Patient Experience, Quality and Safety Committee

Thu 07 November 2024, 10:00 - 13:15

Agenda

10:00 - 10:00
0 min

1. PRELIMINARY MATTERS

PEQS_ Agenda_07NOV24 FINAL.pdf (3 pages)

1.1. Welcome and Apologies

1.2. Declarations of Interest

1.3. Patient Story

Film *Claire Roche*

10:00 - 10:00
0 min

2. CONSENT AGENDA BUSINESS

The Chair will ask if there are any items from the Consent Agenda (Item 6) that Committee Members wish to bring forward to the main agenda.

10:00 - 10:00
0 min

3. ITEMS FOR APPROVAL / DECISION / RATIFICATION

3.1. Minutes of the previous meeting: 05 September 2024

Attached *Kirsty Williams*

PEQS_3.1_Minutes 2024-09-05 PEQS unconfirmed.pdf (4 pages)

3.2. Committee Action Log

Attached *Kirsty Williams*

PEQS_3.2_Action Log November 2024.pdf (2 pages)

10:00 - 10:00
0 min

4. ESCALATED ITEMS

4.1. Mental Health Services update

Attached

PEQS_4.1_Mental Health Services.pdf (6 pages)
PEQS_4.1a_App 1 07 10 24 ERCIP report MHLD PTHB.pdf (13 pages)

4.2. Neurodiversity Services

Attached *Nicola Johnson/Claire Roche*

PEQS_4.2_Neurodevelopmental Escalation.pdf (7 pages)

4.3. Civica - patient experience system

(within Patient Experience Framework - item 6.1)

4.4. Infection Prevention Control

(within Integrated Quality Report - item 5.1)

10:00 - 10:00
0 min

5. ITEMS FOR ASSURANCE

5.1. Integrated Quality Report

Attached *Claire Roche*

- PEQS_5.1_Integrated Quality Report Nov24FINAL.pdf (16 pages)
- PEQS_5.1a_IQR App1 PSOW Annual Review.pdf (9 pages)
- PEQS_5.1b_IQR App4 7 minute briefing.pdf (1 pages)
- PEQS_5.1c_Llais Executive Summary Brecon April 2024.pdf (9 pages)

5.2. Health and Safety Quarterly Report (patient safety focus)

Attached *Debra Wood-Lawson*

- PEQS_5.2_H&S Performance Report Q2 (July-Sept) 2024.pdf (19 pages)

5.3. Monitoring of Health Board actions from Child Practice Review

Attached *Claire Roche*

- PEQS_5.3_Child Practice Review Update.pdf (7 pages)

5.4. Annual Assurance Report Medical Devices and Point of Care Testing

Attached *Claire Madsen*

- PEQS_5.4_Med Devices POCT Annual Report 23_24.pdf (22 pages)

5.5. Clinical Audit Progress Report

Attached *Kate Wright*

- PEQS_5.5_Clinical audit programme mid year.pdf (20 pages)

5.6. Committee Risk Register

Attached *Helen Bushell*

- PEQS_5.6_Committee Risk Report_November 2024 (September's Data).pdf (6 pages)
- PEQS_5.6a_CRR004 (Demand - provider).pdf (4 pages)
- PEQS_5.6b_CRR005 (Demand - commissioner).pdf (4 pages)

10:00 - 10:00
0 min

6. ITEMS FOR DISCUSSION

6.1. Patient Experience Framework

Presentation *Claire Roche*

10:00 - 10:00
0 min

7. CONSENT AGENDA

7.1. Joint Commissioning Committee Quality Patient Safety Committee

Attached *Helen Bushell*

7.1.1. Summary Report 16 July 2024•

PEQS_7.1ai_Quality Patient Safety Committee.pdf (6 pages)
PEQS_7.1aii_Appendix 1 - Services in Escalation Summary.pdf (8 pages)

7.1.2. Summary Report 17 September 2024

PEQS_7.1bi_Quality and Patient Safety Committee.pdf (5 pages)
PEQS_7.1bii_Appendix 1 - Summary of Services Escalation.pdf (10 pages)

7.2. Internal Audit Reports:• End of Life Care Services (Reasonable Assurance)

Attached *Helen Bushell*

PEQS_7.2a_EOL Final Audit Report.pdf (15 pages)

7.3. Work Programme

Attached *Helen Bushell*

PEQS_7.2b_PEQS Work Programme Oct 2024.pdf (1 pages)

10:00 - 10:00
0 min

8. OTHER MATTERS

8.1. Any Other Urgent Business

Kirsty Williams

8.2. Items to be brought to the attention of the Board and/or other Committees

Kirsty Williams

8.3. Committee reflections

8.4. Date of the Next Meeting: 11 February 2025 via Teams

PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE
THURSDAY 7 NOVEMBER 2024
10.00 – 13.15
VIA MICROSOFT TEAMS
CHAIR: KIRSTY WILLIAMS

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

AGENDA				
Time	**Item**	**Title**	**Attached / Verbal**	**Owner**
	1	**PRELIMINARY MATTERS**		
10.00	1.1	Welcome and apologies	Verbal	Chair
	1.2	Declarations of interest	Verbal	All
	1.3	Patient Story	Film	Executive Director of Nursing, Quality, Women and Family Health
	2	**CONSENT AGENDA BUSINESS**		
The Chair will ask if there are any items from the Consent Agenda (Item 7) that Committee Members wish to bring forward to the main agenda.				
	3	**ITEMS FOR APPROVAL / DECISION / RATIFICATION**		
10:20	3.1	Minutes of previous meeting: • 05 September 2024	Attached	Chair
	3.2	Committee Action Log	Attached	Chair
	4	**ESCALATED ITEMS**		
10:35	4.1	Mental Health Services update	Attached	Executive Director of Operations, Community Care and Mental Health
10:50	4.2	Neurodiversity Services	Attached	Executive Director Planning, Performance and Commissioning / Executive Director of Nursing, Quality, Women and Family Health
	4.3	Civica – patient experience system (within Patient Experience Framework item 6.1)	Verbal	Executive Director of Nursing, Quality, Women and Family Health
	4.4	Infection Prevention Control – (within Integrated Quality Report item 5.1)	Verbal	Executive Director of Nursing, Quality, Women and Family Health
	5	**ITEMS FOR ASSURANCE**		
11:05	5.1	Integrated Quality Report including: • PSOW Annual Letter • Clinical Quality Framework	Attached	Executive Director of Nursing, Quality, Women and Family Health
11:40	**COMFORT BREAK (10 minutes)**			
11:50	5.2	Health and Safety Quarterly Report (Patient and Safety focus)	Attached	Executive Director People and Culture
12:05	5.3	Monitoring of Health Board actions from Child Practice Review	Attached	Executive Director of Nursing, Quality, Women and Family Health

12:15	5.4	Annual Assurance Report Medical Devices and Point of Care Testing	Attached	Executive Director of Allied Health Professions, Health Science and Digital
12:25	5.5	Clinical Audit Progress Report	Attached	Executive Medical Director
12:35	5.6	Committee Risk Register	Attached	Director of Corporate Governance
	6	**ITEMS FOR DISCUSSION**		
12:40	6.1	Patient Experience Framework	Presentation	Executive Director of Nursing, Quality, Women and Family Health
	7	**CONSENT AGENDA**		
	7.1	Joint Commissioning Committee Quality Patient Safety Committee Summary Reports: • 16 July 2024 • 17 September 2024 **Purpose**: Assurance	Attached	Director of Corporate Governance
	7.2	Internal Audit Reports: • End of Life Care Services (Reasonable Assurance) **Purpose**: Information	Attached	Director of Corporate Governance
	7.3	Work programme **Purpose**: Information	Attached	Director of Corporate Governance
	8	**OTHER MATTERS**		
13:10	8.1	Any other urgent business	Verbal	Chair
	8.2	Items to be brought to the attention of the Board and/or other Committees	Verbal	Chair
	8.3	Committee reflection	Verbal	All
13:15	8.4	Date of the next meeting: 11 February 2025 via Teams		

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

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

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

Whilst Committee meetings are not public meetings, questions are invited and welcome from members of the public – pleased submit these at least 48 hours in advance of the meeting so a response can either be incorporated into the

Board meeting or be provided directly to the requester. Please submit any questions to PowysDirectorate.CorporateGovernance@wales.nhs.uk.

PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE

UNCONFIRMED MINUTES OF THE MEETING HELD ON 05 SEPTEMBER 2024 AT BRONLLYS HOSPITAL AND VIA MICROSOFT TEAMS

MEMBERS		
Kirsty Williams	KWi	Vice Chair (Committee Chair)
Jennifer Owen Adams	JOA	Independent Member
Simon Wright	SW	Independent Member
IN ATTENDANCE		
Zoe Ashman	ZA	Interim Assistant Director Women & Children
Helen Bushell	HB	Director of Corporate Governance / Board Secretary
Simeon Foreman	SF	Deputy Board Secretary (Meeting support)
Claire Roche	CR	Executive Director of Nursing, Quality, Women and Family Health
Jayne Wheeler-Sexton	JWS	Assistant Director of Nursing, Safeguarding
Kate Wright	KW	Executive Medical Director
APOLOGIES FOR ABSENCE:		
Claire Madsen	CM	Executive Director of Allied Health Professionals, Health Sciences and Digital
Lucie Cornish	LC	Deputy Director of Allied Health Professionals, Health Sciences and Digital

1. PRELIMINARY MATTERS
1.1 WELCOME AND APOLOGIES (PEQS/24/39
The Chair welcomed everyone to the meeting. Apologies for absence were received as recorded above.
1.2 DECLARATIONS OF INTEREST (PEQS/24/40)
No declarations of interests were received in addition to those already recorded on the register.
1.3 MINUTES OF PREVIOUS MEETING (PEQS/24/41)
The minutes of the meeting held on 30 July 2024 were **CONFIRMED** as an accurate record.
2. ITEMS FOR ASSURANCE
2.1 DUTY OF QUALITY ANNUAL REPORT 2023/24 (PEQS/24/42)
CR introduced Powys Teaching Health Board's (PTHB) first Duty of Quality annual report since the duty of quality, as part of the Health and Social Care (Quality and Engagement) (Wales) Act 2020 came into force on 01 April

2023. ZA presented the contents and invited feedback to help shape the next year's report whilst the following was highlighted:

- Variations existed across Wales on how organisations had chosen to present their reports
- Work with Llais and service users was underway to shape the next report
- Incident management framework implemented
- Duty of Candour
- Overview of external reviews undertaken and assurance against the findings
- Friends and Family Test (FFT) scores had improved
- Comments from a commissioner perspective were already an area of focus for next year.

The Committee challenged the 39.72% FFT score related to people feeling they always had assistance when they needed it and noted it was much lower than the other indicators. ZA explained this could relate having a nil or not applicable response and the data was being revisited to gain a better understanding.

The need to balance the quality structure was understood, but questions were raised to seek and understand the Executive's perspective and views on the report and whether it had delivered what was expected:

1) How satisfied were colleagues with the report?
2) Were the right things targeted?
3) Tweak to improve and strengthen for next time?
4) How could the Committee be assured that nothing had fallen through gaps?
5) Recognising the need to balance process and outcomes this time, was there opportunity to have greater focus on data and outcomes?

CR acknowledged these were considered fair questions for the whole organisation and explained that the report reflected the significant amount that had taken place since the Duty of Quality came into force in 2023, as well as the build up to that point. CR explained that it had been necessary to develop a robust infrastructure to strengthen current and future quality reporting. The Committee acknowledged and endorsed these comments and felt the work to date bode well for the future.

Discussion took place on the need to collate and learn from the different stages of quality maturity and approaches being taken across NHS Wales. The Committee asked for a sense of where PTHB wanted to be on quality and what good looked like so the journey could be plotted. CR and KW explained that work was based on self-assessment and showed significant progress over a short period of time across lots of areas that will drive further improvements. A fully embedded quality management system will really help in future to show what is good, as would focus and evidence to demonstrate where quality had driven decisions. There would be examples of these in the next report. Other indicators of good work were highlighted

as alignment to national work and real intelligence derived from outcome and patient experience data.

The final question related to identifying who would provide a critical eye and external review on the report and it was explained that review work was ongoing across Wales that would support triangulation of quality.

The Committee:
Took **ASSURANCE** from the contents of the report and **RECOMMENDED** this for Board approval.

2.2 SAFEGUARDING ANNUAL REPORT 2023/24 (PEQS/24/43)

CR introduced JWS to present the report and the following areas were highlighted:

- PTHB was in line with NHS Wales' Safeguarding Matrix
- Joint Inspection of Child Protection Arrangements (JICPA) had shown good practice and the areas identified for improvement were already known to PTHB
- Informatics to collect more data
- Training to roll out Routine Enquiries in PTHB Minor Injury Units
- Safeguarding Priorities for 2024/25.

It was **NOTED** that there had been a recent Board development session on safeguarding where discussion had answered wider questions from Board Members. For completeness, transparency and audit purposes, the Committee recorded that there had been significant assurance on the progress being made against four recommendations from JICPA and multi-agency working to demonstrate partnership and continue to build trust.

The Committee sought to understand the reasons behind the lower take up on Level 3 training and JWS explained that although the Children Level 3 rates were improving faster than the Adult Level 3 rates, there was common issues related to capacity and the ability for this to be prioritised above other duties, especially when staff know they receive support from the Safeguarding team. It was further explained that the comprehensive competency passport took more time.

The Committee heard that PTHB was providing a safe service and doing as much as possible within the resources available. There was a need for managers to support and release staff to complete and access their training.

In response to a query as to whether PTHB was outlier on Level 3 training, notwithstanding this being hard to complete before time consideration were factored in. JWS confirmed PTHB was not an outlier and instead was one of a few organisations able to interrogate data to identify staff with Level 3 training compliance. JWS added that PTHB was not prepared to compromise on this work and only awarded compliance on completion of the passport.

CR signalled the importance of the JICPA, and the Committee being assured on progress on the recommendations with an update scheduled for February 2025. The Committee: Took **ASSURANCE** from the contents of the safeguarding report and **RECOMMENDED** this for Board approval.
3. OTHER MATTERS
3.1 ITEMS TO BE BROUGHT TO THE ATTENTION OF THE BOARD AND/OR OTHER COMMITTEES (PEQS/24/44)
Both reports from the assurance agenda items will be recommended for Board approval on 25 September 2024. The Committee recorded thanks to both ZA and JWS for their work on the reports, presentations and responses during the meeting.
3.2 ANY OTHER BUSINESS (PEQS/24/45)
There were no items of any other business.
3.3 DATE OF NEXT MEETING ((PEQS/24/46)
07 November 2024

Meeting closed at 16:11

Liz Patterson								
RAG Status:								
At risk	Red - action date passed or revised date needed							
On track	Yellow - action on target to be completed by agreed/revised date							
Completed	Green - action complete							
No longer needed	Blue - action to be removed and/or replaced by new action							
Transferred	Grey - Transferred to another group							
Patient Experience, Quality and Safety Committee								
Meeting Date	**Item Reference**	**Lead**	**Meeting Item Title**	**Details of Action**	**Update on Progress**	**Original target date**	**Revised Target Date**	**RAG status**
OPEN ACTIONS FOR REVIEW								
OPEN ACTIONS - IN PROGRESS BUT NOT YET DUE								
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 **07.11.2024 update -**Date of report changed in agreement with Chair of Committee	Oct-24	Feb-25	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 **07.11.2024 update -**Date of report changed in agreement with Chair of Committee	Oct-24	Feb-25	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
30/07/2024	PEQS/24/31	ED of Primary Care, Community Care and Mental Health	MH Power of Discharge Annual Report	Future annual reports to include trend date over several years, not just the previous year		Jul-25		On track
ACTIONS RECOMMENDED FOR CLOSURE (MEETING 7 NOV 2024)								
24/10/2023	PEQS/23/40a	ED 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** - verbal update in meeting confirmed work on action had taken place but staff absence meant it had not been possible to report to July 2024 meeting. Date change request to November 2024 approved **07.11.2024 update -** information included within the Integrated Quality Report	Jan-24	Nov-24	Completed
30/07/2024	PEQS/24/28	ED of Nursing, Quality, Women and Family Health	Integrated Quality Report	HIW outstanding recommendations - action to be taken to close longstanding recommendations and any outstanding recommendations over 12 months old to be highlighted within the report	**07.11.2024 update -** high level data included in the Integrated Quality Report. More detailed position to be included in IQR for Q3	Nov-24		Completed
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 **07.11.2024 update -**on agenda for 7 Nov 2024.	Nov-24		Completed

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 **07.11.2024 update -**on agenda for 7 Nov 2024.	Nov-24		Completed
30/07/2024	PEQS/24/27	DCG	MH Services Escalation Assurance Report	On de-escalation, colleagues from MH Services to be invited to attend PEQS to share their experience of escalation	**07.11.2024 update -** scheduled for February 2025 Committee	Dependent on date of de-escalation	Feb-25	Completed
30/07/2024	PEQS/24/33	DCG	Committee Risk Register	The risk of availablity of digital information at the point of care to be considered at the Risk and Assurance Group	**07.11.2024 update -** on agenda to consider at the 5 Nov 2024 RAG meeting.	Nov-24		Completed
30/07/2024	PEQS/24/34	DCG	Committee Work Programme	Consideration to be given to where temporary service change and research and innovation should be included in Committee work programmes	**07.11.2024 update -**Confirmed to sit with PPPH and the Board	Nov-24		Completed
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 **07.11.2024 update -** this is included in the Child Practice Review agenda item to	Nov-24		Completed
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 request to November 2024 approved **07.11.2024 update -** IQR provides data on progress with closing incidents	Jul-24	Nov-24	Completed
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 request to November 2024 approved **07.11.2024 update -** included within the November IQR.	Jul-24	Nov-24	Completed
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 status 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 **07.11.2024 update -** included in Point of Care Report to November PEQS	Oct-24		Completed
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 request to November 2024 approved **07.11.2024 update -** Focus on Bereavement service in IQR	Jul-24	Nov-24	Completed

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 4.1

PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE	**07 NOVEMBER 2024**
Subject:	Integrated Quality & Performance Framework – Mental Health Escalation Oversight Group
Approved by:	Claire Roche, Executive Director of Nursing, Quality, Women and Family Health
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, Quality and Safety Committee: 16 April, 30 July 2024 Executive Committee: 15 May; 29 May; 26 June; 31 July; 04 September, 16 October 2024

PURPOSE:

Within the context of the Powys Teaching Health Board (PTHB) Integrated Quality and Performance Framework (IQPF), in March 2024 the Executive Committee agreed that Mental Health Services in PTHB be placed into PTHB's internal 'escalated' status. An Escalation Oversight Group (EOG) has been established.

The purpose of this paper is to provide the Patient Experience, Quality and Safety Committee with an update on current progress and the decision of the Executive Committee to de-escalate the service.

RECOMMENDATION(S):

The Patient Experience, Quality and Safety 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 including progress that has been made against the improvement plan**.**
3. To **NOTE** the Executive Committee decision that the service group is de-escalated at this point, taken on the 16 October 2024.

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	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	

EXECUTIVE SUMMARY

The Executive Committee agreed that, within the context of the Health Board 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 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 and confirms the Executive Committees decision to de-escalate the service on the 16 October on the basis the de-escalation criteria has been met.

DETAILED BACKGROUND AND ASSESSMENT

Background

The EOG for Mental Health Services has held a series of 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: several 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)

		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 11 October 2024 there were 67 open patient safety incidents. The service group is sustaining incident review and closure in line with required timescales.

- Progress against two outstanding areas of assurance provided at recent Escalation and Oversight meeting held on 08 October 2024:
  - <u>Care and Treatment Plan Audit</u>
    - Capacity secured from Bank and work initiated beginning of September.
    - Benchmarking work undertaken - application of National Audit Tool.
    - Co-ordination of random sample CTPs from all areas of service (MH&LD).
    - Audits underway with prioritisation of Inpatient settings.
    - Alignment to Workforce Education Training and Learning Plan.

  - <u>Training</u>
    - Needs analysis completed and matrix applied to capture future workforce training needs across whole service group
    - MH and LD Education, Training and Learning Plan in first draft.

- The 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, and presented to Executive Team on 31 July, 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 the results stage and is due for reassessment in October.

The IQPAF process will see an increase in maturity of the service group having developed a formal capability programme to build skills across clinical and non-clinical colleagues; build service wide skills in application of modern quality improvement methods; aligned with culture where improvement work is becoming integrated into day to day work.

- The Escalation and Oversight group recognised that implementation of the Improvement Plan was on track with the remaining actions having been progressed to a satisfactory degree with clear plans in place to embed the ongoing continuous improvement work around training, education and care and treatment planning quality improvement. It is noted that overall, the service group have significantly strengthened governance arrangements with the SMT structure evidencing robust discussions and clarity of forward plan to sustain the positive improvement against the quality and safety agenda. The improvement plan is provided as a background paper to the Patient Experience, Quality and Safety Committee. This is accompanied by a summary progress report (Appendix One).

- The increased capacity arising as a result of the accelerated work does still require thought in the MH&LD model and establishment moving forward but the new IQPG process will continue to provide oversight and support the work the service group have committed to in maturity assessment and implementing conditions for sustainability.

- Considering the progress made and the continued delivery of the implementation plan with evidenced progress, the Executive Committee agreed that the service group be de-escalated on the 16 October 2024 with it being identified ongoing continuous improvement has become business as usual.

NEXT STEPS:

1. Service performance will form a part of routine Integrated Quality and Performance Group (IQPG) Monitoring on a monthly basis.
2. Executive Committee will receive a progress report in three months time.
3. The Patient Experience, Quality and Safety Committee will receive a further update at its next scheduled meeting in February 2025.

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:

	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			

Escalation Issue/De-escalation criteria

ERCIP Ref	Escalated issue	Reason for escalation	Criteria for de-escalation
1.1	Actions from concerns and incidents	Key actions from previous NRIs not yet completed	Completion of key actions – to be agreed by escalation oversight group. See document in MH recovery plan.
2.2	Policies and SOPS	A number of key policies are missing or are out of date	Completion of those AIMS standards deemed to be 1. Policies covering Essential standards (failure to meet these would result in significant threat to patient safety there by leaving organisation vulnerable) 2. Policies covering Expected standards that most services would meet
2.3	MDT	Formal MDT could not be evidenced	Recorded evidence of MDTs. See documents referenced in MH improvement recovery plan. Clinical audit at 3 months for compliance.
2.1	Clinical audit plan	Limited audit plan	Strengthened plan to be delivered include areas of key learning from incidents and concerns and to include any areas of additional learning from the escalation process. De-escalation will be triggered on production of the plan.
1.2	review of 9 post investigation incidences identified in desktop review needed	Insufficient evidence of incident review	Confirmed investigation, reporting, action and evidence of learning
1.3	Open datix incidents	Backlog	Evidence of incident investigation, action, learning and closure.
2.6	Discharge notification	Evidence of some delay in discharge notification	Clear guidance in place. Clinical audit of practice at 3 months
4.6	PMVA training	Lower than expected rates	Rates significantly Improved
1.5	Care and treatment plan audit	Identified that these are not being carried out bi monthly	Implementation of bi monthly audits
2.5	Training needs analysis	Lack of clear plan	Production of plan with agreed timescales for improvement

ERCIP ref 2.5 Education and Training Plan - Objectives

1. Ensure the MH&LD workforce can be provided with, and undertake, the level of current education and training to provide the knowledge and skills to deliver effective services that meet people's needs now and in the future.
2. Ensure effective induction into services with comprehensive induction packages that relate to key quality and safety indicators, including policies and procedures as well as systems and service knowledge.
3. Encourage continuous professional learning and development, skills mapping, upskilling, and reskilling to promote a capable, resilient and productive workforce.
4. Provide the MH&LD workforce with career development opportunities, such as leadership training, that help them grow and advance within the Division.
5. Influence MH&LD Workforce attitudes and perceptions toward learning or organisational change.
6. Provide the MH&LD Workforce with training that enhances their work-life balance and helps them manage stress and avoid burnout.

Objectives ctd

7. Provide the MH&LD Workforce with training that enhances their knowledge and understanding of organisational policies and procedures, risk reduction and management.

8. Enhance soft skills that the MH&LD Workforce require to succeed in their job roles. These include communication skills, teamwork, leadership, time management, partnership working and problem-solving skills. Enhancing core skills can build better relationships with their colleagues, communicate effectively with clients, and deliver high-quality work.

9. Ensure the MH&LD Workforce are engaged and motivated by providing training that enhances their job satisfaction and helps them feel valued.

10. Provide a Pan Powys position to ensure equity of approach and consistency for service delivery. Identify opportunities for efficiencies within the education and training process including potential alignment across services.

Education and Training Plan – Matrix Example

MH_LD Training Plan 2024.xlsx

	A	B	C	D	E	F	G	H	I	L
1										
2	**Older Adults Mental Health services - Pan Powys.**									
3										
4	**Service or department**	**Name of Training / Course / Qualification**	**Registered / Unregistered staff**	**Band**	**How many staff**	**Name of staff member(s) (if appropriate)**	**Reason for training A: Statutory and Mandatory Training for ALL staff B: Role Essential Education and Development Required for Current Role C: Education, Learning and Development to meet future needs of service/role D: Opportunities for personal and career development**	**Education/ Training provider**	**Service lead**	**Comments**
5	**CMHT's & Liaison**									Enahance clinical practice
6	CMHT OA	Cert in CBT	Reg	6	1/2 per team		B and C	Uni	Bethan Gwalchmai	Enahnace clinical practice
7	CMHT OA	DBT Skills	Reg	6	1/2 per team		B and C	PTHB	Bethan Gwalchmai	Support patient Journey
8	CMHT OA	CTP Trainning	Reg	6	all		A,B,C	PTHB	Bethan Gwalchmai	Enahance clinical practice
9	CMHT OA	Welsh Language Course	Both	4 and 6	3		A, B and C	PTHB	Bethan Gwalchmai	WAG expectation
10	CMHT OA	First Line Manager Collabrativ	Reg	7's	3		B,C and D	PTHB	Bethan Gwalchmai	To support future management
11	CMHT OA	WARRN Trainning	Reg	6	all		A,B,C	PTHB	Bethan Gwalchmai	Support clinical Practice
12	CMHT OA North	EMDR	Reg	6	2		B and C			To support future management
13	CMHT OA	Indepednant Nurse Prescriber	Reg	6	1		D			Enahnce clinical practice.
14	CMHT OA	ILM	Reg	7	2		B,C,D	PTHB	Bethan Gwalchmai	
15										
16	**Memory Service**									
17	MAS	Welsh language course	both	all	all		A,B,C			
18	MAS	First Line Manager collaborative		7			B,C			
19	MAS	Diagnosising dementia trainni	Reg	6 and 7	3		B and C	Online	Bethan Gwalchmai	
20	MAS	CST	both	6 and 3			B,C,D		Bethan Gwalchmai	
21										
22	**DHTT**									
23	DHTT	Dementia Mapping	unreg	3	1		B,C,D	Uni of Braford	Bethan Gwalchmai	
24	DHTT	Newcastle model training	Reg	6					Bethan Gwalchmai	
25	DHTT	Teepa Snow 1,2,3,4	unreg	3	all		B,C,D			
26	DHTT	Clinical Skills Msc module for ANP		7	1	AnnMarie	B,C,D	Uni	Bethan Gwalchmai	
27										

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Current themes

Strengths

- Good balance of statutory, mandatory, role essential, awareness raising and development to meet needs of service
- WARRN
- PMVA Inpatient
- CTP
- Trauma Informed

Gaps

- Core Skills e.g. communication skills, teamwork, leadership, time management, and problem-solving skills
- Administration/Systems
- Cross Team and Partnership considerations
- Leadership

Learning and Development (L&D)

Putting Things Right (PTR)

Leadership and Communication

Audit Outcomes

Quality, Assurance, Integrated Learning and Safety (QuAILS)

Embedding Learninig in Teams (ELIT)

Clinical Policy Advisory Group

Datix Huddles

HIW Improvement Plans

Training Plan

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Priority Areas – Learning Infrastructure

Priority Areas – Training and Education

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Ongoing activity

- Governance and Delivery - WCC
- Training Opportunities
- Leadership Assessment and connectivity to Clinical Leadership Programme
- Alignment of matrix outcomes to HEIW investment end 2024/2025
- Strategic Workforce Plan – Workforce Planning lead advertised

Leadership in MH Services

Graph 7 – How leadership skills have been developed

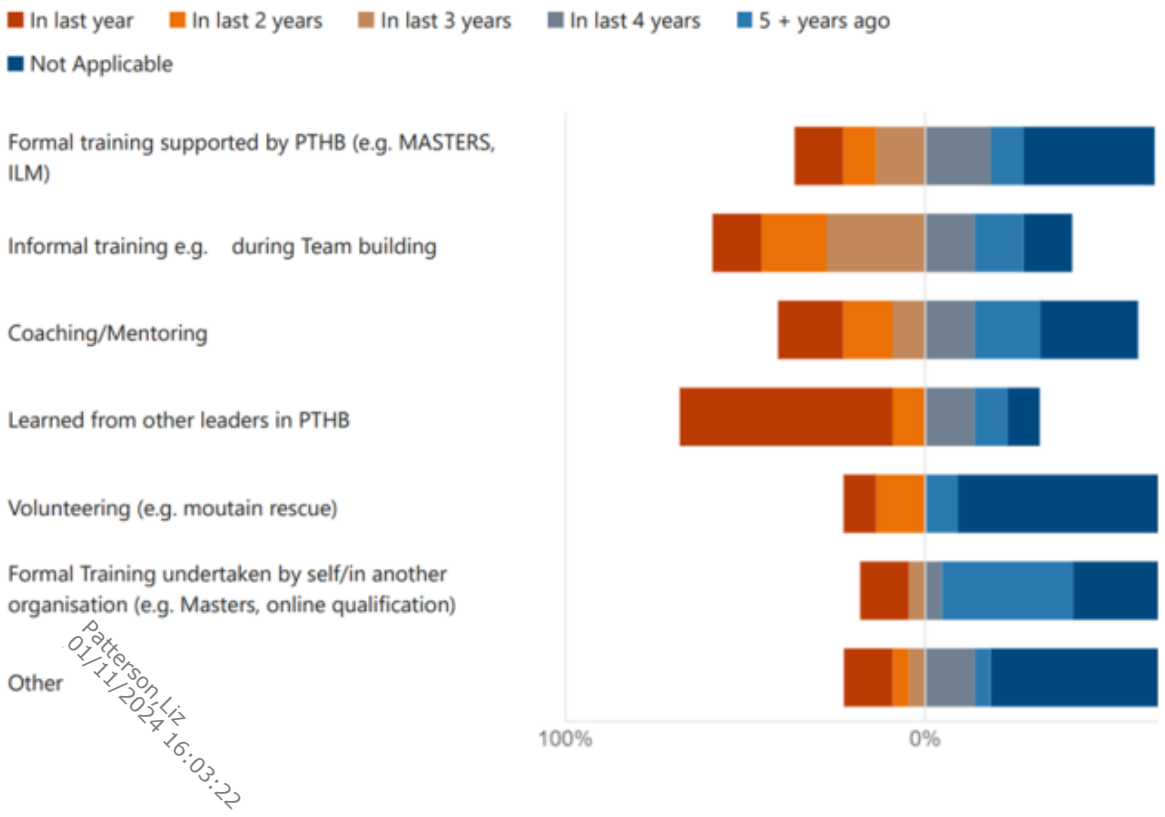

Table 6 - Leadership factors that exist in mental health services	Strongly agree/ Agree %	Neither agree/ Disagree or don't know %	Disagree/ strongly agree %
Genuine concern for others	94.5	-	4.5
Political sensitivity and skills	72.8	22.7	4.5
Decisiveness and self confidence	72.8	18.2	9.1
Integrity, trustworthy, open and honest	77.3	13.6	9.1
Empowers develops potential	63.7	22.7	13.6
Inspirational, networking and promoting	63.6	27.2	9.1
Accessible and approachable	86.5	9	4.5
Strategic thinking	64	27.3	9.1
Values, involves and engages	72.8	22.7	4.5
Adapts to change, supporting others to do same	58.8	22.7	18.2

Leadership in MH Services

Table 4 – Leadership challenge ranked 1st (biggest) to 6th (smallest)

	CHOICE (%)					
Challenge	**1ST**	**2ND**	**3RD**	**4TH**	**5TH**	**6TH**
H	27.36	13.6	18.2	18.2	18.2	4.5
D	13.6	18.2	27.3	22.7	13.6	4.5
I	18.2	27.3	4.5	22.7	9.1	18.1
L	18.2	9.1	22.7	13.6	27.3	9.1
G	18.2	13.6	22.7	9.1	18.2	18.2
M	4.5	18.2	4.5	13.6	13.6	45.5

H = Honing effectiveness – managing workload, strategic thinking, maintaining performance

D = Developing teams and individuals – providing mentorship, prioritising training, managing team relationships

I = Inspiring others – motivating and facilitating job satisfaction

L = Leading in a rural and geographically large County – specific rural challenges and patient needs

G = Guiding change – seeking ownership, inspiring transformation, mitigating consequences of change

M = Managing relationships – with other services, partner agencies, stakeholders, partnership working, managers

Leadership in Mental Health Services - interviews

1. The current leadership model as one of transformation and empowerment. There are challenges in communicating structure, some conflict in clinical and operational leadership roles and certain levels where strategic thinking needs development as well as flexibility in leadership roles. Benefits include the trust built to support autonomy.

2. Transformation and Improvement Journey - A bedrock of basics has been created including a feeling of safety to enable innovation and creativity in transformation and service improvement that will make a difference to patients' lives.

3. Rural Differences - Rurality requires greater creativity in leadership but there are challenges for dispersed teams and perceived divisions that need to be addressed.

4. Existing positive leadership traits and skills - There is a distinct 'kindness', peer support, and compassion to achieve high-quality care existing as foundations for innovation that services are built on which is easier to do in a rural setting as relationships are closer. Having a leadership skill mix is important as this brings strength to problem solving and decision making.

5. Formal and Informal Training approaches - Supporting staff to fulfil potential, grow future leaders and use leadership for project management was seen as an imperative. References to enhancing leadership training linked to 360 feedback, shadowing and finding ways to become more well-rounded.

6. Consideration for Career Progression - Excellent clinicians may not necessary be excellent leaders also. Identifying talent should be mapped more effectively.

7. Leadership will need to change/develop - It will need to be dynamic forever in response to internal/external influences, challenges and changing needs of patients.

8. Capacity for Leadership -Capacity for leadership is thin and it is anticipated this will need to change to grow and meet new demand.

CTP Audit

- CTP Lead through Bank started two weeks ago.
- Benchmarking work undertaken and application of National Audit Tool
- Requested random sample CTPs from all areas of service (MH&LD) (most received)
- Work to audit underway
- Connectivity to Cardiff University
- Alignment to Education Training Plan

Maturity Matrix

Additional Evidence:

- SMT Structure Implemented
- Leadership and Communication Band 7 work
- PADR compliance increased
- CTP Audit work commenced
- Incident Management - improvement sustained
- Datix Huddle Survey Outcomes
- Co-production

Decreasing Maturity:
If additional capacity not sustained

Baseline Assessment (March 2024)	Basic Level	Early Progress	Results	Maturity	Exemplar
Safe and Effective Care	Y				
Quality of Patient and Family Experience		Y			
Quality of Leadership and Management			Y		

Assessment (20/5/24)	Basic Level	Early Progress	Results	Maturity	Exemplar
Safe and Effective Care			Y		
Quality of Patient and Family Experience			Y		
Quality of Leadership and Management			Y		

Assessment (17/07/24)	Basic Level	Early Progress	Results	Maturity	Exemplar
Safe and Effective Care			Y		
Quality of Patient and Family Experience			Y		
Quality of Leadership and Management			Y		

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Agenda item: 4.2

PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE	**Date of Meeting 07 November 2024**
Subject:	**Children's Neurodevelopmental Services**
Approved and presented by:	Claire Roche, Executive Director of Nursing, Quality, Women and Family Health Nicola Johnson, Executive Director of Planning, Performance and Commissioning
Prepared by:	Interim Assistant Director Women & Children Strategic Project Lead Assistant Director of Performance & Commissioning
Other Committees and meetings considered at:	Discussions have been held at Executive Committee in January, August and October 2024. Delivery & Performance Committee – August and October 2024
Appendices :	4.1a – ND Strategic Project Review

PURPOSE:

This paper updates the Committee on the work that has taken place to address clinical delivery of Neuro-Developmental services (ND) in Children and Young People (CYP). Following the paper presented to Executive Committee in August 2024, a continued diagnostic review of the service has been undertaken and an assessment made against the Escalation Framework within the Integrated Quality & Performance Framework (IQPF). The Executive Committee then considered a further paper on the 2 October and placed the service into local escalation level 3 of the Integrated Quality and Performance Framework.

RECOMMENDATION(S):

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

- **RECEIVE** the paper and **NOTE** the Executive Committee's decision to place the service into Level 3 local in line with the escalation framework within the IQPF.
- **NOTE** the assurance reporting timetable back to the PEQs Committee.

Approve/Take Assurance	Discuss	Note
Y	Y	

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:		
1. Focus on Wellbeing	Y	

2. Provide Early Help and Support	Y	The better understanding of the neurodevelopmental diagnostics will improve the quality and value of our services (transforming in partnership) through effective utilisation of human resources and consider future workforce requirements (develop workforce futures) whilst maintaining core standards of care and outcomes for patients (provide early help and support; enable joined up care).
3. Tackle the Big Four	Y	
4. Enable Joined up Care	Y	
5. Develop Workforce Futures	Y	
6. Promote Innovative Environments	N	
7. Put Digital First	N	
8. Transforming in Partnership	Y	

SECTION 1: BACKGROUND

The Powys Teaching Health Board (PTHB) Children and Young People's (CYP) ND service was launched in February 2018. This service superseded the virtual Social Communication Assessment Teams (SCAT) who were responsible for the assessment and diagnosis of children and young people (CYP) with suspected Autism Spectrum Disorder (ASD). The new ND national pathway and its standards now offer CYP diagnostic assessment for both ASD and Attention Deficit Hyperactivity Disorder (ADHD).

An ND Remodel project arose from the COVID PTHB Recovery and Renewal Programme. A business case was developed in response to the poor performance position and continued increase in referral demand (Appendix 1). A separate project to evaluate the Community Paediatric model (Appendix 2) was established in January 2023 to plan, develop and remodel paediatric services for children and young people within Powys. However, this project did not include ND services as this was being considered separately within the business case

The options appraisal within the business case for ND services (Appendix 1) presented to Executive Committee in January 2024 suggested Option 4 (fully compliant service – phased approach) as the preferred option. However, the Executive Committee requested further diagnostic work to be undertaken prior to any further recommendations being considered.

Simultaneously, Welsh Government undertook a national review of ND services in Wales (Appendix 3).

In July 2024, the CEO commissioned an internal review of children's neurodevelopmental services (ND). A subsequent paper was presented to Executive Committee in August, followed by a presentation to Delivery and Performance Committee during August 2024 to further describe the scope of the internal review.

SECTION 2: CURRENT POSITION

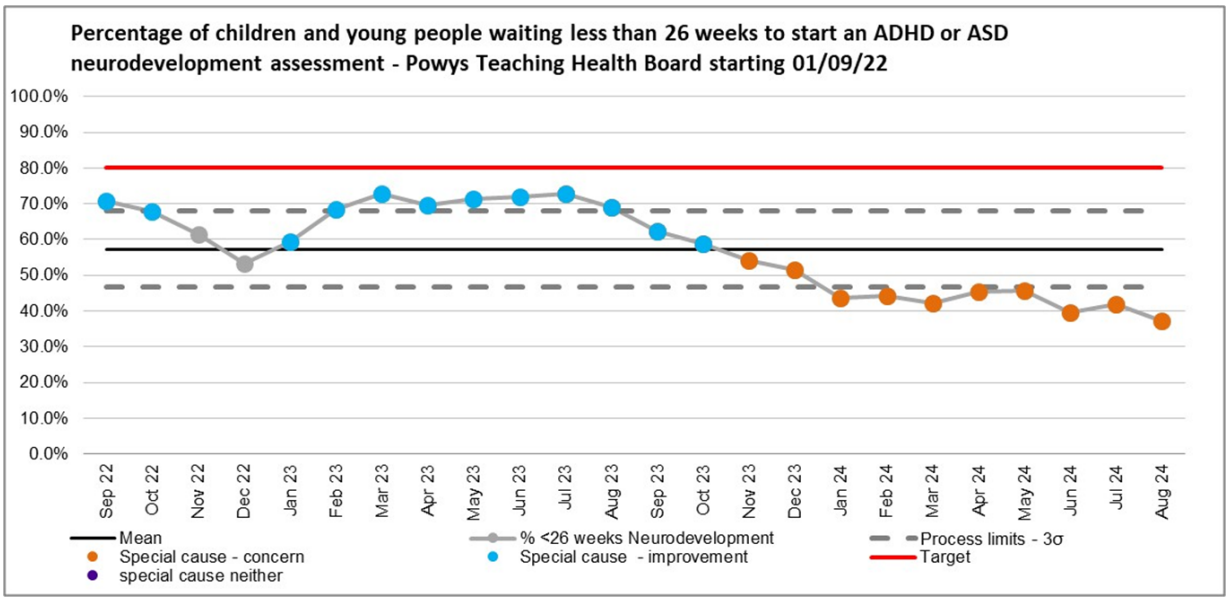
The PTHB ND service has experienced an increased and sustained demand since its inception in 2018. This increase in demand is replicated across Wales. Referrals remain consistently high with an average of 64 per month.

A lack of capacity is believed to be impacting PTHB ability to achieve the Ministerial Measures target resulting in an inability to deliver pre and post diagnostic support, the service is therefore NOT compliant with recommendations from:

- NICE guidelines
- WG delivery of ND service standards
- Wales: Code of Practice on the Delivery of Autism Services (Sept 2021).

Current Performance

The Ministerial Measures waiiting time position has deteriorated (see graph below) as has the 'assessments in progress' backlog. The current compliance position is reflected below. ND performance continues to fall outside of the lower control limit reporting.



On 26/09/24:

- Total **1436** CYP in the system.
- **960** awaiting first appointment.
- **390** (532 in July 2024) awaiting conclusions of their assessment.

Initial key mitigations include:

- Commissioning of Parents and Carers Voices in Wales to support co-production and engagement with parents and carers.
- Robust communication plan in place with parents/carers regarding waiting times and progression within the waiting list and assessment process.
- Implementation of an email access point.
- Agreed clinical schedule to increase clinical capacity.
- Implementation of an MDT structure.
- Training needs analysis.
- Building relationships with colleagues in social care and education to maximise on the support available across the system.

- Establishment of a task and finish group to undertake further work on demand with support of the public health team, and the Local Authority Additional Learning Needs (ALN) team to more accurately calculate future demand.
- Independent review of capacity is being undertaken to clearly identify gaps in provision, this needs to include an overview of current staffing and the use of funding to address core staffing gaps.
- Establishment of job planning to maximise assessment and diagnosis which include pre booked clinic time with capacity for multi-disciplinary / twin track assessments.
- Overlaying demand with population health data for Powys.

SUMMARY OF KEY ISSUES AND CHALLENGES IDENTIFIED TO DATE :

Safe & Effective Care

- Ongoing and sustained deterioration in performance.
- Lack of Pan Powys offer.
- Information and data difficult to navigate and does not reflect whole system pathway.
- Clinical pathways require a review alongside a review of staffing capacity (to include a review of medication supply and patient titration reviews and active caseload reviews). This requires consistent MDT offer.
- No systematic QI.
- Focus of the team to date has been to focus on RTT target of 26 weeks rather than standards.

Quality of Patient & Family Experience

- Hich level of concerns from parents/carers regarding long waits.
- ND pathway is incomplete. No evidence of experience driven improvement.

Quality of Leadership & Management

- Lack of job planning.
- Lack of robust process for medical reviews.
- Lack of clinical leadership and high turnover.
- High turnover of staff, fragile and very part time staffing funded through shot term projects, lack of training and development along with clinical supervision.
- Evidence of individual decision making rather than a collective and a strategic approach to delivery and improvement.

Whole system Remodelling

- Lack of pre and post diagnostic support.
- Lack of clear pathways for early intervention with younger CYP.
- Whole system offer is required to include; Education, CAMHS, LD, early years and social care.
- Further work needed to develop an MDT culture.
- Work will need to be undertaken on capacity when demand is fully understood (inclusive of population health information).

Integrated Quality & Performance Framework (IQPF)

The IQPF is the Health Board's framework applied to all services both provided and commissioned. It is an internal framework that has been developed to oversee the delivery, management and outcomes of services. The summary escalation measure are shown in the table below:

PTHB Integrated Quality & Performance Framework Escalation Framework 2024/25
Please note that this framework replaces the 23/24 business reporting rules as used within the Integrated Performance Framework and report.

Escalation level	Trigger	Action expected	Monitoring and support
Level 1 (No concerns)	• Local delivery of agreed objectives and performance, finance ambitions in line with agreed trajectories. • No exceptions or quality concerns. • Sound governance arrangements in place. • Performance within expected targets either national or local	• No escalation action. • Could result in frequency adjustment for some monitoring mechanisms and meetings including IQPG.	Main monitoring through base performance review process. Key measures bi-annually in IQPR to the Board.
Level 2a (Exception)	• Failure to achieve / maintain delivery in more than 1 key deliverable / area of performance. • Sustained deterioration on 1 or more domain. **This can include:** • Failure to deliver on an NHS Performance Framework target or local target trajectory. • A deviation or departure from the normal or expected course of action signifying specific condition or event that requires attention or further action to address the deviation. • Failure of quality standard. • Where SPC methodology notes variance of concern.	• Correspondence to Clinical service area/corporate dept on reasons for escalation – areas of concern, expected response and confirm any enhanced monitoring. • Recovery plan to be developed that address issues to be recovered/improved. • Depending on issue – change in frequency of and focus of standard meeting and consideration of increasing frequency including IQPG. • Reported through to Executive Committee. • Monthly reporting where appropriate via IQPR as an exception to performance.	**Options include:** • IQPG engagement monthly with Executive • Internal support as required (QI/vbhc/planning – issue dependent). • Consideration of compliance with Professional clinical codes and standards and proportionate response. • Consideration of compliance with managerial code of practice. • Internal peer review. • Executive support (directly or from other teams). • Consider need for bespoke response. • Minimum monthly updates to Executive Committee.
Level 2b (Exception)	**Specially for finance:** • Where Corporate Directorate or Clinical Service Area level budget is overspending by more than £0.5m Year to date or £1m forecast.	Identified through monthly financial reporting	CEO to call a special 'Budget Review Meeting' of all Executive Directors and the Divisional or Directorate budget holder (up to 3 team members may attend in support). **Agreed action plan established:** • Monitored through financial reporting arrangements. • Review period established if plan failing.
Level 3 (Escalation)	• Serious concerns on quality and governance. • Continued and consistent failure to meet agreed performance improvements and trajectories across a number of objectives. • Clear articulation of reasons for escalation and criteria for escalation. **This can include:** • Where a performance matter (exception) does not meet target and hits criteria for higher level of resolution, decision making or further action. • Any measure that continues to fail a health board submitted trajectory as part of the Ministerial Priority measures. • Performance recovery is failing to improve or maintain performance. • Any significant failure of quality standard. • Where IQPG deems that a service or measured outcome requires escalation resulting from identified challenge or significant concern.	• Correspondence to service area/corporate dept on reasons for escalation – areas of concern, expected response and confirm any enhanced monitoring. • Service Area or corporate directorate demonstrating recognition of issues and commitment to improve. • Improvement/recovery plan required to address issues identified. • Reported through to executive and relevant committee. • Escalated frequency of IQPG meetings and resultant remedial action plan completion. • Challenge review on appropriate shift to the Escalations Oversight Group (EOG). • Monthly reporting where appropriate via IQPR as an exception to performance.	**Actions could include:** • Escalation Oversight Group (EOG) • Independent review of service/corporate department effectiveness. • Deployment of appropriate HR policies e.g. Capability policy. • Weekly/fortnightly meetings with CEO and/or relevant execs to track progress against improvement actions (which directly related to de-escalation criteria). • Consideration of compliance with Professional clinical codes and standards and proportionate response. • Consideration of compliance with managerial code of practice. • Suspension or revision of service provision. **De-escalation:** The appropriate outcome for a challenge to be de-escalated. Either challenge has been rectified, requirement has changed, or via senior committee decision. A level 3 escalation may return to any previous lower level of escalation dependant on the remaining challenge and required monitoring.

In line with the performance trigger points for escalation, the framework supports this service being escalated to Level 3. The reason for this escalation being:

- Continued and consistent failure to meet agreed performance improvements, including failure to deliver Ministerial Priority measure.
- Performance for ND assessment continues to fall outside of the lower control limit, with performance flagged as special cause concern due to consecutive decreasing trend.
- Challenge on RTT backlog not resolved as expected.

As per the IQPF, an Executive Oversight Group (EOG) has been mobilised to oversee the improvements required. The Executive Director of Planning, Performance and Commissioning is the Chair of the EOG.

At the first meeting the he Health Board and service to captured the issues and outlined the work required to agree the criteria for de-escalation and associated timeframe at the next meeting. These will be framed in terms of the Duty of Quality and the ND Standards. It will also be important to capture what actions the Health Board, as well as the service, will need to take given the issues raised.

Outcome of the Executive Committee on 2 October 2024

- The Executive Committee RECEIVED and DISCUSSED the Quality and Performance indicators in line with the escalation framework within the IQPF.
- The Executive Committee AGREED the service be escalated to IQPF Level 3.
- The Executive Committee AGREED to mobilise an Executive Oversight Group (EOG) to manage the Level 3 escalation period and CONSIDERED the reporting schedule of the EOG (with monthly updates to the Executive Committee to provide wider oversight and assurance).

Future Reporting and Assurance
Monthly updates will be provided to the Executive Committee together with updates to each meeting of the Patient Experience, Quality and Safety Committee.

IMPACT ASSESSMENTS – 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					Impact assessments have been undertaken for each proposal and accompany this paper.
Timely					
Effective					
Efficient					
Equitable					
Person Centred					
Workforce					
Leadership					
Culture					
Information					
Learn, Improve, Research					
Whole Systems Approach					

EQUALITY:

	No impact	Negative	Positive	Both	
Age					Impact assessments have been undertaken for each proposal and accompany this paper.
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				
	Very Low (0-3)	Low (4-8)	Moderate (9-12)	High (15-25)	
Clinical					Impact assessments have been undertaken for each proposal and accompany this paper.
Financial					
Corporate					
Operational					
Reputational					

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Agenda item: 5.1

PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE	**07 NOVEMBER 2024**
Subject:	**Integrated Quality Report: Quarter 2**
Approved and presented by:	Claire Roche, Executive Director Nursing, Quality, Women & Family Health
Prepared by:	Heidi Sinclair, Head of Quality and Safety
Other Committees and meetings considered at:	Executive Committee - 30 October 2024.

PURPOSE:

The purpose of this report is to provide the Patient Experience, Quality and Safety Committee with an overview of the Quality and 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	
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	

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. With the pilot now complete, PTHB will continue to build services into the risk register functionality, which requires an organisational hierarchy to be created. It is hoped that all services will be on the risk register by Summer 2025.

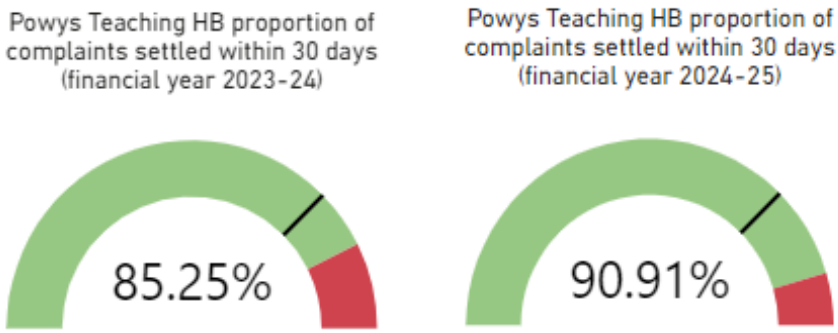
All Mortality reviews are now recorded on RL Datix, this is in line with the reporting/review of all community deaths coming into effect since September 2024

2.2 Putting Things Right – Concerns

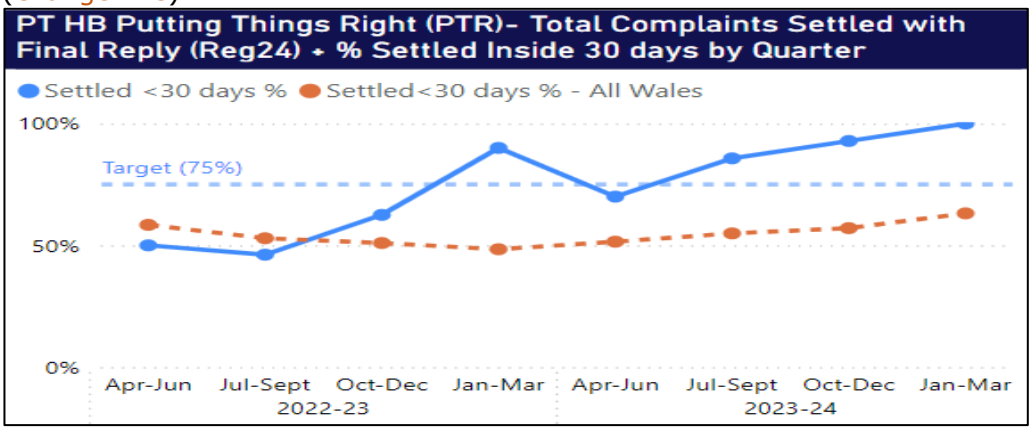
The management of concerns compliance within 30 working days reported nationally at the end of 2023/24 is 85.25% (2nd position nationally) which is a significant improvement 2022-23 of 57.65% and 2021/22 of 27.5% (worst performing health board). There is continued focus to ensure that we maintain our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

The reported compliance for Q2 2024/25 is 75%.

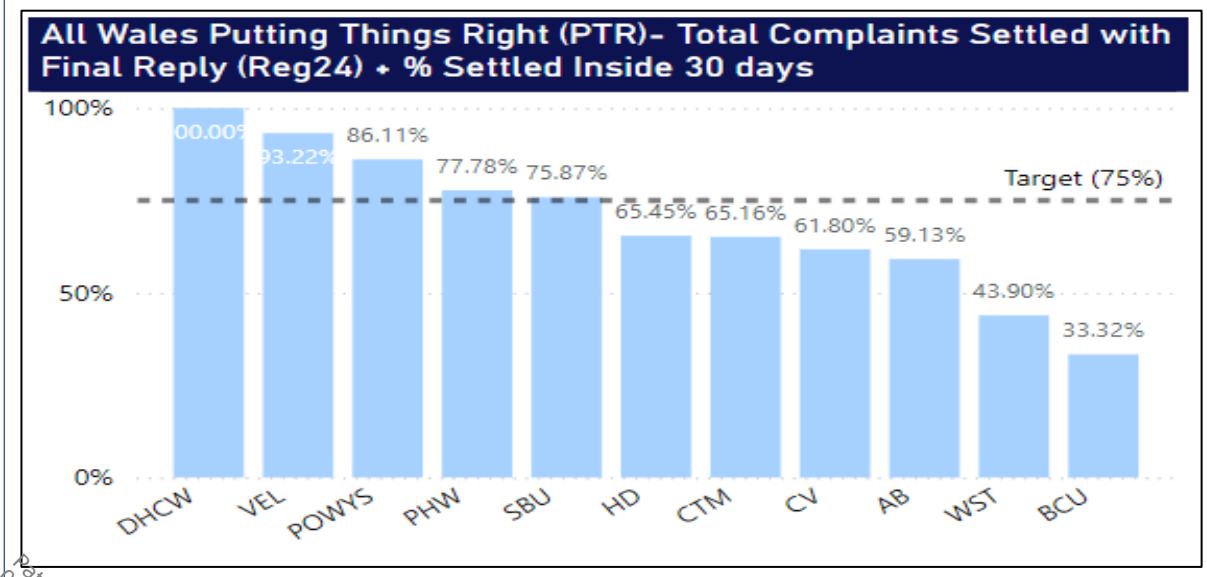
Graph 1 compares compliance 2023/24 with 2024/25 (Data obtained from NHS Executive Beacon Dashboard)



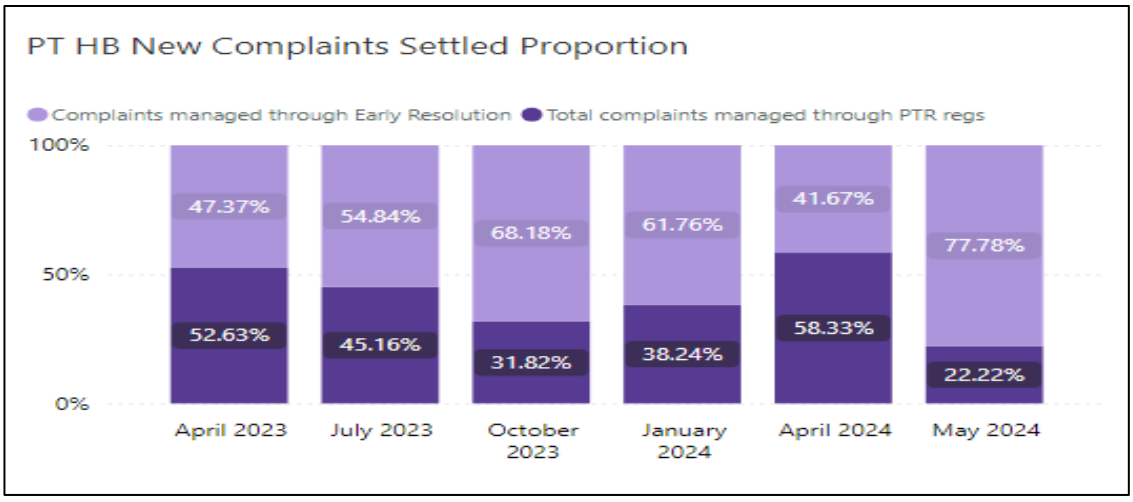
Graph 2 highlights the Powys quarterly compliance (blue line) against the national position (Orange line).



Graph 3 presents the Health Board position nationally (Data obtained from NHS Executive Beacon Dashboard).



Graph 4 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 issues
- Clinical treatment and assessment
- Attitude and behaviour
- Appointments

Themes from concerns (commissioning)

- Access (to services)
- Appointments
- Referrals

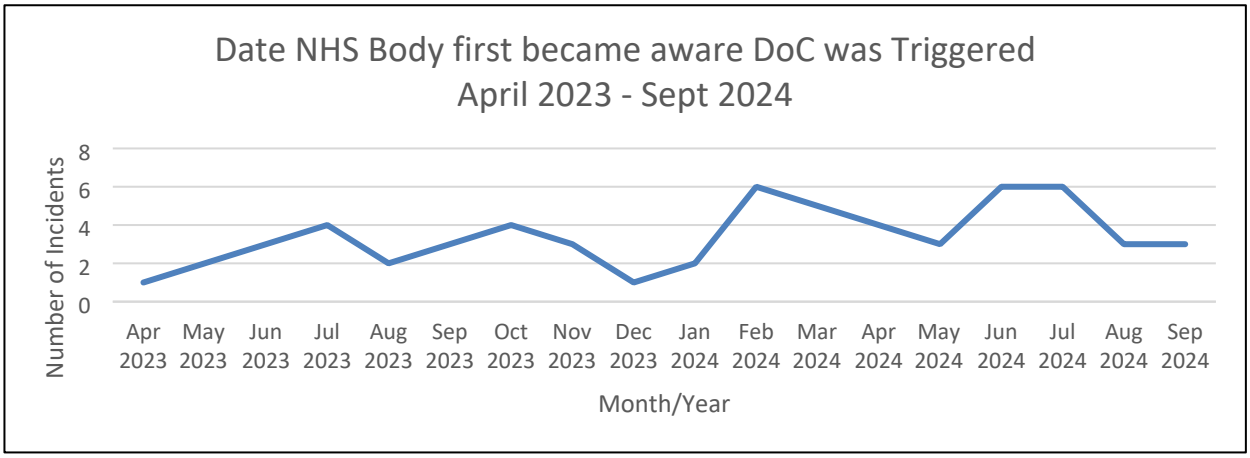
Themes from Early Resolution/Enquiries

- Communication issues
- Clinical treatment and assessment
- Attitude and behaviour

2.3 Duty of Candour

There have been 12 Duty of Candour cases during Q2 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.

Graph 5 numbers of reported Candour cases since implementation



Learning from Duty of Candour

- Education on post falls observations protocol
- Falls risk assessments must be updated as risk change.
- Where appropriate Deprivation of Liberty assessments are kept up to date.
- Up to date training on fracture management.
- Review of Orthopaedic pathway from MIU to DGH

2.4 Claims, Redress & Clinical Negligence Position

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

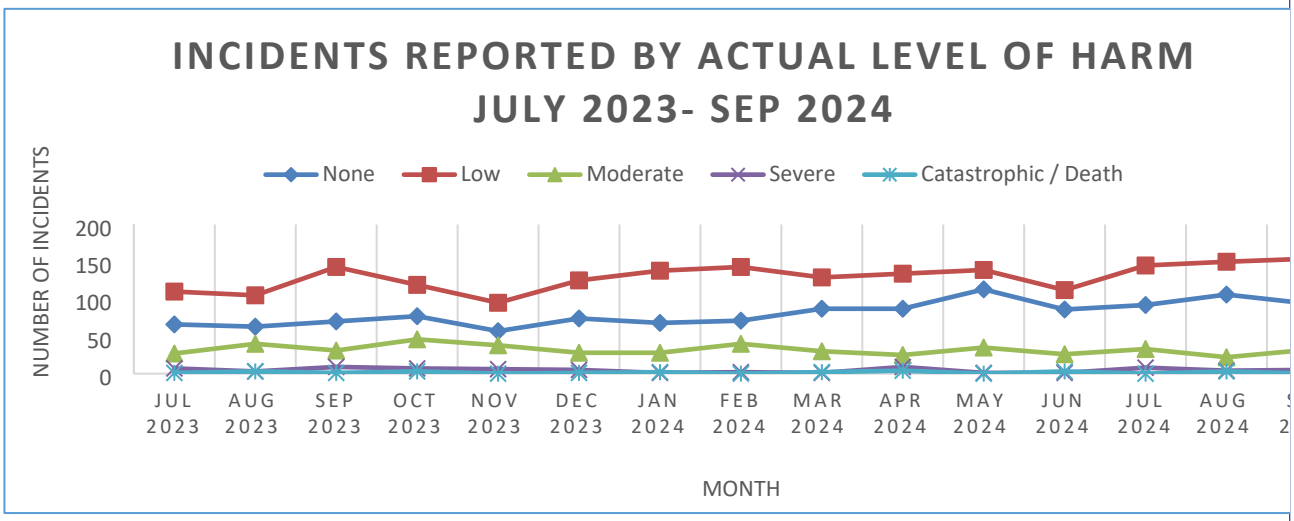
Clinical Negligence
9 confirmed cases

General Medicine Practice Indemnity (GMPI) Claims
4 confirmed cases

2.5 Incident Management

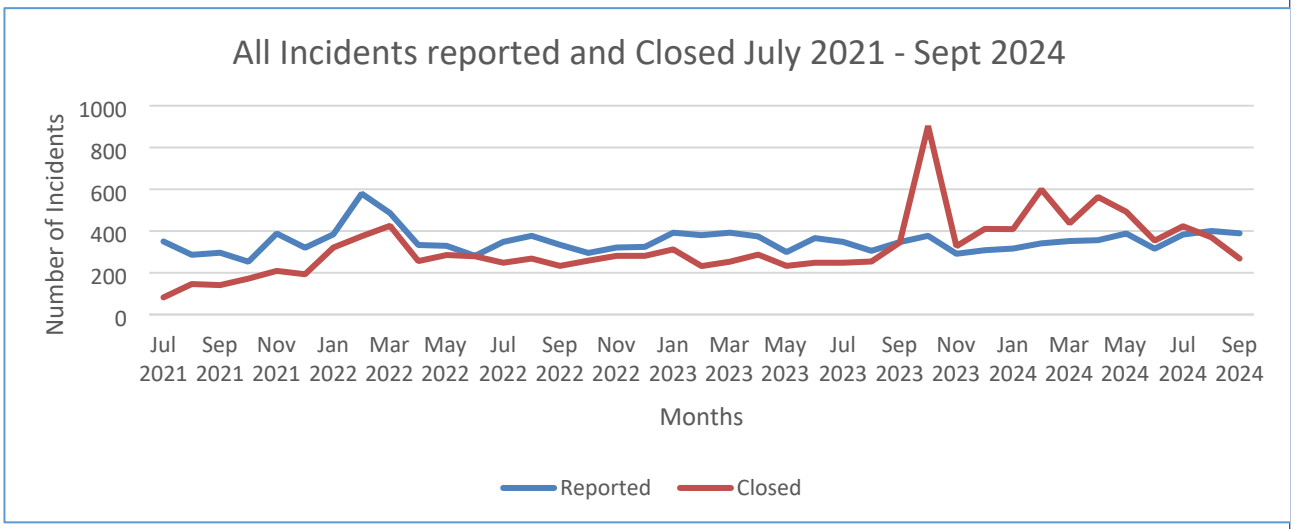
The number of patient safety incidents (Graph 6) reported is stable and appropriate with most incidents reported within the Low and No Harm classification.

Graph 6 Incidents Reported by Actual Level of Harm July 2023-Sept 2024



Improvements have been realised with regards to the timely investigation and closure of incidents. It is visible in Graph 7 below that the number of incidents closed has dipped in September 2024, however, proactive and supportive measures continue with incident position emails to service leads on a weekly basis, with particular emphasis on moderate and above incidents that trigger Duty of Candour.

Graph 7: Data source Datix



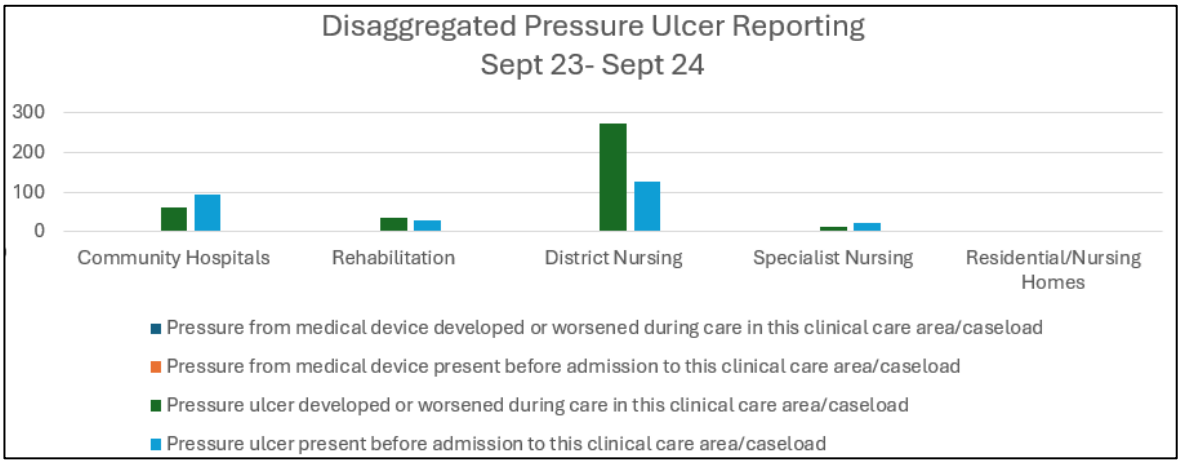
2.6 Management of Incidents reported with Pressure Ulcers/Damage

All pressure incidents are reported and investigated to ensure all care and measures to reduce the occurrence of pressure areas are taken. These incidents are reviewed at 'Pressure Panel' with a multi-disciplinary team in attendance which includes Tissue Viability Nurse (TVN), Safeguarding

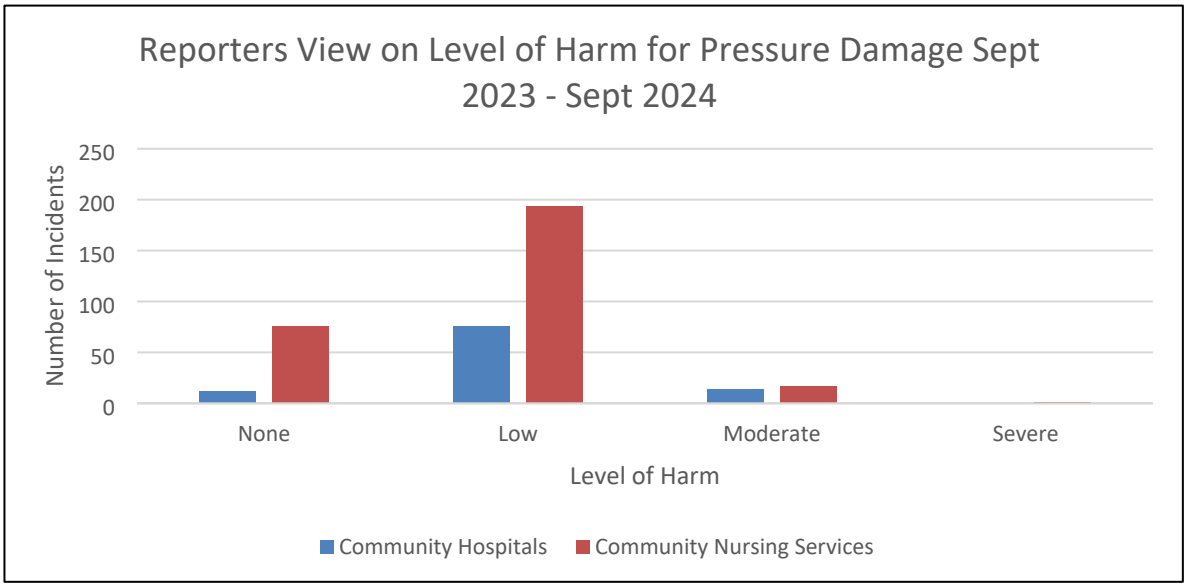
representation, district and hospital nurses along with student nurses. The meeting is chaired by a Clinical Service Manager.

It has been noted that there were a high number of elderly frail residents with multiple comorbidities.

Graph 8 Disaggregated Pressure Ulcer (PU) reporting Sept '23 to September '24



Graph 9 Reporters View on Level of Harm for Pressure Damage Sept 2023-Sept 2024



Graph 8 shows that District Nursing (Community Nursing Services) reports higher rates of PUs that worsen during the period of contact and also PUs present before allocation to caseload. The District Nurses have the highest population of frail and older adults, pans Powys, resulting in this being the service group that will inevitably report higher rates of deterioration of PUs at home and also new patients to caseload where the patient has not previously been known to service and the PU has just been identified. Graph

9 indicates reporters level harm at the time of the incident. Following the managers incident review, 49% of Community Nursing Services during the period were downgraded.

Learning from PU Scrutiny panels Sept 23 – end Feb 24

- Team communication
- Accurate record keeping
- Wound photographs
- Use of pressure ulcer passports
- Timely completion of risk assessments

2.7 Early Warning Notifications (previously No surprises notifications)

8 Early Warning Notifications have been submitted during Q2 2024/2025.

2.8 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 as currently 83.3% of investigations remain open for >90 working days with the average completion time of 186days (the All Wales median is 132days), 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
16	**6**	**10**	**3**

- No NRIs have been closed during Q2.

2.9 Public Service Ombudsman of Wales (PSOW) Annual report (Appendix 1)

From the 21 cases referred to PSOW, the following themes were noted:

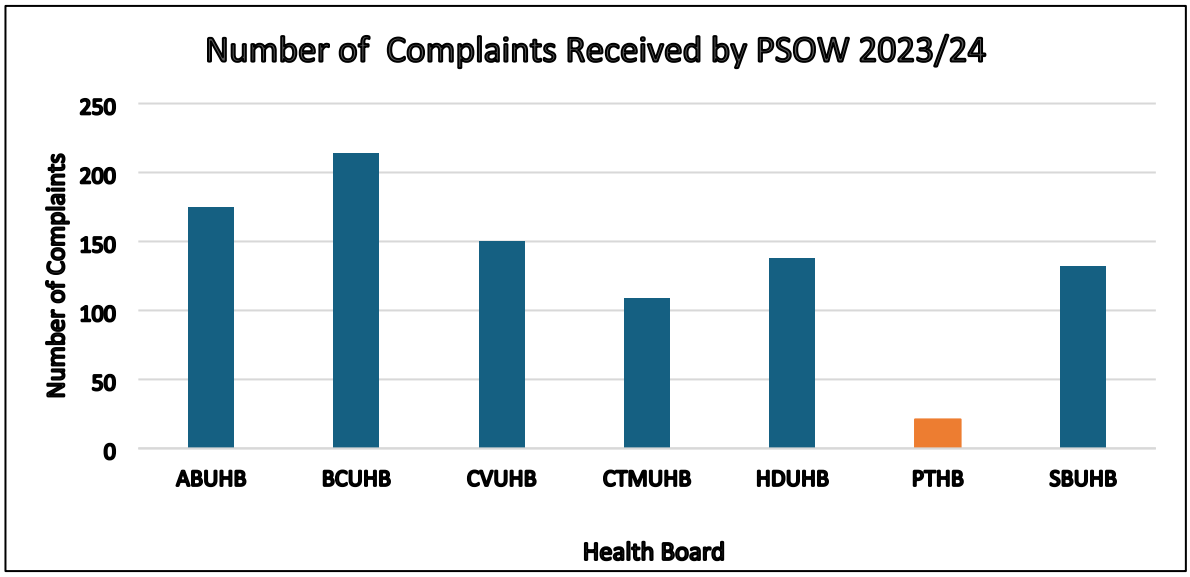
- 4 - Adult Mental Health Services
- 8 - clinical treatment in hospital
- 3 – clinical treatment outside of hospital
- 2 – complaints handling

- 1 – funding
- 1 – poor/no communication or failure to provide information
- 1 - other

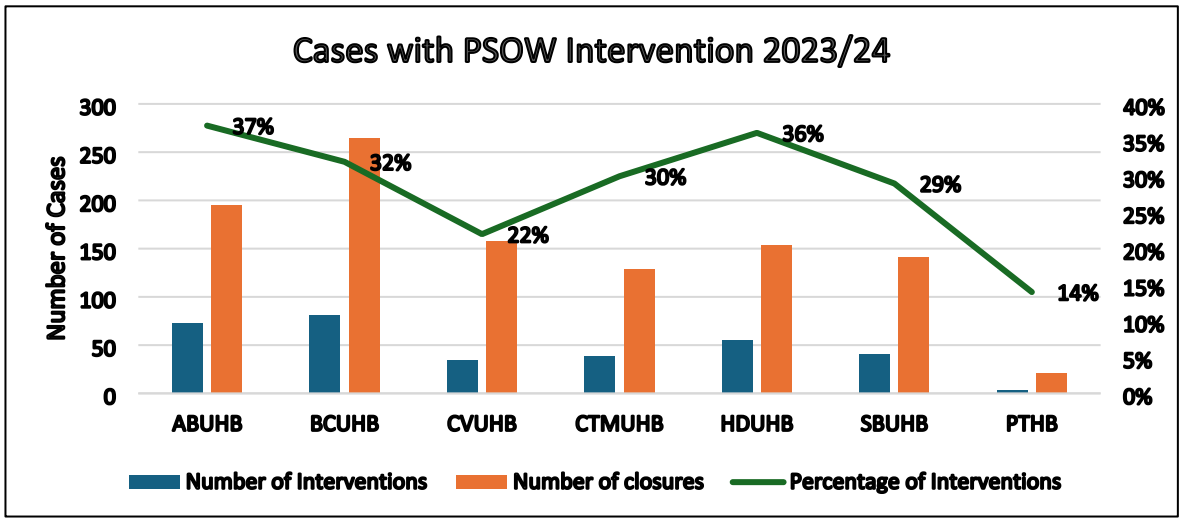
Following PSOW intervention, the following actions have been taken:

1. Clear and robust communication plans will be made with individuals awaiting findings of retrospective continuing health care reviews.
2. New scheduling system embedded.
3. In the event of no access during a community visit, the visit should be rescheduled, and staff should check the patient's medical documentation
4. A GP practice has reviewed the wording of their correspondence.
5. Those investigating concerns should be independent of the care.

Graph 10 shows the national position of complaints received by PSOW



Graph 11 shows the percentage of cases where PSOW intervened



3. Patient Experience

3.1 CIVICA

Your NHS Experience survey is available for all patients that have accessed healthcare. Graph 10 demonstrates the feedback available Q1 and 2 2024-2-25. A system issue, resulting in surveys not being correctly mapped has now been resolved. This means that there is a variation in data reported for Q1 2024/2025 since the last report. 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 12 – Source CIVICA

Question:	Survey	2024 Apr	2024 May	2024 Jun	2024 Jul	2024 Aug	2024 Sept	2024 Oct	Benchmark
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	85	89	86	68	35	71	100	85
4. From the time you realised you needed to use this service, was the time you waited:	Your NHS Wales Experience	45	39	44	-	-	25	-	85
5. Did you feel well cared for?	Your NHS Wales Experience	71	70	66	53	35	63	100	85
6. If you asked for assistance, did you get it when you needed it?	Your NHS Wales Experience	86	89	86	65	40	71	100	85
7. Did you feel you understood what was happening in your care?	Your NHS Wales Experience	81	85	86	63	25	65	100	85
8. Were things explained to you in a way that you could understand?	Your NHS Wales Experience	86	86	87	72	40	75	100	85
9. Were you involved as much as you wanted to be in decisions about your care?	Your NHS Wales Experience	90	87	89	67	40	65	100	85
10. How would you rate your experience 1-10	Your NHS Wales Experience	85	85	86	67	40	75	100	85
Overall:		86	86	87	69	34	68	100	85
Respondents:		83	84	83	65	36	68	100	
		131	215	210	10	5	6	1	

Graph 13 maps specific response to during Q1 and Q2 2024/2025.

Services	Responses	2 - Did you feel that you were listened to?	3 - Were you able to speak in Welsh to staff if you needed to?	4 - From the time you realised you needed to use this service, was the time you waited:	5 - Did you feel well cared for?	6 - If you asked for assistance, did you get it when you needed it?	7 - Did you feel you understood what was happening in your care?	8 - Were things explained to you in a way that you could understand?	9 - Were you involved as much as you wanted to be in decisions about your care?	10 - How would you rate your experience 1-10	Overall
		Your NHS Wales Experience	Your NHS Wales Experience	Your NHS Wales Experience	Your NHS Wales Experience	Your NHS Wales Experience	Your NHS Wales Experience	Your NHS Wales Experience	Your NHS Wales Experience	Your NHS Wales Experience	
General Practice (GP)	17	29	88	24	31	21	33	38	33	28	31
Hospital site other than a Powys Hospital	537	88	41	69	88	85	87	88	86	87	84
Hospitals and services outside Powys	3	8	-	8	17	33	0	75	75	10	23
Pharmacy	1	100	-	75	100	100	-	-	-	-	94
Powys Hospital	6	92	-	75	92	94	92	83	83	87	87
Powys Services	13	98	25	83	98	91	98	100	98	97	93
	Overall	**86**	**42**	**68**	**86**	**83**	**86**	**87**	**85**	**85**	**83**
	Benchmarks	**85**	**85**	**85**	**85**	**85**	**85**	**85**	**85**	**85**	

Graph 14 is a wordle of the most used words within the 'free text' system Q1 and Q2 2024/2025. Negative words are coloured in red with positive words in green.

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 & Q2 2024/25. A current Health Board position on patient experience in line with the National framework will be presented at Executive Committee on 30/10/2024.

4. Infection Prevention and Control (IP&C)

The IPC Improvement plan is 93% complete, with final completion targeted by the end of Q3 2024/25. An Anti-Microbial Stewardship (AMS) pharmacist will join the team in October 2024 to support ongoing initiatives and improvement plans.

Year two objectives are agreed as part of the IPC improvement plan, which was presented to PEQS committee in July 2024 along with the annual report:

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 unavoidable/healthcare associated onset Clostridioides difficile infections across the Health Board, with the aim of a reduction on 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.

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 2023. On the tracker, there are 20 actions still outstanding despite a request of services to be pragmatic around decisions to close actions. Focus on closure will be via the Integrated Quality Performance Framework

Graph 15 Historical Inspections 2017-2020

Historical Inspections up to September 2023

Ref	Inspection Title	Recommendations Made / Actions	Recommendations / Actions Complete	Recommendations / Actions Overdue (agreed timescale)	Overdue Recommendations / Actions Revised Timescale	Recommendations / Actions Not Yet Due	All recommendations / Actions implemented
Mental Health							
212202	Tier 1 Quality Check Clywedog Ward, Llandrindod Wells	2	1		1		
212215	HIW Announced Inspection of community mental health services	55	47	6	2		
222307	HIW Tawe Ward Unannounced Inspection	26	23		3		
232401	HIW All Wales Review of discharge arrangements in Mental Health	40	34		3	3	
Wards							
232402	HIW Inspection Epynt and Y Bannau Wards, Brecon Hospital	99	97		2		
GRAND TOTAL		222	202	6	11	3	

Actions since 2023/2024 to date:

There are currently 19 actions open outside of the HIW timescale across Community Services, CAMHS, Mental Health, Patient Flow along with a review for DNACPR.

Graph 16 Current Open Actions from External Inspections

NEW Process including inspections from October 2023					
Ref	Inspection Title	Recommendations Made / Actions	Recommendations / Acctions Complete	Recommendations /a Actons Paritally complete or overdue (agreed timescale)	All recommendations / Actions implemented
Mental Health					
	CMHT Newtown				
Wards					
232403	HIW Inspection Graham Davies Ward	31	27	4	
232404	HIW Inspection of Brynheulog Ward	15	12	3	
National Reviews - Improvement Plans					
232405	HIW National Review of CAMHS	Outcome of national review awaited			
232406	HIW National Review of Patient Flow	9 Recommendations requiring further information	8	1	
242501	HIW National Review MH Crisis Prevention	19	12	7	
242502	HIW National Review DNACPR - further updates requested	16	12	4	
		90	71	19	

6 Llais

In August 2024, Llais published their report into their locality engagement in Brecon (**Appendix 5**). Key messages from this report included:

- **Praise for services within Powys and outside of the county**. Llais very positive feedback about many health and social care services provided locally in the area and in hospitals outside the area.
- **Accessing services was often challenging**. Llais heard many comments about the difficulty accessing appointments at Brecon Medical Group Practice. Llais heard about being unable to obtain NHS dental services; waiting times for planned care; concerns about travel and transport to services, especially for people who do not have their own vehicle.
- **Need for better communication**. People told Llais that they often had difficulty obtaining the results of their diagnostic tests. Llais heard about the impact that lack of communication following referral has on patients. There were also comments about difficulties in sharing information between services and with patients or their GPs. This problem was worsened when accessing services across the border in England.

- **Need for better support for mental health and well-being.** Llais heard reports of people waiting a long time following a referral for counselling. Some people said they would like more outreach support to help them at home. We also heard about the impact that loneliness and isolation have on people's well-being. Llais noted that there needs to be better awareness of the ChatHealth service that is available for children and young people.
- **Workforce issues and capacity.** Llais heard about the impact that the shortage of staff in some services has on people. Services highlighted were in social work, care work and specialist services such as neurology.

Powys Teaching Health Board have worked closely with Llais during this quarter. The draft Llandrindod Wells & Rhayader locality report was shared with us in August ahead of the locality workshop on 6 September and engagement also took place in Machynlleth during the quarter, with the locality workshop being held on 29 October. We await the publication of these reports as they are an invaluable source of information and intelligence that supports us to improve our services.

7 PAVO

No reports provided for reporting period.

8 Bereavement Framework

The Bereavement Lead has been completing the objectives of the National Bereavement Framework (NBF). The NBF sets out how in Wales we can respond to those who are facing, or have experienced, a bereavement. The framework includes core principles, minimum bereavement care standards and a range of actions to support regional and local planning. The Bereavement Support Grant for third sector organisations has been extended and 21 organisations will continue to receive funding until 31 March 2025. In addition, the £420k (£60k each) bereavement co-ordination funding has been embedded into the health board NHS core allocations and is now available on a recurrent basis. This has enabled PTHB to recruit a whole time equivalent Bereavement Lead into post in April 2024. PTHB must embed the principles of the framework and the national bereavement pathway in strategic plans, spending policies and decisions to help ensure that everyone in the locality who has been bereaved knows that help is there for them. This is done through reporting on the NBF on a bi-annual basis. For the period 01/04/2024-30/09/2024 the following highlights include:

- Establishing the Medical Examiner and Mortality Review process.
- Developing feedback tools within CIVICA for families/NOK and staff
- Establishing a PTHB intranet page of resources for staff and a public facing page of resources.
- Child Bereavement training delivered in September 24 and October 24.

- Exploring the development of Bereavement Champions.
- Pathways for 18-25 year olds are being established through charities; 2 Wish, Papyrus and Rekindle by developing Youth Bereavement Groups.
- Supporting staff following grief/trauma through a joint project with the Postvention Service.
- The PTHB Bereavement Pack has been ratified for print.

NEXT STEPS:

Key Matters for Board/Committee

1. 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 and 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.

2. Ensure the required support and resource is available to support the Patient Experience priorities and agenda.
   ACTION taken: Patient experience has been a key focus for the Health Board during Q1 and Q2. The Head of Quality and Safety has undertaken a national scoping exercise to understand the Health Board requirements in terms of development and needed resources in line with the National Patient Experience Framework.

Appendix 1: PSOW Annual Review 2023/24	See Item 5.1a
Appendix 2: Joint Commissioning Committee Agenda Sept 2024 Quality and Patient Safety Committee Report	See Item 7.1a
Appendix 3: Quality and Patient Safety Committee – Service in Escalation Presentation Sept 2024	See Item 7.1b
Appendix 4: WHC(2024)036 - Oxygen Cylinders - Regulation 28 report and Patient Safety Notice (PSN) 041	See Item 5.1b
Appendix 5: Llais – Brecon Executive Summary Report	See Item 5.1c

IMPACT ASSESSMENT – NOT REQUIRED FOR THIS REPORT

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

Ombwdsmon
Ombudsman
Cymru • Wales

Ask for: Communications
01656 641150
Caseinfo@ombudsman.wales

Date: 9 September 2024

Carl Cooper
Powys Teaching Health Board

By email only
carl.cooper@wales.nhs.uk
Hayley.Thomas@wales.nhs.uk

Annual Letter 2023/24

Dear Carl

Role of PSOW

As you know, the role of the Public Services Ombudsman for Wales is to consider complaints about public services, to investigate alleged breaches of the councillor Code of Conduct, to set standards for complaints handling by public bodies and to drive improvement in complaints handling and learning from complaints. I also undertake investigations into public services on my own initiative.

Purpose of letter

This letter is intended to provide an update on the work of my office, to share key issues for health boards in Wales and to highlight any particular issues for your organisation, together with actions I would like your organisation to take.

Overview of 2023/24

This letter, as always, coincides with my Annual Report – "A New Chapter Unfolds" – and comes at a time when public services continue to be in the spotlight, and under considerable pressures. My office has seen another increase in the number of people asking for our help – a 17% increase in overall contacts compared to the previous year, with nearly 10,000 enquiries and complaints received. Our caseload has increased substantially - by 37% - since 2019.

ombwdsmon.cymru
holwch@ombwdsmon.cymru
0300 790 0203
1 Ffordd yr Hen Gae, CF 35 5LJ
Rydym yn hapus i dderbyn ac ymateb i ohebiaeth yn y Gymraeg.

ombudsman.wales
ask@ombudsman.wales
0300 790 0203
1 Ffordd yr Hen Gae, CF 35 5LJ
We are happy to accept and respond to correspondence in Welsh.

During 2023/24 we considered and closed more enquiries and complaints than we ever have done before, and we reduced the average cost for each case and investigation. We started the year with a focus on reducing our aging cases, those over 12 months old, by 50% by the end of the year. These cases are often the most complex and distressing for the people making the complaint. I am extremely pleased to say we exceeded this target, reducing our aged investigations by over 70%. We are now well on track to meeting our objective to complete investigation of complaints within 12 months.

Public Service Complaints and compliance with recommendations

We received 939 complaints about health boards last year – roughly the same number as the previous year. During this period, we intervened in (upheld, settled or resolved at an early stage) 31% of health board complaints - a similar proportion to previous years.

Last year, we received 21 complaints about Powys Teaching Health Board, we closed 21, and intervened in 14% of cases. Further information on the complaints we dealt with last year can be found in the appendices.

In total, we made 10 recommendations to your health board during the year. To ensure that our investigations and reports drive improvement, we follow up compliance with the recommendations agreed with your organisation. In 2023/24, 12 recommendations were due (some recommendations were made in the previous year) and 67% were complied with in the timescale agreed. The remainder were complied with, but outside the timescales agreed, or remained outstanding as at 9 April 2024.

Recommendations and timescales for complying with recommendations are always agreed with the public body concerned before being finalised, and we therefore expect organisations to comply within the timescales agreed.

Further to the report my office issued in June 2023, Groundhog Day 2: An opportunity for cultural change in complaint handling? I wish to thank the Health Board for its consideration of the report and recommendations. I trust that it has ensured that lessons learned from the PSOW's findings and recommendations on cases we considered last year are included in your Health Board's Annual Report on the Duty of Candour and Quality.

Supporting improvement of public services

We continued our work on supporting improvement in public services last year and worked on our second wider Own Initiative investigation. The investigation considers carers' needs assessments undertaken by local authorities in Wales. My report on this work will be finalised report and published in the near future.

We have continued our work on complaints handling standards for public bodies in Wales and now have 56 public bodies following our model complaints handling policy. These public bodies account for around 85% of the complaints we receive.

We continued our work to publish complaints statistics into a third year with data, gathered from public bodies, now published twice a year. This data allows us to see information with greater context – for example, last year 14% of complaints made to Powys Teaching Health Board's complaints went on to be referred to PSOW. I would encourage all health boards to use this data to better understand their performance on complaints and ensure that all complaints are appropriately logged.

Action we would like your organisation to take

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

- Present my Annual Letter to the Board at the next available opportunity and notify me of when these meetings will take place.

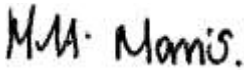
- Consider the data in this letter, alongside your own data, to understand more about your performance on complaints, including any patterns or trends and your organisation's compliance with recommendations made by my office.

- Provide my office with a copy of the Health Board's Annual Report for 2023/24 on the Duty of Candour and Quality.

- Inform me of the outcome of the Board's considerations and proposed actions on the above matters at your earliest opportunity.

Finally, I would like to thank you, and your teams, for your work with my officers in the last year. Their work is important in ensuring that patients and families receive timely and thorough responses to complaints, and in improving outcomes for all service users – not just those who complain.

Yours sincerely,



Michelle Morris
Public Services Ombudsman

Cc. Hayley Thomas, Chief Executive, Powys Teaching Health Board

Ombwdsmon
Ombudsman
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Factsheet

Appendix A - Complaints Received

Health Board	Complaints Received	Received per 1,000 residents
Aneurin Bevan University Health Board	175	0.30
Betsi Cadwaladr University Health Board	214	0.31
Cardiff and Vale University Health Board	150	0.30
Cwm Taf Morgannwg University Health Board	109	0.25
Hywel Dda University Health Board	138	0.36
Powys Teaching Health Board	21	0.16
Swansea Bay University Health Board	132	0.35
Total	939	0.30

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Appendix B - Received by Subject

Powys Teaching Health Board	Complaints Received	% share
Admissions/discharge and transfer procedures	0	0%
Adult Mental Health	4	2%
Ambulance Services	0	0%
Appointment procedures (including outpatients)	0	0%
Child and Adolescent Mental Health	0	0%
Clinical treatment in hospital	8	38%
Clinical treatment outside hospital*	3	14%
Complaints Handling	2	10%
Covid-19	0	0%
Continuing care	0	0%
De-Registration	0	0%
Disclosure of personal information / data loss	0	0%
Funding	1	5%
Independent Health Care providers	0	0%
Medical records/standards of record-keeping	0	0%
Medication > Prescription dispensing	0	0%
Non-medical services	0	0%
Nosocomial*	0	0%
Other*	1	5%
Out of Hours GP care	0	0%
Parking (including enforcement and bailiffs)	0	0%
Patient list issues	0	0%
Poor/No communication or failure to provide information	1	5%
Prisoner Care	0	0%
Recruitment and appointment procedures	0	0%
Referral to Treatment Times	0	0%
Regulation and Inspection (including private sector provision)	0	0%
Rudeness/inconsiderate behaviour/staff attitude	0	0%
Services for people with a disability inc DFGs	0	0%
Service for vulnerable Adults (eg with learning difficulties or mental health issues)	0	0%
Total	**21**	

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Appendix C - Complaint Outcomes
(* denotes intervention)

Powys Teaching Health Board		**% Share**
Out of Jurisdiction	7	33%
Premature	2	10%
Other cases closed after initial consideration	8	38%
Early Resolution/ voluntary settlement*	1	5%
Discontinued	0	0%
Other Reports - Not Upheld	1	5%
Other Reports Upheld*	2	10%
Public Interest Reports*	0	0%
Special Interest Reports*	0	0%
Total	**21**	

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Appendix D - Cases with PSOW Intervention

	No. of Interventions	No. of Closures	% of Interventions
Aneurin Bevan University Health Board	73	195	37%
Betsi Cadwaladr University Health Board	81	256	32%
Cardiff and Vale University Health Board	34	158	22%
Cwm Taf Morgannwg University Health Board	39	129	30%
Hywel Dda University Health Board	55	154	36%
Powys Teaching Health Board	3	21	14%
Swansea Bay University Health Board	41	141	29%
Total	**326**	**1054**	**31%**

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Appendix E – Compliance performance comparison

Health Board	Number of recommendations made in 2023-24	Number of Recommendations falling due in 2023-24	% of recommendations, complied with on time
Aneurin Bevan University Health Board	209	208	75%
Cardiff and Vale University Health Board	104	95	81%
Cwm Taf Morgannwg University Health Board	123	121	60%
Swansea Bay University Health Board	119	127	62%
Hywel Dda University Health Board	160	151	81%
Betsi Cadwaladr University Health Board	253	246	58%
Powys Teaching Health Board	10	12	67%

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Information Sheet

Appendix A shows the number of complaints received by PSOW for all Health Boards in 2023/24. These complaints are contextualised by the number of people each health board reportedly serves.

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

Appendix C shows outcomes of the complaints which PSOW closed for the Health Board in 2023/24. This table shows both the volume, and the proportion that each outcome represents for the Health Board.

Appendix D shows Intervention Rates for all Health Boards in 2023/24. An intervention is categorised by either an upheld complaint (either public interest or non-public interest), an early resolution, or a voluntary settlement.

Appendix E shows compliance performance for all Health Boards.

Oxygen Cylinders –

Risk of death if used incorrectly

7 Minute Briefing

September 2024

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

1) What are the concerns

Patients are continuing to die in NHS hospitals due to oxygen cylinders not being used correctly.

Valves on cylinders must be opened correctly to allow oxygen to flow for administration and they must be closed when a cylinder is not in use to reduce fire risk.

PSN041, Risk of death and severe harm from failure to obtain and continue flow from oxygen cylinders harm, was issued in March 2018 – evidence suggests that the recommendations in this PSN have not been fully implemented.

The key concerns relate to:

- Training (theory and practical) for staff who handle and/or use medical gases.
- Incident reporting and learning

2) Recent national reports

In May 2024 a Regulation 28, Prevention of future deaths report was published after the death of a patient in a Welsh health board following the incorrect use of oxygen cylinders during a resuscitation attempt. Failure to open one of the cylinder valves meant that no oxygen was administered to the patient.

On 30th August 2024 directions to improve safety were issued to health boards via WHC/2024/036.

3) Training requirements for staff who handle and/or use medical gases

All staff who handle and/or use medical gases are required to undertake annual on-line medical gases training, accessible via ESR: '000 The safe use, storage and set up of medical gases and cylinders'.

All staff who use oxygen cylinders are required to undertake the free BOC oxygen integral valve cylinder e-learning course. The course should be undertaken annually, and a record of completion retained.

Staff should practice using medical gas cylinders with a peer on a regular basis.

Written guidance on using medical oxygen integral valve cylinders can be accessed via the SPS website.

Staff must understand how long the oxygen in a cylinder will last according to the cylinder size, contents and flow rate. Download poster

4) Incident and near miss reporting

ALL staff who handle and/or use medical gases have a duty to report ALL safety incidents and near misses relating to medical gases.

Reporting should be made via:

- Datix and/or
- Yellow Card reporting (where appropriate)

Reporting allows lessons to be learned and shared to improve the safety of our patients and our staff.

5) Role of the Medical Gases Governance Group

The Medical Gases Governance Group is responsible for:

- Developing the action plan and monitoring implementation of all recommendations detailed in WHC/2024/036 and PSN041.
- Reviewing patient safety incident themes and identify any areas for Improvement, learning and escalation via board governance.

6) Action for clinical teams

- Discuss this 7 minute briefing at team meetings to ensure that everyone is aware of the concerns and the actions required.
- Ensure that all staff who use and/or handle medical gases have completed the on-line medical gases training (ESR: '000 The safe use, storage and set up of medical gases and cylinders'. NB: This is an annual requirement.
- Ensure that all staff who use oxygen cylinders have completed the free BOC oxygen integral valve cylinder e-learning course. NB: Annual requirement.
- Ensure that staff have regular opportunities to practice using medical gas cylinders.
- Ensure that robust training records are maintained.
- Ensure that staff understand how long an oxygen cylinder will last. Download and display the duration poster.
- Ensure that all members of the clinical team understand the requirement and importance of reporting incidents relating to medical gases, including near misses.

7) What next?

Work is being undertaken to map locations where oxygen cylinders are stored and used across PTHB.

Laminated 'how to use' guides will be prominently displayed next to 'ready to use' portable oxygen cylinder stores, by the pharmacy team, in all clinical areas

Work is being undertaken by the Medical Gases Governance Group to:

- Improve reporting and learning from incidents and near misses relating to medical gases.
- Monitor completion of on-line medical gases training (ESR: '000 The safe use, storage and set up of medical gases and cylinders').
- Make recommendations to improve access to practical, hands-on training for all staff who use oxygen cylinders.
- Establish robust training records for both on-line and face to face training.

Adapted from 7 minute briefing template created by HDUHB

LLAIS
Eich llais mewn iechyd a gofal cymdeithasol | Your voice in health and social care

LLAIS POWYS REGION

WHAT WE'VE HEARD IN POWYS

Community Focused Engagement in Brecon Locality

April 2024

Executive Summary

ACCESSIBLE FORMATS

This report is also available in Welsh.

If you would like this publication in an alternative format and/or language, please contact us.

You can download it from our website or ask for a copy by contacting our office.

ABOUT LLAIS

We believe in a healthier Wales where people get the health and social care services they need in a way that works best for them.

We are here to understand your views and experiences of health and social care, and to make sure your feedback is used by decision-makers to shape your services.

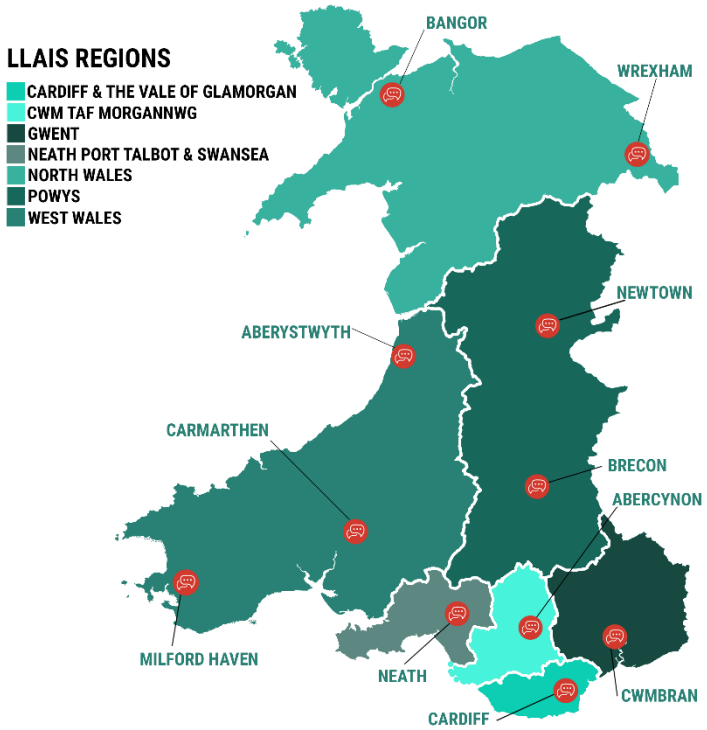
We seek out both good and bad stories so we understand what works well and how services may need to get better. And we look to particularly talk to those whose voices are not often heard.

We also talk to people about their views and experiences by holding events in your local communities or visiting you wherever you're receiving your health or social care service.

We also work with community and interested groups and in line with national initiatives to gather people's views.

And when things go wrong we support you to make complaints.

There are 7 Llais Regions in Wales. Each one represents the "patient and public" voice in different parts of Wales.



EXECUTIVE SUMMARY

During the month of April 2024, Llais Powys engaged with the community of Brecon and the surrounding area, to understand people's experiences of health and social care services. This included various methods of engagement such as surveys, joining various groups and organisations for face-to-face discussion, visiting premises where health and care services are provided and talking to people at community events. We also hosted a free coffee morning for people to come along to chat with us. We spoke to people of different ages and with different health and care needs.

KEY FINDINGS

1. **Praise for services within Powys and outside of the county.**
   We received very positive feedback about many health and social care services provided locally in the area and in hospitals outside the area.

2. **Accessing services was often challenging.**
   We heard many comments about the difficulty accessing appointments at Brecon Medical Group Practice. We also heard about being unable to obtain NHS dental services; waiting times for planned care; concerns about travel and transport to services, especially for people who do not have their own vehicle.

3. **Need for better communication.**
   People told us that they often had difficulty obtaining the results of their diagnostic tests. We heard about the impact that lack of communication following referral has on patients. There were also comments about difficulties in sharing information between services and with patients or their GPs. This problem was worsened when

accessing services across the border in England.

4. **Need for better support for mental health and well-being.**
   We heard reports of people waiting a long time following a referral for counselling. Some people said they would like more outreach support to help them at home. We also heard about the impact that loneliness and isolation have on people's well-being. We noted that there needs to be better awareness of the ChatHealth service that is available for children and young people.

5. **Workforce issues and capacity.**
   We heard about the impact that the shortage of staff in some services has on people. Services highlighted were in social work, care work and specialist services such as neurology.

ACTIONS TAKEN

We are working closely with Powys Teaching Health Board and Powys County Council to ensure that they understand what people think about health and social care services and can make improvements to services where they are needed.

Once we had drafted the report outlining what we heard, we held a joint workshop with the Health Board, County Council and Powys Association of Voluntary Organisations. The aim of the session was to highlight some of the main themes, discuss areas of work which are already underway, and to jointly identify some actions which will be taken.

The following actions were agreed:

1. The Local Authority and Health Board promote a learning attitude towards complaints and would encourage people to contact their Complaints Teams so that individual concerns and issues can be addressed. Llais will ensure its staff and volunteers have the relevant information about services which people can access and

ways for people to be able to contact Social Services or NHS to raise any concerns directly with services.

2. The Health Board Primary Care Team will discuss feedback from the report with Brecon Medical Group Practice to support the continued improvement of services. Llais will arrange a follow-up visit to the Practice.

3. It was noted that access to NHS dentistry remains a challenge across the UK. A new national Dental Access Portal is being established which will help the NHS in Wales to understand overall demand for NHS dental services. Powys has been identified as a pilot area, and the national launch is expected later this year.

4. Comments regarding the age threshold for MIU were noted. The Health Board must ensure that it meets relevant clinical governance and quality standards, and that staff are trained to provide care for people aged 2 and over. The Health Board does not have training and clinical support in place to provide MIU services for children under 2. It is recognised that this does mean there will be additional travel for children under the age of 2.

5. Feedback about appointments at Brecon War Memorial Hospital will inform the Health Board work to develop a Single Point of Access for appointments.

6. The Health Board will use its Commissioning, Quality and Performance Review Meetings with secondary care providers to share the feedback regarding appointments. All health boards have been asked by Welsh Government to introduce Waiting Well services that support people during their waits for planned care treatment.

7. The Health Board will continue to work with providers in England to identify better ways to share patient information across the border. It must be mindful of the need to ensure data protection requirements are met and address risks of sharing information between different systems, including in relation to cyber security.

8. The Health Board will undertake a refreshed marketing campaign to raise awareness of the ChatHealth service for children and young

people.

9. The information within the report about Parkinson's will be shared with the Therapies teams in Powys, to consider the scope for expanding therapy support.

10. Feedback about the wellbeing teams in schools will be picked up with the Local Authority Education Service for consideration.

11. The Director of Social Services will liaise with the Education Service and provide a response to Llais about the closure of the hydrotherapy pool at Ysgol Penmaes in Brecon.

12. The Director of Social Services will raise the issue of poor communication with the senior leadership team at Powys County Council.

CONCLUSION

The engagement activities carried out provided valuable insights into the experiences and needs of the Brecon community regarding health and social care services. The positive feedback about many local and external services highlights the strengths within the current system. However, significant challenges were also identified, particularly in accessing services, communication, mental health support, and workforce capacity.

Our findings underscore the need for targeted improvements to ensure that health and social care services in Powys are accessible, responsive, and adequately supported. The actions agreed upon during the joint workshop demonstrate a committed effort to address these challenges and improve services.

We are confident that the collaborative approach taken will lead to meaningful improvements in the areas identified. Continued engagement with the community and stakeholders will be essential to

monitor progress and ensure that any changes made meet the needs of the residents of Brecon and surrounding areas.

THANKS

We thank everyone who took the time to share their views and experiences with us about their health and care services and to share their ideas.

We hope the feedback people have taken time to share influences healthcare services to recognise and value what they do well – and take action where they need to as quickly as they can, to make things better.

FEEDBACK

We'd love to hear what you think about this publication, and any suggestions about how we could have improved it, so we can use this to make our future work better.

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Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 5.2

PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE	**DATE 07 November 2024**
Subject:	**Health & Safety Performance Report**
Approved and presented by:	**Executive Director People and Culture**
Prepared by:	Deputy Director of People and Culture Senior Health and Safety Officer
Other Committees and meetings considered at:	Executive Committee – 2 October 2024

PURPOSE:

To provide the Executive and PEQS with the key information in relation to the Health Board's Health and Safety Performance for Quarter 2 – 01 June to 30 September 2024.

RECOMMENDATION(S):

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

- **RECEIVE** the contents of the key Health and Safety metrics for Quarter 1 and 2 taking **ASSURANCE** that appropriate reporting arrangements are in place.

Approve/Take Assurance	Discuss	Note
Y	Y	N

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:		
1. Focus on Wellbeing	Y	Provide assurance on the Health Board's approach to managing maters that affect the Health and Safety of the workforce.
2. Provide Early Help and Support	Y	
3. Tackle the Big Four	N	
4. Enable Joined up Care	N	
5. Develop Workforce Futures	Y	
6. Promote Innovative Environments	Y	
7. Put Digital First	N	
8. Transforming in Partnership	N	

EXECUTIVE SUMMARY:

The report sets out the key metrics and updates for Health and Safety for Quarters 1 and 2 of the current financial year

The only outstanding action from the Internal Audit relates to the review and update of the main H&S Policy HSP001. A review of the policy has commenced and is scheduled to be submitted for approval early in Q4. All other polices managed by the Health and Safety Unit are in date.

There has there have been no HSE enforcement or intervention during the first 2 quarters of this year.

In respect to the general accidents and incidents reported in the first 2 quarters, the overall numbers remain low. However, V&A accounts for the highest number of reported incidents for the Health Board a trend that has remained the case for some time. A review is planned, to understand whether the current strategies and training being deployed are proving effective and to identify what further steps can be taken by the Health Board to strengthen its approach and reduce the risks associated.

The number of overall incidents reported for Quarter 1 and 2 remain relatively low other than although there has been an increase in RIDDOR reportable incidents with 11 in the first 2 Quarters, more than there were for all of 2022/23. Although there does not appear to be any underlying pattern to these further details are included within the report.

Stress, anxiety and depression remains the highest reported reason for sickness absence, a pattern that has been the same for a number of years. The People and Culture Directorate are undertaking further analysis to understand if there are any patterns and trends that can be identified. The findings reported to Executive Committee and Health and Safety Group in Quarter 3.

DNA rates continue to be high for training course, including for Face Fit testing. A new approach is being deployed in Quarter 3 to improve both the flexibility of the course delivery and to make it easier for staff to access local delivery. This will begin with a change in the delivery of Face Fit testing and the online presentation.

The Health & Safety Unit continues to strengthen its proactive approach to communicating advice and guidance on H&S across the health board. In Quarter 2 two new sections have been added to the website, one a guide for Managers and Supervisors in relation to their H&S responsibilities, and the other in relation to the creation of department H&S Files. In the first month, these two pages attracted combined total 471 webpage hits.

SITUATION:

Internal Audit Review of Health and Safety Arrangements

An Internal audit was conducted in November 2023 and reported back in December 2023.

Purpose: The overall objective of the audit was to review and assess the adequacy of the processes in place within the Health Board to ensure compliance with Health & Safety legislation.

The internal audit provided an overall rating of Reasonable Assurance but identified training as providing limited assurance, due to the challenges in delivering the training as outlined in the Health and Safety Policy.

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

	Objectives	Assurance
1	The Health Board has health and safety policies in place which comply with the requirements of health and safety legislation. The policies are accessible to staff	Substantial
2	Training requirements and needs have been identified for staff. Training is undertaken and up to date	Limited
3	The health board has an appropriate structure to manage health and safety responsibilities and governance arrangements are in place for the regular monitoring and reporting of health and safety matters	Reasonable
4	Health & Safety risks are appropriately assessed and there is an up-to-date health and safety risk register in place	Substantial

In Q1 out of the nine management actions to be completed following the internal audit, three were still outstanding. In Q2 the following progress has been made:

1. **Update the H&S policies to reflect the new structures and alignments with the other policies such as Fire Safety Policy.**

   This piece of work is being done in two parts:

   The first part was to update the suite of H&S policies under the control of the Health & Safety Unit following the change in directorate. All H&S Policies have been updated to reflect the change in directorate, along with roles and responsibilities, these policies are now live on the intranet.

   The second part requires a complete review and update of the main H&S Policy HSP001, to ensure alignment with policies such as the Fire Safety Policy not under the control of the Health & Safety Unit. This piece of work has commenced, but due to the complexities in aligning this it will be submitted for approval in Q4 (March 2025).

2. **Review and agreeing training requirements for H&S.**

   Following a review of the training requirements set out in the H&S Policy HSP001, it has been agreed that those with senior management responsibility within the organisation will attend the IOSH Managing Safely course. This course is currently being delivered by NPTC at no cost to the Health Board while Welsh Government funding remains available. This course can be delivered both face to face classroom based or online via Teams, to ensure maximum flexibility for staff.

   The H&S training requirement for those who do not have senior management responsibility, will form part of the review of the H&S policy as outlined in point 1 above.

3. **Terms of Reference.**

   The Terms of Reference (TOR) for Site Coordination and Security Group was approved in June and the Fire Safety Group TOR is being tabled for approval at the 22nd October Fire Safety Group meeting.

Policies

The H&S Unit has 14 policies under its control, in Q2 all policies were in date with future policy reviews plotted in the H&S forward work plan.

Policies reviewed and submitted for approval at the Q2 HSG meeting were as follows:

- HSP008 – The Management of Contractors Policy
- HSP018 – First Aid at Work Policy

Standard Operating Procedures (SOP):

In Q1 the H&S Unit developed and presented to the Health & Safety Group a Reporting of Injuries, Diseases and Danger Occurrences Regulations SOP. The SOP has been designed

to assist Managers and Supervisors in identifying and understanding what incidents need to be reported to the Health & Safety Executive in accordance with the Reporting of Injuries, Diseases and Dangerous Occurrence Regulations 2013 (RIDDOR). The document was approved by the Group and during Q2 was uploaded to the H&S web pages and communicated to the organisation through Powys Announcements and tabled at various departmental meetings.

Health and Safety Executive Enforcement Activity

The Health and Safety Executive (HSE) is the regulator for workplace health and safety. They aim to influence change and help organisations manage risks at work. These include:

- providing advice, information, and guidance
- raising awareness in workplaces by influencing and engaging
- operating permissions and licensing activities in major hazard industries
- conducting targeted inspections and investigations
- taking enforcement action to prevent harm and hold those who break the law to account.

Current Enforcement Record

Type of HSE Enforcement Action	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25 Q1	2024/25 Q2	2024/25 Q3	2024/25 Q4
Prosecution									
Prohibition Notice									
Improvement Notice									
Fee for Intervention (FFI)									

There has been no enforcement action by the Health and Safety Executive in Q1 & Q2 – 2024/25.

Ionising Radiation

The update from the Radiation Lead is as follows:

Dosimetry in Radiology is monitored bimonthly, with records stored on SharePoint and locally within departments. To date, no doses have been recorded.

The quality assurance programme has been arranged with support from the medical physics team for theatre in Brecon and Llandrindod following the purchase of a QA radiation phantom testing tool.

- All local rules, service records, training records, and entitlements are current and stored on Radiology SharePoint.
- There is an outstanding radiation risk assessments for the Topas mobile Xray equipment in Brecon currently being completed which will then be sent to the RPA for approval.
- Health & Safety files are all up to date.
- Following the IRMER 24 update RAD004 and RAD 002 are currently under review for ratification.

There have been 3 Datix reportable radiation incidents in Q2:

- 1. Datix 13731- Unintended dose relating to equipment malfunction
- 2. Datix 13426- Unintended dose relating to equipment malfunction
- 3. Datix 13260 – Unintended dose relating to unjustified examination,

Datix 1 - The patient attended for a chest X-ray using the vertical Bucky due to body habitus. A "feedback error" occurred, resulting in a short exposure, prompting a follow-up film outside the Bucky. The radiographer couldn't replicate the issue in subsequent tests. AEC settings were 90kV, 500mA, 10ms, but the exposure time was unrecorded. The supplier was informed, as feedback errors indicate either an unexpectedly long exposure terminated by the AEC backstop or an early termination

Datix 2 - During a chest X-ray, a communication error occurred between the plate reader and image review console, displaying an error code. Despite attempts to retrieve it, the image data was lost, and the examination was halted, with the patient rebooked. The unintended exposure was reported to the Radiation Protection Supervisor, and a radiation incident form was completed. Subsequent tests showed the equipment functioning normally. When reporting to the supplier, a screenshot with the error code and patient information was sent but immediately deleted upon identification as a data breach. The supplier confirmed deletion per their protocol.

Datix 3 - An MIU patient attended for a shoulder/clavicle X-ray following high-impact trauma with pain in the left anterior ribs (4th-5th). Two shoulder views were taken, but the radiographer felt the trauma area wasn't fully covered and proceeded with a chest X-ray. Upon reflection, the radiographer recognized that this additional exposure was unjustified, resulting in an unnecessary radiation dose to the patient.

All Datix were reported to Medical Physics and a dose report filed. None of the reported incidents exceeded the threshold dose and none required external reporting to HIW. Radiographer related incidents follow through with a reflection of learning and Datix are discussed at subsequent staff meetings for learning.

The Capital replacement of the Xray equipment is planned to proceed in two phases. Commencing in November 24 for Welshpool, Llandrindod and Ystradgynlais in the first phase and Jan 25 for Brecon and Newtown in the second phase. All Medical physics teams

have been informed and are actively involved with the room planning to ensure compliance with radiation safety. Once installed the RPS service will test and approve the equipment before authorised to be used.

Asbestos

Asbestos compliance is managed via the Estates team and reported to Board on an annual basis as part of a dedicated Asbestos Annual Report. The Asbestos Manager has provided the following summary for the last quarter:

- Training - 1 Non licensable to allow additional asbestos permit signatory.
- Face fit – 2 face fit tests
- Surveys - 14 surveys on 7 main hospital sites only Llanidloes and Knighton not surveyed during this quarter, surveys were either localised refurbishment or sampling.
- Removal - No removals during Q2
- Non licensable work - 2 tasks, Welshpool with licensed contractor and Brecon within house staff
- Teams database - viewed 263 times

Hand Arm Vibration Syndrome

Hand Arm Vibration Syndrome (HAVS) is a reportable work-related disease, caused by excessive exposure to vibration over time, whilst using handheld or guided vibratory work equipment, causing damage to the nerve, vascular systems in the hands and arms along with muscular skeletal effects of the disease.

In line with the organisations HAVS training strategy, the following training was delivered during Q1 & Q2:

Level 3 HAVS Awareness Training –
One session was delivered to mop up those who had missed the previous training sessions delivered in Q1 and captured a new member of estates staff, and this was recorded on ESR.

Level 1 HAVS Awareness Training –
This level of training is delivered by a department HAVS Leads via department toolbox talk and the HSE Document INDG296. The staff requiring this level of training are predominantly in Support Services.

At the refresher point of April 2024 there were approximately 150 members of Support Services requiring this level of training to be refreshed. In Q2 Support Services report HAVS training compliance for the South at 92% and North 76%. The lower compliance rate in the North was affected by long term absence but full compliance is expected by the end of Quarter 3.

Level 2 HAVS Awareness Training –
There have been significant difficulties create an online level 2 HAVS course that can be accessed through ESR. The training package has been developed and is ready to be converted into an online course, but to date Shared Services have to date failed to engage to enable this piece of work to be completed. Fortunately, at present there is no one within the organisation assessed as requiring the level 2 training at this time, so this gives us some time to investigate this further.

Going forward we will be investigating if this piece of work can be done utilising skill sets within the organisational. If we are unable to proceed, then as there are currently no employees requiring this level of training, we will review the need for the online course.

Work-Related Stress

Stress anxiety and depression (SAD) accounted for 10% of all episodes of absence in the last 12 months for the Health Board and has been one of the highest reported contributing factors to absence within PTHB for several years. This is reflective of the picture across NHS England where SAD related absence is a high contributory factor of absence (data is not available to confirm this is the case in NHS Wales). Despite a continuing trend of reduced absence within PTHB, SAD continues to be the highest reported reason for absence during Quarters 1 & 2. The People and Culture Directorate are undertaking further work to identify if there are any identifiable patterns and trends in absence related SAD. The findings will be presented to the Executive Committee and the Health and Safety Group in Quarter 3 and a summary provide in the next Health and Safety update report to PEQS Committee.

Accidents and Incidents

The data below is taken from the Datix system and covers Q1 & Q2 of the year and is subject to change as investigations close.

General Accidents & Incidents

		Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Total
Accident, Injury	Burns or scalds	0	0	1	2	0	0	3
	Contact with needles or medical sharps	0	0	2	2	0	0	4
	Contact with object or animal	2	0	1	0	2	0	5
	Contact with or exposure to hazardous substance	0	1	0	1	0	0	2
	Entrapment / Drawn in	0	0	0	0	0	0	0
	Manual Handling - Non patient/service user handling	0	0	0	0	3	0	3
	Manual Handling - Patient/service user handling	2	0	0	1	1	1	5
	Patient injury	0	0	0	0	0	0	0

	Road traffic collision	1	0	0	0	0	0	1
	Slip, trip or fall	3	3	1	6	2	3	18
	Struck against or by an object	0	1	2	0	0	0	3
	Total	8	5	7	12	8	4	44
Equipment, Devices	Manual Handling - Equipment	0	0	0	0	0	0	0
	Manual Handling - Patient/service user handling	0	0	1	0	0	0	1
	Medical devices	1	0	1	0	2	0	4
	Non-medical equipment	3	0	1	2	0	4	10
	Total	4	0	3	2	2	4	15
Total		12	5	10	14	10	8	59

Trends and Themes from the Accident and Incident Data

As can be seen from the table above the number of general accidents and incidents remains relatively low, with 27 in total in Q1 and slight increase in Q2 to 32. A total of 59 accidents and incidents over the two quarters.

The highest category over the first two quarters of the year is slips, trips and falls, with 18 in total, 7 incidents in Q1 and 11 in Q2 – 4 of those in Q2 resulted in a specified injury, which were reportable to the HSE in accordance with RIDDOR. These are detailed in the RIDDOR section below, the slip, trip and fall incidents in Q2 include:

3 x slips, trips and falls on the same level.
2 x slips, trips, falls on a wet surface.
2 x falls from height – these were low level falls.
1 x slip, trip, fall on sloping surface.
1 x fall from a chair.
1 x fall on un-even ground.
1 x trip or fall over an object/obstacle.

Many slips, trip and falls are due to un-safe situations, or defects at PTHB premises which have not been reported, repaired, addressed or the risks mitigated by the deployment of temporary measures in a timely manner. The pro-active and early identification, reporting and escalation of unsafe situations, along with prompt action to mitigate any risk is important to prevent injury of not only staff members, but also patients, visitors and contractors.

Regular workplace inspections are a proactive way of identifying and escalating workplace hazards/defects for repair, or for temporary risk mitigation to be deployed to prevent injury. The H&S Unit have a recourse on its web pages, along with workplace inspection check sheets for Departments and Managers to use, to identify and escalate workplace hazards. Along with the Datix system, these should be used to report and escalate issues in their areas of responsibility for action.

The second highest category over the first two quarters, is non-medical equipment with 10 in the last two quarters, 6 of these occurring in Q2, these included:

1 x consulting room panic alarm was activated; the control panel didn't give the correct location.
1 x a ward alarm wasn't functioning in several places when tested.
4 x incidents were reported in the wrong category, an example of this was being struck by a laptop that fell while removing a box from a cupboard, and no access to printers or equipment not functioning correctly.

There has been a slight increase in manual handling incidents in Q2, although the number of incidents remain relatively low in relation to the number of manual handling activities carried out on a daily basis. There were 2 incidents in Q1 and in Q2 there were 6, 3 of which were while handling people and 3 while handling objects.

V&A Incidents

	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Total
Abduction	0	0	0	0	0	0	0
Absconding or missing patient/service user	3	3	2	1	5	2	16
Aggressive/threatening behaviour	13	16	10	12	11	8	70
Anti social behaviour	1	0	2	1	0	0	4
Equality and diversity policy / guidelines	0	0	0	0	0	0	0
Harassment	0	1	2	0	4	2	9
Inappropriate behaviour / attitude	6	3	5	8	9	5	36
Inappropriate use of social media	0	0	0	0	0	1	1
Indecent exposure	0	0	0	0	0	0	0
Patient clinically challenging behaviour	0	1	0	3	3	0	7
Physical assault (physical contact)	5	2	3	6	4	13	33
Privacy and dignity for the patient	0	0	0	0	0	0	0
Protest	0	0	0	0	0	0	0
Restrictive practices	3	4	12	3	5	1	28
Self-harm / self-injurious behaviour	1	2	2	1	2	1	9
Sexual (inappropriate) behaviour	0	0	0	0	1	0	1
Sexual assault	0	0	0	0	0	0	0
Smoking	0	0	1	0	0	0	1
Verbal assault (gender/sexual orientation)	0	1	0	0	0	0	1
Verbal assault (racial abuse)	0	0	0	0	0	0	0
Verbal assault (swearing etc.)	4	4	2	1	3	1	15
Total	36	37	41	36	47	34	231

Trends and Themes from the V&A Incident Data

V&A incidents remain the highest number of reported incidents reported across the organisation. In Q1 there were 114 incidents highlighted in blue in the above table. In Q2 there were 117 incidents reported and increase of 3 in this quarter a total of 231 in Q1 & Q2. This compares to 59 general accidents and incidents over the same periods.

Top 6 Categories -

- Absconding patients – This remains the same over the two reporting periods, at 8 instances in both Q1 & Q2.
- Aggressive/Threatening Behaviour – There as been a slight decrease in this category from 39 incidents in Q1 to 31 in Q2, although this remains the top category.
- Inappropriate behaviour/Attitude – The reported incidents in this category has increase from 14 in Q1 to 22 in Q2 incidents.
- Physical Assault – The reported incidents in this category has increase from 10 incidents in Q1 to 23 in Q2.
- Restrictive Practice – These have reduced from 19 in Q1 to 9 in Q2
- Verbal Assault – This has dropped from 10 in Q1 to 5 In Q2.

A analysis of the V&A incidents will be undertaken in Quarter 3, to identify if the current strategy is working or what further intervention is required to try and reduce the numbers of V&A incident going forward and reported to the Health and Safety Group.

Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR)

RIDDOR Incidents Reported by Category

RIDDOR Category	19/20	20/21	21/22	22/23	23/24	24/25 Q1	24/25 Q2	24/25 Q3	24/25 Q4	Total
Specified Injury		1	1	3	1	1	4			11
Specified Injury (Public)	1			1		3				5
Over 7-day Injury	5	3	7	3	7		1			26
Occupational Disease		5	3	2		1	1			12
Dangerous Occurrence					2					2
Fatality										0
Total	6	9	11	9	10	5	6			56

RIDDOR Incidents Reported by Accident Category

Accident Category	19/20	20/21	21/22	22/23	23/24	24/25 Q1	24/25 Q2	24/25 Q3	24/25 Q4	Total
Slips, Trips & Falls	4	2	2	2	1	3	4			18
Physical Assault	1		1	1	2	1				6

Manual Handling	1		3	1	3					8
Burns / Scalds										0
Struck by Object		1	2							3
Struck Against		1								1
Falls From Height				2			1			3
Occupational Disease		5	3	2		1	1			12
Needle Stick										0
Electric Shock				1						1
Another Kind of Accident					2					2
Release of a Chemical					2					2

There were 11 RIDDOR reportable incidents during Quarters 1 & 2, and these included:

- A member of staff tripped and fell on the uneven surface in the car park to the side of Hafren Ward, fracturing their foot.

  The H&S Unit made enquiries into the cause of the incident and issued advice regarding mitigating the risks associated with the defective areas within the car parks.

- A member of staff using the grass bank as access to Hafren Ward, from the top car park, slipped and fell on the wet grass, fracturing their leg in two places.

  The H&S Unit made enquiries into the cause and location of the incident and issued advice regarding mitigating the risk associated with using unofficial access and egress routes, to prevent further incidents occurring.

- A member of staff carrying out a home visit, tripped on a brick, then while correcting themselves slipped on wet grass and rubble, falling banging their head and losing consciousness.

  The H&S Unit made enquiries into the cause of the incident and issued advice regarding mitigating the risk associated with home visits and, slips, trips and falls, to prevent further incidents occurring.

- A member of staff slipped and fell while using a hedge cutter on a bank, falling on the stationary blade, cutting their fingers and damaging tendons, which required surgery.

  This incident is currently under investigation by the H&S Unit.

- A member of staff while collecting lunch dishes from a ward, caught their foot on a patient's chair, causing them to stumble and fall fracturing two bones in their elbow.

  This incident was investigated by the Ward Manager in conjunction with Support Services and it was identified that no action was needed to prevent a re-occurrence.

- One reported case of Hand Arm Vibration within the Estates department.

The H&S Unit have made enquiries in relation to the levels of vibration exposure for the IP. It is noted that their use of vibratory equipment at work, and exposure to vibration has been very limited over the last 4 years. This is because they have been seconded to a supervisory role. The total recorded exposure in the last 4 years is 179 HSE points and the safe level being HSE 100 points per day.

As a point of note, in Q1 & Q2 of this year there have been 11 reportable incidents to the HSE. This already equals those recorded in 2021/22 which was previously the highest number recorded in any 12-month period, with two quarters remaining to report in the 2024/25 financial year.

Accident / Incident Investigations

An investigation into the RIDDOR reportable incident involving the hedge cutter commenced in Q2.

Training

During Q2 the following training has been delivered via the Health and Safety Unit, either by the in-house resource, or by external providers.

Health and Safety Training Delivered:

- Level 3 Hand Arm Vibration Awareness training.
- The Level 1 Health and Safety e-learning package which is mandatory for all staff continues to be delivered via ESR.
- All new starters attend Corporate Induction which includes a section on H&S – this includes - H&S Responsibilities, V&A, Manual Handling, Fire Safety, Lone working, Driving for work, DSE assessments and Datix reporting.
- New and Aspiring Nurse induction training.
- Patient Handling and Object Handling.
- Manual Handling for Managers.
- PMVA 4-day Foundation and 1-day refresher courses.
- De-escalation and Breakaway Training.
- Face Fit Testing online presentation.

Statutory and Mandatory Training rates for Manual Handling and PMVA.

Training compliance rates are reported through several Groups and Committees within the Health Board. The key challenge reported in the early part of 2023 was the ability of departments to release staff to attend training, which is still the case in Q2 2024.

The table below shows for Q2 compliance percentages against each category remain relatively constant, with a slight drop in compliance in manual handling for managers by 1.3% and a further slight drop in Q2 in Module B violence and aggression training of 0.38%

The other categories of training have once again seen an increase in compliance; however, these are relatively small.

Competence Name	Assignment Count	Required	Achieved	Compliance %	Situation Against Q1
070|LOCAL|Manual Handling for Managers - No Renewal|	228	228	170	74.56%	Down 01.30%
NHS|CSTF|Moving and Handling - Level 1 - 2 Years|	850	850	753	88.59%	Up 01.91%
NHS|CSTF|Moving and Handling - Level 2 - 2 Years|	1584	1584	1255	79.23%	Up 01:66%
NHS|CSTF|Violence and Aggression (Wales) - Module B - 3 Years|	2144	2144	1967	91.74%	Down 00.38%
NHS|MAND|Violence & Aggression Module D - 1 Year|	81	81	59	72.84%	Up 3.61%

Manual Handling Training

The training is delivered in line with the All-Wales NHS Passport scheme and the standards contained therein, this is currently version 3, 2020.

The All-Wales NHS Manual Handling Training Passport and Information Scheme (Passport Scheme) was developed by the All-Wales NHS Manual Handling Group. It was originally launched in 2003 with endorsement from the Welsh Government, NHS Wales and the Health and Safety Executive.

Moving and Handling training is currently planned on a six-month basis, going forward from Q3 onwards we will be moving to three monthly planning and booking of manual handling. This is to make it more flexible to meet the needs within the organisation, and to ensure we can accommodate the recruitment of international Nurses, Aspiring Nurses and those currently on the Bank. Access to the dedicated training facilities where the equipment is located at both Bronllys and Llanidloes continues to be challenging on occasions, due to the block booking of these rooms by some departments and having to book through a third party.

The Health Board is opening a much-needed additional training venue in Llandrindod in late 2024, which is expected to improve the availability for training spaces, this will hopefully give greater availability of the dedicated rooms for manual handling training.

Moving & Handling Courses Breakdown – 1st April – 30th June 2024		
Course	**Number of courses**	**Number attended**
1 Day Refresher	10	70
2 Day Foundation	9	59
Object/Load	16	104

Managers Module G	3	16
Pool Evacuation	2	6
Totals	**40**	**255**

Each of the manual handling courses is expected to take 8 candidates, but where demand requires can take a maximum of 10. The above offering for Q2 was 320 training places based on 8 candidates per course, with an actual attendance of 255, leaving a non-attendance rate of just over 20%.

Prevention Management of Violence & Aggression Training (PMVA)

PMVA training is currently being delivered by Aneurin Bevan Health Board under an SLA, where 3 places are allocated to PTHB staff on the following courses:

- The 4-day PMVA Foundation Course
- The 1-Day PMVA Refresher Course

The 1 Day Breakaway Course is once again being delivered in-house by the V&A Trainer/Advisor and courses are being delivered on demand.

PMVA Courses Breakdown - 1st April – 30th June 2024		
Course	**Number of courses**	**Number attended**
4 Day Foundation	4	7
1 Day Refresher	16	10
1 Day Breakaway	4	26
Totals	**24**	**43**

The attendance rates for Q2 for the above courses are as follows:

- 4-Day Foundation – 12 spaces allocated and 7 attended.
- 1-Day Refresher – 48 spaces allocated and 10 attended.

A total of 60 spaces available over the two courses offering from ABUHB with a total of 17 candidates from PTHB attending, this equates to a non-attendance of 72% across the two -course offering.

It's not currently known if the PMVA course offering from ABUHB exceeds the current training needs of the health board, going forward the V&A Trainer/Advisor will be investigating to ensure the offering meets the needs.

1-Day Breakaway – These courses are currently being run to meet demand, so attendance numbers vary. But based on 8 attending each course these are currently running AT 81% attendance.

Face Fit Testing

Face fit testing for all departments is being delivered in accordance with HSE Guidance and Fit2Fit accreditation. Each member of staff must attend a 30-minute online presentation, delivered by the H&S Unit, before they can attend the practical face fit testing sessions. The practical testing sessions currently take place in 3 hubs across the county: Llanidloes, Builth Wells and Bronllys. The administration and delivery of face fit testing continues to be resourced by the H&S Unit, along with the associated costs which are not currently factored into the H&S Unit budget.

During Q2 only two face fit testing days testing were delivered, this was due to several factors, including staff leave across the organisation over the summer period, limited availability of the rooms used in the 3 hubs.

The tables below indicate both the number of online sessions and practical testing delivered in Q2.

Number of Online Presentations Delivered	Number attended	Average Attendees Per Session
4	10	2.5

Number of Test Days	Location	Available Appointments	Appointments Used	Un-used Appointments
2	Bronllys	20	11	9

A total of 2 face fit testing days were offered in Q2, one of the days was arranged for 4 attendees which was fully subscribed. On the second test day there were 16 appointments available, during this day a total of 9 persons attended, which equates to a 56% attendance rate.

FFT Going forward – Due to the H&S Units administration function reducing in hours, back to the contracted 0.40WTE allocated to the post. The model for the delivery of face fit testing will be changing, this is to reduce the administrative burden associated with the activity.

The changes will include replacing the delivery of the 30-minute face fit testing toolbox talk/presentation, currently delivered by one of the Senior H&S Officers via Teams, to an online version that can be viewed from the H&S website. This will remove the administration associated with arranging and booking the online sessions and notifications to staff. It will also reduce H&S Officer time in delivering the sessions face to face.

Some of the other changes to reduce / remove H&S administration are associated with booking and providing suitable facilities for the practical testing to take place. This has normally been arranged and collated by the H&S Unit and been delivered from 3 hubs, Llanidloes, Builth Wells and Bronllys. Going forward the practical Testing will now take place on each of the sites, but the responsibility for arranging this and providing a suitable location for testing to take place rest with the mangers onsite who require testing for their staff or the site. Another change will be that managers will have to populate and arrange their staff appointments on test days ensuring staff turn up, to reduce the waste of resource and reduce DMA's. Currently the H&S Units Administrator has been chasing appointments to ensure slots are filled, this will not be happening going forward.

Health and Safety – Corporate Web Pages

A key element of the role of the health and safety function is to communicate and support managers and local teams in understand health and safety and raising their awareness in the subject and their roles and responsibilities. One of the methods deployed to do this, is through the use of the H&S Unit web pages, SharePoint and Powys Announcements. With safety critical issues communicated in safety alerts.

Updates to the corporate web pages in Q2 included:

- A new section has been created which relates to department H&S files (red files), this section is designed to guide departments and managers in how to create and maintain a health and safety file for their department, with easy reference in what needs to be included and how to collate this. This was advertised organisation wide, which created 206 web site views in the first month.

- A new section has been created to inform Managers and Supervisors of their H&S responsibilities, as detailed in the H&S Policy HSP001. This section is designed to advise and guide Managers and Supervisors in how to discharge these duties, which created 265 web site views in the first month.

Staff Side Engagement and Support

In Q2 there has been no celebrative working with Staff Side in relation to their inspections across the PTHB estate, and they have not requested any support from the H&S Unit during this period.

The H&S Unit have developed a process which has been agreed by Staff Side to be adopted, to ensure where workplace inspections are undertaken the employer responds appropriately and where required actions and recommendations that are identified these are captured, actioned and progress is tracked where required to completion.

Corporate Health and Safety Risks

In Q2 2024 - There were no Health and Safety Risks to escalate to the Health and Safety Group and Corporate Risk Register.

Risks held on local Directorate Risk Registers are reviewed by the Directorate Management teams on a regular basis and escalated to the Health and Safety Group as required.

Looking Ahead – Q3 & 4

Q3 - Review and Update of the Health and Safety Policy.
Q4 – The Health and Safety Policy tabled for approval.
Q4 – Audit of Manual Handling.
Q4 – Review departmental premises inspection process.

Further updates to the H&S web pages, will include:

- A section for topical bulletins from the HSE.
- Medical gas safety.

CONCLUSION:

The H&S Unit remain committed to ensuring a positive health and safety culture across the organisation. The improvement in reporting of accidents and incidents and the communication of lessons learned, along with ensuring staff receive the appropriate levels of H&S training, relevant to their roles and responsibilities, will help to support, improve, and drive a positive culture across the organisation.

The development and implementation of the two new sections on the H&S web pages in Q2 as noted in this report, will assist and guide departments, Managers and Supervisors in the discharge of their health and safety duties. It will also enable them to have concise and comprehensive health and safety documentation in place and readily available. Both after being adverted through Powys Announcements have generated a lot of interest with combined website hits of 471 in the first month.

As V&A incidents continue to be the largest number of reported incidents across the Health Board. To identify if the current strategy and training to reduce and managed these incidents needs to change or if further violent incident reduction strategies need to be implemented, to try and reduce the number of incidents an analysis will be undertaken and reported to Executive Committee and Health and Safety Group in Quarter 3.

With slips, trips and falls being the highest number of reported general incidents in this quarter and also largest number of PTHB reportable incidents to the HSE, 18 incidents since 2019. It is important departments adopt pro-active workplace inspections, using the resources provided on the H&S web pages. This resource has been available nearly 12 months, and to date there is little evidence department have adopted the process, and there is no evidence the findings are being escalated to the various groups, such as the site coordinators group. This deployment and adoption of the workplace inspections will be reviewed in Q4 to see if improvements can be made.

As part of the Internal Audit process, the delivery of IOSH Managing Safely training as listed in the H&S Policy was to be reviewed. The delivery of the first course has been reviewed and the feedback from attendees was very positive. Based on the review it has been agreed that this is the most suited course for Managers and Supervisors to attend. It is envisaged that attendance will be on a risk-based approach across the organisation. Another IOSH Managing Safely course has been arranged for Q3 and this is fully subscribed, and it is hoped a further two courses will be delivered in Q4.

As reported in the previous performance report, progress is being made in some areas of training attendance, there is still some work to be done to try and reduce non-attendance, including:

Reviewing the current PMVA training offer from ABMU will be undertaken, to ensure courses are targeted to meet the Health Board's requirements. This will reduce the number of DNA's and ensure staff attended the correct training course. At present when staff go out of compliance**,** instead of attending the one-day refresher course, they must re-attend the 4-day foundation course. This is at considerable cost to the organisation, in both course costs, lost time and travel over 4 days, and a loss of resource on the ward which potentially must be backfilled at cost. So**,** it is important that the courses match the staff training requirements and that departments plan for this in advance, so staff can be released to attend.

Toward the end of Q3 we will be moving to a different model for the delivery of Face Fit Testing. This will place a greater ownership on the department managers to arrange and ensure staff attend the practical face fit testing days, as identified in their task-based risk assessments. The online presentation will be moved to a different platform, which will allow staff to access the presentation at a time best suited to themselves and will reduce H&S Officer time in delivery. It is envisaged that this new model of face fit testing delivery will be reviewed in Q4 2024 or Q1 2025.

IMPACT ASSESSMENT - NOT REQUIRED
This section must be completed for all strategic organisational decisions including approval of health board policies.

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 5.3

PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE	**DATE 07 NOVEMBER 2024**
Subject:	Mid and West Wales Safeguarding Board Concise Child Practice Review (CYSUR 3 2021) Action Plan Update
Approved and presented by:	Executive Director of Nursing, Quality and Women and Family Health
Prepared by:	Assistant Director of Nursing for Safeguarding
Other Committees and meetings considered at:	Executive Committee and Patient Experience, Quality and Safety Committee earlier in 2024.

PURPOSE:

To update the Patient Experience, Quality and Safety Committee on the progress of the Concise Child Practice Review (CYSUR 3 2021) Action Plan.

RECOMMENDATION(S):

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

1. Take **ASSURANCE** in relation to the progress and improvements made in implementing the Concise Child Practice Review (CYSUR 3 2021) Action Plan.

Approve/Take Assurance	Discuss	Note
Y	Y	N

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:		
1. Focus on Wellbeing	N	
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	Y	

EXECUTIVE SUMMARY:

1. Executive Summary

On the 10th of October 2020, a 16-year-old female residing in Powys was found deceased in her home. Due to the unexpected nature of her death and the circumstances in which the child was found a Concise Child Practice Review (CPR) was commissioned by the Mid and West Wales Safeguarding Board, the CPR was managed in accordance with the Guidance for Child Practice Reviews working-together-to-safeguard-people-volume-2-child-practice-reviews.pdf (gov.wales)

The Concise Child Practice Review commenced in June 2022, however, due to the ongoing criminal trial the review was immediately suspended and recommenced once both the criminal and coronial matters had concluded.

On the 14th of March 2024, Mid and West Safeguarding Board published the Concise Child Practice Review on their website Published report and 7MB.

The review made 9 recommendations for the Mid and West Wales Safeguarding Board and its member agencies, 5 of which make specific reference to Powys Teaching Health Board.

The recommendations have been translated into an Action Plan which was approved by the Mid and West Wales Safeguarding Board on 16th July 2024.

Progress against all actions is monitored within the Health Board's Safeguarding Practice Improvement Group, which reports to the Safeguarding Strategic Group. Regionally, PTHB will report progress on all actions to both the Multi-Agency Regional Safeguarding Operational Group the Mid and West Wales Safeguarding Board.

2. Powys Teaching Health Board's Action Plan and Progress

Action No 1	**Timescale**
PTHB and PCC to jointly review the systems, processes and pathways that are in place for children with chronic disabilities.	June 2025
Progress – On Track	
PTHB and PCC have established a task and finish group to take forward this action. Once the review is complete any recommendations and/or actions will be considered by both the Local Authority and the Health Board. Initial findings have led to PTHB submitting a bid to the Roald Dahl charity to fund a Roald Dahl Nurse for children with Medical Complexities for 2 years. If successful, the Nurse's role will focus on Palliative Care and the transitioning of	

children into adult services. The rationale for a Roald Dahl Nurse is, while some children with life limiting conditions are open to services, others may not require additional support during childhood and are not actively open to professionals. It is recognised that this cohort of children are at risk of being lost within a system until adulthood, whereby they may require further support. In addition, children with complex needs who, are electively home educated can be monitored and support offered when required. The role will support robust, proactive and inclusive services for all children within PTHB, ensuring services are centered on the needs of the child and the family which is in line with the ethos of the Roald Dahl foundation.

Action No 2	**Timescale**
All agencies to undertake a review of their existing training programmes and policy guidance to ensure the duty on all practitioners, regardless of barriers, to speak to and communicate directly with children, is understood. Their responsibility to engage with and accurately record any communications must be explicitly clear and understood by those responsible for delivering and providing services to children and their families.	June 2025
Progress – On Track	
This piece of work is being coordinated by the Business Unit within the Mid and West Wales Safeguarding Board. Once the review is complete any gaps or opportunities to improve will be taken forward. PTHB are represented on the Group by the Head of Safeguarding in PTHB.	

Action No 3	**Timescale**
Powys Teaching Health Board to raise awareness, implement and embed the updated All Wales Weight Management Pathway for children, young people and families published by Welsh Government in 2021.	June 2025
Progress – On track	
A whole system approach to healthy weight is one of three priority objectives within Powys Wellbeing Plan. [The Powys Well-being Plan - Powys County Council] The Whole System Approach to Health Weight is a population level prevention programme that forms part of the local delivery of the national Obesity Strategy *Healthy Weight Health Wales.*	

The Whole System Approach to Health Weight work is led by the Executive Director of Public Health and distinct from the delivery of weight management services which are clinical services provided to individuals to support achieving and maintaining a healthy weight.

Delivery in 2023/24 included:

- Stakeholder engagement including stakeholder events in November and December 2023
- Identification of four themes of focus within the identified priority sub-system of "children (aged 0-5), families and access to healthy food"
- Establishment of a Strategic Steering Group to develop and oversee the delivery of a Strategic Delivery Plan
- Completion of Strategic Delivery Plan and commencement of delivery
- Establishment of Task and Finish Groups for specific areas of work within the four themes
- Formal adoption of this work by the Public Service Board as one of its three priorities for the period 2023/24 to 2027/28.

The All Wales Weight Management Pathway for children, young people and families was published by Welsh Government in 2021 all-wales-weight-management-pathway-2021-children-young-people-and-families.pdf (gov.wales)

The pathway seeks to improve outcomes for children, young people and their families by ensuring that all levels of service are built on a shared understanding of the complexity of factors which lead to overweight and obesity. Excess weight in childhood can be associated with conditions such as bone and joint problems, prediabetes and poor psychological and emotional health linked to their weight.

The pathway comprises of four levels of care and support, that health boards and their partners should make available to communities.

Level 1 – Community based and early intervention (self-care)
Level 2 – Community and primary care weight management services
Level 3 – Specialist MDT weight management services
Level 4 – Specialist medical and surgical services (bariatric surgery)

Currently PTHB can deliver some but not all levels of the Weight Management Services. Work is ongoing to review the current position of the *Establishment and Implementation of a Children, Young People and Families Weight Management Pathway in Powys Teaching Health Board - A Three-Year Business Case (2022-25)* which was presented to Executives in June 2022, the business case was accepted in principle, however had no resource to progress at the time.

The Safeguarding team are therefore undertaking a gap analysis in partnership with colleagues in the Women and Family Service Group, to include Health visiting, School Nursing and Therapies.

Action No 4	**Timescale**
Powys Teaching Health Board to review the availability of and access to lymphoedema services for children living in Powys. To clarify or create a protocol regarding the regular monitoring of the skin condition of children with complex health needs and mobility limitations, including spina bifida.	June 2025
Progress – On Track	
Review completed. Powys Children have access to a National Paediatric Lymphoedema Service which is hosted by Swansea Bay University Health Board. A Standard Operating Process is in the process of being ratified within PTHB, once approved a plan to promote across the Health Board will be implemented. Challenges have arisen regarding the National Paediatric Lymphoedema service following Swansea Bays Was Not Brought process which is different to PTHB's. PTHB's Safeguarding Team and PTHB Lymphoedema Team lead are working through a solution to this issue. We are aware that the NHS National Safeguarding Service have been asked to develop an All Wales Was Not Brought Policy which will help alleviate this problem.	

Action No 5	**Timescale**
Powys Teaching Health Board to further embed the Was Not Brought policy and to consider cross-border involvement.	Jan 2025
Progress - Completed	
The Policy for Managing Was Not Brought/Did Not Attend/No Access Appointments for Vulnerable People' (SGP 047) has undergone regular audit, updates and promoted throughout the Health Board since 2020. An annual audit plan is in place which was last undertaken in December 2023. Managers/Team Leads also undertake a monthly review of *Children Not Brought* to appointments within their service. The Managing Was Not Brought / Did Not Attend /No Access Appointments for Vulnerable People' Policy (SGP 047) includes a risk assessment and reminds practitioners they must understand family needs/circumstances and work with	

others involved with the child, when managing and scheduling appointments that support children being brought to appointments. A significant events chronology that can be used for each child has been developed on WCCIS. Practitioners can add to and read all entries on the chronology. There is an expectation that any appointment where a child was not brought will be added to the chronology. The updated Managing Was Not Brought/Did Not Attend/No Access Appointments for Vulnerable People' Policy (SGP 047), Significant Events Chronology and accompanying Standard Operation Process have been presented to Managers and Team Leads for cascading within their services. Staff are reminded during safeguarding supervision of the importance of being '*professionally curious.* Regional multi agency training on Professional Curiosity including Was Not Brought is available to staff and has been added as a requirement within PTHB's safeguarding children level 3 passport. A Principles for Managing Discharges process has been developed and should be used in each service area. Assistant Director of Nursing, Safeguarding to be invited to monthly CQPRM pre meetings where any quality issues with providers can be raised. The NHS National Safeguarding Service have been asked by WG to lead on developing an All Wales Was Not Brought Policy. PTHB will engage in this piece of work and have been invited to share our current policy.

NEXT STEPS:
I. Continue to work with our multi agency partners on the whole system improvements within the action plan. II. Continue to monitor progress against the actions within PTHB Operational Safeguarding Group and escalate any issues to PTHB Strategic Safeguarding Group III. Provide a progress report against PTHB actions quarterly to PTHB Strategic Safeguarding Group IV. Provide a progress report against PTHB actions quarterly to the Mid and West Wales Safeguarding Board

IMPACT ASSESSMENT – NOT REQUIRED FOR THIS REPORT

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

QUALITY:

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

EQUALITY:

	No impact	Negative	Positive	Both	
Age					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.
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				
	Very Low (0-3)	Low (4-8)	Moderate (9-12)	High (15-25)	
Clinical					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.
Financial					
Corporate					
Operational					
Reputational					

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

Agenda item: 5.4

Patient Experience, Quality and Safety Committee	**Date of Meeting: 07 November 2024**
Subject:	Medical Devices and Point of Care Testing Annual Report 2023 - 2024
Approved and presented by:	Claire Madsen, Executive Director for Allied Health Professions, Health Sciences and Digital
Prepared by:	Helen Kendrick, Medical Devices and Point of Care Testing Coordinator Melaine Prince, Point of Care Testing Co-ordinator
Other Committees and meetings considered at:	Executive Committee – 30 October 2024

PURPOSE:

This paper has been prepared for information and approval. It provides an overview of the Medical Devices and Point of Care Testing Service, its background to the organisation and its ambitions for 2024 – 2025. The report sets out how the service has performed over the past year, with highlights of the key achievements and a review of the challenges and risks.

RECOMMENDATION(S):

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

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

Approve/Take Assurance	Discuss	Information
✓	x	✓

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING 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	✓	

EXECUTIVE SUMMARY:

This paper has been prepared for information and approval. It provides an overview of the Medical Devices and Point of Care Testing Service, its background to the organisation and its ambitions for 2024 – 2025. The report sets out how the service has performed over the past year, with highlights of the key achievements and a review of the challenges and risks.

Key achievements include the appointment of a Point of Care Testing Co-ordinator that has led to improved governance and development opportunities; progress against internal audit recommendations and medical devices being added to the Community Equipment Service catalogue to enable prompt and efficient prescribing of key items of equipment to patients in the community.

Current **hot topics** for the health board include Welsh Government funding of over £1 million for replacement radiography equipment, development of a long-term replacement programme for high value equipment, new process for reusing walking aids to reduce cost and waste and monitoring of maintenance contracts for servicing and repairs of equipment.

Compliance with statutory and legal requirements is always a priority for the health board. Focused work has been undertaken on the management of Liquid Nitrogen Gas, which is used for minor dermatological procedures, ensuring robust governance is in place to achieve compliance with regulations.

The health board is required to ensure compliance with the Medical Device Regulations (MDR). There are still key decisions required by the Medicines and Healthcare products Regulatory Agency (MHRA) for health boards to confirm their preparedness against the new EU MDR. However, the health board has developed an action plan to monitor progress against the recommendations and is represented on national groups.

A review of bariatric equipment provision (equipment specifically designed to accommodate individuals with higher weight capacities or larger body sizes) has identified improvements are required. A planned approach to ensure inpatient staff can access suitable equipment in a timely manner will prevent any delays in patients being admitted to Powys hospitals and ensure patient experience is not compromised through inappropriate equipment.

DETAILED BACKGROUND AND ASSESSMENT:

A detailed background and assessment has been provided in the main Annual Report document below.

NEXT STEPS:

The Health Board will continue to work towards achieving the priorities listed in the report for 2024/2025.

POWYS TEACHING HEALTH BOARD
MEDICAL DEVICES AND POINT OF CARE TESTING ANNUAL REPORT
1st April 2023 - 31st March 2024

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Background

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

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

Based on the Medicines and Healthcare products Regulatory Agency (MHRA) definition, a Point of Care Testing device can be defined as any device or piece of equipment that analyses or measures a sample taken from a patient in the clinical setting rather than the sample being collected and then sent off to a laboratory for analysis

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

Introduction

This Annual Report describes the Health Board's Medical Device and Point of Care Testing activities undertaken, for the Financial Year commencing the 1st of April 2023 to 31st of March 2024.

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

- Governance Arrangements
- Risk Assessment and Management
- Partnership Working
- Environment and Sustainability
- Assurance
- Key Priorities for April 2024 to March 2025

Governance Arrangements

Medical Device and Point of Care Testing Team

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

The Chief Executive has delegated the responsibility and leadership for Medical Devices and Point of Care Testing to the Executive Director of Allied Health Professions, Health Science and Digital, who has delegated it to the Deputy Director of Allied Health Professions and Health Science.

This role is supported by a full-time Medical Device and Point of Care Testing Manager and a part-time Senior Administrator. The Medical Devices Manager takes responsibility for ensuring that PTHB is compliant with all aspects of Medical Device management and works in collaboration with internal and external service leads, Welsh Government, other NHS organisations and external multiagency partners, to help facilitate a comprehensive integrated approach across the organisation.

PTHB has acknowledged the requirement for a governance and reporting framework for Point of Care Testing to enable development in this area. A Band 7 Point of Care Testing Co-ordinator has been in post since January 2024, funded through the Six Goals for Urgent and Emergency Care Programme. The funding is due to end in September 2025. The post holder is a Specialist Biomedical Scientist with both clinical and technical expertise and scientific qualifications. The post, in conjunction with a formal Service Level Agreement with Aneurin Bevan University Health Board, has enabled a much-needed Governance and Assurance framework to support the development of Point of Care Testing in Powys.

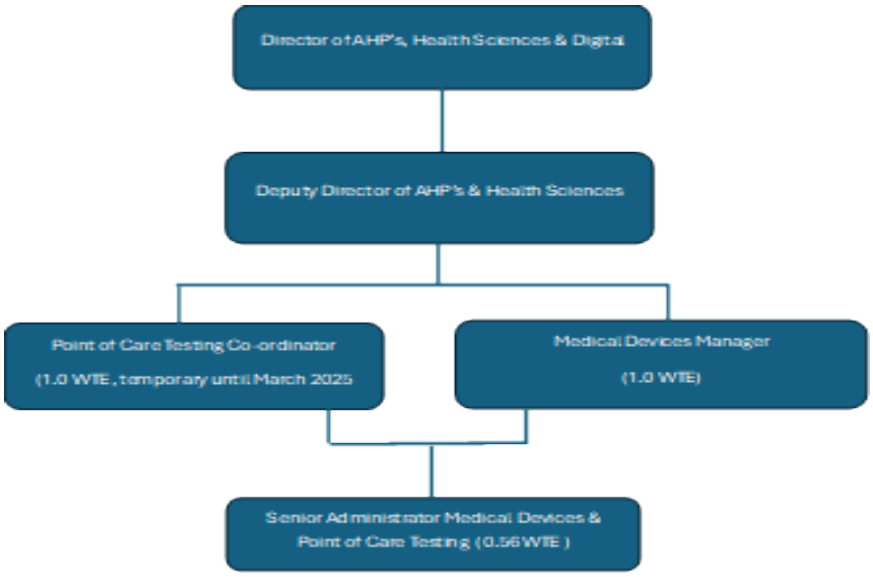


Diagram 1 – Medical Devices and Point of Care Testing Management Structure

Medical Equipment and Devices Internal Audit, October 2021

		Trend
Reasonable 	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.	 2017/18

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

An Internal Audit was carried out in July 2021 with the final report being issued in October 2021. The overall rating of Reasonable Assurance was awarded, a significant improvement on previous audits. Reasonable Assurance reflects the fact that a policy and procedures are in place, but improvements are required in some areas to ensure that controls are being consistently complied with. The key matters requiring management attention have been outlined in an action plan and regularly reviewed and updated through the Medical Device and Point of Care Testing Group. Compliance against the recommendations is also formally reported through internal audit monitoring processes led by the Corporate Governance Team.

Significant improvements have been made against the recommendations, with several fully completed, however, the speed of progress against the remaining recommendations has been limited by capacity of the team. Outstanding actions continue to be closely monitored and full details of these can be referenced in Appendix A.

Recommendation Area	Status
Purchase of New Equipment	**Complete**
Inventory Records	**Complete**
Loaned Equipment	**Complete**
Storage of Medical Equipment Devices & Equipment	**Complete**
Staff Training	**Elements outstanding** Progress is being made against this recommendation. It is anticipated that a robust model will be implemented for high-risk items by end of Financial Year 2024/2025. This will be dependent on resource and capacity, but once embedded the model will be rolled out across all service areas and devices.
Contract Monitoring	**Elements outstanding**

	Progress is being made against this recommendation. Improved processes have positively impacted on contract monitoring, Financial Year cost savings and opportunities to strengthen processes. Limitations within the medical devices team and challenges with the main contract provider continue to be a barrier to continuous improvement against this recommendation.
Point of Care Testing	**Elements outstanding** Progress is being made against this recommendation. Point of Care Testing Coordinator commenced in post January 2024 and is making significant process in terms of strengthening processes and governance for existing POCT. In addition, the co-ordinator is Financial Year opportunities for further development of POCT.

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

Risk Assessment and Management

The Medical Devices and Point of Care Testing Service risk registers are reviewed and updated monthly, and those risks (over 12) are reported into the Directorate risk register. During the timeframe for this report the team had 3 risks (over 12) on the overarching risk register.

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

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

There are ongoing challenges related to the management of Liquid Nitrogen Gas in terms of ownership and responsibility. Liquid Nitrogen is formally identified as a Medical Device and is used in Outpatient areas of the Health Board for minor dermatological procedures. Despite a Standard Operating Procedure being in place, there are risks related to the handling and management of this device which are operational in nature. Discussions are underway with the Community Service Group and Outpatient service to ensure that this is reflected on the operational risk register for the service and to set actions for the health board to be assured that a robust governance and reporting framework is in place. This will be monitored

through the Community Services Group operational governance structure and Medical Devices and POCT group.

Incidents

Incidents are reported into the Medical Device and Point of Care Testing Group where key themes and trends are also identified. The Medical Device and Point of Care Testing Manager is automatically informed of any related incidents. Through the Medical Device and Point of Care Testing Group, awareness has been raised of the importance in selecting correct categories when reporting an incident into Datix. This is to ensure incidents are not missed by relevant personnel in order for appropriate actions and learning to be achieved.

During this reporting period, there have been a total of 67 incidents reported. These fall into subcategories as listed below. Analysis of these figures does not show any trends or themes of concern relating to specific equipment type or service.

Category	Quantity
Failure of Medical Device	22
Other	18
Medical Device User Error	6
Accidental Damage/Loss	6
Lack of Availability of Medical Device consumables	1
Lack of Availability of Medical Device	12
Poorly Maintained Device	2

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

Medical Devices Audit

The Medical Devices Audit relaunched in February 2022 transferring from a manual version into a digital format in Microsoft Forms. The audit covers key areas of medical device management. For example, maintenance; asset tracking; storage; training; infection control and decontamination. Adopting the MS Forms method has resulted in much greater uptake by services. Audit outcomes are reported and monitored through the Medical Device and Point of Care Testing Group. The Medical Device and Point of Care Testing Team provide support to teams who Financial Year through their audit process that improvements are required. Further improvements are being implemented to support services with increasing their uptake further. Specific months have been set to assist with the uptake of the audit, these are January and June. During this reporting period, an audit month occurred in January 2024 of which 100 responses were received from services. The results were overall positive, with a few areas identified as requiring some additional support from the Medical Device and Point of Care Testing Team. The number and types of

queries received from services by the team during audit month suggested the audit was having a positive impact.

Medical Device Training

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

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

Progress has been made with the provision of syringe driver training, with sessions held during this period. Staff captured in these sessions has included the overseas nurses joining the health board.

It is anticipated that a robust model will be implemented for high-risk items by end of Quarter 4 in Financial Year 2024/2025. This will be dependent on resource and capacity, but once embedded the model will be rolled out across all service areas and devices. Whilst work has been steady, it has not been possible to progress fully to where the health board needs to be. Capacity limitations within the medical devices team has been a barrier. However, a more collaborative approach will ensure tasks are equally shared and progress can be made.

Medical Devices Regulations (MDR)

Following the United Kingdom's departure from the European Union, the updated Medical Devices Regulations are in the process of being updated. It is anticipated that EU MDR will implement new requirements for services within health institutions who are considered to manufacture and / or modify medical devices. This activity was previously unregulated. The Medical Devices and Point of Care Testing Manager, along with clinical representation, attend a *Health Education and Improvement Wales* (*HEIW*) led national MDR group which has been tasked with reviewing information and assessing Health Board readiness for the change in regulations which will have legal implications on organisations. In addition, the health board has commissioned the support of Swansea Bay University Health Board (SBUHB) to undertake a review of services in relation to MDR preparedness based on the experience of SBUHB and their pan-Health board approach to MDR preparedness. The review took place between November and December 2023, commencing with a 'MDR Launch Meeting', and subsequent follow up

questionnaires and 'drop in' virtual meetings for discussions. The review identified 9 recommendations which fall into five themes:

1. Pan and Cross Health Board
2. Therapy Services and Audiology Services
3. Dental Service
4. Theatres and Endoscopy
5. Software as a Medical Device

There are still key decisions required by the MHRA in order for health boards to confirm their preparedness against the new EU MDR. However, the health board has developed an action plan to monitor progress against the recommendations with nominated MDR leads from relevant services attending regular meetings.

Partnership Working

Medical Devices Replacement Programme

The Medical Devices Replacement Programme is regularly discussed at the Medical Device and Point of Care Testing Group.

A pilot has commenced in theatre and endoscopy, a service with high value equipment. It is anticipated that by the end of Financial Year 2024/2025 it will be possible to have a register of high value theatre and endoscopy items, expected replacement date and estimated costs. Once the pilot is complete and the model evaluated, the approach will be rolled out across other high value equipment areas including dental and outpatients.

It is recognised that further work is needed in this area with the relevant service areas. The Medical Device and Point of Care Testing Manager has close links with Capital Control Group to ensure any opportunity for funding is secured and allocated through a fair prioritisation process. Prior to medical equipment requests for Capital Funding being presented to the Capital Control Group, they go through the Capital Funding Prioritisation Group where a formal evaluation process takes place. Prioritisation in this way supports the Capital Control Group in allocating funding accordingly.

During Financial Year 2023/2024, the health board was successful in obtaining end of year monies from Welsh Government (WG) which enabled £167,000 of equipment to be purchased across the organisation. This funding is essential to support replacement of key items of equipment required to deliver services across the health board. The prioritisation process is key to this end of year funding, to ensure the health board is able to submit a detailed list of equipment when asked by WG. Timeframes and lead times are dependent on the funding being awarded and the health board being able to deliver within the Financial Year.

Links have been strengthened with Charitable Fund and League of Friends colleagues. This has led to vast improvements, particularly in relation to the

governance arrangements to support acquisition of equipment purchased through these routes, and also raised awareness of funding options available to service leads.

Radiology Informatics System Procurement (RISP)

Welsh Government have approved over £1 million for replacement radiography equipment in PTHB to support delivery of the RISP programme. The Medical Devices team are fully engaged in supporting this capital project.

Clinical Education

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

Community Equipment Contract and Medical Devices

The Medical Devices and Point of Care Testing Service Manager has worked closely with the Head of Therapies and the Strategic Commissioning Manager in Powys County Council to identify medical devices which are suitable for distribution via the Community Equipment Service. These items include nebulisers, suction machines and cough assists and are now available for clinicians to prescribe for patients. Issuing medical devices in this way will ensure that the Health Board is assured that those items are readily available and serviced and maintained as required. These key relationships continue to strengthen enabling improved assurance processes, reporting on activity and compliance into the Medical Device and Point of Care Testing Group on a quarterly basis.

Environment & Sustainability

The Medical Device and Point of Care Testing Manager and the Environment and Sustainability Team work very closely. Collaboratively, improvements have been put in place to support the acquisition and disposal of medical devices ensuring environment and sustainability factors are always considered.

The Health Board is part of an all-Wales contract with an on-line auction company. This company collects and disposes of equipment that is no longer required by the Health Board. This process generates substantial income for the Health Board with a total of £53,000* during Financial Year 2023/2024. Please note this total includes non-medical equipment. This process not only provides some income generation for the Health Board but also ensures items are disposed of in a responsible way. The Medical Device and Point of Care Testing Manager is certified Carbon Literate, along with other members of the AHP and Health Science Directorate.

The contract with the current provider is due to end during Financial Year 2024/2025 for which a formal procurement exercise led by NWSSP will be undertaken.

**this figure is higher than normal as a result of 3 ultrasound machines being sold which are high value items.*

Equipment acquired through planning for COVID-19

Planning for COVID-19 included acquisition of many items of medical devices and equipment, through local and national procurement processes. To store these items a unit was leased in a central location within Powys. A priority for 2023/2024 was to vacate the unit, with considerable planning required to undertake this. This included a replacement programme to distribute beds across the health board. The Medical Device and Point of Care Testing Manager was successful in vacating the unit by November 2023 with all, but a few items, reallocated. The remaining items are stored within the Medical Device and Point of Care Testing office and issued as replacements as and when required.

Assurance

POCT Governance

As a discipline POCT is aligned with laboratory science for regulation under the ISO 15189:2022 Standards. During Q4 The POCT Coordinator began reviewing all PTHB POCT SOPs and policies against these standards and is now working to update any important omissions. This will provide assurance that staff have the right information and instruction to safely and expertly use POCT across the health board ensuring patient safety.

Medical Device Alerts

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

There were 9 alerts received into the Health Board during this reporting period.

Number of alerts received	Number not Applicable to PTHB	Number Closed	Number with actions outstanding
9	4	3	2

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

Bed and Mattress Audit

In December 2023, an external audit was undertaken of beds and mattress across the health board. This included checking condition of the equipment. In relation to mattresses this included checking for signs of staining, tearing and/or punctures and zip damage. The results were disappointing in that a failure rate of 31% was identified for foam mattrasses and 28% of hybrid mattresses (mattresses which can be used in foam or air mode). Prompt action was taken with mattresses and /or covers being replaced accordingly. An improvement plan was put in place, led by the Assistant Director of Community Service Group. Multi-level audits have been implemented which includes routine ward level audits in conjunction with audits undertaken by Infection Prevention and Control and Head of Nursing at agreed intervals. The improvement plan is regularly reviewed and monitored through the Medical Device and Point of Care Testing Group.

Complaints & Patient Feedback

The service is pleased to report there have been no complaints reported in relation to medical devices and point of care testing during the reporting period. However, the Medical Devices Team has listened and taken on board comments made regarding disposal methods for walking aids. A collaborative approach, both internally and externally with neighbouring health boards, has enabled the development of an improved process. A Standard Operating Procedure for "Maintenance, Inspection and Refurbishment of Walking Aids to be Re-issued" has been developed to enable patients to return walking aids to their local hospital, regardless of where they were issued which was not previously permitted. The change also sees the implementation of a re-issuing process, rather than the previous process of disposal of the equipment. Not only does this process offer a far more convenient option for Powys residents, but also ensures the Health Board is acting responsibly in relation to environment and sustainability factors. Whilst these items are generally low value items, the financial benefits to re-issuing such equipment will be significant.

Lessons & Good Practice

Medical Devices and Point of Care Service Testing Group receives quarterly reports from all service areas, which are reviewed and used to formulate lessons learnt and good practice for sharing across the Health Board.

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

Work has been undertaken to ensure that all relevant documentation and guidance has been uploaded to the SharePoint site. This allows staff ease of access to documents, procedures and other useful and up to date information. Improvements have continued to be made which includes progress with the uploading of medical device User Manuals.

Indemnity Forms

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

Freedom of Information Requests

During 2023/2024 there were 5 Freedom of Information requests made with regards to Medical Devices. Of these, 1 breached the timeframe for replies as a result of limited capacity within the team to respond in a timely manner.

Month of Request	Request Subject	Requestor Type	Time taken (days)
April 23	Who holds contract for servicing of medical scales	Company	1
April 23	Type, model, quantity, location of Point of Care Near patient in-vitro diagnostic analysers	Company	10
July 23	What ventilators/life support machines	Company	1
August 23	What MRI and CT Scanners	Company	4
December 23	Respiratory Equipment	Company	1

Table 4 – Freedom of Information requests made during 2023/2024 (*Data Source: Medical Device & Point of Care Testing Team)*

Medical Devices and Point of Care Testing Priorities 2024/25

Point of Care Testing

There is a clinical delivery risk associated with the existing limited governance of Point of Care Testing. The POCT Coordinator has already begun to address risks identified on the directorate register and Internal Audits, through reviewing policies and SOPs, errors, omissions, and implementing any required updates.

POCT is a cornerstone of Strategic Priority 5: Deliver the Planned Care and Diagnostics Programme and has specific goals allocated to POCT within the Integrated Medium-Term Plan 2024-2029 detailed below.

Strategic Priority 5

Key Areas of Delivery	Key Deliverables	Timescale	Intended Outcome/ Impact
Enhance the provision of Point of Care Testing throughout Powys	Review and develop existing POCT provision and governance: Establish QA Compliance framework, analyse asset registry, monitoring initiation and training development	Q1-Q2	Improved assurance and governance
	Expand availability of POCT provision in support of clinical pathway development and governance: Financial Year opportunities in primary & community care, prepare for internal audit	Q3-Q4	Improved access to Point of Care Testing
	Financial Year ongoing funding for the POCT Co-ordinator role	Q3-4	Ensure continuity for future development & expansion of POCT

Table 5 - *How POCT Service meets PTHB Strategic Priorities Integrated Medium Term Plan 2024-29*

Once this work has progressed then the aim is to look at ways in which the latest innovative POCT technology can improve patient pathways and safety. However, the POCT Coordinator is on a fixed term contract until September 2025 which limits the impact that they can have on delivery of Integrated Medium-Term Plan and any future expansion or improvements they might Financial Year during this time. Reverting to zero whole time equivalent (WTE) POCT dedicated resource would present a risk to the health board. So, to mitigate this risk a business case for a permanent POCT resource is being prepared (Submission Quarter 3 2024/25). It contains a phased expansion of staffing that will guarantee there are enough staff in place to ensure that the goals within the Integrated Medium-Term Plan
can be fully achieved and also provide a firm foundation for PTHB to fully capitalise on the potential that Point of Care Testing has to offer the health board.

All Wales Point of Care Testing System (WPOCT)

The Health Board is included in an All-Wales contract for a Point of Care Testing IT solution that enables test results to be transferred electronically from networked Point of care testing devices to Welsh Clinical Portal. Whilst the Health Board contributes financially on annual basis for the solution, it has not yet been possible to fully implement the system across the Health Board. However, the newly appointed POCT Co-ordinator is now leading on this project and work is expected to be complete during Quarter 4 2024/25.

The system also has many quality assurance tools within it, which allow the POCT Coordinator to control, monitor and audit performance of devices and staff remotely, ensuring good governance is maintained for POCT use across the Health Board. The report functions allow for comparison both internally and at national level, as anonymised data is shared with NHS Wales.

In real time filing of test results into the Welsh Clinical Portal reduces time to treatment, improving patient safety and outcomes for those that do require admission or transfer. This is particularly beneficial to Powys residents who are often moved out of Powys for acute/further treatment and whose journey often involves multiple services, both in and outside of Powys.

Business Continuity

A Business Impact Assessment has been undertaken and the service is compliant with the Health Boards requirements. Given the single point of dependency for both Medical Device and Point of Care Testing, there remains ongoing challenges during times of absence. Whilst cross cover is possible to some degree, there will always be limitations in technical and expert knowledge. Should the health board decide not to continue with the Point of Testing Co-ordinator role at the end of the fixed term period, the resource will revert to zero dedicated support for POCT which will create a risk. A review of the Business Impact Assessment is planned for the end of December 2024 in line with the Health Boards Business Continuity process.

Information Communication and Technology (ICT)

Progress has been made in that the Medical Device and Point of Care Testing Audit is now digitalised in the form of MS Forms. Opportunities continue to be identified for further digitalisation with plans to move the Equipment and Device Ordering Form (EDOF) into a digital format. This will create a much more user-friendly version for staff completing the document. It will also create efficiencies within the Medical Device & Point of Care Testing Team.

e-Quip Asset Management System

e-Quip Asset Management System is used by the Health Board to manage medical devices. Following a lengthy project implementation phase which commenced prior to COVID-19, transfer into Business as Usual took place in December 2022. Robust processes have been implemented to support the success of the system. It is essential that service groups adhere to these processes and ensure they are compliant with all elements of medical devices and point of care testing management. Validation exercises continue to be undertaken, in conjunction with services to ensure processes continue to be embedded. As previously referenced, a pilot in Theatre & Endoscopy includes key staff having access to the system to support with replacement planning. All POCT Devices will be managed in e-Quip by the POCT Coordinator.

Contracts

Contract monitoring is a key aspect of Medical Device and Point of Care Testing management. Contracts can include all-Wales purchasing contracts through which the Health Board benefits from reduced costs and maintenance

contracts for maintenance and repair of equipment. As of 1st of April 2022, the main maintenance contract for medical devices was awarded to a new provider. Year one and two of the contract identified some issues, which have been raised with the provider and NWSSP Procurement and worked through collaboratively. These issues include unexpected costs associated with wasted visits and user damage.

The contract covers many general medical devices, excluding specialist items such as beds, hoists, dental and x-ray equipment for example. These specialist items are covered by separate contracts. Since this reporting period, a Contract Improvement Notice has been issued to the provider. An action plan has been developed to monitor progress against the areas identified in Contract Improvement Notice, and Contract Review meetings held in conjunction with NWSSP Procurement colleagues.

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

PTHB Preceptorship Study Day

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

Main Maintenance Contract

With the main contract due to end 31st March 2025, the team are in the process of reviewing the options for maintenance provision from 1st April 2025. The current provider contract term is 3 years +1 +1 so there is scope to extend. However, there must be significant improvements in the service for that to be a feasible option. A refreshed service specification has been developed to support this process and will be utilised if the contract in retendered.

Bariatric Equipment

The health board has experienced challenges with access to bariatric equipment for inpatient wards. This has sometimes led to delayed admissions as suitable equipment has not been available in time to accept patients. The Medical Device and Point of Care Testing Manager has engaged with the Assistant Director for Community Service Group and Head of Nursing. The response to an SBAR was that a formal rental arrangement would be the preferred option to ensure such equipment could be accessed in a timely manner. NHS Wales Shared Services Partnership Procurement Services (NWSSP) are now engaged along with Supply chain, exploring potential suppliers. It is anticipated this formal arrangement will be in place by the end of Financial Year 2024/2025.

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

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

Matter Arising 4 - Storage of Medical Equipment Devices & Equipment (Operating effectiveness)	Status
Management at the Llanidloes Hospital should be asked to review their storage areas within the Graham Davies Ward at Llanidloes Hospital with a view to providing a single, secure storage facility for medical devices and equipment. A general reminder should be issued to all sites within the Health Board of the requirement to ensure that all medical devices and equipment are stored in a safe, secure location when not in use.	**Complete**
Matter Arising 5 - Staff Training (Operating effectiveness)	**Status**
a) The Local Responsible Officers at each ward / department should ensure that all training received by staff in respect of medical devices and equipment is recorded in ESR. b) The manufacturer's instructions for all medical devices and equipment should be scanned and stored together electronically in accordance with the requirements of the Policy for the Management of Medical Devices and Equipment. This may be achieved by developing a central repository for manufacturer's instructions that is accessed via the Medical Devices pages of the intranet, rather than being done by individual wards and departments.	**a) Progress is being made against this recommendation.** It is anticipated that a robust model will be implemented for high-risk items by end of 2024/2025. This will be dependent on resource and capacity, but once embedded the model will be rolled out across all service areas and devices. **b) Complete**
Matter Arising 6 - Contract Monitoring (Control design)	**Status**
The Health Board should introduce suitable monitoring arrangements for all contracts associated with the provision and maintenance of medical devices and equipment. This	**Progress is being made against this recommendation.**

should include the development of key performance indicators (KPI's) and targets for each contract. These could for example include: • Actual expenditure against expected expenditure / annual contract value • The number / percentage of medical devices and equipment serviced each month / quarter (Planned Preventative Maintenance Contracts) • Quality - the number of staff and patient complaints received, number resolved / unresolved, time taken to resolve. • Call out response times (for responsive, unplanned maintenance) Performance should preferably be monitored on a regular basis and reported to the Medical Devices Group.	Improved processes have positively impacted on contract monitoring, Financial Year cost savings and opportunities to strengthen processes. Limitations within the medical devices team and challenges with the main contract provider continue to be a barrier to continuous improvement against this recommendation.
Matter Arising 7 - Point of Care Testing (Operating effectiveness)	**Status**
7.1) Staff and independent contractors across the HB responsible for undertaking POCT should be reminded to ensure that all Internal Quality Control (IQC) checks and External Quality Assessments (EQA's) are recorded in accordance with the requirements of the Management of Point of Care Testing Policy. 7.2) Staff and independent contractors across the HB responsible for the management of medical devices and equipment and undertaking POCT should be reminded of the requirement to periodically complete the Medical Devices Audit Form, in accordance with the Management of Point of Care Testing Policy and the Management of Medical Devices and Equipment Policy. The Management of POCT policy should be updated to include an indicative timescale for undertaking self-audits and completing the Medical Devices Audit Form. A link to the Medical Devices Audit Form should also be added to the Management of Medical Devices and Equipment Policy. 7.3) A Standard Operating Procedure (SOP) should be drawn up for all medical devices and equipment used in POCT, in accordance with the Management of Point of Care Testing Policy.	**Progress is being made against this recommendation.** Point of Care Testing Coordinator commenced in post January 2024 and is making significant process in terms of strengthening processes and governance for existing POCT. In addition, the co-ordinator is Financial Year opportunities for further development of POCT.

IMPACT ASSESSMENT

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				

EQUALITY:

	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			

Statement

Vaccination will be offered to eligible groups as defined by Welsh Government and the JCVI. This will positively impact on those over 65 who will all be eligible, pregnant women and anyone in a clinically 'at risk' group.

There will be consideration given to ensuring equity of access to vaccinations throughout the campaign. Vaccine information will be available in Welsh where required.

RISK ASSESSMENT:

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

Statement

There is a risk to reputation of non delivery. There is a financial and operational risk should the cold chain for vaccinations be compromised or should WG financial or operational support for the programmes change. There is a clinical risk should delivery of vaccination be compromised.

Risks will be minimised through regular updates to Executives (through the Director of Public Health) and through Public Health Directorate quality assurance structures.

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 5.5

PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE	**07 November 2024**
Subject:	2024-2025 Clinical Audit Programme Update Report
Approved and presented by:	Kate Wright, Medical Director (Richard Stratton in KW's absence)
Prepared by:	Howard Cooper, Safety and Quality Improvement Manager
Other Committees and meetings considered at:	Executive Committee - 30 October 2024

PURPOSE:

The purpose of this paper is to provide an update on progress against the 2024-2025 clinical audit plan.

RECOMMENDATION(S):

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

- **RECEIVE** the update report and take **ASSURANCE** that clinical audit is progressing in year.

Approve/Take Assurance	Discuss	Note
Yes	No	N

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:		
1. Focus on Wellbeing	Y	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	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	

BACKGROUND:

The Clinical audit plan was originally developed by the five Assistant Directors with responsibility for;

- Women and Children's Services
- Community Services Group
- Mental Health and Learning Disabilities Group
- Medicines management
- Primary Care

The Patient Experience, Quality and Safety Committee received and approved the plan at its meeting in April 2024.

October 2024 Updates:

Clinical Audit Developments: Introduction of the MEG Audit System

The Nursing Directorate plans to introduce the Medical E-Governance or MEG system to Powys hospital wards. The MEG software will enable staff to electronically record all of the ward-level audits including the Infection Prevention and Control audits onto one system. Currently audits are paper based and require manual analysis and data entry which has proven to be very difficult. The data in one central location will enable management to review local trends and learning and elicit Powys-wide themes and learning. In turn this will allow staff to review, analyse, learn and implement education on findings as well as providing the ability to benchmark areas for the purposes of ward accreditation. It will also allow the Health Board to triangulate against patient feedback and develop action plans from complaints/concerns and HIW inspection reports.

Primary Care Group Audits
As outlined in April, Primary Care clinical audits are traditionally added to the plan during the year, to confirm this is planned to take place at the November meeting of the GMS Contract Reform Group to agree the appropriate audits for supplementary services.

Audit Spotlight: Respiratory Care Programmes for Children with severe Cerebral Palsy

In 2021, research by Noula Gibson and colleagues from Perth, Australia highlighted that respiratory disease is the leading cause of death in children and young people with severe cerebral palsy. Much of this disease burden can be either prevented or minimised if at risk children are identified, and a supportive respiratory physiotherapy programme provided.

Gibson identified seventeen factors that would suggest a child or young person is at high risk. These include a Gross Motor Function Classification System (GMFCS) score of 4 to 5, more than one hospital admission per 12 months, more than four

prescriptions for antibiotics in a year as well as a number of other risk markers around eating and breathing that can contribute to respiratory distress.

Following the publication of this research, Helen Powell, one of the Paediatric Physiotherapy team, cascaded this research to her fellow paediatric physiotherapists in Powys. Following this update, annual respiratory training sessions are now delivered for the paediatric physiotherapy service to refresh respiratory skills in assessment, outline the treatment and prescribing of respiratory physiotherapy programmes and to share good paediatric respiratory practice.

Helen decided to undertake an audit to monitor the effectiveness of the training sessions. 12 children in Powys with a GMFCS score of 4 to 5 were identified and it was identified that seven of these children had a respiratory physiotherapy programme in place, whilst five did not.

Action plans are in place support the implementation of the remaining five respiratory physiotherapy programmes needed, through clinical supervision, the sharing of existing examples of respiratory programmes and the provision of annual respiratory training to expand learning, knowledge and competencies in paediatric respiratory physiotherapy in Powys. It is planned to repeat this audit in 2025.

It is also being planned to extend this work to 42 further children and young people who suffer from a range of neuro-disabilities other than Cerebral Palsy that are of equal severity.

Audit Spotlight: From Audit to Business as Usual
As part of a larger Safeguarding project the Therapies Directorate undertook a number of audits following a Serious Incident in 2020. As a result of needs identified after the investigation of the incident there was a change to Health Board policy that made the service leads responsible for the monitoring of occasions where a child or young person "Was Not Brought" (WNB) to an appointment.

An audit was performed in November of 2021 to monitor the compliance with this new policy and the results of the audit were very positive in terms of compliance with the new policy. In April 2022 a new process was implemented within Therapies and Health Sciences whereby data was pulled off the available systems and a WNB compliance audit was completed every month. From September 2023 Therapies and Health Sciences then implemented a managers assurance tool to ensure the continuous auditing and monitoring of WNBs within services. This is now being adopted within other departments.

This marked a transition from the need to do an *ad hoc* audit to a business-as-usual management system.

It can now be reported that from September 2024 the system has been expanded to allow the reporting of occasions where a vulnerable adult is not brought to an appointment. Work is continuing to establish how many Multi-Agency Referral Forms (MARFs) will be generated as a result of this new reporting mechanism.

Changes to the Annual Clinical Audit Programme:
Similarly, there have been a number of other former audits which have now moved on to business as usual reporting. These include five subject areas from the Theatres and Endoscopy team and two from audiology. They have therefore been removed from the audit programme as they are now reported elsewhere.

In addition. the Quarterly Audiology Wax Management audit has been stood down and replaced with a single annual audit. There have been some minor changes to the original plan where audits have been amalgamated or brought together to be done at the same time.

A few of the audits have been delayed, in the main this is due to situations where the changes to an existing service, or introduction of a new service, has been itself delayed thereby making it impossible to conduct the audit at this time.

Audit trends:
There have been no specific trends identified during this period of clinical audits nor any concerns needed escalation to the respective risk registers.

Appendix A reports the progress against the 2024/25 Clinical Audit programme.

IMPACT ASSESSMENT – NOT REQUIRED
This section must be completed for all strategic organisational decisions including approval of health board policies.

Community Services Group					
Unscheduled Care					
Driver	Audit Title	Expected End Date	Service	Lead	Status
Local Audits for Service Improvement	Missed Fractures Audit	Quarter 4 2024/25	Unscheduled Care	Senior Manager	**UNDERWAY ON TRACK**
Local Audits for Service Improvement	Routine enquiry audit	Quarter 4 2024/25	Unscheduled Care	Senior Manager	**UNDERWAY ON TRACK**
Local Audits for Service Improvement	Hand Hygiene Audit	Quarter 4 2024/25	Unscheduled Care	Senior Manager	**UNDERWAY ON TRACK**
Local Audits for Service Improvement	Adherence to clinical supervision policy	Quarter 4 2024/25	Unscheduled Care	Senior Manager	**UNDERWAY ON TRACK**
Local Audits for Service Improvement	Paramedic/downgrade ambulance audit	Quarter 4 2024/25	Unscheduled Care	Senior Manager	**UNDERWAY ON TRACK**
Local Audits for Service Improvement	PGD Audit	Quarter 4 2024/25	Unscheduled Care	Senior Manager	**UNDERWAY ON TRACK**
Local Audits for Service Improvement	Paeds under five audit – scrutiny of every attender under five	Quarter 4 2024/25	Unscheduled Care	Senior Manager	**UNDERWAY ON TRACK**

Nursing (Ward and Community)					
Driver	Audit Title	Expected End Date		Lead	Status
Local Audits for Service Improvement	Health & Care Monitoring Tool (Includes Hand hygiene audits & Patient surveys, ward cleaning)	Quarter 4 2024/25	Nursing (Wards)	Ward Managers	**UNDERWAY ON TRACK**
Local Audits for Service Improvement	NEWS Audit	Quarter 4 2024/25	Nursing (Wards)	Ward Managers	**UNDERWAY ON TRACK**
Local Audits for Service Improvement	Wristband Audit	Quarter 4 2024/25	Nursing (Wards)	Ward Managers	**UNDERWAY ON TRACK**

Local Audits for Service Improvement	Dols Audit	Quarter 4 2024/25	Nursing (Wards)	Ward Managers	**UNDERWAY ON TRACK**
Local Audits for Service Improvement	Environmental Audit	Quarter 4 2024/25	Nursing (Wards)	Ward Managers	**UNDERWAY ON TRACK**
Local Audits for Service Improvement	Welsh Language Audit	Quarter 4 2024/25	Nursing (Wards)	Ward Managers	**UNDERWAY ON TRACK**
Local Audits for Service Improvement	DNACPR Audit	Quarter 4 2024/25	Nursing (Wards)	Ward Managers	**UNDERWAY ON TRACK**
Local Audits for Service Improvement	Multi-factorial Falls Risk Assessment Audit (Inpatients)	Quarter 4 2024/25		Ward Managers	**UNDERWAY ON TRACK**

Specialist Nursing					
Driver	Audit Title	Expected End Date		Lead	Status
Other National Audit & Service Evaluation	Parkinson's UK National Audit	Quarter 4 2024/25	Specialist Nursing – Parkinson's Disease	Parkinson's Disease ANP	**UNDERWAY ON TRACK**
Local Audits for Service Improvement	Pressure Damage Audit	Quarter 4 2024/252024	Specialist Nursing – Tissue Viability Nurse	Senior Nurses	**UNDERWAY ON TRACK**
Service Evaluation	Clinic PREM Data	Quarter 4 2024/25	Specialist Nursing - Continence	Continence Service Manager	**UNDERWAY ON TRACK**
Service Evaluation	Prescribing Data	Quarter 4 2024/25	Specialist Nursing - Continence	Continence Service Manager	**UNDERWAY ON TRACK**
Service Evaluation	Transition Clinic PREM Data	Quarter 4 2024/25	Specialist Nursing - Continence	Continence Service Manager	**UNDERWAY ON TRACK**
Service Evaluation	Pad PREM	Quarter 4 2024/25	Specialist Nursing - Continence	Continence Service Manager	**UNDERWAY ON TRACK**
Service Evaluation	COBWEB PREM	Quarter 4 2024/25	Specialist Nursing - Continence	Continence Service Manager	**UNDERWAY ON TRACK**
Service Evaluation	CIVICA/PREMS clinic data	Quarter 4 2024/25	Specialist Nursing – Cardiology	Cardiology Team Lead	**UNDERWAY ON TRACK**

Other National Audit & Service Evaluation	National Audit of Cardiac rehab/PROMS	Quarter 4 2024/25	Specialist Nursing – Cardiology	Cardiology Team Lead	**UNDERWAY ON TRACK**
Service Evaluation	CROMS data	Quarter 4 2024/25	Specialist Nursing – Cardiology	Cardiology Team Lead	**UNDERWAY ON TRACK**
Local Audits for Service Improvement	Quality Assurance Audits for ECHO scans at neighbouring DGH.	Quarter 4 2024/25	Specialist Nursing – Cardiology	Cardiology Team Lead	**UNDERWAY ON TRACK**

Surgery and Endoscopy					
Driver	**Audit Title**	Expected End Date	**Service**	**Lead**	Status
Local Audits for Service Improvement	NEWS Audit	Quarter 3 2024/25	Theatre/Endoscopy	Theatre/Endoscopy Lead	**Some aspects already completed but further measures to be audited in Q4**
Service Evaluation	Surgical Performance/DNA/Cancellation data	Quarter 4 2024/25	Theatre	Theatre Lead	**Removed – now reported as performance measure in business meeting**
Service Evaluation	Monthly Surgical Utilisation data	Quarter 4 2024/25	Theatre	Theatre Lead	**Removed – now reported as performance measure in business meeting**
Service Evaluation	Surgical Site Infection data	Quarter 4 2024/25	Theatre	Theatre Lead	**Removed – now**

					reported as performance measure in business meeting
Service Evaluation	Surgical incidents	Quarter 4 2024/25	Theatre	Theatre Lead	**Removed – now reported as performance measure in business meeting**
Service Evaluation	Hand hygiene Audits	Quarter 4 2024/25	Theatre	Theatre staff	**UNDERWAY ON TRACK**
Service Evaluation	Bi weekly C4C audit	Quarter 4 2024/25	Theatre	Facilities	**Removed – now reported as performance measure in business meeting**
Service Evaluation	Legal and ethical audit	Quarter 2 2024	Theatre	Theatre Lead	**COMPLETED**
Service Evaluation	Data protection and GDPR	Quarter 2 2024	Theatre	Theatre Lead	**COMPLETED**
Service Evaluation	Management/Human Resources	Quarter 2 2024	Theatre	Theatre Lead	**COMPLETED**
Service Evaluation	Education	Quarter 2 2024	Theatre	Theatre Lead	**COMPLETED**
Service Evaluation	Five Steps to Safer Surgery	Quarter 2 2024	Theatre	Theatre Lead	**COMPLETED**
Service Evaluation	Managing Perioperative Normothermia	Quarter 2 2024	Theatre	Theatre Lead	**COMPLETED**
Service Evaluation	Risk Management (Organisational and Environmental)	Quarter 2 2024	Theatre	Theatre Lead	**COMPLETED**
Service Evaluation	Decontamination	Quarter 2 2024	Theatre	Theatre Lead	**COMPLETED**
Service Evaluation	Specimen Management	Quarter 2 2024	Theatre	Theatre Lead	**COMPLETED**

Service Evaluation	Tourniquets	Quarter 2 2024	Theatre	Theatre Lead	**COMPLETED**
Service Evaluation	Use and Handling of Surgical Instruments	Quarter 2 2024	Theatre	Theatre Lead	**COMPLETED**
Service Evaluation	Preoperative care for Patients with Dementia	Quarter 3 2024	Theatre	Theatre Lead	**COMPLETED**
Service Evaluation	Anaesthesia	Quarter 3 2024	Theatre	Theatre Lead	**COMPLETED**
Service Evaluation	Surgical record keeping audit & consent	Quarter 3 2024	Theatre	Theatre Lead	**COMPLETED**
Service Evaluation	Post anaesthetic Care	Quarter 3 2024	Theatre	Theatre Lead	**COMPLETED**
Service Evaluation	Surgical Patient Satisfaction audit	Quarter 3 2024	Theatre	Theatre Lead	**UNDERWAY ON TRACK**
Service Evaluation	Electrosurgery	Quarter 3 2024	Theatre	Theatre Lead	**COMPLETED**
Service Evaluation	Fluid Management	Quarter 3 2024	Theatre	Theatre Lead	**COMPLETED**
Service Evaluation	Foreign body aspiration during intubation, advanced airway management or ventilation	Quarter 3 2024	Theatre	Theatre Lead	**Some aspects already completed but further measures to be audited in Q4**
Service Evaluation	Surgical patient story	Quarter 3 2024	Theatre	Theatre Lead	**Delayed to Quarter 4**
Service Evaluation	Pre assessment and Specific Day Case Requirements	Quarter 4 2024/25	Theatre	Theatre Lead	**UNDERWAY ON TRACK**
Service Evaluation	Audit of prosthesis verification data	Quarter 4 2024/25	Theatre	Theatre Lead	**UNDERWAY ON TRACK**
Service Evaluation	Intraoperative Care	Quarter 4 2024/25	Theatre	Theatre Lead	**UNDERWAY ON TRACK**
Local Audits for Service Improvement	Staff Satisfaction	Yearly Quarter 1 2024	Theatre	Theatre Lead	**Removed – will now form part of the Staff Survey**
Service Evaluation	Accountable Items, Swab, Instrument and Sharps Count	Quarter 4 2024/25	Theatre	Theatre Lead	**UNDERWAY ON TRACK**

Service Evaluation	Individual Endoscopist KPI's	TBC	Endoscopy	Clinical Lead Endoscopy	**Delayed awaiting appointment of Clinical Lead**
Service Evaluation	Gastric ulcers rescoped within 12 weeks	Quarter 4 2024/25	Endoscopy	J Harrison Endoscopy coordinator & S Williams Data/Audit Support	**Quarter 2 audit COMPLETE Quarter 4 audit UNDERWAY ON TRACK**
Service Evaluation	Post colonoscopy colorectal cancer rate Links established with Cwm Taf Morgannwg University Health Board MDT. If we are made aware – root cause analysis carried out	Quarter 4 2024/25	Endoscopy	Clinical Lead Endoscopy	**Not Yet Due**
Service Evaluation	Patient Satisfaction survey	Quarter 4 2024/25	Endoscopy	Jane Harrison Endoscopy coordinator & S Williams Data/Audit Support	**Not Yet Due**
Service Evaluation	Staff survey	Quarter 4 2024/25	Endoscopy	Jane Harrison Endoscopy coordinator & S Williams Data/Audit Support	**Not Yet Due**
Service Evaluation	Endoscopist satisfaction survey	Quarter 4 2024/25	Endoscopy	Clinical Lead Endoscopy	**Not Yet Due**
Service Evaluation	Endoscopy Performance e.g DNA cancellations no of procedures late start early finishes	Quarter 4 2024/25	Endoscopy	S Williams Data/Audit Support	**Removed – now reported as performance measure in business meeting**
Other National Audit Programme	Bowel Screening Wales User Experience Survey results	Quarter 4 2024/25	Endoscopy	Clinical Lead Endoscopy	**Not Yet Due**
Local Audits for Service Improvement	Record Keeping	Quarter 4 2024/25	Endoscopy	Clinical Lead Endoscopy	**COMPLETED**

Service Evaluation	Annual planning & productivity report	Quarter 4 2024/25	Endoscopy	Clinical Lead Endoscopy	**COMPLETED**
Service Evaluation	Scope traceability	Quarter 4 2024/25	Endoscopy	Jane Harrison & Tracie Watling	**UNDERWAY ON TRACK**

Therapies and Health Science					
Driver	Audit Title	Expected End Date	Service	Lead	Status
Audits performed for accreditation schemes	Compliance with Standard operating procedures	Quarter 3	Radiography	Head of Radiography	**UNDERWAY ON TRACK**
Audits performed for accreditation schemes	Pregnancy Status	Quarter 3	Radiography	Head of Radiography	**UNDERWAY ON TRACK**
Audits performed for accreditation schemes	Correct use of radiographic markers	Quarter 3	Radiography	Head of Radiography	**UNDERWAY ON TRACK**
Audits performed for accreditation schemes	Non Medical Referrals (NMR) Audit of NMR compliance	Quarter 3	Radiography	Head of Radiography	**UNDERWAY ON TRACK**
Audits performed for accreditation schemes	Reject analysis	Quarter 3	Radiography	Head of Radiography	**UNDERWAY ON TRACK**
Audits performed for accreditation schemes	Radiographer commenting audit	Quarter 3	Radiography	Head of Radiography	**UNDERWAY ON TRACK**
Audits performed for accreditation schemes	QA plain film and NOUS / Midwife Sonography	Quarter 3	Radiography	Head of Radiography	**UNDERWAY ON TRACK**
Local Audits for service improvement	QA reporting Audit	Quarter 3	Radiography	Head of Radiography	**UNDERWAY ON TRACK**
Audits performed for accreditation schemes	Monthly Clinispet/Clinel Wipes Audit	Quarter 3	Radiography	Head of Radiography	**UNDERWAY ON TRACK**
Audits performed for accreditation schemes	Sonography Service Audit	Quarter 3	Radiography	Clinical Governance Lead for Sonography	**UNDERWAY ON TRACK**
Audits performed for accreditation schemes	Reporting Radiography Service Audit	Quarter 1	Radiography	Head of Radiography	**UNDERWAY ON TRACK**
Audits performed for accreditation schemes	MIU NMR Audit for appropriate referrals	Quarter 4	Radiography	Head of Radiography	**Not Yet Due**
Audits performed for accreditation schemes	Red Dot Audit	Quarter 4	Radiography	Head of Radiography	**Not Yet Due**

Local Audits for service improvement	Caseload Management	Quarter 1	All AHP and HS	All HOS	**UNDERWAY ON TRACK**
Local Audits for service improvement	Clinical Records audit focusing on consent, goal planning	Quarter 4	Occupational Therapy	Head of OT	**Not Yet Due**
Local Audits for service improvement	Clinical Records audit focusing on consent, goal planning	Quarter 4	SALT	Head of SALT	**Not Yet Due**
Service Evaluation	Quarterly Wax Management	Quarter 1	Audiology	Head of Audiology	**STOOD DOWN**
Local Audits for Service Improvement	audiology Inappropriate referrals	Quarter 3	Audiology	Head of Audiology	**Removed – as now part of national standards reporting**
Service Evaluation	waiting times/compliance with target	Quarter 3	Audiology	Head of Audiology	**Removed – as now part of national standards reporting**
Service Evaluation	Wax Management Audit	Quarter 4	Audiology	Head of Audiology	**Not Yet Due**
Service Evaluation	Inpatient Nutrition Frailty	Quarter 3	Dietetics	Head of Dietetics	**COMPLETED**
Welsh Government National Audit Programme	Quality Standards Tinnitus Service	Quarter 4	Audiology	Head of Audiology	**Removed – national decision to repeat audit in two years time**
Other National Audits	National Diabetes Foot Care Audit	TBC Nationally	Podiatry	Head of Podiatry	TBC Nationally
Local Audits for Service Improvement	Taxonomy compliance audit	Quarter 4	Podiatry	Head of Podiatry	**Not Yet Due**
Local Audits for Service Improvement	Patient Notes	TBC	Podiatry	Head of Podiatry	**Removed - replaced with consent and dressing audit**
Local Audits for Service Improvement	Nail Surgery Consent and Dressing Audit	Quarter 4	Podiatry	Head of Podiatry	**COMPLETED**

Local Audits for Service Improvement	Implementation of Falls Therapy Practitioner	Quarter 4	Community Therapies	Senior Therapist	**Not Yet Due**
Local Audits for Service Improvement	Implementation of MFA - Falls	Quarter 4	Community Therapies	Senior Therapist	**Not Yet Due**
Service Evaluation	FCP Evaluation - North	Quarter 3	Physiotherapy	Consultant Physio	**UNDERWAY ON TRACK**
Service Evaluation	GTPS Shockwave	Quarter 4	Physiotherapy	Head of Physiotherapy	**UNDERWAY ON TRACK**
Local Audits for Service Improvement	Therapy Outcome Measures Audit	Quarter 4	Speech and Language therapy	Head of Speech and Language therapy	**Likely Delay as new practice not yet implemented**
Other National Audits	National Audit Programme Lymphodema	Quarter 4	Lymphoedema	Team Lead for Lymphoedema services	**Not Yet Due**
Welsh Government National Audit Programme	SNAPP Audit	Quarterly	Therapies	Head of Service	**UNDERWAY ON TRACK**
Local Audits following change to policy or procedure	Adherence to clinical supervision policy	Quarter 4	Therapies	Head of Service	**Not Yet Due**

Primary Care Group					
GP Services					
Driver	Audit Title	Start Date	Service	Lead	End Date
	TBC	TBC	GP Surgery	GP Surgery Staff	TBC

	TBC	TBC	GP Surgery	GP Surgery Staff	TBC
	TBC	TBC	GP Surgery	GP Surgery Staff	TBC
Discussions are planned for the November meeting of the GMS Contract Reform Group to agree the appropriate audits for supplementary services.					
Community Dentistry					
Driver	Audit Title	Expected End Date	Service	Lead	Status
Local Audits for Service Improvement	Clinical Record Keeping Audit	Feb. 2025	Community Dentistry	Susan Bracegirdle	**Not Yet Due**
Other National Audit	WHTM01-05 Equipment decontamination audit	Feb. 2025	Community Dentistry	Rachel Anwyl	**Not Yet Due**
Local Audits for Service Improvement	Written Consent to treatment audit	Jan. 2025	Community Dentistry	Heidi Thomas	**Not Yet Due**
Local Audits for Service Improvement	Compliance with Acorn and Fluoride application for GDS patients	Feb. 2025	Community Dentistry	Evelyn Gough	**Not Yet Due**
Local Audits for Service Improvement	Acorn and contract reform compliance (GDS)	**Removed – Listed in error, a duplicate entry of the audit above.**			
Local Audits for Service Improvement	Antimicrobial Stewardship	Jan. 2025	Community Dentistry	Lloyd Bovensiepen	**Not Yet Due**

Medical Directorate					
Medicines Management					
Driver	Audit Title	Expected End Date	Service	Lead	Status

Identified Risk – Powys has the highest per capita 4C antibiotic prescribing in Wales	4C antimicrobial prescribing in primary care	Quarter 3 2024/25	Medicines Management	Medicines Management Staff	**Delayed until after Primary Care Protected Learning Time (PLT) event on infections/AMS has taken place (2025/26)**
Identified Risk	Allergy status reporting in PTHB community hospitals	Quarter 3 2024/25	Medicines Management	Medicines Management Team	**Audit data collected awaiting finalisation of report**
Identified Risk	The completion of Venous thromboembolism (VTE) risk assessments	Quarter 3 2024/25	Medicines Management	Medicines Management Team	**Audit data collected awaiting finalisation of report**
Identified Risk	Valproate prescribing Audit of compliance with NatPSA/2023/013/MHRA	Quarter 2 2024/25	Medicines Management	Medicines Management Team	**Delayed- more work required with commissioning team to understand referral pathways**

Nursing Directorate (Corporate Functions)					
Safeguarding					
Driver	Audit Title	Expected End Date	Service	Lead	Status
Other National Audit Programme	Safeguarding maturity matrix self-assessment audit	Sept 24	Safeguarding	Asst. Director of Safeguarding and Public Protection	**COMPLETED**

Local Audits for Service Improvement	Quality of child protection case conference reports audit	Dec 24	Safeguarding	Asst. Director of Safeguarding and Public Protection	**UNDERWAY ON TRACK**

Mental Health and Learning Disabilities

Mental Health

Driver	Audit Title	Expected End Date	Service	Lead	Status
Identified Risk – patients may suffer harm if these assessments are not correctly completed	Audit of Environmental Ligature risk assessments	Quarter 4 2024/25	Mental Health Service	Mental Health Service Staff	**Not Yet Due**
Identified Risk – patients may suffer harm if these assessments are not correctly completed	Audit of WARRN risk assessments	Quarter 4 2024/25	Mental Health Service	Mental Health Service Staff	**Not Yet Due**
Identified Risk – patients may suffer harm if these assessments are not correctly completed	Audit of Security Risk Assessment	Quarter 4 2024/25	Mental Health and Learning Disabilities Service	MH&LD staff	**Not Yet Due**
Local Audits for Service Improvement	Audit of Care and treatment plans	Quarter 4 2024/25	Mental Health Service	Mental Health Service Staff	**Not Yet Due**
Welsh Government National Audit Programme	NCISH Suicide audit	Quarter 4 2024/25	Mental Health Service	Mental Health Service Staff	**Not Yet Due**

Welsh Government National Audit Programme	National review of schizophrenia audit	Quarter 4 2024/25	Mental Health Service	Mental Health Service Staff	**Not Yet Due**
Local Audits for Service Improvement	In patient Physical health monitoring audits	Quarter 4 2024/25	Mental Health Service	Mental Health Service Staff	**Not Yet Due**
Local Audits for Service Improvement	RCP/NICE quality standards for inpatient care	Quarter 4 2024/25	Mental Health Service	Mental Health Service Staff	**Not Yet Due**
Local Audits for Service Improvement	Medicine management audit	Quarter 4 2024/25	Mental Health Service	Mental Health Service Staff	**Not Yet Due**
Local Audits for Service Improvement	Hand Hygiene Audit	Reported quarterly	In-patient service	Ward Managers	**Not Yet Due**
Local Audits for Service Improvement	Record Keeping Audit	Quarter 4 2024/25	Mental Health Service	Team Leads	**Not Yet Due**
Local Audits for Service Improvement	Did Not Attend Appointment Audit	Quarter 4 2024/25	Mental Health Service	Performance Manager	**Not Yet Due**
Local Audits for Service Improvement	Falls Risk Assessment Audit	Reported quarterly	In-patient service	Ward Managers	**Not Yet Due**
Local Audits for Service Improvement	Welsh Language Active Offer Audit	Quarter 4 2024/25	Mental Health Service with Workforce Colleagues		**Not Yet Due**
Local Audits for Service Improvement	(Child) Was Not Brought to Appointment Audit	Reported quarterly	CAMHS service	CAMHS staff	**Not Yet Due**
Welsh Government National Audit Programme	Early Intervention in Psychosis Audit	TBC Nationally	CAMHS service	CAMHS staff	**Not Yet Due**
Local Audits for Service Improvement	Outcome Measures Audit	Quarter 4 2024/25	CAMHS service	CAMHS staff	**Not Yet Due**
Local Audits for Service Improvement	LPMHSS Audit	Quarter 4 2024/25	Local Primary Mental Health Support Service (LPMHSS)	Service Manager	**Not Yet Due**
Local Audits for Service Improvement	Policy Audit	Quarter 4 2024/25	Mental Health and Learning Disabilities Service	MH&LD staff	**Not Yet Due**
Local Audits for Service Improvement	Community Medical Caseload Audit	Quarter 4 2024/25	Mental Health Service	Mental Health Service Staff	**Not Yet Due**
Local Audits for Service Improvement	Section 177 Audit	Quarter 4 2024/25	Mental Health Service	Mental Health Service Staff	**Not Yet Due**
Local Audits for Service Improvement	Mental Health Act Compliance Audit	Quarter 4 2024/25	Mental Health Service	Mental Health Service Staff	**Not Yet Due**

Local Audits for Service Improvement	Adult CMHT MDT Audit	Quarter 4 2024/25	Mental Health Service	Mental Health Service Staff	**Not Yet Due**

Women and Children's Service					
Midwifery					
Driver	Audit Title	Expected End Date	Service	Lead	Status
Local Audits for Service Improvement	Antenatal Contacts – HCWP (Health Visiting)	Quarter 4	Health Visiting/School Nursing	Assistant Head of Public Health Nursing	**Not Yet Due**
Identified Risk	Was Not Brought - School Nursing.	Quarter 4	Health Visiting/School Nursing	Assistant Head of Public Health Nursing	**UNDERWAY ON TRACK**
Local Audits for Service Improvement	DTP/MenACWY Uptake	Quarter 2	Health Visiting/School Nursing	Assistant Head of Public Health Nursing	**COMPLETED**
Local Audits for Service Improvement	ChatHealth	Quarter 2	Health Visiting/School Nursing	Assistant Head of Public Health Nursing	**COMPLETED**
Local Audits for Service Improvement	Health Visiting & School Nursing CIVICA Audit	Quarter 2	Health Visiting/School Nursing	Assistant Head of Public Health Nursing	**COMPLETED**
Local Audits for Service Improvement	Health Visiting CNN Audit	Quarter 2	Health Visiting/School Nursing	Assistant Head of Public Health Nursing	**COMPLETED**
Local Audits for Service Improvement	Routine Enquiry (Health Visiting)	Quarter 2	Health Visiting/School Nursing	Assistant Head of Public Health Nursing	**COMPLETED**
Local Audits for Service Improvement	HPV Uptake	Quarter 2	Health Visiting/School Nursing	Assistant Head of Public Health Nursing	**COMPLETED**

Local Audits for Service Improvement	Flu Uptake	Quarter 4	Health Visiting/School Nursing	Assistant Head of Public Health Nursing	**Not Yet Due**
Local Audits for Service Improvement	Record Keeping – Health Visiting and School Nursing	Quarter 4	Health Visiting/School Nursing	Assistant Head of Public Health Nursing	**COMPLETED**
Local Audit for Service Improvement	Recording Keeping – Sexual Health Services	Quarter 2	Sexual Health	Sexual Health Clinical Lead	**COMPLETED**
Local Audit for Service Improvement	Routine Enquiry – (Sexual Health)	Quarter 3	Sexual Health	Sexual Health Clinical Lead	**COMPLETED**
Local Audit for Service Improvement	All Wales Handheld Maternity Records	Quarter 2	Maternity	Clinical Supervisor of Midwives	**COMPLETED**
Local Audit for Service Improvement	Intrapartum Transfers from Powys to DGH	Quarter 2	Maternity	Research Midwife Consultant Midwife	**COMPLETED**
Local Audit for Service Improvement	Clinical Information Sharing Caseload	Quarter 2	Maternity	Consultant Midwife	**No Update Available**
Local Audit for Service Improvement	Record keeping – WCCIS Clinical Assessment form	Quarter 3	Maternity	Endometriosis Clinical Nurse Specialist	**No Update Available**
Local Audit for Service Improvement	ADHD medication monitoring audited against NICE guidelines/new SOP	Quarter 4	Community Paediatrician	Paediatrics	**COMPLETED**
Local Audit for Service Improvement	Monitoring for Children and YP with Down Syndrome	Quarter 3	Community Paediatrician	Paediatrics	**COMPLETED**
Local Audit for Service Improvement	Children and YP with Cerebral Palsy – monitoring including hips (CPIPs), timely diagnosis. And review	Quarter 4	Community Paediatrician and Physio CPIP lead	Paediatrics	**COMPLETED**

Audit Driver Key:

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

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

Agenda item: 5.6

Patient Experience, Quality and Safety Committee	**07 November 2024**
Subject:	**COMMITTEE RISK REGISTER**
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 – 18 September 2024 Board – 25 September 2024

PURPOSE:

To present the Committee version of the Corporate Risk Register (CRR) to support the Committees review and seeking assurance in relation to the risks identified to the delivery of Powys Teaching Health Board's (PTHB) strategic objectives, the controls in place to manage these risks and their efficacy.

The risks provided are the ones agreed by the Board as within the remit of the Committee. The Committee Risk Register is based upon the Corporate Risk Register (CRR) considered by the Board on the 25 September 2024.

RECOMMENDATION(S):

The Delivery and Performance Committee is asked to:

- **RECEIVE** and **DISCUSS** the corporate risks within the Committee's remit and any relevant issues
- **TAKE ASSURANCE** that risks are being managed in line with the Risk Management Framework.

Approve/Take Assurance	Discuss	Note
Y	Y	Y

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:		
1. Focus on Wellbeing	Y	The Corporate Risk Register links to all of the Health Board's objectives by identifying risks that could impact on delivery or achievement.
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	

EXECUTIVE SUMMARY:

The Committee Risk Register draws together relevant risks from the Corporate Risk Register (CRR) to provide a summary of the significant risks to delivery of the Health Board's strategic objectives.

The Corporate Risk Register (CRR) is a cornerstone of the Board Assurance Framework (BAF) and is the central repository for risks to the delivery of PTHB's strategic objectives.

There are 12 risks on the corporate register; 2 of those risks fall within the remit of this Committee and are there provided as the Corporate Risk Register (PEQs Committee).

Appendix 1 (Corporate Risk Dashboard) shows a summary of the risks and the heatmap of risk ratings.

Appendix 2 provides the detail of risks to be considered at the in public meeting – provided as appended documents to this report.

BACKGROUND AND ASSESSMENT

The Health Board approved the Board Assurance Framework (BAF) in May 2024, linked here - CGP 014 Board Assurance Framework May 2024.docx
The Corporate Risk Register (CRR) is a cornerstone of the Board Assurance Framework (BAF) and is the central repository for risks to the delivery of the organisations strategic objectives.

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 (e.g. directorate), and risks for which the cost of control is significantly beyond the scope of the local budget holder.

Risk owners submit updated risk information to the Risk and Assurance Group (RAG) for review, check and challenge. The RAG then makes recommendations to the Executive Committee on amendments to risk scores or assurance ratings. The RAG can also escalate risks from Directorate Risk Registers to the Executive Committee, which is ultimately responsible for recommending the inclusion of risks in the CRR for Board approval.

The Boards risk appetite has been embedded into the CRR and work is underway to review and moderate the assurance ratings of controls to agree a consistent approach to assessing this which removes a degree of subjectivity from risk owners. The RAG will play an instrumental role in helping to achieve.

ROLE OF THE COMMITTEE:

Board Committees have a vital role in supporting Senior Risk Owners and the organisation more broadly to seek assurance on the ongoing development and management of corporate risks.

The corporate risks relevant to the Committee will be provided at each meeting, the Committee is asked to consider these in their own right and also to consider them alongside relevant agenda items through the cycle of Committee business.

Feedback from Committee members will be considered by the executive lead (senior risk owner) for each risk with the relevant staff and any changes will be reflected in the next risk reporting cycle update.

NEXT STEPS:

The Committee will continue to seek assurance on the ongoing development and management of the relevant corporate risks as set out above.

An updated version of the Corporate Risk Register is due to be presented to the Board on 27 November 2024.

Patient Experience, Quality and Safety (PEQS) Committee Risk Register

There is a risk that…

Private Risk (Circulated to Members only)							
Impact	Catastrophic	5					
	Major	4				• CRR 004 - 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.	• CRR 005 - 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				

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

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
DPCCMH	Director of Primary, Community Care and Mental Health
DoNM	Director of Nursing and Midwifery
DFIIT	Director of Finance, Information and IT
MD	Medical Director
DPH	Director Public Health
DWOD	Director of Workforce and OD
DoTHS	Director of Therapies and Health Sciences
DPP	Director of Planning and Performance
BS	Board Secretary
DoE	Director of Environment

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

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:** September 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	Data will be provided at next report	**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 MIUs continue to performance well, in May (latest validated available) reported 100% compliance against 4 hour target and no patients waiting longer than 12 hours.
Date added to the risk register July 24		
Source of risk: Executive Team		

		Mental Health Elements of the service are currently in internal performance and scrutiny escalation		
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. 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	• 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	Reasonable	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	Reasonable	Section in development
7.3	All services - using demand data to plan to provide the correct level of services provision for all services provided in county	Demand, activity and financial information from commissioning datasets used to inform contract plans	Reasonable	Section in development
7.4	Reviewing where services do not meet clinical and operational standards	Various data sources including operational & performance data.	Limited	Section in development
7.5	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)	Various workforce and financial reports recording agency usage at ward and service level	Limited	Section in development
7.6	Improving the outcomes and experience data capture to inform future planning	Various data sources including operational & performance	Limited	Section in development

		data. Qualitative information from PROMS & PREMS reporting, clinical audit, regulatory inspections			
Mitigating Actions (What more will we do?)					
Action		**Lead**	**Action update**	**Deadline**	**Action on Target**
Planned Care ▪ 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	On track
General Service Sustainability & Future Models of Care The health board is currently reviewing models of care as part of its five-year plan but also in response the staffing and financial challenges. A number of service reviews are being undertaken with several 'cases for		Executive Director of Operations/Director of Community & Mental Health	The first two cases for change will be considered by the Board on 24 July.	July 2024 and ongoing	On track

change' being written for onward consideration by the Health Board and stakeholders.				
1 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 improvement is being made towards achievement of the overall target.	Executive Director of Operations/Director of Community & Mental Health	A number of sub-indicator performance targets have been identified. These will be built into the IQPR	August and ongoing	On track
Current Risk Rating		**Update including impact of actions to date on current risk score**		
4 x 4 = 16		• Will be provided at next report.		

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	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.
Date added to the risk register. July 24		
Source of risk: Executive Team		

		Urgent and Emergency Care • Powys MIUs continue to performance well, in May (latest validated available) reported 100% compliance against 4-hour target and zero patients waiting longer than 12 hours. • 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	Reasonable	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	Reasonable	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	Reasonable	Section in development
7.4	Reviewing where services do not meet clinical and operational standards	Various data sources including operational & performance data.	Limited	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	Limited	Section in development

		reporting, clinical audit, regulatory inspections			
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 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 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	On track
Urgent and Emergency Care ▪ Continue series of regular meetings with WAST and commissioned service providers. ▪ Secure performance improvement trajectories and improvement plans from providers.			▪ 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	July 2024 and ongoing	On track

		experience, and patient harm.		
<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.		A number of sub-indicator performance targets have been identified. These will be built into the IQPR	August and ongoing	On track
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.		

Reporting Committee	**Quality Patient Safety Committee (QPSC)**
Chaired by	**Susan Elsmore**
Lead Executive Director	**Director of Nursing & Quality**
Date of Meeting	**24 June 2024**

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

1. CARDIAC PATIENT SOTRY

Members received an informative patient story about a gentleman who had suffered a sudden cardiac arrest. Members noted the challenges that the patient faced at the outset and how a range of JCC services and the public saved his life. The patient and his family praised the care that they had received throughout this traumatic event. The patient story highlighted the positive impact that the EMRTS service and the cardiac services had made to the patient's quality of life.

2. 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 and a summary of the highest scoring risks was provided.

3. 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.

- **South Wales Plastic Surgery**
  Members noted that this service provided by SBUHB remained at Level 2 of the Escalation process and was the only NWJCC commissioned service where patients were waiting over 104 weeks. The JCC made a choice around not accelerating improvements but within the ICP for 2024/2025 it was agreed to continue with this steady improvements towards the target. However, following approval of the ICP, WG published targets to achieve

104 weeks by March 2025. These were further revised in a letter received from the Deputy General/CEO NHS Wales on 7 May 2024 outlining revised Ministerial targets of no patients waiting over 104 weeks by the end of December 2024. This will require a decision to be made by the NWJCC in July 2024 and the NWJCC is undertaking further work currently with SBUHB to understand the demand, activity and efficiency assumptions in this delivery plan and trajectory, and engaging with Health Boards on the approach to the balance between the financial position and performance.

- **Plastic Surgery Outreach at BCUHB**
  This service was currently within the Welsh Government escalation/ special measures framework for BCUHB as the quality issues concern the operational responsibility of BCUHB for the provision of clinic administration and facilities under a Service Level Agreement between the Health Board and MWL. WG have acknowledged that there was evidence of improvement. Since the last meeting the harms review had been completed and it was presented to BCUHB QPSC Committee in June 2024. The report provides assurance that no evidence of patient harm was found. Despite this being a retrospective review, these issues have been mitigated as the level of service support, administration, quality reporting process, activity and waiting times reporting and ongoing monitoring arrangements have been strengthened. In addition, they have also funded waiting list initiatives to address the backlog and there were fewer patients on the waiting list compared to when the review was started.

3.2 Cardiac

Members received an update of the quality issues for services relating to the Cardiac Commissioning Team Portfolio.

- Although the two service providers in South Wales following a Getting it Right First Time (GIRFT) review have been in escalation for some time, they have been on a de-escalation trajectory for most of that time and both services have engaged well with the escalation process. Swansea Bay Cardiac Surgery Service was de-escalated from Level 2 to 0 of the Escalation Framework in May 2024 and was now out of escalation completely. The Cardiff and Vale Cardiac Surgery Service has been de-escalated to Escalation Level 1 pending receipt of an audit report.
- An update was provided on the exercise into any unreported cases of Mycobacterium Chimera. This bacteria is associated with water heater cooling systems used in cardiac surgery. They undertook an extensive piece of work in terms of a look back and this work has concluded with no new cases having been reported within the last 8 years. This extensive work seems to be working as there had been no recent reported cases.

3.3 Neurosciences

Members received an update of the quality issues for services relating to the neurosciences Team Portfolio.

- NWJCC had reallocated funding to address the Neurosurgery risk and agreed additional money within the ICP for 2024-2025.

- There were two service related risks which were being managed in line with the engagement for service change guidance issued by Welsh Government and the NWJCC were keeping in close contact with Llais.

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.

Paediatric Surgery

Members noted the positive progress and good evidence of operational improvement underpinning a reduction in the waiting times and the waiting list in line with the accelerated target over and above the ministerial measures of 52 weeks that the JC agreed last year. The HB was not able to achieve the target by the end of March 2024 due to the industrial action but assurance has been received that the target will be achieved by the end of June 2024. Based on this assurance, the Commissioning Team agreed to de-escalate the service to Level 0 and the service has returned back to normal performance monitoring arrangements. The letter confirming the de-escalation was sent to the provider last week. The JCC ambition for this year was to maintain that 52 week wait.

Wales Fertility Institute

Members noted the positive progress with the Fertility service issues. Due to regulatory issues following an inspection by the HFEA the service was placed in escalation Level 4 with regular reporting through the NWJCC via the Performance Report. A positive inspection report from the HFEA had recently been received and reported through the escalation meeting. There had been good progress in the appointment of a Person responsible (PR) with the intention to appoint more than one person to perform the PR role to ensure sustainability going forward. Following confirmation of the above progress, the Commissioning Team agreed to de-escalate the service to Level 3 and remove the service from the critical escalation Level 4.

Neonatal Care (NICU) and Paediatric Intensive Care (PICU)

Members noted that there was less assurance in relation to Paediatric Intensive Care (PICU) and Neonatal Care and as commissioners it was noted that the same level of progress had not been made within these service areas. A decision was taken to reset the process at executive level and move towards a more outcomes and objectives based escalation. Whilst most of the services have been on a de-escalation trajectory, progress within these two service areas was complicated

due to some underlying themes such as the scarcity of specialist workforce. The NWJCC understood the complexities and this was the reason for the reset approach to try and achieve a better outcome for the population of South Wales.

Members discussed the new approach and questioned how these services would be measured going forward. Members were assured that the NWJCC would be using national benchmarks and metrics and monitoring those together with the Health Board and addressing access to those really highly specialised services to ensure that we are assured on the quality management systems and workforce availability within these two areas.

3.5 Mental Health

Members received an update of the quality issues for services relating to the Mental Health and Vulnerable Groups for the former WHSSC Commissioning Team Portfolio.

Members noted that there had been little change to the commissioning risks since the last report. Funding to address the Neuropsychiatry sustainability risks was approved and was included in the ICP for 2024/2025 with the aim to bring the business case seeking funding release to the Management Group meeting in July 2024.

Members noted the comprehensive summary regarding Gender Development Service (GIDS) for Children and Young People, the Cass review, the new legislation around prescribing puberty supressing hormones and the progress that has been made on Phase one and Phase two of the NHS England transformation programme.

Members were made aware of some issues in relation to a specialist eating disorder provider.

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. Members noted that the Independent Provider Framework Agreement with the independent sector for the provision of home care and parenteral nutrition products ended on 30th June 2024. A procurement process was undertaken by the NHS Wales Shared Services Partnership (NWSSP) to renew the Framework agreement. The three open risks were linked to this issue and will be de-escalated following the renewal of this Framework agreement.

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 Paediatric services in escalation Level 3 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.**

4.2 Quality and Safety Report (Former EASC)

Members received a report providing an update on quality and safety matters for the Emergency Ambulance Services Committee (EASC) commissioned services. Members noted that this report was usually considered under the EASC Management Group before being presented to the EASC Joint Committee.

A range of the measures were presented and discussed. Members provided useful feedback on what information they would find useful for future reports.

4.3 Mental Health and Vulnerable Groups Commissioning Management Team Report

Members received a report providing an update on issues for services relating to the MHVG Commissioning Management Team. Due to the transition of work from the former Quality Assurance Improvement Service into the new NWJCC, the service portfolio reported was focused on the 'National Collaborative Framework for the provision of services for Adult Mental Health Learning Disability / Child and Adolescent Mental Health Hospitals', with a view to presenting a fully integrated MHVG report for the next QPSC meeting.

Members provided useful feedback on what information they would find useful for future reports.

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

A briefing on Healthcare Inspectorate Wales (HIW) and Care Quality Commission (CQC) reports published during the period February 2024 to May 2024 was presented to the committee.

4.5 Incident and Concerns Report

Members received a report outlining the incidents and concerns reported to WHSSC and the actions taken for assurance.

4.6 Policy Group Report

Members received an update on activity and output from the NWJCC Policy Group during the period 1 January 2024 – 31 March 2024 together with an updated overview of all NWJCC policies and service specifications including those published during the current financial year, together with the rationale for their development.

5. ITEMS FOR INFORMATION

Members received a number of documents for information only:

- Chair's Report and Escalation Summary to Joint Committee April 2024;
- Welsh Health Circular: NHS Wales National Clinical Audit and Outcome review plan: Annual Rolling Programme from 2024/2025; and
- QPSC Distribution List.

6. ANY OTHER BUSINESS

Members provided useful feedback on the quality newsletter.

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

Key risks are highlighted in the narrative above and summarised below;

- The general concerns with paediatric services in CVUHB.
- Ensuring future reports are aligned to the new duty of quality.
- Ensuring concerns report contain some trends and themes as well as capturing patient experience/stories.

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	2 September 2024

Executive Director Lead: Nicola Johnson and Carole Bell
Commissioning Lead: Vacancy
Commissioning Team: Women and Children

Date of Escalation Meetings: Most recent - 16/05/24
Date Last Reviewed by Quality & Patient Safety Committee: 19/02/2024

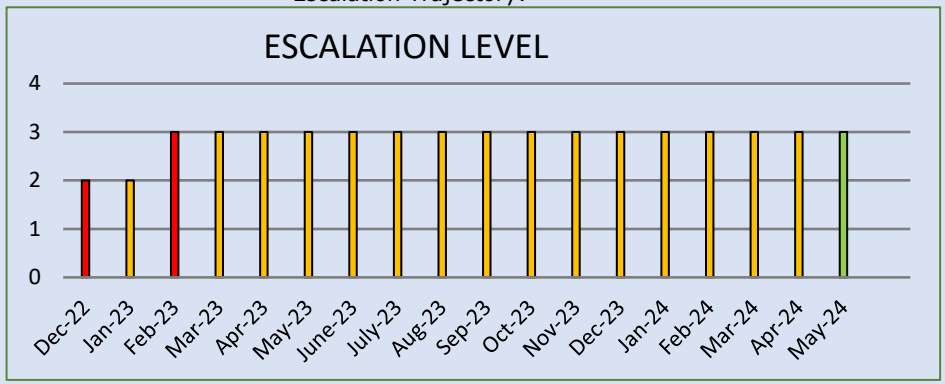
Service in Escalation: Paediatric Surgery

Current Escalation Level 3

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↔ May 2024
↔	Escalation remains the same	
↑	Escalation level escalated	

Escalation Trajectory:



Escalation History:

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

Rationale for Escalation Status :
As a result of the service failing to engage fully with WHSSC regarding contract delivery and waiting time profiles, it was agreed that the service should be further escalated from Level 1 to Level 3 of the WHSSC Escalation Framework. A target of 52 weeks was set by the WHSSC Joint Committee.

Background Information:

• The WHSSC Joint Committee committed to a target of 52 weeks and to maintaining this in the ICP 2024/25. There has been operational improvement in the service.

WHSSC assurance and confidence level in developments:

High – Action plan developed and positive progress made in delivering service improvements and securing additional capacity. The target was not met by the end of March due to the effects of industrial action but assurance has been given on achieving it by the end of June 2024. This has been reported to Management Group and JCC with acknowledgement that de-escalation is to be considered at the Commissioning Team meeting in June 2024.

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	
Triple escalation meetings established to monitor progress of all three paediatric services in escalation against overarching objectives.	Director of Planning & Performance / Director of Nursing and Quality	16 May 2024	

Issues/Risks:
May 2024 – Escalation status being considered at Commissioning Team meeting in June 2024.

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

Date of Escalation Meetings: 10/10/23, 19/12/23, 16/05/24
Date Last Reviewed by Quality & Patient Safety Committee: 19/02/2024

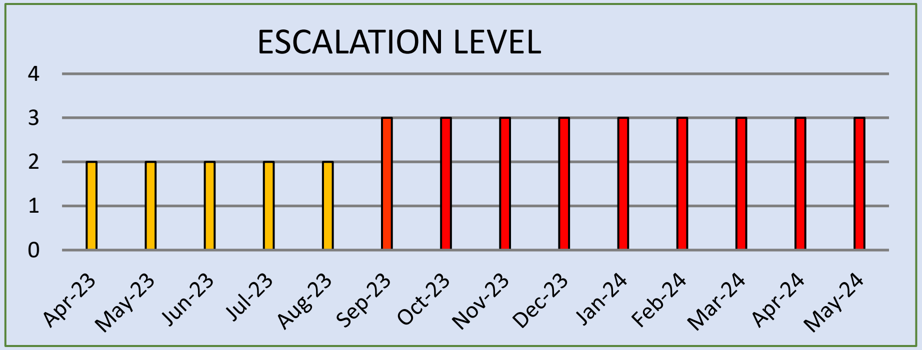
Service in Escalation: Paediatric Intensive Care

Current Escalation Level 3

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↔ May 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. Escalation status being discussed at executive level within the JCC.

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	30 June 2024	
Requested sight of the Pressure Sore report presented to the HB Quality and Patients Safety Committee.	Senior Planning Manager	Ongoing	
Triple Escalation meeting to discuss detail and progress against action plan (monthly)	Senior Planning Manager	16/05/24	

Issues/Risks:

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

Date of Escalation Meetings: 10/10/23, 19/12/23, 16/05/24
Date Last Reviewed by Quality & Patient Safety Committee: 19/02/2024

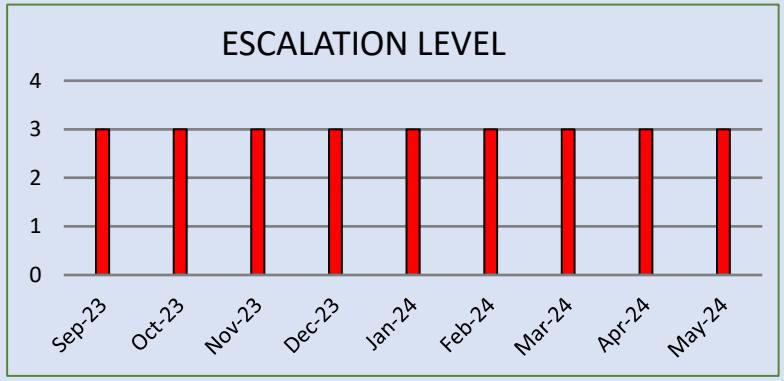
Service in Escalation:
Neonatal Intensive Care Unit

Current Escalation Level 3

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↔ May 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. Escalation status being discussed at executive level within the JCC.

Actions:

Action	WHSSC Lead	Action Due Date	Completion Date
Working with C&V UHB executive team to develop a plan to implement new baseline as all other HBs are in a position to go live	Director of Planning	16/05/24	

Issues/Risks:
March 24 - The service have not submitted an action plan despite being in escalation since Sept 23, they are unable to increase their cot numbers based on the new cot configuration and reported that they cannot safely deliver on the cots that they are currently commissioned, no progress made with exec to exec meeting, possibility that outsourcing from the service may be required, the service remains at escalation level 3 but if there are no improvements increasing the escalation will be considered.
May 24 - Through quarterly assurance meetings with all neonatal units in the South & West of Wales it has been reported that there has been increased pressure across the network for cot availability

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, 15/02/24, 14/03/24, 11/04/24, 08/05/24
Date Last Reviewed by Quality & Patient Safety Committee: 19/02/2024

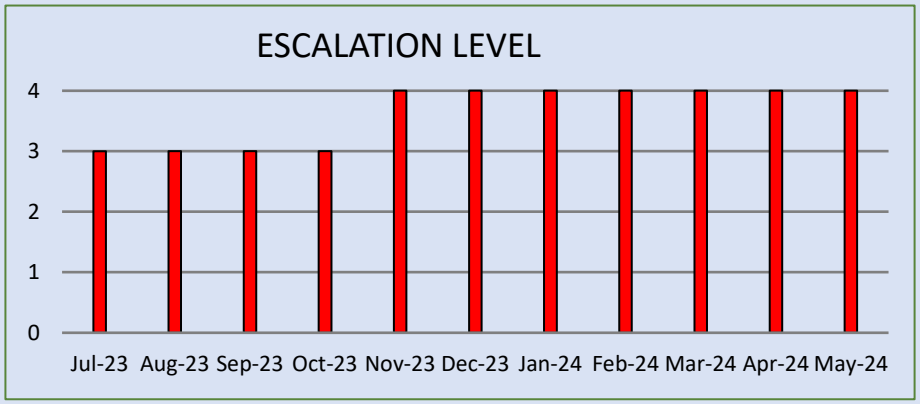
Service in Escalation: Wales Fertility Institute

Current Escalation Level 4

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↔ May 2024
↔	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.

Actions:

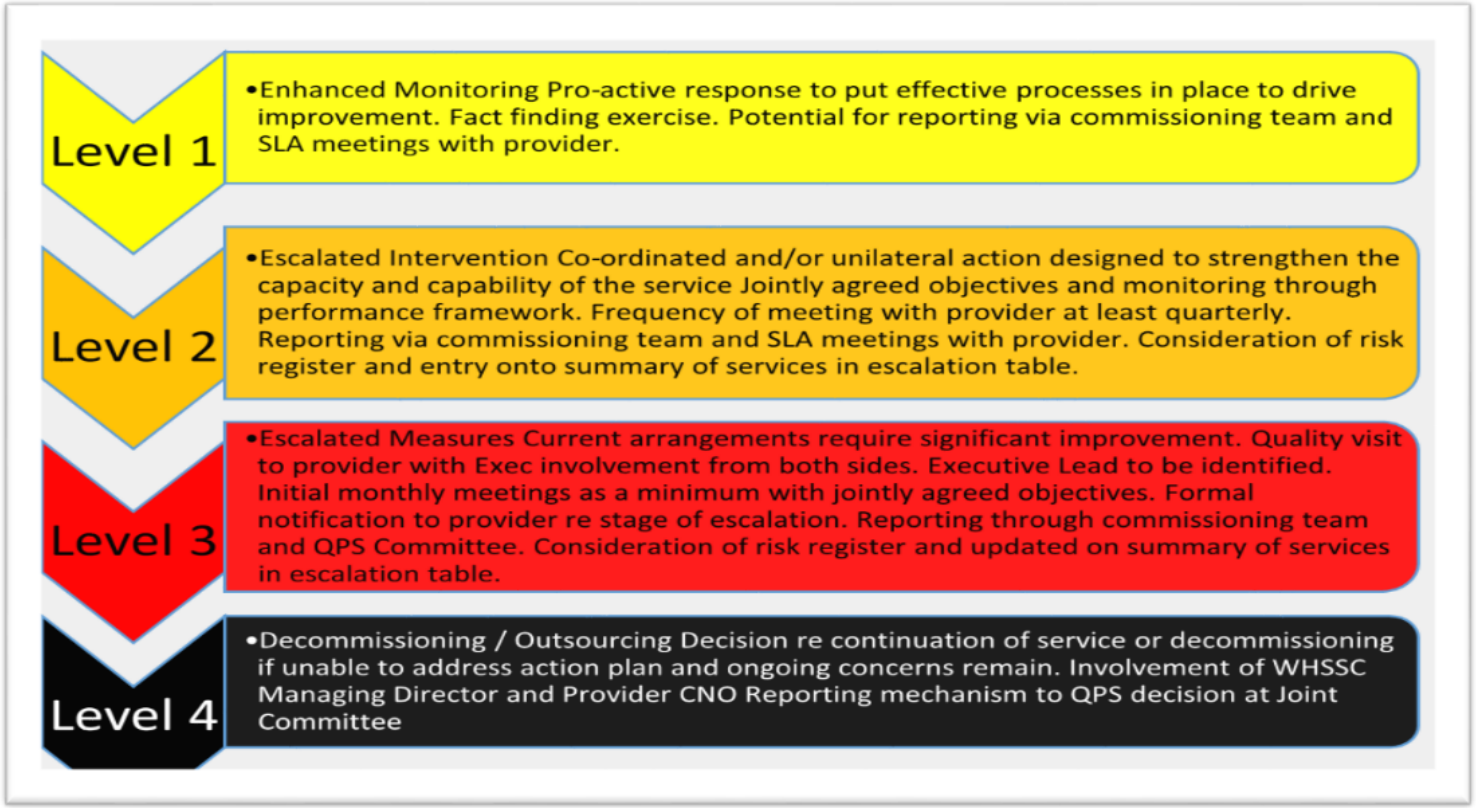
Action	Lead	Action Due Date	Completion Date
Monthly escalation meeting to review progress against Action Plan Escalation meeting 19th September 2023 10th October 2023 7th December 2023 15th February 2024 14th March 2024 9th April 2024 8th May 2024	Assistant Specialised Planner	Monthly	13 June 2024

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 suitable staff to sit the exam, to ensure sustainability of the service with a PR over Cardiff and a PR over Neath Port Talbot. Cardiff inspection took place in March 2024, following the inspection being considered by the HFEA licensing panel who agreed to changing the licence to a storage only facility. The Neath Port Talbot Inspection took place in May 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. A new clinical service manager took up post at the start of May 2024. The HB have agreed to undertake a comprehensive service review to include, performance, finance, complaints, incidents and risks. It was originally intended for the review to be completed by the end of January 2024 however this has been delayed with the review report due to be shared with the HB Board at the end of May 2024.	SMART Action plan reviewed and agreed	Service Manager	19th September 2023	19th September 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

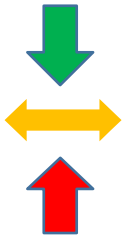
Issues/Risks: There is a risk the Wales Fertility Institute (WFI) in Neath & Port Talbot Hospital is not providing a safe and effective service due to 7 major concerns identified during a relicensing inspection by HFEA in January 2023. There is a consequence that families who have treatment at this centre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

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

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



SERVICES IN ESCALATION



Level of escalation reducing / improving position

Level of escalation unchanged from previous report/month

Reporting Committee	**Quality and Patient Safety Committee (QPSC)**
Chaired by	**Susan Elsmore**
Lead Executive Director	**Director of Nursing & Quality**
Date of Meeting	**2nd September, 2024**

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

1. PATIENT STORY

Members received an ITV media clip which involved a young woman (HL) who formerly was an in-patient in Ty Llidiard the Children and Adolescent mental Health Unit on the Princess of Wales site with a diagnosis of Anorexia Nervosa. The video interviewed Helen and explained the progress that had been made by the unit whilst in special measures. The importance of patient engagement was seen as a critical element in the success working with young people to improve services. Members acknowledged how difficult it can be to tell your story and applauded the patient who has gone on to undertake her medical training. The story also highlighted the collaborative working between the former WHSSC and NCCU in supporting the Health Board in improving the service.

2. FEEDBACK CORONOR'S INQUEST

Members received a presentation containing an update following the Conclusion of the inquest concerning the death of a young woman (aged 29), who was a patient from HDUHB who sadly took her own life whilst an inpatient at a Women's Enhanced Medium Secure (WEMMS) Unit in London. Members noted that the coroner's inquest hearing was held in the West London Coroner's Court and concluded on 23 July 2024. The inquest was held in public with a jury of 8.The recommendations arising from the hearing were shared and it was noted that NHS England have decommissioned the services following a review. The implications of this will be considered as part of the Mental Health Strategy.

The Director of Mental Health and Vulnerable Groups explained that he was currently working with Welsh Government around continuing healthcare, which is a complex area. In response, an independent member stated that little had changed as how continuing health care was managed, it was costly and demand was increasing. It was agreed that these concerns would be escalated to the Joint Commissioning Committee.

3. 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 and a summary of the highest scoring risks was provided.

4. COMMISSIONING TEAM AND NETWORK UPDATES

Reports from individual Commissioning Teams were received and taken by exception. Members noted the information presented and a summary of the services in escalation as attached. 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.

4.1 Cancer & Blood

Quality issues for services relating to the Cancer and Blood Commissioning Team Portfolio.

South Wales Plastic Surgery

It was reported that this service provided by SBUHB remained at Level 2 of the Escalation process and was the only NWJCC commissioned service where patients were waiting over 104 weeks. In July 2024, however, the NWJCC agreed to fund some of this additional capacity focusing on higher priority clinical groups who will receive their surgery before the end of December 2024. This was discussed at the July 2024 JCC and MG meetings. Further consideration will be given in August/September 2024 to the remaining funding required to meet the target in full, taking into account the context of the wider JCC financial position.

Neuroendocrine Tumours

It was noted that following a patient concern a review of the service provided by CVUHB was to be undertaken. The commissioning team will support the review and consideration given to the findings. The timescales and terms of reference are yet to be agreed.

4.2 Cardiac

Members received an update of the quality issues for services relating to the Cardiac Commissioning Team Portfolio.

Obesity Surgery Waiting Times

It was noted that there has been no improvement in the waiting list positon for Salford and little or no activity undertaken over the last twelve months. NWJCC are working closely with providers to open up the pathway to South Wales Service as an alternative, and Llais will be updated in relation to this pathway when it becomes available.

4.3 Neurosciences

Members received an update of the quality issues for services relating to the Neurosciences Team Portfolio.

Deep Brain Stimulation

The service provided by North Bristol NHS Trust (NBNHST) remains temporarily suspended for new referrals. Work is ongoing to secure a temporary alternate pathway into University College Hospitals London (UCL) in partnership with Cardiff and Vale University Health Board (CVUHB) which was agreed by the Senior Leadership Team (SLT) on 19th August 2024. NWJCC are in discussion with NBNHST to gain assurance on the issues raised with a view to reopening the pathway subject to those assurances. NWJCC had reallocated funding to address the Neurosurgery risk and agreed additional money within the ICP for 2024-2025.

4.4 Women & Children

Members received an update on the quality issues for services relating to the Women & Children Commissioning Team Portfolio.

Children's Hospital For Wales

A reset meeting is due to take place on the 18th September to consider the services in escalation and undertake a collaborative approach to agreeing the way forward. It was noted that the Director of Nursing CVUHB had written providing assurance on the review which had been undertaken relating to pressure damage issues on the Paediatric Intensive Care Unit and the actions that had been taken to address the issues.

Princess of Wales Hospital (POW)

Members were informed of the planned closure of the Maternity and Neonatal Unit within Princess of Wales Hospital Bridgend, (POW) and CTMUHB from the 2nd September, 2024 for 12 weeks. This was due to essential maintenance work to be undertaken in both the Neonatal and Maternity Unit. Assurance was given that plans were in place to redirect patient flow.

Wales Fertility Institute

Members were informed that a positive HFEA report had been received by the service. No critical or major concerns within the service were highlighted. Four staff members have passed the exam to be the person responsible (PR).The team agreed that the service has met the required standard to be de-escalated from level 4 to level 3. NWJCC continue to work with the provider on service improvements.

4.5 Mental Health

Members received an update of the quality issues for services relating to the Mental Health and Vulnerable Groups for the former WHSSC Commissioning Team Portfolio.

Eating Disorders (ED)
The new unit in Tŷ Glyn Ebwy Hospital, Hillside and Ebbw Vale was reported at the last meeting to be a 2Q service with an action plan in place with the JCC, via the Framework agreement processes, to improve areas relating to training and supervision arrangements. The service has evidenced improvement in various areas since the last review but quality issues remain, therefore, it is now a 3Q service.

Mother and Baby Unit / North
It was noted that provisional works have begun on the new Mother and Baby Unit in Cheshire and Wirral. Recruitment for the required posts has begun with the ward manager in post. The scheme has been delayed considerably due to increased costs from the contractor which Cheshire and Wirral Partnership have formally declined and a new tender process has commenced.

4.6 Intestinal Failure (IF) – Home Parenteral Nutrition
Members received an update on the quality issues for services relating to the Intestinal Failure Commissioning Team Portfolio. Members noted that there have been some challenges with regards to robust consultant cover within the Intestinal Failure service. This is an issue which remains closely monitored via the commissioning assurance meetings held with Cardiff and Vale University Health Board

5.0 OTHER REPORTS RECEIVED

Members received reports on the following.

5.1 Services in Escalation Summary
Members noted the content of the report and a copy of each of the services in escalation is attached to the report at **Appendix 1.**

5.2 Quality and Safety Report - Ambulance and 111
A report providing an update on quality and safety matters for the Ambulance and 111 commissioned services was received.

5.3 Care Quality Commission (CQC)/ Health Inspectorate Wales (HIW) Summary Update
A briefing on Healthcare Inspectorate Wales (HIW) and Care Quality Commission (CQC) reports published during the period June 2024 to July 2024 was presented to the committee.

5.4 Incident and Concerns Report
Members received a report outlining the incidents and concerns reported to WHSSC and the actions taken for assurance.

5.5 Joint Commissioning Committee Risk Register

The transitional amalgamated risk register for the JCC was presented to the committee, which encompasses risks scoring 15 and above taken from the commissioning teams and directorate risk registers across the former EASC, NCCU and WHSSC predecessor organisation risk registers. This Risk Register was approved by the JCC in July 2024, and considered by the CTM Hosted Bodies Audit and Risk Committee (ARC) in August 2024. Members noted the significant amount of work done to bring this together, mindful there was still a lot of work to be done with scores and assessing risks to ensure consistency across the range of NWJCC services.

6. ITEMS FOR INFORMATION

Members received a number of documents for information only:

- QPSC Distribution List.

7. ANY OTHER BUSINESS

None to note.

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

- Continuing health care and the impact on patients that receive commissioned services, as the concerns continue from the committee.
- Patient story forward to JCC on 17 September 2024.
- An update on the DBS Temporary Service Change was provided and would be relevant for HBs.
- It was important to note that the reset meeting was taking place for Neonatal Cot and PICU and the meeting will be an opportunity to discuss and agree actions/objectives in collaboration with the provider health board.

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

Executive Director Lead: Nicola Johnson
Commissioning Lead:
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, 16/05/24
Date Last Reviewed by Quality & Patient Safety Committee: 24/06/2024

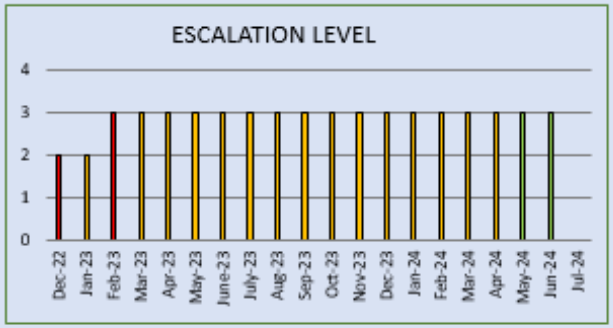
Service in Escalation: Paediatric Surgery

Current Escalation Level 0

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↓ July 2024
↔	Escalation remains the same	
↑	Escalation level escalated	

Escalation Trajectory:



Escalation History:

Date	Escalation Level
March 2023 – JCC escalation	**3**
July 2024	**0**

Rationale for Escalation Status :
As a result of the service failing to engage fully with JCC 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 JCC 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.

JCC 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

Actions:

Action	JCC 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	
Triple escalation meetings established to monitor progress of all three services in escalation against overarching objectives.	Director of Planning & Performance / Director of	16 May 2024	

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. Nuffield contract has concluded. Monitoring progress on a monthly basis and the >52 weeks' position is improving as set out in the trajectories. Escalation status being discussed at executive level within the JCC. Following the assurances received from the Triple Escalation meeting on the 16th May 2024 where the Health Board stated that the 52-week target will be met by the end of June 2024 and with a robust plan to maintain this during 2024/25 in line with the 52-week waiting time agreed by the (previous JCC) Joint Committee in our Integrated Commissioning Plan. In the commissioning team meeting held in July 2024 we agreed to de-escalate the service from Level 3 to Level 0 in line with the previous WHSSC (now NWJCC) Escalation Framework. This escalation has been closed and removed from the women and children's risk register.		Nursing and Quality		

Issues/Risks:

May 2024 – Escalation status being discussed at executive level within the JCC.
July 2024 – De-escalation of paediatric surgery agreed in July W&C commissioning team meeting from level 3 to level 0. Closed on risk register.

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

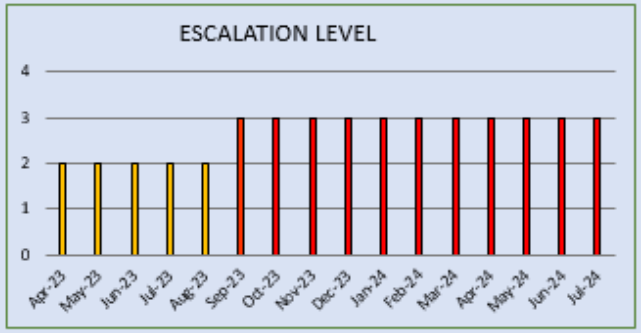
Date of Escalation Meetings: 10/10/23, 19/12/23, 16/05/24
Date Last Reviewed by Quality & Patient Safety Committee: 24/06/2024

Service in Escalation: Paediatric Intensive Care

Current Escalation Level 3

Escalation Trend Level		
Trend	**Rationale**	**Current Trend Level**
↓	Escalation level lowered	↔ July 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 JCC through various routes including HiW and the daily SITREP.

JCC 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

Actions:

Action	NWJCC 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	30 June 2024	
Requested sight of the Pressure Sore report presented to the HB Quality and Patients Safety Committee.	Senior Planning Manager	-	17th July 2024
Escalation meeting to discuss detail and progress against action plan (monthly)	Senior Planning Manager	-	Next meeting to be arranged post re-set meeting

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. JCC are still awaiting detailed demand and capacity in order to develop a sustainable contracting framework for Paediatric Intensive Care and High Dependency. Escalation status being discussed at executive level within the JCC. The Paediatric and Neonatal Escalation Reset Meeting is to take place on the 18th September where an overview of the service will be discussed to gain an understanding from the health boards perspective of where they feel they are in the process, rather than discussing actions and objectives. The overarching objectives for the service are in the development phase and when agreed within the commissioning team they will be shared with the health board for comments and then presented at the reset meeting, to ensure they are agreed collaboratively. New executive leads for both organisations will be agreed as part of this process to ensure all are in agreement.	Re-set meeting to discuss and agree actions/objectives in collaboration with the health board	Senior Planning Manager	18th September 2024	
Issues/Risks:				

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

Date of Escalation Meetings: 10/10/23, 19/12/23, 16/05/24
Date Last Reviewed by Quality & Patient Safety Committee: 24/06/2024

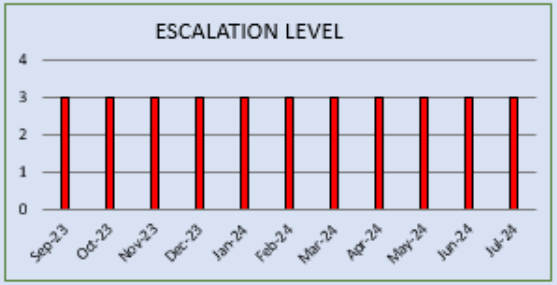
Service in Escalation: Neonatal Intensive Care Unit

Current Escalation Level 3

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↔ July 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.

NWJCC 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. Escalation status being discussed at executive level within the JCC.
The Paediatric and Neonatal Escalation Reset Meeting is to take place on the 18th September where an overview of the service will be discussed to gain an understanding from the health boards perspective of where they feel they are in the process, rather than discussing actions and objectives. The overarching objectives for the service are in the development phase and when agreed within

Actions:

Action	NWJCC Lead	Action Due Date	Completion Date
Working with C&V UHB executive team to develop a plan to implement new baseline as all other HBs are in a position to go live	Director of Planning	16th August 2024	
Escalation meeting to discuss detail and progress against action plan (monthly)	Senior Planning Manager	-	Next meeting to be arranged post re-set meeting
Re-set meeting to discuss and agree actions/objectives in collaboration with the health board	Senior Planning Manager	18th September 2024	

the commissioning team they will be shared with the health board for comments and then presented at the reset meeting, to ensure they are agreed collaboratively. New executive leads for both organisations will be agreed as part of this process to ensure all are in agreement.	

Issues/Risks:
March 24 - The service have not submitted an action plan despite being in escalation since Sept 23, they are unable to increase their cot numbers based on the new cot configuration and reported that they cannot safely deliver on the cots that they are currently commissioned, no progress made with exec to exec meeting, possibility that outsourcing from the service may be required, the service remains at escalation level 3 but if there are no improvements increasing the escalation will be considered.
May 24 - Through quarterly assurance meetings with all neonatal units in the South & West of Wales it has been reported that there has been increased pressure across the network for cot availability
July 24 – Temporary closure of Princess of Wales (PoW) Maternity and Neonatal unit for essential maintenance work from September to December. JCC currently commission 4 High Dependency (HD) cots within the PoW and Prince Charles Hospital (PCH) sites within CTMUHB. PCH are able to flex their cot base from 15 cots to 19 to provide HD capacity and Special Care based on clinical need. Consultation and communication with all stakeholders is underway alongside Maternity users who this will impact upon. Swansea Bay University Health Board and Cardiff and Vale have been asked to support the delivery of maternity care based on demand and demographics of the planned maternity users. Work is currently underway within CMTUHB to gain the appropriate data and demographics of the women currently booked to birth during this period. The Welsh Ambulance Service and the Neonatal network are working with CMTUHB to ensure safe delivery and appropriate preparation of pathways to enable safe transfer and clear guidance for the maternity users and clinical teams. Ongoing weekly project meetings have been put in place, NWJCC have been invited to attend these. Updates from these will be shared within the NWJCC to understand the impact this will have on current commissioned cots. An early warning notification has gone to Welsh Government.

Executive Director Lead: Iolo Doull
Commissioning Lead:

Commissioning Team: Women and Children

Date of Escalation Meetings: 07/08/23, 19/09/23, 10/10/23, 07/12/23, 15/02/24, 14/03/24, 11/04/24, 08/05/24
Date Last Reviewed by Quality & Patient Safety Committee: 24/06/2024

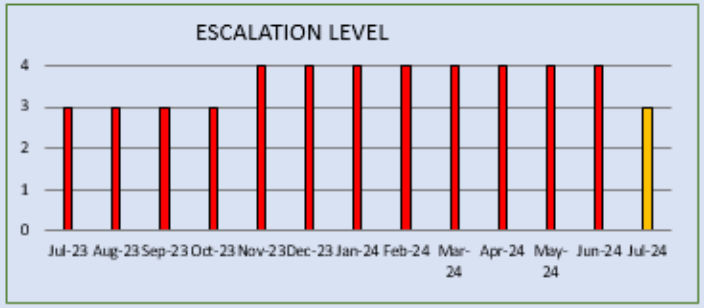
Service in Escalation: Wales Fertility Institute

Current Escalation Level 3

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↓ July 2024
↔	Escalation remains the same	
↑	Escalation level escalated	

Escalation Trajectory:



Escalation History:

Date	Escalation Level
July 2023 – JCC escalation	3
November 2023 – JCC escalation	4
July 2024 – JCC escalation	3

Rationale for Escalation Status :
Concerns from a number of routes with regards to the service including the JCC contract monitoring data submission; adherence to JCC 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, JCC 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.

JCC assurance and confidence level in developments:

Actions:

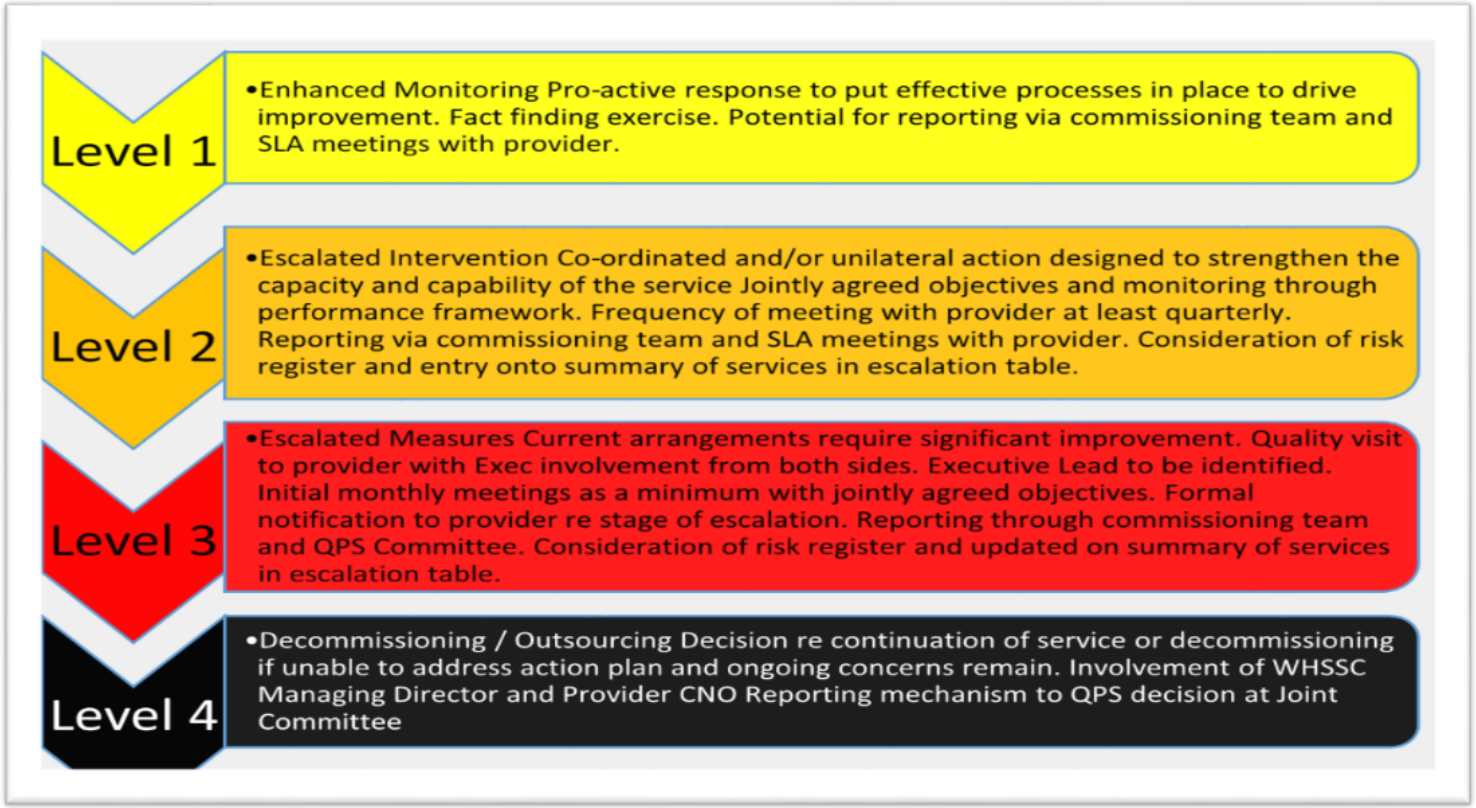
Action	Lead	Action Due Date	Completion Date
Monthly escalation meeting to review progress against Action Plan Escalation meeting 19th September 2023 10th October 2023 7th December 2023 15th February 2024 14th March 2024 9th April 2024 8th May 2024	Assistant Specialised Planner	Monthly	13 June 2024

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 JCC data submissions, however, the service need to ensure time is given both internally and to JCC 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 suitable staff to sit the exam, to ensure sustainability of the service with a PR over Cardiff and a PR over Neath Port Talbot. Cardiff inspection took place in March 2024, following the inspection being considered by the HFEA licensing panel who agreed to changing the licence to a storage only facility. The Neath Port Talbot Inspection took place in May 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. A new clinical service manager took up post at the start of May 2024. The HB have agreed to undertake a comprehensive service review to include, performance, finance, complaints, incidents and risks. It was originally intended for the review to be completed by the end of January 2024 however this has been delayed with the review report due to be shared with the HB Board at the end of May 2024. The Wales Fertility Institute (WFI) in Neath & Port Talbot Hospital risk score reduced from 25 to 15. A positive report from the HFEA highlights there are no critical or major concerns within the service and the fact that four staff members have taken and passed the exam to be the person responsible (PR), the team agreed that the service has met the required standard to be de-escalated from level 4 to level 3. There remains an issue with receiving contract monitoring information, which is in the process of being resolved.			
SMART Action plan reviewed and agreed	Service Manager	19th September 2023	19th September 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 JCC	16th November	Ongoing

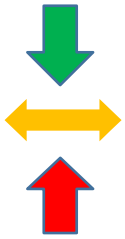
Issues/Risks: There is a risk the Wales Fertility Institute (WFI) in Neath & Port Talbot Hospital is not providing a safe and effective service due to 7 major concerns identified during a relicensing inspection by HFEA in January 2023. There is a consequence that families who have treatment at this centre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

Level 1 ENHANCED MONITORING Patterson Liz 01/11/2024 16:03:22	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 JCC 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 JCC 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 (JCC Executive Lead) • Associate Medical Director - Commissioning Team • Senior Planning Lead – Commissioning Team • JCC Head of Quality • Executive Lead from provider Health Board/Trust • Clinical representative from provider Health Board/Trust • Management representative from provider Health Board/Trust An agreed agenda should be shared prior to the meeting with a request for evidence as necessary. At the conclusion of the meeting a clear timeline for agreed actions will be identified for future monitoring and confirmed in writing if appropriate. Reporting will be through commissioning team to QPS Committee. Consideration of entry on the risk register and summary of services in escalation table for Chairs report to Joint Committee. Consideration to involve and have a discussion with Welsh Government may be considered appropriate at this stage. If there is ongoing concern relating patient care and safety with no clear progress then further escalation will be required to Level 4. On the other hand if progress is made through the escalation Level 3 evidence of this should be presented to CDG/QPS and a formal decision made with the provider to de-escalate to Level 2.
Level 4 **DECOMISSIONING/OUTSOURCING**	Where services have been unable to meet specific targets or demonstrate evidence of improvement a number of actions need to be considered at this stage. This stage will require notification and involvement of the JCC Managing Director and CEO from the provider organisation. Both Quality Patient Safety Committee and Joint Committee should be cited on the level of escalation. The following areas will need to be considered and the most appropriate sanction applied to help resolve the issue: 1. De-commissioning of the service 2. Outsourcing from an alternative provider. This may be permanent or temporary 3. Contractual realignment to take into account the potential need to maintain and agree an alternative provider. Involvement with Welsh Government and the Community Health Council is critical at this stage as often there are political drivers and levers that need to be considered and articulated as part of the decision making. Moving in and out of escalation and between Levels In addition to the Levels described above the process has introduced a traffic light guide within each level. The purpose of this is to help demonstrate the direction of travel within the level. It sets out an approach to help identify progress within the level and lays out the steps required for movement either upwards (escalation) or downwards (de-escalation) through the level. At every stage a red, amber or green colour will be applied to the level to illustrate whether more or less intervention is in place. Red being a higher level of intervention moving down to green. It will also help determine the easing of the escalated measures described and inform movement within the stages of escalation. As the evidence and understanding of the risks from a provider and commissioner become evident decisions can be made to reduce the level of intervention or there may be a need to reintroduce intervention should conditions worsen and trigger the re-introduction of measures if progress is unacceptable. In this way organisations will be able to understand what is being asked of them, progress will be easily identified and it will help avoid any confusion. It will also help in the reporting to provide assurance that action is being taken to meet the agreed timescales.



SERVICES IN ESCALATION



Level of escalation reducing / improving position

Level of escalation unchanged from previous report/month

End of Life Care Services
Final Internal Audit Report

September 2024

Powys Teaching Health Board

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

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

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Review reference:	PTHB-2324-13
Report status:	Final
Fieldwork commencement:	7 May 2024
Fieldwork completion:	7 June 2024
Debrief meeting:	25 June 2024
Draft report issued:	18 July 2024
Management response received:	13 August 2024
Final report issued:	15 August 2024
Auditors:	Ian Virgill, Head of Internal Audit Jayne Gibbon, Audit Manager
Executive sign-off:	Kate Wright, Executive Medical Director
Distribution:	Louise Hymers, Macmillan Lead Nurse for Cancer and Palliative Care
Committee:	Audit Risk & Assurance Committee

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

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

Executive Summary

Purpose

The overall objective of the audit was to review the structures and processes in place for the provision of all End of Life Care services to the residents of Powys.

Overview

We have issued reasonable assurance for this audit.

The matters requiring management attention include:

- Reviewing the establishment for the individual localities to ensure an equitable service is provided to Powys residents.
- Review current reporting arrangements for End of Life Care Services with a view to enhancing the information that is being reported both within and outside the Directorate.

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

Further matters arising concerning the areas for refinement and further development have also been noted (see Appendix A).

Report Opinion

Reasonable

Some matters require management attention in control design or compliance.

Assurance summary[1]

Objectives		Assurance
1	End of Life Care Services are appropriately structured.	Reasonable
2	Services are appropriately managed	Reasonable
3	There are clear documented pathways	Substantial
4	Regular and accurate monitoring	Limited

[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	End of Life Care Services provision	1, 2	Operation	Medium
4	Monitoring and Reporting	4	Design	High

1. Introduction

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

1.2 End of life care is support for people who are in the last months or years of their life and should help the individual to live as well as possible until they die and to die with dignity. End of life care can be received at home, in a care home, hospice or in hospital, depending on individual needs and preference.

1.3 The provision of End of Life Care services to the residents of Powys is delivered through a variety of services including the Health Board's Specialist Palliative Care Team (the 'Team'), with sites in North, Mid and South Powys, GP's, District Nurses, community hospitals and care homes.

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

- Powys residents are unable to access end of life care services; and
- Issues with the provision of services are not identified, escalated or addressed.

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

2. Detailed Audit Findings

Objective 1: End of Life Care services are appropriately structured to allow for equitable access for residents across Powys.

2.1 The Specialist Palliative Care Team is structured across three geographical areas of North, Mid and South Powys. The Team is managed by the Macmillan Lead Nurse for Cancer and Palliative Care and supported by two End of Life GP Facilitators, each providing 2 sessions per week.

2.2 The operating hours for In Hours service provision by the Team is the same across the three localities, with each providing services Monday to Friday 8.30am to 4.30pm.

2.3 The staff structures (establishments) vary between each locality due to the differences in the geography and demographics of each locality. We have been informed that there has not been a review of each locality's staffing establishment for some time. **(Matter Arising 1)**

2.4 The out of hours service provision is provided by the Health Board's District Nursing service as well as providers such as neighboring health boards and third sector organisations commissioned by the Health Board.

Conclusion:

2.5 Whilst the hours of service provision are consistent for each locality, we note the establishments for each locality vary and these establishments have not been reviewed for some time. We have allocated **Reasonable Assurance** for this objective.

Objective 2: The services are appropriately managed, resourced and funded to allow for effective and sustainable on-going provision.

2.6 We note that whilst there is one cost centre for managing the budgets for the In Hours service provided by the Team, the funded establishment is divided into the three localities. As noted in paragraph 2.2 above the 'identified' establishment for each locality was based on the respective geography and demographics.

2.7 As part of our fieldwork, we met with each locality lead to discuss the level of resources available and if they felt it was suitable to meet the needs of the service. The following areas of concerns were raised at these meetings:

- The Team is receiving an increase in the number of patient referrals;
- More complex cases are being referred to the Team, e.g. patients with co-morbidities;
- Current staffing levels allocated are struggling with number of patients being referred;
- Insufficient level of medical cover provision; and
- Access issues to out of hours service is impacting on in hours service.

2.8 In light of the concerns raised by the locality leads a review of the establishment for the Team needs to be undertaken. **(Matter Arising 1)**

2.9 We also note the Duty Nurse 'pilot' that is currently being undertaken within the North Locality team. The purpose of the role is to triage patients referred to the team and allocate to staff caseloads. The role also 'takes' all ad hoc calls made to the team and undertakes follow up calls. We are advised that the pilot has led to better caseload management for the team within the locality.

Conclusion:

2.10 Whilst there are identified establishments in place for each locality, as a result of the concerns that have been raised a review of these establishments should be undertaken. We have allocated **Reasonable Assurance** for this objective.

Objective 3: There are clear, documented pathways in place for Powys residents to either access or be referred into the services, including out of hours provision, and these are publicised and made available to all relevant individuals.

2.11 The Specialist Palliative Care Operational Policy provides details on the referral process to the 'Service' including that referrals should be made via the All Wales Specialist Palliative Care Referral form.

2.12 Each locality has a Patient Information Leaflet that will be given to the patient and their family/carer when they have their first contact with the team after the referral. The leaflet provides information on the Specialist Palliative Care Team, contacts for the In Hours and Out of Hours service and details of the service that the team provides.

2.13 At the first contact with the patient and their family/carer, the wishes of the patient is discussed with the patient with regards to the service provision. This will then be discussed and reviewed at each subsequent contact and care plan/service provision updated accordingly. The team will endeavour to meet the wishes of the patients but there may be occasions where that may not be possible due to the patient's condition, level of support and lack of hospital/hospice provision.

2.14 There are a number of policies and procedures in place within the Health Board that detail the processes to be followed for referring patients to the End of Life Care services and also the management of the patients.

2.15 Our review of the policies and procedures in place highlighted that two of the policies were overdue for review and that whilst one procedure noted that it would be reviewed every three months we were unable to determine if such reviews had taken place. **(Matter Arising 2)**

2.16 The policies and procedures are accessible to all staff via the Health Board's Policies and Procedures page on its Intranet (Sharepoint).

Conclusion:

2.17 There are clear pathways for accessing services and several policies and procedures are in place that document the services provided and are accessible to all staff. We have allocated **Substantial Assurance** for this objective,

Objective 4: Robust arrangements are in place for regular and accurate monitoring and recording of the delivery of services and performance is reported to appropriate management, groups and committees within the Health Board.

2.18 On a monthly basis the Service Lead will provide updates to the Community Services Manager (CSM) under the following headings:

- Caseload;
- Waiting Times;
- Successes; and
- Concerns for Escalation/Awareness.

2.19 The above information is then converted into a slide by the CSM and then submitted to the bi-monthly meetings of the Community Services Group Operational and Quality & Safety meetings. Whilst this information is reviewed within the Directorate there is currently no information regarding the service reported to any Health Board Committee or included as part of the Health Board's Integrated Performance Report (from 24/25 known as the Integrated Quality and Performance and Quality Report). **(Matter Arising 3)**

2.20 Furthermore, we note that the Team collates a plethora of data regarding the service it provides that whilst it is reviewed within the Team it does not appear to be elsewhere within the Directorate. **(Matter Arising 3)**

2.21 We note that there are currently two groups in place within the Health Board whose purpose is to provide strategic direction for the delivery of end of life services. The groups are 'End of Life Care Strategy Group' and 'Last Year of Life Group'. We have been advised that going forward it is the intention to merge the two groups. We are not aware of any performance information being reported to these groups.

Conclusion:

2.22 Whilst some information regarding service activity is reported within the Directorate no information is reported at Committee level. Additionally, the team records data that is not reviewed outside of the service. We have allocated **Limited Assurance** for this objective.

Appendix A: Management Action Plan

Matter Arising 1: EOL End of Life Care Services provision (Operation)	**Impact**
We note that whilst there are no separate budgets for the three localities there are agreed establishments in place for each locality that are based on the demographics and geography of each locality which we are advised have not been reviewed for some time. As part of our fieldwork meetings were held with each locality lead to discuss the current establishment and whether they feel it is sufficient to meet the current needs of the Powys residents. The following concerns were brought to our attention which the leads felt were impacting on the service they are able to provide: • The teams were all experiencing an increase in the number of patients being referred into the service that impacted on staff caseloads; • The number of complex cases being referred has increased, e.g. patients with co-morbidities; • The level of medical provision is insufficient to meet current demands; and • Access issues to out of hours service is impacting on the 'In – Hours' service. We were informed that the North Locality is currently piloting a 'Duty Nurse' post within the team. The role involves receiving all referrals into the team, triaging the calls and then allocating to a team member's caseload. The role will take ad hoc phone calls and also undertake planned follow up calls. Initial feedback on this pilot has led to improved caseload management for the team members.	Powys residents are unable to access end of life care services.

Recommendations		**Priority**
1	Management should undertake a review of the current service needs and provision for end of life services as soon as possible. A review of the pilot being undertaken within the North Locality should also be undertaken with a view to implementing across all localities. Whilst the focus of the audit has been on the In-Hours service provision, due to the concerns raised by staff it is recommended that the provision of Out of Hours Service is also reviewed.	**Medium**

Agreed Management Action		Target Date	Responsible Officer
1	**In Hours** We will work on reporting processes to understand service activity, demand and capacity, and then work to review the establishment of the Specialist Palliative Care Team, as part of sustainability planning within the health board. Review of pilot – triage nurse The Specialist Palliative Care Team will continue to review the pilot of a triage nurse currently being undertaken in North Powys, and share the learning with the Mid and South localities, identifying how this model could support service delivery – N.B. the establishment of staff in the Mid and South is currently lower, therefore the model may not be effectively embedded in these areas until the wider team establishment is reviewed, the option of a Pan-Powys triage approach will be explored. **Out of Hours** Provision of commissioned services provided via hospice partners across Wales is currently being reviewed by the Joint Commissioning Committee, this process commenced in April 2024; with all health boards across Wales being asked to pause any new hospice commissioning agreements. Prior to this change, PTHB was in the process of reviewing the hospice commissioned services to ensure they were fit for purpose and met the needs of our palliative and end of life patients. We are anticipating regular updates from the JCC, and will fully participate in the review process, if required we will build on the JCC work to ensure the needs of our residents at end of life are met.	Q3-Q4 2024/2025 Await update from JCC	Lousie Hymers Macmillan Lead Nurse for Cancer and Palliative Care

Matter Arising 2: Policies & Procedures (Operation)	**Impact**
Our review of the guidance and policies in place relating to end of life services noted that a number of documents were overdue for review as follows: • PTHB/GNP 001 Verification of Death by a Health Care Professional Policy – the policy was due for review in April 2023; and • PTHB/GNP 081 Standard Operating Procedure for the Medical Examiner Process in PTHB Community Hospitals – the procedure was due for review in January 2024. We also noted that the Procedure PTHB/GNP 075 Administration of as-needed subcutaneous medication for common breakthrough symptoms in home-based dying people in Wales (The CARiAD Package) states that the procedure would be reviewed every 3 months. There is no indication on the current version of this document that these reviews have/are taking place. (We do acknowledge that this procedure is an All Wales document).	Guidance in place for staff may be out of date.

Recommendations		**Priority**
2	Management should ensure that those documents overdue for review are reviewed and approved by an appropriate forum as soon as possible. Once approved the updated documents need to be made accessible to all health board staff. For the remaining procedure (PTHB/GNP 075) management need to determine if reviews have taken place and ensure latest version of the document is available to all health board staff.	**Low**

Agreed Management Action		**Target Date**	**Responsible Officer**
2	**PTHB/GNP 001 – Verification of Death by a Health Care Professional Policy**	Q3 2024/2025	Louis Hymers Macmillan Lead Nurse for Cancer and Palliative Care

	We will link with accountable executive (Executive Director of Nursing) to ensure the document is updated		
	PTHB/GNP 081 – Standard Operating Procedure for the Medical Examiner Process in PTHB Community Hospitals Link with accountable executive (Executive Director of Nursing) to ensure the document is updated	Q3 2024/2025	
	PTHB/GNP 075 – Administration of as-needed subcutaneous medication for common breakthrough symptoms in home-based dying people in Wales (The CARiAD Package) Continue to liaise with team in BCUHB who are currently updating the policy – once available to progress through PTHB policy processes	Q3 2024/2025	

Matter Arising 3: Reporting (Design)	**Impact**
From our audit fieldwork we note that information regarding the number of patients accessing the service and also any concerns / issues affecting the service are reported at the Community Services Group Operational and Community Services Group Quality & Safety bi-monthly meetings, however at the current time we note that no information regarding the service activity is currently reported to any Health Board Committees or included within the Health Board's Integrated Performance Report. As part of our fieldwork we noted that the Service records a vast amount of data that currently is not being routinely reported/shared outside of the Service. The information that is currently recorded includes: • Review of acuity of patient caseload on a weekly basis • Number of new referrals (monthly) • Number of discharges (monthly) • Number of deaths (monthly) • Preferred place of death audit (PPD) We were also advised that due to the nature of the service they provide the service also has patients that are re referred into them due to the nature of their illness so data regarding the reasons for re referral and frequency could also be recorded.	Issues with the provision of services are not identified, escalated or addressed.

Recommendations		**Priority**
3	Management should review the data that is currently being collated by the Service in order to consider which information should be included as part of the Health Board's Integrated Quality and Performance Report. We acknowledge that not all data collated can be included with the Health Board's Integrated Performance Report and so management should also review and consider any additional information that should be reported within the Community Services Group.	**High**

Agreed Management Action		Target Date	Responsible Officer
3	We will review the reporting measures of the Specialist Palliative Care Team within the Community Services Group and identify an appropriate reporting mechanism, in line with the recommendations within this report. We will also work with our commissioning team to ensure that systems related to the reporting of commissioned palliative / end of life services are robust	Q3 2024/2025	Louise Hymers Macmillan Lead Nurse for Cancer and Palliative Care

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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

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Patient Experience Quality and Safety Committee 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 PEQS					✓
Governance	Review and Approve Terms of Reference PoDG					✓
Performance	Integrated Quality and Performance Report	✓	✓		✓	✓
	Floor to Board quality (contained within IQPR)				☒	
Clinical Quality	Clinical Quality Framework (contained within IQPR)		☒		☒	
	PSOW Annual Letter (within IQR)				✓	
	Care Inspectorate Wales Report Cottage View Knighton (after IQR)	✓				
Patient Experience	Patient Experience Framework				✓	
	Patient Story	✓	✓		✓	✓
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	✓	✓		✓	✓
Medicines Management	Annual Report of Accountable Officer for Controlled Drugs					✓
Annual Reports	Medicines Management Annual Report				☒	✓
	Safeguarding Annual Report		☒	✓		
	Duty of Quality Annual Report		☒	✓		
	Annual Report Medical Devices and Point of Care Testing				✓	
	Transition of Care Annual Report				☒	✓
Infection Prevention and Control	IPC Annual Assurance Report		✓			
	IPC progress/focus					✓
Health and Safety	Health and Safety Quarterly Report (patient and quality focus)		☒		✓	✓
Comms and Engagement	Comms and Engagement Report for PEQS				☒	✓
Other	Child Practice Review outcome (to April 2024)	✓				
	Monitor Health Board actions of Child Pratice Review				✓	
	Outcome of Joint Inspection of Child Protection Agencies	✓				✓
	Monitor Health Board actions of JIPCA					
	Corporate Parenting Charter					✓
	Staff experience of MH Services in escalation					✓
Actions/follow up	Point of Care Testing (action from Jan 24)				✓	
	Mental Health Deep Dive part 2 (follow up from Jan 24)	✓				
	Maternity Services assurance report					
Escalated Items:	Mental Health escalation				✓	
	Civica (Patient Experience)				✓	
	Neurodiversity (referred from D&P Oct 2024)				✓	
	Joint meeting with Workforce and Culture (October - cancelled)					
TBC	Survey findings - Urgent Suspected Cancer Pathway Survey					
TBC	Children's Services					
TBC	Learning Organisation/Group					
TBC	Primary Care - quality perspective (Exec lead tbc)					

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