Patient Experience, Quality and Safety Committee

Thu 07 July 2022, 09:00 - 13:00

Teams

Agenda

09:00 - 09:00
0 min

1. PRELIMINARY MATTERS

PEQS_Agenda_Master_07July 2022 FINAL 0900 start.pdf (2 pages)

1.1. Welcome and Apologies

Oral *Chair*

1.2. Declarations of Interest

Oral *Chair*

1.3. Minutes from the previous meeting held on the 12 May 2022 for approval

Attached *Chair*

PEQS_Item_1.3_Unconfirmed Minutes 12 May 2022.pdf (13 pages)

1.4. Matters arising from the minutes of the previous meeting held on 12 May 2022

Oral *Chair*

1.5. Patient Experience, Quality and Safety Committee Action Log

Attached *Chair*

PEQS_Item_1.5_Action Log July 2022.pdf (3 pages)

09:00 - 09:00
0 min

2. ITEMS FOR ASSURANCE

2.1. Quality Overview Reporting: Maternity Services

Attached *Director of Nursing and Midwifery*

PEQS_Item_2.1_Quality Overview Report_June_2022.pdf (15 pages)
PEQS_Item_2.1a_Maternity and Neonatal Assurance Report.pdf (7 pages)
PEQS_Item_2.1ai_Appenidix 1_Maternity and Neonatal Assurance_Powys Assesment.pdf (24 pages)
PEQS_Item_2.1aii_Appendix 2_Maternity Assessment Assurance and Exception Reporting Tool.pdf (32 pages)

2.2. Annual Clinical Audit Programme 2022-2023

Attached *Medical Director*

PEQS_Item_2.2_Annual Clinical Audit Programme 2022-23.pdf (22 pages)

2.3. Clinical Audit Assurance Report

Attached *Medical Director*

PEQS_Item_2.3_ Clinical Audit Assurance Report Plan 2021-22.pdf (22 pages)

2.4. Medicines Management Assurance Paper

Attached *Medical Director*

PEQS_Item_2.4_Medicines Management Assurance Report.pdf (18 pages)

09:00 - 09:00
0 min

3. ITEMS FOR DISCUSSION

3.1. Mental Health Act Hospital Managers Power of Discharge Group Terms of Reference and Operating Arrangements

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

PEQS_Item_3.1_Mental Health Act Hospital Managers Power of Discharge cover paper.pdf (4 pages)
PEQS_Item_3.1a_Mental Health Act Hospital Managers Power of Discharge TOR.pdf (6 pages)

3.2. Refreshed Patient Experience Framework

To Follow *Director of Therapies and Health Science*

09:00 - 09:00
0 min

4. BUSINESS CASES, SERVICE PLANNING PROPOSALS, WHOLE SYSTEM PATHWAY DEVELOPMENT AND RE-DESIGN

There are no Business Cases, Service Planning Proposals or Whole System Pathway Developments and Re-designs

09:00 - 09:00
0 min

5. ESCALATED ITEMS

There are no escalated items

09:00 - 09:00
0 min

6. ITEMS FOR INFORMATION

There are no items for information

09:00 - 09:00
0 min

7. OTHER MATTERS

7.1. CORPORATE RISK REGISTER - RISKS OVERSEEN BY THIS COMMITTEE

Attached *Interim Board Secretary*

PEQS_Item_7.1_Committee Risk Report_July_2022.pdf (4 pages)
PEQS_Item_7.1a_Appendix_A_PEQS_Risk_Register_May_22.pdf (11 pages)

7.2. Committee Work Programme

Attached *Interim Board Secretary*

PEQS_Item_7.2_PEQS_Committee_Work Programme_2022-23.pdf (5 pages)

7.3. ITEMS TO BE BROUGHT TO THE ATTENTION OF THE BOARD AND/OR OTHER COMMITTEES

Oral *Chair*

7.4. ANY OTHER URGENT BUSINESS

Oral *Chair*

7.5. DATE OF THE NEXT MEETING: 13 September 2022, 13:00 via Microsoft Teams

POWYS TEACHING HEALTH BOARD
PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE
THURSDAY 7 JULY 2022
09:00 – 12:00
VIA MICROSOFT TEAMS

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

		AGENDA		
Time	**Item**	**Title**	**Attached/Oral**	**Presenter**
	1	**PRELIMINARY MATTERS**		
09:00	1.1	Welcome and Apologies	Oral	Chair
	1.2	Declarations of Interest	Oral	All
	1.3	Minutes from the previous Meeting held on 12 May 2022	Attached	Chair
	1.4	Matters arising from the minutes of the previous meeting held on 12 May 2022	Oral	Chair
	1.5	Patient Experience, Quality and Safety Committee Action Log	Attached	Chair
	2	**ITEMS FOR ASSURANCE**		
09:15	2.1	Quality Overview Reporting: • Maternity Services	Attached	Director of Nursing and Midwifery
09:45	2.2	Annual Clinical Audit Programme 2022-23	Attached	Medical Director
10:00	2.3	Clinical Audit Assurance Report	Attached	Medical Director
10:30		**COMFORT BREAK**		
10:40	2.4	Medicines Management Assurance Paper	Attached	Medical Director
	3	**ITEMS FOR DISCUSSION**		
11:10	3.1	Mental Health Act Hospital Managers Power of Discharge Group Terms of Reference and Operating Arrangements	Attached	Director of Primary Care, Community and Mental Health
11:40	3.2	Refreshed Patient Experience Framework	To follow	Director of Therapies and Health Sciences
	4	**BUSINESS CASES, SERVICE PLANNING PROPOSALS, WHOLE SYSTEM PATHWAY DEVELOPMENT AND RE-DESIGN**		
		There are no Business Cases, Service Planning Proposals or Whole System Pathway Developments and Re-designs.		
	5	**ESCALATED ITEMS**		
		There are no escalated items.		
	6	**ITEMS FOR INFORMATION**		
		There are no items for information.		
	7	**OTHER MATTERS**		
11:40	7.1	Corporate Risk Register – risks overseen by this Committee	Attached	Interim Board Secretary / Director of Nursing and Midwifery

11:50	7.2	Committee Work Programme	Attached	Interim Board Secretary
	7.3	Items to be Brought to the Attention of the Board and/or Other Committees	Oral	Chair
	7.4	Any Other Urgent Business	Oral	Chair
12:00	7.5	Date of the Next Meeting: 13 September 2022, 13:00, via Microsoft Teams		

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

However, in light of the current advice and guidance in relation to Coronavirus (COVID-19), the Board has agreed to run meetings virtually by electronic means as opposed to in a physical location, for the foreseeable future. This will unfortunately mean that members of the public will not be able attend in person. The Board has taken this decision in the best interests of protecting the public, our staff and Board members.

The Board is expediting plans to enable its committee meetings to be made available to the public via live streaming. In the meantime, should you wish to observe a virtual meeting of a committee, please contact the Board Secretary in advance of the meeting in order that your request can be considered on an individual basis (please contact James Quance, Interim Board Secretary, james.quance2@wales.nhs.uk).

In addition, the Board will publish a summary of meetings held on the Health Board's website within ten days of the meeting to promote openness and transparency.

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

MINUTES OF THE MEETING HELD ON THURSDAY 12 MAY 2022 VIA MICROSOFT TEAMS

Present:

Kirsty Williams	Vice-Chair (Committee Chair)
Frances Gerrard	Independent Member
Ian Phillips	Independent Member
Tony Thomas	Independent Member

In Attendance:

Carol Shillabeer	Chief Executive
Claire Roche	Director of Nursing and Midwifery
Claire Madsen	Director of Therapies and Health Sciences
Kate Wright	Medical Director
James Quance	Interim Board Secretary
Zoe Ashman	Assistant Director of Quality and Safety
Julie Richards	Women's and Children's Service Manager
Amanda Edwards	Assistant Director – Innovation and Improvement
Richard Stratton	Assistant Medical Director
Joy Garfitt	Assistant Director for Mental Health Services
Mitchell Parker	Health Inspectorate Wales
Phil Jones	Audit Wales
Sonia Thomas	Community Health Council
Viv Harpwood	PTHB Chair

Apologies for absence:

Mark Taylor	Independent Member
Hayley Thomas	Director of Primary, Community Care and MH
Louise Turner	Assistant Director of Women's and Children's Services
Katie Blackburn	CHC

Committee Support:

Liz Patterson	Interim Head of Corporate Governance

PEQS/22/01	**WELCOME AND APOLOGIES FOR ABSENCE** The Committee Chair welcomed Members and attendees to the meeting and CONFIRMED there was a quorum present. Independent Member Tony Thomas kindly had attended to ensure that the quorum was secure. The Chair welcomed Richard Stratton, newly appointed Assistant Medical Director to his first meeting. Apologies for absence were NOTED as recorded above.
PEQS/22/02	**DECLARATIONS OF INTERESTS** No interests were declared.
PEQS/22/03	**MINUTES OF THE EXPERIENCE, QUALITY AND SAFETY COMMITTEE MEETING HELD ON 24 MARCH 2022 (FOR APPROVAL)** The minutes of the previous meeting held on 24 March 2022 were AGREED as a true and accurate record.
PEQS/22/04	**MATTERS ARISING FROM MINUTES OF PREVIOUS MEETING** *In respect of opioid use will the health board continue to compare against English benchmarks to stretch improvement aims?* The Medical Director confirmed that Welsh guidance would be followed but that it was the intention not to accept good but to strive for excellence.
PEQS/22/05	**PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE ACTION LOG** PEQS/21/50 – The Board Secretary advised that in respect of No Surprises notifications the normal escalations routes would be followed which included Member briefings. It was not necessary to set up a separate process for this issue. PEQS/21/31 – Pressure Ulcers are reported within the Concerns Report. CAUTI (catheter acquired urinary tract

	infections) will be included in the Concerns Report going forward.
ITEMS FOR APPROVAL/RATIFICATION/DECISION	
PEQS/22/06	There were no items for inclusion in this section.
ITEMS FOR ASSURANCE	
PEQS/22/07	**CHC VIRTUAL VISIT** The Director of Nursing and Midwifery presented the report produced by the CHC regarding the Virtual Visits that had taken place supported by colleagues within Community, Nursing, Quality and Safety and Digital teams in the Health Board. The report detailed a number of positive findings including staff were very good and attentive to patient needs; a patient's family were unable to visit but the patient had access to the telephone and had been able to speak to them; and all patients reported they received very good care. A number of areas for improvement were identified including Wi-Fi connections, nutritional needs and estates issues. The recommendations had been shared with Executive colleagues to ascertain how each can be addressed. *Will a formal response be provided to the CHC?* The Director of Nursing and Midwifery advised that the CHC had received an acknowledgment of their report and recommendations but that a response would be prepared which would be shared with Committee members. **Action: Director of Nursing** *What plans are in place for improving patient feedback opportunities?* The Director of Nursing and Midwifery advised that the imminent implementation of Civica patient experience software would enable consistent patient feedback. With regard to face to face visits it is expected that there will be a gradual return to safe infection prevention control visits and the CHC would be welcomed back in this context.

	The Medical Director advised that funding had been made available to survey sites to identify what infrastructure was required. *Connectivity featured highly in the report. Given our commitment to digital first is there a detailed plan to overcome some of the digital issues highlighted?* The Chief Executive confirmed that reliable connectivity was necessary across all sites to allow for the implementation of a hybrid model as a result of the pandemic but also due to climate change. An Interim Digital Strategy is in place and a Board Development session is planned on digital and this is a subject area which will require ongoing focus. **Action: Interim Board Secretary**
PEQS/22/08	**QUALITY PERFORMANCE:** The Director of Nursing and Midwifery presented the three reports advising that these reports would soon be presented as a combined report. **a) COMMISSIONING ASSURANCE REPORT** Attention was drawn to the publication of the Final Ockenden Report on 30 March 2022 following the Independent Review of Maternity Services at Shrewsbury and Telford Hospitals NHS Trust (SaTH) published in December 2020. The December 2020 report identified 52 actions. The status of these actions was outlined. Attention was also drawn to the Cwm Taf Morgannwg University Health Board (CTMUHB) Maternity and Neonates Improvement Programme which remains in place. An unannounced inspection had taken place by the Health Inspectorate Wales (HIW) of Ty Llidiard (CTMUHB). The report was published on 4 March 2022 and found 6 improvements were required. Referral to treatment times continued to be challenging with pressures around workforce capacity, operational capacity and unscheduled care pressures impacting on this. *The paper notes that particular attention is given to those who have waited the longest. Whilst long waits will not be*

	solved overnight what is been done to ensure that this does not result in the deepening of inequality due to geographical differences in access? The Chief Executive advised that this was an area the Executive Committee were working on. There was an intention to bring straight forward activity that had been outsourced back to insourced provision. It may be necessary to make decisions regarding strategic pathway changes (in consultation with the Community Health Council) because of differences in different areas of the county. *Record keeping appears to be a common theme though the report. How will this be addressed?* The Director of Nursing and Midwifery confirmed that record keeping continued to be of concern. The rollout of the electronic All Wales Staffing Record continued, however, it did require staff to input data. This would enable improved quality assurance. *Access to services continues to be a problem which was an issue prior to covid. What action is being taken to address this?* The Medical Director advised that a considerable amount of work would be necessary to tackle this. Proposals regarding regional working were becoming more concrete and harm reduction measures were in place to mitigate for those patients who had the longest waits. The Assistant Medical Director noted that there was a period between primary care making a referral and secondary care seeing a patient when nothing happened. The potential to prioritise waiting lists is an area which the Assistant Medical Director would like to explore. **b) NATIONALLY REPORTABLE INCIDENTS AND CONCERNS REPORT** The Assistant Director for Quality and Safety presented the report which outlined the way in which Putting Things Right is discharged within the health board together with the management of Nationally Reportable Incidents (previously known as Serious Incidents).

	The service has strengthened its learning and development and are implementing incident management meetings on a fortnightly basis. The Once for Wales Content Management System has been implemented and work is being undertaken to use full functionality of the system. The Mortality Model on this system is being introduced this month. Nosocomial infections are reported monthly to Welsh Government. The figures may change as investigations are completed and understanding of nosocomial infection improves. Compliance with the Putting Things Right 30 working day response time is poor and below the 75% target. A review has been undertaken with areas for improvement identified. The Public Services Ombudsman for Wales (PSOW) has identified the following top concerns for the health board: dental services; communications; and delays. The position in respect of Pressure Ulcers was included at the request of the committee. There is a backlog in investigating pressure area incidents but with the information available there does not appear to be a trend. *Is there a mechanism for ensuring that if any PSOW case will be reported in the press that Independent Members are aware of the findings prior to press coverage?* The Chief Executive advised that procedures are in place to ensure this takes place including reporting to the Patient Experience, Quality and Safety Committee In-Committee meeting. *The report notes a series of issues related to data including that, compliance with Putting Things Right at 16% in March is of concern; much reliance has been placed on the refreshed Improvement Plan. May Independent Members see the revisions? What is a realistic trajectory of improvement?* The Director of Nursing and Midwifery confirmed that the concern regarding the Putting Things Right compliance was shared, and it was acknowledged that this needed to

improve. In April the figure had increased to 44% and the number of open concerns had reduced to single figures. The whole system approach with a focus on early resolution has resulted in concerns not translating to formal concerns which was a positive outcome. It was necessary to be realistic about the improvement trajectory and aim for a gradual increase to 75% which could be sustained.

What proportion of issues relate to trips, slips and falls.

The Director of Nursing and Midwifery confirmed that when the Incident Review Forum had been re-established greater insights on themes and trends would be available.

When will the backlog of investigations into pressure ulcers be cleared?

The Director of Nursing and Midwifery acknowledged that it was of concern that there were a number of cases that it had not been possible to review. This would be addressed and the improved position would be brought back to committee.

c) INSPECTIONS AND EXTERNAL BODIES REPORT AND ACTION TRACKING

The Assistant Director of Quality and Safety presented the report which articulated the receipt and outcomes of the regulatory inspections which had occurred during the reporting period and tracker.

There are some longstanding recommendations included in the tracker. Is there a mechanism to identify and complete these?

The Assistant Director of Quality and Safety advised that since the report had been written four actions had been closed and work was underway to review the other actions. Some of the barriers to completion are due to interdependencies with other areas such as the capital programme.

The committee asked that timescales be included within the tracker rather than noting that work was 'ongoing'.

Action: Assistant Director of Quality and Safety

	d) MATERNITY SERVICES ASSURANCE The Head of Midwifery and Sexual Health presented the report outlining the current position relating to maternity assurance and pathways for women and families in Powys. Attention was drawn to the National Maternity and Neonatal Safety Programme where work was taking place jointly with Improvement Cymru to identify key priorities and improvements in the first phase of the programme. Maternity services had been under pressure during the winter period and both Cwm Taf Morgannwg University Health Board (CTMUHB) and Shrewsbury and Telford Hospitals NHS Trust (SaTH) continued to have their own pressures. Health Inspectorate Wales recommendations regarding birth environments remain outstanding for Knighton and Machynlleth. The recommendations relating to Llanidloes will be addressed next. The service has spent time understanding the recommendations contained within the Ockenden Report and a roundtable event will take place on 31 May 2022 to examine the report. The Maternity Operational Framework has been revised and changes made for example to synchronise leave which will improve the escalation position. *What does the Maternity Escalation analysis show (graph on page 7)?* The graph identifies the different issues that contribute to escalation including sickness, vacancies and annual leave. Annual leave has the greatest impact on escalations and the team are working with workforce colleagues to ensure leave is scheduled throughout the year. Sickness has also had an impact although less so than elsewhere. The Chair shared an example of unsolicited feedback that had been received relating to care by the team at Knighton. *It is recognised that are able to feedback via a QR code but what can be done to enable families to shape services rather*

	than commenting on them after they have been experienced? The Head of Midwifery advised that an active Powys Maternity Voices Forum exists and that additional opportunities will be available via the National Maternity and Neonatal Safety Programme. The team have also worked on seeking feedback from Dads. The Director of Nursing and Midwifery advised the Midwifery team were undertaking a full critical analysis of the Ockenden Report looking for blind spots and would provide committee with progress in future assurance reports. The Committee DISCUSSED the Commissioning Assurance Report, Nationally Reportable Incidents and Concerns Report, Inspections and External Bodies and Action Tracking Report and Maternity Assurance Report.
PEQS/22/09	**WOMENS AND CHILDREN'S QUALITY REPORT** The Head of Midwifery and Sexual Health presented the report which provided a summary of patient experiences and concerns during quarter 3 and 4 of 2021/22. *The challenges in meeting demand for neurodevelopment services is apparent and not unusual to Powys. How will these challenges be responded to?* The Director of Nursing and Midwifery advised that this was an action as part of the Children and Young People section of the renewal programme. *How is the Procedural Response to Unexpected Deaths in Children (PRUDiC) review process undertaken?* The Head of Midwifery confirmed that reviews are undertaken on a calendar year basis. An annual event is held to review perinatal and maternal deaths and PRUDiC cases. The Director of Nursing and Midwifery advised that the annual review is presented to the Safeguarding Committee and is then included in the Quarter 1 report to the Patient Experience, Quality and Safety Committee. The Women's and Children's Quality Report was DISCUSSED and NOTED.

PEQS/22/010	**MENTAL HEALTH ACT COMPLIANCE AND POWERS OF DISCHARGE ASSURANCE REPORT** The Assistant Director for Mental Health Services presented the report which provided information to assure the committee that the health board were compliant with the legal duties under the Mental Health Act 1983. In comparison with previous years numbers were similar in relation to detention under Section 5 (Doctor and Nurse Holding Powers); Section 2 (Admission for Assessment); Section 3 (Admission for Treatment); Section 4 (Emergency Admission for Assessment); and Section 17A (Community Treatment Order). The figures for Section 136 (Police powers to remove a person to a place of safety) were lower than previous years. It was noted that the preferred place of safety was a health-care setting but in a small number of cases due to violence patients pathways defined that police cells would be used as the place of safety. This measure did fluctuate and there could spike during festivals. Section 136 cases were reviewed for learning purposes. In many cases they related to an inability to assess due to intoxication. In all cases the use of Section 136 was assessed to be appropriate. 179 sets of Section papers were scrutinised over the year. Errors were found on five or less occasions in each quarter that were corrected. Over the year no fundamental errors were found. There were no deaths of detained patients over the year. 36 applications for discharge to Hospital Managers and the Mental Health Review Tribunal were made. 14 hearings were held and less than 5 patients were discharged. The Chair of the Patient Experience, Safety and Quality Committee will chair the Mental Health Review Tribunals and training is planned for this role over the summer. *The pandemic has meant that there may have been unusual levels of activity recently. Could the timeframe that the information is compared against be extended?* This will be considered in future reports.

	Whilst there are a small number of non-defective errors this is indicative of poor record keeping. What action will be taken to address this? The Assistant Director of Mental Health Services advised that these errors generally occur outside normal working hours when the Nurse in Charge is responsible for checking the paperwork and there may have been a commotion or violence on the ward which needs immediate attention. This is acknowledged to be a challenge. The committee NOTED the report and was assured that the performance of the services in relation to the administration of the Mental Health Act 1983 was compliant with legislation.
	ITEMS FOR DISCUSSION
PEQS/22/11	**STRATEGIC OBJECTIVE REPORT: QUALITY & ENGAGEMENT (WALES) ACT: IMPLEMENTATION UPDATE** The Director of Nursing and Midwifery presented the report outlining the requirements of the Health and Social Care (Quality and Engagement) Act 2022 which was due to be implemented in spring 2023 and was intended to: • support an ongoing, system-wide approach to quality improvement within the NHS in Wales; • further embed a culture of openness and honesty; and • help drive continual public engagement in the design and delivery of health and social care services. The Act reframed and broadened the existing duty of quality on NHS bodies and placed an overarching duty on Welsh Ministers in relation to their health functions. It aimed to improve and protect the health, care and well-being of both current and future populations of Wales by focusing on: • securing Improvement in Health Services; • implementing a Duty of Candour; • establishing a Citizen Voice Body for health and social care; and • the appointment of Vice Chairs for NHS Trusts bringing them in line with Health Boards. The following next steps were intended: • secure Board support; • assess readiness; • secure wider organisational buy in and co-creating a vision;

	• developing improvement skills and infrastructure; • aligning and coordinating activity; and • sustaining a health board wide approach. In the first instance a Board Development session would be arranged. **Action: Interim Board Secretary**
PEQS/22/012	**COMMITTEE RISK REGISTER** The Interim Board Secretary presented the Committee Risk Register outlining the intention for a meeting with Clinical Directors to assess the risk and break it down into constituent parts. *Will there be a focus on balancing between looking back to identify what went wrong and looking forward to implement systems to improve quality?* The Medical Director noted that the situation was continually changing and there was a considerable amount of information available. It was necessary to prioritise risk but would require continual attention due to the pace of change. The Chief Executive noted that the Committee Risk Register related to the pre-pandemic position and arrangements were in place to review it. It was recognised that the situation was dynamic. However, it was necessary to be assured that the right controls and mitigations were in place. The level of risk that would be tolerated would be considered and arrangements for monitoring put in place. The Executive Committee have recently considered risk and a Board Development session on risk would be arranged. *There are some things that are within the control of the health board and some that are not. How can the health board ensure that those areas that are outside of our control can be influenced?* *In some areas the position has moved beyond risk to actual harm (for example ambulance transfers). Where would this be acknowledged?* The Interim naBoard Secretary noted that there needed to be a systematic approach and at present current and residual risks were conflated. The way in which the information was presented would be reviewed to articulate this split more clearly. The Committee CONSIDERED the risks identified within the Committee Risk Register

ITEMS FOR INFORMATION	
PEQS/22/013	**WHSSC QUALITY AND PATIENT SAFETY COMMITTEE CHAIR'S REPORT JANUARY 2022** The WHSSC Quality and Patient Safety Committee Chair's Report January 2022 was RECEIVED.
OTHER MATTERS	
PEQS/22/014	**ITEMS TO BE BROUGHT TO THE ATTENTION OF THE BOARD AND OTHER COMMITTEES** There were no items to be brought to the attention of Board and other Committees.
PEQS/22/015	**ANY OTHER URGENT BUSINESS** There was no other urgent business. The Director of Nursing and Midwifery noted that it was the International Day of the Nurse. On behalf of the Chief Nursing Officer Excellence Awards would be presented for Palliative Care Nurses.
PEQS/22/016	**DATE OF THE NEXT MEETING** 7 July 2022, via Microsoft Teams.

Key:

Completed
Not yet due
Due
Overdue
Transferred

PATIENT EXPERIENCE, QUALITY & SAFETY COMMITTEE

ACTION LOG JULY 2022

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

Minute	Meeting Date	Action	Responsible	Progress Position	Completed
IC_PEQS/21/5	7 Oct 2021	Presentation to In-Committee by Assistant Director of Mental Health and Learning Disability	Director of Primary, Community Care and Mental Health		
PEQS/21/29	2 Dec 2021	Next Quality Report to include details of actions taken as a result of staff survey	Director responsible for Community Services Group		
PEQS/21/31	2 Dec 2021	Information on instances of pressure ulcers and CAUTI (catheter acquired urinary tract infections) in care homes, community hospitals and community nursing to be provided to Committee	Director of Nursing and Midwifery	Information on Pressure Ulcers included in Concerns Report May 2022. Information on CAUTI will be included in future Concerns Reports	
PEQS/21/32	2 Dec 2021	Requests for training to be considered as part of Board Development Programme	Board Secretary		
PEQS/21/78	24 March 2022	To sought and include the outstanding overdue recommendations from	Director of Nursing and Midwifery		

		the inspection of Clywedog Ward, Llandrindod Wells within the Inspections and External Bodies Report to Committee			
PEQS/21/79	24 March 2022	To provide an update on the data issues identified at Shrewsbury and Telford Hospitals within the Infection, Prevention and Control Report at a future committee	Director of Nursing and Midwifery		
PEQS/21/80	24 March 2022	To consider the sharing of a Patient Story on the issues related to controlled drugs	Director of Therapies and Health Science	The programme of patient stories has been agreed for the remainder of the year, but this item could be put forward for a future patient story.	
PEQS/21/84	24 March 2022	To ascertain how telephone/video phlebotomy appointments work.	Director of Primary Community Care and Mental Health		
PEQS/22/07	12 May 2022	Response to CHC on Virtual Visit Report shared with Committee	Director of Nursing and Midwifery		
PEQS/22/07	12 May 2022	A Digital Strategy session to be arranged for Board Development	Interim Board Secretary	This will be the focus of the September Board Development Session	

PEQS/22/08	12 May 2022	Timescales to be included in the Inspection Tracker	Assistant Director of Quality and Safety		
PEQS/22/11	12 May 2022	Board Development session requested on	Interim Board Secretary		

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 2.1

Patient Experience, Quality & Safety Committee	**Date of Meeting: 7 July 2022**
Subject:	**Quality Assurance Overview Report**
Approved and Presented by:	Claire Roche, Executive Director of Nursing & Midwifery
Presented by	Claire Roche, Executive Director of Nursing & Midwifery
Prepared by:	Claire Roche, Executive Director of Nursing & Midwifery Zoe Ashman, Assistant Director Quality & Safety
Other Committees and meetings considered at:	Executive Committee 15 June 2022

PURPOSE:

The purpose of this report is to provide the Patient Experience, Quality & Safety Committee with an overview of the key Quality & Safety matters in the Health Board.

RECOMMENDATION(S):

The Patient Experience, Quality & Safety Committee is asked to DISCUSS and NOTE the contents of this report.

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

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

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

DETAILED BACKGROUND AND ASSESSMENT:

1 Background

The purpose of this report is to provide members with an update to the Health Board's Patient Experience, Quality & Safety Committee about key Quality and Safety matters.

2 Specific matters for consideration by this meeting (Assessment)

2.1 Nationally Reportable Incidents

The National Patient Safety Incident Reporting Policy (May 2021) has been successfully implemented within the Health Board. An updated suite of documents has been launched

to provide a more robust framework and opportunity for SMART action planning along with alignment to redress if required.

The current position for open National Reportable Incidents (NRI) is reported below, with a commitment that all investigations that are overdue will be closed by the end of June 2022.

Number open in time	Number open overdue	Number awaiting final approval	Total
5	**0**	**9**	**14**

The themes for learning and improvement are:

- communication, recognition that communication was ineffective and/or poor.
- standards of record keeping; and
- clear pathways of care and escalation.

Learning themes are escalated to the Learning Group and will be key to the newly established Incident Review Group.

2.2 Once for Wales Content Management System (RLDatix)

Ongoing implementation of the Once for Wales Content Management System (OFWCMS) is complete with the final Risk module being delayed for implementation due to the National work required; this is expected in October 2022.

In the previous paper to this Committee, the occurrence of an information governance breach was noted. In order to ensure the system works effectively the organisational structure and hierarchy within RLDatix required updating. This structure will go live on the 1st of July 2022.

In line with the Health and Social Care (Quality and Engagement) (Wales) Act, (1 June 2020), the provision of quality data dashboards to services, areas and teams is essential and has commenced at pace. This will ensure that quality data is used to triangulate themes and trends whilst informing quality improvements and areas of focus. The data used within this report has been obtained from RLDatix and further improvements will be made to the data quality as the system changes are realised.

2.3 Supporting learning and improvement

Further work is required to strengthen the links for robust learning from incidents, concerns, and investigations. The introduction of an incident review meeting structure will further enhance the wider organisational learning; this group will evolve and mature during 2022/23.

The Learning & Development group has re-commenced as progress was affected due to the impact of the response required for Covid-19 management. The group are feeling

confident that the structure will embed and will be further supported by the incident management process.

Supporting staff to embrace and develop a no-blame learning culture is fundamental to ensuring full engagement with all quality governance activity. Encouraging understanding and adoption of both Safety I and Safety II approaches. Safety I takes accidents as the focus point and tries to prevent things from occurring, while Safety II focuses on ensuring that as much as possible goes well, seeking to prevent incidents and promoting a safety culture. This enables multidisciplinary engagement with and ownership of the quality of services and will necessitate both training and ongoing administrative support from governance and operational management teams.

2.3.1 Learning from an Incident

Following an incident in theatre at Llandrindod Wells a learning event was held which consisted of those directly involved or present when the incident occurred, the purpose of this is to encourage open proactive learning whilst identifying the root cause.

The session was facilitated by the Assistant Director of Quality & Safety and the multi-disciplinary team in attendance included the Chief Pharmacist and Clinical Director from Wye Valley Trust. During the learning event the team talked through the events that led to the incident, taking each opportunity to stop and reflect on opportunities for learning or incidental learning that was not apparent previously.

This is a new model of learning for the team. Following the learning event, the team shared that they felt supported, 'lighter', motivated to make required changes, had heightened awareness of human factors and their impact and were keen to share their learning and experience with others.

The team are currently in the process of creating a short staff video describing the learning event and its impact to share with colleagues across the Health Board. This will be shared with Committee during the September meeting.

2.3.2 Ockenden Report

A round table event was held in person and virtually with all interested parties across the health board in attendance in order to undertake a self-assessment in line with the Welsh Government Assessment, Assurance and Exception Reporting tool – Further detail is included within the Maternity Assurance Paper to Committee.

2.4 Implementation of the National Nosocomial Framework

On 25 January 2021, the Quality & Safety Team at the NHS Wales Delivery Unit (DU) were commissioned by Welsh Government to develop a national Framework to support a consistent national approach towards investigations following patient safety incidents of nosocomial COVID-19. In March 2021, the Framework into the 'Management of patient safety incidents following nosocomial transmission of COVID-19' was published.

Any hospital acquired infection, including COVID-19, is considered a patient safety incident and therefore the provisions of Putting Things Right (PTR) apply.

The number of patient cases that require review in line with the framework is 223 which are broken down by waves as listed below. In line with the framework, the team will be reviewing the cases by wave. The Health Board has not received any concerns to date from families or patients affected by Nosocomial transmission.

The Health Board is required to have a single point of contact for families where further investigation may be required. This is in place. The team has not yet identified cases where severe harm or death have occurred. Therefore, duty of candour conversations have not been required.

	Wave 1 (27/2/2020 - 26/7/2020)	Wave 2 (27/07/2020 - 16/05/2021)	Wave 3 (17/05/2021 - 19/12/2021)	Wave 4 (20/12/2021 - 30/04/2022)
Total Number of Incidents	28	69	51	75

First 6 Month Project Plan

	May	June	July	August	September	October
Wave 1 Review						
Wave 1 Duty of Candour						
Wave 2						
Wave 2 Duty of Candour						
Wave 3 Review						

Key: Completed
On Target

2.5 Putting Things Right (PTR)

Review of 2021/22 PTR Management

A thematic review and overview of concerns management for 2021/22 has been undertaken to ensure learning and improvements have been realised and actioned.

Formal Concerns	Concerns Reopened	Enquiries/Early Resolution	Formal concerns Closed	Closed within 30wd
259	8	217	258	96 (37%)

The following themes for learning from concerns have been identified:

- improved communication required earlier in the concerns management process;
- access to services during the Covid-19 pandemic triggered several concerns and enquiries;
- access to dental care;
- increased waiting times within the Neurodevelopmental Service; and
- communication was a theme throughout a high number of concerns which encompassed visiting difficulties, lack of clarity regarding treatment plans, difficulty obtaining information from services and conflicting information.

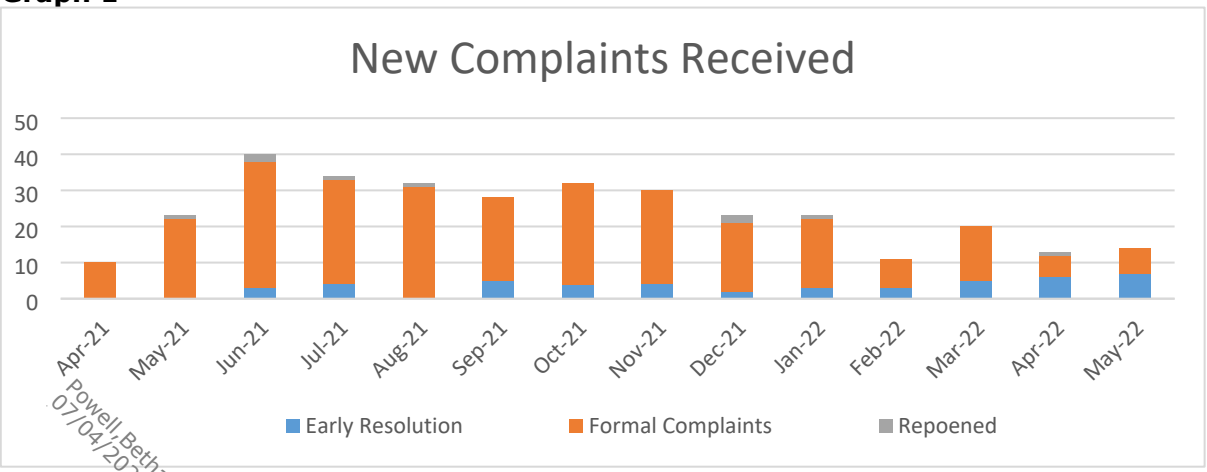
The following actions have been taken:

- implementation of Public Service Ombudsman for Wales (PSOW) facilitated training for 2022/23 regarding concerns management and proactively managing concerns early;
- public facing communication has increased regarding access to services along with point of contact for concerns management;
- proactive management of concerns to ensure early action is taken to ensure resolution;
- ensuring improved communication is in place throughout the concerns management process to ensure those raising concerns remain fully informed regarding progress;
- support for services has increased to manage concerns within the 30 working day timeframe; and
- template letters for concerns management have been refreshed.

2.6 Concerns

The number of concerns received appears to have reduced during the beginning of 2022. However, it would be too early to comment if this is a trend. The team are hopeful that increased awareness of concerns management along with the implementation of training supported by PSOW has supported teams to proactively manage concerns at source before they are escalated to the concerns team. Graph 1 demonstrates the number of concerns received by month.

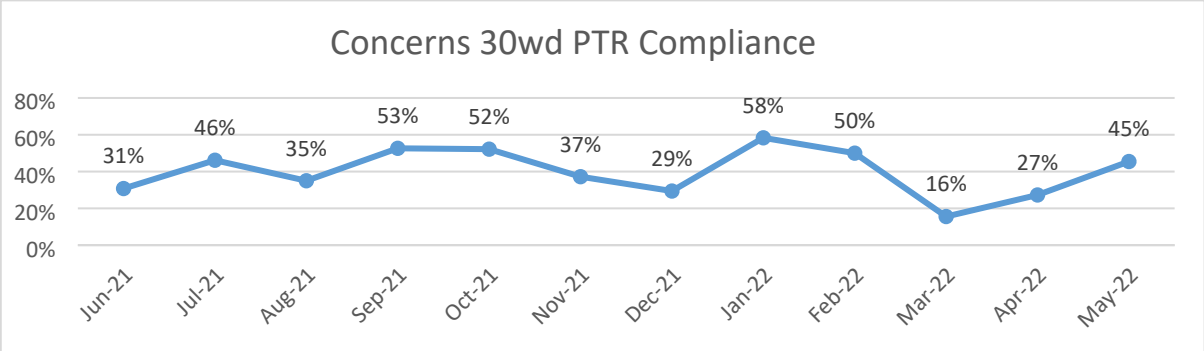
Graph 1



Source: Incidents Module OFWCMS RLDatix system

Monthly concerns compliance is demonstrated in Graph 2, with graduated progress noted during April and May. This improvement is anticipated to continue with the implementation of several improvements over the last few months. It must be noted that the number of open concerns is currently 17*(data accurate 08/06/22)* in comparison to 53 at the beginning of February. With smaller numbers of concerns open, compliance against the concern management process is being developed to give further assurance to the Committee during the next reporting period. This will address the complexity of concerns, as the more complex the concern, the more likely it is to deviate from the 30 day response target.

Graph 2



Source: Incidents Module OFWCMS RLDatix system

The top 3 themes of formal concerns are:

- access to services, clinical treatment/ assessment;
- communication; and
- delays.

An internal audit report published in May 2022 **(Appendix 2)** assessed the adequacy and effectiveness of the internal controls in operation for the tracking and monitoring of concerns and Patient Safety Incidents. The report offered substantial assurance in this area.

2.7 Public Service Ombudsman for Wales (PSOW)

The Health Board has received the position below for 2021/22 from PSOW:

Voluntary Settlement	Not Investigated	Upheld	Total
17% (n1)	50% (n3)	33% (n2)	6

Th current position (08/06/22) **is below:**

Open	Not Investigated	Upheld	Total
9	4	2	15

Due to the impact of the Covid-19 pandemic there is a significant delay with PSOW investigations and outcomes, with timescales currently over 12 months for completion.

Given the significant work undertaken by the health board to close concerns in the past 18 months with a considerable delay noted, it must be recognised that referrals to the PSOW may increase over the next 12 to 18 months consequently to the previously recognised poor compliance with PTR.

Recommendations from the PSOW have included:

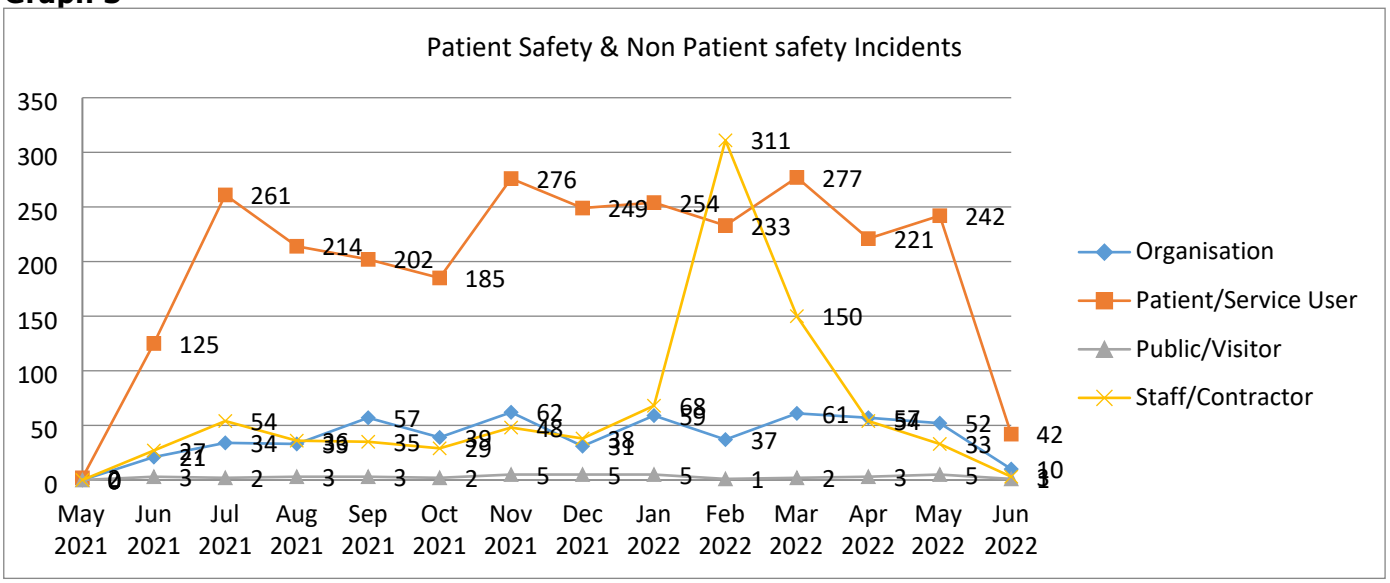
- improvements to the concerns management process; and
- improved communication with complainants during the concerns process.

Both of these themes are being addressed through our improvement plan for managing concerns. In addition to ensuring that we improve our timeliness to respond, by streamlining our quality assurance processes, we are also adopting a pro-active approach to contacting people who have raised a concern and ensuring that a named person is identified as a single point of contact.

2.8 Incident Management

The number of incidents reported is stable **(Graph 3),** with a peak noted during February and March 2022 which can be attributed to the reporting of covid positive staff members in line with the health board policy.

Graph 3



The highest reported incident themes are:

- Pressure or moisture damage (n707)
  Action: All grade 3 and above are reviewed through the multidisciplinary Scrutiny Panel process for wider organisational learning and improvement.
- Slip, trip or fall (n672)
  Action: Planned implementation of a Falls Scrutiny panel during the next quarter is anticipated to further assess the themes and trends of falls to inform the improvements required within the falls framework.

- Covid positive Staff (n488)
  Action: Reported in line with Health Board process.

Ensuring timely investigation, closure and learning from incidents continues to be a priority to ensure timely investigation of incidents is embedded within teams and across the health board. **Graph 4** highlights the number of open incidents along with their current progress within the investigation process. Progress has been made since the last report to Committee and it is hoped that this will continue over the next few months.

Graph 4

	Jun '21	Jul '21	Aug '21	Sep '21	Oct '21	Nov '21	Dec '21	Jan '22	Feb '22	Mar '22	Apr '22	May '22	Jun '22	Total
New Incident	1	4	9	5	21	66	62	56	72	96	79	113	31	615
Management reviewer/Make it safe plus	15	55	62	71	78	60	58	53	68	71	66	80	12	749
Under Investigation	2	2	3	8	7	6	10	18	19	31	25	47	7	185
Awaiting Closure	1	0	0	0	0	0	1	3	0	8	6	13	0	32
Total	19	61	74	84	106	132	131	130	159	206	176	253	50	1581

Source: Incidents Module OFWCMS RLDatix system

The structural changes underway with the RLDatix system will support robust reporting and escalation to services to inform service assurance. Continuing to develop a safe learning culture for improvement is a key requirement within the Health and Social Care (Quality and Engagement) (Wales) Act, (1 June 2020) and remains a priority for the Quality & Safety Team.

2.9 Pressure Ulcers

Monthly pressure scrutiny panels are in place with representation from the multi-disciplinary team. They are held virtually which also supports attendance from a wide audience across the large geographical area. Currently Grade 3, 4, Unstageable and suspected and deep tissue injury (SDTI's) are presented at panel with a view to including Grade 2 pressure areas within the next 6 months. This has been delayed due to the significant number of cases yet to be presented.

Management of incidents related to pressure areas was a focus of the last paper to the Committee and it was recognised that clarity was required regarding the no value fields. The reasons for fields of no value are:

- incomplete investigations; and
- changes/updates to the RLDatix system that require manual processing of completed investigations.

It should be noted that some pressure area incidents are yet to be investigated and as such it is not possible to comment on trends related to avoidable and unavoidable occurrence. This will be a focus for the new Head of Nursing when in post.

Following the data cleansing that is required, further development will be to ensure that pressure ulcer occurrence is defined per 1000 bed days to enable national comparison whilst also informing organisational learning or improvement strategies.

2.11 Early Warning Notifications (previously No surprises notifications)

No Early Warning Notifications have been submitted during the last reporting period.

3. Patient Experience

3.1 Gathering Patient Experience

The health board does not currently have a robust process in place to seek and evaluate citizen feedback. Some services have implemented their own bespoke Patient Reported Experience Measures (PREMS) and Patient Reported Outcome Measures (PROMS) which capture feedback, but this is not currently uniform or across all services provided or commissioned. Work is currently underway to scope the number of PREMS and PROMS that are captured across the organisation.

3.2 Implementation of Civica patient feedback system

Work has commenced to implement the Civica System within the Health Board. The Civica team are building the informatic infrastructure for the programme to be live within the Health Board in August 2022.

Anticipated Programme Plan:

	May	June	July	August	September	October
Call off Contract agreement						
Organisational Hierarchy agreed						
Implementation Meeting Civica						
Development of the System						
Programme Board Implementation						
Programme Go live, Test Period						

Key: Completed
On Target

4. Claims and Redress

There are currently 12 redress files open, which are all progressing. Redress Panels are in place and Legal & Risk Services are instructed as required. Currently all Redress claims that require reimbursement from Welsh Risk Pool (WRP) have been successfully completed and reimbursement achieved.

There are 18 open claims. These consist of a variety of sources which include personal injury claims, motoring accidents, General Medical Practice Indemnity (GMPI) and clinical negligence claims. Those claims are progressing with the support of Legal & Risk Services as required.

4.1 Inquests

During the period of 01 April 2021 to 31 May 2022 there have been 2 HM Coroner enquiries opened, and 3 cases closed.

Following the conclusion of an inquest on the 18th of May 2022, HM Coroner issued a Regulation 28 Report to Prevent Future Deaths jointly to the health board and Powys County Council. A joint response is required within 56 days following completion of the Inquest. The Committee will be updated with the response and subsequent action plan once completed.

5. Health and Social Care Inspections Regulatory Recommendations

5.1 Healthcare Inspectorate Wales (HIW) Inspections

There have been no new inspections for this reporting period.

HIW published the report following inspection of Community Mental Health Team (CMHT) Brecon during December 2022, the findings of which have previously been shared with the Committee **(Appendix 3).**

HIW published its national review of Mental Health Crisis Prevention in the Community on 10 March 2022. This report made 19 recommendations for all health boards to consider and act upon. On 3 May, HIW wrote to all health boards requesting the completion of an action plan with submission due by 27 May 2022. Powys Teaching Health Board completed and submitted its action plan on 23 May 2022 (See **Appendix 1a).**

5.2 Health and Social Care Regulatory Reports

The implementation of recommendations following Healthcare Inspectorate Wales Inspections, are monitored by the Quality & Safety Team with the use of a tracker. Validation of the tracker continues to ensure a current position on progress against all recommendations is captured.

The table below sets out the inspections where all actions have been completed since the previous reporting period.

2017/18	171803	Mental Health Service Inspection (Ystradgynlais Hospital)
2017/18	171808	MH Service Inspection Clywedog Ward Llandrindod Wells
2018/19	181901	Ionising Radiation Regulations and Follow Up Inspection (Brecon and Llandrindod Hospitals)
2018/19	181902	General practice Inspection (Presteigne Medical Practice)
2018/19	181903	Joint HIW & CIW National Review of Mental Health Services Inspection visit to (announced): Welshpool Community Mental Health Team
2019/20	192001	Joint Community Mental Health Team Inspection - The Hazels, Llandrindod
2019/20	192004	Unannounced Twymyn Ward, Machynlleth Community Hospital & Graham Davies Ward, Llanidloes Hospital Inspection
2019/20	192008	NHS Mental Health Service Inspection (Unannounced) Felindre Ward, Bronllys Hospital.
2020/21	20045	Tier 1 Quality Check: Tawe Ward, Ystradgynlais Hospital
2020/21	20050	Tier 1 Quality Check: Maldwyn Ward, Welshpool Hospital
2020/21	20050	Tier 1 Quality Check: Maldwyn Ward, Welshpool Hospital.
2021/22	212204	Deprivation of Liberty Safeguarding annual monitoring report – no actions required
2021/22	212205	Notification of: National Review of Mental Health Crisis Prevention in the Community - Powys Teaching HB – no actions required at this stage

There are 8 outstanding actions from 2017-2020. Updates against these are provided below:

Unannounced Visit to Llewellyn Ward 2019	The health board must produce a policy to support patient self-administration of medication.	Health board-wide policy/guideline in development with anticipated completion September 2022
Birth Centres and Free-Standing Midwifery-led units across Powys	The health board must ensure that a review of the facilities within Llanidloes War Memorial Hospital and Knighton Hospital takes place to ensure that infection prevention and control measures are in line with health board policy.	Work is due to commence summer 2022 and is dependent on capital funding and league of friends.
Management of DoLS referrals	The health board must ensure that sufficient resources are provided to facilitate the timely processing of DoLS referrals.	A business case with options will be presented to Executive Committee June 2022.

HIW Review of Healthcare Services for Young People	Health boards must ensure that children and young people can consistently be treated within designated areas.	Clinic mapping work required which is underway, due to the large scale project the team are not able to define a target date for completion.
HIW Review of Healthcare Services for Young People	Health boards must ensure there are robust systems to monitor transition policies and pathways across healthcare services to ensure approaches are effective.	Work under way
HIW Review of Healthcare Services for Young People	Welsh Government and health boards must ensure there are sufficient resources and capacity to support effective and timely transition.	Work under way
HIW Review of Healthcare Services for Young People	Health boards must ensure they have a formal system for involving young people in the design and delivery of transition processes and learn from their experiences.	Work under way

5.3 Community Health Council

There have been no recent visits by the Community Health Council and subsequent reports. The Quality and Safety team meet with the CHC on a fortnightly basis to support proactive management of concerns along with continued open dialogue.

5.4 Environmental Health Services

Environmental health services carried out an inspection of the kitchens at Llandrindod Wells Hospital on 24th May. A pipe on the ward kitchen required repair which has been completed and a hygiene score of 5 is anticipated.

6 KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

6.1 Timely management of incidents is required to ensure appropriate action is taken. Members are asked to note that as there are a number of incidents that require investigating and managing, there is a potential risk that harm has occurred and is yet to be identified.

ACTION: To ensure managers and those responsible for managing incidents have the appropriate support and training to manage incidents in a timely manner.

6.2 Implementation of a quality data dashboard is a priority to ensure robust reporting and assurance to Board and the Committee.

ACTION: Work continues to ratify the requirements of a quality dashboard in line with developments within RLDatix.

6.3 The continued trajectory of improvement is required with the management of 30wd PTR responses.

ACTION: Proactive management of concerns responses is to remain a focus for the Assistant Director of Quality & Safety to ensure that the improvements currently in place are sustained and embedded within the Health Board.

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

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

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Agenda Item: 2.1a

Patient Experience and Quality Committee	**Date of Meeting: 7 July 2022**
Subject:	**Maternity Assurance Paper**
Approved by:	Claire Roche, Executive Director of Nursing and Midwifery Louise Turner, Assistant Director for Women and Children's services
Prepared and presented by:	Julie Richards, Head of Midwifery and Sexual Health Claire Roche, Director of Nursing and Midwifery
Other Committees and meetings considered at:	Women and Children's Senior Leadership meeting 14th July 2022 Midwifery Management and Leadership 7th June 2022

PURPOSE:

The purpose of this paper is to provide the Patient Experience, Quality and Safety Committee with an update on quality assurance matters in Maternity Services in Powys. The focus of this paper will be to inform the Committee of:

1.The requirement to complete a Maternity and Neonatal Assessment, Assurance and Exception review as requested by Welsh Government and our subsequent return.

2.Recent Nationally Reportable Incidents submitted to the Delivery Unit and the current governance arrangements implemented as a consequence.

3.Outcomes of a governance review in Maternity Services in PTHB and the actions taken for improvement

RECOMMENDATION:

The Patient Experience, Quality and Safety Committee is asked to DISCUSS the report.

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

EXECUTIVE SUMMARY:

This paper provides the Executive Committee with a position in terms of the maternity and neonatal assessment, assurance and exception tool (see appendix 1) which has been developed to support health boards in Wales to assess their current position against the recommendations made within recently published reviews, reports and audit documents. The tool has been used to assess compliance with the recommendations and exception report to enable the identification of action plans for those recommendations which are AMBER and RED (appendix 2).

A letter from Chief Nursing Officer on 13th May 2022 introduced the assessment, assurance and exception tool along with the outline for the planned oversight arrangements and performance monitoring for Maternity and Neonatal services in Wales. The update for Maternity and Neonatal performance will be aligning with the current architecture for assurance and performance related to Maternity. This oversight and monitoring to be included into the IQPD meetings, JET meetings and Quality Delivery Board.

The paper also provides an overview for Recent Nationally Reportable Incidents submitted to the Delivery Unit, the current governance arrangements implemented as a consequence and outcomes of a governance review in Maternity Services in PTHB and the actions taken for improvement.

DETAILED BACKGROUND AND ASSESSMENT:

1. Maternity and Neonatal Assessment, Assurance and Exception review

PTHB have undertaken a roundtable internal review of the Maternity and Neonatal Assessment, Assurance and Exception tool. A multi-disciplinary roundtable meeting was held on the 30th May 2022 which enabled a robust self-assessment within the Health Board. The population of the tool enabled the Health Board to identify areas deemed as amber or red following our assessment. Appendix 1 summarises PTHB current position for AMBER and RED, future actions and mitigation.

A Maternity and Neonatal Network national assurance workshop will be held on the 7 July which will enable all Health Boards to share their self-assessments and related learning to inform national priorities and future direction. The PTHB midwifery team will be attending along with workforce and public health colleagues. PTHB is then planning attendance for the 6 September National Safety Summit to participate in the national conversation embracing feedback from the IMSOP intervention programme and the important learning and improvements delivered subsequently. To summarise the recommendations for AMBER and RED mitigation and consideration;

1.1 **Governance** – 28 recommendations

Green – 20	Amber – 2	Red - 2	Not applicable - 4

Whilst there are processes are in place for data collection and accuracy checking, clinical validation and monitoring of clinical practice and outcomes for Maternity Data captured through multiple sources WPAS and IFOR, CHKS and all Wales Child Health. Public Health Indicators reported through Office for National Statistics which poses challenges to obtain accurate data for the Powys population caseload. Data reported and reviewed through annual Welsh Government Maternity and Neonatal Performance Board but needs to review / validate from a numerous numbers of data sources. The implementation of Digital Maternity Cymru (DMC) will improve the assurance around data collection, accuracy. The DMC project is awaiting Welsh Government funding / approval by which is expected September 2022 and will include a Digital Midwife to support implementation.

Powys does not have a lead midwife for fetal surveillance. The clinical supervisor for midwives and consultant midwife are linked in with the All Wales fetal monitoring group. The consultant midwife is part of a working group looking at All Wales intrapartum fetal surveillance standards and to ensure there is adequate clarification around the standardisation and requirement for training in IA. All midwives complete the Oxford IIA e-learning package currently. The 2022-2023 cycle of midwifery updates includes a 1-hour session on fetal surveillance with a section on fetal physiology. Powys has an action plan for fetal surveillance actions as a result of the Welsh Risk Pool audit on fetal surveillance. Potential HEIW funding will assist in the appointment of Practice Educator Facilitator which will ensure a dedicated fetal surveillance lead

Local investigations are completed for all NRI's in line with Welsh Government framework. Key learning informs annual Midwifery Updates. It is planned to highlight that the all Wales Maternity and Neonatal Safety workshop in regards to the benefits for significant learning across Wales which the assessment tool has highlighted the need to strengthen. Process are being considered through all Wales Maternity and Neonatal network task and finish group for all Wales approach for Maternity and Neonatal Serious Incidents

Regional integration of maternal mental health services should be considered as part of NHS Collaborative for all Wales Perinatal Health standards / provision. Powys Perinatal Mental Steering workplan working towards integrated Maternal Mental Health services. Locally Powys is building Perinatal Mental Health service which is linked to Tertiary Mental Health services.

1. 2. Family Centred Care – 10 Recommendations

Green – 7	Amber – 3	Red - 0	Not applicable - 0

Service users raising concerns are promptly contacted for engagement from the outset of a complaints process. Links with Quality and Safety team to ensure responses are caring and transparent. The W&C Governance lead is linking Quality and Safety team to review service user involvement in complaints process and build on existing Powys MPVP frameworks. The Start Well Children and Young People's partnership pathfinder project is ideally placed for a framework for Family Integrated Care which is in it's infancy through the early years agenda. The peer support networks for families when using and after discharge from the neonatal services are informal and varied dependant of the Health Board / Cross Border neonatal services. There would be opportunity to develop / strengthen as part of all Wales MatNeo Safety Support Programme.

3. Skilled Multi Professional Teams – 16 Recommendations

Green – 10	Amber – 2	Red - 0	Not applicable - 4

All specialist roles current access peer support via relevant all Wales and local forums appropriate to their specialist roles. Each postholder will also access Clinical Supervision and line management support for objective setting for their roles. WoD will support the development of the principles a peer review / clinical supervision for those working in specialist services. This development will be line with PTHB process for peer review and clinical supervision those working in specialist services.

Band 7 competency tool in development to include mentorship in their Band 7 role and Band 7 to be supported with protected time. WoD colleagues have been working with Assistant Head of Midwifery to development Band 7 clinical

development programme (June 2022). The programme will include a lens of quality and safety processes and operational team leader skills for out of hours Bronze level acuity and escalation management. The programme will be undertaking by all Band 7 roles and offer development with a mentor for those recently new to their Band 7 role.

4.Continuity of Care– 1 Recommendation

Green – 1	Amber – 0	Red - 0	Not applicable - 0

Powys model for Continuity of Care was implemented in June 2021 to improve Named Midwife continuity. There has been positive DGH engagement in progress with two Health Boards to increase and improve Continuity from a Named Obstetrician perspective which will be piloted as a quality improvement project alongside the virtual consultations. Some DGH Obstetricians also provide continuity pathways for Women with Medical conditions

5.Sustainable services and workforce planning– 16 Recommendations

Green – 5	Amber – 7	Red - 0	Not applicable – 4

Strategy needs to be developed around the RCM Midwifery leadership manifesto for succession planning and rotational roles for wider Wales exposure. Offer for staff to have exposure to other specialist roles outside of Powys. Succession Planning consideration for key Senior Midwifery roles with consideration for Director for Midwifery and Women's Health services, Deputy Head of Midwifery and Consultant Midwife development post

The Specialist service recommendations were scored Amber based on their fragility of service with the need to be consider what is needed as an integrated public health perspective and the short term funding of some of the project work such as Healthier Lifestyles roles and Research midwife 0.2 wte in place with short term funding until July 2023. It would be expected to build service capacity for further innovation and research for Maternity and Neonatal services through the awaited Welsh Government funding for implementation of MatNeo SSP champions to support improvement Cymru innovations.

2. Maternity National Reportable Incidents (NRI's)

There have recent been 3 NRI's reported in relation to Maternity services. These incidents occurred between February to May 2022. A fortnightly Maternity NRI monitoring meeting has been established to ensure these NRI's are being progressed in regards to quality, timely and effective investigation process. The NRI meeting is chaired by Executive Director of Nursing and Midwifery to maintain an overview which includes a focus on ensuring staff support, engagement with families and responding to any emerging make safe actions.

The initial review work has highlighted an increase in women making choices outside criteria which are drawn up into Clinical Information Sharing (CIS) plans. Interim operating principles are currently being developed to strengthen the links into relevant support such as Obstetric or Neonatal review and escalation to Quality and Safety or Executive level where appropriate. The current complexity of CIS plans are regularly being reviewed by Consultant Midwife and Assistant Head of Midwifery to consider any additional out of hours support and be clear on a point of contact for escalated clinical advice. A make safe message has been shared with the clinical services in regard to robust recordkeeping.

The incidents have highlighted specific actions for GaP and Grow compliance for the detection of Small for Gestational Age (SGA) babies. A recent review of Powys data document demonstrates that for 2021/22, of the expected 1250 births (actual charts produced 1267), only 428 birth data was entered into the system. As this is only a third of the births, we are unable to draw any conclusion as to our detection rates of SGA babies. The trend of only submitting a third of births appears to be continuing into 2022/23. Historically the other two thirds of the data have been captured via DGH obstetric services. Corrective actions have been identified to ensure data entry for all Powys births and the entry of SGA data via the Maternity Day Assessment Unit will enable a Powys specific assurance report. An interim Clinical Lead has been identified to progress immediate actions for the outstanding data to be inputted into the Perinatal Institute system and clear Powys flowchart of managing GAP and GROW.

3. Maternity Governance Review

A governance overview for Women and Children's services was requested by the Director of Nursing and Midwifery. The trigger for the review was a cluster of formal concerns regarding care in labour or subsequent transfer from Maternity services. The scope of the review was to assess the governance processes for the:

- Incident management across the service
- Process for dealing with open concerns and management

The recommendations from the review include:

1) *ensuring that there is a clear pathways are in place for weekly review and investigations of all transfers of care, including outcomes.*

The existing Women and Children's Incident review list is being updated to ensure clear categories for reporting to support thematic trends and learning. The incident list is also defining appropriate level of review in regard to the use of Root Cause Analysis, timelines and SBAR as well as consideration to MDT approaches for incident review. Agreed templates from the Quality and Safety team have been approved at W&C Quality Assurance and Learning forum for immediate implementation. Training and development of staff is being considered with staff members planning to attend Psychological Safety and Human Factors

training to widen their knowledge and learning culture.

2) *recommended the review of the learning framework to provide assurance and ongoing improvement.*

A Maternity Quality and Safety Improvement programme of work has been established with specific workstreams to quality and safety processes, training, knowledge and skills for the Quality and Safety agenda and ensure actions against emerging themes and make safe actions.

Summary

In response to the identification of Nationally reportable incidents and the improvements required following the governance review, an extraordinary assurance meeting has been established.

The Extraordinary Maternity Assurance Forum will meet weekly and will be chaired by the Deputy Director of Nursing. The programme of work reports to Executive Director of Nursing and Midwifery and focuses on outcomes of mothers and babies in the previous week, identification of any incident that requires review and reporting, in addition to assessing potential risks and high risk care plans for women choosing to birth outside of criteria.

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Next Steps

- Maintain oversight of Maternity NRIs and targeted work through Maternity Quality and Safety programme of work
- Review Powys Maternity Improvement Plan following national events in July and September for actions for AMBER and RED recommendations
- Fully engage with the Welsh Government's Maternity and Neonatal Safety Support Improvement Programme
- Continued development of the Powys Maternity and Neonatal Improvement Plan during 2022
- Maintain oversight and escalation of commissioned services through the Commissioning Assurance Framework (CAF), to include increased scrutiny of neonatal services
- Continue to develop and embed governance and maintain reporting arrangements

Maternity and Neonatal Services in Wales
Assessment, Assurance and Exception Reporting Tool

This tool has been developed to support provider health boards to assess their current position against the recommendations made within recently published reviews, reports and audit documents. The tool should be used to assess compliance with the recommendation and exception report and action plan for those recommendations which are **AMBER** and **RED**. It is recommended that an evidence log be created to support the document.

As of May 2022 the following reports and audits have been included. This document can be amended when other reports are published.

Key

Abbreviation	Author	Report Title
R	RCOG / RCM / IMSOP	Review of Maternity Services at Cwm Taf Health Board / Thematic Maternal Category Report / Thematic Stillbirth Category Report / Review of Neonatal Services at Prince Charles Hospital
O	Ockenden	Emerging Findings and Recommendations from the Independent Review of Maternity Services at The Shrewsbury and Telford Hospitals NHS Trust / Findings, Conclusions and Essential Actions from the Independent Review of Maternity Services at The Shrewsbury and Telford Hospital NHS Trust
H	HIW	Phase 1. National Review of the Quality and Safety of Maternity Services
M-MD	MBBRACE-UK	Saving Lives, Improving mothers' Care: Lessons Learned to Inform Maternity Care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2016-2018
M-SND	MBRRACE-UK	Perinatal Confidential Enquiry. Stillbirths and Neonatal Deaths in Twin Pregnancies. Recommendations Identified from Existing Guidance Required to Reduce Stillbirth and Neonatal Death in Twin Pregnancy

1. Safe and Effective Care

Maternity care provision has seen growing levels of complexity over the last decade with rising rates of obesity and chronic medical conditions. To ensure that services are sustainable and provide the best care it is imperative that women and families are cared for within the most appropriate pathways and by the professionals who best meet their needs.

Governance Processes			
Abbrev.	**No.**	**Recommendation**	**RAG Rating**
O	1.1	Patient safety specialist should be in post at each health board. *W&C Governance Lead 1 wte in post which holds the Safety ring for Maternity Governance with 0.6 wte available for Maternity focus (as per 17/18 Midwifery Re-structure)* *Also supported by;* - *Head of Midwifery and Sexual Health* - *Assistant Head of Midwifery* - *Consultant Midwife* - *Clinical Supervisor for Midwives (0.4 wte- substantive) and additional 0.4 wte for 6 months* - *Antenatal Screening Wales Governance Lead – 0.2 wte* - *Lead Midwife for Safeguarding – 0.4 wte* - *Band 7 Midwives* - *W&C Business Support* *AMBER due to notable for the demand / capacity for Patient Safety / Governance agenda across Women and Children services* Ockenden also states that a Practice Development Midwife and Clinical educators and adequate administrative support should form part of the governance structure within services. Neither of which are in place in Powys currently. Mitigation; PROMPT facilitators support governance structure to be included. ZA brought up the governance role is mainly the same in all HB's and although less births Powys have the same Governance Lead. PDA role is vital to support Clinical drills within the birth centres which is not possible at the moment.	

		Offer from Head of Education to review manikins demo for skills and drills- 21st June 2021 Clarity on roles and responsibilities from all senior team members which contribute to the Patient Safety agenda Additional 0.4 wte Clinical Supervision hours for 6 months to assist with learning culture, restorative actions and learning outcomes from incident reviews / concerns responses	
O, R	1.2	Any clinician with the responsibility for clinical governance must have sufficient time within their job plan to deliver their duties. They should also receive training in human factors, causal analysis and family engagement. Have appropriate clinical risk and governance processes and training in place, including a consultant lead. A governance framework from ward to board must be evident ensuring joint ownership form maternity and neonates. *W&C Governance lead has work plan that is reviewed on a quarterly basis as part of PADR / 90 day review process* *W&C Governance Lead attend PTHB RCA training – 3 day training with PTHB Quality and Safety team (January 2021)* *Causal analysis training will need to be arranged* *Training for human factors is included as part of Annual Midwifery PROMPT training. 2 Powys Midwives were able to access Human Factors training via Maternity and Neonatal network.* *Formal family engagement training – previous sessions have been accessed with Whose Shoes training who are recognised experts with England MPVP.*	
O	1.3	Regular progress reports presented at Board level to review progress against improvement plans. *Cycle of Powys Maternity Assurance papers regularly presented to Patient Experience Quality and Safety Committee which reports improvement /progress against a number of assurance reports – including HIW Inspection for Maternity services. Maternity Governance / Quality Metrics included in W&C Quarterly Quality Report*	
R, O	1.4	Processes are in place for data collection and accuracy checking, clinical validation and monitoring of clinical practice and outcomes. Clinical change where required must be embedded across health boards with regional clinical oversight in a timely way. Health boards must be able to provide evidence of this through structured reporting mechanisms.	

		Maternity Data currently captured through multiple sources WPAS and IFOR, CHKS and all Wales Child Health. Public Health Indicators reported through Office for National Statistics which poses challenges to obtain accurate data for the Powys population caseload *Data reported and reviewed through annual Welsh Government Maternity and Neonatal Performance Board but needs to review / validated from a numerous numbers of data sources* *EXCEPTION report – Challenges in accessing **timely** outcome data for Commissioned Data for Powys residents* *ACTION: Implementation of Digital Maternity Cymru will improve the assurance around data collection, accuracy*	
R, H, M-SND	1.5	Identify named midwife/obstetrician to lead on updating policies and procedures, ensuring staff are aware of updates to maintain the delivery of safe and effective care. *Established Midwifery Policies and Procedures group meets monthly which has been led by W&C Governance Lead and Clinical Supervisor for Midwives, supported by Consultant Midwife and Assistant Head of Midwifery. Engagement with Obstetrics and Neonates as part of the guideline, pathways and policy consultation and development* *All Maternity staff are part of the guideline, pathways and policy. Prioritisation plan in place to address outstanding guidelines* *Finalised policies cascaded to teams and highlighted in Midwifery team meetings, clinical supervision sessions. Lunchtime drop in sessions offered for relevant policies for staff to raise / share key point. Work to be progresses for monitoring of dissemination and being able to evidence that staff have read/acknowledged updated guidelines which will be part of additional Clinical Supervisor for Midwives hours* *Consultant midwife is part of All-Wales work into policies that are developed on an All-Wales basis to ensure that input is provided for Powys and then there is appropriate consideration of any implementation issues and mitigation for use in Powys.*	
O	1.6	Systems must be in place to ensure appropriate management of women with high risk of pre-term birth, including: • Counselling of parents • Appropriate monitoring of pregnancy • Mode of delivery • Tertiary discussion • Continuous audit of In-utero transfers	

		All Powys women with high risk of pre-term birth are referred early for appropriate Obstetric and Neonatal planning. Tertiary services are access where needed via Fetal Medicine pathways in line with Antenatal Screening standards. The high risk pathways and tertiary services will offer counselling for parents *Annual Antenatal Screening Standards are reviewed and reported on an annual basis are past of the audit process* *In-utero transfers are audited via all Wales Maternity and Neonatal network as part of the Neonatal standards* All Wales In-utero Guidelines out for comments at the moment. Patient experience does need to be considered. Internal action - consider each point especially around audit around in-utero transfers to a DGH and the pathway of care, including family experience.	
R, O	1.7	Midwifery, neonatal and obstetric co-leads identified for audit, clinical guidelines, mortality and morbidity. *Consultant Midwife is PTHB Maternity Service Audit lead informing the W&C Audit Programme. W&C audit programme is reviewed quarterly with Maternity audit presentations* *Annual Perinatal, Maternal and Child Death audit presentations include Neonatal and Obstetric inputs* *Powys team are able to join all DGH reviews for audit of relevant clinical cases and all Wales Neonatal network audit presentations of morbidity and mortality cases* *EVIDENCE* *- add in W&C Audit programme* *- add to 2022 Summary Case presentation and 2022 outcome report*	
O	1.8	Processes are in place to provide assurance that adherence to guidance is being achieved. Where guidance is not being followed evidence should be available to outline the reasons why *Monthly recordkeeping audits provide assurance in regard to adherence to guidance* *All Maternity transfers are reviewed for assurance to guidance* *Monthly Midwifery Policies and Procedures meeting is place to review* *Audit programme to review specific adherence with agreed guidance* *Adherence to Obstetric / High risk women's pathways would be highlighted via quarterly DGH meetings / Maternity and Neonatal CAF*	
R	1.9	Support a full program of clinical audit. *Programme of W&C audit agreed on an annual basis, reviewed on a quarterly basis. Maternity audit programme led by Consultant Midwife. Audit outcomes reported via W&C quarterly audit meeting and reports highlighted through Midwifery team meetings and annual Midwifery Updates*	

R, H, M-MD	1.10	Ensure appropriate staff training is available, including CTG, emergencies, NLS and Develop an effective department wide multi-disciplinary teaching program. This must include clinical governance, skills and drills for obstetric emergencies, CTG interpretation, human factor training, NLS and psychological safety; incorporating learning from audits. Ensure that staff have timely access to the training that is required for them to carry out their roles. Compliance should be monitored. *Community PROMPT Wales training is delivered as an annual programme in line with all Wales Prompt standards. This is a programme of Obstetric Skills, Intelligent Fetal Auscultation, Maternal and Neonatal Resuscitation. PROMPT training includes human factors training and additional human factors training has been accessed via Maternity and Neonatal network in March 2022. Compliance is monitored and reported through to Welsh Risk pool using PROMPT standards* *Training includes increasing attendance from WAST colleagues and Consultant Midwife will be attending DGH PROMPT assurance visits during 2022-2023. Powys Midwives able to use Birth rate plus 90hrs to join DGH PROMPT sessions* *Internal action: additional 3 faculty PROMPT trainers will be attending Train to Trainers so Community PROMPT session can also be held across Birth Centres*	
O	1.11	Health Boards should appoint a dedicated Lead Midwife and Lead Obstetrician for fetal surveillance who will run regular fetal surveillance meetings, cascade training and lead on the review of cases of adverse outcome involving poor FHR interpretation and practice. *Powys does not have a lead midwife for fetal surveillance. The clinical supervisor for midwives and consultant midwife are linked in with the All Wales fetal monitoring group. We do not hold regular fetal surveillance meetings currently.* *The consultant midwife is part of a working group looking at All Wales intrapartum fetal surveillance standards and to ensure there is adequate clarification around the standardisation and requirement for training in IA.* *All midwives complete the Oxford IIA e-learning package currently.* *This year's cycle of midwifery updates includes a 1-hour session on fetal surveillance with a section on fetal physiology.* *Powys has an action plan for fetal surveillance actions as a result of the Welsh Risk Pool audit on fetal surveillance.* *Sits with Practice Development framework / role to support GAP & Grow framework / Intermittent fetal auscultation.* *Interim GaP and Grow Lead identified for immediate GaP and Grow assurance*	
O	1.12	Clinicians working on labour ward or delivering intrapartum care must be trained in CTG and emergency skills. This must be mandated	

		Intrapatum CTG not used for Powys Midwife Led cases. Intelligent Intermittent Fetal Auscultation and Fetal Wellbeing standards training is part of Midwifery Annual updates	
O	1.13	Local guidelines should be in place for: • When Consultant Obstetrician presence is mandatory • When Consultant Obstetrician and Mangers need to be informed of situations • Escalation to a tertiary unit is required *All Powys women with high risk of pre-term birth are referred early for appropriate Obstetric and Neonatal planning. Tertiary services are access where needed via Fetal Medicine pathways in line with Antenatal Screening standards. The high risk pathways will lead to tertiary services* *Antenatal screening pathways to enable transfer / escalation to tertiary services via DGH Obstetric / Fetal Medicine pathways*	
H	1.14	Ensure medicines management policies in place which include safe storage of medicines and the prescription and administration of medication for the induction of Labour *PTHB Medicines management policies to ensure Birth Centre safe storage of medicines – compliance confirmed by HIW review for Maternity services (Feb 2019). PTHB Medicine Management audits are scheduled for 2022-2023 with initial focus of temperature control* (EA) *Medicine management for IOL not applicable for Powys Midwife Led services*	
R	1.15	Have process in place to facilitate MDT debrief after an unexpected outcome *Safe Space huddles are arranged for and links made for MDT debrief including WAST, Primary Care, Safeguarding, Health Visiting where appropriate. 1:1 Clinical Supervisor for Midwives support also arranged for follow up*	
R, O, H	1.16	Health Boards must work collaboratively to ensure that local investigations into National Reportable Incidents (NRIs) are reported as per Welsh Government Framework. All significant learning should be shared across Wales . Lessons from clinical incidents must inform local multi-disciplinary training *Local investigations will be completed for all NRI's in line with Welsh Government framework. Lessons learnt are drawn up in relevant action plans and monitored through monthly Maternity Governance and W&C Quality Assurance Learning forums. Key learning informs annual Midwifery Updates* *Action: To highlight the benefit for significant learning across Wales*	

		To raise at July Safety workshop (highlight in WG response letter- Exception report)	
R, H	1.17	Ensure that steps are taken to encourage staff to speak up and report incidents without fear of reprisal or repercussion. *Group Clinical for Midwives supervision held monthly to offer a safe space for staff* *Monthly Maternity Clinical Incident provide feedback / outcomes from incident reporting* *Positive incident and concerns reporting from Maternity teams* *Maternity Incidents are reviewed weekly with Band 7's to ensure reporting of key events such as Maternity escalation and Maternity transfers* *90day review meetings opportunity for staff to speak up and explore concerns / challenges* *Annual Midwifery updates feature emerging themes / outcomes from incidents* *Internal discussion / links to July all Wales workshop for Principles of Psychological Safety* *Opportunity with Health Board sign up to RCM Caring for You action plan* *Themes and trends of reporting to be tracked*	
R, O, H, M-SND	1.18	External clinical specialist opinion from outside the Health Board, must be mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death. This should include the use of the PMRT where applicable. *External clinical specialist for Perinatal, Maternal and Neonatal deaths is considered but no formal arrangements in place to mandate. PMRT generated by relevant DGH with opportunity to review / check report / data to ensure a partnership review* *Action: To raise at July Safety workshop for an all Wales approach*	
R, O, M-SND	1.19	Ensure learning and service improvement actions are implemented following incidents, concerns or audit, is effectively shared with staff across all sites. Mechanisms will be in place to capture this information to close the loop. As per 1.17 *Action: to ensure pathway which sets out the mechanism to ensure information is capture to close the loop*	
O	1.20	There must be robust pathways in place for managing women with complex pregnancies. Through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre.	
H	1.21	Ensure that a high standard of documentation is maintained, in particular ensuring that the standard of patient records is improved and prescribing.	

		Monthly recordkeeping audits are undertaken by Clinical Supervisor for Midwives with a rota across all Midwifery teams to ensure compliance / standards of patient records *EVIDENCE – Clinical Supervisor for Midwives to add in 2021-2022 schedule and annual report from recordkeeping audit*	
H	1.22	Ensure the ongoing monitoring in line with health board policy of neonatal resuscitaires and emergency medical equipment. *Birth Centre Neonatal Resuscitation equipment is checked daily as per checking template (confirmed by HIW Maternity review). Powys Midwives equipment weekly check and full kit bag monthly check- Consistent checklist recently revised by Assistant Head of Midwifery and CfSOM. Band 7's undertaking monthly audit. Further Quality Assurance of each Midwives equipment as part of the annual Midwifery updates.*	
Clinical Pathway			
Abbrev.	**No.**	**Recommendation**	**RAG Rating**
O, M-MD	1.23	Development for high-risk pregnancies including rapid referral for neurology review, an epilepsy team, rapid specialist stroke care, specialist multidisciplinary care for pregnant women who have had bariatric surgery *Medical Conditions guideline developed following a recent Ombudsman recommendation – this allows for any high risk pregnancy linked to Medical Condition specialist. This doesn't specifically cover for stroke care or bariatric surgery, but does clarify that where care is not considered to be low-risk or midwifery-led care, then referral to the obstetric team must be completed.* *Point to raise all Wales July Maternity and Neonatal workshop – need to consider all Wales Maternity Hand Held record for risk assessment to include consideration for rapid specialist stroke care, specialist multidisciplinary care for pregnant women who have had bariatric surgery*	
O, M-MD	1.24	Regional integration of maternal mental health services should be considered *To be consider as part of NHS Collaborative for all Wales Perinatal Health standards / provision* *Powys Perinatal Mental Steering workplan working towards integrated Maternal Mental Health services* *Action: To raise at July Safety workshop (highlight in WG response letter- Exception report)*	

O	1.25	All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional and must include ongoing review of the intended place of birth *All Wales Hand Held Record enables risk assessment at every antenatal contact* *Intended place of birth is reviewed at 36 week appointment* *Relevant Obstetric teams included in Clinical Information Sharing plans; Virtual Antenatal appointments increasing opportunity for Obstetric and Named Midwife involvement with antenatal appointments* *Internal action – opportunity to strengthen DGH Obstetric CIS plans*	
O, M-MD	1.26	Ensure early senior involvement in the care of women with extremely preterm prelabour rupture of membranes and a full explanation of the risks and benefits of continuing the pregnancy. This should include discussion of termination of pregnancy. *Pathways into Obstetric services for senior involvement for extremely preterm prelabour rupture of membranes*	
O	1.27	Robust pathways of care in place between hospital and community setting *Powys Midwife Model is supported by all Waled Birth Centre guidance for women for unviser* *Referal for Women* *Internal action: ensure all elements of the service are*	
O	1.28	Complex pregnancy pathways must be in place for • Preconception advice and management of women with pre-existing conditions • Multifetal pregnancies • Pre-existing conditions e.g. Diabetes, cardiac, chronic hypertension *As per 1.23*	
O	1.29	Systems must be in place to ensure appropriate management of women with high risk of pre-term birth, including: • Counselling of parents • Appropriate monitoring of pregnancy • Mode of delivery • Tertiary discussion • Continuous audit of in-utero transfers *As per 1.23*	

O	1.31	During labour and birth women must receive a full clinical assessment on presentation, including a review of risk factors. Women who choose to birth outside of a hospital setting must receive documented information on transfer times to an obstetric unit. *All Wales Normal Labour car pathway is established documentation for Low risk Women for Home or Birth Centre Labour care. Documentation uses Part 1 for Telephone assessment, Part 2 for Early Labour / Home assessment and Part 3 for established labour assessment* *SBAR document in place for transfers*	
O	1.32	Pathways must be in place for induction of labour, that includes the management of delays *No delays for Induction for Labour highlighted via Incident notification process*	
O, M-MD	1.33	Centralised CTG monitoring must be mandated *Not applicable for Powys Midwife Led service*	
O	1.34	There must be clear pathways of care for the provision of neonatal care. Activity outside of the agreed pathways must be supported by NICU advice on resuscitation and management, with all cases outside of pathway exception reported. *Not applicable for Powys Midwife Led service*	
O	1.35	Neonatal staff should have the opportunity for secondment to other units to maintain clinical expertise. Units should maintain Network contacts to share best practice, learning and education *Not applicable for Powys Midwife Led service*	
R, O	1.36	Bereavement care must be available on a daily basis to ensure compassionate, individualised, high quality bereavement care is consistently offered to all families experiencing perinatal loss. This should be included as part of regular training updates. *Comprehensive Bereavement is provided via relevant DGH pathways which has been evaluated well with families experiencing perinatal loss* *Training – see 3.14*	
O	1.37	Obstetric Anaesthetic assessments must be robustly documented in line with Good Medical Practice GMC recommendations. Follow up care should include but not be limited to: postdural puncture headache, accidental awareness during general anaesthesia, intraoperative pain and the need for conversion to general anaesthesia during	

		obstetric interventions, neurological injury relating to anaesthetic interventions, and significant failure of labour analgesia. Resources must be made available for anaesthetic professional bodies to determine a consensus regarding contents of core datasets and what constitutes a satisfactory anaesthetic record in order to maximise national engagement and compliance. *Not applicable for Powys Midwife Led service*	
O	1.38	Postnatal care must include systems in place to ensure a consultant review of all readmissions within 14 hours of readmission, including daily review of unwell postnatal women regardless of clinical setting. Action: To review as part of Quarterly HoM meetings – opportunity to audit as part of Postnatal readmissions	

2. Family Centred Care

Respect and compassion are core values underpinning the care women and their families receive. Respectful family-centred care enables women to have control over their behaviour, surroundings and the treatment they receive. This supports meaningful discussions and shared decision making about their pregnancy, Labour, birth and postnatal care. Maternity services also have a key role in promoting the health and wellbeing of the mother and her family, and in preparing families for parenthood.

Abbrev.	No.	Recommendation	RAG Rating
R	2.1	Maternity and neonatal services must ensure that women and their families are listened to with their voices heard. *Maternity and Parent Voices Partnership (MPVP) is in place in Powys, however engagement has been slow. Chair in place and mechanism for feedback through the MPVP is shared on social media through Bumptalk and the MPVP page. Details are also on the PTHB website for feedback.* *Launch of online MS Forms feedback mechanism in Jan 2022, QR codes and weblinks shared on posters, flyers and social media to gather feedback through separate surveys for:* *On the spot – comment on our service now*	

		Antenatal care *DAU/USS* *Labour care* *Feeding your baby* *Postnatal care* *Dad/partner/co-parent feedback* *Transfers* *MPVP engagement has been online due to Covid. QR codes are great – in person engagement with minimal input from service users. Challenges of geography of Powys to bring face to face engagement. Need to consider the whole Powys pathways where families feel unsure on how to feedback when their care is outside Powys.* *Civica will support our feedback* *part of work has been to link with other units to consider what is done in other areas. Paid time for chair and obstetric / neonatal input is normal practice in England.*	
O	2.2	Service users (ideally through the MVP / MSLC) must be involved in the complaints process, ensuring responses are caring and transparent Service users raising concerns are promptly contacted for engagement from the outset of a complaints process. Links with Quality and Safety team to ensure responses are caring and transparent. Not in relation to MPVP feedback and engagement	
R	2.3	Develop and strengthen the role and capacity of the MSLC/MVP to act as a hub for service user views and involvement of women and families to improve maternity care: *Whilst there is a chair of the MPVP, it has been recognised that her time in the role will need to end and as yet there is no succession plan in place. Would welcome development and support for how these roles can be renumerated to support their involvement. Also need to strengthen engagement from families in addition to be able to feedback via online forms.* *Encourage greater engagement from service users to enhance the MPVP group.*	
H	2.4	Improve the ability of birth partners or family members, to be able to support women, in line with a woman's wishes	

		Feedback can be obtained for partners/family members through online forms. Partners are now able to attend antenatal appointments again. Offer of antenatal Solihull is open, which partners are encouraged to attend too. One off 'dads sessions' on offer. *Action: to ensure partners are integrated back into maternity care and flexibility with birth plan appointment to be able to include birth partner*	
O	2.5	All Health Boards will have pathways in place to provide timely emotional and specialist psychological support *Local pathway in place for the birth reflections and trauma service (MAT066) – this can be accessed after 1 month postnatal or antenatally for support around birth trauma. There is not a direct pathway into psychological services in relation to trauma currently.* *PNMH service is just launching, this will support access to timely support in the perinatal period.* *Midwives are trained in being able to assess suitability and refer into online Silvercloud CBT Perinatal module.* *Consultant midwife is linked with traumatic stress Wales work and development of local pathways in Powys, which will include perinatal period.* *Recognise that there is improvement we can do*	
O	2.6	Psychological support for the most complex levels of need, should be delivered by psychological practitioners, who have specialist expertise in maternity care *There is work underway in Powys for development of pathways for complex trauma including in the perinatal period. These pathways are still in the development stage but aim to give people access to services quickly, if they are presenting with complex trauma. Pathways are being developed including training of staff in EMDR, as well as the 'Spring' programme to support complex PTSD.*	
O	2.7	A framework for Family Integrated Care should be implemented and its impact evidenced. In its infancy and no evidence of its impact. There is scope to improve our facilities to provide an enhanced Family Integrated Care environment. Health lead for pathfinder role would be ideally placed Highlight at July workshop it is difficult to score ourselves against this.	
O	2.8	Peer support networks should be developed for families when using and after discharge from the neonatal services.	

		Informal and varied dependant of the Health Board / Cross Border neonatal services *Opportunity to develop / strengthen as part of the MatNeo Safety Support Programme*	
H	2.9	All Health Boards must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery. All maternity services must ensure the provision to women of accurate and contemporaneous evidence-based information as per national guidance. This must include all aspects of maternity care throughout the antenatal, intrapartum and postnatal periods of care. Women must be enabled to participate equally in all decision-making processes and to make informed choices about their care. Women's choices following a shared and informed decision-making process must be respected. *Women are provided with the place of birth leaflet within the welcome to Powys leaflet to support dialogue around place of birth. Maternal request caesarean pathway varies according to which commissioned service women are referred to. midwives well versed in supporting discussions locally. Ethos of care is around supporting informed choice and shared decision making. Adequate time enabled at antenatal checks for that to happen.* *Action: to ensure data is able to be shared in a more timely way to support decision making around place of birth in Powys – also to ensure we have accurate transfer data including reasons for transfer to be able to share in relation to Powys births.* *Action: to ensure the PTHB maternity webpages are reviewed in relation to place of birth with links to key evidence and documents for families to have access to support decision making.* *Information shared with women is proportionate and offer reasonable amount of information. Suggest its green. We offer birth choices information, one to one conversation about choice of birth. Maybe room for improvement for shared dashboard that could be offered to women to support further their decision making.*	
H	2.10	Ensure that women are aware of how they can request information or support in their language of choice *Use of language line.* *Resources available via ASW website*	

3. Skilled Multi-professional Teams

Professional groups who work together must develop strong inter-professional working skills to ensure that they share clear aims, language and culture in order to deliver safe and effective care. Multi-professional training should be a standard part of professionals' continuous professional development, both in routine and emergency situations

Governance Processes			
Abbrev.	**No.**	**Recommendation**	**RAG Rating**
O	3.1	Health Boards must implement a robust preceptorship programme for newly qualified midwifes *All Wales Preceptorship framework implemented in September 2021 for Newly Qualified Midwives for robust preceptorship programme* *Internal review to ensure all components of the programme are delivered – eg competencies around perineal suturing, IV Cannulation- opportunity to strengthen with potential Practice Education Facilitator*	
O	3.2	Midwives responsible for coordinating labour ward must attend a funded and nationally recognised labour ward coordinator education module. This must be a specialist post with an accompanying Job Description *Powys Midwife Led model has an Operational Team Leader Band 7 role which co-ordinates and oversees the operational activity for Powys Midwife led service. This role is supported by a Job Description that is currently being update via WoD* ***WoD discussion** – Midwifery Training Needs analysis to include Band 7 OTL's to have Bespoke (recognised) educational development. To be part of Band 7 action learning and leadership development scheduled to commence in June 2022 supported by Rhys Brown*	
O	3.3	Health Boards must ensure newly appointed labour ward coordinators receive an orientation package which reflects their individual needs. ***WoD discussion** – as part of 3.2 discussions / actions*	
O	3.4	Health Boards must train a core team of midwives to deliver high dependency maternity care, sufficient in numbers to ensure one midwife is available each shift	

		Not applicable for Powys Midwife Led service	
O	3.5	Competing workloads in obstetric staffing must be risk assessed and discussed at Board (where no separate rota is in place) *Not applicable for Powys Midwife Led services*	
R, O	3.6	Ensure the Medical Director has effective oversight and management of the consultant body by: making sure they are available and responsive to the needs of the service, urgently reviewing and agreeing job plans to ensure the service needs are met, clarifying what is to be covered as part of SPA activity (audit, governance, teaching, guidelines, data assurance, train more consultant obstetricians as appraisers), ensuring the most unwell women are seen initially by a consultant and all women are seen by a consultant within 12 hour NCEPOD recommendation4 (national standard). *Not applicable for Powys Midwife Led services*	
R	3.7	Ensure obstetric consultant cover is achieved in all clinical areas when required by: • reviewing the clinical timetables to ensure that 12-hour cover per day on Labour ward is achieved, • undertake a series of visits to units where extended consultant Labour ward presence has been implemented • Ensure the consultant on-call for the labour ward has ownership of all patients in the maternity unit for the period of call. This must involve the antenatal ward round being performed by the consultant. *Not applicable for Powys Midwife Led services- need to consider OTL cover* Link to 3.2	
R	3.8	Neonatal consultant of the week 09:00-17:00 with a minimum of 4 weeks service per year. *Not applicable for Powys Midwife Led services*	
R, O	3.9	Clinical supervision and consultant oversight of practical procedures must be in place for all staff including specialist midwives and staff doctors. *0.4 wte Clinical Supervision provides Clinical supervision for Powys Midwives* *Additional 0.4 wte* *Need to report that there are no consultants and no staff doctors.*	

		Need to ensure that there is robust supervision for clinical supervision for specialist roles. *Peer review for specialist services must be a priority.* *WOD working on the all wales framework and how this works in Powys for advanced practitioner roles.*	
R, O	3.10	Support training in clinical leadership. The Health Board must allow adequate time and support for clinical leadership to function. Newly appointed Band 7/8 midwives must be allocated a named and experienced mentor to support their transition into leadership and management roles. - *2 x Powys Midwives attend RCM / WG Leadership programme on an annual basis for aspiring Band 6's* - *Band 7's will be supported with PTHB Band 7 clinical development programme (June 2022)* - *Assistant Head of Midwifery and relevant Band 7's are completing PTHB Managers programme* - *Gwella leadership portal available* - *Midwives (2) completing MSc Clinical Leadership modules supported* - *Assistant Head of Midwifery to attend Academy Wales Leadership development* - *Clinical Supervisor for Midwives completed Coaching programme* - *Consultant Midwife has offered Coaching locally and to RCM / WG Leadership programme* - *PTHB Coaching session offered for clinical leadership* ***Internal action*** – Band 7 competency tool in development to include mentorship in their Band 7 role and Band 7 to be supported with protected time	
R, H	3.11	Review their workforce plans to ensure appropriate actions are being taken to address the impact of staff working excessive hours, and any shortfall across staff groups. *Birth rate plus 2022 currently in progress to review 2021 Caseload activity* *Birth Rate Plus Map and Gap 2022 – recommending 20% of non-Clinical roles as part of establishment* *Monthly review of Midwives caseload and time owing. Phase 2 Health Roster implementation in January 2022 affords opportunity for more timely review / response* *WOD can support the work with considering the roles including the non-clinical roles – task driven workforce planning*	
H	3.12	Consider implementation of positive initiatives to recognise the good work carried out by staff within the midwifery and medical teams. - *Midwifery Management and Leadership Thank you cards provided for good work / recognising excellence* - *Women's feedback is proactively shared with members' staff* - *Women's feedback used as a thank you montage for International Day of the Midwife*	

		- *Birth stories featuring good work from staff are shared with the midwives* - *Good practice highlighted through Clinical Supervisor for Midwives sessions* - *Midwives have been nominated for PTHB staff excellence awards*	
H	3.13	Ensure all midwives complete appropriate training before being required to assist in theatre - *Not applicable for Powys Midwife Led services*	
O	3.14	Bereavement training must be offered to all staff *Joint Midwifery and Health Visiting Bereavement training was provided by SANDS in November 2019* *Post Mortem Consent training has been planned for 2022-2023* *Further Bereavement support being considered through task and finish group for Traumatic events*	
O	3.15	Rotation of neonatal staff into exemplar units to ensure competence in key clinical skills and decision making. *Not applicable for Powys Midwife Led services* What we could consider for around neonatal resus, offering opportunities for staff to have experience rotating for areas such as Newborn examination as not always able to achieve their 40 examinations. 90 hours for all staff should include neonatal experience. NLS to be considered Ringfenced monies for midwives to do immediate life support. Nominations then from attendees to obtain trainer.	
R, O	3.16	Investment in neonatal nursing staff, part matron part improvement. Nurse in charge to be supernumerary, ANNP should be expanded to ensure career progression. Nurse consultant roles to be explored. AHP in line with national recommendations including an expansion of pharmacy services. *Not applicable for Powys Midwife Led services*	

4. Continuity of Carer

Continuity of carer affords women and Midwives / Obstetricians the opportunity to build a trusting relationship over the pregnancy journey and into parenthood. It is acknowledged that women often have very individualised journeys through pregnancy from straight forward to complex and requiring multiple specialist inputs

Governance Processes			
Abbrev.	**No.**	**Recommendation**	**RAG Rating**
H	4.1	Take steps to ensure that women have contact with a consistent group of healthcare professionals, to improve continuity of care. *Continuity of Care model implemented in June 2021 to improve Named Midwife continuity* *DGH engagement in progress with two Health Boards / Trust to increase / improve Continuity from a Named Obstetrician perspective. Some DGH Obstetricians also provide continuity pathways for Women with Medical conditions*	

5. Sustainable Services and Workforce Planning

Maternity services in Wales should provide equity across health boards to ensure all women and families have individualised care appropriate to their needs. This will require key resources to ensure sustainable future delivery of services.

Staffing			
Abbrev.	**No.**	**Recommendation**	**RAG Rating**
H	5.1	Multiyear workforce planning process in place, incorporating the whole perinatal team *Not applicable for Powys Midwife Led services*	
H	5.2	Nationally agreed minimum staffing levels based on acuity and complexity of pregnancies, vulnerable families and mandatory training requirements *Included as part of Birth rate Plus assessment*	
H	5.3	When staffing levels cannot be achieved a process of escalation to the highest level of senior management in the organisation	

		Clear process for AMBER / RED escalations which are managed via Assistant Head of Midwifery (in hours) and Band 7 OTL (out of hours). Assistant Director for W&C Services and Executive Director of Nursing are cited on *Monthly review of escalations are considered through W&C Dashboard, Quarterly Quality Report and reported to PEQS committee as part of Maternity Assurance paper*	
H	5.4	Staffing uplift to be representative of the previous 3 years data on sickness, maternity leave, mandatory training and annual leave *All Wales Birth Rate Plus agreement for workforce planning to includes 26.9% headroom for sickness, maternity leave, mandatory training, and annual leave* *Internal action – to confirm actual training hours required as part of 2022 Birth Rate plus assessment*	
H	5.5	The feasibility and accuracy of the Birthrate+ tool and it associated methodology must be reviewed nationally *Birthrate plus for Maternity Services has been reviewed via the MatNeo Discovery programme with a draft report / recommendations being considered against the delivery of Maternity vision* *Internal action – Map and Gap for the Birthrate Plus findings and recommendations has been undertaken to be considered by Assistant Director for W&C services, Director of Nursing and PTHB with a number of key priorities;* - *Opportunity to consider Skill / Administrator infrastructure* - *Review of 2nd midwives for Homebirths / Birth Centres for CIS Plans and NQM's* - *Additional Specialist roles – Infant Feeding Strategic Lead, Public Health Midwife*	
H	5.6	A strategy is in place to support a succession planning programme for the maternity workforce and develop future leaders and senior managers. This must include a gap analysis of all leadership and management posts in midwifery and obstetric Strategy needs to be developed around the RCM Midwifery leadership manifesto for succession planning and rotational roles for wider Wales exposure Offer for staff to have exposure to other specialist roles outside of Powys.	
H	5.7	Obstetric anaesthesia staffing guidance to include: • The role of consultants, SAS doctors and doctors-in-training in service provision, as well as the need for prospective cover, to ensure maintenance of safe services whilst allowing for staff leave.	

		• The full range of obstetric anaesthesia workload including, elective caesarean lists, clinic work, labour ward cover, as well as teaching, attendance at multidisciplinary training, and governance activity. • The competency required for consultant staff who cover obstetric services out of hours, but who have no regular obstetric commitments. • Participation by anaesthetists in the maternity multidisciplinary ward rounds *Not applicable for Powys Midwife Led services*	[redacted]
O	5.8	RCOG guidance on locum management is to be followed *Not applicable for Powys Midwife Led services*	[redacted]
R, H	5.9	Neonatal units must be staffed according to BAPM guidelines. *Not applicable for Powys Midwife Led services*	[redacted]
Specialist Services			
Abbrev.	**No.**	**Recommendation**	**RAG Rating**
R, H	5.10	Consider the introduction of smoking cessation leads to strengthen their approach. - Programme of work for Smoking cessation as part of the Help me Quit, led by Powys Public Health team. Includes re-introduction of CO Monitoring, target support from Maternity DAU team, Healthier Lifestyle workers. Smoking cessation key priority for joint Midwifery, Health Visiting and Public Health team **EXCEPTION REPORT- no current smoking cessation lead / Public Health Midwife or Consultant Midwife with public health portfolio as part of the Midwifery establishment** Fragility around the service is key amber is appropriate, but we need to consider integrated services moving forward. Startwell agenda, pathfinder agenda. Recognition that these services can be delivered in a completely different way Need support from PHW cessation services. Consider as part of CYP recovery work following on from Covid 19	
H	5.11	Consider working with Public Health Wales to further promote healthier living and lifestyles.	

		- Joint Public Health and PTHB Healthier Lifestyles project extended until March 2023 **EXCEPTION REPORT- Evaluation will inform sustainability of the project**	
R, H	5.12	Ensure the appropriate level of breastfeeding advice, guidance, and support is provided at all times. Midwives and Health Visiting practitioners provide breastfeeding advice and guidance. Postnatal support provided as part of the all Wales infant feeding standards. **EXCEPTION REPORT- Funding / arrangements not in place for Infant Feeding Strategic Lead**	
O, H	5.13	Review the adequacy and availability of perinatal and postnatal mental health support for women.	
O, H	5.14	Ensure effective and timely access to dedicated perinatal mental health service is available to all women who require it. *Powys Perinatal Mental Health Team is just establishing in Powys and pathways are still being developed. Women can access support currently, but the final pathways have not been finalised and so the process is not as streamlined currently as it will be as 2022 progresses.*	
H	5.15	Consider how water birth options can be made available across all units. - All 6 Birth Centres in Powys have established Waterbirth options - High homebirth rates where women may also hire Waterbirth pools	
H	5.16	Consider the implementation of champion midwives to support further innovation and research. **EXCEPTION REPORT- Awaiting Welsh Government funding for implementation of MatNeo SSP champions to support improvement Cymru innovations. Research Midwife funding until July 2023 (need a sustainable plan)**	

Exception Reporting Tool

Recommendation Number	
Area assessed as amber / red	
What is currently in place to meet this recommendation?	
How will we evidence that we are meeting this recommendation?	
How do we know that these are effective?	
What further action do we need to take?	
Who and by when?	
What resource or support do we need?	
How will we mitigate risk in the short-term?	

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1.4 Processes are in place for data collection and accuracy checking, clinical validation and monitoring of clinical practice and outcomes. Clinical change where required must be embedded

AMBER

Maternity Data currently captured through multiple sources WPAS and IFOR, CHKS and all Wales Child Health. Public Health Indicators reported through Office for National Statistics which poses challenges to obtain accurate data for the Powys population caseload. Data reported and reviewed

Timely accurate data that is reflective of the Powys population

Monthly , Quarterly and Annual data that will enable monitoring of clinical practice and maternity outc

Implementation of Digital Maternity Cymru will improve the assurance around data collection, accura

Awaiting Welsh Government funding / approval by Maternity Ditigal Cymru - expected September 202

Welsh Government funding for all Wales Maternity ICT systems and Digital Midwife to support implem

Short term funding agreed for Digial Maternity Midwife to support current workstreams. Data being co

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1.11 Health Boards should appoint a dedicated Lead Midwife and Lead Obstetrician for fetal surveillance who will run regular fetal surveillance meetings, cascade training and lead on the review

RED

Powys does not have a lead midwife for fetal surveillance. The clinical supervisor for midwives and consultant midwife are linked in with the All Wales fetal monitoring group. We do not hold regular fetal surveillance meetings currently.The consultant midwife is part of a working group looking at All Wales intrapartum fetal surveillance standards and to ensure there is adequate clarification around the standardisation and requirement for training in IA.All midwives complete the Oxford IIA e-learning package currently. This year's cycle of midwifery updates includes a 1-hour session on fetal

Appointment of Practice Educator Facilitator / Practice Development Midwife will ensure a dedicated f

Sustainability of the Fetal Surveillance standards in regards to regular meetings, cascade training and

Review PEF and PDM funding to develop JD, roles and responsibilities

Head of Midwifery and Head of Clinical Education - by end of July 2022

HEIW funding and existing PDM funding

Clinical Supervisor of Midwives and Consultant Midwife will overview the Fetal surveliance standards

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1.16 Health Boards must work collaboratively to ensure that local investigations into National Reportable Incidents (NRIs) are reported as per Welsh Government Framework. All significant

AMBER

Local investigations will be completed for all NRI's in line with Welsh Government framework. Lessons learnt are drawn up in relevant action plans and monitored through monthly Maternity

Significant learning from all Wales cases are shared for local learning

Evidence of significant learning is shared across an all Wales learning forum and key learning points a

Agreed to highlight the benefit for significant learning across Wales at 7th July Safety workshop

W&C Governance lead to raise via all Wales Maternity and Neonatal network task and finish group

Process to be considered through all Wales Maternity and Neonatal network task and finish group for

To link with DGH Governance meetings for shared learning

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1.24 Regional integration of maternal mental health services should be considered

RED

To be consider as part of NHS Collaborative for all Wales Perinatal Health standards / provision. Powys Perinatal Mental Steering workplan working towards integrated Maternal Mental Health

Powys access to all Wales integrated Maternal Mental Health service

Powys Perinatal Mental Health team and pathways have access to Regional / all Wales Maternal Mer

To raise at July Safety workshop (highlight in WG response letter- Exception report)

NHS Collaborative for Perinatal Mental Health - 2022 -2023 programme of work

Required resources would need to be identfied by NHS Collaborative for Perinatal Mental Health

Locally Powys is building Perinatal Mental Health service which is linked to Tiertiary Mental Health se

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2.2 Service users (ideally through the MVP / MSLC) must be involved in the complaints process,
AMBER

Service users raising concerns are promptly contacted for engagement from the outset of a complaints process. Links with Quality and Safety team to ensure responses are caring and

Service user and MPVP involvement is evident through Maternity complaints process

Robust service user engagement for improving caring and transparent complaint process

Use of Civica system to ensure DGH experiences are also captured as part of service user inolvemer
W&C Governance Lead with Quality and Safety team to review service user involvement in complaint

Build on existing Powys MPVP frameworks

Links with Powys MPVP on reviewing service user consideration for complaints process

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2.7 A framework for Family Integrated Care should be implemented and its impact evidenced.

AMBER

There is scope to improve our facilities to provide an enhanced Family Integrated Care environment through the joint multi agency early years pathfinder project

Family Integrated Care is in it's infancy through the early years agenda

Implementation of Multi agency Pathfinder project

Need to highlight at 7th July Safety workshop, it is difficult to score against
W&C links with Start Well Pathfinder project

Start Well Children and Young People's partnership pathfinder project is ideally placed.

Need to use the terms of reference / scope of the pathfinder project to consider short term actions for

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2.8 Peer support networks should be developed for families when using and after discharge from the
AMBER

Informal and varied dependant of the Health Board / Cross Border neonatal services. Opportunity to c

Benchmark / actions against NICE Guideline NG25

Family feedback / engagement on value and outcomes from peer support networks

Key action as part of Mat Neo Safety Support programme to review / evaluate the peer support netwo

Neonatal champion for MatNeo Safety Support programme will lead on this service improvement (awa

To review family experience of using and after discharge from neonatal services as part of W&C Peop

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3.9 Clinical supervision and consultant oversight of practical procedures must be in place for all staff i

AMBER

0.4 wte Clinical Supervision provides Clinical supervision for Powys Midwives & Additional 0.4 wte Cli

All specialist roles current access peer support via relevant all Wales and local forums appropriate to

Bespoke Clinical Supervision is evident for specialist roles
Need to report that there are no consultants and no staff doctors. WOD working on the all wales framework and how this works in Powys for advanced practitioner roles – is the supervision robust for clinical supervision for specialist roles eg Maternity DAU Perinatal Mental Midwife, Research W&C Governance Lead with support of Clinical Supervisor for Midwives in line with PTHB Supervisio

WoD support to develop principles a peer review / clinical supervision for those working in specialist s

Agree a PTHB process for peer review and clinical supervision those working in specialist services. S

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3.10 Support training in clinical leadership. The Health Board must allow adequate time and support for clinical leadership to function. Newly appointed Band 7/8 midwives must be allocated a named

AMBER

2 x Powys Midwives attend RCM / WG Leadership programme on an annual basis for aspiring Band 6
Band 7's will be supported with PTHB Band 7 clinical development programme (June 2022)
Assistant Head of Midwifery and relevant Band 7's are completing PTHB Managers programme
Gwella leadership portal available
Midwives (2) completing MSc Clinical Leadership modules supported
Assistant Head of Midwifery to attend Academy Wales Leadership development
Clinical Supervisor for Midwives completed Coaching programme
Consultant Midwife has offered Coaching locally and to RCM / WG Leadership programme
PTHB Coaching session offered for clinical leadership

Empowered and enabled clinical leaders that are suppported with a structred Band 7 / 8 Clinical Leda

Band 7 leadership, effective decision and active participation for Midwifery Management, Leadership

Band 7 competency tool in development to include mentorship in their Band 7 role and Band 7 to be s

WoD support to Assistant Head of Midwifery to development Band 7clinical development programme

WoD support has been secured

Senior Midwifery Leadership support to developing Band 7 posts

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5.6 A strategy is in place to support a succession planning programme for the maternity workforce and develop future leaders and senior managers. This must include a gap analysis of all leadership

AMBER

All Wales Maternity Birthrate plus and MatNeo Safety Support programme has highlighted the suppor

links to 3.10

Empowered and enabled clinical leaders that are suppported with a structred Band 7 / 8 Clinical Leda

Strategy needs to be developed around the RCM Midwifery leadership manifesto for succession planning and rotational roles for wider Wales exposure. Offer for staff to have exposure to other WoD support to Assistant Head of Midwifery to development Band 7clinical development programme

WoD support has been secured

Succession Planning consideration for key Senior Midwifery roles - Potential for Director for Midwifery

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5.10 Consider the introduction of smoking cessation leads to strengthen their approach

AMBER

Programme of work for Smoking cessation as part of the Help me Quit, led by Powys Public Health team. Includes re-introduction of CO Monitoring, target support from Maternity DAU team, Healthy

Monitoing via the HMQ programme of referrals and uptake to Smoking cessation programme - regula

Long term sustainability in reduction of number of pregnant women smoking during and post pregnan

No current smoking cessation lead / Public Health Midwife or Consultant Midwife with public health pc

Priority as part of Public Health team

Public Health team have highlighted the fragility around the service- to be consider what is needed as

Ongoing work with Midwifery, Health Visiting and Powys Public Health teams with smoking cessation

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5.11 Consider working with Public Health Wales to further promote healthier living and lifestyles.

AMBER

Joint Public Health and PTHB Healthy Lifestyles project extended until March 2023

Joint Public Health working around Healthy Weights pathway, Active Lifestyles, Smoking Cessation a

Reducing Maternal and Child Obesity, reducing smoking cessation and increasing active lifestyles

Evaluation of the project to inform sustainability of Healthy Lifestyles Practitioner roles

Consultant Midwife leading with links to Head of Midiwfery and Head of Children's Public Health Nurs
Public Health team support to inform the evaluation. WoD support to inform First 1000 days support w

Evaluation will inform sustainability of the Healthy Lifestyles project

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5.12 Ensure the appropriate level of breastfeeding advice, guidance, and support is provided at all tim

AMBER

Midwives and Health Visiting practitioners provide breastfeeding advice and guidance. Postnatal supp

Evidence against the Powys Infant Feeding Action Plan in line with all Wales Breastfeeding 5 year ac

Increase in sustainable Breastfeeding rates at 10 days and 6 weeks

Review actions to support improvements for 10 day and 6 week breastfeeding rates

Powys Infant Feeding steering group to be resummed to progress Powys actions for all Wales Breast

Funding / arrangements not in place for Infant Feeding Strategic Lead as per all Wales Breastfeeding

All Powys Midwives and Health Visiting teams completing 2 day Baby Friendly Initiative training to ensure appropriate level of breastfeeding advice, guidance, and support is provided at all times.
ABA Infant Feeding Research study is being support for all Peer Infant Feeding groups in Powys to

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5.13 Review the adequacy and availability of perinatal and postnatal mental health support for women

AMBER

Powys Perinatal Mental Health Team is in the process of establishing in Powys and pathways are still being developed. Women can access support currently, but the final pathways have not been

Service provision in line with Perinatal Mental Health standards - awaiting outcome of May 2022 peer review for benchmark against standards

Women's experience of effective and timely access to dedicated perinatal mental health service, feedback available via feedback mechanisms in place

Strengthen the fragility of the resources with additional 0.4 wte Perinatal Mental Health Midwife and 0.8 wte (North and South 0.4 wte) Health Visiting

Perinatal Mental Health Steering Group and Mental Health transformational funding

as above

all Powys Midwives and Health Visitors to benefit from 2 day Perinatal Mental Health IHV trainining.

Increase access to Powys MIND Mums Matter groups and Perinatal Mental Silver Cloud

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5.14 Ensure effective and timely access to dedicated perinatal mental health service is available to all

AMBER

Powys Perinatal Mental Health Team is just establishing in Powys and pathways are still being developed. Women can access support currently, but the final pathways have not been finalised and

Service provision in line with Perinatal Mental Health standards - awaiting outcome of May 2022 peer review for benchmark against standards

Women's experience of effective and timely access to dedicated perinatal mental health service available through feedback mechanisms

Strengthen the fragility of resources with additional 0.4 wte Perinatal Mental Health Midwife and 0.8 wte (North and South 0.4 wte) Health Visitiing

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5.16 Consider the implementation of champion midwives to support further innovation and research.
AMBER
Research midwife 0.2 wte in place with short term funding until July 2023. Introductory session for Improvement Cymru to identify Maternity Improvement cymru projects

Build service capacity for further innovation and research for Maternity and Neonatal services

Evidence of service improvements and active research cross cutting across Maternity services in Pow

Sustainable funding and support for innovation and research
Consultant Midiwfe lead with PTHB Research and Innovation team
Awaiting Welsh Government funding for implementation of MatNeo SSP champions to support improvement Cymru innovations. Research Midwife funding until July 2023 (need a sustainable

Quatetrly review of Research Midwife workplan

Agenda item: 2.2

Patient Experience, Quality and Safety Committee	**Date of Meeting: 7 July 2022**
Subject :	2022-2023 Clinical Audit Programme
Approved and Presented by:	Kate Wright, Medical Director
Prepared by:	Howard Cooper, Safety and Quality Improvement Manager Amanda Edwards, Assistant Director Innovation & Improvement
Other Committees and meetings considered at:	

PURPOSE:

The purpose of this paper is to state the organisational ambitions for the for 2022-2023 clinical audit plan.

RECOMMENDATION(S):

The Patient Experience Quality and Safety Committee is asked to note and approve the content.

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

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

Strategic Objectives:	1. Focus on Wellbeing	✓
	2. Provide Early Help and Support	✓
	3. Tackle the Big Four	✓
	4. Enable Joined up Care	✓
	5. Develop Workforce Futures	✓
	6. Promote Innovative Environments	✓

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

	7. Put Digital First	✓
	8. Transforming in Partnership	✓
Health and Care Standards:	1. Staying Healthy	✓
	2. Safe Care	✓
	3. Effective Care	✓
	4. Dignified Care	✓
	5. Timely Care	✓
	6. Individual Care	✓
	7. Staff and Resources	✓
	8. Governance, Leadership & Accountability	✓

EXECUTIVE SUMMARY:

This paper presents the PTHB clinical audit programme for 2022-23 for information and approval.

This paper also reflects on the changing landscape of clinical audit and that the context in which clinical audit is carried out has evolved. There is now a greater understanding and appreciation of the relationship between clinical audit and other quality improvement activities.

This paper identifies how clinical audit will be used as an element of quality improvement to strengthen and make sustainable safety improvements to the care we provide.

BACKGROUND AND ASSESSMENT:

1. Clinical Audit 2022 / 23

Changing landscape

Although the principles of good quality clinical audit have remained unchanged, the context in which clinical audit is carried out has evolved. There is now a greater understanding and appreciation of the relationship between clinical audit and other quality improvement activities.

Clinical effectiveness is an umbrella term describing a range of activities that support clinicians/health care professionals to examine and improve the quality of care. Probably the best-known example is clinical audit, but effectiveness stretches beyond this to include the implementation of nationally agreed guidance as well as agreed standards/clinical performance indicators reflecting 'best practice' (where these exist and are relevant to our services). Its purpose is not only to provide assurance but also to suggest ways in which to improve.

Any future clinical audit plans must reflect the needs of the organisation, reflect themes and provide assurance that effective systems, processes and procedures in place to monitor and audit compliance against clinical standards to safeguard the quality and safety of services provided.

Clinical audit is a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change. Put more simply, clinical audit is all about measuring the quality of care and services against agreed standards and making improvements where necessary.

The recent Ockenden Independent review of maternity services at Shrewsbury and Telford Hospital NHS Trust 2022 identified that the conducting of clinical audits to monitor compliance with clinical guidelines is an integral part of ensuring a service is safe. The review team also identified the following concerns:

- A lack of multidisciplinary input into guideline management and audits
- A lack of a change in practice and monitoring of compliance in response to clinical incidents.

The Clinical Audit plan has been refreshed and strengthened as part of the continued development and local implementation of the National Quality and Safety Framework and the National Clinical Framework, both designed to put Quality at the heart of the NHS in Wales. Mechanisms are in place to incorporate the following into the plan; National Audit Programme, Learning from Serious Incidents (SIs) or complaints, new or changes to existing policy / practice and areas where it has been identified that service improvement is required. The results from audit projects also inform the management of risk within the Health Board.
The learning group brings together Clinical Audit, Quality Improvement, Mortality and Reviews, Learning from Datix, Concerns and complaints, and Patient Experience allowing triangulation and sharing of learning across the disciplines.
Audit topics to be included in the Clinical Audit Plan must be closely aligned with other key streams of governance and quality activity and are linked to clinical and organisational risk and priorities. This will include the learning from the reactive processes, patient safety, complaints, serious incidents, other forms of patient feedback and the analysis of these activities. There is an expectation from the outset that practice will be improved.

It is recognised that the organisational response to the pandemic has impacted on the capacity to deliver some clinical audits. Whilst this has been risk assessed, we now need to ensure that systems and a culture of improvement remain firmly embedded and that there is executive oversight to ensure that we are addressing the important quality improvement issues.

2. Clinical Audit Programme 2022-2023

A Clinical Audit Plan has been drafted for 2022/23 which incorporates the following:

- National Audit Programme elements as they apply to PTHB
- Learning from Serious Incidents (SIs) or concerns

- Other themes identified through the learning group
- New or changes to existing policy / practice and areas where service improvement or development is required.The prioritisation of new and repeat clinical audit projects (taking account of any recognised clinical risks)
- Repeat clinical audits required to confirm that practice has improved.
- A certain proportion of the clinical audit programme will also be accounted for by continuous audit of fundamentals.

In the Clinical Audit Programme for 2022-2023 the ambition of the Health Board will include the following:

Corporate To undertake all applicable audits in the National Audit and Outcome Review Programme.

Women and Children's Service To undertake audits in maternity services and women's health services aligned to patient safety learning identified in concerns/complaints.

Community Services Group to undertake audits based on the Fundamentals of Care and KPIs

Mental Health and Learning Disabilities Group to undertake an audit of care and treatment planning

Medical Directorate: Medicines management to undertake audits on the use of Patient Group Directions and processes around the use of controlled drugs

A copy of the current draft Clinical audit Plan 2022/23 can be found at **Appendix A**

A list of the Welsh National Clinical Audit Programme together with an indication of Powys participation can be found at **Appendix B**. In National Audits the questions that are asked are determined at a national level and cannot be changed or added to locally. These have been reviewed. Directorates will be ask to continue to review national audits related to their area of care to assess applicability and these will be agreed by the executive committee.

3. Reporting of Clinical Audit 2022 / 23

Progress against the Clinical Audit Plan will be reported within agreed timeframes to PEQ&S. This will highlight:

- Action to be taken as a result of audits undertaken
- How learning is shared and sustainable safety improvements made as a result
- Timeframes for action and plan for reaudit.

RECOMMENDATIONS:
That the Experience Quality and Safety Committee notes and agreed the content of this report.

Appendix A

Draft Clinical Audit Plan 2022/23

Medical Directorate Audits				
Medicines Management Team				
Driver	**Audit Title**	**Start Date**	**Lead**	**End Date**
Tier 2 Service Improvement	Audit of authorisation process for staff to use Patient Group Directions (Brought forward from 21/22).	Quarter 3 2022	Medicines Management Staff	Quarter 4 2022
Tier 2 Service Improvement	Record keeping and correct use of Patient Group Directions across the Health Board (Brought forward from 21/22).	Quarter 3 2022	Medicines Management Staff	Quarter 4 2022
Tier 2 – Identified risk	Controlled Drugs Register Audit. (Brought forward from 21/22).	Quarter 3 2022	Medicines Management Staff	Quarter 4 2022
Safety and Quality Improvement				
Driver	**Audit Title**	**Start Date**	**Lead**	**End Date**
Tier 1 - Other National Audits	All Wales audit of completion of DNACPR forms	Quarter 3 2022	Safety & Quality Improvement Manager	Quarter 4 2022
Community Services Group Audits				
Dentistry				
Driver	**Audit Title**	**Start Date**	**Lead**	**End Date**
Tier 2 - Service Improvement	Retrospective audit of e-referral form completeness for Oral Surgery services in north Powys Oct during March 2020 - June 2022	Quarter 3 2022	Dental Staff	Quarter 4 2022

Tier 2 -Changes to Policy and Practice	Audit of staff acceptance of pre- and post-clinic briefings introduced in the Community Dental Service in Powys	Quarter 3 2022	Dental Staff	Quarter 4 2022
Tier 2 - Service Improvement	Audit of subjective image quality ratings of dental radiographs in the Community Dental Service	Quarter 3 2022	Dental Staff	Quarter 4 2022
Tier 2- Audit for accreditation scheme	WHTM01-05 (equipment decontamination) audit	Quarter 3 2022	Dental Staff	Quarter 4 2022
Tier 2 - Service Improvement	Audit of E-referral form completeness for Oral Surgery services in north Powys	Quarter 3 2022	Dental Staff	Quarter 4 2022
Tier 2 - Service Improvement	Audit of Clinical Record Keeping	Quarter 3 2022	Dental Staff	Quarter 4 2022
Tier 2 - Service Improvement	Audit of IPC& Decontamination and Hand Hygiene Protocol	Quarter 3 2022	Dental Staff	Quarter 4 2022
Primary Care				
Driver	**Audit Title**	**Start Date**	**Lead**	**End Date**
Tier 2 Service Improvement	Near Patient Testing of intrinsically high-risk drugs	Quarter 3 2022	GP Surgery Staff	Quarter 4 2022
Tier 2 Service Improvement	Audit of care provided to patients with diabetes	Quarter 3 2022	GP Surgery Staff	Quarter 4 2022
Tier 2 Service Improvement	Audit of the use of Novel Oral Anti-Coagulants	Quarter 3 2022	GP Surgery Staff	Quarter 4 2022
Tier 1- National Audit Programme	National Diabetes Core Audit	On Demand	Data automatically extracted from Practice database by National Audit team.	On Demand
Therapies and Health Sciences				
Driver	**Audit Title**	**Start Date**	**Lead**	**End Date**

Tier 2-Service Improvement	Clinical Record Audit (re-audit of 2020 audit) (Brought forward from 21/22).	Quarter 1 2022	Occupational Therapy staff	Quarter 2 2022
Tier 2-Service Improvement	Clinical Record Audit (re-audit of 2020 audit) (Brought forward from 21/22).	Quarter 2 2022	Physiotherapy staff	Quarter 3 2022
Tier 2-Service Improvement	Clinical Record Audit (Brought forward from 21/22).	Quarter 2 2022	Speech and Language staff	Quarter 3 2022
Tier 2 – Identified risk	Waiting times/compliance with targets (Brought forward from 21/22).	Quarter 2 2022	Audiology staff	Quarter 3 2022
Tier 2-Service Improvement	Spasticity against National Standards (Brought forward from 21/22).	Quarter 2 2022	Physiotherapy staff	Quarter 3 2022
Tier 2- Audit for accreditation scheme	Compliance with Standard operating procedures	Quarter 1 2022	Head of Radiography	Quarter 3 2022
Tier 2- Audit for accreditation scheme	Pregnancy Status	Quarter 1 2022	Head of Radiography	Quarter 3 2022
Tier 2- Audit for accreditation scheme	Correct use of radiographic markers	Quarter 1 2022	Head of Radiography	Quarter 3 2022
Tier 2- Audit for accreditation scheme	Non Medical Referrals (NMR) Audit of NMR compliance	Quarter 1 2022	Head of Radiography	Quarter 3 2022
Tier 2- Audit for accreditation scheme	Reject analysis	Quarter 1 2022	Head of Radiography	Quarter 3 2022
Tier 2- Audit for accreditation scheme	Radiographer commenting audit	Quarter 1 2022	Head of Radiography	Quarter 3 2022
Tier 2- Audit for accreditation scheme	QA plain film and NOUS / Midwife Sonography	Quarter 1 2022	Head of Radiography	Quarter 3 2022
Tier 2- Service Improvement	QA reporting Audit	Quarter 1 2022	Head of Radiography	Quarter 3 2022

Tier 1- National Audit Programme	National Quality Standards Adult Audiology	Quarter 2 2022	Head of Audiology	Quarter 4 2022
Tier 2- Service Improvement	Inappropriate Referrals audit	Quarter 2 2022	Head of Audiology	Quarter 4 2022
Tier 2- Service Improvement	Clinical Record Audit	Quarter 2 2022	Team Leader, Dietetics	Quarter 3 2022
Tier 2- Service Improvement	Clinical Record Audit	Quarter 4 2022	Head of Occupational Therapy	Quarter 1 2023
Tier 2- Service Improvement	Clinical Record Audit	Quarter 4 2022	Head of Podiatry	Quarter 1 2023
Tier 1- National Audit Programme	National Diabetes Foot Care Audit	Quarter 1 2022	Head of Podiatry	Quarter 4 2022
Tier 1- National Audit Programme	National Stroke Audit (SNAPP)	Quarter 1 2022	Consultant Therapist	Quarter 4 2022
Tier 1- National Audit Programme	National Stroke Audit (SNAPP) – Community	Quarter 1 2022	Consultant Therapist	Quarter 4 2022
Tier 2- Service Improvement	Audit of CMATS Osteo arthritis Knee care based on NICE guidance	Quarter 1 2022	Head of Physiotherapy	Quarter 2 2022
Tier 1 - Other National Audits	Parkinson's Care	TBC Nationally	Head of Speech and Language Therapy	TBC Nationally
Tier 2- Service Improvement	Taxonomy Compliance Audit	Quarter 3 2022	Head of Podiatry	Quarter 4 2022
Tier 2- Service Improvement	Paediatric Dietetic Service	Quarter 3 2022	Head of Dietetics	Quarter 4 2022
Tier 2- Service Improvement	Diabetes Prevention - Primary Care	Quarter 4 2022	Head of Dietetics	Quarter 1 2023
Tier 2- Service Improvement	Was Not Brought Compliance Audit	Quarter 1 2022	All Therapies and Health Science Services	Quarter 4 2023
Tier 2- Service Improvement	Caseload Audit	Quarter 2	Therapy Services	Quarter 4

		2022		2023
Tier 2- Service Improvement	Caseload Audit	Quarter 3 2022	Health Science Services	Quarter 4 2023
Tier 2- Service Improvement	Clinical Supervision Compliance Audit	Quarter 3 2022	All Therapies and Health Science Services	Quarter 4 2023
Tier 2- Service Improvement	Nutrition Skills for Life - Performance Targets Audit	Quarter 4 2022	Head of Dietetics	Quarter 1 2023
Tier 2- Service Improvement	Diabetes Prevention Primary Care Service Audit	Quarter 4 2022	Head of Dietetics	Quarter 1 2023
Tier 2- Service Improvement	7 Day Working Service Audit	Quarter 3 2022	Senior Therapist – Rehabilitation and Recovery	Quarter 4 2023
Tier 2- Service Improvement	Sonography Service Audit	Quarter 4 2022	Clinical Governance Lead for Sonography	Quarter 1 2023
Tier 2- Service Improvement	Reporting Radiography Service Audit	Quarter 4 2022	Head of Radiography	Quarter 1 2023
Tier 2- Service Improvement	Wax Management Service Audit	Quarter 4 2022	Head of Audiology	Quarter 1 2023
Tier 2- Service Improvement	First Contact Practitioner Physiotherapy Mid Powys Service Audit	Quarter 4 2022	Consultant MSK Physiotherapist	Quarter 1 2023
Tier 2- Service Improvement	Compliance with Community Therapy Standard Operating Procedure	Quarter 4 2022	Senior Therapist – Rehabilitation and Recovery	Quarter 1 2023
Tier 2- Service Improvement	Compliance with Home First Standard Operating Procedure	Quarter 2 2022	Senior Therapist – Rehabilitation and Recovery	Quarter 3 2022
Unscheduled Care				
Driver	**Audit Title**	**Start Date**	**Lead**	**End Date**
Tier 2-Service Improvement	Missed Fractures Audit	Quarterly	Senior Nurse Unscheduled Care	Quarter 4 2022
Tier 2-Service Improvement	Mattress audit	Quarterly	Senior Nurse Unscheduled Care	Quarter 4 2022
Tier 2-Service Improvement	Hand Hygiene Audit	Quarterly	Senior Nurse Unscheduled Care	Quarter 4 2022

Tier 2-Service Improvement	Primary Care Attenders	Bi Yearly 2021	Senior Nurse Unscheduled Care	Quarter 4 2022
Tier 2-Service Improvement	Paramedic/downgrade ambulance audit	Bi yearly 2021	Senior Nurse Unscheduled Care	Quarter 4 2022
Tier 2-Service Improvement	PGD Audit	Monthly	Senior Nurse Unscheduled Care	Quarter 4 2022
Tier 2-Service Improvement	Paeds under five audit – scrutiny of every attender under five	Bi yearly 2021	Senior Nurse Unscheduled Care	Quarter 4 2022
Nursing (Ward and Community)				
Driver	**Audit Title**	**Start Date**	**Lead**	**End Date**
Tier 2-Service Improvement	Fundamentals of care	Monthly	Senior Nurses	Quarter 4 2022
Tier 2-Service Improvement	Pressure Damage Audit	Quarter 4 2022	Senior Nurses	Quarter 4 2022
Tier 2-Service Improvement	In-Patient Falls Audit	Quarter 4 2022	Senior Nurses	Quarter 4 2022
Tier 2-Service Improvement	Hydration and Nutrition Audit	Quarter 4 2022	Senior Nurses	Quarter 4 2022
Tier 2-Service Improvement	Catheter Care Audit	Quarter 4 2022	Senior Nurses	Quarter 4 2022
Tier 1- National Audit Programme	National Cardiac Rehabilitation Audit	TBC Nationally	Rehabilitation Nursing Staff	TBC Nationally
Tier 1- National Audit Programme	National Pulmonary Rehabilitation Audit	TBC Nationally	Rehabilitation Nursing Staff	TBC Nationally
Surgery and Endoscopy				
Driver	**Audit Title**	**Start Date**	**Lead**	**End Date**
Tier 2-Service Improvement	Five Steps to Safer Surgery	Quarter 1 2022	Surgery and Endoscopy Team	Quarter 2 2022

Tier 2-Service Improvement	Managing Perioperative Normothermia	Quarter 1 2022	Surgery and Endoscopy Team	Quarter 2 2022
Tier 2-Service Improvement	Decontamination	Quarter 1 2022	Surgery and Endoscopy Team	Quarter 2 2022
Tier 2-Service Improvement	Specimen Management	Quarter 1 2022	Surgery and Endoscopy Team	Quarter 2 2022
Tier 2-Service Improvement	Tourniquets	Quarter 1 2022	Surgery and Endoscopy Team	Quarter 2 2022
Tier 2-Service Improvement	Use and Handling of Surgical Instruments	Quarter 1 2022	Surgery and Endoscopy Team	Quarter 2 2022
Tier 2-Service Improvement	Preoperative care for Patients with Dementia	Quarter 2 2022	Surgery and Endoscopy Team	Quarter 3 2022
Tier 2-Service Improvement	Anaesthesia	Quarter 2 2022	Surgery and Endoscopy Team	Quarter 3 2022
Tier 2-Service Improvement	Surgical record keeping audit & consent	Quarter 2 2022	Surgery and Endoscopy Team	Quarter 3 2022
Tier 2-Service Improvement	Post anaesthetic Care	Quarter 2 2022	Surgery and Endoscopy Team	Quarter 3 2022
Tier 2-Service Improvement	Surgical Patient Satisfaction audit	Quarter 2 2022	Surgery and Endoscopy Team	Quarter 3 2022
Tier 2-Service Improvement	Electrosurgery	Quarter 2 2022	Surgery and Endoscopy Team	Quarter 3 2022
Tier 2-Service Improvement	Fluid Management	Quarter 3 2022	Surgery and Endoscopy Team	Quarter 4 2022
Tier 2-Service Improvement	Foreign body aspiration during intubation, advanced airway management or ventilation	Quarter 3 2022	Surgery and Endoscopy Team	Quarter 4 2022
Tier 2-Service Improvement	Pre assessment and Specific Day Case Requirements	Quarter 3 2022	Surgery and Endoscopy Team	Quarter 4 2022
Tier 2-Service Improvement	Audit of prosthesis verification data	Quarter 3 2022	Surgery and Endoscopy Team	Quarter 4 2022

Tier 2-Service Improvement	Intraoperative Care	Quarter 4 2022	Surgery and Endoscopy Team	Quarter 1 2023
Tier 2-Service Improvement	Accountable Items, Swab, Instrument and Sharps Count	Quarter 4 2022	Surgery and Endoscopy Team	Quarter 1 2023

Women's and Children's Service

Maternity Services

Driver	Audit Title	Start Date	Lead	End Date
Tier 1 - National Audit Programme	National Maternity and Perinatal Audit	April 2022	Head of Midwifery & Sexual Health Services & W&C Governance Lead	Quarter 2 2022
Tier 2-Service Improvement	Audit of Compliance with Pool Evacuation Policy	April 2022	Clinical Supervisor of Midwives	Quarter 2 2022
Tier 1 - UNICEF BFI	BFI Infant feeding audits	TBC	Infant Feeding Coordinator	TBC
Tier 1 - Other National Audits	SGA Audit Compliance with GAP/GROW fetal surveillance programme at detecting SGA babies (Brought forward from 21/22).	April 2022	Head of Midwifery & Sexual Health Services	Quarter3 2022
Tier 2-Service Improvement	WAST Transfer Audit - Implementation of new transfer flow chart. (Brought forward from 21/22).	Quarter3 2022	Shelly Higgins Consultant Midwife / Kate Evans	Quarter3 2022
Tier 2-Service Improvement	Clinical Supervision Policy (Brought forward from 21/22).	Autumn 2022	TBC	Quarter3 2022
Tier 2-Service Improvement	Infection Control Audits (Environmental, Hand Hygiene) (Brought forward from 21/22).	Quarter3 2022	W&C Risk and Governance Lead	Quarter3 2022
Tier 2-Service Improvement	Annual Record Keeping Audit of Clinical Records	April 2022	All service leads	Quarter3 2022

Tier 2-Service Improvement	Audit of Access to DAU Service And Care Against DAU Guideline	April 2022	Assistant Head of Midwifery & Sexual Health Services	Quarter3 2022
Tier 2-Service Improvement	Midwifery Sonography Audit to validate findings of local scans	Quarter3 2022	Consultant Midwife	Quarter 4 2022
Tier 2-Service Improvement	Antenatal and intrapartum transfer audits	Quarter3 2022	Consultant Midwife	Quarter 4 2022
Community Paediatrics				
Tier 3- Audit suggested by FOI request	Recording of Antenatal Alcohol Exposure on Adoption Medical Reports. (Brought forward from 21/22).	TBC	Consultant Community Paediatrician	TBC
Tier 2 -Changes to Policy and Practice	Melatonin Use Re-Audit (Brought forward from 21/22).	Quarter 1 2022	Consultant Community Paediatricians	Quarter 1 2022
Tier 1 - National Audit Programme	National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)	TBC	Consultant Community Paediatricians	Quarter 3 2022
Tier 1 - Child Protection Quality Standards (UK)	Child Protection Medicals in Powys (Trends over last 3 years) (Brought forward from 21/22).	Quarter 1 2022	Consultant Community Paediatricians	Quarter 1 2022
Tier 2 – Identified risk	Audit of Was not Brought Policy	Quarter 2 2022	MDT	Quarter 3 2022
Women & Children's Paediatric, Transition & LD Therapies				

Service Evaluation	**Care Aims** – identification of stage of intervention	Jan 2022	HOS Paediatric, Transition & LD OT & Physio	Quarter 3 2022
Local Audits following change to policy or procedure	**Liberty Protection Safeguards**	Jan 2022	HOS Paediatric, Transition & LD OT & Physio	Quarter 3 2022
Local Audits following change to policy or procedure	**ALN health referrals**	Jan 2022	Senior administrator ALN .	Quarter 3
Local Audits in response to a Serious Incident/Identified Risk	**Respiratory** Paediatric Respiratory Risk Matrix	Quarter 4	Clinical specialist Paediatric Physiotherapist; Clinical lead role respiratory	Quarter 4.
Service Evaluation	**Casting interventions**: Lower limb; upper limb; CIMT.	April 2022	Clinical Specialist Paediatric Physiotherapy.	Quarter 1.
Local Audits in response to a Serious Incident/Identified Risk	**Healthy weights:** Participation groups	Jan 2022	Physiotherapy Technician-clinical lead role Physical Activity.	Quarter 4
Service Evaluation	**Wheelchair provision**:	Jan 2022	Clinical Specialist Occupational Therapist.	Quarter 4.
Local Audits in response to a Serious Incident/Identified Risk	**Bone health** – identification of risk.	Quarter 1	HOS Paediatric, Transition & LD OT & Physio & community paediatrics	Quarter 4.
Local Audits in response to a Serious Incident/Identified Risk	**Was Not Brought** Paediatrics & TLD OT	Quarter 1.	HOS Paediatric, Transition & LD OT & Physio & Safeguarding	Quarter 1.
Local Audits in response to a Serious Incident/Identified Risk	**Was Not Brought** Paediatrics & TLD PHYSIO	Quarter 1.	HOS Paediatric, Transition & LD OT & Physio & Safeguarding	Quarter 1.
Service Evaluation	**Clinical Record Keeping OT**	Quarter 4	HOS Paediatric, Transition & LD OT & Physio& Professional Head OT	Quarter 4

Service Evaluation	Clinical Record Keeping PHYSIO	Quarter 4	HOS Paediatric, Transition & LD OT & Physio & Professional head of Physio	Quarter 4
Tier 1 - National Audit Programme	Audit of Quality Standards for Paediatric Audiology	Quarter 2 2022	Professional/Medical Lead for Paediatric Audiology	Quarter 2 2022
Tier 2 -Changes to Policy and Practice	Using TOMS to measure virtual therapy practices (Brought forward from 21/22).	Quarter 3 2022	Head of Children's Speech and Language Therapy/Team Leader North	Quarter 3 2022
Tier 2-Service Improvement	NICE Guidance – Neurodevelopment Service (Brought forward from 21/22).	Quarter 3 2022	ND service	Quarter 3 2022
Children's Nursing/Health Visiting				
Tier 1 - Other National Audits	Health Care Standards Audit (Brought forward from 21/22).	April 2022	Health Visiting	Quarter 3 2022
Tier 1 - Other National Audits	SN Framework and Special School Nursing Framework (Brought forward from 21/22).	April 2022	School Nursing	Quarter 3 2022
Mental Health and Learning Disabilities				
Driver	**Audit Title**	**Start Date**	**Lead**	**End Date**
Tier 2 – Identified risk	Audit of assessments conducted using the Wales Applied Risk Research Network (WARRN) tool. Audit on updating assessments to be added	Quarter 1 2022	Mental Health Staff	Quarter 2 2022
Tier 2-Service Improvement	Audit of Admission Documentation	Quarter 3 2022	Mental Health Staff	Quarter 4 2022

Tier 2-Service Improvement	Audit of Care and Treatment Plan Documentation	Quarter 3 2022	Mental Health Staff	Quarter 4 2022
Tier 2 – service improvement	Audit of MDT working	Quarter 3 2022	Mental Health Staff	Quarter 4 2022
Corporate Nursing Team				
Safeguarding				
Driver	**Audit Title**	**Start Date**	**Lead**	**End Date**
Tier 2-Service Improvement	Safeguarding Maturity Matrix	September 2022	Assistant Director Safeguarding	Quarter 4 2022
Tier 2-Service Improvement	Audit of child exploitation safeguarding procedures	Quarter 4 2022	Assistant Director Safeguarding	Quarter 4 2022
Tier 2-Service Improvement	Audit in the Recording of Safeguarding Advice	Quarter 4 2022	Assistant Director Safeguarding	Quarter 4 2022

Audit Driver Key:

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

	Service Evaluation
	Other

Progress Key:

	Progress
	Complete
	On Track
	Indicates audit Rolled Forward from 2021/22 Programme
	Not undertaken due to lack of capacity
	Cancelled as being no longer required

Appendix B

Welsh National Clinical Audit and Outcome review Programme 2022/23

Audit Title	Powys Participation in 2022/23	Reason for non-participation

Trauma and Orthopaedics		
National Joint Registry	**No**	Powys does not offer orthopaedic surgery.
National Emergency Laparotomy Audit	**No**	Powys does not offer Emergency laparotomy procedures.
Case Mix Programme Audit	**No**	Powys does not offer intensive care facilities.
Major Trauma Audit Trauma Audit and Research Network. (TARN)	**No, but sends data to other Health Boards &s Trusts to support their audit submission.**	Powys does not offer emergency room facilities.
Long Term Conditions		
National Diabetes Foot Care Audit	**Yes**	**-**
National Diabetes Inpatient Safety Audit	**No**	The national audit currently excludes community hospitals from participation as the focus is on people with diabetes who are being treated for other conditions in acute care to ensure that their diabetes isn't neglected or compromised by other therapy.
National Pregnancy in Diabetes Audit	**No**	Powys does not offer care for pregnant people who have diabetes. Primary focus is on management of diabetes.
National Diabetes Core Audit	**Yes**	**-**
National Paediatric Diabetes Audit (NPDA)	**No**	Care for children with diabetes is provided by out of county providers.
COPD Secondary Care	**No**	The audit studies emergency admissions for exacerbation of COPD and focusses on the provision of CPAP and other non-invasive ventilation methods and on the provision of specialist respiratory physician care. Most community hospitals are therefore excluded from this audit.
Adult Asthma	**No**	The audit studies emergency admissions for asthma attacks and focusses on the rapid provision of steroid therapies and on the provision of specialist respiratory physician

		care. Most community hospitals are therefore excluded from this audit.
Paediatric Asthma Secondary Care	**No**	Care for children with asthma is provided by out of county providers.
Pulmonary Rehabilitation	**Yes**	**-**
Renal Registry Audit	**No**	Care for people needing dialysis is provided by out of county providers.
National Early Inflammatory Arthritis Audit	**No**	Care for people needing treatment is provided by out of county providers.
All Wales Audiology Audit	**Yes**	**-**
Older People		
Sentinel Stroke National Audit (SSNAP)	**Yes (Partial)**	Powys does not provide acute phase stroke care but does participate in the rehabilitation part of the audit.
National Audit of Inpatient Falls National Hip Fracture Database	**No**	We do not currently contribute to the audit on inpatient falls. This is more applicable to secondary care. A review will be undertaken to reassess the position for PTHB. Powys does not undertake hip fracture surgery or have 24/7 plastering facilities which are requirements of the audit.
Fracture Liaison Service Database	**No**	Powys does not have a Fracture Liaison Service.
National Audit of Dementia	**No**	Participation in the audit is by invitation only and currently excludes most community hospitals. The audit questions are publicly published however and could be used locally. The audit focuses on the assessment of pain and of delirium for patients with dementia.
Care at the End of Life		

National Audit of Care at the End of Life (NACEL)	**Yes**	**-**
Cardiac Audits		
National Heart Failure Audit	**No**	Powys does not provide in-patient cardiac care.
National Audit of Cardiac Rhythm Management	**No**	Powys does not surgically implant pacemakers or defibrillators.
National Adult Cardiac Surgery Audit	**No**	Powys does not undertake adult cardiac surgery.
National Audit of Percutaneous Coronary Interventions	**No**	Powys does not undertake stenting procedures.
National Congenital Heart Disease Audit	**No**	Powys does not undertake paediatric cardiac surgery.
Myocardial Ischaemia National Audit Project	**No**	Powys does not provide immediate care for heart attack sufferers.
National Audit of Cardiac Rehabilitation	**Yes**	**-**
National Vascular Registry Audit	**No**	Powys does not undertake vascular surgery.
Cancer Audits		
National Lung Cancer Audit	**No**	Powys does not undertake surgery, chemotherapy or radiotherapy for cancer.
National Prostate Cancer Audit	**No**	Powys does not undertake surgery, chemotherapy or radiotherapy for cancer.
National Bowel Cancer Audit	**No**	Powys does not undertake surgery, chemotherapy or radiotherapy for cancer.
National Oesophago-gastic Cancer Audit	**No**	Powys does not undertake surgery, chemotherapy or radiotherapy for cancer.
National Audit of Breast Cancer in Older People (NABCOP)	**No**	Powys does not undertake surgery, chemotherapy or radiotherapy for cancer.

Women and Childrens Health		
Paediatric Intensive Care Audit (PICaNet)	**No**	Powys does not provide paediatric intensive care.
National Neonatal Audit Programme Audit	**No**	Powys does not provide neonatal intensive care.
National Maternity and Perinatal Audit	**Yes**	**-**
National Perinatal Mortality Review Tool	**Yes**	**-**
Other Conditions		
National Clinical Audit of Seizures and Epilepsies for Children and Young People	**Yes (Partial)**	Powys participates in the parts of the audit for which there are local services.
National Clinical Audit of Psychosis	**No**	This is a 5 year programme auditing different areas of practice each year. This is the last year of the current round. Powys participation will be explored for the next round.

Agenda item: 2.3

Patient Experience, Quality and Safety Committee	**Date of Meeting: 7 July 2022**
Subject :	2021 – 2022 Clinical Audit Programme Final Report
Approved and Presented by:	Kate Wright, Medical Director
Prepared by:	Howard Cooper, Safety and Quality Improvement Manager Amanda Edwards, Assistant Director Innovation & Improvement
Other Committees and meetings considered at:	

PURPOSE:

The purpose of this paper is to provide a final overview of the 2021-2022 Clinical Audit Programme

RECOMMENDATION(S):

The Patient Experience Quality and Safety Committee is asked to note and approve the content.

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

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

Strategic Objectives:	1. Focus on Wellbeing	✓
	2. Provide Early Help and Support	✓
	3. Tackle the Big Four	✓
	4. Enable Joined up Care	✓
	5. Develop Workforce Futures	✓
	6. Promote Innovative Environments	✓

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

	7. Put Digital First	✓
	8. Transforming in Partnership	✓
Health and Care Standards:	1. Staying Healthy	✓
	2. Safe Care	✓
	3. Effective Care	✓
	4. Dignified Care	✓
	5. Timely Care	✓
	6. Individual Care	✓
	7. Staff and Resources	✓
	8. Governance, Leadership & Accountability	✓

EXECUTIVE SUMMARY:

This paper presents a final overview of the PTHB clinical audit programme for 2021-2022.

The plan for clinical audit is tiered in nature, ranging from collating clinical audits undertaken by professionals as part of professional revalidation requirements, identifying team-based audits at a local level and any audits undertaken in relation to issues related to organisational risk.

BACKGROUND AND ASSESSMENT:

Report of the PTHB clinical audit programme for 2021-2022

Clinical Audits are classified into three tiers.

Tier 1 are the National Clinical Audit and Outcome Review programme as mandated by Welsh Government or other audits conducted at the national scale. Powys Health Board, as a provider of care at a largely non-specialist level, only qualifies for six of the nearly 40 National Programme Audits. However, Powys Health Board regularly participates in all audits for which they qualify and this was again the case in 2021/22.

Summaries of important national clinical audits produced for the Learning from Experience Group are shared with the PTHB commissioning team. The contracts that we have with the commissioned services state that they should participate in the National clinical audit and patient outcomes programme (NCAPOP) audits. Compliance is not really an issue as for English providers participation in NCAPOP is directly linked to their funding arrangements. Welsh provider participation is now also good following Welsh Government funding of the programme.

Tier 2 will be Organisational Audits selected by the clinical audit leads within the provider services and are designed to support the organisational ambitions of the Health Board to provide safe, effective and timely care.

Tier 3 will be Individual Audits which are performed by members of staff wishing to undertake a local quality improvement project using clinical audit methodology.

1.Summary of total clinical audit activity in PTHB during 2021/22

The clinical audit plan for 2021 /22 was approved in May 2021. A copy of this plan can be found at **Appendix A**.

It is recognised that progress during this reporting period has been affected by the COVID 19 Pandemic. Staff have been asked to make extra-ordinary efforts throughout the past two years and have stepped up and shown their value, flexibility and resilience in the face of unprecedented challenges. Our staff have adapted, transformed and delivered essential services during the most demanding and difficult time of their careers.

It is important to note however, that capacity to deliver clinical audit in some service areas was challenging even before the pandemic.

Any issues identified that prevent the timely completion of a clinical audit expected within the Clinical Audit Plan are escalated by the service area. Where possible support and advice is offered to facilitate delivery. Where this is not possible, the implications of not undertaking the audit are risk assessed to determine when and how this audit should be undertaken.

The Clinical Audit Plan 2021 / 22 comprised the following types of audits:

	Women & Children's Service Group	Community Service Group	Mental Health & LD Service Group
National Audit Programme	2	5	0
Non-Programme National Initiatives	5	0	0
Local Service Improvement Initiatives	14	30	1
Audits required for Accreditation of Services	0	10	0
Response to Incident of identified Risk	3	3	0
Evaluation of introduction of new policy or process	3	11	0
Evaluation of a new service	3	0	0

End of Year summary for audit activity

COMPLETED AUDITS	ONGOING AT YEAR END	POSTPONED TO 22/23	DID NOT PROCEED
53	**9**	**21**	**10**

It is important to note that the numbers of clinical audits undertaken in some service areas is not representative of the amount of quality improvement activity undertaken. This will be demonstrated and presented in future papers e.g., Harm.

1.1. Community Service Group audit activity

The clinical audit plan for the Community Service Group for 2021/22 comprised the following:

	Community Service Group
National Audit Programme	5
Non-Programme National Initiatives	0
Local Service Improvement Initiatives	30
Audits required for Accreditation of Services	10
Response to Incident of identified Risk	3
Evaluation of introduction of new policy or process	11
Evaluation of a new service	0

End of Year summary for Community Services Group audit activity

COMPLETED AUDITS	ONGOING AT YEAR END	POSTPONED TO 22/23	DID NOT PROCEED
36	**8**	**7**	**5**

Five audits did not proceed and were dropped from the audit programme during the year either because they were stood down by Welsh Government or that it was felt that the objectives would be better achieved by taking a non-audit approach to the issue. The impact of Covid 19 epidemic meant that 7 planned audits could not be commenced and these will be taken forward to the 2022/23 audit programme.

There are a couple of National Audits that have been postponed twice due to the covid epidemic but that was a national (UK) decision not a local one, The National Epilepsy audit, the National Cardiac Rehabilitation audit, and the National Diabetic Podiatry. The National Cardiac Rehabilitation audit, and the National Diabetic Podiatry audit are all due to be undertaken in 2022/23. We believe that there has been a change of focus for the Epilepsy audit onto the more specialist care that we don't provide in-county. It will remove the need to us to take part.

Highlight report on audit activity

Staff from the out-patient eye clinic reported the findings of their audit which showed that the new to Powys service of providing intravitreal Anti-VEGF treatment for patients with wet age-related macular degeneration was highly effective in slowing down the progress of this degenerative condition with 56% of patients showing an improvement in vision between appointments.

The Minor Injury Unit team presented data showing the effect of the introduction of their telephone triage service introduced as a response to the Covid pandemic to allow the service to continue but in a socially distanced manner.
The data showed that the number of patients being seen face to face had fallen to 43% (Site 1) and 55% (Site 2) of the equivalent pre-pandemic activity. A total of 3611 patients were redirected from MIU to A&E, GP care, high street pharmacists or self-care in the period April to September 2020.

Work is required to understand what the impact has been on the outcomes for those patients redirected and how does that compare to pre pandemic outcomes.

1.2 Women and Children's Service audit activity

The clinical audit plan for the Women & Children's Service for 2021/22 comprised the following:

	Women & Children's Service Group
National Audit Programme	2
Non-Programme National Initiatives	5
Local Service Improvement Initiatives	14
Audits required for Accreditation of Services	0
Response to Incident of identified Risk	3
Evaluation of introduction of new policy or process	3
Evaluation of a new service	3

Five audits did not proceed and were dropped from the audit programme during the year when it was felt that the objectives would be better achieved by taking a non-audit approach to the problem. The impact of covid 19 epidemic meant that 14 planned audits could not be commenced, and these will be taken forward to the 2022/23 audit programme.

The "Recording of Antenatal Alcohol Exposure on Adoption Medical Reports" audit that was to be undertaken within the Women and Children's Service Group. This has been delayed a couple of times due to lack of consultant paediatrician capacity and availability.

End of Year summary for Women & Children's Services Group audit activity

COMPLETED AUDITS	ONGOING AT YEAR END	POSTPONED TO 22/23	DID NOT PROCEED
11	0	14	5

Highlight report on audit activity

The sexual health team reported the results of their newly introduced Test and Post project. Since 2020, as part of the "Frisky Wales" service, this has allowed for citizens to have test kits for sexually transmitted infections discreetly sent to their homes. 1367 test kits were requested in the previous 12 months by Powys residents with 67 giving a positive indication of infection. Of the 112 cases sampled by the audit the patient was notified of their results within the 10-day standard timeframe in 86% of cases. As well as reporting on note keeping and the speed of testing, the audit noted that compared to the previous year the number of cases of chlamydia had fallen by 40% and those of gonorrhoea by 54%. This may be due to restrictions in social events during the pandemic.

The Paediatric Physiotherapy service presented an audit on whether premature babies are reliably referred to the therapeutic services within Powys as a default position or only if an obvious concern is identified by staff. The referral pathway is complicated by the fact that of the 70 premature births of Powys residents that occurred in 2020, 61 of them took place out of county. The audit identified the 70 cases through data held by the informatics team but found that only 17 of the children had been referred to therapeutic services. An improvement plan has been put in place to advise staff about the therapeutic services available in Powys and to directly identify potential clients through primary data sources.

1.3 Mental Health and Learning Disabilities Service audit activity

The clinical audit plan for the Mental Health and Learning Disabilities Service for 2021/22 comprised the following:

	Mental Health & LD Service Group
National Audit Programme	0
Non-Programme National Initiatives	0
Local Service Improvement Initiatives	1
Audits required for Accreditation of Services	0
Response to Incident of identified Risk	0

Evaluation of introduction of new policy or process	0
Evaluation of a new service	0

End of Year summary for Mental Health and Learning Disabilities Services Group audit activity

COMPLETED AUDITS	ONGOING AT YEAR END	POSTPONED TO 22/23	DID NOT PROCEED
1	**0**	**0**	**0**

Highlight report on audit activity

The Mental Health and learning Disabilities Service successfully completed an audit of 48 patient notes using the Welsh Applied Risk Research Network (WARRN) tool.

The WARRN tool assesses the risk of violence that a patient might pose to themselves or others.

Question Area	Response
The first section examines the "How" "Why" and "Who" of this risk	The audit found it was NOT completed for 10% of the patients.
The next section assessed the "Where" and "When" of how the risk might become an actual event.	The audit found it was NOT completed for 16% of the patients.
The tool asks whether the clinician recorded a clear and concise summary of their overall assessment of the risk situation.	The audit found it was NOT recorded for 25% of the patients.
Patients should be involved in the process of assessing this risk.	The audit found this to be the case in less than half (43%) of the 48 patients whose notes were audited.
Patients should have a review date set for the re-assessment of their risk.	The audit found that 13% had no review date set.

The service notes that plans are in place to set up a WARRN trainers development group to help address the issues found.

RECOMMENDATIONS:

That the Experience Quality and Safety Committee notes the content of this report.

Appendix A

Progress against Clinical Audit Plan 2021 / 22

Community Services Group Audits				
Community Nursing				
Driver	Audit Title	Start Date	Lead	End Date
Tier 1 - National Audit Programme	Pulmonary Rehabilitation	Ongoing national audit	CSM South	To be determined nationally
Tier 1 - National Audit Programme	Cardiac Rehabilitation Audit	Ongoing database	Head of Nursing	Ongoing data collection Next report date to be determined nationally
Tier 2 – Identified risk	Completion of Admission Assessment Documents (re-audit of 2021 audit)	Quarter 2 2021	Emma McGowan	COMPLETED Quarter 4 2021
Tier 2 – Identified risk	Patient Identification Audit	Rolling Monthly audit	Senior Nursing Staff	COMPLETED Rolling Monthly audit
Tier 2 – Identified risk	Completion of DNACPR audit	Rolling Monthly audit	Senior Nursing Staff	COMPLETED Rolling Monthly audit
Tier 2 – Identified risk	Completion of NEWS chart audit	Rolling Monthly audit	Senior Nursing Staff	COMPLETED Rolling

				Monthly audit
Tier 2 – Identified risk	Observation of Hand Hygiene Practice audit	Rolling Monthly audit	Senior Nursing Staff	**COMPLETED** Rolling Monthly audit
Tier 2 – Identified risk	Compliance with the use of Personal Protective Equipment (PPE) audit	Rolling Monthly audit	Senior Nursing Staff	**COMPLETED** Rolling Monthly audit
Out Patient services				
Driver	**Audit Title**	**Start Date**	**Lead**	**End Date**
Tier 2 Service Improvement	Intravitreal Anti-VEGF treatment for wet Age-related macular degeneration	Quarter 1 2021	Eye Clinic	**COMPLETED** Quarter 1 2021
Dentistry				
Driver	**Audit Title**	**Start Date**	**Lead**	**End Date**
Tier 2- Audit for accreditation scheme	WHTM01-05 (equipment decontamination) audit	Quarter 2 2021	Dental staff	**COMPLETED** Quarter 3 2021
Medicines Management Team				
Driver	**Audit Title**	**Start Date**	**Lead**	**End Date**
Tier 2 – Identified risk	Safe Storage of medicines audit	Quarter 3 2021	Medicines Management Staff	**COMPLETED** Quarter 4 2021

Tier 2 Service Improvement	Audit of authorisation process for staff to use Patient Group Directions	Quarter 3 2021	Medicines Management Staff	**Delayed to 2022/23** Quarter 4 2021
Tier 2 Service Improvement	Record keeping regarding the use of Patient Group Directions	Quarter 3 2021	Medicines Management Staff	**UNDERWAY** Quarter 4 2021
Tier 2 Service Improvement	Use of Patient Group Directions across the health Board	Quarter 3 2021	Medicines Management Staff	**Delayed to 2022/23** Quarter 4 2021
Tier 2 – Identified risk	Audit of the use of Standard Operating Procedures with regards to Controlled Drugs	Quarter 3 2021	Medicines Management Staff	**UNDERWAY** Quarter 4 2021
Tier 2 – Identified risk	Controlled Drugs Register Audit	Quarter 3 2021	Medicines Management Staff	**Delayed to 2022/23** Quarter 4 2021
Primary Care				
Driver	**Audit Title**	**Start Date**	**Lead**	**End Date**
Tier 2 Service Improvement	Audit of patients receiving anti-coagulation drugs	Quarter 1 2021	GP Practice staff	**COMPLETED** Quarter 3 2021
Tier 2 Service Improvement	Audit of services provided to patients with diabetes	Quarter 1 2021	GP Practice staff	**COMPLETED** Quarter 3 2021
Tier 2 Service Improvement	Audit of the management of inherently high-risk medications	Quarter 1 2021	GP Practice staff	**COMPLETED** Quarter 3 2021

Therapies and Health Sciences				
Driver	**Audit Title**	**Start Date**	**Lead**	**End Date**
Tier 1 - National Audit Programme	National Diabetes Foot Care Audit	To be determined nationally	Head of Podiatry	Stood down by Welsh Government
Tier 1 - National Audit Programme	All Wales Audiology Audit - 2021 Quality Standards for Children's Hearing Services	To be determined nationally	Head of Audiology	COMPLETED
Tier 1 - National Audit Programme	Stroke Audit (SSNAP)	Quarter 1 2021	Consultant Therapist	COMPLETED Quarter 3 2022
Tier 2-Service Improvement	Notes Audit (re-audit of 2020 audit)	Quarter 3 2021	Occupational Therapy staff	Delayed to 2022/23 Quarter 3 2021
Tier 2-Service Improvement	Notes Audit	Quarter 3 2021	Podiatry staff	COMPLETED Quarter 3 2021
Tier 2-Service Improvement	Notes Audit (re-audit of 2020 audit)	Quarter 3 2021	Physiotherapy staff	Delayed to 2022/23 Quarter 3 2021
Tier 2-Service Improvement	Notes Audit	Quarter 3 2021	Speech and Language staff	Delayed to 2022/23 Quarter 3 2021
Tier 2-Service Improvement	CMATS Osteo arthritis Knee Audit based on NICE guidance.	Quarter 3 2021	Physiotherapy staff	Data Collection

				complete Analysis underway Quarter 4 2021
Tier 2-Service Improvement	Taxonomy Audit	Quarter 3 2021	Podiatry staff	CANCELLED Quarter 4 2021
Tier 2- Audit for accreditation scheme	Non-medical referrers audit	Quarter 3 2021	Radiography staff	COMPLETED Quarter 3 2021
Tier 2- Audit for accreditation scheme	Compliance with Standard operating procedures	Quarter 3 2021	Radiography staff	COMPLETED Quarter 3 2021
Tier 2- Audit for accreditation scheme	Compliance with gonad protection standards	Quarter 3 2021	Radiography staff	COMPLETED Quarter 3 2021
Tier 2- Audit for accreditation scheme	Reject analysis	Quarter 3 2021	Radiography staff	COMPLETED Quarter 3 2021
Tier 2- Audit for accreditation scheme	Recording of date of last menstrual period	Quarter 3 2021	Radiography staff	COMPLETED Quarter 3 2021
Tier 2- Audit for accreditation scheme	Correct use of radiographic markers	Quarter 3 2021	Radiography staff	COMPLETED Quarter 3 2021
Tier 2- Audit for accreditation scheme	Radiographer commenting audit	Quarter 3 2021	Radiography staff	COMPLETED Quarter 3 2021
Tier 2-Service Improvement	Number and appropriateness of referrals received into department	Quarter 3 2021	Audiology staff	COMPLETED

				Quarter 4 2021
Tier 2 – Identified risk	Waiting times/compliance with targets	Quarter 3 2021	Audiology staff	**Delayed to 2022/23** Quarter 4 2021
Tier 2-Service Improvement	Outcome measures for hearing aid users	Quarter 3 2021	Audiology staff	**CANCELLED** Quarter 4 2021
Tier 2 – Identified risk	Daily calibration checks on equipment	Quarter 3 2021	Audiology staff	**COMPLETED** Quarter 4 2021
Tier 3 – Local Audit following change of policy/process	Number of tinnitus referrals into Audiology versus into ENT.	Quarter 3 2021	Audiology staff	**TAKEN FORWARD AS NON-AUDIT WORK** Quarter 4 2021
Tier 2-Service Improvement	Number of hearing aids lost by patients	Quarter 3 2021	Audiology staff	**COMPLETED** Quarter 4 2021
Tier 2-Service Improvement	Spasticity against National Standards	Quarter 3 2021	Physiotherapy staff	**Delayed to 2022/23** Quarter 4 2021
Unscheduled Care				
Driver	**Audit Title**	**Start Date**	**Lead**	**End Date**

Tier 2-Service Improvement	Missed Fractures Audit	Quarterly	Senior Nurse Unscheduled Care	**COMPLETED** Quarter 4 2021
Tier 2-Service Improvement	Mattress audit	Quarterly	Senior Nurse Unscheduled Care	**COMPLETED** Quarter 4 2021
Tier 2-Service Improvement	Hand Hygiene Audit	Quarterly	Senior Nurse Unscheduled Care	**COMPLETED** Quarter 4 2021
Tier 2-Service Improvement	Primary Care Attenders	Bi Yearly 2021	Senior Nurse Unscheduled Care	**COMPLETED** Quarter 4 2021
Tier 2-Service Improvement	Paramedic/downgrade ambulance audit	Bi yearly 2021	Senior Nurse Unscheduled Care	**COMPLETED** Quarter 4 2021
Tier 2-Service Improvement	PGD Audit	Monthly	Senior Nurse Unscheduled Care	**COMPLETED** Quarter 3 2021
Tier 2-Service Improvement	Paeds under five audit – scrutiny of every attender under five	Bi yearly 2021	Senior Nurse Unscheduled Care	**COMPLETED** Quarter 3 2021
Tier 2-Service Improvement	Documentation audit	Bi Yearly 2021	Senior Nurse Unscheduled Care	**COMPLETED** Quarter 3 2021
Tier 2-Service Improvement	PPE Audit	Monthly	Senior Nurse Unscheduled Care	**COMPLETED** Quarter 3 2021
Surgery and Endoscopy				

Tier 2-Service Improvement	Consent to Surgery Audit	Quarter 2 2021	Theatre Data Manager	**COMPLETED** Quarter 3 2021
Tier 2-Service Improvement	Surgical Record Keeping Audit	Quarter 2 2021	Theatre Data Manager	**COMPLETED** Quarter 3 2021
Tier 2-Service Improvement	Consent to Endoscopy Audit	Quarter 3 2021	Theatre Data Manager	**COMPLETED** Quarter 4 2021
Tier 2-Service Improvement	Endoscopy Record Keeping Audit	Quarter 3 2021	Theatre Data Manager	**COMPLETED** Quarter 4 2021
Tier 2- Audit for accreditation scheme	Patient Satisfaction Audit (Surgery)	Quarter 2 2021	Theatre Data Manager	**COMPLETED** Quarter 3 2021
Tier 2- Audit for accreditation scheme	Patient Satisfaction Audit (Endoscopy)	Quarter 3 2021	Theatre Data Manager	**After national advice the yearly audit has been replaced by a monthly sample survey**
Women's and Children's Service				
Maternity Services				
Driver	**Audit Title**	**Start Date**	**Lead**	**End Date**
Tier 1-National Audit Programme	National Maternity and Perinatal Audit	As requested nationally	Head of Midwifery & Sexual Health Services	**Delayed to 2022/23**

Tier 1-National Audit in line with Welsh Health Risk Pool	Clinical Audit report for Intelligent Intermittent Auscultation for Fetal Wellbeing	April 2021 & August 2021 WRP audit visit	Consultant Midwife and Clinical Supervisor of Midwives	**COMPLETED** December 2021
Tier 1-National Audit with Delivery Unit	Neurodevelopmental Demand and Capacity Audit	Quarter 3 2021	Sian Hooban & Delivery Unit	**TAKEN FORWARD AS NON-AUDIT WORK** Quarter 4 2021
Tier 2-Service Improvement	Audit of the use of NICE guidance for Intermittent Auscultation	Quarter 3 2021	Assistant Head of Maternity & Sexual Health Services	**COMPLETED** Quarter 4 2021
Tier 1-National Audit	SGA Audit Compliance with GAP/GROW fetal surveillance programme at detecting SGA babies	Quarter 3 2021	Assistant Head of Midwifery & Sexual Health Services Midwife Sonographer Governance Leads	**Delayed to 2022/23** Quarter 4 2021
Tier 2-Service Improvement	WAST Transfer Audit - Implementation of new transfer flow chart	Quarter 3 2021	Shelly Higgins Consultant Midwife / Kate Evans	**Delayed to 2022/23** Dec 2021
Tier 2-Service Improvement	Clinical Information Sharing Audit	April 2021	Clinical Supervisor for Midwives	**COMPLETED** July 2021
Tier 2-Local Audits in response to a Serious Incident or Case Review	Safeguarding Supervision Policy – Maternity Specific	August 2021	Head of Midwifery & Sexual Health	**COMPLETED** September 2021
Sexual Health				
Tier 3 – Local Audit for service evaluation	Evaluation of Midwife & Health Visitor Led Contraception pilot.	Quarter 1 2021	Sexual Health Clinical Lead	**COMPLETED** Quarter 3 2021

Tier 3 – Local Audit for service evaluation	Evaluate management of referrals to Sexual Health Services via All Wales Test & Post platform	Quarter 1 2021	Sexual Health Clinical Lead	**COMPLETED** Quarter 3 2021
Tier 2-Service Improvement	Evaluation of Midwife & Health Visitor Led Contraception pilot.	Quarter 1 2021	Sexual Health Clinical Lead	**COMPLETED** September 2021
Tier 2-Service Improvement	Referrals to Sexual Health Services via All Wales Test & Post platform	January 2021	Sexual Health Clinical Lead	June 2021 **COMPLETED**
Community Paediatrics				
Tier 3- Audit suggested by FOI request	Recording of Antenatal Alcohol Exposure on Adoption Medical Reports	Quarter 1 2021	Consultant Community Paediatrician	**Delayed to 2022/23** Quarter 3 2021
Tier 1-National Audit Programme	National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)		Consultant Community Paediatrician	**Delayed to 2022/23** Autumn 2021
Tier 2 – Local Audit following change of policy/process	Melatonin Use Re-Audit	July 2021	Consultant Community Paediatrician	**COMPLETED With RE-AUDIT 2022/23** August 2021
Tier 2-Service Improvement	Recording of Antenatal Alcohol Exposure on Adoption Medical Reports	Quarter 3 2021	Consultant Community Paediatrician	**Delayed to 2022/23** Quarter 4 2021
Tier 2-Service Improvement	Child Protection Medicals in Powys (Trends over last 3 years)	June 2020	Consultant Community Paediatrician (IP)	**Delayed to 2022/23** April 2021

				(Delayed presentation but audit Complete)
Children's Therapies				
Tier 2 – Local Audit following change of policy/process	Using TOMS to measure virtual therapy practices	Quarter 1 2021	Head of Children's SLT service	**Delayed to 2022/23** Quarter 3 2021
Children's Nursing/Health Visiting				
Tier 2 - Audits in response to a Serious Incident	CYSUR Action Plan Point 5 – Audit of the use of the SIP2 form	Quarter 1 2021	Assistant Head of Children's Public Health Nursing - Health Visiting and School Nursing & Assistant Head of Midwifery & Sexual Health Services	**TAKEN FORWARD AS NON-AUDIT WORK** Quarter 3 2021
Tier 2-Service Improvement	UNICEF Baby Friendly Initiative Infant feeding audit	Quarter 3 2021	Infant Feeding Coordinator	**Delayed to 2022/23** Quarter 4 2021
Tier 2 - Audits in response to a Serious Incident	Child Was Not Brought To Appointment Policy Audit	Autumn 2021	Sian Hooban & Mary Cottrill & Safeguarding Team	**COMPLETED** March 2022
Tier 2-Service Improvement	CCN Profiling RCN Department of Health Audit	Quarter 3 2021	Childrens Community Nursing	**TAKEN FORWARD AS NON-AUDIT WORK** April 2022

Tier 2-Service Improvement	Audit of the use of NICE guidance with respect to LD Nursing, Neurodevelopment Service and Continence care	September 2021		**Delayed to 2022/23** December 2021
Tier 2-Service Improvement	Audit of the use of All Wales guidance for Continuing Care.	September 2021		**CANCELLED** December 2021
Tier 2-Service Improvement	Record Keeping Audit	January 2022	Childrens Community Nursing	**Delayed to 2022/23**
Tier 2-Service Improvement	Audit of the Healthy Child Wales Programme measures	Quarter 3 2021	Rebecca Hamley Locke	**CANCELLED** March 2022
Tier 1- National Audits	Health Care Standards Audit	Quarter 3 2021	Health Visiting	**Delayed to 2022/23** March 2022
Tier 1- National Audits in accordance with Welsh Government directive	SN Framework and Special School Nursing Framework	September 2021	School Nursing	**Delayed to 2022/23** December 2021
Tier 2- Audits following change to policy or procedure	Clinical Supervision Policy for Childrens Nursing Services	January 2022	Childrens Nursing	**Delayed to 2022/23** March 2022
	Women's Health			
Tier 2-Service Improvement	Benchmarking audit for compliance with NICE Guidance for Endometriosis	August 2021	Specialist Nurse for Women's Health / Endometriosis	**COMPLETED** December 2021
Mental Health and Learning Disabilities				
Driver	**Audit Title**	**Start Date**	**Lead**	**End Date**

Tier 2 – Identified risk	Audit of assessments conducted using the Wales Applied Risk Research Network (WARRN) tool	Quarter 3 2021	Mental Health Staff	COMPLETED Quarter 4 2021
Safeguarding				
Driver	**Audit Title**	**Start Date**	**Lead**	**End Date**
Tier 2 Service Improvement	Safeguarding Maturity Matrix audit	Quarter 3 2021	Head of Safeguarding	COMPLETED Quarter 4 2021
Tier 2 Service Improvement	Safeguarding Supervision audit	Quarter 4 2021	Head of Safeguarding	COMPLETED Quarter 4 2021

Audit Driver Key:

	Driver
	Welsh Government National Audit Programme
	Other National Audits
	Audits performed for accreditation schemes
	Local Audits for service improvement
	Local Audits following change to policy or procedure

	Local Audits in response to a Serious Incident/Identified Risk
	Service Evaluation
	Other

Progress Key:

	Complete
	On Track
	Rolled Forward
	Not undertaken
	Cancelled

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 2.4

PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE	**Date of Meeting: 7 July 2022**
Subject:	Medicines Management Assurance Report 2021/22
Approved and Presented by:	Dr Kate Wright, Medical Director
Prepared by:	Jacqui Seaton, Chief Pharmacist
Other Committees and meetings considered at:	Executive Committee

PURPOSE:
The Medicines Management Assurance Report 2021/22 provides an account of medicines management and pharmacy activities undertaken during 2021/22. It is intended to update the Board on the health board's Pharmacy/Medicines Management arrangements, outlining progress made in year, as well the key areas of concern and plans going forward for the next financial year.
RECOMMENDATION(S):
The Patient Experience, Quality and Safety Committee is requested to RECEIVE and ACCEPT the Medicines Management Assurance Report 2021/22

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

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

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

EXECUTIVE SUMMARY:

In May 2020 the Health Board recruited a Chief Pharmacist to manage and direct all aspects of pharmaceutical and medicines management services across the health board. The COVID-19 pandemic has meant that much of the first 2 years in post have been spent supporting the delivery of the health board's pandemic response. However, despite the pandemic, significant progress has been made in driving forward the medicines management and pharmacy agenda.

This report outlines the scope of the work undertaken by the Medicines Management Team, highlights the progress made during 2021/22, raises awareness of the challenges and discusses the plans for 2022/23.

DETAILED BACKGROUND AND ASSESSMENT:

Background

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 5-10 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 health board's medicines management work 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% (~£35 million) of the health board's overall financial allocation.

The Medicines Management Team 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 Medicines Management Team 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 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 Medicines Management Team links and coordinates 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 smooth the journey for patients between different providers of care.

Workforce

The health board has a small Medicines Management Team (~ 31 WTE) made up of pharmacists (~11 WTE), pre-foundation pharmacists (2 WTE), pharmacy technicians (~10 WTE), pre-foundation pharmacy technicians (2 WTE), Assistant Technical Officers (ATOs) (1.6 WTE), administrators (2 WTE)

, Medicines Management Nurses (0.8 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 is sub-divided into 3 key teams:

- Community Services
- Primary Care
- Commissioned Services and high-cost drugs

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

Recruitment of suitably experienced pharmacy professionals is a significant challenge in Powys. The team has two posts that have remained vacant despite repeated job adverts (1 WTE Band 7 Pharmacist and 1 WTE Band 5 Pharmacy Technician). As a result of the recruitment challenge, skill mix was reviewed during 2021/22 and ATOs were introduced. The ATOs have proved to be huge asset to the team, allowing delegation of appropriate tasks from pharmacists to technicians and from technicians to ATOs.

Areas supported by the team

The team provides medicines management support and advice to health and social care right across the 2,000 square miles geography of Powys: e.g. community nursing teams (e.g. district nurses, school nurses), community hospitals (x 10), specialist teams (e.g. dietetics, tissue viability, immunisations and vaccinations), GP practices (x 16 + branch surgeries), community pharmacies (x 23), care homes (x 41), women and children's services, mental health services, domiciliary care providers, dental practices, patients, carers, members of the public etc.

Functions of the Medicines Management Team

The intention of the list below is to provide the committee with a brief summary of the scope of the work undertaken by the team, the list is not intended to be exhaustive.

- **Medicines optimisation –** improve the health of the population by optimising the use of medicines through: promoting the safe, evidence-based and cost-effective use of medicines, providing up to date, unbiased information about medicines, treatments and care pathways, supporting practitioners and patients to make the best use of medicines, minimising the harm caused by medicines, developing local guidelines and care pathways to optimise the management of chronic conditions, collaborating with providers of acute care and other healthcare providers to support these aims.
- **Medicines guideline/policy development and review**

- **Clinical pharmacy and safe and secure management of medicines services** to community hospitals and other community services (wards, outpatient departments, specialist services (e.g. tissue viability, respiratory physiology), minor injuries, theatres, dental, maternity, therapies etc).
- **Contract/SLA management** – Community Pharmacy Contract; Dispensing Doctors Contract, Quality Controller (Medical Gases Pipeline Systems); Red Kite SLA, Llanfyllin SLA, SLAs with ABUHB and HDUHB for medicines provision, clinical pharmacy support and out of hours support to community hospitals across Powys.
- **Legal requirements, medicines safety and governance –** Medicines Safety Officer, Serious Incident Investigations, Controlled Drugs Accountable Officer, Antimicrobial Stewardship, Patient Group Directions, Shared Care Agreements, Safe and Secure handling of medicines and controlled stationary.
- **Controlled Drugs –** The Chief Pharmacist is the health board's Controlled Drugs Accountable Officer and Chair of the Local Intelligence Network. This is a statutory role with responsibility for the safe and secure management of controlled drugs across the health economy.
- **Primary care –** Medicines Management Incentive Scheme, Decision Support Software, practice visits (annual), Dispensing Services Quality Scheme, medicines related enhanced services management, outline consent applications, input into the contract assurance framework (CAF)
- **Community Pharmacy** – Pharmaceutical Needs Assessment, new contract applications, enhanced service development, monitoring and review, annual contract visits.
- **Commissioned Services** – high-cost drugs management (including Blueteq), biosimilars, homecare, assurance around compliance with local and national guidance/policy
- **Formulary management** – NICE/AWMSG compliance, low value medicines, horizon scanning, INFORM, MicroGuide.
- **Robust and transparent medicines decision making processes** – Area Prescribing Group; Individual Patient Funding Requests panel.
- **Provision of medicines information services**
- **Sustainable medicines management –** e.g. tackling medicines waste, reducing carbon footprint (e.g. inhalers and medical gases).
- **Medical Gases –** Medical gases are medicinal products, the governance of medical gases within the hospital setting is the responsibility of the Chief Pharmacist.
- **Financial Management** – budget management (the Chief Pharmacist is responsible for the management of ~10% of the health board's total financial allocation), Value-Based Healthcare (e.g. reducing costs by improving patient outcomes through medicines optimisation), annual efficiency plans.

- **Immunisation and Vaccination –** national immunisation programmes, COVID-19 vaccination (pandemic room, MVCs, outreach clinics).
- **Data analysis** – CASPA, SPIRA (national key performance indicators, controlled drugs, antimicrobials, low priority prescribing) .
- **Audit –** develop and deliver annual audit plan.
- **Training and education** – pre-foundation pharmacists, pre-foundation pharmacy technicians, post-foundation pharmacists, continuing professional development.
- **Non- medical prescribing** – recruitment to training places, scope of practice monitoring, prescribing monitoring, peer discussion group.
- **Patient centred care** – shared decision making, patient support materials
- **Medicines management support to care homes and domiciliary care**
- **Technology –** Providing medicines management input into the implementation of Electronic Prescribing and Medicines Administration (EPMA), supporting Medicines Transcribing and E-Discharge (MTeD) and working with the national team to identify and develop medicines management tools that empower patients and support disease management and patient independence.
- **Website –** one stop shop for medicines information.
- **Patient and Public Engagement –** collaboration with Community Health Council (CHC).

Key achievements 2021/22

The Medicines Management Team has played a significant role in supporting the delivery of the health board's response to the COVID-19 pandemic. Despite this distraction, the team has succeeded in driving the medicines management agenda forward during 2021/22.

The list below details some of the progress and achievements made during 2021/22:

- Continued support to the COVID-19 response
    - Ordering and distribution on vaccines and COVID therapies
    - Safe and secure handling of the vaccines
    - Supporting healthcare professionals and members of the public with clinical queries
    - nMAB/antiviral clinical triage
    - PGD development and review
    - Provision of Patient Specific Directions
- Primary Care
    - Prescribing priorities developed and distributed to practices
    - Medicines Management Incentive Scheme aligned with prescribing priorities

    - QAIF medicines related harm domain indicators identified, promoted to primary care and actively monitored. (template developed to support monitoring)
    - Routine monitoring and sharing of prescribing data initiated (e.g. national KPIs, low priority indicators, antimicrobial prescribing indicators, controlled drugs prescribing data). Interactive dashboard developed and shared with practices.
    - Strategic approach to medicines management support to primary care introduced.
    - Medicines Management SLAs with Llanfyllin strengthened.
    - Increased input into medicines related enhanced services (e.g. DOAC enhanced service)
    - Quarterly Medicines Management input into the CAF introduced.
    - Lead technician identified to manage primary care decision support software (ScriptSwitch / OptimiseRx).
- Formulary management group introduced
- Pharmaceutical Services
    - The first PTHB Pharmaceutical Needs Assessment (PNA) was published in September
    - More community pharmacists completed training as independent prescribers – this will allow pharmacists to manage more common ailments, helping to alleviate pressure on primary care.
    - New pharmacy contractor in place in Llanwrtyd Wells – addressing the gap in pharmaceutical services highlighted in the PNA.
    - New pharmacy contract effective from 1st April 2022 – work undertaken during 2021/22 to ensure that contractors were aware and ready for the changes.
- Controlled Drugs
    - Controlled Drugs Local Intelligence Network (CDLIN) continued to meet quarterly.
    - Relationship with partner organisations strengthened.
    - Controlled Drugs Accountable Officer's annual report written and submitted to the exec team.
    - Controlled drug incident log established and further developed.
    - Pool of controlled drugs authorised witnesses increased (to support CD destruction).
- Antimicrobial Stewardship
    - Improvement plan in place and regularly updated.
    - Antimicrobial stewardship group established (meets quarterly).
    - Primary care antimicrobial prescribing KPIs monitored quarterly and shared with antimicrobial stewardship group and Infection Prevention and Control (IPC) Group.
    - Updated antimicrobial prescribing guidelines published March 2022.
    - MicroGuide commissioned – app shown to improve compliance with antimicrobial prescribing guidelines.

- Medical gases
    - Medicines management team actively involved in multidisciplinary medical gases audits. Sites visited during 2021/22: Ystradgynlais**,** Brecon**,** Llandrindod Wells**,** Bronllys.
    - Chief Pharmacist completed 'Medical Gases for Service Managers' training (19/10/2021)
    - Chief Pharmacist, Medicines Management Nurse and Head of Community Services Medicine Management completed BOC medical gases e-learning.
    - BOC Medical gases e-learning commissioned for Designated Nursing Officers on all PTHB hospital sites.
    - Quality Controller for Medical Gases Pipeline Systems identified and SLA in final stages of development.
    - Professional medicines management/pharmacy support to the health board's Medical Gases Governance Group in place.
    - Work initiated to strengthen governance and provide medicines management oversight of the home oxygen budget.
    - Chief Pharmacist identified as lead for the national medical gases pharmacy group.
- Financial Management
    - Medicines Management efficiency plan developed covering primary care, community services and commissioned services/high cost drugs.
    - Regular meetings in place with finance to improve budget understanding and monitoring.
    - Invoice approval processes strengthened.
- Training and development
    - The team has supported the training and development of pre-foundation pharmacists, pre-foundation pharmacy technicians and post-foundation pharmacists during 2021/22.
    - All team members have completed Dementia Friends training.
    - Compliance with mandatory training is monitored monthly and a significant improvement in compliance with training requirements has been seen.
- Medicines storage
    - PSN 055 audit undertaken (medicines storage in wards, outpatients, minor injuries units, theatres, maternity etc).
- Medicines Safety
    - Medicines Safety Officer (MSO) identified and put in place.
- Care Homes
    - Medicines Management support to Care Homes strengthened – pharmacy technician with a remit for care homes identified. This has strengthened relationships with the local authority and with care home providers.

- Patient Group Directions
    - Patient Group Direction Governance Group in place – meets quarterly.
    - Governance processes reviewed and strengthened.
    - Single process for developing and reviewing patient group directions in place.
    - Database of PGDs established and workplan prioritised around the database.
    - Dedicated structured section of health board's website established for PGDs.
    - Training in place for staff who develop/review PGDs and for those who work to PGDs
- Non-Medical Prescribing (NMP)
    - Policy reviewed, approved and published.
    - Active engagement with stakeholders to optimise uptake of available NMP places.
- Medicines Management support to the Individual Patient Funding Request (IPFR) panel maintained
- Medicines Management Incident Reporting and Learning:
    - Medicines Management intervention reporting and monitoring tool developed by one of our post graduate pharmacists. Now in routine use and being used to identify areas where guidelines are required. The tool has significantly increased intervention reporting and learning. National interest in the tool has been shown
- Commissioned services
    - Chief Pharmacist leading the national work to implement Blueteq across all health boards.
    - NICE compliance database maintained.
    - High cost drugs/biologics and homecare policies incorporated into provider contracts.
    - Shared care agreements – collaborative working with acute providers and LMC.
    - Patients prescribed clozapine by Midlands Partnership Foundation Trust repatriated to PTHB
        - All Wales community pharmacy clozapine enhanced service developed
- Decision making processes
    - Area Prescribing Group terms of reference drafted and first meeting was May 2022.
- Website
    - New Medicines Management pages of the PTHB website launched. Aiming to make this a one-stop shop for clinicians, patients and members of the public.

Although the progress and achievements may look extensive, it is recognised that there is still considerable work to be done before the Chief Pharmacist is fully assured, and therefore able to assure the executive team, that medicines are managed in line with relevant legislation and regulations, and that national and professional guidance on medicines governance are followed across the organisation.

Challenges

1. **COVID 19:**
   Members of the Medicines Management Team have been redeployed to varying degrees to support the COVID-19 pandemic response. This has had a significant impact on the team's ability to deliver its important function. Although the health board supported the recruitment of additional temporary pharmacy staff early in the response process, most of those recruited have existing 'day jobs' and are therefore only able to offer support outside normal working hours, which limits their contribution. Agreement has now been given for the temporary back-fill a band 6 pharmacy technician post (until March 2023) as the post holder is now working exclusively on the COVID-19 response. Agreement has also been given to recruit a band 4 pharmacy technician and six band 2 ATOs', on temporary contracts until March 2023 to support the programme. This will take some pressure off substantive members of the Medicines Management Team.

2. **Recruitment and workforce**
   Recruitment of suitably experienced pharmacy professionals is a significant challenge in Powys. The team has two posts that have remained vacant despite repeated job adverts (1 WTE Band 7 Pharmacist and 1 WTE Band 5 Pharmacy Technician). Skill mix has been reviewed and the ATO posts introduced allowing delegation of appropriate tasks from pharmacists to technicians and from technicians to ATOs.

   Rather than recruiting to the band 7 and band 5 posts, a band 6 pharmacist and a band 4 technician will be recruited, and any surplus funding will be used to temporarily increase existing team members hours and/or recruit more ATOs. The band 7 and band 5 funding will allow for career progression of the band 6 and band 4 recruits.

   Despite skill mix review and alternative recruitment options being put in place, the current workforce does not allow the provision of an effective, efficient and safe medicines management and pharmacy service. There is no capacity to drive forward cross-cutting programmes of work including transformation/service improvement projects.

Increased investment in the Medicines Management Team is necessary to drive forward this important agenda. Work is ongoing to describe the establishment needed.

3. Policies

The health board has a number of medicines related policies that are in urgent need of review (e.g. the Medicines Policy). As a consequence, health board staff do not have access to policies that are up to date and therefore there is no assurance that staff are working in line with current legislation or current national guidance. This presents a governance risk and a risk to patient safety. This issue has been on the Medicines Management Risk Register for some time. Protected staff time is required to ensure that policies are updated as soon as possible.

4. Safe and secure storage of medicines

The Chief Pharmacist is not assured that medicines are being stored in line with national and manufacturers guidelines.

Temperature monitoring - steps have been taken to ensure that data loggers are in place in all areas where medicines are stored across the health board – for both cold storage and ambient temperature storage. Mean kinetic temperature monitoring has highlighted that some hospital sites are exceeding the 25^{o}C upper limit for medicines requiring ambient storage. As a consequence, drugs may need to be discarded or expiry dates may need to be reduced and patient care may be compromised.

Security of medicines - the Chief Pharmacist is not assured that robust medicines security arrangements are in place across the health board. CCTV has been installed on two hospital sites following the loss of drugs that are known to be subject to abuse, but robust measures need to be put in place across the whole of the health board's estate (e.g. Abloy Cliq)

5. Implementation of self-administration on hospital wards

The absence of processes to allow appropriate patients to self-administer their medicines during an inpatient stay in Powys was picked up during an HIW inspection a number of years ago. Workforce challenges within the Medicines Management Team has prevented this from being progressed to date.

Self-administration whilst in hospital increases patient understanding of their medicines and why they are prescribed, promotes independence and autonomy and prepares them for discharge.

This risk is currently being managed on an individual patient basis. Robust systems and processes need to be put in place to allow widespread implementation. This will support the health board's frailty agenda.

6. Antimicrobial stewardship

Antimicrobial stewardship (AMS) refers to an organisational or healthcare system-wide approach to promoting and monitoring judicious use of antimicrobials to preserve their future effectiveness. Addressing antimicrobial resistance through improving stewardship is a national priority.

WHC(2019)019 published in July 2019 highlighted that a locally focused community infection prevention and antimicrobial stewardship (AMS) resource is vital in all LHBs. There is a significant gap in Powys as we do not currently have an AMS Pharmacist.

We have evidence of compromised patient care due to inadequate oversight of antimicrobial prescribing in community hospitals and in primary care in Powys.

Although Powys has the lowest antimicrobial prescribing rate in Wales (items/1000 STAR-PU), we are not hitting the national target and the latest prescribing data shows that our prescribing between Jan – March 2021 and Jan – March 2022 increased by 17.7%. We are also the highest prescribers of the 4C antimicrobials (co-amoxiclav, cephalosporins, fluoroquinolones and clindamycin) in Wales – these are the antimicrobials that are most frequently linked to healthcare associated infection (HCAI), including Clostridioides difficile infection and Staphylococcus aureus bacteraemia caused by MRSA.

A dedicated antimicrobial stewardship pharmacist is required to strengthen our governance arrangements. This resource will be used to e**nsur**e **that robust guidelines**/policies **are in place**, to support education and training and to provide **regular monitoring and oversight of antimicrobial prescribing across community services an**d primary care. This requirement is being incorporated into the ongoing work describing the establishment needs.

7. Medicines management support to mental health services

PTHB has four mental health wards, three are Older People's Mental Health Wards (OPMH) - Crug (Brecon), Tawe (Ystradgynlais) and Clewedog (Llandrindod). The Fan Gorau (Newtown) and Ty Cloc (Bronllys), the Hazels (Llandrindod) units provide community mental health services. In addition there is an acute assessment unit, Felindre ward at Bronllys hospital.

PTHB currently has access to 0.2 WTE Band 8A pharmacist to support Felindre Ward and query answering - commissioned via an SLA with ABUHB. There is a clear inequity in medicines management support to mental health services when compared to the support provided to services linked to physical health conditions.

The current level of support to mental health services is inadequate and does not meet the needs of the population of PTHB. We are currently unable to provide assurance about effective, prudent and safe use of medicines throughout the service. Investment in dedicated mental health pharmacy support, which is integrated into the Medicines Management Team is essential. This requirement is being incorporated into the ongoing work describing the establishment needs.

8. Electronic Prescribing and Medicines Administration (ePMA)

The implementation of ePMA is being driven at a national level and all health boards and Velindre Trust have been asked to state intention towards ePMA, including expected timelines and to start mobilising local Health Board ePMA project teams.

To date only a member of the Medicines Management Team has joined the national implementation meetings. It is essential that PTHB is not left behind. Urgent action is required:

- Appropriate senior representation at national the WHEPPMA Board must be identified.
- A project lead and multidisciplinary team to progress this work must be identified.
- A business case (Digital Investment Proposal) for ePMA implementation must be developed to apply for WG funding for project team and any capital or infrastructure requirements.

Although the Medicines Management Team must be involved in this work, it is not something that the team should lead on.

9. Training

Being part of a teaching health board, the Medicines Management Team has demonstrated a commitment to supporting pre and post foundation pharmacists and pre-foundation pharmacy technicians. The support provided by the health board has been recognised by HEIW. However, during 2022/23 the health board has been asked to support an increased number of pre-foundation pharmacists (six rather than two). Although the Medicines Management Team recognises the benefits of training pre-foundation pharmacists in Powys, the commitment required from our Education and Training Leads is substantial and could compromise the delivery of our essential work as well as compromising the learning experience of the students. The existing workforce challenges are compounding this issue.

The Medicines Management Team would like to support additional students, although this will only be possible if the workforce challenges are addressed.

10.Care Homes

Dedicated medicines management support to care homes is known to:

- Improve quality of care through better medicines use
- Reduce risk of harm from medicines through medicines optimisation and safer medicines systems and staff training**.**
- Release resources through medicines optimisation and waste reduction (estimated saving = £223 per resident per year), reduction in hospital admissions and release of care home nurse time.

There are 41 care homes in Powys, caring for ~1240 residents. These homes are currently supported by a single pharmacy technician. To improve outcomes for our care home residents and to achieve financial efficiencies, increased investment in the Medicines Management Team is required. A paper was presented to the Investment Benefits Group in June 2021 and although support for the proposal was given, no further progress has been made. This requirement is now being incorporated into the ongoing work describing the establishment needs. The intention would be for the medicines management team to work closely with community pharmacies and GP practices that provide support to care homes, as well supporting homes that do not have dedicated support, through enhanced services, from practices of pharmacies.

NEXT STEPS:

During 2022/23 the Medicines Management Team will build on the work that was undertaken during 2021/22. Work will be undertaken with the executive

team and the wider health board and partner organisations to address the challenges outlined above.

Medicines Management work plans and efficiency plans for 2022/23 have been developed. These will be proactively implemented and regularly monitored and reviewed.

The possibility of applying for a Wholesale Distribution Authorisation (WDA) will be explored as this will support the distribution of medicines outside the legal entity of the health board (e.g. to GP practices and community pharmacies). The benefits of having this ability have been seen during the COVID-19 pandemic. A WDA would be of particular benefit if we are to support public health initiatives like the provision of Healthy Start vitamins to community pharmacies to improve access and increase uptake.

The Medicines Management Team has been heavily involved in medicines distribution during the COVID pandemic. To strengthen our governance arrangements, the Senior Pharmacy Technician involved with the vaccination programme will attend training on 'The role of the responsible person' which is approved by the MHRA and includes 'good distribution practice (GDP)'. Funding will be sought to ensure that other team members involved in medicines distribution have access to GDP training.

The Medicines Management Team will work to improve the health board's performance against each and every medicines related national key performance indicator (KPI). We look beyond performance in Wales and compare our performance to that of English CCGs, and where we believe that the Welsh national targets are not ambitious enough, we will strive to work towards the more ambitious English targets.

Regular prescribing data will be provided to primary care so that each and every practice will be able to see their performance against KPIs and how they compare to other practices.

Work will be undertaken with data analysts to obtain clinical data that can be used to enhance discussions around prescribing data (e.g. practice level data on % of patients treated to blood pressure, HbA1c, cholesterol etc targets)

Annual practice visits will be re-introduced and these will be separate from the annual primary care visit to allow focussed discussions on medicines and performance data.

Work will be undertaken with the value based healthcare team to ensure that the medicines management team is actively involved and participating in all aspects of the value based healthcare agenda.

The Medicines Management Team will push forward with the sustainability agenda, focussing on work that will reduce our carbon footprint e.g. by promoting appropriate inhaler choice, working with the Medical Gases Governance Group to reduce the environmental impact of nitrous oxide, raising awareness of the environmental impact of medicines waste.

SLA and contract management will be strengthened, and providers will no longer be allowed to 'mark their own homework'. Robust performance management arrangements will be introduced with increased collaboration and feedback to providers.

Work will be undertaken with providers to ensure that the health board has sufficient data to allow high-cost drug spend to be scrutinised. This will be supported by the implementation of Blueteq.

The health board's formulary will be improved to ensure that it is a useful document that provides clear guidance that supports prescribers.

MicroGuide will be introduced to improve antimicrobial stewardship – the app has been commissioned and the antimicrobial formulary will be uploaded during quarter one 2022/23 and shared widely. It is hoped that the app based formulary will improve access and compliance with recommendations.

Work will be undertaken with finance to ensure that Medicines Management input is provided to the annual budget setting process. This is something that has been absent in recent years.

The process followed by the Medicines Management Team to approve invoices will be strengthened and a process to reliably track invoices will be introduced.

The Chief Pharmacist and the wider medicines management team will work closely with the Medical Gases Governance Group to strengthen the management and governance of medical gases across the health board and in the community.

The Medicines Management Team will work closely with medical, nursing and therapies leads to develop a strategy for non-medical prescribing. Applications to train as non-medical prescribers are currently led by personal interest rather than service needs.

The Medicines Management Team will work closely with the Primary Care Team to review the varied models of medicines management support/funding that are in place across the health board. Our ambition is to have a standardised model as soon as possible.

The Medicines Management pages of the health board's website will be further developed and populated to ensure that it is an easy to use and helpful website which is accessible to patients, members of the public and clinicians.

The audit programme will be actively progressed during 2022/23. Areas of focus will include Patient Group Directions (PGDs), safe and secure handling of controlled drugs, controlled stationary and medicines storage.

The Chief Pharmacist will work with the Assistant Director for Quality and Safety to improve the quality of medicines related incident reporting and encourage increased reporting to support learning across the organisation.

The Medicines Management Team will spend time working with clinical teams across the organisation to get a better understanding of the medicines management challenges faced on a day to day basis. This will increase awareness of the challenges, improve collaborative working and ensure that clinical teams are supported with medicines management issues.

The Medicines Management Team will work closely with community pharmacy contractors and Community Pharmacy Wales (CPW) to implement the new contract. Contract visits will be reintroduced during 2022/23.

The list above is not intended to be exhaustive, but it is hoped that it provides an overview of the broad plans that are in place.

Finally, the Medicines Management Team's commitment to supporting the health board's pandemic response will continue. The team will continue to monitor and respond to changing requirements and pressures associated with the pandemic to maintain safe and effective medicines management across the organisation, including review of business continuity plans, implementation of new services including vaccination programme, and early identification of risks and implementation of mitigation plans.

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

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

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 3.1

Patient Experience, Quality and Safety Committee	**Date of Meeting: 7 July 2022**
Subject:	Terms of Reference for Power of Discharge Group
Approved and Presented by:	Hayley Thomas (Director of Primary, Community and Mental Health)
Prepared by:	Joy Garfitt (Assistant Director of Mental Health and Learning Disabilities)
Other Committees and meetings considered at:	

PURPOSE:
The purpose of this paper is to update the Patient Experience, Quality and Safety Committee of the updated terms of reference for the Power of Discharge Group.
RECOMMENDATION(S):
Note the contents of this report and the attached Terms of Reference for the Power of Discharge Group.

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

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

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

EXECUTIVE SUMMARY:

The Mental Health Act (1983, amended 2007) requires that 'Hospital Managers' are appointed (independent of paid staff of the Health Board) to hear Tier 1 appeals for patients subject to the Mental Health Act. In turn, the Mental Health Managers form a collective group (Power of Discharge Group) with the responsibility of reporting and assuring the Patient Experience, Quality and Safety Committee that the relevant sections of the Mental Health Act are implemented appropriately by Powys Teaching Health Board.

The Power of discharge Group (PODG) is directly accountable to the Health Board via the Patient Experience, Quality and Safety Committee for its performance in exercising the functions set out in the terms of reference (appendix A).

DETAILED BACKGROUND AND ASSESSMENT:

A primary purpose of the 1983 Act is to ensure that compulsory measures to 'supervise or control' can be taken, where necessary and justified, to ensure that people who live with a mental disorder can receive the care and treatment they need. Because these provisions can place people under compulsory detention (for example to receive treatment) the 1983 Act

(amended 2007) also contains a number of safeguards.

These include, for example, a right to apply for discharge to the MHA Hospital Managers. MHA Hospital Managers have a central role in operating the provisions of the Act and the Health Board has made the decision to delegate this responsibility to the PODG, and assurance will be provided to the Board through monitoring by the Experience, Quality & Safety Committee.

The purpose of the Power of Discharge Group is to:

- Consider all relevant issues for MHA Hospital Managers to undertake their role in accordance with PTHB and legislative requirements.
- Receive activity monitoring reports on the use of the Mental Health Act (MHA)
- Ensure that discharge panels are acting in a fair and reasonable manner and exercised lawfully.
- Consider updates regarding recommendations made during panel hearings.
- Discuss and agree training for MHA Hospital Managers.
- Receive professional advice to support the discharge of the MHA Hospital Manager Role.
- Provide a forum for consideration of any matter impacting on the decision making for discharge of patients detained under the Mental Health Act.
- Receive development/discussion sessions to improve overall knowledge of services**.**

The PODG will provide advice and assure the Patient Experience, Quality & Safety Committee that;

- Processes in place to support discharge panels.
- Advise on issues arising from discharge panels and appeals of an unusual or contentious nature.
- Discuss any impact of legislative changes on role of MHA Hospital Managers.
- Highlight any impact of service changes on the ability to undertake the MHA Hospital Manager role effectively.

NEXT STEPS:
The Power of Discharge Group meets quarterly and provides a written report to the Patient Experience, Quality and Safety Group on a six-monthly basis.

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

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

MENTAL HEALTH ACT HOSPITAL MANAGERS POWER OF DISCHARGE GROUP

Terms of Reference and Operating Arrangements

Reviewed July 2022

1. INTRODUCTION

Powys Teaching Health Board (PTHB) is required under the Mental Health Act (MHA) Code of Practice (para 37.8) to develop a scheme of delegation for the duties identified by the MHA legislation. PTHB has taken a decision to delegate the power of discharge under the MHA to the 'Power of Discharge Group'.

The Power of Discharge Group (PODG) is a Sub-Group of the PTHB Patient Experience, Quality & Safety Committee which is directly accountable to the PTHB Board. The Chair of the PODG must be a member of the Experience, Quality & Safety Committee and will for assurance purposes make regular reports to the Experience, Quality & Safety Committee on the work of the PODG.

The PODG will comprise MHA Hospital Managers who have been independently appointed. The MHA Hospital Managers sit as panels of three or more in order to exercise their power of discharge as detailed in the MHA Code of Practice. The decisions made by the panels are binding and therefore are not required to be ratified by the Patient Experience, Quality & Safety Committee or by the Health Board. However, the procedures and behaviours adopted by the panel are subject to scrutiny and as such the MHA Hospital Managers are accountable to the Board via the Experience, Quality & Safety Committee.

2. REQUIREMENTS OF THE MHA

The primary purpose of the 1983 Act is to ensure that compulsory measures can be taken, where necessary and justified, to ensure that people who suffer from a mental disorder get the care and treatment they need. Because these provisions place people under compulsion (for example to receive treatment) the 1983 Act also contains a number of safeguards. These include, for example, a right to apply for discharge to the MHA Hospital Managers. MHA Hospital Managers have a central role in operating the provisions of the Act and as detailed above the Health Board has made the decision to delegate this responsibility to the PODG, and assurance will be provided to the Board through monitoring by the Experience, Quality & Safety Committee.

3. PURPOSE OF THE POWER OF DISCHARGE SUB-COMMITTEE

3.1 The purpose of the PODG is to:

- Consider all relevant issues for MHA Hospital Managers to undertake their role in accordance with PTHB and legislative requirements.
- Receive activity monitoring reports on the use of the Mental Health Act.
- Ensure that discharge panels are acting in a fair and reasonable manner and exercised lawfully.
- Consider updates regarding recommendations made during panel hearings.
- Discuss and agree training for MHA Hospital Managers.
- Receive professional advice to support the discharge of the MHA Hospital Manager Role.
- Provide a forum for consideration of any matter impacting on the decision making for discharge of patients detained under the Mental Health Act.
- Receive development/discussion sessions to improve overall knowledge of services.

3.2 The PODG will, in respect of its provision of advice to the Patient Experience, Quality & Safety Committee, comment specifically upon:

- Processes in place to support discharge panels.
- Advise on issues arising from discharge panels and appeals of an unusual or contentious nature.
- Discuss any impact of legislative changes on role of MHA Hospital Managers.
- Highlight any impact of service changes on the ability to undertake the MHA Hospital Manager role effectively.

3.3 To achieve this, the Patient Experience, Quality & Safety Committee shall provide assurance to the Board that:

- MHA Hospital Managers are effectively equipped and trained to undertake their role.
- PTHB provides appropriate support to ensure the Discharge Panels operate effectively.
- PTHB is aware of the impact of any legislative or service changes impacting on the Discharge panel's considerations and recommendations.

4. PODG MEMBERSHIP

4.1 The membership of the PODG is as follows: -

Chair	Independent Member (who must be a member of the Patient Experience, Quality & Safety Committee)
Members	All of the Mental Health Act Managers appointed by PTHB
By invitation	The Committee Chair may invite: any other PTHB officials and/or any others from within or outside the organisation

The invitees may be asked to attend all or part of a meeting to assist it with its discussions on any particular matter.

4.2 Secretariat

The secretariat for the PODG will be via the Mental Health Act Administration Team.

4.3 Member Appointments

The membership of the Committee shall be determined by the Patient Experience, Quality & Safety Committee, based on the recommendation of the PODG Chair and the membership of the PODG will be reviewed annually.

5. SUPPORT TO THE PODG

The PODG will receive support from the Mental Health Act Administration Department.

6. PODG MEETINGS

6.1 Quorum
A Quorum of a third of the whole number, including the Independent Member of the Health Board as Chair of the PODG.

6.2 Frequency of Meetings
Meetings shall be held no less than quarterly or more frequently if

deemed necessary by the chair of the PODG.

7. RELATIONSHIP & ACCOUNTABILITIES OF THE PODG

The PODG is directly accountable to the Health Board for its performance in exercising the functions set out in these terms of reference. The accountability is achieved by the appointment of a PODG chair who must be included in the membership of the Patient Experience, Quality & Safety Committee. Accountability will also be achieved by the submission of the minutes of all PODG meetings to the Experience, Quality & Safety Committee acting on behalf of the Board. The Experience, Quality & Safety Committee will also provide assurance reports to the Board, which will include information relating to its monitoring role of the PODG.

8. REPORTING AND ASSURANCE ARRANGEMENTS

The PODG Chair shall:

- report formally, regularly and on a timely basis to the Patient Experience, Quality & Safety Committee on the PODG's activities. This includes verbal updates on activity and the submission of committee minutes and written reports throughout the year;

- bring to the Patient Experience, Quality & Safety Committee's Chair specific attention any significant matters needing their consideration.

- ensure appropriate escalation arrangements are in place to alert the PTHB Chair, Vice Chair, Chief Executive (Accountable Officer) or Chairs of other relevant committees of any urgent/critical matters that may affect the operation and/or reputation of the PTHB.

9. REVIEW

9.1 These PODG terms of reference shall be reviewed annually by the Experience, Quality & Safety Committee.

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 7.1

Patient Experience, Quality and Safety Committee	**Date of Meeting: 7 July 2022**
Subject:	**COMMITTEE BASED RISKS ON THE CORPORATE RISK REGISTER**
Approved and Presented by:	Interim Board Secretary
Prepared by:	Interim Corporate Governance Manger
Other Committees and meetings considered at:	n/a

PURPOSE:

This paper sets out improvement work that has commenced to review and update patient experience, quality and safety risks.

RECOMMENDATION(S):

The group recommends that the Committee NOTES the action taken to date and SUPPORTS the proposed actions to be taken. The group welcomes discussions with the Committee on the development of risk so that it can inform this process.

It is recommended that the Committee NOTES the May 2022 version of the Committee Risk Register, which reflects the risks identified as currently requiring oversight by this Lead Committee.

Approval/Ratification/Decision	Discussion	Information
✖	✓	✓

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

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

EXECUTIVE SUMMARY:

The purpose of the Committee Risk Register is to draw together relevant risks for the Committee from the Corporate Risk Register (CRR), to provide a summary of the significant risks to delivery of the health board's strategic objectives.

BACKGROUND AND ASSESSMENT:

Situation
There is one Corporate Risk assigned by the Board to the PEQS Committee ('the Committee'):

CRR 001 *Risk that: once accessed, residents in Powys may receive poor quality of care*

An action was agreed at the last meeting of the Committee to reassess this risk.

Background
This risk has been on the Corporate Risk Register since 2017 and updated in Quarter 4 2021/22 in light of the Covid 19 pandemic and the impact on the Health and Care system. The risk has become very broad and as a result difficult to monitor systematically as noted by the Committee at its last meeting.

This has also been noted through risk identification work undertaken by the Executive Committee and the Board in its recent development session and the wider review of risk management arrangements.

There is a need to ensure that the Committee is able to identify the specific areas of risk and concern in order to ensure that it can seek and obtain assurance that proportionate and effective mitigating actions and controls are in place.

Assessment
The Interim Board Secretary, Director of Nursing and Midwifery, Medical Director, Director of Community, Primary Care and Mental Health, Director of Therapies and Health Science, Assistant Medical Director and Assistant Director of Nursing and Quality met on the 8th June to undertake an assessment of this risk, consider the actions required and agree and propose next steps.

The group agreed that the risk that is currently articulated is too broad in its current format to be systematically monitored by the Committee and contains a number of risks and issues. It should also be noted that target risk score may need to be reviewed to reflect the current environment within which services are being provided and commissioned.

The consensus was that the following actions are to be taken:

- this small group will meet monthly for the next 6 months to undertake a detailed piece of work on patient experience, quality and safety risks;

- the Assistant Director of Quality and Nursing will commence the risk identification and assessment of a number of risks that have been identified through quality assurance reporting. These draft risks will then be reviewed by the wider group at their next meeting in July and subsequently reported via the risk management process to be considered for the Corporate Risk Register;

- a review of risk registers in the Organisation is currently underway, led by the Interim Board Secretary and assessed at the Risk Assurance Group. This work will take account of any risks that are pertinent to patient experience, quality and safety (although existing escalation arrangements are still expected to be in operation);

- significant risks identified through these routes will be considered by the Executive Committee before recommending to the Board for inclusion in the Corporate Risk Register which will then be delegated to the PEQS Committee for oversight; and

- the Committee should expect to see new risks articulated by the September Committee and further risks will follow (once they have been through the risk management governance process).

The group recommends that the Committee NOTES the action taken to date and SUPPORTS the proposed actions to be taken. The group welcomes discussions with the Committee on the development of risk so that it can inform this process.

The full Committee Risk Register is attached at **Appendix A.**

NEXT STEPS:

The group will lead the ongoing development of patient experience, quality and safety risks as set out above.

Committee Based Risk Register
May 2022

COMMITTEE RISK HEAT MAP: MAY 2022

There is a risk that…

Impact							
	Catastrophic	5					
	Major	4					▪ Once accessed, residents in Powys may receive poor quality of care
	Moderate	3					
	Minor	2					
	Negligible	1					
			1	2	3	4	5
			Rare	Unlikely	Possible	Likely	Almost Certain
			Likelihood				

CORPORATE RISK DASHBOARD – May 2022

Risk Lead	Risk ID	Main Risk Type	Risk Description There is a risk that:	SCORE (Likelihood x Impact)	Trend	Board Risk Appetite	Risk Target	At Target ✓/×	Lead Board Committee	Risk Impacts on
DoN	CRR 001	**Quality & Safety of Services**	Once accessed, residents in Powys may receive poor quality of care	**5 x 4 = 20**	➔	Low	6	×	Patient Experience, Quality & Safety	Organisational Priorities underpinning WBO 1 to 4

KEY:

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

Executive Lead:	
CEO	Chief Executive
DPCMH	Director of Primary, Community Mental Health Services
DN	Director of Nursing
DFIIT	Director of Finance, Information and IT
MD	Medical Director
DPH	Director of Public Health
DWODSS	Director of Workforce & OD and Support Services
DTHS	Director of Therapies & Health Sciences
DPP	Director of Planning & Performance
BS	Board Secretary

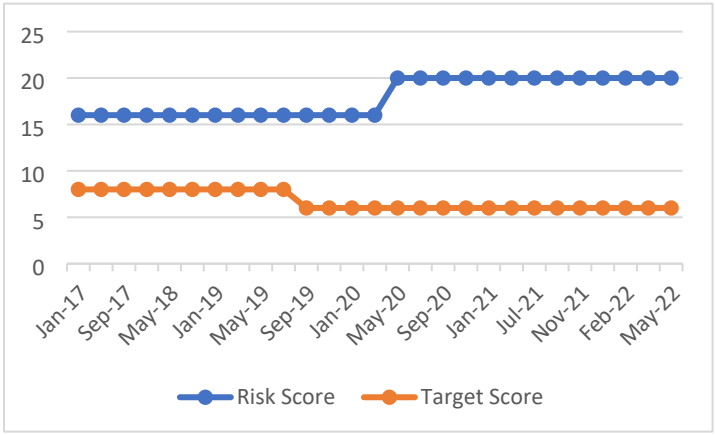
RISK APPETITE		
Category	**Appetite for Risk**	
Quality & Safety of Services	Low	Risk Score 1-6
Regulation & Compliance	Low	Risk Score 1-6
Reputation & Public Confidence	Moderate	Risk Score 8-10
Finance	Moderate	Risk Score 8-10
Innovation & Strategic Change	High	Risk Score 12-15

Trend	
↑	risk score increased
→	risk score remains static
↓	risk score reduced

CRR 001 **Risk that:** once accessed, residents in Powys may receive poor quality of care	**Executive Lead:** Director of Nursing & Midwifery **Assuring Committee:** Patient Experience, Quality and Safety
Risk Impacts on: Organisational Priorities underpinning WBO 1 to 4	**Date last reviewed:** May 2022

Risk Rating
(likelihood x impact):
Initial: 4 x 4 = 16
Current: 5 x 4 = 20
Target: 2 x 3 = 6

Date added to the risk register
January 2017



Rationale for current score:

- National policy direction with some decisions outwith of local control.
- Refining the risk-based approach to health service provision
- The longevity and continued impact of the Covid-19 pandemic, compounded by the omicron variant, articulated via the 5 harms, on the ability of health boards and trusts to provide quality care and treatment, given the accumulative effect of successive waves of infection and its unequitable adverse impact.
- Extension/continuation of the mass vaccination campaign including the redeployment of staff from a finite group to meet continued and increasing demands.
- Staff fatigue across all sectors impacting upon a whole systems approach to health and social care provision, adversely affecting organisation and system wide resilience.
- People presenting for treatment at a later stage resulting in greater acuity and complexity.
- UK wide prioritisation of recovery, opportunity predicated on a range of factors outwith of the Health Board's control.
- Pre and intra pandemic, Regulators and external bodies have identified poor quality of care in health boards and trusts in Wales and England where residents of Powys access services.
- Some services accessed by residents in Powys are in special measures, at level 4 escalation. They have independent oversight and scrutiny mandated by government. The scope, pace and assurance available in terms of improvement varies.
- Some services accessed by residents in Powys have received internal audit reports which provided a limited level of assurance in relation to care and treatment, or services that impact upon it. Dependent oversight and scrutiny is mandated by government.

		The scope, pace and assurance available in terms of improvement varies. • Potential short- and longer-term unplanned changes within the health and social care workforce, adversely affecting organisations and wider systems opportunity to recover and renew. • Commissioning assurance processes have been less achievable as a result of the pandemic and may not identify risks for Powys residents across the whole system. • The capacity, capability and processes for whole system quality and commissioning are finite. • The strategic plan to repatriate services as appropriate into Powys has been impacted upon by the pandemic. • Lack of clarity about pathways for Powys patients leading to sub-optimum care and potential for significant harm. • Non-compliance with statutory requirements including joint commissioning with the local authority (including Section 33). • Events outwith of providers control, e.g. adverse weather

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)** Actions in relation to externally commissioned services including SaTH, the Big 4, the South Powys Programme and waiting times are set out in the organisation's 13 main priorities and revised quarterly plan (rather than the actions in the original annual plan below)		
▪ Cognisance and implementation of Welsh Government policy. ▪ Staff wellbeing initiatives in place internally and within other organisations. ▪ Escalated oversight and assurance arrangements in place related to patient flow, length of stay and community provision, in partnership with PCC and third sector. ▪ Consideration of Local Options Framework where indicated. ▪ Increased oversight and monitoring as part of escalated governance arrangements, in the form of the Delivery Coordination Group, reporting to Gold ▪ Harm review processes being undertaken reported via PEQS March 2022	**Action**	**Lead**	**Deadline**
	Embed whole system commissioning through the implementation of the Strategic Commissioning Framework	DPP / DoNM	In line with Annual Plan for 2021-22
	Embed and ensure implementation of the Commissioning Assurance Framework	DPP / DoNM	In line with Annual Plan for 2021-22
	Implement commissioning intentions for 2021-22	DPP / DoNM	In line with Annual Plan for 2021-22
	Robustly identify and articulate performance of all providers of planned care services for the	DPP / DoNM	In line with Annual Plan for 2021-22

▪ Enhanced reporting to Welsh Government. ▪ IMTP planning predicated on the impacts of COVID-19. ▪ Recovery and renewal key focus of PTHB Annual Plan for 2021/22 overseen by CEO led Portfolio Board. ▪ Non-recurrent revenue and capital secured for first phase of priorities. ▪ Risk-based implementation of the plan in relation to support infrastructure required, including procurement capacity; operational recruitment, particularly in relation to theatre staff; the availability of additional external clinical capacity; and, unscheduled care pressures. ▪ Progression of the North Powys Programme. ▪ Continued implementation of the Strategic Commissioning Framework (for whole system commissioning) – partially restored at present. ▪ Implementation of the Clinical Quality Governance Framework. ▪ Implementation of the OD Framework. ▪ Focus on whole patient pathway improvement inclusive of provided and commissioned services for maternity, neonates, CAMHs. ▪ Refreshed approach to ensuring appropriate deployment of the workforce throughout the health board. ▪ Embedding the Commissioning Assurance Framework (CAF) escalation process - partially restored at present. ▪ Executive Committee Strategic Commissioning and Change Group (including consideration of fragile services – currently replaced by the DGH Log mapping pathway changes across multiple providers across England and Wales due to the COVID-19 pandemic). ▪ Regular review at Delivery and Performance meetings. ▪ Scrutiny by Performance and Resources Committee. ▪ Scrutiny by Patient Experience, Quality and Safety Committee. ▪ Internal Audit. ▪ Contract Quality and Performance Review Meetings for the 15 NHS Providers and key private sector providers. ▪ Individual Patient Funding Request Panel and Policy. ▪ WHSCC Joint Committee and Management Group. ▪ WHSSC ICP agreed within PTHB IMTP – and process underway for 21/22.	people of Powys through the Commissioning Assurance Framework		
	Programme of work to strengthen effective processes to develop and manage condition specific and service plans	DPP / DoNM	In line with Annual Plan for 2021-22
	Strengthening of commissioning intelligence in line with IMTP	DPP / DoNM	In line with Annual Plan for 2021-22
	Review Patient flows and activity into specialised services to ensure safe and appropriate pathways	DPP / DoNM	In line with IMTP/ICP
	Strengthen the organisation's capacity, capability and governance processes for commissioning – including interface with specialised services	DPP / DoNM	In line with IMTP/ICP
	As a member of the Powys Regional Partnership Board, support delivery of the Powys Area Plan which includes commissioning appropriate, effective and efficient accommodation options for older people, individual children and looked after children	DPP / DoNM	In line with Annual Plan for 2021-22
	Through the Joint Partnership Board, continue to develop opportunities for pooling Third Sector commissioning	DPP / DoNM	In line with Annual Plan for 2021-22
	Strengthen the whole system approach to the Big 4	DPP / DoNM	In line with IMTP
	Review of the health board's interface with SATH	DPP / DoNM	July 2021
	Receive the Wales Audit quality governance review and identify key areas for improvement	DONM	Aug 2021
	Agree and establish monitoring of the health boards provision of care and treatment using the principles of the commissioning assurance framework	DPCMH / DoNM	Sept 2021

▪ Emergency Ambulances Services Committee. ▪ Shared Services Framework Agreements. ▪ Section 33 Agreements. ▪ Responsible Commissioner Regulations for Vulnerable Children Placed away from Home. ▪ Specific Organisational Delivery Objectives set out in health board's Annual Plan for 2021-22.	Monitor and review the themes and trends from concerns and complaints to understand what matters to patients, families and communities. This will be key to Patient Safety and Experience reports.	DONM / DOTH /MD	May 2022
▪ Development of a standard operating procedure re quality and safety in commissioned services ▪ Participation in the Cross-Border Network Between England and Wales (Statement of Values and Principles between England and Wales). ▪ Commissioning Intentions set out in IMTP (response to the pandemic currently being implemented not commissioning intentions).	Plans to implement CIVICA to gain continuous feedback from all service users	DONM / DOTH	May 2022
▪ NHS LTA and SLA Overview submitted to the Executive Committee (and approval process). ▪ Executive Committee approved LTA and SLA narrative (updated each year). ▪ CEO signed LTAs and SLAs for healthcare. ▪ CAF developed for General Dental Services. ▪ CAF developed for General Medical Services. ▪ Recruitment of Public Health Consultant to help strengthen commissioning intelligence (currently transferred to COVID-19 related duties).	Establish an Incident Review Forum. Sponsored by the three Clinical Directors and led by ADs, this forum will establish in June 2021. It will operate fortnightly and will review and monitor all patient safety incidents, triangulating intelligence with themes from concerns and complaints.	DONM / DOTH / MD	May 2022
▪ Prior approval policy in place (Following the EU exit the EEA policy has ceased to apply). ▪ INNU policy in place. ▪ Pooled fund manager for Section 33 Residential Care. ▪ SATH Improvement Alliance with UHB in place. ▪ Respiratory and Circulatory Transformation leads in place (but circulatory support was temporarily diverted to help manage changes to emergency flows). Temporary cancer post to help ensure appropriate pathways for patients with cancer. ▪ DGH and Specialised Work-stream within PTHB's COVID-19 response plan. ▪ PTHB CEO lead Programme Board involving 3 health boards and WAST.	Undertake a full review of this risk and consider breaking this risk down into a number of risks. This work will be jointly taken by a number of Executive Leads and the Board Secretary. The aim will be to do this by the next PEQs committee in July 2022.	Board Secretary	May 2022

▪ Participation in cross-border command and control structures. ▪ Essential Services Framework implementation underway. ▪ PTHB Children's Home Group in response to the COVID-19 pandemic. ▪ Scheduled peer meetings with clinical teams in commissioned services focused on addressing concerns and sharing improvements in services where poor care has been identified. ▪ Review of policy and protocols within the health board to consider the whole patient pathway. ▪ CEO escalation where required.			
Current Risk Rating	**Additional Comments**		
5 x 4 = 20	Whilst the overall risk score remains unchanged, the rationale and controls are constantly changing, i.e. the static score does not reflect the nature of the risk itself. The risk resulting from COVID-19 is changeable and is constantly reviewed in terms of directly provided services. During the COVID-19 period the usual commissioning arrangements are not in place, nor the actions set out in the original Annual Plan. Health Boards and NHS Trusts providing services for Powys patients have made service changes in response to directions from respective governments in England and Wales through the different phases of the pandemic. Neighbouring English providers have moved into whole system Silver and Gold command arrangements. Whilst quality governance arrangements are developing within the health board, the pace of change has been stymied by the pandemic with service groups at varying stages of maturity. It was not possible to score the Commissioning Assurance Framework (CAF) in the first COVID-19 peak. It has been restored where possible, but not all domains can be scored or escalated in the usual way (for example Finance and NHS LTAs and SLAs remain in block arrangements and finance and activity patterns are different to anticipated due to the pandemic.) There are recognised extensive delays across the NHS for elective procedures with a growing		

	number of patients waiting more than 52 weeks for treatment (capacity across providers is significantly reduced due to social distancing, PPE and the need to maintain surge capacity and due to the priority of the mass vaccination programme.). In Q4 of 2021/22 the Omicron variant has led to extreme pressure on DGH capacity both from patient volume and staff sickness levels with local decisions being made regarding the ability to receive patients for scheduled and unscheduled treatment. The **cumulative risk** in relation to commissioned services remains extremely challenging. Whilst, changes to emergency flows in South Powys in response to early opening of the Grange University Hospital have been managed; an Improvement Alliance with UHB is in place for SaTH; and the UK has exited the EU with a deal – the underlying position for commissioned services is unprecedented in terms of the pressures arising from COVID-19 (in winter) and the impact this is having on capacity and waiting times for routine services. The need to prioritise accelerated changes in emergency flows in South Powys diverted strategic planning and commissioning resource from other areas including SaTH risks and circulatory services. SaTH remains in special measures and of concern. Transformational resource to address circulatory services is being rebalanced. Mitigating actions in place include: the priorities set out in the Q3&Q4 plan; South Powys Pathways Worksteam Phase 2; DGH & Specialised workstream; participation in the command and control arrangements for neighbouring English regions; monitoring Q&S and maternity information; a weekly DGH log of pathway changes; shared modelling assumptions with NHS partners; implementation of the Welsh Government Essential Services Framework; fast-tracking of elements of the Big 4 respiratory work to strengthen local resilience; Exec led meetings with the Ambulance Service; continued work with the Welsh Health Specialised Services Committee; restoration of the Section 33 Group for residential care; participation in system working in England; a renewed focus on SaTH and

	planning for 2021/22. There will need to be whole system work to renewal including to address waiting times.

PATIENT EXPERIENCE, QUALITY & SAFETY COMMITTEE
PROGRAMME OF BUSINESS APRIL 2022- MARCH 2023

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

This Annual Programme of Business has been developed with reference to:

- the Committee's Terms of Reference as agreed by the Board;
- key risks identified through the Corporate Risk Register, Commissioning Assurance Framework; and Operational Risk Registers.
- audit and regulatory reports identifying weaknesses in internal control (following consideration by the Audit, Risk and Assurance Committee);
- key statutory, national and best practice requirements and reporting arrangements

The Committee was constituted at the meeting of Board in July 2021 and the programme of business for the remainder of 2021-22 was adjusted in order to take into account service and system pressures caused by the pandemic. 2022-23 is therefore the first full year of operation of this Committee's terms of reference.

The majority of items included in the Programme of Business contribute to the Board's assurance over Strategic Priority 22: Improve Quality (Safety, Effectiveness and Experience) Across the Whole System; Building Organisational Effectiveness.

MATTER TO BE CONSIDERED BY COMMITTEE		EXEC LEAD	SCHEDULED COMMITTEE DATES 2022-23					
			12 May	7 July	13 Sept	25 Oct	08 Dec	16 Feb
Strategic Priority (SP)	**Annual Reports**							
	Annual Report of the Accountable Officer for Controlled Drugs	MD						✓
	Safeguarding Annual Report	DNM					✓	
	Quality & Safety Assurance Reports							
	Audit and Regulatory Reports, including annual reports from PSOW, HIW as appropriate	Lead Director	**As and when identified**					
SP22	Clinical Quality Framework Implementation Update including Patient Experience	DNM, DoTHS, MD			✓			✓
SP22, SP25	Commissioning Assurance Report	DNM	✓	Incorporated into Integrated Quality Report				
SP22	Integrated Quality Report, including: - Quality Measures - Serious incidents and concerns, Putting Things Right	DNM		✓	✓	✓	✓	✓
	Women and Children's Quality Report	DPCCMH	✓	Incorporated into Integrated Quality Report				

MATTER TO BE CONSIDERED BY COMMITTEE		EXEC LEAD	SCHEDULED COMMITTEE DATES 2022-23					
			12 May	7 July	13 Sept	25 Oct	08 Dec	16 Feb
SP22	Clinical Audit - Annual Clinical Audit Programme - Clinical Audit Progress and Learning	MD		✓ 22-23		✓		✓ 23-24
	Pharmacy & Medicines Management Assurance Report	MD		✓				✓
	Inspections and External Bodies Report and Action Tracking	DNM	✓		✓		✓	
	Learning from Mortality Report	MD					✓	
	Mental Health Act Compliance & Powers of Discharge	DPCCMH	✓			✓		
SP22	Clinical Effectiveness and Quality Improvement Highlight Report	DNM/DoTHS/ MD					✓	
	Infection Prevention & Control Report Assurance Report (assurance over arrangements - data included in Integrated Quality Report)	DNM				✓		

MATTER TO BE CONSIDERED BY COMMITTEE		EXEC LEAD	SCHEDULED COMMITTEE DATES 2022-23					
			12 May	7 July	13 Sept	25 Oct	08 Dec	16 Feb
SP6, SP22	Maternity Services Assurance Framework Report	DNM	✓	✓		✓		✓
	Additional reports Scheduled as an Organisational Priority/Strategic Risk							
	Quality & Engagement (Wales) Act: Implementation Update	DNM	✓		✓		✓	
	Refreshed Patient Experience Framework	DoTHS		✓				
	WHSSC Quality and Patient Safety Committee Chair's Report	Chair	✓	When available				
	Committee Governance Reports							
	Policies Delegated from the Board for Review and Approval	BS	**As and when identified**					
	Committee Programme of Business	BS			✓	✓	✓	
	Committee Risk Register	BS/DNM	✓	✓	✓	✓	✓	✓
	Committee Requirements as set out in Standing Orders							
	Mental Health Act Hospital Managers Power of Discharge Group Terms of Reference and Operating Arrangements	DPCCMH		✓				
	Development of Committee Annual Programme Business	BS		✓ 22-23				✓ 23-24
	Annual Review of Committee Terms of Reference 2022-23	BS			✓			

MATTER TO BE CONSIDERED BY COMMITTEE		EXEC LEAD	SCHEDULED COMMITTEE DATES 2022-23					
			12 May	7 July	13 Sept	25 Oct	08 Dec	16 Feb
	Annual Self-assessment of Committee effectiveness 2022-23	BS						✓
	Committee Annual Report 2022-23	BS						✓*
	Total Number of Agenda Items		**8**	**8**	**7**	**7**	**8**	**10**

*If available – likely to be first meeting of 2023-24

KEY:

CEO:	Chief Executive
DPP:	Director of Planning and Performance
DFI&IT:	Director of Finance, Information and IT
DPCCMH:	Director of Primary, Community Care and Mental Health
MD:	Medical Director
DoNM:	Director of Nursing and Midwifery
DoTHS:	Director of Therapies and Health Sciences
DWOD:	Director of Workforce & OD
DPH:	Director of Public Health
BS:	Board Secretary
DE	Director of Environment