Patient Experience Quality and Safety Committee

Thu 24 November 2022, 09:30 - 12:30

Agenda

09:30 - 09:30
0 min

1. PRELIMINARY MATTERS

PEQS_Agenda_24 Nov2022.pdf (2 pages)

1.1. Welcome and Apologies

Oral *Chair*

1.2. Declarations of Interest

Oral *Chair*

1.3. Minutes of the previous meeting held on 13 September 2022

Attached *Chair*

PEQS_Item_1.3_Unconfirmed Minutes 2022-09-13.pdf (11 pages)

1.4. Matters Arising from the minutes of the previous meeting

Oral *Chair*

1.5. Patient Experience, Quality and Safety Committee Action Log

Attached *Chair*

PEQS_Item_1.5 PEQS_Action Log Nov 2022.pdf (3 pages)

09:30 - 09:30
0 min

2. ITEMS FOR ASSURANCE

2.1. Integrated Quality Report

Attached *Director of Nursing and Midwifery*

PEQS_Item_2.1_Integrated Quality Report Nov 2022 FINAL.pdf (13 pages)
PEQS_Item_2.1a_App 1 Duty of Quality and Candour implementation Plan.pdf (3 pages)
PEQS_Item_2.1c_Appendix 3 HIW Annual Report 2021-2022.pdf (82 pages)
PEQS_Item_2.1d_Appendix 4 Learning Newsletter Oct 22.pdf (4 pages)

2.2. Maternity Assurance Report

Attached *Director of Nursing and Midwifery*

PEQS_Item_2.2 Maternity Assurance Report.pdf (9 pages)
PEQS_Item_2.2a_Maternity Improvement Action Plan.pdf (10 pages)
PEQS_Item_2.2b_PROMPT WALES QA UPDATE REPORT_NOV2022.pdf (10 pages)

2.3. Clinical Audit Progress and Learning

Attached *Medical Director*

PEQS_Item_2.3_Clinical Audit Programme 2022-23 October Update.pdf (20 pages)

2.4. Infection Prevention and Control Assurance Report

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

- PEQS_Item_2.4_IPC_Update.pdf (6 pages)
- PEQS_Item_2.4a_IPC Annual Report 202122 _Final.pdf (18 pages)
- PEQS_Item_2.4b_App 2 - IPC Quarter 1 Report_2022-23.pdf (9 pages)
- PEQS_Item_2.4c_Appendix 3 - IPC Work Programme 2022-23.pdf (3 pages)

2.5. WHSSC Quality and Patient Safety Committee

Verbal item

09:30 - 09:30
0 min

3. ITEMS FOR DISCUSSION

3.1. Safeguarding Annual Report

Attached *Director of Nursing and Midwifery*

- PEQS_Item_3.1_Safeguarding Annual Report 2021-22.pdf (10 pages)

3.2. Patient Experience Approach

- PEQS_Item_3.2_Patient Experience Framework_October2022.pdf (13 pages)

09:30 - 09:30
0 min

4. ESCALATED ITEMS

There are no escalated items

09:30 - 09:30
0 min

5. ITEMS FOR INFORMATION

There are no items for information

09:30 - 09:30
0 min

6. OTHER MATTERS

6.1. Corporate Risk Register - risks overseen by this Committee

Attached *Lead Directors*

- PEQS_Item_6.1_Committee Risk Report_November 2022.pdf (2 pages)
- PEQS_Item_6.1a_Committee Risk Register Nov 2022.pdf (5 pages)

6.2. Committee Work Programme

Attached *Chair*

- PEQS_Item_6.2_ PEQS Committee Work Programme.pdf (7 pages)

6.3. Annual Review of Committee Terms of Reference 2022-2023

Attached *Interim Board Secretary*

- PEQS_Item_6.3_Review of Committee Terms of Reference cover paper.pdf (3 pages)
- PEQS_Item_6.3a_Patient Experience Quality & Safety Committee_ToR.pdf (11 pages)

6.4. Items to be brought to the Attention of the Board and/or Other Committees

Oral *Chair*

6.5. Any Other Urgent Business

Oral *Chair*

6.6. Date of the next meeting: 16 February 2023 at 09:30 via Microsoft Teams

6.7. In-Committee

6.7.1. Mental Health Act Compliance Report

POWYS TEACHING HEALTH BOARD
PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE
THURSDAY 24 NOVEMBER 2022
09:30- 12:30
VIA MICROSOFT TEAMS

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

AGENDA				
Time	**Item**	**Title**	**Attached/Oral**	**Presenter**
	1	**PRELIMINARY MATTERS**		
09:30	1.1	Welcome and Apologies	Verbal	Chair
	1.2	Declarations of Interest	Verbal	All
09:35	1.3	Minutes from the previous Meeting held on 13 September 2022	Attached	Chair
	1.4	Matters arising from the minutes of the previous meeting	Verbal	Chair
09:40	1.5	Patient Experience, Quality and Safety Committee Action Log	Attached	Chair
	2	**ITEMS FOR ASSURANCE**		
09:45	2.1	Integrated Quality Report	Attached	Director of Nursing and Midwifery
10:30	2.2	Maternity Assurance Report	Attached	Director of Nursing and Midwifery
10:45	2.3	Clinical Audit Progress and Learning	Attached	Medical Director
11:00	3.4	WHSSC Quality and Patient Safety Committee	Verbal	Director of Nursing and Midwifery
11:15		**COMFORT BREAK**		
11:30	2.4	Infection Prevention and Control Assurance Report	Attached	Director of Nursing and Midwifery
	3	**ITEMS FOR DISCUSSION**		
11:40	3.1	Safeguarding Annual Report	Attached	Director of Nursing and Midwifery
11:50	3.2	Patient Experience Approach	Attached	Director of Therapies and Health Sciences
	4	**ESCALATED ITEMS**		
		There are no escalated items		
	5	**ITEMS FOR INFORMATION**		
		There are no items for information		
	6	**OTHER MATTERS**		
12:00	6.1	Corporate Risk Register – risks overseen by this Committee	Attached	Lead Directors
12:05	6.2	Committee Work Programme	Attached	Interim Board Secretary

12:10	6.3	Annual Review of Committee Terms of Reference 2022-23	Attached	Interim Board Secretary
	6.4	Items to be Brought to the Attention of the Board and/or Other Committees	Verbal	Chair
	6.5	Any Other Urgent Business	Verbal	Chair
	6.6	Date of the Next Meeting: Thursday 16 February 2023, 09:30, via Microsoft Teams		

The Chair, with advice from the Board Secretary, has determined that the following items include confidential or commercially sensitive information which is not in the public interest to discuss in an open meeting at this time. The Board is asked to take this advice into account when considering the following motion to exclude the public from this part of the meeting:

Motion under Section 1(2) Public Bodies (Admission to Meetings) Act 1960

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

12:15	6.7	Mental Health Act Compliance Report	Attached	Director of Primary, Community Care and Mental Health

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 TUESDAY 13 SEPTEMBER 2022 VIA MICROSOFT TEAMS

Present:

Kirsty Williams	Vice-Chair (Committee Chair)
Ian Phillips	Independent Member
Mark Taylor	Independent Member

In Attendance:

Hayley Thomas	Director of Primary, Community Care and MH/Deputy CEO
Claire Roche	Director of Nursing and Midwifery
Kate Wright	Medical Director
James Quance	Interim Board Secretary
Amanda Edwards	Assistant Director – Innovation and Improvement
Zoe Ashman	Assistant Director of Quality and Safety
Marie Davies	Deputy Director of Nursing
Sonia Thomas	CHC

Apologies for absence:

Simon Wright	Independent Member
Vivienne Harpwood	PTHB Chair
Carol Shillabeer	Chief Executive
Claire Madson	Director of Therapies and Health Sciences
Mererid Bowley	Interim Director of Public Health
Katie Blackburn	CHC
Bethan Hopkins	Audit Wales

Committee Support:

Liz Patterson	Interim Head of Corporate Governance

PEQS/22/36	**WELCOME AND APOLOGIES FOR ABSENCE** The Committee Chair welcomed Members and attendees to the meeting and CONFIRMED there was a quorum present.
PEQS/22/37	**DECLARATIONS OF INTERESTS** No interests were declared.
PEQS/22/38	**MINUTES OF THE EXPERIENCE, QUALITY AND SAFETY COMMITTEE MEETING HELD ON 7 JULY 2022 (FOR APPROVAL)** The minutes of the previous meeting held on 7 July 2022 were AGREED as a true and accurate record.
PEQS/22/39	**MATTERS ARISING FROM MINUTES OF PREVIOUS MEETING** There were no matters arising from the minutes of the previous meeting.
PEQS/22/40	**PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE ACTION LOG** The Action Log detailed the following actions that had been completed: IC-PEQS/21/5 – presentation on Mental Health to In-Committee – on the agenda for 13 September 2022. PEQS/21/78 – outstanding recommendations from Clywedog Ward to be included in Inspection Tracker – included in September 2022 report to Committee. PEQS/21/80 – consider sharing a patient story on issues related to controlled drugs – will be considered for the 2023/34 patient story programme. PEQS/22/08 – timescales to be included in Inspection Tracker – timescales are now included. PEQS/22/22 – presentation on PTR to September PEQS – on the agenda for 13 September 2022. PEQS/22/24 – presentation of dashboard to PEQS training session – this will be part of discussions regarding PEQS training/development. The following additional detail was provided in the meeting: PEQS/21/29 – next quality report to include detail of actions taken as a result of staff survey – this has been superseded

	by the introduction of the Integrated Quality Report. It will be necessary to ensure the staff survey information is included. PEQS/21/84 – to ascertain how telephone/video phlebotomy appointments work – the Director of Primary, Community Care and MH undertook to circulate a note after the meeting.
ITEMS FOR ASSURANCE	
PEQS/22/41	**INTEGRATED QUALITY REPORT** <u>Quality Overview Report</u> The Director of Nursing and Midwifery presented the report and drew attention to the following areas. • During Quarter 2 there has been a focus on ensuring overdue Nationally Reportable Incidents (NRIs) can be closed. Eight have been closed with a more manageable nine currently open. • In Supporting Learning and Development investigation training will commence which will include psychological safety, human factions, RCA (Root Cause Analysis) investigation and report writing, and SMART (Specific, Measurable, Achievable, Relevant, Time limited) action planning. • The work on reviewing cases of nosocomial transmission continues as planned. There have been no identified cases where severe harm or death occurred to date. • A deep dive was undertaken in Concerns Management. An administrative error was identified which has now been corrected. • There had been a rise in complaints to the Public Services Ombudsman for Wales (PSOW) as a result of closing complaints with an extended response time. When complaints are closed complainants are advised that there is an opportunity for a referral to the PSOW to be made. • The Healthcare Inspectorate Wales (HIW) undertook an Inspection of the Brecon Minor Injury Unit (MIU). A summary of the findings was outlined in the report. *One of the actions from the Brecon MIU report was to* 'Ensure that findings are not systemic across other areas within the wider organisation.' *It will be necessary to add this to the Inspection Tracker.* The Director of Primary Community Care and MH noted that the HIW report was specific to Brecon, but the service is managed pan-Powys. In respect of the environmental issues the organisation will look to ensure that these are all

	considered pan-Powys. This action can be added to the Inspection Tracker. **Action: Director of Primary, Community Care and MH** *The HIW report highlights record keeping. What is the position regarding the Internal Audit Report on Records Management?* The Interim Board Secretary advised that this fell within the remit of the Delivery and Performance Committee who had received an update on the Records Management Improvement Plan at their June 2022 meeting. The Internal Audit Report on Records Management remained on the Internal Audit Recommendations tracker. *It is noted that there are delays in the implementation of the RLDatix Once for Wales content management system. What are the implications of this delay?* The Director of Nursing and Midwifery advised that the health board was not currently using the risk module and therefore the delay in implementation would have minimal effect. The Interim Board Secretary advised that it was disappointing that the risk module had been delayed, but the health board was currently reviewing risks with the intention of implementing the risk management module when it is available. The Chair of Workforce and Culture Committee requested a meeting with the Director of Nursing and Midwifery to discuss cross committee culture issues. **Action: Director of Nursing and Midwifery** *What assurance should be taken from the following statement within the report: '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 PTHB and PCC. A joint response has been submitted on time with no further evidence required.'*? The Director of Nursing and Midwifery advised that the HM Coroner had issued a Regulation 28 report jointly to Powys County Council (PCC) and the health board. Both parties had submitted a response jointly and the HM Coroner was content with the information provided.

	The Chair noted that the report had been pleasing in respect of clinical care but expressed concern regarding the opportunity the health board would have to access capital funds to address the issues raised in respect of estates. <u>Putting Things Right (PTR) Presentation</u> The Assistant Director of Quality and Safety presented a report in response to a request at the previous Committee meeting. An Improvement Plan had been in place since 2020/21 in response to a PSOW report where recommendations for improvement were outlined relating to: • poor concern compliance; • the significant number of open concerns that were out of compliance; and • ensuring patients and families receive a timely and appropriate response. Since 2021, the process had been mapped and revised in respect of formal and informal concerns, all concerns are triaged, concern tracking implemented, concerns management training in place, letter templates standardised, governance leads in place for each Service Group, the Corporate Concerns Team structure has been reviewed, and performance monitoring implemented. By March 2022, an increasing number of concerns were being managed by the service as enquiries with a concurrent reduction in formal concerns. A single point of contact for those raising concerns was introduced and compliance for sending acknowledgment letters within timescale was 90-100%. Since March 2022 the template letters have been further enhanced to reflect PTR regulations; RLDatix is utilised to record and manage concerns (the excel trackers have been discontinued eliminating duplication); further training from PSOW is available for all teams; attendance is offered at service level meetings to raise the profile of concerns management; commissioned led concerns are appropriately recorded (avoiding duplication), and a continued increase in the number of concerns are managed as enquiries/early resolution. The compliance position in August 2022 showed a continued increase in number of concerns managed as enquiries/early resolution, a reduction in new formal concerns, and no open concerns older than 6 months.

	Current challenges include that the reduction in the number of formal concerns has significantly reduced and thus compliance will be more difficult to maintain; data integrity and reliability; appropriate grading of concerns, and concerns go out of compliance whilst waiting for final sign off. The Assistant Director of Quality and Safety explained that the data error had been discovered during the deep dive into Concerns Management. This had resulted in the identification of an additional number of concerns that are Nationally Reportable Incidents. *From the data it appears that the number of complaints is going down and compliance is also falling when it might be expected to improve. Is it known why this is happening?* The Assistant Director of Quality and Safety advised that the more straightforward issues are being dealt with informally which means there are proportionally more complex concerns which can take up to six months to resolve. This adversely affects the 30 day compliance measure. *Now the data is being entered on RLDatix will it be possible to show the complexity of concerns which affects the 30 day compliance measure?* The Director of Nursing and Midwifery confirmed that it would be possible to produce information on Key Performance Indicators such as response time, keeping in touch etc. It would also include information from English Trusts who do not work to the Welsh deadlines but have 60 days to respond. **Action: Director of Nursing and Midwifery** *Given an error was identified and corrected what level of confidence is there that the data is correct now?* The Assistant Director of Quality and Safety confirmed there was now full confidence in the data. The Director of Nursing and Midwifery advised that improvements were needed, and whilst it was necessary to quality assure the response letter this could not be allowed to impact on response times. This was a particular challenge. The CHC representative advised that a quarterly report on Advocacy was produced and offered to share the report with the Committee. The Chair welcomed this offer. **Action: Interim Head of Corporate Governance**

	The Integrated Quality Report was DISCUSSED and NOTED.
PEQS/22/42	**CLINICAL QUALITY FRAMEWORK UPDATE** The Director of Nursing and Midwifery presented the report outlining progress on implementing the Clinical Quality Framework since November 2021 and assessing the national context since the publication of the National Clinical Framework (March 2021), Quality and Safety Framework (September 2021), and the Health and Social Care (Quality and Engagement) (Wales) Act 2020 (coming into force March 2023). Work on this had commenced prior to the Covid-19 pandemic and whilst business as usual had been paused progress had been made as outlined in the Progress Report (Appendix 1). The next steps were outlined as follows: to develop and implement a coherent system that enables the health board to measure and monitor quality and performance; enabling quality improvement within the health board at a system level (informed by the citizen voice and patient experience); acknowledging and identifying the constraints within the health board to deliver that ambition and identifying risks and opportunities in the health boards preparedness for the Quality and Engagement Act. *Action 11 outlines that it is expected to take a year to implement the Civica Patient Experience System across all services in the health board. This seems to be rather a long time.* *Action 15 outlines that there is no resource to collect and produce patient stories. Why are teams from across the organisation not coming forward with such stories?* The Assistant Director – Innovation and Improvement advised that joint work was taking place with Swansea Bay University Health Board to train staff to capture stories for submission. The Director of Nursing and Midwifery noted that early engagement was as important as capturing feedback to embed co-production, but it is necessary to resource this.

	Whilst it is important to get these systems in place to assure patients as well as Board Members where does this fit into organisation priorities? The Director of Primary, Community Care and MH noted that there is a considerable amount of engagement at community and staff level taking place but there is no mechanism to capture these insights. It will be challenging for Board to deal with organisational priorities, and it will be necessary to ascertain where co-production best takes place. This could be in other fora such as the Regional Partnership Board or with Powys County Council in the Joint Partnership Board. *When will this be delivered, what is the project plan, and what happens if it is not delivered?* The Director of Nursing and Midwifery advised that it was expected there would be a stepped approach although there had been no outline of reporting requirements from Welsh Government to date. However, it is expected that it will be necessary to report on Duty of Candour conversations. Civica is in the implementation phase but the way that Civica is utilised will be most important. *It will be necessary to ensure that these strands are all properly interconnected, and Board will need to be sighted on this.* The Interim Board Secretary advised that a Board Development session was planned for the following week where short and longer term priorities would be discussed. The Clinical Quality Framework Update was DISCUSSED and NOTED.
ITEMS FOR DISCUSSION	
PEQS/22/43	There were no items for discussion.
BUSINESS CASES, SERVICE PLANNING PROPOSALS, WHOLE SYSTEM PATHWAY DEVELOPMENT AND RE-DESIGN	

PEQS/22/44	There were no business cases, service planning proposals, whole system pathway developments or redesigns.
ESCALATED ITEMS	
PEQS/22/45	**MATERNITY SERVICES ASSURANCE FRAMEWORK REPORT INCLUDING PROMPT WALES QUALITY ASSURANCE REVIEW** The Director of Nursing and Midwifery presented the report updating Committee on quality assurance matters in Maternity Services in Powys. It was confirmed that the current local escalation arrangements remain in place in response to three NRIS between February and May 2022. A further NRI has been reported since the last Maternity Assurance report to Committee. The team are working with the Perinatal Institute (PI) to ensure that the data to enable the detection of Small for Gestation Age babies is accurate. A number of corrective actions have been taken including staff training, data input for all Powys babies (including those captured via DGH obstetric services) and accessing benchmarking data. As part of the Welsh Government National Maternity and Neonatal Safety Programme a workshop was held on 7 July 2022 and on the 6 September 2022 a Safety Summit was held. The local Maternity/Neonatal Safety Lead post is out to advert. A local follow-up roundtable multi-disciplinary event will take place next week to identify actions needed as a result of the Workshop and Safety Summit. *What are the themes of the NRIs?* The Director of Nursing and Midwifery advised that two thirds of the NRIs related to gestational growth which has resulted in the work undertaken on Gap and Grow analysis. It should be noted that NRIs will always be seen in maternity. However, it was important to put the service into escalation to ensure that when an NRI occurred that the service would be able to investigate it. De-escalation of the service is not dependent on having no NRIs. However, when the initial three NRIs have been closed consideration will be given to de-escalation.

	Given the earlier conversations regarding data, have actions been taken to ensure that small for gestation babies are able to be identified? The Director of Nursing and Midwifery confirmed that the service was working with the PI to ensure that the data was correct. Two thirds of deliveries take place outside the health board area and data can be skewed if the provider is changed. The service is working with partner providers to ensure that the provider is not changed. Once the data is correct it will be possible to benchmark performance. *Do staff feel supported during this period of escalation?* The Director of Nursing and Midwifery confirmed that the approach had been a balance between assurance, accountability, and support. A new Head of Midwifery starts next week and proposals to de-escalate will take this into account. The Medical Director noted that the good care that is provided must not be lost sight of. The Chair requested that arrangements for de-escalation be included in the Maternity Assurance Report when appropriate. **Action: Director of Nursing and Midwifery** The Maternity Assurance Framework Report was DISCUSSED and NOTED.
ITEMS FOR INFORMATION	
PEQS/22/46	The WHSSC Quality and Patient Safety Committee Chair's Reports June and August 2022 were received.
OTHER MATTERS	
PEQS/22/47	**COMMITTEE WORK PROGRAMME** The updated Committee Work Programme was received.
PEQS/22/48	**ITEMS TO BE BROUGHT TO THE ATTENTION OF THE BOARD AND/OR OTHER COMMITTEES** The Chair noted that the matters discussed would be included in the Chair's Report to Board.
PEQS/22/49	**ANY OTHER URGENT BUSINESS**

	There was no other urgent business.
PEQS/22/50	**DATE OF THE NEXT MEETING** 24 November 2022, via Microsoft Teams.
	Under Section 1 (2) of the Public Bodies (Admission to Meetings) Act 1960 the following motion was passed: *Representatives of the press and other members of the public shall be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.*
PEQS/22/51	**MENTAL HEALTH SERVICES** The Director of Primary, Community Care and MH gave a detailed briefing to the In-Committee meeting on the current situation in Mental Health Services including caseloads and the national context. It will be necessary to review resourcing for the service considering a continued expected increase in demand for Mental Health Services as a result of the pandemic. Committee Members requested a further update as service plans are developed to be brought to the December 2022 meeting of the In-Committee. **Action: Director of Primary, Community Care and MH**

Key:

Completed
Not yet due
Due
Overdue

PATIENT EXPERIENCE, QUALITY & SAFETY COMMITTEE

ACTION LOG NOVEMBER 2022

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Minute	Meeting Date	Action	Responsible	Progress Position	Completed
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/21/32	2 Dec 2021	Requests for training to be considered as part of Board Development Programme	Interim Board Secretary	Discussion has been held regarding a PEQS specific training/development session to be developed to run when new members of the Committee are in place	
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	The Q1 update will be considered at the Infection Prevention Control (IPC) Group on 6 September. The issue is ongoing and is in the IPC Work Programme for 2022/23	
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	A response has been sent to the CHC addressing the learning identified	
PEQS/22/21	7 July 2022	Focus on clearing actions	Interim Head of Corporate Governance and Directors	Further detail on the source of actions has been provided to assist Directors to clear actions	
PEQS/22/31	7 July 2022	Discussion on development of risk register at future meeting of PEQS	Interim Board Secretary	This will be scheduled at the appropriate point in the development of quality and safety risks which is currently focussing on Directorate risk registers	
PEQS/22/41	13 Sept 2022	Add a further item to the Inspection Tracker regarding the HIW Inspection of Brecon MIU: 'Ensure that findings are not systemic across other areas within the wider organisation'. (p 31 of HIW report)	Director of Primary, Community Care and MH	This has been actioned and completed	
PEQS/22/41	13 Sept 2022	The Director of Nursing and Midwifery and Chair of Workforce and Culture Committee to meet to discuss cross committee culture issues	Director of Nursing and Midwifery		

PEQS/22/41	13 Sept 2022	Key Performance Indicators to be developed for inclusion in the Integrated Quality Report	Director of Nursing and Midwifery/Director of Therapies and Health Sciences/Medical Director		
PEQS/22/41	13 Sept 2022	The quarterly CHC Advocacy report be circulated to Committee Members	Interim Head of Corporate Governance	Provided and circulated to Committee	
PEQS/22/	13 Sept 2022	Maternity de-escalation arrangements to be reported to Committee	Director of Nursing and Midwifery	A report to the meeting on 24 November 2022 addresses this	
PEQS/22/	13 Sept 2022	A further report on Mental Health Services to be brought to the December 2022 Committee meeting	Director of Primary, Community Care and MH	This update will now come to the February 2023 Committee meeting	

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 2.1

Patient Experience and Quality Committee	**24 November 2022**
Subject:	**Integrated Quality Report**
Approved and Presented by:	Claire Roche, Executive Director of Nursing & Midwifery
Presented by	Claire Roche, Executive Director of Nursing & Midwifery
Prepared by:	Zoe Ashman, Assistant Director Quality & Safety
Other Committees and meetings considered at:	Executive Committee 16 November 2022

PURPOSE:

The purpose of this report is to provide the Patient Experience and Quality Committee on the 24 November 2022 with an overview of the Quality & Safety agenda across the Health Board.

RECOMMENDATION(S):

The Patient Experience and Quality Committee are 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 the Patient Experience and Quality Committee with an update on the quality and safety agenda for Powys Teaching Health Board (PTUHB).

2 Specific matters for consideration by this meeting (Assessment)

2.1 Implementation progress Quality & Engagement Act (2023)

The Health and Social Care (Quality and Engagement) (Wales) Act ('the Act') became law on 1 June 2020 with its full implementation to be completed by spring 2023. The Act aims to:

- support an ongoing, system-wide approach to quality improvement within the NHS in Wales.
- further embed a culture of openness and honesty.
- help drive continual public engagement in the design and delivery of health and social care services.

The Act reframes and broadens the existing duty of quality on NHS bodies and places an overarching duty on Welsh Ministers in relation to their health functions. It aims 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.
- The appointment of Vice Chairs for NHS Trusts bringing them in line with Health Boards.

The Duty of Quality requires NHS bodies and Welsh Ministers to exercise their functions in a way that considers how they improve quality and outcomes on an on-going basis in the services they provide.

Additionally, the Duty seeks to strengthen governance arrangements by requiring NHS bodies and Welsh Ministers to report annually on the steps they have taken to comply with the Duty and assess the extent of any improvement in outcomes that have been achieved.

This statutory guidance helps NHS bodies and Welsh Ministers to deliver the requirements of the Duty. It sets out a national approach that needs to be locally implemented. The guidance has been co-developed with representatives of NHS bodies and Welsh Government. It has also been informed by feedback received through stakeholder workshops and formal public consultation.

A consultation period commenced in October 2022 and closes in January 2023.

The Health Board have several actions which include:

- Executive team readiness assessment completed September 2022
- Implementation action plan **(Appendix 1)**
- Representatives from WG implementation team to attend informal executive meeting December 2022
- Explore the organisational infrastructure for implementation

2.2 Once for Wales Content Management System (RLDatix)

The implementation of the Once for Wales Content Management System (OFWCMS) is complete. However, this excludes the final risk module as this has been delayed for implementation due to the national work required. This is expected to be deployed in April 2023.

With the support of the central team at Welsh Risk Pool (WRP), updates to the organisational hierarchy within RLDatix for the Health Board has been undertaken in August 2022 and this work remains on-going. Therefore, the committee is advised to note that data integrity from RLDatix cannot be guaranteed until this work is complete.

In preparation for 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.

2.3 Supporting learning and improvement

The Learning & Development group is supported by all Clinical Directors and their teams. There is collective agreement within the membership that this structure will be supported by the incident management process, facilitating the implementation of a total quality management system, as described in the Quality and Engagement Act

A Quarterly Newsletter has been produced during Q3 **(Appendix 4)** informed by learning identified through the learning and Development group. This was well received by the Executive Committee on the 16 March with constructive comments for development of the newsletter articulated.

To support staff to understand the principles of a learning culture, investigation training commenced in September 2022 with a structured delivery plan in place until the end of the financial year. The focus of the training includes:

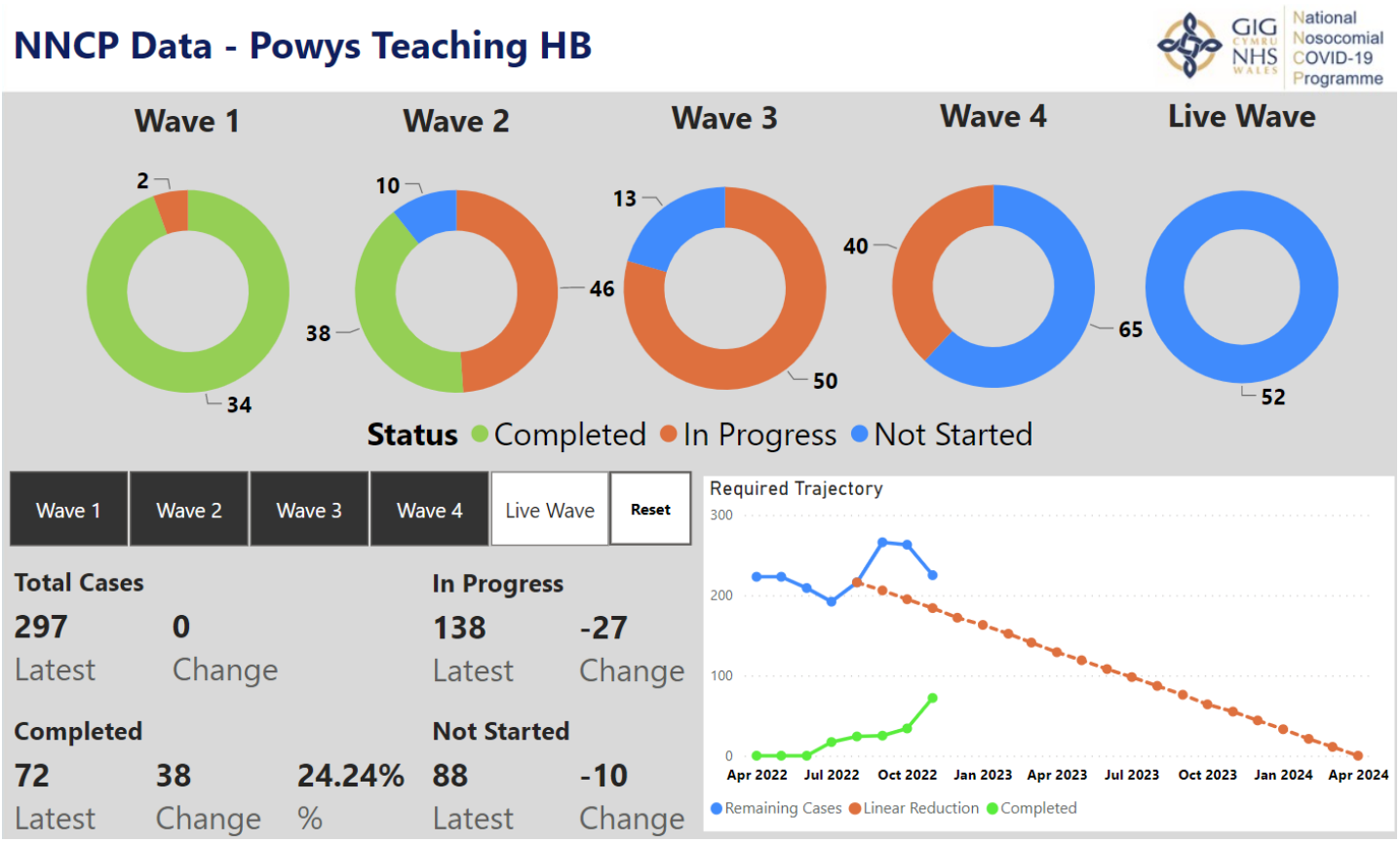
- Psychological Safety
- Human Factors
- RCA Investigation and report writing
- SMART action planning

Training has been well received by Health Board colleagues with all 74 places being filled. Initial feedback when attendees were asked what was most helpful is shown below:

2.4 National Nosocomial Framework

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 the Putting Things Right Regulations (PTR) apply.

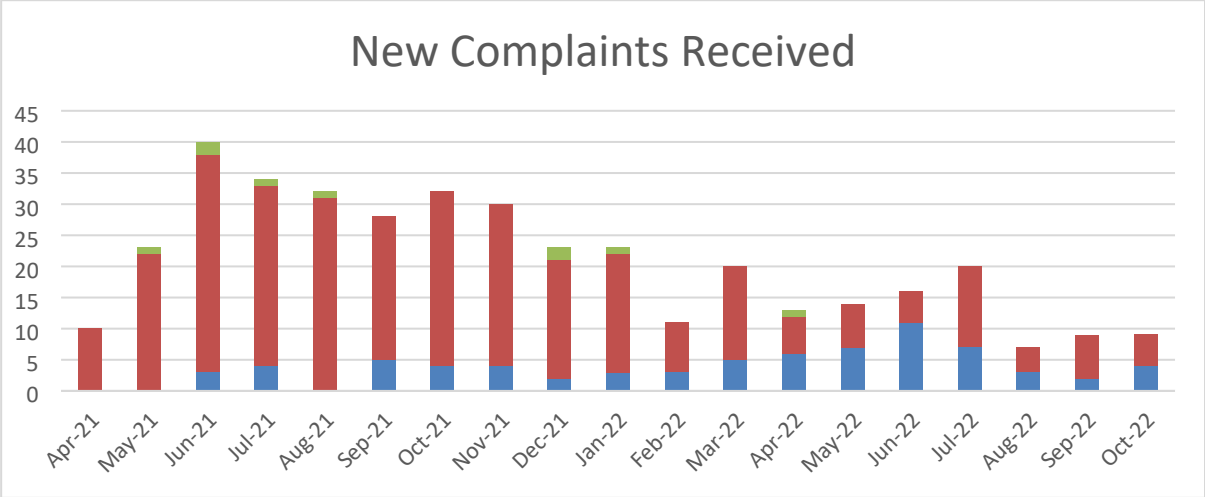
To date, the Health Board has not received any concerns from families or patients affected by nosocomial transmission of Covid-19, no identified cases where severe harm or death have occurred have been identified thus far and therefore, duty of candour conversations with patients and/or families have not been required. Progress is demonstrated in data capture below as monitored by the programme.



2.5 Putting Things Right – Concerns

The number of concerns received continue to demonstrate a reduction during Quarter 1 & 2 and into Quarter 3. Teams are proactively managing concerns at source before they are escalated to the concerns team for formal management. Graph 1 demonstrates the number of concerns received by month.

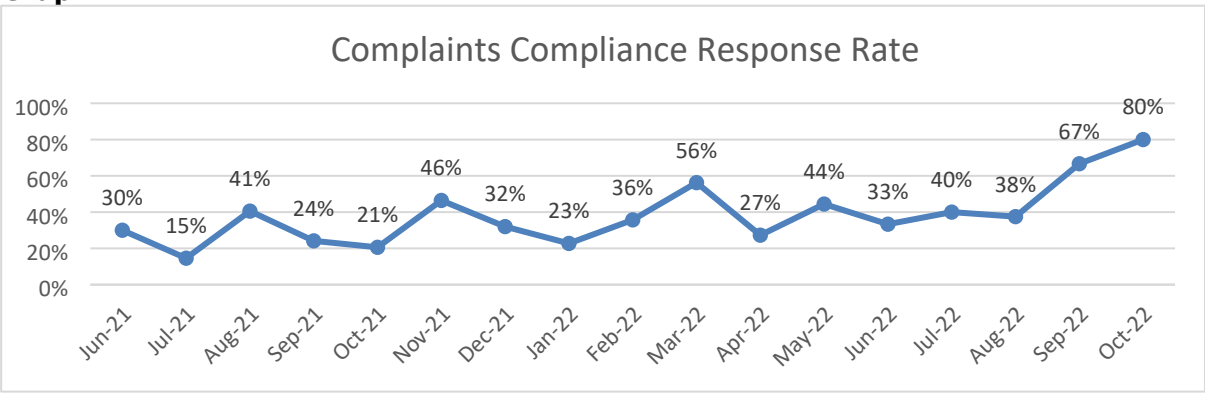
Graph 1



Source: Incidents Module OFWCMS RLDatix system

Significant progress has been made with the management and compliance of formal concerns within 30wd response time (Graph 2). However, it is recognised and acknowledged that continuation of the improvement journey is key to sustained improvement.

Graph 2



Source: Incidents Module OFWCMS RLDatix system

The top 3 themes of formal concerns are:

- Access to services, clinical treatment/ assessment
- Communication: Level of communication from staff regarding patient care and treatment, failure to communicate in a timely manner, lack of robust detail and understanding.
- Delays: Patients waiting longer than expected for appointments, delay in discharge, delay in transfer.

2.6 Public Service Ombudsman for Wales (PSOW)

The Health Board position for 2021/22 with complaints escalated to the PSOW is as below:

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

Our current position as of the 20 August 2022 is as follows:

Open Enquiry	Not Upheld	Partially Upheld	Advice Given	Total
4	12	1	1	18

Given the significant work undertaken by the Health Board to close concerns during 2021/22, several of which did not meet the required PTR timescale, this may have impacted the increased number of referrals to PSOW during 2022/23.

Recommendations from the PSOW office have included.

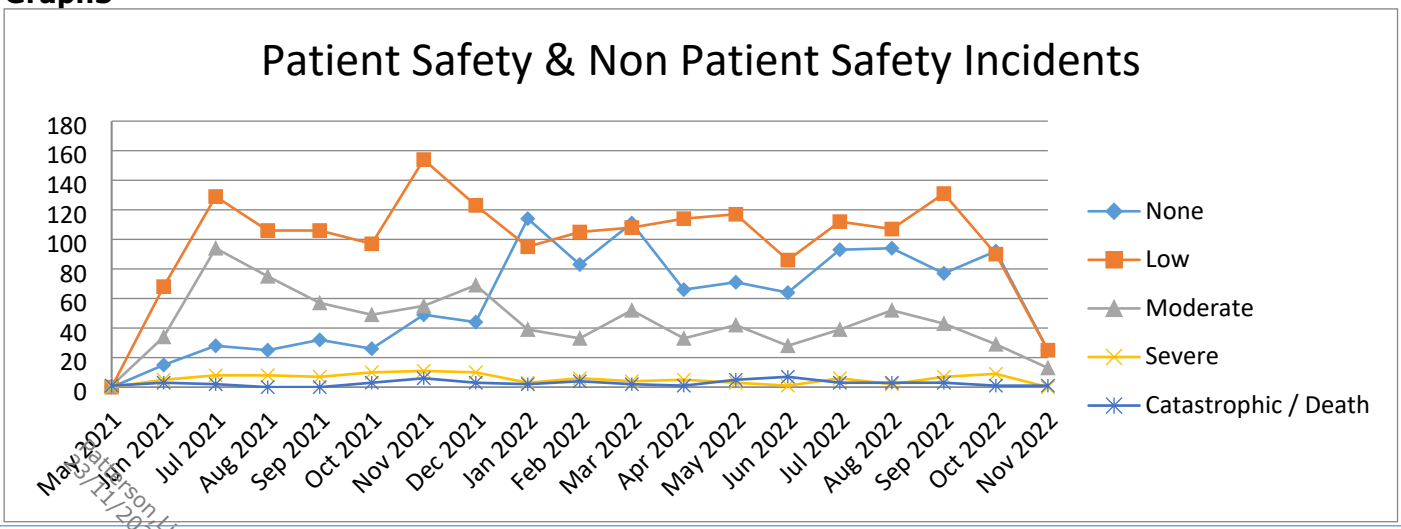
- Improvements to the concerns management process
- Improved communication with complainants during the concerns process

These recommendations are acknowledged and included within our current action plan for improvement with PTR compliance.

2.7 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.

Graph3



The highest reported incident themes during Q2:

- Pressure or moisture damage (n184)
  Action: All grade 3 pressure ulcers and above are reviewed through the multidisciplinary scrutiny panel process for wider organisational learning and improvement.

- Slip, trip or fall (n179)
  Action: Planned implementation of a fall's scrutiny panel during the next quarter is anticipated to assess the themes and trends of falls to inform improvements required within the falls framework. This work will be further supported through the Safe Care Collaborative quality improvement project guided by Improvement Cymru & IHI.

- Behaviour (including violence & aggression) (n156)
  Action: Deep dive to review themes and trends of reporting

2.8 Early Warning Notifications (previously No surprises notifications)

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

2.9 Nationally Reportable Incidents

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

Reported period	Number open in time	Number open overdue	Number awaiting final approval	Closed	Total
Q1	**6**	**0**	**11**	**0**	**16**
Q2	**4**	**2**	**3**	**8**	**17**
Current	**2**	**5**	**2**	**0**	**9**

The themes for learning and improvement include:
- Standards of record keeping
- Clinical Guidelines not followed or not present

3. Patient Experience

For this reporting period a separate Patient Experience Paper will be presented for discussion at the Committee.

4. Mortality Reviews

The Medical Examiner service continues to roll out in Powys Community Hospitals. The service is embedded in Brecon, Bronllys and Ystradgynlais. The roll out has been smooth and will shortly be extended to Machynlleth and Llandindrod Wells. It aims to be implemented on all sites by the end of March 2023. In the meantime the cases of all patients who have died in Powys continue to be reviewed by the Health Board senior team mortality reviews.
Roll out of the Medical Examiner service to patients who have died at home will follow in 2023-24.

Health Board reviews

For the latest round of mortality reviews 118 cases were reviewed. The standard of care was generally good with examples of excellent documentation and decision making.
Four cases have been identified for part 2 review. These are scheduled to take place shortly. The queries do not represent significant concern.
Formal discussion around learning is scheduled to take place in learning group. Themes will be identified and appropriate methods of cascading learning will be agreed.
In addition to identifying any areas of clinical concern the reviewers were asked to comment on specific areas of the clinical notes. The results are given below.

a) The use of the All Wales Care Decisions for the Last Days of Life documentation pack (LDL pack).

The reviewers found that the LDL pack was used in 39% of the cases reviewed.
There was significant site-to-site variation however. Work will continue to improve awareness and use. It is also audited nationally so that progress will be monitored.

b) The use of Do Not Attempt Cardio-Pulmonary Resuscitation orders (DNACPR)

DNACPR orders were found to be in place for 97% of patients. There was no site-to-site variation.
Detail is included in the clinical audit report.

c) Use of Treatment Escalation Plans. These are formal plans recorded in the notes to inform staff about what actions should or should not be undertaken in the event of the patient's condition changing.

The reviewers found that 71% of patients had a Treatment Escalation Plan in place. Although this figure has not been formally recorded previously it is felt that this represents a significant improvement on previous rounds of the review. Site-to-site variation remains significant. Awareness in the importance in use of the documents has been raised in several forums. This will continue and progress will be monitored.

As the mortality review process is superseded by the Medical Examiner process, these areas will be reviewed in standalone clinical audits.

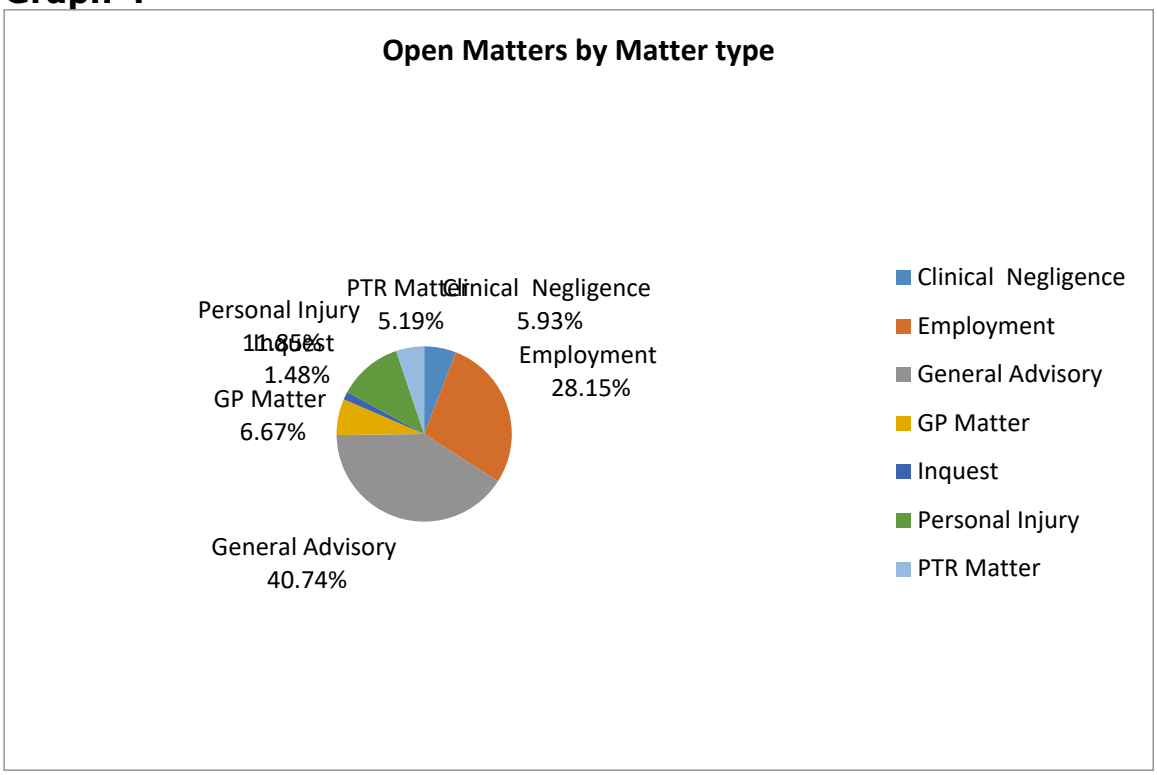
Finally the reviewers were asked to comment on the overall quality of the notes commenting on whether the notes were clear, comprehensive and logically ordered.

70% of the notes were scored as good by the reviewers with a further 23% being regarded as satisfactory. 7% of notes were flagged as unsatisfactory due to missing items or being generally disordered.
A standard format for filing notes has been agreed as part of the Medical Examiner roll out. In addition the use of the Welsh Clinical Nursing Record standardises the recording of information.

5. Claims and Redress
There are currently 12 redress files open, 4 of which are awaiting final settlement. Redress Panels take place as and when required and where appropriate Legal & Risk are instructed. Currently all Redress claims that require reimbursement from Welsh Risk Pool (WRP) have been successfully completed and reimbursement achieved.

Legal and Risk services are instructed and support a number of legal matters for the Health Board which are demonstrated in Graph 4.

Graph 4



Further information can be found in **Appendix 2** (Welsh Risk Pool and Legal & Risk Services annual report 2021/22) and **Background Paper 1** (PTHB case breakdown).

4.1 Inquests

During Q2 there have been 5 HM Coroner enquiries opened, 1 case closed with 18 remaining open.

5. Health and Social Care Inspections Regulatory Recommendations

5.1 Health Inspectorate Wales Inspections

There were no new inspections during this reporting period.

HIW Annual report 2021/22 **Appendix 3**.

5.2 Health and Social Care Regulatory Reports

There were 7 outstanding actions noted in the previous report, 3 of which have been closed and 4 remain outstanding from 2017-2020. Updates against these are provided below:

Unannounced visit to Clywedog Ward	The health board must provide additional storage space on the ward.	Work is being undertaken by the clinical lead for Q&S as part of a health board wide project regarding storage.
Unannounced visit to Clywedog Ward	The health board must ensure that sufficient resources are provided to facilitate the timely processing of DoLS referrals.	July 2022 the DoLs demand continues to exceed PTHBs capacity to satisfy it. Funding from Welsh Government received to support the implementation of the new Liberty Protection Standards (LPS) which will replace DoLS
HIW Review of Healthcare Services for Young People	Health boards must ensure that children and young people can consistently be treated within designated areas.	Discussion on adult OPD environment with scheduled care managers held, consideration given to move some OPD clinics to children's centres- currently being reviewed re capacity and staffing.
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.	Benchmarking against "let me flourish" report 2021 is being undertaken by the Startwell Complex Needs workstream in addition to this being progressed through PTHB transition guidance group

5.3 Community Health Council

There have been no recent visits by the Community Health Council. Please note in **Background Paper 2** Advocacy report provided by the CHC.

Appendices:

Appendix 1: Duty of Quality, Duty of Candour implementation Action Plan
Appendix 2: Welsh Risk Pool Services and Legal & Risk Services annual Report 2021/22
Appendix 3: HIW Annual Report 2021-22
Appendix 4: Learning Newsletter

Background papers:

Paper 1: PTHB L&R Services Provided
Paper 2: CHC Advocacy Report

6 KEY MATTERS FOR BOARD/COMMITTEE

6.1 Timely management of incidents is required to ensure appropriate action is taken. Members are asked to note that whilst there are a significant number of unmanaged incidents 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 incident in a timely manner.

6.2 Implementation of a quality data dashboard is a priority to ensure robust reporting and assurance to board and committee.
ACTION: Work continues to ratify the requirements of a quality dashboard in line with developments within RLDatix.

6.3 Robust framework is required to ensure the requirements of the Quality & Engagement Act are realised.
ACTION: An implementation plan is being developed to further inform the resource and structures required to enable implementation. Powys Teaching Health Board have responded to Welsh Government request for this as a result of the Duty of Quality consultation.

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**
Age	√				
Disability	√				

Gender reassignment	√				***Please provide supporting narrative for any adverse, differential or positive impact that may arise from a decision being taken***
Pregnancy and maternity	√				
Race	√				
Religion/ Belief	√				
Sex	√				
Sexual Orientation	√				
Marriage and civil partnership	√				
Welsh Language	√				

Risk Assessment:

	Level of risk identified				
	None	**Low**	**Moderate**	**High**	**Statement**
Clinical	√				Reputational risk if no improved compliance with Welsh Government performance for management of concerns.
Financial	√				
Corporate	√				
Operational	√				
Reputational			√		

/

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

APPENDIX 1

Preparation for the Duty of Quality and Duty of Candour
Powys Teaching Health Board Self-Assessment Tool

Recommendation	Action needed	Progress & Evidence	Monitoring Arrangements (State HB group where progress is reported)	By who	Deadline date for completion (Use traffic light system to indicate status) & insert date of completion
1. **Executive leadership:** PTHB representations for implementation board/Candour/Quality	EDoN attend implementation Board ADQ&S attend Candour Board MD attend Quality Board	Decision to be taken by Executive Team to confirm membership	HB Implementation Group	EDoTH & AHP to chair this group	October 2022
2. **Local Implementation Group to be established**	EDoTH to chair Membership inclusive of EDoN, MD and ADQS, membership inclusive of all directorates	To be endorsed by executive team	Executive Committee	CEO	November 2022
3. **Infrastructure:** Establish a HB Quality governance infrastructure with robust oversight and	Identified objective in the HB implementation plan overseen by PTHB local implementation group. Review all structures to ensure the Quality &	To be endorsed by executive team	HB Implementation Group	EDoTH & AHP to chair this group	March 2023

Recommendation	Action needed	Progress & Evidence	Monitoring Arrangements (State HB group where progress is reported)	By who	Deadline date for completion (Use traffic light system to indicate status) & insert date of completion
reporting from service group to Board	Engagement Act is considered in all meetings/reports/assurance/ improvement considerations				
4. **Policy and Procedure**: Ensure a framework is in place to review existing policies to ensure the Duty of Quality & Duty of Candour are reflected within	Identified objective in the HB implementation plan overseen by PTHB local implementation group	To be endorsed by executive team	HB Implementation Group	EDoTH	March 2023
5. **Resources**: Scope the requirements of the Duty of Quality & Duty of Candour	Review the HB implementation plan to review the recourse requirements that may be required to support robust implementation.	Consideration has been given for additional resource inclusive of: Administrative support, Management, training/education facilitation	HB Implementation Group	EDoTH	February 2023
6. **Awareness and Training**: Ensure there is a plan in place asses training requirements	Ensure Training Needs Analysis (TNA) is completed for all teams to ensure appropriate training plan can be implemented.	Not Commenced	HB Implementation Group	EDoTH	February 2023

Recommendation	Action needed	Progress & Evidence	Monitoring Arrangements (State HB group where progress is reported)	By who	Deadline date for completion (Use traffic light system to indicate status) & insert date of completion
within all departments					
7. Primary Care - Engagement of your Primary and Community Care Teams will be of critical importance as these duties apply to all Primary and Community Care providers.	Ensure nominated leads are in place to attend National and HB meetings/working groups.	Primary care attendance in National working groups. Attendance at HB Implementation Group	HB Implementation Group	EDoTH	February 2023

Status of action:

GREEN	Complete
AMBER	In progress
RED	Missed deadline for completion - escalate

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Healthcare Inspectorate Wales
Annual Report 2021-2022

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

Our purpose

To check that people in Wales receive good quality healthcare.

Our values

We place patients at the heart of what we do.

We are:

- **Independent**
- **Objective**
- **Caring**
- **Collaborative**
- **Authoritative**

Goal

To encourage improvement in healthcare by doing the right work at the right time in the right place; ensuring what we do is communicated well and makes a difference.

Through our work we aim to:

Provide assurance

Provide an independent view on the quality of care.

Promote improvement

Encourage improvement through reporting and sharing of good practice.

Influence policy and standards

Use what we find to influence policy, standards and practice.

Page 4

Foreword

Welcome to our Annual Report for 2021-2022, a year which continued to be unpredictable and with significant ongoing challenges in both healthcare, and daily life

Page 7-12

Priority 1

To maximise the impact of our work to support improvement in healthcare

Page 15-62

Priority 2

To take action when standards are not met

NHS Health Boards and NHS Trusts

Page 64-65

Priority 3

To be more visible

Collaboration and joint working with other organisations is an integral part of the way in which we work

Page 66

Priority 4

To develop our people and our organisation to do the best job possible

Although the last year has been one of significant change, we have continued to invest in the development HIW

Foreword

Alun Jones
Chief Executive

“I once again commend the strength and resilience shown by staff working at all levels within healthcare services, who continue to deliver care and treatment in the best way they can, despite the many challenges they face daily.”

Welcome to our Annual Report for 2021-2022, a year which continued to be unpredictable and with significant ongoing challenges in both healthcare, and daily life.

Healthcare services continued to be under intense pressure from the impact of the COVID-19 pandemic and our role has been crucial in supporting the delivery of safe healthcare for the people of Wales. Our core purpose of checking the quality and safety of healthcare services did not change, and we continued to adapt our processes and approach to work in response to the ongoing unprecedented situation.

The report sets out our key findings from the regulation, inspection and review of healthcare services in Wales. It outlines how we carried out our functions and the number of inspections and quality checks we undertook across Wales.

Change and flexibility have been key features of life since March 2020 and as an organisation we have learned much about how and where our work can add value to the healthcare improvement agenda. Through this report we will offer an insight into our work over the 12-month period, outlining how we adapted and used our resources most effectively to deliver our work and support improvement. This involved continuing with quality checks which we introduced earlier in the pandemic and enabled us to gain assurance remotely. We worked collaboratively with others to harness insight and understanding, building on lessons learnt. We also used new styles of reporting which enabled us to share our findings quickly to enable healthcare services to take improvement action more quickly.

In a year which has seen healthcare services work hard on recovery from the early days of the pandemic, to restore services which had been paused, whilst continuing to deal with emerging variants, outbreaks and further peaks of COVID-19, we have seen significant turbulence. I once again commend the strength and resilience shown by staff working at all levels within healthcare services, who continue to deliver care and treatment in the best way they can, despite the many challenges they face daily.

Senior managers leading services have demonstrated tenacity and ability to continue innovating and supporting their organisations. Staff working on the front line have continued to demonstrate their compassion and resilience, as once again, patients have told us of their positive experiences of staff despite highly challenging circumstances.

It is clear that there remain many challenges ahead, for services, for the staff who work within them and for the people of Wales whilst the gargantuan task of service recovery continues. For healthcare organisations, it will be staff who will be the key to the success of this recovery. Supporting staff wellbeing, continuing to invest in training and support services for them and continuing to innovate within existing service delivery will be key to the effective recovery of staff and services from the fatigue brought on by the pandemic.

The year in question reflects a time when we worked on the commitments we made in our one year Strategy and Operational plan. We made good progress in meeting the achievements we set out to deliver. I am proud to have continued leading the organisation through this time, working daily alongside a team of professional and committed staff who work hard to support the organisation as we deliver our vision of improving healthcare for the people of Wales.

In March 2022, we published our new and ambitious strategy, and we are fully committed over the next three years, to implementing and delivering our new priorities which further our aim to drive improvement in healthcare.
We will continue to use our role to encourage improvement in healthcare, building on the best of what we have done to date to deliver the greatest impact.

If you have any questions, comments, ideas or feedback on our work, please do get in touch with us – we would love to hear from you.

Alun Jones
Chief Executive, Healthcare Inspectorate Wales

Overview

Our 2021-2022 Strategic Priorities:

1. To maximise the impact of our work to support improvement in healthcare
2. To take action when standards are not met
3. To be more visible
4. To develop our people and our organisation to do the best job possible

For HIW, as for many healthcare services and organisations, it was a year of continued and significant change, where we had to adapt to ensure that we continued to check that people in Wales were receiving good quality healthcare. We introduced new ways of working to ensure we discharged our statutory functions, whilst being as flexible and adaptable as possible to ensure we did not add undue burden to a system already under significant pressure following the COVID-19 pandemic.

We continued with a full range of assurance and inspection activities, building on our enhanced ways of working, allowing us take action where standards were not met but to also support a broader recovery of healthcare services. During the year, we kept our activity under regular review to ensure that we targeted our resources most effectively. We operated responsively, with our work underpinned by our strategic priorities. This report describes our progress against these priorities as we aim to drive improvement and promote quality in healthcare services across Wales.

To maximise the impact of our work to support improvement in healthcare

HIW has an ongoing programme of national and local reviews which helps us to evaluate how healthcare services in Wales are delivered.

Local reviews are pieces of work which explore an aspect of one organisation or region, whilst **national reviews** explore healthcare services across Wales.

National and Local Reviews

COVID-19 National Review - How healthcare services across Wales met the needs of people and maintained their safety during the pandemic

The purpose of our COVID-19 review was to understand how healthcare services across Wales met the needs of people and maintained their safety during the pandemic. We also considered how services managed their environments of care, infection prevention and control measures, and how the physical and mental well-being of staff was supported.

A key theme to have emerged from our review was the need for healthcare services to further strengthen their infection prevention and control arrangements to mitigate the risk of cross infection or further outbreaks of COVID-19. In addition, the arrangements for supporting and maintaining the physical and mental well-being of staff required attention and focus as healthcare services continued through the recovery phase of the pandemic. However, in general, our review found the quality of care being provided across Wales was good and was delivered by hugely committed and dedicated groups of staff.

National Review of Mental Health Crisis Prevention in the Community

The focus of our review was to understand the adequacy of the measures in place across Wales, to help mental health crisis being prevented in the community, through timely and appropriate care. We considered the experiences of people who accessed care and treatment to support their mental health and prevent crisis. In addition, whether the services provided were safe and effective, and how healthcare teams worked collaboratively throughout the community to help prevent mental health crisis. Furthermore, we explored how third sector organisations support this.

Our review found challenges across Wales inhibiting the ability of people to access timely support for their mental health, which could increase the risk to their safety (or to others) and may result in hospital admission.

Key findings included inefficiencies in process, particularly for direct referrals where patients were caught in a cycle of continually accessing GP services to re-commence the referral process. This resulted in individuals experiencing lengthy waiting times and a lack of support for their mental health. HIW's review urged health boards to consider how they can address this gap in provision, strengthening the engagement between GPs and other primary and community care services and secondary mental health services. The review did find healthcare staff were committed and dedicated to providing support and care to people with mental health needs.

HIW noted several positive initiatives across Wales, including the implementation of a single point of access. Where this was in place, it ensured that specialist mental health professionals were available to provide clinical triage, onward referral, and effective signposting to individuals in crisis. HIW made a recommendation that health boards must ensure that single point of access services are implemented across Wales and are accessible to all those experiencing mental health crisis.

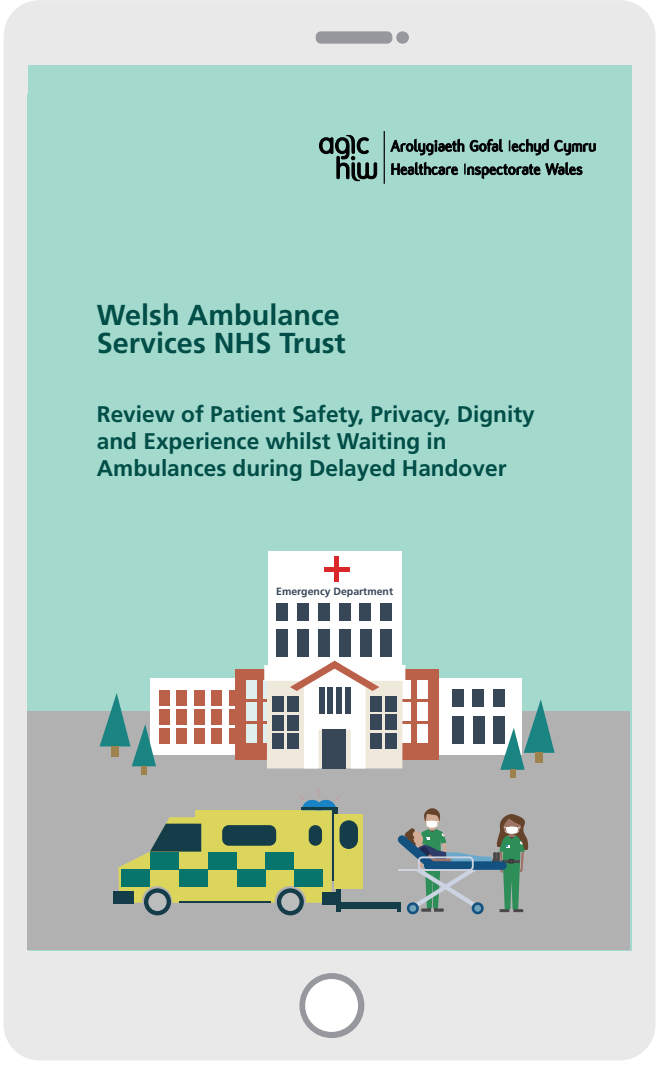
Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances During Delayed Handover

Our review found that the issue of prolonged handover delays is a regular occurrence with ambulance wait times outside Emergency Departments (EDs) across Wales. The delays and variations in process between and within health boards was having a detrimental impact upon the ability of the healthcare system to provide responsive, safe, and dignified care to patients.

Whilst there are expectations and guidance for NHS Wales to follow, and a clear will to meet these guidelines, there are substantial challenges to achieve timely patient handover across Wales which inhibit efforts to consistently achieve these. The challenges are indicative of the wider patient flow issues across all hospitals. Our review team found some inconsistencies and a lack of clarity between the Welsh Ambulance Services NHS Trust (WAST) and ED staff about responsibility for patient care, until transfer of care to health board teams. These types of inconsistencies were increasing risk and having a detrimental impact on patient care and safety.

Patients were generally positive about their experiences and provided good feedback about ambulance crews and ED staff, however, this should not detract from the issues associated with delayed handover.

A significant amount of work is already underway across NHS Wales to tackle these issues. Progress has been made in some areas, and improvement work is ongoing between WAST, health boards and Welsh Government to meet these challenges.

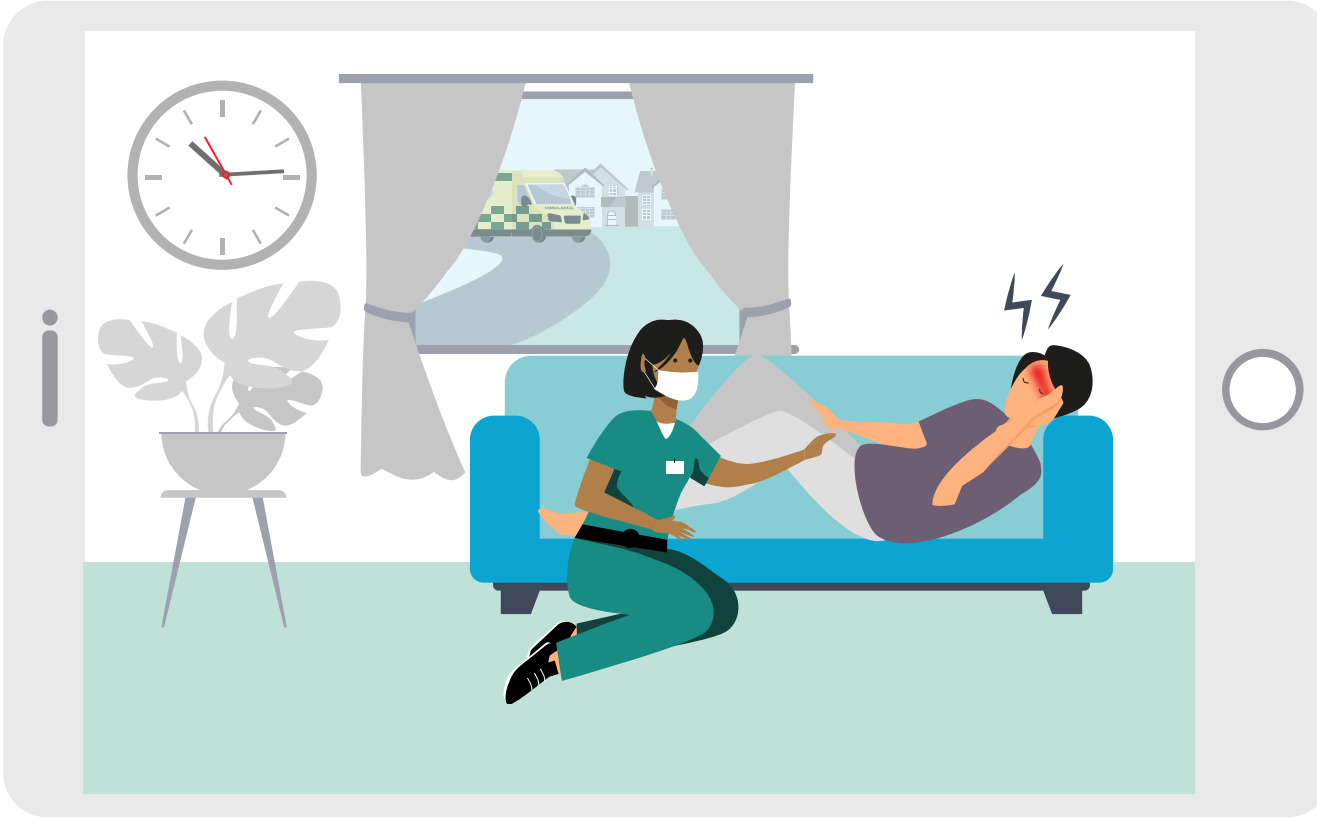


Current Ongoing Reviews

National Review of Patient Flow (Stroke Pathway)

Ineffective and inefficient patient flow can have a significant impact on the quality and safety of patient care. As a result, we decided to undertake a national review of Patient Flow. In order to assess the impact of patient flow challenges on the quality and safety of patients awaiting assessment and treatment, we elected to focus our review on the stroke pathway. We want to understand what is being done to mitigate any harm to those awaiting care, as well as understand how the quality and safety of care is being maintained throughout the stroke pathway.

The planning of the review commenced in autumn 2021, and the field work began in March 2022. Throughout our review we will consider how NHS Wales addresses peoples' access to acute care at the right time and if care is received in the right place, by people with the right skills, through to timely discharge from hospital services. We want to understand what is being done to mitigate any harm to those awaiting care, as well as understand how the quality and safety of care is being maintained throughout the stroke pathway. We aim to publish the review report during winter 2022-2023.



Review of Discharge Arrangements for Adult Patients from Inpatient Mental Health Services in Cwm Taf Morgannwg University Health Board

We made the decision to undertake this review following our assessment of a range of information sources which indicated significant concerns around mental health services within Cwm Taf Morgannwg University Health Board (CTMUHB). We commenced the review in January 2022 which will progress into late summer and the report will be published later in 2022. The focus of the review is to explore the quality and safety of discharge arrangements of adult patients from inpatient mental health units, back into the community.

Local Review of the Quality Governance Arrangements in Place within Swansea Bay University Health Board (SBUHB) for the delivery of Healthcare Services to Her Majesty's Prison (HMP) Swansea

We decided to undertake a review of the effectiveness of Swansea Bay University Health Board's quality governance arrangements for the provision and oversight of healthcare services in HMP Swansea.

The review assessed the actions taken by the health board to address the issues highlighted following previous inspections by Her Majesty's Inspectorate of Prisons, which we contributed to, and how effective the health board's quality governance arrangements are regarding prison healthcare. Our review concluded that the health board's quality governance arrangements do not adequately support the delivery of good quality, safe and effective healthcare services to the population of HMP Swansea.

We identified a need to strengthen these arrangements and raise the profile of prison healthcare within the health board to ensure that the quality of prison healthcare is designed, delivered, and monitored effectively. The review report details our findings and recommendations for improvement within several areas of the health board and Prison Partnership Board.

HIW recommended that prison healthcare, including the quality of the service, needs to feature more prominently on the health board's quality agenda, so that safe, effective care can be provided to the prison residents.
HIW asked the health board and Prison Partnership Board to carefully consider the findings from this review and act upon the recommendations set out within the report.

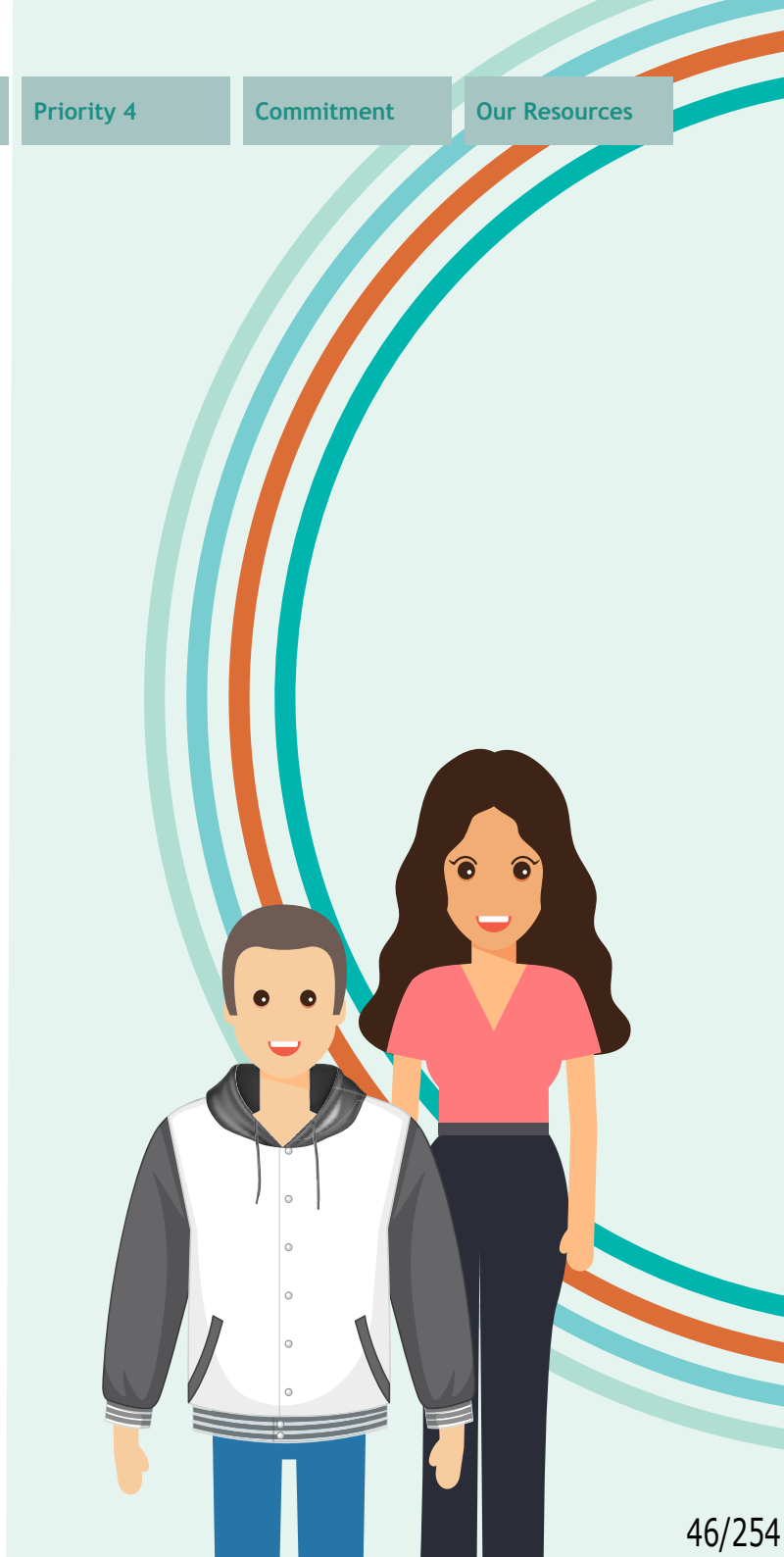
HIW continue to work with the health board to ensure improvements are made in a timely manner and will monitor the progress made. The report was circulated to other health boards to share lessons learnt, and to consider the findings against their own quality governance arrangements.

Joint Inspection of Child Protection Arrangements (JICPA)

During 2021, we worked jointly with four other inspectorates on a second pilot review of child protection arrangements. The review was undertaken in the Neath Port Talbot local authority which is situated within Swansea Bay University Health Board. It was led by Care Inspectorate Wales (CIW), and included HIW, Estyn, Her Majesty's Inspectorate of Constabulary and Fire & Rescue Service and Her Majesty's Inspectorate of Probation.

The focus of the review was to explore the arrangements in place for the multi-agency response to children at risk of criminal and sexual exploitation. On completion of the review, we identified several key strengths across the multi-agency partnership in relation to processes, structures and relationships which helped to facilitate effective partnership working where a child was at risk of exploitation. We also identified areas for improvement throughout the review, which included the need to strengthen contextual safeguarding, and the need to reduce the waiting times for Children and Adolescent Mental Health Services (CAMHS) assessment following referral.

In the last quarter of 2021-2022, HIW, CIW and Estyn submitted a joint business case to Welsh Government to secure additional funding to continue the JICPA work, to enable us to review processes within a further four local authorities across Wales. As part of the plan, we would complete work in six further local authorities and evaluate all JICPA reviews undertaken to produce a national report, which would be published in summer 2024 once all work is complete. A provisional agreement is now in place for the funding early in quarter one of 2022-2023.



To take action when standards are not met

We are responsible for inspecting, reviewing, and investigating NHS services and independent healthcare services throughout Wales. We inspect NHS services and regulate independent healthcare providers against a range of standards, policies, guidance and regulations to highlight areas requiring improvement. When through our work we find this is not the case, we will take action so that health boards and their services know where they need to make improvements.

Service of Concern process introduced for NHS Bodies in Wales

One of the key priorities set out within our strategic plan was to take action when standards are not met. In line with this priority and wishing to increase transparency about how we discharge our role in providing assurance to the public regarding the quality and safety of healthcare services, we introduced a Service of Concern process for the NHS in November 2021.

This process is used when we identify significant service failures, or when there is an accumulation of concerns about a service or setting. The intention of the process is to support improvement and learning, both for the service in question, and across NHS services more broadly. Our escalation and enforcement process for independent healthcare currently utilises such a process.

The process may lead us to make a Service Requiring Significant Improvement designation. This enables us to plan and deliver future activities necessary to gain assurance about the quality and safety of care by a service. We then work with the health board and services to ensure improvements and effective actions are made in a timely manner. We will then consider and review whether the service can be de-escalated and removed from the process.

This process enables a range of stakeholders including health boards to take the rapid action necessary to ensure safe and effective care can be provided to people. The Service of Concern process has strengthened the action we take to drive improvement when services fall significantly short of the required standard. Examples of our use of this process are outlined later within this report.

Use of HIW's legal powers

In February 2022 following a criminal investigation relating to an unregistered service, HIW issued a caution for a breach of section 11 of the Care Standards Act 2000.

As the regulator of independent healthcare services in Wales, HIW is committed to taking action when standards are not met. In order to ensure that patients receive safe effective care the use of legal powers on this occasion highlights how HIW will take action when a healthcare provider does not comply with the regulatory requirements.

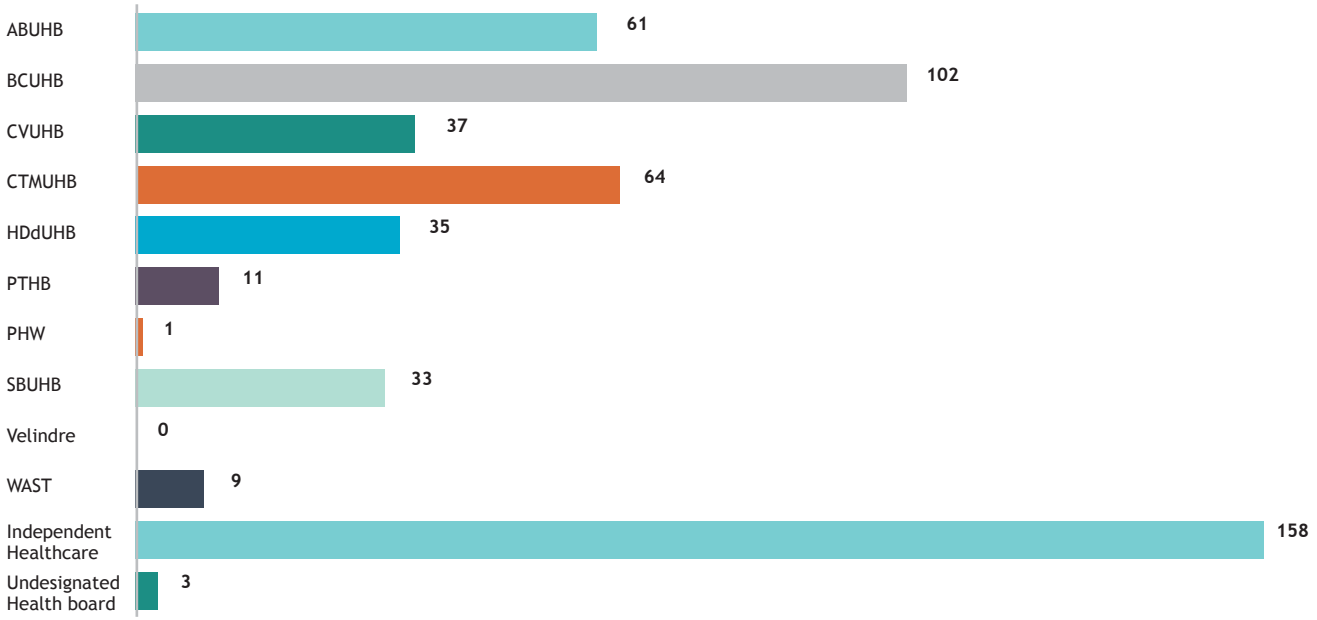
Concerns

The concerns we receive continue to be an invaluable source of intelligence to the organisation and their importance cannot be underestimated. Some of the onsite inspection work we undertook during 2021-2022 was as a direct result of concerns that had been raised with us. In addition to the evidence we have gathered directly from our inspection and Quality Check activity, we have also sought assurance from healthcare organisations in relation to concerns received.

In total, we received 514 concerns from April 2021 to March 2022. This represents an increase of eighty compared to the previous year. Of note, however, is that HIW is seeing a sustained increase in numbers of concerns being raised since the start of the COVID-19 pandemic.

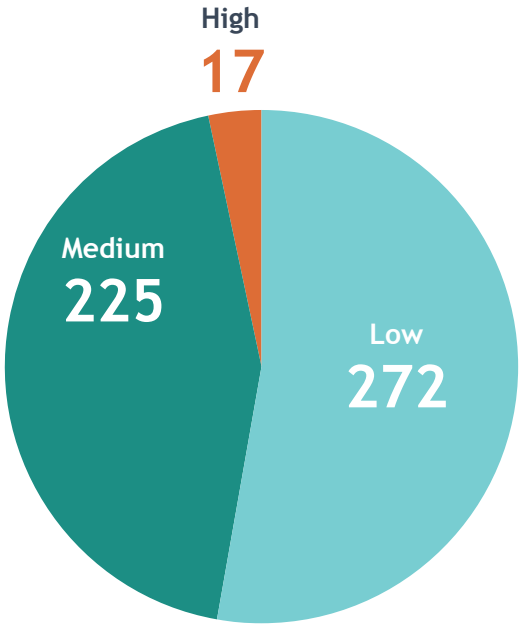
We have seen a **40% increase** in the number of concerns being raised since the 2019-2020 year.

Location of concerns



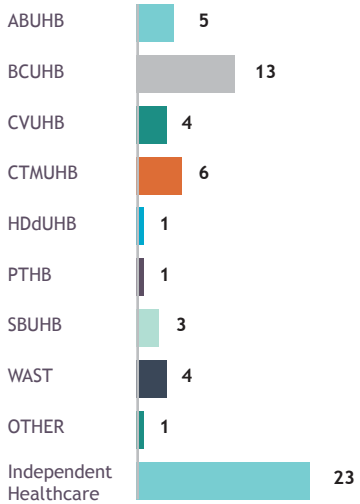
Concerns, Whistleblowing and Safeguarding

Risk levels of concerns received



- High-risk concerns require immediate action and response within 2 working days, either by HIW or other agency.
- Medium-risk concerns may require more direct HIW input, and responses should be actioned within 5 working days.
- Low-risk concerns are those concerns that are generally dealt with by way of signposting towards Putting Things Right or the respective local complaints process for independent health providers and responses should be actioned within 7 working days.

Whistleblowing Concerns



Whistleblowing Concerns

25 received for **2019-2020**

100 received for **2020-2021**

61 received for **2021-2022**

In total, we received 17 high risk concerns in 2021-2022. All high-risk concerns were evaluated, actioned and escalated and assurances requested from health boards / trusts or independent healthcare settings. Where appropriate we also contacted the local safeguarding team and shared any safeguarding concerns that we may have identified. At times we have also had to share information with the emergency services such as the police due to the nature of concerns raised or due to concerns over a person's well-being.

Concerns were received from a range of individuals including, patients, their families, friends, staff, and allied health professionals. It is important to note that of 61 concerns received from whistle-blowers, 37 were in relation to NHS health boards / trusts and 24 were in relation to independent healthcare settings. Common themes identified from concerns received were mainly in relation to two key areas. The first group of concerns were in relation to clinical assessments and treatment. The second group of concerns related to infrastructure, staffing, and facilities.

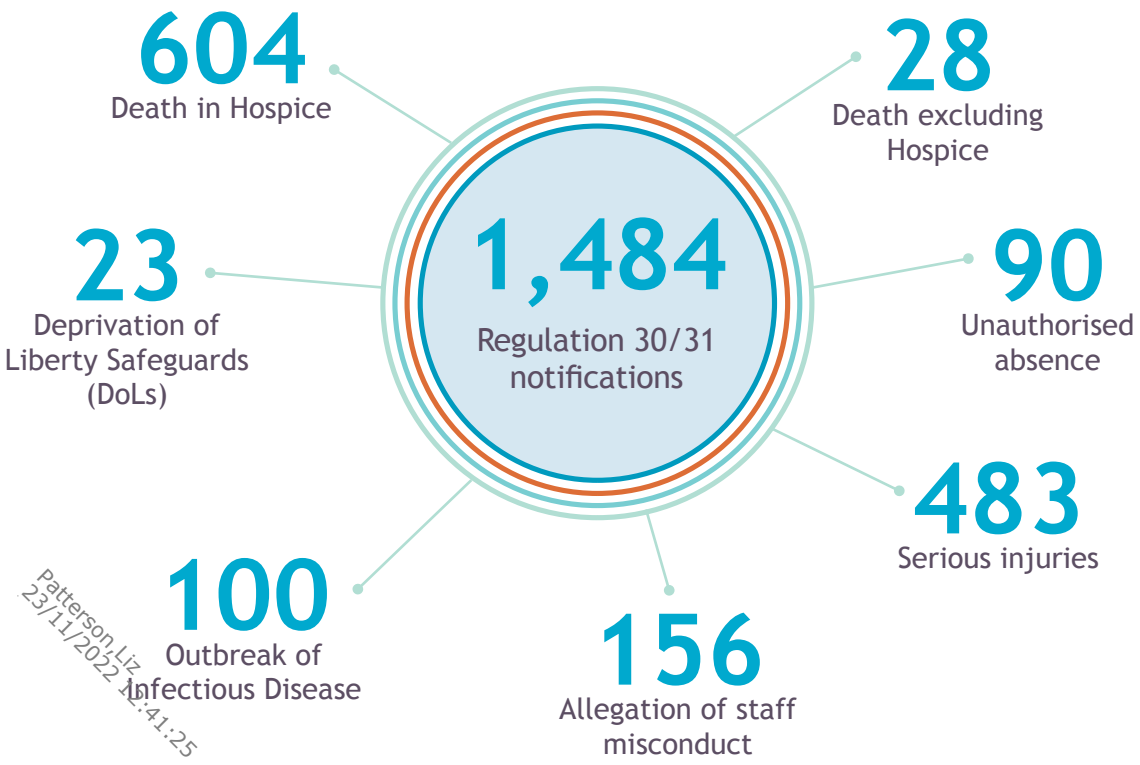
In total we received 404 safeguarding referrals from local authorities.

Local authorities and the police are the statutory lead for all safeguarding referrals and the final decision on action is made by them. HIW is invited to initial strategy meetings where we can have an input into any potential actions that are taken. We also review all referrals that are submitted, and the information is shared internally with relationship managers for intelligence. Relationship managers are the first point of contact for HIW staff and health boards/ trusts. They also take the lead in determining the inspection and assurance activity within each health board. If there is a need for further action, we write out to the health boards / trusts or independent healthcare setting and request assurance or a regulatory notification where applicable.

Regulatory Notifications

Independent healthcare providers are required to inform us of significant events and developments in their service submitting notifications against Regulation 30/31 of the Independent Healthcare (Wales) Regulations 2011.

In total we received 1,484 Regulation 30/31 notifications. A breakdown of the notifications is as follows:



This is a **36% increase** in the number of notifications we received, compared to 2020-2021. The number of serious injuries reported within independent healthcare services has increased significantly by **72%** over the last year.

During 2021-2022 we received 156 Regulation 25 notifications (The Private Dentistry (Wales) Regulations 2017).

They are as follows:

All notifications are reviewed by a case manager when they are submitted and then reviewed weekly by the Investigation team. For every notification submitted we request follow up information to provide reassurance that the incident has been handled appropriately and that the setting has attempted to mitigate the risk of similar incidents happening again. When similar themes are noted, we refer the information to the enforcement team and the escalation and enforcement pathway starts.

Death in Custody Reviews

It is the responsibility of the Prisons and Probation Ombudsman (PPO) to undertake an investigation of every death that occurs in a prison or approved premises in Wales. HIW supports these investigations by undertaking a clinical review of all deaths within a Welsh prison or approved premises. This collaboration has been formally outlined within a Memorandum of Understanding between the PPO and HIW. A link to the agreement can be found on our website.

The purpose of our clinical reviews is to critically examine and evaluate the quality of healthcare services provided to prisoners during their time within a prison or approved premises.

From 1 April 2021 to 31 March 2022, we were commissioned by the PPO to undertake 15 clinical reviews. This is one less compared to 2020-2021. These clinical reviews were conducted at four out of the six prisons located in Wales. No clinical reviews were undertaken in relation to HMP Prescoed or HMP Usk.

The table below identifies the number of reviews and their locations:

Location	Total
HMP Parc	7
HMP Berwyn	2
HMP Cardiff	5
HMP Swansea	1

Overall, our death in custody reviews highlighted that the care provided to prisoners in Wales was equitable with the expected level of care a person in the community would receive. Access to GPs, nursing staff and allied health professionals was deemed sufficient in the vast majority of our reviews.

In all of our clinical reviews we identified the need for improvement and highlighted good practice. There were two key areas highlighted for improvement, these were the need to ensure comprehensive and detailed documentation was completed for all patients and improvement in relation to the timely undertaking of investigations such as blood tests and x-rays.

Good record keeping is a fundamental part of delivering safe and effective patient care. An accurate documented record that details all aspects of the patient's care and treatment is fundamental as it contributes to the dissemination of information amongst different care practitioners involved in the patient's treatment or care. A specific area of documentation that was identified as needing improvement was the recording of physical observations as part of patient assessments. These observations provide a significant insight into a patient's state of health and can alert practitioners to the clinical deterioration of an individual.

It was acknowledged that on some occasions, delays were experienced by prisoners in obtaining blood tests and x-rays. Numerous factors were identified which can impact on the timeliness of these investigations being undertaken, such as transport and the availability of specific staff. In addition, vulnerabilities were identified in alerting healthcare staff when a prisoner had not attended an appointment. The importance of recognising these missed appointments need to be clearly embedded in policies and procedures and escalated accordingly to ensure individuals receive the required investigations.

Our clinical reviews highlighted that healthcare professionals working in prisons were motivated, dedicated and committed. Evidence showed that staff endeavoured to provide high levels of holistic care and treatment to their patients. HIW's findings following a review into the effectiveness of Swansea Bay University Health Board's quality governance arrangements for the provision and oversight of healthcare services in HMP Swansea did provide a differing perspective. Our review concluded that the health board's quality governance arrangements do not adequately support the delivery of good quality, safe and effective healthcare services to the prison population. We identified a need to raise the profile of prison healthcare within the health board to ensure that the quality healthcare is designed, delivered, and monitored effectively. HIW recommended that prison healthcare needs to feature more prominently on the health board's quality agenda, so that safe, effective care can be provided to the prison residents.

NHS Assurance and Inspection Findings

We continued to deliver a blended approach to assurance and inspection via onsite inspections and remote Quality Checks. There was ongoing work to develop and enhance current methodologies, which are the tools used to undertake inspection and assurance work. All methodologies continued to include a specific focus on COVID-19.

Hospitals

COVID-19 continued to impact the way in which we inspected and sought assurance of NHS hospitals throughout 2021-2022. During Winter 2021, rates of COVID-19 transmission continued to increase, including the emergence of the Omicron variant. It was important that we took a cautious approach to reduce burden on the services most affected. We therefore cancelled all routine NHS onsite inspection work throughout December and January. We still undertook onsite inspection work where we considered there to be a high risk to patient safety as a result of specific issues that we were aware of and was not possible to gain assurance remotely. All other work during this period we conducted remotely. In February 2022, we resumed all our routine NHS onsite inspections following the move to alert level 0 across Wales and the general decreasing trend in rates of COVID-19. We provided 24 hours' notice for inspections to elective, scheduled care areas where the flow of patients is planned, and COVID-19 precautions are structured around patients who are being admitted for planned surgery, or where there are patients with compromised immunity due to the treatment they are receiving and in maternity services. This allowed our inspection teams to communicate with NHS staff and for arrangements to be put in place so that the inspection could be undertaken safely. We continued to conduct unannounced inspections (no notice provided) of clinical areas within unscheduled care areas.

During this period, we undertook:

Of the eight onsite inspections we completed, two of those were categorised as a 'green' pathway[1].

Our onsite inspections and Quality Checks covered a variety of different types of hospital wards including emergency departments, maternity, oncology, cardiac, paediatric units, step down facilities and one minor injury unit.

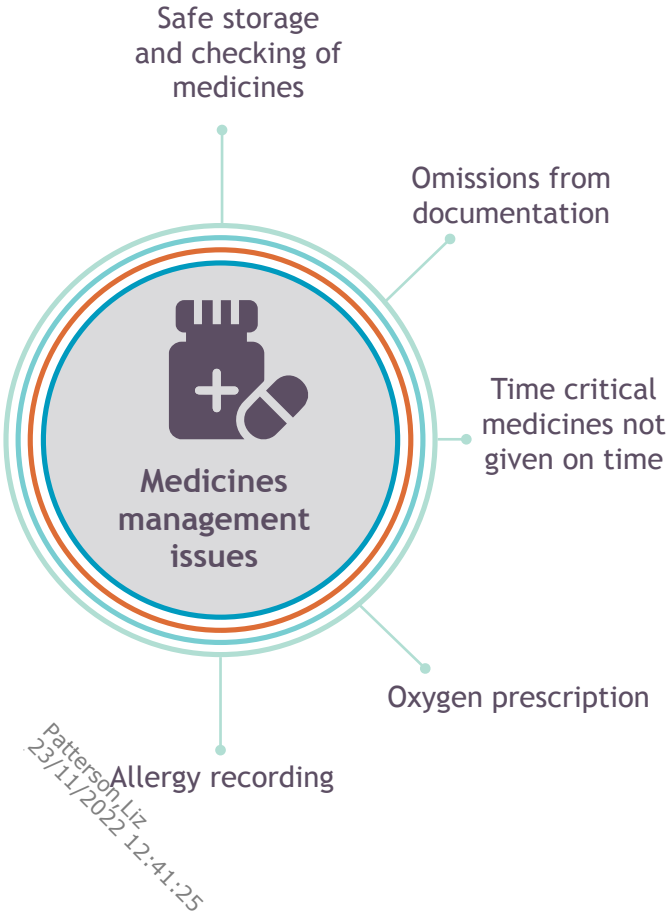
It was clear, from work carried out throughout the year, that there was significant and sustained pressure on the emergency care system, and that this directly impacted patient care. Through our inspection and assurance work we identified a clear difference between scheduled and unscheduled care. We identified many more areas requiring improvement within unscheduled care compared to scheduled care. In particular, scheduled care areas, such as oncology and cardiac wards, where the staff have more control over admission and can provide more patient centred care had fewer areas for improvement.

Although responses we received to our staff questionnaires indicated low staff morale, particularly related to challenges around staffing numbers and high demand for services, this did not generally seem to impact on the experience patients had of staff. Patients told us staff were kind and compassionate.

Our inspections continued to note low levels of compliance with mandatory training for staff. Mandatory training plays a key role in ensuring staff can provide safe and effective care to patients.

[1]The Green Pathway is the term given to COVID-free areas of a hospital. Within the pathway there are specific pathways such as surgical pathways. Measures taken can include patients being assessed as having no current risk of COVID and patients booked for surgery may be asked to self-isolate in their homes.

Medicines management continues to be a concern for HIW, as we identified issues across all of our hospital inspections in relation to:



Through our work we experience many clinical areas. We encounter patients who receive their care within and from services, and when visiting is possible, we also meet relatives, carers and others involved in their lives away from healthcare. We also encounter the staff working within services day to day; therapy staff whose work takes them to departments to support with specific issues, housekeeping staff whose input supports the smooth running of departments, and managers and senior leaders who provide the governance and leadership that is needed daily to ensure services achieve and maintain standards, and where necessary, improve. We have observed services at times of significant pressure, and the staff within them working relentlessly to deliver care. We have seen services at times when pressure is not significant, but staff still working hard to deliver care. We acknowledge the challenge and stress that sustained high pressure can cause. The case studies below demonstrate the way in which we continued to focus on patient safety in 2021-2022, challenging services and health boards to look for different ways of doing things when outcomes for patients could be improved.

Case Study - Inspection of the Emergency Department, Prince Charles Hospital, Cwm Taf Morgannwg University Health Board

In the following case study, we have focussed on the findings and outcome of an inspection we carried out of the Emergency Department (ED) in Prince Charles Hospital. This example of our work illustrates a department working under significant pressures leading to issues with patient safety. What happened next was an example of a health board working responsively and constructively to tackle the issues our work highlighted. By responding in this way, early progress was made in improving patient safety and outcomes for patients.

During our inspection in September 2021, we found that the ED, as the front door to a wider healthcare system, was experiencing a period of heightened pressure due to high demand on services. Patient flow throughout the hospital was clearly an issue.

We acknowledged that this was a very challenging and stressful environment for staff, who continued to work above and beyond in exceptional and challenging conditions.

The inspection revealed extensive issues in relation to patient safety, meaning that we could not be assured that patients in attendance at the ED were receiving safe care. These concerns related to inadequate infection prevention and control arrangements, ineffective arrangements for the segregation of COVID-19 patients, inappropriate or incorrect usage of Personal Protective Equipment, and numerous environmental factors impacting on the ability of staff to provide safe and dignified care. The department and GP assessment unit were significantly overcrowded to a level where this affected patients' dignity and safety. The paediatric area was not sufficiently staffed, and the environment was not conducive to safe and dignified care. Patients were not always monitored at a frequency which would identify deterioration and changes in their condition. Our discussions with staff also revealed concerns about their well-being, due to the environment that they were working within.

We used our Immediate Assurance process, where we formally write to a health board immediately after the inspection, to outline the urgent remedial actions that were needed to ensure patient safety. Our full inspection report identified the longer-term improvements that were required.

Key staff at the health board were positive in their response to our feedback, and in our subsequent engagement, with a clear commitment to addressing the issues highlighted. The health board's responses included a comprehensive set of actions, with much progress already made at the time our report was published.

Due to the significance of the issues found in the inspection, we undertook a follow-up inspection in January 2022.

At the time of the follow-up inspection, we found that the ED continued to experience a period of heightened pressure due to high demand on services. Once again, we acknowledged that this remained a very challenging and stressful environment for some staff, who continued to work above and beyond in exceptional and challenging conditions. Whilst some areas still needed attention, there were no urgent patient safety issues.

There was a clear commitment to addressing the issues highlighted in the initial inspection and we found that the health board had made significant progress in addressing most of the improvements raised in a sustainable way, rather than quick fixes to issues which cannot be maintained. The rapid and positive outcome achieved within this example is of note, with this being achieved through a constructive and supportive style adopted by senior leaders in supporting staff in the department. Staff felt there was a shared responsibility for improvement. Our work provided an insight into challenges at the department, and this will support the health board in continuing to improve delivery of care provided by the ED. The outcome of our work and the effort from the health board was improved patient safety in the department.

Case Study - Enhanced Quality Check Ysbyty Glan Clwyd, Betsi Cadwaladr University Heath Board

In May 2022, we identified the Emergency Department (ED) at Ysbyty Glan Clwyd, Betsi Cadwaladr University Health Board as a Service Requiring Significant Improvement.

This designation was based on an accumulation of evidence where HIW identified specific risks following a No Surprises Notification in January 2022, concerning potential unsafe discharge from the ED. A patient was unfortunately found deceased after discharge. Following insufficient assurances from the health board in response to HIW's initial correspondence, HIW undertook an in-depth review of the case notes of the patient involved. This review highlighted a number of concerns and significant patient safety concerns. This was fed back to the health board and assurance and actions were provided to HIW that safe care and treatment was being provided at this time.

HIW subsequently completed an enhanced Quality Check of the department in March 2022. Quality Checks are a snapshot of the standards of care within healthcare services. They are conducted entirely offsite and focus on three key areas: infection prevention and control, governance (specifically around staffing) and the environment of care.

Due to the issues noted in January 2022, we expanded our usual methodology to seek assurance on how the health board ensures patients are cared for, and discharged, safely.

Our work identified numerous patient safety issues. We issued an Immediate Assurance letter, where we write to the health board immediately after the Quality Check, outlining urgent remedial actions to ensure patient safety.

Whilst the health board responded positively with a detailed action plan, the severity of the issues identified led HIW to remain concerned about wider patient safety at the department. Consequently, we undertook a full onsite inspection in May 2022 to inspect the full environment of care, and ensure the actions set out in the health board's response to the March Quality Check were completed and sustained.

Our onsite inspection identified further significant patient safety issues. We also identified areas where the health board's actions in response to the March Quality Check had been ineffective. We escalated our concerns to senior staff at the health board during the inspection, as well as at our standard feedback meeting at the end of the inspection. We received verbal assurances from the health board on actions that would ensure patient safety, and we issued a further Immediate Assurance letter on 9 May 2022.

Having considered the findings and evidence gathered since January 2022, HIW determined that the health board had not been able to demonstrate sufficient progress against several key areas of concern relating to patient safety and quality of care, with particular concern regarding the poor standard of nursing documentation. Our May 2022 onsite inspection highlighted that the health board had not demonstrated improvement to an acceptable standard in response to the Immediate Assurance issues identified during the March 2022 Quality Check. Furthermore, the May 2022 inspection identified several additional areas of concern relating to patient safety. As a result, we were concerned there was a risk to the safety of patients seeking care at the Emergency Department in Ysbyty Glan Clwyd.

The designation of Ysbyty Glan Clwyd Emergency Department as a Service Requiring Significant Improvement enabled HIW to plan and deliver any future activities necessary to gain assurance about the quality and safety of care in the service. This process considers the timing of any follow up activity, to enable HIW to decide whether the service can be de-escalated and removed from this process.

General Practice

We continued to use Quality Checks to seek assurance on the quality of care being provided by GP practices during 2021-2022. Our Quality Checks continued with a specific focus on COVID-19. During this period, we undertook 25 Quality Checks of GP practices across health boards in Wales.

It was positive to note from our assurance work that there was good evidence of GP practices using their membership of a cluster[2] to support the provision of patient care and sharing of ideas and good practice between GP practices. We noted that most GP practices had made significant changes to their practice environments to ensure that they were safe for patients and could be easily cleaned in response to the challenges of the COVID-19 pandemic.

However, it was disappointing to discover that at some GP practices there was a lack of cleaning policies and full cleaning schedules. We also noted a lack of completed risk assessments at some practices for home visits, practice staff and the environment. Policies and risk assessments are management tools which help to ensure that all staff are aware of what is expected of them, they can be used to help outline and ensure safe practice and they can help to maintain consistency in standards and support improvements in quality. Where these tools are absent or are not kept up to date it indicates a weakness in management practices, and this is of concern. GP practices and primary care leaders within health boards should ensure there are processes and systems in place to support effective management of these services.

We identified a theme through our activity and intelligence relating to the accessibility and availability of face-to-face appointments. This showed that although practices were doing their best to recover services affected by the pandemic, issues of access still persisted. People told us that they could not always get appointments when they needed them and found it difficult in some areas to access practices by phone. We also found that an element of digital exclusion has continued, with some people unable to access services in an equal way due to a focus on online and telephone consultations. We found that practices had continued to respond well to the challenges of the pandemic. This included releasing staff to provide vital support to vaccination programs and clinics. A number of areas had developed innovative approaches to manage consultations and meet the demands of their communities. As a result, we have redesigned our methodology for GP inspections and introduced new peer reviewers to this process. This will ensure that HIW keeps pace with the developments in this sector.

[2] A cluster is a group of GP surgeries working together to pool resources and share best practice in a bid to help patients remain fit and healthy, and to improve the way patients are cared for if they become unwell.

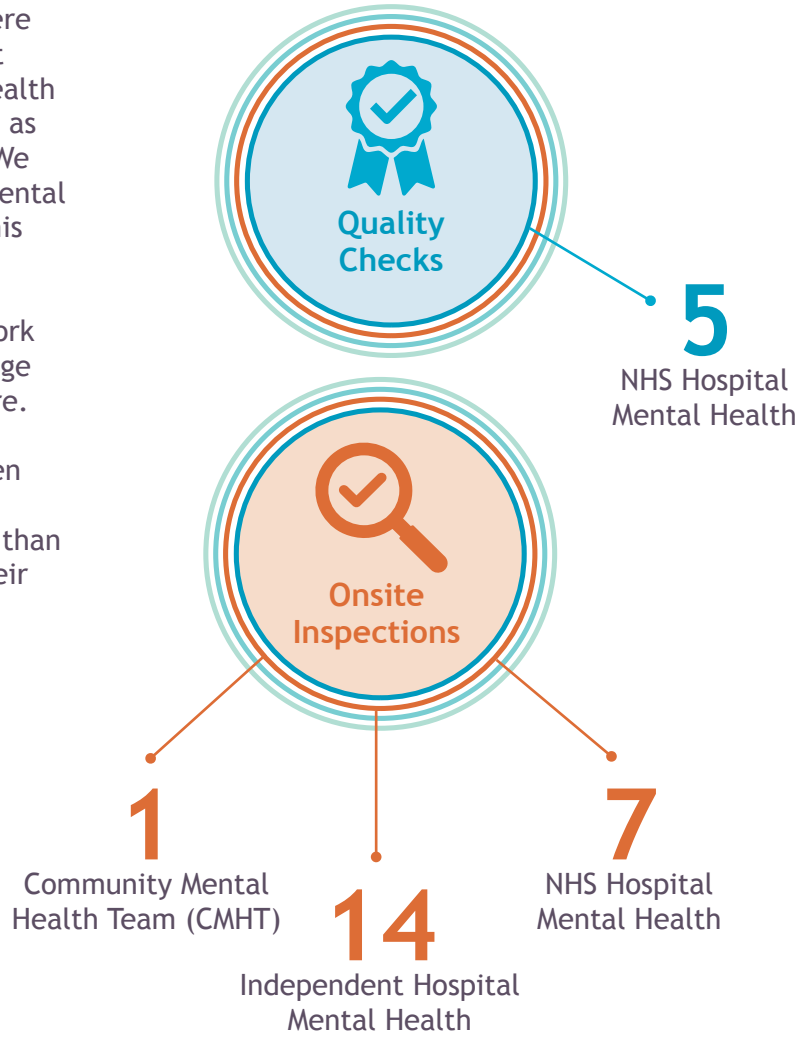
Mental Health

We look at how NHS mental health and independent mental health care services meet and comply with a range of professional standards and guidance, including the Mental Health Act 1983 and the Independent Healthcare (Wales) Regulations 2011.

The provision of mental health care during the pandemic has been challenging and complex for both the NHS and independent healthcare service providers. We continued to use a mix of remote Quality Checks and onsite inspections for our work to mental health care settings. This hybrid approach enabled us to seek assurance from services at a time when the risk threshold for conducting inspection visits was high and to conduct our work onsite when either the COVID-19 risk was lower, or where the risk to patient safety was of significant concern. Our Review Service for Mental Health (RSMH) continued during this time, as well as our concerns and notifications processes. We also continued to respond to patients in mental health settings who contacted us during this period.

Over the past 12 months, our assurance work evidenced several key themes across a range of settings in relation to mental health care. Mental health is challenging and complex and inspections highlighted staff were often required to intervene to manage patient behaviours and ensure their safety, rather than provide care and treatment bespoke to their needs.

During 2021-2022 we undertook:



Inspections also highlighted instances of:

- Mandatory training for staff not being completed or up to date
- Poor medication management including incomplete administration charts and medication being stored incorrectly
- Risks being identified and subsequently not addressed in a timely manner or not addressed at all
- An over reliance on agency staff and repeat periods of inadequate resourcing
- Care and treatment plans not being monitored and regularly updated
- A lack of governance oversight including collaborative working and sharing information for future improvement.

In most cases we found that staff working in services providing mental health care and treatment, treated patients with kindness and respect. We also saw that most services continued to work well to adapt to the changing needs presented by the pandemic. Patients were receiving compassionate care in most cases which promoted their independence and autonomy. We also saw that in some cases the recovery from the pandemic was going well, with improvements on previous inspections noted.

During 2021-2022 we inspected two out of the three children and adolescent mental health units in Wales, Tŷ Llidiard in Bridgend, and Hillview Hospital in Ebbw Vale.

Learning Disability

HIW undertook eight Quality Checks and five inspections of facilities providing learning disability services. In most cases, we found that patients accessing care in these facilities were receiving person centred and compassionate care and treatment. Tailored care plans were in place and allowed staff and patients to work towards common goals for the benefit of patients. We saw that staff interacted with patients in a kind and compassionate manner and worked hard to meet patient needs. However, we did find that staffing numbers were not always at a level which met patient needs. We also saw that the COVID-19 pandemic had negatively affected the promotion of independence in some of these settings. We saw in one case that there were significant issues relating to the environment, governance and safety of the unit. As a result, an Immediate Assurance letter was issued, and significant improvements were implemented by the Hywel Dda University Health Board.

The Second Opinion Appointed Doctor (SOAD) Service

HIW operates the SOAD service for Wales, and we appoint registered medical practitioners to approve some forms of treatment. The role of the SOADs is to safeguard the rights of patients who are detained under the Mental Health Act and either do not consent or are considered incapable of consenting to treatment (section 58 and 58A type treatments). Individual SOADs come to their own opinion about the degree and nature of an individual patient's mental disorder and whether the patient has capacity to consent.

They must be satisfied that the patient's views and rights have been taken into consideration. After careful consideration of the patient and approved clinician's views, a SOAD has the right to change the proposed treatment. For example, a SOAD may decide to authorise only part of the proposed treatment or limit the number of electroconvulsive therapies (ECTs) given.

The SOADs have a responsibility to ensure the proposed treatment is in the best interest of the patient. The appropriate approved clinician should make a referral to HIW for a SOAD opinion relating to:

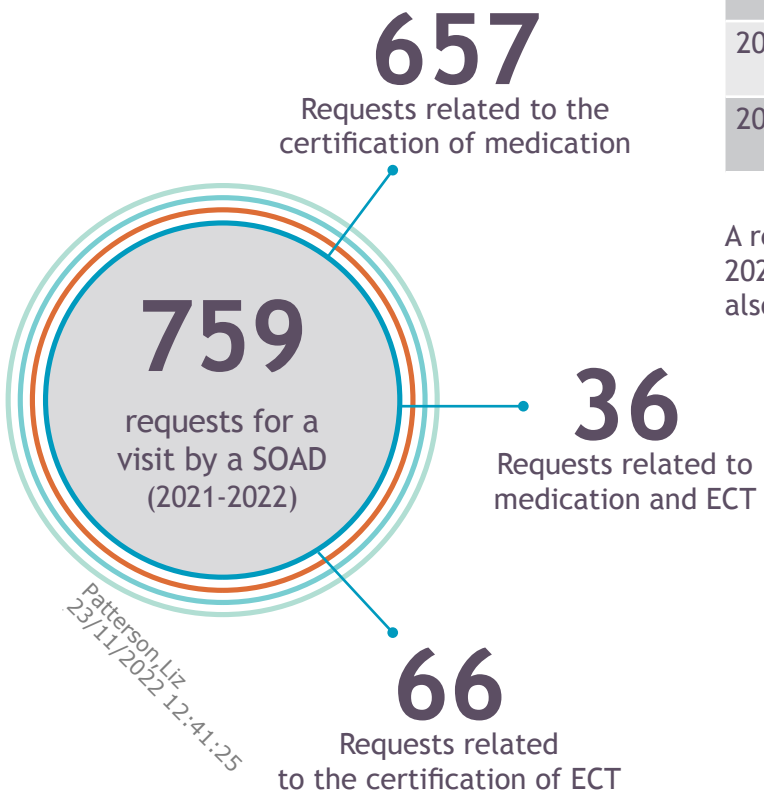
- liable to be detained patients on Community Treatment Orders (CTO) (Section 17A) who lack the capacity to proposed treatment or who do not consent for Part 4A patients
- serious and invasive treatments such as psychosurgery or surgical implements for the purpose of reducing male sex drive (Section 57)
- detained patients of any age who do not consent or lack the capacity to consent to Section 58 type treatments (section 58)
- patients under eighteen years of age, whether detained or informal, for whom Electroconvulsive Therapy (ECT) is proposed, when the patient is consenting having the competency to do so (Section 58A), and
- detained patients of any age who lack the capacity to consent to electroconvulsive therapy (ECT) (Section 58A).

Due to the ongoing COVID-19 pandemic and health and safety concerns regarding on site visits for the SOADs, in 2020-2021 we operated a temporary COVID-19 safe methodology for the SOAD service, wherein onsite hospital visits were temporarily suspended and replaced with teleconference or telephone call appointments. As we move to a post-pandemic operating model, the SOAD service now operates a hybrid methodology where onsite visits, where safe and practicable, are carried out, however, remote certification is still also utilised enabling the efficiencies gained from the remote methodology to continue, whilst ensuring patients safety and rights are prioritised.

We continue to work with Mental Health Act administrators in health boards and independent providers to ensure that patients get timely access to a SOAD and that the process is as smooth as possible to ensure that the rights of patients are protected. We attended the Mental Health Act Administrators annual forum and engaged with stakeholders directly to support understanding of our hybrid methodology.

In Wales during 2021-2022, there were 759 requests for a visit by a SOAD. This figure is a slight drop from the previous year, although it remains broadly consistent with figures from previous years.

These were:



The following table provides a breakdown of requests per year:

Requests for visits by a SOAD in 2021-2022

Year	Medication	ECT	Both	Total
2019-2020	**855**	**50**	**27**	**932**
2020-2021	**869**	**60**	**27**	**956**
2021-2022	**657**	**66**	**36**	**759**

A regular programme of training is provided to all SOADs to encourage best practice. In the year 2021-2022 training which focussed on depression treatment and medications was provided. SOADs also attended a session in winter 2022 focussing on Legal Updates to the Mental Health Act 1983.

Review of Treatment (Section 61)

Following the authorisation of a treatment plan by an authorised medical practitioner (SOAD) that has been appointed by HIW, a report on the treatment and the patient's condition must be provided by the responsible clinician in charge of the patient's treatment and given to HIW. The designated form is provided to the Mental Health Act Administrators office for all local health boards and independent settings for the Responsible Clinician to complete. For the sixth consecutive year HIW undertook an audit of these forms to ensure that adequate patient safeguards were in place. The treatments are reviewed by our lead SOAD for Wales on a monthly basis.

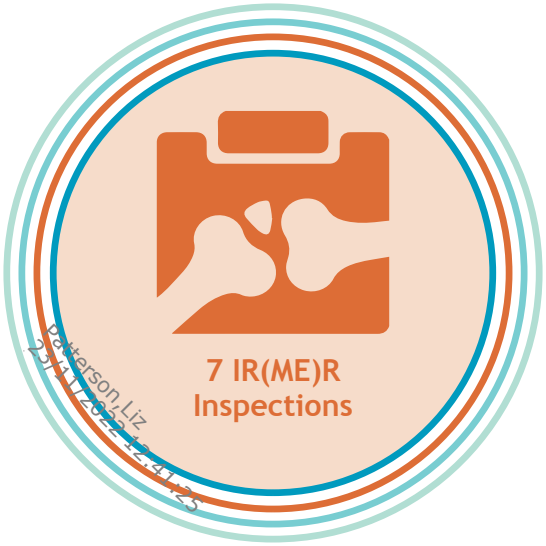
There remain very few instances where discrepancies are identified by the reviewer. Further improvements from our previous report continue in relation to the following areas:

- There continue to be minimal occasions where more medication is listed under the treatment description than is authorised on the CO3 form. In these instances, the reviewer highlights the need for a SOAD request to be submitted by the setting.

[3] The Mental Health (Hospital, Guardianship, Community Treatment and Consent to Treatment) (Wales) Regulations 2008 are the principle regulations dealing with the exercise of compulsory powers in respect of persons liable to be detained in hospital or under guardianship, together with community patients, under the Mental Health Act 1983.
The Regulations prescribe the forms that are to be used in the exercise of powers under the Act, and these are set out in Schedule 1 of the Regulations. These Regulations (and the prescribed forms) came into force on 3 November 2008 and include CO forms.

Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R)

HIW is responsible for monitoring compliance against the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R). The regulations are intended to protect people from hazards associated with ionising radiation. Our inspection approach checks that services are compliant with these (IR(ME)R) regulations and looks at whether care and treatment is being provided in line with the Welsh Government's Health and Care Standards.



During 2021-2022 HIW completed seven IR(ME)R inspections, covering the three modalities of medical exposures. Six of these inspections covered the NHS and one covered independent hospitals.

HIW was assisted in these inspections by a Senior Clinical Diagnostic Officer from the Medical Exposures Group (MEG) of the UK Health Security Agency (UKHSA), who acted in an advisory capacity. All the inspections were undertaken onsite. As part of the process, we asked providers to undertake a full self-assessment and then we held discussions with staff about the content of the self-assessments and the supplementary evidence provided to support the self-assessment. Whilst onsite we also reviewed clinical and other relevant records as well as observing the environment in which services were delivered. We also requested patient and staff feedback through online surveys. The QR code to access the survey was displayed on posters in the services we inspected, and we promoted the surveys through our social media channels. Paper copies of the patient survey are also provided in advance of the inspection to the setting to accommodate patients who are unable to access the online survey. HIW received 273 completed patient questionnaires and 214 staff questionnaires covering these seven inspections.

Feedback from patients was overwhelmingly positive with patients confirming that they had been treated with dignity and respect and had been helped to understand the risks and benefits of the procedure they were receiving. During our IR(ME)R assurance activity we continued to meet experienced and committed teams of professionals, with a good team working ethos. Overall, staff we spoke with demonstrated a good awareness of their responsibilities under IR(ME)R and we were assured that examinations at all sites inspected were undertaken safely.

Medical Physics Experts (MPEs) are qualified staff who are able to act or give advice on matters relating to radiation physics applied to medical exposure in diagnostic radiology, nuclear medicine, and radiotherapy. We noted that the relationships between the various IR(ME)R locations inspected and the MPEs was good, whether this was provided as part of a service level agreement with another health board or by staff employed directly by the health board.

Some common themes have emerged across our IR(ME)R inspections this year. They are summarised as follows:

Employer's Procedures - on several occasions we identified that these did not provide enough detail and did not reflect the actual agreed practices staff described to us. We also saw examples where procedures were not up to date and had not been reviewed. Therefore, whilst staff could describe safe practises to us, we could not be assured that the written procedures would provide new, locum or agency staff with the required level of information to guide them in performing their relevant roles. Examples of common areas where detail was lacking in Employer's Procedures included:

- **The information supplied in the self-assessment form contained additional information which should be included in the employer's procedures to explain the process in more detail.**
- **Pregnancy employer's procedures and relevant documents did not always reflect the terminology used in IR(ME)R 2017. Also, pregnancy enquiry EPs were a common area where agreed practise described by staff was not reflected accurately in the employer's procedures itself.**

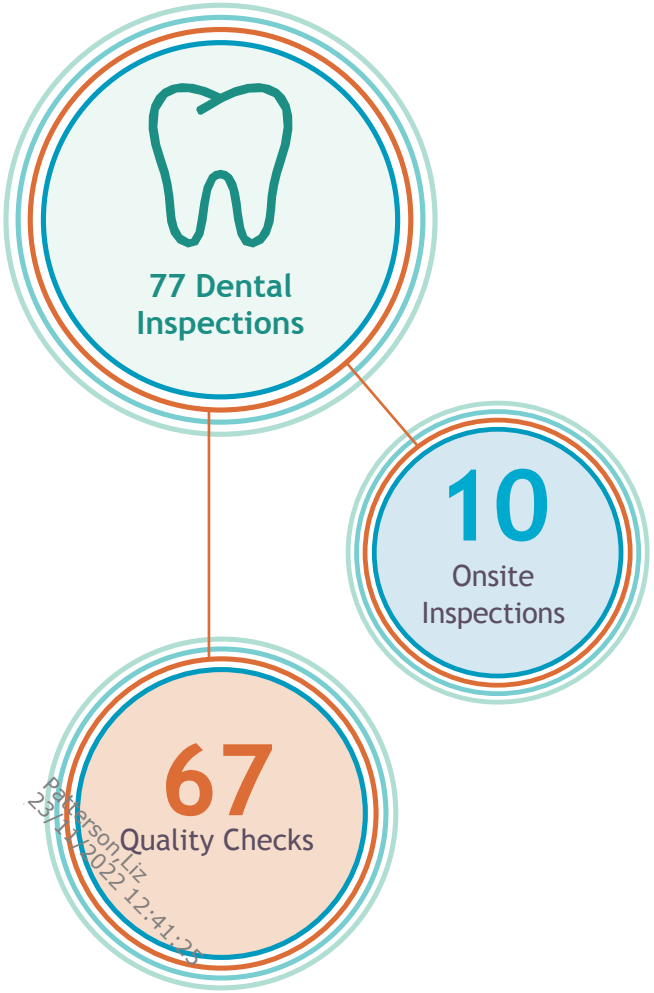
Entitlement - is the process of defining the roles and tasks that individuals, referred to as duty holders, are allowed to undertake. We identified that duty holders had not always been formally notified of their entitlement and scope of practice under IR(ME)R.

Clinical audit - is a key component of improving patient care through identifying areas for improvement and to promote effective use of resources and enhance clinical services. Audits should also highlight any discrepancies between actual practice and standards. Some instances were noted where the difference between IR(ME)R audit and clinical audits was not fully understood and as a result clinical audits had not been completed.

Staff Capacity - in most cases staff told us that they felt supported by senior management and the wider organisation. However, they did tell us that they struggled in terms of capacity to undertake all relevant tasks required as part of their duty holder roles. This may have been evident in the number of recommendations made in relation to mandatory training levels being low and appraisals not being completed in a timely manner.

We identified recommendations for improvement relating to collecting feedback from patients and informing staff of the results of this feedback. In most cases this was due to the COVID-19 pandemic which had reduced the collection of feedback. It is hoped that the process of collecting feedback would return to pre-pandemic levels in 2022-2023.

Dental Practices



Earlier in the pandemic, dental practices worked under a Red Alert which was issued by the Chief Dental Officer for Wales and which prevented them from undertaking any Aerosol Generating Procedures (AGPs). Enhanced cleaning and the requirement for time in between patients, led to a much more limited dental care provision than pre-pandemic. In summer of 2020 dental practices were able to increase the treatment they could provide and during 2021–2022 we saw them steadily increase service provision, working to recover back towards pre-pandemic levels.

During the year we undertook 77 pieces of assurance work across dental practices across Wales. Due to COVID-19 risk levels, we conducted most of this work remotely, and undertook ten onsite inspections where the level of risk to patient safety could not be explored remotely.

In three Quality Checks we had concerns which meant we needed to ask the practices to take immediate action to reduce risks to patient safety; we did this either via our Immediate Assurance process or issuing a Non-Compliance Notice, dependant on whether the practice provided NHS dental treatment, private dental treatment or a mixture of both. In one instance, a health and safety assessment had been correctly carried out by the practice, but the findings had not subsequently been acted on, leaving outstanding areas of health and safety concern. In the other two instances we found that there were inadequate seals to either flooring or to the flooring and worksurfaces in clinical decontamination rooms. Appropriately sealed floors and worksurfaces are necessary to reduce the risk of contamination and to support good standards of infection prevention and control.

Overall, we found evidence that dental practices had effective COVID-19 procedures in place to reduce the risk of virus transmission. This included social distancing, fallow time (settle time in between patients which is necessary for reducing levels of circulating air particles), and quick methods of communication with staff teams to ensure they received timely updates on COVID-19 procedures.

We also found evidence that many dental practices had considered the Welsh language needs of the patient population and were able to provide bilingual information to patients and a bilingual service where possible.

We were also pleased to note the efforts made by some practices to support and accommodate patients with additional needs to receive their treatment. One practice, 'MyDentist' in Wrexham told us that they held dedicated sessions, twice per year, for patients diagnosed with autism to receive treatment in a calming environment. Extra time was set aside for each appointment, lights are dimmed, and the radio volume lowered. We were also told that there were sensory toys, light blocking glasses and ear defenders available for patients to use.

Bryant Dental Practice also told us that during the pandemic, the practice utilised the 'Attend Anywhere' service and remote triage to reach patients who were too nervous to attend the practice due to COVID-19. We were also told that protected appointment slots are made available for vulnerable or at-risk patients at the start or end of each day.

We did find some common areas for improvement through our work. The majority of dental practices needed to improve their documentation recording staff training and ensure that all staff completed mandatory training sessions. We recognise that training has been challenging to source at times during the pandemic, but practices must continue to prioritise this as up to date training supports with quality and patient safety.

We found some areas of management and governance which needed strengthening:

- **A number of practices did not have a system which ensured all risk assessments were being kept up to date. We noted that some fire risk assessments were out of date. Risk assessments are an important management tool which helps to keep patients and staff safe and should be reviewed and updated regularly to reduce risks.**

- **Some dental practices did not have an up-to-date Infection Prevention and Control policy to work from. Whilst we acknowledge there have been some frequent updates to infection control advice over the course of the pandemic, correct IPC procedures (which should be governed through a policy) are crucial for maintaining patient safety.**

- **We also found numerous examples of practices not undertaking audits of their work. Audits offer an opportunity to review the consistency.**

Practices should ensure they take account of the above findings, considering whether they can apply any of this learning to their service to improve the quality and safety of care and treatment that is provided.

Independent Healthcare

Acute Hospitals

Due to the impact of NHS waiting times, independent healthcare is being utilised by patients now more than ever. After exclusively making use of remote Quality Checks throughout 2020-2021, it was important for our inspectors to return to onsite visits of independent hospitals to ensure patients received safe and effective care.

During 2021-2022 we completed four onsite inspections of Independent Hospitals.

Overall, our inspections found that safe and effective care is being provided to patients. Most patients who participated in the inspection expressed satisfaction with the care and treatment received.

Patients told us that staff were kind and caring and we observed good interactions between staff and patients, with staff supporting patients in a calm, dignified and respectful manner.

We found that the staff teams were committed to providing patients with safe and effective care and patients' care needs had been assessed by staff and monitored to promote patient well-being and safety.

The hospitals we inspected were clean and tidy and arrangements were in place to reduce cross infection. This is of high importance as during the time of our inspections, COVID-19 was still prevalent. However, even our most positive of inspections identified issues in medicines management procedures, for example, daily controlled drugs checklists not fully completed. We also noted issues with medications security, storage, and temperature checks.

We found good management and leadership in the hospitals with staff commenting positively on the support that they received from the management team. There was a clear multi-disciplinary approach to provisions of care across all three inspections.

Hospices

Hospices provide care to adults, young people and children who have a terminal illness or a long-term condition that cannot be cured. Due to the vulnerability of the patients, it is imperative that hospices have policies and procedures in place to protected patients from COVID-19.

During the year we completed:

Overall, our assurance and inspection work of hospices throughout the year was positive with evidence that services provided safe and effective care.

Adults

We noted the interaction between staff and patients was good and it was evidence that family members were engaged and involved in their relative's care. There were good examples of multi-disciplinary working to improve provisions of care.

Staff emphasised the importance of maintaining visiting as far as possible for the well-being of patients and their relatives, particularly for patients in their last days of life. Staff described how this was achieved in a timely and effective manner in line with public health guidance at that time. This included initially restricting visiting numbers and COVID-19 testing for relatives before visiting.

We did find some common areas for improvement through our work:

- Environmental risk assessments and action plans were not always complete.
- Low levels of completed mandatory training.

Young People and Children

During our inspection we observed staff being kind and respectful to children. We saw staff making efforts to protect children's privacy and dignity when providing assistance with personal care needs. We viewed staff communicating with children in a calm, friendly and cheerful manner. Staff were observed communicating with children in an encouraging and inclusive manner.

The multi-disciplinary team provided patients with individualised care according to their assessed needs. There were robust processes in place for referring changes in patients' needs to other professionals such as tissue viability nurses, speech and language therapists and dieticians.

Children who completed the online survey told us that they were involved in the planning and provision of their own care. Parents/guardians told us that they were being consulted and encouraged to ask questions and make decisions around care provision.

Treatment using a Class 3B/4 laser or Intense Pulsed Light (IPL)

The 2021-2022 year saw many registered lasers and IPL providers re-open their services to patients following a period of closure due to the COVID-19 pandemic.

[4] https://gov.wales/sites/default/files/publications/2019-07/the-national-minimum-standards-for-independent-health-care-services-in-wales-2011-no-16.pdf

Once these services reopened, we returned to seeking assurance that laser and IPL services were safe for patients through our Quality Checks.

During this period, we conducted 15 Quality Checks and one onsite inspection of laser and IPL registered providers across Wales.

The themes from our work during this time are set out below and providers should use these as learning points, considering whether they can make any improvements based on what we have found and recommended.

Registered laser and IPL services provided us with good evidence of COVID-19 procedures, such as social distancing arrangements for patients and staff in waiting areas. Many services also had comprehensive COVID-19 risk assessments in place. It was reassuring to find that many of the services had taken time during their period of closure to understand the COVID-19 regulations and put safe practices in place to reduce the transmission of COVID-19. We found that nearly all providers ensured that a face-to-face consultation was carried out on prospective patients prior to the start of any treatment. They also ensured consent was obtained from patients ahead of treatment taking place.

During our Quality Checks we discovered that not all providers had an up-to-date safeguarding policy. Safeguarding policies and procedures which are accurate and up to date are an important means of supporting safe practices. We also noted that not all providers had a valid set of local rules that refer to the current IPL device in place. Local rules are set by the Laser Protections Adviser (LPA) which outline the safe and correct use of the laser machine. Providers must have a contract in place with an LPA to be able to provide laser treatments safely and legally.

Many providers were required to update their Infection and Prevention Control Policy.
By ensuring the policy is up to date, providers can be assured that staff and patients are protected infectious diseases and infections.

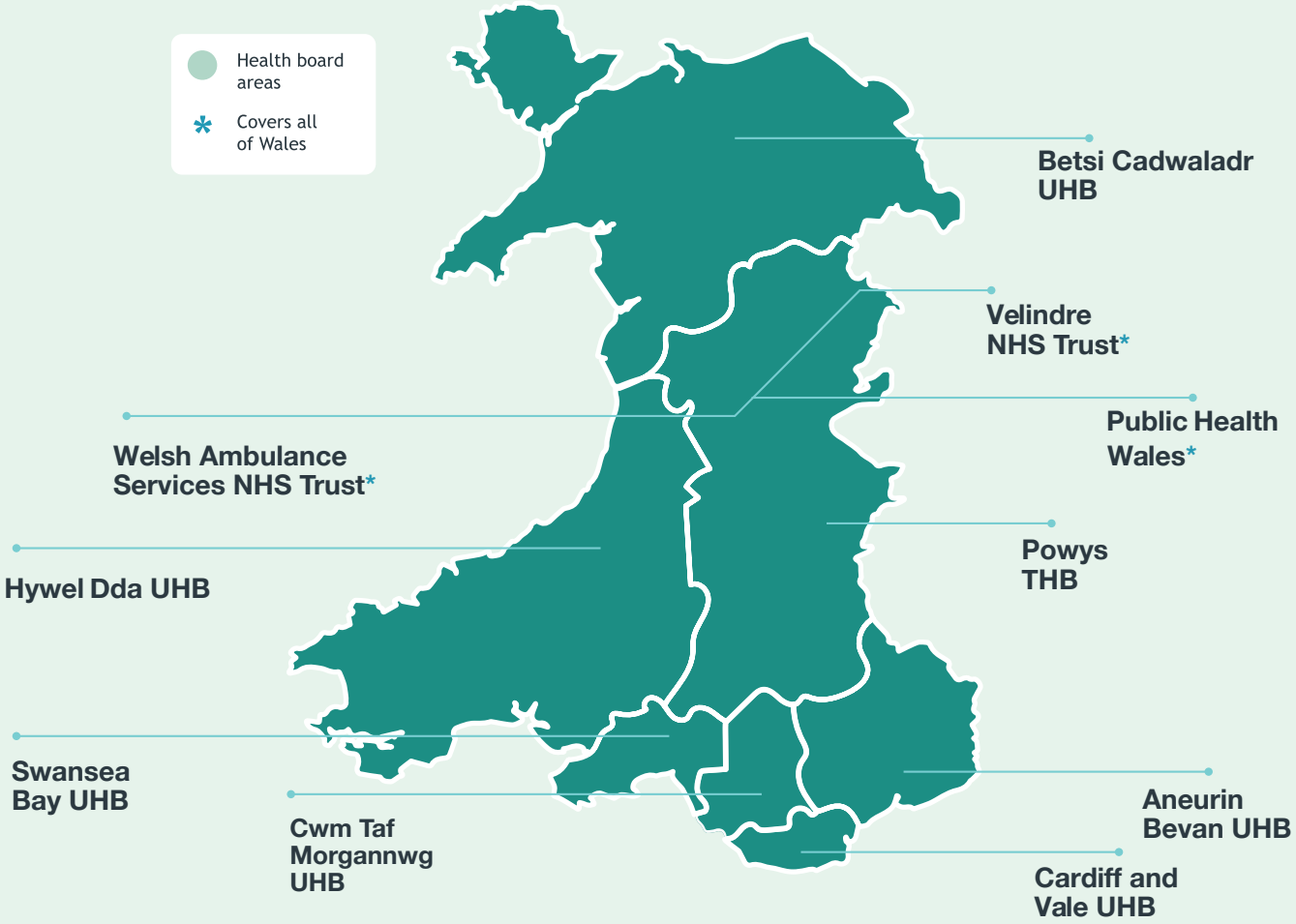
Nearly half of the providers did not have a policy in place which outlined how the service would approach the need to communicate and provide information in Welsh should the patient request it. Standard 18 of the National Minimum Standards of Independent Health Care Services in Wales[4] states that services should comply with legislation and guidance to ensure effective, accessible, appropriate and timely communication and address all language and communication needs.

NHS Health Boards and NHS Trusts

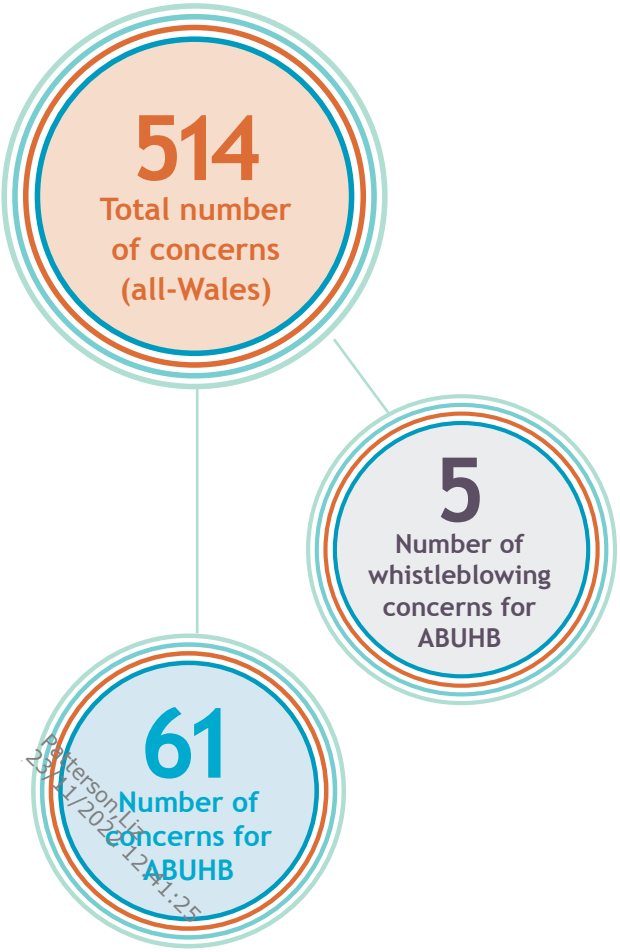
The period covered by this report, 1 April 2021 - 31 March 2022, continued to present healthcare services, and health boards with unique pressures and challenges.

This year they have faced not just the challenge of dealing with COVID-19 itself, but the added challenge of recovering services, tackling long waiting lists and demand for services as a result of many being paused in the initial pandemic response.

Across Wales we noted some common areas of concern through our work; in general, these were pressures associated with recovery of services, waiting times for treatment and significant issues with patient flow in hospitals, and notable pressure and demand on children's services, mental health services and primary care.



Aneurin Bevan University Health Board



Below is a breakdown of quality checks and onsite inspections that took place within the health board

Quality Checks	9
GP	5
Hospital	2
Learning Disability	1
Community Hospital	1

Onsite	3
Hospital	2
IRMER	1
Mental Health Hospital	1

Within Aneurin Bevan University Health Board, during the 2021-2022 period, our work to seek assurance on the safety and quality of care within the health board comprised of a mix of Quality Checks and onsite inspections, consideration of the themes and trends presented by concerns and whistleblowing reports received directly by us, and monitoring of data sets and intelligence shared with us from partner organisations who make up our National Healthcare Summit members [Healthcare Summit | Healthcare Inspectorate Wales (hiw.org.uk)]. The view of the health board developed over this time is a culmination of all the above sources of evidence.

During this period, we have seen evidence of Aneurin Bevan University Health Board working hard through difficult times to resolve the issues that have arisen from the pandemic and in specific service areas where there have been particular challenges.

Changes made to governance structures during the pandemic have been carried forward due to the beneficial impact the health board found these had. We noted that engagement with senior leaders continued to be positive and considered that communication between the health board and HIW had shown improvement.

The health board has been proactive in sharing the learning from our assurance and inspection work across its services and has also proactively worked to deliver and embed actions for improvement that we have recommended through our work. The health board has kept us up to date on its progress on a regular basis.

A challenge for the health board throughout this time has been the newly opened Grange hospital. We undertook an onsite inspection to the emergency department and found several issues, some of which required immediate attention to improve patient safety. Staff who responded to our questionnaire told us about feeling pressured and struggling to cope with high levels of demand. High levels of demand for emergency department treatment have been seen across Wales, but this coupled with a new department, new building and new team pose an additional challenge and we urged the health board to continue with the positive input to support the department as it matures as a service.

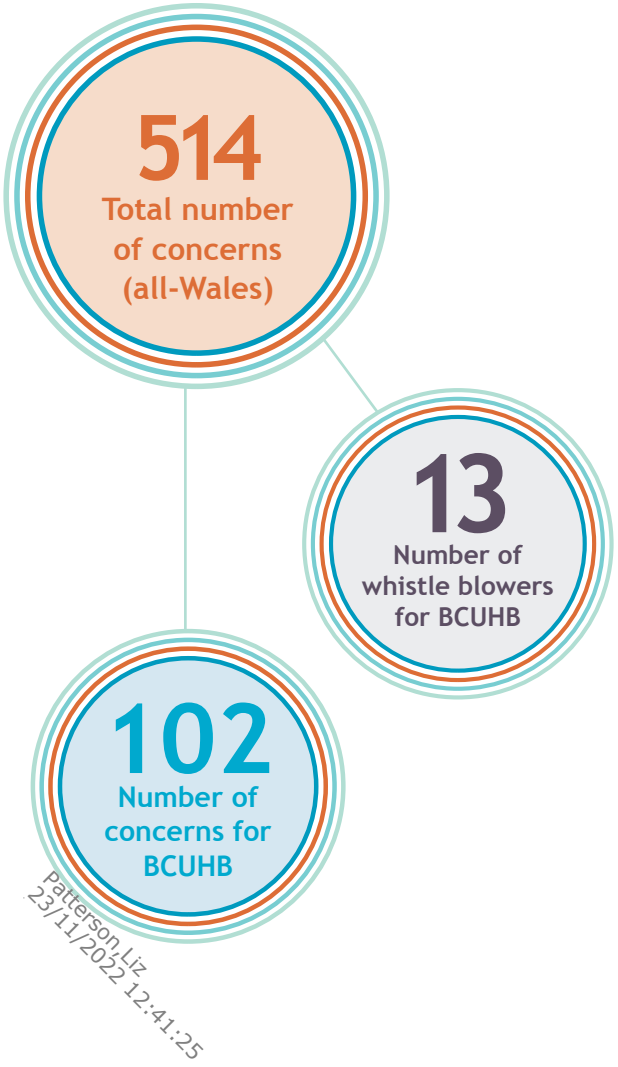
In many of our Quality Checks, our findings were positive, in particular around access to PPE, with minimal improvements required in any area. However, we were disappointed to note that compliance rates with mandatory training continued to need improvement.

During this period, we noted the health board working hard to maintain service delivery in the face of some substantial staffing challenges. At times, emergency actions have needed to be taken, such as temporarily pausing some services until staffing levels were safe again. Recruitment drives and promoting positive working cultures across services will need to be areas of focus for the health board as it continues to tackle this challenge.

The concerns we received the most for Aneurin Bevan UHB related to:

- **Clinical Assessment**
- **Infrastructure (Staff facilities and the environment)**
- **Treatment / Procedure**

Betsi Cadwaladr University Health Board



Below is a breakdown of quality checks and onsite inspections that took place within the health board

Quality Checks	7
GP	3
Hospital	2
Learning Disability	2

Onsite	4
Mental Health Hospital	2
IRMER	1
Learning Disability	1

Within Betsi Cadwaladr University Health Board, during the 2021–2022 period, our work to seek assurance on the safety and quality of care within the health board comprised of a mix of Quality Checks and onsite inspections, consideration of the themes and trends presented by concerns and whistleblowing reports received directly by us, and monitoring of data sets and intelligence shared with us from partner organisations who make up our National Healthcare Summit members [Healthcare Summit | Healthcare Inspectorate Wales (hiw.org.uk)]. The view of the health board developed over this time is a culmination of all the above sources of evidence.
During the period in question, the health board had recently come under the leadership of a new Chief Executive, Jo Whitehead, who was appointed in January 2021. We noted positive evidence of change at this most senior level through open dialogue and a commitment to working together with us and other partners to help bring about change and improvement in services throughout the health board.

We noted that the culture in many areas across the health board still required work to ensure that staff feel empowered to challenge issues and raise concerns. It is critical that the health board continue to work on this area, empowering staff and developing a culture where staff feel confident to raise concerns and constructively challenge.

As a result of ongoing concern about standards of care in mental health inpatient services at the health board we conducted two onsite inspections to the Hergest unit. We were concerned to find issues relating to staffing levels and significant staff fatigue, and infection prevention and control during our inspection work to Hergest.

The health board responded constructively to the challenges we raised as a result of this work, but continued input from the health board will be necessary to bring about and sustain the level of improvement needed in this service. We will continue to monitor the progress made against the specific recommendations we made following our inspection to Hergest and will consider how the learning is shared to other services across the health board.

Poor record keeping was also an area of concern emerging through our ongoing work and monitoring of the health board. As a result of this emerging trend, we specifically focussed on record keeping in work within the health board during this year. We undertook an offsite Quality Check of the emergency department at Ysbyty Glan Clwyd in March 2022, with a significant focus on the evidence drawn from patient record keeping. We found a high level of risk to patient safety through this work and requested the health board take immediate action to reduce the risk. The outcome and findings of this work have contributed to the overall view of this specific service as an emergency department in Wales. We will continue to monitor the progress the health board makes in this specific department and how the learning is shared and used to shape improvement across their services.

The concerns we received the most for Betsi Cadwaladr UHB related to:

- **Infrastructure (Staff facilities and the environment)**
- **Whistleblowing**
- **Clinical Assessment**

Cardiff and Vale University Health Board

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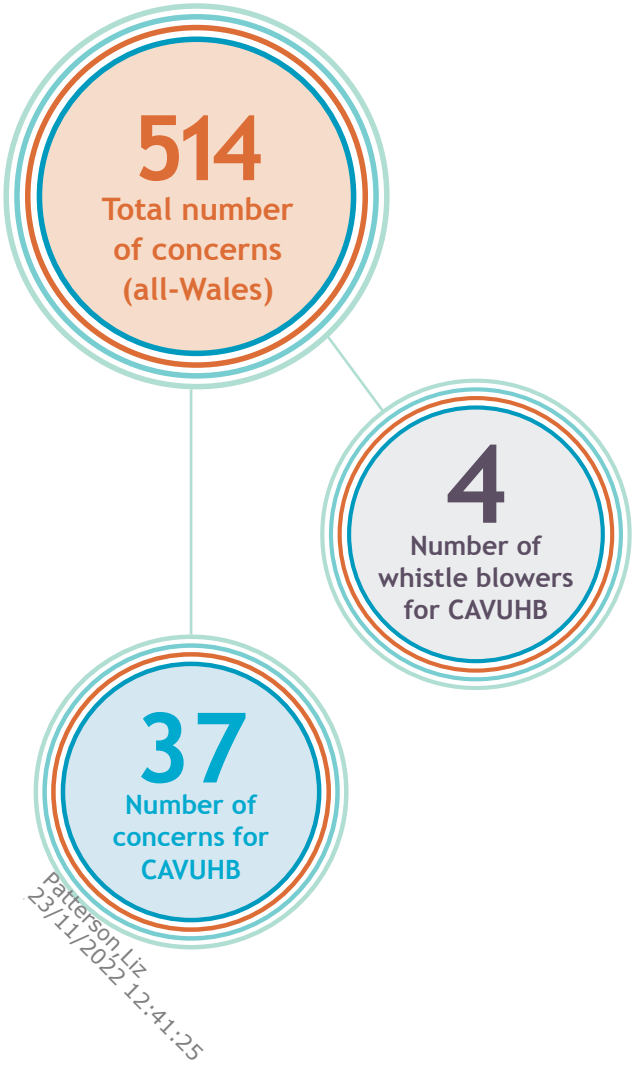
Cardiff and Vale University Health Board



Below is a breakdown of quality checks and onsite inspections that took place within the health board

Quality Checks	6
GP	5
Hospital	1

Onsite	3
Hospital	1
IRMER	1

Within Cardiff and Vale University Health Board, during the 2021-2022 period, our work to seek assurance on the safety and quality of care provided by the health board comprised of a mix of Quality Checks and onsite inspections, consideration of the themes and trends presented by concerns and whistleblowing reports received directly by us, and monitoring of data sets and intelligence shared with us from partner organisations who make up our National Healthcare Summit members [Healthcare Summit | Healthcare Inspectorate Wales (hiw.org.uk)]. The view of the health board developed over this time is a culmination of all the above sources of evidence.

Through our assurance work, we did not identify any significant concerns during the year. However, we noted a significant increase in demand for services, as the health board began recovery form the pandemic. This was also evident within the University Hospital for Wales Emergency Unit, which saw a rapid rise in demand at a time where additional measures were required to help maintain adequate infection prevention and control. The health board is undertaking a significant amount of work to improve the infrastructure, environment, and processes to manage this. We also noted significant pressure within the health board's Mental Health services including Child and Adolescent Mental Health Services (CAMHS).

This includes the timely compliance with referral, assessments, and treatment times. However, the health board has made progress with some improvements already in these areas.

Bed availability within inpatient CAMHS units nationally, is at a premium. Challenges remain in the health board, with its ability access CAHMS inpatient services in other localities.

As a result, where children and adolescents require inpatient treatment, and beds are not available in a specialist unit, some patients require admission to general paediatric areas, with the support of registered mental health nurses, and at times, older adolescents have been admitted to the adult inpatient services located in Hafan Y Coed. The challenge for the health board will be to sustain and continue improvements in this area, particularly when the demand for CAMHS services remains high. We will continue to monitor our findings for the past year throughout the 2022-2023 inspection year. This will include undertaking planned and reactive inspection and assurance work as necessary, maintaining our relationship manager communication with the health board and partner organisations and through our engagement with service users and staff. This will enable us to check that healthcare services are provided in a way which maximises the health and well-being of people who use services within the health board's hospitals and its community services.

Throughout the year, we identified that the health board teams have continued to work tirelessly during several significant challenges which remain as a result of the pandemic. These challenges include an increase in staff absences and vacancies, stretched services and the resulting impact these challenges can have on staff well-being and patient safety. The health board has been proactive in supporting its staff, with a plan in place to support their health and well-being.

Our engagement with the executive team has continued to be positive and constructive, both to HIW and the health board. There has been number of changes within the executive team which included the appointment of a new Chief Executive, and the recruitment process in place to obtain additional key executives, which included the Executive Director of Nursing, Medical Director, and Chief Operating Officer. We endeavour to maintain our positive relationships with the executive team and other senior leaders.

The concerns we received the most for Cardiff and Vale UHB related to:

- **Infrastructure (Staff facilities and the environment)**
- **Mental Health Act**
- **Clinical Assessment**

Cwm Taf Morgannwg University Health Board

Below is a breakdown of quality checks and onsite inspections that took place within the health board

Quality Checks	9
GP	3
Mental Health Hospital	3
Learning Disability	2
Hospital	1

Onsite	5
Hospital	3
IRMER	1
Mental Health Hospital	1

Within Cwm Taf Morgannwg University Health Board, during the 2021-2022 period, our work to seek assurance on the safety and quality of care within the health board comprised of a mix of Quality Checks and onsite inspections, consideration of the themes and trends presented by concerns and whistleblowing reports received directly by us, and monitoring of data sets and intelligence shared with us from partner organisations who make up our National Healthcare Summit members [Healthcare Summit | Healthcare Inspectorate Wales (hiw.org.uk)]. The view of the health board developed over this time is a culmination of all the above sources of evidence.

Overall, we found that the health board was continuing to make progress against the joint Audit Wales and HIW review of governance conducted in 2019. Both organisations jointly followed this up during 2020, reporting in May 2021. We found that there was a greater strategic focus on quality, safety and risk than had been previously found. However, we noted that it was too early to fully assess the effectiveness of the improvements and consequently we will be undertaking a further follow-up review during 2022-2023.

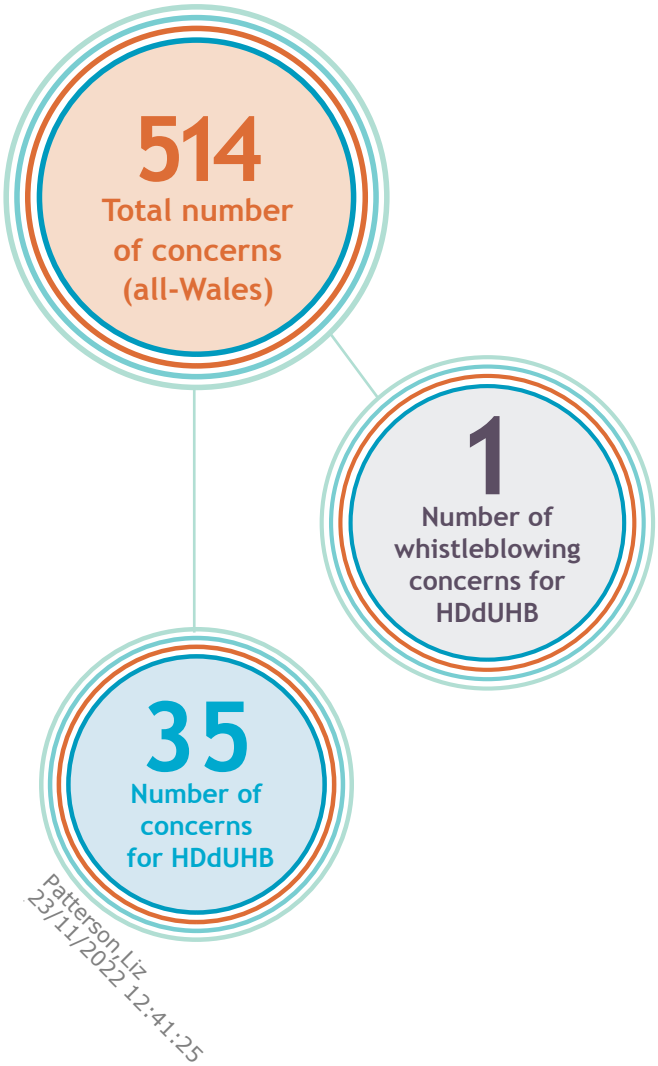
As a result of growing concern about the Emergency Department in Prince Charles Hospital, we carried out an unannounced inspection of the unit. We had significant concerns about patient safety and the potential high levels of risk to patients because of our findings. We were pleased that the health board responded very positively to our findings, noting their openness and willingness to work on tackling and addressing the issues we had highlighted through our work. We returned to the department unannounced four months later to consider their progress and could see several improvement initiatives in place which were already beginning to make a difference. We noted, however, that there were still areas which needed more work and urged the health board to maintain the momentum behind the improvement.

A challenge for Cwm Taf Morgannwg University Health Board will be around sustaining these improvements. Some of the issues we identified indicated that the culture at the department needed to be addressed. Where there are cultural issues, the challenge of maintaining the impetus and embedding changes may be greater. In a health board that has previously faced challenges with quality governance, it was positive to note the beginnings of change and the progress made by the health board to improve and sustain those improvements. The work done on improving the culture, values and behaviours across the organisation is a positive step for the whole health board but one that will need continued focus to make sustainable change.

The concerns we received the most for Cwm Taf Morgannwg UHB related to:

- **Infrastructure (Staff facilities and the environment)**
- **Treatment / Procedure**
- **Clinical Assessment**

Hywel Dda University Health Board



Below is a breakdown of quality checks and onsite inspections that took place within the health board

Quality Checks	8
GP	2
Mental Health Hospital	2
Learning Disability	2
Hospital	2

Onsite	3
Hospital	2
IRMER	1

Within Hywel Dda University Health Board, during the 2021-2022 period, our work to seek assurance on the safety and quality of care within the health board comprised of a mix of Quality Checks and onsite inspections, consideration of the themes and trends presented by concerns and whistleblowing reports received directly by us, and monitoring of data sets and intelligence shared with us from partner organisations who make up our National Healthcare Summit members [Healthcare Summit | Healthcare Inspectorate Wales (hiw.org.uk)]. The view of the health board developed over this time is a culmination of all the above sources of evidence.

During this period, we have seen evidence of Hywel Dda University Health Board working hard through difficult times to recover services following the early restrictions of the pandemic. Through our engagement with senior leaders in the health board and observing at quality and safety meetings, it has been evident that quality is clearly embedded in their approach to leading the health board, and we have seen a strong focus on a learning culture.

Difficulty in recruiting qualified staff continues to be a challenge for the health board, although there had been an increase in numbers of applicants for roles as healthcare support workers. The health board has continued

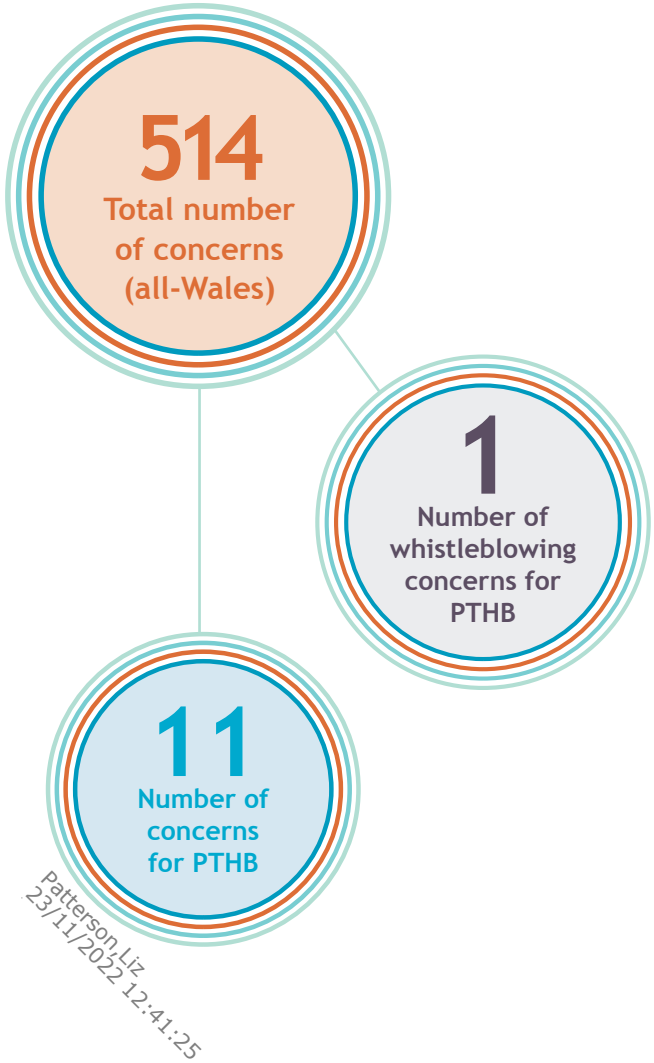
to tackle recruitment challenges through initiatives such as the use of an apprenticeship scheme, which enables people to work and gain healthcare qualifications. Resilience across their services has been fragile at times due to the staffing issues and compounded by the rurality and geographical spread of the health board and their hospitals. We note that senior leaders continue to plan and work proactively in an attempt to develop sustainable services for the future.

We carried out an offsite Quality Check of one of the health board's inpatient learning disability services and had significant concerns about the safety of the environment and the day-to-day management of risks in a service which was caring for vulnerable patients. The health board responded very quickly and constructively to the issues we identified and sped up their intention to discharge the patients to alternative placements. This action meant the service was empty and the health board did not admit any further patients for the remainder of the year while they worked to tackle the numerous service delivery issues that were present. We will continue to closely monitor the progress and re-opening of this service through our work and will consider further intervention and escalation if necessary. Through our partnership working with the Community Health Council (CHC), we were made aware of reports of poor patient experience within maternity services provided by the health board. The CHC ran a survey asking for experiences of maternity services within the health board. The results were mixed and saw several negative responses from patients. We engaged with the health board and have monitored their initial response to the issues; the challenge for them will be to fully embed the changes and maintain the momentum behind the improvements. We will continue to engage with the CHC to understand whether the patient experience within these services is improving and will consider future assurance work to check on the improvements in service delivery that have been made because of these interventions.

The concerns we received the most for Hywel Dda UHB related to:

- **Infrastructure (Staff facilities and the environment)**
- **Treatment / Procedure**
- **Self-harming behaviour**

Powys Teaching Health Board



Below is a breakdown of quality checks and onsite inspections that took place within the health board

Quality Checks	2
GP	2

Onsite	3
Hospital	1
CMHT	1

Within Powys Teaching Health Board, during the 2021-2022 period, our work to seek assurance on the safety and quality of care within the health board comprised of a mix of Quality Checks and onsite inspections, consideration of the themes and trends presented by concerns and whistleblowing reports received directly by us, and monitoring of data sets and intelligence shared with us from partner organisations who make up our National Healthcare Summit members [Healthcare Summit | Healthcare Inspectorate Wales (hiw.org.uk)]. The view of the health board developed over this time is a culmination of all the above sources of evidence.

During this period there have been several changes to senior leadership and management within the health board. This includes staff leaving, retiring, and undertaking secondments elsewhere within the organisation. Due to the level of recruitment, this is an area which may take time to stabilise, but it has been positive to note that the executive team is focusing on supporting and embedding leadership changes as a priority in support of their workforce and the continued delivery of frontline patient care.

There has been continued positive engagement with the leadership team, including regular and ongoing meetings with the Director of Nursing and Medical Director throughout the year.

Powys Teaching Health Board commissions a significant proportion of its services from providers in both England and Wales. There are arrangements in place to monitor the performance of the providers used to deliver services to Powys patients via a Commissioning Assurance Framework. However, some of the performance data was paused earlier in the COVID-19 pandemic, therefore this monitoring arrangement has not been fully functional throughout the year. As some services are provided by other health boards and trusts, the restarting of services has been variable, leading to a potential inconsistency and impact on Powys residents.

The health board has been monitoring this closely, reporting issues openly at quality, safety, and performance forums. We will continue to engage with the health board on this to ensure we remain up to date on this complex situation, and we will consider future work to better understand commissioning arrangements.

We undertook an onsite inspection to the mental health ward at Bronllys Hospital and identified that there had been limited improvements to some of the recommendations we had made at an inspection we carried out there in 2019. The lack of progress seemed to be particularly around the buildings and maintenance issues that we had identified. We urged the health board to improve their oversight of this area and make progress on these actions. Since then, it has been pleasing to observe updates provided by the health board to their quality and safety committee regarding the overall progress made against HIW recommendations and their subsequent completion.

The concerns we received the most for Powys THB related to:

- **Infrastructure (Staff facilities and the environment)**
- **Treatment / Procedure**
- **Clinical Assessment**

Swansea Bay University Health Board

Below is a breakdown of quality checks and onsite inspections that took place within the health board

Quality Checks	8
GP	5
Hospital	2
Learning Disability	1

Onsite	4
Learning Disability	1
Mental Health Hospital	1
IRMER	1
HMP	1

Within Swansea Bay University Health Board, during the 2021-2022 period, our work to seek assurance on the safety and quality of care within the health board comprised of a mix of Quality Checks and onsite inspections, consideration of the themes and trends presented by concerns and whistleblowing reports received directly by us, and monitoring of data sets and intelligence shared with us from partner organisations who make up our National Healthcare Summit members [Healthcare Summit | Healthcare Inspectorate Wales (hiw.org.uk)]. The view of the health board developed over this time is a culmination of all the above sources of evidence.

During this period, we have seen evidence of Swansea Bay University Health Board working hard through difficult times to resolve the issues that have arisen from the pandemic and also in specific service areas where there have been particular challenges.

There have been changes in the executive team over a number of years, however, the health board has made new executive appointments, including a new CEO and Executive Nurse Director. We also note the positive impact of stability in the executive team will require time to achieve and will continue to monitor progress through our work.

As a result of negative findings from a previous HIW inspection to Morriston Hospital Emergency Department in January 2020, we undertook an offsite Quality Check to check on progress and to consider how the department was responding to the ongoing challenges of the pandemic. We found that there had been improvements made but a significant demand for emergency care and lack of capacity elsewhere in the hospital due to the high number of inpatients was continuing to be a challenge. We were concerned to find that the training data being maintained by the department was not up to date so we could not be assured that there was an appropriate number of trained staff covering the area. The health board responded positively to this challenge and was able to assure us of sufficient numbers of trained staff by providing additional evidence. Whilst this is one specific example, we noted that demand and capacity challenges were present in other areas, these can present immediate challenges and divert the focus away from longer term improvement work.We were pleased to see that the health board was continuing to look for solutions to demand and capacity issues, such as dedicating the Neath Port Talbot site for planned and elective surgical procedures, supporting a better flow of patients at acute sites and to ensure continued attempts to reduce lengthy waiting lists. We recognise this is an ongoing challenge for the health board which will need to support and maintain the resilience of its workforce to meet continued high demand.

We also carried out a review of the governance arrangements in place by the health board in the provision of healthcare services to the prison population in HMP Swansea. This review was as a result of previous concerns raised by Her Majesty's Inspectorate of Prisons (HMIP) regarding the prison. The evidence we gathered pointed to gaps in oversight by the health board and processes that were not robust enough to ensure an effective service was being provided. The health board responded constructively and positively to our findings on this and will need to continue working on the recommended actions in order to create and sustain improvement.

The concerns we received the most for Swansea Bay UHB related to:

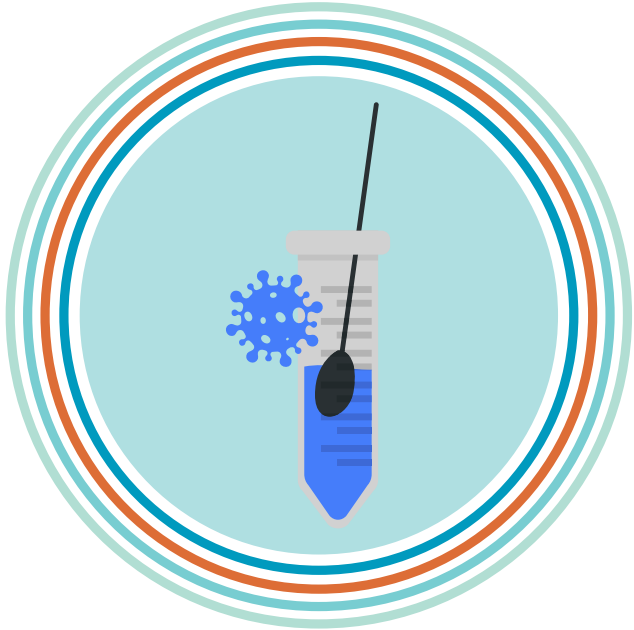
- **Infrastructure (Staff facilities and the environment)**
- **Safeguarding**
- **Clinical Assessment**

Public Health Wales

Within Public Health Wales, during the 2021–2022 period, our work to seek assurance on the safety and quality of care within the trust comprised of consideration of the themes and trends arising from concerns, attendance at quality and safety meetings, engagement with the senior executive team, monitoring of data sets and intelligence shared with us from partner organisations who make up our National Healthcare Summit members [Healthcare Summit | Healthcare Inspectorate Wales (hiw.org.uk)]. The view of the trust developed over this time is a culmination of all the above sources of evidence.

During this period, we observed Public Health Wales providing an important contribution to the ongoing surveillance of COVID-19 rates and communication of this to the public. Health Improvement programmes demonstrated innovation to delivering services remotely. Valued work was undertaken to support schools and businesses look after the emotional and mental well-being of pupils and staff as the nation came out of the pandemic. The delivery of vital public health screening services provided by the trust continued to be impacted by the COVID-19 pandemic. We saw evidence of services working to overcome these challenges in line with agreed recovery plans. Dedicated resource has been invested to tackle demand for each service and find solutions to the loss of community facilities which were used to host clinics pre-pandemic.

We recognised improvements with the recovery of services such as bowel and cervical screening and activities operating at pre-pandemic capacities for services such as breast screening and abdominal aortic aneurysm screening. We have noted the trust has an open and constructive culture amongst their staff and senior leaders which is positive as they continue working post-COVID-19. Through our work and engagement with the trust we will continue to monitor these areas which have been a particular challenge and will consider undertaking assurance work to further investigate issues as appropriate.

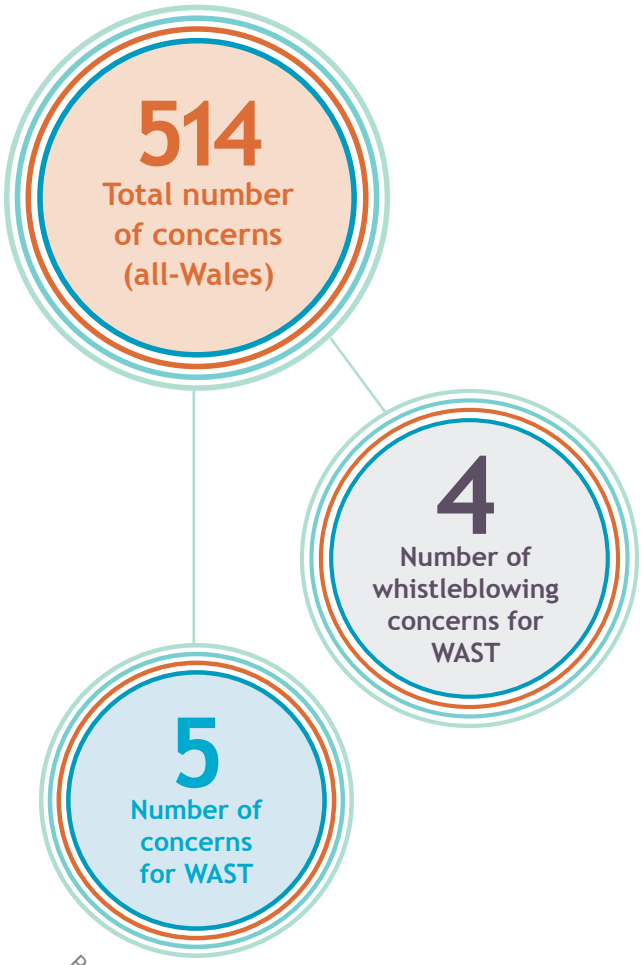


Velindre University NHS Trust

Our work to seek assurance on the safety and quality of care within Velindre University NHS Trust during the 2021–2022 period comprised of an offsite Quality Check of the inpatient service and monitoring of data sets and intelligence shared with us from partner organisations who make up our National Healthcare Summit members [Healthcare Summit | Healthcare Inspectorate Wales (hiw.org.uk)].The view of the trust developed over this time is a culmination of all the above sources of evidence.

We saw evidence of Velindre University NHS Trust working very hard to maintain the services they provide through specialist cancer inpatient and outpatient services, and also across Wales through the Welsh Blood Service. COVID-19 remained the biggest risk to service delivery with staff absences, capacity reductions and increasing patient numbers impacting on the trusts ability to reduce waiting times for treatment and services such as radiotherapy. Attempts to undertake HIW assurance work at the trust were hindered by an increase in infections in early 2022. This work will now take place in 2022-2023 and will provide us with a sense of how services are recovering from the pandemic.

We noted the efforts of the Welsh Blood Service to build and sustain blood stocks throughout the pandemic. We noted evidence of the organisation continuing to plan for future service requirements and monitored progress with the Transforming Cancer Service Programme. We have seen transparent and constructive challenge taking place by independent members on all aspects of the trust at committee meetings. Engagement between HIW and the executive team for the trust remains positive and constructive, with a welcome for the scrutiny we are able to provide.



Welsh Ambulance Services NHS Trust

During the 2021-2022 period, our work to seek assurance on the safety and quality of care within the trust comprised of the final part of our local review exploring the impact of patients being delayed on the back of ambulances, consideration of the themes and trends presented by concerns and whistleblowing reports received directly by us, and monitoring of data sets and intelligence shared with us from partner organisations who make up our National Healthcare Summit members [Healthcare Summit | Healthcare Inspectorate Wales (hiw.org.uk)]. The view of the trust developed over this time is a culmination of all the above sources of evidence.

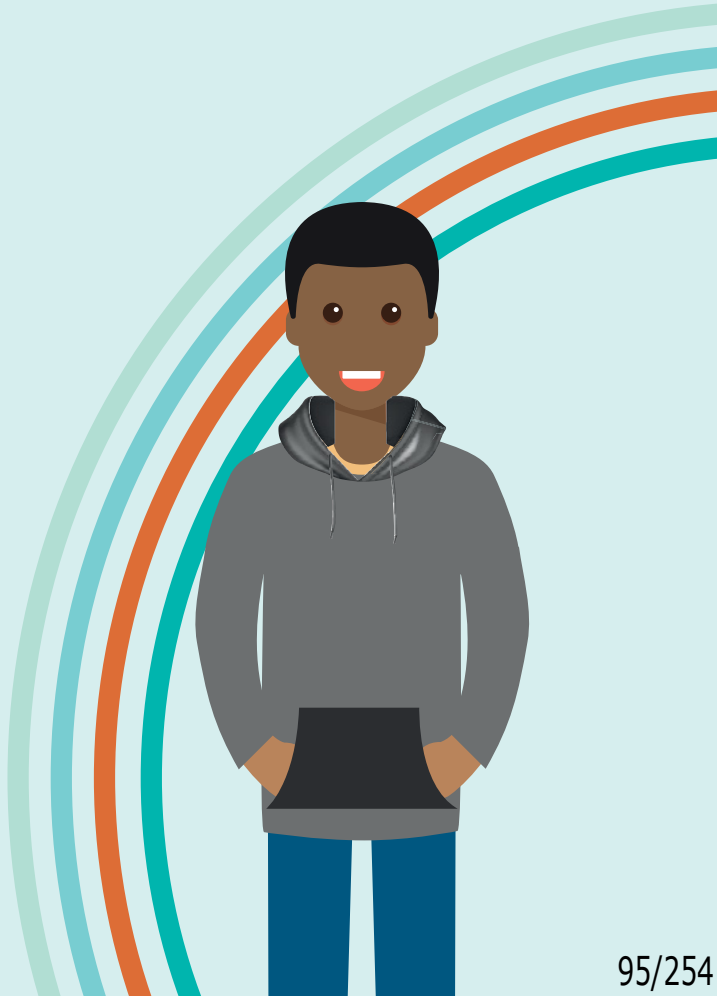
During this period, we noted the trust working through highly challenging times to provide their services and expertise across all parts of Wales.

Throughout the year the trust has been very open and honest with HIW, responding promptly to requests for information and data. We observed good levels of scrutiny and challenge at quality and safety meetings and have been assured that senior leaders seem to clearly recognise the issues they are facing and are committed to improvement. However, we also noted ongoing issues in service delivery despite this commitment to improvement.

Staffing has been a particular and significant challenge for the trust as it continues to see COVID-19 related absences impacting their workforce. Military personnel were brought in to support on community response vehicles and whilst this may have provided a temporary solution, once this resource is no longer available, the trust will need to continue to find solutions to their workforce challenge. We realise that this will not be simple to resolve and we will continue to monitor the trust's approach to service design and workforce planning through our work.

Our local review of patient experience whilst waiting in the back of ambulances found a number of examples where delays in handover had impacted extremely negatively on patients, but also on the ambulance staff providing their care. Staff told us that they were frustrated to find themselves waiting for long periods of time, sometimes entire shifts, waiting outside a hospital to transfer a patient and felt demoralised at not being able to provide care to patients in need of their help within the community. Whilst patients reported being cared for well by the ambulance staff who looked after them, they did not report positively about the length of time spent in the ambulance environment.

We made several recommendations through our review which we recognised were a substantial challenge to the trust and wider NHS system, however, to improve patient safety and tackle the impact on staff well-being, these recommendations must be acted on. The challenge for the trust will be the need to collaborate with health boards across Wales, all of whom have their own unique features and challenges. Supporting the well-being of ambulance staff who provide direct patient care and have direct contact with patients as call handlers will need to be of the utmost priority to the trust as it continues working on the recommendations and through this challenging time.



To be more visible

Collaboration and Engagement

Collaboration and joint working with other organisations are an integral part of the way in which we work. This year we continued to build on the strong relationships we have in place with our partners, once again acknowledging the additional insight this provided and the positive impact on our work that this gave us.

Collaboration

We continued to work with partners to explore how we can share data and intelligence. This included hosting two Healthcare Summits, in May and November 2021.

The summits were attended by the key regulatory and improvement bodies for healthcare in Wales. We agreed a collective view on the key national issues and risks across Wales, for example access to Child and Adolescent Mental Health Services (CAMHS). We shared these concerns, on behalf of all partners, with the NHS Wales Chief Executive. The purpose of this was to help us better understand what improvement action is underway at a national level. This forum continued to be a rich and valuable source of information and route for information sharing. We also started working with partners to develop a new mechanism, for members of the Healthcare Summit to share emerging serious patient safety risks and concerns across the sector. The work to develop this new mechanism will continue into 2022-2023.

During the year we continued to work closely with our partner, Care Inspectorate Wales (CIW).

In March 2022 we jointly published our report into the use of Deprivation of Liberty Safeguards (DoLS) in Wales. The safeguards apply to people over the age of 18 in hospitals or care homes, who cannot consent to treatment or care. We worked alongside CIW again, plus Her Majesty's Inspectorates of Probation (HMIP) and of Constabulary and Fire Services (HMICFRS), as well as Estyn, the education and training inspectorate for Wales to review the child protection arrangements in place in the Neath Port Talbot area.

We also work closely with Audit Wales, and in May 2021 we published a report providing detail on the progress made by Cwm Taf Morgannwg University Health Board in addressing the recommendations from our 2019 joint review into their governance arrangements. HIW's clinical team has been actively working in collaboration with training providers and professional organisations to support training delivered by the General Medical Council and to pre-registration nursing students. This supports greater awareness and understanding of the role of HIW in Wales. The clinical team has also been sharing good practice we have identified through our inspection work by signposting health board teams to the services they can approach to learn from.

Engagement

Speaking and listening to people who use healthcare services and who work within healthcare services is of the highest priority to us. By doing this, we can better understand what matters to people and can gain a greater understanding of the culture within a service and insight into the experience patients receive.

During our inspection and review work we ask patients to tell us about the care they receive by completing a short survey, and when we are able to speak to patients in person during onsite visits, we gather views directly. This year, for example, we used a short engaging video on social media to help explain our National Review of Patient Flow and to encourage people to tell us about their personal experience, or the experience of their loved ones if they have been treated for a stroke. In January 2022, we launched a refreshed area on our website, keeping all our surveys in one place and making it easier for people to find out what active work we have ongoing, and provide their comments. Work on our 2022-2025 strategy was a key focus during the year and as part of this we undertook two large scale online surveys open to stakeholders and the public. We used these surveys to help shape our future direction through the increased understanding the responses gave us about the impact of our work on people and services.

In February 2022, we increased our social media presence and launched on LinkedIn. We recognised this as an important additional avenue for engagement with healthcare professionals. We have continued to use Twitter and Facebook to engage widely with social media users about our work, encouraging people to click through to our website where they can find out more about our work and role in Wales. Across our digital platforms we have seen an increase in engagement with a higher number of impressions and a wider reach of our content.

We also developed a new methodology for onsite inspections of Mental Health Units. One important change in this area is the implementation of a process to use questionnaires for patients, staff, friends, and family members. This will increase our engagement with people who use mental health services and those who work within them.

In response to previous feedback from the public that our reports can be hard to understand, we concluded a project to implement a new reporting style for onsite inspections. This new approach was implemented in April 2022 and involves publishing a public summary and a full detailed report for the setting. We also reviewed how we report to remove unnecessary duplication and make the reports easier to read. The outcome of this will be reports that are easier to understand and engage with.

To develop our people and our organisation to do the best job possible

Internal Update

Although the last year has been one of significant change, we have continued to invest in the development of HIW and its people in order to ensure we monitor and check that people in Wales are receiving good quality healthcare. We introduced many new ways of working to continue to fulfil our organisational functions, whilst being flexible to any emerging risks. People are at the heart of what we do, and it is important we strive to share lessons learnt, reflect on what has worked well and take forward this learning to continuously improve.

We listened to and supported the well-being of our people to enable them and our organisation to do the best possible job and keep our communities safe and well. Our Corporate Service department developed a bespoke Learning and Development programme for our staff, tailoring unique opportunities to enable our workforce to build on vital skills. Following the launch and implementation of our internal Well-being Strategy our staff survey scores have shown clear signs of improvement across our key themes including inclusion, leadership and change.

We have also recruited to several new roles including Mental Health Act and peer reviewers to strengthen our access to clinical expertise alongside developing a professional pathway f or all our HIW inspectors. Over the past 12 months we have recruited a number of peer reviewers with experience in specialised nursing roles including stroke and child and adolescent mental health.

We implemented a new Customer Relationship Management system in March 2022. The new system replaced many of our existing spreadsheets and documentation. The system has been successfully rolled out and allows our staff to use data and information more effectively and efficiently to strengthen our ability to generate intelligence and insight. We have continued to work with partners to explore how we can share data and intelligence. This includes early collaborative work to develop a new process for healthcare organisations and partners in Wales to share serious patient safety risks and concerns across the sector.
We have held regular staff forums to discuss lessons learnt, areas of improvement and empower our workforce to have their say. The forum and anonymous staff suggestion box are monitored and fed back to senior leadership, where ideas, concerns and proposals are reviewed and actioned.

Commitment Matrix

The following table is a list of the objectives HIW set itself for 2021-2022, together with details of how we met the objective.

What we said	Measured by	Outcome
Regulating independent healthcare		
Deliverable 1		
Process applications to register, or changes to registration, in a timely manner. Ensure all applicants can demonstrate they meet relevant regulation and minimum standards.	Registration applications determined within 12 weeks of full and complete submission.	The following registration work was completed during 2021-2022 **Independent Healthcare Services** • 44 New Registrations • 28 Changes of Registered Managers • 12 Changes of Responsible Individuals • 22 Variations of HIW Registration Conditions **Private Dental Practices** • 14 New Registrations • 37 Changes of Registered Managers • 12 Changes of Responsible Individuals • 1 Variation of HIW Registration Conditions

What we said	Measured by	Outcome
Regulating independent healthcare		
Deliverable 2		
Conduct a programme of visits to suspected unregistered providers as required. Deliver a programme of assurance and inspection work on independent settings in line with our frequency rules. Continue to plan and deliver the rest of our work programme in areas where we believe there is the highest level of risk to patient safety.	Number of visits undertaken. Number of Quality Checks undertaken. Number of reports published four weeks following Quality Check. Number of full inspections undertaken. Number of reports published three months following an inspection. Where urgent action is required, following assurance working the independent sector, the service will be issued with a Non-Compliance Notice within two days.	We carried out three visits to unregistered providers. We carried out 91 Quality Checks of independent services. We carried out 34 onsite inspections of independent services. We published 91 Quality Checks during 2021-2022. 75 of these were published within four weeks. We published 34 onsite inspections reports during 2021-2022. 28 of these were published within three months following the inspection. We issued 16 Non-Compliance Notices.

What we said	Measured by	Outcome
Regulating independent healthcare		
Deliverable 3		
Ensure that concerns and Regulation 30/31 notifications are dealt with in a timely and professional manner.	Number of concerns received. Number of Regulation 30/31 notifications received. Analysis of source and action taken.	During 2021-2022 we received 144 concerns from the public or staff. We also received 16 concerns in relation to unregistered providers or settings that do not require registration with HIW. All concerns are reviewed and evaluated on a weekly basis and inform decisions about our inspection activities and priorities. Independent healthcare providers are required to inform us of significant events and developments in their service. These Regulation 30/31 notifications continue to be managed in line with our process and dealt with effectively. In total we received 1,484 Regulation 30/31 notifications. A breakdown of the notifications are as follows: • Death in Hospice – 604 • Death excluding Hospice -28 • Unauthorised absence – 90 • Serious injuries – 483 • Allegation of staff misconduct – 156 • Outbreak of Infectious Disease – 100 • Deprivation of Liberty Safeguards (DoLs) – 23

What we said	Measured by	Outcome
Regulating independent healthcare		
Deliverable 3		
		In total we received 156 Regulation 25 (The Private Dentistry (Wales) Regulations 2017) notifications during 2021-2022. They are as follows: • Serious injuries – 8 • Outbreak of an Infectious Disease – 147 • Allegation of staff misconduct – 1 • Death of a patient – 0 All notifications were evaluated, and additional assurances were sought where necessary.

What we said	Measured by	Outcome
Inspecting the NHS		
Deliverable 4		
Deliver a programme of assurance and inspection work in the NHS across all settings informed by analysis of risk and how our resources are best deployed. Continue to plan and deliver the rest of our work programme in areas where we believe there is the highest level of risk to patient safety.	Number of Quality Checks undertaken. Number of reports published five weeks following Quality Check. Number of full inspections undertaken. Number of reports published three months following an inspection. Where immediate assurance is required following an NHS assurance process, letters will be issued to the Chief Executive of the organisation within two days.	We carried out the following Quality Checks and inspections: **Quality Checks** 25 GP 10 NHS Hospital 5 NHS Mental Health Hospitals 8 Learning Disability 1 Step Down Community Hospital **Onsite Inspections** 8 NHS Hospitals 7 NHS Mental Health Hospitals 5 Learning Disability 6 IR(ME)R We published 49 Quality Checks during 2021-2022. 26 of these were published within four weeks. We published 23 onsite inspection reports during 2021-2022. 17 of these were published within three months following the inspection. We issued 12 out of 14 Immediate Assurance letters within two days of inspection/Quality Check.

What we said	Measured by	Outcome
Inspecting the NHS		
Deliverable 5		
Continue our programme of reviews including: • Mental health crisis prevention in the community. • Medicines management review. • Focused local reviews; one of these will be a local review of WAST. That will consider thesafety, dignity, well-being and overall experience of patients whilst waiting in ambulances at hospital emergency departments. • COVID-19: Themes and learning from our work. Undertake follow-up work on previously published local or national reviews, including: • Phase one of our National Review of Maternity Services. • Review of Patient Discharge from hospital to GP Practices. • Review of Integrated Care: Focus on Falls. • Substance Misuse Services in Wales. • WAST – Assessment of Patient Management Arrangements within Emergency Medical Service Clinical Contact Centers. • PHW – Assessment of how the breast screening process is managed in a timely manner for women who have an abnormal screening mammogram.	Analysis, production and publication of the review. Publication of terms of reference for these reviews. Commence programme of follow up work.	During the year we published: • COVID-19 National Review • National Review of Mental Health Crisis Prevention in the Community • Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover We also completed our local review of Governance Arrangements at Swansea Bay University Health Board for the Provision of Healthcare services to Her Majesty's Prison Swansea. We started work on our National Review of Patient Flow (Stroke Pathway) and Local Review of Discharge Arrangements for Adult Patients from Inpatient Mental Health Services in Cwm Taf Morgannwg University Health Board.

What we said	Measured by	Outcome
Inspecting the NHS		
Deliverable 6		
Conduct a high-level review of each NHS body through: • Further development of the Relationship Management function. • Producing an annual statement for each health board and NHS trust.	Publication of health board and NHS trust annual statements.	As part of our 2021-2022 annual report, we have undertaken a high level review of each NHS health board and trust. We have produced a statement for each health board and trust, and these can be found in the *'To take action when standards are not met'* section of this report.

What we said	Measured by	Outcome
Our work in mental health		
Deliverable 7		
Undertake a programme of assurance and inspection work on NHS, independent mental health and learning disability settings. Continue to plan and deliver the rest of our work programme in areas where we believe there is the highest level of risk to patient safety. Undertake a minimum of one piece of Learning Disability assurance work in each Health Board area in this inspection year.	Number of assurance and inspection activities undertaken.	During 2021-2022, we undertook the following assurance and inspection work across NHS, independent mental health and learning disability settings: **Quality Checks** • 5 NHS Mental Health Hospitals • 8 Learning Disability **Inspections** • 14 Independent Mental Health Hospitals • 7 NHS Mental Health Hospitals • 5 Learning Disability

What we said	Measured by	Outcome
Our work in mental health		
Deliverable 8		
Provide a Second Opinion Appointed Doctor service for approximately 1000 SOAD requests.	Publication of Key Performance Indicators.	The SOAD services undertook 759 case reviews. These were: • 657 – Medication • 66 – ECT • 36 – Medication and ECT

What we said	Measured by	Outcome
Sharing what we find		
Deliverable 9		
Publish reports from all our assurance activity in accordance with our performance standards.	Publication of reports according to our Publication Schedule. Publication of HIW performance against targets. Publication of Annual Report for 2020-2021.	We published 140 Quality Checks during 2021-2022. 101 of these were published within four weeks. We published 57 inspection reports during 2021-2022. 45 of these were published within three months following the inspection.

What we said	Measured by	Outcome
Sharing what we find		
Deliverable 10		
To actively share our findings and recommendations with stakeholders, service providers and the public to influence and drive improvements in healthcare. In particular in relation to: • Hospital Assurance activity • GP Practices • Dental Practices • Mental Health Act Annual Monitoring Report • Deprivation of Liberty Safeguards (DOLS) • IR(ME)R • Lasers • HIW Annual Report	Publication and dissemination of our findings in a number of ways including: Learning bulletins distributed. Case studies of good practice distributed. Improved website content.	We held regular workshops with Community Health Councils and quarterly summits key stakeholders for the NHS and independent healthcare sector. We issued 19 newsletters throughout the year ranging from updates and guidance to dental practices, winter update to stakeholders, and monthly newsletters. We have supported improvements to our website in 2021-2022 including: • created a new surveys section on our website. • created a new social media feature on our website. • Made regular improvements to the functionality of the website to provide a better user experience including engaging features, streamlined navigation tools and the use of branded imagery.

What we said	Measured by	Outcome
Working with others		
Deliverable 11		
Continue our joint inspection work with UK agencies. Details to be agreed on a quarterly basis.	Number of inspections undertaken.	We carried out 15 death in custody investigations. We undertook two prison inspections with HMI Prisons and HMI Probation.

What we said	Measured by	Outcome
Working with others		
Deliverable 12		
Continue working with other agencies on inspections and influencing best practice. Our five planned reviews with other Inspection Wales and Her Majesty's Inspectorate services are: • Review of Health Board and Trust Quality Governance arrangements (Governance reviews with Audit Wales).	Participation in joint work. Consolidation of the key findings and emerging themes from our joint work, and consider how these can inform our future work programmes.	CIW had involvement in design of work through our stakeholder group for our Mental Health Crisis review. We continued to work with Audit Wales to review Health Board and Trust Quality Governance arrangements. We undertook a JICPA second pilot review with all relevant agencies of child protection arrangements.

What we said	Measured by	Outcome
Working with others		
Deliverable 12		
• CIW providing support to our Mental Health Crisis Prevention review. • Joint Inspectorate of Child Protection Arrangements (JICPA) review (with CIW, Her Majesty's Inspectorate of Constabulary and Fire and Rescue Services, Her Majesty's Inspectorate of Probation (HMI Probation) and Estyn). • Supporting HMI Probation with their joint thematic inspection of community-based drug treatment and recovery work with probation service users (for intelligence to support our Mental Health Crisis Prevention review). • Supporting HMI Prisons with their inspections of prison services in Wales. • Work with the Welsh Government, Care Inspectorate Wales and other stakeholders to review the effectiveness of Regional Partnership Board joint working.		HIW, CIW and Estyn submitted a joint business case to Welsh Government to secure additional funding to continue our JICPA work, to enable us to review processes within a further four local authorities across Wales. Within the plan, we would conclude the work undertaken in six local authorities and will evaluate all JICPA reviews undertaken to produce a national picture within a report, which would be published in summer 2024 once all work is complete. A provisional agreement is now in place for the funding early in quarter one of 2022-2023. HIW continued to work closely with CIW and Welsh Government to undertake work with and assess the effectiveness of the regional partnership boards. Our newly appointed Director of Strategy and Engagement will be leading this work through work with the partnership boards and providing regular updates to our review steering board.

Our priorities for 2022-2025

Healthcare exists for people and communities, and the work we carry out looks at whether it meets the needs of a community and whether it is of a good quality. Where we find inequalities in healthcare provision, where a service is not designed for the needs of the community it serves, we will challenge this.

Equality and diversity is embedded in the work we do and we consider how healthcare services reach those who face the greatest barriers to accessing quality healthcare.

Our responsibilities in relation to mental health span both the NHS and the independent sector. HIW also works with other review and inspectorate bodies to consider the quality of healthcare delivered in non-healthcare settings such as prisons.

As we head into the next three years we will be working to our new strategy.

Our goal is:

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

These priorities will help us to consider whether healthcare meets the needs of a community and whether it is of a good quality. Equality and diversity will be core to the work we do and our strategy supports us to consider how healthcare services reach those who face the greatest barriers to access, and poorest outcomes in health.

Our Resources

For 2021-2022 we had a budget of approximately £4.3m. Although the pandemic impacted our ability to deliver a full programme of onsite activity, we continued to make use of our new method for gaining assurance offsite, known as a Quality Check, where appropriate. We strengthened this approach during 2021-2022 following an evaluation of its effectiveness and suitability for its use beyond the pandemic. However, we continued to respond to emerging in-year intelligence which gave us immediate cause for concern or where the risk to patient safety was such that onsite activity was the most appropriate method for gaining assurance.

We have posts equivalent to approximately 83 full-time equivalent staff. We currently have a panel of over 200 specialist peer reviewers with backgrounds including specialist and general nurses, GPs, dentists, anaesthetists, and GP practice managers. We also have specialists in Mental Health Act Administration and a panel of psychiatrists who provide our Second Opinion Appointed Doctor (SOAD) service. We have over 30 Patient Experience Reviewers and Experts by Experience.

The table shows the number of full or part time posts in each team within HIW during 2021-2022.

Team	Whole time posts
Senior Executive	3
Inspection, Regulation and Concerns	39
Partnerships, Intelligence, and Methodology	14
Strategy, Policy and Communication	5
Clinical advice (including SOAD service)	4
Corporate Services (including business support)	18
Total	83

Finance

The table shows how we used the financial resources available to us in the last financial year to deliver our 2021-2022 Operational Plan.

	£000's
HIW Total Budget	**£4,376,000**

Expenditure	£000's
Staff costs	**3,882,624**
Travel and Subsistence	**13,150**
Learning & Development	**18,883**
Non staff costs	**45,944**
Translation	**59,939**
Reviewer costs	**414,358**
ICT Change Program costs	**333,816**
ICT Non CRM costs	**15,102**
Depreciation of assets	**13,866**
Total expenditure (a) £	**4,797,682**

Income	£000's
Independent healthcare	**311,790**
Private dental registrations	**241,900**
Total income (b) £	**553,690**
Total Net Expenditure (a-b) £	**4,243,992**

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Contact us

Healthcare Inspectorate Wales
Welsh Government
Rhydycar Business Park
Merthyr Tydfil
CF48 1UZ

By email: **hiw@gov.wales**
By phone: **0300 062 8163**

www.hiw.org.uk

Find us on:

WG46034

978-1-80364-857-6

LEARNING NEWSLETTER

OCTOBER 22, ISSUE 1

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board
Ysgol Ymchwil, Datblygu ac Arloesi
School of Research, Development and Innovation

Brought to you by your: Quality and Safety Team and Powys Regional Innovation Co-ordination (RIC) Hub

MEDICINES MANAGEMENT UPDATE

Medicines Policy

At the beginning of September the new PTHB 'Medicines Policy' was approved by the Area Prescribing Group (APG) and is now published on the health board's website.The Medicines Policy is the overarching policy with respect to medicines use across the health board. It contains legislative, regulatory and best practice guidance. Staff are encouraged to read the whole policy and refer to it when necessary.

The policy will be kept under constant review and updated when required. To ensure that staff are referring to the most up to date version, it is recommended that the document is accessed from the website rather than being downloaded and saved.

Any questions relating to the policy should be sent to: info.medicinesmanagement.powys@wales.nhs.uk

Covid-19 Vaccines

During the COVID-19 vaccination programme mistakes have happened because staff have failed to check patients' Welsh Immunisation System (WIS) records before administering a dose.

To help avoid administration errors, WIS records MUST ALWAYS be checked before a dose is administered. This is a requirement irrespective of where the patient is vaccinated (e.g. MVC, GP practice, care home, hospital ward). It is also essential that WIS records are updated promptly after a dose has been given.

Patient Experience

Goodbye Scooter, Goodbye easy chair
My new found friends are always there,
My me 'Commode' is what I need
In crucial times to do my deed,
Oh, what freedom they both give
And change the way of how I live,
When commode; I'll sit and stare
At my new friend who's always there,

And my new found friends from the O.T,
Have been so very kind to me,
For with commode and Zimmer frame
My life will never be the same,
With frame to help me get around
And 'Commode' so solid on the ground,
What a great service are O.T,
To meet the needs of folk like me.

Their prompt reaction to my plea,
Is a great credit to O.T,
Only on the morn they got the call.
And by mid-noon had settled all,
What a gift to us in the N.H.S,
And always their for all of us,
It is a jewel in our crown,
And will never ever let us down.

With special thanks 'Emyr ap Erddan'

LEARNING NEWSLETTER

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

Ysgol Ymchwil, Datblygu ac Arloesi School of Research, Development and Innovation

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CIVICA TRAINING

CIVICA – Feedback and Experience System

Over the next few months PTHB are implementing the CIVICA patient experience feedback system. This system enables healthcare organisations to understand real-time patient feedback, prioritise risk areas and drive service improvement, as well as highlighting positive comments. The software provides multi-channel data collection, bespoke analysis and reporting, providing a continuous feedback loop between the patient and healthcare professional.

This training is available to those managers and staff who have registered their need to access the system with Quality and Safety.

Please book your course on ESR:
070 CIVICA Training General

Please note all sessions will be hosted via Teams. Contact susannah.jermyn@wales.nhs.uk for further information.

Date	Time
10/10/2022	3pm-4pm
11/10/2022	1.30pm-2.30pm
11/10/2022	3pm-4pm
12/10/2022	1.30pm-2.30pm
12/10/2022	3pm-4pm
18/10/2022	10am-11am
18/10/2022	12pm-1pm
18/10/2022	2pm-3pm
19/10/2022	1.30pm-2.30pm
19/10/2022	3pm-4pm
20/10/2022	1.30pm-2.30pm
20/10/2022	3pm-4pm
25/10/2022	1.30pm-2.30pm
25/10/202	3pm-4pm
27/10/2022	10am-11am
27/10/2022	12pm-1pm

Improvment and Innovation

On the 5th and 6th September, Powys Teaching Health Board hosted a Foundational Site Visit for IHI and IC colleagues. Over the two day visit, the team met with a variety of teams and Heads of Service Leads to discuss how the leads and their teams attitudes and behaviours contribute towards learning and improvement. The visit was facilitated and arrange by the RIC Hub (Regional Innovation Co-ordination Hub) who also met with the group as part of their introduction to the Innovation and Improvement team. The IHI and IC reported back with feedback at the end of the two days and the health board expects to receive a full report with suggestions for PTHB to strengthen their learning and improvement services provided to them.

For any further information on current or existing Research, Innovation or Improvement, please contact us at bright.ideaspowys@wales.nhs.uk

LEARN MORE https://phw.nhs.wales/services-and-teams/improvement-cymru/improvement-cymru-strategy/

TALK TO US! @ concerns.qualityandsafety.POW@wales.nhs.uk

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18/10/2022	10am-11am
18/10/2022	12pm-1pm
18/10/2022	2pm-3pm
19/10/2022	1.30pm-2.30pm
19/10/2022	3pm-4pm
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CONCERNS

Concern
Service user was awaiting a procedure at Llandrindod Wells and was sent an appointment on 3 occasions in error to attend Brecon War Memorial Hospital, it was only that the service user contacted the booking team to question the location was the error noted. Adjustments were not made the first time which resulted in two further letters and appointments being sent for the wrong Hospital Site.
Learning: Ensure there is a process of checking demographics and Hospital site when making appointments.

Concern
Service user was experiencing a significant challenge in their personal circumstances and did not feel the team provided compassionate and supportive contact regarding their health needs.
Learning: Evidence of good standard of documentation in place to support a robust level of communication and support.

Concern
Family raised concerns regarding the provision of intensive Physiotherapy to support rehabilitation.
Learning: unplanned gaps in Physiotherapy service provision which were not communicated with the patient and his family adequately.
It was noted that provision was appropriate.

Concern
Concern regarding provision of care, it was noted that concern management had not been timely with failure to provide robust communication.
NOT UPHELD

For further information on the Putting Thing Right Framework, please visit:

NHS Wales complaints and concerns: Putting Things Right | GOV.WALES

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda Item: 2.2

Patient Experience and Quality Committee	**Date of Meeting: 24 November 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:	Claire Roche, Director of Nursing and Midwifery Senior Midwifery Team.
Other Committees and meetings considered at:	Executive Committee 16 November 2022.

PURPOSE:

The purpose of this paper is to provide the Patient Experience and Quality Committee with the current position related to maternity assurance.

RECOMMENDATION:

The Patient Experience and Quality 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:

The purpose of this paper is to provide the Patient Experience and Quality Committee with an update on quality assurance matters in Maternity Services in Powys.

The paper focuses on:

- Powys Provider Maternity Service: Update on current escalated arrangements and de-escalation plan;
- an update on Maternity Services commissioned by Powys Teaching Health Boards which are in high levels of Scrutiny: namely Shrewsbury and Telford NHS Trust and Cwm Taf Morgannwg Health Board;
- an update on national improvement work-streams related to maternity and neonatal services in Wales; and
- external Reports: Prompt Wales.

DETAILED BACKGROUND AND ASSESSMENT:

1) Powys Provider Maternity Service

In July 2022 the Powys Teaching Health Board midwifery service was placed into Local Escalation due to an increase in National Reportable Incidents and a lack of data relating to small for gestational age babies. Local Escalation resulted in increased monitoring for quality/ safety and assurance purposes. A weekly escalation meeting was put in place chaired by the Deputy Director of Nursing. The meeting which includes both the AD for women and Children's service group, and the Head of Midwifery scrutinises weekly metrics, progress against gap and grow reporting and all weekly incidents. It also allows for escalation of any issues arising on a weekly basis. A highlight report is produced for assurance to the Director of Nursing and midwifery and tabled at the monthly Maternity Matters group. In

addition to this a fortnightly meeting is also in operation to scrutinise progress, learning and actions arising from the five current NRIs to ensure timely actioning of outcomes and make safes within the service.

De-escalation criteria and indicative timelines have now been drafted covering four key areas and an Improvement plan metrics/timeframe and accountable leads confirmed. The Core data set to continue to be monitored through the local escalation meeting until this is stepped down into business are usual governance mechanisms. Weekly safety meetings have been in place and Monthly Senior clinical Leadership meetings continue to monitor the dashboard metrics. Gap and Grow Data monitoring and reporting compliance is now in place and all NRI investigations have been completed.

The attached Maternity Improvement Action Plan (Appendix 1) identified the steps needed to transition from "Local Escalation" to "Business as Usual". There are three categories of actions:

- Leadership and Culture
- Quality and Safety
- Clinical Excellence

Some actions have already been completed and others have intended timescales for completion documented. All actions are expected to be completed by March 2023 and therefore the aim is to transition to business as usual arrangements by that time. These will however be new and improved arrangements to ensure strong governance arrangements to support a service that is safe, effective and provides positive experiences for mothers, babies and families.

However, the intention is to have an on-going Continuous Improvement Plan for Maternity Services. This will ensure that priorities for improvement identified through triangulated assurance mechanisms (concerns, complaints, incidents and national reports) are identified and actioned continuously. This will ensure that the Quality Management System (proposed and mandated in the Quality and Engagement (Wales) Act) will be live and meaningful in our maternity services, leading to and supporting continuous learning.

The Improvement Plan was presented to the Executive Committee on the 16 November. It was agreed that a progress paper will be presented to the Executive Committee in January 2023, followed by a further paper in March 2023. On both occasions, assurance will be sought as to the evidence for achieving the improvement actions. The Improvement Plan will now be further updated to include a column that will detail the evidence of actions taken and implemented.

2) Maternity Services Commissioned by Powys Teaching Health Board

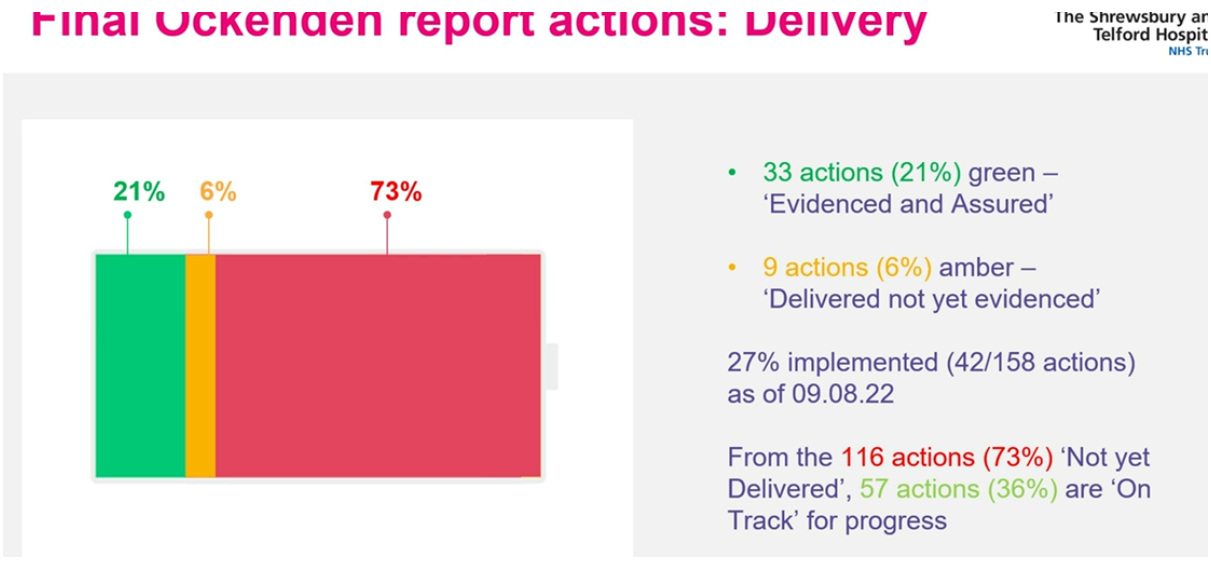
Shrewsbury and Telford NHS Trust (SaTH)

The Executive Director of Nursing and Midwifery for Powys THB is a member of the Ockenden Review Assurance Committee. This public monthly meeting is independently chaired and monitors the progress with the improvements being made in SaTH in response to the Ockenden Report recommendations.

The team at SaTH present the progress with their actions as being either:

- ✓ Green: evidenced and assured or
- ✓ Amber: delivered, not yet evidenced.

An example of this is demonstrated below**:**



The below graphics illustrate the progress with the actions, the proposed timeframes for completion and a summary to date.

Final Ockenden report actions: Timeframes

The Shrewsbury and Telford Hospital NHS Trust

The current timeframe profile for actions to be delivered is, as follows:

Financial year	Number of actions expected to be fully implemented during this period
2022-23	51
2023-24	85
Yet to be determined	22

With regards to the overall responsibility for leading on the delivery of the required actions, the breakdown is, as follows:

Lead agent	Number of Actions
Internal (Trust only)	131
External (combined Trust- external agencies)	27 (Addition of IEA 11.4 - external dependency on Royal College of Anaesthetics, as advised by Anaesthetics Division at recent planning workshop)

Summary (final report)

The Shrewsbury a Telford Hospi NHS T

- From the final report, 42/158 (27%) of the actions have been 'delivered', with 33 (21%) of these 'evidenced and assured'.
- The Trust is getting positive external and stakeholder feedback (NHSE/I and CQC) on its progress to date: *RPQCG (Regional Perinatal Quality Committee) described SaTH, (and two other trusts) as 'shining examples following the Ockenden assurance visit'.*
- There is still much more to do.
- Work continues at pace to deliver the rest of the programme.

Powys Maternity Services have a good working relationship with SATH maternity team. They attend our regular commissioning meetings and provide opportunity to share round table discussions with them when there is a case to share. Powys Women and Children's Governance lead is invited to their regular Quality & Safety meetings, offering the opportunity to escalate any issues faced for Powys residents.

Cwm Taf Morgannwg University Health Board

Routine commissioning meetings between Governance teams continue to strengthen. Cwm Taf respond well to queries regarding services and have demonstrated actions taken to improve the return of Powys handheld records.

The senior management team within Powys Maternity services attended the All Wales Maternity and Neonatal Safety Summit on the 6th September. At the event, the Independent Maternity Services Oversight Panel (IMSOP) review was shared and improvements made by the Cwm Taf Morgannwg Maternity and Neonatal teams was presented by the Cwm Taf Morgannwg (CTM) team.

Powys is a member of the on-going CTM Maternity and Neonatal Improvement Board. At the most recent meeting, the team at CTM presented their Maternity and Neonatal Strategy for 2022-2025 "Starting Well". The strategy sets out the objectives for the maternity and neonatal services at the Health Board aligned to their four strategic pillars and future ambition as set out below:

1. Creating Health – ***Reducing health inequalities providing family cantered care through continuity of care***
2. Improving Care – ***Delivering safe, effective and Compassionate care***
3. Sustaining our future – ***Embedding quality, value based healthcare***
4. Inspiring People – ***Investing in skilled multi-professional teams***

Care Quality Commission (CQC) Reports

The Care Quality Commission (CQC) published their report in July 2022 detailing the outcome of their unannounced visit to Gloucestershire Maternity Services in June 2022. The report rated the maternity service as inadequate as a result of the following findings:

- The service did not always have enough staff to care for women and keep them safe. Not all staff had updated their training in key skills. Not all equipment checks were completed daily. Some safety incidents were not investigated fully, or in a timely way and lessons were not always learned from them.
- Not all staff felt respected, supported, and valued. The service did not have a clear vision, values or strategy, although this was in development. There was not sufficient leadership capacity to focus on governance and risk management. Leaders did not always have reliable information systems to support them to monitor services.
- There were not sufficient competency frameworks for midwives and the professional midwifery advocate (PMA) service, to support midwives, had been significantly reduced due to vacancies within the team. Managers did not have effective systems and processes to proactively monitor and improve services.

However:

- Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Midwifery staff knew how to make a safeguarding referral and who to inform if they had concerns.
- Ward areas were visibly clean and had suitable furnishings which were clean and well-maintained. Cleaning records demonstrated that most areas were cleaned regularly. Staff disposed of clinical waste safely.
- Leaders understood the priorities and issues the service faced. Most were visible and approachable in the service for patients and staff.

Powys residents do not get booked for the maternity services at Gloucester, however they may be transferred from Wye Valley Trust (WVT) as a complex case. Utilisation of the maternity assurance framework with WVT will provide the Health Board with on-going assurance.

The CQC report for Gloucester provides us with an opportunity to benchmark Powys Maternity services against the report, including:

• Infection prevention and control: cleanliness/decontamination of birth pools.
• Training on recognising the deteriorating patient
• Competency frameworks for midwives
• Recognition of staff well-being.

3) National Maternity and Neonatal Safety Programme (Mat/Neo)

At the National Maternity and Neonatal Safety Summit on the 6 September 2022, the Chief Nursing Office and Deputy Chief Medical Officer for Wales shared the plans for the Maternity & Neonatal Safety Programme.

At this summit, the Independent Maternity Services Assurance Panel (IMSOP) shared their experience of their scrutiny of Cwm Taf Morgannwg (CTM) maternity services and the CTM maternity and neonatal team (multi-disciplinary) shared their experience of special measures and the subsequent learning and action taken.

The Maternity and Neonatal Safety programme (Mat/Neo) is currently in the "Discovery Phase". Following the submission of the Maternity and Neonatal Assessment, Assurance and Exception review as requested by Welsh Government (as reported in the July 2022 Maternity Assurance Paper), a national workshop was held on the 7 July, where all maternity services in Wales shared their local assessments.

The programme intends to focus on 6 aspects of improvement:

- Leadership
- Governance
- QI approach
- Safety Culture
- Patient Voice
- Staff Engagement

Powys Teaching Health Board is fully engaged with this work supported by Improvement Cymru and we have now recruited into post our Mat/Neo Safety Champion. The provision for Powys has been increased to 0.8WTE from the original 0.6WTE for maternity services and we are currently reviewing the neonatal aspect of the role.

Within the Health Board, a follow-up round table consisting of a muti-disciplinary team is being arranged to ensure that we address and implement plans for those areas assessed within the assurance and exception reporting to Welsh Government as red or amber RAG rated.

4) External Reports

Powys Teaching Health Board received The Prompt Wales Quality Assurance Update Report on the 4th November 2022. This report details the findings of the team following a return visit to Powys THB on the back of their initial report earlier in the year. The purpose of the follow up visit was to assess the actions we had taken in response to the recommendations made in the first report.

The full report is attached in Appendix 2. A summary of the findings of the report is below:

"Community PROMPT Wales training at PTHB maintains fidelity to the context of community midwifery. This is more recently supported by the introduction of simulated emergencies in the birth centres. This is a very good course with human factors threaded throughout. It is delivered by an enthusiastic faculty team who are always open to suggestions for ongoing improvement, often making on the spot changes when suggested. The PROMPT Wales National Team can identify that the recommendations previously made during the QA process are being addressed by the health board. The review team would like to commend the local faculty for their efforts in addressing previous findings and encourage the members of faculty to continue programme development and evolution."

Next Steps
• Maintain oversight and escalation of commissioned services through the Commissioning Assurance Framework (CAF). • Continued engagement with the Welsh Government's Maternity and Neonatal Safety Support Improvement Programme • Agree de-escalation criteria from local escalation arrangements utilising the Maternity Improvement Action Plan.

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Maternity Improvement Action Plan

Introduction

There is a current five-year vision for the future of maternity services in Wales (2019-2024).

As well as this paper, Powys Teaching Health Board is also committed to the health strategy of Start Well for families across Powys to deliver high standards of health care including maternity provision across Powys.

The overall ambition for the United Kingdom is to halve the number of stillbirths, neonatal deaths & brain injuries by 2030 is supported by delivery of the maternity transformation programme workstreams aligned with safe care including:

- Saving Babies Lives Care Bundle Version 2: (england.nhs.uk)
- Maternity Incentive Scheme Year 4: (resolution.nhs.uk).
- Maternity Care in Wales Gov.wales
- Start well pthb.nhs.wales
- HIW national review of Maternity services
- Institute for Health care Improvement-white paper/mat -neo safety champion programme for Wales

The NMC Code of Professional Practice (nmc.org.uk) outlines four distinct Requirements in the provision of maternity care including;

- Prioritise people
- Practice Effectively
- Preserve Safety
- Promote Professionalism and Trust

The GMC Good Medical Practice (gmc-uk.org) outlines four distinct domains in the provision of medical care including;

- Knowledge, skills & performance
- Safety & Quality
- Communication, partnership and teamwork
- Maintaining trust

The Ockenden Initial & Final Reports identified Immediate & Essential Safety actions (IEA's) for implementation into maternity services to support the provision of safe, high quality maternity services.

- OCKENDEN REPORT - MATERNITY SERVICES AT THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST (ockendenmaternityreview.org.uk)
- Findings, conclusions and essential actions from the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust - final Ockenden report

The Maternity and Neonatal Safety Improvement Programme supports five national workstreams, applying quality improvement methodology to the continuous improvement of services.

Maternity Improvement Action Plan

We work closely with our Maternity & Parent Voices Partnership (MPVP) to co-produce services, ensuring that the experience of our service users supports the development and progression of maternity services which meet the needs of those accessing care.

The experience of our staff is a priority to ensuring the development of a positive safety culture where we embed the principles of human factors to support a psychologically safe environment in which everyone has the potential to thrive.

The Executive Committee was informed by the Executive Director of Nursing Midwifery that local escalation arrangements had been enacted within the Midwifery Service in Powys on the 29th of June 2022. The decision to enact local escalation was in response to the following:

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

It was agreed at the Executive Committee that regular monthly updates would be provided to the Executive team regarding progress and next steps. The Committee was last updated on the 27 July 2022. However, in addition, the Maternity Assurance Paper due to be presented at the Patient Experience and Quality Committee (PEQs) on the 13 September 2022 was shared and discussed at the Executive Committee on the 5 September 2022.

The below Maternity Improvement Action Plan is the steps needed to transition from "Local Escalation" to Business as Usual". However, the intention is to have an on-going Continuous Improvement Plan for Maternity Services. This will ensure that priorities for improvement identified through triangulated assurance mechanisms (concerns, complaints, incidents and national reports) are identified and actioned continuously. This will Ensure that the Quality Management System (proposed and mandated in the Quality and Engagement (Wales) Act) will be live and meaningful in our maternity services, leading to and supporting continuous learning.

Maternity Improvement Action Plan

NAME	REFERENCE	TITLE
Louise Turner	LT	Assistant Director Women & Childrens (W&C)
Abbi Maddox	AM	Interim Head of Midwifery and Sexual Health
Kate Evans	KE	Women & Children's (W&C) Clinical Governance and Risk Lead
Emma Adamson	EA	Assistant Head of Midwifery and Sexual Health
Shelly Higgins	SH	Consultant Midwife
Sue Pardoe - Bouchard	SPB	Clinical Supervisor of Midwives
Liz Glyn- Jones	LG	Clinical Supervisor of Midwives
Mary Cottrill	MC	Head of Childrens Nursing and Paediatrics
Rebecca James	RJ	W&C Partnership and Project Manager
Zara Abberley	ZA	W&C Business Support Manager

Maternity Improvement Action Plan

Performance against measurable targets e.g., NHS Wales Performance measures	Delivery of plan milestones and objectives
Performance meeting set target	Objective/Annual priority fully achieved
	On track to deliver objective/annual priority
Performance within tolerance (if appropriate for measure)	At risk/issues present
Performance does not meet target	Not delivered/behind schedule
Measure not applicable or missing appropriate data	Plan for delivery on hold or amended

Trends in Performance		Data Quality	
↑	Performance improvement from previous period		Data confidence is high
→	No change in performance from previous period		Data confidence is limited
↓	Performance decline from previous period		Data confidence is poor or currently under investigation
	Data for trend unavailable		Data unavailable

Maternity Improvement Action Plan

REF	ACTION/ACTIVITY (Describe the activity, who, what, where, when and why)	LEAD	TARGET DATE	BRAG	OUTCOME	HOW WILL OUTCOMES BE ACHIEVED?	Comments
1.0 QUALITY and SAFETY							
1.1	Review of Governance and Escalation mechanisms	**Head of Midwifery**	October 2022				Underway and due for completion mid- December
1.2	Weekly safety meetings to discuss and agree actions in relation to incident management.	**W omen and Childrens Governance Lead**	October 2022		To have assurance of processes and embedding of learning within the maternity service	Evidence of robust and clear escalation process and incident management	Weekly safety meeting and escalation meeting currently remain in place as of November 2022
1.3	Systems for reporting NRI / Concerns / Incidents / Learning to be strengthened	**W and CH Governance Lead**	October/Nov 2022		Updated Governance process within senior team and understanding	Senior leadership team have worked with governance team to improve standards and processes. Training with staff	Underway. Revised trigger list and instructions for Datix sent out. Drop in Datix sessions for all staff 3x weekly ongoing.
1.4	RCA training to be undertaken by all relevant roles	**Senior Midwives**	December 2022		Relevant staff have received RCA training	Training needs Analysis	RCA training completed by leadership team and Midwives ongoing.

Maternity Improvement Action Plan

REF	ACTION/ACTIVITY (Describe the activity, who, what, where, when and why)	LEAD	TARGET DATE	BRAG	OUTCOME	HOW WILL OUTCOMES BE ACHIEVED?	Comments
					and understand process	database to reflect training	
1.5	Peer- to – peer Audit review of CIS cases- process to be set up for ongoing monitoring	**Clinical supervisors/ Consultant MW**	December 2022		To update training database as evidence	Policy to reflect process/staff training	Learning events to commence November 2022 to embed documents and
1.6	Day Assessment Unit: Review Service against Specification	**Head of Midwifery/ Radiology**	March 2023		To improve standards in the maternity provision against Day Assessment criteria	Smart objectives improvement in service needs. Updated service specification	Review of service provision and criteria
2.0 Leadership and Culture							
2.1	Training Needs Analysis to be undertaken with focus on training requirements as determined by outcome of reviews/ incidents/ concerns.	**Head of Midwifery/ Practice development Midwife**	December 2022		Up to date mandatory skills requirement for Midwives	Review of current skills requirements. Identify any gaps in learning	Ongoing through senior leadership meetings and workforce meetings. Refresh agreements with DGH partners for skills refreshers e.g., Cannulation

Maternity Improvement Action Plan

REF	ACTION/ACTIVITY *(Describe the activity, who, what, where, when and why)*	LEAD	TARGET DATE	BRAG	OUTCOME	HOW WILL OUTCOMES BE ACHIEVED?	Comments
2.2	Band 7 & leadership development and OD programme to be implemented across 2023	**Associate Head of Midwifery**	September 2023		Clear roles and responsibilities greater leadership responsibilities	Reflection from senior Midwives on effectiveness of development course and improvement to personal leadership development	Started training sessions held with OD team October and November 2022. To define and ensure outcomes of development course are captured in evaluation at end of course
2.3	Management of CIS Cases and RISK review	**Consultant Midwife**	October 2022		Ratified guideline and team have received training on process for CIS	Training and new guideline to demonstrate process	Weekly meeting reviewed CIS . Guideline ratified.
2.4	Workforce Planning- to include consideration of Birth Rate Plus, And Specialist Midwifery Roles eg Fetal surveillance Midwife, Digital Midwife	**Head of Midwifery/ workforce and recruitment**	March 2023		Reduction in vacancy rate and spend	Deep dive into budgets and establishment with finance team as well as working with	Digital Midwife post currently being job matched. Further work on individual team establishments to be commenced December 22. Understanding wte against actual budget.

Maternity Improvement Action Plan

REF	ACTION/ACTIVITY *(Describe the activity, who, what, where, when and why)*	LEAD	TARGET DATE	BRAG	OUTCOME	HOW WILL OUTCOMES BE ACHIEVED?	Comments
						individual teams to understand current working practices	Benchmark workforce requirements against maternity review action plan and agreed mandatory requirements
2.5	Map of caseload demand / boundaries and capacity review.	**Head of Midwifery and Deputy Head of Midwifery**	March 2023		Clear pathways of care and criteria between neighbouring partners and multi-disciplinary reviews of incidents to strengthen working relationships and s Also strengthen governance processes	Reduction in enhanced pay as well as feedback from staff in terms of equity and consistency within teams	Work commencing with teams as of November 22 to include Allocate rostering and current working patterns. Ongoing meetings with Heads of Midwifery within Wales for peer support and to share practice.
3.0 Clinical Excellence							

Maternity Improvement Action Plan

REF	ACTION/ACTIVITY *(Describe the activity, who, what, where, when and why)*	LEAD	TARGET DATE	BRAG	OUTCOME	HOW WILL OUTCOMES BE ACHIEVED?	Comments
4.1	Digital Maternity Cymru Implementation	**Head of Midwifery/ Digital project lead**	Ongoing		Await confirmation of national roll out	On going project review meetings with project manager and key stakeholders	Project board meeting – awaiting Job Description sign off and recruitment. Also awaiting Welsh Government final plan for national rollout
4.2	Data systems / quality and collection and Dashboard build (Mat Neo Plan)	**Leadership Team/ maternity Safety Champion**	March 2023		Production of Maternity Dashboard	Performance of key performance indicators	Will King convening session. Maternity Champion appointed too. Discovery programme and ongoing engagement with team to develop key performance indicators across Wales
4.3	Perinatal Institute Reporting Monitoring	**SPB/ DAU team to be agreed**	November 2022		Accuracy of data reporting to Perinatal Institute and increased detection of Small for Gestational age babies	Ongoing monthly meetings to review data with Perinatal Institute	Meeting convened for November 2022 to present last quarter data report and improvements with pathway

Maternity Improvement Action Plan

REF	ACTION/ACTIVITY *(Describe the activity, who, what, where, when and why)*	LEAD	TARGET DATE	BRAG	OUTCOME	HOW WILL OUTCOMES BE ACHIEVED?	Comments
4.4	Migration from Standalone Database Gap and Grow to RLdatix systems	**SPB/ Datix Team**	End of December 2022		Improved data collection and as a result greater accuracy in reporting for small for gestational age Pathway	Monthly data collection and review at leadership meetings	meetings held with Datix team to scope work. Discussions ongoing
4.4	Polices/SOP/ guideline review to enable priority documents to be revised/ updated and signed off and published.	**Consultant Midwife**	March 23		Policies and guidelines database will be up to date and will no longer be required to be on the risk register	Up to date database by reviewing monthly and having additional working group to manage oversight of database	23 needed – phased priority list for completion compiled. Monthly review meeting in place. Further policy team to be developed in January 23.

PROMPT WALES
QUALITY ASSURANCE UPDATE

CYMRU / WALES
PROMPT
PRactical Obstetric Multi-Professional Training
Hyfforddiant Aml-broffesiynol Ymarferol mewn Obstetreg

POWYS TEACHING HEALTH BOARD

QA VISIT DATE:	**12TH OCTOBER 2022**
REPORT ISSUED:	**3RD NOVEMBER 2022**

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Cronfa Risg Cymru
Shared Services Partnership
Welsh Risk Pool Services

Gwella Diogelwch Cleifion Trwy Ddysgu
Improving Patient Safety Through Learning

PROMPT Wales Quality Assurance visit at Powys Teaching Health Board

Date: 12th October 2022

Location:

Three Wells Hotel, Howey.

The Welsh Risk Pool observing team:

Sarah Hookes – Senior Safety & Learning Advisor

Amy Hayman – PROMPT Wales Midwife

PTHB PROMPT Wales faculty on date of visit:

Shelly Higgins, Consultant Midwife

Suzanne Pardoe-Bouchard, Community Midwife

Flora Cheetham, Community Midwife

Sarah Williams, Community Midwife

Debbie Allmark, Community Midwife

Carys Griffiths, Community Midwife

Liz Glyn-Jones, Community Midwife

Louise Noyes, Community Midwife

Tomos Turner, Paramedic

CONTENTS

01 Introduction

PROMPT Wales aims to meet the needs of Welsh NHS organisations, in making childbirth safer and improving outcomes for women and babies through the provision of high quality training which meets the standards set out in the PROMPT Wales Strategy (2018)[1].

During April - July 2022, the national PROMPT Wales team carried out a series of Quality Assurance visits to all training sites to seek assurance that high standards of PROMPT training were being met across Wales. Reports were issued highlighting areas of good practice and recommendations for further improvement. Action plans were requested to outline the steps being taken by each health board to address the recommendations.

Between October 2022 - January 2023, a series of follow up visits are being undertaken at each organisation, approximately six months after the initial review. The National Team will be observing the implementation of the actions and this report will present the findings.

Through this quality assurance process, our aim is to promote a consistent approach to training and authenticity to the PROMPT principles throughout NHS Wales, and to encourage continuous improvement of PROMPT Wales training through our objective and balanced feedback. The report will be shared with the Welsh Risk Pool Committee and Welsh Government and contribute to the evaluation of the programme at an all Wales level.

02 PTHB Quality Assurance Action Plan Update

Action Reference	Summary of recommendations from first Quality Assurance review	Observations from current Quality Assurance review
PWPT01	Further embed use of resources such as OBS Cymru in clinical practice	Observed improvement
PWPT02	Standardised approach to briefing and debriefing	Some improvement observed but we continue to encourage use of the Facilitator's Aide Memoir to guide these important elements of the scenario
PWPT03	Support for less experience faculty	Less experienced faculty supported by Consultant Midwife (CM) who rotated throughout the day Annual faculty team update day arranged
PWPT04	Sharing of good practice with other Health Boards	CM making plans for faculty to attend PW training in neighbouring health boards to share learning both ways Encouraging faculty to support the CPW national Quality Assurance Reviews
Additional	Supernumerary member of faculty at PROMPT days	Addressed
Additional	Complete launch of MEOWS locally	Used in scenarios. Appears embedded
Additional	Rotation of WAST attendees	Paramedic in each group on this occasion but will rotate between groups if less than 4 on future courses
Additional	Birth centre scenarios	Skills drills commenced in birth centres to address the testing of systems associated with in-situ training
Additional	Faulty to join resus team for maternal resus to utilise scenarios and PROMPT methodology	Addressed

03 Organisation of PROMPT Wales training

This section provides further detail relating to the observations of the review team.

03.1. PTHB have adopted the Community PROMPT Wales training package.

03.2 Conducting PROMPT Wales Training in the clinical area is considered to be an essential component of effective training[2], enabling the testing of systems and processes and contributing to organisational improvement[3,4,5,6]. Community PROMPT Wales promotes training in settings which bear fidelity to clinical practice. The Three Ways Hotel provides an authentic simulated environment with bedrooms used for clinical scenarios. The team access equipment from their own community bags. To address the concept of in-situ training, additional training scenarios have recently been implemented in the birth centres in Powys.

03.3 This is a well-structured programme consisting of a mix of interesting scenarios and workstations of 45 minutes each. Additional relevant mandatory training sessions are wrapped around the PROMPT Wales training but this works well and does not detract from the ethos of PROMPT.

03.4 The Community PROMPT Wales Human Factors presentation is presented and it was good to see other facilitators getting involved this time. We thought it would be good moving forward if the paramedic facilitator presented the section on the ambulance service.

03.5 The effectiveness of PROMPT training is underpinned by the multi-professional approach. It was good to note a multi-professional team which included 14 community midwives, 2 healthcare assistants and 6 paramedics. The delegates were divided into four groups.

03.6 It was good to have a paramedic on the faculty and this should be encouraged when there are paramedics attending the training.

03.7 A pre-course faculty huddle was facilitated by the CM to prepare the faculty for the day ahead. It was nice to see the PROMPT Wales 'Faculty huddle sheet' used as a reminder of what to include.

03.8 The course had been very well organised and there was a real team approach amongst the faculty. The CM was able to remain supernumerary in the main, providing valuable oversight of the running and authenticity of the programme, and providing support to those facilitating for the first time.

03.9 Participants were warmly welcomed and introductions took place. An informal introduction to the day was given with the team reminded that the purpose was to 'improve safety through learning.'

03:10 The ice-breaker was planned to take place in teams ahead of the first scenarios but time restrictions impacted on this.

03:11 We discussed as a team how to make best use of the time in the morning in readiness for the next course. A suggestion was to sit participants on arrival in the room where the introductions and presentation takes place as it is gathering them together which seems to create the delayed start.

03:12 The team regrouped at the end of the course to complete a course evaluation using a QR code.

03.13 The faculty came together at the end of the course for discussion and debriefing.

04 Scenario Implementation

04.01 The scenarios were PPH, sepsis, breech and maternal collapse. Scenarios had been well prepared with props, algorithms and paperwork available. The community midwives accessed equipment and paperwork from their bags, adding to the realism.

04.02 Feedback from the previous report had been addressed and a PROMPT scenario was incorporated into the mandatory Basic Life Support update/assessments delivered by the Resuscitation Team, along with a PROMPT Wales facilitator. This worked well and it was good to see the BLS algorithm encouraged. It would be useful to have a MEOWS chart to plot the observations if taken before the woman collapses.

04.03 It was good to see 'patient-actors' used for scenarios, this encouraging thoughtful communication, information sharing and adding to the realism. The patient-actor was invited to feed back to the team on how they felt during the scenarios.

04.04 Roles were appropriately allocated and observers were identified to complete and feedback on the clinical and human factors checklists.

04.05 There were some good examples of briefing. Where this could be improved, the facilitators welcomed feedback from the reviewers with demonstrable improvement with the following teams. We continue to encourage the use of the Facilitator's Aide

Memoir to support a structured briefing and debrief and where this was used, some excellent briefing was observed.

04.06 The ambulance was an interesting addition to the breech scenario and was enjoyed by all. We didn't observe a briefing in this scenario but the Facilitator's Aide Memoir was used to support a structured debrief. One reviewer suggested that following the scenario in the ambulance, the practise of manoeuvres be carried out in the room where there is more space and visibility. Everyone had chance to practise. We like to hand an algorithm to all team members when going through the manoeuvres.

04.07 Whilst teams worked through the Sepsis Six checklist (as far as possible in a community setting), the Sepsis Risk Assessment tool was not used to risk assess for sepsis in the first instance. This a common observation and requires further reinforcing through training. You can tell the team as part of your brief to plot the observations on the MEOWS chart and as they will 'trigger,' they should complete the Sepsis Risk Assessment tool. This will empower the midwives when referring a woman to the obstetric unit.

04.08 Scenarios were concluded with the Key Learning Points.

05 Workstation Management

05.1 Shoulder dystocia was ran as a workstation which is appropriate and ensures there is time for everyone (relevant to role) to have hands on practice. The algorithm and proforma were used and the Key Learning Points covered. The team enjoyed the practise with your new Force Monitor.

05.2 The annual newborn resuscitation update/assessments were included on the day for the midwives. However, a short scenario was included which everyone was able to get involved with. The RCUK algorithm was followed. Unfortunately, the doll supplied by the resuscitation team was in a poor condition and it was impossible to demonstrate inflation of the lungs. The tear drop mask used should be swapped to a circular mask. Our reviewer discussed official I-gel training for community midwives who could then carry them in their kit. This might be worth investigating.

06 Summary

Community PROMPT Wales training at PTHB maintains fidelity to the context of community midwifery. This is more recently supported by the introduction of simulated emergencies in the birth centres. This is a very good course with human factors threaded throughout. It is delivered by an enthusiastic faculty team who are always open to suggestions for ongoing improvement, often making on the spot changes when suggested.

The PROMPT Wales National Team can identify that the recommendations previously made during the QA process are being addressed by the health board. The review team would like to commend the local faculty for their efforts in addressing previous findings and encourage the members of faculty to continue programme development and evolution.

07 References

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Agenda item: 2.3

Patient Experience and Quality Committee	**Date of Meeting: 24 November 2022**
Subject :	Update on the 2022-2023 Clinical Audit Programme
Approved and Presented by:	Kate Wright, Medical Director
Prepared by:	Howard Cooper, Safety and Quality Improvement Manager
Other Committees and meetings considered at:	

PURPOSE:

The purpose of this paper is to provide an update on the 2022-2023 clinical audit plan.

RECOMMENDATION(S):

The Executive 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	✓
	7. Put Digital First	✓

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

	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 an update on the 2022-23 clinical audit programme for information and approval.

BACKGROUND AND ASSESSMENT:

Organisational Changes to the Management of Clinical Audit

National Changes
Prior to the Covid pandemic, Welsh Government required a formal submission from the Health Board's Medical Director in response to the findings of any audits from the National Programme. Two submissions were required, one within 6 weeks of the audit report, and a second within six months to report on actions achieved. This process however was suspended at the start of the pandemic.

In June 2022 a Ministerial Direction was issued that stated that the process would **not** be restarted. The National Audit programme itself would continue to be issued, but any findings that identified actions required by the Health Board should now be monitored locally by an assurance committee such as the Patient Experience, Quality and Safety Committee. This is the process that will be adopted moving forward.

Local changes and arrangements
The Community Services Group is refreshing its approach to the management of clinical audit. It is planned that a service-level quality meeting will be synchronised to the timetable of the Patient Experience and Quality Committee. This will allow for the efficient flow of audit reports. This approach could be adopted across the Organisation and will be explored as part of our readiness for the Quality and Engagement Act.

For Therapies, clinical audit is an agenda item for each monthly Heads of Service Meeting.

For the Mental Health Team learning from clinical audit is presented to the Mental Health learning group and Operational Managers group as agenda items. Recommendations are put into action through these groups.

Senior-level direction of the Clinical Audit programme
The Learning from Experience Group is now well established and considers themes and important topics from concerns and incidents. These will act as a focus for future clinical audits. These topics will be reflected in service group action plans for improvement and will be brought to the attention of the senior operational managers and clinical teams in time for the inclusion of work into the 2023/24 Clinical Audit Programme.

Service groups will be asked to provide a summary of important clinical audit findings to each learning group.

Progress on the 2022/23 Clinical Audit Programme
Despite the operational pressures facing the organisation, the 2022/23 clinical audit plan has proceeded on schedule. The following audits have been completed with most being reported to their respective management groups.

NATIONAL AUDITS

National Audit of Care at the End of Life.
The palliative care team report that this audit is well underway with data from the case notes for 27 of the required 44 patients already having been reviewed and submitted to the audit. The National Report is expected to be published in the New Year.

National Audit on the Completion of the Do Not Attempt Cardio-Pulmonary Resuscitation Form.
The Safety & Quality Improvement Manager reports the completion of this National (non-programme) audit. Standards achieved were high with 100% of cases studied reporting there had been conversations with the patient and/or their relatives concerning the decision not to resuscitate. In most cases the forms had been completed by a single doctor rather than two, the latter situation being a recommendation but not a requirement. This can be challenging given the organisation of medical cover for the community hospitals, but work will be undertaken to raise awareness and to improve practice.

LOCAL AUDITS

The Women and Children's service report that they have completed their audit of the Quality Standards for Paediatric Audiology and have conducted a re-audit of the 2017 use of Melatonin audit.

Audit Focus
45 children receiving melatonin for sleep disorders were included in the audit. Half of these children have a diagnosis of autism, over half have a diagnosis of more than one condition. The audit found that seven of the children (15%) had no documentation recording whether the therapy was effective or not. These were flagged for further review to decide whether treatment should continue.

Most GP practices now have protocols in place for the care of these children to be shared with the Powys consultant.

The audit results were used in an expert opinion sent to the All Wales Medicines Strategy Group for their appraisal of Slenyto (a prolonged release melatonin medication).

The Surgery and Endoscopy service have completed a number of audits from the 2022/23 program. These include the Surgical record keeping audit, the consent to treatment audit, an infection control audit, an audit on the consideration of legal and ethical issues and on data protection and GDPR.

Audit Focus
The surgical services were reviewed using the Association for Perioperative Procedures (AfPP) audit pack. The audit reported that the service was fully compliant with 102 of the measures audited. 17 other measures were identified where the service was significantly compliant but where some non-urgent improvement could be made. Two measures were identified where immediate action is required. The first was the over-crowding of the storage space used for supplies and consumables. Action is currently underway to produce a more streamlined and controlled ordering system to utilise the existing space more efficiently. The second identified issue was that some of the scrub nurses do not hold the recommended "Surgical First Assistant" qualification. This will be addressed during this year's staff training programme.

Other completed audits were based on the established standards for the "Five Steps to Safer Surgery", the management of perioperative normothermia, and on the decontamination and use of surgical instruments.

The Adult Physiotherapy service reports the completion of their audit of osteo arthritis knee care based on NICE guidance.

The audit confirmed that the service is largely practicing within NICE guidelines but identified three areas for improvement. The first was to achieve equitable access to patient education and self-management resources between patients who preferred digital platforms and those who preferred paper-based materials. The second was to improve the utilisation of both NHS provided and external organisation provided exercise classes. The final improvement area was to develop a deeper consideration of the psychosocial factors that inform the presentation and self-management of osteo arthritis.

The Mental Health Service repeated their 2021 audit on the use of the Wales Applied Risk Research Network (WARRN) tool.

WARRN is a structured assessment to assess the patient's risk of harming themselves or others. Whilst there were improvements in a number of areas, unfortunately the section which scored most poorly in 2021, the involvement of the patient in the assessment process, showed only a modest improvement. However, this is just part of a large programme of work improving the training on WARRN as well as its application and recording. It will be included in the 2022/23 audit programme.

A complete list of the audits achieved this period is given in Appendix A
RECOMMENDATION:
That the Committee NOTES the progress made with the Clinical Audit Programme.

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	COMPLETED but not yet reported. 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	Notes Audit (re-audit of 2020 audit) (Brought forward from 21/22).	Quarter 2 2022	Occupational Therapy staff	Quarter 4 2022
Tier 2-Service Improvement	Notes Audit (re-audit of 2020 audit) (Brought forward from 21/22).	Quarter 2 2022	Physiotherapy staff	Quarter 4 2022
Tier 2-Service Improvement	Notes Audit (Brought forward from 21/22).	Quarter 2 2022	Speech and Language staff	Quarter 4 2022
Tier 2 – Identified risk	Waiting times/compliance with targets (Brought forward from 21/22).	Quarter 2 2022	Audiology staff	Quarter 4 2022
Tier 2-Service Improvement	Spasticity against National Standards (Brought forward from 21/22).	Quarter 2 2022	Physiotherapy staff	Quarter 4 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	TBC	Head of Audiology	TBC
Tier 2- Service Improvement	Notes Audit	Quarter 3 2022	Head of Adult Speech and Language Therapy	Quarter 4 2022
Tier 2- Service Improvement	Notes Audit	Quarter 2 2022	Team Leader, Dietetics	Quarter 3 2022
Tier 2- Service Improvement	Notes Audit	Quarter 1 2022	Head of Occupational Therapy	Quarter 3 2022
Tier 2- Service Improvement	Notes Audit	Quarter 2 2022	Head of Physiotherapy	Quarter 3 2022
Tier 2- Service Improvement	Notes Audit	Quarter 4 2022	Head of Podiatry	Quarter 4 2022
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 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	Spasticity care against National Standards	Quarter 3 2022	Consultant Therapist	Quarter 4 2022
Tier 2- Service Improvement	Taxonomy 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 4 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	COMPLETED Quarter 2 2022
Tier 2-Service Improvement	Managing Perioperative Normothermia	Quarter 1 2022	Surgery and Endoscopy Team	COMPLETED Quarter 2 2022
Tier 2-Service Improvement	Decontamination	Quarter 1 2022	Surgery and Endoscopy Team	COMPLETED Quarter 2 2022
Tier 2-Service Improvement	Specimen Management	Quarter 1 2022	Surgery and Endoscopy Team	COMPLETED Quarter 2 2022
Tier 2-Service Improvement	Tourniquets	Quarter 1 2022	Surgery and Endoscopy Team	COMPLETED Quarter 2 2022
Tier 2-Service Improvement	Use and Handling of Surgical Instruments	Quarter 1 2022	Surgery and Endoscopy Team	COMPLETED Quarter 2 2022

Tier 2-Service Improvement	Preoperative care for Patients with Dementia	Quarter 2 2022	Surgery and Endoscopy Team	COMPLETED Quarter 3 2022
Tier 2-Service Improvement	Anaesthesia	Quarter 2 2022	Surgery and Endoscopy Team	COMPLETED Quarter 3 2022
Tier 2-Service Improvement	Surgical record keeping audit & consent	Quarter 2 2022	Surgery and Endoscopy Team	COMPLETED 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	UNDERWAY 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	COMPLETED 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	DELAYED due to consultant staff sickness Quarter 1 2022
Children's Therapies				
Tier 1 - National Audit Programme	Audit of Quality Standards for Paediatric Audiology	Quarter 2 2022	Professional/Medical Lead for Paediatric Audiology	COMPLETED 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	Quarter 1 2022	Mental Health Staff	COMPLETED 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
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 joint replacement 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.
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**	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	**Yes**	Powys has not taken part in previous audits but will do so for future rounds.

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 2.4

Patient Experience, Quality and Safety Committee	**Date of Meeting: 24 November 2022**
Subject:	**Infection Prevention and Control Update**
Approved and Presented by:	**Claire Roche – Director of Nursing and Midwifery**
Prepared by:	**Marie Davies – Deputy Director of Nursing** **Jason Crowl – Interim Deputy Director of Nursing**
Other Committees and meetings considered at:	**Infection, Prevention and Control Group 6th September 2022** **Executive Committee 5th October 2022**

PURPOSE:

This paper provides an update of the work undertaken in Infection, Prevention and Control in the last year.

Specifically, this paper presents the Powys Teaching Health Board Annual Report for Infection, Prevention and Control, Quarter 1 report for 2022-23 and the IPC Work Programme for 2022-23.

RECOMMENDATION(S):

The Patient Experience, Quality and Safety Committee is asked to:
NOTE and APPROVE the Infection, Prevention and Control Annual Report for 2021-22, and IPC Quarter 1 (April – June 2022)

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:

This paper provides an update of the work undertaken in Infection, Prevention and Control in the last year.

Specifically, this paper presents the Powys Teaching Health Board Annual Report for Infection, Prevention and Control, the Quarter 1 report for 2022-23 and the current IPC Work Programme.

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

1. Note the Annual Report for 2021-22 and Quarter 1 report (April to June 2022)
3. Note the IPC Work Programme for 2022-23 and the plan to delay some workstreams due to capacity in the IPC Team.

DETAILED BACKGROUND AND ASSESSMENT:

1. Background

The NHS in Wales is committed to zero tolerance of preventable healthcare associated infections (HCAIs).

NHS organisations in Wales have made significant improvements in reducing HCAIs in recent years, including Meticillin resistant Staphylococcus aureus (MRSA) bloodstream infections and infections caused by Clostridium difficile; however, as the **Code of Practice for the Prevention and Control of Healthcare Associated Infections 2014** states "*more can and must be done to protect service users and achieve world class standards of service user safety*".

Effective infection prevention and control needs to be everybody's business and must be integral to everyday healthcare practice, and based on the best available evidence.

The Code of Practice sets out the minimum necessary infection prevention and control (IP&C) arrangements for NHS healthcare providers in Wales. The nine elements are set out as standards for achievement, and are expected to be met in full across the range of healthcare services that they provide.

Compliance with these standards should be evident to service users, visitors, staff and to the Welsh Government including Healthcare Inspectorate Wales.

These standards are also reflected in the Health and Care Standards Section 2.4 Infection, Prevention and Control (IPC) and Decontamination.

2. Infection, Prevention and Control Annual Report

The annual report, outlining the activities and arrangements for IPC in Powys Teaching Health Board in 2021 -22 is shown at Appendix 1.

This annual report provides an overview of the governance arrangements for Infection, Prevention and Control activities; analysis of the surveillance data, quality assurance through audit and oversight of structures supporting IPC activities, education and training, and policies developed to support and direct patient care. This data has been collected and produced by the Infection Prevention & Control Team (IPC) for the time period from April 2021 – March 2022 with assistance from the chairs of the task groups supporting this programme of work (Figure 1).

Figure 1: Chairs of the IPC Task Groups

Sub Group	Chair
Antimicrobial Stewardship Group (AMR)	Chief Pharmacist

Environmental Cleanliness & Operational Guidance (ECOG)	Service Improvement Manager: Compliance and Quality
Water Safety and Ventilation (WSV)	Responsible Person Water & Authorised Person Ventilation Assistant Director Property & Estates (Chair)
Decontamination Group	Assistant Director: Community Services Group (Also acted as Interim Deputy Director of Nursing January – July 2022)
Medical Devices (MD)	Medical Devices & Point of Care Testing Manager
Nosocomial Group	Deputy Director of Nursing

2.1 Summary of HCAI targets achieved during 2021-22

Performance against national targets are summarised below:

- HCAI 2021/22 Full Year Reduction Expectations
  - C. difficile: Rate of 25 per 100,000 - Achieved
  - S. aureus bacteraemia: Rate of 20 per 1000,000 population - Achieved
  - E. coli bacteraemia: Rate of 67 per 1000,000 population - Achieved
  - Klebsiella sp. Bacteraemia: 10% reduction in numbers for April 2021 to Mar 2022 from the 2017/18 - Achieved
  - P. aeruginosa bacteraemia: 10% reduction in numbers for April 2021 to Mar 2022 from the 2017/18 - Achieved
  - 8 years since last MRSA bacteraemia.

2.2 General Developments

- Management of the continued impact and challenges associated with COVID-19, including management of outbreaks.
- Considerable work undertaken by the team, wards and departments to maintain standards and reduce nosocomial infections.
- There is renewal work required as part of the recovery to business as usual arrangements.
- IPC Team skill-mix review undertaken

3. Quarter 1 Report for April – June 2022

The Quarter 1 report, outlining the activities and arrangements for IPC in Powys Teaching Health Board for April to June 2022 is attached at Appendix 2.

Highlights from the report are listed below:

3.1 Summary of HCAI targets achieved during 2021-22

- During Q1 there was 6 outbreaks of COVID 19 in Powys Teaching Health Board inpatient wards.

3.2 Progress with work programme

- There has been considerable work undertaken by the team, wards, and departments to maintain standards and reduce nosocomial infections.
- There is renewal work required as part of the recovery to business-as-usual arrangements.
- The IPC Work Programme is attached at Appendix 3 for information. Some work streams have been delayed due to capacity and restructure of the dedicated IPC Team. The items delayed have been risk assessed, and mainly consists of developmental work and further audit work. Where possible and capacity allows, some of the work is progressing. For example, visits and audits at care homes were carried out during the year. These included a number of unannounced visits and where required follow-up audits undertaken jointly with the complex care team.
- Recruitment is underway for an 8b IPC Consultant Practitioner, and this will complete the team to full capacity by Quarter 4.

NEXT STEPS:

If approved, the Annual Report will be added to the public website and Quarter 2 report for 2022-23 will be considered at the next Infection, Prevention and Control Group on the 13th December 2022.

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					

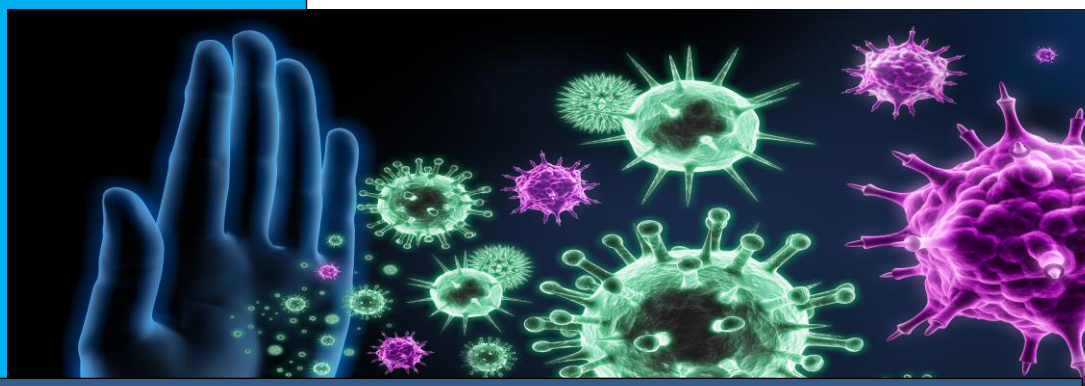
Appendices:

1: IP&C Annual Report 2021-22

2: Quarter 1 Report (April to June 2022)

3: IP&C Work Programme for 2022-23

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board



Powys Teaching Health Board

Infection Prevention and Control Annual Report

2021-2022

Contents

1 Executive Summary

Powys Teaching Health Board (PTHB) is committed to delivering safe and effective care for all, as outlined in the Health and Care Strategy for Powys. Healthcare Associated Infections (HCAI) remain a key patient safety issue and results in a significant burden of disease and financial cost to the NHS in Wales.

The pandemic has greatly impacted on health and social care services for both patients and staff alike. Powys Teaching Health Board has worked with national, regional, and local services to ensure that the national approach to the pandemic has been adopted, and in implementing systems to ensure safety for patients, carers and families, and staff.

Powys Teaching Health Board is committed to reducing HCAI and adopts a zero tolerance to all preventable infections. There are effective management arrangements, assurance systems and reporting processes in place to support and drive the infection prevention and control (IPC) agenda. The Health Board acts as a commissioner, and a direct provider of healthcare, and is different to other health boards in Wales in relation to the proportion of services that are provided to the population by other health care providers.

The directly provided services in the Health Board are delivered through a network of community services and community hospitals which includes mental health, learning disabilities, maternity, and children's services. Care is also provided in Powys through primary care contractors, such as General Practices and Dental Practices. There is also provision of an increasing range of consultant, nurse and therapy led outpatient sessions, day theatre and diagnostics in community facilities, bringing care closer into Powys itself and closer to people's own communities and homes. Being an entirely rural county with no major urban conurbations and no acute general hospitals, people in Powys have to travel outside the county for many services, including secondary and specialist healthcare. As well as providing oversight for directly provided services, the IPC team work closely with the Health Board's Quality and Safety Team to review performance against key patient experience, quality, and safety indicators, focusing on infection, prevention, and control reports. The team attend regular regional, organisational, and national meetings to represent the population of Powys.

The team's capacity and capability continue to be strengthened across the Health Board, and is supported by a comprehensive range of infection prevention and control policies and procedures which act as an invaluable resource for staff.

This annual report is produced to provide an overview of the governance arrangements for Infection, Prevention and Control activities; analysis of the surveillance data, quality assurance through audit and oversight of structures supporting IPC activities, education and training, and policies developed to support and direct patient care. This data has been collected and produced by the Infection Prevention & Control Team (IPC) for the time from April 2021 – March 2022 with assistance from the wider team supporting this programme of work.

Due to the ongoing pandemic, COVID-19 preparedness and response has been the main focus for the IPC team for the past year and therefore some elements of the IPC work have not been completed fully and will be included in the 2022-23 work programme.

2 Key achievements

- The IPC Team have been integral to the planning and response to the COVID-19 pandemic, working collaboratively with a range of multi-professional colleagues, including national bodies Welsh Government and Public Health Wales, and regional partners: Powys County Council, Powys Primary Care, and the independent sector, significantly those in care home provision.

- The IPC Link Workers programme has been an effective part of improving local training be able to cascade new guidance easily and quickly, and to learn about IPC issues on the ground. There are over 50 IPC Link Workers in place and meetings were held monthly - a decision made by the IPC Link Workers themselves as they expressed a need for regular support due to the frequently changing COVID-19 guidance.

- The Medicines Management Team has developed the antimicrobial stewardship improvement plan which is regularly reviewed and considered by the Antimicrobial Stewardship Group. Primary Care antimicrobial prescribing data is carefully scrutinised at health board, practice and UK levels. Antimicrobial prescribing is included in the annual Medicines Management Incentive Scheme and in relevant Service Level Agreements. MicroGuide has been commissioned to improve access and compliance with antimicrobial formularies, and antimicrobial prescribing is now discussed during every practice meeting.

- Multi-professional relationships were key to responding to the demands of the pandemic. The IPC team acknowledge the diligence and arduous work of all staff both clinical and non-clinical who play a vital role in improving the quality of patient and stakeholder experience as well as helping to reduce the risk of infections. Additionally, the Health Board works collaboratively with outside agencies as part of its IPC governance arrangements including:
    - Public Health Wales
    - Powys County Council
    - Environmental Health Office (EHO)

- For services commissioned by the Health Board, IPC performance or concerns are included as part of the routine agenda 'Quality' component of all meetings held with providers as part of the overall Clinical, Quality, Performance, Review Meetings (CQPRMs). Any patient or service IPC incidents specifically impacting upon Powys residents are reviewed by the respective Quality Teams.

This data in this report has been collected and produced by the Infection Prevention & Control Team (IPC) for the time period from April 2021 – March 2022 with assistance from the chairs of the task groups supporting this programme of work (Figure 1). It represents a point in time and notes the significant journey travelled in 2021-22 and the challenges that lie ahead.

Figure 1: Chairs of the IPC Task Groups

Subgroup	Chair
Antimicrobial Stewardship (AMS) Group	**Chief Pharmacist**
Environmental Cleanliness & Operational Guidance (ECOG)	**Service Improvement Manager: Compliance and Quality**
Water Safety Group (WSG)	**Assistant Director Property & Estates (Chair)**
Ventilation Safety Group (VSG)	**Estates Officer, Engineering Specialist**
Decontamination Group	**Assistant Director: Community Services Group**
Medical Devices (MD)	**Medical Devices & Point of Care Testing Manager**
Nosocomial Group	**Deputy Director of Nursing**

3 Healthcare associated infections (HCAI): statistics and performance

Effective infection prevention and control needs to be everybody's business and must be part of everyday healthcare practice and based on the best available evidence so that people are protected from preventable healthcare associated infections.

4 Welsh Government (WG) reduction expectations for April 21-March 22

PTHB is not benchmarked at an All-Wales level, owing to modest infection rates due to the nature of our services however, the Health Board is committed to reducing infections in line with national expectations. Comparison data below gives absolute figures when results return greater than five.

Figure 2: Number and rate of *C. difficile, S.aureus* bacteraemia, *E. coli* bacteraemia, Klebsiella sp. bacteraemia and Pseudomonas aeruginosa bacteraemia per 100,000 population.

2020-2021

	Rate of C. difficile/ 100,000 population		Rate of MRSA bacteraemia/ 100,000 population		Rate of MSSA bacteraemia/ 100,000 population		Rate of E. coli bacteraemia/ 100,000 population		Rate of Klebsiella sp. bacteraemia/ 100,000 population		Rate of Pseudo aer bacteraemia/ 100,000 population	
	No. of cases	Rate	No. of cases	Rate	No. of cases	Rate	No. of cases	Rate	No. of cases	Rate	No. of cases	Rate
Powys Teaching Health Board	7	5.26	0	0	<5	0.75	5	3.76	<5	1.5	<5	0.75
All Wales	880	28.04	47	1.50	733	23.35	1882	59.96	620	19.75	148	4.72

2021-2022

	Rate of C. difficile/ 100,000 population		Rate of MRSA bacteraemia/ 100,000 population		Rate of MSSA bacteraemia/ 100,000 population		Rate of E. coli bacteraemia/ 100,000 population		Rate of Klebsiella sp. bacteraemia/ 100,000 population		Rate of Pseudo aer bacteraemia/ 100,000 population	
	No. of cases	Rate	No. of cases	Rate	No. of cases	Rate	No. of cases	Rate	No. of cases	Rate	No. of cases	Rate
Powys Teaching Health Board	11	8.27	0	0	0	0	<5	2.26	0	0	0	0
All Wales	880	28.04	47	1.50	733	23.35	1882	59.96	620	19.75	148	4.72

(A) *Clostridioidesdifficile* Infection (CDI):

Powys has a low incidence of CDI. The very rural nature of Powys means that the majority of local services are provided locally, through GPs and other primary care services, community hospitals and community services, however Powys residents receive specialist hospital services in hospitals outside of the county in both England and Wales.

Figure 3: Definitions of C. difficile cases:

Hospital onset healthcare associated (HOHA)	Cases that are detected in the hospital two or more days after admission
Community onset healthcare associated (COHA)	Cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous four weeks
Community onset indeterminate association (COIA)	cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous 12 weeks but not the most recent four weeks

Community onset community associated (COCA)	cases that occur in the community (or within two days of admission) when the patient has not been an inpatient in the trust reporting the case in the previous 12 weeks.

Monthly numbers of C.difficile for 2021/2022

Monthly numbers for equivalent period 2020-2021.

Figure 4: C.Difficile Cases 2019/20, 2020/21 and 2021/22 (Source HARP)

C.difficile cases 2019/20	**No. Pts**
HOHA - PTHB	<5
Cases in GP	**15**
Cases YTD 2019/20	**19**
C.difficile cases 2020/21	**No pts**
HOHA - PTHB	**<5**
GP sample	**<5**
YTD cases 2020/21	**7**
C.difficile cases 2021/22	**No pts**
HOHA - PTHB	**5**
Cases in GP	**6**
Cases YTD 2021/2022	**11**

Hospital acquired cases have reduced slightly for inpatients and a slight increase in General Practice cases. The pandemic may have had some effect on the prevention of transmission but demonstrates the impact of prevention that can be made in primary care. Reducing C.*difficile* infection in primary care is key to reducing the overall C. *difficile* rate in Powys. Work with primary care to further prevent C. *difficile* has been outlined in the 2022-2023 work programme.

The health board has recently established a panel to review all CDI cases. This is a multidisciplinary panel (IPC, Medicines Management, nursing, microbiology) that establishes any potential contributing factors associated with each CDI case (e.g. comorbidities, prescribing, infection control issues). A screening panel has been introduced to ensure that all of the required information is available to the panel when it meets. The intention is to identify any potential causal factors and share learning that may reduce the risk of future CDI cases.

(B) *Staphylococcus aureus* Bacteraemia (MSSA & MRSA) blood stream infections

Powys had zero cases of MSSA and MRSA blood stream infections in the last year. The last MRSA occurred in 2014, and the last MSSA occurred in 2020.

(C) Gram-negative bacteria blood stream infections (GNBBSIs)

Reducing gram-negative blood stream infections is a key part of the Government's UK AMR (Antimicrobial Resistance) strategy and is monitored nationally. A gram-negative blood stream infection is only considered as hospital onset if the sample is taken 48 hours after admission, any sample taken before this point is considered as community-onset.

Figure 5: Number of GNBBI's 2020/21 and 2021/22

	No pts
E. coli	
2020/21	5
2021/22	<5
Klebsiella Pneumoniae	
2020/21	<5
2021/22	0
Pseudomonas aeruginosa	
2020/21	<5
2021/22	0
Total GNBSI YTD 20/21	8
Total GNBSI YTD 21/22	5

All gram-negative blood stream infections reported were hospital acquired, and show improvement over the previous year. Local improvement work continues to strengthen the learning opportunities to reduce the number further. The IPC team will lead post-infection reviews acknowledging that clinical engagement is critical to provide opportunities for multi professional learning.

5 Outbreaks of other infectious diseases incidents and other communicable diseases

In 2021-22 there were no outbreaks other than those related to COVID-19.

COVID-19

The emergence of Omicron variant of SARS-CoV2 in November 2021, had a major impact on the services as increased numbers of staff were reported absent due to either being positive or having close contact with a positive case. Guidance from the Welsh Government kept changing rapidly especially affecting staff dealing with immunocompromised or extremely clinically vulnerable patient population.
The IPCT kept staff informed of the many changes in national and local guidance though training and Powys announcements. Guidance for the Health Board was updated accordingly.

Hospitals and care settings have been identified as high-risk sites for potential COVID-19 transmission. Nosocomial infections are infections that have been caught in a hospital, or health care setting.

Building on existing reporting systems, it was agreed that a standardised national approach to the reporting and investigation of possible hospital-acquired COVID-19 infections would help determine if additional infection prevention and control measures are required, aiming to reduce the risk of further transmission between patients. Toolkits for patients have been developed on an All-Wales basis. There is a process in place within the Health Board to investigate cases which includes a scrutiny panel with multidisciplinary membership.

Nationally, a weekly nosocomial report is being produced by the Healthcare Associated Infection, Antimicrobial Resistance and Prescribing Programme (HARP) team of Public Health Wales, using data from ICNet.

The proactive programme including IPC training, best-practice guidance, PPE instruction (donning and doffing - the practice of employees putting on and removing work-related protective gear, clothing, and uniforms), ventilation, use of buildings and rooms in estates, and fit test training introduced and delivered across the Health Board. A Social Distancing Group was established in 2020, chaired by DPCCMH to bring together operational, workforce and staff side partners to develop supportive advice for staff. It was stood down in 2021. There has been an approach to share learning and these early lessons have been included through Powys Announcements.

The work of the IPC team was significantly impacted by the COVID-19 pandemic from February 2020, with the management of potential cases of COVID-19, and then later, as the number of cases rose within the health board and care homes. The IPC team continue to offer a rolling programme of updates via a virtual platform as well as updating written guidance alongside policies and operating procedures as situations change and evolve.

6 Incidents and Adverse Events

All adverse incidents are reported to a National Incident Reporting System. There were nine reported incidents relating to clostridium difficile which highlighted good practice from wards.

7 IPC Policies Approved in 2021/22

The following Infection Prevention and Control policies/procedures guidelines and action cards were approved at the Clinical and Operational Policy Group. All documents are accessible for staff via the Intranet. Alongside this the team have supported other departments in the development of their Standard Operating Procedures (SOP) and policies as the pandemic progressed.

Figure 6: IPC Guidance Approved in 2021/22

	Title
SOP	Mass Vaccination Centres IPC, PPE, and cleaning advice
SOP	Decontamination, Storage and Use of Flexible and Rigid Endoscopes

SOP	Supplemental guidance for Mass Vaccination Centres on what to do if a person with a suspected case of COVID-19 enters the building
SOP	Standard Operating Procedure for Visitors to Inpatient and Birthing Centres
SOP	Management of Diarrhoea and/or vomiting outbreaks for PTHB Staff and Other Workers
Model Policy	Update to Aseptic Non-Touch technique (ANTT)
Guidelines	Infection Prevention and Control: Link Worker Roles and Responsibilities

8 Internal Audit Programme and Performance

All clinical areas perform monthly hand hygiene and environmental audits. Directorates monitor and act on their audit findings and report to the Health Board IPC Group quarterly meetings. This data from adult in-patient wards is entered onto the Healthcare Monitoring System to provide ward to board assurance.

The IPC Team has a rolling annual audit programme including all clinical areas and departments for independent verifications. As stated, the IPC team were unable to fully complete the audit programme completely in 2021/22 due to the pandemic but unannounced spot checks were carried out regularly during ward visits and non-compliance with IPC policies addressed at the time of the visit. Outcomes from these audits will be provided to the respective reporting groups to enable a collective understanding and assurance of each site's performance.

9 Audit Results

9.1 Hand Hygiene Audits

Hand hygiene audits are based on the World Health Organisation's (WHO) "5 moments for hand hygiene" which applies to all staff working in clinical areas including community teams. They involve an observer discreetly watching their colleagues to audit them against the WHO's '5 Moments of Hand Hygiene':

- Before touching a patient
- Before clean/aseptic procedures
- After a body fluid exposure/risk
- After touching the patient
- After touching patient surroundings

Hand hygiene is the single most important measure to prevent cross infection, and clinical engagement is paramount in improving compliance with hand hygiene practice. Infection prevention and control is everybody's business and all staff must practice infection prevention and control precautions at all times. It has been acknowledged that there are data quality issues with the reporting of hand hygiene audit scores completed within the inpatient wards. Areas that have reported show compliance ranging from 95% to 100%. The IPC team also supported the

development and audit of practice within the Mass Vaccination Centres, and these have been incorporated into the future audit programme.

The IPC team acknowledge that there is a need to ensure all clinical settings are reporting consistently and through one system, this will be further developed in 2022/23. The team will also review the hand hygiene audit tool.

9.2 Environmental Cleanliness Audits

Environmental Cleanliness
Routine rolling environmental cleanliness audits exist primarily to enable Support Service teams to maintain close supervision of the standards of cleaning being achieved and to prioritise reactive work to respond to any shortfalls in a timely manner. They also provide assurance of the cleanliness standards achieved through reports covering any given area for any given period. Environmental cleanliness reporting is comprehensive and reaches into the Infection, Prevention & Control Group, the Environmental Cleanliness & Operational Guidance Group, the Nosocomial Scrutiny Panels and Support Services Management Team Meetings.

Cleaning and auditing frequencies for all PTHB areas are determined by their assessed risk levels. Each functional area is identified as either a Very High Risk, High Risk, Significant Risk or Low Risk. Each of these risk levels attracts a cleanliness target of achievement i.e., 98%, 95%, 85%, and 75% respectively. Likewise, each risk category attracts a target audit frequency i.e., Weekly, Monthly, Quarterly and 6-Montly, respectively. To add some context the level of scrutiny during 2021/22, an average of 1350 room audits were completed each month by the Support Services teams Management and Supervisors.

Nationally, it was identified that a more agile approach was required to quickly assess and modify the cleaning frequency and auditing requirements of a functional area when affected by increased prevalence of respiratory diseases in our communities. PTHB played a key part in working up a response to this by leading design and development of the Nationally adopted electronic Cleaning and Audit Frequency Risk Assessment Tool. Cleaning and Auditing Frequency Calculator.xlsx. This gave local teams the ability to identify and agree the enhanced cleaning and auditing requirements to meet rapidly changing infection risks found in our Heath Boards. The risk factors to be considered being "What is the likelihood of transmission of infection between Patients, Visitors and Staff in the area for assessment taking also into consideration the current National Alert Level" and "What level of clinical interventions are likely in the area being assessed and the likely volume of."

In terms of the overall standards of cleanliness achieved across all areas for the period 21/22 by risk areas, PTHB have largely met the national standards with only a marginal improvement required in the two highest risk areas. The focus on environmental cleanliness standards has improved significantly during this last period and its trajectory assures that outcomes for the next period to be further improved.

Figure 7: Cleanliness Audits of In-Patient Settings

Risk Area Target	Overall Average Audit Score Achieved 21/22
Very High Risk (98%)	97.40%
High Risk (95%)	94.46%
Significant Risk (85%)	94.00%
Low Risk (75%)	94.10%

9.3 Food Hygiene

It is paramount that the food services that PTHB provides for our patients, staff and visitors is safe but also that we are consistently able to prove that it is safe i.e., that any food we provide is free from food borne disease and from other forms of contamination such as physical, chemical, and unexpected allergens.

Assurance is provided by the checks and controls in place of PTHB's safe systems of work and other procedural arrangements. Technical advice in this area is provided inhouse and available from its Primary Authority when required. In addition, at least annually all catering services within PTHB are inspected by an Environmental Health Officer.

Figure 8: Food Hygiene Rating

The Environmental Health Officer inspections are comprehensively detailed and specifically focus on PTHB's Food Hygiene Procedures, the Kitchens Structural and Cleaning Standards and the confidence that can be found in the Management and their control procedures.

During the period 21/22 for the first time PTHB has achieved a level 5 award under the Food Hygiene Scheme in all 9 sites.

9.4 Care Homes

Several Infection Prevention visits and audits at care homes were carried out during the year. These included a number of unannounced visits and a follow-up audit of The Mountains Care Home, jointly with the complex care team.

Invitations to link worker meetings and update training were extended to the care homes in Q4 and while capacity for proactive work was compromised due to staffing, a fortnightly 'drop in' meeting via MS TEAMS was stood up to allow contact and

support for the sector. The IPC team also receives feedback from Public Health on areas of concern/outbreak etc and support is offered when relevant.

10 Education and Training Activities

10.1 Statutory and Mandatory Training

Training, where possible, was converted to a virtual platform although essential face to face activities such as face mask fit testing continued. It is noted that overall compliance for Level 1 training of 87.93% remained above the compliance target of 85% and improved from the previous year. Level 2 compliance also improved from the previous year to 81.50%. Work is continuing with staff groups to promote the importance of completion through regular communication via internal Powys Announcements and Link Worker meetings. For the year 2020/2021 the training was reported as a combined figure of 71.8%.

Only Level 2 IPC training on ESR is mandatory for registered staff which will explain the outliers in the below table.

Figure 9: Annual compliance for IPC Mandatory Training, levels 1 & 2 (Source ESR)

IPC Level 1

Staff Group	Assignment Count	Required	Achieved	Compliance %
Add Prof Scientific and Technic	**3**	**3**	**1**	**33.33%**
Administrative and Clerical	**708**	**708**	**625**	**88.28%**
Allied Health Professionals	**15**	**15**	**13**	**86.67%**
Estates and Ancillary	**250**	**250**	**220**	**88.00%**
Medical and Dental	**1**	**1**	**0**	**0.00%**
Nursing and Midwifery Registered	**1**	**1**	**1**	**100.00%**
Grand Total	978	978	860	87.93%

IPC Level 2

Staff Group	Assignment Count	Required	Achieved	Compliance %
Add Prof Scientific and Technic	**86**	**86**	**68**	**79.07%**

Additional Clinical Services	**510**	**510**	**410**	**80.39%**
Administrative and Clerical	**13**	**13**	**7**	**53.85%**
Allied Health Professionals	**149**	**149**	**128**	**85.91%**
Healthcare Scientists	**5**	**5**	**4**	**80.00%**
Medical and Dental	**44**	**44**	**27**	**61.36%**
Nursing and Midwifery Registered	**717**	**717**	**598**	**83.40%**
Grand Total	1524	1524	1242	81.50%

10.2 PPE and FFP3 training

PPE Personal Protective Equipment is clothing or equipment designed to reduce employee exposure to chemical, biological, and physical hazards when in work).

During 2021/22 staff training was available through scheduled and 'drop in' sessions for FFP3 mask fit testing, and workstations for donning and doffing, hand hygiene, insertion of cannula and venepuncture. This was positively received by staff who attended, and their attendance was recorded on ESR.

Face to face or online sessions were organised across the year, offering a comprehensive update on COVID-19 and the IPC/PPE requirements to manage it. 25 sessions were offered, with 1075 staff attending. A donning and doffing competency assessment document was created in line with other Health Boards across Wales, to give assurance that clinical staff were competent.

The IPC team staff members continued to provide opportunistic training while on the wards and other hospital sites alongside maintaining sessions via a virtual platform.

FFP3 mask fit testing was completed across the organisation (An FFP3 mask is used to protect against respiratory borne pathogens. To use these masks, relevant staff must be 'face fit tested' to ensure that they can achieve a suitable face fit of the mask and that it operates at the required efficiency). The IPC team supported colleagues in the Local Authority by conducting face mask fit testing for staff working in care homes and some domiciliary care agencies. The Local Authority has since arranged alternative methods of continuing to mask fit staff. In February 2021, the remit for mask fit testing moved to the portfolio of the Health & Safety team.

PPE is defined as 'all equipment (including clothing affording protection against the weather) which is intended to be worn or held by a person at work and which

protects the person against one or more risks to that person's health or safety, and any addition or accessory designed to meet that objective.'

Where an employer finds PPE to be necessary after a risk assessment, using the hierarchy of controls explained below, they have a duty to provide it free of charge. During April 2021 staff Face Fit Testing was available through scheduled and 'drop in' sessions for FFP3 mask fit testing, and attend workstations for donning and doffing, hand hygiene, insertion of cannula and venepuncture. This was positively received by staff who attended, and their attendance was recorded on ESR.

Face to face or online sessions were organised across the year, offering a comprehensive update on COVID-19 and the IPC/PPE requirements to manage it. 25 sessions were offered, with 1075 staff attending. A donning and doffing competency assessment document was created in line with other Health Boards across Wales, to give assurance that clinical staff were competent.
The IPC team staff members continued to provide opportunistic training while on the wards and other hospital sites alongside maintaining sessions via a virtual platform.

Aseptic Non-Touch Technique (ANTT)

Aseptic Non-Touch Technique (ANTT) is a comprehensive practice framework for aseptic technique used for all invasive procedures. All health board employees, who perform aseptic procedures as part of their role, must complete the ANTT e-learning package which is available via NHS learning Wales. Staff are then competency assessed in their areas by designated ANTT trainers for the organisation. Compliance for ANTT training lasts for 3 years so there is a rolling program. Powys now has 373 clinical staff who have undertaken the e-learning ANTT module, this is an increase of 62 from the previous year.

11 Strategic Decontamination Group

The group has maintained oversight of a range of decontamination equipment during the particularly challenging period when services and site inspections were stepped back to deal with the pandemic.

The role of Decontamination Authorised Person has been successfully appointed to. This role will strengthen the environmental and engineering aspects related to decontamination equipment ensuring the clinical teams have access to advice and support when needed. The Group oversaw a review of the list of equipment in use in Powys and supported several site audits by shared services when these recommenced.

The Reverse Osmosis Machines and Automated Endoscopy Reprocessing machines have been installed. All equipment between Llandrindod Wells and Brecon departments are from the same manufacturer which will make servicing, training, and quality checks more efficient.
The IHEEM (Institute of Healthcare Engineering and Estate Management) inspection update was completed. An action plan was agreed by the Decontamination Group which will monitor progress in conjunction with the decontamination lead from Shared Services.

The Authorised Engineer Decontamination Highlight Reports 2021 provided the Health Board with an overall assurance rating of Reasonable Assurance. An action plan has been subsequently developed and will be monitored through the health board Decontamination Group. Powys Teaching Health Board is now represented at the All-Wales Decontamination and Sterilisation Group.

12 Legionella/Water Hygiene and Ventilation

The Estates Team has a proactive sampling regime that identifies and resolves water quality issues along with a management system.

There is an ongoing Pseudomonas sampling requirement at Welshpool Renal unit which is being managed by the Estates and Facilities teams, to maintain a low level and monitored by IPC and Microbiologist and Water Safety Group. Estates have well established subgroups within all these disciplines which feeds into the respective main IPC groups.

The Water Safety Group seeks assurance and monitors activity across a number of areas of responsibility including the distribution and maintenance of water coolers, ensuring appropriate water hygiene requirements are met on completion of project activity and that new Water Risk Assessments are in place, overseeing audit activity, etc. The group ensures an appropriate management structure is in place including suitably trained and experienced Responsible Person (Water) and Deputy, along with Competent Persons to work on the water systems. Good progress is being made towards the introduction of a requirement for all relevant internal staff to be Watersafe accredited, and the intension is to incorporate this as a requirement for external Providers as part of a programme to strengthen and improve the Estates Compliance Maintenance Contracts.

A Ventilation Safety Group was convened in July 2021 to oversee a range of issues including ventilation requirements related to COVID-19 following the introduction of mechanical ventilation systems into the ward environment in three of the community hospitals and several dental suites. An additional element of work was initiated in conjunction with NHS Wales Shared Services Partnership, Specialist Estates Services (NWSSP-SES), Authorising Engineer (Ventilation), to consider the potential benefits of air scrubbers, particularly in relation to aerosol generating procedures in the dental service. The group has also considered suitable control measures in relation to requests for cooling and fans in extremes of heat in the various clinical and non-clinical environments.

13 Antimicrobial Stewardship

Antimicrobial Stewardship is a key priority for the health board. An Antimicrobial Stewardship Improvement Plan has been developed – this is regularly updated and reviewed. The Medicines Management Team monitors antimicrobial use in both primary care and community services. To encourage practices to focus on this important area, antimicrobial prescribing has been included in the annual Medicines Management Incentive Scheme and also in relevant Service Level Agreements. Monthly data, showing how each practice compares to other practices across the health board, is shared with practices – this covers overall antimicrobial prescribing (volume) and also prescribing of the antimicrobials that are linked to healthcare

acquired infections. Antimicrobial prescribing is discussed during every meeting that the Medicines Management Team holds with practices. Targeted meetings are held with practices that are identified as outliers.

To improve access and compliance with antimicrobial guidelines/formularies, the health board has commissioned access to the MicroGuide app.

Due to the absence of electronic records, antimicrobial prescribing in community hospitals is challenging to monitor. Our ability to monitor ward level prescribing will improve with the implementation of Electronic Prescribing and Administration in 2024.

The Medicines Management Team is reviewing antimicrobial stock holding on all hospital sites and is centralising stocks of rarely used antimicrobials (avoiding holding stock on all sites). It is hoped that these steps will reduce antimicrobial waste.

14 Challenges this year and priorities for 2022/23

Challenges faced in the past year:

- IPC work has been prioritised on a day to day and week by week basis to ensure the team is focused on the preparedness and response agenda for COVID-19.
- Increased workload due to the pandemic and responding/supporting to the COVID-19 outbreaks across PTHB.
- Reduced staffing levels.
- Unable to achieve a full audit programme due to the impact of COVID-19
- Unable to progress with all planned improvement work.
- Managing with rapidly changing COVID-19 infection profiles and changes in guidance
- No dedicated antimicrobial stewardship pharmacist

Priorities for 2022/23

Plans for the next financial year:

Development of the team and the duties provided, to include:

- Complete team the design of the IPC team and function
- Implement work plan for 2022/23
- Forward planning for a potential increase in COVID-19 cases/winter pressures including Influenza.
- Maintaining the PPE & IPC Update training, to be delivered online and face-to-face.
- Reintroduction of routine IPC audits across the inpatient wards.
- Developing revised facilitated review for post-infection reviews for C. *difficile* and Gram-negative bacteria BSIs, to enable learning to be identified. Focusing on prevention of C. *difficile* in Primary care.
- Ongoing PPE training and IPC Link Worker meetings. Developing the role and knowledge of the IPC Link Worker to support PTHB in meeting All Wales directives regarding AMR and HCAIs.
- Implementation of the Operational IPC Meeting

- Continuing to meet departments and work with/provide support to colleagues.
- Providing support to all departments with regards to returning to 'Business as Usual' and ongoing IPC requirements as part of living with COVID-19
- Contribution to the All-Wales groups on ANTT development and the digitalisation of patient records
- Supporting care homes via the Care Home Forum and acting as a local resource
- Provide bespoke placements with the IPC team for student nurses.

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item:

Patient Experience, Quality and Safety Committee	**24th November 2022**
Subject:	Infection Control Quarter 1 Report: 1st April to 30th June 2022
Approved and presented by:	Claire Roche, Executive Director of Nursing and Midwifery
Prepared by:	Jason Crowl, Interim Deputy Director of Nursing Alex Smith IPC Specialist Practitioner Marie Davies, Deputy Director of Nursing
Other Committees and meetings considered at:	N/A

PURPOSE:
This paper provides the Group with the oversight and assurance on activity regarding IPC compliance standards during Quarter 1 of 2022/23
RECOMMENDATION(S):
The PEQS Committee is asked to: • Discuss this update. • Note the introduction of an Operational IPC Group

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	✓/×

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

	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:

- During Q1 there was 6 outbreaks of COVID 19 in Powys Teaching Health Board inpatient wards.
- There has been <5 C. *Difficile* and E.Coli recorded cases in Powys in this quarter
- There has been considerable work undertaken by the team, wards, and departments to maintain standards and reduce nosocomial infections.
- There is renewal work required as part of the recovery to business-as-usual arrangements.

DETAILED BACKGROUND AND ASSESSMENT:

Introduction:

This paper provides information to the Powys Teaching Health Board Infection Prevention & Control Group on the activities performed by the Infection, Prevention and Control (IPC) Team during Quarter 1 of financial year 2022/23.
It covers Healthcare Associated Infections (HCAI), including COVID-19 infection, with data around cases and outbreaks, and infection prevention and control activities undertaken to control its spread.
Data used in this report has been taken from PHW (Public Health Wales) data https://phw-tableau.cymru.nhs.uk/views/WalesHBAHHCAIMonthlyUpdate2022-23-NHS/WalesHCAIMonthlyUpdate?:showAppBanner=false&:display_count=n&:showVizHome=n&:origin=viz_share_link

Workforce

The team has undergone a number of changes and challenges during this quarter. During this period, the team structure has temporarily changed due to staff moving onto other roles. Recruitment to a number of posts has been challenging resulting in a review of staffing which will be finalised in Q2.

Data management issues

PTHB has had an ongoing issue with patient data management, and this continues into Quarter 1 2022. Shrewsbury & Telford Hospital NHS Trust (SATH) does not have a patient data management system that links into PTHB. This means that it is difficult to say with confidence that the data being retrieved from different patient management systems used in PTHB is correct. This remains an issue to be resolved on the IPC work plan.

Healthcare associated infections (HCAI): statistics and performance

Welsh Health Circular (WHC) 2021(028) published on 27th September 2021 sets out the AMR and HCAI improvement goals for 2021 – 22. These goals are in line with the UK AMR Strategy and the UK 5-year action plan 2019-24, both of which aim to combat antimicrobial resistance through lowering the burden of infections, improving treatments, and optimising our use of antimicrobial in humans.

Similar to previous years, the improvement goals focus on 2 categories:

1. Optimising the use of antimicrobials, and
2. Lowering the burden of infection

For PTHB this is a 10% reduction on 2019-20 figures, however annual numbers are very small therefore it may not be possible to sustain a continuous reduction. The aim of the infection prevention and control team is to investigate the cases as they arise to identify any lessons to be learnt to improve outcomes and reduce incidences.

C. *difficile* Infection

The geography of Powys means that the majority of local services are provided locally, through general practitioners and other primary care services, community hospitals and community services, however Powys residents receive specialist hospital services in hospitals outside of the county in both England and Wales.

Cases of C. *difficile* in PTHB have increased to date this year, this reflects the National increasing trend of cases. Individual hospital cases are investigated, and lessons learnt shared to improve care and patient outcomes.

The health board has recently established a panel to review all CDI cases. This is a multidisciplinary panel (IPC, Medicines Management, nursing, microbiology) that establishes any potential contributing factors associated with each CDI case (e.g. comorbidities, prescribing, infection control issues). A screening panel has been introduced to ensure that all of the required information is available to the panel when it meets. The intention is to identify any potential causal factors and share learning that may reduce the risk of future CDI cases.

Staphylococcus aureus (MSSA & MRSA) blood stream infections

There have been no cases of MSSA BSIs since August 2020. It has been 9 years since the last case of MRSA bacteraemia, which is an achievement to celebrate.

Gram-negative blood stream infections

All GNBSIs allocated to PTHB are hospital-acquired. This can be explained by the fact that most BSIs acquired in the community require admission at an Acute Hospital and therefore will not be admitted to PTHB.

PTHB are currently on target to have an annual reduction in gram negative bacteraemia.

COVID-19

The emergence of a sub variant of SARS-CoV2 in during Q1 has had a major impact on the service, as increased numbers of staff were reported absent due to either being positive or having close contact with a positive case. Guidance from the Welsh Government kept changing rapidly especially affecting staff dealing with immunocompromised or extremely clinically vulnerable patient population.

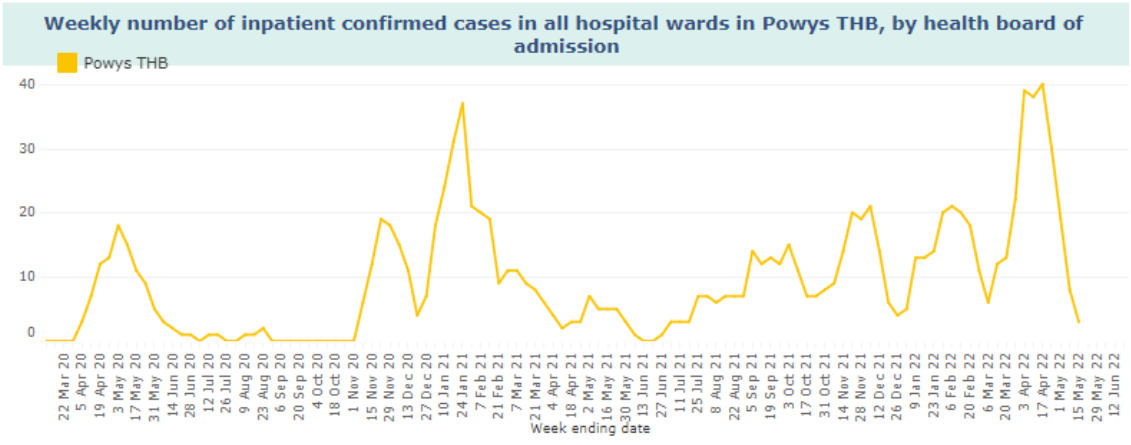
The IPCT kept staff informed of the many changes in national and local guidance though training and Powys announcements. Guidance on PTHB website was updated accordingly.

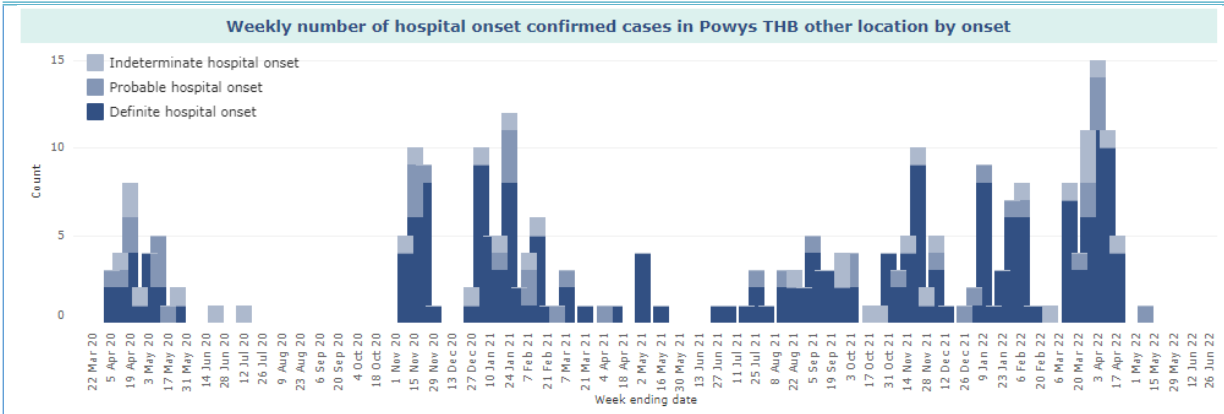
Nationally, a weekly nosocomial report is being produced by the Healthcare Associated Infection, Antimicrobial Resistance and Prescribing Programme (HARP) team of Public Health Wales, using data from ICNet*. This information is analysed by the Nosocomial Group to identify and prioritise cases for investigation based upon the national surveillance definitions.

*ICNet data is not directly available for Shrewsbury and Telford NHS Trust, as the administration system linking with the Powys system is not scheduled for upgrade until July 2023. This has been raised at a system wide quality meeting for Shrewsbury, Telford and Wrekin area. This is a known risk, and mitigations in place to share data affecting Powys patients via email until this can be achieved.

Nationally agreed surveillance definitions:

- **Community onset**: specimens taken on day of admission or day after (days 1 and 2)
- **Hospital onset, indeterminate healthcare associated:** specimens taken on days 3 to 7 of admission
- **Hospital onset, probable healthcare associated**: specimens taken on days 8 to 14 of admission
- **Hospital onset, actual healthcare associated**: specimens taken >14 days after admission.





Nosocomial COVID-19 infections can be identified from a number of sources. The main sources include:

- A patient safety incident reported in Datix
- Findings from mortality reviews (stage 1 or stage 2)
- Suspected or confirmed outbreaks or Period of Increased Incidence (PII's)
- Surveillance data from ICNet

Building on existing reporting systems, it was agreed that a standardised national approach to the reporting and investigation of possible hospital and work acquired COVID-19 infections would help determine if additional infection prevention and control measures are required, aiming to reduce the risk of further transmission between staff, patients, and visitors. Toolkits for both staff and patients have been developed on an All-Wales basis and Powys have adopted these with some minor additions to capture some additional information on the staff toolkit. There is a process in place within the Health Board to investigate cases. Data quality has been an issue and the number of cases remains under close scrutiny.

There have been 3 marked periods of increased incidence in inpatient areas which were deemed an outbreak by the Incident Management Team. Graham Davies Ward, Felindre ward and Adelina Patti Ward - outbreaks occurred during a period where community transmission was increasing.

There were no other communicable diseases reported in this quarter.

Incidents and Adverse Events.
All adverse incidents are reported through the National Incident Reporting System.

Audit Results
Hand Hygiene Audits
Currently, hand hygiene audits are carried out by an observer discreetly watching their colleagues to assess them against the WHO's '5 Moments of Hand Hygiene':

1. Before touching a patient.
2. Before clean/aseptic procedure
3. After body fluid exposure risk
4. After touching a patient.
5. After touching patient's surroundings.

Data is available for the general inpatient wards and day surgery for Quarter 1, with most areas achieving 100%, the lowest was 67%.
A new hand hygiene tool & audit process has been launched this quarter, utilising the IPC link workers with on-going validation audits by the IPC team scheduled as an on-going activity. The purpose of the new tool is to provide focus on the '5 Moments' and the appropriate technique and to better capture accurate audit data.

Environmental Cleanliness Audits
The IPC Team have continued to carry out joint audits with the Service Improvement Manager to support the Cleanliness Audit. These are reported separately to IPC Group.

Site Visits
Several IPC visits have been undertaken in the last 3 months. The IPC team spent time in Brecon hospital, Ystradgynlais Community Hospital and the Bronllys site.

Dental Department
The IPC team visited the Dental practice in Newtown and Builth. The standard of PPE wearing was particularly good. The main issue they are experiencing is due to the Sodium Hypochlorite in the cleaning processes, there was deterioration in some of the stainless-steel cupboard and drawer handles. The IPC team continues to look at the best way to manage this and anticipates a resolution soon.

Care Home Visits
The IPC team remain available for advice and guidance to Care Homes on an individual basis. A drop-in session via Teams is diarised fortnightly, for queries and questions.

Events
The IPC team participated in an event in May hosted by the Senior Manager for Unscheduled Care, attended by ward managers and senior sisters. The aim of the IPC presentation was to deliver information about current guidelines around admissions/discharges and management of patients with respiratory infections as well as a Q&A session.

First IPC Operational Group meeting took place in July 2022, and will be reported in Quarter 2.

This quarter saw the end of COVID-19 – specific policies and the return of standard IPC measures as documented in the National Infection Prevention and Control Manual.

Education & Training Activities
IPC Mandatory Training – levels 1 & 2
There has been a slight increase in training compliance in Q1, particularly in the medical and nursing and midwifery categories which provides assurance.

Level 1 IPC Training compliance

IPC Level 1 Q1				
Staff Group	Assignment Count	Required	Achieved	Compliance %
Add Prof Scientific and Technic	2	2	1	50.00%
Administrative and Clerical	701	701	611	87.16%
Allied Health Professionals	13	13	10	76.92%
Estates and Ancillary	244	244	221	90.57%
Medical and Dental	1	1	0	0.00%
Nursing and Midwifery Registered	1	1	1	100.00%
Grand Total	**962**	**962**	**844**	**87.73%**
IPC Level 2 Q1				
Add Prof Scientific and Technic	89	89	70	78.65%
Additional Clinical Services	507	507	411	81.07%
Administrative and Clerical	13	13	10	76.92%
Allied Health Professionals	149	149	120	80.54%
Healthcare Scientists	4	4	4	100.00%
Medical and Dental	44	44	25	56.82%
Nursing and Midwifery Registered	697	697	579	83.07%
Grand Total	**1503**	**1503**	**1219**	**81.10%**

Work is continuing with staff groups to promote the importance of completion through regular communication via internal Powys Announcements and Link Worker meetings.

IPC & PPE Updates

Training has remained largely virtual during Q1. Regular updates have also been communicated through Powys Announcements. The updated training for COVID-19 related PPE and infection control measures was brought in after the start of the pandemic and training over 1000 staff has been an amazing achievement. Since legal requirements for COVID-19 specific PPE were lifted, the PPE training has been stood down. Guidance for departments relating to COVID-19 is now actioned on a case-by-case basis.

IPC Link Worker Meetings

Monthly IPC Link Worker Meetings have continued through Q1, allowing staff to mention concerns and for the IPC Team to feedback useful information and findings from audits, visits etc.

ANTT

On the 5th of May 2022, 11 PTHB staff attended a PHW organised ANTT assessors training day at Llandrindod Media Resource Centre, with the anticipation of rejuvenating the ANTT programme across PTHB.

Since then, meetings have been held to support the new assessors and push the programme forward. It is the ambition of the programme to achieve Bronze accreditation for the health board by the end of the year.

Nosocomial Group
To be reported to the IPC &AMR Group, in the Nosocomial Group Report.

Decontamination Group
To be reported to the IPC &AMR Group by exception, in the Decontamination Group Report.

Legionella/Water
To be reported to the IPC & AMR Group by exception, in the Estates report.

Priorities for Q2

- Implement a revised team structure for the IPC Team
- Introducing and embedding an audit framework to cover a variety of KPI's as well as environmental audits
- Continuing to progress the IPC work plan
- Working to raise the profile of the IPCT
- Developing Quality improvement methodologies to assist PTHB to maintain low HCAI rates
- Plan to refresh and strengthen the link nurse programme
- Working to return to business as usual while still responding to the demands of the pandemic
- Continuing ANTT work to increase uptake and reduce infection rates

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 x				
Pregnancy and maternity	x				
Race	x				
Religion/ Belief	x				
Sex	x				

Sexual Orientation	x x				
Marriage and civil partnership	x				
Welsh Language	x				

Risk Assessment:					
	Level of risk identified				
	None	**Low**	**Moderate**	**High**	**Statement** Effective infection prevention and control needs to be everybody's business and must be part of everyday healthcare practice and based on the best available evidence so that people are protected from preventable healthcare associated infections.
Clinical			x		
Financial		x			
Corporate			x		
Operational			x		
Reputational			x		

	Welsh Improvement Goal/Objective	Goal	Lead	Reporting	Frequency/by when?	BRAG	Comments as at 26/5/2022	
1	To reduce C. Difficile Infection (CDI) and other specific HCAIs to target levels: - A reduction of 10% on 2019/20 figures (unless 2019/20 was higher than 2018/19) - Includes E. coli, Klebsiella sp and Ps. aeruginosa and S. aureus Blood Stream Infections	Support PTHB staff and Care Home staff to manage and contain cases of HCAI.	IPC Team		Mar-23		IPC teams have supported care homes during the pandemic and continue to prioritise areas of concern.	Activity is limited to escalation. Drop in sessions available - to be rejuvenated. Advice to manage outbreaks.
		Completion of Post-Infection Review (PIR) within 30 days of positive result, to comply with new Datix requirements.	IPC Team - to oversee process Relevant HB departments/Primary care/Care Homes		Mar-23		Started. Process needs embedding.	On-going. Ability to complete within 30 days may not be possible.
		Monitor cases/rates of HCAIs against PHW data to ensure accuracy and to identify trends.	IPC Team		Mar-23		Ongoing	ongoing
		Training of PTHB staff re. HCAIs (to meet Welsh Health Circulars)	IPC Team		Monthly		Ongoing	Stat & Man via ESR. Training programme limited to Hand Hygiene, PPE, ANTT, Link workers
		Manage & contain outbreaks of HCAIs to ensure they affect as few patients/staff as possible.	IPC Team Ward staff		As required		Ongoing	on-going
		COVID19 management & preparation	IPC Team		As required		Ongoing	On-going at present. in the event of new waves, resources attached to this will need review.
2	To reduce the burden of infection and risks of blood stream infections derived from the community:	Implement evidence-based interventions in the management of:					Ongoing	
		- People who inject drugs (PWID)	PWID Lead		Mar-23		Ongoing	On-going accountabilities lie outside of direct IPC team
		- Wound / chronic ulcer management	TV Nurse		Mar-23		Ongoing	On-going accountabilities lie outside of direct IPC team
		Prevention of respiratory infections:					On going	On-going accountabilities lie outside of direct IPC team
		- Oral Care	Dental teams		Mar-23		On going	On-going accountabilities lie outside of direct IPC team
		- Immunisation against influenza	GP practices, School Nurses				Ongoing	On-going accountabilities lie outside of direct IPC team
		- COPD management	Respiratory Team				Ongoing	On-going accountabilities lie outside of direct IPC team
3	Roll out of ANTT in all healthcare settings.	Roll out of Aseptic Non-Touch Technique (ANTT) in hospital settings (rollout in community settings to be introduced in 2023-24)	IPC Team/Education/Primary Care/Care Home Leads		Mar-23		Commenced	on-going - Seeking bronze accreditation by end of calendar year 2022
4	To improve UTI prevention, diagnosis and appropriate management across the whole healthcare system utilising 'UTI 9' standards.	Support PTHB staff to manage urinary health.	IPC Team/Continence Team		Mar-23		Commenced	on-going Leadership within the Continence Team
	Other objectives							
	Audit	Implement annual audit programme across PTHB to include:					Commenced	
		Renewal of audit programme to be introduced to relevant wards and departments	IPC Team		Mar-23		Programme Commenced	
		All identified wards/departments to have an annual IPC audit - to include inpatient wards, outpatient departments & maternity.	IPC Team		Across the year		Programme Commenced	Audit programme delayed until Q4.
		Ensure all inpatient wards have an audit done in conjunction with Environmental Cleanliness – in addition to above	IPC Team		Across the year		commenced 11/8/22 rolling month program	on-going
		Ensure theatres and endoscopy have regular audits to meet JAG requirements	IPC Team/Theatres		Mar-23		Programme Commenced	Decontamination lead remains with Assistant Director of Community Services Group
		Baseline training status of staff to be collected from Department Managers, to include IPC Module 1&2, Hand hygiene training, PPE training and fit testing date.	IPC Team to oversee collection of data Department Managers to ensure completion of Fit testing. Fit testing under remit of H&S.		Mar-22			Reported Qtly

5		Hand hygiene compliance programme: - Baseline validation audit to be carried out in March 2022 - Renewal of hand hygiene compliance programme to be introduced in March 2022 with relevant inpatient wards and departments - Hand hygiene observation audits to be carried out, to meet standard of up top 15 observations over a month time period, incorporating multi-disciplinary staff groups: - Submissions to be reviewed monthly & actions followed up - Validation audits to be carried out annually,	Department staff - IPC Link Workers? Department Managers/Link workers. External Auditor (E.g. Eco Lab) IPC team		by end April 2022 July launched April 2022 July 22 April 2022		Programme Commenced	Launch completed July 22. Awaiting data from ward managers. Reported monthly with validation audit annually (the annual external audit has begun Sept 22)
		PPE donning/doffing compliance: - Baseline validation audit to be carried out in March 2022 - PPE donning/doffing compliance audits to be carried out, to meet standard of 20 observations over a month time period, with 5 observations of each of the following staff groups: - Nursing team staff - Doctors - Allied Health Professionals - Support staff (facilities, domestics etc) - Results to be submitted monthly - Submissions to be reviewed monthly & actions followed up	IPC Team Department staff - IPC Link Workers? Department Managers IPC Team		March 2022 by end May 2022 May 2022 monthly			Training is on request. Activity is limited to escalation. Programme to be reviewed.
		Other audits to be included: - Management of enteral feeding lines - Non tunnelled venous catheters (CVC) Peripheral Intravenous (PVC) lines - VIP Score To include clinical practice audits & surveillance audits	Department Managers/IPC Team		By end Q3			Delayed until Q4
		MRSA screening compliance	IPC Team		Weekly			Delayed until Q4
		(CPO screening compliance)	TBC		TBC			To align with PHW policy for CPO screening once published expected Q3/4
		Datix reporting compliance	IPC Team		Weekly			Delayed until Q4
		Mattress audit	Audit completed by Ward/department staff Completed audits reviewed by IPC Team		Monthly Quarterly		Programme Commenced	Leadership with Medical Device and Point of Care Testing Team supported by IPC.
		Undertake specific audits as required - Eg following an outbreak or cluster, or in response to a complaint	IPC Team		Mar-23		Programme Commenced	As requested
7	Decontamination	Monitor decontamination risks and incidents across PTHB as part of the Quarterly Decontamination Group and during IPC duties.	Band 8a IPC Team		Mar-23		Audit planned for September 2022	Decontamination lead remains with Assistant Director of Public Health and Vaccination Programmes
	Training & Education	Expand IPC Link Worker programme to ensure PTHB has effective IPC representation in all departments	IPC Team/Nursing Operational Directorate		Mar-23		The role of IPC link worker is being further developed and will be a key part of the prevention and promotion role	on-going
		Expand IPC Link Worker programme to include all GP practices	IPC Team		by end of Q3		Will be prioritised in September	Delayed until Q4
		Ensure PTHB staff are competent and compliant with correct donning, wearing & doffing of PPE, including new starters.	IPC Team/Education/Department Managers		Mar-23			Accountabilities lie outside of the IPC team
8	Meetings/areas of work	To ensure all groups & subgroups have IPC representation as required	IPC Team		44986		Supporting as capacity allows	Limited capacity within IPC team may mean non-attendance at some sub groups
		Strategic – every meeting						
		Operational – as required						
		Departmental – min. twice a year						
9	Enquiries/Datix	To ensure all wards and departments of PTHB, plus primary care GP practices, can access IPC advice.	IPC Team		Mar-23		Access to IPC advice is being maintained as a priority area	on-going
		To ensure the Datix process is completed as per Welsh Government expectations.	IPC Team		Mar-23		Review of DATIX is being maintained as a priority area	Delayed until Q4
10	Visibility of Team	All hospital inpatient wards will be visited every month	IPC Team		Mar-23		Rolling visits in place but will be reduced until new posts have been filled due to capacity	Site visits limited to joint environmental audits and as requested
		All other onsite departments will be visited every 2 months	IPC Team		Mar-23		Rolling visits in place but will be reduced until new posts have been filled due to capacity	Delayed until Q4

	Visibility of Team	All staff will feel confident about the current IPC policies/procedures in PTHB and will be able to ask questions.	IPC Team		Mar-23			Audit delayed until Q4
		The PTHB intranet will be keep up-to-date	IPC Team		Mar-23		Not complete	To be discussed
11	Assurance/Governance	Maintenance of IPC risk register	IPC Team		Mar-23			Completed by DDoN
		To ensure that policies remain in-date.	IPC Team		01-Mar		Targeting high priority areas until end of year 2022 due to staffing capacity	needs prioritisation
		To identify requirement for new policies, SOPs and Action Cards and produce these for sign off in a timely manner.	IPC Team		Mar-23		Being drafted as new changes come in to place. These are treated as a priority area for the service	
	Project work	Getting back to BAU across PTHB	IPC Team		Mar-23		Targeting high priority areas until September 2022 due to staffing capacity	on-going
		IPC input to Buildings & Estates works	IPC Team		As required		Targeting high priority areas until September 2022 due to staffing capacity	on-going
		Input into national and local campaigns	IPC Team/comms		As required		Targeting high priority areas until September 2022 due to staffing capacity	delayed
	To postpone until IPC Team more embedded.	Ensure all GP practices have an accompanied IPC audit every year	IPC Team		Mar-23		Targeting high priority areas until September 2022 due to staffing capacity	delayed
		Ensure all Care Homes (Residential and Nursing) have an accompanied IPC audit every year.	IPC Team		Mar-23		Targeting high priority areas until September 2022 due to staffing capacity	delayed

Agenda Item: 3.1

Patient Experience, Quality and Safety Committee	**Date of Meeting: 24 November 2022**
Subject:	**Safeguarding Update: 2021-22 Annual Report**
Approved and presented by:	Claire Roche - Executive Director of Nursing and Midwifery
Prepared by	Jayne Wheeler Sexton - Assistant Director for Safeguarding and Public Protection
Other Committees and meetings considered at:	The Annual Safeguarding Report has been received at the Safeguarding Strategic Group and will be presented to the Patient Experience, Quality and Safety Committee on the 24 November 2022.

PURPOSE:

The purpose of this paper is to:

To present the 2021-2022 Safeguarding Annual Report to the Patient Experience, Quality and Safety Committee.

RECOMMENDATION:

Patient Experience, Quality and Safety Committee are asked to:

- Note the contents of this paper

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

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

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:	• Staying Healthy	✓
	• Safe Care	✓
	• Effective Care	✓
	• Dignified Care	✓
	• Timely Care	✓
	• Individual Care	✓
	• Staff and Resources	✓
	• Governance, Leadership & Accountability	✓

EXECUTIVE SUMMARY:

PTHB Safeguarding Annual Report presents the key areas of development and achievement which have supported the Health Board to meet its statutory responsibilities in safeguarding the people of Powys during 2021/22. The report is aligned to the Standards of the Safeguarding Maturity Matrix (SMM); a self-assessment tool which addresses the interdependent strands regarding safeguarding; service quality improvement, compliance against agreed standards and learning from incidents and reviews.

Improvements within each of the SMM Standards; Governance and Rights Based Approach, Safe Care, ACE's Informed, Learning Culture and Multiagency Partnership Working, are highlighted within the report and demonstrates the vast and varied safeguarding and public protection agenda.

The Safeguarding Team has been both visible and accessible across the whole Health Board driving change and improvements throughout 2021 – 2022. The challenges for 2022-23 are noted.

1. Introduction

1.1 NHS Wales has an essential role in ensuring that all adults and children receive the care, support and services they need to promote a healthy, safer and fairer Wales, however measuring the effectiveness of health services and their contribution to safeguarding adults and children is difficult and complex. Powys Teaching Health Board is committed to ensuring safeguarding is part of its core business. The Health Board recognises that safeguarding children and adults at risk is a shared responsibility that requires all our employees to have the competencies to safeguard people and be able to develop strong effective joint working relationships with our partner agencies and colleagues. Our vision is that Powys residents live their lives free from violence, abuse, neglect and exploitation. The Health Board will promote the United Nations Convention on the Rights of the Child, Human Rights and the United Nations principles for Older Persons in all its work.

1.2 The Annual Report outlines, with some examples, how the safeguarding service is performing and innovating to deliver an accessible, research led service. It provides an update on safeguarding priorities during 2021-2022 and identifies safeguarding key developments coming during 2022-2023. The Safeguarding Service acknowledges the need to build on what has already been achieved to ensure PTHB and all contracted services, fully meet their statutory responsibilities for preventing harm, and act in a timely way on concerns raised about the welfare of people who reside, work or visit Powys.

1.3 This Safeguarding Annual Report is aligned to the Standards of the Safeguarding Maturity Matrix (SMM); a self-assessment tool which addresses the interdependent strands regarding safeguarding; service quality improvement, compliance against agreed standards and learning from incidents and reviews.

1.4 A SMM self-assessment tool and improvement plan is completed by Powys Teaching Health Board annually, and submitted to the National Safeguarding Team, which inform a national report through the NHS Wales Safeguarding Network, to the Chief Nursing Officer in Welsh Government. The aim of capturing and collating a national SMM is to provide assurance, share practice and drives improvements towards a 'Once for Wales' consistent approach to safeguarding across Wales.

1.5 The SMM Standards are Governance and Rights Based Approach, Safe Care, ACE's Informed, Leaning Culture and Multiagency Partnership Working. PTHB SMM 2021-22 Improvement Plan was developed and monitored via the Safeguarding Strategic Group.

2. Governance and Rights Based Approach

2.1 PTHB has in place clear lines of communication, responsibility and accountability. The Safeguarding Strategic Group meet quarterly. Key issues in relation to Safeguarding and Public Protection activity across PTHB are presented using a Data Set which assists in identifying good practice, themes, issues, risks and providing assurance to support PTHB to demonstrate how it is meeting its statutory responsibilities for safeguarding and public protection. The Safeguarding Strategic Group provides a link between PTHB, the Regional Safeguarding Board, the Violence Against Women, Domestic Abuse and Sexual Violence Strategic Group and The NHS Wales National Safeguarding Network.

2.2 NHS Wales Shared Services Partnership Audit and Assurance Service undertook one Internal Audit: Midwifery Safeguarding Supervision. The audit provided overall reasonable assurance to the Health Board, an action plan was developed and implemented.

Governance and Rights Base Approach: We Said	We Achieved	We need to progress
Children Rights/Children's Pledge must be embedded throughout the Health Board	LAC Nurses share The Childrens Pledge with children who are looked after and their carers at their first contact	Expand this model across all services Progress the development of enabling feedback from Children Looked After & their carers
All Safeguarding documents to be moved to Teams, utilise Office 365 to create Forms for Training feedback and analysis. Design new booking system for supervision. Link systems to enable efficient and accurate data collection	New Data set developed and presented quarterly at SSG Forms created for Training feed back New Booking system for group supervision	Completed

3. Safe Care

3.1. In accordance with the Social Services and Well-being (Wales) Act 2014 and the Children Act 1989/2004, the Health Board has a statutory duty to report a child or adult who is (a) experiencing or is at risk of abuse, neglect or other kinds of harm, and (b) has needs for care and support needs.

A total of 191 child safeguarding reports were made by PTHB staff during 2021-22. 32% raised concerns about neglect, 18% of the reports related to domestic abuse and 10% were in respect of emotional abuse.

35 Children required a Child Protection Medical during 2021-22. 18 female and 17 males. 20 were between birth and 4 years and 15 were 5 years and over. Work has continued with CTUHB who support PTHB with the child protection medical process for children living in South Powys. Terms of Reference have been drafted for a multi-agency CP Medical Forum.

3.2 Child Exploitation
Multi Agency Child Exploitation (MACE) meetings provide a framework to facilitate regular information sharing, data analysis, quality assurance, performance and professional challenge on information and intelligence relating to Victims of exploitation, Offenders, Locations and Themes. PTHB are represented at each MACE meeting and during 2021-2022 have been working to develop a data set of information which supports the multi-agency response required to keep children safe from exploitation.

PTHB is promoting the use of a Child Sexual Exploitation Risk Questionnaire (CSERQ4/15), designed to be used within health settings.

3.3 Looked After Children (LAC) are children up to the age of 18 for whom the Local Authority is providing accommodation or care for a period of more than 24 hours (Children Act 1989). LAC are amongst the most socially excluded groups in our society and have been found to have significantly increased health needs in comparison with children from comparable socio-economic backgrounds (Sampeys 2015)**.**

Improving the health of looked after children is a multi-agency responsibility. PTHB has a duty to comply with the related legislation: Part 6, Social Services & Wellbeing (Wales) Act 2014 – Looked After & Accommodated Children.

During 2021-22 368 Looked after Children health assessments were carried out by PTHB LAC Nurses and Health Visitors. 84% were completed within statutory time frames. 293 health assessments were with children from Powys and 75 were with children from other Local Authorities placed in Powys

Redesign of Looked After children Health Questionnaire
During the COVID-19 pandemic PTHB introduced virtual health assessments due to necessity, over time it became evident that developing choices for

children regarding their Health Assessment was needed. This resulted in a redesign and digitalisation of the Health Questionnaire with input from children looked after and carers. Some children expressed they did not want to answer some of the questions due to the way they were worded and there was nowhere to add free text, one example of the changes made on the children's request is we have added to the sexuality question '*would prefer not to say'*. The children now have a choice for their Health Assessments, face to face, virtual via Teams or via the Health Questionnaire. By valuing the children's needs and choices we are less likely to encounter refusals and can provide the support they need.

The LAC Team also developed training slides for the Local Authority to use during a Social Workers Induction. The slides:

- support and improve Social Workers understanding of the Looked After Children Clinical Nurse Specialist role
- Remind Social Workers of the importance of informing health of changes in children's placements and providing consent for a child's Initial Health Assessment

3.4 A total of 102 adult safeguarding reports were made by PTHB staff during 2021-22. 34% of the reports related to neglect, 16% were in respect of financial abuse and 6% raised concerns about emotional abuse.

3.5 Work continued during 2021/2022 to improve internal processes and practitioner knowledge of DoLS and MCA, this includes the development of a MCA Competency Framework.

A Welsh Government Grant funded an additional Best Interest Assessor and the Spot purchasing of Best Interest Assessments to support managing the DoLS backlog. Two Best Interest Assessors supported to attend Assessing Capacity post-graduation course at Swansea University.

3.6 Violence against women, domestic abuse and sexual violence has far reaching consequences for families, children, communities and society. The direct harm to the health and well-being of victims is clear, and at its most severe can, and does, result in death. However, impacts are not just on health and wellbeing but include human rights, poverty, unemployment, homelessness and the economy.

PTHB Safeguarding Team continue to work closely with partner agencies to respond to VAWDASV and provide staff with safeguarding supervision and support, deliver VAWDASV Training and produce bi-monthly VAWDASV Newsletters to share the latest information in relation to national, regional and local support agencies, trends and emerging themes. The Safeguarding Team also continue to engage operationally in Domestic Abuse Conference Calls and Multi Agency Risk Assessment Conference, these are meetings where high-risk victims of abuse are safety planned.

Safe Care: We Said	We Achieved	We need to progress
PTHB must prepare for the implementation of Liberty Protection Safeguards, PTHB workforce need to increase their knowledge, skills and confidence in MCA and DoLS	Upskilling of staff knowledge and skills re MCA & DoLS has been a focus yet there remains gaps in its application. Development of LPS Working Group Responded to MCA Code of Practice and Welsh Regulations consultation	Progress secondment for MCA Lead & additional BIAs Upskilling of staff knowledge & skills using MCA competency framework
PTHB to be assured professionals are aware of, and using PTHB's Was Not Brought Protocol	Protocol audited, revised and relaunched Chronology Function created in WCCIS Team Leads Dash Boards display WNB	Repeat Audit planned for 2022/23 Team Leads to review Dash Boards monthly
PTHB must comply with the National Standards for CP Medicals. The CP Medical rota requires strengthening to meets the needs of the children in Powys. To seek assurance of the quality of CP Medicals	Links with CTMUHB to support CP rota. Regular meetings with LA to establish CP Medicals group and how we deliver multi agency Childhood Injuries Training	Formalise links with CTMUHB Set date to commence CP Medical Group with LA & Police Deliver multi agency training

4. Ace Informed

4.1 Adverse Childhood Experiences (ACEs) are traumatic events, particularly those in early childhood that significantly affect the health and wellbeing of people in Wales, the rest of the UK and the world. We can break the cycle of ACEs at any stage; it's never too late. Preventing ACEs in a single generation or reducing their impact can benefit not only those children but also future generations in Wales.

ACE Informed: We Said	We Achieved	We need to progress
PTHB to be assured that the CSERQ15 is used routinely within health settings & establish a system to identify children at risk of Child Exploitation within the Electronic Health Board's System.	Audit practitioner knowledge of CSERQ Newsletter on the use of the CSERQ developed to raise awareness, child at	Further work planned around safeguarding and exploitation

	risk of CE alert added to electronic system Improved data shared at MACE	
Audit Safeguarding Children Standards for Adult Mental Health Professionals	Audit completed	Consider an annual joint MH & Safeguarding Audit

5. Learning Culture

5.1 All organisations have a responsibility to support their employees to develop their knowledge, skills and capability to perform effectively in their role. PTHB have signed up to the National Safeguarding Training Framework co-produced by NST, Health Boards and Trusts. The framework is aligned to and benchmarked against the Intercollegiate guidance, national workforce competencies; UK Core Skills Training Framework 2018, Adverse Childhood Experiences (ACEs) Skills and Knowledge Framework for Wales (March 2019), National Training Framework for Violence Against Women Domestic Abuse and Sexual Violence 2016.

5.2 During 2021-22 the Safeguarding Team have delivered 35 training sessions to 674 practitioners. Compliance in safeguarding adult and children level 1, 2 and 4 training has been maintained at or increased to over 80%. Level 3 adults and children's compliance has been slow with an increase in adults from 34.28% to 43.51% and children from 64.53% to 68.81%. Training compliance is monitored via the Strategic Safeguarding Group.

5.3 Staff should also be able to raise concerns and feel supported in their safeguarding role. Effective safeguarding supervision is important in promoting good standards of practice and to support individual staff members; it should assist in ensuring health practitioners are competent and confident and provides a safe environment for challenging practice. Types of Safeguarding Supervision include;

i. Immediate Telephone Supervision, Advice, Support
ii. Requested Individual Safeguarding Supervision
iii. Group Supervision Sessions
iv. Debrief Sessions
v. Peer Review for Medical Paediatric Staff

During 2021-22 the Safeguarding Team offered *96* Group Supervision Sessions with *412* staff attending these sessions and received 671 calls for advice, support and supervision via our safeguarding hub.

5.4 The Safeguarding Team has redesigned its Intranet Page to make it more user friendly and easier for staff to navigate. The page has links to all the relevant legislation and associated guidance which outlines the roles and responsibilities of individual practitioners and agencies in relation to safeguarding and public protection and the levels of accountability, the skills and competencies required by staff to perform their duties, handling individual cases and effective interagency working at all levels.

Learning Culture: We Said	**We Achieved**	**We need to progress**
Safeguarding Supervision and Training compliance requires improvement Develop a system to monitor compliance within each Service Group	Audit Safeguarding Supervision – recommendations completed Quarterly compliance shared with Heads of Service Groups and at SSG & OSG	Continue to monitor and report Support improvement
Improve health practitioner awareness, understanding and how to respond to concerns regarding child & adult neglect	Neglect Newsletters Included in Level 3 Training	Training Package being developed by end of 2022

6. Multi Agency Partnership Working

6.1 Multi-agency working is fundamental to the delivery of safe and good quality care. The benefits are most commonly identified as being improved and more effective services and joint problem solving, it also allows for the ability to take a holistic approach and increased understanding and trust between agencies.

6.2 PTHB are committed to working alongside our partners at a National, Regional and Local level. Throughout 2021 -22 there are numerous examples on how have worked in partnership;

i. Contribution to Safeguarding Week
ii. Co-produced Regional Documents and Leaflets
iii. Support within the NHS Safeguarding Teamwork streams

Multiagency Partnership Working: We Said	We Achieved	We need to progress
PTHB to increase our contribution to strategy discussions with the LA and	Safeguarding Hub has enabled a Lead Nurse to be part of adult and child strategy discussions	Monitor activity and report activity

Police via PTHB Safeguarding HUB	Flows of information and calls into the safeguarding team is more efficient and effective	

In summary, the report highlights the vast and varied safeguarding and public protection agenda, how the Safeguarding Team continues to engage with our partners locally, regionally and at a national level. The service is both visible and accessible across the whole Health Board and has been able to drive change throughout 2021 – 2022.

Next steps:

Safeguarding & Public Protection; A Look Ahead into 2022-23

- Progress PTHB's 2022-23 Safeguarding Maturity Matric Improvement Plan

Navigate the Health Board through the planned National changes to;

- how statutory agencies undertake safeguarding reviews using the new framework; Single Unified Safeguarding Review (SUSR)
- depriving someone of their liberty using the Liberty Protection Safeguards

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Powys Teaching Health Board

Agenda item: 3.2

Patient Experience, Quality and Safety Committee	**Date of Meeting: 24 November 2022**
Subject :	Patient Experience Framework
Approved and Presented by:	Claire Madsen, Executive Director of Therapies & Allied Health Professionals
Prepared by:	Zoe Ashman, Assistant Director of Quality & Safety
Other Committees and meetings considered at:	Executive Committee

PURPOSE:

The purpose of this paper is to update the Committee regarding the development of a Patient Experience Framework.

This activity contributes to the achievement of Strategic Priority 22 – Improve quality (safety, effectiveness and experience) across the whole system, building organisational effectiveness.

RECOMMENDATION(S):

The Committee is asked to RECEIVE this paper for DISCUSSION.

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:

It is proposed that Powys Teaching Health Board's (PTHB) Patient Experience Improvement Plan (Appendix 1) replaces the Board's Patient Experience Strategy/Framework. This has been reviewed and refreshed to reflect the progress made and areas for continued improvement and focus for 2022/23. A new Patient Experience Strategy is expected from Welsh Government in the next year. Going forward, progress in this area will be reported as part of the Integrated Quality Paper presented at the Patient Experience, Quality and Safety Committee and through the Integrated Performance Framework and not as a separate paper.

DETAILED BACKGROUND AND ASSESSMENT:

In 2015 a White Paper *'Listening and learning to improve the experience of care: Understanding what it feels like to use services in NHS Wales'* (June 2015)[2] explained how the NHS Wales Framework for Assuring Service User Experience (published in May 2013) set out three domains that could be used to describe the patient experience:

[2] Improving Healthcare White Paper Series – No. 14 *'Listening and learning to improve the experience of care: Understanding what it feels like to use services in NHS Wales'* (June 2015, 1000 Lives Improvement)

1. First and lasting impressions, including dignity and respect.
2. Receiving care in a safe, supportive, healing environment.
3. Understanding of and involvement in care.

The White Paper, described a range of methods that could be used to gather feedback and gain a balanced view of patient experience. These included 'real time' methods, retrospective surveys, social media patient stories and surveys. The framework enabled NHS bodies to focus on listening to, learning from and acting on the views of patients, carers and families. The latter has been reinforced through various reports since that time, for example, *Using the Gift of Complaints* (published April 2015)[3] and the Health and Care Standards (2015)[4].

This has been further strengthened with the implementation of The Health and Social Care (Quality and Engagement) (Wales) Act ('the Act') became law on 1 June 2020 with its full implementation to be completed by spring 2023. Two of the intentions are to:

- further embed a culture of openness and honesty.
- help drive continual public engagement in the design and delivery of health and social care services.

The Act reframes and broadens the existing duty of quality on NHS bodies and places an overarching duty on Welsh Ministers in relation to their health functions. It aims 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 Candor.
- Establishing a Citizen Voice Body for health and social care.

The Duty of Quality requires NHS bodies and Welsh Ministers to exercise their functions in a way that considers how they improve quality and outcomes on an on-going basis in the services they provide.

In response to these national and local drivers several mechanisms are in place within PTHB to ensure citizen experience of health are captured and inform service improvements and developments. It is vital that the patient experience agenda is a golden thread throughout the organisation to ensure that experience and feedback is considered by all.

Proactively seeking service user feedback through open lines of communication supports the values of a listening organisation and enables all citizens of Powys Teaching Health Board to have a voice within several platforms.

[3] Evans, K. (2014) *Using the Gift of Complaints.* Cardiff: Welsh Government (Available from 28 April 2015)

[4] Welsh Government (2015) *Health and Care Standards.* Cardiff: The Welsh Government.

It must be noted that patient experience measures are collated within many of the transformational workstreams, and further work is required to collate that rich data, to ensure the value is realised across the organisation.

Integrated Performance Framework
Ensuring the health board can robustly assess performance across all aspects of service and delivery (provider and commissioned) the Improving Performance Framework supports an integrated approach. To enable an integrated approach to performance improvement, the framework sets out the necessary attributes and coverage requirements of performance management and reporting processes.

Patient experience and effectiveness is a core area that is covered in the updated framework and therefore will support the future development and areas for focus and development as the framework evolves. It is essential to ensure that quality outcome measures, experience and performance are triangulated to inform decision making.

Work has commenced with the Planning & Commissioning team to review KPI's and a quality matrix for inclusion within the IPF. Action has also been taken to ensure all experience questionnaires that are produced and used within the health board seek feedback from those that have commissioned care; this will for the first time provide targeted feedback rather than just the Friends and Family Test data received currently.

Patient Experience Steering Group
The steering group meet every two months with representation from all clinical services and support services, including invitations for attendance to the Community Health Council and PAVO. Further work is required to ensure improved attendance from Dentistry and Primary Care colleagues.

A set of national core questions were developed, to support real time methods for use by each NHS Wales health board and NHS Trust. In supporting a balanced approach, a four-quadrant framework was developed, incorporating a range of feedback methods, both qualitative and quantitative.

This approach continues to be used across Wales and within Powys with services using the four-quadrant approach to provide an overview of patient experience activity, reported via the Patient Experience Steering Group. Work has been carried out in the past year to improve the quality of completion of the quadrants, particularly in the areas of 'so what' and shared learning. Completion of the quadrants remains erratic, and work will be done with service managers to improve this. More capacity is needed to thematically collate and report on these quadrants.

A focus for improvement for the next two quarters is to emphasis the hardwiring of patient experience into all areas of the Health Board. Work will be done to improve the compliance of services to produce a quadrant report which is reviewed as part of their own business meetings. Learning from service users must become business as usual and not seen as a 'one off' event or action.

Patient Stories

Patient Stories are captured by the Welsh Language and Equalities Team and shared within Board meetings and Committees, this needs to be further enhanced to encompass service level meetings and team meetings. Stories will be sought from all areas of healthcare and encompass both positive and negative experiences. The health board actively seeks patient stories with the use of a leaflet **(Appendix 1)**, social media and health board website.

Patient Reported Experience Measures (PREMS) & Patient Reported Outcome Measures (PROMS)

The number of PREMS & PROMS in place across the health board was unknown as they were not managed or logged centrally, therefore a survey was carried out to support further understanding of their use. The findings demonstrated that PREMS and PROMS were in use in many services, were not standardised or always validated measures, were not overall supported with electronic systems, and did not always inform service development and improvements.

The challenges of collecting PREMS and PROMS were overwhelmingly noted to be financial, lack or robust systems and resource/staffing. More work needs to be done in this area, which currently sits with the value based health care workstream

Respondents were asked how responses informed service improvements and the responses are captured below.

The CIVICA, patient experience system, when implemented, will further inform service improvements due to the robust reporting processes and ability for teams to analyse data and thematic responses.

CIVICA, Patient Experience System

The decision to opt into the Once for Wales contract for the implementation of the CIVICA Patient Experience system will provide the Health Board the opportunity for the first time to introduce an electronic system that captures 'real time' service user feedback in a systematic, coordinated, and timely manner. The benefits of this system ensure the health board seek and act on direct service user feedback, thus enabling and supporting proactive quality improvements to all areas of care provided.

For Powys Teaching Health Board to reasonably seek service user feedback in line with its own Clinical Quality Framework (2020) the CIVICA system will be essential. The scope of the system is broad enough to meet the challenges and the diversity of provided and commissioned services, which are unique to Powys. It also will be more efficient, effective and have greater impact due to its ability to produce data/ information in a variety of formats, accessibility, languages, etc. whilst capturing a wider audience, providing timely analysis and evaluation.

Benchmarking will be achievable as patient experience is analysed and offers the opportunity to look across services, which is not currently possible. Triangulation of quality and safety data is essential to highlight not only areas of improvement, but also enable services to share across specialities when feedback demonstrates significant satisfaction.

The Improvement Plan also outlines areas where significant steps have been taken to ensure patient stories are collected and shared at the patient experience group, Committees and Board meetings and also there are plans for wider sharing of stories at local and service level meetings.

Implementation Programme

- Phase 1: System build, completed by the Civica system team, completed October 2022
- Phase 2: Commenced June 2022 to include an implementation group within PTHB, ongoing whilst system goes live
- Phase 3: Test and readiness programme, CIVICA have completed their element of work, PTHB are required to test the feedback system which is anticipated to take place during November 2022.

	May	June	July	August	Sept	October	November	December
Call off Contract agreement								
Organisational Hierarchy agreed								
Implementation Meeting CIVICA								
Development of the System								

Programme Board Implementation								
Programme build, Test Period								
Health Board Training								
Friend and Family Test questionnaire Live								

There are a number of questionnaires that are planned to go live during Q3 these include:

- Have your say
- Post discharge
- Maternity Care
- Cardiac Rehab

It is anticipated that the CIVICA programme board will continue for at least 12 months, this would be in line with experiences of other health boards during their implementation phase. PTHB are also represented at the national programme meeting to ensure shared learning across Wales, it is anticipated where possible that national questionnaire templates will be used to support health boards in their ability to compare experience throughout Wales using the same matrix.

Due to the limited capacity in the Quality and Safety team, this will be the focus of work for the next 6-12 months.

Concerns & Incidents

Experience is captured within the management of concerns and incidents that are Nationally Reported (NRI), a key component of both the Putting Things Right (PTR) Regulation along with the management of NRI's is learning and improving. This is currently shared within the reporting structures to Patient Experience Quality & Safety Committee, this will be further strengthened to capture wider experience measures discussed within this paper.

Incidents that have resulted in harm or poor patient/family experience will inform thematic learning within the Listening and Learning Group to support improvements in care and/or experience. These further support patient or user stories which are shared at board/committee and service led meetings.

NEXT STEPS:

The implementation of Civica will be a key enabler for PTHB to further strengthen and develop the Patient Experience Framework to ensure that feedback can be used to inform and triangulate with other soft intelligence; namely concerns, complements and enquiries which will inform service development and improvements.

We await new Welsh Government Patient Experience Strategy, following which our PTHB Patient Experience Framework will be refreshed.

KEY MATTERS FOR COMMITTEE TO NOTE:

1. Lack of a dedicated resource to proactively support the patient experience framework will reduce the ability of the health board to progress the agenda at pace. It therefore must be recognised that targets of achievement may not be realised in a reasonable timescale.
   ACTION: Continue to support and embed the patient experience agenda within the structures, services and capacity in place, unless funding becomes available to consider other options, currently prioritising the implementation of Civica.
2. Implementation of a quality data dashboard is a priority to ensure robust triangulation, reporting and assurance to board and committee.
   ACTION: Work continues to ratify the requirements of a quality dashboard in line with developments within RLDatix. This is led by the Quality Team and the Planning Team
3. Implementation of the Duty of Quality & Duty of Candour will require robust consideration for patient experience measures to be included, this may be challenging due to limited resources.
   ACTION: Ensure priority areas are considered and become a focus for the limited resource available.

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**
Age					

Disability					***Please provide supporting narrative for any adverse, differential or positive impact that may arise from a decision being taken***
Gender reassignment					
Pregnancy and maternity					
Race					
Religion/ Belief					
Sex					
Sexual Orientation					
Marriage and civil partnership					
Welsh Language					

Risk Assessment:

	Level of risk identified				
	None	**Low**	**Moderate**	**High**	**Statement** ***Please provide supporting narrative for any risks identified that may occur if a decision is taken***
Clinical					
Financial					
Corporate					
Operational					
Reputational					

APPENDIX 1

Do you have a story to tell?

Telling your story can help us understand what works well and how we can improve care and patient experience.

We want to hear about your personal experience, whether good or bad, so that we can share them with Health Board staff, our Board members and communities across Powys to help us identify ways we can continue to improve our services for patients and their families.

Why is it important we hear your story?	**We want to know what matters most to you, in your own words. By listening to your story, we can learn what we did well and what we need to do better. This helps us to improve our services and patient experience.**
Who can tell their story?	**Any patient or family member/ carer who either live in Powys or who have received their health care in Powys.** **You can tell your story at any time, and it's a very simple process.** **We want to collect stories that reflect the broad range of patients that use our services, and we are particularly interested in hearing from patients of**

	diverse backgrounds such as different ages, ethnicities, languages, and from those with disabilities.
Will my story impact or affect my care?	**No, it won't affect your care if you tell us your story. We can share the story without your name or details on if you prefer. The story is also kept safe and not kept on your record, unless you would like it to be.** **We usually tell the team involved about your story so they can learn from it.**
How can I tell my story?	**You can choose how to tell your story. We can record your voice to write your story, we can help you to write your story, we can film you or you may prefer to use art or photographs. We will not share your story with anyone until you are happy with it.** **You can tell us your story in Welsh, English, BSL or any other Language.**
What happens to my story?	**You will decide where you are happy to share your story. You can change your mind at any time about where your story is shared by letting us know. Your story can be shared with the Board, with staff, with teams and individuals and publicly.**
Can I remain anonymous?	**Yes, we can use your story and not identify you in anyway.** **You can use our consent form to tell us with whom you would like to share your story. If you'd like to discuss this first with us, please get in touch.** **Powys.equalityandwelsh@wales.nhs.uk**
Who will my Patient Experience Story information be shared with?	**Depending on the consent you've given, it can be shared as follows:** **Training and Staff Development Material** **Briefings for the Board, other committees and staff of Powys Teaching Health Board.** **Newsletters and Reports related to Patient Stories**

	Annual Reports and other related reports **External and Internal Websites (Internet and Intranet)** **Leaflets** **PowerPoint and other Presentations**
Will I get feedback from Patient Experience Story?	**You will not usually receive any individual feedback from your patient story.**
What if I want a response/feedback from my Patient Experience Story?	**Patient stories are about learning, not redress; if you wish to make a complaint you should use our Complaints procedure. Further Information on the feedback and complaints procedure can be seen here**

You may at any time, now or in the future, ask us not to use or share your experience. You should not feel under any obligation or pressure to allow us to keep, use and share your experience if you change your mind.

How to get in touch?

If you'd like to tell your story or would like to talk to us first, please get in touch: Powys.equalityandwelsh@wales.nhs.uk

Diolch / Thank you

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 6.1

Patient Experience, Quality and Safety Committee	**Date of Meeting: 24 November 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:

The purpose of this paper is to provide the Committee with the end of September 2022 version of the Committee Risk Register for information.

RECOMMENDATION(S):

It is recommended that the Committee CONSIDERS the risks identified as 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:

The CRR provides a summary of the significant risks to the delivery of the health board's strategic objectives. Corporate risks also include risks that are widespread beyond the local area, and risks for which the cost of control is significantly beyond the scope of the local budget holder. The CRR is reviewed by the Executive Committee on a bi-monthly basis and is noted by the Board.

The Committee is asked to DISCUSS the risks relating to Patient Experience, Quality and Safety and the risk targets within the Committee Risk Register, and to CONSIDER whether the targets identified are achievable and realistic.

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

NEXT STEPS:

The Risk and Assurance Group will lead the ongoing development of the CRR, escalating any organisational risks for proposal to the CRR, for consideration by the Executive Committee.

Patient Experience, Quality and Safety Committee Risk Register November 2022

PATIENT EXPERIENCE QUALITY AND SAFETY RISK HEAT MAP: November 2022

There is a risk that…

Impact							
	Catastrophic	5					
	Major	4				• citizens of Powys receive poor quality care (quality defined as safety, effectiveness and experience) from one or more of a range of providers	
	Moderate	3					
	Minor	2					
	Negligible	1					
			1	2	3	4	5
			Rare	Unlikely	Possible	Likely	Almost Certain
			Likelihood				

Patterson,Liz
23/11/2022 12:41:25

COMMITTEE RISK DASHBOARD – NOVEMBER 2022

Risk Lead	Risk ID	Main Risk Type	Risk Description There is a risk that:	SCORE (Likelihood x Impact)	Board Risk Appetite	Risk Target	At Target ✓/×	Lead Board Committee	Risk Impacts on
DoN, MD	CRR 003	**Quality & Safety of Services**	Citizens of Powys receive poor quality care (quality defined as safety, effectiveness and experience) from one or more of a range of providers	**4 x 4 = 16**	Low	6	×	Patient Experience, Quality and 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

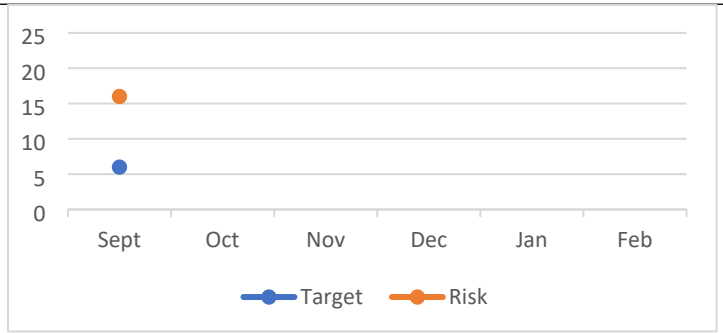
Trend	
↑	risk score increased
→	risk score remains static
↓	risk score reduced

CRR 003 **Risk that:** citizens of Powys receive poor quality care (quality defined as safety, effectiveness and experience) from one or more of a range of providers	**Executive Lead:** Director of Nursing and Midwifery, Medical Director **Assuring Committee:** Patient Experience, Quality and Safety
Risk Impacts on: Organisational Priorities underpinning WBO 1 to 4	**Date last reviewed:** September 2022

Risk Rating

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

Date added to the risk register
Risk Updated September 2022



Rationale for current score:

- Intelligence from incidents, concerns and complaints
- Intelligence from patient engagement
- Intelligence and communication from all stakeholders and partners
- Increased pressure on the NHS as a result of multiple factors (aging population, winter pressures, post Covid-19 pandemic)

Controls (What are we currently doing about the risk?)

- Integrated Performance Framework
- Powys Clinical Audit plan
- Internal Audit annual plan of audits
- NHS Wales collaborative management groups and associated peer groups
- Collaboration with the Delivery Unit (NHS Wales)
- Review of CQC and HIW reports for all providers where Powys residents receive care
- Triangulation of concerns, complaints (PTR) and incidents
- Operational arrangements for operational delivery (e.g DCG)
- Partnership with PCC
- Communication and engagement with the public and stakeholders

Mitigating actions (What more will we do?)

Action	Lead	Deadline
Improve and refine the Integrated Performance Framework	DoPP	Sept 2022
Monitor fundamentals of care (provider services)	DoNM	Ongoing
Mortality Reviews	MD	Ongoing
Address inequalities of access	DoPP/ DOMHP PC DoTH	Ongoing
Implement Patient experience system (Civica)		Dec 2022

Current Risk Rating

4 x 4 = 16

Update including impact of actions to date on current risk score

The rationale and controls are constantly changing in response to variation in risk. Whilst summarised at a high level for the CRR, this risk is subject to further development for reporting to the PEQS Committee.

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~~	24 Nov	~~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					

MATTER TO BE CONSIDERED BY COMMITTEE		EXEC LEAD	SCHEDULED COMMITTEE DATES 2022-23						
			12 May	**7 July**	**13 Sept**	**~~25 Oct~~**	**24 Nov**	**~~08 Dec~~**	**16 Feb**
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					
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	✓		✓			~~✓~~	

MATTER TO BE CONSIDERED BY COMMITTEE		EXEC LEAD	SCHEDULED COMMITTEE DATES 2022-23						
			12 May	**7 July**	**13 Sept**	**~~25 Oct~~**	**24 Nov**	**~~08 Dec~~**	**16 Feb**
	Learning from Mortality Report	MD					✓ **(In IQR)**	✓	
	Mental Health Act Compliance & Powers of Discharge	DPCCMH	✓			✓ **~~Too early for Q2 move to Dec~~**	✓	✓	
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				✓	✓		✓
SP6, SP22	Maternity Services Assurance Framework Report	DNM	✓	✓	✓ **Additional item**	✓	✓	✓	✓

MATTER TO BE CONSIDERED BY COMMITTEE		EXEC LEAD	SCHEDULED COMMITTEE DATES 2022-23						
			12 May	7 July	13 Sept	~~25 Oct~~	24 Nov	~~08 Dec~~	16 Feb
	De-escalation arrangements (action PEQS/22/45)								
	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								

MATTER TO BE CONSIDERED BY COMMITTEE		EXEC LEAD	SCHEDULED COMMITTEE DATES 2022-23						
			12 May	**7 July**	**13 Sept**	**~~25 Oct~~**	**24 Nov**	**~~08 Dec~~**	**16 Feb**
	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				~~✓~~	✓		
	Annual Self-assessment of Committee effectiveness 2022-23	BS							✓
	Committee Annual Report 2022-23	BS							✓*
	Total Number of Agenda Items		**8**	**8**	**7**		**8**		
	ADDITIONAL ITEMS FROM ACTION LOG								
	Update on Mental Health Services (PEQS/22/51)								✓

*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

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 6.3

Patient Experience, Quality and Safety Committee	**Date of Meeting: 24 November 2022**
Subject :	**Patient Experience, Quality and Safety Committee Terms of Reference**
Approved and Presented by:	**James Quance, Interim Board Secretary**
Prepared by:	**James Quance, Interim Board Secretary**
Other Committees and meetings considered at:	

PURPOSE:
The purpose of this paper is for the Committee to consider its Terms of Reference in order to ensure that they remain fit for purpose.
RECOMMENDATION(S):
The Committee is asked to discuss any suggested amendments at the meeting on 24 November 2022.

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

x

Patterson,Liz 23/11/2022 12:34:23

[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:

Under the Standing Orders of the Health Board, Board Committees are required to review their Terms of Reference on an annual basis and these are attached as Appendix 1 for that purpose.

Any suggested changes will need to be brought to the attention of the Board Secretary for consideration. If there are no suggested amendments the Committee is able to note that the review has been undertaken in its Annual Report.

NEXT STEPS:

If any proposed changes are made these will be taken forward for consideration by the 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	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				
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					

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

Patient Experience, Quality and Safety Committee

Terms of Reference & Operating Arrangements

September 2021

1. INTRODUCTION

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

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

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

2. PURPOSE

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

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

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

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

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

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

3 DELEGATED POWERS AND AUTHORITY

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

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

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

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

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

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

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

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

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

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

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

Authority

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

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

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

Access

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

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

Sub Committees

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

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

Committee Programme of Work

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

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

4 MEMBERSHIP

Members

4.1 Membership will comprise:

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

Attendees

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

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

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

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

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

Secretariat

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

Member Appointments

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

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

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

Support to Committee Members

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

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

5 COMMITTEE MEETINGS

Quorum

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

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

Frequency of Meetings

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

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

Openness and Transparency

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

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

Withdrawal of individuals in attendance

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

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

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

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

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

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

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

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

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

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

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

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

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

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

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

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

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

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

- Quorum
- Issue of Committee papers

9. CHAIR'S ACTION ON URGENT MATTERS

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

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

10. REVIEW

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