI)) is a serious concern. Powys Teaching Health Board is the highest prescriber of 4C antimicrobials in Wales (4C antimicrobial items per 1,000 patients) and is currently 62.8% above the national target for 4C prescribing.

WHC 2023/031 sets out the AMR & HCAI improvement goals for 2023/24. The goals reflect the UK's 20-year vision to tackle antimicrobial resistance which improves a commitment to reduce antimicrobial prescribing by 25% against performance in baseline year 2013/14. Powys Teaching Health Board is not on track and is unlikely to meet this target.

The health board has established an Antimicrobial Stewardship (AMS) Group, chaired by the Chief Pharmacist. This meets quarterly and provides highlight reports to the

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health board's IP&C Group, chaired by the Executive Director of Nursing, Quality, Women and Family Health.

An Antimicrobial Stewardship Plan is in place and is regularly reviewed by the Medicines Management Team and the AMS Group.

The Pharmacy/Medicines Management Team routinely monitors primary care antimicrobial prescribing and practices are provided with monthly antimicrobial key prescribing indicator data covering:

- Total antimicrobial prescribing (items per 1,000 STAR-PU)
- 4C antimicrobials (items per 1,000 patients)
- Co-amoxiclav (items per 1,000 patients)
- Cephalosporins (items per 1,000 patients)
- Quinolones (items per 1,000 patients)
- Silver dressings (cost per 1,000 patients)

Antimicrobial prescribing is discussed at every practice meeting.

In the absence of an electronic prescribing system, the Pharmacy Team has limited ability to monitor antimicrobial prescribing in Powys Community Hospitals. This ability will change with the implementation of electronic prescribing and medicines administration (ePMA) over the next couple of years. However, given that most of the prescribing undertaken in our hospitals, is done by our primary care clinicians, we can anticipate that the concerns seen in primary care are also present in our community hospitals.

The Medicines Management Team has commissioned access to the MicroGuide App to improve access to the health board's antimicrobial prescribing guidelines.

Primary care audits have been undertaken to get a better understanding of 4C antimicrobial prescribing, although not all practices agreed to participate in these audits.

Collaboratively the Health Board's Infection Prevention and Control and Medicines Management team diligently review all cases of CDI, including those in Primary Care. This approach continues to reveal a concerning trend in inappropriate or sub-optimal prescribing practices and compliance with first-line treatment protocols for CDI management. Despite the clear benefits, the Medicines Management Team struggles to provide the support required within current resources.

Agenda item: 2.2

Patient Experience, Quality and Safety Committee	**30 July 2024**
Subject:	Integrated Quality & Performance Framework – Mental Health Escalation Oversight Group
Approved by:	Kate Wright, Executive Medical Director Marie Davies, Deputy Director of Nursing
Prepared and presented by:	Louisa Kerr, Assistant Director of Mental Health and Learning Disabilities Chris Moss, Assistant Director of Performance and Commissioning
Other Committees and meetings considered at:	Patient Experience and Quality Committee 16 April 2024 Executive Committee 15 May 2024 Executive Committee 29 May 2024 Executive Committee 26 June 2024

PURPOSE:

In March 2024 the Executive Committee agreed that Powys Teaching Health Board (PTHB) Mental Health Services be placed into PTHB's internal 'escalated' status.

The PTHB Integrated Quality & Performance Framework (IQPF) came into effect from the 01 April 2024. In the context of the IQPF, an Escalation Oversight Group (EOG) for Mental Health Services has been established.

The purpose of this paper is to provide the Executive Committee with an update on current progress.

RECOMMENDATION(S):

The Executive Committee is asked to:

1. **TAKE ASSURANCE** that the implementation of the IQPF Escalation Oversight mechanism is providing robust oversight of the quality improvement and risk mitigation work being undertaken within Mental Health Services.

2. To **NOTE** and **DISCUSS** the contents of the report and including the action plan, progress that has been made and updated maturity assessment.

Approve/Take Assurance	**Discuss**	**Note**
Y	Y	Y

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ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:		
1. Focus on Wellbeing	Y	
2. Provide Early Help and Support	Y	
3. Tackle the Big Four	Y	
4. Enable Joined up Care	Y	
5. Develop Workforce Futures	Y	
6. Promote Innovative Environments	Y	
7. Put Digital First	Y	
8. Transforming in Partnership	Y	

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EXECUTIVE SUMMARY

The Executive Committee agreed that, within the context of the Health Board Integrated Quality Performance Framework (IQPF), Mental Health Services in PTHB be placed into an escalated (internal within the Health Board) status.

Escalation is considered against the 4 IQPF domains and 3 levels of escalation. An Escalation Oversight Group (EOG) has been established, which describes the process of escalation, de-escalation and intervention process; the levels of escalation; and the four domains of the IQPF against which each service in escalation will be assessed. Services can be in escalation for any or all of these four domains.

PTHB Mental Health services have been placed in escalation level 2a from the 06 March 2024. This paper provides an update on current progress and escalation status.

DETAILED BACKGROUND AND ASSESSMENT

Background

The EOG for Mental Health Services has held a series of weekly meetings since the 08 April 2024. The group is chaired by the Executive Director of Nursing, Quality, Women and Family Health.

In response to being placed in level 2a, the Mental Health service has developed an Improvement Plan which incorporates existing work already underway within the service and focuses on 5 areas, the EOG having agreed the corresponding de-escalation criteria:

Workstream	Summary of Challenge	De-escalation criteria
Incident Management	Key actions from previous NRIs not yet completed Insufficient evidence of review of 9 post investigation incidences identified in desktop review Backlog of open datix incidents Care and Treatment Plan audit not being carried out bi-monthly	Completion of key actions from previous NRIs Confirmed investigation, reporting, action and evidence of learning Evidence of incident investigation, action, learning and closure Implementation of bi-monthly CTP audits
Clinical Audit Response	Limited audit plan Policies and Standard Operating Procedures: a number key policies missing or out of date	Strengthened clinical audit plan to be delivered include areas of learning from key incidents and concerns to include any areas of additional learning from the escalation process Completion of AIMs standards deemed to be: 1. Policies covering Essential standards (failure to meet these would result in significant threat to patient safety thereby leaving organisation vulnerable)

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		2. Policies covering Expected standards that most services would meet
Governance	Formal MDT could not be evidenced	Recorded evidence of MDTs. Clinical audit at 3 months for compliance
Training, Education and Learning	Training needs analysis (lack of clear plan) PMVA training lower than expected rates	Production of plan with agreed timescales for improvement
Workforce, Communications and Culture	Incorporates already established work focusing on workforce planning; staff well-being; strengthening MDT approaches; communication; training and ongoing professional development; clinical education; finance and variable pay; PADR; sickness; vacancies and recruitment.	

Progress to date

- Significant reduction in overdue patient safety incidents. At the time of our initial deep dive (reported in January 2024), we had circa 480 overdue incidents. At 15 July 2024 there were 84 open patient safety incidents. Almost all historic incidents closed. The service group is reporting 70 – 80 new incidents per month.

- Significant improvement in PMVA training: 77% compliance whole service with 80% compliance at our acute adult in-patient ward with a plan in place for those staff our of compliance.

- MDT arrangements at our in-patient adult ward redeveloped and improved with increased and improved attendance from the wider MDT: Plans to evaluate and audit effectiveness in place.

- All policies assessed and prioritised. UP to date Policy tracker in place. All policies for updating allocated to a named individual with timescales in place for completion.

- Revised clinical audit plan and progress with audits reported at the oversight group and learning group. Ward Manager audit cycle rolled out led by the In-patient Matron/ Senio Nurse. New audit and policy tracker in place.

- Revised quality governance infrastructure established in the service

- Workforce, Communication and Culture Group established, co-chaired by WOD business partner and MH operational leadership. Focus on engagement, leadership, training and development (including a targeted approach to PADR)

- Appointment of new ward manager for Felindre

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An Integrated Quality and Performance Assessment Framework (IQPAF) and Conditions for Sustainability has been developed for the service placed in escalation to undertake a self-assessment of service maturity using a simple matrix, which is subjective, but requires service leaders to demonstrate their subjective assessment with evidence.

The most recent assessment of the IQPAF was undertaken on the 17 July 2024 by the Senior Leadership Team which identified:

- Increasing maturity for the domains of:
  - Safe and Effective Care (moved from Results to borderline Results/Maturity)
  - Quality of Leadership and Management (moved from borderline Early Progress/Results to Results).

- Quality of Patient Experience remains at Results.

The IQPAF continues to be overseen by the EOG and is presented to the Executive Committee for discussion and approval of current progress and recommended level of maturity.

The proposed Conditions for Sustainability have been developed and are bring considered by the Execuitve Committee on the 31 July 2024. This is already being, and will continue to be, utilised within the Mental Health Service to ensure that the learning from the escalation process is sustained with a focus on continuous improvement and embedding as business as usual.

Clinical Audit

The CD for Mental Health gave a presentation on recent clinical audits to the Learning from Experience Group on 04 July 2024. He outlined that an audit tracker has been developed for the Mental Health service.
He summarised the audits outlined below:

<u>Audit of Physical Health Reviews – May 2024</u>
An improvement was noted compared to previous audit with good evidence that Physical Health Reviews were being actively undertaken. There could still be some improvement in stengthening recording of education in lifestyle choices.
An action was to expand this to older adult Mental Health patients and to reaudit in December 2024.

<u>Audit of Discharge Summaries 2024</u>
An audit demonstrated that there were still delays incompleting timely discharge summaries for some patients.

An action has been completed to develop a nurse completed discharge notification form which is handed to the patient at time of discharge. A new formal discharge

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proforma has been developed to be completed within 72 hours of discharge. Both forms have been developed in line with College guidance.
A repeat audit will be carried out in 6 months time.

Audit of completion of WARRN risk assessments December 2023
A comparison was made to a previous audit in 2021 demonstrating improvement in most domains of completion. Improvement is still needed in demonstrating collaboration with patients and families and also in updating with change of circumstance. Feedback has been provided to teams and there will be a repeat audit in December 2024.

The learning group heard about other improvements in the service such as biweekly safety huddles. It was outlined by the group that there should be sharing of some of the new practices with other service groups as they appear to have been effective in bringing sustained improvement to the management of incidents.

The Escalation and Oversight Group recognise that implementation of the Improvement Plan is on track to have been fully delivered by September 2024 and that appropriate governance arrangements within the Directorate have been strengthened. The monitoring of evidenced progress will continue with a view to recommending de-escalation when all actions are fully expedited, and that the identified ongoing continuous improvement has become business as usual.

NEXT STEPS:

1. The Escalation and Oversight Group will continue to meet as scheduled
2. Executive Committee will continue to receive fortnightly updates
3. The Patient Experience, Quality and Safety Committee will receive a further update at its next scheduled meeting in November.

IMPACT ASSESSMENT – NOT REQUIRED FOR THIS REPORT

This section must be completed for all strategic organisational decisions including approval of health board policies.

QUALITY:

	No impact	Negative	Positive	Both	
Safe			X		
Timely			X		
Effective			X		
Efficient			X		
Equitable			X		
Person Centred			X		
Workforce			X		
Leadership			X		
Culture			X		
Information			X		
Learn, Improve, Research			X		
Whole Systems Approach			X		

EQUALITY:

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	No impact	Negative	Positive	Both	
Age	X				
Disability	X				
Gender reassignment	X				
Marriage / civil partnership	X				
Pregnancy / maternity	X				
Race	X				
Religion or Belief	X				
Gender	X				
Sexual Orientation	X				
Welsh Language	X				
Socio-economic status	X				
Social exclusion	X				
Carers	X				

RISK ASSESSMENT:

	Very Low (0-3)	Low (4-8)	Moderate (9-12)	High (15-25)	
Clinical	X				
Financial	X				
Corporate	X				
Operational	X				
Reputational	X				

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Agenda item: 3.1

Patient Experience, Quality and Safety Committee	**DATE: 30 July 2024**
Subject:	**Integrated Quality Report**
Approved and presented by:	Claire Roche, Executive Director of Nursing, Quality, Women and Family Health Marie Davies, Deputy Director Nursing
Prepared by:	Zoe Ashman, Assistant Director Quality & Safety
Other Committees and meetings considered at:	Executive Committee - 10 July 2024

PURPOSE:

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

RECOMMENDATION(S):

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

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

Approve/Take Assurance	Discuss	Note
N	Y	Y

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:		
1. Focus on Wellbeing	N	Use this space to provide a brief narrative explanation of alignment with the health board's wellbeing objectives including reference to our strategic priorities. This can include reference to the Board Assurance Framework.
2. Provide Early Help and Support	N	
3. Tackle the Big Four	N	
4. Enable Joined up Care	Y	
5. Develop Workforce Futures	N	
6. Promote Innovative Environments	N	
7. Put Digital First	N	
8. Transforming in Partnership	N	

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EXECUTIVE SUMMARY:

1 Background

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

2 Specific matters for consideration by this meeting (Assessment)

2.1 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, 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.

2.2 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.

Feedback from Medical Examiner has resulted in learning for clinical teams to ensure:

- Families/NOK are notified in a timely manner when their relative/loved one's condition deteriorates.
- Ensure pathways of care are clearly explained to patients and their families/NOK.
- Ensure open lines of communication are in place for families/NOK.

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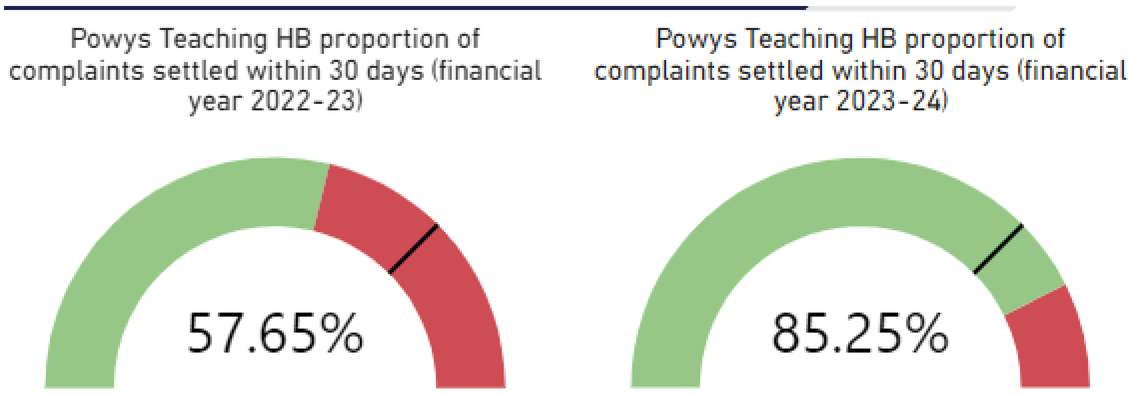
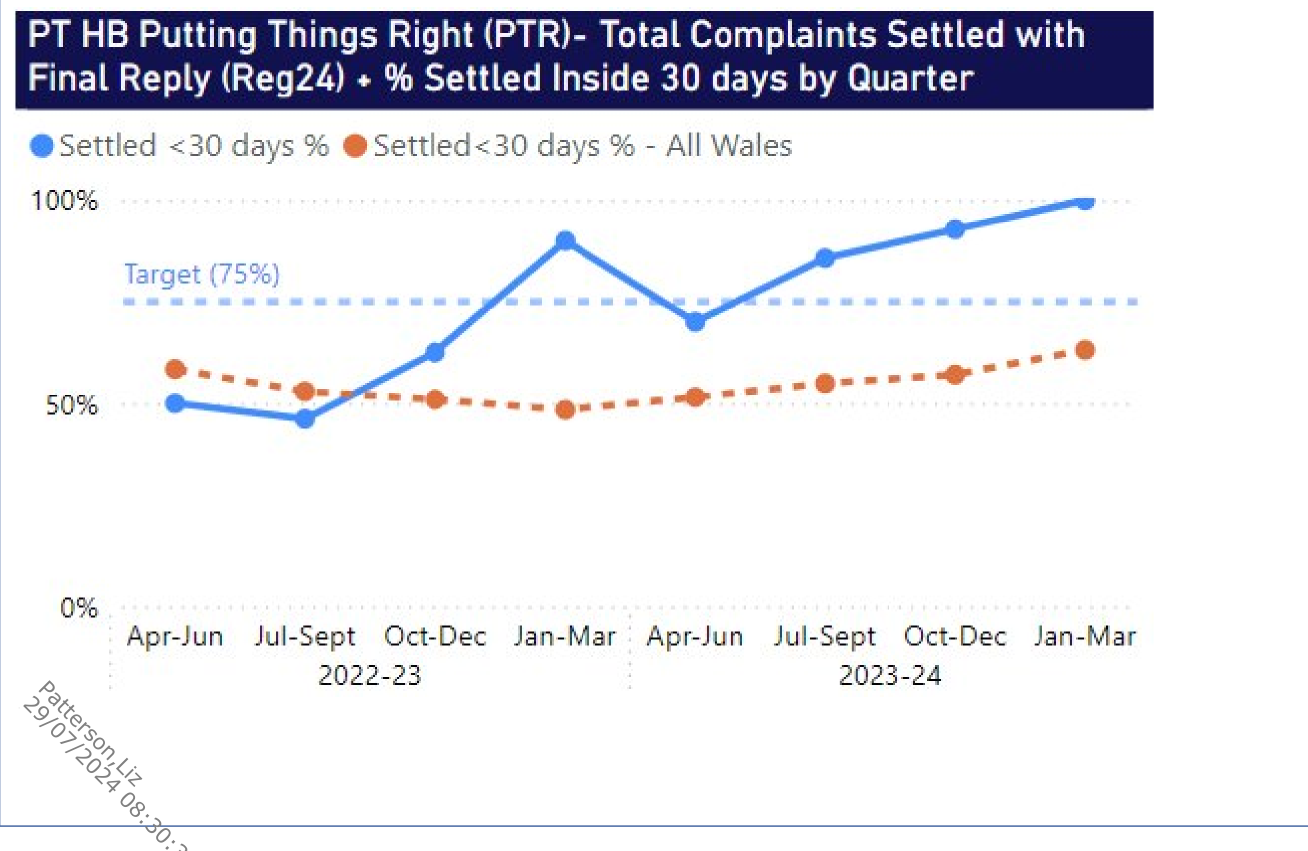
2.3 Putting Things Right – Concerns

The management of concerns compliance within 30 working days reported nationally at the end of 2023/24 85.25% (2nd position nationally) which is a significant improvement 2022-23 of 57.65% and 2021/22 of 27.5% (worst performing health board). Continued focus is maintained to ensure concerns are managed in a timely manner with the appropriate investigation and response. The reported compliance for Q1 2024/25 is 68%.

Graph 1 compares compliance 2022/23 with 2023/24 (Data obtained from NHS Executive Beacon Dashboard)



Graph 2 highlights the Powys quarterly compliance (blue line) against the national position (Orange line) (Data obtained from NHS Executive Beacon Dashboard)



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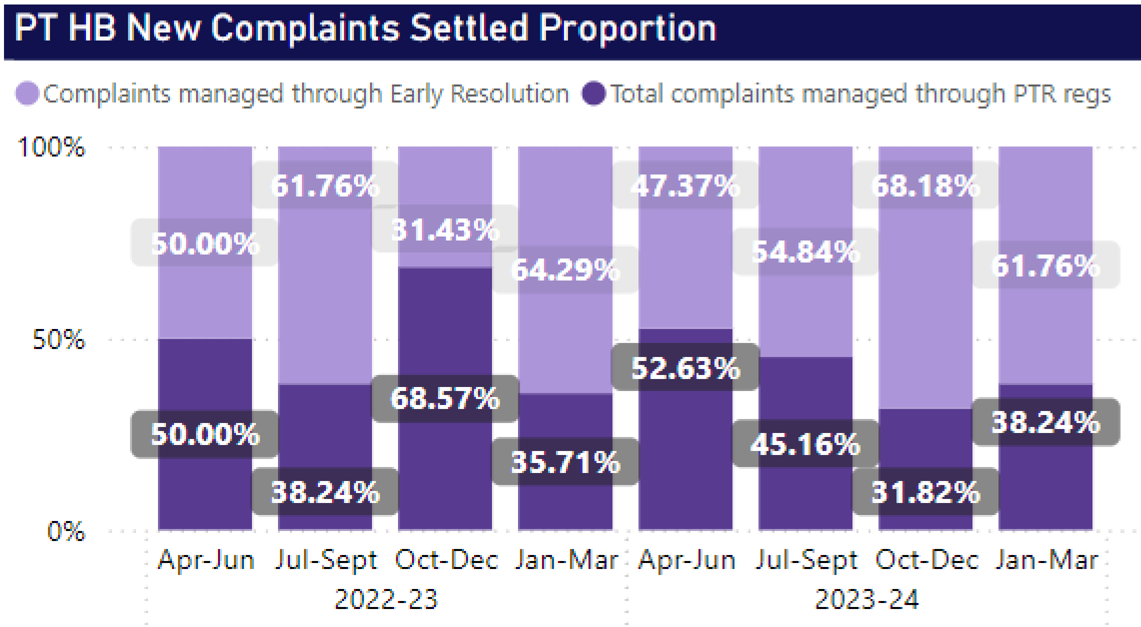
Graph 3 notes the percentage of concerns managed as early resolution (light purple) and formally (Dark purple) (Data obtained from NHS Executive Beacon Dashboard)



Themes from concerns (provider)

- Communication with families.
- Delays in prescribing medication.
- Waiting time for appointments in planned care.
- Attitude and behaviour of clinical staff to patient/relatives.

Themes from concerns (commissioning)

- Availability and funding for Avastin injections for Welsh patients
- Waiting time for hysterectomy procedure at SaTH
- Waiting time to see a consultant at RJAH

Themes from Early Resolution/Enquiries

- Reliability of medication delivery services offered to Powys residents.
- Use and cost of Welsh Language resources.
- Access to Orthodontist services outside of Powys
- Option to choose the type of covid vaccination because patients reacted badly to Moderna vaccine.

2.4 Duty of Candour

There have been 13 Duty of Candour cases during Q1 2024/25. All cases are at various points of investigation. The number of candour cases have increased throughout the year, this is attributed to colleagues increased awareness and understanding of the requirements of the Act; duty of candour has had no impact on number of Redress cases to date.

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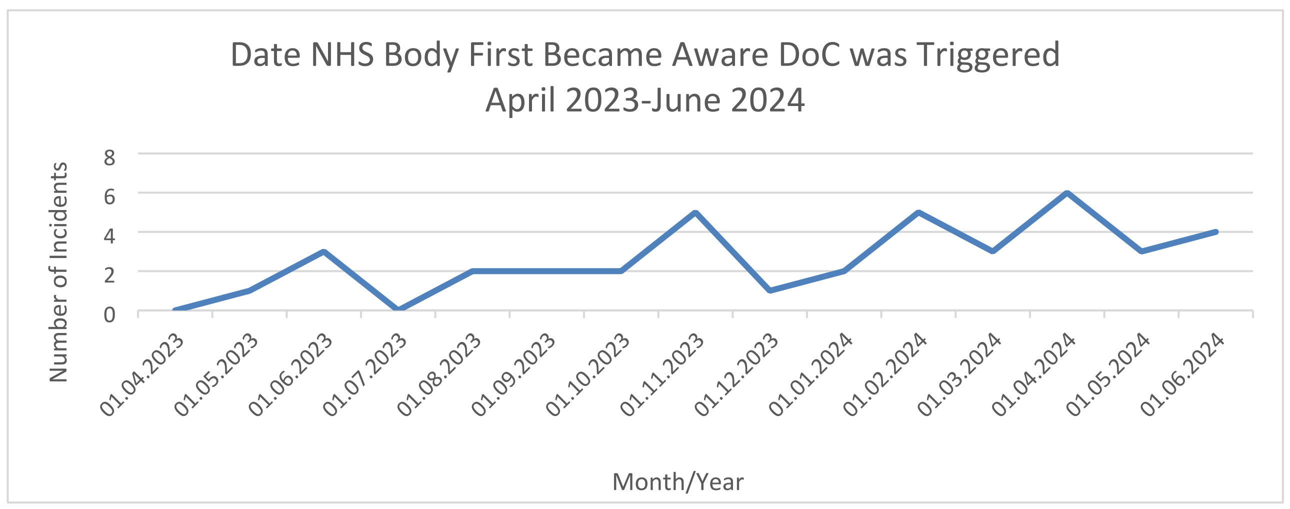
Graph 4 numbers of reported Candour cases since implementation



Learning from Duty of Candour

- Review staff training compliance regarding manual handling.
- Ensure all patient risk assessments are completed on admission to hospital.
- Management of the deteriorating patient; management of NEWS & Sepsis 6.
- Pain management.
- Management of staff allocated to provide 1:1 care.

2.5 Claims, Redress & Clinical Negligence Position

Redress
6 confirmed cases
100% compliance with re-imbursement recovery.

Clinical Negligence
8 confirmed cases

General Medicine Practice Indemnity (GMPI) Claims
4 confirmed cases

2.6 Incident Management

The number of patient safety incidents (Graph 5) reported is stable and appropriate with most incidents reported within the Low and No Harm classification.

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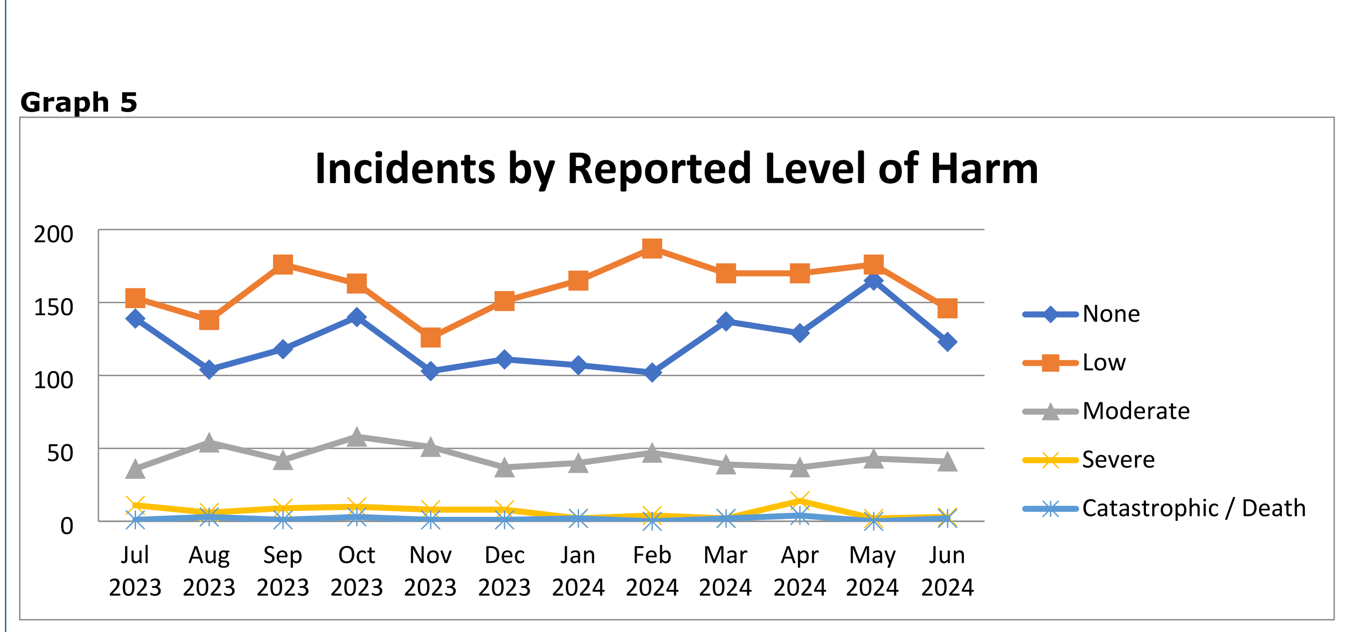
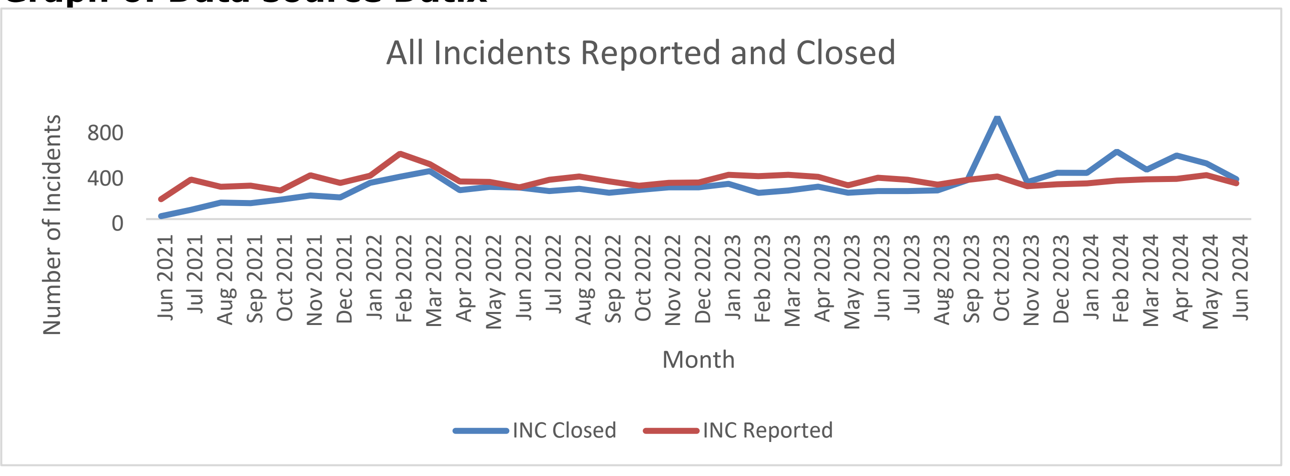
Graph 5



Improvements have been realised with regards to the timely investigation and closure of incidents. It is visible in Graph 5 below that the number of incidents closed has remained higher than the number reported since September 2023 when proactive and supportive measures were implemented.

Graph 6: Data source Datix



Further analysis of pressure ulcer incidents and occurrence will be a focus for reporting to committee during Q3 2024/25.

2.10 Early Warning Notifications (previously No surprises notifications)

1 Early Warning Notification has been submitted during Q1 2024/2025.

2.11 Nationally Reportable Incidents

The current position for open Nationally Reportable Incidents (NRI's) is reported in the table below. Improved timeliness of investigations is a focus for 2024/25

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as currently 66.7% of investigations remain open for >90 working days with the average completion time of 188days, this can be attributed to complex mental health cases which are anticipated to be completed by 120days. With the consideration of the most complex cases, investigation timeliness requires improvement to ensure investigations are shared with families and learning consolidated.

Number open	**Number open in time**	**Number open overdue**	**Number awaiting final approval**
11	**6**	**5**	**3**

The themes for learning and improvement include:
- Appropriate ward cleaning schedules and use of correct cleaning products
- Standards of record keeping care planning and documentation systems.
- Consent to treatment.
- The WARRN and MHM MH&LD assessments should be viewed as live documents and updated when new information is available.
- Complex pathway of care.
- Review training requirements for all staff for all ward based clinical activities (NEWS, SEPSIS and the Deteriorating Patient).
- Robust induction of agency staff.
- Risk assessments to be updated as patient`s condition changes.
- Ensure robust medicines management processes are in place across the inpatient wards.

3. Patient Experience

3.1 CIVICA

Your NHS Experience survey is available for all patients that have accessed healthcare. **Graph 6** demonstrates the feedback available Q4 2023/24 and Q1 2024/25, it is noted during Q1 there has been a technology issue which has impacted outcomes being available; this is being addressed. The 'heat map' approach to data is described as:
- **Green >85%**
- **Amber 75-84%**
- **Red <75%**

Narrative analysis of responses is an area for development to further inform ongoing learning and service development.

Graph 7 – Source CIVICA

Question:	2024 Jan	2024 Feb	2024 Mar	2024 Apr	2024 May	2024 Jun	Benchmark
2. Did you feel that you were listened to?	86	87	88	80	81	50	85
3. Were you able to speak in Welsh to staff if you needed to?	46	33	35	40	25	-	85
4. From the time you realised you needed to use this service, was the time you waited:	74	65	69	60	63	31	85
5. Did you feel well cared for?	87	85	88	79	75	50	85
6. If you asked for assistance, did you get it when you needed it?	85	82	88	72	63	38	85
7. Did you feel you understood what was happening in your care?	88	86	89	81	75	58	85
8. Were things explained to you in a way that you could understand?	88	88	91	86	81	92	85
9. Were you involved as much as you wanted to be in decisions about your care?	85	84	88	83	75	83	85
10. How would you rate your experience 1-10	85	85	88	81	78	63	85
Overall:	84	82	85	77	73	57	
Respondents:	219	174	210	37	4	4	

Graph 8 maps specific response to services, it has been noted that 646 responses have not been mapped against a service which is due to respondents not selecting a service option.

Graph 8 Service Specific Responses

Services	Responses	2 - Did you feel that you were listened to? Your NHS Wales Experience	3 - Were you able to speak in Welsh to staff if you needed to? Your NHS Wales Experience	4 - From the time you realised you needed to use this service, was the time you waited: Your NHS Wales Experience	5 - Did you feel well cared for? Your NHS Wales Experience	6 - If you asked for assistance, did you get it when you needed it? Your NHS Wales Experience	7 - Did you feel you understood what was happening in your care? Your NHS Wales Experience	8 - Were things explained to you in a way that you could understand? Your NHS Wales Experience	9 - Were you involved as much as you wanted to be in decisions about your care? Your NHS Wales Experience	10 - How would you rate your experience 1-10 Your NHS Wales Experience	Overall
Dental Practice	4	31	-	31	31	25	44	44	19	38	33
General Practice (GP)	17	37	67	28	34	37	42	46	38	37	38
Hospital site other than a Powys Hospital	211	88	50	75	88	86	89	89	87	87	86
Hospitals and services outside Powys	2	0	-	13	13	38	0	75	75	10	24
Powys Hospital	1	100	-	75	100	-	100	100	100	100	96
Powys Services	25	80	30	71	84	79	79	85	80	79	78
Unmapped	646	89	39	69	88	86	88	90	87	88	85
Virtual Consultation	1	25	-	100	25	-	25	0	0	0	25
	Overall	87	41	70	87	84	87	89	86	86	84
	Benchmarks	85	85	85	85	85	85	85	85	85	

Graph 8 is a wordle of the most used words within the 'free text' system Q4 23/24 & Q1 24/25. Negative words are coloured in red with positive words in green. Further analysis is required for the negative responses as this is not consistent with previous reporting periods which have been 90% Green.

Graph 8 – Source CIVICA

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complicated
"refused to listen"
ashamed
"not listen" stressful
"at ease" complained
happy ignored sadly
unhelpful
impossible
excellent wish
inaccuracies
"not listening"
frustrating
apologetic

Powys Maternity Service

Powys Maternity service has embedded the Civica PREMS (Patient Reported Experience Measure) data collection platform in their work, with six surveys currently active to collect feedback relating to care at various stages of the pregnancy journey from booking until discharge, a survey for partner/co-parent as well as a survey for the provision of Solihull antenatal classes. Invitations to complete four the surveys are automatically text to individuals at certain points in their care, and 2 others are optional surveys. In addition to the Civica surveys, feedback is also collected from women who transfer in labour or shortly after birth via a separate Forms survey.

The surveys consistently show that people feel listened to, and that their care reflects what is important to them – 98% of respondents have said they were treated with kindness and understanding during their pregnancy, 96% have had enough information to make decisions about labour and birth and 91% were extremely likely or likely to recommend the service to others. The service is exploring with Civica the ability to pull responses straight through to the service dashboard for review. The service will also be developing 'You said, we did' responses to demonstrate learning from feedback received. Results from all surveys, including any comments provided, which are now shared monthly to teams and on social media as posters. **(Appendix 2)**

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3.2 Patient Stories

Development of a library of patient stories to support learning, improvement along with team meetings, Board and Committee has been an area of focus during Q1 2024/25. NHS Executive have provided national training which PTHB were fortunate to be selected to attend during June 2024, this will support the robust production of patient stories across the health board.

4. Infection Prevention and Control (IP&C)

IPC presented as a separate Agenda Item, to include Annual Report and Year2 improvement plan priorities.

5. Health and Social Care Inspections Regulatory Recommendations

5.1 Health Inspectorate Wales Inspections

The historical actions from 2017-2020 are closed and the oldest outstanding actions now relate to inspections conducted from 2021 to date (shown below).

	Recommendations / Actions Overdue (agreed timescale)	Overdue Recommendations / Actions Revised Timescale	Recommendations / Actions Not Yet Due
Tier 1 Quality Check Clywedog Ward, Llandrindod Wells		**1**	
HIW Announced Inspection of community mental health services	**6**	**2**	
HIW Tawe Ward Unannounced Inspection		**3**	
HIW All Wales Review of discharge arrangements in Mental Health		**3**	**3**
HIW Inspection Y Bannau and Epynt Wards, Brecon Hosptial	**2**	**3**	

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5.2 Thematic review of HIW Inspections carried out during 2023/24 has been completed by Linzi Shone, Professional Head of Nursing, Community Services Group (Appendix 1). The report outlines the thematic learning which has been shared across all wards within the community Hospitals.
In Summary from the inspections for Claerwen, Adelina Patti, Epynt, Y Bannau, Bryn Heulog and Graham Davies Ward:

Quality of Patient Experience

- Staff provided respectful and dignified care.
- Patients were encouraged to be active and were given equipment to help them walk and move.
- Occupational therapists and assistants worked well with patients.
- Initiatives were introduced to help care for patients living with dementia.
- Patients expressed satisfaction with the care and treatment received.
- Staff interactions with patients were dignified and respectful.
- Some aspects of the environment required improvement.

Delivery of safe and effective care

- Staff demonstrated commitment to providing safe and effective patient care.
- Suitable equipment was available and used to prevent pressure sores and falls.
- Medication management and storage were handled safely and effectively.
- A pharmacy technician provided valuable support to the ward staff.
- The All-Wales Hospital Nutrition Care pathway standards were generally met.
- On-site food preparation was well-presented and appetizing.
- Patient records were up-to-date and well-completed.
- Weekly checks on emergency equipment were conducted.
- The ward environment was clean and accessible, with appropriate equipment.

However, there were areas for improvement:

- Infection control, medication management, and record keeping required attention.
- Storage space was lacking, and better communication between staff was necessary.
- Blood transfusion policy was out of date and staff required training in some areas.
- Education in the areas of Sepsis, NEWS scoring, care of the deteriorating patient, blood transfusion and inpatient falls was noted to require focus by the health board.

6. Llais

No reports provided for reporting period.

7. PAVO

No reports provided for reporting period.

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8. Medical Examiner

The introduction of Medical Examiners (ME) provides NHS Wales with an opportunity to enhance mortality reviews (MR) for greater learning, harm prevention, and improved experiences for patients, families, and NHS staff. Issues necessitating an MR often involve various professions and services, underscoring the importance of a comprehensive approach. This framework aims to establish a coordinated and systematic approach to the mortality review (MR) process across Wales, facilitating both local and national implementation of the lessons learned.

Consideration of all deaths in Hospital by the Medical Examiner commenced during 2023, which provided an element of independence and also learning and improvement. This will be further supported when all community deaths are also considered by the ME from 9 September 2024, processes are in place to support training and education for all involved to ensure teams are ready for the change.

During 2023/24 the following number of cases were referred to the HB for consideration:

MONTH	No. of referrals received	No. of referrals sent to DGH's for investigation	No. of referrals for PTHB to investigate
TOTAL	45	10	35

Learning identified:

- Ensure families/NOK are notified when a patient's condition changes during the night.
- Ensure all documentation (including digital records) are shared with the ME.
- Improved communication is required for families/NOK when patients are at the end of life.

9. KEY MATTERS FOR BOARD/COMMITTEE

Timely management of NRI investigation to ensure learning is realised and outcomes shared with patients and families.

ACTION taken: Additional focus and support is being provided by the Head of Quality & Safety to ensure reports are managed in a timely manner and learning identified and shared throughout the process. Governance leads within the services are required to take ownership of the management and escalation of investigations if timescales are not being met.

Appendices included with this report are as follows:

- Appendix 1: HIW Thematic review following Inspections
- Appendix 2: Maternity Feedback Poster

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NEXT STEPS:
The report will continue to e provided to the Executive Committee and Patient Experience, Quality and Safety Committee on a quarterly basis.

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IMPACT ASSESSMENT – NOT REQUIRED FOR THIS REPORT

This section must be completed for all strategic organisational decisions including approval of health board policies.

QUALITY:

	No impact	Negative	Positive	Both
Safe	√			
Timely	√			
Effective	√			
Efficient	√			
Equitable	√			
Person Centred	√			
Workforce	√			
Leadership	√			
Culture	√			
Information	√			
Learn, Improve, Research	√			
Whole Systems Approach	√			

A Quality Impact Assessment must be undertaken for all reports requesting approval, ratification or decision in line with health board Duty of Quality processes (under development). In this space you should provide supporting narrative to explain the potential adverse and positive impacts that may arise from a decision being taken, and the steps being taken to mitigate adverse impacts. Where required, the full Quality Impact Assessment should be available as a supporting document to inform the decision making process.

EQUALITY:

	No impact	Negative	Positive	Both
Age	√			
Disability	√			
Gender reassignment	√			
Marriage / civil partnership	√			
Pregnancy / maternity	√			
Race	√			
Religion or Belief	√			
Gender	√			
Sexual Orientation	√			
Welsh Language	√			
Socio-economic status	√			
Social exclusion	√			
Carers	√			

An Equality Impact Assessment must be undertaken for all reports requesting approval, ratification or decision in line with health board Equality Impact Assessment policies and procedures (CGP009). In this space you should provide supporting narrative to explain the potential adverse and positive impacts that may arise from a decision being taken, and the steps being taken to mitigate adverse impacts. Where required, the full Equality Impact Assessment should be available as a supporting document to inform the decision making process.

RISK ASSESSMENT:

	Level of risk identified			
	Very Low (0-3)	Low (4-8)	Moderate (9-12)	High (15-25)
Clinical	√			
Financial	√			
Corporate	√			
Operational	√			
Reputational			√	

A Risk Assessment should be undertaken for all reports requesting approval, ratification or decision in line with health board Risk Management Framework CGP005. In this space you should briefly describe the key risks and the steps being taken to manage them, and also how these risks relate to the Board's stated Risk Appetite.

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Thematic review of actions following inspections by HIW in 2023 for inpatient adult wards in PTHB.

Author: Linzi Shone Professional Head of Nursing – Community Services Group

Introduction

Between January and September 2023, 6 unannounced inspections from HIW within the inpatient wards were carried out: namely Claerwen, Adelina Patti, Epynt, Y Bannau, Graham Davies and Bryn Heulog ward.

The visiting team from HIW were similar on each visit and could therefore provide a health board wide view of culture and the provision of high standard patient centred care.

In all inspections, the visiting teams reviewed.

- Quality of patient experience
- Delivery of safe and effective care
- Quality of management and leadership.

The individual ward action plans and reports are held centrally & updated monthly. When an action plan has been fully completed, the ward manager and community services manager revisit the closed actions every 3 months to monitor sustained improvement, this is tracked through the recent introduction of a ward accountability framework.

As a result of the visits, a review of findings has been undertaken to cross reference similar feedback in all areas. The learning and actions from this feedback will enable a broader health board response and the ability to assure the executive board of the actions and outcomes of that shared learning.

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Summary of narrative HIW findings for Claerwen, Adelina Patti, Epynt, Y Bannau, Bryn Heulog and Graham Davies Ward.

Quality of Patient Experience

- Staff provided respectful and dignified care.
- Patients were encouraged to be active and were given equipment to help them walk and move.
- Occupational therapists and assistants worked well with patients.
- Initiatives were introduced to help care for patients living with dementia.
- Patients expressed satisfaction with the care and treatment received.
- Staff interactions with patients were dignified and respectful.
- Some aspects of the environment required improvement.

Delivery of safe and effective care

- Staff demonstrated commitment to providing safe and effective patient care.
- Suitable equipment was available and used to prevent pressure sores and falls.
- Medication management and storage were handled safely and effectively.
- A pharmacy technician provided valuable support to the ward staff.
- The All-Wales Hospital Nutrition Care pathway standards were generally met.
- On-site food preparation was well-presented and appetizing.
- Patient records were up-to-date and well-completed.
- Weekly checks on emergency equipment were conducted.
- The ward environment was clean and accessible, with appropriate equipment.

However, there were areas for improvement:

- Infection control, medication management, and record keeping required attention.
- Storage space was lacking, and better communication between staff was necessary.
- Blood transfusion policy was out of date and staff required training in some areas.
- Education in the areas of Sepsis, NEWS scoring, care of the deteriorating patient, blood transfusion and inpatient falls was noted to require focus by the health board.

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Quality of management and leadership

- **Staff Engagement and Reporting Concerns**: Staff reported that senior managers were visible and engaged, and they felt comfortable reporting concerns.
- **High Acuity Ward**: The ward operated at high acuity, with many patients needing enhanced support. Staff faced challenges in spending sufficient time with patients while ensuring safe care.
- **Staff Wellbeing**: Concerns were raised about staff wellbeing due to the high patient acuity.
- **Recommendations for Improvement**: The inspection led to several recommendations for better oversight by senior managers in day-to-day ward operations.
- **Positive Management and Leadership**: Both wards demonstrated good management and leadership, with positive feedback from staff.
    - Staff received positive support from the management team.
    - An ethos of continual improvement was evident.
    - Commitment to delivering a high standard of care to patients.
    - Overall, an open and supportive culture existed among staff.
- **Areas for Improvement**: Staff supervision and certain aspects of training needed enhancement.
- **Collaboration with Services**: Multiple organizations and services were involved in discharge planning.
- **Compliance and Audits**: Overall compliance with mandatory training was high (82%). Audits monitored best practices, and scrutiny meetings addressed issues like falls and pressure ulcers.
- **Feedback on Leadership Culture**: Some staff feedback highlighted issues with leadership approachability and visibility.
- **Leadership and Management Culture**:
    - Specific examples highlighted issues with senior management:
        - **Approachability and Visibility**: Senior management was perceived as not being approachable or visible in some areas.
        - **Communication Gap**: Effective communication between senior management and staff was lacking.
        - **Potential Blame Culture**: References were made to a prevalent 'blame culture' on the ward.
    - **Health Board Action**: The health board has been asked to engage with staff, fully understand their views, and identify actions for improvement.

It is recognised that there is variation in feedback in relation to senior management visibility and accessibility, this is being reviewed with the relevant personnel. Communication is being addressed, there are monthly meetings with Band 7's with shared learning, updates and feedback and ward managers have been asked to ensure they are undertaking frequent ward meetings to relay this information to ward staff. Senior colleagues visiting the wards are committed to speaking with teams during each visit and following up on any concerns addressed. There is some discrepancy between who is considered a senior manager, but for the purposes of this report it is taken that this relates to those in a role of 8B and above.

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All detailed actions for improvement, identified in feedback from HIW were analysed for areas of similarity and the findings are present below in figure 1.

Category	Count
DOORS/CUPBOARDS UNLOCKED	3
PATIENT ID BANDS	2
WELSH SPEAKING STAFF	3
MFRA TIMLEY ASSESSMENTS	3
STAT/MAND TRAINING COMPLIANCE	5
UNDERSTANDING OF DUTY OF CANDOUR AND TRAINING	3
BLOOD TRANSFUSION POLICY AND STAFF COMPETENCE	4
DOLS ASSESSMENT, TRAINING AND DOCUMENTATION	4
SEPSIS TRAINING AND ESCALATION	5
AUDIT RESULTS	3
PADR'S	4
DEMENTIA CARE	4
ENVIRONMENT	5
RISK ASSESSMENTS	2

Figure 1.

Key: Complete In Progress Incomplete

HIW Theme	Area of Impact	Components	Actions and Recommendations	Status
Quality of Patient Experience	Welsh Language	Welsh Speaking staff	• Focused work on the Welsh offer. • Staff encouraged to take up training places. • Increased awareness regarding accessing translation services.	In Progress
	Dealing with complaints and Duty of Candour.	Understanding of duty of candour	• At the time of the visits this was being implemented. • All areas have Llais boards displaying how to raise concerns. • Ongoing work with teams to ensure the Duty of candour (DoC) is deployed effectively.	In Progress
	Implementation of PREMS at ward level	Organisation of ward level survey and QR code.	• Ward managers meeting in June to complete actions for questions. With a planned launch for July 2024.	In Progress
	Narrative: All wards received positive feedback from the visits in relation to dignified, safe, patient centred care. It was noted in one ward the level of patient centred care was the best the inspectors had seen for a very long time. It was also noted following all 6 visits that this was a consistent theme in all 6 wards and spoke to the culture of care in PTHB positively.			
Delivery of safe, effective care	COSHH	Doors/Cupboards unlocked	• Health and Safety Policy has been updated at ward level and all teams reminded of the importance of Hazardous substances and their management and storage. This is spot checked by CSM and HON during ward visits to ensure the improvement has embedded. • Spot check Audit required to provide a mechanism of assurance. • Digital Audit system to be implemented – in process of procurement May 24.	In Progress
	NPSA Patient safety	Patient ID Bands	• One ward was identified as falling below the standard for positive patient identification. • This was addressed immediately on the ward of concern and with all other inpatient wards. The policy was shared, and all staff signed to agree they had read the policy. Monthly ID band Audits are undertaken and provide assurance that this is being conducted correctly. If a patient cannot wear an ID band there is an alternative mechanism in place which is evidenced in the audits.	Complete
	Patient care assessments	MRFA Timely assessment was not undertaken within	• Multi factorial risk falls assessment (MRFA) should be undertaken within 6 hours of admission to an inpatient ward and should be updated weekly, or where there has been a change in condition requiring reassessment, or following a fall.	Complete

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		the recommended time scale	• The 6-hour standard for completing assessments can be audited on the Welsh nursing care records (WNCR).	
	Education	Stat/Mandatory training compliance required focussed improvement in all areas	• Some areas have reduced compliance with mandatory training requirements. • Since the visits from HIW an accountability framework has been introduced where the ward managers' report training levels to the HON and barriers to improvements are addressed. • There remains a variation in training for in person events with staff having to be released to travel to a study day. Further information is being gathered with a supported Clinical education team working in collaboration.	
	Education	Blood transfusion policy and staff training	• This is identified in 3 wards. • Additional training and sign off required for ward staff.	
		DOLS assessment training and documentation	• There was a lack of monitoring of dates in relation to DoLS expiration dates, this has been resolved in the sites where this was identified. • DoLS Audits taking place monthly.	
	Audit results	Audit results are not always visible on each ward and/or not updated monthly	• Audits are undertaken monthly and using paper formats which makes collation and reporting onerous and impossible with resources and workload commitments. • Digital solution has been sourced and is going through procurement, this will be implemented in June and July with support from the procured company to educate teams.	
	Sepsis Education and training for NEWS and care of the deteriorating patient.	Sepsis training and escalation	• During the visits inspectors found that the recording of vital observations was not always documented or escalated in line with guidance and that Sepsis bundles were not always implemented. Whilst varying justifiable reasons can exist for this, on review we found that Sepsis training and NEWS training (how to document vital observations that guide escalation) is not part of the mandatory training matrix for nurses working on inpatient wards. • A recent review of the mandatory matrix for registrants has taken place and this is due to come onto the mandatory framework pending executive sign off.	
	Risk assessments	Health and safety processes required updating in 2 of the wards visited.	• This has been reviewed and updated and all 9 wards have undertaken this work to ensure shared learning.	
	Dementia Care	Dementia Care	• Dementia hospital charter meetings are taking place monthly with QI projects in place to make improvements to environment of care. Group includes those with lived experience and carers to help shape our services.	

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			• Llewelyn Ward have participated in a QI project that has volunteers on the ward who undertake group work with patients, including painting, games, drawing – this combined with a trial of all Wales enhanced care program has resulted in no additional staff being required to provide 1:1 care for the past 8 months. • This work is being reviewed against other areas for replication.	
	Infection and Prevention Controls.	Infection and Prevention	• Environmental aspects of IP&C were highlighted in the reports and have been escalated onto the risk register and shared with estates. This ranges from flooring to sky lights. • Additional concerns were found in relation to processes such as infectious waste and IV needle systems. These have been addressed with ward teams and policies reshared. • Storage was highlighted as a concern with some boxes of items stored on ward floors. This has been addressed with all teams and Bi-Annual decluttering sessions introduced, however given the size of some wards, storage remains an issue of concern. • We have reviewed IP&C mandatory training results and despite improvements in scores, we have not seen this reflected into practice. In collaboration with IP&C colleagues we have reviewed internal training and are implementing OSCE style training at ward level, the theory being that training in the place of work carries higher relevance to staff members – this has successfully been trialled in Machynlleth and is being rolled out across inpatient wards. The rollout of this has been impacted by a reduction in resource within the IP&C team.	
	Environment of care	• EOL suites • Flooring • Skylights	• These areas have been reported to the relevant teams and added to the CSG risk register, there are delays in completion due to estates priority and backlog of existing works.	
Quality of Leadership and Management.	Recruitment and retention	PADRS	• Wards had variable levels of PADR compliance. Each ward is reporting on this through the recently introduced accountability framework and is tracked through CSG Quality and safety meetings. • The value of a robust PADR is understood as being a core component of recruitment and retention among all nursing and leadership teams. • There is now a focused plan in place to support the areas below 60% and a clear strategy for improvement in the areas below 85%.	
	Analysis and openness of sharing ward level information	Audit results	• 7 Audits are undertaken monthly within inpatient wards. These are undertaken manually and held at ward level – there is no mechanism for collation of 61 documents to provide a central reporting system. • The implementation of a digital audit system will resolve this and enable a higher-level organisational view of care at ward level.	

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	Ward meetings	Communication	• HIW identified a lack of ward level communication and recommended that ward meetings were recommenced. This action has been implemented throughout wards, but there is a lack of admin to ensure that minutes are provided that can be shared. • Staff reported in some areas that there was a lack of feedback – verbal feedback on subsequent site visits indicates that communication has improved in relation to organisational updates, datix feedback etc.	
	Ward level leadership	Education and Development	• Review with Clinical Education and DDON to implement nursing specific leadership element and develop competency framework. • Room for 8a Clinical leadership to provide quality and safety focus and clinical supervision.	
	Senior management	Visibility of senior management	• Varying responses from areas has highlighted that we have a lack of clinical oversight at senior nursing level. • From a CSG perspective each area has a CSM who visits weekly, HoN also visits, this is less frequent. Senior nursing colleagues from IP&C, Corporate nursing and AD frequently attend sites. • The CSG team would benefit from 8a clinical leadership to provide education, development and support the quality and safety agenda. • There is a proposal to undertake ward accreditation visits with the implementation of the digital audit system, which enables this to be recorded and monitored centrally, and enables benchmarking and quality improvements to move forward.	

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Feedback May 2024 Adborth Cadarnhaol Mai

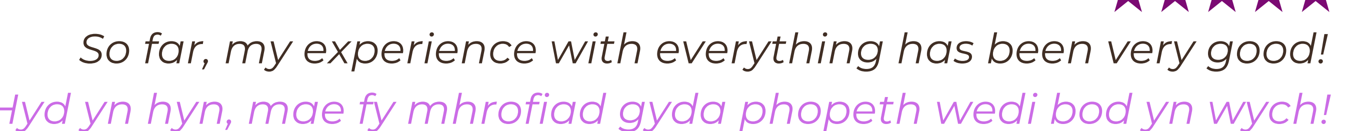
Antenatal Care 20 weeks Gofal Cynenedigol 20 wythnos

Newtown Birth Centre

I have/ are enjoying every moment under Newtown midwifery services. I have felt supported through all three of my pregnancies and my current pregnancy. I couldn't be happier, and my midwife is amazing. Definelty would recommend this service they have listened to me and support me through pregnancy, labour and post baby. They have treated me like an individual and made me and my husband feel like we are important and listen to.

Canolfan eni Drenewydd

Rwyf wedi/yn mwynhau pob eiliad dan wasanaethau bydwreigiaeth y Drenewydd. Rwy'n teimlo fy mod wedi cael fy nghefnogi trwy'r tri beichiogrwydd a'm beichiogrwydd presennol. Ni allwn fod yn hapusach, ac mae fy mydwraig yn anhygoel. Byddaf yn sicr yn argymell y gwasanaeth hwn, maen nhw wedi gwrando arnaf ac yn wedi fy nghefnogi trwy'r beichiogrwydd, yr enedigaeth ac ar ôl y babi. Maen nhw wedi fy nhrin fel unigolyn ac wedi gwneud i mi a fy ngŵr deimlo ein bod ni'n bwysig ac yn gwrando arnom.



★★★★★

So far, my experience with everything has been very good!

Hyd yn hyn, mae fy mhrofiad gyda phopeth wedi bod yn wych!

Canolfan eni Llandiloes

Hyd yn hyn, dwi wedi cael profiad gwych gyda fy mydwraig Sioned o Lanidloes. Mae hi wedi bod yn gefnogol iawn, yn sylwgar iawn ac rwy'n teimlo'n hollol ddiogel ac yn gyfforddus i ofyn cwestiynau iddi a rhannu unrhyw ofnau sydd gen i. Diolch.

Llanidloes Birth Centre

So far, I've had a wonderful experience with my midwife Sioned from Llanidloes. She has been very supportive, attentive and I feel totally safe and comfortable to ask her my questions and share any fears I have. Thank you.

Patterson Liz
29/07/2024 08:30:1?

Babies born in Powys

Babanod a anwyd yn Mhowys

Newtown Birth Centre

I can't thank the Newtown team who have looked after me from the start of my pregnancy through to the birth of our baby girl. They have restored my faith in giving birth (after a traumatic first birth) and made me feel empowered by my experience and have left me wanting to share my positive story far and wide. We can't thank James enough for being so supportive throughout. His positive attitude, guidance and knowledge gave us the opportunity to experience a positive home birth! Thank you!

Canolfan eni Drenewydd

Ni allaf ddiolch digon i dîm Y Drenewydd sydd wedi gofalu amdanaf o ddechrau fy meichiogrwydd hyd at enedigaeth ein merch fach. Maen nhw wedi adfer fy ffydd wrth roi genedigaeth (ar ôl genedigaeth gyntaf drawmatig) ac wedi gwneud i mi deimlo fy mod wedi fy ngrymuso gan fy mhrofiad ac wedi fy ngadael eisiau rhannu fy stori gadarnhaol gyda phawb. Allwn ni ddim diolch digon i James am fod mor gefnogol drwy'r cyfan. Rhoddodd ei agwedd gadarnhaol, ei arweiniad a'i wybodaeth y cyfle i ni brofi genedigaeth gartref bositif! Diolch yn fawr!

I got to do what was best for me and my family. I never thought I'd say I enjoyed giving birth, and to give birth at home made it even more magical. Being left alone in my home comfort I believe helped me have a positive birth.

Roeddwn i'n gallu gwneud yr hyn roedd orau i mi a fy nheulu. Wnes i erioed feddwl y byddwn i'n dweud fy mod i'n mwynhau rhoi genedigaeth, ac roedd rhoi genedigaeth gartref yn ei wneud hyd yn oed yn fwy hudolus. Roedd cael fy ngadael ar fy mhen fy hun yng nghysur fy nghartref i fy helpu cael genedigaeth bositif.

Patterson Liz
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Maternity Infant feeding postnatal care and reflections on your maternity journey.

Mamolaeth, bwydo Babanod, gofal ôl-enedigol a myfyrdodau ar eich taith mamolaeth

Llanidloes Birth Centre

I would like to give a massive thank you to the women of Llanidloes maternity unit! And a big special thank you to Rachel and Sioned who really helped me and my family along our journey. They were very caring towards me and helped me feel confident (even though I suffer with anxiety) I always felt so safe around them. I never felt rushed and that I could ask them about anything. Thank you so much ladies.

Canolfan eni Llandiloes

Hoffwn ddiolch yn fawr iawn i fenywod yr uned mamolaeth yn Llanidloes!
A diolch arbennig iawn i Rachel a Sioned a helpodd fi a fy nheulu ar hyd ein taith. Roedden nhw'n gofalu amdanaf ac yn fy helpu teimlo'n hyderus (er fy mod i'n dioddef o orbryder) roeddwn bob amser yn teimlo mor ddiogel o'u cwmpas. Doeddwn i byth yn teimlo wedi fy rhuthro ac y gallwn ofyn iddyn nhw am unrhyw beth. Diolch o galon merched!

Newtown Birth Centre

Penny was my midwife, and she was amazing on the odd occasions she had been called out for a birth. I had Sarah and she was equally as good. I also met James on one occasion and felt he was very supportive. I feel there is a great team at the birthing centre in Newtown. A big thank you to them all.

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Canolfan eni Drenewydd

Penny oedd fy mydwraig, ac roedd hi'n anhygoel ar yr adegau iddi gael ei galw allan am enedigaeth. Roedd Sarah gen i ac roedd hi yr un mor dda. Cwrddais â James ar un achlysur hefyd ac roeddwn yn teimlo ei fod yn gefnogol iawn. Rwy'n teimlo bod tîm gwych yn y ganolfan eni yn y Drenewydd. Diolch yn fawr iawn iddyn nhw i gyd.

Maternity Infant feeding postnatal care and reflections on your maternity journey.

Mamolaeth, bwydo Babanod, gofal ôl-enedigol a myfyrdodau ar eich taith mamolaeth

Newtown Birth Centre

My midwife James made a huge difference to both my pregnancy and birthing experience. He was really supportive, and I always felt heard by him. I felt quite anxious about labour, as my first was in a hospital and was quite traumatic in some ways. However, the relaxed approach at the birth centre and with support from James, I had a really good experience this time with my second child.

Canolfan eni Drenewydd

Gwnaeth fy mydwraig James wahaniaeth enfawr i'm profiad beichiogrwydd a genedigaeth. Roedd yn gefnogol iawn, ac roeddwn i'n teimlo ei fod yn gwrando arnaf bob amser. Roeddwn i'n teimlo'n eithaf gorbryderus am yr enedigaeth, gan fod fy nhro cyntaf mewn ysbyty ac yn eithaf trawmatig mewn rhai ffyrdd. Fodd bynnag, gyda'r dull hamddenol yn y ganolfan eni a gyda chefnogaeth James, cefais brofiad da iawn y tro hwn gyda fy ail blentyn.

Knighton Birth Centre

Hannah was absolutely great always listened to what I wanted can't thank her enough for what she did

Canolfan eni Tref-y-Clawdd

Roedd Hannah bob amser yn gwrando ar yr hyn roeddwn i ei eisiau, dydw i ddim yn gallu diolch digon iddi am yr hyn a wnaeth.

★★★★★

My care from the team in Powys, both Brecon Hospital and Newtown birth centre was amazing

Roedd fy ngofal gan y tîm ym Mhowys, yn Ysbyty Aberhonddu a chanolfan eni'r Drenewydd yn anhygoel

Feedback April 2024 Adborth Cadarnhaol Ebrill

Antenatal Care 20 weeks Gofal Cynenedigol 20 wythnos

Excellent care & support received so far. Thank you

Gofal a chefnogaeth ragorol hyd yn hyn. Diolch yn fawr

Sioned at Llanidloes is an asset to Powys. I'm so grateful to have her as my midwife. From losing previously she settles my anxieties. She is full of knowledge and just a bright/bubbly lady. I could not ask for a better midwife!! The ladies at Newtown who have done my scans have been wonderful and made it such an enjoyable experience despite my nerves. Could not fault the team.

Mae Sioned yn Llanidloes yn ased i Bowys. Rydw i mor ddiolchgar o'i chael hi fel bydwraig. Ar ôl i mi golli yn y gorffennol, mae'n tawelu fy ngorbryderon. Mae'n llawn gwybodaeth ac ar y cyfan yn fenyw mor bybli a hapus. Gallwn i ddim ofyn am fydwraig well! Mae'r menywod yn y Drenewydd sydd wedi gwneud fy sganiau mor wych ac wedi gwneud profiad mor hwylus, er gwaethaf fy nerfau. Does gen i ddim un peth gwael i ddweud am y tîm.

Fantastic care, and amazing staff. Gofal gwych a staff anhygoel.

All the staff have made me feel so comfortable answering any questions i had and during the scans explained everything too me, when I've contacted the team they've always made me feel important and that theres no reason to small to contact, feel so lucky to be under the care of such a caring team of professionals

Mae'r staff i gyd wedi gwneud i mi deimlo mor gyfforddus yn ateb unrhyw gwestiynau roedd gen i ac yn ystod y sganiau eglurodd popeth hefyd i mi, pan fyddaf wedi cysylltu â'r tîm maen nhw bob amser wedi gwneud i mi deimlo'n bwysig ac nad oes rheswm i gysylltu sy'n rhy fach, rwy'n teimlo mor lwcus i fod yn derbyn gofal gan dîm mor ofalgar o weithwyr proffesiynol.

Patterson,Liz
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Antenatal Care 20 weeks

Gofal Cynenedigol 20 wythnos

My midwife has been just the other end of the phone if I ever need anything and when I had concerns she got back to me so quickly! Even though she went on holiday while having some tests, the second midwife has also been amazing!
I cannot fault them in any way!

Mae fy mydwraig o hyd wedi bod ben arall y ffôn os oes angen unrhyw beth arnaf a phan oedd gen i bryderon, fe ddaeth yn ôl ataf mor gyflym! Er iddi fynd ar wyliau wrth i mi gael rhai profion, mae'r ail fydwraig hefyd wedi bod yn anhygoel! Does dim un peth gwael amdanyn nhw!

I think the Powys midwives are all amazing. They do set a perfect/professional example. All I would suggest in making the service better is an automated appointment reminders for people like myself with baby brain and a busy life.

Patterson Liz
29/07/2024 08:30:32

Rwy'n credu bod bydwragedd Powys i gyd yn anhygoel. Maen nhw’n gosod esiampl berffaith/broffesiynol. Y cyfan y byddwn i'n ei awgrymu wrth wella'r gwasanaeth yw negeseuon atgoffa o apwyntiadau awtomataidd i bobl fel fi fy hun ag ymennydd babi a bywyd prysur.

Babies born in Powys

Babanod a anwyd yn Mhowys

aromatherapy

It was very helpful and nice to see Powys health board offering alternatives to medication.

aromatherapi

Roedd yn ddefnyddiol iawn ac yn braf gweld bwrdd iechyd Powys yn cynnig dewisiadau amgen i feddyginiaeth.

I want to say a big thankyou to Rosie and the rest of the team at Knighton Hospital, the care and support me and my family received during our pregnancy, labour and after care of our son Ralph was the best. We had the best birthing experience; I was very anxious after my experience with my daughter. Rosie put me at ease and was very helpful and supportive to me and Phil. Thank you all again!

Hoffwn ddiolch yn fawr i Rosie a gweddill y tîm yn Ysbyty Tref-y-clawdd am y gofal a'r gefnogaeth a gefais i a fy nheulu yn ystod ein beichiogrwydd, yr enedigaeth ac ôl-ofal ein mab Ralph. Cawsom y profiad geni gorau; roeddwn yn orbryderus iawn ar ôl fy mhrofiad gyda fy merch. Roedd Rosie yn fy ngwneud yn gartrefol ac roedd yn gymwynasgar a chefnogol iawn i mi a Phil. Diolch i chi i gyd eto!

Midwives were excellent, I felt comfortable to have a home birth with my first child. Aftercare was also brilliant.

Roedd y bydwragedd yn ardderchog, roeddwn i'n teimlo'n gyfforddus i gael genedigaeth gartref gyda fy mhlentyn cyntaf. Roedd yr ôl-ofal yn wych hefyd.

Beth oedd yn dda am y eich genedigaeth yn Mhowys?

What was good about your labour and birth in Powys?

That my birth plan was listened to and my wishes were supported and listened to by my midwife

Bod rhywun yn gwrando ar fy nghynllun geni a bod fy nymuniadau yn cael eu cefnogi gan fy mydwraig.

Babies born in Powys

Babanod a anwyd yn Mhowys

It was relaxed, midwives were very calm and supportive at all times and only intervened when needed. Would highly recommend Brecon Birth centre to anyone with a low risk pregnancy.

Roedd yn hamddenol, roedd y bydwragedd yn ddigynnwrf a chefnogol iawn bob amser a dim ond yn ymyrryd pan oedd angen. Byddai'n argymell yn gryf ganolfan eni Aberhonddu i unrhyw un sydd â beichiogrwydd risg isel.

Beth oedd yn dda am y eich genedigaeth yn Mhowys?

What was good about your labour and birth in Powys?

We knew the midwives and trusted them to help us make the right choices when things didn't go to plan. We felt comfortable and safe around the midwives in Newtown birthing centre.

Roeddem yn adnabod y bydwragedd ac yn ymddiried ynddynt i'n helpu gwneud y dewisiadau cywir pan nad oedd pethau'n mynd fel y cynlluniwyd. Roedden ni'n teimlo'n gyfforddus ac yn ddiogel o amgylch y bydwragedd yng nghanolfan geni'r Drenewydd.

Assessed at home so didn't need to attend birth centre too early Unplanned home birth allowed me to stay at home after birth. Stitches done at home by midwife. Care received was patient, caring and made me feel at ease after delivering baby with husband alone at home.

Cefais fy asesu gartref felly nid oedd angen mynd i'r ganolfan eni’n rhy gynnar. Roedd genedigaeth gartref heb ei chynllunio yn caniatáu imi aros gartref ar ôl fy ngeni. Cefais y pwythau gartref gan fydwraig. Roedd y gofal y ces i’n amyneddgar, yn ofalgar ac yn gwneud i mi deimlo'n gartrefol ar ôl geni fy mabi ar ben fy hun gyda fy ngŵr gartref.

Patterson Liz
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★★★★★

Please tell us about how your labour and birth experience could have been improved

Dywedwch wrthym sut y gellid bod wedi gwella eich profiad o'r enedigaeth.

Not in any way, I felt the midwives went above and beyond, and having seen and spoken to different midwives during the pregnancy, birth and postnatal, every one of them has been brilliant.
Ddim mewn unrhyw ffordd, teimlais fod y bydwragedd yn mynd y filltir ychwanegol, ac ar ôl gweld a siarad â gwahanol fydwragedd yn ystod y beichiogrwydd, genedigaeth ac ôl-enedigol, mae pob un ohonynt wedi bod yn wych.

Nothing could have been improved, I was very happy with the whole process.

Ni allai unrhyw beth fod wedi gwella, roeddwn yn hapus iawn gyda'r broses gyfan.

I give birth at home unplanned and with no midwives. Baby delivered by husband before midwife and paramedics arrived. Not thought to be in active labour during home assessment but didn't have an examination as was thought not to be required. This was made clear that it was my choice if I did want to proceed though. Perhaps this could have anticipated process was further along than first thought and could have made way to birth centre but maybe not.

Fe wnes i roi genedigaeth gartref heb ei gynllunio a heb unrhyw fydwragedd. Cafodd fy mabi ei eni gan fy ngŵr cyn i'r fydwraig a pharafeddygon gyrraedd. Doedden nhw ddim yn fy ystyried fel genedigaeth actif yn ystod fy asesiad cartref, ond ces i ddim archwiliad gan nad oedd yn ofynnol. Gwnaed hyn yn glir mai fy newis i oedd hi pe bawn i eisiau symud ymlaen. Efallai y gallai hyn fod wedi rhagweld fy mod i ymhellach ymlaen nag y tybiwyd yn gyntaf a gallent fod dechrau'r ffordd i'r ganolfan geni ond efallai ddim.

Labour didn't go to plan as I needed an episiotomy which I found difficult, but I felt so supported in that decision.
Aeth yr enedigaeth ddim yn ôl y cynllun gan fod angen episiotomi a oedd yn anodd i mi, ond roeddwn i'n teimlo cymaint o gefnogaeth yn y penderfyniad hwnnw.

PattersonLiz
29/07/2024 08:30:32

Maternity Infant feeding postnatal

Bwydo Babanod mamolaeth ôl-enedigol

I couldn't be more grateful of the excellent care from Llani midwives, in particular Nat. The support and care provided was exceptional and we will be forever grateful.

Allwn i ddim fod yn fwy diolchgar o'r gofal ardderchog gan fydwragedd Llani, yn enwedig Nat. Roedd y gefnogaeth a'r gofal a ddarparwyd yn eithriadol a byddwn yn ddiolchgar am byth.

I was moved around between Newtown, Wrexham and Liverpool for my care, also I was told I would need to be induced at Wrexham. Thankfully my midwife urged me to do what I wanted to and decline induction and have a natural spontaneous labour. Just wish in this area that maternity care wasn't passed around due to few hospitals.
More preparation/ less fear of c section.

Cefais fy symud o gwmpas rhwng Y Drenewydd, Wrecsam a Lerpwl ar gyfer fy ngofal, a dywedwyd wrthyf hefyd y byddai angen prysuro'r geni yn Wrecsam. Diolch byth fe wnaeth fy mydwraig fy annog i wneud yr hyn roeddwn i eisiau ei wneud a gwrthod y prysuro a chael genedigaeth ddigymell naturiol. Byddwn i'n hoffi os na chafodd gofal mamolaeth ei basio o gwmpas yn yr ardal hon oherwydd ychydig o ysbytai.
Mwy o baratoi/ llai o ofn o doriad cesaraidd.

Llanidloes Midwives, in particular Nat Thomas. For going above and beyond in her care, for being such an immense support during pregnancy and post partum for myself and baby. Nat obviously loves what she does and is everything a midwife should be- I can't thank her enough!

Bydwragedd Llanidloes, yn enwedig Nat Thomas am fynd y filltir ychwanegol yn ei gofal, am fod yn gefnogaeth mor wych yn ystod y beichiogrwydd ac ar ôl yr enedigaeth i mi a'r babi. Mae'n amlwg bod Nat wrth ei bodd â'r hyn mae hi'n ei wneud ac mae'n bopeth y dylai bydwraig fod- ni allaf ddiolch digon iddi!

Patterson Liz 29/07/2024 08:39:32

★★★★★

Sarah- she stayed with me throughout my whole birth- from coming to my house after my waters broke and stayed with me until after my son was born. It was nice to have a midwife with me during labour at all times rather than what it would be like in a bigger hospital. Didn't feel as if I was being passed around and felt comfortable to tell her if I needed a break and what I wanted during my labour - she wasn't pushy with anything.

Sarah- arhosodd gyda mi trwy gydol fy ngenedigaeth - o ddod i'm tŷ ar ôl i'm dyfroedd dorri ac aros gyda mi tan ar ôl i'm mab gael ei eni. Roedd hi'n braf cael bydwraig gyda fi yn ystod yr enedigaeth bob amser yn hytrach na sut brofiad fyddai hi mewn ysbyty mwy. Doeddwn i ddim yn teimlo fel pe bawn i'n cael fy mhasio o gwmpas ac yn teimlo'n gyfforddus i ddweud wrthi os oedd angen seibiant arnaf a beth roeddwn i ei eisiau yn ystod yr enedigaeth - doedd hi ddim yn gwthio unrhyw beth.

Everyone was great, but especially Sîan, Katie and Lizzy.

Roedd pawb yn wych, ond yn enwedig Sîan, Katie a Lizzy.

Brecon midwives were fantastic. I have spoken to and seen a number of different midwives during my pregnancy, labour and postnatal and every one has been brilliant

Brecon midwives were fantastic. I have spoken to and seen a number of different midwives during my pregnancy, labour and postnatal and every one has been brilliant

Roedd bydwragedd Aberhonddu yn wych. Rwyf wedi siarad â nifer o fydwragedd gwahanol yn ystod fy meichiogrwydd, yr enedigaeth ac ôl-enedigaeth ac mae pob un wedi bod yn wych.

Fliss my midwife in Brecon was very supportive thorough out the whole of my pregnancy, birth and afterwards Emily the student midwife made us feel relax and supported in the birth and afterwards

Roedd Fliss fy mydwraig yn Aberhonddu yn gefnogol iawn trwy fy holl feichiogrwydd, fy ngenedigaeth ac wedyn fe wnaeth Emily, y myfyriwr bydwreigiaeth wneud i ni deimlo'n gyfforddus a chefnogi yn yr enedigaeth ac ar ôl.

Flora Sian Sarah Sonographers

Flora Sian Sarah Sonograffwyr

Fiona is amazing, outstanding, and is very understanding of situations and birth plans.

Mae Fiona yn anhygoel, yn wych ac mae gwirioneddol yn deall sefyllfaoedd a chynlluniau geni.

	Agenda item: 3.2
Patient Experience, Quality and Safety Committee	**Date of Meeting: 30 July 2024**

Subject:	**Cottage View Care Inspectorate Wales Report**
Approved and Presented by:	Claire Madsen, Executive Director Therapies and Health Sciences; David Farnsworth Interim Executive Director Community and Mental Health Services
Prepared by:	Jason Crowl, Assistant Director Health and Safety and Support Services (Responsible Individual)
Other Committees and meetings considered at:	

PURPOSE:

To provide the Committee with an update on the recent Care Inspectorate Wales Inspection to Cottage View Residential Home.

RECOMMENDATION:

The Committee is asked to:

- **DISCUSS** and take **ASSURANCE** from the Inspection Report.

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

EXECUTIVE SUMMARY

In February 2024, Care Inspectorate Wales completed an inspection of Cottage View Care Home. The inspection found that all outstanding improvement notices had been completed and there were no new notices or priority action notices issued. The overall inspection report was incredibly positive and reflect the hard work and commitment of the Care Home manager and the leadership of the Directorate of Community Care and Mental Health Services.

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

This paper outlines the background to the care home the key roles required as part of registration and the recent history of inspections. A copy of the Inspection Report accompanies this paper.

BACKGROUND AND ASSESSMENT:

Background

Cottage view is a residential home registered with Care Inspectorate Wales as a 'Care Home Service for Adults Without Nursing.'
There are 15 places available. 10 are for long stay residents and 5 are to provide reablement as part of the mid Powys collaborative with Powys County Council to improve care pathways and early discharge. Funding is via a mix of private self-funded residents or a contract with Powys County Council.

The care home was originally transferred to the then Powys NHS Trust in 1998 in partnership with the council when the council run care home called 'The Cottage' was closed and a purpose built 10 bedded wing was added to Knighton Hospital.

The Health Board was responsible under the Heath and Social Care Wales Act for registering and managing the service. In 2016, the Regulation and Inspection of Social Care (Wales) Act (RISCA) received Royal Assent and became law on 18 January 2016. The new RISCA regulations significantly tightened the responsibilities in law for the provider, the responsible individual and the manager.

The Regulations set out in RISCA are absolute and all inspections and assurance is measured against the 89 separate standards.
Regulations, statutory guidance and National Minimum Standards: Adult and children's services | Care Inspectorate Wales

Unlike Health Inspectorate Wales, CIW has the power to remove the 'licence' to provide a care service and also to prosecute poor care providers who have repeatedly failed to improve the service. Unlike HIW, the regulations and the associated inspections cover all aspects of running a care home business, including the back-office functions, estates compliance, financial management, recruitment, training, care delivery, care culture and care environment.

All information regarding the registration is held on the CIW Online system which will include the name, responsibilities and date of birth for the following role holders:

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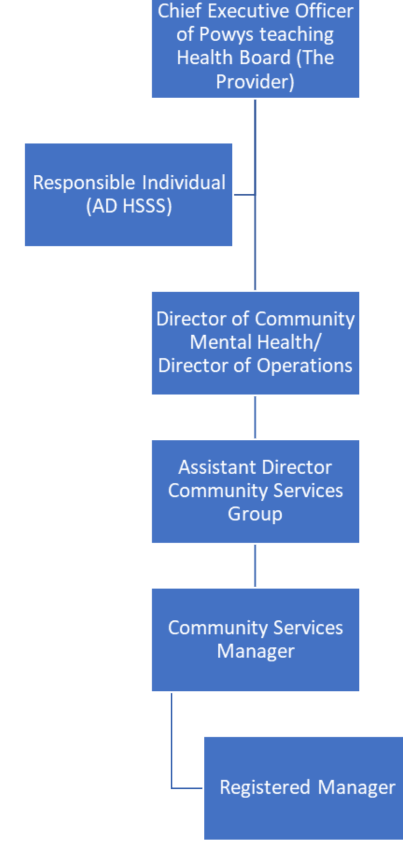
- The Provider – This is the Chief Executive Officer and carries full legal responsibility for the care home. In PTHB this is delegated on a day-to-day basis to the Executive Director Community and Mental Health Services.

- The Responsible Individual – This is currently the Assistant Director Health and Safety and Support Services and is responsible for completing regular inspections and completing internal assurance reports for the provider and recruiting the registered manager.

- The Registered Manager – This is the Cottage View Care Home Manager and is responsible for the day-to-day operational delivery of all aspects of the care service.

Of the three registered roles it is only the Responsible Individual which has to be vetted and authorised by CIW. The application process takes about 4-5 months and includes an online application, presentation of evidence of suitability and a formal interview.

Cottage View Registration Organisation Chart March 2024



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PTHB is the only NHS organisation which manages a care home in Wales. Under the regulations, social services can delegate the responsibility from the Director of Social Services to an officer role. In local authorities the Responsible Individual is a dedicated assurance monitoring role for a number of care services and would be at a salary range equivalent of a specialist nurse or therapist role.
However, as PTHB is an NHS organisation the regulations require the organisation to position the Responsible Individual role at the same level as the independent sector which is the level of Director, Deputy Director or Assistant Director level reflecting the level of responsibility expected by CIW.

Care Home Inspection
Since 2016 and the introduction of the new RISCA regulations the Health Board has received a number of inspections resulting in Priority Action Notices which related to the governance, management and administration requirements associated with the service.
By 2019 the Health Board had changed the RI role three times and the position had been vacant leading to a priority action notice and failure to provide evidence of regular inspections and correct statement of process.
A number of improvement notices were also issued regarding the quality and content of reports, the assessment and review process.
The service managers, responsible individual and care home manager developed an improvement plan which was supported by the local CIW Inspector who provided guidance and support in strengthening the governance and care requirements.
In 2022 inspection report all the previous immediate action notifications and improvement notices had been achieved and two new improvement notifications were identified.
The work needed to resolve the new improvement notices was completed in 2023. This coincided with a significant redevelopment and improvement of the care home which dramatically improved the environment and experience for residents.

Cottage View was reinspected on the 24th of February 2024 and confirmed that the Previous Improvement Notices have now all been completed, and these will be removed from the system once the report is published online.
There are no Priority Action Notices and no new Improvement Notices, and the commentary was positive in respect to the four thematic areas covered by the inspection.
Currently CIW are piloting a new rating system which are act as 'silent' ratings to help providers understand the position of their service. The pilot ratings will

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not appear on reports or be shared with commissioners. They are only for the use of the Health Board only.

- In areas of Wellbeing – Good
- In areas of Care and Support – Good
- In Areas of Leadership and Management – Good
- In Areas of Environment – Good

Unless there are any escalations to CIW then the next routine visit will be in 12 to 18 months.

Conclusion

This is an incredibly positive report for the care home, it has never had a report without improvement notices to date and is a credit to the care home manager and the care team and also the leadership of the Community and Mental Health Services Directorate which manage the service. It is also important to reflect the contribution of all the various departments that have supported the improvement in the rating including Workforce, Estates, Finance and Support Services. PTHB is the only NHS organisation in Wales running a care home with long stay beds and reablement beds and we are doing that successfully.

RECOMMENDATIONS:

The Committee is asked to DISCUSS and take ASSURANCE from the CIW Inspection Report.

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	✓

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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** **This cover paper and the associated CIW report support equality criteria.**
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				
	None	**Low**	**Moderate**	**High**	**Statement** **This cover paper and the associated CIW report are low risk against the assessed criteria**
Clinical		✓			
Financial		✓			
Corporate		✓			
Operational		✓			
Reputational		✓			

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Inspection Report on

Cottage View

Powys Health Care Nhs Trust
Knighton Hospital
Ffrydd Road
Knighton
LD7 1DF

Date Inspection Completed

15/02/2024

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29/07/2024 08:30:12

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About Cottage View

Type of care provided	Care Home Service Adults Without Nursing
Registered Provider	Powys Teaching Health Board
Registered places	15
Language of the service	English
Previous Care Inspectorate Wales inspection	15 August 2022
Does this service promote Welsh language and culture?	This service is working towards providing an 'Active Offer' of the Welsh language and demonstrates a significant effort to promoting the use of the Welsh language and culture

Summary

People are happy with the care and support they receive at Cottage View. Care staff are friendly, caring and kind. They work very hard to make sure people feel at home and their personal outcomes are met. There are opportunities for people to do things they enjoy and are interested in.

The manager has very good oversight of the service. Care staff feel very well supported and good teamwork is evident. They have training opportunities, so they have the knowledge and skills to provide the right care for people. Information within personal plans tell care staff how people want to be supported and people are involved in reviewing these to make sure their personal outcomes are met.

The responsible individual (RI) visits the service as part of the quality assurance process. Reports are produced showing what is working well and what needs to improve. The management demonstrate a commitment to making sure people feel happy living in Cottage View and they have the right support to achieve their personal outcomes.

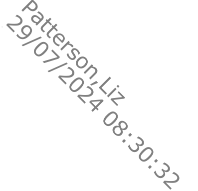
Well-being

People have choice and control over their daily lives. They have information about what to expect from the service and have opportunities to contribute their ideas about what works well and what they would like to see improved. We saw people spending time in the communal areas as well as in their own bedrooms. They told us care staff respect the decisions they make. It is clear people have good relationships with the care staff. This allows them to know what is important to the individual and the care and support they need can be tailored to individual preferences. At the time of our visit, there were no care staff fluent in the Welsh language, but they told us they try very hard to have some conversation in Welsh with people where possible.

The manager and staff promote people's health and well-being. There is a range of activities available based on people's likes and preferences. Care staff work hard to encourage and include people in social activities. We heard so much laughter which clearly helps to enhance the well -being of people. Relatives and friends visit regularly helping to maintain important relationships. Care staff are attentive and respond quickly when people need support. Medication is managed well. Referrals to health professionals are made in a timely way making sure people get the support they need quickly.

People are protected from abuse and neglect. Care staff know what to look out for and how to raise concerns if they suspect someone's well-being is compromised. They receive training relating to safeguarding and policies and procedures are in place to guide their practice. Care records give care staff the information they need to provide them with the right care and support.

People live in accommodation which is safe and promotes their well-being. The home is clean and comfortable. It is nicely decorated, and people's bedrooms are personalised with items important to them. There is an ongoing programme of maintenance and checks of equipment to make sure people are kept as safe as possible. The outside space is being improved and includes a courtyard with raised flower beds where people can sit and relax.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Care and Support

People can say how they want their care and support needs met. They and their family/ representative are involved in initial assessments to make sure their individual needs can be met when they move into Cottage View. Personal plans are developed, taking into consideration individual likes and preferences. People are involved in reviewing the plans to make sure they continue to meet their personal outcomes. The provider has recognised the need to have more consistency in the care files and is in the process of introducing a new electronic care planning system to help with this.

People are supported to remain as healthy as possible. We saw health professionals visiting people during our visit. Care records show people have access to professionals including doctors when they need it. Information about people's health needs is available for care staff in the care records. There is a dedicated room where medication is stored securely. Regular audits take place and care staff have training in medication management. Care staff we spoke with confidently showed us the medication management system and there is a policy in place to guide their practice.

Processes are in place to keep people as safe as possible. Care staff are visible in all areas of the service and respond quickly when people need assistance. They know people very well and report any concerns they have about people's well-being promptly. Restrictions are only placed on people's liberty when it is in their best interest.

People can do things important to them. The activity programme is based around what people like to do. Individual books are developed with the person and include things people are interested in. Photographs show activities they have taken part in which we saw includes sewing, crafts and enjoying celebrations including birthdays. We saw people taking part in group activities. They were clearly enjoying themselves. There was a lot of laughter with people clearly at ease with the care staff. People told us *"I like it here, I can make my own cup of tea" and "I'm very happy here, the girls are good."*

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Environment

People live in accommodation to meet their needs. The living accommodation has been extended since our last inspection to accommodate more people. There is now more space for people to socialise, meet people in private or spend time on their own. The dining room is more spacious. We saw people enjoying meals together. Tables were nicely laid with menus on each table. There is a mural on the wall of the local town which promotes conversation between people. We saw fruit and cold drinks readily available and a kitchenette where people can make drinks and have snacks. People tell us they have all they need in their bedrooms which we saw are personalised with items important to them. Communal areas have been decorated. Signage around the home is in Welsh and English. The outside space has been extended which is a nice accessible area for people to enjoy and includes some raised beds.

People live in an environment which is clean and tidy. Domestic staff were visible cleaning all areas. Care staff have infection prevention and control training both online and face to face. Personal protective equipment is readily available. Audits of the environment take place regularly so issues can be identified and quickly addressed.

The provider has health and safety systems in place to protect people. Regular checks of equipment are carried out including fire safety. Staff have fire safety training, so they know what to do in an emergency. There is a system in place to report any concerns care staff have about the environment. They say issues impacting on the well-being of people are responded to quickly.

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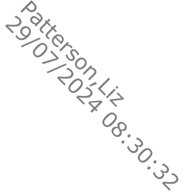
Leadership and Management

The provider has systems in place to make sure the quality of the service is continuously reviewed, and improvements are made for the benefit of people living at Cottage View. People's views are sought through daily discussion with care staff and the manager, resident meetings, and care plan review meetings. The responsible individual speaks to people and care staff during their visits. The six-monthly quality of care report shows what is working well in the service and what needs improving. There is a system to oversee complaints and concerns so if any improvements are identified, they can be actioned quickly. People tell us all the staff are approachable including the manager. They feel confident to speak with them about any issues they may have. The manager tells us she feels supported in her role. She demonstrates a commitment to implementing new ideas to benefit people living and working at the service. Care staff spoken with speak very highly of the support they have from the manager. Comments include "*we work very well as a team*" and "*not only are the residents happy here, the staff are too*".

People have information about the service. The statement of purpose is reflective of the service provided. The guide to the service includes useful information for people when they move into Cottage View.

Care staff have opportunities to learn and develop to help support people living in Cottage View. Care staff tell us they feel very well supported in their role. Records show they have regular one to one meetings with the manager and an annual appraisal of their work. This allows them to discuss career progression and training opportunities they may need for their personal development. Team meetings are held to share information, but care staff tell us the manager is always approachable. We saw good communication between the manager, care staff and people using the service. This helped to create the friendly atmosphere we experienced. We identified some issues with the recruitment of care staff, but these were addressed immediately making sure all the required checks are in place before new staff start work.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Summary of Non-Compliance	
Status	**What each means**
New	This non-compliance was identified at this inspection.
Reviewed	Compliance was reviewed at this inspection and was not achieved. The target date for compliance is in the future and will be tested at next inspection.
Not Achieved	Compliance was tested at this inspection and was not achieved.
Achieved	Compliance was tested at this inspection and was achieved.

We respond to non-compliance with regulations where poor outcomes for people, and / or risk to people's well-being are identified by issuing Priority Action Notice (s).

The provider must take immediate steps to address this and make improvements. Where providers fail to take priority action by the target date we may escalate the matter to an Improvement and Enforcement Panel.

Priority Action Notice(s)		
Regulation	Summary	Status
N/A	No non-compliance of this type was identified at this inspection	N/A

Where we find non-compliance with regulations but no immediate or significant risk for people using the service is identified we highlight these as Areas for Improvement.

We expect the provider to take action to rectify this and we will follow this up at the next inspection. Where the provider has failed to make the necessary improvements we will escalate the matter by issuing a Priority Action Notice.

Area(s) for Improvement		
Regulation	Summary	Status

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N/A	No non-compliance of this type was identified at this inspection	N/A
35	The provider does not undertake Disclosure and Barring Service checks as often as required in the Regulations.	Achieved
16	People, their representatives and the placing authority (where applicable) are not involved in three monthly reviews of their personal plans.	Achieved

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Was this report helpful?

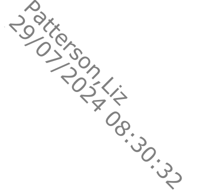
We want to hear your views and experiences of reading our inspection reports. This will help us understand whether our reports provide clear and valuable information to you.

To share your views on our reports please visit the following link to complete a short survey:

- Inspection report survey

If you wish to provide general feedback about a service, please visit our Feedback surveys page.

Date Published 04/04/2024



Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Review of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Decisions for Adults in Wales

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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.

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Foreword

I am pleased to be publishing this report which presents the findings from our Review of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions for adults in Wales.

DNACPR decisions are an important part of end-of-life care, and during the course of our lives many of us will become involved in these discussions either on a personal level or in relation to a loved one. It is important that these discussions, and the decisions made, happen in a sensitive and effective way in order to respect the wishes and views of all of those involved. When done well, DNACPR discussions can be a positive experience, offering clarity at a time of uncertainty, ensuring that distractions are limited at such an important time.

Our work has allowed us to highlight areas of good practice, and to identify areas for improvement, which is timely with the forthcoming biennial review of the all-Wales DNACPR policy.

It is clear that understanding the patient's wishes at the end of their life is an essential element of good care and I expect health boards, trusts, and Welsh Government to carefully consider the content of this report and the overall findings from our review. I also expect health boards and trusts to consider the staff and public's feedback highlighted throughout the report, to determine how these can influence improvement with the quality of the DNACPR decision making process.

I would like to express my thanks to the staff who helped inform our review by sharing information, participating in our interviews and focus groups, and for completing our surveys. In addition, to Professor Mark Taubert for his continuous support and professional advice throughout, and finally to those who supported us by completing our public survey.

To close, I must take this opportunity to pay tribute to the staff who take part in discussions about DNACPR decisions, and to those who provide care and support to people at the end of their lives. The compassion and dedication of those we engaged with throughout this work is heartening and provides a strong and positive basis upon which to improve.

Alun Jones

Chief Executive

Healthcare Inspectorate Wales

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Summary

The review explored whether patients are actively involved in decision making about DNACPR and whether those decisions are clearly recorded and communicated between healthcare professionals.

It is clear from our review's findings that there are examples of noteworthy practice across Wales regarding the DNACPR decision making process. However, we have also identified opportunities to improve. These include the need to strengthen the quality of communication with both patients and those close to them, and across different healthcare teams. This is to ensure that discussions and DNACPR decisions and the rationale behind these, are clearly recorded and communicated between healthcare teams.

Cardiopulmonary Resuscitation (CPR) can in theory, be attempted on any person when their heart and their lungs cease to function. The joint guidance from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing; Decisions Relating to Cardiopulmonary Resuscitation, highlights that clinical outcomes following CPR are dependent on the clinical factors that led to the situation. Unfortunately, in many instances, the CPR procedure does not always result in a good clinical outcome, and when people do survive, there is significant risk of harm and long-term complications.

When people are affected by life-limiting and palliative illnesses, an open discussion about the reasons not to resuscitate them if their heart and lungs cease to function, can be an important part of advance care planning, and can help minimise distress at a later stage. To facilitate and support the DNACPR decision process, clinicians in Wales who make decisions not to resuscitate a person, must legibly and fully complete a DNACPR Form. This will ensure that the patient's wishes are respected and that decisions reflect the best interests of an individual. This is highlighted within the all-Wales DNACPR Policy.

A key area and focal point during our review, and one where improvement is required, is the need for accurate and effective recording on DNACPR forms. Our review has highlighted that across Wales, the legible and full completion of DNACPR forms and the supporting or additional written accounts within an individual's clinical records was variable. Illegible or incomplete records can have a negative impact on effective communication across healthcare teams about a DNACPR decision.

We reviewed approximately 280 DNACPR forms during our work. It was positive to find some good examples of concise and thorough explanations of patient

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discussions, and instances where a clear indication had been given for any absence of discussion with patients and/or those close to them. We also found examples of comprehensive narratives written within patient clinical records to support the DNACPR form. However, improvements are needed in the way that information is recorded on the forms to support communication of the DNACPR decision.

A central element that is critical to making DNACPR decisions is communication. There is room for improvement to ensure that people's experience of DNACPR discussions is as informative and holistic as possible. Most staff who we engaged with felt that individualised communication is at the centre of all DNACPR decision making, and that this is done in an open and honest way. However, we found that this could be strengthened further, by having DNACPR discussion with patients at an earlier point during their illness, instead of these taking place closer to the end of their life. This is crucial in enabling people to feel informed and understand what will or will not happen once the decision not to resuscitate is made.

Understanding the patient's wishes at the end of their life is a fundamental element of good care. We feel more can be done to improve people's awareness of DNACPR and access to information resources, to help them come to terms with and understand the DNACPR decision process. Whilst our review identified that resources are available to support this, it was disappointing to find that three quarters of respondents to our public survey said they were not provided with supporting information about the decision not to resuscitate.

Whilst a third of respondents to our public survey felt they were aware of what a DNACPR decision meant, prior to discussing this with clinicians, over half felt their understanding did not change following a DNACPR discussion. However, we received some positive examples where patients said they had received ongoing care and active cancer treatment, and the DNACPR decision did not mean this would discontinue, as they originally thought.

It is therefore evident that improvement is needed to support the public's understanding of the DNACPR decision making process, and its implications for individuals receiving care and support for their ongoing health needs. A DNACPR decision does not mean an immediate end to patient care and support, rather it means the individual will not be resuscitated in the event of cardiac arrest or dying naturally, because of deterioration in their existing clinical condition.

It was disappointing to find that almost half the respondents in our public survey felt their accessibility needs were not considered during DNACPR discussions, with most saying that their communication needs or preferences were not discussed. However, we also heard positive comments from people about the resources which helped their understanding, such as videos and leaflets. These included, "Sharing and Involving"- Information for patients and their carers to help make decisions

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about CPR, and online resources, such as Talk CPR – Discuss DNACPR, and the dedicated YouTube Channel Byw Nawr – Live Now.

A key issue to have emerged from our review relates to patients having the mental capacity to make and communicate decisions about CPR, and the quality of how these details were recorded on the DNACPR form. Whilst this section of the form was generally well-completed for people who had capacity, this was not always the case for those who may have lacked capacity. We found some forms and clinical records either contradicted each other, were incomplete, or there was no evidence that a mental capacity assessment had been undertaken and without rationale. We are therefore not assured, based on the records we reviewed, that the DNACPR decision making process is always completed in line with the all-Wales Policy, for patients who were deemed to lack capacity. This issue must be addressed by health boards and trusts.

Training and support for staff around DNACPR discussions and decision making, emerged as a consistent theme through our review. Training modules, resources, and information to support clinicians is available nationally. However, a recurring issue appears to be staff awareness of these resources and their ability to access them in a timely manner. These resources are valuable and can help ensure that DNACPR discussions can be held in a person-centred way, that meet the needs of people. For instance, it can be challenging to hold conversations with people about DNACPR when communicating with those who have strong beliefs, for instance cultural or religious, or with people who have learning disabilities. Only 40% of staff survey respondents said their organisation provides appropriate equality and diversity training or support, which contradicted information provided to us by each organisation.

It was positive to find that communication aids for people with language barriers and sensory or cognitive impairments are widely available across Wales. Access to interpretation and translation services is also available and includes support for those with hearing and sight impairments. However, once again we heard that staff were not always aware of the resources available to support them when having discussions with people who have communication challenges.

The general disparity regarding staff training may in part be due to constraints on the ability of staff to attend, or a lack of awareness of its availability. Irrespective, we believe more should be done to ensure staff can access the resources available to them to support effective DNACPR conversations.

We found the summaries of main clinical conditions and reasons why CPR would be inappropriate were generally well-completed on the DNACPR forms. However, the form's free text box has minimal space for a clinician to record all relevant information. On a practical level, staff felt that expanding the size of the free text

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box on the form would aid with capturing the more pertinent points more effectively. Whilst we saw some positive examples of concise and thorough summaries of patient clinical conditions, and clear indications why CPR would be inappropriate, we also saw other summaries which were sparse or illegible. We therefore concluded that documentation in the clinical condition section of the form must be strengthened, to help ensure there is no ambiguity or misinterpretation of what is recorded.

It was concerning to find that almost a third of staff responding to our survey, felt that communication across healthcare teams about DNACPR was not at all effective. A theme arising from our survey was the need for effective information sharing across healthcare teams, with particular reference to the need for an all-Wales electronic repository for the DNACPR form. The benefits of an electronic system would enable people and services, such as patients, clinicians, GP practices, out-of-hours services, WAST staff and the NHS 111 service, to access a central system promptly, to establish if a patient has a DNACPR decision in place.

Whilst an electronic repository would not eradicate all risks and challenges, as it would still be reliant upon its effective usage by staff, such a system may be beneficial in bridging the gap between hospital, community and primary care settings, or from one health board to another. Such a system could help to support the efficient sharing of crucial information around DNACPR.

It is clear, that lessons can be learned from both the staff and public's experience and feedback of DNACPR decision-making as highlighted throughout this report. Health boards and trusts should consider these views and identify how they could influence improvement around the quality of the DNACPR decision process, and the experience of patients and those close to them.

It is important to highlight that the staff we engaged with during interviews, focus groups, and through the responses received in our staff survey, endeavour to support people with the dignity and respect they deserve during the end of a person's life. We have found that there are positive examples where DNACPR discussions take place well, and in a timely manner before the end of someone's life. However, these can be challenging and distressful times for those involved, and sometimes there is little time available for thorough discussions, particularly during unforeseen emergency situations.

Overall, we found examples of noteworthy practice, but also areas needing improvement. Health boards and trusts must consider the findings of our review and act on our recommendations to drive improvement in relation to the DNACPR process. This includes the need to reflect on the experiences of staff and the public, which are highlighted throughout the report.

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We would like to express our thanks to the staff who helped inform our review by sharing information, participating in our interviews and focus groups, and for completing our surveys. In addition, we are thankful to Professor Mark Taubert for his continuous support and professional advice throughout our review, which was appreciatively received. Finally, we wish to thank those who supported our work by completing our public survey.

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Context

With the unprecedented demand on the healthcare system worldwide during the COVID-19 pandemic, there was a significant increase of patients being admitted to hospital with the virus. The pandemic drew into focus and highlighted concerns about conversations on what Cardiopulmonary Resuscitation (CPR) involves, and its success rates for those with COVID-19.

In April 2020, Welsh Government was alerted to concerns from advocates of disabled and learning disability communities. This related to the Clinical Frailty Scale being used inappropriately at times, when making clinical decisions on escalation of care, ceilings of treatment and DNACPR, for individuals positive with COVID-19. Subsequently, the Chief Medical and Nursing officers for Wales issued a joint letter across NHS Wales, highlighting the implementation of a framework of values and principles for healthcare delivery in Wales, to support services when making decisions during the pandemic.

The framework addressed the importance of openness and transparency to those with professional and legal responsibilities when making DNACPR decisions. It also highlights the existing all-Wales DNACPR policy; Sharing and Involving - a clinical policy for Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) for adults in Wales, relating to the 'the duty to consult' patients, and those close to them, when clinicians are making decisions about DNACPR.

The report, Protect, Respect, Connect - Decisions about Living and Dying Well During COVID-19, was also published by the Care Quality Commission (CQC) in March 2021. It was commissioned by the UK Government in response to media stories, complaints, and campaigns about perceived failings with DNACPR decisions in NHS England. The report's outcomes acknowledged that the extreme demands of the pandemic response had increased pressure on health and care staff which may have hampered decisions, and specifically communication around DNACPR. In addition, that DNACPR decisions do not exist in isolation but are part of a broader spectrum of care planning for long term conditions, advance care planning for end-of-life decisions, and emergency treatment escalation plans. Furthermore, there was clear acknowledgment from CQC that clinicians should be doing more of all these things.

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What We Did

In response to the national concerns highlighted in the context section, and key intelligence held by HIW, we wanted to understand more about DNACPR decisions in Wales and decided to commence a review. In January 2023, we commenced the scoping of our work and engaged with a sample of NHS Wales services and the public, to help inform and refine the review. We paused our work to explore and consider other projects being undertaken across Wales in relation to DNACPR, then recommenced our review in September 2023.

We wanted to consider the practices in place when DNACPR decisions are applied to adults (over the age of 18), and whether patient views and considerations are respected. We explored whether DNACPR decisions reflect the priorities of an individual, including their preferred requirements, and whether a DNACPR decision was clearly recorded and communicated between healthcare teams, and to the patient and those close to them.

The key question that we have sought to answer is whether DNACPR decisions are being respectfully communicated to patients and those close to them, and are they clearly recorded and communicated between healthcare professionals?

Scope and Methodology

We requested key documents and information from all health boards and Velindre University NHS Trust (Velindre). We also considered documents and information shared with us by the Welsh Ambulance Services NHS Trust (WAST).

The review considered:

- DNACPR forms submitted to HIW by health boards and Velindre (remotely)
- DNACPR forms and accompanying clinical records at two health boards (onsite)
- Organisational policies and procedures for DNACPR decisions
- Organisational processes for auditing DNACPR decision making
- How healthcare staff maintain their knowledge and skills in communication with people in relation to DNACPR.

Staff Engagement

We engaged with healthcare staff through interviews and focus groups to provide them with the opportunity to discuss the DNACPR processes in place in their organisation. We also launched a staff survey to gain an understanding of their experience and perception of their organisation's DNACPR processes. This was

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circulated to staff via health boards, and was promoted through our stakeholders, our website and our social media channels.
We received 65 responses to the survey, some were partially completed, however, all were considered during the review. Most respondents (59%) worked in secondary care settings, and 'others' were from hospice care, research teams, WAST and community and primary care settings. Our findings on staff engagement will be highlighted throughout the report.

Public survey

We launched a public survey to seek peoples' experience relating to DNACPR, and whether decisions were respectfully communicated to patients and those close to them. The survey was available online, in hardcopy, and people could complete the survey over the telephone with a member of the review team, and our stakeholders also helped share the survey.

We received 32 responses, some were partially completed, however, all were considered during the review. The greatest response came from relatives and carers, who represented 75% of respondents, 14% from those with lasting power of attorney, 6% stated they were 'other' and 5% from patients. Our public survey findings will be highlighted throughout the report.

Fieldwork

Most of our fieldwork was completed remotely, supplemented by onsite visits at two health boards, namely 'Aneurin Bevan' and 'Hywel Dda' University Health Boards. These health boards were selected having considered information provided to us during our scoping phase in early 2023, the intelligence held by HIW, and the age demographics of individuals aged 65 and over for each health board area as published by Stats Wales. We attended Aneurin Bevan during November 2023, and Hywel Dda during December 2023, where we reviewed DNACPR forms alongside the relevant clinical records and considered the completeness and quality of documentation. In total, we reviewed 66 DNACPR forms in depth, alongside the relevant clinical records.

Review team

Our review team consisted of:

- HIW Senior Healthcare Inspector (who led the review)
- HIW Healthcare Inspector (who supported the lead and review team)
- Two Clinical Peer Reviewers with significant expertise in both acute and long-term clinical patient care

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Clinical guidance for DNACPR in NHS Wales

In considering the effectiveness of processes relating to DNACPR decision making, we looked at whether health boards and trusts comply with the all-Wales DNACPR

Policy. This policy was launched in February 2015 and was revised and updated in 2017, 2020 and 2022, and will be reviewed every two years. Throughout this report, we refer to this as the ‘all-Wales Policy’. It acts as a form of ‘highway code’ for best practice decision making when it comes to naturally anticipated and accepted deaths, where a DNACPR conversation and decision should be considered.

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What We Found

The all-Wales DNACPR Policy

The all-Wales DNACPR Policy provides the framework for clinicians in Wales to help ensure a uniformed approach to decision making about the provision of CPR at the end of life. It also aims to raise awareness of the importance of discussions that relate to peoples' wishes at the end of their life. The framework helps ensure that a patient's wishes are respected, that decisions reflect the best interests of an individual, and benefits are not outweighed by burdens, and that a DNACPR decision is clearly recorded and communicated between clinicians.

The policy reflects that CPR, in theory, can be attempted on any person when their heart and their lungs cease to function. However, as highlighted in the publication; Decisions Relating to Cardiopulmonary Resuscitation, clinical outcome is dependent on a person's clinical factors that led to the situation, and the policy outlines that in many instances, CPR does not result in a good clinical outcome. When people do survive, there is significant risk of harm and ongoing patient complications. The policy highlights that undertaking CPR may not be appropriate for all people, and therefore stipulates that a decision not to attempt CPR should be reached, based on a proper and appropriately informed discussion with patients, whilst involving those close to them.

The policy sets out the requirements for the clinician completing the DNACPR Form (Adult) Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) discussion. A copy of the form can be found below; this is for reference as we will refer to sections of the form throughout the report. The form can also be found within the all-Wales DNACPR Policy.

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Copy of the all-Wales DNACPR Form (Adult):

DNACPR Form (Adult) DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION (DNACPR) DISCUSSION

Date of DNACPR Discussion:	/ /
Date(s) Reviewed	/ /
Reviewed by	
(Signature/Reg. No)	

Surname:
First Name:
NHS/Hospital No:
Date of Birth:
Home Address:

THIS FORM **MUST** BE FILED AT THE FRONT OF THE PATIENT'S HEALTHCARE RECORD

1. **Does the patient have capacity to make and communicate decisions about CPR?** YES / NO
If "NO"
Are you aware of a valid Advance Decision to Refuse Treatment (ADRT) refusing CPR which is relevant to the current condition? If Yes, please append a copy YES / NO
Has the patient appointed a Health & Welfare Attorney to make decisions on their behalf? YES / NO
If "YES" they must be consulted.

2. **Summary of the main clinical conditions and reasons why CPR would be inappropriate, unsuccessful or not in the patient's best interests**

Clinical Summary (must be filled in)

Select reasons that apply to this individual situation:
Not in the best interest/harm from CPR>benefit ☐
Patient refused CPR ☐
This is a natural anticipated and accepted death ☐
Other (please elaborate in patient's healthcare record) ☐

3. **Has a discussion taken place with the patient?** YES / NO
Please summarise decision below. If NOT discussed, please record reasons, incl potential for harm from discussion:

Summary (must be filled in):

4. **Has appropriate discussion taken place with those close to the patient, a Health and Welfare Attorney or an IMCA? Please also record unsuccessful attempts to contact them in text box.** YES / NO

Name of person:.. Relationship to patient:...

Summary (must be filled in):

5. **Healthcare Professional completing this form (must inform Senior Responsible Clinician):**

Name (PRINT):.. Position:..
Contact Details:.. GMC No: .... NMC/HCPC No:........................
Signature:.. Date: ....../....../...... Time: ....

6. **Senior Responsible Clinician with oversight to sign below:**
(Must inform MDT/others involved in the care of the patient of the decision – record the communication in section 8)

Name (PRINT):.. Position:..
Contact Details:.. GMC/NMC No: ....
Signature:.. Date: ....../....../...... Time: ....

7. **CANCELLATION of decision: NB: Cross form CLEARLY and write "CANCELLED" across form – notify ALL copy holders (see details below)**

Name (PRINT):.. Position:..
Contact Details:.. GMC/NMC No: ....
Signature:.. Date: ....../....../...... Time: ....

8. **COPIES of this DNACPR decision form have been sent to:**
1. ☐ **Patient /Carer** ....
2. ☐ **GP/Consultants involved** ....
3. ☐ **Care Home** ....
4. ☐ **Out-of-hours providers** ....

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The DNACPR form is used to advise clinicians not to attempt CPR when death occurs, due to the stated medical reasons on the form, such as a person with lung cancer, with spread to other part of the body. Therefore, denoting a life limiting incurable condition as highlighted in the publication, 'Decisions Relating to Cardiopulmonary Resuscitation' highlighted earlier. The DNACPR form is designed to be easily recognised and swiftly verifiable on one page, thereby allowing clinicians to make quick treatment decisions in both hospital and community settings about starting CPR. These are often split-second decisions, so a form must be brief and to the point.

The form also aids communication between patients, relatives, and all clinicians in scenarios where CPR should not be attempted. Without a form in place, it is likely that full CPR may be attempted against the patient's wishes. The General Medical Council (GMC) and Nursing and Midwifery Council (NMC) clearly state that where appropriate, clinicians can make a clinical decision not to administer CPR, even if no form is in place, and that this must be an individualised decision.

The DNACPR form was revised in July 2023 following publication of the 'All Wales Competency Framework for Completion of the all-Wales DNACPR form (Section 5) by Registered Health Care Professionals (HCPs). This framework was implemented to support the appropriate registered HCPs, such as Advanced Paramedic Practitioners, to undertake the required training and demonstrate key competencies, to allow them to hold DNACPR discussions and to make decisions about commencing CPR. During our staff focus groups within Hywel Dda, we also found that some community based Advanced Nurse Practitioners have also undertaken training to enable them to complete section 5.

Regardless of which clinician completes a DNACPR form, the all-Wales Policy states that all sections must be legibly completed and must contain up-to-date clinical information. Once complete, the form can be used anywhere, for example, in a person's home, in hospitals, hospices, care homes, and during ambulance journeys.

Date of DNACPR discussion and patient identification

The initial section to be completed on the form contains the dates of any DNACPR discussion (and review dates), and patient identification details. During our remote review of the DNACPR forms, we were unable to review the patient details as these had been appropriately redacted by the organisations prior to submission to HIW.

We found the date of discussions was completed on most forms, however, the review dates, the signature of reviewing clinician and their GMC registration numbers were sometimes incomplete. A review date omission may be due to a patient's status not requiring a review. However, for those that were completed,

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several GMC registration numbers were illegible, although, it was positive to note that within some, an ink stamp with the GMC number was inserted.

Recommendation 1:

Health boards and trusts should ensure that clinicians completing the date section 'for review' within a DNACPR form, must clearly document all the required information including the date and their professional registration numbers, to ensure that clinicians are identifiable if required.

When reviewing DNACPR forms and clinical records onsite within Aneurin Bevan, we had concerns which needed immediate attention around documentation in general and the filing and storage of clinical records. We wrote to the health board outlining our concerns in line with our immediate assurance process. The health board responded with an improvement plan demonstrating how it will address our concerns, which has since been accepted. We will continue to monitor the progress of improvements and their sustainability, through our reviews follow-up process. We will refer to our concerns where applicable throughout the report.

Are DNACPR decisions being respectfully communicated to patients and those close to them?

We have chosen to divide the review's main question into two parts and will initially focus upon the patient experience, and effectiveness and quality of the communication of DNACPR decisions to patients and those close to them. In considering this question, we will draw from our analysis of the relevant sections of the DNACPR form and the findings from our fieldwork and public and staff surveys.

Has a discussion taken place with the patient?

The all-Wales Policy highlights that in most cases a DNACPR decision should be made after a carefully planned discussion in partnership with the patient, and should involve those close to them, if the patient agrees. The policy highlights that decisions relating to DNACPR must be accorded a high level of prominence, to ensure discussions are allocated sufficient time, and peoples' views are explored. Clinicians must state clearly what was discussed and agreed with the patient, and if the DNACPR decision was not discussed, the reason should be documented.

In our review of section 3 on the DNACPR form, it was positive to find good examples of concise and thorough explanations of patient discussions during our remote review, and clear indications for any absence of discussions. However, we found some examples needing improvement, where free text sections had not

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been completed at all. We were not able to cross-check this within the clinical records since we did not have access to these remotely, so they may have contained detail on discussions within them. We acknowledge this may be considered a limitation in our review; however, we can appropriately report our findings relating to our remote review of the forms we received during our scoping of the work.

During our onsite fieldwork, we found some examples of positive practice. This included comprehensive narratives within clinical records and clear summaries of patient discussions or with those close to them. For example, detailed discussions about the risks and benefits of CPR and the DNACPR process to fully inform the patient in making a DNACPR decision. However, we found one example following a patient admission to the Emergency Department, where documentation said "DNACPR in community, brought copy in". However, there was no evidence of the DNACPR form within the clinical records, which meant it was not clear whether a patient discussion had been appropriately held. We found another example where a most recent copy of a completed DNACPR form had no details of a patient discussion.

We acknowledge that the free text box within section 3 is limited, therefore, clinicians should be succinct, with further narrative about patient discussions captured in clinical records. Ensuring the succinct recording of patient discussions on the DNACPR forms is pivotal in supporting lines of communication across healthcare teams, without needing to further explore this in the relevant clinical records.

Has an appropriate discussion taken place with those close to the patient, a Health and Welfare Attorney or an Independent Mental Capacity Advocate (IMCA)?

If the patient does not have mental capacity, then those close to them must be consulted, and may be able to support the discussion by indicating the patient's recent wishes. Their name and relationship to the patient should be recorded on the DNACPR form. They should not be asked to make the decision to withhold CPR, which is a clinical decision, but should share what the patient's views and wishes are regarding CPR. If the patient has appointed a Lasting Power of Attorney (LPA) for health and welfare to make decisions on their behalf, that person must be consulted.

Our remote and onsite findings for section 4 were variable. We found good examples of clear information on some forms, and some examples where attempts were made to contact a named patient advocate or LPA, which was supported by clear documentation. We also found a clearly documented example where a patient had expressed their wish for the family not to be consulted about their

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DNACPR decision, which is an important consideration for clinicians. However, we found some examples where section 4 had not been completed at all. Some forms had brief details, such as *'a broad discussion with relatives had taken place with patient present'*, and another stating '*the patient was drowsy*', with no evidence that further attempts to hold discussion with them, or with their relatives.

During our fieldwork in Aneurin Bevan, we were not assured that all staff were maintaining an appropriate standard of documentation following DNACPR discussions, which could impact on communication across relevant teams. We addressed this issue with the health board through our immediate assurance process as highlighted earlier.

Staff experiences of discussions for DNACPR decisions

Our staff survey highlighted a mixed response about the quality of DNACPR discussions with patients. Over 50% felt they provided information and clarity for patients to understand a DNACPR decision, however, very few felt that sufficient time was available for patients to make an informed decision. One comment included:

> *"The discussion regarding DNACPR is left too late and needs to have a higher priority within a patient's illness. Even if there is not completion of the form per se there should be dedicated time in a patient's care, to introduce the concepts of DNACPR and advance care planning".*

This comment resonates with National Institute for Clinical Excellent's Quality Standard 13, End of Life Care for Adults. It highlights 'adults approaching the end of their life should have opportunities to discuss advance care planning' to provide the opportunity to have meaningful, person-led discussions, that allow people to make decisions and plans for their future care while they have the capacity to do so.

We also found positive examples through our engagement with staff about them holding open and honest discussions. This included, giving people opportunities to discuss the decisions, and provide them with emotional support. Staff also elaborated and empathised at how difficult these conversations are. 68% felt individualised communication is at the centre of all DNACPR decision making. This was supported by comments highlighting good practice, and suggestions for improvement, which included:

> *"Some clinicians have a very good way of explaining what DNACPR is and what that means. It's always inspiring to see a good DNACPR discussion. Guidance on how to approach the conversation using scenarios would be helpful. I am always impressed at how the palliative care team approach the conversations".*

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In relation to improving the DNACPR decision process within their organisations, comments included the need to facilitate earlier patient discussions about DNACPR, and that nursing staff could begin having conversations with patients if supported by relevant training. 45% of staff felt that the documentation does not always suitably capture the full communication with patients and those close to them about DNACPR. One staff commented:

"Whenever I have had a DNACPR conversation, I have found that the comments box is too small to document fully what was said and with whom".

We also received a comment highlighting issues with accessing evidence of a DNACPR discussion held with the patient and family within clinical records, during previous hospital admissions. It was felt that additional documentation about discussions is not always added or attached to the DNACPR form, and attempting to find this within previous clinical records can be a challenge. Other comments included:

"…although the amount of narrative sometimes varies depending on who completes it. I like to put some detail about what was discussed and the pts priorities and goals regarding ceilings of treatment/ end of life care in relation to CPR".

The space within the free text box for sections 3 and 4 is limited, and it is not always possible to capture details of a full discussion in either box. However, as highlighted earlier, the policy states the expectation that a clinician should capture key elements on the form and provide further detail within the clinical records (which can be referenced on the form against a specific date, for ease of finding it later).

Patient understanding of DNACPR decisions

In the publication by Marie Curie Palliative Care Research Centre in Cardiff University, following its large national survey on Public Attitudes to Death and Dying in Wales, it was reported that 92% of the 8077 UK respondents (total of 4215 people participating from Wales), think it is important to express future health and care preferences in advance of serious illness and dying. It is, therefore, fundamental that patients and their nominated proxy understand that a DNACPR decision is about addressing attempted full CPR in the event of cardiac arrest or natural dying and does not mean that patients will not receive the required care and treatment prior to that event.

Regardless of when a DNACPR decision is made, patients should continue to have the relevant care, treatment and support they need, up to the point of death. People must also be given the chance to understand how the DNACPR decision is made, and why CPR may not be suitable for them. The patient's wishes and

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preferences should always be considered; however, it is important to note that the clinician, can and will, make the final decision around resuscitation.

To support the patient understanding of a DNACPR decision, further conversations should provide additional clarification once they have had the time to reflect on the decision made. We considered staff evaluation of the patients' understanding in our survey. 71% felt that clarity is always provided to support the patient's understanding that a DNACPR decision relates to active full CPR and does not mean withholding other forms of care or treatment prior to cardiac arrest or natural dying. We found several staff comments highlighting how they seek assurance that patients and families understand what was said during the DNACPR discussion, which include the following:

"I usually go back and check with patients and families [regarding] their understanding if I have had the conversation, or if it has happened recently with another professional. Also, if patients are admitted from community with an existing DNACPR on their electronic record, I recheck their understanding and awareness of this".

"It is always reassuring when appropriate questions are asked following the discussion, indicating that they have followed and understood the information given".

We also considered the public's understanding of DNACPR. Although the response rate was low to the public survey, of those who responded, 60% felt that the clinician did not adequately answer their questions, and 67% felt that there was not enough information provided, and time, to make an informed decision.

We also enquired whether people understood the meaning of DNACPR decisions prior to discussing this with a clinician, and the responses varied. Over 30% felt they were aware of what the decision meant prior to the discussion, whilst others said they did not know much about the topic, or their understanding was to agree the *"correct course of action"*. Some examples include:

"We thought it was to allow doctors instead of the patient and/or a family member to make the decision not to resuscitate".

"That they would not be revived. That their illness [and] age was a factor in the decision making".

"To inform medical professionals of the patient's wishes not to carry out an intrusive process if their heart should stop".

Some patient resources in Wales describe in detail, what can be the brutal process of full CPR at the point of dying. We therefore asked people in our survey whether their understanding of DNACPR changed following the discussion with a clinician.

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55% felt their understanding did not change following a discussion, and when asked to expand on their answer, one comment included:

> *“It was made clear it was a medical decision and patient/family views were not considered in making that decision. It was also NOT made clear that there were no medical concerns at the time about its likely need, just that it was being spoken about as 'best practice' on admission to an acute medical ward”.*

Some people better understood what the DNACPR decision meant following their conversation with a clinician. One comment reflected their understanding had changed, and their treatment had continued following the DNACPR decision. They had received full cancer treatment since the discussion was held, and the DNACPR decision had not changed their treatment plan. This response highlights the importance of ensuring that clinicians provide patients and relatives with sufficient information and clarity, to ensure people can have a fully informed discussion to understand and make a DNACPR decision.

We asked people in our public survey whether there was anything they found particularly helpful or could be improved upon in their experience of the DNACPR discussion. The main theme arising from comments, was that an improvement in clinician attitudes could be made during the discussion around DNACPR. Some comments reflected their experiences as:

> *“More respect, empathy required. Especially when a patient has difficulty understanding even the most basic information. Should be discussed at an appropriate time NOT when you are distressed and in pain”.*
>
> *“How it was delivered (as it sounded very flippant). Who was there and consulted on about it. The vulnerability of the patient needs to be [considered] before having the conversation”.*

Sadly, this resonates with some of the findings highlighted in the report; What People Need from a DNACPR Decision and Discussion, where people described their accounts of poor experiences during DNACPR discussions.

We did receive comments of a more positive experience which reflected:

> *“Good to talk through with the nurse who explained it all. Very clear communication. Then talked to a doctor. Was given form to take home and given to my son, too”.*

We also asked the public whether there was anything further they would like to tell us about their experience of a DNACPR discussion. The comments were mixed, with some reflecting discussions which took place over the telephone. Whilst we cannot confirm the reason for this, we must acknowledge that this may have occurred during the height of the COVID-19 pandemic, when the healthcare system’s response to the pandemic and national lockdown meant that a family

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member was not allowed to visit the hospital. Therefore, clinicians had no other option than to discuss this over the telephone. Some comments included:

"The phone call came out of the blue - it just upset my mother greatly. I feel this discussion should always be done face to face unless the persons involved are fully aware of the conversation which will be taking place".

"It would be more appropriate to discuss with a loved one NOT, I repeat, NOT leave a voicemail".

The above highlights the difficulty in finding the balance between the duty to consult and inform, versus the need to sensitively convey this information, ideally at the next face-to-face visit (if relatives are allowed to visit). We also found that resources were shared with NHS staff by the Wales Cancer Alliance on how to break bad news remotely via video-calls and telephone. This helped support staff during covid with remote discussions about DNACPR. Additionally, it is still a relevant resource if required to undertake remote discussion in the future. In most situations, such conversations take place face-to-face.

In our public survey, we asked questions which considered the quality of the DNACPR discussion. It was disappointing to find over 51% felt they were not treated with dignity and respect, and 57% felt they were not listened to. In addition, 60% felt they were not as involved in the decision as they wanted to be, and that the role of the clinicians within the DNACPR decision process, was not explained clearly to them.

Patient information supporting DNACPR decisions

The all-Wales Policy highlights that patients and those close to them should have the opportunity to further explore their understanding of DNACPR, and how successful or unsuccessful a CPR attempt may be. The policy highlights that people should be offered resources to support their understanding. Examples of these include:

- The 'Sharing and Involving' Information for patients and their carers to help make decisions about CPR (Cardiopulmonary Resuscitation)
- Online resources, such as Talk CPR – Discuss DNACPR
- The dedicated YouTube Channel Byw Nawr - Live Now

The Older People's Commissioner for Wales also provides resources to people which can be accessed on the website; 'Understanding DNACPR': Information and Advice about Do Not Attempt Cardiopulmonary Resuscitation Decisions.

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Supporting information can help a person reflect on discussions or help develop their understanding about CPR and DNACPR decisions. In our public survey, we

asked people if they felt sufficiently informed regarding their DNACPR decision; 76% felt that no informative resources were shared with them about DNACPR. For those who did receive information, some said they were provided with resources, such as leaflets and links to the Talk CPR online resource.

Through analysis of the pre-fieldwork information sent to us by health boards and trusts, we found both staff and patient resources are available for staff to access on health board or trust intranet sites. The intranet sites also provide links to additional resources external to an organisation. We discussed information resources with staff in our focus groups, and it was highlighted that many patient resources are electronic, therefore, it can be a challenge to access for some people who cannot use electronic resources. It was also felt that further consideration should be given to the accessibility of offline resources. We also received comments relating to patient information in our staff surveys, which included:

“Sharing and involving booklets routinely offered. DNACPR conversations can take [several] conversations - patients/ [next of kin] given time to process information when needed. Joint conversations with oncology and palliative care teams can be effective for complex decisions/discussions”.

“Proper promotion of what DNACPR means. Information leaflets that patients can go home and read. Early discussion so that patients aren't shocked by the discussion”.

Whilst there are several resources available which people can access about DNACPR, our review has found that improvements should be made to ensure people can easily access this information.

Recommendation 2:

Health boards and trusts should ensure that clinicians are providing or signposting patients and those close to them with sufficient information resources, in an appropriate format, to help them understand and consider the CPR process, and what DNACPR means.

Recommendation 3:

The Advance and Future Care Planning Group (Wales) should consider how to further increase public awareness within health boards and trusts regarding the existing resources and the meaning and process for DNACPR decision making, to ensure people can appropriately engage in conversations about their preferences during the end of their lives.

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Quality of Staff/Patient discussions around DNACPR

During our staff focus group at Hywel Dda, we heard examples of staff taking a holistic approach to DNACPR discussions, with some occurring over several days or

weeks. For example, nurses often have an opportunity to get to know the patient whilst providing care in hospital or the community and discuss with patients and their family their thoughts and feelings around resuscitation. It was explained that these conversations are empathetic and sensitive throughout. Further evidencing this approach, we found these conversations recorded in some clinical records to provide the Senior Responsible Clinician with key information, ahead of any DNACPR discussion. This is a positive example of building a good rapport with people, and to support their understanding around DNACPR.

We acknowledge that not all situations can happen in a planned way, as there are often challenges faced by clinicians in conducting a conversation around a DNACPR decision. During our staff focus group at Aneurin Bevan, we heard examples where a patient may attend ED in an emergency, and clinicians have limited time to hold sensitive discussions, which can be challenging. We also heard about clinician efforts to hold sensitive conversations around DNACPR at an earlier stage in the person's illness, and to hold these within the community where possible.

Our review has noted several examples of positive practice relating to DNACPR discussions; however, some aspects can be strengthened to ensure appropriate and informative discussions are held with all patients and their families. Understanding the patient's wishes at the end of their life is a central element of good care. Holding appropriate conversations and making a DNACPR decision before a patient becomes too unwell, or loses the capacity to do this, should be the aim. Clinicians must consider how and when to approach the discussion sensitively, and wherever possible, should understand the patient's clinical condition, their wishes, attitude, and cultural beliefs, to allow sufficient time for a meaningful and informative conversation. They should also be aware that on first discussion, this may not be welcome news for patients and those close to them.

Recommendation 4:

Health boards and trusts should explore how clinicians can consider holding DNACPR discussions as early as appropriate with patients and those close to them, to allow them time to understand the decision, reflect on discussions and to generate follow-up discussions if appropriate.

Recommendation 5:

Health boards and trusts must ensure that following DNACPR discussions, clinicians clearly document the details and decision rationale on the DNACPR form and within clinical records (where necessary).

Recommendation 6:

In line with the all-Wales Policy, health boards and trusts should ensure that clinicians fully engage in appropriate discussions with patients and family, to

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ensure an individual's life is respected and valued, and to make clear that a DNACPR decision does not prejudice any other aspect of care.

Consideration of equality and diversity in DNACPR discussions and decisions

Any DNACPR discussion should be approached with recognition of the individual's particular circumstances, their values, and their religious or cultural beliefs. In addition, any DNACPR decision should never discriminate against anyone, including those with protected characteristics.

A clinician's knowledge and understanding should be supported with resources around equality, diversity, and inclusion. When considering this in our staff survey, we received the following comment:

"We have had good feedback [regarding] DNACPR conversations, in particular from patients and from those close to them for whom this has been of utmost importance. Resources and learning shared with groups like Muslim Doctors Cymru have been very helpful in sharing with people of faith who have had queries about CPR/DNACPR, who have mistakenly linked it to euthanasia (which is not permitted in Islam)".

We sought to understand how health boards and trusts ensure clinicians consider equality and diversity when making DNACPR decisions. Overall, the responses from health boards indicated that clinicians take a person-centred approach with individuals. We found an example in one organisation where an equality and diversity lead were in post to support staff with DNACPR discussions.

We were provided with data and information of how health boards and trusts offer training opportunities to staff and provide access to online resources relating to equality and diversity. This included information on gender equality in palliative and end of life care, supporting those with learning disabilities when discussing and making decisions about DNACPR or end of life care, DNACPR discussions with people from Islamic cultures, and information about gender or transgender needs during end-of-life care. We also found that health boards and trusts utilise the DNACPR Equality Impact Assessment.

We asked staff in our survey whether they felt that appropriate training and support was available relating to equality and diversity when making DNACPR decisions. Only 40% felt their organisation provides appropriate training or support. This contrasts with the information provided to us pre-fieldwork from health boards and trusts.

Within the staff survey, some said they did not have sufficient awareness to fully enable them to consider equality and diversity when making DNACPR decisions.

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Some also felt they had insufficient time to undertake training to familiarise themselves with the needs of people across diverse cultures. We did, however, receive a positive comment, reflecting access to other resources, which includes access to the report; I just want to be me, Trans and Gender Diverse Communities' Access to and Experiences of Palliative & End of Life Care, and a comment included:

"Our Trust has information, resources and training packages on this, [including] the recent Hospice UK report on LGBTQ+ resources for DNACPR and [Advance and Future Care Planning Group]".

We received a balanced response from staff relating to the support available when considering a person's spiritual and cultural beliefs during DNACPR discussions. One respondent said they were yet to be challenged by any issues relating to DNACPR decisions and spiritual/cultural beliefs. However, when considering all beliefs, it was felt there to be a lack of available information to support staff. However, we did receive a positive comment which said:

"Useful to have recently read about Islam and its approach towards [end of life] care and DNACPR, following a presentation on DNACPR in our trust, we had a Muslim family who were concerned that it went against Islam. We were quickly able to allay these concerns due to the teaching provided. DNACPR is part of acceptable practice in Islam".

When we considered the documentation for capturing a patient's needs, beliefs and values, 41% in our staff survey felt it was insufficient. We also asked the public whether their needs, beliefs and values were considered, and disappointingly, 58% felt this was not taken into consideration.

Our review has found that overall, the provision of resources and support for staff regarding equality and diversity is satisfactory and consistent across Wales. However, informing staff about the information available, and supporting them with adequate time to access this or undertake training, is an area that requires strengthening. This includes access to training other than mandatory equality and diversity, and to other resources specific to diverse cultures, religions, and gender equality.

Recommendation 7:

Health boards and trusts should consider how staff can be supported with appropriate time to undertake training, and access the information resources available, to support them with considering people's spiritual needs, values, and beliefs, when making DNACPR decisions.

Recommendation 8:

The all-Wales Advance and Future Care Planning Group should consider whether the current DNACPR and/or Advance and Future Care Plan policy and relevant

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documents can cater for individuals' spiritual needs, values, and beliefs, so this information can be more readily accessible and can be considered by all clinicians involved in a person's care.

Communication challenges

We considered how health boards and trusts ensure clinicians adequately engage with people who have communication difficulties, such as those with language barriers and sensory or cognitive impairments. We found several measures in place for people with communication challenges, which included accessing Welsh speaking members of staff to assist patients whose first language is Welsh.

Across Wales, staff have access to the Welsh Interpretation and Translation Service, which is also available in over 120 languages, including British Sign Language. We heard examples that discussions are often held in other languages, supported by bilingual staff. The Language Line translation service is also available to NHS Wales, and can be provided by video, face-to-face or telephone. We also found that where necessary, involvement of a learning disability advocate can support the discussions around the DNACPR decision making process.

We found examples of accessible staff resources to support them with communication challenges. This included hearing loops, translation services, learning disability and gender equality resources, and help for people with literacy challenges. In one health board, we found a good example where a sensory loss tool kit had been developed, which provides guidance on supporting patients with sensory needs.

We also found that staff can access SignLive for support when having DNACPR discussions with patients who have sensory issues, such as hearing impairments, and other examples which support patients with sight impairments. The Talk CPR resource has audios for those with visual and sight issues and has videos for people with deafness and hearing impairments, which explains the DNACPR decision process. This is positive in enabling patients and their families to understand the DNACPR decision making process.

We also found examples in clinical records, where communication needs and equality and diversity had been identified, which demonstrated that efforts to accommodate their needs had been explored and met.

We asked staff in our survey how well their organisation supports them to have inclusive and accessible DNACPR discussions when faced with communication challenges; 58% felt their organisation was somewhat or very effective, 32% felt not at all effective, and 10% were not sure. A theme notable within the comments was their lack of awareness about the support available to staff. One comment suggested they were not aware of any support available to staff; however, it did

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not mean that it was not available, just not very well communicated. Other staff comments included:

"I have not had language barriers, but if I had a non-English speaker, it would be problematic".

"We don't do this as well as we could and would be useful to have awareness of tools which may facilitate better conversations and inclusivity".

We asked a similar question in our public survey around people's accessibility needs during DNACPR discussions. Disappointingly, almost half felt their accessibility needs were not considered. In addition, most respondents felt their communication needs or preferences were not discussed beforehand. Comments included:

"My Father was blind and [it] was not explained fully what this meant".

"Patient is very hard of hearing and wears hearing aids and did not have them in place at the time of arrival of [clinician]. He was not asked if he could hear/ understand at any point, and I had to stop the conversation immediately to tell her he needed hearing aids and for her to stand closer so he could hear".

We also received some positive comments around the support of patient resources which included:

"I can't focus on leaflets for very long, I prefer an explanation, or a video. I saw a video on it, after the conversation, which was very helpful".

"English is not my first language, but resources were easy to understand. To be honest, more people should know about successes and failures of CPR even before they get admitted".

It was positive to find some staff feel supported by their organisation to have inclusive and accessible DNACPR discussions, but unfortunately this is not consistent across Wales.

Information provided to us by health boards and trusts indicate that resources are available to support inclusivity. This was also corroborated by some staff and patient feedback, with these resources accessible via one central site (through the NHS Wales DNACPR website). However, overall, our review has found a lack of staff awareness of the resources available to them around inclusive and accessible DNACPR discussions. Therefore, more must be done by health boards and trusts to raise staff awareness.

Recommendation 9:

Health boards and trusts should consider its staff awareness of the support, resources and training available to them about inclusive and accessible DNACPR discussions, and how to improve the promotion of its availability.

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Are DNACPR decisions clearly recorded and communicated between healthcare professionals?

The following sections will focus on the second part of our key question, in particular around how DNACPR decisions are recorded and communicated between healthcare professionals. This will draw on evidence gathered during our analysis of the relevant sections of the DNACPR form, as well as other evidence.

Does the patient have capacity to make and communicate decisions about CPR?

In line with the all-Wales Policy, clinicians must consider whether patients have mental capacity to make and communicate decisions about CPR. If the patient does not have capacity to weigh up and retain details for a DNACPR decision, a Mental Capacity Assessment must be undertaken, and the best interests of the patient must be considered and recorded within their clinical records. If a patient does not have a person close to them who is willing and able to be consulted about DNACPR, then an IMCA should be instructed. Clinicians must also ensure that any existing Advance Decision to Refuse Treatment (ADRT) or LPA for health and welfare document is specific, valid, and applicable to the patient's current circumstances.

Our review of DNACPR forms found this section was generally well-completed, with most reflecting patients having capacity to make their own decisions. However, some demonstrated conflicting information. One example included a patient who was deemed not to have capacity, but the DNACPR discussion had occurred with the patient alone. We did not have access to clinical records to establish whether additional information was documented within the relevant clinical records.

We also found examples where patients were marked *'NO'*, not having capacity, however, the sub-questions regarding ADRT and LPA were not completed. We, therefore, could not establish whether the patient had made a previous DNACPR decision to refuse treatment, or had instructed someone to make decisions regarding this on their behalf. We also found examples where neither '*YES' or 'NO'* were indicated, thus not allowing us to establish whether the clinician had considered the patient's capacity or whether key documents were in place to support this.

During our fieldwork in Aneurin Bevan, we found examples of ambiguous information documented around patient capacity. This included a DNACPR form indicating the patient did not have capacity, and no documentation relating to an LPA, or rationale that the decision was in the patient's best interests when making a DNACPR decision. Neither was evidence of this documented in the clinical records. Another example included a form stating a patient did not have capacity, however, the clinical records, reflected that the patient, perhaps, did have

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capacity, since there were entries made by two staff who documented the patient was able to correctly, albeit with difficulty, answer questions appropriately.

Due to our collective findings regarding capacity assessments in Aneurin Bevan, we were not assured that these were being undertaken appropriately. We therefore addressed this with the health board through our immediate concern process as highlighted earlier.

In Hywel Dda, we found some positive examples of clear documentation around capacity. This included well-documented accounts of patient cognitive function, and good evidence of legal measures taken for a patient who did not have capacity, a next of kin or other family. Reference to the patients' capacity was recorded primarily in the medical records and was also clear within the nursing records. We also found good examples of best interest decisions and Mental Capacity Assessments, in clinical records, which was supported by clear documentation of discussions with relatives, who had LPA.

We considered the findings around capacity in our staff survey and 60% felt that individuals are encouraged to participate in conversations about their DNACPR decision, regardless of capacity. However, there were mixed comments suggesting parts of the DNACPR form were not being completed, particularly for LPA and ADRT.

We also considered comments about capacity within our public survey. It was disappointing to see one respondent said:

"The consultant clearly did not understand people's human rights, the value of life or the impact on family to state without discussion that my father was no longer of any value. I have a good understanding of mental capacity assessment and the legal requirement to support people to fully understand any treatment offered or withdrawn having worked across Gwent social services for 20 years. I understood, the consultant did not".

We asked staff in our survey to share their thoughts on how the DNACPR process could be improved. Comments included the need for improvement on the DNACPR form for recording mental capacity and the form should encourage or reference a more thorough mental capacity assessment. It was positive to find other comments referencing the National Mental Capacity Forum webinar on DNACPR, which accounts the different approaches to DNCAPR, and elaborated this as an excellent resource that all clinicians responsible for DNACPR should watch. This is available through the NHS Wales DNACPR website.

Comments in our staff survey and focus groups also highlighted that additional training would be beneficial for completing mental capacity assessments, and how to record the evidence for concluding the capacity decision.

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Whilst there was some evidence of positive practice relating to patient capacity, undertaking assessments and consideration, or establishing an ADRT or LPA should be improved. Strengthening the process for mental capacity assessments is also an area HIW has found in other aspects of its assurance work. Therefore, completing these assessments should be strengthened more widely across health boards and trusts, and is not exclusive to the DNACPR decision process.

Recommendation 10:

In the absence of patient capacity to engage in and understand a DNACPR decision, health boards and trusts must ensure that clinicians complete all relevant parts of section 1 of the DNACPR form. Additionally, a mental capacity assessment and the decisions around the best interests of a patient should be appropriately recorded and filed in the clinical records.

Recommendation 11:

Health boards and trusts should undertake a training needs analysis relating to the Mental Capacity Act and completion of mental capacity assessments. This should be considered widely across the organisation and not exclusively for those completing a DNACPR decision form.

Summary of the main clinical conditions and reasons why CPR would be inappropriate, unsuccessful, or not in the patient's best interests

Section 2 of the form mandates that a clinical summary is completed and should include the reasons why CPR would be inappropriate, unsuccessful, or not in the patient's best interests. The all-Wales Policy states this should be succinct but as specific as possible, and that more detailed information can be recorded in the patient's clinical record.

On most DNACPR forms, we found this section was well-completed. Our ability to evaluate this during our remote review of DNACPR forms was more challenging, due to our inability to consider corresponding clinical records. As noted earlier in the report, we acknowledge that the free text box in section 2 has minimal space for recording the required information. Nevertheless, we saw positive examples of concise and thorough summaries of patients' main clinical conditions, with clear indications why CPR would be inappropriate. However, we found some examples using jargon and/or abbreviations on forms, which were not clear to justify why CPR would be inappropriate.

We found other examples where section 2 had not been completed at all. As previously discussed, a balance must be struck between a brief record that is concise and quickly reviewed in an emergency, when every second counts, versus having more detailed information to read. The DNACPR form can co-exist with

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other forms, such as the all-Wales Advance and Future Care Plans form which can be accessed online for more detail and more nuance on a person's wishes.

Within Aneurin Bevan, we found that documentation was generally of a lower standard, which included recording the patients' clinical condition and why CPR would be inappropriate. Some examples had limited, or insufficient information recorded, and some where the handwriting was illegible. Other examples evidenced completion of section 2; however, there was no rationale why CPR was considered inappropriate. We addressed our concerns for this with the health board as part of our immediate concerns process as highlighted earlier.

Whilst we found some good examples of clear and comprehensive documentation for section 2, our conclusion is that improvements can be made. It is important that section 2 is completed well. The form should capture a succinct clinical summary, and reasons why CPR would be inappropriate. This can be supported with additional information within the clinical records, as highlighted in the all-Wales policy.

Recommendation 12:

Health boards and trusts must ensure that clinicians clearly and succinctly record a patient's clinical summary within section 2, and the reasons why CPR would be inappropriate, in line with the all-Wales Policy.

We have reported on sections 5 and 6 of the DNACPR form together, as they relate to clinicians completing and/or having oversight of the form:

Healthcare professional completing this DNACPR form, and Senior Responsible Clinician (SRC) with oversight

The all-Wales Policy states that the clinician completing section 5 of the form should have knowledge of the patient's current and past medical history. Those completing the form must clearly sign and date it and provide their professional registration number. The DNACPR form must be overseen by an SRC (usually the Consultant or General Practitioner (GP), and in some settings, a Consultant Nurse, or Advanced Nurse Practitioner). The SRC should be consulted as soon as reasonably possible about the DNACPR decision, this can be done remotely, but must be recorded. This must be signed and dated, together with the SRC's professional registration number.

We found that section 5 was generally well-completed, however, contact details, such as bleep or telephone numbers were frequently omitted. The completion rates in section 6 regarding the SRC, was variable. Some were completed, others were not. The all-Wales Policy highlights that section 6 should be signed by the SRC at the earliest possible opportunity. However, the signature at section 5

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already denotes the DNACPR decision, and should be regarded as such, in the event of a cardiopulmonary arrest or natural dying. All details in section 5 and 6 must be completed, to ensure others can contact individuals about the decision made on the form.

Delays in completion of section 6 was a finding in most organisations and not isolated to one. We also found examples of delays of several days, and in some, there was more than a month delay in completing section 6. These delays were also highlighted in our staff survey. This highlights the importance of holding DNACPR discussions as early as possible, however, we acknowledge that a patient's clinical condition may deteriorate rapidly, therefore, it will not always be possible to maintain a timely completion of section 6 by an SRC.

Recommendation 13:

Health boards and trusts must ensure that section 6 of the DNACPR form is completed in a timely manner by the Senior Responsible Clinicians in line with the all-Wales Policy.

Cancellation of the DNACPR decision

There may be situations where it is appropriate for a clinician to cancel a DNACPR decision. The all-Wales Policy states that when this is necessary, the original form should be clearly crossed through with two diagonal lines in black ink, with "*CANCELLED*" written between them and must be signed by the relevant clinician.

The SRC involved in the patient's care must also be consulted about this decision if they have not initiated this themselves. All previous recipients of the DNACPR decision form must be notified immediately. The communication must be in writing and logged in all relevant records, and where possible, contain a copy of the original overwritten cancelled document. The patient's own form should be returned and filed in the clinical record, to reduce the risk of rescuers not attempting CPR. If a patient has destroyed their copy, this must also be recorded in the clinical record.

We considered (where appropriate), whether the cancellation of a DNACPR decision had been correctly completed. We found two examples where a cancellation of the DNACPR decision had been made, and both were appropriately completed. However, we were unable to establish whether cancellation of the DNACPR decision had been communicated to all form copy holders in line with the all-Wales Policy.

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Disseminating copies of the DNACPR decision form

The all-Wales Policy stipulates that clinicians must ensure communication of a DNACPR decision is made across relevant teams, such as to the GP, Care Home, or out-of-hours care providers. The patient or those close to them should also receive

a copy the form. The Policy also reflects that health boards and trusts should ensure out-of-hours services, EDs and GP surgeries have systems that can store, coordinate, manage and respond to DNACPR data. This should include a protocol for alerting WAST when patient transport is requested for a patient with a current DNACPR decision in place.

Any Welsh language DNACPR forms must be appended with an English language version. We received a comment in our staff survey where a Welsh language DNACPR form had been completed, however, there was no English language version appended. As a non-Welsh speaker, they said they were unable to read or translate the content of the form. This example highlights the importance of ensuring an English language version of a DNACPR form must always be appended to a Welsh language form, to safeguard that all relevant people can understand that documented on the form.

Our review found several forms that did not contain a section 8, as they were older and previous versions of the DNACPR form. However, where this section was present, it was by far, the least completed. This could mean that a copy of the form is not provided to relevant others when the patient was discharged, however, we could not establish this in the records.

We discussed the completion of section 8 with staff during our focus groups. Examples were shared with us of the challenges faced by paramedics or ambulance crew in attending the home, or care home of a patient, and a DNACPR form had not accompanied the patient home. Therefore, no evidence that a DNACPR decision had been made. This was supported by a comment in our staff survey which said:

"While the DNACPR form is usually filled out correctly the communication with other areas of healthcare is not always very good. There may or may not be a brief mention on the discharge paperwork of their being a DNACPR form in place, but rarely any detail about discussions. I have also come across nurses not realising that they need to give the patient a copy of the DNACPR form when they are discharged. Also, we are unable to see on the parts of the GP record we have access to whether a patient has a DNACPR form in the community.
All of this means that we are often not aware of whether a patient has a DNACPR form and the reasons for this".

The comment above, highlights the risk that in the event of a patient cardiac arrest or natural death at home, clinical staff are likely to commence CPR on a patient, against their wishes, if there is no evidence that a DNACPR decision has been made.

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Communication across healthcare teams

We considered how well clinical teams communicate DNACPR decisions. In our staff survey, we asked people to tell us how they rated the communication of DNACPR decisions across healthcare teams. It was concerning to find that almost 30% felt that communication of DNACPR was not at all effective, and a further 58% felt they found it just somewhat effective. We received several staff comments around communication, which included:

"Needs to be more obvious on CWS [electronic clinical record system] when a DNACPR has been made and if it is an ongoing one or not, so it is easy to find in future admissions (and not buried in large amount of random documentation)".

"Limited communication, not available to community teams, even when recorded digitally can be difficult to find".

"It varies, very effective in our team but not as effective in some teams and settings. For example, some medics will write in the notes that a patient is not for escalation or not for CPR but not complete the form and it may not be clear if they have had a conversation with the pt and what was said in that conversation."

A theme which emerged from the comments was the need for effective information sharing, particularly with references to the implementation of an electronic DNACPR form. Some staff comments included:

"Problem of accessing discussion held on previous admissions and sometimes finding DNACPR records from previous admissions. one issue is that discussions not always attached to the DNACPR form (due to lack of space) and finding where they are written in old notes can be a challenge".

"Electronic DNACPR forms may help with sharing information between primary, secondary and tertiary teams".

"A central database of DNACPR decisions that removes the keeping of these important documents from the unwell patient / carer. This system could then be accessed by those supporting the patient/family/carers".

Our survey results clearly reflect an issue with the communication of DNACPR decisions across healthcare teams. Poor communication increases the risk that a patient may receive CPR against their decision and wishes. Therefore, more needs to be done across Wales to ensure communication of DNACPR decisions is improved across clinical teams.

Electronic repository for DNACPR decision forms

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Our overall findings recognise the benefits that an electronic system could bring in supporting the communication of DNACPR decisions, and enable sharing electronically with patients, for instance, via resources created for NHS Wales

patients to access their own health records. This would be beneficial in bridging the gap between community and primary care settings and acute hospital settings, and from one health board area to another.

The benefits of a repository would also enable patients, clinicians, GP practices, Out-of-Hours services, WAST staff and the NHS 111 service to access a central system. This would establish if a patient had a DNACPR decision form in place or has an advocate to make care decisions, Advanced Decision to Refuse Treatment or an Advance Care Plan in place.

We learnt during our review that efforts had been made by the all-Wales Advance and Future Care Planning Strategy Group to introduce a central electronic repository for DNACPR decision forms. This would accompany or replace the hard copy of the form and would help ensure the form is easily found promptly. However, funding is yet to be secured to implement this.

The introduction of an electronic system would not be without risk. However, there have been examples in the UK media regarding serious communication failures around the provision of CPR to patients, even where electronic record sharing of CPR status has been in place. This includes an example in England highlighted in a Senior Coroner Regulation 28: Report to Prevent Future Deaths, where a patient with a DNACPR decision in place choked on a piece of food. Whilst the patient had a DNACPR decision form in place which he had agreed, it was for an altogether different health reason. Due to this, the patient did not receive prompt assessment by emergency staff, nor made a priority for a paramedic response. The choking was a potentially reversible cause that may have sustained the life of the patient for longer, irrespective of their long-term conditions. However, miscommunication prevented any life support.

Other examples of poor communication are highlighted in the report; What People Need from a DNACPR Decision and Discussion: Findings from Focus Groups with Older People, about people having a DNACPR decision in place, however, despite this, patients were resuscitated against their wishes.

Overall, the existence of an electronic DNACPR repository may mitigate against such issues, since the forms would be completed online and would be accessible to all healthcare providers across Wales, including patients and their families. The benefits of the electronic system may include:

- Improved documentation of key clinical details regarding about the DNACPR decision in one accessible system
- Immediate notification to ED staff when patient may arrive in an emergency, such as cardiac arrest
- Immediate notification to the repository if a DNACPR decision is cancelled.

In addition, the system may mitigate against the risk of:

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- The need to document additional information in clinical records (which are then not accessible outside hospital)
- The physical loss of paper DNACPR forms
- Other healthcare providers not being alerted to a DNACPR decision (such as WAST or GP).

This list is not exhaustive but provides examples of the benefits of an electronic repository. In addition, an electronic system could ensure that each section of the form is completed in full (as mandatory fields), which would mitigate against our review's findings of not completing sections.

Recommendation 14:

Health boards and trusts must ensure that communication of a DNACPR decision is improved across to the relevant clinical teams involved in the care of patients, and these within section 8 of the DNACPR form, such as their GP, care home and out of hours providers where appropriate.

Recommendation 15:

Welsh Government should consider the benefits of an all-Wales electronic patient repository for recording DNACPR decisions, for instance within Welsh Clinical Portal, to help achieve prompt and robust communication of these decisions throughout Wales. This would benefit patients and those close to them, communication nationally across different health board teams in secondary care, and community and primary care, and in care homes, and emergency services.

Training for DNACPR decision making

Undertaking DNACPR training is not mandatory in Wales but is considered best practice. The all-Wales Policy highlights that employers should support clinicians to access training for Advance and Future Care Planning and DNACPR processes and have easy access to relevant policies.

Health board and trust induction programmes for clinical staff should raise awareness of the all-Wales DNACPR policy. Primary care professionals must also be provided with access to any Advance and Future Care Planning or DNACPR training provided by their local Health Board or trust. The policy also highlights the importance that it spans the 'whole system of care', and all relevant NHS staff should have easy access to knowledge sources, senior clinical support and to training opportunities to deliver an effective process for DNACPR conversations.

Clinicians who complete DNACPR decision forms should undertake regular training on DNACPR, as part of their professional appraisal and revalidation cycles. As discussed earlier, training is accessible across Wales via the Electronic Staff Record and the e-learning programme; End of Life Care for All (e-ECLA). The Wales

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DNACPR website also provides ample resources, including ESR modules that staff holding such conversations can access.

In our staff survey, we asked what training staff had received in the last 12 months to assist with their understanding, recording and communication of DNACPR decisions and equality and diversity. Across Wales, Mental Capacity Act, and Equality, Diversity and Human Rights training is mandatory, but the results of our survey demonstrated that more must be done to ensure and support staff to complete DNACPR training.

The e-ELCA programme (as highlighted above), provides resources to enhance the knowledge and skills of health and social care staff, to ensure well-informed and high-quality care can be provided by confident and competent staff and volunteers. Less than 23% of staff had completed the e-ECLA and DNACPR Communication skills learning modules.

Most respondents to our staff survey said they had read the current all-Wales DNACPR policy, and had undertaken the 'Equality, Diversity & Human Rights' and 'Mental Capacity Act' e-learning. Some staff also said they had undertaken other related training which included Palliative Care and Cancer training courses, MSc Advanced Clinical Practice, MSc modules on ethics, and communication in end-of-life care.

We asked staff to tell us whether any different or additional training would be useful. The responses included:

"A conference on DNACPR and AFCP, perhaps organised by HIW (together with CIW) and/or HEIW may be useful. There was a great national Welsh conference on future care planning in 2019, we should aim to repeat these events every few years".

Other staff comments included:

"Listened to multiple podcasts which detail the all-Wales DNACPR Policy, End of Life care and I have visited the Talk CPR website".

"The NHS Wales module on the Care Decisions for last days of life guidance which is found on ESR and covers the dying process and decision making at [end of life]".

Regarding what improvements could be made to the DNACPR process, staff suggested improved access to training across various clinical teams, and the need to educate clinicians in the most suitable way of carrying out empathetic DNACPR discussions.

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DNACPR Audit and data collection

Welsh Government and NHS Wales organisations are committed to the principles of value-based healthcare to help meet the challenges of rising costs and increasing

demand, while continuing to improve the quality of care. Clinical audit is an integral component of the quality improvement process and is highlighted in the all-Wales policy. It states that health boards and trusts should undertake an audit of at least 50 DNACPR forms every two years, to establish whether the DNACPR decision making process and communication is robust, and to identify areas for improvement.

We considered the last three DNACPR audits which had been undertaken in each health board and Velindre. The dates of audit data varied across organisations and ranged from 2018 through to 2023. Overall, the compliance rates we saw were high. We were also told that health boards and trusts consider the audit outcomes and the results with any action required are escalated through their individual governance processes. However, we did not triangulate this data across all health boards.

We considered the audit data submitted to us by Aneurin Bevan from February 2023, which demonstrated a compliance of 95%. However, during our review of DNACPR forms remotely and onsite alongside clinical records, there was a discrepancy in our findings, as highlighted earlier. We were subsequently not assured that the DNACPR audit processes in place was representative. We addressed this with the health board through our immediate assurance process as highlighted earlier.

We asked staff in our survey to tell us whether their organisation undertakes regular audits of the DNACPR process and documentation, almost half said they were not sure. This therefore highlights that any identified issues or learning from audit is not effectively shared across teams. One comment we received implied that their organisation should audit the DNACPR process and completion of the forms.

Health boards and trusts should reflect on the lack of staff awareness around the audit of DNACPR decision making process and consider whether their overall processes need strengthening. This should include sharing the learning following audit across all relevant teams. We were made aware of a good example of an audit quality improvement project, undertaken in one Welsh Trust; Do not attempt cardiopulmonary resuscitation documentation: a quality improvement project. The learning from this was communicated to staff through a presentation and at several teaching events and has also been shared nationally.

Recommendation 16:

Health boards and trusts must consider their audit processes for the DNACPR form in line with the all-Wales Policy, to ensure when this is conducted, the process is robust, and that learning is shared across their organisation.

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Capturing and acting on staff and patient feedback

It is clear throughout our review that lessons can be learned from both the staff and the public's feedback about their experiences of DNACPR decisions. Our findings and recommendations identified throughout this review also resonate with that highlighted in the report; What People Need from a DNACPR Decision and Discussion, which was published in March 2024 by the charity Compassion in Dying. Therefore, health boards and trusts should consider these comments and determine how these could influence improvement with the quality of the DNACPR decision making process, and the experience of patients and those close to them across Wales.

Recommendation 17:

Health boards and trusts must consider the staff and public's experience and comments highlighted throughout this report and determine how these could influence improvement with the quality of the DNACPR decision making process, and the overall patient experience.

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Conclusion

It is clear from our findings that there are examples of noteworthy practice across Wales regarding the DNACPR decision making process. However, we have also identified opportunities to improve. These include the need to strengthen the quality of communication with both patients and those close to them, and across different healthcare teams. This is to ensure that discussions and DNACPR decisions and the rationale behind these, are clearly recorded and communicated between healthcare teams.

Staff need to feel supported and empowered to hold open and honest conversations with people, and equally patients and their families should be supported and encouraged to talk about what they would like to happen at the end of their lives. Early DNACPR conversations can support the overall DNACPR decision making process and can help ensure people understand what will or will not happen once the decision not to resuscitate is made, to maintain a respectful and dignified time during death.

Health boards and trusts should ensure that the resources they provide to support staff to hold DNACPR discussions are shared, accessed, and utilised. Our review has found training is a theme that needs attention.

Further attention to detail is required by staff when recording information on the all-Wales DNACPR form. The form should be completed in full, and staff should ensure any additional or supporting information is legibly recorded within clinical records about the decision-making rationale, including conversations with patients and their families.

The communication of a DNACPR decision should be clear and without ambiguity, to ensure relevant people involved in the care of the patient, are aware of the decision and plans. This includes departments across health boards or trusts, GPs, care homes and out-of-hours providers, as appropriate.

DNACPR decisions are an important part of end-of-life care that can ensure a respectful and dignified death. Yet, it is important that these decisions are communicated sensitively and effectively. Through our review we hope to drive improvement in relation to these decisions and ensure that clinical intervention aligns with and respects the wishes of patients.

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What Next?

We expect health boards, trusts, and Welsh Government to carefully consider the content of this report and the overall findings from our review. Organisations must also consider and act upon the recommendations set out within the report.

We also expect health boards and trusts to consider the staff and public's feedback highlighted throughout the report and determine how these can influence improvement with the quality of the DNACPR decision making process.

We hope this review will be used to help health boards and trusts improve their processes relating to the DNACPR decision making process, and the communication between clinicians and patients and those close to them. Healthcare teams across Wales should be encouraged to collaborate and benchmark with each other to share and learn from good and innovative practice.

All relevant stakeholders highlighted within this report are required to submit an improvement plan in response to the review's recommendations. This is to ensure that the matters raised by our review are being addressed. HIW will continue to review progress against recommendations though its review follow-up process. The findings highlighted in our report, and the responses that we receive, will support HIW in considering other work in the future.

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Appendix A

Recommendations

As a result of the findings from this review, we have made the following recommendations.

	Recommendations:
1	Health boards and trusts should ensure that clinicians completing the date section 'for review' within a DNACPR form, must clearly document all the required information including the date and their professional registration numbers, to ensure that clinicians are identifiable if required.
2	Health boards and trusts should ensure that clinicians are providing or signposting patients and those close to them with sufficient information resources, in an appropriate format, to help them understand and consider the CPR process, and what DNACPR means.
3	The Advance and Future Care Planning Group (Wales) should consider how to further increase public awareness within health boards and trusts regarding the existing resources and the meaning and process for DNACPR decision making, to ensure people can appropriately engage in conversations about their preferences during the end of their lives.
4	Health boards and trusts should explore how clinicians can consider holding DNACPR discussions as early as appropriate with patients and those close to them, to allow them time to understand the decision, reflect on discussions and to generate follow-up discussions if appropriate.
5	Health boards and trusts must ensure that following DNACPR discussions, clinicians clearly document the details and decision rationale on the DNACPR form and within clinical records (where necessary).
6	In line with the all-Wales Policy, health boards and trusts should ensure that clinicians fully engage in appropriate discussions with patients and family, to ensure an individual's life is respected and valued, and to make clear that a DNACPR decision does not prejudice any other aspect of care.
7	Health boards and trusts should consider how staff can be supported with appropriate time to undertake training, and access the information resources available, to support them with considering people's spiritual needs, values, and beliefs, when making DNACPR decisions.
8	The all-Wales Advance and Future Care Planning Group should consider whether the current DNACPR and/or Advance and Future Care Plan policy and relevant documents can cater for individuals' spiritual needs, values, and beliefs, so this information can be more readily accessible and can be considered by all clinicians involved in a person's care.

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9	Health boards and trusts should consider its staff awareness of the support, resources and training available to them about inclusive and accessible DNACPR discussions, and how to improve the promotion of its availability.
10	In the absence of patient capacity to engage in and understand a DNACPR decision, health boards and trusts must ensure that clinicians complete all relevant parts of section 1 of the DNACPR form. Additionally, a mental capacity assessment and the decisions around the best interests of a patient should be appropriately recorded and filed in the clinical records.
11	Health boards and trusts should undertake a training needs analysis relating to the Mental Capacity Act and completion of mental capacity assessments. This should be considered widely across the organisation and not exclusively for those completing a DNACPR decision form.
12	Health boards and trusts must ensure that clinicians clearly and succinctly record a patient's clinical summary within section 2, and the reasons why CPR would be inappropriate, in line with the all-Wales Policy.
13	Health boards and trusts must ensure that section 6 of the DNACPR form is completed in a timely manner by the Senior Responsible Clinicians in line with the all-Wales Policy.
14	Health boards and trusts must ensure that communication of a DNACPR decision is improved across to the relevant clinical teams involved in the care of patients, and these within section 8 of the DNACPR form, such as their GP, care home and out of hours providers where appropriate.
15	Welsh Government should consider the benefits of an all-Wales electronic patient repository for recording DNACPR decisions, for instance within Welsh Clinical Portal, to help achieve prompt and robust communication of these decisions throughout Wales. This would benefit patients and those close to them, communication nationally across different health board teams in secondary care, and community and primary care, and in care homes, and emergency services.
16	Health boards and trusts must consider their audit processes for the DNACPR form in line with the all-Wales Policy, to ensure when this is conducted, the process is robust, and that learning is shared across their organisation.
17	Health boards and trusts must consider the staff and public's experience and comments highlighted throughout this report and determine how these could influence improvement with the quality of the DNACPR decision making process, and the overall patient experience.

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Mae'r ddogfen hon ar gael yn Gymraeg hefyd / This document is also available in Welsh
Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg / We welcome correspondence and telephone calls in Welsh

Agenda item: 4.1

Patient Experience, Quality and Safety Committee	**Date of Meeting: 30 July 2024**
Subject:	Mental Health Act Compliance Report for the 12 month period : 1 April to 30 June 2023 (Q1) 1 July to 30 September 2023 (Q2) 1 October to 31 December 2023 (Q3) 1 January to 31 March 2024 (Q4)
Approved and Presented by:	Joy Garfitt, Interim Director of Operations / Director of Community and Mental Health
Prepared by:	Melissa Brooks, Mental Health Act Administrator
Other Committees and meetings considered at:	Executive Committee 17 July 2024
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):

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

- **RECEIVE** the contents of this report and take **ASSURANCE** that the performance of the service in relation to the administration of the Mental Health Act 1983 has been compliant with legislation.

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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.

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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)	**6**	**9**
Sec 5 (2)	**18**	**18**

The use of both Section 5(4) and Section 5(2) powers has increased over the last three years and the service will continue to monitor the use of s5(2) powers closely during 2024/25.

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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 101 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 98 occasions.

Once again, it is likely that the Covid 19 pandemic has had 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.

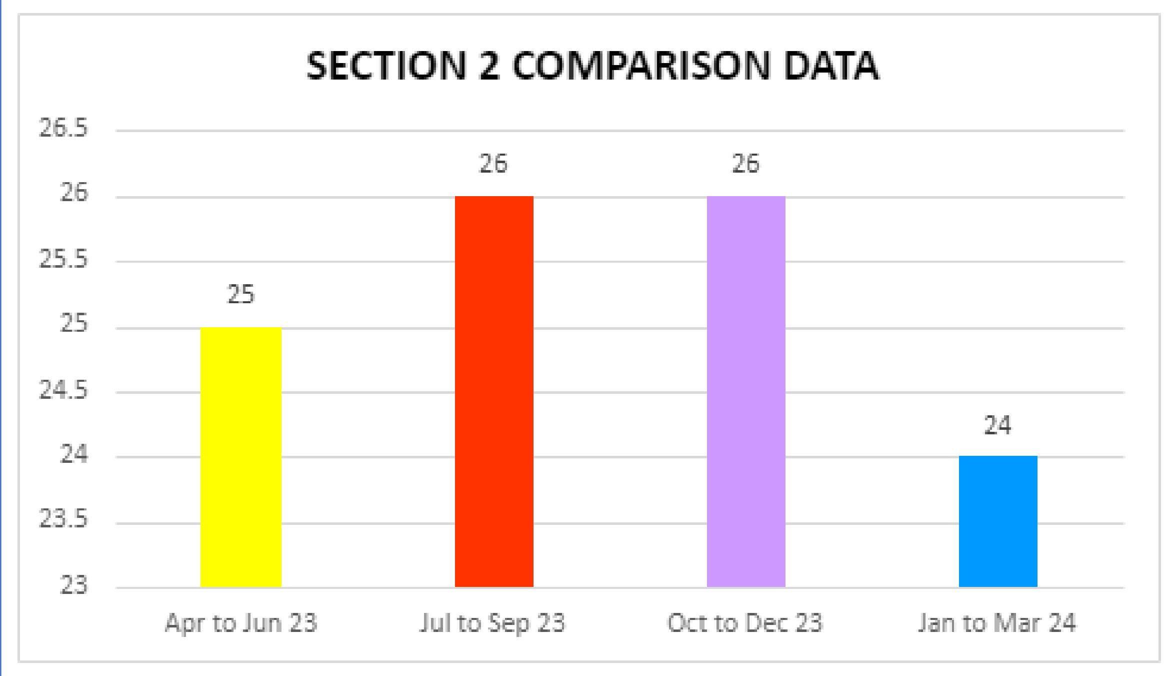

Table 1: Use of Section 2 over the last 12-month period

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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 46 occasions.
For the same period last year, section 3 was used on a total of 43 occasions. This decrease may be linked to COVID restrictions being lifted and services being able to engage with clients at home with support as restrictions eased.

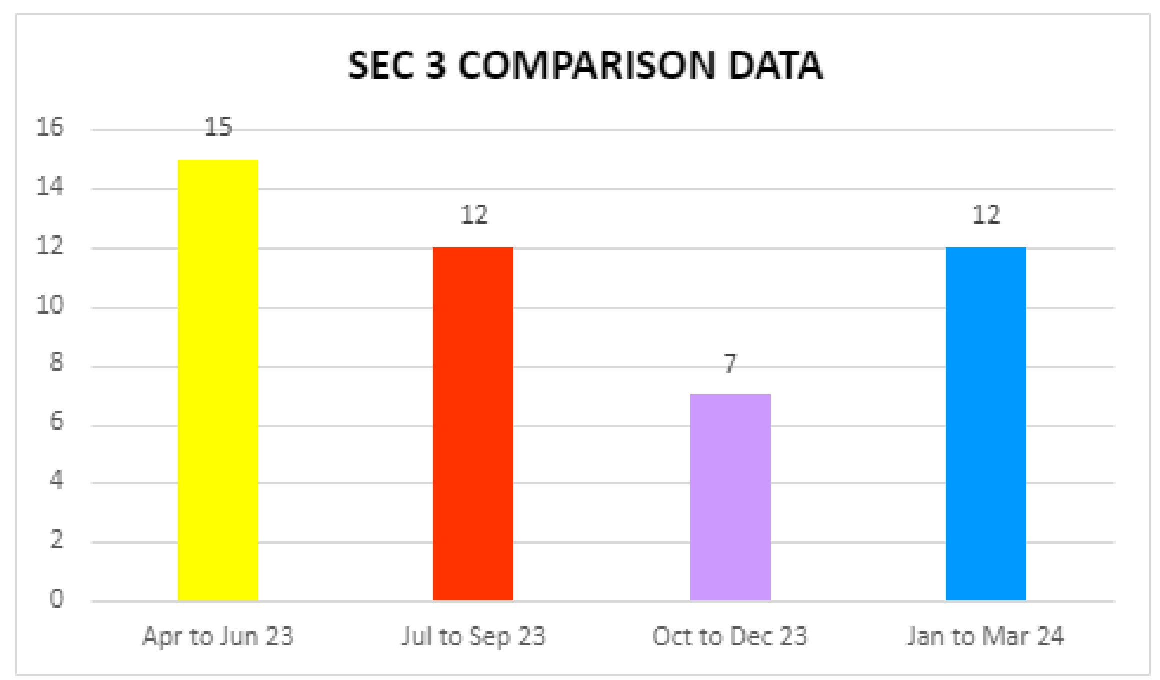
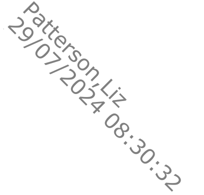


Table 2: Use of Section 3 over the last 12 month period

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.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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 less than 5 times during this 12-month period. For the same period last year, section 4 was used on a total of less than 5 occasions. Whilst there have been concerns expressed in the past about AMHP's being able to access Section 12 approved Doctors the low number of Section 4's suggests this is being managed well.

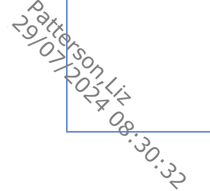
v) Section 17A – Community Treatment Order (CTO)

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 11 community treatment orders (CTO) in place as at 31st March 2024. CTO activity during the 12-month period 1st April 2023 to 31st March 2024 includes 5 new CTO's; 3 patients were recalls/revocations and 5 discharged from the CTO. By comparison on 31st March 2023 there were 15 community treatment orders in place.

During the period one CTO lapsed due to the expiry date being overlooked.



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, the vast majority of 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 22 occasions during the twelve-month period 1 April 2023 to 31 March 2024. 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 higher than in the previous 12-month period when it was used on a total of 21 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.

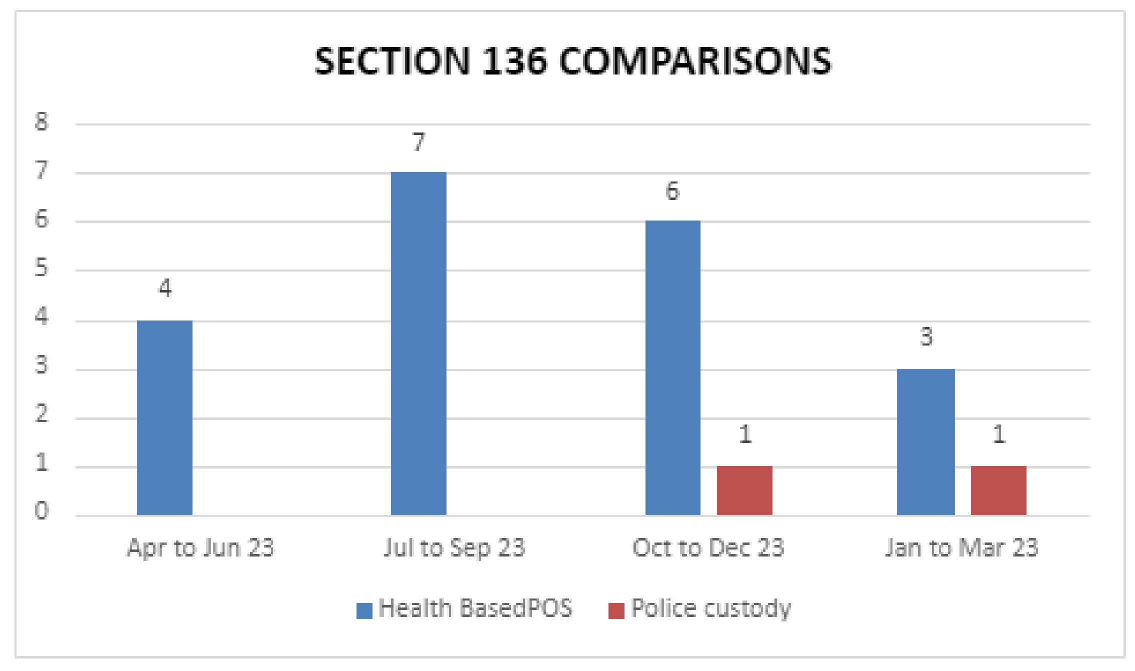


Table 3: **Location of completed Section 136 assessments highlights that police cells were used on two occasions as a place of safety during the period.**

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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 11 rectifications compared to 10 in the previous year. Error types are spelling errors in patient's names, omission of a patient's middle name, Doctor crossing through statement in error and digital signatures applied to English medical recommendations which are not acceptable in Wales.

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 1 1 Apr to 30 Jun 23	**Two occasions**
Quarter 2 1 Jul to 30 Sep 23	**Three**
Quarter 3 1 Oct to 31 Dec 23	**Two**
Quarter 4 1 Jan to 31 Mar 24	**Four**
Fundamentally Defective Detentions	
Quarter 1 1 Apr to 30 Jun 23	**One**
Quarter 2 1 Jul to 30 Sep 23	**None**
Quarter 3 1 Oct to 31 Dec 23	**None**
Quarter 4 1 Jan to 31 Mar 24	**None**

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viii) Deaths of detained patients

During the period there were no deaths of patients detained under the Mental Health Act 1983.

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

During the 12-month reporting period reporting period, 31 applications/ referrals were made to the MHRT:

- No patients were discharged from detention by the Tribunal.

There were 12 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 period, IMHAs attended one 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.

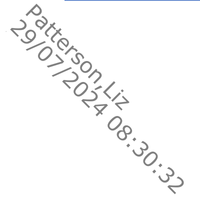
This is reviewed by the quarterly Powers of Discharge Committee which is satisfied those patients are being made aware of their rights and have sufficient information to appoint an advocate if they want one.

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 were no visits by HIW.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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)

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Continuing Healthcare & Funded Nursing Care

Final Internal Audit Report

May 2024

Powys Teaching Health Board

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Review reference:	PTHB-2324-17
Report status:	Final
Fieldwork commencement:	17th December 2023
Fieldwork completion:	26th April 2024
Debrief meeting:	23rd April 2024
Draft report issued:	2nd May 2024
Management response received:	24th May 2024
Final report issued:	24th May 2024
Auditors:	Jayne Gibbon, Audit Manager Ian Virgill, Head of Internal Audit
Executive sign-off:	David Farnsworth, Interim Executive Director of Operations/Director of Community and Mental Health
Distribution:	Ruth Derrick, Assistant Director Complex Care Jacqui John, Head of Complex Care & Unscheduled Care (MH&LD) Rhian Proce-Evans, Lead Nurse of Complex Care and Care Home Governance
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.

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Executive Summary

Purpose

The overall objective of the audit was to review the processes in place for the assessment, approval, recording and monitoring of CHC and FNC to ensure that care is provided to the required standards with appropriate financial controls in operation.

Overview

We have issued reasonable assurance for this audit.

The matters requiring management attention include:

- Ensuring that the overdue review of Standard Operating Procedure CCP005 for CHC is undertaken as soon as possible.
- The number of CHC packages that are approved retrospectively.
- Improving the timeliness of patient reviews.
- Improving the frequency that updates on CHC are reported at Board level.
- Reviewing the reporting arrangements for the Quality Safety Experience Group for Complex Care.

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

Report Opinion

Reasonable

Some matters require management attention in control design or compliance.

Assurance summary[1]

	Objectives	Assurance
1	Approved Health Board Procedures	Reasonable
2	Eligibility assessments	Reasonable
3	Ongoing Monitoring	Limited
4	NCC Database Updated	Substantial
5	Invoices Received	Substantial
6	Reporting and Monitoring	Reasonable

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

Key Matters Arising

	Key Matters Arising	Objective	Control Design or Operation	Recommendation Priority
1	Standard Operating Procedure	1	Design	High
2	Eligibility Assessments	2	Operational	Medium
3	Monitoring of Packages	3	Operation	High
6	Reporting Arrangements	6	Design	Medium
7	QSEG Complex Care Group	6	Design	Medium

1. Introduction

1.1 Our review of Continuing Healthcare (CHC) and Funded Nursing Care (FNC) was completed in line with the 2023/24 Internal Audit Plan for Powys Teaching Health Board (the 'Health Board').

1.2 Continuing Healthcare (CHC) is a package of care that is arranged and funded solely by the NHS for individuals who have been assessed as having a primary health need. CHC can be received in any setting, including a patient's home where costs such as that of a community nurse or specialist therapist will be paid. In a care home, if the individual is eligible for CHC, the NHS will pay the care home fees.

1.3 The request to undertake an assessment of a patient to determine the eligibility for CHC funding may be made by the patient themselves, a family member, or a health care professional. The Health Board should have processes in place to assess and approve applications in line with 'Continuing NHS Healthcare: The National Framework for Implementation in Wales'. Once approved, all recipients of CHC are recorded in the All-Wales National Complex Care Database (NCCD) that is used for monitoring purposes and financial forecasting.

1.4 People receive Funded Nursing Care (FNC) if they live in a care home and are not eligible for CHC but have been assessed as requiring the services of a registered nurse. Each year, the health care needs of people receiving FNC are reviewed against specific criteria. If their needs have changed, they may be entitled to fully funded CHC if they have a primary health care need. People may move between criteria levels as their health needs change.

1.5 The potential risks considered during this audit were as follows:

- Non-compliance with the national framework guidance;
- Patients do not receive the level and standard of funded care that they are entitled to;
- The Health Board is unaware of key issues and risks in respect of CHC due to ineffective reporting arrangements; and
- Financial loss due to inability to adequately forecast CHC and FNC costs.

1.6 The Executive lead for this review is the Interim Executive Director of Operations/Director of Community and Mental Health.

2. Detailed Audit Findings

Objective 1: There are approved Health Board procedures in place for CHC/FNC that align to the revised National Framework.

2.1 The Health Board has two standard operating procedures (SOP's) in place that detail the processes for managing Continuing Healthcare (CHC) packages:

- PHB/CCP005 Continuing NHS Healthcare Standard Operating Procedure which is specifically concerned with the processes to be followed when the health

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needs of a patient indicates that there may be a need for a CHC Package. The procedure sets out the processes that the Health Board has put in place to ensure compliance with the Welsh Government's National Framework for Continuing Healthcare; and

- PHB/CCP008 NHS Continuing Health Care Local Organisational Dispute Procedure which sets out the processes to be followed where there are disputes between the Health Board and the Local Authority regarding a CHC package.

2.2 Both procedures are available to all staff and can be accessed on the Health Board's Policies and Procedures page on the intranet.

2.3 CCP008 is a new SOP and was approved by the Health Board in August 2023.

2.4 With regards to CCP005 the SOP is overdue for review and needs to be updated to reflect the change in Executive responsibility. **(Matter Arising 1)**

Conclusion:

2.5 Whilst there are Standard Operating procedures in place, CCP005 is overdue for review and does not reflect current Executive responsibility. We have provided **Reasonable Assurance** for this objective.

Objective 2: Eligibility assessments for funding are undertaken in line with agreed process and approval is in line with the Health Board's Scheme of Delegation.

2.6 The process that Health Board employees are required to follow for the consideration for the eligibility of CHC funding is detailed in the SOP CCPO05 Continuing NHS Healthcare.

2.7 For the two 'specialties' that were reviewed as part of the audit we noted that weekly panels take place for the consideration of patients that may be eligible for continuing healthcare support. Membership of the panels includes senior staff from the complex care teams with admin support from team administrators.

2.8 The weekly panel meetings are made up of two main parts; the Scrutiny Panel which scrutinises each submission before approving eligibility for CHC support and the Resource Panel which approves the costs of the CHC package proposed.

2.9 As part of our fieldwork we observed at two panel meetings (Mental Health & LD and Adults General) to note processes / discussions in place for the scrutinisation and where appropriate the approval of CHC packages. Our observations were as follows:

- All requests were supported by a completed Decision Support Tool (DST). Each request was presented by the assigned complex care lead;
- All requests were subject to the appropriate scrutiny by panel members before being submitted to the resource panel;
- For a number of requests there was insufficient information recorded within the DST which resulted in the complex care lead being asked to provide additional

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information and update the DST accordingly. The Updated DST to then be submitted to the next panel meeting for consideration; and

- For those requests approved by the scrutiny panel the actual costs of the packages were then formally approved by the resource panel.

2.10 All decisions made at the weekly panel are then recorded on the NCC database, this will include any requests that were deemed ineligible. Such cases would be recorded as 'not ratified' on the database.

2.11 We undertook testing on a sample of 20 CHC packages that had been approved in 2023/24 to ensure compliance with the guidance in place. The following observations were noted:

- 11 of the 20 packages of care were submitted retrospectively for approval, with a delay ranging from one month to almost a year from the commencement of providing care; **(Matter Arising 2)**
- For nine of the sample we note that the care package was implemented within eight weeks of the care package being approved by the panel; and
- All of the sample had been subject to scrutiny and then formal approval by the respective panels.

Conclusion:

2.12 Whilst there is a robust process in place for the scrutiny and approval of CHC packages our testing identified an issue with the timeliness of some of the requests being submitted to panel. We have allocated **Reasonable Assurance** for this objective.

Objective 3: Individual needs assessments and ongoing monitoring is undertaken on a regular basis in line with the National Framework.

2.13 The requirements for the ongoing reviewing and monitoring of approved CHC packages are detailed in the Health Board's CCP005 Continuing NHS Healthcare SOP. Patients should receive an initial review three months after the package of care commenced and thereafter annually unless at the review the patient's health indicates the need for more frequent reviews.

2.14 Updates on patients' reviews undertaken will be reported at the weekly panel meetings and from our observations of the panels that took place (see paragraph 2.9) we can confirm that updates on patient reviews are reported and discussed.

2.15 With regards to patient reviews at the panel meetings we observed, we were able to note good practice in that Complex Care Leads would agree to undertake reviews on behalf of another lead whilst visiting a care provider in order to effectively utilise time spent there. In some cases, this would result in reviews being undertaken early.

2.16 We undertook testing on a sample of 20 care packages that were approved and commenced in 2022/23 to ensure that all patients had received reviews in accordance with guidance.

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2.17 We noted that no reviews had been undertaken at all for three of the sampled packages, and for a further eight there were delays in undertaking the initial review, ranging from one month to almost a year from the date the package commenced. **(Matter Arising 3)**

Conclusion:

2.18 Whilst the service is aware of the requirements for undertaking reviews on patients with CHC packages our testing identified that there were significant delays in the undertaking some of the reviews. We have allocated **Limited Assurance** for this objective.

Objective 4: The National Complex Care Database and local records are accurately maintained and updated in a timely manner.

2.19 From the testing that has been undertaken for objectives 2,3 and 5 we have been able to confirm that the NCC database records a wealth of information for patients that have been awarded packages of care including and not limited to:

- Details of agreed package of care for patient noting the agreed original weekly cost and care provider;
- Dates package of care reviewed by the Scrutiny and Resource Panels;
- Details of agreed inflationary uplifts and revised weekly cost;
- Details of invoices that have been paid; and
- Details of reviews that have taken place and scheduled.

2.20 The database is updated by the Complex Care Teams on a weekly basis to reflect review updates and decisions made at the weekly panels.

Conclusion:

2.21 Our testing found that the database is accurately maintained and updated on a regular basis. We have allocated **Substantial Assurance** for this objective.

Objective 5: Invoices received are reconciled to agreed care packages. Inflationary cost increases are managed and agreed.

2.22 Annual inflationary uplifts are set by the Finance Department based on Welsh Government guidance and are approved by the Health Board's Executive Committee before advising the complex care teams.

2.23 Any care increase requests by care providers received by the complex care teams that exceed the agreed percentage uplift will be referred to the Finance Department for formal approval before being applied.

2.24 We undertook testing on a sample of ten continuing healthcare packages to ensure that any uplifts applied were in line with agreed rate set by Finance and the following was noted:

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- For six of the sample the agreed rate was applied;

- Two of the sample were FNC packages and uplift was determined by Welsh Government;
- For one of the sample the patient was deceased; and
- For one of the sample the uplift applied exceeded the rate agreed by Finance. However, the package in place was a joint package with the Local Authority who was the lead. This in turn meant that the Authority was responsible for agreeing the annual uplift to be applied with the Health Board having to accept what was agreed.

2.25 Whilst undertaking our testing we noted that there were different practices between the two teams within the administration processes for approving and recording inflationary uplifts:

- Whilst the mental health team submit the recommended annual inflation uplift to the resource panel for approval the adults general complex team do not; and
- When updating the NCC database for uplifts the mental health complex care team note the uplift percentage and the revised weekly cost within the package details for each patient whilst the adults general complex care team will commence a 'new' package of care. **(Matter Arising 4)**

2.26 When complex care teams receive invoices for CHC packages they will review details and amounts charged to what was agreed as per the database. If there are no queries, they will be forwarded to the Assistant Director of Complex Care for sign off before being forwarded to the Finance Department for processing against the relevant purchase order. If there are any queries then the care provider will be contacted for further information. The invoice will not be processed until the query is resolved.

2.27 With regards to invoices received for patients receiving FNC the payment of invoices are overseen by the Finance Department who liaise with the Local Authority. The Local Authority has primary responsibility for paying the care providers and will then seek reimbursement from the Health Board.

2.28 Testing was also undertaken on a sample of 15 packages of care to ensure that invoices received and paid were in accordance with the agreed value of the care package. The results of our testing were as follows:

- Two of the sample had only recently been approved and at the time of our fieldwork so no invoices had been received;
- Two of our sample were FNC packages with the complex care teams having no involvement in the payment of the invoices; and
- For the remaining 11 packages we were able to confirm that a sample of invoices received and paid matched the agreed package of care value.

2.29 As part of our testing, we did identify some minor issues regarding purchase orders raised in respect of CHC packages. **(Matter Arising 5)**

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Conclusion:

2.30 We found that the processes in place for the payment and management of inflationary increases were robust and effective although some minor

enhancements were identified. We have allocated **Substantial Assurance** for this objective.

Objective 6: Periodic reports on CHC/FNC are produced and submitted to appropriate Health Board forums for monitoring purposes.

2.31 Regular updates on Continuing Healthcare financial costs are reported as part of the monthly finance report. A copy of the latest report is submitted to each meeting of the Health Board's Board and Delivery & Performance Committee.

2.32 In accordance with the workplan for the Delivery & Performance Committee updates regarding Continuing Healthcare were submitted to the August 2023 and February 2024 meetings. A review of the reports submitted noted that the reports included information on activity, financial costs and issues facing the service.

2.33 A review of the Health Board's Integrated Performance Report that is submitted to the Delivery & Performance Committee as well as Health Board meetings identified that currently no information regarding continuing healthcare activity is included. **(Matter Arising 6)**

2.34 We note that there is a Quality, Safety & Experience Group for Complex Care (QSEG) in place which meets bi-monthly where operational issues are reported and discussed. The meeting also receives reports for each CHC specialty that provides updates on numbers of patients, issues with care providers, number of overdue reviews and pressures that the teams are experiencing.

2.35 There are terms of reference in place for the QSEG which notes that the group is advisory only with decisions being referred to the Patient Experience, Quality & Safety Committee (PEQS).

2.36 Our review of meetings of the PEQS committee meetings that have taken place this year found that no requests for decisions had been referred by QESG. We also noted that the Integrated Quality Report does not include any information relating to continuing healthcare. Consideration should be given to formalising QESG thereby ensuring that regular updates are provided to each meeting of the PEQS committee. **(Matters Arising 5 & 6)**

Conclusion:

2.37 Whilst financial information concerning CHC costs are regularly reported at Health Board and activity is reported to the Delivery & Performance Committee, there is currently an absence of regular reporting of quality & safety related CHC information at the Health Board level. We have allocated **Reasonable Assurance** for this objective.

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Appendix A: Management Action Plan

Matter Arising 1: Standard Operating Procedure (Design)			**Impact**
Our review of CCP005 Continuing NHS Healthcare Standard Operating Procedure (SOP) noted that it is overdue for review. The current version of the SOP was approved in April 2015, and it is acknowledged that planned future reviews did not take place due to the delay in the publishing of the Welsh Government's National Framework for Continuing NHS Healthcare. However, we note that the updated Framework has since been published in July 2021 with an implementation date of April 2022. We have reviewed the current version of the SOP and would recommend that the following be considered when undertaking the review: • In light of recent changes to the portfolios for the Health Board's Executive Directors update the 'owner' of the SOP; • NHS Wales Health & Care Standards are no longer applicable; • Are the financial values and named authorisers noted in the SOP still current? and • Are the Roles and Responsibilities for key individuals still applicable?			Non-compliance with the national framework guidance.
Recommendations			**Priority**
1	Management should ensure that the current version of the SOP is reviewed and updated as soon as possible to ensure that it complies with current governance arrangements within the Health Board and the National Framework.		**High**
Agreed Management Action		**Target Date**	**Responsible Officer**
1	The SOP was reviewed in 2021 and we are not clear why this version was not available for this Audit. However, we acknowledge the need for a document revision in line with the refreshed Framework and to reflect Executive changes.	31.08.2024	Ruth Derrick

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Matter Arising 2: Retrospective Submission of Care Packages (Operation)	**Impact**
We undertook testing on a sample of 20 continuing healthcare packages approved in 2023/24 to ensure compliance with guidance in place regarding the submission, consideration and approval of care packages. We noted that all packages had undergone appropriate scrutiny prior to the care packages being approved by the relevant resource panels. Our testing however did note that 11 of 20 care packages had been retrospectively submitted after the provision of care had commenced. For one of the 11 the package was submitted almost a year after the care provision commenced. The delay for the remainder of the sample ranged from 1 month to 7 months. We do acknowledge that some of the packages related to patients who were subject to a D2A (Discharge to Assessment) discharge from a secondary care setting. We also note that one of the sample concerned a patient that had been placed in a care setting within Powys from another Health Body.	Financial loss due to inability to adequately forecast CHC and FNC costs.

Recommendations		**Priority**
2	Management should consider reviewing the circumstances for the submission of retrospective care packages in order to identify areas where improvements in communication could be made so that the Complex Care Teams are made aware of the patients sooner. This would reduce delay in submitting the packages for approval and also improve information for financial purposes.	**Medium**

Agreed Management Action		**Target Date**	**Responsible Officer**
2	It is recognised that the audit has highlighted the quality of compliance with our own administrative processes. The teams do struggle with capacity to meet the diverse demands generally, however, continuously strive to liaise with other teams for information. The aim is to consistently improve communication systems but there are limitations to what can be done within the current resources. Practice changes have taken place, and it is recognised that there is	30.06.2024	Rhian Price Evans/Jacqui John

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	an interdependence between teams, although the impact falls on the performance of the Complex Care teams who cannot control the speed at which information is presented from external sources. With a small amount of additional resource to add to current practice changes, improvement in the speed of processes will occur. Both teams are mindful of patient need and *out of panel decisions* are made where this is necessary for timely implementation of patient care.		

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Matter Arising 3: Ongoing Monitoring of Packages (Operation)	**Impact**
Testing was undertaken on the monitoring arrangements for a sample of 20 care packages that had been approved during the 2022/23 financial year. Guidance states that all patients should undergo an initial review 3 months after the care package commences and thereafter annually unless it is indicated that more frequent reviews are required. Of the sample of 20 selected one care package which was for FNC was not applicable as the patient was discharged from the care home before the reviews were due. The results of our testing are as follows: • Three of the remaining sample of 19 had not had any initial or annual reviews undertaken. (Adults General) <u>Initial (3 Month) Reviews</u> • Eight of the sample had received an initial review within the required timescales. (5 Mental Health, 3 Adults General) • For the remaining 8 whilst initial reviews had been undertaken there were delays ranging from a month to almost a year after the care package commenced. (5 Mental Health, 3 Adults General) <u>Annual Reviews</u> • For three of our sample the initial review indicated more frequent reviews and audit noted that these had taken place and been recorded on the database. (Mental Health 2, Adults General 1) • For one of the sample the patient ‘passed away’ before the annual review date. (Adults General) • For one of the sample the annual review was undertaken within required timescale. (Mental Health) • For one of the sample the annual review was overdue. (Adults General) • For ten of the sample the annual reviews were scheduled for later in 2024. (Mental Health 7, Adults General 3)	Patients do not receive the level and standard of funded care that they are entitled to.

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Recommendations			Priority
3	Management should ensure that all care packages are undertaken within the required timescales. Where delays occur management should ascertain the reasons for the delay and take appropriate action to remedy the matter.		**High**
Agreed Management Action		**Target Date**	**Responsible Officer**
3	Capacity in the teams has been reviewed and will be addressed in a business case presented to the Investments and Benefits Group for consideration of some additional resources and a Committee report scheduled for August 2024.	31.07.2024	Ruth Derrick

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Matter Arising 4: Inflationary Uplifts (Design)	**Impact**
When undertaking testing on the processes in place for the approval of inflationary uplifts to existing continuing healthcare packages we identified differences between the Complex Care Team (MH & LD) and Complex Care Team (Adults General) processes for formally approving the uplifts, and also updating the information recorded on the NCC database. The details of the differences are noted as follows: • Whilst the annual uplifts information issued by the Finance Department are formally approved at the Mental Health Resource Panel there is no formal approval by the Adults General Resource Panel. • Once the uplift is applied to a package of care the administrator within the Mental Health Complex Care Team will update the information within the 'Package History' section within the database whereas the Adults General will 'create' a new package of care for the patient.	Non standardised processes in place

Recommendations		**Priority**
4	Management should review the processes in place within both teams for the approval and application of annual inflationary increases in order to standardise the processes to be followed. Management may wish to consider producing a local 'desktop' procedure that sets out actions/processes to be followed for updating the NCC database.	**Low**

Agreed Management Action		**Target Date**	**Responsible Officer**
4	Focussed work on annual uplifts has commenced with finance colleagues and there is a shared objective to improve the health board approach around this. We will give full consideration to improvements and timely updates on the NCCD database as part of the service review.	31.12.2024	Ruth Derrick/Rhian Price Evans/Jacqui John/Finance Team

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Matter Arising 5: Purchase Orders (Operation)			**Impact**
When undertaking testing on the processing of invoices to ensure that the costs noted on the invoices matched the agreed costs of the packages of care, the following observations were noted on the information recorded on the related purchase orders: • Purchase Orders relating to Mental Health Patients did not always note the patient's initials but did note the period that the care package covered; • Purchase Orders relating to Adults General patients noted care provider name and patients ID but did not note the period that the care package covered; and • None of the orders reviewed noted the actual weekly cost of the care package for the patient.			Incomplete audit trail
Recommendations			**Priority**
5	Management should, review all information that is currently recorded on purchasing orders raised for continuing healthcare packages with a view to standardising the information to be detailed across the service.		**Low**
Agreed Management Action		**Target Date**	**Responsible Officer**
5	Work has commenced with finance colleagues around how improvements and consistency can be achieved.	31.08.2024	Rhian Price Evans/Jacqui John

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<table>
<tr><th colspan="3">Matter Arising 6: Reporting Arrangements (Design)</th><th>Impact</th></tr>
<tr><td colspan="3">Information regarding the financial position for continuing healthcare services is regularly reported as part of the monthly Finance Report submitted to the Health Board's Board and Delivery & Performance Committee meetings, and reports on CHC activity, financial costs and issues facing the service are periodically submitted to the Delivery and Performance Committee.
However, we note that currently no information regarding continuing healthcare activity or quality and safety issues is included in the following Health Board reports:
• Integrated Performance Report submitted to the Delivery & Performance Committee
• Integrated Quality Report submitted to Patient Experience Quality & Safety Committee.</td><td>The Health Board is unaware of issues relating to Continuing Healthcare</td></tr>
<tr><th colspan="3">Recommendations</th><th>Priority</th></tr>
<tr><td>6</td><td colspan="2">Management should ensure that key information regarding continuing healthcare activity and quality and safety issues are included in Health Board reports for submission to the appropriate Health Board Committees.</td><td>Medium</td></tr>
<tr><th colspan="2">Agreed Management Action</th><th>Target Date</th><th>Responsible Officer</th></tr>
<tr><td>6</td><td>There is a highlight report produced and shared monthly that illustrates CHC activity and more. This is being reviewed and revised with a meeting scheduled with the Performance team on 22.05.24 to see how they can support this work and create a more inclusive reporting system.</td><td>31.08.2024</td><td>Ruth Derrick</td></tr>
</table>

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Matter Arising 7: QSEG for Complex Care (Design)			**Impact**
We note that there is a Quality, Safety & Experience Group for Complex Care (QSEG) in place which meets bi-monthly and is attended by key staff associated with the management and delivery of continuing healthcare services. At the meeting highlight reports are submitted by specialty leads providing updates on the number of patients, overdue reviews and any issues the specialty is experiencing with care providers. There are terms of reference in place for the group which highlights that the group is an advisory one noting that no decisions can be made but should be deferred to the appropriate Service Group or PEQS Committee. As part of our audit, we reviewed a number of the meetings of the Health Board's PEQS Committee meetings to ascertain if any request regarding continuing healthcare had been submitted that required a decision to be made. Our review noted that no requests had been submitted by the QSEG for Complex Care to the Committee requiring a decision. It was also noted that no updates of the QSEG are provided to the Committee.			Without regular updates at an appropriate committee the Health Board may be unaware of any issues concerning continuing healthcare
Recommendations			**Priority**
7	Management should consider reviewing the reporting arrangements of the QSEG to allow for regular update reports from the group to be submitted to the Health Board's PEQS Committee.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
7	Reporting to PECS has been discussed at QSEG and it is agreed that there does need to be the reporting of quality themes/issues in place. The current committee structure is changing to implement an integrated reporting system where quality and performance can be included in a single report.	31.08.2024	Ruth Derrick/Marie Davies

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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
Final Internal Audit Report

June 2024

Powys Teaching Health Board

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Fieldwork completion:	5 June 2024
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Final report issued:	27 June 2024
Auditors:	Geoffrey Woolley, Principal Internal Auditor
Executive sign-off:	Claire Roche, Director of Nursing and Midwifery
Distribution:	Zoe Ashman, Assistant Director of Quality & Safety Lucie Cornish, Assistant Director Therapies and Health Science Victoria Deakins, Head of Therapies
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.

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Executive Summary

Purpose

The overall objective of the audit was to review the arrangements and processes in place within the Health Board for capturing and utilising patient experience.

Overview

We have issued reasonable assurance on this area, noting the following points:

- There are appropriate mechanisms and resources in place within the Therapies Directorate for the collation and analysis of patient experience.
- Patient experience is appropriately reported to the Patient Experience and Quality Committee and required improvements are being identified and action taken.

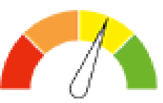
However, the matters requiring management attention include:

- The Health Board's patient experience strategy is dated 2016 - 2019 and so is overdue for formal review.
- Patient experience survey response rates within the Therapies Directorate are low, typically below 2% of patients treated, and have been implemented inconsistently.

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

Report Opinion

Reasonable



Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Assurance summary[1]

	Objectives	Assurance
1	Patient experience strategy in place	Reasonable
2	Appropriate mechanisms and resources in place	Reasonable
3	Feedback used to inform and drive improvement	Substantial
4	Patient experience is monitored and reported	Substantial

[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
1	Formal review of the patient experience strategy is overdue	1	Operation	Medium
2	Low patient experience survey response rates	2	Operation	Medium

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1. Introduction

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

1.2 Patients and carers have a right to experience respectful and professional care, in a considerate and supportive environment, where their privacy is protected, and dignity maintained. A high-quality experience should be fundamental, underpinned by appropriate standards, whatever and wherever the setting of care and treatment.

1.3 The Welsh Government Framework for Assuring Service User Experience was first introduced in 2013 and then updated in 2015. It describes the evidence based key determinants of a good service user experience and identifies the key attributes and uses of a range of feedback methods. The Framework was further updated in 2018 to reflect a set of eleven validated questions to be used in all NHS Wales organisations to obtain real time feedback.

1.4 The Health Board is implementing the CIVICA patient experience system to collect real time patient experience data through the use of patient experience surveys, the results of which can be viewed and downloaded through a number of reporting templates.

1.5 The audit included a focus on the processes for gathering patient experience within the Therapies Directorate.

1.6 The Director of Nursing and Midwifery was the Executive lead for this review.

Audit Risks

1.7 Patient feedback is not captured, reviewed or acted on, potentially resulting in:

- reputational damage due to negative patient experience; and
- harm to patients.

2. Detailed Audit Findings

Objective 1: The Health Board has a patient experience strategy in place detailing its commitment and approach to listening and learning from patient's experience.

2.1 The most recent patient experience strategy which the Health Board has produced is PEP 007 Powys Patient Experience Strategy 2016 - 2019 which, starting from the Welsh Government Framework for Assuring Service User Experience, is a comprehensive document which sets out appropriate guidance and details the Health Board's commitment and approach to listening and learning from patient's experience.

2.2 However, the Strategy is overdue for formal review, although we have been informed that any changes necessary would be unlikely to be significant. (Matter Arising 1)

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Conclusion:

2.3 The Health Board has a patient experience strategy in place which sets out appropriate guidance and details its commitment and approach to listening and learning from patient's experience. However, it is overdue for formal review. We have provided Reasonable Assurance for this objective.

Objective 2: Appropriate mechanisms and resources are in place for the collation and analysis of patient experience, with the identification of trends and themes and the triangulation to other types of data including complaints, concerns and incidents.

2.4 In addition to informal / ad hoc patient experience feedback received, the Health Board has in place the All Wales CIVICA system to set up patient experience surveys accessible via QR codes displayed on posters or postcards in patient areas and then monitor responses received.

2.5 However, our review of the Therapies Directorate highlighted that the results obtained have been low, typically below 2% of patients treated, although one service area has achieved 14%. Furthermore, not all service areas are using CIVICA, although some use alternatives such as Microsoft or paper forms. (Matter Arising 2)

2.6 The Directorate is aware that the low patient experience response rates need to be improved and is working with a range of teams, including the CIVICA team, to identify the best way to achieve this. (Matter Arising 2)

2.7 The patient experience feedback received is considered at the Community Services Group Heads of Service operational monthly meetings which have included reports on good news / patient experience from each Head of Service since July 2023.

2.8 These reports are captured by the Therapies Directorate's Service Improvement Manager and included in their patient experience reports and presentations to the quarterly Patient Experience Steering Group (PESG) which is chaired by the Executive Director of Nursing & Midwifery and attended by the service areas which provide patient care.

2.9 PESG has formal agenda, minutes and action tracker and has supporting papers and presentations embedded within its agenda and minutes. It has standing items which cover:

- Patient experience developments and learning from patient experience and concerns;
- Citizen Voice Body / Llais and PAVO updates; and
- Patient experience feedback reports and presentations from Community Services (including Therapies), Mental Health & Learning Disabilities, Women & Child Health, Primary Care and Dental.

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2.10 The patient experience reports follow the four quadrant requirements set out in the Health Board's strategy and the presentations summarise service successes,

areas for learning, areas for improvement and learning areas that would benefit other service areas.

Conclusion:

2.11 While mechanisms are in place for the collation and analysis of patient experience, survey response rates have been low and some mechanisms have been applied inconsistently. Therefore, further work is required to identify which mechanisms work most effectively and then roll them out consistently to other service areas. We have provided Reasonable Assurance for this objective.

Objective 3: Feedback is used to inform and drive improvement throughout the organisation, with evidence of action taken to address identified issues and share good practice.

2.12 The Health Board is aware of the benefit of using feedback to inform and drive improvement and seeks to achieve this as illustrated by the following two examples within the Therapies Directorate:

- Physiotherapy Musculoskeletal (MSK) Services.
  - Work has been done with Physiotherapy MSK Services reviewing Did Not Attend (DNA) appointments and seeking to reduce the proportion from the initial 16% to the 5% internal target.
  - Questionnaires were initially undertaken with patients to understand the reasons for the DNA appointments which led to the introduction of one way and then two way text reminders for the appointments and making it easier for patients to cancel and rebook appointments.
  - Furthermore, posters were introduced in the waiting area explaining to patients the impact of DNA appointments on the service.
  - Following this exercise, the DNA appointment level was reduced to around 6% or 7% which is only slightly higher than the 5% internal target.
  - Finally, a review and lessons learnt was presented to the Community Services Group Heads of Service Performance meeting in January 2024.
- Virtual Adult Speech and Language Therapy Service Delivery Audit August 2023.
  - Patient case studies were included as part of this review to assist the Head of Service to shape the service going forward.

2.13 Furthermore, a Therapies Directorate all staff learning group is being introduced in 2024/25 to share audit, complaints and patient experience, with the first meeting scheduled for 3 June 2024 to cover the first quarter's performance.

Conclusion:

2.14 The Health Board is aware of the benefit of using feedback to inform and drive improvement and seeks to achieve this. We have provided Substantial Assurance for this objective.

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Objective 4: Patient experience is monitored and reported to the Board (or appropriate sub-committee) to provide assurance that the key components of the service user experience are being assessed and that action is taken to deliver improvements.

2.15 Patient Experience updates are presented to the quarterly Patient Experience and Quality Committee as part of the Integrated Quality Report which is prepared by the Executive Director of Nursing & Midwifery who, as noted under objective 2, is Chair of the Patient Experience Steering Group (PESG).

2.16 Each of the updates during the year includes narrative information plus high level data and the more recent reports also include CIVICA monthly questionnaire results, graphical mind map word summaries plus examples of patient feedback received.

2.17 Furthermore, there is evidence that required improvements are being identified and action taken by the Health Board and there is appropriate scrutiny and challenge by the Committee.

Conclusion:

2.18 Patient experience is appropriately reported to the Patient Experience and Quality Committee by the Executive Director of Nursing & Midwifery, required improvements are being identified and action taken by the Health Board and there is appropriate scrutiny and challenge by the Committee. We have provided Substantial Assurance for this objective.

Appendix A: Management Action Plan

<table>
<tr><th colspan="3">Matter Arising 1: Formal review of the patient experience strategy is overdue (Operation)</th><th>Impact</th></tr>
<tr><td colspan="3">The most recent patient experience strategy which the Health Board has produced is PEP 007 'Powys Patient Experience Strategy 2016 – 2019' which, starting from the Welsh Government Framework for Assuring Service User Experience, is a comprehensive document which sets out appropriate guidance and details its commitment and approach to listening and learning from patient's experience.
However, it is overdue for formal review, and although we have been informed that any changes necessary would be unlikely to be significant, there would be some including:
• Consideration of the Duty of Candour legal requirement to be open and honest with service users receiving care and treatment which was introduced in the Health and Social Care (Quality and Engagement) (Wales) Act 2020;
• Listing the eleven validated questions used to obtain feedback as set out in the Welsh Government Framework; and
• Reference to the 2018 update of the Welsh Government Framework and the CIVICA system used by the Health Board.</td><td>Potential risk that all required matters may not be adequately covered.</td></tr>
<tr><th colspan="3">Recommendations</th><th>Priority</th></tr>
<tr><td>1.1</td><td colspan="2">The patient experience strategy should be formally reviewed to ensure that it adequately covers all required matters.</td><td>Medium</td></tr>
<tr><th colspan="2">Agreed Management Action</th><th>Target Date</th><th>Responsible Officer</th></tr>
<tr><td>1.1</td><td>Recommendation accepted.
Review PEP 007 'Powys Patient Experience Strategy 2016 – 2019' and consider updating in line with Welsh Government Framework and Quality & Engagement (Wales) Act 2020.</td><td>April 2025</td><td>Assistant Director Quality & Safety</td></tr>
</table>

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Matter Arising 2: Low patient experience survey response rates (Operation)	Impact
The Health Board has in place the All Wales CIVICA system to set up patient experience surveys accessible via QR codes displayed on posters or postcards in patient areas and then monitor responses received. However, within the Therapies Directorate the results obtained have been low, typically below 2% of patients treated, although one service area (Occupational Therapy – Hand Therapy) has achieved 14%. Furthermore, not all service areas are using CIVICA, as it is only used by: • Audiology – Wax Management; • Audiology – Adults; • Audiology – Paediatrics; • Occupational Therapy – Hand Therapy; • Occupational Therapy – Mental Health; • Radiography – Non Obstetrics Ultrasound; • Radiography – X-Ray; and • Speech and Language Therapy. Some service areas use alternatives such as Microsoft or paper forms which historically have achieved better response rates. The Directorate is aware that the low patient experience response rates need to be improved and is working with a range of teams, including the CIVICA team, to identify the best way to achieve this. For example, a tablet is being piloted in waiting areas at Brecon and Welshpool hospitals which will enable patients to easily provide feedback which will be rolled out to other service areas if successful.	Patient feedback is not captured, reviewed or acted on, potentially resulting in reputational damage due to negative patient experience and harm to patients.

Recommendations		Priority
2.1	Further work is required to identify how the low patient experience response rates can be improved and then roll out the lessons learnt to be applied consistently to all service areas.	**Medium**

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Agreed Management Action		Target Date	Responsible Officer
2.1	Recommendation accepted. Continue to ensure response rates to CIVICA surveys are considered within service meetings, Patient Experience Group along with Patient Experience Quality & Safety Committee. With a continuous focus of improvement to address variation in the way feedback is obtained recognising marginal groups and digital poverty. Sharing of learning from across services regarding increased response 'hot spots to ensure consistency across the organisation.	30 September 2024	Assistant Director 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:

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

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

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Reporting Committee	**Quality Patient Safety Committee (QPSC)**
Chaired by	**Carolyn Donoghue**
Lead Executive Director	**Director of Nursing & Quality**
Date of Meeting	**19 February 2024**

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

1.0 MENTAL HEALTH UPDATE (INCLUDING NEUROPSYCHIATRY PATIENT SOTRY)

Members received a comprehensive presentation and an update on developments within Mental Health. The presentation delivered by David Roberts (DR) provided updates on the following key areas;

- Mental Health Strategy
- Secure Services
- CAMHS
- Eating Disorders
- Mother & Baby Unit (MBU)
- Neuropsychiatry

The Interim Business Manager for the Wales Neuropsychiatry Service provided members with a presentation containing an outline of the Neuropsychiatry service in Wales and it was noted that the sustainability of the service was highlighted as a risk on the CRAF.

Members received an informative patient story about a gentleman who had sustained a serious brain injury at the age of 59 and how a technique called "Rich Pictures" was used to obtain his thoughts and feedback. Members noted the challenges that the patient faced at the outset and how the Neuropsychiatry service helped the patient and his family to obtain much needed support. The patient story highlighted the positive impact that the Neuropsychiatry services had made to the patient's quality of life.

2.0 WELSH KIDNEY NETWORK REPORT

Members received a report outlining the current Quality and Patient Safety issues within the services that are commissioned by the Welsh Kidney Network (WKN) across Wales. Some queries were raised on the new WKN risks which included Interventional Radiology and the Financial risk and growth within the Integrated Commissioning Plan (ICP).

In terms of interventional radiology, it was noted that this was not a WHSSC commissioned service, but it has an impact on renal service provision as there is

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a need to often access urgent treatments for patients following complications from kidney biopsies, urgent and elective vascular access procedures. Members were assured that all Chief Executives were currently aware of the issues and significant work was underway to address the sustainability of the service. Members of the committee asked for this to be highlighted to the JC.

3.0 COMMISSIONING TEAM AND NETWORK UPDATES

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

3.1 Cancer & Blood

Members received an update of the quality issues for services relating to the Cancer and Blood Commissioning Team Portfolio.

- The All-Wales Lymphoma Panel (AWLP) service was removed from the WHSSC escalation process in November 2023 due to implementation of the agreed action plan and an improvement in immunohistochemistry turnaround times.
- The Burns service has been de-escalated from Level 3 to Level 2 due to the capital case having been approved by Welsh Government. It is anticipated that the interim staffing arrangements can be sustained until the new build is complete.
- Plastic Surgery outreach in BCUHB remains in Welsh Government escalation/special measures framework and the next escalation meeting is due to take place in March 2024. WHSSC is contributing to the Welsh Government escalation arrangements and continue to attend the Task and Finish Group as an advisor. There has been some progress on some of the Commissioning and operational arrangements.
- South Wales Plastic Surgery - It was noted that Plastic Surgery waiting times continued to breach the Ministerial measures waiting times for treatment at Swansea Bay UHB but there has been some improvement. The service will remain in escalation level 2 to ensure this continued improvement. The Health Board shared the plastic surgery delivery plan and trajectory at the escalation meeting in October 2023.
- An update on the BCUHB plastics surgery and the harms review was provided. The interim report found no evidence of patient harm but once completed, the report will the shared with WHSSC QPSC after it has been through BCUHB QPSC. Members requested that this be highlighted to the JC.

3.2 Cardiac

Members received an update of the quality issues for services relating to the Cardiac Commissioning Team Portfolio and noted that two new risks for the portfolio had been added to the Risk Register since the last report.

- The first risk relates to waiting times for patients from BCUHB and North Powys awaiting obesity surgery procedures in Salford Royal Hospital. The waiting times were unlikely to reduce in the short to medium term. Since writing the report, a pathway has been agreed and the pathway is open for patients to travel to south Wales to access treatment at the Welsh Institute of Metabolic and Obesity Surgery (WIMOS).

- The second risk relates to a cyber-security attack on the Trauma Audit Research Network Database (TARN) which resulted in the database being taken offline. A sustainable long-term solution for this data collection which will support the ability of the Network to benchmark performance is delayed. TARN has issued a standardised spreadsheet for interim data collection, but this will not be sufficient to undertake national benchmarking and WHSSC will be unable to monitor performance against the business case. A letter has been written to NHS England and this has been escalated and a response is awaited. There is also clinical concern as the data is also used for clinical audit.

- Both cardiac services remain in escalation level 2. In terms of CVUHB the planned repatriation of cardiothoracic surgery to UHW has been delayed until April 2024. An escalation focused review meeting with the Health Board was convened on in January 2024, at which progress against those outstanding escalation actions was noted with a follow up meeting arranged for March 2024.

- Swansea Bay Cardiac Surgery Service continues to make progress against its planned escalation actions as assessed by means of its performance dashboard. A report providing an update on the status of the remaining actions was delayed as a result of the HB reconvening its Gold Command meetings and the need for the report to be subject to internal governance and oversight. NJ provided members with assurance that the Gold command meetings were not as a result of cardiac surgery – the Gold command was instigated in response to very high levels of emergency pressures across the Health Board during December 2023 and January 2024.

3.3 Neurosciences

Members noted one new risk and one increased risk relating to neurosurgery waiting times in both south Wales and north Wales. Both are being managed through the Performance Management Framework and were being closely monitored.

Concerns with the Deep Brain Stimulation (DBS) service in Bristol were highlighted. Concerns had been raised around communication with referring clinicians and patients but there had been no engagement and no improvement despite repeated efforts. As a result, expressions of interest were requested for a new provider to support the south Wales gatekeeper.

The ALAC service review around Micro Processor Knee (MPK) was also highlighted, and it was noted that this will be fed into Individual Patient Funding Requests (IPFR) as part of the outcomes work.

3.4 Women & Children

Members received an update on the quality issues for services relating to the Women & Children Commissioning Team Portfolio. The risks largely mirror the services in escalation, and it was acknowledged that the volume of risks and escalation issues within the portfolio are concerning and make this a complex and challenging area.

Members were informed that the Paediatric Cardiac Surgery service in University Hospital Bristol had shown improved performance against waiting times. There had been a notable decrease in the number of children breaching their recommended treatment date and the length of time patients were waiting beyond their recommended treatment date had also decreased. The risk was reduced, and the service de-escalated to Level 2 in January 2024.

There remain three services in escalation Level 3 and one in escalation Level 4. Three of the services (Paediatric Surgery, PICU and Neonatal Intensive Care) are at Level 3 and are provided by Cardiff and Vale University Health Board. The escalation continues to be managed as a 'Triple Escalation'. Due to the complexity of managing all three escalations together there are two Executive Leads from the Health Board and two Executive Leads from WHSSC involved.

Neonatal Care

Members were informed that an escalation meeting took place this morning and WHSSC will consider the next steps following this meeting.

Paediatric Surgery

Members received an update following the Joint Committee workshop that was held in November 2023 in which Paediatric Surgery was discussed. Members were informed that a commitment was made by the HB to deliver against a target of zero paediatric patients waiting over 52 weeks by the end of March 2024. This was to be delivered to through a hybrid model of additional lists within the Health Board and continued outsourcing to Nuffield. There is evidence of improvement and there is a high confidence rating that the service will deliver. Joint Committee also agreed with a recommendation in the ICP 2024/25 that the 52 week is maintained now that the backlog is reduced.

Paediatric Intensive Care

Financial support has been provided to the HB to support winter pressures by increasing the workforce to support the unit. Despite previous assurance received from the Health Board regarding pressure area concerns WHSSC has been notified that a Joint Review of Child Protection Arrangements (JIGPA) that was undertaken in December 2023 has highlighted concerns which need to be

readdressed. A letter has been received from the CVUHB Director of Nursing on the 9th February outlining the request for the Acute Child Health Directorate to undertake a retrospective audit of the care of thirty children in PICU since September. The results of this audit will be shared with WHSSC on completion and brought back to the QPS committee. Assurance has also been given that the CVUHB Executive Team are sighted on the concerns and work needed to review the cases.

The Committee were informed that since writing the report a letter had been received from the DoN in CVUHB and this provided detail of the actions that they were taking. It was agreed to highlight these continued concerns to JC in the QPSC Chairs Report and await an update on the further actions currently being undertaken.

Wales Fertility Institute
Despite the service remaining in escalation Level 4 there has been some recent progress with securing a new Person Responsible (PR). The HB have nominated a number of staff to sit the HFEA exams ; this will enable each site Neath and Cardiff to have their own PR, with staff ready to step up should they become unavailable to fulfil the statutory requirements of the role of PR. The PR had been a single point of failure and the intention to have more than one PR will help mitigate this risk in the future.

3.5 Mental Health
The Mental Health and Vulnerable Groups update was provided during the presentation.

3.6 Intestinal Failure (IF) – Home Parenteral Nutrition
Members received an update on 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 and since the report had been written a letter of assurance had been received outlining measures for the sustainability for the service going forward. They will be appointing a local consultant, and it is likely that on the basis of this letter of assurance the risks will be reduced at the next commissioning team meeting.

4.0 OTHER REPORTS RECEIVED

Members received reports on the following:

4.1 Services in Escalation Summary
Members noted the content of the report and the three Paediatric services in escalation Level 3 were noted and were discussed in detail above under the Women and Children's Report.

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

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

One new organisational risk was highlighted and this related to the formation of the new JCC and the business continuity risk associated with this. The mitigations required will be critical as we are close to the go live date for the new JCC and a lot of the detail was still unclear. Members requested for this to be highlighted as a matter of concern to the JC.

4.3 Care Quality Commission (CQC)/ Health Inspectorate Wales (HIW) Summary Update
A briefing on Healthcare Inspectorate Wales (HIW) and Care Quality Commission (CQC) reports published during the period July 2023 to January 2024 was presented to the committee.

4.4 Incident and Concerns Report
Members received a report outlining the incidents and concerns reported to WHSSC and the actions taken for assurance.

4.5 Service Improvement and Innovation
Members received a report providing an update on the Service Improvement and Innovation Days and similar externally organised events relating to specialised services.

Members noted the content of the report, the summary of activities, aims and key points of learning and sharing. The report demonstrated the positive work that had been achieved and undertaken by clinicians. Members also noted the comprehensive update following the WHSSC QPSC development day.

4.6 Duty of Quality
Members received a report providing the steps taken by the organisation to meet the requirements of the Duty of Quality Act and to consider the revised templates to support the reporting mechanisms in accordance with the Act. Members noted that the report and the template was developed following the work undertaken in the Development Day.

5.0 ITEMS FOR INFORMATION:
Members received a number of documents for information only:

- Chair's Report and Escalation Summary to Joint Committee November 2023,
- Oversight and Escalation Framework – NHS Wales Organisations; and
- QPSC Distribution List.

6.0 ANY OTHER BUSINESS

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There was no other business.

Key risks and issues/matters of concern and any mitigating actions
Key risks are highlighted in the narrative above and summarised below;
- The Interventional Radiology risk and impact on the renal service provision.
- The outstanding Harms review and BCUHB plastics.
- The pressure issues and Paediatric Intensive Care and general concerns with paediatric services CVUHB
- Approval of proposed templates to meet Duty of Quality Act
- The Business Continuity Risk on the CRAF

Members continued to express 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	TBC

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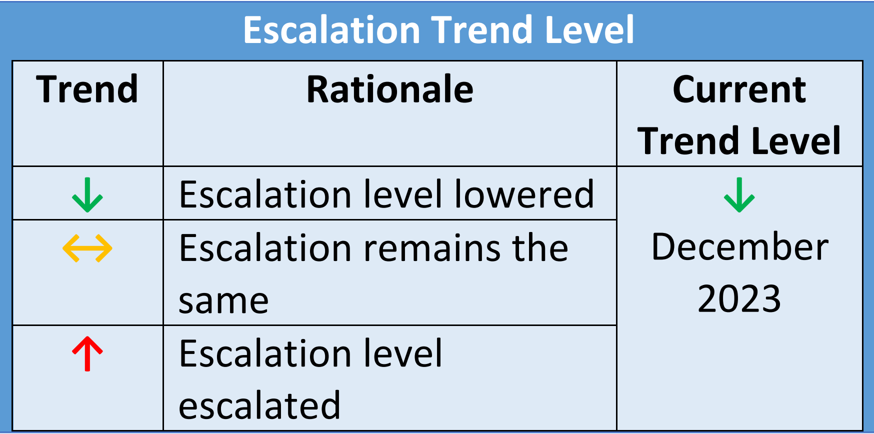
Executive Director Lead: Nicola Johnson
Commissioning Lead: Luke Archard
Commissioning Team: Cancer and Blood

Date of Escalation Meetings: 27/09/22, 01/12/2022, 03/03/2023, 03/05/2023
Date Last Reviewed by Quality & Patient Safety Committee: 23/10/23

Service in Escalation: Burns

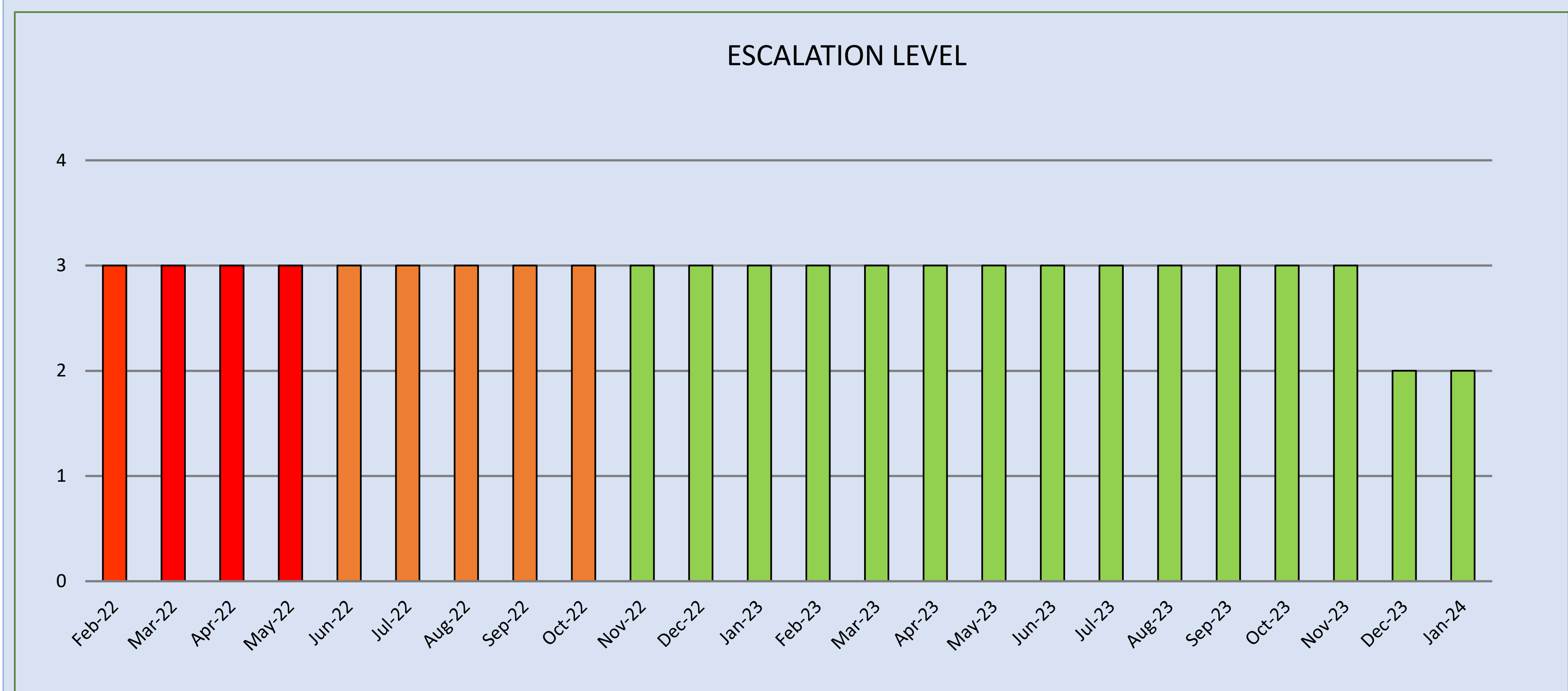
Current Escalation Level 2

Escalation Trend Level



Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↓ December 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**
December 2023 – WHSSC escalation	**2**

Rationale for Escalation Status :
De-escalated to 2.
The current timeline for completion of the capital works to enable relocation of burns ITU to general ITU at Morriston Hospital is Autumn 2024.

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

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	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 capital programme has commenced and is due to complete by October 2024. In view of this, the level of escalation has been reduced from level 3 to level 2. It is anticipated that the interim staffing arrangements can be sustained until the new build is complete. Level 2 escalation has been maintained in case issues or risks arise during the implementation of the capital development.	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.**

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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 & 19/12/23
Date Last Reviewed by Quality & Patient Safety Committee: 23/10/23

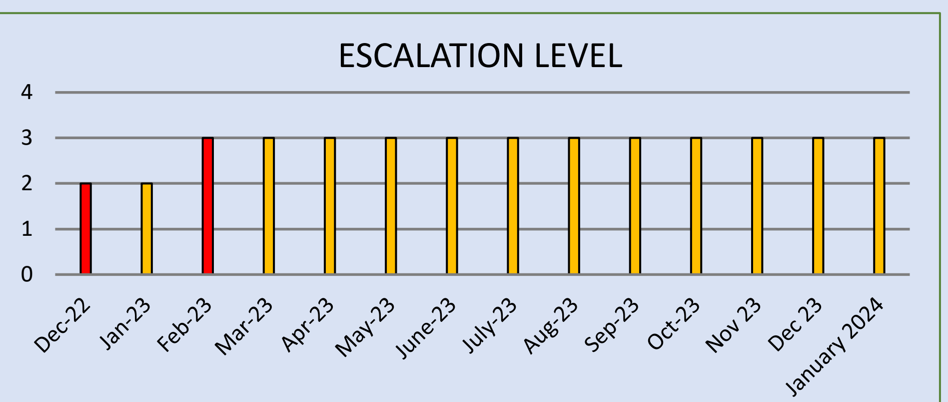
Service in Escalation: Paediatric Surgery

Current Escalation Level 3

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↔ January 2024
↔	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:

High – Action plan developed and positive progress made in designing a number of new pilot schemes and securing additional capacity, some delays in implementation. The service has committed to deliver a 52-week inpatient waiting list position by year end. The delivery of this is against a robust plan of increasing day case surgery and outsourcing 37 cases to Nuffield. Monitoring progress on a monthly basis and the >52 weeks position is improving as set out in the trajectories.

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	Completed 23/10/23
Triple escalation meetings established to monitor progress of all three services in escalation against overarching objectives.	DOP and DON	23 January 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.

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

Date of Escalation Meetings: 10/10/23 & 19/12/23
Date Last Reviewed by Quality & Patient Safety Committee: 23/10/23

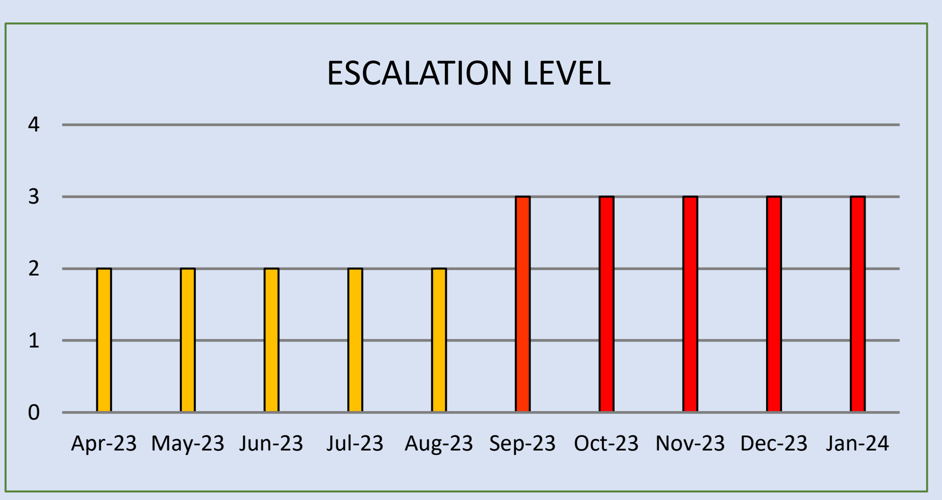
Service in Escalation: Paediatric Intensive Care

Current Escalation Level 3

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↔ January 2024
↔	Escalation remains the same	
↑	Escalation level escalated	

Escalation Trajectory:



Escalation History:

Date	Escalation Level
April 2023	**2**
September 2023 – Increased level from 2 to 3	**3**

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. WHSSC are still awaiting detailed demand and capacity in order to develop a sustainable contracting framework for Paediatric Intensive Care and High Dependency. Further work is required on the Pressure area concerns following a JIGPA review undertaken in December 2023.

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	23 January 2024	
Requested action plan to be developed against the escalation objectives.	Senior Planning Manager	31 October 2023	Completed 19/12/23
Requested sight of the Pressure Sore report presented to the HB Quality and Patients Safety Committee.	Director of Nursing	Ongoing	
Special Executive to Executive meeting scheduled with provider	Director of Planning	23 October 2023	Completed

Issues/Risks:

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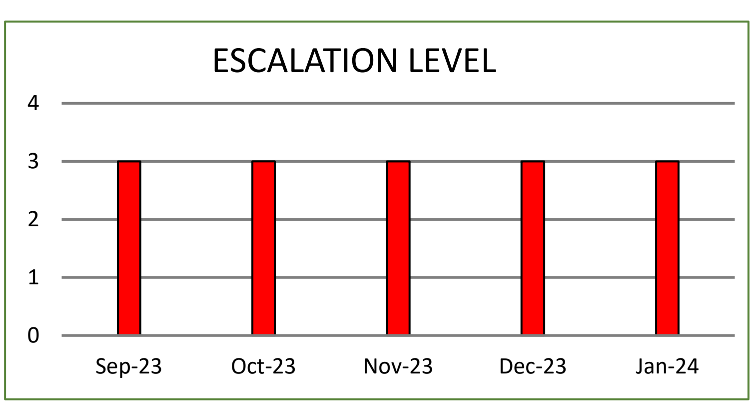
Executive Director Lead: Nicola Johnson **Commissioning Lead: Kimberley Meringolo** **Commissioning Team: Women and Children** **Date of Escalation Meetings: 10/10/23 & 19/12/23** **Date Last Reviewed by Quality & Patient Safety Committee: 23/10/23**	Service in Escalation: Neonatal Intensive Care Unit **Current Escalation Level 3**

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↔ January 2024
↔	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:

Low / Medium – First draft of an action plan has been received however further detail has been requested. The mitigations required to support safe staffing levels and improvements against infection rates requires a robust workforce plan which has a medium to long term lead time for completion.

Actions:

Action	WHSSC Lead	Action Due Date	Completion Date
Develop agreed objectives for escalation	Planning Manager	31 October 2023	Completed 19/12/23
Health Board to develop detailed action plan against the agreed objectives	Planning Manager	14 November 2023	Completed 19/12/23
Special Executive to Executive meeting scheduled with provider	Director of Planning	Date currently being agreed	

Issues/Risks:

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

Date of Escalation Meetings: 14/12/23
Date Last Reviewed by Quality & Patient Safety Committee: 23/10/2023

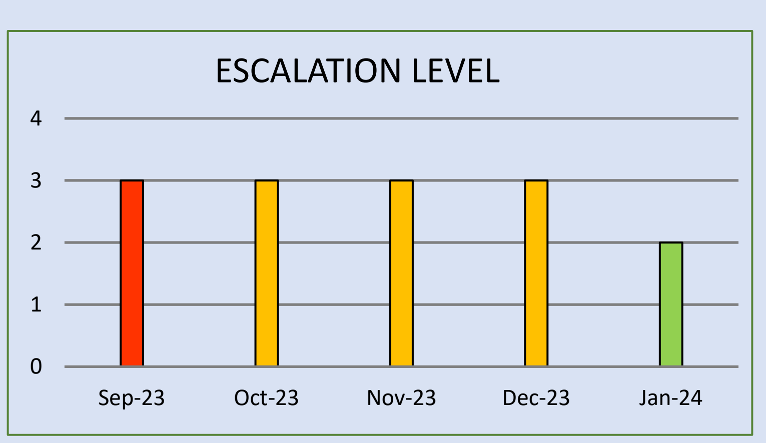
Service in Escalation: Paediatric Cardiac Surgery

Current Escalation Level 2

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↓ January 2024
↔	Escalation remains the same	
↑	Escalation level escalated	

Escalation Trajectory:



Escalation History:

Date	Escalation Level
September 2023	**3**
January 2024	**2**

Rationale for Escalation Status :

A number of waiting were breaching the recommended date for treatment as set by the Joint Cardiac Committee. The period of time people were breaching was far in excess

Background Information:

Paediatric Cardiac surgery was placed in escalation level 3 due to the number of patients waiting in for surgery and those breaching their target date by over 200 days. Formal escalation meetings were established in September 2023 with Executive leadership from both the Trust and WHSSC.

WHSSC assurance and confidence level in developments:

High – Service de-escalated to level 2, robust reporting mechanisms have been established and the waiting list position has improved. There are currently only two patients that are breaching their recommended surgery date.

Actions:

Action	WHSSC Lead	Action Due Date	Completion Date
Escalation meeting to discuss progress and trajectories	Director of Nursing & Quality	14 December 2023	Completed 14 December 2023

Issues/Risks:

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Executive Director Lead: Iolo Doull
Commissioning Lead: Dominique Gray-Williams
Commissioning Team: Women and Children
Date of Escalation Meetings: 07/08/23, 19/09/23, 10/10/23, 07/12/23
Date Last Reviewed by Quality & Patient Safety Committee: 23/10/23

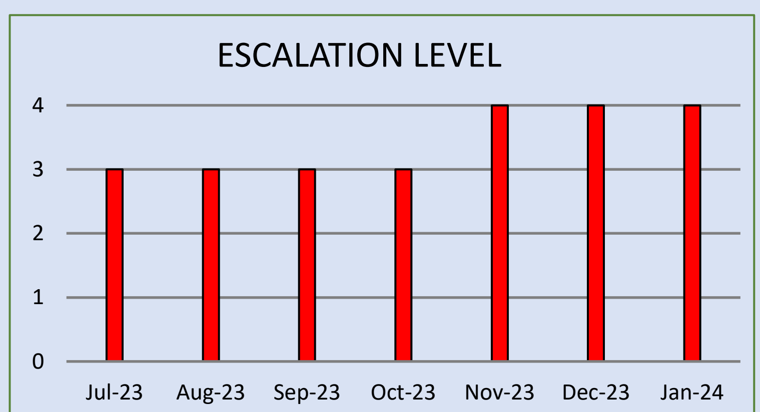
Service in Escalation: Wales Fertility Institute

Current Escalation Level 4

Escalation Trend Level

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

Escalation Trajectory:



Escalation History:

Date	Escalation Level
July 2023 – WHSSC escalation	**3**
November 2023 – WHSSC escalation	**4**

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 submitted an audit of notes to the HFEA at the end of December, they are awaiting feedback from this submission.
The service have identified a number of suitable staff members to prepare and take on the role of PR. The intention is for all staff to sit the exam, to ensure sustainability of the service with a PR over Cardiff and a PR over Neath Port Talbot. Neath Port Talbot are due to be inspected in March 2024 and Cardiff in January 2024.
A review of the HB escalation process has been undertaken and reconfigured to form a WFI sustainability group which feeds into the WFI Assurance, Recovery and Accountability Board.
The Directorate Manger and Associate Directorate managers have left and being replaced with a clinical manager.
The HB have agreed to undertake a comprehensive service review to include, performance, finance, complaints, incidents and risks. This review is due to be completed by the end of January and identify if any outsourcing is required.

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, 10th October 2023, 7th December 2023	Assistant Specialised Planner	Monthly	Ongoing
Quality visit, this has been temporarily paused due to increase in escalation level to escalation level 4	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	19/09/2023	19/09/2023
Regular Executive to executive meetings 16th November 2023, 21st November 2023, 1st December 2023, 7th December 2023, 21st December 2023	Executive lead SBUHB/ Medical Director WHSSC	16th November	Ongoing

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

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

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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.

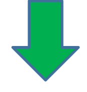
Level 1
- Enhanced Monitoring Pro-active response to put effective processes in place to drive improvement. Fact finding exercise. Potential for reporting via commissioning team and SLA meetings with provider.

Level 2
- Escalated Intervention Co-ordinated and/or unilateral action designed to strengthen the capacity and capability of the service Jointly agreed objectives and monitoring through performance framework. Frequency of meeting with provider at least quarterly. Reporting via commissioning team and SLA meetings with provider. Consideration of risk register and entry onto summary of services in escalation table.

Level 3
- Escalated Measures Current arrangements require significant improvement. Quality visit to provider with Exec involvement from both sides. Executive Lead to be identified. Initial monthly meetings as a minimum with jointly agreed objectives. Formal notification to provider re stage of escalation. Reporting through commissioning team and QPS Committee. Consideration of risk register and updated on summary of services in escalation table.

Level 4
- Decommissioning / Outsourcing Decision re continuation of service or decommissioning if unable to address action plan and ongoing concerns remain. Involvement of WHSSC Managing Director and Provider CNO Reporting mechanism to QPS decision at Joint Committee

SERVICES IN ESCALATION

 Level of escalation reducing / improving position

Level of escalation unchanged from previous report/month

Level of escalation increasing /

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Agenda item: 8.1

Patient Experience, Quality and Safety Committee	**30 July 2024**
Subject:	**Corporate Risk Register** (Relevant to the committee)
Approved and presented by:	Director of Corporate Governance / Board Secretary
Prepared by:	Corporate Governance Assurance and Risk Officer
Other Committees and meetings considered at:	Executive Committee – 17 July 2024 Board – 24 July 2024

PURPOSE:

The purpose of the Committee Risk Register is to draw together relevant risks for the Committee from the Corporate Risk Register (CRR), to provide a summary of the significant risks to delivery of the health board's strategic objectives.

RECOMMENDATION(S):

It is recommended that the Committee CONSIDER the July 2024 version of the Committee Risk Register, which reflects the risks identified as requiring oversight by this Committee. This copy of the Committee Risk Register is based upon the newly revised Corporate Risk Register (CRR) to be considered by the Board on 25 September 2024.

The Committee is asked to **consider** the corporate risks within the committee's remit, **discuss** any relevant issues and take **assurance** that risks are being managed in line with the Risk Management Framework.

Approve/Take Assurance	Discuss	Note
Y	Y	N

EXECUTIVE SUMMARY:

The Committee Risk Register draws together relevant risks for the Committee from the Corporate Risk Register (CRR), to provide a summary of the significant risks to delivery of the Health Board's strategic objectives.

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The Board received a revised Corporate Risk register at its meeting on the 24 May 2024, reflective of the current strategic risks for the organisation in light of the PTHB Integrated Plan 2024-29 and PTHB Annual Delivery Plan 2024/25.

BACKGROUND AND ASSESSMENT:

The CRR provides a summary of the significant risks to the delivery of the health board's strategic objectives. Corporate risks also include risks that are widespread beyond the local area/directorate, and risks for which the cost of control is significantly beyond the scope of the local budget holder. The CRR is reviewed by the Executive Committee on a bi-monthly basis and is noted by the Board.

The Committee is asked to **DISCUSS** the risks relating to Patient Experience, Quality and Safety Committee and the risk targets within the Committee Based Risk Register, and to **CONSIDER** whether the targets identified are achievable and realistic.

The full Committee Risk Register is attached at **Appendix A.**

NEXT STEPS:

The Committee will continue to seek assurance on the ongoing development and management of patient experience, quality and safety risks as set out above.

An updated version of the Corporate Risk Register is due to be presented to the Board on 25 September 2024.

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:		
1. Focus on Wellbeing	Y	The corporate risk register reflects the key strategic risks for the organisation and therefore underpins a number of wellbeing objectives.
2. Provide Early Help and Support	Y	
3. Tackle the Big Four	Y	
4. Enable Joined up Care	Y	
5. Develop Workforce Futures	N	
6. Promote Innovative Environments	Y	
7. Put Digital First	N	
8. Transforming in Partnership	N	

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IMPACT ASSESSMENT – NOT REQUIRED FOR THIS REPORT					
This section must be completed for all strategic organisational decisions including approval of health board policies.					
QUALITY:					
	No impact	Negative	Positive	Both	A Quality Impact Assessment must be undertaken for all reports requesting approval, ratification or decision in line with health board Duty of Quality processes (under development). In this space you should provide supporting narrative to explain the potential adverse and positive impacts that may arise from a decision being taken, and the steps being taken to mitigate adverse impacts. Where required, the full Quality Impact Assessment should be available as a supporting document to inform the decision making process.
Safe					
Timely					
Effective					
Efficient					
Equitable					
Person Centred					
Workforce					
Leadership					
Culture					
Information					
Learn, Improve, Research					
Whole Systems Approach					
EQUALITY:					
	No impact	Negative	Positive	Both	An Equality Impact Assessment must be undertaken for all reports requesting approval, ratification or decision in line with health board Equality Impact Assessment policies and procedures (CGP009). In this space you should provide supporting narrative to explain the potential adverse and positive impacts that may arise from a decision being taken, and the steps being taken to mitigate adverse impacts. Where required, the full Equality Impact Assessment should be available as a supporting document to inform the decision making process.
Age					
Disability					
Gender reassignment					
Marriage / civil partnership					
Pregnancy / maternity					
Race					
Religion or Belief					
Gender					
Sexual Orientation					
Welsh Language					
Socio-economic status					
Social exclusion					
Carers					
RISK ASSESSMENT:					
	Level of risk identified				A Risk Assessment should be undertaken for all reports requesting approval, ratification or decision in line with health board Risk Management Framework CGP005. In this space you should briefly describe the key risks and the steps being taken to manage them, and also how these risks relate to the Board's stated Risk Appetite.
	Very Low (0-3)	Low (4-8)	Moderate (9-12)	High (15-25)	
Clinical					
Financial					
Corporate					
Operational					
Reputational					

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Patient Experience, Quality and Safety Committee
(30 July 2024)
Committee Based Risk Register

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CORPORATE RISK HEAT MAP:

There is a risk that…

Impact							
	Catastrophic	**5**					
	Major	**4**				Increase in demand, inequality of access, complexity of patient needs, or failure to respond to demand pressures for PTHB provided services results in poorer outcomes and experience for the citizens of Powys.	Increase in demand, inequality of access, complexity of patient needs, or failure to respond to demand pressures for commissioned services results in poorer outcomes and experience for the citizens of Powys. Commissioned services may include urgent and emergency health and social care system.
	Moderate	**3**					
	Minor	**2**					
	Negligible	**1**					
			1	**2**	**3**	**4**	**5**
			Rare	**Unlikely**	**Possible**	**Likely**	**Almost Certain**
			Likelihood				

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CORPORATE RISK DASHBOARD

Risk Lead	Risk ID	Main Risk Category	Risk Description There is a risk that:	SCORE (Likelihood x Impact)	Board Risk Appetite	Risk Target	At Target ✓/✗	Lead Board Committee
D Ops / ED PP&C	CRR 004	Quality	Increase in demand, inequality of access, complexity of patient needs, or failure to respond to demand pressures for PTHB provided services results in poorer outcomes and experience for the citizens of Powys.	**4 x 4 = 16**	Cautious	12	x	Patient Experience, Quality and Safety Committee
ED PP&C	CRR 005	Quality	Increase in demand, inequality of access, complexity of patient needs, or failure to respond to demand pressures for commissioned services results in poorer outcomes and experience for the citizens of Powys. Commissioned services may include urgent and emergency health and social care system.	**5 x 4 = 20**	Cautious	12	x	Patient Experience, Quality and Safety Committee

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KEY

Risk Appetite Descriptors and Categories

Risk Appetite	Description
Averse	Avoidance of risk and uncertainty in achievement of key deliverables or initiatives is key objective. Activities undertaken will only be those considered to carry virtually no inherent risk.
Minimal	Preference for very safe business delivery options that have a low degree of inherent risk with the potential for benefit/return not a key driver. Activities will only be undertaken where they have a low degree of inherent risk.
Cautious	Preference for safe options that have low degree of inherent risk and only limited potential for benefit. Willing to tolerate a degree of risk in selecting which activities to undertake to achieve key deliverables or initiatives, where we have identified scope to achieve significant benefit and/or realise an opportunity. Activities undertaken may carry a high degree of inherent risk that is deemed controllable to a large extent.
Open	Willing to consider all options and choose one most likely to result in successful delivery while providing an acceptable level of benefit. Seek to achieve a balance between a high likelihood of successful delivery and a high degree of benefit and value for money. Activities themselves may potentially carry, or contribute to, a high degree of residual risk.
Eager	Eager to be innovative and to choose options based on maximising opportunities and potential higher benefit even if those activities carry a very high residual risk.

Executive Lead:	
CEO	Chief Executive
DFIT	Director of Finance, Information and IT
D Ops	Director of Operations/Director of Community and Mental Health
DoNM	Director of Nursing and Midwifery
MD	Medical Director
DPH	Director of Public Health
DWOD	Director of Workforce & Organisational Development
DoTHS	Director of Therapies & Health Sciences
DP&C	Director of Performance and Commissioning
ADoEP	Associate Director of Estates and Property
DCG	Director of Corporate Governance

Risk Scoring

LIKELIHOOD	IMPACT				
	Insignificant 1	Minor 2	Moderate 3	Major 4	Catastrophic 5
Almost Certain 5	5	10	15	20	25
Likely 4	4	8	12	16	20
Possible 3	3	6	9	12	15
Unlikely 2	2	4	6	8	10
Rare 1	1	2	3	4	5

Very Low	1-3	Low	4-8	Moderate	9-12	High	15-25

RISK APPETITE	
Category	**Appetite for Risk**
Safety	Averse
Quality	Minimal
Regulation and Compliance	Cautious
Reputation and Public Confidence	Cautious
Performance and Service Sustainability	Cautious
Financial Sustainability	Cautious
Workforce	Cautious
Partnerships	Open
Innovation and Strategic Change	Open

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CRR 004 **Risk that: Increase in demand, inequality of access, complexity of patient needs, or failure to respond to demand pressures for PTHB provided services results in poorer outcomes and experience for the citizens of Powys.**		**Executive Lead: Interim** Executive Director of Operations/Director of Community & Mental Health July 2024 – provided by Interim Executive Director Planning, Performance and Commissioning) **Assuring Committee:** Patient Experience, Quality & Safety Committee
Risk Impacts on: Organisational Priorities underpinning WBO 8		**Date last reviewed:** July 2024
Risk Category: Quality		**Boards Risk Appetite:** Cautious
Risk Rating (likelihood x impact): Inherent: 4 x 4 = 16 Current: 4 x 4 = 16 Target: 3 x 4 = 12 **Date added to the risk register** July 24 **Source of risk:** Executive Team	Graph will be provided at next report when there is more than one data point.	**Rationale for current score:** **Planned Care** NHS Wales • Whilst services generally perform well against access targets, the fragility of some of the in-reach SLAs creates inherent operational risk to delivery. **Inpatient Beds** • At present capacity is part staffed by continued reliance upon agency staff. This is not a sustainable or affordable model. • On any given day, up to 40% of our beds can be occupied by patients that are medically and clinically fit for discharge. They are delayed due to a lack of capacity in onward parts of the pathway. Elongated lengths of stay can have a detrimental impact on overall rehabilitation **Primary Care** • There are some recruitment challenges for staffing in primary care. • Dental access and capacity required does not currently meet demand. **Minor Injury Units** • Powys MIU's continue to performance well, in May (latest validated available) reported 100% compliance against 4 hour target and 0 patients waiting longer than 12 hours.

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<table>
<tr><td></td><td></td><td colspan="3"><u>Mental Health</u>
• Elements of the service are currently in internal performance and scrutiny escalation</td></tr>
<tr><th colspan="2">Controls (What are we currently doing about the risk?)</th><th>Sources of Assurance</th><th>Level of Assurance</th><th>Highest Assurance provided to:</th></tr>
<tr><td>7.1</td><td>For Planned Care Services - Regular review of demand pressures by looking at referral levels into services.
Reviewing all in-reach SLA with partner organisations to achieve a more sustainable offer.
Implement as many GIRFT and 5 Goals for Planned Care as appropriate for a community based provider</td><td>• Referral data into services from commissioning data sets and supplementary reports received from commissioned providers
• Best practice guidance from GIRFT and Welsh Government / NHS Exec</td><td></td><td>Section in development</td></tr>
<tr><td>7.2</td><td>For Urgent & Emergency Services – Regular review of demand pressure by reviewing attendance rates and emergency inpatient volumes</td><td>Attendance data into services from commissioning data sets and supplementary reports received from commissioned providers</td><td></td><td>Section in development</td></tr>
<tr><td>7.3</td><td>All services - using demand data to plan to provide the correct level of services provision for all services provided in county</td><td>Demand, activity and financial information from commissioning datasets used to inform contract plans</td><td></td><td>Section in development</td></tr>
<tr><td>7.4</td><td>Reviewing where services do not meet clinical and operational standards</td><td>Various data sources including operational & performance data.</td><td></td><td>Section in development</td></tr>
<tr><td>7.5</td><td>Constantly reviewing staffing level and the amount of agency staff being used. Additional control procedures in place to authorise the use of agency staff (particularly higher cost agency providers)</td><td>Various workforce and financial reports recording agency usage at ward and service level</td><td></td><td>Section in development</td></tr>
<tr><td>7.6</td><td>Improving the outcomes and experience data capture to inform future planning</td><td>Various data sources including operational & performance data. Qualitative information from PROMS & PREMS reporting, clinical audit, regulatory inspections</td><td></td><td>Section in development</td></tr>
<tr><th colspan="5">Mitigating Actions (What more will we do?)</th></tr>
<tr><th>Action</th><th>Lead</th><th>Action update</th><th>Deadline</th><th>Action on Target</th></tr>
</table>

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<u>Planned Care</u> ▪ Continue series of regular meetings with service leads ▪ Monitor and manage delivery against performance improvement trajectories for our own services. ▪ Medinet contract previously extended to offer Powys residents experiencing long waits in commissioned service providers in NHS Wales to be treated in Powys. Work being progressed to issue a tender for insourced provision in 2024/25. ▪ Ongoing scrutiny and oversight through CQPR meetings with escalation through Integrated Performance Report.	Executive Director of Operations/Director of Community & Mental Health	▪ Performance Trajectories being routinely monitored and managed.	July 2024 and ongoing	YES
<u>General Service Sustainability & Future Models of Care</u> The health board is currently reviewing models of care as part of its 5 year plan but also in response the staffing and financial challenges. A number of service reviews are being undertaken with several 'cases for change' being written for onward consideration by the Health Board and stakeholders. <u>All indicators</u> There are some performance indicators that continue to fail the operational standard eg Neuro-developmental target. The Health Board will develop a suite of indicator sub-sets to determine if any	Executive Director of Operations/Director of Community & Mental Health	• The first 2 cases for change will be considered by the Board on the 24th July • A number of sub-indicator performance targets have been identified. These will be built into the IQPR	July 2024 and ongoing August and ongoing	YES YES

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PEQS Committee
30 July 2024
Item 8.1 Appendix A

improvement is being made towards achievement of the overall target.				
Current Risk Rating		**Update including impact of actions to date on current risk score**		
4 x 4 = 16		• Will be provided at next report.		

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CRR 005 **Risk that:** Increase in demand, inequality of access, complexity of patient needs, or failure to respond to demand pressures for commissioned services results in poorer outcomes and experience for the citizens of Powys. Commissioned services may include urgent and emergency health and social care system.		**Executive Lead:** Interim Executive Director of Planning, Performance & Commissioning **Assuring Committee:** Patient Experience, Quality & Safety Committee
Risk Impacts on: Organisational Priorities underpinning WBO 8		**Date last reviewed:** July 2024
Risk Category: Quality		**Boards Risk Appetite:** Cautious
Risk Rating (likelihood x impact): Inherent: 5 x 4 = 20 Current: 5 x 4 = 20 Target: 3 x 4 = 12 **Date added to the risk register.** July 24 **Source of risk:** Executive Team	Graph will be provided at next report when there is more than one data point.	**Rationale for current score:** Planned Care NHS Wales • Powys residents in Welsh acute care providers have continued to see exceptionally long waits fall, however the waiting list as a total continues to grow. • Total waiting list position deteriorated from April to May 2024 for those waiting over 36 weeks and 52 weeks, improving for those patients waiting over 104 weeks (albeit still substantial number of patients). • Long wait pressure by treatment specialty remains within General Surgery, Trauma & Orthopaedics, ENT, and Ophthalmology. NHS England • Powys residents in English acute care providers have continued to see generally faster access for treatment. • Total waiting list position deteriorated from March 2024 for those waiting over 36 weeks, 52 weeks, and over 104 weeks. • English providers still report an improved position when compared to waiting pathways in Wales. • Long wait pressure by treatment specialty remains within General Surgery, Trauma & Orthopaedics, ENT, and Ophthalmology. Urgent and Emergency Care • Powys MIU's continue to performance well, in May (latest validated available) reported 100% compliance against 4-hour target and zero patients waiting longer than 12 hours.

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		• WAST red and amber response remains challenged. • Performance in commissioned providers UEC departments does not meet required targets (both in Wales and England).

Controls (What are we currently doing about the risk?)		Sources of Assurance	Level of Assurance	Highest Assurance provided to:
7.1	For Planned Care Services - Regular review of demand pressures by looking at referral levels into services	Referral data into services from commissioning data sets and supplementary reports received from commissioned providers		Section in development
7.2	For Urgent & Emergency Services – Regular review of demand pressure by reviewing attendance rates and emergency inpatient volumes	Attendance data into services from commissioning data sets and supplementary reports received from commissioned providers		Section in development
7.3	Using demand data to plan to commission the correct level of services provision for all services provided out of county	Demand, activity and financial information from commissioning datasets used to inform contract plans		Section in development
7.4	Reviewing where services do not meet clinical and operational standards	Various data sources including operational & performance data.		Section in development
7.5	Improving the outcomes and experience data capture to inform future planning	Various data sources including operational & performance data. Qualitative information from PROMS & PREMS reporting, clinical audit, regulatory inspections		Section in development

Mitigating Actions (What more will we do?)

Action	Lead	Action update	Deadline	Action on Target
Planned Care ▪ Continue series of regular meetings with commissioned service providers. ▪ Secure performance improvement trajectories from providers. ▪ Medinet contract previously extended to offer Powys residents experiencing long	Executive Director of Planning, Performance and Commissioning	▪ Performance Trajectories and details on harm reviews for Powys residents requested from commissioned service providers in NHS England and NHS Wales to understand expected performance 2024/25 and to be reviewed and discussed through CQPRMs.	July 2024 and ongoing	Yes

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waits in commissioned service providers in NHS Wales to be treated in Powys. Work being progressed to issue a tender for insourced provision in 2024/25. ▪ Ongoing scrutiny and oversight through CQPR meetings with escalation through Integrated Performance Report.				
<u>Urgent and Emergency Care</u> ▪ Continue series of regular meetings with WAST and commissioned service providers. ▪ Secure performance improvement trajectories and improvement plans from providers. <u>All indicators</u> There are some performance indicators that continue to fail the operational standard e.g. 4 Hour ED waits. The Health Board will develop a suite of indicator sub-sets to determine if any improvement is being made towards achievement of the overall target.		▪ Regular meetings (ICAP and Q&S) with Health Boards and WAST to cover performance, patient experience, incidents and resultant investigations, clinical indicators. ▪ Standing agenda item in CQPRMs to review improvement plans, patient experience, and patient harm. • A number of sub-indicator performance targets have been identified. These will be built into the IQPR	July 2024 and ongoing August and ongoing	Yes Yes

Current Risk Rating	**Update including impact of actions to date on current risk score**
5 x 4 = 20	Improved performance experienced within NHS England commissioned service providers; same level of improvement not being experienced in NHS Wales commissioned service providers creating inequity of access for Powys residents. All commissioned providers failing to deliver the majority of pre-pandemic extant operational standards for access.

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Patient Experience Quality and Safety Committee 2024-25

Theme	Item Title	April 16/04/2024	July 30/07/2024	September 05/09/2024	November 07/11/2024	February 11/02/2025
Governance	Minutes of previous meeting	✓	✓	✓	✓	✓
Governance	Declaration of Interests	✓	✓	✓	✓	✓
Governance	Action Log	✓	✓		✓	✓
Governance	Committee Risk Register	✓	✓		✓	✓
Governance	Annual Work Programme	✓				
Governance	Committee Work Programme (updated through year)		✓		✓	✓
Governance	Items to be brought to the attention of the Board and/or other Committees	✓	✓		✓	✓
Governance	Annual Assessment of Committee Effectiveness					✓
Governance	Committee Annual Report	✓				
Governance	Review of Terms of Reference					✓
Performance	Integrated Quality and Performance Report	✓	✓		✓	✓
	PSOW Annual Letter (within IQR)				✓	
Patient Experience	Patient Experience Framework				✓	
	Patient Stories	✓	✓		✓	✓
	Floor to Board quality				✓	
MH Compliance	MH Power of Discharge Annual Report including MH compliance with legislation		✓			✓
Clincial Audit	Annual Programme Clinical Audit	✓				
	Progress Report Clinical Audit				✓	
Audit Reports	Any Internal Audit/Wales Audit reports received - for information	✓	✓		✓	✓
Clinical Quality	Clinical Quality Framework		☒		✓	
Medicines Management	Annual Report of Accountable Officer for Controlled Drugs					✓
	Medicines Management Annual Report				✓	
Safeguarding	Safeguarding Annual Report		☒	✓		
	Children's Services					
Infection Prevention and Control	IPC Annual Assurance Report		✓			
	IPC progress/focus					✓
	Child Practice Review outcome (to April 2024)	✓				
	Monitor Health Board actions of Child Pratice Review				✓	
	Annual Report Medical Devices and Point of Care Testing				✓	
	Survey findings - Urgent Suspected Cancer Pathway Survey					
	Comms and Engagement Report for PEQS				✓	
Health and Safety	Health and Safety Quarterly Report (patient and quality focus)		☒		✓	✓
	Point of Care Testing (action from Jan 24)				✓	
	Mental Health Deep Dive part 2 (follow up from Jan 24)	✓				
	Duty of Quality Annual Report		☒	✓		
	Outcome of Joint Inspection of Child Protection Agencies	✓				✓
	Monitor Health Board actions of JIPCA					
	Care Inspectorate Wales Report Cottage View Knighton (after I	✓				
	Maternity Services assurance report					
Escalated Items:						
	Joint meeting with Workforce and Culture (October)					
	Learning Organisation/Group					
	Primary Care - quality perspective (Exec lead tbc)					
	Corporate Parenting Charter					✓
Date to be confirmed						
Item deferred						
Item brought forward						
Going to Board						
Due to Committee						
Find Exec Cttee date						
Added to draft agenda						
Date/Item to be confirmed						

Agenda item: 8.3

Patient Experience, Quality and Safety Committee	Date of Meeting: 30 July 2024
Subject:	**Review of Escalated Items to the Board**
Approved and Presented by:	Director of Corporate Governance / Board Secretary
Prepared by:	Director of Corporate Governance
Other Committees and meetings considered at:	Board – 24 July 2024

PURPOSE:

At each meeting, the Committee determines if there are any items to bring to the Board attention. The Board then receives a report from all Committees at each Board meeting summarising the activities of each Committee and informing the Board of any 'escalated' items.

On reflection, some issues raised to the Boards attention are or awareness, not specifically as an escalated item for action.

The purpose of this report is to support the Committee in reviewing the item, s escalated to the Board and determine their current status and therefore an appropriate update to the next Board meeting on the 25 September 2024.

RECOMMENDATION(S):

The Committee is asked to:

- **REVIEW** the escalated items to the Board
- **DETERMINE** the current position and therefore relevant update for the next Board meeting.

Approval/Ratification/Decision	Discussion	Information
x	✓	x

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

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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 Committee Risk Register draws together relevant risks for the Committee from the Corporate Risk Register (CRR), to provide a summary of the significant risks to delivery of the health board's strategic objectives.

BACKGROUND AND ASSESSMENT:

The following items are currently reported

Meeting	Escalated matter	Update
PEQS 25 April 2023	Concerns regarding capacity constraints in respect of the use of Civica in relation to patient experience (Reported to Board July 2023)	**PEQS 24 Oct 2023:** • received an update within the Integrated Quality Report on Patient Experience – Civica (see PEQS Chair's Report to Board) **PEQS 23 Jan 2024:** • received an update within the Integrated Quality Report on Patient Experience – Civica. Noting the system continues to evolve and become established with feedback used to improve the system. Successes and opportunities were outlined along with ongoing priorities.

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		PEQS 16 April 2024: • received an update within the Integrated Quality Report – in relation to the Patient Experience Stories, recording equipment has been purchased but limited administrative support available to support the production of patient stories. Nothing further to escalate to the Board at this stage.
PEQS 4 July 2023	Infection Prevention and Control (Reported to Board IC July 2023)	**PEQS 24 Oct 2023:** • received an update within the Integrated Quality Report on progress on the Infection Prevention and Control Improvement Plan which will be repeated on an agreed timeframe, and • agreed the Board level statement on Infection Prevention and Control (see PEQS Chair's Report to Board) **PEQS 23 Jan 2024:** • received an update within the Integrated Quality Report on progress on the Infection Prevention and Control Improvement Plan which outlined that 60% of activities were complete, 19% were making good progress, 2% were behind schedule and 19% were on track. The priorities for Quarter 4 were outlined to Committee **PEQS 16 April 2024:** Action plan is nearing completion and all actions are on track

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		The Committee has not de-escalated this item.
PEQS 16 April 2024	Mental Health Services have been placed in Level 2a local escalation	PEQs 16 April 2024: The Committee: • NOTED the actions that have been taken since 23 January 2024 • NOTED the escalated status of Mental Health Services to Level 2a (in line with the newly approved escalation framework within the Integrated Quality and Performance Framework IQPF) • Took ASSURANCE of the plans in place to monitor progress in mental health services to ensure effective oversight, assurance and improvement. The Committee will continue to monitor, seek assurance and report to the Board.

Recommended actions for consideration at PEQS (30 July 2024)

Concerns regarding capacity constraints in respect of the use of Civica in relation to patient experience	Determine if this is an issue for the lead Executive Director to manage with Executive Colleagues providing update to the Committee periodically
Infection Prevention and Control	Determine update following IP&C annual report on PEQS agenda for 30 July 2024
Mental Health Services have been placed in Level 2a local escalation	Provide an update to the Board following the report on PEQS agenda for 30 July 2024

NEXT STEPS:

An update to be provided to the Board meeting on the 25 September following discussion about escalated items from the PEQS Committee on the 30 July 2024.

The Committee Chairs report to be reformatted to make clear the purpose of items being raised to the Boards attention.

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