# Patient Experience, Quality and Safety Committee

*Tue 13 September 2022, 13:00 - 16:00*

**Teams**

# Agenda

**13:00 - 13:00**
0 min

## 1. PRELIMINARY MATTERS

PEQS_Agenda_13Sept2022v7 FINAL.pdf (2 pages)

### 1.1. Welcome and Apologies

### 1.2. Declarations of Interest

*Oral* *Chair*

### 1.3. Minutes from the previous meeting held on the 7 July 2022 for approval

*Attached* *Chair*

PEQS_Item_1.3_Unconfirmed Minutes 2022-07-07.pdf (12 pages)

### 1.4. Matters arising from the previous meeting

*Oral* *Chair*

### 1.5. Patient Experience, Quality and Safety Committee Action Log

*Attached* *Chair*

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

**13:00 - 13:00**
0 min

## 2. ITEMS FOR ASSURANCE

### 2.1. INTEGRATED QUALITY REPORT

*Attached* *Director of Nursing and Midwifery*

PEQS_Item_2.1_Integrated Quality Report.pdf (16 pages)
PEQS_Item_2.1a_Appendix 1.pdf (47 pages)
PEQS_Item_2.1b_Appendix 2.pdf (13 pages)
PEQS_Item_2.1c_Appendix 3.pdf (16 pages)

### 2.2. CLINICAL QUALITY FRAMEWORK IMPLEMENTATION UPDATE

*Attached* *Medical Director & Director of Nursing and Midwifery*

PEQS_Item_2.2_Clinical Quality Implementation Update.pdf (26 pages)



**13:00 - 13:00**
0 min

## 3. ITEMS FOR DISCUSSION

*There are not items for discussion*

13:00 - 13:00
0 min

## 4. BUSINESS CASES, SERVICE PLANNING PROPOSALS, WHOLE SYSTEM PATHWAY DEVELOPMENT AND REDESIGN

*There are no items under this section*

13:00 - 13:00
0 min

## 5. ESCALATED ITEMS

### 5.1. Maternity Services Assurance Framework Report

*Attached* *Director of Nursing and Midwifery*

- PEQS_Item_5.1_Maternity Services Assurance Framework Cover Paper.pdf (7 pages)
- PEQS_Item_5.1a_PROMPT quality assurance Report.pdf (13 pages)

13:00 - 13:00
0 min

## 6. ITEMS FOR INFORMATION

### 6.1. WHSSC Quality and Safety Committee Chair's Report June 2022

*Attached* *For Information*

- PEQS_Item_6.1a_Chairs Report Quality & Patient Safety August 2022.pdf (15 pages)
- PEQS_Item_6.1_Chairs Report Quality & Patient Safety June 2022.pdf (26 pages)

13:00 - 13:00
0 min

## 7. OTHER MATTERS

### 7.1. Committee Work Programme

*Attached* *Board Secretary*

- PEQS_Item_7.1_PEQS_Committee_Work Programme_2022-23 September 2022.pdf (5 pages)

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

*Oral* *Chair*

### 7.3. Any other urgent business

### 7.4. Date of next meeting

*Tuesday 25 October 2022*

### 7.5. Motion to exclude the public from this part of the meeting

*Confidential*

### 7.6. Mental Health Services

*Confidential Item* *Director of Primary, Community Care & Mental Health Services*

**POWYS TEACHING HEALTH BOARD**
**PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE**
**TUESDAY 13 SEPTEMBER 2022**
**13:00 – 17:00**
**VIA MICROSOFT TEAMS**

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

| AGENDA | | | | |
|---|---|---|---|---|
| **Time** | **Item** | **Title** | **Attached/Oral** | **Presenter** |
| | **1** | **PRELIMINARY MATTERS** | | |
| 13:00 | 1.1 | Welcome and Apologies | Oral | Chair |
| | 1.2 | Declarations of Interest | Oral | All |
| | 1.3 | Minutes from the previous Meeting held on 7 July 2022 | Attached | Chair |
| | 1.4 | Matters arising from the minutes of the previous meeting | Oral | Chair |
| 13:10 | 1.5 | Patient Experience, Quality and Safety Committee Action Log | Attached | Chair |
| | **2** | **ITEMS FOR ASSURANCE** | | |
| 13:20 | 2.1 | Integrated Quality Report including:<br>- Quality Measures<br>- Serious incidents and concerns<br>- Putting Things Right (including PTR Action Plan presentation)<br>- Inspections and External Bodies report and Action Tracking | To Follow | Director of Nursing and Midwifery |
| 14:20 | 2.2 | Clinical Quality Framework Update | Attached | Medical Director/ Director of Nursing and Midwifery |
| | **3** | **ITEMS FOR DISCUSSION** | | |
| | | *There are no items under this section* | | |
| | **4** | **BUSINESS CASES, SERVICE PLANNING PROPOSALS, WHOLE SYSTEM PATHWAY DEVELOPMENT AND RE-DESIGN** | | |
| | | *There are no items under this section* | | |
| 15:00 | | **COMFORT BREAK** | | |
| | **5** | **ESCALATED ITEMS** | | |
| 15:15 | 5.1 | Maternity Services Assurance Framework Report - including Prompt Wales Quality Assurance Review | Attached | Director of Nursing and Midwifery |
| | **6** | **ITEMS FOR INFORMATION** | | |
| | 6.1 | WHSSC Quality and Patient Safety Committee Chair's Reports June and August 2022 | | |

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| | **7** | **OTHER MATTERS** | | |
| 15:45 | 7.1 | Committee Work Programme | Attached | Interim Board Secretary |
| 15:55 | 7.2 | Items to be Brought to the Attention of the Board and/or Other Committees | Oral | Chair |
| | 7.3 | Any Other Urgent Business | Oral | Chair |
| 16:00 | 7.4 | Date of the Next Meeting: Tuesday 25 October 2022, 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:<br>Motion under Section 1(2) Public Bodies (Admission to Meetings) Act 1960<br>***"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"*** | | | | |
| 16:00 | 7.6 | Mental Health Services | Presentation | 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 THURSDAY 7 July 2022 VIA MICROSOFT TEAMS

**Present:**

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

**In Attendance:**

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| Hayley Thomas | Director of Primary, Community Care and MH/Deputy CEO |
| Claire Roche | Director of Nursing and Midwifery |
| Kate Wright | Medical Director |
| Claire Madsen | Director of Therapies and Health Sciences |
| Mererid Bowley | Interim Director of Public Health |
| James Quance | Interim Board Secretary (from Item 7.1) |
| Amanda Edwards | Assistant Director – Innovation and Improvement |
| Jacqueline Seaton | Chief Pharmacist (for Item 2.4) |
| Bethan Hopkins | Audit Wales |

**Apologies for absence:**

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| Vivienne Harpwood | PTHB Chair |
| Carol Shillabeer | Chief Executive |
| Zoe Ashman | Assistant Director of Quality and Safety |
| Mitchell Parker | Health Inspectorate Wales |
| Katie Blackburn | CHC |

**Committee Support:**

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| Liz Patterson | Interim Head of Corporate Governance |

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| PEQS/22/17 | **WELCOME AND APOLOGIES FOR ABSENCE**<br>The Committee Chair welcomed Members and attendees to the meeting and CONFIRMED there was a quorum present. |
| PEQS/22/18 | **DECLARATIONS OF INTERESTS**<br>No interests were declared. |
| PEQS/22/19 | **MINUTES OF THE EXPERIENCE, QUALITY AND SAFETY COMMITTEE MEETING HELD ON 12 May 2022 (FOR APPROVAL)**<br>The minutes of the previous meeting held on 12 May 2022 were AGREED as a true and accurate record subject to the following amendment:<br><br>Page 5 paragraph 2:<br>'The rollout of the electronic All Wales ~~Staffing~~ *Nursing Care* Record continued….' |
| PEQS/22/20 | **MATTERS ARISING FROM MINUTES OF PREVIOUS MEETING**<br><br>There were no matters arising from the minutes of the previous meeting. |
| PEQS/22/21 | **PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE ACTION LOG**<br><br>It was noted that a number of actions had been outstanding for some time and there had been staffing changes in the interim period. It was requested that additional information be provided to each Director in relation to their actions which would enable a full response to be provided to the next meeting.<br>**Action: Interim Head of Corporate Governance and all Directors with actions.** |
| **ITEMS FOR ASSURANCE** | |
| PEQS/22/22 | **INTEGRATED QUALITY REPORT**<br><u>Quality Overview Report</u><br>The Director of Nursing and Midwifery presented the report and drew attention to a number of areas. |

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| | • A multi-disciplinary learning event facilitated by the Assistant Director of Quality and Safety had been held to learn from an incident which had taken place. The team had been nervous to take part in this new way of learning, but feedback had been positive, and the staff were creating a short video describing the event and its impact which would be shared with the Committee in the September meeting.<br>• The timetable for the implementation of the National Nosocomial Framework was outlined. The review of Wave 1 of the pandemic had concluded and no cases of harm/death had been identified, therefore it had not been necessary to undertake duty of candour conversations.<br>• Further detail was provided regarding pressure area incidents with the reasons for no value fields outlined as:<br>o incomplete investigations; and<br>o changes/updates to the RLDatix system which required manual processing of completed investigations<br>This area of work was a particular focus for the Assistant Director of Quality and Safety.<br><br>• Since the last meeting of this Committee and following an Inquest, the health board has received a Regulation 28 Notice. The Committee will be updated on the Regulation 28 Notice when this is completed.<br><br>*The detail within the report is welcomed. In respect of concerns it appears that there is capacity to manage around 30 concerns at a time but if there are more, or the concerns are complex, then the ability to respond within the 30 day response target is affected. What number of concerns should the health board be able to deal with and meet the 30 day response target?*<br><br>The Director of Midwifery and Nursing advised that there is a backlog of concerns which need to be addressed. The target is to respond to 75% of concerns within a 30 day response period. This recognises that some concerns are too complex to be able to be responded to within 30 days. To improve the position it is intended to build confidence in early resolution, to improve the confidence of the investigators, and to improve the quality assurance process.<br><br>Further work is required with the service groups to understand what the organisation is capable of before it is possible to ascertain if additional capacity is required. |

*Additional information regarding the work undertaken would help Independent Members assess if additional capacity is required.*

Additional information including a summary of work to date, identified areas for improvement, and expected outcomes will be included as a presentation in the next quality report to assist the Committee to explore this matter.

**Action: Director of Nursing and Midwifery**

*What was the outcome at Executive Committee in June 2022 of the business case presented regarding the Management of Deprivation of Liberty Safeguards?*

The Director of Nursing and Midwifery advised that the paper had not gone to the Executive Committee but had gone back to the Investment Benefits Group to prepare for the forthcoming implementation of the Liberty Protection Standards.

The Committee DISCUSSED and NOTED the Quality Overview Report.

Maternity Assurance

The Director of Nursing and Midwifery presented the report and noted that there had been a requirement to complete a Maternity and Neonatal Assessment, Assurance and Exception Review and return to Welsh Government. This had taken place at a multi-disciplinary session on 31 May 2022. The findings would be used to inform national priorities, but the process had also been of use to the health board.

There have been three Nationally Reportable Incidents (NRIs) submitted to the Delivery Unit between February and May 2022. For each incident, an Investigative Officer has been appointed. One incident would be subject to an external review and the other two investigations may also be subject to an external review. As Lead Officer the Director of Nursing and Midwifery had instigated fortnightly meetings to monitor the three incidents, and as findings became apparent, measures were immediately put in place. Issues of concern included an increase in women making choices outside guidelines and interim arrangements are in place to strengthen links with relevant support. A further

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| | issue related to the recording of data in relation to detecting small for gestational age babies, some of this was historically recorded by District General Hospital (DGH) Obstetric services. Arrangements have been put in place to ensure the input of this data for all Powys pregnancies. This will enable a Powys specific assurance report to be produced.<br><br>The Maternity Governance Review was put in place because of a cluster of formal concerns regarding care in labour, or subsequent transfer from Maternity Services. It examined the incident management across the service and the process for dealing with open concerns and management. As a result of the review the Director of Nursing and Midwifery has placed the service in escalation and receives a weekly report including feedback on incidents and identification of any women close to their due date who are opting to act outside guidelines.<br><br>*The establishment of a weekly forum is an extraordinary escalation. Is this a temporary arrangement and what would be the mechanism to step this down?*<br><br>The Director of Nursing and Midwifery confirmed this was a temporary measure and was due to extraordinary circumstances. The current Head of Midwifery was leaving shortly to start a role elsewhere in Wales and this job had just gone out to advert. There would be a gap between appointments and interim arrangements would be put in place. It was likely that the escalation would remain in place until the new Head of Midwifery was in post.<br><br>*The gap and grow compliance is of concern. Can the Committee be provided with details of why such little data has been collected and how long this has been taking place?*<br><br>The Director of Nursing and Midwifery confirmed that a request had been made for details of compliance for the last financial year, and this year to date. This is important as with the low compliance of data input on gap and grow it has not been possible to use data to understand referral rates for low gestational weight babies. There had been some misunderstanding regarding data input, and addressing this is a key part of the escalation. A senior member of staff has been appointed to oversee this.<br><br>*The Maternity and Neonatal Assurance Assessment has a number of items coded black for services which are not* |

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| | *provided by the health board. Does the Commissioning Assurance Framework provide assurance in these areas?*<br><br>The Director of Nursing and Midwifery confirmed there were a number of gaps relating to services provided by commissioned partners and this would be a key area to examine with other health boards at the national conference taking place on 7 July 2022.<br><br>*Committee Members have long been assured this is an area that performs well. These reports appear to identify longstanding issues. What has changed from an assurance perspective?*<br><br>The Director of Nursing and Midwifery acknowledged it was unusual to have three NRIs in short succession and this has provoked questions including in relation to low gestational growth. It is not thought that previously there was false assurance, the assurance given would have been what was known at the time.<br><br>The Medical Director confirmed that the three NRIs had been correctly identified and should be considered against a backdrop of low patient numbers. The gap and grow position is of more concern and will need to be addressed. The robust actions put in place to support the teams feel an appropriate and proportionate response.<br><br>*Has a lack of staffing (covid-19, sickness) impacted on the services?*<br><br>The Director of Nursing and Midwifery noted that workforce issues are a key part of assurance and whilst there have been staffing issues in Ystradgynlais the escalation arrangements meant that attention was drawn to this at an early stage and mitigations which were put in place.<br><br>The Committee<br><br>a) DISCUSSED the Maternity Assurance Report,<br>b) NOTED the escalated arrangements outlined by the Director of Nursing and Midwifery, and<br>c) CONFIRMED that this matter would be escalated to Board. |
| PEQS/22/23 | **ANNUAL CLINICAL AUDIT PROGRAMME 2022-23**<br><br>The Medical Director presented the report noting the links between clinical audit and other quality improvement activities had been strengthened. |

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| | M Bowley left 10.00<br><br>*The report does not include mortality reviews. Will these still take place?*<br>The Medical Director confirmed that mortality reviews continue to take place and are reported separately to the Committee.<br><br>*The presentation makes it difficult to identify if items are on track. Is there capacity to undertake the considerable number of audits outlined?*<br>The Medical Director advised the presentation style would be reviewed. It was acknowledged that there were many audits identified and it would be necessary to focus on key areas.<br><br>*Are all the items identified appropriate for audit or do they include those which should be taken as business as usual?*<br>The Medical Director confirmed it was the intention to focus on the exceptional rather than the routine but that the current report contained all items for completeness.<br><br>The Committee NOTED the report. |
| PEQS/22/24 | **CLINICAL AUDIT ASSURANCE REPORT**<br><br>The Medical Director presented the report noting that of the 92 audits planned for 2021/22, 55 had been completed. The remaining audits had been risk assessed to ensure that any key areas were not missed.<br><br>The importance of sharing learning with the learning groups was emphasised.<br><br>*Why are there low numbers of audits taking place in Mental Health Services?*<br>The Medical Director advised that it was not known why a low number of audits had been undertaken in that area over the previous year, during which time service improvements were taking place. An increased number of |

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| | audits in Mental Health Services have been identified for the current year.<br><br>*Where are service improvements captured other than via audit?*<br><br>The Director of Primary, Community Care and MH noted that service improvement work was identified within service reviews adding that there had been staffing issues within the clinical audit team.<br><br>*There are five audits identified which have not been taken forward. How can an item that has been identified as requiring audit be removed?*<br><br>The Director of Primary, Community Care and MH confirmed that there was a balance in identifying areas for audit with an increasing focus on national audit work.<br><br>*The Mental Health audit picked up incomplete use of the Wales Applied Risk Research Network (WARRN) tool. The action sits with the WARRN trainers development group which does not give confidence that practice has changed.*<br><br>The Medical Director confirmed the risk assessment is robust and is used. It has been updated and has been shared with service groups. This was a specific area which the service requested be audited.<br><br>*What is the position with the 10% of cases not audited using the WARRN tool?*<br><br>The Director of Primary, Community Care and MH confirmed that all patients had been fully risk assessed and the issue related to the input of data on WCCIS. If any fields are left blank it will appear that the risk assessment had not taken place.<br><br>The Director of Nursing and Midwifery advised that colleagues were in discussion to implement a system which would allow a live dashboard to be available rather than reporting the historic position. Clinical audit is maturing as a process, and it now seen as participatory rather than something that is done to a service.<br><br>The Chair requested a demonstration of the Dashboard in a training session. |

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| | **Action: Director of Nursing and Midwifery** |
| PEQS/22/25 | **MEDICINES MANAGEMENT ASSURANCE PAPER**<br><br>The Medical Director introduced the Chief Pharmacist who presented the report and drew attention to the following challenges:<br>• a difficulty in making available monoclonal antibodies to Powys patients;<br>• recruitment and retention;<br>• medicines storage - some areas reaching temperatures above 25° C;<br>• medicines security continues to be an issue – a bid has been submitted to Welsh Government;<br>• antimicrobial stewardship – the service does not have a dedicated person to manage this, and high use of antimicrobials may be taking place. Additional analysis and comparisons will be required;<br>• a gap in support to Mental Health services currently commissioned but intended to be brought back in house;<br>• electronic prescribing is taking place on wards, and it is intended to roll this out from GPs to pharmacies;<br>• training; and<br>• a lack of capacity to support prescribing in care homes.<br><br>*This appears to be a large agenda with too little capacity and a recruitment/retention problem. The next steps outlined in the report appear ambitious but is it realistic and achievable? Are there opportunities across the organisation for cost avoidance/reduction?*<br><br>The Medical Director confirmed the team has been stretched but has achieved a large amount, in particular acknowledging the workload supporting mass vaccination. The Innovation team undertaking a large piece of work mapping what pharmacy should look like across Powys. Until this work is complete it is difficult to say if the team lacks capacity.<br><br>*The lack of support to Mental Health services is of concern. What is the timetable to establish what is required?*<br><br>The Medical Director confirmed it had been scheduled for completion, but the omicron wave had delayed this. It will now be necessary to prioritise this in September. |

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| | The Committee NOTED the Medicines Management Assurance Report. |
| **ITEMS FOR DISCUSSION** | |
| PEQS/22/26 | **MENTAL HEALTH ACT HOSPITAL MANAGERS POWER OF DISCHARGE GROUP TERMS OF REFERENCE AND OPERATING ARRANGEMENTS**<br><br>The Director of Primary, Community Care and MH presented the report noting that the Mental Health Act Hospital Managers Power of Discharge Group (PODG) last met in December 2021.<br><br>The PODG is Chaired by the Chair of the Patient Experience, Quality and Safety Committee and will next meet on 26 July 2022. Between meetings of the PODG, activity has continued including training, a Hospital Managers Conference which took place in May 2022 and a Clinicians meeting on the Power of Discharge in July 2022. The PODG will report regularly to the Committee.<br><br>The Committee NOTED the Mental Health Act Hospital Managers Power of Discharge Group Report. |
| PEQS/22/27 | **REFRESHED PATIENT EXPERIENCE FRAMEWORK**<br><br>The Director of Therapies and Health Sciences advised that there had been a logistics issue which had resulted in the paper being unavailable for the meeting. The Corporate Services Team and Corporate Governance Team were putting in place processes to guard against this happening in the future. |
| **BUSINESS CASES, SERVICE PLANNING PROPOSALS, WHOLE SYSTEM PATHWAY DEVELOPMENT AND RE-DESIGN** | |
| PEQS/22/28 | There are no Business Cases, Service Planning Proposals or Whole System Pathway Developments and Re-designs. |
| **ESCALATED ITEMS** | |

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| PEQS/22/29 | There were no escalated items. |
| **ITEMS FOR INFORMATION** | |
| PEQS/22/30 | There are no items for information |
| **OTHER MATTERS** | |
| PEQS/22/31 | **CORPORATE RISK REGISTER – RISKS OVERSEEN BY THIS COMMITTEE**<br><br>The Interim Board Secretary presented the report and noted that a meeting had been arranged with the Service Managers to ensure that the work to develop the risk registers was given the necessary priority.<br><br>*This work to improve the risk registers is welcomed. How can the organisation balance long term risks which are outside the influence of the health board?*<br>The Interim Board Secretary suggested a future discussion on the development of the risk register at Committee may aid understanding.<br>**Action: Interim Board Secretary**<br><br>The Committee:<br>a) NOTED the action taken to date and SUPPORTS the proposed action to develop the risk register; and<br>b) NOTED the May 2022 version of the Committee Risk Register. |
| PEQS/22/32 | **COMMITTEE WORK PROGRAMME**<br><br>The Interim Board Secretary presented the April 2022 – March 2023 Committee Work Programme. The Corporate Governance Team would collaborate with the Executive Director PAs to ensure that appropriate notice was given regarding items due to be brought to the Committee.<br><br>*Should Clinical Effectiveness and Quality Improvement Highlight Reports be brought to the Committee more frequently?*<br>The Medical Director confirmed that every Committee examined clinical effectiveness and the report would be brought to the meeting in September where a view could be taken of the appropriate frequency for this item. |

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| | The Committee Work Programme was AGREED. |
| PEQS/22/33 | **ITEMS TO BE BROUGHT TO THE ATTENTION OF THE BOARD AND/OR OTHER COMMITTEES**<br><br>The Committee will bring to the attention of Board the escalation of Maternity Services as outlined in PEQS/22/22. |
| PEQS/22/34 | **ANY OTHER URGENT BUSINESS**<br><br>There was no other urgent business. |
| PEQS/22/35 | **DATE OF THE NEXT MEETING**<br>13 September 2022, via Microsoft Teams. |

Key:

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| Completed |
| Not yet due |
| Due |
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# PATIENT EXPERIENCE, QUALITY & SAFETY COMMITTEE

## ACTION LOG SEPTEMBER 2022

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

| Minute | Meeting Date | Action | Responsible | Progress Position | Completed |
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| IC_PEQS/21/5 | 7 Oct 2021 | Presentation of MH Services to In-Committee by Assistant Director of Mental Health and Learning Disability | Director of Primary, Community Care and Mental Health | Arranged for 13th September In-committee | |
| 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/21/78 | 24 March 2022 | To include the outstanding overdue recommendations from the inspection of Clywedog Ward, Llandrindod Wells within the Inspections and External Bodies Report to Committee | Director of Nursing and Midwifery | These are included in the September 2022 report to the PEQS Committee | |

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| 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/21/80 | 24 March 2022 | To consider the sharing of a Patient Story on the issues related to controlled drugs | Director of Therapies and Health Science | The programme of patient stories has been agreed for the remainder of the year. This item will be considered for a future patient story. | |
| PEQS/21/84 | 24 March 2022 | To ascertain how telephone/video phlebotomy appointments work. | Director of Primary Community Care and Mental Health | | |
| PEQS/22/07 | 12 May 2022 | Response to CHC on Virtual Visit Report shared with Committee | Director of Nursing and Midwifery | A response has been sent to the CHC addressing the learning identified | |
| PEQS/22/08 | 12 May 2022 | Timescales to be included in the Inspection Tracker | Assistant Director of Quality and Safety | All timescales are within the tracker | |
| PEQS/22/11 | 12 May 2022 | Board Development session requested on Health and Social Care (Quality and Engagement) Act 2022 | Interim Board Secretary | This is included in the programme for later in the year | |
| PEQS/22/21 | 7 July 2022 | Focus on clearing actions | Interim Head of Corporate | Further detail on the source of actions has been | |

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| | | | Governance and Directors | provided to assist Directors to clear actions | |
| PEQS/22/22 | 7 July 2022 | Presentation on PTR to September PEQS | Director of Nursing and Midwifery | Inclusive within the Quality Report planned for September 2022 | |
| PEQS/22/24 | 7 July 2022 | Presentation of dashboard to PEQS training session | Director of Nursing and Midwifery | This will form part of discussions in the recommendation regarding PEQs training/development | |
| 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 | |

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

**Agenda item: 2.1**

| **Patient Experience, Quality and Safety Committee** | **Date of Meeting: 12 September 2022** |
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| **Subject:** | **Integrated Quality Assurance 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 5 September 2022 |

**PURPOSE:**

The purpose of this report is to provide the Patient Experience, Quality and Safety Committee on the 13 September 2022 with an overview of the Quality & Safety agenda across the Health Board.

**RECOMMENDATION(S):**

The Patient Experience, Quality and Safety 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 of the All Wales Patient Safety Framework

The National Patient Safety Incident Reporting Policy (May 2021) has been successfully implemented within the Health Board. An updated suite of documents has been launched providing a robust framework for the identification, management, and investigation of incidents. This enables SMART (specific, measurable, achievable, relevant, and timely) action planning aligned to redress arrangements where required.

The current position for open Nationally Reportable Incidents (NRI's) is reported in the table below. It should be noted that there has been significant pace to close incidents within date during quarter 2.

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

The themes for learning and improvement include:

- Standards of record keeping
- Clear pathways of care and escalation

It is also important to note that since the introduction of the new National Reporting Framework which ensures the appropriate level of investigation of incidents, many of the overdue incidents cited above would not meet the threshold for reporting today.

## 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 October 2022.

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 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

Further work is required to strengthen robust learning from incidents, concerns, and investigations. The introduction of an incident review meeting structure will further enhance organisational learning and build capability, skills and knowledge across the

Health Board. The aim is that this group will evolve and mature during 2022/23 supporting the maturity of a learning culture.

The Learning & Development group has re-commenced as progress was affected due to the impact of the response required for Covid-19 management. The membership of this 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 described above, facilitating the implementation of a total quality management system, as described in the Quality and Engagement Act

Supporting staff to embrace and develop a no-blame learning culture is fundamental to ensuring full engagement with all quality governance activity. Encouraging understanding and adoption of both Safety II and Safety I approaches* supports multidisciplinary working practices and ownership of the quality of services.

(* Safety I take accidents as the focus point and tries to prevent bad things from occurring, while Safety-II is emphasizing on ensuring that as much as possible goes right, expanding much more than the area of incident prevention and promoting a real safety management over a simple risk assessment)

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

- 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. This will be evaluated and the Executive and PEQs Committees will be updated as to the response from staff and the impact of the training.

## 2.4 Implementation of the National Nosocomial Framework

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

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

The number of patient cases that require a review within Powys THB, in line with the framework has increased from 223 to 291. This is due to a deep dive into the IPC system namely *ICNet* which identified further cases. It should be noted that the team are

confident that wave 1-4 data will not significantly increase further as this work is now complete. However, live case data may continue to increase within this framework as this will be dependent on Covid 19 transmission and prevalence.

In line with the framework, the team will be reviewing the cases by Covid-19 waves. 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.

The table below details the volume of cases by Covid-19 waves:

| | Wave 1 (27/2/2020 - 26/7/2020) | Wave 2 (27/07/2020 - 16/05/2021) | Wave 3 (17/05/2021 - 19/12/2021) | Wave 4 (20/12/2021 - 30/04/2022) | 01/05/22 – LIVE Data |
|---|---|---|---|---|---|
| Total Number of Incidents | 34 | 94 | 62 | 101 | 40 |

The table below illustrates the project timeline and action status:

**First 6 Month Project Plan**

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

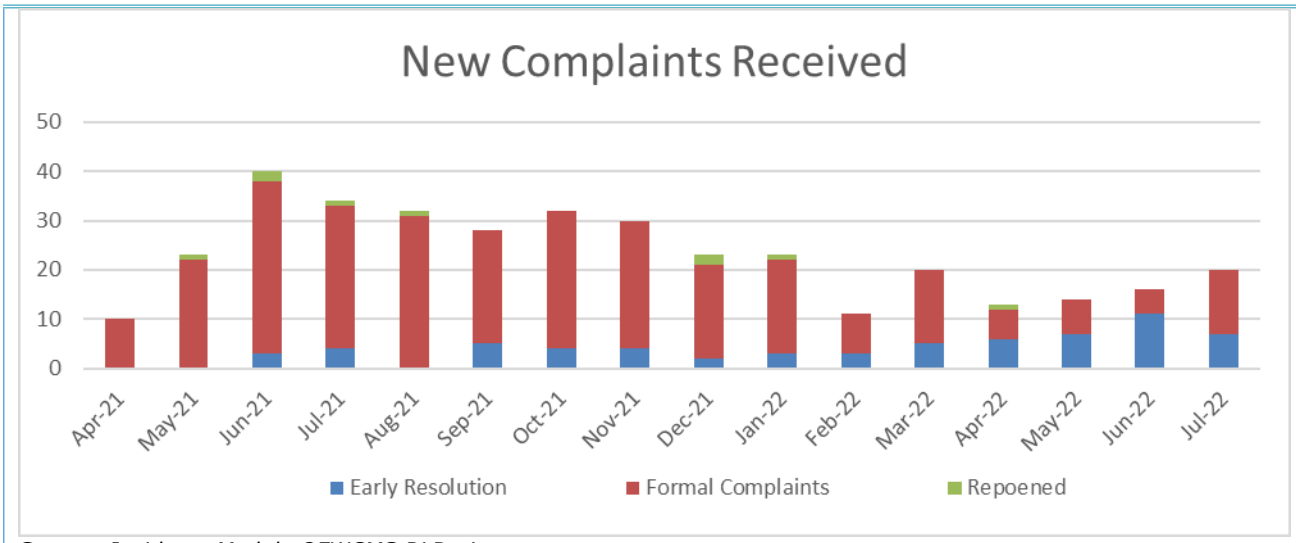
Key: Completed
On Target

## 2.5 Putting Things Right - Concerns

The number of concerns received appear to have reduced during Quarter 1 and this appears to be an ongoing trend into Quarter 2. Whilst it may be too early to correlate a direct impact, it is possible that increased awareness of concerns management along with the implementation of training supported by the Public Services Ombudsman Wales (PSOW) has supported teams to proactively manage 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*

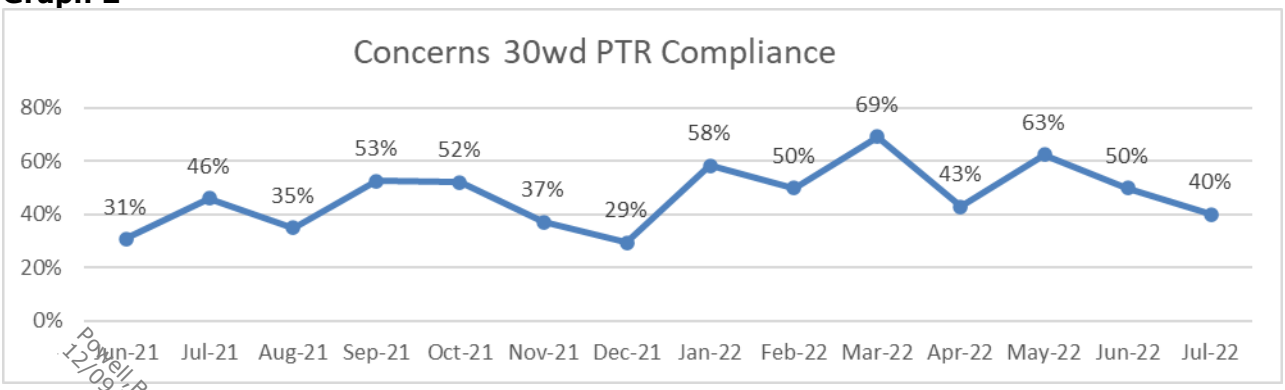
During a deep dive exercise into concerns management, it was noted that the concerns compliance had been incorrectly calculated. This administrative error has been rectified and an updated monthly concerns compliance is demonstrated in **Graph 2**. The Committee is asked to note that compliance data previously reported in July 2022 to committee for comparison in **Graph 3** has also been included in the report.

The local methodology is reported monthly using the DATIX sourced data. This is described below:

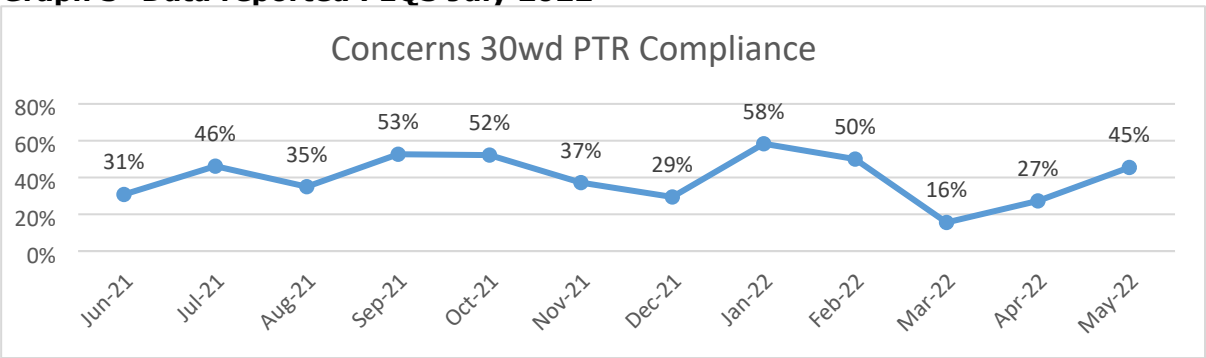
- **Numerator** "Of the complaints final response done, number responded to within 30 Working days"
- **divided by the denominator** Number of formal complaints (final response Due)

For the national operational measure as reported by Welsh Government a similar methodology is used quarterly, but its uses closed complaints submitted under regulation 24 by health boards with the addition of redress cases from the Welsh risk pool. These totals then use the same numerator/denominator calculation as described above.

**Graph 2**



**Graph 3- Data reported PEQS July 2022**




*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.

It must be noted that the number of concerns **open** is 15 *(data accurate 20/08/22)* in comparison to 53 at the beginning of February 2022. Assurance can be given that those concerns currently open over 30 working days are complex in their nature, requiring input from one or multiple commissioned organisations.

## 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 | Not Investigated | Upheld | Total |
|---|---|---|---|
| 9 | 6 | 2 | 17 |

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

Given the significant work undertaken by the Health Board to close concerns in the past 18 months, it must be recognised that referrals to the ombudsman may increase over the next 12 to 18 months as a consequence of the long delays to respond to complaints.

Recommendations from the PSOW office have included.

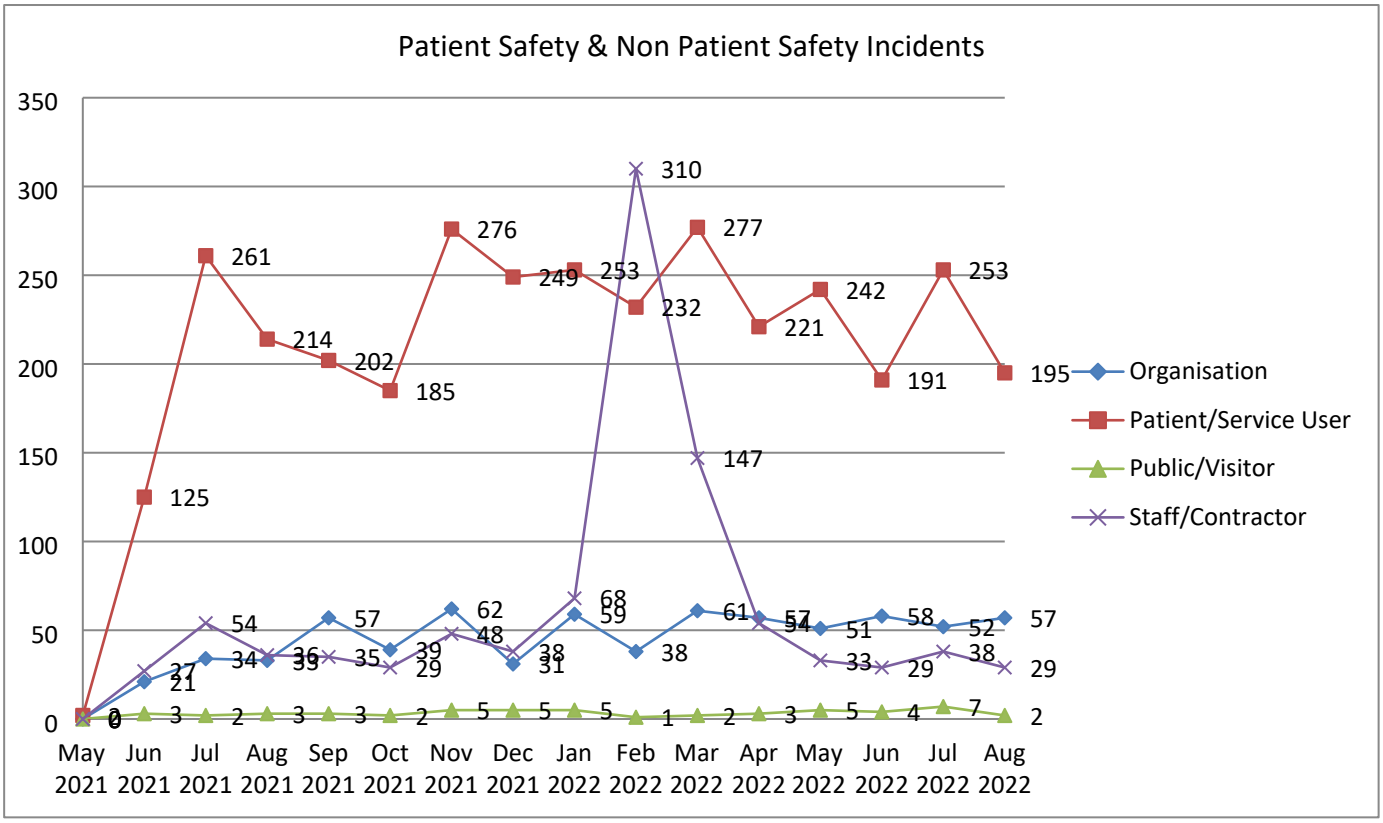
- Improvements to the concerns management process
- Improved communication with complainants during the concerns process

Both of 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 4)** with a peak noted during February and March 2022 which can be attributed to the reporting of covid positive staff members in line with the health board policy.

**Graph 4**




The highest reported incident themes:

- Pressure or moisture damage (n862)
  **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 (n826)
  **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.

- Behaviour (including violence & aggression) (n492)
  **Action:** Deep dive to review themes and trends of reporting

The timely investigation, closure and learning from incidents continues to be a priority thus ensuring that the learning from incidents is embedded within teams and across the Health Board. **Graph 5** highlights the number of open incidents along with their current progress within the investigation process. Progress has been made since the last report to committee and there will continue to be a focus on maintaining this improvement over the next few months.

**Graph 5**

| | Jun 2021 | Jul 2021 | Aug 2021 | Sep 2021 | Oct 2021 | Nov 2021 | Dec 2021 | Jan 2022 | Feb 2022 | Mar 2022 | Apr 2022 | May 2022 | Jun 2022 | Jul 2022 | Aug 2022 | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| New Incident | 0 | 1 | 3 | 5 | 16 | 54 | 49 | 38 | 50 | 71 | 55 | 51 | 50 | 93 | 128 | 664 |
| Management reviewer/Make it safe plus | 7 | 31 | 42 | 51 | 68 | 53 | 54 | 53 | 61 | 58 | 52 | 67 | 72 | 118 | 77 | 864 |
| Under Investigation | 2 | 2 | 1 | 7 | 6 | 3 | 8 | 15 | 10 | 8 | 19 | 35 | 17 | 25 | 26 | 184 |
| Awaiting Closure | 1 | 0 | 3 | 0 | 3 | 0 | 2 | 1 | 6 | 12 | 10 | 11 | 6 | 16 | 14 | 85 |
| Total | 10 | 34 | 49 | 63 | 93 | 110 | 113 | 107 | 127 | 149 | 136 | 164 | 145 | 252 | 245 | 1797 |

*Source: Incidents Module OFWCMS RLDatix system*

The structural changes underway with the RLDatix system will support robust reporting and escalation to services to support both assurance and improvement priorities within services. Continuing to develop a safe learning culture for improvement is a key recommendation within the Health and Social Care (Quality and Engagement) (Wales) Act, (1 June 2020). Whilst this is a priority for the Quality & Safety Team, collective ownership across all departments is required.

## 2.11 Early Warning Notifications (previously No surprises notifications)

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

## 3. Patient Experience

## 3.1 Gathering Patient Experience

The health board do not currently have a robust process in place to seek and evaluate citizen feedback, some services have implemented their own bespoke Patient Reported Experience Measures (PREMS) and PROMS which capture feedback, but this is not

currently uniformed or across all services, both provided or commissioned. Work is currently underway to scope the number of PREMS and PROMS that are captured across the organisation.

### 3.2 Implementation of Civica patient feedback system

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

Anticipated Programme Plan:

| | May | June | July | August | September | October |
|---|---|---|---|---|---|---|
| Call off Contract agreement | | | | | | |
| Organisational Hierarchy agreed | | | | | | |
| Implementation Meeting Civica | | | | | | |
| Development of the System | | | | | | |
| Programme Board Implementation | | | | | | |
| Programme build, Test Period | | | | | | |
| Health Board Training | | | | | | |
| Friend and Family Test questionnaire Live | | | | | | |

Key: Completed
On Target

## 4. Claims and Redress

There are currently 11 redress files open. 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.

There are 20 open claims consisting of personal injury claims, motoring accidents, General Medicine Practice Indemnity (GMPI) and clinical negligence claims. These claims are progressing with the support of Legal & Risk Services as required.



### 4.1 Inquests

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

Following the conclusion of an inquest on the 18th of May 2022 HM Coroner issued a Regulation 28 Report to Prevent Future Deaths jointly to PTHB and PCC. A joint response has been submitted on time with no further evidence required.

## 5. Health and Social Care Inspections Regulatory Recommendations

### 5.1 Health Inspectorate Wales Inspections

An inspection of Brecon MIU took place on 8th and 9th March 2022. In June 2022 HIW submitted an action plan for completion by the service.

Overall, HIW found evidence that the service provided safe and effective care. They identified some good practice and noted staff treated patients with dignity and kindness. This was reflected in comments made by patients. However, HIW identified areas that were not fully compliant with the Health and Care Standards and improvement was therefore required.

HIW assessment of what the service does well:

- Patients spoke highly of the staff and the service they received
- There was a positive team dynamic, and staff felt supported by management
- The telephone appointment system allowed staff to triage and screen patients for the Covid-19 virus prior to attending the unit
- We saw evidence that all patients who attended MIU in the last two years had been treated within the required four hours waiting time target
- Patient notes were well written and provided a comprehensive account of care and treatment
- Safeguarding procedures were up to date and flow charts were well presented and detailed in clinical notes.

HIW recommend the service could improve in the following areas. Please note a full list of improvements is available in the report:

- Appropriate services, information, and signage through the medium of Welsh as well as English should be available.
- Feedback forms should be made available to patients to provide them with an opportunity to provide an account of their healthcare experience
- To provide information on concerns raised by patients, lessons learned, and improvements
- To protect people's rights, MIU should have appropriate and adequate chaperone arrangements in place during night shifts
- The health board should ensure the Risk Management Framework and SARS Covid-19 IPC corporate policy are reviewed and updated

- Emergency bells should be fitted in all consultation rooms
- Areas of wear and tear should be reviewed to establish if they are adequate for purpose and in line with national minimum standards for cleanliness
- Staff should initial appropriate checklists to confirm checks on cleaning, controlled drugs, medical devices, and equipment
- Contents of the children's emergency resuscitation box should be checked
- Management should ensure adequate and sufficient staff resources are available on night shifts to protect service continuity
- Full compliance is required for staff mandatory training and staff supervision should be formally documented

Only one immediate concern was identified "the digital lock to the sluice was not in use and we were able to walk straight into room and noted chemicals on work surfaces. We were informed that staff had not been provided with the key code to the lock and as a result the room was not being secured."

However, the lock was replaced at the time of the inspection and HIW noted the room was locked when not in use.

No immediate assurance issues were raised during the inspection period.

The full report and action plan can be seen at **Appendix 1**.

## 5.2 Health and Social Care Regulatory Reports

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

There are 7 outstanding actions 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. | Business Manager for the CPCCMH who will now follow up to facilitate closure. |
| Unannounced visit to Clywedog Ward | The health board must ensure that sufficient resources are provided to facilitate the timely | July 2022 the DoLs demand continues to exceed PTHBs capacity to satisfy it. |

| | | |
|---|---|---|
| | processing of DoLS referrals. | Funding from Welsh Government received to support the implementation of the new Liberty Protection Standards (LPS) which will replace DoLS |
| Unannounced visit to Llewellyn Ward | The health board must produce a policy to support patient self-administration of medication. | Medicines Policy, including an overarching statement regarding self-administration is on track for publication by the end of August 2022. |
| Birth Centres and Free-Standing Midwifery-led units across Powys | The health board must ensure that a review of the facilities within Llanidloes War Memorial Hospital and Knighton Hospital takes place to ensure that infection prevention and control measures are in line with health board policy. | Interdependencies for progressing the work is based on Capital Control programme of work and agreement for League of Friend funding for both Knighton and Llanidloes.<br>Completion TBC by capital estates. |
| 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. | The transition pathways from Children's Services to Adult Services are being reviewed jointly by the Assistant Director for Therapies and the Deputy Director for Nursing |
| HIW Review of Healthcare Services for Young People | Health boards must ensure they have a formal system for involving young people in the design and delivery of transition processes and learn from their experiences. | Engagement with PCC has recommenced to progress this work.<br>Progress will be fed into start well board.<br>This is a key new objective for the Children and Young People Renewal programme |

## 5.3 Community Health Council

There have been no recent visits by the Community Health Council.

## 5.4 Environmental Health Services

Environmental health services carried out an inspection of the kitchens at Knighton on 13th June and Ystradgynlais on 28th June and both areas received a food hygiene rating of 5.

## 5.5 HIW Maternity Improvement Plan 2021 Priorities

Action 8: The health board must ensure smoking cessation and healthier lifestyles are continued to reduce risk of still birth and improve health and wellbeing of families.

The service action to address action 8 was to re-establish a smoking cessation lead to support the delivery of PTHB's tobacco control action plan. However, although this is in place funding is only in place until March 2023.

| | |
|---|---|
| **Appendix 1: Brecon MIU Final Report** | 220715 Inspection Report.pdf |
| **Appendix 2: Dashboard** | 220810 HSCRRR Dashboard.xlsx |
| **Appendix 3: Tracker** | 220705%20HSCRRR%20Tracker%20-%20LIV |

## 6 KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

6.1 Timely management of incidents is required to ensure appropriate action is taken. Members are asked to note that 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 Continued trajectory of improvement is required with the management of 30wd PTR responses.
**ACTION:** Proactive management of concerns responses to remain a focus for the Assistant Director of Quality & Safety to ensure that the improvements currently in place are sustained and embedded within the Health Board.

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

| IMPACT ASSESSMENT | | | | | |
|---|---|---|---|---|---|
| **Equality Act 2010, Protected Characteristics:** | | | | | |
| | **No impact** | **Adverse** | **Differential** | **Positive** | **Statement**<br><br>***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**<br><br>Reputational risk if no improved compliance with Welsh Government performance for management of concerns. |
| | **None** | **Low** | **Moderate** | **High** | |
| **Clinical** | √ | | | | |
| **Financial** | √ | | | | |
| **Corporate** | √ | | | | |
| **Operational** | √ | | | | |
| **Reputational** | | | √ | | |

/

# Hospital Inspection (Unannounced)

## Brecon War Memorial Hospital / Minor Injuries Unit / Powys Teaching Health Board

Inspection date: 08 and 09 March 2022

Publication date: 15 July 2022

This publication and other HIW information can be provided in alternative formats or languages on request. There will be a short delay as alternative languages and formats are produced when requested to meet individual needs. Please contact us for assistance.

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# Contents

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of 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

# Our priorities

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 |

# 1. What we did

Healthcare Inspectorate Wales (HIW) completed an unannounced inspection of Brecon Minor Injuries Unit in Powys Teaching Health Board on 8 and 9 March 2022.

Our team, for the inspection comprised of two HIW Inspectors, one clinical peer reviewer and a patient experience reviewer. The inspection was led by a senior healthcare inspector.

HIW explored how the service met the Health and Care Standards (2015).

Further details about how we conduct hospital inspections can be found in Section 5 and on our website.

# 2. Summary of our inspection

Overall, we found evidence that the service provided safe and effective care. We identified some good practice and noted staff treated patients with dignity and kindness. This was reflected in comments made by patients.

However, we identified areas that were not fully compliant with a number of Health and Care Standards and require improvement.

This is what we found the service did well:

- Patients spoke highly of the staff and the service they received
- There was a positive team dynamic and staff felt supported by management
- The telephone appointment system allowed staff to triage and screen patients for the Covid-19 virus prior to attending the unit
- We saw evidence that all patients who attended MIU in the last two years had been treated within the required four hours waiting time target
- Patient notes were well written and provided a comprehensive account of care and treatment
- Safeguarding procedures were up to date and flow charts were well presented and detailed in clinical notes.

This is what we recommend the service could improve. Please note a full list of improvements is available in Appendix A:

- Appropriate services, information and signage through the medium of Welsh as well as English
- Feedback forms should be made available to patients to provide them with an opportunity to provide an account of their healthcare experience
- To provide information on concerns raised by patients, lessons learned and improvements made

- To protect people's rights, MIU should have appropriate and adequate chaperone arrangements in place during night shifts
- The health board should ensure the Risk Management Framework and SARS Covid-19 IPC corporate policy are reviewed and updated
- Emergency bells should be fitted in all consultation rooms
- Areas of wear and tear should be reviewed to establish if they are adequate for purpose and in line with national minimum standards for cleanliness
- Staff should initial appropriate checklists to confirm checks on cleaning, controlled drugs, medical devices and equipment
- Contents of the children's emergency resuscitation box should be checked
- Management should ensure adequate and sufficient staff resources are available on night shifts to protect service continuity
- Full compliance is required for staff mandatory training and staff supervision should be formally documented.

# 3. What we found

## Background of the service

Powys Teaching Health Board (Powys THB) is one of seven health boards across Wales. The health board covers a large rural community of 2,000 square miles and provides health services to 133,000 people in the area. Based on the small population the health board does not provide a District General Hospital. The health board has arrangements in place for its residents to attend specialist hospital services in hospitals outside of the county in both England and Wales.

Powys THB does not have any Emergency Department (ED) provision, only minor injury units. These are located in Brecon, Llandrindod Wells, Welshpool and Ystradgynlais.

Brecon Minor Injuries Unit (MIU) is based in Brecon War Memorial Hospital. The main facilities at Brecon War Memorial Hospital include:

- Outpatient Facilities
- Inpatient General / Medical Ward (Y Bannau Ward)
- Inpatient Elderly Mental Health Ward (Crug Ward)
- Inpatient Rehabilitation Ward (Epynt Ward)
- Midwife-Led Birth Centre
- Minor Injury Unit
- X-Ray Facilities
- Therapy Services
- Minor Surgery and Endoscopy
- Day Hospital
- Community Dentistry
- Children's Centre.



Brecon War Memorial Hospital's MIU employs a team leader who is supported by three qualified Emergency Nurse Practitioners (ENP), three trainee ENPs and one healthcare support worker.

At present appointments can be made to attend the MIU although the unit will always endeavour to see a patient who requires medical attention. Patients are required to contact the hospital and request to speak to MIU. A member of staff from MIU calls the patient to offer a telephone consultation. If they need to be seen, they will be provided with a designated clinic time.

Powys THB annual report for 2020/21 identified they were consistently providing a rapid and comprehensive service via its Minor Injury Units.

## Quality of patient experience

*We spoke with patients, their relatives, representatives and/or advocates (where appropriate) to ensure that the patients' perspective is at the centre of our approach to inspection.*

We noted staff treated patients with dignity and kindness. An appointment system helped to ensure patients were seen promptly. Patients told us they were happy with the service and spoke highly of staff.

We noted some areas that require improvement particularly around provision of patient information, and listening and learning from patient feedback.

During the inspection we distributed HIW questionnaires to patients and carers to obtain their views on the services provided. We also spoke to five patients during the inspection. Patient comments included the following:

> *We would come to Brecon MIU over any of the other hospitals as we received good well rounded care.*
>
> *We are fortunate to have MIU facilities in Brecon given Neville Hall Hospital ED was a distance away.*
>
> *MIU asks patients to call before attending and I feel the unit is making the assumption that everyone has access to a mobile phone. This of course may not always be the case.*

A number of patients told us it was difficult to get a car parking space and alternative parking was situated some way from the hospital site.

### Dignified care

We saw staff treating patients with dignity, respect, compassion and kindness. All patients we spoke to indicated they were happy with the service provided and spoke highly of the staff.

The waiting room was situated close to the main entrance of the hospital and provided adequate seating and a quiet ambience. Most appointments had been booked in advance providing patients with plenty of space to sit safely and in line with current social distancing requirements.

Staff were keen to protect patient confidentiality and sound proofed consultation room doors were closed when patients were being assessed.

### Patient information

We noted that the sepsis board for staff and clinicians was appropriately populated and informative.

MIU did not display any information in the waiting room or clinical areas relating to the Choose Well campaign that raises public awareness about the NHS services available to patients. Nor was there any information relating to NHS 111 Wales health advice and information service.

We noted information was displayed in MIU that promoted mental health services. However, this was only provided through the medium of Welsh and not English. We also noted information relating to support groups, dementia, modern slavery and access to foodbanks. Some of these were not presented bilingually.

Signage directing patients to MIU was not clear or easy to read and not displayed bilingually.

We were unable to locate information in MIU relating to smoking cessation or the community health council.

Improvement needed

Management should ensure all relevant patient information and signage is displayed clearly and bilingually in MIU.

### Communicating effectively

We saw staff communicating effectively with each other and with patients. We were informed that none of the staff working in MIU were able to speak Welsh. However, we noted all patients seen during the course of the inspection were happy to speak through the medium of English.

Staff adapted communication styles to meet the needs of individuals and introduced themselves by name upon initial contact.

Staff were professional and we saw evidence of an experienced member of staff de-escalating a challenging situation.

Staff told us the team leader in charge of MIU had an open door policy. We observed positive and cohesive interaction between the staff and management on duty during the course of the inspection.

We noted MIU was clearly signposted from the car park. A ramp was in situ at the main entrance to the hospital and MIU was situated on the ground floor.

Improvement needed

The health board must ensure they fulfil their statutory duty to provide appropriate services through the medium of Welsh as well as English ensuring equality of both languages.

## Timely care

We noted MIU provided an appointment system encouraging patients to call the hospital before presenting. This enabled staff to speak directly to the patient and allocate appointment times, or re-direct the patient to appropriate services. The unit provides 30 minutes appointment slots over 24 hours. Patients told us they were happy with the appointment system as they were seen promptly.

We were also informed that MIU accepts self-presenting patients and key performance indictors indicate all patients are seen within four hours of arrival.

We also saw a prompt response from staff in MIU to the hospital emergency bell.

We were informed by one patient that they had attended MIU and understood a full 24 hour service was available. However, the X-ray department was closed. X-ray department opening hours are between 9.30am and 4pm. The patient was re-directed to Neville Hall Hospital in Abergavenny. This resulted in an additional 50 mile round trip for the patient. Other patients indicated there had been some delays waiting for an X-ray and receiving the results.

The majority of patients we spoke to told us car parking was an issue at the hospital. Patients told us it was difficult to get a car parking space and alternative parking was situated some way from the hospital site.

Improvement needed

The health board should ensure information relating to the availability of X-ray services in Powys THB is accessible to all members of the public. Information should also outline alternative X-ray facilities and extended opening hours provided by other health boards.

The health board should actively review patient concerns raised in relation to the limited availability of car parking at Brecon.

## Individual care

### Planning care to promote independence

We saw staff providing care to patients who required assistance with walking.

We saw staff dealing with a challenging family member and the situation was appropriately de-escalated.

We saw a patient arrive with breathing difficulties and this was dealt with promptly and professionally by staff. The patient was safely re-directed to the GP out of Hours Service (GPOOH)[1] for medical care.

### People's rights

There was no public information available in MIU to promote equality and diversity. The Health and Care Standards require health boards to embed quality and human rights across all functions recognising the diversity of the population and the rights of individuals under equality, diversity and human rights legislation.

We were told that only one member of staff is on duty on the night shift. We noted that this could potentially impact on a person's right to request the same sex clinician or a chaperone.

Improvement needed

Information relating to equality and diversity should be made available to patients attending MIU and staff employed within the unit.

[1] A service that provides health care for urgent medical problems outside normal GP surgery hours.

The health board should ensure they have arrangements in place to ensure they comply with the requirements of the Health and Care Standards in relation to a person's right to request a same sex clinician or a chaperone.

## Listening and learning from feedback

We were unable to locate any information in the MIU waiting room that related to Putting Things Right (PTR)[2]. In line with the NHS Concerns, Complaints and Redress Arrangements (Wales) Regulations 2011, health boards must provide patients with advice on how to raise a concern. The concept of Putting Things Right provides assurance to the patient that the NHS operates a consistent method for investigating concerns which is inclusive and transparent.

At the time of the inspection we noted patient feedback forms were not readily available to patients in the waiting room or other areas of the MIU. In addition the patient feedback form collection box had been placed on a high shelf in the waiting room out of reach of most patients. We saw two feedback forms inside. Neither had been dated.

A review of the minutes from meetings of MIU Team leaders identified a lack of discussion around listening and learning from patient feedback. There was also an absence of discussion around the collection of patient stories. Patient feedback and the personal account of a patient's healthcare journey provide the health board with the opportunity to identify good practice and recognize areas that require improvement.

There was no evidence in the waiting room to indicate the health board were informing patients of feedback, lessons learned and improvements made.

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[2] https://gov.wales/nhs-wales-complaints-and-concerns-putting-things-right#:~:text=The%20process%20for%20raising%20concerns%20or%20complaints%20in,a%20carer%2C%20friend%20or%20relative%20to%20represent%20you.

Improvement needed

Management should ensure information on Putting Things Right is made available to patients in MIU along with feedback forms to provide patients with an opportunity to provide an account of their healthcare experience.

MIU Team leaders should ensure they review patient feedback on a regular basis, and consider collating patient stories with a view to implement a listening and learning culture in the department. In turn, information should be made available in the waiting room in MIU to assure patients that the health board acknowledges their feedback, learns lessons and make improvements.

## Delivery of safe and effective care

*We considered the extent to which services provide high quality, safe and reliable care centred on individual patients.*

The MIU was clean and we saw enhanced cleaning of chairs and surfaces in consultation rooms after each patient had been seen.

Adequate stocks of Personal Protective Equipment and antibacterial hand gel were readily available in the unit.

Patients were screened for Covid-19 prior to attending the unit and large signs were displayed encouraging social distancing and informing patients not to enter the premises if they were presenting symptoms of the Covid-19 virus.

Patient notes were well written and presented in a clear logical sequence of diagnosis.

Documented checks on adult resuscitation equipment and controlled drugs had not been routinely initialled to confirm completion and the some items in the children's emergency resuscitation box had expired in January 2022.

### Safe care

#### Managing risk and promoting health and safety

We reviewed the Risk Management Framework and noted it was out of date and due for review in September 2020. However we noted the health board has a documented strategic approach to system resilience which covers the period 2021/22 and aims to manage and mitigate risk.

We reviewed the Health & Safety file held in MIU and noted a number of policies were out of date. This was immediately rectified by the team lead.

We noted wear and tear on work surfaces and wooden cupboard handles in all consultation rooms. We expressed concerns around the limitations of MIU to ensure high levels of cleanliness and active infection prevention when trying to clean these areas. We observed a dripping tap in a small basin unit and stained

sink units and saw an obsolete plug socket that had been covered in tape in one of the consultation rooms.

We were informed that the doors to rear of MIU needed replacing as they were no longer fit for purpose. They had been consistently locking staff out of the building. This presented a health and safety risk to both staff and patients.

We were able to walk into the sluice room and noted chemicals on work surfaces. This presented a risk to patients and we informed MIU immediately. We were informed that staff had not been provided with the key code to the lock and as a result the room was not being secured. The lock was replaced at the time of the inspection and we noted the room was locked when not in use.

We noted that two of the three consultation rooms did not have an emergency bell. This presented a risk to members of staff particularly lone and night shift workers. We were informed staff carry personal alarms however, a fixed emergency alarm in all rooms would ensure best practice and mitigation of risk.

We noticed a corner of the waiting room was being used as a storage for wheelchairs. They did not appear to present a trip hazard however, it made the room appear untidy. We also noted that children's chairs were not readily available in the waiting room as they had been piled together and placed aside.

MIU had identified ligature points[3] but we could not be assured the unit had adequate mitigation in place to ensure the health and safety of patients at risk of self-harm when un-supervised in consultation rooms.

We were informed that staff working in MIU used to access advice and guidance via a direct line to a nominated consultant at Neville Hall Hospital. This consultant also made regular monthly visits to Brecon MIU. However, this service was no longer available and staff expressed concerns that they did not feel adequately supported. Staff explained they had to phone the Grange Hospital in Cwmbran and seek help and advice from a range of specialist services and then re-direct patients to Prince Charles Hospital in Merthyr Tydfil.

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[3] A ligature point is anything that can be used to tie a rope, cord or other type of material for the purpose of self-harm by hanging.

Improvement needed

The health board should ensure the Risk Management Framework is reviewed and updated.

Obsolete plug sockets should be reviewed by Estates management and appropriate action taken in line with health and safety.

Areas of wear and tear on work surfaces and wooden door handles should be reviewed to establish if they are adequate for purpose and the ability to clean them is in line with national minimum standards for cleanliness as advised in The National Standards for Cleaning in NHS Wales.

Doors to the rear of the unit should be assessed and action taken to prompt remedial work or replacement to protect the health and safety of patients and staff.

Emergency bells to be fitted in all consultation rooms in MIU.

Management to review the appropriate storage of wheelchairs and children's seating to be made readily available to patients.

The health board should ensure MIU staff are able to access a dedicated and consistent medical advice and guidance service.

## Preventing pressure and tissue damage

Staff were not aware there were any specific guidelines or policies for preventing pressure and tissue damage. We reviewed a sample of patient notes and identified that staff were not routinely completing pressure or tissue damage assessments. Whilst we acknowledged patients are not on the unit for extended periods of time we felt the unit should be assessing patients with pre-existing conditions and mobility issues.

Staff told us the hospital has appropriate pressure relieving equipment at their disposal should they require it.

Improvement needed

Staff should ensure pressure and tissue damage assessments are completed at the appropriate time and documented in patients' notes.

## Falls prevention

We were informed the unit has access to slings, hoists and walkers for those patients at risk of falls.

We were informed that staff working alone on night shifts can request assistance from hospital wards in the event they require support with a patient at risk of falls.

## Infection prevention and control

A review of policies identified the SARS Covid-19 Infection Prevention Control (IPC) corporate policy was out of date and due for review August 2021. The timely review of this policy is necessary to ensure the appropriate management of the virus during the course of the rapidly evolving pandemic.

The MIU appeared to be clean and we saw domestic staff cleaning floors and chairs. We saw enhanced cleaning of chairs and surfaces in consultation rooms after each patient had been seen. Toilet facilities were situated within MIU and were found to be clean and accessible to all patients.

Staff told us they were provided with appropriate Personal Protective Equipment (PPE)[4] and FFP3 masks[5] in response to the pandemic. Adequate stocks of PPE were readily available in the unit and we saw staff provide patients with NHS approved fluid resistant surgical masks.

We were informed staff are mandated to complete a covid risk assessment every six months and this is input onto the electronic staff record (ESR)[6].

Patients are screened for Covid-19 prior to attending the unit via the appointment system and large signs had been displayed at the hospital informing patients not to enter the premises if they were presenting symptoms of the Covid-19 virus.

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[4] https://phw.nhs.wales/about-us/policies-and-procedures/policies-and-procedures-documents/risk-management-health-and-safety-and-estates-supporting-documents/management-of-personal-protective-equipment-guidance/

[5] https://phw.nhs.wales/topics/latest-information-on-novel-coronavirus-covid-19/information-for-health-and-social-care/faq-003/

[6] https://my.esr.nhs.uk/dashboard/web/esrweb

In line with current government guidelines we saw signs that encouraged patients and staff to maintain a two metre distance and noted seating areas had been adapted to maintain social distancing. Antibacterial hand gel and face masks were available at the entrance to the hospital and also in MIU.

MIU were not displaying information relating to their compliance with the health board's requirements for infection prevention and control, however, we saw evidence of departmental hand hygiene audits and noted all staff were compliant with the health board requirement for regular hand washing between patients, treatments and the bare below the elbow uniform policy.

Improvement needed

SARS Covid-19 IPC corporate policy to be reviewed and updated.

MIU to display IPC compliance in the patient waiting room.

### Nutrition and hydration

We saw patients had access to a water dispenser in the waiting room in the MIU.

The large vending machine that had offered a variety of drinks and snacks was now out of service but remained in situ in the waiting room. We were informed that patients would be offered food and drink at the appropriate time however, we noted canteen facilities were limited and opening times restricted to daytime hours.

Improvement needed

Management should review the current facilities in place for nutrition and hydration of patients and their families whilst attending MIU and ensure they meet service needs and are compliant with the Health and Care Standards.

## Medicines management

Medicines appeared to be safely stored and controlled drugs[7] were locked away. We did however note that the daily check for controlled drugs had not been completed for a period of 3 days during one 14 day period. The absence of initials on the daily checking record was raised with the team leader who assured us the regular agency member of staff had checked these but had not initialled the check record.

We noted that the health board had up to date standard operating procedures for the management of refrigerated medicines however, information presented on the medicine fridge in MIU indicated a service was overdue as the period for maintenance had expired in March 2021.

A review of patient's notes confirmed the administration of medication was being documented consistently and contemporaneously.

We were informed that all drugs prescribed by MIU are administered through the Patient Group Directive (PGD) or authorised by a GP or Out Of Hours (OOH) service as none of the staff in MIU are trained prescribers. A review of the PDG procedure identified the document was out of date and had been due for review in October 2021. This procedure empowers health professionals to supply and administer medicines in line with NICE guidance and should be kept up to date to ensure the safe administration of medicines to patients.

We were informed that the PGD had not approved the use of antibiotics to specifically target infected wounds and as a result MIU have to contact local GP's or the GP OOH service to request and authorise a prescription. This can delay effective treatment and potentially impact on safe and effective care.

Clinical guidelines for Powys THB were out of date. We noted that these were being used by staff in MIU and should have been reviewed in 2019 (written in 2016).

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[7] https://www.nice.org.uk/guidance/NG46/ifp/chapter/information-for-people-using-and-looking-after-controlled-medicines

Improvement needed

Checks of controlled drugs to be initialled on a timely basis to confirm completion.

Management to consider current arrangements for prescribing drugs and any training needs.

PGD procedure to be reviewed and updated.

PGD to approve use of antibiotics in MIU to ensure the delivery of effective treatment.

Clinical guidelines to the reviewed and updated.

Arrangements to be made to ensure the medicine fridge is serviced without delay in line with health board standing operating procedures.

## Safeguarding children and adults at risk

Powys THB had an up to date Safeguarding policy in place that had been developed around the Social Services and Well-being (Wales) Act 2014.

Staff told us they are aware of the procedure to raise a safeguarding concern and had access to policies and procedures on the health board's MIU intranet page should they require further guidance.

Safeguarding flow charts were well presented and detailed in clinical notes.

Three members of staff were not up to date with mandatory safeguarding training requirements. The team leader informed us that efforts were being made to secure places on appropriate courses.

Staff expressed concerns that self-presenting patients at risk of self-harm require a mental health assessment by a GP. Staff were concerned that delays in arranging and accessing assessments could potentially impact on the health and safety of the patient.

Improvement needed

Staff to complete mandatory safeguarding training.

Management should review and improve the current process of obtaining mental health assessments for patients at risk of self-harm.

### Medical devices, equipment and diagnostic systems

We saw documented checks of medical devices and equipment held in consultation rooms. However, we noted that checks on adult resuscitation equipment had not been initialled by staff for three days within a 14 day period. We raised this immediately with the team leader who assured us that this had been completed by a regular member of agency staff however, she recognized the need to remind the individual to initial in the appropriate section.

We saw the children's emergency resuscitation box had been obscured and was covered in papers. We considered this was poor practice as the equipment was not fully visible. This posed a risk in the event of an emergency, particularly for new and agency staff. We were informed that Cwm Taf Morgannwg University Health Board are responsible for the review of the contents of the box and appropriate testing of equipment. Maintenance documentation indicated the resuscitation box was not due for review until August 2022 however, we noticed a number of items inside the box had expired in January 2022.

Improvement needed

All staff should be reminded to initial appropriate check list to confirm checks on medical devices and equipment have been completed.

Arrangements should be made to ensure the contents of the children's emergency resuscitation box are checked.

## Effective care

### Safe and clinically effective care

We reviewed and checked five sets of patient's notes during our inspection. Information relating to a patient's clinical history and appropriate observations were well written and presented in a clear logical sequence of diagnosis. We noted some duplication of clinical notes that had been both hand written and input onto the Wales Patient Administration Scheme (WPAS)[8] system.

[8] https://nwis.nhs.wales/systems-and-services/secondary-care/

The level of pain experienced by patients was appropriately assessed and documented upon initial consultation. Staff told us they use NEWS[9] scores on acutely unwell patients and escalated concerns to ambulance control at the appropriate time. Sepsis screening was also evident.

All patient identifiable information relating to MIU was kept in a separate room away from clinical areas and waiting rooms. We saw the X-ray department audit book with patient identifiable information was closed at all times.

We saw evidence that staff were adequately trained in Immediate Life Support[10] and most staff had been trained in Paediatric Immediate Life Support[11]. We were also informed that two members of staff were trained in Advanced Life Support.

Staff were not aware if the health board had a documented standard operating procedure for the transfer of patients by ambulance from MIU or a procedure to manage the transportation of patients to home addresses. Staff told us they had experienced some delays in requesting ambulance transfer of patients from MIU to another hospital however, they told us that they could call ambulance control and re-classify requests if a patient's condition deteriorated.

We noticed the lighting in the main corridor was dim and low level and questioned whether this could pose difficulties for patients with dementia and visual impairment.

Improvement needed

Staff to be provided with documented standard operating procedures for the transfer of patients from MIU via the Wales Ambulance Service Trust or procedures to manage patients' transport to home addresses.

[9] National Early Warning Score (NEWS) is a tool developed by the Royal College of Physicians which improves the detection and response to clinical deterioration in adult patients and is a key element of patient safety and improving patient outcomes.

[10] https://www.resus.org.uk/training-courses/adult-life-support/ils-immediate-life-support

[11] https://www.resus.org.uk/training-courses/paediatric-life-support/pils-paediatric-immediate-life-support

## Quality improvement, research and innovation

Staff told us the introduction of the appointment system had improved patient care as it had enabled them to effectively and efficiently triage patients, screen for Covid-19 and offer appointments that enabled social distancing and timely care.

They also told us that this system enabled them to re-direct patients to the appropriate service as and when required.

We noted that the health board had an up to date Clinical Quality Framework that aimed to deliver high quality clinical care with sustained and continuous year on year improvement.

## Information governance and communications technology

We found a set of patient notes in the female toilets located in MIU. We were informed that a patient visiting the outpatients department in Brecon hospital had been given the notes and asked to present them at their appointment. The patient had inadvertently left them in the toilets. The senior manager for unscheduled care informed us that this was an oversight and notes would not normally be handed to patients as they were ordinarily transported between sites by the Powys THB. We expressed concerns that this may have resulted in a breach of confidentiality. Management assured us this incident would be reported on the Datix[12] system and reviewed accordingly.

The MIU did not display waiting times in the waiting room. However we were provided with evidence that confirmed patients were consistently treated within four hours of appointment time right across of MIU's in Powys.

[12] https://nwssp.nhs.wales/all-wales-programmes/community-pharmacy-patient-safety-incident-reporting-wales/incident-reporting-documents/ofwcms-community-pharmacy-patient-safety-reporting-april-2022-pdf-520kb/

Improvement needed

Management to investigate the incident relating to the patient notes found in the female toilets in MIU and ensure lessons are learned and poor practice is not repeated.

## Record keeping

We noted that patient medical notes were comprehensive and well written.

We reviewed documented cleaning checks in the resuscitation, children's and Omnicell[13] rooms and noted a number of examples where the checklists had not been completed in full. Management assured us the checks had been completed and the member of staff had failed to initial the appropriate sections. Management confirmed they would remind staff of the importance of initialling documentation as confirmation of completion.

We reviewed a series of mattress checks and X-ray audits. Whilst they were completed on a regular basis the details appeared to be incomplete and outcome of each audit was not documented.

Improvement needed

Cleaning checks to be initialled to indicate completion.

Auditing of mattresses and X-ray to be reviewed with a view to providing a full documented audit trail and outcome.



[13] Omnicell is an automated dispensing medication cabinet.

## Quality of management and leadership

*We considered how services are managed and led and whether the workplace and organisational culture supports the provision of safe and effective care. We also considered how the service review and monitor their own performance against the Health and Care Standards.*

Staff feel supported by their line manager and we saw a good team dynamic. The unit demonstrated they were successfully attracting and training new employees.

We saw a dedicated space on the health board intranet providing MIU staff with access to all relevant and appropriate working policies, procedures and guidance.

We saw an effective telephone appointment and triage system and evidence that patients were seen within four hours of their appointment time.

### Governance, leadership and accountability

Management were visible and maintained an open door policy. Staff indicated they felt adequately supported and had access to Occupational Therapy and Wellbeing Services.

We reviewed a comprehensive MIU intranet page that provided staff with general information, clinical guidelines and policy references. It also included information relating to medication, safeguarding, governance and training.

We reviewed documented key performance indicators that showed the health board was actively collating data on patient numbers attending MIU in Brecon. This data indicated that the number of patients attending the unit was now increasing following the restrictions imposed as a result of the pandemic.

Management informed us that an appointment booking system had been implemented in MIU in Brecon in response to the pandemic. This booking system was still in place at the time of the inspection. We observed staff speaking to patients on the telephone and making preliminary assessments to determine the urgency of their need for treatment. We noted that staff took the opportunity to

screen patients for Covid-19 prior to giving an appointment or re-directing to the appropriate health care service.

Management told us the appointment system ensured patients were provided with an allotted time for presentation at the unit ensuring a timely response to their needs. We were provided with data that indicated all patients seen in Brecon MIU were seen within four hours of their appointment time for the past two years.

## Staff and resources

### Workforce

During the inspection we spoke to staff on duty and distributed HIW questionnaires to staff to obtain their views on the services provided. Staff told us:

*They would recommend Powys THB as a place to work*

*Facilities were appropriate to enable them to complete daily tasks and the environment allowed them to provide appropriate care to patients at the point of attendance*

*Staff indicated training, learning and development allowed them to do their jobs effectively and safely*

*Staff told us they had adequate materials, supplies and equipment and were able to meet all the conflicting demands of work*

The MIU employs three qualified Emergency Nurse Practitioners (ENP) and is operating a successful initiative to attract and train ENPs.

Trainee ENPs benefit from an employee incentive scheme and are supported by the health board to study and gain the ENP qualification. These staff are committed to work for MIU for a period of two years following qualification. This provides the health board with some resource assurance and contributes to the sustainability of workforce planning.

We were told that one trained and one untrained member of staff work day shifts whilst only one trained ENP works on the night shift. We were informed that MIU use agency services to cover gaps in resource.

During the course of the inspection the unit was closed overnight for a period of 12 hours. This was a result of last minute sickness being reported by a member of agency staff. We confirmed the correct process had been followed by MIU in relation to service closure. However, we were informed that the health board is

currently unable to inform the NHS 111 medical helpline of unit closure. This service provides a free to call non-emergency medical helpline to patients in Wales. As NHS 111 had not been informed of the closure they could have potentially and inappropriately directed a member of the public to the unit. This may have compromised the health and safety of the patient.

We were informed that the ENP's employed by MIU in Brecon were not able to prescribe medication as they did not have the necessary qualifications. Reliance was placed on local GPs and the GP OOH service which sometimes delayed patient care and discharge.

Overall compliance with the requirements for mandatory training was reported as 81%. We were informed that some face to face training had not been available during the course of the pandemic. A review of the Electric Staff Record (ESR) indicated management had been actively booking staff onto resuscitation, moving and handling and health, safety and welfare training courses.

We were provided with evidence to show staff had received personal appraisal and development reviews (PADR) and ESR indicated MIU were 87.5% compliant. However, a review of documentation identified some of the appraisal forms were incomplete and had not been signed or dated.

We were informed that team meetings had become infrequent during the course of the pandemic with the last meeting taking place in August 2021. Management also cited some staff found it difficult to attend meetings. Staff meetings should be encouraged as they provide management with an opportunity to share current information, encourage team dynamic and provide a forum for open discussion.

We were informed that staff supervision is done on an informal basis and not documented. Supervision should be documented to provide evidence of professional support and learning that contributes to staff personal and professional development.

Improvement needed

Management should ensure adequate and sufficient staff resources are available on night shifts to protect service continuity.

Management to make arrangements to inform the NHS 111 medical helpline of unit closure.

Consideration should be given to encourage and support staff to obtain a Non-Medical Prescribing or Independent Nurse Prescribing qualification.

Management should ensure full compliance with staff mandatory training.

Management should ensure full completion of PADR documentation in line with health board requirements.

Management should ensure staff attend regular team meetings, discussions are documented and outcomes shared with those staff who were unable to attend.

Management should ensure staff supervision is formally documented.

# 4. What next?

Where we have identified improvements and immediate concerns during our inspection which require the service to take action, these are detailed in the following ways within the appendices of this report (where these apply):

- Appendix A: Includes a summary of any concerns regarding patient safety which were escalated and resolved during the inspection
- Appendix B: Includes any immediate concerns regarding patient safety where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking
- Appendix C: Includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas

The improvement plans should:

- Clearly state when and how the findings identified will be addressed, including timescales
- Ensure actions taken in response to the issues identified are specific, measurable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed.

As a result of the findings from this inspection the service should:

- Ensure that findings are not systemic across other areas within the wider organisation
- Provide HIW with updates where actions remain outstanding and/or in progress, to confirm when these have been addressed.

The improvement plan, once agreed, will be published on HIW's website.

# 5. How we inspect hospitals

We have a variety of approaches available to us when we inspect NHS hospitals, including:

- In-depth single ward inspection: we undertake a thorough and detailed review of one ward
- Multi ward inspection: we visit a number of wards and departments within one hospital site to identify issues or themes which may apply to the whole hospital
- Multi hospital inspection: we visit a number of hospitals within the same health board to assess the governance and delivery of whole services.

Hospital inspections are usually unannounced. We will always seek to conduct unannounced inspections because this allows us to see services in the way they usually operate. The service does not receive any advance warning of an unannounced inspection.

Feedback is made available to service representatives at the end of the inspection, in a way which supports learning, development and improvement at both operational and strategic levels.

We check how hospitals are meeting the Health and Care Standards 2015. We consider other professional standards and guidance as applicable.

These inspections capture a snapshot of the standards of care within hospitals.

Further detail about how HIW inspects the NHS can be found on our website.

## Appendix A – Summary of concerns resolved during the inspection

The table below summarises the concerns identified and escalated during our inspection. Due to the impact/potential impact on patient care and treatment these concerns needed to be addressed straight away, during the inspection.

| Immediate concerns identified | Impact/potential impact on patient care and treatment | How HIW escalated the concern | How the concern was resolved |
|---|---|---|---|
| The digital lock to the sluice was not in use and we were able to walk straight into room and noted chemicals on work surfaces. We were informed that staff had not been provided with the key code to the lock and as a result the room was not being secured. | Access to chemicals presents a risk to patients. Standard 2.1 Managing risk and promoting health and safety | Management were informed. | The lock was replaced at the time of the inspection and we noted the room was locked when not in use. |

## Appendix B – Immediate improvement plan

**Hospital:** Brecon War Memorial Hospital

**Ward/department:** Minor Injuries Unit

**Date of inspection:** 8th and 9th March 2022

The table below includes any immediate concerns about patient safety identified during the inspection where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking.

| Immediate improvement needed | Standard | Service action | Responsible officer | Timescale |
|---|---|---|---|---|
| There were no immediate assurance issues raised during this inspection. | | | | |

## Appendix C – Improvement plan

**Hospital:** Brecon War Memorial Hospital

**Ward/department:** Minor Injuries Unit

**Date of inspection:** 8th and 9th March 2022

The table below includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

| Improvement needed | Standard | Service action | Responsible officer | Timescale |
|---|---|---|---|---|
| **Quality of the patient experience** | | | | |
| Management should ensure all relevant patient information and signage is displayed clearly and bilingually in MIU. | 4.2 Patient Information | Translate all information on display within the Minor Injury Unit for both Welsh and English with a clear display. More boards to be purchased to facilitate increased signage. | Team Lead Brecon Minor Injury Unit | End of July 2022 |
| The health board must ensure they fulfil their statutory duty to provide appropriate services through the medium of Welsh as well as English ensuring equality of both languages. | 3.2 Communicating effectively | Ensure all signage for services within the hospital is available in both Welsh and English. All information on the health board intranet for Minor Injury Unit's has been reviewed and is available in both Welsh and English | Senior Manager Unscheduled Care | End of August 2022 |

| Improvement needed | Standard | Service action | Responsible officer | Timescale |
|---|---|---|---|---|
| The health board should ensure information relating to the availability of X-ray services in Powys THB is accessible to all members of the public. Information should also outline alternative X-ray facilities and extended opening hours provided by other health boards. | 5.1 Timely access | A timetable of x – ray services to be clearly displayed to all members of the public within the Minor Injury Unit display board in both Welsh and English. Alternative facilities and operational hours to be included in display. X -ray service times are available on the intranet. | Team Lead Brecon Minor Injury Unit | End of July 2022 |
| The health board should actively review patient concerns raised in relation to the limited availability of car parking at Brecon. | | Common themes of car parking complaints to be identified alongside the quality and safety team. A new car park development is underway. This development is to be clearly displayed on an information board for all individuals accessing Brecon Hospital to reflect the health board's actions and plans. | Senior Manager Unscheduled Care | End of August 2022<br><br>Completion of car park due November 2022 |
| Information relating to equality and diversity should be made available to patients attending MIU and staff employed within the unit. | 6.2 Peoples rights | Information relating to equality and diversity will be made available to those MIU and staff employed within the unit. This will be displayed as a corporate commitment poster detailing the health | Team Lead Brecon Minor Injury Unit and Senior Manager | End of September 2022 |

| Improvement needed | Standard | Service action | Responsible officer | Timescale |
|---|---|---|---|---|
| | | board's view on equality and diversity and how this is met within the unit | Unscheduled Care | |
| The health board should ensure they have arrangements in place to ensure they comply with the requirements of the Health and Care Standards in relation to a person's right to request a same sex clinician or a chaperone. | | All Minor Injury Unit staff to ensure that before a patient is seen they are offered a chaperone where a same sex clinician is not available. Patient assessment forms to be reviewed to include this question and used for audit and compliance purposes. Minor Injury Unit to work with wards to ensure peer to peer support for the offering of the chaperone. | Senior Manager Unscheduled Care | End of September 2022 |
| Management should ensure information on Putting Things Right is made available to patients in MIU along with feedback forms to provide patients with an opportunity to provide an account of their healthcare experience. | 6.3 Listening and Learning from feedback | Implementation of electronic feedback system to be included in the Minor Injury Unit.<br><br>As an interim measure, forms to be placed more visibly in the waiting area with a sign to encourage completion and an explanation of what the Unit will do with the feedback. | Assistant Director of Quality & Safety<br><br>Team Lead Minor Injury Unit for interim measure | By end of October 2022<br><br>By end of July 2022 |

| Improvement needed | Standard | Service action | Responsible officer | Timescale |
|---|---|---|---|---|
| MIU Team leaders should ensure they review patient feedback on a regular basis, and consider collating patient stories with a view to implement a listening and learning culture in the department. In turn, information should be made available in the waiting room in MIU to assure patients that the health board acknowledges their feedback, learns lessons and make improvements. | | Re-establish a “Know how we are doing board” within the Unit which includes feedback from complaints/compliments and what the Unit and health board has done as a result.<br><br>Use feedback opportunities to request patient stories, share these on the board and also share in MIU Team Lead meetings on a monthly basis with greater detail and actions taken. The feedback to be via a electronic form or paper dependant on patient choice. | Team Lead Minor Injury Unit<br><br>Senior Manager Unscheduled Care | By end of July 2022<br><br>By end of September 2022 |
| **Delivery of safe and effective care** | | | | |
| The health board should ensure the Risk Management Framework is reviewed and updated. | 2.1 Managing risk and promoting health and safety | Risk management framework will be reviewed and updated. | Assistant Director of Primary & Community Services. | End of August 2022 |
| Obsolete plug sockets should be reviewed by Estates management and appropriate action taken in line with health and safety. | | Plug sockets to be reported for maintenance and repair. | Assistant Director of Estates and Property | Complete as now repaired, |

| Improvement needed | Standard | Service action | Responsible officer | Timescale |
|---|---|---|---|---|
| | | | | |
| Areas of wear and tear on work surfaces and wooden door handles should be reviewed to establish if they are adequate for purpose and the ability to clean them is in line with national minimum standards for cleanliness as advised in The National Standards for Cleaning in NHS Wales. | | Work surfaces and handles logged by the team lead of the Minor Injury Unit for repair and inspection | Assistant Director of Estates and Property | End of July 2022 |
| Doors to the rear of the unit should be assessed and action taken to prompt remedial work or replacement to protect the health and safety of patients and staff. | | Assessed and reported to estates by minor injury unit team lead prior to inspection. Inspected by estates, new doors agreed. Awaiting arrival and fitting of doors. | Assistant Director of Estates and Property | End of August 2022 |
| Emergency bells to be fitted in all consultation rooms in MIU. | | Assessed and reported to estates by minor injury unit team lead. Awaiting installation by estates team. | Assistant Director of Estates and Property | End of August 2022 |

| Improvement needed | Standard | Service action | Responsible officer | Timescale |
|---|---|---|---|---|
| Management to review the appropriate storage of wheelchairs and children's seating to be made readily available to patients. | | Identify an area of storage space within the unit for wheelchairs and children's seating. Explore options of removing cupboards to other areas within the hospital to allow for storage within the unit. | Assistant Director of Estates and Property | End of August 2022 |
| The health board should ensure MIU staff are able to access a dedicated and consistent medical advice and guidance service. | | Consultant in Emergency Department in neighbouring acute hospital now identified as a point of contact to offer the medical services as previously received. | Senior Manager Unscheduled Care | Complete |
| Staff should ensure pressure and tissue damage assessments are completed at the appropriate time and documented in patients' notes. | 2.2 Preventing pressure and tissue damage | Standard Operating Procedure for assessment of pressure and tissue damage now in place with assessments and audit in place. | Senior Manager Unscheduled Care | Complete |
| SARS Covid-19 IPC corporate policy to be reviewed and updated. | 2.4 Infection Prevention and Control (IPC) and Decontamination | Policy needs review and to be updated to reflect recent change in guidance | Senior Nurse Infection Prevention and Control | End of August 2022 |

| Improvement needed | Standard | Service action | Responsible officer | Timescale |
|---|---|---|---|---|
| MIU to display IPC compliance in the patient waiting room. | | The unit will ensure the new display board reflects IPC compliance with hand hygiene, cleaning rota, training and any other relevant information is displayed clearly, | Team Lead Brecon MIU | End of July 2022 |
| Management should review the current facilities in place for nutrition and hydration of patients and their families whilst attending MIU and ensure they meet service needs and are compliant with the Health and Care Standards. | 2.5 Nutrition and Hydration | Facilities to review re-establishing vending machine in the unit for drinks. As an interim measure, staff to put up clear signage of water fountain and encourage patients to ask if food and drink is needed.<br>As part of the standard operating procedure for those with long waiting times nutrition and hydration is included as an assessment. | Support Services Manager (South and Mid Powys) | End of August 2022 |
| Checks of controlled drugs to be initialled on a timely basis to confirm completion. | 2.6 Medicines Management | Audits of controlled drugs is now fed back into each monthly minor injury unit team leads meeting.<br>Checking controlled drugs at handover has been implemented to maintain routine and ensure checks are complete | Team Lead Brecon Minor Injury Unit | Complete |

| Improvement needed | Standard | Service action | Responsible officer | Timescale |
|---|---|---|---|---|
| Management to consider current arrangements for prescribing drugs and any training needs. | | Two nurses placed on training to become nurse prescribers in September 2022. Once completed will encourage attendance for more to obtain further coverage of prescribers | Team Lead Brecon Minor Injury Unit | Complete |
| PGD procedure to be reviewed and updated. | | PGD procedure requires review and update to reflect need and ensure they are in date. | Head of Community Services Medicines Management/Pharmacy | End of October 2022 |
| PGD to approved use of antibiotics in MIU to ensure the delivery of effective treatment. | | Medicines management to approve PDG for antibiotics for frequently seen conditions in Minor Injury Unit. Minor Injury Unit team to continue to attend PGD group for discussion and justification of use. | Head of Community Services Medicines Management/Pharmacy | End of September 2022 |

| Improvement needed | Standard | Service action | Responsible officer | Timescale |
|---|---|---|---|---|
| Clinical guidelines to the reviewed and updated. | | | | |
| Arrangements to be made to ensure the medicine fridge is serviced without delay in line with health board standing operating procedures. | | Service the fridge in line with requirements | Team Lead Brecon Minor Injury Unit | Complete |
| Staff to complete mandatory safeguarding training. | 2.7 Safeguarding children and adults at risk | Staff now completed or booked on for safeguarding mandatory training. Staff have also attended safeguarding supervision on two occasions since the report. | Team Lead Brecon Minor Injury Unit | Complete |
| Management should review and improve the current process of obtaining mental health assessments for patients at risk of self-harm. | | Minor Injury Units have received training from the mental health team in assessing, signposting and availability of pathways within the mental health service in Powys. Pathways and referral process has now been mapped and available for teams. Increased literature available for patients needing mental health support is also now available in the unit. | Team Lead Brecon Minor Injury Unit | Complete |

| Improvement needed | Standard | Service action | Responsible officer | Timescale |
|---|---|---|---|---|
| All staff should be reminded to initial appropriate check list to confirm checks on medical devices and equipment have been completed. | 2.9 Medical devices, equipment and diagnostic systems | Audits of medical devices and equipment are now fed back into each monthly minor injury unit team leads meeting.<br><br>Audits are held electronically for monitoring | Team Lead Brecon Minor Injury Unit | Complete |
| Arrangements should be made to ensure the contents of the children's emergency resuscitation box are checked. | | Audits of children's emergency boxes is now fed back into each monthly minor injury unit team leads meeting. | Team Lead Brecon Minor Injury Unit | Complete |
| Staff to be provided with documented standard operating procedures for the transfer of patients from MIU via the Wales Ambulance Service Trust or procedures to manage patients' transport to home addresses. | 3.1 Safe and Clinically Effective care | Standard operating procedure for transport of patients via WAST is now complete and available for all teams electronically and in paper form | Senior Manager Unscheduled Care | Complete |
| Management to investigate the incident relating to the patient notes found in the female toilets in MIU and ensure lessons are learned and poor practice is not repeated. | 3.4 Information Governance and Communications Technology | DATIX completed with lessons learnt and investigation completed. Clear lessons learnt and education of sharing and transportation of patients notes held to ensure lessons have been learnt. | Community Service Manager South Powys | Complete |

| Improvement needed | Standard | Service action | Responsible officer | Timescale |
|---|---|---|---|---|
| Cleaning checks to be initialled to indicate completion. | 3.5 Record keeping | Audits of cleaning schedule is now fed back into each monthly minor injury unit team leads meeting. | Team Lead Brecon Minor Injury Unit | Complete |
| Auditing of mattresses and X-ray to be reviewed with a view to providing a full documented audit trail and outcome. | | Audits reviewed for accuracy and improvements for completion and visibility.<br><br>Audits of mattress and X-ray is now fed back into each monthly minor injury unit team leads meeting. | Team Lead Brecon Minor Injury Unit | Complete |
| **Quality of management and leadership** | | | | |
| Management should ensure adequate and sufficient staff resources are available on night shifts to protect service continuity. | 7.1 Workforce | Increased number of emergency nurse practitioners on the bank with one member of staff on a fixed-term contract. This has allowed for service continuity and cover of the unit 24 hours a day. | Team Lead Brecon MIU | Complete |

| Improvement needed | Standard | Service action | Responsible officer | Timescale |
|---|---|---|---|---|
| Management to make arrangements to inform the NHS 111 medical helpline of unit closure. | | Process now established and shared digitally as well as paper copy to the unit closure process and notification to 111. | Team Lead Brecon MIU | Complete |
| Consideration should be given to encourage and support staff to obtain a Non-Medical Prescribing or Independent Nurse Prescribing qualification. | | Two staff members due to commence training to become nurse prescribers in September. Once completed will review for more applicants to allow for service sustainability | Team Lead Brecon MIU | Complete |
| Management should ensure full compliance with staff mandatory training. | | Full compliance for mandatory training is required with a more frequent audit process on such implemented every three months. Each member of the team has booked or completed mandatory training. | Team Lead Brecon MIU | Complete |
| Management should ensure full completion of PADR documentation in line with health board requirements. | | Full compliance of PADRs' within the unit is now achieved and evidenced on the electronic staff record system. | Team Lead Brecon MIU | Complete |
| Management should ensure staff attend regular team meetings, discussions are documented and | | Team lead meetings are now recorded and minutes taken by personal assistant by the Senior Manager of Unscheduled Care. Minutes are shared, stored in an | Senior Manager Unscheduled Care | Complete |

| Improvement needed | Standard | Service action | Responsible officer | Timescale |
|---|---|---|---|---|
| outcomes shared with those staff who were unable to attend. | | electronic file for those unable to attend with decision making recorded and reflected by naming those involved. | | |
| Management should ensure staff supervision is formally documented. | | Management have now attended training on how to record supervision on to the electronic staff record for formal record and reflection of the ongoing supervision completed within the Unit.<br>Supervision is being uploaded as completed and will be a continual process. | Senior Manager Unscheduled Care & Team Lead Brecon Unit | Complete |

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

**Service representative**

**Name (print): Claudia O'Shea**

**Job role: Senior Manager Unscheduled Care**

**Date: 28/6/2022**

# Health and Social Care Regulatory Report Recommendations Dashboard April 2022

| Ref | Ref | Inspection Title | Recommendations Made | Recommendations Complete | Recommendations Overdue (agreed timescale) | Overdue Recommendation Revised Timescale | Recommendations Not Yet Due | All recommendations implemented |
|---|---|---|---|---|---|---|---|---|
| 2017/18 | 171808 | Mental Health Service Inspection (Clywedog Ward, Llandrindod) | 9 | 9 | | | | Yes |
| | **TOTAL** | | 9 | 9 | | 1 | | |
| 2019/20 | 192003 | Unannounced Mental Health Service Inspection (Clywedog Ward, Llandrindod) | 23 | 21 | 1 | 1 | | |
| 2019/20 | 192006 | Unannounced Hospital Inspection: Llewellyn Ward, Bronllys Hospital | 13 | 12 | 1 | | | |
| | 192007 | Birth Centres (Free Standing Midwifery Led Unit) Across Powys | 9 | 8 | 1 | | | |
| | 192009 | HIW Review of Healthcare Servcies for Young People | 37 (5 N/A) | 34 | 3 | | | |
| | **TOTAL** | | 82 | 75 | 6 | 1 | | |
| 2021/22 | 212201 | HIW National Maternity Improvement Plan 2021 Priorities | 25 | 16 | 1 | 4 | 4 | |
| | 212202 | Tier 1 Quality Check Clywedog Ward, Llandrindod Wells | 2 | 1 | 1 | | | |
| | 212207 | CIW Inspection of Cottage View | 8 | 7 | 1 | | | |
| | 212208 | HIW Tier 1 Quality Check: Felindre Ward, Bronllys Hospital | 27 | 20 | | 1 | 6 | |
| | 212215 | HIW Announced Inspection of community mental health services | 55 | 24 | 1 | 1 | 29 | |
| | 212217 | All Wales Intrapartum Fetal Surveillance Standards | 1 | | | 1 | | |
| | 212222 | HIW Unannounced Inspection of Brecon MIU | 43 | 34 | | | 9 | |
| | **TOTAL** | | 160 | 102 | 4 | 6 | 48 | |
| | **GRAND TOTAL** | | 252 | 186 | 10 | 8 | 48 | |

# Health and Social Care Regulatory Report Recommendations Dashboard April 2022

| Ref | Ref | Inspection Title | Recommendations Made | Recommendations Complete | Recommendations Overdue (agreed timescale) | Overdue Recommendation Revised Timescale | Recommendations Not Yet Due | All recommendations implemented |
|---|---|---|---|---|---|---|---|---|
| 2017/18 | 171808 | Mental Health Service Inspection (Clywedog Ward, Llandrindod) | 9 | 9 | | | | Yes |
| | **TOTAL** | | 9 | 9 | | 1 | | |
| 2019/20 | 192003 | Unannounced Mental Health Service Inspection (Clywedog Ward, Llandrindod) | 23 | 21 | 1 | 1 | | |
| | 192006 | Unannounced Hospital Inspection: Llewellyn Ward, Bronllys Hospital | 13 | 12 | 1 | | | |
| | 192007 | Birth Centres (Free Standing Midwifery Led Unit) Across Powys | 9 | 8 | 1 | | | |
| | 192008 | NHS Mental Health Service Inspection (Unannounced): Felindre Ward, Bronllys Hospital | 23 | 23 | | | | Yes |
| | 192009 | HIW Review of Healthcare Servcies for Young People | 37 (5 N/A) | 33 | 4 | | 1 | |
| | **TOTAL** | | 105 | 97 | 7 | 1 | 1 | |
| 2021/22 | 212201 | HIW National Maternity Improvement Plan 2021 Priorities | 25 | 15 | 6 | | 4 | |
| | 212202 | Tier 1 Quality Check Clywedog Ward, Llandrindod Wells | 2 | 1 | | | 1 | |
| | 212207 | CIW Inspection of Cottage View | 8 | 7 | 1 | | | |
| | 212208 | HIW Tier 1 Quality Check: Felindre Ward, Bronllys Hospital | 27 | 20 | | 1 | 6 | |
| | 212215 | HIW Announced Inspection of community mental health services | 55 | 24 | 1 | 1 | 29 | |
| | **TOTAL** | | 117 | 67 | 8 | 2 | 40 | |
| | **GRAND TOTAL** | | 231 | 173 | 13 | 4 | 41 | |

# Health and Social Care Regulatory Report Recommendations Dashboard April 2022

| Ref | Ref | Inspection Title | Recommendations Made | Recommendations Complete | Recommendations Overdue (agreed timescale) | Overdue Recommendation Revised Timescale | Recommendations Not Yet Due | All recommendations implemented |
|---|---|---|---|---|---|---|---|---|
| 2017/18 | 171808 | Mental Health Service Inspection (Clywedog Ward, Llandrindod) | 9 | 8 | | 1 | | |
| | **TOTAL** | | 9 | 8 | | 1 | | |
| 2019/20 | 192003 | Unannounced Mental Health Service Inspection (Clywedog Ward, Llandrindod) | 23 | 21 | 1 | 1 | | |
| | 192006 | Unannounced Hospital Inspection: Llewellyn Ward, Bronllys Hospital | 13 | 12 | 1 | | | |
| | 192007 | Birth Centres (Free Standing Midwifery Led Unit) Across Powys | 9 | 8 | 1 | | | |
| | 192008 | NHS Mental Health Service Inspection (Unannounced): Felindre Ward, Bronllys Hospital | 23 | 21 | 1 | | 1 | |
| | 192009 | HIW Review of Healthcare Servcies for Young People | 37 (5 N/A) | 36 | 1 | | | |
| | **TOTAL** | | 105 | 98 | 5 | 1 | 1 | |
| 2021/22 | 212201 | HIW National Maternity Improvement Plan 2021 Priorities | 25 | 15 | 6 | | 4 | |
| | 212202 | Tier 1 Quality Check Clywedog Ward, Llandrindod Wells | 2 | 1 | | | 1 | |
| | 212207 | CIW Inspection of Cottage View | 8 | 7 | 1 | | | |
| | 212208 | HIW Tier 1 Quality Check: Felindre Ward, Bronllys Hospital | 27 | 20 | | 1 | 6 | |
| | 212215 | HIW Announced Inspection of community mental health services | 55 | 24 | 1 | 1 | 29 | |
| | **TOTAL** | | 117 | 67 | 8 | 2 | 40 | |
| | **GRAND TOTAL** | | 231 | 173 | 13 | 4 | 41 | |

# Health and Social Care Regulatory Report Recommendations Dashboard Feb 22

| Ref | Ref | Inspection Title | Recommendations Made | Recommendations Complete | Recommendations Overdue (agreed timescale) | Overdue Recommendation Revised Timescale | Recommendations Not Yet Due | All recommendations implemented |
|---|---|---|---|---|---|---|---|---|
| 2017/18 | 171808 | Mental Health Service Inspection (Clywedog Ward, Llandrindod) | 9 | 8 | | 1 | | |
| | **TOTAL** | | 9 | 8 | | 1 | | |
| 2019/20 | 192003 | Unannounced Mental Health Service Inspection (Clywedog Ward, Llandrindod) | 23 | 21 | 1 | 1 | | |
| | 192004 | Unannounced Twymyn Ward, Machynlleth Community Hospital & Graham Davies Ward, Llanidloes Hospital Inspection | 20 | 20 | | | | Yes |
| | 192006 | Unannounced Hospital Inspection: Llewellyn Ward, Bronllys Hospital | 13 | 12 | 1 | | | |
| | 192007 | Birth Centres (Free Standing Midwifery Led Unit) Across Powys | 9 | 8 | 1 | | | |
| | 192008 | NHS Mental Health Service Inspection (Unannounced): Felindre Ward, Bronllys Hospital | 23 | 21 | 1 | 1 | | |
| | 192009 | HIW Review of Healthcare Servcies for Young People | 37 (5 N/A) | 36 | 1 | | | |
| | **TOTAL** | | 125 | 117 | 6 | 2 | | |
| 2020/21 | 20050 | Tier 1 Quality Check: Maldwyn Ward, Welshpool Hospital | 2 | 2 | | | | Yes |
| | **TOTAL** | | 2 | 2 | | | | |
| 2021/22 | 212201 | HIW National Maternity Improvement Plan 2021 Priorities | 25 | 15 | 6 | | 4 | |
| | 212202 | Tier 1 Quality Check Clywedog Ward, Llandrindod Wells | 2 | 1 | | | 1 | |
| | 212207 | CIW Inspection of Cottage View | 8 | 7 | | | 1 | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | 212208 | HIW Tier 1 Quality Check: Felindre Ward, Bronllys Hospital | 27 | 20 | | 1 | 6 | |
| | 212215 | HIW Announced Inspection of community mental health services | Report Awaited | | | | | |
| | **TOTAL** | | 62 | 43 | 6 | 1 | 12 | |
| | **GRAND TOTAL** | | 198 | 170 | 12 | 4 | 12 | |

# Health and Social Care Regulatory Report Recommendations Dashboard Dec 21

| Ref | Ref | Inspection Title | Recommendations Made | Recommendations Complete | Recommendations Overdue (agreed timescale) | Overdue Recommendation Revised Timescale | Recommendations Not Yet Due | All recommendations implemented |
|---|---|---|---|---|---|---|---|---|
| 2017/18 | 171808 | Mental Health Service Inspection (Clywedog Ward, Llandrindod) | 9 | 8 | | 1 | | |
| | **TOTAL** | | 9 | 8 | | 1 | | |
| 2019/20 | 192003 | Unannounced Mental Health Service Inspection (Clywedog Ward, Llandrindod) | 23 | 21 | 1 | 1 | | |
| | 192004 | Unannounced Twymyn Ward, Machynlleth Community Hospital & Graham Davies Ward, Llanidloes Hospital Inspection | 20 | 19 | 1 | | | |
| | 192006 | Unannounced Hospital Inspection: Llewellyn Ward, Bronllys Hospital | 13 | 12 | 1 | | | |
| | 192007 | Birth Centres (Free Standing Midwifery Led Unit) Across Powys | 9 | 8 | 1 | | | |
| | 192008 | NHS Mental Health Service Inspection (Unannounced): Felindre Ward, Bronllys Hospital | 23 | 21 | 1 | 1 | | |
| | 192009 | HIW Review of Healthcare Servcies for Young People | 37 (5 N/A) | 36 | 1 | | | |
| | **TOTAL** | | 125 | 117 | 6 | 2 | | |
| 2020/21 | 20050 | Tier 1 Quality Check: Maldwyn Ward, Welshpool Hospital | 2 | 2 | | | | Yes |
| | **TOTAL** | | 2 | 2 | | | | |
| 2021/22 | 212201 | HIW National Maternity Improvement Plan 2021 Priorities | 25 | 15 | 6 | | 4 | |
| | 212202 | Tier 1 Quality Check Clywedog Ward, Llandrindod Wells | 2 | 1 | | | 1 | |
| | 212207 | CIW Inspection of Cottage View | 8 | 7 | | | 1 | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | 212208 | HIW Tier 1 Quality Check: Felindre Ward, Bronllys Hospital | 27 | 20 | | 1 | 6 | |
| | 212215 | HIW Announced Inspection of community mental health services | Report Awaited | | | | | |
| | **TOTAL** | | 62 | 43 | 6 | 1 | 12 | |
| | **GRAND TOTAL** | | 198 | 170 | 12 | 4 | 12 | |

# Health and Social Care Regulatory Report Recommendations Dashboard Oct 21

| Ref | Ref | Inspection Title | Recommendations Made | Recommendations Complete | Recommendations Overdue (agreed timescale) | Overdue Recommendation Revised Timescale | Recommendations Not Yet Due | All recommendations implemented |
|---|---|---|---|---|---|---|---|---|
| 2017/18 | 171808 | Mental Health Service Inspection (Clywedog Ward, Llandrindod) | 9 | 8 | | 1 | | |
| | **TOTAL** | | 9 | 8 | | 1 | | |
| 2019/20 | 192003 | Unannounced Mental Health Service Inspection (Clywedog Ward, Llandrindod) | 23 | 21 | 1 | 1 | | |
| | 192004 | Unannounced Twymyn Ward, Machynlleth Community Hospital & Graham Davies Ward, Llanidloes Hospital Inspection | 20 | 19 | 1 | | | |
| | 192006 | Unannounced Hospital Inspection: Llewellyn Ward, Bronllys Hospital | 13 | 12 | 1 | | | |
| | 192007 | Birth Centres (Free Standing Midwifery Led Unit) Across Powys | 9 | 6 | 3 | | | |
| | 192008 | NHS Mental Health Service Inspection (Unannounced): Felindre Ward, Bronllys Hospital | 23 | 21 | 1 | 1 | | |
| | 192009 | HIW Review of Healthcare Servcies for Young People | 37<br>(5 N/A) | 36 | 1 | | | |
| | **TOTAL** | | 125 | 115 | 8 | 2 | | |
| 2020/21 | 20050 | Tier 1 Quality Check: Maldwyn Ward, Welshpool Hospital | 2 | 2 | | 1 | | |
| | **TOTAL** | | 2 | 1 | | 1 | | |
| 2021/22 | 212201 | HIW National Maternity Improvement Plan 2021 Priorities | 25 | 15 | 6 | | 4 | |
| | 212202 | Tier 1 Quality Check Clywedog Ward, Llandrindod Wells | 2 | 1 | | | 1 | |
| | 212207 | CIW Inspection of Cottage View | 8 | 7 | | | 1 | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | 212208 | HIW Tier 1 Quality Check: Felindre Ward, Bronllys Hospital | 27 | 17 | | 1 | 6 | |
| | **TOTAL** | | 62 | 26 | 12 | 11 | 5 | |
| | **GRAND TOTAL** | | 198 | 150 | 20 | 15 | 13 | |

# Health and Social Care Regulatory Report Recommendations Dashboard July 21

| Ref | Ref | Inspection Title | Recommendations Made | Recommendations Complete | Recommendations Overdue (agreed timescale) | Overdue Recommendation Revised Timescale | Recommendations Not Yet Due | All recommendations implemented |
|---|---|---|---|---|---|---|---|---|
| 2017/18 | 171808 | Mental Health Service Inspection (Clywedog Ward, Llandrindod) | 9 | 8 | | 1 | | |
| | **TOTAL** | | 9 | 8 | | 1 | | |
| 2019/20 | 192003 | Unannounced Mental Health Service Inspection (Clywedog Ward, Llandrindod) | 23 | 21 | | 2 | | |
| | 192004 | Unannounced Twymyn Ward, Machynlleth Community Hospital & Graham Davies Ward, Llanidloes Hospital Inspection | 20 | 19 | | 1 | | |
| | 192006 | Unannounced Hospital Inspection: Llewellyn Ward, Bronllys Hospital | 13 | 12 | | 1 | | |
| | 192007 | Birth Centres (Free Standing Midwifery Led Unit) Across Powys | 9 | 6 | | 3 | | |
| | 192008 | NHS Mental Health Service Inspection (Unannounced): Felindre Ward, Bronllys Hospital | 23 | 21 | | 2 | | |
| | 192009 | HIW Review of Healthcare Servcies for Young People | 37 (5 N/A) | 36 | | 1 | | |
| | **TOTAL** | | 125 | 115 | | 10 | | |
| 2020/21 | 20050 | Tier 1 Quality Check: Maldwyn Ward, Welshpool Hospital | 2 | 1 | | 1 | | |
| | **TOTAL** | | 2 | 1 | | 1 | | |
| 2021/22 | 212201 | HIW National Maternity Improvement Plan 2021 Priorities | 25 | 3 | 7 | | 15 | |
| | 212202 | Tier 1 Quality Check Clywedog Ward, Llandrindod Wells | 2 | 1 | | | 1 | |
| | 212207 | CIW Inspection of Cottage View | Outcome awaited | | | | | |
| | 212208 | HIW Tier 1 Quality Check: Felindre Ward, Bronllys Hospital | 27 | 13 | 3 | 11 | | |
| | **TOTAL** | | 54 | 17 | 10 | 11 | 16 | |
| | **GRAND TOTAL** | | 190 | 141 | 10 | 23 | 16 | |

# Health and Social Care Regulatory Report Recommendations Dashboard May 21

| Ref | Ref | Inspection Title | Recommendations Made | Recommendations Complete | Recommendations Overdue (agreed timescale) | Overdue Recommendation Revised Timescale | Recommendations Not Yet Due | All recommendations implemented |
|---|---|---|---|---|---|---|---|---|
| 2017/18 | 171808 | Mental Health Service Inspection (Clywedog Ward, Llandrindod) | 9 | 8 | | 1 | | |
| | **TOTAL** | | 9 | 8 | | 1 | | |
| 2019/20 | 192003 | Unannounced Mental Health Service Inspection (Clywedog Ward, Llandrindod) | 23 | 20 | | 3 | | |
| | 192004 | Unannounced Twymyn Ward, Machynlleth Community Hospital & Graham Davies Ward, Llanidloes Hospital Inspection | 20 | 19 | 1 | | | |
| | 192006 | Unannounced Hospital Inspection: Llewellyn Ward, Bronllys Hospital | 13 | 12 | 1 | | | |
| | 192007 | Birth Centres (Free Standing Midwifery Led Unit) Across Powys | 9 | 6 | 3 | | | |
| | 192008 | NHS Mental Health Service Inspection (Unannounced): Felindre Ward, Bronllys Hospital | 23 | 21 | 1 | 1 | | |
| | 192009 | HIW Review of Healthcare Servcies for Young People | 37 (5 N/A) | 36 | 1 | | | |
| | **TOTAL** | | 125 | 114 | 7 | 4 | | |
| 2020/21 | 20050 | Tier 1 Quality Check: Maldwyn Ward, Welshpool Hospital | 2 | | 2 | | | |
| | **TOTAL** | | 2 | | 2 | | | |
| 2021/22 | 212201 | HIW National Maternity Improvement Plan 2021 Priorities | 25 | 3 | 7 | | 15 | |
| | 212202 | Tier 1 Quality Check Clywedog Ward, Llandrindod Wells | 2 | 1 | | | 1 | |
| | 212207 | CIW Inspection of Cottage View | Outcome awaited | | | | | |
| | **TOTAL** | | 27 | 4 | 7 | | 16 | |
| | **GRAND TOTAL** | | 163 | 126 | 16 | 5 | 16 | |

# Health and Social Care Regulatory Report Recommendations Dashboard March 21

| Ref | Ref | Inspection Title | Recommendations Made | Recommendations Complete | Recommendations Overdue (agreed timescale) | Overdue Recommendation Revised Timescale | Recommendations Not Yet Due | All recommendations implemented |
|---|---|---|---|---|---|---|---|---|
| 2017/18 | | | | | | | | |
| | 171803 | Mental Health Service Inspection (Ystradgynlais Hospital) | 25 | 25 | | | | √ |
| | 171808 | Mental Health Service Inspection (Clywedog Ward, Llandrindod) | 9 | 9 | | | | √ |
| | **TOTAL** | | 34 | 34 | | | | |
| 2018/19 | | | | | | | | |
| | 181901 | Ionising Radiation Regulations and Follow Up Inspection (Brecon and Llandrindod Hospitals) | 9 | 9 | | | | √ |
| | 181902 | General practice Inspection (Presteigne Medical Practice) | 13 | 13 | | | | √ |
| | 181903 | Joint HIW & CIW National Review of Mental Health Services Inspection visit to (announced): Welshpool Community Mental Health Team | 25 | 25 | | | | √ |
| | **TOTAL** | | 47 | 47 | | | | |
| 2019/20 | | | | | | | | |
| | 192001 | Joint Community Mental Health Team Inspection - The Hazels, Llandrindod | 19 | 19 | | | | √ |
| | 192003 | Unannounced Mental Health Service Inspection (Clywedog Ward, Llandrindod) | 23 | 20 | | 3 | | |
| | 192004 | Unannounced Twymyn Ward, Machynlleth Community Hospital & Graham Davies Ward, Llanidloes Hospital Inspection | 20 | 19 | 1 | | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | 192006 | Unannounced Hospital Inspection: Llewellyn Ward, Bronllys Hospital | 13 | 12 | 1 | | | |
| | 192007 | Birth Centres (Free Standing Midwifery Led Unit) Across Powys | 9 | 6 | 3 | | | |
| | 192008 | NHS Mental Health Service Inspection (Unannounced): Felindre Ward, Bronllys Hospital | 23 | 21 | | 1 | 1 | |
| | **TOTAL** | | 107 | 97 | 5 | 4 | 1 | |
| 2020/21 | | | | | | | | |
| | 20045 | Tier 1 Quality Check: Tawe Ward, Ystradgynlais Hospital | 2 | 1 | | 1 | | |
| | 20050 | Tier 1 Quality Check: Maldwyn Ward, Welshpool Hospital | 2 | | 2 | | | |
| | **TOTAL** | | 4 | 1 | 2 | 0 | 0 | 0 |
| | **GRAND TOTAL** | | 193 | 179 | 7 | 6 | 1 | |

# Directory of Health and Social Care Regulatory Reports

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

| PTHB Code | Regulatory Body Code | Date of Inspection | Title |
|---|---|---|---|
| 171801 | | 10/04/2017 | General Practice Inspection Crickhowell Memorial Health Centre |
| 171802 | | 20/04/2017 | General Practice Inspection Ty Henry Vaughan Medical Group |
| 171803 | | 03&04/05/17 | MH Service Inspection Ystradgynlais Hospital - Tawe |
| 171804 | | 30&31/7/19 | General Practice Inspection Wylcwm Street Surgery Knighton |
| 171805 | | 24/01/2017 | General Practice Inspection Llandrindod Wells Medical Practice |
| 171806 | | 06/02/2017 | General Practice Inspection Builth Wells Medical Practice |
| 171807 | | 21/02/2017 | General Practice Inspection Rhayader Surgery |
| 171808 | | 21/08/2017 | MH Service Inspection Clywedog Ward Llandrindod Wells |
| 171809 | | 13/06/2017 | Dental Follow Up Hay on Wye Dental Centre |
| 171810 | | 06/06/2017 | Dental Follow Up Clverly Dental Practice |
| | | Aug-17 | Review of Substance Misuse report published June/July 18 |
| | | 7&8/09/17 | Joint HIW/CIW National Review of MH Services Welshpool Communkity MH Team |
| | | 10/10/2017 | Dental Follow Up Llanfynllin Dental Practice |
| 181901 | | 6&7/11/17 | Ionising Radiation Regulations and Follow Up Inspection Brecon and Llandrindod Wells Hospital |
| 181902 | | 25/09/2018 | General Practice Inspection Presteigne Medical Practice |
| 181903 | | 07&08/9/17 | Joint MH Servcie Inspection Welshpool Community Mental Health Team |
| 181904 | | 13/03/2018 | General Dental Practice Inspection Evans Dental Ltd |
| | | 23/11/2018 | BPAS HIW Inspection |
| 181905 | | 10/10/2107 | General Dental Practice Inspection Llanfyllin Dental Practice |
| 192001 | | 15&16/01/2019 | Joint Community MH Team Inspection The Hazels Llandrindod Wells |
| | | 07/02/2019 | Thematic Review of Community Mental Health Teams |
| 192002 | | 19/02/2019 | General Practice Inspection Welshpool Medical Centre |
| 192003 | | 15,16 & 17/7/19 | NHS MH Service Inspection Clewedog Ward |
| 192004 | | 30&31/7/19 | Llanidloes War Memorial Hospital Updated Final Improvement Plan |
| 192005 | | 31/07/2019 | Twymyn Ward Machynlleth Final Report |
| | | 01/09/2019 | Focus on Falls |
| 192005 | | 29/10/2019 | Machynlleth Community Hospital Improvement Plan Accepted |
| 192006 | | 29&30/10/19 | Llewellyn Ward Bronllys Hospital Appendix C Improvement Plan |
| 192007 | | 10-14/01/20 | Powys Home from Home Birth Centres Immediate Improvement Plan |
| 192008 | | 18-20/11/19 | NHS Mental Health Service Inspection, Unannounced: Felindre Ward, Bronllys Hospital |
| 192009 | | 29/03/2019 | HIW Review of Healthcare Servcies for Young People |
| 192010 | | Feb-20 | National Maternity Review |
| 20035 | | 15/10/2020 | Tier 1 Quality Check: Bryn Heulog Ward, Newtown Hospital |
| 20045 | | 30/09/2020 | Tier 1 Quality Check: Tawe Ward, Ystradgynlais Hospita |
| 20049 | | 21/10/2020 | Tier 1 Quality Check: Brecon War Memorial Hospital |
| 20050 | | 15/10/2020 | Tier 1 Quality Check: Maldwyn Ward, Welshpool Hospital |
| 212201.1 | | 01/04/2021 | WAST Review - see 212212 |
| 212201 | | Mar-21 | HIW National Maternity Improvement Plan 2021 Priorities |
| 212202 | | 23/03/2021 | Tier 1 Quality Check: Clywedog Ward, Llandrindod Wells Hospital |
| 212203 | | 27/04/2021 | Tier 1 Quality Check: Felindre Ward, Bronllys Hospital (Cancelled at short notice) |
| 212204 | | 24/03/2021 | Report Published: Deprivation of Liberty Safeguarding Annual Monitoring Report |
| 212205 | | 23/04/2021 | Notification of: National Review of Mental Health Crisis Prevention in the Community - Powys Teaching HB |
| 212206 | | 01/06/2021 | Environmental Health Inspection: Ystradgynlais Hospital ( No actions as scored 5) |
| 212207 | | 03/06/2021 | CIW Inspection of Cottage View |
| 212208 | 21005 | 16/06/21 - 17/06/21 | Tier 1 Quality Check: Unannounced Visit: Felindre Ward, Bronllys Hospital |
| 212209 | | 29/06/2021 | My Dentist Welshpool |
| 212210 | | 30/06/2021 | HIW Covid 19 National Review |
| 212211 | | 12/05/2021 | HIW Ystradgynlais Dental Practice - The Martin Partnership (no actions were identified) |
| 212212 | | 2021 | WAST Local Review |
| 212213 | | 14/07/2021 | My Dentist Newtown - no areas of improvement identified |



## Committee Reporting Dates

| Circulate to TEAM | Deadline for team Response | Executive Committee | Papers in Date | Patient Experience, Quality & Safety Committee | Papers in Date |
|---|---|---|---|---|---|
| 16/07/2021 | 09/08/2021 | 22/09/2021 | 15/09/2021 | 07/10/2021 | 21/09/2021 |
| 08/10/2021 | 22/10/2021 | 17/11/2021 | 10/11/2021 | 02/12/2021 | 19/11/2021 |
| 06/12/2021 | 24/12/2021 | 12/01/2021 | 05/01/2021 | 03/02/2022 | 21/01/2022 |
| 01/02/2022 | 18/02/2022 | 09/03/2022 | 02/03/2022 | 24/03/2022 | 14/03/2022 |

| | | | | | |
|---|---|---|---|---|---|

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|---|---|---|---|
| 212214 | | 19/05/2021 | Crickhowell GP Surgery - no areas of improvement identified |
| 212215 | 21119 | 14&15/12/2021 | HIW Announced Inspection of community mental health services |
| 212216 | | 23&24/11/21 | Cervical Screening Wales: visit to Brecon and Newtown on 23rd and 24th November 21 |
| 212217 | | 2021 | Welsh Risk Pool: All Wales Intrapartum Fetal Surveillance Standards |
| 212218 | | 16/11/2021 | HIW My Dentist Brecon - one minor amend to patient leaflet - completed |
| 212219 | | 20/12/2022 | HIW National Review of Patient Flow |
| 212220 | 21124 | 08/02/2022 | HIW Caereinion Medical Practice - no areas of improvement identified |
| 212221 | | 06&07/07/22 | HIW National Review of Patient Flow: Stroke Pathway Visit to Brecon Hospital |
| 212222 | 21049 | 08&09/03/22 | Unannouced HIW visit to Brecon Hospital MIU |

| Date of Update | Name of Person making update | PTHB Ref. No. | Regulators Reference | No of Inspection | Report Title | Inspection Date | Action or Recommendation Number | Responsible Director | Responsible Officer | Recommendation | Service Action | Agreed Deadline | Revised Deadline MUST BE AGREED WITH DIRECTOR | Status | If closed and not complete, please provide justification | Due | Progress being made to implement recommendation<br><br>Progress of work underway:<br>Barriers to implementation including and interdependencies:<br>How is the risk identified being mitigated pending implementation:<br>When will the implementation be achieved? | If action is complete, can evidence be provided upon request?<br>THIS MUST BE COMPLETED<br>Yes or no |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 04/08/2022 | Kate Evans | 212201 | | 1 | HIW National Maternity Improvement Plan 2021 Priorities | Mar-21 | 1 | DPCCMH | W&C Governance Lead | The health board must ensure that the Powys Midwives and Health Visitors receive Bereavement training to improve the quality and consistency of Bereavement support to be offered to Powys Families | 1.1<br>As part of the Women and Children's Bereavement Improvement group Stillbirth and Neonatal Death Society (SANDS) training has been arranged for 2021 for outstanding Midwives and Health Visitors | Oct-21 | | Partially complete | | Not yet due | SANDS training arrangements agreed with bespoke training package to enable TEAMS training for Midwives and Health Visitors . Charitable funds application ready and to be taken to Bereavement forum 13-04-2022. Will be offered over 3 sessions. Bereavement group agreed application. Will be forwarded and planned for winter 2022 due to staffing pressures | |
| 04/08/2022 | Kate Evans | 212201 | | 1 | HIW National Maternity Improvement Plan 2021 Priorities | Mar-21 | 2 | DPCCMH | W&C Governance Lead | | 1.2<br>Maternity and Health Visiting teams to also access all Wales Maternity and Neonatal network Bereavement training to scheduled for 2021 | Oct-21 | | Partially complete | | Not yet due | as above - joint training in development | |
| 05/08/2022 | Shelly Higgins | 212201 | | 1 | HIW National Maternity Improvement Plan 2021 Priorities | Mar-21 | 8 | DPCCMH | Consultant Midwife and Health Lifestyles Lead | The Health Board must ensure smoking cessation and healthier lifestyles are continued to reduce risk of stillbirth and improve the health and wellbeing of Powys families | 3.1<br>To review launch of Healthy Lifestyles Support Worker roles who will lead on smoking cessation support in pregnancy, Foodwise for Life, Foodwise for Pregnancy, buggy walks and healthy lifestyles advice and the 1st 1000 Days | Oct-21 | | Partially complete | | Not yet due | 2 additional funded posts due to commence w/c 3/5/2021, Foodwise and smoking cessation support already in post from existing Healthy Lifestyles Support Workers (HLSW), 3 programmes of Foodwise delivered with fourth due to start. Process for evaluation in place. Buggy walks now recommenced June 2021. 04/08/21 Healthy lifestyle workers liaising with multi-disciplinary team, including health visiting and midwifery colleagues, to increase service offer and work in collaboration with existing available services avoiding duplication and increasing access.<br>10/11/21<br>RCOG Covid 19 version 14 (August 2021) recommends that pregnant women shoudl be offered CO montioring. The requirements for a paper to the prevent and response committee for Powys midwifery and HV services to resume CO monitoring in line with evidence based practice has been highlighted with the Powys public health team. there is hesitancy due to going covid 19 prevleance dates for the suitability of resuming CO monitoring. Risk assessment tools for staff and client safety have been adapted by other health boards in Wales and will be included as part of the paper. The assessment tools have been discussed through joint midwifery and HV meetings with an implementation plan to support the reintrooution of CO monitoring.<br>15/02/22 - initial evaluation of the healthy lifestyles service has been completed. reports from Help Me Quit demonstrate that increased referrals are being accepted with the HLSW in comparison to with generic Help me quit team. validated quit rate is no different currently. funding for the posts have been confirmed for a further 12 months initially and posts will be going out to advert in March 2022 to ensure the work can continue, it is anticipated that we will have increased staff in post under a new title of Assistant Practitioners. CO monitoring re-introduction still requires review and plans. Update 11/04/2022 | |
| 05/08/2022 | Shelly Higgins | 212201 | | 1 | HIW National Maternity Improvement Plan 2021 Priorities | Mar-21 | 12 | DPCCMH | Powys Midwifery Management and Leadership team | The Health Board to support the implementation of full roll of Continuity of Care in Powys by 8 teams across Powys to commence in May 2021 and explore pathways with commissioned services to enhance continuity with obstetric colleagues to include named consultant for PTHB and use of virtual means such as Attend Anywhere. | 4.2<br>SaTH have confirmed an opportunity to established Named Obstetric arrangements with their planned implementation of Continuity of Care team | May-21 | | Partially complete | | Deadline Revised | SaTH engagement meeting 31st July remains positive for the concept for Named Obstetrician but awaiting further guidance from West Midlands network as part of Ockenden Assurance local improvements.<br>10/12/21<br>Quaterly DGH engagements have positive commitment from all health boards to agree named obstetrician arrangements as part of the implementation of Powys continuity of care models. Medical Director will be supporting developments of MDT working arrangements and interface with commissioned services. Paper to be developed early 2022. 31/5/22 work continues with DGH's to ensure there is named Obstetric lead for Powys women to ensure continuity of carer for Obstetric led women. 5/8/22 - no further formal progression of this work currently | |
| 05/08/2022 | Shelly Higgins | 212201 | | 1 | HIW National Maternity Improvement Plan 2021 Priorities | Mar-21 | 14 | DPCCMH | Powys Midwifery Management and Leadership team | | 4.4<br>To review Maternity Support worker role support to Continuity of Care teams as part of skill mix for Maternity services | May-21 | | | | Deadline Revised | Not started yet due to COVID19 and Operational pressures - Request Revised deadline for October 2021.<br>10/12/21<br>Not progressed - part of the maternity work plan for early 2022. 5-8-22 - no further progress in Powys currently - wider piece of All-Wales work currently underway for birth rate plus including exploration of support worker role | |
| | | 212201 | | 1 | HIW National Maternity Improvement Plan 2021 Priorities | Mar-21 | 15 | DoN | Director of Nursing and Midwifery | The Health Board to ensure the appropriate level of breastfeeding advice, guidance and support is provided at all times | To develop a business case to present to the Regional Partnership Board via Start Well Programme Board for the implementation Welsh Government Recommendation 4 for all Wales Breastfeeding Action Plan for Strategic Lead for Breastfeeding | Sep-21 | | | | Overdue | Powys Infant Feeding Steering group to delayed in resume in July to support implementation of Powys delivery of Infant Feeding Action Plan due to COVID19 and Operational pressures. Suggest revised deadline for December 2021.<br>10/12/21<br>Powys infant feeding action plan reviewed in readiness for Powys infant feeding group to resume. Programme of training for joint midwifery and HV two-day baby friendly initiative being held during Winter/Spring 21/22. 31.5.22 Infant feeding training offered by lead for IF - dates in calendar | |
| | | 212201 | | 1 | HIW National Maternity Improvement Plan 2021 Priorities | Mar-21 | 18 | DoN | Powys PNMH steering group | The Health Board to ensure the adequacy and availability of perinatal and postnatal mental health support for women | 6.3<br>Consider recommendations from the Dads study report and how these can be implemented in Powys | Powys Perinatal Mental Health 2021-22 Workplan | | Partially complete | | Not yet due | Evaluation plan in place and being led by interim specialist PNMH midwife. Remains on PNMH midwife work plan. 15/2/22 - substantive PNMH Specialist midwife now in 0.4WTE, specialist PNMH team in place and launch of service due early 2022 subject to finalisation of local pathways. confirmed funding of 7k to support implementation of Dads support - plans to consider tendering process in early 2022 to support possible peer support programme locally. update 8/4/22 - awaiting confirmation of availability fo ongoing menatl health transformation monies for 22/23 and whether 7k is still available for this year to proceed with tendering process for 3rd sector support for dads Pan Powys.<br>31.5.22 no further updates as yet | |
| 04/08/2022 | Kate Evans | 212201 | | 1 | HIW National Maternity Improvement Plan 2021 Priorities | Mar-21 | 24 | DPCCMH | Head of Midwifery and Sexual Health services | The Health Board to prepare for the timely implementation of a single maternity dashboard for Maternity services in Wales | 9.1<br>To link with Welsh Government to prepare for the implementation of a single maternity dashboard for Wales (Maternity Digital Cymru). The dashboard needs to work with commissioned services who are implementing Badgernet as their preferred Maternity system | Apr-21 | | Partially complete | | Deadline Revised | work is ongoing with Maternity and Neonatal Network to agree the dashboard requirements on an All Wales basis. Network to seek confirmation from WG about funding and when this can be expected. Scoping work due to report in Autumn 2021. Request revised deadline Dec 21.<br>10/12/21<br>Welsh government project commenced to support the implementation of digital maternity Cymru. Powys digital project board established in Nov 21 to oversee implementation for Powys. 31.5.22 W&CH actively involved in meetings to drive this agenda forward - awaiting update from All Wales perspective. 05.08.2022 all Wales project plan awaiting Ministerial approval | |
| 04/08/2022 | Kate Evans | 212201 | | 1 | HIW National Maternity Improvement Plan 2021 Priorities | Mar-21 | 25 | DPCCMH | Head of Midwifery and Sexual Health services | | 9.2<br>To use the WG resource for implementation to support Digital Midwife to help support with the implementation of a single maternity dashboard for Powys | May-21 | | Partially complete | | Deadline Revised | Digital Cymru Maternity Paper presented to NHS collaborative in June 2021. Powys implementation group to be formed in July 2021 with support of Assistant Director for Digital Transformation and W&C Project Manager. Will require Digital Midwife support for implementation.<br>10/12/21 - update as previous action 31.5.22 No further update as yet.<br>05.08.22 - Digital Midwife JD delayed with Job Evaluation process | |
| 29/07/2022 | Ruth Derrick | 212202 | | 2 | Tier 1 Quality Check: Clywedog Ward, Llandrindod Wells Hospital | 23/03/2021 | 1 | DPCCMH | Assistant Director Mental Health/ Learning Disabilities | The health board must provide HIW with assurance as to how the site can best meet the needs of these patient groups [functional and organic] in both the short term and longer term, specifically if the use of bays in accommodating patients with organic and functional needs fully promotes patient wellbeing and dignity. | Due to the Covid-19 pandemic, engagement on new models of inpatient services has been suspended. The mental health service will follow national guidance around the option of progressing this work until such time as it becomes possible to fully consult in a face to face manner with our communities, to consider the best way forward. Risks to service users are identified, assessed, managed, recorded and reviewed on an individual basis through the WARRN assessment. Necessary action is taken as quickly as possible to mitigate risks and safeguard the wellbeing of each individual patient. Care and Treatment Plan (CTP) Audit will identify the effectiveness of this. Wherever possible, we seek to separate patients with functional and organic needs from sharing accommodation within the same bay. | Workshop with stakeholders in the autumn of 2021 to produce bed configuration options including the potential for separating clinical needs for the benefit of patient care. 31st October 2021.<br><br>CTP Audit is annual next due: December – January 2022 | Oct-21 | | | Not yet due | Workshop with stakeholders planned for autumn of 2021 to produce bed configuration options including the potential for separating clinical needs for the benefit of patient care had to be put on hold due to COVID. Once COVID restrictions are lifted then this work will be progressed<br><br>CTP Audit took place in January 2022 and is annual and is next due: December – January 2023.<br>29.07.2022: Transformation workstream will commence in September 2022. | |
| | | 212207 | | | CIW Inspection of Cottage View | 03/06/2021 | 8 of 8 | DPCCMH | Responsible Individual | The registered provider has not ensured quality of care reviews are carried out every six months as required. | New template provided and reviews will be completed on 6 monthly basis. | January 31st 2022 | | Partially complete | | Overdue | | |
| 29/07/2022 | Ruth Derrick | 212208 | 21005 | | HIW Tier 1 Inspection Felindre Ward, Bronllys Hospital | 15-17/06/21 | 1 of 27 | DPCCMH | Ward Manager and Head of Mental Health Operational Services | The health board must ensure that the smoking room is replaced with a gym | The service will work with Estates to undertake any essential painting of the room. Gym equipment will be identified, ordered following an application to charitable funds and installed. We will set up a co-production focus group to oversee the development of the gym. The date for closure of the smoking room is September 2022, but the service has set a date of March 31st 2022 to complete this. | March 31st 2022 | | Partially complete | | Not yet due | 31.05.22 Funding in place for gym equipment. Smoking room is now closed. Action for next phase is to set up co-production development group and link with Brecon Leisure Centre contact for professional guidance on equipment and Health & Safety collegues. On target for completion. 29.07.2022:<br>The gym equipment has now been ordered. | |
| 29/07/2022 | Ruth Derrick | 212208 | 21005 | | HIW Tier 1 Inspection Felindre Ward, Bronllys Hospital | 15-17/06/21 | 4 of 27 | DPCCMH | Head of Estates and Head of Mental Health Operational Services | The health board must ensure that improvements are made to the environment to ensure patient have a level of privacy in bedroom areas | The two-bedded room is being separated into two rooms ensuring the privacy of all patients. This work is currently out to tender | March 31st 2022 | | Partially complete | | Not yet due | 31.05.22 Works has begun and is on track for completion September2022. | 29.07.2022: Work is continuing on site. |
| 29/07/2022 | Ruth Derrick | 212208 | 21005 | | HIW Tier 1 Inspection Felindre Ward, Bronllys Hospital | 15-17/06/21 | 5 of 27 | DPCCMH | Head of Estates and Head of Mental Health Operational Services | The health board must ensure that staff can check on the well-being of patients with minimal disruption | New Doors have been ordered and this work is currently out to tender for fitting | March 31st 2022 | | Partially complete | | Not yet due | 31.05.22 New doors programme is underway expected to finish September 22.<br>29.07.2022: Work is continuing on site. | |

| | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 212208 | 21005 | | HIW Tier 1 Inspection Felindre Ward, Bronllys Hospital | 15-17/06/21 | 11 of 27 | DPCCMH | Head of Mental Health Operational Services and Head of Estates | The health board must ensure that ward areas are freshly painted. | Decoration is undertaken on a rolling programme of maintenance | March 31st 2022 | | Partially complete | | Not yet due | 31.05.22 Redecoration work will be completed following door replacement programme. | |
| 29/07/2022 | Ruth Derrick | 212208 | 21005 | | HIW Tier 1 Inspection Felindre Ward, Bronllys Hospital | 15-17/06/21 | 19 of 27 | DPCCMH | Clinical Lead Quality and Safety | The health board must ensure that all policies are updated and reviewed | The service will engage with other service areas to progress the relevant out of date policies. We will undertake a review of all mental health policies to ensure the policy reviews are up to date | March 31st 2022 | | Partially complete | | Not yet due | 31.05.22 Service Group policy group implemented and met on October 2021 and includes a practitioner sub-group. programme for reviewing out of date policies is in place. 29.07.2022: Clinical Policy Review Group for service - TOR are currently out for consultation, due for SMT sign off 17th August 2022. | |
| | | 212208 | 21005 | | HIW Tier 1 Inspection Felindre Ward, Bronllys Hospital | 15-17/06/21 | 20 of 27 | DPCCMH | Clinical Lead Quality and Safety | The health board must ensure that there is a routine audit of policies to ensure that ward staff have access to, and are referring to, the most recent version. | The service will engage with other service areas to progress the relevant out of date policies. We will undertake a review of all mental health policies to ensure the policy reviews are up to date | March 31st 2022 | | Partially complete | | Not yet due | 31.05.22 MH P&P are broadly up to date. This recommendation in the main, referred to corporate / PTHB wide policies. As above. | |
| 29/07/2022 | Ruth Derrick | 212208 | 21005 | | HIW Tier 1 Inspection Felindre Ward, Bronllys Hospital | 15-17/06/21 | 27 of 27 | DPCCMH | Service Manager | The health board must ensure that mandatory training rates are improved. | Service Manager will undertake an audit and ensure that this is included in the new Ward Manager's induction programme. The health board target is 85% and the Felindre is currently reaching 82%. | November 30th 2021 | | Partially complete | | Deadline Revised | 31.05.22 Staff and Managers discuss S&M training in each 121. SMT review progress on PADR and S&M training compliance on a monthly basis. It should be noted that some of the training is currently difficult to access - where this is classroom/face to face, due to the current social distancing situation. Completion is effected by a number of new starters. Recovery plan in place. 29.07.2022: This is an ongoing challenge due to staff absences. Raised at Ops | |
| 29/07/2022 | Ruth Derrick | 212215 | 21119 | | Brecon Community Mental Health Team | | 1 of 55 | | Head of Mental Health Operations | The health board and local authority must continue with the work of refurbishing Ty Illtyd to improve access for people with mobility problems | Upgrade work at Ty Illtyd including anti-ligature and accessibility improvements is ongoing. The ligature risk review was evaluated in December 2021. Project Requestion documentation has been completed for improvements to car park at rear of premises. Building and environment upgrades are incorporated in a bespoke plan and monitored via monthly Mental Health and Estates meetings. | 31/05/2022 | | No progress | | Not yet due | 31.05.22 ongoing. 29.07.2022: Works have completed much of the improvements. The new disabled toilet is in place, however there is a part outstanding to facilitate full function. Towel and soap dispensers are outstanding at time of report. | |
| 29/07/2022 | Ruth Derrick | 212215 | 21119 | | Brecon Community Mental Health Team | | 2 of 55 | | Assistant Director MHLD | The Health Board and local authority review the provision of ADHD services and ensure that service users are assessed in a timely fashion and appropriately supported. | The Mental Health Service is preparing to recruit a new role of ADHD non-medical prescribers who will work under the supervision of a Consultant Psychiatrist and focus on the provision of ADHD assessments and post diagnostic support. | 30/09/2022 | | No progress | | Not yet due | 31.05.22 job is going through evaluation and then will be progressed through the recuitment process. 29.07.2022: The Job Description remains in Job Evaluation process. | |
| 10.08.2022 | Ruth Derrick | 212215 | 21119 | | Brecon Community Mental Health Team | | 3 of 55 | | Senior Social Work Practitioner | The Health Board and Local Authority must continue to review the workload of AMHPs and move forward with their recruitment plans. | Post inspection, we have doubled the AMHP numbers from 3 to 6 in the South of the County. This will support AMHP capacity. PCC have withdrawn from undertaking Duty. | Completed | | Partially complete | | Deadline Revised | Staffing changes are anticipated in the near future regarding ongoing recruitment and retention.31.05.22 10.08.22 Update from social care: all vacancies are covered with agency staff. | |
| 10.08.2022 | Ruth Derrick | 212215 | | | | | 4 of 55 | | Project Development Manager | | PTHB continues to work with Social Care to find solutions and mitigate impact on the duty system, associated work, seeking alternative solutions and pursuing and alternative sustainable model for delivery. Social Worker staffing changes (increased capacity) are anticipated soon regarding ongoing recruitment and retention. Social Worker staffing changes (increased capacity) are anticipated soon regarding ongoing recruitment and retention. | Recruitment will be ongoing as required. | | Partially complete | | Not yet due | PCC have introduced as £3000 market supplement recently to stabilise and maintain the AMHP work force. As above update from social care on 10.08.2022 | |
| 10.08.2022 | Ruth Derrick | 212215 | | | | | 5 of 55 | | Project Development Manager | | PTHB are part of NHS Wales developments focused on the Mental Health workforce strategy in line with national guidance. | 31/05/2022 | | Partially complete | | Not yet due | 10.08.2022: No further update at this time | |
| 29/07/2022 | Ruth Derrick | 212215 | | | | | 8 of 55 | | Head of Mental Health Operations | The Health Board and Local Authority must ensure that service users know how to access the out of hours service and how to contact the team in a crisis | The 111 (Single Point of Access) pilot commenced 26.02.2022 which will be evaluated. PTHB has also recirculated the process flow chart to all stakeholders in respect of access to the Crisis Resolution and Home Treatment Service. | 31/05/2022 | | Partially complete | | Not yet due | 31.05.22 Social services have written to their clients. 29.07.2022: PTHB have undertaken the review and the evaluation workshop was completed on 29.07.2022 to make key decisions. Next steps - November. | |
| | | 212215 | | | | | 9 of 55 | | Head of Nursing Quality and Safety | | All patients have an individual safety plan and written details of how to contact services out of hours. An action plan as an outcome of the National Review of Mental Health Crisis and Liaison Services is in progress. | 30/04/2022 | | Partially complete | | Not yet due | 31.05 HB hasve offered to be a pilot site for a programme of work regarding Person Centred Care that the delivery unit is providing | |
| 10.08.2022 | Ruth Derrick | 212215 | 21119 | | Brecon Community Mental Health Team | | 10 of 55 | | Senior Social Work Practitioner | The Health Board and local authority must explore why some service users told us that they have faced discrimination when accessing or using the service and ensure that this does not happen in future. | Social Care will ensure that equalities training is undertaken by all new team members. Within Social Care team meetings discrimination will be acknowledged in all forms as a particular focus for reflection for all team members. Discrimination will be discussed within the monthly case supervision process. World Social Work Day – as part of submission, social care provided anti-discrimination presentation given to staff | 31/03/2022 Team meetings and supervision action will remain open | | Partially complete | | Not yet due | Update 10.08.22 from social care: Anti- discrimination training is mandatory for staff. | |
| 10.08.2022 | Ruth Derrick | 212215 | | | | | 11 of 55 | | Service Manager Adult Mental Health | | PTHB will extend their work with Diverse Cymru and facilitate staff training. Patients raising specific issues when they feel they have been treated less fairly will have the opportunity to discuss their concerns with the manager, or a staff member independent of the service. | 30/09/2022 | | No progress | | Not yet due | Update 10.08.22: Meeting is scheduled between PTHB and Diverse Cymru for 26.08.2022 | |
| 29/07/2022 | Ruth Derrick | 212215 | 21119 | | Brecon Community Mental Health Team | | 18 of 55 | | Service Manager Adult Mental Health South Powys | The Health Board and Local Authority must ensure that the WCCIS electronic records management system is operating effectively, and that staff have unhindered access to service users' care notes in order to effectively plan and deliver care and support. | Challenges with the WCCIS system have been experienced across Wales. PTHB are stakeholders represented on the WCCIS Programme Board where problems with the system are escalated and resolution sought. It should be noted that since the last major upgrade (beginning of February 2022) the system has become far more stable. Both PCC and PTHB will continue to work with Welsh Government to peruse a pan-Wales effective client information system. Regular feedback and bulletins are provided to staff and regular senior meetings with suppliers held at a corporate and national level. Escalation to the Minister by Director of Social Services previously undertaken. Internal escalation processes currently in place which staff are aware of and utilise, (within the NHS this is raised through the DATIX system). This information is used to inform senior management team of the practice issue impact on client care. WCCIS issues are included in the service Risk Register, and this is reviewed monthly at Senior Management Team. | 31/05/2022 | | No progress | | Not yet due | 31.05.22 Social Care staff are advised to also identify risks on Personal Safety Register so enable access to all staff. Health Board Change Management Group has been put back in place to capture WCCIS system challenges and resolutions. | |
| 10.08.2022 | Ruth Derrick | 212215 | 21119 | | Brecon Community Mental Health Team | | 19 of 55 | | Social Care Manager Mental Health | The health board and local authority must continue with the development of integrated assessment documentation. | Social Care is working hard to ensure at a national level integrated assessment documentation reflects the Social Services and Wellbeing Act. The pandemic has hindered the progress on this work, the team are awaiting recommencement of national meetings. | Awaiting National Meetings progress | | No progress | | Not yet due | Update from social care 10.08.2022: There are no further National developments to report at this time. | |
| | | 212215 | | | | | 20 of 55 | | Head of MH Operations | | PTHB will work in partnership with the Local Authority regarding the development of integrated documentation, to ensure it is in line with the Care and Treatment Planning process. | As directed by national agenda | | No progress | | Not yet due | | |
| 10.08.2022 | Ruth Derrick | 212215 | 21119 | | Brecon Community Mental Health Team | | 21 of 55 | | Senior Social Work Practitioner | The Health Board and Local Authority must ensure that blank documents are deleted from the electronic system in order to prevent confusion. | All social care blank documents will be deleted as and when identified. | Ongoing data cleanse | | Partially complete | | Not yet due | Update 10.08.2022: This is part of normal practice now for both health and social care. | |
| 10.08.2022 | Ruth Derrick | 212215 | 21119 | | Brecon Community Mental Health Team | | 23 of 55 | | Project Development Manager; Head of Psychological Therapies; Head of MH Operations; Head of Nursing, Quality & Safety | The Health Board and Local Authority must explore ways to improve/enhance the involvement of psychiatry and psychology staff in the MDT care planning process. | MDT will pilot the 'Co-lead team basics' working approach facilitated by Workforce and Organisational Development This is a programme to address Joint Leadership across the service group and professional disciplines. This will commence in line with the pandemic safe management strategy. | 30/09/2022 | | No progress | | Not yet due | 31.05 Co-lead work is due to start in the CMHT's. Update 10.08.2022: Teamswithin MHLD have been identified. Discussions regarding the toolkit have taken place with Service Mananger. Plan to roll out Autumn. | |
| 10.08.2022 | Ruth Derrick | 212215 | 21119 | | Brecon Community Mental Health Team | | 24 of 55 | | Project Development Manager; Head of Psychological Therapies; Head of MH Operations; Head of Nursing, Quality & Safety | The Health Board and Local Authority must further explore and clarify clinical leadership. | MDT will pilot the 'Co-lead team basics' working approach facilitated by Workforce and Organisational Development This is a programme to address Joint Leadership across the service group and professional disciplines. This will commence in line with the pandemic safe management strategy. | 30/09/2022 | | No progress | | Not yet due | | |

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| 10.08.2022 | Ruth Derrick | 212215 | 21119 | | Brecon Community Mental Health Team | | 26 of 55 | | Senior Social Wor | The Health Board and Local Authority must explore GP engagement in the provision of service to ensure that service users have good access to holistic care. | Care Co-ordinators will continue to develop local relationships to ensure service users receive appropriate and proportionate primary care for physical and mental health needs. We will consistently share appropriate documentation with GPs. | Ongoing. 10.08.2022 upd | | Partially complete | | Not yet due | | |
| 29/07/2022 | Ruth Derrick | 212215 | 21119 | | Brecon Community Mental Health Team | | 28 of 55 | | Assistant Director MHLD/Head of Nursing, Quality & Safety | The Health Board and Local Authority must consider introducing regular health check clinics for service users. | Further development of the Clozapine Clinics to incorporate wider health screening is planned. A new medic will commence on 1/4/22 in a substantive post providing physical health monitoring sessions to the service. | Ongoing - to be reviewed 31/07/22 | | Partially complete | | Not yet due | 31.05.22 recommendation has been actioned, required resources are being sought and health clinics are being progressed in adult and older adult. 29.07.2022: Preparatory work has been undertaken by Consultant Psychiatrist lead and NMP. The will come together to develop a policy in the next quarter. | |
| 10.08.2022 | Ruth Derrick | 212215 | 21119 | | Brecon Community Mental Health Team | | 30 of 55 | | Head of Nursing, Quality & Safety | The Health Board and Local Authority must review the administrative support available to the Mental Health Act Administrator. | A workstream review is in progress focused on the role of Mental Health Act Administrator. Currently, there is support to this role from a Band 5 Administrator and Nurse Consultant | 30/04/2022 | | | | Not yet due | 31.05.22 Review took place. MHA administrator now comes under the Head of Nursing with direct support from Nurse Consultant. Update 10.08.2022: Implementaion is pending and job evaluation is in progress | |
| 10.08.2022 | Ruth Derrick | 212215 | 21119 | | Brecon Community Mental Health Team | | 31 of 55 | | Consultant Nurse | The Health Board and Local Authority must develop a more systematic approach to monitoring Mental Health Act compliance to ensure better governance and more effective quality improvement. | An anticipated outcome of the administrative workstream is to ensure the appropriate structure is in place to facilitate efficient and effective governance regarding the Mental Health Act compliance. | 31/05/2022 | | | | Not yet due | 10.08.22 as above | |
| 10.08.2022 | Ruth Derrick | 212215 | 21119 | | Brecon Community Mental Health Team | | 32 of 55 | | Senior Social Work Practitioner | The Health Board and Local Authority must ensure that the social circumstance reports reflected the service user's wishes and 'what matters' conversation. | Powys County Council (PCC) will work with the Improvement and Quality Assurance Manager to embed a WCCIS document for social circumstance reports. | 30/09/22 This is dependent on corporate capacity to support | | No progress | | Not yet due | This action sits with PCC. Update from social care on 10.08.2022 is that this is in place. | |
| 10.08.2022 | Ruth Derrick | 212215 | 21119 | | Brecon Community Mental Health Team | | 34 of 55 | | Senior Social Work Practitioner | The Health Board and Local Authority must ensure that the social circumstance report includes narrative around the nature of any ongoing risks and the views of other professionals | Social Care – see above action | 30/09/2022 | | No progress | | Not yet due | This action sits with PCC and is ongoing. | |
| 10.08.2022 | Ruth Derrick | 212215 | | | | | 35 of 55 | | PCC ICT WCCIC Lead | | We will replicate the Mental Health Wales Tribunal reports and templates within WCCIS. | 30/09/2022 | | No progress | | Not yet due | This action sits with PCC and is ongoing. Update 10.08.2022: Report templates are in development currently. | |
| 10.08.2022 | Ruth Derrick | 212215 | | | | | 36 of 55 | | Team Managers | | PTHB will await the outcome of PCC, as the lead on social circumstance reporting | 31/05/2022 | | Partially complete | | Not yet due | As above | |
| 10.08.2022 | Ruth Derrick | 212215 | 21119 | | Brecon Community Mental Health Team | | 37 of 55 | | Senior Social Work pratitioner | The Health Board and Local Authority must ensure that all relevant staff have access to Mental Health Act training. | Powys County Council provide Mental Health Act Training for staff facilitated by the Cheshire and Wirral Mental Health Partnership. This is a minimum of 18 hours p.a. for AMHPs. Health colleagues can share this training resource based on places available. | Training on-going subject to legal and CPD requirements. | | Partially complete | | Not yet due | This action sits with PCC. Update from social care 10.08.2022 is that this is in place and complete. | |
| 10.08.2022 | Ruth Derrick | 212215 | | | | | 38 of 55 | | Team Managers | | PTHB welcome the inclusion of training dates to be received from social care colleagues. | 30/09/2022 and ongoing | | | | Not yet due | As above. Update 10.08.2022: PTHB await available training dates to come through from PCC. | |
| 10.08.2022 | Ruth Derrick | 212215 | 21119 | | Brecon Community Mental Health Team | | 39 of 55 | | Assistant Director MHLD | The Health Board and Local Authority must take steps to ensure adequate Section 12 Approved Doctors cover. | The Health Board operates a Section 12 list and is seeking to recruit additional Section 12 Doctors to this list. | 30/09/2022 | | | | Not yet due | 31.05 ongoing. one new section 12 has joined the team. interviews planned in the next month for substantive older adult consultant. Update 10.08.2022: Medic recruitment continues. | |
| 10.08.2022 | Ruth Derrick | 212215 | 21119 | | Brecon Community Mental Health Team | | 42 of 55 | | Senior Social Work Practitioner<br><br>PCC ICT WCCIC lead | The Health Board and Local Authority must continue to ensure that the person centred and empowering approach to the provision of care and support is fully embedded across the service and that care documentation is amended to better capture and reflect service users' views on how they wish to be cared for. | Social Care are promoting strengths-based training which is mandatory for all workers. All current staff members in Brecon Social Services have completed the training. | As and when training is available for new staff | | | | Not yet due | This action sits with PCC. Update 10.08.2022 social care report that this action is complete. | |
| 10.08.2022 | Ruth Derrick | 212215 | | | | | 43 of 55 | | | | Care documentation will be reviewed. | 31/03/2023 | | | | | this action sits with PCC. Not yet due. | |
| 10.08.2022 | Ruth Derrick | 212215 | | | | | 49 of 55 | | Head of Operational Services/ Head of Nursing, Quality & Safety | PTHB continue to fully support the in-practice operation of the CMHT and welcomes any support from Social Care, when Welsh Government guidance to Social Care recognises issues of equity regarding expectations of health staff working in community settings | | As soon as possible | | Partially complete | | Not yet due | Discussions are ongoing with PCC. Update 10.08.2022: There is a meeting pending in September 2022. | |
| 10.08.2022 | Ruth Derrick | 212215 | 21119 | | Brecon Community Mental Health Team | | 50 of 55 | | Project Development Service Manager | The Health Board and Local Authority must review the availability of administration staff to support clinical staff. | PTHB will undertake a whole service review of the administrative functions within the next twelve months. | 31/03/2023 | | Partially complete | | Not yet due | 31.05.22 review has been undertaken. agreed outcomes being implemented over the next 6 months. Update 10.08.2022: progress continues with the next stage, an appointmet has been made and a start date is within the trac system currently | |
| 10.08.2022 | Ruth Derrick | 212215 | 21119 | | Brecon Community Mental Health Team | | 52 of 55 | | Senior Social Work Practitioner | The Health board and Local Authority must evaluate the service user comments in the various sections of this report, and responses to the questionnaire, and consider whether further improvements can be made to the provision of services. | Social Care always have regard to the expressed views and opinions of users of the service. We reflect on concerns to identify learning and whilst also taking time to celebrate compliments. This is an ongoing process but linked to our pre-existing skill base in terms of having "what matters" conversations. This translates into individualised service user support and planning. Regular audits are "on hold" due to business continuity but as part of the process we do contact service users for direct feedback. | To be discussed in team meetings 30/06/22 and ongoing for audits | | Partially complete | | Not yet due | This action sits with PCC. Update 10.08.2022: Social care report that there are mechanisms in palce and that the meetings are no longer on hold due to the pandemic. | |
| 04/08/2022 | Kate Evans | 212217 | N/A | N/A | All Wales Intrapartum Fetal Surveillance Standards | Field Work July and Aug 2021 | | DoN | Head of Midwifery and Sexual Health services | PTHB to review the document and produce an action plan to address the recommendations | Action plan in place and being worked towards - see appendix/embedded document with paper to committee. | Action Plan due in: 01/02/22 | | Partially complete | Deadline Revised | In progress - on schedule to submit reposnse by end of January. 11-04-2022 Update. Plan in place to have mandatory session for all midwives on second day of updates. This will include documentation in NCP, fetal surveillance and intrapartum care. 31.5.22 This has been actioned into mandatory updates. Once full year of updates completed and induction of new starters undertaken, we will provide assurance that all staff have been updated on fetal surveillance | | |
| 01.08.2022 | Claudia O'Shea | 212222 | 21049 | | Brecon War Memorial Hospital MIU | | 4 0f 43 | DPCCMH | Senior Manager Unscheduled Care | The health board should actively review patient concerns raised in relation to the limited availability of car parking at Brecon. | Common themes of car parking complaints to be identified alongside the quality and safety team. A new car park development is underway. This development is to be clearly displayed on an information board for all individuals accessing Brecon Hospital to reflect the health board's actions and plans. | 30/08/2022 | | Partially complete | | Not yet due | Car park due to be completed on the 1/10/22 - no complaints since inspection recieved. Confirmed with other heads of departments in H&S meeting 2/8/22 | Yes |
| 01.08.2022 | Claudia O'Shea | 212222 | 21049 | | | | 5 0f 43 | DPCCMH | Senior Manager Unscheduled Care | The health board should actively review patient concerns raised in relation to the limited availability of car parking at Brecon. | Completion of car park | 30/11/2022 | | Partially complete | | Not yet due | Car park due to be completed on the 1/10/22 | Yes |
| 01.08.2022 | Claudia O'Shea | 212222 | 21049 | | Brecon War Memorial Hospital MIU | 212222 | 8 0f 43 | DPCCMH | Assistant Director | Management should ensure information on Putting Things Right is made available to patients in MIU along with feedback forms to provide patients with an opportunity to provide an account of their healthcare experience. | Implementation of electronic feedback system to be included in the Minor Injury Unit. Information on 'Putting Things Right' has been made available in the department. As an interim measure until the electronic feedback system is in place, forms are placed more visibly in the waiting area with a sign to encourage completion and an explanation of what the Unit will do with the feedback. | 31/10/2022 | | Partially complete | | Not yet due | Box for adding in patient feedback much more visible within unit to encourage participation. Electronic systems due soon | yes |
| | | 212222 | 21049 | | Brecon War Memorial Hospital MIU | 212222 | 9 of 43 | DPCCMH | Assistant Director of Primary & Community Services. | The health board should ensure the Risk Management Framework is reviewed and updated | Risk management framework will be reviewed and updated | 31/08/2022 | | | | Not yet due | | yes |
| 01.08.2022 | Claudia O'Shea | 212222 | 21049 | | Brecon War Memorial Hospital MIU | 08&09/03/2022 | 10 0f 43 | DPCCMH | Team Lead MIU | MIU Team leaders should ensure they review patient feedback on a regular basis, and consider collating patient stories with a view to implement a listening and learning culture in the department. In turn, information should be made available in the waiting room in MIU to assure patients that the health board acknowledges their feedback, learns lessons and make improvements. | Re-establish a "Know how we are doing board" within the Unit which includes feedback from complaints/compliments and what the Unit and health board has done as a result.<br>Use feedback opportunities to request patient stories, share these on the board and also share in MIU Team Lead meetings on a monthly basis with greater detail and actions taken. The feedback to be via a electronic form or paper dependant on patient choice. | 31/07/2022 | | Partially complete | | Not yet due | Board ordered as new one needed. Data being collected and agreed in team leads on the 28/7/22. Feedback from complaints & compliments reviewed in each team leads (monthly) and minuted | yes |
| | | 212222 | 21049 | | Brecon War Memorial Hospital MIU | 08&09/03/2022 | 11 0f 43 | DPCCMH | Senior Manager Unscheduled Care | MIU Team leaders should ensure they review patient feedback on a regular basis, and consider collating patient stories with a view to implement a listening and learning culture in the department. In turn, information should be made available in the waiting room in MIU to assure patients that the health board acknowledges their | Use feedback opportunities to request patient stories, share these on the board and also share in MIU Team Lead meetings on a monthly basis with greater detail and actions taken. The feedback to be via a electronic form or paper dependant on patient choice. | 30/09/2022 | | | | Not yet due | | |
| | | 212222 | 21049 | | Brecon War Memorial Hospital MIU | 08&09/03/2022 | 15 0f 43 | DPCCMH | Assistant Director of Estates and Property | Doors to the rear of the unit should be assessed and action taken to prompt remedial work or replacement to protect the health and safety of patients and staff. | Assessed and reported to estates by minor injury unit team lead prior to inspection. Inspected by estates, new doors agreed. Awaiting arrival and fitting of doors. | 31/08/2022 | | Partially complete | | Not yet due | | |
| | | 212222 | 21049 | | Brecon War Memorial Hospital MIU | 08&09/03/2022 | 16 0f 43 | DPCCMH | Assistant Director of Estates and Property | Emergency bells to be fitted in all consultation rooms in MIU. | Assessed and reported to estates by minor injury unit team lead. Awaiting installation by estates team. | 31/08/2022 | | No progress | | Not yet due | | |
| 01.08.2022 | Claudia O'Shea | 212222 | 21049 | | Brecon War Memorial Hospital MIU | 08&09/03/2022 | 20 0f 43 | DPCCMH | Senior Nurse Infection Prevention and Control | SARS Covid-19 IPC corporate policy to be reviewed and updated. | Policy needs review and to be updated to reflect recent change in guidance | 31/08/2022 | | No progress | | Not yet due | IPC team reviewing policy, awaiting update. Delays due to structural changes | |

| Date of Update | Name of Person making update | PTHB Ref. No. | Regulators Reference | No of Inspection | Report Title | Inspection Date | 1 Of 43 | Responsible Director | Responsible Officer | Recommendation | Service Action | Agreed Deadline | Revised Deadline MUST BE AGREED WITH DIRECTOR | Status | If closed and not complete, please provide justification | Due | Progress being made to implement recommendation | If action is complete, can evidence be provided upon request? THIS MUST BE COMPLETED Yes or no |
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| Date of Update | Name of Person making update | PTHB Ref. No. | Report Title | Inspection Date | Date added to Tracker | Action Number | Director | Responsible Officer | Ref. | Recommendation | Service Action | Agreed Deadline | Revised Deadline | Status | If closed and not complete, please | Due | Progress being made to implement recommendation | | | | If action is complete, can evidence be provided upon | No. of months past agreed deadline |
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| | | | | | | | | | | | | | | | | | Progress of work underway | Barriers to implementation including any interdependencies | How is the risk identified being mitigated pending implementation? | When will implementation be achieved? | | |
| | | 192003 | Unannounced Mental Health Service Inspection (Clywedog Ward, Llandrindod) | 15,16 & 17/7/19 | | 2 of 23 | Director of PCCMH | Service Manager for OPMH | UMHSLL2 | The health board must provide additional storage space on the ward. | We will explore the option of having storage placed outside the for Older Persons months and if ward to allow for the additional storage this is a viable issue to be addressed, previously the use of an external shed had been explored and we will again look at this option. We will approach the estates manager and discuss the various options that are open to the ward, then obtain quotes and apply for funding to achieve the additional storage. Staff will continue to attempt limit the disruption that the lack of storage causes to patients and the delivery of safe effective care. They will risk assess the ward and place the surplus equipment, if appropriate in the large open corridor area.<br>This is a high priority service action and will be addressed as such. | Jul-20 | Aug-21 | Partially complete | NA | Deadline Revised | There has been no further progress due to the ongoing work on the Llandrindood site and the prioritisation of service and estates functions on covid specific matters.<br>Estates are working with MH to identify a solution, however this may be some time away due to works. | Prioritisation of service and estates functions on covid-19 specific matters. | Ward Manager and Service Manager continue to work with Estate to manage this risk while awaiting physical works to the building. | At this point in time a deadline for completion cannot be formulated due to physical works taking place on Llandrindod Hospital site. A peice of work is being undertaken by the Clinical Lead for Quality & Safety as part of a whole health board project on storage issues coming out of the POCT group. | Not at this time. | 9 |
| 20/07/2022 | jws | 192003 | Unannounced Mental Health Service Inspection (Clywedog Ward, Llandrindod) | 15,16 & 17/2019 | | 21 of 23 | Director of PCCMH | Assistant Director of Nursing/ Safeguarding | UMHSLL17 | The health board must ensure that sufficient resources are provided to facilitate the timely processing of DoLS referrals. | [Aligned with a recommendation arising from PTHB DoLS Internal Audit, PTHB will undertake a formal capacity and demand assessment to demonstrate<br>current shortfall in Best Interest Assessor (BIA) provision.<br>Funding to support existing trained BIAs working in other roles in PTHB to undertake additional hours to complete BIAs, is being explored. | Nov-19 | | Partially complete | NA | Overdue | Ths action sits outside of Mental Health services and is managed through the Safeguarding Team. A range of training has been implemented over the past six months to support ongoing development. A new DoLS sign off rota including senior managers from MH/LD is in place.<br>MH service is working with the Directorate of Nursing (who lead on DoLS) concerning a Powys wide approach to this issue. 14.06.2021 Business case for addition BIA resouces being prepared for submission in June 2021. July 2021 - business case submitted to IBG where the proposal was accepted to progress to Executives for a decision on options regarding BIA's and MCA Lead. | Resources within this area. Changes in legislation due 2021 which may create resource opportunities at a national level. | Cross service working as far as possible. | Awaiting new national guidance for Liberty Protection Safeguards.<br>July 2021 - awaiting outcome of Business case presesented to Executive Committee. Oct 2021 PTHB has agreed that BIA can be spot purchased when required to support the backlog, in addition to this we are awaiting the outcome of a bid for extra financial support from WG. 13.10.21 WG funded awarded enabling the HB to purchase external BIA assessments until March 2022<br>May 2022 Business Casewith options to be presented to Execs in June 22.<br>July 2022 the DoLs demand continues to exceed PTHBs capacity to satisfy it. Business case to be updated and presnetd to IBG | Yes | 6 |
| 26/07/2022 | Jacqui Seaton | 192006 | Unannounced Llewelyn Ward, Bronllys Hospital | 29-30/10/19 | 03/12/2020 | 11 of13 | Director of PCCMH | Ward Sister | LLW9 | The health board must produce a policy to support patient self-administration of medication. | The Medicines Management Team will ensure that the Medicines Policy includes an overarching statement relating to self-administration of medicines. The MMT will also ensure that the 'Policy for the self-administration of medicines', that was produced in 2017, is reviewed. Both policies will be taken through PTHB's governance processes and published during 2022 (it was hoped that the documents would be published before the end of 2020, but the COVID vaccination programme has resulted in a delay).<br><br>Staffing resources within the Medicines Management Team are hindering both policy development and preparation for supporting self administration across all PTHB sites. The executive team is aware of the challenges and meetings are being held during April 2022 to try to resolve the issues. | Mar-20 | Summer 2 | Partially complete | | Overdue | The PTHB Medicines Policy is currently going through a full revision process. The policy will include an overarching policy statement relating to self-administration.<br>The Medicines Management Team is also in the process of reviewing the 'Policy for the self-administration of medicines' that was produced in 2017. Both policies will be taken through PTHB's governance processes and published during 2022 | The wider medicines managemet team had not been sighted on the HIW report. The Head of Pharmacy left the organisation at the end of July 2020 and the new Chief Pharmacist (recruited May 2020) only became aware of the report when asked to update this HIW tracker. | Self-administration is not currently taking place within any PTHB community hospitals. If , in advance of the updated policies being approved, individual patients are identified that would benefit from self-administration to support the discharge process, medicines management support will be provided and a safe and secure system put in place to support the individual patient and staff members (under the guidance of the 2017 policy). | July 21. The timeline for the medicines policy has been pushed back due to the committment to the vaccination programme. A new deadline of 30th September has been set<br><br>Nov 21 The Medicine Management Team's involvement in the LHBs reponse to the COVID-19 pandemic continues to hinder progress on policy development/reviews. In the absence of a policy, the team will continue to support patients who need to self administer and aim to get a health board wide policy/guideline in place by Mid 2022.<br><br>March 2022 As above (Nov 2021) with the added challenge of staff shortages. We do however aim to get a healthbaord wide police/guideline in place by mid-2022.<br><br>July 2022. Medicines Policy, including an overarching statement about self-administration is on track for publication by the end of August 2022. The policy on self-administration will be updated will be revised and published by the end of September 2022. | | M |
| 04/08/2022 | kate evans | 192007 | Birth Centres (Free Standing Midwifery Led Unit), Across Powys | 10-14/01/20 | 03/12/2020 | 7 of 9 | Director of Nursing & Midwifery | W&C Governance Lead<br>Assistant Head of Midwifery and Sexual Health<br><br>Resuscitation committee<br><br>Head of Clinical Education Resuscitation Committee<br><br>Assistant Director Quality & Safety | BCP2 | The health board must ensure that a review of the facilities within Llanidloes War Memorial Hospital and Knighton Hospital takes place to ensure that infection prevention and control measures are in line with health board policy. | Maternity services are working in partnership with Capital Estates for review of Llanidloes War Memorial Hospital and Knighton Hospital to improve facilities for the environment. Plans for Phase 1 (redecoration), 2 (bathroom improvement) and 3 (Pool Hoist insertion and Double Bed) have been developed for Knighton Birth Centre).<br>Llanidloes Birth Centre improvement plan to be developed on completion of Welshpool and Knighton project plans. Plans slightly delayed due COVID19 pressures but will be scheduled to be progress in Q1 (April - June 2021) | Mar-21 | | Partially complete | | Overdue | Knighton programme of work commenced with phase 1 completed. Costings have been prepared for Capital Estates for Phase 2 and 3 (scheduled to be completed March 2021). Scope of work to be developed for Llanidloes Birth Centre By end of April 2021. UPDATE - project request submitted to capital control on 2/6/21, which was approved for refurbishment. Project team will now scope the work and provide costs for Llanidloes. Knighton project has been scoped and costed and we are in the process of approaching the league of friends for support with funding.<br><br>10/12/21<br>Maternity Services are working in partnership with capital estates for reivew of Llanidloes War Memorial Hospital to improve factilities for the environment. Plans for Phase 1 (redecoration), 2 (bathroom improvement), and 3 (pool hoist insertion and double bed) have been developed for Knighton birth centre.<br><br>Llanidloes birth centre improvement plan is being developed with the capital estates team and fudning in discussion with league of friends. Plans have been slightly delayed due to Covid 19 pressures have been progressed in Q2 (Sept/Dec 2021).<br><br>November update - league of friends letter and presentation provided for Llanidloes birth centre improvement. CEO commitment to 100K capital investment. 8/4/22 - follow up meeting has occured with capital/estates - plans reviewed. list of requirements completed for whole unit to future proof the space for office, group work, antenatal contacts as well as labour care. 04/05/22 - meetings to scope the work which is scheduled to commence in the Summer of 2022 (revised timescales). Negotiation continues to ensure work is planned appropriately to utilise the space to full potential | Interdependencies for progressing the work is based on Capital Control programme of work and agreement for League of Friend funding for both Knighton and Llanidloes | | Completion TBC by capital estates work plan The Llanidloes / Knighton Birth Centre upgrades as per HIW recommendations are being reported correctly as overdue / incomplete | | |
| 4.8.22 | Mary Cottrill | 192009 | HIW Review of Healthcare Servcies for Young People | 29/03/2019 | Apr-21 | 11 of 37 | DPCCMH | Head of Children's Public Health Nursing and Paediatric services/Unscheduled Care manager/Scheduled care manager | | Health boards must ensure that children and young people can consistently be treated within designated areas. | Reviewed October 2020 and assessed as **in progress** based on the following evidence:<br>•PTHB has 2 dedicated Children's Centres, one in Brecon and one in Newtown where most children are treated<br>•The community hospitals also hold children's outpatients which are child friendly areas but are not designated children's areas<br>•MIUs have a child friendly treatment room but not waiting areas<br>Action required:<br>•Post Covid19, PTHB will scope outpatient and MIU waiting areas with the aim of creating a child friendly waiting area. | Apr-21 | | Partially complete | | Overdue | We will be moitioring the agreed action closely as we move out of c.19.<br>15.06.21 - new team in post, will provide full update for next round of updates. Remains amber at the moment.<br>29.6.21 Discussed at W and C senior leadership meeting- Outpatient and MIU managers to be contacted by MC to establish if the scope for the outstanding action has been commenced. 29.9.21 MC has made contact with OPD and MIU managers- scope has not already been commenced therefore this work needs to be progressed- meeting to be arranged. 13.12.21 email contact with unscheduled and scheduled care managers- gathering information on sites. 04/05/22 •A meeting is being held between the Head of Children's Nursing and Public Health Nursing and the Scheduled Care Manager on the 6th may to progress the action.<br>01/06/22 meeting held on 4th May. Clinic mapping work required. Further meetings to be held once mapping work complete. Unable to quantify time scale at prensent due the amount of work required. 4.8.22 discussion on adult OPD environment with scheduled care managers held, considertaion to move some OPD clinics to chidrens centres- currently being reviewed re capacity and staffing. No enagement from unscheduled care in review - further contact to be made. | | | | | |

| Date of Update | Name of Person making update | PTHB Ref. No. | Report Title | Inspection Date | Date added to Tracker | Action Number | Director | Responsible Officer | Ref. | Recommendation | Service Action | Agreed Deadline | Revised Deadline | Status | If closed and not complete, please | Due | Progress being made to implement recommendation | If action is complete, can evidence be provided upon | No. of months past agreed deadline |
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| | | 192009 | HIW Review of Healthcare Servcies for Young People | 29/03/2019 | Apr-21 | 22 of 37 | DPCCMH | Senior Nurse for CHC | | Health boards must ensure there are robust systems to monitor transition policies and pathways across healthcare services to ensure approaches are effective. | Reviewed October 2020 and assessed as **in progress** based on the following evidence:<br>•In relation to transitions for complex care, adult and children teams are currently working together to ensure operating procedures around transition are aligned. The process of transition is being incorporated into the Adult Continuing Health Care (CHC) Standard Operating Procedures<br>Action required:<br>•Completion of Adult CHC Standard Operating Procedures | Dec-20 | | Partially complete | | Overdue | 01.06.22 Work under way | | |
| 4.8.22 | mary Cott | 192009 | HIW Review of Healthcare Servcies for Young People | 29/03/2019 | Apr-21 | 25 of 37 | DPCCMH | Assistant Head of Children's Nursing | | Health boards must ensure they have a formal systems for involving young people in the design and delivery of transition processes and learn from their experiences. | Reviewed October 2020 and assessed as **in progress** based on the following evidence:<br>•PTHB are engaged with Powys County Council (PCC) to review the experience of transition for young people on a multi-agency basis. This has been suspended during the Covid19 pandemic<br>Action required:<br>•The HB will re-engage with PCC when this work is re-commenced | Apr-21 | | Partially complete | | Overdue | Work under way 4.8.22 engagement with PCC has recommenced to progress this work.<br>Progress will be fed into start well board. | | |

| PTHB Ref. No. | Report Title | Inspection Date | Date added to Tracker | Action Number | Director | Responsible Officer | Ref. | Recommendation | Service Action | Agreed Deadline | Revised Deadline | Status | If closed and not complete, | Due | Progress being made to implement recommendation | If action is complete, can evidence be provided upon request? | No. of months past agreed deadline | Reporting Date |
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| PTHB Ref. No. | | Report Title | Director | Responsible Officer | Ref. | Recommendation | Service Action | Agreed Deadline | Status | Due | Update on progress being made to implement recommendations / Closing position | Reporting Date | No. of months past agreed deadline |
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| 171801 | 1 | General Practice Inspections (Crickhowell War Memorial) | | Practice Manager | CRWM1 | The practice must ensure that all staff are fully aware as to where to obtain information in relation to the All Wales Child Protection Policy.Health and Care Standard 2.7* All relevant staff should have disclosure and barring service (DBS) check. * | Revise all safeguarding practices and information in the next staff / training session. Next PLT is scheduled for June 28th this will be added to the agenda.<br>We will add the safeguarding pathway to the notice board in the reception area. | Jun-17 | No progress | Overdue | | Aug-19 | 26 |
| 171801 | 1 | General Practice Inspections (Crickhowell War Memorial) | | Office Manager | CRWM2 | Practices should ensure they have considered their obligations in meeting the Welsh and other language needs of patients.Health and Care Standard 3.2 Improvements required in relation to the utilisation of the Welsh languange resources / provisions. ** Welsh language provision. | We will ensure that there are more booklets and leaflets in Welsh, we have programmed the automated booking in system to offer Welsh or English | Apr-17 | No progress | Overdue | | Aug-19 | 28 |
| 171801 | 1 | General Practice Inspections (Crickhowell War Memorial) | | Practice Manager | CRWM3 | Crickhowell War memorial Health Centre and Brecon Medical Group Practice -* There was not enough privacy for patients to have private discussion. * Practices must ensure patients are able to tell health services about the care they receive, and make improvements.Health and Care Standard 6.3 | Reorganise the consulting rooms so that the consulting area is away from the door.<br>Move the reception radio to the wall between the consulting room<br>We have met with the builder and agreed to upgrade the doors to provide enhanced sound proofing.<br>Review reception floor plan to look at seating plan alternatives | Sep-17 | No progress | Overdue | | Aug-19 | 23 |
| 171801 | 1 | General Practice Inspections (Crickhowell War Memorial) | | Practice Manager Dr Paton | CRWM4 | Focus Task Group meeting minutes should be made freely available to the public. 6.3 Listening and Learning from feedback | We will add this to the agenda in the next focus group meeting. Possible options include: Sign post the service in the Crickhowell news / reception notice board / prescription scripts. Publish the meeting minutes on practice website and / or hold copies in the reception area. The focus group will can also use its resources to circulate to the public. | Jul-17 | No progress | Overdue | | Aug-19 | 25 |
| 171801 | 1 | General Practice Inspections (Crickhowell War Memorial) | | Data Manager | CRWM5 | The practice is required to inform HIW on how it intends to provide feedback to patients in a consistent and proactive manner. | We will create a feedback section on our internet page where we will publish news and updates on common concerns and patient surveys. This can be updated as and when or on a quarterly update. Data | Jun-17 | No progress | Overdue | | Aug-19 | 26 |
| 171801 | 1 | General Practice Inspections (Crickhowell War Memorial) | | Office Manager | CRWM6 | All relevant staff should have disclosure and barring service (DBS) check. * | All clinical staff have had a full enhanced DBS. The health board cannot supply any documentation that requires reception and admin staff to be DBS checked The practice policy from March 2016 has been that all new members of staff will undergo a DBS check including reception and administrative staff. We will document a practice policy to ensure reception and admin staff that have not been DBS checked are not called for as chaperones and are not left alone with patients. This will be risk assessed on an annual basis. | Jun-17 | No progress | Overdue | | Aug-19 | 26 |
| 171801 | 1 | General Practice Inspections (Crickhowell War Memorial) | | Practice Manager and Office Manager | CRWM7 | The practice must ensure that all staff receive an annual appraisal. | The practice has always given annual appraisals to all staff. In 2016 our office manager resigned before completing this task and the Practice Manager was not able to cover all the work required. This resulted in some members of staff missing their annual review We now have a full complement of management staff and the annual appraisal policy will be resumed for all staff | Jul-17 | No progress | Overdue | | Aug-19 | 25 |
| 171802 | 2 | General Practice Inspections (Brecon Medical Group Practice) | | Management Team | BRMGP1 | Patients must be made aware that they can have confidential discussions with reception staff in a room away from the reception area in accordance with their wishes. | Information will made available to the practice population to indicate that if a patient wishes to speak to someone regarding a confidential matter measures will be undertaken to do so in a quiet area. Staff training will be made available regarding this and included in the induction procedures.<br>This will be publicised via our: Webmedia screens, Website/practice leaflet | Jul-17 | No progress | Overdue | | Aug-19 | 25 |
| 171802 | 2 | General Practice Inspections (Brecon Medical Group Practice) | | Senior Partner | BRMGP2 | The practice must inform HIW how it intends to ensure the privacy and dignity of patients utilising the treatment room. | The practice will look to review the access to the clinical area. An option of review is the current appointment system and clinical space is an issue and is causing difficulty to provide segregated care. | On Going | No progress | Overdue | | Aug-19 | #VALUE! |

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| 171802 | 2 | General Practice Inspections (Brecon Medical Group Practice) | | Management Team | BRMGP3 | The practice must evaluate the current lunch time procedure, whereby all in-coming telephone calls were received at the main reception desk. | The practice has recently installed a “telephone recording system”. This gives the practice the ability to review the number and nature of the calls during the lunchtime period. This will enable us to adopt an appropriate solution, which may include, additional resourcing to enable calls to be handled elsewhere or further training to ensure confidentiality in that area. | Sep-17 | No progress | Overdue | | Aug-19 | 23 |
| 171802 | 2 | General Practice Inspections (Brecon Medical Group Practice) | | Management Team | BRMGP4 | All clinical and reception staff must be proficient in the use of the hearing aid loop system. | Update training awareness sessions will be scheduled for in-house training annually for all administration team members, which will include proficiency in use of equipment to assist patient services. | Jun-17 | No progress | Overdue | | Aug-19 | 26 |
| 171802 | 2 | General Practice Inspections (Brecon Medical Group Practice) | | Practice Team | BRMGP5 | The practice must ensure that information available in the Welsh language receives the same weight and level of attention as that of the English language | The practice will endeavour to seek information in alternative languages to assist signposting services | On Going | No progress | Overdue | | Aug-19 | #VALUE! |
| 171802 | 2 | General Practice Inspections (Brecon Medical Group Practice) | | Practice Team | BRMGP6 | The practice must develop a system of providing formal feedback to all patients of the practice in relation to comments/suggestions received and actions delivered as a consequence of the feedback received. | Currently responses are provided to individuals directly as deemed appropriate. The practice will develop such responses so that they are routinely provided to individuals and collectively where appropriate using the recently installed media screens in the practice waiting areas, practice web site and via the Patient Participation Group. | On Going | No progress | Overdue | | Aug-19 | #VALUE! |
| 171802 | 2 | General Practice Inspections (Brecon Medical Group Practice) | | Management Team | BRMGP7 | The practice must ensure that all appropriate staff receive infection prevention and control training in a timely manner | All health care professional and staff providing clinical care must undertake level II infection prevention training via e learning each year. All non clinical staff must undertake Level I infection prevention training via e learning annually. The practice will also participate in training arranged for primary care through the local health board.<br>A schedule of training is maintained, will be monitored and action will be taken to ensure that minimum training is up to date at all times. | On going | No progress | Overdue | | Aug-19 | #VALUE! |
| 171802 | 2 | General Practice Inspections (Brecon Medical Group Practice) | | Operational Manager | BRMGP8 | The practice must ensure that rooms used to store medication are checked daily in order to ensure that the temperature does not exceed 25C. | Room temperature gauge placed in the room and Standard Operating Procedure to be written by the team to enable monitoring and auditing. | Jul-17 | No progress | Overdue | | Aug-19 | 25 |
| 171802 | 2 | General Practice Inspections (Brecon Medical Group Practice) | | GP Partners, Practice Management & Team Leaders | BRMGP9 | The practice must ensure that all policies and procedures are reviewed in accordance within the designated timescales identified on each specific document. | A schedule for reviews has been agreed with Management Team & Lead GPs.<br>Complete portfolio of policies and procedures to be accessible centrally and reviewed in accordance with the designated timescale. | | No progress | Overdue | | Aug-19 | 1435 |
| 171802 | 2 | General Practice Inspections (Brecon Medical Group Practice) | | GPs | BRMGP10 | The service must ensure that GPs consultations with patients are documented in patient's records in a comprehensive and robust manner. | The practice is moving towards a more uniform clinical template driven approach to record keeping. | Annually | No progress | Overdue | | Aug-19 | #VALUE! |
| 171802 | 2 | General Practice Inspections (Brecon Medical Group Practice) | | Management Team & Team Leaders | BRMGP11 | The practice is required to describe the action to be taken in order to address the absence of staff (DSE) health and safety risk assessments. | All new employees are required to undertake an assessment as part of their induction. All current employees will have valid assessments by the 16th June. A schedule of assessments will be maintained and updated regularly to ensure compliance with H&S regulation | Jun-17 | No progress | Overdue | | Aug-19 | 26 |
| 171804 | 3 | General Practice Inspection (Wylcwm Surgery, Knighton) | | Juliet Tyler | GPK1 | People attending the practice should be informed of the opportunity to ‘check in’ or have private discussions at the alternate area to the side of the main reception desk should they wish. | A notice for Private discussions to take place at the side window is displayed at the front desk and can be reiterated by reception staff | Mar-17 | No progress | Overdue | | Aug-19 | 29 |
| 171804 | 3 | General Practice Inspection (Wylcwm Surgery, Knighton) | | Juliet Tyler | GPK2 | The practice must look at developing a system whereby all feedback regarding the surgery is monitored and reported upon on a regular basis. | A questionnaire has been compiled by the PPG. Data analysis will take place after completion.<br>Comments/suggestions to be reviewed monthly and feedback either by the website/waiting room or PPG. | Apr-17 | No progress | Overdue | | Aug-19 | 28 |

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| 171804 | 3 | General Practice Inspection (Wylcwm Surgery, Knighton) | | Juliet Tyler | GPK3 | The surgery must ensure that access issues into the building are carefully evaluated and improved. In addition the surgery must review the disabled parking provision provided. | Re visit the quote for automatic doors and levelling of the entrance, PPG already looking at funding (a letter has been drafted for Boots the chemist).<br>Re visit quote for the remarking of the car park, to include the disabled parking. | Jun-17 | No progress | Overdue | | Aug-19 | 26 |
| 171804 | 3 | General Practice Inspection (Wylcwm Surgery, Knighton) | | Juliet Tyler | GPK4 | The surgery must ensure that there is a full up to date list of all health and safety policies and procedures in place that covers all mandatory areas and that all risk assessments are completed and re-evaluated in a timely manner. | A site visit has been carried out by Citation H&S advisor. We now have a structure in place to cover all H&S aspects.<br>Fire Risk assessment is booked for 21st March 2017, to also include staff fire training. | Mar-17 | No progress | Overdue | | Aug-19 | 28 |
| 171804 | 3 | General Practice Inspection (Wylcwm Surgery, Knighton) | | Juliet Tyler/ Dr Kliff/ DrLempert | GPK5 | The surgery should review all policies and procedures and ensure that all have the correct version and revision dates clearly identified | Currently being reviewed and updated alongside Citation H&S and HR departments.<br>Clinical policy and procedure are also under review. | Jul-17 | No progress | Overdue | | Aug-19 | 24 |
| 171804 | 3 | General Practice Inspection (Wylcwm Surgery, Knighton) | | Juliet Tyler | GPK6 | The surgery must ensure that all staff received mandatory training and role specific training in a timely manner and that records of training courses are maintained accurately | Blue stream online training has commenced. A spreadsheet will be developed in order to record them. | May-17 | No progress | Overdue | | Aug-19 | 26 |
| 171804 | 3 | General Practice Inspection (Wylcwm Surgery, Knighton) | | Juliet Tyler | GPK7 | The surgery must ensure that all staff receive an annual appraisal and additional support sessions as necessary. | The 1st staff appraisal is to take place on 6th March 2017. This will include looking at job description, contracts and PDP. | Jul-17 | No progress | Overdue | | Aug-19 | 24 |
| 171805 | 3 | General Practice Inspection (Wylcwm Surgery, Knighton) | | Practice Manager | GPLW1 | The practice is to ensure that the information available in the Welsh language receives the same weight and level of attention as that of the English language. | 1. The Practice will ensure that key documents given to patients :<br>- Practice Leaflet<br>- "How we use your information"<br>- Patient Charter<br>are translated into Welsh.<br>2. Every effort will be made to ensure that posters and leaflets in Welsh are sited next to the English versions.<br>3. Explore opportunities to add Welsh presentations on the Jayex screens in the waiting room.<br>4. Enlist help of translation services to ensure signage is available in both English and Welsh. | Apr-17 | No progress | Overdue | | Aug-19 | 28 |
| 171805 | 4 | General Practice Inspection (Llandrindod Wells Medical Practice) | | Practice Manager / Office Manager | GPLW2 | The practice must ensure that there is clear information available throughout the practice identifying how patients / relatives can raise a concern / complaint. | 1. More signs to be displayed in both English and Welsh in the Reception area and at other key positions in the building informing patients how to raise any concerns .<br>2. Leaflets to be freely available and on display at the Reception desk explaining the Complaints Procedure.<br>3. Will ask translation services to provide a Welsh version of the Complaints leaflet<br>4. Move the complaints box to a more visible position with good signage. | May-17 | No progress | Overdue | | Aug-19 | 26 |
| 171805 | 4 | General Practice Inspection (Llandrindod Wells Medical Practice) | | Practice Manager | GPLW3 | The practice must ensure that the room which stores the patient's records is always securely locked in order to prevent any data protection breaches. | Arrangements being made to have a key code entry system to the back door to Reception. | Apr-17 | No progress | Overdue | | Aug-19 | 28 |
| 171805 | 4 | General Practice Inspection (Llandrindod Wells Medical Practice) | | Practice Manager | GPLW4 | The practice should ensure that regular reports of the comments / suggestions received and the actions resulting of these comments are reported back to the practices patients in a formal and timely manner. | The results of patient surveys, will in future, be displayed in the waiting room and on the Practice website. | May-17 | No progress | Overdue | | Aug-19 | 26 |

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| 171805 | 4 | General Practice Inspection (Llandrindod Wells Medical Practice) | | Practice Manager | GPLW5 | The practice should ensure that all staff files are up to date and include all employment details such as signed contracts of employment and that training of all staff is undertaken in a timely manner. | All staff information to be available in the staff members file and completed within appropriate timescales. Training attended and training plans will continue to be kept in the main file as inspected by HIW.<br>Importance of providing Certificates for training attended to be highlighted with staff to ensure they are credited for their participation in training.<br>All training certificates to be checked against record of staff attending events to ensure that proof of attendance is available. | May-19 | No progress | Overdue | | Aug-19 | 3 |
| 171806 | 5 | General Practice Inspection (Builth Wells Medical Practice) | | Gill Hodgetts | GPBW1 | The practice is to ensure that Welsh receives the same level of attention as that of the English language. | We have made a request to interpreter services to translate our key leaflets.<br>We use bilingual posters when they are provided | Jul-19 | No progress | Overdue | | Aug-19 | 1 |
| 171805 | 5 | General Practice Inspection (Builth Wells Medical Practice) | | Jane Stephens/Dr Walters | GPBW2 | The practice is to review how it evaluates the service provided and how feedback can be provided to the patients of the practice. | We do use twitter and facebook. In the past we have used a paper newsletter when information has needed to be cascaded and this will continue. The practice regularly receives feedback either through the concerns process or friends and family , these are discussed at an annual review meeting with the GPs and following our review we will in future provide an annual bulleting showing themes and actions that we have taken to date as well as ones that are outside or our control. This will be cascaded as above. | Jan-18 | No progress | Overdue | | Aug-19 | 19 |
| 171805 | 5 | General Practice Inspection (Builth Wells Medical Practice) | | Dr/Nurse Team | GPBW3 | The practice must ensure that all hazardous specimen pots and cleaning products are stored securely at all times. | Nurses have moved the pots to more secure storage - a formal discussion to agree working arrangements for this and no. 15 below is being arranged | Aug-17 | No progress | Overdue | | Aug-19 | 24 |
| 171805 | 5 | General Practice Inspection (Builth Wells Medical Practice) | | Jane Stephens | GPBW4 | The practice must ensure that all wash hand basins have liquid soap available and that any loose tiles are replaced in a timely manner to reduce infection risks. | Builder has been in and added to his schedule | May-17 | No progress | Overdue | | Aug-19 | 27 |
| 171805 | 5 | General Practice Inspection (Builth Wells Medical Practice) | | Dr/Nurse Team | GPBW5 | he practice is to ensure that fridges containing medication are locked when not being used and keys kept secure. | a formal discussion to agree working arrangements for this and no. 15 below is being arranged | Aug-17 | No progress | Overdue | | Aug-19 | 24 |
| 171806 | 6 | General Practice Inspection (Rhayader Surgery) | | Jane Jones | GPRH1 | The practice should evaluate the present domestic door bell available at the entrance to the practice as it can potentially be difficult for people with fine motor function difficulty to engage and summon help. | The practice will try and purchase a larger doorbell suitable for all patients. | Dec-17 | No progress | Overdue | | Aug-19 | 20 |
| 171806 | 7 | General Practice Inspection (Builth Wells Medical Practice) | | Jane Jones | GPRH2 | The practice should evaluate and implement a system whereby it is clear to identify if recalled patients have attended their appointments. | The practice will implement a task process so that a member of staff can check that patients have attended their follow up appointment with the Dr. | Dec-17 | No progress | Overdue | | Aug-19 | 20 |
| 171806 | 7 | General Practice Inspection (Builth Wells Medical Practice) | | Jane Jones | GPRH3 | The practice must ensure that Welsh language information and notices receive the same level of attention as that of the English language. | The practice will ensure that all advertising material provided in Welsh is put on display. | Dec-17 | No progress | Overdue | | Aug-19 | 20 |
| 171806 | 7 | General Practice Inspection (Builth Wells Medical Practice) | | Jane Jones | GPRH4 | The practice should develop and implement a formal process for providing feedback to patients. A consideration of patients' surveys and the creation of a patient participation group should also be evaluated as excellent methods of facilitating feedback on the service provision provided by the practice. | The notice board in the porch will be the Patient Information Notice Board, this will provide information regarding purchases of Equipment bought through the Equipment Fund, and any new services such as Urgent Care Practitioners and Telemedicine. | Dec-17 | No progress | Overdue | | Aug-19 | 20 |
| 171806 | 7 | General Practice Inspection (Builth Wells Medical Practice) | | Jane Jones | GPRH5 | All staff using display screen equipment for many hours during each working day must receive a comprehensive display screen risk assessments. | Carry out up to date risk assessments for all staff using display screen equipment. | Dec-17 | No progress | Overdue | | Aug-19 | 20 |

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| 171806 | 7 | General Practice Inspection (Builth Wells Medical Practice) | | Jane Jones | GPRH6 | All bins in toilets must be foot operated. | Purchase new pedal bin for the patients toilet. | Dec-17 | No progress | Overdue | | Aug-19 | 20 |
| 171806 | 7 | General Practice Inspection (Builth Wells Medical Practice) | | Jane Jones | GPRH7 | All medication must be stored and secured in a safe and appropriate manner. | Remove B12 and Contraceptive Injections from current place and move to lockable safe in reception | Dec-17 | No progress | Overdue | | Aug-19 | 20 |
| 171806 | 7 | General Practice Inspection (Builth Wells Medical Practice) | | Jane Jones | GPRH8 | All fridges must be locked and the keys stored securely when not being used or supervised. | Discuss at Practice Meeting. Ask Nurse/Health Care Assistant to lock their fridges at the end of their shift. | Dec-17 | No progress | Overdue | | Aug-19 | 20 |
| 171807 | 7 | General Practice Inspection (Builth Wells Medical Practice) | | Jane Jones | GPRH9 | All staff should receive annual appraisal. | Staff have received a review of their training needs and their job descriptions have updated accordingly. This will be changed pre appraisal questionnaire | Dec-17 | No progress | Overdue | | Aug-19 | 20 |
| 171809 | 8 | Dental Follow-Up Inspection (Hay on Wye Dental) | | Practice Manager | DFUH1 | Patient notes need to be reviewed to ensure:<br>- medical histories are checked and documented at every appointment<br>- Social histories need to be recorded consistently<br>- The justification for taking radiographs is comprehensively recorded | Practice Manager to address in staff meeting on July 20th 2017, | Jul-17 | No progress | Overdue | | Aug-19 | 25 |
| 171809 | 8 | Dental Follow-Up Inspection (Hay on Wye Dental) | | | DFUH2 | Senior management must ensure that the practice manager at Hay on Wye Dental Centre is supported to deliver and ensure that Welsh regulations and standards are adhered to and to cease implementing English regulatory standards which may cause confusion at the practice. | Copy of HIW report given to Mitesh Badiani in person Thursday 6th July 2017. | | No progress | Overdue | | Aug-19 | 1435 |
| 171810 | 9 | Dental Follow-Up Inspection (Cloverly Dental Practice) | | S Griffiths | DFUC1 | An analysis of completed questionnaires should be completed to evidence when the feedback was obtained and what the results of the surveys mean for the practice. | System to be put in place for survey analysis. Denplan will be helping | Jun-17 | No progress | Overdue | | Aug-19 | 26 |
| 171810 | 9 | Dental Follow-Up Inspection (Cloverly Dental Practice) | | S Griffiths | DFUC2 | An analysis of completed questionnaires should be completed to evidence when the feedback was obtained and what the results of the surveys mean for the practice. | System to be put in place for survey analysis. Denplan will be helping | Jun-17 | No progress | Overdue | | Aug-19 | 26 |
| 171810 | 9 | Dental Follow-Up Inspection (Cloverly Dental Practice) | | S Griffiths | DFUC3 | The practice needs to improve the availability of patient information to enable patients to make informed decisions about their care and treatment. | Looking into different patient information leaflets including Welsh language | Jun-17 | No progress | Overdue | | Aug-19 | 26 |
| 171810 | 9 | Dental Follow-Up Inspection (Cloverly Dental Practice) | | S Griffiths | DFUC4 | The appraisal template needs to be amended to remove all English references to regulations, standards and organisations and where w be updated to apply in Wales. | New Welsh relevent appraisal template to be created, Denplan will help me with this | Jul-17 | No progress | Overdue | | Aug-19 | 25 |
| 181904 | 10 | General Dental Practice Inspection (Evans Dental Limited) | | D G Evans | GDPE1 | Ensure one member of staff renews their training in CPR. | Annual CPR Training is carried out and has been booked for 2018. This will be mandatory for all Staff. | Jul-18 | No progress | Overdue | | Sep-19 | 14 |
| 181904 | 10 | General Dental Practice Inspection (Evans Dental Limited) | | D G Evans | GDPE2 | Ensure at least one member of staff at the practice is trained in first aid. | Appropriate members of Staff have been identified for this role who will be booked onto an appropriate course. | Jun-18 | No progress | Overdue | | Oct-19 | 16 |
| 181904 | 10 | General Dental Practice Inspection (Evans Dental Limited) | | D G Evans | GDPE3 | Ensure all staff working at the practice undertake or renew their training in the protection of children and vulnerable adults | Level 2 Safeguarding training for children and vulnerable adults has been provided December 2017. Those Staff unable to attend will undertake appropriate and relevant training as advised by HIW. | Jun-18 | No progress | Overdue | | Nov-19 | 17 |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 181904 | 10 | General Dental Practice Inspection (Evans Dental Limited) | | D G Evans | GDPE4 | Forward to HIW details of the renewed DBS certificate for one dentist. | Renewed DBS certificate has been applied for and will be forwarded to HIW on arrival. | Mar-18 | No progress | Overdue | | Dec-19 | 21 |
| 181904 | 10 | General Dental Practice Inspection (Evans Dental Limited) | | J Evans | GDPE5 | Self evaluate using the Maturity Matrix Dentistry tool. | MD tool will be reviewed and self-evaluation will be carried out as advised by HIW. | Jul-18 | No progress | Overdue | | Jan-20 | 18 |
| 181904 | 10 | General Dental Practice Inspection (Evans Dental Limited) | | D G Evans | GDPE6 | Ensure patients' medical histories are recorded and countersigned by the dentists.<br>Ensure that all treatment planning and options discussed with patients are recorded.<br>Ensure all treatment plans for Band 2 and Band 3 patients are signed and dated.<br>Ensure soft tissue examination and cancer screening recorded. | Record keeping has been improved in line with HIW recommendations. | Mar-18 | No progress | Overdue | | Feb-20 | 23 |
| 181904 | 10 | General Dental Practice Inspection (Evans Dental Limited) | | J Evans | GDPE7 | Undertake more regular audits of patients records to ensure the quality is consistent. | The next Audit of Clinical Records is scheduled for 3 months' time in order to ensure that these recommendations have been implemented. | Jun-18 | No progress | Overdue | | Mar-20 | 21 |
| 181905 | 11 | General Dental Practice Inspection (Llanfyllin Dental Practice ) | | | GDPL1 | The practice is to ensure all staff receive cardiopulmonary resuscitation training every twelve months | All Present Staff have up to date CPR Certificates.<br>When the Inspection took place we had a Trainee Nurse who hadn't got a CPR Certificate. This Nurse no longer is employed by us.<br>Annual CPR Training Booked | Aug-18 | No progress | Overdue | | Apr-20 | 20 |
| 181905 | 11 | General Dental Practice Inspection (Llanfyllin Dental Practice ) | | | GDPL2 | We recommend the practice ensures all staff receive training in child and adult safeguardin | Adult Protection/ Safeguarding Certificates All up to Date Dated Sep 24th 2017 | Sep-18 | No progress | Overdue | | May-20 | 20 |
| 181905 | 11 | General Dental Practice Inspection (Llanfyllin Dental Practice ) | | | GDPL3 | The practice must renew the principle dentist's Disclosure and Barring Service (DBS) Certificate | Applications for enahnced DBS certificates for all staff have been submitted | Feb-18 | No progress | Overdue | | Jun-20 | 28 |
| 192002 | 12 | General Practice Inspection (Welshpool Medical Centre) | | Christine Brown | WMCGP1 | Suitable blinds or curtains should be provided to windows within the toilet adjacent to the reception. | Blinds ordered and being fitted. | Mar-19 | No progress | Overdue | | Aug-19 | 5 |
| | 13 | | | LC-PM | | The practice should compile a training skills matrix for all staff, to ensure there is sufficient oversight of training in IPC (and other areas) at a practice wide level. | Noted and will be actioned | Mar-20 | No progress | Overdue | | | |

| Date of Update | Name of Person making update | PTHB Ref. No. | Regulators Reference | Report Title | Inspection Date | Action Number | Responsible Director | Responsible Officer | Recommendation | Service Action | Agreed Deadline | Revised Deadline MUST BE AGREED WITH DIRECTOR | Status | If closed and not complete, please provide justification | Due | Progress being made to implement recommendation<br>Progress of work underway:<br>Barriers to Implementation Including and interdependencies:<br>How is the risk identified being mitigated pending implementation:<br>When will the implementation be achieved? | If action is complete, can evidence be provided upon request?<br>THIS MUST BE COMPLETED<br>Yes or no |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 212209 | 21014 | HIW Inspection My Dentist Welshpool | 29/06/2021 | 1 | DPCCMH | Practice Manager | The Registered Provider must take appropriate action to ensure that there are no outstanding actions associated with the h. ealth and safety risk assessment completed in October 2019. Regulations 8(1)(c)(e)(k)(o) of the Private Dentistry (Wales) Regulations | The action plan submitted had no written progress dates due to each practice within Mydentist having an electronic system for updating risk assessments. Each risk assessment action is uploaded to 'works tracker'. The process for this is that each action is set a deadline for completion where the practice manager has to open each task and individually review each one and complete electronically to confirm the actions have been completed for which they are given a reference number when completed. For this practice the previous registered practice manager had completed all actions electronically to say they had all been actioned following the Risk assessment in 2019 with the exception of a small number of facilities assigned actions that were still showing as outstanding. We have conducted a full review of these facilities actions and can confirm that the outstanding actions showing were completed and can provide evidence from contractors if required. We just have one or two remedial actions outstanding following on from the completion of the damp survey conducted. Contractors are on site today and this week completing these remedial works and will review the previous works. To support the new manager in the practice and to ensure a further full review is undertaken and that all tasks have been actioned, we have brought forward the annual review date from August and have today re-opened all actions so that she can fully work through the list and be confident that the previous manager- completed actions have all been reviewed and completed correctly. | Previous manager completed annual review in 2020, new manager will complete a further review by 16th July 2021 | | | | | | |
| | | 212209 | 21014 | HIW Inspection My Dentist Welshpool | 29/06/2021 | 2 | DPCCMH | Practice Manager and Health & Safety team | The Registered Provider must take appropriate action to ensure that an updated health and safety risk assessment is undertaken as soon as possible. Regulations 8(1)(c)(e)(k)(o) of the Private Dentistry (Wales) Regulations | The last Health & Safety risk assessment was completed 09/10/2019 and reviewed in 2020. We would normally re-complete a full new H&S and Fire risk assessment every 5 years or sooner if practice has undergone significant physical / structural changes and complete an annual review as above, however to provide assurance, we will arrange for a new H&S and Fire Risk assessment visit to be completed week commencing 12th July. | 16th July 2021 | | | | | | |
| | | 212209 | 21014 | HIW Inspection My Dentist Welshpool | 29/06/2021 | 3 | DPCCMH | Practice Manager | The Registered Provider must take appropriate action to ensure that there are no outstanding actions associated with the fire safety risk assessment completed in October 2019. Regulation 22(4)(f) of the Private Dentistry (Wales) Regulations | The action plan submitted had no written progress dates due to each practice within Mydentist having an electronic system for updating risk assessments. Each risk assessment action is uploaded to 'works tracker'. The process for this is that each action is set a deadline for completion where the practice manager has to open each task and individually review each one and complete electronically to confirm the actions have been completed for which they are given a reference number when completed. For this practice the previous registered practice manager had completed all actions electronically to say they had all been actioned following the Risk assessment in 2019 with the exception of a small number of facilities assigned actions that were still showing as outstanding. We have conducted a full review of these facilities actions and can confirm that the outstanding actions showing were completed and can provide evidence from contractors if required. We just have one or two remedial actions outstanding following on from the completion of the damp survey conducted. Contractors are on site today and this week completing these remedial works and will review the previous works. To support the new manager in the practice and to ensure a further full review is undertaken and that all tasks have been actioned, we have brought forward the annual review date from August and have today re-opened all actions so that she can fully work through the list and be confident that the previous manager- completed actions have all been reviewed and completed correctly. | Previous manager completed annual review in 2020, new manager will complete a further review by 16th July 2021 | | | | | | |
| | | 212209 | 21014 | HIW Inspection My Dentist Welshpool | 29/06/2021 | 4 | DPCCMH | Practice Manager and Health & Safety team | The Registered Provider must take appropriate action to ensure that an updated fire safety risk assessment is undertaken as soon as possible. Regulation 22(4)(f) of the Private Dentistry (Wales) Regulations | The last Fire risk assessment was completed 09/10/2019 and reviewed in 2020. We would normally re-complete a full new H&S and Fire risk assessment every 5 years or sooner if practice has undergone significant physical / structural changes and complete an annual review as above, however to provide assurance, we will arrange for a new H&S and Fire Risk assessment visit to be completed week commencing 12th July. | 16th July 2021 | | | | | | |
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Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

**Agenda item: 2.2**

| **Patient Experience, Quality and Safety Committee** | **Date of Meeting: 13 September 2022** |
|---|---|
| **Subject:** | **PTHB Clinical Quality Framework Update** |
| **Approved and Presented by:** | **Claire Roche, Director of Nursing & Midwifery** |
| **Prepared by:** | **Amanda Edwards, Assistant Director Innovation & Improvement**<br>**Claire Roche, Director of Nursing and Midwifery** |
| **Other Committees and meetings considered at:** | **Patient Experience, Quality and Safety Committee 13 September 2022** |

**PURPOSE:**

The purpose of this report is to:

- Present progress made on implementing the health board's Clinical Quality Framework Implementation Plan, 2020-2023, since the last report in November 2021.
- Assess the current national context since the publication of the National Clinical Framework (WG 2021), the Quality and Safety Framework (WG 2021) and the Health and Social Care (Quality and Engagement) (Wales) Act, which became law in 2020 and will come into force in March 2023.
- Consider the interdependencies with Powys THB Performance Improvement Plan and Commissioning Assurance Framework

**RECOMMENDATION(S):**

The Patient Experience Quality & Safety Committee is asked to:

**DISCUSS the contents of this report and consider next steps for the maturity of the Clinical Quality Framework informed by national and local drivers**

| 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 | ✓ |
| | 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 PTHB Integrated Medium Term Plan 2022- 2025 identifies quality as a core component of the health board's strategic direction, improving quality across the whole system, building organisational effectiveness.

In 2020, PTHB developed a Clinical Quality Framework (CQF) to continue to build the capacity and capability of the organisation to enable high quality services are secured and provided for the people of Powys. Elements include safety, effectiveness, experience, organisational culture, clinical leadership, improvement, and intelligence. Key areas of focus include Putting Things Right (learning and responding to complaints, concerns, and incidents) quality assurance of both commissioning and provider services, maternity and neonatal services and partnership work on safeguarding and vulnerable groups. Critical to the CQF is the experience and outcomes of our population.



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

Progress with the CQF implementation was naturally adversely affected by the response required to the Covid-19 pandemic and since its development, key national frameworks have been published along with the national preparations for the Health and Social Care (Quality and Engagement) (Wales) Act.

It is therefore timely that we assess our progress with the Health Board's Clinical Quality Framework's actions and consider next steps for maturing clinical quality governance as we prepare for the enforcement of the Quality and Engagement Act in 2023.

## DETAILED BACKGROUND AND ASSESSMENT:

### Introduction and Background

The PTHB Integrated Medium Term Plan 2022-2023 identifies quality as a core component of the health boards strategic direction, improving quality across the whole system, building organisational effectiveness.

Following an internal review of arrangements in relation to clinical quality governance, a Clinical Quality Framework was developed to further improve and assure the quality of clinical services during 2020 to 2023. The implementation plan was presented to and approved by the Experience Quality and Safety Committee in June 2020. The last update to Patient Experience Quality & Safety Committee was in November 2021.

The development and endorsement of the Clinical Quality Framework Implementation Plan set out the health board's ambition to progress with the actions required to achieve 5 agreed goals with a lead Director identified for each of the goals.

However, since the development of the Health Board's Clinical Quality Framework (2020-2023), it is important to note that two key national frameworks were published by Welsh Government in 2021:

- National Clinical Framework: published on the 22 March 2021
- Quality and Safety Framework: published on the 17 September 2021

Both Frameworks are informed and driven by A Healthier Wales (Welsh Government 2018) and the **Health and Social Care** (Quality and Engagement) (Wales) Act which became law on the 1 June 2020 and which comes into force in Wales in March 2023.

### Progress against Clinical Quality Framework Action Plan

A summary of progress made in implementing the existing priorities as of August 2022 is captured in **Appendix 1.**

A Progress Report: implementing the Clinical Quality Framework can be found at **Appendix 2**

## Requests for change

Responsible Executive Directors have recently met to discuss the progress with the original actions in the CQF and having reviewed the progress of the actions, the following requests for change were agreed at the Executive Committee on the 5 September.

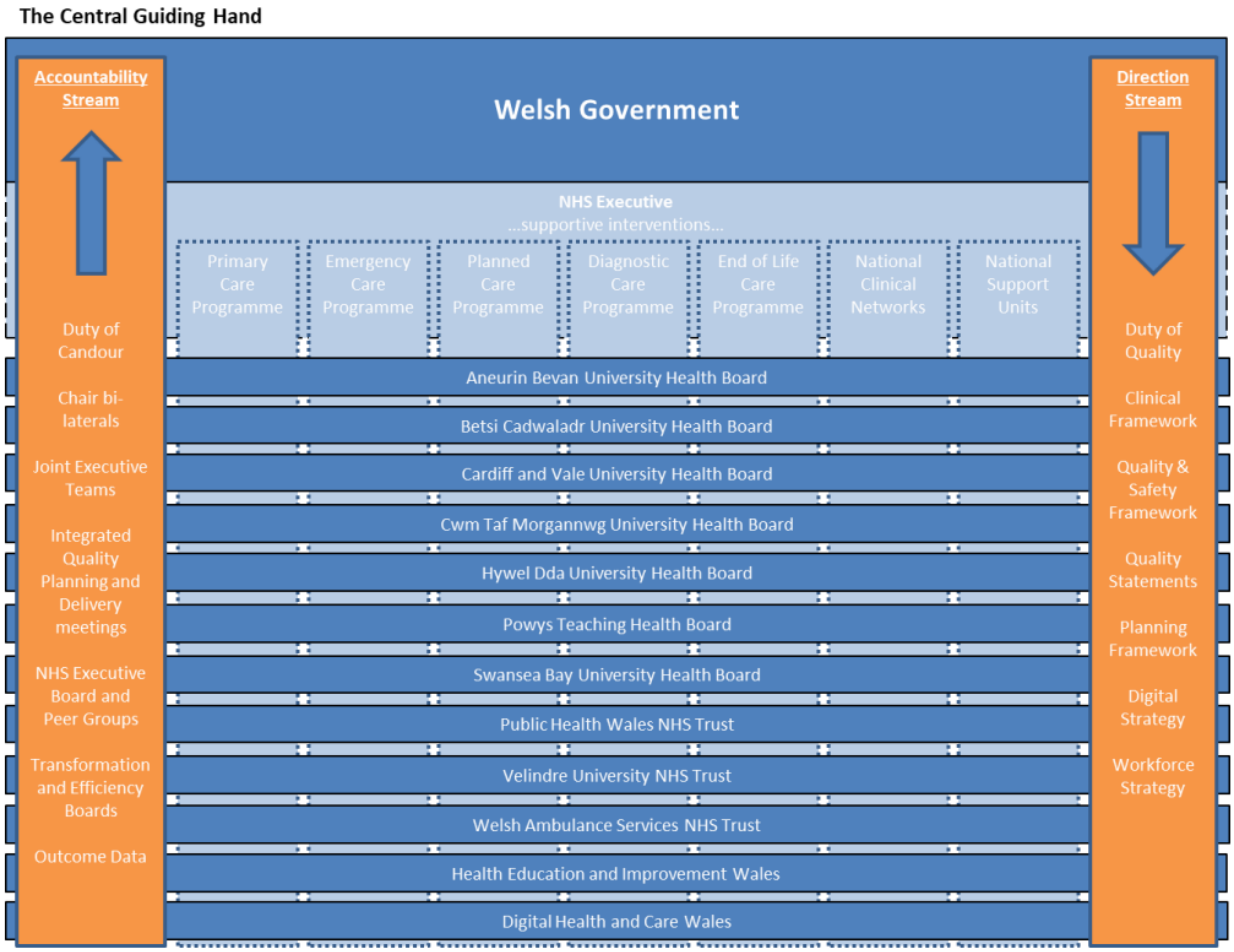
| | | | |
|---|---|---|---|
| **Goal 1c EXPERIENCE Director of Therapies & Health Sciences** | | | |
| 13.0 | Consider alignment of resources for Patient Experience to enable intelligence gathered to inform clinical care and Board decisions | Existing Deadline 31.3.22 | Revised deadline requested 31.03.2023 |
| **Goal 5 INTELLIGENCE Director of Public Health** | | | |
| 1.0 | Review and develop performance monitoring arrangements for clinical services; aligning to work undertaken on Commissioning Assurance Framework(s) | It is requested that responsibility for GOAL 5 and its associated actions move from the Director of Public Health to Director of Performance | |
| 2.0 | Review and develop ward/department and service-level dashboards | | |
| 3.0 | Develop arrangements for the clinical validation/interpretation of the core datasets relating to clinical services, including the use and interpretation of data in providing assurance | | |
| 4.0 | Review and develop performance monitoring arrangements for clinical services, aligning to work undertaken on Commissioning Assurance Framework(s) | | |

## Current Context

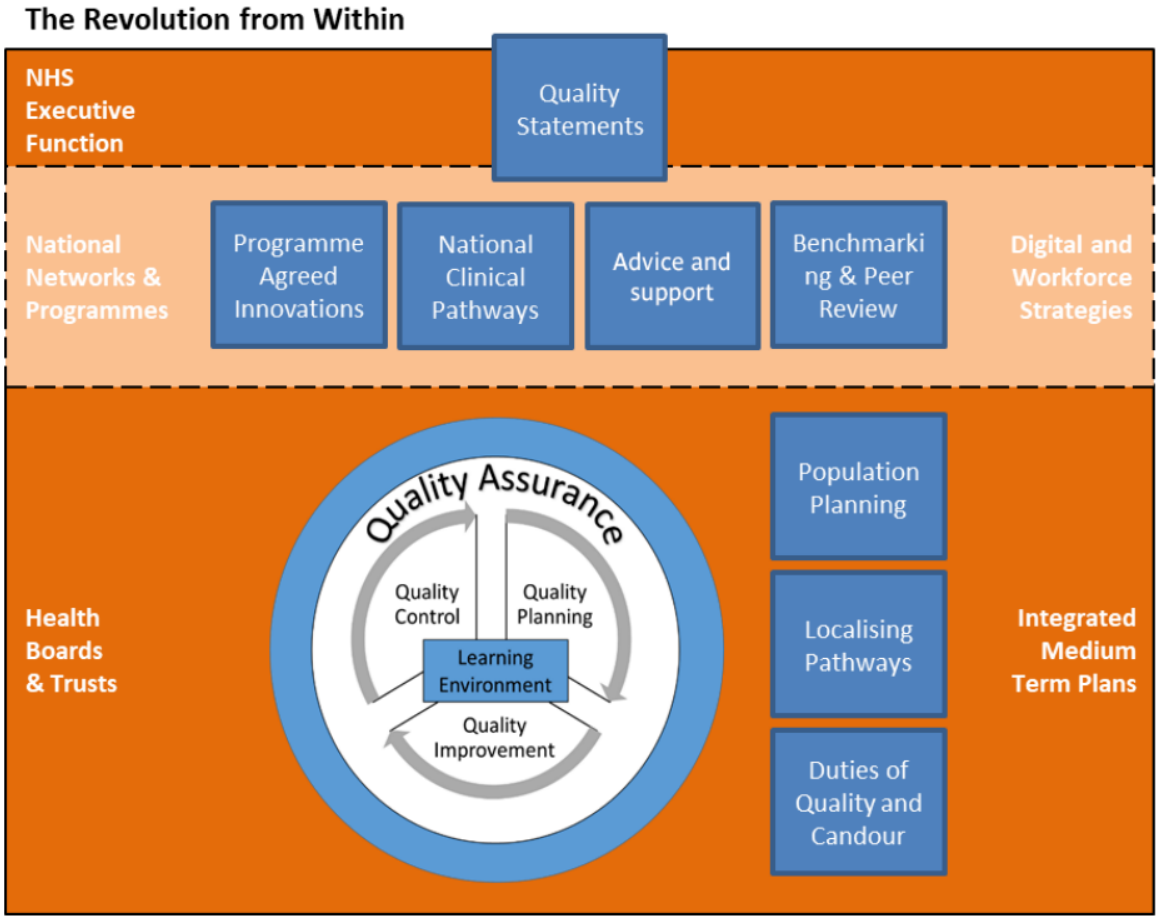
A mapping exercise was carried out in 2021 to map the quality and safety framework to PTHB CQF. Further work is now required to map to the requirements in the Quality and Engagement Act, in particular the duty of quality, the duty of candour and the role of the citizen voice. In addition, within Powys Teaching Health Board, work is underway to review

the Performance Improvement Framework (PIF) and the Commissioning Assurance Framework (CAF).

The establishment of the NHS Executive is now progressing at speed, led by Welsh Government and in the National Clinical Framework (WG 2021) this is described as emerging as the central guiding hand, as illustrated below:




The National Clinical Framework further describes how "to stimulate the revolution from within called for by the Parliamentary Review" and this is depicted below. It is important to note that central to this from a Health Board perspective is the implementation of the Quality Management System.




As mentioned at the start of this paper a mapping exercise has previously been undertaken to look at the alignment of the Health Board's Clinical Quality Framework with the 15 actions in the Quality and Safety Framework (WG September 2021).

This provides a helpful assessment that will inform the action we now need to take to align to the enforcement of the Quality and Engagement Act and the associated implementation guidance that is due to be published by Welsh Government in the near future and to ensure that within the Health Board, we align the requirements of a quality management system and clinical governance with our performance frameworks.

**NEXT STEPS:**

- To develop and implement a consistent and coherent system that enables the Health Board to measure and monitor quality and performance (assurance), enabling quality improvement within the Health Board and at a system level. Critically, this must be informed by the citizen voice and patient experience will be integral to this.
- Acknowledge and identify the constraints that exist within the Health Board required to deliver the above ambition.
- Identify risks and opportunities in our preparedness for the Quality and Engagement Act

**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** | **The implementation of the Clinical Quality Framework will support the upholding of the Equality Act 2010** |
| **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** | | | | **The implementation of the Clinical Quality Framework will reduce risk in all aspects of health board business** |
| | **None** | **Low** | **Moderate** | **High** | |
| **Clinical** | | x | | | |
| **Financial** | | | x | | |
| **Corporate** | | x | | | |
| **Operational** | | | x | | |
| **Reputational** | | x | | | |

**Appendix 1**

**Progress Report: implementing the Clinical Quality Framework August 2022**

**RAG key**

| | |
|---|---|
| No progress made | |
| Progress made but slower than anticipated | |
| Progress satisfactory | |
| Completed | |
| Not yet due | |

| **GOAL 1a: SAFETY Director or Nursing & Midwifery** | | | |
|---|---|---|---|
| | **Action** | **Lead Exec** | **Update** |
| 1.0 | Implement the revised Putting Things Right Policy | **CR** | ▪ The National Patient Safety Incident Reporting Policy (May 2021) has been successfully implemented within the Health Board. An updated suite of documents has been launched to provide a more robust framework and opportunity for SMART action planning along with alignment to redress if required.<br>▪ Ongoing implementation of the Once for Wales Content Management System (OFWCMS) is complete with the final Risk module being delayed for implementation due to the National work required; this is expected in October2022.<br>▪ In line with the Health and Social Care (Quality and Engagement) (Wales) Act, (June 2020), the provision of quality data dashboards to services, areas and teams is essential and has commenced at pace. |

| | | | |
|---|---|---|---|
| | | | This will ensure that quality data is used to triangulate themes and trends whilst informing quality improvements and areas of focus. The data used within this report has been obtained from RLDatix and further improvements will be made to the data quality as the system changes are realised. |
| 2.0 | Implement the five key improvement actions relating to Serious Incident management - | **CR** | ▪ The national patient safety incident (PSI) framework was launched 14 June 2021, to be in place by end of March 2022. The health board implemented a robust framework to support the framework roll out across all services.<br>▪ 7minute briefing has been drafted a shared with teams to explain the framework and roll out.<br>▪ Health board representation at national meeting.<br>▪ A new Learning from Events Report document has been implemented with adherence to the required timelines for submission monitored at a local and national level.<br>▪ Incident management framework requires updating to reflect the NRI process. Ensure historic incidents are proactively managed to closure.<br>▪ Implementation of a training framework to support robust investigation, to include RCA writing, Human Factors and Psychological Safety |
| 3.0 | Develop and implement a revised approach to organisational learning | **KW** | ▪ The Learning from Experience Group was a new forum established in March 2021. Its purpose was to support the safe and effective delivery of the care given to Powys residents both within the county and at commissioned services. |

| | | | |
|---|---|---|---|
| | | | ▪ The Learning from Experience Group triangulates with themes from concerns/incidents/audit/national clinical audits, learning from mortality reviews, Acute Kidney Injury (AKI) and (AKI).<br>▪ Plan 22-23 to improve access to shared learning – promotion of 7-minute briefing /relaunch of Powys Bitesize<br>▪ Consideration is being given to holding a national Annual Safety Event at the Healthcare Academy with all clinical Executives leading on a particular aspect of care such as Sepsis or AKI and issues arising from the group, learning from safeguarding, legal cases, Prudic work etc. as well as maybe NICE work and Alerts |
| 4.0 | Assess Systems of communication and support that enable staff to raise concerns | **CR** | ▪ Mechanisms already exist for staff to raise concerns through the incident reporting system and via Putting Things Right.<br>▪ Confidential concerns are managed via W&OD, albeit the incident reporting system is used to collate them where reported. |
| 5.0 | Review and revise systems for safety alerts/notices | **CR** | ▪ Alerts policy approved via Clinical policy group 2nd November. New model of managing alerts in place.<br>▪ Huddles at two levels in place (1) huddle of governance leads and heads of services discuss new alerts / notices and agree lead person to collate evidence of compliance for reporting to corporate team and the actions to be taken at local level. (2) local huddles within service groups whereby they discuss the alert/ notice and agree local actions to seek out evidence and report compliance. |

| **GOAL 1b EFFECTIVENESS Medical Director** | | | |
|---|---|---|---|
| | **Action** | **Lead Exec** | **Update** |

| | | | |
|---|---|---|---|
| 6.0 | Implement the improvement plan for clinical audit | **KW** | ▪ A review of the clinical audit programme was caried out in early 2022.<br>▪ Audit priorities were reviewed, and directorates were asked to ensure that audits were directed to areas of known risk and concern.<br>▪ There is further focus in the learning from experience group which will capture themes and actions from concerns and incidents and ensure that key topics are included in future clinical audit plans.<br>▪ A summarising report was taken to PEQS. |
| 7.0 | Review and develop organisation approach to implementation of national clinical guidelines. | **KW** | ▪ Further discussion has taken place and a summary position will be agreed in the learning from experience group. |
| 8.0 | Accelerate Value-Based healthcare programme in the organisation | **KW** | ▪ Work is underway to implement key initiatives at pace and to scope next areas for focus. Several staff have undergone training and a value based approach is being applied in funding decisions. Work is underway to establish PROMS collection in line with All Wales methodology. |
| 9.0 | Review approach to Health Care Standards | **CR** | ▪ Through the implementation of the Quality and Engagement Act this framework will be updated to align with the requirements of the Act. |
| 10.0 | Develop an approach for programme of external peer review | **ALL** | ▪ Focused areas of work in community paediatrics as part of service transformation work. Securing external reviewers remains challenging - likely as a result of capacity and system pressures. GIRFT reviews underway and IHI review. |
| **GOAL 1c. EXPERIENCE Director of Therapies & Health Sciences** | | | |

| | Action | Lead Exec | Update |
|---|---|---|---|
| 11.0 | Integrate the PTHB Patient Experience Framework into the Clinical Quality Framework in line with the new legislation | **CM** | ▪ Improvement plan in place to support a structure to ensure patient experience is shared, recognised, and informs decisions along with service improvements and learning framework.<br>▪ Civica Patient Experience System set up will be integral to this work beginning and health board roll out commences implementation during August 2022 with anticipated use of FFT survey during October 2022.This will take up to a year to implement across all services in PTHB |
| 12.0 | Review arrangements for learning from patient experience in all clinical services | **CM** | ▪ Quadrant framework still being promoted, and staff supported to complete<br>▪ Learning shared at patient experience meeting and all quadrant reports shared.<br>▪ TOR of experience group updated<br>▪ Weekly CIVICA meetings diarised from 17/08/22 to end November 2022 (will be extended if required).<br>▪ Monthly All Wales CIVICA System Leads meetings in place. |
| 13.0 | Consider alignment of resources for Patient Experience to enable intelligence gathered to inform clinical care and Board decisions | **CM** | Implementation of the Civica Patient Experience system will support the health board to ensure feedback is aligned and informs clinical care and board decisions.<br>Civica implementation begins in August 2022 with initial FFT questionnaires anticipated 'go live' during October 2022. This will then need evaluation regarding resources needed to respond to feedback and act upon learning. |

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| | | | **31.3.22 Request for the deadline to be amended to 31.3.23** |
| 14.0 | Review and develop the link between documented patient experience and Board decision making | **CM** | For next financial year |
| 15.0 | Review the impact of the patient stories presented at PTHB Board | **CM** | For next financial year<br>There is currently no resource for collection of and production of patient stories and this is currently being supported by the Welsh Language and Equalities Manager |

| **GOAL 2: Organisational culture Director of Workforce & Organisational Development** | | | |
|---|---|---|---|
| | **Action** | **Lead Exec** | ▪ **Update** |
| 1.0 | Consider aligning Values and Behaviours Framework to compassionate leadership | **DWOD** | ▪ The Values are aligned to the compassionate leadership model, with no indication from staff surveys that this needs to be changed.<br>▪ Chat2Change has aligned the wording of the Values and Behaviours Framework to reflect the Compassionate Leadership Model<br>▪ Values and Behaviours Framework will be published on the intranet as Workforce pages are built. |
| 2.0 | Consider deployment arrangements including roles/accountabilities of Executive Directors/teams | **DWOD** | ▪ A review and any necessary realignment of Executive Director portfolios was approved by the Remuneration and Terms of Service Committee in October 2021. |

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| 3.0 | Design/implement an organisational and staff development programme to embed Clinical Quality Framework | **DWOD** | ▪ AD Therapies, DD Nursing & AD Quality & Safety have undertaken the Institute IHI / Improvement Cymru Safe Care Partnership training. The aim of the Safe Care Partnership is to provide nationally coordinated, locally delivered support for safe reliable and effective care. It will support national collaboration and cross boundary learning<br>▪ Discussion needed to identify the infrastructure to deliver this in Powys . |
| 4.0 | Evaluate the current culture of the organisation | **DWOD** | ▪ In September 2021, an agile working and wellbeing survey has been completed which reviewed and revisited employee engagement. This showed an overall sense of wellbeing rating of 4.15 out of 6 (an increase on the 2020 wellbeing survey). Those working in the workplace (mainly clinicians) reported a lower score than those working from home of 3.84 out of 6<br>▪ The last National Staff survey in 2020 showed the same Engagement Index score as 2018 (78% or 3.92 out of 5) with a response rate of 29%. Both of these values were the highest of the health boards in Wales. The next National Staff Survey is due for release in Autumn 2022. |
| 5.0 | Review Terms of Reference of relevant committees to reflect Framework | **JQ** | ▪ The PEQS TOR contain clear references to the assurance required regarding the CQF.<br>▪ Terms of reference are due for review in the autumn of this year. |
| 6.0 | Review the resources available to support clinical quality improvement | **KW** | ▪ 3 clinical ADs have undertaken the Institute IHI / Improvement Cymru Safe Care Partnership training. The aim of the Safe Care Partnership is to provide nationally coordinated, locally delivered support for safe reliable and effective care. It will support national collaboration and cross boundary learning. |

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| | | | ▪ Discussion needed to identify the infrastructure to deliver this in Powys<br>▪ A range of tools and online resources are being developed for staff to utilise. Powys Bitesize is being relaunched to share learning, knowledge and improve skills.<br>▪ Plans underway develop a bespoke QI training programme. |
| 7.0 | Ensure a multi-disciplinary approach to clinical risk assessment and management | **CR** | ▪ Clinical risks recognised through services governance structures and reported/escalated to the organisational Risk Register when risks are >16.<br>▪ The use of the RLDatix Risk Module anticipated implementation during October 2022 will ensure a robust structure to report and manage mitigation and risk more robustly. |

| **GOAL 3: Clinical Leadership Clinical Execs** | | | |
|---|---|---|---|
| | **Action** | **Lead Exec** | ▪ **Update** |
| 1.0 | Visible Clinical Executive Director leadership in the roll-out of the Clinical Quality Framework review and comment | CR | ▪ Bimonthly heads of service in Therapies and Health Sciences meetings well established and new professional leads meeting being set up.<br>▪ ADoTHS across Wales completed a piece of work on professional accountability guidance that was signed off by Welsh Gov and HEIW that is being implemented in Powys |

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| 2.0 | Consider assigning a named PTHB clinical lead to specific quality governance areas | **CR** | Executive Leads are now identified for nationally reportable incidents There are three governance leads in services, all of who are clinical Further work is required to further define this action and the objectives required to meet it. |
| 3.0 | Design and implement an approach to develop and sustain clinical leadership across the health board | **DWOD** | ▪ Clinical Leadership programme currently in development, starting work with B7 Midwives in Sept 2022.<br>▪ Compassionate Leadership programme under development by Prof Michael West and will be trialled in PTHB as part of the Clinical Leadership offer. Course due to be published in Q3.<br>▪ HEIW have agreed to part fund a fixed-term band 7 Clinical Leadership Facilitator to work in PTHB for 12-months to roll out training.<br>▪ Advanced Clinical Leadership programme being delivered by HEIW<br>▪ 3 clinical ADs have undertaken the Institute IHI / Improvement Cymru Safe Care Partnership training... The aim of the Safe Care Partnership is to provide nationally coordinated, locally delivered support for safe reliable and effective care. It will support national collaboration and cross boundary learning.<br>▪ Discussion needed to identify the infrastructure to deliver this in Powys |
| 4.0 | Review/improve clinical leadership in design, review and action from performance/intelligence on clinical services | | A new role of Workforce Design and Transformation has been appointed to in the Workforce & OD Directorate. They will lead on Workforce Planning and Design across service areas, utilising intelligence on Clinical areas to support the plans in identifying the leadership and skill mixes required to support delivery of effective |

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| | | | clinical services. PTHB are also a partner with USW in the delivery of one of WG's Intensive Learning Academies (ILAs) – delivering "leading digital transformation" aimed at levels 3 to MSC in HSC. |
| 5.0 | Develop a clinically led programme of periodic "deep dive" reviews of specific clinical areas | | This is off target and requires attention |

| GOAL 4: Improvement methodology Medical Director | | | |
|---|---|---|---|
| | **Action** | **Lead Exec** | **Update** |
| 1.0 | Agree and adopt an approach to clinical quality improvement, including the methodology, knowledge and skills | **KW** | ▪ Work is continuing to ensure that work is aligned to the Q&S framework and in line with Quality and Engagement act. The aim is to develop an overarching framework that delivers all the key requirements and supports the delivery of safe and effective systems for Powys. |
| 2.0 | Using a prioritised and risk-based approach, define and deliver a programme of clinical quality improvement projects | **KW** | ▪ See 1.0 above. |
| 3.0 | Develop a training programme to enable staff to have improved knowledge and skills | **KW** | ▪ A range of tools and online resources are being developed for staff to utilise. Powys Bitesize is being relaunched to share learning, knowledge and improve skills. Plans underway develop a bespoke QI training programme. |
| 4.0 | Review and develop the resources available to lead | **KW** | ▪ See 3.0 above |

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| | and support clinical quality improvement across the organisation | | ▪ 3 clinical ADs have undertaken the Institute IHI / Improvement Cymru Safe Care Partnership training. The aim of the Safe Care Partnership is to provide nationally coordinated, locally delivered support for safe reliable and effective care. It will support national collaboration and cross boundary learning. |
| 5.0 | Assess the potential for formalising a partnership between the health board and other UK expert organisations for quality improvement in health care | **KW** | ▪ We have increased our collaboration with academic and industry partners and other Health Boards including Tech Cymru, Welsh Institute Digital Information (WIDI) a range of universities and HDUHB. This will enable us to further explore innovative approaches to provision of care and delivery of research, particularly in the context of rural community health and care.<br>▪ We also partnered with Life Science Hub Wales on recent POCT project |

| **GOAL 5: Intelligence Director of Public Health** | | | |
|---|---|---|---|
| | **Action** | **Lead Exec** | ▪ **Update** |
| 1.0 | Review and develop performance monitoring arrangements for clinical services; aligning to work undertaken on Commissioning Assurance Framework(s) | **DP&P** | ▪ PTHB's Commissioning Assurance Framework (CAF) is in place and is an accepted, established part of the mechanism for performance monitoring quality and safety in clinical services.<br>▪ Since the Improving Clinical Quality Framework was developed, PTHB provider services, mental health and maternity services have either been added to the CAF, or the range of performance measures used has been strengthened to improve internal (and external) performance monitoring.<br>How the CAF is used as part of an overall internal performance |

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| | | | monitoring arrangement for provider services does require further development, and this an element of the first action under Goal 5 that remains subject to ongoing refinement. |
| 2.0 | Review and develop ward/department and service-level dashboards | **DP&P** | ▪ This has been subject to a number of discussions with Improvement Cymru, PTHB Innovation and Improvement, and Nursing representatives regarding a ward level programme exploring the development and use of a quality dashboard.<br>▪ Improvement Cymru have expressed an interest in supporting this as part of one of their behaviours change programmes, but the detail of the proposal and planning for this work still need to be worked through.<br>▪ A potential inpatient setting for the work has been identified. |
| 3.0 | Develop arrangements for the clinical validation/interpretation of the core datasets relating to clinical services, including the use and interpretation of data in providing assurance | **DP&P** | ▪ This action requires a number of steps in order to be fulfilled including: -<br>○ The location and assembly of all core datasets in a single location<br>○ For the data to be structured to allow interrogation, interpretation, and validation.<br>○ For a data quality assessment to be undertaken as part of the overall assurance process |
| 4.0 | Develop/integrate a valid and robust organisational benchmarking approach, using national/international comparators where available | **DP&P** | ▪ This action requires a number of steps in order to be fulfilled including:-<br>○ The location and assembly of all core datasets in a single location<br>○ For the relevant set of benchmarking indicators to be identified to allow benchmarking to occur |

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| | | | ○ Indicators will be drawn from sources of information contained within Wales, the wider UK and internationally eg DHCW, CHKS, NHS Benchmarking Network |

**Appendix 2**

**At a glance status of clinical quality framework activity**

The table below provides an 'at a glance' summary of status in relation to each of the activities up until August 2022. There have been some changes to RAG ratings since the last report to PEQS in November 2021.

**RAG key**

| | |
|---|---|
| No progress made | |
| Progress made but slower than anticipated | |
| Progress satisfactory | |
| Completed | |
| Not yet due | |

| **Goal** | Status Nov 2020 | Status April 2021 | Status Nov 2021 | Status August 2022 |
|---|---|---|---|---|
| **GOAL 1a. SAFETY Director of Nursing & Midwifery** | | | | |
| Implement the revised Putting Things Right policy | | | | |
| Implement the five key improvement actions relating to Serious Incident management | | | | |
| Develop and implement a revised approach to organisational learning | | | | |

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| Assess systems of communication and support that enable staff to raise concerns | | | | |
| Review & revise system for safety alerts/notices | | | | |
| **GOAL 1b. EFFECTIVENESS Medical Director** | | | | |
| Implement the improvement plan for clinical audit | | | | |
| Review & develop organisation approach to implementation of national clinical guidelines | | | | |
| Accelerate Value-Based Healthcare Programme in the organisation | | | | |
| Review approach to Health and Care Standards | | | | |
| Develop an approach for programme of external peer review | | | | |
| **GOAL 1c. EXPERIENCE Director of Therapies & Health Sciences** | | | | |
| Refresh the PTHB Patient Experience Framework | | | | |
| Review arrangements for learning from patient experience in all clinical services | | | | |

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| Consider alignment of resources for Patient Experience to enable intelligence gathered to inform clinical care and Board decisions | | | | |
| Review and develop the link between documented patient experience and Board decision making | | | | |
| Review the impact of the patient stories presented at PTHB Board | | | | |
| **GOAL 2: Organisational culture Director of Workforce & Organisational Development** | | | | |
| Consider aligning Values and Behaviours Framework to compassionate leadership | | | | |
| Consider deployment arrangements including roles/accountabilities of Executive Directors/teams | | | | |
| Design/implement an organisational and staff development programme to embed Clinical Quality Framework | | | | |
| Evaluate the current culture of the organisation | | | | |
| Review Terms of Reference of relevant committees to reflect Framework | | | | |
| Review the resources available to support clinical quality improvement | | | | |

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| Ensure a multi-disciplinary approach to clinical risk assessment and management | | | | |
| Evaluate the current culture of the organisation | | | | |
| Ensure a multidisciplinary approach to clinical risk assessment and management | | | | |
| **GOAL 3: Clinical Leadership Director of Therapies & Health Sciences** | | | | |
| Visible Clinical Executive Director leadership in the roll-out of the Clinical Quality Framework | | | | |
| Consider assigning a named PTHB clinical lead to specific quality governance areas | | | | |
| Design and implement an approach to develop and sustain clinical leadership across the health board | | | | |
| Review/improve clinical leadership in design, review and action from performance/intelligence on clinical services | | | | |
| Develop a clinically-led programme of periodic "deep dive" reviews of specific clinical areas | | | | |
| **GOAL 4: Improvement methodology Medical Director** | | | | |

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| Agree and adopt an approach to clinical quality improvement, including the methodology, knowledge and skills | | | | |
| Using a prioritised and risk-based approach, define and deliver a programme of clinical quality improvement projects | | | | |
| Develop a training programme to enable staff to have improved knowledge and skills | | | | |
| Review and develop the resources available to lead and support clinical quality improvement across the organisation | | | | |
| Assess the potential for formalising a partnership between the health board and other UK expert organisations for quality improvement in health care | | | | |
| **GOAL 5: Intelligence Director of Public Health** | | | | |
| Review and develop performance monitoring arrangements for clinical services; aligning to work undertaken on Commissioning Assurance Framework(s) | | | | |
| Review and develop ward/department and service-level dashboards | | | | |
| Develop arrangements for the clinical validation/interpretation of the core datasets relating to clinical services, including the use and interpretation of data in providing assurance | | | | |

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| Develop/integrate a valid and robust organisational benchmarking approach, using national/international comparators where available | | | | |

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

**Agenda item: 5.1**

| **Patient Experience, Quality and Safety Committee** | **Date of Meeting: 13th September 2022** |
|---|---|
| **Subject :** | Maternity Services Assurance Framework Report |
| **Approved and Presented by:** | **Claire Roche, Executive Director of Nursing and Midwifery**<br>**Louise Turner, Assistant Director for Women and Children's services** |
| **Prepared by:** | **Claire Roche, Director of Nursing and Midwifery**<br>**Senior Midwifery Team** |
| **Other Committees and meetings considered at:** | **Executive Committee 5th September 2022** |

| **PURPOSE:** |
|---|
| The purpose of this paper is to provide the Patient Experience, Quality and Safety Committee with the current position related to maternity assurance. |
| **RECOMMENDATION(S):** |
| The Patient Experience, Qu Patient Experience, Quality and Safety Committee is asked to DISCUSS the report. |

| **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:

The purpose of this paper is to provide the Patient Experience, Quality and Safety Committee with an update on quality assurance matters in Maternity Services in Powys. The previous Maternity Assurance paper (June 2022) proposed the following next steps:

- Maintain oversight of Maternity NRIs and targeted work through Maternity Quality and Safety programme of work
- Review Powys Maternity Improvement Plan following national events in July and September for actions for AMBER and RED recommendations (WG Assurance Return)
- Fully engage with the Welsh Government's Maternity and Neonatal Safety Support Improvement Programme
- Continued development of the Powys Maternity and Neonatal Improvement Plan during 2022

- Maintain oversight and escalation of commissioned services through the Commissioning Assurance Framework (CAF), to include increased scrutiny of neonatal services
- Continue to develop and embed governance and maintain reporting arrangements

This paper will provide an update with the progress of the actions above, including progress with the current local escalation arrangements.

## DETAILED BACKGROUND AND ASSESSMENT:

1. Current Escalation Arrangements

As highlighted in the July Patient Experience and Quality (PEQs) Committee, local escalation arrangements had been enacted within the Midwifery Service in Powys in response to three Nationally Reportable Incidents (NRIs) between February and May 2022 and improvements required with the Perinatal Institutes' GAP/GROW pathway. Findings from a local review of governance in the Midwifery Service highlighted improvements were required in the review of maternity transfers (particularly intra-partum), review of patient safety incidents and the undertaking of root cause analysis (RCA) investigations.

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

1.2 Maternity National Reportable Incidents (NRI)

Maternity NRIs are being reviewed separately with executive oversight by the Executive Director of Nursing and Midwifery. A fortnightly review meeting is tracking the progress of the investigations, ensuring immediate make safe actions are being implemented and assessing the contact with the families involved.

The three identified NRIs, reported in the last report have all been investigated via a Root Cause Analysis (RCA) methodology. Two of these are within the timescales for completion of the investigation. One is out of compliance due to the complexity of the investigation and an agreed extension has been negotiated with the Delivery Unit.

A further NRI has been reported to the Delivery Unit since the last Maternity Assurance Report. This is now also reviewed via the fortnightly NRI meeting,

has been allocated an Investigating Officer and immediate make safe actions have been identified.

1.3 Perinatal Institute (PI) GAP/GROW Compliance

One of the key drivers for the implementation of local escalation arrangements was the identification of incidents that highlighted specific actions for GAP and Grow compliance for the detection of Small for Gestational Age (SGA) babies. In our previous report, we shared that a recent review of Powys data demonstrated that for 2021/22, of the expected 1250 births (actual charts produced 1267), only 428 birth data was entered into the system. As this was only a third of the births, we were unable to draw any conclusion as to our detection rates of SGA babies. We shared that this trend of only submitting a third of births appeared to be continuing into 2022/23. Historically the other two thirds of the data have been captured via DGH obstetric services.

Since July, corrective actions have been identified. These include:

- Training and accreditation for all staff involved in clinical care: A report generated by the PI in June 2022 indicated that not all midwives had completed this within the previous 12 months. Action has been taken to address this and all Powys THB midwives are now compliant with the annual e-learning requirements
- Improved knowledge and skills in use of the customised growth chart: During 2022/2023, midwifery updates also include a session led by midwife-sonographers to further strengthen clinical skills in the use and interpretation of the customised growth chart. As it will take 12 months to ensure all midwives have accessed this session via mandatory updates, additional sessions are being delivered to each midwifery team to ensure midwives are competent and confident regarding the identification and management of suspected SGA babies. To date 18 midwives have attended the additional training session, with a further two sessions scheduled for August 2022, therefore the service is on target to achieve over 50 percent attendance prior to September
- Audit and benchmarking Performance: The Perinatal Institute's Gap/ Grow programme has functionality that monitors the detection and referral rates for babies that are small for gestational age (SGA). This ensures that all maternity services in the UK are provided with a report on their detection and referral rates and provides a benchmark with other maternity services. It was identified that Powys THB did not have sufficient data entered into the system for the reports to be meaningful and helpful for both assurance and improvement. Actions have been taken internally and externally. These include:

  - ✓ Identification of appropriate midwives who have received training and been granted access to be able to input data from the proforma onto the online system.

- ✓ All retrospective data for 2021/22 has now been submitted to the Perinatal Institute (PI). 2022/23 data has been submitted up to end of July 2022. The PI are now cleansing this data and will be providing Powys THB with our specific report on our detection and referral rates for SGA babies at the October Maternity Matters meeting.

Communication with other maternity services to not change the provider service at birth.

National Maternity and Neonatal Safety Programme (Mat/Neo)

The Mat/Neo safety programme initiated by Welsh Government 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 7th of July, where all maternity services in Wales shared their local assessments. The intelligence gathered at this workshop will now inform a national Maternity and Neonatal Safety Summit on the 6th of September.

The local Mat/Neo safety lead posts are out to advert (all Health Boards in Wales will have this post) and the national safety lead roles are also out to advert (these posts will be based in Improvement Cymru). Powys THB is fully engaged with this work.

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.

**Quality Governance**

**Recent External Reviews**

PROMPT quality assurance Report (Appendix 1)

The PROMPT quality assurance visit was conducted by the Welsh Risk Pool team on 25th May 2022 to observe the Community PROMPT Wales programme in Powys. The quality assurance review identified several positive aspects to the teaching and training provided in Powys. The QA visit acknowledged the Community PROMPT Wales training at Powys THB maintains authenticity to the context of community midwifery. Staff from all teams come together providing the opportunity to get to know their colleagues from the other Powys community teams. The outcome report recognised that faculty are clearly committed to providing a quality training experience and understand the overarching purpose of PROMPT; bringing teams together to train in a safe environment. It was highlighted the value of Paramedics being invited to attend every course, this facilitating an understanding and appreciation of each other's roles and how Paramedics and Midwives can support each other to achieve the best outcome.

The PROMPT Wales National Team recognise the high quality of organisation and execution of Community PROMPT Wales training in Powys THB and made recommendations to build on the effectiveness of the training. These were regarding further embedding the use of resources such as MEOWS charts, OBS Cymru PPH Management Checklist etc. in clinical practice, ensuring a standardised approach to briefing and debriefing in every station/scenario. The action for the recommendations has also considered an arrangement for experienced faculty members to remain available to support less experienced faculty and increase the opportunity to facilitate regularly by hosting birth centre environment scenarios. Powys PROMPT faculty team have been approached to share their good practice with other Health Boards in Wales who are developing their Community PROMPT Wales training and will link into Quality Assurance visits with neighbouring DGHs which enhances MDT working.

**NEXT STEPS:**

- Maintain the weekly Extraordinary Maternity Assurance Forum for the foreseeable future, not only to receive assurance on quality and safety but also to provide support to the midwifery team at a time of change in senior leadership.
- Agree de-escalation criteria from local escalation arrangements
- Continue with fortnightly NRI oversight meetings until all investigations and associated action plans are completed.
- Maintain oversight and escalation of commissioned services through the Commissioning Assurance Framework (CAF) to increase scrutiny of neonatal services
  Continued engagement with the Welsh Government's Maternity and Neonatal Safety Support Improvement Programme

**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**<br><br>***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**<br><br>***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** | | | | | |

# PROMPT WALES
# QUALITY ASSURANCE REVIEW

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

## POWYS TEACHING HEALTH BOARD

| | |
|---|---|
| **QA VISIT DATE:** | **25TH MAY 2022** |
| **DRAFT REPORT ISSUED:** | **13TH JUNE 2022** |
| **CONFIRMED ACTION PLAN:** | |
| **FINAL REPORT ISSUED:** | |



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

## QA REPORT STATUS: DRAFT

This report is issued in draft form to enable the Health Board faculty to review the information, advise the Welsh Risk Pool team of any points of clarification and develop an action plan to address the recommendations provided.

Once feedback has been received from the Health Board and details of actions have been provided, the report will be published and presented to the WRP Maternity Safety & Learning Board.

DEADLINE FOR RESPONSE: **11th July 2022**

The Health Board should ensure that feedback, including any points of clarification and action plans are provided to the Welsh Risk Pool team by this deadline. Feedback and action plans should be directed to the team mailbox prompt.wales@wales.nhs.uk.



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The PROMPT Wales National Team hope that the feedback and recommendations in the report are valuable and provide your organisation with useful guidance for further development of your PROMPT Wales training. The National Team are available as a resource for guidance around the recommendations.

REFERENCES

1. Siassakos, D., Crofts, J. F., Winter, C., & Weiner, C. P. (2009). *The active components of effective training in obstetric emergencies*. BJOG, 1028–1032. https://doi.org/10.1111/j.1471-0528.2009.02178.x

2. Ockenden, D. (2022). *Ockenden Report* – Final. https://www.donnaockenden.com/downloads/news/2020/12/ockenden-report.pdf

# PROMPT Wales Quality Assurance visit at Powys Teaching Health Board

**Date:** 25th May 2022

**Location:**

Three Wells Hotel, Howey.

**The Welsh Risk Pool observing team:**

Sarah Hookes – Senior Safety & Learning Advisor

Jenilee Harrison – PROMPT Wales Midwife

**Accompanied by:** Miss A Pinto, Consultant Obstetrician, ABUHB.

**PTHB PROMPT Wales faculty on date of visit:**

Shelly Higgins, Consultant Midwife

James Bourton, Community Midwife

Suzanne Pardoe-Bouchard, Community Midwife

Flora Cheetham, Community Midwife

Evie Doman, Community Midwife

Stacey Laidlaw, Community Midwife

Sarah Williams, Community Midwife

## CONTENTS

## 00 What is PROMPT Wales

00.1 PROMPT Wales is a maternity safety programme funded by the Welsh Risk Pool and supported by the PROMPT Maternity Foundation. PROMPT Wales has been successfully implemented in all obstetric-led units in Wales since January 2018. PROMPT Wales training was initially adapted to meet the needs of PTHB community midwifery services until the development and implementation of Community PROMPT Wales in 2020.

00.2 PROMPT Wales is centrally coordinated by a multi-professional National Team who provide oversight of this all-Wales programme and offer support and guidance to local faculty teams. Local PROMPT Wales Leads are responsible for the planning and organisation of PROMPT Wales training in their unit and are supported by a wider multi-professional faculty who have undergone an accredited PROMPT or PROMPT Wales faculty training course. In PTHB, the Consultant Midwife has taken the role of local PROMPT Wales lead.

00.3 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 PROMPT Wales Standards (2018).

00.4 Commencing in April 2022, the National PROMPT Wales team have coordinated a series of Quality Assurance visits to all training sites to ensure that high standards of PROMPT training are being met across Wales. This report will present the findings of the National Team and will include examples of good practice and recommendations for action before the next scheduled visit. We aim to promote a consistent approach 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.

## 01 Venue for Training

01.1 Conducting PROMPT Wales Training in the clinical area is considered to be an essential component of effective training[1]. This promotes the principle of 'teams that work together, should train together' which underpins PROMPT training and enables the testing of systems and processes - contributing to organisational improvement. Community PROMPT Wales training 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 community bags.

## 02 Organisation of the training

02.1 Structure of the session

02.1.1 PTHB have adopted the Community PROMPT Wales training package.

02.1.2 Three courses are held annually which is sufficient to train all members of the team. The course observed was the first of the year with a new programme. The faculty had held a planning day ahead of the course where the scenarios had been organised and practised.

02.1.3 The team receive two days of mandatory training, with four Community PROMPT Wales sessions of 40 minutes each included on day one. On this day the team also received their annual mandatory Basic Life Support update delivered by the Resuscitation Team, a neonatal resuscitation update from midwife Suzanne Pardoe-Bouchard, a session on GAP/GROW and a kit check.

02.1.4 The Community PROMPT Wales Human Factors presentation is presented face-to-face.

02.1.5 The effectiveness of PROMPT training is underpinned by the multi-professional approach. It was good to note the multi-professional team on the day of the Quality Assurance visit which included 12 Community Midwives, 3 Healthcare Assistants, 2 Paramedics, along with the Risk & Governance Midwife, Research Midwife and trainee Midwife Sonographer and student midwives. The delegates were divided into four groups.

02.1.6 The Community PROMPT Wales sessions were facilitated by the PROMPT trained faculty – seven midwives. The Consultant Midwife had made contact with the local paramedic faculty, but they were unable to provide a facilitator for this course.

02.2 Welcome and introductory talk

02.2.1 The delegates received a warm welcome and introductions and an ice-breaker took place.

02.3 End of Session Plenary & Feedback

02.3.1 It is useful for delegates to come together at the end of the day as this provides an opportunity to regroup, raise any questions and concludes the day nicely. The delegates had an opportunity to group together with faculty before leaving. They each gave one key message they had taken from the day which concluded the day nicely.

02.3.2 Evaluations were completed using a QR code.

02.4 Faculty Debrief

02.4.1 This provided an opportunity for discussion and reflection, to review the feedback and identify any required changes for future courses.

## 03 Learning Presentations

03.1 The Community PROMPT Wales Human Factors was presented. This provided an introduction to Community PROMPT Wales, a reminder about the importance and impact of human factors and set the expectations of the day. From our observations across NHS Wales, we have noted that teams perform more effectively in scenarios in relation to human factors when they have received the Human Factors presentation face-to-face on the day. Delegates are also provided with the link to access the online Community PROMPT Wales/PPH presentation before attending providing valuable preparation ahead of the PPH scenario.

## 04 Scenarios

04.1 PPH Scenario

04.1.1 This scenario was facilitated by two midwives - one midwife was the patient-actor.

04.1.2 Excellent props and set up with the OBS Cymru checklist and a MEOWS chart available for the team. The delegates accessed the required equipment from their community bags.

04.1.3 The team received a good briefing before the scenario guided by the Facilitator's Aide Memoir. The team were orientated to the setting and resources and reminded about human factors. Observers were allocated to complete the clinical and human factors checklists. Team members remained in their own roles.

04.1.4 Faculty were supportive and let the scenario run without interrupting.

04.1.5 The team performed well on the whole. 'Blood loss' was measured but the team were slow to use OBS Cymru PPH Management Checklist and MEOWS chart, despite being gently prompted by the facilitator. PROMPT Wales training provides the opportunity to embed this into clinical practice and the facilitator reminded the team during the debriefing that all women should be risk assessed for PPH using OBS Cymru PPH Management Checklist and this should be used to guide the management when the measured blood loss reaches 500mls. The scenario was nicely concluded with an SBAR handover.

04.1.6 It is important to aim for real time as far as possible and it was good to see the teams actually 'taking' the blood pressure, pulse rate etc. Observations and findings were appropriately given when the action had been carried out.

04.1.7 A good debrief followed. The observers were invited to feedback and were encouraged to read through the checklists and provide examples, and this generated some valuable discussion. The patient-actor was asked to feedback.

04.1.8 Incidental spare time was used for teaching and discussion.

04.2 <u>Sepsis Scenario</u>

04.2.1 This scenario was facilitated by two midwives - one midwife was the patient-actor.

04.2.2 Props and equipment were good and the Sepsis Risk Assessment Tool, Sepsis Six checklist and MEOWS chart were available.

04.2.3 A thorough briefing, guided by the Facilitator's Aide Memoir prepared the team well. The team were orientated to the setting and resources and reminded about human factors. Explaining this in the briefing will encourage the team to make use of the tools designed 'to make the right way the easy way' and embed this into clinical practice. Remind the team before every scenario to declare the emergency, identify a lead and use closed loop communication.

04.2.4 Faculty were supportive and let the scenario run without interrupting. Observations and information were given as requested and plotted on the MEOWS chart. After a gentle reminder, the observed team plotted observations on the MEOWS chart and used the Sepsis Risk Assessment Tool before declaring sepsis. The Sepsis Six checklist was followed as far as possible in the community setting.

04.2.5 The Facilitator's Aide Memoir was used to guide an excellent debrief. Observers were invited to feedback and read through the clinical and human factors checklists in full generating useful discussion.

04.2.6 It was good to observe the Key Learning Points from the Sepsis chapter in the Community PROMPT Wales Trainer's Booklet were used to conclude the scenario, ensuring all essential points had been covered.

04.2.7 When the scenario had finished, there was a practice station on bladder filling. It is excellent that the faculty have identified a need for this to remain on the programme this year to ensure this essential skill is taught. However, adding this at the end of the sepsis scenario reduces the time available for sepsis.

04.3 Shoulder Dystocia Workstation

04.3.1 This was facilitated by two midwives and was an excellent example of a shoulder dystocia workstation.

04.3.2 The Community PROMPT Wales Shoulder Dystocia algorithm and proforma were available and handed to team members.

04.3.3 The PROMPT Flex manikin and baby were used to demonstration the manoeuvres.

04.3.4 It is essential that all delegates get the opportunity to practise the manoeuvres (relevant to their role). The faculty have taken note of previous feedback from the National Team and concentrated on a good quality workstation over a scenario *and* workstation, and this provided unhurried time for practise.

04.3.5 All key points were discussed including risk factors, signs, diagnosis and routine axial traction etc and the Key Learning Points were referred to.

04.3.6 It was good to see the HCAs empowered to use the algorithms and proformas.

04.3.7 Time was filled appropriately with relevant discussion and learning.

04.4 Breech Scenario and Workstation

04.4.1 This scenario was facilitated by three midwives – one of whom was the patient-actor.

04.4.2 The scenario started in the birthing pool making it authentic for this team.

04.4.3 The PROMPT Flex manikin and baby were used.

04.4.4 The team were briefed, and observers were allocated to complete the human factors and clinical checklists.

04.4.5 The Community PROMPT Wales Vaginal Breech Birth algorithm and proforma were used by the team.

04.4.6 Following the scenario, the facilitators demonstrated the breech manoeuvres, and everyone had an opportunity practise.

04.4.6 An excellent debrief took place guided by the Facilitator's Aide Memoir. The observers and the patient-actor were invited to feedback and the checklists were read through in detail.

04.4.7 Remaining time was spent on relevant discussion and learning.

04.5 Newborn resuscitation

04.5.1 This station was intended as the midwives annual mandatory update and not a Community PROMPT Wales workstation or scenario. However, as the facilitator *is* 'PROMPT' trained, there were elements of PROMPT evident which was pleasing to see. This was an excellent update where all members of the team (relevant to role) had an opportunity to practise resuscitation of the newborn following the Resuscitation Council UK algorithm (2021) whilst supported and guided by the facilitator. The human factors checklist was given out and the Community PROMPT Wales Key Learning Points were used to conclude the session.

04.6 Additional Sessions

04.6.1 The teams received their annual mandatory Basic Life Support session which is facilitated by the Resuscitation Team from Cwm Taf Morgannwg UHB. This could also be combined with a scenario from the Community PROMPT Wales Trainer's Booklet, providing one of the faculty joined the Resuscitation Officers.

04.6.2 A very useful session took place where the Community Midwives checked their bags and equipment.

04.6.3 The teams received an update on the new neonatal sepsis pathway.

04.6.4 A very informative and interactive update on GAP/GROW was provided by a midwife from the Day Assessment Unit and was clearly valuable for the midwives.

## 05 Overall observations

05.1 Community PROMPT Wales training at PTHB maintains authenticity to the context of community midwifery. Staff from all teams come together providing the opportunity to get to know their colleagues from the other Powys community teams. The chosen environment is particularly suitable with scenarios taking place in the bedrooms. The

midwives use their own kit, which encourages them to practise retrieving equipment under pressure in a simulated emergency situation.

05.2 The day is well planned and organised. The faculty are clearly committed to providing a quality training experience and understand the overarching purpose of PROMPT; bringing teams together to train in a safe environment. They are welcoming, supportive and inclusive. The course was facilitated to a very good standard.

05.3 Paramedics are invited to attend every course, this facilitating an understanding and appreciation of each other's roles and how Paramedics and Midwives can support each other to achieve the best outcome. Two of the teams had the benefit of a Paramedic in their team. An alternative could be that the paramedics swap teams in the afternoon, so all the midwives get the opportunity to train with them.

05.3 We noted the Facilitator's Aide Memoir was used to structure the briefing and debriefing most of the time. We continue to encourage it's use as it acts as a reminder and ensures the teams are reminded ahead of every scenario to; declare the emergency, call for help, practise closed loop communication and to use the algorithms, checklists proformas, MEOWS etc.

05.4 It was good to see the Key Learning Points from each chapter in the Trainer's Booklet had been laminated and were used to conclude most of the sessions, ensuring all essential points had been covered.

05.5 We were informed that a MEOWS chart is being introduced to PTHB and a pilot version was available on the day. Training is an ideal opportunity to introduce new tools, and the MEOWS chart was provided in the sepsis and PPH scenarios. We would recommend that the midwives carry these at all times and plot observations if a woman presents as unwell. This can be reinforced in the scenarios.

05.6 Use of the Community PROMPT Wales algorithms and proformas appears to have embedded in practice in the Heath Board. The midwives reported that they all carry them in their bags. Their use was reinforced by the faculty, demonstrating the application of training to clinical practice.

05.7 In teams who do not include an SBAR, the scenario can be concluded by asking for an SBAR handover. If the SBAR *is* done but not done well, this can be tactfully revisited during the debrief. This can really empower the Community Midwives when needing to transfer a woman or baby in to an obstetric unit.

05.8 Faculty huddles are recommended before the start of the course and again at the end and demonstrates the commitment of all faculty members to continually improving training and it was good to see this.

05.12 The PROMPT Wales National Team are advising all Health Boards of the benefit of the Practice Development Midwives remaining supernumerary if faculty numbers allow, as they are an essential resource for less experienced faculty. As there is no PDM in PTHB, an experienced facilitator could take this on and from our observations on the day, the new faculty members were well supported by their experienced team. The new facilitators should be commended for their evident preparation and authentic PROMPT facilitation.

## 06 Good Practice Noted

06.1 The PROMPT Wales National Team note areas of good practice which can be adopted by other teams and share this information with other faculties and at national development events. A number of areas of good practice were noted during this QA Review.

06.2 Training in the community setting

*Training in the clinical setting has been shown to be an essential component of effective training*

06.3 Training facilitated by Community Midwives

*Training facilitated by Community Midwives maintains authenticity to the context of community midwifery.*

06.4 Relevant stations from the Community PROMPT Wales Trainer's Booklet

*The volume of clinical topics included is good and reflect local priorities.*

06.5 Faculty used any incidental spare time at the end of scenarios for further learning relevant to the topic.

06.6 Use of a patient-actors.

*This adds realism and provides the opportunity for the patient-actor to feedback to the team providing the 'woman's' perspective on the care received.*

06.7 Good organisation of equipment and training resources.

*This demonstrates a commitment to the provision of high quality training.*

## 07 Our Recommendations for further development

07.1 The PROMPT Wales National Team recognise the high quality of organisation and execution of Community PROMPT Wales training in PTHB and make the following recommendations to build on the effectiveness of the training.

PWPT01 To further embed the use of resources such as MEOWS charts, OBS Cymru PPH Management Checklist etc. in clinical practice, these could be discussed in the morning presentation or ahead of each station as part of the briefing.

PWPT02 To ensure a standardised approach to briefing and debriefing in every station/scenario, the faculty could meet to discuss the format of the Facilitator's Aide Memoir.

PWPT03 Experienced faculty members remain available to support less experienced faculty or those who do not get the opportunity to facilitate regularly.

PWPT04 The faculty team be willing to share their good practice with other Health Boards in Wales who are developing their Community PROMPT Wales training.

## 08 Health Board Action Plan

08.1 The local faculty leadership team is required to provide an action plan with measurable, time-bound outcomes, which address the recommendations made.

08.2 This report is in draft form and the Health Board is required to submit its action plan to the PROMPT Wales National Team by **11th July**.

| Action Ref | Action Title | Action Description | Timescale for completion |
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| **Reporting Committee** | **Quality Patient Safety Committee** |
| **Chaired by** | **Ceri Phillips** |
| **Lead Executive Director** | **Director of Nursing & Quality** |
| **Date of Meeting** | **9th August 2022** |

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

## 1.0 Mother & Baby Serious Untoward Incident Feedback

An informative presentation was received from Aneurin Bevan University Health Board (ABUHB) on the learning and reflections following a Serious Untoward Incident relating to a Mother and Baby Unit placement that occurred in December 2019. This had been shared with the South Wales Mother and Baby Unit for shared learning in terms of the importance of communication and care and treatment plans for home leave.

## 2.0 Commissioning Team and Network Updates

Reports from each of the Commissioning Teams were received and taken by exception. Members noted the information presented in the reports and a summary of the services in escalation is attached to this report. The key points for each service are summarised below:

- **Cancer & Blood**

The Committee was pleased to receive the formal notification that the Neuroendocrine Tumour (NET) Service in Cardiff & Vale University Health Board (CVUHB) had received UK ENET's accreditation. The team were congratulated on their achievement.

- **Cardiac**

The Committee was informed of the improving position in Swansea Bay University Health Board (SBUHB) cardiac services. The level of escalation will be considered once the invited services review report has been received and reviewed by the commissioning team.

- **Neurosciences**

An update was provided on the Artificial Limb Service. It was agreed that it would be beneficial to request an update on patient outcome as part of future work with the service.

- **Women & Children**

An update was provided to the committee regarding Paediatric Surgery, which continued to be monitored with the Clinical Board at CVUHB and through Service Level Agreements (SLA) meetings. It was noted that the SiTREP meetings had been reinstated as a result of ongoing pressures on neonatal cot capacity. This was primarily as a result of workforce issues. Concern was raised regarding the progress in setting up the Welsh Government Maternity & Neonatal Safety programme which would oversee the work. The Committee was made aware of a letter from Welsh Government (WG), dated 14th July, that had been sent to the Neonatal network and copied to WHSSC highlighting growing concerns around neonatal intensive care cot capacity across south Wales. A paper outlining the extent of these issues over the past six months across Wales had been requested, which will be signed off by the EDoN prior to submission to WG. An update regarding the neonatal transport positon was provided to the committee and it was agreed that the neonatal update report submitted to Joint Committee would be shared after the meeting.

- **Intestinal Failure (IF)– Home Parenteral Nutrition**

A verbal update was provided to the committee and a detailed report was requested for the next meeting.

- **Mental Health & Vulnerable Groups**

The committee was provided with a summary of the services in escalation and Members received a presentation from the Cwm Taf Morgannwg University Health Board (CTMUHB) Exec Lead on the progress made at Ty Llidiard, which is currently in Escalation Level 4. It was noted that good progress has been made against the service improvement plan and a further update was requested at the next meeting to ensure a sustained improvement.

Members received a presentation on the recommendations and findings of a coroner's inquest that took place on 22nd February 2022. This was as a result of a serious untoward incident at Arnold Lodge Women's Enhanced Medium Secure Service in July 2018. Whilst no Regulation 28 was issued, a Quality Improvement Plan was put in place that is monitored by Mental Health Specialised Commissioning NHS England Midlands Region. The committee was assured that a joint meeting involving National Collaborative Commissioning Unit (NCCU), WHSSC Health Board and NHS England took place immediately following the inquest and an in-depth Ward Review was undertaken on the 16th June, which will be considered by the commissioning team once published. There were no Welsh placements currently with the NHS provider.

Members were provided with an update regarding service provision for Welsh patients with Eating Disorders. Negotiations with NHS England continue and it is planned that the 'gatekeepers' will visit the two potential units and develop a seamless pathway for patients. This will be an interim arrangement and long-term plans will be considered as part of the Mental Health Strategy. Assurance has been

sought that current patients in Cotswold House will continue with their treatment and be unaffected by any changes to the contract.

The members were provided with an update on the new model and Early Adopter services for the Gender Identity Development Service (GIDS) patients that NHS England announced on 29th July. Dr Cass recommended new regional centres be led by specialist children's hospitals, which are hoped will be operational by Spring 2023. Once operational, these services will take over clinical responsibility for all GIDS patients and those on the waiting list. The London-based service will be formed as a partnership between Great Ormond Street Hospital for Children and Evelina London Children's Hospital, with specialist mental health support provided by South London and Maudsley NHS Foundation Trust. The North West-based service will be formed as a partnership between Alder Hey Children's NHS Foundation Trust and Royal Manchester Children's Hospital, who both provide specialist Children and Young People's Mental Health services.

**3.0 Other Reports Received**

Members received reports on the following:

- **Services in Escalation Summary**

WHSSC currently has seven services in escalation. The status of each service in escalation remains unchanged. However, the Cardiac services are making good progress and it is hoped that WHSSC will be in a position to de-escalate these over the next few months. The North Wales Adolescent Unit is also waiting for the NCCU review and should also be in a position to be de-escalated.

- **CRAF Risk Assurance Framework**

Members noted a new risk relating to neonatal cots and were provided with an updated positon regarding the WHSSC Individual Patient Funding Panel Terms of Reference position and noted the progress made.

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

The committee was updated regarding the unannounced inspection that HIW undertook on Hillview Independent Hospital on 15-17 November 2021 and published their report on July 8 2022. Regis Healthcare Ltd is registered to provide an independent hospital for Children and Adolescent Mental Health patients at Hillview Hospital based in Ebbw Vale. The improvement plan will be overseen as part of the NCCU Framework.

The CQC undertook an unannounced inspection of St Mary's Hospital (Elysium Healthcare) focusing on Cavendish and Leo wards on the 21st and 22nd July. This was as a result of recent concerning restraint episodes and the death of a NHS England patient. The commissioning team report will consider the findings once published and WHSSC are a member of the Quality Assurance Board which will oversee the improvement plan.

- **Incident and Concerns report**

A concern was raised by a parent of a child regarding care at Hillview. This is being managed through the NCCU and legal advice has been sought. A copy of the response has been received. The same individual recently featured in a media article and an alternative placement is being actively sought.

- **Policy Group Report**

Received for assurance.

**4.0 Items for information:**

Members received a number of documents for information only, which members needed to be aware of:

- Chair's Report and Escalation Summary to Joint Committee 12 July 2022,
- Welsh Health Circular – Never Events,
- Welsh Health Circular - National Clinical Audit and Outcome Review Plan,
- Draft Development Day Agenda,
- QPS Distribution List; and
- QPS Forward Work Plan.

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

Key risks are highlighted in the narrative above.

**Summary of services in Escalation (Appendix 1 attached)**

**Matters requiring Committee level consideration and/or approval**

There were no specific issues requiring escalation to the committee.

**Matters referred to other Committees**

None were noted.

Confirmed minutes for the meeting are available upon request

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| **Date of next scheduled meeting:** | 11th October 2022 at 13.00hrs |

## 1.0 SERVICES IN ESCALATION

| Date of Escalation | Service | Provider | Level of Escalation | Reason for Escalation | Current Position 03.08.2022 | Movement from last month |
|---|---|---|---|---|---|---|
| November 2017 | North Wales Adolescent Service (NWAS) | BCUHB | 2 | • Medical workforce and shortages operational capacity<br>• Lack of access to other Health Board provision including Paediatrics and Adult Mental Health. Number of Out-of- Area admissions | • QAIS report outlined key areas for development including the recommendation to consider the location of NWAS due to lack of access on site to other health board provision – This is being considered in the Mental Health Specialised Services Strategy.<br>• Medical workforce issues improved with further appointments made and the issue of GMC registration resolved for 1 clinician.<br>• Bed panel data submitted electronically.<br>• NCCU undertook Annual Review on 29th June 2022 report yet to be published. |  |

| Date of Escalation | Service | Provider | Level of Escalation | Reason for Escalation | Current Position 03.08.2022 | Movement from last month |
|---|---|---|---|---|---|---|
| March 2018<br><br>Sept 2020<br><br>Aug 2021 | Ty Llidiard | CTMUHB | 4 | • Unexpected Patient death and frequent SUIs revealed patient safety concerns due to environmental shortfalls and poor governance<br>• SUI 11 September | • Escalation meetings held monthly, Exec Lead identified from Health Board. Last escalation meeting 20th July.<br>• Improvement Board established to oversee delivery of an integrated improvement plan.<br>• Emergency SOP has been fully implemented.<br>• Successful recruitment to posts created under a revised nursing workforce model.<br>• All new therapy posts have been advertised and will be completed by end of August.<br>• A new consultant has been appointed to lead the medical staff complement which now includes a further consultant post and a physicians associate grade post.<br>• Completion of a 4C's engagement process. |  |

| Date of Escalation | Service | Provider | Level of Escalation | Reason for Escalation | Current Position 03.08.2022 | Movement from last month |
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| September 2020 | FACTS | CTMUHB | 3 | • Workforce issue | • Next escalation meeting proposed July 20th but has been postponed due to lack of IGL availability however written update provided as alternative<br>• Staff proposal approved by BDGB, to increase resilience<br>• Work ongoing to address issues in HMP YOI<br>• Consultant Psychiatrist job description remains with College for approval |  |

| Date of Escalation | Service | Provider | Level of Escalation | Reason for Escalation | Current Position 03.08.2022 | Movement from last month |
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| July 2021 | Cardiac Surgery | SBUHB | 3 | • Lack of assurance regarding current performance, processes and quality and patient safety based on the findings from the Getting It Right First Time review | Continued six weekly meetings in place to receive and monitor against the improvement plan.<br><br>Although the service was de-escalated on delivery of the immediate actions required by the GIRFT recommendations (per March update), further work is required between SBUHB, C&VUHB and WHSSC to improve the aorto-vascular pathways and develop the preferred options. In the meantime, the pathway will remain unchanged.<br><br>Escalation level will be reviewed – |  |

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| | | | | | discussion planned for September 2022 – on provision of six months of data following delivery of GIRFT recommendations and the submission to WHSSC of the recent Royal College of Surgeons of England (RCS England) Invited Service Review report. | |

| Date of Escalation | Service | Provider | Level of Escalation | Reason for Escalation | Current Position 03.08.2022 | Movement from last month |
|---|---|---|---|---|---|---|
| July 2021<br><br>April 2022<br>(from 2-3) | Cardiac Surgery | C&VUHB | 3 | • Lack of assurance regarding processes and patient flow which impact on patient experience | • C&VUHB had previously agreed a programme of improvement work to address the recommendations set out in the GIRFT report.<br>• In view of continued failure to provide the GIRFT improvement plan and HEIW report the service was re- escalated in April 2022.<br>• Level 3 meetings were held in June and July, and subsequent meetings will be held at six-weekly intervals.<br>• These Executive level escalation meetings supersede bi- monthly meetings previously instituted for |  |

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| | | | | | monitoring purposes.<br>• The service has now provided the requested GIRFT improvement plan and HEIW report (and action plan), and is has been agreed that WHSSC develop de-escalation criteria based on the recommendations in the GIRFT report and action plans. | |

| Date of Escalation | Service | Provider | Level of Escalation | Reason for Escalation | Current Position 03.08.2022 | Movement from last month |
|---|---|---|---|---|---|---|
| November 2021 | Burns | SBUHB | 3 | • The burns service at SBUHB is currently unable to provide major burns level care due to staffing issues in burns ITU. | • The burns ICU is restored to full capacity (3 beds) with support from general ICU and anaesthetics consultants (stage 1 of the plan).<br>• Mutual assistance is available via the South West and Wales Burns Network and wider UK burns escalation arrangements, should it be required.<br>• The three-stage plan has been agreed following advice and support from the Burns Network and a peer visit to Swansea.<br>• Escalation monitoring meeting arranged for 12th August 2022.<br>• The current timeline |  |

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| | | | | | for completion of the capital works to enable relocation of burns ITU to general ITU at Morriston Hospital is the end of 2023. | |

| Date of Escalation | Service | Provider | Level of Escalation | Reason for Escalation | Current Position 03.08.2022 | Movement from last month |
|---|---|---|---|---|---|---|
| February 2022 | PETIC | Cardiff University | 3 | Concern over management capacity within the service to ensure a safe, high quality timely service is maintained for patients.<br><br>These concerns include:<br>• Recent suspension of production of PSMA due a critical quality control issue identified during MHRA inspection. Service slow to address impact on service for patients.<br>• Failure to undertake a timely recruitment exercise leading to isotope production failures.<br>• Failure to produce a business case of sufficient quality in a timely manner for | • The next escalation monitoring meeting is arranged for 23rd September 2022.<br>• PETIC is taking forward the agreed actions with regard to increasing management capacity within the service and clarifying the governance arrangements for the service. | ⇔ |

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| | | | | replacement of the scanner. | | |

Level of escalation reducing / improving position

Level of escalation unchanged from previous report/month

Level of escalation increasing / worsening position

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| **Reporting Committee** | **Quality Patient Safety Committee** |
| **Chaired by** | **Ceri Phillips** |
| **Lead Executive Director** | **Director of Nursing & Quality** |
| **Date of Meeting** | **June 7th 2022** |

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

**Commissioning Team and Network Updates**

Reports from each of the Commissioning Teams were received and taken by exception. Members noted the information presented in the reports and a summary of the services in escalation is attached to this report. The key points for each service are summarised below:

## 1.0 Welsh Renal Clinical Network (WRCN)

The Committee received the report from the network. There were no issues to report.

## 2.0 Cancer & Blood

The Welsh Centre for Burns and Plastic Surgery, Morriston Hospital, Swansea Bay University Health Board (SBUHB) remained at escalation level 3. Work continued with Swansea around the long-term model, which was dependent on the redevelopment of Morriston's ICU unit, including receipt of capital for a long-term plan. WHSSC continued to monitor the two phase action plan with input and advice from the South West & Wales Burns Network (SW&WBN).

The Positron Emission Tomography Imaging Centre (PETIC) remained in Escalation and monitoring meetings were in place. Another concern around the of the age of the current scanner was also highlighted. There is a procurement process underway to replace this scanner which will mitigate this risk. The service was maintaining turnaround times within the agreed target of 10 working days.

The committee noted that there were long waiting times for plastic surgery within Swansea Bay. A recovery plan had been requested but this had not been received to date.

## 3.0 Cardiac

Members received an update regarding the two cardiac surgical services in South Wales that remained in escalation. An update was received on the action plan in place in response to the GIRFT report undertaken at SBUHB and the Committee

received assurance that SBUHB was making good progress on its delivery and the level of escalation would be reconsidered shortly.

Cardiff and Vale University Health Board (C&VHB) had recently been re-escalated from Level 2 to Level 3 due to the lack of assurance to engage with WHSSC regarding their GIRFT improvement plan. WHSSC have since received a more detailed action plan with involvement from the Surgical Clinical Board and good engagement at the last escalation meeting. WHSSC have facilitated the engagement of the two Health Boards to share learning and will continue to monitor the service against key indicators.

Despite the services being in escalation the committee noted that the risk for patients waiting for cardiac surgery had been reduced. Cardiac Surgery waiting lists were currently at their lowest for four years. However, there were growing concerns around diagnostics and cardiology clinical pathways within Health Boards as people are not making their way onto cardiac surgery lists.

## 4.0 Mental Health & Vulnerable Groups

Members received a separate update report regarding Ty Llidiard, which was currently in Escalation Level 4. Members requested that their concerns regarding the length of time that the services had been in escalation and the slow progress be escalated to Joint Committee for further discussion and assurance.

The committee were informed that a stakeholder engagement with NHS England, with the aim of securing a new Perinatal Mother & Baby Unit service for mid Wales and North Wales patients, was ongoing but this was dependent on the securing of capital funding by NHSE.

Following receipt of notice for the termination of the WHSSC contract with Oxford Health NHS Foundation Trust, colleagues in NCCU were scoping alternative providers to ensure ongoing and uninterrupted service provision.

Prior to the Welsh Gender Service (WGS) being set up in 2019, patients were referred to the London GIC in Charing Cross hosted by Tavistock & Portman NHS Foundation Trust (T&PNFT). In 2019, the WGS repatriated a number of patients based on the level of complexity they could manage at that time. The WGS has now completed the repatriation of the remaining validated waiting list of 130 patients. It was also noted that additional funding had been secured in order to set up a satellite clinic for North Wales and Powys patients to reduce the distance to access treatment.

The Committee was informed that work was ongoing with NHS England to consider a clinical model for the Gender Identity Development Service (GIDS) and explore a regional solution given the recommendation from the Cass Review to move away from a single provider.

## 5.0 Neurosciences

Members noted one significant area of concern about the use of an imaging platform that health boards have been using to transfer images between NHS Wales and thrombectomy providers in North Bristol and the Walton. The issue had been escalated to the Delivery Unit and Welsh Government and work was currently being undertaken to improve stroke pathways.

## 6.0 Women & Children

Concerns remained with paediatric intensive care beds, as a result of staffing issues, which could potentially result in paediatric patients requiring intensive care being transferred out of Wales. The Committee was assured that work was ongoing and a set of controls was in place to mitigate the risk.

Members were informed that Paediatric Surgery remained a concern. There was a risk that paediatric patients waiting for surgery in the Children's Hospital of Wales were waiting in excess of 36 weeks, due to the COVID-19 pandemic and that, as a consequence, the condition of the patient could worsen. The WHSS team had asked for a recovery trajectory and plan and there is continuous monitoring with the Clinical Board at CVUHB and through SLA meetings.

## 7.0 Intestinal Failure (IF)– Home Parenteral Nutrition

The Committee was provided with a detailed update on the creation of a temporary IF commissioning team and the on-going review of IF arrangements. The report highlighted some concerns with the current supply issues with Calea and progress with the HPN contract renewal. It was confirmed that WHSSC had formally instructed procurement to act on behalf of WHSSC in raising concerns around the contract performance. The ultimate aim is to move to an NHS provided service in order to mitigate the risk further.

## Other Reports Received

Members received reports on the following:

- **Services in Escalation Summary**

WHSSC currently has seven services in escalation. One service had increased its level of escalation and all others remain unchanged; progress and further work was detailed in the commissioning team reports.

- **CRAF Risk Assurance Framework**

Members received a report presenting the updated Corporate Risk Assurance Framework (CRAF) and outline the risks scoring 15 or above on the commissioning teams and directorate risk registers. There were currently 18 risks on the CRAF of which 16 were commissioning risks and two were organisational risks. Four risks were de-escalated during the period between February - May 2022 and work continues with the commissioning teams to address the remaining risks. It was noted that IPFR remained one of the highest risks. The Committee was informed that following a meeting with WG it had been confirmed that WHSSC were able to commence a wider engagement exercise to

consider the ToR and will be referenced in the Joint Committee's Managing Director's Report in July 2022 and a final report will be presented in September 2022.

- **CQC/HIW Summary Update**

- **Quality Newsletter**

Members received a draft copy of the First Quality Newsletter for comment and feedback. This was well received and is an appendix to the report for wider circulation as appropriate.

- **Service Innovation & Improvement Report**

The report which provided an update on the Service Improvement and Innovation Workshops and similar externally organised events that have taken place since the Covid-19 pandemic was received.

- **Policy Group Report**

**Items for information**

Members received a number of documents for information only, which members needed to be aware of:

- Chair's Report and Escalation Summary to Joint Committee 12 May 2022;
- Datix – Cymru Incident Investigation – User Guide
- QPS Forward Work Plan;
- QPS Distribution List

**QPSC Committee Effectiveness Self- Assessment Results and Forward Work Plan**

The findings of the self-assessment results were shared and it was confirmed that they had also been presented to IGC and to the JC in July. Overall the comments were positive. It was difficult for some members to comment as there had been a change in membership at the same time as the survey was circulated

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

The items highlighted above.

**Summary of services in Escalation (Appendix 1 attached)**

**Quality Newsletter (Appendix 2 attached)**

**Matters requiring Committee level consideration and/or approval**

Members agreed the following would be highlighted in the Chair's Report to Joint Committee.

- Ty Llidard updates and to include paper as Appendix to JC,
- Increased escalation of PICU,
- Intestinal Failure position; and
- CRAF - Concerns around IPFR more specifically the changes to the Terms of Reference and governance review.

| | |
|---|---|
| **Matters referred to other Committees**<br>Ensure chairs report are part of health board's agenda items | |
| Confirmed minutes for the meeting are available upon request | |
| **Date of next scheduled meeting:** | 9th August 2022 at 13.00hrs |

## 1.0 SERVICES IN ESCALATION

| Date of Escalation | Service | Provider | Level of Escalation | Reason for Escalation | Current Position 31.05.2022 | Movement from last month |
|---|---|---|---|---|---|---|
| November 2017 | North Wales Adolescent Service (NWAS) | BCUHB | 2 | • Medical workforce and shortages operational capacity<br>• Lack of access to other Health Board provision including Paediatrics and Adult Mental Health. Number of Out-of-Area admissions | • QAIS report outlined key areas for development including the recommendation to consider the location of NWAS due to lack of access on site to other health board provision – This is being considered in the Mental Health Specialised Services Strategy.<br>• Participation in weekly bed management panel meeting.<br>• Medical workforce issues improved with further appointments made and the issue of GMC registration resolved for 1 clinician. |  |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | • Level of escalation will be considered following QAIS annual review in June | |

| Date of Escalation | Service | Provider | Level of Escalation | Reason for Escalation | Current Position 31.05.2022 | Movement from last month |
|---|---|---|---|---|---|---|
| March 2018<br><br>Sept 2020<br><br>Aug 2021 | Ty Llidiard | CTMUHB | 4 | • Unexpected Patient death and frequent SUIs revealed patient safety concerns due to environmental shortfalls and poor governance<br>• SUI 11 September | • Escalation meetings held monthly, however March 22 meeting stood down for the report on a visit from NCCU into the unit to be published to inform ongoing discussions.<br>• Service spec discussions progressed with work ongoing to consider the requirements of the unit.<br>• Awaiting publication and implementation of Medical Emergency Response SOP by CTM.<br>• Coroner's inquest concluded. Implementation of outcomes of inquest to be incorporated into escalation plan alongside the outcomes of HIW and NCCU visits |  |

| | | | | | | |
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| | | | | | • Executive meeting held on May 3rd 2022.<br>• Managing Director wrote to CEO CTUHB on 6th May with agreed actions following meeting.<br>• Response received from Health Board 12th May outlining work and jointly agreed improvement plan going forward. | |

| Date of Escalation | Service | Provider | Level of Escalation | Reason for Escalation | Current Position 31.05.2022 | Movement from last month |
|---|---|---|---|---|---|---|
| September 2020 | FACTS | CTMUHB | 3 | • Workforce issue | The 12 CQV meetings have now been held. The service remains at level 3. Good progress is being made against the key actions key actions remaining:<br>• Substantive Consultant Psychiatrist job description is with the Royal College of Psychiatrists for approval.<br>• Clinical Lead to be advertised once CAMHS Consultant posts have been appointed.<br>• The service has been asked to submit a revised staffing plan to increase the resilience of the team using underspend.<br>• The FACTS service specification (for CAMHS) is planned to go to policy group on |  |

| | | | | | | |
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| | | | | | 13th July for approval to consult.<br>• FACTS have ongoing issues in Parc Prison linked to offsite system access and personal safety that have been escalated via the appropriate channels. | |

| Date of Escalation | Service | Provider | Level of Escalation | Reason for Escalation | Current Position 31.05.2022 | Movement from last month |
|---|---|---|---|---|---|---|
| July 2021 | Cardiac Surgery | SBUHB | 3 | • Lack of assurance regarding current performance, processes and quality and patient safety based on the findings from the Getting It Right First Time review | • Continued six weekly meetings in place to receive and monitor against the improvement plan.<br>• Although the service was de-escalated on delivery of the immediate actions required by the GIRFT recommendations (per March update), further work is required between SBUHB, C&VUHB and WHSSC to improve the aorto-vascular pathways and develop the preferred options. In the meantime, the pathway will remain unchanged.<br>• Escalation level will |  |

| | | | | | | |
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| | | | | | be reviewed on provision of six months of data following delivery of GIRFT recommendations. | |

| Date of Escalation | Service | Provider | Level of Escalation | Reason for Escalation | Current Position 31.05.2022 | Movement from last month |
|---|---|---|---|---|---|---|
| July 2021<br><br>April 2022 (from 2-3) | Cardiac Surgery | C&VUHB | 3 | • Lack of assurance regarding processes and patient flow which impact on patient experience | • C&VUHB had previously agreed a programme of improvement work to address the recommendations set out in the GIRFT report.<br>• In view of continued failure to provide the GIRFT improvement plan and HEIW report the service has been re-escalated<br>• First level 3 meeting scheduled for 1 June, with subsequent meetings at 6 weekly intervals; these supersede bi-monthly meetings previously agreed for monitoring purposes. |  |

| Date of Escalation | Service | Provider | Level of Escalation | Reason for Escalation | Current Position 31.05.2022 | Movement from last month |
|---|---|---|---|---|---|---|
| November 2021 | Burns | SBUHB | 3 | • The burns service at SBUHB is currently unable to provide major burns level care due to staffing issues in burns ITU. | • The burns ICU is restored to full capacity (3 beds) with support from general ICU and anaesthetics consultants (stage 1 of the plan).<br>• Mutual assistance is available via the South West and Wales Burns Network and wider UK burns escalation arrangements, should it be required.<br>• The three-stage plan has been agreed following advice and support from the Burns Network and a peer visit to Swansea.<br>• The service re- |  |

| | | | | | | |
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| | | | | | opened on Monday 14 February with an interim service model delivered with the support of general anaesthetics and general ICU consultants.<br>• The escalation meetings will be led by WHSSC with support and advice from the Burns Network to ensure standards are maintained through the transition process.<br>• An outline scoping case for the capital development of ITU at Morriston Hospital was shared with WHSSC in May. The first escalation monitoring meeting with SBUHB is currently being arranged. | |

| Date of Escalation | Service | Provider | Level of Escalation | Reason for Escalation | Current Position | Movement from last month |
|---|---|---|---|---|---|---|
| February 2022 | PETIC | Cardiff University | 3 | Concern over management capacity within the service to ensure a safe, high quality timely service is maintained for patients.<br><br>These concerns include:<br>• Recent suspension of production of PSMA due a critical quality control issue identified during MHRA inspection. Service slow to address impact on service for patients.<br>• Failure to undertake a timely recruitment exercise leading to isotope production failures.<br>• Failure to produce a | • The quality control issue has been addressed and isotope production restarted on 25 February after a three week suspension.<br>• Analysis of the impact of the delays on patients indicates that while it caused patient anxiety and stress, it is unlikely there will be harm to patients' clinical outcomes.<br>• Current waiting times are within the target turnaround time of 10 days.<br>• The first escalation meeting took place on Friday 25 March.<br>• An action plan has |  |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | business case of sufficient quality in a timely manner for replacement of the scanner. | been agreed with focus on the management and governance arrangements for the service. The next escalation meeting is on Tuesday 7th June 2022. | |

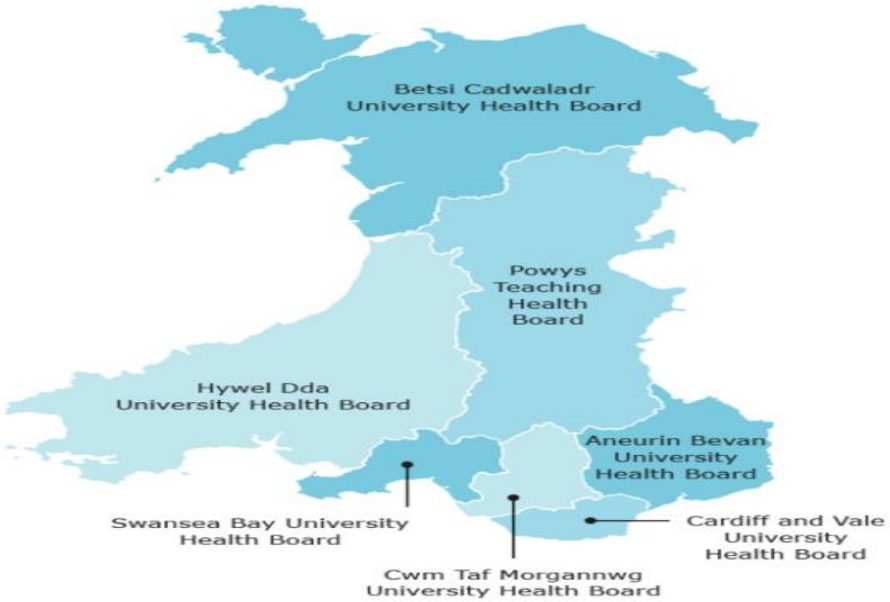
Level of escalation reducing / improving position

Level of escalation unchanged from previous report/month

Level of escalation increasing / worsening position

Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru (PGIAC)
Welsh Health Specialised Services Committee (WHSSC)

# WELSH HEALTH SERVICES SPECIALISED COMMISSIONING QUALITY UPDATE



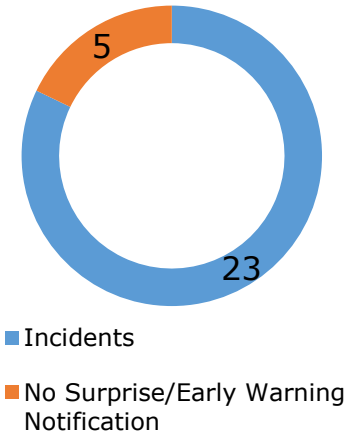

This is the 1st edition of the Quality newsletter from the Welsh Health Specialised Services team in Wales. Our plan is for these to be developed on a quarterly basis to supplement some of the reports and data which already feedback through different forums into the Welsh Health Boards.

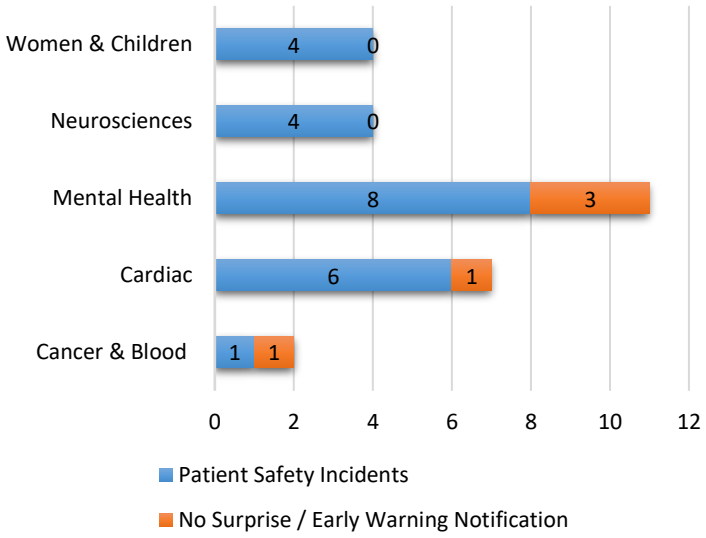
These are some of the highlights and an overview of some of the work we are involved with from a commissioning perspective. The services commissioned from WHSSC are both in Wales and with NHS England this will only provide a very brief snapshot of some of these.

## Reporting for the last Quarter

WHSSC do not investigate incidents but are responsible for supporting the investigations into these alongside the monitoring and reporting to the Health Boards. WHSSC are responsible for ensuring the delivery of safe services and any action plans themes or trends arising from concerns are completed and support learning. WHSSC facilitate the continued monitoring of commissioned services and work with providers when any issues arise.

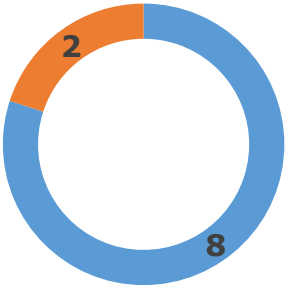
As at March 2022 there are **23** Patient Safety Incidents and **5** No Surprise/Early




## Complaints

As at March 2022 a total of **8** Patient Safety Incidents and **2** No Surprise/Early



## Service Innovation and Improvement Days
## Formerly known as Audit and Outcome Days


During the Covid period these were put on hold but are now back and underway. To date, two days have been held this year one with the Intestinal Failure team and another with the Cancer Network and the Sarcoma specialist teams. A further date is planned for July 2022 with the Cystic Fibrosis team. The days have been really beneficial and the following is an illustration of some of the themes which have emerged:-




These have provided a forum for patient experience to be shared and an opportunity to hear about innovation and different ways of working which

have been adopted to support and deliver services through Covid. They have also provided an opportunity for services to discuss horizon scanning and the development of new services / pathways to support emerging new treatment and therapies. They have facilitated networking opportunities and provided a platform for benchmarking.

The following are some comments received from attendees of the day:-

Whatever the future holds, I am confident that I have received the very best treatment currently available to science to minimise the risk of a re-occurrence. It is reassuring that I am regularly being rechecked and have been made aware of the self-surveillance I need to be undertaking.
Know that I still have the support at the end of the telephone, helps me and my family get answers to questions when they arise, although I try to keep these to a minimum.

Overall having a team that I could have confidence in had a really positive impact on both my mental and physical health.

Thanks for the skills of the medical team and the care I have received. My quality of life is much the same is was pre-sarcoma. I have come through this with as much of a positive mental attitude for the future as I enjoyed in the past.

The fact that to achieve this quality care incurred travelling a greater distance than to my local general hospital has been more than worthwhile. Throughout my treatment, I felt I was more part of the team than just a patient. This was achieved by keeping me well informed and giving me guidance on the options available.

## Update from the Patient Care Team
## IPFR (Individual Patient Funding Request)

The Patient Care Team receives and manages individual patient funding requests for healthcare that falls outside of agreed range of services.

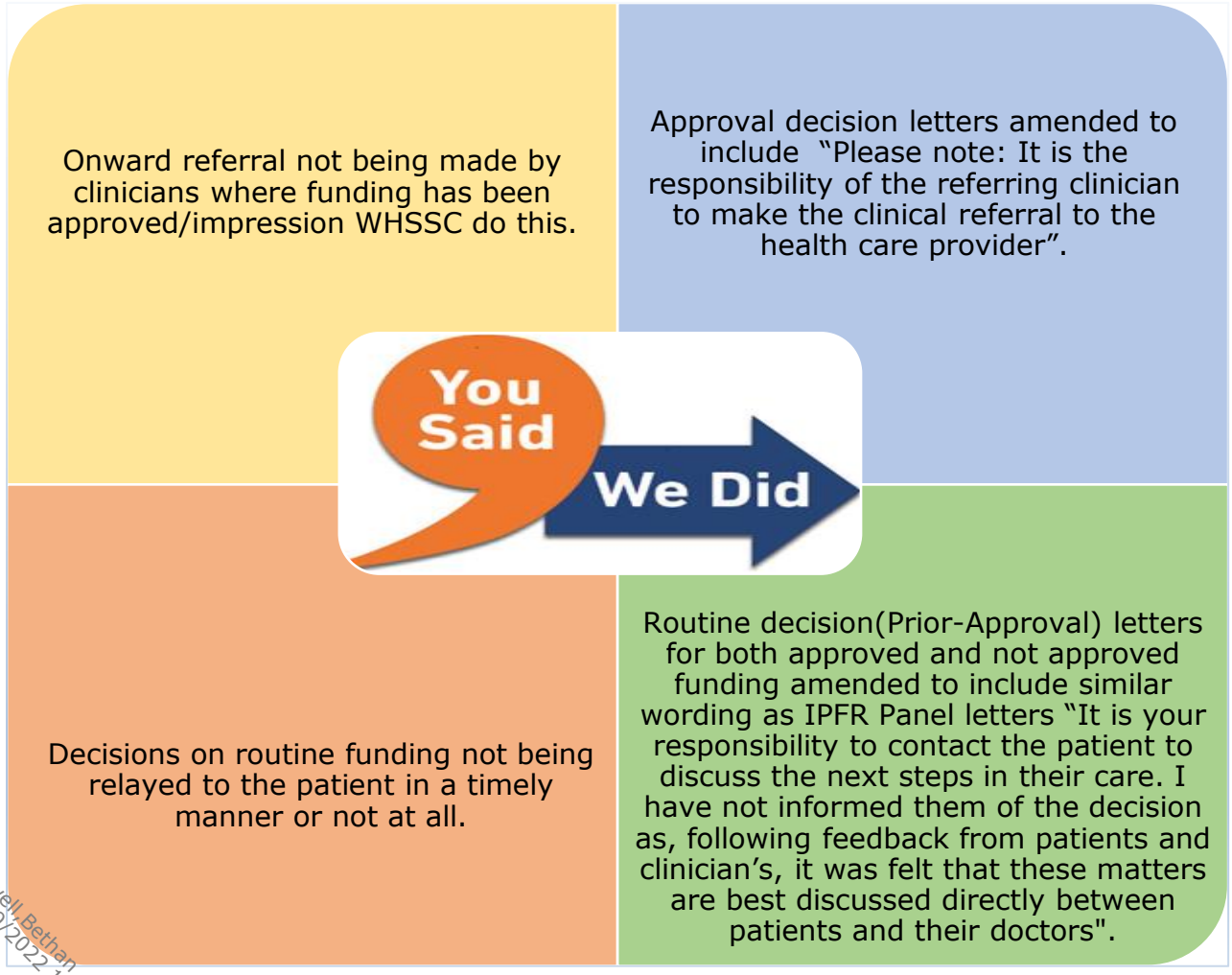
An overview of IPFRs processed 2021 – 2022 (Quarter 1 – 4):

| | |
|---|---|
| Qtr 1 | |
| April – June | 551 |
| Qtr 2 | |
| July – September | 449 |
| Qtr 3 | |
| October – December | 434 |
| Qtr 4 | |
| Jan – March | 603 |

**Total Number of IPFRs 2038**

**Feedback received to the IPFR team**

You Said, We Did – listening to feedback and implementing change:-



## Engagement with Patient Experience


Listening and learning from Patient stories and experience provides the team with great insight into the services commissioned by WHSSC. One story shared with the team last year was from the prosthetic team in Cardiff and involved a patient who had received a microprocessor prosthetic knee. The patient was able to demonstrate over Teams the difference this had made to his mobility and the impact and improvement this had on his quality of life. The prosthetic team were also able to demonstrate how important their work is and how individual this had to be to patients requiring their services.

Many teams have had to work in different ways over the last year and have had to be very innovative in their approach. Some of the teams have shared how they have had to adapt to working with SMART phones and apps with their patients to monitor their wellbeing over virtual appointments and how much they have learnt through doing them to this. Some of this has promoted independence in some of their client groups and been enabling for them.

Some data shared with the team form the Clinical Nurses in Adult Congenital heart disease included an evaluation from patients on virtual clinics.

The Survey was undertaken through survey monkey and sent to **64** patients, a total of **35** responses were received resulting in the following summary,

- A blended approach mix of virtual and face to face appointments thought to work well by patients

- Virtual clinics to be offered as video rather than telephone call to improve the patient experience
- Prior to virtual appointment, patients who require tests such as ECG and Echocardiograms beforehand are undertaken prior to the appointment.
- Promotion and support of patient self-management such as Blood pressure self-monitoring, weight management and symptoms, use of fit watches, pulse measurement apps for heart rhythm recognition felt to be helpful and supportive.

It was evident the Team had learnt to respond and manage patients during the pandemic in new and innovative ways. The experience has seen the team and the patients become more confident with the new ways of working and the ongoing approach to be more of a blended approach.

Other surveys and stories which WHSSC have supported have been the impact delays have had on patients in treatment within certain specialties, such congenital cleft lip and palate, , the following are just a few comments from patients into the survey:-

## Quick Round up of Commissioning Teams

**Mental Health**

5 year strategy being developed and well underway with excellent engagement and support from the Welsh Clinical Teams.

**Women and Chidren's**

Paediatric Strategy is gaining momentum and moving forward with improved engagement

**Neurosciences and long term condition**

Plan to develop All Wales strategy to improve outcomes and experience of patients receiving specialised rehabilitation

**Cancer and Blood**

Recent successful Sarcoma Service Improvement and Innovation Day held.

**Cardiac**

Richard Palmer has joined the commissiong team as a planner . Andrea will be returning to supporting Patient care team after a brief retirement

**Intestinal Failure**

Ongoing work being undertaken with the recently formed IF commissioning team and as a result of the IF review and Service Improvement and Innovation Day

## Recognition of significant events and useful links

Well done to the team Professor Iolo Doull/ Sian Lewis and Andrew Champion on their recent publication:-

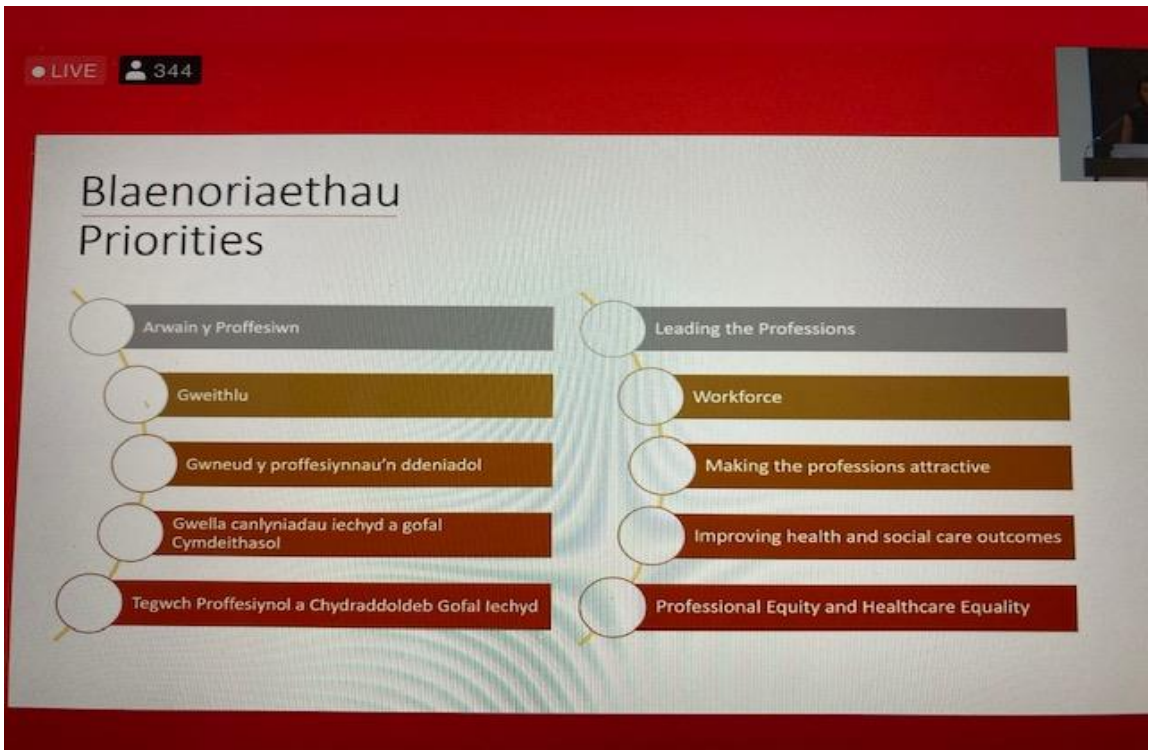
**A Case Study on Reviewing Specialist Services Commissioning in Wales:**
**TAVI for Severe Aortic Stenosis**
Applied Health Economics and Health Policy Journal

A Case Study on Reviewing Specialist Services Commissioning in Wales: TAVI for Severe Aortic Stenosis | SpringerLink

## Chief Nursing Officer Conference Wales

**Sue Tranka, Chief Nursing Officer for Wales**

The recent Chief Nursing Officer Conference held in April 2022 saw the launch of the CNO priorities included below. WHSSC team will be supporting and continuing to incorporate these into their practice. The theme of the conference was very much around professional leadership and delivering this with kindness and Compassion.




Developed in collaboration with stakeholders, the five priorities are:

- Leading the profession - invest in and develop nurse and midwife leaders at all levels in health and social care through dedicated leadership programmes;
- Workforce - close the vacancy gap and attract, recruit and retain a motivated, skilled workforce;
- Making the professions attractive - inspire people to enter the nursing and midwifery professions as the most attractive healthcare career choice in Wales;
- Improving health and social care outcomes - deliver equitable, good-quality, person-centred care; and
- Professional equity and healthcare equality - create a nursing and midwifery workforce that reflects the population it serves and addresses inequalities.

220405 Patient Safety Update 5 April 2022 i:

OTHER USEFUL LINKS WHSSC WEBSITE ….

Welsh Health Specialised Services 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 | 08 Dec | 16 Feb |
| **Strategic Priority (SP)** | **Annual Reports** | | | | | | | |
| | Annual Report of the Accountable Officer for Controlled Drugs | MD | | | | | | ✓ |
| | Safeguarding Annual Report | DNM | | | | | ✓ | |
| | **Quality & Safety Assurance Reports** | | | | | | | |
| | Audit and Regulatory Reports, including annual reports from PSOW, HIW as appropriate | Lead Director | **As and when identified** | | | | | |
| SP22 | Clinical Quality Framework Implementation Update including Patient Experience | DNM, DoTHS, MD | | | ✓ | | | ✓ |
| SP22, SP25 | Commissioning Assurance Report | DNM | ✓ | Incorporated into Integrated Quality Report | | | | |
| SP22 | Integrated Quality Report, including:<br>- Quality Measures<br>- Serious incidents and concerns, Putting Things Right | DNM | | ✓ | ✓ | ✓ | ✓ | ✓ |
| | Women and Children's Quality Report | DPCCMH | ✓ | Incorporated into Integrated Quality Report | | | | |

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

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

| MATTER TO BE CONSIDERED BY COMMITTEE | | EXEC LEAD | SCHEDULED COMMITTEE DATES 2022-23 | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | 12 May | 7 July | 13 Sept | 25 Oct | 08 Dec | 16 Feb |
| | Annual Self-assessment of Committee effectiveness 2022-23 | BS | | | | | | ✓ |
| | Committee Annual Report 2022-23 | BS | | | | | | ✓* |
| | **Total Number of Agenda Items** | | **8** | **7** | **7** | **9** | **9** | **10** |

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

KEY:

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