Patient Experience, Quality and Safety Committee

Tue 11 February 2025, 13:00 - 16:00

Agenda

13:00 - 13:00
0 min

1. PRELIMINARY MATTERS

PEQS_ Agenda_11FEB25 FINAL.pdf (3 pages)

1.1. Welcome and Apologies

1.2. Declarations of Interest

PEQS_1.2_Board Members Declaration Of Interests summary 2024-25Jan.pdf (4 pages)

13:00 - 13:00
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.

13:00 - 13:00
0 min

3. ITEMS FOR APPROVAL / DECISION / RATIFICATION

3.1. Minutes of the previous meeting: 07 November 2024

PEQS_3.1_Minutes 2024-11-07 PEQS unconfirmed.pdf (11 pages)

3.2. Committee Action Log

PEQS_3.2_Action Log February 2025.pdf (2 pages)

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0 min

4. ESCALATED ITEMS

4.1. Children's Neurodiversity Services update

PEQS_4.1_Childrens ND services update.pdf (8 pages)
PEQS_4.1a_App 1 ND Escalation 03 February 2025.pdf (13 pages)
PEQS_4.1b_Childrens ND App 2.pdf (10 pages)

4.2. People Experience Framework update

PEQS_4.2_Peoples Experience Framework.pdf (5 pages)

4.3. Infection Prevention Control (within Integrated Quality Report)

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0 min

5. ITEMS FOR ASSURANCE

5.1. Integrated Quality Report

- PEQS_5.1_Integrated Quality Report Jan 2025.pdf (19 pages)
- PEQS_5.1a_App1_sustaining quality and safety improvement in MH and LD Jan 25.pdf (7 pages)

5.2. Adult Mental Health Services monitoring post local escalation

- PEQS_5.2_MH and LD services monitoring post local escalation.pdf (6 pages)

5.3. Maternity Services Assurance Report

- PEQS_5.3_Maternity Assurrance Report.pdf (12 pages)
- PEQS_5.3a_ LA Birth Story.pdf (6 pages)
- PEQS_5.3b_ Civica Feedback.pdf (5 pages)
- PEQS_5.3c_Vaping PP for CWTCH Nov 24.pdf (15 pages)

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

- PEQS_5.4_MHA Compliance.pdf (11 pages)

5.5. Medicines Management Annual Report

- PEQS_5.5_Medicines Management cover paper.pdf (2 pages)
- PEQS_5.5a_Medicines Management and Pharmacy Annual Report 2023-24.pdf (33 pages)

5.6. Annual Report of Accountable Officer for Controlled Drugs

- PEQS_5.6_Controlled Drugs Accountable Officer Annual Update Feb 2025.pdf (13 pages)

5.7. Transition of Care Annual Report

- PEQS_5.7_Transition and Handover Annual Report 2023-2024.pdf (3 pages)
- PEQS_5.7a_PTHB Transition and Handover Annual Report 2023 - 2024.pdf (24 pages)

5.8. Committee Risk Register

- PEQS_5.8_ Committee Risk Report_February 2025 (January's Data).pdf (6 pages)
- PEQS_5.8a_CRR004 (Demand - provider) Jan 2025.pdf (4 pages)
- PEQS_5.8b_CRR005 (Demand - commissioner) Jan 2025.pdf (6 pages)

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6. ITEMS FOR DISCUSSION

There are no items for discussion

13:00 - 13:00
0 min

7. CONSENT AGENDA

7.1. Internal Audit Reports:

7.1.1. Deprivation of Liberty Safeguards

- PEQS_7.1a_PTH-2425-15 Deprivation of Liberty Safeguards Final IA Report.pdf (17 pages)

7.1.2. Committee and Board Effectiveness

- PEQS_7.1b_PTH-2425-02 Board Effectiveness Final IA Report.pdf (6 pages)

7.2. Work Programme

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PEQS_7.2_Work Programme February 2024.pdf (1 pages)

7.3. Glossary

PEQS_7.3_Powys Teaching Health Board Glossary February 2025.pdf (5 pages)

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8. OTHER MATTERS

8.1. Any Other Urgent Business

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

8.3. Committee reflections

8.4. Date of the Next Meeting: 29 April 2025 - in person Machynlleth

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8.5.

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POWYS TEACHING HEALTH BOARD
PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE

THURSDAY 11 FEBRUARY 2025
13:00 – 16:10
VIA MICROSOFT TEAMS

AGENDA				
Time	**Item**	**Title**	**Attached/Oral**	**Presenter**
	1	**PRELIMINARY MATTERS**		
13.00	1.1	Welcome and apologies	Verbal	Chair
	1.2	Declarations of interest	Verbal	All
	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**		
13.05	3.1	Minutes of previous meeting: • 07 November 2024	Attached	Chair
	3.2	Committee Action Log	Attached	Chair
	4	**ESCALATED ITEMS**		
13.10	4.1	Children's Neurodiversity Services update	Attached	Executive Director of Planning, Performance and Commissioning
13.40	4.2	People Experience Framework update	Attached	Executive Director of Nursing, Quality, Women and Family Health
	4.3	Infection Prevention Control – (within Integrated Quality Report)	Verbal	Executive Director of Nursing, Quality, Women and Family Health
	5	**ITEMS FOR ASSURANCE**		
13.50	5.1	Integrated Quality Report • Including Floor to Board quality	Attached	Executive Director of Nursing, Quality, Women and Family Health
14.20 15 mins	5.2	Adult Mental Health Services monitoring post local escalation	Attached	Executive Director of Primary, Community Care and Mental Health
14.35	**COMFORT BREAK (10 minutes)**			
14.45	5.3	Maternity Services Assurance Report	Attached	Executive Director of Nursing, Quality, Women and Family Health
15.00	5.4	Mental Health Power of Discharge Annual Report including Compliance with legislation	Attached	Executive Director of Primary, Community Care and Mental Health

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15.10	5.5	Medicines Management Annual Report	Attached	Executive Medical Director
15.25	5.6	Annual Report of Accountable Officer for Controlled drugs	Attached	Executive Medical Director
15.35	5.7	Transition of Care Annual Report	Attached	Executive Director of Nursing, Quality, Women and Family Health
15.50	5.8	Committee Risk Register	Attached	Director of Corporate Governance
	6	**ITEMS FOR DISCUSSION**		
		There are no items for discussion		
	7	**CONSENT AGENDA**		
	7.1	Internal Audit Reports: • Deprivation of Liberty Safeguards • Committee and Board Effectiveness **Purpose**: Information	Attached	Director of Corporate Governance
	7.2	Work programme **Purpose**: Information	Attached	Director of Corporate Governance
	7.3	Glossary **Purpose**: Information	Attached	Director of Corporate Governance
	8	**OTHER MATTERS**		
15.55	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 Reflections	Verbal	Chair
16.00	8.4	Date of the next meeting: 29 April 2025 – in person Machynlleth		

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.

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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.

POWYS TEACHING HEALTH BOARD - REGISTER OF DECLARATION OF INTERESTS 2024/25

Updated: January 2025

Position	Name	Nature of Interest	Nature of Declaration	Relevant Dates from	Relevant Dates to	Description of Declaration	Comment	Date Returned	Last day in Powys Teaching Health Board
INDEPENDENT MEMBERS									
PTHB Chair	**Carl Cooper**	Personal	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	2017	2025	Board Member, Social Care Wales	Remunerated Public Appointment	03/06/2024	
		Spouse/Partner/Other	Ownership or part ownership, of private companies, businesses or consultancies likely or possibly seeking to do business with PTHB.	2018	Ongoing	Sole Trader, Mandy Williams, Consulting	NIL		
Vice Chair	**Kirsty Williams**	Personal	A position of authority in a Charity of Voluntary Body in the field of health and/or social care	May-22	Current	Deputy Director Samaritans Powys	None	22/05/2024	
			Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	Nov-22	Current	ILEP- A Subsidory of Cardiff University	None		
			Employment by any other body where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice	Feb-24	Ongoing	Commissioner for South Wales Fire and Rescue	Ministerial Appointment		
		Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		
Independent Member (General)	**Rhobert Lewis**	Personal	Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests.	Nov-21	Current	Chair NPTC Group of Colleges	NIL	08/04/2024	
				Sep-23	Current	Chair Confederal Governance UWTSD	NIL		
				Nov-21	Current	Member of National Assesmbly of Wales Cross-Party Group on STEMM	NIL		
		Spouse/Partner/Other	NIL	NIL	NIL	NIL			
Independent Member (Trade Union)	**Cathie Poynton**	Personal	NIL	NIL	NIL	NIL	NIL	02/04/2024	
		Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		
Independent Member (Information and Technology)	**Ian Phillips**	Personal	Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests.	01-Aug-21	Current	Independent Chair Welsh Kidney Network	Remunerated	08/04/2024	22/08/2024
		Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		
Independent Member (finance)	**Steve Elliot**	Spouse/Partner/Other	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	04/02/2024	Current	Director of Oshi's World Private Limited Company	NIL	19/08/2024	
		Personal	Ownership or part ownweship of private companies, businesses or consultancies likely or possibly seeking to do business with PTHB	22/09/2023	31/03/2024	Special Advisor (Finance) to Powys tHB Audit and Delivery and Performance Committees	Yes		
		Spouse/Partner/Other	A position of authority in a Charity or Voluntary Body in the field of health and/or social care	04/02/2024	Current	Trustee of Oshi's World Charity	NIL		
Independent Member (General)	**Ronnie Alexander**	Personal	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	2012	Current	Director of RA and CJ Consulting Limited	Dividend Payment only	15/08/2024	
			A position of authority in a Charity or Voluntary Body in the field of health and/or social care.	2017	Current	Member of Finance, Risk and Audit Committee Hafod/Hendre Housing Association	£2500.00 per annum		
			Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests	Mar-21	Current to Dec-27	Personal: Independent Monitoring Authority (IMA) – Non Executive Director	£7500.00 per annum		
		Spouse/Partner/Other	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	2017	Current	Director of RA and CJ Consulting Limited	Dividend Payment only		
Independent Member (University)	**Simon Wright**	Personal	Employment by any other body where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice	2015	Current	Personal: Academic Registrar, Cardiff University- Various Healthcare Programmes	Salaried Employment	08/07/2024	
		Spouse/Partner/Other	A personal or departmental interest in any part of the Pharmaceutical / healthcare industry that could be perceived as having an influence on decision making or on the provision of advice to members of the team	2001	Current	Sister: Senior Operational Manager, Milestone Trust, Bristol	Salaried Employment		

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			Employment by any other body where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice.	2021	Current	Spouse: District Nurse, Cardiff and Vale UHB	Salaried Employment		
Independent Member (Third Sector)	**Jennifer Owen Adams**	Personal	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	Jun-16	Ongoing	Member (not a NED) of Glas Cymru the holding company of Dwr Cymru/Welsh Water	None	30/04/2024	
			Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests	Apr-14	Ongoing	Trustee of Impelo Dance CIO	None		
				Jul-05	Ongoing	Chair Public Services Board Scrutiny Committee	None		
		Spouse/Partner/Other	Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests	2013	Ongoing	Brother - Senior Manager Freedom Leisure (Lead responsibility for Swansea and South Powys).	NIL		
Independent Member (Local Authority)	**Christopher Walsh**	Personal	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.			Member of Community Speed Wath Group Member of Society Genealogists Associate Member of the Association of Genealogists and Registered Archivists	NIL	09/09/2024	
			Ownership or part ownweship of private companies, businesses or consultancies likely or possibly seeking to do business with PTHB		Ongoing	Sole Trader/Owner of Celebratory Gifts Heraldic Names Sole Trader/Owner:CTW Genealogy Research and	NIL		
			A position of authority in a Charity or Voluntary Body in the field of health and/or social care.		Ongoing	Elected Member Powys County Council •Trustee/Chair: Brecon University Scholarship Fund •Brecon Town Council Elected Member •Governor of Priory Church in Wales School •Member Brecon Beacons National Park Authority SDF & Grant Advisory Panel	NIL		
			Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests.		Ongoing	•Member of Royal College of Nursing •Registered Member of Nursing and Midwifery Council	NIL		
			Employment by any other body where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice.		Ongoing	Labour Party	NIL		
Independent Member (Capital)	**Michael Giannai**	Personal	Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests	2019	Current	Chair of the Board of Social Care Wales (Welsh Government Sponsored Body).	Remunerated	01/04/2024	
		Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		
Independent Member	**Ian Thomas**	Personal	Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests.	Jan-23	Current	Family Fund (UK Charity)	NIL	09/01/2025	
				Jun-24	Currne t	Family Fund Business Services (FFBS)	NIL		
EXECUTIVE MEMBERS									
Chief Executive Officer	**Hayley Thomas**	Personal	NIL	NIL	NIL	NIL	NIL	30/05/2024	
		Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		
Executive Director of Planning, Performance & Commissioning	**Stephen Powell**	Personal	NIL	NIL	NIL	NIL	NIL	03/07/2024	18/10/2024
		Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		
Executive Director of Finance, Capital and Support Services	**Pete Hopgood**	Personal	NIL	NIL	NIL	NIL	NIL	22/05/2024	
		Spouse/Partner/Other	A personal or departmental interest in any part of the Pharmaceutical / healthcare industry that could be perceived as having an influence on decision making or on the provision of advice to members of the team	Ongoing	Ongoing	Partner is Finance Manager working in SBUHB	Not Relevant		

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Executive Director of Allied Health Professions, Health Science and Digital	**Claire Madsen**	Personal	Employment by any other body where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice.	07-Jan-19	Current	Occasional Lecturer for University of West of England.	Hourly rate	02/04/2024	
			Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	10-Jun-05	Current	Member of the The Chartered Society of Physiotherapy	NIL		
		Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		
Executive Director of Nursing, Quality, Women and Family Health	**Claire Roche**	Personal	A personal or departmental interest in any part of the Pharmaceutical / healthcare industry that could be perceived as having an influence on decision making or on the provision of advice to members of the team	2018	Current	Member of the Royal College of Nursing	NIL	22/08/2024	
				1994	Current	Member of the Royal College of Midwifery			
		Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		
Executive Medical Director	**Kate Wright**	Personal	Employment by any other body where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice.	01-Aug-91	Current	Member of the British Medical Association		12/08/2024	
		Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		
Executive Director of People and Culture	**Debra Wood Lawson**	Personal	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	01-Nov-24	Current	Non Executive Board Director - Cadarn Housing Group Limited (Powys is a zonal partner)	NIL	18/11/2024	
		Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		
Executive Director of Public Health	**Mererid Bowley**	Personal	Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests.	NIL	NIL	Member of Faculty of Public Health	NIL	23/05/2024	
		Spouse/Partner/Other	Ownership or part ownership, of private companies, businesses or consultancies likely or possibly seeking to do business with PTHB.	NIL	NIL	Husband works for Mitie Engineering who hold contracts/work with some NHS bodies/organisations. Shares held by husband and myself and Mitie Company	NIL		
Interim Executive Director of Operations	**Joy Garfitt**	Personal	NIL	NIL	NIL	NIL	NIL	No change from 2023 submission	30/09/2024
		Spouse/Partner/Other	A personal or departmental interest in any part of the Pharmaceutical / healthcare industry that could be perceived as having an influence on decision making or on the provision of advice to members of the team	2012	Current	Spouse employed by PTHB within Mental Health Department	NIL		
Director of Corporate Governance/ Board Secretary	**Helen Bushell**	Personal	Employment by any other body where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice.	Nov-21	Current	School Governor – primary school (Bridgend Local Authority)	Not remunerated	03/06/2024	
		Spouse/Parter or other Relative	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	Sep-16	Current	Board Diretor and Chair of the Board Cadarn Housing Ltd (Powys is a zonal partner)	Remunerated part time role, 2-4 days per month		
			A personal or departmental interest in any part of the Pharmaceutical / healthcare industry that could be perceived as having an influence on decision making or on the provision of advice to members of the team	Jul-24	Oct-24	Spouse member of the PTHB Bank working occasionally for the Health Board	Paid per hour/day of work		
			Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests.	Sep-22	Current	Public Appointment - Youth Work strategy and implementation Board - Oct 22 - Sept 24	Remunerated 2-4 days per month		
Associate Director of Capital and Estates	**Wayne Tannahill**	Personal	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	1996	2016	Director of Pembrokeshire Surveyors Ltd. Sole proprietor, small architectural business, made dormant April 2016 (formally closed April 2017)		24/04/2024	
		Spouse/Parter or other Relative	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	1996	2016	Daughter Kate was Company Secretary			
Director of Strategic Improvement and Transformation	**Lucie Cornish**	Nil	Nil	Nil	Nil	Nil	Nil	13/11/2024	
Executive Director of Planning, Performance & Commissioning	**Nicola Johnson From 07/10/24**	Nil	Nil	Nil	Nil	Nil	Nil	16/10/2024	

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Executive Director of Primary, Community Care and Mental Health	**Elaine Lorton From 30/09/2024**	Personal	A position of authority in a Charity or Voluntary Body in the field of health and/or social care.	Nov-19	Current	Chair – West Wales Care & Repair	Nil	17/10/2024	
				Apr-24	Current	Independent Member – ateb	£2,960 Per Annum		

PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE

UNCONFIRMED MINUTES OF THE MEETING HELD ON 07 NOVEMBER 2024 at 10:00 VIA MICROSOFT TEAMS

MEMBERS		
Kirsty Williams	KWi	Vice Chair (Committee Chair)
Steve Elliot	SE	Independent Member
Mick Giannasi	MG	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
Jason Crowl	JC	Assistant Director of Support Services (for item 4.4)
Amanda Edwards	AE	Assistant Director Innovation and Improvement
Nicola Johnson	NJ	Executive Director of Planning, Performance and Commissioning (for item 4.2)
Elaine Lorton	EL	Executive Director of Primary Care, Community and Mental Health
Claire Madsen	CM	Executive Director of Allied Health Professionals, Health Sciences and Digital
Mark McIntyre	MM	Deputy Director People and Culture (for item 5.2)
Claire Roche	CR	Executive Director of Nursing, Quality, Women and Family Health
Heidi Sinclair	HS	Head of Quality and Safety
Richard Stratton	RS	Assistant Medical Director
Jayne Wheeler-Sexton	JWS	Assistant Director of Nursing, Safeguarding
APOLOGIES FOR ABSENCE:		
Jennifer Owen Adams	JOA	Independent Member
Hayley Thomas	HT	Chief Executive
Debra Wood Lawson	DWL	Executive Director People and Culture
Kate Wright	KW	Executive Medical Director

1. PRELIMINARY MATTERS
1.1 WELCOME AND APOLOGIES (PEQS/24/47)
The Chair welcomed everyone to the meeting. Apologies for absence were received as recorded above.

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1.2 DECLARATIONS OF INTEREST (PEQS/24/48)

No declarations of interests were received in addition to those already recorded on the register.

1.3 PATIENT STORY (PEQS/24/49)

The Committee received a recording produced by Larna Andrew, Paediatric Physiotherapist outlining Meggie's experience of physiotherapy in Powys.

Members welcomed the story noting how there had been a focus on supporting Meggie to achieve her goal of becoming a lifeguard. Arrangements for transition between children's and adult services was raised and it was confirmed that a paper on transition arrangements would be brought to the next meeting.
Action: Executive Director of Nursing, Quality, Women and Family Health

Thanks were expressed to Meggie and the Physiotherapy Team for sharing the story.

2. CONSENT AGENDA BUSINESS

The Chair asked members if they wish to bring forward any items from the Consent agenda to the main agenda. No items were raised.

3. ITEMS FOR APPROVAL / DECISION / RATIFICATION

3.1 MINUTES OF PREVIOUS MEETING (PEQS/24/50)

The minutes of the meeting held on 05 September 2024 were **CONFIRMED** as an accurate record.

3.2 COMMITTEE ACTION LOG (PEQS/24/51)

HB outlined the Action Log recorded updates with the following information provided:

- Two actions (PEQS/23/39a and b) have been deferred to the February 2025 meeting with the consent of the Chair and remain recorded as 'on track',
- Two actions (PEQS/24/10 and 24/31) are not yet due and remain 'on track', and
- The remaining outstanding actions had been closed.

4. ESCALATED ITEMS

4.1 MENTAL HEALTH SERVICES UPDATE (PEQS/24/52)

CR presented the update outlining that Mental Health Services had been placed in local escalation by the Executive Committee under the Integrated Quality and Performance Framework in March 2024. An Executive Oversight Group had been established chaired by the Executive Director of Nursing, Quality, Women and Family Health. An Improvement Plan was established and the progress to date outlined. The Executive Committee had considered the progress made and continued delivery of the implementation plan and agreed the service be de-escalated from 16 October 2024.

Members asked the following questions for assurance:

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How is the organisation responding to the leadership scores on page 9 of the appendix which appear to show concerns relating to 'empowers develops potential' and 'adapts to change, supporting others to do the same'?
CR advised that a Workforce and Culture Group had been established comprised of colleagues from Mental Health Services and the People and Culture service to improve leadership skills in the service.

Has the service been in local escalation for sufficient time to demonstrate sustained improvement, and, how robust is the evaluation process which has led to the de-escalation – the service has moved through the maturity matrix at lightning speed; however, the report contains information such as in relation to levels of agency staffing which do not align with a mature service?
CR advised that local escalation was a means to put in place an immediate support and oversight group with very specific parameters for improvement. On de-escalation, services are overseen by way of Integrated Quality and Performance Groups. Mental Health Services were the first service to be put into local escalation under the Integrated Quality and Performance Framework and learning from this experience will be used when considering arrangements for other services which may be at risk of going into local escalation.

When a service goes into local escalation a considerable amount of support is put in place which will disappear when the service is de-escalated. What confidence is there that the necessary improvements will continue when intense levels of support are removed?
EL advised that whilst the team have been in escalation there has not been a substantive Executive Director in post, but her recent appointment had settled this position. The focus now was to review the interim leadership team and make substantive appointments and ensure the progress made to date was built upon.

NJ noted that a lessons learned report would be undertaken which would be considered by Executive Committee and this Committee. The first round of Integrated Quality Performance Reports was taking place and a one-year review of the Integrated Quality and Performance Framework was also planned.

HB added that colleagues from Mental Health Services would be invited to a future meeting of the Committee to outline their experience of a service under escalation.

The Committee:
1. **TOOK 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. **NOTED** and **DISCUSSED** the contents of the report including progress that has been made against the improvement plan**.**
3. **NOTED** the Executive Committee decision that the service group is de-escalated at this point, taken on the 16 October 2024.
4. **NOTED** the service would continue to need further support.
5. **REQUESTED** an update to the February 2025 meeting of the Committee.

Action: Executive Director of Primary Care, Community and Mental Health

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6. **REQUESTED** the review of the Integrated Quality and Performance Framework be brought to a future meeting of the Committee.

Action: Executive Director of Planning, Performance and Commissioning

4.2 NEURODIVERSITY SERVICES (PEQS/24/53)

KWi advised that this item had been transferred from the Delivery and Performance Committee to ensure an appropriate focus on quality as well as performance of the service.

ND as Senior Responsible Officer introduced the item outlining that Executive Committee via the Integrated Quality and Performance Framework had identified concerns that has resulted in a decision to put the service into Level 3 local escalation. An Executive Oversight Group (EOG) had been established which will meet fortnightly where the improvement plan and de-escalation criteria will be established. The EOG will report monthly to Executive Committee and to each meeting of this Committee.

Members asked the following questions for assurance:
Can assurance be given that putting a service into escalation will not delay improvement?
CR as operational lead for the service explained that the service welcomed the additional focus that local escalation would provide. The service was already working on improvements rather than waiting to produce an improvement plan. Learning from the experience of Mental Health Services in escalation has shown a need to be clear about de-escalation criteria.

NJ shared that in addition to the operational improvement already taking place additional funding to tackle the backlog has been confirmed by Welsh Government.

What mechanisms can be put in place to enable the Committee to receive feedback from the two Co-production Groups that have been established?
ZA confirmed that two Co-production Groups had been established with representatives from the Health Board, the County Council and parents of children and young people. Feedback from these groups would be brought to the February 2025 meeting of the Committee.
Action: Executive Director of Nursing, Quality, Women and Family Health

There appears to be common issues arising among the two services that have gone into escalation (leadership, staffing etc). What actions are being taken to enable early identification of issues that can be addressed to avoid escalation?
CR advised that, as the arrangements put in place to undertake Integrated Quality Performance Reports, and as the Integrated Quality and Performance Framework matured, it will be possible to identify themes and areas of commonality which will enable earlier identification of emerging issues.
CR thanked Deb Austin for the work she had undertaken, commissioned by the Chief Executive to review the service and offer constructive challenge.

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The Committee:

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

4.3 CIVICA – PATIENT EXPERIENCE SYSTEM (PEQS/24/54)

KWi noted this item was escalated to the Board, however, would be addressed under item 6.1 Patient Experience Framework.

4.4 INFECTION PREVENTION CONTROL (PEQS/24/55)

KWi noted this item was escalated to the Board, however, would be addressed under item 5.1 Integrated Quality Report.

5.ITEMS FOR ASSURANCE

5.1 INTEGRATED QUALITY REPORT (PEQS/24/56)

CR introduced the paper and drew attention to the following areas:

- Progress in responding to concerns within the 30-day deadline had been sustained although low numbers meant this indicator may be subject to volatility. It is necessary to ensure that the quality of response is maintained,
- Overall, the organisation is predominantly responding to concerns via early resolution,
- Incident management figures are shown in graphs 6 and 7 and show the Health Board has focussed on closing incidents in a timely manner (the large number of open incidents in Mental Health Services had been an indicator of problems in that service),
- The disaggregated data for pressure ulcers is included along with learning that has taken place in pressure ulcer panels,
- The Public Services Ombudsman for Wales (PSOW) Annual Letter had been received confirming 21 complaints had been submitted, and the PSOW had intervened in 14% of cases, and
- Infection Prevention and Control remains an escalated item (in quarter 1 of year 2 of the improvement plan). 93% of actions are completed and improvements now need to be embedded and sustained.

Members asked the following questions for assurance:

What is the mechanism for responding to concerns and issues raised in the Llais reports?

HB advised that a group including participants from the Health Board, Llais and the County Council meet regularly to consider feedback to Llais. Llais send a Regional Directors report to the bi-monthly Board meetings.

Most of the feedback shown in graph 13 relates to outreach services. What response is received from locally provided services including GPs and Pharmacies?

HS acknowledged that there was much work to be done to fully utilise the Civica system and this would be covered further in the Patient Experience Framework presentation.

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The Committee:

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

5.2 HEALTH AND SAFETY QUARTERLY REPORT (PEQS/24/57)

MM presented the quarter 2 report on Health and Safety Performance and drew attention to the following areas:

- An Internal Audit Review of Health and Safety arrangements had given 'Reasonable' assurance in 2023 with nine management actions. Three remain outstanding and the progress made was detailed within the report,
- Overall, the number of incidents remains low, however, the number of RIDDOR reports is increasing. Analysis of these reports show there is no particular trend or area of concern,
- The number of incidents of violence and aggression is of concern and further work has been requested to analyse the data to check against the strategies and training in place,
- Stress, anxiety and depression account for 10% of all episodes of absence and further work is taking place to ascertain if patterns of stress absence can be identified, and
- Did Not Attend rates at training sessions are an area of concern, particularly in relation to face fit testing.

Members asked the following questions for assurance:
There appears to be a mismatch between training for violence and aggression and incidents thereof. Does the training offered meet what is required?
MM advised that Aneurin Bevan University Health Board had been commissioned to provide this training and it will be necessary to ascertain if the original amount of training commissioned was more than was actually required.

Is there a cost to training not attended?
MM confirmed there was a cost relating to training not attended. There is a degree of complexity relating to front line staff accessing training.

Is over provision of training restricted to Health and Safety training or is it wider noting the Cabinet Secretary has been clear that NHS Wales must drive out waste?
MM noted there was an ever-increasing demand from Government for statutory and mandatory training. Frontline clinical staff are required to undertake 67 hours of training within their first year, however, with pressures on front line staff it is difficult to provide accessible training. The People and Culture team alongside the Nursing Directorate are considering how to prioritise the training offer but this is acknowledged as a risk. A conversation is also taking place with Welsh Government as, whilst each individual training requirement makes sense, cumulatively it is unsustainable. The aim is to reduce the rate of Did Not Attend training.

Can training be provided ward by ward to enable frontline staff to be away from their post for the shortest time? Travel is a barrier to training accessibility.
MM confirmed this was part of the wider discussion to enable the most people to access training at an economy of scale.

The Committee:

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

5.3 MONITORING OF HEALTH BOARD ACTIONS FROM CHILD PRACTICE REVIEW (PEQS/24/58)

CR presented the update of progress against actions arising from the Concise Child Practice Review (CYSUR 3 2021) resulting from the sad unexpected death of a young person in Powys in 2020. The Mid and West Wales Safeguarding Board are responsible for monitoring improvements against the nine recommendations made. Five of the recommendations relate specifically to the Health Board and progress against the five recommendations was outlined within the report.

The Committee:

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

5.4 ANNUAL ASSURANCE REPORT MEDICAL DEVICES AND POINT OF CARE TESTING (PEQS/24/59)

JC presented the paper which gave an overview of the performance of the Medical Devices and Point of Care Testing over 2023-24 and a review of the challenges and risks drawing attention to the following areas:

- Progress is being made against the recommendations of the Internal Audit undertaken in 2021 with four recommendations complete and elements outstanding in relation to staff training, contract monitoring and point of care testing,
- Risks on the Therapies and Health Sciences Directorate Risk Register include point of care testing and governance, equipment maintenance and acquisition of medical devices,
- There have been 67 incidents report with no particular theme other than failure of a medical device,
- 17 Freedom of Information requests have been received largely from the commercial sector,
- Training challenges relate to capacity and ability to undertake training across the Powys sites,
- £167k has been received to purchase replacement equipment,
- £1m has been received as part of the Radiology Information System Procurement for new radiology equipment,
- Additional equipment made available during the pandemic has been distributed, and
- Contract monitoring has improved.

EL welcomed the report, supported the point of care testing arrangements in place and would like to see the service extended to the rural population in Powys.

Members asked the following questions for assurance:

The replacement of out-of-date equipment is welcomed. What arrangements are in place for this to be removed from service areas rather than taking up valuable storage space?

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JC advised that close working was being undertaken with contractors picking up stock that needs to be removed and recycled via appropriate decontamination arrangements.

What arrangements are in place to ensure appropriate storage arrangements are in place across the whole of the estate?
JC acknowledged storage is a challenge to ensure that items are stored appropriately across multiple sites. The service is working with estates on arrangements to have a central site in Bronllys that would provide equipment on a 'just in time' basis.

CM added that when the service transferred to her area there was no electronic inventory. An inventory system W-POCT was purchased, and items uploaded from beds to handheld items used by community colleagues. The system receives alerts relating to individual pieces of kit that need to be removed. A governance structure has been put in place with the clusters which will develop this work in primary care to the further benefit of patients.

The Committee:
- **REVIEWED** the attached report and accept this as an accurate overview of the service.
- Took **ASSURANCE** that the medical devices and Point of Care Testing requirements have been fulfilled.

5.5 CLINCIAL AUDIT PROGRESS REPORT (PEQS/24/60)

RS presented the report giving an update on the 2024/25 Clinical Audit Plan drawing attention to:
- the introduction of the Medical E-Governance (MEG) system for ward level audits enabling trends and learning to be identified,
- the intended work with primary care regarding audit and improvement activities as part of revalidation processes,
- a spotlight audit of the Respiratory Care Programme for children with severe Cerebral Palsy, and
- changes to the clinical audit programme were outlined

The Committee:
- **RECEIVED** the update report and took **ASSURANCE** that clinical audit is progressing in year.

5.6 COMMITTEE RISK REGISTER (PEQS/24/61)

HB presented the report advising that this was the first time the new version of the Committee Risk Register had been shared with the Committee since the revised Corporate Risks were taken through Board in September 2024. Two risks fall under this Committee:
- Risk 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, and
- Risk 005: Increase in demand, inequality of access, complexity of patient needs, or failure to respond to demand pressures for commissioned

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services results in poorer outcomes and experience for the citizens of Powys. Commissioned services may include urgent and emergency health and social care system.

Risk 004 is owned by the Executive Director of Planning, Performance and Commissioning and the Executive Director of Primary Care, Community and Mental Health, and Risk 005 is owned by the Executive Director of Planning, Performance and Commissioning.

The Risk Register is reported to each meeting of the Board and the Committee will get information slightly before Board, or information that has already been received at Board depending on the Committee and Board meeting cycle.

The Committee:
- **RECEIVED** and **DISCUSSED** the corporate risks within the Committee's remit and any relevant issues
- **TOOK ASSURANCE** that risks are being managed in line with the Risk Management Framework.

6. ITEMS FOR DISCUSSION

6.1 PATIENT EXPERIENCE FRAMEWORK (PEQS/24/62)

CR gave a presentation on the People's Experience Framework to be made available with Committee Members after the meeting:
- The title has changed from 'Patient Experience Framework' to 'People's Experience Framework' to align with work ongoing nationally with an official national launch anticipated in Spring 2025,
- The Framework will encompass a number of areas including Putting Things Right, Duty of Candour, collaborative partnerships with Llais – Independent Advocacy, Public Services Ombudsman for Wales, and support the Health and Care Quality Standards,
- The Framework will require experience measures to be built into contractual arrangements (commissioned services),
- Robust validation will be required to include five core questions in every survey,
- The Safe Care Partnership will support public co-design of services,
- The HOPE (Head of Patient Experience) Network is a peer network in place for support and shared learning,
- PTHB assets include a Bereavement Service, the CIVICA patient experience survey system (in place since December 2022), the DATIX system which records enquires and concerns and the Patient Experience Steering Group including participants from across the Health Board, Primary Care and Community Services colleagues,
- Other assets include the Dementia Leads Steering Group, a multi-stakeholder group with colleagues from Powys County Council and people living with dementia, the Engagement and Insight Group (which includes the Regional Partnership Board and Public Service Board), Mental Health Services stakeholder groups, Children's Services stakeholder groups and a Quality and Safety Patient Experiences group for Therapies and Health Sciences,
- There are a number of building blocks in place and these need to be developed and connected so the whole patient experience story is told,

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- It is intended to appoint a Patient Experience Co-ordinator reporting to the Head of Quality and Safety from within the Directorate to bring together all the work taking place across the organisation on patient experience,
- The Audacity App is available to help produce patient stories by colleagues across the various services but there is a current lack of capacity within the team to support this, and
- A draft Patient Experience Framework will be brought to the next meeting of the Committee.

Members made the following comments:
- *Can the Framework be explicit to outline how both themes are being picked up, and action is being taken by the organisation to address such themes?*
- *Whilst it is difficult to make a case for investment in the current financial situation it is incumbent on Board Members to champion the use of Patient Experience to improve safety and reduce harm in a very difficult environment.*
- *Can the Framework make explicit the links to other parts of the system such as Risk?*

CR suggested that the use of Patient Stories in other Committees could be considered, along with accessing patient stories collected by other organisations such as the Welsh Ambulance Services Trust which relate to patients in Powys.

Action: Director of Nursing, Quality, Women and Family Health (to bring the Draft People Experience Framework to the February 2025 meeting of the Committee).

7. CONSENT AGENDA

7.1 JOINT COMMISSIONING COMMITTEE QUALITY PATIENT SAFETY COMMITTEE SUMMARY REPORTS (PEQS/24/63)

The Committee **RECEIVED** the Joint Commissioning Committee Quality Patient Safety Committee Summary Reports of 16 July and 17 September 2024.

7.2 INTERNAL AUDIT REPORTS (PEQS/24/64)

The Committee **RECEIVED** the Internal Audit Report on End-of-Life Care Services which had been received by the Audit, Risk and Assurance Committee on 08 October 2024. Further Internal Audits would be received where relevant to the remit of the Committee.

7.3 WORK PROGRAMME (PEQS/24/65)

The Committee **RECEIVED** the Committee Work Programme as of November 2024.

8. OTHER MATTERS

8.1 ANY OTHER URGENT BUSINESS (PEQS/24/66)

There were no items of any other business.

8.2 ITEMS TO BE BROUGHT TO THE ATTENTION OF THE BOARD AND/OR OTHER COMMITTEES (PEQS/24/67)

It was noted that the Chair would reference that:

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- Mental Health Services had been removed from local escalation by the Executive Committee, but that a further update report would be brought to the next meeting of the Committee and this item would remain escalated to Board,
- Neurodiversity Services have been put into local escalation (a new escalation to Board),
- Patient Experience Framework – that work continued, and a draft Framework will be brought to Committee in February 2024, and
- The improvement plan for Infection, Prevention and Control is broadly complete and assurance will now be sought that the improvements are embedded.

8.2 COMMITTEE REFLECTION (PEQS/24/68)

The following summary of business and reflections were provided by members:

- A temporary member of the Committee took assurance that the organisation has an open and transparent approach that is not shy to put services into local escalation where appropriate
- A different temporary member of the Committee welcomed the easy to read, informative papers which picked out key issues. The open conduct at the meeting was welcomed and the lack of defensiveness noted
- An Executive Director noted real challenge from Independent Members with a good level of scrutiny and impactful questions
- The Director of Corporate Governance noted the important link between finance and quality and welcomed the discussion and Independent Member feedback on Patient Experience.

8.3 DATE OF NEXT MEETING (PEQS/24/69)

The date of the next meeting is scheduled on 11 February 2025 at 09:30 via Microsoft Teams.

Meeting closed at 13.08

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Liz Patterson

RAG Status:

RAG Status	Description
At risk	Red - action date passed or revised date needed
On track	Yellow - action on target to be completed by agreed/revised date
Completed	Green - action complete
No longer needed	Blue - action to be removed and/or replaced by new action
Transferred	Grey - Transferred to another group

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

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								
07-Nov-24	PEQS/24/52b	Executive Director of Nursing, Quality, Women and Family Health	Mental Health Services Update	An review of the Integrated Quality and Performance Framework be brought to a future meeting of PEQS	**Update 11.02.25**: The has been scheduled to be completed by 30 April 2025	Jul-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 **Update 11.02.25:** Item will be scheduled into the 2025/26 work programme	Feb-25	Timescales TBC within 2025/26	On track
14-Nov-24	PPPH/24/012	DoNQW&FH	Antibiotic Resistance	Antibiotic Resistance is of Public Health significance, clarity as what frequency would committee expect to see report updates would be confirmed in February 2025	**02.02.2025 update** - The Director of Nursing, Quality, Womens and Family Health confirmed that reporting would be placed at the PEQS Committee given its remit. **Update 11.02.25:** Item will be scheduled into the 2025/26 work programme	Feb-25		Transferred
OPEN ACTIONS - IN PROGRESS BUT NOT YET DUE								
05-Dec-24	D&P/24/086a	Executive Medical Director	In-reach Fragility	It was agreed that an update report regarding JAG accreditation would be considered to the Patient Experience, Quality and Safety Committee to reflect on quality elements to provide further assurance on what is being done to regain the accreditation.	**Transfered to PEQS Committee.** **11.02.25 update** - scheduled to July 2025 meeting. PPPH and D&P are considering a JAG accreditation update w/c 3 Feb 2025	Jul-25		On track
05-Dec-24	D&P/24/083c	Executive Director of Primary, Community Care and Mental Health.	Primary Care: GDS	It was agreed that a report would be considered at the Patient Experience, Quality and Safety Committee in the near future to fully understand how quality is measured from a general and community dental perspective.	**Transferred to PEQS Committee** **Update 11.02.25:** Item will be added to the 2025/26 work programme, date to be confirmed	Timescales TBC within 2025/26		Transferred
14-Jan-25	ARAC/24/075	Executive Director of Nursing, Quality, Women and Family Health	Items to be brought to the attention of other Committees	Deprivation of Liberty Safeguards to be transferred to PEQS for monitoring progress against recommendations	**Transferred to PEQS Committee** **Update 11.02.25:** Item added to work programme for 2025/26. The internal audit report has been shared for information within the agenda and papers for the 11.02.25 meeting	Timescales TBC within 2025/26		Transferred
ACTIONS RECOMMENDED FOR CLOSURE (MEETING 11 FEB 2025)								
07-Nov-24	PEQS/24/53	Executive Director of Nursing, Quality, Women and Family Health	Neurodiversity Services	Feedback from the Neurodiversity co-production groups be brought to February 2025 Committee	**Update 11.02.25**: A verbal update will be provided within the Chilsrens Neurodiversity agenda item	Feb-25		Completed
07-Nov-24	PEQS/24/52a	Executive Director of Nursing, Quality, Women and Family Health	Mental Health Services Update	An update on MH Services be provided to the February 2025 Committee	**Update 11.02.25:** This is an agenda item on the February 2025 meeting	Feb-25		Completed
07-Nov-24	PEQS/24/62	Executive Director of Nursing, Quality, Women and Family Health	Patient Experience Framework	Draft People Experience Framework to be brought to February Committee	**Update 11.02.25:** This is an agenda item on the February 2025 meeting	Feb-25		Completed

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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 **Update 11.02.25:** On agenda for 11.02.25	Oct-24	Feb-25	Completed
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 updat**e - 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 **11.02.25 update:** On agenda for 11.02.25	Oct-24	Feb-25	Completed
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	**Update 11.02.25:** On agenda for 11.02.25, previous 7 years data appended to show trends	Jul-25		Completed

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Agenda item: 4.1

PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE	**11 February 2025**
Subject:	Integrated Quality & Performance Framework – Children & Young People (CYP) Neurodevelopmental Services Escalation Oversight Group
Approved and presented by:	Nicola Johnson, Executive Director of Planning, Performance and Commissioning
Prepared by:	Executive Director for Nursing, Quality, Women and Family Health Assistant Director, Women and Children Assistant Director of Performance and Commissioning
Other Committees and meetings considered at:	Executive Committee 02 October 2024; 13 November 2024; 11 December 2024, 5 February 2025.

PURPOSE:

In October 2024 the Executive Committee agreed that Children and Young People's (CYP) Neurodevelopmental Services in Powys Teaching Health Board (PTHB) be placed into PTHB's internal 'escalated' status.

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

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

RECOMMENDATION(S):

The 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 Neurodevelopmental Services.
2. To **NOTE** and **DISCUSS** the contents of the report and including the action plan and progress report.

Approve/Take Assurance	Discuss	Note
Y	Y	Y

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

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EXECUTIVE SUMMARY

In October 2024, the Executive Committee agreed that, within the context of the Health Board IQPF, CYP Neurodevelopmental 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:

Domains	Escalation levels
Access and Activity Finance and Value Quality, Safety and Patient Experience Workforce and Culture	Level 1: Normal arrangements Level 2a: Failure to achieve/maintain delivery in more than 1 key deliverable/area of performance; Sustained deterioration on 1 or more deliverable/area of performance. Level 2b: Corporate Directorate or Clinical Service area level budget is overspending by more than £0.5m year to date or £1m forecast. Level 3: Serious concerns on quality and governance; Continued and consistent failure to meet agreed performance improvements and trajectories across a number of objectives.

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.

CYP Neurodevelopmental services have been placed in escalation level 3 of the IQPF escalation framework:

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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.

This paper provides an update on current progress and escalation status.

DETAILED BACKGROUND AND ASSESSMENT

Background

The PTHB CYP Neurodevelopmental 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 CYP with suspected Autistic Spectrum Disorder (ASD). The new Neurodevelopmental national pathway and its standards now offer CYP diagnostic assessment for both ASD and Attention Deficit Hyperactivity Disorder (ADHD).

Since its inception, the CYP Neurodevelopmental service has experienced increased and sustained demand with capacity constraints in the service adversely impacting on the ability to achieve the Welsh Government Referral to Treatment (RTT) targets of 80% of CYP waiting less than 26 weeks to start an ADHD or ASD neurodevelopment assessment. It has been identified that the service is not compliant with recommendations from:

- National Institute for Health and Care Excellence (NICE) guidelines.
- Welsh Government delivery of Neurodevelopmental service standards.
- Wales Code of Practice on the Delivery of Autism Servies (Sept 2021).

In line with the performance triggers for escalation within the IQPF, the CYP Neurodevelopmental service has been escalated to level 3, the reason for the escalation being:

- Continued and consistent failure to meet agreed performance improvements, including failure to deliver Ministerial Priority measure.

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- Performance for Neurodevelopmental 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 EOG for CYP Neurodevelopmental Services has been established with the first formal of the weekly meetings being held on 29 October 2024. The group is chaired by the Executive Director of Planning, Performance and Commissioning with membership drawn from Executive Directors, Women and Children's Services and Corporate Directorates.

The aim of the EOG is to:

- Provide assurance to the Health Board on the provision of safe and high quality care to the population we serve;
- Support an ethos of continuous quality improvement, listening, learning and acting, seeking continual improvement in communication and openness within and across Health Board to enable positive outcomes and shared learning;
- Provide support to the PTHB service placed in escalation and establish a robust monitoring process to gain assurance of improvements being realised and to establish where progress is not being made, ensuring remedial action and/or escalation to the Executive Team;
- Support and enable the service placed in escalation to make improvements and to provide assurance against the four domains of the IQPF.

In response to being placed in level 3, the Neurodevelopmental service has developed an Improvement Plan with actions identified to address the long term commitment in addressing performance requirements in:

- Address assessment backlogs prioritising longest waits initially; Meeting RTT waits and reduce breaches (Waiting list recovery project).
- Establishing a parents and carers group focussed on 0-5 and 5-11 year olds and address IG requirements to co-produce a padlet as a shared platform for centrally approved resources.
- Meet increased and sustained demand through a robust and sustainable workforce plan for PTHB and consider partnership roles with Powys County Council where appropriate.
- Provide a pre and post diagnostic service as set out in Welsh Government Standards and respective NICE guidance.

Current Progress
A copy of the Improvement Plan is included at Appendix One. This plan is underpinned by more granular plans for each workstream which can also be made available. This is accompanied by a summary progress report included at Appendix Two.

From these supporting documents the issues of note are:

- Appendix One: Improvement Plan
    - 43 actions
        - 15 completed.
        - 9 progress being made and on track and will be completed within timescale.
        - 18 progress being made, action likely to be achieve within timescale.
        - 1 is significantly behind schedule with no progress made / or progress made but timescale not achieved. This action is being addressed to support job planning with support of an Assistant Medical Director.
        - All 8 Welsh Government (WG) standards are met within current service delivery model.

- Appendix Two: Progress Report
    - Funding Submission
        - The WG has approved funding to support the improvement in waiting times for Children's Neurodevelopmental services, PTHB receiving a non-recurrent allocation of £265,018 with the expectation that this additional funding is utilised by March 2025 and will be issued on confirmation from PTHB of delivery, milestones, trajectories and actual expenditure on a monthly basis until March 2025.
        - Expected activity of additional 420 completed assessments, resulting in 300 children waiting > 1 year with 0 children waiting > 2 years.
        - Funding will not be withheld if delivery plan is not achieved, payment will be made for costs incurred.
        - Ministerial priorities for all waits > 2 years to be addressed where possible.
        - Current activity 04/11/24 – 26/01/25: 200 concluded pathways.
    - Waiting List
        - The current waiting list position is:

Date	Total	<1 year	1-2 years	2-3 years	> 3 years
6/1/25	1377	664	577	125	11
13/1/25	1376	660	582	125	9
20/1/25	1389	657	602	120	10
27/1/25	1382	653	601	121	7

        - Procured activity to commence February.

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- Performance
  - MDT week 20/01/25 – 57 quick closures (5 discharged, 52 feedback and close); 25 to return to MDT in 2 weeks. No harm identified for this patient cohort.
  - Number of pathways concluded in month increasing significantly month on month since June 2024.
  - Significant work undertaken to assure trajectories and understand the underlying demand/capacity gap.
  - Trajectory to deliver 0 patients waiting > 3 years: 61 assessments required per month to achieve trajectory. Predicted to achieve trajectory with 0 patients waiting > 3 years by 31st March 2025.
  - Trajectory to deliver 0 patients waiting > 2 years by end of March 2025: 126 assessments required per month to achieve trajectory. Inclusive of procured assessments 113 assessments/first appointments are planned each month, shortfall to required activity levels. This would result in 26 patients waiting > 2 years by 31st March 2025, with mitigating actions being sought. Activity will be planned and booked into April 2025 from the beginning of March.
  - Trajectory to reach 300 patients waiting >1 year; revised forecast shows will not be achieved by 31st March 2025 due to demand/capacity gap, likely to have 550-600 patients waiting over 52 weeks at end March.
  - Delivery against trajectory is being reported in line with WG requirements to the NHS Executive on a weekly basis and thereby to the Cabinet Secretary. Internal oversight is via the EOG and thereby monthly to the Executive Committee, as well as reporting via the IQPF.
  - Significant risk to further reduction in waiting times and maintenance of 104 weeks post 1st April 2025 without additional funding – choices to be included in discussion on the Integrated Plan.
  - Neurodivergence Improvement Programme (NDIP) funding via Regional Partnership Board currently £198,358 annually (£59,833 children, £138,525 adult). Potential for review of current allocation for 2025/26.

- Focused actions:
  - Completion of Job Planning for Consultant Paediatricians. Commenced with support of an AMD. To confirm progress and anticipated completion date.
  - Review service delivery and additional funding requirements to support activity. Demand and capacity modelling required to inform service specification for future sustainable service.
  - Commencement of additional procured activity in February.
  - Continued focused activity for MDT discussions to support conclusions and outcomes.

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- Progression of the co-production activity to support pathway development and transformation.
- Development of standardised documentation to support concise and timely reporting and conclusions.

NEXT STEPS:

The Committee is asked:

1. **TAKE ASSURANCE** that the implementation of the IQPF Escalation Oversight mechanism is providing robust oversight of the improvement work being undertaken within Neurodevelopmental Services.

2. To **NOTE** and **DISCUSS** the contents of the improvement plan and progress report including:
   - Of the 43 improvement plan actions, all except one are either completed or on course for completion, with mitigating action to address.
   - Positive impact of MDT week 20/01/2025. Number of pathways concluded in month increasing significantly month on month since June 2024.
   - The Health Board will exceed 300 patients waiting < 2 years by 31st March.
   - Current forecast of 26 patients that will wait > 2 years by 31st March 2025, with mitigating actions being sought. Activity will be planned and booked into April 2025 from the beginning of March.
   - Forecast to deliver 0 patients > 3 years by 31st March 2025.
   - Risk to future performance post 1st April 2025 without additional funding.
   - Opportunity to review NDIP regional funding.

IMPACT ASSESSMENT

Not required

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CYP Neurodevelopmental Escalation

Overview and Position 03/02/25

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Neurodevelopmental Services Improvement Plan Progress Update January 2025

Lead : Executive Director of Nursing, Quality, Women and Family Health
Assistant Director of Women and Children

THINGS YOU NEED TO KNOW

- One RED action which is being addressed to support job planning.
- All other actions are on track to address quality of the service within the transformation activity.
- New pathway aligns to all 8 standards.

RISKS

Risk/Issue	Description and mitigation	RAG
Inability to increase consultant activity to address longest waits	Job planning has commenced with the support of an AMD	Red
Inability to sustain improvements and realise change without continued funding	Review service delivery and additional funding requirements to support activity. Demand and capacity modelling required to inform service specification for the future sustainable service.	Red
		Amber

ESCALATIONS/ SUPPORT NEEDED

Support being provided by AMD

Workstream	Status/Progress Update	RAG
Safety: Leadership	1 Red, 6 Amber, 3 Green	Red
Timely: Culture and Leadership	4 Amber, 1 Green	Amber
Effective: Information	2 Amber, 4 Blue, 2 Green	Blue
Efficient: Learning Improvement and Research	3 Amber, 3 Blue, 4 Green	Blue
Equitable: Whole System Approach	2 Amber, 1 Blue, 2 Green	Amber
Patient Centred: Experience	1 Amber, 1 Blue, 3 Green	Amber
Standards	All 8 Standards are met within current service delivery Model	Green

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

Funding submission

- Funding submission, expected activity with additional funding **420** completed assessments.
- Resulting in **300** children waiting >1yr, Zero waits >2yrs
- Risk noted for those children that have an increased wait over the time of the accelerated activity.
- Current activity 04/11/24 to 26/01/25 **200** concluded pathways(data 30/01/25)

	Current position & shortfall			Additional Funding Impact			
Milestone	Total activity needed to reach milestone by end March 25 1 unit = 1 assessment	Total core activity available to end March 25 (no additional funding) 1 unit = 1 assessment	Capacity shortfall 1 unit = 1 assessment	Total number of additional assessments available with additional funding 1 unit = 1 assessment	Total activity (core & additional funding)		Projected number of patients waiting over milestone at year end
3 years	19		0			> 3years	0
2 years	141		0			> 2 years	0
1 year	560	220	500	200	420	> 1 year	300

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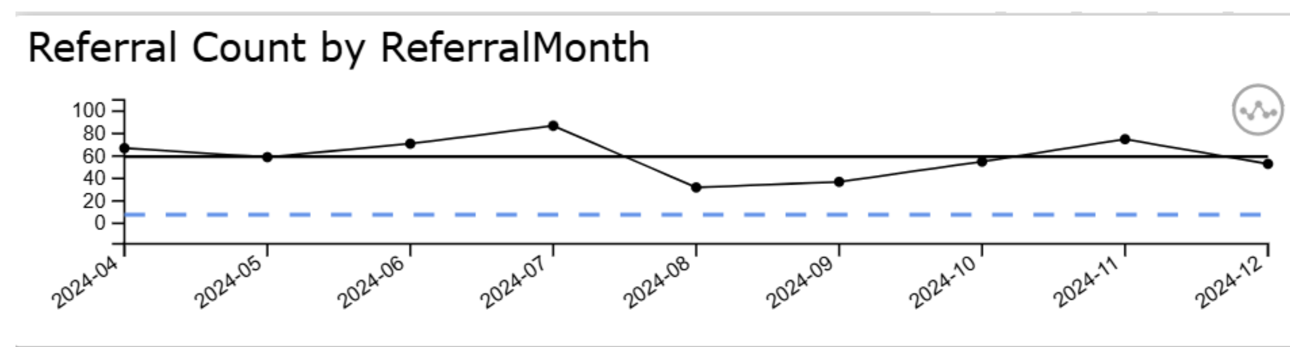
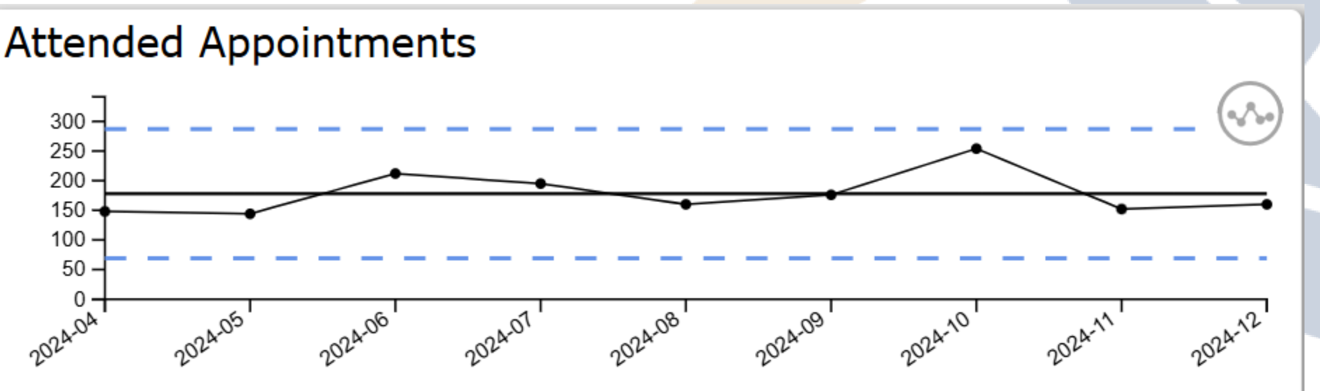
Pathway Management - Appointments

- 23/24 97% of all referrals accepted.
- 24/25 94% of all referrals accepted.
- New MDT triage process commenced 29/01/25.
- 230 children currently with an open pathway.
- Total DNA rate across all disciplines 2%.
- Activity 2weeks lag in completion to ensure time provided to write reports, feedback and conclude (+/- Additional MDT)





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MDT week overview 20/01/25

Learning Identified:

- No standardised way of using WCCIS to record activity.
- Would have been helpful if clinicians had included their assessment or impression at the end of their observation/documentation to inform decision making.
- No standard format for observations or reports.
- Many children <6yrs not been seen by a paediatrician despite being on the list for 3yrs.
- Missing documentation.
- The team were able to use reports from SLT(not a member of ND) and others to inform decision.
- Large proportion of cases could have been concluded many months previously.
- No Duty of Candour identified.

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<table>
<tr><th>Action needed</th><th colspan="2">Number of children</th></tr>
<tr><td>Discharge (all complete)</td><td>5</td><td rowspan="2">57 Quick closures – within 2 weeks</td></tr>
<tr><td>Feedback and close with simple combined reports</td><td>52</td></tr>
<tr><td>ADOS – MDT-Feedback</td><td>3</td><td rowspan="6">25 To return to MDT in 2 weeks</td></tr>
<tr><td>Connors – MDT-Feedback</td><td>6</td></tr>
<tr><td>Info clarity – MDT - feedback</td><td>4</td></tr>
<tr><td>Reports of assessments completed needed – may need to be reappointed</td><td>5</td></tr>
<tr><td>F2F Paeds appointment/LD appointment</td><td>3</td></tr>
<tr><td>Virtual Appoints (Parent Consultation)</td><td>4</td></tr>
<tr><td>Total</td><td colspan="2">82</td></tr>
</table>

Waiting list

- All waiting >3yrs will be concluded by 05/02/25.
- Clinic schedule in place until end of March.
- Procured activity to commence February with a plan to increase numbers within the financial envelope.

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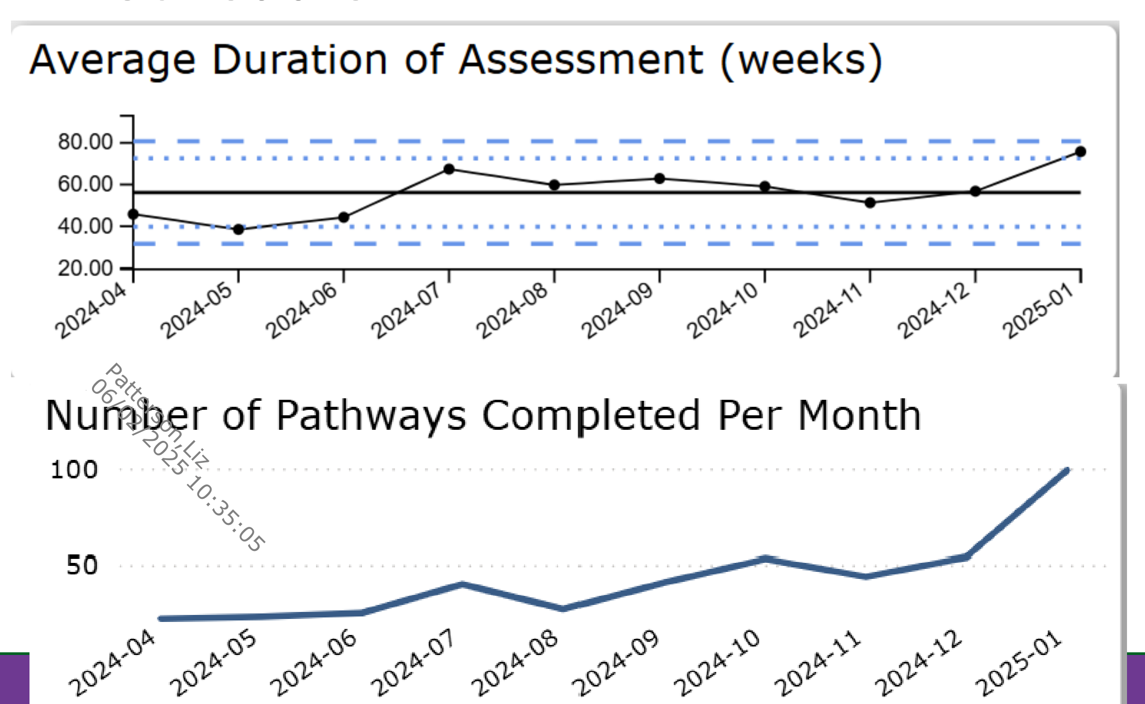
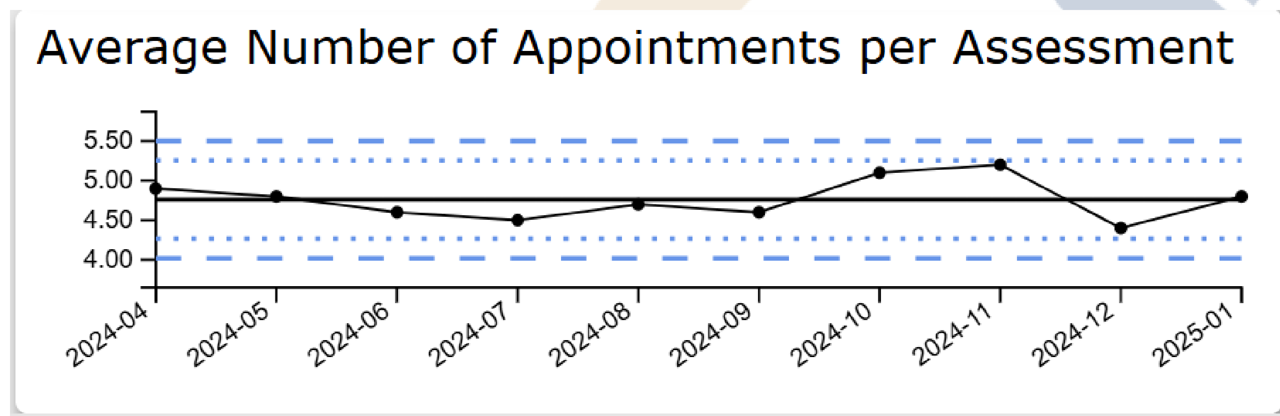
Actual Waits

Date	< 1 yr	1-2 yrs	2-3 yrs	> 3 yrs
2024-11-11	685	496	134	12
2024-11-18	686	503	133	12
2024-11-25	681	507	130	11
2024-12-02	699	520	129	11
2024-12-09	689	532	128	11
2024-12-16	675	547	126	11
2024-12-23	657	570	125	11
2024-12-30	663	570	125	11
2025-01-06	664	577	125	11
2025-01-13	660	582	125	9
2025-01-20	657	602	120	10
2025-01-27	653	601	121	7

Pathway management – Completed Assessments

- Average duration of completed assessments 80weeks – this has increased in year due to prioritisation of longer pathways.
- Number of pathways concluded in month increasing significantly month on Month since June 2024.
- Number of appointments required to conclude reducing in line with new schedule.





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Performance

- Funding conversation with NHS Executive 31/01/25, financial plan of spend required ASAP for payments to be made from WG.
- Funding will not be withheld if delivery plan is not achieved, payment will be made for costs incurred.
- Ministerial priorities in for all waits >2yrs to be addressed where possible.
- NDIP funding (RPB) discussed total funding allocation £198,358.00 annually, £59,833.00 for children's services and £138,525.00 for adult services (IAS), it is suggested that given the focus and escalation within children's services the funding allocation in PTHB is reviewed for 2025/26.
- Significant risk for ND performance post 1st April without additional funding in place to address waits.

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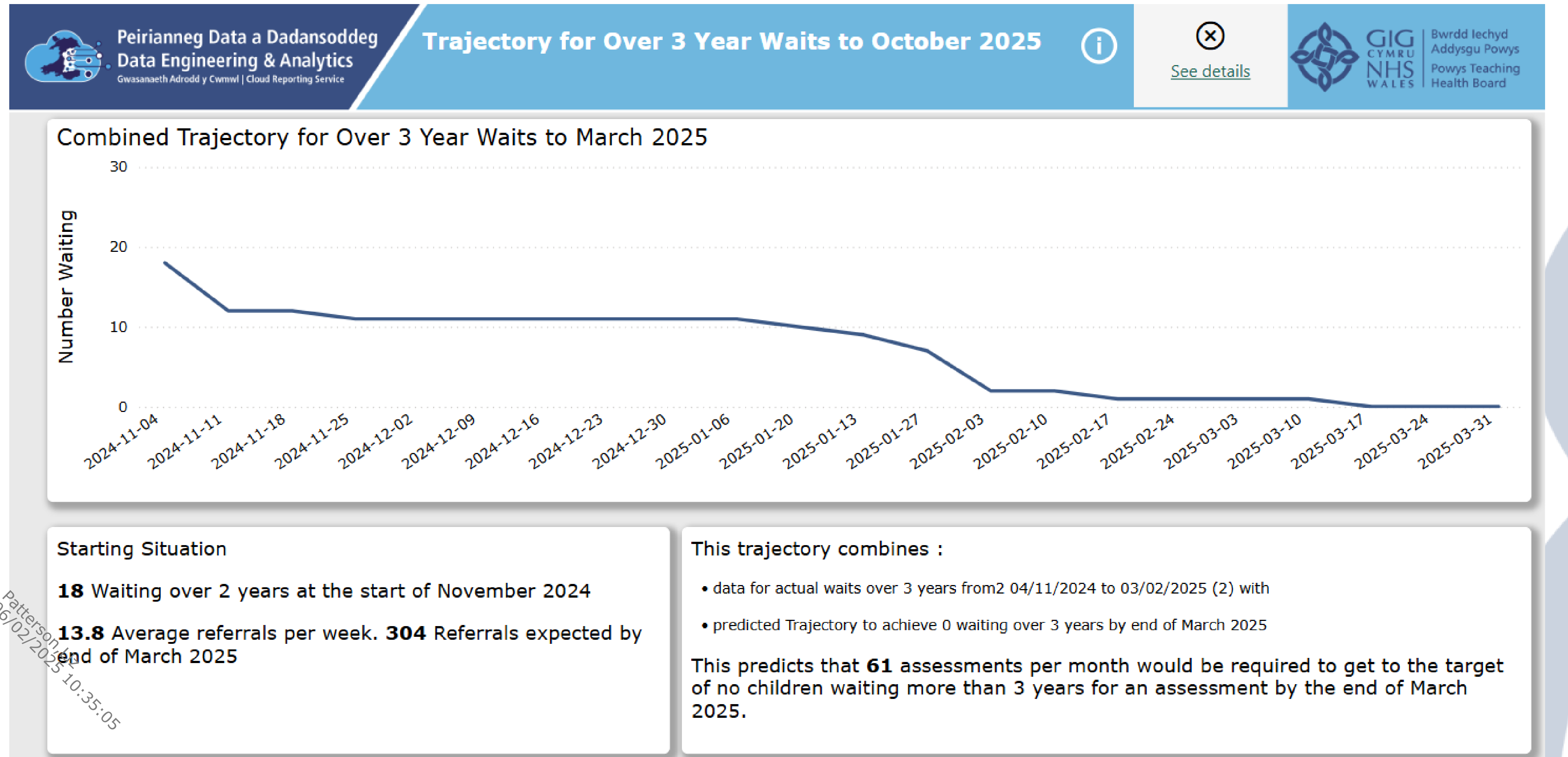
Trajectory to meet <3yr waits



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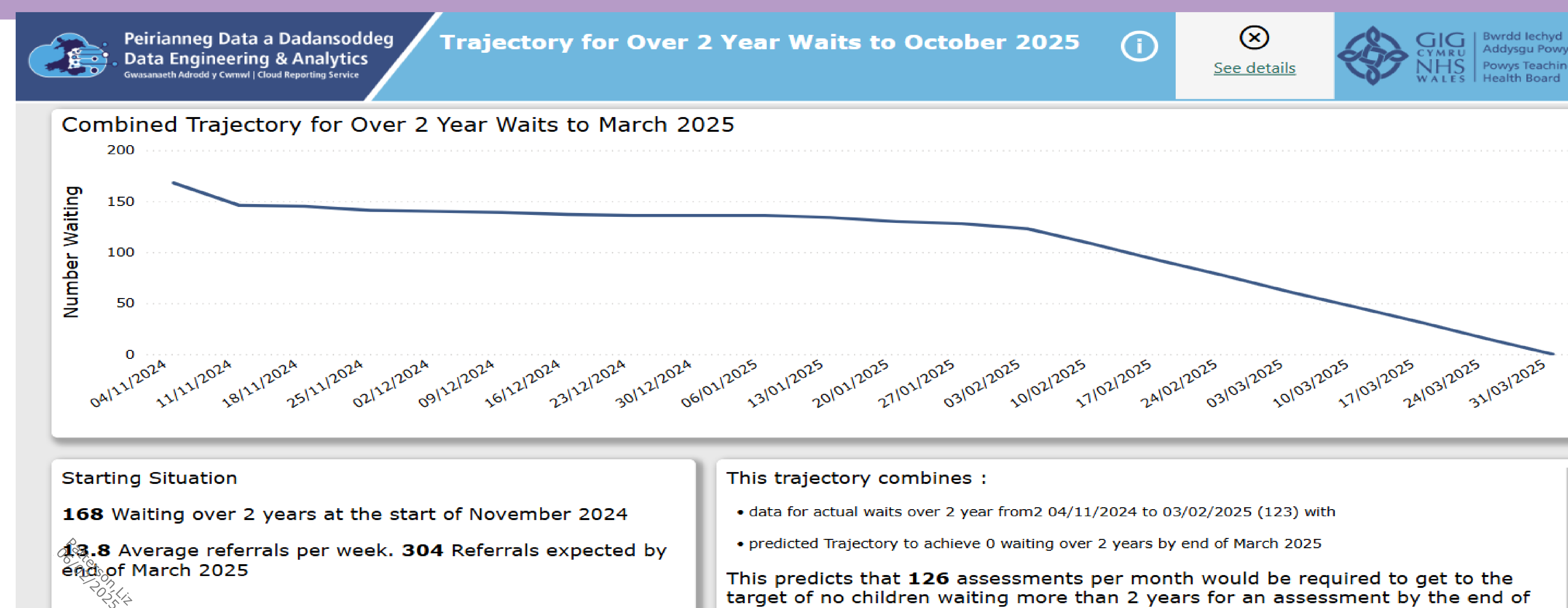
Trajectory to meet <2yr waits



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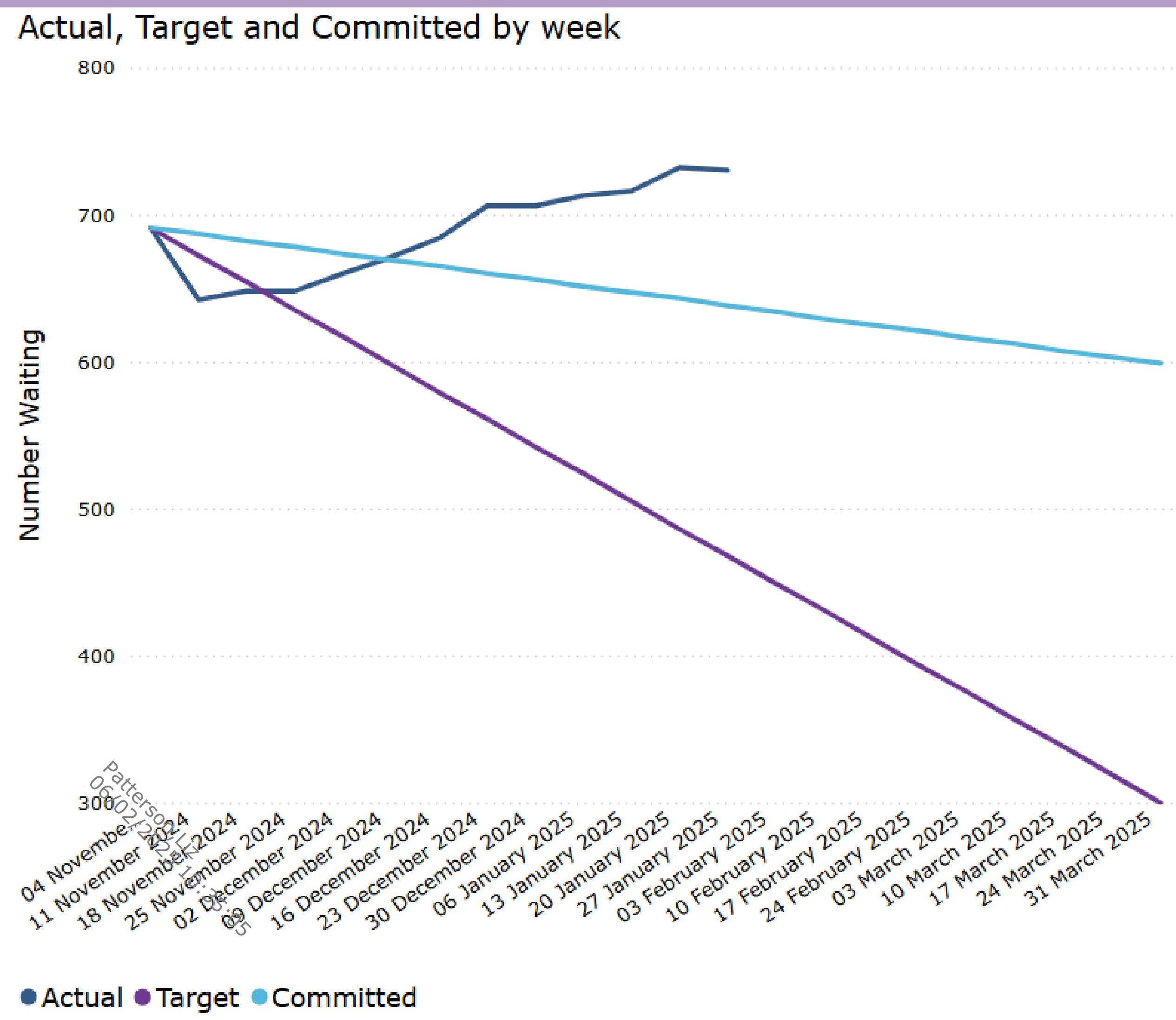
Inclusive of procured assessments 113 assessments/first appointments are planned each month

Current Performance – 52 weeks waits



- Additional team members did not commence in post until end of January / early February 2025.
- Documentation challenges impacted requirement for additional appointments.
- To meet the 300waiting >1yr target 140 first appointments are required each month previously suggested to be 82.3 which excluded the triangulation of time and movements along the pathway of those waiting.
- Actual – providing detail on all open pathways to ensure continued focus on conclusion of assessment.
- Target – for there to be 300 patients waiting > 1 year for first appointment.
- Committed – number waiting (559) based on average number of assessments per week (20) from commitment of 420 total assessments.

Co-Production Overview

- Logo agreement, awaiting Junior Startwell feedback too.
- Template letter for assessment conclusion.
- Production of literature for 0-5yrs and 5-11yrs.
- Plan to produce a digital story during Q4 – require support from comms.
- Feedback regarding communication plan.
- Production of experiential questionnaires to be utilised on CIVICA
- Uniform preferences, Hoody and polo tops.

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Staffing/process update

- Recruitment of additional team members 2.6WTE (HV, RN, OT) to support ND assessments, commence end January.
- Further agency support from SLT will not progress due to fragility of service.
- 1.6WTE substantive team absence.
- Administration review underway.
- Further enhancement to Dictate IT technology to support timely report writing being trialled.
- Where missing records have been identified appropriate action has been taken to support pathway to conclusion.

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PTHB INTEGRATED QUALITY AND PERFORMANCE FRAMEWORK
IMPROVEMENT /REMEDIAL ACTION PLAN
DATE: January 2025

Service area	Neurodevelopmental services	**Clinical Lead**	
Lead Exec	Claire Roche, Executive Director of Nursing, Quality, Women and Family Health	**Managerial Lead**	Zoe Ashman, Assistant Director of Women and Children

Summary of challenge
The Neurodevelopmental service has been placed in enhanced monitoring due to deriorating performance against the 26 week RTT target with actions identified to address the long term commitment in addressing performance requirements in:
- Address assessment backlogs prioritising longest waits initially; Meeting RTT waits and reduce breaches (Waiting list recovery project)
- Establishing a parents and carers group focussed on 0-5 and 5-11 year olds and address IG requirements to coproduce a padlet as a shared platform for centrally approved resources
- Meet increased and sustained demand through a robust and sustainable workforce plan for PTHB and consider partnership roles with PCC where appropriate
- Provide a pre and post diagnostic service as set out in Welsh Government Standards and respective National Institute for Health and Care Excellence (NICE).

No	Workstream	Target Completion Date	RAG (against target completion date)
1	Safety: Leadership	01/06/2025	
2	Timely: Culture & Workforce	01/06/2025	
3	Effective: Information	01/06/2025	
4	Efficient: Learning Improvement and Research	01/06/2025	
5	Equitable: Whole System approach	01/06/2025	
6	Patient Centred: Experience	01/06/2025	
7	Standards	01/04/2025	

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

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PTHB INTEGRATED QUALITY AND PERFORMANCE FRAMEWORK
IMPROVEMENT /REMEDIAL ACTION PLAN
DATE: JANUARY 2025

Service area	Neurodevelopmental Ser **Safety: Leadership**	Clinical Lead	Susan Dinsdale & Rachel Lindoewood
Lead Exec	Claire Roche, Executive Director of Nursing, Quality, Women and Family Health	Managerial Lead	Zoe Ashman, Assistant Director of Women and Children

Summary of challenge:
-

Criteria for de-escalation;
-

Ref	Improvement needed / actions required	Is this on risk register (Y/N)	Risk register identifier	Risk score	Responsible Lead	Start Date	Completion date	Completed? (Y/N)	RABG	Expected outcomes/ Benefits	KPI/ Measure	Evidence/ Output	Evidence Received	Comment/Changes in month
1.1	Completion of Job planning for Consultant Paediatricians	N	N/A	N/A	Zoe Ashman Asst Director W&C	01/08/2024	01/11/2024	N		Improved processes and efficiencies. Clear activity and availability to inform clinic scheduling. Robust governance of activity and reporting of performance against RTT & RTA	Clinic Scheduling. Increased activity and improvement of RTT and RTA aligned to performance.	Quality & Performance data		
1.2	Completion of Job planning and scheduling of wider ND clinical team	N	N/A	N/A	Catrin Davies Interim Asst Head Children's Nursing	01/11/2024	01/12/2024	N		Improved processes and efficiencies. Clear activity and availability to inform clinic scheduling. Robust governance of activity and reporting of performance against RTA	Clinic Scheduling. Increased activity and improvement of RTT and RTA aligned to performance.	Quality & Performance data		
1.3	Substantive recruitment of third Paediatric consultant	Y		4x4=16	Zoe Ashman Asst Director W&C	01/07/2024	01/08/2025	N		Robust substantive structure to support continuity of care for children and families.	Recruitment	Advert not successful during August 2024, time to be given to review structures and obtain stability of a locum with the support of an NHS locum contract.	Y	Current locum accepted NHS locum contract to remain employed for a further 6months (July 2024)
1.4	Review interim structures within Childrens services to secure substantive roles to support long term structure.	Y		4x4=16	Susan Dinsdale Head of Childrens Public Health Nursing & Paediatric Services	01/07/2024	01/03/2025	N		Robust substantive structure to support clear leadership and management requirements.	Recruitment			
1.5	Ensure clinical supervision is in place for all clinicians within ND servic	N	N/A	N/A	Catrin Davies Interim Asst Head Children's Nursing	01/11/2024	01/12/2024	Y		Appropriate support for the wider ND team	Attendance.	First date for group supervision for the ND team with Rhys Brown In W&D. This is due to commence January 25	Y	R&D support and structure plan in place
1.6	Wider W&C workforce capacity to support whole system ND service	N	N/A	N/A	Zoe Ashman Asst Director W&C	01/08/2024	06/01/2025	N		Wider children's service virtual capacity to ND service delivery to offer a MDT approach, upskill workforce in respect of ND and improve experience for CYPF.	Agreed commitment from CAMHS and paediatric therapies to participate and inform the ND diagnostic assessment service operationally.	Confirmation of CAMHS and paediatric therapies offer to ND service.		Initial meetings with CAMHS and therapies held to understand current commitment to ND. Discussions in progress to negotiate and agree future opertational ask. Demand and capacity work will inform the project as to future capacity required to meet referral demand.
1.7	Implement single pan Powys MDT panel for ND service	N	N/A	N/A	Catrin Davies Interim Asst Head Children's Nursing	07/07/2024	23/08/2024	Y		To enable professional collaboration and shared identity, and lead to better communication and trust between members offering a most hoslitic person centred approach.	Triage and outcome of children within the service - Improved performance. Auditable outcomes.	Agenda/Calendar		
1.8	Consider the potential for a clinical director within the service	N	N/A	N/A	Zoe Ashman Asst Director W&C	01/01/2025	31/03/2025	N		Medical leadership and oversight		Workforce Plan	N	
1.9	Ongoing audit and workforce support to improve the robustness of evidence based decision making in a psychologically safe environment	N	N/A	N/A	Susan Dinsdale Head of Childrens Public Health Nursing & Paediatric Services	12/01/2024	31/3/25	N		Understanding varience and reducing any unintentional bias from the pathway. Robust evidence based triage; Safe and effective diagnostic pathway, optimum team/wider team functioning		Audit, new pathway development for triage, new educational framework		
1.10	Develop Medications management framework, with resource	N	N/A	N/A	Susan Dinsdale Head of Childrens Public Health Nursing & Paediatric Services	12/01/2024	31/3/25	N		Safe initial prescribing of medication; safe onward management of follow up/dose (both effectiveness and titration); safe management of shared care arrangements		Demand and capacity assessment, educational framework, enhanced resource in this space		

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PTHB INTEGRATED QUALITY AND PERFORMANCE FRAMEWORK
IMPROVEMENT /REMEDIAL ACTION PLAN
DATE: JANUARY 2025

Service area	Neurodevelopmental Services Timely: Culture & Workforce	**Clinical/Operational Lead**	Catrin Davies/Rebecca James
Lead Exec	Claire Roche, Executive Director of Nursing, Quality, Women and Family Health	**Managerial Lead**	Zoe Ashman, Assistant Director of Women and Children

Summary of challenge:
-

Criteria for de-escalation
-

Ref	Improvement needed / actions required	Is this on risk register (Y/N)	Risk register identifier	Risk score	Responsible Lead	Start Date	Completion date	Completed? (Y/N)	RABG	Expected outcomes/ Benefits	KPI/ Measure	Evidence/ Output	Evidence Received	Comment/Changes in month
2.1	Completion of a training needs analysis for the ND workforce and wider childrens services teams.	N	N/A	N/A	Catrin Davies, Assistant Head of Nursing/Rebecca James, W&C Partnership & Project Manager	01/10/2024	06/03/2025	N		Tiered approach to multi agency, multi disciplinary ND training to ensure employees receive appropriate skills to their role to be able to support ND CYP.	Training compliance along with delivery	Training needs analysis Training and development plan	N	
2.2	Workforce plan is required utilising examples of good practice, with consideration of current skills matrix and identify key gaps.	N	N/A	N/A	Zoe Ashman, Assistant Director Women & Children	01/01/2025	31/03/2025	N		Robust workforce plan to meet the needs of the population demand	Recruitment and retention	Successful business case and recruitment	N	
2.3	Further align ALN activity to ND service/team to ensure alignment of Powys CC education and social care colleagues	N	N/A	N/A	Zoe Ashman, Assistant Director Women & Children	01/08/2024	06/01/2025	N		Alignment of ALN strategy across PCC and PTHB	Ensure seamless support and approach for children within education	ALN action plan	N	
2.4	Implement pan Powys MDT panel for ND service	N	N/A	N/A	Catrin Davies Interim Asst Head Children's Nursing	07/07/2024	23/8/24	Y		To enable professional collaboration and shared identity, and lead to better communictation and trust between members offering a holistic person centred approach.	Review and revision to a single pan Powys ND MDT panel model	Terms of Reference	Y	ND triage and a single point of access for all triage referrals to prevent duplication and ensure they are processed in a timely manner and any necessary screeners forwarded to the family to prevent delay
2.5	Ensure a robust plan is in place to achieve ministerial target of RTT <26weeks	Y		16	Zoe Ashman, Assistant Director Women & Children	01/07/2024	31/03/2024	N		Improved experience for children along with their parents/carers	RTT	RTT along with patient experience feedback	N	

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PTHB INTEGRATED QUALITY AND PERFORMANCE FRAMEWORK
IMPROVEMENT /REMEDIAL ACTION PLAN
DATE: JANUARY 2025

Service area	Neurodevelopmental Services Effective: Information	**Clinical/operational Lead**	Catrin Davies/Rebecca James
Lead Exec	Claire Roche, Executive Director of Nursing, Quality, Women and Family Health	**Managerial Lead**	Zoe Ashman, Assistant Director of Women and Children

Summary of challenge:
-

Criteria for de-escalation
-

Ref	Improvement needed / actions required	Is this on risk register (Y/N)	Risk register identifier	Risk score	Responsible Lead	Start Date	Completion date	Completed? (Y/N)	RABG	Expected outcomes/ Benefits	KPI/ Measure	Evidence/ Output	Evidence Received	Comment/Changes in month
3.1	Map service provision against all 8 ND standards.	N	N/A	N/A	Rebecca James W&C Partnership & Project Manager/Catrin Davies, Assistant Head of Nursing	15/07/2024	02/09/2024	Y		Support prioritisation and ongoing action planning.	Actions aligned to the 8 standards	Improvement plan	Y	
3.2	Develop, implement and monitor new MDT clinic plan	N	N/A	N/A	Zoe Ashman AD W&C	01/11/2024	30/12/24	N		Joint appointment schedule offering MDT approach and conclusion of diagnostic assessment in a single appointment.	Approved 5 week clinic schedule in operation	5 week joint appointment clinic scheule	Y	Draft clinic schedule developed and approved by steering group. Appointnments booked 6 week sin advance. Pilot period to commence 01 11 24 and subject to review.
3.3	Demand and capacity mapping when demand is fully realised (including population health information)	N	N/A	N/A	Zoe Ashman AD W&C	01/08/2024	02/02/2025	N		Ability to plan service delivery to inform strutures required to meet demand.	Performance indicators aligned to clinic attendance, discharge, support and ongoing care as required	Business case to support service provision for the future model of care	N	
3.4	Requirement to engage multi agancy partners in the design and delivery of ND provision	N	N/A	N/A	Zoe Ashman Asst Director W&C	10/01/2024	31/10/24	23/10/2024		Engagement workshop with partners to initate relations to support collaborative design and delivery of ND services.	Workshop held and partenrs attendance	Action log	Y	Effective workshop held with multi agency attendance. Whole system approach agreed under the Start Well agenda.
3.5	Review and development of PTHB and PCC ND webpages *(to be informed long terms by coproduction forums)*	N	N/A	N/A	Rebecca James W&C Partnership & Project Manager	25/10/24	06/01/2025	N		Use of webpage and social media to share staff and patient stories, promote latwest news and events as well as enage with the ND community of POwys.	1. Close current Facebook page (as not monitored and maintained) 2. Draft, approve and post new interim ND service information to PTHB. 3. Create link from PCC ND webpage to ensure consistent info shared	New ND Service section on the PTHB Learning Disability and Neurodiversity webpage	Y	Initial draft information produced. Subject to comment and approval. ANticipate on PTHB internet page w/c 4/11/24.
3.6	Improve effectiveness of report writing without impacting quality	N	N/A	N/A	Susan Dinsdale Head of Childrens Public Health Nursing & Paediatric Services	12/01/2024	02/01/2025	N		Develop report template, fit for purpose with clinicans and service user group	Improvement to flow with improved report template	Audit and feedback from professionals and service users		
3.7	Develop effective team to support sustainability	N	N/A	N/A	Susan Dinsdale Head of Childrens Public Health Nursing & Paediatric Services	12/01/2024	02/01/2025	N		Team acknowledgement/awareness of the possibility of unintentional bias within the diagnostic system - ensuring process is evidence based	Improvement to flow due to reduced assessment requirements	Education framework for specialist team roles		
3.8	Consider sustainability of improvements supported and measured through team accreditation framework	N	N/A	N/A	Susan Dinsdale Head of Childrens Public Health Nursing & Paediatric Services	04/01/2025	30/6/25	N		Regular measures identified and collected/celebrated locally as being the outcome of improvement work	to be determined	Ongoing assurance of improvement		

PTHB INTEGRATED QUALITY AND PERFORMANCE FRAMEWORK
IMPROVEMENT /REMEDIAL ACTION PLAN
DATE: JANUARY 2025

Service area	Neurodevelopmental Services Efficient: Learning Improvement and Research	**Clinical Lead**	Rachel Lindoewood/Susan Dinsdale
Lead Exec	Claire Roche, Executive Director of Nursing, Quality, Women and Family Health	**Managerial Lead**	Zoe Ashman, Assistant Director of Women and Children

Summary of challenge:
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Criteria for de-escalation
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Ref	Improvement needed / actions required	Is this on risk register (Y/N)	Risk register identifier	Risk score	Responsible Lead	Start Date	Completion date	Completed? (Y/N)	RABG	Expected outcomes/ Benefits	KPI/ Measure	Evidence/ Output	Evidence Received	Comment/Changes in month
4.1	Identification of good practice for each of the ND standards	N	N/A	N/A	Rebecca James W&C Partnership & Project Manager/ Catrin Davies, Assistant Head of childrens services	01/10/2022	02/02/2025	N		Robust pathway that meets the standards	Mapping the pathway against the 8 standards	Qualitative and Quantitative measures	N	
4.2	Identification of good practice for the wider system (aligned to NYTH / NEST)	N	N/A	N/A	Rebecca James W&C Partnership & Project Manager	01/10/2024	30/9/25	N		To ensure a whole system approach for developing mental health, wellbeing and support services for CYP ND Powys population and their families.		NYTH Self ND service self assessment pro forma	Yes	NYTH NEST self assessment for ND service completed with team and wider W&C professionals Oct 2024. Position to be reviewed mid year during implementation and follow up self assessment at Sept 2025.
4.3	Option appraisal of new model (s) - Rapid Redesign Programme - pilot from Jan 2025	N	N/A	N/A	Zoe Ashman, AD W&C	1/11/2024	06/01/2025	N		Enable innovative whole system transformation of ND services for CYPF of Powys based on a needs led model in partnerhsip with health, eductaion, social care and citizens.	Revise/develop a business including options appraisal.	Business case; Options Appraisal. Service delivery model updated to commence 20/01/25	N	Rapid design event 27th and 28th November 2024.
4.4	ND service compliance against national ND pathway and 8 standards	N	N/A	N/A	Zoe Ashman Asst Director W&C	01/08/2024	20/08/2024	N		Mapping against national pathway and respective standards to establish a clear baseline	Completed assessment of ND service conformity with 8 ND standards for Wales.	Tabled evidence of ND service compliance position against national standards.	Yes	Initial mapping complete as part of original ND Remodel business case. However, this is subject to review to reflect the current position.
4.5	NICE and WG Standards compliant ND service pathway	N	N/A	N/A	Rebecca James W&C Partnership & Project Manager	11/01/2024	01/12/2024	N		Pathway and processes for the Powys ND service that align to the national standards and clinical guidelines to ensure a STEEP approach to provision.	Approved new version ND pathway. Approved new version SOPs - clincial and administrative.	Review and update ND operational and administrative Standard Operating Procedures (SOP)s. NICE baseline audit assessment for ASD and ADHD guidlines	Yes	SOP reviews in progress.
4.6	Identify solution and procurement of digital dictation system for Community Paediatrics and ND services	N	N/A	N/A	Rebecca James W&C Partnership & Project Manager	07/01/2024	31/11/24	N		A dictation system to support an efficient process for service clinic letters and reporting.	Procurement complete, training delivered, implementation and review of Dictate IT system.	Training user manual, evaluation report	Yes	Approval from finance and digital services given to procure Dictate IT. System procurement complete. Initial training delivered 22/10/24 and 29/10/24. Dictate IT operational in Comm Paeds and ND services thereafter. Under review.
4.7	Establishment of a ND Remodel steering group	N	N/A	N/A	Zoe Ashman	06/01/2024	30/6/24	Y		Steering group to provide oversight to the remodel implementation.	Group established and regular meeting scheduled.	Terms of Reference	yes	W&C group established and meetings scheduled for 2024/25.
4.8	Introduction of high quality and timely clinical correspondence - System letter automation	N	N/A	N/A	Rebecca James W&C Partnership & Project Manager	07/01/2024	30/10/24	Y		Patient benefits - faster, consistent and accurate patient letters to support optimum care for the CYPF. *PTHB benefits* - better corrrespondence tracking, increase in productivity, efficiency in process, electronic process reduces labour cost, decrease in ERs / formal concerns and better information security.	WPAS software development to enable automatic generated correspondence.	System generate acknoweldgement, acceptance and appointment letters.	Yes	Letter wording drafted and approved for ND service. Software development complete by Digital services. ND service letter automation operational.
4.9	Welsh Government RTA waiting list initiative Nov24-March25	N	N/A	N/A	Zoe Ashman Asst Director W&C	05/11/2024	31/03/2025	N		Immediate focus on reducing ND service waiting times (WG additional non recurrent funding)	Recruitment of additional workforce. Number of completed diagnostic assessments from 993 (Sept24) to ??	RTT waiting list position - *Source IFOR*	Y	Awaiting WG annoucement of funding to enable recruitment of additional workforce. Joint clinic schedule developed to support this initiative and scoping of temporary staff complete for the period Nov24-Mar25.
4.1	Ensure standardised templates are in place for use to record attendance at clinic and final outcome	N	N/A	N/A	Susan Dinsdale, Head of Nursing	06/01/2025	27/01/2025	N		Standardised reporting and process		Audit compliance. Standardisation of process		

PTHB INTEGRATED QUALITY AND PERFORMANCE FRAMEWORK
IMPROVEMENT /REMEDIAL ACTION PLAN
DATE: JANUARY 2025

Service area	Neurodevelopmental Services Equitable: Whole System approach	**Clinical Lead**	Rachel Lindoewood/Susan Dinsdale
Lead Exec	Claire Roche, Executive Director of Nursing, Quality, Women and Family Health	**Managerial Lead**	Zoe Ashman, Assistant Director of Women and Children

Summary of challenge:
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Criteria for de-escalation
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Ref	Improvement needed / actions required	Is this on risk register (Y/N)	Risk register identifier	Risk score	Responsible Lead	Start Date	Completion date	Completed? (Y/N)	RABG	Expected outcomes/ Benefits	KPI/ Measure	Evidence/ Output	Evidence Received	Comment/Changes in month
5.1	Scope for prevelance mapping and projections for Neurodiversity in Powys	No	N/A	N/A	Dr Ellie Messham Public Health Medicine Consultant	09/01/2024	21/01/2025	N		The data collected will be utilitised to support a review of current service provision, identifying unmet and met needs. The information gained will contribute to an evidence informed approach to aid developing future models of care.	Measures identified in exercise Scope - see Comments for detail.	A written report of the findings inclusive of tables and graphs to illsutrate information collected.	No	Dr Ellie Messham, Public Health Medicine Consultant, conducting scoping exercise on behalf of ND service. Work commenced Sept 24, report awaited.
5.2	Map provision available to support both pre and post diagnostic activity from PTHB, PCC and third sector.	No	N/A	N/A	Rebecca James W&C Partnership & Project Manager	01/09/2024	01/11/2024	Y		Further understanding of support available	Complaince with standard 1 and Stand 8 within the ND standards	Completed template of provision to inform service provision	Y	Directory of multi agency pre and post diagnostic support produced. Subject to review by wider partners under Start Well. Digital partnership solution to be agreed to promote ND related reoureces and support.
5.3	Ensure Pathways of care for 0-5, 5-11 and 11-18yrs are defined and clear	No	N/A	N/A	Susan Dinsdale Head of Children's Public Health Nursing and Paediatric Services	01/10/2024	01/03/2025	N		Improved timeliness of management of children along with clarity of pathways and approach	Children seen in order of need and priority. Level of risk clearly defined and informing service provision.	Performance and informatics data aligned to the management of RTA	No	
5.4	Mapping of tranistion between childrens and adults services	No	N/A	N/A	Samantha Shore Head of Young People's MH and Early Intervention Services/ Susan Dinsdale HoN	01/10/2024	01/12/2024	N		Seamless and well supported process for children to transition to adult services and provision.	Data aligned to transition. Review of caseloads to ensure compliance with transition framework	Data aligned to transition framework	No	
5.5	Map and secure appropriate clinic space for ND diagnostic assessments to meet ongoing referral demand	No	N/A	N/A	Zoe Ashman Asst Director W&C	01/09/2024	01/12/2024	N		CYP appropriate protected clinic space identified for ND pan Powys to meet demand.	Adequate clinic space across Powys to undertake joint ND service diganostic assessments.	Room bookings secured on online system for 24/25 and 25/26.	Y	BCC and YYP space secured - long term room bookings required. Waterloo Rd clinic space now exclusively for W&C services only inc ND. *Need to secure long term of use of Park St Clinic current CAMHS and SLT rooms for 2025.*
5.6														

PTHB INTEGRATED QUALITY AND PERFORMANCE FRAMEWORK
IMPROVEMENT /REMEDIAL ACTION PLAN
DATE: JANUARY 2025

Service area	Neurodevelopmental Services Patient Centred: Experience	**Clinical Lead**	Catrin Davies/Rebecca James
Lead Exec	Claire Roche, Executive Director of Nursing, Quality, Women and Family Health	**Managerial Lead**	Zoe Ashman, Assistant Director of Women and Children

Summary of challenge:
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Criteria for de-escalation
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Ref	Improvement needed / actions required	Is this on risk register (Y/N)	Risk register identifier	Risk score	Responsible Lead	Start Date	Completion date	Completed? (Y/N)	RABG	Expected outcomes/ Benefits	KPI/ Measure	Evidence/ Output	Evidence Received	Comment/Changes in month
7.1	Implementation of a co-production framework to inform service provision for the future model *NB Ref Standard 8 all Wales ND Pathway*	N	N/A	N/A	Rebecca James	01/08/2024	01/09/2024	Y		Service design and implementation in line with feedback from Co-production	0-5 and 5-11 years forums established and meetings scheduled for 12 months	Specification, Commissioning, Priorities identified, implemtnation, review	Y	Specification developed and agreed. Parents Voice In Wales commmissioned (inc learning from ABUHB). Families for two age groups have been identified. PTHB professionals copro membership identified. Initial meeting scheduled for Nov24.
7.2	Implementation of a patient experience framework aligned to ND pathway	N	N/A	N/A	Susan Dinsdale Head of Children's Public Health Nursing and Paediatric Services	01/11/2024	31/03/2024	N		Service design and implementation in line with feedback from Co-production	Feedback	Use of feedback mechanisms to inform service delivery	N	
7.3	Introduce nationally endorsed coproduced ND facts sheet	N	N/A	N/A	Rebecca James W&C Partnership & Project Manager	22/07/2024	13/9/24	Y		Consistent, evidenced based and coproduced national suite of resources for CYPF in Powys.	Powys suite of fact sheets in operational use by ND service	Powys fact sheets x 9	Y	Facts sheets revised to reflect Pows including, *Communication, Emotions and Behaviour, Everyday Living, Friendships, Getting Organised, Learning to learn, Managing change, Nutrition and Sleep*
7.4	Review of Concerns - Early Resolution and Formal to improve experience for CYPF	N	N/A	N/A	Catrin Davies Interim Asst Head Children's Nursing	01/08/2024	30/09/2024	Y		Improved experience and feedback	Number of Early Resolutions Number of Formal Concerns Review including responses Identify proactive ND offer to reduce complaints including MDT and cross service offer	Reduction in Concerns received.	Y	Continuous process to review and understand experience to ensure responsiveness of service.
7.5	Improved communication with families as a non emergency service given telephone line issues and untimely response by ND service	N	N/A	N/A	Zoe Ashman Asst Director W&C	08/08/2024	19/08/2024	Y		To provide an alternative, timely and consistent response to ND telephone queries.	1. Closure of ND service telephone line. 2. Review of ND email account. 3. Training for administrative staff and asst practitioners. 4. Data cleanse of Inbox to respond to all existing queries.	Procedures for email account management inc stock responses. Adherence to 5 day response time.	Y	Telephone line no longer in operation. Brecon main reception, Concerns dept and other key colleagues informed of change. PTHB and PCC Comms Teams advised accordingly and tel no removed from websites. New email approach being piloted. Initial review identified issues to be addressed re timely response. New measures and rota in place. Position to be further monitored. All message responded to as at 31/10/24.

	Quantitative	Qualitative	Quantative	Qualitative	Lead
Standard 1 - There is a single point of access for diagnostic assesment of all ND disorders	Do you have a single point of acess (SPOA) for the receipt of referrals?	How has the SPOA process been experienced by the referer?	Direct, self and PIP		Katie Higgins
	What number/ % of people were referred directly to the ND team? By GP/school/parent/other source		IFOR, WCCIS		Rebecca James

	Quantitative	Qualitative	Quantative	Qualitative	Lead
Standard 2 - The decision as to whether to accept a referral or not is made on the quality of information provided. Where there is adequate Information to supportconcern, access should not be subject to permitted referrers, the use of screening questionnaires or other specifications	Number/% of referrals accepted and rejected	How has the referral process been experienced by the referrer (e.g. where referrals not accepted)?	IFOR - Query acceptance rate		Rebecca James
	Number/% of referrals not accepted and reasons/time delay on rejected referrals being resent	How has the referral process been experienced by the child and/or family?	Query quality of information		Rebecca James

	Quantitative	Qualitative	Quantative	Qualitative	Lead
Standard 3: When referrals are not expected, the referrer is provided with rationale along with advice to improve referral. Standard 4: Assessment are planned in a child centred way	Waiting times for assessment being collected by Welsh Government (standard RTT times - from GP referral to when? How to capture non GP referrals?)	Parent (and child) experience of assessment	IFOR, not U 5's (WPAS)		Rebecca James
	Evidence of multidisciplinary child centered assessment (how assessed?)	Feedback using CIVICA	WPAS - query quality information and 2nd opinion. Name clinicans and map		Catrin Davies
	Evidence of assessment of co-exisiting physical health conditions and mental health problems as appropriate	Feedback using CIVICA	In place but not robust		Catrin Davies

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	Quantitative	Qualitative	Quantative	Qualitative	Lead

Standard 5 - Timely MDT discussion for those involved with assesment, a profile of child's strngths and difficulties and agreement on future (local determination of process)	Of assessments undertaken number/% of completed reports timescale?	Staff experience of assessment and multidisciplinary discussion inclusing timelines	WPAS - Discharge.		Rebecca James
	Number/% of reports which details evidence for the outcome of assessment	Family experience of process			
	Evidence of multidisciplinary involvement				Catrin Davies

	Quantitative	Qualitative	Quantative	Qualitative	Lead
Standard 6 - Feedback of Assesment, followed up in writing along with consent sharing with professionals supporting the child.	Number/% of post assessment face to face discussions undertaken	Child and/or families experience of assessment, follow up and forward plan			Catrin Davies
	Number/% of families offered and taking up the follow up appointment	Staff experience of assessment, follow up and forward plan			Rebecca James
	Of assessments undertaken number/% of completed profiles	Narrative on feedback not face to face	IFOR - Data quality		Rebecca James
	Number/% of completed profiles shared with family				Rebecca James
	Evidence of consent to share information given				Catrin Davies

	Quantitative	Qualitative	Quantative	Qualitative	Lead
Standard 7 - Post assessment considerations discussed with family and where appropriate the child	Number/% of parents whose children received a diagnosis of either ADHD or ASD provided with information and education on the core features of the childs assessment and or diagnosis	Child and/or families experience of assessment, follow up and forward plan			Catrin Davies
	Number/% of parents whose children did not receive a diagnosis who were provided with relevant information				Catrin Davies
	Number/% of parents whose children received a diagnosis of either ADHD or ASD who have: Been informed of parenting training courses and attended parenting training courses				Catrin Davies

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	Quantitative	Qualitative	Quantative	Qualitative	Lead

Standard 8 - Post assesment interventions should be based on best possible evidence	What evidence based interventions does your service provide?	What has been the impact of those interventions? How have these been measured?	Need to Map - need evidence based review	No - IAS feedback is available	Catrin Davies
		Families and, as appropriate, children's experince of interventions?		No	

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Agenda item: 4.2

PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE	11 FEBRUARY 2025
Subject:	**People Experience Framework**
Approved and presented by:	Claire Roche, Executive Director of Nursing, Quality, Women & Family Health
Prepared by:	Head of Quality
Other Committees and meetings considered at:	Executive Committee - 22 January 2025

PURPOSE:

The purpose of this paper is to provide the Patient Experience and Quality Committee with an update on the forth-coming all-Wales People's Experience Framework and plans for implementation in Powys Teaching Health Board.

RECOMMENDATION(S):

The Patient Experience and Quality Committee is asked to:

- **RECEIVE** the report and take **ASSURANCE** that an appropriate plan is in place to respond to the new Welsh Government national People's Experience Framework due for release in April 2025.

Approve/Take Assurance	Discuss	Note
N	Y	N

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	N
5. Develop Workforce Futures	N
6. Promote Innovative Environments	N
7. Put Digital First	N
8. Transforming in Partnership	N

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EXECUTIVE SUMMARY:
A national People's Experience Framework is anticipated that will inform all Welsh NHS Organisations. Powys Teaching Health Board is preparing for this and this paper provides the Patient Experience and Quality Committee with details of the framework and how we will implement within Powys.
DETAILED BACKGROUND AND ASSESSMENT:

The Welsh Government's People's Experience Framework (The Framework) is expected to arrive with health boards imminently. The official launch of the Framework is due to take place in early April 2025.

The Framework describes people's experience as:

"People's experience is 'the sum of all interactions, shaped by the culture of the organisation, staff and systems. People's experience can be described as how people feel when using any services and programmes offered by NHS in Wales. Whether it be in a hospital ward, outpatient appointment, participation in national screening programs, engagement with primary care services (such as GP, Optometrist, Pharmacist, Dentist), interaction with health promotion practitioners, or attendance at any event hosted by an NHS Wales Organisation. In essence, the definition of People's Experience is fundamental to Person and Population-centredness.

The integration of all strands of experience feedback relies on local expertise and resources. However, the triangulation of experience feedback data alongside other metrics, e.g. outcomes, as depicted on the Listening and Learning Tree is indicative of an organisation committed to quality."

Patient experience encompasses:

- Compliments
- Chaplaincy
- Bereavement services
- Digital stories
- Patient Experience Survey
- Unpaid carers
- Voluntary services
- Concerns and complaints

Nationally, the new Safe Care Partnership now has public members to support co-design, all Welsh health boards use the CIVICA patients experience survey

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system, the Head of Patient Experience Network (HOPE) has peer support and shared learning, and Welsh Risk Pool have a People's Experience Feedback Network.

Work was undertaken during 2024 by Welsh Government, together with the NHS Wales Shared Services Partnership to develop a People's Experience Framework covering all aspects of patient experience. The Framework also aligns with the Duty of Quality Statutory Guidance 2023.

The Framework contains several required elements, aligned to the listening and learning tree which all health boards will need to enact. These will include:

- The completion of a self-assessment tool to judge the health board's readiness (as at 08/01/2025 the Framework is still awaited).
- 5 of the newly updated People's Experience Survey (PES) (formerly Your NHS Experience Survey) will need to be included in every new survey developed by the health board.
- The Framework encompasses legislation, including Putting Things Right, Duty of Candour and collaborative partnerships with Llais, independent advocacy, public services and Ombudsman for Wales.
- A change of language – people as opposed to patients.
- It introduces a requirement to build experience measures into contractual arrangements such as commissioned service (aligns with NHSE Friend and Family test)

The Health Board has several assets in place including:

- A bereavement service
- CIVICA patient experience survey system
- Datix
- Patient Experience Steering Group (PESG)
- Dementia Steering Group

Mental health:

- ✓ Engagement and Insight group supporting co-production
- ✓ Partnership participation officer
- ✓ Your Voice Project
- ✓ Engage to change group
- ✓ Patient Councils on both mental health wards
- ✓ Staff attendance at service user and carer forum
- ✓ Outcome measures, including patient experience, provided to WG programme.

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Children:

- ✓ WCH Quality & Performance Group.
- ✓ Digital patient stories
- ✓ RPB Start Well Board
- ✓ Parents Voices in Wales commissioned to support co-production in ND.
- ✓ Links with Early Help & Play Workstream

Working towards CIVICA surveys

Therapies:

- Quality and Safety Patient Experience Therapies and Health Care Sciences Group.
- Patient experience audit group for all registrants
- 7-minute briefings to share learning
- CIVICA surveys in place for some service areas

Planned Care:

- Endoscopy survey live on CIVICA
- Survey results reported via Endoscopy & Audit Group.
- Patient representative on Endoscopy and Audit Group
- Annual theatres patient survey undertaken

Powys Living Well Service:

- Bi-monthly patient experience panel
- CIVICA questionnaires in place
- EQ5D-5L tool used on regular basis.
- Engagement calls two weeks after the welcome pack is shared with prospective service users

The Health Board will need to rapidly undertake the self-assessment once the Framework has been received to enable it to understand the needs of the Framework, what will be required to implement it and whether the above assets fulfil the Framework.

NEXT STEPS:

On receipt of the Framework the Health Board will need:

- To complete the self-assessment tool as soon as the Framework is received.
- To develop a Patient Experience Framework (PEF) action plan and steering group
- To urgently recruit a Patient Experience Lead to oversee the required work and engage in the People's Experience network, representing the Health Board at a national level.

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- Regularly record patient stories.
- To review the purpose of the Patient Experience Steering Group to align it with the Framework.
- Provide further update to the Patient Experience and Quality Committee with the outcome of the above and consider the Boards role in agreeing our Patient Experience approach.

IMPACT ASSESSMENT
Not Required

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Agenda item: 5.1

Patient Experience and Quality Committee	**11 February 2025**
Subject:	**Integrated Quality Report: Quarter 3**
Approved and presented by:	Claire Roche, Executive Director Nursing, Quality, Women & Family Health Jayne Wheeler-Sexton: Assistant Director of Nursing
Prepared by:	Head of Quality and Safety
Other Committees and meetings considered at:	Executive Committee - 22 January 2025

PURPOSE:

The purpose of this report is to provide the Executive 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
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	N

Patterson,Liz
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EXECUTIVE SUMMARY:

1 Background
The purpose of this report is to provide the 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)

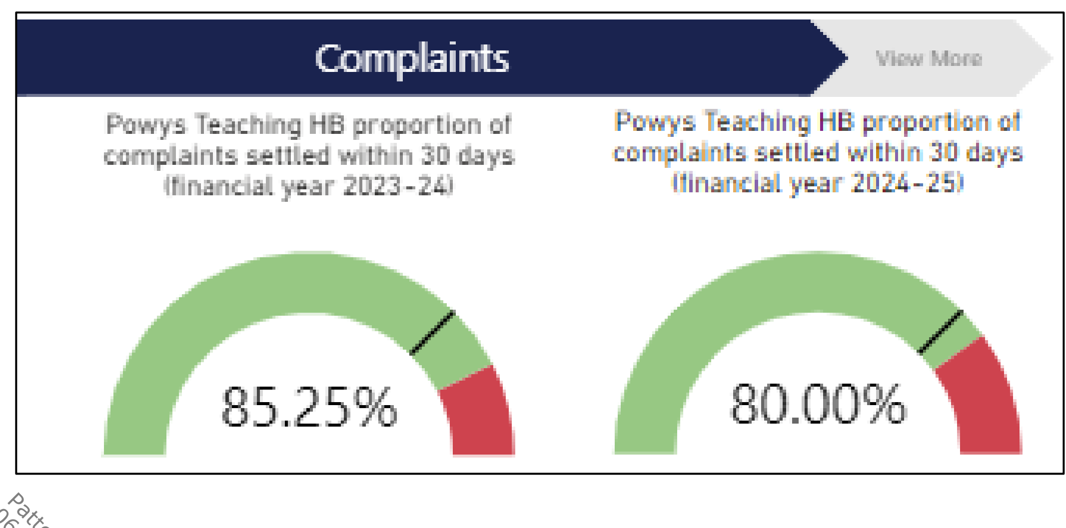
Changes to the RLDatix system in Q3 comprised of reporting of Nationally Reportable Incidents (NRI) through the Datix portal. Previously, NRI incidents have been emailed to the NHS Executive following Executive approval. The recent changes are now completely embedded in current process and will be reflected in the Incident Management Framework following a planned review.

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). The current position is 80% (2024-25). There is continued focus to ensure our concerns are managed in a timely manner with the appropriate investigation and response.

The reported compliance for Q3 2024/25 is 76%.

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



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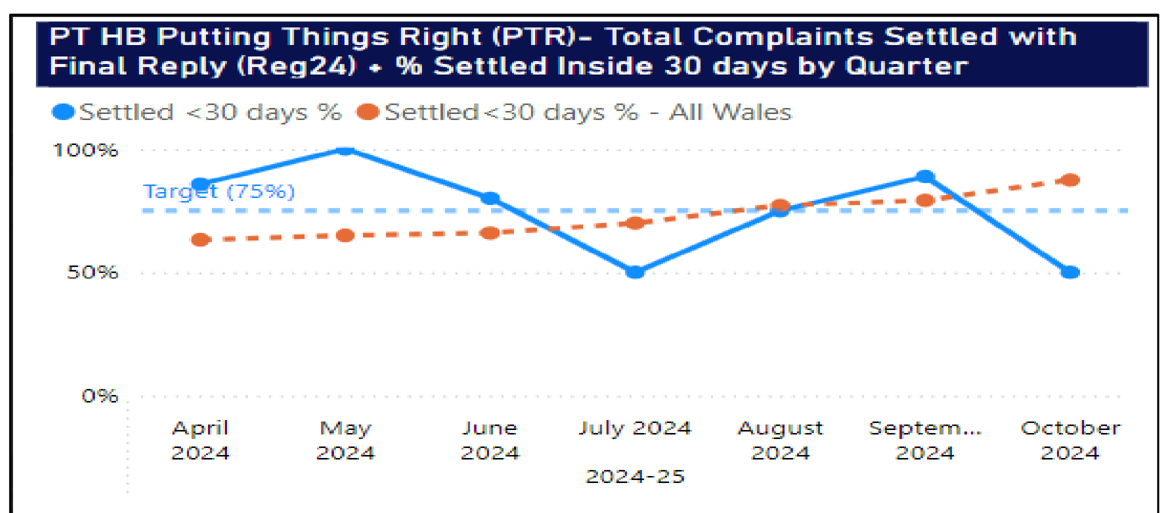
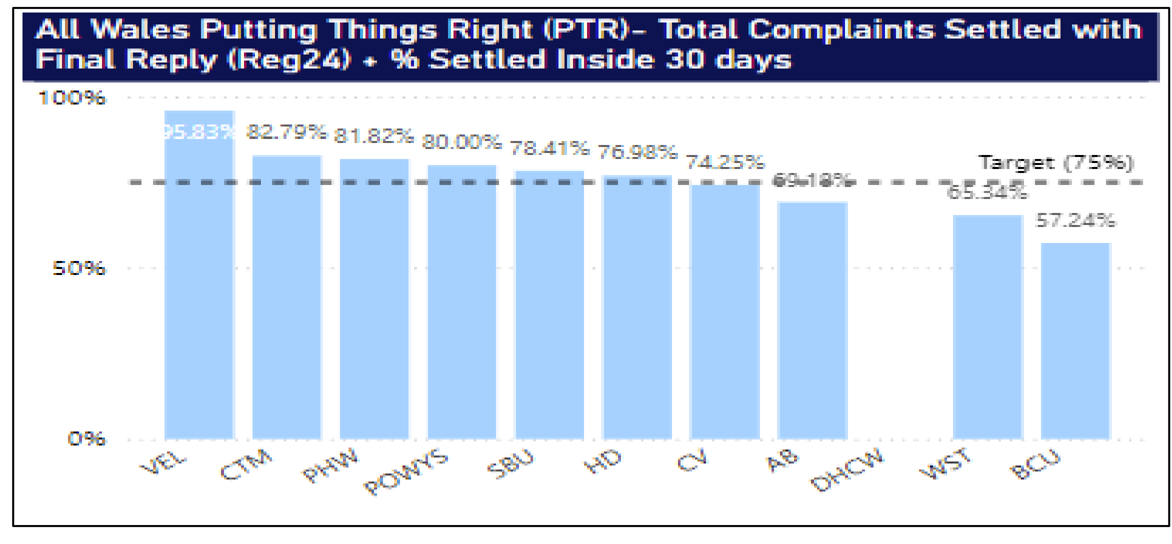
Graph 2 highlights the Powys quarterly compliance (blue line) against the national position (Orange line).



Graph 3 presents the Health Board position nationally (Data obtained from NHS Executive Beacon Dashboard 08/01/2025).



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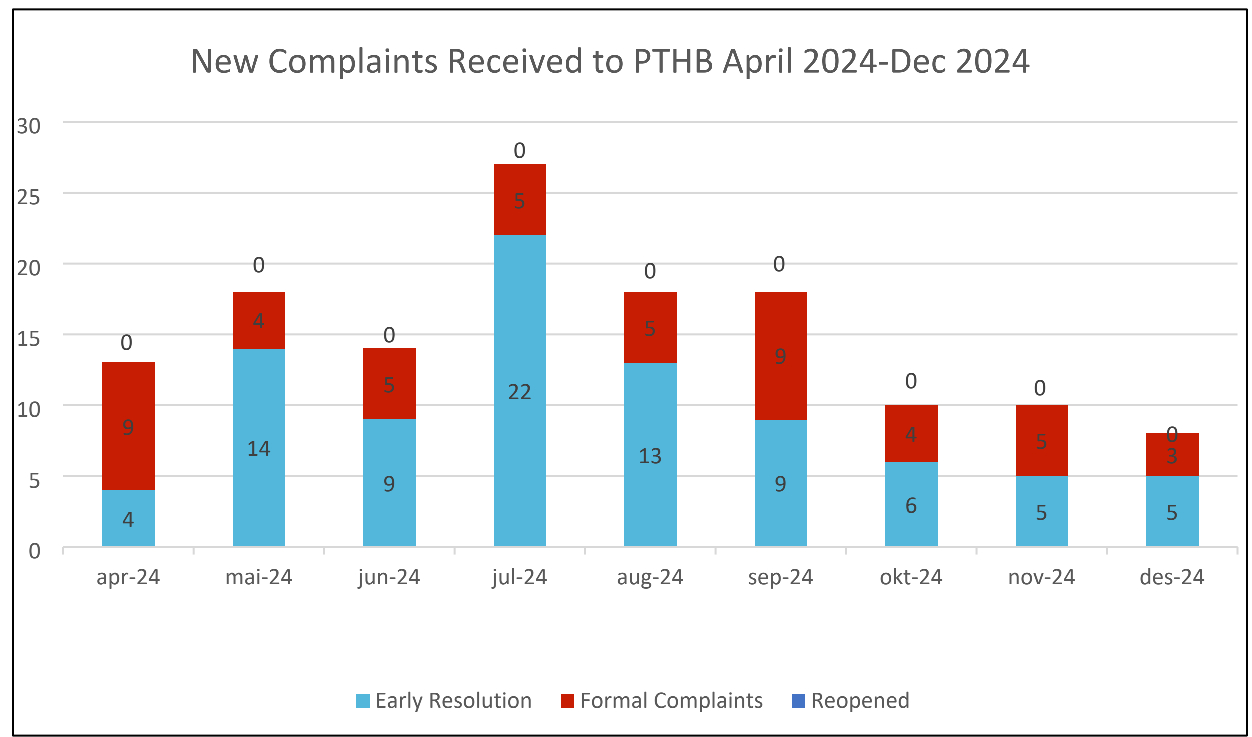
Graph 4 notes the percentage of concerns managed as early resolution (light purple) and formally (Dark purple) (Data obtained from NHS Executive Beacon Dashboard)



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 (DoC)

There have been 14 Duty of Candour cases during Q3 2024/25. All cases are at various points of investigation. The number of candour cases have increased throughout the year, this is attributed to colleagues increased awareness and understanding of the requirements of the Act; Duty of Candour has had no impact on number of Redress cases to date.

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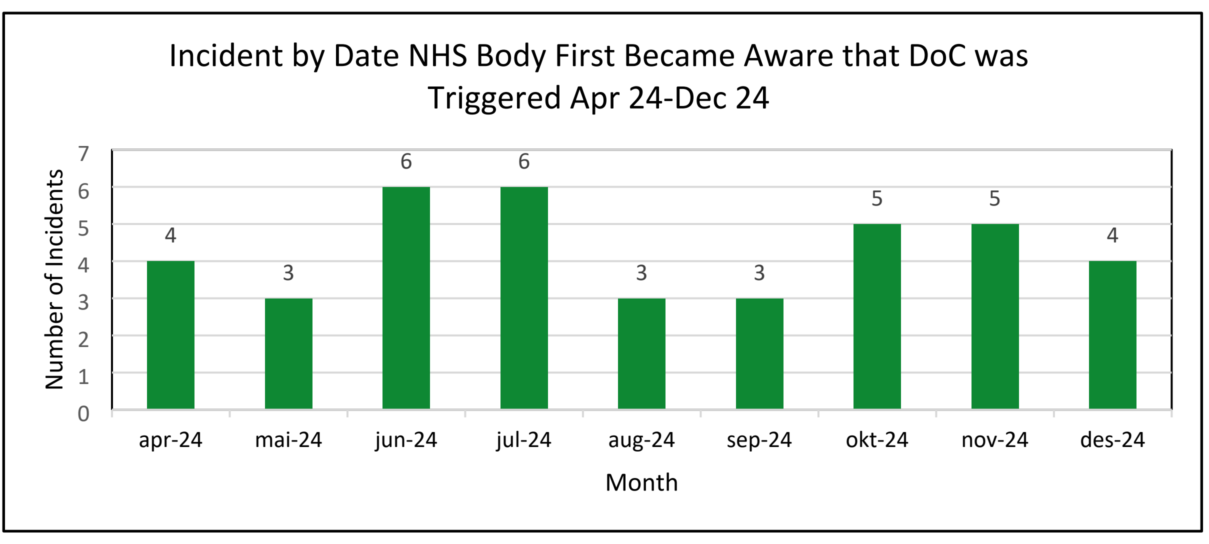
There are currently 26 open DoC case in various stages of investigation. Themes include:

- Avoidable falls
- Unexpected death of a patient known to mental health services
- Administration errors with vaccinations
- Avoidable pressure damage

Graph 5 numbers of reported Candour cases since implementation



Learning from Duty of Candour

- When English is not the first language an interpreter should always be offered, and family members should not be relied upon to ensure the routine enquiry can be carried out.
- When a woman presents to a birth centre a full antenatal assessment should be carried out to inform on going care plans.
- Multiple missed opportunities to administer pertussis vaccination due to Boostrix not being in stock.
- Birth centres to adopt a weekly stock check of medicines.
- School pupils with verbal consent must have their names crossed off the 'to do vaccination' list as soon as the consent is taken.
- WCCIS standards require monitoring and audit, and robust training and support for staff using this documentation system.
- Expectations of standards need to be made Enhanced care staff roles and responsibilities

2.4 Claims, Redress & Clinical Negligence Position

Redress

6 confirmed cases, 2 potential cases.

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100% compliance with re-imbursement recovery. The next redress panel has been arranged for 14 January 2025 and will now be conducted monthly to discuss the general position of redress, regardless of if there are any cases to present to panel.

Clinical Negligence
10 confirmed cases, 2 potential cases

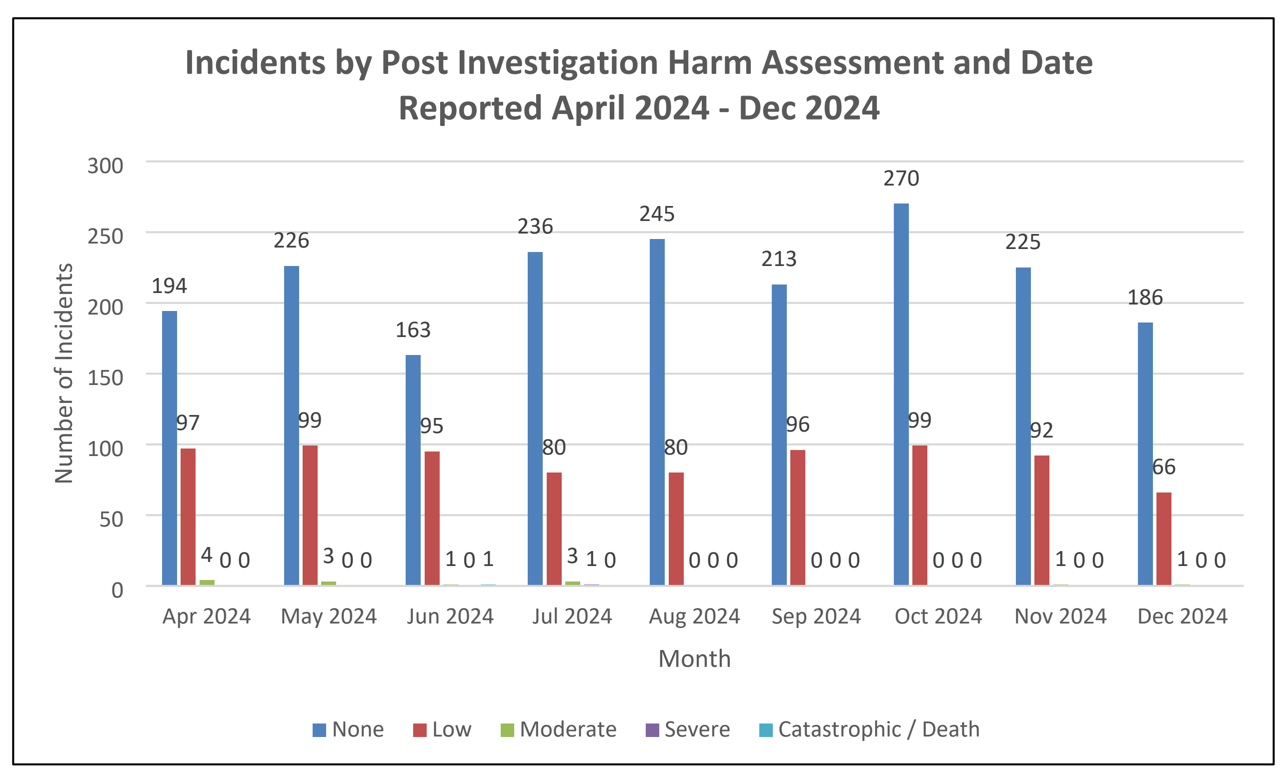
General Medicine Practice Indemnity (GMPI) Claims
2 confirmed cases, 6 potential cases.

Personal Injury
4 confirmed cases, 0 potential

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.

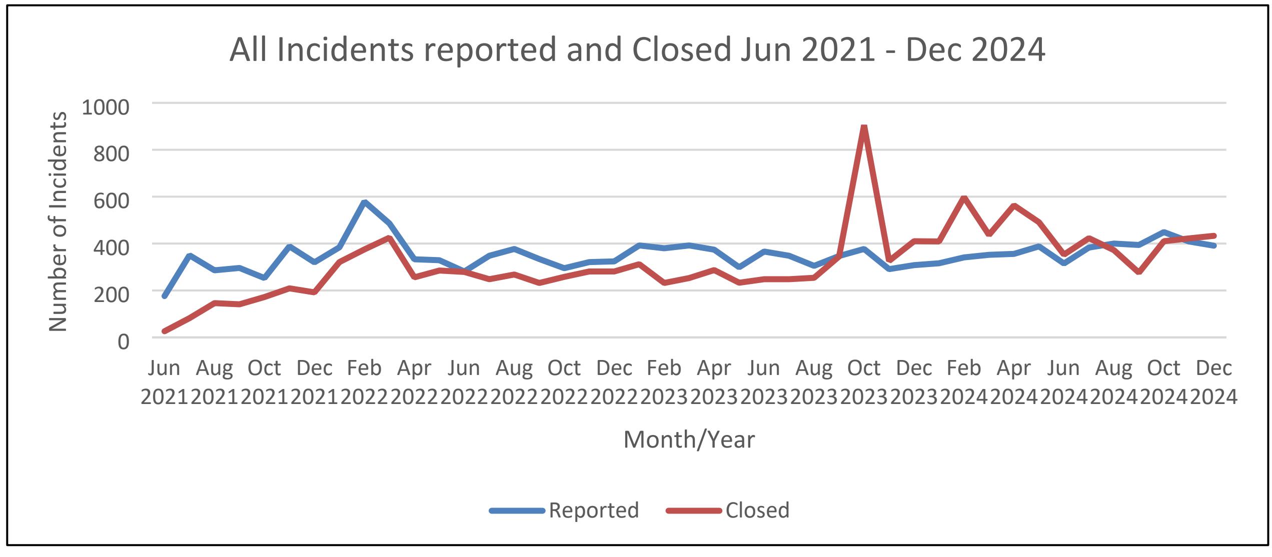
Graph 6 Incidents Reported by Actual Level of Harm April 2024-Dec 2024



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 risen gradually since September 2024, following proactive and supportive measures which 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 Single Unified Safeguarding Review (SUSR): Statutory Guidance

The Single Unified Safeguarding Review (SUSR) is a single review process incorporating all safeguarding reviews in Wales. The SUSR was launched on the 1st of October 2024, following 4 years of substantial cross-sector collaboration with partners including Safeguarding Boards, Community Safety Partnerships, the Home Office, Police and Crime Commissioners, Health and third sector organisations. Wales is the first country in the UK to take this new approach to safeguarding reviews.
The SUSR will remove the need for multiple reviews when any life is lost or is significantly impacted through abuse, neglect, or violence.

The SUSR provides the framework for Adult and Child Practice Reviews, Domestic Homicide Reviews (DHR) and introduces Mental Health Homicide reviews and Offensive Weapon Homicide reviews into one single, proportionate and rigorous process

Combining Adult Practice, Child Practice, Mental Health Homicide, Domestic Homicide and Offensive Weapon Homicide reviews into one process will prevent the need for families to take part in multiple, often onerous and traumatising reviews & ensure the subject and family are at the heart of the process

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The process allows multi-agency review teams to quickly identify learning; build a greater understanding of what happened during an incident and provide a clear action plan to improve services.

The SUSR will support learning throughout Wales. Central to this being achieved is the development of the Wales Safeguarding Repository. This digital repository stores all reviews and can be interrogated using social science and machine learning to extract learning, thematic information and good practice which can be used to deliver positive change in practice & prevent future harm

The SUSR process will be reviewed after 12 months to ensure that any changes required to improve the process are made. A formal launch will take place later in the year with key stakeholders and members of the SUSR Ministerial Board.

Within PTHB all referrals for consideration for an SUSR must be made into the Mid and West Safeguarding Board with the support of PTHB's Head of Safeguarding and Safeguarding Team

2.7 Early Warning Notifications (previously No surprises notifications)

6 Early Warning Notifications have been submitted during Q3 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 52.4% 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
21	**11**	**10**	**4**

- 2 NRIs have been closed during Q3.

2.9 Mental Health Update Sustaining Quality and Safety Improvement Post-Escalation (Appendix 1)

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Mental Health services were placed into internal escalation following a systems and process review (December 2023) and a service review (February 2024) in April 2024. Weekly escalation meetings were held to discuss key areas of concern and to develop an action plan of improvement. The key areas included:

- Actions from concerns and incidents
- Policies and service operational procedures
- MDT process
- Clinical audit plan
- Desktop review for review of post incident investigation of 9 incidents.
- Closure of outstanding open Datix reports
- Delay in discharge notifications
- PMVA training
- Care and Treatment Plan audit
- Training needs analysis.

As a result of escalation, the following has been achieved:

- Historical Datix incidents have been investigated and closed and the service are managing incidents within the 'live' monthly period.
- Bi-monthly CTP audits have commenced.
- Maturity Matrix developed.
- QuAILS (Quality Assurance Integrated Learning and Safety) meeting framework established for monitoring.

3. Patient Experience

3.1 CIVICA

Your NHS Experience survey is available for all patients that have accessed healthcare is available on the Health Board's website, together with a shorter Friends and Family test survey. The CIVICA system administrator receives a notification each time a Friends and Family test is completed, the feedback from which is shared with the service area highlighted in the feedback

Graphs 8 and 9 are heat maps, the data for which builds over time and gives an overview of responses to specific questions. The heat maps below are for the current financial year but area available from the installation of CIVICA. The 'heat map' approach to data is described as:

- Green >85%
- Amber 75-84%
- Red <75%

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

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Graph 8 – Source CIVICA
Your NHS Experience Survey Heat Map across all services, internal and external

Question:	Survey	2024 Apr	2024 May	2024 Jun	2024 Jul	2024 Aug	2024 Sept	2024 Oct	2024 Nov	2024 Dec	Benchmark
2. Did you feel that you were listened to?	Your NHS Wales Experience	85	89	85	68	35	71	56	67	39	85
3. Were you able to speak in Welsh to staff if you needed to?	Your NHS Wales Experience	45	39	44	-	-	25	10	25	25	85
4. From the time you realised you needed to use this service, was the time you waited:	Your NHS Wales Experience	71	70	66	53	35	63	45	42	50	85
5. Did you feel well cared for?	Your NHS Wales Experience	86	89	85	65	40	71	56	50	54	85
6. If you asked for assistance, did you get it when you needed it?	Your NHS Wales Experience	81	85	85	63	25	65	50	25	38	85
7. Did you feel you understood what was happening in your care?	Your NHS Wales Experience	86	86	87	72	40	75	58	50	40	85
8. Were things explained to you in a way that you could understand?	Your NHS Wales Experience	90	87	89	67	40	65	63	50	45	85
9. Were you involved as much as you wanted to be in decisions about your care?	Your NHS Wales Experience	85	85	86	67	40	75	59	50	40	85
10. How would you rate your experience 1-10	Your NHS Wales Experience	86	86	86	69	34	68	57	40	56	85
Overall:		83	84	83	65	36	68	54	47	45	
Respondents:		131	215	211	10	5	6	16	3	7	

Graph 9 – Source CIVICA
Your NHS Experience Heat Map for Powys Teaching Health Board Services only

Question:	Survey	2024 Apr	2024 May	2024 Jun	2024 Jul	2024 Aug	2024 Sept	2024 Oct	2024 Nov	2024 Dec	Benchmark
2. Did you feel that you were listened to?	Your NHS Wales Experience	92	100	-	100	100	100	96	-	100	85
3. Were you able to speak in Welsh to staff if you needed to?	Your NHS Wales Experience	25	25	-	-	-	25	-	-	-	85
4. From the time you realised you needed to use this service, was the time you waited:	Your NHS Wales Experience	67	83	-	83	100	92	75	-	100	85
5. Did you feel well cared for?	Your NHS Wales Experience	100	100	-	92	100	100	96	-	100	85
6. If you asked for assistance, did you get it when you needed it?	Your NHS Wales Experience	63	100	-	100	100	100	95	-	-	85
7. Did you feel you understood what was happening in your care?	Your NHS Wales Experience	92	100	-	100	100	100	96	-	100	85
8. Were things explained to you in a way that you could understand?	Your NHS Wales Experience	100	100	-	100	100	100	96	-	100	85
9. Were you involved as much as you wanted to be in decisions about your care?	Your NHS Wales Experience	92	100	-	100	100	100	93	-	100	85
10. How would you rate your experience 1-10	Your NHS Wales Experience	90	97	-	100	100	100	94	-	100	85
Overall:		85	94	-	97	100	96	93	-	100	
Respondents:		3	3	0	3	1	3	7	0	1	

Graph 10 and 11– Source CIVICA
A wordle of negative words around waiting on the left and the number of times each word appears on the right.

"wasting staff time"
"took 5 weeks" "took a very long"
"hour before i was"
"took a further hour" "wasted appointment time"
"further hour" "for hours" eventually "hours later"
"for 5hrs" "took a long" "running late" "taking so long"
"in a queue" "minutes late" waited ages "for an hour"
"after 24 hours" lengthy chase wait finally delays postponed
"take so long" waits queue waiting delay "waste time"
"put off" delayed
"for 65hours" cancelled chased "hour to get"
"hour late" "waste of time" "for 48 hours"
"wasting there time" "wasnt seen"
"running very late" "wasting her time"
"another 24 hours" "took 3 weeks" "took 4 hours"
"for several hours"
"wasting everyone time"

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Graph 11

SHOW ALL OF THE SUMMARY

SUMMARY:

Words	Score
wait (@1) - 64 times	64
waiting (@1) - 42 times	42
waited (@1) - 15 times	15
delay (@1) - 10 times	10
cancelled (@1) - 10 times	10
chase (@1) - 8 times	8
running late (@1) - 8 times	8
finally (@1) - 7 times	7
queue (@1) - 6 times	6
ages (@1) - 5 times	5

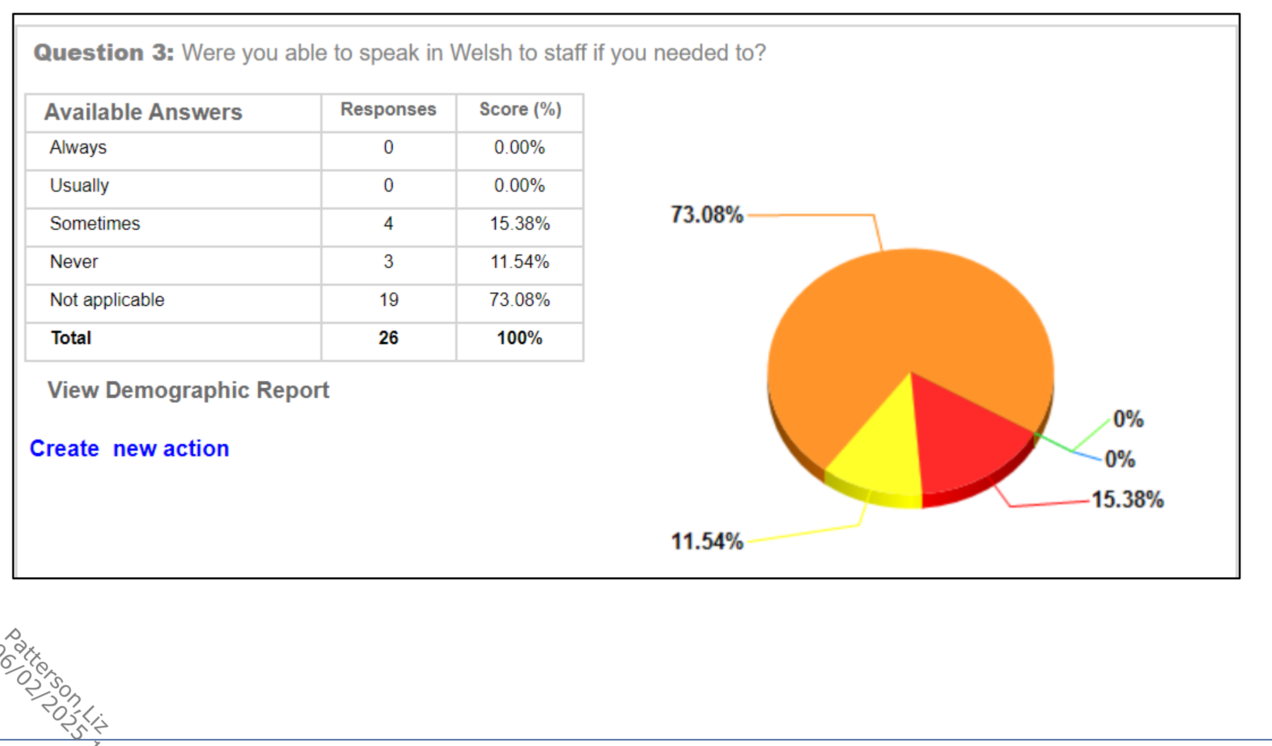
Graphs 12 and 13 – Source CIVICA
Your NHS Experience all emotions word cloud on the left with the number of times each word appears on the right.

SHOW ALL OF THE SUMMARY

SUMMARY:

Words	Score
excellent (@3) - 241 times	723
friendly (@1) - 198 times	198
lovely (@3) - 124 times	372
amazing (@3) - 100 times	300
happy (@3) - 64 times	192
wonderful (@1) - 50 times	50
fantastic (@3) - 48 times	144
supportive (@2) - 47 times	94
brilliant (@3) - 39 times	117
at ease (@1) - 37 times	37

Graph 14 – Source CIVICA
Your NHS Experience – Were you able to speak Welsh if you need to?



Question 3: Were you able to speak in Welsh to staff if you needed to?

Available Answers	Responses	Score (%)
Always	0	0.00%
Usually	0	0.00%
Sometimes	4	15.38%
Never	3	11.54%
Not applicable	19	73.08%
Total	**26**	**100%**

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3.2 Patient Stories

An SBAR (**Appendix 1)** for the Health Board current position has been completed in line with the pending People's Experience Framework (PEF). In December 3 people's experience stories were shared in association with Grief Awareness Week and shared on SharePoint Journeying through Grief - 3 Stories of Loss and Hope.

3.3 People's Experience Framework (PEF)

Following on from the PowerPoint shared at Executive Committee in November 2024, the Health Board has completed an SBAR (separate paper) detailing a scoping exercise in readiness for the PEF to be released by Welsh Government in early 2025. It is expected that health board's will be providing assurance on the Framework from April 2025 and work is already underway in the Health Board in preparing for this including:

- Understanding resources already available across the Health Board.
- Creation of a People's Experience Lead substantive post.
- Complete a self-assessment tool against the PEF on receipt.
- To review the Patient Experience Steering Group against the PEF.

3.4 Llais Activity

Llais is undertook a period of locality engagement in the Hay on Wye and Talgarth area during November 2024.

The health board has set out key actions to respond to the feedback in the draft report and a workshop will be arranged by Llais to discuss the feedback.

4. Infection Prevention and Control (IP&C)

The IP&C improvement plan continues to progress, with the progress against delivery outlined below:

- **46 actions** have been successfully completed
- **1 action** remains on track and is expected to be completed within the planned timeframe
- **1 action** is progressing positively, with its completion likely by the end of February 2025

Key developments since the previous update:

- Recruitment of an Antimicrobial Stewardship (AMS) Pharmacist to enhance the delivery of AMR/HCAI reduction strategies and actively participate in post infection reviews for improved learning outcomes

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- Implementation of electronic auditing system scheduled to go live in January 2025
- Laboratory results from SaTH are now incorporated into a daily email sent to the IP&C team
- Recruitment of an additional IPC Nurse, set to commence in January 2025, to bolster team resilience and expand capacity, including support for primary care.

Clostridioides difficile Framework for Wales 2025-2027
The IP&C team and AMS Pharmacist are currently reviewing recommendations within the framework against existing resources of the Health Board. These findings, along with proposed recommendations, will be submitted to the IP&C group for further discussion.

5 Health and Social Care Inspections Regulatory Recommendations

5.1 Health Inspectorate Wales Inspections

The oldest outstanding actions now relate to inspections conducted from 2021 to 2023, of which 5 relate to the CMHT inspection 21/22).

Mental Health have undertaken a deep dive during December 2024 of all outstanding actions and have made significant progress with closure. All outstanding actions will now be tracked and progressed through the QuAILS group (Quality Assurance Integrated Learning and Safety).

The two outstanding actions for Epynt Ward during an inspection in 23/24 relate to flooring. Two areas have been repaired but funding is required to complete the rest.

Graph 15 Historical Inspections 2021-2023

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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	2				Yes
212215	HIW Announced Inspection of community mental health services	55 (4 of which PCC led)	50	4	1		
222307	HIW Tawe Ward Unannounced Inspection	26	26				Yes
232401	HIW All Wales Review of discharge arrangements in Mental Health	40	40				Yes
Wards							
232402	HIW Inspection Epynt and Y Bannau Wards, Brecon Hospital	99	97		2		
TOTALS		222	215	4	3		

Actions since 2023/2024 to date:

There are currently 18 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					
242503	CMHT Newtown	25	24	1	
Wards					
232403	HIW Inspection Graham Davies Ward	31	29	2	
232404	HIW Inspection of Brynheulog Ward	15	12	3	
National Reviews - Improvement Plans					
232405	HIW National Review of CAMHS	Action plan due for submission to HIW 03/02/25			
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 (+1 recommendation N/A)	12	4	
		115	97	18	

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Graph 17 Summary Position of all inspections

Year/ Reference No	Inspection Title	Recommendations Made / Actions	Recommendations / Actions Complete	Recommendations / Actions Overdue (agreed timescale)	Overdue Recommendations / Actions Revised Timescale	Recommendations / Actions Not Yet Due
212202	Tier 1 Quality Check Clywedog Ward, Llandrindod Wells	2	2			
212215	HIW Announced Inspection of community mental health services	55 (4 of which PCC led)	50	4	1	
222307	HIW Tawe Ward Unannounced Inspection	26	26			
232401	HIW All Wales Review of discharge arrangements in Mental Health	40	40			
232402	HIW Inspection Epynt and Y Bannau Wards, Brecon Hospital	99	97		2	
232403	HIW Inspection Graham Davies Ward	31	29	2		
232404	HIW Inspection of Brynheulog Ward	15	12	3		
232406	HIW National Review of Patient Flow	9	8	1		
242501	HIW National Review MH Crisis Prevention	19	12	7		
242502	HIW National Review DNACPR - further updates requested	16	12	4		
242503	CMHT Newtown	25	12	13		
Totals		**232**	**300**	**21**	**3**	

6 Llais

Powys Teaching Health Board have worked closely with Llais during Q3. 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 2024. 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). Following reporting for the period 01/04/2024-30/09/2024 feedback has asked for assurance on the following:

- The assessment of the local population's bereavement needs including the needs of those with protected characteristics
- Commissioning of bereavement support from external providers and their progress in providing this.
- Activities undertaken to support the roll-out of the pathways and to support child bereavement in Children's Services and CAHMS.

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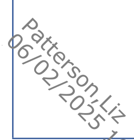
- Health Board progress in obtaining feedback from bereaved people on the service received from all bereavement services in the HB.
- Bereavement provision out of hours, at weekends, and Bank Holidays.

Focus on these objectives will continue throughout 2025. Alongside this, the Bereavement Lead has achieved the following:

- Commissioning Grief First Aid training to establish Grief Awareness Champions throughout the Health Board.
- Newly published Powys focused bereavement packs have been distributed across all hospitals.
- The Bereavement Lead has created an ESR Bereavement Training package (comprising of 6 modules) to be piloted in PTHB, with the intention of rolling this out as All-Wales training across all health boards.
- Collaborating with Brecon MIND to review provision to individuals in Neurodevelopment, End of Life, Mental Health and CAMHS services.
- Grief Awareness Week – events were held 2-8 December 2024 in Bronllys and St Mary's Church, Brecon. A raffle was held in Bronllys with £268 raised for St David's Hospice and for setting up a PTHB Bereavement Service fund. As previously mentioned, three stories on personal grief experiences were shared and are available to view on SharePoint.
- Mortality review – since the introduction of the Medical Examiner reviewing all deaths, there has been an expected increase in cases being forwarded to the Health Board for review. 10 cases were forwarded in December with the following themes:
  - Issues concerning DNACPR
  - Delays in issuing of a death certificate

9 Pressure Damage Assurance

PTHB has Care Pathways in place to reduce the risk of avoidable pressure damage by the implementation of timely, targeted, appropriate interventions for all those at risk of pressure damage.
If pressure damage occurs, regardless or grade, they must be reported via the Datix system for scrutiny and monitoring, this should include a completed focused review prior to presenting at the Health Boards Pressure Damage Scrutiny and Learning Panel.



Pressure Damage Scrutiny and Panel
The Pressure Damage Scrutiny and Learning Panel ensure related investigation and reporting processes are followed and supports the governance arrangements and its associated assurance framework. The ToR outline clear definitions of Avoidable and Unavoidable pressure damage to support constancy across the Health Board. The Panel meets monthly. The core membership include:

- Head of Nursing or nominated deputy
- Podiatry Lead
- Head of Safeguarding
- Head of Quality & Safety
- Tissue Viability Nurse Specialist

Functions of the Pressure Damage Scrutiny and Panel:

- Timely review of avoidable pressure damage affecting Powys residents who are provided care through community hospitals, district general hospitals, in community settings, care homes and residential settings.
- Scrutiny of investigations and reporting of avoidable pressure damage.
- The investigation and reporting processes are scrutinised to consider safeguarding.
- Monitoring of reporting to Welsh Government
- Assurance that lessons and wider learning is shared across the health board and used to inform education and awareness.

Reporting
Reporting the outcome of scrutiny discussions is within Quality Governance Groups and Patient Experience, Quality & Safety Committee via the Integrated Performance Report and quality indicator reports/ dashboards.
Reporting wider across the Health Board is through existing hospital and community forums, care and residential care home meetings, and within the quarterly Safeguarding Report to Strategic Safeguarding Group.

Ongoing Review and Improvements
The Pressure Damage Scrutiny and Learning Panel ToR is currently under review and will be finalised once the All-Wales Pressure Damage Guidance has been published. Improvements in managing all incidents (which include pressure damage) via Datix is required on 3 wards. This is being addressed and monitored via Individual Development Plans.
The Health Boards Q&S Team have agreed to offer some bespoke training in Q4 to ward managers regarding the use of the Datix system and its functions.
An Annual Learning Event that shares learning from incidents should be considered.

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NEXT STEPS:

Key Matters for Committee:

1. Timely management of Duty of Candour investigations and delivery outcomes to all families.
   ACTION taken: Additional focus and support is being provided by the Head of Quality and Safety to ensure investigations are managed in a timely manner and learning identified and shared throughout the process. The Quality and Safety Team has completed a deep dive of all Duty of Candour incidents since implementation in April 2023 and will be working with services to ensure all incidents are complete.

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-Q3. 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: Mental Health Update Sustaining Quality and Safety Improvement Post Escalation

IMPACT ASSESSMENT – NOT REQUIRED FOR THIS REPORT
Not required

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Sustaining Q&S Improvement in MH&LD

Jan 2025

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De-escalation 16th Oct 2024

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.
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. Ongoing improvement work but minimum standard met
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

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Policy, Audit and Action plans

- WARRN audit completed. CTP audit will be fed back in February QUAILS
- 4 new Policies or reviews have been completed – with Execs for sign off
- HIW action plan tracker progress – reviewed in Quails. Several closed with clear plans for rest. Will be reviewed each month in QUAILS

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Quality and Safety Indicators

- NRI position – 13 open in December. 2 closed – 1 awaiting action plan, 7 are close to sign off, with MH&LD division for review and 4 incidents are currently under investigation.
- 2 new NRIs this months
- Duty of Candour - 17 cases remain under review.
- No current PSOWs
- Three formal concerns are currently being addressed and it is anticipated these will be closed at the end of January 2025
- Incident management 97 currently in system. Respiratory illness on Felindre Ward impacted management so minor backlog being resolved within closure timescales.

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Care and Treatment

- Whole division (MH&LD) CTP audit now completed
- Improvement themes identified
- CTP training implemented, prioritising inpatients settings.
- Working with ABUHB to share resources for learning and empowering staff and also to re-establish All Wales CTP Group.
- Seeking to sustain the CTP lead post part of the review of management structure within the Directorate who will then work with Teams for bi-monthly CTP auditing.

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Sustaining improvement

- Progress is assessed using the Maturity Matrix developed as part of IQPAF, assessment takes place on a quarterly basis and the next assessment is due (and planned) to take place in February
- This Conditions of Sustainability are built into the cycle and structure of MH&LD SMT. Continuous Improvement is being captured.
- Roles that were temporarily introduced to support Q&S improvement work are prioritised to be recommended as being retained permanently in new management structure.
- QuAILS meetings in SMT structure monitor progress against escalation measures but also all Q&S tracker work e.g. HIW action plans.

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Advise/Inform: **From period of sustained incident management numbers (70-80), increase to 97 in January 2025 which are awaiting review/closure. Impact due to short terms sickness and backlog being addressed.**	**Assure:** **Q&S Themes are being picked up and managed in timely way with intervention resolution enabled as a result. E.g. recent theme of increasing safeguarding themes in datix responded to.**
Alert: Attendance at PTR has dropped – this is due to increased operational pressures and acuity. Work to address attendance underway.	**Good news:** **PTHB MH Services are to be pilot area for suicide risk assessment training in Wales** **PTHB leading on Community of Practice for CMHTs working with NHS Executive**

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Agenda item: 5.2

Patient Experience, Quality and Safety Committee	11th February 2025
Subject:	**Mental Health and Learning Disabilities Services monitoring post local escalation**
Approved by:	Elaine Lorton,
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:	N/A

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) was established to provide robust oversight of the quality improvement and risk mitigation work undertaken within Mental Health Services with regular progress reports provided to both Executive Committee and PEQs on progress against the continuous improvement plan developed by the service. On the 16th October 2024 Executive Committee took the decision to de-escalate the Service.

The purpose of this paper is to provide the Patient Experience, Quality and Safety (PEQS) Committee with the current position against the measure for which the service was originally escalated and to advise on progress on the continuous improvement agenda.

RECOMMENDATION(S):

The PEQS Committee is asked to:

1. **TAKE ASSURANCE** that MH&LD Services are maintaining good practice achieved through delivery of the continuous improvement response plan in relation to measures for which they were escalated.
2. To **NOTE** and **DISCUSS** the contents of the report.
3. Take **ASSURANCE** from the ongoing monitoring and evaluation mechanisms in place as part of the Integrated Quality and Performance Framework (IQPF).

Approve/Take Assurance	Discuss	Note

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Y	Y	N

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

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EXECUTIVE SUMMARY

Escalation is considered against the 4 IQPF domains and 3 levels of escalation. The IQPAF 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 are assessed. Services can be in escalation for any or all of these four domains.

The Executive Committee agreed that, within the context of the Health Board IQPF, Mental Health and Learning Disabilities (MH&LD) Services in PTHB be placed into an escalated (internal within the Health Board) status in March 2024.

On the 16th October 2024 Executive Committee took the decision to de-escalate the Service. This paper provides an overview of update on progress and delivery of the delivery of the current position against measures for which the service was escalated and progress summary against the continuous improvement plan for quality and safety that the Service are delivering post escalation.

DETAILED BACKGROUND AND ASSESSMENT

Background

In response to being placed in level 2a, the Mental Health service had developed a Continuous Improvement Plan which incorporated existing work the Service had been undertaken pre-escalation and has been built upon through escalation and thereafter. During March 2024-October 2025, the service focused on 5 areas, the EOG had 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)

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

The significant progress made in the 8 months period of escalation resulted in the decision to de-escalate the service and with the IQPG process picking up the ongoing monitoring of activity.

The current position of MH&LD in relation to these is as follows;

- Sustained reduction in overdue patient safety incidents. At the time of the initial deep dive (reported in January 2024), there were 480 overdue incidents. As at 5th February 2025 there are 102 open patient safety incidents. The service group has been sustaining incident review and closure in line with required timescales between 60-80 between October – December 2024. Due to a period of circulating respiratory tract infection sickness in the inpatient setting where a large number of incidences are generated from, capacity to close in January 2025 has been impacted meaning that it is likely that this number would have been lower at this point in the month. However, it still remains that all 102 are within compliance timescales and are under review. Datix huddles still operating effectively.
- The NRI position in mid January stands at 10. Three of these have been quality assured and signed off at Executive level, 3 have been passed to Corporate Q&S Team at final approval stage, 1 is currently with the Investigating Officer for comment, 1 is under review by MH Head of Nursing and the final 2 will be closed within the next 3 weeks.
- Policy and Audit Trackers remain up to date with an even further enhanced governance process added to the Service's process to improve the assurance for sign off. A further 10 policies have been updated/reviewed and signed off by their Senior Management Team since October 2024.
- At the time of de-escalation substantial progress had been made against Care and Treatment Planning Audit and in the undertaking if a Training Matrix but the final CTP audit report and final Education, Training and Development Plan were two products due for completion by the end of January 2025. The updates against these two pieces of work are as follows;

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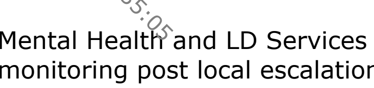
▪ Care and Treatment Plan Audit

- Benchmarking work undertaken - application of National Audit Tool.
    - Co-ordination of random sample CTPs from all areas of service (MH&LD) complete.
    - Audits completed across all service areas underway with prioritisation of Inpatient settings.
    - Information sent to Power BI for interactive visualisation capability.
    - CTP Audit themes identified and to be reported to the February Quality Assurance Integrated Learning and Safety Forum. Main themes for improvement are; involvement of patients and carers in CTP formulation, timely and good quality recording practice in some areas, consistency across Teams including those that are specialist.
    - The outcomes will be drawn in the MH&LD Education, Training and Learning Plan.

- Education, Training and Learning Plan.
    - Needs analysis completed and matrix applied to capture future workforce training needs across whole service group
    - MH and LD Education, Training and Learning Plan is now in final draft. It will be finalised for sign off at the next MH&LD Senior Management Team meeting but has remained in final draft awaiting the outcomes of the CTP Audit.

Maturity Matrix and Conditions for Sustainability

- 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 service continues to utilise these tools for ongoing assessment with the next one due on the 19th February.
- The ongoing 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.
- At the time of de-escalation, the increased capacity arising as a result of the accelerated work still required thought in the MH&LD model and establishment moving forward. Through the Executive Director of Primary Community Care and Mental Health work to develop proposals for sustainable management structures, the MH&LD service have reviewed the current model and developed plans to absorb and create a structure that incorporates the resource temporarily put in place as part of escalation. If approved this would see the existing roles become substantive including the addition of a CTP Lead for PTHB.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Monitoring
Progress against the Continuous Improvement Plan as highlighted above is incorporated in the IQPG monitoring process and reported through to IQPD also on monthly basis.

Noting the progress made and the continued delivery of the implementation plan with evidenced progress, PEQS is asked to take assurance on the business as usual position and the arrangements in place to ensure ongoing monitoring.

NEXT STEPS:
The Committee will continue to receive updates at agreed intervals.

IMPACT ASSESSMENT – NOT REQUIRED FOR THIS REPORT
Not required

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Agenda Item: 5.3

Patient Experience and Quality Committee	**11 February 2025**
Subject:	**Maternity Assurance Paper**
Approved by:	Claire Roche, Executive Director of Nursing, Quality, Women & Family Health
Prepared and presented by:	Interim Head of Midwifery and Sexual Health
Other Committees and meetings considered at:	Maternity leadership and management meeting Maternity Matters Assurance Forum Executive Committee - 22 January 2025

PURPOSE:

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

RECOMMENDATION:

The Patient Experience and Quality Committee is asked to:

- **RECEIVE** the report and take **ASSURANCE** about the quality and safety governance mechanisms in place within maternity services.

Approval/Ratification/Decision	Discussion	Information
✓	✓	

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

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

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	Dignified Care	✓
	Timely Care	✓
	Individual Care	✓
	Staff and Resources	✓
	Governance, Leadership & Accountability	✓

EXECUTIVE SUMMARY:

The purpose of this paper is to provide the Executive Committee with an update on progress in maternity services in Powys, providing assurance on the continued work undertaken within the service to maintain quality and safety.

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

DETAILED BACKGROUND AND ASSESSMENT:

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

- Identification of three Nationally Reportable Incidents (NRIs) between February and May 2022.
- Findings from a local review of governance in the Midwifery Service that highlighted improvements were required in the review of maternity transfers (particularly intra-partum), review of incidents and the undertaking of root cause analysis (RCA) investigations.
- Concerns around the use of the Perinatal Institute's Gap/Grow programme (fetal growth assessment tool).

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

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

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

Maternity National Reportable Incidents (NRI's)

A Nationally Reported Incident (NRI) is defined as an incident that occurred during the provision of NHS funded healthcare. NRI's are reported to the NHS Executive in line with the Patient Safety Incident reporting framework which focuses on learning and improvement.

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There has been 1 NRI incident reported within Q1-Q3 of 2024. This case has been presented at a learning event for staff and will be included in the annual Perinatal death review where learning will be shared with the wider audience.

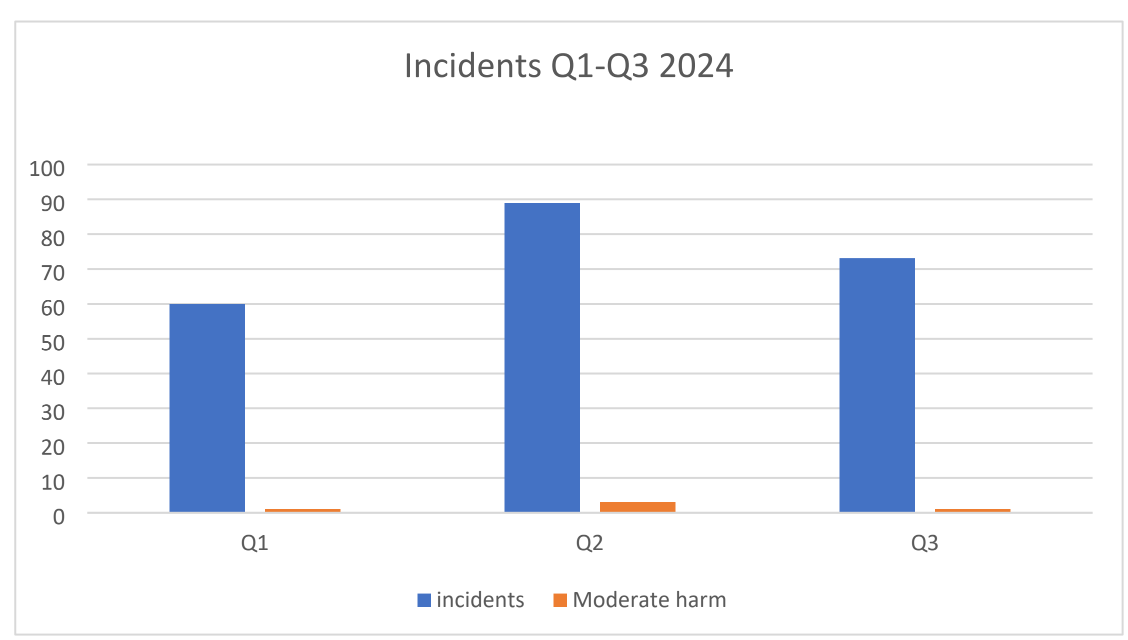
Concerns Summary Position

Concerns are received the service as Early Resolution, Putting Things Right and Duty of Candour. Between Q1-Q3 there were 12 concerns, most of which were early resolution. Learning from concerns includes:

- Advising staff to ensure patients understand the care plan agreed for the care they receive in pregnancy with Powys and out commissioned services. If obstetric care is unclear to ensure a discussion happens with the commissioned service.
- Remind staff to behave in a professional manner when caring for women that reflects compassion and kindness.

Incident Reporting

During Q1-Q3 there were 222 incidents, of which <5 were reported as moderate. Any incident that is reported as moderate harm or above would also trigger the Duty of Candour.



Incident Themes (highest reported) Q1-Q3

- **Intrapartum transfers from Powys to Secondary care** – all intrapartum transfers are reviewed with an associated SBAR report or timeline when indicated, to highlight any learning or good practice to share with others. This is shared at clinical supervision sessions, via Greatex and at Midwifery Management Governance monthly meetings.

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- **Staffing escalation**- Amber and red escalations, which are usually due to short term staffing issues, are reported on a weekly basis. There have been no red escalations in Q3.
- **Safeguarding** - Any safeguarding concerns which require referral to Local Authority are also reported through DATIX to ensure appropriate escalation.

Intrapartum Transfers:
In Q1-Q3 2024 the transfer rate remains static between 19-20% of women who choose to birth in Powys. This includes some women who birth and are transferred in the postnatal period for clinical reasons relating to them or their baby.
Overall, 20% of Powys women birthing in a local midwifery led area.
Overall homebirth rate for Powys is 9% against the Welsh rate of 3.1% which is a great achievement and one we hope to increase over time.

Open incidents and levels of harm:
There are 14 open incidents in Maternity at the end of Q3 2024, all of which are overdue. These are reviewed with the Band 7 Team Leads in the bronze meetings and with the senior leadership team in weekly safety meetings to ensure appropriate investigation and review, acknowledging that some cases take longer to review than others, especially in relation to intrapartum transfers.

There are no incidents reported that have not been reviewed in the first instance to determine the initial level of harm.

Closing the loop and feedback to staff
Learning and good practice is cascaded in several ways to ensure accessibility for all staff. A governance themed supervision session is now embedded in the monthly midwifery Pan-Powys (shire) meetings for the midwifery staff to share learning that comes out from incidents or concerns. Posters are shared with staff monthly to disseminate incidental learning which has been identified during the review process. Learning is shared through the weekly brief, 7-minute briefings, and any immediate make safes identified are shared through email.

Learning is shared at the service wide monthly assurance meeting, and the actions required are tracked to ensure timely completion and closure.
Since November 2023 there has been the introduction of weekly drop in 'cwtch' sessions for all staff led jointly by the clinical supervisors and the consultant midwife. These focus on specific areas of learning or development such as assessing progress in labour and other clinical situations informed by case studies and events that have occurred. To date there has been a high level of engagement from staff. An example of learning at a Cwtch session is included in Appendix 2.

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The themes for learning and improvement during Q1-Q3 2024/25 include:

- **Antenatal Assessments** – When a woman presents to a birth centre a full antenatal assessment should be carried out to inform on going care plans.
- **Interpretation Services** – Midwives have been reminded that where English is not a woman's first language interpretation services should be offered, and family members should not be relied upon for this.
- **Emergency Proformas** – Midwives have been advised to ensure that they use the PROMPT (mandatory All Wales midwifery training programme) proforma for all cases of antepartum haemorrhage to prompt appropriate care and timely escalation.
- **Medical Devices** – Midwives have been advised to ensure devices are decontaminated and an accompanying certificate is provided prior to Avensys commencing any work to avoid unnecessary costs.
- **Communication** - Midwives have been advised that when calling a District General Hospital in an emergency, discussion should be with an obstetric colleague to support clinical decision making.

Outstanding Claims

There are <5 open claims.

Maternity service oversight

All previously reported mechanisms to ensure oversight of maternity services remain in place including:

- Leadership and management team 'check-in' meetings on a Monday and Friday which enable responsiveness to any issues around operational escalation and incidents.
- Weekly safety meeting to:
    - Monitor key data for maternity services including escalation, births, and Clinical Information Sharing (CIS) cases (women who choose to birth outside of guidelines).
    - Review progress of incident reviews through review of data obtained from Datix daily.
    - Confirm the method of investigation/review for cases including SBAR, Timeline, RCA/NRI.
    - Manage the progress of RCA reports for NRI's and escalate any issues.
    - Ensure concerns are dealt with in a timely manner.
    - Discuss themes and trends related to incidents and concerns.
    - Monitor peripartum transfer data
    - Consider any items for escalation
    - Discuss any family feedback received related to incidents.

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- Weekly Team Leader meeting (bronze) for escalation to the leadership and management team and dissemination to clinical staff of significant information. Meeting also offers opportunity to share new guidelines or policies.
- Review of the maternity improvement plan as a standard agenda item for week 1 of the monthly leadership and management meetings.
- Review of the incident learning actions as a standard agenda item for week 2 of the monthly leadership and management meetings.
- Monthly Women and Children's Quality & Performance Group where Quality & Safety paper is shared. This forum offers the opportunity to review themes and trends within W&C for incidents, concerns, patient experience, and audit.
- Day Assessment Unit (DAU) Pathway/Oversight Meeting to support monitoring of the ultrasound provision through maternity services.
- Monthly Maternity Matters meeting chaired by the Executive Director of Nursing, Quality, Women & Family Health, which has an established cycle of business for updating and reporting including a quarterly assurance report.

Patient safety round table meetings convened with Quality and Safety input when required as per the Maternity Assurance Framework.

Commissioning Update

Powys maternity services have quarterly commissioning meetings with the commissioned services seeking assurance for Powys residents. To keep up to date with any issues, the weekly safety tracker now reports any commissioning issues to be escalated within the quarterly meetings.

There are ongoing discussions with the commissioning team to see how this mechanism can be strengthened and included within the CQPRM structure.

Shropshire & Telford Hospitals (SaTH):

There is a clear pathway if need to escalate any issues. A shared agreement in place for Gap/Grow scanning which allows both organisations to view the growth chart. Nil to escalate.

Cwm Taf Morganwg University Health Board (CTM):

POW closed for 12 weeks from 1st September for maternity and neonatal due to urgent refurbishment. Patient flow to Cardiff, Aneurin Bevan and Swansea. No update on whether the closure will be longer than 12 weeks due to the recent flooding that occurred at the Princess of Wales Hospital Bridgend.
WVT have agreed to take Powys residents who are impacted by the increased patient flow through Prince Charles Hospital (PCH).

Aneurin Bevan UHB:

Nothing to escalate

Swansea Bay UHB:

Swansea have reopened Neath Port Talbot Birth Centre, no impact noted for Powys residents.

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An independent review of maternity services has been commissioned following concerns raised from over 70 families. We are not aware of any Powys families who have raised concerns or are included in the review currently.

Hywel Dda UHB:
Director of Midwifery post has been filled and the post holder has commenced in post, an interim structure remains for the Head of Midwifery.

Betsi Cadwaladr UHB:
Nothing to escalate

Wye Valley NHS Trust:
Agreement with Hereford to accept Powys women who wish to move from Cwm Taf. Women are encouraged to attend WVT during pregnancy for review if required or orientation to the unit. Birth centre promotion of this offer to women who are booked with Cwm Taf in the next 12-16 weeks.

Learning from service users and feedback

Patient Story

All women who transfer from Powys in the peripartum period are directly contacted and asked if they would like to feedback on their experiences. This mechanism for feedback has been valuable to gain first-hand information from Powys residents who decide to birth in one of the birth centres or at home. This can be shared on social media within Bumptalk (maternity services page) and we offer a link to give the women an opportunity to share on their own page

The service is also proactively reaching out to families who have had their baby in Powys to ask them to feedback and consider writing a birth story to be shared with the team and via social media. This was launched in January 2024, and there have been 11 stories shared so far. Annex 1 is an example of the feedback from women and families.

Feedback from Civica

Civica is now able to offer families the opportunity to feedback to the maternity service. QR codes are being shared with families and placed in clinical settings.

The service has commenced automatic texting of surveys as specific points in the maternity journey. There are 5 surveys in use for women to complete and 1 for partners to use too which have been in use since May 2023.

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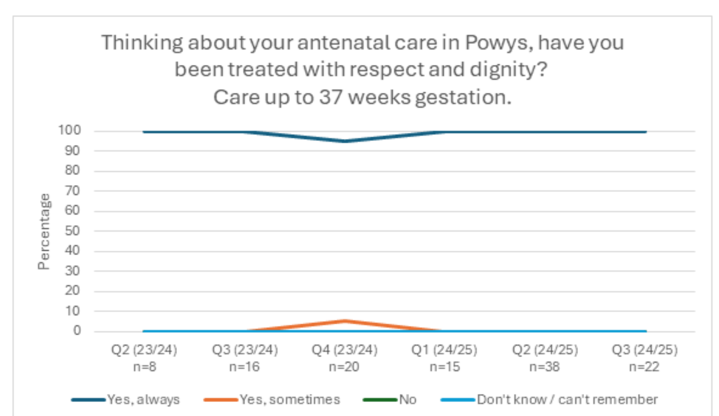
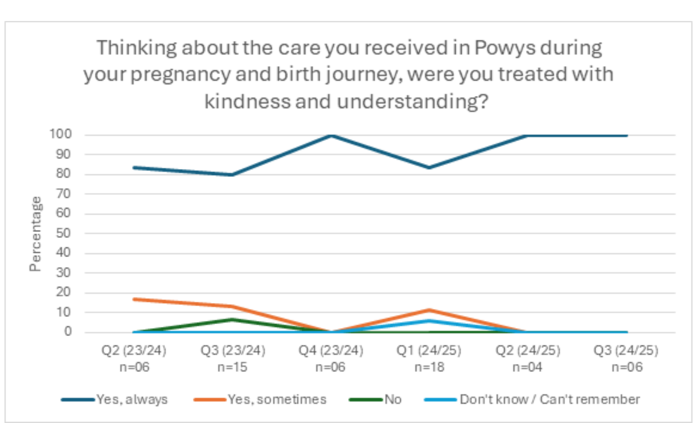
Powys maternity service will be one of the pilot sites for the implementation of the National feedback for maternity and neonatal services. This will result in some minor changes to the local surveys, but this will enable direct reporting into the national dashboard for certain questions to enable comparison across Wales. The service has also linked locally with CIVICA and the Powys dashboard development team to explore all

surveys responses being available for review through the local dashboard enabling easier monitoring of trends in feedback.

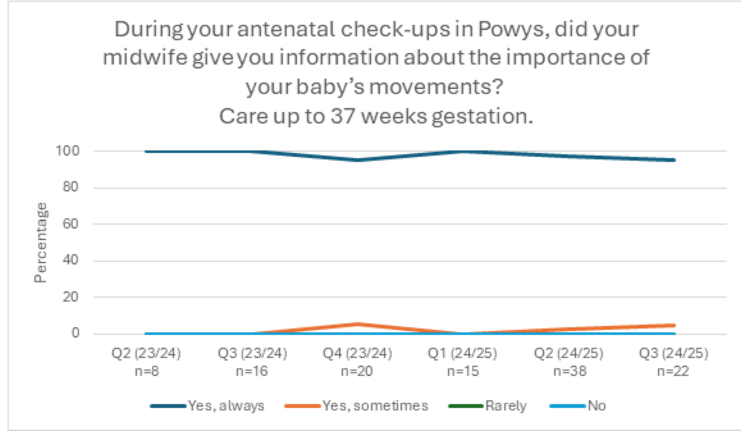
The feedback is analysed monthly to ensure learning and quality improvement. Interpretation of the data should be done cautiously due to the sparsity of respondents in some quarters. Feedback varies in quantity, and you can see in the feedback below that on two of the slides, Q3 had 22 responses and one of the surveys had 6 responses so it must be acknowledged that smaller numbers can alter the data significantly.

Below is a sample, further examples of survey responses can be found in Appendix 1.





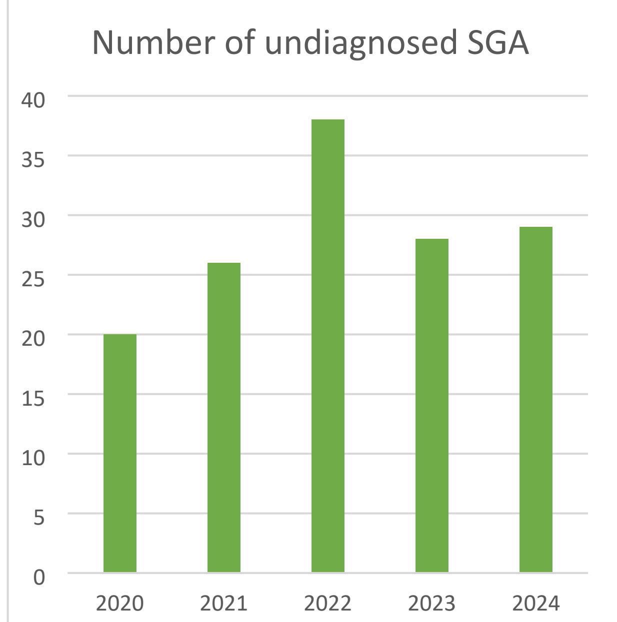
The feedback above shows that midwives work hard to uphold health board values.



A theme was identified where several women reported altered fetal movements after experiencing a stillbirth.
A campaign to remind women about the importance of fetal movements was launched and the responses to this survey question demonstrate that most women agree they were given information about the importance of reporting altered fetal movements. The message on the importance of discussing fetal movements at all antenatal contacts is reiterated to midwives at learning events to further strengthen this critical message.

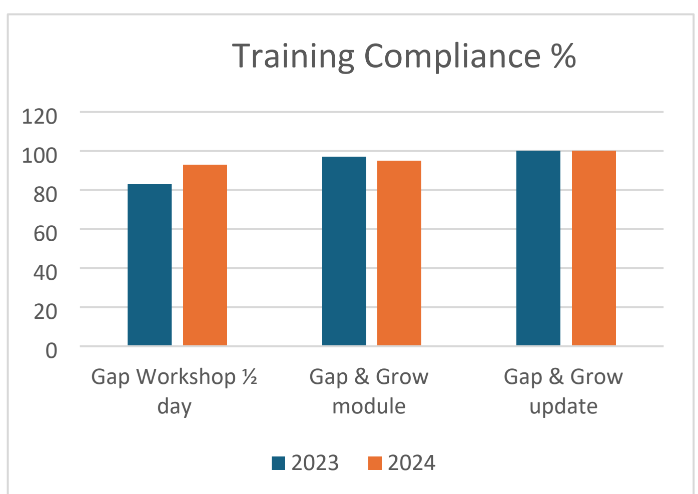
Perinatal Institute (PI) GAP/GROW Compliance

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



- Consistent auditing of undiagnosed small for gestational age (SGA) babies born under Powys over 5year period. (see table above). These are babies that have received all their ultrasound scans (USS) or symphysis fundal height (SFH) measurements completed in Powys.
- No taxonomies noted on the Gap score system. All cases that are identified as more than 15% error margin have an image audit completed by our Governance lead. Any untoward measurements can be reported, of which there are zero.
- Currently working between GROW 1.5 and Grow 2.0 resulting in requirement to use 2 systems. This is impacting the ability to give a true picture of our submitted data and compliance currently.

GROW Training



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- A rolling training programme is in place.
- Comprising of
  - Biannual half-day session with the Perinatal Institute 93% (n=41 from 44)
  - Annual online learning for GAP/GROW through E-Learning for Health (E-LfH). 95% (n=42 from 44)

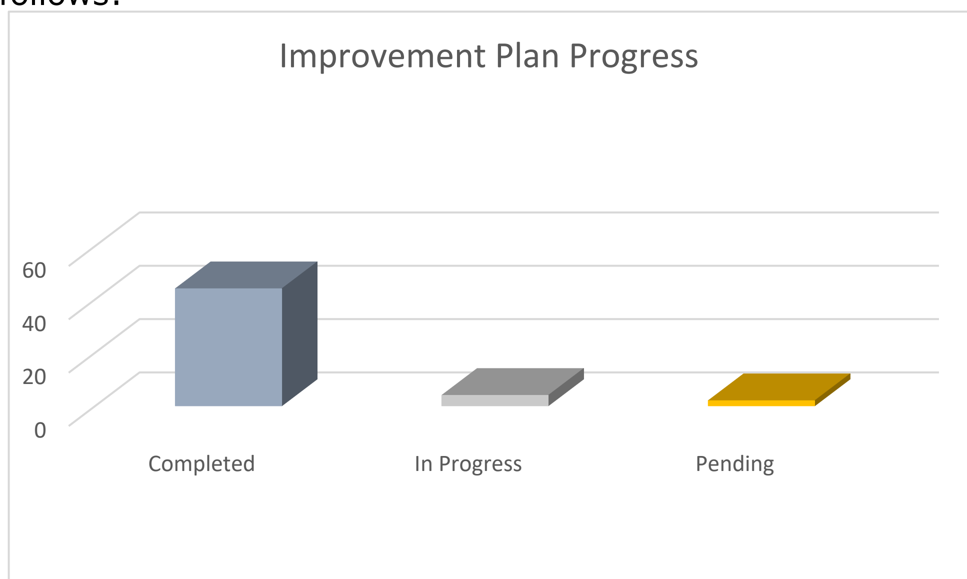
- The training database is reviewed monthly through the leadership and management meetings, and email reminders are sent to staff who are going to go out of compliance. The Team leads are sighted in this email. Compliance is also discussed at Team Lead monthly meetings. This is being followed by the Assistant Head of Midwifery (AHoM) and Clinical Supervisor for Midwives (CSfM).

Maternity Improvement Plan

The Maternity continuous improvement plan is in place and a progress report against the improvement plan is monitored via maternity matters. New actions are added as required based on learning and national drivers. There are five key components of the plan:

- Quality and Safety
- Leadership and Culture
- Clinical Excellence
- Finance and Workforce
- Maternity and neonatal (MATNEO) Safety Support Programmes National Recommendations

The improvement plan was initiated with 50 outstanding actions and to date we have completed as follows:



Since the last update in April 2024, work has progressed against several actions including:

- Monthly review on progress with maternity guidelines.
- Band 7 team lead development support with 4 sessions held to date. These sessions are now for all staff in the leadership/senior team and have included organisational development support, exploration of culture as well as sessions including roster and sickness management and incident management.
- Maternity telephone triage service to be extended to cover overnight period too.
- Review of pathway for women to access their midwife following feedback from women they found it frustrating going via switchboard.
- Powys Maternity services dashboard now in use (links with national recommendations of MATNEO report)

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- Bronze accreditation for the work done on equality, diversity and inclusion (EDI)
- EDI training for all midwives from Diverse Cymru
- Online sessions for women who are considering birth in Powys
- Working with Powys retention working party trialling self-rostering across the service.

Future actions requiring progress include:

- Re-establishing the maternity and neonatal voices partnership (MNVP). Powys maternity services now have a lay representative who is actively involved in work within the maternity service. There continues to be work Wales wide considering the future of service user engagement as a whole and this will feature the function of MNVP.

One item on the improvement plan was rated as 'red' in March 2024. This is the workforce review, and this work has been paused while an interim senior management team are in place. The health board is currently advertising for a Director of Midwifery, Women & Family which will be the start of substantive posts, offering security in the management structure.

The maternity and neonatal safety support programme continues until April 2025 when the structure will change. The workforce structure from April is currently unconfirmed and under consideration with NHS Executive to agree the way forward. The current key pieces of work that have been delivered in Powys including:

- Implementation of Maternity Early Warning Score (MEWS) and community escalation. Powys are part of a national piece of work looking at the implementation of the National English MEWS tool for use in out of hospital settings.
- Implementation of NEWTT2 (risk assessment for unwell neonate) to assist in recognition of deterioration in neonates.
- ATAIN (Avoiding term admissions in neonatal units) is business as usual. Powys will be involved in a round table with the neonatal team if there are any cases to report. Currently there are none.
- Evaluation of maternity triage 9-5 Monday to Friday where findings were shared widely with staff. The success of triage has led to the extension of the service to cover overnight Monday-Friday.
- Leading on the equality, diversity and inclusion work which led to bronze accreditation for cultural competency from Diverse Cymru.
- Leading the dashboard development in Powys in partnership with the digital team which has led to a successful maternity dashboard.

Next Steps

- The Committee can be assured that the business-as-usual mechanisms have continued and are planned throughout the year to ensure continuity of the meetings, reporting, and learning that takes place.
- The business-as-usual mechanisms include the Monthly Maternity Matters meeting, chaired by the Executive Director of Nursing, Quality, Women & Family Health.

Paterson,Liz
08/02/2025 10:35:05

Appendices
5.3a - Annex 1: Birth story
5.3b - Appendix 1: Civica Feedback
5.3c - Appendix 2: Cwtch documentation

POWYS HOME BIRTH

6TH JUNE 2024 - 05:25

MIDWIFE: JAMES

OUR BIRTH IN POWYS

Patterson,Liz 06/02/2025 ...5:05

LISA, CALLUM
&
BABY
MADILYN-MAE

At 42 weeks pregnant, with no signs of Baby's arrival, we remained determined to have a water birth at home and avoid unnecessary interventions. Our dedicated midwife, James, guided us with information to help us make informed choices, never pressuring us but always supporting us alongside the team at Newtown birthing centre.

Despite facing challenges, such as a pediatrician insisting on a hospital visit for a scan, which we declined, James went the extra mile to ensure our needs were met. Thanks to his persistence, we were able to have the scan at Newtown and confirm our baby's health. The next day, labor finally began (42+2) and James and the midwives supported us, allowing us to labor comfortably at home, making decisions that felt right for us.

In the early hours, our daughter Madilyn made her entrance into the world, bringing us indescribable joy and gratitude. We will forever be thankful to the incredible midwives, especially James, for their unwavering support and care throughout this journey. This experience has shown us the importance of choice and the beauty of welcoming new life into the world on our terms. Our hearts are full of gratitude

Patterson,Liz
06/02/2025 10:35:05

We are delighted that we stayed committed to our decision to have our baby at home. Our pregnancy was healthy and worry-free, with no concerns about the baby's movements. The idea of going to the hospital would have caused us unnecessary stress and anxiety. Even though it was new territory for us, having the support of our midwife was reassuring. Additionally, reading about others' experiences and seeking support from online groups played a crucial role in helping us achieve the birthing experience we had always envisioned.

We wanted to have control over how our baby would be born, and our midwives supported us in making decisions even when we went past 42 weeks. They didn't pressure us, which made us feel comfortable and special during labor and delivery, surrounded by familiar faces who had been there for us throughout.

The most unforgettable moment was when our daughter was born at home in the water, creating the most special experience.

Patterson,Liz
06/02/2025 10:35:05

LISA , CALLUM
&
BABY
MADILYN-MAE

Patterson,Liz 06/02/2025

Yn 42 wythnos yn feichiog, heb unrhyw arwyddion o'r babi yn cyrraedd, roeddem yn benderfynol o gael genedigaeth ddŵr gartref ac osgoi ymyriadau diangen. Bu ein bydwraig ymroddedig, James, yn ein harwain gyda gwybodaeth i'n helpu gwneud dewisiadau gwybodus, byth yn rhoi pwysau arnom, ond bob amser yn ein cefnogi ochr yn ochr â'r tîm yng nghanolfan geni'r Drenewydd.

Er gwaethaf wynebu heriau, fel pediatregydd yn mynnu ymweliad i'r ysbyty am sgan, a wnaethom wrthod, aeth James y filltir ychwanegol i sicrhau bod ein hanghenion yn cael eu diwallu. Diolch i'w ddyfalbarhad, roeddem yn gallu cael y sgan yn Y Drenewydd a chadarnhau iechyd ein babi. Y diwrnod canlynol, dechreuodd yr enedigaeth o'r diwedd (42+2) a bu James a'r bydwragedd yn ein cefnogi, gan ganiatáu i ni eni'r babi yn gyfforddus gartref, gan wneud penderfyniadau a oedd yn teimlo'n iawn i ni.

Yn yr oriau mân, croesawon ein merch Madilyn i'r byd, gan ddod â llawenydd a diolchgarwch annisgrifiadwy i ni. Byddwn yn ddiolchgar am byth i'r bydwragedd anhygoel, yn enwedig James, am eu cefnogaeth a'u gofal diwyro trwy gydol y daith hon. Mae'r profiad hwn wedi dangos i ni bwysigrwydd dewis a'r harddwch o groesawu bywyd newydd i'r byd ar ein telerau ni. Mae ein calonnau'n llawn diolchgarwch

Patterson,Liz
06/02/2025 10:35:05

Rydym wrth ein bodd ein bod wedi cadw at ein penderfyniad i gael ein babi gartref. Roedd ein beichiogrwydd yn iach ac yn ddi-bryder, heb unrhyw bryderon am symudiadau'r babi. Byddai'r syniad o fynd i'r ysbyty wedi achosi straen a gorbryder diangen i ni. Er ei fod yn brofiad newydd i ni, roedd cael cefnogaeth ein bydwraig yn gysur. Yn ogystal, roedd darllen am brofiadau pobl eraill a cheisio cefnogaeth gan grwpiau ar-lein yn chwarae rhan hanfodol wrth ein helpu ni sicrhau'r profiad geni yr oeddem o hyd wedi dychmygu.

Roeddem am gael rheolaeth dros sut y byddai ein babi'n cael ei eni, ac roedd ein bydwragedd yn ein cefnogi i wneud penderfyniadau hyd yn oed pan aethom heibio 42 wythnos. Doedden nhw ddim yn rhoi pwysau arnom, a oedd yn gwneud i ni deimlo'n gyfforddus ac yn arbennig yn ystod yr enedigaeth, gyda wynebau cyfarwydd o'n cwmpas a oedd wedi bod yno i ni drwyddi draw.

Y foment fwyaf cofiadwy oedd pan gaf
odd ein merch ei geni gartref yn y dŵr, gan greu'r profiad mwyaf arbennig.

Patterson,Liz
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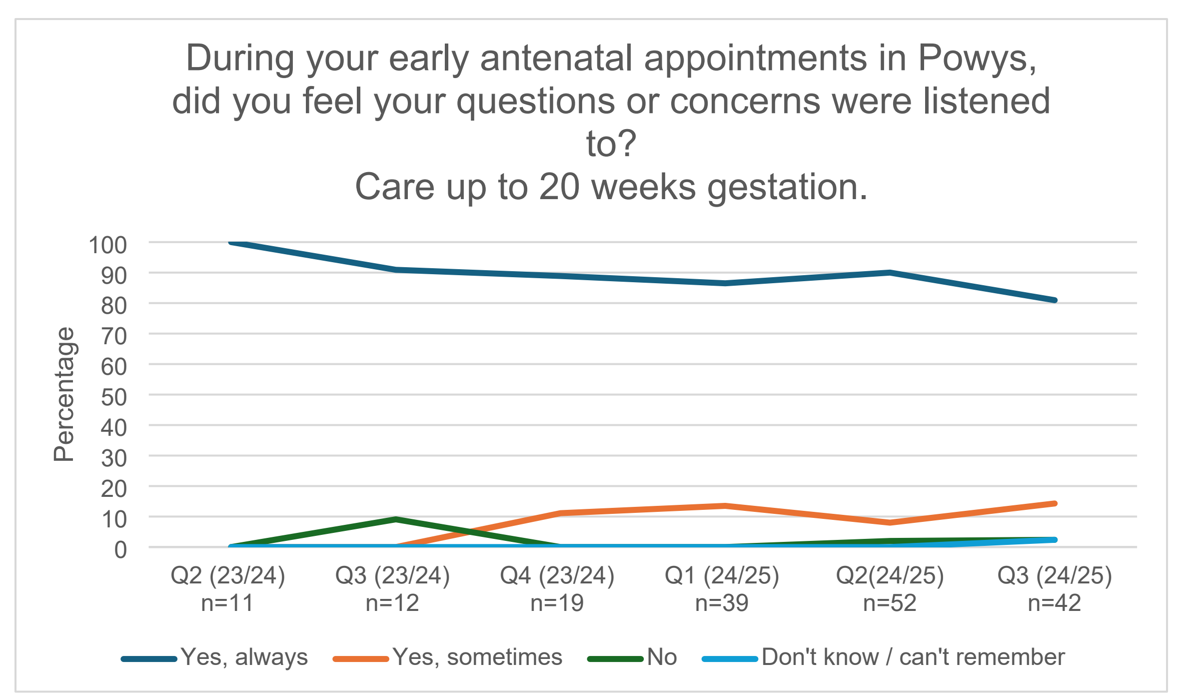
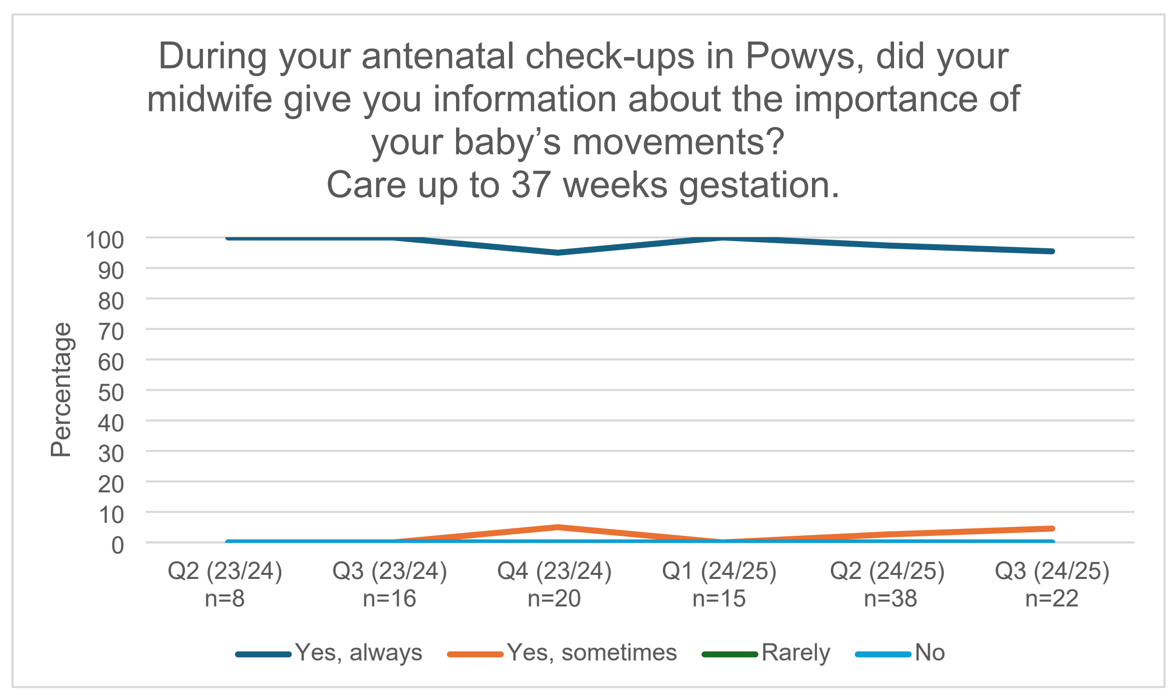
LISA , CALLUM
A
BABI
MADILYN-MAE





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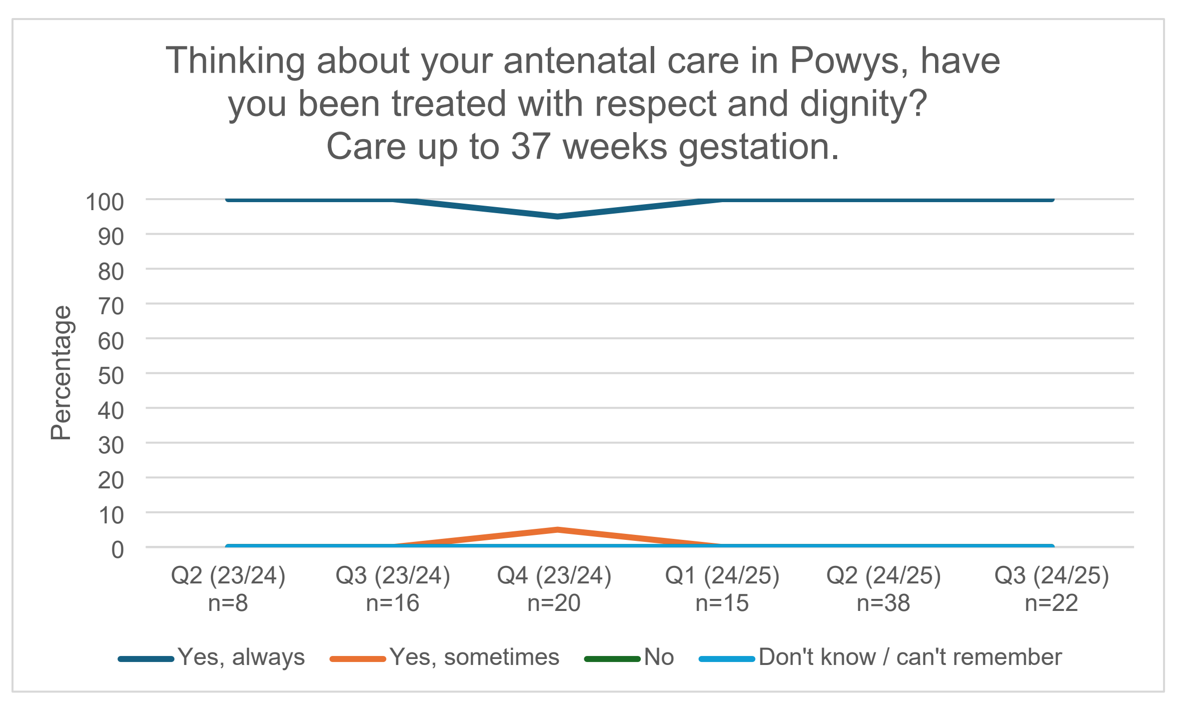

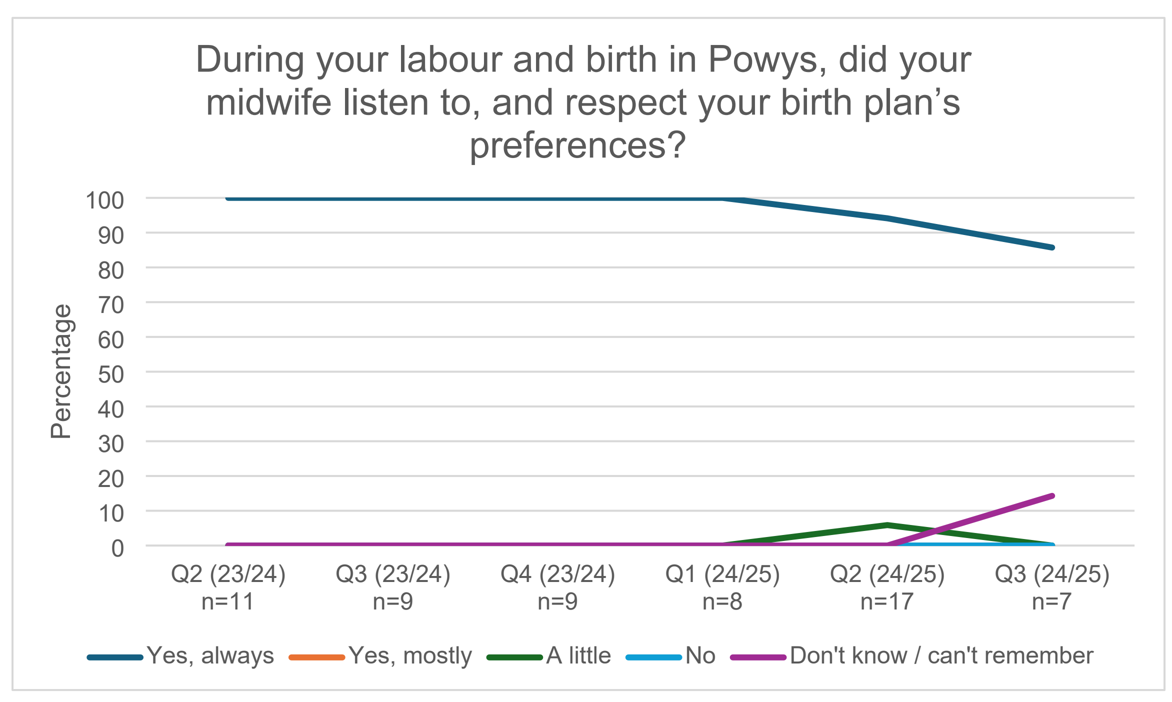

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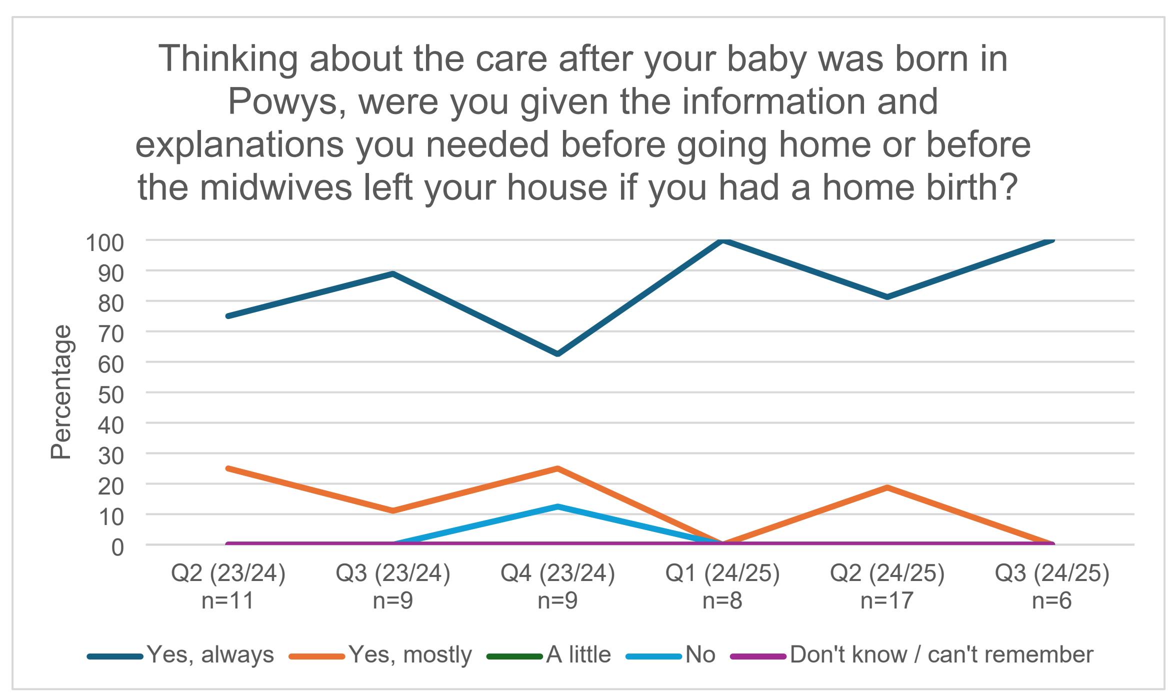
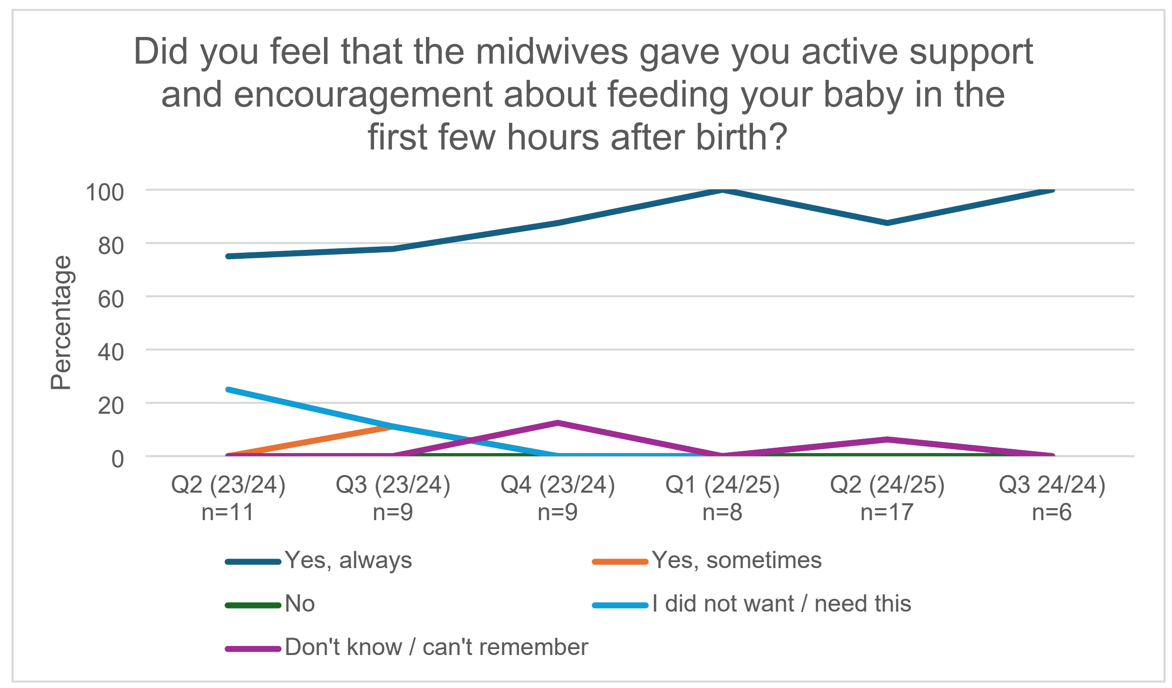

Thinking about the care after your baby was born in Powys, were you given the information and explanations you needed before going home or before the midwives left your house if you had a home birth?
Percentage
100
90
80
70
60
50
40
30
20
10
0
Q2 (23/24) n=11
Q3 (23/24) n=9
Q4 (23/24) n=9
Q1 (24/25) n=8
Q2 (24/25) n=17
Q3 (24/25) n=6
Yes, always
Yes, mostly
A little
No
Don't know / can't remember


Did you feel that the midwives gave you active support and encouragement about feeding your baby in the first few hours after birth?
Percentage
100
80
60
40
20
0
Q2 (23/24) n=11
Q3 (23/24) n=9
Q4 (23/24) n=9
Q1 (24/25) n=8
Q2 (24/25) n=17
Q3 24/24) n=6
Yes, always
Yes, sometimes
No
I did not want / need this
Don't know / can't remember

Patterson,Liz
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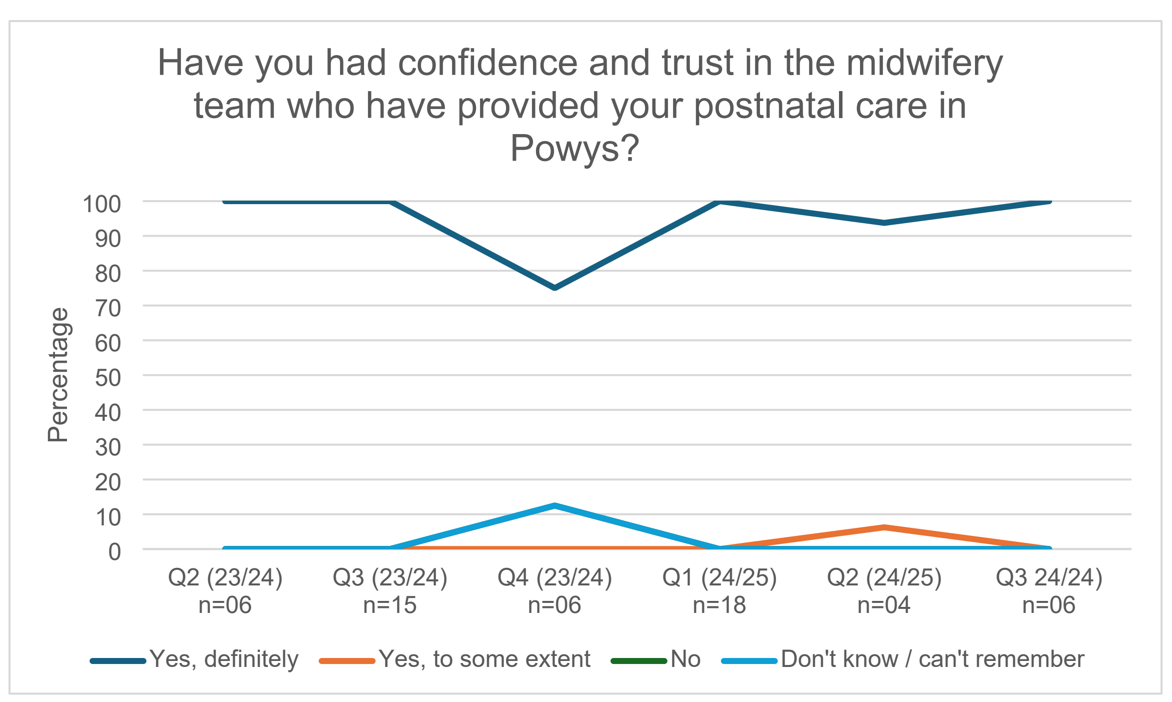
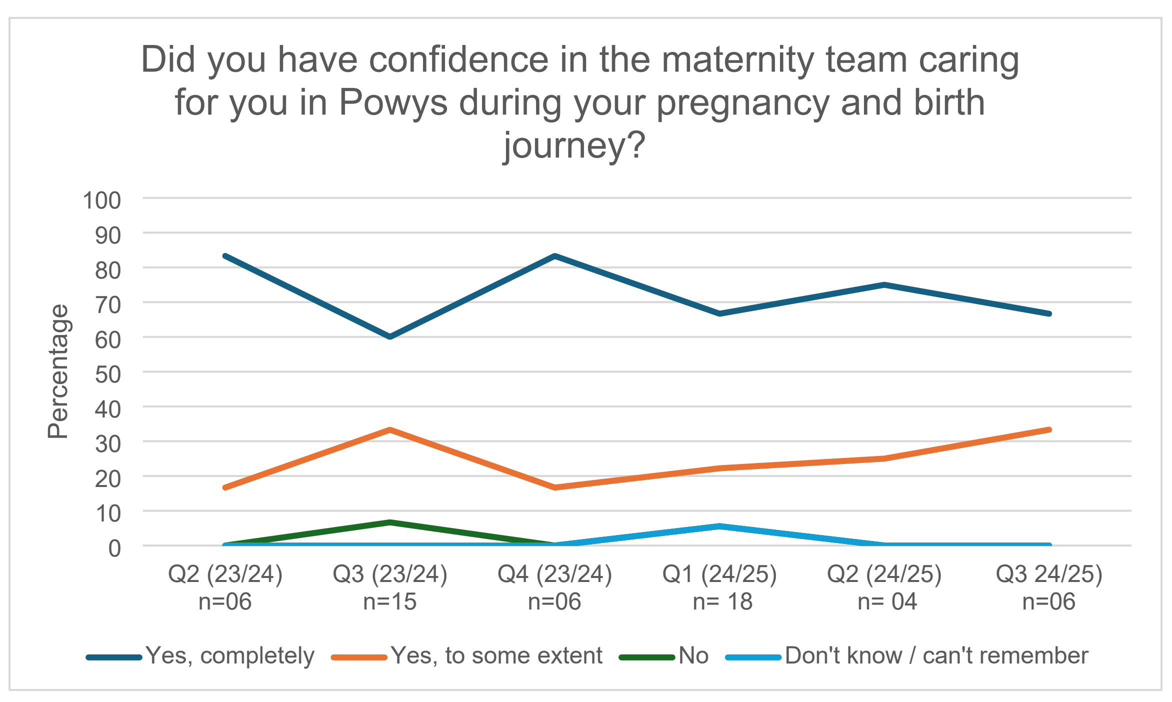

Have you had confidence and trust in the midwifery team who have provided your postnatal care in Powys?
Percentage
100
90
80
70
60
50
40
30
20
10
0
Q2 (23/24) n=06
Q3 (23/24) n=15
Q4 (23/24) n=06
Q1 (24/25) n=18
Q2 (24/25) n=04
Q3 24/24) n=06
Yes, definitely
Yes, to some extent
No
Don't know / can't remember


Did you have confidence in the maternity team caring for you in Powys during your pregnancy and birth journey?
Percentage
100
90
80
70
60
50
40
30
20
10
0
Q2 (23/24) n=06
Q3 (23/24) n=15
Q4 (23/24) n=06
Q1 (24/25) n= 18
Q2 (24/25) n= 04
Q3 24/25) n=06
Yes, completely
Yes, to some extent
No
Don't know / can't remember

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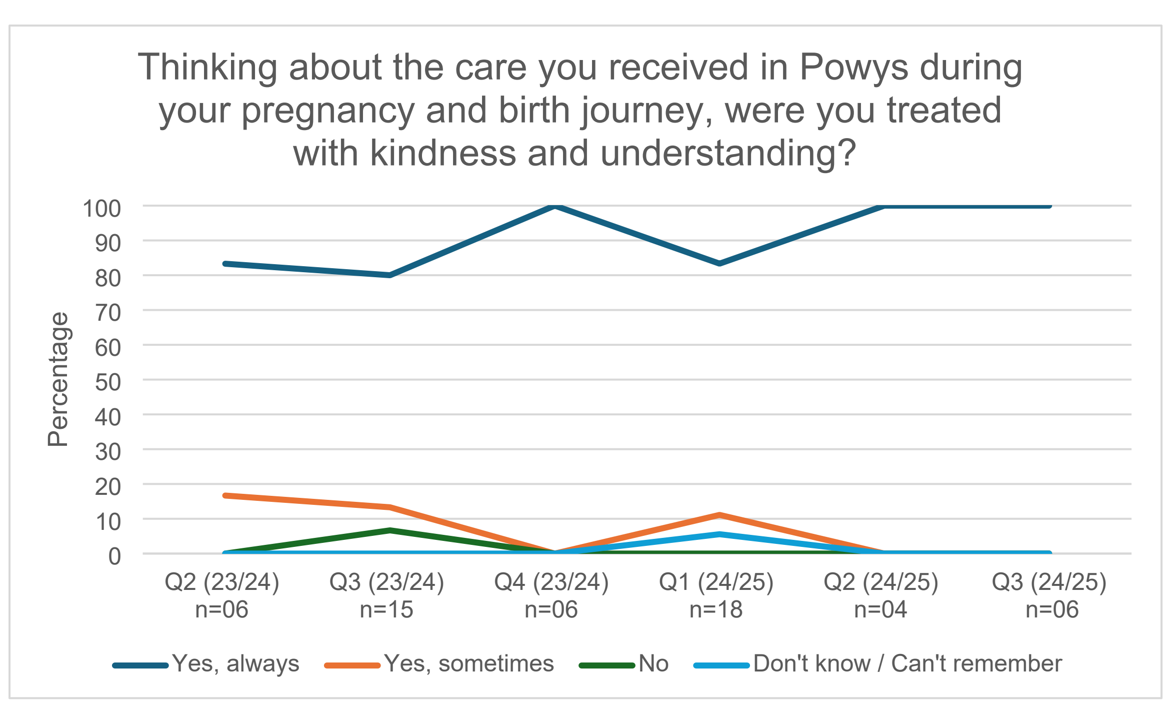

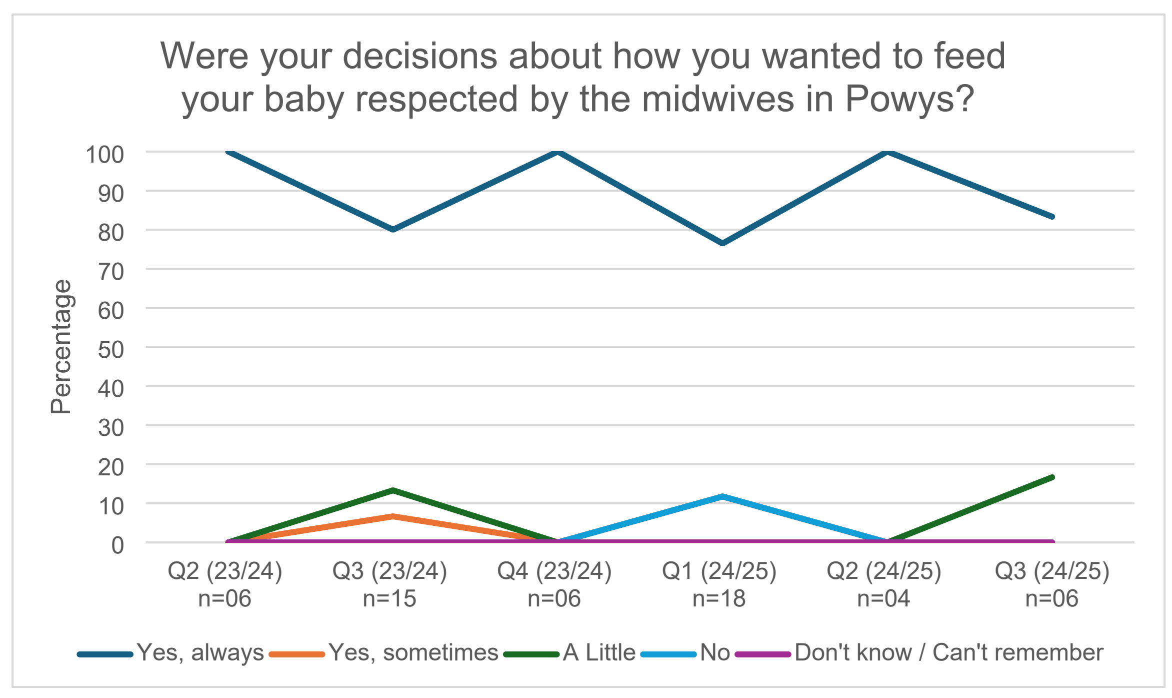

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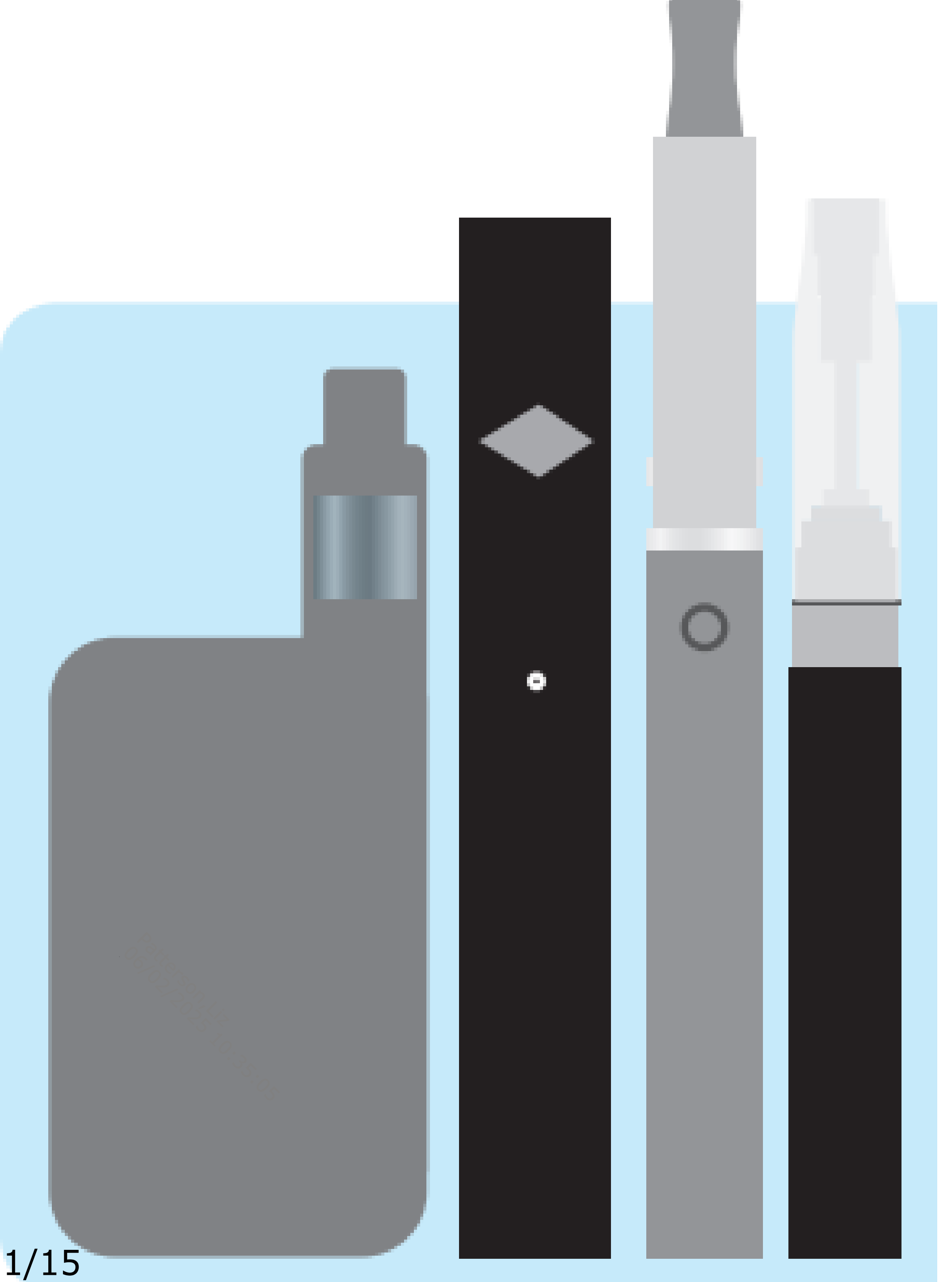

Vaping in Pregnancy

Evie (CSfM) and Shelly (Consultant Midwife)

What is Vaping?

E-cigarettes, also called vapes, are designed for users to inhale nicotine through a vapour rather than smoke. They work by heating a solution that typically contains nicotine, propylene glycol and/ or vegetable glycerine, and flavourings.

E-cigarettes are not risk free; however, they carry a small fraction of the risk of smoking. Based on the available evidence, experts have estimated that vaping is at least 95% less harmful to health than smoking, a figure endorsed by Public Health England.

Patterson,Liz
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Vaping in Pregnancy - Research

Evidence shows that e-cigarettes are effective at helping people quit smoking

Based on the available evidence on e-cigarette safety there is no reason to believe that using an e-cigarette would compromise breastfeeding

There is currently no evidence of harm to bystanders from exposure to e-cigarette vapour and any risks are likely to be extremely low

E-cigarettes do not contain carbon monoxide (CO) or many of the other harmful chemicals found in cigarettes

2019-Challenge-Group-ecigs-briefing-FINAL.pdf

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Vaping in Pregnancy- Research

A major UK clinical trial published in January 2019 found e-cigarettes, when combined with expert face-to-face support are up to twice as effective for quitting smoking as other nicotine replacement products such as patches or gum

While it is nicotine that makes tobacco so addictive, it is relatively harmless on its own and is significantly less addictive when delivered though nicotine replacement products such as patches, gum and inhalers

Patterson, Liz
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Vaping in Pregnancy Research

Systematic reviews and meta-analyses conclude that there is unclear evidence on whether the use of NRT during pregnancy is harmful to the fetus

A challenge with research establishing health consequences of vaping in pregnancy is that most vapers are former or current smokers and in the studies reporting risks of vaping it is not clear whether the harms were caused by smoking

While more studies found no evidence of increased risk of exclusive-vaping compared with non-use and evidence of comparable risk for exclusive-vaping and exclusive-smoking, the quality of the evidence limits conclusions

Vaping during pregnancy: a systematic review of health outcomes | BMC Pregnancy and Childbirth | Full Text

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Vaping and VTE risk

The Public Health Team have reviewed Reducing the Risk of Thrombosis and Embolism during Pregnancy and the Puerperium (Green-top Guideline No. 37a) | RCOG and recognised that smoking is referenced (without indication of amount) and no reference to vaping. They have interpreted this as any level of smoking is a potential risk for VTE during pregnancy and that evidence is currently insufficient to include vaping as a risk factor within this guideline.

Patterson,Liz
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Vaping Advice

Patterson,Liz
06/02/2025 10:35:05

It is recognised that stopping smoking is one of the best things a pregnant person can do to protect the health of their baby through pregnancy and beyond. While licensed nicotine replacement (NRT) products are the recommended option, if a pregnant person chooses to use an e-cigarette to help quit smoking and stay smokefree, they should be supported to do so.

CO monitoring is key

FOR NON-SMOKERS – CO READING AT BOOKING AND 36 WEEKS

CO READING AT EVERY APPOINTMENT

- SMOKER
- E-CIGARETTES OR VAPING
- ON NICOTINE REPLACEMENT THERAPY (NRT)
- QUITTING SMOKING OR RECENTLY QUIT (WITHIN LAST 2 WEEKS)
- C0 ≥ 4 AT FIRST BOOKING APPT

Patterson,Liz
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All Wales - Small for Gestational Age and Fetal Growth Restricted Babies – Antenatal Management

Vaping and USS in pregnancy

Guideline is up for review Sept 24

Patterson, Liz 06/02/2025 10:35:05

Major Risk Factors

Personal

- Maternal age equals or more than 40 years
- Smoker (Any)
- Cocaine use or drug misuse
- Maternal BMI at booking <18

Past History

- Previous SGA (Birth weight < 10th centile)
- Previous stillbirth
- Previous pre-eclampsia resulting in birth before 34 weeks of gestation
- Previous pre-eclampsia

Current Pregnancy factors

- Low serum PAPP-A (<0.415 MoM) in first trimester
- Chronic hypertension
- Cyanotic Heart disease
- Diabetes and vascular disease
- Renal disease
- Anti-phospholipid syndrome or Systemic Lupus Erythematosus
- Heavy bleeding (like menstrual period) or recurrent vaginal bleeding in first trimester
- Significant bleed in pregnancy
- Women with large or multiple uterine fibroid which leads to clinically significant distortion of size or shape of uterus
- Maternal BMI > 35.
- Echogenic fetal bowel

Investigation and Care of a Small-for-Gestational-Age Fetus and a Growth Restricted Fetus (Green-top Guideline No. 31)

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- Evidence from an RCT where women who smoked in pregnancy were randomised to e-cigarettes or NRT found that e-cigarettes were more effective than NRT for smoking cessation and the infants born to women in the e-cigarette group were less likely to be of LBW than those randomised to NRT
- **Women who use e-cigarettes or NRT who have carbon monoxide test > 4 ppm should be offered the serial growth scans pathway as for smokers.**

Serial growth USS Referral

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Serial growth scans should be offered for:

- Any Smoking
- Vaping CO ≥ 4ppm
- NRT CO ≥ 4ppm
- Recently quit smoking (within the last 2 weeks) CO ≥ 4ppm

If any of the above is detected within the 3rd trimester, a referral for serial growth USS should be completed and **scan completed within 72 hours**

Change to Guidelines

If the woman has commenced serial scans for vaping, they should continue on the serial scan pathway

If the woman has not yet commenced serial scans (under 28 weeks), they should be offered SFH measurements and CO monitoring at every appointment

Named midwives will need to have a discussion with women who have already been offered serial scans, but have not commenced the pathway to explain the change in guidance

Patterson,Liz
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CO Levels – [NHS England » Saving babies' lives: version 3]

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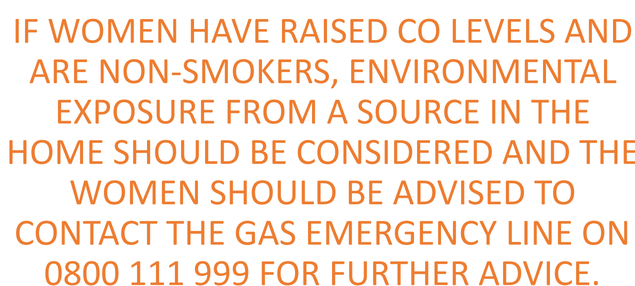

IF WOMEN HAVE RAISED CO LEVELS AND ARE NON-SMOKERS, ENVIRONMENTAL EXPOSURE FROM A SOURCE IN THE HOME SHOULD BE CONSIDERED AND THE WOMEN SHOULD BE ADVISED TO CONTACT THE GAS EMERGENCY LINE ON 0800 111 999 FOR FURTHER ADVICE.

REFERRAL FOR FURTHER MEDICAL ADVICE SHOULD BE SOUGHT IF SYMPTOMS ARE CONSISTENT WITH CO POISONING.

Take home message

E-cigarettes/Vaping does not increase the risk of a VTE

CO monitoring is required at every appt for smoking, vaping (E-Cigarettes), nicotine replacement therapy (NRT), quitting smoking or recently quit in last 2 week

Serial growth scans should be offered for:

Any Smoking

Vaping CO ≥ 4ppm

NRT CO ≥ 4ppm

Recently quit smoking CO ≥ 4ppm

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Resources

- rcm-position-statement-support-to-quit-smoking-in-pregnancy.pdf
- Investigation and Care of a Small-for-Gestational-Age Fetus and a Growth Restricted Fetus (Green-top Guideline No. 31)
- Saving-Babies-Lives-Care-Bundle-Version-Two-Updated-Final-Version.pdf
- NHS England » Saving babies' lives: version 3

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Agenda item: 5.4

Patient Experience, Quality and Safety Committee	11 February 2025
Subject:	Mental Health Act Compliance Report for the 12 month period : 1 January to 31 March 2024 (Q1) 1 April to 30 June 2024 (Q2) 1 July to 30 September 2024 (Q3) 1 October to 31 December 2024 (Q4)
Approved and presented by:	Elaine Lorton, Executive Director of Primary, Community Care and Mental Health and Learning Disabilities
Prepared by:	Acting Asst Dir Mental Health and Learning Disabilities Mental Health Act Administrator
Other Committees and meetings considered at:	Executive Committee – 5 February 2025

PURPOSE:

The purpose of this paper is to assure the committee that Powys Teaching Health Board is compliant with the legal duties under the Mental Health Act 1983 (MHA).

RECOMMENDATION(S):

That the committee:

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

Approve/Take Assurance	Discuss	Note
Y	Y	N

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:	
1. Focus on Wellbeing	Y
2. Provide Early Help and Support	N
3. Tackle the Big Four	Y
4. Enable Joined up Care	N

Patterson,Liz
06/02/2025 10:35:05

5. Develop Workforce Futures	N	
6. Promote Innovative Environments	N	
7. Put Digital First	N	
8. Transforming in Partnership	N	

Patterson,Liz
06/02/2025 10:35:05

EXECUTIVE SUMMARY:
This report seeks to provide assurance that the services delivered, and Mental Health Act requirements, have been discharged by the Mental Health and Learning Disabilities service group during the reporting period in compliance with the Mental Health Act (1983, as amended 2007). This includes functions of the Mental Health Act which have been delegated to officers and staff under the policy for Hospital Managers' Scheme of Delegation are being carried out correctly and that the wider operation of the Act across the Health Board area is operating within the legislative framework.

HEADING:

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

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

Mental Health Act, 1983 - Data Collection and Exception Reporting

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

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

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

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

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

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

	2023 (12 months)	2024 (12 months)
Sec 5 (4)	**8**	**6**
Sec 5 (2)	**19**	**15**

The use of both Section 5(4) and Section 5(2) powers has fluctuated over the last three years and the service will continue to monitor the use of s5(2) powers closely during 2025/26.

ii) Section 2 – Admission for Assessment

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

Section 2 was used on 96 occasions during this 12-month period. The majority of patients reverted to voluntary status following this period of detention under the Act. For the same period last year, section 2 was used on a total of 106 occasions.

The number of patients detained on Section 2 has remained high since the Covid 19 pandemic.

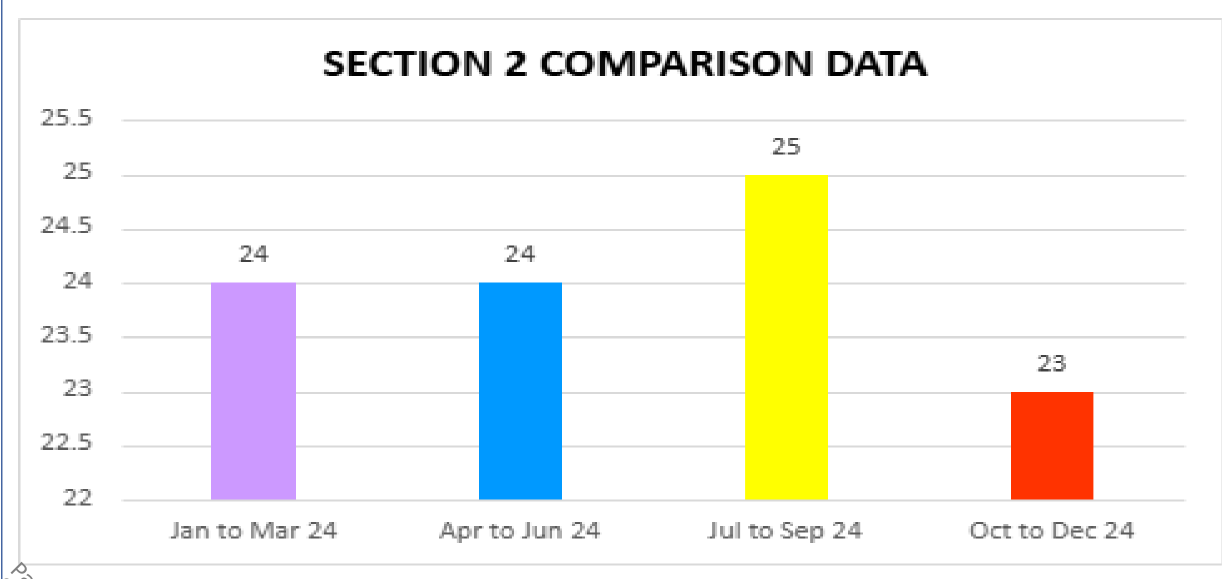

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Table 1: Use of Section 2 over the last 12-month period

iii) Section 3 – Admission for Treatment

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

During this 12-month period section 3 was used on 41 occasions.
For the same period last year, section 3 was used on a total of 43 occasions.

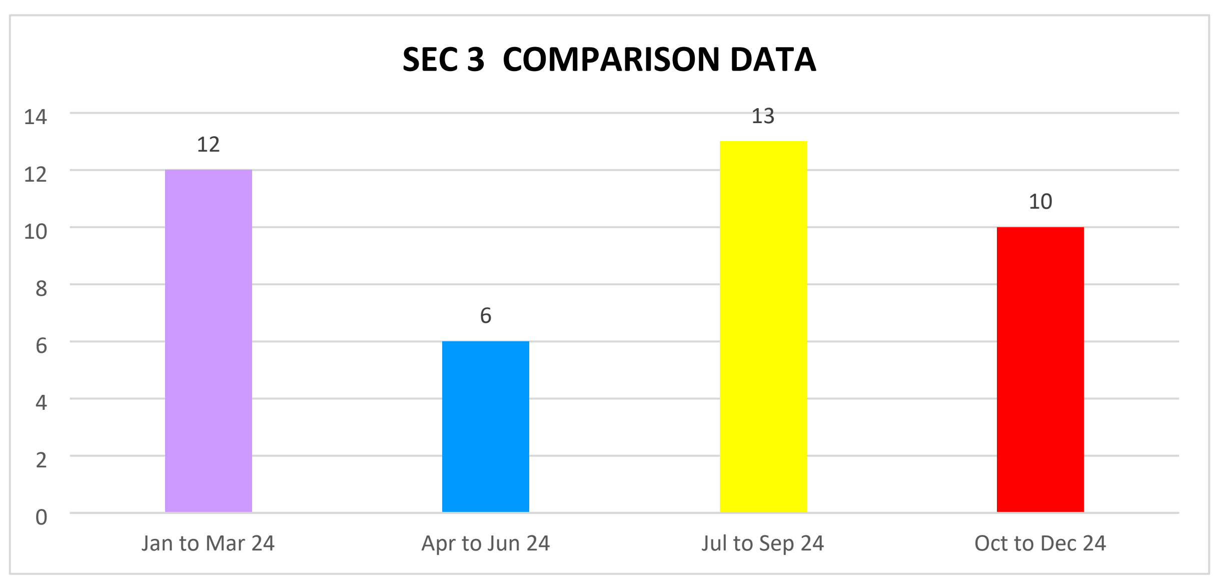

Table 2: Use of Section 3 over the last 12 month period

iv) Section 4 – Emergency Admission for Assessment

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

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An alternative section is preferred (if at all possible) as best practice would involve two medical opinions. Section 4 (up to 72 hours holding power) should only be used to avoid an unacceptable delay and as such is infrequently used. If it is likely that the patient requires detention past 72 hours, a new Mental Health Act assessment must be undertaken (with two Doctors). This section is specifically examined by Mental Health Act Managers when it is applied. Section 4 was used less than 5 times during this 12-month period. For the same period last year, section 4 was used on a total of less than 5 occasions. Whilst there have been concerns expressed in the past about AMHP's being able to access Section 12 approved Doctors the low number of Section 4's suggests this is being managed well.

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

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

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

In PTHB, there were 15 community treatment orders (CTO) in place as at 31 December 2024. CTO activity during the 12-month period 1 January 2024 to 31 December 2024 includes 8 new CTO's; 2 were recalls/revocations: 12 CTO's were renewed and 3 patients were discharged from their CTO. By comparison on 31 December 2023 there were 13 community treatment orders in place.

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

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

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Section 136 was used on 25 occasions during the twelve-month period 1 January 2024 to 31 December 2024. During the reporting period under half (12) of those assessed resulted in the admission or further detention of the person. The number of assessments undertaken under s136 powers, was a little higher than in the previous 12-month period when it was used on a total of 22 occasions (over the last five years an average of twenty two s136 assessments undertaken per year), however all assessments referred and conducted were appropriate.

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

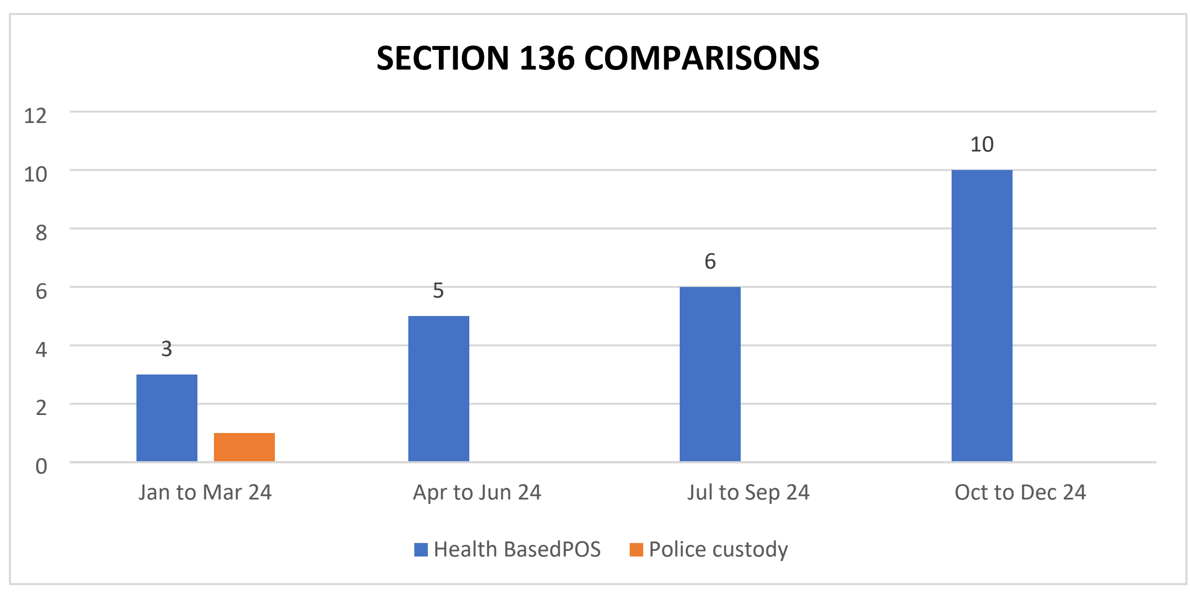

Table 3: Location of completed Section 136 assessments.

This table highlights that police cells were used on one occasion as a place of safety during the period. It was reported to the Live Well MHPDP that this was appropriate. It is worth noting that the Mental Health Bill which is currently being scrutinised by the Health and Social Care Committee of the Senedd has laid out in Legislative Consent Memorandum and Supplementary Legislative Consent Memorandum (Memorandum No. 2) as laid by the Welsh Government on 10 January 2025, proposes the removal of police stations as places of safety.

vii) Scrutiny of Documents

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

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

Rectifications	**Number of Errors**
Quarter 1 1 Jan to 31 Mar 24	**Four**
Quarter 2 1 Apr to 30 Jun 24	**Eight**
Quarter 3 1 Jul to 30 Sep 24	**Four**
Quarter 4 1 Oct to 31 Dec 24	**Five**
Fundamentally Defective Detentions	
Quarter 1 1 Jan to 31 Mar 24	**None**
Quarter 2 1 Apr to 30 Jun 24	**None**
Quarter 3 1 Jul to 30 Sep 24	**None**
Quarter 4 1 Oct to 31 Dec 24	**None**

viii) Deaths of detained patients

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

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

During the 12-month reporting period reporting period, 25 applications/ referrals were made to the MHRT:

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- Less than 5 patients were discharged from detention by the Tribunal
- Less than 5 hearings were adjourned or postponed
- Eleven patients were discharged by the responsible clinician and less than 5 patients withdrew their application

There were 17 Hospital Managers Hearings held during the period. By comparison there were 13 Hospital Managers Hearings for the same period in the previous year.

All patients attending hearings are entitled to be accompanied by an Independent Mental Health Advocate (IMHA) and are provided with information about this service to have representation. In this period, IMHAs attended two of the hearings. The Mental Health services continue to encourage patients to accept the support of an IMHA and there is ongoing work to address the poor uptake of commissioned advocacy services.

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

Hospital Managers Power of Discharge Group

Meetings for the above Group made up of the Hospital Managers and Independent Members were held during the year and quarterly performance was reported, scrutinised and discussed. Unfortunately, the last meeting of the Group did not take place due to capacity and could not be rearranged due to availability. Appended to this report are the minutes of the meetings held within the period.

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

During the reporting period there was one planned visit by HIW to the CMHT in Newtown which took place on 1st and 2nd October 2024. The subsequent report stated that HIW found the Mental Health Act administration process to be effective and robust with accurate record keeping. There is still a need to improve resilience in the system and strengthen capacity. This a key priority PTHB are committed to providing support, funding has been sourced and a job description drafted to be processed via job evaluation.

NEXT STEPS:

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The committee is asked to note the contents of this report and receive assurance that the performance of the service in relation to the administration of the Mental Health Act 1983 has been compliant with legislation.

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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					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)	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.
Clinical					
Financial					
Corporate					
Operational					
Reputational					

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Agenda item: 5.5

PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE	**DATE: 11 FEBRUARY 2025**
Subject:	**Medicines Management and Pharmacy Annual Report 2023/24**
Approved and presented by:	Kate Wright, Medical Director
Prepared by:	Chief Pharmacist
Other Committees and meetings considered at:	Executive Committee - 16 October 2024 (delayed from November 2024 PEQs Committee to February 2025 due to staff availability).

PURPOSE:

The Medicines Management and Pharmacy Annual Report aims to provide an understanding of the roles and responsibilities of the Medicines Management / Pharmacy Team (MMT), the scope of the work undertaken, and the progress made during 2023/24. The report also outlines key medicines management / pharmacy challenges facing the team and the wider Health Board.

RECOMMENDATION(S):

That the committee:
- **RECEIVES** the report and take **ASSURANCE** that the necessary responsibilities in relation to Medicine Management are being met.

Approve/Take Assurance	Discuss	Note
Y	Y	N

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

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EXECUTIVE SUMMARY:
This report attached outlines the scope of the work undertaken by the Medicines Management Team (MMT), highlights the progress made between October 2023 and September 2024, raises awareness of the challenges and discusses the plans for the next 12 months.

IMPACT ASSESSMENT
Not required for this report.

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Medicines Management and Pharmacy

Annual Report

2023 -24

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1. Executive Summary

The Medicines Management and Pharmacy Annual Report aims to provide the Executive Team with an understanding of the roles and responsibilities of the Medicines Management / Pharmacy Team (MMT), the scope of the work undertaken, and the progress made during 2023/24. The report also outlines key medicines management/pharmacy challenges facing the team and the wider health board.

The report is structured to broadly reflect the themes of the Health and Care Quality Standards.

2. Introduction

In 2016, a report published by the Wales Audit Office (Managing medicines in primary and secondary care) identified the need to increase the profile of medicines management at Board level and recommended that health boards ensured that performance against the National Prescribing Indicators is considered regularly by the Board, alongside progress in delivering wider cost and quality improvements in primary care prescribing. In September 2023 a report published by the Royal Pharmaceutical Society following the independent review of clinical pharmacy services in NHS hospitals across Wales, also recommended that Pharmacy must be better represented within health board and trust senior leadership teams, and improving the quality of medicines use should figure more prominently in discussions at board level. Welsh Government's response to the independent review endorsed this recommendation.

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

Medicines are the most common therapeutic intervention and the second highest area of NHS spending after staffing costs. Used correctly, medicines prevent, treat or manage many illnesses or conditions. However, medicines also have the potential to cause harm. Between 510 per cent of all hospital admissions are medicines related, two-thirds of medicines-related hospital admissions are preventable and 30-50 per cent of medicines prescribed for long-term conditions are not taken as intended.

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

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

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

Although the term 'medicines management' is still used, the team is focussed on medicines optimisation. This is a person-centred approach to safe and effective medicines use, to ensure that

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people obtain the best possible outcomes from their medicines. The concept is often summarised as 'right medicine, right patient, right time'. Effective medicines optimisation contributes to:

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

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

3. Health Promotion, Protection and Improvement

3.1 Immunisation and vaccination

The MMT has become increasingly involved with the health board's delivery of national immunisation and vaccination programmes since the COVID pandemic. A central pharmacy vaccine store has been established on the Bronllys site, supporting vaccine distribution to our vaccination centres, hospital wards, maternity services, community nursing teams (including schools and care homes) and, if necessary, to primary care.

A substantive senior pharmacy technician was recruited during 2023/24 to lead this service.

Pharmacy involvement has strengthened governance around the safe and secure management of vaccines from the point at which they are received by the health board to the point of administration to the patient. The MMT is also taking a leading role in preventing and reducing vaccine waste.

The number and types of vaccines handled by the Medicines Management Team continues to grow and will grow further as the National Immunisation Framework for Wales is implemented.

3.2 Covid-19 treatments

Whilst vaccinations remain the most effective way to protect people from illness from COVID19, some vulnerable people can receive treatment (e.g. antiviral, monoclonal antibody) if they contract COVID and remain at high risk of severe COVID.

The eligibility criteria for access to COVID treatments has and continues to expand.

Vulnerable patients who test positive for COVID using lateral flow tests are referred to the health board by NHS 111 Wales. Responsibility for triaging and providing access to COVID treatments, via Patient Group Directions (PGDs), sits with the MMT.

During 2023/24, the Medicines Management Team triaged 157 patients for COVID treatments. 55 (35%) patients were given access to Paxlovid® (an oral antiviral), 12 (7.6%) patients received sotrovimab (intravenous monoclonal antibody).

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3.3 Antimicrobial Stewardship (AMS)

Antimicrobial resistance (AMR) has been identified as one of the most pressing global challenges. The World Health Organisation (WHO) has declared AMR one of the top 10 global public health threats, and AMR is listed on the UK Government's National Risk Register.

The widespread and often excessive use of antimicrobials is one of the main factors contributing to the increasing emergence of AMR. To help address the challenge, Welsh Government introduced antimicrobial improvement goals in 2019, to be achieved by the end of 2023/24 (WHC/2019/019).

Although there was a notable decrease in antimicrobial usage during the COVID pandemic (2020/21), the group A streptococcus outbreak towards the end of 2022/23 resulted in significant increases in antimicrobial prescribing and PTHB has not yet recovered its previous good position.

The Health Board has observed an increase in Clostridium Difficile cases. As of the end of February 2024, we recorded 25 cases, marking an increase of 9 cases compared to the same period in 2022/23.

An antimicrobial stewardship pharmacist has been appointed. They will lead the development, implementation and review of the AMS Improvement Plan. Antimicrobial use is audited and results are fed back to clinical teams.

3.4 Community Pharmacy

Community pharmacies play a vital role in communities across Powys. As providers of NHS services, they contribute directly to improving the health and wellbeing of the people, both by ensuring they get the medicines they need to keep themselves well and by providing an alternative to other NHS services for a range of health and advice needs.

There are 23 community pharmacies in Powys, providing care closer to home, often without an appointment, taking pressure of other parts of the NHS and releasing time for other services to deliver the care only they can provide.

In April 2022, substantial reforms to the way the NHS contracted with community pharmacies were introduced, encouraging the provision of clinical services and promoting integration with other primary care contractors, the NHS and social care. Building on the traditional strengths and values of the sector to ensure the continued safe dispensing of prescribed medicines, pharmacies now deliver more clinical services more consistently and in greater number than ever before. This has been instrumental in reshaping the way that many people access NHS services in Wales

Each year the Medicines Management Team provides an annual ‘Community Pharmacy Performance Report’ which is presented to the Delivery and Performance Committee. This report provides a detailed insight into community pharmacy services in Powys and the challenges they face.

3.4.1 Smoking cessation

Around 10% of adults in Powys are smokers, compared to 13% of adults across the whole of Wales

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Evidence shows that smokers are more likely to successfully quit with specialist support. Health boards are expected to treat at least 5% of their smoking population via specialist smoking cessation services each year.

In Powys, dedicated specialist smoking cessation support is available through community pharmacy and the Powys Smoking Cessation Team. Both form part of the national Help Me Quit service.

During 2023, the MMT worked with the Public Health Team to update the training package for pharmacy professionals and to promote the service that pharmacies offer. The aim was to increase knowledge, confidence and skills of the pharmacy professionals providing smoking cessation support and to promote the service they offer.

3.4.2 Influenza vaccination

All community pharmacies across Powys continue to provide access to inactivated influenza vaccination for adults aged 18 years and over who meet the eligibility criteria.

3.4.3 Syringe and needle exchange

Eight pharmacies provided access to sterile equipment to injecting drug users across Powys during 2023/24. The service encourages the return of used equipment, promotes safer injecting practice and acts as a gateway to other health services. These pharmacies were involved in 563 transactions for 152 unique clients.

This service is currently only commissioned in Powys' larger centres of population (Newtown, Welshpool, Llandrindod Wells, Brecon and Ystradgynlais). Plans for 2024/25 involve extending the commissioning of this service to cover all areas of Powys, as well as widely commissioning the naloxone supply component of the service, meaning injecting drug users and their friends and family will have access to potentially life-saving treatment for opioid overdose in the community.

4. Safe Care

4.1 Medicines Safety

Improving all aspects of medicines safety is a priority for the MMT.
The Chief Pharmacist is responsible for overseeing medicines safety and medication error incident reporting and learning. Increasing medication incident reporting, improving the quality of incident reports, maximise learning and guiding practice to minimise harm from medication errors is a priority for the MMT.

4.1.1 Medicines Safety Officer

The Medication Safety Officer (MSO) chairs the medicines safety group and is responsible for embedding of clinical standards, improving medicines safety and sharing of learning from medication safety incidents.

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During 2023/24 the MSO progressed work to develop a medication safety team, including more junior members of the pharmacy team, pharmacy technicians, medicines management nurses and other HCPs. The aim is to have medicines champions within every clinical team, in every clinical service across PTHB. Once in place, a network for medicines safety champions will be established to provide support and share learning across the organisation.

4.1.2 Medicines Safety Group

The Medicines Safety Group (MSG) is a subgroup of the Area Prescribing Group (APG). It provides quarterly highlight reports to the APG and highlights any concerns around medicines safety.

During 2023/24 a sub-group of the MSG was established to co-ordinate the implementation of the new regulatory measures on valproate, as detailed in the National Patient Safety Alert on valproate, published in November 2023. An Action and Improvement Plan is in place which is being actively implemented and monitored.

4.1.3 Datix

Medicines related incidents are reported via the Once For Wales Concerns Management System (Datix). The Chief Pharmacist is notified of all incidents involving medicines and, where necessary, support is provided by the MMT to investigate and share learning.

During 2023/24 further work was undertaken with the health board's Safety Systems and Information Co-ordinator to develop routine reports from the Datix system, extracting information on the themes associated with the incidents, to help identify the priority areas that need to be address.

The health board's Medicines Management Nurse plays an active role in supporting clinical staff to learn from medicines incidents and now produces a quarterly newsletter 'Medicines Matters' which shares learning from Datix reports.

During 2024/25 further work will be undertaken to improve the quality of Datix reports, encourage wider reporting of medicines related incidents, refine the reports extracted from Datix and to ensure that processes are in place to support widespread learning from the incidents.

4.1.4 Yellow Cards

Yellow Card reporting supports the identification and collation of adverse drug reactions (ADRs) which may not have been identified before.

A strong safety culture requires good reporting of adverse events and critical incidents from across all professions and healthcare settings, as well as from patients.

The MSO is working with stakeholders to increase awareness of the importance and value of Yellow Card reporting.

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4.1.5 Patient safety notices/alerts

In December 2023, the Area Prescribing Group approved the Standard Operating Procedure for the Management of Safety, Stock and Other Alerts.

Over 90 alerts/notices (excluding those relating to medicines supply challenges) were received, recorded and actioned by the MMT during 23/24.

Over 103 medicines shortage notices were received from the Medicines Shortage Advisory Group Wales via the Chief Pharmaceutical Officer during 2023/24. This represents a 66% increase on the number of shortage notices received during 2022/23. Medicines shortages continue to have a significant impact on patient care, clinician/pharmacy professional workload and drug costs as concessions are introduced.

4.1.6 Medicines safety campaigns

#MedSafetyWeek is a national social media campaign that takes place annually, usually in November, and each year there is a different focus or theme to encourage the reporting of suspected side effects from medicines.

The 2023 campaign (6th-12th November) focussed on who can report. Patients, doctors, nurses, and pharmacists all have a key role to play in the cycle of medicines safety. The aim was to explore the different perspectives that come from these groups and how the information they provide can help make medicines safer.

Each year the Medicines Management Team participates in #MedSafetyWeek by raising awareness and sharing national resources.

4.2 Clinical Pharmacy Services

The health board's clinical pharmacy team is managed by the Head of Community Services Medicines Management. Services are provided at ward level to all PTHB hospital sites by pharmacists, pharmacy technicians, medicines management nurses and assistant technical officers.

Our clinical pharmacy service ensures that the use of medication is both safe and appropriate, and that patients receive the best possible care. The service provided by the team includes, but is not limited to:

- Clinical advice and support to healthcare professionals
- Ensuring that medicines alerts/recalls are actioned
- Medication history taking
- Supporting self-administration
- Medicines reconciliation
- Patient counselling
- Managing medicines via MTeD
- Management of patients own drugs
- Ensuring the safe and secure management of medicines
- Mentoring and supervising support staff and students
- Attending multidisciplinary team meetings
- discharge planning (including liaison with primary care, care homes; assembling and checking TTOs)
- Accuracy checking dispensed items
- Medicines ordering

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- Drug chart review
- Monitoring formulary compliance and ensuring that prescribing is evidence based and cost-effective

There is a pharmacy presence on each of our hospital sites at least twice a week and the team provide remote support when they are not physically present on the site.

4.2.1 Pharmacy Intervention Reporting Tool

Interventions undertaken by the Clinical Pharmacy team are recorded on the Pharmacy Intervention Power BI tool. 592 interventions were recorded during 2023/24.
The Power BI tool allows interventions to be analysed to identify areas where further work may be required e.g. development of prescribing guidelines.

Ward level reports can be extracted from the Power BI tool. These are discussed within the pharmacy team and also with ward clinical teams to share learning.

4.2.2 Medicines Reconciliation

Medicines reconciliation is the process of identifying an accurate list of a person's current medicines and comparing it with the current list in use. Any discrepancies should be identified, and any changes documented. The result is a complete list of medicines, accurately communicated to all health and social care professionals involved in the person's care, in which any issues with the medicines, such as wrong dosage or omission, have been addressed.

NICE has issued Quality Statements for medicines reconciliation in both primary and secondary care. To meet the NICE Quality Standard for inpatients, medicines reconciliation should occur within 24 hours of admission.

With regards to primary care, the NICE Quality Standard requires that people discharged from a care setting have a reconciled list of their medicines in their GP record within 1 week of the GP practice receiving the information, and before a prescription or new supply of medicines is issued. PTHB aims to support practices to achieve this requirement, by ensuring, wherever possible, that information about the medicines that patients are discharged on is provided withing 24 hours of discharge, with more detailed information provided within 14 days of discharge.

4.2.3 Medicines Transcribing and electronic Discharge (MTeD)

The Welsh Clinical Portal electronic patient record enables timely transfer of information between hospitals, GP practice and community pharmacies. The system enables multidisciplinary working with the recording and sharing of electronic information from the point of hospital admission, throughout the patient journey to post discharge.

Clinicians and pharmacy professionals are able to transcribe the information from the patient's prescription/drug chart onto MTeD. The Discharge Advice Letter (DAL) enables clinicians to record a summary of a patient's hospital stay, including medicines information, which can be sent electronically to the GP when the patient is discharged.

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4.3 Electronic Prescribing and Medicines Administration (ePMA)

Electronic Prescribing and Medicines Administration (ePMA) in secondary care is one of the four priority areas of the NHS Wales Digital Transformation Portfolio.

Replacing paper medicine charts and prescriptions with an ePMA system will make the entire process safer, easier and more efficient. Doctors, nurses, pharmacists and other health professionals will have information at their fingertips to inform vital clinical decisions. Paper drug charts will disappear from our wards.

During 2023/24 members of the pharmacy team helped to progress plans for procurement and implementation of an ePMA system. Implementation of the system is due to commence in spring 2025.

An overview of all ePMA Project activities can be found on the PTHB ePMA Home page.

4.4 Community Pharmacy

4.4.1 Discharge Medicines Review (DMR) Service

The DMR Service is offered by all pharmacies in Powys. The aim is to improve patient safety by reducing the risk of medication errors and adverse drug events following discharge from a care setting. 195 DMRs were delivered by pharmacies in Powys during 2023/24.

4.5 Primary Care Decision Support Software

During 2023/24 two clinical decision support software systems were in use in practices across Powys. Both systems aim to support clinicians to maximise prescribing quality and value.

4.6 Medical Gases

Medical gases are medicinal products that are supplied for patient use either via medical gas pipeline systems or medical gas cylinders.

In PTHB the Medical Gases Governance Group ensures that the health board manages medical gases safely, securely and effectively.

During 2023/24 the MGGG focussed on improving safety of gases delivery, improving efficiency of gases delivery, and providing access to online training for staff.

During 2024/25 work will continue to strengthen governance around medical gases.

5. Timely Care

5.1 Non-medical prescribing

A number of groups of healthcare professionals other than doctors and dentists are, subject to completing additional training, able to prescribe medicines, within their scope of clinical practice, for

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patients as either independent or supplementary prescribers, these healthcare professionals are collectively referred to as non-medical prescribers (NMPs).

Non-medical prescribing offers a number of advantages:

- Enhances patient care by supporting timely access to treatment with medicines
- Enables choice whilst helping to reduce waiting times
- Makes better use of the skills of health professionals.

The MMT facilitates access to non-medical prescribing training) and ensures that robust governance arrangements are in place for NMPs, sits with the MMT.

Work has been undertaken with service managers to ensure that the requirement for nonmedical prescribing is included inService Development Plans.

Between 2022/23 and 2023/24, the number of qualified non-medical prescribers increased as the health board supported a number of clinicians through training:

Qualified prescribers	**Total 2022/23**	**Total 2023/24**
Community Practitioner Nurse Prescribers (CPNPs)*	45	51
Independent NMPs	70	73

Our Independent NMPs work across a broad range of clinical areas including mental health, respiratory, minor injuries, cardiology, palliative care, continence, paediatrics, Parkinson's, diabetes, learning disabilities, sexual health and podiatry.

5.2 Community Pharmacy Services

5.2.1 Common Ailments Services (CAS)

The CAS provides advice and treatment to people who have minor illnesses. It is offered by every community pharmacy contractor in Powys and it covers 27 different conditions, from acne to warts and verruca's.

The service can be accessed by anyone, including tourists, as long as they plan to stay in Wales for at least 24 hours after visiting the pharmacist.

During 2023/24, 10,021 CAS consultations were undertaken in community pharmacies across Powys. This represents a 36% increase in consultations compared to 2022/23.

The illustration below provides information on the top 10 ailments treated through the service.

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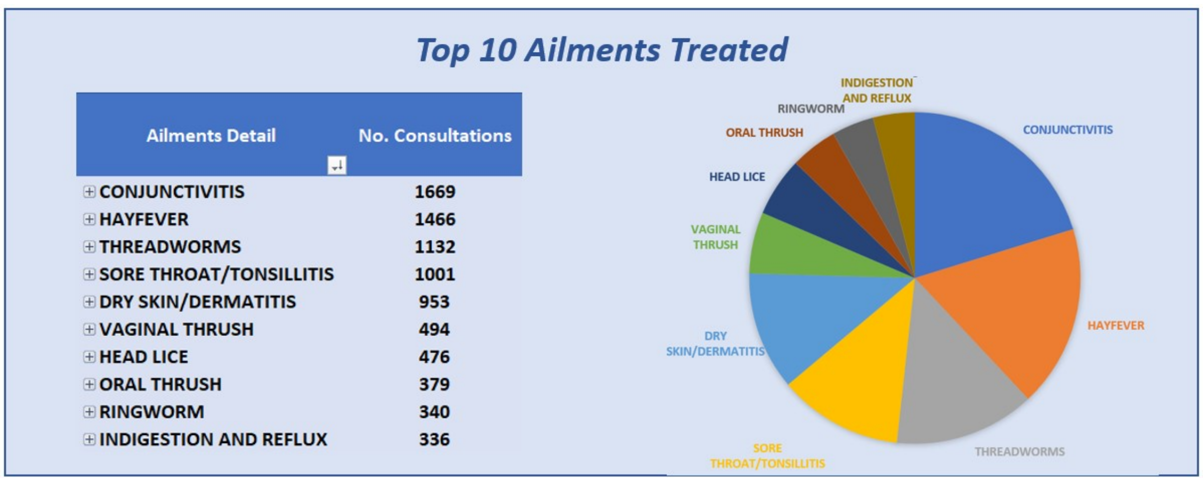

Top 10 Ailments Treated

Ailments Detail	No. Consultations
CONJUNCTIVITIS	1669
HAYFEVER	1466
THREADWORMS	1132
SORE THROAT/TONSILLITIS	1001
DRY SKIN/DERMATITIS	953
VAGINAL THRUSH	494
HEAD LICE	476
ORAL THRUSH	379
RINGWORM	340
INDIGESTION AND REFLUX	336

The Medicines Management Team monitors provision of this service and provides monthly reports to contractors.

5.2.2 Contraception Services

This service provides access to emergency hormonal contraception, QuickStart contraception using a progestogen-only contraceptive (i.e. immediate initiation of a contraceptive method at the time a woman requests it, rather than waiting for the next natural menstrual period) and sexual health advice where clinically indicated. It is provided by all Community Pharmacy Contractors across Powys.

During 2023/24 there were 659 consultations in community pharmacies across Powys for emergency contraception. This represents a 4% decrease in consultations compared to 2022/23. 96.4% of these consultations resulted in the supply of emergency contraception (either Ulipristal or levonorgestrel), under the guidance of a PGD.

5.2.3 Emergency Medicines Supply Service (EMS)

The EMS allows community pharmacy contractors to supply previously prescribed medicines to patients, via the NHS, where, for example, a patient may have run out of their medicine or they may have lost their medication or left it at home if they are on holiday in Wales. The service is available if the patient is unable to obtain a prescription before their next dose is due.

During 2023/24, 2,090 emergency supplies were made by community pharmacy contractors in Powys. This represents an 8% increase on the number of supplies made during 2022/23. The table below shows the reasons why access to the EMS service was required.

Reason for supply

Reason for Supply	No. Consultations	%
Not ordered in time	647	31%
Prescription not available in the GP practice for collection	585	31%
On holiday and medication forgotten	565	23%
Lost or misplaced medicine	184	10%
Not able to collect from usual pharmacy	109	5%
Total	2090	100%

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5.2.4 Pharmacist Independent Prescribing Service (PIPS)

Six community pharmacy sites across Powys offered a prescribing service to the local population during 2023/24. Patients were able to access treatment for an extended range of common conditions that might otherwise have required treatment from a GP surgery - including upper and lower respiratory infections, urinary tract infections and impetigo.

The MMT is working with contractors and Welsh Government to support the national ambition to have an independent prescribing pharmacist in every pharmacy in Wales. Another three pharmacies are expected to start delivering prescribing services in Powys during 2024/25.

5.3 Patient Group Directions (PGDs)

Although the majority of clinical care involving supplying and/or administering medicines should be provided on an individual, patient-specific basis, PGDs allow healthcare professionals to supply and administer specified medicines without a prescription to pre-defined groups of patients, for the limited situations in which they offer an advantage for patient care, without compromising patient safety.

29 new PGDs were developed and 32 existing PGDs were reviewed during 2023/24

There are currently 109 PGDs in place across the health board, and an additional 31 PGDs in use in community pharmacies. PGDs are published on the health board's website.

During 2023/24 the Medicines Management Team continued to audit PGD use.

These audits have allowed the Medicines Management Team to identify areas for improvements, as well as identifying PGDs that may no longer be required and areas where nonmedical prescribing needs to be prioritised to reduce the necessity for PGDs.

5.4 Shared Care Protocols (SCP)

Shared care protocols are formal agreements between specialists and primary care clinicians. They are clinically focussed and detail the responsibilities of the specialist and the primary care clinician. They support primary care clinicians to accept responsibility for the safe prescribing and monitoring of specialist medicines. They allow patients to access care closer to home.

During 2023/24 work was initiated to scope the shared care agreements that are required to support PTHB provided specialist services. The requirement to develop shared care protocols to support attention deficit hyperactivity disorder services (child, adolescent and adult) was prioritised.

During 2024/25 work on the ADHD SCPs will continue and additional SCPs (e.g. denosumab) will be developed to support PTHB provider services.

Work will continue with providers outside Powys, commissioned to provide services to Powys patients, to ensure that appropriate shared care agreements are made available to primary care.

During 2023/24 primary care acceptance of shared care was challenging, with a number of practices declining the invitation to accept prescribing responsibility for shared care drugs, impacting on patient ability to access their medicines closer to home.

During 2024/25 the MMT will continue to work with the Local Medical Committee (LMC), primary care clinicians and the health board's Primary Care Team to understand and help address the barriers to shared care.

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6. Effective Care

6.1 Area Prescribing Group (APG)

Ensuring that medicines are well managed across a health community, in terms of entry of new medicines and interventions, safe and effective choices, and equitable access for patients, requires the input of all stakeholder organisations.

The clinical and financial risks and benefits associated with medicines are best managed using a collaborative, co-ordinated, area wide approach to medicines optimisation. The implementation of this approach in Powys is supported by the APG.

The APG provides a forum for transparent decision making relating to medicines. The meetings are held quarterly and are chaired by the Medical Director.

During 2023/24 a large number of policies, procedures and guidelines were considered and agreed by the APG.

The APG also received quarterly highlight reports from the Formulary Working Group (see 6.1.1), the Medicines Safety Group (see 4.1.2) and the PGD sub-group (see 5.3).

6.1.1 Formulary Working Group

The Formulary Working Group (FWG) was established in 2023 and is a sub-group of the Area Prescribing Group (APG). Formulary Management Guideline and FWG Terms of Reference were developed along with forms to request additions / changes to the PTHB formulary.

In additio several NICE Technology Appraisals were considered by FWG in 23/24 and submitted to APG for ratification

6.1.1.1 Formularies

Medicines that have been approved for use within the health board are collected into a list, or formulary. Formularies are important to help ensure the safe and effective use of medicines

During 2023 the FWG commenced a BNF chapter review of the PTHB formulary, completing a number of chapters. Work will be ongoing to complete the remaining chapters and the FWG will continue to review and update the formulary on an ongoing basis.

The health board also has an antimicrobial formulary which is managed collaboratively by the Antimicrobial Stewardship Group (AMS Group) and the FWG:

During 2024/25 work will be undertaken to get a better understanding of formulary compliance in primary care and within our community hospitals so that targeted work can be undertaken to bring improvements.

6.2 National guidelines/policies and the National Treatment Fund

6.2.1 NICE

NICE guidance used in Wales is subject to Welsh legislation. All technology appraisals (TA) must be made available within 60 calendar days of the publication of the Final Appraisal Determination (FAD) or Final Evaluation Document (FED). The New Treatment Fund (NTF) is provided to help health boards and trusts achieve this. In order to monitor compliance with the New Treatment Fund, the

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health board is required to inform Welsh Government how quickly NICE approved medicines are added to our formulary.

During 2023/24, 71 NICE FAD/FED approved medicines were added to the National Treatment Fund list and assurance was provided to Welsh Government by PTHB that they were all made available within 60 days of the NICE FAD/FED being published.

Work was initiated during 2023/24 to agree a process to consider and prioritise non-mandated NICE guidance relating to medicines. This work will be progressed by the APG during 2024/25, with the support of the FWG.

6.2.2 AWMSG

The All Wales Medicines Strategy Group (AWMSG) advises Welsh Government about the use, management and prescribing of medicines. All Wales Therapeutics and Toxicology Centre (AWTTC) supports AWMSG and its subgroups.

One of the health board's Medicines Management Nurses is the deputy nurse representative on the AWMSG.

During 2023/24 the AWMSG published a range of prescribing guidelines and resources, all of which were actively promoted and implemented by the MMT, facilitated by the APG:

- Understanding unlicensed medicines
- All Wales paediatric asthma management and prescribing guideline
- All Wales Common Ailments Formulary
- All Wales protocol for the appropriate prescribing of antipsychotics for people living with dementia
- All Wales adult asthma management and prescribing guidelines
- All Wales Policy for Medicines Administration, Recording, Review, Storage and Disposal (MARRS)

Updates were also made to resources published prior to 2023/24

- Primary care antimicrobial guidelines
- Endocrine management of gender incongruence in adults: prescribing guidance for nonhttps://awttc.nhs.wales/medicines-optimisation-and-safety/medicines-optimisation-guidance-resources-and-data/prescribing-guidance/endocrine-management-of-gender-incongruence-in-adults/specialist practitioners
- All Wales chronic obstructive pulmonary disease (COPD) management and prescribing guideline

The Medicines MMT proactively supports AWMSG by providing feedback on any consultation documents that are relevant to the work of the health board.

6.3 Individual Patient Funding Request Panel (IPFR)

During 2023/24, 42 medicines related funding requests were considered by the IPFR panel. 13 of these cases were new and 29 were reviews of previously considered requests.

Each case involving a medicine requires considerable input and highly specialist support from a member of the MMT.

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7. Efficient Care

7.1 Prudent Prescribing/Sustainable Medicines Management

Prudent healthcare aims to secure health and well-being for future generations. As well as delivering better outcomes at reduced cost, the MMT ensures that optimising also considers sustainability and how a medicine impacts on our environment.

7.1.1 Reducing inappropriate prescribing

Over the last 30 years, we have seen a significant increase in the number of medicines that people, particularly older people, are prescribed. There are many reasons for this, including:

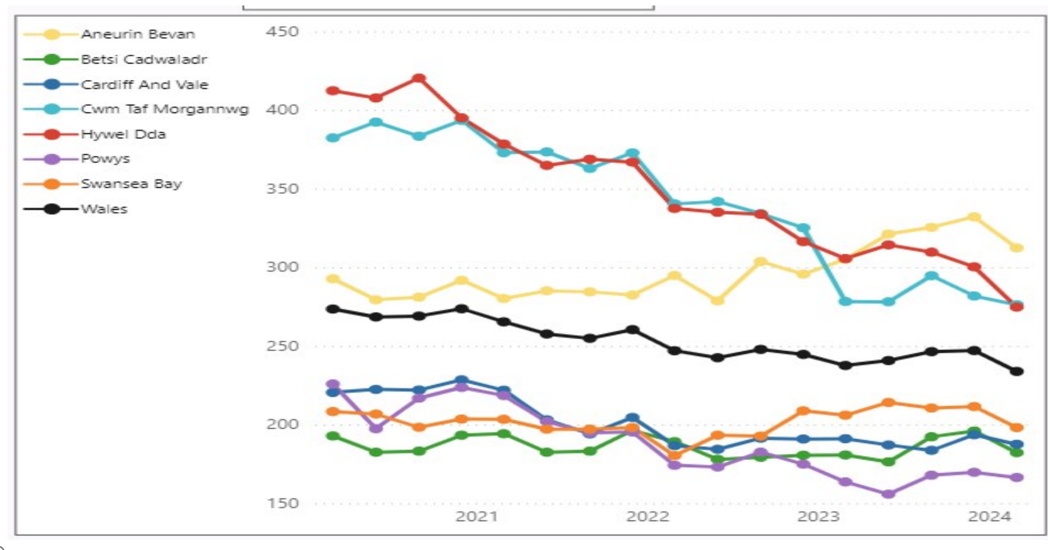
- the advent of evidence-based medicine
- increase in multiple morbidity and longevity
- promotion of age-independent access to the increasing number of treatments
- increasing expectations for treatment from patients and their families

However, there are increasing concerns about the risks associated with prescribing multiple medicines, including:

- adverse drug events
- hospital admissions
- health care costs
- non-adherence

Polypharmacy is the term used when more medicines are prescribed or taken than are clinically required. Addressing polypharmacy and supporting deprescribing is a significant and complex challenge.

During 2023/24 the key focus of the Medicines Management deprescribing work was on items identified as low value for prescribing (i.e. medicines that offer a limited clinical benefit to patients and where more cost-effective treatments are available). Practices were provided with quarterly progress reports against the low value KPI (cost per 1,000 patients). The graph below shows PTHB's performance compared to that of other health boards.



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A requirement to optimise medicines use and safety, improve patient adherence and reduce medicines waste, through medicines reviews including polypharmacy reviews and deprescribing was also embedded in the Red Kite SLA.

The Medicines Management Team will continue to prioritise the work to address problematic polypharmacy, support deprescribing and promoting structured medication reviews during 2024/25.

7.1.2 Tackling waste

Medicines waste is recognised as a significant issue. In our in-patient settings the Pharmacy Team continued to work with clinical teams to minimise waste during 2023/24. When medicines are no longer required, nursing staff are asked to quarantine the medicines for inspection by pharmacy staff. Wherever possible medicines are reused and not destroyed. Ward stock lists are frequently reviewed to ensure that they reflect ward requirements, avoiding the risk of medicines going out of date before they are used wherever possible. The MMT also facilitates the use of Patient's Own Drugs and dispensing for discharge (see section 8.2) to help reduce waste.

In primary care the Medicines Management Team continued its work to ensure that patients are empowered to take responsibility for their own medicines. This included providing resources to support patient involvement in decisions about the medicines they are prescribed, to help improve compliance. Work also continued on encouraging patients and pharmacy contractors operating 'managed repeat' services, to only ordered the medicines that are needed – this reduces the risk of hoarding, reduces waste and improves patient safety.

7.1.3 Reducing our carbon footprint in respiratory medicine

In November 2023 the National Strategy for Wales on Decarbonisation: inhaler prescribing, use and disposal 2023-2030 was published. The Medicines Management Team is committed to working with all stakeholders to implement this strategy, focussing on three broad areas:

- Prescribing of inhalers
- Use of inhalers
- Responsible disposal of inhalers

During 2023/24 GP practices across Powys were provided with monthly key performance indicator data to help drive this agenda forward.

Performance data shows good progress against the majority of KPIs.

The All Wales asthma and COPD management guidelines are actively promoted to support this work.

The team will continue to progress this work during 2024/25.

7.2 Value based approach

Promoting and delivering a value-based approach is a core function of the MMT and embedded in everything that the team does.

Areas of focus for value-based prescribing include:

- Optimal prescribing for increased patient safety
- Optimal prescribing for increased efficiency
- Optimal prescribing for higher health gain

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- Optimal prescribing for higher environmental benefit
- Optimal prescribing for increased equity

7.3 Budget Management

The Chief Pharmacist is responsible, with the support of the wider MMT, for managing the following budgets:

- Primary care prescribing budget
- Community pharmacy contract budget
- Red Kite SLA budget
- Community service medicines budget (including the costs associated with the SLAs held with ABUHB and HDUHB)
- Medicines Management Team budget

These budgets account for approximately 10% of the health board's overall annual financial allocation.

The Chief Pharmacist and wider medicines management team work in collaboration with finance business partners to set and manage these budgets.

7.3.1 Efficiency Plan

During 2023/24 the MMT developed a comprehensive efficiency plan covering primary care prescribing, secondary care prescribing (commissioned services) and medicines costs associated PTHB provider services.

The plan was broad and included all of the national value and sustainability priorities, along with locally identified priorities.

The national value and sustainability priorities for 2023/24 included:

- Maximising use of biosimilar drugs
- Stopping brand name prescribing where lower cost generics were available;
- Preferential use of aniticoagulant apixaban in primary care;
- Stopping the prescribing of medicines on low value list;
- Restricting prescribing of bath and shower emollients;
- Selection of dry eye preparations in accordance with local formularies

At the end of the financial year the team had exceeded its efficiency target and delivered £1.7 million efficiencies. However, putting this into perspective, it should be noted that the cost pressures on the Medicines Management budgets during this period were considerably higher than the efficiencies delivered (pressures ~ £3.1 million).

7.4 Acute Trust Contract/SLA management

PTHB does not have its own pharmacy department. Medicines used across the health board are supplied by two Welsh Health Boards – Nevill Hall Hospital and Bronglais Hospital.

Both Nevill Hall Hospital and Bronglais Hospital provide out-of-hours pharmacy on-call support to our clinical services.

During 2023/24 Nevill Hall Hospital also provided 0.2 WTE specialist mental health pharmacy support to Powys.

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The MMT is responsible for managing the Service Level Agreements (SLAs) that are in place with Nevill Hall Hospital and Bronglais Hospital for pharmacy services.

In November 2021, the Chief Pharmacist for HDUHB serviced notice on the support provided to PTHB by Bronglais Hospital. No other Health Board was willing to take on the additional work and following negotiations between PTHB and HBUHB Chief Pharmacists, the notice was withdrawn.

During 2023/24 the fragility of the services provided by both Nevill Hall Hospital and Bronglais Hospital were evident. Both providers flagged workforce challenges and the impact that this was having on their ability to support PTHB.

7.5 Commissioning for quality in medicines

The MMT has developed a 'Commissioning for Quality in Medicines' document which sets out the medicines/prescribing expectations that the health board has of commissioned Welsh and English provider organisations. The document outlines the roles and responsibilities of our provider organisations in ensuring a transparent and collaborative approach to the safe and cost-effective management of medicines, seamless care of patients between NHS organisations and ensuring high quality prescribing.

The Commissioning for Quality in Medicines document is embedded in provider Long Term Agreements (LTAs) and is reviewed annually. Compliance with the requirements is monitored by the MMT.

7.6 High cost drug management

Prior to 2023/24 the Medicines Management Team had very limited input into the management of the high cost drugbudget. The value and importance of pharmacy professional support in the management of high cost drugs was recognised and during 2023 a Senior Pharmacy Technician was recruited to work alongside the Senior Pharmacist for High-cost-drugs and formulary management.

Working in collaboration with the Medicine Management Team's Data Analyst, the pharmacy professionals have strengthened the health board's understanding of high cost drug use and spend, and supported the commissioning team to raise challenges with providers about costs associated with high cost drug use.

Regular meetings are now held between the commissioning and medicines management teams and a record of challenges and efficiencies delivered through this collaboration is maintained.

7.6.1 Blueteq

Blueteq is a web-based software system that improves both clinical and financial governance of high cost drugs, results in faster access to medicines for patients and ensures that medicines are prescribed in accordance with mandated guidance issued by AWMSG and NICE.

In 2018, Welsh Government invested in the purchase of Blueteq High-Cost Drug system (Blueteq HCD) to improve monitoring of expenditure on, and use of high-cost medicines commissioned by the Welsh Health Specialised Services Committee (WHSSC).

In March 2023, a requirement was set for health boards to extend the use of the Blueteq High-Cost Drug system (Blueteq HCD) to support the financial and clinical governance of high cost drug use.

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Progress on implementing the Blueteq HCD system during 2023/24 was slow due to information governance and cyber challenges.

During 2024/25PTHB will work closely with English NHS providers, to roll out Blueteq. Once all other health boards have approved their data sharing agreements, roll out across Wales will start.

Blueteq will replace the current paper based high cost drug application and approval process that is in place in Powys. It will enhance our understanding of high cost drug spend and support audits and financial forecasting.

7.7 National Prescribing Indicators

The All Wales Medicines Strategy Group (AWMSG) has developed and endorsed National Prescribing Indicators (NPIs) since 2003 to help promote safe and cost-effective prescribing. The indicators allow health boards, primary care clusters, GP practices and prescribers to compare their current prescribing practice against an agreed standard of quality. For 2022https://awttc.nhs.wales/medicines-optimisation-and-safety/medicines-optimisation-guidance-resources-and-data/national-prescribing-indicators/national-prescribing-indicators-2022-2025/2025, the National Prescribing Indicators: Supporting Safe and Optimised Prescribing focus on the following priority areas:

- Analgesics (including opioids, tramadol, and gabapentin and pregabalin)
- Anticoagulants in atrial fibrillation
- Antimicrobial stewardship (including total antibacterial items and the '4C antimicrobials': co-amoxiclav, cephalosporins, fluoroquinolones and clindamycin)
- Decarbonisation of inhalers

These four priority areas were supported by additional indicators:

- Safety ○ Prescribing safety indicators ○ Hypnotics and anxiolytics ○ Yellow Cards
- Efficiency ○ Best value biological medicines ○ Low value for prescribing

The threshold for achievement is based on the prescribing rate of the best performing 25% of practices in Wales, for quarter 3 of the preceding financial year. The target is therefore not an absolute value and can be achieved if there is movement towards the threshold set.

The health board operates a prescribing incentive scheme which incentivises practices to improve performance against a number of the national priorities. During 2023/24 the following indicators were included in the incentive scheme:

Prescribing Indicator	Unit of measurement
Hypnotics and anxiolytics	ADQ per 1,000 STAR-PUs
Pregabalin and gabapentin	DDD per 1,000 patients
Opioid burden	DDD per 1,000 patients
Antimicrobials	Items per 1,000 STAR-Pus
4C antimicrobials	Items per 1,000 patients
Proton pump inhibitors	DDD per 1,000 Pus
Decarbonisation of inhalers	DPIs and SMIs as a % of all inhalers
Low value prescribing	Spend per 1,000 patients

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Practices were provided with monthly reports that showed their performance against each of the indicators and allowed comparison with other practices.

The annual medicines management practice visits are used to discuss each of the prescribing indicators. Targeted conversations with practices are also held throughout the year where specific challenges are identified.

7.8 Pharmacy Stores

In addition to the central pharmacy vaccine store on the Bronllys site, a further pharmacy store was established on the same site during 2023/24 to support PTHB wards with the supply of Oral Nutritional Supplements (ONS). This service is supported by a Band 2 Assistant Technical Officer (0.4 WTE). Previously the PTHB community services pharmacy team ordered and managed ONS stock on behalf of our wards, however, wholesale deliveries were often incorrectly directed to the Medicines Management Team (MMT) office on the Bronllys site. This meant that other MMT staff would spend a significant amount of time processing these orders for delivery to the correct site via PTHB transport services. This created significant delays to the receipt of ONS on the wards with the potential to impact on patient care.

The ONS pharmacy store acts as a central storage area whereby stocks of ONS are procured, receipted, managed, and distributed safely and efficiently to our hospitals and is supported by a robust stock management system. The service has been well-received by ward staff and the wider community services pharmacy team. During 2024/25 the pharmacy store will be expanded further to include stock holding and management of wound care products and consumables (e.g. cartons, labels, bottles, pill cutters, oral syringes etc).

The Pharmacy Store Team also took on the responsibility for several batch assembly operations during 2023/24 e.g. assembly and management of ward emergency cardiac boxes and provision of a small-scale medicines/vaccine repacking/over labelling service to support the COVID-19 vaccination programme and COVID-19 therapies service.

7.9 Electronic Prescription Services (EPS)

The way people collect prescriptions and receive their medication in Wales is changing from a paper-based process to a digital service. This will make the prescribing and dispensing of medicines easier, safer, more efficient and more convenient for patients and staff.

At the moment, GPs and other prescribers in primary care – including community pharmacists, dentists and optometrists – sign paper prescriptions by hand. These paper prescriptions are then taken to the pharmacy for the medication to be dispensed.

EPS is an end-to-end electronic process, allowing prescribers to send prescriptions electronically to a pharmacy (or another dispenser) of the patient's choice.

During 2023/24 the Medicines Management Team worked closely with Digital Health and Care Wales (DHCW) to prioritise the implementation of EPS across Powys. Joint meetings were held with general practice and community pharmacy contractors, the Local Medical Committee and Community Pharmacy Wales to prepare for implementation during 2024/25.

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8. Person Centred Care

8.1 Self administration

Self-administration of medicines during a hospital stay empowers patients to take responsibility for their medicines, promotes independence and improves confidence. It is recognised that self-administration helps to reduce the impact of deconditioning that occurs during a hospital stay and prepares patients for discharge.

During 2023/24, the Pharmacy Team progressed the work to ensure that self-administration is an option for all suitable patients admitted to PTHB hospital sites.

Self-administration was made available on Llewellyn Ward (Bronllys Hospital) and training was provided to nursing staff on Claerwen Ward (Llandrindod Wells Hospital), with one patient being initiated on self -administration on this ward.

The pharmacy team is responsible for training nursing staff and for supporting the multidisciplinary team with the decision about the suitability of individual patients for self- administration

Self-administration is available at 2 levels:
The Pharmacy Teams ability to ensure that self-administration is available on all wards has been compromised due to workforce challenges. However, the team recognises the importance and the benefits of cascading access to self-administration to all PTHB hospital sites and will progress this work during 2024/25

8.2 Patients Own Drugs (PODs) and Dispensing for Discharge

Supporting the use of PODs (i.e. medicines brought into hospital with the patient) during a hospital stay has many advantages:

- Reducing medicines related errors on admission by increasing the accuracy of Medicines Reconciliation.
- Encouraging patients to ask questions about their medication and help identify compliance /adherence and counselling issues.
- Reducing confusion by allowing patients to maintain the familiarity of their own medicines.
- Reducing omitted and delayed doses due to waiting for medicines to arrive from Pharmacy.
- Reducing waste by preventing the unnecessary re-supply of medicines.
- Allowing identification of expired and discontinued medication patients may have in their possession.
- Reducing discharge delays by having PODs available on the ward to reconcile with the discharge prescription.
- Supporting self-care by allowing progression to self-administration by patients.

Across our hospital sites, each patient's bedside has a PODs locker where medicines taken on a regular basis are stored. Following an assessment of suitability, the Pharmacy Team ensures that PODs brought into hospital by the patient are used where possible. The Pharmacy Team ensures that the PODs lockers contain a minimum of 14 days of correctly labelled medicines - in many cases this allows the medicines to be used at discharge, helping to reduce avoidable discharge delays. This is known as 'Dispensing for Discharge'.

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'Dispensing for Discharge' is provided on all medical wards, with the exception of Graham

Davies Ward (Llanidloes). The service is not currently provided to our mental health wards.

8.3 Outpatient Parenteral Antimicrobial Therapy (OPAT) services

OPAT services allow patients to receive intravenous antibiotic therapy in the community or outpatient settings, they help to avoid hospital admission or facilitates discharge, allowing care to be provided either in the patient's home or closer to their home. The aim is to provide safe, patient centred care.

PTHB does not currently have a dedicated OPAT service, and there are questions about our capacity and the necessity to establish such a service. The health board's preference is to build capacity and competence to deliver an OPAT service within existing community nursing teams, working in collaboration with acute providers, recognising that the majority of patients who would benefit from an OPAT service are discharged from acute hospitals outside Powys, rather than from our own community hospitals.

During 2023/24 PTHB patients receiving care from Wye Valley Trust (WVT) had access to their OPAT service. It was acknowledged that without access to this service, 1-2 PTHB patients would otherwise occupy a WVT inpatient bed every day.

Although WVT had processes in place to collaborate with the PTHB Community Nursing Teams and GP practices, towards the end of 2023/24 it became clear that work was needed to improve safety and governance of the system.

Work was initiated to address these concerns. The Medicines Management Team worked with the Assistant Director (Community Services Group), WVT Pharmacy Team, WVT Discharge Coordinator and the WVT Infectious Disease Specialist. Recognising the value that the WVT OPAT service provides to PTHB patients, this work will continue during 2024/25.

8.4 Shared Decision Making

Shared decision making is a joint process in which a healthcare professional works together with a person to reach a decision about care. It involves choosing tests and treatments based both on evidence and on the person's individual preferences, beliefs and values. It makes sure the person understands the risks, benefits and possible consequences of different options through discussion and information sharing.

The MMT actively identifies and promotes the use of appropriate, approved patient decision aids (e.g. NICE library of decision aids, NHS England » Decision support tools) to help people decide on healthcare options involving medicines.

8.5 Medicines Management Support to Care Homes and Domiciliary Care

The MMT has a dedicated resource available to support care homes and domiciliary care providers.

During 2023/24 the MMT provided support to 39 care homes, 29 of which received at least one physical visit. Visits were prioritised according to need (e.g. if the home had had a medicine related incident or if a medicine related safeguarding concern had been raised) and requests for support. The MMT supported care homes to review all processes including ordering, storage, administration and disposal of medicines and offered support and guidance based on best practice.

The MMT works closely with Powys County Council and social care agencies, and regularly supports investigations into incidents involving medicines.

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During 2023/24, a joint medicines policy was drafted with Powys County Council for the administration of medicines within domiciliary care settings. This policy, although directly pertinent to staff members employed by agencies under contract with the local authority, is still relevant to health board staff and is expected to be signed off by all parties during 2024/25.

9. Staff and Resources

9.1 Team structure

The health board has a small MMT (~ 31 WTE) made up of pharmacists (~10 WTE), pharmacy technicians (~16 WTE), Assistant Technical Officers (ATOs) (1 WTE), administrators (1.4 WTE), Medicines Management Nurses (0.9 WTE), a data analyst (1 WTE) and a project manager (1 WTE). Pharmacists and pharmacy technicians are registered professionals, regulated by the General Pharmaceutical Council.

The team provides medicines management support and advice to health and social care right across the 2,000 square miles geography of Powys, including but not restricted to: community nursing teams (e.g. community nurses, district nurses, school nurses, health visitors), community hospitals (x 10), specialist teams (e.g. dietetics, tissue viability, Occupational Health, immunisations and vaccinations, Gender Specialist), GP practices (x 16 + branch surgeries), community pharmacies (x 23), care homes (x 39), women and children's services, mental health services, domiciliary care providers, dental practices, optometrists, patients, carers, members of the public etc.

The team is sub-divided into 5 key teams:

- Primary Care
- Community Services
- Commissioned Services and high-cost drugs
- Digital transformation and Medicines Safety
- Pharmacy Stores

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

Recruitment of suitably experienced pharmacy professionals is a significant challenge for the NHS in general, but it is particularly challenging for PTHB due to our expensive rural geography.

9.2 Skill mix

The introduction of the Assistant Technical Officer (ATO) role to the team during 2021/22 has proved to be a huge success, allowing delegation of appropriate tasks from pharmacists to technicians and from technicians to ATOs, relieving some of the pressure presented by the recruitment challenge and ensuring that pharmacy professional skills are used appropriately.

All pharmacy professionals are expected to work at the top of their license.

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9.3 Training

9.3.1 Undergraduate, foundation and postgraduate training

During 2023/24 the following training was undertaken by members of the MMT, with considerable time commitment and support from our Education and Training Lead, workplace supervisors and other team members:

- One pharmacy technician successfully completed the Medicines Management training programme, attaining competence in: ○ Module 1 Accurately supplying medicines to individual patients ○ Module 2 – Determining the suitability of Patient's Own Drugs for use ○ Module 3 – Medicines reconciliation (Level 1 & 2)
- One medicines management hospital support pharmacy technician successfully completed the level 4 clinical diploma.
- One medicines management hospital support pharmacy technician successfully completed the Accredited Checking Pharmacy Technician (ACPT) qualification.
- One HEIW funded pre-registration pharmacy technician (PRPT) successfully joined the General Pharmaceutical Council's register as a qualified pharmacy technician.
- Three trainee pharmacists were hosed, each spending 4 months in secondary care.
  - The health board received financial support from HEIW to allow the additional work required to support these students to be undertaken.
- Two pharmacists and one medicines management lead technician completed the Institute of Leadership and Management (ILM) level 5 course in leadership and management.
- One pharmacist completed the ILM level 5 course in effective coaching and mentoring.
- One pharmacy Assistant Technical Officer gained an NVQ level 2

9.3.2 Medicines Management Training

Medicines Management Training is provided by members of the MMT to PTHB staff. This includes Medicines Administration, Recording, Review, Storage and disposal (MARRS) training and Discretionary/homely medicines training.

9.3.2.1 Medicines Administration, Recording, Review, Storage and disposal (MARRS) The purpose of the training is to set out the minimum standards of practice that must be adopted by all healthcare staff involved in the administration (including supporting patient /servicer user self-administration), recording, review, storage and disposal of medicines. The training is based on the All Wales Policy for MARRS. Training sessions are held monthly and are delivered by a Medicines Management Nurse.

Eight, one hour sessions were held during 2023/24 and despite the requirement for every healthcare professional who administers medicines to complete this training, and feedback confirmed that the training is informative, beneficial and relatable to the roles of those attending, attendance was poor. During 2024/25 more work will be undertaken to promote the course and improve attendance rates and contribution/interaction during the training.

9.3.2.2 Discretionary/homely medicines training

The Area Prescribing Group approved the updated Discretionary Medicines Policy in June 2023. Training to support the implementation of the updated policy began in October 2023. Training sessions are offered once a month and are delivered by the Medicines Management Nurse.

41 nurses booked to attend the training during 2023/24 with 30 of them actually attending.

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Feedback confirmed that the training was informative, beneficial and relatable to the roles of those attending. During 2024/25 more work will be undertaken to promote the course and improve attendance rates and contribution/interaction during the training.

9.3.3 Vaccination Teams

Training is provided by the Pharmacy Stores Team to healthcare professionals across the health board to ensure that vaccine management is robust, ensuring that patients receive safe and effective vaccinations/immunisations.

10. Governance

10.1 Safe and secure management of medicines

Medicines are used right across the health board and the safe and secure handling of medicines is essential to ensure patient safety.

Overall accountability for the safe and secure management of medicines sits with the executive team. The Chief Pharmacist, appointed by the executive team, is responsible for setting the overall framework and policy standards for the safe and secure management of medicines across the health board and for raising awareness of the potential risks involved in the safe and secure management of medicines and how they impact patient and public safety.

Operational leaders are responsible for ensuring that the organisation's medicines requirements are reflected in operational frameworks, procedures and plans,.

Individuals handling medicines must be competent, legally entitled, appropriately trained and authorised to do the job.

The MMT uses four core governance principles to underpin a framework for the safe and secure handling of medicines, to develop working practices, policies and procedures:

- Principle 1: Establish assurance arrangements – 'say what we do and why we do it'
- Principle 2: Ensure capacity and capability – 'train people and ensure they have the necessary competencies and resources'
- Principle 3: Seek assurance – 'do what we say and prove it'
- Principle 4: Continually improve – 'improve what we do'

Highlighting the responsibility for the safe and secure management of medicines remains a key priority for the MMT. The team is working to embed a culture of evaluation and learning and improvement throughout the organisation, ensuring that it is seen as everybody's responsibility.

The Pharmacy Team routinely audits all key processes (e.g. CD stock checks, expiry date checks, stock rotation, temperature monitoring, key management) and consequent remedial action, including escalation, is taken where necessary.

10.1.1 Transport

Stock and named patient medicines are supplied to PTHB clinical services by Nevill Hall Hospital (NHH). Bronglais Hospital also supplies named patient medicines to our clinical services in the north of Powys. These services are provided under SLAs held between PTHB and ABUHB/HDUHB.

In July 2023, NHH identified that medicines requiring ambient temperature storage were being exposed to temperatures in excess of 25°C during the transportation process. To address this issue,

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the Pharmacy Teams (NHH and PTHB) worked in collaboration with PTHB Support Services and the Health Courier Service to identify a solution. In November 2023a temperature controlled vehicle was commissioned to transport medicines from NHH to PTHB sites, providing assurance that the temperatures required for both ambient and cold storage medicines were being maintained throughout the transportation process.

10.1.2 Temperature monitoring

Routine monitoring of ambient and cold temperature medicines storage areas across the health board is embedded in the work undertaken by the Pharmacy Team. Thermometers and data loggers are in use in all medicines storage areas.

The age of the health board's estate and our limited ability to invest in upgrading medicines storage areas means that ambient temperature breaches are not uncommon, particularly in the warmer summer months.

2023 was the second hottest year on record for the UK. Consequently, the Pharmacy Team received frequent reports of ambient temperatures rising above 25°C. Obvious causes were identified and addressed (e.g. blinds left open during a heat wave) and mean kinetic temperature monitoring was used to provide an overall temperature reading for the period in question to establish whether further action was required (e.g. reduction of product expiry dates).

The MMT also provides support in the event of cold chain breaches. During 2023/24 the team was made aware of 17 cold chain breaches on health board sites and 32 incidents in primary care (i.e. GP practices). Every incident that the MMT is made aware of is investigated, consuming considerable resource in terms of staff time. Many of the incidents have a financial consequence due to the loss of medicines/vaccines. Some incidents have a direct impact on patient care as a result of a medicines not being available following a cold chain breach. Work is being undertaken to increase the uptake of cold chain management training and to share learning associated with incidents, to help reduce any avoidable loss of medicines/vaccines and the associated impact on patient care and staff time.

During 2023/24 the Pharmacy Team worked closely with clinical teams to raise awareness of the importance of temperature monitoring and escalation of concerns. Ensuring that temperature monitoring, along with the safe and secure management of medicines is everyone's concern and not just that of the Pharmacy Team continues to be a priority.

10.2 Risk register

The Medicines Management/Pharmacy Team has an established risk register that is used to highlight and monitor identified risks.

There were 18 individual risks on the Medicines Management Risk Register during 2023/24. 14 of the risks were managed to a satisfactory level and 4 risks were escalated.

The escalated risk included:

- Inadequate specialist mentally health pharmacy professional support.
- Legal access to medicines for 'visiting' clinicians ○ Request for legal advice submitted
- Health board ability to support triage and access to COVID-19 treatments for eligible patients
- Pharmacy recruitment challenge in north and impact on wider pharmacy team.

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Throughout 2023/24 the risk register was reviewed and updated on a regular basis.

During 2024/25 the MMT will work with the Risk and Assurance Group to ensure that risks are managed, reviewed and escalated to the executive team as appropriate

10.3 Safe and secure management of controlled stationery

Controlled stationery is any stationery, which, in the wrong hands, could be used to obtain medicines fraudulently.

During 2023/24 the Medicines Management Team undertook work to strengthened arrangements for the safe management, storage, distribution and use of prescription forms. Work was started on the development of a standard operating procedure to ensure robust management of controlled stationary across the health board. This work will continue during 2024/25.

During the course of this work it was identified that a number of clinical teams were posting prescriptions to patients. Work has been undertaken with these teams to ensure that the postal route is only used as a last resort, in exceptional circumstances. Where posting is necessary staff have been reminded of the requirements detailed in the Medicines Policy (page 161-162).

Further work will be undertaken during 2024/25 to ensure that the health board has a full understanding of the extent to which postal services are used for prescriptions and medicines. The Medicines Management Team will then work with clinical services to review current practice and to ensure that safe, robust auditable processes are in place.

10.4 Controlled Drugs

The Controlled Drugs Accountable Officer (CDAO) provides an annual report to PEQS. The latest report was provided in January 2024 and should be referred to for further information. The next report will be submitted to PEQS for consideration early in 2025.

10.4.1 Home Office Licences

In February 2023 the Chief Pharmaceutical Officer for Wales and the Home Office's Head of Drugs and Firearms Licensing Unit wrote to Chief Pharmacists, CDAOs and Board Secretaries requesting that health boards assured themselves of compliance with the requirements for controlled drugs licensing.

In response, the health board reviewed all services and identified areas where controlled drugs licenses may be required. Applications were submitted to the Home Office during 2023 for licenses for each of the health board dental clinics that are not located on health board hospital sites, including the dental bus.

Although the Home Office Licences are not yet in place, the Chief Pharmacist and Dental Director have worked closely with the Home Office's Head of Drugs and Firearm Licensing Unit and assurance has been provided by the Home Office that the Dental Clinics can continue to hold controlled drugs and use them in an emergency whilst the Home Office considers the licensing requirements for Powys. This work will continue during 2024/25.

10.5 Audit

During 2023/24 the MMT Annual Audit Plan included:

- **National audit:**

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- Antimicrobial stewardship (Start Smart Then Focus)

- **Local service improvement audits** ○ Compliance with Patient Safety Notice 055 (PSN 055)
  - safe storage of medicines (including controlled drugs) ○ Patient Group Directions – legal requirements
  - Audit of authorisation process for staff to use PGDs
  - Record keeping regarding the use of PGDs
  - Use of PGDs across the health board
- Chief Pharmacist responsibilities: Medical Gases ○ Storage, supply and usage

A closure report was provided to PEQS at the end of the financial year.

11. Challenges/opportunities for improvement

11.1 Implementing 56-day prescribing

In October 2022, the All Wales Medicines Strategy Group published 'All Wales Guidance for Prescribing Intervals'. The guidance encourages a move away from the 28-day prescribing interval to longer prescribing intervals where clinically appropriate, recognising the benefits to pharmacies, GP practices and patients.

Although the health board is committed to implementing this guidance given the benefits that it would bring, the unforeseen consequence of significant financial loss to dispensing GP practices has not been resolved.

The health board is continuing to discuss this challenge with Welsh Government.

11.2 Governance arrangements

The Medicines Management and Pharmacy Team is committed to ensuring that processes are in place to support evidence-based, cost-effective and transparent decision making. During 2024/25 work will be undertaken with the executive team to ensure that decision making is appropriately delegated and that reporting structures are in place for all medicines related groups.

11.3 Access to data

Although access to primary care prescribing data is good , prescribing data alone does not allow informed discussions to take place with prescribers. Access to admissions data and key primary care performance data is essential if we are going to proactively drive change in primary care prescribing and understand where we need to focus our efforts. For example, we need to understand what is driving our unplanned admissions so that we can explore how changes in prescribing practice can have an impact on improving patient outcomes and reducing the financial burden.

We also need improved access to primary care data (e.g. condition specific prevalence data, performance against HbA1c, cholesterol, blood pressure targets) so that we can identify areas that we need to focus on to improve outcomes and reduce financial burden.

Prescribing data for patients admitted to our community hospitals is not currently easily accessible, although the imminent implementation of ePMA will change this Until ePMA is implemented, inpatient prescribing data can only be accessed by manual reviews of prescription charts.

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11.4 Recruitment

Attracting pharmacy professionals to work in Powys is an ongoing challenge. North Powys is particularly challenging and two clinical pharmacist posts have remained vacant since February 2024, despite repeated adverts to attract suitable candidates.

Locum pharmacists are used as an absolute last resort, however even that option has become more challenging. Since COVID, locums appear to be more interested in roles that they can do remotely. Where a locum has been interested in providing face to face support, accommodation costs have been prohibitively expensive.

The recruitment challenge continues to put additional pressure on the existing clinical pharmacy professional team and risks compromising patient care due to the team's reduced presence, particularly in North Powys.

11.5 Specialist Mental Health Pharmacy Professional support

The health board has four mental health wards, Crug (Brecon), Tawe (Ystradgynlais) and Clewedog (Llandrindod) wards and Felindre (Bronllys); three sites delivering community mental health services , Fan Gorau (Newtown), Ty Cloc (Bronllys) and The Hazels (Llandrindod) and an acute mental health assessment unit, Felindre (Bronllys).

During 2023/24 Felindre Ward received limited support from a specialist mental health pharmacist (0.2 WTE), commissioned through the pharmacy SLA held with ABUHB. Although the specialist pharmacist was also available to answer ad hoc queries, no dedicated specialist pharmacy professional support was available to our other inpatient units or community mental health services.

During 2023/24 ABUHB serviced notice on the mental health pharmacy professional support they were providing to PTHB due to workforce challenges within their own organisation. Consequently, no specialist pharmacy professional support will be available to our mental health services from mid 2024/25.

In the absence of support from specialist mental health pharmacy professionals, we are unable to provide assurance that medicines use is safe, secure, effective and prudent within our mental health services.

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Agenda item: 5.6

PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE	**11 FEBRUARY 2025**
Subject:	Controlled Drugs Accountable Officer Annual Update October 2023 – September 2024
Approved and presented by:	Kate Wright, Executive Medical Director, Jacqui Seaton, Chief Pharmacist
Prepared by:	Chief Pharmacist & Controlled Drugs Accountable Officer
Other Committees and meetings considered at:	Controlled Drugs Local Intelligence Network (January 2025) Executive Committee - 15 January 2025

PURPOSE:

To provide PEQS with the Controlled Drugs Accountable Officer's (CDAO) Annual Update for October 2023-September 2024. The report provides:

- Background information about the legislation relating to CD governance
- Information about the CDAO and the Controlled Drugs Local Intelligence Network (CD LIN).
- Summary of CD incident reports received, and common themes associated with them
- Details of arrangements for:
    - CD declarations/self-assessments and baseline assessments
    - CD Authorised Witnesses (for CD destructions)
    - Standard Operating Procedures (SOPs)
    - Education and training
    - Monitoring CD prescribing
    - Home Office Domestic CD Licensing
- Outline of the plans for the year ahead

RECOMMENDATION(S):

The Committee is asked to:

- **RECOGNISE** the progress that has been made during the last 12 months **NOTING** that there is further work required to strengthen some arrangements across the health board and through collaborative working with partners., as outlined in the report.
- Take **ASSURANCE** that future actions have been identified to address the further work.

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

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Y	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	Y	

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EXECUTIVE SUMMARY:

Controlled Drugs Accountable Officer (CDAO) Annual Update October 2023 – September 2024

1. Introduction

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

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

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

2. Controlled Drugs Accountable Officer (CDAO)

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

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

The health board's CDAO is responsible for all aspect of controlled drugs management across the organisation. The roles and responsibilities of the CDAO are detailed in the Regulations.

3. Powys Controlled Drugs Local Intelligence Network (CDLIN)

Regulation 18 requires the health board's CDAO to establish a local intelligence network (CDLIN) to support the sharing of information relating to CDs across the health economy. Members of the CDLIN have a duty to cooperate by disclosing relevant information to the CDLIN (Regulation 25)

Powys CDLIN membership includes:

PTHB Controlled Drug Accountable Officer (Chair)	NHS Counter Fraud officer
PTHB Medical Director/Deputy Medical Director	Healthcare Inspectorate Wales (HIW)
PTHB Head of Primary Care Medicines Management	General Pharmaceutical Council (GPhC)
PTHB Senior Pharmacy Technician Primary Care	Shropshire Doctors OOH provider (Shropdoc)

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PTHB Head of Community Services Pharmacy	Local Authority Representative
PTHB Senior Technician Community Services	Ministry of Defense (MOD)
Care and Social Service Inspectorate Wales (CSSIW)	Drug and alcohol service (Kaleidoscope)
Welsh Ambulance Services NHS Trust (WAST)	Representatives from Powys provider hospitals
Dyfed-Powys Police	National Controlled Drugs Lead

The CDLIN meets quarterly; four meetings were held between October 2023 and September 2024. Attendance at the meetings was good, although Healthcare Inspectorate Wales (HIW) has not provided a new member since their previous representative moved to a new position.

4. CD incident reports/Quarterly Occurrence Reports

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

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

The CDLIN receives quarterly Occurrence Reports (providing details of incident reports received) from designated bodies:

- Powys Teaching Health Board
- Welsh Ambulance Service

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

Number of incidents reported through Occurrence Reports received by the CDLIN from designated bodies:

Designated body	Number of incidents reported to CD LIN Oct 22 – Sept 23	Number of incidents reported to CD LIN Oct 23 – Sept 24
Powys Teaching Health Board	43*	48*
Welsh Ambulance Service	4**	3**

*The numbers include CD incidents reported by PTHB provider services (e.g. community hospital wards/departments, community nurses), primary care contractors, care homes and Dyfed-Powys Police.
** Incidents occurring within the geography of Powys

In last year's annual update, the CDAO committed to increase the number of CD incident reports received from community pharmacies. In the last 12 months there has been a fourfold increase in reporting from community pharmacies, although it has not been necessary to report all of these incidents through the CD LIN (therefore, not all incidents are reflected in the numbers in the table above). 56.5% of our pharmacies submitted CD incident reports in the last 12 months, compared to 30% in the previous year.

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Summary of key CD incident themes:

PTHB	Welsh Ambulance Service
• Dispensing error/query • Balance discrepancy • Lost or stollen CDs/CD Prescriptions • Damaged/spilled CDs • Prescribing error/query • Safe custody breach • Administration error (e.g. wrong drug) • Inappropriate destruction • Fatal drug poisoning (suspected suicide)	• Accidental loss of CD during dose preparation • Omissions in administration records

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

Over the last 2 years work has been undertaken to strengthen mapping of CD incidents, allowing identification of common themes as well as identifying areas that have experienced multiple CD incidents and those that are not reporting incidents at all. This work has helped to identify areas requiring targeted interventions and allowed enhanced surveillance to be implemented where necessary.

5. CD Standard Operating Procedures (SOPs)

Regulation 9 requires the CDAO to ensure that there are adequate and up to date SOPs in place to support the safe management and use of controlled drugs. CD SOPs are detailed written instructions that aim to achieve uniformity in the way that CDs are managed across the health board. They are live documents that are kept under constant review.

Benefits of CD SOPs include:

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

The list below provides details of the health board's current CD SOPs:

- Ordering of stock and named patient controlled drugs (MMP 437)
- Receipt and storage of controlled drugs (MMP 435)
- Prescribing of controlled drugs (MMP 436)
- Administration of controlled drugs (MMP 448)
- Controlled Drugs record keeping (MMP 450)
- Destruction of controlled drugs (SOP for authorised witnesses) (MMP 419)
- Collection of medication (including controlled drugs) from community pharmacies. (MMP 425)

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- Management of concerns or incidents relating to controlled drugs (MMP 434)

Two additional SOPs are being developed and will be finalised and published before the end of the current financial year:

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

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

The safe and secure management of CDs is also covered in the health board's Medicines Policy which can be accessed via the Medicines Management pages of the health board's website.

6. CD destruction/Authorised witnesses (Regulation 10)

The CDAO is responsible for ensuring that the health board, and any body or person acting on behalf of, or providing services under arrangements with the health board, establishes and operates appropriate arrangements for securing the safe destruction and disposal of controlled drugs.

To support this responsibility, nine members of the Medicines Management Team are currently trained to witness the destruction of controlled drugs. These individuals are known as Authorised Witnesses.

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

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

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

Time period	**Number of requests received to witness the destruction of CDs (% by area)**
October 2020 – September 2021	41 (56% hospital, 34% pharmacy, 5% GP, 5% dentist)
October 2021 – September 2022	69 (63.8% hospital, 27.5% pharmacy, 7.2%GP, 1.5% dentist)
October 2022 – September 2023	88 (61.3% hospital, 18.2% pharmacy, 12.5% GP, 8% dentist)
October 2023 – September 2024	78 (51.3% hospital, 25.6% pharmacy, 15.4% dentist, 7.7% GP)

The percentage of requested destructions waiting more than 28 days from the date that the request was received, to the date that the Authorised Witness attended, continues to decline (59% (Oct 20 – Sept 21), 32% (Oct 21 – Sept 22), 22% (Oct 22 – Sept 23), 19% (Oct 23 – Sept 24)).

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7. **Declarations and self-assessments** (Regulation 12)

As part of the CD monitoring and auditing arrangements, CDAOs have the power to request periodic declarations/self-assessments from general medical practitioners on the health boards performers list. These are used to obtain information about:

a) whether the practitioner uses controlled drugs at any of the premises from which he or she provides primary medical services as part of the health service; and

b) how the practitioner manages and uses controlled drugs at those premises.

Practice level declarations/self assessments were obtained during 2023/24 and these were used to inform additional questions that needed to be asked and to identify practices requiring assurance visits.

Over the last 12 months, progress has been made with the development of a Microsoft Form to facilitate the collection of declarations/self-assessments from individual general medical practitioners on the health board's performers list. The Microsoft Form will be finalised before the end of the current financial year, following which all general medical practitioner on the health board's medical performers list will be required to complete and submit a declaration/self-assessment. These will be used to provide further assurance that robust systems and processes are in place to ensure the safe and secure management and use of controlled drugs in primary care. Any issues identified in the declarations will be addressed.

After 2025/26, the performers list will be reviewed annually to identify new additions, these individuals will then be asked to complete a declaration/self-assessment as soon as possible. It is anticipated that resubmission of 'periodic' declarations will be requested every 3 years following the initial submission.

It should also be noted that the legislation also empowers other organisations to request periodic declarations /self-assessments:

- Healthcare Inspectorate Wales may request an appropriate periodic declaration and an appropriate self-assessment from:

    a) an NHS Trust, or a person registered with that NHS Trust who provides health care; and

    b) a Local Health Board

- Care Inspectorate Wales may request an appropriate periodic declaration/self-assessment from a Welsh Care Home.

- The General Pharmaceutical Council may request an appropriate periodic declaration/self-assessment from a registered pharmacy

8. **Education and training resources**

Regulation 13 requires the CDAO to ensure that relevant individuals receive appropriate training.

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

To be approved as an Authorised Witnesses, suitable candidates are required to complete training and demonstrate competence before being authorised to undertake this role by the CDAO.

Over that last 2 years, 37 healthcare professionals (GPs, pharmacists, pharmacy technicians and nurses) from 9 GP practices across Powys have completed the PrescQIPP e-learning course ('reducing opioid prescribing in chronic pain') that was included in the Medicines Management Incentive Scheme. The course provides tools and information required to tackle the growth in opioid use and to improve outcomes for patients with chronic non-cancer pain.

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

- All Wales Analgesic Stewardship Guidance (updated July 2023) – aimed at improving patient outcomes, reducing analgesic-related harm and ensuring cost-effective use of analgesics to provide optimal pain management.
- All Wales Pharmacological Management of Pain Guidance (updated July 2023) – supporting prescribers to make the best choice when using medicines for pain management. This guideline was accompanies by four appendices covering: low back pain, neuropathic pain, fibromyalgia and key messages

Both guidelines and the associated appendices have continued to be actively promoted to clinicians over the last 12 months.

Health Education and Improvement Wales (HEIW) resources to support analgesic stewardship and pain management are also actively promoted to clinicians

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

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

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

9. Monitoring CD Prescribing

The health board's Medicines Management Team routinely monitors CD prescribing. Local monitoring includes:

- CD key performance indicators:
  - Opioid burden (Oral Morphine Equivalent (OME) per 1,000 patients) see Graph 1 below

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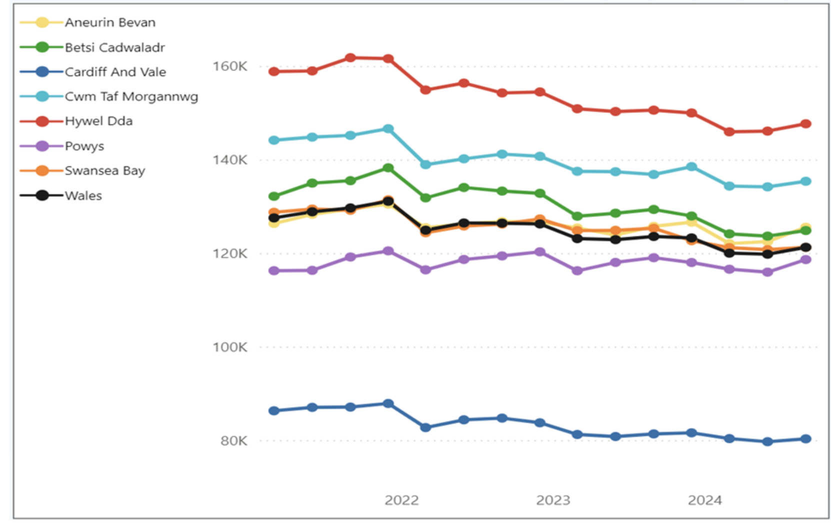
- High dose opioid burden (OME per 1,000 patients) see Graph 2 below
- Hypnotics and anxiolytics (ADQ per 1,000 patients)
- Hypnotics (temazepam, zolpidem and zopiclone) average prescription quantity
- Gabapentin and pregabalin (DDD per 1,000 patients) see Graph 3 below
- Tramadol (DDD per 1,000 patients)

- Monitoring for excessive/inappropriate prescribing (e.g. prescribing in excess of 30 days' supply at any one time).
- Monitoring increases and decreases in prescribing of CD chemical substances.

The monitoring reports are used to prioritise the CD focussed work of the Medicines Management Team. Quarterly updates are provided to the CDLIN.

Graph 1: The graph below shows health board performance against the **Opioid Burden (oral morphine equivalent per 1,000 patients)** key performance indicator:



Graph 2: The graph below shows health board performance against the **High Strength Oral Morphine Equivalent per 1,000 patients** key performance indictor:

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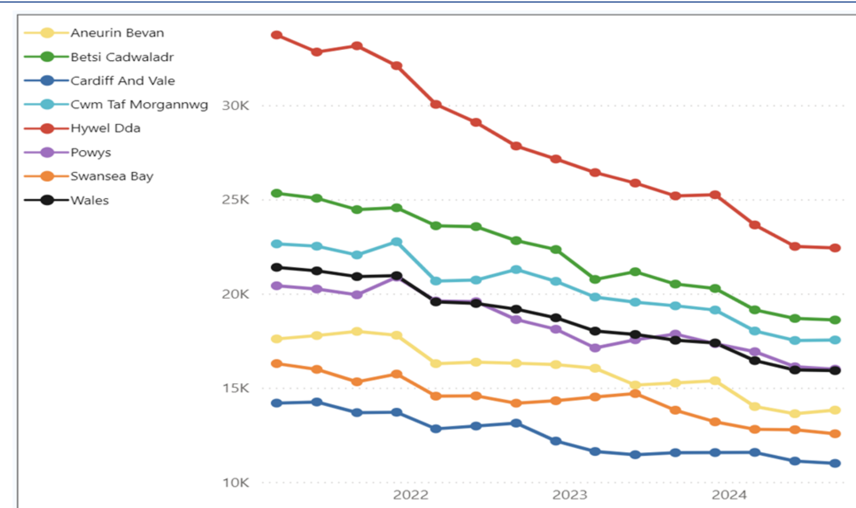
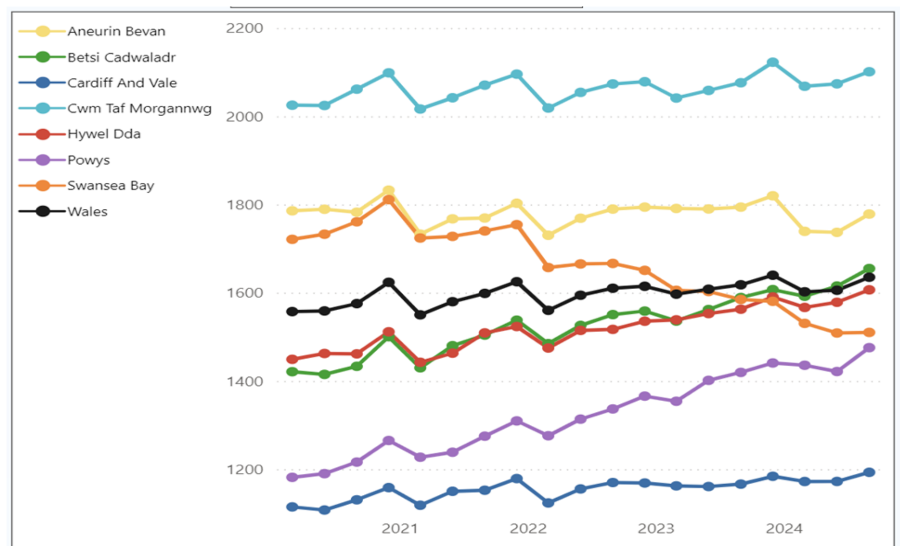


Graph 3: The graph below shows health board performance against the **'pregabalin and gabapentin DDD (defined daily doses) per 1,000 patients'** key performance indicator (the growth in prescribing of these products in Powys is a concern – one practice has been identified as a significant outlier and targeted discussions are being held with the practice to implement an action plan to address the issue)



Performance indicators are used to encourage the appropriate use of opioids, hypnotics and gabapentinoids in primary care, helping to reduce the risk of dependence, misuse, diversion and adverse drug reactions. They help the Medicines Management Team identify priority areas and practices requiring targeted interventions.

In last year's report we said that we would do further work to get a better understanding of what was driving the growth in Schedule 2 CD prescribing – a key driver in both cost and volume has been associated with ADHD prescribing.

GP practices are provided with quarterly reports showing their performance against key performance indicators compared to other practices. Practices are also contacted when any excessive and/or potentially inappropriate prescribing associated with their practice is identified. They are expected to provide an explanation and/or amend prescribing practice, as

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appropriate, in response to these queries. Although most practices respond to queries raised on behalf of the CDAO efficiently, more focussed work is being undertaken and will continue with a small number of practices.

10. Home Office CD Licenses

Following national guidance, the health board submitted four applications for domestic CD licenses for each of the dental clinics that are located off PTHB hospital sites:

- Welshpool Community Dental Clinic (Application Ref 9936813)
- Park Street Dental Clinic, Newtown (Application ref: 9939675)
- Glan Irfon Dental Clinic, Builth Wells (Application ref: 9936811)
- Dental Bus (currently located in Hay on Wye) (Application ref: 9938880)

The only controlled drug that these clinics hold is midazolam for use in emergency situations.

Although the applications were submitted to the Home Office during 2023, the Home Office is still considering whether the licenses are required in Powys.

The Home Office's Head of Drug and Firearms Licensing Unit visited PTHB during 2024 to meet with the CDAO and Dental Director. She has confirmed that current arrangements can continue while the Home Office deliberates over whether Domestic CD Licenses are required.

11. Plans for the year ahead

To comply with the legislative requirements, ensure patient safety and maintain public confidence, the safe management and use of controlled drugs, the work of the CDAO and CDLIN, must remain a high priority.

Priorities:
Continue to raise awareness: Ensure that there is widespread awareness of the identity and roles/responsibilities of the CDAO across the health board and geography of Powys. Ensure that the risks associated with CDs are understood and that staff are aware of their responsibilities around CD governance and incident reporting. Ensure that there is a clear understanding of the duty to cooperate with the CDAO when concerns relating to CDs are identified.

Continue to learn from incidents and proactively share learning.

Declarations/Self-assessments: Obtain declarations/self-assessments from every general medical practitioner on the health boards performers list and address any concerns identified.

Strengthen governance arrangements: Continue to ensure that good CD governance is embedded into everyday practice. Areas to be prioritised include processes to ensure that:

- all CD incidents are reported to the CDAO within 24 hours of occurrence/identification.
- all clinical areas have robust auditable processes in place to control access to CDs.

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- balance checks are carried out routinely at a frequency that is fit for the purpose of the service.
- prescribing data is further scrutinised to identify excessive and/or inappropriate CD prescribing (expanding scrutiny beyond Schedule 2 and 3 CDs)

Develop a Microsoft Form to facilitate CD incident reporting by community pharmacy contractors: As highlighted in the report, the health board has seen a significant increase in CD incident reporting from community pharmacy contractors. However, further improvements are required (i.e. to encourage more contractors to report) and to facilitated this, members of the Medicines Management Team have worked with community pharmacy contractors to develop a Microsoft Form to simplify the reporting process. The form was approved by the CD LIN in October 2024 and is now being rolled out.

Engage with GP practices to:

- **Increase CD incident reporting:** Over the last 12 months there has been little improvement in the reporting of CD incidents by GP practices. Numbers remain low (i.e. only 2 reports in each of the last 2 years), however with the active promotion and increasing use of Datix in primary care, it is anticipated that the numbers will now grow. It should also be noted that the health board has used the practice level declarations/self-assessments to obtain assurance that robust governance processes are in place in primary care to support the safe and secure management of CDs. In last year's report we committed to including CD incident reports in the medicines management section of the primary care 'contract assurance framework' (CAF), however, in April 2024 a new contract was introduced and the focus since then has been on implementing the new national assurance framework. It is hoped that local adaptations to the CAF can be added during 2025/26, in which case CD incident reporting will be added. In the meantime, the Medicines Management Team will continue to contribute to the 'desk-top review' exercises to guide practice visits, highlighting low level reporting and areas of poor engagement. The Medicines Management Team will continue to promote and encourage active early reporting of CD incidents to the CDAO by primary care contractors.
- **Ensure prompt responses to queries raised by the CDAO**. The Medicines Management Team will continue to work with practices to improve engagement. Challenges will be escalated as appropriate.

Increase CD incident reporting by care homes and continue to strengthen governance arrangements in care homes: CD incident reporting by care homes remains very low. During 2024, the health board recruited a new senior pharmacy technician with responsibility for care homes and domiciliary care. This post holder with help to strengthen collaboration with care homes and the local authority and facilitate work to promote the benefits of incident reporting. Over the next 12 months we will actively encourage all care homes to report incidents relating to medicines, including CDs.

Home Office CD Licenses: Continue to work with the Home Office to progress the domestic CD license applications if it is concluded that the licenses are required.

Continue to **strengthen the monitoring of CD prescribing and use** in primary care and across the health board. The implementation of electronic prescribing and administration

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(ePMA) will provide an opportunity to get a much better understanding of how controlled drugs are being used in our community hospitals.

Area Planning Board (APB): Over the next 12 months, the CDAO will work in collaboration with the APB to raise awareness of the challenges associated with controlled drug prescribing across Powys (particularly the gabapentinoids), to improve access to substance misuse services for citizens addicted to prescriptions medicines, to progress work to implement shared care arrangements to allow primary care clinicians to accept responsibility for substitute opioid prescribing (to facilitate access to care closer to home and to release capacity within the specialist service), and to improve access to services offered by community pharmacies to support citizens with challenges associated with substance misuse (e.g. blood borne virus testing, syringe and needle exchange, supervised consumption).

Private clinicians: Work with Welsh Government and CDAOs across Wales to establish standardised assurance processes for applications to requisition controlled drugs as part of a clinician's private practice. CDAOs across Wales have seen an increase in such applications over the last 12 months and this has highlighted the need for a national standardised process which provides CDAOs with assurance that it is appropriate to approve an individual, and also provides a robust monitoring process of activities of any clinician approved.

12. Conclusion

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

It is recognised that there is still work to be done, particularly to support primary care contractors and care homes to report CD incidents to help us understand incident themes and to allow learning to be shared to enhance the safe and secure management of CDs and improve patient safety. It should however be noted that considerable progress has been made with community pharmacy contractors, resulting in a fourfold increase in incident reporting over the last 12 months.

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

IMPACT ASSESSMENT
Not required for this report

Patterson,Liz
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Agenda item: 5.7

Patient Experience Quality Safety Committee	**11 February 2025**
Subject:	**Transition and Handover Annual Report 2023-24**
Approved and presented by:	Claire Roche Executive Director of Nursing, Quality, Womens and Family Health
Prepared by:	Jayne Wheeler Sexton Assistant Director of Nursing, Safeguarding
Other Committees and meetings considered at:	Executive Committee - 22 January 2025

PURPOSE:

To present to the Patient Experience, Quality & Safety Committee Powys Teaching Health Board's Transition and Handover Annual Report 2023-24

RECOMMENDATION(S):

PEQS Committee are asked to;

1. RECEIVE and take ASSURANCE against the progress being made across the Health Board in relation to Welsh Government Transition and Handover Guidance (2022).

Approve/Take Assurance	Discuss	Note
Y	Y	N

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

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EXECUTIVE SUMMARY:
PTHB Transition and Handover Annual Report presents the progress made during 2023-2024 which have supported the Health Board to meet the Welsh Government Transition and Handover Guidance. The guidance can be accessed here - The Transition and Handover Guidance February 2022 The Annual Report identifies key improvements required following the 2022 Gap Analysis, the role of PTHB Transition & Handover Task & Finish Group, which is now PTHB Oversight Group, what was achieved in 2023-2024, Service Updates and Next Steps
1. Introduction The Transition and Handover Annual Report outlines, with some examples from service groups, how each service is working towards embedding and operationalising the Welsh Government Transition and Handover Guidance. It also highlights the next steps required which will form the ongoing transition and handover improvement action plan. The Gap Analysis undertaken in 2022 using the Transition and Handover Guidance 2022, identified good practice in the following areas; some services have transition SOPs in place, are not age dependent, are ensuring a seamless transition at 18 years, can support children through to their early 20's, have identified tools for transition across some areas, good networks in place to support transition and are represented by both adult and children's services at the Joint Transition Operational Group with local authority. The Gap Analysis also identified areas for development namely; no standardised age for transition, lack of named key workers, differences between geographical locations in what services are/are not available at transition, referral to adult services may be dependent on GP/specialist centres if no child provision available in Powys, limited recognition of Additional Learning Needs Act for services up to 25 years, limited service specific transition pathways in place, increasing requests post 16 for residential placements assessments and funding. To meet the requirements within the Transition and Handover Guidance, Powys Teaching Health Board should ensure that there is clear accountability and delivery mechanisms in place which include identifying a Senior Lead who reports to the Quality and Safety Committee. There should also be mechanisms in place to capture the child and family/carers thoughts on the handover process after 6 and 12 months to help inform future service provision. There should be suitable and effective monitoring arrangements in place to monitor the guidance and a 2 yearly review to ensure it remains fit for purpose and key outcome achieved. Every child

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should have a named key worker and a documented Transition and Handover Plan (THP).
This formed the objectives for the PTHB Transition & Handover Task and Finish Group and the annual report details what was achieved in 2023-2024 again these objectives.

NEXT STEPS:

The Transition and Handover Task and Finish Group will move to an Oversight Group, accompanied by a review of its terms of reference and membership. Consideration to be given to development of a Transition and Handover Risk Register and continued collaboration with Informatics to enhance data collection and analysis efficiency. Additionally, a Multi-Professional Complex Care Panel to be developed, and opportunities for school-based planning meetings to be explored. Links with further education establishments to be strengthened, and new approaches to service sharing and feedback through the Experience Feedback Survey to be considered. Practitioner training needs to be assessed, and further development of complex transition pathways to be prioritised.

The Patient Experience, Quality and Safety (PEQS) Committee are asked to acknowledge the summary of progress to date and the ongoing work to further embed the guidance.

IMPACT ASSESSMENT – NOT REQUIRED FOR THIS REPORT
Not required

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Powys Teaching Health Board Transition and Handover Annual Report 2023-2024

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Introduction

The provision of appropriate healthcare for children and young people between the ages of 16 and 25, and handover of care and accountability from children to adult services has previously been highlighted as a key priority requiring improvement by both Welsh Government The Emotional and Mental Health of Children and Young People in Wales and the Childrens Commissioner for Wales Annual-Report-2018-19.pdf

In February 2022, the Welsh Government published a guidance document on the **management, handover and accountability** of healthcare services for children and young people during their transition from children to adult services **Transition and handover from children to adult health services | GOV.WALES**

The Transition and Handover Guidance details the steps that health services in Wales must take to meet the 2016 NICE Guidance on Transition Overview | Transition from children to adults' services for young people using health or social care services | Guidance | NICE. (National Institute for Clinical Excellence)

Between October and December 2022, Powys Teaching Health Board undertook a baseline scoping exercise against the guidance. The scoping identified local demographic information and gathered case studies, it also reviewed existing processes, completion of Transition and Handover Plans, the allocation of Transition Key Workers and existing monitoring mechanisms as defined in the guidance.

The findings indicated that very few services had Transition and Handover Plans in place and no services had a process to identify and allocate Transition Key Workers. Monitoring arrangements were either not in place or not consistent or coordinated. Transition was discussed within children's services on an individual child basis; however, this was not coordinated as an MDT (Multi-Disciplinary Team) approach and the engagement of adult services in transition planning was limited.

To support Powys Teaching Health Board, meet the Guidelines within the Transition and Handover Guidance, an implementation task and finish group was established, this was initially under the leadership of the Assistant Director of Therapies and Health Science and Deputy Director of Nursing who had co-chair responsibility for the group, the group chair has now transferred to the Assistant Director of Women and Family Health and has become an oversight group

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Welsh Government Transition Guidance states;

- Health boards and trusts must have a clear accountability and delivery mechanism in place, which includes identifying and designating a senior lead reporting to the Quality and Safety Committee, who will have accountability for ensuring implementation and quality of the transition and handover guidance across all primary, secondary, tertiary, and community services. The senior lead will be responsible for championing transition and handover at a strategic level.
- Every child and young person transferring from children to adult services will have a documented Transition and Handover Plan (THP), or equivalent.
- A Handover Named Worker is appointed from the NHS body's children's or adult services to support the transition and handover of healthcare for every child and young person.
- The health board or trust must ensure that there are suitable and effective monitoring arrangements in place.
- There should be a mechanism put in place to capture the child and young person/family/carer's impression of the transition and handover process after 6 months and after 12 months to help inform future service provision. In addition, a mechanism to capture how many people have made a representation under Putting Things Right.
- Health boards and trusts should monitor implementation of the transition and handover guidance using service user feedback, service standards, and recognised national audit outcomes, and undertake a review of structures, processes and outcomes after 2 years to ensure it remains fit for purpose and key services user outcomes have been achieved.

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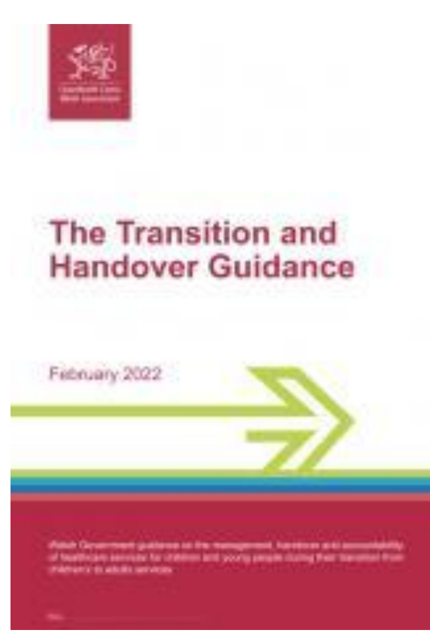
To Support Implementation of the Guidance, Welsh Government produced several resources



Moving from children to adult healthcare services - YouTube

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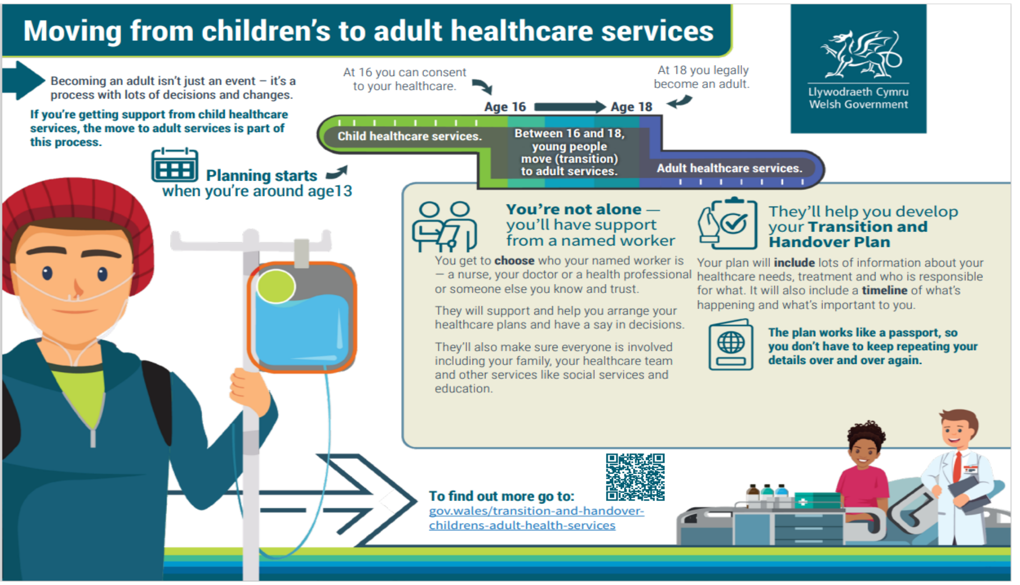

To meet requirements within the **Transition & Handover Guidance**, Powys Teaching Health Board should ensure that:

Clear accountability and delivery mechanisms in place, which include identifying and designating a Senior Lead reporting to the Quality and Safety Committee.

There are mechanisms in place to capture the child and family/carers impression of the handover process after 6 and 12 months to help inform future service provision.

Suitable and effective monitoring arrangements are in place.

PTHB monitor implementation of the guidance and undertake a review after 2 years to ensure it remains fit for purpose and key outcomes have been achieved.

Each child has handover named key worker in both child and adult services to support transition and handover

Every child transferring from children to adult services has a documented Transition and Handover Plan (THP)

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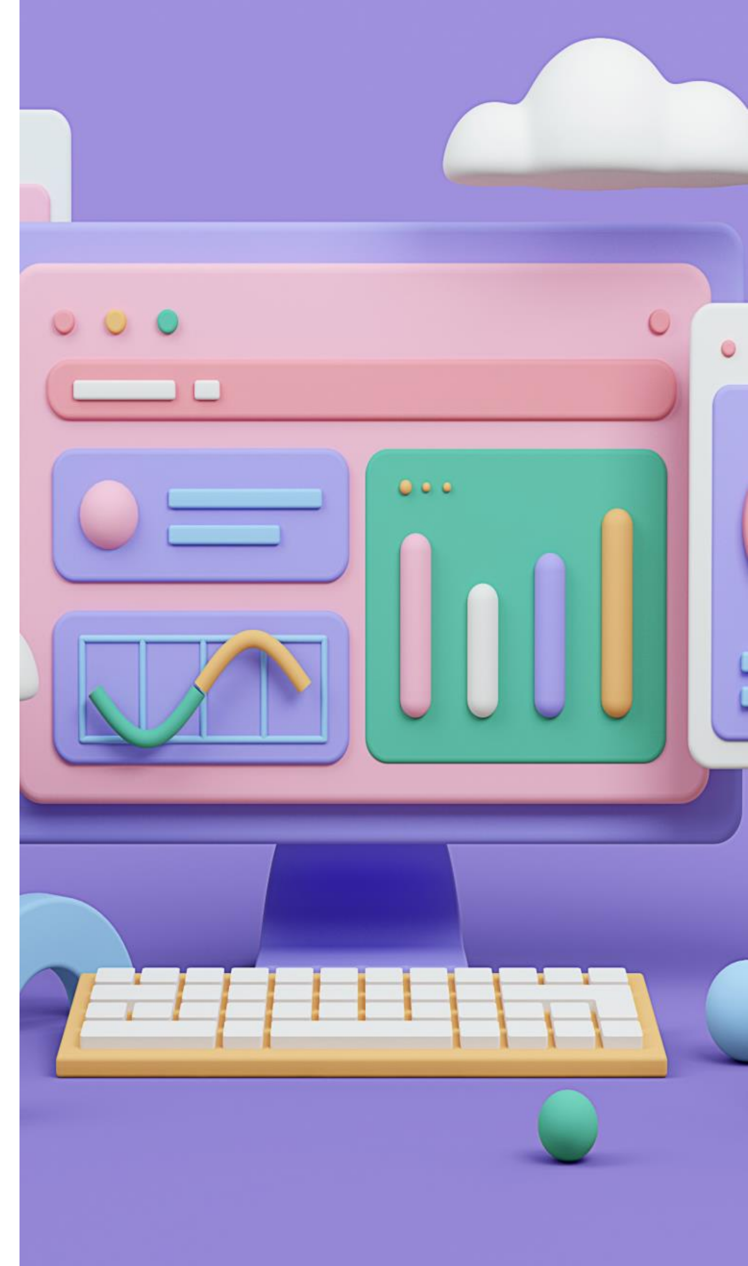
In 2022, a Gap Analysis was undertaken in Powys Teaching Health Board for children transitioning to adult services, using the Transition and Handover Guidance 2022

The gap analysis reviewed existing processes, completion of Transition and Handover Plans, the allocation of Transition Key Workers and existing monitoring mechanisms as defined in the guidance.

The findings indicated that very few services had Transition and Handover Plans in place and no services had a process to identify and allocate Transition Key Workers.

Monitoring arrangements were either not in place or not consistent or coordinated.

Transition was discussed within children's services on an individual child basis however this was not coordinated as an MDT (Multi-Disciplinary Team) approach and the engagement of adult services in transition planning was limited.



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Powys Children Population as of 31.03.24 there were;

23097	4229	1423
0 to 18 year olds	14 to 16 year olds	16 to 18 year olds

of the population of 14-18 year olds 5652, there were 12317 health contacts were made across many different services.

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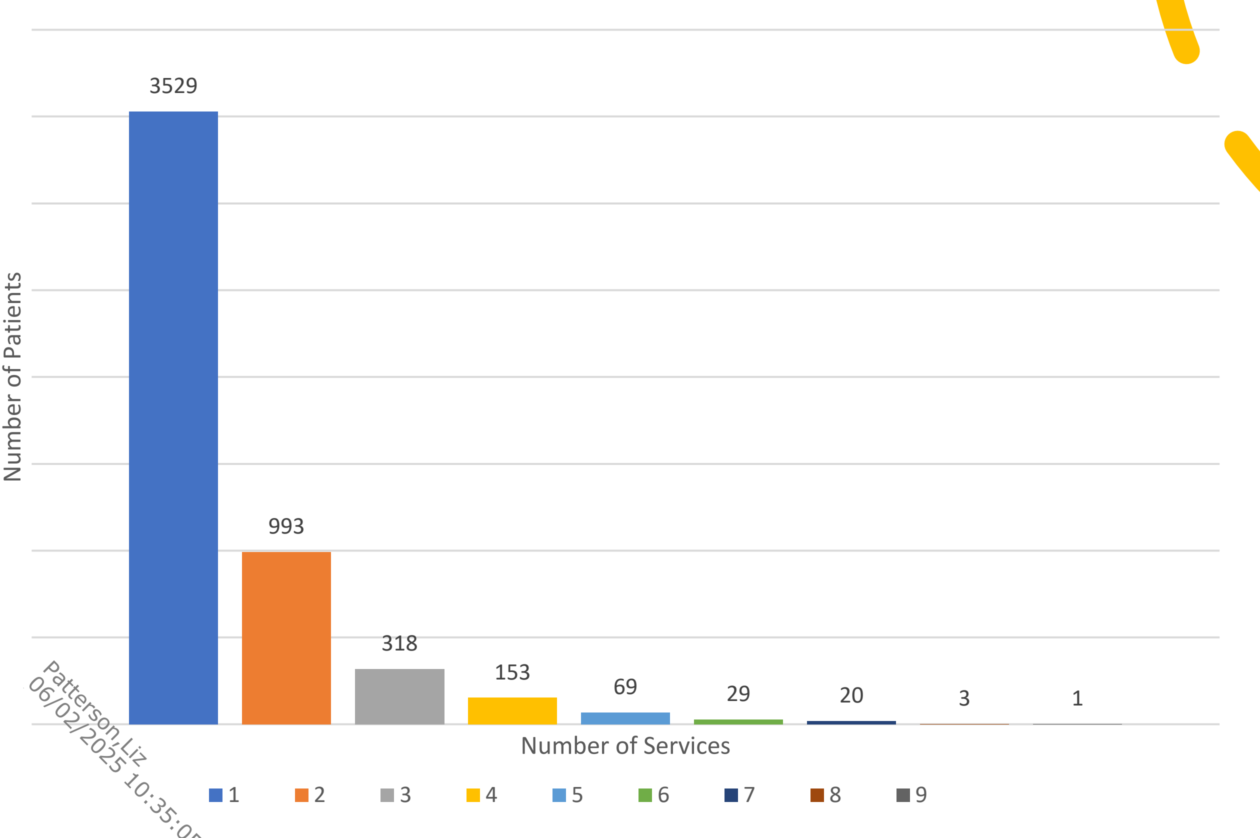
Powys Children Population



Identified Good Practice following the Gap Analysis undertaken in Powys Teaching Health Board in 2022 for children transitioning to adult services, using the Transition and Handover Guidance 2022

Agreed transition SOPs are in place in some areas e.g. audiology & continence service.	Some services are not age dependent e.g. orthotics so there is seamless transition at 18 years.	Some services can support children through to their early 20s (Physiotherapy/Occupational Therapy).
Identified tools for transition across some areas of children's services ('Ready, Steady, Go' or 'Together for Short Lives' pathway).	Individual services have good networks in place to support transitions e.g. Learning Disabilities	PTHB representation at Joint Transition Operational Group with local authority - attendance from both children and adult services.

Areas for Development following the Gap Analysis undertaken in Powys Teaching Health Board in 2022 for children transitioning to adult services, using the Transition and Handover Guidance 2022

No standardised age for transition to adult services – ages range between 16-18.	Lack of named key worker to support transition.	Differences evident between geographical locations in what services are / are not available at transition.
Referral to adult services may be dependent on GP / specialist centres if no child provision in PTHB (e.g. diabetes / brittle asthma).	Limited recognition / awareness of Additional Learning Needs Act and requirement for services up to 25 years.	Limited-service specific transition pathways in place. & Lack of formal handovers between services.
Limited like for like services across children/adults so may not have identified teams /individuals to transition to.	Apart from Children, Young People Occupational Therapy /Physiotherapy, no recognised transition roles within PTHB.	Increasing requests post 16 for residential placement assessments and funding – no formal space to discuss this and no process

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Role of PTHB Transition & Handover Task and Finish Group

The Task and Finish Group focus in 2023/24 objectives were to work towards meeting the requirements within the **Transition & Handover Guidance** and included;

1. Develop and implement a clear accountability and delivery mechanism.
2. Identify a designated senior lead reporting to the Patient, Experience, Quality and Safety Committee
3. That every child and young person transitioning from children to adult services will have a documented Transition and Handover Plan (THP), or equivalent.
4. A Handover Named Worker is appointed
5. Ensure that there are suitable and effective monitoring arrangements in place.
6. Have a mechanism in place to capture the child/family/carer's impression of the transition and handover process after 6 months and 12 months
7. Undertake a review of structures, processes and outcomes after 2 years to ensure it remains fit for purpose and key services user outcomes have been achieved
8. Prepare for Welsh Government annual review after two years on implementation.

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What was Achieved in 2023-2024 against the Task and Finish Group Objectives – Number 1 & 2

Develop and implement a clear accountability and delivery mechanism & Identify a designated senior lead reporting to the Quality and Safety Committee

Transition of Care and Handover Task and Finish Group was jointly chaired by Deputy Director of Nursing and Assistant Director of Therapies & Health Sciences. They were scheduled as monthly meetings with appropriate representatives.

Terms of Reference identified the tasks of the group, and an implementation action plan reflected the requirements within the Transition and Handover Guidance.

A reporting mechanism through to Patient, Experience, Quality & Safety Committee was in place along with an Escalation pathway to Executives.

The Groups plan included working towards "business as usual" in 2024

A Map & Gap Analysis was undertaken against the Transition of Care and Handover Guidance which included a summary of the child demographic in Powys

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What was achieved in 2023-2024 against the Task & Finish Group Objectives – Number 3

That every child and young person transitioning from children to adult services will have a documented Transition and Handover Plan (THP), or equivalent & a Toolkit

The Transition and Handover Plan, included in the WG Guidance documentation, has been adopted as a standardised plan for all children receiving healthcare in PTHB services. The plan was successfully piloted for use by the Learning Disabilities Team. The Transition and Handover paperwork was promoted through presentations delivered within service groups.

A SharePoint site hosted by the Quality & Safety Team called "Transition This is Me", developed for all staff to access support documentation including the This Is Me document.

Transition of Care Support Documentation PTHB Transition This is Me.docx

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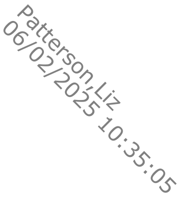
What was Achieved in 2023-2024 against the Task & Finish Group Objectives – Number 4

A Handover Named Worker is appointed

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



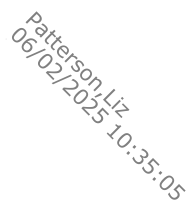
What was Achieved in 2023-2024 against the Task & Finish Group Objectives – Number 5

Ensure that there are suitable and effective monitoring arrangements in place.

During 2023-24 all Service Group Senior Management Teams received a presentation on the Transition & Handover Guidance from members of the Task and Finish group.

This included the requirements for monitoring and reporting arrangements to be developed and that these arrangements may differ for each service group.

Following conclusion of the implementation period in February 2024, the Task and Finish group changed to an Oversight Group. Service Groups became responsible for providing assurance relating to compliance to the Transition and Handover Guidance.



What was Achieved in 2023-2024 against the Task & Finish Group Objectives – Number 6

Have a mechanism in place to capture the child/family/carer's impression of the transition and handover process after 6 months and 12 months

- Mechanisms in place to raise a concern via Putting Things Right Framework
- A child/family/carers Experience Feedback Survey developed. Access to the survey via a QR code
- Posters and A5 leaflets with the a QR Code embedded available for staff to promote feedback
- Easy read version available via the QR Code
- All services are required to report Patient Experience Steering Group.

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What was Achieved in 2023-2024 against the Task & Finish Group Objectives – Number 7 & 8

Undertake a review of structures, processes and outcomes after 2 years to ensure it remains fit for purpose and key services user outcomes have been achieved & prepare for Welsh Government annual review after two years on implementation

Welsh Government annual review expected to be requested in 2025 which is when an internal review will also be undertaken

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Service Group Transition and Handover Updates

Therapies and Health Sciences

CAMHS

Learning Disability

Children Services

Paediatric Occupational Therapy & Physiotherapy

Paediatric Occupational Therapy and Physiotherapy has a mechanism in place for the implementation of the Transition and Handover guidance. This requires further work to ensure a multi professional approach supported by data systems.

Transition Champions identified in Paediatric Occupational Therapies and Physiotherapy, who attend a therapy only meeting to discuss transition.

Staff attend educational transition meetings and have strong links with further education colleges to support health needs in future educational establishments.

Ready, Steady Go documentation adopted, roll out continues and is standing agenda item at team meetings.

Health practitioners are stepping forward to be named worker

6 monthly reviews of children on caseload

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Therapies and Health Sciences

Therapies & Health Science Staff received the presentation outlining the Transition & Handover Guidance.

Bi-annual Meetings have commenced between teams which supports the identification of children and planning

Speech and Language Therapy have identified a practitioner to work with 16 plus age group of children on both child and parent/carer expectations

A patient story captured the child’s voice about their experience of being a service user from child to adult services.

Staff have received training on the Transition and Handover Guidance and a transition booklet it is in place

Monthly meetings between CAMHS and Adult Mental Health, a process is in place for introductory meetings with Adult services.

Reporting structure in place for transition between CAMHS and Adult Mental Health, project to be scrutinised through Live Well Partnership Board.

Joint Operation Policy in place between CAMHS and Adult Mental Health, work will commence to map a child's journey through the process to ensure the operational policy is being followed

A transition tracker is under development

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Care Co-Ordinator will be allocated to the child throughout the transition process

CAMHS worker can be involved with a child for 6 months beyond their 18th birthday.

Actively encouraging young people and families to utilise the feedback survey

Challenges are being worked through around the different thresholds when a child is transitioning to adults

Established a bi-annual task and finish group with paediatric services and adult learning disabilities team to agree pathways and protocol for all children transitioning

Two Task and Finish Groups have been established to review required documentation and to monitor arrangements, this includes learning disabilities, paediatric services and local authority and assurance is feedback via the PTHB Oversight Group

Senior leads within the Learning Disabilities team have been identified to enable smooth transition and handover

Children's Learning Disabilities team were part of the pilot of the Ready, Steady, Go framework, consideration is now being given to the development of a digital form and pathway

Adult Learning Disabilities service have two transitional link workers who attend transitional meetings

Plan is in place for Adult Learning Disabilities team to deploy the patient experience survey

Transition meetings are well represented by all services, with identified leads having responsibility to escalate and cascade information as required.

Identified transition named workers within Children's services and where there are children with complex conditions and co-morbidities, there is an identified key worker arrangement for families.

Identified children nearing transition age through caseload reviews and validated through audit process

Service are at an early stage of implementing the handover plan and in initiating the Ready, Steady, Go framework for supporting the empowerment of children and families at transition

Children's services monitor and review transition arrangements via audit and professional support and challenge

Children's Services have an MDT process in place

Received individual patient stories about transition that have helped inform service development

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Plans going forward

Children's services plan to undertake work to better understand the long-term health needs and transitioning pathways of children who are in pathways with secondary/ tertiary care and how they transition either back to Powys adult services or adult services provided by commissioned partners

Work is required to establish a dataset and tracker and to develop complex care pathways

Powys Teaching Health Board Transition & Handover - going Forward

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Next Steps;

- Transition and Handover Task and Finish Group will move to an Oversight Group
- Review the Terms and Reference of the Transition and Handover Oversight Group Terms of Reference and Membership
- Consider the development of a Transition & Handover Risk Register
- Continue to work with Informatics to develop systems to improve the efficiencies and effectiveness of data collection and analysis
- Develop a Multi Professional Complex Care Panel
- Research for what opportunities there are to join planning meeting within a child's school
- Improve links for further education establishments
- Consider new approaches to how services share and encourage use of the Experience Feedback Survey
- Review additional training needs of practitioners and deploy training
- Complex Transition Pathways required further development

Agenda item: 5.8

Patient Experience, Quality and Safety Committee	**11 February 2025**
Subject:	**COMMITTEE RISK REGISTER**
Approved and presented by:	Helen Bushell, Director of Corporate Governance/Board Secretary
Prepared by:	Corporate Governance Assurance and Risk Officer
Other Committees and meetings considered at:	Executive Committee – 22 January 2025 Board – 29 January 2029

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 29 January 2025.

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	N

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	

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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.

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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 26 March 2025.

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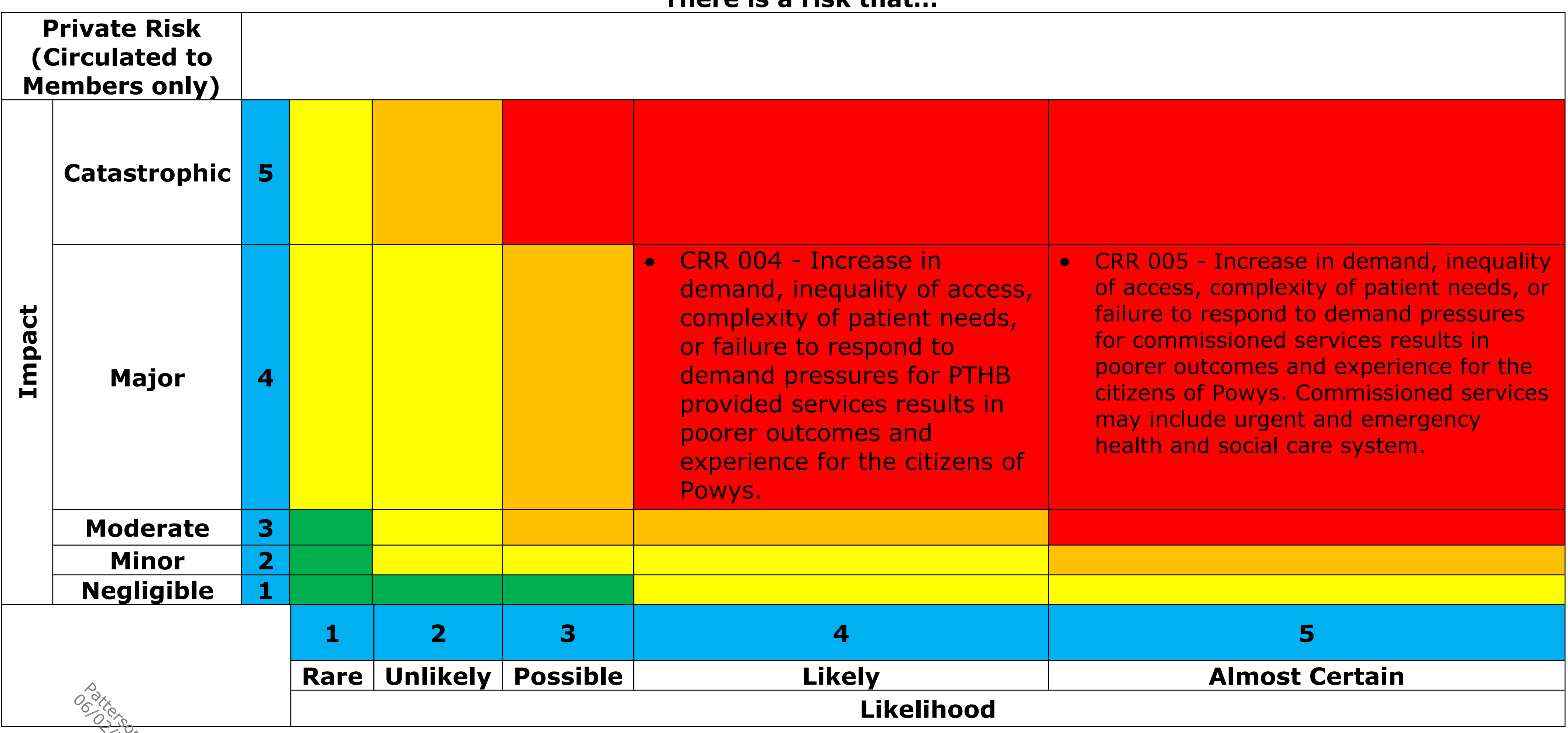
Delivery and Performance (D&P) Committee Risk Register

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				

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Risk Lead	Risk ID	Main Risk Category	Risk Description There is a risk that:	SCORE (Likelihood x Impact)	Board Risk Appetite	Risk Target	At Target ✓/✗	Lead Board Committee
D Ops / ED PP&C	CRR 004	Quality	Increase in demand, inequality of access, complexity of patient needs, or failure to respond to demand pressures for PTHB provided services results in poorer outcomes and experience for the citizens of Powys.	**4 x 4 = 16**	Cautious	12	x	Patient Experience, Quality and Safety Committee
ED PP&C	CRR 005	Quality	Increase in demand, inequality of access, complexity of patient needs, or failure to respond to demand pressures for commissioned services results in poorer outcomes and experience for the citizens of Powys. Commissioned services may include urgent and emergency health and social care system.	**5 x 4 = 20**	Cautious	12	x	Patient Experience, Quality and Safety Committee

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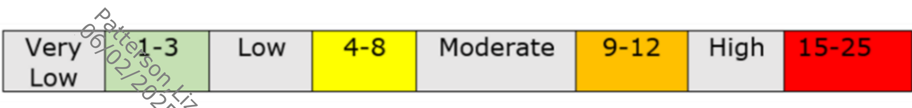
Key:
Risk Appetite Descriptors and Categories

Risk Appetite	Description
Averse	Avoidance of risk and uncertainty in achievement of key deliverables or initiatives is key objective. Activities undertaken will only be those considered to carry virtually no inherent risk.
Minimal	Preference for very safe business delivery options that have a low degree of inherent risk with the potential for benefit/return not a key driver. Activities will only be undertaken where they have a low degree of inherent risk.
Cautious	Preference for safe options that have low degree of inherent risk and only limited potential for benefit. Willing to tolerate a degree of risk in selecting which activities to undertake to achieve key deliverables or initiatives, where we have identified scope to achieve significant benefit and/or realise an opportunity. Activities undertaken may carry a high degree of inherent risk that is deemed controllable to a large extent.
Open	Willing to consider all options and choose one most likely to result in successful delivery while providing an acceptable level of benefit. Seek to achieve a balance between a high likelihood of successful delivery and a high degree of benefit and value for money. Activities themselves may potentially carry, or contribute to, a high degree of residual risk.
Eager	Eager to be innovative and to choose options based on maximising opportunities and potential higher benefit even if those activities carry a very high residual risk.

Executive Lead:	
CEO	Chief Executive
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

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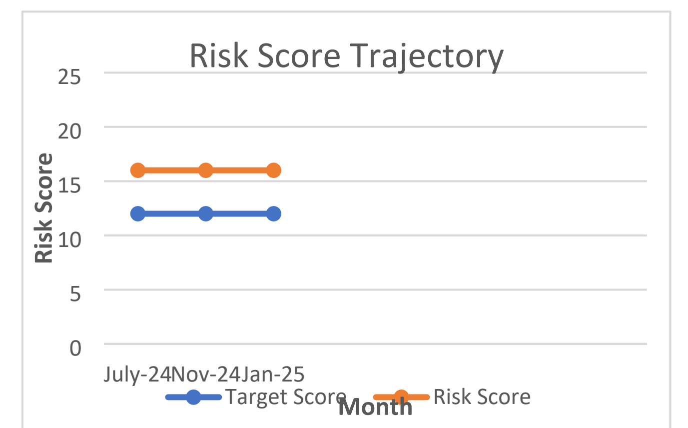
RISK APPETITE	
Category	Appetite for Risk
Safety	Averse
Quality	Minimal
Regulation and Compliance	Cautious
Reputation and Public Confidence	Cautious
Performance and Service Sustainability	Cautious
Financial Sustainability	Cautious
Workforce	Cautious
Partnerships	Open
Innovation and Strategic Change	Open

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:** Executive Director of Primary Care, Community and Mental Health. **Assuring Committee:** Patient Experience, Quality & Safety Committee
Risk Impacts on: Organisational Priorities underpinning WBO 8		**Date last reviewed:** January 2025
Risk Category: Quality		**Boards Risk Appetite:** Cautious
Risk Rating (likelihood x impact): Inherent: 4 x 4 = 16 Current: 4 x 4 = 16 Target: 3 x 4 = 12 **Date added to the risk register** July 24 **Source of risk:** Executive Team		**Rationale for current score:** **Planned Care** • NHS Wales Ministerial standards • 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 50% of our beds can be occupied by patients that are clinically optimised and ready 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 to the long term needs for patients, and an increase to overall rehabilitation needs **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**

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		• 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. **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	Delivery & Performance
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	Delivery & Performance
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	Delivery & Performance
7.4	Reviewing where services do not meet clinical and operational standards	Various data sources including operational & performance data.	Reasonable	Delivery & Performance
7.5	Constantly reviewing staffing level and the amount of agency staff being used. Additional control procedures in	Various workforce and financial reports recording	Limited	Delivery & Performance

	place to authorise the use of agency staff (particularly higher cost agency providers)	agency usage at ward and service level		
7.6	Improving the outcomes and experience data capture to inform future planning	Various data sources including operational & performance data. Qualitative information from PROMS & PREMS reporting, clinical audit, regulatory inspections	Limited	Delivery & Performance

Mitigating Actions (What more will we do?)

Action	Lead	Action update	Deadline	Action on Target
Planned Care ▪ Continue series of regular meetings with service providers ▪ 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.	February 2025and ongoing	On track

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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 change' having been approved by the Health Board and stakeholders.	Executive Director of Operations/Director of Community & Mental Health	The first two cases for change were approved by the Board in October 2024.	March 2025 and ongoing	On track
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	December 2024 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.

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CRR 005

Risk that: Increase in demand, inequality of access, complexity of patient needs, or failure to respond to demand pressures for commissioned services results in poorer outcomes and experience for the citizens of Powys. The risk relates to the Timely, Equitable, Effective and Patient Experience elements of the Duty of Quality.

Executive Lead: Executive Director of Planning, Performance & Commissioning

Assuring Committee: Patient Experience, Quality & Safety Committee

Risk Impacts on: Organisational Priorities underpinning WBO 8	**Date last reviewed:** January 2025
Risk Category: Quality	**Boards Risk Appetite:** Cautious

Risk Rating (likelihood x impact):

Inherent: 5 x 4 = 20
Current: 5 x 4 = 20
Target: 3 x 4 = 12

Date added to the risk register.
July 24

Source of risk:
Executive Team

Rationale for current score:

Planned Care

NHS Wales

- Latest validated position to month 7 (October 2024):
    - PTHB provider services continue to perform well with zero patients >52 weeks for new outpatient appointment; and zero patients >104 weeks for referral to treatment.
    - Position of PTHB commissioned services from NHS Wales providers has deteriorated for >104 weeks and > 52 weeks.
    - Additional planned care monies issued to NHS Wales providers by WG in October; improvement expected, under assessment for Powys residents.
    - Long wait pressure by treatment specialty remains within General Surgery, Trauma & Orthopaedics, ENT, and Ophthalmology.

NHS England

- Latest validated position month 6 (September 2024):

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		○ Total pathways waiting has fallen for first time since 2022/23. NHSE providers continue to aim for zero patients waiting over 65 weeks (target September 2024). ○ Powys residents who can access services in NHSE experience lower waiting times than Powys residents access services in NHSW services. ○ NHSE providers report an improved position of patients waiting > 52 weeks. ○ RJAH experiencing growing challenge for all long wait measures. ○ SATH and WVT position improved for patients waiting over 52 weeks. ○ Long wait pressure by treatment specialty remains within General Surgery, Trauma & Orthopaedics, ENT, and Ophthalmology. **Cancer** • Cancer performance remains poor against the 62 day targets in both English and Welsh commissioned services. **Urgent and Emergency Care** • In month 7 (October 2024) PTHB MIU continue to perform well with no patients waiting over 12hrs and 100% compliance on the 4 hour target. • Welsh Ambulance performance times remain challenging, however have shown slight improvement from September to October in both % of emergency responses to red calls arriving within 8 minutes and median emergency response time to amber calls.

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		• Performance in commissioned providers UEC departments does not meet required targets (both in Wales and England) but NHS Wales performance in emergency departments remains better than NHSE for Powys residents, but all major units are extremely challenged to provide timely care.

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	tbc
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	Executive Director
7.3	Using demand data to plan to commission sufficient service provision for all services provided out of county, noting the need to agree a balanced finance and performance position as part of the IMTP process	Demand, activity and financial information from commissioning datasets used to inform contract plans	Reasonable	Executive Director
7.4	Reviewing where services do not meet clinical and operational standards	Various data sources including operational & performance data.	Limited	Executive Director
7.5	Improving the outcomes and experience data capture to inform future reporting on commissioned services to the DPC and Board as well as future planning	Various data sources including operational & performance data. Qualitative information from QMS, PROMS & PREMS	Limited	Executive Director

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		reporting, concerns, NRIs, clinical audit, regulatory inspections		

Mitigating Actions (What more will we do?)

Action	Lead	Action update	Deadline	Action on Target
Planned Care ▪ Continue 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 re-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. Delays experienced in receiving improvement trajectories from some providers. Planned Care Insourced provision tender exercise delayed. Mitigating actions put in place to ensure continuity of service provision whilst tender exercise undertaken.	July 2024 and ongoing	On track

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Cancer	TBA	Added to this version of the risk register. Actions to be agreed.	TBA	TBC
Urgent and Emergency Care ▪ Continue series of regular meetings with WAST and commissioned service providers. ▪ Continue commissioning of ambulance services in partnership through the Joint Commissiong Committee ▪ Secure performance improvement trajectories and improvement plans from providers.	TBCTBC	▪ Historically had regular meetings (ICAP and Q&S) with Health Boards and WAST to cover performance, patient experience, incidents and resultant investigations, clinical indicators. Several recent ICAP meetings have been cancelled. ▪ Regular attendance at JCC and Management Group. ▪ Standing agenda item in CQPRMs to review improvement plans, patient experience, and patient harm.	July 2024 and ongoing	On track
All indicators There are some performance indicators that continue to fail the operational standard e.g. Single Cancer Pathway, 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.	TBC	A number of sub-indicator performance targets have been identified. These will be built into the IQPR	August and ongoing	On track

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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; expected improvement in NHS Wales expected following issue of additional planned care monies in October 2024 has not been delivered. Continued inequity of access for PTHB residents accessing NHSW services in comparison with NHSE. More work to do to understand the quality and patient experience impacts of this inequity.

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Deprivation of Liberty Safeguards Final Internal Audit Report

January 2025

Powys Teaching Health Board

Patterson,Liz
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Review reference:	PTHB-2425-10
Report status:	Final
Fieldwork commencement:	11 September 2024
Fieldwork completion:	06 November 2024
Debrief meeting:	26 November 2024
Draft report issued:	08 November 2024 & 10 December 2024
Management response received:	23 December 2024
Final report issued:	30 December 2024
Auditors:	Ian Virgil Head of Internal Audit John Cundy Principal Auditor
Executive sign-off:	Claire Roche Executive Director of Nursing, Quality, Women and Family Health
Distribution:	Jayne Wheeler Sexton, Assistant Director Nursing - Safeguarding Rachel Lewis, Safeguarding Business Support Manager Michelle Lewis, Senior Practitioner for Mental Capacity
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.

Disclaimer notice - please note
This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit Risk and Assurance Committee.

Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services, and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of Powys Teaching Health Board no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with Powys Teaching Health Board. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

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Executive Summary

Purpose

The overall objective of the audit was to review the controls and processes in place for the control, operation and reporting of the Deprivation of Liberty Safeguards (DoLS) as operated by the Health Board.

Overview:

We have issued Limited assurance on this area.

We note that following a period of difficulty for the DoLS process due to staff shortages within PTHB and PCC the situation is now improved but is not sustainable going forward. Clarity is required over the future provision of the DoLS Supervisory Body role and there are issues around capacity and delays in key stages of the DoLS application process.

The matters requiring management attention include:

- Review of the DoLS Policy;
- Ensuring appropriate on-going provision of training around the Managing Authority responsibilities;
- Contractor supplied Best Interest Assessors should have their qualifications confirmed periodically;
- Establishing a sustainable approach for the future delivery of the DoLS Supervisory Body role;
- Improvement to the process and timeliness for authorisation of DoLS applications; and
- Case tracking and Management Information could be improved with qualitative data as well as quantitative.

Report Opinion

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

Assurance summary[1]

	Objectives	Assurance
1	Policy and procedure documentation	Reasonable
2	Training and Accreditation	Reasonable
3	Process Operation	Limited
4	Reporting	Limited

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

Key Matters Arising

	Key Matters Arising	Objective	Control Design or Operation	Recommendation Priority
1	Policy and process document	1	Design	Medium
2	Provision of Training on Managing Authority Responsibilities	2	Design	Medium
3	BIA contractor qualification	2	Design	Medium
4	Provision of DoLS Supervisory Body role	3	Design	High
5	Authorisation of DoLS Applications	3 & 4	Operation	High
6	Case tracking	4	Operation	High

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1. Introduction

1.1 Our audit of the Deprivation of Liberty Safeguards (DoLS) policy and procedures was undertaken in line with the 2024/25 Internal Audit Plan for Powys Teaching Health Board ('the Health Board').

1.2 The Deprivation of Liberty Safeguards (DoLS) are an amendment to the Mental Capacity Act 2005 (the 'Act'), and provides protection for vulnerable people, in care homes or hospitals who lack capacity to consent to the care or treatment they need. In 2014, following a Supreme Court ruling, the law in relation to DoLS changed, meaning the Act applied to far more people than it had previously, with the number of people subject to DoLS increasing significantly.

1.3 In 2019 the law was changed with an amended Mental Capacity Act (2019) (MCA). The MCA (amendment) 2019 was to put in place new legislation, the publication of a new code, and regulations under Liberty Protection Safeguards (LPS). These changes were originally scheduled to replace the DoLS legislation and procedures from 1 October 2020. However, in April 2023 the Department of Health and Social Care announced the implementation of the Liberty Protection Safeguards (LPS), the Mental Capacity (Amendment) Act 2019, would be delayed "beyond the life of this Parliament" (therefore beyond Autumn 2024). As such, the existing 2009 amendment from the Mental capacity Act (2005), with its codes of practice, policies, rules and regulations are still extant.

1.4 Our review looked at the current processes for DoLS applications to ensure they are managed in accordance with the DoLS Code of Practice, Welsh Government guidance and Health Board procedures.

1.5 The potential risks considered for this review were as follows:

- Policies, procedures and responsibilities relating to DoLS are not clear resulting in non-compliance with regulations.
- DoLS applications are not logged and actioned promptly causing delays in assessments, patient's clinical needs not being met, and possible patient harm.
- Information used for monitoring DoLS applications is not up to date, accurate or complete and action is not taken to address backlogs, causing reputational damage to the Health Board and the risk of financial penalties.

2. Detailed Audit Findings

Objective 1: The Health Board policies and procedures covering DoLS are consistent with Welsh Government requirements and accepted best practice; properly implemented, and fully and consistently applied.

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2.1 The Health Board's intranet contains copies of all the extant DoLS policies and documents. The Powys County Council (PCC) website also linked to publicly available documentation on DoLS and contact details for the PCC DoLS team.

2.2 The Health Board policy documents, 'SGP 042 Deprivation of Liberty Safeguards Policy and Procedure' and 'SGP 050 SOP for Deprivation of Liberty Safeguards Signatory' are clear and concise documents. They are easy to read and understand and an excellent source of information on the Health Board's DoLS process.

2.3 There is an issue with the policy review date having passed, but this was explained at the outset of the audit as being due to the ongoing delay and indecision around the potential implementation of the Liberty Protection Safeguards (LPS). We further noted there is nothing in the Health Board's Policies on the requirements for reporting the DoLS position, though we have confirmed this does happen (As noted under Objective 4). **See Matter Arising 1**

Conclusion:

2.4 We have identified a matter arising regarding the Health Board DoLS Policy and Procedure documentation. We have provided **Reasonable Assurance** for this objective.

Objective 2: Staff and external contractors directly involved in DoLS operations are trained, with role specific certification and accreditation where necessary.

2.5 The DoLS policy mandates a DoLS training requirement and that staff with key roles in the process are correctly certified and that the certifications are in-date.

2.6 The Health Board utilise nationally available DoLS awareness courses on ESR. (Awareness is for all staff). The courses are for level one and level two. ESR management information supplied shows 83.7% of staff have completed the level one course and 90.37% have completed the level two course. Both courses remain accessible from ESR.

2.7 The DoLS process is commenced by a registered nurse who completes a form 1 to start the process. Level 3 training on the MCA has been offered to registered nurses. The next series of courses are at differing locations in Powys in November 2024 and targeted at registered staff working on Adult wards, Community staff e.g. District Nurses, Therapies or Complex Care Nurses.

2.8 The Health Board does not currently have an on-going cycle of DoLS training directed towards the Managing Authority responsibilities. This gap in training is linked to the current lack of a DoLS co-ordinator post within the Health Board, which is further noted under objective 3. **See Matter Arising 2**

2.9 A key role in the DoLS process is the Best Interest Assessor (BIA). We noted that the Health Board has a robust process to ensure that its directly employed BIA are appropriately qualified when initially appointed and that any certifications are maintained throughout employment.

2.10 There is a third-party supplier of BIA personnel, Action First, contracted to provide additional BIA on a case-by-case basis as required. At the time of the audit, we were unable to confirm what processes the Health Board has in place to ensure BIA provided by Action First are appropriately qualified. **See Matter Arising 3**

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Conclusion:

2.11 The DoLS and MCA training and certification requirements for the key ward staff likely to be involved in the DoLS process are well understood within the Health Board and systems are in place to deliver. There is however a need for delivery of training on the DoLS Managing Authority responsibilities. There is also an area where work should potentially be done to confirm contractor staff are also appropriately trained and qualified. We have provided **Reasonable Assurance** for this objective.

Objective 3: An appropriate functioning operational system is in place to control all aspects of DoLS applications. This should ensure actions are appropriately logged and completed within mandated timescales with completed documentation authorised by responsible and accountable people where necessary

2.12 The primary operational control of the Health Board DoLS process is provided by a DoLS Administration Team. This team is employed by Powys County Council (PCC), their services are commissioned by the Health Board. The team's responsibilities are clearly defined in the SGP042 DoLS Policy. This means that the DoLS managing authority is the ward where the patient is situated; the supervising authority is PTHB with PCC DoLS providing the administration team. The Health Board remain the Supervisory Body for PTHB but do not have a post within PTHB to undertake this role. **See Matter Arising 4**

2.13 The PCC team's DoLS application receipt and control processes are well documented and are well understood and operated effectively. They maintain a case tracker spreadsheet that contains a full and comprehensive record of all key information for the managing of a DoLS case for each patient. It supports date and deadline monitoring and effectively gives PTHB a full report on every DoLS case they are administering for them, and at what stage of the process it is at. As stated above, PTHB do not have a role responsible to oversee this and ensure the required monitoring and subsequent action is achieved. In addition, the DoLS Signatories element of the process is reliant on senior staff agreeing to be part of a DoLS Signatory rota which is challenging to maintain due to being additional to normal duties and increased difficulties fulfilling this rota and maintaining timely responses are identified. **See Matter Arising 5**

2.14 We spoke to the ward sister or leading staff nurse at three hospital locations across the health board. They all confirmed they have staff who are trained to level 3 MCA and qualified to complete the form 1 when necessary. They are aware of the guidance available to them and that they can contact the safeguarding team if they need any assistance. They did note that there is sometimes a reluctance by staff to start this process, even when qualified. There was also universal concern over the time the process can take. (objective 4 includes a comment and recommendation on qualitative information on case management).

2.15 It was acknowledged at the commencement of the audit that staff changes and shortages in both the Health Board and PCC DoLS teams had a negative effect on

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the process operation. Individuals left and recruitment for replacements took a long time, leaving both teams short of key personnel. There has been additional administration recruited until March 25. This is an interim measure to ensure essential DoLS Supervisory Body processes are achieved to an acceptable level. This is managed by the MCA Senior Practitioner working outside of her role with subsequent gaps identified in the delivery of PTHB Supervisory Body, and is not sustainable. PTHB has a significant gap in the delivery of PTHB Supervisory Body function and any improvements are temporary until March 2025 and a permanent solution is required as raised to PTHB executives. **See Matter Arising 4**

2.16 As part of their management oversight the Health Board's Safeguarding Team carried out a MCA gap analysis including DoLS. Which identified the following:

- critical omissions in documentation;
- No resource for a rolling training programme of DoLS awareness training;
- Non-Compliance with requirements resulting in patients deprived of their liberty without authorisation;
- Demand exceeds capacity; and
- No process for court protection work.

2.17 The analysis findings were presented to the Health Board executive team and Senior Safeguarding Group in March 2024 with three options to address the situation. This resulted in the development of an approved improvement plan and a risk register. The improvement plan is in spreadsheet format with actions, owners, timeframe, RAG status and update information present. At the time of our audit, plan delivery is ongoing with several of the objectives completed; the plan has been updated with a 2024-25 version which is now in operation. The mitigations identified are not permanent at this current stage whilst there is no PTHB Supervisory Body practitioner, additional BIA, or administration.

2.18 We noted the safeguarding risk on the risk register and that it has been managed and reviewed in line with the risk management policy. We also noted that the process problems occurred when key staff left from both the Health Board and PCC DoLS teams.

2.19 A case tracking spreadsheet is produced by the PCC admin team to facilitate progress monitoring of the Health Board DoLS cases. This has been changed to allow PTHB to now access this spreadsheet in real time since October 2024.

2.20 The only target dates in the DoLS guidance relate to completion within 28 days for a standard application and 7 days (extendable by 7) for an urgent (unplanned)one. The Health Board is not currently meeting these targets as 77% of urgent applications were not completed within 7 days and 68% were not completed within 14 days. For the standard applications only 50% were completed within 28 days but the numbers are small because the majority of applications are urgent. As this spreadsheet is a new development it should be developed further and refined to facilitate target date tracking on a case-by-case basis. **See Matter Arising 4.**

2.21 We reviewed the assessment and decision documents for a sample of cases both granted, and not granted. All decisions were correctly and appropriately signed and

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recorded. The assessments looked complete and well documented in a manner that a lay person could follow and understand the rationale behind the decision. All the decisions, forms 5 and 6 were signed electronically (Docu-sign) by an appropriately authorised signatory.

Conclusion:

2.22 The current arrangements for managing the DoLS process are not sustainable going forward due to the lack of a dedicated resource to provide the DoLS Supervisory Body role. There is also a lack of management review to ensure that DoLS applications are processed in line with required timescales. We have provided **Limited Assurance** for this objective.

Objective 4: The Health Board maintains up to date, accurate and complete data on DoLS operational activity, and uses this to produce relevant management information on the volume and quality of DoLS casework

2.23 We have under objective 3 reviewed the tracker spreadsheet in use since April 2024 and consider that has a complete record of the data on individual DoLS cases and consider it is sufficient to meet the requirements of the objective at this time.

2.24 The PCC DoLS admin team supply numerical information on a monthly and quarterly basis to the Health Board which identifies the volumes of cases at the various stages of the process. We note that the reports seen are quantitative only, there is no qualitative information e.g % target date achievement. We further note that review of the tracker spreadsheet highlights that there is currently a considerable delay in the appointment of BIA for urgent and non-urgent DoLS applications. **See Matter Arising 4**

2.25 The Welsh Government require an annual return on the DoLS position from all Health Boards, councils, and bodies that operate a DoLS system. They specify the format, content requirements and due date.

2.26 The Health Boards last return was prepared and submitted by the PCC DoLS admin team, on time and in the correct format.

Conclusion:

2.27 Although reporting on DoLS is currently limited and quantitative we note that it is compliant with Welsh government requirements, and the opportunities for improving reporting have only recently become available. However, scrutiny of the DoLS data is required on a consistent and reliable basis to ensure the quality of the work and timely challenge of identified gaps. We have provided **Limited Assurance** for this objective.

Appendix A: Management Action Plan

Matter Arising 1: Policy and process document (Design)	**Impact**
There is an issue with the October 2022 review date for the Health Board's DoLS policy having passed. Although this was explained at the outset of the audit as initially being due to the UK Government delay and indecision with any potential implementation of the Liberty Protection Safeguards (LPS), which were effectively 'abandoned' in April 2023. Currently, the DoLS policy is unable to reflect updates within its policy until PTHB determine its Supervisory Body Role, following the Local Authority notice that they cannot continue their role of DoLS Co-ordination. This remains an identified gap within PTHB. The Policy should still be formally reviewed and updated where required. We also noted that there is nothing in the Health Board's Policies on the requirements for reporting the DoLS position, though we have confirmed this does happen, and also note that the WG policy does not include reporting either.	Potential risk of: • Guidance fails to keep up with legislative changes. • Out of date guidance loses credibility with its users or causes time loss as they search for an up to date version.

Recommendations		**Priority**
1	The DoLS policy should be reviewed and brought up to date as necessary with a date of the next review noted in line with any appropriate Health Board guidance on Policy documentation maintenance. The updated policy should include reporting requirements, including frequency, content, to whom, and format (spreadsheet, table, dashboard etc).	**Medium**

Agreed Management Action		**Target Date**	**Responsible Officer**
1	Update DoLS policy.	June 2025	Jayne Wheeler Sexton

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Matter Arising 2: Provision of Training on Managing Authority Responsibilities (Design)			**Impact**
The Health Board has effective arrangements in place for providing training to nursing staff on the wards relating to DoLS processes. However, there is currently no on-going cycle of DoLS training in place that is directed towards the Managing Authority responsibilities. This gap in training is linked to the current lack of a DoLS co-ordinator post within the Health Board, which is noted under matter arising 4.			Potential risk of: • Inappropriate actions being undertaken by untrained staff.
Recommendations			**Priority**
2	Once the DoLS co-ordinator post is in place, training on the DoLS Managing Authority responsibilities should be developed along with a plan for on-going delivery.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
2	A business case will need to be made for the role of DoLS co-ordinator. A training needs analysis will be undertaken to determine required cycle of training. Identified training put into place for the Managing Authority.	March 2025 July 2025 September 2025	Jayne Wheeler Sexton Jayne Wheeler Sexton Jayne Wheeler Sexton

Matter Arising 3: BIA Contractor Qualification (Design)			**Impact**
Action First are contracted to the Health Board to provide BIA personnel when the demand rises above a level that can be managed by the Health Board Staff. The Health Board have been unable to confirm what/if any process exists to ensure the Action First staff are fully qualified and currently certified to fulfil the role.			Potential risk of: • Unqualified staff working on NHS patients
Recommendations			**Priority**
3	The Health Board DoLS team should create a process to ensure that any staff provided by Action First are fully qualified and that any certification requirements for the role are up to date.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
3	Safeguarding Team to ensure they have a process to maintain evidence of correct qualifications from external assessors. To ensure that procurement amend the contract as required.	Feb 2025	Jayne Wheeler Sexton

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Matter Arising 4: Provision of DoLS Supervisory Body role (Design)			Impact
The DoLS process previously failed to operate correctly when key personnel left the Health Board. The current interim measure has allowed additional administration for PCC to support the DoLS process using Welsh Government grant money. The MCA Senior Practitioner is also stepping outside of her role to undertake some responsibilities required in the DoLS Co-ordination responsibility. However, there remains a gap in the provision of a dedicated DoLS Supervisory Body role within PTHB, that provides oversight and co-ordination of the process and decision-making required. This is a gap that has been identified to PTHB Executive team			Potential risk of: • Process failure due to key staff leaving.
Recommendations			**Priority**
4	The Health Board should ensure that arrangements are put in place as soon as possible to allow for the on-going provision of the DoLS Supervisory Body Role.		**High**
Agreed Management Action		**Target Date**	**Responsible Officer**
4	A business case will need to be made for the role of DoLS co-ordinator, administration and Best Interest Assessors. Depending on outcome of business case, recruitment into positions will be required.	March 2025 June 2025	Jayne Wheeler Sexton Jayne Wheeler Sexton

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Matter Arising 5: Authorisation of DoLS Applications (Operation)	**Impact**
Delays are currently being experienced in obtaining timely sign-off of DoLS applications. The DoLS Signatories element of the process is reliant on senior staff agreeing to be part of a DoLS Signatory rota which is challenging to maintain due to being additional to the MCA Senior Practitioners normal duties. The DoLS Co-ordinator role would help to reduce this pressure and ensure timely scrutiny and sign-off of DoLS applications.	Potential risk of: • Unqualified staff working on NHS patients

Recommendations		**Priority**
5	The Health Board must ensure that all DoLS applications are reviewed and signed-off in a timely manner.	**High**

Agreed Management Action		**Target Date**	**Responsible Officer**
5	A business case will need to be made for the role of DoLS co-ordinator, This role will include to sign off the applications and review the current signatories process and manage the signatory's rota.	March 2025 June 2025	Jayne Wheeler Sexton Jayne Wheeler sexton

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<table>
<tr><th colspan="2">Matter Arising 6: Case tracking (Operation)</th><th>Impact</th></tr>
<tr><td colspan="2">The DoLS applications have timescales for completion, being within 28 days for a standard application and 7 days (extendable by 7) for an urgent (unplanned) one.

To date the Health Board has not monitored or reported whether or not the target dates have been achieved.

The case tracking spreadsheet updated by the DoLS Admin team, is available to PTHB in real time since October 2024 and prior to this the spreadsheet was shared for the purpose of the audit from April 2024. This identifies within that time frame for the standard applications the target date was not achieved in 50% of cases. For urgent applications, 77% were not completed within the 7 day time limit and 68% were not completed within the 14-day extended.

We were informed by the MCA Senior Practitioner that the current demand of application's are above what the Health Board can provide with the number of BIA's available and that the procurement of Action First is dependent on WG grant money being available for this.</td><td>Potential risk of:
• Failure to achieve DoLS case target dates
• People within PTHB are deprived of their liberty without legal authorisation for this.</td></tr>
<tr><th colspan="2">Recommendations</th><th>Priority</th></tr>
<tr><td>6</td><td>Management reports should be developed to record ongoing performance against the target dates.

These should then be reported to an appropriate group and / or Committee with actions identified to improve performance where required.

The case tracker spreadsheet could be developed to track and monitor progress on a case-by-case basis to confirm whether or not the target dates are being achieved and facilitate qualitative reporting, not just quantitative. Ideally a shared system should be used to enable all authorised users at least read access to live case data.</td><td>High</td></tr>
</table>

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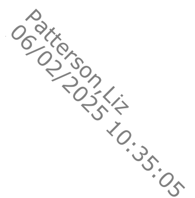
Agreed Management Action		Target Date	Responsible Officer
6	The case tracker spreadsheet will be updated and accessible in real time for PTHB Supervisory Body.	March 2025	Jayne Wheeler Sexton
	A Dols Co-ordinator role will need to be in place to provide the challenge and scrutiny.	June 2025	Jayne Wheeler Sexton
	Performance will be reported into PTHB Strategic Safeguarding Group.	June 2025	Jayne Wheeler Sexton



Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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

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Board & Committee Structure/Effectiveness

Final Internal Audit Report

2024/25

Powys Teaching Health Board

Substantial Assurance

Contents

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Appendix A 5

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Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd

Shared Services Partnership
Audit and Assurance Services

Review Reference	PTH-2425-02
Fieldwork	September - November 2024
Executive Sign Off	03 December 2024
Audit Committee	January 2025
Executive Lead	Helen Bushell, Director of Corporate Governance/Board Secretary
Audit Team	Ian Virgill, Head of Internal Audit
	Lucy Jugessur, Deputy Head of Internal Audit

Executive Summary

Purpose

To evaluate Powys Teaching Health Board's (the 'Health Board') Board and Committee structure and assess the operation of the Board and Committees to ensure effective and efficient reporting, scrutiny and decision making on areas of accountability.

Overview

The current committee structure of the Health Board has been in place since August 2021 with the following committees currently in operation:

- Audit, Risk and Assurance Committee.
- Charitable Funds Committee.
- Delivery and Performance Committee.
- Executive Committee.
- Patient, Experience, Quality & Safety Committee.
- Planning, Partnerships and Population Health Committee.
- Remuneration and Terms of Service Committee; and
- Workforce and Culture Committee.

This review follows on from the previous audit of Board & Committee Structure/ Effectiveness which we completed in 2023/24, and covers the workings of the Board; Audit, Risk and Assurance Committee; Planning, Partnerships and Population Health Committee; and Workforce and Culture Committee.

We have concluded **Substantial** assurance on this area. We have identified no key matters for reporting in our review.

Opportunities for Enhancement

The following opportunities for enhancement have been identified that do not impact the overall opinion and are highlighted for management information:

- Consideration should be given to discussing with Welsh Government the potential of ongoing training and awareness exercises for Independent Members post-appointment, outside that already provided by the Health Board.

Scope & Assurance Summary

	Objectives	Related Findings	Assurance
1	The Health Board has clear, defined Board and Committee governance and assurance structures.	-	**Substantial**
2	The Committee structure provides for clear, effective and efficient decision-making and scrutiny on areas of accountability.	-	**Substantial**
3	Board and Committee work programmes are aligned to the Health Board's strategic objectives and risks.	-	**Substantial**
4	Board and Committee reporting is clear and concise and provides effective triangulation of business activity.	-	**Substantial**

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Findings & Agreed Action Plan

Objective 1: The Health Board has clear, defined Board and Committee governance and assurance structures.	**Substantial**

Overview / Summary of Observations

The Health Board has current Standing Financial Instructions and Standing Orders in place that outline and formalise the Board and Committee governance structures and arrangements, and these were recently reviewed and updated, and approved by the Board in May 2024.

The Board's Terms of Reference (ToR) forms part of the Health Board's Standing Orders and is current in its constitution. All three sampled Committees (Audit, Risk and Assurance Committee; Planning, Partnerships and Population Health Committee; and Workforce and Culture Committee) ToR are also current in content having been reviewed and updated and approved by the Board in May 2024.

Additionally, each ToR states the constituent membership, roles and responsibilities of the Committee; and their reporting arrangements, membership quoracy and frequency of meetings to be held.

Our review of Committee meeting structures, and of their respective areas of responsibility as stated within the Standing Orders and Committee ToR documents, confirmed that they were appropriate and did not identify any potential overlap or conflict of subject matter between Committees.

<u>Independent Member Induction and ongoing training/development</u>

The Health Board has an induction process for new members, and provides ongoing support, training and development that enables Independent Members to effectively undertake their roles and management of their respective Committees.

Our discussions with the Committee Chairs of the three sampled Committees identified their satisfaction with the Health Board's induction process, and the regular and ongoing provision of training, development and guidance available to them, and also the support provided by the Corporate Governance Team.

However, we identified that upon completion of the Welsh Government induction process undertaken by Independent Members upon appointment, no further training/awareness is provided to them by Welsh Government. As such, the Health Board should consider discussing with Welsh Government, the possibility of introducing ongoing Independent Member training, outside that already provided by the Health Board, to further enrich their roles within NHS Wales Health Bodies.

Objective 2: The Committee structure provides for clear, effective and efficient decision-making and scrutiny on areas of accountability.	**Substantial**

Overview / Summary of Observations

As part of our review, we attended meetings of the Board; Audit, Risk and Assurance Committee; Planning, Partnerships and Population Health Committee; and Workforce and Culture Committee. We also met with the Board Chair and Chairs of the aforementioned Committees to discuss their views and approach toward effective Committee management and proceedings

As such, we can confirm that the Health Board Chair and the sampled Committee Chairs effectively manage their meetings and engage with their membership to allow appropriate scrutiny, dialogue, and debate of Agenda items in an efficient manner, in accordance with their prescribed roles and respective experience that they bring to the Health Board.

Additionally, our review of the minutes from a sample of Board and Committee meetings undertaken during 2024/25 demonstrated the scrutiny undertaken, decisions made, and the follow up and confirmation of action completion as appropriate in subsequent Committee Action Plans. This process is supported by an action/issues log tracker spreadsheet for Board and all Committees meetings, and this is accurately maintained by the Corporate Governance Department.

Declarations of Interests

The Corporate Governance Department has a process in place to monitor and manage the annual return of Declarations of Interests, and our testing confirmed that all Board Members and the Executive Team had completed and submitted a Declaration of Interest form for 2024/25.

The Board and Committee Chairs also confirm if there are any specific declarations of interest to be made at the start of each meeting, relating to items included within the individual agendas. Any declarations highlighted through this process would be effectively managed within the meeting to ensure no conflict of interest arises.

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Objective 3: Board and Committee work programmes are aligned to the Health Board's strategic objectives and risks. **Substantial**

Overview / Summary of Observations

Current Work Programmes are in place for 2024/25 to ensure that the Board and its Committee's annual activity is effectively timetabled, and covers all required areas, as detailed within the Health Board's Standing Orders and the respective TOR.

Our review of the Work Programmes for the Board and the three sampled committees also confirmed that they are aligned to, and provide effective coverage of, the Health Board's strategic objectives and key risks.

Where applicable, deferment or removal of Agenda items are recorded accordingly within the respective Work Programmes.

Our testing of the minutes from a sample of Audit, Risk and Assurance Committee; Planning, Partnerships and Population Health Committee; and Workforce and Culture Committee meetings held during 2024/25 confirmed that all items stated on their Work Programmes were undertaken as timetabled.

Objective 4: Board and Committee reporting is clear and concise and provides effective triangulation of business activity. **Substantial**

Overview / Summary of Observations

Our testing of the sample of Board; Audit, Risk and Assurance Committee; Planning, Partnerships and Population Health Committee; and Workforce and Culture Committee meetings held during 2024/25 confirms that the minutes are accurately documented, and their actions and decisions are clearly delivered. The papers are made available for Board and Committee Chairs and their constituent membership in a timely manner prior to commencement of each meeting.

We also confirm that the agendas, minutes and other papers for these Board and Committee meetings were made available to Health Board staff, the general public and stakeholders for scrutiny, by being published on the Health Board's website in advance of each meeting held.

Our review of the aforementioned Committee meeting cover papers and reports confirm that they are of a high quality, and are detailed and thorough in content, and our conversations with Committee Chairs confirmed their satisfaction in this regard.

Furthermore, our testing also confirmed the submission of each Committee Chair's Update Report to subsequent Board meetings, evidencing the reporting of their key Agenda items and outcomes/actions to be undertaken.

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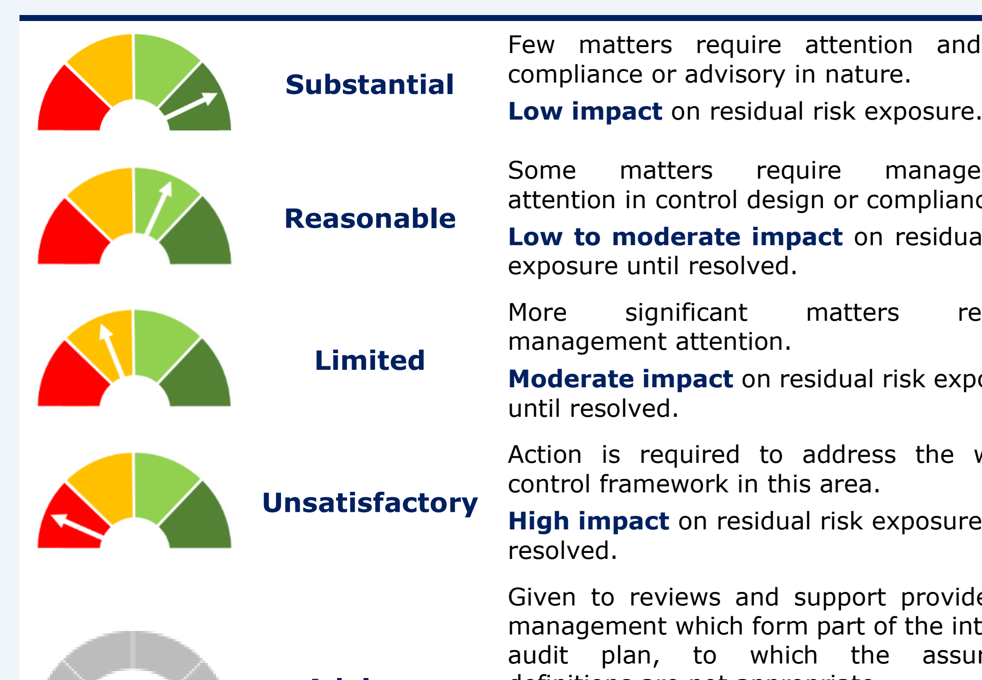
Appendix A

Assurance Opinion



Substantial	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
Reasonable	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
Limited	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
Unsatisfactory	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
Advisory	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 Findings

Priority	Explanation
High	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
Medium	Some risk to achievement of a system objective. Minor weakness in system design OR limited non-compliance.

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

Disclaimer

This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit Committee.

Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Teaching Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

The report is based on the review work undertaken and is not necessarily a complete statement of all weaknesses that exist or potential improvements. Whilst every care has been taken to ensure that the information provided in this report is as accurate as possible, no complete guarantee or warranty can be given with regard to the advice and information contained.

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with management of the Teaching Health Board. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Public Sector Internal Audit Standards

Audit work undertaken by NHS Wales Audit and Assurance Services conforms with the International Standards for the Professional Practice of Internal Auditing and associated Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

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 Six monthly 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 (included within the IQR)					
	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)					
Items to be considered for 2025/26						
TBC	Survey findings - Urgent Suspected Cancer Pathway Survey					
TBC	Children's Services					
TBC	Learning Organisation/Group					
TBC	Primary Care - quality perspective (Exec lead tbc)					

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Powys Teaching Health Board Glossary (January 2025)

Acronym	
ADoECP	Associate Director of Estates, Capital & Property
CEO	Chief Executive Officer
DCG	Director of Corporate Governance
DIT	Director of Improvement & Transformation
EMD	Executive Medical Director
ED PH	Executive Director of Public Health
ED P&C	Executive Director of People and Culture
ED PP&C	Executive Director of Planning, Performance and Commissioning
ED FCSS	Executive Director of Finance, Capital & Support Services
ED AHPHSD	Executive Director of Allied Health Professions, Health Sciences and Digital
ED NQW&FH	Executive Director of Nursing, Quality, Women and Family Health
EDPCCMH	Executive Director of Primary Care, Community & Mental Health
ABUHB	Aneurin Bevan University Health Board
AFC	Agenda for Change
AGW	The Auditor General for Wales
AHPs	Allied Health Professionals
ALN	Additional Learning Needs
AO	Accountable Officer
ARAC	Audit, Risk and Assurance Committee
ASM	Accelerated Sustainable Model
AR	Audit Recommendations
BAF	Board Assurance Framework
BCUHB	Betsi Cadwaladr University Health Board
BMA	British Medical Association
CAAP	Clinical Associate in Applied Psychology
CAMHS	Child and Adolescent Mental Health Services
CCN	Childrens Community Nursing
CEMT	Chief Executive Management Team
CHC	Continuing Health Care
CIW	Care Inspectorate for Wales
CLIP	Collaborative Learning in Practice
CNO	Chief Nursing Officer
CPD	Continued Professional Development

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CPR	Child Practice Review
CRR	Corporate Risk Register
CSP	Clinical Service Plan
CTMUHB	Cwm Taff Morgannwg University Health Board
CV	Curriculum Vitae
CVUHB	Cardiff and Vale University Health Board
CWMPAS	Mid and West Wales Regional Safeguarding Adults Board
CYSUR	Mid and West Wales Regional Safeguarding Children Board
DATIX	Incident Management System
D&P	Delivery and Performance Committee
DCG	Delivery Co-ordination Group
DGH	District General Hospital
DHCW	Digital Health and Care Wales
DNA	Did not Attend
DPA	Data Protection Act
DToC	Delayed Transfer of Care
D2RA	Discharge to Recover and Assess
EASC	Emergency Ambulance Services Committee
EOG	Executive Oversight Group
EOY	End of Year
EMRTS	Emergency Medical Retrieval & Transfer Service?
ESR	Electronic Staff Record
EMI	Elderly Mentally Infirm
FBC	Full Business Case
FOI	Freedom of Information
FFT	Friends and Family Test
FTE	Full Time Equivalent
GDS	General Dental Services
GIRFT	Getting It Right First Time
GMC	General Medical Council
GMS	General Medical Services
GP	General Practitioner
H&S	Health and Safety
HCA	Health Care Assistant
HCS	Health and Care Standards
HCSW	Health Care Support Worker
HDUHB	Hywel Dda University Health Board
HEIW	Health Education and Improvement Wales
HIW	Healthcare Inspectorate Wales
HPF	Healthcare Professionals Forum

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ICF	Integrated Care Funding
IEN	Internationally Educated Nurse
IG	Information Governance
IM	Independent Members
IMTP	Integrated Medium Term Plan
IP&C	Infection Prevention and Control
IQPF	Integrated Quality Performance Framework
IQPG	Integrated Quality & Performance Group
IQPR	Integrated Quality Performance Report
IT	Information Technology
JAG	Joint Advisory Group (on Gastrointestinal Endoscopy)
JCC	Joint Commissioning Committee
JD	Job Description
JET	Joint Executive Team
JIPCA	Joint Inspection of Child Protection Arrangements
JLT	Joint Leadership Team (PTHB and PCC)
JR	Judicial Review
KPI	Key Performance Indicator
LoF	League of Friends
LA	Local Authority
LHB	Learning Health Board
LMC	Local Medical Committee
LPF	Local Partnership Forum
LRF	Local Resilience Forum
LTA	Long Term Agreement
MD	Ministerial Direction
MDTs	Multi-Disciplinary Teams
MEG	Medical E-Governance System
MEG	Main Expenditure Group
MH	Mental Health
MHD	Mental Health & Learning Disability
MIU	Minor Injury Unit
MOU	Memorandum of Understanding
MOA	Memorandum of Agreement
MSK	Musculoskeletal
NHSE	National Health Service England
NHS	National Health Service
NHSWE	NHS Wales Executive
NICE	National Institute of Health and Clinical Excellence

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NRI	Nationally Reportable Incidents
NWSSP	NHS Wales Shared Services Partnership
OBC	Outline Business Case
OCP	Organisational Change Process
OOC	Out of County
OOH	Out of Hours
OSCE	Objective Structured Clinical Examination
OT	Occupational Therapy
PA	Physician Associate
PADR	Personal Appraisal Development Review
PAVO	Powys Association of Voluntary Organisations
PCC	Powys County Council
PEQS	Patient Experience, Quality and Safety Committee
PHE	Public Health England
PHW	Public Health Wales
PPPH	Planning, Partnerships and Population Health Committee
PSB	Public Service Board
PSOW	Public Services Ombudsman for Wales
PTHB	Powys Teaching Health Board
PTR	Putting Things Right
QA	Quality Assurance
RaTS	Remuneration and Terms of Service Committee
RCN	Royal College of Nursing
RIIC	Research, Innovation & Improvement Coordination
RIF	Regional Investment Fund
RISP	Radiology Information System Procurement
RJAH	Robert Jones and Agnes Hunt
RN	Registered Nurse
RPB	Regional Partnership Board
RTT	Referral to Treatment
RTS	Routemap To Sustainability
Q1 Q2 Q3 Q4	Quarter 1 (April, May, June), Quarter 2 (July, August, September), Quarter 3 (October, November, December), Quarter 4 (January, February, March)
SAR	Subject Access Request
SAS	Specialty and Specialist
SBAR	Situation, Background, Assessment, Recommendation
SBUHB	Swansea Bay University Health Board
SLA	Service Level Agreement

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SOC	Strategy Outline Case
SOP	Standard Operating Procedure
SaTH	Shrewsbury and Telford Hospital NHS Trust
SPB	Strategic Programme Board
SRO	Senior Responsible Owner
TI	Targeted Intervention
ToR	Terms of Reference
TRAC	Online Recruitment Management System
T&V	Transformation & Value
VERS	Voluntary Early Release Scheme
WAST	Welsh Ambulance Services NHS Trust
W&C	Workforce and Culture Committee
WCCIS	Welsh Community Care Information System
WG	Welsh Government
WHC	Welsh Health Circular
WHSSC	Welsh Health Specialised Service Committee
WNB	Was Not Brought
WOD	Workforce and Organisational Development
WPAS	Welsh Patient Administration System
WPOCT	Welsh Point of Care Test System
WTE	Whole Time Equivalent
WVT	Wye Valley Trust
YTD	Year to Date