Patient Experience, Quality and Safety Committee

Thu 02 December 2021, 14:00 - 17:00

via Teams

Agenda

14:00 - 14:00
0 min

1. PRELIMINARY MATTERS

PEQS_Agenda_02Dec21_Final.pdf (2 pages)

1.1. Welcome and Apologies

1.2. Declarations of Interest

1.3. Minutes from the previous meeting held on 7 October 2021 for approval

PEQS_Item_1.3_PEQS Minutes 7 October 2021.pdf (14 pages)

1.4. Matters arising from the previous meeting

1.5. Patient Experience, Quality and Safety Committee Action Log

PEQS_Item_1.5_PEQS Action Log_2Dec 21.pdf (1 pages)

14:00 - 14:00
0 min

2. ITEMS FOR APPROVAL / RATIFICIATION / DECISION

14:00 - 14:00
0 min

3. ITEMS FOR DISCUSSION

3.1. Audit Wales Review: PTHB Quality Governance Arrangements

PEQS_Item_3.1_wales audit review paper Dec 2021.pdf (4 pages)
PEQS_Item_3.1a_App1_Quality Governance Project Brief_v2.pdf (9 pages)
PEQS_Item_3.1b_App2_2551A2021-22_Powys_Quality_Governance_Report_Eng.pdf (38 pages)
PEQS_Item_3.1bi_App2_2551A2021-22_Powys_Quality_Governance_Report_Cy.pdf (42 pages)
PEQS_Item_3.1c_App3__Quality and Safety Framework_Learning & Improving_W.pdf (22 pages)
PEQS_Item_3.1d_App4_Welsh Health Circular - Cover Page - Q&SF - 2021-08-23 PDF.pdf (3 pages)

3.2. Quality Governance Arrangements: Primary Care Services

PEQS_Item_3.2_PC Quality Governance Framework PEQS DecFINAL.pdf (9 pages)

3.3. Integrated Quality Report: Directorate of Primary, Community Care and Mental Health

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PEQS_Item_3.3_Cover Paper for Quality Report Dec PEQS.pdf (3 pages)
PEQS_Item_3.3a_CSG Quality Governance Paper PEQS Dec.pdf (13 pages)
PEQS_Item_3.3b_MHLD Quality Dec PEQS.pdf (10 pages)
PEQS_Item_3.3c_QGG W and C Quality Report Dec PEQS committee.pdf (11 pages)

3.4. Mental Health Act Compliance Report, including a report of the Power of Discharge Sub-

Group

- PEQS_Item_3.4_MHA Compliance Report PEQS Dec2021 FINAL.pdf (11 pages)

3.5. Putting Things Right, Compensation and Claims Report

- PEQS_Item_3.5_Concerns Patient Experience Paper.pdf (11 pages)
- PEQS_Item_3.5i_Appendix 1 - Audit Report Qtr 2 2021-2022.pdf (9 pages)
- PEQS_Item_3.5ii_Appendix 2 - Improvement Plan PtR-November 2021.pdf (20 pages)
- PEQS_Item_3.5iii_Appendix 3 - Training Catalogue.pdf (5 pages)
- PEQS_Item_3.5iv_Appendix 4 - LFER form - pilot version 2.2.pdf (10 pages)
- PEQS_Item_3.5v_Appendix 5 - PTHB Complaints Return 20102021.pdf (5 pages)
- PEQS_Item_3.5vi_Appendix 6 - Patient Experience Framework.pdf (8 pages)
- PEQS_Item_3.5vii_Appendix 7 - Equality Impact Assessment.pdf (15 pages)

3.6. Regulatory Inspections Report

- PEQS_Item_3.6_Committee- Regulatory Paper (V2) 02122021.pdf (5 pages)
- PEQS_Item_3.6i_Appendix 1 - Brecon And District Community and Mental Health Centre - Booking Letter.pdf (8 pages)
- PEQS_Item_3.6iiAppendix 2 - HSCRR Report Recommendations Dashboard.pdf (1 pages)

3.7. Safeguarding:

3.7.1. Annual Report

- PEQS_Item_3.7a_Safeguarding Annual Report PEQS.pdf (11 pages)
- PEQS_Item_3.7ai_Powys Safeguarding Annual Report 2020-2021.pdf (45 pages)

3.7.2. Internal Audit Report – Midwifery Safeguarding Supervision

- PEQS_Item_3.7b_Report of Internal Audit into Midwifery Safeguarding Supervision.pdf (6 pages)
- PEQS_Item_3.7bi_PTHB_2122_09 Midwifery Safeguarding Supervision Final Report.pdf (13 pages)

3.8. Commissioning Escalation Report

- PEQS_Item_3.8_EQS Committee - Commissioning Escalation Report 02122021.pdf (17 pages)
- PEQS_Item_3.8a_Appendix 1 - SaTH CQC Inspection Report.pdf (235 pages)

3.9. Quality Improvement Update including:

- PEQS_Item_3.9_PEQS Quality Improvement.pdf (6 pages)

3.9.1. Quality Improvement Activity

3.9.2. Research and Development Update

3.9.3. Learning Update

3.10. Clinical Quality Framework Update

- PEQS_Item_3.10_PEQS CQF implementation plan update 15.11.2021.pdf (35 pages)

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14:00 - 14:00
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4. ITEMS FOR INFORMATION

14:00 - 14:00
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5. OTHER MATTERS

5.1. Items to be Brought to the Attention of Board and Other Committees

5.2. Any Other Urgent Business

5.3. Date of the Next Meeting: 3 February 2022, 10:00

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POWYS TEACHING HEALTH BOARD
PATIENT EXPERIENCE, QUALITY & SAFETY COMMITTEE

02 DECEMBER 2021,
14.45 – 17:00
TO BE HELD VIRTUALLY VIA MICROSOFT TEAMS

AGENDA			
Item	**Title**	**Attached /Oral**	**Presenter**
1	**PRELIMINARY MATTERS**		
1.1	Welcome and Apologies	Oral	Chair
1.2	Declarations of Interest	Oral	All
1.3	Minutes of the previous meeting held on 07 October 2021 (for approval)	Attached	Chair
1.4	Matters Arising from Minutes of Previous Meetings	Attached	Chair
1.5	Patient Experience, Quality and Safety Committee Action Log	Attached	Chair
2	**ITEMS FOR APPROVAL/RATIFICATION/DECISION**		
	There are no items for inclusion in this section		
3	**ITEMS FOR DISCUSSION**		
3.1	Audit Wales Review: PTHB Quality Governance Arrangements	Attached	Audit Wales & Director of Nursing and Midwifery
3.2	Quality Governance Arrangements: Primary Care Services	Attached	Director of Primary, Community Care and Mental Health
3.3	Integrated Quality Report: Directorate of Primary, Community Care and Mental Health	Attached	Director of Primary, Community Care and Mental Health
3.4	Mental Health Act Compliance Report, including a report of the Power of Discharge Sub-Group	Attached	Director of Primary, Community Care and Mental Health
3.5	Putting Things Right, Compensation and Claims Report	Attached	Director of Nursing and Midwifery
3.6	Regulatory Inspections Report	Attached	Director of Nursing and Midwifery
3.7	Safeguarding: a) Annual Report b) Internal Audit Report – Midwifery Safeguarding Supervision	Attached	Director of Nursing and Midwifery
3.8	Commissioning Escalation Report	Attached	Director of Nursing and Midwifery
3.9	Quality Improvement Update including: a) Quality Improvement Activity b) Research and Development Update c) Learning Update	Attached	Medical Director

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3.10	Clinical Quality Framework Update	Attached	Director of Nursing and Midwifery
4	**ITEMS FOR INFORMATION**		
	There are no items for inclusion in this section		
5	**OTHER MATTERS**		
5.1	Items to be Brought to the Attention of the Board and Other Committees	Oral	Chair
5.2	Any Other Urgent Business	Oral	Chair
5.3	Date of the Next Meeting: • 03 February 2022 at 10.00am, via Microsoft Teams		

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

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

The Board is expediting plans to enable its committee meetings to be made available to the public via live streaming. In the meantime, should you wish to observe a virtual meeting of a committee, please contact the Board Secretary in advance of the meeting in order that your request can be considered on an individual basis (please contact Rani Mallison, Board Secretary, rani.mallison2@wales.nhs.uk).

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POWYS TEACHING HEALTH BOARD
PATIENT EXPERIENCE, QUALITY & SAFETY COMMITTEE

UNCONFIRMED

MINUTES OF THE MEETING HELD ON THURSDAY 7 OCTOBER 2021 VIA MICROSOFT TEAMS

Present:

Melanie Davies	Vice-Chair (Committee Chair)
Trish Buchan	Independent Member (Committee Vice-Chair)
Frances Gerrard	Independent Member
Ian Phillips	Independent member
Mark Taylor	Independent member

In Attendance:

Alison Davies	Director of Nursing and Midwifery
Claire Madsen	Director of Therapies and Health Sciences
Jamie Marchant	Director of Primary, Community Care and Mental Health
Kate Wright	Medical Director
Stuart Bourne	Director of Public Health
Marie Davies	Deputy Director of Nursing
Wendy Morgan	Assistant Director of Quality and Safety
Julie Richards	Women and Children's Service Manager
Rani Mallison	Board Secretary

Apologies for absence:

Rebecca Collier	Welsh Government

Committee Support:

Holly McLellan	Senior Administrator/Personal Assistant to Board Secretary

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PEQS/21/01	**WELCOME AND APOLOGIES FOR ABSENCE** The Committee Chair welcomed Members and attendees to the meeting, and CONFIRMED there was a quorum present. Apologies for absence were NOTED as recorded above.
PEQS/21/02	**DECLARATIONS OF INTERESTS** No interests were declared.
PEQS/21/03	**UNCONFIRMED MINUTES OF THE EXPERIENCE, QUALITY AND SAFETY COMMITTEE MEETING HELD ON 2 July 2020** The minutes of the previous meeting held on 30 July 2020 were AGREED as being a true and accurate record.
PEQS/21/04	**MATTERS ARISING FROM PREVIOUS MEETINGS** No matters arising were declared.
PEQS/21/05	**COMMITTEE ACTION LOG** There were no action log updates.
ITEMS FOR APPROVAL/RATIFICATION/DECISION	
PEQS/21/06	There were no items for inclusion in this section.
ITEMS FOR DISCUSSION	
PEQS/21/07	**Integrated Quality Report: Directorate of Primary, Community Care and Mental Health** The Director of Primary, Community Care and Mental Health presented the report which provided the Committee with a summary of patient quality and safety metrics across three service groups within the DPCCMH Directorate for the period of April to June 2021. The report was the first report developed directly by the Service Groups and Directorate and followed on from reports from each Group to the Experience Quality and Safety Committee earlier in 2021/22 which outlined the mechanisms within the groups to monitor and manage the area of work. Further work would continue to develop the scope of the reports with work undertaken closely with colleagues across PTHB including the Quality and Safety team and the new Assistant Director of Performance. A focus would be on

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	consistency of format and presentation, where applicable, but also detailed trend analysis and any potential for benchmarking. The report was process heavy whereas moving forward outcomes would become a focus. *Could a sentence outlining the average performance be included moving forward? The patient input of QR codes was positive but information needed to be triangulated. Awareness of the pressures put on staff to fill out additional data for mapping should be considered.* The Director of Primary, Community Care and Mental Health agreed that the overlap between reports needed to be refined to balance between duplicating and reporting. There was a section around patient experience which covered the wider Health Board. The Director of Nursing and Midwifery added that in terms of duplication of reporting the Putting Things Right and claims report had been moved to a Health Board wide perspective. *In terms of the Ligature Risk Management what was the second component of compliance comprised of?* The Deputy Director of Nursing responded that the first component disclosed that the policies were in place, the second component was to test compliance. The Assistant Director of Quality and Safety noted that compliance had been reported on the review of local authority compliance. *Was there a metric to report on the Learning Disability Mental Health of individuals?* The Director of Primary, Community Care and Mental Health responded that there was national work on Mental Health but Learning Disabilities had not been part of this. *Could more information on the School Nurse Service be provided?* The Director of Primary, Community Care and Mental Health responded that School Nurse Services were in place but the focus currently was on influenza vaccinations. *The Neurodevelopment (ND) Service would be a key topic moving forward could the Board be further sighted on this?* The Director of Primary, Community Care and Mental Health responded that the Delivery and Performance

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	Committee had been updated and further updates would be brought to the next committee. *What was being done to address Powys families who have reported that they are feeling they are missing out on face to face antenatal class?* The Director of Primary, Community Care and Mental Health responded that virtual group meetings were being worked on nationally in an effort to bring together group services. *To what extent did the Hospital Acquired Pressure Ulcer rates change?* The Director of Primary, Community Care and Mental Health responded that it was difficult to capture the differential. There was a decrease in recorded level 3 Full Thickness Skin Loss and level 4 Full Thickness Tissue Loss. *Could prospective plans to ensure patients had the best care be developed as opposed to identifying issues after the event?* The Director of Primary, Community Care and Mental Health offered to discuss outside of the committee, work was being undertaken on system resilience for the winter. The Board Secretary raised there should be awareness of the separation of management information from committee information. *Was Clinical Staff attendance on shared learning poor?* The Director of Primary, Community Care and Mental Health responded that the range was key, ensuring all professional groups attended not just a large number of staff. **Action: The Director of Primary, Community Care and Mental Health to confirm statistics on clinical staff attendance of shared learning.** The Chair raised that cover papers were helpful to draw out the most significant points, achievements and concerns. The Board Secretary responded that an overarching dashboard would be brought in to draw out the key points. The Director of Primary, Community Care and Mental Health advised that the level of detail was to provide assurance. As the report developed it would become more

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	streamlined for the next committees. The Executive Director of Therapies & Health Science raised that the Audit Cycle would support the quality driven approach. Highlighting the top 3 concerns in the Executive Summary would allow for horizon scanning in supplement or addition to a dashboard. The Committee DISCUSSED and NOTED the contents of the report including the planned work to scope additional metrics relating to quality and safety in specific areas.
PEQS/21/08	**Putting Things Right, Compensation and Claims Report** The Assistant Director of Quality and Safety presented the paper which provided an overview of the way in which Putting Things Right was discharged within the Health Board, along with compensation claims activity for the period 1 April 2021 to 31 July 2021. The paper provided an overview of the Health Boards approach to Putting Things Right, which included the systems and processes in place to support discharge of the function, along with any outputs and outcomes. Reference was made to patient experience and concerns, which included complaints, patient safety incidents, and compensation claims for the period 1 April 2021 to 31 July 2021 and trends. Recent data issues in the extraction of data from old Datix to new Datix were identified. Sessions would be created for staff to help with the extraction of data and reports from the system going forwards. Despite concerns that incident reporting would fall there had been an increase of incidents reported. There had been an increase in complaints in primary care around access to dental services. The Public Services Ombudsman for Wales (PSOW) report had been brought forwards. Reporting was to be submitted by 15 November 2021. No themes or trends were identified in the complaints data.

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	In the Ombudsman report did the 0.12 complaints received per 1000 residents for PTHB show that PTHB alongside CVUHB had the least complaints? The Assistant Director of Quality and Safety confirmed and noted improvements would be recognised going forward. The engagement and training sessions were noted as positive. *For complaints handling, to what extent could low numbers be identified in complaints under the direct control of PTHB?* The Assistant Director of Quality and Safety responded that some issues had been identified and had been used to inform the improvement plan. *When was the PTHB Putting Things Right policy undergoing its first Audit?* The Director of Nursing and Midwifery responded that the Putting Things Right policy was undergoing its first structured Audit, reactive information had been utilised to drive improvements. A deep dive was underway to ensure plans were progressing appropriately. *To what extent would it be expected to see PTHB placed below the national average on the Serious Incidents Graph considering PTHB did not have acute services?* The Director of Nursing and Midwifery responded that being placed below the national average was not a measure that could be easily translated as being meaningful, given the reporting of all incidents, including those designated as serious, was actively encouraged. The information enabled incident reporting parameters to be benchmarked with the rest of Wales. It was possibly more helpful to understand whether there were themes or trends in certain areas, for example, avoidable falls or skin damage, which better enable comparisons and improvement where needed. Feedback would be provided to the Delivery and Performance Committee. *Did the Serious Incidents Graph relate to Powys provided services of Powys patients in other locations?* The Assistant Director of Quality and Safety confirmed the incidents were drawn from services provided in Powys.

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	How was a serious incident categorised? The Assistant Director of Quality and Safety responded that categorisation was defined within the new patient safety framework and had changed from previous definitions used within Putting Things Right. Future reports would include the definition utilised. The Committee DISCUSSED and NOTED the report.
PEQS/21/09	**Regulatory Inspections Report** The Assistant Director of Quality and Safety presented the report which articulated the receipt and outcomes of regulatory inspections that had occurred during the reporting period and shared the Health and Social Care Regulatory Reports dashboard. Recent activity related to Healthcare Inspectorate Wales (HIW) inspections provided assurance on progress with Tier 1 and unannounced inspections. Quality check summary reports for dental practices were highlighted within the report, the primary care team lead the assurance monitoring arrangements. An update on the National Maternity improvement plan priorities 2021, was seeking agreement to extend the timeframe for 5 actions. HIW had confirmed their decision not to progress with phase 2 of the review. A dashboard overview of the current position was provided, related to the implementation of actions in response to recommendations from the Health and Social Care Regulators. *What was the status of the 11 actions outstanding for Felindre from 2021/22 and the outstanding action from 2019/20 from the Health Inspectorate Wales review of Mental Health services?* The Director of Primary, Community Care and Mental Health responded that updates were being pursued and would follow with more context. A number of the outstanding Felindre actions sat with the Estates Department. The lack of current information was as a result of the synchronisation of the Committee schedule with potential update dates.

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	The Committee DISCUSSED the report and AGREED the revised timeframes for the National Maternity Improvement Plan priorities 2021.
PEQS/21/10	**Infection Prevention and Control Report** The Deputy Director of Nursing presented the report which provided an update of the work undertaken in Infection, Prevention and Control in the last year. Included were the Powys Teaching Health Board Annual Report for Infection, Prevention and Control and the Annual Authorised Engineer Report into Decontamination Services. The report Infection Prevention and Control Annual Report made three formal recommendations: • The Operational Decontamination Lead or Infection Prevention Control nomination should represent Powys Teaching Health Board on the All Wales Decontamination and Sterilization Group. Such representation was historically in place. Status: Completed • Decontamination centres that undertook the reprocessing of flexible endoscopes should strive to achieve accreditation, and operation of a quality management system, in compliance with the medical devices directive/ISO 13485 standard. This represented best practice and a policy should be in place for the Health Board to work towards this standard. Status: Work was ongoing towards completion. • The management structure was in place across the organisations. However, interviews indicated concerns with resource time allocation needed to undertake the management of decontamination across the organisation. It was recommended the structure be reviewed and appropriate resource allocated. Status: Estates were to assess the role and if there was a case to increase capacity. *The IPC team were commended for their work over the last 18 months.*

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	Assurance over IPC had improved greatly. Antimicrobial resistance, plans were being put in place to strengthen the 2022 response. Given the recommendations had not previously been progressed due to the absence of a Chief Pharmacist what assurance could be taken moving forward? The Director of Nursing and Midwifery responded that a recent Welsh Health Circular had been received on the topic. Progression was a priority the Antimicrobial Stewardship Group (AMR) had identified the need to strengthen the resource to achieve this. The Committee 1. DISCUSSED and NOTED the annual report. 2. DISCUSSED AND NOTED the planned approach to address the improvement actions required by the Annual Authorised Engineer Report into Decontamination Services 3. RECEIVED the update provided in investigation of Covid-19 infection within hospital settings in Powys
PEQS/21/11	**Maternity Assurance Report** The Head of Midwifery and Sexual Health presented the report which provided the position in terms of the maternity pathway for the women of Powys, with a focus on: 1. Maternity Commissioning Assurance Framework. 2. Commissioned maternity services subject to special measures. 3. South Powys Programme Maternity and Neonatal Workstream. 4. Powys Maternity Improvement Plan, main focus. 5. External scrutiny. Moving forward the next steps would be: • Continued implementation of the Powys Maternity Improvement Plan. • Maintain oversight and escalation of commissioned services through the Commissioning Assurance Framework (CAF), to include increased scrutiny of neonatal services.

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- Continue to develop and embed governance and maintain reporting arrangements.

Were Powys residents delivering in the Grange University Hospital?

The Head of Midwifery and Sexual Health confirmed there was normal flow through the pathways which meant deliveries did go to the Grange University Hospital. Patients reported the obstetric care appointments to be accessible. Some appointments had been virtual which was received positively during the pandemic. Patients appreciated the individual rooms in the Grange University Hospital. High risk patients were going into pressured maternity services, PTHB was mindful of this and the support that could be offered. The Grange University Hospital were expecting a significant increase of patients in September 2021 with an approximate 600 births expected instead of the normal 450. Midwives reported few significant events or concerns but highlighted that the service was pressured.

The Director of Public Health raised that there was tentative news that investment in Healthy Lifestyles would reoccur.

Could more information be provided on the Wye Valley NHS Trust inaccessibility incident?

The Head of Midwifery and Sexual Health responded that Wye Valley NHS Trust had been experiencing a high level of acuity, the Community Midwife had tried to access a postnatal re-admission. The Community Midwife was concerned that if the patient was admitted there would be a lack of capacity to provide care. The Community Midwife outsourced admission to a district general hospital due to concern for the patient. The Wye Valley NHS Trust provided assurance that the hospital did have capacity.

Had an event of this nature occurred before or occurred in other areas?

The Head of Midwifery and Sexual Health responded that an event of this nature had not occurred before and it was a standalone event. A weekly cross Wales meeting took place to discuss assurance on pressures in neonatal services.

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	The Director of Nursing and Midwifery highlighted that there was openness and transparency around the work in progress and risk mitigation. The Committee DISCUSSED and NOTED the report.
PEQS/21/12	**Commissioning Escalation Report** The Director of Nursing and Midwifery presented the report which highlighted providers in Special Measures or scored as Level 4 and above following the 18 August 2021 PTHB Internal Commissioning Assurance Meeting (ICAM). At the time of the last meeting there were: • 2 providers with services in Special Measures; • 1 provider at Level 4. The report also provided: A high-level summary of key issues in relation Shrewsbury and Telford Hospitals NHS Trust (SaTH) and Cwm Taf Morgannwg University Health Board (CTMUHB). *Was any information from the Prince Charles Hospital available?* *Would all PTHB providers be in special measures for access in the near future?* It was confirmed that most services were under pressure as a result of the ill effects of the covid19 pandemic . *The Chair questioned if the Commissioning Escalation report should be escalated by the Committee?* The Director of Nursing and Midwifery responded that this was a consideration for Wales and the UK, the Corporate Risk Register (CRR) looked at the quality and performance as separate entities currently. Quality in relation to the receipt of poor care was identified. The CRR provides an opportunity for this to be discussed in more detail. The Chair raised that although PTHB was in an improved position there was still an overlay of winter pressures. PTHB had not seen that degree of pressure before. The Medical Director agreed that it was an important point to raise, openness was needed around how high the risks were for patients. There should be mindfulness not to reset

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	PTHB's risk tolerance. The current level of risk should not become the new normal. The Director of Public Health raised that a draft of a winter plan came out on the week of 4 October 2021, framed around the 5 harms of COVID-19. Part of the plan centred around capacity in the system. The Board Secretary advised that the CRR was actively reviewed and used to inform workplans of committees and the Board. The Committee DISCUSSED and NOTED the report.
PEQS/21/13	**Clinical Quality Framework: Goal 5, Intelligence** The Director of Public Health presented the report which provided a summary of progress in the implementation of the actions set out under Goal 5 of the Health Board's *Improving Clinical Quality Framework.* There were four actions under Goal 5, two of which had had work taken forward, and two of which required further work to define and describe their scope. The paper also noted two more recent developments; a draft report from Audit Wales and a Welsh Government quality framework, which recognised that there was a need to align elements of these two documents under Goal 5 to recognise their contribution to the aim of this goal. *What were the timeframes on the Clinical Quality Framework?* The Director of Public Health responded that the Audit Wales recommendations had a set timeframe. The Board Secretary added that the report was being finalised and would be presented to Audit, Risk and Assurance Committee on 16 November 2021. The ambition was to have work completed within a 6-month time frame. *In terms of data analytics, Welsh Government would want datasets manipulated and managed. Could infrastructure be put in place prior to this to deal with the quantity of data output?* The Director of Public Health responded that, PTHB's analytic capability at current would not be sufficient. A

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	strategic understanding of the direction of development over the next few years would be necessary. *For the input of primary data sources, what consideration had been given to minimising additional work at ward level?* The Director of Public Health responded that, additional data sources would have to be sourced as a bi-product that was secondary to routine. It needed to be built into systems but it was hoped that the Welsh Government infrastructure would provide a national approach. *To what extent could additional support be bought into PTHB? Could funding be provided through Charitable Funds?* The Director of Public Health responded that Charitable Funds funding would need to be scoped to assess if it met the criteria. The result of an unsustainable project due to outsourcing or bring in non-team staff would be a potential issue. The free resource of Senior Medical Students could be utilised for 6 weeks of projects. The Committee DISCUSSED and NOTED the report.
PEQS/21/14	**Committee Workplan 2021/22** The Board Secretary presented the paper. The greater proportion of agenda items were rolling standard items. The work plan was dynamic and would be picked up through agenda setting meetings. *Could an A4 summary of the Committee's Terms of Reference (ToR) be set as the front or last page of the agenda pack as a reminder for the Committee?* The Board Secretary responded that a summary of the ToR could be tailored from the paper taken to the Board on 28 July 2021. The work plan would not always be able to provide full coverage of the breadth of the Committee but would provide the scope. The Committee DISCUSSED and NOTED the report.
	ITEMS FOR INFORMATION

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PEQS/21/15	**Approved Minutes of the Experience, Quality & Safety Committee meeting held 15 July 2021** The minutes of the previous meeting held on 15 July 2021 were AGREED as being a true and accurate record.
PEQS/21/16	**Patient Experience, Quality & Safety Committee Terms of Reference, approved by Board 29 September 2021** The Committee NOTED the report.
PEQS/21/17	**Audit Wales Review: WHSSC Governance Arrangements and WHSSC Management Response** *How would issues identified in WHSSC be addressed?* The Chair responded that PTHB needed to decide what was appropriate and proportionate. The Board Secretary added that quality issues were not the only factor. **Action: Board Secretary to progress.** The Committee NOTED the report.
PEQS/21/18	**WHSSC Quality Patient Safety Committee Summary from meeting on 10 August 2021** The Committee NOTED the report.
PEQS/21/19	**Quality and Engagement Act Implementation Programme Summer Newsletter** The Committee NOTED the report.
OTHER MATTERS	
PEQS/21/20	**ITEMS TO BE BROUGHT TO THE ATTENTION OF THE BOARD AND OTHER COMMITTEES** There are no items for inclusion in this section
PEQS/21/21	**ANY OTHER URGENT BUSINESS** There was no urgent business.
PEQS/21/22	**DATE OF THE NEXT MEETING** 2 December 2021 at 14:00, via Microsoft Teams.

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Key:

Completed
Not yet due
Due
Overdue
Transferred

PATIENT EXPERIENCE, QUALITY & SAFETY COMMITTEE

ACTION LOG DECEMBER 2021

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Minute	Meeting Date	Action	Responsible	Progress Position	Completed
ACTIONS TRANSFERRED TO PEQS COMMITTEE FROM FORMER EQS COMMITTEE					
IC_EQS/21/06 Complex Concerns & SIs	15 April 2021	A final brief on the PSOW report be provided to EQS (In-Committee)	Director of Nursing and Midwifery	Update report to be presented when available.	
PEQS/21/07	7 Oct 2021	The statistics on clinical staff attendance of shared learning to be shared.	Director of Primary, Community Care and Mental Health		
PEQS/21/17	7 Oct 2021	How issues identified in Audit Wales: WHSSC Governance Arrangements and WHSSC Management response would be addressed	Board Secretary		
IC_PEQS/21/5	7 Oct 2021	Presentation to In-Committee by Assistant Director of Mental Health and Learning Disability	Director of Primary, Community Care and Mental Health		

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AGENDA ITEM: 3.1

PATIENT EXPERIENCE QUALITY AND SAFETY COMMITTEE	**DATE OF MEETING: 2 December 2021**
Subject:	**Audit Wales Review of Powys Teaching Health Board's Quality Governance Arrangements**
Approved and Presented by:	Alison Davies Director of Nursing & Midwifery
Prepared by:	Alison Davies Director of Nursing & Midwifery
Other Committees and meetings considered at:	Audit, Risk and Assurance Committee, 16 November 2021

PURPOSE:

The purpose of this paper is to highlight the completion of Audit Wales Review of Powys teaching health Board's Quality Governance Arrangements and the accompanying management response.

RECOMMENDATION(S):

It is recommended that the Patient Experience Quality and Safety Committee DISCUSSES the review and NOTES the management response.

Approval/Ratification/Decision	Discussion	Information
✓	✓	

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

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

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	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 Wales Audit Review of Quality Governance Arrangements within Powys teaching Health Board commenced in March 2021, reported during September 2021, with the final report received during October 2021.

The methodology used to generate data and intelligence to inform the review was comprehensive, inclusive of document review, staff and Board Member interviews, staff survey and observation of key meetings and Committees.

The Review concludes that overall, *"the Health Board is committed to ensure high quality, safe and effective services and has taken steps to improve its quality governance arrangements. There remains work to embed these arrangements, articulate the quality priorities of the organisation and ensure there are measures in place to demonstrate and monitor achievement to drive improvements across the full range of services provided and commissioned".*

Implementation of the recommendations of the Review will form part of the health board's approach to securing highly effective quality governance arrangements, in line with expectations articulated in the newly published Welsh Government's Quality and Safety Framework: Learning and Improving (published 17 September 2021), supported by a Welsh Health Circular.

DETAILED BACKGROUND AND ASSESSMENT:

As previously reported, the Wales Audit Review of Quality Governance Arrangements within Powys teaching Health Board commenced in March 2021. The review, originally planned during 2020, was delayed as a result of the covid 19 pandemic.

The review, and that of other health boards and NHS Trusts in Wales, forms part of the programme of work that the Auditor General will undertake to identify whether NHS bodies have proper arrangements to secure the efficient, effective and economical use of resources, as required by Section 61 of the Public Audit Wales Act 2004. A briefing note included in **Appendix 1**, sets out Audit Wales approach to the review.

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Audit Wales work from the premise that quality should be at the heart of all aspects of healthcare and 'putting quality and safety' above all else is one of the core values underpinning the NHS in Wales.

The review examined operational and corporate approach to quality governance, looking at issues such as organisational culture and behaviours, strategy, structures and processes, information flows and reporting. The review sought to assert whether the organisation's governance arrangements support delivery of high-quality, safe, and effective services. Key lines of enquiry included:

- Does quality drive the organisational strategy?
- Does the organisation promote a quality and patient-safety-focused culture?
- Do organisational structures and processes support delivery of high-quality, safe and effective services?
- Do corporate and operational arrangements for performance monitoring and reporting provide an adequate focus on quality and patient safety?

The methodology employed by Audit Wales included review of key documents, interviews with staff and board members, Community Services Group data collection and staff survey, along with, corporate data collection, and observations of key meetings and Committees.

The final report received in October 2021 which includes the management response is included in **appendix 2**. The Review concludes that overall*, "the Health Board is committed to ensure high quality, safe and effective services and has taken steps to improve its quality governance arrangements. There remains work to embed these arrangements, articulate the quality priorities of the organisation and ensure there are measures in place to demonstrate and monitor achievement to drive improvements across the full range of services provided and commissioned.*

There is a clear commitment to ensure the provision of safe and high-quality services supported by corporate frameworks and improving risk management. The Health Board has well established values and behaviours and staff feel supported to raise concerns. The introduction of the new Clinical Quality Framework is positive, and its roll out is starting to strengthen operational governance, alongside an increase in resources.

However, the quality priorities and success measures need to be clearer in order to measure impact and improvement. Work on capturing patient feedback needs to be more consistent and there needs to be better systems for demonstrating learning. Capacity constraints within the concerns team remain an issue which needs to be addressed. There is also scope to broaden the current performance reporting to ensure a clearer focus on quality matters covering the breadth of services provided, as well as developing a quality dashboard reflecting the unique nature of the Health Board'. (p.5)

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The report provides a level of external assurance in terms of progress made and constructive recommendations in relation to further strengthening the quality governance arrangements within the health board.

The management response will form part of the health board's overarching approach to quality governance, expressed through the Clinical Quality Framework, which will be reviewed in light of the review recommendations and to ensure full cognisance of Welsh Government's Quality and Safety Framework: Learning and Improving published on 17 September 2021 (**appendix 3**), which is supported by a Welsh health Circular (**appendix 4**).

NEXT STEPS

The activity listed within the management response will be progressed and reported to the Executive Committee and the Patient Experience, Quality and Safety Committee.

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Archwilio Cymru
Audit Wales

Project brief

Reference: March 2021

Date issued: 1794A2019-20

Review of Quality Governance Arrangements

Background

1 The Auditor General has included an examination of quality governance arrangements in his programme of performance audit work at relevant NHS bodies. The review forms part of the programme of work that he will undertake to satisfy himself that NHS bodies have proper arrangements to secure the efficient, effective and economical use of resources, as required by Section 61 of the Public Audit Wales Act 2004. The Auditor General's powers under section 145A of the Government of Wales Act 1998 are also relevant to this review.

2 We had originally planned to begin our reviews of quality governance during the early part of 2020, but the onset of the pandemic meant that we needed to pause the planned work. That pause has allowed us to adjust both our scope and approach to fit within the context of COVID-19. This briefing note sets out our intended approach to the review.

3 Where we process personal data, this is in accordance with data protection legislation, including the Data Protection Act 2018 and the General Data Protection Regulation. Further information is set out in our fair processing notice attached at Appendix 1. We ask that you share this project brief with officers, independent members/non-executive directors and any other staff that we will be interviewing or meeting with as part of this work. This will help to ensure they understand the purpose of our review and how we will use the information we collect.

Why are we doing this work

4 Quality should be at the 'heart' of all aspects of healthcare and 'putting quality and safety' above all else is one of the core values underpinning the NHS in Wales. Poor quality care can be costly in terms of harm, waste and variation.

5 The drive to improve quality has been reinforced in successive health and social care strategies and policies over the last two decades. In June 2020, the Health and Social Care (Quality and Engagement) (Wales) Act became law. The Act will strengthen the duty to secure system-wide quality improvements, as well as placing a duty of candour on NHS bodies, requiring them to be open and honest when things go wrong to enable learning. The Act indicates that quality includes but is not limited to the effectiveness and safety of health services and the experience of service users.

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6 Quality and safety must run through all aspects of service planning and provision and be explicit within NHS bodies integrated medium-term plans. NHS bodies are expected to monitor quality and safety at board level and throughout the entirety of services, partnerships and care settings but our annual Structured Assessment work across Wales has pointed to various challenges. These challenges include the need to improve the flows of assurance around quality and safety, the oversight of clinical audit and the tracking of regulation and inspection findings and recommendations.

7 Given this context, it is important that NHS boards, the public and key stakeholders are assured that quality governance arrangements are effective and that NHS bodies are maintaining an adequate focus on quality in responding to the pandemic. The current NHS Wales planning framework reflects the need to consider the direct and indirect harm associated with COVID-19. It is important that NHS bodies ensure their quality governance arrangements support good organisational oversight of these harms as part of their wider approach to ensuring safe and effective services.

8 Our review will examine both the operational and corporate approach to quality governance, looking at issues such as organisational culture and behaviours, strategy, structures and processes, information flows and reporting. It will draw on the methodology that was used in the 2019 joint review of quality governance arrangements at Cwm Taf Morgannwg University Health Board. It will form part of a wider programme of work aimed at getting a better understanding of quality governance arrangements across NHS Wales.

Audit approach

9 The review will seek to address the following question: **Do the organisation's governance arrangements support delivery of high-quality, safe, and effective services**? **Exhibit 1** sets out the key lines of enquiry we will consider.

Exhibit 1: key lines of enquiry

Do the organisation's governance arrangements support delivery of high-quality, safe and effective services?
1. Does quality drive the organisational strategy? a. Are quality and patient safety priorities clearly defined, documented and periodically reviewed? b. Are COVID and non-COVID risks to quality and patient safety identified and documented along with mitigation to eliminate or reduce their impact?

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Do the organisation's governance arrangements support delivery of high-quality, safe and effective services?

2. Does the organisation promote a quality and patient-safety-focused culture?
   a. Is the organisation actively participating in quality improvement initiatives?
   b. Do organisational values and behaviours support a quality and patient-safety-focused culture?
   c. Does the organisation take steps to listen to patients and staff and involve them in monitoring service change/improvement?
   d. Is there a strong culture of learning lessons from patient and staff feedback or concerns?
   e. Is quality and patient safety an integral part of workforce management processes?

3. Do organisational structures and processes support delivery of high-quality, safe and effective services?
   a. Are there clear lines of accountability for quality and patient safety across the organisational structure i.e. 'floor to Board'?
   b. Are there effective corporate and operational controls to support delivery of high-quality and safe services?
   c. Is there enough resource and expertise to support and improve quality governance arrangements?

4. Do corporate and operational arrangements for performance monitoring and reporting provide an adequate focus on quality and patient safety?
   a. Does the organisation have comprehensive and timely information for monitoring and reporting on quality and patient safety?
   b. Is the organisation examining the direct and indirect harms known to result from COVID?
   c. Does quality and patient safety receive effective coverage at both corporate and operational management meetings?
   d. Does the Board and its committees receive information about quality and patient safety to support effective scrutiny and assurance?

10 In addition to reviewing corporate level quality governance arrangements for commissioned and provided services, we plan to test the 'floor to board' perspective. To test the floor to board perspective, we will focus on the general medical, rehabilitation and palliative care wards within the Community Services Group. We discussed the details and practical arrangements for testing the floor to board arrangements, along with our proposed methodology (**Exhibit 2**), with the Health Board at a set-up meeting on 4th March 2021.

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Exhibit 2: proposed methodology

Methodology	Activity
Document review	Our review will include, but is not limited to, relevant organisational strategies for quality and safety, board, committee and sub-committee papers, executive and operational management team papers related to quality and safety, relevant policies/procedures, risk registers, performance reports or quality dashboards and patient experience reports. Where documents are not publicly available, we will request these from the Health Board to provide evidence against our lines of enquiry. We may use evidence from other agencies, such as the NHS Internal Audit and Assurance Service and Healthcare Inspectorate Wales.
Interviews with staff and board members	We will arrange virtual interviews with relevant individuals, including board members, executive directors, and corporate and operational staff. The interviews will cover broad themes, such as quality and safety priorities, organisational culture, roles, and responsibilities, monitoring and reporting performance, quality improvement activity and sharing learning and lessons.
Community Services Group data collection form	We will ask the Community Services Group to complete a data collection form that seeks information on aspects of the Group's quality governance arrangements.
Corporate data collection form	We will ask the Health Board to complete a data collection form that seeks information about the level and type of corporate resource available to support and improve quality governance arrangements.

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Methodology	Activity
Staff survey	We will invite operational staff working in the hospitals to take part in our online attitude survey about quality and patient safety arrangements within the organisation or their area of work.
Observations	We will draw on observations at the Experience, Quality and Safety Committee within the review period. We also aim to observe at least one relevant meeting of the Quality Governance Group and other Community Services Group meetings with a quality and safety focus.

11 Auditors will work remotely to carry out the audit given our on-site work remains suspended in accordance with COVID legislative requirements and our desire to ensure our work does not impede the Health Board's continuing response to the pandemic. We will work with the lead executive director for the audit to agree the timing and focus of interviews with operational staff and board members, and the information required to support our work. Interviews will be undertaken virtually via telephone, MS Teams or Skype.

12 We have engaged with Healthcare Inspectorate Wales (HIW) to inform the scope and audit approach for this work, building on the learning from our 2019 joint review of quality governance at Cwm Taf Morgannwg University Health Board. While the work described in this document is not being conducted as a formal joint review, we will continue to work closely with HIW to ensure relevant information is shared and to prevent any duplication of activity. HIW relationship managers may join us at interviews and attend our internal meetings to discuss audit findings.

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Timing of the work

13 The indicative timescales for the key stages of the audit work are shown in **Exhibit 3**. Where appropriate, we will give interim feedback if issues of concern arise during our work.

14 We will keep our delivery arrangements and the timescales under close review and adjust them to avoid unnecessary burden on the Health Board at a time when it is still responding to the COVID-19 pandemic. We accept that these factors may impair the ability of Health Board to respond in a timely way to requests for information and interviews.

Exhibit 3: indicative timescales for the work

Key stage	Timing
Set up	March 2021
Evidence gathering	April to May 2021
Draft report	June 2021
Final report	July 2021

Reporting our findings

15 We will prepare a report for the Health Board setting out local findings and any recommendations arising from the work. In line with the Audit Wales arrangements for public reporting, we will publish the report on our website once it has been formally considered by the relevant Board committee.

16 We may summarise the findings from our local work at NHS bodies in a national publication which may then be laid before the Senedd in line with the Auditor General's powers set out in Section 145A of the Government of Wales Act 1998.

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Audit Wales Contacts

17 The project team and their contact details are set out in **Exhibit 4**.

Exhibit 4: project team

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Archwilio Cymru
Audit Wales

Review of Quality Governance Arrangements – Powys Teaching Health Board

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Summary report

About this report

1 Quality should be at the 'heart' of all aspects of healthcare and putting quality and patient safety above all else is one of the core values underpinning the NHS in Wales. Poor quality care can also be costly in terms of harm, waste, and variation. NHS organisations and the individuals who work in them need to have a sound governance framework in place to help ensure the delivery of safe, effective, and high-quality healthcare. A key purpose of these 'quality governance' arrangements is to help organisations and their staff both monitor and where necessary improve standards of care.

2 The drive to improve quality has been reinforced in successive health and social care strategies and policies over the last two decades. In June 2020, the Health and Social Care (Quality and Engagement) (Wales) Act became law. The Act strengthens the duty to secure system-wide quality improvements, as well as placing a duty of candour on NHS bodies, requiring them to be open and honest when things go wrong to enable learning. The Act indicates that quality includes but is not limited to the effectiveness and safety of health services and the experience of service users.

3 Quality and safety must run through all aspects of service planning and provision and be explicit within NHS bodies' integrated medium-term plans. NHS bodies are expected to monitor quality and safety at board level and throughout the entirety of services, partnerships, and care settings. In recent years, our annual Structured Assessment work across Wales has pointed to various challenges, including the need to improve the flows of assurance around quality and safety, the oversight of clinical audit, and the tracking of regulation and inspection findings and recommendations. There have also been high profile concerns around quality of care and associated governance mechanisms in individual NHS bodies.

4 Given this context, it is important that NHS boards, the public and key stakeholders are assured that quality governance arrangements are effective and that NHS bodies are maintaining an adequate focus on quality in responding to the COVID-19 pandemic. The current NHS Wales planning framework reflects the need to consider the direct and indirect harm associated with COVID-19. It is important that NHS bodies ensure their quality governance arrangements support good organisational oversight of these harms as part of their wider approach to ensuring safe and effective services.

5 Our audit examined whether the organisation's governance arrangements support delivery of high quality, safe and effective services. We focused on both the operational and corporate approach to quality governance, organisational culture and behaviours, strategy, structures and processes, information flows and reporting. This report summarises the findings from our work at Powys Teaching Health Board (the Health Board) carried out between April and July 2021. To test the 'floor to board' perspective, we examined the arrangements for Community

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Services. We also reviewed the high-level arrangements for assuring quality of provider services.

Key messages

6 Overall, we found that **the Health Board is committed to ensure high quality, safe and effective services and has taken steps to improve its quality governance arrangements. There remains work to embed these arrangements, articulate the quality priorities of the organisation and ensure there are measures in place to demonstrate and monitor achievement to drive improvements across the full range of services provided and commissioned.**

7 There is a clear commitment to ensure the provision of safe and high-quality services supported by corporate frameworks and improving risk management. The Health Board has well established values and behaviours and staff feel supported to raise concerns. The introduction of the new Clinical Quality Framework is positive, and its roll out is starting to strengthen operational governance, alongside an increase in resources.

8 However, the quality priorities and success measures need to be clearer in order to measure impact and improvement. Work on capturing patient feedback needs to be more consistent and there needs to be better systems for demonstrating learning. Capacity constraints within the concerns team remain an issue which needs to be addressed. There is also scope to broaden the current performance reporting to ensure a clearer focus on quality matters covering the breadth of services provided, as well as developing a quality dashboard reflecting the unique nature of the Health Board.

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Recommendations

9 Recommendations arising from this audit are detailed in **Exhibit 1**. The Health Board's management response to these recommendations is summarised in **Appendix 1**.

Exhibit 1: recommendations

Recommendations
Commissioning Assurance Framework R1 The commissioning assurance framework is the mechanism to provide assurance on the quality of services provided to Powys residents. • Review the Commissioning Assurance Framework to include measures on the standards of care provided or patient outcomes.
Clinical Quality Framework R2 The current clinical quality framework articulates the steps needed to improve clinical quality governance. It does not clearly set out the mechanism in place within the Health Board to provide strategic and operational oversight. • Develop a governance map for the organisation to clearly identify the range of activities in place at the strategic and operational level to ensure there is a clear line of sight from service to Board and identify any overlaps or gaps between groups.
Alignment of Frameworks R3 Currently the Health Board has a clinical quality framework (CQF), which focusses on developing the Health Board's quality governance arrangements, and a commissioning assurance framework (CAF) which sets the framework for providing assurance on the quality of services. The CAF has been predominantly focussed on commissioned services, however there is an intention for this approach to be implemented within directly provided services (in place for Mental Health Services and Maternity Services). There are potential synergies between these frameworks and the Health Board should consider repositioning these two frameworks to further build on the inter-relationships. • Review the potential for alignment of the Clinical Quality Framework and the Commissioning Assurance Framework.

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Recommendations

Concerns and Complaints

R4 As a significant percentage of activity is delivered by commissioned services there needs to be greater clarity on the oversight of complaints from Powys residents on these services.

- Ensure that all complaints by Powys residents (directly and indirectly reported to the Health Board) on commissioned services are captured and reported to the Patient Experience, Quality and Safety Committee.
- Update the Commissioning Assurance Framework to ensure clarity on responsibility for monitoring and reporting of complaints.

Performance Measures

R5 Our work found that there needed to be articulation of the quality measures in place across the range of services provided. These needed to be clearly identified with a baseline undertaken in order measure the success of the clinical quality framework.

- Develop a quality dashboard which articulates the quality and patient safety performance measures and key performance indicators for the Health Board, in order to measure success and demonstrate improvements.

DATIX

R6 Our work found that at a corporate level only some staff received training and support on how to use the DATIX system to report concerns and near misses.

- Ensure that all corporate staff receive training appropriate to their role.

Training

R7 Statutory and mandatory training is important for ensuring staff and patient safety and wellbeing; however, compliance often falls short of what is required.

- Ensure that all statutory and mandatory training compliance meets the required target.

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Recommendations

Data Analytics

R8 Our work found that the Community Services Group did not have a quality dashboard to provide performance information, in addition we found within the Health Board there was no dedicated data analytics team for analysing and interpreting data on quality and safety. Without this information it is difficult to provide a performance baseline, assess progress or identify areas where performance needs to improve.

- Build capacity within the operational teams to undertake analytical analysis within their teams to better understand and evaluate performance.

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Detailed report

Organisational strategy for quality and patient safety

10 Our work considered the extent to which there are clearly defined priorities for quality and patient safety and effective mitigation of the risks to achieving them.

11 We found that **there is a clear commitment to ensure the provision of safe and high-quality services supported by corporate frameworks and improving risk management. There is scope to develop clearer quality priorities and articulate success measures to measure impact and improvement.**

Quality and patient safety priorities

12 **The Health Board is committed to ensuring quality from its commissioned and provided services and has developed supporting frameworks to achieve this, but they are yet to define measurable quality priorities and metrics or use quality impact assessments when reviewing service provision.**

13 The Health Board does not have standalone quality and patient safety priorities. Instead, it has signalled its commitment to deliver the highest quality clinical care to its local population through its strategy 'A Healthy Caring Powys', Integrated Medium Term Plan (IMTP) and Annual Plan for 2021-22.

14 Within the IMTP 'Quality and Citizen Experience' is an organisational priority for the Health Board. Linked to this are a number of priority actions, such as develop a serious incident improvement plan and establish a pressure ulcer scrutiny panel. The 2021-22 annual plan clearly states that clinical quality and improvement remain a priority as the Health Board moves towards recovery post COVID-19. The Powys Health and Care Strategy 'A Healthy Caring Powys' coproduced with Powys County Council and the Powys Regional Partnership Board in 2017 demonstrates stakeholder engagement in relation to the need to secure high quality and safe services to have maximum impact on population needs.

15 To support the achievement of quality services from both its provided and commissioned services the Health Board has established two frameworks which are discussed in further detail later in the report. The **Clinical Quality Framework** (CQF) agreed by the Board in 2020 sets out a programme of work to improve quality governance, which in turn supports the delivery of improved quality outcomes. The CQF outlines five organisational goals which have synergy with the Integrated Medium-Term plan and the Annual plans. The CQF is largely process driven, identifying improvement actions across the Health Board. Each of these areas has specific actions identified, as well as a nominated lead executive. The Health Board is essentially putting the foundation blocks in place to establish and strengthen processes and procedures to deliver on its vision. However, the Health Board has not defined outcomes or expected standards against which to measure and assess success. The stated actions within the current documents relate to processes, which need to be established in order to support effective quality

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governance. From our work we did not identify any local targets or priorities within the community services group.

16 To support the delivery of commissioned services, the Health Board developed a **Commissioning Assurance Framework (CAF)** in 2018. The CAF describes a continuous assurance process to ensure that commissioned services are safe, personal, effective, and continuously improving. All providers bar one have signed up to this framework, and there are currently ongoing discussions as to the reasons for this with the aim of addressing this issue in the near future.

17 There is currently no reference to the use of Quality Impact Assessments (QIA) for productivity and efficiency schemes. These assessments ask organisations to consider the impact on quality and safety of potential service changes and redesigns. Although the podiatry service redesign approved by the Board in August 2020 did contain a detailed Equality Impact Assessment (EQI) which covered access to services and protected characteristics, there was no assessment on effectiveness and outcomes in relation to the change in service provision.

Risk management

18 **The Health Board has a clear risk management framework, and risk identification and management are maturing. Work is needed to update the Board Assurance Framework in light of the new strategic priorities and ensure a clearer line of sight from the directorate risk registers to the corporate risk register and ensure that mitigations in registers are sufficient for assurance.**

19 The Health Board revised its risk management framework in 2019. The Health Board has described its risk appetite and has clearly stated that it has no appetite for risks that materially impact on the quality and safety of services the Health Board provides or commissions. However, the Health Board's corporate risk register which covers both commissioned and provider services identifies a number of risks, of which 60% are linked to the quality and safety of services. Executives are currently refreshing the register by reviewing their portfolio of risks. The Health Board plans to develop committee risk registers, and work in this area had started but was paused due to COVID-19. A programme of work is underway to map the committees to the risks as well as other assurance sources, such as clinical audit.

20 Our 2020 structured assessment[1] reported that the Health Board had a maturing system of risk management, and as part of the response to the pandemic developed and regularly monitored a dedicated COVID-19 gold risk register. The risks from the COVID-19 gold risk register have been merged into the Health Board's corporate risk register.

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[1] Audit Wales, Powys Teaching Health Board Structured Assessment 2020, November 2020

21 The Heath Board has a Board Assurance Framework (BAF), however, in light of the pandemic and the annual priorities of the Board changing the BAF not been reported since January 2020, in the meantime the corporate risk register has continued to be reported to Board with details of the current controls and mitigating actions articulated against each risk.

22 The Health Board does not currently use DATIX for risk management, instead they have developed a system of Excel templates to manage the risk management process across the organisation. Through our work we reviewed a sample of these in use which shows they have been adopted widely by the organisation although moving to an electronic system would provide a more robust evidence trail of changes to risk scores over time. The Health Board will be adopting the national Once for Wales Concerns Management system[2] during 2021, and this will also include use of the DATIX risk management module.

23 The Health Board's Risk and Assurance Group usually meets bi-monthly and reports to the Executive Committee. The Group was stood down in September 2020 due to COVID-19, but meetings are scheduled to resumed in July 2021. The Group's main purpose is to discuss and ensure consistency of risk scoring across the Health Board.

24 Training in risk management has been limited. At the time of our work, Independent Members (IMs) had not received any specific training on risks, or on their roles and responsibilities in relation to risk management. The planned roll out of training for staff on risk registers had been paused due to COVID-19, although the Health Board is engaging with other risk leads across Wales in the development of a standardised risk management training module for use.

25 In 2019, the Health Board invested in risk management capacity by appointing a Head of Risk and Assurance and identifying the right level of administrative support. This small, dedicated risk management team (two full-time equivalent staff) provides risk management training and support to operational teams. Within the Community Services Group there is a dedicated lead for risk management.

26 As part of our work, we reviewed the Community Services Group's risk register and that of the Director of Primary, Community and Mental Health (directorate). These registers were up to date, with evidence of risks being escalated appropriately from the Community Services register to the Primary, Community and Mental Health Register. However, there were some areas where mitigations were missing, and the evidence for the risk scoring reducing were not clear.

27 Our observation of the Community Services Group's patient experience and quality group found there was discussion on the directorate risk register, but this was focussed on the red risks only, rather than the totality of risk. There is potential for some risks not to receive sufficient discussion. There are multiple risks associated

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[2] Once for Wales Concerns Management System Programme was developed from the recommendations in the Welsh Government Report 'The Gift of Complaints'. All Health Boards will be moving to this system at some point.

with some services, eg Radiotherapy, but because these are not flagged as red risks they do not attract much attention, consequently opportunities to take a more thematic analysis of risk in this area are missed. There is the potential for a more holistic view of the risks of the register and the exploring of themes to be raised.

Organisational culture

28 NHS organisations should be focused on continually improving the quality of care and using finite resources to achieve better outcomes and experiences for patients and service users. Our work considered the extent to which the Health Board is promoting a quality and patient-safety-focused culture, including improving compliance with statutory and mandatory training, participating in quality improvement processes that are integral with wider governance structures, listening and acting upon feedback from staff and patients, and learning lessons.

29 We found that **Quality improvement is important to the Health Board, however, resources are limited. There are well-established values and behaviours within the organisation and staff feel supported to raise concerns. There remains work to improve consistency of capturing patient feedback and demonstrating learning from this.**

Quality improvement

30 **The Health Board is committed to growing its quality improvement capacity. There has been better use of clinical audit, although there are opportunities to better utilise clinical audit as a source of assurance.**

Resources to support quality Improvement

31 Corporately, the Health Board has a very small, dedicated quality improvement team (0.5 FTE staff), providing staff training on quality improvement methods. Improving Quality Together (IQT) is the national quality improvement training programme for NHS staff in Wales. The goal of the programme is to develop quality improvement capability within NHS Wales using a common language for quality improvement. Information provided by the Health Board shows that a high proportion (74%) of staff had completed the IQT training Bronze level. The team also provides dedicated support to staff completing quality improvement projects for the IQT Silver level. However, only 1% of Health Board staff have achieved IQT Silver.

32 The quality improvement team has begun working with the Research, Innovation, and Improvement Hub. This joint venture between the Health Board and Powys County Council aims to co-ordinate and support research, improve services, and support new ways of working at a Powys wide level. The Health Board are using the Research, Innovation, and Improvement hub to look at innovative ways to share learning, although this work is currently in its early development stages. To

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support the hub, the Health Board has recruited a small number of staff (2.4 FTE), these staff are not immediate members of the Health Board's quality improvement team. This resource is funded until March 2022 with the staff employed on fixed term contracts. The Health Board needs to evaluate the impact of this initiative and look to fund it on a more sustainable footing if it has proved successful.

33 The Health Board has increased resources to focus on value-based healthcare through the recent appointment of a Director for Strategy and value-based healthcare, as part of the Clinical Quality Framework activities. The aim for this role is to support prudent and values-based healthcare to shape quality improvement.

34 Progress on the development of the Clinical Effectiveness and Quality Improvement Strategy articulated in the CQF has been further delayed as a result of COVID-19. This work involves using a prioritised and risk-based approach to define and deliver a programme of clinical quality improvement targets. This remains a priority for the Health Board during 2021-22.

Clinical Audit

35 Clinical audit is an important way of providing assurance about the quality and safety of services. The Health Board has an approved clinical audit plan for 2021-22 covering national clinical audits and outcome reviews mandated by the Welsh Government. The plan also includes clinical audits based on local priorities and risks identified by senior clinical managers. COVID-19 affected the Health Board's ability to deliver the 2020-21 Clinical Audit Plan because of limitations on resources with staff being redeployed to focus on COVID-19. The Health Board reviewed the 2020-21 plan and risk assessed the outstanding audits and reprofiled new dates to ensure the work is completed, and incorporated this into the 2021-22 clinical audit plan.

36 Clinical audit findings and learning are shared with both operational and strategic groups or committees. Reports are presented to the Quality Governance Group (QGG) chaired by the Medical Director and Director of Therapies and Health Sciences and the Experience, Quality and Safety Committee (EQS). Clinical audit outcomes were also considered as part of a suite of information at the inaugural meeting and subsequent meetings of the new quarterly Learning from Experience Group, which is chaired the Director of Clinical Strategy. The composition of this group includes the Director of Therapies and Health Sciences as well as the Director of Nursing and Midwifery, which ensures mechanisms to share information between this group and the Quality Governance Group. This group has identified issues from national audits and has started to discuss some of the issues raised. Operationally, monthly clinical audit and improvement meetings within both the Women's and Children's Service Group and the Community Services Group identify and share learning. All these arrangements are only recent, and need to embed and realise the planned benefits, however, early signs are they are beneficial and have been well received by staff.

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37 Corporate resources for clinical audit are limited with only 0.5 FTE staff, yet demand for clinical audit is growing. Work on reauditing to ensure that learning has been embedded and improved results is also an area where further work is needed. In addition, clinical audit should serve as an important source of assurance in the board assurance framework and corporate and operational risk registers, however, this was not evident from the documents reviewed.

Mortality reviews

38 Multidisciplinary mortality and morbidity review meetings provide a systematic approach for the peer review of adverse events, complications, or mortality to reflect, learn and improve patient care. This is a positive area for Powys, having been the only health board in Wales to pilot the new medical examiner role alongside five other organisations across the United Kingdom. There are clear processes in place for mortality and morbidity reviews, with results as well as learning routinely reported to the Experience and Quality and Safety (EQS) committee and the Learning from Experience Group. Examples of learning have been demonstrated, for example, concerns raised recently about completion of formal documentation for care at the end of life has led to the formation of a small group to determine the ideal set of notes and commit to updating organisational clinical policy.

39 Currently the Health Board's EQS does not have any oversight of mortality reviews undertaken within commissioned service providers for Powys residents. There is corporate oversight through the commissioning assurance framework where cases that have been subject to a serious incident investigation within a commissioned service are flagged to the Health Board. The Once for Wales concerns management system had been expected to establish the core functionality for the learning from mortality system, however, implementation has been delayed by factors outside the control of the Health Board.

Values and behaviour

40 **There is a well-established values and behaviours framework in place with plans to revisit this soon, staff feel supported to report their concerns, however, there is further work to support staff experiencing bullying and harassment.**

41 The Health Board's Values and Behaviours Framework was published in 2015 and sets out its vision for a quality and patient-safety-focused culture with a focus on continuous improvement, openness, transparency and learning when things go wrong. The Health Board plans to bring the framework up to date alongside its organisational development strategic framework for improving organisational effectiveness. Staff induction covers expectations in relation to the Values and Behaviours framework as well as the support staff can expect in order to deliver high quality care.

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42 Our work revealed a varied picture in relation to the culture around reporting errors, near misses or incidents and raising concerns. Of the staff who completed our survey[3], (81%) staff agreed or strongly agreed that the organisation encourages staff to report errors, near misses or incidents. Some staff (54%) agreed or strongly agreed that staff involved in an error, near miss or incident are treated fairly by the organisation. Most staff (65%) agreed or strongly agreed that the organisation acts to ensure that errors, near misses or incidents do not happen again.

43 It is positive that staff responding to the recent NHS Wales staff survey[4] reported low levels of bullying, harassment, or abuse by another colleague, member of the public or line manager over the past year (14.6%, 10%, and 8.6%, respectively). However, action is still needed to address the concerns of staff experiencing bullying, harassment, or abuse, given that fewer than half (45.7%) agreed or strongly agreed that the organisation takes effective action when it did occur.

44 Staff are encouraged to use DATIX to report incidents and during our interviews there was a positive culture expressed on reporting incidents, however, corporately only some staff receive training and support on how to use the DATIX system to report concerns and near misses. The Community Services Group indicated in their survey that all their staff receive training or support in using the DATIX system to report incidents or near misses.

45 Statutory and mandatory training is important for ensuring staff and patient safety and wellbeing, yet our annual Structured Assessment has found that compliance often falls short of that required. Within the Community Services Group, only (42%) of staff responding to our survey agreed or strongly agreed that they have enough time at work to complete any statutory and mandatory training. To improve compliance, the community services group told us that local managers are working with teams to improve the position post COVID-19.

46 Improving compliance with personal appraisal and development reviews is another area of focus for the Health Board. The Health Board achieved a rate of 69% compliance in May 2021, which is below the 85% target but was still the fourth best in Wales. This is lower than previous years, but completion has been affected by the pandemic response and staff being redeployed. There are routine meetings with directorates to improve compliance, and the achievement of this is on the agenda for directorate managers. Organisational scrutiny of this metric is undertaken at both Performance and Resources Committee and Board.

[3] We invited operational staff working across the community services group to take part in our online attitude survey about quality and patient safety arrangements. The Health Board publicised the survey on our behalf. Although the findings are unlikely to be representative of the views of all staff across community services, we have used them to illustrate particular issues.

[4] The NHS Wales staff survey ran for three weeks in November 2020 at the same time as the second surge in COVID-19 transmission and rising numbers of hospital admissions. The survey response rate was 29%.

Listening and learning from feedback

47 **The Health Board has a range of formal mechanisms for capturing patient experience, however, these have been affected by COVID-19. Work is underway to develop a new Patient Experience Engagement Framework and Strategy and implement a new real time system to capture patient feedback. There remains work to do to show evidence of learning from feedback.**

Patient Experience

48 The Health Board's current patient experience strategy is out of date. As part of the Clinical Quality Framework there are plans to address this through the development of a new Patient Experience Engagement Framework and Strategy. The Health Board are aiming to develop arrangements for learning from patient experience to ensure that patient experience is used to inform staff and clinical service development. However, the Assistant Director, Quality and Safety has been diverted to operational work on concerns, and other staff have been diverted to other areas due to COVID-19, which has resulted in the patient experience engagement framework and strategy falling behind schedule, although work has recently restarted and is scheduled to be completed at the end of 2021.

49 The Experience, Quality and Safety Committee (EQS) receive regular thematic reports on concerns and incidents covering all services, these reports identify lessons learnt and highlight actions taken in response. Further detail is provided to the in-committee session of the EQS to enable a more in-depth discussion of issues with patient identifiable data. Currently these reports are only considered at a corporate level, however, there are plans for the next iteration of these reports to be considered by the service groups themselves to improve ownership of the actions as well as the concerns.

50 Through our work we have found a lack of clarity regarding the capture of concerns and complaints from commissioned services. Many services for Powys residents are provided by commissioned services and the current reports only identify complaints which are directly reported to the Health Board. There needs to be further clarity on who is responsible for concerns and complaints from commissioned services and ensure the Health Board are notified in all cases of concerns raised by Powys residents, and actions taken in response.

51 The Health Board has a well-established Patient Experience Steering Group that captures and monitors patient experience activity, across provided and commissioned services. The Group, which reports to the Executive team, meets quarterly. Service groups, such as the Community Service Group, submit regular updates on their patient experience activity to the Patient Experience Steering Group, and there are plans for the Community Service Group to present reports to Experience, Quality and Safety Committee by autumn. The patient experience and outcome measures include incidents and complaints and findings from patient surveys and feedback cards. There was evidence of themes being identified

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through the Patient Experience Steering Group, but actions in response were not clearly identified.

52 Through our work, we reviewed evidence of work undertaken to evaluate patient experience, such as recent surveys on the new podiatry service, which demonstrates the Health Board's commitment to obtaining patient feedback. Following the concerns regarding maternity services at Shrewsbury and Telford NHS Trust (SaTH) targeted work was undertaken with Powys residents to understand their experiences to inform the ongoing discussions with the NHS Trust. The Health Board is also currently writing a proposal to purchase Civica software to enable real-time capture of patient experience.

53 As part of our work, we asked the Community Services Group about the mechanisms used to seek patient and staff feedback more generally, and how the learning from this feedback was disseminated. Methods used included patient questionnaires, and letters as well as direct questions, with the feedback disseminated through their patient experience report shared with the Patient Experience Group and there are plans for future reports to be presented to the Experience, Quality and Safety committee. The group indicated that the majority of patient experience activity had been negatively affected by COVID-19. This was due to limited staff resources, as well as access to patients being reduced as part of infection, prevention and control arrangements. Our staff survey indicates that more needs to be done to disseminate information on patient experience to staff, given that less than half (45%) of those responding to our survey indicated that they agreed or strongly agreed that they receive regular updates on patient feedback for their work area. The Health Board also needs to consider how it can capture any concerns staff have got about patient experience. We could not see any evidence that this information was routinely captured and considered.

54 The Health Board has delivered additional training on investigating complaints and incidents, but further roll out of this training has been affected by COVID-19. The Community Services Group were unable to tell us the percentages of staff who had received training on investigating complaints or undertaking root cause analysis.

Patient Stories

55 The Board also has mechanisms for understanding patient experience. Patient stories are told by individuals from their own perspective, and in a healthcare setting, provide an opportunity to understand their experience of the care received helping organisations to learn the good and bad and what can be done to improve the experience. At the time of our audit, patient stories had not been received at Board since January 2020, and the EQS last received a patient story in October 2020. There are plans to restart these within the next few months.

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Safety Walkarounds

56 Safety walkarounds provide board members with an understanding of the reality for staff and patients, help to make data more meaningful, support the triangulation process, provide assurance from more than one source of information. At the time of our audit, the Health Board did not have an established programme of patient safety walkrounds, but signalled its intent to start these later in the year with a revised set of guidance to support Independent Members.

Governance structures and processes

57 Our work considered the extent to which organisational structures and processes at and below board level support the delivery of high-quality, safe, and effective services.

58 We found that **the new clinical quality framework is starting to strengthen operational governance arrangements although the new arrangements need further time to develop and embed. Whilst there has been a small increase in quality governance resources, there are still capacity constraints within the concerns team which need to be addressed.**

Organisational design to support effective governance

59 **Recent developments have strengthened lines of accountability and oversight of scrutiny to improve flows of assurance but these need to be embedded.**

60 There is clear collective responsibility for quality and patient safety amongst the Executive leadership of the Health Board. Recent substantive appointments made to the Executive team including the Director of Nursing and Midwifery, Director of Therapies and Health Sciences and Medical Director have strengthened this. Furthermore, there is now a Deputy Director of Nursing, who leads on Quality and Safety to provide additional capacity and focus. The Health Board have stated their intent in the clinical quality framework to prioritise clinical leadership development to ensure they become a truly clinically led organisation.

61 In March 2021, the Health Board established a Learning from Experience Group as a place for the clinical leaders of the organisation to share information from a range of sources, including clinical audit and mortality reviews with a view to disseminating learning across the organisation. This group has met twice, and an upward report on its work has been provided to the Experience, Quality and Safety group outlining its activities and proposed actions. Early signs of the impact of this group are positive demonstrating the effective triangulation of issues from a range of areas.

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Clinical Quality Framework

62 The Clinical Quality Framework (CQF) approved by the Board in 2020, sets out a programme of work to improve quality governance over three years. Progress in implementing the framework has been slower than planned because COVID-19 has placed pressures on the teams. Work is currently underway to review and reprioritise the actions and adjust the remaining timescales.

63 As part of the Clinical Quality Framework the Health Board will be agreeing and adopting a Clinical Quality Improvement methodology. In June 2021 a progress update to the Experience, Quality and Safety Committee reported the Health Board had yet to define and deliver a programme of quality improvement projects and work on agreeing and adopting an approach to clinical quality improvement including the methodology not yet started. There was no update on the revised timescales for this work, however, it remains a priority for the Health Board during 2021-22.

64 At a strategic level, the development and implementation of the CQF is overseen by the Quality Governance Group (QGG). The QGG established in 2019 was initially chaired by the Chief Executive to oversee the Health Board's governance approach. Recently the terms of reference for this group have been revised and although its remit remains the same, the leadership has changed to the Director of Nursing and Midwifery and the Medical Director, with attendance from all the Assistant Directors of the Service groups as well to enable a clear line of sight from service to Board. The QGG will also now directly report to the Experience, Quality and Safety committee, as opposed to through the Executive committee. The Experience, Quality and Safety committee provide Board oversight of implementation of the clinical quality framework, receiving regular milestone reports which identify progress, and areas behind target.

Commissioning Assurance Framework

65 The Health Board is primarily a commissioning organisation. The largest proportion of its budget is devoted to securing health care services, including unscheduled and planned care from neighbouring NHS Wales health boards and NHS trusts in England. To assure themselves and their resident population of the safety, quality, and sustainability of these commissioned services, the Health Board developed a commissioning assurance framework (CAF) in 2018. The CAF describes a continuous assurance process to ensure that commissioned services are safe, personal, effective, and continuously improving. The experience of patients is also reviewed as well as numbers of complaints and incidents in order to detect deteriorating quality. All of the Health Board's directorates feed into this process, and there are regular reports and commissioning assurance meetings held with providers to discuss performance, quality and safety and patient experience. The CAF uses a rating system for providers across four domains: access, finance and activity, quality and safety and patient experience. Each provider is rated by the Health Board against the four domains using a red/amber/green process. Special

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measures and levels of Government intervention are recorded. All this information is then captured in a high level dashboard to show at a glance the provider rating. Services provided by organisations who have been escalated as part of the respective arrangements within NHS England and Wales, and/ or those who score level 4 on the CAF, are scrutinised and monitored by the Performance and Resources Committee and the Quality Governance Group.

66 To ensure a quality focus, the Health Board has a Quality and Safety Commissioning lead, who reports to the Assistant Director, Quality and Safety in order to support the CAF process in assessing quality and safety issues within commissioned services. The Quality and Safety commissioning lead attends all commissioning review meetings with providers. The CAF currently does not include any measures on the standards of care provided or patient outcomes.

67 However, due to the pandemic the usual commissioning arrangements have not been in place since March 2020. Since July 2021 work has stepped up to restore the CAF but there remain significant limitations and escalation arrangements cannot operate in the usual way; this has affected quality reporting as well as information on patient experience.

Community Services Group

68 The structure of the Community Services Group supports multidisciplinary working through a Head of Nursing and a Head of Therapies. The Group has also recently appointed a lead clinician for quality and safety and is supported by the Assistant Medical Director to provide medical leadership. Also, there are no senior nurse roles for the inpatient wards, which leaves a potential gap in specialist ward nursing oversight and maintenance of nursing practice and quality culture.

69 The service groups across the Health Board have started to formally set out their quality governance arrangements and patient safety structures. This work has been ongoing since 2020, but is at varying degrees of implementation across the organisation as a result of capacity being diverted to respond to the pandemic. At the time of our audit, three of the five service groups had produced their quality governance and patient safety structure setting out the processes for oversight of quality and patient safety. Pace has picked up recently and there is a desire to get the new arrangements functioning. Further work is planned regarding delegating aspects of corporate reporting including concerns and incidents into service groups to improve oversight, ownership, and scrutiny of performance at a service group level by improved upward reporting within the next three months.

70 We reviewed the governance arrangements within the Community Services Group and observed one of their patient experience and quality groups. These meetings take place bi-monthly and have a standardised agenda. There is currently no quality and patient safety dashboard in place. At the time of our work, there was no formal sharing of the minutes from the quality and patient safety meetings to the executive Quality Governance Group. There was also no formal sharing of minutes

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to the directorate meetings, although there was upward reporting on an exception basis.

Resources and expertise to support quality governance

71 **Health Board resources to support quality governance are limited, and historical capacity constrains within the concerns team are affecting the timeliness of responses to complaints, but recent operational appointments are positive.**

72 The Health Board reviewed the available resource to support improvement to quality governance arrangements at both a corporate and operational level. It found that service group governance needed strengthening to ensure sufficient capacity and capability at the local level. Following this the Health Board invested in additional operational capacity across some service groups to support quality improvement activities such as clinical audit, and complaints and incident handling. For example, the Community Service Group recently appointed (June 2021) a quality lead ensuring parity with other service groups.

73 Health Board resources for both patient experience and concerns are limited. There is no dedicated patient experience team, with the concerns team taking the lead in this area. This was highlighted by the Public Services Ombudsman for Wales[5] in his special report in October 2020 which tasked the Health Board with undertaking a review of the complaints handling team and its ability and capacity to deal with complaints under the Putting Things Right (PTR) regime in an effective and timely way. The capacity of the concerns team has been limited for a significant time and complaint response times within 30 days have historically been low. However, the latest performance data for May 2021 was more positive, with over 90% of complaints being responded to within 30 days. There is a backlog of concerns which needed to be addressed, an increasing number of concerns related to possible harm from COVID-19 and the rise in concerns relating to commissioned services and General Practice. The lack of capacity has been recognised, and temporary staff are in post and plans to make substantive appointments within the next six months.

74 At the time of our audit work, the Health Board was undertaking an internal review of the wider elements of PTR in response to the Public Services Ombudsman's report. The Health Board has identified a number of actions and developed an action plan, which EQS committee considered in July 2021. The plan identifies a number of actions during 2021 including training and the development of a new team structure which is currently being considered. The Health Board is monitoring its work on PTR though weekly accountability and assurance meetings where case management and complex issues are discussed by the Chief Executive, Director of

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[5] Public Services Ombudsman for Wales, Special Report issued under s28 of the Public Services Ombudsman (Wales) Act 2019 following a complaint made by Mrs A against Powys Teaching Health Board, October 2020

Nursing, Deputy Director of Nursing and the Assistant Director, Quality and Safety. There are also weekly meetings with operational teams to monitor work on addressing concerns.

75 The Assistant Director, Quality and Safety has had to step into a more operational role due to the capacity constraints within the concerns team. This is affecting their ability to work on other areas of their remit, including patient experience, DATIX and also the commissioning lead for quality and safety. Currently there are increasing demands on the concerns team.

Arrangements for monitoring and reporting

76 Our work considered whether arrangements for performance monitoring and reporting at both an operational and strategic level provide an adequate focus on quality and patient safety.

77 We found that **there is scope to broaden the current reporting to ensure a clearer focus on quality matters covering the breadth of services provided and reflecting the unique nature of the Health Board.**

Information for scrutiny and assurance

78 **There is a commitment from the Health Board to ensure that information is available to provide information for scrutiny and assurance and commentary on harm from COVID, however the introduction quality dashboards at both the corporate and operational levels would strengthen oversight.**

79 There is a clear commitment and understanding from the Health Board that the identification and work in assessing harm from COVID-19 is vital. Papers from the EQS, and the QGG along with our interviews acknowledge the need for the Health Board to work to identify these. However, understanding and assessing harm represents a significant challenge for the Health Board as with others. The Health Board has identified a number of proposed assessment methodologies in order to understand harm across the four harms[6] and work is ongoing in these areas. However, these assessment methodologies focus on secondary care indicators, and there are no proposed measures related to primary and community care, such as childhood vaccinations or on the wider population health impacts. This work is in its early stages and there remains further work to do as with other Health Boards in Wales.

80 The Health Board has undertaken work to better understand the issues around nosocomial transmission of COVID-19. Reports have been produced and learning identified in relation to the improvements needed in data quality of some reporting systems.

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[6] Organisations should be monitoring potential harm across the four quadrants set out in the quarterly operational planning framework.

81 Data systems within the organisation do produce information and local teams have access to these and support to interpret information and develop bespoke reports. However, there are limitations and the current systems lack the ability to produce statistical charts or year-on-year comparisons. There is no dedicated data analytics team for analysing and interpreting data on quality and safety, either corporately or operationally.

82 At an operational level, the Quality and Patient Experience meetings within the Community Services Group provide oversight of the quality and performance within the service group, which then informs the routine Primary Care, Mental Health and Community directorate meetings. Some of these meetings were stood down during COVID-19 and the reporting focussed more on COVID-19-related risks on a more frequent basis and routine quality indicators less frequently. The routine meetings are now re-established. We observed one of the Community Services Quality and Patient Experience groups, and this aligned to the expected agenda as described within their quality governance framework. Information was provided on patient experience which included Serious Incidents as well as complaints and compliments. There were also highlight reports from each area identifying issues and concerns for escalation. However, the group did not have a performance dashboard of quality metrics in place. Although the governance structure does set out expectations of quality reporting in line with the NHS delivery Framework and identification of measures, these are not currently reported.

83 As there are currently no patient safety dashboards in place it is difficult to see an overall summary across service groups or identify any trends and issues. Workforce issues such as sickness are not presented to enable triangulation of sources of information. In addition, due to the nature of the Health Board it is challenging to compare its performance on quality measures against others. It can be difficult therefore to ensure sufficient context to identify if reported figures are of concern.

Coverage of quality and patient safety matters

84 **There is scope to broaden coverage at the corporate and operational level of quality and patient safety matters, and to ensure sufficient coverage on primary care as well as secondary services.**

85 Performance reporting within the Health Board aligns to the current national delivery framework with the 84 measures in place mapped to the Healthier Wales quadruple aims. These reports presented to Board clearly identify trend information, and commentary is provided to explain performance and actions being taken to address areas where performance is not in line with expectations. The current performance report, although in line with the NHS delivery framework, does not have any specific broader measures of performance in areas such as District Nursing, and there are no locally agreed measures in place. There are no other performance reports relating to quality and patient safety reported to the Board.

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86 The agendas of the EQS committee are balanced and informed by routine reports on concerns and complaints. A Putting Things Right report is produced for every meeting and data is interpreted and information on performance as well as commentary on actions taken following concerns and incidents is provided. The EQS also receives updates on commissioned services that are in escalation through the CAF process. Currently, performance on services is contained in corporate reports but there are plans underway as part of the Clinical Quality Framework (CQF) for the service groups to produce and present their own performance reports to EQS and QGG which will enable better Independent Member and executive scrutiny. A report on clinical audit progress is also received at the EQS routinely to provide assurance on progress delivering the Health Board's clinical audit plan.

87 The Community Services Group delivers a unique portfolio of services including general community nursing and therapy services, alongside unscheduled care, and minor injuries, including outpatients, elective surgery, endoscopy and diagnostic ultrasound and radiography services. Current quality reporting identified within their quality governance and patient safety structure does not cover all these services, with information largely focused on hospital-based service settings in response to the NHS Wales national delivery framework. Previous audit work has identified the need for more tailored performance metrics for district nursing services, but progress to address this issue appears limited.

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Appendix 1

Management response to audit recommendations

Exhibit 2: management response

Recommendation	Management response	Completion date	Responsible officer
Commissioning Assurance Framework R1 The commissioning assurance framework is the mechanism to provide assurance on the quality of services provided to Powys residents. • Review the Commissioning Assurance Framework to include measures on the standards of care provided or patient outcomes.	The Health Board will undertake a review of the Commissioning Assurance process to ensure: (i) it identifies/reflects patient/service risks post COVID-19; and (ii) it is accessible (in a user-friendly format) to engage a wider range of staff to enable them to inform the corporate view of patient/service risks.	March 2022	Director of Planning and Performance and Director of Nursing and Midwifery

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Recommendation	Management response	Completion date	Responsible officer
Clinical Quality Framework R2 The current clinical quality framework articulates the steps needed to improve clinical quality governance. It does not clearly set out the mechanism in place within the Health Board to provide strategic and operational oversight. • Develop a governance map for the organisation to clearly identify the range of activities in place at the strategic and operational level to ensure there is a clear line of sight from service to Board and identify any overlaps between groups.	Changes to the Board's assurance committees for 2021/22 have been approved by Board (July 2021) and are currently being implemented. A review of the management groups enabling Committees is currently underway. On approval of a revised management group structure, the Clinical Quality Framework will clearly set out the mechanism in place within the Health Board to provide strategic and operational oversight.	March 2022	Board Secretary and Director of Nursing and Midwifery

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Recommendation	Management response	Completion date	Responsible officer
Alignment of Frameworks R3 Currently, the Health Board has a clinical quality framework (CQF), which focusses on developing the Health Board's quality governance arrangements, and a commissioning assurance framework (CAF) which sets the framework for providing assurance on the quality of services. The CAF has been predominantly focussed on commissioned services, however there is an intention for this approach to be implemented within directly provided services (in place for Mental Health Services and Maternity Services). There are potential synergies between these frameworks and the Health Board should consider repositioning these two frameworks to further build on the inter-relationships. • Review the potential for alignment of the Clinical Quality Framework and the Commissioning Assurance Framework.	The Clinical Quality Framework sets out the Health Board's primary strategic approach to continuous development of high-quality services for the people of Powys. The Commissioning Assurance Framework will be more closely aligned to the Clinical Quality Framework. The Commissioning Assurance Framework will be applied to services directly provided by the Health Board.	31 December 2021 March 2022	Director of Nursing and Midwifery

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Recommendation	Management response	Completion date	Responsible officer
Concerns and Complaints R4 As a significant percentage of activity is delivered by commissioned services, there needs to be greater clarity on the oversight of complaints from Powys residents on these services. • Ensure that all complaints by Powys residents (directly and indirectly reported to the Health Board) on commissioned services are captured and reported to the Patient Experience, Quality and Safety Committee.	The current commissioning assurance mechanisms will be strengthened to ensure that all complaints by Powys residents (directly and indirectly reported to the Health Board) on commissioned services are captured and reported to the Patient Experience, Quality and Safety Committee.	30 September 2021	Director of Nursing and Midwifery

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Recommendation	Management response	Completion date	Responsible officer
Performance Measures R5 Our work found that there needed to be articulation of the quality measures in place across the range of services provided. These needed to be clearly identified with a baseline undertaken in order measure the success of the clinical quality framework. • Develop a quality dashboard which articulates the quality and patient safety performance measures and key performance indicators for the Health Board in order to measure success and demonstrate improvements.	Within the Clinical Quality Framework (Goal 5) Health Board has committed to 'Develop Excellent Information and Intelligence Systems, to Enable High Quality Clinical Care' (Goal 5). This workstream will focus on: • reviewing and developing performance monitoring arrangements for clinical services; aligning to work undertaken on the Commissioning Assurance Framework; • reviewing and developing ward/department and service-level dashboards; • developing arrangements for the clinical validation/interpretation of the core datasets relating to clinical services, including the use and interpretation of data in providing assurance; and • developing/integrating a valid and robust organisational benchmarking approach, using national/international comparators where available.	September 2022	Director of Public Health

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Recommendation	Management response	Completion date	Responsible officer
DATIX R6 Our work found that at a corporate level only some staff received training and support on how to use the DATIX system to report concerns and near misses. • Ensure that all corporate staff receive training appropriate to their role.	As part of the implementation of the new Once for Wales Concerns Management System there is a full programme of training that is being delivered across the organisation and includes all relevant staff who require access. This training programme will be monitored and reported on to ensure full coverage. Developments will also link to the national programme re implementation, training and module release.	March 2022	Director of Finance and IT
Training R7 Statutory and mandatory training is important for ensuring staff and patient safety and wellbeing; however, compliance often falls short of what is required. • Ensure that all statutory and mandatory training compliance meets the required target.	Statutory and Mandatory training compliance was 81% as of August 2021, which shows an increase of 1% when compared to the previous month (80%). The Workforce & OD team continue to work with managers to improve Statutory and Mandatory Training compliance. Particular focus will be given to those areas who are below the current organisational compliance rate of 85%. Directors will take a personal role in ensuring statutory and mandatory training within their function continues to improve to meet the 85% standard.	31 March 2022	Director of Workforce & OD with Executive Directors

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Recommendation	Management response	Completion date	Responsible officer
Data Analytics R8 Our work found that the Community Services Group did not have a quality dashboard to provide performance information, in addition we found within the Health Board there was no dedicated data analytics team for analysing and interpreting data on quality and safety. Without this information it is difficult to provide a performance baseline, assess progress or identify areas where performance needs to improve. • Build capacity within the operational teams to undertake analytical analysis within their teams to better understand and evaluate performance.	Within the Clinical Quality Framework (Goal 5) Health Board has committed to 'Develop Excellent Information and Intelligence Systems, to Enable High Quality Clinical Care' (Goal 5). This workstream will focus on: • reviewing and developing performance monitoring arrangements for clinical services; aligning to work undertaken on the Commissioning Assurance Framework; • reviewing and developing ward/department and service-level dashboards; • developing arrangements for the clinical validation/interpretation of the core datasets relating to clinical services, including the use and interpretation of data in providing assurance; and • developing/integrating a valid and robust organisational benchmarking approach, using national/international comparators where available.	September 2022	Director of Public Health

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Appendix 2

Staff survey findings

Exhibit 3: staff survey findings

Breakdown of Respondents	Number of Responses
Administration and Clerical	**3**
Allied Health Professional	**23**
Ancillary	**15**
Healthcare Support Worker	**21**
Management	**6**
Nursing or Healthcare Assistant	**13**
Registered Nurse	**51**

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Breakdown of Respondents	Number of Responses
Other	**5**

Attitude statements	Number of staff agreeing or disagreeing with statements					Total respondents[7]
	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	
Delivering safe and effective care						
1. Care of patients is my organisation's top priority.	61	52	13	11	1	138
2. I am satisfied with the quality of care I give to patients.	64	55	7	6	1	135

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[7] Not all respondents answered every question therefore the total respondents may vary by question.

Attitude statements	Number of staff agreeing or disagreeing with statements					Total respondents[8]
	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	
Delivering safe and effective care						
3. There are enough staff within my work area/department to support the delivery of safe and effective care.	18	32	33	32	16	134
4. My working environment supports safe and effective care.	38	57	20	14	4	133
5. I receive regular updates on patient feedback for my work area/department.	16	45	36	28	7	132

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[8] Not all respondents answered every question therefore the total respondents may vary by question.

Attitude statements	Number of staff agreeing or disagreeing with statements					Total respondents[9]
	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	
Managing patient and staff concerns						
6. My organisation acts on concerns raised by patients.	42	50	24	7	3	126
7. My organisation acts on concerns raised by staff.	21	56	30	18	7	132
8. My organisation encourages staff to report errors, near misses or incidents.	51	58	19	5	0	133
9. Staff who are involved in an error, near miss or incident are treated fairly by the organisation.	27	47	36	6	1	117

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[9] Not all respondents answered every question therefore the total respondents may vary by question.

Attitude statements	Number of staff agreeing or disagreeing with statements					Total respondents[10]
	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	
Managing patient and staff concerns						
10. When errors, near misses or patient safety incidents are reported, my organisation acts to ensure that they do not happen again.	34	54	30	3	2	123
11. We are given feedback about changes made in response to reported errors, near misses and incidents.	19	41	43	24	2	129
12. I would feel confident raising concerns about unsafe clinical practice.	45	63	14	8	4	134
13. I am confident that my organisation acts on concerns about unsafe clinical practice.	36	49	27	12	2	126

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[10] Not all respondents answered every question therefore the total respondents may vary by question.

Attitude statements	Number of staff agreeing or disagreeing with statements					Total respondents[11]
	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	
Working in my organisation						
14. Communication between senior management and staff is effective.	19	46	43	18	10	136
15. My organisation encourages teamwork.	32	69	20	9	5	135
16. I have enough time at work to complete any statutory and mandatory training.	16	41	31	37	11	136
17. Induction arrangements for new and temporary staff (eg agency/locum/bank/re-deployed staff) in my work area/department support safe and effective care.	19	58	37	12	15	131

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[11] Not all respondents answered every question therefore the total respondents may vary by question.

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We welcome correspondence and telephone calls in Welsh and English.
Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

Mick Langdon
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Adolygiad o Drefniadau Llywodraethu Ansawdd – Bwrdd Iechyd Addysgu Powys

Blwyddyn archwilio: 2019

Dyddiad cyhoeddi: Hydref 2021

Cyfeirnod y ddogfen: 2551A2021-22

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Paratowyd y ddogfen hon ar gyfer defnydd mewnol gan Bwrdd Iechyd Addysgu Powys yn rhan o'r gwaith a gyflawnwyd/gyflawnir yn unol â swyddogaethau statudol.

Mae gan yr Archwilydd Cyffredinol ystod eang o swyddogaethau archwilio a swyddogaethau cysylltiedig, gan gynnwys archwilio cyfrifon cyrff GIG Cymru, ac adrodd i'r Senedd ar ddarbodusrwydd, effeithlonrwydd ac effeithiolrwydd y sefydliadau hynny o ran eu defnydd o'u hadnoddau. Mae'r Archwilydd Cyffredinol yn ymgymryd â'i waith gan ddefnyddio staff ac adnoddau eraill a ddarperir gan Swyddfa Archwilio Cymru, sy'n fwrdd statudol a sefydlwyd at y diben hwnnw ac i fonitro a chynghori'r Archwilydd Cyffredinol.

Archwilio Cymru yw'r enw cyfunol anstatudol ar gyfer Archwilydd Cyffredinol Cymru a Swyddfa Archwilio Cymru, sy'n endidau cyfreithiol ar wahân y mae gan y ddau ohonynt eu swyddogaethau cyfreithiol eu hunain fel y disgrifir uchod. Nid yw Archwilio Cymru yn endid cyfreithiol ac nid oes ganddo unrhyw swyddogaethau.

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Nid yw'r Archwilydd Cyffredinol na staff Swyddfa Archwilio Cymru yn derbyn unrhyw gyfrifoldeb mewn cysylltiad ag unrhyw aelod, cyfarwyddwr, swyddog na chyflogai arall yn eu rhinwedd unigol, nac unrhyw drydydd parti, mewn cysylltiad â'r adroddiad hwn.

Os gwneir cais am wybodaeth y gallai'r ddogfen hon fod yn berthnasol iddi, tynnir sylw at y Cod Ymarfer a gyhoeddwyd o dan adran 45 o Ddeddf Rhyddid Gwybodaeth 2000. Mae Cod adran 45 yn nodi'r ymarfer a ddisgwylir gan awdurdodau cyhoeddus wrth ymdrin â cheisiadau, gan gynnwys ymgynghori â thrydydd partïon perthnasol. Mewn cysylltiad â'r ddogfen hon, mae Archwilydd Cyffredinol Cymru a Swyddfa Archwilio Cymru yn drydydd partïon perthnasol. Dylid anfon unrhyw ymholiadau ynglŷn â datgelu neu ailddefnyddio'r ddogfen hon i Archwilio Cymru yn infoofficer@audit.wales.

Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg. Ni fydd gohebu yn Gymraeg yn arwain at oedi. We welcome correspondence and telephone calls in Welsh and English. Corresponding in Welsh will not lead to delay.

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Adroddiad cryno

Am yr adroddiad hwn

1 Dylai ansawdd fod wrth wraidd pob agwedd ar ofal iechyd ac mae rhoi ansawdd a diogelwch cleifion yn anad popeth arall yn un o'r gwerthoedd craidd sy'n sail i'r GIG yng Nghymru. Gall gofal o ansawdd gwael fod yn gostus hefyd o ran niwed, gwastraff ac amrywiad. Mae angen rhoi fframwaith llywodraethu cadarn ar waith ar sefydliadau'r GIG a'r unigolion sy'n gweithio ynddynt er mwyn helpu i sicrhau y darperir gofal iechyd diogel, effeithiol ac o ansawdd uchel. Un o ddibenion allweddol y trefniadau 'llywodraethu ansawdd' hyn yw helpu sefydliadau a'u staff i fonitro safonau gofal, gan eu gwella yn ôl yr angen.

2 Atgyfnerthwyd y sbardun i wella ansawdd mewn strategaethau a pholisïau iechyd a gofal cymdeithasol olynol dros y ddau ddegawd diwethaf. Ym mis Mehefin 2020, daeth Deddf Iechyd a Gofal Cymdeithasol (Ansawdd ac Ymgysylltu) (Cymru) yn gyfraith. Mae'r Ddeddf yn cryfhau'r ddyletswydd i sicrhau gwelliannau ansawdd ar draws y system, yn ogystal â rhoi dyletswydd ar gyrff y GIG i fod yn ddidwyll, gan ei gwneud yn ofynnol iddynt fod yn agored ac yn onest pan fo pethau'n mynd o chwith er mwyn galluogi dysg. Mae'r Ddeddf yn nodi bod ansawdd yn cynnwys, ond heb fod yn gyfyngedig i effeithiolrwydd a diogelwch gwasanaethau iechyd a phrofiadau'r defnyddwyr gwasanaeth.

3 Mae'n rhaid i ansawdd a diogelwch dreiddio bob agwedd ar y broses o gynllunio ac o ddarparu gwasanaethau, gan fod yn amlwg yng nghynlluniau tymor canolig integredig cyrff y GIG. Disgwylir i gyrff y GIG fonitro ansawdd a diogelwch ar lefel y bwrdd a thrwy'r holl leoliadau gwasanaethau, partneriaethau a gofal. Dros y blynyddoedd diwethaf, mae ein gwaith Asesu Strwythuredig blynyddol ledled Cymru wedi tynnu sylw at heriau amrywiol, gan gynnwys yr angen i wella'r llifau sicrwydd o ran ansawdd a diogelwch, goruchwylio archwiliadau clinigol, a'r gwaith o olrhain canfyddiadau ac argymhellion rheoleiddio ac arolygu. Bu pryderon proffil uchel hefyd ynghylch ansawdd gofal a dulliau llywodraethu cysylltiedig mewn cyrff GIG unigol.

4 O ystyried y cyd-destun hwn, mae'n bwysig bod byrddau'r GIG, y cyhoedd a rhanddeiliaid allweddol yn cael sicrwydd bod trefniadau llywodraethu o ansawdd yn effeithiol a bod cyrff y GIG yn parhau i ganolbwyntio'n ddigonol ar ansawdd wrth ymateb i bandemig COVID-19. Mae fframwaith cynllunio presennol GIG Cymru yn adlewyrchu'r angen i ystyried y niwed uniongyrchol ac anuniongyrchol sy'n gysylltiedig â COVID-19. Mae'n bwysig bod cyrff y GIG yn sicrhau bod eu trefniadau llywodraethu o ansawdd yn cefnogi goruchwyliaeth sefydliadol dda o'r niwed hyn yn rhan o'u dull ehangach o sicrhau gwasanaethau diogel ac effeithiol.

5 Archwiliodd ein harchwiliad a yw trefniadau llywodraethu'r sefydliad yn cefnogi'r broses o ddarparu gwasanaethau diogel ac effeithiol o ansawdd uchel. Canolbwyntiwyd ar y dull gweithredol a chorfforaethol o lywodraethu ansawdd, y diwylliant ac ymddygiad sefydliadol, strategaeth, strwythurau a phrosesau, llifau gwybodaeth ac adrodd. Mae'r adroddiad hwn yn crynhoi canfyddiadau ein gwaith ym Mwrdd Iechyd Addysgu Powys (y Bwrdd Iechyd) a gynhaliwyd rhwng mis Ebrill

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a mis Gorffennaf 2021. Er mwyn profi'r safbwynt 'o'r llawr i'r bwrdd', gwnaethom archwilio'r trefniadau ar gyfer Gwasanaethau Cymunedol. Gwnaethom adolygu hefyd y trefniadau lefel uchel ar gyfer sicrhau ansawdd gwasanaethau darparwyr.

Negeseuon allweddol

6 Yn gyffredinol, canfuom fod **y Bwrdd Iechyd wedi ymrwymo i sicrhau gwasanaethau diogel ac effeithiol o ansawdd uchel a'i fod wedi cymryd camau i wella ei drefniadau llywodraethu ansawdd. Mae gwaith o hyd o ran ymwreiddio'r trefniadau hyn, mynegi blaenoriaethau ansawdd y sefydliad a sicrhau bod mesurau ar waith i ddangos a monitro i ba raddau y cyflawnwyd y dasg o ysgogi gwelliannau ar draws yr ystod lawn o wasanaethau a ddarperir ac a gomisiynwyd.**

7 Mae ymrwymiad clir i sicrhau y darperir gwasanaethau diogel ac o ansawdd uchel a gefnogir gan fframweithiau corfforaethol a thrwy wella'r broses o reoli risgiau. Mae gan y Bwrdd Iechyd werthoedd ac ymddygiad sefydledig ac mae'r staff yn teimlo eu bod yn cael eu cefnogi i godi pryderon. Mae cyflwyno'r Fframwaith Ansawdd Clinigol newydd yn gam cadarnhaol ac mae hyn yn dechrau cryfhau'r gwaith llywodraethu gweithredol, yn ogystal â chynyddu adnoddau.

8 Fodd bynnag, mae angen i'r blaenoriaethau ansawdd a'r mesurau llwyddiant fod yn gliriach er mwyn mesur yr effaith a'r gwelliant. Mae angen i'r gwaith o gasglu sylwadau cleifion fod yn fwy cyson ac mae angen gwell systemau i ddangos yr hyn a ddysgir. Mae cyfyngiadau capasiti yn y tîm pryderon yn parhau i fod yn fater y mae angen mynd i'r afael ag ef. Mae lle hefyd i ehangu'r adroddiadau perfformiad presennol er mwyn sicrhau bod pwyslais cliriach ar faterion ansawdd sy'n cwmpasu ehangder y gwasanaethau a ddarperir, yn ogystal â datblygu dangosfwrdd ansawdd sy'n adlewyrchu natur unigryw y Bwrdd Iechyd.

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Argymhellion

9 Manylir ar yr argymhellion sy'n deillio o'r archwiliad hwn yn **Arddangosyn 1**. Ceir crynodeb o ymateb rheolwyr y Bwrdd Iechyd i'r argymhellion hyn yn **Atodiad 1**.

Arddangosyn 1: argymhellion

Argymhellion
Fframwaith Sicrwydd Comisiynu A1 Y fframwaith sicrwydd comisiynu yw'r dull o roi sicrwydd ar ansawdd y gwasanaethau a ddarperir i drigolion Powys. • Adolygu'r Fframwaith Sicrwydd Comisiynu i gynnwys mesurau ar y safonau gofal a ddarperir neu ar ganlyniadau cleifion.
Fframwaith Ansawdd Clinigol A2 Mae'r fframwaith ansawdd clinigol presennol yn nodi'r camau sydd eu hangen i wella'r broses o lywodraethu ansawdd clinigol. Nid yw'n nodi'n glir y dulliau sydd ar waith yn y Bwrdd Iechyd i ddarparu goruchwyliaeth strategol a gweithredol. • Datblygu map llywodraethu fel y gall y sefydliad nodi'n glir yr ystod o weithgareddau sydd ar waith ar lefel strategol a gweithredol er mwyn sicrhau bod llinell olwg glir o'r gwasanaeth at y Bwrdd a nodi unrhyw orgyffyrddiadau neu fylchau sy'n bodoli rhwng grwpiau.
Alinio Fframweithiau A3 Ar hyn o bryd, mae gan y Bwrdd Iechyd fframwaith ansawdd clinigol sy'n canolbwyntio ar ddatblygu trefniadau llywodraethu ansawdd y Bwrdd Iechyd, a fframwaith sicrwydd comisiynu sy'n pennu'r fframwaith ar gyfer rhoi sicrwydd ar ansawdd gwasanaethau. Mae'r fframwaith sicrwydd comisiynu wedi canolbwyntio'n bennaf ar wasanaethau a gomisiynwyd, fodd bynnag, mae bwriad i roi'r dull hwn o weithredu ar waith mewn gwasanaethau a ddarperir yn uniongyrchol (ar waith ar gyfer Gwasanaethau Iechyd Meddwl a Gwasanaethau Mamolaeth). Mae synergeddau posibl rhwng y fframweithiau hyn, a dylai'r Bwrdd Iechyd ystyried adleoli'r ddau fframwaith hyn er mwyn adeiladu ar y rhyngberthnasau ymhellach. • Adolygu'r potensial o ran alinio'r Fframwaith Ansawdd Clinigol a'r Fframwaith Sicrwydd Comisiynu.

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Argymhellion

Pryderon a Chwynion

A4 Oherwydd bod canran sylweddol o weithgareddau yn cael ei darparu gan wasanaethau a gomisiynwyd, mae angen eglurder gwell wrth oruchwylio cwynion gan drigolion Powys ynghylch y gwasanaethau hyn.

- Sicrhau bod yr holl gwynion gan drigolion Powys (a adroddir i'r Bwrdd Iechyd yn uniongyrchol ac yn anuniongyrchol) ynghylch gwasanaethau a gomisiynwyd yn cael eu casglu a'u hadrodd i'r Pwyllgor Ansawdd, Profiad a Diogelwch Cleifion.
- Diweddaru'r Fframwaith Sicrwydd Comisiynu er mwyn sicrhau eglurder o ran cyfrifoldeb am y gwaith o fonitro ac adrodd cwynion.

Mesurau Perfformiad

A5 Canfu ein gwaith fod angen mynegi'r mesurau ansawdd sydd ar waith ar draws yr ystod o wasanaethau a ddarperir. Roedd angen nodi'r rhain yn glir â llinell sylfaen a gynhaliwyd er mwyn mesur llwyddiant y fframwaith ansawdd clinigol.

- Datblygu dangosfwrdd ansawdd sy'n mynegi'r mesurau perfformiad ansawdd a diogelwch cleifion a dangosyddion perfformiad allweddol ar gyfer y Bwrdd Iechyd, er mwyn mesur llwyddiant a dangos gwelliannau.

DATIX

A6 Canfu ein gwaith mai dim ond rhai staff ar lefel gorfforaethol a gafodd gymorth a hyfforddiant ar sut i ddefnyddio system DATIX i adrodd pryderon a damweiniau a fu bron a digwydd.

- Sicrhau bod yr holl staff corfforaethol yn cael hyfforddiant sy'n briodol i'w swyddogaeth.

Hyfforddiant

A7 Mae hyfforddiant statudol a gorfodol yn bwysig o ran sicrhau diogelwch a lles staff a chleifion; fodd bynnag, mae lefel y cydymffurfio yn methu â bodloni'r gofynion yn aml.

- Sicrhau bod yr holl gydymffurfio statudol a gorfodol o ran hyfforddiant yn cyflawni'r targed gofynnol.

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Argymhellion

Dadansoddi Data

A8 Canfu ein gwaith nad oedd gan y Grŵp Gwasanaethau Cymunedol ddangosfwrdd ansawdd i ddarparu gwybodaeth am berfformiad, a gwelsom hefyd, yn y Bwrdd Iechyd, nad oedd tîm dadansoddi data pwrpasol i ddadansoddi a dehongli data ar ansawdd a diogelwch. Heb yr wybodaeth hon, mae'n anodd darparu llinell sylfaen ar berfformiad, asesu cynnydd neu nodi'r meysydd y mae angen gwella perfformiad ynddynt.

- Er mwyn deall a gwerthuso perfformiad yn well, meithrin gallu yn y timau gweithredol i gynnal dadansoddiad dadansoddol yn eu timau.

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Adroddiad manwl

Strategaeth sefydliadol ar gyfer ansawdd a diogelwch cleifion

10 Ystyriodd ein gwaith i ba raddau y mae blaenoriaethau sydd wedi eu diffinio'n glir ar gyfer ansawdd a diogelwch cleifion, ac i ba raddau y llinierir y risgiau i'w cyflawni nhw'n effeithiol.

11 Canfuom fod **ymrwymiad clir i sicrhau y darperir gwasanaethau diogel ac o ansawdd uchel a gefnogir gan fframweithiau corfforaethol a thrwy wella'r broses o reoli risgiau. Mae lle i ddatblygu blaenoriaethau ansawdd cliriach ac i fynegi mesurau llwyddiant er mwyn mesur effaith a gwelliant.**

Blaenoriaethau ansawdd a diogelwch cleifion

12 **Mae'r Bwrdd Iechyd wedi ymrwymo i sicrhau ansawdd o'i wasanaethau a gomisiynir ac a ddarperir ac mae wedi datblygu fframweithiau ategol i gyflawni hyn, ond nid yw wedi diffinio metrigau na blaenoriaethau ansawdd mesuradwy, na defnyddio asesiadau o'r effaith ar ansawdd wrth adolygu'r gwasanaethau a ddarperir.**

13 Nid oes gan y Bwrdd Iechyd flaenoriaethau ansawdd na diogelwch cleifion annibynnol. Yn hytrach, mae wedi dangos ei ymrwymiad i ddarparu gofal clinigol o'r ansawdd uchaf i'w boblogaeth leol drwy ei strategaeth 'Powys Iach Ofalgar', sef Cynllun Tymor Canolig Integredig a Chynllun Blynyddol ar gyfer 2021-22.

14 Yn y Cynllun Tymor Canolig Integredig, mae 'Ansawdd a Phrofiad Dinasyddion' yn flaenoriaeth sefydliadol i'r Bwrdd Iechyd. Yn gysylltiedig â hyn, mae nifer o gamau gweithredu â blaenoriaeth, megis datblygu cynllun gwella digwyddiadau difrifol a sefydlu panel craffu ar wlserau pwyso. Mae cynllun blynyddol 2021-22 yn nodi'n glir bod ansawdd a gwelliant clinigol yn parhau i fod yn flaenoriaeth wrth i'r Bwrdd Iechyd symud tuag at adfer yn sgil COVID-19. Mae Strategaeth Iechyd a Gofal Powys, 'Powys Iach Ofalgar' a gynhyrchwyd â Cyngor Sir Powys a Bwrdd Partneriaeth Rhanbarthol Powys yn 2017 yn dangos ymgysylltiad rhanddeiliaid mewn cysylltiad â'r angen i sicrhau gwasanaethau diogel o ansawdd uchel er mwyn cael yr effaith fwyaf bosibl ar anghenion y boblogaeth.

15 Er mwyn cefnogi'r gwaith o gyflawni gwasanaethau o ansawdd o'i wasanaethau a ddarperir ac a gomisiynir, mae'r Bwrdd Iechyd wedi sefydlu dau fframwaith a drafodir yn fanylach yn ddiweddarach yn yr adroddiad. Mae'r **Fframwaith Ansawdd Clinigol** y cytunwyd arno gan y Bwrdd yn 2020 yn nodi rhaglen waith i wella'r llywodraeth ansawdd, sydd yn ei thro, yn cefnogi'r gwaith o gyflawni canlyniadau ansawdd gwell. Mae'r Fframwaith Ansawdd Clinigol yn amlinellu pum nod sefydliadol y mae ganddynt synergedd â'r cynllun Tymor Canolig Integredig a'r cynlluniau Blynyddol. Caiff y Fframwaith Ansawdd Clinigol ei lywio gan brosesau i raddau helaeth, gan nodi camau gwella ar draws y Bwrdd Iechyd. Mae gan bob un o'r meysydd hyn gamau gweithredu penodol a nodir, yn ogystal â swyddog gweithredol arweiniol a ddewiswyd. Yn hanfodol, mae'r Bwrdd Iechyd yn rhoi'r

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blociau sylfaen ar waith i sefydlu a chryfhau prosesau a gweithdrefnau er mwyn cyflawni ei weledigaeth. Fodd bynnag, nid yw'r Bwrdd Iechyd wedi diffinio canlyniadau na safonau disgwyliedig y gellid cymharu â nhw er mwyn mesur ac asesu llwyddiant. Mae'r camau gweithredu a nodir yn y dogfennau presennol yn ymwneud â phrosesau y mae angen eu sefydlu er mwyn cefnogi llywodraeth o ansawdd effeithiol. O'n gwaith ni, ni wnaethom nodi unrhyw dargedau na blaenoriaethau lleol yn y grŵp gwasanaethau cymunedol.

16 Er mwyn cefnogi'r gwaith o ddarparu gwasanaethau a gomisiynwyd, datblygodd y Bwrdd Iechyd **Fframwaith Sicrwydd Comisiynu** yn 2018. Disgrifia'r fframwaith sicrwydd comisiynu broses sicrwydd barhaus er mwyn sicrhau bod gwasanaethau a gomisiynir yn ddiogel, yn bersonol, yn effeithiol ac yn gwella'n barhaus. Mae pob darparwr ond un wedi ymrwymo i'r fframwaith hwn, ac ar hyn o bryd, mae trafodaethau'n mynd rhagddynt ynglŷn â'r rhesymau dros hyn gyda'r nod o fynd i'r afael â'r mater hwn yn y dyfodol agos.

17 Ar hyn o bryd, nid oes dim y gellir cyfeirio ato o ran defnyddio Asesiadau o'r Effaith ar Ansawdd ar gyfer cynlluniau cynhyrchiant ac effeithlonrwydd. Mae'r asesiadau hyn yn gofyn i sefydliadau ystyried effaith newidiadau ac ailgynllunio posibl i wasanaethau ar ansawdd a diogelwch. Er bod y gwaith o ailgynllunio'r gwasanaeth podiatreg a gymeradwywyd gan y Bwrdd ym mis Awst 2020 yn cynnwys Asesiad manwl o'r Effaith ar Gydraddoldeb a oedd yn cwmpasu'r gallu i ddefnyddio gwasanaethau a nodweddion gwarchodedig, nid oedd asesiad ar effeithiolrwydd na chanlyniadau mewn cysylltiad â'r newid yn y gwasanaethau a ddarperid.

Rheoli risgiau

18 **Mae gan y Bwrdd Iechyd fframwaith rheoli risgiau clir, ac mae'r gwaith o adnabod a rheoli risgiau yn aeddfedu. Mae angen gwaith i ddiweddaru Fframwaith Sicrwydd y Bwrdd yng ngoleuni'r blaenoriaethau strategol newydd ac i sicrhau bod llinell olwg gliriach o gofrestrau risgiau y gyfarwyddiaeth i'r gofrestr risgiau corfforaethol, ac i sicrhau bod camau lliniaru mewn cofrestrau yn ddigonol i roi sicrwydd.**

19 Diwygiodd y Bwrdd Iechyd ei fframwaith rheoli risgiau yn 2019. Mae'r Bwrdd Iechyd wedi disgrifio ei barodrwydd i dderbyn risg ac wedi datgan yn glir nad yw'n barod i dderbyn unrhyw risgiau sy'n effeithio'n sylweddol ar ansawdd a diogelwch y gwasanaethau a ddarperir neu a gomisiynir gan y Bwrdd Iechyd. Fodd bynnag, mae cofrestr risgiau corfforaethol y Bwrdd Iechyd sy'n cwmpasu gwasanaethau a gomisiynir ac a ddarperir yn nodi nifer o risgiau, ac mae 60% ohonynt yn gysylltiedig ag ansawdd a diogelwch gwasanaethau. Ar hyn o bryd, mae swyddogion gweithredol yn adnewyddu'r gofrestr drwy adolygu eu portffolio o risgiau. Mae'r Bwrdd Iechyd yn bwriadu datblygu cofrestrau risgiau pwyllgorau, ac roedd y gwaith yn y maes hwn wedi dechrau ond fe'i gohiriwyd oherwydd COVID-19. Mae rhaglen waith ar y gweill i fapio'r pwyllgorau i'r risgiau yn ogystal â ffynonellau sicrwydd eraill, megis archwilio clinigol.

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20 Nododd ein hasesiad strwythuredig yn 2020[1] fod gan y Bwrdd Iechyd system sy'n aeddfedu ar gyfer rheoli risgiau, ac yn rhan o'r ymateb i'r pandemig, ei fod wedi datblygu cofrestr risg aur COVID-19 benodol a oedd yn cael ei monitro yn aml. Mae'r risgiau ar gofrestr risg aur COVID-19 wedi eu huno â chofrestr risg gorfforaethol y Bwrdd Iechyd.

21 Mae gan y Bwrdd Iechyd Fframwaith Sicrwydd y Bwrdd, fodd bynnag, yng ngoleuni'r pandemig a blaenoriaethau newidiol blynyddol y Bwrdd nad adroddwyd ers mis Ionawr 2020 yn y cyfamser, mae'r gofrestr risgiau corfforaethol wedi parhau i gael ei hadrodd i'r Bwrdd, gan fynegi manylion y rheolaethau presennol a'r camau lliniaru o'u cymharu â phob risg.

22 Nid yw'r Bwrdd Iechyd yn defnyddio DATIX ar gyfer rheoli risgiau ar hyn o bryd, yn lle hynny mae wedi datblygu system templedi Excel ar gyfer rheoli risgiau ar draws y sefydliad. Trwy ein gwaith, gwnaethom adolygu sampl o'r rhai hyn sy'n cael eu defnyddio, sy'n dangos eu bod wedi eu mabwysiadu'n eang gan y sefydliad, er y byddai symud i system electronig yn darparu llwybr tystiolaeth newidiadau mwy cadarn ar gyfer sgorio risgiau dros amser. Bydd y Bwrdd Iechyd yn mabwysiadu System Rheoli Pryderon Unwaith i Gymru[2] yn ystod 2021, a bydd hyn hefyd yn cynnwys defnyddio modiwl rheoli risgiau DATIX.

23 Mae Grŵp Risg a Sicrwydd y Bwrdd Iechyd yn arfer cwrdd pob deufis, gan adrodd i'r Pwyllgor Gweithredol. Rhoddodd y Grŵp y gorau i weithredu ym mis Medi 2020 oherwydd COVID-19, ond disgwylir i gyfarfodydd ailddechrau ym mis Gorffennaf 2021. Prif ddiben y Grŵp yw trafod a sicrhau cysondeb o ran sgorio risgiau ar draws y Bwrdd Iechyd.

24 Mae hyfforddiant mewn rheoli risgiau wedi bod yn gyfyngedig. Ar adeg ein gwaith, nid oedd Aelodau Annibynnol wedi cael unrhyw hyfforddiant penodol ynghylch risgiau, eu swyddogaethau na'u cyfrifoldebau mewn cysylltiad â rheoli risgiau. Ni chyflwynwyd hyfforddiant ar gofrestrau risgiau yn ôl y bwriad oherwydd COVID-19, er bod y Bwrdd Iechyd yn ymgysylltu ag arweinwyr risgiau eraill ledled Cymru wrth ddatblygu modiwl hyfforddi rheoli risgiau safonol i'w ddefnyddio.

25 Yn 2019, buddsoddodd y Bwrdd Iechyd yn y gallu i reoli risgiau drwy benodi Pennaeth Risg a Sicrwydd a thrwy nodi'r lefel gywir o gymorth gweinyddol. Mae'r tîm rheoli risgiau bach, ymroddedig hwn (dau aelod o staff cyfwerth ag amser llawn) yn darparu hyfforddiant a chymorth rheoli risgiau i dimau gweithredol. Mae arweinydd penodol ar gyfer rheoli risgiau yn y Grŵp Gwasanaethau Cymunedol.

26 Yn rhan o'n gwaith, gwnaethom adolygu cofrestr risgiau y Grŵp Gwasanaethau Cymunedol a chofrestr risgiau y Cyfarwyddwr Gofal Sylfaenol, Cymunedol ac Iechyd Meddwl (cyfarwyddiaeth). Roedd y cofrestrau hyn yn ddiweddar, ac roedd

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[1] Archwilio Cymru, Bwrdd Iechyd Addysgu Powys - Asesiad Strwythuredig 2020, Tachwedd 2020

[2] Datblygwyd Rhaglen System Rheoli Pryderon Unwaith i Gymru o'r argymhellion yn Adroddiad Llywodraeth Cymru 'Defnyddio Cwynion yn Rhodd'. Bydd pob Bwrdd Iechyd yn symud i'r system hon rywbryd.

tystiolaeth o risgiau'n cael eu huwchgyfeirio yn briodol o'r gofrestr Gwasanaethau Cymunedol i'r Gofrestr Gofal Sylfaenol, Cymunedol ac Iechyd Meddwl. Fodd bynnag, roedd rhai meysydd yr oedd mesurau lliniaru ar goll ynddynt, ac nid oedd y dystiolaeth ar gyfer lleihau'r sgoriau risg yn glir.

27 Canfu ein harsylliad o grŵp ansawdd a phrofiadau cleifion y Grŵp Gwasanaethau Cymunedol fod trafodaeth ar gofrestr risgiau y gyfarwyddiaeth, ond dim ond ar y risgiau coch yr oedd y rhain yn canolbwyntio, yn hytrach na chyfanrwydd y risg. Mae potensial i rai risgiau beidio â chael digon o drafodaeth. Mae risgiau lluosog sy'n gysylltiedig â rhai gwasanaethau, ee Radiotherapi, ond oherwydd nad yw'r rhain yn wedi eu nodi fel risgiau coch, nid ydynt yn denu llawer o sylw, ac o ganlyniad, collir cyfleoedd i wneud dadansoddiad risgiau mwy thematig yn y maes hwn. Mae potensial cael golwg fwy cyfannol ar risgiau'r gofrestr a'r broses o archwilio themâu i'w codi.

Diwylliant sefydliadol

28 Dylai sefydliadau'r GIG ganolbwyntio yn barhaus ar wella ansawdd gofal a defnyddio adnoddau cyfyngedig i sicrhau gwell canlyniadau a phrofiadau i gleifion a defnyddwyr gwasanaethau. Ystyriodd ein gwaith i ba raddau y mae'r Bwrdd Iechyd yn hybu diwylliant ansawdd a diwylliant diogelwch sy'n canolbwyntio ar gleifion, gan gynnwys gwella cydymffurfio â hyfforddiant statudol a gorfodol, cymryd rhan mewn prosesau gwella ansawdd sy'n rhan annatod o strwythurau llywodraethu ehangach, gwrando a gweithredu ar sylwadau gan staff a chleifion, a dysgu gwersi.

29 Canfuom fod **Gwella ansawdd yn bwysig i'r Bwrdd Iechyd, fodd bynnag, mae adnoddau'n gyfyngedig. Ceir gwerthoedd ac ymddygiad sefydledig yn y sefydliad ac mae'r staff yn teimlo eu bod yn cael eu cefnogi i godi pryderon. Mae gwaith o hyd o ran gwella cysondeb wrth gasglu sylwadau cleifion a dangos dysg o hyn.**

Gwella ansawdd

30 **Mae'r Bwrdd Iechyd wedi ymrwymo i dyfu ei allu i wella ansawdd. Bu gwell defnydd o archwiliadau clinigol, er bod cyfleoedd i ddefnyddio archwiliadau clinigol yn well fel ffynhonnell sicrwydd.**

Adnoddau i gefnogi'r broses Gwella ansawdd

31 Yn gorfforaethol, mae gan y Bwrdd Iechyd dîm gwella ansawdd bach, ymroddedig iawn (0.5 aelod staff FTE), sy'n darparu hyfforddiant ar ddulliau gwella ansawdd i'r staff. Gwella Ansawdd Gyda'n Gilydd yw'r rhaglen hyfforddiant gwella ansawdd genedlaethol ar gyfer staff y GIG yng Nghymru. Nod y rhaglen yw datblygu'r gallu i wella ansawdd yn GIG Cymru gan ddefnyddio iaith gyffredin ar gyfer gwella ansawdd. Mae'r wybodaeth a ddarparwyd gan y Bwrdd Iechyd yn dangos bod

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cyfran uchel (74%) o'r staff wedi cwblhau lefel Efydd hyfforddiant Gwella Ansawdd Gyda'n Gilydd. Mae'r tîm hefyd yn darparu cymorth penodol i staff sy'n cwblhau prosiectau gwella ansawdd ar gyfer lefel Arian Gwella Ansawdd Gyda'n Gilydd. Fodd bynnag, dim ond 1% o staff y Bwrdd Iechyd sydd wedi cyflawni Gwella Ansawdd Gyda'n Gilydd Arian.

32 Mae'r tîm gwella ansawdd wedi dechrau gweithio gyda'r Hwb Ymchwil, Arloesi a Gwella. Nod y fenter ar y cyd rhwng y Bwrdd Iechyd a Cyngor Sir Powys yw cydlynu a chefnogi ymchwil, gwella gwasanaethau, a chefnogi ffyrdd newydd o weithio ar lefel Powys gyfan. Mae'r Bwrdd Iechyd yn defnyddio'r Hwb Ymchwil, Arloesi a Gwella i edrych ar ffyrdd arloesol o rannu dysg, er mai yn ei gamau datblygu cynnar y mae'r gwaith hwn ar hyn o bryd. Er mwyn cefnogi'r hwb, mae'r Bwrdd Iechyd wedi recriwtio nifer bach o staff (2.4 FTE); nid yw'r staff hyn yn aelodau uniongyrchol o dîm gwella ansawdd y Bwrdd Iechyd. Ariennir yr adnodd hwn tan fis Mawrth 2022, a chyflogir y staff ar gontractau cyfnod penodol. Mae angen i'r Bwrdd Iechyd werthuso effaith y fenter hon a cheisio ei hariannu ar sail fwy cynaliadwy os oedd hi'n llwyddiannus.

33 Mae'r Bwrdd Iechyd wedi cynyddu adnoddau er mwyn canolbwyntio ar ofal iechyd sy'n seiliedig ar werth drwy benodi Cyfarwyddwr Strategaeth a gofal iechyd sy'n seiliedig ar werth yn ddiweddar, yn rhan o weithgareddau'r Fframwaith Ansawdd Clinigol. Y nod ar gyfer y swyddogaeth hon yw cefnogi gofal iechyd darbodus sy'n seiliedig ar werthoedd i lywio'r broses gwella ansawdd.

34 Mae cynnydd o ran datblygu'r Strategaeth Effeithiolrwydd Clinigol a Gwella Ansawdd a nodir yn y fframwaith ansawdd clinigol wedi ei ohirio eto o ganlyniad i COVID-19. Mae'r gwaith hwn yn cynnwys defnyddio dull blaenoriaethol sy'n seiliedig ar risg i ddiffinio a chyflawni rhaglen targedau gwella ansawdd clinigol. Mae hyn yn parhau i fod yn flaenoriaeth i'r Bwrdd Iechyd yn ystod 2021-22.

Archwiliad Clinigol

35 Mae archwilio clinigol yn ffordd bwysig o roi sicrwydd ynghylch ansawdd a diogelwch gwasanaethau. Mae gan y Bwrdd Iechyd gynllun archwilio clinigol cymeradwy ar gyfer 2021-22 sy'n cwmpasu archwiliadau clinigol cenedlaethol ac adolygiadau o ganlyniadau a orfodwyd gan Lywodraeth Cymru. Mae'r cynllun hefyd yn cynnwys archwiliadau clinigol sy'n seiliedig ar flaenoriaethau a risgiau lleol a nodir gan uwch-reolwyr clinigol. Effeithiodd COVID-19 ar allu'r Bwrdd Iechyd i gyflawni Cynllun Archwilio Clinigol 2020-21 oherwydd cyfyngiadau ar adnoddau, gyda staff yn cael eu hadleoli er mwyn canolbwyntio ar COVID-19. Adolygodd y Bwrdd Iechyd gynllun 2020-21 ac asesodd risg yr archwiliadau a oedd yn weddill ac ailbroffilio dyddiadau newydd er mwyn sicrhau bod y gwaith yn cael ei gwblhau, a'i ymgorffori yng nghynllun archwilio clinigol 2021-22.

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36 Rhennir canfyddiadau a dysg archwiliadau clinigol â grwpiau gweithredol a strategol neu bwyllgorau. Cyflwynir adroddiadau i'r Grŵp Llywodraethu Ansawdd a gadeirir gan y Cyfarwyddwr Meddygol a'r Cyfarwyddwr Therapïau a Gwyddorau Iechyd a'r Pwyllgor Ansawdd, Profiad a Diogelwch Cleifion. Ystyriwyd canlyniadau

archwiliadau clinigol yn rhan o gyfres o wybodaeth hefyd yng nghyfarfod cyntaf a chyfarfodydd dilynol y Grŵp Dysgu o Brofiad chwarterol newydd a gadeirir gan y Cyfarwyddwr Strategaeth Glinigol. Mae cyfansoddiad y grŵp hwn yn cynnwys Cyfarwyddwr Therapïau a Gwyddorau Iechyd yn ogystal â'r Cyfarwyddwr Nyrsio a Bydwreigiaeth, sy'n sicrhau dulliau o rannu gwybodaeth rhwng y grŵp hwn a'r Grŵp Llywodraethu Ansawdd. Mae'r grŵp hwn wedi nodi materion o archwiliadau cenedlaethol ac wedi dechrau trafod rhai o'r materion a godwyd. Yn weithredol, mae cyfarfodydd gwella ac archwilio clinigol misol yn y Grŵp Gwasanaeth Menywod a Phlant a'r Grŵp Gwasanaethau Cymunedol yn nodi ac yn rhannu dysg. Dim ond trefniadau diweddar yw'r holl drefniadau hyn, ac mae angen iddynt ymwreiddio a gwireddu'r manteision arfaethedig, er hynny, mae'r arwyddion cynnar yn fuddiol ac fe'u croesawyd gan y staff.

37 Cyfyngedig yw'r adnoddau corfforaethol ar gyfer archwiliadau clinigol, gyda 0.5 aelod staff FTE yn unig; er hynny, mae'r galw am archwiliadau clinigol yn cynyddu. Mae gwaith ailarchwilio er mwyn sicrhau bod dysg wedi ei hymwreiddio a bod canlyniadau gwell hefyd yn faes y mae angen gwneud rhagor o waith ynddo. Yn ogystal â hynny, dylai archwiliadau clinigol fod yn ffynhonnell bwysig o sicrwydd yn fframwaith sicrwydd y bwrdd ac mewn cofrestrau o risgiau corfforaethol a gweithredol, fodd bynnag, nid oedd hyn yn amlwg yn y dogfennau a adolygwyd.

Adolygu marwolaethau

38 Mae cyfarfodydd adolygu marwolaethau ac afiachedd amlddisgyblaethol yn darparu dull systematig fel y gall gymheiriaid adolygu digwyddiadau andwyol, cymhlethdodau neu farwolaethau er mwyn dysgu a myfyrio ar ofal cleifion, gan ei wella. Mae hwn yn faes cadarnhaol i Bowys, sef yr unig fwrdd iechyd yng Nghymru a dreialodd swyddogaeth yr arholwr meddygol newydd ochr yn ochr â phum sefydliad arall ledled y Deyrnas Unedig. Mae prosesau clir ar waith ar gyfer adolygu marwolaethau ac afiachedd, ac adroddwyd canlyniadau yn ogystal â dysg yn rheolaidd i'r pwyllgor Profiad ac Ansawdd a Diogelwch a'r Grŵp Dysgu o Brofiad. Dangoswyd enghreifftiau o'r hyn a ddysgwyd, er enghraifft, arweiniodd pryderon a godwyd yn ddiweddar ynghylch cwblhau dogfennau ffurfiol ar ofal diwedd oes at ffurfio grŵp bach i lunio'r set ddelfrydol o nodiadau ac ymrwymiad i ddiweddaru'r polisïau clinigol sefydliadol.

39 Ar hyn o bryd, nid yw pwyllgor Ansawdd, Profiad a Diogelwch Cleifion y Bwrdd Iechyd yn goruchwylio unrhyw adolygiadau marwolaethau a ymgymerir mewn darparwyr gwasanaethau a gomisiynwyd ar gyfer trigolion Powys. Ceir goruchwyliaeth gorfforaethol drwy'r fframwaith sicrwydd comisiynu ble mae achosion sydd wedi bod yn destun ymchwiliad i ddigwyddiad difrifol mewn gwasanaeth a gomisiynwyd yn cael eu hadrodd i'r Bwrdd Iechyd. Roedd disgwyl i system reoli Unwaith i Gymru sefydlu'r swyddogaeth graidd ar gyfer dysgu o'r system farwolaethau, fodd bynnag, mae ffactorau y tu hwnt i reolaeth y Bwrdd Iechyd wedi gohirio'r broses o roi hyn ar waith.

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Gwerthoedd ac ymddygiad

40 **Mae fframwaith gwerthoedd ac ymddygiad sefydledig ar waith, gyda chynlluniau i ailedrych ar hyn yn fuan. Mae'r staff yn teimlo eu bod yn cael eu cefnogi i adrodd am eu pryderon, fodd bynnag, mae rhagor o waith i'w wneud o ran cefnogi staff sy'n profi bwlio ac aflonyddwch.**

41 Cyhoeddwyd Fframwaith Gwerthoedd ac Ymddygiad y Bwrdd Iechyd yn 2015 sy'n nodi ei weledigaeth ar gyfer diwylliant ansawdd a diwylliant diogelwch sy'n canolbwyntio ar gleifion, sy'n canolbwyntio ar welliant parhaus, ar fod yn agored, tryloywder, ac ar ddysgu pan fo pethau'n mynd o chwith. Mae'r Bwrdd Iechyd yn bwriadu diweddaru'r fframwaith ochr yn ochr â'i fframwaith datblygu strategol ar lefel sefydliadol er mwyn gwella effeithiolrwydd sefydliadol. Mae cynefino staff yn cynnwys disgwyliadau mewn cysylltiad â'r fframwaith Gwerthoedd ac Ymddygiad yn ogystal â'r cymorth y gall staff ei ddisgwyl er mwyn darparu gofal o ansawdd uchel.

42 Datgelodd ein gwaith ddarlun amrywiol mewn cysylltiad â'r diwylliant sy'n ymwneud ag adrodd camgymeriadau, damweiniau a fu bron a digwydd neu ddigwyddiadau a chodi pryderon. O'r staff a gwblhaodd ein harolwg[3], roedd (81%) ohonynt yn cytuno neu'n cytuno'n gryf bod y sefydliad yn annog y staff i adrodd camgymeriadau, damweiniau a fu bron a digwydd neu ddigwyddiadau. Roedd rhai aelodau o staff (54%) yn cytuno neu'n cytuno'n gryf bod staff sy'n gysylltiedig â chamgymeriad, damwain a fu bron a digwydd neu ddigwyddiad yn cael eu trin yn deg gan y sefydliad. Roedd mwyafrif y staff (65%) yn cytuno neu'n cytuno'n gryf bod y sefydliad yn gweithredu er mwyn sicrhau nad yw camgymeriadau, damweiniau a fu bron a digwydd na digwyddiadau yn digwydd eto.

43 Mae'n gadarnhaol bod y staff a ymatebodd i arolwg staff diweddar GIG Cymru[4] wedi nodi lefelau isel o fwlio, aflonyddwch neu gam-drin gan gydweithwyr eraill, aelodau o'r cyhoedd neu reolwyr llinell yn ystod y flwyddyn ddiwethaf (14.6%, 10%, ac 8.6%, yn y drefn honno). Fodd bynnag, mae angen gweithredu o hyd er mwyn mynd i'r afael â phryderon staff sy'n profi bwlio, aflonyddwch neu gam-drin, o ystyried mai llai na hanner y staff (45.7%) oedd yn cytuno neu'n cytuno'n gryf bod y sefydliad yn cymryd camau effeithiol pan fo hynny'n digwydd.

44 Anogir staff i ddefnyddio DATIX i adrodd digwyddiadau, a mynegwyd diwylliant cadarnhaol o ran adrodd digwyddiadau yn ystod ein cyfweliadau, fodd bynnag, yn gorfforaethol, dim ond rhai aelodau staff sy'n cael cymorth a hyfforddiant ar sut i

[3] Gwnaethom wahodd staff gweithredol sy'n gweithio ar draws y grŵp gwasanaethau cymunedol i gymryd rhan yn ein harolwg o agweddau ar-lein ynghylch trefniadau ansawdd a diogelwch cleifion. Rhoddodd y Bwrdd Iechyd gyhoeddusrwydd i'r arolwg ar ein rhan. Er nad yw'r canfyddiadau'n debygol o gynrychioli safbwyntiau yr holl staff ar draws gwasanaethau cymunedol, rydym wedi eu defnyddio i ddangos materion penodol.

[4] Cynhaliwyd arolwg staff GIG Cymru am dair wythnos ym mis Tachwedd 2020, yr un pryd ag ail don y trosglwyddiadau COVID-19 a nifer cynyddol o dderbyniadau i'r ysbyty. Naw ar hugain y cant o'r staff a ymatebodd i'r arolwg.

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ddefnyddio system DATIX i adrodd pryderon a damweiniau a fu bron a digwydd. Noda'r Grŵp Gwasanaethau Cymunedol yn ei arolwg fod ei holl staff yn cael cymorth neu hyfforddiant ar sut i ddefnyddio system DATIX i adrodd digwyddiadau neu ddamweiniau a fu bron a digwydd.

45 Mae hyfforddiant statudol a gorfodol yn bwysig er mwyn sicrhau diogelwch a lles staff a chleifion; er hynny, mae ein Hasesiad Strwythuredig blynyddol wedi canfod bod cydymffurfio yn llai na'r hyn sy'n ofynnol yn aml. Yn y Grŵp Gwasanaethau Cymunedol, dim ond (42%) o'r staff a ymatebodd i'n harolwg a gytunodd neu a gytunodd yn gryf fod ganddynt ddigon o amser yn y gwaith i gwblhau unrhyw hyfforddiant statudol a gorfodol. Er mwyn gwella cydymffurfiaeth, dywedodd y grŵp gwasanaethau cymunedol wrthym fod rheolwyr lleol yn gweithio gyda thimau i wella'r sefyllfa yn sgil COVID-19.

46 Mae gwella cydymffurfiaeth ag adolygiadau datblygu ac arfarnu personol yn faes arall i'r Bwrdd Iechyd bwysleisio arno. Cyflawnodd y Bwrdd Iechyd gyfradd gydymffurfio o 69% ym mis Mai 2021, sy'n is na'r targed o 85% er mai'r pedwerydd bwrdd iechyd gorau yng Nghymru ydoedd. Mae hyn yn is na'r gyfradd ar gyfer blynyddoedd blaenorol, ond mae'r ymateb i'r pandemig a staff sy'n cael eu hadleoli wedi effeithio ar y gwaith cwblhau. Cynhelir cyfarfodydd rheolaidd â chyfarwyddiaethau er mwyn gwella cydymffurfiaeth, ac mae'r dasg o gyflawni hyn ar yr agenda ar gyfer rheolwyr cyfarwyddiaethau. Mae'r Pwyllgor Perfformiad ac Adnoddau a'r Bwrdd yn ymgymryd â gwaith craffu sefydliadol ar y metrig hwn.

Gwrando a dysgu o sylwadau

47 **Mae gan y Bwrdd Iechyd amrywiaeth o ddulliau ffurfiol o gasglu profiadau cleifion, fodd bynnag, mae COVID-19 wedi effeithio ar y rhain. Mae gwaith ar y gweill i ddatblygu Fframwaith a Strategaeth Ymgysylltu â Phrofiadau Cleifion newydd ac i roi system amser real newydd ar waith i gasglu sylwadau gan gleifion. Mae gwaith i'w wneud o hyd i ddangos tystiolaeth o'r hyn a ddysgwyd o'r sylwadau.**

Profiadau Cleifion

48 Mae strategaeth profiadau cleifion presennol y Bwrdd Iechyd wedi dyddio. Yn rhan o'r Fframwaith Ansawdd Clinigol, mae cynlluniau i fynd i'r afael â hyn drwy ddatblygu Fframwaith a Strategaeth Ymgysylltu â Phrofiadau Cleifion newydd. Nod y Bwrdd Iechyd yw datblygu trefniadau i ddysgu o brofiadau cleifion er mwyn sicrhau bod profiadau cleifion yn cael eu defnyddio i lywio datblygiad staff a gwasanaethau clinigol. Fodd bynnag, mae Cyfarwyddwr Cynorthwyol Ansawdd a Diogelwch wedi ei ddargyfeirio i waith gweithredol ar bryderon, ac mae staff eraill wedi eu dargyfeirio i ardaloedd eraill oherwydd COVID-19, sydd wedi arwain at y fframwaith a'r strategaeth ymgysylltu â phrofiadau cleifion yn mynd ar ei hôl hi o ran yr amserlen, er bod gwaith wedi ailddechrau yn ddiweddar a disgwylir y bydd wedi ei gwblhau ddiwedd 2021.

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49 Mae'r Pwyllgor Ansawdd, Profiad a Diogelwch Cleifion yn cael adroddiadau thematig rheolaidd ar bryderon a digwyddiadau sy'n cwmpasu'r holl wasanaethau. Mae'r adroddiadau hyn yn nodi'r gwersi a ddysgwyd ac yn tynnu sylw at y camau a gymerwyd mewn ymateb i hynny. Er mwyn galluogi trafodaeth fanylach ar faterion sy'n ymwneud â data adnabyddadwy cleifion, darperir rhagor o fanylion i sesiwn y Pwyllgor Ansawdd, Profiad a Diogelwch Cleifion yn y pwyllgor. Ar hyn o bryd, dim ond ar lefel gorfforaethol yr ystyrir yr adroddiadau hyn, fodd bynnag, mae cynlluniau i'r grwpiau gwasanaeth eu hunain ystyried adrifiad nesaf yr adroddiadau hyn er mwyn eu hannog i ysgwyddo cyfrifoldeb am y camau gweithredu yn ogystal â'r pryderon.

50 Trwy ein gwaith, rydym wedi canfod diffyg eglurder wrth gasglu pryderon a chwynion gan wasanaethau a gomisiynwyd. Darperir llawer o wasanaethau i drigolion Powys gan wasanaethau a gomisiynwyd, a dim ond cwynion a adroddir yn uniongyrchol i'r Bwrdd Iechyd y mae'r adroddiadau presennol yn eu nodi. Mae angen rhagor o eglurder gan wasanaethau a gomisiynwyd ynghylch pwy sy'n gyfrifol am bryderon a chwynion, gan sicrhau bod y Bwrdd Iechyd yn cael ei hysbysu ym mhob achos o bryder a godir gan drigolion Powys, a'r camau a gymerir mewn ymateb i hynny.

51 Mae gan y Bwrdd Iechyd Grŵp Llywio Profiadau Cleifion sefydledig sy'n casglu ac yn monitro gweithgarwch profiadau cleifion, ar draws gwasanaethau a ddarperir ac a gomisiynir. Mae'r Grŵp, sy'n adrodd i'r tîm Gweithredol, yn cwrdd bob chwarter. Mae grwpiau gwasanaeth, megis y Grŵp Gwasanaethau Cymunedol, yn cyflwyno'r wybodaeth ddiweddaraf i'r Grŵp Llywio Profiadau Cleifion yn rheolaidd ar eu gweithgarwch profiadau cleifion, ac mae cynlluniau i'r Grŵp Gwasanaethau Cymunedol gyflwyno adroddiadau i'r Pwyllgor Ansawdd, Profiad a Diogelwch Cleifion erbyn yr hydref. Mae'r mesurau profiadau cleifion a chanlyniadau yn cynnwys digwyddiadau a chwynion a chanfyddiadau o arolygon cleifion a chardiau sylwadau. Roedd tystiolaeth o themâu yn cael eu nodi drwy'r Grŵp Llywio Profiadau Cleifion, ond ni nodiwyd yn glir y camau gweithredu mewn ymateb iddynt.

52 Trwy ein gwaith, gwnaethom adolygu tystiolaeth o'r gwaith a wnaed i werthuso profiadau cleifion, megis arolygon diweddar ar y gwasanaeth podiatreg newydd, sy'n dangos ymrwymiad y Bwrdd Iechyd i gael sylwadau gan gleifion. Yn dilyn y pryderon ynghylch gwasanaethau mamolaeth yn Ymddiriedolaeth GIG Amwythig a Telford, gwnaed gwaith a dargedwyd gyda thrigolion Powys i ddeall eu profiadau er mwyn llywio'r trafodaethau parhaus ag Ymddiriedolaeth y GIG. Mae'r Bwrdd Iechyd wrthi hefyd yn ysgrifennu cynnig i brynu meddalwedd Civica, i'w alluogi i gasglu profiadau cleifion mewn amser real.

53 Yn rhan o'n gwaith, gofynnwyd i'r Grŵp Gwasanaethau Cymunedol am y dulliau a ddefnyddiwyd ganddo i geisio cael sylwadau cleifion a staff yn fwy cyffredinol, a sut y cafodd y ddysg o'r sylwadau hyn ei lledaenu. Roedd y dulliau a ddefnyddiwyd yn cynnwys holiaduron cleifion, a llythyrau yn ogystal â chwestiynau uniongyrchol, a lledaenwyd y sylwadau drwy ei adroddiad profiadau cleifion a rennir â'r Grŵp Profiadau Cleifion ac mae cynlluniau i gyflwyno adroddiadau i'r pwyllgor Ansawdd,

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Profiad a Diogelwch Cleifion yn y dyfodol. Nododd y grŵp fod COVID-19 wedi effeithio'n negyddol ar y rhan fwyaf o weithgarwch profiadau cleifion. Roedd hyn oherwydd adnoddau staff cyfyngedig, yn ogystal â lleihad yn nifer y cleifion, yn rhan o'r trefniadau atal a rheoli heintiau. Mae ein harolwg staff yn dangos bod angen gwneud mwy i ledaenu gwybodaeth am brofiad cleifion i'r staff, o gofio bod llai na hanner (45%) y rhai a ymatebodd i'n harolwg wedi nodi eu bod yn cytuno neu'n cytuno'n gryf eu bod yn cael yr wybodaeth ddiweddaraf yn rheolaidd ynghylch sylwadau cleifion ar gyfer eu maes gwaith. Mae angen i'r Bwrdd Iechyd ystyried hefyd sut y gall gasglu unrhyw bryderon sydd gan y staff am brofiadau cleifion. Ni allem weld unrhyw dystiolaeth bod yr wybodaeth hon yn cael ei chasglu a'i hystyried fel mater o drefn.

54 Mae'r Bwrdd Iechyd wedi darparu hyfforddiant ychwanegol ar ymchwilio i gwynion a digwyddiadau, ond mae COVID-19 wedi effeithio ar y broses o gyflwyno'r hyfforddiant hwn ymhellach. Nid oedd y Grŵp Gwasanaethau Cymunedol yn gallu dweud wrthym beth oedd canrannau'r staff a oedd wedi dilyn hyfforddiant ar ymchwilio i gwynion neu hyfforddiant ar gynnal dadansoddiad o achosion sylfaenol.

Hanesion Cleifion

55 Mae gan y Bwrdd ddulliau hefyd ar gyfer deall profiadau cleifion. Mae hanesion cleifion a adroddir gan unigolion o'u safbwynt eu hunain, ac mewn lleoliad gofal iechyd, yn gyfle i ddeall eu profiadau o'r gofal a dderbyniwyd, gan helpu sefydliadau i ddysgu'r da a'r drwg, a'r hyn y gellir ei wneud i wella'r profiadau hynny. Ar adeg ein harchwiliad, nid oedd y Bwrdd wedi derbyn hanes claf ers mis Ionawr 2020, ac ym mis Hydref 2020 y cafodd y Pwyllgor Ansawdd, Profiad a Diogelwch Cleifion hanes claf ddiwethaf. Mae cynlluniau i ailddechrau y rhain o fewn y misoedd nesaf.

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Teithiau Cerdded Diogelwch

56 Mae teithiau cerdded diogelwch yn rhoi dealltwriaeth i aelodau'r bwrdd o'r realiti i staff a chleifion, yn helpu i wneud data'n fwy ystyrlon, yn cefnogi'r broses triongli, yn rhoi sicrwydd o fwy nag un ffynhonnell wybodaeth. Ar adeg ein harchwiliad, nid oedd gan y Bwrdd Iechyd raglen sefydledig o deithiau cerdded er diogelwch cleifion, ond nododd ei fwriad i ddechrau'r rhain yn ddiweddarach yn y flwyddyn gyda chyfres ddiwygiedig o ganllawiau i gefnogi Aelodau Annibynnol.

Strwythurau a phrosesau llywodraethu

57 Ystyriodd ein gwaith i ba raddau y mae strwythurau a phrosesau sefydliadol ar lefel y bwrdd ac islaw lefel y bwrdd yn cefnogi'r gwaith o ddarparu gwasanaethau diogel ac effeithiol o ansawdd uchel.

58 Canfuom fod **y fframwaith ansawdd clinigol newydd yn dechrau cryfhau trefniadau llywodraethu gweithredol er bod angen rhagor o amser fel y gall y trefniadau newydd ddatblygu ac ymwreiddio. Er y bu cynnydd bach mewn adnoddau llywodraethu o ansawdd, mae cyfyngiadau capasiti o hyd yn y tîm pryderon y mae angen mynd i'r afael â nhw.**

Dylunio sefydliadol er mwyn cefnogi llywodraethu effeithiol

59 **Mae datblygiadau diweddar wedi cryfhau llinellau atebolrwydd a'r broses o oruchwylio gwaith craffu, er mwyn gwella llifau sicrwydd, ond mae angen ymwreiddio'r rhain.**

60 Ceir cydgyfrifoldeb clir am ansawdd a diogelwch cleifion ymhlith arweinyddiaeth Weithredol y Bwrdd Iechyd. Mae penodiadau sylweddol a wnaed i'r tîm Gweithredol yn ddiweddar, gan gynnwys y Cyfarwyddwr Nyrsio a Bydwreigiaeth, y Cyfarwyddwr Therapïau a Gwyddorau Iechyd a'r Cyfarwyddwr Meddygol, wedi cryfhau hyn. Hefyd, ceir Dirprwy Gyfarwyddwr Nyrsio yn awr, sy'n arwain ar Ansawdd a Diogelwch er mwyn darparu capasiti a phwyslais ychwanegol. Er mwyn sicrhau ei fod yn dod yn sefydliad a arweinir yn glinigol mewn gwirionedd, mae'r Bwrdd Iechyd wedi datgan ei fwriad o roi blaenoriaeth i'r gwaith o ddatblygu arweinyddiaeth glinigol yn y fframwaith ansawdd clinigol.

61 Ym mis Mawrth 2021, sefydlodd y Bwrdd Iechyd Grŵp Dysgu o Brofiad i weithredu fel lle ble gall arweinwyr clinigol y sefydliad rannu gwybodaeth o amrywiaeth o ffynonellau, gan gynnwys archwiliadau clinigol ac adolygiadau marwolaethau, gyda'r nod o ledaenu dysg ar draws y sefydliad. Mae'r grŵp hwn wedi cwrdd ddwywaith, a darparwyd adroddiad ar i fyny ar ei waith i'r grŵp Ansawdd, Profiad a Diogelwch Cleifion sy'n amlinellu ei weithgareddau a'i gamau gweithredu arfaethedig. Mae arwyddion cynnar effaith y grŵp hwn yn gadarnhaol, gan ddangos triongli materion yn effeithiol o amrywiaeth o feysydd.

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Fframwaith Ansawdd Clinigol

62 Mae'r Fframwaith Ansawdd Clinigol a gymeradwywyd gan y Bwrdd yn 2020 yn nodi rhaglen waith er mwyn gwella llywodraeth o ansawdd dros gyfnod o dair blynedd. Oherwydd bod COVID-19 wedi rhoi pwysau ar y timau, mae'r cynnydd o ran gweithredu'r fframwaith wedi bod yn arafach na'r disgwyl. Mae gwaith adolygu ac ailflaenoriaethu'r camau gweithredu, ac addasu'r amserlenni sy'n weddill, ar y gweill ar hyn o bryd.

63 Yn rhan o'r Fframwaith Ansawdd Clinigol, bydd y Bwrdd Iechyd yn cytuno ar fethodoleg Gwella Ansawdd Clinigol, gan ei mabwysiadu. Ym mis Mehefin 2021, nododd yr wybodaeth ddiweddaraf am y cynnydd i'r Pwyllgor Ansawdd, Profiad a Diogelwch Cleifion nad oedd y Bwrdd Iechyd wedi diffinio na chyflwyno rhaglen o brosiectau gwella ansawdd eto ac nad oedd y gwaith o gytuno ar ddull gwella ansawdd clinigol a'i fabwysiadu, gan gynnwys y fethodoleg, wedi ei ddechrau eto. Ni chafwyd unrhyw ddiweddariad ynghylch yr amserlenni diwygiedig ar gyfer y gwaith hwn, fodd bynnag, mae'n parhau i fod yn flaenoriaeth i'r Bwrdd Iechyd yn ystod 2021-22.

64 Ar lefel strategol, mae'r Grŵp Llywodraethu Ansawdd yn goruchwylio'r gwaith o ddatblygu a gweithredu fframwaith ansawdd clinigol. Cadeiriwyd y Grŵp Llywodraethu Ansawdd a sefydlwyd yn 2019 gan y Prif Weithredwr i ddechrau, er mwyn goruchwylio dull llywodraethu y Bwrdd Iechyd. Diwygiwyd cylch gorchwyl y grŵp hwn yn ddiweddar ac er bod ei gylch gwaith yn aros yr un fath, newidiwyd yr arweinyddiaeth i'r Cyfarwyddwr Nyrsio a Bydwreigiaeth a'r Cyfarwyddwr Meddygol, gyda phresenoldeb holl Gyfarwyddwyr Cynorthwyol y grwpiau Gwasanaeth yn ogystal â galluogi llinell olwg glir o'r gwasanaeth at y Bwrdd. Hefyd, bydd y Grŵp Llywodraethu Ansawdd yn adrodd yn uniongyrchol i'r pwyllgor Ansawdd, Profiad a Diogelwch Cleifion yn awr, yn hytrach na mynd drwy'r pwyllgor Gweithredol. Mae'r pwyllgor Ansawdd, Profiad a Diogelwch Cleifion yn darparu goruchwyliaeth o'r broses o weithredu'r fframwaith ansawdd clinigol i'r Bwrdd, sy'n derbyn adroddiadau carreg filltir rheolaidd i nodi'r cynnydd, a'r meysydd sydd ar ôl y targed.

Fframwaith Sicrwydd Comisiynu

65 Sefydliad comisiynu yw'r Bwrdd Iechyd yn bennaf. Mae'r gyfran fwyaf o'i gyllideb wedi ei neilltuo ar gyfer sicrhau gwasanaethau gofal iechyd, gan gynnwys gofal heb ei drefnu a gofal wedi ei gynllunio gan fyrddau iechyd cyfagos GIG Cymru ac ymddiriedolaethau'r GIG yn Lloegr. Er mwyn sicrhau eu hun a'i boblogaeth breswyl o ddiogelwch, ansawdd a chynaliadwyedd y gwasanaethau hyn a gomisiynwyd, datblygodd y Bwrdd Iechyd fframwaith sicrwydd comisiynu yn 2018. Disgrifia'r fframwaith sicrwydd comisiynu broses sicrwydd barhaus er mwyn sicrhau bod gwasanaethau a gomisiynir yn ddiogel, yn bersonol, yn effeithiol ac yn gwella'n barhaus. Adolygir profiadau cleifion hefyd yn ogystal â nifer y cwynion a digwyddiadau, er mwyn canfod ansawdd sy'n dirywio. Mae holl gyfarwyddiaethau'r Bwrdd Iechyd yn bwydo i mewn i'r broses hon, ac mae adroddiadau rheolaidd a

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chyfarfodydd sicrwydd comisiynu a gynhelir gyda darparwyr i drafod perfformiad, ansawdd a diogelwch a phrofiadau cleifion. Mae'r fframwaith sicrwydd comisiynu yn defnyddio system sgorio ar draws pedwar maes ar gyfer darparwyr: y gallu i ddefnyddio gwasanaethau, cyllid a gweithgarwch, ansawdd a diogelwch a phrofiadau cleifion. Caiff pob darparwr ei raddio gan y Bwrdd Iechyd o'i gymharu â'r pedwar maes, gan ddefnyddio proses coch/oren/gwyrdd. Cofnodir mesurau arbennig a lefelau ymyrraeth y Llywodraeth. Yna, caiff yr holl wybodaeth hon ei chasglu mewn dangosfwrdd lefel uchel er mwyn dangos ar gipolwg sgôr y darparwr. Mae'r Pwyllgor Perfformiad ac Adnoddau a'r Grŵp Llywodraethu Ansawdd yn monitro ac yn craffu ar y gwasanaethau a ddarperir gan sefydliadau sydd wedi eu huwchgyfeirio yn rhan o'r trefniadau perthnasol yn GIG Cymru a Lloegr, a/ neu'r rhai sy'n sgorio lefel 4 ar y fframwaith sicrwydd comisiynu.

66 Er mwyn sicrhau y canolbwyntir ar ansawdd, mae gan y Bwrdd Iechyd arweinydd Comisiynu Ansawdd a Diogelwch, sy'n adrodd i Gyfarwyddwr Cynorthwyol Ansawdd a Diogelwch er mwyn cefnogi'r broses fframwaith sicrwydd comisiynu wrth asesu materion ansawdd a diogelwch mewn gwasanaethau a gomisiynir. Mae'r arweinydd comisiynu Ansawdd a Diogelwch yn mynd i bob cyfarfod adolygu yr hyn a gomisiynir gyda darparwyr. Ar hyn o bryd, nid yw'r fframwaith sicrwydd comisiynu yn cynnwys unrhyw fesurau ar safonau'r gofal a ddarperir na chanlyniadau'r cleifion.

67 Er hynny, oherwydd y pandemig, nid yw'r trefniadau comisiynu arferol wedi bod ar waith ers mis Mawrth 2020. Ers mis Gorffennaf 2021, mae gwaith wedi cynyddu er mwyn adfer y fframwaith sicrwydd comisiynu, ond mae cyfyngiadau sylweddol o hyd ac ni all trefniadau uwchgyfeirio weithredu yn y ffordd arferol; mae hyn wedi effeithio ar y broses o adrodd ar ansawdd yn ogystal â gwybodaeth am brofiadau cleifion.

Y Grŵp Gwasanaethau Cymunedol

68 Mae strwythur y Grŵp Gwasanaethau Cymunedol yn cefnogi gweithio amlddisgyblaethol trwy Bennaeth Nyrsio a Phennaeth Therapïau. Mae'r Grŵp hefyd wedi penodi clinigydd arweiniol dros ansawdd a diogelwch yn ddiweddar ac mae'r Cyfarwyddwr Meddygol Cynorthwyol yn ei gefnogi i ddarparu arweinyddiaeth feddygol. Hefyd, nid oes swyddogaethau uwch-nyrsio ar gyfer y wardiau cleifion mewnol, sy'n gadael bwlch posibl o ran goruchwyliaeth nyrsio mewn wardiau arbenigol a chynnal arferion nyrsio a diwylliant o safon.

69 Mae'r grwpiau gwasanaeth ar draws y Bwrdd Iechyd wedi dechrau nodi'n ffurfiol eu trefniadau llywodraethu ansawdd a'u strwythurau diogelwch cleifion. Mae'r gwaith hwn wedi bod yn mynd rhagddo ers 2020, ond, o ganlyniad i ddargyfeirio capasiti er mwyn ymateb i'r pandemig, mae wedi ei weithredu ar wahanol raddau ar draws sefydliad. Ar adeg ein harchwiliad, roedd tri o'r pum grŵp gwasanaeth wedi cynhyrchu eu strwythur llywodraethu ansawdd a diogelwch cleifion i nodi'r prosesau ar gyfer goruchwylio ansawdd a diogelwch cleifion. Mae'r broses wedi cyflymu yn ddiweddar ac mae awydd i roi'r trefniadau newydd ar waith. Mae rhagor

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o waith wedi ei gynllunio mewn cysylltiad â dirprwyo agweddau ar adrodd corfforaethol, gan gynnwys pryderon a digwyddiadau mewn grwpiau gwasanaeth er mwyn gwella goruchwyliaeth, annog grwpiau gwasanaeth i dderbyn cyfrifoldeb, a chraffu ar berfformiad ar lefel grwpiau gwasanaeth drwy wella'r broses o adrodd ar i fyny yn ystod y tri mis nesaf.

70 Gwnaethom adolygu'r trefniadau llywodraethu yn y Grŵp Gwasanaethau Cymunedol a gwelsom un o'u profiadau cleifion a'u grwpiau ansawdd. Cynhelir y cyfarfodydd hyn bob deufis ac mae ganddynt agenda safonedig. Ar hyn o bryd, nid oes dangosfwrdd ansawdd na diogelwch cleifion ar waith. Ar adeg ein gwaith, nid oedd cofnodion y cyfarfodydd ansawdd a diogelwch cleifion yn cael eu rhannu'n ffurfiol â'r Grŵp Llywodraethu Ansawdd gweithredol. Nid oedd cofnodion yn cael eu rhannu â chyfarfodydd y gyfarwyddiaeth yn ffurfiol, er bod adrodd ar i fyny yn digwydd yn eithriad i hyn.

Adnoddau ac arbenigedd er mwyn cefnogi llywodraethu o ansawdd

71 **Cyfyngedig yw adnoddau'r Bwrdd Iechyd ar gyfer cefnogi'r gwaith o lywodraethu ansawdd, ac mae cyfyngiadau capasiti hanesyddol yn y tîm pryderon yn effeithio ar amseroldeb yr ymatebion i gwynion, er bod penodiadau gweithredol diweddar yn gadarnhaol.**

72 Adolygodd y Bwrdd Iechyd yr adnodd sydd ar gael i gefnogi gwelliant i drefniadau llywodraethu ansawdd ar lefel gorfforaethol a gweithredol. Canfu fod angen cryfhau llywodraeth grwpiau gwasanaeth er mwyn sicrhau bod digon o gapasiti a gallu ar lefel leol. Yn dilyn hyn, buddsoddodd y Bwrdd Iechyd mewn capasiti gweithredol ychwanegol ar draws rhai grwpiau gwasanaeth er mwyn cefnogi gweithgareddau gwella ansawdd megis archwilio clinigol, a chwynion ac ymdrin â digwyddiadau. Er enghraifft, sicrhaodd y Grŵp Gwasanaethau Cymunedol gydraddoldeb â grwpiau gwasanaeth eraill yn ddiweddar (Mehefin 2021) drwy benodi arweinydd ansawdd.

73 Mae adnoddau'r Bwrdd Iechyd ar gyfer profiadau cleifion a phryderon yn gyfyngedig. Nid oes tîm profiadau cleifion penodol, a'r tîm pryderon sy'n arwain yn y maes hwn. Amlygwyd hyn gan Ombwdsmon Gwasanaethau Cyhoeddus Cymru[5] yn ei adroddiad arbennig ym mis Hydref 2020 a roes y dasg i'r Bwrdd Iechyd o adolygu'r tîm ymdrin â chwynion a'i allu i ymdrin â chwynion mewn ffordd effeithiol ac amserol o dan y drefn Gweithio i Wella. Mae gallu'r tîm pryderon wedi bod yn gyfyngedig ers peth amser ac mae'r amseroedd a gymerir i ymateb i gwynion o fewn 30 niwrnod wedi bod yn isel yn hanesyddol. Fodd bynnag, roedd y data perfformiad diweddaraf ar gyfer mis Mai 2021 yn fwy cadarnhaol, gan ddangos ymateb i dros 90% o gwynion o fewn 30 niwrnod. Mae ôl-groniad o bryderon yr oedd angen mynd i'r afael â nhw, nifer cynyddol o bryderon yn ymwneud â niwed posibl oherwydd COVID-19, a chynnydd mewn pryderon yn ymwneud â

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[5] Ombwdsmon Gwasanaethau Cyhoeddus Cymru, Adroddiad Arbennig a gyhoeddwyd o dan adran 28 o Ddeddf Ombwdsmon Gwasanaethau Cyhoeddus (Cymru) 2019 yn dilyn cwyn a wnaed gan Mrs A yn erbyn Bwrdd Iechyd Addysgu Powys, Hydref 2020

gwasanaethau a gomisiynwyd ac Ymarfer Cyffredinol. Mae'r diffyg capasiti wedi ei gydnabod, a chyda staff dros dro mewn swyddi, mae cynlluniau i wneud penodiadau sylweddol o fewn y chwe mis nesaf.

74 Ar adeg ein gwaith archwilio, roedd y Bwrdd Iechyd yn cynnal adolygiad mewnol o elfennau ehangach Gweithio i Wella mewn ymateb i adroddiad Ombwdsmon y Gwasanaethau Cyhoeddus. Mae'r Bwrdd Iechyd wedi nodi nifer o gamau gweithredu ac wedi datblygu cynllun gweithredu, a ystyriwyd gan y pwyllgor Ansawdd, Profiad a Diogelwch Cleifion ym mis Gorffennaf 2021. Mae'r cynllun yn nodi nifer o gamau gweithredu yn ystod 2021, gan gynnwys hyfforddiant a datblygu strwythur tîm newydd, sy'n cael ei ystyried ar hyn o bryd. Mae'r Bwrdd Iechyd yn monitro ei waith ar Gweithio i Wella drwy gyfarfodydd atebolrwydd a sicrwydd wythnosol y mae'r Prif Weithredwr, y Cyfarwyddwr Nyrsio, y Dirprwy Gyfarwyddwr Nyrsio a'r Cyfarwyddwr Cynorthwyol Ansawdd a Diogelwch yn trafod rheoli achosion a materion cymhleth ynddynt. Ceir cyfarfodydd wythnosol gyda thimau gweithredol hefyd er mwyn monitro'r gwaith o fynd i'r afael â phryderon.

75 Mae'r Cyfarwyddwr Cynorthwyol Ansawdd a Diogelwch wedi gorfod camu i swyddogaeth fwy gweithredol oherwydd y cyfyngiadau capasiti yn y tîm pryderon. Mae hyn yn effeithio ar ei allu i weithio ar feysydd eraill ei gylch gwaith, gan gynnwys profiadau cleifion, DATIX a'r arweinydd comisiynu ar gyfer ansawdd a diogelwch hefyd. Mae galw cynyddol ar y tîm pryderon ar hyn o bryd.

Trefniadau ar gyfer monitro ac adrodd

76 Ystyriodd ein gwaith a yw'r trefniadau ar gyfer monitro ac adrodd ar berfformiad ar lefel weithredol a strategol yn rhoi pwyslais digonol ar ansawdd a diogelwch cleifion.

77 Canfuom **fod lle i ehangu'r adrodd presennol er mwyn sicrhau pwyslais cliriach ar faterion ansawdd sy'n cwmpasu ehangder y gwasanaethau a ddarperir ac sy'n adlewyrchu natur unigryw y Bwrdd Iechyd.**

Gwybodaeth ar gyfer craffu a sicrwydd

78 **Mae'r Bwrdd Iechyd wedi ymrwymo i sicrhau bod gwybodaeth ar gael i ddarparu gwybodaeth ar gyfer gwaith craffu a sicrwydd a sylwebaeth ar y niwed sy'n deillio o COVID-19, fodd bynnag, byddai cyflwyno dangosfyrddau ansawdd ar lefelau corfforaethol a gweithredol yn cryfhau goruchwyliaeth.**

79 Ceir dealltwriaeth ac ymrwymiad clir gan y Bwrdd Iechyd bod adnabod a gweithio i asesu'r niwed sy'n deillio o COVID-19 yn hanfodol. Mae papurau'r Pwyllgor Ansawdd, Profiad a Diogelwch Cleifion, a'r Grŵp Llywodraethu Ansawdd ynghyd â'n cyfweliadau yn cydnabod yr angen i'r Bwrdd Iechyd weithio i nodi y rhain. Fodd bynnag, mae deall ac asesu niwed yn her sylweddol i'r Bwrdd Iechyd fel y mae i eraill. Mae'r Bwrdd Iechyd wedi nodi nifer o fethodolegau asesu arfaethedig er

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mwyn deall niwed ar draws y pedwar niwed[6] ac mae gwaith yn mynd rhagddo yn y meysydd hyn. Fodd bynnag, ar ddangosyddion gofal eilaidd y mae'r methodolegau asesu hyn yn canolbwyntio, ac nid oes unrhyw fesurau arfaethedig sy'n ymwneud â gofal sylfaenol na gofal cymunedol, megis brechiadau i blant neu effeithiau ehangach ar iechyd y boblogaeth. Yn ei gamau cynnar y mae'r gwaith hwn ac mae gwaith ychwanegol i'w wneud o hyd fel gyda Byrddau Iechyd eraill yng Nghymru.

80 Mae'r Bwrdd Iechyd wedi gwneud gwaith i ddeall yn well y materion sy'n ymwneud â throsglwyddo COVID-19 mewn ysbytai. Lluniwyd adroddiadau a nodwyd yr hyn a ddysgwyd mewn cysylltiad â'r gwelliannau sydd eu hangen yn ansawdd data rhai systemau adrodd.

81 Mae systemau data yn y sefydliad yn cynhyrchu gwybodaeth ac mae timau lleol yn gallu cael gafael ar yr wybodaeth hon a chymorth i ddehongli gwybodaeth, ac maent yn gallu datblygu adroddiadau pwrpasol. Fodd bynnag, mae cyfyngiadau ac nid oes gan y systemau presennol y gallu i gynhyrchu siartiau ystadegol na chymariaethau o'r naill flwyddyn i'r llall. Nid oes tîm dadansoddi data pwrpasol ar gyfer dadansoddi a dehongli data ar ansawdd a diogelwch, nid yn gorfforaethol nac yn weithredol.

82 Ar lefel weithredol, mae'r cyfarfodydd Ansawdd a Phrofiadau Cleifion yn y Grŵp Gwasanaethau Cymunedol yn goruchwylio ansawdd a pherfformiad yn y grŵp gwasanaeth, sydd wedyn yn llywio cyfarfodydd arferol y gyfarwyddiaeth Gofal Sylfaenol, Iechyd Meddwl a Chymunedol. Rhoes rhai o'r cyfarfodydd hyn y gorau i ddigwydd yn ystod COVID-19 ac roedd yr adroddiadau'n canolbwyntio yn fwy ar risgiau sy'n gysylltiedig â COVID-19 yn amlach, gan ganolbwyntio ar ddangosyddion ansawdd rheolaidd yn llai aml. Mae'r cyfarfodydd arferol wedi eu hailsefydlu bellach. Gwelsom un o'r grwpiau Ansawdd Gwasanaethau Cymunedol a Phrofiadau Cleifion, ac roedd yn cyd-fynd â'r agenda ddisgwyliedig fel y disgrifiwyd yn ei fframwaith llywodraethu ansawdd. Darparwyd gwybodaeth am brofiadau cleifion a oedd yn cynnwys Digwyddiadau Difrifol yn ogystal â chwynion a chanmoliaeth. Hefyd, roedd adroddiadau o bob maes yn nodi materion a phryderon i'w huwchgyfeirio. Fodd bynnag, nid oedd gan y grŵp ddangosfwrdd perfformiad o fetrigau ansawdd ar waith. Er bod y strwythur llywodraethu yn nodi disgwyliadau o ran adrodd ar ansawdd yn unol â Fframwaith cyflawni'r GIG a nodi mesurau, nid yw'r rhain yn cael eu hadrodd ar hyn o bryd.

83 Oherwydd nad oes dangosfyrddau diogelwch cleifion ar waith ar hyn o bryd, mae'n anodd gweld crynodeb cyffredinol ar draws grwpiau gwasanaeth a nodi unrhyw dueddiadau a materion. Er mwyn gallu triongli ffynonellau gwybodaeth, ni chyflwynir materion sy'n ymwneud â'r gweithlu, megis salwch. Hefyd, oherwydd natur y Bwrdd Iechyd, mae'n heriol cymharu ei berfformiad ar fesurau ansawdd ag eraill. O'r herwydd, gall fod yn anodd sicrhau cyd-destun digonol i nodi a yw'r ffigurau a adroddir yn peri pryder.

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[6] Dylai sefydliadau fod yn monitro niwed posibl ar draws y pedwar cwadrant a nodir yn y fframwaith cynllunio gweithredol chwarterol.

Cwmpasu materion ansawdd a diogelwch cleifion

84 **Mae lle i ehangu cwmpas materion ansawdd a diogelwch cleifion ar lefel gorfforaethol a gweithredol, ac i sicrhau bod digon o gwmpas ar ofal sylfaenol yn ogystal â gwasanaethau eilaidd.**

85 Mae'r broses o adrodd ar berfformiad yn y Bwrdd Iechyd yn cyd-fynd â'r fframwaith cyflawni cenedlaethol presennol, gyda'r 84 mesur ar waith sydd wedi eu mapio i bedwar nod Cymru Iachach. Mae'r adroddiadau hyn a gyflwynir i'r Bwrdd yn nodi gwybodaeth am dueddiadau yn glir, a darperir sylwebaeth i esbonio perfformiad a chamau gweithredu a gymerir i fynd i'r afael â meysydd pan nad yw'r perfformiad yn cyd-fynd â'r disgwyliadau. Er ei fod yn unol â fframwaith cyflawni'r GIG, nid oes gan yr adroddiad perfformiad presennol unrhyw fesurau perfformiad ehangach penodol mewn meysydd megis Nyrsio Ardal, ac nid oes unrhyw fesurau y cytunwyd arnynt yn lleol ar waith. Nid oes unrhyw adroddiadau perfformiad eraill sy'n ymwneud ag ansawdd a diogelwch cleifion a adroddir i'r Bwrdd.

86 Mae agendâu y pwyllgor Ansawdd, Profiad a Diogelwch Cleifion yn gytbwys ac fe'u llywir gan adroddiadau rheolaidd ar bryderon a chwynion. Mae adroddiad Gweithio i Wella yn cael ei lunio ar gyfer pob cyfarfod a dehonglir data a darperir gwybodaeth am berfformiad yn ogystal â sylwebaeth ar y camau a gymerwyd yn dilyn pryderon a digwyddiadau. Mae'r pwyllgor Ansawdd, Profiad a Diogelwch Cleifion hefyd yn cael yr wybodaeth ddiweddaraf am wasanaethau a gomisiynwyd sy'n cael eu huwchgyfeirio drwy'r broses fframwaith ansawdd clinigol. Caiff perfformiad ar wasanaethau ei gynnwys mewn adroddiadau corfforaethol ar hyn o bryd, ond mae cynlluniau ar y gweill yn rhan o'r Fframwaith Ansawdd Clinigol i'r grwpiau gwasanaeth lunio a chyflwyno eu hadroddiadau perfformiad eu hunain i'r pwyllgor Ansawdd, Profiad a Diogelwch Cleifion a Grŵp Llywodraethu Ansawdd a fydd yn galluogi gwaith craffu gwell ar Aelodau Annibynnol a gweithredol. Derbynnir adroddiad ar gynnydd archwilio clinigol yn y pwyllgor Ansawdd, Profiad a Diogelwch Cleifion hefyd fel mater o drefn, er mwyn rhoi sicrwydd ar y cynnydd wrth gyflawni cynllun archwilio clinigol y Bwrdd Iechyd.

87 Mae'r Grŵp Gwasanaethau Cymunedol yn darparu portffolio unigryw o wasanaethau, gan gynnwys gwasanaethau nyrsio a therapi cymunedol cyffredinol, ochr yn ochr â gofal heb ei drefnu, a mân anafiadau, gan gynnwys cleifion allanol, llawdriniaeth ddewisol, endosgopi a gwasanaethau uwchsain diagnostig a radiograffeg. Nid yw'r adroddiadau ansawdd presennol a nodir yn ei strwythur llywodraethu ansawdd a diogelwch cleifion yn cwmpasu'r holl wasanaethau hyn, ac mae'r wybodaeth yn canolbwyntio'n bennaf ar leoliadau gwasanaeth mewn ysbytai mewn ymateb i fframwaith cyflawni cenedlaethol GIG Cymru. Mae gwaith archwilio blaenorol wedi nodi'r angen am fetrigau perfformiad sydd wedi eu haddasu'n well ar gyfer gwasanaethau nyrsio ardal, ond mae'n ymddangos mai cyfyngedig yw'r cynnydd wrth fynd i'r afael â'r mater hwn.

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Atodiad 1

Ymateb y rheolwyr i argymhellion archwilio

Arddangosyn 2: ymateb y rheolwyr

Argymhelliad	Ymateb y rheolwyr	Dyddiad cwblhau	Swyddog cyfrifol
Fframwaith Sicrwydd Comisiynu A1 Y fframwaith sicrwydd comisiynu yw'r dull o roi sicrwydd ar ansawdd y gwasanaethau a ddarperir i drigolion Powys. • Adolygu'r Fframwaith Sicrwydd Comisiynu i gynnwys mesurau ar y safonau gofal a ddarperir neu ar ganlyniadau cleifion.	Bydd y Bwrdd Iechyd yn cynnal adolygiad o'r broses Sicrwydd Comisiynu er mwyn sicrhau: (i) ei fod yn nodi/adlewyrchu risgiau cleifion/gwasanaethau yn sgil COVID-19; a (ii) ei fod yn hygyrch (mewn fformat hawdd ei ddefnyddio) er mwyn ymgysylltu ag ystod ehangach o staff i'w galluogi i lywio barn gorfforaethol ynghylch risgiau cleifion/gwasanaethau.	Mawrth 2022	Y Cyfarwyddwr Cynllunio a Pherfformiad a'r Cyfarwyddwr Nyrsio a Bydwreigiaeth

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Argymhelliad	Ymateb y rheolwyr	Dyddiad cwblhau	Swyddog cyfrifol
Fframwaith Ansawdd Clinigol A2 Mae'r fframwaith ansawdd clinigol presennol yn nodi'r camau sydd eu hangen i wella'r broses o lywodraethu ansawdd clinigol. Nid yw'n nodi'n glir y dulliau sydd ar waith yn y Bwrdd Iechyd i ddarparu goruchwyliaeth strategol a gweithredol. • Datblygu map llywodraethu fel y gall y sefydliad nodi'n glir yr ystod o weithgareddau sydd ar waith ar lefel strategol a gweithredol er mwyn sicrhau bod llinell olwg glir o'r gwasanaeth at y Bwrdd a nodi unrhyw orgyffyrddiadau sy'n bodoli rhwng grwpiau.	Mae newidiadau i bwyllgorau sicrwydd y Bwrdd ar gyfer 2021/22 wedi eu cymeradwyo gan y Bwrdd (Gorffennaf 2021) ac maent yn cael eu gweithredu ar hyn o bryd. Mae adolygiad o'r grwpiau rheoli sy'n galluogi Pwyllgorau ar y gweill ar hyn o bryd. Ar ôl cymeradwyo strwythur grŵp rheoli diwygiedig, bydd y Fframwaith Ansawdd Clinigol yn nodi'n glir y dull sydd ar waith yn y Bwrdd Iechyd ar gyfer darparu goruchwyliaeth strategol a gweithredol.	Mawrth 2022	Ysgrifennydd y Bwrdd a'r Cyfarwyddwr Nyrsio a Bydwreigiaeth

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Argymhelliad	Ymateb y rheolwyr	Dyddiad cwblhau	Swyddog cyfrifol
Alinio Fframweithiau A3 Ar hyn o bryd, mae gan y Bwrdd Iechyd fframwaith ansawdd clinigol sy'n canolbwyntio ar ddatblygu trefniadau llywodraethu ansawdd y Bwrdd Iechyd, a fframwaith sicrwydd comisiynu sy'n pennu'r fframwaith ar gyfer rhoi sicrwydd ar ansawdd gwasanaethau. Mae'r fframwaith sicrwydd comisiynu wedi canolbwyntio'n bennaf ar wasanaethau a gomisiynwyd, fodd bynnag, mae bwriad i roi'r dull hwn o weithredu ar waith mewn gwasanaethau a ddarperir yn uniongyrchol (ar waith ar gyfer Gwasanaethau Iechyd Meddwl a Gwasanaethau Mamolaeth). Mae synergeddau posibl rhwng y fframweithiau hyn, a dylai'r Bwrdd Iechyd ystyried adleoli'r ddau fframwaith hyn er mwyn adeiladu ar y rhyngberthnasau ymhellach. • Adolygu'r potensial o ran alinio'r Fframwaith Ansawdd Clinigol a'r Fframwaith Sicrwydd Comisiynu.	Mae'r Fframwaith Ansawdd Clinigol yn nodi prif ddull strategol y Bwrdd Iechyd o ddatblygu gwasanaethau o ansawdd uchel yn barhaus i bobl Powys. Bydd y Fframwaith Sicrwydd Comisiynu yn cyd-fynd yn well â'r Fframwaith Ansawdd Clinigol. Bydd y Fframwaith Sicrwydd Comisiynu yn cael ei gymhwyso i wasanaethau a ddarperir yn uniongyrchol gan y Bwrdd Iechyd.	31 Rhagfyr 2021 Mawrth 2022	Y Cyfarwyddwr Nyrsio a Bydwreigiaeth

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Argymhelliad	Ymateb y rheolwyr	Dyddiad cwblhau	Swyddog cyfrifol
Pryderon a Chwynion A4 Oherwydd bod canran sylweddol o weithgareddau yn cael ei darparu gan wasanaethau a gomisiynwyd, mae angen eglurder gwell wrth oruchwylio cwynion gan drigolion Powys ynghylch y gwasanaethau hyn. • Sicrhau bod yr holl gwynion gan drigolion Powys (a adroddir i'r Bwrdd Iechyd yn uniongyrchol ac yn anuniongyrchol) ynghylch gwasanaethau a gomisiynwyd yn cael eu casglu a'u hadrodd i'r Pwyllgor Ansawdd, Profiad a Diogelwch Cleifion.	Bydd y dulliau sicrwydd comisiynu presennol yn cael eu cryfhau er mwyn sicrhau bod yr holl gwynion gan drigolion Powys (a adroddir i'r Bwrdd Iechyd yn uniongyrchol ac yn anuniongyrchol) ynghylch gwasanaethau a gomisiynwyd yn cael eu casglu a'u hadrodd i'r Pwyllgor Ansawdd, Profiad a Diogelwch Cleifion.	30 Medi 2021	Y Cyfarwyddwr Nyrsio a Bydwreigiaeth

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Argymhelliad	Ymateb y rheolwyr	Dyddiad cwblhau	Swyddog cyfrifol
Mesurau Perfformiad A5 Canfu ein gwaith fod angen mynegi'r mesurau ansawdd sydd ar waith ar draws yr ystod o wasanaethau a ddarperir. Roedd angen nodi'r rhain yn glir â llinell sylfaen a gynhaliwyd er mwyn mesur llwyddiant y fframwaith ansawdd clinigol. • Datblygu dangosfwrdd ansawdd sy'n mynegi'r mesurau perfformiad ansawdd a diogelwch cleifion a dangosyddion perfformiad allweddol ar gyfer y Bwrdd Iechyd, er mwyn mesur llwyddiant a dangos gwelliannau.	Yn y Fframwaith Ansawdd Clinigol (Nod 5), mae'r Bwrdd Iechyd wedi ymrwymo i 'D[d]atblygu systemau gwybodaeth, er mwyn galluogi gofal clinigol o ansawdd uchel ' (Nod 5) Bydd y ffrwd waith hon yn canolbwyntio ar: • adolygu a datblygu trefniadau monitro perfformiad ar gyfer gwasanaethau clinigol; sicrhau cysondeb â'r gwaith a wnaed ar y Fframwaith Sicrwydd Comisiynu; • adolygu a datblygu dangosfyrddau ward/adran a lefel gwasanaeth; • datblygu trefniadau ar gyfer dehongli/dilysu yn glinigol y setiau data craidd sy'n ymwneud â gwasanaethau clinigol, gan gynnwys defnyddio a dehongli data wrth ddarparu sicrwydd; a • datblygu/integreiddio dull meincnodi sefydliadol dilys a chadarn, gan ddefnyddio cymaryddion cenedlaethol/rhyngwladol pan fônt ar gael.	Medi 2022	Cyfarwyddwr Iechyd y Cyhoedd

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Argymhelliad	Ymateb y rheolwyr	Dyddiad cwblhau	Swyddog cyfrifol
DATIX A6 Canfu ein gwaith mai dim ond rhai staff ar lefel gorfforaethol a gafodd gymorth a hyfforddiant ar sut i ddefnyddio system DATIX i adrodd pryderon a damweiniau a fu bron a digwydd. • Sicrhau bod yr holl staff corfforaethol yn cael hyfforddiant sy'n briodol i'w swyddogaeth.	Yn rhan o roi System Rheoli Pryderon newydd Unwaith i Gymru ar waith, darperir rhaglen hyfforddiant lawn ar draws y sefydliad ac mae'n cynnwys yr holl staff perthnasol y mae angen mynediad arnynt. Caiff y rhaglen hyfforddi hon ei monitro, gan adrodd amdani, er mwyn sicrhau cwmpas llawn. Bydd datblygiadau hefyd yn cysylltu â'r rhaglen genedlaethol ynghylch gweithredu, hyfforddi a rhyddhau modiwlau.	Mawrth 2022	Y Cyfarwyddwr Cyllid a TG
Hyfforddiant A7 Mae hyfforddiant statudol a gorfodol yn bwysig o ran sicrhau diogelwch a lles staff a chleifion; fodd bynnag, mae lefel y cydymffurfio yn methu â bodloni'r gofynion yn aml. • Sicrhau bod yr holl gydymffurfio statudol a gorfodol o ran hyfforddiant yn cyflawni'r targed gofynnol.	Roedd cydymffurfiaeth hyfforddiant Statudol a Gorfodol yn 81% ym mis Awst 2021, sy'n dangos cynnydd o 1% o'i gymharu â'r mis blaenorol (80%). Mae'r tîm Gweithlu a Datblygu Sefydliadol yn parhau i weithio gyda rheolwyr er mwyn gwella cydymffurfiaeth o ran Hyfforddiant Statudol a Gorfodol. Rhoddir pwyslais arbennig ar y meysydd hynny sy'n is na'r gyfradd cydymffurfio sefydliadol bresennol o 85%. Bydd cyfarwyddwyr yn cymryd rôl bersonol o ran sicrhau bod hyfforddiant statudol a gorfodol yn eu swyddogaeth yn parhau i wella er mwyn cyrraedd y safon o 85%.	31 Mawrth 2022	Cyfarwyddwr y Gweithlu a Datblygu Sefydliadol gyda Chyfarwyddwyr Gweithredol

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Argymhelliad	Ymateb y rheolwyr	Dyddiad cwblhau	Swyddog cyfrifol
Dadansoddi Data A8 Canfu ein gwaith nad oedd gan y Grŵp Gwasanaethau Cymunedol ddangosfwrdd ansawdd i ddarparu gwybodaeth am berfformiad, a gwelsom hefyd, yn y Bwrdd Iechyd, nad oedd tîm dadansoddi data pwrpasol i ddadansoddi a dehongli data ar ansawdd a diogelwch. Heb yr wybodaeth hon, mae'n anodd darparu llinell sylfaen ar berfformiad, asesu cynnydd neu nodi'r meysydd y mae angen gwella perfformiad ynddynt. • Er mwyn deall a gwerthuso perfformiad yn well, meithrin gallu yn y timau gweithredol i gynnal dadansoddiad dadansoddol yn eu timau.	Yn y Fframwaith Ansawdd Clinigol (Nod 5), mae'r Bwrdd Iechyd wedi ymrwymo i 'Ddatblygu systemau gwybodaeth, er mwyn galluogi gofal clinigol o ansawdd uchel ' (Nod 5) Bydd y ffrwd waith hon yn canolbwyntio ar: • adolygu a datblygu trefniadau monitro perfformiad ar gyfer gwasanaethau clinigol; sicrhau cysondeb â'r gwaith a wnaed ar y Fframwaith Sicrwydd Comisiynu; • adolygu a datblygu dangosfyrddau ward/adran a lefel gwasanaeth; • datblygu trefniadau ar gyfer dehongli/dilysu yn glinigol y setiau data craidd sy'n ymwneud â gwasanaethau clinigol, gan gynnwys defnyddio a dehongli data wrth ddarparu sicrwydd; a • datblygu/integreiddio dull meincnodi sefydliadol dilys a chadarn, gan ddefnyddio cymaryddion cenedlaethol/rhyngwladol pan fônt ar gael.	Medi 2022	Cyfarwyddwr Iechyd y Cyhoedd

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Atodiad 2

Canfyddiadau arolwg y staff

Arddangosyn 3 – canfyddiadau'r arolwg staff

Dadansoddiad o'r Ymatebwyr	Nifer yr Ymatebion
Gweinyddol a Chlerigol	**3**
Proffesiynol sy'n Gysylltiedig ag Iechyd	**23**
Ategol	**15**
Gweithiwr Cymorth Gofal Iechyd	**21**
Rheoli	**6**
Cynorthwy-ydd Nyrsio neu Ofal Iechyd	**13**

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Dadansoddiad o'r Ymatebwyr	Nifer yr Ymatebion
Nyrs Gofrestredig	**51**
Arall	**5**

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Datganiadau ynghylch agweddau	Nifer y staff sy'n cytuno neu'n anghytuno â datganiadau					Cyfanswm yr ymatebwyr [7]
	Cytuno'n gryf	Cytuno	Ddim yn cytuno nac yn anghytuno	Anghytuno	Anghy-tuno'n gryf	
Darparu gofal diogel ac effeithiol						
1. Gofalu am gleifion yw prif flaenoriaeth fy sefydliad.	61	52	13	11	1	138
2. Rwyf yn fodlon ar ansawdd y gofal a roddaf i gleifion.	64	55	7	6	1	135
3. Mae digon o staff yn fy maes gwaith/adran i gefnogi'r gwaith o ddarparu gofal diogel ac effeithiol.	18	32	33	32	16	134

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[7] Ni atebodd pob ymatebydd bob un cwestiwn felly gallai cyfanswm yr ymatebwyr amrywio fesul cwestiwn.

Datganiadau ynghylch agweddau	Nifer y staff sy'n cytuno neu'n anghytuno â datganiadau					Cyfanswm yr ymatebwyr [8]
	Cytuno'n gryf	Cytuno	Ddim yn cytuno nac yn anghytuno	Anghytuno	Anghy-tuno'n gryf	
Darparu gofal diogel ac effeithiol						
4. Mae fy amgylchedd gwaith yn cefnogi gofal diogel ac effeithiol.	38	57	20	14	4	133
5. Rwyf yn cael yr wybodaeth ddiweddaraf yn rheolaidd ynghylch sylwadau cleifion ar fy maes gwaith/adran.	16	45	36	28	7	132

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[8] Ni atebodd pob ymatebydd bob un cwestiwn felly gallai cyfanswm yr ymatebwyr amrywio fesul cwestiwn.

Datganiadau ynghylch agweddau	Nifer y staff sy'n cytuno neu'n anghytuno â datganiadau					Cyfanswm yr ymatebwyr[9]
	Cytuno'n gryf	Cytuno	Ddim yn cytuno nac yn anghytuno	Anghytuno	Anghytu-no'n gryf	
Rheoli pryderon cleifion a staff						
6. Mae fy sefydliad yn gweithredu ar bryderon a godir gan gleifion.	42	50	24	7	3	126
7. Mae fy sefydliad yn gweithredu ar bryderon a godir gan staff.	21	56	30	18	7	132
8. Mae fy sefydliad yn annog staff i adrodd camgymeriadau, damweiniau a fu bron â digwydd neu ddigwyddiadau.	51	58	19	5	0	133

McLellan,Holly
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[9] Ni atebodd pob ymatebydd bob un cwestiwn felly gallai cyfanswm yr ymatebwyr amrywio fesul cwestiwn.

Datganiadau ynghylch agweddau	Nifer y staff sy'n cytuno neu'n anghytuno â datganiadau					Cyfanswm yr ymatebwyr[10]
	Cytuno'n gryf	Cytuno	Ddim yn cytuno nac yn anghytuno	Anghytuno	Anghytu-no'n gryf	
Rheoli pryderon cleifion a staff						
9. Mae staff sy'n gysylltiedig â chamgymeriad, damwain a fu bron â digwydd neu ddigwyddiad yn cael eu trin yn deg gan y sefydliad.	27	47	36	6	1	117
10. Pan adroddir camgymeriadau, damweiniau a fu bron â digwydd neu ddigwyddiadau, mae fy sefydliad yn gweithredu er mwyn sicrhau na fyddant yn digwydd eto.	34	54	30	3	2	123
11. Rhoddir sylwadau i ni am newidiadau a wnaed mewn ymateb i gamgymeriadau, damweiniau a fu bron â digwydd a digwyddiadau a adroddwyd.	19	41	43	24	2	129

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[10] Ni atebodd pob ymatebydd bob un cwestiwn felly gallai cyfanswm yr ymatebwyr amrywio fesul cwestiwn.

Datganiadau ynghylch agweddau	Nifer y staff sy'n cytuno neu'n anghytuno â datganiadau					Cyfanswm yr ymatebwyr[11]
	Cytuno'n gryf	Cytuno	Ddim yn cytuno nac yn anghytuno	Anghytuno	Anghytu-no'n gryf	
Rheoli pryderon cleifion a staff						
12. Byddwn yn teimlo'n hyderus pe bawn i'n codi pryderon ynghylch ymarfer clinigol anniogel.	45	63	14	8	4	134
13. Rwyf yn hyderus bod fy sefydliad yn gweithredu ar bryderon ynghylch ymarfer clinigol anniogel.	36	49	27	12	2	126

McLellan,Holly
11/26/2021 12:38:21

[11] Ni atebodd pob ymatebydd bob un cwestiwn felly gallai cyfanswm yr ymatebwyr amrywio fesul cwestiwn.

Datganiadau ynghylch agweddau	Nifer y staff sy'n cytuno neu'n anghytuno â datganiadau					Cyfanswm yr ymatebwyr[12]
	Cytuno'n gryf	Cytuno	Ddim yn cytuno nac yn anghytuno	Anghytuno	Anghytuno'n gryf	
Gweithio yn fy sefydliad						
14. Mae'r cyfathrebu rhwng uwch-reolwyr a staff yn effeithiol.	19	46	43	18	10	136
15. Mae fy sefydliad yn annog gwaith tîm.	32	69	20	9	5	135
16. Mae gennyf ddigon o amser yn y gwaith i gwblhau unrhyw hyfforddiant statudol a mandadol.	16	41	31	37	11	136

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[12] Ni atebodd pob ymatebydd bob un cwestiwn felly gallai cyfanswm yr ymatebwyr amrywio fesul cwestiwn.

Datganiadau ynghylch agweddau	Nifer y staff sy'n cytuno neu'n anghytuno â datganiadau					Cyfanswm yr ymatebwyr[13]
	Cytuno'n gryf	Cytuno	Ddim yn cytuno nac yn anghytuno	Anghytuno	Anghytuno'n gryf	
Gweithio yn fy sefydliad						
17. Mae'r trefniadau cynefino ar gyfer staff newydd a dros dro (ee staff asiantaeth/locwm/bank/staff a adleolir) yn fy maes gwaith/adran yn cefnogi gofal diogel ac effeithiol.	19	58	37	12	15	131

McLellan,Holly
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[13] Ni atebodd pob ymatebydd bob un cwestiwn felly gallai cyfanswm yr ymatebwyr amrywio fesul cwestiwn.

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Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.
We welcome correspondence and telephone calls in Welsh and English.

Michelle Phillips
11/26/2021 12:38:21

Llywodraeth Cymru
Welsh Government

Fframwaith Ansawdd a Diogelwch:

Dysgu a Gwella

Llywodraeth Cymru 2021

McLellan,Holly
11/26/2021 12:38:21

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RHAGAIR

Yn 2016, dywedodd y Sefydliad ar gyfer Cydweithrediad a Datblygiad Economaidd (OECD) fod ansawdd wrth galon y Gwasanaeth Iechyd Gwladol (GIG) yng Nghymru. Cafodd y pwynt hwn ei bwysleisio unwaith yn rhagor pan gyhoeddwyd Cymru Iachach, gydag ansawdd a diogelwch yn cael eu hamlygu fel blaenoriaeth cyn popeth arall. Fel dinesydd yng Nghymru, rwy'n cydnabod pa mor allweddol bwysig yw gallu manteisio ar wasanaeth diogel ac effeithiol, sy'n rhoi profiad rhagorol i'r defnyddiwr.

Er gwaetha'r cynnydd a wnaed o ran sefydlu'r GIG fel system sy'n cael ei harwain gan ansawdd, mae mwy i'w wneud eto. Cafodd Deddf Iechyd a Gofal Cymdeithasol (Ansawdd ac Ymgysylltu) (Cymru) 2020 ei phasio gan aelodau'r Senedd y llynedd er mwyn cyflwyno Dyletswydd Ansawdd a Dyletswydd Gonestrwydd wedi'u cryfhau ar gyfer y GIG yng Nghymru, ac i greu Corff Llais y Dinesydd i gryfhau llais y bobl. Y ddeddfwriaeth hon, ynghyd â'r angen i ddysgu o fethiannau system diweddar yn y GIG, ac adfer yn sgil pandemig COVID-19 yw'r prif ysgogiadau ar gyfer datblygu'r Fframwaith Ansawdd a Diogelwch hwn.

Mae'r Fframwaith yn dweud y dylai sefydliadau ar bob lefel weithredu fel system rheoli ansawdd i sicrhau bod chwe maes ansawdd yn cael eu bodloni wrth ddarparu gofal: gofal sy'n ddiogel, sy'n effeithiol, sy'n canolbwyntio ar y claf, sy'n amserol, sy'n effeithlon ac sy'n deg.

Mae'n nodi'r angen am fframwaith sicrhau ansawdd cadarn sy'n dod â'r holl wybodaeth ynghylch ansawdd ynghyd er mwyn ei defnyddio i gyflawni newid a gwelliannau effeithiol mewn gofal.

Pandemig COVID-19 yw'r her fwyaf i'r GIG ei hwynebu ers iddo gael ei greu gan Aneurin Bevan, ac mae ein gweithlu wedi ymateb yn y ffyrdd mwyaf anhygoel. Fodd bynnag, er gwaetha'r ymdrechion hyn, mae'r clefyd newydd hwn wedi achosi niwed y gellid bod wedi'i osgoi, a bydd yn parhau i wneud hynny oni bai bod ansawdd a diogelwch yn cael lle canolog wrth inni fwrw ati gyda'r adferiad. Mae arloesi a thrawsnewid fel rhan o'r adferiad hwn yn un o'm prif flaenoriaethau, ac mae'r chwe maes ansawdd yn darparu fframwaith inni ar gyfer cyflawni hyn.

Bydd Rhaglen Ansawdd a Diogelwch a oruchwylir gan Fwrdd Ansawdd a Diogelwch Cenedlaethol newydd yn cael ei datblygu i ysgogi'r camau gweithredu lefel uchel a ddisgrifir yn y Fframwaith hwn. Bydd y Bwrdd yn hwyluso arweinyddiaeth glinigol gadarn gyda dull amlddisgyblaethol i helpu i ysgogi sefydliadau'r GIG yng Nghymru ar eu taith tuag at fod yn gyrff sydd wirioneddol yn cael eu harwain gan ansawdd.

Nawr, efallai'n fwy nag erioed o'r blaen yn hanes y GIG, rhaid inni sicrhau ein bod yn canolbwyntio'n ddi-ildio ar ansawdd a diogelwch, ac mai hyn fydd yn cael blaenoriaeth cyn popeth arall. Dylai hyn fod wrth wraidd unrhyw benderfyniadau ynghylch materion gofal y boblogaeth a'r broses o gynllunio gwasanaethau. Rwy'n falch o gymeradwyo'r fframwaith hwn a byddaf yn buddsoddi mewn Rhaglen Ansawdd a Diogelwch gyda'r nod o sicrhau bod ein GIG yn cael ei ysgogi gan ansawdd.

McLeodDolly
11/26/2021 2:23:21

Eluned Morgan, y Gweinidog Iechyd a Gwasanaethau Cymdeithasol

McLellan,Holly
11/26/2021 12:38:21

Diben y ddogfen

Un o nodau cyffredinol y GIG yw gwella canlyniadau i bobl, ni waeth pwy ydynt na ble maent yn byw, trwy sicrhau bod pobl yn gallu cael iechyd a gofal o'r radd flaenaf, a hynny trwy gyfrwng diwylliant cynaliadwy o ddysgu a gwella.

Er bod ansawdd iechyd a gofal yn cael ei gydnabod yn eang, gall fod yn anodd ei ddiffinio. Mae'r fframwaith hwn yn cynnig trosolwg o sut beth yw ansawdd, a hefyd mae'n tynnu sylw at yr egwyddorion allweddol sy'n sail iddo a'r trefniadau y mae angen iddynt fod ar waith er mwyn sicrhau gwasanaethau o ansawdd uchel bob amser. Bydd angen canolbwyntio'n fanwl ar ansawdd a diogelwch wrth inni ddod allan o'r pandemig Covid-19, gan geisio deall y gwir niwed sydd wedi digwydd yn ystod y deunaw mis diwethaf a sicrhau, wrth symud ymlaen, ein bod yn diwallu anghenion ein poblogaeth.

Caiff nifer o feysydd yn y GIG eu cydnabod fel rhai sy'n darparu gwasanaethau o ansawdd eithriadol o uchel. Mae'r fframwaith hwn yn cynnig canllawiau a chyfarwyddyd i holl sefydliadau'r GIG, ac mae'n canolbwyntio ar sicrhau bod system rheoli ansawdd gref ar waith ar bob lefel, rhywbeth a fydd, yn ei dro, yn lleihau amrywiad o ran ansawdd. Mae hyn yn hollbwysig o ran gwireddu'r dyheadau a nodir yn Cymru Iachach ar gyfer cael GIG seiliedig ar ansawdd yng Nghymru, ac mae'n hollbwysig hefyd o ran paratoi ar gyfer bodloni disgwyliadau'r ddyletswydd ansawdd newydd a chryfach.

Mae gan bawb rôl yn y dasg o wella ansawdd, a dengys y fframwaith yr elfennau y mae angen iddynt fod ar waith er mwyn sicrhau bod llais pawb yn cael ei glywed. Mae'r ddogfen hon yn disodli Cynllun Sicrhau Ansawdd Llywodraeth Cymru o fethiannau diweddar yn systemau Cymru, yn ogystal â phandemig y coronafeirws a'i botensial cysylltiedig i greu niwed. Mae hefyd yn gam ar y ffordd tuag at y dyletswyddau ansawdd a gonestrwydd newydd a ddisgwylir yn 2023.

1. Cyd-destun a chefndir

1.1 Cefndir strategol

Mae Cymru Iachach yn nodi gweledigaeth hirdymor, sef y dylai pawb yng Nghymru gael bywydau hirach, iachach a hapusach. Mae'n cynnig dull system gyfan o ymdrin ag iechyd a gofal cymdeithasol – dull teg lle caiff gwasanaethau eu cynllunio ar gyfer unigolion a grwpiau ar sail eu hanghenion unigryw a'r hyn sy'n bwysig iddynt, yn ogystal â chanlyniadau ansawdd a diogelwch. Y gwerth craidd cyntaf a ddisgrifir yn Cymru Iachach ar gyfer GIG Cymru yw "Rhoi ansawdd a diogelwch uwchlaw popeth – darparu gofal gwerth uchel sy'n seiliedig ar dystiolaeth ar gyfer ein cleifion bob amser."

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Mae sefydliadau gofal iechyd yng Nghymru yn canolbwyntio ar fodloni nod pedwarplyg, sef gwella iechyd a lles y boblogaeth, gwella profiadau personol o ofal,

sicrhau'r gwerth gorau o ran adnoddau, a sicrhau gweithlu brwd ac ymroddedig. Mae ein hathroniaeth o iechyd a gofal darbodus sy'n seiliedig ar werthoedd, yn sail i hyn, a bydd yn parhau i fod yn nodwedd neilltuol ar system Cymru. Bydd Deddf Iechyd a Gofal Cymdeithasol (Ansawdd ac Ymgysylltu) (Cymru) 2020, sy'n gosod dyletswydd ansawdd uwch a dyletswydd gonestrwydd sefydliadol, yn cryfhau'r dull o sicrhau gofal diogel o ansawdd uchel.

Er mwyn gwireddu'r dyhead o gael gwasanaeth iechyd a gaiff ei arwain gan ansawdd, rhaid i bob sefydliad weithredu o fewn system rheoli ansawdd effeithiol. Mae'r Fframwaith Ansawdd a Diogelwch hwn yn disgrifio'r elfennau allweddol cydgysylltiol y mae'n ofynnol iddynt weithio gyda'i gilydd bob amser er mwyn sicrhau gwelliant parhaus mewn ansawdd, sef: cynllunio; gwella; a rheoli; ac er mwyn rhoi sicrwydd cyffredinol fod y system yn gweithio'n effeithiol i gyflawni'r canlyniadau y mae pob un ohonom yn dymuno'u cael i bobl Cymru.

Yn unol â'r cyfeiriad a bennir yn Cymru Iachach, mae gwaith yn parhau ar ddwyn ynghyd yr agendâu ansawdd oddi mewn i iechyd a gofal cymdeithasol. Fodd bynnag, mae'r fframwaith hwn yn canolbwyntio'n bennaf ar sefydliadau'r GIG yng Nghymru, gan gydnabod yn llwyr fod gweithio mewn partneriaeth yn hollbwysig i lwyddiant.

Mae'r Fframwaith Clinigol Cenedlaethol a gyhoeddwyd yn ddiweddar yn cynnig dehongliad clinigol o Cymru Iachach, ac mae'n disgrifio system iechyd a gofal sy'n dysgu, system gydol oes sydd wedi'i seilio ar lwybrau clinigol sy'n canolbwyntio ar y claf. Mewn blynyddoedd diweddar, roedd cynlluniau cyflawni ar gyfer cyflyrau iechyd difrifol wedi pennu disgwyliadau polisi ar gyfer gwasanaethau clinigol â blaenoriaeth uchel. Daeth y cynlluniau hyn i ben ym mis Rhagfyr 2020 ac fel y nodir yn y Fframwaith Clinigol Cenedlaethol, byddant yn cael eu disodli'n raddol gan Ddatganiadau Ansawdd. Bydd y trefniadau ar gyfer olynydd hyn yn helpu i bennu'r hyn sydd, ym marn rhanddeiliaid, yn briodoleddau ansawdd pwysig mewn meysydd clinigol â blaenoriaeth uchel, megis gwasanaethau canser, clefyd y galon a strôc; yn ogystal â gwasanaethau megis gofal critigol a gofal diwedd oes.

1.2 Adfer ar ôl y Pandemig COVID-19

Yn ystod y flwyddyn ddiwethaf mae'r GIG wedi wynebu'i her fwyaf ers ei sefydlu, a hynny ar ffurf y pandemig COVID-19 digyffelyb. Mae staff ac arweinwyr sefydliadau'r GIG wedi ymateb i'r her hon mewn modd anhygoel trwy ddatblygu ffyrdd newydd o weithio er mwyn cynorthwyo ein poblogaeth. Yn ystod y pandemig gwelsom enghreifftiau gwych o ofal ansawdd uchel, yn cynnwys ailhyfforddi staff a'u symud i'r meysydd risg uchaf, gwaith tîm a chyfathrebu effeithiol ac, uwchlaw popeth arall, trefniadau a ganolbwyntiai ar anghenion newydd a newidiol pobl.

Wrth inni ddod allan o'r pandemig, mae sefydliadau'r GIG yn ystyried sut i addasu gwasanaethau a dysgu o'r arferion arloesol a'r arweinyddiaeth glinigol eithriadol a welsom. Bydd ansawdd a diogelwch o'r pwys mwyaf yn y broses adfer hon, ac mae hi'n hanfodol i'r ffocws hwn ar ansawdd a diogelwch ddigwydd ar bob lefel. Bydd symptomau a risgiau ar lefelau hynod amrywiol yn dod i ran cleifion sy'n aros am driniaeth, felly rhaid i'r adnodd clinigol cyfyngedig sydd ar gael yn awr gael ei dargedu at y rhai sy'n debygol o gael y budd mwyaf. Er mwyn ennill a chynnal

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dealltwriaeth a hyder y cyhoedd, bydd yn ofynnol cael dull cydgynhyrchiol o ymdrin â gofal clinigol a gwneud penderfyniadau.

Yn ddiweddar mae Llywodraeth Cymru wedi cyhoeddi Edrych tua'r dyfodol er mwyn helpu gwasanaethau iechyd a gofal cymdeithasol i ddod allan o'r pandemig. Yma, nodir mai'r her yw creu'r gwasanaeth iechyd a gofal cymdeithasol integredig y dymunwn ei gael wrth symud ymlaen a delio ag effeithiau hirdymor COVID-19. Newid er gwell yw'r nod, gan gydnabod bod COVID-19 gyda ni o hyd.

Agwedd allweddol ar yr adferiad hwn yw sicrhau bod gofal mor ddiogel â phosibl, a bod unrhyw niwed yn cael ei leihau. Y pedwar niwed a ddisgrifiwn mewn perthynas ag iechyd a gofal yng Nghymru yw:

1. Niwed uniongyrchol yn sgil COVID-19 ei hun
2. Niwed anuniongyrchol yn sgil COVID-19 oherwydd bod y system iechyd a gofal cymdeithasol yn cael ei gorlethu a bod llai o weithgarwch gofal iechyd o ganlyniad
3. Niwed yn sgil mesurau diogelu iechyd ar sail poblogaeth, hy niwed addysgol
4. Niwed economaidd o ganlyniad uniongyrchol ac anuniongyrchol i COVID-19, hy diweithdra yn sgil y cyfyngiadau ar symud
5. Niwed oherwydd bod anghydraddoldebau mewn cymdeithas yn gwaethygu neu am fod anghydraddoldebau newydd yn dod i'r amlwg

Yn ddi-os, mae niwed wedi dod i ran pobl a'u hanwyliaid o ganlyniad i'r pandemig; a phan ddaw hi'n fater o niwed yn sgil gofal iechyd, fe fydd meysydd fel trosglwyddiad nosocomiaidd a gohirio gofal iechyd oherwydd lleihad mewn gwasanaethau arferol, ynghyd â phobl yn ceisio peidio â gorlethu'r GIG, wedi arwain eisoes, neu'n arwain yn y misoedd nesaf, at niwed i rai unigolion.

Mae deall gwir lefel y niwed sydd wedi digwydd, neu'r niwed a all ddigwydd eto os na chymerir camau lliniaru, yn dasg sylweddol ond hynod bwysig wrth inni adfer ar ôl y pandemig. Yn anffodus, mewn rhai amgylchiadau bydd pobl wedi cael niwed ac o bosibl wedi marw, a rhaid inni sicrhau bod y gofal a roddwyd mewn achosion o'r fath yn cael ei adolygu'n drylwyr er mwyn deall a oedd modd atal y niwed o gwbl a hefyd er mwyn inni allu dysgu a sicrhau bod ein polisïau'n esblygu o ganlyniad (yn enwedig polisïau'n ymwneud â rheoli ac atal heintiau).

Cam Gweithredu 1: Dylai sefydliadau'r GIG sicrhau bod y niwed (uniongyrchol yn ogystal ag anuniongyrchol) sy'n gysylltiedig â'r pandemig COVID-19 yn cael ei leihau. Dylai sefydliadau weithredu dull sy'n canolbwyntio ar risgiau a buddion wrth adfer gwasanaethau eraill, gan fesur, monitro a dysgu yn sgil unrhyw niwed.

Wrth symud ymlaen, bydd cyd-gynhyrchu gwasanaethau yn agwedd hollbwysig ar yr adferiad. Fel y nodir yn "Edrych tua'r dyfodol", rhaid inni adeiladu ar ffyrdd arloesol o gyflawni gwasanaethau, yn enwedig trwy ddefnyddio technoleg. Bydd hyn yn allweddol o ran gallu cadw mewn cysylltiad ag unigolion sy'n aros am driniaeth a sicrhau bod trefniadau cadarn ar waith fel y bydd modd rhoi blaenoriaeth i'r rhai sy'n wynebu'r risg fwyaf. Bydd angen pwyso a mesur, ynghyd â sicrhau bod unrhyw ymyriadau yn rhai gwerth uchel ac yn gwella canlyniadau i bobl.

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1.3 Ansawdd yng Nghymru a'r Ddeddf Ansawdd ac Ymgysylltu (2020)

Rydym eisoes wedi cyhoeddi nifer o ddogfennau polisi yn ymwneud ag ansawdd yn y GIG yng Nghymru. Roedd y Cynllun Sicrhau Ansawdd (2012) blaenorol yn nodi camau ar gyfer ysgogi gwelliant parhaus mewn gwasanaethau a thryloywder, yn cynnwys cyflwyno Datganiadau Ansawdd Blynyddol. Yn 2013, cynigiwyd fframwaith llywodraethu cenedlaethol yn *'Darparu Gofal Diogel, Gofal Tosturiol'*. Mae'r fframwaith hwn yn adeiladu ar y dogfennau blaenorol hyn, ac yn eu disodli.

Yn ei Adolygiad o Ansawdd Gofal Iechyd a gyhoeddwyd yn 2016, dywedodd yr OECD fod ansawdd wrth galon a chraidd y system gofal iechyd yng Nghymru, ond cyflwynodd argymhellion i gryfhau'r hyn a oedd eisoes ar waith. Roedd yr argymhellion hyn yn cynnwys perthynas gryfach rhwng byrddau iechyd a Llywodraeth Cymru, ynghyd ag atebolrwydd mwy gweladwy mewn byrddau iechyd, gyda'r gallu technegol, y gallu o ran rheolwyr a'r gallu o ran arweinwyr i wella safonau.

Ym mis Mehefin 2020, rhoddwyd cydsyniad brenhinol i ddeddfwriaeth newydd, sef Deddf Iechyd a Gofal Cymdeithasol (Ansawdd ac Ymgysylltu) (Cymru) 2020. Mae'r Ddeddf yn cyflwyno dyletswydd ansawdd newydd a roddir ar gyrff y GIG a Gweinidogion Cymru (o ran eu swyddogaethau cysylltiedig ag iechyd). Mae'r ddyletswydd gyfreithiol uwch hon yn nodi y dylai'r holl benderfyniadau a wneir gael eu gwneud er mwyn sicrhau gwelliant yn ansawdd y gwasanaethau a ddarperir yn y GIG yng Nghymru, ac er mwyn sicrhau canlyniadau gwell i bobl Cymru. Mae'r ddeddfwriaeth hon yn pwysleisio'r angen i sefydliadau fynd y tu hwnt i gynnal eu gwasanaethau'n unig, ac mae'n nodi y dylent anelu at welliant parhaus a rhagoriaeth, gan roi cymaint o bwyslais ar wella a diogelu iechyd ag a roddant ar reoli salwch.

Bydd ail-lunio'r ddyletswydd ansawdd yn y ffordd hon, gan symud y tu hwnt i'r ddyletswydd bresennol, yn newid ffocws penderfyniadau ac yn cynrychioli cam pellach ar y siwrnai tuag at safonau uwch fyth mewn gwasanaethau iechyd sy'n canolbwyntio ar unigolion yng Nghymru.

I atgyfnerthu'r pwyslais y dymunwn ei roi ar wasanaethau sy'n canolbwyntio ar unigolion a phwysigrwydd profiad cleifion fel modd o bennu gwasanaeth o ansawdd, mae'r Ddeddf yn mynd ati'n benodol i nodi bod profiad cleifion yn elfen graidd o'r ddyletswydd ansawdd newydd.

Ymhellach, rhaid i sefydliadau ystyried Safonau Iechyd a Gofal Llywodraeth Cymru wrth iddynt gyflawni eu dyletswydd ansawdd. Bwriad y fframwaith safonau hwn yw cynorthwyo'r GIG a phartner-sefydliadau i ddarparu gwasanaethau o ansawdd ym mhob lleoliad gofal iechyd. Mae'r safonau yma'n nodi'r hyn y gall pobl Cymru ei ddisgwyl pan fyddant yn defnyddio gwasanaethau iechyd.

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Diweddarwyd y safonau hyn ddiwethaf yn 2015, ac er mwyn sicrhau eu bod yn cyd-fynd â'r ddyletswydd ansawdd newydd byddant yn cael eu hadolygu a'u diweddaru yn awr.

Cam Gweithredu 2: Dylai Llywodraeth Cymru weithio gyda rhanddeiliaid allweddol i adolygu a diweddaru'r safonau lechyd a Gofal, gan adlewyrchu'r ddyletswydd ansawdd gryfach.

Mae'r ddyletswydd ansawdd yn nodi ei bod hi'n ofynnol i sefydliadau'r GIG ymrwymo i welliannau, yn ogystal â chyflawni gwelliannau, yn ansawdd gwasanaethau iechyd. Bydd yn ofynnol i sefydliadau'r GIG gyhoeddi adroddiad blynyddol yn nodi'r camau a gymerwyd ganddynt i sicrhau'r gwelliannau hyn, a chynnwys asesiad yn nodi i ba raddau y cyflawnwyd unrhyw welliannau mewn canlyniadau. Bydd yr adroddiad newydd hwn yn disodli'r Datganiad Ansawdd Blynyddol presennol.

Ymhellach, am y tro cyntaf bydd hi'n ofynnol i Weinidogion Cymru gyflwyno'u hadroddiad blynyddol eu hunain i Senedd Cymru ynglŷn â'r camau a gymerwyd ganddynt i sicrhau gwelliannau a fydd yn arwain at ofal o ansawdd gwell i boblogaeth Cymru. Mae rhaglen waith ar y gweill er mwyn paratoi ar gyfer gweithredu'r ddyletswydd newydd.

Yn ogystal â dyletswydd ansawdd, mae Deddf 2020 hefyd yn cyflwyno dyletswydd gonestrwydd newydd ar sefydliadau. Bydd y ddyletswydd yn berthnasol i sefydliadau'r GIG, darparwyr gofal sylfaenol mewn perthynas â gwasanaethau'r GIG, a darparwyr gofal iechyd annibynnol. Bydd y ddyletswydd yn berthnasol pan fo canlyniad anffafriol wedi dod i ran unigolyn a gafodd ofal iechyd, a phan oedd neu y gallai'r ddarpariaeth gofal iechyd fod yn ffactor yn y canlyniad anffafriol hwnnw. Yn y cyd-destun hwn, bydd canlyniad anffafriol yn golygu bod yr unigolyn wedi dioddef, neu y gallai ddioddef, niwed annisgwyl neu anfwriadol sy'n fwy na niwed bach iawn.

Mae cysylltiad clir rhwng gonestrwydd ac ansawdd gwasanaethau. Ceir tystiolaeth fod bod yn fwy agored, yn fwy tryloyw ac yn fwy gonest yn gysylltiedig â darparu gwasanaethau iechyd a gofal cymdeithasol o ansawdd uwch. Mae sefydliadau a chanddynt ddiwylliannau agored a thryloyw yn fwy tebygol o dreulio amser yn dysgu o ddigwyddiadau, ac maent yn fwy tebygol o fod â phrosesau a systemau ar waith i gynorthwyo staff a defnyddwyr gwasanaethau os aiff pethau o'u lle. Mae hyn yn hollbwysig mewn lleoliad iechyd a gofal lle mae gan gleifion berthnasoedd parhaus yn aml â'u darparwyr iechyd a gofal. Yn gyffredinol, mae cleifion a defnyddwyr gwasanaethau eisiau cael gwybod y gwir am yr hyn a ddigwyddodd, a chael sicrwydd bod popeth yn cael ei wneud i ddysgu o'r hyn a aeth o'i le.

Bydd gosod dyletswydd gonestrwydd ar sefydliadau'r GIG, yn cynnwys darparwyr gofal sylfaenol, yn gwella profiad y rhai sy'n defnyddio'r gwasanaethau, yn ogystal â gwella cyfathrebu ac ymgysylltu rhwng y GIG a defnyddwyr y gwasanaethau. Bydd yn adeiladu ar y gwaith sydd eisoes wedi'i wneud trwy gyfrwng trefniadau Gweithio i Wella ar gyfer delio â phryderon, cwynion a digwyddiadau.

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Cam Gweithredu 3: Dylai Llywodraeth Cymru weithio gyda rhanddeiliaid allweddol ar roi'r dyletswyddau ansawdd a gonestrwydd ar waith er mwyn galluogi sefydliadau'r GIG i ymbaratoi erbyn y daw'r dyletswyddau i rym.

Pan ddaw Deddf 2020 i rym, fe fydd hi hefyd yn sefydlu 'Corff Llais y Dinesydd' newydd ar gyfer Iechyd a Gofal Cymdeithasol. Amcan cyffredinol Corff Llais y Dinesydd yw cynrychioli buddiannau'r cyhoedd mewn materion yn ymwneud â gwasanaethau iechyd a chymdeithasol. Ymhellach, bydd modd i Gorff Llais y Dinesydd gyflwyno sylwadau i sefydliadau'r GIG ac awdurdodau lleol ynghylch materion o'r fath, a gosodir dyletswyddau cydweithredu ar sefydliadau'r GIG, awdurdodau lleol a Chorff Llais y Dinesydd o dan y Ddeddf. Rhagwelwn y bydd Corff Llais y Dinesydd yn datblygu perthynas weithio agos â'r GIG ac awdurdodau lleol. Bydd yn ffynhonnell ddefnyddiol dros ben ar gyfer cael adborth gan ddefnyddwyr gwasanaethau a'r cyhoedd ehangach. Ein dyhead yw y bydd arweinwyr y GIG yn ystyried Corff Llais y Dinesydd fel ffynhonnell wybodaeth a chyngor ynglŷn â barn pobl am wasanaethau iechyd ar lefel genedlaethol a lleol. Fel Corff sy'n cyflawni swyddogaethau ar draws gwasanaethau iechyd a chymdeithasol, mae hefyd yn helpu i wireddu argymhellion yr Adolygiad Seneddol o Iechyd a Gofal Cymdeithasol ar gyfer integreiddio gwasanaethau iechyd a gofal cymdeithasol ochr yn ochr ag ymgysylltu mwy integredig â dinasyddion.

Mae'r fframwaith hwn yn cydnabod bod galluogi pobl i ddefnyddio gwasanaethau drwy gyfrwng y Gymraeg yn hanfodol o safbwynt ansawdd gofal, ac mae'n helpu i sicrhau diogelwch, urddas a phrofiad siaradwyr Cymraeg. Bydd y camau gweithredu a ddisgrifir yn y fframwaith hwn yn cael eu datblygu yn unol â'r egwyddor hon a'r fframwaith Mwy na geiriau.

2. System o ansawdd

2.1 Beth yw ansawdd da?

Mae yna amryfal ffyrdd o ddisgrifio ansawdd mewn gofal iechyd. Ym 1999, fe wnaeth y Sefydliad Meddyginiaethau, fel yr oedd ar y pryd, fynd ati i ddisgrifio chwe nodwedd sy'n perthyn i ansawdd:

- Diogel – osgoi niwed
- Effeithiol – priodol a seiliedig ar dystiolaeth
- Canolbwyntio ar yr unigolyn – llawn parch ac yn ymateb i anghenion a dymuniadau unigolion
- Amserol – ar yr amser iawn
- Effeithlon – osgoi gwastraff
- Teg – siawns gyfartal o gael yr un canlyniad, ni waeth be fo'r lleoliad, statws economaidd-gymdeithasol ac ati.

Mae'r nodweddion ansawdd hyn yn cyd-fynd â'n hegwyddorion iechyd a gofal darbodus:

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- Cyflawni iechyd a lles gyda'r cyhoedd, cleifion a gweithwyr proffesiynol yn bartneriaid cyfartal yn y broses trwy gyd-gynhyrchu (canolbwyntio ar unigolion)

- Gofalu am y rhai sydd â'r anghenion iechyd mwyaf yn gyntaf, gan wneud y defnydd mwyaf effeithiol o'r holl sgiliau ac adnoddau (amserol, effeithlon, effeithiol)
- Gwneud dim ond yr hyn sydd angen ei wneud, dim mwy, dim llai (diogel, effeithlon)
- Lleihau amrywiadau amhriodol gan ddefnyddio arferion sy'n seiliedig ar dystiolaeth mewn modd cyson a thryloyw (teg, effeithiol, effeithlon)

Rydym yn datblygu iechyd a gofal darbodus trwy'r cysyniad Gofal Iechyd sy'n Seiliedig ar Werthoedd, er mwyn sicrhau y bydd gofal o ansawdd uchel yn cael ei ddarparu a hefyd er mwyn sicrhau y bydd modd iddo fod mor effeithiol â phosibl i bob unigolyn.

2.2 Diogelwch

2.2.1 Diogelwch Cleifion

Un maes ansawdd sy'n taro tant arbennig gyda'r cyhoedd a'r staff yw diogelwch cleifion. Mae nifer o systemau iechyd yn canolbwyntio'n gyfan gwbl ar hyn. Mae gan y GIG yng Nghymru ymrwymiad hirsefydlog i ddiogelwch, ers y rhaglen 1000 o Fywydau a fu ar waith rhwng 2008 a 2010. Mae'r ymrwymiad hwnnw i'w weld o hyd yn nifer o'n prosesau a'n harferion, yn cynnwys adolygiadau marwolaethau, cofnodi digwyddiadau cenedlaethol a nifer o raglenni parhaus yn cynnwys, er enghraifft, rhaglenni'n ymwneud ag anaf acíwt i'r arennau, cysylltwyr niwro-echelinol a diogelwch meddyginiaethau.

Mae modd archwilio diogelwch cleifion mewn dwy ffordd gyffredinol. Mae Diogelwch I yn disgrifio'r dull traddodiadol lle caiff diogelwch ei ystyried fel 'absenoldeb gweithredoedd anniogel'. Mewn gofal iechyd, mae dull Diogelwch I wedi arwain at ganolbwyntio ar y lleiafrif o ddigwyddiadau mewn gofal lle mae rhywbeth wedi mynd o'i le. Yng Nghymru, rydym eisiau symud tuag at ddull Diogelwch II, lle caiff diogelwch ei ystyried fel 'rhywbeth sy'n digwydd pan aiff pethau'n iawn'. Bydd dull Diogelwch II yn annog mwy o ystyried a dysgu ar sail yr hyn sydd wedi mynd yn dda yn ogystal â'r hyn sydd wedi mynd o'i le, gan gynnig golwg fwy cyfannol ar ddiogelwch. Bob diwrnod, er gwaethaf amgylcheddau cymhleth, pwysau staffio a thystiolaeth newidiol a thriniaethau newydd, mae staff y GIG yn addasu er mwyn darparu gofal gwych. Mae hi'n bwysig deall sut maent yn gallu goresgyn y materion hyn, fel y gellir dathlu'r gamp honno a lledaenu'r hyn a ddysgir.

Agwedd arall ar ddiogelwch cleifion yw niwed i gleifion, nid oherwydd ymyriadau gofal iechyd ond oherwydd diffyg triniaeth – niwed trwy anweithred. Fel y nodwyd eisoes, bu'n rhaid atal nifer o wasanaethau rheolaidd yn ystod y pandemig er mwyn rhoi blaenoriaeth i ddarparu gofal acíwt i bobl â COVID-19. Fodd bynnag, efallai y bydd y boblogaeth yn dioddef niwed os na chaiff y gwasanaethau hyn eu hailddechrau. Cafodd Gwasanaethau Hanfodol, a ddisgrifir fel gwasanaethau ar gyfer cyflyrau sy'n cyfyngu ar fywyd neu sy'n effeithio ar fywyd, eu cynnal yn ystod y pandemig. Mae'r fframwaith sicrhau ansawdd ar gyfer gwasanaethau hanfodol a gyhoeddwyd gan Lywodraeth Cymru yn canolbwyntio ar yr angen am atebolrwydd lleol, trefniadau llywodraethu, canllawiau a sicrwydd seiliedig ar dystiolaeth.

McLeod, Kathryn
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Mae cofnodi digwyddiadau ac ymchwilio i ddigwyddiadau yn bwysig o ran newid diwylliant, tryloywder a rhannu'r hyn a ddysgir ar ôl i niwed ddigwydd. Mae fframwaith cyfredol Cymru ar gyfer cofnodi digwyddiadau'n cael ei adolygu ar hyn o bryd er mwyn sicrhau y bydd yn helpu i ddatblygu'r meysydd hynny, yn creu ffocws ar gamau y gellir eu cymryd yn syth i sicrhau diogelwch, yn ysgogi gwelliannau ac yn cyd-fynd â'r ddyletswydd gonestrwydd. Er mwyn i'r ymchwiliadau esgor ar yr effaith fwyaf a llwyddo i ganfod problemau yn y system, rhaid iddynt gael eu targedu. Gall achosion yn y system gofal iechyd ddigwydd yn unrhyw le yng Nghymru, a rhaid canolbwyntio'n ddiysgog ar rannu'r dysgu sy'n digwydd ledled Cymru, gyda'r nod o wneud gofal mor ddiogel â phosibl. Rhaid i'r fframwaith newydd ein galluogi i ddysgu yn sgil digwyddiadau Diogelwch I a Diogelwch II.

Cam Gweithredu 4: Dylai Llywodraeth Cymru weithio gyda rhanddeiliaid i ddatblygu fframwaith Cofnodi Digwyddiadau Cenedlaethol newydd sy'n canolbwyntio ar gynyddu a rhannu'r hyn a ddysgir yn sgil digwyddiadau.

Yng Nghymru, mae adolygu marwolaethau wedi bod yn orfodol ers 2013 yn achos marwolaethau mewn ysbytai, ac mae'r adolygiadau hyn wedi bod yn hollbwysig o ran cadarnhau meysydd pwysig ar gyfer gwelliant parhaus, yn cynnwys sepsis ac adnabod cleifion gwael. Erbyn hyn, mae gwasanaeth archwilwyr meddygol yn cael ei roi ar waith ledled Cymru, gydag ymrwymiad i wella diogelwch cleifion a gofal diwedd oes. Mae archwilwyr meddygol yn craffu'n annibynnol ar yr holl farwolaethau nad yw'r crwner yn ymchwilio iddynt. Mae gwaith craffu'r archwilwyr meddygol yn cynnwys gofyn i anwyliaid yr unigolyn a oes ganddynt unrhyw bryderon. Pan fydd y gwasanaeth archwilwyr meddygol yn dod o hyd i broblemau posibl yn ymwneud â gofal y claf, byddant yn tynnu sylw sefydliadau'r GIG atynt fel y gellir eu hadolygu. Bydd y broses hon yn adeiladu ar yr hyn sydd eisoes wedi'i ddatblygu gydag adolygiadau marwolaethau yng Nghymru ac yn tynnu sylw at feysydd dysgu.

Cam Gweithredu 5: Dylid mynd i'r afael â gwaith cenedlaethol i ddatblygu fframwaith 'dysgu o farwolaethau', gan adeiladu ar y gwaith parhaus o gyflwyno'r Gwasanaeth Archwilwyr Meddygol drwy'r wlad ynghyd â'r prosesau sydd eisoes ar waith ar gyfer adolygu marwolaethau.

2.2.2 Diogelwch Systemau

Mae hi'n bwysig hefyd inni ddysgu yn sgil materion penodol a ddaw i'r amlwg yn ymwneud â diogelwch a gofal cleifion. Yn 2020, fe wnaeth *First Do No Harm: The report from the Independent Medicines and Medical Devices Safety Review* ystyried y defnydd o rwyllau pelfis a sodiwm falproad, a'r niwed a achoswyd i fenywod a phlant o ganlyniad i'r ymyriadau hyn. Roedd yr adroddiad hwn yn edrych yn benodol ar y defnydd o'r ymyriadau hyn yn Lloegr, ond gall y GIG yng Nghymru ddysgu gwersi gwerthfawr yn ei sgil. Mae wedi tynnu sylw at y ffaith na wnaeth y system gofal iechyd yn ei chyfanrwydd ymateb yn ddigon cyflym i wrando ar y pryderon a fynegwyd gan gleifion a gweithredu yn gynt.

McLellan, Holly
11/26/2024 12:58:32

Mae gwasanaethau mamolaeth a newyddenedigol yn enghraifft o systemau lle mae angen dull strategol pan ddaw hi'n fater o ddiogelwch, a lle mae angen gwneud y gorau o'r gwersi a ddysgir ar lefel Cymru gyfan pan fo niwed wedi digwydd a phan

nodir fod angen gwelliannau. Rydym eisiau adeiladu ar yr hyn a ddysgwyd trwy Gymru gyfan eisoes yn dilyn adolygiad Coleg Brenhinol yr Obstetryddion a'r Gynaecolegwyr a Choleg Brenhinol y Bydwragedd o wasanaethau mamolaeth yn hen Fwrdd Iechyd Prifysgol Cwm Taf ac adolygiadau eraill o'r fath a gynhaliwyd yn y DU, a hynny er mwyn sicrhau bod gwelliannau cyson a pharhaus yn cael eu cyflwyno a'u cynnal.

Cam Gweithredu 6: Dylid mynd i'r afael â gwaith cenedlaethol i arwain dull gwella Cymru gyfan er mwyn gwneud y gorau o'r cyfleoedd i ddysgu yn sgil adolygiadau annibynnol o wasanaethau mamolaeth a newyddenedigol.

Bydd gweithredu'r dyletswyddau ansawdd a gonestrwydd newydd, ynghyd â Chorff Llais y Dinesydd, yn cryfhau'n fawr y dulliau sydd gennym o fewn ein systemau ar gyfer sicrhau na fydd profiadau anodd o'r fath yn cael eu hailadrodd, yn enwedig o ran pa mor hollbwysig yw hi inni wrando ar gleifion, eu teuluoedd a'r staff pan aiff pethau o'u lle.

Mae angen i ddiogelwch ym maes gofal iechyd fynd y tu hwnt i ddiogelwch cleifion unigol ac ystyried diogelwch ein systemau. Wrth i'r gwasanaethau esblygu y tu hwnt i ffiniau sefydliadol i greu systemau gofal iechyd, rhaid inni sicrhau bod y systemau cyfan hyn yn ddiogel. Mae angen cymhwyso'r cysyniad Diogelwch I / Diogelwch II at systemau yn eu cyfanrwydd, gan fyfyrio ar yr hyn y gallwn ei ddysgu gan systemau diogel a chymhwyso'r dysgu hwnnw at bob un o'n systemau. Hefyd, mae angen inni ystyried meysydd megis sicrhau bod y dyfeisiau meddygol a ddefnyddir yn ddiogel, a phan fo yna bryderon, sicrhau bod y pryderon hyn yn cael eu huwchgyfeirio i'r Asiantaeth Rheoleiddio Meddyginiaethau a Chynhyrchion Gofal Iechyd (MHRA). Mae angen inni fuddsoddi mewn systemau electronig a all sicrhau ymarfer cyson. Hefyd, mae angen inni fonitro'r defnydd a wneir o'r systemau hyn a mesur canlyniadau ymyriadau clinigol, yn cynnwys mewnblannu dyfeisiau. Mae'r systemau electronig hyn yn cynnwys rhai fel systemau rhagnodi electronig.

Cam Gweithredu 7: Dylai Llywodraeth Cymru weithio gyda sefydliadau'r GIG i roi systemau electronig anhepgor ar waith i ategu gofal diogel, megis Systemau Electronig ar gyfer Rhagnodi a Gweinyddu Meddyginiaethau, Sganio er Diogelwch a'r System Wybodaeth ar gyfer Dyfeisiau Meddygol.

3. Y Cylch Ansawdd

3.1 Y Cylch Ansawdd – System rheoli ansawdd

Mae pobl angen i wasanaethau cyhoeddus gael eu trefnu o amgylch eu hanghenion a'u profiadau. Mae angen i'r diwylliant yn y gwasanaethau hyn fod yn agored ac yn gefnogol ac ennyn ymddiriedaeth, ac mae angen i brosesau cynllunio, gwella a mesur fod yn gysylltiedig a chanolbwyntio ar ansawdd a dysgu. Rhaid i'r elfennau sy'n perthyn i'r cylch gwella fod yn asgwrn cefn i'r sefydliad, a chael eu hysgogi o'r brig. Mae hi'n hanfodol i sefydliadau greu'r amodau ar gyfer hyn, trwy weledigaeth glir ac arweinyddiaeth gref.

McLeanJoly 11/26/2025 12:18:21

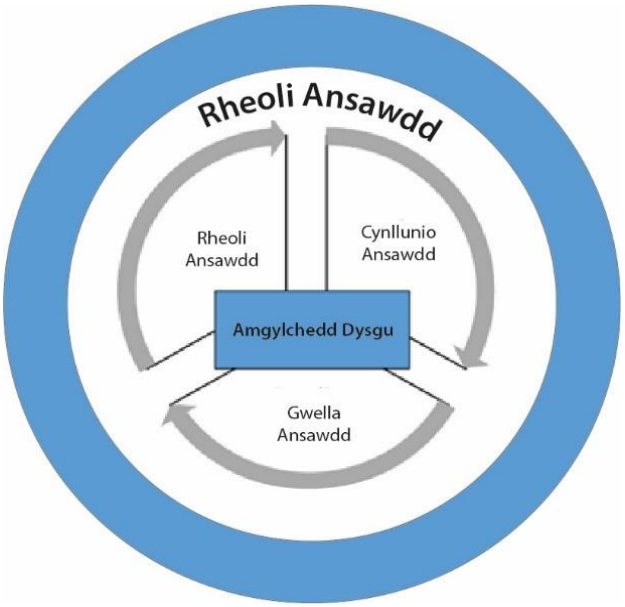
Rhaid i’r bwrdd ysgogi system rheoli ansawdd effeithiol trwy’r holl sefydliad. Pan fydd methiannau mewn gwasanaethau megis mamolaeth neu ofal pobl eiddil oedrannus, fel arfer mae yna wendid sefydliadol ehangach, yng Nghymru fel mewn mannau eraill.

Ar draws y byd, mae yna bryder y gall byrddau roi blaenoriaeth i gyllid a pherfformiad uwchlaw ansawdd. Mae’r elfennau hyn yn haws eu monitro a’u defnyddio mewn trafodaethau atebolrwydd, ond mae modd iddynt gael eu cyflawni ar draul ansawdd.

Gall byrddau sefydliadau fod wedi cyrraedd cyfnodau aeddfedrwydd gwahanol yn eu dull o lywodraethu gwelliannau. Mae sefydliadau a chanddynt lefelau aeddfedrwydd uchel o ran ansawdd yn tueddu i roi blaenoriaeth i wella ansawdd gyda ffocws hirdymor, ac yn tueddu i ddefnyddio data er budd gwelliannau, nid er budd sicrwydd neu reolaeth yn unig, yn ogystal â chynnwys staff a chleifion yn y dasg o wella ansawdd gyda diwylliant agored o welliant parhaus ac arweinyddiaeth glinigol wirioneddol.

Mae Gwella Ansawdd yn gysyniad cyffredin a drafodir mewn gofal iechyd, ond mae angen iddo fod yn rhan o broses fwy – sef System Rheoli Ansawdd.

Ffig 1



Mae angen i’r cylch ansawdd hwn fod yn gyflawn ac yn gysylltiedig ar lefel leol, lefel ranbarthol a lefel genedlaethol er mwyn galluogi ac ysgogi’r gwelliant mwyaf. Rhaid i bawb ddeall eu rôl yn y system ansawdd hon. Rhaid i’r staff, yn ogystal â’r cyhoedd a’r cleifion, allu cyfrannu at bob rhan o’r cylch, trwy gydgynllunio a chyd-gynhyrchu, er mwyn sicrhau bod y camau gweithredu’n berthnasol ac yn ystyrlon i’r rhai sy’n gorfod elwa.

McLellan, Alex
11/26/2019 12:08:21

Mae dysgu parhaus yn ganolog i’r system rheoli ansawdd. Nid digon yw ailadrodd y cylch yn unig; bob tro rhaid inni fanteisio ar yr hyn a ddysgwyd o’r tro blaenorol, gan gywain gwybodaeth o bob ffynhonnell a gwella’r broses.

3.2 Cynllunio Ansawdd

System gofal iechyd wedi'i gynllunio yw'r GIG yng Nghymru. Rhaid i sefydliadau gynllunio i wella iechyd y boblogaeth a wasanaethant. Mae'r cyfrifoldeb hwn yn dechrau gyda'r elfen fwyaf hanfodol, sef atal, er mwyn cadw pobl yn iach ac yn eu cartrefi pa bryd bynnag y bo modd ac, yn y pen draw, er mwyn gwella canlyniadau iechyd i'r boblogaeth i gyd. Mae angen cael gwybodaeth amserol o ansawdd da er mwyn gweld ble mae angen cyflwyno gwelliannau ar bob lefel yn ein systemau; mae hyn yn cynnwys barn y staff a'r cleifion. Mae'r ddyletswydd ansawdd hefyd yn pennu'r disgwyliad hwn, a bydd angen i'r adroddiadau blynyddol sefydliadol gadarnhau sut caiff gwelliannau mewn ansawdd eu gwireddu.

Cyn y pandemig COVID-19, roedd hi'n ofynnol i fyrddau iechyd fynd ati'n flynyddol i gyflwyno'u Cynllun Tymor Canolig Integredig ar gyfer y tair blynedd ganlynol i Lywodraeth Cymru, er mwyn cael cymeradwyaeth Gweinidogol. Yn ystod y pandemig, newidiodd gwaith cynllunio'r GIG gyda ffocws mwy uniongyrchol ar leihau niwed ac ymateb i COVID-19. Dros dro, cafodd Cynlluniau Tymor Canolig Integredig eu disodli gan broses gynllunio chwarterol. Erys GIG Cymru yn system gofal wedi'i gynllunio, ond rhaid i'r broses hon fod yn un ddynamig. Wrth i waith cynllunio tymor hwy, yn cynnwys prosesau Cynlluniau Tymor Canolig Integredig, ailddechrau, dylai sefydliadau'r GIG adeiladu ar yr hyn a ddysgwyd o'u profiad o'r pandemig, er mwyn gwella'u gwaith cynllunio, a sicrhau y bydd ansawdd yn parhau i fod yn hanfodol ym mhopeth a wnânt.

Mae sefydliadau'r GIG yn parhau i ddefnyddio Deddf Llesiant Cenedlaethau'r Dyfodol a'r pum ffordd o weithio fel cyd-destun ar gyfer eu gwaith cynllunio. Fe fydd hyn yn sicrhau y bydd y modd mae sefydliadau'n gweithio, pwy fyddant yn ei gynnwys, a pha benderfyniadau a wneir, yn esgor ar effaith gadarnhaol yn awr ac yn y dyfodol. Rhaid i ansawdd fod yn ganolog i'r penderfyniadau hyn bob amser.

Mae Cymru'n wlad ddwyieithog ac mae'n hollbwysig i'n gwasanaethau iechyd adlewyrchu hyn a datblygu gyda'r egwyddor honno mewn cof. Dylai pobl sy'n defnyddio'r gwasanaeth iechyd a'r staff sy'n gweithio yn y gwasanaeth allu cyfathrebu yn Gymraeg os ydynt yn dymuno.

Cam Gweithredu 8: Dylai sefydliadau'r GIG ddangos trwy gyfrwng eu cynlluniau fod gofal a phrofiad cleifion yn ganolog i'w dull a'u prosesau cyflawni, a bod eu trefniadau llywodraethu'n ategu'r gofyniad hwn.

3.3 Gwella Ansawdd

Ceir tystiolaeth fyd-eang ynglŷn â sut i gefnogi gwelliannau, a rhaid i sefydliadau'r GIG sicrhau bod gan eu staff y sgiliau iawn, y cymorth iawn a'r caniatâd iawn i gyflwyno gwelliannau yn eu gwaith beunyddiol, a bod modd iddynt godi llais pan fydd meysydd i'w gwella y tu hwnt i'w rôl neu eu harbenigedd. Nid digon yw addysgu'r ddamcaniaeth wella i'r gweithlu; mae'r gweithlu angen y gallu i gyflwyno gwelliannau a gwneud hynny yn eu gwaith beunyddiol. Yn yr un modd, os mai'r nod yw esgor ar newid gwirioneddol drawsnewidiol trwy'r holl sefydliad, rhaid i welliannau rheng flaen

McLean, Lynn
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gael eu cydbwyso â nifer o welliannau strategol cynlluniedig sy'n gysylltiedig â blaenoriaethau'r sefydliadau.

Mae'r Sefydliad Iechyd wedi nodi'r angen am ddull sefydliadol o ymdrin â gwella ansawdd. Heb arweinyddiaeth ar lefel y bwrdd, ni fydd gwelliannau yn y system yn llwyddo. Mae hi'n hollbwysig creu'r amodau iawn ar gyfer gwella ansawdd ar bob lefel yn y sefydliad.

Fodd bynnag, efallai na fydd sefydliadau'n hollol gymwys eto i gyflwyno gwelliannau. Rhaid cael cysylltiad cryf rhwng timau cynllunio, mesur a gwella. Mae yna feysydd lle caiff newid effeithiol ei gyflawni, ac mae angen inni ganolbwyntio ar ehangu newid effeithiol ledled Cymru a sicrhau bod pobl yn cael gofal teg.

Mewn ymateb i Cymru Iachach, mae Gwelliant Cymru, sef ein gwasanaeth cenedlaethol ar gyfer cefnogi gwelliannau, yn newid er mwyn cefnogi'r cylch ansawdd ar draws sefydliadau, gan ddefnyddio dull cyson i ledaenu gwelliannau a dysgu. Yn Cymru Iachach, nodir chwe maes allweddol ar gyfer gwella, sef: rheoli meddyginiaethau; llwybrau llawdriniaeth; gofal pobl eiddil oedrannus; salwch acíwt; gwasanaethau iechyd a gofal cymdeithasol teg; a gofal diwedd oes. Er bod ymateb i'r pandemig COVID-19 wedi effeithio ar y cynlluniau hyn, erys y meysydd yn berthnasol ac yn ganolbwynt i Gwelliant Cymru wrth inni ddechrau adfer ar ôl COVID.

Mae angen cynnwys ymddygiadau a sgiliau gwella yng ngwaith pawb sy'n gweithio yn y maes gofal iechyd, er mwyn i'r diwylliant ddatblygu'n ddiwylliant sy'n cynnwys her bersonol a chadarnhaol barhaus o ran sut gallwn wneud pethau'n well. Mae'r profiad personol boddhaol sy'n perthyn i arwain gwelliannau yn meithrin hyder ac yn dechrau creu arweinwyr y dyfodol.

Cam Gweithredu 9: Dylai sefydliadau gofal iechyd sicrhau bod ganddynt y capasiti a'r gallu i wella a dysgu'n barhaus.

3.4 Rheoli Ansawdd

Mae rheoli ansawdd yn digwydd ar reng flaen ein gwasanaethau. Mae angen i bobl sy'n darparu gwasanaethau gytuno ar yr ansawdd y dymunant ei gyrraedd yn y gwasanaethau a ddarperir ganddynt, ynghyd â chynnal a monitro'r ansawdd hwnnw. Hefyd, mae angen iddynt allu canfod achosion pan fydd yr ansawdd hwnnw'n amrywio o'r hyn a ddymunir, ac ymateb i hynny. Mae angen i sefydliadau greu prosesau a diwylliant a fydd yn galluogi'u staff i reoli a safoni eu gwaith beunyddiol. Rhaid galluogi hyn drwy edrych ar y sefydliad o safbwynt systemau, a rhaid cael cyfathrebu a mesurau clir a chyson trwy'r holl sefydliad.

3.5 Sicrhau ansawdd

McLeod,Kathy
11/26/2021 11:38:21

Mae sicrhau ansawdd yn hanfodol er mwyn i fyrddau sefydliadau ddeall ansawdd y gwasanaethau a ddarperir, yn cynnwys gwasanaethau a gomisiynir gan eraill, gweld sut mae'n cymharu ag eraill, a sicrhau bod gwaith gwella (os pennwyd gwaith o'r fath) yn gwneud gwahaniaeth. Gall dull systematig o gynllunio ansawdd, gwella

ansawdd a rheoli ansawdd ddarparu hyn. Yn ogystal â'r rhifau, mae angen i'r broses sicrhau ansawdd gynnwys 'gwybodaeth ansoddol', fel profiadau staff, cleifion a gofalwyr, oherwydd mae'r rhain yn aml yn tynnu sylw at broblemau cyn i'r gwaith mesur wneud hynny. Mae'r Fframwaith Sicrhau Profiadau Defnyddwyr Gwasanaethau yn nodi amrywiaeth o ddulliau y gellir eu defnyddio.

Felly, mae nifer o ffactorau'n cyfrannu at sicrhau ansawdd, yn cynnwys adborth, pryderon a chanmoliaeth cleifion / defnyddwyr, dysgu yn sgil marwolaethau, digwyddiadau yn cynnwys cofnodi digwyddiadau difrifol, archwiliadau clinigol, a dangosyddion ansawdd a meincnodi. Rydym angen system sicrhau ansawdd sy'n dwyn ynghyd wybodaeth am bob agwedd ar y cylch rheoli ansawdd fel y gallwn gael darlun cydlynol o ansawdd y gofal a ddarperir gan sefydliadau.

Er bod gan reoleiddwyr ac arolygwyr ran hollbwysig yn y dasg o sicrhau ansawdd, nid ydynt yn disodli'r angen am fframwaith sicrhau sefydliadol cryf.

Cam Gweithredu 10: Dylid mynd i'r afael â gwaith cenedlaethol ar y cyd â rhanddeiliaid allweddol i ddatblygu Fframwaith Sicrhau Ansawdd er mwyn helpu i grynhoi holl elfennau system rheoli ansawdd. Bydd hyn yn cynnwys diweddaru'r Fframwaith Sicrhau Profiadau Defnyddwyr Gwasanaethau, a bydd yn helpu i baratoi'r ffordd ar gyfer y dyletswyddau ansawdd a gonestrwydd.

3.6 Gwybodaeth drwy gydol y cylch ansawdd

Mae gwybodaeth yn hanfodol i brosesau gwella a sicrhau, a dylai gwybodaeth fod yn gyson ac ar gael yn eang. Mae data amserol yn hollbwysig ar gyfer deall beth sy'n digwydd mewn sefydliadau ar unrhyw adeg, a hefyd ar gyfer ystyried canlyniadau, pennu meysydd i'w gwella a meincnodi. Rhaid i sefydliadau fod yn dryloyw pan ddaw hi'n fater o ddata a rhannu hyn ledled Cymru, gan anelu at wneud gofal yn deg. Bydd yr Adnodd Data Cenedlaethol, sy'n cael ei ddatblygu ar hyn o bryd, yn helpu yn hyn o beth.

Mewn gofal iechyd, caiff gwerth ei wireddu pan fyddwn yn llwyddo i gyflawni'r canlyniadau gofal iechyd gorau posibl ar gyfer ein poblogaeth gyda'r adnoddau sydd gennym wrth law. Dylai'r canlyniadau hyn fod cystal â'r rhai gorau yn y byd, ac eisoes mae Gofal Iechyd Darbodus wedi cynnig sylfaen gref ar gyfer gwella gofal iechyd yng Nghymru. Er mwyn gwireddu gwerth mewn gofal iechyd mae angen gwella'r modd y caiff data canlyniadau ei adrodd a'i gasglu fel y gellir ceisio deall pa ymyriadau sy'n cynnig y gwerth gorau i bobl a ble mae amrywio anesgusodol yn bodoli. Mae hi'n hanfodol inni ddarparu gofal teg sy'n defnyddio dull seiliedig ar dystiolaeth, gan roi canllawiau NICE ar waith er mwyn helpu i sicrhau gofal uchel ei werth.

Mae newidiadau mewn iechyd yn gerrig milltir pwysig ym mywydau cleifion a dylem ddefnyddio Dulliau Mesur Canlyniadau a Gofnodir gan y Claf (PROMs) i'w mesur. Gall hyn ein helpu i asesu a diwallu anghenion cleifion, a deall eu profiad o ofal, a gwella gwasanaethau.

McLennan,Holly
11/26/2021 12:37:12

Mae System Rheoli Pryderon Unwaith i Gymru (OfWCMS) yn ddull newydd a ddefnyddir gan sefydliadau'r GIG yng Nghymru i adrodd, cofnodi, dysgu a monitro

gwelliannau mewn modd cyson yn dilyn digwyddiadau, cwynion, hawliadau ac achosion anffafriol eraill sy'n digwydd mewn gofal iechyd. Trwy ddwyn y data hanfodol hwn i gyd at ei gilydd, mae yna gyfle i gael platfform a fydd yn galluogi dysgu ar y cyd ac a fydd yn helpu i wella diogelwch cleifion yn ogystal â phrofiad cleifion. Er mai dyddiau cynnar yw hi, mae yna bosibilrwydd y bydd modd i sefydliadau iechyd ddefnyddio data gan OfWCMS fel rhan o'u gwybodaeth reoli gyffredinol ynglŷn ag ansawdd, gan bennu meysydd y mae angen cyflwyno gwelliannau ynddynt a helpu i newid y diwylliant.

Mae angen inni ddefnyddio'r wybodaeth sydd ar gael inni ar draws pob agwedd ar ein systemau rheoli ansawdd i fesur ansawdd gofal a chanlyniadau gofal. Gellir ei defnyddio'n lleol ac yn genedlaethol, a bydd modd iddi lywio fframwaith ar gyfer mesur a meincnodi. Rhaid rhoi'r un pwysigrwydd i fesurau ansawdd ag a roddir i fesurau perfformiad a mesurau cyllid, os nad mwy.

Cam Gweithredu 11: Dylid gwneud gwaith yn genedlaethol ac yn lleol i ddatblygu fframwaith mesur ar gyfer llywio system rheoli ansawdd, a ategir gan well gwybodaeth am ansawdd gofal.

3.7 Sicrhau bod system rheoli ansawdd sefydliadol effeithiol ar waith

Mae'r Sefydliad Gwella Gofal Iechyd (IHI) wedi disgrifio fframwaith ar gyfer llywodraethau ansawdd yn effeithiol. Ni welodd y Sefydliad fawr ddim tystiolaeth fod aelodau annibynnol wedi cael eu haddysgu sut i reoli ansawdd yn effeithiol, a phan oedd addysg o'r fath yn bodoli, yn aml roedd yn canolbwyntio ar ddiogelwch cleifion (un elfen yn unig o blith chwe elfen ansawdd gofal iechyd) a hefyd ar ysbytai, yn hytrach nag ar iechyd y gymuned a'r boblogaeth. Er bod y gwaith ymchwil hwn wedi'i seilio ar system gofal iechyd America, mae'n debygol y byddai modd dod o hyd i faterion tebyg yn y GIG.

Dylai sefydliadau'r GIG adolygu'r systemau rheoli ansawdd sydd ganddynt ar hyn o bryd, ac ystyried beth yw eu sefyllfa, a ble mae angen iddynt ddatblygu, er mwyn sicrhau bod eu system rheoli ansawdd mor effeithiol â phosibl.

Cam Gweithredu 12: Dylai sefydliadau'r GIG adolygu ac ystyried yr elfennau y mae angen iddynt fod ar waith er mwyn datblygu system rheoli ansawdd gwbl weithredol, yn cynnwys sicrhau bod y Bwrdd yn meddu ar y sgiliau a'r wybodaeth briodol i arwain y system yn effeithiol.

Cam Gweithredu 13: Dylid gwneud gwaith cenedlaethol i ddatblygu pecyn cymorth y gall sefydliadau ei ddefnyddio i gael sicrwydd ynglŷn â System Rheoli Ansawdd effeithiol.

McLellan Hugh
11/26/2021 12:38:21

4. Gwerthoedd, diwylliant ac arweinyddiaeth

Er mwyn cael system seiliedig ar ansawdd, mae angen i GIG Cymru sicrhau bod y gwerthoedd iawn yn sail i'r sefydliad, a bod diwylliant teg ac arweinyddiaeth dosturiol. Mae angen i GIG Cymru wrando'n weithredol er mwyn deall yn iawn beth yw barn ei staff, y cleifion sy'n defnyddio'r gwasanaethau a'u teuluoedd, a gwneud y gwrando gweithredol hwn yn rhan annatod o'r cylch ansawdd. Mae angen i aelodau'r Bwrdd fod â phresenoldeb yn y gymuned ac mewn ysbytai. Rhaid iddynt fod yn barod i herio ac annog adborth agored gan ddinasyddion ac aelodau o staff ynghylch sut gellir gwella gofal.

Rhaid i arweinwyr ganolbwyntio'n ddiwyro ar bwrpas, gwerthoedd ac ansawdd cyffredin, gan wella'n barhaus a dangos tosturi tuag at bawb. Gall arweinyddiaeth dosturiol – arweinyddiaeth dosturiol ar gyfer gwasanaethau iechyd tosturiol – gynnwys rhoi sylw (i staff); deall (canfod dealltwriaeth gyffredin o'r sefyllfa); dangos empathi; a helpu (cymryd camau craff er mwyn helpu).

Mae Arweinyddiaeth Dosturiol wedi bod yn hollbwysig yn ystod y pandemig. Mae gweithwyr gofal iechyd wedi wynebu pwysau na welwyd mo'i debyg erioed o'r blaen, o ran y perygl a'r ofn o ddal COVID-19 yn y gweithle ond hefyd o ran y dymuniad i gynnig y gofal gorau posibl i gleifion mewn amgylchiadau anodd. Nid yw arweinyddiaeth gref erioed wedi bod yn bwysicach, ac yn awr mae angen parhau â'r arweinyddiaeth hon, gan gael pawb i gyfrannu ati.

Mae diwylliant agored o ddysgu a gwella yn hanfodol. Mae angen inni ddathlu'r pethau a aiff yn dda a chydnabod y gofal a'r gwasanaethau gwirioneddol anhygoel y mae holl staff gofal iechyd Cymru yn eu darparu.

Fodd bynnag, pan fydd rhywbeth yn methu neu'n mynd o'i le, rhaid i'r staff deimlo'n ddiogel, teimlo eu bod yn cael eu cefnogi, a theimlo bod modd iddynt gael dweud eu dweud ynglŷn â'r mater, gan fod yn hyderus y bydd rhywun yn gwrando arnynt. Os crybwyllir pryderon ynglŷn ag ansawdd gofal, mae angen i rywun wrando arnynt, eu cydnabod, a gweithredu yn eu cylch. Mae angen i staff y GIG wybod bod pryderon yn cael eu cymryd o ddifrif – yn wir, cânt eu croesawu. Pan fo sefydliad yn agored ac yn onest, mae'r staff yn teimlo bod modd iddynt grybwyll pryderon a rhoi camau gwella ar waith. Nid oes yr un gwasanaeth iechyd yn berffaith, a rhaid cydnabod hyn er mwyn teimlo'n hyderus mewn gwasanaeth sy'n gwella'n barhaus. Bydd cyflwyno'r ddyletswydd gonestrwydd yn ategu hyn.

Pan fydd camgymeriadau'n digwydd, dylid ymchwilio iddynt er mwyn deall sut methodd y system, gan gymryd camau'n ddi-oed i rwystro'r perygl rhag digwydd eto. Ni ddylai'r dull hwn fynd ati i fwrw bai. Hyd yn oed os mai camgymeriad gan unigolyn a arweiniodd at y cam allweddol, bydd amryfal gamau wedi cyfrannu ato, a rhaid deall y rhain. Mae angen rhoi cymorth digonol i'r claf a'i anwyliaid, ond hefyd i'r staff dan sylw er mwyn iddynt wybod eu bod yn parhau i gael eu gwerthfawrogi a'u cefnogi trwy unrhyw ymchwiliad. Mae amgylchedd cosbol yn rhwystr pwerus i fyfyrio teg a dilys. Mae diwylliant teg sy'n dysgu yn cydbwyso tegwch, cyfiawnder a dysgu gyda chyfrifoldeb ac atebolrwydd.

McLellan-Hall
11/26/2024 2:12:38 PM

Ymhellach, mae angen annog cleifion i godi llais pan aiff pethau o'u lle, gan wybod y bydd rhywun yn gwrando ar eu pryderon a'u profiadau yn hytrach na'u diystyru. Mae hyn yn hanfodol mewn system sy'n dysgu yng ngwir ystyr y gair.

Mae angen i'r gweithlu cyfan gyfrannu' llawn at yr angen i wella. Mae lles personol yn un o'r gofynion sylfaenol yn hyn o beth. Os bydd aelodau o staff wedi ymlâdd neu wedi ymddieithrio oddi wrth y sefydliad, yn anochel fe fydd y dasg o wella'r gwasanaeth yn llithro; ond os rhoddir blaenoriaeth i les, bydd gofal cleifion yn fwy diogel ac yn cyrraedd ansawdd gwell, a bydd y gwasanaeth yn gwella'n barhaus.

Bydd gweithredu'r pwyntiau a nodir yn strategaeth gweithlu AaGIC, Cymru Iachach: Strategaeth Gweithlu ar gyfer Iechyd a Gofal Cymdeithasol, yn helpu sefydliadau i ymdrin â phrinder staff trwy wella'u gallu i ddal gafael ar eu staff a hefyd trwy wella'r broses recriwtio. Nod y Strategaeth yw cyfoethogi lles a phrofiad gweithio'r rhai sy'n darparu gwasanaethau iechyd a gofal cymdeithasol ar hyn o bryd, yn cynnwys gwirfoddolwyr a gofalwyr, a hyrwyddo iechyd a gofal cymdeithasol fel y sector o ddewis i weithlu'r dyfodol. Y nod cyffredinol ar gyfer 2030 yw darparu'r nifer priodol o bobl fedrus, ddynamig a llawn cymhelliant i helpu i ddiwallu anghenion gofal iechyd y boblogaeth a wasanaethant mewn modd cynaliadwy a chost-effeithiol.

Yn y pen draw, mae ansawdd yn fater i bawb, ac mae angen rhoi dull amlddisgyblaethol ar waith yn lleol ac yn genedlaethol. Rhaid ymwreiddio'r cysyniad hwn yn niwylliant ein gweithlu, gan ddeall a gwella ansawdd y gofal a ddarparwn.

Cam Gweithredu 14: Dylai sefydliadau iechyd ennyn diddordeb eu gweithlu yn yr agenda gofal a grymuso pawb i gymryd rhan er mwyn helpu i wneud y GIG yng Nghymru yn system sy'n cael ei harwain gan ansawdd.

5. Atebolrwydd

Er mwyn i'r GIG ddatblygu ar hyd ei siwrnai ansawdd, mae'n ofynnol cael atebolrwydd cryf ar gyfer pob agwedd ar y system rheoli ansawdd, yn ogystal â thrwy'r fframwaith sicrhau ansawdd, gan roi cymaint o sylw i ansawdd ag a roddir i berfformiad a chyllid. Bydd y strwythurau atebolrwydd yn cryfhau ar ôl creu swyddogaeth Gweithrediaeth y GIG, gan sicrhau y ceir ffocws cryf ar ansawdd bob amser.

Mae angen inni sicrhau y bydd unrhyw ddata a ddaw i law, boed hynny trwy archwiliadau clinigol, adolygiadau gan gymheiriaid neu gamgymeriadau mewn gofal iechyd, yn cael ei ddefnyddio i ysgogi newid er gwell. Mae angen dal y GIG i gyfrif er mwyn sicrhau bod newid yn digwydd ac y bydd data'n arwain at ganlyniadau ystyrlon a gwell i'n poblogaeth.

McLeod, Holly
11/26/2021 12:38:00

6. Edrych tua'r dyfodol

Mae angen i ansawdd fod yn fater i bawb gydag arweinyddiaeth gref trwy'r holl GIG yng Nghymru. Man cychwyn y cam nesaf ar y siwrnai ansawdd yw'r camau

gweithredu cyffredinol a nodir yn y fframwaith hwn, a bydd y dasg o weithredu'r dyletswyddau ansawdd a gonestrwydd yn adeiladu ar y camau hyn ac yn helpu i sicrhau bod gennym system rheoli ansawdd effeithiol ar bob lefel yng Nghymru. Yn awr, mae angen i sefydliadau ystyried sut i weithredu a gwella'r system rheoli ansawdd, yn arbennig yng ngoleuni'r pandemig, a chyflymu ein siwrnai.

I hwyluso hyn, mae angen adolygu strwythurau sicrhau ansawdd cenedlaethol sydd eisoes yn bodoli er mwyn sicrhau bod dulliau cadarn ar gyfer llywodraethu ansawdd a diogelwch, ac er mwyn ysgogi'r GIG ar hyd ei siwrnai.

Cam Gweithredu 15: Bydd rhaglen Ansawdd a Diogelwch yn cael ei sefydlu i fwrw ymlaen â'r camau gweithredu cenedlaethol a nodir yn y Fframwaith hwn. Bydd Bwrdd Ansawdd a Diogelwch newydd, a hwylusir gan swyddogaeth Gweithrediaeth y GIG, yn goruchwylio'r rhaglen hon. Bydd y bwrdd hwn yn mynd ati i ysgogi'r agenda ansawdd a diogelwch a bydd yn cael ei arwain mewn partneriaeth â'r GIG. Bydd ganddo ddull amlddisgyblaethol a bydd grwpiau proffesiynol gwahanol yn cymryd rhan ynddo.

Mae'r pandemig COVID-19 wedi dangos bod gennym wasanaeth iechyd anhygoel yng Nghymru, a gweithlu y gallwn ymfalchïo'n fawr ynddo. Mae llawer o heriau o'n blaenau o hyd. Bydd dull cenedlaethol o ymdrin â rheoli ansawdd, gydag ymrwymiad uwch dan y ddyletswydd ansawdd newydd, yn annog y GIG yng Nghymru ar hyd ei siwrnai tuag at ddod yn system sy'n wirioneddol seiliedig ar ansawdd, gan ddarparu'r gofal gorau i bobl Cymru.

McLellan,Holly
11/26/2021 12:38:21

Crynodeb o'r Camau Gweithredu

Cam Gweithredu 1: Dylai sefydliadau'r GIG sicrhau bod y niwed (uniongyrchol yn ogystal ag anuniongyrchol) sy'n gysylltiedig â'r pandemig COVID-19 yn cael ei leihau. Dylai sefydliadau weithredu dull sy'n canolbwyntio ar risgiau a buddion wrth adfer gwasanaethau eraill, gan fesur, monitro a dysgu yn sgil unrhyw niwed.

Cam Gweithredu 2: Dylai Llywodraeth Cymru weithio gyda rhanddeiliaid allweddol i adolygu a diweddaru'r safonau Iechyd a Gofal, gan adlewyrchu'r ddyletswydd ansawdd gryfach.

Cam Gweithredu 3: Dylai Llywodraeth Cymru weithio gyda rhanddeiliaid allweddol ar roi'r dyletswyddau ansawdd a gonestrwydd ar waith er mwyn galluogi sefydliadau'r GIG i ymbaratoi erbyn y daw'r dyletswyddau i rym.

Cam Gweithredu 4: Dylai Llywodraeth Cymru weithio gyda rhanddeiliaid i ddatblygu fframwaith Cofnodi Digwyddiadau Cenedlaethol newydd sy'n canolbwyntio ar gynyddu a rhannu'r hyn a ddysgir yn sgil digwyddiadau.

Cam Gweithredu 5: Dylid mynd i'r afael â gwaith cenedlaethol i ddatblygu fframwaith 'dysgu o farwolaethau', gan adeiladu ar y gwaith parhaus o gyflwyno'r Gwasanaeth Archwilwyr Meddygol drwy'r wlad ynghyd â'r prosesau sydd eisoes ar waith ar gyfer adolygu marwolaethau.

Cam Gweithredu 6: Dylid mynd i'r afael â gwaith cenedlaethol i arwain dull gwella Cymru gyfan er mwyn gwneud y gorau o'r cyfleoedd i ddysgu yn sgil adolygiadau annibynnol o wasanaethau mamolaeth a newyddenedigol.

Cam Gweithredu 7: Dylai Llywodraeth Cymru weithio gyda sefydliadau'r GIG i roi systemau electronig anhepgor ar waith i ategu gofal diogel, megis Systemau Electronig ar gyfer Rhagnodi a Gweinyddu Meddyginiaethau, Sganio er Diogelwch a'r System Wybodaeth ar gyfer Dyfeisiau Meddygol.

Cam Gweithredu 8: Dylai sefydliadau'r GIG ddangos trwy gyfrwng eu cynlluniau fod gofal a phrofiad cleifion yn ganolog i'w dull a'u prosesau cyflawni, a bod eu trefniadau llywodraethu'n ategu'r gofyniad hwn.

Cam Gweithredu 9: Dylai sefydliadau gofal iechyd sicrhau bod ganddynt y capasiti a'r gallu i wella a dysgu'n barhaus.

Cam Gweithredu 10: Dylid mynd i'r afael â gwaith cenedlaethol ar y cyd â rhanddeiliaid allweddol i ddatblygu Fframwaith Sicrhau Ansawdd er mwyn helpu i grynhoi holl elfennau system rheoli ansawdd. Bydd hyn yn cynnwys diweddaru'r Fframwaith Sicrhau Profiadau Defnyddwyr Gwasanaethau, a bydd yn helpu i baratoi'r ffordd ar gyfer y dyletswyddau ansawdd a gonestrwydd.

McLellan, Hywy
11/26/2021 10:38:21

Cam Gweithredu 11: Dylid gwneud gwaith yn genedlaethol ac yn lleol i ddatblygu fframwaith mesur ar gyfer llywio system rheoli ansawdd, a ategir gan well gwybodaeth am ansawdd gofal.

Cam Gweithredu 12: Dylai sefydliadau'r GIG adolygu ac ystyried yr elfennau y mae angen iddynt fod ar waith er mwyn datblygu system rheoli ansawdd gwbl weithredol, yn cynnwys sicrhau bod y Bwrdd yn meddu ar y sgiliau a'r wybodaeth briodol i arwain y system yn effeithiol.

Cam Gweithredu 13: Dylid gwneud gwaith cenedlaethol i ddatblygu pecyn cymorth y gall sefydliadau ei ddefnyddio i gael sicrwydd ynglŷn â System Rheoli Ansawdd effeithiol.

Cam Gweithredu 14: Dylai sefydliadau iechyd ennyn diddordeb eu gweithlu yn yr agenda gofal a grymuso pawb i gymryd rhan er mwyn helpu i wneud y GIG yng Nghymru yn system sy'n cael ei harwain gan ansawdd.

Cam Gweithredu 15: Bydd rhaglen Ansawdd a Diogelwch yn cael ei sefydlu i fwrw ymlaen â'r camau gweithredu cenedlaethol a nodir yn y Fframwaith hwn. Bydd Bwrdd Ansawdd a Diogelwch newydd, a hwylusir gan swyddogaeth Gweithrediaeth y GIG, yn goruchwylio'r rhaglen hon. Bydd y bwrdd hwn yn mynd ati i ysgogi'r agenda ansawdd a diogelwch a bydd yn cael ei arwain mewn partneriaeth â'r GIG. Bydd ganddo ddull amlddisgyblaethol a bydd grwpiau proffesiynol gwahanol yn cymryd rhan ynddo.

McLellan,Holly
11/26/2021 12:38:21

WHC 2021/022

WELSH HEALTH CIRCULAR

Llywodraeth Cymru
Welsh Government

sue Date: 17/09/2021

STATUS: COMPLIANCE / ACTION / INFORMATION

CATEGORY: QUALITY & SAFETY

Title: Publication of the Quality and Safety Framework

Date of Expiry / Review N/A

For Action by:
Chief Executives
All NHS Health and Care Staff

Action required by:
Local action to improve the quality and safety of atient care to link with the National Programme and meet the requirement of the Duty of Quality coming into force in April 2023.

Sender: Professor Chris Jones, Deputy Chief Medical Officer

HSSG Welsh Government Contact(s) :
atherine Bridges, Healthcare Quality Development, Population Healthcare, Welsh Government – 03000 256427
catherine.bridges@gov.wales

McLellan,Holly
11/26/2021 12:38:21

Enclosure(s): Letter from Prof Chris Jones

Professor Chris Jones
Dirprwy Brif Swyddog Meddygol
Deputy Chief Medical Officer

Llywodraeth Cymru
Welsh Government

Chief Executive Officers, LHBs and NHS Trusts
All Health and Care Staff, LHBs and NHS Trusts

17 September 2021

Dear Colleagues

A Heathier Wales was published in 2018 and set out the ten-year vision for health and social care in Wales, with quality and safety of care the primary focus in the provision of healthcare across Wales. The *Quality and Safety Framework* now published will be a key driver to ensure quality and safety is firmly placed at the heart of NHS healthcare provision, from community care right through to acute services.

This *Quality and Safety Framework* requires services to be built on the foundations of a robust quality management system, which continuously connects quality assurance, planning and improvement. The COVID-19 pandemic presents the NHS with a far greater challenge to adapt and improve services already significantly altered during the height of the pandemic, while remaining focused on meeting the quadruple aim within *A Healthier Wales*.

It sets the direction for implementation of the *Health and Social Care (Quality and Engagement) (Wales) Act,* with particular emphasis on the duties of quality and candour, which come into force from April 2023. The Framework facilitates organisations' preparedness for the Act.

Can you please share this Framework, link attached below, with all health and care staff within your organisations and continue to embed the ethos of good quality, safe care above all else.

https://gov.wales/nhs-quality-and-safety-framework

McLellan,Holly
11/26/2021 12:38:2

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Further information will be shared about the National Programme and what this will mean in practice once the purpose, function and membership of the Quality and Safety Programme Board has been worked through in more detail.

Yours sincerely

PROFESSOR CHRIS JONES

McLellan, Holly
11/26/2021 12:38:2

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

Agenda item: 3.2

Patient Experience, Quality and Safety Committee	**Date of Meeting: 2 December 2021**
Subject :	**Primary Care quality governance arrangements in GMS, GDS and Pharmacy**
Approved and Presented by:	Jamie Marchant, Executive Director of Primary, Community Care and Mental Health
Prepared by:	Jayne Lawrence, Assistant Director or Primary Care/Jacqui Seaton, Chief Pharmacist
Other Committees and meetings considered at:	Executive Committee 17 November 2021

PURPOSE:		
The purpose of this paper is to provide an update on the Primary Care quality governance arrangements across independent contractors.		
RECOMMENDATION:		
The Patient Experience, Quality & Safety (PEQS) Committee is asked to DISCUSS and NOTE the report.		
Approval/Ratification/Decision	**Discussion**	**Information**
✘	✓	✓

McLellan,Holly
11/26/2021 12:38:21

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 monitoring and assurance of the delivery of General Medical Services (GMS) and General Dental Services (GDS) across PTHB is pulled together via the PTHB Commissioning Assurance Framework (CAF).

The overarching principles of the CAF for both GMS and GDS are the same and provide a continuous holistic assurance process that PTHB is effectively commissioning safe, high-quality and sustainable primary care services.

The assurance captured is cumulative and takes place throughout the year in line with contractual and non-contractual trigger points which are monitored by the Primary Care Team.

CAF dashboards are in place for all GDS and GMS contracts and exceptions linking to an agreed CAF RAG rating are actioned appropriately. It is important to note that the elements in the CAF that link to the regulations are the only enforceable contractual levers the health board can progress.

An annual CAF summary Report is presented to the Delivery & Performance Committee and these are scheduled to be presented to the Delivery and Performance Committee in December.

Community Pharmacy does not have a CAF in place at this point. Community Pharmacy contractors operate in line with a contractual framework, as set out in the NHS (Pharmaceutical Services) (Wales) Regulations 2020. This national framework is currently being revised, with a new one expected to be phased in from April 2022.

McLellan,Kay
11/26/2021 11:38:21

Assurance of compliance with contractual requirements is gained through online toolkits, contract management visits and access to national information relating to the provision of enhanced and advanced services.

Optometry services are not contracted in the same way as the other three contractors at this stage, however national Optometry Contract Reform is currently ongoing and expected to be phased in from April 2022 onwards over a three year period – this will inform future contract monitoring requirements.

DETAILED BACKGROUND AND ASSESSMENT:

The Primary Care CAF (GDS and GMS) offers an assurance framework in the following five key areas:

- ✓ Access to Care
- ✓ Quality and Safety
- ✓ Finance & Activity
- ✓ Patient Experience
- ✓ Governance and regulation

The broad principles which underpin both the GMS and GDS CAF include providing confidence on

- primary care commissioned services, from a safe and sustainable perspective
- the delivery of services within the respective regulations and contracts

The assurance captured is cumulative and takes place throughout the year in line with contractual and non-contractual trigger points which are monitored by the Primary Care Team. Further detail on each contractor profession monitoring arrangements is below.

In reviewing the CAF there is a need to be open minded in understanding the reasons for variation and, where a problem is found, clear on the consequences and actions that need to be taken. It is important to note that the elements in the CAF that link to the regulations are the only enforceable contractual levers the health board has. However, all the components of the CAF need to be considered as they provide a holistic measure of assurance to PTHB.

GDS

The GDS CAF monitors general dental services contracts only. Dental Services contracts between health boards and general dental service providers are delivered within the National Health Service (General Dental Services Contracts) (Wales) Regulations 2006. These Regulations set out, for Wales, the framework for general dental services contracts under section 28K of the National Health Service Act 1977. The regulations are enforceable. Parameters not covered within the regulations are not enforceable.

The GDS CAF was agreed by the PTHB Strategic Planning and Commissioning Group in January 2019. To support the CAF, tolerance levels to report against the CAF are linked to RAG ratings.

McLellan,Kelly
11/26/2021 11:38:21

The CAF is updated on a monthly basis and internal assurance is delivered through the General Dental Services Monitoring Meetings which provide the opportunity for key people to meet on a monthly basis to look at dental data. The meeting will usually comprise of representatives from dental, primary care and finance who consider and review key information relating to each of the GDS dental providers within Powys. The meeting is chaired by the Assistant Director for Primary Care and the Associate Dental Director is also in attendance (Appendix 1 GDS Monitoring Group TOR).

CAF dashboards are in place for all GDS contracts and exceptions linking to the agreed CAF RAG rating are actioned appropriately. The assurance on the delivery of GDS is summative and takes place throughout the year as ongoing data is reviewed and regular dialogue takes place with contractors as necessary. If a problem is found, the GDS Monitoring Group is clear on the consequences and actions that need to be taken.

The data and discussion enables the GDS Monitoring Group to form conclusions on whether there are any areas of concern and whether to 'step up' or 'step down' the Escalation Process within the CAF.

There are two pivotal reporting timelines within the GDS CAF, linked to the regulations which can enable contract sanctions to be progressed if appropriate, namely the mid-year (30th September) and end of year (30th June) review process. Other measures within the CAF are measures to provide assurance on the delivery of services, as opposed to contract levers. It is important to note that only the CAF indicators linked to the regulations are enforceable and that parameters within the CAF not covered within the regulations are not enforceable.

Due to the pandemic, national contract changes have been introduced around various aspects of the delivery of dental services. These are not changes in legislation, however have been developed by Welsh Government from pre-covid contract reform initiatives. Therefore, the various assurance components within the CAF have had to be adapted to reflect current contract and commissioning expectations. As WG introduce new/additional metrics into the contract this is reflected in the CAF. Currently for GDS 2021/2022 contract assurance the CAF continues to be an evolving document.

The current assurance components of the CAF are as follows:

*Quality & Safety	Finance (Cost & Activity)	Access	Patient Experience
▪ Compliance with NHS Wales General Dental Services Regulations 2006 ▪ Compliance with Dental Performer Regulations	▪ Cost against the contract ▪ Activity against the contract (linked to Dental Assurance	▪ Patient access ▪ Open lists ▪ Recruitment issues	▪ Public service ombudsman responses ▪ Health Inspectorate Wales (HIW) reports

McLellan,Holly
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▪ Quality Assurance Self-Assessment ▪ Serious incidents (including themes) ▪ Complaints and claims ▪ Internal / External Audit ▪ Health Inspectorate Wales (HIW) reports ▪ Dental Assurance Framework ** ▪ Occupational Health status reports ▪ Clinical Record Card Reviews	Framework metrics**) ▪ Mid-Year Contract Review ▪ End of Year Contract Review		▪ Community Health Council Reports ▪ Concerns and compliments from any source ▪ Patient Experience performance, e.g. survey (currently suspended due to pandemic)

APPENDIX 2 General Dental Services Commissioning Assurance Framework Document

Appendix 3 General Dental Services Commissioning Assurance Framework tolerance levels

An annual GDS CAF summary Report is presented to the Delivery & Performance Committee. This would normally be in Q2 but this will be presented to the Committee in December 2021. Routinely final contract achievement data for the GDS financial year is not published until mid-June. The delay in presentation of the CAF to committee is due to the evolving change in contract metrics and delays in reporting.

GMS

General Medical Service contracts between health boards and general medical service providers are delivered within the National Health Service (General medical services Contracts) (Wales) Regulations 2004. These Regulations set out, for Wales, the framework for general medical services contracts under section 28K of the National Health Service Act 1977. The regulations are enforceable. Parameters not covered within the regulations are not enforceable.

The General Medical Services (GMS) Commissioning Assurance Framework (CAF) was developed following an internal audit on the Commissioning of Primary Care Services and was signed off by the Strategic Planning and Commissioning Group on 09/05/2019.

McLellan,Holly
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Reporting against the GMS CAF commenced during mid quarter 3 of 19/20 but was suspended due to the impact of the COVID-19 pandemic and the contract relaxation measures introduced by Welsh Government. Efforts were instead focussed on ensuring General Medical Services core contract delivery of essential services. To support the CAF, tolerance levels to report against the CAF are linked to RAG ratings.

The current assurance components of the CAF are as follows:

*Quality & Safety	Finance (Cost & Activity)	Access	Patient Experience
▪ Compliance with NHS Wales General medical services Regulations 2004 ▪ Compliance with GP Performer Regulations ▪ Clinical governance self-assessment ▪ Serious incidents (including themes) ▪ Complaints and claims ▪ Internal / External Audit ▪ Health Inspectorate Wales (HIW) reports ▪ Enhanced Service audits ▪ National audits (Diabetes/ COPD/CKD) ▪ GMS annual contract returns ▪ Information Governance self-assessment ▪ Childhood immunisations targets ▪ Flu immunisations targets ▪ Quality Assurance Improvement Framework achievement ▪ Local primary care performance measures ▪ National Prescribing indicators (linked to finance) ▪ Outpatient referral rates(linked to finance) ▪ Inpatient Admission rates(linked to finance)	▪ Post payment verification reports	▪ Access Standards ▪ Opening hours ▪ Appointment availability ▪ Open lists ▪ Recruitment issues ▪ Unscheduled care hospital admission rates	▪ Public service ombudsman responses ▪ Health Inspectorate Wales (HIW) reports ▪ Community Health Council Reports ▪ Concerns and compliments from any source ▪ Patient Experience performance, e.g. survey
Sustainability Status			

APPENDIX 4 General Medical Services Commissioning Assurance Framework Document

Appendix 5 General Medical Services Commissioning Assurance Framework tolerance levels

The CAF is updated on a quarterly basis and internal assurance is delivered through the GMS Contract Management Group. The meeting is chaired by the Assistant Director for Primary Care and the Assistant Medical Director is also in attendance. Appendix 6 GMS Contract Management Group Terms of Reference.

CAF dashboards are in place for all GMS contracts and exceptions linking to the agreed CAF RAG rating are actioned appropriately. The assurance on the delivery of GMS takes place throughout the year as ongoing data is reviewed and regular dialogue takes place with contractors as necessary. If a problem is found, the Primary Care Contract Management Team progress resolution with the practice.

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The data and discussion enables the Primary Care Team to form conclusions on whether there are any areas of concern and whether to 'step up' or 'step down' the Escalation Process within the CAF.

The annual GMS CAF summary Report will be presented to the Delivery & Performance Committee in December. Final achievement data relating to the Quality Assurance Improvement Framework is reported at 30th September and not published for health board sign off until November; therefore, the CAF review process relating to a financial year cannot be completed until then.

Community Pharmacy

Community pharmacy contractors are required, as part of their clinical governance requirements, to complete an online information governance and information security toolkit before the end of each financial year. This toolkit is used by the health board to identify any areas of concern/potential concern.

In addition to the toolkit the health board has a process in place to monitor contractual compliance, this consists of contract management visits (every 2 years) and additional visits when considered necessary. There is also a process in place to review concerns and complaints relating to pharmacy contractors and ensure that appropriate action is taken.

The health board has access to, and receives regular updates on contractors' provision of enhanced and advanced services. This information is used to support discussions during contract management visits and also to identify good practice and opportunities for improvement.

Optometry

Currently Optometry does not have a contract and payments for the delivery of General Ophthalmic Services (GOS) are reimbursed to Optometrists on an 'item for service' (IOS) basis. This mainly relates to eye test claims and are paid from a non-cash limited budget. There is no performance data linked to the completion of a GOS claim.

Currently Optometrists can also offer enhanced services relating to Eye Health Examination Wales Service (EHEW) and the Low Vision Wales Service (LWSW). Both these enhanced services are paid on an IOS basis also.

National Optometry Contract Reform is currently ongoing and expected to be phased in from April 2022 onwards over a three year period. The contract will deliver a more healthcare focussed model through various levels of service which will require contractual monitoring. Following contract finalisation, Primary Care will be able to assess the contract monitoring requirements.

NEXT STEPS

1) Present GDS and GMS year end of year CAF report in December 2021 to the Delivery and Performance Committee

McLellan, Holly
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2) Consider Optometry Contract Reform contract monitoring requirements in readiness for contract implementation.

RECOMMENDATION

The Patient Experience, Quality & Safety (PEQS) Committee is asked to DISCUSS and NOTE the report.

Appendix 1 GDS Monitoring Group TOR

20160610 FINAL GDS Terms of Refere

Appendix 2 General Dental Services Commissioning Assurance Framework Document

PTHB Commissioning Assu

Appendix 3 General Dental Services Commissioning Assurance Framework tolerance levels

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Appendix 4 General Medical Services Commissioning Assurance Framework Document

PTHB Commisiong Assurance Framewo

Appendix 5 General Medical Services Commissioning Assurance Framework tolerance levels

GMS CAF Tolerance Levels updated Nov

Appendix 6 GMS Contract Management Group TOR

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GMS Contract Management Group

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

Agenda item: 3.3

Patient Experience, Quality and Safety Committee	**2 December 2021**
Subject :	**Quality Report for Q2 for Service Groups within Director of Primary Care, Community and Mental Health**
Approved and Presented by:	Jamie Marchant, Executive Director, Primary Care, Community and Mental Health Services
Prepared by:	Jamie Marchant, Executive Director, Primary Care, Community and Mental Health Services (DPCCMH)
Other Committees and meetings considered at:	The papers attached from the 3 service groups were considered within the DPCCMH Directorate Management Team on 19th October 2021.

PURPOSE:		
The purpose of this report is to provide the Committee with a summary of patient quality and safety metrics across three service groups within the DPCCMH Directorate. This report consolidates information across these three groups for the period up to September 2021		
RECOMMENDATION:		
The Committee is asked to DISCUSS and NOTE the contents of the paper.		
Approval/Ratification/Decision	**Discussion**	**Information**
×	✓	x

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11/26/2021 12:38:21

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

EXECUTIVE SUMMARY:

This report consolidates information across these three groups for the period upto September 2021. Following on from the report to Committee in October 2021 this is the second report produced by the Service Groups.

The reports are provided as attachments to this paper for ease of review. The standard rule of presenting some low numbers as <5 has been used in some cases but the reports do contain small numbers where the view is that cannot lead to identifying the patient.

During the discussions at Committee of the previous report, whilst the report was greatly welcomed for the level of detail, the Director was asked to summarise any specific issues or positive notes from the 3 service groups. There are a lot of positive aspects to the report but also some specific challenges;

Whilst formal reporting of Delayed Transfers of Care is suspended nationally, the issue of patient delays remains. The level of delays due to challenges in the care home and domiciliary care sector is at its highest level for a number of years and is having a demonstrable impact within the Powys wards, both community and mental health wards. This is impacting on patient length of stay and has inherent risks for patients in terms of issues such as deconditioning associated with longer lengths of stay.

There is a focus on this area within the winter and system resilience plans of the health board, with partners, to radically reduce this in the coming weeks.

Maellan Hollis 12/26/2021 12:08:21

Whilst these reports show improved performance in waiting time positions, which is a fundamental quality and experience issue for patients, services are still facing workforce challenges. Some services have seen a reduction in waiting time performance in recent months associated with short term and unplanned staff absences. Services will continue to manage these issues closely but specific examples within these reports include Child and Adolescent Mental Health Services (CAMHS) as well as small deterioration in a number of therapy services.

The challenge of workforce availability is a key context to the aforementioned delays on wards. A higher level of bed occupancy due to delays with increased patient demands does place a pressure on staffing and an increased use of bank and agency to ensure appropriate cover of wards. This is a specific demand for registered nurses.

A key priority for the Women and Childrens service group remains the improvement in access to neuro-developmental (ND) services. Through the health board's renewal priority of children and young person investment has been provided to recruit additional posts to improve this position.

The Mental Health report provides a summary of the use of restrictive powers but a specific report on the Mental Health Act is being presented to this Committee meeting. At the October committee, members asked for additional information relating to Learning Disability services. Whilst the Q2 report does include more information, there is additional capacity at a Head of Nursing for LD level whose priorities will include development of this area.

The Committee is also receiving a separate paper on the processes for monitoring quality across primary care contractors at meeting of 2nd December 2021.

The Audit Wales' "Review of PTHB's Quality Governance Arrangements" is being considered at this Committee meeting and may have implications for the future format and contents of this DPCCMH report as the potential to develop Commissioning Assurance Frameworks (CAFs) for Community Services and Childrens services will be considered. The Committee is to note that CAFs are already in place for maternity and mental health/learning disabilities services.

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

Agenda item: 3.3a

Patient Experience, Quality and Safety Committee	**Date of Meeting: 2 December 2021**
Subject:	**CSG Quality Governance Paper Q2 2021**
Approved and Presented by:	**Jason Crowl Assistant Director of Community Services**
Prepared by:	**Lynda Mathias, Lead Clinician Quality and Safety, Community Services Group**
Other Committees and meetings considered at:	

PURPOSE:
To provide an overview of Quality and Governance activity within the Community Service Group from July to September 2021.
RECOMMENDATION(S):
NOTE and ACCEPT the actions taken to date.

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	✖

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

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

EXECUTIVE SUMMARY:

This report expands on the report presented for Q1 to the PEQS Committee in October 2021, outlining the position relevant to Q2.

The Community Service Group 2021/22 Priority Quality Metrics are aligned against the organisational goals and are used as a basis in which to report and provide an update on Quality and Governance activity within the Group.
The following Quality Metrics will be discussed within this paper:

- Update on the work of the CSG Quality and Patient Experience Group
- Hospital Acquired Pressure Ulcers
- Inpatient Falls
- Infection Prevention and Control (IPC) data
- Patient Experience Report
- Updates on audits reported, presented through Learning Groups
- Health Inspectorate Wales (HIW) and Care Inspectorate Wales (CIW) inspections
- Elective Waiting Times, including Therapies and Diagnostics
- Delayed Transfers of Care (DTOC)
- Serious Incident Report, themes
- Complaints received, themes and response times
- Lessons learned

Due to the change over from Datix to the Once for Wales System some data has not been made available at the time the report was produced.

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DETAILED BACKGROUND AND ASSESSMENT:

Hospital Acquired Pressure Ulcers

		Q1			Q2		
Indicator		**Apr 21**	**May 21**	**Jun 21**	**Jul 21**	**Aug 21**	
Stage I	Hospital	0	1	1	0	1	
	Outside Hospital	3	5	6	3	1	
	Total	**3**	**6**	**7**	**3**	**2**	
Stage II	Hospital	7	11	8	7	12	
	Outside Hospital	15	14	16	18	21	
	Total	**22**	**25**	**24**	**25**	**33**	
Stage III	Hospital	1	1	2	0	1	
	Outside Hospital	1	1	2	0	0	
	Total	**2**	**2**	**4**	**0**	**1**	
Stage IV	Hospital	0	0	0	1	1	
	Outside Hospital	0	0	0	0	0	
	Total	**0**	**0**	**0**	**1**	**1**	
Unstageable	Hospital	0	1	2	0	1	
	Outside Hospital	3	3	2	0	2	
	Total	**3**	**4**	**4**	**0**	**3**	
Suspected Deep Tissue Injury	Hospital	0	2	2	1	1	
	Outside Hospital	7	5	7	12	4	
	Total	**7**	**7**	**9**	**13**	**5**	
Total instances of healthcare acquired pressure ulcers	Hospital	8	16	15	9	17	
	Outside Hospital	29	28	33	33	28	
	TOTAL	**37**	**44**	**48**	**42**	**45**	

Monthly Incidence of Pressure Ulcers for Hospital and Outside Hospital *Data source DATIX Team

Due to ongoing work establishing dashboards for the new reporting system the data for September is not yet available at the time of reporting however between July and August 2021, PTHB recorded 87 reports of Pressure Ulcers. This shows reporting remains consistent with previous months. 26 reports were from within hospital and 61 from outside of hospital. The largest category reported remains Stage II pressure damage. The data provided is all that is currently available from the DATIX team and will have different inclusion criteria from the data provided in the last Quality Governance report as it does not indicate the hospital site or where the pressure damage was acquired.

In patient Falls

A total of 82 falls were reported on DATIX between 1 July to 30 Sept 2021. This compares with a total of 76 falls reported in Q1.

	Q1			Q2		
Area	**Apr 21**	**May 21**	**Jun 21**	**July 21**	**Aug 21**	**Sept 21**
North	-	-	-	22	11	12
Mid	-	-	-	1	4	2
South	-	-	-	17	7	6

McLellan, Kelly 11/26/2021 12:34:21

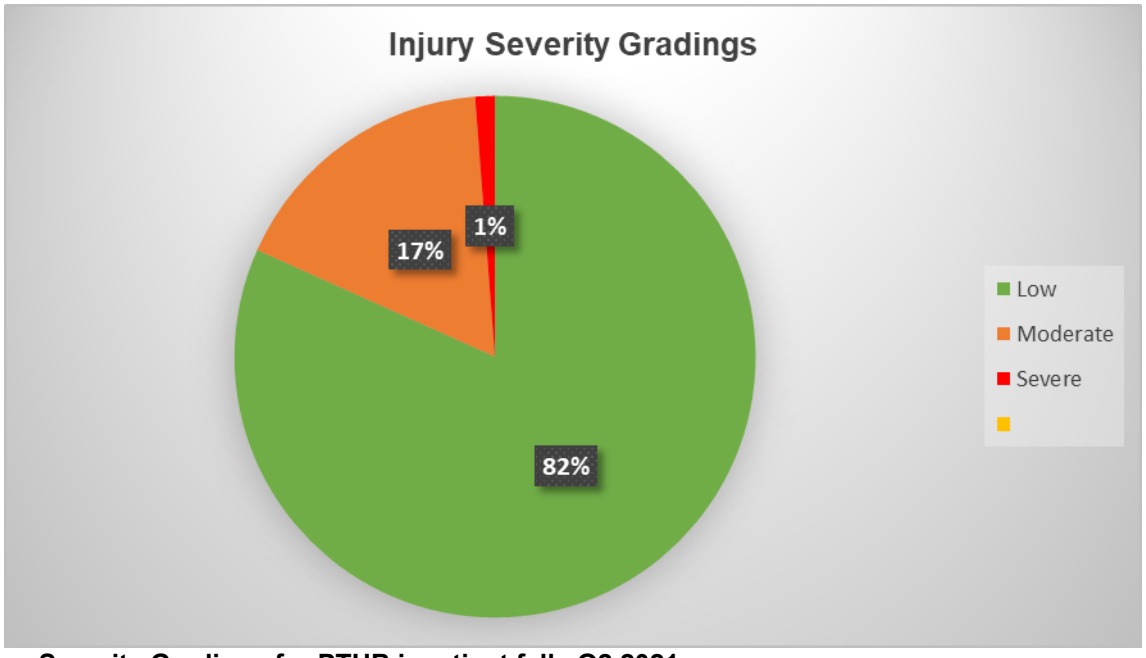
Total	29	34	13*	40	22	20
	76			**82**		

Monthly incident of Inpatient Falls 2021
*Lower figure for June accounted for by change in reporting system to the 'Once for Wales Concerns Management System' (OFWCMS) on 14th June 2021.

55% (n=45) of falls occurred in North Powys, reported across four wards, 9% (n=7) in Mid Powys reported from one ward and one care home, and 37% (n=30) in South Powys reported across four wards. The reduction in falls reported in June 21 may have been caused by a change in reporting systems and the possibility that some falls may have gone unreported, however the increase in falls reported in July in both the North and South cannot necessarily be put down to late reporting from June, as analysis of the data reveals that all incidents were reported either the same day or the next day.

The majority of falls were reported as being unwitnessed (88%) by staff.

The Injury Severity Gradings of falls from the DATIX reports show 82% (n=67) were graded Low, 17% (n=14) were graded Moderate and 1% (n=1) were graded Severe.



Injury Severity Gradings for PTHB inpatient falls Q2 2021

Further scrutiny of DATIX reports reveals that the majority of falls resulted in either no injuries (70%, n=57) or minor/superficial injuries (23%, n=19), such as bruising, abrasions or skin tears that required either no or minimal treatment. 1% of reports did not state if injury was sustained. Significant injuries accounted for 6% (n=5) of falls, reporting fractures which included neck of femur and wrist, and head injuries.

McLellan,Holly
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It was observed that some DATIX reports graded an incident as Moderate Injury Severity when the patient did not sustain any injuries. This along with failing to document whether any injuries were observed has been fed back to departments to ensure accurate reporting.

It should also be noted that North Powys reported 55% of inpatient falls. It was observed that two wards had high levels of reporting, with each ward reporting 17 falls each over Q2, compared with other wards who ranged from 1 to 9 reports. Neither of these wards however reported falls that had resulted in significant injury such as fractures. On further investigation it appears that data has been affected by single patients falling multiple times in these wards. Current dashboards are not yet established to report this detail however whilst this will continue to be monitored there is no further action required at this time.

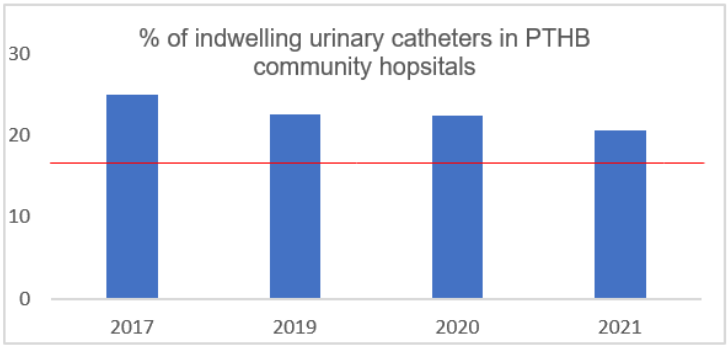
Patient Safety Incident Huddles were held following 6 incidents of inpatient falls however none of the incidents required National reporting to the Delivery Unit having been agreed by the panel that there was no evidence of any action or inaction from staff that may have caused or contributed to the fall.

Infection Prevention and Control (IPC)
Data for inpatient infectious diseases is not available at time this report has been produced. The IPC team are currently revising their reporting arrangements and the data will be available in Q3.

Catheter Associated Urinary Tract Infection (CAUTI)

Data for CAUTI is only collected for in-patients in Community Hospitals however catheter numbers and compliance with the catheter passport is collated for both hospitals and within the Community.

Work that originally commenced in Jan 2020 but delayed due to COVID-19, has now resumed. It aims to ensure data collected is meaningful and contextual to the population of Powys. This was due to concern that figures representative of our demographics could be misinterpreted, as initial data suggested high use of in-dwelling catheters in PTHB.



Welsh Average at 17% (Public Health Wales, 2017)

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Work has been conducted to reflect the PTHB population that generally consists of an ageing, community hospital, longer-stay inpatient population that differs greatly from the short-term acute admissions and high turnover across the majority of the rest of Wales. The PTHB Catheter Passport merges essential features from the catheter insertion care bundle to produce a single document suitable in Powys for inpatient and community use, whilst the use of the 'HOUDINI'[2] acronym included in Catheter Passport indicates the clinical reasoning for the indwelling catheter to be in situ. Results for Q2 are:

Hospital Results

- 135 beds occupied and 28 indwelling catheters across PTHB giving a prevalence percentage of 20.7%
- 3 out of 135 on antibiotics for urinary symptoms (2.2%)
- 3 out of 3 (100%) use of Public Health Algorithm
- 28 catheters with 28 confirmed passports (100%)
- 28 Catheter passports with 19 confirmed (67.8%) HOUDINI
- No inappropriate use of antibiotics for urinary symptoms.

Community Results

- Indwelling catheters prevalence range from 3.3% to 15.8%
- PTHB community average 6.88%

(UK average prevalence on community caseloads is 10.8% (Prieto et al, 2020) (Range 2.36% - 22.02%)

This is the first formal data collection since the COVID-19 pandemic.
HOUDINI data needs further investigation by the Continence Service Team to ensure wards understand the importance of this data. Q3 data will be collected in person by the Continence Service Team to audit HOUDINI compliance.
Some community teams were unable to provide data in the time frame required. The Link Nurse forum will re-commence in November 2021 which will assist in highlighting data collection dates.

Patient Experience

The CSG Patient Experience Quadrant is reported quarterly and captures patient experience activity and outcomes as well as incorporating the "You said, We did" approach to facilitate learning.

Audits

Updates on audits reported, presented through Learning Group

[2] HOUDINI: Haematuria with clot retention; Obstruction/ Retention; Urological/ Neurological; Damaged Skin; Input/output fluid monitoring; Nursing Care; Immobility due to physical constraint e.g. unstable fracture Dawson CH, Gallo M and Prevc K (2017) TWOC around the clock: a multimodal approach to improving catheter care. *Journal of Infection Prevention*. Vol.18, No. 2, 57-64. (Adapted from this paper to reflect unique needs of patients in PTHB Community Health Board)

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The CSG Audit Feedback and Learning Sessions meet every 6 weeks however due to annual leave and absences, there have been no further sessions since the last Quality Governance report.

The Sentinel Stroke National Audit Programme (SNAPP)

The Sentinel Stroke National Audit Programme (SSNAP) is a major national healthcare quality improvement programme that measures the quality and organisation of stroke care in the NHS. It measures both the processes of care (clinical audit) provided to stroke patients, as well as the structure of stroke services (organisational audit) against evidence-based standards. The overall aim of SSNAP is to provide timely information to clinicians, commissioners, patients, and the public on how well stroke care is being delivered so it can be used as a tool to improve the quality of care that is provided to patients.

Brecon Hospital

Measure	SSNAP Audit Jan - Mar 2021	Jul-21 Numerator	Jul-21 Denominator	Score May-21	Score Jun-21	Score Jul-21	% Variation
Inpatient Rehab							
Percentage of patients who spent at least 90% of their stay on stroke unit *	77.3%	0	0				
Compliance with patients receiving the required minutes for OT (3-month rolling)	91.8%	18.36	25.7	66.3%	52.9%	71.4%	18.6%
Compliance with patients receiving the required minutes for physiotherapy (3-month rolling)	87.0%	16.53	27.3	71.9%	60.2%	60.6%	0.3%
Compliance with patients receiving the required minutes for SALT (3-month rolling)	57.2%	5.32	16.1	85.0%	54.3%	33.1%	-21.3%
Discharge Standards							
Percentage of applicable patients screened for nutrition and seen by a dietitian by discharge (exc. Palliative care pts)	80.4%	0	0	100.0%			
Percentage of patients discharged with ESD/Community Therapy Multidisciplinary Team	47.2%	0	9	0.0%	0.0%	0.0%	0.0%
Six month follow-up assessment	#N/A	0	0				

Newtown Hospital

Measure	SSNAP Audit Jan - Mar 2021	Jul-21 Numerator	Jul-21 Denominator	Score May-21	Score Jun-21	Score Jul-21	% Variation
Inpatient Rehab							
Percentage of patients who spent at least 90% of their stay on stroke unit *	77.3%	0	0				
Compliance with patients receiving the required minutes for OT (3-month rolling)	91.8%	14.96	25.7	46.7%	56.0%	58.2%	2.2%
Compliance with patients receiving the required minutes for physiotherapy (3-month rolling)	87.0%	51.15	27.3	103.9%	187.4%	187.4%	0.0%
Compliance with patients receiving the required minutes for SALT (3-month rolling)	57.2%	0.85	16.1	11.5%	4.7%	5.3%	0.6%
Discharge Standards							
Percentage of applicable patients screened for nutrition and seen by a dietitian by discharge (exc. Palliative care pts)	80.4%	2	2		100.0%	100.0%	0.0%
Percentage of patients discharged with ESD/Community Therapy Multidisciplinary Team	47.2%	3	5	100.0%	66.7%	60.0%	-6.7%
Six month follow-up assessment	#N/A	0	0				

The Consultant for Stroke and Neuro has developed an action plan in liaison with the operational teams to review the inputting of data and the staffing variances. This is reported to the Stroke and Neuro steering Group Chaired by Director of Public Health.

McLellan Hywy
11/26/2021 12:38:21

Inspections and Quality Assurance visits

Health Inspectorate Wales (HIW) and Care Inspectorate Wales (CIW) inspections
No Healthcare Inspectorate Wales (HIW) or Care Inspectorate Wales (CIW) visits were conducted in July to September 2021 to facilities within the CSG.

Cervical Screening Wales Colposcopy Quality Assurance Visit to PTHB
Each Health Board is visited every four years as a minimum, and assessed against Cervical Screening Wales (CSW) Colposcopy standards. Following a visit, recommendations may be made and a report will be produced for the Health Board, with a timescale provided for recommended changes. The Quality Assurance (QA) Colposcopy Team will consist of a CSW QA Colposcopist, a CSW Clinical Lead, a CSW Head of Programme or Regional Programme Manager, a Regional Lead Nurse Specialist, a Programme Support Manager and a CSW Quality Lead. The next PTHB visit is scheduled for Nov 2021.

Endoscopy Joint Advisory Group (JAG) Annual Review
Accredited services undertake an annual review every year for 4 years. In year five of the accreditation cycle they undergo a reaccreditation assessment, which is a full accreditation assessment including site assessment. The service must pass its final annual review to progress to its reaccreditation assessment. The PTHB annual review submission was provided to the Joint Advisory Group (JAG) on 1 June 2021. Due to C19 pressures there are delays in JAG assessment therefore PTHB are still awaiting the outcome of submission.

Elective Waiting Times
Improvement work to manage waiting lists in line with the National Planned Care Programme Outpatient Transformation and Speciality Boards continues with activity levels closely monitored locally via the daily review of patient lists and weekly Referral to Treatment Times (RTT) meetings.

Waiting lists are clinically validated and risk stratified in addition to administrative waiting list validation. Theatre lists are clinically prioritised utilising the Federation of Surgical Speciality Association C19 prioritisation tool with the vast majority of patients categorised as priority 4 (low risk), however all long waiters are regularly, clinically reviewed to ensure their condition is not changing and in need of re-prioritising. Any patients requiring urgent treatment are transferred to DGH urgent pathways if immediate lists are not available in PTHB.

The WG 52-week risk stratification exercise commenced in Q1 2021/21 with letters sent to patients waiting over 52 weeks in orthopaedics. This initiative was clinically supported by PTHB musculoskeletal physiotherapist who was also able to contact and review orthopaedic patients waiting 36-51 weeks and 100% overdue follow up patients.

Throughout 2020/21 and 2021/22 the Assistant Clinical Director for Community Dental Services has undertaken a similar clinical review exercise for long waiting dental/oral surgery patients.

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Therapies and Health Sciences
Waiting lists for Therapies and Health Sciences are continuously scrutinised by the Heads of Service following the good practice guidelines for RTT. There are ongoing developments regarding Patient Reported Outcome Measures (PROMs) and Patient Reported Experience Measures (PREMs) within the service.

Community Occupational Therapy and Physiotherapy Therapies
This service is developing key performance indicators in line with the development of 'Discharge to Recover then Assess (D2RA) pathways and the Rehab framework. These will be implemented following the outcome of the consultation for seven day working and will include PROMs for the service.

Delayed Transfers of Care (DTOC)

There are still significant delays in the Community Hospitals. The average Length of Stay (LoS) for April to August 2021 was 40.69, with the same period in 21/21 recorded as 38.9. There are limitations to this comparison however as activity was half the normal capacity due to Covid-19.

It is acknowledged that harm is potentially caused if patients become deconditioned as a result of not being in their home environment, isolated from friends and family and potentially residing in a care home permanently due to loss of independence. Additionally, assessing individuals for CHC in community hospital beds is leading to a prolonged LoS. Checklists and DST's are being increasingly requested by Powys County Council and due to the low threshold of the checklist this incorporates a large amount of our patients. Nurse and social worker capacity, funding disputes and the quality of DST's is all prolonging this further.

There is still a high number of patients awaiting DST's. These are not currently declared in the Delivery Unit delay returns as DST's should not be done within a hospital setting therefore are not factored in delay reporting. This is set to change when national DTOC reporting changes, anticipated to be later this year.

Patient Safety Incidents, Concerns and Compliments

Patient Safety Incidents

A CSG tracker records all Patient Safety Incidents (PSI) reportable to National level. Since changes were introduced through the National Patient Safety Incident Reporting policy in May 2021, there have been no new incidents requiring National reporting. Of the 14 incidents that are currently held on the CSG tracker, 5 remain open with Service and 9 have been submitted to the Quality and Safety Team and are either awaiting feedback or closure.

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PSIs currently held on CSG tracker

	Number held on tracker*	Number open with Service*	Number with Quality & Safety Team*
Q1 Report*	16	4 (25%)	12 (75%)
Q2 Report*	14	5 (36%)	9 (64%)

* Figures will only give a snapshot of activity at time of report and will vary over the reporting period.

The majority of PSIs reported are from the Nursing service and most are due to Falls or Pressure Damage which are discussed at the Learning Panels.

PSIs by Service Area

Service Area	Number of PSI*	
	Q1*	Q2
Nursing	15 (94%)	13 (93%)
Therapies	0	0
Planned Care	1 (6%)	1 (7%)
Unscheduled Care	0	0
Total	**16**	**14**

* Figures indicate PSIs open during the reporting period

Concerns

CSG received 16 new formal concerns/complaints during Q2. The response 'due-by' dates vary depending on the complexity of the concern raised however within Q2, of those required to meet a 30-day response, 2 exceeded this date. As a result of this, there is now improved communication within CSG to ensure that nominated investigating officers particularly those with less experience, are provided with support where required early in the process.

Service Area	No. of Concerns
Nursing	7 (44%)
Therapies	2 (12%)
Planned Care	4 (25%)
Unscheduled Care	3 (19%)
Total	**16**

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Number of Concerns received in Q2

The Nursing service received the majority of concerns/complaints however no trends emerged, with concerns noted across all themes identified in the service areas.

Themes Identified – all Service Areas	No. of Concerns
Access to Services	6 (38%)
Care and treatment provided	8 (50%)
Discharge Management	1 (6%)
Staff Attitude	1 (6%)
Total	**16**

Themes identified of concerns across all services

Compliments

39 compliments were recorded during Q2 which includes verbal or written messages, gifts and donations. The majority of compliments recorded were received by the Nursing service of which the majority were for Community Nursing Teams (n=14) and Palliative Care Nurse Specialist (n=9). All departments are encouraged to record any compliments received by their teams.

Service Area	No. of Compliments
Nursing	30 (77%)
Community Nursing (DNs)	*14*
Palliative Care Nurse Specialist	*9*
Continence Nurse Specialist	*2*
Community Hospitals (Wards)	*5*
Therapies	1 (2%)
Planned Care	0 (0%)
Unscheduled Care	8 (21%)
Total	**39**

Compliments by Service Area

Lessons learned

The process of Learning and Sharing from PSIs and Concerns is now embedded within the Patient Safety Incident / Concerns, In-patient Falls and Pressure Damage Learning Panels. Work is continuing to ensure it is shared widely across the Community Services Group and also across PTHB. Work is continuing to identify how learning and sharing can be communicated most effectively within the Group, ensuring it captures all areas that include Concerns, Audit and Action Plans from investigation reports. There is also a

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requirement to provide the Welsh Risk Pool with evidence of learning and sharing.

RECOMMENDATIONS:

Note and accept the actions taken to date.

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

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

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Agenda item: 3.3b

Patient Experience, Quality and Safety Committee	**Date of Meeting: 2 December 2021**
Subject:	Mental Health and Learning Disabilities Service Group Quality Metrics
Approved and Presented by:	Joy Garfitt Assistant Director MHLD
Prepared by:	Ruth Derrick Head of Nursing Quality & Safety Rob George Business and Performance Improvement Manager Mental Health
Other Committees and meetings to be considered at:	

PURPOSE:
The purpose of this paper is to present the quality indicators identified in the MHLD service group that form the service Quality Metrics currently being monitored by the service group for the reporting period July to September 2021
RECOMMENDATION(S):
Patient Experience, Quality and Safety Committee is asked to: NOTE and DISCUSS the Mental Health Learning Disabilities Service Group Quality Indicators.

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

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[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:

Reports to Quality Governance Group in June and Patient Experience and Quality and Safety (PEQS) Committee in July 2021, outlined the mechanisms for monitoring quality and safety. Following on from the report to PEQS in October 2021, this report presents specific metrics for the Mental Health and Learning Disabilities (MHLD) service group for the period of July to September 2021.

This report includes data from the Commissioning Assurance Framework (CAF) for Mental Health and Learning Disabilities (MHLD) Service Group as a quality assurance and performance process within the health board, reflecting the service progress against the Mental Health (Wales) Measure 2010. This paper includes indicators in addition to the Mental Health Measure, highlighting wider quality components of the MHLD services. A separate paper on compliance with the Mental Health Act has been developed for the PEQS committee for December 2021.

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BACKGROUND

DMT is aware that Together for Mental Health (T4MH), ten-year national plan along with the Mental Health (Wales) Measure, drives performance and service quality across a cohort of domains. The plan was refreshed in 2020 and has five themes, addressing six priority areas which are reflected within the range of indicators presented.

Table One presents indicators and analysis demonstrating a range of metrics to illustrate how the performance activity supports quality governance in addition to the CAF data.

Table One: Period up to and including September 2021

Measure	Q4/20-21	Q1/21-22	Q2/21-22	Comment
Timeliness of care and access to services				
MH Measure Part 1 - Assessment's (Target 80%)	92.80%	93.90%	86.90%	Target achieved
MH Measure Part 1 - Interventions (Target 80%)	81.10%	85.60%	74.20%	Target not achieved driven by workforce challenges
CAMHS % of assessments within 28 days (target 80%)	96.9%	83%	74.5%	Target not achieved driven by workforce challenges
CAMHS % of interventions within 28 days (target 80%)	100%	85.7%	72.2%	Target not achieved driven by workforce challenges
MH Measure Part 2 - CTP Completion (Target 90%)	91.40%	92.50%	91.70%	Target achieved
MH Measure Part 3 - Self Referral Patients sent their Outcome Assessments within 11 days (target 100%)	100%	100%	75%	1 of 4 missed. There was a delay in reporting due to reduced capacity of workers to complete the assessment and formulate the care plan.
Overall staff sickness levels for front-facing staff group (Ward Nursing) at quarter end/Rolling Sickness Rate at Quarter End	3.7 WTE	4.4 WTE	2.9 WTE	
Overall staff sickness levels at quarter end/Rolling Sickness Rate at Quarter End	4.45% / 5.37%	6.02% / 5.43%	4.77% / 5.74%	Slight peaks and troughs in line with presenting sickness within the pandemic and season
Average % of DNA appointments for community-based services within the quarter/Total DNAs in Quarter - ADULT	9% / 69	12% / 94	12.5% / 71	Continued improvement
Average % of DNA appointments for community-based services within the quarter/Total DNAs in Quarter - OLDER ADULT	2.4% / 23	2.8% / 27	1.76% / 13	Low numbers improving
Average % of DNA appointments for community-based services within the quarter/Total DNAs in Quarter - LEARNING DISABILITIES	8% / 9	6.8% / 9	4.6% / 13	Low numbers but improving – trends to be monitored

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Number of delayed transfers of care counted as days spent in hospital when ready for discharge within the quarter (Number of DTOCs)	178 (5 DTOC)	141 (9 DTOC)	330 (8 DTOC)	Delayed transfers of care remain challenging due to Covid 19 and where partner agency service is required: such as care home admissions delayed due to Covid outbreaks; care home not being identified prior to patients becoming fit for discharge.
Suitably skilled and qualified staff				
WTE Bank/Agency Staffing - Ward Nursing - Cumulative for Quarter	9.1/1.4 WTE	18.3/14.3 WTE	19.5/10.2 WTE	Data from Establishment spreadsheet
WTE staff vacancies - Ward Nursing - RN/HCSW - as at Quarter End	-7.3/-3.8 WTE	-5.4/-3.4 WTE	-6.9/-8.2 WTE	Data from MH Charts spreadsheet
% of mandatory training that reaches the required health board target level within the quarter	Not available	74%	74%	Service has highlighted to all staff and continued improvement is anticipated.
Percentage of staff who have an up to date PADR at the end of the Quarter	Not available	63%	62%	Service has highlighted to all staff and continued improvement is anticipated.
Use of Restrictive Powers				
Number of compulsory admissions who are discharged to a placement under section 117 shared care arrangements within the quarter	<5	6	<5	Community Treatment Order (CTO) Recall
No. of detained patients and length of detention	38/876 days	52/1023 days	41/1308 days	Length of detention is taken from 1st day of detention and included in the quarter the person was detained.
Number of Patients discharged at Hospital Manager hearing and Tribunal during the Quarter	0	<5	<5	Numbers are generally low, evidencing appropriate formal hospital admission.
Number of Section 136 MHA Police holding Power to place of safety.	<5	6	6	Improvement to date compared with last year's total data of 26 Section 136 holds
Effectiveness of Service				
Number of incidents of physical violence where restraint is used within the quarter	Not recorded	13	16	Trends being monitored
Suicide rates per 100,000 population of people known to mental health services within the quarter	3	1	2*	*Data remains as suspected suicides until confirmed by HM Coroner at Inquest.
% of patients who are prescribed clozapine who are monitored at a nurse-led clinic within the quarter, (Total clozapine patients	85.71% (30/35)	85.71% (30/35)	88.57% (31/35)	Slight improvement in clinic attendance. North & Mid Area Only. Reasons for non - attendance at clinics: service

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monitored/Total Clozapine Patients) x %				users in care homes; bloods taken by their district nurse, care managed by GP.
% of first presentation psychosis patients who are allocated an EIP worker within the quarter (Total allocated/total presenting x 100%)	55%	55%	62%	NB: Only those allocated an EIP worker. Some may be jointly managed with CMHT/CAMHS. New Team lead in post 01/11/21.
% of first presentation Eating Disorder patients who have an allocated specialist worker within the quarter	2 allocated	4 allocated	4 allocated.	Currently unable to calculate % as total number of first presentation eating disorder patients is not available, only the number with allocated specialist workers.
% Readmissions to hospital within 28 days of discharge within the quarter	5/46 (11%)	11/70 (16%)	9/58 (16%)	
Number of hospital admissions avoided through DHTT intervention and community support	57	75	76	Stability of hospital avoidance maintained despite some staffing absence pressures from pandemic
% of patients accessing post diagnostic support for autism	80%	80%	82%	These figures are based on the assessments carried out that have had a positive diagnosis and of those who require support (some do not wish to access support after diagnosis). The waiting list for assessment at present is 12 months which has been reduced from 15 months in 2020 with 89 currently awaiting assessment.
Number of Patient Council Meetings held in Adult Services within the period	0	5	9	Pandemic impacted on group meetings, now progressing in socially distanced/PPE use context.
No of clients with LD with PBS plans.	8	8	8	Positive Behaviour Support (PBS) Plans are long term
Frequency and Use of PBM techniques for staff employed by PTHB - LD	0	0	0	Positive Behaviour Management (PBM)
Engagement of patients in their care/contribution to service development				
No. of families, carers receiving PBM training - LD	3	3	2	Training on hold due to families being unable to recruit Personal Assistant's
No. of first Health Equality Framework assessments and follow ups - LD	1	9	1	Majority of HEF 'S are due in 2022, therefore low numbers reflect how many have been completed during this quarter. Some are new whilst others are follow-up assessments.

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Patients / users of services contributing to service developments.	18	21	8	Reflects a decrease in group activity during the pandemic.
Patient Voice				
Number of new qualifying people accepted in Advocacy services within the quarter	46	56	38	It is not clear if these numbers are in any way deflated by covid. Both virtual and face to face support is in place. This trend will be monitored
Total number of Qualifying patients currently in receipt of IMHA Services at the end of the Quarter	28	48	31	

Analysis

Part 1: Target 80%: achieved overall for assessments – 87.9%. Interventions 73.9% - the target was not met for interventions with a specific challenge in the north area. This was linked to staff sickness and turnover. Some recruitment has been successful and the service continues to seek every opportunity to improve the position in the coming months

For children under 18 for CAMHS the target delivery has not been met. This has also been affected by staff turnover compounded by the previously reported increase in the complexity of cases in the last quarter. Additional staff have been recruited and agency staff are being used in the short term to support the service. The management of this caseload and target is a priority for the service in the next quarter.

The number of Section 136 MHA Police Holding Power to place of safety has reduced to date with 12 holds as compared to 26 (2020), and 29(2019), recognising that this year is not yet finished. The important fact here is not the actual number of police holds, but in the number of police holds which result in hospital admission. This year so far, 67% of Section 136 holds has resulted in subsequent hospital admission. The previous year, this figure was just 44% so this is positive in that it indicates appropriate use of police holding power with the right people being held due to police concerns for their mental wellbeing. At year end, we will analyse the whole data set alongside the total number of compulsory admissions to see how the pandemic may have impacted across the sector in terms of formal admissions to an in-patient setting, comparing Mental Health Act assessment data for the same period which was not as a result of Section 136.

Eating Disorder (ED) data collection from adult services is proving difficult to obtain, impacting on fully understanding demand and capacity. Work is underway to assess Tier 3 support provided from services commissioned through other health boards. We acknowledge that recruitment has been difficult to these roles. Specialist training for adult services has been developed to progress improved understanding of risk, appropriate interventions, differentials between Tier 1 and Tier 2. A task and finish group has been implemented to progress this work as the service progresses towards

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establishing a single point of access into ED. A multidisciplinary team (MDT) has been established within CAMHS and plans for same in Adult services.

Data from Learning Disability services has been included within table 1. This is showing the use of Positive Behaviour Support plans to be stable, in keeping with patient population demand. These plans are in place, tailored for individuals to support providers on how to work with individuals with complex behaviours. It is positive that there is currently no requirement for Positive Behaviour Management, a risk assessment on techniques tailored for individual's with behaviours that challenge. The zero data demonstrates that support plans are working well within the service.

All new referrals into the LD team will have a completed Health Equality Framework (HEF) assessment which will determine what is required from team interventions. This assessment will be repeated within 6 months to review and re-assess if the need has been addressed and new actions implemented based on the outcome of the review.

Health Education and Improvement Wales

HEIW and Social Care Wales are implementing an engagement exercise on whether there should be a change to the Mental Health (Wales) Measure (2010). A survey will run for four weeks from Friday 15 October to Friday up until 12th November 2021. A proposed options paper is included within the survey and we will encourage participation from managers and practitioners.

Patient Safety Incidents and Concerns

There have been eight concerns raised within this quarter. Three of these have had local resolution completed over the period. There have been less than 5 patient safety incidents within the quarter and no recorded falls from mental health in-patient areas. The PSI figures are based on Delivery Unit (DU) notifications and outcomes from the Coroner. It is important to wait for the outcome of an inquest as the Coroner decision is not always one of suicide and it may be decided that accidental death or death by misadventure, for example is the conclusion. There can be lengthy delays in obtaining an outcome due to pressures within the Coroners Court. There are two criteria for for HM Coroner to formally conclude that a death can be recorded as suicide: that the person acted deliberately and alone and that in all probability, death was to be the intended outcome.

The small Quality and Safety team within the service continue to support the corporate developments that are emerging from the new national policy. MHLD is piloting the new Alerts system to support the bedding-in of new ways of working, due for evaluation in December. The team has commenced weekly meeting with corporate Quality & Safety colleagues to maintain progress in meeting timescales.

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Outcome Measurement in Wales

The Mental Health Service Steering Group has been implemented to drive and guide this national work with the support of the national team from Public Health Wales. The programme runs across Adult, Children and Young People Services, including Older People. There is ongoing work with the development of appropriate tools for those affected by Dementia. The Learning Disabilities programme will commence in the New Year.

Ligature Risk Management

Estates work is continuing, driven and co-ordinated by the Anti-Ligature Risk Management Project Board to ensure timely implementation of the resources for this safety improvement work. The clinical management group facilitated through the MHLD service is meeting quarterly with the next meeting scheduled for November 8th 2021. This includes updates from all sites and confirms that all environmental ligature risk reviews had been updated. National Workstream feedback was shared and the progress towards a national policy which is being facilitated by the Delivery Unit, has continued to progress. The next National meeting is planned for November 23rd 2021.

Learning Themes

Table two below, shows the learning themes that have arisen for patient safety incidents (PSI's) over the past twelve months. The themes have largely remained similar to the previous twelve months of data collated and it is anticipated that next year, when there will be three years of data, that this will give a more consistent illustration of trends. There were 12 PSI's for that period all with a range of action plans in place. The 'other' category relates to three elements;

- Links with the Police in reporting
- Links with other services relating to involvement of mental health active case
- Death Notifications delays

Communication issues remain the highest topic recorded as a point for learning. There has been some significant action taken in this period with the aim of improving communication across all service domains. It is noted that learning around Wales Applied Risk Research Network (WARRN) is highlighted in the period and this has been addressed through an audit which has been reported to HM Coroners at the end of October 2021 as an outcome from an inquest held within the period. Services had not been identified as being unsatisfactory in any way and there was no requirement for a regulation 28 (Prevention of Future Death) report.

The service intends to improve on the value of the analysis of learning from PSI's in line with new capacity within the MHLD quality and safety team. This is included in the workplan with feedback planned to the wider MHLD service through the monthly meeting of the Learning & Development Group.

Table Two: Learning Themes October 2020 – September 2021

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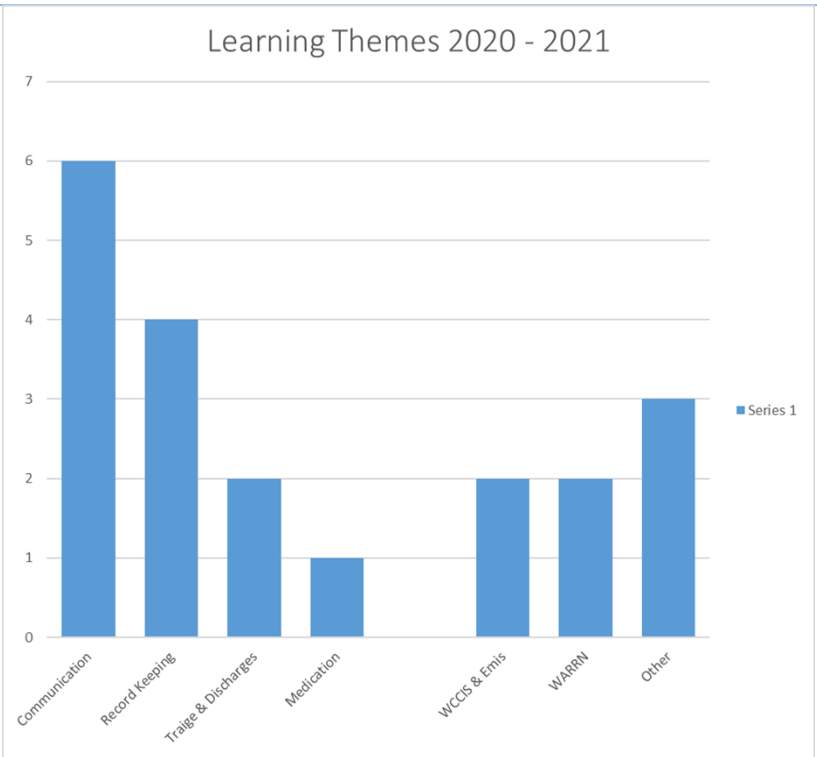

RECOMMENDATIONS:

DMT is asked to:

NOTE and DISCUSS the Mental Health Learning Disabilities Service Group Quality Indicators.

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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 a proposed Quality and Patient Safety Structure for the CG will support patient experience and not discriminate against protected characteristics.**
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				This risk assessment is based on new QGPS Structure being provided
	None	**Low**	**Moderate**	**High**	
Clinical		x			
Financial		x			
Corporate		x			
Operational		x			
Reputational		x			

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Agenda item: 3.3c

Patient Experience, Quality and Safety Committee	**2 December 2021**
Subject:	**Quality Report for Women and Childrens (W&C) service Group**
Approved and Presented by:	Louise Turner, Assistant Director for Woman's and Children's Group
Prepared by:	Kate Evans, W&C Risk & Governance Lead
Other Committees and meetings considered at:	

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	✓

PURPOSE:

The purpose of this report is to provide the Patient Experience, Quality and Safety Committee with a summary of patient experience and concerns, within this second quarter of 2021/22.

Recommendation(S):

The Committee are asked to DISCUSS and NOTE the contents of this report

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

McLellan,Holly
11/26/2021 12:30PM

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

DETAILED BACKGROUND AND ASSESSMENT:

This paper provides a summary of patient experience and concerns, including complaints, serious incidents from within the women and children (W&C) service group and performance analysis of key metrics for the quarter July to September 2021.

Further to recent reports to the Quality Governance Group and Experience Quality and Safety Committee the W&C service group, outlined the processes for monitoring and managing quality and safety within the group. The group has been working through the key metrics it currently collects, the metrics that will require development and the triangulation of data to allow for analysis and learning across the group. This report considers the quality information collected for quarter 2 analysis and learning and further developments. The Quarter 2 report now includes actions from concerns to improve services in Patient Experience feedback. This focus will aid demonstration of share learning at every opportunity. We have also explored strengthening the shared learning of patient experience into the existing W&C governance forums and how to be more effective in cascading into team meetings and frontline staff

1.0 What People Say

The W&C People's Experience forum has enhanced the quality and content of the quarterly PTHB Patient Experience reports with a number of patient stories featured in W&C quality governance meetings to ensure patients stories are a vehicle of shared learning examples are cascaded across the services.

1.1 Patient Story

"The birth of my beautiful daughter on the 9th July @ 04.08am weighing 7lb13oz.
After having not so smooth labour with my first-born son, I was apprehensive and scared about being pregnant again knowing at some point I am going to have to deliver another baby whether I liked it or not. Throughout my pregnancy, I tried numerous things to get over the anxiety I was feeling. I could not recommend Hypnobirthing breathing techniques more. I used an app call head space throughout the whole of my pregnancy practising the pregnancy modules every night before bed, in these you would learn the breathing techniques. I was overdue so I used homeopathy, acupressure and reflexology to help move things on and during my labour.
I was contracting every 10 minutes so I went downstairs to go and sit on my birthing ball and continue to time them and see if there was a regular pattern. They were coming every 10minutes regularly so I rang my midwife. We agreed I would ring back when they were every 3 minutes. Soon after I was on the phone again and the midwives were on their way. The midwife arrived and had started to listen to her heart beat which was all she had time for as I felt I needed to push. She was born soon after. I picked her up and could not believe how truly empowering the whole thing was, I was in control. I loved every second of my labour and would honestly recommend a home birth for everyone, it's a place you are able to relax and feel safe in order to loosen your muscles and go with the process"

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1.2 Compliments/Examples of Good Practice

During July to September 2021, a total of 14 compliments registered have been received from patients, relatives, carers and other health services in Powys Teaching Health Board Women & Children's services (PTHB). These consisted of a combination of cards, letters, donations, verbal compliments. The W&C People's Experience forum is reviewing emerging themes for compliments and highlighting the benefits of using the Once for Wales notification system to improve the recording of compliments received across all W&C services. It has been recognised within the services that they do not routinely good share all the compliments and thank you notes they receive. Within the birth centres there are now mechanisms to record, comments, cards or gifts they receive and the maternity support workers will input the data onto the Once For Wales system and this will allow us to demonstrate on a much larger scale, how many satisfied patients we have.

Examples of compliments are:

"The whole team! Everyone has been kind, caring, efficient & respectful. Couldn't have been looked after by a better team."

How calmly the midwives came into my home. They let me take full control and generally were onboard and non-judgemental about using alternative medicine homeopathy."

"Ability to have CTG monitoring, AFI and doppler and growth scans at local (Newtown) hospital every week. Very good to have the equipment nearby rather than 1+ hour trips."

"The compassion, passion, knowledge & friendliness of all the Midwives and continuity of care."

Maternity Services continue to work on an electronic version of their feedback card that can be shared online and a QR code can be added to the postnatal notes, giving women more access to provide feedback on their experience. The electronic version will be ready for release in the autumn once shared with our patient experience user groups for feedback and once we have an agreed format, this will be translated into Welsh before publishing for use. It has been agreed that once the format has been set for the electronic version of feedback, this can be utilised by the other services to improve their patient feedback and improvement plan.

2.0 Serious Incidents

A serious incident (SI) is defined as an incident that occurred during the provision of NHS funded healthcare. SIs are now reported to the Delivery Unit arm of Welsh Government (WG), who have taken over the serious incident reporting process. A new patient safety incident reporting framework is being implemented to help support learning and improvement. There were zero SI in W&C group in this reporting period. Comprehensive plans are in place for oversight within a multi-disciplinary forum when a patient safety incident does occur.

Maternity services are linked to a wider Commissioning Assurance Framework (CAF)and future reports from W&CH group will include additional metrics. The Maternity and Neonatal CAF has been updated in Q1 which now provides a three overview of commissioned Maternity SI's that have been jointly reviewed and considered for commissioned services. The emerging themes

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and progression of shared learning has been reported through the Summer Welsh Government Maternity and Neonatal performance review with Welsh Government (July 2021). Q2 will be shared at October ICAM meeting as the September ICAM was cancelled.

3.0 Formal Concerns Summary Position

The following Quarter 2 2021/22 data, shows the number of W&C concerns received:

Specialty	Q2 No. of Concerns	Q1 No. of Concerns
Midwifery	3	0
Health Visiting	1	2
Childrens Services	6	3

Comparing Q1 with Q2, there was a slight increase this quarter for midwifery and learning has been reflected upon by the clinical team. There have been increased number of concerns raised for children's services, both the speech & language service and neurodevelopment services have had issues raised with waiting times for referral and treatment. A shared learning forum is planned for November using a similar format to the Maternity Clinical Incident forum to bring together staff to review the emerging themes from these concerns

An emerging theme arising from W&C concerns is related to treatment plans and referral pathways for Health Visiting and Community Paediatrics. As a result of learning from concerns, we aim to ensure there is an associated improvement plan that accompanies each complaint and use this to share with teams involved. We also present at team meetings and group supervision sessions ensuring key messages are shared with as many staff as possible. We are in the process of creating a Governance Newsletter that will be shared with all W&C staff on a bi-monthly basis and will include key messages that arise from concerns and incidents. We also send out Team Briefs which include any key messages that are deemed priority for staff to be aware of which have included ensuring staff communicate with their colleagues if taking a rest break before an on call, ensuring the weekly equipment checklist has been done and that all care is reflected on the electronic patient records in a timely manner

4.0 Incident Reporting

4.1 Incident Reporting Data

The following data demonstrates how many incidents were reported in W&C in Quarter 2 2021/22 from available local data and a comparison to Q1 2021/22. There were 150 incidents reported in July to Sept 2021 from local trackers. The increase is actually reassuring as it reflects the positive culture that incident reporting should be viewed by staff and that reporting works as a tool to improve our services and is not a blame culture. Some of the increased number of Maternity service incident notification is in relation to emerging themes from pressurised Maternity and Neonatal services across Health Boards in Wales and Cross Borders with a focus on WAST, Access to DGH care and Maternity care events. There is also notable increase in COVID19 positive pregnant women (13 notifications) which hasn't been previously reported.

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Service	No of Incidents Quarter 1 2021/22	No of Incidents Quarter 2 2021/22
Midwifery	81	104
School Nursing	9	8
Childrens Nursing	15	15
Health Visiting	4	8
Physiotherapy	1	5
Childrens Services	6	9
Sexual Health	0	1
TOTAL	**116**	**150**

W&C Services incidents are largely received from Community Midwifery services who have a well-established patient safety culture in recognising and reporting a defined criteria of incident notification. The Childrens Nursing and School Nursing are the second largest reporting area. A regular review between Quality Safety team and W&C governance lead considers the volume of incidents per month and looks to ensure reporting does not diminish in addition tracking the type of incidents and trends. We recognise an ongoing increase in incidents from Quarter 1 2021/22 to Quarter 2 2021/22.

The quarterly analysis of the last 4 quarters shows an increase in the number of incident reporting as seen below, which is consistent with the approach to raise awareness of the use of Datix reporting and the benefit of subsequent learning

THEMES	Q2 2021	Q1 2021	Q4 2020	Q3 2020	Q2 2020
DATIX	146	114	82	96	78
Transfers / Readmissions	37	22	32	32	42
MARFS / Safeguarding	13	21	11	16	18
C.19 reporting for pregnant women	13	2	5	7	1
Ultrasound	1	3	1	2	11

4.2 Top Themes of Incidents Reported

Work is ongoing to continue to promote positive reporting of incidents to enable learning across the service groups. Top themes included below:

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4.2.1 Transfers: Transfer of Care District General Hospital – Quarterly total is 37

Incident reporting relating to transfers relate to periods of care mainly during labour or delivery. We had reports of transfers in the first stage of labour which were for delay in progress in labour. We also transferred for fetal distress, antepartum haemorrhage, hypertension and threatened pre-term birth. Following birth, we had transfers for identified 3rd degree perineal tears which required consultant obstetrician repair and post-partum haemorrhage and for concerns with the neonate immediately after birth.

From the beginning of 2021, we have reviewed all cases of transfers to ensure appropriate transfer care, times and documentation and are assured that all were conducted appropriately and part of the clinical audit process for the recently implemented all Wales transportation framework to monitor any delays in transfer.

4.2.2 MARF (Multi-Agency Referral Forms) Safeguarding –Quarterly total is 13

Multi agency referral forms are submitted to the safeguarding team whenever there is a concern raised by a midwife, HV or SN or any speciality. This process enables early identification of any serious issues in relation to the safety of the woman and her baby / child.

4.2.3 Covid Positive Pregnant Women –Quarterly total is 13

Reporting via incident reporting is undertaken for any pregnant woman who tests positive for Covid-19. The midwife undertakes an SBAR to ensure the woman does not miss any appointments while self-isolating and the Antenatal Screening Specialist Midwife reports the cases to CARIS Register who are undertaking further studies on the effect of Covid-19 long term. Fortunately, we have not had any women hospitalised with Covid-19.

The themes have changed this quarter with transfers, MARFS and Covid-19 now the top 3. Transfers were for meconium stained liquor, fetal distress, delay in first stage of labour, delay in second stage of labour and 3rd degree tear. The themes and trends remain quite static in relation to the reasons for transfers. There has been an increase in Pre-term transfers and admissions which is being considered as a potential side effect from Covid-19 as other maternity units are seeing an increase in these numbers too. Neonatal admissions were for Jaundice, an unwell infant with signs of sepsis and for observations after a shoulder dystocia at birth. MARFS submitted highlighted no concerns from Safeguarding and continue to work well as a highlight mechanism between services and safeguarding.

5.0 Learning from Incidents & Concerns

An action plan tracker has been created to ensure services remain on track with any learning that has been identified through incident reporting or concerns.
Learning is regularly shared within Midwifery and it has been agreed to improve the way learning is shared in the other services within the Directorate. Currently learning is shared with midwives through monthly clinical supervision sessions, via the Band 7 Management meetings and by presentation at the "Shire" midwifery meetings.
Future plans include re-structuring of the Incident Oversight Group to include sharing of lessons learned by all service groups within the Directorate to allow for wider cascading of the learning. Additional action plan trackers will be created for the services groups to use which will allow easy tracking of any additional learning that remains outstanding and provide the opportunity to embed the learning evidence within the tracker.

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6.0 HIW Regulatory Tracker Progress

There were no HIW inspections in the last period.

The Powys Maternity Improvement Plan is informed by the Local (July 2020) and National Report for Healthcare Inspectorate Wales (HIW) recommendations for Maternity services (March 2021). The areas of progress in Q2 have included the installation of Welshpool Birthpool, Capital Estate agreed developments for Llanidloes Birth Centre, commencement of Perinatal Mental Health Midwife and Research Midwife. During Q3 the Maternity services is establishing a project board in readiness for the implementation of Digital Maternity Cymru and Sustainability plan for Healthier Lifestyles support worker roles.

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7.0 Current Quality Performance Metrics

7.1 W&C Performance Data

W&C Performance Data	July 2021	Aug 2021	Sept 2021	Q2 total	Q1 total
Number of Bookings - Maternity	102	96	82	280	269
Number of women birthing – Powys	28	17	23	68	68
Number of elective caesarean section – Out of County	5	3	1	9	15
Number of emergency caesarean section - Out of County	2	1	1	4	12
Number of Escalations - AMBER-Maternity	0	2	3	5	0
Number of Escalations - RED-Maternity	0	0	1	1	0
Paediatric Physiotherapy -Number waiting > 14 weeks	0	0	0	0	0
Paediatric Occupational Therapy - Number waiting > 14 weeks	0	0	0	0	0

8.0 Maternity

The quality metrics for Maternity services has continued to be a focus for Quarter 2 2021/22 and the priority has been to monitor bookings into the service in comparative to previous 3-year trend with an increase number of bookings noted by the service in April 2021. Information team reviewed the data in August 2021 which doesn't show an overall annual increase over the 3 year analysis. This comparative to similar data reported via all Wales Maternity and Neonatal services are potentially reflective of families that have delayed pregnancy choices during COVID19 period in 2021. Introducing Continuity of Care teams in June 2021 is helping ensure equity of caseload numbers for midwives across Powys and opportunity to closely monitor any ongoing increase to ensure sufficient Midwifery resources in line with Birth Rate plus Maternity staffing.

Amber / Red escalation is where maternity services are put on high alert due to acuity (number of women requiring urgent care) and the staff available. The Band 7 midwives escalate through to Assistant and Head of Midwifery, if they identify that the service is heading towards Amber / Red and a Datix is submitted to ensure we know when we have had periods of high acuity across Powys. In Quarter 2 PTHB had 1 Red escalation and 5 Amber.

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9.0 Health Visiting

Healthy Child Wales Programme (HCWP) utilises a range of contact methods. The core contacts are recorded on the Child Health System (CHS) and monthly reports reviewed for performance. Quarter 1 and Quarter 2 data requires cleansing to ensure all contacts have been recorded on the CHS and where contacts have not been accessed, the reasons documented. This work is being progressed with the teams. The data cleanse for Q1 has been sent to the HV teams to ensure that any retrospect reporting is entered onto the system and forms an accurate picture of contacts delivered in the reporting period. This exercise for Q2 is ongoing and due for completion at the end of November . Following the publication of Q4 2020/21data it has become apparent that there is incompleteness of data being recorded on the CHS. This is being explored to improve data collection to ensure an accurate record of activity is available.

9.1 School Nurse Service

Quality metrics will be based on the School Nurse Framework (2017) and require development to capture the data in order to provide analysis. National work to review the school nursing element of the HCWP for School Nursing Service has been recommenced in recent months and this work will inform local quality metrics.

Locally in the meantime we will populate a performance dashboard with number of referrals and safeguarding activity. We will include the flu offer and uptake as this is a priority workstream.

9.2 Neurodevelopment (ND) Service

The service model is under review and development. Referrals into the service have increased during June and July 2021, the trend has continued into August and September. This is an expected increase due to the return to normal delivery of services and the potential impact COVID-19 has had on children and young people.

Project initiation and planning is now completed and is inclusive of national engagement, business case, current funding request, PID and project plan. The ND Service pathway is nearing completion to embed national standards and ensure NICE compliance. The backlog significantly reduced in relation to those CYP already in the system. The RTT waiting list is to be addressed in Qtr 3 and 4 2021/22 thanks to additional, temporary workforce capacity.

Recruitment to satisfy new model well underway and anticipated commencement dates for all positions by November 2021. A new Data and Information 'task & finish' group established to ensure local and statutory reporting are satisfied with particular reference to the 26 week RTT waiting time target.

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Neurodevelopment (ND) Service Performance Quarter 2 – 2021/22			
Target	**July 2021**	**August 2021**	**Sept 2021**
Number of new referrals received	20	24	27
Number of CYP waiting for first appointment	188	202	208
Number of CYP diagnostic assessments in progress	122	77	78

9.3 Community Care Nurses/Learning Disability/Continence Nursing

As a service we have now identified 3 x Champions for user feedback, these colleagues will lead on user feedback for the team. Capturing and collating feedback so the team can identify areas of good practice and where we need to learn and improve.

Feedback will include a number of tools which are age and developmentally appropriate. We will also be capturing patient stories and looking to utilise quality of life indicators to evidence the impact of the service for children and young people & their families.

We are developing tools to evidence the impact of the training we deliver to parents / Carers and partner agencies with regards to clinical interventions, again to evidence the increase in their skills and knowledge to look after CYP with clinical needs'.

10.Analysis Quarter 2 2021/22

Demand for services is increasing, as services begin the recovery journey there will be further development of the quality metrics which will seek to triangulate performance, quality and patient feedback. In quarter 2 we can see that there were 1 episode of RED escalation and 5 AMBER episodes in maternity service which have been managed through the flexibility of Powys Midwives to reduce the need to close and transfer Low risk Powys Women to DGH's which are already pressurised**.** The number of SI was 0 in Q2. Therapies waits remained within compliance waiting time breaches were experienced in the ND service only. Therapy waits are low and testimony to how the services are meeting demand in a timely way.

11. Metrics to be Developed – by March 2022

The Service Group will be developing further metrics to inform and improve services and patient experiences.

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- Surveys to determine customer satisfaction across the group. HV/SN /Continence Care
- Electronic feedback in maternity
- Further Development of the patient forum group

- Further trend analysis of themes- ie using run charts/ trend reporting.

12. How Learning is Shared across the Directorate and Learning to Date

W&C Service Clinical Audit Plan and Clinical Audit Improvement Plan which outlines the W&C's commitment to continuous improvement through clinical audit and service improvement has been reviewed for the closure. The 2020/2021 programme and identify a roll forward programme for 2021/2022 (as per PTHB Clinical Effectiveness and Quality Improvement Strategy). The focus of required National audits and relevant clinical audits especially requirements emerging from concerns, incidents, PRUDICs and recently introduced clinical guidelines and pathways, will be finalised at the 1st September W&C quarterly audit meeting. This ensure that the W&C audit programme continues its increased activity and effectiveness building on the established audit improvement from 2020. The recently appointed Research Midwife funded for two years from Charitable funds will help build the level of clinical audit and links into the research capacity and capability across W&C services to secure better outcomes for families in Powys.

Quarter 2 June W&C Audit are scheduled for December 2021 and March 2022 with some reflection on widening the scope of shared learning to increase the attendance to the audit presentation meetings and widen the cascade of learning to frontline services.

The W&C Bereavement forum is supporting improved pathways, family support and staff bereavement training. The Powys Perinatal and Child Death review monthly meetings continue to ensure focused data, intelligence and analysis, to understand the quality and standards of care provided and commissioned by Powys Teaching Health Board.

13.0 Next Steps

- Continued Use of the patient experience forum to explore more gathering of data /surveys and patient stories to understand how services are being delivered and what improvements can be made – work is ongoing with the group.
- Further Development and Collection of Quality Metrics across W&C Services Group. These will include the following but is not an exhaustive list:
  - Surveys to determine customer satisfaction across the group. HV/SN /Children Continence
  - Electronic feedback in maternity
  - Further work with the patient experience Group
  - Further analysis and triangulation of data to detail trends and chart improvement and impact.

  This work is scheduled for completion by the end of Quarter 3 2021/22.
- A shared learning forum will be held in November across the service Group.

RECOMMENDATION

To DISCUSS and NOTE the contents of this paper.

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Agenda item: 3.4

Patient Experience, Quality and Safety Committee	**Date of Meeting: 2 December 2021**
Subject:	**Mental Health Act Compliance Report for the 12 month period :** **1 October to 31 December 2020 (Q3)** **1 January to 31 March 2021 (Q4)** **1 April to 30 June 2021 (Q1)** **1 July to 30 September 2021 (Q2)**
Approved and Presented by:	Jamie Marchant Executive Director Primary Care, Community and Mental Health
Prepared by:	Amanda Rees, Mental Health Administrator and Melissa Brooks, Mental Health Act Administrator
Other Committees and meetings considered at:	Executive Committee 17 November 2021
References	*Monitoring the Mental Health* 2018/19 (2020). **www.cqc.org.uk/mhareport** *Mental Health, Learning Disability Hospitals and Mental Health Act Monitoring Annual Report* 2018/19 (2020)Healthcare Inspectorate Wales **www.hiw.org**

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

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That the committee NOTES the contents of this report and receives assurance that the performance of the service in relation to the administration of the Mental Health Act 1983 has been compliant with legislation.

Approval	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:

This report seeks to provide assurance that the services delivered and Mental Health Act requirements discharged by the Mental Health and Learning Disabilities service group during the reporting period are compliant with the Mental Health Act (1983, amended 2007).

This includes functions of the Mental Health Act which have been delegated to officers and staff under the policy for Hospital Managers' Scheme of Delegation are being carried out correctly and that the wider operation of the Act across the Health Board area is operating within the legislative framework.

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DETAILED BACKGROUND AND ASSESSMENT:

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

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

Mental Health Act, 1983 - Data Collection and Exception Reporting

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

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

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

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

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

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

	2021 (9 months to date)	2020 (full 12 months)
Sec 5 (4)	**5**	**4**
Sec 5 (2)	**17**	**25**

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The increase in the use of both Section 5(4) and Section 5(2) powers should be noted. It is likely that the Covid 19 pandemic had a direct influence on the usage of s5(2). A number of our S12(2) Doctors travel into Powys from outside of the county, and the services has noted a reticence of several Doctors to undertake extended travel into Powys during the three peaks of the pandemic. The service will continue to monitor the used of s5(2) powers closely during 2022.

ii) Section 2 – Admission for Assessment

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

Section 2 was used on 91 occasions during this 12-month period. The majority of patients reverted to voluntary status following this period of detention under the Act. For the same period last year, section 2 was used on a total of 72 occasions.

Once again, it is likely that the Covid 19 pandemic has had a direct impact on the number of patients detained on a section 2. This may be due to higher than usual presentations of mental distress, and the effect of patients isolating and Mental Health services becoming aware of a citizen's deteriorating mental health when it has reached a crisis point.

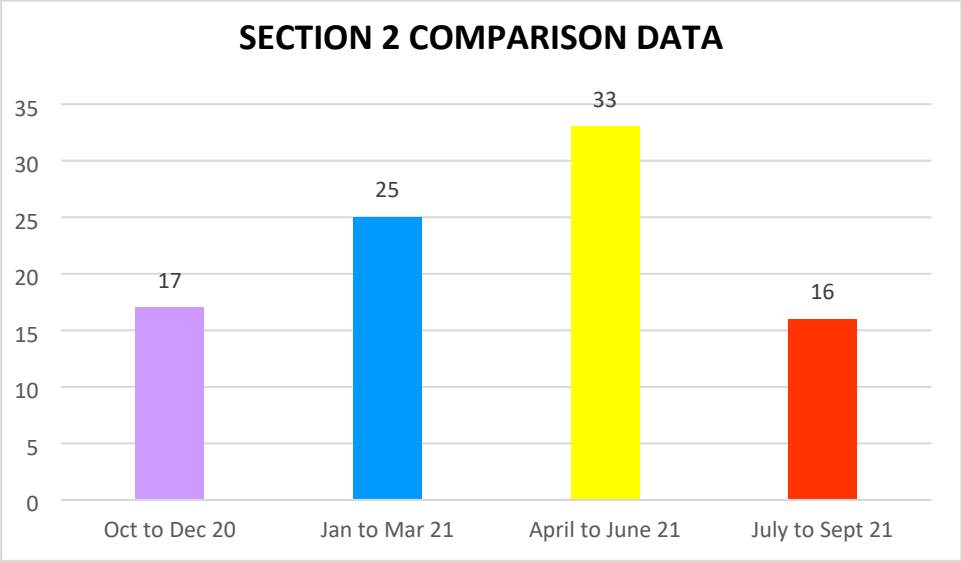

Table 1: Use of section 2 over the last 12-month period

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iii) Section 3 – Admission for Treatment

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

During this 12-month period section 3 was used on 38 occasions. Eighteen patients subject to section 2 had their sections converted to section 3.
For the same period last year, section 3 was used on a total of 41 occasions. This evidences that detentions for the medium and longer treatment of patients has remained broadly consistent, despite the pandemic.

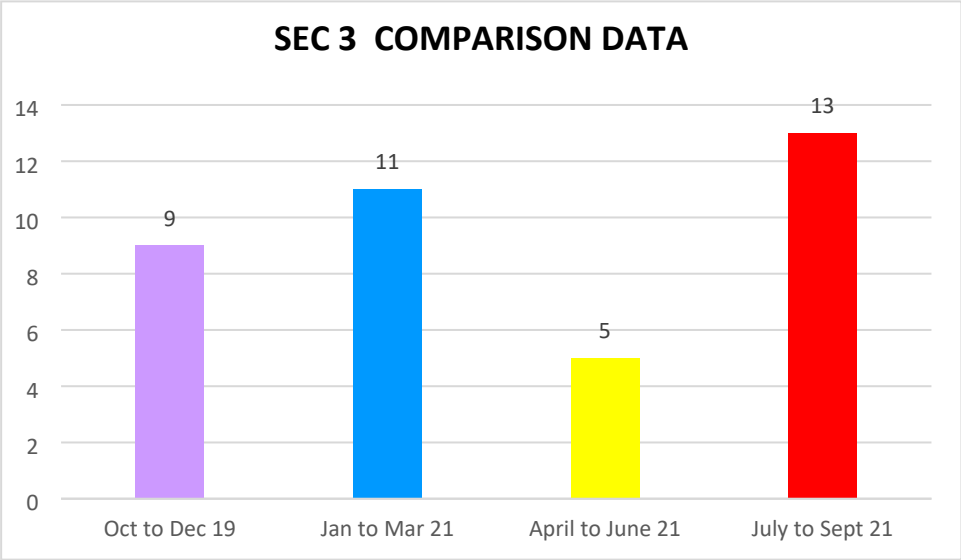

Table 2: Use of section 3 over the last 12 month period

iv) Section 4 – Emergency Admission for Assessment

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

An alternative section is preferred (if at all possible) as best practice would involve two medical opinions. Section 4 (up to 72 hour holding power) should only be used to avoid an unacceptable delay and as such is infrequently used. If it is likely that the patient requires detention past 72 hours, a new Mental Health Act assessment must be undertaken (with two Doctors). This section is specifically examined by Mental Health Act Managers when it is applied. Section 4, was used 5 times during this 12-month period. For the same period last year, section 4 was used on a total of 6 occasions, therefore very similar to last year's figures.

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

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

A CTO can only be used for a patient who has already been detained in hospital (under a section 3) and there will be conditions that the patient must comply with regarding their treatment within the community. If the patient does not adhere to the conditions of the CTO, they can be recalled to hospital for up to 72 hours to enable an assessment of their mental health.

In PTHB, there were fourteen community treatment orders in place as at 1 November 2021. CTO activity during the 12-month period 1 October 2020 to 30 September 2021 includes six new CTO's, fifteen extensions and fewer than five recall/revocations and eight discharges. No patients were discharged from their CTO by the Mental Health Review Tribunal. By comparison on 1 November 2020 there were sixteen community treatment orders in place.

Future patient engagement will include patient views on how the use of a CTO has impacted on their lifestyle. CTO's are used for patients who have serious mental illness and have experienced admission to hospital under the Act. It is likely that they would need the support of a CTO to accept treatment that will help them to remain mentally well outside of a hospital setting.

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

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

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Section 136 was used during the twelve-month period 1 October 2020 to 30 September 2021 on twenty-two occasions. During the reporting period the majority of those assessed did not result in the admission or further detention of the person. The number of assessments undertaken under s136 powers, was lower than in the previous 12-month period when it was used on a total on twenty-nine occasions (over the last five years approximately twenty-seven s136 assessments are undertaken per year), however all assessments referred and conducted were appropriate.

Sixteen people assessed under s136 powers were previously known to mental health services. A multi-disciplinary sub-committee of the Mental Health Planning & Development Partnership is reviewing the use of s136 powers and meets regularly to discuss cases and identify areas for improvement and learning.

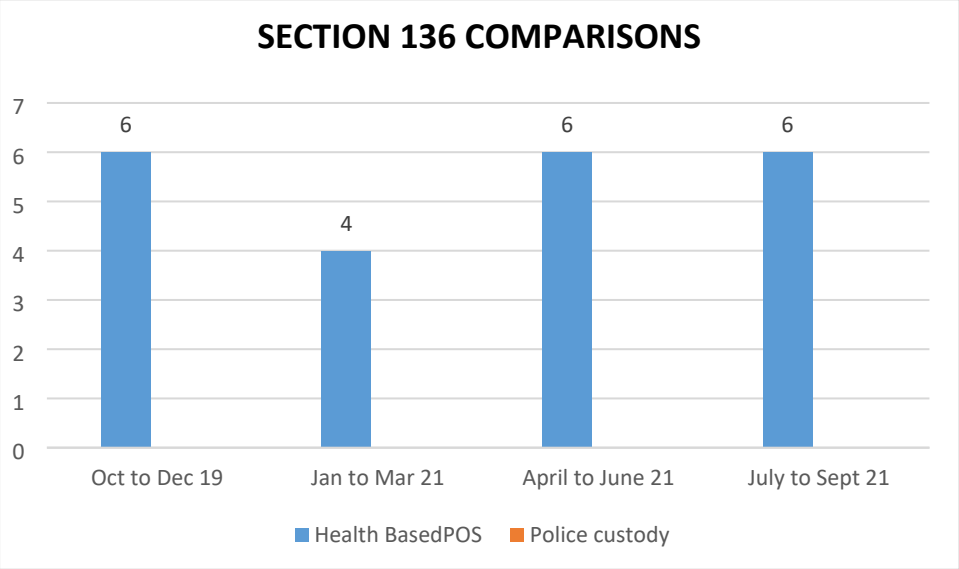

Table 3: **Location of completed section 136 assessments highlights that police cells were not used as a place of safety during the period.**

vii) Scrutiny of Documents

Hospital managers must ensure that Mental Health Act admission documents are received and scrutinised correctly by formally delegated officers. Section 15 of the Act provides for certain admission documents, which if found to be incorrect or defective must be rectified within fourteen days of the patient's admission. Rectification or correction is mainly concerned with inaccurate recording (e.g. spelling of a patient's name) and it cannot be used to enable a fundamentally defective application to be retrospectively validated. For example, a spelling error on a document, if corrected ensures the detention remain valid. For this 12 month period there were thirteen rectifications and one fundamentally defective detention.

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The number of statutory documents scrutinised totalled 194 sets of section papers for this 12-month period, this was compared to 203 for the same period in the previous year. Errors found that were required to be rectified within the fourteen days statutory time limits under section 15 of the Act were:

Rectifications		**Number of Errors**
Quarter 3	1 Oct to 31 Dec 20	**Less than five occasions** (spelling error in patients name and Dr entered time as am instead of pm)
Quarter 4	1 Jan to 31 Mar 21	**Five occasions** (spelling error in patients name, wrong form completed, error in hospital address, further information required)
Quarter 1	1 Apr to 30 June 21	**Less than five occasions** (spelling error in patients name, spelling error in name of local authority, spelling error in address, incomplete address of Approved Mental Health Professional
Quarter 2	1 July to 30 Sept 21	**less than five** (spelling error in patients name and error in address)
Fundamentally Defective Detentions		
Quarter 3	1 Oct to 31 Dec 20	**One occasion** (patients name not entered on form)
Quarter 4	1 Jan to 31 Mar 21	None
Quarter 1	1 Apr to 30 June 21	None
Quarter 2	1 July to 30 Sept 21	None

viii) Deaths of detained patients

During the period there were no deaths of patients who were subject to detention under the Mental Health Act 1983.

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

During the 12-month reporting period reporting period, 36 applications applications/referrals were made to the MHRT and fourteen hearings took place;

- Fewer than five patients were discharged
- Fewer than five hearings were adjourned or postponed.
- Twelve patients were discharged by the responsible clinician and six patients withdrew their applications**.**

Eighteen Hospital Managers Hearings were held during the period, fewer than five hearings were held to review the continued detention of the patient under a Section 3 and fifteen hearings were held for the extension of a Community Treatment Order.

McLellan, Nicola
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All patients attending tribunals are entitled to be accompanied by an Independent Mental Health Advocate (IMHA) and are provided with information about this service in order to have representation. In this quarter, IMHAs attended one of the hearings, largely due to the nature of the tribunals and the decisions the patients made not to attend themselves. The Mental Health services continue to encourage patients to accept the support of an IMHA.

This is reviewed by the quarterly Powers of Discharge Committee which is satisfied that patients are being made aware of their rights and have sufficient information to appoint an advocate if they want one. A review of the Powers of Discharge Committee Policy and Terms of Reference has commenced and will be considered at a future Board meeting.

5. Hospital Managers Power of Discharge Committee

A meeting for the above committee made up of the Hospital Managers and Independent Members was held on 22 July 2021 and 28 October 2021 and quarterly performance was reported, scrutinised and discussed. The three meetings were arranged for October 2020, January 2021 and April 2021 but were cancelled due to Terms of Reference being reviewed. The next meeting is scheduled for January 2022.

An All Wales training day for Hospital Managers was arranged for Spring 2021 due to be held in Powys, but this was postponed until Summer 2022 due to current Covid 19 pandemic.

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

During the reporting period there was one visit by HIW to hospital inpatient units which took place in June 2021 to Felindre unit and no urgent recommendations were made by HIW.

RECOMMENDATION:

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

McLellan,Holly
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Appendix

KEY TO MENTAL HEALTH ACT SECTIONS

Part 2 – Compulsory Admission to Hospital or Guardianship

- Section 5(4) Nurses Holding Power (up to 6 hours)
- Section 5(2) Doctors Holding Power (up to 72 hours)
- Section 4 Emergency Admission for Assessment (up to 72 hours)
- Section 2 Admission for Assessment (up to 28 days)
- Section 3 Admission for Treatment (6 months, renewable)
- Section 7 Application for Guardianship (6 months, renewable)
- Section 17A Community Treatment Order (6 months, renewable)

Part 3 - Patients Concerned with Criminal Proceedings or Under Sentence

- Section 35 Remand for reports (28 days, maximum 12 weeks)
- Section 36 Remand for treatment (28 days, maximum 12 weeks)
- Section 38 Interim Hospital Order (Initial 12 weeks, maximum 1 year)
- Section 47/49 Transfer of sentenced prisoner to hospital
- Section 48/49 Transfer of un-sentenced prisoner to hospital
- Section 37 Hospital or Guardianship Order (6 months, renewable)
- Section 37/41 Hospital Order with restriction (Indefinite period)
- Section 45A Hospital Direction and Limitation Direction
- CPI 5 Criminal Procedure (Insanity) & Unfitness to Plead

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(Indefinite period)

Part 10 – Miscellaneous and Supplementary

- Section 135(1) Warrant to enter and remove (up to 24 hours)
- Section 135(2) Warrant to enter and take or retake (up to 24 hours)
- Section 136 Removal to a place of safety (up to 24 hours)

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

Agenda item: 3.5

Patient Experience, Quality & Safety Committee	**2 December 2021**
Subject :	**PUTTING THINGS RIGHT, COMPENSATION CLAIMS REPORT** **PATIENT EXPERIENCE FRAMEWORK**
Approved and Presented by:	Alison Davies, Executive Director of Nursing & Midwifery Claire Madsen, Executive Director Therapies & Heath Science Wendy Morgan, Assistant Director Quality & Safety
Prepared by:	Alison Davies, Director of Nursing & Midwifery Claire Madsen, Executive Director Therapies & Heath Science Wendy Morgan, Assistant Director Quality & Safety
Other Committees and meetings considered at:	Executive Committee 17 November 2021

PURPOSE:

The purpose of this report is to provide the Patient, Experience, Quality & Safety Committee with an overview of the way in which Putting Things Right is discharged within the health board, along with compensation claims activity for the period 1 August 2021 to 31 October 2021.

Progress on refreshing the patient experience framework is reported alongside related activities, following the Patient Experience Steering Group in November 2021.

RECOMMENDATION(S):

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The Patient Experience, Quality & Safety Committee are asked to discuss and note the contents of this report.		
Approval/Ratification/Decision	**Discussion**	**Information**
✗	✓	✗

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

DETAILED BACKGROUND AND ASSESSMENT:

1 Background.

This paper provides an overview of the health boards approach to Putting Things Right, including the systems and processes in place to discharge of the function, along with any outputs and outcomes. Reference is made to patient experience and concerns, including complaints, patient safety incidents, and compensation claims for the period 1 August 2021 to 31 October 2021, including trends.

This paper also shares the health board's approved Patient Experience Framework, reflecting the requirements of the Clinical Quality Framework Goal 1 aimed at implementing the Darzi model for clinical quality, encompassing safety, effectiveness and patient experience.

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2 Assessment

2.1 Policies and procedures

Following national policy change and wide internal consultation along with a second round to targeted groups, namely Directors, the following policies, procedures and guidance underpinning the implementation of Putting Things Right, were approved by the Clinical Policy Group on 2nd November 2021:

- PEP 001 Putting Things Right Policy - requires Board approval
- Putting Things Right Procedure
- Putting Things Right Guidance for Residents
- PEP 005 Statement Writing Inquests Attending Court and Assisting with Police Investigations
- Managing Disruptive or Aggressive Members of the Public

2.2 Putting Things Right Audit and Assurance Plan

This paper provides an overview of the second quarter audit completed as per schedule, at **appendix 1**. Implementing improvements identified in quarter 1, quarter 2 has highlighted further areas where additional emphasis is being placed including obtaining consent for sharing of concerns, accessing medical records, investigation of concerns and timely production of responses by service groups as well as communication with individuals as part of the redress process. These areas are included within the Putting Things Right improvement plan and are monitored regularly (**appendix 2)** to ensure there is a single aggregated plan to maximise improvement.

The health board's approach to training and skills development in relation to Putting Things Right has been captured in a Training Catalogue (**appendix 3)**, which sets out the planned training over the next three years. The focus includes managing complaints and undertaking investigations, communication skills and managing expectations, resilience and accountability. The training will include Duty of Candour and other elements required to comply with the Health and Social Care (Quality and Engagement) (Wales) Act, as these emerge. The programme is also supported by the Public Service Ombudsman for Wales Office along with Community Health Council colleagues who bring a constructive and independent perspective.

2.3 Implementing the all Wales Patient Safety Framework

Regular scheduled meetings at a senior level continue to oversee the implementation of the revised all Wales Patient Safety Framework, generating assurance regarding its delivery and compliance with its requirements. This work is supported by proactive incident management oversight meetings led by the Director of Therapies and Health Sciences which has been successful in securing the timely management of incident reporting. There are now less than 100 clinical incident reports that remain open on the reporting system that preceded the Once for Wales Concerns Management System, with an expectation of closure or transfer onto the new system, depending on status.

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With the aim of increasing capacity and capacity related to investigation of clinical incidents, a tender has been established to attract interested parties to provide investigation officer services with a closing date of 22 November 2021 following which all applications will be considered and the contract awarded accordingly.

Phase 2 of the national work is progressing through the National Reporting Incident Implementation Collaborative (NRIIC). A Learning from Events Report (**appendix 4)**, is currently being piloted by Swansea Bay University Health Board. The intention is to use the report for the purpose of capturing learning from national reported patient safety incidents and as part of the existing process for submissions to the Welsh Risk Pool for claiming reimbursement of monies paid out on redress matters and compensation claims.

2.4 Once for Wales Content Management System

The implementation of the Once for Wales Content Management System continues Wales wide. Locally, this is overseen by an Executive led Project Board and forms part of the health board's Digital First Strategy. The governance arrangements include regular monitoring of incident reporting rates and any issues arising from the implementation of the new system that requires addressing. During October 2021, as a result of an unplanned change to security settings, an information governance breach occurred that meant that personally identifiable information related to a small number of individuals was made available to members of staff who would not normally receive it. The issue was identified within minutes and actions taken to prevent further exposure. The issue has been shared with and explored by the national team, with a request to consider adding a recall process to the system. The health board reported the incident to the Information Governance Commissioner and implemented a range of make safe actions, including informing individuals involved as required. The event, whilst undesirable, has resulted in local and national learning and has identified areas that can be further strengthened to help prevent reoccurrence.

Proactively, the health board will be the first to benefit from the introduction of a Business Intelligence Tool anticipated during January 2022 followed by a gradual roll out to the rest of Wales. Whilst access to data has been adversely affected as reported last quarter, this has now been resolved with additional functionality now available in support of dashboard development and generation of data enabling greater analysis.

2.5 Supporting learning and improvement

The learning from experience group, chaired by the Medical Director, is becoming more established with strengthening links with other elements within the health board where learning occurs, with the aim of maximising spread throughout clinical areas. Additionally, learning from concerns and compensation claims feature within the quarterly Patient Experience Steering Group, supporting learning shared within

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service groups governance arrangements. The use of Powys Announcements, a health board wide notification system, is well used to share learning and improvement.

Learning from Events Reports (LFERs) are completed for all redress and compensation claims, and underpin the reimbursement of financial compensation via the Welsh Risk Pool. Through these reports actions recommendations and learning have to be clearly evidenced; service groups are currently engaged within this process.

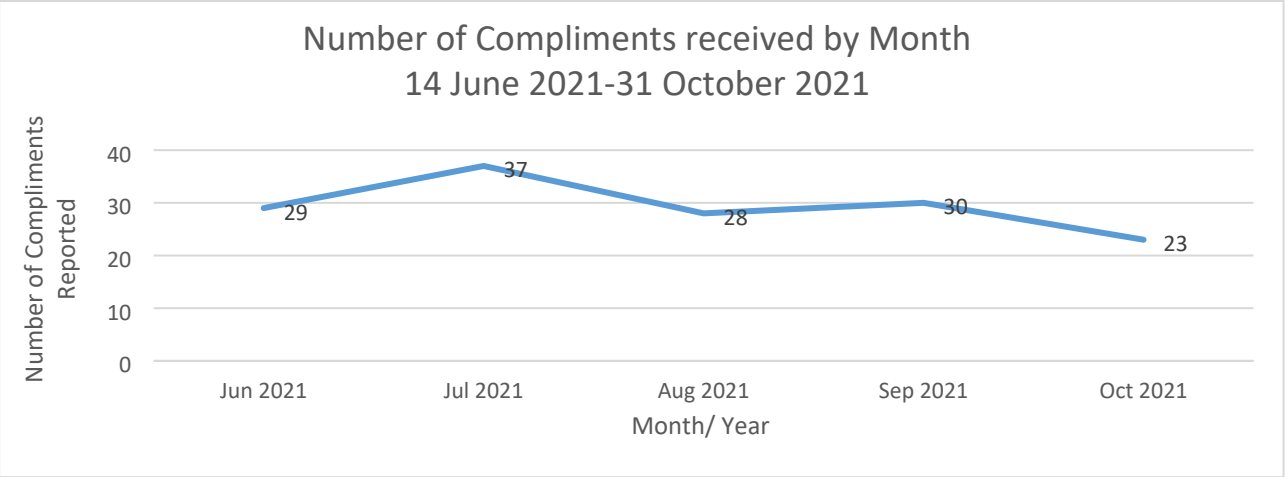
2.6 Outputs and outcomes of Putting Things Right

The data used within this report has been extracted from the new Once for Wales Content Management System (RLDatix) and reflects health board wide reporting patterns.

2.6.1 Compliments

Between 14 June 2021 to 31 October 2021, a total of 153 compliments were recorded on the RLDatix system, a combination of cards, letters, emails, gifts and food & drink. This reflects a slightly downward trend which is being monitored and considered by the Patient Experience Group.

Graph 1: Total number of compliments received between 14th June – 31st October recorded via the OFWCMS RLDatix system



Source: Feedback Module OFWCMS RLDatix system

Graph 2: Compliments by Service/ Department Reported via the OFWCMS RLDatix system

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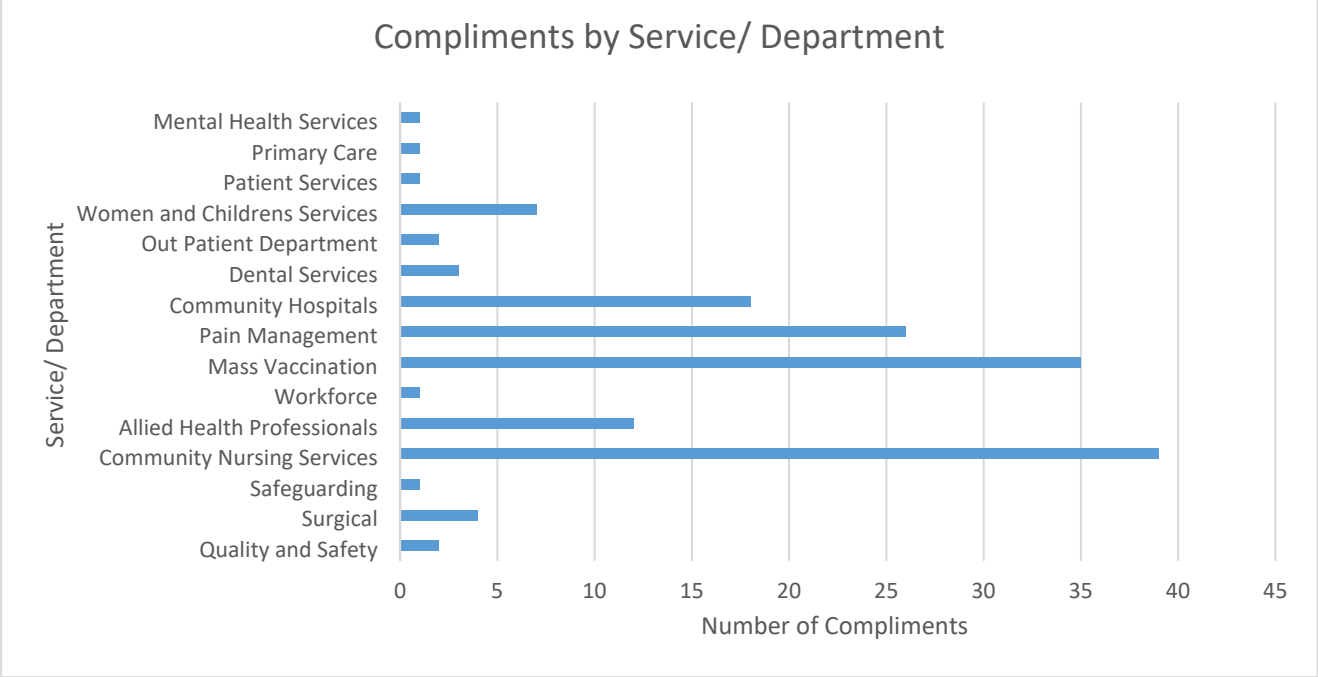
Source: Feedback Module OFWCMS RLDatix system



2.6.2 Concerns (complaints) Summary Position

For the purpose of this report, the concerns data is taken from the quarterly validated return provided to Welsh Government (**appendix 5**). Between 1 July 2021 to 30 September 2021, the health board received 85 new complaints, including those managed through the Putting Things Right Regulations and through Early Resolution.

Based on the validated return data, a total of 62% (28/45) of concerns closed within quarter 2 were within 30 working days. 36% were within the expected 30 working days to 6 months, and 2% closed after a period of being open for more than 6 months. This is a continually improving picture as an outcome of the deep dive undertaken over preceding months.

Graph 3 shows the total number of informal and formal concerns received each quarter, although quarter 2 is less than the previous quarter, the trend supports an increase in the total number of complaints received:

Graph 3 – Total number of new complaints received each quarter, 2020/21 to 2021/22

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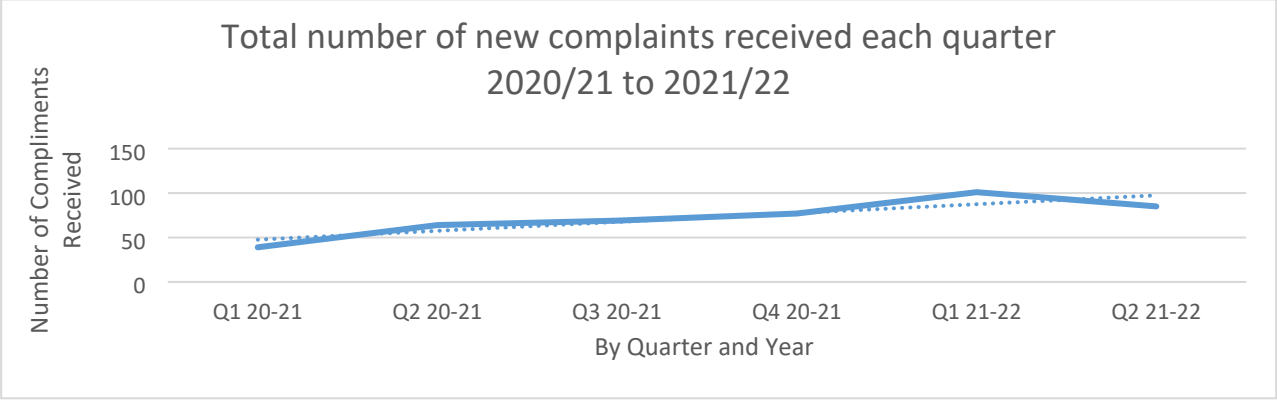


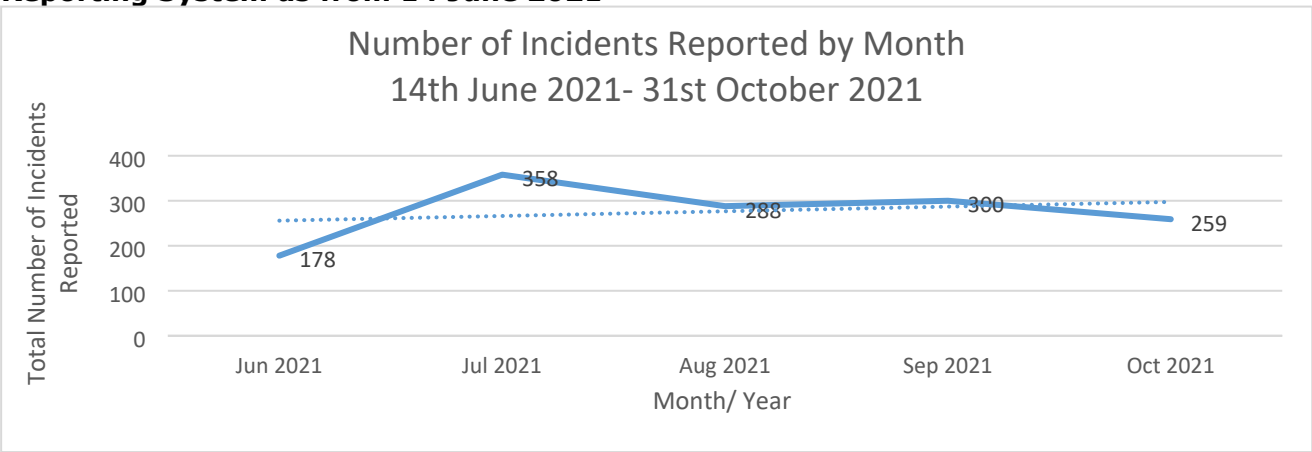
Source: OFWCMS RLDatix data reported via the quarterly NHS Concerns data returns to Welsh Government (example at Appendix 5)

The primary subject areas related to clinical treatment/ assessment (n25) access to services (n26), attitude/ behaviour (n14), appointments (n13) and access (n10), with a range of other subject areas with numbers <10. Issues of access remains focussed on dental and primary care services. The number of complaints by staff group are in the main remain medical and dental (n31) along with nursing, midwifery and health visiting (n22). This is unsurprising given these are our largest staff groups and reflects previous patterns.

2.6.3 Incident Reporting

An incident is defined as an event that occurs in relation to NHS-funded services and care resulting in unexpected or avoidable death, harm or injury to patient, carer, staff or visitor. Continuous monitoring of incident reporting across the health board has shown sustained reporting of the number of incidents since the introduction of the new RLDatix system. The number of incidents reported are consistent with numbers reported over previous years, an average of 250-300 per month.

Graph 4: Powys total number of incidents reported monthly via the new Once for Wales Reporting System as from 14 June 2021



Source: Incidents Module OFWCMS RLDatix system

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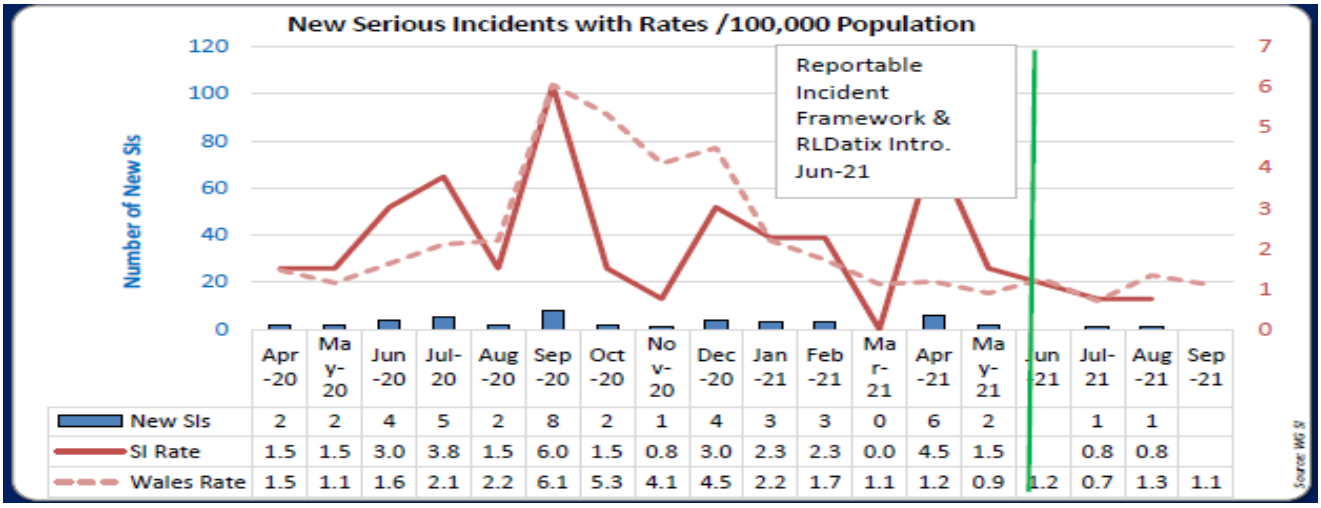
Since the introduction of the new RLDatix system on 14 June 2021 to 10 November 2021, the top 3 areas reporting new incidents that to date have not been reviewed is community hospitals (n235), community nursing services (n76) and mental

health services (n67). All others services/ departments are <16. Service areas have been asked to review these incidents as swiftly as possible to ensure any actions required are taken accordingly and learning implemented.

With regards reporting of patient safety incidents at national level, graph 5 provides the position as at September 2021 on Powys' position reference All Wales reporting of nationally reportable clinical incidents per 100,000 population. During April 2021 (Q1), Powys reports were higher than the Wales rate. The reports have been reviewed to identify potential reasons for this. Each of the 6 reports were individualised and unrelated to one another, hence no themes or trends were evident. It is noted that reporting in March 2021 was slightly below the Wales rate and since May 2021, mirrors more closely the Wales rate. Less than 5 patient safety incidents (figure quoted less than 5 where small numbers used, to protect personally identifiable information of individuals) were reported at national level during quarter 2, with one case downgraded as it did not meet the new reporting criteria.

Graph 5: Powys Serious Incident Reporting Rate reference All Wales Reporting Rate



	Apr -20	May-20	Jun -20	Jul-20	Aug -20	Sep -20	Oct -20	Nov-20	Dec -20	Jan -21	Feb -21	Mar-21	Apr -21	May-21	Jun -21	Jul-21	Aug -21	Sep -21
New SIs	2	2	4	5	2	8	2	1	4	3	3	0	6	2		1	1	
SI Rate	1.5	1.5	3.0	3.8	1.5	6.0	1.5	0.8	3.0	2.3	2.3	0.0	4.5	1.5		0.8	0.8	
Wales Rate	1.5	1.1	1.6	2.1	2.2	6.1	5.3	4.1	4.5	2.2	1.7	1.1	1.2	0.9	1.2	0.7	1.3	1.1

Source: WG SI

2.6.4 No surprises notifications

Welsh Government are notified of sensitive issues via a process known as no surprises, which are subsequently closed automatically within 3 working days of reporting. Between 01 August 2021 to 31 October 2021, the health board have reported less than 5 (figure quoted less than 5 where small numbers used, to protect personally identifiable information of individuals) no surprises to Welsh Government. The main focus issues related to patient care and treatment.

2.6.5 Inquests

During the period of 01 August 2021 to 31 October 2021 there have been less than 5 HM Coroner enquiries opened, and <5 cases closed. Learning identified for the health board included the importance of submitting all inquest related investigation reports and action plans timely to the HM Coroner to enable due consideration pre-inquest. No adverse consequences arose as a result of this identified learning.

McLellan,Polly
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The new policy developed 'PEP005 Statement Writing, Inquests, Attending Court and Assisting with Police Investigations (April 2021)' to support staff when attending inquests has been shared with Legal & Risk Solicitors to seek their advice on the robustness of content.

2.6.6 Public Service Ombudsman for Wales

If a patient remains dissatisfied with a response to a concern investigated by the health board, the person has the right to raise the matter the Public Services Ombudsman (PSOW). The PSOW determines whether to pursue a full investigation, with the authority to impose sanctions on the health board. During the period of 01 August 2021 to 31 October 2021, the health board received <5 PSOW enquiries, all of which confirmed that the PSOW would not be taking any further action in terms of the complaints made.

2.8.6 Claims

Powys Teaching Health Board continues to hold a small claims portfolio; with 15 open, inclusive of clinical negligence, personal injury, General Medical Practitioner Indemnity (GMPI) claims and others such as former health authority claim and motor claims. Following review of the claims for the health board, there have been no identified themes and trends. Amendments to the Welsh Risk Pool Reimbursement Procedure were received in October 2021, they are now in use.

3. Patient Experience

The Clinical Quality Framework aimed at implementing the Darzi model for clinical quality, encompassing safety, effectiveness and patient experience. The action for Year 1 required action to refresh the health board Patient Experience Framework.

3.1 Patient Experience Framework

A working group led by the Executive Director Therapies & Health Science has led a working group to refresh the patient experience framework. The framework included in **appendix 6**, and sets out the aims and expectations under key headings of leadership (for patient focus), organisational culture, analysis and triangulation, using patient feedback to drive quality improvement and learning, and reporting and publication. A key requirement to indicate planned improvements and what will good like once achieved. Quarterly monitoring of the framework will be via the Patient Experience Steering Group.

3.2 Patient Stories

Work has commenced to reinstate patient stories at Board, commencing January 2022. A schedule of patient stories is in development supported through the service groups. Staff in Mental Health and Learning Disability Service and Equality

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and Welsh Language Services are currently completing a digital storytelling training course. There are many examples of patient stories in the system some which focus on systems and processes and other patient experience, which are used at local level by service groups. A draft policy and guidance to support staff in gathering patient stories is in place and being further developed.

3.3 Gathering Patient Experience

There are a variety of mechanisms in use across the health board for gathering service user feedback form residents who access healthcare in though provided and commissioned services, both in hospital and outside of hospital. The health board does not have a system that provides 'real time' feedback'. The Once for Wales Concerns Management System National Team have procured a Framework Agreement with options for a call-off contract for NHS bodies to take up a service user feedback system provided by Civica who aim to turn patient feedback into real-time insights.

Work has been in progress since May 2021 to develop the business case to procure the system for use, with the support of the national team and Civica. A paper is currently being considered by the Digital Governance Board, before progressing through to the Investment Benefits Group and Executive Committee for final approval.

3.4 Equality Impact Assessments

A new Equality Impact Assessment template, at **appendix 7**, was agreed for use at the Patient Experience Steering Group meeting, providing clear guidance to staff with regards its application and use.

4. Patient Safety Solutions

Performance for all Health Boards and NHS Trusts in Wales can be found at http://www.patientsafety.wales.nhs.uk/safety-solutions-compliance-data. The Policy PEP 023 Management and Distribution of Alerts and Safety Notices was approved via the Clinical Policy Group on 2nd November 2021. The current safety alerts module is on the old Datix system and is still in use across wales. As and when the safety module goes live on the new RLDatix system, the policy will be reviewed to take account of any changes required.

The new approach to managing alerts and notices once received into the health board has commenced. Huddles comprising service group Governance Leads and Heads of Services take place on receipt of an alert, and the time is taken to determine who will be the lead person for coordinating the response and the actions required in reporting compliance. A second huddle then takes place at local level within service groups whereby the relevant Governance Lead and Head of Service then goes through the actions required and agree a way forward to collate the evidence required to report compliance. The evidence is then fed through to the coordinating lead who provides an overall compliance response to the

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corporate team for reporting through to the Executive lead prior to reporting compliance to the Delivery Unit. This approach is being adopted for all other types of alerts where indicated, for example, medical devices.

The health board are currently progressing work to report compliance with two overdue patient safety solutions: (1) PSN 034: Supporting the introduction of the National Safety Standards for Invasive Procedures. An update on progress is provided via the quality report provided by the Director of Primary Care Community and Mental Health, and (2) PSN055: This notice replaced PSN030 Safe Storage of Medicines: Cupboards. The notice is very clear with regards all new builds and refurbishments commissioned after issue of the notice that must comply with its requirements. For all existing clinical areas, a risk assessment of medication storage areas and facilities must be undertaken and remedial action undertaken proportionate to identified risks by 30 September 2021. Risk reduction strategies are in place with regards the estate and environments, and as refurbishments are progressed the medicines management team are ensuring recommendations are met. Some of the work will require significant capital investment, for example, where medication storage rooms have been deemed too small, or temperature control is needed. Remedial action has been taken where needed to, for example, replacing non-complying locks and putting in place risk reduction strategies around ambient temperature control issues.

The health board have recently reported compliance with PSN058 Urgent assessment/treatment following ingestion of 'super strong' magnets and PSN 061 Inappropriate anticoagulation of patients with a mechanical heart valve.

The All Wales Patient Safety Solutions Group led by the Delivery Unit continues to meet bi-monthly. A symposium is being held on the 24th November 2021 focussing on 'Never Events: Invasive Procedure & Human Factors Symposium', representatives of the health board will be in attendance.

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Putting Things Right
Audit Report
Quarter 2
July – September 2021

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Introduction

The Audit Programme Cycle for 2021-2022 focuses on three key areas: process compliance, listening and learning and duty of candour.

A phased approach throughout the year, the second quarter has focussed on concerns management, staff concerns, management of redress cases claims management, complainant experience, organisational learning and duty of candour.

This report further focusses on the learning identified from Quarter 1, and improvements put in place.

Standard Concerns

The expectation is that NHS Bodies have an effective process for managing concerns raised by patients and staff in accordance with the NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 which complements and supports the existing processes for the management of clinical negligence claims.

A 10% random sample audit comprising 8 cases.

STANDARD ↓
Compliance with timeframes
2 working days acknowledgement
5 working days for sharing with another body
30 working days
30 working days - 6 months
GDPR- Any Concerns highlighted
Process as stipulated in the policy (management of concern)
Accurate grading (initial triage and closure)
Proportionality (investigation)
Appropriate escalation
Open timely accurate communication (to complainant and staff)
Complaint support (CHC, internal support)
Storage (on J drive and Datix)
Retention (compliance with retention timeframes)
Records
Access
Release
Accuracy and current record keeping (Good (G), Not Good (NG))
Report and output quality (Good (G), Not Good (NG))

McLeod, Nicola
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Received
Date Sent

Findings:

1) Delay in service providing draft concerns response.
2) Delay in final review of response.
3) No holding letter to complainant.
4) Consent not received immediately, only 1 follow up letter was sent to complainant, the draft response was not received in a timely manner; the situation was escalated on a number of occasions. Once draft response received, it was of poor quality and written as a report rather than a letter of response, requiring further work.
5) Consent was not received during the whole concerns process, it was followed up on two occasions. As a result of non-receipt of consent unable to access medical records to undertake investigation and not able to release response to the complainant. The case was closed and closure letter sent explaining response remains on file and can be progressed further on receipt of signed consent.
6) Complainant reluctant to sign consent and content with general response to concerns.

Improvements/ Actions:

(1) Escalation process in place and being utilised where delays with service response timeframes.
(2) Ensure holding letter is sent to complainant 10 days before expected final response due date in order to manage complainant's expectations.
(3) Follow up letters for consent to be actioned and sent sooner, further escalating more promptly. Previously, attempts would be made to provide the complainant a general response, but legal advice taken indicates the health board does not have to provide a general response, to only proceed with an investigation if consent is in place. Enquiries across Wales to ascertain how other health bodies deal with issues of non-response to consent, agreed two follow-ups to be issued and if no consent, the case is closed and response to complaint held on file until received. This can result in a limited investigation as a result of inability to access relevant medical records, etc. This approach has been adopted.
(4) Support to services with draft responses and explain response letter is required rather than a report. Two training sessions took

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place in September and October focussing on drafting of concerns.

Staff Concerns

No cases recorded between July - September 2021

Management of Redress Cases

To ensure an effective process for managing concerns involving a qualifying liability in tort resolved by way of redress, this can be an offer of financial compensation and/or remedial treatment, on the proviso that the person will not seek to pursue the same through further civil proceedings; the giving of an explanation; a written apology; and a report on the action which has or will be taken to prevent similar concerns arising.

<5 cases was reviewed for the relevant period.

Findings:

(1) Delay with redress decision/action. The Redress Panel took place in May 2018 where Breach of Duty was agreed and causation indicated as to be confirmed. The family were not aware of the case at the time.
(2) Email to Redress Panel to authorise financial redress to be made but no email on file to authorise payment and no record of outcome of this email.
(3) Redress outcome letter was not issued due to error in corporate services, further issues regard care and treatment identified and the letter was never issued.
(4) Poor / lack of communication with person, a gap of 9 months noted. When communication took place a further two points for further follow up were identified for investigation. The opportunity was taken to provide a full explanation of the redress process. No investigation report had been completed in respect of the original issue identified, although it was considered breach of duty and possible causation.
(5) Poor record keeping in relation to Datix, progress notes vague and not updated.

Improvements/ Actions:

(1) To ensure the principles of 'being open' are fully embedded into practice.
(2) Ensure email correspondence is saved to file for audit purposes.

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(3) Ensure Redress outcome letters are issued in a timely manner and a full audit trail of follow up emails are documented.
(4) Improvements required in relation to communicating and updating the person on case.
(5) Improvement required around accuracy and precise minute taking of Redress Panels. A template is now in use which enables key information to be captured and recorded.
(6) Improvements to be made in relation to record keeping, in particular on Datix and to update progress notes/documents on a regular basis.

Claims Management

As detailed in the Claims Management procedure, the audit will ascertain the accuracy of reports, costs, compensation claims and, further to ascertain that claims/refunds and dealt with in accordance with the Welsh Risk Pool Reimbursement Scheme.

< 5 cases reviewed.

Findings:

Case managed through concerns and redress process initially and then transferred to compensation claims pathway following request by claimant's solicitors to withdrawn from redress, managed through Legal & Risk (L&RS) Solicitors on behalf of the health board.

Evidence of proactive management, regular communication and discussion on case involving L&RS and the health board. Delegated authority in accordance with agreed delegation criteria. Evidence of expert opinion informing the management of the case, costs reviewed and advice provided accordingly. Compliance with Welsh Risk Pool Reimbursement Scheme for monies paid out, request for a cost schedule to be submitted and this was duly responded to; outcome awaited.

Improvements/ Actions:

Requirement for cost schedule to be provided each time a compensation claim for reimbursement is submitted to the Welsh Risk Pool Reimbursement Scheme.

Complainant Experience

McLellan,Molly
11/26/2021 12:39:21

A person should be able to notify their concern through a single point of entry; have their concern dealt with efficiently and openly; have their concern investigated properly and appropriately; have their expectations

and involvement in the process established early on; bee treated with respect and courtesy; be given advice on the availability of assistance to pursue their concern, and where they may obtain it; have a named contact throughout the handling of the concern and know how to contact that person. If an investigation reveals that there is a qualifying liability, the Welsh NHS body must give consideration to the application of the Redress arrangements; receive a timely and appropriate response to their concern and be kept informed if there is a delay; be informed of the outcome of the investigation; be assured that appropriate action has been taken as a result of raising their concern and lessons learn and have their concern managed and investigated in line with guidance issued by Welsh Ministers.

<5 cases reviewed for this period.

Findings:

(1) Communication issues were identified.

Improvements/ Actions:

(1) To ensure timely and regular communication with regards progress of the matter and issues identified.

Organisational Learning

To ensure good organisational learning from all events (including concerns (incidents, complaints, claims under redress) compensation claims, claims reviews etc) with high level commitment to the objective and the process adopted.

Evidence of actions taken to remedy identified issues and changes put in place, with a focus on improvements clearly indicated in responses. In some cases, where policies, procedural changes indicated, sharing the new policy with the complainant to evidence the change.

Learning from concerns and compensation claims features as part of patient experience reports to the Patient Experience Steering Group on a quarterly basis. Actions are being taken to link learning across to the Learning Group chaired by the Medical Director.

McLellan,Nolly
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Learning from Events Reports (LFERs) are completed for all redress and compensation claim cases, and underpin the reimbursement of financial compensation via the Welsh Risk Pool. Through these reports actions

recommendations and learning have to be clearly evidenced; service groups are engaged within this process.

The Learning from Events Reports (LFERs) have also been recently extended to the reporting of patient safety incidents at national level. They are currently being trialled by Swansea Bay University Health Board with the intention of being rolled out across Wales in the near future.

Duty of Candour

Audit will look for evidence that demonstrates compliance with duties/requirements set out in Health and Social Care (Quality and Engagement) (Wales) Act 2020 Part 3. Duty of Candour has been applied in instances where more than minimal harm has occurred where health care was a factor, that is, was the person informed and apologised to within an appropriate timeframe and through appropriate means? Records are accurate and up to date.

Preparation for implementing the Health and Social Care (Quality and Engagement) (Wales) Act 2020 is being progressed at an all Wales level in preparation for enacting the Duty of Candour in April 2023. Regular communication to staff across the health board via Powys announcements to start embedding the principle and what it means in practice is taking place.

The current NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 requires health bodies to ensure the principles of 'Being Open' are at the heart of Putting Things Right arrangements and support improvements in the management of concerns. The Concerns team work closely with service groups and their staff to promote an open culture with patients, carers and families.

Reflecting on Quarter 1 reported improvements/ actions

Findings in quarter 2 have not highlighted a repeat of issues with recording grading of concerns, use of correct templates for responses, recording of timeframes, supporting improvements in the actions taken by the Concerns Team.

McLean, Kelly
11/26/2021 17:38:31

Consent was an issue in quarter 1 audit cycle and this has now been addressed in quarter 2 as indicated above. Ensuring patients, carers and families are kept up-to-date with regards progress has appeared for redress cases on this occasion, there is now a weekly meeting to ensure

that all people are kept up to date with progress of their concerns and redress cases.

McLellan,Holly
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Appendix 1: audit programme cycle

Area		Activity	Delivery timeframe for internal activity				External Audit (EA)
			Q1	Q2	Q3	Q4	
Process compliance A combination of open and closed cases in a set period of time may be required for a 10% sample.	Standard concerns (all concerns excluding categories below)	random sample audit					
	Staff concerns	random sample audit of specific category					
	Children and Adults at Risk	random sample audit of specific category (Or 10 unique if 10% < 10)					
	Serious Concerns	random sample audit of specific category (Or 10 unique if 10% < 10)					
	Never Events	random sample audit of specific category (Or 10 unique if 10% < 10)					
	Management of Redress Cases	random sample audit of specific category (Or 10 unique if 10% < 10)				(EA)	Yes - Annual
	Claims Management	random sample audit of specific category (Or 10 unique if 10% < 10)				(EA)	Yes – Annual (25%/25 unique)
	Commissioned services concerns	random sample audit of specific category (Or 10 unique if 10% < 10)					
	Cross Border concerns	10% random sample audit of specific category (Or 10 unique if 10% < 10)					
	Multi-agency concerns	10% random sample audit of specific category (Or 10 unique if 10% < 10)					
Listening & Learning	Complainant experience	Ongoing feedback monitoring					
		High level review of monitoring /red flags and learning					
		10% random sample deep dive audit					
	Organisational learning	Combined audit and review activity					
Duty of Candour	Duty of Candour	10% random sample audit					

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High Level Implementation Plan

Putting Things Right

for the period: Quarter 2 (April - June) 2021

Version 1 01/07/21

Complete
On track
Delayed
No Progress

McLellan Holly
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Ref	Theme
1.1	**Concerns are not consistently processed by the simplest path**
1.2	**Process pathways for responding to complaints need clarification and simplification**

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1.3	**Service group governance needs strengthening to ensure capacity and capability at a local level**
1.4	**Corporate concerns team structure review**
1.5	**Capability needs further development to include a structured training Programme**

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1.6	**Performance monitoring including quality assurance**
1.7	**The Health Board should consider introducing an executive panel for oversight of complaints and serious incidents chaired jointly by the Executive Director of Nursing and Medical Director**
1.8	**Learning from concerns, complaints and incidents**
1.9	
1.1	

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1.11

1.12

1.13

1.14

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Learning and Action Taken
Ongoing development with service group leads. Where a short turnaround is identified this is actively followed up by the concerns team
This was actively flagged for development in the November workshop and needs further development. This will include the use of revised templates for reports and responses to ensure consistently high-quality deliver

McLellan,Holly
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Plans are in place to develop governance support in Primary and Community Services. A new governance lead has been appointed in the Womens' and Children service group
The Assistant Director of Quality and Safety has been released from some corporate responsibilities temporarily to provide senior oversight. An options appraisal is underway and is due to report in Q1 21/22.
Training is being commissioned by the Assistant Director of Quality and Safety in conjunction with the Executive Director of Nursing and Midwifery. Training conducted in 2021: January 2021 – 2 day Investigating Officer training conducted. February 2021 - Two webinars took place on the topics "Writing Witness Statements and What to Expect When Attending Court"

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Performance against the standards for Putting Things Right needs further development and a dashboard / scorecard for both corporate and service group individual performance. Initially this should be monitored weekly and then reduced to monthly as performance improves. An audit programme for monitoring assurance against the standards should be in place.
This panel would maintain oversight of formal complaints, serious incidents, coroner cases and Public Health Ombudsman cases including driving performance with service groups.
The health board's first 'Learning from Experience Group', chaired by the Director of Clinical Strategy, took place in March 2021. This group will provide assurance and inform the strategic direction from learning on issues of quality and safety.

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Executive Lead	AD / Operational lead(s)
Director of Nursing & Midwifery	AD for Quality and Safety
Director of Nursing & Midwifery	AD for Quality and Safety

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Director of Primary, Community & Mental Health Services	AD for Primary Care, Mental Health and Women and Children's Services
Director of Nursing & Midwifery	AD for Quality and Safety
Director of Nursing & Midwifery	AD for Quality and Safety

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Director of Nursing & Midwifery	AD for Quality and Safety
Director of Nursing & Midwifery	AD for Quality and Safety
Director of Clinical Strategy	

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Update June 2021
Process mapping completed in December 2020 and process revised in respect of informal and informal concerns All concerns are triaged at the point of receipt to determine the most appropriate management. Concerns suitable for early resolution are identified and action taken to resolve within 24 hours, the next working day. Tracking system put in place for all concerns and incidents February 2021 Mental Health Service Group focusing on early resolution.
Work has been progressed (22 June 2021) with the concerns team and practice managers in primary care to refresh knowledge and understanding of how to manage related concerns. All commissioned service concerns are actively managed by the commissioning lead for quality and safety. Templates are being used for all activity and are in the early stage of revision. Trackers exist for all concerns and compensation claims to support active monitoring and management.

McLellan,Holly
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Governance leads in place in each Service Group as from June 2021.
Review is underway An interim structure is currently in place with two new staff for a 6-month period started w/c 22 June, (1) Concerns and Public Services Ombudsman for Wales coordinator and (2) Redress, Inquest and Claims Coordinator, in addition to a senior administrator role to support.
Training in March 2021 – 2 days complaints handling and investigation training skills provided via the Public Services Ombudsman for Wales Complaints Standards Authority. Further investigation skills training to be procured.

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Assistant Director Quality & Safety holds a daily catch up meetings with the concerns team and a weekly in-depth review of all cases. AD for Quality & Safety meets with HoNMs weekly to review cases and agree any remedial action required Weekly review meetings with CEO; EDoN & Midwifery; AD Quality and Safety and DDoN to have oversight of performance
The patient safety incident implementation group are currently considering this approach.
Learning from concerns and compensation claims to be reported through this group.

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Actions Remaining	Deadline
(1) Maintain triage process (2) Increased focus on early resolution across all specialties/ services.	30 September 2021
(1) Revision of templates to align with Once for Wales project (2) Trackers to be included in PTR audit programme	30 September 2021 31 December 2021

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(1) Service Groups to present governance arrangements including handling concerns, incidents and general quality and safety matters to QGG (2) Improvement trajectories to be agreed with each service group - in line with Section 1.6 (3) Develop dashboard to monitor performance within service groups and use of CAF process by corporate team to provide assurance of performance	31 October 2021
(1) Report the outcome of the options appraisal.	30 August 2021
(1) Training Programme to be formalised and yearly programme set including induction requirements (2) Training to be aligned with revised PTR arrangements and new patient safety framework (3) Procure incident investigation training in Q2	31 October 2021 31 October 2021 30 September 2021

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(1) Development of dashboards on the new OFWCMS to support monitoring. (2) Weekly overview meetings continued. (3) Report Quarterly findings audit and assurance cycle. (4) Establish improvement trajectory to achieve compliance by 30/09/21 (5) Use of CAF process for commissioning services to performance monitor	30 September 2021 Ongoing 31 August 2021
(1) To confirm agreement and planned approach in line with the requirements for PTR and the new patient safety incident framework. (2) Develop examples of 'good practice' responses to concerns; investigation reports for incidents so investigators understand 'what good looks like'.	01 March 2022
(1) Active reporting through QGG; EQS; Service Group Quality and Safety arrangements; Internal bulletins	31 March 2021

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Status	Comments
	Work continues daily to triage all concerns and enquiries received. This is now an embeded process.
	Putting Things Right Policy approved via the clinical policy group on the 2nd November 2021. The Policy now requires scheduling at the next Board meeting for approval. Audit programme Qtr 2 completed and reported. Trackers in place for all cases under each heading of concerns (provided and commissioned), redress, Ombudsman, inquests, compensation claims and patient safety incidents reported at national level.

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	Presented papers to be embedded. Weekly meetings in place with service groups to ensure tracking of concerns, etc. Dashboard functionality for RLDatix received 1st October and dashboard requests have been prioritised for development reflecting strategic and operational needs.
	The Concerns team model is now agreed. Substantive appointments are being progressed based on the interim model.
	Training schedule developed, content being developed and will be finalised in December 2021. Further work required to explore need for external investigation.

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	The Health Board continues to progress improvements in performance, however current performance is below Welsh Government targets.
	The new incident framework is formally in place from April 2022 and the Health Board is working towards compliance in 2021-22.
	In place. Quality Governance Group temporarily stood down and reporting through Executive Committee.

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Powys Teaching Health Board
Putting Things Right and Investigation Training
Catalogue 2022-2024

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2022

Patient Safety Incidents **Trainer:** **PTHB**	**March 2022**	**June 2022**	**September 2022**	**December 2022**
Investigation Training **Trainer:** **PTHB**	**January 2022**	**April 2022**	**July 2022**	**October 2022**
Concerns Management **Trainer:** **PTHB**	**January 2022**	**April 2022**	**July 2022**	**October 2022**
Customer Care: **Trainer:** **Public Services Ombudsman**	**February 2022** **Complaints and Negotiation**	**May 2022** **Complaints and Negotiation**	**August 2022** **Complaints and Negotiation**	**November 2022** **Complaints and Negotiation**
Customer Care **Trainer:** **Public Services Ombudsman**	**February 2022** **Communication Skills**	**May 2022** **Communication Skills**	**August 2022** **Communication Skills**	**November 2022** **Communication Skills**
Customer Care **Trainer:** **Public Services Ombudsman**	**February 2022** **Managing Expectations, Resilience and Accountability**	**June 2022** **Managing Expectations, Resilience and Accountability**	**October 2022** **Managing Expectations, Resilience and Accountability**	
Customer Care **Trainer:** **Concerns Team**	**April 2022** **Managing Expectations, Resilience and Accountability**	**August 2022** **Managing Expectations, Resilience and Accountability**	**December 2022** **Managing Expectations, Resilience and Accountability**	
Redress and Compensation **Trainer:** **PTHB**	**February 2022**	**June 2022**	**October 2022**	

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2023

Patient Safety Incidents **Trainer:** **PTHB**	**March 2023**	**June 2023**	**September 2023**	**December 2023**
Investigation Training **Trainer:** **PTHB**	**January 2023**	**April 2023**	**July 2023**	**October 2023**
Concerns Management **Trainer:** **PTHB**	**January 2023**	**April 2023**	**July 2023**	**October 2023**
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Redress and Compensation **Trainer:** **PTHB**	**February 2023**	**June 2023**	**October 2023**	

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2024

Patient Safety Incidents **Trainer:** **PTHB**	**March 2024**	**June 2024**	**September 2024**	**December 2024**
Investigation Training **Trainer:** **PTHB**	**January 2024**	**April 2024**	**July 2024**	**October 2024**
Concerns Management **Trainer:** **PTHB**	**January 2024**	**April 2024**	**July 2024**	**October 2024**
Customer Care: **Trainer:** **Public Services Ombudsman**	**February 2024** **Complaints and Negotiation**	**May 2024** **Complaints and Negotiation**	**August 2024** **Complaints and Negotiation**	**November 2024** **Complaints and Negotiation**
Customer Care **Trainer:** **Public Services Ombudsman**	**February 2024** **Communication Skills**	**May 2024** **Communication Skills**	**August 2024** **Communication Skills**	**November 2024** **Communication Skills**
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Customer Care **Trainer:** **Concerns Team**	**April 2024** **Managing Expectations, Resilience and Accountability**	**August 2024** **Managing Expectations, Resilience and Accountability**	**December 2024** **Managing Expectations, Resilience and Accountability**	
Redress and Compensation **Trainer:** **PTHB**	**February 2024**	**June 2024**	**October 2024**	

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Learning from Events Report

Report on Learning following investigation

Checklist S1C V2.2[draft]

LFER Report Submission to: *Mark the appropriate recipient of the LFER with an 'X'*	NHS Wales Delivery Unit	
	Welsh Risk Pool Safety & Learning Team	
Name of Health Body		
Health Body Case Reference		
Nationally Reported Incident Reference *Reference number provided by the NHS Wales Delivery Unit*		
Welsh Risk Pool Case Reference *Reference number provided by the Welsh Risk Pool*		

COVID-19		
Is this case related to arrangements, care or processes related to COVID19?	YES / NO	
Analysis of the Four Harms of Covid-19	Harm from Covid itself	
	Harm from overwhelmed NHS & Social Care system	
	Harm from reduction in non-Covid activity	
	Harm from wider societal actions / lockdown	

CLINICAL NEGLIGENCE CASES *This section is only applicable for matters submitted to the Welsh Risk Pool*		
Is this case linked to a clinical negligence claim or redress matter handled under the PTR Regs?	YES / NO	
Date of decision to settle case		
Trigger for decision to settle case	Redress QL determined	
	Decision to make admissions	
	Decision to make offer	
	Decision to accept offer	
	Damages awarded at trial	
	Other	
>£1m Case?	Is the case definitely or likely to exceed £1m in value, where Welsh Government approval is required to settle the matter?	YES / NO

SAFETY COMPLIANCE	
Is this case considered to be a NEVER EVENT	YES / NO
Is this case associated with non-compliance of a Patient Safety Alert or Notice	YES / NO

RECURRING THEME	
Does the Health Body consider that this event is caused by a common or recurring root cause? *If YES please provide details*	YES / NO

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This Learning from Events Report has been produced to outline the learning from nationally reported incidents, clinical claims and redress cases. The report is to be submitted to the NHS Wales Delivery Unit or Welsh Risk Pool within defined timescales.

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

Learning from Events Report

Report on Learning following investigation

Checklist S1C V2.1[draft]

CONTENTS

01.00 Case Summary
02.00 Investigation Approach & Findings
03.00 Harm or outcome arising from the case
04.00 Additional or incidental findings
05.00 Issues & Actions
06.00 Learning Assurance Plans
07.00 Being Open / Duty of Candour
08.00 Sharing of Learning & Improvement
09.00 Supporting documentation
10.00 Thematic Analysis
11.00 Learning from Events Declarations
- Checklist & Guide for Completion

Submission Arrangements

LFERs relating to Nationally Reportable Incidents are submitted to the NHS Wales Delivery Unit via email:
NationalSIreports@wales.nhs.uk

LFERs relating to Clinical Negligence Claims or Redress Cases are submitted to the Welsh Risk Pool via email:
WRPS.ClaimsReimbursement@wales.nhs.uk

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1.00 Case Summary

1.01

2.00 Investigation Approach and Findings

2.01

3.00 Harm or outcome arising from the Event

3.01

4.00 Additional or incidental findings

4.01

5.00 Issues & Actions

Issue	Actions		Status
	REF		

Issue	Actions		Status
	REF		
	REF		

6.00 Learning Assurance Plans

Ref	Topic	Plan Summary	Status

McLaren,Holly
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7.00 Being Open / Duty of Candour

7.01

8.00 Sharing of Learning & Improvement

8.01

Key Message for National Sharing	*What is the one key message from this case for sharing with other NHS Organisations?*

9.00 Supporting Documentation

Ref	Title	Outline

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10.00 Categorisation / Thematic Review

National organisations are monitoring themes and trends associated with the issues that arise within events that are the subject of learning reports. Please flag any of the categories which directly or indirectly relate to the issues identified in this case. *NB The categories are intentionally broad to enable further analysis of the case by specialist teams.*

Category / Theme	Related to this case? *Mark any that are related with a X*
Maternity Services	
CTG Interpretation	
Radiology Images	
Consent to Examination or Treatment	
VTE Management	
Delay to Treatment / Lost to Follow-up	

DEATH OF PERSON AFFECTED		
Does this case relate to a patient who has died?	YES / NO	
Cause of death		
Inquest status	☐ Inquest scheduled (specify date): ☐ Inquest taken place (specify date): ☐ Coroner has decided not to open an inquest ☐ Pending Coroner's decision to open an inquest	
Inquest status	☐ Inquest scheduled (specify date): ☐ Inquest taken place (specify date): ☐ Coroner has decided not to open an inquest ☐ Pending Coroner's decision to open an inquest	
Coroner's Conclusion *If relevant and available, please provide full details of the Coroner's conclusion*	☐ Natural causes ☐ Accidental Death ☐ Unlawful Lawful killing ☐ Alcohol / Drugs related ☐ Narrative *(provide details)*	☐ Industrial Disease ☐ Road Traffic Collision ☐ Open ☐ Suicide
Was a Regulation 28 issued by the Coroner?	☐ Inquest not yet held ☐ Inquest held but a Regulation 28 was not issued ☐ Yes, a Regulation 28 was issued *(please provide details):*	

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11.00 Learning from Events Declarations

GOVERNANCE LEAD DECLARATION
To be signed in all cases
I have considered fully the investigation findings, issues, actions plans and learning assurance, and confirm that the details recorded above are complete, accurate and reasonable response to the findings of the case. Signed by Date: Print Name – Position –

LEGAL CASE MANAGER'S DECLARATION
To be signed by the Claims Handler or Redress Case Handler for all submissions to the Welsh Risk Pool
I have considered fully the management of this claim and my findings are recorded. I confirm that the details recorded in each relevant section are complete and accurate and that these aspects of the appropriate scheme guidance have been properly considered and actioned. Signed by Date: Print Name – Position –

EXECUTIVE'S DECLARATION
To be signed by an Executive Officer for all National Reported Incidents
I confirm that this incident has been thoroughly investigated and the findings and recommendations have been agreed by the appropriate committee and have either been acted upon or plans are in place to implement the actions within an agreed timescale. Signed by Date: Print Name – Position –

McLellan,Holly
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Checklist and Guide to Completion

The Learning from Events Report is used by Health Bodies in NHS Wales to report the issues that have been identified following investigation of a Nationally Reportable Incident or from a clinical claim or redress Investigation. The report also outlines how the identified issues have been addressed to reduce the risk of reoccurrence or reduce the impact of a future event. An alternative version of the document is available for use with non-clinical legal cases - including personal injury or violence & aggression matters.

Improvement to quality and safety in healthcare is aligned to learning which flows from case investigations, and the Learning from Events Report provides a framework for regulators and inspection bodies to gather assurance that appropriate improvement has been implemented. This version of the LFER document has been developed to facilitate use with reports made to the NHS Wales Delivery Unit as well as the Welsh Risk Pool.

It is important that the Learning from Events Report provides a sufficient explanation of the circumstances and background to the events which have led to the case, in order that colleagues who are scrutinising the report can identify the links to the findings and learning outcomes.

Supporting information, such as action plans, expert reports and review findings may be appended to the Learning from Events Report to evidence the learning activity. These should be referenced in the main document and the relevance of the attachments clearly outlined.

The Report must be signed by appropriate key staff within the organisation concerned. This will generally include senior staff within the service(s) involved who are required to take responsibility for ensuring actions and improvements are implemented.

For Claims and Redress Cases, the person responsible for coordinating the matter should also countersign the report (this is usually the claims handler).

For Nationally Reportable Incidents, an Executive Director must sign the declaration.

This checklist should be used to ensure that appropriate and relevant information is included in the report.

McLellan,Holly
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SUMMARY & REFERENCE SECTION

Submission of LFER to National Bodies

The organisation submitting the LFER should identify which national body the report is being submitted to.

Name of Health Body

The established Health Body needs to be identified. If the case relates to the services of a hosted or sub–contracted organisation, the relationship with the established health body must be outlined.

Case Reference Numbers

The local case reference number used by the organisation submitting the LFER should be provided. Additionally, the reference numbers provided by the NHS Wales Delivery Unit or the Welsh Risk Pool should be provided. LFER's may be returned if the appropriate reference number is not provided.

Covid19 Cases

Please state YES or NO to identify if the case is related to the management of patients with coronavirus, contraction of infection or another matter related to the pandemic. A breakdown of the four harms of Covid19 is also required and all harms which apply to the case should be confirmed. Details of the Covid impact should be outlined within the case summary section.

Clinical Negligence Cases

For clinical negligence claims or redress cases handled under PTR regulations, specific information is required:

- *Decision to settle case*

The date of a decision by the health body to settle the case must be provided.

- *Trigger for settlement*

The date that the decision was reached by the Health Body to settle the matter must be recorded. For Redress matters, this is the date that a Qualifying Liability was determined. For clinical claims, this is the date that a decision to make an offer, accept an offer, make admissions or award of damages at trial occurs.

- *Confirmation of >£1m case*

Where the case is definitely or likely to exceed £1m, and therefore require Welsh Government approval to settle the matter, this needs to be established in order that the Welsh Risk Pool can include the Welsh Government Healthcare Quality Team in the scrutiny process.

Safety Compliance

Details must be provided of whether the LFER relates to an incident or legal matter that is considered a Never Event or non-compliance with a Patient Safety Alert / Notice.

Recurring Theme

If there is considered to be a recurring causal theme, details should be outlined. It is important to note that this should relate to causal themes and not event themes. Examples of causal themes include 'omitted medication administration' or 'missing documentation'.

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SECTION ONE Case Summary

A basic case summary of the circumstances of the events.
Remember to include the age and sex of the patient.
The name of the hospital or service and details of the unit, ward or team, on which the incident occurred should be included.
An outline of the relevant events relating to the case is required, and this should where possible be presented in in chronological order.
Where appropriate, outline the long-term outcome – whether the patient died or they continue to experience ongoing symptoms or have fully recovered.

SECTION TWO Investigation Approach & Findings

Outline the approach to the investigation; include how the investigation is proportionate to the circumstances
Were there any linked or associated investigations or internal reviews (such as SI investigations, complaint investigations or inquest reports)?
What relevant internal comments were obtained?
What relevant external specialist comments were obtained?
For legal matters, outline the breaches of duty identified in the case, along with any causation issues.

SECTION THREE Harm or outcome arising from Event

What harm did the investigation findings identify?
Are there any outstanding issues relating to harm investigation?

SECTION FOUR Additional or incidental findings

Are there any incidental findings which are not related directly to the incident or case allegations?

SECTION FIVE Issues & Actions

What issues were highlighted from the investigation?
– such as failing in clinical care, errors in procedures and process or other breaches of duty?
What actions are being taken to reduce the likelihood of a reoccurrence?
What actions are being taken to reduce the impact of a repeat event?
How will the completion of the actions be measured (eg audit/ reports/ data)
For actions which are not yet complete, ensure clear timescales are provided.

SECTION SIX Learning Assurance Plans

What plans or reviews are in place to monitor the actions taken?
How will the Health Body monitor the quality of service or care provision?
How has the case been shared for wider learning?

SECTION SEVEN Being Open / Duty of Candour

How has the duty of being open been complied with?
Outline of communication with persons affected or advocates

SECTION EIGHT Sharing of Learning & Improvement
Key Message for National Sharing

McLellan, Holly
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Outline details of how learning from the case has, or is, being shared within the organisation. Provide details of any national sharing of learning that has been carried out by the health body.

In addition to details of local and national sharing of learning that has been carried out, an outline should be provided of the key message that the health body feels should be shared nationally. National bodies will collate and share key messages.

SECTION NINE Supporting Documentation

Name and outline of documentation appended to this report

It is usual practice to include supporting documentation as evidence of an action plan or action completion.

SECTION TEN Categorisation / Thematic Review

Flag any themes from the identified list.

The theme should be flagged if the case involves the category directly or indirectly. If the case is associated with the death of a patient, details of involvement of HM Coroner must be outlined.

SECTION ELEVEN Learning from Events Declarations

For all cases, the signature of Governance Lead(s) within services involved in the case is required. Where the matter relates to multiple teams / services / divisions, the signature section can be replicated for each signatory.

For legal claims or redress cases, the signature of the claims handler or redress case manager is required to comply with WRP Reimbursement Procedures.

For LFER's related to nationally reported incidents, the signature of an Executive Director is required.

Where a signature section is not required in a specific case, these can simply be deleted.

McLellan,Holly
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Guidance Notes

General Points

(1) Organisations to provide one c

(2) Redress cases on the Closed CC

(3) The submission

ta relating	bmission Date
ril - June 20	1st July 2021
September	t October 2021
r - Decembe	t January 2022
ary - March	th April 2022

(4) All submissions should be e-ma

HSS.Performance@gov.wales

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NEW COMPLAINTS - 2021/22			Q1
1	New complaints: Total number of new complaints received by the organisation during the quarter [both those to be managed through PTR regulations and through Early Resolution]		101
2	Of the total number of new complaints received by the organisation during the quarter, how many were made by or on behalf of someone who wished to communicate through the Welsh Language		0
3	Complaints by SETTING / LOCATION How many new complaints received by the organisation during the quarter were in relation to the following settings or locations: *(Only the Principal setting / location should be submitted)*	**Acute / general hospital**	
		Inpatient	13
		Outpatient	9
		Emergency Department	4
		Community Hospital	
		Inpatient	5
		Outpatient	13
		Mental Health and Learning Disabilities	
		Inpatient	5
		Outpatient	0
		Community Mental Health	7
		Minor Injurys Unit (Acute or community based)	6
		Out of Hours GP services	1
		Ambulance service	
		Emergency and general transport	2
		111 services	1
		Welsh Blood Services	0
		Public Health Services	0
		Primary Care Services	
		General Practice (Independent Services)	20
		General practice (Health Board Managed Practices)	1
		NHS Dentists	8
		NHS Opticians	0
		NHS Pharmacies	3
		NHS Health Care provided in the Community	
		Inpatient setting eg nursing home	0
		patient's own home	0
		Externally Commissioned Services non NHS Wales	0
		Prison	0
		Other	3
4	Complaints by STAFF GROUP How many new complaints received by the organisation during the quarter were in relation to the following professions: *(Only the Principal profession should be submitted)*	Medical and dental staff	28
		Nursing, midwifery and health visiting staff	62
		Maintenance & Auxiliary Staff	0
		Clerical and Admin Staff	1
		Scientific, therapeutic and technical staff	2
		Healthcare assistants and support staff	0
		Ambulance Clinical Staff	0
		Concern not related to a profession	3
		Other	3
		Staff Not employed by the organisation	2
		Unknown	0
5	Complaints by SUBJECT How many new complaints received by the organisation during the quarter were in relation to the following subjects: *(Only the Principal subject should be submitted)*	Access (to services)	26
		Accident / falls	0
		Admissions	1
		Appointments	16
		Attitude / behaviour	9
		Assault	0
		Post death issues	1
		Catering	0
		Cleanliness	0
		Clinical treatment / assessment	7
		Communication issues (including language)	6
		Concerns handling	2
		Confidentiality	7

McLellan,Holly
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NEW COMPLAINTS - 2021/22			Q1
		Consent	0
		Discharge issues	5
		Equality	0
		Equipment	2
		Environment / facilities	5
		Infection control	0
		Medication	7
		Monitoring / observation issues	0
		Nutrition / hydration issues	0
		Patient care	1
		Personal property / finance	0
		Privacy / dignity	0
		Referrals	4
		Record keeping	1
		Resources	0
		Skin damage	0
		Test and investigation results	0
		Other	1
6	**Total number of written compliments received in the quarter**		**61**
7	**Total number of previously closed complaints that were reopened during the quarter**		**2**

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CLOSED COMPLAINTS - 2021/22

Q1

NOTE - ALL REDRESS CASE INFORMATION WILL BE SUPPLIED BY THE WELSH RISK POOL

8	**Complaints Closed during the Quarter:** **Of the total number of Closed Complaints closed by the organisation during the quarter , how many were categorised as:**	**Complaints managed through PTR Regulations:**	
		Complaints Managed as FORMAL COMPLAINTS	**49**
		Complaints Managed as INFORMAL COMPLAINTS	**12**
		Total number of complaints managed through PTR Regs	**61**
		Complaints managed through Early Resolution	**0**
		Total number of Complaints Closed during the quarter	**61**
9	**Regulation 24 Complaints** **Of the total number of Complaints managed through the PTR Regulations closed during the quarter, how many Complaints had received a final reply (under Regulation 24):**	Up to and including 30 working days of the date the Complaint was first received by the organisation	**23**
		After 30 working days and up to and including 127 working days (6 months) of the date the Complaint was first received by the organisation	**23**
		After 127 working days (6 months) of the date the Complaint was first received by the organisation	**3**
		Total number of Regulation 24 Complaints settled and received a final reply during the quarter	**49**

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Aneurin Bevan UHB
Betsi Cadwaladr UHB
Cardiff & Vale UHB
Cwm Taf Morgannwg UHB
Hywel Dda UHB
Powys Teaching HB
Swansea Bay UHB
Public Health Wales NHS Trust
Velindre NHS Trust
Welsh Ambulance Service NHS Trust
Health Education and Improvement Wales
Digital Health and Care Wales

McLellan Holly
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Patient Experience Framework

Leadership (for Patient Focus)

Ref	Aim	What this will look like	Current Position	Planned action to improve	What will Good look like?
1	The board has a framework to deliver improved patient experience and the Health Board (HB) regularly engages with groups of patients and other key stakeholders to inform plans to deliver the strategy.	1A. The HB has a patient experience framework (either a stand- alone document or integrated into a strategy for improving quality) Patient experience should be both fully aligned with and integral to quality improvement.			
		1B. The HB has a delivery plan, impact measures and review timetable and carries out an annual review of progress towards achieving the aims.			
		1C. The HB has a programme of patient, patient representative and public engagement which informs key decisions.			
2	Patient experience is embedded in all HB leadership development work (including that undertaken by operational managers and clinical staff).	2A. Patient experience is embedded in all aspects of leadership development.			

Mclellan,Nolwen
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3	An identified executive lead is accountable for leading quality improvements in patient experience.	3A. The executive lead for patient experience routinely provides the board with reports and proactively leads this area of work within the organisation. Patient stories are routinely used at board meetings and other settings.			
		3B. The senior leadership team is accessible and visible in the organisation and routinely engages with patients and frontline staff.			
4	There is clear clinical leadership from the clinical and operational directors in the development of the quality strategy and clinical strategy which focus on quality, patient experience and safety.	4A. All clinicians are engaged and provide input into the development of services and efficiency changes and how change impacts on patients and front-line staff.			

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Organisational Culture

Ref	Aim	What this will look like	Current Position	Planned action to improve	What will Good look like?
9	The HB participates in all mandated surveys and works to develop and implement rapid/real, or near real-time patient feedback	9A. Full compliance with all mandated surveys, and a comprehensive programme to seeking real or near real- time from patients using the most up to date technology available.			
10	The HB has a patient- friendly complaints process, which complies with national guidance.	10A. The HB has an accessible user-friendly complaints process. Information is visible in all location's patients receive care, and where applicable is available from community staff.			
		10B. Complaints information is clearly displayed on the trust's website.			
		10C. Complainants are offered a virtual or face-to-face meeting, supported throughout the process and their feedback sought on completion of dealing with the complaint.			
		10D. Feedback about how the complaint was handled is routinely gathered.			
		10E.There is evidence that practice has changed following complaints			

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		and improvements have been sustained			
11	Frontline staff take ownership of, and deal with, issues raised by patients, and only where necessary refer on to others. When patients express a wish to complain clear information is provided and support given. The Duty of Candour is followed.	11A. Frontline staff are supported by managers and their teams to address concerns raised by patients, and there is a process for teams to share and learn from this.			
		11B. Duty of Candour regulations are well understood and embedded. The organisation's processes are clear and transparent.			
12	Patients are given information about the range of ways they can provide feedback (which might include paper-based surveys, comment cards, web, text, devices, and apps) and are supported by staff to use these. Approaches offered take account of the needs of patients who are less able or less willing to feedback	12A. The HB provides information to patients about how to give feedback in a range of different ways.			
		12B. The HB employs a range of methods to collect patient feedback, based on patient need and preference. Staff are familiar with these and encourage and support patients.			

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Analysis and Triangulation

Ref	Aim	What this will look like	Current Position	Planned action to improve	What will Good look like?
13	The HB has a systematic way of analysing patient feedback in all its forms, including complaints and produces clear helpful reports	13A. The HB routinely and systematically analyses feedback, brings together all strands and identifies themes which it acts on.			
14	The HB produces reports that demonstrate the correlation between improving patient outcomes, patient safety and patient experience.	14A. Reports highlight themes where patient experience correlates with other quality measures (for example patient safety and clinical outcomes) and board reports clearly articulate the relationships and the quality improvement actions arising.			
15	The HB is able to use patient experience data effectively to identify and locate deteriorating performance, and to enable quick action to address the causes	15A.The HB effectively uses patient experience data to provide an early warning system for deteriorating standards of care that enables leaders at a range of levels to spot when there are concerns, using quality improvement approaches.			
16	Patient feedback is routinely considered and acted upon by frontline teams, and escalated when larger scale service redesign work is required	16A. Frontline teams routinely discuss patient feedback and use it to improve care. 16B. The trust has an effective approach to celebrating and sharing learning locally.			

McLellan,Amy
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Using patient feedback to drive quality improvement and learning

Ref	Aim	What this will look like	Current Position	Planned Action to improve	What will Good look like?
17	The organisation supports staff to use shared decision making about care and treatment with patients, and actively supports staff to involve patients in their care.	17A. Staff demonstrate a good understanding of the theory and practice of shared decision making, its principles are underpinned through training programmes.			
		17B. Patients and their families are involved in their care and understood what is expected in relation to their care.			
18	The HB uses staff appraisal to identify training needs and based on need, implements training for staff so they able and confident to use feedback to improve services using quality improvement methods and tools.	18A. HB has a systematic approach to identifying staff training needs related to using patient feedback to improve services.			
		18B. There is a consistent approach to sharing learning across the organisation.			
19	All proposals for service change, project initiation documents and business cases are accompanied by an EIA.	19A. The results of an EIA are always included within proposals.			
20	The HB uses quality improvement methods and tools to try to continuously improve quality of experience of care and outcomes for patients.	20A. Frontline staff engage in quality improvement and are given the skills required to identify quality problems, carry out tests of change, measure their impact and act on the results.			

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Reporting and publication

Ref	Aim	What this will look like	Current Position	Planned action to improve	What will Good look like?
21	Patient experience is a key component of the trust's annual quality accounts.	21A. The quality accounts include information about patient experience and how the trust is listening and responding to patients, along with examples of improvements to services or care it has made as a result.			
22	The HB routinely publishes transparent and publicly accessible information about the feedback patients have provided, and its response to feedback (e.g. you said, we did).	22A. Information is available and accessible to patients and the public.			
		22B. The organisation has a Communications strategy in place which is clear about who the organisation shares information about patient experience.			
23	The HB is working towards a model of co-production and supports patients and staff to deliver this approach.	23A. Co-production is used, and the organisation can cite examples of co-production, including the use of specific improvement methodologies, where staff have worked in			

McEwan,Holly
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		partnership with patients to improve services.			

McLellan,Holly
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Equality Impact Assessment Template

For:	(Insert title of proposal, service, decision etc.)
Date form completed:	
Name of Completer	

Any organisation providing a public function is subject to the general duty under the Equality Act 2020.

In summary, those subject to the general equality duty must have had due regard to the need to:

a) Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Equality Act.
b) Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it.
c) Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

Equality Impact Assessments **must** be carried out for all new policies, strategies, service plans, new services and service change proposals.

Generally speaking, the majority of new policies, strategies, and plans, will be developed with the intention of improving conditions for members of staff and the public. They usually promote equality and seek to have a positive impact. However, you should still complete the template on page 6 to accompany your documents prior to gaining approval. The EIA template may prompt you to make further improvements to your document which you may not have considered previously. It could also highlight any possible omissions or issues which you may need to address before seeking approval.

New service proposals and service change will require a more in-depth consultation and engagement procedure, and will required a more detailed EIA.

The following guidelines provide a simple template to help you consider the general equality duty in relation to the services you provide, and particularly in relation to any plans for changes in the ways those services are provided.

It is good practice to engage with service users and other stakeholders in the development and ongoing review of your equality impact assessment. For example, by asking them what they think the impact might be, working with them to agree mitigation actions to address adverse impact, and continuing your dialogue to check that your actions are having the desired effect.

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Equality Impact Assessment Template

In addition to the statutory duties under the Equality Act it is also good practice for independent contractors to also consider the impact on:

- Welsh Language
- Carers
- People living in Socio Economic Disadvantage

Preparing your EIA document

Service Change Proposal / Strategy / Policy

You should state the title outline the nature of what you are equality impact assessing here.

Background / Introduction:

Use this section to give context to the EIA. You should introduce the EIA outlining the details of the proposal. This section should also include details about the nature of your service, the area it covers and the population it serves. You should refer to data in the most recent Population Needs Assessment to inform your EIA.

For example, you should you should provide the following:

- General information on the service area – which areas does it cover? Who does it serve?. It would be good to include some basic info about the local population and your service users if they are available to you, e.g. age range of service users / how many have a registered disability / any social deprivation / rural challenges, etc.
- Description of the proposal / Background situation e.g. why are you undertaking an EIA? What changes to services are you making? What do you propose? Why are you making these changes? How have demands on the primary care service changed and what changes are needed to incorporate them? What is your current capacity to deliver the required changes? What resources are available to meet the needs of your service users and implement the required changes? (It would be good if you could include some data / statistics / graphs here to illustrate the type of services accessed over a set period of time to demonstrate any trends / changes in access to services. Is there any data that you can share to demonstrate how you have reached your decision to make the proposed changes?

Description of the EIA undertaken

Mclean,Huw
1/26/2021 11:58:21

What did you do? You should provide details about the level of consultation and engagement you have undertaken. The feedback obtained from the consultation

and engagement needs to inform your EIA, so giving details about the type of engagement you have done is paramount.

You should include precise details – dates, timescales, how people were invited to respond, etc.

You should provide more specific details of the consultation and engagement which took place e.g. give details of public meeting events, social media engagement, letter correspondence, posters, notices, local press announcements, etc. Did you consider any other form of consultation and engagement? What there any restrictions? For example due to COVID-19, inclement weather, etc, and what impact did this have?

How many responses were received? How were they received? How have you analysed them?

Do you have plans for any continued consultation / communication with service users?

What was the expected outcome of the EIA? Dis this differ to the actual outcome?

Was there a mix of positive and negative responses to the proposals?

Common Themes

You should acknowledge and analyse any common themes arising from the responses received. It is important to demonstrate that you have listened to the concerns raised and have explored mitigating actions. What discussions have taken place after the consultation and engagement? How have you analysed the responses? Have you sought advice from external organisations? E.g. support from Service Improvement Manager for Equality in PTHB, 3rd Sector organisations, etc.? Do you intend to seek advice from other organisations to help put mitigating actions in place? E.g. Local Councils, Accessibility Powys, RNIB, local action groups, patient stakeholder groups, etc?

Lessons Learned / Mitigating Actions

You should look at each of the common themes identified and explain how you have or will address any concerns.

For example, if a key theme appears to be miscommunication, a mitigating action would be to develop clear communication channels between your team and your service users in order to alleviate concerns. For example, you could work with Local Councils, other service areas, 3rd sector organisations, etc, to help promote further communication to service users and the public to help clarify your

Welsh NHS
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proposals and what this will mean for your service users to avoid any future misunderstanding and misinterpretation.

How does your service promote equality?

Look at the EIA template which lists the protected characteristics, Welsh Language, Carers and Socio-economic conditions. You should provide details of the procedures you have in place to deal with the specific individual needs of your service users, for example, how is your service accessible to those with a physical disability? How do you promote this accessibility? Does your service have alternative methods for communicating with individuals who have a sensory loss? Do you use interpretation services, emailing and text services for those who are hard or hearing? Do you use interpretation services for individuals who's first language is not English? Is your signage and documentation available in Welsh and English? Do you have any Welsh speaking staff? If you do not have any systems in place to cater for individual needs, you should state how you will mitigate these risks, and outline the actions you will take. You should approach this thinking about the protected groups as a whole but also take into consideration the specific comments received from individuals.

For example, if an individual has made comments on physical access to buildings, you could refer to any mitigating actions that you already have in place, or will put in place to resolve this issue. You should outline any further steps which could take e.g. methods of promoting accessibility to buildings. This could be included under the disability section of the EIA template.

Another example could be how your service deals with services users who have a sensory loss. You should state your intention to work with relevant 3rd sector organisations to introduce and promote available support such as the use of live sign / Relay UK, Type Talk, or establish an email / text system for Deaf/deaf patients. You could also look to source sensory loss awareness training for staff and specialist advice in the future to help improve accessibility to your services for those with sensory loss.

Conclusions

You should summarise all of the above and state your intentions whether you wish to continue with your proposed changes or not.

You should summarise what you feel the impact of the proposals will be upon your service users, in particular those who may face additional challenges due to a protected characteristic.

McGlynnPolly
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You should acknowledge any challenges which remain and how you will continue to address them. What impact should the mitigating actions have? How will you improve service delivery?

Did you consider any alternative service change proposals? Could they have had a worst impact upon service users to those which you propose?

You should reinforce your reasons for the proposed changes and outline how you intend to monitor the changes and how it will impact upon your service users in the future. Will you review the situation within a set timescale? Will you continue to monitor the impact the changes have upon those with a protected characteristic? For example, establish a service user stakeholder group? Work with local action groups? Repeat engagement activity at regular intervals? Etc.

EIA Table

Please indicate overleaf that you have considered the impact of the proposal on the protected characteristics for all those that might be impacted (service users, patients, staff, patient's relatives and carers etc.).

McLellan,Holly
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Equality Impact Assessment Template

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken Make reference to where the mitigation is included in the document, as appropriate
Age For most purposes, the main categories are: • under 18; • between 18 and 65; and • over 65			
Persons with a disability as defined in the Equality Act 2010 Those with physical impairments, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes			
People of different genders: Consider men, women, people undergoing gender reassignment **NB** Gender-reassignment is anyone who proposes to, starts, is going through or who has completed a process to change			

McLellan, Kelly
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Equality Impact Assessment Template

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken Make reference to where the mitigation is included in the document, as appropriate
his or her gender with or without going through any medical procedures. Sometimes referred to as Trans or Transgender			
People who are married or who have a civil partner.			
Women who are expecting a baby, who are on a break from work after having a baby, or who are breastfeeding. They are protected for 26 weeks after having a baby whether or not they are on maternity leave.			
People of a different race, nationality, colour, culture or ethnic origin including non-English speakers,			

McLellan, Hayley
11/26/2018 12:08:21

Equality Impact Assessment Template

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken Make reference to where the mitigation is included in the document, as appropriate
gypsies/travellers, migrant workers			
People with a religion or belief or with no religion or belief. The term 'religion' includes a religious or philosophical belief			
People who are attracted to other people of: • the opposite sex (heterosexual); • the same sex (lesbian or gay); • both sexes (bisexual)			
People who communicate using the Welsh language in terms of correspondence,			

McLellan,Holly
11/26/2024 12:38:21

Equality Impact Assessment Template

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken Make reference to where the mitigation is included in the document, as appropriate
information leaflets, or service plans and design Well-being Goal – A Wales of vibrant culture and thriving Welsh language			
People according to their income related group: Consider people on low income, economically inactive, unemployed/workless, people who are unable to work due to ill-health			
People according to where they live: Consider people living in areas known to exhibit poor economic and/or health indicators, people unable to access services and facilities. This also may include wifi			

McLellanNolly
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Equality Impact Assessment Template

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken Make reference to where the mitigation is included in the document, as appropriate
poverty, travel poverty and fuel poverty.			
Consider any other groups and risk factors relevant to this strategy, policy, plan, procedure and/or service			

How will the strategy, policy, plan, procedure and/or service impact on the health and well-being of our population and help address inequalities in health?

Questions in this section relate to the impact on the overall health of individual people and on the impact on our population. Specific alignment with the 7 goals of the Well-being of Future Generations (Wales) Act 2015 is included against the relevant sections.

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
People being able to access the service offered:			

McLellan,Holly
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Equality Impact Assessment Template

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
Consider access for those living in areas of deprivation and/or those experiencing health inequalities Well-being Goal - A more equal Wales			
People being able to improve /maintain healthy lifestyles: Consider the impact on healthy lifestyles, including healthy eating, being active, no smoking /smoking cessation, reducing the harm caused by alcohol and /or non-prescribed drugs plus access to services that support disease prevention (eg immunisation and vaccination, falls prevention). Also consider impact on access to supportive			

McLellan,Sally
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Equality Impact Assessment Template

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
services including smoking cessation services, weight management services etc Well-being Goal – A healthier Wales			
People in terms of their income and employment status: Consider the impact on the availability and accessibility of work, paid/ unpaid employment, wage levels, job security, working conditions Well-being Goal – A prosperous Wales			

McLellan,Hey
11/26/2021 11:08:21

Equality Impact Assessment Template

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
People in terms of their use of the physical environment: Consider the impact on the availability and accessibility of transport, healthy food, leisure activities, green spaces; of the design of the built environment on the physical and mental health of patients, staff and visitors; on air quality, exposure to pollutants; safety of neighbourhoods, exposure to crime; road safety and preventing injuries/accidents; quality and safety of play areas and open spaces Well-being Goal – A resilient Wales			

McLellan,Holly
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Equality Impact Assessment Template

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
People in terms of social and community influences on their health: Consider the impact on family organisation and roles; social support and social networks; neighbourliness and sense of belonging; social isolation; peer pressure; community identity; cultural and spiritual ethos Well-being Goal – A Wales of cohesive communities			
People in terms of macro-economic, environmental and			

McLellan,Holly
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Equality Impact Assessment Template

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
sustainability factors: Consider the impact of government policies; gross domestic product; economic development; biological diversity; climate Well-being Goal – A globally responsible Wales			

McLellan,Holly
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Agenda item: 3.6

Patient Experience, Quality & Safety Committee	**2 December 2021**
Subject:	**Regulatory Inspections Report**
Approved and Presented by:	Alison Davies, Executive Director of Nursing & Midwifery
Prepared by:	Wendy Morgan, Assistant Director Quality & Safety Susannah Jermyn, Service Development Officer
Other Committees and meetings considered at:	Executive Committee 17 November 2021

PURPOSE:

The purpose of this report is to articulate the receipt and outcomes of regulatory inspections that have occurred during this reporting period and to share the Health and Social Care Regulatory Reports dashboard.

RECOMMENDATION(S):

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

Approval/Ratification/Decision	**Discussion**	**Information**
x	**x**	**√**

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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:

Recent activity relating to Healthcare Inspectorate Wales (HIW) inspections includes the notification of an inspection of the Brecon and District Community Mental Health Team, which is scheduled to take place on 14th and 15th December 2021.

A Quality Assurance Inspection by Cervical Screening Wales is to be undertaken of the Colposcopy Service at Newtown Hospital on 23rd November 2021.

A dashboard overview of the current position is provided, relating to the implementation of actions in response to recommendations from the Health and Social Care Regulators.

DETAILED BACKGROUND AND ASSESSMENT:

1. Health Inspectorate Wales Inspections

Health Inspectorate Wales (HIW) and Care Inspectorate Wales (CIW) Inspection Visit

Healthcare Inspectorate Wales (HIW) and Care inspectorate Wales (CIW) have committed to undertaking inspections of Community Mental Health Teams (CMHT's) across Wales (**appendix 1**).

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This follows the 2017-18 joint thematic review of adult mental health in the community and further CMHT inspections conducted in 2018-19. These inspections focus on community adult mental health services (people between the ages of 18-65). The inspections are informed by legislation, policies and guidance documentation, including the Mental Health (Wales) Measure 2010, the Mental Health Act 1983, the Health and Care Standards 2015 and the Social Services and Well-being (Wales) Act 2014.

The health board have received notification of a Community Mental Health Team (CMHT) inspection visit to Powys Teaching Health Board / Powys County Council to be undertaken on 14 and 15 December 2021. The selected CMHT is Brecon and District, the visit to be conducted over two days. The inspection will include discussions with CMHT staff, service users and carers, as well as examining documentation including service user records, policies, staff records and system reviews.

During the visit, HIW will require to see a sample of patient records, for patients who have both nurse-led and social work-led care and treatment plans. They will use the sample to look at the experiences of service users and carers.

The health board have completed and returned the pre-inspection information by the deadline of Friday 12 November 2021.

2. Cervical Screening Wales Inspection

A Quality Assurance Inspection by Cervical Screening Wales is to be undertaken of the Colposcopy Service at Newtown Hospital on 23rd November 2021. Further details will follow as and when available.

3. National Maternity Improvement Plan 2021 Priorities

The Powys Maternity Improvement Plan is informed by the local (July 2020) and national reports generated by Healthcare Inspectorate Wales (HIW) which make recommendations for maternity services (March 2021).

The areas of progress in Q2 have included the installation of Welshpool Birth Pool, capital estates agreed developments for Llanidloes Birth Centre, commencement of the service delivered via a Perinatal Mental Health Midwife and Research Midwife. During Q3 maternity services are establishing a Project Board in readiness for the implementation of Digital Maternity Cymru and sustainability plan for healthier lifestyles support worker roles.

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4. Health and Social Care Regulatory Reports: Recommendations and Tracker

The overview of the current position relating to the implementation of recommendations following Healthcare Inspectorate Wales Inspections, and any made by Care Inspectorate Wales, is at **appendix 2**. Validation of the tracker continues to articulate the current position on progress against all recommendations is captured.

The following table (1) sets out the inspections where all actions have been completed since the previous reporting period; the position remains the same as previously reported, with no further inspection reports being fully closed during the last reporting period.

Table 1: Inspections with actions completed

2017/18	171803	Mental Health Service Inspection (Ystradgynlais Hospital)
2018/19	181901	Ionising Radiation Regulations and Follow Up Inspection (Brecon and Llandrindod Hospitals)
2018/19	181902	General practice Inspection (Presteigne Medical Practice)
2018/19	181903	Joint HIW & CIW National Review of Mental Health Services Inspection visit to (announced): Welshpool Community Mental Health Team
2019/20	192001	Joint Community Mental Health Team Inspection - The Hazels, Llandrindod
2019/20	192003	Unannounced Mental Health Service Inspection (Clywedog Ward, Llandrindod)
2019/20	192004	Unannounced Twymyn Ward, Machynlleth Community Hospital & Graham Davies Ward, Llanidloes Hospital Inspection
2019/20	192007	Birth Centres (Free Standing Midwifery Led Unit) Across Powys
2019/20	192008	NHS Mental Health Service Inspection (Unannounced): Felindre Ward, Bronllys Hospital
2020/21	20045	Tier 1 Quality Check: Tawe Ward, Ystradgynlais Hospital
2021/22	212203	Tier 1 Quality Check Felindre Ward – cancelled at short notice. Unannounced visit 15 June 2021.

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2021/22	212204	Deprivation of Liberty Safeguarding annual monitoring report – no actions required
2021/22	212205	Notification of: National Review of Mental Health Crisis Prevention in the Community - Powys Teaching HB – no actions required at this stage
2021/22	212207	CIW Inspection of Cottage View

Inspections added to the tracker since the last report, featured in Table (2) below, support ongoing monitoring and assurance:

Table 2: Inspections added to the tracker

2021/22	212208	Tier 1 Quality Check: Unannounced Visit: Felindre Ward, Bronllys Hospital
2021/22	212209	My Dentist Welshpool
2021/22	212210	HIW Covid 19 National Review
2021/22	212211	HIW Ystradgynlais Dental Practice - The Martin Partnership (no actions were identified)
2021/22	212212	WAST Local Review
2021/22	212213	My Dentist Newtown - no areas of improvement identified
2021/22	212214	Crickhowell GP Surgery - no areas of improvement identified
2021/22	212215	HIW Announced Inspection of community mental health services

A verbal report will be provided during Committee by service leads in terms of overdue actions, to enable the most current position to be explored.

5. Community Health Council

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

6. Environmental Health Services

There have been no recent inspections.

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Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Arolygiaeth Gofal Cymru
Care Inspectorate Wales

OFFICIAL SENSITIVE

BY EMAIL

Direct Line: 0300 062 8163
E-mail: HIWInspections@gov.wales

Carol Shillabeer
Chief Executive
Powys Teaching Health Board
Carol.shillabeer2@wales.nhs.uk

Alison Bulman
Director of Social Services – Powys County Council
alison.bulman@powys.gov.uk

27/09/21

Dear Carol Shillabeer and Alison Bulman,

INSPECTION OF COMMUNITY MENTAL HEALTH TEAM
Reference number - 21119

Healthcare Inspectorate Wales (HIW) and Care inspectorate Wales (CIW) have committed to undertaking inspections of Community Mental Health Teams (CMHT's) across Wales. This follows the 2017-18 joint thematic review of adult mental health in the community and further CMHT inspections conducted in 2018-19. These inspections focus on community adult mental health services (people between the ages of 18-65).

Our inspections are informed by legislation, policies and guidance documentation, including the Mental Health (Wales) Measure 2010, the Mental Health Act 1983, the Health and Care Standards 2015 and the Social Services and Well-being (Wales) Act 2014.

I am writing to inform you that the CMHT inspection visit to Powys Teaching Health Board / Powys County Council will be undertaken on 14 and 15 December 2021. The selected CMHT is Brecon and District CMHT.

The inspection will be conducted over two days, and will include discussions with CMHT staff, service users and carers, as well as examining documentation including service user records, policies, staff records and system reviews. We have provided further

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Gwirio bod pobl yng Nghymru yn derbyn gofal da

Checking people in Wales are receiving good care

details of the information required both prior to and during the inspection in the attached appendices.

The inspection team will include one HIW Inspection Manager, one CIW Inspector, one HIW clinical peer reviewer and one HIW Mental Health Act Reviewer.

During the visit, we need to see a sample of patient records. The sample we see must be for patients who have both nurse-led and social work-led care and treatment plans. We will use that sample to look at the experiences of service users and carers. More information on how we request that sample can be found in the attached Inspection Briefing.

The themes to be covered during the inspection visit will include:

- Quality of Patient Experience
- Delivery of Safe and Effective care
- Management and Leadership

A report of our findings will be published three months after the inspection. A draft copy of the report will be supplied to the setting prior to report publication.

You can find out more about HIW and how we inspect NHS services in Wales at the following link: http://hiw.org.uk/about/whatwedo/inspect/nhs/?lang=en

Immediate Next Steps:

- Please acknowledge receipt of this letter and provide contact details for the CMHT manager by email to HIWInspections@gov.wales

- Identify two liaison members of staff – who can work with our inspection team on any pre visit preparation and during the inspection visit itself. Please provide their names and contact details to HIWInspections@gov.wales

- Inform staff, elected members and partners of the inspection dates and their need to be available during that period; confirm any special needs or issues the inspectorate will need to consider

- Read the Inspection Briefing below, ensuring you complete all required steps in preparation for the visit.

Please forward this letter and appendices to the CMHT manager and health board mental health leads.

Please complete and return the pre-inspection information requested **by Friday 12 November 2021**.

If you have any queries about this letter, or the inspection process, please do not hesitate to contact: Nigel Williams, nigel.williams@gov.Wales

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Yours sincerely

Alun Jones
Deputy Chief Executive

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Inspection Briefing Pack

Prior to the Inspection visit

We require documented performance information to help us understand your work and to allow the inspection to run effectively.

Preparing advance information:

- Prepare the advance information so that the specified documents below are **available by 9am on the first day of inspection**

Self assessment and Case file selection:

- Complete the case file sample spreadsheet and return to HIW via Objective Connect
- We will select cases for review and notify you of these so that they can be made available / **ready for us to inspect by 9am on the first day of inspection.**
- Please **undertake a case note audit and evaluation** of each of the case notes we pre select, attaching this to the front of each file. (Please note that we may request to see additional case notes during the inspection visit)
- Complete the self assessment and return to HIW via Objective Connect

Questionnaires:

- We will send you copies of both our patient questionnaire and staff questionnaire (in Welsh and English). **Please distribute them** so that patients and staff have the opportunity to complete the questionnaire and submit anonymously before the inspection date.
  We will also send a link to our digital staff questionnaire so that staff have the opportunity to submit returns digitally.
  The links to these questionnaires are:
  https://www.smartsurvey.co.uk/s/CMHTSU/ (Service User)
  https://www.smartsurvey.co.uk/s/CMHTSQ/ (Staff)
  HIW will also spend time on the day of the inspection talking to patients to listen to their views. We will include anonymised patient and staff comments in our feedback and in our inspection report.

Please prepare a short presentation (**No more than 15 minutes long)** to give to the inspection team on the first morning of the inspection. The presentation must inform the team about the structure of the service, details about how it is set up and what it does well. Please ensure that key **senior managers / staff attend or deliver the presentation** and are available to speak with us afterwards, in case there are areas requiring further discussion.

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ADVANCE INFORMATION

1. Case file sample list (refer to Appendix A for guidance)

2. Self –assessment to be completed and returned by the specified date

Objective Connect

Please note we use the Welsh Government secure portal called 'Objective Connect' in order for you to submit your information securely. All documentation should be submitted using Objective Connect, which is a secure data transmission format. The links to the guidance are provided below:

Registering from an email invitation:-
http://player.vimeo.com/video/205500192?title=0&portrait=0&autoplay=1

Adding a document:-
http://player.vimeo.com/video/205499825?title=0&portrait=0&autoplay=1

Downloading a document:-
https://player.vimeo.com/video/205500628?title=0&portrait=0&autoplay=1

Getting started guidance:- http://www.objective.com/assets/get-started-guide/objective-connect-participant-getting-started-guide.pdf

INFORMATION REQUIRED ON THE DAY

1. Health board/ local authority arrangements for delivering/ funding (integrated) community mental health services.
2. Arrangements to support joint funded projects
3. Carers Strategy
4. Commissioning Strategy
5. Service Standards/ KPIs
6. Any case file audit reports on service user files completed six months prior to the inspection
7. Any relevant reports to local authority elected members for the period six months prior to the inspection
8. Minutes of/ reports to Learning Disabilities & Mental Health Partnership Board (or equivalent) between six months prior to inspection
9. Protocol for transition from children's services to CMHTs
10. Community Treatment Order policy and process.
11. Care and Treatment planning policy and process.

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12. Conveyancing Policy and available data

13. Multidisciplinary/multi-agency working policy

14. Multidisciplinary Team Meeting Minutes for last month

15. Complaints/compliments policy and data for CMHT services covering six months prior to visit.

16. Data for all incidents (anonymised) in setting covering six months prior to visit.

17. Staff policies including staff supervision, training/learning, performance reviews and development.

18. Data for compliance with staff training and appraisals.

19. Staff files

20. Advocacy Arrangements policy

21. Protocol for out of hours service cover

22. Duty arrangements policy

23. Reports to Adult Safeguarding Board, including learning and/or prevention work

24. Policy for workforce caseloads. Provide caseload data for each staff member of the CMHT.

25. Evidence of engagement with service users and carers/families; in particular in respect of obtaining feedback about the quality of services.

Please note that this list of information requirements is not exhaustive. There may be additional information required at the inspection.

ACTIVITIES TO BE UNDERTAKEN AT THE INSPECTION

Where applicable to your CMHT, please ensure the following people are available for us to speak with during the inspection. We may not speak to every person listed below but it is important they have availability for the inspection team over the two days, in case it is necessary to do so. It is essential that we speak with the people highlighted in bold:

- **CMHT Integrated Manager**
- **Deputy / Assistant Director of Social Services**
- **Mental Health Act Administrator**
- **Care coordinators for case files selected (or responsible professional for that person's care)**
- **Designated Social Workers (in accordance with the cases selected)**

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- **Service Users (can be flexible face to face/ phone by preference)**
- **Carers if available**
- Occupational Therapy lead
- Nurse lead
- Social Services lead
- Psychology team lead
- Psychiatrists
- Physiotherapy lead
-
- Clinical Governance lead
- Pharmacist

If possible we will want to attend:

- Multi-disciplinary team meetings (MDT) or equivalent
- Start of day/ end of day meeting

Please note that this list is not exhaustive. It may be necessary to speak with other relevant stakeholders and attend other meetings as the inspection progresses.

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APPENDIX A

Sample specification/ selection: The CMHT is asked to provide a list of anonymised service users by care coordinator type (Nurse, Social Worker, Psychiatrist, Physiotherapist, Occupational Therapist, those under Community Treatment Order's, jointly care coordinated etc).

The inspection team will then choose the case sample for case tracking and further review. We will provide this list to you a week in advance of the inspection to provide time to gather the case files together.

We may also select some additional cases for review on the day.

A printed copy of the selected case file sample should be provided to each inspector on arrival; this will be retained in the premises at all times. Once the inspector has finished with the case file sample list, it will be returned for secure destruction.

Appendix A is a caseload sample selection spreadsheet. Please provide this **21 calendar days** prior to inspection date. Look at the **specification tab** for guidance on the date ranges.

Note: We will notify you of the selected caseload sample for the visit **7-10 calendar days** before the inspection. We will phone you in the lead up to the inspection and provide you with the list securely through objective connect.

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Appendix 2-DASHBOARD OF IMPLEMENTATION OF HEALTH AND SOCIAL CARE REGULATORY REPORT RECOMMENDATIONS

Health and Social Care Regulatory Report Recommendations Dashboard October 2021

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 Services for Young People	37 (**32** - 5 N/A)	31	1			
	TOTAL		120	110	8	2		
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	12	9		4	
	212202	Tier 1 Quality Check Clywedog Ward, Llandrindod Wells	2	1			1	
	212207	CIW Inspection of Cottage View	8	Not Updated	Not Updated	Not Updated	Not Updated	
	212208	HIW Tier 1 Quality Check: Felindre Ward, Bronllys Hospital	27	13	3	11		
	TOTAL		62	26	12	11	5	
	GRAND TOTAL		193	145	20	15	5	8 Cottage view not reported on

McLellan,Holly
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Agenda Item: 3.7a

Patient Experience, Quality and Safety Committee	**Date of Meeting: 2 December 2021**
Subject:	**Safeguarding Annual Report**
Approved and presented by:	Alison Davies Executive Director of Nursing and Midwifery
Prepared by	Jayne Wheeler Sexton Assistant Director of Nursing for Safeguarding and Public Protection
Other Committees and meetings considered at:	The Annual Safeguarding Report has been received at the Safeguarding Strategic Group. Executive Committee 17 November 2021

PURPOSE:

The purpose of this paper is to:

To present the Patient Experience, Quality and Safety Committee with the 2020-2021 Safeguarding Annual Report.

RECOMMENDATION:

Patient Experience, Quality and Safety Committee is asked to:

- Note the contents of this paper

Approval/Ratification/Decision	Discussion	Information
		x

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	✓

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	6. Promote Innovative Environments	✓
	7. Put Digital First	
	8. Transforming in Partnership	✓
Health and Care Standards:	• Staying Healthy	✓
	• Safe Care	✓
	• Effective Care	✓
	• Dignified Care	✓
	• Timely Care	✓
	• Individual Care	✓
	• Staff and Resources	✓
	• Governance, Leadership & Accountability	✓

EXECUTIVE SUMMARY:

PTHB Safeguarding Annual Report presents the key areas of development and achievement which have supported the Health Board to meet its statutory responsibilities in safeguarding the people of Powys during 2020/21. The report is aligned to the Standards of the Safeguarding Maturity Matrix (SMM); a self-assessment tool which addresses the interdependent strands regarding safeguarding; service quality improvement, compliance against agreed standards and learning from incidents and reviews.

The SMM Standards are; Governance and Rights Based Approach, Safe Care, ACE's Informed, Learning Culture and Multiagency Partnership Working.

The report highlights key areas of development and improvement over the past 12 months within each Standard and sets out the actions we said we would achieve and the progress made.

Powys Teaching Health Board's SMM self-assessment and improvement plan is completed annually and submitted to the National Safeguarding Team. Both are used, alongside other Health Boards submissions, to inform a national report through the NHS Wales Safeguarding Network to the Chief Nursing Officer in Welsh Government. The aim of capturing and collating a national SMM is to provide assurance, share practice and drive improvements towards a 'Once for Wales' consistent approach to safeguarding across Wales.

1. Introduction

1.1 NHS Wales has an essential role in ensuring that all adults and children receive the care, support and services they need in order to promote a healthy, safer and fairer Wales, however measuring the effectiveness of health services and their contribution to safeguarding adults and children is difficult and complex.

McLellan,Holly
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Powys Teaching Health Board is committed to ensuring safeguarding is part of its core business. The Health Board recognises that safeguarding children and adults at risk is a shared responsibility that requires all our employees to have the competencies to safeguard people, and are able to develop strong effective joint working relationships with our partner agencies and colleagues. Our vision is that Powys residents live their lives free from violence, abuse, neglect and exploitation. The Health Board will promote the United Nations Convention on the Rights of the Child, Human Rights and the United Nations principles for Older Persons in all its work.

1.2 The annual report outlines, with some examples, how the safeguarding service is performing and innovating to deliver an accessible, research led service. It provides an update on safeguarding priorities during 2020-2021 and identifies safeguarding key developments coming during 2021-2022. The Safeguarding Service acknowledges the need to build on what has already been achieved to ensure PTHB and all contracted services, fully meet their statutory responsibilities for preventing harm, and act in a timely way on concerns raised about the welfare of people who reside, work or visit Powys.

1.3 The Covid-19 pandemic has had a profound impact on the way health care services have been delivered over the past year. The stay at home guidance during the height of the first lockdown limited and re-shaped the usual contact with patients, carers and professionals, all of which may have impacted upon the Health Board's ability to recognise an adult or child at risk.

1.4 Safeguarding remained a key priority within the Health Board during this uncertain and unprecedented time, this is evidenced by the Safeguarding Team not being redeployed as part of the Health Board's response to the pandemic. Legislation that drives the Health Board's 'Safeguarding Agenda' did not change, this includes the SS&WW Act 2014, Violence against Women, Domestic Abuse, Sexual Violence (Wales) Act 2015, Wales Safeguarding Procedures 2019 and the MCA 2005. At all times PTHB continued to have a legal duty to report safeguarding concerns.

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

McLellan,Holly
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1.6 A SMM self-assessment tool and improvement plan is completed by Powys Teaching Health Board annually, and submitted to the National Safeguarding Team, these helps inform a national report through the NHS Wales

Safeguarding Network, to the Chief Nursing Officer in Welsh Government. The aim of capturing and collating a national SMM is to provide assurance, share practice and drives improvements towards a 'Once for Wales' consistent approach to safeguarding across Wales.

1.7 The SMM Standards are; Governance and Rights Based Approach, Safe Care, ACE's Informed, Leaning Culture and Multiagency Partnership Working. PTHB SMM 2020-21 Improvement Plan was developed and monitored via the Safeguarding Strategic Group.

2. Governance and Right Based Approach

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

2.2 NHS Wales Shared Services Partnership Audit and Assurance Service undertook two Internal Audits; one to review a previous audit that gave limited assurance in regard to DoLS and one in respect of Safeguarding Process during the height of the Covid-19 pandemic. Both audits provided overall reasonable assurance to the Health Board.

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

2.4 The Health Board has engaged with the Childrens Commissioner for Wales Office who presented an Introduction to Childrens Rights to PTHB Safeguarding Operational Group, a Safeguarding Newsletter has re-introduced the Childrens Pledge and a work plan is being developed around undertaking The Right Way Matrix; a self-assessment tool to help us take Childrens Rights forward within the Health Board.

McLellan,Holly
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2.5 Governance and Rights Base Approach: We Said	We Achieved	We need to progress
Children Rights/Children's Pledge must be embedded throughout the Health Board	Relaunch of the Childrens Pledge and presentation to the Operational Safeguarding Group by the Childrens Commissioners Office	develop Train the Trainer model to deliver Children's Rights Awareness across PTHB
Data presented to the SSG requires improvement to enable areas of good practice, risks, trends and themes to be identified	New Data set developed and presented quarterly	Completed

3. Safe Care

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

A total of 165 child safeguarding reports were made by PTHB staff during 2020-21. 24% of the reports related to domestic abuse, 13% raised concerns about neglect and 12% were in respect of emotional abuse.

29 Children required a Child Protection Medical during 2020-21. 15 female and 14 males. 17 were 5 years and over.

Work has commenced with CTMUHB to support PTHB with the child protection process. Once agreed the CP Medical Policy will be updated. ToR have been drafted for a multiagency CP Medical Forum, we hope the first meeting will take place in the next few months.

3.2 Child Exploitation

MACE (Multi Agency Child Exploitation) meetings provide a framework to facilitate regular information sharing, data analysis, quality assurance, performance and professional challenge on information and intelligence relating to Victims, Offenders, Locations and Themes. Use this analysis to direct resources under the four strands of Prevent, Pursue, Prepare and Protect.

MACE meetings are quarterly. Each meeting is attended by a senior representative for the PTHB Safeguarding Team. During 2020-2021; 135 children were subject to Exploitation, this included; trafficking, criminal and sexual exploitation, Online abuse and harmful sexual behaviour. 61% were female and 39% male.

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

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

During 2021-21 368 Looked after Children health assessments were carried out by PTHB lac Nurses. 84% were completed within statutory time frames. 293 health assessments were with children from Powys and 75 were with children from other Local Authorities.

A multi-agency meeting to support children's homes response to Covid-19 continue to meet weekly, this has enabled a proactive approach to any concern, issue, or sharing of good practice regarding testing, PPE, contacts and outbreaks of Covid-19.

3.4 A total of 77 adult safeguarding reports were made by PTHB staff during 2020-21. 14% of the reports related to neglect, 12% raised concerns about emotional abuse and 10% were in respect of financial abuse.

3.5 The Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS) was not waived by the COVID 19 Act, however due to the restrictions on visiting hospitals, residential and nursing care homes during the outbreak of COVID-19, the Mid and West Wales Safeguarding Board Region agreed a regional process to managing Deprivation of Liberty Safeguards (DoLS) applications and authorisations. This resulted in the majority of best interest and DoLS assessment being undertaken remotely, and only face to face when necessary for most of 2020-21.

PTHB DoLS applications throughout 2020-21 steadily increased, this is despite reduced activity on some of the wards. During April through to June 2020, 82 DoLS applications were made compare to 107 during January to March 2021.

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The amount of outstanding DoLS applications also rose in line with the increase in applications. Additional funding from Welsh Government enabled the Health Board to purchase Best Interest Assessments to address the gap

in resource bringing the outstanding applications down to 19 at the end of March 2021.

A suite of resources has been developed to support practitioner's knowledge and skills in regards to the Mental Capacity Act and Deprivation of Liberty Safeguards. These include; MCA Policy, MCA training became mandatory, DoLS signatory training and development of a SOP, working closely with our partners to co-produce guidance on Deprivation of Liberty Safeguards applications and authorisations during Covid-19. Newsletter and modular training available to staff.

An Internal Audit review undertaken by NHS Wales Shared Services Partnership in 2021 gave the Health Board Reasonable Assurance. All recommendation within the Improvement Plan have been completed.

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

Whilst the Covid-19 pandemic did not cause domestic abuse, it created a *perfect storm* of challenges for survivors and the services supporting them. The Covid-19 virus and lockdown measures designed to fight it, gave perpetrators a tool that they quickly learnt to use for coercion, manipulation and to induce fear.

Statutory and third sector organisations become concerned that not every home is a place of safety, and for some, it may become a place where social isolation increases the risk of abuse and control. Numerous reports over the past 12 months have described the impact of lockdown measure on violence as a *'shadow pandemic'* that has accompanied Covid-19 (UN 2020)

PTHB Safeguarding Team have continued to works closely with partner agencies to respond to VAWDASV and provide staff with safeguarding supervision and support, delivered VAWDASV Training and produced monthly VAWDASV Newsletters to share the latest information in relation to national, regional and local support agencies, trends and emerging themes and training links. The Safeguarding team have also continued to engage operationally in Domestic Abuse Conference Calls and Multi Agency Risk Assessment Conference, these are meetings where high-risk victims of abuse are discussed. The safeguarding Team have continued to offer VAWDASV Group

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2 Training via MS Teams. There as been a steady increase in compliance over the past 12 months from 17.9% to 57.06%.

3.7 Safe Care: We Said	We Achieved	We need to progress
PTHB must prepare for the implementation of Liberty Protection Safeguards, PTHB workforce need to increase their knowledge, skills and confidence in MCA and DoLS	Upskilling of staff knowledge and skills re MCA & DoLS has been a focus. Development of LPS Working and Oversight Groups	continue planning, await Code of Practice and Regulations
PTHB to be assured professionals are aware of, and using PTHB's Was Not Brought Protocol	Protocol updated and relaunched	Audit planned for 2021/22
PTHB must comply with the National Standards for CP Medicals. The CP Medical rota requires strengthening to meets the needs of the children in Powys. To seek assurance of the quality of CP Medicals	Links with CTMUHB to support CP rota. Regular meetings with LA to establish CP Medicals group and how we deliver multi agency Childhood Injuries Training	Strengthen further links with CTMUHB Set date to commence CP Medical Group with LA & Police Deliver multi agency training

4. Ace Informed

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

4.2 The National lockdown in response to Covid-19 is known to have increased calls to Childline with concerns involving ACE's. The NSPCC report that the most common concerns for people contacting the helpline is "parent/adult health and/or behaviour" and Parental alcohol/substance misuse". Data from the PHW HWB survey found that almost a quarter of adults that live with a child under 18 years old reported drinking more alcohol since lockdown, and just over a fifth of those living with someone under 18 years also reported having a diagnosed mental illness.

4.3 ACE Informed: We Said	We Achieved	We need to progress
PTHB to be assured that the CSERQ15 is used routinely within health settings & establish a system to identify children at risk of Child Exploitation within the Electronic Health Board's System.	Newsletter on the use of the CSERQ15 developed to raise awareness, child at risk of CE alert added to electronic system	Audit CSERQ15 Oct 2021

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Audited Safeguarding Children Standards for Adult Mental Health Professionals	We were unable to progress this	Added to 2021-22 plan

5. Learning Culture

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

5.2 Over the past 12 months PTHB Safeguarding Team reviewed how we enable staff to achieve their safeguarding training competencies. A blended learning approach has been developed which includes the following;

i. MS Teams training sessions developed for; Safeguarding Adults and Children Level 3, VAWDASV Group 2 Ask and Act, Mental Capacity Act, Deprivation of Liberty Safeguards and Looked after Children.
ii. Introduction of an additional training platform called Modular learning. Modules provided flexible access to training material for practitioners. To date 8 modules have been recorded over power point presentations and uploaded to you tube.
iii. Newsletters & Safeguarding Briefings have been produced monthly
iv. PTHB Competency Training Passport has been updated and re launched, an exemplar of a completed passport has been developed.

5.3 Training compliance in safeguarding adult and children level 1, 2 and 4 has been maintained at or increased to over 80%. Level 3 adults and children's progress in compliance has been slow with an increase of 10% over the year; adults from 24.77% to 34.28% and children from 55.05% to 64.53%. training compliance is monitored via the Strategic Safeguarding Group.

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

i. Immediate Telephone Supervision, Advice, Support
ii. Requested Individual Safeguarding Supervision

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iii. Group Supervision Sessions
iv. Debrief Sessions
v. Peer Review for Medical Paediatric Staff
During 2020-21 the Safeguarding Team offered *100* Group Supervision Sessions with *466* staff attending these sessions.

5.5 To support the principles of Child, Adult and Domestic Homicide Reviews, PTHB formed a Practice Review Group, the first meeting was held in July 2021. There was one published Child Practice Review during 2020-21. An action plan was developed by the Safeguarding Team who have worked with representatives from Midwifery and Health Visiting to address the following;

i. Joint Safeguarding Group Supervision for Health Visitors & Midwives
ii. Training & Education provision to ensure professional curiosity and disguised compliance is explored
iii. Establish the *Chronology* function on WCCIS
iv. Review guidance in relation to Concealed Pregnancy and late Bookings

5.6 Learning Culture: We Said	We Achieved	We need to progress
Actions from Practice Reviews and DHR'S should be tracked until completed. PTHB will improve how we share the learning points from Practice Reviews and DHR's with our staff, in a way that will support and influence practice.	Development of Practice Review Group, learning from reviews delivered in training, supervision, newsletters.	Completed
Safeguarding Team will share appropriate and relevant documents, articles and links with PTHB workforce in a way that supports staff to have the information in an easy to read format	Developed monthly newsletters, 7 Minutes briefings and Month Briefings which are distributed via Powys Announcements & SSG & SOG	Completed

6. Multi Agency Partnership Working

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

6.2 PTHB are committed to working alongside our partners at a National, Regional and Local level. Throughout 2020 -21 there are numerous examples on how have worked in partnership;

i. Contribution to Safeguarding Week
ii. Co-produced Regional Documents and Leaflets
iii. Partnership response to supporting Children's Homes during Covid-19
iv. Support within the NHS Safeguarding Team VAWDASV Work stream

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6.2 Multiagency Partnership Working: We Said	We Achieved	We need to progress
Standard of MARF's require auditing and Quality Assuring	Process in place where all MARF's are tracked by the Safeguarding Team and QA.	Completed
PTHB to increase our contribution to strategy discussions with the LA and Police via PTHB Safeguarding HUB	Safeguarding HUB model developed, improved links regarding CP Medicals	Pilot ongoing with the LA & Police re strategy discussions

In summary, the Patient Experience and Quality Safety Committee can take assurance that safeguarding and public protection has been maintained throughout 2020-21. The service is both visible and accessible across the whole Health Board and has been able to drive change during the unprecedented circumstances Covid-19 presented to the Health Board and society.

Next steps include:

- Progress the Safeguarding Maturity Matrix Improvement Plan
- LPS is due to replace DoLS in April 2022, WG has recommended to national government that this date is not practicable, PTHB will however continue with the Health Boards preparation for the implementation of LPS while awaiting further instruction from WG.
- Promote the new Children Wales Act which will become law on 21st March 2022. The new Act abolishes the defence of reasonable punishment in Wales, making all forms of child physical punishment in Wales a criminal offence.
- Attend the Regional Sexual Assault Referral Centre work streams to ensure Powys is fully engaged and represented.

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Powys Teaching Health Board Safeguarding Annual Report 2020-2021

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Introduction

Powys Teaching Health Board (PTHB) is responsible for providing health care and well-being services for approximately 133,000 people living throughout the area of Powys, this includes health services both provided by and commissioned on behalf of PTHB.

PTHB employs 3006 members of staff which includes 573 bank staff. Care is delivered across a network of services and practitioners. The geography and rurality can make access to some services a challenge and requires the health board to be innovative and creative to ensure Powys residents have timely access to high quality services to meet their needs. PTHB is uniquely positioned as Powys accounts for a quarter of the land mass in Wales and borders a number of other Welsh and English Health Boards.

Powys Teaching Health Board is committed to ensuring safeguarding is part of its core business. The Health Board recognises that safeguarding children and adults at risk is a shared responsibility that requires all our employees to have the competencies to safeguard people, and are able to develop strong effective joint working relationships with our partner agencies and colleagues.

Our vision is that Powys Residents live their lives free from violence, abuse, neglect and exploitation. The Health Board will promote the United Nations Convention on the Rights of the Child, Human Rights and the United Nations principles for Older Persons in all its work.

This annual report outlines, with some examples, how the safeguarding service is performing and innovating to deliver an accessible, research led service. It provides an update on safeguarding priorities during 2020-2021 and identifies safeguarding key developments during 2021-2022.

The Safeguarding Service acknowledges we need to build on what has already been achieved to ensure PTHB and all contracted services fully meet their statutory responsibilities for preventing harm and act in a timely way on concerns raised about the welfare of people who reside, work or visit Powys.

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The beginning of 2020 & Covid-19

At the end of February 2020, the UK Government confirmed that the first case of the Covid-19 virus had been transmitted inside the country. Lockdown measures to control the spread of the virus came into force in March 2020; schools were closed and we were instructed to only go outside to purchase essential items, to exercise once a day, or to go to work if we absolutely could not work from home.

The Covid-19 pandemic has had a profound impact on the way health care services have been delivered over the past year. The stay at home guidance during the height of the first lockdown limited and re-shaped the usual contact with patients, carers and professionals, all of which may have impacted upon the health board's ability to recognise an adult or child at risk.

The Safeguarding Team issued a guide to the safeguarding processes during the Covid-19 pandemic. The guide reiterated that safeguarding people is everyone's responsibility and must remain in the forefront of our thoughts, and considered during all contacts with people. Safeguarding remained a key priority within the Health Board during this uncertain and unprecedented time, evidenced by the Safeguarding Team not being redeployed as part of the Health Board's response to the pandemic.

Legislation that drives the Health Board's 'Safeguarding Agenda' did not change, this includes the SS&WW Act 2014, Violence against Women, Domestic Abuse, Sexual Violence (Wales) Act 2015, Wales Safeguarding Procedures 2019 and the MCA 2005. At all times PTHB continued to have a legal duty to report safeguarding concerns.

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Safeguarding Maturity Matrix

NHS Wales has an essential role in ensuring that all adults and children receive the care, support and services they need in order to promote a healthy, safer and fairer Wales, however measuring the effectiveness of health services and their contribution to safeguarding adults and children is difficult and complex.

The Safeguarding Maturity Matrix (SMM) is a self-assessment tool which addresses the interdependent strands regarding safeguarding; service quality improvement, compliance against agreed standards and learning from incidents and reviews. Powys Teaching Health Board's SMM self-assessment and improvement plan is completed annually and submitted to the National Safeguarding Team. Both are used, alongside other health boards submissions, to inform a national report through the NHS Wales Safeguarding Network to the Chief Nursing Officer in Welsh Government. The aim of capturing and collating a national SMM is to provide assurance, share practice and drives improvements towards a 'Once for Wales' consistent approach to safeguarding across Wales.

This Safeguarding Annual Report is aligned to the Standards of the Safeguarding Maturity Matrix;

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Safeguarding Maturity Matrix

PTHB Safeguarding Maturity Matrix Improvement Plan Included;

GOVERNANCE & Rights Base Approach

Children Rights/Children's Pledge must be embedded throughout the Health Board

Reporting data to the Strategic Safeguarding Group requires improvement to enable areas of good practice, risks, trends and themes to be identified

Safe Care

PTHB must prepare for the implementation of Liberty Protection Safeguards, PTHB workforce need to increase their knowledge, skills and confidence in MCA and DoLS

PTHB to be assured professionals are aware of and using PTHB's Was Not Brought Protocol

PTHB must comply with the forthcoming National Standards for Child Protection Medicals. The Child Protection Medical rota in Powys requires strengthening to ensure the service meets the needs of the children in Powys and to be assured of the quality of commissioned service for Child Protection Medicals

ACE Informed

PTHB to be assured that the CSERQ15 is used routinely within health settings

Establish a system to identify children at risk of Child Exploitation within the Electronic Health Board's system. PTHB last audited Safeguarding Children Standards for Adult Mental Health Professionals in 2018, the audit recommended repeating in 2020

Learning Culture

Actions from Practice Reviews and DHR'S should be tracked until completed

PTHB must improve how we share the learning points from Practice Reviews and DHR's with our staff, in a way that will support and influence practice.

PTHB Safeguarding Team will share appropriate and relevant documents, articles and links with our workforce in a way that supports staff to have the information in an easy to read format

Multiagency Partnership Working

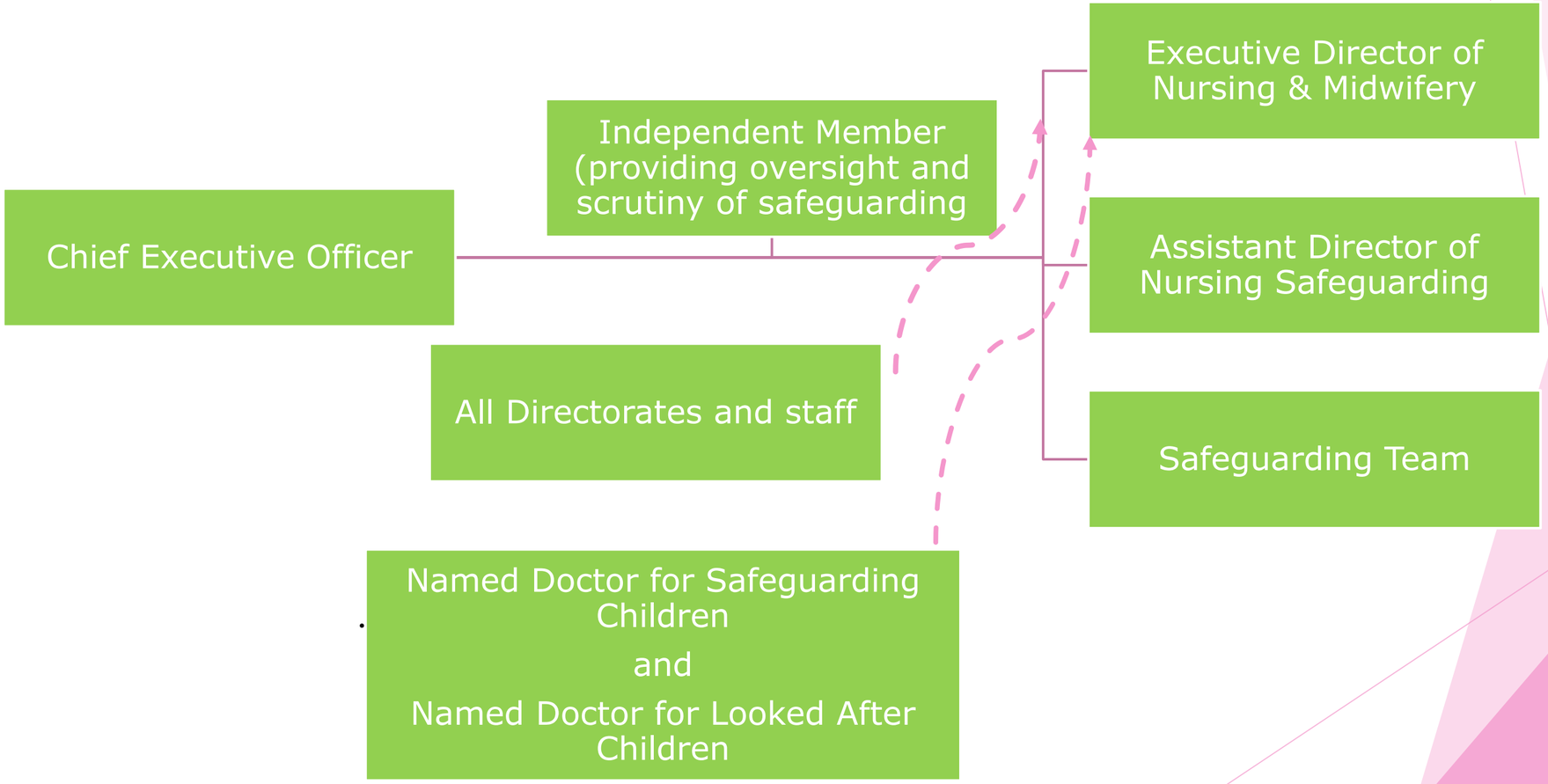
The standard of MARFs require auditing and Quality Assuring

PTHB to increase our contribution to Strategy Discussions with the LA and Police via PTHB Safeguarding HUB

Governance & Rights Based Approach

Although the Chief Executive assumes overall responsibility for safeguarding, the Executive Director of Nursing and Midwifery is the delegated Executive Lead for Safeguarding. The Health Board's Vice Chair is the designated Lead Independent Member for children's and young people's services with responsibility for providing oversight and scrutiny of the broader safeguarding agenda.

Safeguarding Lines of Accountability



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Governance & Rights Based Approach

Reporting arrangements

PTHB has in place clear lines of communication, responsibility and accountability. Whilst the Chief Executive has the overall responsibility for Safeguarding, the Executive Director of Nursing and Midwifery is the lead Executive Officer in taking forward strategic direction, policy implementation and reports on safeguarding matters to the Board.

Governance Reporting Structure

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Governance & Rights Based Approach

Legislation and associated guidance details the roles and responsibilities of agencies in relation to safeguarding and public protection and include levels of accountability; responsibilities and duties of staff; the skills and competencies required by staff to perform their duties; handling individual cases and effective interagency working at all levels. These include;

- Children Act 1989 & 2004
- United Nations Convention on the Rights of the Child UNCRC
- Wales Safeguarding Procedures (2019)
- Working Together to Safeguard Children (2018)
- Protecting Children & Young People, GMC (2012)
- Safeguarding Children & Young People Intercollegiate Document: Roles & Responsibilities for Health Care Staff – January 2019 4th Edition
- Adult Safeguarding: Roles and Competencies for Health Care Staff – August 2018 1st Edition
- Social Services & Well-being (Wales) Act 2014
- The Well Being of Future Generations (Wales) Act 2015
- NSF, Health Inspectorate Wales, Vulnerable Groups Act (2006)
- NICE 16, Standard 13 (Vulnerable Groups)
- Mental Capacity Act 2005 & Mental Capacity (Amendment) Act 2019 (Liberty Protection Safeguards)
- Dignified Care: Two Years On (2014): Older People
- Violence Against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015
- Mental Health Act, 1983
- Health and Care Standards (April 2015) Standards 2.7
- Counter Terrorism and Security Act 2015

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Governance & Rights Based Approach

PTHB Safeguarding Strategic Group is chaired by Executive Director of Nursing and Midwifery, the group supports the Health Board to execute its duties to safeguard children and adults at risk within the statutory frameworks (Social Services & Well-being (Wales) Act 2014, Children Act 1989, 2004). It also aims to ensure that the Health Board promotes and protects the welfare and safety of children and adults who become vulnerable or are at risk at any time.

The Safeguarding Strategic Group has an Independent Board Member within its membership and each Service Area is represented by a Senior Manager. The group ensures there is scrutiny of the data being presented, the implementation, monitoring and audit of relevant guidance, receives the reports from Domestic Homicide Reviews, Adult and Child Practice Reviews. Monitor the implementation of recommendations and share lessons learnt across the organisation.

The Safeguarding Strategic Group provides a link between PTHB, the Regional Safeguarding Board, the Violence Against Women, Domestic Abuse and Sexual Violence Strategic Group and The NHS Wales National Safeguarding Network. The Safeguarding Strategic Group reports directly to the Quality Governance Group.

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PTHB Safeguarding Intranet Page hosts a suite of National, Regional & PTHB Policies and documents

PTHB | Safeguarding

Wales Safeguarding Procedures (2019) became operational in April 2020

Safeguarding Presentation made to PTHB Board Members

NHS Safeguarding Maturity Matrix completed

Safeguarding Strategic Group meet quarterly

Safeguarding Operational Group First meeting September 2020

PTHB represented at M&WW Safeguarding Board

NHS Wales Audit & Assurance Services; DoLs & Safeguarding Internal Audit completed

Governance & Rights Based Approach

Childrens Rights

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Sept 2020
- SMM Action Plan identifies Childrens Rights as a priority action

April 2021
- Childrens Commissioner Officer presented an introduction to Childrens Rights to PTHB Safeguarding Operational Group

April 2021
- Childrens Rights Newsletter re introduced Childrens Pledge

July 2021
- Train the Trainer training planned for end of year

Safe Care

Safeguarding Referrals Raised by PTHB Staff during 2020-21
In accordance with the Social Services and Well-being (Wales) Act 2014 and the Children Act 1989/2004, the Health Board has a statutory duty to report a child or adult who is (a) experiencing or is at risk of abuse, neglect or other kinds of harm, and (b) has needs for care and support needs.

165 **child** reports were made by PTHB staff in 2020-2021

24% of reports related to **domestic abuse** and

13% raised concerns about **neglect**

Safeguarding Children at Risk

12% of reports were in relation **emotional abuse**

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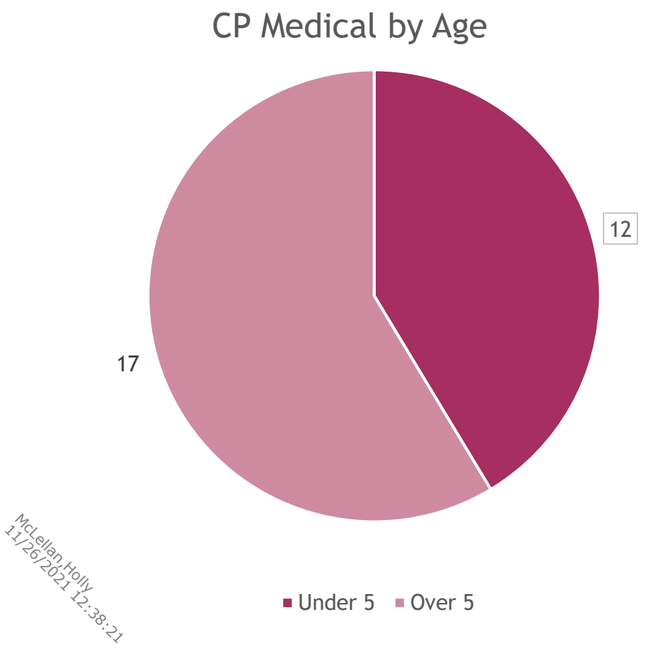
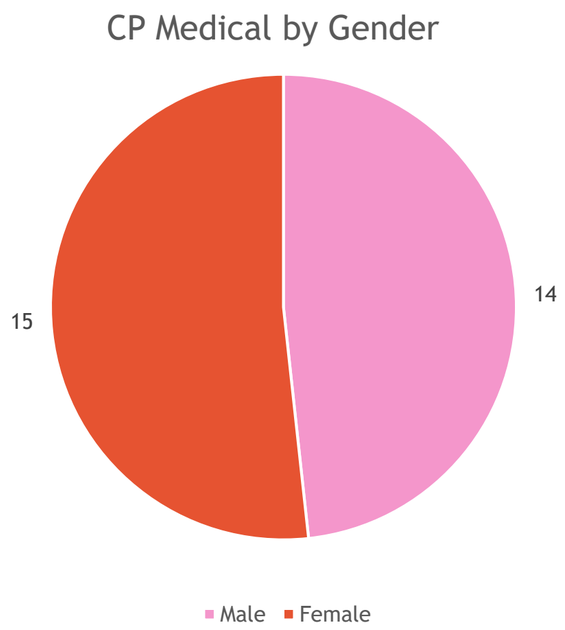
Safe Care

Child Protection Medicals

29 Child Protection medicals were carried out 2020-2021.





New National Standards for Child Protection medicals were published in October 2020. Implementing and auditing the New Standards has been identified as an action in the Safeguarding Maturity Matrix Improvement Plan.

A new CP Pathway to support PTHB Community Paediatricians with CP Medicals has been established with CTMUHB. Work is planned to update PTHB's CP Medical Policy and to consider multi agency reflection on CP medical cases.

Safe Care

Child Exploitation

During 2020-2021 135 children were subject to the following types of exploitation

Trafficking
Sexual Exploitation
Criminal Exploitation
Harmful Sexual Behaviour
On Line Abuse
Multiple Categories

MACE (Multi Agency Child Exploitation)
MACE meetings provide a framework to facilitate regular information sharing, data analysis, quality assurance, performance and professional challenge on information and intelligence relating to Victims, Offenders, Locations and Themes all relating to Child Exploitation.
The MACE Panel have the ability to;

- Use this analysis to direct resources under the four strands of Prevent, Pursue, Prepare and Protect. Identify broader themes and best practice in relations to interventions.
- Provide evidence towards outcomes and actions from the National Action Plan to Tackle Child Sexual Exploitation (Wales) on behalf of the Mid and West Safeguarding Board.

MACE meetings are held quarterly. PTHB is represented by the Senior Nurse Safeguarding

61% were female

39% were male

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Safe Care
Looked After Children (LAC)

- The strict lockdown measures to prevent the spread of the Covid-19 virus had an immediate impact on the work of the Powys Teaching Health Boards Looked after Children Team. A rapid response was required to safeguard staff by ensuring that they could work safely from home and interim measures to promote the safety and well-being of Looked After Children remotely.
- The LAC Nurses continued to offer direct advice and support for professionals and children via telephone or via SKYPE/Teams. This included, LAC health assessments, attending LAC reviews, Pathway Plans for the 16+, strategy meetings and being a point of support for the child.
- A risk assessment tool was developed and when the lock down rules allowed, some LAC health assessments were completed face to face by maintaining social distancing and ensuring that they took place outside.
- Some young people were offered a review health assessment early as there were concerns that the LAC nurses could be re-deployed. All young people who received an early health assessment have since received a follow up contact from the LAC Nurses.

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Looked After Children (LAC)

The views of Looked After Children (LAC) are captured during their statutory health assessment and help to shape the child's LAC Health Plan

368 Health Assessments were completed by Powys Looked After Children Nurses

84% were completed within statutory timescales

293 Health Assessments were with children from Powys

75 Health Assessments were with children from other Local Authorities

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Looked After Children

A perspective of a Looked After Child during COVID19: the following speech bubbles represent the voice and words of a looked after child. Their views, reflections and feelings were captured during a conversational interview with one of the LAC Nurses, we would like to thank the young person for such a personal contribution

I was upset I may never have the opportunity to do the simple things again like go to Primark or something again

I was very uncertain about the future and what's going to happen with school, work, that kind of thing.

people are very selfish

Everything has completely changed

I do think that people have been very irresponsible. It makes me feel upset and frustrated

I was worried my mental health would spiral

it's not a family situation

I didn't know what was going to happen if staff got sick.

Contact with family has completely stopped

It's like living on an isolated island

If I wasn't in lockdown I'd be in work by now

It is very difficult spending ten weeks completely on your own in a care home

I was scared

the only thing I'm allowed to do is go to the garage

I was talking to people a lot on line but then eventually I just kind of stopped.

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Safe Care

Safeguarding Referrals Raised by PTHB Staff during 2020-21
In accordance with the Social Services and Well-being (Wales) Act 2014 and the Children Act 1989/2004, the Health Board has a statutory duty to report a child or adult who is (a) experiencing or is at risk of abuse, neglect or other kinds of harm, and (b) has needs for care and support needs.

Safeguarding Adults at Risk

77 **adult** reports were made by PTHB staff in 2020-2021

14% of the reports were in relation to **neglect**

12% were in relation to **emotional** abuse

10% of reports were in relation to **financial** abuse

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Safe Care

Best Interest Assessments, Mental Capacity Assessments and Deprivation of Liberty Safeguards

The Deprivation of Liberty Safeguards (DoLS), (Mental Capacity Act (2005)) became effective on 1st April 2009. Its purpose is to provide a legal framework for safeguarding the deprivation of an individual's liberty in a hospital or care home setting.

The DoLS apply to anyone aged 18 and over, who suffers from a mental disorder or disability of the mind, such as dementia, or a profound learning disability; who lacks the capacity to give informed consent to the arrangements made for their care or treatment and for whom deprivation of liberty (within the meaning of Article 5 of the European Convention of Human Rights) is considered, after an independent assessment, to be necessary and in their best interest and to protect them from harm.

Process

Once patients are deemed to lack capacity an application is sent to the DoLS Team, applications are prioritized and assessments are allocated. The current process involves independent assessments from trained Best Interest Assessors (BIAs) and medical staff qualified in the field of psychiatry, who are registered under Section 12 of the MHA. Once decisions are made that a patient is suitable for DoLS assessments are scrutinized and signed by a PTHB signatory.

DoLS activity: 2020/21

PTHB Monthly DoLS Figures	Q1 2020/21	Q2 2020/21	Q3 2020/21	Q4 2020/21
Number of referrals for the period	82	99	113	107
Number of urgent referrals for the period	74	87	102	83
Number of standard/renewal referrals for the period	8	12	11	24
Number withdrawn/not granted	52	85	76	88
Number allocated to internal BIAs	18	20	21	17
Number allocated to external BIAs	2	4	2	45
Number granted	13	18	15	23
Total outstanding applications	30	25	46	19

Safe Care

Work undertaken during 2020/21 to improve processes and knowledge of DoLS and MCA

Quarter 1

- MCA Policy Ratified
- Mid and West Wales Safeguarding Board agreed a regional process to managing Deprivation of Liberty Safeguards (DoLS) applications and authorisations during Covid

Quarter 2

- MCA Managers Training delivered
- MCA Training became mandatory for staff
- DoLS Signatory Training delivered
- MCA & DoLS Newsletters shared across the Health Board

Quarter 3

- DoLS Signatory rota in place
- MCA and DoLS additional training module uploaded onto Youtube
- LPS Working Group Established
- Supported preparation for Covid 19 Vaccine role out to vulnerable people

Quarter 4

- DoLS Signatory SOP agreed
- Internal DoLS Audit- Reasonable Assurance
- Supervision for BIAs and DoLS signatories by an external provider
- DoLS care plan rolled out to all wards
- DoLS monitoring tool commenced on wards
- WG Money funded extra Best Interest Assessments

McLellan,Holly
11/25/2021 12:38:21

Safe Care

Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV)

Violence against women, including domestic abuse and sexual violence (VAWDASV) is a major public health problem in Wales and globally, and is a violation of human rights. Through taking a public health approach to VAWDASV, we can make progress towards achieving our vision:

a Wales that is free from violence against women, domestic abuse and sexual violence.

All forms of violence and abuse are unacceptable, anyone who experiences violence against women, domestic abuse and sexual violence deserves an effective and timely response from all public services. The enactment of the Violence Against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015 requires the public sector in Wales to work together, in a consistent and cohesive way, to improve the outcomes for individuals and their families subjected to violence against women, domestic abuse or sexual violence.

TYPES OF VAWDASV

Coercion & Control

Emotional

Sexual Violence

Child to Parent

Financial

FGM

Modern Slavery

Cuckooing

Physical

Forced Marriage

McLellan,Holly
11/26/2021 12:38:21

Safe Care

Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV)

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

Whilst the Covid-19 pandemic did not cause domestic abuse, it created a *perfect storm* of challenges for survivors and the services supporting them. The Covid-19 virus and lockdown measures designed to fight it, gave perpetrators a tool that they quickly learnt to use for coercion, manipulation and to induce fear.

Statutory and third sector organisations become concerned that not every home is a place of safety, and for some, it may become a place where social isolation increases the risk of abuse and control. Numerous reports over the past 12 months have described the impact of lockdown measure on violence as a *'shadow pandemic'* that has accompanied Covid-19 (UN 2020)

Meryan Hill
11/28/2021 15:38:21

Home Office Statistics (2020) inform us;

- 1 in 4 women and 1 in 6 men are victims of some form of VAWDASV
- 5 in 6 victims (83%) do not report their experiences to the police.
- The Crime Survey of England and Wales estimates 20% of women have experienced some type of sexual assault since the age of 16, equivalent to an estimated 3.4 million female victims.
- 2 Women a week are killed in the UK by a partner or ex-partner
- Approximately 2 million adults experienced domestic abuse last year.
- An estimated 3.1% of women aged 16-59 experienced sexual assault in the last year.

Safe Care
Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV)

Powys Teaching Health Board works closely with partner agencies to respond to VAWDASV. Initially Regional Operational VAWDASV Meetings increased to enable a proactive response to the emerging Covid-19 crisis. The development of a Regional VAWDASV Pathway supported practitioners to navigate advice and support for victims. Also, in preparation for the recovery phase partners contributed to the 2021/22 VAWDASV Regional Priorities

PTHB Safeguarding Team have continued to provide staff with safeguarding supervision and support, delivered VAWDASV Training and produced monthly VAWDASV Newsletters to share the latest information in relation to national, regional and local support agencies, trends and emerging themes and training links.

The Safeguarding team have also continued to engage operationally in Domestic Abuse Conference Calls and Multi Agency Risk Assessment Conference, these are meetings where high-risk victims of abuse are discussed.

McLellan,Holly
11/26/2021 12:38:21

Safe Care

Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV)

Powys Teaching Health Board receives Daily Domestic Abuse Notifications from Dyfed Powys Police following a report of Domestic Abuse when an individual involved is pregnant or there are children associated with the victim or perpetrator.

During 2020-2021 there were **372** *D*aily Domestic Incident Notifications received from the Police which were shared with the appropriate GP, HV Hub, School Nurse Hub and Midwifery

McLellan,Holly
11/26/2021 12:38:21

Safe Care

Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV)

Domestic Abuse Daily Discussion (DADD) is a multi-agency conference call where all high risk victims of domestic abuse are discussed within 48 hours of a domestic incident, enabling earlier intervention, joint decision making and timely decisions around Claire's Law disclosures. If a high risk case requires additional safety planning via the MARAC process, the MARAC is better informed regarding risk and risk management.

During 2020-2021 there were

93 daily discussions and

259 cases were discussed

McLellan,Holly
11/26/2021 12:38:21

Safe Care

Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV)

PTHB Safeguarding Team actively participate in all aspects of the MARAC process. A representative from the Safeguarding Team attends all MARAC meetings along with our colleagues in Mental Health.

Domestic Abuse Multi Agency Risk Assessment Conferences (MARAC) are held every two weeks. MARAC meetings are victim-focused, agencies share information on the highest risk cases of domestic abuse. A safety plan for each victim is developed.

During 2020-2021 there were

21 MARAC *meetings which developed safety plans for*

78 high risk victims

McLellan,Holly
11/26/2021 12:38:21

Safe Care

Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV)

VAWDASV Key activities in PTHB during 2020-21;

- Partnership Working
- A virtual Chat Bot Agent pilot – an advice, guidance & sign posting tool added to PTHB Internet
- Delivery of VAWDASV Group 2 Ask & Act training via MS Teams
- Awareness raising regarding VAWDASV within PTHB monthly newsletters
- Mass Vaccination Sites provided with information packs on VAWDASV
- Domestic Abuse Risk assessment Training for Midwives & HV's
- PTHB Domestic Abuse Policy added 'Safe Leave' guidance for employees requiring support if suffering VAWDASV
- The Violence Prevention unit of Dyfed Powys Police presented at the PTHB Safeguarding Strategic Group to strengthen links and explore data sharing to support the development of a Powys Vulnerability Map.

McLellan Holly
11/26/2021 12:38:21

ACE Informed

Adverse Childhood Experiences (ACEs) are traumatic events, particularly those in early childhood that significantly affect the health and wellbeing of people in Wales, the rest of the UK and the world.

We can break the cycle of ACEs at any stage; it's never too late. Preventing ACEs in a single generation or reducing their impact can benefit not only those children but also future generations in Wales.

McLellan,Holly
11/26/2021 12:38:21

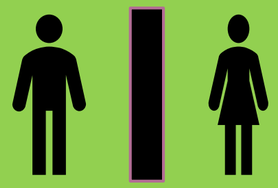
ACE Informed

Adverse Childhood Experiences range from children suffering from or being in a household where there is;

Verbal Abuse

Physical Abuse

Sexual Abuse



Parental Separation

Mental Illness

Alcohol Abuse

Drug Use

Incarceration

McLellan,Holly
11/26/2021 12:38:21

ACE Informed

Impact of lockdown on ACEs

Data from Childline shows a weekly increase since lockdown of Covid-19 related calls. Mental health, suicidal thoughts and feelings, and family relationships are the three main concerns expressed by children.

The NSPCC report that the most common concerns for people contacting the helpline is "parent/adult health and/or behaviour" and Parental alcohol/substance misuse"

Data from the PHW HWB survey found that almost a quarter of adults that live with a child under 18 years old reported drinking more alcohol since lockdown.

Data from the PHW HWB survey found that just over a fifth of those living with someone under 18 years also reported having a diagnosed mental illness

McLellan,Holly
11/26/2021 12:38:21

Learning Culture

Learning from Reviews

The Social Services and Well-being (Wales) Act 2014; Working Together to Safeguard People: Volumes 2 and 3 sets out the arrangements for multi-agency adult and child practice reviews.

PTHB Safeguarding Team, continue to engage with a number of Practice Reviews commissioned by the Mid and West Wales Safeguarding Board.

A Domestic Homicide Review is a multi-agency review of the circumstances in which the death of a person, aged 16 or over, has or appears to have resulted from violence, abuse or neglect by a person to whom they were related or with whom they were, or had been, in an intimate personal relationship, or a member of the same household as themselves. There is a statutory requirement for agencies to conduct DHRs (*Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews 2016).* The Community Safety Partnerships within each Locality Authority area lead on DHRs

There was one published Child Practice Review during 2020-21

An action plan was developed by the Safeguarding Team who have worked with representatives from Midwifery and Health Visiting to address the following;

- **Joint Safeguarding Group Supervision for Health Visitors & Midwives**
- **Training & Education provision to ensure professional curiosity and disguised compliance is explored**
- **Establish the *Chronology* function on WCCIS**
- **Review guidance in relation to Concealed Pregnancy and late Bookings**

Mc ellan Holly
11/28/2021 12:38:21

Learning Culture

Learning from Reviews

To support the principles of Child, Adult and Domestic Homicide Reviews, PTHB formed a Practice Review Group, the first meeting was held in July 2021

The objectives of the group include;

- Ensure all actions plans for CPRs, APRs, MAPFs and DHRs are monitored until completed.
- Review and scrutinise all health records following a serious safeguarding incident to identify immediate learning and develop an action plan to improve practice if needed. This action should not wait until the outcome of a practice review.
- Identify specific audits when required so that lessons may be learnt and fed back into practice.
- Identify specific audits to ensure that changes in practice or processes has been achieved and maintained.
- Identify the development of policies or guidance in response to any learning or change in practice identified as the result of a review.
- Ensure that the dissemination of learning and themes identified following a practice review forms part of the action plan and is shared in a way that engages all relevant staff groups, for example, use of Briefings, posters, learning events, MS Teams.
- Review Regional Practice Reviews to identify learning and cross reference with practice in PTHB

Multi Agency

Shared Learning

Themes Identified

Learning from Incidents

Transparent

Learning Event

Family Consulted

Morgan Hollis
11/26/2021 9:39:

Learning Culture

Training & Development

Over the past 12 months PTHB Safeguarding Team reviewed how we enable staff to achieve their safeguarding training competencies. A blended learning approach has been developed which includes the following;

- MS Teams training sessions developed for; Safeguarding Adults and Children Level 3, VAWDASV Group 2 Ask and Act, Mental Capacity Act, Deprivation of Liberty Safeguards and Looked after Children.

- Introduction of an additional training platform called **Modular learning**. Modules provided flexible access to training material for practitioners. To date 8 modules have been recorded over power point presentations and uploaded to you tube.

- Newsletters & Safeguarding Briefings have been produced monthly

- PTHB Competency Training Passport has been updated and re launched, an exemplar of a completed passport has been developed.

McLellan,Holly
11/26/2021 12:38:21

Learning Culture
Training & Development

- PTHB Safeguarding News Letters

PTHB | Safeguarding Team Newsletters

- PTHB 7 Minute Briefings

PTHB | PTHB Safeguarding 7 Minute Briefings

- PTHB Safeguarding Monthly Briefings

PTHB | Safeguarding Monthly Briefings (wales.nhs.uk)

- PTHB Modular Training

PTHB | Safeguarding Level 3 Modular Training

Themes

McLellan,Holly
11/26/2021 12:38:21

Learning Culture
Training & Development

during 2020-21 the Safeguarding Team delivered a variety of training over MS Teams to PTHB Practitioners;

155 *attended MCA training*

512 *attended Ask & Act training*

165 *attended Safeguarding Children Level 3*

617 *attended Safeguarding Adults Level 3*

McLellan,Holly
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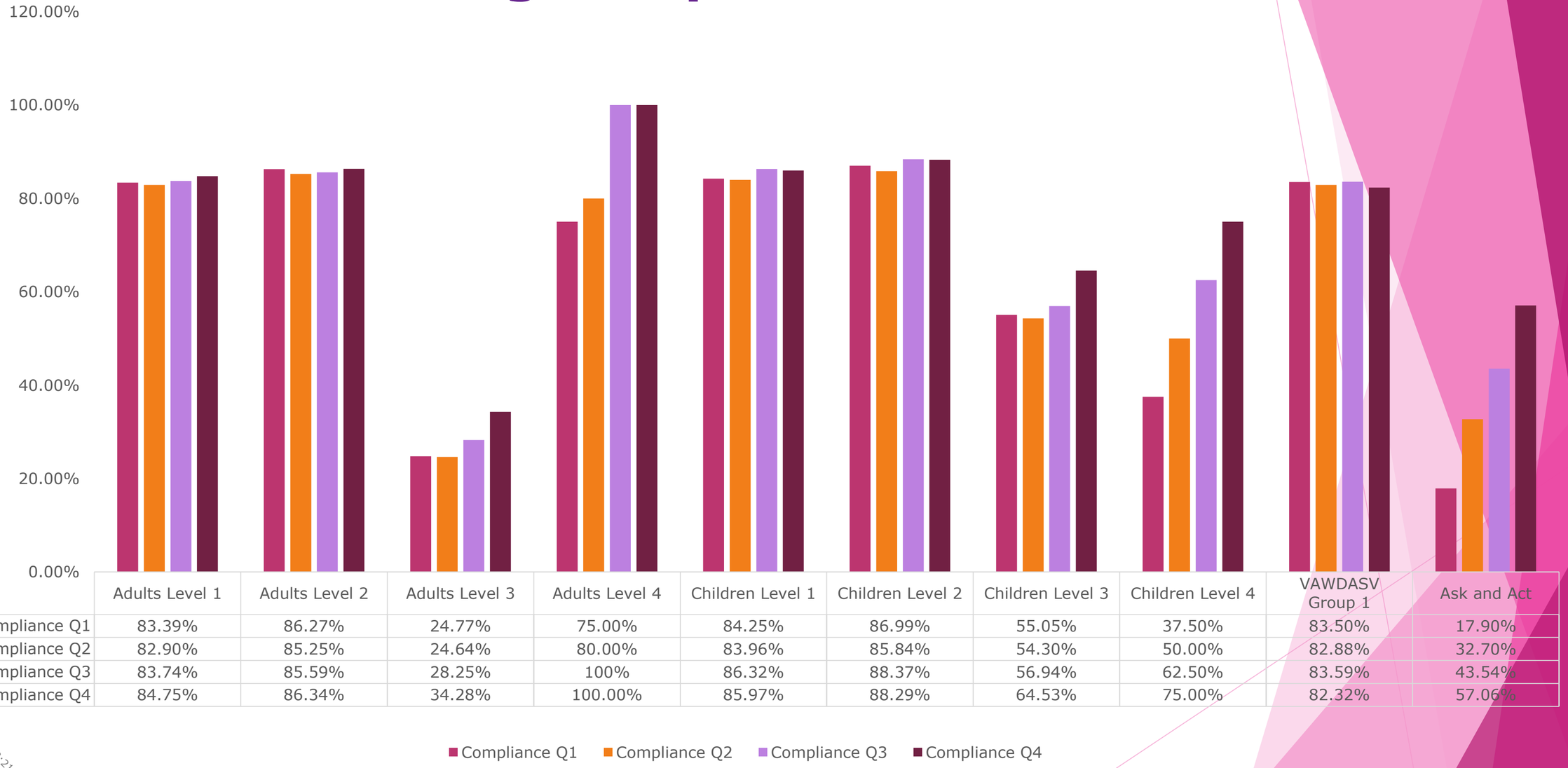
Learning Culture
Training Compliance 2020-21



	Adults Level 1	Adults Level 2	Adults Level 3	Adults Level 4	Children Level 1	Children Level 2	Children Level 3	Children Level 4	VAWDASV Group 1	Ask and Act
Compliance Q1	83.39%	86.27%	24.77%	75.00%	84.25%	86.99%	55.05%	37.50%	83.50%	17.90%
Compliance Q2	82.90%	85.25%	24.64%	80.00%	83.96%	85.84%	54.30%	50.00%	82.88%	32.70%
Compliance Q3	83.74%	85.59%	28.25%	100%	86.32%	88.37%	56.94%	62.50%	83.59%	43.54%
Compliance Q4	84.75%	86.34%	34.28%	100.00%	85.97%	88.29%	64.53%	75.00%	82.32%	57.06%

McLellan,Holly
11/26/2021 12:38:21

Learning Culture

Safeguarding Supervision

Powys Teaching Health Board is responsible for ensuring that all staff are competent to carry out their responsibilities for safeguarding and promoting the welfare of children and adults.

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

Principles of Safeguarding Supervision

Good quality safeguarding supervision can help to;

- Provide an opportunity for reflection and critical incident analysis.
- Identify and learn from near misses and best practice.
- Ensure best outcomes for children and adults at risk, their families/carers and colleagues.
- Promote good standards of practice and support individual colleagues.
- Ensure that practice is soundly based and consistent with PTHB, regional and national policies, procedures and best practice guidance.
- Provide a forum for the practitioner to discuss the emotional impact of working within this challenging area of practice.
- Identify the training and development needs of practitioners, which enhance practitioner skills to provide an effective service.
- Provide advice and expertise to endorse judgements at certain key points in the safeguarding processes.
- Agree key decisions; these should always be recorded on case files

Jones, Holly
12/12/2021 12:38:21

PTHB Safeguarding Supervision Protocol can be viewed on PTHB Safeguarding Intranet page

http://nww.powysthb.wales.nhs/safeguarding-policies-local

Types of Safeguarding Supervision include;

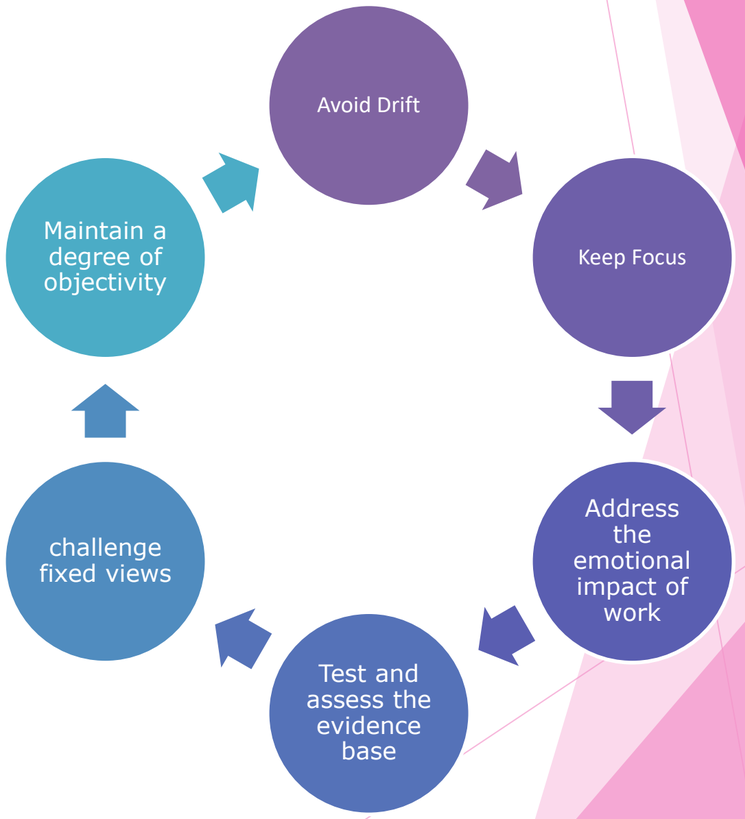
- Immediate Telephone Supervision, Advice, Support
- Requested Individual Safeguarding Supervision
- Group Supervision Sessions
- Debrief Sessions
- Peer Review for Medical Paediatric Staff

Learning Culture

Safeguarding Supervision

PTHB Corporate Safeguarding Team's arrangements for supervision are;	Safeguarding supervision primary functions are to;

- Immediate telephone supervision
- Requested Individual Safeguarding Supervision
- Group supervision
- Professionals who access 3 monthly group supervision; Health Visitors, School Nurses, Midwives, CAMHS registrants, Community Paediatric Nurses, Children with Learning Disability Nurses
- Professionals who access 6 monthly group supervision; Paediatric Allied Health Professionals, Adult Learning Disability Nurses, District Nurses
- Minor Injury Unit Staff, Continuing Health Care Staff, Adult Mental Health Professionals
- Debrief sessions
- Peer Review for Medical Paediatric Staff



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11/26/2021 12:38:21

Learning Culture

Safeguarding Supervision

During 2020-21 the Safeguarding Team

offered **100** Group Supervision Sessions

with **466** staff attending these sessions.

McLellan,Holly
11/26/2021 12:38:21

Multi Agency Partnership Working

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

PTHB are committed to working alongside our partners at a National, Regional and Local level.

Throughout 2020 -21 there are numerous examples on how we have worked in partnership;

- **Contribution to Safeguarding Week**
- **Co-produced Regional Documents and Leaflets**
- **Partnership response to supporting Children's Homes during Covid-19**
- **Support within the NHS Safeguarding Team VAWDASV Work stream**

McLellan,Hywel
11/28/2022 2:34 PM

Multi Agency Partnership Working

PTHB Actively Contributes to Meetings and Groups across the Safeguarding Arena

National Meetings

- NHS Safeguarding Network
- SARC Project Board & Implementation Group
- Safeguarding Maturity Matrix
- WG Abolition of Physical Punishment Bill
- WG Strategic LPS Implementation Group
- NHS VAWDASV Steering Group
- NHS Network LAC Steering Group
- All Wales Self Neglect Policy Group
- NHS Training Sub-group
- NHS DOLS/LPS/MCA Task & Finish Group
- LAC Cymru (Peer Group)

McLellan,Holly
11/26/2021 12:38:21

Regional Meetings

- M&WWSB Board
- M&WWSB CPR/APR/MAPF Sub-Group
- VAWDASV Strategic Group
- VAWDASV Training Sub-Group
- VAWDASV Delivery group
- VAWDASV Commissioning Group
- M&WWSB Appeal Panel
- M&WWSB Training Sub-Group
- M&WWSB MAPF Group
- M&WWSB Policy and Procedure Sub-Group
- Regional DoLS/LPS and MCA Forum
- M&WWSB Safeguarding Child working Group
- M&WWSB Safeguarding Adult working Group
- Regional Anti-Slavery Group

Local Meetings

- PLOG
- Corporate Parenting Group
- CPR/APR/DHR/MAPF Panel
- Youth Justice Board
- Start Well Project
- MARAC Steering Group
- MARAC
- PRUDiC
- DDAC
- Channel Panel
- MAPPA Level 2 and 3
- MASCE
- National Safeguarding Week Planning Group
- Community Safety Partnership (CSP)
- Professional Abuse Strategy meetings
- Complex Strategy meetings

Health Board

- Pressure Ulcer Scrutiny Panel
- Heads of Nursing/Midwifery
- DoLS Signatory
- Child Death Review Group
- Safeguarding Strategic Group
- Safeguarding Operational Group
- LPS Oversight Group
- LPS Working Group
- JIMP
- QSE Funded Nursing Care
- Falls Group

How did we do with our Safeguarding Maturity Matrix Improvement Plan?

GOVERNANCE & Rights Base Approach

We Said	We Achieved	We need to progress
Children Rights/Children's Pledge must be embedded throughout the Health Board	Relaunch of the Childrens Pledge and presentation to the Operational Safeguarding Group by the Childrens Commissioners Office	develop Train the Trainer model to deliver Children's Rights Awareness across PTHB
Data presented to the SSG requires improvement to enable areas of good practice, risks, trends and themes to be identified	New Data set developed and presented quarterly	Completed

Safe Care

We Said	We Achieved	We need to progress
PTHB must prepare for the implementation of Liberty Protection Safeguards, PTHB workforce need to increase their knowledge, skills and confidence in MCA and DoLS	Upskilling of staff knowledge and skills re MCA & DoLS has been a focus. Development of LPS Working and Oversight Groups	continue planning, await Code of Practice and Regulations
PTHB to be assured professionals are aware of, and using PTHB's Was Not Brought Protocol	Protocol updated and relaunched	Audit planned for 2021/22
PTHB must comply with the National Standards for CP Medicals. The CP Medical rota requires strengthening to meets the needs of the children in Powys. To seek assurance of the quality of CP Medicals	Links with CTMUHB to support CP rota. Regular meetings with LA to establish CP Medicals group and how we deliver multi agency Childhood Injuries Training	Strengthen further links with CTMUHB Set date to commence CP Medical Group with LA & Police Deliver multi agency training

McLellan,Holly
11/26/2021 12:38:21

How did we do with our Safeguarding Maturity Matrix Improvement Plan?

ACE Informed

We Said	We Achieved	We need to progress
PTHB to be assured that the CSERQ15 is used routinely within health settings & establish a system to identify children at risk of Child Exploitation within the Electronic Health Board's System.	Newsletter on the use of the CSERQ15 developed to raise awareness, child at risk of CE alert added to electronic system	Audit CSERQ15 Oct 2021
Audited Safeguarding Children Standards for Adult Mental Health Professionals	We were unable to progress this	Added to 2021-22 plan

Learning Culture

We Said	We Achieved	We need to progress
Actions from Practice Reviews and DHR'S should be tracked until completed. PTHB will improve how we share the learning points from Practice Reviews and DHR's with our staff, in a way that will support and influence practice.	Development of Practice Review Group, learning from reviews delivered in training, supervision, newsletters.	Completed
Safeguarding Team will share appropriate and relevant documents, articles and links with PTHB workforce in a way that supports staff to have the information in an easy to read format	Developed monthly newsletters, 7 Minutes briefings and Month Briefings which are distributed via Powys Announcements & SSG & SOG	Completed

Multiagency Partnership Working

We Said	We Achieved	We need to progress
Standard of MARF's require auditing and Quality Assuring	Process in place where all MARF's are tracked by the Safeguarding Team and QA.	Completed
PTHB to increase our contribution to strategy discussions with the LA and Police via PTHB Safeguarding HUB	Safeguarding HUB model developed, improved links regarding CP Medicals	Pilot ongoing with the LA & Police re strategy discussions

Morgan, Holly
16/7/2021 12:38:21

What's on the Horizon

Abolition of Physical Punishment Bill

Ending Physical Punishment in Wales

- In January 2020 The Senedd passed *The Children Abolition of Defence of Reasonable Punishment (Wales) Bill known as the* **Children Wales Act.** This received Royal Ascent on 20th March 2020 and will come into force on Monday 21st March 2022.

The Act will;

- **Remove the defence of Reasonable Punishment**
- **Remove the legal loop hole**
- **Protect and give children the same rights as adults**
- **Provide clarity.**

The Act will not;

- **Create a new offence**
- **Stop parental discipline**
- **Interfere with parents ability to parent**

PTHB Staff have been asked to watch a short *Youtube* clip to gain more information on the new Bill https://youtu.be/pzKhzNIj-j8

There is no place for physical punishment in modern Wales; gov.wales/endphysicalpunishment

McLean,Holly
11/26/2021 12:38:21

What's on the Horizon

Liberty Protection Safeguards

- The Mental Capacity (Amendment) Act 2019 which received Royal Assent on 16 May 2019 introduced Liberty Protection Safeguards (LPS) to replace the current Deprivation of Liberty Safeguards system.
- The legislation provides for the repeal of the Deprivation of Liberty Safeguards (DoLS) contained in the Mental Capacity Act 2005 (MCA), and their replacement with a new scheme called the Liberty Protection Safeguards (LPS) https://www.youtube.com/watch?v=J3EzLXKZx2E
- **In preparation for the new Liberty Protection Safeguards in April 2022 PTHB has;**

- Established an Oversight and Working LPS Group
- Provided training and factsheets on the Mental Capacity Act to support staff knowledge and skill across the organisation
- PTHB are represented on the National, Regional and local LPS Groups and responded to a Welsh Government National Training needs analysis
- Promoted the introduction of LPS via newsletters and sharing a LPS video link
- Reviewed outstanding DoLS applications
- Presented an update on LPS to PTHB Executive Committee

McGuinn Holly
11/28/2021 12:38:21

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

Agenda item: 3.7b

Patient Experience Quality Safety Group	**Date of Meeting:**
Subject:	**Midwifery Safeguarding Supervision Internal Audit Report**
Approved and Presented by:	Alison Davies Executive Director of Nursing and Midwifery
Prepared by:	Jayne Wheeler Sexton Assistant Director of Nursing for Safeguarding and Public Protection
Other Committees and meetings considered at:	

PURPOSE:		
Provide the Patient Experience Quality Safety Group with the findings of the Internal Audit into Midwifery Safeguarding Supervision		
RECOMMENDATION(S):		
The Executive Committee is asked to note the report for information		
Approval/Ratification/Decision	**Discussion**	**Information**
x	✓	x

McLellan,Holly
11/26/2021 12:38:21

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:

A review of Midwifery Safeguarding Supervision was undertaken and completed in line with the 2021/22 Internal Audit Plan for Powys Health Board.

The purpose of the audit was to evaluate and determine the adequacy of the systems and controls in place within the Health Board for Midwifery Safeguarding Supervision. The audit gave an overall rating of Reasonable Assurance which was a combination of;

- **i.** Appropriate Safeguarding Supervision: *Assurance Substantial*
- **ii.** Robust processes in place within midwifery services: *Assurance Reasonable*
- **iii.** Supervision sessions appropriately documented: *Assurance Substantial*
- **iv.** Monitoring and reporting arrangements: *Assurance Reasonable*

Two *Matters Arising* were identified as requiring a management response and action plan:

- **i.** Compliance rates for safeguarding supervision are low, management need to ensure that the action plan is implemented.
- **ii.** Enhancements are required to present the safeguarding supervision data in the safeguarding performance report by discipline.

McLellan,Holly
11/26/2021 12:38:21

An action plan has been developed to ensure the recommendations are managed and completed by December 2021

DETAILED BACKGROUND AND ASSESSMENT:

Introduction

1.1 Powys Teaching Health Board is responsible for ensuring that all staff are competent to carry out their responsibilities for safeguarding and promoting the welfare of children and adults. Staff should be able to raise concerns and feel supported in their safeguarding role.

1.2 Effective safeguarding supervision is important in promoting good standards of practice, sharing experiences, keeping focused and to empower individual staff members; it should assist in ensuring health practitioners are competent and confident and provides a safe environment for challenging practice**.**

1.3 Good quality supervision can help to:

- **I.** Provide an opportunity for reflection and critical incident analysis.
- **II.** Identify and learn from near misses and best practice.
- **III.** Ensure best outcomes for children and adults at risk, their families/carers and colleagues.
- **IV.** Promote good standards of practice and support individual colleagues.
- **V.** Ensure that practice is soundly based and consistent with PTHB, regional and national policies, procedures and best practice guidance.
- **VI.** Provide a forum for the practitioner to discuss the emotional impact of working within this challenging area of practice.
- **VII.** Identify the training and development needs of practitioners, so each has the skills to provide an effective service.
- **VIII.** Provide advice and expertise to endorse judgements at certain key points in the safeguarding processes.
- **IX.** Agree key decisions; these should always be recorded on case files

1.4 The review of Midwifery Safeguarding Supervision was undertaken and completed in line with the 2021/22 Internal Audit Plan for Powys Health Board.

1.5 The potential risks considered in the audit are;

- **I.** non-compliance with applicable legislation, guidance and policy.

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II. a lack of training and development of staff to ensure effective working.

III. a duty of care to children and adults at risk not being implemented

2. Audit Objectives, Findings and Recommendations

2.1 Objective 1; is there an appropriate Safeguarding Supervision guidance/policy in place and are all relevant staff aware of their responsibilities.

2.2 PTHB Safeguarding Supervision Protocol is in place and reported to be comprehensive, up to date and accessible to staff via the dedicated Safeguarding Intranet page. A Safeguarding Supervision Newsletter was also produced to support engagement with practitioners. Feedback from a sample of midwifery staff contacted noted that staff are aware of requirements regarding attending safeguarding supervision sessions and the advice available to them.

2.3 Findings noted s*ubstantial assurance* against this objective.

2.4 Objective 2; are there robust processes are in place within Midwifery services to ensure that staff comply with safeguarding supervision requirements and appropriate supervision sessions are provided.

2.5 Whilst safeguarding supervision compliance rates fell during the pandemic, a work plan has been developed which, once implemented, should help to ensure that the rates improve.

2.6 Safeguarding Supervision sessions for midwives are run jointly with health visiting staff. The Safeguarding Team are responsible for scheduling the sessions and midwives responsible for managing their own bookings via a MS Teams booking system, the new system automatically sends reminders to staff and enables them to undertake changes to their booking. Midwives can now attend any safeguarding supervision session throughout Powys offering more flexibility and availability in terms of dates and times of sessions.

2.7 Findings noted r*easonable assurance against this objective.* Recommendations made include;

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I. Management should ensure that staff are reminded of their responsibility to attend a Safeguarding Supervision Session every three months.

II. Management should also ensure that the Work Plan drawn up to improve compliance is effectively implemented

2.8 Objective 3; supervision sessions are appropriately documented and actions are taken to address any identified issues, concerns or staff training and development needs.

2.9 At each safeguarding group supervision session an agreement and record of the supervision session is completed by the Safeguarding Lead for the Session and are forwarded to the midwife's manager. When required one to one sessions are also available to midwives. Following a specific case discussion, a safeguarding plan of care is drawn up and placed on the patient's case notes. Themes, challenges and good practice discussed at the session are used to inform future learning.

2.10 Findings noted s*ubstantial assurance against this objective.*

2.11 Objective 4; there are appropriate arrangements in place within the midwifery service for the monitoring and reporting of safeguarding supervision.

2.12 Safeguarding supervision compliance is presented monthly at the Midwifery Management Team meeting by the Lead Midwife for Safeguarding. Midwifery is represented at the Health Board's Safeguarding Strategic group by the Head of Midwifery who provides a highlight report from the service. The Lead Midwife for Safeguarding attends the Health Board's Operational Safeguarding group.

2.13 Safeguarding Supervision compliance from across the Health Board is presented by the Safeguarding Team at each safeguarding group meeting. In addition to this, to support Midwifery improve their compliance percentages the Safeguarding Team developed and introduced a Safeguarding Supervision Compliance Tracker during May 2021.

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2.14 The Tracker has been successful as it provides a clear picture of the midwives who attend regularly and those who don't. It has enabled targeted support by managers and the development of an action plan to improve compliance rates. The Safeguarding Tracker has now been rolled out across all Service Groups. The first version was shared with all Heads of Nursing/Therapies during October and will be repeated every quarter.

2.15 Findings noted *reasonable assurance against this objective.* Recommendations made include;

I. Management should consider separating the safeguarding compliance information for midwifery and health visiting that is reported within the performance report. Separating out the two services will mean that issues regarding compliance specific to each service can be identified.

II. Management may also wish to consider enhancing the current reporting data by also reporting current compliance as a percentage and even setting a target percentage for compliance

2.16 Both these actions have been implemented and completed.

3. Summary

In summary, the audit provides overall Reasonable Assurance in respect of the adequacy of the systems and controls in place within the Health Board for Midwifery Safeguarding Supervision. Recommendations made within the audit have been accepted by senior management and an action plan has been implemented.

NEXT STEPS:

- Share the report at the Strategic Safeguarding Group and weekly Midwifery Management Team meeting
- Deliver against the agreed management action plan
- Report progress of the action plan to the Strategic Safeguarding Group and weekly Midwifery Management Team meeting

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Midwifery – Safeguarding Supervision Final Internal Audit Report

November 2021

Powys Teaching Health Board

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Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

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Auditors:	Jayne Gibbon, Audit Manager Ian Virgil, Head of Internal Audit
Executive sign-off:	Alison Davies, Director of Nursing & Midwifery
Distribution:	Jayne Wheeler-Sexton, Assistant Director of Nursing Safeguarding Julie Richards, Head of Midwifery & Sexual Health
Committee:	Audit, Risk & Assurance Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors.

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

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Executive Summary

Purpose

To evaluate and determine the adequacy of the systems and controls in place within the Health Board for Midwifery – Safeguarding Supervision.

Overview

Our overall rating of Reasonable Assurance reflects the protocol and guidance that is in place and available to all staff. A number of areas requiring improvement were identified.

We identified two key matters requiring management attention:

- Compliance rates for safeguarding supervision are low, management need to ensure that the action plan is implemented.
- Enhancements are required to the safeguarding supervision data reported in the Safeguarding performance Report.

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

Report Classification

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Assurance summary[1]

	Assurance objectives	Assurance
1	Appropriate Safeguarding Supervision guidance	Substantial
2	Robust processes in place within the Midwifery service	Reasonable
3	Supervision sessions appropriately documented	Substantial
4	Monitoring and reporting arrangements	Reasonable

[1]The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

	Key Matters Arising	Assurance Objective	Control Design or Operation	Recommendation Priority
1	Attendance at Safeguarding Supervision Sessions	2	Operation	Medium
2	Reporting of Compliance	4	Design	Medium

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1. Introduction

1.1 The review of Midwifery – Safeguarding Supervision was undertaken and completed in line with the 2021/22 Internal Audit Plan for Powys Health Board ('The Health Board').

1.2 The relevant Executive Director for the review is the Director of Nursing and Midwifery.

1.3 Healthcare professionals are required to assure their professional regulator, employer, service users and themselves that they are fit to practice safely and effectively by having up-to-date knowledge and clinical skills. Safeguarding supervision is one of the most important vehicles through which practitioners can gather evidence that they have achieved this.

1.4 Supervision is a term used to describe a formally agreed process of professional support and learning which enables practitioners to develop knowledge and competence.

1.5 The purpose of safeguarding supervision is to ensure that all staff are competent to carry out their responsibilities for safeguarding and promoting the welfare of children and adults at risk.

1.6 The potential risks considered in this review were as follows:

- Non-compliance with applicable legislation, guidance and policy;
- A lack of training and development of staff to ensure effective working; and
- A duty of care to children and adults at risk not being implemented.

2. Detailed Audit Findings

Objective 1: There is appropriate Safeguarding Supervision guidance / policy in place and all relevant staff are aware of their responsibilities.

2.1 The Health Board has a Safeguarding Supervision Protocol in place which is available to all staff on the Safeguarding page on the Health Board's intranet.

2.2 The protocol document was found to be comprehensive and up to date and included responsibilities for all staff, information on different types of supervision and how to access.

2.3 There is a dedicated page for Safeguarding on the Health Board's intranet where advice on safeguarding issues can be accessed.

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2.4 As a result of the Covid-19 pandemic in September 2020 a Safeguarding newsletter was introduced to provide staff with updates on safeguarding issues. The newsletter was well received and has now become a regular issue.

2.5 Feedback from a sample of midwifery staff contacted noted that staff are aware of requirements regarding attending safeguarding supervision sessions and the advice that is available on the Safeguarding page of the Intranet.

Conclusion:

2.6 There is appropriate guidance in place for Safeguarding Supervision. We have provided substantial assurance against this objective.

Objective 2: Robust processes are in place within Midwifery services to ensure that staff comply with safeguarding supervision requirements and appropriate supervision sessions are provided

2.7 Safeguarding Supervision sessions for midwifery staff are run jointly with health visiting staff, with the central Safeguarding Department scheduling the sessions. Once the sessions have been scheduled the information will be shared with all staff.

2.8 Responsibility for booking onto a session lies with the individual member of staff, if a session is not fully booked then reminder emails will be issued to request staff book a place.

2.9 Since the 1st April 2021 a 'Safeguarding Tracker' has been in place for Safeguarding Sessions attended. Whilst the tracker is maintained by the Corporate Safeguarding Team the Lead Midwife for Safeguarding is able to access and review the compliance of midwifery staff.

2.10 When midwifery staff fail to attend a safeguarding supervision session an email will be sent to their line manager to advise of the non attendance.

2.11 The service was aware that compliance for safeguarding supervision sessions had fallen during the Covid-19 pandemic. As a result of this a Safeguarding Women and Children Work Plan covering midwifery staff was drawn up to address the situation. **(Matter Arising 1)**

2.12 We undertook testing on a sample of midwifery staff to ascertain their safeguarding session compliance. Of the 20 staff selected we noted that 1 member of staff had not attended a safeguarding session at the time of the fieldwork. **(Matter Arising 1)**

Conclusion:

2.13 Whilst safeguarding supervision compliance rates fell during the pandemic, a work plan has been developed which, once implemented, should help to ensure that the rates improve. We have provided reasonable assurance against this objective.

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Objective 3: Supervision sessions are appropriately documented and actions are taken to address any identified issues, concerns or staff training and development needs.

2.14 For each supervision session that takes place a document titled 'safeguarding group supervision agreement and record of supervision session' is completed by the Safeguarding Lead for the Session. The document records:

- 2.14.1 Attendee name and designation
- 2.14.2 Theme discussed at the session and main discussion points
- 2.14.3 Agreed actions, completion date and name of action lead.

2.15 A copy of the completed form will then be forwarded to the Corporate Safeguarding Team, all session participants and their line managers.

2.16 When required one to one sessions will take place for staff. They usually arise out of a concern for a specific case and will result in a safeguarding plan of care being drawn up and placed in the patient's case notes.

2.17 The 'supervision records' are reviewed by the Safeguarding Team to highlight any themes/trends. If any are identified then the Safeguarding Lead Midwife will meet with the relevant team to discuss the issue and agree appropriate actions. The theme would also be a discussion point for a future safeguarding session.

Conclusion:

2.18 We found that supervision sessions are appropriately documented. We have provided substantial assurance against this objective.

Objective 4: Appropriate arrangements are in place within the midwifery service for the monitoring and reporting of safeguarding supervision.

2.19 Safeguarding compliance will be reviewed and discussed at the Weekly Midwifery Management Team meeting when the agenda theme is governance.

2.20 At the above meeting the Midwifery aspect of the Women and Children Action plan will be reviewed.

2.21 An update on Midwifery Compliance for the specific month is also presented by the Lead Midwife for Safeguarding.

2.22 The service is represented at the Health Board's Safeguarding Strategic group by the Head of Midwifery and the Health Board's Operational Safeguarding group by Lead Midwife for Safeguarding.

2.23 The Head of Midwifery will provide updates to the Safeguarding Strategic Group on any safeguarding issues.

2.24 Midwifery Safeguarding Supervision Sessions Compliance is reported with the Safeguarding Performance Report that is produced by the Corporate Safeguarding

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Team. The report is submitted to both the Safeguarding Strategic and Operational Safeguarding Groups quarterly.

2.25 We were provided with a copy of the 2020/21 Quarter 4 Performance Report. From our review of the report we confirmed that data concerning safeguarding sessions is reported. We also noted that midwifery compliance is reported jointly with health visiting staff resulting in us being unable to ascertain the actual level of compliance for midwifery services. **(Matter Arising 2)**

Conclusion:

2.26 There are processes within both Midwifery Services and Corporately for monitoring and reporting safeguarding supervision compliance however enhancements regarding the information reported Corporately are recommended. We have provided Reasonable assurance against this objective.

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Appendix A: Management Action Plan

Matter Arising 1: Attendance at Safeguarding Supervision Sessions (Operating Effectiveness)	Impact
In accordance with the Safeguarding Supervision Protocol midwifery staff are expected to attend a Safeguarding Supervision session every 3 months. A random sample of midwifery staff was selected to ascertain compliance for the period 1st April 2021 to 30th September 2021. The following was noted from the testing: • Of the 20 staff selected 1 member of staff had not attended a supervision session during that period. As a result of the Covid pandemic, compliance levels for safeguarding supervision had reduced and this has been acknowledged and reported by the department as part of the compliance figures detailed in Matter Arising 2 below. As a result of this, a Safeguarding Women and Children Work Plan covering midwifery staff supervision was drawn up in December 20 to address the situation. At the time of review, the work plan had not been updated to confirm the status of the actions.	Failure of staff to attend sessions could lead to ineffective working and a failure of duty of care to patients.
Recommendations	**Priority**
1.1 Management should ensure that staff are reminded of their responsibility to attend a Safeguarding Supervision Session every three months. 1.2 Management should also ensure that the Work Plan drawn up to improve compliance is effectively implemented.	Medium

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Agreed Management Action	Target Date	Responsible Officer
1.1 a) Head of Midwifery to highlight to all Midwives at all Powys Midwifery meeting on their responsibility to attend Safeguarding Supervision every three months	11th Nov 2021	Julie Richards, Head of Midwifery and Sexual Health
b) Head of Midwifery will be reviewing compliance through weekly Bronze meetings with Band 7 Midwives	Nov 2021	Julie Richards Head of Midwifery and Sexual Health
c) Requirements to attend Safeguarding supervision and available dates for Q3 are highlighted through the Midwifery Weekly brief that is shared to all Powys Midwives	Completed	Debbie Howells, Named Midwife for Safeguarding supervision
1.2 a) Safeguarding supervision compliance will be monitored through monthly Midwifery Management and Leadership Governance meeting and has been included into the Women and Children's Senior Leadership Performance Dashboard	December 2021	Julie Richards, Head of Midwifery and Sexual Health
b) Women and Children's Safeguarding Work plan to be reviewed and updated to ensure improvements with compliance is effectively implemented	December 2021	Louise Turner, Assistant Director for Women and Children's services

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Matter Arising 2: Reporting of Compliance (Control Design)	Impact
We note that Safeguarding Supervision Sessions compliance is reported as part of the Performance report that is considered at the Health Board's Safeguarding Strategic and Operation Safeguarding Group meetings. As part of our audit fieldwork we were provided with a copy of the 2020/21 Quarter 4 Performance Report. From our review of the report we made the following observations: • There is no separate compliance figure report for Midwifery Safeguarding compliance, it is reported as a joint figure with Health Visiting. • For the period 1st July 2020 to 28th February 2021 (which was reported in the Quarter 4 Safeguarding Performance Report that went to the July 21 Safeguarding Group) there were 78 midwifery and health visiting staff in post meaning there should have been 156 attendances. The actual number of attendances reported was 70 which is a compliance rate of 45%. • Due to the fact that midwifery and health visiting staff compliance is reported as one figure we are unable to identify the actual compliance rate for midwifery staff.	Health Board is not aware of the true compliance rate for midwifery staff.
Recommendations	**Priority**
2.1 Management should consider separating the safeguarding compliance information for midwifery and health visiting that is reported within the performance report. Separating out the two services will mean that issues regarding compliance specific to each service can be identified.	Medium
2.2 Management may also wish to consider enhancing the current reporting data by also reporting current compliance as a percentage and even setting a target percentage for compliance.	

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Agreed Management Action	Target Date	Responsible Officer
2.1 and 2.2 We commenced separating all service groups in July 2021. This has enabled the corporate safeguarding team to produce individual compliance reports that clearly identifies each registrant's compliance and the overall percentage compliance for each service. The Quarter 2 Reports were distributed to the Heads of Service for the first time at the end of Q2 and will be reported at the next Strategic and Operational Safeguarding Groups. I accept that we should set targets.	2.1 and 2.2 completed	Jayne Wheeler-Sexton Assistant Director of Nursing Safeguarding

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Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

	Substantial assurance	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	Reasonable assurance	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	Limited assurance	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	No assurance	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	Assurance not applicable	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

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* Unless a more appropriate timescale is identified/agreed at the assignment.

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AGENDA ITEM: 3.8

Patient Experience, Quality and Safety Committee	**DATE OF MEETING: 2 December 2021**
Subject:	**COMMISSIONING ESCALATION REPORT**
Approved and Presented by:	Director of Nursing & Midwifery Director of Planning and Performance
Prepared by:	Assistant Director of Performance and Commissioning Quality and Safety Commissioning Lead
Other Committees and meetings considered at:	Delivery & Performance Group 21 October 2021 Executive Committee 17 November 2021 This report provides supplementary information in relation to the two providers with services in Special Measures.

PURPOSE:

The purpose of this paper is to highlight to the Patient Experience Quality & Safety Committee the providers in Special Measures or scored as Level 4 and above under the PTHB Commissioning Assurance Framework.

RECOMMENDATION(S):

It is recommended that the Patient Experience Quality & Safety Committee DISCUSSES this Commissioning Escalation Report.

Approval/Ratification/Decision	Discussion	Information
	✓	

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

EXECUTIVE SUMMARY:

This report highlights providers in Special Measures or scored as Level 4 and above. The PTHB Internal Commissioning Assurance Meeting (ICAM) did not meet in September 2021. Based on commissioner / provider meetings with all commissioned providers outside of Powys during September and October 2021, along with the information gathered via that process, Commissioning Assurance Framework (CAF) scores and ratings have been maintained from those set in August 2021. As reported to the recent Delivery & Performance Group held on 21 October 2021, there were:

- 2 providers with services in Special Measures
- 1 provider at Level 4.

The report also provides:

- A high-level summary of key issues in relation Shrewsbury and Telford Hospitals NHS Trust (SaTH) and Cwm Taf Morgannwg University Health Board (CTMUHB)
- Referral to treatment times (RTT) times.

It is noted that an inspection undertaken in September 2021 by Health Inspectorate Wales focusing on Prince Charles Hospital, Merthyr Tydfil is due to be published on 15 December 2021. This will be included in subsequent reports to the Patient Experience Quality and Safety Committee.

This report does not yet consider reports related to the Grange Hospital, Aneurin Bevan University Health Board and the functioning of its emergency pathways. This latest information will be reviewed at the next South Powys

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Programme Board meeting, and will be subsequently reported to the Patient Experience, Quality and Safety Committee.

DETAILED BACKGROUND AND ASSESSMENT:

PTHB's Commissioning Assurance Framework (CAF) helps to identify and escalate emerging patterns of poor performance and risk in health services used by Powys patients.

It considers patient experience, quality, safety, access, activity, finance governance and strategic change. It is a continuous process, considering information from a broad range of sources including "credible soft intelligence". It is not a performance report between fixed points. Each PTHB Directorate is invited to contribute information to the CAF and to attend the ICAM.

Formal inspection reports for the NHS organisations commissioned are available on the websites of Health Inspection Wales (HIW) and the Care Quality Commission (CQC). PTHB attempts to draw from providers' existing Board reports, plans, returns to Government and nationally mandated information wherever possible.

The usual commissioning arrangements have not been in place since March 2020 due to the pandemic. Since July 2020, PTHB has been working to restore the CAF, although there remain significant limitations due to the national position. It is not possible to score all domains, for example "block" financial arrangements do not reflect pre-COVID budgets or Long-term Agreements. Escalation processes cannot operate in the usual way, for example, elective care delays are at an unprecedented level due to the pandemic. The Public Health resource assisting with the interpretation of the Clinical Health Knowledge System results which was diverted to COVID 19 outbreak is being restarted focusing on maternity services.

Given lengthening Referral to Treatment Times (RTT) across all NHS providers that will take time to recover, the CAF escalation scoring and access measurement process is to be reviewed. Additionally, and for this reason, the way in which the CAF escalation scoring is calculated with regard to patient experience also requires revision. Currently, the Patient Experience component of the CAF reflects the reported position by providers, for example, using the Friend and Family Test and reported patient experience feedback via Welsh NHS organisations, supplemented by evidence gained via other routes, for example, surveys, regulatory reports, incidents and complaints.

Unfortunately, it is envisaged that most providers will take a number of years to recover the waiting list position, enabling the residents of Powys to receive timely intervention where this is indicated.

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Wye Valley NHS Trust

Wye Valley NHS Trust remains at level 4 as assessed sign the PTHB Commissioning Assurance Framework. Whilst a number of indicators are stable, access to services, as in the vast majority of providers in Wales and England, is adversely affected as a result of pandemic service change.

Level 4					
Provider	**Area of Measure**	**July 2021**	**Aug 2021**	**Sept 2021**	**Change in Status**
Wye Valley NHS Trust	Quality & Safety				↔
	Patient Experience				
	Access				
	Finance	BLOCK AGREEMENT			
	Governance & Strategic Change	NOT RATED			

Shrewsbury and Telford Hospitals NHS Trust (SATH)

As previously reported to the Performance and Resources Committee SATH is in special measures and is rated as "inadequate" overall. There have been a series of concerning reports following inspections by the Care Quality Commission (CQC) resulting in Section 31 Notices imposing conditions on the regulated activity there. The full reports can be accessed via the CQC website (**www.cqc.org.uk**) but include concerns in relation to the management of:

- Pressure area care
- Falls
- Nursing documentation
- Learning from previous incidents
- Mental Capacity Act and Deprivation of Liberty Safeguards
- Children and young people with mental health needs, learning disabilities and behaviours that challenge
- End of life care
- Maternity Services
- the oversight of audits and the improvement of outcomes
- the culture.

Reports on these matters have been considered by the Experience, Quality and Safety Committee (EQS) on the 15th April, 2021; 3rd June, 2021; and 15th July 2021. The Performance and Resources Committee was updated on the 24th June, 2021. The current status of SATH is demonstrated below:

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Special Measures					
Provider	**Area of Measure**	**July 2021**	**August 2021**	**Sept 2021**	**Change in Status**
Shrewsbury and Telford Hospital NHS Trust	Quality & Safety				↔
	Patient Experience				
	Access				
	Finance	BLOCK AGREEMENT			
	Governance & Strategic Change	NOT RATED			

On 18 November 2021, A Care Quality Commission (CQC) report was published (appendix 1), following an unannounced inspection undertaken between 6 July - 19 August 2021, over 6 separate site visits, https://www.cqc.org.uk/what-we-do/how-we-do-our-job/inspection-reports. urgent and emergency care, medical care, and end of life care at both the Royal Shrewsbury Hospital and the Princess Royal Hospital, and maternity services at the Princess Royal – as well as undertaking a 'well-led' inspection for the Trust overall.

The CQC has rated the Trust overall as inadequate because, although the Trust had made improvements since their last inspection, further work was needed to improve the rating.

Overall trust quality rating	Inadequate
Are services safe?	Inadequate
Are services effective?	Requires Improvement
Are services caring?	Requires Improvement
Are services responsive?	Inadequate
Are services well-led?	Requires Improvement

The Royal Shrewsbury Hospital and the Princess Royal Hospital were inspected. Both hospitals provide a wide range of acute hospital services including accident & emergency, outpatients, diagnostics, inpatient medical care and critical care. There were seven services inspected of which five were rated 'Requires Improvement' and two rated as 'Inadequate', the two related to End of Life Care and Urgent & Emergency Services.

The report found that the Trust has experienced significant challenges over the past 18 months due to the COVID-19 pandemic. Staff were redeployed from substantive roles to care for the most acutely ill patients and support staff in critical areas. Services had to be redesigned and moved at short notice.

Michelle Hay 1/12/2021 12:38:21

At the time of the CQC inspection, the Trust was part of an improvement alliance with an NHS Trust based in Birmingham, the alliance involved the sharing of resources, staff, expertise and learning to facilitate improvement.

The inspection found that:

- staff did not always assess and respond to patient risk
- Records were not always of good quality, stored safely or easily available to staff to ensure that they could provide safe nursing care.
- Staff did not consistently complete and update risk assessments for each patient or take actions to remove or minimise risks.
- Staff did not always identify or quickly act upon patients at risk of deterioration.
- Infection prevention and control varied in performance and the environment across many core services did not promote safe and high-quality care.
- Staff did not consistently use equipment and control measures to protect patients, themselves and others from infection.
- On two occasions the CQC inspectors witnessed staff entering patient isolation rooms without appropriate PPE.
- Staff were not routinely tested for covid-19 unless they were symptomatic, or they were working in an area where there had been a covid-19 outbreak.
- Only 18% of frontline staff had participated in the lateral flow tests from April to June 2021.
- Staff did not always treat patients with compassion and kindness but it is acknowledged their ability to do so was impacted by other challenges the Trust faced. Individual needs were not always met.
- Pain relief for patients varied across core services.
- Individual needs were not always met, people could not always access the service when they needed it and did not receive the right care promptly.
- Vacancies within nursing, medical and allied health professional staffing was still impacting on the safety and quality of patient care.
- Some areas did not have enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. However, managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.
- Leadership at Trust level and across core services had improved but there was further work to do which included but was not limited to management of risk and performance, culture and governance.
- Leaders had the skills and abilities to run the Trust but there were gaps in experience and capacity.
- Staff had mixed views regarding the visibility and how approachable Trust leaders were.
- The Trust has a vision for what it wants to achieve but does not yet have an overarching Trust-wide strategy to turn it into action.

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- Services had improved safeguarding practices which improved safety for service users, and mental health provision for service users had improved.
- Staff provided emotional support to patients, families and carers to minimise their distress.
- Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment,
- medicines were generally managed well, with some exceptions in some areas.
- There was evidence that the Board was developing and starting to work well together.

The CQC found outstanding practice within the midwifery staff, they showed immense levels of resilience as they were able to continue to provide high levels of care to women and babies, and maintained a positive and caring attitude during extremely challenging circumstances. The maternity department was under considerable scrutiny following the publication of the first Ockenden review (independent review of maternity services) and during the COVID-19 pandemic. This was in addition to the maternity service's ongoing challenges with the stability of the senior maternity leadership team which further impacted on staff.

Shrewsbury and Telford NHS Trust were informed by CQC that they MUST act to ensure they bring the services into line with 71 Legal requirements, the actions requested below relate to all the seven services inspected:

- Children who present to the emergency department are assessed within 15 minutes of arrival in accordance with the relevant national clinical guidelines.

- Implement an effective system with the aim of ensuring that all adults who present to the emergency department are assessed within 15 minutes of arrival in accordance with the relevant national clinical guidelines.

- A system is in place which ensures that all children who leave the emergency department without being seen are followed up in a timely way by a competent healthcare professional.

- The Trust must carry out accurate clinical risk assessment and care planning, this includes ensuring patients' needs are individualised, recorded and acted upon, and implement an effective system to monitor and improve the quality of care planning records.

The Chief Executive at SaTH welcomed the CQC inspection report noting it identifies meaningful progress in the Trust, but also shows that more work is required to improve the services we deliver for communities, with plans in place to achieve this: "In incredibly difficult circumstances, progress has been made in key areas and much has been done to improve the way we work and

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deliver care. Our team has shown enormous dedication and commitment and I want to thank them for their exceptionally hard work to bring about these positive changes. However, the report also reinforces the amount there is still to do on the Trust's improvement journey. We are determined to build on this progress and use this, and the report, as a stepping stone to provide excellent care across all our services for patients and families'.

PTHB will continue to monitor the care and services provided by SATH to the population of Powys using the established commissioning assurance framework and utilising other data sources for triangulation and escalation processes where indicated.

Whilst the inspection report above has not yet been publicly reported to the SaTH Board, the key issues reported to the SaTH Board on 6th October, 2021, are summarised as follows:

- August has seen an increase in the prevalence and the number of patients admitted with COVID-19. Our vaccination programme performs well. One of the unfortunate consequences in August has been the impact on elective services, in particular the loss of our elective orthopaedic capacity at Princess Royal Hospital (PRH), and we are working with The Robert Jones & Agnes Hunt Orthopaedic Hospital (RJAH) to improve the availability of services for patients.

- Feedback from our Friends and Family scores regarding the quality and standard of our catering is positive. We are also seeing continuing good scores for cleanliness.

- The focus on infection prevention and control as part of our Quality Improvement Strategy continues, with performance against expected standards being closely monitored.

- During August, our operational challenges have intensified with high levels of attendances and acuity in our emergency departments, delays to discharge for medically fit patients, referrals for Cancer services returning to pre-pandemic levels and longer waiting times for many of our patients waiting for out-patient consultations, diagnostic tests and elective surgery.

- We are continuing to work as part of the whole system to address the unscheduled care pressures and within SaTH are moving forward with the capital development of our emergency department in Shrewsbury so as to create a larger treatment area for our patients. The first phase of this is scheduled for completion in September.

- We are continuing to provide patient appointments virtually where possible, as well as restoring face-to-face consultations where virtual clinics are not suitable. We have an additional Vanguard theatre and

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recovery facility at PRH and have an additional CT and MRI scanner being installed. The CT scanner will be operational during October, and the MRI scanner will become operational as soon as recruitment for additional MRI Radiographers has been finalised.

- Our recovery of elective capacity has been affected by both the unscheduled and COVID-19 pressures combined with absences in our own staff. It is positive to see the number of new doctors taking up post during the month and the international recruitment recommencing. We have also been successful in recruiting midwives and look forward to them taking up post during September.

- Our income and expenditure has been adversely affected by the reduction in the elective recovery and the change in the Elective Recovery Framework (ERF) threshold introduced in July 2021. We are working to finalise our H2 activity plans and looking to balance the needs of our elective recovery with the increasing demands we may face over the winter months. Our efficiency plans show a positive variance in the year to date.

- Our Phase 2 Getting to Good plans are showing all 9 programmes making progress. Through this we are seeking to ensure our good work in Year 1 is embedded in our services to improve outcomes for our patients. We are working to review and strengthen actions in areas which are behind plan'

It is important for PTHB to understand the assurances being received by the SaTH Board. SaTH's Quality and Safety Assurance Committee was alerted, advised and assured in relation to the following matters*:*

Alert	Complaint response times remain a concern. The process is being revised and streamlined.
Assurance	The Management of Datix incidents is improving. The Committee is continuing to monitor this.
Advised	The Committee received a verbal report from the Director of Nursing in relation to the CQC visits. *"Whilst CQC continue to raise some concerns there is a greater confidence in the Trust's management to respond appropriately and work with the CQC to provide additional explanations, evidence and feedback."* The Committee was also advised about a 6.5% increase in A&E activity compared to June 2020. Ambulances are reporting activity on a par with winter demands. The Trust's public Board is to receive information about Serious incidents. The Badgernet maternity system will start a gradual implementation on the 9th August 2021.

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"Freedom to Speak Up" Arrangements are in place for staff. Over half of the concerns raised in the most recent quarter were about behaviours, relationships, bullying and harassment. A behaviours framework has been launched and work is being undertaken in relation to values and culture. A range of initiatives are being undertaken to address the issues raised by staff including HR processes, mediation, leadership development, organisational development, and workshops on "courageous conversations" and "civility saves lives".

A Secretary of State initiated Independent Review of Maternity Services at the Trust, chaired by Donna Ockenden, is underway. The first report of the Independent Review was published on the 10th December 2020 and presents emerging findings and recommendations from 250 clinical reviews, highlighting significant failings in maternity care at the Trust between 2000 and 2018/19. The "*Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust*" (known as the first "Ockenden Report") recommended 52 actions in total. These include local actions (LAFL) which are specific requirements for SaTH, together with immediate and essential actions (IEA) for all NHS providers.

The Trust reports that "*good progress continues to be made against the required actions from the first Ockenden Report (2020) and this work continues at pace. There are some challenges; however, work continues to address all of the required action.*" (A Maternity Services update is being provided to the next EQS Committee.) The latest update from SATH is available from the following website link 249.21-Ockenden-Report-Progress-Report.pdf (sath.nhs.uk)

PTHB is a member of a SaTH Oversight Assurance Group (SOAG) including regulators. The most recent meeting was on the 25th August, 2021, and PTHB was represented by the Nursing Directorate. In addition to the on-going inspection the following key issues were noted: further improvements are needed to end of life care, including across the system; and a Director of Midwifery post is being advertised.

SATH remains in an "Improvement Alliance" with the University Hospitals Birmingham NHS Foundation Trust (UHB) to help improve the quality and safety of its services. Work is underway within the trust including a "Getting to Good" improvement plan; a renewed focus on governance and culture; a revised Board Assessment Framework (BAF); and improved integrated performance reports.

The PTHB Deputy Medical Director attends the ICAM and feeds-in any concerns from North Powys GPs. Rather than just individual cases GPs have wider systemic concerns including the relationship between acute and out-patient services; scanning, particularly CT in relation to cancer; and the responsiveness of SaTH to concerns. SaTH is revising its process in order to

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ensure a timelier response to concerns, it is addressing CT capacity and states it is prioritising cancer patients.

SATH remains an escalated matter for PTHB. Following the Executive Committee deep dive meeting in relation to SaTH on the 23rd June, 2021 there has been further liaison with other stakeholders including UHB and the CQC and participation in the Oversight Group. Overall the metrics and intelligence show an organisation still addressing major difficulties. However, the view of other stakeholders appears to be that the appropriate improvement actions are underway although it will take time to fully turn this situation around. PTHB will seek to restore the regular CEO level escalation meetings which were disrupted by the COVID pandemic.

Cwm Taf University Health Board (CTMUHB)

The Experience, Quality and Safety Committee received updates on the 3rd June, 2021 and 15th July, 2021. The Performance and Resources Committee was updated on the 24th June, 2021.

CTMUHB's maternity services are in special measures. An Independent Maternity Oversight Panel (IMSOP) is in place, which provides independent oversight arrangements of maternity and neonatal services at CTMUHB. Whilst there has been neonatal expertise as part of the IMSOP's work in relation to the Clinical Review Programme and within the Quality Assurance Panel, there is now also neonatal expertise within the full Panel.

When the Panel reported in September 2020, it concluded that the health board had done remarkably well to maintain the focus and momentum of its Maternity and Neonatal Improvement Programme (MNIP) during the first wave of the COVID-19 pandemic. In the circumstances which have prevailed over the past twelve months and the last six months in particular, the Panel has advised that the current pace of progress is entirely understandable in their view.

An IMSOP report was published on 25 January 2021 (which was the first report of the Clinical Review Programme and the first of three thematic reports). Key factors in the Clinical Review Report were the diagnosis and the recognition of the high-risk status of the woman, the treatment provided and clinical leadership. Poor communication with women or between health professionals was also a common theme. The Panel recognised that CTMUHB had been open, transparent and compassionate, also identifying that over the past two years significant improvements have been achieved and progress made against the 70 recommendations of the RCOG and RCM report. (Although it is recognised some progress slowed due to the second COVID-19 peak.)

Magellan Hollis
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A Programme Director for Neonatal Services in CTMUHB is in place and a high-level neonatal improvement plan was submitted to the January 2021

CTMUHB Improvement Board. A further update about the independent oversight arrangements of maternity and neonatal services at CTMUHB was provided by the Minister for Health and Social Services on the 22nd March 2021. Whilst there has been neonatal expertise as part of the Independent Maternity Oversight Panel's work in relation to the Clinical Review Programme and within the Quality Assurance Panel, there is now also neonatal expertise within the full Panel.

It is important to ensure that as the learning emerges it is fed into the wider improvement programme. Alongside this the panel is undertaking a deep dive to take stock of the current neonatal service and its improvement plan to provide assurance that services are safe, effective, well led and importantly integrated with the maternity service to provide a seamless service for women and babies. This should help inform improvements CTMUHB is making on their journey to provide exemplar maternity and neonatal services.

A written statement released by the Health Minister on 7 September 2021 presented the interim findings from the deep-dive into neonatal care, which was subsequently published on 5 October 2021. The Ministers Statement made on that date noted that: *'overall, the findings from the stillbirth review category closely mirror the areas of concern identified by the Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives following their review of maternity services in 2019. They also reflect those identified in the panel's first review category, which involved the care of mothers who needed emergency care and treatment. While these findings are therefore not wholly unexpected, they will undoubtedly be deeply upsetting and, in some cases, devastating, for the women and families involved'.* Written Statement: Cwm Taf Morgannwg University Health Board – Publication of the Independent Maternity Services Oversight Panel's Thematic Stillbirth Category Report and September 2021 Progress Report (5 October 2021) | GOV.WALES

The Thematic Stillbirth Category Report, the second report in the series focuses on the care of mothers and their babies who sadly, were stillborn. It identifies the key themes and issues which emerged from the clinical review of 63 individual episodes of care which were provided by the Health Board between 01 January 2016 and 30 September 2018. A further thematic report will be published once the reviews relating to the care of babies who sadly died or required specialist neonatal care following their birth are complete. Once the three individual reports have been produced, the Panel will develop an overarching report which draws together the cumulative learning from the programme.

CTMUHB responded to the report acknowledging the tragedies suffered by women, their families and staff, and identifying the learning as the foundation on which improvement plans were being built. Improvements listed included a new approach to smoking cessation in pregnancy, more robust reviews of stillbirth cases, instigation of routine Perinatal Mortality Review Tool

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meetings, enhanced staff training, better support for grieving families and shared learning.

Progress made in relation to implementing the revised improvement plan for neonatal services within CTMUHB will help inform the timing of the strategic change of maternity and neonatal services to Prince Charles Hospital; along with the findings of the deep dive, expected early in 2022. It is expected that the neonatal improvement plan will be shared with PTHB in the near future.

Monitoring maternity and neonatal care across complex systems is a significant challenge. PTHB has complex pathways involving multiple commissioned services in other Welsh health boards and in English trusts, as well as being a provider of local services.

Special Measures					
Cwm Taf Morgannwg University Health Board	Quality & Safety				↔
	Patient Experience				
	Access				
	Finance	BLOCK AGREEMENT			
	Governance & Strategic Change	NOT RATED			

PTHB is seeking to ensure it has the right data feeding into the process, the best available methods for this kind of analysis, automation where possible and appropriate scrutiny of outputs.

PTHB has been working to ensure the use of funnel plots and statistical process control (SPC) charts following the work of Sir David Spiegelhalter, so that unacceptable variation and outliers can be highlighted. Whilst progress was disrupted by the pandemic, and there is further work to do, the Clinical Health Knowledge System (CHKS) has been asked to provide PTHB with a bespoke extract of data that is suitable for the preparation of funnel plots for key maternity indicators. An automated routine using the bespoke CHKS extract has been developed to create a set of funnel plots for each of the maternity indicators for each available year.

This is because accurate data and intelligence are absolutely key in informing decision making in terms of identifying the optimum time to implement strategic change in obstetric and neonatal pathways, along with continuing development of the maternity and neonatal assurance framework. Maximising the use of available information to more accurately understand clinical outcomes is essential, so that quality of care is articulated

The PTHB Maternity Assurance Framework (MAF) has closely reviewed the domains, with a verbal update provided to the Internal Commissioning Assurance Meeting (ICAM) on a monthly basis and formal quarterly reporting. The Quarter 2 (Q2) MAF records that there have been no incident reports or MBRACCE reports for Perinatal or Maternity Morbidity for 2021.

In regard to Patient Experience, Powys women have been reporting positively on their experience of accessing care through CTMUHB with Obstetric Care planning. Q2 has seen pressure across all Maternity and Neonatal services involving health boards and cross border NHS Trusts. However, there have been no access issues with CTMUHB. The neonatal aspect of the CAF framework is to be developed in readiness for 2022-2023 Long Term Agreement.

It is noted that an inspection undertaken in September 2021 by Health Inspectorate Wales focusing on Prince Charles Hospital, Merthyr Tydfil is due to be published on 15 December 2021. This will be included in subsequent reports to the Patient Experience Quality and Safety Committee.

Referral to Treatment Times (RTT)

As reported nationally there is now an unprecedented challenge in relation to timely access to routine services across the NHS as a result of the response to the pandemic. The Director General of Health and Social Services in Wales has warned that the situation may take a number of years to resolve. Capacity was significantly reduced in order to care for the surge in COVID patients and to prevent the spread of infection. Private sector capacity has been used to maintain essential services, such as for those with suspected cancer. The situation has been exacerbated through the summer due to unscheduled care pressures, with activity exceeding pre-pandemic levels.

There have also been considerable difficulties with flow in surrounding DGHs due to capacity and pressure on domiciliary care services, which are crucial to timely discharge from hospital.

Addressing this situation is a key focus of the approach to renewal in the PTHB Annual Plan for 2021/2022. Major renewal priorities emerged from a full appraisal of the impact of the pandemic. The renewal priorities focus on the things which will matter most to the wellbeing of the population of Powys and those things which will work best to address the critical challenges ahead. The scale of the challenge will not be met by existing approaches and will require new, radical solutions bounded in a value-based healthcare.

A portfolio of renewal work is being established across priority areas to transform services. The portfolio is working at pace across boundaries, but recognising that true transformation is a long-term process. The priority areas are: frailty and community model; long term conditions and wellbeing; diagnostics, ambulatory and planned care; advice, support and pre-habilitation; children and young people; and tackling the Big 4 (respiratory, cancer, circulatory and mental health).

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£2.5M non-recurrent revenue and £550k capital has been secured from Welsh Government to take forward the first phase of priorities. A CEO chaired Renewal

Strategic Portfolio Board has been established; executive leads for each priority identified and miles-stones built into the annual plan and delivery plan. Programmes for priority areas are at different points of development – some are building on well-established programmes, such as Breathe Well, whilst others involve establishing new programmes such as for the crucially important frailty and community model.

Where other health boards have received funding directly from Welsh Government, PTHB will need an arrangement to take account of this within commissioning arrangements. The funding arrangements for additional recovery activity taking place in England is to be confirmed. Actual activity versus activity trajectories submitted are now being monitored by Welsh Government on a quarterly basis. Out own provider services met the quarter 1 targets submitted. Progress against quarter 2 is being prepared for submission to Welsh Government on the 1st November 2021.

The Renewal Strategic Portfolio Board will be considering risk management in more detail, but key risks are recruitment to the support infrastructure including procurement capacity; operational recruitment, particularly in relation to theatre staff; the availability of additional external clinical capacity; and unscheduled care pressures.

Annexe 1 provides the break-down of waiting times, by speciality, across each provider. Key areas of concern are orthopaedics, ophthalmology, general surgery and urology. The current COVID and unscheduled care situation is being monitored carefully due to the potential impact on the restoration of elective services. PTHB's Medical DirectOE is leading work to understand and mitigate potential harm caused by extended waiting times for elective services.

Powys Provider Referral to Treatment (RTT)

RTT waits by specialty and bar	Weeks wait band						
Main Specialty	0 to 25 Weeks	26 to 35 Weeks	36 to 52 Weeks	53 to 76 Weeks	77 to 104 Weeks	Over 104 weeks	Grand Total
100 - GENERAL SURGERY	411	39	15	11	17	1	**494**
101 - UROLOGY	135	14	21	4	0	0	**174**
110 - TRAUMA & ORTHOPAEDICS	517	48	52	44	45	0	**706**
120 - ENT	395	20	11	2	0	0	**428**
130 - OPHTHALMOLOGY	724	95	44	3	1	0	**867**
140 - ORAL SURGERY	154	49	52	27	72	0	**354**
143 - ORTHODONTICS	10	0	0	0	0	0	**10**
191 - PAIN MANAGEMENT	57	0	0	0	0	0	**57**
300 - GENERAL MEDICINE	40	6	0	0	0	0	**46**
320 - CARDIOLOGY	113	9	1	0	0	0	**123**
330 - DERMATOLOGY	32	0	0	0	0	0	**32**
410 - RHEUMATOLOGY	109	11	7	0	0	0	**127**
420 - PAEDIATRICS	36	0	0	0	0	0	**36**
430 - GERIATRIC MEDICINE	21	0	0	0	0	0	**21**
502 - GYNAECOLOGY	335	4	3	0	0	0	**342**
Grand Total	**3089**	**295**	**206**	**91**	**135**	**1**	**3817**

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NHS Commissioned Service Provider Referral to Treatment (RTT)

	Aug 2021	Patients Waiting						
Welsh Providers	% of Powys residents < 26 weeks for treatment (Target 95%)	0-25 Weeks	26-35 Weeks	36-52 Weeks	53 to 76 Weeks	77 to 104 Weeks	Over 104 Weeks	Total Waiting
Aneurin Bevan Local Health	56.2%	1192	186	231	179	292	41	2121
Betsi Cadwaladr University Local Health Board	42.2%	216	57	42	55	113	29	512
Cardiff & Vale University Local Health Board	52.7%	213	41	42	34	64	10	404
Cwm Taf Morgannwg University Local Health Board	45.5%	216	33	57	47	103	19	475
Hywel Dda Local Health Board	54.9%	767	112	220	106	179	13	1397
Swansea Bay University Local Health Board	46.4%	825	146	237	125	317	127	1777
Totals		3429	575	829	546	1068	239	6686

	Jul 2021	Patients Waiting						
English Providers	% of Powys residents < 26 weeks for treatment (Target 95%)	0-25 Weeks	26-35 Weeks	36-52 Weeks	53 to 76 Weeks	77 to 104 Weeks	Over 104 Weeks	Total Waiting
English Other	76.4%	133	11	11	8	10	1	174
Robert Jones & Agnes Hunt Orthopaedic & District Trust	66.3%	1592	263	277	155	106	7	2400
Shrewsbury & Telford Hospital NHS Trust	71.3%	2328	322	351	120	142	0	3263
*Wye Valley NHS Trust - **data from submission file**	71.3%	2140	290	340	108	112	10	3000
Total		6193	886	979	391	370	18	8837

Conclusion

There are two neighbouring NHS organisations with services in special measures. An update has been provided in relation to Shrewsbury and Telford Hospitals NHS Trust which remains at the highest level of escalation under the PTHB CAF. Maternity services in CTMUHB are in special measures and an Independent Oversight Panel is in place. Further work is underway to provide independent assurance that neonatal services are safe, effective, well led and importantly integrated with the maternity service to provide a seamless service for women and babies.

As reported nationally there is now an unprecedented challenge in relation to timely access to routine services across the NHS as a result of the response to the pandemic. This has been exacerbated this summer by unscheduled care pressures within surrounding DGHs, which exceed the pre-COVID levels.

Addressing this situation is a key focus of the renewal approach in the annual plan for 2021/2022. The renewal priorities focus on the things which will matter

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most to the wellbeing of the population of Powys and those things which will work best to address the critical challenges ahead. The scale of the challenge will not be met by existing approaches and will require new, radical solutions bounded in a value-based healthcare. £2.5million non-recurrent revenue and £550,000 capital have been secured to help take forward Phase 1. However, at present, there are significant risks in relation to recruitment, procured solutions and the pace of recovery due to unscheduled care demand.

NEXT STEPS

In line with the PTHB Commissioning Assurance Framework providers scored as Level 4 or in Special Measures will continue to be reported to the relevant Board Committees.

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Care Quality Commission

Shrewsbury and Telford Hospital NHS Trust

Inspection report

Mytton Oak Road
Shrewsbury
SY3 8XQ
Tel: 01743261000
www.sath.nhs.uk

Date of inspection visit: 6 July, 7 July, 13 July, 14 July, 19 July, 20 July 2021, 17 August, 18 August and 19 August 2021
Date of publication: 18/11/2021

Ratings

Overall trust quality rating	Inadequate
Are services safe?	**Inadequate**
Are services effective?	**Requires Improvement**
Are services caring?	**Requires Improvement**
Are services responsive?	**Inadequate**
Are services well-led?	**Requires Improvement**

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Our findings

Our reports

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

We award the Use of Resources rating based on an assessment carried out by NHS Improvement. Our combined rating for Quality and Use of Resources summarises the performance of the trust taking into account the quality of services as well as the trust's productivity and sustainability. This rating combines our five trust-level quality ratings of safe, effective, caring, responsive and well-led with the Use of Resources rating.

Overall summary

What we found

Overall trust

The Shrewsbury and Telford Hospital NHS Trust is the main provider of district general hospital services for nearly half a million people in Shropshire, Telford & Wrekin and mid Wales. There are two hospital sites:

- The Royal Shrewsbury Hospital; and
- The Princess Royal Hospital

Both hospitals provide a wide range of acute hospital services including accident & emergency, outpatients, diagnostics, inpatient medical care and critical care.

During 2012/13, the Princess Royal Hospital became the main specialist centre for inpatient head and neck surgery with the establishment of a new head and neck ward and enhanced outpatient facilities. It also became the main centre for inpatient women and children's services following the opening of the Shropshire women and children's centre in September 2014.

During 2012/13, the Royal Shrewsbury Hospital became the main specialist centre for acute surgery with a surgical assessment unit, surgical short stay unit and ambulatory care facilities.

McLaughlin, Polly 1126 (1) 2021 12:39:21

Together the hospitals have just over 800 beds and assessment & treatment trolleys. The trust operates, on average, over 5,000 outpatients' clinics per week.

The trust has over 5,800 whole time equivalent members of staff.

Our findings

Alongside the services at the Princess Royal and Royal Shrewsbury, the trust also provides community and outreach services such as:

- Consultant-led outreach clinics
- Midwife-led unit
- Renal dialysis outreach services
- Community services including Midwifery, Audiology and Therapies.

The trust had experienced significant challenges over the past 18 months due to the COVID-19 pandemic. Staff were redeployed from substantive roles to care for the most acutely ill patients and support staff in critical areas. Services had to be redesigned and moved at short notice.

At the time of our inspection, the trust was part of an improvement alliance with an NHS trust based in Birmingham, which had commenced in 2020 and was still in operation. The alliance involved the sharing of resources, staff, expertise and learning to facilitate improvement across the trust.

We carried out this unannounced inspection of Shrewsbury and Telford Hospitals NHS Trust because at our last inspections in 2018 and 2019 we rated the trust overall as inadequate, and the trust was placed in special measures. We inspected to see what improvements had been made.

We carried out an unannounced inspection of the following acute services provided by the trust:

- Urgent and emergency care at both the Royal Shrewsbury Hospital and the Princess Royal Hospital;
- Medical care at both the Royal Shrewsbury Hospital and the Princess Royal Hospital;
- End of life services at both the Royal Shrewsbury Hospital and the Princess Royal Hospital; and
- Maternity services at the Princess Royal Hospital.

We also inspected the well-led key question for the trust overall.

We inspected these services because during previous inspections we had identified concerns and had taken enforcement action to check whether the trust had made improvements to the care and treatment delivered.

We did not inspect all the services previously rated as requires improvement because this inspection was focused only on services where we had concerns. We are monitoring the progress of improvements to services and will re-inspect them as appropriate. Services previously rated as requires improvement and not inspected this time include:

The Royal Shrewsbury Hospital:

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- Surgery;
- Critical Care; and
- Outpatients.

The Princess Royal Hospital:

Our findings

- Surgery;
- Critical Care; and
- Services for children and young people.

Our rating of services stayed the same. We rated them as inadequate because:

- The trust had made improvements since our last inspection but further work was needed to improve the rating.
- We rated safe and responsive as inadequate and caring as requires improvement. Effective and well-led had improved to requires improvement. Well-led is the overall trust-wide rating, not an aggregation of services ratings.
- We rated four out of the seven services inspected as requires improvement and three as inadequate.
- In rating the trust, we took into account the current ratings of the seven services not inspected this time.
- Staff did not always assess and respond to patient risk. Records were not always of good quality, stored safely or easily available to staff to ensure that they could provide safe nursing care
- Vacancies within nursing, medical and allied health professional staffing was still impacting on the safety and quality of patient care.
- Practice in respect of infection prevention and control was varied in performance and the environment across many core services did not promote safe and high-quality care.
- Practice in relation to pain relief for patients varied across core services. The availability of key services was varied with patients not being able to access them seven days a week, especially in respect of the services provided by allied health professionals.
- Staff did not always treat patients with compassion and kindness but it is acknowledged their ability to do so was impacted by other challenges the trust faced.
- Individual needs were not always met. People could not always access the service when they needed it and did not receive the right care promptly.
- Leadership at trust level and across core services had improved but there was further work to do which included but was not limited to management of risk and performance, culture and governance.

However:

- Staff provided emotional support to patients, families and carers to minimise their distress. Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.
- Services had improved safeguarding practices which improved safety for service users.
- Mental health provision for service users had improved.
- Actions were being taken to recruit nursing, medical staff and effective leaders.
- Medicines were generally managed well, with some exceptions in some areas. The safety culture within the trust had improved since our last inspection but learning was not always shared effectively.
- Services generally provided care and treatment based on national guidance and evidence-based practice. Staff monitored the effectiveness of care and treatment. The service made sure staff were competent for their roles. Staff worked together as a team to benefit patients. Key services were available to support patient care. Practice in relation to Mental Capacity Act and Deprivation of Liberty Safeguards had improved across the whole of the trust.

Michelle Nolke 11/26/2021 12:39:24

Our findings

- The board was developing and starting to work well together.

How we carried out the inspection

We carried out this inspection on various days throughout July 2021. We visited areas relevant to each of the core services inspected and spoke with a number of patients and staff, as well as holding focus groups.

During the inspection we visited:

- 12 wards within medical services at the Royal Shrewsbury Hospital;
- 10 wards within medical services at the Princess Royal Hospital;
- All areas of the emergency department within urgent and emergency care services at the Royal Shrewsbury Hospital;
- All areas of the emergency department within urgent and emergency care services at the Princess Royal Hospital;
- Five wards where end of life care services was delivered and the mortuary at the Royal Shrewsbury Hospital;
- Five wards where end of life care services was delivered and the mortuary at the Princess Royal Hospital; and
- All areas within maternity services at the Princess Royal Hospital.

We spoke with 192 staff members of various speciality and profession including, consultants, doctors, radiotherapists, midwives, nurses, healthcare support workers, allied health professionals, pharmacists, patient experience, domestic staff and administrators.

We spoke with 41 patients throughout the departments and reviewed 135 patient records.

You can find further information about how we carry out our inspections on our website: www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Outstanding practice

We found the following outstanding practice:

Midwifery staff showed immense levels of resilience as they were able to continue to provide high levels of care to women and babies and maintained a positive and caring attitude during extremely challenging circumstances. The maternity department was under considerable scrutiny following the publication of the first Ockenden review (independent review of maternity services) and during the COVID-19 pandemic. This was in addition to the maternity service's ongoing challenges with the stability of the senior maternity leadership team which further impacted on staff.

Areas for improvement

Russellan Holt 12/08/2021 10:08:14

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

Our findings

We told the trust that it must take action to bring services into line with 71 legal requirements. This action related to seven services.

Trust wide

- The trust must ensure that all children who present to the emergency department are assessed within 15 minutes of arrival in accordance with the relevant national clinical guidelines. (Regulation 12 (1)(2)(a))
- The trust must ensure it implements an effective system with the aim of ensuring that all adults who present to the emergency department are assessed within 15 minutes of arrival in accordance with the relevant national clinical guidelines. (Regulation 12 (1)(2)(a))
- The trust must ensure there is a system in place which ensures that all children who leave the emergency department without being seen are followed up in a timely way by a competent healthcare professional. (Regulation 12 (1)(2)(a))
- The trust must ensure practice in respect of carrying out accurate clinical risk assessment and care planning improves. This includes ensuring patients' needs are individualised, recorded and acted upon. (Regulation 12 (1)(2)(a))
- The trust must ensure it has an effective system to monitor and improve the quality of care planning records. (Regulation 17 (2)(c))

The Royal Shrewsbury Hospital Urgent and Emergency Care

- The service must ensure that staff comply with nationally recognised infection control standards. (Regulation 12(1)(2)(h))
- The service must ensure patients are risk assessed in a timely way and that risks associated with the delivery of health care is mitigated as far as is reasonably practicable. (Regulation 12(1)(2)(a)(b))
- The service must ensure that all patients are triaged within 15 minutes of arrival to the ED. (Regulation 12 (1)(2)(a))
- The service must ensure the premises are secure to protect patients from the risk of harm and to mitigate the risk of equipment from being tampered with or missed. (Regulation 12(1)(2)(a))
- The service must ensure that equipment that could be used for self-harm or harm to others is stored securely. (Regulation 12 (1)(2)(a))
- The service must ensure there are enough numbers of staff across all professions and grades with the right skills, competency and experience, are always employed and deployed. This includes but is not limited to ensuring there are enough numbers of competent staff to care for infants and children. (Regulation 18(1)(2)(a))
- The service must ensure the (ED) nursing and medical staff consistently complete mandatory training, including safeguarding training in line with trust targets. (Regulation 18 (1)(2)(a))
- The service must ensure patients can access care and treatment in a timely way. (Regulation 12(1)(2)(a)(b))
- The service must ensure there are robust governance processes in place which assist in evaluating and improving the quality of care provided to patients accessing the emergency care pathway. (Regulation 17(1)(2)(a)(b))
- The service must ensure that effective systems are in place to ensure emergency equipment in the ED is checked in line with guidance to ensure it remains in date and available for use. (Regulation 12 (1)(2)(e) and (f): Safe care and treatment.)

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Our findings

- The service must ensure that ED records are stored securely and contain a clear and contemporaneous account of the care and treatment provided. (Regulation 17(1)(2)(c))
- The service must ensure that all patients have a pain assessment at triage, and regularly monitored for pain throughout their time in the ED, and suitable analgesia must be prescribed and provided. (Regulation 12 (1)(2)(a)(b))

The Royal Shrewsbury Hospital Medical Care

- The service must ensure that there are adequate numbers or nursing, medical and therapy staff to provide safe and effective care and treatment. (Regulation 18 (1))
- The service must ensure that policies and procedures which are in place to prevent the spread of infection, are followed by all staff at all times. (Regulation 12 (2)(h))
- The service must ensure that there is effective cleaning of medical wards and that checklists are completed to evidence this. (Regulation 15 (1)(a)(2))
- The service must ensure effective systems are in place to assess and mitigate individual patient safety risks. This includes but is not limited to; venous thromboembolism (VTE), falls, pressure care, and fluid balance monitoring. (Regulation 12 (1)(2)(a)(b))
- The service must ensure that deteriorating patients are identified and escalated in line with trust policy. (Regulation 12 (2)(a))
- The service must ensure that medical patients have their individual needs assessed and that care planning is personalised to meet individual needs. (Regulation 9 (1)(2)(3))
- The service must ensure complete and accurate records are maintained that describe the care and treatment delivered to individual patients. (Regulation 17 (2)(c))
- The service must ensure effective systems are in place to learn from audit, outcome and performance data in order to make improvements to the quality and safety of patient care. (Regulation 17 (1)(2)(a))
- The service must ensure there are adequate risk oversight systems in place to identify, review and mitigate risks within the service. (Regulation 17 (2)(b))
- The service must ensure that all equipment safety checks are completed in line with testing frequencies identified in the trust policy. (Regulation 15 (1)(e))

The Royal Shrewsbury Hospital End of Life Care

- The service must ensure staff are competent in their roles. This includes but is not limited to infection prevention control, mental capacity, deprivation of liberty and Mental Health Act training. (Regulation 12 (1)(2)(c) and (e))
- The service must ensure all risks associated to the health and safety of service users receiving care or treatment are assessed and reviewed regularly. (Regulation 12(1)(a))
- The service must ensure nurse staffing levels meet the minimum standards of the National Institute of Health and Care Excellence. (Regulation 18 (1))
- The service must ensure medical staffing levels meet the minimum standards of the Royal College of Physicians. (Regulation 18 (1))

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Our findings

- The service must ensure staff have access to the information they need to provide person centred care. This includes the maintenance of complete and accurate records that describe patients' individual needs and preferences, including those highlighted as part of care planning and specialist team intervention. (Regulation 9 (1)(a)(b)(c) and (3)(a)(b)).
- The service must ensure all patients receive medicines when they are prescribed and without delay to avoid harm to the patients who use the service. (Regulation 1212(1)(2)(g))
- The service must ensure service users are treated with dignity and respect. (Regulation 10(1))
- The service must ensure staff receive appropriate clinical supervision to ensure they are competent and skilled in order to carry out their role. (Regulation 18(1)(2))
- The trust must ensure it had full oversight of end of life care services, develops a robust programme of audit to monitor outcomes for patients and fully embeds the end of life care team into the governance processes. (Regulation 17(1)(2)(a))
- The service must have an effective system which accurately identifies, triages and tracks end of life and palliative care patients. (Regulation 17(1) (2)(a))
- The service must ensure all risks identified through governance processes are identified, recorded, reviewed and mitigated. (Regulation 17(1)(2))

The Princess Royal Hospital Urgent and Emergency Care

- The service must ensure that staff comply with nationally recognised infection control standards. (Regulation 12(1)(2)(h))
- The service must ensure that all patients are triaged within 15 minutes of arrival to the ED. (Regulation 12 (1)(2)(a))
- The service must ensure patients can access care and treatment in a timely way. (Regulation 12(1)(2)(a)(b))
- The service must ensure records are stored securely and contain a clear and contemporaneous account of the care and treatment provided. (Regulation 17(1)(2)(c))
- The service must ensure refrigerators for the storage of medicines within the department are monitored effectively in order to store medicines safely. (Regulation 12(1)(2)(e)(g))

The Princess Royal Hospital Medical Care

- The service must ensure that ward moves per admission and ward moves at night are recorded so that individual needs are accounted for. (Regulation 9)
- The service must ensure that medical patients at the Princess Royal Hospital have their individual needs assessed and planned for. (Regulation 9)
- The service must ensure that staff have access to the information they need to provide person centred care. This includes the maintenance of complete and accurate records that describe patients' individual needs and preferences, including needs relevant to the formulation of care plans and mental health needs where appropriate. (Regulation 9 (1)(a)(b)(c) and (3)(a)(b))
- The service must ensure that policies and procedures in place to prevent the spread of infection are adhered to in medical services at the Princess Royal Hospital. (Regulation 12(2)(h))

Michelle.Nolan@nhs.net 11/12/2025 12:38:21

Our findings

- The service must ensure environmental risks are appropriately assessed and mitigated. This includes but is not limited to; environmental hazards, ward-based storage, patient equipment and security. (Regulation 12(1)(2)(d))
- The service must ensure effective systems are in place to assess and mitigate individual patient safety risks. This includes, but is not limited to; bed rails, falls, pressure care, repositioning, fluid balance monitoring, diabetic patient needs and pre-existing medical conditions and behaviours that challenge. (Regulation 12(1)(2)(a) and (b))
- The service must ensure that medical patients at risk of developing a pressure ulcer have their needs continually assessed, the appropriate equipment in place and on-going records updated in relation to pressure care. (Regulation 12(1)(2)(a) and (b))
- The service must ensure staff are competent in their roles. This includes but is not limited to the use of; equipment to meet individual needs, care planning and management. (Regulation 12(1)(2)(c) and (e))
- The service must ensure complete and accurate records are maintained that describe the care and treatment delivered to individual patients. (Regulation 17(1)(2)(c))
- The service must ensure effective systems are in place to effectively identify and share learning from incidents to prevent further incidents from occurring. (Regulation 17(1)(2)(b))
- The service must ensure effective systems are in place to consistently assess, monitor and improve patient safety, quality and outcomes of care provided. This includes but is not limited to processes to identify where quality and/or safety are being compromised, quality and safety audits and incident investigation oversight processes including quality improvement oversight. (Regulation 17(1)(2)(a) and (b))
- The service must ensure that effective governance systems and process are in place to assess, monitor and improve all aspects of care delivered. (Regulation 17(1)(2)(a))

The Princess Royal Hospital End of Life Care

- The service must ensure staff are competent in their roles. This includes but is not limited to infection prevention control, mental capacity, deprivation of liberty and Mental Health Act training. (Regulation 12(1)(2)(c) and (e))
- The service must ensure that premises and equipment is maintained to prevent and control the spread of infections that are health care associated. (Regulation 12(1)(2)(e)(h))
- The service must ensure all risks associated to the health and safety of service users receiving care or treatment are assessed and reviewed regularly. (Regulation 12(1)(a))
- The service must ensure nurse staffing levels meet the minimum standards of the National Institute of Health and Care Excellence. (Regulation 18(1))
- The service must ensure medical staffing levels meet the minimum standards of the Royal College of Physicians. (Regulation 18(1))
- The service must ensure staff have access to the information they need to provide person centred care. This includes the maintenance of complete and accurate records that describe patients' individual needs and preferences, including those highlighted as part of care planning and specialist team intervention. (Regulation 9 (1)(a)(b)(c) and (3)(a)(b))
- The service must ensure effective systems are in place to share learning from incidents to prevent further incidents from occurring. (Regulation 17 (1)(2)(b))
- The service must ensure all patients receive medicines when they are prescribed and without delay to avoid harm to the patients who use the service. (Regulation 12(1)(2)(g))

Mr Stephen Holly 17/08/2021 12:08:16

Our findings

- The service must ensure service users are treated with dignity and respect. (Regulation 10(1))
- The service must ensure staff receive appropriate clinical supervision to ensure they are competent and skilled in order to carry out their role. (Regulation 18(1)(2))
- The service must ensure it had full oversight of end of life care services, develops a robust programme of audit to monitor outcomes for patients and fully embeds the end of life care team into the governance processes. (Regulation 17(1)(2)(a))
- The service must have an effective system which accurately identifies, triages and tracks end of life and palliative care patients. (Regulation 17(1)(2)(a))
- The service must ensure all risks identified through governance processes are identified, recorded, reviewed and mitigated. (Regulation 17(1)(2))

The Princess Royal Hospital Maternity Care

- The service must ensure that the emergency buzzer in the Wrekin midwifery led unit is operational to alert all relevant staff to an emergency. (Regulation 12(1)(2)(a)(b))
- The service must ensure staff complete required training for safeguarding children and adults training, PREVENT and Mental Capacity Act 2005 and Deprivation of Liberty Safeguards in line with the trust target. (Regulation 12(1)(2)(c))
- The service must ensure staff are able to access and update women's electronic records in the birthing rooms in the Wrekin midwifery led unit. (Regulation 17(1)(2)(c))

Action the trust SHOULD take to improve:

The Royal Shrewsbury Hospital Urgent and Emergency Care

- The service should ensure that all medicines are stored securely and correctly with restricted access to authorised staff.
- The service should ensure that emergency medicines are always available within the ED.
- The service should ensure the privacy and dignity of patients is protected at all times. The service must ensure that patients within all areas of the ED consistently have their right to privacy respected.
- The service should ensure that all relevant risks within the ED are included and planned for in the service's risk register.
- The service should ensure that patients who require food and drink within the ED have their dietary needs assessed and planned for.
- The service should consider new ways of consistently involving patients in the plans to improve their ED services so they reflect the needs of the local population.
- The service should consider reviewing the contents of their action plans in relation to their RCEM audit results and ensure they are effectively driving improvements and demonstrating good patient outcomes.

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The Royal Shrewsbury Hospital Medical Care

- The trust should ensure that all staff within the medical care service complete the mandatory training assigned to them.

Our findings

- The service should review the consistency of decision making processes for administering medication that controls people behaviour, such as rapid tranquilisers.
- The service should ensure all staff complete the mandatory safeguarding training assigned to them.
- The service should consider if complaints information is widely displayed so that patients know how to complain.
- The service should consider how all patients can have access to consultant review seven days a week.
- The service should consider how it can meet the requirement to provide therapy services over seven days
- The service should consider using the security systems in place, such as medical records trolleys locks and secure ward entry systems, to reduce the risk of unauthorised access to records and ward areas.
- The service should consider using a system for recording the site of application or removal of transdermal medicine patches.
- The service should consider how medicines are stored on AMU to ensure they are organised and tidy.
- The service should consider patients privacy and dignity and ensure this is maintained during all care provision
- The service should review the use of communication support resources, including interpreting services and communication books and consider if they are used appropriately.
- The service should consider if individual patient needs in relation to patients living with dementia are fully met.
- The service should consider if there is an adequate process for all ward staff to consistently receive relevant information, especially on wards where staff meetings are not routinely held.

The Royal Shrewsbury Hospital End of Life Care

- The service should ensure patients are referred for end of life care in accordance with the General Medical Council guidance.
- The service should audit the recording of consent within the service to ensure records are fully completed.
- The service should develop an effective process to monitor patient outcomes for the services users requiring end of life or palliative care.
- The service should ensure all members of the end of life and specialist palliative care team are included within the governance structure and communication systems.
- The service should ensure information is available in accordance with the accessible information standards.
- The service should have a service level agreement in place in place to ensure the continuation of the out of hours service.
- The service should undertake audits of end of life care patients preferred place of care or death.
- The service should undertake audits for pain or symptom control for end of life care patients.

The Princess Royal Hospital Urgent and Emergency Care

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- The service should ensure the nursing and medical staff consistently complete mandatory training, including safeguarding training in line with trust compliance rates.
- The service should ensure the privacy and dignity of patients is protected at all times.

Our findings

- The service should ensure that patients within all areas of the ED consistently have their right to privacy respected.
- The service should ensure that all relevant risks within the ED are included and planned for in the service's risk register.
- The service should consider how to effectively display patient safety information within the ED, including waiting times.
- The service should consider reviewing the clinical policies and pathways that relate to ED care and reference the best practice and national guidance that they are based upon.

The Princess Royal Hospital Medical Care

- The service should ensure timely access to Computerised Tomography (CT) scans for patients with a suspected stroke.
- The service should ensure deteriorating patients are identified and escalated in line with trust policy within medical care at the Princess Royal Hospital.
- The service should ensure key information is shared and documented when handing over care from one ward to another.
- The service should ensure all new and temporary medical staff have timely induction and access to electronic patient record systems.
- The service should ensure the equipment used for providing care or treatment to a service user is safe for such use and safety checks are carried out.
- The service should ensure there is a system in place for recording the site of application or removal of transdermal medicine patches.
- The service should ensure all staff within medical services at the Princess Royal Hospital complete the mandatory safeguarding training assigned to them.
- The service should ensure patients requiring swallow screening and assessment have these completed in a timely manner to ensure people who use services have adequate nutrition and hydration to sustain life and reduce the risks of malnutrition and dehydration while they receive care and treatment.
- The service should ensure all premises and equipment is suitable for the purpose for which they are being used and properly maintained.
- The service should ensure that effective processes are in place to investigate and respond to complaints in line with trust policy.
- The service should ensure nursing and medical staff within medical services at The Princess Royal Hospital complete the mandatory training assigned to them.
- The service should ensure active recruitment into medical and nursing posts within medical services at the Princess Royal Hospital continues.
- The service should ensure all staff have timely access to electronic records to enable them to undertake their role effectively.

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The Princess Royal Hospital End of Life Care

Our findings

- The service should ensure patients are referred for end of life care in accordance with the General Medical Council guidance.
- The service should audit the recording of consent within the service to ensure records are fully completed.
- The service should develop an effective process to monitor patient outcomes for the services users requiring end of life or palliative care.
- The service should ensure all members of the end of life and specialist palliative care team are included within the governance structure and communication systems.
- The service should ensure information is available in accordance with the accessible information standards.
- The service should have a service level agreement in place in place to ensure the continuation of the out of hours service.
- The service should undertake audits of end of life care patients preferred place of care or death.
- The service should undertake audits for pain or symptom control for end of life care patients.

The Princess Royal Hospital Maternity Care

- The service should ensure there are enough midwifery staff to meet minimum safe staffing levels, allow staff to be released to conduct mandatory training and ensure staff can take their breaks.
- The service should ensure that skills drills are conducted in all parts of the maternity unit including at night.
- The trust should ensure all women have one-to-one care.
- The service should ensure they audit data to evidence they are complying with recommended sepsis pathway timelines, such as women receiving antibiotics within 60 minutes.
- The service should ensure the service has a comprehensive programme of repeated audits to check improvement over time.
- The service should ensure all nursing and midwifery staff rotate to different areas of the maternity unit to ensure they maintain up-to-date skills.
- The service should ensure investigations into staff performance are investigated in a timely way.
- The service should ensure maternity safety champions meet regularly with the trust level safety leads to escalate locally identified issues.
- The service should ensure the new midwifery leadership structure is implemented in a timely way.
- The service should ensure the date risks are added to the risk register are recorded to enable service leaders to monitor whether risks are mitigated in a timely way.
- The service should consider incident reporting when actual staffing levels fell below planned levels to evidence the regularity and impact of the reduced staffing levels.
- The service should consider including baby abduction drills in maternity specific training to ensure all staff know what to do in emergency situations.
- The service should consider either soundproofing the bereavement suite or re-locating it away from the delivery suite.

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Our findings

- The service should consider using the maternity dashboard to monitor workforce performance indicators such as sickness, mandatory training compliance and skills and drills to improve compliance and identify areas for improvement.
- The service should consider continuing to improve their engagement with the clinical staff.
- The service should consider clearly displaying safety information in clinical areas for staff and visitors.

Is this organisation well-led?

Our rating of well-led improved. We rated it as requires improvement because:

- Within the leadership team, there were gaps in experience and a potential risk of instability.
- Staff had mixed views regarding the visibility and how approachable trust leaders were.
- The trust had a vision for what it wanted to achieve but did not yet have an overarching trust wide strategy to turn it into action.
- Staff feelings regarding feeling respected, supported and valued were mixed but there had been significant improvement since the last inspection.
- The trust was at the start of its equality and diversity agenda work.
- Governance processes required further development to assure they were aligned with strategic, operational and clinical risk.
- A review of and improvement of the board assurance framework and risk registers was required.
- The trust did not always collect reliable data and analyse it effectively. Data was not always in easily accessible formats due to the multiple systems used. Staff could not always find the data they needed to understand performance, make decisions and improvements.
- There were areas identified for improvement at our last inspection which were still of concern. Understanding of good quality improvement methods was mixed and staff did not always have the capacity to be effective in implementing improvement initiatives. There was limited evidence that innovation was encouraged.

However:

- The trust leadership team had a comprehensive knowledge of current priorities and challenges and took action to address them.
- The trust had a vision for what it wanted to achieve and the vision was focused on sustainability of services and referred to working with providers within the wider health economy to improve patient pathways.
- Staff were focused on the needs of patients receiving care and the trust promoted an open culture where patients, their families and staff could raise concerns without fear.
- Leaders were generally clear about their roles and accountabilities but there was some overlap which meant roles and responsibilities could be unclear. They had regular opportunities to meet, discuss and learn from the performance of the service.
- Leaders and teams used systems to manage performance.
- Most relevant risks and issues were identified and escalated and actions to reduce their impact were implemented.

Pickman-Hey 11/26/2021 11:38:01

Our findings

- Data or notifications were consistently submitted to external organisations as required.
- Leaders and staff were engaging with patients, staff, equality groups, the public and local organisations to plan and manage services but feedback needed to be collated and used to formulate the trust's strategy and improvement plans. They collaborated with partner organisations to help improve services for patients.
- Generally, all staff were committed to continually learning and improving services.
- Work was being carried out to improve patient outcomes.

Leadership

Leaders had the skills and abilities to run the trust but there were gaps in experience and capacity. They understood the priorities and issues the trust faced. Staff had mixed views regarding the visibility and how approachable trust leaders were. They supported staff to develop their skills and take on more senior roles.

The trust board was currently still developing as a leadership team. As a leadership team, they mostly held the appropriate range of skills, knowledge and experience to perform its role. There had been many changes to the board since our last inspection but with the new additions, it was developing and starting to work well together.

The leadership team, including the non-executive directors, understood the priorities and issues they faced. It was acknowledged by the board the trust was on an improvement journey and further work was required to ensure quality and safety were assured.

Some roles within the board had been appointed to on an interim basis which was a potential risk to stability within the leadership team. However, we were told, although we did not see, there was a strategy for addressing this with plans to appoint to permanent positions.

Within the leadership team, there were gaps in experience, due to the number of interim appointments of first time executive posts, but this had been identified and was being mitigated using seconded experienced leader support from a local NHS trust. It was also being addressed through the implementation of board development plans, focusing on unitary board concepts and development of strategy planning.

There were gaps in leadership below those at director level. There were posts at deputy director level which had not yet been recruited to which meant aspects of the large and complex portfolios, held by directors, could not be delegated. However, recruitment was beginning to take place, specifically at deputy director of medicine level.

The trust had a lead for child and adolescent mental health, learning disability and autism. This role was held by the interim director of nursing, who was supported in this role by their deputy director of nursing and specialist nursing leads for both adult and children's mental health.

Fit and Proper Person checks were in place, were appropriate and in line with the regulations.

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Executive and non-executive directors were also required to complete an annual self-declaration, to confirm they did not fall into the definition of an "unfit person" or any other criteria set out in the guidance. We reviewed evidence to confirm this was completed.

The trust leadership team had comprehensive knowledge of current priorities and challenges and took action to address them. It was recognised by the trust that leadership at divisional level needed to be clinically led. The decision was taken

Our findings

to ensure each directorate had a triumvirate of a divisional clinical director, head of nursing and head of operations. The changes had been made not only to improve the voice of the clinicians but also cohesiveness, effectiveness and accountability. The success of the restructure was not yet known as it had only recently been implemented. Some divisional leadership triumvirates had developed faster than others.

Leadership development opportunities were available, but at the time of our inspection the focus was on staff at band 8b or above. The programme was focused on developing their self, team and organisation for the ultimate benefit of patient care and experience. It included content to support senior leaders to develop as leaders, change agents and managers throughout and after the programme.

The executive board were working to gain the trust of divisional and local leaders as there had been frequent changes in key roles. This work was acknowledged by staff working within divisions and throughout the trust, including at non-executive director level. Executive directors, specifically the director of nursing and the co-medical directors, visited wards before board meetings to improve visibility but also to gain an understanding of the issues in areas they visited. However, we carried out a staff survey from 6 July 2021 to 22 July 2021 which focused on culture and leadership. There were 837 completed responses, and 470 incomplete responses. Only 30% of staff said that they had confidence in the executive team.

Vision and Strategy

The trust had a vision for what it wanted to achieve but did not yet have an overarching trust wide strategy to turn it into action. The vision was focused on sustainability of services and referred to working with providers within the wider health economy to improve patient pathways.

The trust had a clear vision and set of values with quality and sustainability as the top priorities. The vision of the trust was to provide excellent care for the communities they served. The values were partnering, ambitious, caring and trusted. The leadership team were invested in the values and staff knew what they were. They had been developed following engagement with staff.

There were multiple workstreams addressing the trust strategy, but they had not yet been brought together, as the overall trust strategy was still being developed. It was anticipated that a refreshed strategy would be completed before the end of December 2021. The trust did not have a specific strategy document which encompassed all of work they were doing to achieve their vision, however, they did have a methodology and framework for "getting to good". This was being used to review the trust's areas for development across all their divisions, the actions they were taking to address them and to monitor their progress over time.

Steps had been taken to engage with divisional teams and staff to begin the process of formalising a trust wide strategy. Within divisions, strategies were being developed which were in line with the trust's priorities, but further work was still required at trust level to ensure all strategies were aligned to what the trust wanted to achieve. A workshop with clinical support services had taken place before our inspection and workshops with divisions were going to take place through September 2021.

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Local providers and people who use services had been involved in developing the strategy. The trust was working with their local integrated care system (ICS) to ensure both strategies were aligned. The trust was also working with other local NHS trusts, outside of their ICS, to develop pathways and services to improve patient care for those within and outside of their community. For example, work was being done with others to improve critical care, interventional radiology and pathology services.

Our findings

Further development, to gain full assurance of the quality of care improvement, was required. The importance of improvement in patient care and treatment was being expressed but further work was needed to ensure that it results in improvement in care and delivery.

Not all staff felt confident any changes to the organisation would be implemented effectively. We carried out a staff survey from 6 July 2021 to 22 July 2021 which focused on culture and leadership. There were 837 completed responses, and 470 incomplete responses. Only 26.8% of staff agreed that "This organisation introduces and implements organisational change well".

Culture

Staff feelings in regard to feeling respected, supported and valued were mixed but there had been significant improvement since the last inspection. Staff were focused on the needs of patients receiving care. The trust was at the start of its equality and diversity agenda work but promoted an open culture where patients, their families and staff could raise concerns without fear.

Improvements had been made in the number of staff who felt respected, supported and valued. Across core services, there was a mixed perspective amongst staff, with some positive in how leadership made them feel, but others felt less valued and respected.

The trust's vision and values underpinned a culture which was patient centred. Everyone at both executive level and divisional level expressed compassion for the wellbeing of staff. Most leaders spoke about the need to be inclusive but it was recognised further work was needed to ensure they were meeting the needs of all of their staff.

In general, staff felt positive and proud about working for the trust and their team.

Leaders and staff at all levels were concerned about and recognised, following the pandemic, the wellbeing of the workforce and continued support was required to support recovery of exhaustion. This included ensuring psychological support was available to all staff.

The trust recognised staff success by staff awards and through feedback.

There had been improvements in how the trust engaged and worked with trade unions. Trust policies were also becoming more transparent and were being reviewed when concerns or issues were raised to ensure they were clearer to follow and promote consistency of practice.

Managers addressed poor staff performance where needed. Action was taken when performance or behaviours were not in line with expectations. However, there were concerns grievance processes were not always effective. This had been raised at appropriate forums and reviews of policies had been carried out as a result.

McLellan, Hayley
11/28/2021 12:13:38 PM

The trust had appointed a Freedom To Speak Up (FTSU) Guardian and staff were supported to raise concerns. Processes had been reviewed to enable the Guardian to report to the board on a quarterly basis. In between reporting, the guardian had monthly meetings with the heads of nursing and the non-executive director lead. They also worked with human resources and employee relations to work collaboratively to find solutions to some of the concerns raised.

Staff felt able to raise concerns without fear of retribution. Staff raised concerns or issues with their managers and would also report through the FTSU process.

Our findings

Staff knew how to use the whistle-blowing process and about the role of the Speak Up Guardian. Reporting to the FTSU Guardian had increased since our last inspection with 302 contacts in 2020/21 being reported, and 100 contacts in quarter one of 2021/22. There were areas which needed to be improved, which included but was not limited to addressing themes and trends and creating action plans to address. For example; triangulating allegations of bullying and harassment to ensure what was raised by staff was being addressed effectively. Also, there was no equality data monitoring which meant there was a lost opportunity to use this data to monitor themes in those raising concerns.

The trust applied Duty of Candour appropriately. We reviewed seven serious incident reports and found the trust had followed the appropriate Duty of Candour processes. There was an up to date policy and most staff were aware of and could apply Duty of Candour principles.

At the time of our inspection, not all staff had the opportunity to discuss their learning and career development needs at appraisal. However, the trust had performed well in light of the Covid-19 pandemic as 85% of staff had an appraisal against a national target of 90%.

Rates in respect of sickness, turnover and temporary staff usage were higher than the national average. The trust had undertaken a programme to recruit oversea nurses and were on track to fill vacancies.

Not all staff felt equality and diversity were promoted in their day to day work and when looking at opportunities for career progression. According to the trust's Workforce Race Equality Standard (WRES) annual report from 2020, there had been some overall improvements but their performance was worse than the England average in a number of metrics, across Black, Asian and Minority Ethnic (BAME) staff. For example, in respect of staff experiencing harassment, bullying or abuse (35% against the England average of 29%); equal opportunities for career or promotion (71% against the England average of 74%); experiences of discrimination from a manager/colleagues (16% against an England average of 14%). However, the trust had identified actions to address areas of poor performance which had resulted in improvements over time in most metrics.

The trust was involved in a piece of work with a local university to look at rural racism following reports of racism experienced by a small number of overseas nurses.

The equality, diversity and inclusion (EDI) programme of work within the trust was at its early stages and required further development to ensure it led to improvements in both staff and patient experience. Resources were limited but an EDI manager, band seven, was in post. Work around the EDI agenda within the trust was not embedded and was in its infancy. There was limited focus on EDI in relation to patients and service users.

The trust had recognised the importance of EDI but the pace of delivery to improve it within the organisation was slow. A piece of work had been commissioned at board level which identified three key priorities, which were to consider the leadership on the inclusion agenda, focus on EDI at board level and support for the EDI lead. However, no action plan had been developed to address this.

There were limited staff networks which promoted the diversity of staff. Within the trust there was a race, disability and pride network but these had only been recently set up. The networks only encompassed some but not all staff diversity and membership within the networks was low and varied in terms of stability.

McLaughlin, Emily
11/06/2021 12:38:21

Our findings

We carried out a staff survey from 6 July 2021 to 22 July 2021 which focused on culture and leadership. There were 837 completed responses, and 470 incomplete responses. Only 34% of staff agreed that "The organisation values staff and provides them with effective support to do their jobs to the best of their ability". Reponses for all other questions in the survey were less positive however noting these respondents were a small number of the total staff employed, whilst respecting and acknowledging their responses we were unable to come to any significant conclusions.

Governance

Governance processes required further development to assure they were aligned with strategic risk. Leaders were generally clear about their roles and accountabilities but there was some overlap which was not entirely clear. They had regular opportunities to meet, discuss and learn from the performance of the service.

The trust had structures, systems and processes to support the delivery of its strategic aims which included sub-board committees, divisional committees, team meetings and senior managers. However, the governance processes in operation throughout the trust were not standardised and therefore had varying levels of effectiveness. It was acknowledged some processes at each level of governance required further development to provide assurance to leaders at both local and board level they were aligned with strategic and clinical risk. There was a committee structure but as it was in the process of being reviewed, so it was not fully operational.

The committee structure had been streamlined and improvements to the effectiveness of the committee meetings had been made. However, there was a potential risk some issues and risks did not have the appropriate attention, time and scrutiny dedicated to it. For example; the trust did not have a dedicated workforce board sub-committee. Workforce related issues were fed into the finance and performance committee. This was a potential risk due to the fact many of the trust's challenges were workforce related and did not have the same level of scrutiny from trust leadership. An operational workforce group had been established which fed into the finance and performance committee. It was focused on workforce and safety but did not have the same status as a dedicated workforce committee and did not have a non-executive director chair.

Papers for board meetings and other committees had improved with most containing appropriate information. However, improvement was required to ensure reliable assurance was present within minutes and reports through each stage of the governance process. There were concerns information within reports was not always triangulated.

Non-executive and executive directors were clear about their areas of responsibility but it was recognised further development was required. For example, development sessions were being carried out to look at the executive directors' and non-executive directors' role in reviewing and challenging the board assurance framework.

Governance arrangements in relation to Mental Health Act administration and compliance were in place but further work was required to ensure its importance across the trust was embedded. The practice, performance and focus on compliance with the Mental Health Act had improved but further improvements were not aided by the fact the trust did not have a non-executive lead for mental health or that they did not have a dedicated mental health and learning disability operational group. It was hoped by the leads within the trust one could be created to help force through the work that needed to be done. However, mental health was included as an agenda item within governance processes. For example, it was discussed at heads of nursing meetings.

Helen Kelly 11/08/2022 12:38:21

There was a framework which set out the structure of ward/service team, division and senior trust meetings but as governance structures across the organisation were not standardised, the flow of information was not as effective as it could be.

Our findings

Managers used meetings to share essential information such as learning from incidents and complaints and to take action as needed. However, further development needed to take place to ensure action plans were reviewed and progressed.

Staff at all levels of the organisation understood their roles and responsibilities and what to escalate to a more senior person.

Business cases were reviewed by the finance and performance committee.

At the time of our inspection, we were told that there were some board committees which took place after board papers should be produced. As a result, the trust was going to rearrange when board meetings take place to ensure there was enough time to complete the required work between committee and board meetings.

The trust faces significant challenges. The recently appointed finance leadership team were implementing remedial financial governance processes and systems at pace. The design and implementation of these systems and processes was encouraging, and to be encouraged.

There was early evidence of an improvement trajectory through the stabilisation of run-rate expenditure, the strengthening of the financial leadership team, full and transparent engagement in recovery activities, a clearer organisational shared understanding of the casual effects of underlying deficits, greater clarity regarding the improvement activities that are necessary to remedy the financial challenges, and improving relationships and confidence in the trust from regulatory and system partners.

The recency of these actions was such that further improvement was required to demonstrate a sustainable and consistent improvement trajectory.

The trust was credibly forecasting achievement of the agreed financial outturn for Half 1 (H1) of 2021/22, which will be the first time in 4 years that the trust has delivered against the requirements.

There had been a significant improvement in engagement and transparency with system partners and Regulatory bodies. The trajectory to improvement remains in its infancy and the evidence of sustained and embedded improvement will only be persuasive if the trust continues to deliver against these commitments in 2021/22.

The finance leads demonstrated a clear understanding of the drivers of the deficits of the organisation and have strengthened and improved the systems of control and oversight necessary to assess progress and delivery.

The trust has high levels of agency spending. The recruitment to substantive posts was significantly dependent upon overseas recruitment. The increased investment in substantive posts was based upon a reduction in temporary and premium pay locum costs. The trust's history of delivery of productivity and efficiency savings was not strong. The trust hospital transformation plan required detailed and challenging workforce transformation plans. These risks were recognised as critical to the delivery of trust strategic objectives. The oversight and scrutiny of these workforce and transformation plans was an essential source of assurance to the organisation.

Mrs Julia Hay 11/08/2021 12:38:21

Management of risk, issues and performance

Our findings

Leaders and teams used systems to manage performance. A review of and improvement of the board assurance framework and risk registers was required, but this was recognised by leaders. Most relevant risks and issues were identified and escalated and actions to reduce their impact were implemented. They had plans to cope with unexpected events but they were not always effective.

The trust had systems to identify learning from incidents and safeguarding alerts and make improvements but not all learning was identified. We reviewed six serious incident reports and generally, most learning had been recorded but within two investigation reports, additional lessons and actions should have been identified.

It was not always clear learning had been identified during the investigation of complaints. Within three of the five complaint responses we reviewed, the learning sections were blank. Another response had only been partially completed. In each response actions had been identified in each of the responses.

Dissemination of learning from incidents was not always effective. As part of our inspection, we carried out a staff survey which covered many aspects in respect of working for the trust. One question specifically related to the sharing of information in relation to incidents. According to the results only 59% of staff said that they heard about incidents in their part of the organisation and the learning from them and only 38 % had said they heard about incidents and the associated learning from other parts of the organisation. We also saw that even when learning had been identified, it was not always embedded.

Senior management committees and the board reviewed performance reports. The trust had a finance and performance committee which had sight of an integrated performance report. Members of the committee reviewed data to assess the trust's performance. However, the performance metrics were predominantly nursing focussed and there were areas of performance and quality which were missing. Leaders regularly reviewed performance but improvements were not always made, despite actions being taken.

Processes in relation to identifying, recording and mitigating risk required improvement. However, staff had access to the risk register either at a team or division level and were able to effectively escalate concerns as needed.

The trust was aware their board assurance framework (BAF) and corporate risk register needed to be reviewed and improved. The BAF was focused predominantly on operational risks and did not contain any strategic risks. The trust did not have a specific corporate risk register but used a refined trust wide risk register, which contained over 100 risks. This did not allow for detailed conversation around the highest and most concerning risks within the trust.

Each risk on the trust wide risk register recorded the risk, causes and effect, risk score, risk controls, actions required, responsible person and when actions needed to be implemented by. However, not all risks had been updated with progress notes. We were told risks for review by the trust board should be scored 15 or above, however, this did not always appear to be the case. It was therefore unclear, which risks would need to be escalated to the trust board.

Risk registers were in operation at each core service level but there was variation in how they were reviewed, their content and in their effectiveness. For example; evidence was limited on when risks had been reviewed and some registers did not contain all identified risks. We were told, but were not provided with any evidence, that a review process had been discussed and plans had been implemented to start work on reviewing and improving these processes. In addition, training around these processes was being provided to the trust board to build further understanding.

Kirkpatrick, Kelly 01/06/2021 12:39:21

Our findings

The trust had recognised assurance was needed to ensure divisions know and have plans to address performance issues. The trust and divisions have developed an integrated performance report (IPR) which used data across different metrics to demonstrate how each specific division was performing. Each IPR was reviewed periodically to review and challenge performance. Actions were then taken to address areas of improvement. Areas of concern were escalated, especially if there were repeated issues in the management of performance. However, performance monitoring of the end of life care services was limited, there were no systems to monitor quality or key performance indicators.

The quality of the data used to monitor performance was not always acceptable. We were told and could see data relating to performance did not always make sense and they was an acknowledgement that there was not absolute confidence in it. Despite this the trust were taking steps to make improvements. This could be seen through the trust's maternity improvement plan. The trust maintained oversight of the plan using data and could identify improvements over time but also address any dips in performance and implement effective actions.

Performance in respect of responding to complaints required improvement. At the time of our inspection, the trust had a backlog of 100 complaints. The trust had started a mapping process to identify barriers to responding to complaints in a timely way. However, the trust did not have a clear trajectory of when they would be able to clear the backlog.

Information Management

The trust did not always collect reliable data and analysed it effectively. Data was not always in easily accessible formats due to the multiple systems used. Staff could not always find the data they needed to understand performance, make decisions and improvements. The information systems were not integrated but they appeared to be secure. Data or notifications were consistently submitted to external organisations as required.

The board received information on service quality and sustainability. As mentioned above, the board received an integrated performance report for each division within the trust. However, it was acknowledged the data set contained in the reports needed to be reviewed to ensure the board were sighted on all the necessary information as some metrics were omitted. For example, not all the necessary national indicators were included in the integrated performance report dashboard reviewed at board level. For example; it did not include the metric in relation to sepsis, however, it was included at board committee level. There were some concerns over the level of assurance the reports provided. Some were not assured they had access to all necessary information but everyone felt they could challenge its reliability.

Leaders used meeting agendas to address quality and sustainability sufficiently at all levels across the trust.

The trust was aware of most of its services' performance through the use of key performance indicators (KPIs) and other metrics through the use of divisional and trust wide integrated performance reports, with the exception of specialist palliative and end of life care services.

Team managers had access to a range of information to support them with their management role. This included information on the performance of the service, staffing and patient care. However, locum doctors did not have access to trust communication platforms which meant access to important safety updates was limited. and were often missed out of meetings where information was shared. This was not on the service risk register.

Duplicate Entry 11/08/2021 12:38:21

Not all board and senior staff expressed confidence in the quality of the data but challenge was welcomed.

Our findings

Information was not always in an accessible format, timely, accurate and identified areas for improvement. Trust guidelines and policies were not always stored in the most accessible way and there were issues with version control. Work was also being carried out to review current policies to ensure they were compliant. The trust used both paper and electronic records across divisions and throughout the trust. This made access to information more difficult. The trust did have plans to implement more electronic recording systems across the trust.

Systems were in place to collect data from wards/service teams.

Staff did not always have access to the IT equipment and systems needed to do their work. For example, within the Wrekin midwifery led unit.

Leaders submitted notifications to external bodies as required.

There were information governance systems but they did not always protect the confidentiality of patient records. Poor practice was identified across multiple core services in relations to the security and confidentiality of patient records.

Engagement

Leaders and staff engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The trust was beginning to develop a structured and systematic approach to engaging with people who use services, those close to them and their representatives. The trust had a director of public participation who was working with stakeholders and community groups to engage and draw the thoughts, ideas and feedback into the trust to help shape and improve services.

Communication systems such as the intranet and newsletters were in place to ensure staff, patients and carers had access to up to date information about the work of the trust and the services they used.

Patients, carers and staff had opportunities to give feedback on the service they received in a manner that reflected their individual needs.

The trust did engage with people and staff in some equality groups. However, more work was required to ensure all staff had a voice.

The trust had a structured and systematic approach to staff engagement. For example, the trust held staff engagement sessions on the improvement alliance with a local NHS trust, to explain the nature of the alliance and its impact. The trust had also introduced a monthly cascade briefing as part of a formal cascade mechanism.

Staff were involved in decision making about changes to the trust services. Staff had been able to engage in process to gather feedback and ideas on service developments.

Mzelvar, Holly 21/07/2021 12:58:32

Patients, staff and carers were able to meet with members of the trust's leadership team and governors to give feedback. For example, at quarterly board meetings time was given to hear from patients/families to share their stories in relation to their experiences while using services provided by the trust.

Our findings

Division leaders/middle managers, on behalf of front-line staff, did not engage with external stakeholders such as commissioners and Healthwatch. The engagement with Healthwatch, when it did take place, was at executive leadership level.

The trust was actively engaged in collaborative work with external partners, such as involvement with sustainability and transformation plans. The trust was working with their local integrated care system (ICS). They were also actively engaged with healthcare providers outside of their ICS to improve care pathways and services to ensure effective and sustainable care for those in their communities.

External stakeholders said they received open and transparent feedback on performance from the trust. However, some felt their importance was not rated as highly as other stakeholders.

The trust had engaged with external stakeholders and system partners to start making improvements to services. For example; improvement work within children and young people's services was being carried out, in partnership with system partners, to address safety issues and better meet the needs of those who used the service.

Learning, continuous improvement and innovation

Generally, all staff were committed to continually learning and improving services, however, there were areas identified for improvement at our last inspection which were still of concern. Understanding of good quality improvement methods was mixed and staff did not always have the capacity to be effective in implementing improvement initiatives. There was limited evidence that innovation was encouraged but there was some participation in research. Work was being done to improve patient outcomes.

There was limited evidence the trust was actively seeking participation in national improvement and innovation projects. The trust expressed a desire to improve the care and treatment provided within their organisation but we were not provided with evidence demonstrating participation in national projects. The trust was working with two trusts to share learning to improve services, specifically in maternity.

Staff were encouraged to make suggestions for improvement and gave examples of ideas which had been implemented. For example; during the COVID-19 pandemic, the end of life team had introduced a number of measures such as memory stones for each patient who lost their life, kindness hearts, one for a patient and another for their loved one, and bereavement support sessions for staff. Evidence showed that these had been much valued by families, patients, friends and staff.

There were organisational systems to support improvement work. For example; there was a planned programme of work, known as "Getting to Good", which was monitored and reported on weekly. There was a structured two-year plan which included a committee, chaired by the Chief Executive Officer, who maintained oversight of progress.

Systems were in place to identify and learn from unanticipated deaths, however resources dedicated to this were limited which impacted on the ability to improve the system. The trust had an up to date policy which set out the process to follow. We reviewed three learning from deaths records and found that all appropriate steps had been taken to ensure all learning could be identified. Families were encouraged to be involved with the process and there was appropriate partnership working internally and with external partners. The team dedicated to facilitating the learning from deaths initiatives was composed of a mortality lead and a medical examiner, but only the mortality lead was in a full time post. There was support from a medical examiner manager and a medical examiner service manager.

Mr Edward Kelly 11/10/2021 12:38:21

Our findings

We reviewed five complaints and one did not meet the trust's response target but updates were provided to the complainant. One complaint had been reviewed by the Parliamentary and Health Service Ombudsman who had identified the trust's original response was not adequate.

Staff did not always have time and support to consider opportunities for improvements and innovation. However, there was areas of improvements throughout the trust. For example, process and practice regarding mental capacity assessments, best interest decisions and applications for deprivation of liberty safeguards had improved across the trust.

External organisations had recognised the trust's improvement work. Individual staff and teams received awards for improvements made and shared learning. For example; members of the end of life care team had been awarded the Dundas medal for their work 'taste for pleasure' work using a patient's favourite flavours when providing mouth care towards the end of life. The team had produced information leaflets for staff and patients and their families and friends to underpin this.

Data was being used to drive improvement. However, as stated above under "Management of risk, issues and performance" and "information management", data sets and streams were being reviewed and improved to ensure it could be used more effectively.

There were processes to identify learning but further development was required to ensure it was embedded and consistently used to drive improvement and outcomes for patients.

McLellan, Holly
11/26/2021 12:38:21

Key to tables					
Ratings	**Not rated**	**Inadequate**	**Requires improvement**	**Good**	**Outstanding**
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	➔🡐	🡅	🡅🡅	🡇	🡇🡇
Month Year = Date last rating published					

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Inadequate ➔🡐 Nov 2021	Requires Improvement 🡅 Nov 2021	Requires Improvement ➔🡐 Nov 2021	Inadequate ➔🡐 Nov 2021	Requires Improvement 🡅 Nov 2021	Inadequate ➔🡐 Nov 2021

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

McLellan, Holly
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Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Royal Shrewsbury Hospital	Inadequate ➔🡐 Nov 2021	Requires Improvement 🡅 Nov 2021	Requires Improvement ➔🡐 Nov 2021	Inadequate ➔🡐 Nov 2021	Requires Improvement 🡅 Nov 2021	Inadequate ➔🡐 Nov 2021
The Princess Royal Hospital	Inadequate ➔🡐 Nov 2021	Inadequate ➔🡐 Nov 2021	Requires Improvement ➔🡐 Nov 2021	Inadequate ➔🡐 Nov 2021	Inadequate ➔🡐 Nov 2021	Inadequate ➔🡐 Nov 2021
Bridgnorth Community Hospital	Good Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017
Oswestry Maternity Unit	Good Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017
Ludlow Community Hospital	Requires improvement Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017	Requires improvement Aug 2017	Requires improvement Aug 2017
Overall trust	Inadequate ➔🡐 Nov 2021	Requires Improvement 🡅 Nov 2021	Requires Improvement ➔🡐 Nov 2021	Inadequate ➔🡐 Nov 2021	Requires Improvement 🡅 Nov 2021	Inadequate ➔🡐 Nov 2021

Ratings for the trust are from combining ratings for hospitals. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

McLellan, Holly
11/26/2021 12:38:21

Rating for Royal Shrewsbury Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Inadequate ➔🡐 Nov 2021	Requires Improvement ↑ Nov 2021	Requires Improvement ➔🡐 Nov 2021	Requires Improvement ↑ Nov 2021	Requires Improvement ↑ Nov 2021	Requires Improvement ↑ Nov 2021
Services for children & young people	Good Jan 2015	Good Jan 2015	Good Jan 2015	Good Jan 2015	Good Jan 2015	Good Jan 2015
Critical care	Requires improvement Nov 2018	Requires improvement Nov 2018	Good Nov 2018	Requires improvement Nov 2018	Requires improvement Nov 2018	Requires improvement Nov 2018
End of life care	Inadequate ➔🡐 Nov 2021	Inadequate ➔🡐 Nov 2021	Requires Improvement ↓ Nov 2021	Inadequate ↓ Nov 2021	Inadequate ➔🡐 Nov 2021	Inadequate ➔🡐 Nov 2021
Surgery	Requires improvement Apr 2020	Requires improvement Apr 2020	Requires improvement Apr 2020	Requires improvement Apr 2020	Requires improvement Apr 2020	Requires improvement Apr 2020
Urgent and emergency services	Inadequate ➔🡐 Nov 2021	Requires Improvement ↑ Nov 2021	Requires Improvement ↑ Nov 2021	Inadequate ➔🡐 Nov 2021	Requires Improvement ↑ Nov 2021	Inadequate ➔🡐 Nov 2021
Maternity	Inadequate Nov 2018	Requires improvement Nov 2018	Good Nov 2018	Requires improvement Nov 2018	Requires improvement Nov 2018	Requires improvement Nov 2018
Outpatients	Requires improvement Apr 2020	Not rated	Good Apr 2020	Requires improvement Apr 2020	Good Apr 2020	Requires improvement Apr 2020
Overall	Inadequate ➔🡐 Nov 2021	Requires Improvement ↑ Nov 2021	Requires Improvement ➔🡐 Nov 2021	Inadequate ➔🡐 Nov 2021	Requires Improvement ↑ Nov 2021	Inadequate ➔🡐 Nov 2021

McLellan,Holly
11/26/2021 12:38:21

Rating for The Princess Royal Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Requires Improvement ↑ Nov 2021	Requires Improvement ↑ Nov 2021	Good ↑ Nov 2021	Requires Improvement ↑ Nov 2021	Requires Improvement ↑ Nov 2021	Requires Improvement ↑ Nov 2021
Services for children & young people	Inadequate Apr 2021	Inadequate Apr 2021	Requires improvement Apr 2020	Inadequate Apr 2021	Inadequate Apr 2021	Inadequate Apr 2021
Critical care	Requires improvement Nov 2018	Requires improvement Nov 2018	Good Nov 2018	Requires improvement Nov 2018	Requires improvement Nov 2018	Requires improvement Nov 2018
End of life care	Inadequate →← Nov 2021	Inadequate →← Nov 2021	Requires Improvement →← Nov 2021	Inadequate ↓ Nov 2021	Inadequate →← Nov 2021	Inadequate →← Nov 2021
Surgery	Requires improvement Apr 2020	Requires improvement Apr 2020	Good Apr 2020	Requires improvement Apr 2020	Requires improvement Apr 2020	Requires improvement Apr 2020
Urgent and emergency services	Requires Improvement ↑ Nov 2021	Good ↑↑ Nov 2021	Good ↑ Nov 2021	Requires Improvement ↑ Nov 2021	Requires Improvement ↑ Nov 2021	Requires Improvement ↑ Nov 2021
Maternity	Requires Improvement →← Nov 2021	Good →← Nov 2021	Good →← Nov 2021	Good →← Nov 2021	Requires Improvement →← Nov 2021	Requires Improvement →← Nov 2021
Outpatients	Good Apr 2020	Not rated	Good Apr 2020	Good Apr 2020	Good Apr 2020	Good Apr 2020
Overall	Inadequate →← Nov 2021	Inadequate →← Nov 2021	Requires Improvement →← Nov 2021	Inadequate →← Nov 2021	Inadequate →← Nov 2021	Inadequate →← Nov 2021

Rating for Bridgnorth Community Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Maternity and gynaecology	Good Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017
Overall	Good Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017

McLellan,Holly
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Rating for Oswestry Maternity Unit

	Safe	Effective	Caring	Responsive	Well-led	Overall
Maternity and gynaecology	Good Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017
Overall	Good Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017

Rating for Ludlow Community Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Maternity and gynaecology	Requires improvement Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017	Requires improvement Aug 2017	Requires improvement Aug 2017
Overall	Requires improvement Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017	Requires improvement Aug 2017	Requires improvement Aug 2017

McLellan,Holly
11/26/2021 12:38:21

Care Quality Commission

Royal Shrewsbury Hospital

Mytton Oak Road
Shrewsbury
SY3 8XQ
Tel: 01743261000
www.sath.nhs.uk

Description of this hospital

The Royal Shrewsbury Hospital is part of Shrewsbury and Telford Hospitals NHS Trust and provides acute services to those living in Shrewsbury and surrounding areas.

Services at the Royal Shrewsbury Hospital include urgent and emergency care services, emergency medicine and surgery and end of life care services. Along with diagnostic and screening, critical care and outpatient services.

The urgent and emergency care service provides services 24 hours a day, seven days a week. The service consists of a booking reception area, a main waiting area, a children's waiting area, two adult triage rooms, four bedded resuscitation bay, 12 majors' cubicles, 'pit stop' with four trolleys, four bedded clinical decisions unit (CDU), one children's cubicle and one children's triage room.

The hospital's medical care services comprised of cardiology, renal, respiratory and dermatology, stroke, care of the elderly and neurology, diabetes and endocrine, clinical support services, oncology and haematology.

The end of life care service comprised of two service lines, a specialist palliative care team and an end of life care team. The palliative care team at Shrewsbury and Telford Hospitals NHS Trust works across both hospitals. They provide specialist advice and support to people living with a serious, life-limiting illness who are currently staying in either the Royal Shrewsbury Hospital, or the Princess Royal Hospital in Telford. In-patients who might benefit from the service can be referred to the hospital palliative care team by any healthcare professional, carer or community team.

During our inspection we visited all areas within urgent and emergency care, ward 22 (short stay), 22 (respiratory), 23, 28 (frailty and gen med), 27 (general med), 23 (oncology), 24c (cardiology), 24E (endocrinology), 32 (respiratory), 35 (nephrology), 36, acute medical unit, surgical assessment unit and endoscopy.

We spoke with 86 members of staff, including doctors, nursing staff of various grades, healthcare support workers, physiotherapists and managers. We spoke with 21 patients and we looked at 79 sets of patient records.

McLellan, Holly
11/26/2021 12:38:21

Medical care (including older people's care)

Requires Improvement ↑

Is the service safe?

Inadequate →←

Our rating of safe stayed the same. We rated it as inadequate.

Mandatory Training

The service provided mandatory training in key skills to most staff and made sure that most staff completed it.

Nursing staff received mandatory training but not all staff kept up to date with this. Data provided by the trust showed that not all staff were compliant with mandatory training requirements. The trust target for training compliance was 90%. Data provided by the trust following our inspection showed that for additional clinical services staff (healthcare assistants and nursing associates) four out of ten training sessions met the target compliance. For registered nursing staff six out of ten sessions met the target compliance. For therapy staff six out of ten sessions met the target compliance. Where target compliance was not met for training sessions, it was close to the target for most sessions. The training sessions with the lowest level of compliance were information governance and basic life support (BLS). Nursing staff told us that they had training sessions cancelled when staffing levels were reduced. Some staff told us they did not have time to complete online learning during a shift and had to complete this in their own time at home. There was not a consistent approach across ward managers for staff to be given the time back or additional pay for these hours.

Medical staff received mandatory training but not all staff kept up to date with this. Data provided by the trust following our inspection showed that for medical staff two out of eight required training sessions met the target for compliance. Where target compliance was not met for training sessions, compliance rates were variable. The training sessions with the lowest level of compliance for medical staff were information governance, patient moving and handling and basic life support.

The mandatory training was comprehensive and met the needs of patients and staff. Mandatory training topics included fire safety, infection prevention and control, hand hygiene, patient moving and handling, adult basic life support, food safety and hygiene, conflict resolution, equality and diversity, information governance, and health and safety. The majority of training sessions were completed as online learning.

Clinical staff did not consistently complete training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. The service provided data for completion of Mental Capacity Act (MCA), Deprivation of Liberty Safeguarding (DoLS) and Mental Health Act (MHA) training. Average compliance for completion of these training sessions across staff groups in medicine was 73%. Medical staff had the lowest overall compliance for these training sessions at 44%.

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There was no requirement for clinical staff to complete mandatory training in learning disabilities, autism or dementia. However, the dementia specialist nurses told us that all staff were expected to complete tier one dementia training as a workbook. The aim was for 90% compliance for completion by September 2021. Dementia awareness was not listed as

one of the mandatory training sessions in the information provided by the service, and no data for completion of this training was provided. Tier two training was available to senior staff such as ward managers and this was in the early stages of being rolled out to staff. Learning disability e-learning and training workshops were available but were not mandatory.

Managers monitored mandatory training and alerted staff when they needed to update their training. Ward managers told us that compliance was monitored through a corporate education team who sent monthly compliance reports to ward managers. The ward manager reminded any staff who were not compliant to update their training. Staff compliance with training was reported by each ward to the matrons and head of nursing in a monthly meeting.

Safeguarding

Most staff had completed training appropriate to their role on how to recognise and report abuse. Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff knew how to apply safeguarding knowledge.

Most nursing staff received training specific for their role on how to recognise and report abuse. Data provided showed the target for adult safeguarding level two training was met and was almost met for safeguarding children level two training.

Additional clinical services staff (healthcare assistants and nursing associates) received training specific for their role on how to recognise and report abuse. Data provided showed that 92% had completed safeguarding adults level two training and 93% had completed safeguarding children level two training. This met the trust target for completion of safeguarding training of 90%.

Most medical staff received training specific for their role on how to recognise and report abuse. Data provided showed that 94% had completed safeguarding adults level two training and 82% had completed safeguarding children level two training. Compliance with children's safeguarding training did not meet the trust target of 90%.

Most therapy staff had received training specific for their role on how to recognise and report abuse. Data provided by the trust showed that 90% of therapy staff had completed safeguarding adults level two training and 88% had completed safeguarding children level two training. This almost met the trust target for completion of safeguarding training of 90%.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff gave examples of when they would raise a safeguarding concern and could explain the process for escalating concerns and reporting them to the local authority. The safeguarding specialist nurse team worked closely with the local authorities in the region to manage safeguarding referrals and processes.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. We saw 'Safeguarding is everyone's responsibility' information displayed on medical records trolleys. This provided staff with information and advice on how to report safeguarding concerns.

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Staff were supported in managing safeguarding concerns by a specialist safeguarding nurse team who provided training and advice.

Staff usually followed safe procedures for children visiting the ward. However, at the time of our inspection, visiting was restricted, and no children were allowed to visit due to the COVID-19 pandemic.

Medical care (including older people's care)

Cleanliness, infection control and hygiene

The service did not always control infection risk well. Staff did not consistently use equipment and control measures to protect patients, themselves and others from infection. However, they kept equipment and the premises visibly clean.

Ward areas appeared visibly clean and had suitable furnishings which were clean and well-maintained.

The service generally performed well for cleanliness. Hospital wide (patient led assessments of the care environment (PLACE) scores for 2019 were 99.57% for cleanliness.

Cleaning records were not up to date. The service had a process for twice daily cleaning tasks to be carried out using a checklist to evidence completion. This was in line with the trust operational cleaning policy. During our inspection we saw that daily cleaning schedules were not always fully completed. We reviewed 12 copies of daily cleaning schedules during our inspection and found significant gaps in completion. None of the 12 schedules were fully completed. The trust told us that at the time of inspection there was no reference to deep cleaning in the cleanliness policy. The policy was under review as part of the work on implementing the National Standards of Healthcare Cleanliness and there was a plan to add deep cleaning to the policy. The service told us they performed reactive specialist cleaning during or after periods of infection outbreak. In addition, they undertook proactive specialist periodic cleaning as an annual programmed clean of wards. Cleaning records showed that reactive decontamination had been completed in side rooms and bathroom areas when a patient with an infectious illness was moved to another ward or area. The service used automated room decontaminations systems using hydrogen peroxide vapour or ultraviolet light for this process. Cleaning records for the three months before our inspection did not provide any evidence of proactive decontamination. The service could not demonstrate that all areas were cleaned in accordance with the trust operational cleaning policy.

Staff did not always follow infection control principles, including the use of personal protective equipment (PPE). We observed that some staff were entering wards without decontaminating their hands which was not in line with trust policy. Whilst all staff wore face masks, not all staff were clear on the trust's policy on their use. Staff we spoke with told us they were required to change their mask on entering a ward, but this was not outlined in trust policy. This only applied if patients had aerosol generating procedures in a bay, which required masks to be worn on entry to that area and removed on exit. We saw that where there were infectious patients in side rooms, there were clear signs on the door to make all staff aware of required precautions. However, on two occasions we witnessed staff entering patient isolation rooms without appropriate PPE. We did see that staff were bare below the elbow in line with infection prevention and control guidance.

Hand hygiene audits and infection prevention and control audits were completed monthly on all wards. Audit results showed that compliance with audit standards was mostly good. The medical wards achieved the trust target of over 90% most of the time in both audits. However, the infection prevention and control audit data for March 2021 showed that none of the medical wards achieved the target. Average compliance of medical wards in March 2021 was 79%.

We saw that there were hand hygiene posters above clinical handwashing sinks that reminded staff of effective hand washing techniques.

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Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We saw that 'I am clean' stickers were routinely used on patient equipment to indicate that the item had been cleaned after use and was ready for the next patient to use.

The service had adopted clear curtains between bed spaces, which were wipe clean. This was to promote social distancing in line with COVID-19 guidance. It also allowed patients and staff to see each other when their privacy curtains were open.

Wards had adopted the use of 'ready rooms' to create additional isolation facilities when these were required for patients with infectious illnesses.

All patients were regularly tested for COVID-19 using polymerase chain reaction tests. They were tested on the day of admission, on days three and five following admission and weekly thereafter. However, staff were not routinely tested unless they were symptomatic, or they were working in an area where there had been a COVID-19 outbreak. There was a voluntary lateral flow testing process which staff could choose to consent to. Data provided by the trust showed that on average, 18% of frontline staff had participated in the lateral flow tests from April to June 2021.

Wards had spill kits to enable the safe collection and disposal of blood and other body fluids in the event of a spillage.

In the endoscopy department we saw that dirty equipment was kept separate from clean equipment and was decontaminated in a separate area. There was an endoscope decontamination policy which detailed the requirements for cleaning and disinfecting endoscopic equipment. Staff followed this to reduce the risk of infection for service users and staff following contact with a piece of equipment used in the patient care process. The trust had also adopted the British Society of Gastroenterology (BSG) guidelines for decontamination of equipment for gastrointestinal endoscopy. I am clean stickers were placed on the clean endoscopes and traceability stickers were used in patient records. A log was kept of each endoscope used detailing the brand and type of scope, serial number, decontamination method, and patient use identification. This meant that there was full traceability of the scopes and a record of their decontamination.

We saw that staff in the endoscopy department changed their PPE (masks, aprons and gloves) between each patient.

Hospital acquired infection rates from April 2020 to March 2021 for the Royal Shrewsbury Hospital, showed there was one case of Methicillin-resistant Staphylococcus Aureus (MRSA), 12 cases of Methicillin-susceptible Staphylococcus Aureus (MSSA) and eight cases of clostridium difficile and four catheter associated urinary tract infections.

We requested water sampling certificates for endoscopy and Legionella and Pseudomonas certificates, but the service did not provide these. However, the service sent us the trust Legionella Control Association (LCA) certificate which was valid until 31 August 2021. LCA certificates demonstrate that providers have complied with the LCA code of conduct and service standards and are committed to preventing legionellosis and keeping their water systems safe. They also sent the trust water safety plan which was a draft version from 2016. This incorporated Legionella and Pseudomonas aeruginosa, "safe" hot water, cold water, drinking water and ventilation systems management and control. There was no evidence of this plan being signed off. We were not assured that there were effective water safety systems in place.

Environment and equipment

The design and use of facilities and premises kept people safe. However, equipment was not in date for annual safety checks. Staff did not manage clinical waste well.

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Patients could reach call bells and staff responded quickly when called. All patient beds had access to call bells, and we saw that these were left where patients could access them. Staff completed two-hourly comfort assessments with all patients which included checking that patients had access to a call bell. We observed that staff responded quickly when patients used the call bell.

Medical care (including older people's care)

The design of the environment followed national guidance. Each ward was a mixture of single sex bays and side rooms. There were identified toilet and bathroom facilities for each bay or side room. However, some wards were cluttered with equipment. There were cleaning trolleys, patient records trolleys, computer trolleys and equipment such as wheelchairs in the ward corridors. This meant it could be difficult for patients to safely navigate the environment.

Staff carried out daily safety checks of emergency equipment, however, annual safety tests on equipment were not up to date. Resuscitation equipment for use in an emergency was available in all areas we visited. Staff carried out daily safety checks of resuscitation equipment. We saw the daily checks were in place across all wards we visited. There was a trust process for new devices to be identified with a yellow new equipment tag and then added to the equipment database. Once equipment items had been tested, they were released for use and added to a maintenance database. We saw a log for 435 items of equipment within the medical service. We found that 336 (77%) of these equipment items had not been tested within the planned testing date. The longest delay in testing was 829 days after the planned testing date. Equipment items included thermometers, monitors, suction pumps, scales, syringe drivers and infusion pumps. However, all items of equipment we checked during our inspection had stickers to identify they were in date for testing. We were not assured that there was a robust process for maintaining equipment to ensure it was safe for use.

The service had enough suitable equipment to help them to safely care for patients. Staff had access to equipment they required to carry out their role, such as equipment for patient observations, hoists and commodes. We saw that equipment such as beds and bedrails was in good condition. Wards had store rooms that contained consumables such as dressings and fluids. Store rooms were tidy and well organised and there was a process in place for monitoring stock levels and expiry dates of items.

Staff did not always dispose of clinical waste safely. We saw that there were waste bags on the floor on some ward corridors. When bins were full, waste bags were removed and replaced but the full waste bags were not always removed from the clinical environment in a timely way.

Wards were not secure, there was no secure entry and exit system in use on most wards. There were intercom entry systems, but these were not being used on most wards we visited and doors to wards were unlocked. This meant that anyone could enter or leave the ward, including unauthorised visitors and patients on DoLS who were not free to leave.

Cleaning products subject to the control of substances hazardous to health (COSHH) regulations were not always stored securely. We saw that a cleaning trolley which held hazardous substances was stored in the corridor of one ward. The cleaning cupboards in the store room on the renal ward were not locked meaning anyone could access hazardous cleaning products, including patients. Cleaners told us this was since there was only key for the cupboards, so they had to be left unlocked to allow all cleaning staff to be able to access them. We raised this during our inspection and immediate action was taken to resolve the concern. A system was put in place where the key was kept securely with other ward keys under the control of the ward sister / manager. This meant the cupboards could be locked but cleaning staff could still access them as required. As a longer term solution, we were told that a digital door lock would be ordered to keep the store room secure.

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Assessing and responding to patient risk

Staff did not consistently complete and update risk assessments for each patient or take actions to remove or minimise risks. Staff did not always identify or quickly act upon patients at risk of deterioration.

Staff used a nationally recognised tool to identify deteriorating patients but did not always escalate them appropriately. Staff used the National Early Warning Score (NEWS) system to monitor patients at risk of deterioration. We saw evidence that NEWS scores were routinely completed on appropriate patients. Any patient with a NEWS score of 3 or above was

highlighted during the shift handover and board round. However, deteriorating patients were not always escalated in line with trust process. There was a critical care outreach team of doctors and nurses who could be bleeped for urgent review of deteriorating patients. Staff evidenced escalation of deteriorating patients by the use of a yellow sticker in the patient's medical records. We saw evidence of these stickers being used in some of the records we reviewed. There was a daily process for ward managers to review all records of patients who had scored a NEWS of five and above in the previous 24 hours, to monitor if they had been appropriately escalated in line with the trust policy. Data from this review process for a 12-week period from March to June 2021 showed that 76 patients on medical wards at the hospital did not have documented evidence of timely escalation when triggering a NEWS score of five or more. In addition, there was a weekly sepsis screening audit which monitored whether patients with a triggering NEWS had been escalated and received appropriate treatment. We reviewed data for these audits for the same time period and saw that there was variable compliance for escalating patients with a triggering NEWS score. For 11 out of 12 weeks there were some medical wards scoring amber (less than 90%) or red (less than 80%) for compliance with the audit standard for appropriate NEWS escalation. During the 12-week period there were 11 occasions of medical wards scoring amber for compliance and 18 occasions of medical wards scoring red for compliance with appropriate NEWS escalation. We were not assured that deteriorating patients were consistently escalated appropriately.

There was a sepsis care bundle tool kit used to identify key elements of care regarding the diagnosis and treatment of patients with suspected sepsis to enable consistent and timely treatment. Wards had a sepsis trolley which contained equipment for treating patients with suspected sepsis and this was checked daily. However, data provided by the trust showed that the sepsis care bundle was not always implemented appropriately for deteriorating patients. For a 12-week period from March to June 2021, there were nine weeks where some medical wards scored amber or red for compliance with the audit standard of following clinical response guidance. During the 12-week period there were six occasions when medical wards scored amber for compliance and 10 occasions of medical wards scoring red for compliance with following clinical response guidance. We were not assured that deteriorating patients consistently received timely treatment.

Staff did not always complete all risk assessments for each patient on admission or review these regularly. Although staff used recognised tools within a nursing assessment booklet, these were not consistently completed for all patients, for all risks, and were not always reviewed and updated in line with trust policy. For example, we reviewed 12 falls risk assessment tools within nursing records and found that although all 12 records had an initial falls risk assessment completed, eight of the 12 had no re-assessment documented. We reviewed 20 venous thromboembolism (VTE) risk assessments and found that two patients had not had a VTE risk assessment on admission and 15 patients had not had a reassessment within 72 hours. We reviewed 10 pressure risk assessments and found that although all 10 records had an initial risk assessment, three had no weekly re-assessment. We were not assured that comprehensive risk assessments and reviews of risk assessments were consistently carried out on all patients.

Staff did not always know about any specific risk issues as the risk assessment tools were inconsistently completed. When risks were identified there were associated management plans in the nursing assessment booklet, but these were not always fully completed. We saw that six patients identified as a high falls risk had incomplete or blank management plans. Another patient had an identified action in the falls management plan to refer to therapy but there was no evidence that this action had been completed. A patient identified as high risk on a pressure assessment did not have any pressure prevention plan documented. We saw that in five repositioning charts we reviewed, none of these were fully complete. Staff did not routinely document which position a patient had been moved from and to, or the required frequency of repositioning. This meant that staff may not always be redistributing the pressure on a patient's skin in order to relieve pressure and prevent pressure sores. We were not assured that all risks identified on nursing assessments were managed positively in order to keep patients safe. However, we saw that when patients had a high risk of VTE, they were on appropriate prophylactic treatment to reduce the risk.

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Medical care (including older people's care)

The service had a 'think yellow' campaign to highlight patients at risk of falls. Any patient identified at risk was given a yellow wrist band to wear so that staff could easily see they were at increased risk of falling. In addition, these patients had a falls icon displayed on a patient board above their bed and on the patient status at a glance board.

Patients at high risk of falls were put on enhanced supervision observations where appropriate. The need for enhanced patient supervision (EPS) was determined through an initial risk assessment and daily review. This meant that patients may be nursed in a cohort bay with additional staff observing patients in the bay or may receive one to one supervision if the risk was identified as high. Staff observing patients in a cohort bay operated a tagging system. Staff wore a yellow tagging badge and needed to keep the patients in line of sight at all times. They could not leave the bay without passing the tagging badge to another member of staff. We observed this process on one ward and saw that staff followed the procedure as set out in the policy. Observations of patients receiving one to one supervision should be documented hourly in accordance with the trust's enhanced care policy. Enhanced patient supervision records for three patients showed that for one patient receiving one to one supervision observations had not been documented on the previous day. The service did not currently audit against this policy.

Staff on ward 22 told us that there was reduced visibility into some side rooms which made patient observation difficult. They explained that this had impacted on the frequency of patient falls in the past, but they had increased staffing levels on the ward in mitigation of this.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a patient's mental health). Staff were supported by a specialist mental health liaison team who provided a 24-hour response service. Each area had a special mental health resource file for information and advice.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. Staff were able to access a consultant psychiatrist through the mental health liaison team for any patients with complex mental health needs.

Staff shared key information to keep patients safe when handing over their care to others. Shift changes and handovers included all necessary key information to keep patients safe. We observed board rounds between nursing, medical and therapy staff. All staff involved were given a written handover document which summarised key information about each patient in a situation, background, assessment, recommendation (SBAR) format. SBAR is a recognised tool for structured communication of critical information.

Patient's requiring a procedure in the endoscopy department were offered a pre-procedure assessment if they had certain conditions such as diabetes or were taking medication such as anticoagulants (blood thinning medication). Any diabetic patients had a glucose sticker placed in their records and were prioritised on the procedure list for the beginning of the day. In the event of an unexpected complication during a procedure, such as a gastrointestinal bleed, staff would involve the resuscitation team and the named gastroenterologist for the day. Staff followed national guidance for safety standards for invasive procedures (NATSSIPS) and had developed local guidance (locSSIPS) based on these. Following an endoscopy procedure, patients went from the procedure room to the recovery area where their observations were monitored using an adapted National Early Warning Score (NEWS) system. Patients could only be discharged if their NEWS score was less than two. The service had a set of criteria for nurse-led discharge of outpatients using the endoscopy service.

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Medical care (including older people's care)

Staff in the endoscopy department used World Health Organisation (WHO) checklists to ensure that patient safety was communicated by the team of operating room professionals. There was one overall WHO checklist report submitted for the trust. This included audits for areas where endoscopy procedures were undertaken but was not specific to endoscopy. Audit results from January to June 2021 showed 100% compliance for each standard audited; team brief, time out, sign out and completion of the WHO checklist.

All patients should have timely access to consultants for assessment in order to identify and respond to any risks. The trust provided trust wide data for compliance with standards within the seven day services self-assessment tool relating to consultant assessment. The most recent data available was for March 2020. Achievement of the target for 90% of patients to be assessed by a consultant within 14 hours of emergency admission was not met. Trust data showed that 65% of patients were seen within this timeframe. Achievement of the target for 90% of patients on an established care pathway to see a consultant at least once a day was not met. Trust data showed that 75% of patients saw a consultant at least once a day. Achievement of the target for 90% of high dependency patients to receive a twice daily review by a consultant was not met. Trust data showed that 57% of high dependency patients saw a consultant twice a day.

Staffing

Nurse staffing

The service did not have enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. However, managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service did not have enough nursing and support staff to keep patients safe. During our inspection, staff told us that there were not always enough staff to provide care. Ward managers and matrons told us that staffing concerns were on their risk registers. Band 7 staff in ward manager roles were covering clinical work on some wards due to reduced staffing on the day of our inspection. The number of nurses and healthcare assistants did not always match the planned numbers. Planned and actual staffing numbers displayed for wards we visited showed that actual staffing levels did not always meet planned staffing levels. Managers could escalate reduced actual staffing levels, but they did not always receive additional staff.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. Managers told us that there was a continued cycle of nursing recruitment for vacancies. Recruitment plans were in place for vacancies at the time of our inspection. Managers told us that some vacancies had been filled and were awaiting staff start dates and further recruitment adverts were out. There was an ongoing programme of international nurse recruitment and a new cohort of international nurses were planned to start in the service by September 2021. To mitigate vacancies in the interim period the service used temporary staff (bank staff and agency staff) and overtime where required.

The ward manager could adjust staffing levels daily according to the needs of patients. There was a matron on each site each day who performed a safe staffing overview. Wards used a nationally recognised tool to calculate required staffing levels for each shift on each ward. The matron held a daily safety brief call with ward managers from all wards to check staffing levels, skill mix and acuity. Matrons planned staffing for 24 hours ahead and kept a staffing spreadsheet of agreed and actual staffing numbers for each ward. This enabled the matron to identify if there were unfilled shifts so this could be escalated, and mitigations could be put in place. Mitigations included moving staff to different wards if there

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was an area of greater need, or the use of temporary staffing. Staffing rosters were approved at least six to eight weeks in advance to make sure the right skill mix was put in place. When there were high numbers of patients with enhanced care supervision needs, managers were able to request additional staff to support these needs. This was usually provided in the form of bank or agency staff.

The service had high vacancy rates for registered nursing staff. Data from July 2020 to June 2021 showed an average vacancy rate of 15.8% for registered nursing staff.

The service had lower vacancy rates for nursing support staff. Data from July 2020 to June 2021 showed an average vacancy rate for health care assistant (HCA) staff of 5.3%

As a result of vacancies and sickness, the service had high rates of bank and agency nurses and HCA staff usage on the wards. From June 2020 to May 2021 a total of 31.5% of all registered nursing shifts and 38% of all HCA shifts were covered by non-substantive staff. Managers were unable to limit their use of bank and agency staff and were dependent on non-substantive staff to cover unfilled shifts. However, through the use of bank and agency staff, the service managed to cover the majority of required shifts. From June 2020 to May 2021 there were only 0.3% unfilled registered nursing shifts and 0.95% unfilled HCA shifts.

Managers made sure all bank and agency nursing staff had a full induction and understood the service. We saw that agency staff were orientated to the ward at the beginning of their shift and completed an induction checklist with the nurse in charge.

Medical staffing

The service did not always have enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The service did not always have enough medical staff to keep patients safe. Data showed that the service reported an overall surplus of 8.5% medical staffing across all medical staff grades. However, there was a vacancy rate of 17.0% for consultants. The overall surplus staffing was made up of 14.3% over-staffing of middle grade medical staff and 36% over-staffing of junior grade medical staff. The highest consultant vacancy rates were in general medicine, cardiology and nephrology. We saw there were four whole time equivalent (WTE) budgeted consultant staff in cardiology but two of these posts were filled by locum consultant staff as the service had experienced difficulty in recruiting consultant cardiologists.

Managers made sure locums had a full induction to the service before they started work. A locum member of medical staff who we spoke with told us they had an induction and a tour of the department when they started in post.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. Data showed that there was a budgeted establishment of 70.6 WTE medical staff which were skill mixed across different grades. However, the actual skill mix in post across different medical grades did not match the planned budgeted skill mix. The trust had not been able to recruit to the establishment for all grades of doctor: they mitigated the shortfall in consultants and doctors in training by over recruiting middle grade doctors.

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The service had high rates of bank and locum staff. Managers told us this was to provide additional numbers to the staffing establishment to address the pressures during COVID-19. The trust told us that medical staff bank hours, locum hours and unfilled hours could not be calculated as a percentage of available hours as this was not recorded on their

roster system. Instead, the trust provided fill rate data. This showed that managers could not always access bank and agency when they needed additional medical staff. Not all medical shifts requested to be filled by bank staff were filled. The lowest bank staff fill rates were for consultants in renal medicine However, most medical shifts requested to be filled by agency staff, were filled, with the exception of acute medicine where there were low agency fill rates for consultants and foundation year one doctors. This specialty accounted for nearly half of the shifts that were requested to be covered by agency staff in medicine.

AHP staffing

The service did not have enough therapy staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and escalated concerns about staffing levels, but these were not always acted on. There was not evidence that bank and agency staff received a full induction.

The service did not have enough therapy staff to provide the right care and treatment. Therapy managers used an algorithm for safe staffing levels and that therapy staffing was consistently below the safe staffing levels. There was an aspiration for all patients to get all the therapy they needed but managers told us they could not meet this within the current staffing establishment. Safe staffing was the number one concern for therapy managers. Staffing concerns had been escalated to senior managers and staffing was on the corporate risk register with a score of 20 (the highest possible score). Therapy staffing concerns had been on the trust risk register for four years, but managers told us it was not the trust board's highest priority. Therapy managers mitigated the staffing issues by completing a monthly forward view of staffing requirements. There was regular use of bank and agency therapy staff. There was a plan to review staff skill mix to help better manage the demands on the therapy service. Managers hoped to improve staff retention through offering rotations across organisations and offering career development opportunities such as apprenticeships and advanced practitioner roles. They recognised that the ability to recruit enough new staff to meet the requirements of seven-day rota working was a huge challenge.

There was a prioritisation system which placed inpatients in three priority groups depending on the urgency of their needs. Managers told us that staff were rarely able to see the lowest level three priority patients due to limited staffing capacity.

Therapy staffing data showed that there were not high numbers of vacancies. However, therapy staff we spoke with told us that were unable to see patients for ongoing treatment and had to focus on patients who were medically fit for discharge. Although there were not high numbers of vacancies, there were not enough therapy staff within the budgeted establishment to meet the demands of the service.

Managers did not make sure locum therapy staff had a full induction to the service before they started work. One locum therapist we spoke with told us they had not received any induction. They were allocated to different wards on a daily basis.

Records

Staff kept detailed records of patients' care and treatment. Records were not always organised, up-to-date, or stored securely. However, all records were kept in records trolleys which were easily available to all staff providing care.

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Patient notes were not always comprehensive. We reviewed 40 records and found that risk assessment documents and required action plans were not consistently completed. In addition, fluid balance and repositioning charts were not fully completed, and allergies were not routinely documented in patient's records.

All staff could access patient records easily. Records were multidisciplinary; therapy staff documented findings in the medical records. Nursing and medical records were kept together in the records trolleys. This meant that all staff were able to access all patient records when required.

Records were not stored securely. We found that records trolleys which held medical and nursing records were generally left unlocked even though digital coded locks were on each trolley. In addition, patient notes were left open and unattended and were not always locked away in the records trolleys. Observation charts holding personal information were routinely left outside of ward bays. Managers told us that these charts were removed from patient's bed sides to outside of the bay to comply with COVID-19 infection prevention and control recommendations. However, this meant that there was potential for unauthorised people, including non-clinical members of staff, ward visitors and patients to access records.

Records storage was not well organised, and we saw that there were a lot of loose sheets and documents in record sets that had not been securely filed. This meant that patient information could go missing or become part of another patients records in error. Nursing records were not always stored in folders and we saw that some were held together by treasury tags. This was not secure and meant that parts of the record could become detached and lost.

Medicines

The service did not always use systems and processes to safely prescribe, administer, record and store medicines.

Staff didn't always follow systems and processes when safely prescribing, administering, recording and storing medicines.

The pharmacy team ensured there was a patient centred approach to medicine optimisation. Medicines advice and supply were available seven days a week. An on-call pharmacist was available outside of core working hours.

Although staff knew the routes to contact pharmacy to obtain medicines, we found medicines were not always available to administer to patients. Due to the COVID-19 pandemic the pharmacy missed dose audits could not be undertaken, although the next audit was planned to be undertaken during July 2021. However, compliance was still monitored via the completion of the matron quality audits on a monthly basis. The results submitted for the hospital showed an average compliance of 80% from January 2021 to June 2021.

Managers told us there was a system for recording the site of application or removal of transdermal medicine patches, but staff told us the process was still under development and was awaiting approval at the time of our inspection. The system was not, therefore, consistently used by staff at the time of the inspection. Such a system is important to check that the patch is still in place or to prevent the application of other patches in error. Also, to communicate information about patches when a person is transferred between wards or other healthcare settings.

Staff were not always able to review patient's medicines and provide specific advice to patients and carers about their medicines.

McLellan, Holly
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Doctors were not always able to check patients prescribed medicines and allergies because they did not all have access to the patient's summary care records. This presented a risk when assessing and treating patients when they were admitted. We reviewed one patient who was not administered their prescribed medicines on admission because they had not brought in their medicines and there was no record of their regular prescribed medicines.

Medical care (including older people's care)

Members of the pharmacy team regularly reviewed patients' medicines throughout their admission and prior to discharge. This involved counselling and discussions with patients wherever possible.

Staff did not always store and manage all medicines and prescribing documents in line with the provider's policy.

Medicines were stored safely and securely apart from the Acute Medical Unit (AMU). Despite a weekly top up service by pharmacy, which included tidying up the cupboards, we found an untidy and poorly managed system of medicine storage within AMU. This was brought to the attention of the ward manager.

FP10 prescriptions were stored securely with a robust checking system to track their use.

Controlled drugs were stored and recorded following policy. Daily checks were undertaken, and any discrepancies were investigated.

Staff followed current national practice to check patients had the correct medicines.

Medicine optimisation was undertaken by members of the pharmacy team. Any discrepancies were immediately identified and highlighted to the relevant team.

Patients allergies or known sensitivities to medicines were documented on all the medicine records reviewed.

Antibiotics were prescribed following the trust antimicrobial guidelines including details of their indication for use, length of treatment and review dates. The antimicrobial stewardship pharmacist undertook reviews and snap-shot audits which highlighted any areas for improvement.

Dedicated sepsis trollies or boxes were available for the immediate treatment of sepsis. These were checked daily to ensure the medicines were available and in date and therefore safe to use. This helped to ensure that staff could follow The National Institute for Health and Care Excellence (NICE) guidance which states patients should receive intravenous antibiotics within 60 minutes.

Resuscitation trollies were immediately available in the event of an emergency. These were sealed with tamper evident tags. This follows the guidance from the UK Resuscitation Council. Evidence of daily checks were recorded to ensure the medicines were available and safe to use. Venous thromboembolism (VTE) protocols were in place. Checks to ensure any necessary prescribing for the prevention of a VTE were undertaken by pharmacists.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

Any medicine incidents would be reported onto the incident reporting system. Learning from incidents would be shared across the trust.

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Decision making processes were not always in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines.

When a medicine was administered to manage agitation or aggression (rapid tranquilisation), medicines were not always appropriately prescribed and monitored. We reviewed the medicine records for two patients. The Standard Operating Procedure for rapid tranquilisation had been followed for one patient and the decision-making process was

documented along with an assessment of the patient's mental capacity. However, the other patient's records showed that staff administered medicines to control their behaviour with no prior attempts to using calming or distraction techniques. There was no reference in the medical notes or care plans to guide staff on how to de-escalate situations to avoid the use of medicines.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

All staff knew what incidents to report and how to report them. All staff had access to an electronic incident reporting system and could explain what concerns they would raise as an incident.

Staff raised concerns and reported incidents and near misses in line with trust/provider policy. The trust had an incident reporting policy which staff in the medical care service followed.

The service had no never events on any wards but did have a never event in the endoscopy department in January 2020. This involved the wrong patient undergoing a procedure in error. Managers shared learning about never events with their staff and across the trust. During our inspection we saw evidence that learning had been shared and appropriate actions were in place to prevent a recurrence. Staff told us that new documentation was now used to ensure the correct patient was presenting for the procedure. The learning and actions were shared at safety huddles, team meetings and through social media closed communication groups.

Staff reported serious incidents clearly and in line with trust policy. In accordance with the Serious Incident Framework 2015, the trust reported 15 serious incidents (SIs) in medical care at Royal Shrewsbury Hospital which met the reporting criteria set by NHS England from July 2020 to June 2021.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong.

Staff received feedback from investigation of incidents, both internal and external to the service. Incidents were discussed at daily ward safety huddles and team meetings, where these were held. Senior staff shared national patient safety alerts in a structured way to ensure that learning from these was disseminated to all relevant staff.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Managers investigated incidents in accordance with guidance in the clinical incident management policy. Incidents were investigated on varying levels depending on the severity of the incident. There was a patient safety team who supported staff to identify when to carry out differing levels of investigation. Managers investigated incidents and completed reports identifying required actions and feedback. Patients were involved in agreeing key lines of enquiry for incident investigations when they met the criteria of moderate harm or above. Patients and/or their family had the opportunity to discuss incident investigation findings with staff.

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Managers debriefed and supported staff after any serious incident. The ward manager on one ward explained how they had spoken with staff following an inquest outcome for a patient that had been on the ward. They told us how they had shared the inquest outcome with staff and given them the opportunity to discuss and reflect on the learning identified.

Medical care (including older people's care)

Safety Performance

The service did not always use monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors but there was not evidence that information was used to improve safety.

The service continually monitored safety performance. Safety performance dashboard data was displayed on most wards for staff and patients to see. Quality boards displayed data demonstrating the ward compliance with nursing quality assurance audits. This included data for skin integrity, falls and infection prevention control (IPC). Wards RAG rated the performance as red, amber or green to indicate levels of compliance with the quality assurance standards.

The safety performance data did not show that the service achieved harm free care within the data period information was provided for. The service provided safety performance dashboard data from March to May 2021. It was not clear if this data was site specific or service specific. The data showed that there was underperformance for falls, skin integrity, and IPC which were all rated amber for overall compliance. The service did not provide any further data to compare trends over time.

Staff used the safety performance data to identify areas requiring improvement. However, there was not evidence that improvements were achieved or sustained. We saw that there was a monthly integrated performance report to board which included a quality summary presented by the director of nursing. Safety performance was monitored through a monthly review of the service achievement of the safety metrics against target performance. Where issues in safety performance were identified there were associated actions set out to make improvements. However, safety performance dashboard data did not always show improvement in areas of poor performance.

Is the service effective?

Requires Improvement ↑

Our rating of effective improved. We rated it as requires improvement.

Evidence-based care and treatment

The service provided care and treatment guidelines based on national guidance and evidence-based practice. However, staff did not always follow this guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

The service had up-to-date policies to plan and deliver high quality care according to best practice and national guidance, however, staff did not always follow guidance. The service had a range of policies to support staff to deliver appropriate care. There were policies for pressure ulcer prevention and the prevention and management of inpatient falls which referenced the most up to date National Institute of Clinical Excellence (NICE) guidance. There was a process in place to review any new guidelines published and identify any changes in practice that were required based on these. However, we saw that staff did not always follow guidance outlined in these policies. For example, the inpatient falls policy identified the need for staff to reassess patient's falls risk assessments as a minimum every seven days and also when a patient's condition changed, or they fell. In eight out of 12 falls risk assessments we reviewed there were no reassessments. We reviewed 10 pressure risk assessments and found that three records had no evidence of reassessment and two had no documented pressure management plan despite the patients being identified as high risk. This was not in line with the trust policy.

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Medical care (including older people's care)

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. We did not identify any patients who were detained under the Mental Health Act during our inspection. Staff were able to tell us what they would do or who to contact for advice and support if they were caring for a detained patient. There was a mental health specialist team who supported the service in improving quality of care for patients living with mental health conditions.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. We saw that nursing handover documents identified where patients were suffering from anxiety or depression. We heard discussions about doctors having conversations with relatives and carers to ensure they understood the care plans for their loved ones.

Nutrition and hydration

Staff could not be sure they gave patients enough food and drink to meet their needs and improve their health. However, they used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Staff could not be sure that patients had enough to eat and drink, including those with specialist nutrition and hydration needs. There was inconsistent completion of fluid and nutrition charts meaning staff were not accurately monitoring if patients' dietary requirements were being met.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition but did not complete these consistently. Data from the performance dashboard from March to May 2021 showed that nutrition risk assessment tools were red rated for compliance with 79% of assessments being completed.

Staff did not accurately monitor patients fluid intake. Data from the performance dashboard from March to May 2021 showed that completion of fluid balance charts was red rated for compliance with 72% being completed. During our inspection we reviewed 14 fluid balance charts and saw that 13 of these were incomplete. We found there were missing entries, input and output volumes were not totalled and overall fluid balances were not calculated. This meant that staff did not accurately monitor patients fluid intake to ensure that they were sufficiently hydrated. We saw that two of the patients whose charts we reviewed had entries in their medical notes stating to encourage fluids. Despite this, neither of these patients had fully completed fluid balance charts.

Specialist support from staff such as dietitians and speech and language therapists was available for patients who needed it. Ward staff were able to contact the therapy centre and request assessments from specialist staff for patients with specific nutritional needs.

Patients were given meal choices and hot drinks were offered in between meals. Staff provided patients with a menu and supported them to make appropriate meal choices. Any patients with special nutritional needs were identified to the ward hostess and appropriate food choices were overseen by the ward manager for those patients on special diets. There were icons on boards above patients' beds indicating if they had any special nutritional requirements. Special diets to meet patients cultural and religious needs were available. Soft and pureed diets were offered to those patients with swallowing difficulties where appropriate.

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Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool. Pain scores were assessed and recorded regularly. We saw these were documented in all endoscopy records and most ward patients records that we reviewed. We saw that staff asked about pain levels during routine regular comfort assessments completed with all ward patients. The service told us that they used the Abbey pain scoring system as a method for identifying the signs of pain in people with communication difficulties, for example those living with dementia. However, we did not see this in use in the records that we reviewed.

Patients received pain relief soon after requesting it. In the endoscopy service we saw that pain relief was administered promptly in response to a patient expressing they were experiencing pain.

Staff prescribed, administered and recorded pain relief accurately. Medicine charts we reviewed confirmed pain relief was prescribed and delivered appropriately.

Patient outcomes

Staff monitored the effectiveness of care and treatment. The endoscopy service had been accredited under the Joint Advisory Group on Gastrointestinal Endoscopy (JAG) scheme. However, staff did not always use the findings to make improvements and outcomes for patients did not always meet expectations.

The service participated in relevant national clinical audits. Audits included the National Lung Cancer Audit, National Audit of Dementia, National Audit of Inpatient Falls, and National Diabetes Inpatient Audit. The service did submit some data to the Sentinel Stroke National Audit Programme but the main site for acute stroke care was at the Princess Royal Hospital so the data for the Royal Shrewsbury Hospital was not comparable to other acute stroke units.

Outcomes for patients were varied and did not always meet expectations, such as national standards. The National Lung Cancer Audit results were based on 2018 data. This showed that the service performed as expected for three metrics and worse than expected for the other two metrics. We asked the service for action plans in relation to the national lung cancer audit performance, but they did not provide these.

In the 2019 National Audit of Dementia Royal Shrewsbury Hospital was in the bottom 25% for three out of four metrics. This meant that it was performing poorly in comparison to other national providers. We asked the service for action plans in relation to national audit of dementia performance, but they did not provide these. However, the service provided a dementia workplan dated June 2020 which targeted some of the audit metrics. There were actions in relation to staffing, partnership working, assessment and care planning, the environment and governance.

The National Diabetes Inpatient Audit results were based on data from September 2019. These showed mixed performance with lower than national average performance in the staffing structure, clinical outcomes and harm domains. There was similar to national average performance for patient experience and better than national average performance for visits from a specialist team. We asked the service for action plans in relation to the national diabetes audit performance, but they did not provide these.

The national audit of inpatient falls the trust provided annualised values based on 8 cases averaged over 12 months to the end of April 2021. This showed that the trust performed worse than the national average in two domains and about the same as the national average in one domain.We asked the service for action plans in relation to the national inpatient falls audit performance and they provided a falls prevention plan based on findings from a thematic review of inpatient falls. Most of the actions identified were marked with the status of ongoing.

Ian Kelly 11/06/2021 12:38:21

Medical care (including older people's care)

Outcome data was reviewed at specialty and divisional quality and safety meetings. These included learning from deaths. The reports seen included details of all national and local audits. Managers and staff investigated outliers and implemented local changes to improve care and monitored the improvement over time. Managers shared and made sure staff understood information from the audits. Improvement was checked and monitored. We saw that action plans were in place to support improvements.

Managers and staff did not use the results from national audits to improve patients' outcomes. The medical division committee meeting and governance meeting minutes did not provide evidence of review and discussion of national audit results.

The service had a lower than expected risk of readmission for elective care than the England average.

The service had a lower than expected risk of readmission for non-elective care than the England average.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. There was a programme of local audit which was reported as part of the monthly integrated performance reports. These included matron quality audits, ward audits and controlled drug audits. Results were reported on a performance dashboard where audit results were rated red, amber or green for compliance. The performance report highlighted key risks and issues across all domains of performance.

The service provided us with a list of 33 clinical specialty audits that had been carried out within the division. Each audit had an associated report or presentation detailing the findings. Governance meetings for the medical division had a standing agenda item of clinical audit feedback and specialty audit findings were presented at these meetings.

Managers used information from the audits with the aim of improving care and treatment but improvements in care were not always able to be demonstrated. The integrated performance reports were discussed at board level and any audit areas of performance concern had associated actions in place. Ward managers displayed copies of performance dashboards on each ward so that staff, patients and visitors could see the audit results. Where there were areas of concern, we saw targeted actions were put in place, for example we saw ward link boards for sharing information on audits and good practise. We saw boards highlighting information around fluid balance, sepsis and dementia. Managers told us that wards with known areas for improvement were being given additional focused and specialised support with additional training and education to improve quality standards. However, performance dashboards from March 2021 to May 2021 showed that areas of amber or red performance, such as nutrition, falls, fluid balance and dementia screening continued to perform poorly and had not improved.

Therapy staff told us that although they recorded some patient outcome measures as part of their assessment, these were not repeated. This was since patients were not seen by therapists for long enough for the opportunity to complete before and after outcome measures. This meant that therapy outcome measures were unable to be used to improve care and treatment.

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Managers shared and made sure staff understood information from the audits. There was a monthly Matron and Ward Manager Quality Metrics Assurance Meeting which reviewed compliance with the Nursing Quality Assurance Metrics. This identified areas demonstrating improvement or continued good compliance as well as areas requiring improvement. Managers told us that audit performance information was shared with staff at ward staff meetings (where these happened) and any areas of performance concern were highlighted. However, we found there was little evidence of regular team meetings at ward level and the minutes did not evidence sharing of audit performance information. Audit results were shared at care forum groups. We saw that the Recommended Summary Plan for Emergency Care and

Treatment (ReSPECT) audit findings were shared through a presentation delivered to the renal governance forum. At the neurology care group forum, findings of an audit on inpatient Administration of Parkinson's Disease Medication was presented. Following these presentations, we saw that recommendations were made so that appropriate actions could be implemented.

Improvement was checked and monitored. Although audit performance was monitored through performance dashboards and board reports, there was no evidence of consistent improvement in audit performance.

The endoscopy service was accredited by the Joint Advisory Group on Gastrointestinal Endoscopy (JAG). The latest submission to JAG had resulted in the service being fully accredited having successfully implemented an action plan to improve.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance. However, supervision meetings were not held consistently with staff to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Nursing staff worked together using a skill mix approach to ensure staff had the appropriate skills to provide safe care for patients. Nursing shifts were covered by both registered nurses, nursing associates and health care assistants and were supported by a senior nurse who was in charge of the ward. Newly qualified nursing staff were supported to complete preceptorship training. Preceptorship is a period of time to guide and support all newly qualified practitioners to translate their knowledge into everyday practice and make the transition from students to develop their practice further. Newly qualified nursing staff completed competencies for procedures such as nasogastric feeding, catheter care and intravenous access. Some healthcare assistant staff had been supported to complete the trainee nursing associate programme. All registered nursing staff are required to complete revalidation to renew their professional registration, and we were told that the trust actively supported this process. Overseas nursing staff were supported to complete their objective structured clinical examinations (OSCE) in order to become registered with the Nursing and Midwifery Council (NMC). Staff working on medical specialty wards such as respiratory, cardiology and endocrinology completed competency-based training to develop specialist nursing skills.

Junior doctors received weekly teaching and said there were no issues attending this. They described a good level of teaching from consultant staff. Senior medical staff told us that new junior doctors received teaching sessions when they started in a new department and that regular half day teaching sessions were included in their working rotas as protected time.

Therapy staff were supported by therapy support workers who worked across different therapy disciplines. Support workers completed competencies in order to develop specific skills.

In the endoscopy unit, the unit was closed (except for emergencies) to enable all staff to complete specialist training every four months.

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Managers gave most new staff a full induction tailored to their role before they started work. Overseas nursing staff worked supernumerary to planned nurse staffing numbers until they had completed their OSCE. Agency nursing and medical staff we spoke with told us that they had received a tour of the ward / department and completed an induction checklist. However, an agency member of therapy staff we spoke with told us that they had not received any induction and were sent to many different wards to provide cover without any information.

Medical care (including older people's care)

Managers supported most staff to develop through yearly, constructive appraisals of their work. Staff we spoke with told us they had received appraisals. Data provided by the service demonstrated that 75% of registered nursing staff had received an appraisal in the last year. For additional clinical services staff (healthcare assistants and nursing associates) 76% of staff had received an annual appraisal. In addition, 94% of therapy staff and 97% of medical staff had received an annual appraisal in the last year. This was an overall compliance rate of 85.5%.

Managers could not demonstrate that they supported nursing staff to develop through regular, constructive clinical supervision of their work. There was no system or process for nursing staff to receive any form of regular supervision. However, junior doctors we spoke with told us that they received good supervision from consultants. Junior doctors had nominated clinical supervisors. Therapy staff we spoke with described a regular system of supervision every six to eight weeks, which was documented.

The clinical educators supported the learning and development needs of staff. There were specialist nurses who had a remit to support staff in developing specialist knowledge and skills. This was through advice and support, training sessions and the signing off of specialist competencies. There were specialist nurses in respiratory, dialysis, end of life care, dementia and mental health.

Managers did not make sure staff attended team meetings. However, there was access to meeting notes when staff could not attend. Meetings did not consistently happen at ward level. Nursing staff told us that there no regular team meetings. Managers told us that whilst there had been some team meetings prior to the COVID-19 pandemic, these had not continued in any format. We asked the trust to send minutes of the last two meetings held on each ward in the medicine service, but they could not provide these. We did see evidence of a recent meeting on the renal unit, and another in the endoscopy service, but these were exceptions. Ward level meetings did not routinely happen in the medical care service. We did see some evidence of daily team briefings held on the renal unit where patient safety issues, topics of the day and any trust updates were discussed. Copies of each brief were kept in a folder at the nursing station so staff who had not been on shift could access the information. Therapy staff told us that monthly therapy staff meetings were held which all therapy staff were invited to attend. These meetings were documented and minutes were circulated by email.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Managers used the appraisal process to identify any individual staff learning and development needs. On the renal unit there were three staff who were completing the trainee nurse associate programme after identifying this as a learning opportunity in their appraisal. In addition, therapy staff told us they held a programme of regular in-service training sessions to develop staff knowledge and skills. Senior managers told us they were promoting a skills-based approach to working, through joined up educational programmes rather than role specific. They recognised that staff in roles such as advanced care practitioners, doctors and advanced nurse practitioners had similar skills and training needs. All these groups of staff were invited to departmental teaching sessions.

Managers made sure staff received any specialist training for their role. Staff who worked on the respiratory ward completed competencies for the management of patients receiving non-invasive ventilation (NIV). This involved staff receiving training and observed practice in the care of NIV patients. Staff did not have responsibility for NIV patients until their competencies were signed off by a senior member of staff.

michelle.holly 18/06/2021 12:31:24

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Medical care (including older people's care)

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Data showed attendance at weekly multidisciplinary team (MDT) meetings was quorate without palliative care attendance for 85% of the time for lung MDTs from April to June. This meant that a specialist nurse, radiologist, consultant surgeon and oncologist were routinely meeting together to make decisions regarding recommended treatment of individual patients. In addition, we observed that there were daily multidisciplinary board rounds held on each ward. These were attended by nursing, medical and therapy staff with a purpose of sharing up to date information about patients and making shared decisions about their care and treatment plans and discharge planning. We observed that all staff had a voice during these meetings and there was effective discussion as an MDT. Therapy staff explained that although there was pressure to discharge medically fit patients, medical staff respected therapists opinions when they felt patients were not ready for discharge.

Staff worked across health care disciplines and with other agencies when required to care for patients. There were good working relationships between nursing and therapy staff and we saw that there was a holistic approach to patient care. Therapy staff worked with nursing staff to incorporate rehabilitation into routine ward activities to ensure therapy was purposeful. There was a recognition that therapy resources were limited and that nurses could incorporate a rehabilitative approach into their care based on advice from therapists. Therapy staff worked with community rehabilitation services to coordinate safe discharge and continuation of care.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression. There was a mental health liaison team who supported staff to provide appropriate care for patients experiencing mental ill health. Staff were able to contact the team 24 hours a day for specialist assessment of patients with complex mental health needs.

Patients had their care pathway reviewed by relevant consultants. Consultants completed daily ward rounds on all medical care wards. Patients would receive care on medical specialty wards where appropriate in order that they were under the care management of the most appropriate consultant.

Seven-day services

Key services were not all available seven days a week to support timely patient care.

Consultants led daily ward rounds on all wards, including weekends. Patients were regularly reviewed by consultants depending on the care pathway. However, the trust did not meet the standards within the seven-day services self-assessment tool relating to review. Trust data showed that 75% of patients on an established care pathway saw a consultant at least once a day.

Staff could not call for support from all disciplines, including therapy services, mental health services and diagnostic tests, 24 hours a day, seven days a week. Therapy services were not widely available seven days a week. Most wards had five-day therapy cover, Monday to Friday. Emergency physiotherapy cover was available for respiratory patients in the evenings and at weekends. Managers told us that the frequency of weekend working for physiotherapy staff could be as much as one or two weekends per month. In addition, therapy managers told us that there was a discharge occupational therapist and physiotherapist who worked on a rota to provide weekend cover. Since there was not the capacity in the therapy staffing resource to give staff who worked at weekends time off in the week, this meant that it was difficult to sustain weekend working for therapy services. Despite the national requirement to achieve seven day working, this was not yet in place for therapy staff. A business case was in progress, but this had not been agreed at the time of our inspection. However, the acute medical unit had therapy cover from 8am to 6pm seven days a week. This was to facilitate timely discharge and avoid unnecessary hospital admission as it was a short stay ward with a target length of stay of less than 24 hours.

Michael Reilly 14/06/2021 09:38:24

Pharmacy services were provided to wards from 8am to 6pm Monday to Friday and from 9am to 12 noon on Saturdays. There was an emergency duty pharmacist available 24 hours a day, seven days a week to provide urgent support and advice when required.

Mental health liaison services were available for 24 hour support seven days a week.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards/units. We saw information display boards and health promotion leaflets on most wards we visited. However, we did not see evidence that staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. Staff did not always document assessment of patients' lifestyles including smoking and alcohol use. We saw that this section of the nursing assessment template was often not completed. We did not see evidence in patient's records that any healthy lifestyle advice was given.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used measures that limit patients' liberty appropriately. However, not all staff had completed training in the Mental Capacity Act, Deprivation of Liberty Safeguards and Mental Health Act.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff completed mental capacity assessments in patient records where there were concerns over an individual's ability to consent to care and treatment. Staff were able to explain the process for assessing a patients mental capacity. The process was clearly documented in patient's records. For example, we reviewed the records of 14 patients who were under a DoLS application and we saw that in each case a mental capacity assessment and best interests decision had been completed.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. We observed nursing and therapy care during our inspection and heard staff asking patients for verbal consent to provide care or treatment, where they were able to provide this. In the endoscopy clinic, there were written consent processes in place and we saw these were followed in line with guidance.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. The service used a hospital passport document to identify patient's individual wishes. These were completed by the dementia team with the involvement of a patient's relative and provided information about a patient's care preferences. Best interest decision documents were completed where mental capacity assessments indicated patients did not have the capacity to make a particular decision. In the 14 records we reviewed of patients under a DoLS application we saw that best interest decisions had been recorded in all 14 records. Best interest decisions were made as a MDT and involved the patient's relatives or carers where possible.

Helen Kelly 11/06/2021 12:38:21

Medical care (including older people's care)

Staff made sure patients consented to treatment based on all the information available. We saw that there was an informed consent process in the endoscopy clinic to ensure patients had all the appropriate information about the procedure available before consenting to it. Patients told us that they had been given information about endoscopy procedures and staff had taken time before the procedure to ensure they understood the information. Information provided included the procedure process and any risks associated with the procedure.

Staff clearly recorded consent in most patients' records. We reviewed four patient endoscopy records and saw that consent to the procedure was recorded in all of these. However, staff did not always record verbal consent given for the provision of nursing and therapy care on a day to day basis.

Staff did not all receive or keep up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. The service provided data for completion of Mental Capacity Act (MCA), Deprivation of Liberty Safeguarding (DoLS) and Mental Health Act (MHA) training. Average compliance for completion of these training sessions across all staff groups in medicine was 73%. Medical staff had the lowest overall compliance for these training sessions at 44%. However, the service told us that there had been a three month pause on the delivery of this training due to the impact of the COVID-19 pandemic.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. Staff were supported in making decisions in line with legislation and guidance by the safeguarding lead. The lead had a visible presence on the medical care wards from Monday to Friday to offer specialist support and advice to staff. Staff told us that if they required advice, they could easily access the safeguarding lead.

Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them. Staff were supported in DoLS applications by the safeguarding lead who visited wards daily. They provided training, advice and support with the DoLS application process and reviewed all applications made. All staff were given a DoLS principles card on completion of training which prompted them when to consider DoLS applications and how to complete these. There was a process where the safeguarding lead reviewed records of DoLS applications made against a list of applications received by the local authority. This meant that the safeguarding lead had oversight of the number of patients in the service under a DoLS at any time.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. There was a trust intranet page which outlined the process for making DoLS applications. The process was detailed in the trust DoLS policy.

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary. Nursing quality metrics were completed monthly. MCA and DoLS documentation was audited. Following the inspection, the service provided us with audits from April 2021 to June 2021 which demonstrated on average the service was 78% compliant with these measures. This was below the trust expected standards.

Mclean,Billy
11/06/2021 12:39:21

Staff implemented Deprivation of Liberty Safeguards in line with approved documentation. We saw from the patient records we reviewed that all DoLS applications had been made in line with trust process. All staff had completed mental capacity assessments around the specific question of being able to give consent to remain in care and to care arrangements. Urgent and standard DoLS applications were made on appropriate paperwork and the dates were accurately documented.

Medical care (including older people's care)

Is the service caring?

Requires Improvement ➔🡐

Our rating of caring stayed the same. We rated it as requires improvement.

Compassionate care

Staff treated patients with compassion and kindness and took account of their individual needs. However, they did not always respect patient's privacy and dignity.

Staff were generally discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. During our inspection we saw a caring approach from staff. We saw that staff of all grades and roles talked to patients in a friendly and reassuring manner. For example, during an endoscopy procedure we heard staff explaining the process and reassuring the patient. We heard a ward hostess discussing meal choice options with patients and observed them displaying a friendly and helpful approach.

Patients said staff treated them well and with kindness. We did not have opportunity to speak with many patients during our inspection. However, comments from inpatient surveys completed from October 2020 to March 2021 included 'always treated with respect, patience and humour' 'the staff were very helpful and caring. Very professional' and 'nursing staff were very caring and understanding and respectful'. The surveys showed that for the period October to December 2020 97.4% of patients said that staff were caring and compassionate, and 96% of patients said staff treated them with dignity and respect. For the period January to March 2021, 98.1% of patients said that staff were caring and compassionate and 96.6.% of patients said they were treated with dignity and respect.

Staff did not always follow policy to keep patient care and treatment confidential. We observed incidents where we saw patient dignity was not upheld. On two occasions on different wards we saw that patients were left uncovered on the bed. We observed one patient have care provided by staff without the privacy curtains being fully closed, meaning they could be seen by staff and ward visitors.

Staff did not always demonstrate that they understood and respected the individual needs of each patient. The nursing assessment document had an option for completing generic and individualised care plans when risks or care needs were identified. We saw that these were poorly completed. None of the records we reviewed had individual care plans completed for any aspects of nursing care. Staff relied on pre-populated generic risk assessment templates which did not allow for individualisation of care planning. We were not assured that staff were considering the individual needs of patients.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Chaplain support was available 24 hours a day seven days per week. Holy communion took place every Sunday and this was able to be received on the wards for those patients not able to attend. Prayer facilities were also available for Muslim worshippers.

Marella, Holly
12/7/2021 12:08:34

Emotional support

Staff did not always have time to provide emotional support to patients, families and carers to minimise their distress. However, they understood patients' personal, cultural and religious needs.

Medical care (including older people's care)

Staff were not always able to give patients and those close to them help, emotional support and advice when they needed it. During our inspection we observed that nursing staff were very busy and had little time to interact with patients other than when providing personal care. Nursing staff in bays focused on delivering tasks and care and did not appear to have time to fully engage with patients on the ward. However, data from the latest local inpatient survey (trust wide) showed that most patients felt staff spoke to them appropriately and most staff were caring and compassionate.

Staff supported patients who became distressed in an open environment. We observed staff providing enhanced care support in cohort bays or as one to one care. There was a process for identifying patients who required enhanced care support and wards were usually able to seek additional staffing to support these patients and ensure care was safe. This meant that staff were able to focus care and attention on these patients and meet their needs. We saw one occasion where staff arranged for a confused patient who was agitated to have a television provided to enable them to watch sport. Staff recognised the patient's distress and took action to address this, which resulted in the patient becoming more settled.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Data from the latest quarterly local inpatient survey (trust wide) found that and most patients had confidence and trust in the nurses and doctors treating them and could find someone on the hospital staff to talk to about any worries and fears.

Understanding and involvement of patients and those close to them

Staff did not always appropriately support patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. In the endoscopy clinic we saw that staff took time to explain procedures both before they took place and throughout the procedure. We heard, during board rounds, doctors state they planned to talk to family members to update them on care and discharge plans.

Staff did not always talk with patients, families and carers in a way they could understand, using communication aids where necessary. Where a patient's first language was not English, we were not assured that staff always involved appropriate communication support. We understood that staff had access to interpreting services, however we saw on one ward that staff planned to use another staff member, who spoke the same language, rather than interpreting services, to support communication with a patient whose first language was not English. However, the staff member was not on shift for two days and the only communication tool staff were using was a communication sheet with 12 pictures. This was not sufficient to ensure that staff fully understood the patient's care needs.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. There was a local quarterly inpatient survey which comprised of 26 questions and a comments section. The survey was sent out on a monthly basis to a randomly selected sample of 1,000 patients, aged 18 or over, who had spent at least one night in hospital during the sample month. The results were compiled on a quarterly basis for the trust as a whole. The data was not specific to medical care wards. The latest trust wide data available for January to March 2021 showed a response rate of 36.3%. In addition, the service participated in the friends and family test (FFT) and displayed the results of these on ward quality boards. On wards we visited we saw the FFT latest data displayed for May 2021. We saw there was a response rate of around 20%.

mcleanmolly
11/26/2021 12:38:21

Medical care (including older people's care)

Staff supported patients to make advanced decisions about their care. We saw Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) forms were completed in patient records where appropriate. The ReSPECT process supports patients to identify their care and treatment wishes for the future in a situation where they may be unable to make or express choices. We saw that these choices were made through conversation between patients, their families, and staff and were recorded on ReSPECT forms stored in patients' medical records.

Staff supported patients to make informed decisions about their care. We saw in the endoscopy clinic that patients were provided with information about procedures, including risks and benefits, before undergoing the procedure. Staff were available to answer any questions they had. This meant they could make informed choices about their treatment.

Patients gave positive feedback about the service. Patient experience data from the quality dashboards showed an average compliance with this quality indicator of 94%, meaning patients felt positively about the care they received. The local quarterly inpatient survey results for January to March 2021 for the trust as a whole were mostly positive, with 72.9% of patients rating their overall experience as eight or higher out of 10.

Is the service responsive?

Requires Improvement ↑

Our rating of responsive improved. We rated it as requires improvement.

Service planning and delivery to meet the needs of the local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services so they met the changing needs of the local population. The service worked with local organisations and the wider system to identify needs of the local population. The frailty service and short stay wards worked closely with community rehabilitation and support services to ensure patients care needs were continued to be met on discharge from hospital. The service operated seven days a week to ensure that patients could be discharged in a timely manner and avoid unnecessary extended length of stays. Senior managers told us there has been a focus on public engagement, aiming to model the best care that the population will need. This work involved the clinical commissioning group to help inform planning of future services. There was work in progress to develop integrated care pathways with community colleagues.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. All wards we visited had single sex bays or side rooms with allocated single sex bathroom facilities. We did not observe any single sex breaches during our inspection. Between April to June 2021 there had been four reported mixed sex breaches in the medicine service. All of these were in the coronary care unit area of ward 24.

McLellan,Nicola
11/2021 12:18:23

Facilities and premises were mostly appropriate for the services being delivered. Wards were designed so that care could be provided in several bedded bays, or in side rooms if there was a need for patients to be treated in isolation. This was with the exception of ward 22 (short stay) where there were no side rooms. Nursing stations were situated in the heart of the ward to enable staff to observe the most vulnerable or unwell patients. However, on ward 22 (short stay) we were told that the environment made it difficult to observe patients as the nurses' station did not have a good view of patient bays. This had been escalated and additional healthcare assistant staff had been allocated to shifts to mitigate the risk.

Medical care (including older people's care)

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with acute, complex mental health problems. There was a mental health lead supported by a mental health liaison team who could provide an emergency response when required. There was specialist support for patients with learning disabilities and dementia, but this was not available 24 hours a day. For learning disabilities support there was a contracted liaison service and an inreach service based on the hospital site. The service had access to trust wide dementia specialist nurses were employed by the trust and worked across the hospital site.

The service had systems to help care for patients in need of additional support or specialist intervention. There was an enhanced patient supervision policy which identified the process for identifying patients requiring additional supervision and ensuring appropriate enhanced supervision requirements were met. There were patient boards above beds which used symbols to identify if patients had special care requirements. These symbols were also used on the patient status at a glance board which was located at the ward nursing station. Symbols were used to identify if patients had dementia, were at risk of falls or required support from specialist nurses or therapy staff.

The service relieved pressure on other departments when they could treat patients in a day. The medical care service worked closely with urgent and emergency care, the care coordination centre and the same day emergency care (SDEC) service. There were identified short stay wards and an acute medical unit which supported patient flow. There were regular site meetings involving medical care staff to review and discuss any blockages in the emergency department and how medical care could support these. Medical care reported its bed status at a daily bed management meeting which meant the hospital had oversight of bed capacity. Daily multidisciplinary board round meetings enabled staff to make timely decisions about patient discharge to ensure patients did not have any unnecessary length of stay days.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. They coordinated care with other services and providers. However, staff did not always make reasonable adjustments to help patients access services.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. There were specialist teams to support patients with mental health problems, learning disabilities and dementia. These teams visited the medical wards regularly to provide advice and support. The dementia specialist nursing team kept a database of all patients admitted to the hospital with a known diagnosis of dementia. They visited wards where these patients were receiving care to review if their care needs were being met.

The service used a butterfly icon on bedside and patient status at a glance boards to identify any patients with dementia. We saw these used routinely on wards that we visited.

We saw the use of red trays at meal times to indicate which patients needed support with feeding.

Additional resources used for dementia care included the use of activity boxes which included colouring equipment, soft toys, and games, the use of doll therapy, and the availability of electronic tablet devices for reminiscence therapy.

McClellan,Kelly
11/26/2021 12:38:21

A sensory trolley was in the process of being made available for use by patients with dementia or a learning disability.

Wards were not designed to specifically meet the needs of patients living with dementia. We did not see any environmental adaptations to wards to make them dementia friendly. The use of contrasting colours in bathrooms, clear

signage, handrails, visible large face clocks are all recognised principles of dementia friendly ward designs. We did not see any of these in use on any wards during our inspection. In addition, secure entry and exit systems to the wards were generally not in use during our inspection. This meant patients with dementia who may be confused, were at risk of being able to freely leave the ward.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. The dementia team supported staff to identify patients' preferences and interests through completion of hospital passport documents. The team worked with patients and their family to complete a document which provided nursing staff with information to help them meet dementia patients specific care needs. These documents were completed on yellow sheets and stored in Perspex holders by the patients' bedside to ensure they were visible to all staff providing care. We saw two such documents in use on one of the general medical wards we visited.

The service did not have information leaflets available in languages other than English. Staff were not able to tell us if they could access leaflets in other languages that may be spoken by the patients and local community.

Managers did not always make sure staff, patients, or patient's loved ones and carers could get help from interpreters or signers when needed. We saw that staff did not always seek the support of interpreters where necessary. There was a patient who did not receive interpreting support during our inspection as staff were relying on a staff member being able to interpret for the patient when they were on shift. However, interpreting services were available on request.

Patients were given a choice of food and drink to meet their cultural and religious preferences. If the daily food menu did not provide a suitable meal choice, staff told us that a special request could be made to the kitchen for an alternative meal.

Staff had access to communication aids to help patients become partners in their care and treatment. However, the example we saw of one communication sheet used was very basic and was not sufficient to fully support communication around patient care needs.

Access and flow

People could not always access the service when they needed it and did not always receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards.

Managers monitored waiting times but were not always able to make sure patients could access services when needed or receive treatment within agreed timeframes and national targets.

Incomplete Referral to Treatment (RTT) pathways:

As of April 2021, the trust ranked 16th out of the 21 non-specialist acute trusts in the midlands, for the proportion of patients on incomplete pathways that had waited less than 18 weeks. This meant they were not performing well against the requirement to treat patients within 18 weeks of referral for incomplete pathways.

Mclellan, Holly
11/10/2021 16:38:51

Data provided for the number of incomplete pathways where the patient had been waiting more than 52 weeks, showed the trust had no such waits from November 2019 to February 2020. However, during the pandemic the number increased considerably, reaching 3,295 in April 2021. This had reduced to 2,925 in May 2021 demonstrating that performance was improving.

Medical care (including older people's care)

As of April 2021, the trust ranked 9th out of the 21 non-specialist acute trusts in the midlands for the proportion of patients on completed admitted pathways that had waited less than 18 weeks. This meant the trust was performing similar to the overall midlands and England performance for referral to treatment times for completed admitted pathways.

Complete Referral to Treatment (RTT) pathways:

The number of completed admitted pathways where the patient had been waiting more than 52 weeks for treatment was three, from November 2019 to February 2020. During the pandemic the number increased considerably, reaching 160 in October 2020. In April 2021 the number waiting more than 52 weeks was 154 meaning improvement in reducing wait times for completed admitted pathways was slow.

As of April 2021, the trust ranked 4th out of the 21 non-specialist acute trusts in the Midlands for the proportion of patients on completed non-admitted pathways that had waited less than 18 weeks. This meant that the trust performed better than the overall midlands and England performance for referral to treatment times for completed non-admitted pathways.

The number of completed non-admitted pathways where the patient had been waiting more than 52 weeks for treatment was zero from November 2019 to March 2020. During the pandemic the number increased considerably, reaching 253 in March 2021. By April 2021 this had reduced to 181 demonstrating that performance was improving.

Managers and staff worked to make sure patients did not stay longer than they needed to. From March 2020 to February 2021 the average length of stay across all medical specialties was similar to or lower than expected based on the England average, for both elective and non-elective admissions at both hospital sites in the trust.

The trust had a 'Sath2Home' service which was a domiciliary care bridging service which allowed patients to return home if their care could not be sourced in a timely manner. The service supported the reduction in length of stay (LOS) by facilitating discharge at short notice to ensure patients were discharged in line with national discharge guidelines. Sath2home supported patients who were discharged home where the local authority could not provide care. They also provided bridging support to patients who did not qualify for local authority care support. Managers told us that the impact was a reduced length of stay for complex patients who were medically fit for discharge.

Managers monitored the number of delayed discharges, knew which wards had the highest number and took action to prevent them. From November 2020 to May 2021, the percentage of delayed discharges fluctuated over time. As of May 2021, the percentage of delayed discharges across the trust was 55.5%. Compared to other trusts in the Midlands region, the percentage of delayed discharges over time has been better than most trusts. The service monitored stranded (those in hospital more than seven days) and super-stranded (in hospital more than 21 days) patient numbers. The trust provided data for stranded and super-stranded patients within the medical service, although this was not split by hospital site or ward. The data showed that from January to June 2021 there were an average of 290 stranded and 49 super-stranded patients on medical wards. There were weekly LOS meetings that reviewed all stranded and super-stranded patients in the hospital. This enabled staff to work in a targeted way with patients who were not medically optimised for discharge. This included support for the clinicians from the medical directors to unblock or remove barriers and working with system partners to flag patients who required escalation to support their discharge.

Michael Kelly 11/06/2021 12:38:21

Medical care (including older people's care)

The complex discharge team routinely visited medical wards and had conversations with nurses and therapists on each ward to identify any blockages to patient flow. They reviewed the patient status at a glance boards with staff. There were twice daily board rounds on the short stay wards and close working with the emergency department to give a clear picture for the day of admissions and discharges. However, staff told us that patient flow was impacted by the lack of a discharge lounge facility.

The service moved patients only when there was a clear medical reason or in their best interest. Managers told us that they tried to avoid moving patients where possible. However, they recognised that patients were sometimes moved to different wards in order to facilitate patient flow. Managers monitored the number of patient bed moves. Data showed there was an average of 1429 patient ward moves per month on medical care wards from January to June 2021. Ward moves should be limited per admission, but the service did not provide information about average number of ward moves per patient on the medical wards. The service did not provide any information about how ward move data was used to reduce the number of ward moves per patient.

Staff did sometimes move patients between wards at night. Data provided following our inspection showed that there was an average of 392 patient ward moves at night per month on medical care wards from January to June 2021. Night-time moves were moves between the hours of 10pm and 8am. Night moves can be disorientating for elderly and confused patients and should be avoided unless it is essential for the persons care. We saw that as a total of all ward moves, 27.5% of moves happened at night. The service did not provide any information about how night moves data was used to try and reduce the frequency of night moves.

Managers and staff worked to make sure that they started discharge planning as early as possible. The service had a pro-active team work approach to start conversations around discharge planning with complex patients and family before they were medically fit. There were six patient journey facilitator staff employed across the hospital, some of who supported the medical service. They worked from 8am to 4pm Monday to Friday and on Saturdays on a rota basis. Their remit was to support the ward with all aspects relating to the patient journey and discharge. This included transport arrangements, chasing diagnostic test results, to take out (TTO's) medication, chasing patient discharge summaries, and liaising with families, care providers and external stakeholders. They linked in with the integrated discharge team hub to ensure planned discharges happened in a timely manner. We were told that these staff attended daily board rounds and huddles, however, we did not see them in attendance at the board rounds we observed during our inspection. There were integrated health and social care teams on the hospital site which supported discharge planning. Managers told us this improved the timeliness of exchange of information and decision making in relation to discharges through co-location and joined up working.

Managers made sure they had arrangements for medical staff to review any medical patients on non-medical wards. Junior doctors explained that there was a system for identifying any medical patients who were outliers on non-medical wards. There was a process to ensure outlying medical patients received regular medical review in line with policy and guidance.

Learning from complaints and concerns

It was not always easy for people to give feedback and raise concerns about care received. However, the service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Mr Shan Hollis 1126262 2022-08-24 22:38:21

Patients, relatives and carers did not always know how to complain or raise concerns. The service did not clearly display information about how to raise a concern in all patient areas. Complaints information was not visible in the form of leaflets or posters on some wards we visited. Staff told us that leaflets were available to patients which outlined how to

complain but on one ward when the manager showed us where these should be the leaflet rack was empty. Results from the latest local inpatient quarterly survey (trust wide data) showed that only 13.7% of patients said they saw, or were given, any information explaining how to complain to the hospital about the care they received. However, there was information on the trust website which told patients how they could raise concerns or make a complaint.

Staff understood the policy on complaints and knew how to handle them. Staff we spoke with explained that there was a local resolution approach to any concerns or complaints raised. This was encouraged for any concern that could be dealt with immediately and may be resolved quickly by members of staff who were directly involved in the patient's care. Where local resolution was not possible or appropriate, staff said they would refer the complaint to their immediate manager. All written complaints received by staff had to be forwarded to the trust complaints department.

Managers investigated complaints and identified themes. Managers explained that they were responsible for investigating complaints relevant to their clinical area. All complaint responses were collated by the complaints department and numbers of complaints and any themes were detailed in the patient and liaison service (PALS), complaints and patient experience quarterly reports. The latest report provided which was for January to March 2021 showed that the trust received a total of 183 complaints, which equated to 0.89 in every 1000 patients complaining. Of the 121 complaints closed during quarter four, 20% (24) were not upheld, 55% (67) were partly upheld and 25% (30) were fully upheld. There were 114 complaints in progress in the medicine and emergency division identified in the quarterly report. Of these, 71 were cases where the final response was overdue. Key themes included staff values and behaviours, patient care, communication, admission and discharge and clinical treatment.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. The process for investigating complaints was set out in the trust complaints policy. Investigating managers were required to review patient's health records and any information obtained from statements or interviews conducted with staff. The manager then was expected to identify actions and learning arising from the complaint and produce a written response within the expected deadline. The response period for complaints varied from 30 to 60 days and depended on the complexity of the complaint and level of investigation required. We saw copies of recent complaint investigations and patient responses that the service had completed which were comprehensive and in line with the policy.

Managers shared feedback from complaints with staff and learning was used to improve the service. The quarterly PALS, complaints and patient experience reports identified any learning from complaints investigations and actions that had been taken as a result. The report also included patient stories which provided insight of personal experiences of care within the trust. Managers told us the stories were powerful tools which could help to improve understanding and learning. Managers told us that complaints were discussed at daily safety huddles and in team meetings, where these happened. This provided further opportunity for learning.

Staff could give examples of how they used patient feedback to improve daily practice. We saw that there were ward display boards which highlighted any learning from complaints and actions taken to make improvement. Ward managers produced and shared synopsis episode of care documents relating to complaints received. These were discussed at safety huddles and identified what went well and areas for learning and improvement.

Nicholson, Holly
11/06/2021 15:58:21

Is the service well-led?

Requires Improvement

Medical care (including older people's care)

Our rating of well-led improved. We rated it as requires improvement.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The medical care core service sat within the Medicine and Emergency Care division. The division was strategically led by a triumvirate made up of a Divisional Medical Director, Divisional Director of Operations and Divisional Director of Nursing, and centre managers. The triumvirate told us they worked well together and had received positive feedback from staff about their visibility and approachability. They said staff knew who the triumvirate were and that they could raise concerns to them. The triumvirate team held divisional meetings to get communications across to teams and listen to what staff want from them as a leadership team. They told us staff could speak honestly with them and be heard. There was transparency in their approach. When we spoke with staff on wards there was a mixed response to questions about the visibility of the senior leadership team. Whilst some managers said they were aware of who they were and felt they were visible, some ward staff reported that they had no knowledge of who the senior team were or what they looked like.

Local leadership was provided by matrons and ward managers. Staff told us that their ward managers were supportive and that they saw their matron most days. Matrons were visible, supportive, and approachable. There were quality matrons with specific portfolios such as safeguarding and falls who supported the matron team. The quality matrons visited the wards daily and worked with matrons and ward managers on any identified areas for improvement. They described a consistent single team approach where staff felt empowered to talk to matrons and escalate concerns. There were weekly matron meetings to share improvements and issues of concern. The matrons were given the opportunity to enhance their leadership skills through a leadership programme offering leadership master classes. All matrons were invited to regional and national forum groups where they had the opportunity to talk about leadership.

The divisional leadership team had focused on developing matrons and ward managers competence. The senior team provided guidance to support matrons skills and confidence to review incident investigations. In turn ward managers were supported to develop skills in identifying incident themes and action planning with more confidence than before.

There were lead nurses for mental health, dementia and safeguarding who provided trust wide guidance and direction on their specialist area. They promoted the implementation of best practice and provided specialist advice. Staff knew about the specialist lead nurse roles and told us these staff were accessible and acted as a useful resource.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

McLellan, Kelly 11/26/2021 12:39:21

The division had a vision ‘to provide excellent care for the communities we serve’ and this was aligned to the trust values and behaviours of Partnering- Ambitious -Caring- Trusted (PACT). There was a medicine and emergency divisional, strategy, people plan and behaviour framework. The document set out a strategy with eight pillars and identified the priority areas and next steps in achieving these. A people promise set out outcomes, priorities and principles for supporting staff to enable safe patient care. There was a recognition that effective communication was vital to help drive change within an organisation and build a desirable reputation. This resulted in a divisional

communication plan aimed at making sustained changes, building trust and understanding. The plan was designed to share key messages with staff and give them opportunity to provide feedback. The strategy identified a range of quality metrics and a milestone action plan to measure success of achievement of strategy. Progress against these were reviewed at monthly meetings.

The strategy fed into the overall trust strategy which was developed through a multi-faceted process including staff engagement, needs analysis and external inputs (such as national guidance, local population health inequalities and the local integrated care system). The trust strategy was sent out for public and stakeholder engagement once a draft version had been approved.

At a ward level there were specific visions and achievements displayed which had been developed by staff on the wards. Each ward had a board displaying successes, aspirations, learning and pride and joy. Managers told us that the aspirations were agreed as a team based on current ward issues and desired areas for improvement or achievement.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff told us they felt supported, respected and valued by their ward managers and matrons. Managers told us there had been investment in staff wellbeing and development and that staff wellbeing and morale was one of their top priorities. They gave an example of the 'catch a breath' trust campaign which recognized the need to create safe and calm spaces for staff to have a break. This provision had a positive impact on staff wellbeing. Managers said they do not wait for the staff survey to find out what staff think. They actively go to staff areas and ask how they are feeling and what the issues are for them.

There was a range of wellbeing support available to staff through human resources, such as the trauma risk management (TRIM) helpline, suicide bereavement and the staff wellbeing psychological hub.

Junior doctors told us there was a focus on wellbeing and that they received wellbeing support. Consultants were available, approachable and supportive and invested time in teaching and developing junior doctors.

International nurses said that they had been well supported during their transition to working in the UK. All grades of staff had been helpful and welcoming, and they had not experienced any racial discrimination. There was an international nurse lead and they worked alongside the trust freedom to speak up guardian and assigned nurse ambassadors to support new international nurses.

There was a culture of team working where all grades and disciplines of staff were respected. Therapy staff, nursing staff and medical staff all worked well together with a holistic approach to patient care.

McLellan, Lilly 11/06/2021 12:39:21

Some therapy staff told us they felt demoralised as the staffing levels impacted on the amount of time they could spend with patients. They felt they were not always able to see all appropriate patients or do a good job. Middle managers for therapy services were visible and supportive but senior therapy managers were not regularly seen as they were based at the Telford hospital site.

We reviewed the 2020 NHS staff survey results for the medicine and emergency division. The service performed below the national average for five areas: health and wellbeing, quality of care, safe environment (bullying and harassment),

staff engagement and teamwork. There was an improvement action plan based on the staff survey results which had been presented to staff. The service did not provide evidence of its progress in achieving the actions highlighted in the plan. The triumvirate were focused on investing in the workforce and addressing behaviours to shift the culture. A behavioural framework has been developed by consulting all staff groups. The framework formed part of the divisional strategy and held people to account. Managers said the framework empowered teams to have a voice and influence change. They recognised that there was still work to do to embed and sustain changes in culture.

The service had an open culture where patients, their families and staff could raise concerns without fear.Most staff felt able to report concerns to their managers, but they also had the option of the freedom to speak up guardian (FTSUG) route. From April to June 2021 there had been 95 concerns raised with the FTSUG across the trust. 45 of these had related to behaviour, which double the number of the previous quarter. A contributing factor for the increase was that the FTSUG had done drop-in sessions for teams which had raised staff awareness. Various actions had been taken to address these concerns including escalation, involvement of human resources, mediation, values and behaviours workshops and roll out of a trust wide cultural programme 'Making a Difference Together'.

The service promoted equality and diversity in daily work and provided opportunities for career development. Staff told us there were opportunities for progression including taking on lead roles, leadership training and opportunities such as the nurse associate programme.

Governance

Leaders did not always operate effective governance processes throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities. However, not all ward staff had regular opportunities to meet, discuss and learn from the performance of the service.

There were governance frameworks in place to provide oversight of quality and safety performance, however, we were not assured they were sufficiently robust in consistently maintaining standards. Nursing quality audits were completed monthly and the findings were discussed at weekly meetings between matrons and ward managers. Quality performance issues were raised, and the quality matrons worked with ward managers to identify actions for improvement. We found that there was consistently poor performance in some nursing quality metrics which had not improved despite the agreed actions. Matrons told us they were aware of issues with completion of fluid balance charts and had done a piece of work to raise awareness and target improvement of this. However, during our inspection we found poor compliance with completion of fluid balance charts. Quality and safety performance data was routinely reported to the board through divisional governance meetings. Although there were systems in place to collect, monitor and report quality and safety performance, these were not always effective.

There were clear systems for reporting, investigating and learning from incidents.

Clinical and divisional leaders attended monthly divisional meetings where senior managers discussed performance, quality, risk, governance and human resources. Arrangements supported the cascading of information from board to ward level. The medicine and emergency care division committee meeting took place monthly and was attended by senior divisional leaders. Information was cascaded through divisional matron and ward manager meetings, medicine safety huddles and ward meetings and daily ward safety huddles. During our inspection we found that ward meetings were irregular and, in most areas, had not happened for some time. However, we saw that daily ward safety huddles were commonplace and were an opportunity for sharing board level information with ward staff. We were not assured that all staff received relevant information in a consistent and timely manner.

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Speciality governance meetings took place and we saw these were well attended. These covered performance, quality and mortality reviews. We saw there were processes in place to align these to divisional meetings.

Mortality and morbidity meetings took place and fed up to divisional meetings. These meetings were well attended by a wide range of clinical and operational staff and followed a set agenda.

Management of risk, issues and performance

Leaders and teams did not use systems to manage performance effectively. They did not identify and escalate all relevant risks and issues nor identify actions to reduce their impact. There was no evidence that staff contributed to decision-making to help avoid financial pressures compromising the quality of care. However, the service had plans to cope with unexpected events.

The service provided the medicine division risk register which identified three divisional risks. One around the suitability of ward kitchen facilities was red RAG rated and two others were amber RAG rated; one around the impact of kitchen refurbishment and one around staff room facilities. When we asked senior managers about their top risks in the division, they told us these were around medical and nursing staffing and staff skill mix and competence. However, this was not identified on the divisional risk register provided to us. We did see reference to other risks in the minutes of a divisional committee meeting, but these were not listed on the risk register document provided to us following our inspection. Divisional committee meeting minutes showed that risk was discussed as a standing agenda item. In February 2021 minutes stated that no new risks had been added to the risk register as there was no operational risk group. However, managers told us the division met bi-monthly to review the risk register and update it with actions and mitigations. However, these meetings were not minuted. Managers also told us risks were reviewed at a divisional operational group quarterly for oversight, but no evidence of this was provided. Minutes for the divisional committee meeting in March 2021 detailed a review of existing risks with a score of 15 and above. In April 2021 the minutes stated there were no new risks but there was no review of existing risk. Minutes of a ward managers and divisional matrons meeting did not evidence any review or discussion of risk. We were not assured that divisional review and oversight of risk processes were effective.

Managers recognised staffing was the major risk to the service and the hospital as a whole. There were recruitment and retention initiatives in place to attempt to mitigate the risk. Overseas recruitment, close working with the deanery and securing additional finances had all proved successful. However, it was recognised that shortages were still seen in key roles and there was reliance on agency staff.

The service had a nursing and quality performance dashboard which included outcomes from audits, patient safety outcomes, infection prevention and control compliance, medicines management audit, training and staffing data. This was used by the division to monitor performance. Managers told us they had regular meetings with their matrons and divisional director of nursing to discuss ward performance and set actions for improvement. This data was incorporated into the integrated performance report which went to the trust board and quality and safety board. We saw ward individual performance was displayed on most wards we visited. However, we did not see evidence of monitoring of improvement plans in relation to patient outcomes in divisional governance and committee meetings. We saw specialities reported into these meetings, however, did not provide updates on quality performance. There was no process for monitoring progress with any action plans for improved performance.

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Performance in national audit outcomes was not integrated into the governance structures. There was no evidence of discussion of actions to address performance concerns in divisional governance or committee meeting minutes.

Medical care (including older people's care)

We were not assured there was effective oversight of the performance of local and national audit or that improvement action plans were regularly reviewed, and their progress monitored.

Although matrons and senior managers told us that staff could talk to them and escalate concerns, had a voice and felt empowered, we did not see evidence that staff were able to actively contribute to decision making about service delivery.

There were business continuity plans in place to maintain delivery of services in the event of planned or unplanned closure.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Information technology systems were used to monitor delivery and outcomes of patient care. A wide range of information was available to enable managers to assess and understand performance in relation to quality, safety, patient experience, human resources, operational performance and finance. Access to all electronic systems was secure and required password access.

There was an electronic system that recorded patients observations and allowed nursing staff to monitor change over time. This data was automatically uploaded to the electronic performance dashboard system. All safety and quality audit performance was recorded on the electronic performance dashboard which ward managers had access to. Performance outcomes were RAG rated to identify areas of compliance and concern. Managers could see their own ward performance information as well as that of other wards so it could be compared. The dashboard tracked performance over time and enabled staff to identify any areas of worsening performance.

The trust shared data securely with the Care Quality Commission and other agencies in accordance with legislation. Serious reportable incidents were reported when they occurred in line with the National Reporting and Learning System (NRLS) requirements.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Most staff and managers we spoke with said there had been opportunities to feedback to senior managers and trust wide managers. Managers held drop-in sessions for engagement so that staff felt listened to and able to raise concerns. Freedom to speak up guardians had offered drop-in sessions to increase opportunities for engagement with staff. Examples of actions taken following engagement were plans to improve staff break areas and putting air conditioning in place in specific areas to improve staff wellbeing.

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The freedom to speak up guardian reports to the board demonstrated that staff were speaking up, including junior doctors, therapy staff and nursing staff.

Managers used the values and behaviour framework to engage with staff. Staff had opportunity to contribute to the framework and identify acceptable and unacceptable behaviours.

Medical care (including older people's care)

Most staff told us they felt engaged with by the service managers.

Patient feedback was collected and used to shape services. The service used the friends and family test (FFT) feedback, local inpatient surveys, 'gather' (matron and senior nurse weekend checks) and exemplar feedback to gather information on patient experience of the services the hospital provided. In addition, patients could provide feedback through the feedback hub on the trust website through submitting a feedback form, sharing their story (through text, audio and video options), completing an FFT survey online, through completing a survey, or raising a concern or sharing feedback. There was a patient experience team who produced quarterly reports that collated all patient feedback along with any themes from complaints and compliments. The report was presented to board and widely shared with staff across the trust. It identified learning and any actions required from the feedback. Priorities for next steps to improve patient experience were also highlighted.

There was a patient and carer experience panel which consisted of public and staff representatives who worked together in a collaborative approach towards quality improvement and patient experience within the Trust.

The patient experience team worked closely with other local providers and charitable organisations to implement improvements for patient experience.

The trust engaged with key stake holders through attendance at council meetings in the development of their operational plans and local strategic initiatives. There was regular engagement with the local clinical commissioning group to review the service delivery to ensure it was satisfactory and met the needs of the local population.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. However, there were areas identified for improvement at our last inspection which were still of concern.

All staff we spoke to were committed to making improvements. The service leaders as a team were in their infancy but recognised the need to drive improvement across the service. They understood the issues within the service and were committed to improving the quality and safety of the service. Leaders engaged staff when making improvements.

During our inspection we found there were some improvements since our previous inspections in 2019 and 2020. For example, staff felt more supported by senior management. There were improvements in the completion and quality of mental capacity assessments, best interest decisions and applications for deprivation of liberty safeguards. There was more focus on supporting patients living with mental ill health and dementia and specialist roles had been developed to support staff in managing patients living with these conditions. However, we found there were continued breaches consistent with findings in previous inspections. For example, there were continued concerns around individualised care planning, completion of fluid balance charts, and completion of risk assessments such as nutrition and falls. Whilst we saw some improvements had been made in some areas within the service, the pace at which the improvements were being made was slow and areas of required improvements were not consistently addressed. This raised concerns of on-going risk of harm to patients.

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End of life care

Inadequate ● ➔🡐

Is the service safe?

Inadequate ● ➔🡐

Our rating of safe stayed the same. We rated it as inadequate.

Mandatory training

The service did not always provide mandatory training in key skills to all staff or make sure everyone completed it.

Staff did not always receive and keep up to date with their mandatory training.

Mandatory training was largely delivered through the online learning portal but was not comprehensive to meet the needs of patients and staff. The trust mandatory training target was 90% but not all staff groups within end of life and palliative care met this target. Overall compliance for the team was 84%. Mandatory training requirements were different for the various members of the team. For example, the mortuary staff were not required to undertake infection prevention and control training. We requested further clarification from the trust but did not receive it. Data submitted by the trust showed palliative care doctors had not completed updated training for two out of the eight mandatory modules, which included fire safety and equality and diversity. Overall compliance was 75%.

Clinical staff did not always complete training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia.

Bereavement and chaplain staff did not receive Mental Capacity Act, Deprivation of Liberty and Mental Health Act training. This had the potential to affect patient care and lead to serious safety risks amongst the bereavement and chaplaincy services.

Safeguarding

Staff understood how to protect patients from abuse, however they did not always have training on how to recognise and report abuse or how to apply it.

Staff did not receive training appropriate to their role on how to recognise and report abuse.

The intercollegiate document 'Adult Safeguarding Roles and Competencies for Health Care Staff' 2019, states that all practitioners who have regular contact with patients, their families, carers or the public should complete level 2 Safeguarding Adults training.

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The trust target was 90% for Safeguarding Adults level 2, but not all staff groups met this target for their mandatory training. Overall compliance for the end of life and the specialist palliative care team was 88%. Mandatory training requirements were different for the various members of the team. At the time of our inspection data showed palliative care doctors had not had update training for safeguarding children level 2, PREVENT level 1 and had not completed PREVENT level 3. The bereavement and chaplain staff were not required to undertake this training despite the requirement as outlined in the intercollegiate document.

End of life care

The intercollegiate document 'Safeguarding Children and Young People: Roles and Competencies for Health care staff' 2019 states all non-clinical and clinical staff who have any contact (however small) with children, young people and / or parents/ careers or any adult who may pose a risk to children should complete level 2 safeguard children training. This had the potential to affect patient care and pose serious risks to patients due to staff not being able to recognise safeguarding concerns.

Staff knew how to make a safeguarding referral and who to inform if they had concerns but were unable to describe recent safeguarding referrals or any subsequent learning following them.

Cleanliness, infection control and hygiene

Staff used infection control measures when visiting patients on wards and transporting patients after death.

Ward areas we visited, and the mortuary were visibly clean and had suitable furnishings which were clean and well-maintained. However, staff did not always follow infection control principles. Staff were aware of current infection prevention and control guidelines, including the process for screening patients for COVID-19, MRSA and Clostridium Difficile, prior to and during an admission to wards. Staff observed social distancing where this was possible and wore appropriate PPE. There were handwashing facilities and PPE stations on wards we visited, which were well stocked and included information on PPE requirements.

Most cleaning records were up-to-date and demonstrated that most areas were cleaned regularly. However, cleaning records for the mortuary were not fit for purpose as they showed only signatures of the staff whom had carried out the cleaning. Staff were not able to describe effective cleaning processes and were not able to articulate deep cleaning requirements for these high-risk areas. There were no policies or procedures to outline the cleaning requirements for the mortuary. This posed a significant risk of infection spreading to the immediate mortuary staff and throughout the hospital.

Inspectors raised these concerns immediately with the trust and the provider developed a draft cleaning process following inspection.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff managed clinical waste well.

The mortuary had an additional designated external entrance, set in landscaped gardens and would be accessed by families and loved ones. This entrance was effectively designed and bright and airy. The mortuary had capacity for 96 patients, which included four freezer spaces and nine bariatric body stores.

Transport and security measures in relation to the mortuary were effective. Patients were transported to the mortuary by porters and all staff accessing the mortuary were required to log entry at all hours of the day and night. Records were up to date and completed

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appropriately. Thermostatic temperature checks for all of the refrigerated body stores checks were monitored electronically and linked to a central alarm system should one of the fridges detect a significant change in temperature.

End of life care

The service had suitable facilities to meet the needs of patients' families. However, side rooms were limited on the wards and demand for these rooms was high when dealing with infection control issues. The hospital had several SWAN rooms which were specifically developed and designed rooms to support patients receiving end of life care. The Royal Shrewsbury Hospital had 14 SWAN rooms, one of which was unavailable at the time of inspection due to maintenance issues.

End of life resource boxes which were designed and provided by the end of life team, were available on all wards we visited. These boxes had recently been introduced to assist ward staff with advice and support across all areas of palliative and end of life care.

The service had enough suitable equipment to help them to safely care for patients. The service used specialist syringe drivers for patients who required a continuous infusion of medication to help control their symptoms. Staff explained there were occasional difficulties obtaining the syringe drivers, but the availability had generally improved.

'Grab and go' boxes were introduced across all wards which contained relevant equipment to make up two syringe drivers.

Staff disposed of clinical waste safely. We observed that waste was segregated appropriately between clinical and non-clinical waste.

Assessing and responding to patient risk

Staff completed risk assessments for each patient and removed or minimised risks, however risk assessments were not always reviewed regularly. Staff did not always identify and act upon patients at risk of deterioration

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Risks assessments for each patient were completed upon admission but some assessments were not reviewed consistently.

Specialist palliative care nurses and end of life nurses were accessed through separate referral processes. Ward staff were required to make a manual telephone referral as the trust did not operate an electronic system. Risks were not routinely requested or reviewed at this stage.

Some end of life patients were identified through the electronic system, as they had been assessed as requiring 'no observations'. This meant patients were often at the very end stage of their lives before they would be known to the palliative and end of life teams.

The service's application and use of ReSPECT forms still needed to improve. A trust wide audit of the use of ReSPECT forms was carried out in May 2021 and signed off in August 2021. It showed personal preferences were only completed 80% of the time but 59% of these did not have capacity, so it should not have been completed. It also showed evidence of a ReSPECT discussion was only present in 64% of patient notes. The audit also highlighted only 53% of patients had any involvement in the making of their plan and only 42% was discussed with others when the patient themselves did not have capacity.

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The criteria for referral to the end of life team was the patient was deemed to be in the last 72hrs of life. There was no oversight across the whole of the hospital of all end of life or palliative patients, this posed a significant risk that individuals requiring intervention, did not receive it.

End of life care

The service had still not established an effective system to ensure the identification of all patients who were at the end of life. Following inspection, the provider developed an action plan which included plans to address this.

Most staff shared key information to keep patients safe when handing over their care to others. However, during shift changes and handovers staff did not include all of the key information to keep patients safe.

The specialist palliative care and end of life teams carried out a 'huddle' each morning to identify which patients were to be seen within the hospital. Specialist palliative care staff explained they did not use a clinical triage system to determine patient prioritisation or acuity. Basic information such as the name of the patient, reason for the referral and the name of the member of staff, whom was making the referral, was recorded. In the absence of a clinical triage process there was a potential risk to patients, who were at greatest need or at the highest risk, may not be prioritised effectively. Staff explained they would always try and see everyone, but this decision was not made on clinical need.

Nurse staffing

The service did not have enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

All staff throughout the hospital delivered end of life and palliative care but were supported by a dedicated end of life care team and a specialist palliative care team. These teams worked across both the Royal Shrewsbury Hospital and Princess Royal Hospital sites.

The end of life care team consisted of a whole time equivalent (WTE) band 7 end of life care facilitator and three band 6 end of life care specialist nurses. These nurses equated to the equivalent of 1.8 (WTE) staff and provided end of life cover across sites from 8.30am to 4.30pm. No cover was provided on Friday afternoons.

An administrative assistant provided WTE 0.8 band 3 support. There were no vacancies within the end of life team at the time of inspection.

Nursing staffing levels still did not meet the minimum standard of the National Institute of Health and Care Excellence (NICE). These standards state access to specialist palliative care should be made available seven days per week. The specialist palliative care team consisted of six WTE band 7 clinical nurse specialists (CNS), two of whom has been recruited recently. The six nurses worked across both sites and provided a service Monday to Friday 8.00am – 6.00pm and staffing was adjusted throughout the week to meet the needs of the patients across both sites. Out of hours cover, including weekend cover, was provided through an on-call service at a local hospice.

Staff explained that plans were in place to offer specialist palliative nurse cover, seven days per week from September 2021. This would include a palliative care team leader who would manage the specialist palliative care nurses and the end of life care team.

Medical staffing

The service did not have enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Although, managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

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The trust employed 0.9 WTE palliative consultant who provided cover to both the Royal Shrewsbury Hospital and the Princess Royal Hospital sites, Monday to Friday. The cover was provided on site for four days of the week and one day remotely.

End of life care

In addition, one palliative medicine consultant was employed by a local hospice who provided the equivalent of 0.4 WTE cover to the trust. However, this position was a fixed term contract which was due to end in July 2021. There were no arrangements in place to provide ongoing cover after this time.

Improvements in respect of consultant cover had been made but medical staffing levels still did not meet the minimum standard of the Royal College of Physicians (RCP), which requires 1.4 WTE consultants based on the size of the trust and level of patient activity. Cover had been increased from 0.8 WTE to 1.3 WTE despite difficulties in recruiting. The trust had secured a budgetary increase to 3 WTE which they were currently recruiting too, however there was a shortage nationally.

Medical staffing recruitment was an ongoing challenge for the trust and several attempts to fill an additional substantive palliative care consultant post had been unsuccessful.

Records

Staff did not always keep detailed records of patients' care and treatment. Records were not always clear, and up-to-date. However, records were stored securely and easily available to all staff providing care.

The trust utilised paper-based records for assessment and care planning with vital observations such as blood pressure monitoring, oxygen saturation and pulse recordings logged electronically.

Patients receiving end of life care were commenced on the 'Caring for adults in the last few hours and days of life' care plan. However, as patients were not identified as requiring end of life care until 72hrs prior to death, this documentation was not completed prior this point.

We reviewed trust guidance provided to staff to support them with the completion of the 'Care of the dying care plan' document and saw that guidance did not define appropriate timescales for the necessary completion of the document. This resulted in the care plans being incomplete which potentially impacted on the safe care and treatment patients received. We saw two examples of the original version of the care plan in use, however the document had not been fully completed. In addition, recommended summary plans for emergency care and treatment patients (ReSPECT) plans were not in place. ReSPECT includes a plan for future care to guide health professionals to providing the appropriate care and treatment. A new updated version of this care plan was to be piloted at The Princess Royal Hospital, at the time of inspection.

The trust had not made improvements to ensure staff had access to the information they needed to provide person centred care. Patient records did not include a complete and accurate record that described patients' individual needs and preferences.

We saw patients receiving specialist palliative care support, who did not have bespoke documentation and any intervention provided by the team was recorded within the patient's medical records, which posed a risk that this documentation would be missed.

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We did see evidence of patients preferred place of care and do not attempt cardio-pulmonary resuscitation (DNACPR) discussions in patients' notes and completed capacity and consent records in both records.

Records were located at the nurse's station and were stored securely.

End of life care

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines. However, medicines were not always provided in a timely manner.

Staff followed systems and processes when safely prescribing, recording and storing medicines. A pharmacist visited wards Monday to Friday to review prescribing of medicines including palliative care and end of life care prescribing. The pharmacy team checked patient's medicines to ensure they were prescribed correctly, any discrepancies were identified and highlight to the relevant teams.

There was a medicines advice and supply service available seven days a week. An on-call pharmacist was available outside of core working hours.

Prescribing guidelines for anticipatory end of life care were available on the trust intranet. This included information on the medicines available and information on prescribing.

Anticipatory end of life medicines were available on all wards visited.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. Patient's allergies or known sensitivities to medicines were documented on all the medicine records reviewed.

Patients' weights were documented on all the medicine records reviewed.

Pharmacists checked that prescribed medicines were compatible when syringe drivers were used.

Pharmacy provided counselling and support to patients and carers to explain changes in medicines or when new medicines were started and allow them to raise concerns and ask questions.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. Medicines were stored in dedicated secure storage areas with access restricted to authorised staff. Medicine trolleys and patient's bedside lockers were also used.

Controlled drugs were stored and recorded following policy. Daily checks were undertaken, and any discrepancies were investigated.

Staff followed current national practice to check patients had the correct medicines. Prescribed pain relief medicines were checked by a pharmacist to ensure the correct pain relief was prescribed. However, we saw delays in patients receiving prescribed analgesia.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Any medicine incidents would be reported onto the incident reporting system. Learning from incidents and any medicine alerts would be shared across the trust.

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Incidents

The service generally managed patient safety incidents well. Staff recognised and reported incidents and near misses. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers shared lessons learned with the whole team and the wider service.

End of life care

At the last inspection in June 2020 the trust were told they must ensure effective systems are in place to share learning from incidents to prevent further incidents from occurring. We requested the last ten incidents which were reported under end of life or palliative care and we saw there were themes associated with a delay in verifying death, the environment in which end of life was delivered and medicines management, with the remaining incidents varying in theme.

Staff knew what incidents to report and how to report them. We reviewed an incident on ward 28 relating to care of the deceased. Staff explained how the incident was investigated swiftly, and action taken to mitigate further incident. Staff were encouraged to reflect on the events of the incident and share learning across the ward.

We reviewed the minutes of the last end of life steering group meeting and saw that incidents were regularly discussed and reviewed.

We saw evidence of shared learning on most of the wards we visited and actions were taken by the hospital to improve services. However, not all staff, we spoke with, delivering end of life or palliative care were unable to identify incidents that had recently occurred within the speciality and we did not see any overarching trust action plans to address themes emerging across the speciality. For example, care of the deceased.

Is the service effective?

Inadequate ● ➔ 🡐

Our rating of effective stayed the same. We rated it as inadequate.

Evidence-based care and treatment

The service did not always provide care and treatment based on national guidance and evidence-based practice.

The trust developed the 'Caring for adults in the last few hours and days of life' care plan, which was developed for patients who were entering the last days of life and was designed to address the holistic needs of the dying person by providing supportive and compassionate person-centred care. The document introduced in 2014 by the trust, replaced the Liverpool Care Pathway document. Plans were in place to roll out an updated version of the care plan, but staff explained that the original version was the only document in use at the time of inspection, whilst staff awaited training.

Staff followed up-to-date policies to plan and deliver high quality care. However, this did not always follow best practice and national guidance. Patients were commenced on the care of the dying care plan, when they were assessed as 'end of life' or meeting the 72hr criteria for end of life care. However, the service was not following best practice, for example, the General Medical Council (GMC) states that end of life patients are those identified as likely to die in the next 12 months.

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The trust's last audit of the care of the dying care plan was October 2020, and results were mixed. In some areas of the document, such as evidence of conversation between the patient and the medical team responsible for their care was 33% and evidence of consultant involvement was 53%. However, evidence of conversation between patients' relatives and staff scored 100% and in June 2020 it was recorded that all twelve patients receiving end of life care were found to have the care plan in place. In the same audit 92% of patients had a recorded ReSPECT document in place.

End of life care

Ward staff delivering end of life and specialist palliative care, told us they were able to access policies on the trust intranet. The end of life team had a dedicated website offering symptom guidance, referral pathways and general advice, which reflected national evidence based best practice and guidelines.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. Staff explained that referrals could be made to the mental health liaison team and outlined support that were available when required.

The trust did not have oversight of all patients requiring end of life or palliative care within the hospital. There was currently no electronic palliative care co-ordination system (EPaCCS) in place. The trust utilised an electronic ward review system, but it did not incorporate any software for alerts or co-ordination of palliative care or EOL patients.

The service still did not have an effective system to identify where patients at the end of life were, throughout the hospital.

The most recent visit to mortuary services by the Human Tissue Authority (HTA) in 2016 concluded that despite some minor shortfalls, several strengths were identified. The associated action plan to rectify the one shortfall provided by the trust was appropriate and set reasonable targets for completion.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. The trust used a Malnutrition Universal Screening Tool (MUST), which identified nutritional risks. Records showed staff followed MUST scoring for nutrition and hydration appropriately.

Staff made sure patients had enough to eat and drink, particularly those with specialist nutrition and hydration needs. We saw records within the generic nursing notes which recorded nutritional needs and evidence of nutritionist involvement. However, nutrition and hydration needs could not be recorded using the care of the dying care plan as the section related only to artificial hydration and nutrition. Staff explained that pain assessments could be improved as occasionally referral to dieticians was delayed.

We reviewed the results of the October 2020 National Care Audit of Care at The End of Life of (NACEL) audit and saw the trust performed worse when compared nationally with other similar providers. For example, the risks and benefits of hydration options, were discussed with families and others in 10% of cases, compared to 35% nationally. For 72% of patients, no reason for not discussing this was recorded. This was worse than the national proportion of 49%. The risks and benefits of nutrition options were not discussed with families and others for any cases. Nationally the figure was 28%.

We saw evidence of mouth care for those patients unable to tolerate fluids and care plans for patient mouth care. Staff explained that the end of life team were supporting ward staff with additional mouthcare training.

Kirkham, Holly
11/06/2021 12:38:41

Pain relief

Staff did not always assess and monitor patients regularly to see if they were in pain or give pain relief in a timely way.

End of life care

We saw pain assessments were inconsistently documented for palliative and end of life care patients across some wards we visited. We saw varying pain assessment tools available to clinical staff. Upon review of three patient records, we saw only one completed pain assessment tool. All the patients we reviewed had experienced pain or discomfort and had been prescribed analgesia. We found that pain assessments were not reflective of the patient's current pain levels and had not been updated. This had the potential to affect patient care and pose serious risks to patients due to the lack of staff intervention through regular assessment.

The care of the dying care plan did not support individualised care planning regarding pain management and did incorporate a pain scoring tool. Tick box prompts were used if a patient was experiencing pain with a limited amount of space in the document to record evaluation.

Patients did not always receive pain relief, soon after requesting it. We visited two patients, currently receiving end of life or palliative care, and found both patients in pain. One patient had been waiting for a replacement syringe pump to be commenced and family told us they had chased this with staff three times before action was taken. We reviewed medication records which corroborated the delay in administering analgesia through the syringe pump. Family explained this had happened on more than one occasion. Another patient was found to have had a bladder washout, but staff had not emptied this in accordance with clinical guidance causing severe pain and distress. Inspectors brought this to the attention of staff, who took immediate action.

Anticipatory end of life medicines were available to all wards we visited.

We reviewed the results of the October 2020 National Care Audit of Care at The End of Life of (NACEL) audit and saw the trust performed worse when compared nationally with other similar providers. For example, anticipatory medicines for symptoms likely to occur in the last days of life were prescribed and administered in 34% of cases, compared to 68% nationally.

The service was not undertaking specific audits for pain or symptom management.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes

The service did not have an end of life care dashboard to give an overview of quality metrics and key performance indicators. The service could not measure its impact at ward level. However, leaders explained that there were plans in place to implement both elements.

The end of life and specialist palliative care teams' input was monitored using forms, completed by the team, detailing how their patient was referred and what their input was. However, these documents did not monitor how comprehensive the team's record keeping was, nor the effectiveness of their care in influencing outcomes for patients. The trust did not have a policy or process to define this, to ensure consistency of recording.

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Managers and staff carried out a programme of audits to check improvement over time. We requested details of all audits relevant to end of life care, which were undertaken. We received audit details relating to the October 2020 National Care Audit of Care at The End of Life of (NACEL), Care after Death Audit, SWAN Room audits, Care of the

End of life care

Deceased mortuary audit, bereavement survey results, the End of Life Care Plan Audit February 2021, mouthcare and an audit of the Swan "Grab and go T34 syringe driver policy. The mouth care audit (which included all patients not just end of life patients) was dated September 2020, showed 41% of staff were not aware of the mouth care policy and 52% of staff stated they had used a mouth care chart.

Managers and staff did not use the results of these audits, to improve patients' outcomes and we did not see an action plan to address these findings.

Competent staff

The service did not always ensure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

The trust included end of life as part of mandatory training for all staff. The trust provided training figures for end of life training with compliance being 81% as of July 2021.

The service did not have a clinical educator role, however, the team delivered and oversaw a programme training relevant to end of life and palliative care. Also, the End of Life team offered bespoke training sessions to ward staff when requested. Ward staff explained that these sessions had been beneficial, but there was no formal review of training, to show how this had potentially improved patient care. They did not monitor where and when training had been delivered.

Wards were provided with an end of life resource file which included guidance in symptom management, referral pathways, useful contact numbers and care planning information.

At the last inspection in June 2020, the trust were told they must ensure staff were competent in their roles. This included but was not limited to the use and the completion of ReSPECT forms and the use of syringe pumps. Syringe driver compliance figures supplied by the trust demonstrated compliance at the hospital was 91%.

We told the trust in August 2020, that improvements must be made to ensure that staff were competent in the use of syringe pumps when required. Syringe drivers were used in accordance with the NPSA Rapid Response Report; Safer Ambulatory Syringe Drivers (NPSA/2010/RRR019) published in December 2010 and had checklists to ensure they were used appropriately. However, we reviewed two copies of syringe driver documentation and saw that these checks were not completed in accordance with the trust standard operating procedure; 'Grab and go Box for T34 Syringe pumps'. The guidance states that the cannula should be checked every four hours, but records showed checks were carried out between five and six hourly intervals. The trust did not audit syringe driver documentation.

End of life champions were available on some of the wards, but we did not see any evidence of cross-directorate working to share learning and best practice. For example, performing last offices, which is the term given to the care after death.

McLeod, Holly
11/08/2021 12:38:21

Specific counselling training was provided to some staff in the bereavement team. One of the bereavement staff explained they had completed a 'Sage and Thyme' which is a counselling course and is supportive of staff working within bereavement services. But this did not appear to be routinely offered to all staff.

Managers gave all new staff a full induction tailored to their role, before they started work. We saw two newly seconded specialist palliative care nurses supported by mentors as part of their induction.

End of life care

Managers supported staff to develop through yearly, constructive appraisals of their work. Appraisal compliance rates for the end of life and specialist palliative care team was 100%. However, none of the specialist palliative care nurses received clinical peer supervision or received regular clinical competency training reviews.

Managers made sure staff attended team meetings and provided access to full notes when they could not attend. End of life steering group minutes were distributed to the team.

Multidisciplinary working

Doctors, nurses and other healthcare professionals did not always work together as a team to benefit patients.

Systems did not support effective communication between multi-disciplinary teams. For example, specialist palliative care nurses received ward referrals by telephone, patients admitted to the hospital by the hospice were referred electronically and GP (General Practitioners) referrals were submitted through the electronic hospital database. All processes were independent of one another and none of the end of life staff had oversight of all the patients requiring potential support in the hospital. However, end of life and specialist palliative care teams met each morning virtually, to review referrals Monday to Friday.

Clinical outcomes were not clearly documented, clinical triage was not in place and effective collaborative team working was not measurable due to the lack of clinical care planning. For example, the patients we saw experiencing pain and discomfort were known to and had been visited by the specialist teams

Ward staff explained that fast track and end of life discharges were managed by the complex care team. However, none of the staff we spoke with were able to outline the last end of life patients whom were discharged by the complex care team. Data provided by the trust showed, from August 2020 to June 2021, 293 patients were discharged via the complex discharge team at the hospital.

All ward staff we spoke with told us that end of life and specialist palliative care colleagues were visible on the wards and we saw staff working together to share information.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. However, end of life steering group meetings were not consistently attended by all members of staff. Specialist palliative care nurses explained that they required a laptop to access the meetings and this was not always available.

Mortuary staff were not included in these meetings and explained that they had offered training to support ward staff to undertake last offices, but the training was not implemented.

A local hospice provided out of hours advice and support to staff and patients, however, information collated by the hospice was not reviewed by the trust. For example, referral and patient outcome information.

Seven-day services

Key services were not available seven days a week to support timely patient care.

Arleen Holly 11/10/2021 17:38:41

The service was still not available seven days per week. Services were only available Monday to Friday, with out of hours advice offered by the local hospice. This was still not in line with the NHS Seven Day Clinical Standards (2017) which states that specialist palliative care should be available at any time of day or night. The trust was aware of this shortfall and this was on the haematology and oncology risk register due to staffing shortages. However, plans were in place to extend the specialist palliative care team availability to seven days, commencing in September 2021.

End of life care

Mortuary staff did not routinely work at evenings or weekends but were on call and told us they would come in if a body needed to be released during these periods. They told us they could release a body in a timely manner if all relevant paperwork was complete.

Chaplains were on call at evenings and weekends and aimed to respond promptly to urgent requests, however the lead chaplain was currently not available due to sickness absence. Staff explained that there was a recognition with the chaplaincy to expand the staffing and a recent interview had taken place which resulted in the appointment of two additional chaplains equating to 1.5WTE.

Health promotion

Staff gave patients practical support to help them live well until they died.

We saw relevant information promoting healthy lifestyle choices and wellbeing support on every ward we visited.

Staff assessed each patient's health when admitted using the initial assessment documentation.

End of life boxes contained information to support patients and their families across a range of areas, for example; eating and drinking at end of life and supported staff to enable individuals to live a healthier lifestyle.

We saw information support centres in the hospital, offering leaflets and guidance for patients and their relatives in a range of subjects, including emotional, financial and therapy information.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. However, consent was not always clearly documented.

The service had improved practice when carrying out and completing Mental Capacity Act assessments for all patients who were deemed to not have capacity. Mental capacity assessments were fully completed, and decisions made, were consistently documented and had a clear rationale.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Assessments documents included specific reference to capacity and assessment outcomes.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff made sure patients consented to treatment based on all the information available. However, staff did not always clearly record consent in patient records. Consent was not included in the 'Caring for adults in the last few hours and days of life' document.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Mandatory training compliance figures showed 100% for those staff who were identified as requiring this course.

Mayelyn Holly 11/28/2021 12:38:41

Staff could describe and knew how to access relevant policies and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. Staff were able to articulate deprivation of liberty applications and referral processes to request mental health advice and support.

End of life care

Is the service caring?

Requires Improvement ↓

Our rating of caring went down. We rated it as requires improvement.

Compassionate care

Staff treated patients with compassion and kindness. Privacy and dignity were generally respected but there were issues when caring for patients after they had died.

Staff explained end of life care was provided where possible using the SWAN or side rooms. During inspection we observed patients being cared for in this way. Patients families told us that if their loved ones needed to be moved for any reason, staff took the time to explain this to them.

During inspection we observed several staff and patient interactions, which demonstrated staff's kindness and respect for privacy and dignity. Staff cared for patients with compassion.

Patients said staff treated them well and with kindness. A patient on ward 33 told us that this was the 'best hospital they had stayed in' and the staff were 'amazing'.

Last offices were not always carried out for the deceased prior to arrival at the mortuary. Last offices is the term given to the care of the body after death, Mortuary staff explained the omission of this care by ward staff, resulted in patients arriving in an undignified manner. Mortuary staff explained that the impact of this for visiting families was significant and potentially highly upsetting.

Emotional support

Staff did not always provide emotional support to patients, families and carers to minimise their distress.

The end of life team had recently developed complimentary support boxes, which were offered to families at the discretion of ward staff. Boxes contained woollen hearts, drinks vouchers, parking discounts and support and advice. All wards we visited were able to provide these boxes.

Staff explained there were currently no arrangements to enable patients' families to view the deceased in the mortuary. Viewing arrangements had been stopped during the peak of

the pandemic by senior leaders of the organisation, and there were no plans in place to review this rule. Mortuary staff explained that viewing had been arranged for one patient as a special request, but it was not clear why this single request had been supported whilst others were declined.

McLellan,Holly
11/26/2021 12:16:21

The children's viewing within the mortuary room was not fit for purpose. The room, which was utilised and used as a fridge, was not appropriate for families wishing to spend any time with their loved ones, due to the temperature and noise from the refrigeration system. Mortuary staff explained however, that the refrigeration system was not switched on at the time of viewings.

End of life care

The bereavement survey dated May 2021 showed that 100% of families stated that they were given the opportunity to see their relative, on the ward, after they died. Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Bereavement team staff told us they were able to support bereaved families as they had received training regarding difficult conversations through Sage and Thyme. However, in the same survey we saw 71% of families felt that religious / cultural and spiritual beliefs had not been taken into consideration, when liaising with the bereavement office staff.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their conditions and make decisions about their care and treatment. However, this was not always timely.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Families were encouraged to complete a bereavement survey and feedback was shared at the end of life steering group and fed back to all staff.

However, staff did not always support patients to make advanced decisions about their care. Referrals to the palliative and end of life teams were not timely, and early identification was not systematic across the trust. As a result, although those who were identified as needing the support of the team were unable to make decisions and on many occasions, these were late and reactive, rather than proactive.

Is the service responsive?

Inadequate ● ↓

Our rating of responsive went down. We rated it as inadequate.

Service delivery to meet the needs of local people

The service did not plan and provide care in a way that met the needs of local people and the communities served. It did not always work with others in the wider system and local organisation to plan care.

Managers did not plan and organise services, so they met the needs of the local population. Staff did not have a comprehensive system to identify the total number of patients who could benefit from their services, so did not know the level of unmet need in either the trust itself, or the wider community.

The service did not monitor inappropriate referrals. As a result, the palliative and end of life care teams identified the needs of some, but not all, of those requiring palliative or end of life care within the community they served.

The service worked closely with the local hospice, relying on their telephone advice line out of hours when no specialist hospital team was available. However, they were not working with the wider palliative care community providers to plan care.

Mcellan, Holly
11/26/2021 12:08:2

The service had basic systems to help care for patients in need of additional support or specialist intervention, but these did not identify all patients. The palliative and end of life care teams relied on wards to make referrals to them,

supported by an electronic system which flagged up patients in the very last days or hours of life. This system did not identify all patients who were receiving palliative or end of life care, and teams felt they would not be able to meet demand if it did. However, once patients were seen by the team, they were able to refer to other specialist support such as speech and language, physiotherapy and dietitian services.

Meeting people's individual needs

The service was generally inclusive and usually took patient's individual needs and preferences into account. However, there were issues which meant this was not the case for everyone. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Wards where people received care towards the end of their lives could access dementia and mental health champions.

There were EOL champions based on some wards, but they did not link up with each other to share learning or provide peer support. Staff told us they had plans to make the EOL champion training more structured and build in more support.

Staff equality and diversity training levels were at 84%, which was below the trust target of 90%.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents which were well completed.

The service did not provide information leaflets available in languages spoken by the patients and local community but could access translation facilities when needed. Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed.

Patients were given a choice of food and drink to meet their cultural and religious preferences.

There were no restrictions placed on friends or families wishing to visit those receiving end of life care. Staff explained that where possible, patients would be moved to a SWAN room, or other single room area to ensure that patients' privacy and dignity was maintained, and that friends or relatives had the opportunity to stay with them overnight. This had been difficult to achieve during the last year due to COVID, as infection control had taken precedent, but additionally one SWAN room onsite was out of use.

Chaplains visited patients when requested by ward staff. They explained that often this was very late in a patient's illness. There was no electronic system to alert chaplains that a visit was needed. All of the chaplaincy team were Christian; however, they could access external faith leaders in a variety of faiths. A 'dial a chaplain' service, advertised in public places, was innovative but poorly thought through, requiring a member of the public to use the trust switchboard which was not easily available to visitors.

McLellan,Henry 11/26/2021 14:38:21

There was no separate multifaith room in the trust for patient and family use. The chapel had fixed Christian symbols and therefore could not be easily adapted to become a non-denominational space. Staff following other faiths had found other space to use elsewhere in the trust, but chaplaincy staff had not been engaged during this process.

End of life care

Access and flow

Patients could not always access the specialist palliative care service when they needed it. Waiting times from referral to achievement of preferred place of care and death, where known, were in line with good practice.

Managers monitored waiting times but could not ensure patients could access services when needed. The team did not provide a seven-day service so patients could not always access support when they needed it. Evidence in a patient's notes showed, they were referred to the team on a Friday, who was not seen by them until the Monday. Notes showed that their pain was not well controlled in the meantime. The service's monitoring showed that in 2021, the percentage of patients waiting more than a day to access support from the team had risen from 15% in January to 18% in March 2021. We did not see an action plan to improve this

The end of life team saw an average of 39% of all patients who died at the Royal Shrewsbury Hospital (RSH) in 2021, which was better than the Princess Royal Hospital. As there was no catchall system in place to ensure they could accurately assess who would most benefit from their input, the team had no way of knowing that the remaining, majority of patients who passed away at the hospital did not need or would not benefit from their care. Additionally, the teams did not have a way of recording patients seen by both teams (potentially duplicating work). Ward staff told us that sometimes a patient could have several visits from both teams on the same day, as care was not coordinated.

Managers and staff worked to make sure that they started discharge planning as early as possible. Of those patients known to the palliative care team, just over 88% achieved their preferred place of death. However, not all palliative patients within the trust were identified. Therefore the trust could not accurately reflect their achievement of preferred place of death as they only recorded the outcomes for the patients who had been referred to the relevant teams.

Staff planned patients' discharge. Patients nearing the end of their life could be referred to a fast track discharge pathway, with a target of getting a patient to their preferred place within 48 hours. However, fast track discharges were not achieved. We reviewed the last 91 discharges across the trust and saw the average discharge time for the fast-track discharge of patients in receipt of end of life care was just over three days.

Trust policy stated that the complex care discharge team, who worked seven days a week, should co-ordinate end of life discharges. However, in practice this was done by the palliative care team, who did not work over the weekend, and as a result end of life rapid discharges over the weekend were rare. This impacted on patient's preferred place of death.

Staff supported patients when they were referred or transferred between services. Partner services receiving patients felt they were well informed, although delays in discharge, usually caused by transport, had led to people not moving between services seamlessly. We did not see an action plan to improve this.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

McLellan, Kelly
11/26/2021 12:38:21

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas. Staff understood the policy on complaints and knew how to handle them.

Staff working on wards described how they would endeavour to resolve complaints informally and as soon as possible. However, the trust did not provide evidence of the end of life care team's involvement in the investigation of any of the

last three complaints relating to patient deaths, even though it was clear from one response letter that the team had seen the patient. Specialist staff were not able to recall when asked the last complaint they had had input into. There was therefore a lack of assurance that complaints were being appropriately categorised and discussed with the end of life care team.

Staff could give examples of how they used patient feedback to improve daily practice.

The end of life team had been asked by a carer if the new kindness hearts provided to patients and their loved ones could continue. The team have agreed that kindness hearts will become an integrated part of their practice.

Is the service well-led?

Inadequate ● ➔🡐

Our rating of well-led stayed the same. We rated it as inadequate.

Leadership

Leaders had the skills and abilities to run the service. They understood the issues the service faced. They were visible and approachable in the service for patients and staff.

The service had a clear line of accountability and staff explained they knew who to go to if they needed support. Staff spoke positively about leaders and the support they had offered throughout the COVID-19 pandemic. However, mortuary, chaplaincy and bereavement service staff did not feature on the schematic diagram provided to CQC to explain the service's leadership structure, and bereavement services sat under a different management structure. Therefore, the team was not cohesive and there was disconnect within the existing communication systems.

Leaders were aware of and could articulate the current issues faced by the service in terms of capacity, and a historical separation between teams which they had plans to address.

However, they did not recognise the overreliance on the experience of individual practitioners or the effect their failure to monitor outcomes was having on patients receiving or wanted to access the service. This meant there was a lack of effective oversight of the quality of the service and the impact this had on the patient's quality of care.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to underpin this aligned to national priorities. The vision and strategy were focused on sustainability of services, but it was not clear how they would monitor progress.

The end of life care strategy document, which included the specialist palliative care team, covered the period 2019-2022. There had been no revisions to timescales or adjustment of aims to incorporate the challenges posed by the COVID-19 pandemic.

Mcellarholly
17/2/2021 12:38:21

End of life care

The strategy set out six aims, underpinned by sub-statements. However, the aims were not clear objectives, and as such were not clearly measurable, time-limited and focussed. For example "all clinical staff to be able to recognise all forms of distress" and "good communication between all staff" were wide ranging, difficult to measure and it would be almost impossible to show the service's individual impact towards meeting the objective.

The strategy featured 'indicators of success' but these were not tied to aims or objectives, so it was not clear how the service would know that it had improved, and how it would know if it was on track with its aims.

Monitoring of the end of life care strategy through the specialist palliative care steering group was unclear, as although there was a standing agenda item titled 'strategy' this was not used to record progress against stated aims or flag any areas that were behind schedule.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care, but did not always see end of life care as everyone's responsibility.

End of life care was not a tangible priority on wards. Ward staff were not fully engaged in making dying everyone's responsibility. This was reflected in the fact that in more than one area, staff did not recognise patients under their care as end of life or palliative, even when prompted.

Staff within the EOL team told us they felt valued and respected.

The trust were unable to identify EOL team responses to the staff survey due results for small teams not being published as that would identify individual team responses in a small team, and no other evidence of a mechanism for capturing or identifying the views of the team was provided to CQC.

Governance

Leaders did not operate effective governance processes, throughout the service and with partner organisations. Staff at all levels were not always clear about their roles and accountabilities.

There were areas of the service which continued to be of concern and had been previously identified during our inspection in 2020.

The trust had developed a memorandum of understanding with their local hospice to provide mutual support with a view to improve both services. However, this was in draft at the time of inspection, and did not contain any detail of how the effectiveness of the agreement would be monitored.

The trust did not monitor its current use of out of hours support provided by external partners and there were no channels of communication, by which to share themes and learning from the out of hours support.

McLellan, Hayley
11/2/2021 11:38:41

The most recently planned audit programme fails to measure the performance or quality of the end of life care service. An audit plan had been produced for 2021-22. The trust normally contributed to national audits such as the National Audit of Care at the End of Life and planned to do so in future (having briefly suspended over the COVID-19 period). Audits conducted over the previous 12 months and the audit plan for 2021-22 focussed on the implementation of, or changes in practice by, ward staff, rather than any quality monitoring of the end of life team, their record keeping or effectiveness. Therefore, the trust did not measure quality improvements to the service.

End of life care

Action plans were not implemented even when poor performance or practice had been identified through audit. Where issues had been identified in audits, for example, in the 'compliance with the care after death policy in clinical practice' audit of April 2021, where 63% of deceased patients were transported to the mortuary in a less dignified manner, there was no associated action plan, and results were not discussed (or not documented) at the next end of life care steering group in May 2021. Staff delivering the training to ward staff around the importance of good care immediately after death explained that they had been asked to deliver training once which was poorly attended and had not been asked to revisit this.

The governance around the end of life care steering group was inconsistent. A review of the terms of reference and steering group took place in early 2020. The end of life steering group met monthly and was generally well attended. However, the agenda did not state who was chairing, whether the meeting was quorate, and had no regular space for mortuary staff to input or provide updates.

Management of risk, issues and performance

Leaders and teams did not always identify and escalate relevant risks and issues or identify actions to reduce their impact. However, they had plans to cope with unexpected events.

The team did not hold their own separate risk register. Risks for the end of life team were recorded within the oncology and haematology risk register. Two open risks related specifically to the end of life and specialist palliative care team. These included a shortage of specialist palliative care consultant input and a risk that the size of the team was not sufficient to meet the expected patient demand.

Senior leaders knew what the major key risks were for the team and explained what was being done to address this. However, other risks, such as those relating to the cleanliness of mortuary areas and capacity in the chaplaincy team were not stored centrally on the risk register and were therefore not being actively addressed.

Not all relevant staff had received an individualised COVID-19 risk assessment despite working across all wards during the pandemic. In addition, the associated risk of staff becoming ill due to COVID-19, were not included on the risk register.

Information Management

The service collected limited data. The information systems were integrated and secure.

The service was not using data to monitor performance or quality. The service did not have any systems to give an overview of quality metrics and key performance indicators. The service could not measure its impact at ward level and did not work to any key performance indicators. However, leaders explained there were plans to implement both elements. This was a risk to patients as the lack of quality metrics and key performance indicators meant the service did not know, other than anecdotally, whether what it was doing was adding value or improving outcomes for patients.

Engagement

Leaders and staff engaged with patients and families. They collaborated with partner organisations to help improve services for patients.

Clean Copy 11/08/2021 12:38:01

The trust had continued to gather feedback from bereaved friends and families throughout the difficult COVID-19 pandemic period. Feedback was generally positive, however, in June 2021 30% of people thought that their relative was not free of pain in their last days, and 40% felt that their hygiene had not been maintained. These results were not discussed at the end of life steering group and it was not clear what had been done to act upon this feedback.

End of life care

The trust contributed to the wider system end of life care group and collaborated closely with local end of life care providers. For example, commissioners and hospice providers.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Members of the team had been awarded the Dundas medal for their work 'taste for pleasure' work using a patient's favourite flavours when providing mouth care towards the end of life. The team had produced information leaflets for staff and patients and their families and friends to underpin this.

During the COVID-19 pandemic, the end of life team had introduced a number of measures such as memory stones for each patient who lost their life, kindness hearts, one for a patient and another for their loved one, and bereavement support sessions for staff. Evidence showed that these had been much valued by families, patients, friends and staff.

McLellan,Holly
11/26/2021 12:38:21

Urgent and emergency services

Inadequate ● ➔ ➔

Is the service safe?

Inadequate ● ➔ ➔

Our rating of safe stayed the same. We rated it as inadequate.

Mandatory training

Mandatory training in key skills was not completed by all staff, including the highest level of life support training.

The trust provided mandatory training in key skills but they did not ensure all staff completed it. There were 15 mandatory training skills and the trust set a compliance rate of 90% for each one. Compliance to the highest level of life support training was not achieved.

Nursing staff did not keep their mandatory skills training up to date. For example, data obtained during our inspection showed infection prevention and control was 72%, fire training was 73%, the two-yearly manual handling training was 59% and information governance was 73%.

Nurses did not all have the level of higher life support training recommended by the Royal College of Emergency Medicine (RCEM). Current life support data for nurses was intermediate life support training (ILS) 85%, paediatric intermediate life support (PILS) 60%, European advanced paediatric life support (EPALS) 54% and advanced life support adults (ALS) 54%. Access to training had been impacted nationally and locally by the impact of Covid 19 with many courses stood down. The senior team had clear trajectories and staff were allocated to courses.

Medical staff received and mostly kept up-to-date with their mandatory training. Medical staff training mostly met the target of 90%. However, the compliance rates for information governance were 76%, hand hygiene was 58%, manual handling was 70% and PREVENT training was 82%.

Most medical staff kept their mandatory life support skills training up to date, however, advanced life support training compliance amongst junior doctors was slightly lower than the trust's target of 90%, with a compliance rate of 88%.

The mandatory training was comprehensive and met the needs of patients and staff. The mandatory training covered a variety of training topics. Staff also undertook additional emergency department skills training, which included but was not limited to cannulation, taking blood cultures and paediatric nurse competencies.

The department had a clinical educator who was improving access to training. Senior nurses said their staff were required to complete many extra hours of training which was not accommodated for in the staffing establishment, however a business case was submitted to increase nurses and improve training opportunities.

Michelle Holly 21/12/2021 11:38:21

Not all clinical staff had completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. Nurse compliance mental health awareness training was 68%, and mental health crisis support was 54%; Mental Health Act training was 60% and dementia training was 64%. Amongst medical staff, only 74% had completed dementia training. Training in autism was not part of the trust's training programme.

Nurses told us they could access much of the training online from home, and that a phone app allowed quick access to some courses. One nurse said they did not get allocated time on the rota to attend most of the training and often training sessions were cancelled due to staff shortages. One nurse told us they completed their training from home and did not request their time back or payment, although they believed it was possible to request this.

Managers monitored mandatory training and alerted staff when they needed to update their training. Training data was on display in the ED corridor and in the staff room. Staff and managers were aware of training compliance.

Safeguarding

Not all staff followed processes to protect patients from abuse and not all staff had training on how to recognise and report abuse. The service worked well with other agencies.

Staff were not always up to date with the safeguarding training that would enable them to consistently recognise and report abuse. Nursing and medical staff did not consistently complete their safeguarding training which was specific for their role on how to recognise and report abuse. The trust set a target of 90% for completion of safeguarding training. All staff received level one children and adult safeguarding training when they joined the trust. Trust data showed compliance with children safeguarding level three training was 88%, and adult safeguarding level three was 70%. However, information received following our inspection showed nursing compliance to level three children safeguarding as 50% and we were therefore not assured of actual compliance in this area.

Medical staff had not received safeguarding adults level three training. This had been identified as an omission and there was a plan to start a bi-monthly training role out in September 2021. However, 84 % of medical staff had completed children's level three safeguarding.

Staff did not always follow safe procedures for children visiting the department. Some children left the ED without being seen and were not followed up by doctors the next day. Some children were not followed up for four days. ED consultants were required to check all children leaving for evidence of harm, and report monthly data to demonstrate they had followed up every unseen child, the next day. From 23 May to 19 June 2021, 33 children left without being seen. The trust provided details of 23 of these cases and showed that only four of these children were followed up the next day. Additionally, two children had no action recorded at all and two children had no date of the action recorded. The trust investigated incidents where children had not been followed up and shared details where a child, with suspected non accidental injuries, had left without being seen and was not referred to social services in a timely way or contacted by medical staff. The child was later removed from their parents. However, the actions to prevent similar occurrences included 'reminding staff' of the correct process. This was not robust enough for us to gain assurance similar events would not occur again.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Nurses gave examples of how they had supported patients with protected characteristics.

McLaughlin, Kelly 11/08/2021 11:38:21

Staff mostly knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. Most children identified as being at risk while in the ED were referred to the trust safeguarding team and to the local authority appropriately. From July 2020 to July 2021, the department had made 211 children referrals and 50 adult referrals to local authority safeguarding teams.

Urgent and emergency services

Cleanliness, infection control and hygiene

The service did not control infection risk well. Equipment and control measures were not always used to protect patients, themselves and others from infection. Cleaning records were not always completed to show the premises had been cleaned in line with their schedules.

Staff did not always follow infection control principles, including the use of personal protective equipment (PPE). Nurses did not wear appropriate PPE for high risk patients suspected of having COVID-19. When COVID-19 swabs were taken, and direct patient care was provided, this was carried out without the use of eye protection. Staff told us they only wore eye protection for aerosol generating procedures (AGP). This was not in line with trust guidance which stated eye protection should be worn for routine patient care when patients are suspected of having or have COVID-19, subject to a risk assessment. We were not provided with evidence showing staff were carry out risk assessments. Following our inspection, the trust updated its guidance to ensure all staff wore eye protection for direct patient contact. PPE compliance had also been highlighted to staff during a trust audit in June 2021, where it was noted staff in two areas of the ED did not wear gloves or aprons when within two meters of patients.

Patients were not routinely screened for signs and symptoms of COVID-19 when entering the department or during triage. This was not in line with the Royal College of Emergency Medicine (RCEM) guidance February 2021, Emergency Department Infection Prevention Control during the Coronavirus Pandemic. We observed six patients booking in at reception and five patients being triaged. None of these patients were asked about signs or symptoms of COVID-19. All patients were directed to the same waiting area. Reception staff said they asked screening questions if the patient reported a known symptom, for example coughing. The triage nurse told us they did not screen for COVID-19 unless the patient showed signs and symptoms or self-reported signs and symptoms. Following our inspection the trust implemented COVID-19 screening for all patients on arrival to the department.

Patients with possible infections were not always identified and isolated in a timely way and there was a lack of awareness of basic isolation principles. One patient was admitted with a possible diagnosis of infective diarrhoea. This was not communicated to the nurse looking after the patient, and the patient was initially nursed in a two bedded bay in the clinical decision unit (CDU) before being moved to a side room. One patient with respiratory symptoms was nursed in the low risk COVID-19 area despite not having been screened for COVID-19. We saw a COVID-19 positive patient was admitted to the red AGP room while the doors were left open, increasing the risk to other patients in the area of virus exposure.

Staff did not always have access to appropriate hand hygiene facilities. Outside of the red bay in the red area, where staff doffed their soiled PPE, there was no alcohol gel or handwash basin. In CDU there was no hand hygiene sink in the dirty utility and the sink in the pitstop/CDU nurses' area was none compliant with hand hygiene sink standards.

We did not see staff routinely washing their hands with soap and water after patient care, including after removing gloves following contact with bodily fluids. Staff used alcohol gel following patient contact.

Cleaning records were not always up-to-date and did not demonstrated all areas were cleaned regularly. For example, the general cleaning checklist on the ambulance corridor had not been signed for five days in July and 14 nights in July 2021 (up to 20 July 2021). The red area resus room had no record of cleaning on 16 or 19 July 2021, day or night. A trust audit carried out in July 2021 identified that although some cleaning checklists had been ticked to say the cleaning was done, some areas were still found to be dirty.

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Staff did not clean all equipment after patient contact or label equipment to show when it was last cleaned. Beds and trolleys were cleaned between patients but equipment was not always cleaned. We saw five patients being triaged who had their observations taken using the same devices. None of the devices were cleaned before or after each use.

All areas were clean and had suitable furnishings which were clean and well-maintained. However, there were several areas throughout the department where the flooring had been stuck down with tape and others with sticky residue. It was not possible to effectively clean these surfaces.

Following the inspection, the trust were made aware of the concerns regarding infection prevention and control in the department. The trust immediately implemented an action plan. The action plan covered the areas of concern and was to be monitored regularly by senior staff and the director of infection prevention and control.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not keep people safe. Staff did not manage clinical waste well.

The design of the environment did not follow national guidance. The emergency department (ED) premises were outdated and did not meet guidance from Health Building Note 15-01: Accident and emergency departments planning and design or the 2018 Royal College of Paediatrics and Child Health (RCPCH) guidance, Facing the Future: Standards for children in emergency care. Building work to improve the department was ongoing during our inspection, and some improvements had been made since our last inspection. Building plans showed more space and extra cubicles would be available upon completion of the work.

Environmental standards for children in the waiting room, required the area to be monitored to protect children from harm, and to provide the ability to contain someone wishing to leave against clinical advice, was not met.

The ED environment was not secure. All areas of the ED were accessible to staff, patients and visitors, including the resuscitation bay. Vulnerable patients were not always protected from people who may pose a threat to their health and wellbeing.

Equipment was accessible and could be damaged or stolen. The dirty utility door in the minor's area was wedged open giving patients access to used linen, clinical waste, sharps bins, plus some diluted and undiluted cleaning chemicals. This had previously been highlighted by an internal audit of the department in June 2021.

Patients presenting with acute mental health concerns had access to one room which met national guidance relating to the provision of a safe environment. This had improved since our last inspection. However, patients using this room had access to toilets and bathrooms which were unsafe environments with ligature risks and access to equipment. Ligature risks in the toilets had been assessed in March 2021.

Patients using the mental health room had a security guard with them most of the time. However, this was not always the case, and it would have been possible for patients to move freely about the ED. Reducing ligature risks had been incorporated into the ongoing refurbishment.

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There were four small resuscitation bays in the department but there was insufficient space to comfortably accommodate all the staff and equipment required during an emergency. One of the resuscitation bays was dedicated

to children, however it was not exclusively for children and was regularly used for adults. During our inspection a child waited in the resuscitation bay for six hours before transfer to the children's ward at Princess Royal Hospital. This was an unsuitable environment for a child. Building work was ongoing during our inspection. Once completed, a designated children and young people emergency zone and resuscitation bay would be available.

The majors area cubicles and corridor were crowded with equipment, staff and patients. The side room doors were too narrow to fit a proper bed, and equipment, required during cleaning, was constantly moved to allow ambulances trollies entry. Security staff observing patients at risk of harm also provided another corridor obstacle along with electrocardiogram (ECG) machines, bladder scanners and lifting equipment, which was required regularly to aid patient care.

Patients were sometimes cared for in the ED corridors, including overnight during our inspection, leaving even less space for movement in the event of an emergency.

The pit stop area used for assessing patients and carrying out initial tests was often used as an extra capacity area for patients awaiting hospital admission. The CDU area was used to cover surges in demand and therefore lost its ability to function as a CDU facility. This included accepting patients who would otherwise be nursed in the major's area.

There was no fit to sit area due to building work in the department.

Staff did not always carry out daily safety checks of specialist equipment. Checks were not always completed on all emergency equipment trolleys. For example; within the red area resuscitation bay, one emergency equipment trolley had no checks recorded on 1, 9, or 13 July 2021 and bay two had no checks recorded on 3, 4, 9, 13 July 2021. The main resuscitation trolley in the red corridor had no recorded check on 18 July 2021 and there was no recorded check of the airway trolley for several months. In the major's area of ED, the paediatric bay resuscitation equipment (which included children's airway equipment) was not checked for five days in June 2021 and the resuscitation 'general' equipment trolley in majors was not checked for 3 days in July 2021. The resuscitation fluid warmer temperature checks were not done for five days in July 2021.

The emergency airway trolley in the red area of ED was unlocked and assessable to all patients' staff and visitors. This trolley contained items which would be required in an emergency to insert an airway into the patient, for example intubation tubes and four vials of medicine.

Staff did not dispose of clinical waste safely. National guidance on waste disposal was not always followed. Used PPE, including gloves and aprons was disposed of in domestic waste bins. One triage room had three bins, including an unlidded 'wastepaper basket'. This contained both confidential patient information and empty drinks bottles. An unlidded sharps bin in the major's dirty utility area contained a used IV line alongside empty medicine bottles, used urine sample pots, unopened cans of beer and used batteries.

The service did not have suitable facilities to meet the needs of patients' families. Relatives of seriously ill patients could not always access the relative's room. The room was frequently used for patients due to capacity in the department.

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Most patients had access to call bells and staff responded as quickly as possible when called. Some patients in the majors area during our inspection were left waiting longer than expected before their call bell was responded to. Two patients who were unable to use their call bell were heard calling out for assistance.

The service mostly had enough suitable equipment to help them to safely care for patients. However, the department layout and doorway restrictions meant it could only accommodate six hospital beds for patients at risk of skin damage. Two additional air mattress trolly toppers were available.

Assessing and responding to patient risk

Staff did not always promptly identify and quickly act upon patients at risk of deterioration. Staff completed risk assessments on patients admitted to the department and tried to remove or minimise risks.

Patients were booked in at the emergency department (ED) through reception or with the nurse navigator. They were then seen by a triage nurse for an initial assessment in time order, unless they presented with a red flag condition, such as suspected stroke. The triage nurse used a recognised triage tool to categorise each patients' risk score. Higher risk patients were seen by medical staff sooner.

National guidance by the Royal College of Emergency Medicine (RCEM) relating to the initial assessment times of patients in ED was not always met and many patients waited more than 15 minutes from arrival time to their initial assessment and triage. Triage is a face-to-face contact with a patient to prioritise their need for further assessment and treatment in a system where the demand for patient care outstrips the ability of the system to deliver it at the time of presentation. During our inspection children were triaged within 15 minutes of arrival. However, in July 2021, only 62% of children were triaged within 15 minutes of arrival, and the longest paediatric wait for triage was 94 minutes. In June 2021, the average time to paediatric assessment was 21 minutes

Adult patients were not triaged within 15 minutes of arrival for 29 patients out of the 34 patients we reviewed. The longest wait for triage was 5 hours and seven minutes. In June 2021, 50% adult of patients were triaged within 15 minutes of arrival.

There were delays for patients arriving by ambulance despite some patients having serious conditions. For example, during our inspection an elderly patient with a fractured hip and dehydration had been on the ambulance for over three hours and many other patients over 75 years old had waited between two and three hours before accessing the ED.

In April 2021, there were 346 occasions where an ambulance was delayed more than an hour before handing over the patient to ED staff. The trust and the ambulance services were monitoring these delays which impacted on patient care and delayed ambulance arrival times for other patients who may require one in an emergency. The proportion of patients attending by emergency ambulance that waited over 60 minutes from arrival to handover was considerably higher than the midlands and England averages. As of 27 June 2021, 19.0% of patients waited over 60 minutes. This compared to the midlands average of 5.9% and England average of 3.8%.

Medical staff reviewed patients waiting on ambulances. Some ambulance patient records had evidence of a brief review by medical staff documented in their notes. The medical review contained an instruction that ambulance staff continue to monitor the patient and admit them as soon as possible. A dedicated nurse navigator reviewed patients who arrived by ambulance. The navigator also assessed ambulance patients, however they did not always record the times of their assessments.

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The divisional leadership team and ED staff were clear patients held on ambulances were the responsibility of the hospital, however, because they were in the care of health care professionals, it was deemed safe for patients to remain on ambulances.

Urgent and emergency services

There were long delays in transferring patients to specialist care outside of the resuscitation bay. We saw an adult patient who required dialysis and ITU care. The teams of doctors outside of ED did not agree an appropriate pathway for this patient, which left the patient at an increased risk of harm and blocked a resuscitation bed. We also saw a child, who required transfer to the local children's ward, had waited many hours in a resuscitation bay bed space, despite not requiring this level of care.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Patients attending the ED who had their observations taken, had an early warning score recorded, which was used to identify those at risk of deterioration. The department used a National Early Warning Score (NEWS) system for acutely ill patients, which supported staff with the early recognition of deteriorating patients. The NEWS score was calculated using a handheld device for recording patients' vital signs.

The NEWS we looked at during the inspection were escalated and monitored in line with frequency rules. The trust audited their compliance to frequency rules and the results varied. The four-week average compliance in July 2021 assessed by the departments own staff was 97%, and 56% when assessed by departmental peers.

National guidance relating to the assessment, recording and monitoring of children's vital signs was not always followed. The Royal College of Paediatrics and Child Health recommends that, children presenting with a medical illness or significant trauma should have a set of vital signs recorded. Not all patients attending the ED had their observations taken, including some children. Triage staff told us they made a clinical decision as whether a set of observations was required.

The trust audited their sepsis care. The four-week average compliance to screening in July 2021 was 98% and compliance in respect of appropriate antibiotics within 60 munities was 91%. During our inspection we looked at two patients with sepsis, both of which had been given antibiotic treatment outside of the recommended one-hour timeframe, and although most records showed patients had been screened, we found two patients who had not.

Risk assessments for each patient were mostly done on admission using a recognised tool and reviewed regularly. Staff knew about and dealt with any specific risk issues. Risk assessments for falls and pressure damage were included in the patient's admission documentation pack along with bed rail assessments.

The pressure damage risk assessment included a tick checklist, and a visual inspection of the patient's skin. The visual records were not completed in the records we looked at. Instead staff had written the patient self-reported their skin was intact. Patients identified as being a high risk for pressure damage, and who were in the department for a long time were transferred onto a hospital bed, although some patients had already been in the department or on the back of an ambulance for several hours on a trolly before their assessments were carried out.

Falls risk assessments had been completed, although a patient identified as having a high risk of falling, did not have the required falls wrist band.

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VTE risk assessments were completed electronically and doctors told us these were normally completed prior to prescribing preventative medicines to patients. VTE assessments had been completed on the records we checked, and patients had been prescribed preventative medicines.

The service had 24-hour access to mental health liaison and specialist mental health support for patients who presented with acute mental concerns. Staff completed, or arranged, psychosocial assessments and risk assessments for patients

thought to be at risk of self-harm or suicide. Nurses made appropriate referrals to the mental health liaison team and psychiatrists when needed and sought support for patients who presented at the ED with behaviours that placed them or others at risk. Some patients required physical interventions in the form of physical restraint to keep them and others safe.

National guidance was not always followed to ensure the risks associated with restraining patients were being mitigated. For example, from 5 April to 14 June 2021, restraint was used 52 times, 22 of these where chemical restraints. Post restraint observations were not recorded for seven of these 22 patients and although all patients had a body map completed prior to restraint, six patients did not have a body map completed post restraint. Any related injuries may be unreported.

Staff mostly shared key information to keep patients safe when handing over their care to others. Verbal handovers were provided when transferring patients to ambulance staff. Doctors shared information with GP's when patients were discharged from the department.

ED consultants monitored children who left the department before being treated and were required to contact the family within 24hours of their attendance to identify any harm as a result of children leaving before treatment. In the week commencing 14 June 2021, 3.5% of all children left the ED before being seen. From 23 May to 19 June 2021, 33 children left the department without being seen. The trust provided details of 23 of these cases and showed that only four of these children were followed up the next day. Additionally, two children had no action recorded at all and two children had no date of the action recorded.

Process to follow up adult patients who left the department before completion of treatment were not robust. Some adults who presented to the department with potentially serious symptoms, including chest pain and pregnancy related concerns, left before being fully assessed. Patients who left before any treatment was given had a basic discharge summary sent to their GP. However, medical staff we spoke with could not confirm this always happened, and there were no audits to check this. Patients who had started treatment and left before its completion would have a discharge summary sent to their GP automatically.

Shift changes and handovers included all necessary key information to keep patients safe. The trust's Urgent and Emergency Care Survey 2018 scored significantly worse than other trusts for giving information about how to get test results after leaving the ED.

Staffing

Nurse staffing

The service did not always have enough nursing staff with the right qualifications, skills, training and experience to consistently keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix. Staffing gaps were filled with temporary bank and agency staff and gave them a full induction.

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The service did not have enough substantive nursing staff and support staff to always keep patients safe. The number of nurses and healthcare assistants did not always match the planned numbers. Due to recent activity levels in the department, the numbers had been increased by one nurse and one HCA for both day and night shifts. Planned emergency department (ED) daytime staffing was now 15 qualified nurses and at night 12 qualified nurses.

Current staffing requirements had not been calculated using a recognised staffing tool, for example, the Royal College of Emergency Medicine (RCEM) Baseline Emergency Staffing Tool. Senior nurses told us that the current staffing

establishment was not calculated using any recognised tool or method, and believed if a recognised tool was used, a bigger establishment of nurses would be determined. A business case had been submitted for more nurses and HCA's to be added to the emergency department (ED) establishment requirements, however nurses were unsure when or if this might be approved. Following our inspection, managers told us nurse staffing in the ED had been calculated using an adapted nurse staffing tool and the RCEM Baseline Emergency Staffing Tool. Nurse staffing was on the departmental risk register.

The major's area was allocated three nurses and one HCA and accommodated 12 patients. One nurse was often moved to cover another area of the ED. During our inspection, two nurses and one HCA were caring for 12 majors' patients. The nurse in charge had been asked to open the ED corridor to accommodate ambulance arrivals but was unable to do so due to nurse shortages. Additionally, the department tried to incorporate an ambulance handover nurse on its roster with responsibility for a cohort of up to four ambulance patients. Staff shortages meant this role was not always filled. Similarly, the pit stop was not always fully functional due to nurse staff shortages.

The standard operating procedure for the clinical decision unit (CDU) required it be staffed by one nurse and two HCA's. During our inspection, one nurse only was allocated to this area.

The ED was short of three nurses during the two days of our inspection, and additionally on day two it was short an HCA and an emergency nurse practitioner. This impacted on patient care. For example, patients had not been kept up to date with the plans for their treatment. All patients we spoke with told us staff appeared very busy although they were trying to help as much as possible. One member of staff reported they would go without their break because there was no one who could safely relieve them.

During the four weeks from 13 June to 10 July 2021, the ED staff rota showed shifts were down a qualified nurse on 13 out of the 28 days. Most of the shortages were for one nurse, although on four occasions the shortage was for two or three qualified nurses. However, these gaps were only what the e-rostering system identified as gaps, and this was based on the programmed e-rostering establishment figures. Senior nurses told us a larger establishment was required to improve patient care and safety.

The trust did not have enough registered children's nurses (RCN) to meet the Royal College of Paediatric and Children's Health (RCPCH) guidance and were unable to ensure two RCN's were available on each shift. In order to reduce the risk of this, the ED aimed to have one RCN and one adult nurse who had completed a set of children's competencies on duty. The trust was unable to meet this requirement every day. During our inspection there were no RCN and only one nurse in the department who had children's competencies on the day shift on 20 July 2021 and there were no children's nurses scheduled for the night shift. At the time of our inspection, most band six and band seven nurses had theses competencies, however, only 8% of band 5 staff nurses had completed these. There was a training plan to address this shortfall. Senior nurses told us there was an ongoing campaign to recruit more children's nurses and that some had already been appointed and were due to start very soon.

The service had reducing rates of bank and agency nurses. All shifts from January to April 2021 had more substantive staff than agency staff and the department's reliance on agency staff had declined steadily from 41% in September 2020 to 23% in April 2021.

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Managers calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift. Staff shortages were discussed at bed meetings throughout the day and had oversight of any shortages. Senior managers moved clinical staff to improve safety.

The department manager could adjust staffing levels daily according to the needs of patients. We saw managers requested extra staff when the department was full and they wanted to open the corridor to handover patients waiting on ambulances.

Managers limited their use of bank and agency staff and requested staff familiar with the service. Agency staff we spoke with during our inspection all worked regularly in the ED and knew how the department operated.

Managers made sure all bank and agency staff had a full induction and understood the service. The service used an agency induction booklet and checklist for new starters.

Medical staffing

The service did not always have enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave locum staff a full induction.

The service did not have enough medical staff to keep patients safe. There was a high reliance on agency and locum staff. There were four whole time equivalent (WTE) consultants in the emergency department (ED). This did not allow the service to meet recommendations from the Royal College of Emergency Medicine (RCEM), that consultant staffing in the ED to be present in the ED for a minimum of 16 hours a day. At RSH consultants worked Monday to Friday from 8am to 10pm and from 9am to 3pm at weekends. On call cover was provided at all other times.

Clinical leaders told us it required ten WTE consultants to run safely and effectively.

The trust had been unable to recruit a paediatric emergency medicine consultant as recommended in the Royal College of Paediatric and Children's Health (RCPCH) guidance, Facing the Future: Standards for children in emergency care settings. Paediatric advice was available from the Princes Royal Hospital in Telford.

Medical staffing was on the department risk register.

Managers could access locums when they needed additional medical staff and made sure locums had a full induction to the service before they started work. The locums used were regular doctors who had worked in the service for some time.

The service always had a consultant on call during evenings and weekends. Weekend consultant cover was by locums only as there were insufficient substantive consultants to cover this period.

There were gaps in the medical rota that the service were unable to fill. Medical staff told us they managed the service as safely as possible with the resources available. Medical leads said they reviewed staffing to ensure it was 'adequate', and as safe as possible. However, we found there was insufficient middle grade doctors allocated to cover the weekend hours and that the department relied heavily on junior doctors. At night, there were only two registrars available. During the inspection, a registrar grade doctor was allocated to cover the resuscitation bay, where the sickest patients were nursed, while the more senior consultant covered the major's area and carried out some administrative tasks. The layout of the department meant the most senior person was not always visible or immediately locatable.

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The service had high vacancy rates for medical staff.

There were ongoing plans to recruit new staff and managers were creative in employing experienced senior registrars to fill consultant roles within the department.

The service reviewed its skill mix of medical staff on each shift regularly. There were less consultant staff working in the ED than the England average. In January 2021, 11 % of medical staff were consultants, the England average was 29%. 34% of medical staff were middle career grade doctors, 47% were registrars and 8% were junior doctors. *(Source: NHS Digital Workforce Statistics.)*

Managers told us they required 44 middle grade doctors to cover Royal Shrewsbury Hospital and Princess Royal Hospital, Telford. There were currently 28, dropping to 20 in August as middle grade doctors moved to training places and promotions outside of the trust. The department had trained and recruited some advanced nurse practitioners and emergency nurse practitioners to support junior doctor roles.

Records

Staff mostly kept detailed records of patients' care and treatment. Records were clear, up-to-date, and easily available to all staff providing care. Not all records were stored securely.

Staff could access patient notes easily but notes were not always comprehensive. Nursing and medical staff had access to patients' paper and electronic records. Records contained information about the patients care and their risk assessments. Some ongoing care records were ticked and did not contain details of interventions. For example, the hourly check proforma included a pain section which was mostly ticked and did not recording a pain score, or interventions, and the food section was ticked, but no details of what the patient had been offered was recorded.

When patients transferred to a new team, there were no delays in staff accessing their records. Paper records were transferred with patients to other departments within hospital and electronic records were available throughout the trust. Patients who were not admitted, had their notes scanned in by administrative staff. Some staff reported delays in scanning.

Records were not always stored securely. Notes trolley were unlocked throughout our inspection and in the clinical decision unit area, patient notes were left unattended on top of the nurses' station.

Medicines

Staff mostly followed systems and processes when prescribing, administering, and recording medicines. Most medicine was locked away.

Staff followed systems and processes to safely prescribe, administer and record medicines. Medicines administration records were maintained to show the medicines that had been prescribed had been administered. The allergy status of patients was recorded.

Some patients experienced a delay in being given their medicine once it had been prescribed. We saw some delays in the administration of some antibiotics which ranged from 45mins to 1hour and 45mins, and there were some delays in the commencement of IV fluids of up to two hours. Delays also occurred in prescribing medicines as a result of patients waiting in ambulances to access the department.

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Analgesia was not routinely offered during triage. Triage nurses told us they did not always offer analgesia at triage because it required a doctor to prescribe it, which would increase delays. Triage nurses told us patient group directives (PGDs) were no longer available in the department, and so they were unable to offer simple analgesia themselves. Following our inspection, matrons told us PGD's had been available in the department and had recently been updated. Pharmacists confirmed PGD's were available and were unaware staff were not using them.

Some paediatric medicines were not always available, especially at weekends and out of hours. Stock levels of paediatric medicines were currently being reviewed with advice from pharmacy. Medicines were delivered twice a week and alternative treatment advice was provided if any medicine was not available.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. Doctors reviewed patient's medicines on admission which was documented in patients notes.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. Prescribing documents were stored safely in dedicated secure storage areas. FP10 prescriptions were stored securely with a checking system to track their use. New improved security systems had been implemented which ensured only authorised staff had access to medicines. Controlled drugs were stored and recorded following policy. Twice daily checks were undertaken, and any discrepancies were reported and investigated.

Staff mostly followed current national practice to check patients had the correct medicines. Dedicated sepsis trollies were available for the immediate treatment of sepsis. Medicine reconciliation was undertaken by doctors in ED. Antibiotics were prescribed following the trust antimicrobial guidelines including details of their indication for use, length of treatment and review dates. Venous thromboembolism (VTE) protocols were in place and completed for patients along with appropriate prophylactic medicine.

Guidelines on the safe dosage of some paediatric medicines were not available at the point of use. For example, intranasal diamorphine, for children in severe pain. This medicine required titration based on the age and weight of a child and is available in different strengths. It is important when administering this medicine that the correct amount is used. Medical staff we spoke with were unsure about the guidance.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Safety alerts and medicine incidents were discussed in daily huddles and in team meetings.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. Medicines used to manage agitation or aggression (rapid tranquilisation) were prescribed following appropriate safety checks and in line with guidance.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Nicola Kelly
11/06/2021 12:38:21

Urgent and emergency services

Staff knew what incidents to report and how to report them and staff raised concerns and reported incidents and near misses in line with trust policy. We looked at some incident reports submitted by the trust. Staff gave examples of incidents they had reported. Delays to patient care as a result of delayed ambulance handovers were not routinely reported as incidents due to the amount of administrative work this would involve, although if there was a harm identified by the delay, staff said this would trigger an incident report.

Staff shared feedback from investigations and incidents, both internal and external to the service. Staff met to discuss the feedback and look at improvements to patient care. Incidents were shared across ED departments and at daily managers meetings and cascaded to staff as required. Local incidents were discussed in daily huddles and at team meetings. There were messages of the week, and any themes from incidents were used as messages. Not all staff reporting incidents received feedback from managers in relation to incidents they had reported. However, leaders were aware of this and were instigating new processes to improve this.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. There was evidence that changes had been made as a result of feedback. Senior nurses described how patients were invited to contribute to investigations, where appropriate.

Managers debriefed and supported staff after any serious incident. Staff discussed a recent event in the department and we saw evidence that staff had been given the opportunity to receive support.

The service had no never events or serious incidents in the previous 12 months. Managers shared learning with their staff about never events that happened elsewhere. Staff were not aware of any recent never events in the trust but could articulate what one was.

Safety Thermometer

The service collected patient safety data. However, this information was not always up to date or clearly displayed for patients and staff to view.

The service continually monitored safety performance. Quality performance reports were displayed on the triage corridor which was not easily accessible for patients. The reports displayed were for April 2021 and were printed directly off the trust quality dashboard system on A4 paper. The information was difficult to read and interpret for lay people. However, the information demonstrated the service were carrying out quality audits. Most areas were compliant, except for nutrition which was red and scored 71%. Medicine management scored 80% and tissue viability scored 82% and both were flagged as amber. There was no falls information displayed.

Is the service effective?

McLellan, Kim
11/26/2021 12:38:3

Requires Improvement ↑

Our rating of effective improved. We rated it as requires improvement.

Urgent and emergency services

Evidence-based care and treatment

Clinical pathways and policies were not always updated in line with national guidance and staff had difficulty in accessing these. There were some checks to ensure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Some policies were out of date and difficult to find, although we did not see any evidence of staff following incorrect guidance. For example, printed guidance for the pathway management of diabetic ketoacidosis in adults (DKA) was dated June 2010, despite a national guidance update in 2021. An electronic version sent to us following our inspection was also dated 2010, although the trust's DKA policy had been updated in line with the recent guidance.

Medical staff told us electronic guidelines were difficult to find and were located under different directorates and there was no one central catalogue of guidance. Mangers told us this had been recognised and that they were hoping to release a directory of all trust guidance soon. We were told if staff were unable to find the correct guidance, or guidance which they believed was sufficiently in date, then staff followed national guidelines instead.

Audit information was collected regularly. For example; compliance with sepsis screening and escalation of deteriorating patients. Actions following any audited non-compliance included individual coaching and teaching and any departmental learning points were discussed at daily huddles and team meetings to raise awareness.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. Records we checked during the inspection showed staff had followed the correct Code of Practice to protect patients subject to the Mental Health Act 1983 (MHA). Patients presenting with self-harm and suicidal ideation were given one to one support by security staff and had received all the required mental health assessments, risk assessments and authority to detain. Trust data for June 2021 showed 100% of patients appropriately received a mental health triage assessment.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. Staff were aware of patients who required extra support with their mental health and wellbeing. Notes were appropriately flagged, and specific needs were discussed at handovers.

Nutrition and hydration

Staff did not have access to specialist support staff or assess all patients using a nationally recognised screening tool. Staff mostly gave patients enough food and drink to meet their needs and improve their health once they were inside the department. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Staff did not use a nationally recognised screening tool to monitor patients at risk of malnutrition. We were told nutritional screening was done on admission to the ward. However, many patients were in the department a long time and could arrive with a poor nutritional status.

Specialist support from staff such as dietitians and speech and language therapists was not available for patients who needed it. Patients had a basic swallowing assessment from nursing and medical staff, and those identified as at risk were placed on nil by mouth until admitted. Intravenous fluids were provided instead.

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Staff mostly made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs once inside the department. However, there were long delays in accessing care which left some patients without food and drink for a long time, and there were some delays in starting intravenous fluids for dehydrated patients. Some patients on the back of ambulances were given water and offered snacks, although some trust harm reviews undertaken on patients waiting over four hours found there was no evidence that food or drink had been offered.

We did not see any records where a patient's nutritional preference had been recorded, for example, requires a soft diet only. A department nutritional audit for April 2021 showed compliance with nutrition was 71%.

Patients in the emergency department (ED) overnight told us they would have preferred hot food, rather than sandwiches.

Staff completed basic details in patients' fluid and nutrition charts where needed. ED checklists confirmed patients had been offered diet and fluids, although they did not always record what had been provided to the patient. Fluid balances were commenced for patients receiving IV fluids, but they did not always record any oral intake, or any output.

Pain relief

There were delays to patients in receiving pain relief and additional pain relief was not always offered. Patients did not routinely have a pain score assessment recorded on admission, although pain was monitored through the ED checklists. Staff supported those unable to communicate using suitable assessment tools.

Pain relief was not always given in line with individual needs and best practice and not all patients had a pain score recorded using a recognised tool on admission. Pain scores were not recorded at triage for seven out of the eight records we checked. Pain relief was offered to two of the eight patients. Local and national guidance on pain relief was not always followed. A child with a fractured elbow and a pain score of eight out of ten was given paracetamol only. Staff confirmed their policy would have enabled further pain relief to be offered.

Patients identified as in pain did not always have appropriate pain relief prescribed soon after it was identified they needed it. A patient reporting a score of nine out of ten at triage was not offered analgesia. A patient with a pain score of seven, recorded twice during their 19-hour admission, had not been prescribed any analgesia until the inspection team raised it.

Staff prescribed, administered and recorded pain relief accurately. We did not see any prescribing or recording errors on prescriptions.

Patient outcomes

Staff did not always monitor the effectiveness of all care and treatment. Some audit findings were used to make improvements for patient outcomes. Data supplied for some national audits was incomplete.

The service participated in relevant national clinical audits. This included the following Royal College of Emergency Medicine (RCEM) audits;

Anderson Holly 11/08/2021 12:38:2

- RCEM Audit: Vital signs in adults 2018/2019
- RCEM Audit: Feverish child 2018/2019
- RCEM Audit: VTE in lower limb immobilisation 2018/2019

- RCEM Audit: Assessing Cognitive Impairment in Older Adults 2019/2020.
- RCEM Audit: Mental Health (Self Harm) 2019/2020.
- RCEM Audit: Care of Children in the Emergency Department 2019/2020.

Audit results and actions plans were requested from the trust. The audits showed the service performed worse than the national average for all three of the 2019 - 2020 audits they participated in, and worse for one of the three 2018-2019 audits. Some of the audits contained incomplete data and therefore it was not possible to compare the results for all audits with the national performance. We were not provided with action plans although medical staff said they continually monitored the quality of their patient outcomes and followed up action plans to improve standards.

Outcomes for patients were not always positive, consistent or met expectations, such as national standards. For example, the Care of Children in the Emergency Department audit had a measure that included infants who were at high risk of potential safeguarding presentations were reviewed by a senior clinician whilst in the ED. This ED submitted one patient record only. This record failed to meet the standard. The standard to 'assess psychosocial risks using a national or locally developed risk assessment tool' was not met for any of the five cases submitted to the audit.

For the Assessment for Cognitive Impairment in Older People audit, the ED performed worse than the national average for all six measures for which its data was available.

The Mental Health (self-harm) audit showed the ED performed worse than the national average for eight of the nine metrics where data was available.

Managers and staff used the results to improve patients' outcomes, and to improve care and treatment. Action plans to improve performance were in place and were updated and discussed regularly within the medical teams. Junior doctors participated in audit data improvements and this formed part of their clinical education.

Managers and staff carried out a comprehensive programme of local audits to check improvement over time. Regular local quality audits were undertaken in the ED and the results were fed back into the trust's internal quality assurance systems. Externally reported audits were completed although some RCEM audits showed limited case inclusions which made compliance to standards difficult to ascertain.

Managers shared and made sure staff understood information from the audits. Audit results were discussed locally within the department, divisionally at quality meetings, and trust wide at board level.

The service had a lower than expected risk of re-attendance than the England average. The reattendance rate at this trust in May 2021 was 6% and 8% in the midlands.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Morellan Holly
11/26/2021 12:18:3

Senior nurses were experienced, qualified and had the right skills and knowledge to meet the needs of patients. The department was run by senior nurses who were experienced in providing emergency care. However, due to a need to increase nurse staff numbers, many nurses working in the emergency department (ED) were junior, new to the service or were international nurses who had recently joined the services training programme. This group of staff did not have all

the necessary skills to meet all patient needs, although there was a comprehensive training programme to address this. For example, only 8% of band five staff nurses had children's nurse competencies and there was a plan to address this by October 2021. Following our inspection, managers told us that 96% of ED staff who were responsible for children in the department, had completed all of their children's competencies.

Managers gave new staff a full induction tailored to their role before they started work. The induction period was flexible to accommodate individual learning requirements and new nurses told us they were happy with the training and support they were receiving in the ED.

Managers supported staff to develop through yearly, constructive appraisals of their work. Data showed 80% of ED nurses and 84% of medical staff had an in-date formal appraisal recorded. Although this did not meet the trust target of 90%, staff had access to ongoing one to one support and development conversations. Delays in appraisals were largely due to the extra pressures on staff during the COVID-19 pandemic.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Junior doctors had access to regular, high quality training which covered their learning needs. Feedback from junior doctors about their experience and access to clinical supervision in the department was positive.

The clinical educators supported the learning and development needs of staff and managers made sure staff received any specialist training for their role. The department had recently appointed a full-time clinical educator to ensure staff had the right support and access to relevant training. Each ED nurse was required to complete 49 hours of training annually and a business case had been submitted to ensure ED nurses had access to all this.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Staff meetings could be attended in person or using video conference facilities. Team meeting minutes and outcomes or actions were shared with staff via email, social media or by a dedicated staff app. Additionally, relevant messages and updates from team meetings were shared at the daily huddles and board rounds.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Poor staff performance was identified promptly. A new nurse leadership structure had been implemented in the ED which allocated a group of junior staff to a dedicated band seven nurse. This allowed close supervision of junior nurses and improved the early identification of any extra training which may be required on an individual basis.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Daily huddles around the white board included all disciplines of staff. Leaders described how they worked closely with the medical division to improve medical reviews and access onto a medical ward if required. The frailty team were active in supporting staff and patients in the emergency department (ED), although there were no inpatient frailty beds at the hospital. The frailty team included occupational therapists, physiotherapists, advanced care practitioners, a geriatrician and a social worker.

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Staff mostly worked well across health care disciplines and with other agencies when required to care for patients. Doctors from the medical team worked in the ED regularly to assess and care for their patients. Speciality doctors were

mostly responsive when asked to review patients in the ED although there were delays for some patients. For example, a patient required admitting and a disagreement over which department would accept the patient meant there was a delay in treatment and the patient remained in ED longer than necessary. Another patient waiting ten hours for a surgical bed was refused the bed when it became available because a CT scan had not been performed.

Staff referred patients for mental health assessments when they showed signs of mental ill health or depression. The mental health liaison service worked closely with ED staff and provided advice and support when required.

Seven-day services

Key services were available seven days a week to support timely patient care.

Staff could call for support from doctors and most other disciplines and diagnostic services, including mental health services, 24 hours a day, seven days a week.

The frailty team was available Monday to Friday and the last referral time was 4pm. Saturday occupational therapy and physiotherapy cover for the emergency department (ED) was included in the hospital site therapy weekend rota but was not dedicated to ED patients, although dedicated support was available on Sundays.

There was good access to imaging 24 hours a day, seven days per week and staff were not concerned about any delays in reporting or accessing results.

Health Promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support in the emergency department (ED). Leaflets were available and given to patients for a range of conditions and we saw staff signposting patients to other helpful services during triage.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. Assessment of a patient's physical, psychological and social needs formed part of the ED admissions booklet. Patients were referred to their GP for continuing support if required.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Patients' records had evidence of appropriate assessments.

McLellan, Hilary 11/26/2021 1:38:01

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Most consent was gained verbally although we saw formal written consent was obtained when required, for example to undergo some diagnostic tests. Some emergency department (ED) nurses had clearly recorded they had sought consent from a patient before carrying out an intervention.

Urgent and emergency services

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. We saw appropriate referrals and assessment had taken place for patients presenting with acute mental health concerns.

Staff understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment. Staff described how they supported children to make decisions about their care and treatment.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards, they did not all keep up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Data showed 60% of nurses had completed this training at the time of our inspection. Senior nurses told us training was booked for most nurses. Medical staff compliance was 86%.

Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them. Applications for Depravation of Liberty Safeguards (DoLS) were not routinely completed in the department. Patients requiring a DoLS application had this completed once the patient was admitted to a ward. Patients in the ED had their best interests assessed.

Is the service caring?

Requires Improvement ↑

Our rating of caring improved. We rated it as requires improvement.

Compassionate care

Although individual staff members treated patients with compassion and kindness, the service was not designed in a manner that always respected patients' privacy and dignity. Staff did not always have the time to interact with people in a meaningful way.

Although we found improvements since our last inspection, issues with the emergency department (ED) environment and staff numbers meant patients did not always receive meaningful compassionate care.

We inspected the ED at a time when it was under enormous pressure due to the volume of patients trying to access services and having lower than planned staffing. Patients waited longer for staff to attend to their needs and many were left on the back of ambulances or in the waiting room for a very long time. Less patients were cared for in the ED corridor than during our previous inspections, but some patients were nursed there overnight, and others waited for many hours on a trolley in the back of an ambulance. Patients sat on the floor outside of ED and some patients waiting to access the service were not offered analgesia, even after triage.

Magellan Health
11/26/2021 10:58:38

Staff tried to remain discreet and responsive when caring for patients. Staff worked hard to protect the privacy and dignity of patients, despite working in a heavily congested and busy department. Interactions between nurses, doctors and their patients demonstrated kindness and compassion. However, we observed that staff did not always have enough time to spend with patients beyond carrying out essential tasks. Some patients in the major's area appeared confused and were unsupported for long periods of time.

Patients said staff treated them well and with kindness. All patient we spoke with were happy with the care they had received and felt grateful to the staff looking after them. However, most patients also said that the nurses appeared very busy and used phrases such as ‘’always running about’’, and ‘’trying their best to look after everyone’’.

Staff mostly followed policy to keep patient care and treatment confidential. Although staff tried to keep treatment and conversations confidential, the environment was such that most conversations could be heard by other patients, staff and visitors. For example, in the major’s area, we overheard a private conversation regarding a patient’s personal hygiene care needs, and we heard a medical assessment which included how much alcohol the patient drank daily. The reception area booking in windows were close together alongside the waiting room meaning it was difficult for confidential information not to be overheard. Notes trolleys were not locked, and in the CDU area patient notes were left on top of the nurse’s station. Patients and visitors were free to walk around the ED as all areas were freely accessible. Some bay curtains and doors were open meaning patients could be freely observed. Private areas were not always available, for example the family room, as it had been used for an extra patient bed space.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. Security guards in uniform were used to look after patients who presented with mental health concerns and who were at risk of self-harm. Guards accompanied these patients throughout the ED, including outside and in the waiting rooms. We observed a female patient in a side room was being observed by two male security guards outside of her windowed room.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Staff told us they had access to resources on cultural needs and were able to offer these to patients as required. We were told most patients moved out of the ED before requiring culturally specific care.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Patients confirmed staff were caring and sensitive to their emotional state.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. The dedicated relative’s room was unavailable during our inspection however staff said an alternative private space was available for families if required. Most of the emergency department (ED) was open, and conversations could be overheard, although staff pulled curtains round bed spaces, and closed doors where these were available.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Staff showed an understanding of the individual end of life care needs for patients and their families. There was an end of life support box available which contained resources for families.

Staff understood the emotional and social impact that a person’s care, treatment or condition had on their wellbeing and on those close to them. Staff were aware of the life changing conditions some patients presented with and discussed these sensitively with patients.

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Understanding and involvement of patients and those close to them

Staff mostly supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Urgent and emergency services

Staff did not always make sure patients and those close to them understood their care and treatment. Patients were told of their care journey through the emergency department (ED) during the triage process, although patients waiting a long time were not kept up to date with delays and waiting times. We spoke with patients waiting outside after triage, who had been there for several hours, and who said no one had spoken to them since their initial assessment, and they wondered if they had been missed. We saw some patients return to reception to request an update and reception staff were unable to provide this. Some patients waiting to be admitted to a hospital bed told us they were not aware of what their plan of care was. Waiting times were not displayed.

Staff talked to patients in a way they could understand, using communication aids where necessary. Staff spoke with patients, families and carers using language they could understand, and communication tools were available if necessary.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Information about the Friends and Family Test (FFT) and the trust's complaints service was available in the department, although engagement in the FFT low. Managers were aware of this and were working on alternative ways to gather patient feedback.

Staff supported patients to make advanced decisions about their care. Patient's wishes for their end of life care and resuscitation decisions and a preferred place of death were recorded using the ReSPECT form as recommended in guidance.

Is the service responsive?

Inadequate ● ➔🡐

Our rating of responsive stayed the same. We rated it as inadequate.

Service delivery to meet the needs of local people

The service was not designed in a way that always met the needs of local people and the communities it served due to the department's infrastructure and pressures within the local healthcare system. Managers and staff worked with others in the wider system and local organisations to plan care.

The emergency department (ED) at Royal Shrewsbury Hospital was open 24 hours a day, seven days per week. A public consultation (Future Fit) took place in 2018 confirming the agreed way forward for the future configuration of clinical services, including emergency services. A Strategic Outline Case is being finalised for submission to regulatory and national bodies seeking approval and funding for the resultant Hospital Transformation Plan.

Managers tried to plan and organise services to meet the needs of the local population, although they were hampered by an unsuitable environment, premises and a lack of inpatient hospital beds. The facilities and premises were not appropriate for all the services being delivered. Children spent a long time in adult resuscitation bays and the children's treatment room was normally used for adults. There were insufficient toileting and washing facilities and the lack of a medical admissions unit meant some patients stayed overnight in the department on trolleys when they would otherwise be admitted to a bedded area with bathrooms. The waiting room could not accommodate the number of patients wanting to use the service and the number of seats had been reduced further due to social distancing measures. Many patients sat on the ground outside the emergency department (ED) for a long time while waiting to be

seen. A patient who said they were unable to walk was sat in a wheelchair for over five hours outside. At the time of our inspection the trust was in the process of redeveloping the department and plans showed some of the environmental issues would be addressed by the improvements. However, this did not address the bed capacity in the hospital which was identified as still being a challenge despite the improvements.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. Staff said any mixed sex breaches in the clinical decision unit would be reported, although those we asked, were not aware of any recent mixed sex breaches. Mixed sex rules were not applicable to other areas in the ED.

Staff could access emergency mental health support 24 hours a day, 7 days a week for patients with mental health problems, learning disabilities and dementia. Patients' records showed they had been referred appropriately and had been seen by supporting organisations. Dementia support staff worked in the trust and visited the ED to provide support and guidance to staff.

The service had systems to help care for patients in need of additional support or specialist intervention. Physiotherapy follow up clinics were run within the ED to provide advice and support to patients who presented with musculoskeletal injuries. ED staff had access to specialist nurses with a range of skills including tissue viability, sepsis, infection control and safeguarding.

The service relieved pressure on other departments when they could treat patients in a day. Patients were not admitted for an overnight stay unless this was required and admission rates were monitored. A frailty team was in place to provide additional support to frail elderly patients who could go home with extra support instead.

Managers and staff worked with other providers to organise care. Patients were assessed on arrival to ensure they were treated by the most appropriate service and were redirected to the onsite GP service, urgent care centre or to primary care if required.

Leaders worked closely with the commissioners and community providers to find system responses to the capacity issues both in the ED and the wider trust and were active members in the regional urgent and emergency care group. They met monthly with the ambulance service to improve services.

Meeting people's individual needs

The service was mostly inclusive and took account of patients' individual needs and preferences. Staff made some reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet most of their needs. Most areas of the department were bright, busy and noisy which some groups of patients might find distressing, and there were very few side rooms where quieter care could be provided. Staff did not always have enough time to support and respond to the individual needs of all patients.

McLellan,Holly 11/26/2021 12:38:21

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. Dementia nurses supported emergency department (ED) staff to complete 'This is me' passports. However, the ED environment was not designed to meet the needs of patients living with dementia. The CDU area had a 'twiddle box' which contained items of distraction for patients who might benefit from this.

There was limited space in the department to accommodate wheelchairs, bariatric equipment and hospital beds.

Care plans were used for patients who attended the department frequently and these patients were easily identifiable on each admission.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. A hearing system was available at reception and staff sought to provide any additional support patients required as a result of their disability.

All printed information leaflets were in English, although staff had access to some online information in alternative languages which they could print for patients. Leaflets and signs in the department were in English which was in line with a large proportion of the local demographic. There was no information available in Welsh, despite the ED being close to the border.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Interpretation services were primarily provided over the phone, although staff said they could get them and signers into the ED if required.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Most food offered in the ED was sandwiches, plus toast and cereals at breakfast time. Staff said they had access to other food types and were able to meet patient's individual preferences.

Access and flow

People could not always access the service when they needed to, and they did not always receive the right care promptly. Waiting times from arrival to treatment and arrangements to admit, treat and discharge patients fell below national standards.

Patients could not always access emergency services when needed and did not always receive treatment within agreed timeframes and national targets. Managers monitored waiting times.

During our inspection, the service was operating under severe pressure and patients had long waits for every stage of their emergency department (ED) attendance. This included for some patients, over four hours to disembark from ambulances, over four hours to access triage, and over four hours to see a doctor. Capacity in the department was on the ED risk register.

Department leads said they were hampered by the lack of an acute medical assessment unit where ED patients could be directly admitted to. This area had been converted to a red pathway during Covid-19. Nurses said the lack of a discharge lounge impacted on their ability to get patients out of the department who were waiting for transport, or medicines to take home.

The Royal College of Emergency Medicine (RCEM) recommends patients wait no more than one hour from time of arrival to receiving treatment. The trust consistently failed to meet this standard and performed worse than the England average over the 12 month period from May 2020 to April 2021. In April 2021, the trust reported an average time to treatment of 82 minutes. This was longer than the England average of 57 minutes.

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The proportion of patients who attended by ambulance and waited over 60 minutes from arrival to handover from 7 March to 27 June 2021 was higher than average across the Midlands region and across England. As of 27 June 2021, 19% of ambulance patients waited over 60 minutes; the Midlands average was 6% and the England average was 4%.

Urgent and emergency services

On 20 July 2021 at 9am, compliance to the RCEM guidance to see, treat, admit or discharge within the four-hour target was 53%. On 19 July 2021, at 3pm, there were 19, 12-hour breaches with ten more patients about to reach their 12 hours wait.

Managers and staff mostly worked to make sure patients did not stay longer than they needed to. ED staff tried to facilitate care as quickly as possible for every patient. A newly created flow coordinator role helped to get patients moving through the department and identify any delays as early as possible. At the time of our inspection, it was too soon to access the impact of the new role on patient flow through the department. However, an ED nurse in charge told us the flow co-ordinator undertook some of the jobs they previously had to do and it therefore gave the nurse in charge more time to focus on running of the department.

ED doctors reported that speciality staff mostly reviewed their patients while in ED as quickly as possible and that there was a memorandum of understanding to ensure this process was escalated if necessary. We saw some delays for patients awaiting a specialist review during our inspection.

Escalation processes were in place to allow the ED to highlight problems with access and flow quickly. However, ED staff said trust leaders did not always escalate the department pressures sufficiently high or in line with guidance, to ensure the maximum external support was always available. The trust used the NHS England operational escalation framework referred to as Operational Pressures Escalation Level (OPEL). The OPEL level was regularly communicated within the trust and to stakeholders to ensure the wider health and social care systems were aware of the current access and flow status.

During our inspection the department had declared a level three OPEL, with level four evoking the maximum system supports possible. The trust escalation plan was based on the NHS England operational escalation framework referred to as Operational Pressures Escalation Level (OPEL). As this included access to an intensive care bed it was not entirely reflective of the emergency department. Staff were identifying the department was at OPEL four. However, this was not escalated by the trust as they had an ITU bed. This sometimes meant that staff were not necessarily receiving external support in a timely way to expediate discharges or admissions. Staff felt they were working at level four but did not always feel empowered to take action.

The number of patients leaving the service before being seen for treatments was low. The trust reported similar numbers to other trusts, both locally and nationally. There had been a steady increase in patients leaving before being seen since January 2021.

Managers and staff worked to make sure they started discharge planning as early as possible. The frailty team attended the ED to assist with discharges. There was a trust wide initiative to free up hospital beds earlier in the day and to improve patient flow out of the ED. Daily calls were held with partner organisations in order to free up hospital beds and obtain access to continuing care for patients who required it.

The trust were working with commissioners and community providers to access rapid response nursing teams who could help patients going home and prevent some admissions. However, at the time of our inspection, there was no date known when this service might start.

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The trust worked to reduce the number of patients admitted to hospital following attendance at ED. In June 2021, the trust admitted 24% of all type one attendances which was below the England average.

Staff planned patient discharges carefully, particularly for those with complex mental health and social care needs. Patients were referred in a timely way to appropriate mental health services for help with ongoing care and treatment. However, there was a national shortage of mental health inpatient beds, and this was reflected in the number of patients with mental health needs staying in the department longer than was necessary. We observed one patient, who was waiting for an inpatient mental health bed, who had been in the department for more than 35 hours.

Staff supported patients when they were referred or transferred between services. Navigators and triage staff provided information to patients who were referred to other services, such as the out of hours GP service.

Managers monitored patient transfers and followed national standards. Children were transferred to other hospitals using recognised safety standards. Children's nurses were trained specifically for this.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns and the service clearly displayed information about how to raise a concern in patient areas. Information was available in the emergency department (ED) waiting areas on how to make a complaint. Complainants received a response from the ED within 15 days of making a complaint. The ED received more complaints per 1000 patient attendances than most other ED's in the country. Out of 123 ED's the trust was ranked number 102.

From April to June 2021, there were 17 complaints and six compliments. In June 2021 the department received 12 complaints, most of which were about clinical care and treatment.

Staff understood the policy on complaints and knew how to handle them. Nurses told us they provided patients with information about the Patient Liaison Advisory service (PALS) if they were unable to resolve a complaint at the time. However, nurses said they always attempted to resolve a patient's concerns locally and at the time of the incident.

Managers investigated complaints and identified themes. Feedback from complaints was shared with staff and learning was used to improve the service. Themes were shared with staff during team meetings, huddles and at daily handovers. Complaints were discussed at clinical governance meetings.

Recent complaints were mostly about delays to care. Formal complaints were discussed during divisional governance meetings and where appropriate lessons were learned, they were shared throughout the trust.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Managers told us they kept the patient and family up to date with complaint progression as soon as they were able. Managers were allocated administration time in order to respond to complaints.

McLellan, Harry 11/26/2021 14:38:21

Staff could give examples of how they used patient feedback to improve daily practice. This included feedback from the patient volunteer group and local Healthwatch who had made suggestions to improve the environment in ED following feedback they had received from patients.

Urgent and emergency services

Is the service well-led?

Requires Improvement ↑

Our rating of well-led improved. We rated it as requires improvement.

Leadership

Leaders mostly had the skills and abilities to run the service. They understood and were making improvements to manage the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The emergency department was managed under the medicine and emergency care division and was run by the divisional medical director and divisional director of operations. The leadership structure in the emergency department side of the division consisted of a clinical director, centre manager, and divisional director of nursing and divisional deputy director of nursing. The nursing team were led by a matron who was supported by a team of band seven nurses who took charge of the daily operational running of the service.

Local leaders were clear about their own roles and accountabilities. Some staff said the trust wide management team were not always fully sighted on the real time issues faced by the department or fully aligned with the departments view on finding solutions. For example, during our inspection the department was under extreme pressure, however trust managers had not declared a level four OPEL incident. Internal actions had been set in place which were aligned to level four incidents, but the failure to declare a level four externally meant some systems of support which may have been available, had not have been fully explored. ED leaders said this occurred regularly. From April to July 2021, OPEL level four had been declared five times, and OPEL level three had been instigated 53 times. The trust did not always declare a level four if they still had an intensive care bed available.

Local leaders expressed some frustration because when extra actions were required these largely fell to ED staff. For example, nurses said some tasks undertaken in ED could be done by nurses working in other directorates, and although nurses were occasionally redeployed to ED to cover a shift, shortages were largely left to the department to absorb via more creative staff rostering and the use of extra bank and agency staff. Staff said there was little visible support provided by other specialities in the trust.

Divisional leaders told us they visited the department and spoke to staff during walkabouts. They reported using a ''ask five questions'' methodology, whereby they asked different staff the same five questions to gain an insight into what was happening in the department.

Nursing staff told us the nursing and medical leadership team were very visible in the department and that other members of the senior leadership team had recently become more visible. Some staff said senior leaders came to the department only when it was under extreme pressure.

Meellan Hold 12/26/2022 10:08:34

The ED matron supported the daily running of the service along with an increased number of band seven nurses. Each band seven had a group of junior staff which they managed along with a specific area of responsibility in the ED, for example, lead for safeguarding.

There was a band seven nurse in charge every day who had oversight of each clinical area and was required to maintain an overview of patients in the department. When the department operated at maximum capacity, and had up to 60

patients present, it was not possible for one person to have full oversight of every patient. This had been recognised by the leadership team who introduced a more senior leadership structure in the ED. This included recruiting more band six nurses whose role included leading staff covering each clinical area, for example, the major's area. Staff we spoke with were enthusiastic about the impact this would have on the smooth running of the department and on patient safety.

Vision and Strategy

The service had an emerging vision for what it wanted to achieve and an emerging strategy to turn it into action, developed with some relevant stakeholders. The vision and strategy were focused on sustainability of services. Leaders and staff understood and knew how to apply them and monitor progress.

There were seven strands to the strategy. These were; excellence in patient care, leadership, team recognition, wellbeing, professional development, shared decision making and the workforce of the future.

Clinical staff did not specifically discuss the strategy however it was clear work was underway in some of the identified areas. For example, the recently appointed clinical educators assisted with professional development and allowed each nurse to receive two weeks of training before the end of this financial year.

There was an operational plan which set out how the trust intended to respond to local and national challenges. The plan included trajectory improvements in meeting performance such as a reduction in ambulance handover delays and improving four hour waits.

Staff were aware that some of the improvements they planned were dependent upon external factors, including hospital bed capacity, accessibility of GP services and primary care, and the availability of skilled doctors and nurses. Nevertheless, ED leads were also aware of where more local changes were needed to make service improvements. For example, there was a lack of electronic prescribing of medicine which impacted on patient discharges, and the availability of therapy staff to support speedier patient assessments. One of the successful ED priorities, to reduce the number of patients cared for in the ED corridor, had improved the working environment for staff in ED. However, patients were still unable to access the service ay quicker and were held instead on the back of ambulances.

The trust were involved in addressing external issues collaboratively and were active members of the urgent and emergency care delivery group. They worked closely with other providers, 111 services, commissioners and Health Education England in order to realise their strategy.

Senior members of the ED met regularly along with other senior departmental representatives to discuss the trust's "Getting to Good" Plan

This involved identifying actions in each area which would impact on the safety, quality and effectiveness of the care they provided. This helped to ensure many of the concerns identified in the ED were discussed as trust wide issues, and not just problems isolated to the emergency department.

McLellan, Kelly
11/26/2014 11:38:21

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Urgent and emergency services

All staff we spoke with said they felt respected, supported and valued, and that communication in the department had greatly improved recently. In our previous inspection, some staff reported a bullying culture from senior leaders however we did not hear that during this inspection. CQC received a written allegation of bullying during our inspection although matrons told us they were not aware of any allegations of bullying in the department. Nurses told us they were aware of how to escalate concerns around bullying and they were aware of the trust's freedom to speak up guardians.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Clinical governance meetings were regular, well attended and covered a wide range of issues including for example, complaints, incidents, training, safety alerts and mortality and morbidity meeting outcomes. The minutes were shared with staff and available electronically for anyone unable to attend. Minutes showed clear outstanding actions and included an action owner along with an expected timeframe for completion.

Lessons learned from incidents and complaints were discussed in the department newsletter and formed part of the junior doctors teaching. Some junior doctors told us they were not aware of incidents and complaints.

Management of risk, issues and performance

Leaders identified some relevant risks and issues and identified actions to reduce their impact. Staff did not always contribute to decision-making to help avoid compromising the quality of care. Some risks were not always escalated. Leaders and teams used systems to manage performance and had plans to cope with unexpected events.

The risk register contained identified risks and a latest review date, a record of when the risk was added to the register and an audit trail with the history and updates for each risk.

Not all risks were listed on the register or managed well. For example, in July 2021, the trust had 751 overdue incidents across both ED's. There was a risk that some preventable incidents may go undetected. The risks associated with extreme demand in the ED were not always agreed and staff expressed frustration at the trust's response to their concerns. For example, when ED leads believed they were working at level four OPEL and required maximum support from the system to reduce risks, there was discrepancies with managers about how this should be managed.

Decisions about when to accept patients in the ED corridors were not always made with clinicians in the department. The SOP for handling ambulance queues included a statement by senior clinical ED staff that they did not approve of any corridor care as it was never safe or appropriate and it did not allow for social distancing. The trust were unable to provide details about how many patients had been cared for in the corridor, or for how long.

Some senior staff in the department believed the changes to the environment did not go far enough in addressing the current issues and said that although some performance, staff and patient experiences would improve, the changes would not solve all of the problems associated with demand, capacity and flow at the hospital.

Michelle Kelly 11/10/2021 12:38:21

Performance was discussed at team meetings. However, actions from these were not always completed. For example, our inspection identified an airway trolley in the red resuscitation area had not been checked for several months. This had been discussed at the ED leads meeting on 1 June 2021 yet had remained unchecked on 20 July.

Executive leads were aware of the real time position of ED in terms of current waiting times, delays, staffing issues etc. Feedback was provided to them following the 'safe today' divisional calls. Overall, ED performance was reported monthly to the board. Monthly meetings were held with the ambulance service where both organisations worked on improving the quality of services.

Local improvement plans had been agreed with commissioners, including an agreement that achieving the four-hour target for 95% of patients was unattainable. An alternative trajectory meant the trust was aiming for 85% instead. However, in June 2021, the trust was off its trajectory, achieving 68% instead of the planned 71%.

Information Management

The information systems were not integrated and staff could not always access patient data when they needed it. The service collected some pertinent data and analysed it. Data or notifications were consistently submitted to external organisations as required.

The trust emergency department assurance report for June 2021 identified there were seven items in their CQC improvement plan that remained off track, which were attributed to IT problems in the emergency department (ED).

The ED used paper and electronic records to care for patients. Paper records were scanned so they were accessible if a patient returned to ED. Some doctors told us there were sometimes delays in scanning.

The ED recorded patient observations using a different scoring system from the rest of the hospital. ED staff used an early warning score (EWS) and hospital staff recorded a NEWS2 score. We were told this was because there were different electronic systems used in the hospital to record patient observations.

Prescriptions for medicine were paper based, which led to some delays in prescribing medicines and arranging for medicines for patients going home.

Sepsis screening and paediatric observations were not recorded electronically, unlike other patient observations. Paper records were used which made audits more difficult.

Guidelines were not all stored in the same place on the trust intranet and there was an issue with version control for printed copies of some documents, although there was a working group set up to rectify this. A prototype new ED intranet page was about to be tested which contained direct links to all trust guidelines. There was no timescale for implementation.

Some data provided by the trust was incomplete or contradictory, for example training data and data concerning the number of patients cared for in the corridor.

There was no system of displaying waiting times although there was a plan to introduce this.

McLellan, Hilary
11/2/2022 11:38:21

Engagement

Leaders and staff engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Leaders told us they engaged with patients through Healthwatch and through their patient volunteer networks. However, due to the COVID-19 pandemic, there had been limited opportunities to engage with patients.

Urgent and emergency services

Emergency department staff said they tried to encourage patients to give feedback and to complete friends and family surveys but the demands in the department regularly meant this type of activity was not possible.

There was a range of communications to staff to advise them of changes and improvements, such as emails, staff huddles, an improvement newsletter and ward meetings for each grade. Staff were also encouraged to identify changes that would improve patient care and safety and there was a closed social media group for staff to share ideas for improvements.

Learning, continuous improvement and innovation

Staff were committed to learning and improving services, although high demand in the department meant there was not enough time dedicated to improvement initiatives and outcomes. Some quality improvement methods were used, and staff were learning to implement these. While staff were focussed on performance, there was little time for innovation.

Improvements in the department included regular quality audits on patient care and safety. For example, sepsis audits, compliance to escalation of sick patient protocols and mental health patient triage and assessment documentation. Some of these improvements were instigated following our previous inspections. Results from the audits largely showed an upward trend in compliance.

The departments new nurse staffing structure, which included a dedicated, on site matron, more senior nurses and a clinical educator allowed for greater monitoring, oversight and training opportunities.

However, high demand for services, insufficient nursing and medical staff, poor patient flow and an inadequate physical environment had meant many of the quality improvements required were not achieved.

The trust was compliant in providing CQC with information. Some of the information supplied did not evidence sufficient improvement and some items on their improvement plan remained off track.

Some of the newly implemented quality improvements had not improved care for patients at the time of our inspection. For example, the new on site SDEC had not specifically improved patient assessment times or enabled targets to be met, and although the frailty assessment team helped assess elderly care patients quickly, it was not available seven days per week. There was no acute medical assessment area or designated frailty ward for these patients to be looked after in.

The environmental upgrade which was ongoing during our inspection was unlikely to improve flow out of the department and it would not significantly increase the department bed base or give patients more access to admission beds. Corridor care had been reduced, but this had impacted on ambulance delays and had not led to overall improved patient care.

In our previous comprehensive inspection in 2019, 26 regulatory breaches covering eight regulations were identified. During this inspection, 14 of these breaches remained, covering five regulations. We also found one new regulatory breach relating to pain management.

Arleston Holly
11/08/2021 12:38:21

Care Quality Commission

The Princess Royal Hospital

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TF1 6TF
Tel: 01952641222
www.sath.nhs.uk

Description of this hospital

The Princess Royal Hospital is part of Shrewsbury and Telford Hospitals NHS Trust and provides acute services to those living in Telford and surrounding areas.

Services at the Princess Royal Hospital include urgent and emergency care services, emergency medicine and surgery, paediatric services, and maternity and end of life care services. Along with diagnostic and screening, critical care and outpatient services.

The urgent and emergency care service at Princess Royal Hospital (PRH) provides services 24-hours per day, seven days per week service. The hospital is the main receiving centre for the acutely unwell child. The ED comprised of booking in and streaming area, a main waiting area, a children's waiting area for those aged under 13 years, one triage room, a three bedded resuscitation bay, eight majors' cubicles, a four bed 'pit stop', a respiratory isolation unit, (RIU), that could accommodate up to two patients in separate side rooms plus additional space for patients well enough not to require a trolley. The RIU operated limited hours, opening at 10.30am and closing at 10pm, four minors' cubicles providing care to patients who presented with minor injuries, a fit to sit area; a children's assessment and treatment cubicle, and a "Pit stop" or rapid assessment area for patients arriving by ambulance, or for those patients who self-presented to the ED who were prioritised by nursing staff.

The hospital's medical care services comprised of cardiology, renal, respiratory and dermatology, stroke, care of the elderly and neurology, diabetes and endocrine, clinical support services, oncology and haematology.

The end of life care service comprised of two service lines, a specialist palliative care team and an end of life care team. The palliative care team at Shrewsbury and Telford Hospitals NHS Trust works across both hospitals. They provide specialist advice and support to people living with a serious, life-limiting illness who are currently staying in either the Royal Shrewsbury Hospital, or the Princess Royal Hospital in Telford. In-patients who might benefit from the service can be referred to the hospital palliative care team by any healthcare professional, carer or community team.

McLellan, Molly
11/29/2023 12:38:2

During our inspection we visited all areas within urgent and emergency care and maternity and wards 7, 9, 10, 11, 15, 16, 17, acute medical unit and endoscopy.

We spoke with 140 members of staff, including doctors, nursing staff of various grades, healthcare support workers, physiotherapists and managers. We spoke with 27 patients and we looked at 75 sets of patient records.

End of life care

Inadequate ● ➔ 🡐

Is the service safe?

Inadequate ● ➔ 🡐

Our rating of safe stayed the same. We rated it as inadequate.

Mandatory Training

The service did not always provide mandatory training in key skills to all staff or make sure everyone completed it.

Staff did not always receive and keep up to date with their mandatory training.

Mandatory training was largely delivered through the online learning portal but was not comprehensive to meet the needs of patients and staff. The trust mandatory training target was 90% but not all staff groups within end of life and palliative care met this target. Overall compliance for the team was 84%. Mandatory training requirements were different for the various members of the team. For example, the mortuary staff were not required to undertake infection prevention and control training. We requested further clarification from the trust but did not receive it. Data submitted by the trust showed palliative care doctors had not completed updated training for two out of the eight mandatory modules, which included fire safety and equality and diversity. Overall compliance was 75%.

Clinical staff did not always complete training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia.

Bereavement and chaplain staff did not receive Mental Capacity Act, Deprivation of Liberty and Mental Health Act training. This had the potential to affect patient care and lead to serious safety risks amongst the bereavement and chaplaincy services.

Safeguarding

Staff understood how to protect patients from abuse, however they did not always have training on how to recognise and report abuse or how to apply it.

Staff did not receive training appropriate to their role on how to recognise and report abuse.

The intercollegiate document 'Adult Safeguarding Roles and Competencies for Health Care Staff' 2019, states that all practitioners who have regular contact with patients, their families, carers or the public should complete level 2 Safeguarding Adults training. The trust target was 90% for Safeguarding Adults level 2, but not all staff groups met this target for their mandatory training. Overall compliance for the end of life and the specialist palliative care team was 88%. Mandatory training requirements were different for the various members of the team. For example, at the time of our inspection, data showed palliative care doctors had not had update training for safeguarding children level 2, PREVENT level 1 and had not completed PREVENT level 3. The bereavement and chaplain staff were not required to undertake this training despite the requirement as outlined in the intercollegiate document.

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End of life care

The intercollegiate document 'Safeguarding Children and Young People: Roles and Competencies for Health care staff' 2019 states all non-clinical and clinical staff who have any contact (however small) with children, young people and / or parents/ careers or any adult who may pose a risk to children should complete level 2 safeguard children training.

Overall compliance for the end of life and the specialist palliative care team was 88%. Mandatory training was again different across the staff groups and the bereavement and chaplain staff were not required to undertake this training despite the requirement as outlined in the intercollegiate document.

This had the potential to affect patient care and pose serious risks to patients due to staff not being able to recognise safeguarding concerns.

Staff knew how to make a safeguarding referral and who to inform if they had concerns but were unable to describe recent safeguarding referrals or any subsequent learning following them.

Cleanliness, infection control and hygiene

Staff used infection control measures when visiting patients on wards and transporting patients after death. However, measures were not followed within the mortuary.

Ward areas we visited were visibly clean and had suitable furnishings which were clean and well-maintained. However, staff did not always follow infection control principles. Staff were aware of current infection prevention and control guidelines, including the process for screening patients for COVID-19, MRSA and Clostridium Difficile, prior to and during an admission to wards. Staff observed social distancing where this was possible and wore appropriate PPE. There were handwashing facilities and PPE stations on wards we visited, which were well stocked and included information on PPE requirements.

The provider did not comply with the Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance, which states that providers must provide and maintain a clean and appropriate environment in managed premises that facilitates the control of infections.

The mortuary was visibly unclean in several areas. Liquid was observed leaving the condensing pipe below the main refrigerated body store, creating a small pool of fluid which was green in colour. Inspectors noted odour in this area.

Bench surfaces in the post-mortem room were visibly unclean, and the area was cluttered. It was not evident when a thorough cleaning of this area had been carried out, as cleaning records did not include this detail.

The outdoor additional refrigerated bariatric body storage area, was found to have large amounts of visible dirt on the floor including general litter, chewing gum and debris from the nearby situated bins.

Cleaning records for the mortuary were not fit for purpose as they showed only signatures of the staff whom had carried out the cleaning. Staff were not able to describe effective cleaning processes and unable to articulate deep cleaning requirements for these high-risk areas. There were no policies or procedures to outline the cleaning requirements for the mortuary or the outdoor bariatric storage area. Staff explained that the outdoor storage area had recently been used but there was no evidence to show this area had been cleaned.

Mrsehuhn
11/10/2021 12:38:21

The lack of cleaning and supporting policies to ensure appropriate levels of cleaning had been undertaken, posed a significant risk of infection spreading to the immediate mortuary staff and throughout the hospital.

Inspectors raised these concerns immediately with the trust, who arranged for a deep clean of the area and the subsequent development of draft cleaning processes.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff managed clinical waste well.

The mortuary had capacity for 30 patients in the main mortuary with additional storage in the adjacent refrigerated 'SWAN' room. The SWAN logo was used across the hospital to recognise end of life and the supporting end of life care team. Thermostatic checks were completed manually, due to the age of the refrigerators. Outside, another body storage area had been created which could accommodate three bariatric patients. Two temporary storage units were situated in what was the previous post-mortem room.

Staff explained there had never been an issue with capacity, but if this were to cause a problem, they would use their links with local funeral directors to manage flow through the unit.

Patients were transported to the mortuary by porters and all staff accessing the mortuary were required to log entry at all hours of the day and night. Records were up to date and completed appropriately.

Lighting in the outside body storage was broken with only partial illumination of one side of the area. This posed a potential risk of injury to staff entering the area, particularly during the evening and night.

Mortuary staff explained they were waiting for a chest freezer to be replaced which was used to store ice used during transportation. At the time of our inspection ice was obtained from other internal departments.

The service had suitable facilities to meet the needs of patients' families. However, side rooms were limited on the wards and demand for these rooms was high when dealing with infection control issues. The hospital had several SWAN rooms which were specifically developed and designed rooms to support patients receiving end of life care. The Princess Royal Hospital had nine SWAN rooms, one of which was unavailable at the time of our inspection, due to maintenance issues.

SWAN resource boxes, which were designed and provided by the End of Life team, were available on all wards we visited. These boxes had recently been introduced to assist ward staff with advice and support across all areas of palliative and end of life care.

The service had enough suitable equipment to help them to safely care for patients. The service used specialist syringe drivers for patients who required a continuous infusion of medication to help control their symptoms. These were readily available and obtained from a trust wide medical device library and staff explained that arrangements to access syringe drivers had improved significantly since the last inspection.

Grab and go' boxes were introduced across all wards which contained relevant equipment to make up two syringe drivers.

Mcellan,Holly 11/26/2021 11:38:21

Staff disposed of clinical waste safely. We observed that waste was segregated appropriately between clinical and non-clinical waste.

End of life care

Assessing and responding to patient risk

Staff did not always complete and update risk assessments for each patient and remove or minimise risks. Risk assessments did not always consider patients who were deteriorating and in the last days or hours of their life.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Risk assessments for each patient were completed upon admission but were not updated and reviewed consistently.

We reviewed the risk assessments records for four patients receiving end of life or palliative care and saw risk assessments such as tissue viability, falls, enteral feeding and pressure ulcer prevention were not reviewed consistently. One record showed a pressure ulcer assessment was carried out upon admission, which scored the patient as high risk, however a further assessment was not carried out until nine days later. Another patient record showed a falls assessment had been completed upon admission but was not signed by staff and was not re-assessed until a further seven days later. Upon review of another two records, these showed conflicting re-assessment dates when assisting patients with moving and handling needs. This had the potential to affect patient care and pose serious risks to patients due to the lack of staff intervention through regular assessment.

The service's application and use of ReSPECT forms still needed to improve. A trust wide audit of the use of ReSPECT forms was carried out in May 2021 and signed off in August 2021. It showed personal preferences were completed 76% of the time for those with capacity (22 out of the 7 patients with capacity). Out of the 66 patients with a ReSPECT form in place 33 were identified as not having capacity (52.4%), so unable to complete. It also showed evidence of a ReSPECT discussion was only present in 71% of patient notes, where they had capacity. The audit also highlighted 91% of patients had involvement in the making of their plan and only 42% was discussed with others when the patient themselves did not have capacity.

Specialist palliative care nurses and end of life nurses were accessed through separate referral processes. Ward staff were required to make a manual telephone referral as the trust did not operate an electronic system. Risks were not routinely requested or reviewed at this stage.

Some end of life patients were identified through an electronic system, as they had been assessed as requiring 'no observations'. This meant patients were often at the very end stage of their lives before they would be known to the palliative and end of life teams.

The criteria for referral to the End of Life team was the patient was deemed to be in the last 72hrs of life. There was no oversight across the whole of the hospital of all end of life or palliative patients, this posed a significant risk that individuals requiring intervention, did not receive it.

The service had still not established an effective system to ensure the identification of all patients, whom were at the end of life. Following inspection, the provider developed an action plan which included plans to address this.

Most staff shared key information to keep patients safe when handing over their care to others. However, during shift changes and handovers staff did not include all of the key information to keep patients safe.

Mcclean,Holly 11/08/2021 12:38:21

The specialist palliative care and end of life teams carried out a 'huddle' each morning to identify which patients were to be seen within the hospital. Specialist palliative care staff explained they did not use a clinical triage system to

determine patient prioritisation or acuity. Basic information such as the name of the patient, reason for the referral and the name of the member of staff, whom was making the referral, was recorded. In the absence of a clinical triage process there was a potential risk to patients, who were at greatest need or at the highest risk, may not be prioritised effectively. Staff explained they would always try and see everyone, but this decision was not made on clinical need.

Nurse staffing

The service did not have enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

All staff throughout the hospital delivered end of life and palliative care but were supported by a dedicated end of life care team and a specialist palliative care team. These teams worked across both the Princess Royal Hospital and the Royal Shrewsbury Hospital sites.

The end of life care team consisted of a whole time equivalent (WTE) band 7 end of life care facilitator and three band 6 end of life care specialist nurses. These nurses equated to the equivalent of 1.8 (WTE) staff and provided end of life cover across sites from 8.30am to 4.30pm. Cover was provided remotely on Friday afternoons, but there was also a palliative CNS available on Fridays and would review any End of Life patients.

An administrative assistant provided WTE 0.8 band 3 support. There were no vacancies within the end of life team at the time of inspection.

Nursing staffing levels still did not meet the minimum standard of the National Institute of Health and Care Excellence (NICE). These standards state access to specialist palliative care should be made available seven days per week. The specialist palliative care team consisted of six WTE band 7 clinical nurse specialists (CNS), two of whom has been recruited recently. The six nurses worked across sites and provided a service Monday to Friday 8.00am – 6.00pm and staffing was adjusted through the week to meet the needs of the patients across both sites. Out of hours cover including weekend cover was provided through an on-call service at a local hospice.

Staff explained that plans were in place to offer specialist palliative nurse cover, seven days per week from September 2021. This would include a palliative care team leader whom would manage the specialist palliative care nurses and the end of life care team.

Medical staffing

The service did not have enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. However, managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The trust employed 0.9 WTE palliative consultant who provided cover to both the Royal Shrewsbury Hospital and the Princess Royal Hospital sites, Monday to Friday. The cover was provided on site for four days of the week and one day remotely.

McLellan, Holly 11/26/2021 12:38:21

In addition, one palliative medicine consultant was employed by a local hospice who provided the equivalent of 0.4 WTE cover to the trust. However, this position was a fixed term contract which was due to end in July 2021. There were no arrangements to provide ongoing cover after this time.

End of life care

Improvements in respect of consultant cover had been made but medical staffing levels still did not meet the minimum standard of the Royal College of Physicians (RCP), which requires 1.4 WTE consultants based on the size of the trust and level of patient activity. Cover had been increased from 0.8 WTE to 1.3 WTE despite difficulties in recruiting. The trust had secured a budgetary increase to 3 WTE which they were currently recruiting too, however there was a shortage nationally.

Medical staffing recruitment was an ongoing challenge for the trust and several attempts to fill an additional substantive palliative care consultant post had been unsuccessful.

Records

Staff did not always keep detailed records of patients' care and treatment. Records were not always clear, and up-to-date. However, records were stored securely and easily available to all staff providing care.

The trust utilised paper-based records for assessment and care planning with vital observations such as blood pressure monitoring, oxygen saturation and pulse recordings logged electronically.

Patients receiving end of life care were commenced on the 'Caring for adults in the last few hours and days of life' care plan. However, as patients were not identified as requiring end of life care until 72hrs prior to death, this documentation was not utilised prior this point.

We reviewed trust guidance provided to staff to support them with the completion of the 'Care of the dying care plan' document and saw that guidance did not define appropriate timescales for the necessary completion of the document. This resulted in the care plans being incomplete which potentially impacted on the safe care and treatment patients received.

A new updated version of this care plan was to be piloted on wards 10 and 11, but they were not in use at the time of inspection.

The trust had not made improvements to ensure staff had access to the information they needed to provide person centred care. Patient records did not include a complete and accurate record that described patients' individual needs and preferences.

Patients receiving specialist palliative care support did not have bespoke documentation. Any intervention provided by the team was recorded within the patient's medical records, which posed a risk that this documentation would be missed.

We reviewed care of the dying care plans for two patients and saw that the document was not written to support staff to personalise care planning or record individual outcomes for patients receiving end of life care. For example, they did not detail specific nutritional requirements, comfort, spirituality, or communication. Staff explained that the new care plan would support staff to capture patients' wishes in this way and were awaiting training on the new document.

Caellan Hny 11/26/2021 14:38 v1

Some care plans had not been signed or dated, including enteral feeding and the admission pack had also not been fully completed. In another patient record, religious beliefs were not completed, although family explained that the patient had been visited by the chaplain. Skin checks were not completed in accordance with trust policy and anticipatory medicines (including syringe driver) were not ticked as required, despite the patient having a syringe driver in situ.

End of life care

We did see evidence of patients preferred place of care and do not attempt cardio-pulmonary resuscitation (DNACPR) discussions in patients' notes and completed capacity and consent records in both records.

Records were located at the nurse's station and were stored securely.

Medicines

The service used systems and processes to safely prescribe, record and store medicines. However, medicines were not always provided in a timely manner.

Staff followed systems and processes when safely prescribing, recording and storing medicines. A pharmacist visited wards Monday to Friday to review prescribing of medicines including palliative care and end of life care prescribing. The pharmacy team checked patient's medicines to ensure they were prescribed correctly, any discrepancies were identified and highlight to the relevant teams.

There was a medicines advice and supply service available seven days a week. An on-call pharmacist was available outside of core working hours.

Prescribing guidelines for anticipatory end of life care were available on the trust intranet. This included information on the medicines available and information on prescribing.

Anticipatory end of life medicines were available on all wards visited.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. Patients allergies or known sensitivities to medicines were documented on all the medicine records reviewed.

Patients weights were documented on all the medicine records reviewed.

Pharmacists checked that prescribed medicines were compatible when syringe drivers were used.

Pharmacy provided counselling and support to patients and carers to explain changes in medicines or when new medicines were started and allow them to raise concerns and ask questions.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. Medicines were stored in dedicated secure storage areas with access restricted to authorised staff. Medicine trolleys and patient's bedside lockers were also used.

Controlled drugs were stored and recorded following policy. Daily checks were undertaken, and any discrepancies were investigated.

Staff followed current national practice to check patients had the correct medicines. Prescribed pain relief medicines were checked by a pharmacist to ensure the correct pain relief was prescribed. However, we saw delays in patients receiving prescribed analgesia.

Mozella Hardy 1/7/2022 12:38:24

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Any medicine incidents would be reported onto the incident reporting system. Learning from incidents and any medicine alerts would be shared across the trust.

End of life care

Incidents

The service generally managed patient safety incidents well. Staff recognised and reported incidents and near misses. When things went wrong, staff apologised and gave patients honest information and suitable support. However, managers did not always shared lessons learned with the whole team and the wider service.

The trust were told they must ensure effective systems were in place to share learning from incidents to prevent further incidents from occurring. We requested the last ten incidents which were reported under end of life or palliative care and saw that there were themes associated with the lack of care provided to the deceased and medicines management, with the remaining incidents varying in theme.

Staff knew what incidents to report and how to report them. We reviewed an incident on ward 10 relating to care of the deceased. We saw the incident was investigated swiftly, and action taken to mitigate further incident. Staff were encouraged to reflect on the events of the incident and share learning across the ward.

We reviewed the minutes of the last end of life steering group meeting and saw that incidents were regularly discussed and reviewed. However, all staff we spoke with delivering end of life or palliative care were unable to identify any incidents that had recently occurred within the speciality, and we did not see any overarching trust action plans to address themes emerging. For example, care of the deceased, across the speciality. Therefore, we were not assured that managers within the speciality were aware of these incidents or had taken steps to share them.

Is the service effective?

Inadequate ● ➔ 🡐

Our rating of effective stayed the same. We rated it as inadequate.

Evidence-based care and treatment

The service did not always provide care and treatment based on national guidance and evidence-based practice.

The trust developed the 'Caring for adults in the last few hours and days of life' care plan, which was developed for patients who were entering the last days of life and was designed to address the holistic needs of the dying person by providing supportive and compassionate person-centred care. The document introduced in 2014 by the trust, replaced the Liverpool Care Pathway document. Plans were in place to roll out an updated version of the care plan, but staff explained that the original version was the only document in use at the time of inspection, whilst staff awaited training.

Staff followed up-to-date policies to plan and deliver high quality care. However, this did not always follow best practice. For example, the General Medical Council (GMC) states that end of life patients are those identified as likely to die in the next 12 months. The trust's criteria for referral was 72hrs and documentation commenced at this point was not complete. We reviewed all documents relating to four patients receiving end of life care and found that documentation and care planning was inconsistent and, in some cases, incomplete. Two patients did not have the end of life care plan document in place, whilst the remaining two patients had a partially completed document. Staff explained that this was due to the patients no longer being assessed as 'end of life' or meeting the 72hr criteria for end of life care and the documentation was stopped. This was carried out in line with the trust's policy. Two of the four patients had completed recommended summary plans for emergency care and treatment patients (ReSPECT) in place. ReSPECT includes a plan for future care to guide health professionals to providing the appropriate care and treatment.

Mr Ellamthiyil 01/12/2021 10:58:32

End of life care

The trust's last audit of the care of the dying care plan was October 2020, and results were mixed. In some areas of the document, such as evidence of conversation between the patient and the medical team responsible for their care was 33% and evidence of consultant involvement was 53%. However, evidence of conversation between patients loved and staff scored 100% and in June 2020, it was recorded that all twelve patients receiving end of life care were found to have the care plan in place. In the same audit 92% of patients had a recorded ReSPECT document in place.

Ward staff delivering end of life and specialist palliative care, told us they were able to access policies on the trust intranet. The end of life team had a dedicated website offering symptom guidance, referral pathways and general advice, which reflected national evidence based best practice and guidelines.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. Staff explained that referrals could be made to the mental health liaison team and outlined support that was available.

The trust did not have oversight of all patients requiring end of life or palliative care within the hospital. There was currently no electronic palliative care co-ordination system (EPaCCS). The trust utilised an electronic ward review system, but it did not incorporate any software for alerts or co-ordination of palliative care or EOL patients.

The service still did not have an effective system to identify where patients, at the end of life, were throughout the hospital.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. The trust used a Malnutrition Universal Screening Tool (MUST), which identified nutritional risks. Records showed that staff followed MUST scoring for nutrition and hydration appropriately.

Staff made sure patients had enough to eat and drink, particularly those with specialist nutrition and hydration needs. We saw records within the generic nursing notes which recorded nutritional needs and evidence of nutritionist involvement. However, not all nutrition and hydration needs could be recorded using the care of the dying care plan, as the section in the care plan related only to artificial hydration and nutrition.

In addition, we saw evidence of mouth care for those patients unable to tolerate fluids and care plans for patient mouth care. Staff explained that the end of life team were supporting ward staff with additional mouthcare training.

We reviewed the results of the October 2020 National Care Audit of Care at The End of Life of (NACEL) audit and saw the provider performed worse when compared nationally with other similar providers. For example, the risks and benefits of hydration options, were discussed with families and others in 10% of cases, compared to 35% nationally. For 72% of patients, no reason for not discussing this was recorded. This was worse than the national proportion of 49%.

McLean, Holly
11/08/2021 14:38:21

The risks and benefits of nutrition options were not discussed with families and others for any cases. Nationally the figure was 28%.

Pain relief

End of life care

Staff did not always assess and monitor patients regularly to see if they were in pain or give pain relief in a timely way.

We saw pain assessments were inconsistently documented for palliative and end of life care patients across the wards we visited. We saw varying pain assessment tools available to clinical staff, however we reviewed two patient records and saw only one completed pain assessment tool. Both the patients we reviewed had experienced pain or discomfort and had been prescribed analgesia.

The care of the dying care plan did not support individualised care planning regarding pain management and did incorporate a pain scoring tool. Tick box prompts were used if a patient was experiencing pain with a limited amount of space in the document to record evaluation.

Managers of the service told us that electronic pain scores were recorded as part of the electronic ward monitoring system. We reviewed two patients through this system and saw that pain scores were not completed.

Patients did not always receive pain relief, soon after requesting it. We visited two patients, who at the time were receiving end of life or palliative care and found both patients acutely in pain. One patient had been waiting for a review of analgesia, whilst the second patient had not received medication for pain despite asking staff several times.

Anticipatory end of life medicines were available to all wards we visited.

We reviewed the results of the most recent National Care Audit of Care at The End of Life of (NACEL) audit and saw the trust performed worse when compared nationally with other similar providers. For example, anticipatory medicines for symptoms likely to occur in the last days of life were prescribed and administered in 34% of cases, compared to 68% nationally.

The service was not undertaking specific audits for pain or symptom management.

Patient outcomes

Staff did not always monitor the effectiveness of care and treatment or use the findings to make improvements and achieve good outcomes for patients. The service had not been accredited under any relevant clinical accreditation schemes

The service did not have an end of life care dashboard to give an overview of quality metrics and key performance indicators. The service could not measure its impact at ward level. However, leaders explained that there were plans in place to implement both elements.

The end of life and specialist palliative care teams' input was monitored using forms, completed by the team, detailing how their patient was referred and what their input was. However, these documents did not monitor how comprehensive the team's record keeping was, nor the effectiveness of their care in influencing outcomes for patients. The trust did not have a policy or process to define this, to ensure consistency of recording.

Michelle Hoy 01/02/2021 12:38:14

Managers and staff carried out a programme of audits to check improvement over time. We requested details of all audits relevant to end of life care, which were undertaken. We received audit details relating to the October 2020 National Care Audit of Care at The End of Life of (NACEL), Care after Death Audit, SWAN Room audits, Care of the

End of life care

Deceased mortuary audit, bereavement survey results, the End of Life Care Plan Audit February 2021, mouthcare and an audit of the Swan "Grab and go T34 syringe driver policy. The mouth care audit (which included all patients not just end of life patients) was dated September 2020, showed 41% of staff were not aware of the mouth care policy and 52% of staff stated they had used a mouth care chart.

Managers and staff did not use the results of these audits, to improve patients' outcomes and we did not see an action plan to address these findings.

Competent staff

The service did not always ensure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

The trust included end of life as part of mandatory training for all staff. The trust provided training figures for end of life training with compliance being 80% as of July 2021.

The service did not have a clinical educator role, however, the team delivered and oversaw a programme training relevant to end of life and palliative care. Also, the end of life team offered bespoke training sessions to ward staff when requested. Ward staff explained that these sessions had been beneficial, but there was no formal review of training, to show how this had potentially improved patient care. They did not monitor where and when training had been delivered.

Wards were provided with an end of life resource file which included guidance in symptom management, referral pathways, useful contact numbers and care planning information.

At the last inspection in June 2020, the trust were told they must ensure staff were competent in their roles. This included but was not limited to the use and the completion of ReSPECT forms and the use of syringe pumps. Syringe driver compliance figures supplied by the trust demonstrated compliance at the hospital was 91%.

We told the trust in August 2020, that improvements must be made to ensure that staff were competent in the use of syringe pumps when required. Syringe drivers were used in accordance with the NPSA Rapid Response Report; Safer Ambulatory Syringe Drivers (NPSA/2010/RRR019) published in December 2010 and had checklists to ensure they were used appropriately. However, we reviewed two copies of syringe driver documentation and saw that these checks were not completed in accordance with the trust standard operating procedure; 'Grab and go Box for T34 Syringe pumps'. The guidance states that the cannula should be checked every four hours, but records showed checks were carried out between five and six hourly intervals. The trust did not audit syringe driver documentation.

End of life champions were available on some of the wards, but we did not see any evidence of cross directorate working to share learning and best practice. For example, performing last offices, which is the term given to the care after death.

Specific counselling training was provided to some staff in the bereavement team. One of the bereavement staff explained they had completed a 'Sage and Thyme' which is a counselling course and is supportive of staff working within bereavement services. But this did not appear to be routinely offered to all staff.

Kirsten Hilly 11/06/2021 12:38:11

Managers gave all new staff a full induction tailored to their role before they started work and we saw two newly seconded specialist palliative care nurses supported by mentors as part of their induction.

End of life care

Managers supported staff to develop through yearly, constructive appraisals of their work. Appraisal compliance rates for the end of life and specialist palliative care team was 100%. However, none of the specialist palliative care nurses received clinical peer supervision or received regular clinical competency training reviews.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. End of life steering group minutes were distributed to the team.

Multidisciplinary working

Doctors, nurses and other healthcare professionals did not always work together as a team to benefit patients.

Systems did not support effective communication between multi-disciplinary teams. For example, specialist palliative care nurses received ward referrals by telephone, patients admitted to the hospital by the hospice were referred electronically and GP (General Practitioner) referrals were submitted through the electronic hospital database. All processes were independent of one another and none of the end of life staff had oversight of all of the patients requiring potential support in the hospital. However, end of life and specialist palliative care teams met each morning virtually, to review referrals Monday to Friday.

Clinical outcomes were not clearly documented, clinical triage was not in place and effective collaborative team working was not measurable due to the lack of clinical care planning. For example, the patients we saw experiencing pain and discomfort were both visited regularly by the specialist teams. In one case the patient was seen six times by the specialist palliative care team but was still experiencing severe pain. It was not documented what the outcome was for the patients, what the goal was to be and when it should be achieved.

Ward staff explained that fast track and end of life discharges were managed by the complex care team. However, none of the staff we spoke with were able to outline the last end of life patients whom were discharged by the complex care team. Data provided by the trust showed, from August 2020 to June 2021, 153 patients were discharged via the complex discharge team at the hospital.

All ward staff we spoke with told us that end of life and specialist palliative care colleagues were visible on the wards and we saw staff working together to share information.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. However, end of life steering group meetings were not consistently attended by all members of staff. Specialist palliative care nurses explained that they required a laptop to access the meetings and this was not always available.

Mortuary staff were not included in these meetings and explained that they had offered training to support ward staff to undertake last offices, but the training was not implemented.

A local hospice provided out of hours advice and support to staff and patients, however information collated by the hospice was not reviewed by the trust. For example, referral and patient outcome information.

McLellan,Hilary
11/26/2021 11:38:21

Seven-day services

Key services were not available seven days a week to support timely patient care.

End of life care

The service was still not available seven days per week. Services were only available Monday to Friday, with out of hours advice offered by the local hospice. This was still not in line with the NHS Seven Day Clinical Standards (2017) which states that specialist palliative care should be available at any time of day or night. The trust were aware of this shortfall and this was on the haematology and oncology risk register due to staffing shortages. However, plans were in place to extend the specialist palliative care team availability to seven days, commencing in September 2021.

Mortuary staff did not routinely work at evenings or weekends but were on call and told us they would come in if a body needed to be released during these periods. They told us they could release a body in a timely manner if all relevant paperwork was complete.

Chaplains were on call at evenings and weekends and aimed to respond promptly to urgent requests, however the lead chaplain was currently not available due to sickness absence. Staff explained that there was a recognition with the chaplaincy to expand the staffing and a recent interview had taken place which resulted in the appointment of two additional chaplains equating to 1.5WTE.

Health promotion

Staff gave patients practical support to help them live well until they died.

We saw relevant information promoting healthy lifestyle choices and wellbeing support on every ward we visited.

Staff assessed each patient's health when admitted using the initial assessment documentation.

End of Life boxes contained information to support patients and their families across a range of areas, for example; eating and drinking at end of life and supported staff to enable individuals to live a healthier lifestyle.

We saw information support centres in the hospital, offering leaflets and guidance for patients and their relatives in a range of subjects, including emotional, financial and therapy information.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. However, consent was not always clearly documented.

The service had improved practice when carrying out and completing Mental Capacity Act assessments for all patients who were deemed to not have capacity. Mental capacity assessments were fully completed, and decisions made, were consistently documented and had a clear rationale.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Assessment documents included specific reference to capacity and assessment outcomes.

McLellan, Hilary
11/2/2021 11:38:21

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff made sure patients consented to treatment based on all the information available. However, staff did not always clearly record consent in patient records. Consent was not included in the 'Caring for adults in the last few hours and days of life' document.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Mandatory training compliance figures showed 100% for those staff who were identified as requiring this course.

End of life care

Staff could describe and knew how to access relevant policies and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. Staff were able to articulate deprivation of liberty applications and referral processes to request mental health advice and support.

Is the service caring?

Requires Improvement ➔🡐

Our rating of caring stayed the same. We rated it as requires improvement.

Compassionate care

Staff did not always treat patients with compassion and kindness, respect their privacy and dignity or take account of their individual needs, there were also issues with caring for patients after they had died.

Staff explained end of life care was provided where possible using the SWAN or side rooms. During inspection we observed patients being cared for in this way. However, families explained staff did not always demonstrate compassionate care and felt that staff did not always have time to support them. The family became upset when staff told them there were 'other patients more poorly' and were not advised when clinical procedures were going ahead.

Another family member explained sometimes basic requests were declined. For example, requests for cups of tea and restricted visiting time, despite the patient receiving end of life care.

One family member explained communication had been an ongoing concern and requested several times for assistance with pain relief for their family member. Another family member told us that there were often lengthy delays in answering the call bell and their family member needing to wait extended periods before analgesic was offered.

However, one patient on ward 8 explained that staff had been 'amazing' and had assisted them to access the garden in the grounds of the hospital. The palliative consultant was described as particular caring and understanding.

Staff did not always understand and respect the personal, cultural, social and religious needs of patients and how they may relate to care needs.

We reviewed the bereavement survey dated May 2021 and saw that 66.7% of patients and their families felt that they had received less support than was needed in dealing with feelings surrounding death.

One family explained that they had not seen the chaplain despite requesting a visit through ward staff.

Last offices were not always carried out for the deceased prior to arrival at the mortuary. Last offices is the term given to the care of the body after death. Mortuary staff explained the omission of this care by ward staff, resulted in patients arriving in an undignified manner. Mortuary staff explained that the impact of this for visiting families was significant and potentially highly upsetting.

Mcellarnolly 12/26/2022 12:38:27

Emotional support

Staff did not always provide emotional support to patients, families and carers to minimise their distress.

End of life care

The end of life team had recently developed complimentary support boxes, which were offered to families at the discretion of ward staff. Boxes contained woollen hearts, drinks vouchers, parking discounts and support and advice. All wards we visited were able to provide these boxes.

Staff explained there were currently no arrangements to enable patients' families to view the deceased in the mortuary. Viewing arrangements had been stopped during the peak of the pandemic by senior leaders of the organisation, and there were no plans in place to review this rule. Mortuary staff explained that viewing had been arranged for one patient as a special request, but it was not clear why this single request had been supported whilst others were declined.

The children's viewing within the mortuary room was not fit for purpose. The room, which was utilised and used as a fridge, was not appropriate for families wishing to spend any time with their loved ones, due to the temperature and noise from the refrigeration system. Mortuary staff explained that it was rarely used as a viewing area as most families chose to visit relatives on the ward.

The bereavement survey dated May 2021 showed that 100% of families stated that they were given the opportunity to see their relative, on the ward, after they died.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Bereavement team staff told us they were able to support bereaved families as they had received training regarding difficult conversations through Sage and Thyme. However, In the same survey we saw 71% of families felt that religious / cultural and spiritual beliefs had not been taken into consideration, when liaising with the bereavement office staff.

Understanding and involvement of patients and those close to them

Staff did not always support and involve patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff did not always talk with patients, families and carers in a way they could understand. Two families we spoke with told us communication with nursing staff had been difficult due to language barriers. Some of the ward nursing staff were described as having a lack of 'good spoken English' which made difficult conversations more challenging. Families explained that due to staffing issues they were not offered support with communication.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Families were encouraged to complete a bereavement survey and feedback was shared at the end of life steering group and fed back to all staff.

Staff did not always support patients to make advanced decisions about their care. Referrals to the palliative and end of life teams were not timely, and early identification was not systematic across the trust. As a result, although those who were identified as needing the support of the team were unable to make decisions and on many occasions, these were late and reactive, rather than proactive.

McLellan,Holly
11/26/2021 12:38:21

Is the service responsive?

Inadequate ↓

Our rating of responsive went down. We rated it as inadequate.

End of life care

Service delivery to meet the needs of local people

The service did not plan and provide care in a way that met the needs of local people and the communities served. It did not always work with others in the wider system and local organisations to plan care.

Managers did not plan and organise services, so they met the needs of the local population. Staff did not have a comprehensive system to identify the total number of patients who could benefit from their services, so did not know the level of unmet need in either the trust itself, or the wider community.

The service did not monitor inappropriate referrals. As a result, the palliative and end of life care teams identified the needs of some, but not all, of those requiring palliative or end of life care within the community they served.

The service worked closely with the local hospice, relying on their telephone advice line, out of hours, when no specialist hospital team was available. However, they were not working with the wider palliative care community providers to plan care.

The service had basic systems to help care for patients in need of additional support or specialist intervention. The specialist palliative and end of life care teams relied on wards to make referrals to them, supported by an electronic system which flagged up patients in the very last days or hours of life. This system did not identify all patients who were receiving palliative or end of life care, and teams felt they would not be able to meet demand if it did. However, once patients were seen by the team, they were able to refer to other specialist support such as speech and language, physiotherapy and dietitian services.

Meeting people's individual needs

The service was not always inclusive and did not always take account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Wards where people received care towards the end of their lives could access dementia and mental health champions.

There were end of life champions based on some wards, but they did not link up with each other to share learning or provide peer support. Staff explained they had plans to make the end of life champion training more structured and build in more support.

Staff equality and diversity training levels were at 84%, which was below the trust target of 90%.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents which were well completed.

McLellan, Hany
11/20/2021 12:38:4

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss.

The service did not provide information leaflets available in languages spoken by the patients and local community but could access translation facilities when needed. Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed.

End of life care

Patients were given a choice of food and drink to meet their cultural and religious preferences.

Staff explained there were no restrictions placed on friends or families wishing to visit those receiving end of life care. However, this did not corroborate with feedback received from families who told us visiting times were reduced by the length of time families could stay and how many people could visit. Staff explained that where possible, patients would be moved to a SWAN room, or other single room area to ensure that patients' privacy and dignity was maintained, and that friends or relatives had the opportunity to stay with them overnight. This had been difficult to achieve during the last year due to COVID-19, as infection control had taken precedent, but additionally one SWAN room onsite was out of use.

Chaplains visited patients when requested by ward staff. They explained that often this was very late in a patient's illness. There was no electronic system to alert chaplains that a visit was needed. All of the chaplaincy team were Christian; however, they could access external faith leaders in a variety of faiths. A 'dial a chaplain' service, advertised in public places, was innovative but poorly thought through, requiring a member of the public to use the trust switchboard, not easily available to visitors.

There was no separate multifaith room in the trust. Staff, patients and families, following other faiths had found other space to use elsewhere in the trust rather than using the chapel. Chaplaincy staff had not been engaged during this process.

Access and flow

Patients could not always access the specialist palliative care service when they needed it. Waiting times from referral to achievement of preferred place of care and death, where known, were not always in line with good practice.

Managers monitored waiting times but could not ensure patients could access services when needed. Neither team provided a seven-day service so patients could always access support when they needed it. The service's monitoring showed that in 2021, the percentage of patients waiting more than a day to access support from the team had risen from 15% in January to 18% in March 2021. We did not see an action plan to improve this.

The end of life team saw an average of a quarter of all patients who died at the Princess Royal Hospital in 2021, which was worse than the Royal Shrewsbury Hospital. As there was no catchall system to ensure they could accurately assess who would most benefit from their input, the team had no way of knowing that the remaining, majority of patients who passed away at the hospital did not need or would not benefit from their care. Additionally, the teams did not have a way of recording patients seen by both teams (potentially duplicating work). Ward staff explained that sometimes a patient could have several visits from both teams on the same day, as care was not co-ordinated.

Managers and staff worked to ensure they started discharge planning as early as possible. Of those patients known to the palliative care team, just over 88% achieved their preferred place of death. However, not all palliative patients within the trust were identified. Therefore the trust could not accurately reflect their achievement of preferred place of death as they only recorded the outcomes for the patients who had been referred to the relevant teams.

Michelen Holly
11/08/2021 12:39:21

Staff planned patients' discharge. Patients nearing the end of their life could be referred to a fast track discharge pathway, with a target of getting a patient to their preferred place within 48 hours. However, fast track discharges were not achieved. We reviewed the last 91 discharges across the trust and saw the average discharge time for the fast-track discharge of patients in receipt of end of life care was just over three days.

End of life care

The service was not following the trust's policy in respect of complex discharges. Trust policy stated that the complex care discharge team, who worked seven days a week, should co-ordinate end of life discharges. However, in practice this was done by the palliative care team, who did not work over the weekend, and as a result end of life rapid discharges over the weekend were rare. This impacted on patient's preferred place of death.

Staff supported patients when they were referred or transferred between services. Partner services receiving patients felt they were well informed, although delays in discharge, usually caused by transport, had led to people not moving between services seamlessly. We did not see an action plan to improve this.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns. Information was displayed across all areas of the hospital advising as to how to make a complaint.

Staff understood the policy on complaints and knew how to handle them. The policy set out clear timescales for complaint responses and included supporting information for investigations, writing staff statements and meeting the standards required by regulators.

Managers investigated complaints, staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. However, we requested the last three complaints specific to end of life and palliative care from the provider and saw that all three complaints had not been investigated in accordance with the providers timescales, outlined within the incident investigation policy.

The end of life team had been asked by a carer if the new kindness hearts provided to patients and their loved ones could continue. The team have agreed that kindness hearts will become an integrated part of their practice.

Is the service well-led?

Inadequate ● ➔🡐

Our rating of well-led stayed the same. We rated it as inadequate.

Leadership

Leaders had the skills and abilities to run the service and understood all of the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.

McLellan,Holly 11/29/2021 12:46:2

The service had a clear line of accountability and staff explained they knew who to go to if they needed support. Staff spoke positively about leaders and the support they had offered throughout the COVID-19 pandemic. However, mortuary, chaplaincy and bereavement service staff did not feature on the schematic diagram provided to CQC to explain the service's leadership structure, and bereavement services sat under a different management structure. Therefore, the team was not cohesive and there was disconnect within the existing communication systems.

End of life care

Leaders were aware of and could articulate the current issues faced by the service in terms of capacity, and a historical separation between teams which they had plans to address. However, they did not recognise the overreliance on the experience of individual practitioners or the effect their failure to monitor outcomes was having on patients receiving or wanted to access the service. This meant there was a lack of effective oversight of the quality of the service and the impact this had on the patient's quality of care.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to underpin this aligned to national priorities. The vision and strategy were focused on sustainability of services, but it was not clear how they would monitor progress.

The end of life care strategy document which included the specialist palliative care team, covered the period 2019-2022. There had been no revisions to timescales or adjustment of aims to incorporate the challenges posed by the COVID-19 pandemic.

The strategy set out six aims, underpinned by sub-statements. However, the aims were unclear objectives, and as such were not clearly measurable, time-limited or focussed. For example “all clinical staff to be able to recognise all forms of distress” and “good communication between all staff” were wide ranging, difficult to measure and it would be almost impossible to show the service’s individual impact towards meeting the objective.

The strategy featured ‘indicators of success’ but these were not tied to aims or objectives, so it was unclear how the service would know that it had improved, and how it would know if it was on track with its aims.

Monitoring of the end of life care strategy through specialist palliative care steering group was unclear, as although there was a standing agenda item titled ‘strategy’ this was not used to record progress against stated aims or flag any areas that were behind schedule.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care but did not always see end of life care as everyone’s responsibility.

End of life care was not a priority on wards. Ward staff were not fully engaged in making dying everyone’s responsibility. This was reflected in the fact that in more than one area, staff did not recognise patients under their care as end of life or palliative, even when prompted.

However, staff within the EOL team told us they did feel valued and respected.

The trust were unable to identify EOL team responses to the staff survey due results for small teams not being published as that would identify individual team responses in a small team, and no other evidence of a mechanism for capturing or identifying the views of the team was provided to CQC.

Magellan, Holly
11/26/2021 12:38:01

Governance

Leaders did not operate effective governance processes, throughout the service and with partner organisations. Staff at all levels were not always clear about their roles and accountabilities.

End of life care

There were areas of the service which continued to be of concern and had been previously identified during our inspection in 2020.

The trust had developed a memorandum of understanding with their local hospice to provide mutual support with a view to improve both services. However, this was in draft at the time of inspection, and did not contain any detail of how the effectiveness of the agreement would be monitored.

The trust did not monitor its current use of out of hours support provided by external partners and there were no channels of communication, by which to share themes and learning from the out of hours support.

The most recently planned audit programme fails to measure the performance or quality of the end of life care service. An audit plan had been produced for 2021-22. The trust normally contributed to national audits such as the National Audit of Care at the End of Life and planned to do so in future (having briefly suspended over the COVID-19 period). Audits conducted over the previous 12 months and the audit plan for 2021-22 focussed on the implementation of, or changes in practice by, ward staff, rather than any quality monitoring of the end of life team, their record keeping or effectiveness. Therefore, the trust did not measure quality improvements to the service.

Action plans were not implemented even when poor performance or practice had been identified through audit. Where issues had been identified in audits, for example, in the 'compliance with the care after death policy in clinical practice' audit of April 2021, where 63% of deceased patients were transported to the mortuary in an undignified manner, there was no associated action plan, and results were not discussed (or not documented) at the next end of life care steering group in May 2021. Staff delivering the training to ward staff around the importance of good care immediately after death explained that they had been asked to deliver training once which was poorly attended and had not been asked to revisit this.

The governance around the end of life care steering group was inconsistent. A review of the terms of reference for the end of life care steering group took place in early 2020. The end of life steering group met monthly and was generally well attended. However, the agenda did not state who was chairing, whether the meeting was quorate, and had no regular space for mortuary staff to input or provide updates.

Management of risk, issues and performance

Leaders and teams did not always identify and escalate relevant risks and issues or identify actions to reduce their impact. However, they had plans to cope with unexpected events.

The team did not hold their own separate risk register. Risks for the end of life team were recorded within the oncology and haematology risk register. Two open risks related specifically to the end of life and specialist palliative care team. These included a shortage of specialist palliative care consultant input and a risk that the size of the team was not sufficient to meet the expected patient demand.

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Senior leaders knew what the major key risks were for the team and explained what was being done to address this. However, other risks, such as those relating to the cleanliness of mortuary areas and capacity in the chaplaincy team were not stored centrally on the risk register and were therefore not being actively addressed.

Not all relevant staff had received an individualised COVID-19 risk assessment despite working across all wards during the pandemic. In addition, the associated risk of staff becoming ill due to COVID-19, were not included on the risk register.

End of life care

Information Management

The service collected limited data. The information systems were integrated and secure.

The service was not using data to monitor performance or quality. The service did not have any systems to give an overview of quality metrics and key performance indicators. The service could not measure its impact at ward level and did not work to any key performance indicators. However, leaders explained there were plans to implement both elements. This was a risk to patients as the lack of quality metrics and key performance indicators meant the service did not know, other than anecdotally, whether what it was doing was adding value or improving outcomes for patients.

Engagement

Leaders and staff engaged with patients and families. However, there was no evidence feedback from patients and families was used to improve services. They collaborated with partner organisations to help improve services for patients.

The service had not made improvements to their service despite receiving feedback relating to patients not receiving good care. The trust had continued to gather feedback from bereaved friends and families throughout the COVID-19 pandemic period. Feedback was generally positive, however, in June 2021 30% of people thought their relative was not free of pain in their last days, and 40% felt that their hygiene had not been maintained. These results were not discussed at the end of life steering group and it was not clear what had been done to act upon this feedback.

The trust contributed to the wider system end of life care group and collaborated closely with local end of life care providers. For example, commissioners and hospice providers.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Members of the team had been awarded the Dundas medal for their work 'taste for pleasure' work using a patient's favourite flavours when providing mouth care towards the end of life. The team had produced information leaflets for staff and patients and their families and friends to underpin this.

During the COVID-19 pandemic, the end of life team had introduced a number of measures such as memory stones for each patient who lost their life, kindness hearts, one for a patient and another for their loved one, and bereavement support sessions for staff. Evidence showed that these had been much valued by families, patients, friends and staff.

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Urgent and emergency services

Requires Improvement ↑

Is the service safe?

Requires Improvement ↑

Our rating of safe improved. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills including the highest level of life support training to all staff.

Staff used a web based electronic system to book training. We were told staff undertook competency and relevant mandatory training to enable them to support the department. Some topics were delivered face to face and others online. The pandemic had affected face to face delivery of some training modules. Training was staggered throughout the year; this was so that managers could maintain staffing levels in the department.

Most staff received and kept up to date with their mandatory training. The trust provided us with a breakdown of medical and nursing staff completion of mandatory training. The trust provided us with information including 15 mandatory training modules for nurses and medical staff. Nursing staff at Princess Royal Hospital were compliant with the trust target for this training in ten out of the 15 modules. Medical staff were compliant with the trust target for this training in 13 out of the 21 modules. With rolling trajectories to meet the others within the current financial year. Face to face modules of mandatory training had been reduced during the pandemic. The department had a plan in place to increase this training as the pressure of the pandemic was decreasing.

The mandatory training was comprehensive and met the needs of patients and staff. Mandatory training modules included key areas relevant to emergency department staff such as: health and safety, fire safety, patient moving and handling, infection prevention and control, equality and diversity, information governance and basic life support.

Clinical staff completed training on recognising and responding to patients with mental health needs and dementia.

Managers monitored mandatory training and alerted staff when they needed to update their training. The emergency department had increased from one education lead to three in order to facilitate and maintain improved access to the training needs of staff. All staff we spoke with identified this had a positive impact on training timeliness.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

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Nursing and medical staff received training specific for their role on how to recognise and report abuse. However, staff did not meet the trust target of 90% for safeguarding children level three training. Senior leaders were aware of this deficit and had identified a need to facilitate an increase in available sessions. A large staff recruitment programme had impacted on availability of some training modules for staff already in post and staff were already aware of trust policy and procedure in this area.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. A significant improvement in referral rates and simplification of the procedure for referrals had led to an increase in completed documentation.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. We observed completed documentation in all 28 records; identifying a review of safeguarding for adults and/or children. We also reviewed three records with completed comprehensive referrals to the local safeguarding team.

Cleanliness, infection control and hygiene

The service controlled general infection risk well. They kept equipment and the premises visibly clean. However, staff did not always use equipment and control measures to protect patients, themselves and others from Covid -19 infection.

All areas were clean and had suitable furnishings which were clean and maintained.

The service generally performed well for cleanliness.

Cleaning records were mostly up-to-date and demonstrated that all areas were cleaned regularly.

Staff did not always follow infection control principles including the use of personal protective equipment (PPE). Staff did not appear to be aware of current infection prevention and control guidelines. During our inspection we observed 12 staff members working within the respiratory isolation unit (RIU) who did not

Staff cleaned equipment after patient contact and sometimes labelled equipment to show when it was last cleaned. Labelling was not consistent; however, we did observe items being cleaned.

Patients were not questioned on arrival in the department in relation to their Covid-19 status and patients were not routinely tested until a decision to admit had been agreed. This meant that patients and relatives were in the department with an unknown Covid-19 status. Children were not routinely tested, and staff did not appear to consider children to be a possible Covid-19 risk. Several children were seen with respiratory illnesses. None of these were questioned with regards to Covid -19.

PPE compliance had also been highlighted to staff during a trust audit in June 2021, where it was noted staff in two areas of the ED did not wear gloves or aprons when within two metres of patients.

These serious concerns were raised with the trust during our inspection and immediately afterwards in writing. The trust produced an action plan which offered assurance that these concerns were to be addressed immediately.

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Environment and equipment

The maintenance and use of facilities, premises and equipment mostly kept people safe. Staff were trained to use equipment. Staff mostly managed clinical waste well.

Urgent and emergency services

Patients could reach call bells and staff responded when called. However, call bells and pump alarms were often left alarming despite staff being aware intravenous fluids or medications needed changing. We observed three staff during the inspection identify appropriately that changes were required without silencing the alarm. This could cause distress to patients due to the noise.

The design of the paediatric environment did not follow national guidance. The environment standards set out in the June 2018 Royal College of Paediatrics and Child Health (RCPCH) guidance, Facing the Future: Standards for children in emergency care settings was not being followed. Children waiting to be seen by the triage nurse were required to wait in the main adult waiting area. During periods of peak activity, nursing staff reported it was not unusual for children to wait up to one hour before being seen by the triage nurse. There was a dedicated waiting room for children. However, this appeared only to be accessible after triage. This meant that children were mixing with adults in the general waiting area for, on some occasions, long periods of time. The children's waiting room was also not available to anyone over the age of 13.

All staff we spoke with in the department were aware of this and regularly discussed this with senior leaders within and across other areas of the trust. Whilst the paediatric resus room was private and away from the busy pitstop and minor's adult area, the two paediatric cubicles were housed next too and between adult cubicles. These were under observation by staff whilst we were in the department. However, children and their parents were in the presence of, on occasion, inappropriate adult patient behaviour. Staff we spoke with did express concerns regarding this and said they would report any incidents of an untoward nature in view of any paediatric patients.

Compliance with national guidance relating to the provision of a safe environment for patients presenting at the ED with acute mental health concerns had improved. The trust had adapted a room which complied with the July 2017 Royal College of Emergency Medicine, Best Practice Guideline: Emergency Department Care standards which recommends that ED's provide a dedicated psychiatric assessment room that conforms to Psychiatric Liaison Accreditation Network (PLAN) standards. The room had two means of exit; doors were fitted with anti-ligature handles and anti-barricade frames allowing for staff to remove the door in the event of an emergency; emergency alarms had been fitted through the room; doors had privacy glass to allow for discrete observation of patients and lighting was adjustable to allow patients to get rest.

It was noted at our last inspection that the mental health assessment room was not meeting required standards due to unsecured furniture being present. We observed the room on three occasions during our visit, one directly after a patient had been transferred. There were no items present that could have been used as projectiles to cause harm to patients or staff. The room had been risk assessed including a ligature risk assessment. Staff did identify the room would be better located in an area with more space due to the increased number of staff needed for patient observation, sometimes including police officers, security and clinical staff. There was only one toilet for the eight majors' patients and any patient in the mental health room. This had also been risk assessed for ligatures and patients were closely observed when using the facility according to an individual patient risk assessment.

Due to bed capacity challenges at the trust, where patients had on previous inspections been cared for on corridors, they were now cared for in the ambulances they were conveyed in. Whilst this was not what senior staff in the department wanted it allowed for patients to be monitored by a paramedic whilst waiting for transfer into the ED. In order to mitigate patient risk, we observed patients being reviewed on arrival by the ED consultant and or navigator to assess patient acuity. We witnessed a fast positive, (possible stroke), patient be reviewed for thrombolysis (treatment to dissolve dangerous clots in blood vessels), intervention in order that a delay did not occur for treatment if required. The

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senior leadership team performed harm reviews on patients held in ambulances over 30 minutes in order to identify any unknown risks or incidents. We witnessed a patient arrive that urgently needed a hospital bed. The staff in ED immediately organised an extra bed in resus to accommodate the patient. Completed harm reviews had not identified any patient harm as a result of ambulance handover delays.

We spoke with paramedics during our visit who all told us they would escalate any patients immediately if any sign of deterioration was noted. During our inspection we witnessed eight ambulances holding patients outside of the department. Patients we spoke with said that whilst the wait was not ideal, they felt safe knowing they were being monitored by a health care professional.

Staff within the department were constantly reviewing and expediating transfers out. However, patient numbers arriving at the ED were in excess of the bed numbers available throughout the trust.

The service had some suitable facilities to meet the needs of patients' and families. For example, during a previous inspection, privacy and confidentiality had been a concern at the patient reception. This had now been changed in order to offer a greater degree of privacy for patients when giving personal details.

Staff carried out daily safety checks of specialist equipment. We reviewed safety checks on all resuscitation, airway and sepsis trolleys. All were checked as per the trust policy and included all relevant equipment.

Electrical equipment had been safety tested in the department; this was on a rolling programme.

The service mostly had enough suitable equipment to help them to safely care for patients. However, staff we spoke with expressed concern that the arterial blood gas machine in the adult resus area was out of order on regular occasions. During our visit we witnessed an out of order sign on it three times. This could reduce the access to timely blood gas analysis. One member of staff was allocated to ensuring the regular functioning of the machine however, when they were out of the department or busy; repair or resetting of the machine could be delayed.

Staff mostly disposed of clinical waste safely. However, we did witness one occasion where clinical waste was not removed safely from an isolation area. This was raised with staff during our inspection and was subsequently addressed.

Needle sharp bins in the department were not over full (more than ¾ full) and the bins were dated and signed by a member of staff, (as required by the trust's policy).

Assessing and responding to patient risk

Staff completed risk assessments for each patient. They removed or minimised risks and updated the assessments. Staff identified and quickly acted upon patients at risk of deterioration.

National guidance relating to the initial assessment of patients who presented at the emergency department (ED) was not always followed. The February 2017 Royal College of Emergency Medicine Initial Assessment of Emergency Department Patients states that patients should be triaged within 15 minutes of arrival. Triage is a face-to-face contact with a patient to prioritise their need for further assessment and treatment in a system where the demand for patient care outstrips the ability of the system to deliver it at the time of presentation. At the time of the inspection six out of fifteen patients we observed waited more than 15 minutes for an initial assessment by the triage coordinator. This

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correlates with the data provided by the trust for June 2021 when 45% of children were reported to have been triaged within 15 minutes (with an average of 21 minutes) and 40% of adults (with an average of 30 minutes). However, we did observe a patient bypass triage and be allocated immediately into the minor's area due to nature of their illness. Increased attendances and acuity had impacted on the delivery of improved triage times.

The severity and risk level of the patient's condition was determined by their presentation and the outcome of the triaging tool used in triage area This reflected the order in which patients were seen by a clinician. Patients received an initial assessment by a band six triage nurse. Once seen they were streamed to the most appropriate area for diagnostics or treatment. The initial assessment included appropriate investigations that would assist clinicians with a diagnosis and treatment. Patients arriving by ambulance entered through a dedicated entrance specifically for ambulances. During busy times, staff reported clinicians would go out to the ambulance to review the patient if paramedics raised concerns about the patients' conditions. An electronic communication board in the department kept staff up to date with details of any patients waiting in the ambulance. A dedicated nurse navigator reviewed patients who arrived by ambulance.

The department coordinator was a band seven nurse and sepsis leads were identified by a red arm band. During our inspection there were sepsis leads identified from both medical and nursing staff on duty each day as per trust guidance.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. The department used a National Early Warning Score (NEWS) system for acutely ill patients, which supported staff with the early recognition of deteriorating patients. This ensured early intervention from skilled staff. We checked records and found all 28 records had evidence of NEWS2. Patients were appropriately escalated and treated according to sepsis guidelines in all 10 sets of notes we reviewed for this purpose. The NEWS score was calculated using a handheld device for recording patients' vital signs. This was then available on the department white board for clinicians to see immediately. Increasing the oversight of potentially seriously ill patients.

The department also used the paediatric early warning score (PEWS). The PEWS tool was developed by the Royal College of Paediatrics and Child Health. Staff in all areas completed these observations, including a pain score, in accordance with trust policy, and staff knew the clear escalation process for patients who scored high. However, staff would escalate patients they were worried about even if they did not have a high NEWS or PEWS score.

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. For example, we observed patients care being reviewed and reassessed directly after return from x-ray in order to provide treatment for a fractured wrist.

Staff knew about and dealt with any specific risk issues. The assessment booklet contained for example; assessments for sepsis, falls, mental capacity, frailty and skin integrity.

An ED patient safety checklist had been introduced to increase documentation of specific care requirements during a patient journey through the department. The document identified specific tasks that should be assessed during each hour of the patients stay. Including understanding of the care plan, dietary and refreshment needs, pain relief and access to a call bell. All patients note we reviewed had one of these checklists. However, consistency of completion of the document varied. There did not appear to be a specific way to complete them as they were all different. For example; one section asks the nurse to document four things- reposition, call bell, refreshment, and diet. Staff signed against the section but did not necessarily address all four actions. This could mean patients did not receive food or appropriate repositioning for example as the specific task was not always signed for.

Uncontrolled when printed

The service had 24-hour access to mental health liaison and specialist mental health support. (if staff were concerned about a patient's mental health). However, direct access was dependent on the time of day between 07:45 and 20:00 support was available with an expected response of one hour, seven days a week. An out of hours cross county service was available outside of these hours.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide.

Staff shared key information to keep patients safe when handing over their care to others. We observed a patient handover for a patient needing a surgical transfer to the Royal Shrewsbury Hospital. We also observed a staff handover between shifts and a whole team board round.

Shift changes and handovers included all necessary key information to keep patients safe.

Staffing

Nurse staffing

The service mostly had enough nursing staff and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix, and gave bank and agency staff a full induction.

The service mostly had enough nursing and support staff to keep patients safe these were not all trust staff. We reviewed four shift rotas which identified shifts covered with a mixture of permanent and agency staff. During the previous six months the trust had completely reorganised the nurse staffing ratios in order to increase senior oversight and support for all staff. Each shift was coordinated by a band seven nurse with oversight from a departmental matron. This had led to an increase in band six nurses being available to provide care and support to patients and junior staff. We witnessed staffing during our inspection and whilst there were staff shortages due to sickness on one of the days, the second day was fully staffed, according to the off-duty rota. Staff skill mix was monitored to include at least one paediatric nurse per shift. This was complemented by adult nurses that had completed a comprehensive paediatric competency package.

Managers calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. Current staffing requirements were calculated using a recognised staffing tool. The Royal College of Emergency Medicine (RCEM) Baseline Emergency Staffing Tool was used alongside an adapted tool supported by NHS England and ECIST that had formed the foundation for the 2019 workforce review paper. However, the trust had not recently completed a full staffing review. Senior staff we spoke with felt this would be beneficial to ensure accuracy of staffing numbers. The trust identified this was necessary and were planning to complete a full staffing review.

The department manager could adjust staffing levels daily according to the needs of patients. The matron and the band seven had access to the agency booking system in order to book extra staff as necessary for covering sickness and needs according to patient acuity. During previous inspections the department had been staffed with mainly bank and agency staff. This had improved as there had been an increase in substantive staff throughout the department. Shifts were now covered with at least 60% permanent staff and regular agency staff familiar with the department.

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The number of nurses and healthcare assistants mostly matched the planned numbers.

The service had reducing vacancy rates. A rolling recruitment process was in place for adult and paediatric nurses. A further three paediatric nurses were recruited during our inspection.

The service had reducing turnover rates. The introduction of new band seven roles across the department had increased opportunities within the team for development. Leading to increased staff retention.

The service had reducing sickness rates.

The service had reducing rates of bank and agency nurses. However, this could change daily according to staff sickness.

Managers monitored their use of bank and agency staff and requested staff familiar with the service.

Managers made sure all bank and agency staff had a full induction and understood the service. We spoke with agency nurses that booked block periods of time in the department to ensure continuity for the patients and the team. All agency and bank staff had access to the trust systems and handheld devices to ensure observations could be taken and uploaded in a timely way.

Medical staffing

The service had increased the number of medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix and gave locum staff a full induction.

The service mostly had enough permanent medical staff to keep patients safe. There was a reliance on agency and locum staff. However, these were contracted for regular periods of time.

The trust was commissioned to provide type one and type two emergency care services across two acute locations, Royal Shrewsbury Hospital and Princess Royal Hospital in Telford. At the time of the inspection, the trust employed eight whole time equivalent consultants against an anticipated establishment of 20. This provided four per site. There was a rolling advert for emergency care consultants, and also a long term plan for the trust to recruit suitable individuals to gain their certificate of eligibility for specialist registration (CESR) (a General Medical Council initiative which supports doctors to register as a consultant, first having joined a specialist registrar, when individuals have either trained in non-approved posts or they have entered an approved training post at a later starting point and completed the rest of the programme and gained the remaining competencies). The department was supported by five further locum emergency department (ED) consultants.

The trust continued not meet the Royal College of Emergency Medicine (RCEM) Workforce Recommendations 2018: Consultant Staffing in Emergency Departments in the UK which state a consultant should be present in the ED for a minimum of 16 hours a day (8:00am – 00:00am). At Princess Royal Hospital, consultants worked in the ED Monday to Friday between 8:00am and 10:00pm and 9:00am and 3:00pm at weekends. On call consultant cover was provided at all other times.

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The trust now had a temporary Paediatric Emergency Medicine (PEM) consultant as recommended in the June 2018 RCPCH guidance, Facing the Future: Standards for children in emergency care settings. However, when this secondment from another trust ended staff were uncertain how the service and improvements would be maintained.

The service always had a consultant on call during evenings and weekends. Weekend consultant cover was by locums only as there were insufficient substantive consultants to cover this period.

There were gaps in the medical rota that the service were unable to fill. Medical staff told us they managed the service as safely as possible with the resources available. Medical leads told us they constantly reviewed staffing to ensure it was both adequate, and as safe as possible.

The service had high vacancy rates for medical staff. There were ongoing plans to recruit new staff and managers had been creative in employing experienced senior registrars to fill consultant roles within the department.

Sickness rates for medical staff reducing.

Managers could access locums when they needed additional medical staff and made sure locums had a full induction to the service before they started work. The locums used were regular doctors who had worked in the service for some time.

Managers made sure locums had a full induction to the service before they started work.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. There were less consultant staff working in the ED than the England average. In January 2021, 11 % of medical staff were consultants, the England average was 29%. 34% of medical staff working in the trust ED departments were middle career grade doctors, 47% were registrars and 8% were junior doctors. *(Source: NHS Digital Workforce Statistics.)* Managers told us they required 44 middle grade doctors to cover Royal Shrewsbury Hospital and Princess Royal hospital. There were currently 28, dropping to 20 in the following month, due to the middle grades securing training places and promotions elsewhere. The trust department was actively training and recruiting advanced nurse practitioners and emergency nurse practitioners to support junior doctor roles.

Records

Staff kept records of patients' care and treatment however these were not always complete. Records were not always clear or stored securely. However, were up-to-date, and easily available to all staff providing care.

Patient notes were mostly comprehensive, and all staff could access them easily. However, notes were not always organised to prevent loss of individual documents. We observed loose documents within all sets of notes. This could lead to loss of vital patient records.

In each set of notes we looked at, entries were not always signed and dated with staff designation and name stamp or capital letters. There was also no signature legend available. Errors in medical notes were not crossed out according to General Medical Council guidance. (Good Medical Practice 2013). Matrons completed documentation audits as part of the department audit programme. However, they did not appear to correspond with the notes that we reviewed.

Staff acknowledged loose notes were an ongoing problem and whilst they had plans to add new sheets to the current proforma these had not been actioned as the department was awaiting a transfer to electronic notes. They were not aware of a timeline for this.

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Whilst records were stored securely. The trolley slots were not labelled with patient identifiable information. This meant that staff were reliant on identifying patients notes through use of bed allocation. Whilst staff caring directly for the patients mostly knew patient names not all visiting staff did. We observed two doctors unable to locate a patient's notes as they were not in the expected trolley slot. This was compounded by the fact the doctors did not know the patients names they were coming to review. This meant they may have chosen incorrect notes if they were misfiled leading to a potential delay in diagnosis/ treatment. This was the same throughout the department.

We spoke with staff about labelling of patient bed spaces and the trolley. Staff suggested this was to protect patient confidentiality.

When patients transferred to a new team, there were no delays in staff accessing their records. These were taken with them for direct handover from the emergency department staff.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines. However, systems and processes were not always utilised.

Staff did not always follow systems and processes when safely prescribing, administering, recording and storing medicines. Staff did not always communicate or seek support from pharmacy especially when there were issues following processes for prescribing. For example, Patient Group Directions (PGD) were in place for nurses to safely prescribe certain named medicines to specific groups of patients. However, this process had been temporarily stopped due to a misunderstanding of using PGDs. This had led to delays, particularly for patients in triage, receiving some medicines. Pharmacy had not been informed and would have been able to provide the correct advice to staff. There was no dedicated pharmacy team working within the emergency department (ED). This had the potential to reduce communication with the pharmacy department and lead to delays in provision of medicines.

Medicines were delivered from pharmacy twice a week. If there were any medicine shortages or non-availability, then pharmacy provided advice regarding alternative treatment options.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. Doctors reviewed patient’s medicines on admission which was documented in patients notes and on medicine records.

Staff mostly stored and managed medicines and prescribing documents in line with the provider’s policy. Medicines were stored safely in dedicated secure storage areas. New improved security systems had been implemented which ensured only authorised staff had access to medicines. FP10 prescriptions were stored securely with a robust checking system to track their use. Controlled drugs were stored and recorded in line with policy. Twice daily checks were undertaken, and any discrepancies were reported and investigated. However, refrigerators used to store medications were not monitored according to trust policy. We observed 2 fridges in the ED that had high recorded temperatures for several consecutive days in July 2021. Despite the policy identifying staff should record any action taken and report temperatures over eight degrees centigrade to pharmacy for advice this had not happened. We could therefore not be assured all medicines were stored safely. We informed staff of our findings during our inspection. However, this did not lead to immediate action.

Staff followed current national practice to check patients had the correct medicines.

Medicine reconciliation was undertaken by doctors in ED. Patients allergies or known sensitivities to medicines were documented on all the medicine records reviewed.

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Antibiotics were prescribed following the trust antimicrobial guidelines including details of their indication for use, length of treatment and review dates. The sepsis screening tool was completed and antibiotics for treating sepsis prescribed and administered when appropriate.

Dedicated sepsis trolleys were available for the immediate treatment of sepsis. These were checked daily to ensure the medicines were available and in date and therefore safe to use. This helped to ensure that staff could follow The National Institute for Health and Care Excellence (NICE) guidance which states patients should receive intravenous antibiotics within 60 minutes.

Resuscitation trollies were immediately available in the event of an emergency. These were sealed with tamper evident tags. This follows the guidance from the UK Resuscitation Council. Evidence of daily checks were recorded to ensure the medicines were available and safe to use.

Venous thromboembolism (VTE) protocols were in place and completed for all patients seen and when appropriate were prescribed a prophylactic medicine.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Any medicine incidents would be reported onto the incident reporting system. Learning from incidents was shared across the trust.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. Decision making processes including a mental capacity assessment were in place for staff to follow if a medicine was administered to manage agitation or aggression (rapid tranquilisation).

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff could provide examples of incidents they had reported and whether improvements had been made as a result.

Staff raised concerns and reported incidents and near misses in line with trust/provider policy.

The service had no never events in the department.

Managers shared learning with their staff about never events that happened elsewhere. Staff were able to tell us about incidents that may influence the care they provided.

Staff reported serious incidents clearly and in line with trust policy. There were seven serious incidents open to the Medical and Emergency Care directorate from March 2021 to June 2021 One of these was relevant to Princess Royal hospital and related to timeliness of computer tomography (CT) scan reporting. This was under investigation during our inspection.

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Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong. Patient stories were also used within the department to identify specific areas of learning.

Staff received feedback from investigation of incidents, both internal and external to the service.

Urgent and emergency services

Staff met to discuss the feedback and look at improvements to patient care. This information was fed back after governance meetings as an action for the week at all staff huddles.

There was evidence changes had been made as a result of feedback. After a patient story was heard at the trust board, improvements were planned to provide a trust values and behaviours workshop and the introduction of Civility Saves Lives workshops in September 2021. The workshops were used to highlight the importance of values and behaviours at work and the impact they have on others. A volunteer role was also being introduced into the ED waiting rooms to provide visibility, assistance, and a point of contact for people waiting.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Managers debriefed and supported staff after any serious incident. Staff we spoke with told us they had access to support through small groups or the wider team depending on the situation.

Managers shared learning with their staff about never events that happened elsewhere.

Safety Performance

The service used monitoring results well to improve safety. Staff collected safety information and shared it with colleagues.

The service continually monitored safety performance. Information was recorded twice daily from 10 patient records on both day and night shifts. This information was uploaded into a software system and findings were discussed at the matrons and senior nurse meetings on a weekly basis. This information was then shared with staff through several different routes. For example; private social media groups, department huddles, emails and at handovers.

The safety performance data showed the service where they needed to improve in a timely way. This was further reviewed by a trust wide exemplar tool. Which was displayed for staff to see in the corridor outside majors.

Staff used the safety data to further improve services.

Is the service effective?

Good ● ↑↑

Our rating of effective improved. We rated it as good.

Evidence-based care and treatment

Clinical pathways and policies were not always updated in line with national guidance and staff had difficulty in accessing these. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Michelle Nicholly 26/06/2021 12:36:24

Some policies were out of date and difficult to find, although we did not see any evidence of staff following incorrect guidance. Staff of all grades directed us to printed and electronic trust guidance that was not current. For example, diabetic keto acidosis (DKA) guidance dated 2010 and a fractured neck of femur guideline /pathway that had two dates,

so we were unclear if it was current or not. We discussed this with senior members of the team who were aware that some of the guidelines were not up to date and that a new database was in the process of being implemented. This would include all local guidelines and pathways and we were told would be easier to navigate on the trust intranet system.

Staff working in the department daily did not appear to be aware of this and a completion date was not indicated. Whilst staff appeared to be aware of pathways, they could not sign post us to clear list of common emergency presentations and comprehensive guidelines and pathways to manage these conditions. This meant that new staff may not be able to access them in a timely way.

After our inspection we were provided with the trust pathway for DKA which was documented as having been reviewed in February 2021. However, the guidance was still based on NHS Diabetes: The Management of Diabetic Ketoacidosis in Adults June 2010 this national guidance has since been updated in June 2021.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. New documentation had been introduced which directed staff on managing patients presenting with a mental Health condition. We reviewed five sets of notes for this specific information all of them had the completed documentation and a plan of care. Patients presenting with self-harm and suicidal ideation were given one to one support by security staff and had received all the required mental health assessments, risk assessments and authority to detain. Trust data for June 2021 showed 100% of patients appropriately received a mental health triage assessment.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers.

Nutrition and hydration

Staff mostly gave patients enough food and drink to meet their needs. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs.

Staff did not always fully and accurately complete patients' fluid charts where needed. We reviewed three sets of notes that specifically asked for accurate input and output records. These were not completed to the correct standard. There were no completed calculations of input/output for the whole period the patient was in the department. Food was offered according to the ED patient safety checklist. However, it was not always clear if food had been accepted or declined as this was not always recorded.

Specialist support from staff such as dietitians and speech and language therapists were available for patients who needed it. Staff in the department could access this specialist support if required.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

11/08/2021 12:38:21

Staff initially assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. However, in eight out of the ten records checked, pain scores did not appear to have been re-assessed within 60 minutes of the initial assessment.

Urgent and emergency services

Patients received pain relief soon after it was identified they needed it, or they requested it.

Staff prescribed, administered and recorded pain relief accurately. However, we did observe one patient given pain relief despite the records identifying an allergy.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.

The service participated in relevant national clinical audits. This included participation in the following Royal College of Emergency Medicine (RCEM) audits:

- RCEM Audit: Assessing Cognitive Impairment in Older Adults
- RCEM Audit: Mental Health (Self Harm)
- RCEM Audit: Care of Children in the Emergency Department

Outcomes for patients were identified from RCEM audits to be showing signs of improvement particularly within care of children in the emergency department. Medical staff said they were continually monitoring the quality of their patient outcomes and followed up action plans to improve standards. For example, a patient improvement action plan that is reported externally. This had identified improvements to:

Standard 1: Infants at high risk of potential safeguarding. All patients are now discussed with a senior prior to discharge

Standard 2: A review of the notes is undertaken by a senior clinician when an infant, child or adolescent leaves or is removed from the department without being seen. This is now routine practice and reported externally. We observed evidence of this on inspection.

Standard 3: Older child and adolescent psychosocial risk is assessed using a national or locally developed risk assessment tool suitable for use with children or adolescents. If over 16 years of age are assessed by Rapid Assessment Interface and Discharge team (RAID) and if under 16 years of age have direct access to a CAMHS consultant.

Standards 4-6: These are required organisational standards that relate to frequent attenders of the department, potential safeguarding cases and unexpected departures prior to treatment. These are now all covered by Trust policies.

Managers and staff used the results to improve patients' outcomes, and to improve care and treatment. Action plans to improve performance were in place and were updated and discussed regularly within the clinical teams. Junior doctors participated in audit data improvements and this formed part of their clinical education. Band seven nurses led small teams of staff within the department to focus on specific improvements in care including sepsis management, complaints and tissue viability. We observed and reviewed evidence of staffing fully recruited to the department leadership teams as well as Band 6 and 7 nurses, consultant presence in ED between 8am and 10pm 5 days per week, and 6 hours per day on weekends at both sites at least twice daily consultant led Board Rounds. And the introduction of flow coordinators who support early escalation, white board oversight and performance monitoring.

Mojallali-Holly, 11/26/2025 12:58:21

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Regular local quality audits were undertaken in the emergency department and the results were fed back into the trusts internal quality assurance systems. Externally reported audits were completed as required.

Managers shared and made sure staff understood information from the audits. Audit results were discussed locally within the department, divisionally at quality meetings, and trust wide at board level.

The service had a lower than expected risk of re-attendance than the England average. The reattendance rate at this trust in May 2021 was 6% and 8% in the midlands.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Senior nurses were experienced, qualified and had the right skills and knowledge to meet the needs of patients. The department was run by senior nurses who were experience in providing emergency care. However, due to a need to increase nurse staff numbers, many nurses working in the emergency department (ED) were junior or were international nurses who had recently joined the service. This group of staff did not initially have all the necessary skills to meet all patient needs. In order to achieve this there was a comprehensive ongoing training programme to address this. Senior nurses we spoke with told us that each day staff were becoming more confident and learning new skills.

Managers gave all new staff a full induction tailored to their role before they started work. Nurses spoke highly of the induction process which had been developed based on staff suggestions for improvement. They told us it was very thorough, and they were given time to settle into the department and work a supernumerary period before being counted in the nurse staffing figures with suitable supervision and a buddy system in operation. A cohort of overseas nurses had joined the department recently and they had all been supported through an extended induction to ensure they were comfortable with the transition. We spoke with six of these staff and they all felt extremely supported.

Managers supported staff to develop through yearly, constructive appraisals of their work. 85% of ED nurses had an in-date formal appraisal recorded. Although this did not meet the trust target of 90%, staff had access to ongoing one to one support development conversations. Delays in appraisals were largely due to the extra pressures on staff during the Covid-19 pandemic. 84% of medical staff had received an appraisal. Staff told us of new development opportunities that had arisen as a result of the appraisal process. Including support to apply for roles to develop outside of the department which would benefit the trust as a whole.

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work. A recent restructure of the nursing clinical leadership had encouraged staff to develop into different roles which supported the overall running of the department.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Junior doctors had access to regular, high quality training which covered their learning needs. Feedback from junior doctors about their experience and access to clinical supervision in the department was extremely positive. Staff we spoke with told us they had seen improvements in the department and had decided to stay. A number of medical staff were also now taking up training posts within the region.

Helen Lilly 17/08/2021 17:39:21

The clinical educators supported the learning and development needs of staff. There was a team of three clinical nurse educators to support nurses to maintain and further develop their professional skills and experience. All the nurses

working in the department were allocated into teams. These were led by a band seven nurse and were identified leads for different speciality subjects. They then trained other nurses in that subject or assisted other nurses in caring for patients. There were link nurses for dementia; stroke; cardiology, diabetes, mental health; alcohol; trauma and others. These included cross site staff to ensure both ED's were discussing and sharing the same content. This developed supervision of junior nurses and improved the early identification of any extra training which may be required on an individual basis.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Staff meetings could be attended in person or using video conferencing facilities. Team meeting minutes and outcomes or actions were shared with all staff via email, social media or by a dedicated staff app. Additionally, relevant messages and updates from team meetings were shared at the daily huddles and board rounds.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.Medical staff told us they received additional specialist training and had dedicated learning time within their rotas. Health Education England (HEE) had recently congratulated the trust on providing excellent training and supervision to junior doctors. There were regular training sessions during handovers and evidence of emergency scenario training sessions for both adult and paediatric emergencies for all clinical staff.

Managers identified poor staff performance promptly and supported staff to improve.

Managers recruited, trained and supported volunteers to support patients in the service. There was to be a new volunteer role introduced into ED waiting areas to better signpost and support waiting patients.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Daily huddles around the white board included all disciplines of staff. Leaders described how they worked closely with the medical division to improves medical reviews and access onto a medical ward if required. The frailty team were active in supporting staff and patients in the emergency department (ED), although there were no inpatient frailty beds at the hospital. The team consisted of occupational therapists, physiotherapists and a social worker. Plans were in place for a geriatrician to join the team this summer. Staff told us this was essential to develop the service. Currently the frailty service was only available for limited hours which meant that some patients may be admitted onto wards when they could have been discharged, compounding flow throughout the medical division, particularly at weekends.

Staff worked across health care disciplines and with other agencies when required to care for patients. Medical doctors and advanced nurse practitioners were in the ED regularly. Staff we spoke with informed us that speciality doctors were mostly responsive when asked to review patients they were contacted by the flow coordinator on duty and if there had been no response within the hour it was immediately escalated to the consultant. We observed a number of telephone discussions (and saw documented in medical notes), with speciality teams that facilitated patients being accepted for admission in order to reduce delays and facilitate timely care for patients. Patients who required admission to the Royal Shrewsbury Hospital had delays in being transferred as a result of transport. However, during our inspection we did observe a patient being transferred from Telford to Shrewsbury for surgical care and to aid the patients a patient swap was organised for some one that required a move from Shrewsbury for on-going care.

McLaughlin, Billy
11/06/2021 12:38:21

Urgent and emergency services

Staff referred patients for mental health assessments when they showed signs of mental ill health or depression. The mental health liaison service worked closely with ED staff and provided advice and support when required. Staff we spoke with also told us there was to be an increase in access to mental health support and a plan had been agreed to employ registered mental health nurses directly into the ED to provide further support and specialist care for patients without relying on agency staffing.

Seven-day services

Key services were available seven days a week to support timely patient care.

Staff could call for support from doctors and most other disciplines and diagnostic services, including mental health services, 24 hours a day, seven days a week.

The frailty team was available Monday to Friday and the last referral time was 4pm. The staff we spoke with felt that if the service could be developed and extended there would be a greater reduction in hospital admissions. Staff at PRH were awaiting the arrival of a geriatrician to join the team. They told us that patients attending during the evening and overnight would, by default, be admitted. However, if they had been able to access the frailty team, admission could have been avoided

Occupational therapy and physiotherapy cover for the emergency department (ED) was included in the hospital site therapy rotas and was therefore not dedicated to ED patients, except on a Tuesday morning when four hours was dedicated to ED. Staff we spoke with felt an increase in cover would ensure more timely care for some patients particularly if they were going to be transferred onto wards where they would require therapy. The early access, for example, for stroke patients would potentially ensure patients started any exercise at the earliest opportunity.

We were told staff had good access to imaging 24 hours a day, seven days per week and they were not concerned about any delays in reporting or accessing results.

Health Promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support in the emergency department (ED). Leaflets were available and given to patients for a range of conditions and we saw staff signposting patients to other helpful services during triage. However due to Covid-19 leaflets were no longer on racks in the department.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. Assessment of a patients physical, psychological and social needs formed part of the ED admissions booklet. Patients were referred to their GP for continuing support if required.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

Uncontrolled when printed 11/08/2021 12:38:21

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Patients records we reviewed had evidence of appropriate assessments.

Urgent and emergency services

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Most consent was gained verbally although we saw formal written consent was obtained when required, for example to undergo some diagnostic tests. Some emergency department (ED) nurses had clearly recorded they had sought consent from a patient before carrying out an intervention.

When patients could not give consent, staff made decisions in their best interest, considering patients' wishes, culture and traditions. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. We saw appropriate referrals and assessment had taken place for patients presenting with acute mental health concerns.

Staff understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment. Staff described how they supported children to make decisions about their care and treatment.

Nursing and medical staff did not keep up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Data showed 84 % of nurses had completed this training at the time of our inspection. Senior staff told us training was booked on a rolling programme. Medical staff compliance was 86%.

Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them. Applications for Deprivation of Liberty Safeguards (DoLS) were not routinely completed in the department. Patients requiring a DoLS application had this completed once the patient was admitted to a ward. Patients in the ED had their best interests assessed.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards.

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary. The ED monitored its use of chemical and physical restraint and provided an up to date policy and procedure for staff to refer to which included a process chart for ease of understanding.

Is the service caring?

Good ● ↑

Our rating of caring improved. We rated it as good.

Compassionate care

Although individual staff members treated patients with compassion and kindness, the service was not designed in a manner that always respected patients' privacy and dignity. Staff did not always have the time to interact with people in a meaningful way.

Michelle Holly 14/12/2021 12:08:2

Although we found improvements since our last inspection, issues with the environment and patient flow meant patients did not always receive good compassionate care.

Urgent and emergency services

Patients waited longer for staff to attend to their needs and we witnessed two patients shouting out in distress waiting for staff to assist them. However, when staff were available, they showed genuine kindness and compassion holding the patients' hand and trying to calm them with soothing words.

Staff remained discreet and responsive when caring for patients. Staff worked hard to protect the privacy and dignity of patients with use of curtains and screens. Interactions between nurses, doctors and their patients mostly demonstrated kindness and compassion. However, we observed that staff particularly in majors did not always have enough time to spend talking to patients beyond carrying out essential tasks.

Patients said staff treated them well and with kindness. Without exception all patients we spoke with were happy with the care they had received and felt grateful to the staff looking after them. They understood the time it took to gain access to a bed and were grateful to all staff for how hard they were working to keep them safe and comfortable.

Staff followed trust policy to keep patient care and treatment confidential. However, some conversations could be overheard by other patients. For example, a patient had been admitted into the major's area and a number of non-trust staff were able to hear a confidential conversation between a patient and a doctor.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. We observed staff were non-judgemental when caring for patients with acute mental health conditions. However, the number of security staff and police present presented staff and other patients with space and privacy issues when attempting to access the toilet or medical notes in majors.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Staff told us they had access to resources on cultural needs and were able to offer these to patients as required. Most patients moved out of the emergency department however, before requiring culturally specific care.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Patients confirmed staff were caring and sensitive to their emotional state. For example, one patient was concerned for their partners welfare more than their own physical health so staff expediated care to ensure the partner was not left alone for longer than necessary.

Staff supported patients who became distressed in an open environment and tried to help them maintain their privacy and dignity. However, this was not always possible as there was limited facilities available for personal care. We observed one patient admitted in a dishevelled state who was not able to be supported to be cleaned effectively in the department.

McLellan, Emily
11/26/2021 12:39:21

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Staff showed an understanding of the individual end of life care needs for patients and their families. There was an end of life support box available which contained resources for families.

Urgent and emergency services

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Staff were aware of the life changing conditions some patients presented with and discussed these sensitively with patients and relatives.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Patients were happy with the information provided to them by the clinical team. Plans were explained in detail and in language they could mostly understand. However, patients who were still awaiting a review after triage were sometimes left for up to three hours without any further update. Senior staff were aware of this and were developing a volunteer role within the waiting areas to support patients in accessing further information.

Staff talked to patients in a way they could understand, using communication aids where necessary. Staff spoke with patients, families and carers using language they could understand, and communication tools were available if necessary.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Information about the Friends and Family Test and the hospitals complaints service was available in the department. Although during the pandemic friends and family had not been allowed into the department. This had led to a reduction in feedback overall.

Staff supported patients to make advanced decisions about their care. The ReSPECT form was used in the emergency department to record patient's wishes for their end of life care and included resuscitation decisions and a preferred place of death.

Staff supported patients to make informed decisions about their care. Doctors and nurses explained to patients and their relative's alternatives to treatments where these were available.

Is the service responsive?

Requires Improvement ● ↑

Our rating of responsive improved. We rated it as requires improvement.

Service delivery to meet the needs of local people

The service was designed to provide care in a way that met the needs of local people and the communities served. Managers and staff worked with others in the wider system and local organisations to plan care.

Michelle Holly 11/26/2021 12:08:23

Managers planned and organised services to meet the needs of the local population. However, there were challenges within the environment that made this difficult.

Urgent and emergency services

The emergency department (ED) at Princess Royal Hospital was open 24 hours a day, seven days per week. A public consultation (Future Fit) took place in 2018 which confirmed the agreed way forward for the future configuration of clinical services, including emergency services. A Strategic Outline Case was being finalised for submission to regulatory and national bodies seeking approval and funding for the resultant Hospital Transformation Plan.

We found the physical environment was not always fit for purpose. For example, the children's cubicles were adjacent to the fit to sit area and not adjoining each other, the resus room was a large open plan space separated by wheeled partitions which offered limited privacy and no confidentiality, there was limited availability of a safe area to undertake aerosol generating procedures in the event of an emergency in resus . There was a lack of toilet and wash facilities for patients spending long periods of time in the department. Whilst a room was available for mental health (MH) patients it was small and there was no space outside it for security or police officers that may be required. During our inspection we observed two police officers and a security guard in majors outside the MH room. This caused congestion around the toilet area and the only area available for staff to review notes and access the computers. This meant confidentiality could be compromised for all patients in the major's area. However, senior leaders were aware of these problems but were unable to address the issues whilst funding and system changes were waiting to be finalised.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. Staff understood the need to report mixed sex breaches in the respiratory isolation unit (RIU) and reported one whilst we were on site. Mixed sex rules were not applicable to other areas in the emergency department (ED).

Staff could access emergency mental health support 12 hours a day, 7 days a week for patients with mental health problems, learning disabilities and dementia. The trust had plans to increase this level of cover and were in discussion with the local mental health the trust and commissioning colleagues.

Patients records showed they had been referred appropriately and had been seen by supporting organisations. Dementia support staff worked in the trust and visited the ED daily to provide support and guidance to staff. The department also had staff champions within the team to support specialist care.

The service had systems to help care for patients in need of additional support or specialist intervention. The frailty team were available Monday to Friday, at present, in ED to provide advice and support to patients who presented with musculoskeletal injuries or who required social support to return home without a prolonged hospital stay. ED staff had access to specialist nurses with a range of skills including tissue viability, sepsis, learning disability and safeguarding.

The service relieved pressure on other departments when they could treat patients in a day. Staff monitored and reviewed inappropriate admissions. They tried not to admit patients unless it was medically required. However, as the frailty team were not available in evenings and weekends it was inevitable that some patients were unnecessarily admitted. The frailty team told us they monitored this across both sites after an additional evening and weekend frailty therapy cover commenced December 2020 as part of a winter pressure scheme the data form this project did demonstrate the impact evening and weekend frailty input can have. There are also out of hours admission avoidance pathways accessible to all front door staff.

McLellan, Billy 11/26/2021 12:38:21

We reviewed evidence that the extended frailty project data identified that frailty's input out of hours does increase the identification of patients that could have their admission avoided and also increased the rate of patients going home instead of to step down beds. A further review of 100 patients at each site was planned to commence September 2021 to assess the appropriateness of admission in relation to community services that are available according to day/time of admission.

Urgent and emergency services

Managers and staff worked with other providers to organise care. There was a triage system to enable patients to be treated by the most appropriate service. Some patients were redirected to the onsite GP service for example. ED leaders worked closely with the commissioners and community providers to try and find system responses to the capacity issues both in the ED and the wider trust. The ED leadership team were active in the regional urgent and emergency care group and met monthly with the ambulance service to improve services. As a result they had employed an ambulance navigator within ED to review patients in ambulances. This enabled patients to be assessed and potentially moved into the ED according to their acuity. We observed a patient reviewed by the stroke team and a patient moved into ED after it was identified that they needed a hospital bed.

Meeting people's individual needs

The service was mostly inclusive and mostly took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet their needs. However, the department (particularly majors) was noisy as a result of pump alarms not being managed in a timely way and there did not appear to be a quiet space or room that a patient living with dementia could be cared for separately.

We observed several patients in the major's area who appeared confused and were unsupported for long periods of time. We also witnessed; several staff members who were not aware of the patients names they had come to see. When we questioned this, we were told they 'have a lot of patients to see'.

The children's waiting room was decorated with child friendly images on the walls. The area was quieter; and provided privacy from the main waiting area. A baby changing unit and toilet facilities were available to those using this area.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. Specialist nurses and department champions supported emergency department (ED) staff to identify methods of assisting these patients. The department had a drawer with items that may be useful for distraction; for example, twiddle muffs.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. A hearing loop was available at reception and staff provided any additional support patients required as a result of their disability.

All printed information leaflets were in English, although staff had access to some online information in alternative languages which they could print for patients. Leaflets and signs in the department were in English which was in line with the local demographic. There was no information available in Welsh, despite the ED being close to the border. Staff we spoke with reported they had never been asked for any information in Welsh.

McLellan, Kelly 11/26/2021 12:39:21

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. This was primarily over the phone; therefore, staff reported that if they required alternative provisions such as a British Sign Language interpreter, this could be arranged. We saw that the department had a set of 'communication cards' which were developed by an external company for use by hospitals to communicate with patients. These cards had many images on; for example, a variety of body parts for patients to indicate pain, pictures of procedures to explain what may be undertaken with the patient, and basic symbols for food and drink.

Patients were given a choice of food and drink to meet their cultural and religious preferences. This was mainly sandwiches, plus toast and cereals at breakfast time. However, staff said they could access hot food on an individual basis if required.

Access and flow

People did not always have timely access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards. The service was not meeting national standards to admit, treat, transfer or discharge patients within four hours. There was a declining picture, consistent with increasing numbers of patients coming into the service, the numbers of patients attending the department had exceeded the number attending each day prior to the pandemic. Patients were not discharged from the department or admitted to the ward in a timely way.

Patients accessed emergency services when needed. However, they did not always receive treatment within agreed timeframes and national targets. Managers monitored waiting times.

The Royal College of Emergency Medicine recommends patients should wait no more than one hour from time of arrival to receiving treatment. The trust consistently failed to meet this standard and performed worse than the England average over the 12-month period from May 2020 to April 2021. In April 2021, the trust reported a median time to treatment of 82 minutes. This was longer than the England average of 57 minutes. The trust's recent performance had improved compared to the same period two years ago, when in May 2019 it was 102 minutes.

The trust's proportion of patients admitted, transferred or discharged within four hours of arrival was consistently amongst the lowest in the region over the two years April 2019 to January 2021. However, there was an increase from 62.6% in January 2021 to 72.9% in May 2021. The midlands regional average was 78.7% and England average 83.7%.

The proportion of patients attending by emergency ambulance that waited over 60 minutes from arrival to handover was higher than the midlands and England averages from 7 March to 27 June 2021. As of 27 June, 19% of patients waited over 60 minutes on the back of an ambulance. The midlands average was 6% and the England average was 4%. There were ongoing discussions with system partners to try to reduce this handover delay. All staff we spoke with were aware of the potential risk to patients in the community. Senior divisional leads felt that now the medical division and the emergency care division were one team they were starting to see small improvements in flow. Although it was too early to note any sustained improvements.

During our inspection, the service was operating under severe pressure and we saw patients had long waits to be seen. This included delays in ambulance handovers, access to triage, and review by a doctor. Capacity in the department was on the emergency department (ED) risk register. There were a number of mitigations in place to try to improve flow. These included two matrons appointed to coordinate the management of patient flow within all areas of the Trust, four daily site safety meetings with senior and clinical ED representation, Patient flow projects including frailty and stranded patients, twice daily clinical board rounds, 2 hourly huddles, daily conference calls with partners to facilitate patient discharge and admission and the introduction of an ambulance handover nurse for 12 hours a day to review patients delayed in ambulances.

Michael Reilly 11/08/2021 12:39:21

On 19 July 2021, the departments compliance to the four-hour target to see, treat, admit or discharge was 64%. In June 2021, the trust wide figure was 68%.

On 19 July 2021, there were four, 12-hour breaches and one on 20 July 2021. In April 2021, the trust wide figure was 12.

Department leads identified numerous on-going actions to improve flow through the department. These included; a continuation of monthly system wide demand and capacity meetings, audit of appropriateness of urgent treatment centre (UTC) usage, a focus session scheduled to include initial assessment from ED to increase opportunities to further stream to UTC and Same Day Emergency care (SDEC) and planned action for paramedic referral to SDEC over the winter period.

Managers and staff worked to make sure patients did not stay longer than they needed to. ED department staff tried to facilitate care as quickly as possible for every patient. A newly created flow coordinator role helped to get patients moving through the department and identify any delays as early as possible. Delays in triage were not displayed so some patients were unaware of how long they could be waiting However, once seen in the department staff made every effort to keep patients and relatives up to date with delays and changes to treatment plans.

ED doctors reported that speciality staff mostly reviewed their patients while in ED as quickly as possible and that there was a memorandum of understanding to ensure this process could be escalated if necessary. We saw a number of patients discussed over the telephone to expediate admissions where possible. For example, patients with a diagnosed fracture could be fast tracked through the department for admission if appropriate.

Escalation processes were in place for staff to follow when capacity in the department began to deteriorate. Reviews of the department were made at least two hourly by the flow coordinator and the nurse in charge. These looked at patient safety and risk for patients in the department and those awaiting offloading from an ambulance and flow through the department to discharge or admission.

The trust escalation plan was based on the NHS England operational escalation framework referred to as Operational Pressures Escalation Level (OPEL). As this included access to an intensive care bed it was not entirely reflective of the emergency department. Staff were identifying the department was at OPEL four. However, this was not escalated by the trust as they had an ITU bed. This sometimes meant that staff were not necessarily receiving external support in a timely way to expediate discharges or admissions. Staff we spoke with said “flow was still seen as an ED problem”. Staff felt they were working at level four but did not always feel empowered to take action. We observed an extra bed added to resus and patients being expediated although this did not happen until quite late on in the shift.

Senior staff said they were frustrated at the trusts failure to declare the highest OPEL level.

Following our inspection, the trust provided an action log to demonstrate the actions they had undertaken during this period. They told us they had treated the situation like a level four internally, and provided maximum support internally, despite declaring the situation externally as a level three.

The trust worked to reduce the number of patients admitted to hospital following attendance at ED. In June 2021, the trust admitted 24% of all type one attendances, which was below the England average. This was better than in March 2021, when they admitted 34% of all type one attendances.

Mclean,Billy
11/06/2021 12:38:21

The number of patients leaving the service before being seen for treatments was low. The numbers were similar to other trusts both regionally and nationally. There had been a steady increase in patients leaving before being seen since January 2021. However, we saw evidence of follow up of both adults and children being contacted to ensure they were safe.

Managers and staff worked to make sure they started discharge planning as early as possible. The frailty team attended the ED Monday- Friday to assist with discharges. There was a trust wide initiative to free up hospital beds earlier in the

day and to improve patient flow out of the ED. Daily calls were held with partner organisations in order free up hospital beds and obtain access to continuing care for patients who required this. The trust were working with commissioners and community providers to access rapid response teams of nurses who could help patients going home and prevent some admissions. However, at the time of our inspection, this service had not started.

Staff planned patient discharges carefully, particularly for those with complex mental health and social care needs. Patients were referred in a timely way to appropriate mental health services for help with ongoing care and treatment. However, there was a national shortage of mental health inpatient beds, and this was reflected in the number of patients with mental health needs staying in the department longer than was necessary. We observed one patient who was waiting for an inpatient mental health bed was in the department for more than 50 hours.

Staff supported patients when they were referred or transferred between services. Navigators and triage staff provided information to patients who were referred to other services.

Managers monitored patient transfers and followed national standards. Surgical patients were transferred to other hospitals using recognised safety standards.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns and the service clearly displayed information about how to raise a concern in patient areas. Information was available in the ED waiting areas on how to make a complaint. Complainants received a response from the ED within 20 days of making a complaint. From April to June 2021, there were 27 complaints and three compliments. The department received 10 complaints in June 2021, most were about clinical care and treatment. The time taken for the emergency department (ED) part of the investigation took an average of 20 days from June 2020 – July 2021.

Staff understood the policy on complaints and knew how to handle them. Nurses told us they provided patients with information about the Patient Liaison Advisory service (PALS) if they were unable to resolve a complain at the time. However, nurses said they always attempted to resolve a patient's concerns locally and at the time of the incident.

Managers investigated complaints and identified themes. Feedback from complaints was shared with staff and learning was used to improve the service. Themes were shared with staff during team meetings, huddles and at daily handovers. Complaints were discussed at clinical governance meetings.

Recent complaints were mostly about delays to care. Formal complaints were discussed during divisional governance meetings and where appropriate lessons learned were shared throughout the trust.

McLellan,Hilly 01/26/2021 12:38:21

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Managers told us they kept the patient and family up to date with complaint progression as soon as they were able. Managers were allocated administration time in order to respond to complaints.

Staff could give examples of how they used patient feedback to improve daily practice. This included feedback from the patient volunteer group and local Healthwatch who had made suggestions to improve the environment in ED following feedback they had received from patients. The decision to have volunteers within the waiting rooms and enhance staff values and behaviours training had also come from patient feedback after a patient story to the board.

Is the service well-led?

Requires Improvement ↑

Our rating of well-led improved. We rated it as requires improvement.

Leadership

Leaders mostly had the skills and abilities to run the service. They understood and were making improvements to managing the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The Emergency Centre was managed under the Medicine and Emergency Care division and was run by the Divisional Medical Director and Divisional Director of Operations. The leadership structure in The Emergency Centre side of the division consisted of a Clinical Director, Centre Manager, and Divisional Director of Nursing and Divisional Deputy Director of Nursing. The nursing team were led by a matron who was supported by a team of band seven nurses who took charge of the daily operational running of the service.

Local leaders we spoke with were clear about their own roles and accountabilities, although some staff said they believed the trust wide leadership team were not always fully sighted on the issues faced by the department or fully aligned with the departments view on finding solutions. For example, during our inspection the department was under extreme pressure, however managers had not declared a level four OPEL incident. Internal actions had been set in place which were aligned to level four incidents, but the failure to declare a level four externally meant some systems of support which may have been available, had not have been fully explored. From April to July 2021, OPEL level four had been instigated five times, and OPEL level three had been instigated 53 times. We were told this was because the trust did not identify as level four if they still had an intensive care bed available.

Local leaders also felt some frustration that when extra actions were required, these largely fell to ED staff. For example, nurses said some tasks undertaken in ED could be done by nurses working in other directorates, and although nurses were occasionally redeployed to ED to cover a shift, shortages were largely left to the department to absorb through more creative staff rostering and the use of extra bank and agency staff. Staff said there was little visible support provided by other specialities in the trust. This was something the divisional senior team were highlighting across the trust in order to ensure that other divisions were sighted on how problems of flow within ED impacted elsewhere.

McLellan, Hilary
11/2021 15:08:32

Divisional leaders told us they visited the department and spoke to staff during walkabouts. They reported using a ''ask five questions'' methodology, whereby they asked different staff the same five questions to gain an insight into what was happening in the department. Nursing staff told us the nursing and medical leadership team were very visible in the department and that other members of the senior leadership team had recently become more visible. The ED matron was based in the department and supported the daily running of the service.

Urgent and emergency services

There was a band seven nurse in charge every day who had oversight of each clinical area and was required to maintain an overview of every patient in the department. This enabled band six nurses to directly care for patients and support more junior staff in all clinical areas. The career progression this allowed had encouraged several staff to stay in the department as there was now a potential development path.

Vision and Strategy

The service had an emerging vision for what it wanted to achieve and an emerging strategy to turn it into action, developed with some relevant stakeholders. The vision and strategy were focused on sustainability of services. Leaders and staff understood and knew how to apply them and monitor progress.

There were seven strands to the strategy. These were; excellence in patient care, leadership, team recognition, wellbeing, professional development, shared decision making and the workforce of the future.

Staff did not talk about this strategy during the inspection; however, it was clear work was underway in some of these areas. For example, the department had recently appointed clinical educators to each site to assist with professional development and had budgeted for each nurse to receive two weeks of training before the end of this financial year.

There was an operational plan which set out how the trust intended to respond to local and national challenges. The plan included improvements in meeting performance such as a reduction in ambulance handover delays and improving four hour waits.

The trust were aware that many of the improvements required were dependent upon external factors, including hospital bed capacity, accessibility of GP services and primary care, and availability of skilled doctors and nurses. The trust were trying to address these issues collaboratively and were active members of the urgent and emergency care delivery group. They worked closely with other providers, 111 services, commissioners and Health Education England in order to realise their strategy.

During our last inspection, one of the trust's priorities had been to reduce the number of patients being cared for in the ED corridor. Although the trust had been largely successful in this area, these patients were still unable to access the service, and were now held on the back of ambulances for long periods of time instead of the ED corridor.

Senior members of the ED department were part of a group who met regularly along with other departmental representatives to discuss the trusts ''getting to good'' plan. This involved identifying actions to each service which would impact on the safety, quality and effectiveness of the care they provided.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

McLellan, Holly
21/07/2021 12:38:31

All staff we spoke to said they felt respected, supported and valued, and that communication in the department had greatly improved. In our previous inspection, some staff reported a bullying culture from senior leaders however we did not hear that during this inspection. CQC received a written allegation of bullying during our inspection although matrons told us they were not aware of any allegations of bullying in the department. Nurses told us they were aware of how to escalate concerns around bullying and they were aware of the trust's freedom to speak up guardians.

Urgent and emergency services

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There were opportunities to meet, discuss and learn from the performance of the service. Clinical governance meetings were regular, well attended and covered a wide range of issues including for example, complaints, incidents, training, safety alerts and mortality and morbidity meeting outcomes. The minutes were shared with staff at all levels of the department and available electronically for anyone unable to attend. Minutes showed clear outstanding actions and included an action owner along with an expected timeframe for completion.

Some policies were out of date and difficult to find, although we did not see any evidence of staff following incorrect guidance. Staff of all grades directed us to printed and electronic trust guidance that was not current. We discussed this with senior members of the team who were aware that some of the guidelines were not up to date and that a new database was in the process of being implemented. This would include all local guidelines and pathways and we were told would be easier to navigate on the trust intranet system.

Staff working in the department daily did not appear to be aware of this and a completion date was not indicated. Whilst staff appeared to be aware of pathways, they could not sign post us to clear list of common emergency presentations and comprehensive guidelines and pathways to manage these conditions. This meant that new staff may not be able to access them in a timely way.

After our inspection we were provided with the trust pathway for DKA which was documented as having been reviewed in February 2021. However, the guidance was still based on NHS Diabetes: The Management of Diabetic Ketoacidosis in Adults June 2010 this national guidance has since been updated in June 2021.

Lessons learned from incidents and complaints were discussed in the department newsletter and formed part of the junior doctors teaching. Some junior doctors told us they were not aware of incidents and complaints.

Management of risk, issues and performance

Leaders and teams mostly used systems to manage performance effectively. They identified some relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff did not always contribute to decision-making to help avoid compromising the quality of care. Some risks were not always escalated.

The risk register contained identified risks and a latest review date, a record of when the risk was added to the register with a clear audit trail with the history, monitoring and updates recorded for each risk through the trust's risk management system.

Mcellan-Hey 21/26/2021 14:38:11

Not all risks were listed on the register. For example, in June 2021, the department meeting minutes identified a risk to adult mental health patients as a result of limited or no availability at the 136 suite. This had been escalated and alternatives across the system were to be considered. However, there was a risk to patients being managed within the emergency department for long periods of time. During our inspection one patient was in the department for in excess of 50 hours.

Senior staff had identified that mandatory training figures were not reaching the trust target of 90%. This was compounded by the pandemic and the intensive support /training of new staff members. So, although this risk was known it was not identified within the department risk register.

However, staff were able to articulate what the department's main risks were, particularly patient flow and staffing. These were discussed in detail at department governance meetings and minutes were circulated and fed back to teams through other team meetings and huddle debriefs.

We reviewed the department escalation policy for managing increased admissions at times when

demand exceeds capacity. Whilst the policy was comprehensive, staff did not always feel empowered to implement any considered actions early enough in the day. This meant that escalations were made late in the day which negated the chance of further discharges taking place from wards as care home capacity would be limited and frailty reviews were unavailable. The trust escalation plan was based on the NHS England operational escalation framework referred to as Operational Pressures Escalation Level (OPEL). As this included access to an intensive care bed it was not entirely reflective of the emergency department. Staff were identifying the department was at OPEL four. However, this was not escalated by the trust as they had an ITU bed. This sometimes meant that staff were not necessarily receiving external support in a timely way to expediate discharges or admissions. Staff we spoke with said "flow was still seen as an ED problem". Staff felt they were working at level four but did not always feel empowered to act.

Data from the trust showed that emergency department co-ordinators; band seven nurses, who ran the department day to day, maintained daily shift logs for both day and night shifts. These logs highlighted issues of performance breaches, staffing concerns (nursing and medical) and how these were managed and any other unusual events, or events which had impacted upon performance. This ensured all staff were aware of ongoing day to day issues and concerns.

The trust had agreed local improvement plans with local commissioners. It was agreed that achieving the four-hour time for 95% of patients was unattainable, and that the trust trajectory should aim for 85% instead. In June 2021, the trust was achieving 68%, which was below the 71% from the previous month.

Information Management

The information systems were not integrated, and staff could not always access patient data when they needed it. The service collected some pertinent data and analysed it. Data or notifications were consistently submitted to external organisations as required.

The emergency department (ED) used both paper and electronic records to care for patients. Paper records were scanned so they were accessible if a patient returned to ED or if information for contacting a patient was required; for example, if they had left the department prior to treatment.

Data was collected to measure performance using several IT systems. Included in this were the time from arrival to treatment, overall time in the unit and outcome such as discharge, transfer and x-ray results. However, patients that left without being seen was captured on paper. We were able to review this documentation which was complete during our inspection and for the two previous months. We were not aware of any plans to implement a change to this method of data collection.

Mr Elgin Lim
11/10/2021 12:38:21

Urgent and emergency services

The department had an electronic dashboard showing patient information for the staff. This was used so staff could identify, at a glance, the patient's time in the department and patient acuity. It also identified decision to admit information and patient flags; for example, diabetes and frailty.

There was a secure electronic incident reporting system that could be used to analyse themes and trends in reported incidents to enable reviews and appropriate mitigating actions to be taken. Staff had access to policies and procedures via the trust secure intranet. However, these were found in multiple different storage locations and were not easily found.

Patient observations were recorded electronically, however, currently all other documentation was paper based. The trust were in the process of an electronic documentation roll out. Staff in the ED were not aware of any dates for this implementation. This meant that paper assessment booklets had extra sheets slotted into them which may be lost or misplaced. Prescriptions for medicine were paper based, and this led to some delays in prescribing medicines and arranging for medicines to be ready for patients to take home.

There was a performance dashboard which monitored quality audits and which the ED leaders had access to. This information was printed and displayed in the department for all staff to see. Band seven nurses were leads for the performance audit areas and had a team of staff that would champion the specific areas to share best practice news and encourage colleagues to improve certain aspects of care according to patient requirements.

Guidelines were not all stored in the same place on the trust intranet and there was an issue with version control for printed versions of some documents. ED leaders were aware of these issues and said there was a working group set up to manage this. A prototype of a new ED intranet page was about to be tested and this contained links to all relevant guidelines. There was no timescale for final completion.

We were told the trust were working on a system to display waiting times electronically. This would particularly benefit the patients in the waiting area. There were also plans to introduce an ED volunteer to assist and signpost people while they were waiting.

Engagement

Leaders and staff engaged with patients, staff, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Leaders told us they engaged with patients through Healthwatch and through their patient volunteer networks. However, due to the COVID-19 pandemic, there had been limited opportunities to engage with patients.

Emergency department staff said they tried to encourage patients to give feedback and to complete friends and family surveys but the demands in the department regularly meant this type of activity could not be undertaken.

McLellan, Lucy
11/08/2021 11:38:41

Some staff in their band seven teams would deliver a learning session and delivered training to colleagues and had notice boards dedicated to a topic in the staff room. There was a range of communications to staff to advise them of changes and improvements, such as emails, staff huddles, an improvement newsletter and ward meetings for each grade. Staff were also keen to identify changes that would improve patient care and safety. For example, a reconfiguration to the care of children in the department to ensure closer monitoring in an area separate to the adults. This, however, would require finance agreement. There was a closed social media group for staff to share ideas for improvements.

Urgent and emergency services

Learning, continuous improvement and innovation

Staff were committed to learning and improving services, although high demand in the department meant there was not enough time dedicated to improvement initiatives and outcomes. Some quality improvement methods were used, and staff were learning to implement these. While staff were focussed on performance, there was little time for innovation.

Improvements in the department included regular quality audits on patient care and safety. For example, sepsis audits, compliance to escalation of sick patient protocols and mental health patient triage and assessment documentation. Some of these improvements were instigated following our previous inspections. Results from the audits largely showed an upward trend in compliance.

The department's new nurse staffing structure, which included a dedicated, on site matron, more senior nurses and three clinical educators across both sites allowed for greater monitoring, oversight and training opportunities.

However, high demand for services, increased requirements for nursing and medical staff, difficulty in consistent recruitment, reduced patient flow and a poor physical environment had meant some of the quality improvements required would take longer to complete. However, without exception all the staff we spoke with working within the department were fully committed to continuing what they described as a "journey". Everyone had a great sense of pride and achievement with how far they had come since our last inspection.

Some of the new pathways and initiatives were still 'a work in progress'. For example, the SDEC (same day emergency care),was still embedding new processes and identifying improved patient assessment pathways to reduce admissions, and the frailty assessment team helped ensure reduced admissions for elderly care patients quickly, it was not available seven days per week.

McLellan,Holly
11/26/2021 12:38:21

Maternity

Requires Improvement ● ➔🡐

Is the service safe?

Requires Improvement ● ➔🡐

Our rating of safe stayed the same. We rated it as requires improvement.

Mandatory training

The service ensured most staff completed mandatory training in key skills.

Most nursing, midwifery and medical staff were up-to-date with their mandatory training. However, the number of staff who completed it did not meet trust targets. As at July 2021, nursing, midwifery staff and medical staff overall training compliance rates were below the trust target of 90% at 86% and 82% respectively.

Due to nursing, midwifery and medical staffing challenges in the maternity department, staff were sometimes unable to be released to conduct their mandatory training. Staff could access mandatory training in several ways including online e-learning and face-to-face socially distanced sessions.

The service mostly conducted weekly obstetric skills and drills training on all areas of the maternity unit. However, staff did not carry out skills drills training in the antenatal clinics or in any part of the maternity unit, particularly the post-natal ward which was not always fully staffed with midwives at night. This meant staff may not know how to effectively respond to an emergency in the antenatal clinic or be able to identify any gaps in emergency provision at night.

The mandatory training was comprehensive and met the needs of women and staff. Maternity and medical staff attended a multidisciplinary training course, which covered an annual PRactical Obstetric Multi-Professional Training (PROMPT) style 'skills and drills' training. For Practical Obstetric Multi-Professional (PROMPT) training, completion rates were high for consultants, midwives and women support assistants. As at July 2021, 98% of midwives and 94% of consultants had completed PROMPT training which was above the 90% trust target.

Staff completed annual 'K2' online training to assess staff competency to interpret cardiotocography (CTGs). Cardiotocography (CTG) measures a baby's heart rate and monitors the contractions in the womb (uterus). As at July 2021, 92% of midwives and 94% of medical staff had completed their CTG interpretation assessments. This was higher than the trust target of 90%.

Clinical staff completed training on recognising and responding to women with mental health needs, learning disabilities, autism and dementia. Staff attended learning disability awareness training days to improve their knowledge of supporting women living with additional learning needs.

Michelle Holly 11/28/2021 12:38:21

Managers monitored mandatory training and alerted staff when they needed to update their training. The education midwife monitored staff training completion and arranged staff training sessions. The clinical governance boards in each area of the maternity department displayed the current staff training compliance rates and encouraged staff to continue to check when their own training was due.

Maternity

Senior staff discussed training compliance rates and future training plans at monthly training faculty meetings. Additional virtual training sessions had been arranged during the pandemic to enable staff to complete some training from home to try to increase training compliance rates. However, the maternity education team lacked some staffing capacity and space to conduct larger training sessions. This impacted on the number of training sessions that could be arranged. The service was supported by the trust's leadership team to increase the staffing establishment for the maternity education team to address this. The education building was available for some larger training sessions however, the service was also reviewing other suitable training venues.

Safeguarding

Not all staff were compliant with the most up-to-date safeguarding adults training Mental Capacity Act 2005 and Deprivation of Liberty Safeguards training. Despite this, staff understood how to protect women from abuse and the service worked well with other agencies to do so. Most midwives and women's support assistants (WSA) had completed safeguarding training on how to recognise and report abuse and they knew how to apply it.

Nursing and midwifery staff mostly received training specific for their role on how to recognise and report abuse. As of 1 July 2021, the trust's 90% training completion target for safeguarding adults and children training was met for nursing and midwifery staff for five of the six required modules. Safeguarding children training rates for nursing and midwifery staff were above the trust target for all levels with safeguarding children level 1 at 100%, level 2 at 97% and level 3 at 91%. Training compliance rates for safeguarding adults level 1 was at 97% and safeguarding adults level 2 at 96%. However, training compliance rates were below the trust target for safeguarding adults level 3 training at 36%. This training became mandatory for nursing and midwifery staff in February 2021. The safeguarding midwife had increased the frequency of virtual safeguarding training sessions to increase the safeguarding training rates throughout the forthcoming year.

As at July 2021, most nursing and midwifery staff had completed Mental Capacity Act (MCA), Deprivation of Liberty Safeguards (DoLS) and Mental Health Act training with training compliance rates at 87%.

Medical staff had not received some training specific for their role on how to recognise and report abuse. As of 1 July 2021, the trust's 90% training completion target was not met for medical staff for three of the six required modules. Safeguarding adults' level 2 compliance was at 81% and safeguarding children level 3 was at 89%. No medical staff had completed safeguarding adults' level 3 training as required in line with the safeguarding intercollegiate guidance. This states clinical staff working with adults who could contribute to assessing, planning and intervening and evaluating the needs of an adult should be trained to safeguarding adults at level 3. A recent external safeguarding review had identified all medical staff should be trained in level 3 adult safeguarding. The clinical leadership team had agreed that this training along with MCA and DoLS would be included in the next clinical training cycle. The first training event was scheduled for September 2021 as part of the rolling training programmes conducted on a bi-monthly basis.

As at July 2021, medical staff training compliance rates for the Mental Capacity Act, Deprivation of Liberty Safeguards (DoLS) and the Mental Health Act were significantly below the trust target of 90% at 59%. This meant medical staff may not have current knowledge of the Mental Capacity Act, Deprivation of Liberty Safeguards and the Mental Health Act to ensure they apply them appropriately. However, medical staff training compliance rates were above the trust target for safeguarding adults' level 1 at 93%, safeguarding children level 1 at 96% and safeguarding children level 2 at 96%.

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Some nursing, midwifery and medical staff had not received PREVENT awareness training to inform them how to safeguard vulnerable people from being radicalised into supporting terrorism or being terrorists themselves. As at July 2021, PREVENT training compliance levels for nursing, midwifery and medical staff were just below the trust and

national target of 85%. For PREVENT level 1 training, 89% of nursing and midwifery staff and 59% of medical staff had completed this training. For PREVENT level 3 (WRAP) training, 83% of nursing and midwifery staff and 52% of medical staff had completed this training. This meant some staff may not recognise the signs of vulnerable people becoming radicalised and take appropriate action.

Staff could give examples of how to protect women from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. The named safeguarding midwife advised and supported staff with safeguarding concerns. They worked together with the trust's safeguarding team and external agencies to safeguard women and babies. Staff gave examples of when they have had escalated concerns to protect women and babies from avoidable harm and abuse.

Staff described the trust's midwifery safeguarding team as visible and they helped staff to raise concerns. However, as the maternity safeguarding team were part of maternity services, they were managed by the director of midwifery (DoM). This meant they were not always aligned with the corporate safeguarding team, particularly with the children's safeguarding team, to ensure they all had a coordinated approach. This team was due to move to the trust's corporate safeguarding team to mitigate this as this was a recommendation from an external maternal safeguarding review.

The safeguarding midwife shared learning from safeguarding referrals with maternity staff in the weekly safeguarding newsletters and during safeguarding training. They ensured safeguarding referrals information was easily accessible to staff on the trust's intranet and displayed on posters on the wards.

The service had low numbers of women with Female Genital Mutilation (FGM). An obstetrician in the service led on FGM and supported the safeguarding midwife to provide training to staff.

Staff followed safe procedures for children visiting the ward. All visitors to the maternity unit, apart from partners were limited in accordance with the trust's COVID-19 restrictions response. However, staff were aware of the risks to children when able to visit.

Staff followed the baby abduction procedures in the trust's new-born security policy. The service used an electronic baby tagging system to alert staff if a baby was attempted to be removed from the department. Staff regularly tested the alarm system was working effectively.

Staff did not undertake baby abduction drills. Baby abduction drills were not included in the maternity specific 'skills drills' scenario training. This meant some staff may not understand the procedure to follow if a baby was abducted from the unit. The safeguarding midwife told us abducted baby procedures would be included in the next skills and drills courses.

Cleanliness, infection control and hygiene

The service did not always monitor staff compliance with effective infection, prevention and control practices. Staff used equipment and control measures to protect women, themselves and others from infection. They kept equipment and the premises visibly clean.

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The service generally performed well for cleanliness. Hand hygiene audits were 100% for each month on the delivery suite for the last 12 months. However, some infection, prevention and control audits were not conducted during the pandemic.

Maternity

Training compliance rates for all nursing, midwifery and medical staff were below the trust target of 90% for infection, prevention and control (IPC) training. Despite this, all areas of the maternity department were clean and well-maintained. As at July 2021, overall IPC training compliance rates for maternity were below the 90% trust target at 75%. Low training compliance rates had been discussed at the divisional IPC meeting held in June 2021. Ward managers had been informed where compliance rates needed improvement, with action plans produced to monitor actions taken.

The daily tap flushing schedule for May 2020 to April 2021 showed this had been completed every day on the delivery suite. This is carried out to prevent water-borne infection, such as Legionella from thriving. However, daily flushing compliance was variable on the Wrekin midwife led unit which may increase infection risks. Compliance rates were below 100% for five of the 12 months with compliance ranging from 67% to 87%.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Staff had fully completed cleaning checklists for June 2021 and July 2021.

Staff followed infection control principles including the use of personal protective equipment (PPE). From April 2020 to March 2021, there had been no women with signs of wound infection following caesarean section.

Staff and visitors followed additional COVID-19 precautions across the service. Face masks and alcohol hand gel were easily accessible. Staff had their arms bare below the elbows in line with the trust's IPC policy. This ensured staff effectively washed their hands to reduce the risk of spreading infections.

Hand sanitising and handwashing facilities were easily accessible with handwashing posters clearly displayed prompting staff, women and visitors to wash their hands.

Staff complied with social distancing precautions when required. IPC and COVID-19 precaution information for staff and visitors was clearly displayed across the service.

Ward areas were clean and had suitable furnishings which were clean and well-maintained. Staff cleaned equipment after each patient contact however, equipment was not always labelled to show when it was last cleaned. The use of 'I am clean' labels was inconsistent across all areas of the maternity service which meant staff may not know when equipment needed cleaning.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment mostly kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Women could reach call bells and staff responded quickly when called. Obstetric emergency drills were carried out on each area of the maternity unit during the day.

McLellan, Hayley 11/27/2021 11:38:11

However, the Wrekin Midwife Led Unit (MLU) did not have an emergency buzzer that was audible outside of the MLU which may have slowed the arrival of the delivery suite staff who will support the MLU staff to continue or transfer care. The service was already aware of this risk when we raised it directly with them during the inspection. They had implemented some mitigations to limit the impact on safety to women and babies which included ensuring staff were aware of the procedures to follow when escalating an incident via the emergency hospital number. This risk had been recorded on the trust's electronic risk recording system but not recorded on the local maternity risk register to ensure the service regularly monitored the actions taken to mitigate this risk in a timely way.

Maternity

There had been an emergency on the MLU where a baby had a shoulder dystocia and staff needed support through an emergency call out. A shoulder dystocia is a birth injury that happens when one or both of a baby's shoulders get stuck inside the mother's pelvis during labour and birth. Staff had reported a delay with the emergency response for this incident. The incident report highlighted that delays were more likely at night when staffing levels were lower. As emergency drills were not conducted at night, the service was unable to fully assess the impact of having a non-operational buzzer.

The design of the environment followed national guidance. However, there had been a recent incident when the MLU had to be evacuated as part of the ceiling became unsecure. Staff ensured three women were safely transferred to the delivery suite. Senior staff reported and risk assessed this incident appropriately. They arranged for contractors to quickly rectify the problem to prevent recurrence and to allow the MLU to re-open.

Staff carried out daily safety checks of specialist equipment, and weekly checks of emergency equipment which was used less frequently.

The service mostly had suitable facilities to meet the needs of women's families. There was a dedicated bereavement room on the delivery suite for parents to stay following the loss of their baby. This was sympathetically decorated and had facilities for parents to stay overnight to remain close to their baby for as long as possible. There was also a separate entrance so bereaved parents could avoid using the main corridor. However, as the bereavement suite was next to the delivery suite and it was not soundproofed, parents may be able to hear noise from the delivery suite. The Department of Health's Building Note 09-02 – Maternity care facilities (2013) guidance states the maternity unit suite should have in-patient facilities away from the birthing area for use in the event of a bereavement.

The service had enough suitable equipment to help them to safely care for women and babies. Each birthing room on the delivery suite had a rescusitaire (emergency baby resuscitation equipment) and access to digital systems to write labour records. In addition, staff could easily access emergency equipment and blood products which meant there was no delay if a woman required a blood transfusion in an emergency. However, MLU staff did not have access to digital systems in the birthing rooms on the MLU. This meant staff may not have up-to-date records for women, were not recording contemporaneous notes and had to transfer the information from the handwritten notes onto the digital systems when they could access the digital systems.

Staff had access to equipment to remove women from the birthing pools in an emergency. Staff conducted drills to practise this and to gain any learning.

Staff disposed of clinical waste safely. Staff segregated general and clinical waste and disposed of sharps including needles safely, in line with national guidance.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each woman and took action to remove or minimise risks. Staff identified and quickly acted upon women at risk of deterioration

Michellan Kelly 11/26/2021 12:39:21

Staff used a nationally recognised tool to identify women at risk of deterioration and escalated them appropriately. Staff appropriately used the Modified Early Obstetric Warning Score (MEOWS) to identify if a woman's condition was deteriorating and needed increased observations or immediate escalation to medical staff.

Maternity

Twice weekly cardiotocography (CTG) meetings were now held to discuss and share learning. A cardiotocography (CTG) measures a baby's heart rate and monitors the contractions in the womb (uterus). Maternity staff reviewed CTG's with consultants and learned from incidents where CTG interpretation was incorrect. Fresh eyes checks were performed every hour for continuous fetal monitoring. The service had learned from previous serious maternity incidents where CTGs had been incorrectly categorised to prevent recurrence.

Staff on the postnatal ward had started to use the Newborn Early Warning Trigger and Track (NEWTT) tool to aid earlier identification of babies that may need additional support after birth.

Staff completed risk assessments for each woman on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. Records showed staff conducted risk assessments appropriately at booking, following birth and at every admission.

The Triage Assessment Cards in use in the triage unit were based upon the Birmingham Symptom Specific Obstetric Triage System (BSOTS). This is a nationally recognised, published and recommended system to support obstetric triage and ensure a woman is correctly triaged according to her need.

Carbon monoxide screening, which was part of the 'Saving Babies' Lives 2016' initiative had been suspended during COVID-19. This had affected the compliance rates as the average rate of women who had their carbon monoxide reading taken between April 2020 and March 2021 was 19.3% compared against a local target of above 90%. However, as the service had gradually re-introduced screening, rates were now increasing.

Staff knew about and dealt with any specific risk issues including sepsis and venous thromboembolism (VTE). The Maternity department had a sepsis guideline, with the latest version updated in May 2021. Sepsis is when the body has an unusually severe response to an infection. Staff received sepsis training as part of their maternity specific PROMPT training. This included an assessment to test staff' knowledge. Staff involved in the maternity sepsis workstream were updating sepsis screening tools to ensure they were suitable for staff to identify sepsis of women and babies. However, the service was not currently auditing data to evidence they were complying with the recommended sepsis pathway timelines, such as women receiving antibiotics within 60 minutes. Service leads planned to start this audit to monitor the timelines once staff were using the sepsis screening tools. Staff completed VTE assessments in line with service guidelines. VTE is a life-threatening condition where a blood clot forms in a vein. The service did not record the overall individual VTE results for each area of the trust, including maternity. However, the maternity observation management part of the electronic record was a mandatory field and ensured every woman had a VTE assessment. Senior staff confirmed VTE monitoring would be included in the revised audit programme.

The service had 24-hour access to mental health liaison and specialist mental health support if staff were concerned about a woman's mental health. Staff could access specialist mental health support for women when needed. A consultant psychologist and a specialist perinatal mental health midwife provided women with psychological support. The service was coordinating with a local mental health provider to support women with mental health difficulties following pregnancy loss or trauma. women with mental health difficulties following explained that the Matern

Mcclellan-Kelly 11/26/2021 2:39:21

Staff completed, or arranged, psychosocial assessments and risk assessments for women thought to be at risk of self-harm or suicide. Staff now checked every woman's' risk of domestic violence status during every appointment. This was clearly recorded in the patient records and flagged on the electronic patient record system. Specialist support was available if a woman was at risk of domestic violence and required intervention. The maternity service had links with domestic violence charities to signpost women for additional support.

Maternity

Staff shared key information to keep women safe when handing over their care to others. The service was working to implement the Continuity of Carer care model to ensure women had a named midwife allocated throughout their care. This helped to ensure staff had all the necessary information at each stage of a woman's pregnancy from their initial booking to their babies' delivery.

Staff performed swab counts in theatre and had implemented learning from a surgical never event in April 2020 where a swab had not been removed, to prevent recurrence. Women now wore a coloured bracelet to indicate they had some internal swabbing material present to remind staff this needed to be removed.

Shift changes and handovers included all necessary key information to keep women and babies safe. Staff discussed all inpatients at the midwifery and nursing handover and the multi-disciplinary team (MDT) shift handover meetings. This ensured midwives and medical staff remained up-to-date about all women and babies.

Midwifery and Nurse staffing

The service did not always have enough maternity staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment. However, managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service did not always have enough nursing and midwifery staff to keep women and babies safe. The numbers of midwives and women support assistants did not always meet the planned numbers. Actual staffing levels for all areas of the maternity department regularly did not meet the planned staffing levels despite from January to December 2020 the trust's ratio of births to midwifery staff was 17.95 being significantly better than the national average of 22.31. For June 2021, the fill rate showed midwifery and nursing staffing levels were below planned levels for all maternity areas apart from the delivery suite during the day when the trust reported surpluses for all staff groups for all shifts except non-registered staff working night shifts (92.9%). The fill rate is calculated by comparing planned staffing hours and actual staffing achieved and indicates gaps in staff when 100% is not achieved.

For June 2021, nursing and maternity staffing for all remaining areas of maternity were below planned levels. The antenatal ward daytime fill rates were 84.5% for midwives and 91.0% for non-registered staff and for night shifts the rates were 98.5% for midwives and 86.7% for unqualified care staff. For the postnatal ward the daytime fill rates were 97.0% for midwives and 93.2% for unqualified care staff and for night shifts the rate was 82.6% for midwives and 96.7% for unqualified care staff.

Senior leaders had used a midwifery workforce planning tool to calculate whether there were enough midwifery staff to provide the required level of care to women and babies. On the delivery suite from 29 March 2021 to 21 June 2021, the acuity levels were met for 64.8% of shifts, 20.7% of shifts were up to two midwives short and 4.2% of shifts were more than two midwives short. For the antenatal ward from 1 January to 30 June 2021, acuity was met for 80% of shifts with up to one midwife short for 15% of shifts, and between two midwives to greater than four midwives short for the remaining 5% of shifts. For the postnatal ward from 1 January to 30 June 2021, acuity was met for 59% of shifts, 22% of shifts had up to one midwife short, 11% of shifts had up to two midwives short, 6% of shifts had up to three midwives short and four and above midwives short for the remaining 2% of shifts.

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The maternity clinical dashboard showed between April 2020 and March 2021, most women in established labour received one-to-one care, with an average compliance rate of 99.3%. This was above the local target of above 90%. However, 100% of women should receive this in line with National Institute for Health and Care Excellence (NICE) NG4 guidance: Safe Midwifery Staffing.

Maternity

Lower than planned staffing levels were affecting staff morale and reduced the ability of staff to complete tasks such as mandatory training. Staff in the Wrekin midwifery led unit (MLU) often did not take breaks due to having to cover unfilled shifts on the delivery suite or to cover other staff when they took their breaks. MLU staff also felt anxious as they were regularly moved to other higher risk areas of the maternity department at late notice. Staffing levels impacted on students in the department as they had multiple mentors and their training support lacked continuity.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. Maternity leaders had completed a staffing paper to highlight the staffing requirements for the department to the trust board. They had a rolling recruitment programme acting to improve maternity staffing levels. They were well supported by the board to recruit new staff. Service leaders regularly reviewed maternity staffing requirements at monthly maternity governance meetings.

The ward manager could adjust staffing levels daily according to the needs of women. Although staffing levels were often lower than planned, managers regularly reviewed and adjusted staffing levels and skill mix to ensure women and babies remained safe. Actions were taken to meet patient acuity in line with the escalation policy. Senior leaders now held twice daily huddles in all areas of maternity to regularly monitor safety and deploy staff to where they were most needed. The escalation policy was followed when there were unfilled gaps in staffing.

The theatres and recovery bay on the delivery suite were staffed by the main theatres. An on-call team of scrub nurses and operating department practitioners were available for the planned elective lists. Another theatre team was on standby in case the second theatre needed to be opened in an emergency.

The service had high vacancy rates. As of March 2021, there were 9.1 whole time equivalent (WTE) band 6 midwife vacancies and 14 WTE band 5 midwife vacancies. These were approximate figures as service leaders were still conducting a staffing review to calculate accurate figures. However, a number of posts had been filled and recruited to in July 2021.

The service had high turnover rates. From July 2020 to June 2021, turnover rates ranged from the lowest rate of 5.9% for healthcare assistants on the delivery suite to the highest rate of 53.8% for sister/charge nurse on the antenatal ward. However, this very high rate may be due to the small staff group.

The service had high nursing and midwifery sickness rates. Staff sickness particularly on the delivery suite, in addition to some staff having to isolate due to COVID-19, and high levels of maternity staff on maternity leave significantly impacted on nursing and midwifery staffing numbers. For the last 12 months, among midwives, sickness rates ranged from their lowest at 4.3% for band 6 midwives on the postnatal ward to the highest sickness rates of 19.2% for healthcare support workers on the delivery suite.

The service had low rates of bank and agency nurses. Managers limited their use of bank and agency staff and requested staff familiar with the service. Senior leaders had introduced incentivised bank shifts between June 2021 and July 2021 to help improve staffing levels until the recently recruited midwifery staff had started their roles.

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Managers made sure all bank and agency staff had a full induction and understood the service. The service used regular bank and agency staff who understood the department.

Maternity

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep women and babies safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The service had enough medical staff to keep women and babies safe. The medical staff matched the planned number. For the last six months, consultant obstetric cover was met for all shifts. Junior staff felt well supported and supervised by senior medical staff.

The service had low vacancies for medical staff. As at July 2021 there were two staff grade vacancies which were soon due to be filled.

The service had high turnover rates for medical staff. Over the 12 months from July 2020 to June 2021, there were very high turnover rates for consultants at 4.9% and for speciality doctors at 97.3% although this figure was extremely high due to the small number of staff in this staff group.

Sickness rates for some medical staff were high. From July 2020 to June 2021, the highest sickness rates were for specialty doctors at 7.9%, followed by specialty registrars (3.4%) and trust grade doctor – specialty registrar at 2.3%. All other medical staff groups reported less than 1% sickness over the 12 months.

The service had low rates of bank and locum staff. The service had not used agency consultants in the past six months and used their own consultants to fill gaps in medical staffing provision.

Managers could access locums when they needed additional medical staff. Managers made sure locums had a full induction to the service before they started work. Regular locums were used to fill any gaps in medical staffing who were knowledgeable about the service.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. In the event of high activity and/or inadequate staffing, senior staff followed the maternity escalation policy to assess whether staffing levels met the acuity of women. They redeployed staff to where they were most needed.

The service always had a consultant on call during evenings and weekends. Senior leaders were increasing the resident obstetric consultant cover to 24 hours a day, seven days a week. This was above the medical staffing requirements of this service with between 4,000 and 5,000 births a year.

Records

Staff kept detailed records of women's care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Women's notes were comprehensive and all staff could access them easily. Records were stored securely. Paper records were securely stored in locked notes trollies.

McLellan, Holly 01/08/2021 11:38:21

When women transferred to a new team, there were no delays in staff accessing their records. Patient records were a mix of handheld records for community care and electronic for women's inpatient stay. The service planned to move all

records to electronic records beginning in August 2021. Reports would then be able to be produced from the electronic system and staff would be able to communicate directly with GPs. The introduction of the new digital record meant women would be able to easily access their maternity notes and add personalised information and plans for birth to inform their midwife.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes when safely prescribing, administering and recording medicines. There was a patient centred approach to medicine prescribing. A pharmacist visited the maternity department from Monday to Friday to review prescribing of medicines. There was a medicines advice and supply service available seven days a week. An on-call pharmacist was available outside of core working hours. Maternity staff always knew how to contact pharmacy staff for support.

Staff reviewed women's medicines regularly and provided specific advice to patients and carers about their medicines. Patients' allergies or known sensitivities to medicines were documented on all the medicine records reviewed. The trust's pharmacy team provided counselling and support to patients to explain changes in medicines or when new medicines were started to allow them to raise concerns and ask questions. The pharmacist also provided advice on breastfeeding and medicines.

Staff mostly stored and managed medicines and prescribing documents in line with the provider's policy. Medicines were stored in dedicated secure storage areas with access restricted to authorised staff. Controlled drugs were stored and recorded in line with the trust's policy. Daily checks were undertaken, and any differences were investigated.

Resuscitation trolleys were immediately available in the event of an emergency. These were sealed with tamper evident tags. This follows the guidance from the UK Resuscitation Council. Emergency grab boxes were also available for postpartum haemorrhage, eclampsia, cord prolapse and hypoglycaemia. Evidence of daily checks were recorded to ensure the medicines were available and safe to use.

Staff could access dedicated sepsis trolleys or boxes for the immediate treatment of sepsis. These were checked each day to ensure the medicines were available and in date and therefore safe to use.

However, three medicines used to assist women with their birth and to prevent excessive bleeding were not stored appropriately on the Wrekin midwife-led unit (MLU). These medicines should be stored in the fridge at a specific temperature to ensure they work effectively. We raised this directly with the midwife in charge on the MLU. They gave immediate assurances to quickly address this with staff.

Staff followed current national practice to check women had the correct medicines. All patients we checked had venous thromboembolism (VTE) assessments checked by a pharmacist and staff appropriately prescribed a prophylactic (a medicine used to help prevent disease) medicine. A recent audit on prophylactic prescribing for VTE within maternity had led to improvements in prescribing.

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Where antibiotics were prescribed, we saw evidence that prescribing was in line with national and local guidance. A pharmacist ensured that any queries about antibiotic prescribing were discussed and followed up with the prescriber. These decisions were documented in the patients notes.

Prescribed pain relief medicines were checked by a pharmacist to ensure the correct pain relief was prescribed. Any required changes were highlighted to the prescriber including post-natal pain relief advice.

The service had systems to ensure staff knew about safety alerts and incidents, so women received their medicines safely. Any medicine incidents would be reported onto the trust's incident reporting system. Learning from incidents and any medicine alerts would be shared across the trust.

Incidents

The service had made some improvements regarding their management of safety incidents. Staff mostly recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. They were supported by external agencies to ensure the incident reviewing process was thorough and robust. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Most staff knew what incidents to report and how to report them. Staff raised concerns and reported all levels of incidents and near misses in line with trust policy. Staff at all levels could clearly explain how to report an incident on the trust's incident reporting system. However, staff did not always incident report when staffing levels fell below planned levels to provide evidence of how regularly this occurred and what mitigations were put in place. Good practice and positive feedback received from families was now added onto the trust's incident reporting system from February 2021. This ensured positive feedback and learning was communicated directly with staff.

The service did not have any never events in the 12 months before our inspection. The service had one surgical never event in March 2020. Learning had been implemented to ensure swab count checks were performed in theatre to prevent recurrence of a swab being retained.

Managers shared learning about never events with their staff and across the trust. Incident feedback meetings were held to discuss learning from recent incidents. Learning was shared with staff at ward safety huddles and team meetings.

Staff now understood the duty of candour. They were open and transparent and gave women and families a full explanation when things went wrong. Duty of candour is a regulatory duty that requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person, under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. A notifiable safety incident includes any incident that could result in, or appears to have resulted in, the death of the person using the service or severe, moderate or prolonged psychological harm. Staff could access the trust's duty of candour policy on the trust's intranet for guidance.

As part of our ongoing monitoring of the service and at the previous inspection, due to the previous inconsistency of the grading of incidents in maternity services at the trust, we were not assured the service had an open and transparent method of incident grading. This meant women and families may not receive an appropriate response and support from staff in line with the duty of candour. During this inspection, we observed a neonatal and obstetric incident review (NOIR) meeting, where a maternity incident was discussed, and staff were allocated actions to complete. All incidents were now reviewed at the NOIR meeting which was a multidisciplinary meeting with midwifery, neonatal and medical representation. This ensured the duty of candour was complied with as early as possible. Staff from external maternity

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units joined this meeting which added an extra level of incident scrutiny. Staff now had a clearer understanding of the need to support women and their families to put matters right and to clearly explain what had happened. The service was continuing to review their incident grading process to ensure incidents were graded correctly. This would help to ensure duty of candour was always met in a timely way.

Staff received feedback from investigation of incidents, both internal and external to the service. Each area of the maternity department had a clinical governance board which displayed learning including good practice identified from incidents and serious incidents.

The perinatal mortality review tool (PMRT) group included representation from other NHS organisations, to provide external scrutiny and oversight of the trust processes. The service was receiving support from several external organisations in both clinical practice and incident management to provide an additional level of scrutiny.

Staff met to discuss the feedback and look at improvements to patient care. Senior leaders had implemented changes to improve safety for women and their babies in response to learning from incidents. Obstetricians from another NHS trust attended incident review meetings to ensure incidents were appropriately reviewed and graded.

Managers investigated incidents thoroughly. Women and their families were involved in these investigations. Through our ongoing monitoring of this service, we had identified ongoing issues with incident grading particularly for some tears and when women had heavy bleeding after giving birth.

The service now ensured incidents graded moderate or higher at the NOIR meeting were then escalated to the division oversight group (DOG) meeting. Any incident identified as a serious incident would then be presented at the corporate incident review group. This meant there may be a delay between an incident occurring to it being declared as a serious incident. If a serious incident did not require any further discussion, there was a clear process for a serious incident to be declared without it needing to be discussed at these three incident groups.

However, maternity governance committee minutes for May 2021 stated resources and staffing changes were affecting the management of incidents. This meant there were many incidents awaiting further reviews and associated updates regarding actions.

There was evidence that changes had been made as a result of feedback. However, the incident reviewing process for maternity was still not streamlined and learning was not always gained in a timely way. Service leaders understood this process needed to be more defined and were reviewing it to ensure it was fit for purpose.

Managers debriefed and supported staff after any serious incident. Incident reviews also highlighted good practice points to ensure staff were aware of where they had performed well and in line with national guidance.

Safety Thermometer

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, women and visitors.

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The service continually monitored safety performance. Staff used the maternity dashboard data to further improve services. The Safety Thermometer is no longer completed nationally and the maternity department stopped this data collection early last year. This was replaced by the maternity survey with all other data monitored on the maternity dashboard.

Maternity

Is the service effective?

Good ➔ 🡐

Our rating of effective stayed the same. We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of women subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. We reviewed nine policies relating to the maternity department which were all up-to-date. The service had an effective system to ensure policies and clinical pathways reflected national guidance and were reviewed according to the review dates.

Staff protected the rights of women subject to the Mental Health Act and followed the Code of Practice. We observed multidisciplinary medical and nursing handover meetings. Staff routinely referred to the psychological and emotional needs of women, their relatives and carers. During medical and nursing handover meetings we saw ongoing plans of care were discussed which included women's ongoing emotional and psychological needs.

Nutrition and hydration

Staff gave women enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for women's religious, cultural and other needs.

Staff made sure women had enough to eat and drink, including those with specialist nutrition and hydration needs. Women were pleased with the food and drink provided to them in all areas of the maternity unit

Infant feeding midwives supported women with their feeding choice for their baby. Staff stored expressed breast milk and baby formula milk safely. As at July 2021, the breastfeeding initiation rates within 48 hours of delivery were at an average of 74.6% between April 2020 and March 2021. This was above the national target of 68.1%.

Staff fully and accurately completed women's fluid and nutrition charts where needed and used a nationally recognised screening tool to monitor women at risk of malnutrition. Specialist support from staff such as dietitians was available for women who needed it. Staff had recorded when women had dietitian input.

Pain relief

Staff assessed and monitored women regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Michelle Holly 1/12/2021 12:38:2

Staff assessed women's pain using a recognised tool and gave pain relief in line with individual needs and best practice. Women confirmed their pain was well managed before, during and following labour.

Staff prescribed, administered and recorded pain relief accurately to ensure women received pain relief soon after requesting it. Staff stored ready prepared packs of pain relief medicines and they were available out of hours. They could be supplied through a prescription or using a Patient Group Direction (PGD).

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for women.

The service participated in relevant national clinical audits. The maternity service at the Princess Royal Hospital participated in the National Neonatal Audit Programme 2020 (based on data from 2019.) The trust was within the expected range, or better than expected, for all six metrics in the audit that apply to individual hospitals.

The findings from audits were presented at monthly audit meetings.

Managers and staff did not carry out a comprehensive programme of repeated audits to check improvement over time. The current audit programme was limited to reactive audits and Saving Babies Lives Care Bundle audits. However, the service had recently recruited a lead specialist midwife for audit. They were in the process of producing an audit plan for 2021/2022 to be aligned to the planned more streamlined governance processes to enable senior leaders to monitor the outcomes for women and their babies more effectively.

Outcomes for women were mostly positive, consistent and met expectations, such as national standards. Managers and staff used the results to improve women's outcomes. The service used the maternity clinical dashboard to report on and monitor a range of indicators for the service. The dashboard tracked monthly performance against locally agreed thresholds and national targets, where available. This allowed the service to benchmark their performance against other similar services in addition to enabling the service to target reviews and improvements at the appropriate parameters.

The service had a low expected risk of readmission for elective and non-elective care. For the last 12 months, the elective readmission rate for maternity patients was 1.29% (64) and 1.30% (6 readmissions) for non-elective care.

Managers and staff investigated outliers and implemented local changes to improve care and monitored the improvement over time. Maternity services did not currently have any outliers. The trust was supported by external organisations to ensure improvements were sustained and became well embedded.

Managers shared and made sure staff understood information from the audits. The service was effectively using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard.

Improvement was checked and monitored. The trust had monthly Ockenden Report Action Plan progress meetings to discuss the services' progress against the actions the trust was required to take in response to the findings of the first Ockenden report published in 2020. This ensured the service took the necessary action to ensure the actions were being progressed in the required timeframes. The Ockenden review was commissioned following a letter sent by bereaved families in 2017, raising concerns where babies and mothers died or potentially suffered significant harm whilst receiving maternity care at the trust. The government commissioned a review to assess the quality of investigations relating to new-born, infant and maternal harm at the trust. As at July 2021, most actions had either been completed or had clear workable plans to ensure they were completed.

Anonymous
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Maternity

Competent staff

The service generally made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and mostly had the knowledge to meet the needs of women. The education midwife and Professional Midwifery Advocates (PMA) supported the learning and development needs of staff. However, there was limited rotation across all areas of the maternity department. Band five midwives would rotate into different areas of the department however, once they became band six staff they could request to work in their chosen areas for example, antenatal and postnatal wards. There was a perception that more experienced staff were nervous to work on the delivery suite, caring for higher risk women. More junior midwifery staff would be continually moved to the delivery suite where there was high activity. We were not assured all midwifery staff were competent to conduct their midwifery role in all areas of the department as more experienced and specialist midwives may become de-skilled in caring for women on the delivery suite due to remaining in their preferred areas of the department.

Managers gave all new staff a full induction tailored to their role before they started work. Newly trained and staff who had recently begun working in the department were well supported. New midwives had a buddy to support them in their first 12 months of registration and to help them put their midwifery training into practice.

Managers supported staff to develop through yearly, constructive appraisals of their work. Most staff had received an annual appraisal. The trust set a target of 90% completion. As at July 2021, 87% of midwifery staff and 91% of medical staff had received their annual appraisal.

Managers did not always support staff to develop through regular, constructive clinical supervision of their work. Staff did not always have the opportunity to discuss training needs with their line manager and receive support to develop their skills and knowledge. Due to the staffing challenges the department was currently experiencing, it was not always possible for staff to dedicate time to support staff with their supervision work.

Managers now made sure staff attended team meetings or had access to full notes when they could not attend. Senior leaders acknowledged team meetings had not previously been held regularly to fully update staff. They were now more established and the interim Director of Midwifery had begun to hold daily updates with matrons and ward managers.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Less experienced nursing and medical staff were well supported by more experienced staff.

Managers made sure staff received any specialist training for their role. The service had several specialist midwives for example, infant feeding specialist midwife and bereavement midwives. They had completed specialist training to support staff and provided tailored and individualised specialist support to women and their partners. Consultants and midwives had additional bereavement training following the national bereavement pathway.

Managers identified poor staff performance promptly and supported staff to improve. Consultants were clearly assessed on their competencies. Medical leaders assessed the skills and competence of locum doctors to ensure they met the expected standards for the department. However, several maternity staff had been away from work for extended periods and these roles were covered by staff in interim roles.

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Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit women. They supported each other to provide good care.

Maternity

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Senior leaders held recently implemented twice daily huddles to monitor safety and staff deployment across unit.

Staff worked across health care disciplines and with other agencies when required to care for patients. The department had links with domestic abuse charities to ensure women received specialist support. Midwifery staff understood how to protect women who were at risk of domestic abuse.

Staff referred women for mental health assessments when they showed signs of mental ill health. The service had a specialist midwife who was trained to support vulnerable women and women living with mental health concerns.

Seven-day services

Key services were available seven days a week to support timely care.

Consultants led daily ward rounds on all wards, including weekends. Women were reviewed by consultants depending on the care pathway. Senior leaders were in the process of recruiting a further six consultants to increase the resident consultant cover to 24-hour cover, seven days per week for the maternity department by December 2021. This is above the consultant cover requirements for a service this size.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. Women could also contact an on-call community midwife out-of-hours, particularly if they were booked in for a home birth and had any queries or concerns.

Health Promotion

Staff gave women practical support and advice to lead healthier lives.

The service had a healthy lifestyles team and relevant information available to women promoting healthy lifestyles and support. Health promotion information was clearly displayed in the antenatal clinic areas. The Personalised Care and Support Plan (PCSP) included guidance for women to stay healthy during pregnancy such as physical activity, healthy eating and smoking advice.

Staff assessed each woman's health when admitted and provided support for any individual needs to live a healthier lifestyle. The service had arranged virtual parenting sessions which included advice on healthy lifestyles during pregnancy as staff were unable to offer face-to-face classes due to COVID-19.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff supported women to make informed decisions about their care and treatment. They followed national guidance to gain women's consent. They knew how to support women who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit women's liberty. However, medical staff may not have up-to-date knowledge of Consent, Mental Capacity Act and Deprivation of Liberty safeguards due to low training compliance rates.

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Staff understood how and when to assess whether a woman had the capacity to make decisions about their care. Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff made sure women consented to treatment based on all the information available. Staff clearly recorded consent in the woman's records. Staff gained consent and documented it in patient records including for women having procedures including caesarean sections.

Maternity

When patients could not give consent, staff made decisions in their best interest, taking into account women's wishes, culture and traditions. Midwifery staff were supported by consultants to obtain consent when women lacked capacity.

Staff obtained consent before carrying out any internal investigation or procedures including, caesarean sections.

Staff understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment. The service had a teenage pregnancy specialist midwife to support young mothers and to help them to understand all the birth choices available to them.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. However, not all medical staff received and kept up-to-date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards and may not have current knowledge about how to apply this in practice.

Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them. Staff implemented Deprivation of Liberty Safeguards in line with approved documentation. Staff did not often need to use DoLS in the maternity department however, they were supported by staff with specialist knowledge if they needed to.

Staff could describe and knew how to access the trust policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. The trust's mental capacity and best interest policy and procedures was available on the trust's intranet for staff to easily access.

Is the service caring?

Good ➔ 🡐

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated women with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for women. Staff took time to interact with women and those close to them in a respectful and considerate way. Staff closed curtains to ensure they respected women's privacy and dignity particularly during physical or intimate care examinations.

Women said staff treated them well and with kindness. Without exception, during the inspection maternity staff were dedicated to ensuring women and babies received compassionate care. Women and partners confirmed all staff had taken the time to interact with them in a respectful and considerable way, even when the maternity department was very busy.

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Staff followed the trust policy to keep women's care and treatment confidential. Staff now ensured women were not identifiable by name on the patient boards in all areas of maternity and specifically on the postnatal ward, so women's information remained confidential.

Maternity

Staff understood and respected the individual needs of each woman and showed understanding and a non-judgmental attitude when caring for or discussing women with mental health needs. During the midwifery and medical handovers, staff were respectful when discussing women with mental health concerns and certain mental health diagnoses.

Staff understood and respected the personal, cultural, social and religious needs of women and how they may relate to care needs. Women who had previously suffered pregnancy loss were well supported at specialist pre-term clinics and by the bereavement midwives for later pregnancies.

Emotional support

Staff provided emotional support to women, families and carers to minimise their distress. They understood women's personal, cultural and religious needs.

Staff gave women and those close to them help, emotional support and advice when they needed it. Staff followed bereavement policies and procedures to support women in cases of stillbirth or neonatal death with additional specialist support provided by a specialist bereavement midwifery team. Staff valued the emotional and social needs of women and their relatives. During the initial phases of the pandemic the bereavement midwifes attended scan appointments with women when requested when partners were unable to attend.

The service provided parents with a choice of memory boxes from several infant loss charities to best suit their requirements. In addition, staff gave parents who were staying in the bereavement room self-care kits which included sweets and shower gels.

The midwifery bereavement team supported all women who had experienced the loss of a baby. Women and their families who were undergoing a termination of pregnancy from 12 weeks where their baby had been identified as having a congenital malformation were cared for on the delivery suite. Women suffering a miscarriage were cared for on the gynaecology ward until 16 weeks.

Staff supported women who became distressed in an open environment and helped them maintain their privacy and dignity. The service had a dedicated self-contained bereavement room where staff could take parents to offer them time to come to terms with the loss of their baby. The service had cold cots which allowed families additional time to spend with their baby.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. All staff conducted bereavement training with staff attending additional bereavement day training sessions when available. Consultants would usually break bad news to women and those close to them. The midwifery bereavement team were planning to implement the National Bereavement Care Pathway (NBCP) to improve the quality and consistency of bereavement care received by parents after pregnancy or baby loss.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. The service took part in a project called "Lighthouse" which identified women who required additional and specialist support from a counselling psychologist following any type of birth trauma which included delivery complications and infant loss. Women also have access to a specialist perinatal mental health team, which includes specialist perinatal psychiatrists, and specialist mental health nurses. All maternity staff received pregnancy and infant loss training as part of their mandatory training. The midwifery bereavement midwives worked with the local children's hospice to support and provide palliative care for families.

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Maternity

Understanding and involvement of women and those close to them

Staff supported and involved women, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure women and those close to them understood their care and treatment. Information was available in different languages for women and families whose first language was not English.

Staff talked with women, families and carers in a way they could understand, using communication aids where necessary. Women confirmed all staff explained information, particularly complex medical information in a way they could understand. Staff gave them the opportunity to ask questions.

Women and their families could give feedback on the service and their treatment and staff supported them to do this. Women gave positive feedback about the service. The service took part in the Maternity Friends and Family Test (FFT)which asks women to rate their experience as “very good”, “good”, “neither good nor bad”, “poor”, “very poor” or “don’t know”. During the pandemic, data was not collected from March 2020 to November 2020. We reviewed a range of the maternity Friends and Family Tests (FFT) and found scores were consistently over 90% in all areas and generally scored slightly better than the England average.

Staff supported women to make advanced and informed decisions about their care. Staff included birth partners in the planning for the birth and during post-natal care. Staff encouraged women to use the Personalised Care and Support Plan (PCSP) to ensure their preferred birth choices were recorded.

Is the service responsive?

Good ● ➔ ➔

Our rating of responsive stayed the same. We rated it as good.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers mostly planned and organised services so they met the needs of the local population. Women were able to attend antenatal appointments at the location which was closest to their homes. However, as the Royal Shrewsbury Hospital and the Bridgnorth, Ludlow and Oswestry community maternity units remained closed to inpatients women sometimes had to travel further to the Princess Royal Hospital to give birth. The service had promoted home births as an alternative option for women. From January 2021 to March 2021, the home birth rate had increased to 1.9% which was above the national target of 1.4%.

McLellan Nicola
11/26/2021 12:08:21

Facilities and premises were appropriate for the services being delivered. Staff could access emergency mental health support 24 hours a day 7 days a week for women with mental health problems, learning disabilities and dementia. The maternity department also had a specialist mental health midwife who was easily accessible to provide mental health support to women.

Maternity

The service had systems to help care for women in need of additional support or specialist intervention. Women with mental health conditions or living with a learning disability had their needs met. Staff were aware when women needed additional support as the electronic patient records system flagged this requirement.

Managers monitored and took action to minimise missed appointments. Women received a reminder text message before their antenatal appointments.

Managers ensured that women who did not attend appointments were contacted. Administration staff monitored when women did not attend appointments. They contacted women to offer them another appointment to ensure they were rebooked to attend.

The service relieved pressure on other departments when they could treat patients in a day. The service ensured women could attend multiple specialist antenatal clinics and have any scans or tests on the same day to avoid them having to return on several separate occasions.

Meeting people's individual needs

The service was inclusive and took account of women's individual needs and preferences. Staff made reasonable adjustments to help women access services. They coordinated care with other services and providers.

The bereavement room was sympathetically decorated and could be accessed by a separate entrance to the delivery suite. This meant parents did not have to use the same entrance as families taking their babies home. However, the bereavement room was not sound proofed, which meant parents may still hear babies crying.

Staff made sure women living with mental health problems and learning disabilities received the necessary care to meet all their needs. The maternity service had specialist midwives in mental health and learning disabilities to support women.

Staff understood and applied the policy on meeting the information and communication needs of women with a disability or sensory loss. The service had information leaflets available in languages spoken by the women and local community. Staff could provide women with leaflets in an easy read format if required.

Managers made sure staff, women, loved ones and carers could get help from interpreters or signers when needed. During a nursing and midwifery morning handover, staff were arranging translation support for a woman who spoke limited English. Staff also had access to a telephone interpreting and translation service to support women to fully understand their care and treatment. The service and the MVP had produced a postnatal video to provide pregnancy advice to women and was due to be available in Polish, Romanian, Bulgarian, Urdu and Punjabi.

Women were given a choice of food and drink to meet their cultural and religious preferences. Women confirmed they were given enough choice regarding food and drinks. Staff provided women with hot and cold drinks. The service had coordinated with the local Maternity Voices Partnership to develop The Personalised Care and Support Plan (PCSP) to provide women with a document to record all their birth and health and wellbeing preferences.

Acteon Holly 11/08/2021 12:38:21

Staff had access to communication aids to help women become partners in their care and treatment. Staff could provide easy read and larger print leaflets to women and families to support their understanding of their care and treatment.

Maternity

Access and flow

Women could mostly access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge women were in line with national standards.

Managers monitored waiting times and made sure women could mostly access services when needed and received treatment within agreed timeframes and national targets. Staff monitored and incident reported when women did not attend their antenatal appointments. Staff conducted follow up calls to check the women's wellbeing and to reschedule their appointment for them. However, the Wrekin midwife led unit (MLU) had been closed for 13 days between 31 January 2021 and 16 July 2021 which meant nine women were transferred to the delivery suite and were unable to give birth in their chosen birth setting. Staffing shortages and staff sickness, including staff isolating due to COVID-19 were the main reasons the MLU had to be closed. All three birthing rooms were in use on five occasions between 31 December 2021 and 20 June 2021 which meant women's birth care was transferred to the delivery suite.

Managers monitored waiting times and made sure women could access emergency services when needed and received treatment within agreed timeframes and national targets. Women were triaged on admission into the service to ensure they received the most appropriate care and treatment in a timely way.

Managers and staff worked to make sure women did not stay longer than they needed to. Women had several appointments and checks scheduled on the same day to limit the amount of antenatal appointments they needed to attend. However, the pre-term antenatal clinic regularly ran over capacity. This was one factor which had led to a serious incident in early 2021 as a woman could not access the clinic in line with Saving Babies Lives Version 2. This recommends maternity services set-up early pregnancy and pre-term clinics to support women who are at a risk of delivering their babies early. The service had acted on these findings to extend the current capacity by recruiting a new consultant with a specialism in pre-term labour to support the clinic.

Managers worked to keep the number of cancelled appointments to a minimum. When women had their appointments cancelled at the last minute, managers made sure they were rearranged as soon as possible and within national targets and guidance.

Staff planned women's discharge carefully, particularly for those with complex mental health and social care needs. The service had strong links with external agencies to ensure women received appropriate and timely support following their discharge.

Staff supported women and babies when they were referred or transferred between services. The services vision and strategy included the roll out of the Continuity of Carer model to ensure women received care from the same midwife or midwifery team throughout their pregnancy. The service was particularly focusing on ensuring women living in deprived areas and women from a Black, Asian and minority ethnic (BAME) background as they may face additional maternity risks.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included women in the investigation of their complaint.

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Maternity

Women, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas. Posters were clearly displayed throughout the maternity department to direct women to the trust's Patient Advice and Liaison Service (PALS) to make a complaint. Leaders of the service tried to alleviate women's and their families' concerns as early as possible to prevent them from needing to raise a formal complaint.

Staff understood the policy on complaints and knew how to handle them. The trust had a concern and complaints policy and procedure for staff to follow.

Staff knew how to acknowledge complaints and women received feedback from managers after the investigation into their complaint. Managers investigated complaints and identified themes. We reviewed three recent complaints regarding the maternity service. These complaints were handled effectively to ensure openness and transparency with a timely response, in accordance with the deadlines specified in the trust policy.

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff could give examples of how they used women's feedback to improve daily practice.

Managers shared feedback from complaints and compliments with staff at team meetings and staff huddles. Each area of the maternity department displayed a clinical governance board which included the number of complaints and compliments received for each maternity area for that month. Staff were aware the main complaints theme for maternity for June 2021 was staff communication.

Is the service well-led?

Requires Improvement ➔➔

Our rating of well-led stayed the same. We rated it as requires improvement.

Leadership

Some leaders did not have all necessary skills and abilities to run the service. However, leaders had plans to make improvements and understood the main challenges the service faced.

The entire substantive senior midwifery leadership team were not currently in post. These positions were filled with interim post arrangements which were overseen by the Director of Nursing.

Overall staffing in maternity including midwifery leadership was one of the main risks for the department. This was recorded on the service's risk register as this presented the risk of destabilisation of the maternity service, lack of managerial oversight and lack of leadership of the midwifery team.

McLellan,Carol
11/26/2022 08:2

The service had proposed a temporary maternity service structure to provide some stability for staff before the permanent organisational structure could be implemented. The permanent structure was in line with the Royal College of Midwives (RCM). The new senior management structure included a consultant midwife and matron for quality and safety to further strengthen the governance structures. The maternity leadership team could describe the structure they were working towards however, due to the current instability of the senior midwifery leadership team, there was no proposed deadline for this to be implemented.

Maternity

Service leaders were not always visible and approachable in the service for patients and staff. However, they supported staff to develop their skills and take on more senior roles.

The interim Director of Midwifery had started weekly team meetings and focus groups with staff. Staff now felt more engaged with the leadership team however, staff stated further improvements with engaging with midwifery staff at all levels was required to ensure they were kept fully updated.

The service now had two maternity champions. They met regularly with the trust level safety leads to escalate locally identified issues. They also conducted safety walkabouts of the department. The service had introduced new models of service delivery including Continuity of Carer. The service had recently secured funds for Continuity of Carer forward planning needed to ensure this model could be further developed without affecting current staff levels elsewhere in the department, particularly in peak annual leave periods.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The maternity service had a vision and workable plans to turn it into action developed with the involvement of women, and the local community. The services vision and strategy included the roll out of the Continuity of Carer model to ensure women received care from the same midwife or midwifery team throughout their pregnancy.

The service engaged well with women, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.

The service worked with neighbouring trusts, clinical commissioning groups, other stakeholders, and service users to establish Local Maternity Neonatal System (LMNS), in line with national maternity recommendations.

Culture

Staff did not always feel respected, supported and valued.

Managers were trying to implement change to improve the culture in the maternity department however, they had not effectively engaged with all staff and particularly junior level staff. This meant some staff did not fully understand the proposed new structure and share a common purpose with the leadership team based on shared values.

Staff from other areas of the maternity unit did not always feel valued by delivery suite staff. There was sometimes no acknowledgment that they were supporting them to keep women and babies safe by increasing staffing levels on the delivery suite. Some staff felt unsupported and did not always have breaks due to covering other staff to have their breaks on the delivery suite. This was recorded on the maternity risk register.

McLellan, Hilary 11/26/2021 11:38:21

Staff were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Maternity

Staff were passionate to provide the highest levels of care to women and their babies. Senior maternity staff praised staff for their resilience particularly in response to the ongoing leadership changes in the maternity department, the high levels of external scrutiny of the department and continuing staffing challenges.

Staff understood how to access the trust's freedom to speak up guardian and ambassadors to raise concerns about the maternity service. They felt able to use this service without fear of repercussions. Some staff had previously left the maternity service and returned due to enjoying working at the trust.

We found there was a perception that more experienced staff refused to work on the delivery suite and identified more junior midwifery staff would be continually moved to where there was high activity namely delivery suite.

During the pandemic we were informed that some midwives in specialist roles were redeployed to support the general wards by carrying about basic nursing care for example bed baths. However, we did not find any midwives in specialist roles supported staffing concerns on the delivery suite or antenatal and post-natal wards. The senior leadership team were aware of this and informed us this formed part of their ongoing strategy to ensure specialist midwives maintained their skills by undertaking one clinical shift per week or fortnight.

Governance

Leaders did not always operate effective governance processes, throughout the service and with partner organisations.

The trust had now made some improvements to the maternity leadership and governance structures. However, these changes had not yet been fully implemented and there was no confirmed date for this structure to be achieved by. This meant leaders still lacked oversight and assurance in some areas. An external organisation had recently conducted a review of the maternity governance at the trust. We were unable to review the findings as this was awaiting final sign off.

Staff at all levels were not always clear about their roles and accountabilities.

The department had high levels of senior staff in interim positions which meant the leadership team lacked stability. There had been regular senior staff changes which further impacted staff as they were unclear about the leadership teams' roles and functions.

Staff had regular opportunities to meet, discuss and learn from the performance of the service.

The Maternity Transformation Assurance Committee ensured there was oversight of the delivery and evidencing of the first Ockenden Report and Maternity Transformation Plan actions.

However, these process improvements were not always aligned to the internal maternity governance processes and opportunities for improvement in governance processes were sometimes missed.

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11/28/2021 15:38:11

The trust was conducting a review of the governance team structure and had begun to recruit a dedicated head of clinical governance, initially for a six-month period. The trust has also set up two new divisional governance forums, neonatal and obstetric incident review (NOIR) and division oversight group (DOG) meetings. The aim was to ensure investigations were thorough and completed in a timely way to allow for learning to be shared as quickly as possible to prevent recurrence. However, these meetings and processes were not yet fully embedded and still required further streamlining.

Maternity

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

Senior maternity staff monitored maternity performance through the maternity dashboard, with red, amber and green colour coding. This enabled staff to identify where the department was performing better and where improvement was needed. However, the maternity dashboard was not displayed in clinical areas, this meant that staff and the public were not clearly informed of the outcomes for women and babies.

Maternity leaders mitigated gaps in maternity staffing risks by moving staff to where they were most needed, in line with the escalation policy. Senior maternity staff had a clear understanding of the frequency of staff movement.

The service had a maternity risk register to identify, record and mitigate risks and mitigating actions. There was alignment between the risks recorded on the risk register and what staff were concerned about. The risk register recorded the dates when the risk was last reviewed, the risk owner and the date the risk actions should be implemented by. However, the risk register did not record the date each risk was added to the risk register to enable service leaders to monitor whether risks were mitigated in a timely way.

Senior leaders were not using the dashboard to monitor workforce performance indicators such as sickness, mandatory training compliance and skills and drills training for all grades of staff. This should be monitored on the dashboard to improve compliance and identify areas for improvement.

Information Management

The service did not always collect reliable data and analyse it effectively. Data was not always in easily accessible formats due to the multiple systems used. Staff could not always find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. Data or notifications were consistently submitted to external organisations as required, but recommendations were not always shared or implemented in a timely manner.

The service had improved its processes to act on recommendations and actions from external reviews of incidents and the performance of the maternity service. However, the service leaders recognised improvement was still needed to ensure these changes were implemented quickly to prevent recurrence.

The birthing rooms in the Wrekin midwifery led unit did not have dedicated computers which meant patient information was duplicated as it had to be manually written by staff and later transferred onto electronic records. Staff may not have fully up-to-date information about the women they were caring for.

The database used to record the maternity specific training compliance rates were not linked to the corporate training database. This meant staff training requirements and due dates were not visible to staff. The maternity education team needed to manually record staffing training compliance and requirements. The trust was addressing this as they were implementing a database which would give staff easy access to their training information and take ownership for ensuring they complete it.

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The service was planning to move all records to electronic records with the role out planned to start in August 2021. The service had a lead and superusers to assist staff with this process. The service aimed to improve overall patient care from this implementation as care for women would be more coordinated.

Maternity

The service submitted data to external bodies as required, such as the National Neonatal Audit Programme 2020 and Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK Mothers (MBRRACE-UK.) This enabled the service to benchmark performance against other providers and national outcomes.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The maternity service was supported by several external organisations to help embed improvements the service was required to make in the maternity service in response to the requirements of external reviews of the maternity service. Senior staff were also engaged in Sustainability Transformation partnerships (STPs) relevant to the whole service.

Maternity staff were engaged with the Local Maternity Neonatal System (LMNS). They were working towards a buddy system with neighbouring LMNS. The service had a positive and productive relationship the local MVP who offered support, challenge and co-production to the service. The service in collaboration with the MVP had recently introduced the 'UX' ('User Experience) card system to gather direct, actionable user feedback, and which was praised by the local media and by the British Intrapartum Care Society.

The maternity service worked with the MVP to involve a range of equality groups to inform the planning for the service. The MVP recently held a meeting about increasing the diversity of the MVP and to discuss how to improve engagement with harder to reach women.

A Maternity Services User Group (Maternity Voices Partnership), supported by the Trust's Patient and Public Involvement (PPI) department informed the decision-making process for the Trust's Maternity and Neonatal Services.

The MVP had recently involved in the transformation workstreams and the delivery suite forum. They had also been involved in a discussion regarding website content to tailor communication to needs of women from a Black, Asian and minority ethnic (BAME) background.

The Maternity Voices Partnership in Shropshire and Telford and Wrekin had been working with the Maternity Transformation team at the trust to ensure the women and families voices were being heard and involved in the ongoing transformation work. They had been coordinating the development of a system to collate themes collated by the MVP, such as language and communication and continuity of care. GovernancutesV0.1Page -11·Lateral Flow ·

The postnatal ward allocated a colleague of the day to acknowledge where staff had performed well.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. Staff were still developing an understanding of quality improvement methods and the skills to use them to support sustained improvement of the service. Despite staff being focused on implementing the improvements required to ensure women received safe care and treatment they still promoted innovative practice.

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Some previous concerns we had told the service required improvement at our previous inspection remained. For example, not all staff had completed mandatory training, including safeguarding of vulnerable children and adults in line with the trust target.

Maternity

The maternity senior leadership team had made some improvements regarding the governance and oversight of risk and quality improvement, this was not yet fully embedded and still required further improvements.

Improvements had been made to grade incident harm and report incidents correctly. However, the process was not yet streamlined and the current governance processes of incident reviewing delayed initial learning and taking action to prevent recurrence.

The senior leadership team had improved oversight of the relevant risks within the service to identify mitigations; but this was not yet fully embedded.

The service had made several improvements following our previous inspection where we had identified areas for improvement, for example:

- The service now ensured high risk women are reviewed in a suitable environment by the most appropriate staff member.
- Staff now asked women about domestic violence in line with trust policy.
- All areas of maternity now had twice daily ward level huddles to ensure information is shared with all staff.
- The service had now colour coded the maternity clinical dashboard to clearly indicate where compliance levels were below the national or local targets.
- The board at the midwives' station on the postnatal ward no longer had women's names clearly displayed for visitors to see.
- Most staff now had an annual appraisal.
- The service had launched a Maternity Transformation Programme supported by an external agency to monitor and improve the safety and care provided to women and babies in maternity.

Senior leaders were supported by several external organisations in both clinical practice and incident management to provide an additional level of scrutiny. They assisted the service to act on the outcomes and actions from serious investigation reviews, recommendations from the Healthcare Safety Investigation Branch(HSIB) and the first Ockenden review in a timely way. For example, staff were now conducting fresh eyes checks every hour for continuous fetal monitoring in line with Saving Babies' Lives Care Bundle. This was in response to learning from previous incidents where cardiotocography's (CTGs) had been incorrectly categorised and staff were not always regularly conducting CTG monitoring. However, the governance of incident reviewing needed to be further refined as it still took the service too long to ensure actions were taken to prevent recurrence of similar incidents.

The service now had a better understanding A new Saving Babies' Lives midwife was now in post who monitored the service's progress to implement the actions required by the Saving Babies' Lives care programme.

The service had several examples of innovative practice from the last 12 months. For example, the service had launched a postnatal video with the local MVP by engaging with women to provide pregnancy information on a range of topics including signs of a healthy baby and postnatal depression. After giving birth, every new mum was given details to access the postnatal video. The card also provided contact details for the Shropshire and Telford and Wrekin Maternity Voices Partnership who co-produced the card and details of a digital app for parents and parents-to-be.

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The service was planning a new pelvic health service for pregnant women and new mums to prevent and treat incontinence and other pelvic floor issues as they were selected to be an early implementer of this service. This is part of

the NHS's Long-Term Plan commitment to improve the prevention, identification and treatment of pelvic floor dysfunction, so that fewer women experience ongoing issues after giving birth and later in life. Clinics will provide specialist multidisciplinary support to women with symptoms, with specialist physiotherapists, a specialist obstetrician and a specialist midwife attending the clinics. Every woman receiving maternity care at the trust will be able to access the service throughout their pregnancy. This includes providing exercises that can help to prevent problems from developing in the first place. Physiotherapists can teach women how to exercise pelvic floor muscles correctly, give advice on diet and fluid intake as well as helping women to monitor their progress.

In line with the Better Births Postnatal Improvement Plan guidance which states women should have the opportunity to re-visit their birth experience, the maternity service supported by the Local Maternity Systems and MVP has developed a birth reflections service to support women's emotional wellbeing. External funding has been secured for some midwives to complete specialist training to run this service. A steering group, for this project is currently meeting regularly.

McLellan,Holly
11/26/2021 12:38:21

Medical care (including older people's care)

Requires Improvement ↑

Is the service safe?

Requires Improvement ↑

Our rating of safe improved. We rated it as requires improvement.

Mandatory Training

The service provided mandatory training in key skills to all staff, however, not everyone had completed it. The service did not always provide staff with time to complete mandatory training.

Nursing staff did not always keep up to date with their mandatory training. A 90% target was set for completion of mandatory training. Up to date training compliance data sent to us following the inspection showed the target was met for three out of 10 mandatory training modules for which registered nurses were eligible. Non-registered nursing staff were compliant with three out of 10 mandatory training modules.

Medical staff did not always keep up to date with their mandatory training. A 90% target was set for completion of mandatory training. Up to date training compliance data sent to us following the inspection showed the target was not met for any of the eight mandatory training modules for which medical staff were eligible.

Mandatory training for new staff was incorporated into the induction, and mandatory training compliance was reviewed as part of annual appraisals.

The mandatory training was comprehensive and met the needs of patients and staff. Training was mostly online during the COVID-19 pandemic, however face to face sessions had restarted.

Staff received training on sepsis recognition and treatment. Training levels had improved to 84% for medical and nursing staff since 2019. Furthermore, 81% of all staff had completed training in the use of the National Early Warning Score (NEWS2).

As of the end of June 2021, an average of 66% of relevant staff had completed blood transfusion training. The service had continued to complete ward based training sessions such as falls prevention of which 91% of ward-based staff had completed at the time of the inspection.

Data provided by the trust showed 73% of nursing and 81% if medical staff had completed basic life support which was below the trust target. The service did not provide us with immediate life support (ILS) training compliance data. However, the service risk register stated there were insufficient numbers of nursing staff in the coronary care unit trained in ILS. As a mitigation, the service planned the rota so there was at least one nurse on shift trained.

Michelson Holly 27/07/2021 11:38:31

Not all clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. On average 64% of nursing and medical staff had completed tier one dementia training and only 34% of allied health professional had completed it. A plan was in place to meet the expected level of compliance by September 2021.

Medical care (including older people's care)

Just over half (54%) of registered nurses had completed training in learning disabilities. Compliance was worse for non-registered nurses (48%) and allied health professionals (36%). The service did not provide us with data for medical staff.

Training compliance was monitored by managers who alerted staff when they needed to update their training. However, staff were not always given the time to complete it. Most staff and managers we spoke with told us staff were expected to complete on-line mandatory training in their own time and were not always given the time back. Some managers told us they did not have enough staff to provide them with dedicated work time to complete training and the service would not allow staff to take the time back.

Safeguarding

Staff had not all completed training appropriate to their role on how to recognise and report abuse. However, staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff knew how to apply safeguarding knowledge.

Staff received training specific for their role on how to recognise and report abuse, however, not all staff had completed it. A 90% target was set for completion of level two mandatory safeguarding adults and children training. Up to date training compliance data provided following the inspection showed the target for safeguarding adults and children level two training was not met for registered nurses or medical staff but was for non-trained nursing staff. This was a significant improvement for medical staff.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. An assessment tool was used to gather information which helped staff identify any issues. Staff were aware of the signs of abuse and told us they would report any concerns to the ward manager or safeguarding lead. There were systems to highlight any safeguarding concerns. We saw safeguarding issues were discussed at handover and daily huddles.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff told us they would escalate any concerns to the safeguarding lead, as well as their manager. All wards we visited had a safeguarding process chart with key contacts. During our inspection we saw detailed examples of safeguarding referrals made by staff having identified patients at risk of harm.

Staff knew how to follow safe procedures for children visiting the ward. However, at the time of our inspection, visiting was restricted, and no children could visit due to the COVID-19 pandemic.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. Staff kept equipment and premises visibly clean. However, staff did not always use equipment and control measures to protect patients, themselves and others from infection.

McLellan Lynn
11/08/2021 12:38:21

Ward areas were visibly clean and had suitable furnishings which were well-maintained. Cleaning records we reviewed during our inspection were up-to-date and demonstrated all areas were cleaned regularly. This included general cleaning, cleaning of patient areas and equipment.

Medical care (including older people's care)

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Equipment was cleaned after use and stickers were used to enable staff to recognise when equipment was last cleaned. Reactive decontamination took place in side-rooms and bathroom areas when a patient with an infectious illness was discharged or moved to another ward or area.

Staff did not always follow infection control principles. Compliance with hand hygiene practice was variable. Staff did not always wash their hands before and after attending to patients' hygiene needs on ward nine, 11 and on the acute medical unit. Furthermore, staff completing patient observations on ward 17 did not wash their hands or use sanitising hand gel between patients. Some staff were observed not to decontaminate their hands before entering a ward as instructed.

Whilst all staff wore face masks, not all staff were clear on the trust's policy on their use. Staff we spoke with told us they were required to change their mask on entering a ward, but this was not outlined in trust policy. This only applied if patients had aerosol generating procedures in a bay, which required masks to be worn on entry to that area and removed on exit. Some staff were observed not to decontaminate their hands before entering a ward as instructed.

However, most staff used personal protective equipment (PPE) such as gloves and aprons and these were available across all areas. Hand sanitiser gel was available on entry to and within all wards and areas. All staff were bare below the elbow. Following the inspection, the service provided us with their infection, prevention and control (IPC) and hand hygiene audits. IPC audits from January to June 2021 showed the service was generally above 90% compliance except for ward 15 which averaged 87%.

COVID-19 precautions were generally safe. Gel sanitiser and masks were freely available. Suitable posters were visible across the hospital and medical wards regarding IPC, COVID-19 and social distancing measures. However, we found staff did not always comply with social distancing precautions when required. For example, we saw staff congregating at nurses' stations and offices for clinical staff on wards.

Clear curtains had been introduced between bed spaces, which were wipe clean. This was to promote social distancing in line with COVID-19 guidance. It also allowed patients and staff to see each other when their privacy curtains were open.

Patients were regularly tested for COVID-19 using polymerase chain reaction (PCR) tests. They were tested on the day of admission, day three and five following admission and weekly thereafter. However, staff were not routinely tested unless they were symptomatic, or they were working in an area where there had been a COVID-19 outbreak. There was a voluntary lateral flow testing process which staff could choose to consent to. Data provided by the trust showed that on average, 18% of frontline staff had participated in the lateral flow tests from April to June 2021.

Infection prevention and control practices in relation to endoscopy were in line with best practice.

Dialysis machine decontamination processes were safe and processes to improve safety had been implemented. However, during our inspection we were made aware of an incident where an isolation machine was used repeatedly for other patients. Following the inspection, the service advised us the machine had been cleaned as per the standard protocol. However, acknowledged isolating the machine is an additional safeguard that was not complied with. The service provided assurance additional measures had been put in place to avoid a reoccurrence. No harm had come to patients.

Mr Sean Kelly
11/08/2021 12:39:21

Medical care (including older people's care)

Hospital acquired infection rates for the medical care core service at Princess Royal Hospital from April 2020 to March 2021 showed there was one case of Methicillin-resistant Staphylococcus Aureus (MRSA), 12 cases of Methicillin-susceptible Staphylococcus Aureus (MSSA) and eight cases of clostridium difficile and four catheter associated urinary tract infections.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff were trained to use equipment. Staff managed clinical waste well.

The design of the environment did not always follow national guidance. Storage space was limited on most wards we visited. For example, hoists were stored in patient bathrooms or corridors on most wards we visited. A fire exit on ward 17 was partially restricted due to several items of equipment such as seated scales, a hoist and mobility equipment being stored against the wall. A sign on the wall instructed staff not to store equipment yet equipment continued to be stored there. This presented a risk of accidental trips and a risk to vulnerable patients. Staff told us they had nowhere else to store equipment but would arrange for items to be removed.

We were not assured the access to and space in bay A on ward nine was adequate to enable sufficient access for equipment required in an emergency. There was limited space in the bay and beds were very close together. Managers cited this as a known risk which they had escalated yet was not on the service risk register. Some assurance was provided following our inspection risks were mitigated by only allocating low risk patients to the bay. For example, they would not admit patients requiring enhanced supervision, requiring equipment such as hoists and bariatric equipment or requiring a high low bed. However, we found this not to be the case during our inspection as we observed patients living with dementia were admitted to the bay. This meant mitigations were not fully embedded and patients were exposed t potential harm.

Store cupboards and sluice rooms did not always have a lock on the door to prevent unauthorised access. Patients could access these areas, containing harmful chemicals and equipment, which presented a risk of harm. For example, the sluice rooms on ward 11, 15 and 16 did not have a lock to prevent unauthorised access and contained chemicals such as bleach which we observed were not securely stored in a locked cupboard.

The kitchen on ward nine was in a side room. Managers told us this was temporary whilst the kitchen was being refurbished. The state of the kitchens was added to the service risk register in relation to wards nine, 10, 11, 15, 16 and the acute medical unit. The risk registers described the kitchens as 'in a state of disrepair, which is a significant health and safety and infection risk'. There was a plan to refurbish all kitchens which was underway at the time of the inspection.

There were some areas within the division which were safe and well designed. Corridors and communal areas were generally wide and spacious to allow passage of beds and wheelchairs. The design of the endoscopy unit was in line with national guidance.

McLeanDolly
11/06/2021 12:39:21

The service did not always have enough suitable equipment to help them to safely care for patients. Wards ten, 11 and the acute medical unit had limited or no stock of male and female urinals on the day of our inspection and three days prior. Feedback from staff suggested this occurred on a regular basis, including limited access to clean linen and patent gowns. Staff on several wards also told us they often struggle to find patient observation machines, which were used to monitor vital signs, as there were not enough on the ward. This presented a risk of patient observations not being reviewed and recorded on time.

Bariatric equipment was available and accessible. Bariatric beds and chairs were used appropriately. Staff were provided with training to use specialist equipment when delivered to the ward, so they knew how to use it safely.

Annual safety tests of electrical equipment were not up to date. We reviewed the most up to date service equipment asset log and found annual safety tests on equipment were not up to date. Of 248 items of equipment logged within the medical service,144 (42%) items of equipment had not been tested within the planned testing date. The longest delay in testing was 322 days after the planned testing date. Equipment items included thermometers, monitors, suction pumps, scales, syringe drivers and infusion pumps. We were not assured there was a robust process for maintaining equipment to ensure it was safe for use.

Staff carried out daily safety checks of specialist equipment. Resuscitation equipment for use in an emergency was available in all areas we visited. Staff carried out daily safety checks of resuscitation equipment across all wards we visited. Patient call bells were generally within reach and staff mostly responded quickly when called. Staff were generally within patient bays and were on-hand to assist patients. Staff checked call bells worked.

The service had suitable facilities to meet the needs of patients' families. Each bed space was provided with a bed, chair, patient locker and over bed table. Clear curtains had been erected between patient bays as an additional measure to prevent the spread of COVID-19.

Staff disposed of clinical waste safely. Appropriate facilities were in place for storage and disposal of household and clinical waste, including sharps.

Assessing and responding to patient risk

Staff did not always complete and update risk assessments for each patient and did not always remove or minimise risks. Performance in relation to staff identifying and quickly acting upon patients at risk of deterioration had improved but practice was not always safe.

The service used a nationally recognised tool to identify deteriorating patients. Improvements had been made in the timely completion of clinical observations; such as blood pressure, heart rate temperature, oxygen levels and respirations. The National Early Warning Score (NEWS2) was used to record clinical observations and identify patients at risk of deteriorating. All but one of the 22 patient NEWS records we reviewed were consistently recorded in a timely manner. However, two out of three endoscopy records did not record a NEWS score but did monitor observations. Electronic 'Patient Status At a Glance' (PSAG) boards provided a live overview of information about patient risk, NEWS scores and timeliness of them. During our inspection we observed NEWS scores were generally completed within set timescales. The nurse in charge of each ward had a good oversight of patients scoring high on NEWS and could demonstrate the actions they had taken to manage the patient. Audits demonstrated good compliance.

Patients were not always escalated appropriately in line with trust policy. Deteriorating patient stickers were introduced for staff to document set actions to be taken to manage a deteriorating patient. We found these completed in only five of the 11 patient records we reviewed, where escalation was required. However, the records did demonstrate staff acted and the patients had been escalated in a timely manner. Weekly escalation compliance audits from March to June 2021 demonstrated patients were not always escalated in line with trust policy. However, audit outcomes indicate this had improved overtime. The service introduced an effective process to identify non-compliance. For example, weekly ward manager and matron audits were undertaken to assess compliance against the deteriorating patient policy. Furthermore, ward managers were required to follow a daily process of reviewing all records of patients who had scored a NEWS of five and above in the previous 24 hours, to monitor if they had been appropriately escalated in line with trust policy.

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Medical care (including older people's care)

Whilst improvements had been made, they were not fully embedded across all wards. Deviations from the deteriorating patient policy in terms of escalation had been identified in previous serious incidents. Whilst we saw monitoring processes were in place and improvements had been made, the outcome of audits continues to demonstrate variable compliance with performance.

Staff did not always complete relevant risk assessments for each patient and risks were not always effectively assessed. Recognised assessments tools were used to assess specific risks such as falls and pressure ulcers. Whilst improvements had been made in some areas; risk assessments were not always updated, and risks related to specific conditions were not always assessed and mitigated. Nursing assessments were not fully completed in 18 out of 22 records we reviewed. Staff did not always document key information to assess a patient's holistic needs and help staff safely care for them.

The risk of a patient developing sepsis was not always effectively assessed by staff. Eight out of 21 sepsis screen assessments we reviewed in the nursing assessment booklet were not accurately completed by nursing staff to indicate whether a patient was low risk or high risk of developing sepsis. In seven of these cases, there was no impact on the care received. However, a patient on ward ten was identified as red flag sepsis and actions to treat them were not all completed within the hour. For example, intravenous fluids (IV) and antibiotics were not administered until one hour 35 minutes after the sepsis clock was started. All other actions were completed in a timely manner and no harm came to the patient.

Diabetic patient needs were not effectively assessed. Diabetes status and capillary blood glucose levels were not accurately recorded in the nursing assessment booklet as required in eight diabetic patient records. Seven out of eight patients did not undergo an assessment of the condition of their feet as required. Documentation did not address specific needs such as how diabetes was controlled or assessment of any diabetic related conditions. Generic diabetes care plans were available but only in place for two out of eight diabetic patients. This meant there were not any personalised plans in place to determine the patient's dietary requirements, blood glucose monitoring and guidance for administration of medicines and management of the patient in the event of deterioration.

We continued to see poor compliance with completion of bed rails risk assessments. Nine out of 16 bed rail assessments were not fully assessed or completed. For example, staff had not completed the bed rails matrix to assess mobility level and state of confusion to determine whether bedrails were indicated. Where bed rails had been ticked as safe to use, the rationale for this decision was not always documented. Reviews were generally completed, however there was no rationale as to why bed rails were used or not. Bed rails were used when contraindicated and unsafe to be used for five patients we observed. This meant patients continued to be placed at risk of serious harm from bedrails.

Improvements were noted in the completion of falls risk assessments. However, risks were not always fully assessed, reviewed and specific to individual needs of the patient. All 22 records we reviewed had a falls risk assessment completed upon admission. However, five had not been reviewed in line with trust policy. Lying or standing blood pressure was not documented in 19 out of 22 records. Three out of 19 patients identified at risk of falling did not have a completed falls prevention management plan. A further seven patients prevention plans were not fully completed and did not reflect the risks identified.

McLellan,Polly
11/26/2021 12:18:21

Limited assurance could be provided to demonstrate the improvements effectively identified and mitigated against patients with changing needs. For example, a patient's risk had not been reviewed following an unwitnessed fall on ward seven. Multiple falls in hospital was a theme in three serious incidents we reviewed. On ward 17 the level of risk for a patient had changed significantly from the point of admission yet the risk assessment did not reflect the heightened

risk of falling. Serious incidents we reviewed from June 2020 to May 2021 identified three incidents whether the patients had fallen in hospital prior to the fall meeting the serious incident threshold. This meant patients continued to be exposed to harm from falling as risks were not always being reviewed following a fall to ensure individualised action was taken.

Documentation did not enable holistic assessment of individualised needs to support effective falls prevention planning. Staff indicated a risk was present with a tick against a pre-set measure. The rationale for identifying the risk was not documented in any of the records we reviewed which prevented staff from understanding the patients' individual needs.

Staff were not always aware of or dealt with specific risks to patients. Improvements in staff awareness of risks associated with falling had been made. However, improvements were not consistently embedded. Oversight of patients at risk of falling had improved. Staff implemented measures to reduce the risk of falling such as falls wrist bands, anti-slip footwear, clutter free environments, low beds and crash mats. Records we reviewed generally reflected what actions had been taken.

Processes to observe patients at risk of falling requiring closer supervision were not always consistently implemented. It was not always clear who was responsible for tagging a bay where more than one patient was admitted who required closer observation. A tagging system was not in place in bay B on ward 11 where there was more than one patient at risk of falling. We observed one patient who was confused and unsteady attempting to get up and leave the bay. We had to intervene and alert staff to the risk. Staff told us they were short staffed and had to support other bays, however, there were no mitigations in place. Unwitnessed falls was a theme in previous serious incidents we reviewed. This meant patients were not always effectively supervised in line with trust policy to reduce the risk of unwitnessed falls.

Staff sometimes lacked situational awareness in their approach to falls prevention. For example, we identified a patient at high risk of falling on ward 17 placed in a side room furthest away from the nurses' station. Staff implemented standard falls prevention methods but did not consider how they would mitigate the risk of being so far away and out of sight of nursing staff. Furthermore, patient walking aids were sometimes out of reach which meant if a patient got up to walk, they were at increased risk of falling.

Fluid balance monitoring was inconsistently recorded for patients on a fluid restriction and those at risk of dehydration. Out of 22 records we reviewed, 15 fluid balance charts were not fully or consistently completed. This included a patient with chronic kidney disease who required strict monitoring.

There was inconsistent practice around pressure ulcer prevention and management to reduce the risk of hospital acquired (HA) pressure ulcers. Waterlow risk assessments were used to assess a patient's risk of developing a pressure ulcer and these were generally completed on admission and reviewed in line with trust policy. However, the on-going assessment and monitoring of patients at risk of developing a pressure ulcer or those who had an existing wound was poor. Nine out of 14 skin assessment pressure ulcer prevention booklets we reviewed were not been fully completed. Pressure ulcer prevention assessments were not always completed or reviewed. Body maps were not completed accurately so did not effectively record the condition of the skin. Where wounds were present, documentation lacked detail as to the size and depth of the wound. This meant that a nurse could not assess if a patient's skin was improving or deteriorating. Repositioning frequency was generally not documented. Documentation of repositioning was inconsistent in all nine records we reviewed. Nine patients required a pressure relieving mattress, however four did not have one in place. This meant patients continued to be at risk of suffering a preventable deterioration in their skin.

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Medical care (including older people's care)

Bariatric equipment was not always in place for patients who needed it. For example, we identified two patients on ward 11 who did not have a bariatric bed. In one record it was documented the patient did not initially want one and in the other the assessment was not fully completed.

The individual needs of patients displaying challenging or aggressive behaviour were not always clear or documented. Enhanced supervision risk assessments were not always fully completed or did not contain enough detail to assess patient needs. Two out of eight patient records, where the patient displayed challenging behaviour, did not have a risk assessment completed. This meant two patients did not have their individual needs identified or met to support staff to safely and effectively care for the patient. Of the six that were completed, there was limited information to guide staff how to effectively care for the patient. For example, assessments lacked detail of the patient's behaviour causing concern, their current state and individualised strategies to support the patient.

Enhanced observation charts were mostly in place where required as part of the bedside records. However, we found they were not always up to date and did not outline what actions were taken to alleviate distress or reduce any risks identified in the assessment. The trust policy asks staff to document 'What did we do to alleviate any distress, & how did the person respond / Have we met needs re Pain, Hunger, Thirst, Elimination, reduce Noise'. The records mostly commented briefly on the patient's behaviour. There was variable compliance with hourly updates being documented by staff.

Practice in relation to the assessment of venous thromboembolisms (VTE) was inconsistent. We found VTE assessments were completed for all patients upon admission and recorded on the electronic patient record. However, evidence patients had undergone a VTE review within 24 hours of the initial review or when there was a change in condition was limited. For example, one patient had undergone a surgical procedure to insert a central line and we did not see evidence of a VTE re-assessment post-surgery. Four patients were assessed as high risk of developing a VTE yet there was no evidence of a re-assessment. We observed one patient being re-assessed during a ward round but did not see this recorded on the electronic system.

The service did not always effectively assess and plan for the risks associated with pre-existing conditions patients were admitted with. For example, a patient with a stoma did not have a care plan to assist staff in caring for them. Staff caring for the patient at the time were competent to manage the stoma. However, an absence of a care plan meant there was a risk of poor care should temporary or more junior staff with limited experience be caring for the patient. Staff looking after the patient had not received training in this area. We also identified a patient on Continuous Positive Airway Pressure (CPAP) for obstructive sleep apnoea who did not have a care plan. Whilst the service had a standard operating procedure in place, there was no specific care plan to ensure staff were aware how to support the patient safely should they no longer be able to self-manage the CPAP or if their oxygen levels deteriorated. Staff looking after this patient has not had any specific training to care for a patient on CPAP at the time of the inspection. Processes were in place to safely care for patients requiring non-invasive ventilation (NIV).

Access to specialist stroke assessment and treatment was variable. A below average number of patients received timely medicine within the hour to prevent the stroke worsening. However, the service had improved and was performing consistently with the national average in the proportion of eligible patients being given thrombolysis following admission. Staffing levels had improved since the last inspection and supernumerary staff were available to respond to stroke patients admitted to ED and directly to the ward. More registrar grade medical staff had been trained to administer thrombolysis. However, a continued risk cited by staff and on the service risk register was the lack of capacity to complete Computerised Tomography (CT) scans within the hour impacted time to receive appropriate medicine.

Medical care (including older people's care) 11/06/2021 12:16:24

Medical care (including older people's care)

Not all patients were reviewed by a consultant within 14 hours of arrival to hospital. From April 2019 to March 2020, 65% of patients had been reviewed by a consultant within 14 hours of arrival. More up to date information was not provided. Consultant review times were not always recorded in patient records therefore we could not determine compliance during our inspection. Each morning the consultant who was on call the night before, with the on-call juniors, reviewed every new patient who had been transferred out from the acute medical unit overnight, who had only been seen by a registrar. Consultant board rounds were held daily on each ward. Two consultant board rounds per day were held within the acute stroke unit.

The service had 24-hour access to mental health liaison or specialist mental health support (if staff were concerned about a patient's mental health). Furthermore, the service recruited a mental health lead who provided additional support to staff in caring for patients with mental health needs.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. We saw evidence in patients records that patients had undergone assessments with the mental health liaison team.

Key information to keep patients safe when handing over their care to others was inconsistently communicated. A transfer of care form was included in the nursing assessment booklet to communicate key information when transferring from one ward to another. These were completed in only eight out of 22 records where a transfer had taken place. This meant there was a risk key information relating to managing a patients' specific needs were not always clearly handed over. There was evidence within recent serious incident reports that a lack of formal handover of falls prevention methods were contributory factors in the patient falling.

Shift changes and handovers included all necessary key information to keep patients safe. For example, they included a brief overview of all patients, risks such as falls, capacity status, actions required and treatment plan.

Nurse staffing

The service did not always have enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. However, managers did attempt to mitigate this by regularly reviewing and adjusting staffing levels and skill mix. Bank and agency staff were given a full induction.

The service did not always have enough nursing and support staff to keep patients safe. Leaders, managers and staff described staffing as being the main risk to service care and provision. This was included on the service risk register. The number of nurses and healthcare assistants did not always match the planned numbers. Planned and actual staffing numbers displayed at the time of our inspection showed staffing levels did not always meet planned staffing levels. Managers escalated where staffing levels were reduced but they did not always receive additional staff. Data received from the trust following our inspection showed that from June 2020 to May 2021 0.2% of registered nurse shifts and 0.5% of health care assistant shifts were not filled. We reviewed the roster for period 11 July 2021 to 7 August 2021 which showed a significant number of shifts were not filled.

mclellan-kelly 11/26/2021 12:39:21

The service had high and variable vacancy rates. From July 2020 to June 2021 the average vacancy rate for registered nurses and health care assistants was higher than the trust 11% vacancy target. Whilst the vacancy rates had generally improved, managers and staff felt the pressure of long-term high vacancy rates. For example, not being able to complete patient risk assessments in a timely manner. The service had undergone an international recruitment campaign and had plans underway to further fill vacancies.

Medical care (including older people's care)

The service had a high volume of junior staff. This was a challenge for managers when planning the roster to ensure appropriate skill mix. Junior nurses recruited from abroad required additional support to adjust to working in a new country and environment. Lack of support for junior nurses was escalated and addressed and support was put in place, but ward managers expressed they often lacked confidence to take on nurse in charge roles or shift co-ordination roles. This was on the service risk register.

The service had high turnover rates. From June 2020 to May 2021 the average annual turnover rate for registered was 17% and health care assistants 14.8%. Both were higher than the trust turnover target of 11%.

The service had high sickness rates. From June 2020 to May 2021 the average sickness rate for registered nurses and healthcare assistants was higher than the trust sickness target of 4%.

Managers and staff told us they did not always receive additional staff to provide one to one enhanced care when escalated but this was improving. For example, we observed Ward 15 did not have additional healthcare assistants to provide one to one enhanced care to more than one patient who required it. However, mitigated through supernumerary staff and the patients were always monitored.

Agency staff were used to fill gaps and managers worked clinically when required. Staffing levels were discussed at ward handover meetings. Staff discussed acuity of patients, activity on the ward and when additional support was required. Processes were in place to escalate staffing issues to the matron who escalated the gaps at daily safety meetings.

Staff reported incidents where staffing levels were affected. From June 2020 to May 2021, 98 staffing incidents had been reported by staff. In June 2020 there were three red flag staff incidents reported on wards nine, 10 and 11 where patient safety had been compromised as a result of staffing levels. All were night shifts where there were not enough registered nurses as a result of unexpected absence.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. However, this was not always done in a timely manner. Ward rotas were devised using the safe care nursing tool. Issues identified with staffing vacancies and fill rates were escalated to matrons. Managers had access to a staffing plan which showed agreed staffing levels and actual staffing levels. Managers used this to identify any gaps and request bank or agency.

Matrons reviewed staffing levels twice yearly which was submitted to the director of nursing. Matrons told us rosters were approved at least 6-8 weeks in advance to make sure the skill mix was right. However, several staff we spoke to told us rosters were not always approved within reasonable timescales. We reviewed matron and ward manager medicine division meeting minutes. Matron and ward manager meeting minutes on 30 June 2021 indicated the Royal College of Nursing (RCN) had received concerns rosters were not being sent out in a timely manner and requested a meeting with the trust. Freedom to speak up guardians also raised concerns rosters were not being authorised which impacted on patient safety as skill mix was not always confirmed to enable appropriate bank and agency cover.

McLean, Lilly
11/06/2021 21:36:21

Concerns were identified about the night-time staffing levels on ward ten, care of the elderly ward. Some staff felt staffing levels and skill mix left the ward unsafe. The registered nurse to patient ratio was approximately 1:9 with three healthcare assistants to support. The ward often had patients requiring enhanced supervision and staff told us there were a high ratio of junior nurses who were not ready to be in charge of the ward. However, on occasions they were in charge alongside agency staff. Staff told us this had been escalated as a concern and a recommendation provided to

increase the registered nurse numbers at night-time, but it had not been responded to. We reviewed the risk registers for care of the elderly and saw 'high number of nursing vacancies and junior staff in post' as a risk with the effect being 'the nursing team struggle to give safe, effective care to patients'. The risk did not specify the night-time nurse levels or how they were mitigated, therefore we were not assured this had been effectively addressed.

The ward manager could adjust staffing levels daily according to the needs of patients. A matron of the day was responsible for completing a safe staffing overview. Managers reported into the matron daily on staffing levels, skill mix and acuity. This included any requirements for enhanced care which was presented at daily safety briefings.

The service had high rates of bank and agency nurses used on the wards. High levels of bank and agency staff were observed during our inspection. Data from June 2020 to May 2021 showed 34.7% of registered nurse shifts and 31.5% of health care assistant shifts were covered by non-substantive staff.

Managers could not always limit their use of bank and agency staff, however, where possible requested staff familiar with the service. Managers we spoke to raised concerns that the high percentage of agency staff usage significantly impacted on the service ability to implement quality improvements and lessons learnt following incidents.

Managers made sure all bank and agency staff had a full induction and understood the service. Agency staff received an orientation to the ward including an overview of current topics, risks and emergency procedures. Managers kept a log of agency induction checklists on the ward.

Medical staffing

The service did not have enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix. Locum Doctors used did not always have a full induction.

The service did not always have enough medical staff to keep patients safe. Nursing staff told us doctor shortages impacted as they were not always able to respond in a timely manner especially out of hours. Junior doctors told us the impact of this was being unable to respond to requests to review patients, complete daily tasks and discharge patients in a timely manner. Furthermore, junior doctors told us shortages in all grades impacted on them being involved with regular teaching sessions. Senior leaders told us they mitigated junior doctors' shortages by moving doctors to wards where they were particularly short. However, junior doctors told us this was a risk as they were often used to complete tasks such as discharging patients, they had limited knowledge about.

Managers had recruitment plans in place for key vacant post such as stroke consultants and care of the elderly. Service leaders told us the consultants' budget in the medicine division was not fit for purpose, however a recent establishment review had been completed, and business case put forward and approved to increase to 20 whole time equivalent consultants across both Princess Royal Hospital and Royal Shrewsbury Hospital sites. Leaders recognised they still had some work to do to improve recruitment and retention.

McLean, Emily
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During our inspection, medical staff told us there was a shortage of junior doctors. Following our inspection, we requested vacancy rates for medical staff. Data provided for May 2021 demonstrated there were 18.31 whole time equivalent vacancies for junior doctors within the medical division. Six of which were in the nephrology specialty and 3.42 in general medicine. This was consistent with feedback given to freedom to speak up guardians as outlined in information we received following the inspection. Lack of out of hours medical cover and consultant review was cited as a concern from staff.

Medical care (including older people's care)

Processes were in place to review medical staffing. Medical staffing was discussed every Monday with operational managers and the medical staffing department. Medical staffing was planned for the week ahead. The junior doctor rota was planned a week in advance so that gaps could be identified, and cover arranged. The Divisional medical director told us the service works on two junior doctors for every 20 beds and this was mainly achieved. Some specialities had smaller bed numbers but there was still a requirement for two junior doctors. Junior doctors' meetings were held every Friday to review the staffing levels for the weekend.

The service junior doctor co-ordinator role had recently become vacant which meant the junior doctor rota was being jointly overseen by operational managers who were prioritising maintaining the fill rates.

The service had high but reducing vacancy rates for medical staff. From June 2020 to May 2021, the hospital reported vacancy rates for consultants was 13.1% and middle grades doctors 23.1%. Vacancy rates impacted the time to first consultant review, additional pressures to cover the services and support provided to junior doctors. At the time of our inspection only three out of five stroke consultants were available which posed additional pressure to provide cover for the wards and clinics. However, vacant posts were being recruited into. The care of the elderly speciality had a vacant consultant post which was mitigated with associate specialist doctors and registrars covering the ward. Locum doctors were block booked but not all were specialists in care of the elderly and were unable to supervise more junior substantive staff. The service had been actively recruiting and had a consultant planned to start in August 2021. A general medical consultant was available on-call 24 hours a day, seven days per week. There was consultant presence on site from 8am to 5pm. Medical staffing vacancies was on the service risk register and locums were used to fill vacancies whilst recruitment took place.

The service had lower than average turnover rates for medical staff. From June 2020 to May 2021 the average annual turnover was 7.9%.

Sickness rates for medical staff lower than the trust target. From June 2020 to May 2021 the average annual sickness rate was 1.8%.

The service had high rates of bank and locum staff. From April 2021 to June 2021, the service had 25% unfilled medical staff shifts. Managers could access locums when they needed additional medical staff. Locums were recruited to fill vacancies and block booked them where possible. Locum doctors were also used to fill short term sickness.

Managers did not make sure locums had a full induction to the service before they started work. Locum doctors we spoke to told us they did not have an induction. They generally reported feeling not part of the team and pressure to work 'excessive hours'. Locums did not have full access to trust electronic systems such as the email system and did not receive a name badge. This meant that locum doctors were not always included in any safety alerts or invited to governance meetings where learning was shared. Locum doctors told us they did not always receive feedback about incidents, receive memos or any circulations and meeting invites. We discussed this with senior leaders who felt there was a supportive attitude towards locums, however, recognised improvements were required to improve their integration and access to governance processes.

mcclellanpolly 11/26/2021 12:38:21

The service did not have a good skill mix of medical staff on each shift and reviewed this regularly. In July 2021, the proportion of consultant staff reported to be working in medical care at the trust was 34% which was lower than the England average. The proportion of middle grade was 29% which was much higher than the England average. The proportion of junior (foundation year 1-2) staff was 16% which was lower than the England average. The proportions of registrar staff reported to be working at the trust was 21% and higher than the England average.

Medical care (including older people's care)

Records

Staff did not keep detailed records of patients' care and treatment. Records were not always clear and up to date. This meant that care staff could not easily identify care to be given to individual patients. This had not improved since the last two inspections. Records were not always stored securely and were not always easily available to all staff providing care.

Patient notes were not always comprehensive. We reviewed 22 nursing and medical assessment records and found 18 were not fully completed and missing key information. Information needed to guide staff how to provide safe and consistent care was not always available. For example, none of the generic care plans we reviewed highlighted the care and treatment each of the 22 patients required to meet their needs. This meant patients were at risk of receiving unsafe and inconsistent care that was not in line with their individual needs.

Records were not always accessible to all staff. Medical staff including locum doctors did not receive timely access to electronic patient records upon commencement of their employment in the service. Locum doctors told us they did not have access to trust communication systems such as email. Following the inspection, the trust reviewed the process and acknowledged there were delays in access being given to doctors, however, we were not assured there was a plan to address this.

Access to computers caused delays in doctors accessing patient records. During our inspection we saw medical staff waiting for computers to become available. Staff told us the impact of this was delays in discharging patients, difficulties tracking patients and the potential to not have immediate access for clinical decision making.

Records were not always stored securely. Medical and nursing records were generally stored in locked trolley. We checked records trollies on most wards we visited and found they were generally locked to prevent unauthorised access. However, we did see on occasion, medical records left at nurses' stations and in offices which were accessible.

Patient bedside records were not always stored securely. For example, on ward 17, we observed bedside records were on clipboards and hanging on the wall outside of the bays. This meant that the patient records were easily accessible to unauthorised persons.

When patients transferred to a new team, there were no delays in staff accessing their records. Records were transferred with patients and access to electronic records were readily available.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. The pharmacy team ensured there was a patient centred approach to medicine optimisation. Medicines advice and supply were available seven days a week. An on-call pharmacist was available outside of core working hours.

McLellan, Emily
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There was no system for recording the site of application or removal of transdermal medicine patches. This is important to check that the patch is still in place or to prevent the application of other patches in error. Also, to communicate information about patches when a person is transferred between wards or other healthcare settings. We were informed a process had been developed and was waiting for approval.

Medical care (including older people's care)

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. Members of the pharmacy team regularly reviewed patients' medicines throughout their admission and prior to discharge. This involved counselling and discussions with patients wherever possible.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. Medicines were stored safely and securely. FP10 prescriptions were stored securely with a robust checking system to track their use. Controlled drugs were stored and recorded following policy. Daily checks were undertaken, and any discrepancies were investigated.

Staff followed current national practice to check patients had the correct medicines. Medicine optimisation was undertaken by members of the pharmacy team. Any discrepancies were immediately identified and highlighted to the relevant team. Patients allergies or known sensitivities to medicines were documented on all the medicine records reviewed.

Antibiotics were prescribed following the trust antimicrobial guidelines including details of their indication for use, length of treatment and review dates. The antimicrobial stewardship pharmacist undertook reviews and snap-shot audits which highlighted any areas for improvement.

Dedicated sepsis trollies or boxes were available for the immediate treatment of sepsis. These were checked daily to ensure the medicines were available and in date and therefore safe to use. This helped to ensure that staff could follow The National Institute for Health and Care Excellence (NICE) guidance which states patients should receive intravenous antibiotics within 60 minutes.

Resuscitation trollies were immediately available in the event of an emergency. These were sealed with tamper evident tags. This follows the guidance from the UK Resuscitation Council. Evidence of daily checks were recorded to ensure the medicines were available and safe to use.

Venous thromboembolism (VTE) protocols were in place. Checks to ensure any necessary prescribing for the prevention of a VTE were undertaken by pharmacists.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Any medicine incidents would be reported onto the incident reporting system. Learning from incidents and any medicine alerts would be shared across the trust

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. We did not observe excessive and inappropriate use of medicines. The service had improved systems and processes in place to identify patients who were prescribed rapid tranquilisation medication. We saw examples of less restrictive methods being used to manage patients who were being aggressive or were agitated such as one to one assistance and oral medicines.

McLellan, Kelly
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Incidents

The service managed patient safety incidents well when reported. Staff recognised but did not always report incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team but not always the wider service. However, this learning was not always embedded. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Medical care (including older people's care)

All staff knew what incidents to report and how to report them. However, staff did not always raise concerns or report incidents and near misses in line with trust policy. For example, staff told us they did not always report falls incidents where no harm had occurred or failures to accurately record fluid balances which impacted on clinical decision making. We also reviewed a patient record on ward 11 where nursing entries indicated aggressive behaviour to staff and the patient had been administered oral sedation. This was not reported as an incident at the time, however, we escalated this to managers and the incident was reported nine days later with identified learning. This meant opportunities for learning and improvements were always made as not all incidents were reported by staff.

Managers shared learning about never events with their staff and across the trust. The service had two never events in endoscopy. All staff in endoscopy knew about them and could describe how learning had been implemented. Both never events had been discussed with staff at different forums such as safety huddles, patient safety groups and staff meetings.

Staff reported serious incidents clearly and in line with trust policy. The service reported 11 serious incidents (SIs) in medical care at Princess Royal Hospital which met the reporting criteria set by NHS England From July 2020 to June 2021.

Managers shared learning with their staff about serious incidents and never events that happened elsewhere. Learning was shared at clinical and operational governance meetings. We observed incidents were discussed and learning identified with actions to disseminate learning.

Staff could describe recent serious incidents on their ward and elsewhere. For example, staff told us about recent pressure ulcer incidents and failures to escalate deteriorating patients. Staff could tell us what their role was in reducing further occurrences of incidents. Staff in the dialysis unit demonstrated to us how they had implemented learning from a recent serious incident.

Staff on ward 17 were able to describe incidents relating to non-invasive ventilation (NIV) therapy on another site where the NIV disconnected from the oxygen supply. Staff could describe steps they took to complete regular checks of NIV connections and how they documented it. There were no patients in on NIV at the time of our inspection, so we were unable to check the learning had been implemented fully, however we were assured staff understood their role and the risks of not checking.

Most staff we spoke to understood duty of candour. We saw the service was open and transparent and gave patients and families a full explanation if things went wrong. Having reviewed serious incident reports, duty of candour had been applied in line with trust policy. Duty of candour was applied to other incidents not meeting the serious incident criteria where there was a near miss and potential exposure to harm.

Staff did not always receive feedback from investigation of incidents, both internal and external to the service. Some staff told us when they reported an incident, they did not receive feedback from their manager to let them know the outcome. Locum doctors told us they did not receive feedback following incidents. However, we saw evidence that learning from incidents was disseminated at meetings and safety huddles. We spoke to nursing and therapy staff who told us they would be updated about relevant incidents at their morning huddles. We saw that outcomes of serious incident reports were communicated across the trust in weekly newsletter and bulletin emails. However, temporary medical and nursing staff did not have access to electronic communication systems which meant they did not receive this feedback.

nicholas.jolly@nhs.net 11/06/2021 12:39:21

Staff met to discuss the feedback and look at improvements to patient care. There were processes in place for staff to discuss incidents and improvements required. For example, weekly ward manager and matrons' meetings took place and learning from incidents was shared across the division and hospital site. Ward based safety huddles took place where learning from incidents was shared.

Changes made as a result of learning and feedback from incidents were not always effectively implemented. Systems to monitor implementation of learning from incidents were not always effective in ensuring improvements had been made and sustained. Action plans to improve the quality of care were not always effective or fully implemented.

Prior to our inspection we reviewed serious incident investigation reports relating to hospital acquired pressure ulcers. We found there were recurrent themes and contributory factors such as body maps and repositioning not being consistently recorded, poor completion of risk assessments, care plans and patient monitoring. Records we reviewed during our inspection provided limited assurance improvements had been made. Managers made us aware of a recent incident where a patient developed a 'grade four' hospital acquired pressure ulcer on ward 11. Skin assessments had not been completed correctly and the patient did not have the correct pressure relieving mattress. Two records on ward 11 demonstrated learning had not been implemented following this incident. Neither had a pressure ulcer prevention plan despite being assessed as high risk of developing a pressure ulcer, one did not have a pressure relieving mattress and one did not have consistent skin surveillance. This meant learning had not been effectively implemented and patients continued to be at risk of harm from developing a preventable pressure ulcer.

We reviewed two serious incidents relating to patient falls and found learning from these incidents had not been consistently implemented. For example, there was learning around implementation of falls prevention strategies, management of patients at risk of falling in a side room and ensuring the tagging system was in place where required. We found these risk factors continued to be an issue.

Speciality learning across sites was not always effectively implemented. We were advised of a near miss in the dialysis unit regarding a breakdown in infection prevention and control procedures for isolating dialysis machines. Following the inspection, we were advised of a similar incident that had occurred at Royal Shrewsbury Hospital in May 2021 where learning had been identified. This learning was not effectively shared across sites in which could have prevented the second incident at Princes Royal Hospital dialysis unit.

Managers investigated incidents thoroughly although there were delays in incidents being concluded. Whilst improvements had been made, not all incidents were reviewed in a timely manner. This meant learning from these incidents could not be identified, shared and implemented in timely manner.

Managers debriefed and supported staff after any serious incident. However, some staff told us managers did not always provide support following aggressive behaviour from patients. Serious incident investigations documented support being offered to staff following an incident. Most staff reported feeling supported by their manager. However, some staff told us when they had experienced aggressive and violent behaviour from patients, such as physical aggression, they were not debriefed of supported by management.

McLellan, Polly
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Safety Thermometer

Staff collected safety information and shared with staff, patients and visitors. The service used monitoring results to improve safety.

Safety performance data was displayed on most but not all wards we visited for staff and patients to see. Quality boards were in place on most wards and displayed metrics which reflected ward-based quality and performance audit

outcomes. Performance metrics were updated monthly and at the point of inspection publicised May 2021 data. The service used audit outcomes to determine safety performance. We saw wards had educational campaign boards in place which reflected areas where the ward was underperforming. For example, we saw fluid monitoring awareness boards and falls boards.

Is the service effective?

Requires Improvement ↑

Our rating of effective improved. We rated it as requires improvement.

Evidence-based care and treatment

The service did not always provide care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance, however, it was not always followed. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff did not always follow up-to-date policies to plan and deliver high quality care according to best practice and national guidance. A policy was in place to ensure best practice guidelines were worked to. The policy outlined how new guidelines published by the National Institute for Health and Care Excellence (NICE) were logged upon are database with a lead clinician identified. Baseline assessment tools were then used to update and implement new guidance when needed.

For example, since our last focused inspection the trust had updated policies and procedures, we identified as not reflecting most up to date guidance. The trust procedure for the 'Prevention and Management Inpatient Falls guidance was approved in April 2021 by the quality and safety operational group and referenced the most up to date National Institute of Clinical Excellence (NICE) falls guidance for older people 2013. The guidance recommends all patients aged 65 and over received a multifactorial falls assessment and intervention plan.

Furthermore, the trust's, 'Pressure Ulcer Prevention and Management Policy' which was approved in June 2021 referenced the most up to date NICE guidance for pressure ulcer prevention and management 2019 NICE update. This had been updated since our last focused inspection.

Whilst policies were in place, we found they were not always followed by staff. For example, we found patients who were diabetic did not have a diabetic care plan in place. We found staff did not always implement the pressure ulcer prevention and management policy as we saw patients' high risk of developing pressure ulcers did not always have the correct equipment in place as outlined in policy or regular repositioning where required.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. We did not identify any patients who were detained under the Mental Health Act but when asked staff were able to tell us what they would do or who to contact for advice and support.

Maddie Holly 17/08/2021 12:08:24

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. We also observed a board round where patients mental health, well-being and safeguarding needs were discussed.

Medical care (including older people's care)

Managers and staff carried out a programme of repeated audits to check improvement over time. An audit programme outlining participation in national, NICE, specialist and local priority audits was in place. Named data collection or co-ordinators were in place for each audit and the status of the audit was identified. Managers used information from the audits to improve care and treatment, however, during our inspection, we identified areas of non-compliance with policies and procedures therefore we were not assured the audits were always effective in during improvements. For example, nursing standards audits did not always drive improvements in fluid balance monitoring and pressure care management. We found these were continued areas of concern identified at our last inspection, in service audits and poor compliance we found on this inspection.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health, however this was not always documented when required. Specialist feeding and hydration techniques were used when necessary. However, patients admitted with a stroke did not always have timely swallow screening and assessment. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. A range of foods were available to patients to suit their medical and cultural meals. For example, there were options for patients with low sodium and diabetic diets. Staff told us there were soft options available at each mealtime. There were icons on boards above beds indicating if the patient had any special nutritional requirements. Protected mealtimes were in place on all wards we visited.

Staff supported patients at mealtimes when required. Red place mats were used where a patient required assistance, so staff knew who required assistance. These were in place during our inspection, however an audit from 01 April to 31 April identified only 25 out of 34 patients living with dementia had these in place.

Systems were in place to ensure patients at risk of aspiration due to swallowing difficulties had their nutrition and hydration needs met. However, staffing pressures meant stroke patients requiring specialist swallow screens did not always receive this within four hours of admission. Performance was significantly below the national average for stroke patients. At the time of the inspection training had been facilitated to increase the number of staffed trained to complete the swallow screens and another planned for October 2021. Furthermore only 68.4% of patients received a formal swallow assessment by a speech and language team within 72 hours. This was below the 75% target and 89% national average. The service provided assurance patients nutrition and hydration needs were met. All stroke patients received a sip test within the hour to assess whether they were safe to take oral fluids. Patients were provided with intravenous fluids if required. Patients were reviewed twice daily by a consultant where risks were escalated, and nasogastric feeds were prescribed if required. A business case had been approved to recruit additional nursing staff to improve timeliness of swallow screens being completed. In addition, the service had increased the provision of speech and language therapists to provide six-day cover to enable improvements in swallow assessments being completed. This was beginning to improve the wait time for assessment. Whilst there were delays with swallow assessments, we did not see any evidence of harm and there had been no incidents reported at the time of the inspection.

Staff did not always fully and accurately complete patients' fluid and nutrition charts where needed. Nutrition charts were in place, however, we found they were not always up to date and there were gaps in most records we reviewed. Nursing quality metrics from March 2021 to May 2021 showed overall compliance with nutrition monitoring was 79% and fluid balance monitoring 72%. Following the inspection, we reviewed a dementia indicator audit completed from 01 April 2021 to 31 April 2021 which showed 18 out 34 patients living with dementia did not have their nutrition and fluid intake recorded accurately. This meant nutrition and hydration monitoring was not effectively implemented for vulnerable patients and those where clinically indicated.

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Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. These were generally completed on admission and then repeated upon transfer to a new ward or within timescales outlined in the trust policy. Specialist support from staff such as dietitians and speech and language therapists were available for patients who needed it.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. However, they did not always support those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool, however, specialist pain assessments for patients with communication difficulties were not consistently used. Pain scores were assessed and recorded regularly on the electronic patient record. Staff asked whether patients were in any pain during comfort rounds. The abbey pain scoring system as a method for identifying the signs of pain in people living with dementia was used. We reviewed two patient records of patients who were unable to effectively communicate their needs. One record did not have any Abbey pain scores recorded and one patient had one Abbey pain score recorded. Both patients had been assessed by the dementia service who requested the Abbey pain score was used, however this was not acted on. Not all staff we spoke to knew what the Abbey pain score was or where it was recorded. This meant patients who were unable to communicate did not always have their pain effectively assessed or managed.

Patients received pain relief soon after requesting it. Patients we spoke to told us they were given pain relief on request and were comfortable. Staff prescribed, administered and recorded pain relief accurately. Medicine charts we reviewed confirmed pain relief was prescribed and delivered appropriately.

Patient outcomes

Staff monitored the effectiveness of care and treatment. However, they did not always use the findings to make improvements and achieve good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.

The service participated in relevant national clinical audits. For example, the Sentinel Stroke National Audit Programme (SSNAP), national audit of dementia, national audit of inpatient falls, diabetes, chronic obstructive pulmonary disease (COPD) and lung cancer audits.

Outcomes for patients were not always positive, consistent and did not always meet expectations, such as national standards.

Princess Royal Hospital participated in the Sentinel Stroke National Audit Programme Clinical Audit 2020/21. Hospitals performance is graded on a scale of A-E, where A is best, and E is worst. The service was graded C overall from April 2020 to March 2021, demonstrating improvement overall since the previous year which was graded D.

McLellan, Lilly 11/08/2021 12:38:11

Managers and staff did not always use the results to improve patient outcomes where indicated. Risks associated with poor outcomes for stroke were added to the speciality risk register. For example, risks associated with medical and nurse staffing, therapy staffing, scanning pathways and psychological interventions. We reviewed the stroke improvement programme action plan and saw there were 26 actions, 22 of which had been on the action plan for more than two years, three more than one year and one added in 2021. For example, direct access to computerised

tomography (CT) scanning had been on the plan since January 2019 with an original due date of 30 June 2019. However, this continued to be an area of underperformance. We saw actions from the improvement plan were discussed however, we were not assured there was effective oversight to move the actions forward with most actions continuing to be outstanding.

The trust was below national performance in some aspects of care for patients with lung cancer. To address this the trust had increased the lung cancer nurse specialist team in order to improve patient accessibility to specialists. The service had also implemented a direct to Computerised Tomography (CT) pathway. Monthly lung cancer multidisciplinary meetings were in place and we saw these were well attended.

The service had a dementia workplan in place dated June 2020 to improve outcomes for patients living with dementia. We saw there were actions in relation to assessment and care planning, the environment and governance. Not all actions had been effectively implemented such as addressing night ward moves. A night moves audit had been planned for May 2021 and was now planned for September 2021. The environment was not always dementia friendly. For example, we did not see orientation clocks were visible for all patients and in good working order. Improvements had been made in relation to the care of patients living with dementia. For example, we saw the butterfly scheme was visible and significant improvements were noted in mental capacity assessments, best interests' documentation and Deprivation of Liberty Safeguard (DoLS) applications. However, we continued to find variable compliance with personalised care planning and implementation of 'this is me' documents which were not always displayed at the bedside.

Managers did not always share and make sure staff understood information from national audits. We reviewed divisional governance meetings minutes but did not see evidence outcomes from national audits were routinely discussed or considered in relation to improving the quality and improving outcomes of the service. Divisional governance and management meetings took place and we saw specialities provided feedback; however, this was not in relation to national reporting.

The service had a mostly lower than expected risk of readmission for elective and non-elective care than the England average. In all but one of the specialities the rate of readmission was at or below the England average. From February 2020 to January 2021 the rate of readmission for elective respiratory medicine at Princess Royal Hospital was higher than expected. The endoscopy service was accredited by Joint Advisory Group (JAG). The latest submission to JAG had resulted in the service being fully accredited having successfully implemented an action plan to improve.

Competent staff

The service did not always make sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were qualified and had the right skills and knowledge to meet the needs of patients. However, junior nurses did not always have the experience to confidently undertake aspects of their role. Staff had the right qualifications, skills and experience to do their jobs, and were supported to develop specialist skills where required. There were trust competencies for nursing skills such as cannulation, which newly qualified staff were supported to complete through competency based training. The service had specialist nurses providing nurse-led care. Many general nurses completed additional training to support the effective care of patients in the specialism in which they worked.

mcleanpolly 11/06/2021 12:38:21

Junior nurses were sometimes assigned nurse in charge responsibilities due to staffing levels in which they did not always feel confident. This was mostly on night shifts.

Medical care (including older people's care)

Medical staff we spoke with told us junior doctors had implemented their own teaching programme in the absence of a divisional one. Doctors told us this had developed and was now supported by consultants who were generally supportive, and their educational needs were being met. Leaders told us half day teaching sessions were added to doctor rotas on a Tuesday and Wednesday. Half day teachings were included on the rota to ensure teaching time was protected. Junior doctors told us they did not always receive unimpeded access to a consultant and during the COVID-19 pandemic, ward round based learning opportunities had reduced.

Managers gave all new staff a full induction tailored to their role before they started work. Most nursing staff we spoke to told us they received an induction before starting their role. This included a formal induction where they completed mandatory training and a ward based supernumerary period. Overseas nurses who were completing competencies to achieve their UK nursing registration were also supernumerary to the ward during this period and for two weeks after this was completed.

New bank and agency staff were provided with an orientation to the ward at the beginning of the shift. We saw there was a checklist in place for agency staff we spoke to which was completed by managers and nurse in charge.

Managers supported staff to develop through yearly, constructive appraisals of their work. Appraisal rates as of the end of June 2021 showed 82% of registered nurses had received an appraisal, 73% of medical staff and 95% of non-registered nursing staff. Most staff felt the appraisal was a useful process.

The clinical educators supported the learning and development needs of staff. Clinical educators in specialities such as respiratory and dialysis supported staff and signed off specialist competencies. Specialist nurses in dementia and mental health provided ward based training session to enhance skills and competence.

Managers did not always make sure staff attended team meetings but did provide access to full notes when they could not attend. Team meetings did not consistently happen across all wards. Notes of meetings that did happen were taken and stored on the ward. Daily huddles took place on most wards and notes were written to cover areas of concerns shared.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Ward based learning sessions took place and this was offered to bank and agency staff. Time was not always given to staff to complete mandatory training in their working hours.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Opportunities were created for staff to take on lead roles in specific areas such as falls prevention. For example, staff on ward 11 had specific link roles in learning disability, sepsis, diabetes, end of life care and mental health. There were opportunities for progression, for example, for health care assistants, who were supported to apply to the nurse associate programme. Managers we spoke to were in the process of completing leadership training sessions.

McLaughlin, Emily
11/06/2021 16:39:21

Managers did not always ensure staff received any specialist training for their role. For example, staff caring for patients receiving Continuous Positive Airway Pressure (CPAP) on ward nine, had not received training to care for patients on CPAP. Furthermore, not all registered nurses on the stroke unit had been trained to complete swallow screens which meant the service was significantly below average for the percentage of patients receiving a swallow screen within four hours of admission.

However, we saw on Ward 17, staff had undergone or were in the process of completing competencies in managing patients on non-invasive ventilation (NIV). Annual respiratory study days were facilitated for staff on ward 17. NIV machine manufacturers also provide training to staff. The stroke speciality had a study day due to take place in July 2021 which all new staff would be required to complete and yearly thereafter for updates.

Managers identified poor staff performance promptly and supported staff to improve. Managers told us additional support was given to staff who needed more supervision in developing their skills to ensure standards had been achieved. There were systems in place, supported by the human resources department with regards to revalidation and registration with the relevant professional bodies for example nursing and midwifery council (NMC) and general medical council (GMC). Local management had oversite of the registration status of staff they line managed. Staff told us they had been supported with revalidation.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff generally held regular and effective multidisciplinary team (MDT) meetings to discuss patients and improve their care. Patients had their care pathway reviewed by relevant consultants. Daily consultant led board rounds took place as well as regular MDT meetings in specialities. We observed board rounds and MDTs during our inspection. These were generally well attended by a range of clinical, nursing and therapy staff as required. Therapy staff provided effective input to these meetings and their opinions were respected. The meetings covered the holistic needs of the patient such as care, treatment, safeguarding and social needs.

However, we observed one board round on ward 11 where a registered nurse was not present for the board round. Doctors told us this was a regular occurrence due to staff shortages and impacted the effectiveness of care provided as actions were not always implemented such as fluid balance monitoring.

Staff worked across health care disciplines and with other agencies when required to care for patients. Specialist staff were available to provide timely review and specialist assessment where required. For example, we saw stroke specialist nurses were available to provide timely assessment and treatment to patients identified as having a stroke. Staff were available to assist patients and staff across all disciplines including the emergency and medicine division.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression. During our inspection, we saw evidence where patients had been assessed by the mental health liaison service. Staff were aware who they could contact should they need advice or support in caring for patients with mental health needs.

Seven-day services

Key services were not always available seven days a week to support timely patient care.

Consultants led daily ward rounds happened on all wards, including weekends. Patients were reviewed by consultants depending on the care pathway. However, data provided by the trust showed the service did not always meet the 14 hours to consultant review standard. From April 2019 to March 2020, 65% of patients had been reviewed by a consultant within 14 hours of arrival to hospital. The service was unable to provide us with more up to date information at the time of the inspection.

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Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. Staff could access mental health services 24 hours a day, seven days a week. The service

intended to improve their mental health liaison so there was on-site cover out of hours as opposed to on-call access to the crisis team. Therapists told us seven-day working had negatively impacted upon patients as backfill arrangements in the week were not robust meaning, they could not deliver the care needed to all patients in line with national guidance. The occupational therapy and physio 24-hour response time was not being met. Dietitian and speech and language therapy (SALT) provided Monday to Friday service only with on call cover at the weekend.

Pharmacy services were provided to wards from 8am to 6pm Monday to Friday and from 9am to 12noon on Saturdays. A 24 hour a day, seven day a week emergency duty pharmacist was also accessible for urgent inpatients items and advice.

The frailty service was not available outside normal working hours.

Seven-day services were available in the stroke wards including physio and occupational therapy. However, SALT was only available six days a week. The service was also in the process of recruiting additional stroke clinical nurse specialists to enable effective seven-day provision.

The service did not have enough scanning capacity to enable timely access for stroke patients. For example, Computerised Tomography (CT) scanning provision was not available seven days to ensure timely access for stroke patients to receive thrombolysis. Furthermore, there were only three doppler slots available Monday to Friday for patients with a suspected Transient Ischaemic Attack (TIA). This meant patients with suspected TIA could have a delayed diagnosis or come to harm. To mitigate this, additional consultant slots had been created to enable consultant reviews within 24 hours and scans offered as outpatients.

This was a risk on the service risk register since 2018 with no resolution as the CT/radiology department did not have capacity.

Health promotion

Staff did not give patients practical support and advice to lead healthier lives.

The service had limited information promoting healthy lifestyles and support on wards. Staff did not fully assess each patient's health when admitted and we did not always see support from staff for any individual needs to live a healthier lifestyle. For example, we did not see evidence that staff always assessed patients' lifestyles including smoking and alcohol use. Staff often left this section of the nursing assessment blank. We did not see evidence that any healthy lifestyle advice was given in any records we reviewed.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Not all staff had completed mandatory training in mental Capacity and Deprivation of Liberty Safeguards. Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used measures that limit patients' liberty appropriately.

McLaughlin Kevin 11/08/2021 11:38:11

Not all staff had received training in the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). The trust set a target of 90% for completion of Mental Capacity Act (MCA) level 2 training. Up to date training compliance levels provided following the inspection showed the 90% training target was met for registered nursing staff (90%). However, the 90% target continued not to be met for medical staff who were significantly below the trust target (58%) and other clinical staff (77%).

Medical care (including older people's care)

Most staff understood how and when to assess whether a patient had the capacity to make decisions about their care. This was an improvement since our last comprehensive inspection in 2019. Staff could demonstrate their understanding and give examples of how to apply and record assessments regarding the MCA and DoLS. We reviewed seven patient records where the patient lacked capacity and found MCA assessments and Best Interest (BI) decisions were completed and individualised to the patient. We found one record where a capacity assessment and best interests had been completed on admission but had been reviewed by the dementia team who had requested the assessment be completed. We also found evidence that mental health liaison and dementia teams reviewed patients and provided guidance to staff about managing the patient and actions they should take.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. We observed staff asking patients consent to complete routine tasks such as taking blood pressure. In endoscopy we reviewed three records and found consent for procedures was documented.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. We reviewed eight MCA assessments and BI decisions and found in general they contained detailed information about the patient and their wishes. The documentation was specific and detailed actions to be taken in the patient's best interests such as administering medicines and undergoing diagnostic procedures.

Staff made sure patients consented to treatment based on all the information available. Staff clearly recorded consent in the patients' records. Consent was clearly recorded in two endoscopy records we reviewed.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. Staff explained how they would support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care. Assessment documentation prompted staff to raise any concerns about mental capacity. Mental health specialist nurses and dementia nurses told us they worked across both sites supporting staff with decision making.

Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them. Staff documented on shift handovers which patients were deprived of their liberty and we saw this was discussed at safety huddles. All staff we spoke to knew which patients who were deprived of their liberty. Staff knew when they needed to reapply for a DoLS and managers monitored this. Furthermore, the dementia team assessed patients living with dementia and we saw they provided direction and support to staff where a patient lacked capacity and required a DoLS to be in place.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. Substantive staff were aware of how to access policies and procedures and they knew who to contact should they need advice and support.

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary. Nursing quality metrics were completed monthly. MCA and DoLS documentation was audited. Audits from April 2021 to June 2021 demonstrated on average the service was 78% complaint with these expected standards which was below the trust target.

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Medical care (including older people's care)

Staff implemented Deprivation of Liberty Safeguards in line with approved documentation. We found this had improved since our previous comprehensive inspection on 2019. We saw staff completed DoLS applications in line with approved documentation. These were stored in patient records. We observed that DoLS renewals were completed once urgent applications had expired. It was clear from records when the urgent DoLS was due to be renewed.

Is the service caring?

Good ↑

Our rating of caring improved. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff interacted with patients and those close to them in a respectful and considerate way. We observed interactions with patients and found staff generally had a good rapport with patients. Whilst delivering care and treatment, staff took time to talk to patients about how they were feeling and respond to any queries they had. We saw staff taking an interest in patients by asking them questions about their family or how they were feeling.

Patients said staff treated them well and with kindness. We spoke to seven patients who all spoke positively about staff. For example, patients used words such a 'lovely' and 'kind' to describe staff. One patient told us staff would sit with a patient who was agitated and confused and helped to calm them down.

Staff followed policy to keep patient care and treatment confidential. Staff understood and respected the individual needs of each patient. We saw staff showed understanding and a non-judgmental attitude when caring for patients with challenging behaviours. Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. We observed curtains being drawn around patient beds by doctors when having conversations with patients and side room doors being closed. Staff told us they could utilise meeting rooms should they need to have sensitive conversations with patients.

Emotional support

Staff generally provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. However, the quality of interactions was not always consistent. We observed agency staff interactions with patients when providing enhanced supervision, were not as engaging with patients as were substantive staff. On two occasions we observed limited and task focused interactions from staff to a patient on enhanced supervision. The interactions were not always engaging, or person centred. However, we recognise that on these two occasions staff had not worked on the ward or with the patient before.

Mrs Ellis Taylor 21/12/2021 10:08:21

In general, we observed staff interacting with patients including patients who were confused. Staff generally provided reassurance and took time to talk to patients despite being very busy. Patients told us staff were kind and told us they spent time interacting with other confused patients when required.

Medical care (including older people's care)

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. We observed staff providing one to one care to patients who were displaying challenging behaviour. We observed positive interactions, use of conversation and attempts to be as least restrictive as possible as well as ensuring the safety of all patients. We saw health care assistants were utilised to provide one to one care. Staff generally understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Clinical nurse specialists were employed who supported patients through their treatment pathway. Chaplin support was available 24 hours a day seven days per week and staff could access them through the hospital switchboard. Holy communion took place every Sunday and this was able to be received on the wards for those patients not able to attend. Prayer facilities were also available for Muslim worshippers.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Therapists worked together with patients to identify and agree joint goals to set for treatment outcomes. Specialist nurses took time to meet patients to discuss their treatment, providing emotional support in dealing with their condition. Staff talked with patients, families and carers in a way they could understand. Staff were able to access interpreting service for patients whose first language was not English.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. For example, on ward 15 we saw 'as a result of your feedback' boards which listed feedback and what the ward had done to improve. Ward 15 had implemented a relative communication folder and appointment system for relatives to speak to nursing and medical staff following feedback family were struggling to speak to staff.

Patients gave positive feedback about the service. Leaflets were displayed for patients and relatives to read about how to make a complaint and share their views. Family and Friends Test (FFT) cards were given to patients at the point of discharge. We saw each ward displayed their FFT results which were updated for May 2021. For example, 100% patients who had completed them on ward 16 and 17 in the Month of May said they would recommend the service to family and friends. Following the inspection, the service provided us with their Friends and Family Test (FFT) performance from July 2020 to June 2021. All wards and units scored 94% or higher on an annual basis. However, due to the COVID-19 pandemic, data was not submitted every month. All wards within the medicine division scored 100% in June 2021.

Is the service responsive?

Requires Improvement

Our rating of responsive improved. We rated it as requires improvement.

McLellan,Hon 11/2/2021 18:21

Service planning and delivery to meet the needs of the local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the changing needs of the local population. The service worked with local organisations and the wider system to identify needs of the local population. Improvements had been made to respond to the needs of the aging population. Frailty assessments were completed for patients referred and we saw

evidence the frailty team had contact with patients to support their care and discharge needs. The service worked alongside community services to support 'Home First' discharge planning. The frailty assessment team aimed to improve care and reduce the length of stay and readmission rates for elderly patients with complex medical needs. The stroke services had expanded to seven days to offer improved therapy support to patients to improve quality outcomes.

The service relieved pressure on other departments when they could treat patients in a day. Same Day Emergency Care (SDEC) operated within the acute medical unit. SDEC aimed to ensure patients were treated by a senior clinician in the most suitable environment to support their needs and reduce the impact on the emergency department. During our inspection we saw patients were referred into these areas from ED for lower acuity and ambulatory patients.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. Wards and departments were designed in a way to provide single sex accommodation. No single sex breaches were observed during our inspection. The hyper acute stroke unit had improved its process since our previous inspection in 2019 to ensure no single sex breaches. However, 11 single sex breaches were reported on the coronary care unit from April 2021 to June 2021. These were due to delays in being able to access a step-down bed following a period of high intervention care and the patient then waiting for a bed within the normal medical bed provision.

Most facilities and premises were mostly appropriate for the services being delivered. However, we continued to observe limited adaptations to the physical environment to support patients living with dementia.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia. Whilst the mental health liaison service did not provide out of hours cover, there was a pathway into the crisis intervention service to support any patient requiring support. There was a plan to increase the provision to 24 hours at Princes Royal Hospital in line with provision at Royal Shrewsbury Hospital.

The service had systems to help care for patients in need of additional support or specialist intervention. For example, the service provided a dialysis service six days a week. The service provided a Hyper Acute Stroke Unit (HASU) which enabled urgent assessment, treatment and monitoring of patients who had experienced a stroke. Thrombolysis was offered 24 hours a day from a specialised room within the stroke unit.

Meeting people's individual needs

The service did not always take into account patients' individual needs and preferences. Staff did not always make reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff did not always make sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Patients were assessed on admission to identify any additional support or needs. A dementia support team was in place led by a dementia clinical specialist. As a part of the dementia screening process they would routinely screen all patients who were 75 years and older within 72 hours of admission.

McLean, Kelly 11/08/2021 1:39:21

A dementia friendly hospital charter and action plan was in place. Processes to identify patients living with dementia included a butterfly sticker in patient records, a butterfly magnet on bedside boards and also on electronic patient at a glance board. We saw these were generally in place. However, an audit from 01 April 2021 to 31 April 2021 found 28 out of 34 patients living with dementia did not have the butterfly box selected on the bedside board.

The service had activity boxes in place to support patients living with dementia. However, we did not see evidence these were used during our inspection or that all staff knew about them.

Medical care (including older people's care)

We reviewed the records of ten patients living with dementia. We found staff did not complete a full and holistic assessment of need for eight of these patients. For example, we found the patients communication needs were generally not assessed. In one record a staff member documented 'dementia' in answer to problems the patient had which were associated with the communication barrier. This meant patients communication needs were not fully assessed.

Patients were assessed by the dementia team, however, the outcome of this was a sticker of actions to guide staff how to care for the patient. Specialist staff used a highlighter to draw attention to staff actions they should take. For example, to complete a mental capacity assessment, support with meals and fluid intake. There was limited evidence of the patient's individual needs being outlined and care planned in a personalised way. We did however see good practice in response to a patient being assessed by the mental health service who provided ward staff with a very detailed outline of the patients' personal needs. This included a communication plan and guidance for staff to support the patient where their behaviour changed.

Generic care plans were used by nursing staff which meant patients living with mental health problems, learning disabilities and dementia did not always have their identified or individual care needs recorded.

Wards were not always designed to meet the needs of patients living with dementia. Not all wards we visited had security access in and out which meant that patients who were confused were at risk of leaving the ward unattended and being exposed to potential harm. We also found most dirty utility rooms did not have a lock which could pose a risk to vulnerable patients.

We observed dementia clocks were not always visible. The dementia charter included an action for all orientation clocks to be within sight of all patients, including the hospital name. During our inspection there was limited evidence this was consistently in place across all wards, however, there was an action for this to be in place by September 2021.

Staff did not always support patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. Four out of ten patients who were living with dementia had a 'this is me' document visible at the bedside. Without the details of the individuals needs and preferences the service would be unable to provide personalised and compassionate care that met each individual's needs.

A learning disability liaison service was available. One staff member was available onsite to assess patients living with a learning disability and ensure their needs were being met.

The service did not have information leaflets available in languages spoken by the patients and local community. Staff told us they could access information online or use google translate. Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff had access to communication aids to help patients become partners in their care and treatment but did not always use them. Managers told us communication books were available to staff to support patients to communicate their needs, however, we did not see these being used during our inspection.

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Access and flow

People could not always access the service when they needed it or receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards.

Medical care (including older people's care)

Managers monitored waiting times and made sure patients could access services when needed. However, patients did not always receive treatment within agreed timeframes and national targets.

Incomplete Referral to Treatment (RTT) pathways

As of April 2021, the trust had the fifth lowest proportion (55.1%) of patients on incomplete pathways who had waited less than 18 weeks, out of the 21 non-specialist acute trusts in the midlands. This was lower than the overall Midlands performance and considerably lower than the overall England average. The trust had 3,295 patients on incomplete pathways waiting more than 52 weeks for treatment. The trust had no such waits from November 2019 to February 2020. However, during the COVID-19 pandemic the number increased considerably. New data received following our inspection and published on 8 July 2021, showed the number of incomplete pathways where the patient had been waiting more than 52 weeks reduced to 2,925 in May 2021.

Complete Referral to Treatment (RTT) pathways

As of April 2021, the trust had the twelfth lowest proportion of patients on complete admitted pathways who had waited less than 18 weeks, out of the 21 non-specialist acute trusts in the midlands. This was similar to the overall Midlands performance and England average. There was a considerable improvement in performance from October 2020 to January 2021. However, this had subsequently deteriorated.

The number of patients waiting more than 52 weeks for treatment over time on completed admitted pathways fluctuated and as of April 2021 the trust had 154 patients waiting more than 52 weeks. The service had been working through a backlog of exceptionally long waiters as a result of the COVID-19 pandemic and continued to increase capacity to improve performance and access to treatment.

The risk of not meeting the operational standards was on the trust risk register. The service had implemented processes to review all patients and undertake harm reviews where required.

Managers and staff worked to make sure patients did not stay longer than they needed to. From March 2020 to February 2021 the average length of stay across all medical specialties was similar to or lower than expected based on the England average, for both elective and non-elective admissions. Over this period the average length of stay for elective cardiology at Princess Royal Hospital was higher than expected based on the England average. The same was true of non-elective cardiology. Daily multidisciplinary board rounds ensured there was daily progress updates on care and treatment to identify treatment delays so that time in hospital was optimised.

The trust had a 'Sath2Home' service which was a domiciliary care bridging service which allowed patients to return home if their care could not be sourced in a timely manner. The service supported the reduction in length of stay (LOS) by facilitating discharge at short notice to ensure patients were discharged in line with national discharge guidelines.

The service moved patients only when there was a clear medical reason or in their best interest. Staff told us where possible they avoided moving patients, particularly patients with complex needs. However, staff told us at times of high pressure, patient were sometimes moved to accommodate new admissions. For example, where patients were medically fit, they were sometimes moved when a specialist bed was required for another patient. Managers monitored that patient moves between wards. However, it was unclear how this was used to reduce the number of bed moves. Data provided to us following the inspection showed between January 2021 and June 2021 there was ranging between 1023 and 1208 moves monthly. Records did not include the rationale for moving a patient.

Active Monitoring 11/08/2021 12:38:21

Staff moved patients between wards at night. Data provided to us following our inspection demonstrated that from January 2021 to June 2021, 1949 ward moves occurred from 10pm to 7am. This accounted for 29% of all bed moves. We were concerned patients living with dementia had been moved at night which is disorientating and can lead to harms such as emotional distress and falls. This was a continued concern raised in our 2018 and 2019 inspections as we were concerned individual patients needs were not being considered or met due to moves between wards and moved for clinical or non-clinical reasons.

Frequent night moves may also be indicative of poor flow planning in the day. Ward moves should be limited per admission with night moves being avoided unless essential for the person's care.

Managers and staff worked to make sure that they started discharge planning as early as possible. Daily board rounds took place with nursing, therapy, medical staff as well as patient journey facilitators. Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs. The service had six patient journey facilitators based on wards Monday to Saturday. They supported the ward with all aspects relating to the patient journey and blockages to discharge. For example, arranging transport, following up outstanding diagnostics, ensuring discharge summaries and take-home medicines are ready, liaising with families and care providers and external stakeholders.

Managers monitored the number of delayed discharges, knew which wards had the highest number and took action to prevent them. From November 2020 to May 2021, the percentage of delayed discharges fluctuated over time. As of May 2021, the percentage of delayed discharges across the trust was 55.5%. Compared to other trusts in the Midlands region, the percentage of delayed discharges over time has been better than most trusts.

The service monitored stranded (those in hospital more than seven days) and super-stranded (in hospital more than 21 days) patient numbers. Managers had regular meetings to discuss progress with blockages to discharge for these patients and ensured board rounds were used effectively to optimise admissions to hospital.

Weekly meetings were held to review all stranded and super-stranded patients in the hospital. This enabled staff to work in a targeted way with patients who were not medically optimised for discharge. This included support for the clinicians from the medical directors to unblock or remove barriers and working with system partners to flag patients who required escalation to support their discharge. The service worked with system partners to address community blockages to discharging these patients who may be waiting for a social care package.

Managers worked to minimise the number of medical patients on non-medical wards. Managers made sure they had arrangements for medical staff to review any medical patients on non-medical wards.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. However, managers told us there was a backlog in complaint investigations. The service included patients in the investigation of their complaint.

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Patients, relatives and carers knew how to complain or raise concerns. Most patients we spoke to were aware how to complain should they have any concerns. Matrons completed weekly audits which included speaking to patients to gather feedback about care and treatment. The service clearly displayed information about how to raise a concern in patient areas. Information was displayed on ward notice boards and on the trust website. Leaflets were available to patients which outlined how the trust dealt with complaints and how to complain.

Medical care (including older people's care)

Staff understood the policy on complaints and knew how to handle them. The trust had a complaints policy and staff knew how to access the policy. Staff we spoke to said they would initially try to resolve any complaints received. Staff were familiar with the process for escalating complaints to either their manager or signposting patients and their relatives to the patient advice and liaison service (PALS). Out of hours, staff could escalate complaints to the site manager.

Managers investigated complaints and identified themes. We saw examples of complaint investigations and outcomes of complaints which demonstrated managers thoroughly investigated complaints. At ward level, managers collated themes and trends from complaints and used these to improve services.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Managers investigating complaints were aware of the timescales to provide initial feedback to patients to acknowledge the complaint. We reviewed three complaints and saw complainants were provided with an outcome letter including an overview of their investigation and apology. However, during our inspection, managers told us there was a backlog in concluding complaints. As a result, the medicine division was in the process of implementing a revised process to ensure complaints were responded to and investigated in a timely manner and managers had oversight.

Managers shared feedback from complaints with staff and learning was used to improve the service. Complaints were discussed at divisional governance and matron meetings. Staff told us they received feedback in daily huddles from any complaints received and actions to improve to avoid further complaints.

Staff could give examples of how they used patient feedback to improve daily practice. We saw staff had implemented a communication sheet following feedback and complaints during the COVID-19 pandemic that relatives had not been sufficiently communicated with. These sheets contained information to communicate with relatives and to record conversations clearly. An appointment system was set up so relatives had set times to call in.

At the end of 2020 managers noticed there was a trend in patient complaints that showed staff were not working in a joined-up way. As a result, staff instigated an afternoon huddle, attended by the multidisciplinary team where all patients on the ward were discussed to helps staff approach the patient holistically. This also heled improve management of discharge.

Is the service well-led?

Requires Improvement ↑

Our rating of well-led improved. We rated it as requires improvement.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Modification 15/12/2021 12:38:2

Changes had been made to the senior leadership team since our last comprehensive inspection in November 2019. The medical care core service sat within the trust emergency and acute medicine division. The division was strategically led

by a triumvirate made up of a divisional director of nursing, divisional medical director and centre managers. The senior leadership team worked well together, and we received positive feedback from staff throughout the inspection that the new divisional leadership team provided more direction and was more visible and responsive. Several staff commented they had confidence in the new structure and recognised improvements were being made.

Local leadership was provided by matrons and ward managers. Most staff told us matrons were visible, supportive, and approachable. Staff told us if their matron was away, another matron visited to check on issues and any support required. Managers told us there was a matron on call seven days a week. In addition, quality matrons were visible on wards daily supporting staff with key areas of development such as falls prevention.

Senior leaders had prioritised and invested in developing the management structure in the division. A leadership training programme had been implemented. Work had been undertaken to improve the skills, competencies and joined up working of matrons. This included an away day aimed at team building and planning for improvements. Matrons had taken on lead roles in specific areas to improve clinical leadership. Some examples of lead roles included tissue viability, documentation, nutrition and hydration, safeguarding, mental capacity, mental health and restrictive interventions. A second away day was planned for October 2021.

Ward managers had started leadership courses and valued the investment in their development. which made them feel appreciated and more connected to the trust.

Specialist nurses provided advice, support and direction to staff in specific specialities such as stroke, mental health and dementia. Staff told us these staff members were more visible on the wards.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

Leaders had a clear vision of what they wanted to achieve and understood the need to work closely with other divisions across the trust to achieve its objectives. The strategy was plainly set out and easy to understand. There were eight strands to the strategy including: achieving for our patients, keeping great people, engagement and wellbeing, people development and leadership, support and belonging, attracting people, transforming the trust and equality, diversity and inclusion. A people plan had been produced which mapped out key priorities to achieve the trusts eight priorities.

Staff were involved in the formulation of the strategy which set out a 'PACT' (Partnering, Ambitious, Caring and Trusted) with staff outlining how they intended to support management and staff to improve safe patient care. The strategy identified a range of quality metrics and a milestone action plan to measure success. Progress against these were reviewed at monthly meetings. Senior managers reported on progress against achieving their strategic objectives through quality and performance reports to the divisional board.

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The service was in the process of applying the priorities along with their values and behaviour framework across the division. A behaviour framework had been produced based on staff feedback. All wards and departments in the division had been tasked to self-assess themselves against the framework and we saw evidence this was underway or had been completed in most areas. Following the inspection, the service sent us examples of how different specialities had adapted the framework to their service to make it relevant.

There was recognition that effective communication was vital to help drive change within the service to build reputation. This resulted in a divisional communication plan aimed at making sustained changes, building trust and understanding. The plan outlined how the leadership team intended to embed the strategy and how they were going to communicate with staff. Local managers and most staff we spoke to understood some of these strategic objectives, However, staff were not always aware of the trust vision and values when asked.

Leaders had invested in external work to ensure services are sustainable and aligned to local plans. This included public engagement and engagement from local services and commissioners. For example, work was underway to restructure cardiology services to create improved and integrated pathways locally. Senior leaders were involved with the newly formed Integrated care System (ICS), contributing to the management of resources locally to improve the health of the local population. Outcomes of the meeting communicated to managers at the divisional huddle.

Culture

Staff did not always feel respected, supported and valued. However, most staff recognised improvements had been made. Staff were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff did not always feel supported, respected and valued but most staff felt improvements had been made. Service leaders told us staff wellbeing and morale was one of their top priorities and had a plan in place to improve this. For example, there was limited places for staff to take breaks. The service had created a garden area for staff and patients to go in the summer and were investing in developing indoor space. Most staff confirmed there had been investment in staff wellbeing and development since our previous inspection.

International nurses recruited since our previous inspection in 2019 generally liked working at the trust. However, initially it was a difficult transition, particularly those who started during the COVID-19 pandemic. Some managers told us the first cohort of international nurses were not supported initially to integrate into the service. This was escalated and the Freedom To Speak Up Guardian (FTSUG) was involved in addressing some concerns. This resulted in improvements being made and an improved induction including support with non-work activities such as assistance with accommodation. An international nurse lead and worked alongside the trust FTSUG and assigned nurse ambassadors to support new international nurses.

Locum doctors told us they did not always feel supported by the service as they were not included in communications and meetings other than ward rounds and multi-disciplinary team meetings.

Therapy staff told us they felt the service was improving, however, staffing levels impacted. Therapy staff felt they were unable to provide a good service due to being stretched to cover seven days. Whilst improvements were acknowledged in the more joined up approach of working, some therapy staff did not feel their roles were as valued.

Most staff commented the culture had improved within the service. For example, work had been undertaken to improve staff wellbeing and safety culture on ward 15 and 16. A new ward manager had been recruited providing leadership, engagement and support to staff. During our previous inspection ward 10 and 11 were cited as an area of concern. Staff raised concern about the culture. During this inspection, most staff appreciated work had been done to address cultural concerns and they had seen some improvements. Continuity of leadership had remained an issue on ward 10, however, staff were positive that improvements had been made and more staff were brought in. Staff vacancies remained an area for concern impacting on staff morale. Managers and staff acknowledged whilst progress had been made, further improvements were required to continue to improve the culture.

Pol-sen/Kelly 17/06/2021 at 3:38:21

Medical care (including older people's care)

We reviewed the 2020 NHS staff survey results for the medicine division. In general, the service performed worse than average. The service performed worse in the 'safety culture' measure and had done for the three years prior. Five areas were below average including: health and wellbeing, quality of care, safe environment and bullying, staff engagement and teamwork. There was an improvement action plan based on the staff survey results which had been presented to staff. The service did not provide evidence of its progress in achieving the actions highlighted in the plan. The triumvirate were focused on investing in the workforce and addressing behaviours to shift the culture.

The culture was centred on the needs and experience of people who use services. Leaders recognised the importance of creating a healthy and engaged workforce in improving the quality of care provided to patients. Action was taken to address behaviour and performance that was inconsistent with the vision and values, regardless of seniority.

The service had an open culture where patients, their families and staff could raise concerns without fear. Leaders told us they had been working to improve the culture of openness and transparency throughout the division. Leaders recognised this work was still on-going. Most staff felt able to report concerns to their managers, but they also had the option of the freedom to speak up guardian (FTSUG) route. Drop-in session with the FTSPGs took place across the division. Staff on ward 11 had a recent drop-in session and felt this was helpful and useful to share concerns and ideas to improve. FTSUG reports demonstrated an increase in the numbers of staff approaching them which reflected leaders providing more opportunities for transparency and feedback. Various actions had been taken to address these concerns including escalation, involvement of human resources, mediation, values and behaviours workshops and roll out of a trust wide cultural programme 'Making a Difference Together'.

There was information displayed on the ward advising staff how to raise a concern. This suggested the trust had an 'open culture' in which staff could raise concerns without fear. All staff we asked understood the trust policy and would feel comfortable using it if necessary.

The service promoted equality and diversity in daily work and provided opportunities for career development. Staff told us there were opportunities for progression including taking on lead roles, leadership training and opportunities such as the nurse associate programme.

Governance

Leaders did not always operate effective governance processes; however, the service had made improvements. Staff at all levels were clear about their roles and accountabilities. Opportunities to meet, discuss and learn from the performance of the service was inconsistent.

There were governance frameworks in place to provide oversight of quality and safety performance, however, we were not assured they were sufficiently robust in consistently maintaining standards. Nursing quality audits were completed monthly and the findings were discussed at weekly meetings between matrons and ward managers and monthly confirm and challenge meetings led by the deputy director of nursing. Quality performance issues were raised, and the quality matrons worked with ward managers to identify actions for improvement. We found that there was consistently poor performance in some nursing quality metrics which had not improved despite the agreed actions. For example, fluid balance monitoring and pressure care. However, we did see some improvements where there had been a drive such as compliance with mental capacity assessments, Deprivation of Liberty Safeguard (DoLS) documentation and escalation of deteriorating patients.

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Systems and processes for implementing learning following incidents was not always effective. For example, we saw actions to improve pressure care following serious incidents, however, during our inspection we found poor compliance with processes to prevent patients developing a pressure ulcer.

Medical care (including older people's care)

Service leaders told us the governance processes had changed and significantly improved to enable better ward to board reporting and accountability. However, leaders recognised there is still improvements to be made in embedding effective processes to capture learning and embed changes. For example, leaders recognised the governance around complaints in the division required improvements to ensure complaints were dealt with appropriately, responded to within trust policy timescales and learning fully embedded.

Clinical and divisional leaders attended monthly divisional meetings where senior managers discussed performance, quality, risk, governance and human resources. Arrangements supported the cascading of information from board to ward level. For example, the medicine and emergency care division committee meeting took place monthly. These were attended by senior leaders and information was cascaded down to divisional matron and ward manager meetings, medicine safety huddles and ward meetings and daily ward safety huddles. During our inspection we saw examples of ward meeting minutes and daily huddle information sharing. However, ward meetings were irregular and varied in quality and content. We were therefore not assured all staff received information in an aligned, consistent and timely manner.

Speciality governance meetings took place and were well attended. These covered performance, quality and mortality reviews. We saw there were processes in place to align these to divisional meetings.

Leaders recognised they struggled to embed changes due to the volume of temporary staffing. The service had improved communication with staff through agency by creating and regularly updating a trust induction booklet with information required to work on wards. For example, where there was learning from serious incidents, this had been included. Agency nursing staff were also involved in ward-based training sessions and meetings. However, we were concerned medical locum staff did not have access to systems to enable them to receive important risk and safety information. Therefore, we were not assured the governance systems were always effective in communicating with locum doctors.

Management of risk, issues and performance

Not all risks were identified and escalated so that actions to reduce their impact were implemented. Leaders and teams did not always use systems to manage performance effectively.

Divisional risk register review and oversight processes were not always effective. It was unclear who had oversight of the risk registers. Managers we spoke with were generally unable to tell us what was on the service risk register. Whilst we saw risk registers had been updated, we did not see how the reviews linked into existing governance structures. We reviewed the medicine and emergency care divisional committee minutes for 26 February 2021. The number of new risks was discussed but there was no evidence that the risks were reviewed or that existing risks were considered. It was documented that leaders did not have assurance risks were being added appropriately as there was no Operational Risk Group (ORG). Divisional leaders we spoke to during our inspection acknowledged improvements were required to improve the process. Leaders had reviewed the process and intended to train local leaders to understand and review the risk registers that related to them and implement a process for feeding into divisional meetings. After the inspection, the trust told us that the division met bi-monthly to review the risk register and update the live register with updates on actions and mitigations. These meetings were not minuted, but oversight of risks went to the divisional operational group quarterly for oversight.

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We reviewed the risk register following our inspection. We found they did not identify all risk issues we observed during our inspection such as environmental risks in bay A on ward 10, lack of side rooms for isolation and poor compliance with swallow screening and assessment. These were known risks yet not on the risk register or risk assessed, therefore, we were not assured risks were effectively mitigated.

Medical care (including older people's care)

Managers recognised staffing was the major risk to the service and the hospital. There were recruitment and retention initiatives in place to attempt to mitigate the risk. Overseas recruitment, close working with the deanery and securing additional finances had all proved successful. However, it was recognised there were still vacancies in key roles and continued reliance on agency staff.

Incidents were not always investigated in a timely manner meaning there were potentially missed opportunities for shared learning. A system was in place to track serious incident investigations and progress made. We reviewed the tracker which showed not all incidents were reviewed in a timely manner, meaning learning from these incidents could not be identified, shared and implemented.

A nursing and quality performance dashboard was in place which included outcomes from audits, patient safety outcomes, infection prevention and control compliance, medicines management audits, training and staffing data. This was used by the division to monitor performance. Managers told us they had regular meetings with their matrons and divisional director of nursing to discuss ward performance and set actions for improvement. This data was incorporated into the integrated performance report which went to the trust board and quality and safety board. We saw ward individual performance was displayed on most wards we visited.

Performance in national audit outcomes was not integrated into the governance structures to ensure management oversight. There was a lack of interface between patient outcome performance and internal quality indicators in working together to improve overall performance. For example, we did not see evidence of consideration of patient outcomes and monitoring of improvements plans in governance and committee meetings. Whilst specialities reported into these meetings, they did not provide updates on progress.

We were not assured there was effective oversight of the Sentinel Stroke National Audit programme (SSNAP) improvement plan. We did not see this reported on in divisional meetings minutes we reviewed, and we saw most actions had been on the action plan for more than two years with no resolution. The service was ineffective in addressing gaps in provision such as radiology department capacity to enable Computerised Tomography (CT) scanning within the hour.

Information Management

Staff could not always find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The service collected reliable data and analysed it. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Staff did not always have access to clinical information in a timely manner. Junior and locum doctors told us the service did not provide them with access to electronic systems as soon as they started and had to wait to be granted access. This meant they used colleagues' details to access electronic systems. Locum doctors told us they did not have access to trust communication platforms such as email which meant they did not receive important safety updates and were often missed out of meetings where information was shared. This was not on the service risk register. However, service leaders told us there had been some staffing turnover in the medical staffing team which may have impacted this.

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Information technology systems were used to monitor patient care. A wide range of information was available to enable managers to assess and understand performance in relation to quality, safety, patient experience, human resources, operational performance and finance. Access to all electronic systems was secure and required password access.

There was an electronic system that recorded patients' observations and allowed nursing staff to monitor change over time. This data was automatically uploaded to the electronic performance dashboard system. All safety and quality

audit performance was recorded on the electronic performance dashboard which ward managers had access to. Performance outcomes were RAG rated to identify areas of compliance and concern. Managers could see their own ward performance information as well as that of other wards so it could be compared. The dashboard tracked performance over time and enabled staff to identify any areas of worsening performance.

The trust shared data securely with us and other agencies in accordance with legislation. Serious reportable incidents were reported to us when they occurred in line with the National Reporting and Learning System (NRLS) as required.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Most staff and managers said there had been many opportunities to feedback to senior managers and trust wide managers. Managers held drop-in sessions for engagement so that staff felt listened to and able to raise concerns. Freedom to speak up guardians had offered drop-in sessions to increase opportunities for engagement with staff. Examples of actions taken following engagement is plans to improve staff break areas and put air conditioning in place in specific areas to improve staff wellbeing.

The freedom to speak up guardian reports to the board demonstrated staff were speaking up including junior doctors, therapy staff and nursing staff.

Managers used the values and behaviour framework to engage with staff. Staff had opportunity to contribute to the framework and identify acceptable and unacceptable behaviours.

Patient feedback was collected and used to shape services. For example, the service used the friends and family test (FFT), local inpatient surveys, 'gather' (matron and senior nurse weekend checks) and exemplar feedback to gather information on patient experience of the services the hospital provided. In addition, patients could provide feedback through the feedback hub on the trust website through submitting a feedback form, sharing their story (through text, audio and video options), completing an FFT survey online, or raising a concern or sharing feedback. There was a patient experience team who produced quarterly reports that collated all patient feedback along with any themes from complaints and compliments. The report was presented to board and widely shared with staff across the service. It identified learning and any actions required from the feedback. Priorities for next steps to improve patient experience were also highlighted.

The trust engaged with key stake holders through attendance at council meetings in the development of their operational plans and local strategic initiatives. There was regular engagement with the local clinical commissioning group to review the service delivery to ensure it was satisfactory and met the needs of the local population.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. However, there were areas identified for improvement at our last inspection which were still of concern.

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Staff of all roles and levels were committed to making improvements. The service leaders as a team were in their infancy but recognised the need to drive improvement across the service. They understood the issues within the service and were committed to improving the quality and safety of the service. Leaders engaged staff when making improvements.

Medical care (including older people's care)

During our inspection we found there were some improvements since our previous inspections in 2019 and 2020. For example, staff felt more supported by senior management. There were improvements in the completion and quality of mental capacity assessments, best interest decisions and applications for deprivation of liberty safeguards. We also saw evidence of improved compliance with some trust risk assessments such as nutrition and falls risks assessments. There was also more focus on supporting patients living with mental ill health and dementia. However, we found there were continued breaches consistent with findings in previous inspection and serious incident investigations. For example, we found there were continued concerns with risk assessments, personalised care planning, implementation of the falls care bundle, continued examples of bed rails being used when contraindicated and lack of demonstrable and consistent learning from incidents. Whilst improvements had been made at all levels within the service, the pace at which the improvements were being made was slow and raised concerns of on-going risk of harm to patients.

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Agenda item: 3.9

PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE	**2 December 2021**
Subject:	**Quality Improvement Activity Update**
Approved and Presented by:	Kate Wright; Medical Director
Prepared by:	Amanda Edwards; Assistant Director Innovation & Improvement Howard Cooper; Safety & Quality Improvement Manager Gemma Beynon; Research & Development Manager
Other Committees and meetings considered at:	Executive Committee 17 November 2021

PURPOSE:

The purpose of this paper is to provide an update to Patient Experience, Quality & Safety Committee on quality improvement activity within Powys Teaching Health Board (PTHB).

RECOMMENDATION(S):

The Committee is asked to note and approve the quality improvement activity within PTHB.

Approval/Ratification/Decision	Discussion	Information
✓	×	×

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

Strategic Objectives:	1. Focus on Wellbeing	✓
	2. Provide Early Help and Support	✓
	3. Tackle the Big Four	✓
	4. Enable Joined up Care	✓
	5. Develop Workforce Futures	✓
	6. Promote Innovative Environments	✓
	7. Put Digital First	✓
	8. Transforming in Partnership	✓
Health and Care	1. Staying Healthy	✓
	2. Safe Care	✓

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Standards:	3. Effective Care	✓
	4. Dignified Care	✓
	5. Timely Care	✓
	6. Individual Care	✓
	7. Staff and Resources	✓
	8. Governance, Leadership & Accountability	✗

EXECUTIVE SUMMARY:

The challenges facing health and care services are well documented. It is widely known that continuing to do more of the same will not meet the challenges of the future. Innovation and improvement is one of the key enablers that will support the achievement of our collective ambition to improve health care services for the people of Powys. There is a need, more than ever before, to maximise the value from innovation and improvement.

Our staff and patients are best placed to identify, create and deliver the improvements that need to be made to our services. To achieve this a culture of learning, openness and transparency is required. Staff need to be supported with the training and development needed to support their care delivery. Innovation and improvement are to be encouraged. This means many things, not least nurturing an enquiring, curious and experimental environment that supports all staff to put their ideas into practice. This will help us improve patient care, outcomes and to develop value based models of care.

This paper provides an overview of Quality Improvement, Research and Development and learning activity across PTHB.

DETAILED BACKGROUND AND ASSESSMENT:

Background

An overarching goal of the NHS is to improve outcomes for people, whoever they are and wherever they live, by providing people with access to high-quality health care, delivered through a sustainable culture of learning and improvement. Everyone has a role in improving quality, to deliver improved outcomes for the people of Powys.

There is well established evidence on how to support improvement. NHS organisations must ensure their staff have the right skills, support and permission to make improvements in their everyday work, and to speak up when there are areas for improvement outside of their role or expertise. Quality Improvement, or QI, is the term used to describe an improvement approach.

1. **Quality Improvement (QI)**

QI works best in improving existing systems rather than in the introduction of new ones, as it is fundamentally evolutionary, rather than revolutionary in nature. It can be particularly effective at looking at systems where the precise nature of the problem isn't understood and where there is not a previously identified solution.

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Healthcare organisations in Wales are focused on meeting the quadruple aim of excellence in population health and wellbeing, personal experiences of care, best value from resources and an engaged and committed workforce. The philosophy of Value-Based, prudent, health and care underpin this and will continue to be a distinctive feature of the Welsh system. The recent Health and Social Care (Quality and Engagement) (Wales) Act 2020 which places both an enhanced duty of quality and an organisational duty of candour will strengthen the approach to high quality, safe care.

The National Clinical Framework: A Learning Health and Care System and The Quality and Safety Framework: Learning and Improving set out the national ambition for improving the quality of care.

National Quality Improvement (QI) Position

Improvement Cymru

The Improvement Cymru organisation has been the central hub for QI activity in Wales since its formation as the 1000 Lives Campaign in 2008. In late 2019 it was the ambition of Improvement Cymru to move away from being an organisation that provided support for specific, patient safety-based, concerns to become a more general "Improvement Academy" style organisation, focussed on growing the capacity of improvement knowledge throughout Wales.

The re-branding and re-launch of Improvement Cymru coincided with the outbreak of the Coronavirus epidemic and as Improvement Cymru is a Public Health Wales based organisation, many of its staff were redeployed to health protection roles in Wales. This has limited the progress of Improvement Cymru.

As organisations adjust to the new normalities, there has been renewed engagement with Improvement Cymru. It is planned for there to be virtual meetings starting in the near future to discuss the shape of improvement training that could be offered. Two members of Powys staff have taken up the offer, facilitated by Improvement Cymru, to participate in the Scottish Improvement Leaders Course, which begins in November. Powys currently has just a single member of staff with dedicated time to teach QI methodology but the Nursing directorate has ambitions to establish a small cadre of staff who could be trained into this role.

Improvement Cymru has also held meetings with the Deputy Director of Nursing to discuss what assistance they could provide to the ongoing Behavioural Change work stream being undertaken in Powys.

The Q Community

The Q Community is an initiative of The Health Foundation, a large independent charity. The community doesn't have its own improvement agenda as such but seeks to connect people with QI expertise across the home countries of the United Kingdom and the Republic of Ireland. One of its modes of action is to support Q Labs, a learning space on a particular topic where people with an interest in and knowledge of a particular topic can discuss ideas.

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Initially the Q Community was mostly England-based but the Health Foundation has now established a formal partnership with Improvement Cymru who have appointed

a manager to help align the work of the two organisations and to develop the Q Community in Wales.

Membership of the Q Community is granted by examination and recently four more Powys members of staff were accepted bringing the total to ten. Members of the Powys Pain and Fatigue Management service are particularly well represented in this number and Consultant Counselling Psychologist Owen Hughes is featured on the Q Community web site where he talks about his experience of participating in the Q Lab on Mental Health and Pain Management.

https://q.health.org.uk/blog-post/testing-improvement-ideas-powys-health-teaching-board/

The Bevan Commission

The Bevan Commission is a panel of 25 nationally and internationally renowned experts in the development of healthcare. Since 2015 they have held an annual competition where the successful candidates are supported to develop an improvement project.

One of our Community Nurses, Tamsyn Cowden, feels passionately about the environmental impact of activities and was successful in her application to become a Bevan Exemplar to explore her ideas further. In this 10-minute video she tells of both the successes and frustrations of her improvement journey.

https://www.youtube.com/watch?v=VyBLIsAEQCs

Another aspect of the Bevan Commission's work is to promote ideas from previous rounds of the competition that have been a proven benefit. Sarah Wheeler from our Macmillan Palliative Care team was successful in obtaining £13,600 of funding from the Bevan Commission in order to improve the planning of end of life care in Powys nursing and residential homes.

Local QI activity

Whilst the award of the "Silver" level quality improvement qualification has been suspended at the national level by Improvement Cymru there is still value in introducing staff to the methodology. The Safety & Quality Improvement manager has delivered presentations on the QI curriculum at the Nursing and Midwifery Leaders Event and to the Women & Childrens and the Community Services Group Audit groups.

More detailed discussions were held with two members of staff who might undertake an improvement project once the "Silver" award or its replacement regains its accredited status.

PTHB has a history of taking medical students on placement during their training. We are working to support future medical students placed within PTHB to undertake a QI project during their placement.

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Link between Clinical Audit and Quality Improvement

Some aspects of clinical audit and QI methodologically are very similar. Both involve the measurement of system performance against a desired standard, and both require action to improve the results of the system. The "Model for Improvement" aspect of QI in particular could be considered as a series of rapid audit cycles.
A number of projects previously reported to this committee in the Clinical Audit reports could equally be regarded as Quality Improvement activities. These include:

- The Sexual Health Testing by Post Service
- The Premature Infants Referral to Therapies Pathway
- The provision of intravitreal Anti-VEGF treatment for patients with wet age-related macular degeneration

To further support staff knowledge of QI methodology, a page has been created on the PTHB web site giving instruction on Failure Modes and Effects Analysis, Fishbone Diagrams, Pareto Charts and other useful QI methods.

2. **PTHB Research and Development**

Healthcare research and development will improve the quality of care for our patients. We recognise that patients benefit enormously from research and innovation, with breakthroughs enabling prevention of ill-health, earlier diagnosis, more effective treatments, better outcomes and faster recovery.

As a Health Board we are committed to working both locally and nationally and drive service transformation, education and contribution to the quality agenda. We will seek to ensure high quality research becomes increasingly culturally embedded in all aspects of clinical service delivery, in order to improve healthcare outcomes and contribute to knowledge to further improve the provision of evidenced based practice.

The health board currently has several actively recruiting research portfolio studies open across different clinical areas.

In addition, the Women and Childrens Directorate have two portfolio research studies about to open within the areas of Episiotomy and breastfeeding.

The Research & Development Department have recently supported a number of clinicians with research funding bids for competitive funding schemes run by Welsh Government. In addition, the R&D spending plan for 2022/3 has been completed and submitted to Health and Care Research Wales.

The SIREN research Covid antibody study is currently running follow up clinics on a monthly basis at both Bronllys and Welshpool. These clinics are covered by a core group of health board Bank Nurses.

Following the launch of the Improvement Cymru strategy, discussion is underway to understand how they might support PTHB with our quality and safety priorities. Focused across the whole continuum of care they will provide intensive local support and build on existing work already underway in Powys. We are exploring the potential for a frailty collaborative and some possible analytics/research support to help understand our workforce/hospital site models.

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Powys Research, Innovation and Improvement Co-ordination (RIIC) Hub
The RIIC Hub in Powys will be the coordination and driving vehicle for Research, Innovation and Improvement activity across the Powys footprint. It's regional presence and position in the network across the seven health boards means that it remains engaged and at the forefront of RII in Wales and in prime position to capitalise on opportunities for engagement, learning, funding and collaborations and optimise Powys profile, reach, sharing and contribution to the wider Wales agenda

3. Learning

An organisational approach to improvement is one that aims to embed a culture of continuous improvement and learning across an organisation, along with the means to make it a reality, with a view to delivering sustained improvements in the quality and experience of care. Creating a learning culture within the Health Board is an effective way to improve performance and innovation and provides an opportunity to expand the way we learn as an organisation, including learning from excellence.

PTHB is committed to improving the safety and quality of care by learning lessons from the investigations and analysis of incidents, complaints, claims, audits, and mortality reviews. As a Health Board we recognise that learning can come from a variety of sources and so it is useful to routinely review all types of learning to ensure that this is embedded into local practice and to prevent recurrence of events that led to the learning in the first place. The **Learning from Experience Group** provides a Health Board wide forum where all types of learning and good practice can be captured and shared across service group areas. Its purpose is to support the safe and effective delivery of care given to Powys residents both within the county and through commissioned services. A key function of the group is to identify thematic learning from across care groups for onward sharing across the Health Board.

The Learning from Experience Group has met on two occasions, the main focus of the most recent meeting learning from mortality reviews, Acute Kidney Injury (AKI) and findings from national clinical audits. Consideration is being given to holding a national Annual Safety Event at the Health & Care Academy with all clinical Executives leading on a particular aspect of care such as Sepsis or AKI and issues arising from the committee.

Further work is underway to understand how best to cascade learning across the organisation.

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Agenda item: 3.10

Patient Experience Quality & Safety Committee	**Date of Meeting:**
Subject:	**PTHB Clinical Quality Framework Update**
Approved and Presented by:	Alison Davies, Director of Nursing & Midwifery
Prepared by:	Amanda Edwards, Assistant Director Innovation & Improvement
Other Committees and meetings considered at:	Executive Committee

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 June 2021. The Clinical Quality Framework contributes to the Organisational Development Strategic Framework.
- Describe the WHC 2021/022 Publication of the Quality and Safety Framework and understand how this impacts PTHB
- Identify the requirements of the Quality & Safety Framework, where they are currently met within the Clinical Quality Framework Action Plan actions, any gaps and how these could be met
- Describe the impact our learning from Covid-19 has had along with the revised expectations nationally, and whether this has changed our priorities and / or timelines

RECOMMENDATION(S):

The Patient Experience Quality & Safety Committee is asked to:

DISCUSS the contents of this report.

Approval/Ratification/Decision	Discussion	Information
☒	✓	☒

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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 2020-2023 identifies quality as a core component of the health boards strategic direction and along with the Organisational Development Strategic Framework, which focusses on improving the effectiveness of the health board and to support the alignment, delivery and improvement approach across all areas.

WHC 2021/022; Publication of the Quality and Safety Framework was issued on 17th September 2021. Despite the progress that has been made in terms of establishing the NHS as a quality-led system, there is further work to do. Senedd members last year passed the **Health and Social Care (Quality and Engagement) Act 2020** to introduce a strengthened Duty of Quality and Duty of Candour for the NHS in Wales, as well as create a Citizen Voice Body to strengthen the voice of our population. This legislation, together with the need to learn from recent system failings in the NHS, and to recover from the COVID-19 pandemic are the principle drivers in developing this Quality and Safety Framework.

The Framework states that organisations at every level should function as a quality management system to ensure that care meets the six domains of quality; care that is safe, effective, patient-centred, timely, efficient and equitable. It sets out the need for a robust quality assurance framework that brings all the information surrounding quality together so it is utilised to implement effective change and improvement in care.

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The COVID-19 pandemic has been the biggest challenge the NHS has faced since its creation and our workforce has responded in the most incredible ways. However, despite these efforts, this new disease has caused avoidable harm. A Quality and Safety Programme overseen by a new National Quality and Safety Board will be developed to drive the high level actions described in this Framework. This Board will enable strong clinical leadership with a multi-disciplinary approach to help drive the NHS organisations in Wales along their journeys to being truly quality led.

DETAILED BACKGROUND AND ASSESSMENT:

1 Implementation of the Clinical Quality Framework

1.1 Introduction and Background

The PTHB Integrated Medium Term Plan 2020-2023 identifies quality as a core component of the health boards strategic direction and, 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 the next three years (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 Quality Governance Group was in June 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 the 5 goals as agreed, with a lead Director identified for each of the goals.

The overall implementation of the Clinical Quality Framework Implementation Plan has been adversely affected since the emergence of the Covid19 pandemic, however, progress has been made and/or maintained in most of the goals but has slowed during the last 12 months.

Following papers presented and discussion at the Experience Quality and Safety Committee and Executive Committee in April 2021, it was agreed that Directors would review the reprioritise activities within the goals they lead and provide a revised plan for consideration at Quality Governance Group. Once agreed, the revised priorities will be scheduled for delivery during 2021-2022.

It was anticipated that the results of the individual Director led reviews and the generation of revised priorities was due to be reported to the Quality Governance Group on 6 July 2021. This was delayed. These individual Director reviews have now taken place and are included in this report.

1.2 Insight and Learning from COVID-19 Pandemic

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Over the last year, the NHS has faced its biggest challenge since its inception, with the unprecedented COVID-19 pandemic. The staff and leadership of NHS organisations have responded to this challenge in an extraordinary way by developing new ways of working

to support our population. During the pandemic we saw wonderful examples of high-quality care, including the retraining and redeployment of staff to the highest risk areas, effective team working and communication and, above all, arrangements centred on the new and changing needs of people.

As we emerge from the pandemic, NHS organisations are considering how to adapt services and learn from the innovative practice and outstanding clinical leadership that we have seen. Quality and safety are going to be of paramount importance in this recovery process and it is essential there is this quality and safety focus at every level. Patients waiting for treatment will be exposed to widely varying levels of symptoms and risk, so the limited clinical resource now available must be targeted at those likely to gain the most benefit. A co-productive approach to clinical care and decision making will be essential to gain and maintain public understanding and confidence.

There has been a number of important changes - implemented at an unprecedented, un-paralleled pace across our Health Board since March 2020 - in ways of working, roles, the rapid introduction of new technologies and innovations as well as the ways in which we have worked with our partners, stakeholders and our local communities.

There was a need to understand at a local level both the ways in which change has happened and was managed as well as the impacts, benefits, value and challenges of the changes themselves, so that we can reflect, learn and help inform decisions about what we keep doing, what we let go, what we invest in and develop so we can plan for an improved, sustainable, effective and efficient future. This learning has been considered to understand what impact our learning from covid has had on the Clinical Quality Framework action plan along with the revised expectations nationally; whether this has changed our priorities or impacted timelines.

Following a review of the actions alongside lessons learned there are no changed recommended at this time to the priorities within the action plan however, there are changes requested to timescales for some actions and these are set out in section 1.4 below.

1.3 Progress against Clinical Quality Framework Action Plan

A summary of progress made in implementing the existing priorities as at November 2021 is captured in **Appendix 1.**
A Progress Report: implementing the Clinical Quality Framework can be found at **Appendix 2**

Within the Clinical Quality Framework action plan there were 7 areas identified as red. A description of these RED actions is set out in the table below:

Goal1b EFFECTIVENESS Medical Director		
7	Review and develop organisation approach to implementation of national clinical guidelines.	Capacity challenge due to Covid19

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10	Develop an approach for programme of external peer review	Capacity challenge due to Covid19
Goal 1c EXPERIENCE Director of Therapies & Health Sciences		
11	Refresh the PTHB Patient Experience Framework	Capacity challenge due to Covid19
12	Review arrangements for learning from patient experience in all clinical services	Capacity challenge due to Covid19
GOAL 2 ORGANISATIONAL CULTURE Director of Workforce & Organisational Development		
7	Ensure a multi-disciplinary approach to clinical risk assessment and management	Capacity challenge due to Covid19. Review of Lead Exec requested
Goal 5 INTELLIGENCE Director of Public Health		
3	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	Requires redefining
4	Develop/integrate a valid and robust organisational benchmarking approach, using national/international comparators where available	Requires redefining

1.4 Requests for change

Having reviewed the progress of the actions the following requests for change have been requested:

Goal 1c EXPERIENCE Director of Therapies & Health Sciences			
11.0	Refresh the PTHB Patient Experience Framework	Current deadline 31.3.21	Deadline to be revised to 31st March 2022
12.0	Review arrangements for learning from patient experience in all clinical services	Current deadline 31.3.21	Deadline to be revised to 31st March 2022
Goal 2 ORGANISATIONAL CULTURE Director of Workforce & Organisational Design			
1.0	Consider aligning Values and Behaviours Framework to compassionate leadership	Current deadline 31.3.21	Deadline to be revised to 31st March 2022
2.0	Consider deployment arrangements including roles/accountabilities of Executive Directors/teams	Current deadline 31.3.21	Deadline to be revised to 31st March 2022

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5.0	Review Terms of Reference of relevant committees to reflect Framework	Currently assigned to DWOD	Request that this be reassigned to Board Sec
6.0	Review the resources available to support clinical quality improvement	Currently assigned to DWOD	Request that this be reassigned to Medical Director
7.0	Ensure a multi-disciplinary approach to clinical risk assessment and management	Current deadline 31.3.21 Currently assigned to DWOD	Although DoWOD is lead exec for H&S Risk this action relates to Clinical risk. Suggest this needs to be reviewed by a clinical director. Deadline to be extended to 31.3.22
Goal 5 INTELLIGENCE Director of Public Health			
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	This action requires further redefining	
4.0	Develop/integrate a valid and robust organisational benchmarking approach, using national/international comparators where available	This action requires further redefining	

2. WHC 2021/022; Publication of the Quality and Safety Framework

2.1 Introduction

A Heathier Wales was published in 2018 and set out the ten-year vision for health and social care in Wales, with quality and safety of care the primary focus in the provision of healthcare across Wales. The Quality and Safety Framework now published will be a key driver to ensure quality and safety is firmly placed at the heart of NHS healthcare provision, from community care right through to acute services.

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This Quality and Safety Framework requires services to be built on the foundations of a robust quality management system, which continuously connects quality assurance, planning and improvement. The COVID-19 pandemic presents the NHS with a far greater challenge to adapt and improve services already significantly altered during the height of the pandemic, while remaining focused on meeting the quadruple aim within A Healthier Wales. It sets the direction for implementation of the Health and Social Care (Quality and Engagement) (Wales) Act, with particular emphasis on the duties of quality and candour, which come into force from April 2023. The Framework facilitates organisations' preparedness for the Act.

2.2 Strategic background

A Healthier Wales (AHW) sets out a long-term vision that everyone in Wales should have longer, healthier and happier lives. It proposes a whole-system approach to health and social care which is equitable, and where services are designed around individuals and groups based on their unique needs and what matters to them, as well as quality and safety outcomes. The first NHS Wales core value described in A Healthier Wales is "Putting quality and safety above all else – providing high-value evidence-based care for our patients at all times."

Healthcare organisations in Wales are focused on meeting the quadruple aim of excellence in population health and wellbeing, personal experiences of care, best value from resources and an engaged and committed workforce. Our philosophy of Value-Based, prudent, health and care underpins this and will continue to be a distinctive feature of the Welsh system. The recent Health and Social Care (Quality and Engagement) (Wales) Act 2020 which places both an enhanced duty of quality and an organisational duty of candour will strengthen the approach to high quality, safe care.

To achieve the aspiration of having a quality-led health service, all organisations need to operate within an effective quality management system. The Quality and Safety Framework describes the interlinked key elements that must always be working together to ensure continuous improvement in quality: planning; improvement; and control; and to provide overall assurance that the system is working effectively to deliver the outcomes that we need for the people of Wales.

2.3 Quality and Safety Framework: Improvement and Learning Welsh Government Actions

- Action 1: NHS organisations to ensure harm (both direct and indirect) associated with the COVID-19 pandemic is minimised. Organisations should implement a risk and benefit focussed approach to recovery of other services, and measure, monitor and learn from any harm.
- Action 2: Welsh Government to work with key stakeholders to review and update Health and Care Standards reflecting the strengthened duty of quality.

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- Action 3: Welsh Government to work with key stakeholders on implementation of the duties of quality and candour to enable NHS organisations to be ready when the duties come into force.

- Action 4: Welsh Government to work with key stakeholders to develop a new National Incident Reporting framework focussing on maximising and sharing learning from incidents.

- Action 5: National work to be undertaken to develop a learning from deaths framework, building on the continued national roll out of the Medical Examiner Service and processes already in place for reviewing mortality.

- Action 6: National work to be undertaken to lead an all-Wales improvement approach to maximise the opportunity for learning from independent reviews of maternity and neonatal services.

- Action 7: Welsh Government to work with NHS organisations to implement vital electronic systems to support safe care, such as Electronic Prescribing and Medication Administration, Scan for Safety and the Medical Devices Information System.

- Action 8: NHS organisations demonstrate through their plans that patient care and experience is central to their approach and delivery and that their governance arrangements support this requirement.

- Action 9: Healthcare organisations to ensure they have the capacity and capability for continuous improvement and learning.

- Action 10: National work to be undertaken in conjunction with key stakeholders to develop a Quality Assurance Framework to help capture all the elements of a quality management system. This will include a refreshed Framework for Assuring Service User Experience, and help prepare the way for the duties of quality and candour

- Action 11: Work to be undertaken nationally and locally to develop a measurement framework to inform a quality management system, underpinned by improved information about the quality of care.

- Action 12: NHS organisations to review and consider what needs to be in place in order to develop a fully-functioning quality management system, including ensuring the Board have the appropriate skills and knowledge to provide effective leadership of the system.

- Action 13: National work to be undertaken to develop a toolkit that organisations can use to gain assurance of an effective Quality Management System.

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- Action 14: Health organisations to engage their workforce with the quality agenda and empower all to get involved to help make the NHS in Wales a quality-led system.

- Action 15: A Quality and Safety programme will be established to drive forward the national actions set out in this Framework. This programme will be overseen by a new Quality and Safety Board facilitated by an NHS Executive function. This board will work to drive the quality and safety agenda and be led in partnership with the NHS. It will have a multi-disciplinary approach with participation from different professional groups.

The requirements of each action have been analysed to understand:

- Where these are already captured within the Clinical Quality Framework action plan within existing goals
- Those not yet captured
- Suggestions of how those currently not captured can be included within the Clinical Quality Framework action plan

A summary of Quality and Safety Framework requirements, fit with Clinical Quality Framework existing actions and potential solutions for gaps can be found at **Appendix 3**

NEXT STEPS:

To amend the Clinical Quality Framework Action Plan in light of discussion and the agreement of this committee.

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Appendix 1

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 November 2021. There have been some changes to RAG ratings since the last report to QGG in March 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
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			
Assess systems of communication and support that enable staff to raise concerns			
Review & revise system for safety alerts/notices			

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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			
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			

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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			
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			

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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			
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			

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

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Appendix 2:

Progress Report: implementing the Clinical Quality Framework

RAG key

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

GOAL 1a: SAFETY Director or Nursing & Midwifery

1.0	Implement the revised Putting Things Right Policy		▪ A deep dive into the health board's approach to Putting Things Right commenced during November 2020, and is nearing completion. ▪ Policy approved July 2019 and implementation in progress. Paper drafted for Execs for investigation training September 2020. ▪ Quality Improvement work triggered to review management of concerns pathway. No formal audit programme in place although some individual cases reviewed to establish learning / improvement. Complainant evaluation survey developed in August 2020 and currently being reviewed by CEO ▪ Putting Things Right Policy updated and approved at clinical policy group on the 2nd November; to be presented to Board for final approval. Suite of supporting policies also approved – Putting Things Right procedure, Putting Things Right guide for public plus an unreasonable behaviour policy. ▪ Quarter 2 audit cycle completed and findings to be presented to the Executive Committee 17th November as part of Concerns Paper update; learning and improvements incorporated into Putting Things Right Improvement Plan.

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			▪ Paper going to EQS Committee 2nd December. New model for Concerns team agreed, interim posts currently being recruited to, interviews w/c 15th November 2021.
2.0	Implement the five key improvement actions relating to Serious Incident management - WHAT are the 5 key improvement areas?		▪ The national patient safety incident (PSI) framework was launched 14 June 2021, to be in place by end of March 2022. The health board initiated an implementation group to support the changes in practice. ▪ Local huddle guide developed, easy read guidance produced for staff reflecting the national framework. ▪ Health board representation at national meeting to progress work to finalise the framework. ▪ A new Learning from Events Report to be used as part of patient safety incident reporting framework currently being piloted at Swansea Bay and will be rolled out across all health boards over coming weeks. ▪ Policy work commenced but not finalised as awaiting final framework. ▪ Proactive work in place to address open historic serious incidents. ▪ A 3-year training schedule developed and features as part of Concerns papers to Executive and EQS Committee, with external Ombudsman Office training featuring on complaints and negotiation, communication skills, managing expectations, resilience & accountability and Community Health Council support and input. ▪ Threshold audit is developing and in very early stages, as new PSI framework allows a degree of judgement to reporting based on investigation findings/ outcomes.
3.0	Develop and implement a revised approach to organisational learning		▪ 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 has met on two occasions, the main focus of the most recent meeting learning from mortality reviews, Acute Kidney Injury (AKI) and findings from national clinical audits. ▪ 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.

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4.0	Assess Systems of communication and support that enable staff to raise concerns		▪ Mechanisms already exist for staff to raise concerns through the incident reporting system and via Putting Things Right. ▪ 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		▪ Alerts policy approved via Clinical policy group 2nd November. New model of managing alerts in place. ▪ 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			
6.0	Implement the improvement plan for clinical audit		▪ The local Powys clinical audit plan has been realigned from being directorate-based to being service based. The audit plan now falls into three service categories; the Women & Childrens Service, the Community Services Group and the Mental Health & Learning Disabilities Service. ▪ The first two of these services hold a meeting every six weeks to discuss the audit plan with every third meeting being a presentation of results as a learning session. The MH&LD service is hoping to restart its audit plan once staffing levels become more stable. ▪ A summary report outlining the results from the clinical audits and any changes to the local clinical audit plan are reported to the Experience Quality and Safety Committee three times per year
7.0	Review and develop organisation approach to implementation of national clinical guidelines.		▪ NICE & Clinical Guidelines have been discussed in the Learning Group. ▪ There are challenges to deliver NICE & Clinical Guidelines in Powys. A paper will be drafted that describes the challenges and taken to PEQ&S.

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			▪ There is responsibility on individual clinical quality groups to be aware of the guidance relevant to their speciality however further consideration will be needed to seek assurance that we are aware of and following the appropriate guidance.
8.0	Accelerate Value-Based healthcare programme in the organisation		▪ Value based healthcare Programme now established as part of Renewals and plans are progressing to commence initial projects. ▪ Progress is being made with the Rural Value Collaborative to share learning.
9.0	Review approach to Health Care Standards		▪ A working group is being established to coordinate and gather assurance across services
10.0	Develop an approach for programme of external peer review		▪ Discussions ongoing about how this is introduced within PTHB
GOAL 1c. EXPERIENCE Director of Therapies & Health Sciences			
11.0	Refresh the PTHB Patient Experience Framework		▪ Workshop to revisiting framework took place on 19.10.2021 Business case being written to procure electronic feedback system with analysis function. Business Case to be completed by end Q3 ▪ Patient experience Group stood back up on 22.04.2021 and workplan to be reviewed in line with renewal plans. ▪ Patient Experience group deferred during 2nd wave of coronavirus.
12.0	Review arrangements for learning from patient experience in all clinical services		▪ See above – Review to take place of quadrant framework that staff complete. ▪ There have been 2 iterations to date Need to ensure is embedded. QI Manager to be invited to future meetings. Review ToR at next meeting
13.0	Consider alignment of resources for Patient Experience to enable intelligence gathered to inform clinical care and Board decisions		

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14.0	Review and develop the link between documented patient experience and Board decision making		
15.0	Review the impact of the patient stories presented at PTHB Board		

GOAL 2: Organisational culture Director of Workforce & Organisational Development			
1.0	Consider aligning Values and Behaviours Framework to compassionate leadership		▪ The Values are aligned to the compassionate leadership model, with no indication from staff surveys that this needs to be changed. ▪ Chat2Change will align the wording in the Values and Behaviours framework to reflect the Compassionate Leadership model. ▪ Anticipate the deadline for this to be the end of the financial year to coincide with the launch of the new intranet so we can have a specific page for values and behaviours
2.0	Consider deployment arrangements including roles/accountabilities of Executive Directors/teams		▪ Work underway to review the realignment of 2018 undertaking an assessment of achievement against original objectives. ▪ Once complete this work will be presented to the exec team as the oversight group for the realignment work. ▪ Exec portfolios to be reviewed as part of this process
3.0	Design/implement an organisational and staff development programme to embed Clinical Quality Framework		▪ Review the need for a specific programme and any potential curriculum in light of the value approach the organisation is undertaking.
4.0	Evaluate the current culture of the organisation		▪ More recently an agile working survey has been completed which reviewed and revisited employee engagement. ▪ Covid-19 survey and organisational learning survey complete.

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5.0	Review Terms of Reference of relevant committees to reflect Framework		▪ Richard Bevan work in train. This includes Review Terms of Reference of relevant committees
6.0	Review the resources available to support clinical quality improvement		▪ 2 members of staff undertaking Scottish Improvement Leaders Course with the intention of cascading through PTHB. ▪ Discussions taking place to host and support medical students from Cardiff Uni in delivering QI projects within PTHB
7.0	Ensure a multi-disciplinary approach to clinical risk assessment and management		▪ Although DoWOD is lead exec for H&S Risk this action relates to Clinical risk. Suggest this needs to be reviewed by a clinical director

GOAL 3: Clinical Leadership Director of Therapies & Health Sciences			
1.0	Visible Clinical Executive Director leadership in the roll-out of the Clinical Quality Framework		▪ New MD in post with clear responsibilities on the Quality agenda ▪ Clear Link to goal 5 – with the need to work collaboratively. ▪ A range of new clinical leadership clinical leadership positions have been established. ▪ An assistant Director programme is one way in which this approach will be supported. ▪ Two Heads of Nursing and Midwifery have been successful in achieving a place on the prestigious Kings Fund leadership development course - deferred to alternative development with HEIW due to the pandemic. ▪ A revised professional nursing structure has been established to maximise opportunities for nurses, midwives and members of the nursing family. ▪ Twice yearly professional nursing and midwifery forums have been established. ▪ Work to strengthen professional leadership within therapies is almost complete.
2.0	Consider assigning a named PTHB clinical lead to specific quality governance areas		▪ It is believed that a governance lead in in place for each service area. ▪ This needs to be check to provide assurance that there are no gaps. ▪ Leads attend meeting with DoHTs ▪ ToR to be reviewed at next meeting

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3.0	Design and implement an approach to develop and sustain clinical leadership across the health board		▪ 2 members of staff undertaking Scottish Improvement Leaders Course with the intention of cascading through PTHB. ▪ Discussions underway to host and support medical students from Cardiff Uni in delivering QI projects within PTHB
4.0	Review/improve clinical leadership in design, review and action from performance/intelligence on clinical services		
5.0	Develop a clinically-led programme of periodic "deep dive" reviews of specific clinical areas		

GOAL 4: Improvement methodology Medical Director			
1.0	Agree and adopt an approach to clinical quality improvement, including the methodology, knowledge and skills		▪ Need to align our approach with the new WG Quality & Safety Framework
2.0	Using a prioritised and risk-based approach, define and deliver a programme of clinical quality improvement projects		▪ Revisit CE&QI Strategy to ensure aligned to Q&S Framework and Renewal programme.
3.0	Develop a training programme to enable staff to have improved knowledge and skills		▪ 2 members of staff undertaking Scottish Improvement Leaders Course with the intention of cascading through PTHB
4.0	Review and develop the resources available to lead and support clinical quality improvement across the organisation		▪ 2 members of staff undertaking Scottish Improvement Leaders Course with the intention of cascading through PTHB. ▪ Discussions to host and support medical students from Cardiff Uni in delivering QI projects within PTHB

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5.0	Assess the potential for formalising a partnership between the health board and other UK expert organisations for quality improvement in health care		▪ Positive discussions with Improvement Cymru with draft TOR in place. Plans developing to support us in some cultural and QI work. ▪ 2 members of staff undertaking Scottish Improvement Leaders Course with the intention of cascading through PTHB

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)		▪ 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. ▪ 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 to strengthened to improve internal (and external) performance monitoring. How the CAF is used as part of an overall internal performance 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		▪ 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. ▪ Improvement Cymru have expressed an interest in supporting this as part of one of their behaviour change programmes, but the detail of the proposal and planning for this work still need to be worked through. ▪ 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		▪ This action requires further redefining

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	interpretation of data in providing assurance		
4.0	Develop/integrate a valid and robust organisational benchmarking approach, using national/international comparators where available		▪ This action requires further redefining

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Appendix 3

Quality and Safety Framework: Improvement and Learning Welsh Government Requirements, fit with Clinical Quality Framework existing actions & potential solutions for gaps

Key

	Covered within existing CQF Goal
	Partially Covered within existing CQF Goal
	Not covered within existing CQF Goal – consider amendment

Quality and Safety Framework: Improvement and Learning Welsh Government					
Ref	Summary of Requirement	Actions required	PTHB Clinical Quality Framework	Gap	Lead exec
ACTION 1	NHS organisations to ensure harm (both direct and indirect) associated with the COVID-19 pandemic is minimised. Organisations should implement a risk and benefit focussed approach to recovery of other services, and measure, monitor and learn from any harm.	To ensure harm (both direct and indirect) associated with the COVID-19 pandemic is minimised.	No specific reference at present - Cross reference to annual plan & IMTP and Commissioning Assurance Framework	Include in **Goal 1** Dimensions of Clinical Quality - 1a Safety to ensure harm (both direct and indirect) associated with the COVID-19 pandemic is minimised.	DoMN
ACTION 1		To implement a risk and benefit focussed approach to recovery of other services	**Goal 2** - Ensure a multi-disciplinary approach to clinical risk assessment and management (DoWOD) **Goal 4** - Using a prioritised and risk-based approach, define and deliver a programme of clinical quality improvement projects (MD)	Widen Goal 2 and Goal 4 to specifically include recovery of other services	DoWOD / MD

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ACTION 1		Measure, monitor and learn from any harm	No specific reference at present - Cross reference to annual plan & IMTP and Commissioning Assurance Framework	Include in Goal 1 Dimensions of Clinical Quality - 1a Safety Measure, monitor and learn from any harm	MD
ACTION 1		To build on the innovative ways of delivering services particularly using technology. This will be key to be able to keep in touch with individuals awaiting treatment	No specific reference at present - Cross reference to annual plan & IMTP and Commissioning Assurance Framework	Include in Goal 4 To build on the innovative ways of delivering services particularly using technology. This will be key to be able to keep in touch with individuals awaiting treatment	DOTH
ACTION 1		To ensure that any interventions are of high value and improve outcomes for people	No specific reference at present	Include in **Goal1** Dimensions of Clinical Quality - 1b Effectiveness. To ensure that any interventions are of high value and improve outcomes for people	MD
ACTION 2	Welsh Government to work with key stakeholders to review and update Health and Care Standards reflecting the strengthened duty of quality.	The duty of quality mandates the requirement for NHS organisations to commit to and deliver improvements in the quality of health services.	**Goal 4** Implement a defined programme of Improvement methodology to Enable High Quality Clinical Care	Include specific mention of Duty of Quality in Goal 4	MD / DoNM

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ACTION 2		NHS organisations will be required to publish an annual report setting out the steps they have taken to secure these improvements, and include an assessment of the extent to which any improvements in outcomes that have been achieved. This new report will replace the current Annual Quality Statement.	No specific mention at present	Include under Goal 1 Dimensions of Clinical Quality - 1a Safety	DoNM
ACTION 2		Duty of Candor - The duty will apply when a person who has received healthcare has suffered an adverse outcome and the provision of health care was or may have been a factor. In this context an adverse outcome will mean if the individual has experienced, or could experience, any unexpected or unintended harm that is more than minimal.	No specific reference at present - Cross reference to annual plan & IMTP and Commissioning Assurance Framework	Include under Goal 1 Dimensions of Clinical Quality - 1a Safety	DoNM
ACTION 3	Welsh Government to work with key stakeholders on implementation of the duties of quality and candour to enable NHS organisations to be ready when the duties come into force.	Implement Duty of Quality & Duty of Candor	No specific reference at present - Cross reference to annual plan & IMTP and Commissioning Assurance Framework	Include under Goal 1 Dimensions of Clinical Quality - 1a Safety	DoNM

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ACTION 4	Welsh Government to work with key stakeholders to develop a new National Incident Reporting framework focussing on maximising and sharing learning from incidents.	Continue to use mortality reviews to highlight areas for continuous improvement, including sepsis and recognition of the unwell patient	No specific reference at present - Cross reference to annual plan & IMTP and Commissioning Assurance Framework	Include under Goal 1 Dimensions of Clinical Quality - 1a Safety	MD
ACTION 5	National work to be undertaken to develop a learning from deaths framework, building on the continued national roll out of the Medical Examiner Service and processes already in place for reviewing mortality.	Mortality Review - continue to share learning across PTHB from specific patient safety and care issues that may emerge.	No specific reference at present - Cross reference to annual plan & IMTP and Commissioning Assurance Framework	Include under Goal 1 Dimensions of Clinical Quality - 1a Safety Goal 1 Dimensions of Clinical Quality - 1c Experience	MD
ACTION 6	National work to be undertaken to lead an all-Wales improvement approach to maximise the opportunity for learning from independent reviews of maternity and neonatal services.	Ensure whole system safety applying the Safety I / Safety II concept to systems as a whole with reflection on what we can learn from systems that are safe and apply that learning to all our systems.	No specific reference at present - Cross reference to annual plan & IMTP and Commissioning Assurance Framework	Include under Goal 1 Dimensions of Clinical Quality - 1a Safety Goal 1 Dimensions of Clinical Quality - 1c Experience	DoNM
ACTION 6		consider areas such as ensuring the medical devices used are safe and that where there are concerns, these are escalated to the Medicines and Healthcare products Regulatory Agency (MHRA).	No specific reference at present	Include under Goal 1 Dimensions of Clinical Quality - 1a Safety	DOTH

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ACTION 6		To monitor use of systems and measure outcomes from clinical interventions including device implantation. Electronic systems include those such as electronic prescribing.	No specific reference at present - Cross reference to annual plan & IMTP and Commissioning Assurance Framework	Include under **Goal 5** Develop Excellent Information and Intelligence Systems, to Enable High Quality Clinical Care	DoPH
ACTION 7	Welsh Government to work with NHS organisations to implement vital electronic systems to support safe care, such as Electronic Prescribing and Medication Administration, Scan for Safety and the Medical Devices Information System.	Prioritise and implement an effective quality management system across the organisation.	No specific reference at present - Cross reference to annual plan & IMTP and Commissioning Assurance Framework	Include under **Goal 4** Implement a defined programme of Improvement methodology to Enable High Quality Cli	MD
ACTION 7		Using data for improvement, not just for assurance or control	No specific reference at present - Cross reference to annual plan & IMTP and Commissioning Assurance Framework	Include under **Goal 5** Develop Excellent Information and Intelligence Systems, to Enable High Quality Clinical Care	DPH
ACTION 7		Engaging staff in quality improvement with an open culture of continuous improvement and true clinical leadership.	**Goal 2** Optimise organisational culture, to enable high quality clinical care (linked to Organisational Development Framework)		DoWOD
ACTION 7		Engaging patients in quality improvement with an open culture of continuous improvement and true clinical leadership.	**Goal 1** Dimensions of Clinical Quality - 1c Experience		DoTH
ACTION 7		Link quality management system to continuous learning, capitalise on what was learnt from the previous round,	**Goal 1** Dimensions of Clinical Quality - 1a Safety		DoNM

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		gaining intelligence from all sources and improving the process			
ACTION 8	NHS organisations demonstrate through their plans that patient care and experience is central to their approach and delivery and that their governance arrangements support this requirement.	Ensure staff have the right skills, support and permission to make improvements in their everyday work, and to speak up when there are areas for improvement outside of their role or expertise. the workforce needs the capacity to carry out improvement and build it into every day work. Improvement skills and behaviours needs to be built into the work of everyone working in healthcare, so the culture becomes one of continual personal and positive challenge as to how can we do better	**Goal 2** Optimise organisational culture, to enable high quality clinical care (linked to Organisational Development Framework) **Goal 4** Implement a defined programme of Improvement methodology to Enable High Quality Clinical Care		DoWOD / MD
ACTION 8		PTHB's approach to quality improvement to be linked to the HB's priorities to enable truly transformational, organisation-wide change	**Goal 3** Develop Excellent Clinical Leadership, to Enable High Quality Clinical Care	Consider widening **Goal 3** to specifically link to organisational priorities Cross reference to annual plan & IMTP and Commissioning Assurance Framework	DOTH

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ACTION 8		There are areas where effective change is delivered and we need to focus on how to scale up effective change across Wales and ensure people are receiving equitable care. In response to A Healthier Wales, Improvement Cymru, our national improvement support service, is changing to support the quality cycle across organisations, using a consistent approach to the spread of improvement and learning. Within A Healthier Wales six key areas for improvement were identified: medicines management; surgery and surgical pathways; frail elderly care; acute illness; equitable health and social care; and end of life care.	No specific reference at present - Cross reference to annual plan & IMTP and Commissioning Assurance Framework	Consider widening **Goal 4** Implement a defined programme of Improvement methodology to Enable High Quality Clinical Care	MD
ACTION 9	Healthcare organisations to ensure they have the capacity and capability for continuous improvement and learning.	Quality assurance is essential for PTHB to understand the quality of services being provided, including those commissioned from others, how it compares with others and that, if identified, improvement work is making a difference. Ensure a	No specific reference at present - Cross reference to annual plan & IMTP and Commissioning Assurance Framework	Include in **Goal1** Dimensions of Clinical Quality - 1b Effectiveness	Board Secretary

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		systematic approach to quality planning, quality improvement and quality control			
ACTION 9		Quality assurance needs to accommodate 'qualitative intelligence', such as the lived experiences of staff, patients and carers, as these often highlight problems before the measurement does. The existing Framework for Assuring Service User Experience sets out a range of methods to be used	No specific reference at present - Cross reference to annual plan & IMTP and Commissioning Assurance Framework	Include in **Goal 1** Dimensions of Clinical Quality - 1c Experience	DOTH
ACTION 10	National work to be undertaken in conjunction with key stakeholders to develop a Quality Assurance Framework to help capture all the elements of a quality management system. This will include a refreshed Framework for Assuring Service User Experience, and help prepare the way for the duties of quality and candour	Timely data is key to both understanding what is happening in organisations at any point in time but also to look at outcomes, identify areas for improvement as well as for benchmarking.	No specific mention at present	Include in Goal 5 Develop Excellent Information and Intelligence Systems, to Enable High Quality Clinical Care	DPH
ACTION 10		Value in healthcare is realised when we achieve the best possible healthcare outcomes for our population with the resources that we have.	**Goal1** Dimensions of Clinical Quality - 1b Effectiveness		MD

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ACTION 10		It is vital that we provide care that is equitable and uses an evidence-based approach with implementation of NICE guidelines to help ensure high-value care.	No specific mention at present	Include in Goal1 - Dimensions of Clinical Quality - 1b Effectiveness	MD
ACTION 10		Changes in health are important milestones in the lives of patients and we should use Patient Reported Outcome Measures (PROMs) to measure them. help us assess and meet patient needs, and to understand their experience of care, and to improve services.	No specific mention at present	Include in **Goal 1** Dimensions of Clinical Quality - 1c Experience	DOTH
ACTION 10		We need to harness the information that is available to us across all aspects of quality management systems to measure the quality and outcomes of care. This can be used locally and nationally, and can inform a framework for measurement and benchmarking. Quality measures need to be on at least an equal footing with performance and finance measures.	Goal 5 Develop Excellent Information and Intelligence Systems, to Enable High Quality Clinical Care		DPH

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ACTION 11	Work to be undertaken nationally and locally to develop a measurement framework to inform a quality management system, underpinned by improved information about the quality of care.	To review PTHBs current quality management systems, and consider where they are, and where they need to develop, to ensure they maximise the effectiveness of their quality management system.	Goal 4 Implement a defined programme of Improvement methodology to Enable High Quality Clinical Care		MD
ACTION 11		Ensure education / Training for independent members on effective quality management includes the six domains of healthcare quality	No specific mention at present	Include in **Goal 4** Implement a defined programme of Improvement methodology to Enable High Quality Clinical Care	MD
ACTION 12	NHS organisations to review and consider what needs to be in place in order to develop a fully-functioning quality management system, including ensuring the Board have the appropriate skills and knowledge to provide effective leadership of the system.	The staff of PTHB need to know that concerns are taken seriously, indeed they are welcomed.	**Goal 1** Dimensions of Clinical Quality - 1a Safety		DoNM
ACTION 12		When errors do occur, they need to be investigated to understand how the system failed, with rapid action taken to prevent the risk being repeated. This approach needs to not apportion blame.	Not specifically mentioned at present	Include in **Goal 1** Dimensions of Clinical Quality - 1a Safety	DoNM
ACTION 12		Patients also need to be encouraged to speak up when things go wrong and know that their concerns and experiences are listened to and not dismissed.	No specific reference at present - Cross reference to annual plan & IMTP and Commissioning Assurance Framework	Include in **Goal 1** Dimensions of Clinical Quality - 1c Experience	DOTH

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ACTION 12		Personal wellbeing is a fundamental requirement for this to take place. If members of staff are suffering from burnout or feeling disengaged from the organisation, service improvement will inevitably drop off, but if wellbeing is prioritised, patient care will be safer and of higher quality and continual service improvement will occur.	Not specifically mentioned at present	Include in **Goal 2** Optimise organisational culture, to enable high quality clinical care (linked to Organisational Development Framework)	DWoD
ACTION 13	National work to be undertaken to develop a toolkit that organisations can use to gain assurance of an effective Quality Management System.				
ACTION 14	Health organisations to engage their workforce with the quality agenda and empower all to get involved to help make the NHS in Wales a quality-led system.	Duty of Quality	Not specifically mentioned at present	Include in **Goal 1** Dimensions of Clinical Quality - 1a Safety	DoNM
ACTION 14		We need to assure that any data obtained, be it through clinical audit, peer review or errors in healthcare, is used to drive change for the better.	Not specifically mentioned at present	Include in **Goal 5** Develop Excellent Information and Intelligence Systems, to Enable High Quality Clinical Care	DPH

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ACTION 15	A Quality and Safety programme will be established to drive forward the national actions set out in this Framework. This programme will be overseen by a new Quality and Safety Board facilitated by an NHS Executive function. This board will work to drive the quality and safety agenda and be led in partnership with the NHS. It will have a multi-disciplinary approach with participation from different professional groups.	Duty of Quality	Not specifically mentioned at present	Include in **Goal 1** Dimensions of Clinical Quality - 1a Safety	DoNM

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