Patient Experience, Quality and Safety Committee

Thu 07 October 2021, 14:45 - 17:00

via Teams

Agenda

14:45 - 14:45
0 min

1. PRELIMINARY MATTERS

PEQS_Agenda_07Oct21_Final.pdf (2 pages)

1.1. Welcome and Apologies

1.2. Declarations of Interest

1.3. Action Log (brought forward from the former Experience, Quality and Safety Committee)

PEQS_Item_1.3_PEQS Action Log_7Oct 21.pdf (2 pages)

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2. ITEMS FOR APPROVAL / RATIFICIATION / DECISION

There are not items for inclusion in this secton

14:45 - 14:45
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3. ITEMS FOR DISCUSSION

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

PEQS_Item_3.1_DPCCMH Quality report for PEQS.pdf (32 pages)

3.2. Putting Things Right, Compensation and Claims Report

PEQS_Item_3.2 PTR - Concerns Paper 24092021.pdf (12 pages)
PEQS_Item_3.2a_Appendix 1 - Improvement Paan PtR Agust 2021.pdf (3 pages)
PEQS_Item_3.2b_Appendix 2 - Audit Report Qtr 1 2021-2022.pdf (9 pages)
PEQs_Item_3.2c_Appendix 3 - Patient Safety Incident Huddle Guide.pdf (7 pages)
PEQS_Item_3.2d_Appendix 4 - Doctrina Summer 2021.pdf (4 pages)
PEQS_Item_3.2e_Appendix 5 PTHB Complaints Return 30-07-2021.pdf (6 pages)
PEQS_Item_3.2f_Appendix 6 - GMPI Claims.pdf (1 pages)
PEQS_Item_3.2g_PSOW - Powys THB.pdf (7 pages)

3.3. Regulatory Inspections Report

PEQS_Item_3.3 Committee_Regulatory Inspections Report 24092021.pdf (8 pages)
PEQS_Item_3.3a_Appendix 1 HIW Quality Check Clywedog Ward Llandod 3 month plan accepted.pdf (1 pages)
PEQS_Item_3.3b_Appendix 2 - 20210920Bronllys (Felindre)-EN.pdf (43 pages)
PEQS_Item_3.3ci_Appendix 3a - 20210616ystradgynlaisdentalen.pdf (8 pages)
PEQS_Item_3.3cii_Appendix 3b - 20210803MyDentistWelshpool-EN.pdf (13 pages)
PEQS_Item_3.3ciii_Appendix 3c - 20210816MyDentistNewtown-EN.pdf (9 pages)
PEQS_Item_3.3di_Appendix 4a - 20175 - WAST local review - HIW - covering letter.pdf (3 pages)
PEQS_Item_3.3dii_Appendix 4b - HIW - WAST Local Review 2021for FA comments.pdf (62 pages)
PEQS_Item_3.3e_Appendix 5 - 210810 Cottage View Inspection Report.pdf (11 pages)
PEQS_Item_3.3f_Appendix 6 - HIW to CEO Chairs NHS Wales - Mat Servs Nat Review Phase 2 _.pdf (1 pages)

PEQS_Item_3.3g_Appendix 7 -HSCRR Report Recommendations Dashboard.pdf (1 pages)

3.4. Infection Prevention and Control Report

PEQS_Item_3.4_ IPC Update_07102021.pdf (10 pages)
PEQS_Item_3.4a_Appendix 1 IPC Annual Report_October 2021.pdf (17 pages)
PEQS_Item_3.4b_IPC update_Appendix 2_A E ANNUAL REPORT PTHB.docx issue july 21.pdf (11 pages)
PEQS_Item_3.4c_IPC Update_App 3_AED Report ODG Actions and Improvement Plan Aug 2021.pdf (6 pages)

3.5. Maternity Assurance Report

PEQS_Item_3.5_Maternity Assurance and Improvement plan update.pdf (11 pages)
PEQS_Item_3.5a_Appendix 1 ORAC-Sep_2021_Ockenden_Report_Actions_Completed_To_Date-vF.pdf (34 pages)

3.6. Commissioning Escalation Report

PEQS_Item_3.6_Commissioning Escalation Report PEQS.pdf (8 pages)

3.7. Clinical Quality Framework: Goal 5, Intelligence

PEQS_Item_3.7 PEQS_07Oct21_Clinical Quality Framework Goal 5 Intelligence.pdf (4 pages)

3.8. Committee Workplan 2021/22

PEQS_Item_3.8_Committee_Work Programme_2021-22_Final.pdf (5 pages)

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4. ITEMS FOR INFORMATION

4.1. Approved Minutes of the Experience, Quality and Safety Committee meeting held 15 July 2021

PEQS_Item_4.1_EQS_confirmed Minutes_15 July 2021.pdf (14 pages)

4.2. Patient Experience, Quality & Safety Committee Terms of Reference, approved by Board 29 September 2021

PEQS_Item_4.2_Patient Experience Quality & Safety Committee_ToR_Sept21_Final.pdf (11 pages)

4.3. Audit Wales Review: WHSSC Governance Arrangements and WHSSC Management Response

PEQS_Item_4.3a_WHSSC-Eng.pdf (32 pages)
PEQS_Item_4.3b_WHSSC mgmt response.pdf (16 pages)

4.4. WHSSC Quality Patient Safety Committee Summary from meeting on 10 August 2021

PEQS_Item_4.4_WHSSC QPS Chair's Report 10Aug21.pdf (10 pages)

4.5. Quality and Engagement Act Implementation Programme Summer Newsletter

PEQS_Item_4.5_Q&E Act Summer 2021 Newsletter (English).pdf (5 pages)

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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 Next Meeting:

2 December 2021 at 14:00 via Teams

POWYS TEACHING HEALTH BOARD
PATIENT EXPERIENCE, QUALITY & SAFETY COMMITTEE

07 OCTOBER 2021,
14.45 – 17.00
TO BE HELD VIRTUALLY VIA MICROSOFT TEAMS

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

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	Action Log (brought forward from the former Experience, Quality and Safety Committee)	Attached	Chair
2	**ITEMS FOR APPROVAL/RATIFICATION/DECISION**		
	There are no items for inclusion in this section		
3	**ITEMS FOR DISCUSSION**		
3.1	Integrated Quality Report: Directorate of Primary, Community Care and Mental Health	Attached	Director of Primary, Community Care and Mental Health
3.2	Putting Things Right, Compensation and Claims Report	Attached	Director of Nursing and Midwifery
3.3	Regulatory Inspections Report	Attached	Director of Nursing and Midwifery
3.4	Infection Prevention and Control Report	Attached	Director of Nursing and Midwifery
3.5	Maternity Assurance Report	Attached	Director of Nursing and Midwifery
3.6	Commissioning Escalation Report	Attached	Director of Nursing and Midwifery
3.7	Clinical Quality Framework: Goal 5, Intelligence	Attached	Director of Public Health
3.8	Committee Workplan 2021/22	Attached	Board Secretary
4	**ITEMS FOR INFORMATION**		
4.1	Approved Minutes of the Experience, Quality & Safety Committee meeting held 15th July 2021		
4.2	Patient Experience, Quality & Safety Committee Terms of Reference, approved by Board 29 September 2021		
4.3	Audit Wales Review: WHSSC Governance Arrangements and WHSSC Management Response		
4.4	WHSSC Quality Patient Safety Committee Summary from meeting on 10 August 2021		
4.5	Quality and Engagement Act Implementation Programme Summer Newsletter		

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: • 02 December 2021 at 14.00, via Microsoft Teams		

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

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

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

Key:

Completed
Not yet due
Due
Overdue
Transferred

PATIENT EXPERIENCE, QUALITY & SAFETY COMMITTEE

ACTION LOG October 2021

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Minute	Meeting Date	Action	Responsible	Progress Position	Completed
ACTIONS TRANSFERRED TO PEQS COMMITTEE FROM FORMER EQS COMMITTEE					
EQS/19/76 Research and Development & Innovation Update	3 December 2019	The Research and Development and Innovation Update report was requested to be strengthened and taken forward in conjunction with the Clinical Quality Framework.	Medical Director	Scheduled within the PEQS Committee's workplan for 2021/22	
EQS/19/89 Follow on from EQS/19/54 (IPC Training)	4 February 2020	Information regarding how PTHB receive assurance that visiting clinicians are compliant with training will be circulated with Committee Members.	Medical Director and Director of Workforce, OD and Support Services	Scheduled within the PEQS Committee's workplan for 2021/22	
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.	
EQS/21/37 Clinical Audit Programme Report	3 June 2021	Update on Falls Audit to be included within report of DPCCMH	Director of Primary, Community Care and MH	This audit to be completed in Q2 after which an update will be provided by DPCCMH. Scheduled within	

				the PEQS Committee's workplan for 2021/22	
IC-EQS/21/24	15 July 2021	An update on the national working taking place on CAHMS to be provided	Director of Primary, Community Care and MH	Scheduled within the PEQS Committee's workplan for 2021/22	

Agenda item: 3.1

PATIENT EXPERIENCE, QUALITY & SAFETY COMMITTEE	07 October 2021
Subject:	**Quality Report for Q1 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 (DPCCMH)
Prepared by:	Louise Turner, Assistant Director Women and Childrens Service Group (W&C) Kate Evans, Women and Children Risk Governance Lead Jason Crowl, Assistant Director Community Services Group (CSG) Lynda Mathias, Lead Clinician Quality and Safety, Community Services Group Sue Pearce Head of Nursing Community Service Group Joy Garfitt, Assistant Director Mental Health and Learning Disabilities (MHLD) Ruth Derrick, Head of Nursing, Quality and Safety Mental Health
Other Committees and meetings considered at:	Respective service group reports were considered at each Service Groups senior teams whilst each report was considered at DPCCMH Directorate Management Team - 17th August 2021. Executive Committee 22nd September

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 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 of April to June 2021.

This report is the first report developed directly by the Service Groups and Directorate and follows 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 this important area of work.

Further work will continue to develop the scope of this reports working closely with colleagues across PTHB including the Quality and Safety team but also the new Assistant Director of Performance. A focus will be on consistency of format and presentation, where applicable, but also detailed trend analysis and any potential for benchmarking

Recommendation:

The Committee is asked to discuss and note the contents of this report including the planned work to scope additional metrics relating to quality and safety in specific areas.

Approval/Ratification/Decision	Discussion	Information
✗	✓	✗

DETAILED BACKGROUND AND ASSESSMENT:

This report consolidates information across these three groups for the period of April to June 2021.

This report is the first report developed directly by the Service Groups and Directorate and follows on from reports from each Group to the Committee earlier in 2021/22 which outlined the mechanisms within the groups to monitor and manage this important area of work.

Further work will continue to develop the scope of this reports working closely with colleagues across PTHB.

Each service group reported at the Directorate Management Team (DMT) 17th August 2021 and this paper consolidates these reports under the remit of the DPCCMH.

More detailed documentation and appendices was provided within the DMT papers to inform the consideration and review of the papers. For the purposes of this committee report, in line with appropriate governance rules and reporting to public facing committees these elements have been summarised.

WOMEN AND CHILDRENS SERVICE GROUP

This paper provides a summary of patient experience and concerns, including complaints, serious incidents from within the women and children portfolio of service groups and performance analysis of key metrics for the quarter.

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 1 analysis and learning and further developments.

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 Compliment to the Flying Start Welshpool Health Visiting (HV) team:

"Whilst I know I'm coping better and making it through, when I got off the phone today it was a clear reminder of how much more buoyant I feel after your advice, encouragement and direction. I just want to say I owe an

incredible amount to you. We discussed my call for help back in October and you said you were glad I felt I could ring. I'd like to say that I'm eternally grateful for the response! I got to my call. It's not always a case that people don't ask for help, sometimes they do but it's not everyone or every team that takes action. I wish commissioners could read real life stories and see what matters and not look at data as the bee all and end all. If I had not lived within the flying start area I really don't know what might have become of our family unit. I class us as average and so often that means you get lost in a hole. I know you must have some very challenging cases to deal with but you saw our needs as equal and gave the time, compassion and input needed to help steer us through some really uncertain and difficult times. The role you played saved us from a longer lasting crisis and you are still equipping me with the tools, strength and courage to continue to make our way through the challenging days and ensuring ….. has stability".

1.2 Other Compliments/Examples of Good Practice

During April to June 2021, a total of 23 compliments registered have been received from patients, relatives, carers and other health services in Powys Teaching Health Board (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.

The compliments consisted of expressions of thanks for services, care and treatment provided and included thank you cards. As is often the case, compliments are wide ranging and some are not solely or specifically for the patient experience of W&C services. Compliments received have acknowledged how staff assisted patients in the community, such as the swift provision of replacement hearing aids, supporting a family member whilst an inpatient, service from minor injuries and end of life care describing the services as prompt, efficient and caring. Maternity Services are looking at 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. Childrens Community Nursing (CCN), Paediatric Continence Services and School Nursing (SN) also received a certificate of appreciation at a recent award ceremony.

2.0 Women and Childrens Service Group (W&C) Analysis

As at 10am on the 14th June 2021 PTHB moved from the old Datix system to the new Once for Wales Concerns Management System (OFWCMS). Unfortunately, the new system does not allow information to be able to be drawn out and we are awaiting new tools to enable data extraction during this transitional period whilst we change systems.

Work is on-going to ensure all staff within the W&C are aware of the recent changes to Nationally Reportable Patient Safety Incidents (PSI) and understanding what should be reported to the Delivery Unit.

3.0 Formal Concerns (Complaints) Received, Themes and Response Times

Data extraction and analysis of complaints, themes and response times is also affected by the move from Datix to the Once for Wales Concerns Management System (OFWCMS) and is not currently available during this period of transition.

4.0 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 was less than 5 SI in W&C group in this reporting period. Comprehensive plans are in place for oversight within a multi-disciplinary forum.

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 and progression of shared learning has been reported through the Summer Welsh Government Maternity and Neonatal performance review with Welsh Government (July 2021)

5.0 Formal Concerns Summary Position

The following Quarter 1 2021/22 data, shows the number of W&C concerns received:

Specialty	No. of Concerns
Midwifery	0
Health Visiting	<5
Community Paediatrics	<5

An emerging theme arising from W&C concerns is related to treatment plans and referral pathways for HV 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.

6.0 Incident Reporting

6.1 Incident Reporting Data

The following data demonstrates how many incidents were reported in W&C in Quarter 1 2021/22 from available local data and a comparison to Q4 2020/21. There were 116 incidents reported in April to June 2021 from local trackers.

Service	No of Incidents Quarter 4 2020/21	No of Incidents Quarter 1 2021/22
Midwifery	78	81
School Nursing	5	9
Childrens Nursing	5	15
Health Visiting	<5	<5
Physiotherapy	0	<5
Childrens Services Safeguarding	0	<5
Sexual Health	<5	0
TOTAL	**91**	**116**

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 SN 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 increase in incidents from quarter 4 2020/21 to quarter 1 2021/22. This is due to focused activity to promote incident reporting in this area.

6.2 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:

6.2.1 Transfers: Transfer of Care District General Hospital – Quarterly total is 15

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 and second stage of labour which were for delay in progress in labour. We also transferred for fetal distress, possible scar rupture, breech presentation and labour that was not appropriate in a midwife led setting as the woman was consultant led care. Following birth, we had transfers for identified 3rd degree perineal tears which required consultant obstetrician repair and post-partum haemorrhage.

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.

6.2.2 Neonatal Admissions: Admission to DGH of a baby – Quarterly total is 12

Neonatal admissions were for concerns over jaundice, neonatal infection and when an infant is identified as small for gestational age and required neonatal review.

6.2.3 MARF (Multi-Agency Referral Forms) Safeguarding –Quarterly total is 21

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.

The themes remain static with transfers, neonatal admissions and MARFS remaining the top 3. Transfers were for same reasons of meconium stained liquor, fetal distress, delay in first stage of labour, delay in second stage of labour and 3rd degree tear. Neonatal admissions were for Jaundice and weight loss. MARFS submitted highlighted no concerns from Safeguarding and continue to work well as a highlight mechanism between services and safeguarding.

7.0 HIW Regulatory Tracker Progress

As a result of the National Maternity Healthcare Inspection report, the Powys directly managed maternity service has been focusing on the 27 priority recommendations in line with the all Wales Maternity vision and renewal priorities as part of the COVID19 recovery plan. A key priority has been Sustainable workforce including staff wellbeing, and the additional 2.4WTE Newly Qualified Midwives through Midwifery Streamlining is a positive step in supporting the sustainable workforce and these posts are being supported with a robust all Wales Preceptorship Programme. Funding has also been received through additional resources for Mental Health which has enabled the appointment of a Perinatal Mental Health Specialist Midwife. Charitable funding has also enabled the appointment of 2-year fixed term contract for a Research Midwife to build and grow capacity for cross cutting research as part of the Women and Children's Renewal priorities. Additional Clinical Supervisor of Midwives resource is being considered as an additional support mechanism for the ongoing support for the clinical services. With regards to Digital Maternity Cymru, , once the Welsh Government scoping paper has been approved the PTHB are expecting Welsh Government resource for implementation including the support of a Digital Midwife to help support with the implementation of a single maternity dashboard for Powys and this work will need support of the PTHB Digital Transformation team.

The Welshpool Birth Pool installation and refurbishment was successfully installed in September 2021 with a formal launch planned for October. The Powys Maternity Improvement Plan includes a focus on profiling the birth options through Powys Birth Centre services and will further promote the availability of waterbirth options. HIW highlighted the need for modernisation of Llanidloes and Knighton Birth Centre environments and plans are currently in development to present to the Health Board Capital Control Group in October. In regards to ongoing review for Maternity services and follow up with HIW, recent correspondence has been received to acknowledge that satisfactory responses were received from each Health Board for the improvement plans against the self-assessment of the National recommendations and the position for phase two part of the review has been reconsidered alongside HIW risk-based inspection and reviews programme for 2021-22. The Powys Maternity Improvement plan will continue to be maintained and progressed in readiness for the follow up in 2022.

8.0 Current Quality Performance Metrics

8.1 W&C Performance Data

W&C Performance Data	April 2021	May 2021	June 2021
Number of Bookings - Maternity	110	75	77
Number of women birthing – Powys	23	22	23
Number of elective caesarean section – Out of County	<5	<5	<5
Number of emergency caesarean section - Out of County	7	<5	<5
Number of Escalations - AMBER-Maternity	0	0	0
Number of Escalations - RED-Maternity	0	0	0
Paediatric Physiotherapy -Number waiting > 14 weeks	0	0	0
Paediatric Occupational Therapy - Number waiting > 14 weeks	<5	0	0

8.2 Maternity

The quality metrics for Maternity services with a key focus during Quarter 1 2021/22 have 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. 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 1, PTHB had no Amber or Red escalations which means our staffing to women (especially needing care in labour) was at safe levels. All periods of escalation for any Amber or Red for Maternity services are reviewing with no episodes during Quarter 1 in comparison to less than 5 episodes of RED periods in Quarter 4 2020/2021 which was related to availability of staff and high intrapartum acuity.

A separate report is scheduled for this Committee meeting relating to Maternity Assurance and Improvement Plan which provides additional information relating to maternity services within PTHB.

8.3 Health Visiting

Healthy Child Wales Programme (HCWP) full delivery of the programme utilises a range of contact methods. The core contacts are recorded on the Child Health System (CHS) and monthly reports reviewed for performance. Welsh Government are due to re-instate publication of the national statistics and following their analysis will write to Health Boards with any queries regarding delivery and uptake. 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. This is anticipated for completion in the following timescales: Quarter 1 data by end of September, Quarter 2 end of October.

8.4 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.

8.5 Neurodevelopment (ND) Service

The service model is under review and development. Referrals into the service have increased during June and July 2021. 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. A detailed paper on the ND service was provided to the Delivery and Performance Committee 2nd September.

8.6 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'.

8.7 Analysis Quarter 1 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 1 we can see that there were no episodes of RED escalation in maternity service. The number of SI was less than 5. 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.

8.8 Metrics to be Developed – by March 2021/22

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

- 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.

9.0 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.

The Quarter 1 June W&C presentation meeting focused on a detailed presentation for referrals into Physiotherapy for early intervention for premature babies. This included the value of an MDT approach for discharge plans for babies in neonatal services in line with National Institute for Health and Care Excellence (NICE) guidance for Premature babies and long-term plans and a summary clinical audit poster evaluating the uptake of Test and Post Online Sexual Health screening which was implemented for Powys in June 2021. An improvement plan from the Midwives and HV survey of Pelvic Health knowledge and skills has been developed from learning from a concern and training with Women's Health and Continence team is being planned through the Health and Care Academy. The quarterly W&C audit feedback meetings are scheduled for December 2021 and March 2022 with some reflection on widen the scope of the showcasing shared learning to increase the attendance to the audit presentation meetings and widen the cascade of learning to frontline services.

In Quarter 1, the annual Perinatal & Child Death Review was held with the objectives of the group to Monitor and review perinatal & child deaths for Powys resident on a monthly rather than annual basis in collaboration with the relevant commissioned services such as DGH Obstetric services, DGH Paediatric services and All Wales Paediatric Network. There were 5 Perinatal Cases for Powys Residents, 1 Expected Child Death and 2 cases of Unexpected Deaths (reviewed via PRUDIC process) considered as part of the audit presentation event. The outcomes of the annual event is being reported through the Safeguarding Strategic forum (Quarter 2) to highlight the data analysis, themes and trends and evidence the learning from the monthly reviews. The report provides a summary of 2021/2022 recommendations from the learning event which includes some of the key actions:

- Review the acceptance of referral rates for smoking cessation. Review WPAS referral data on WPAS.
- Audit Compliance with the Was Not Brought/Did not attend policy
- Compliance with safeguarding supervision.
- Confirmation of 2021 Annual CARIS event
- Confirmation of arrangements for CONI update for Powys Midwives
- Exploring staff support and supervision arrangements for those providing bereavement support

The outcomes of the annual event are being reported through the Safeguarding Strategic forum (Q2) to highlight the data analysis, themes and trends and evidence the learning from the monthly reviews.

The W&C Bereavement forum is supporting improved pathways, family support and staff bereavement training. The Powys Perinatal and Child Death review monthly meetings have continued during Q1 to ensure focused data, intelligence and analysis, to understand the quality and standards of care provided and commissioned by Powys Teaching Health Board.

10.0 The 'So what' Question? What Has the Service Done Differently as a Result of Learning

The summary of learning is being presented through a 'You Said, We Did' format for the W&C People's Experience report with the following examples having been reported to August 2021 PTHB Patient Experience Steering Group (PESG):

- The Transfers times and arrangements from Midwifery care has been added in greater detail to Welcome to Midwifery leaflet and will be used as part of the Maternity section update for the PTHB website developments
- Learning from complaints – highlights what actions the health visiting service is doing to support better communication
- Neurodevelopmental Service – work to progress additional resource through project work supporting in renewal priorities delivery to reduce waiting times.
- Requests from families for support to learn Makaton and Makaton signing for babies' group – Makaton can be defined as language that uses signs and symbols and speech to enable people to communicate. This has been successfully delivered virtually with signs now regularly being posted via Social Media.
- Paediatric Physiotherapy referrals has been changed to contact the patient as soon as possible, usually making a phone call to book the initial appointment and booking in as soon as possible. Having that first conversation over the phone with the patient/'s family has been reported to helps to put them at ease and reassure them they are important and we are listening and responding to their request for help as soon as we are able.
- Powys families have reported that they are feeling they are missing out on face to face antenatal class so provision so a programme of parental support using the Solihull Antenatal Education package is being further developed with Midwifery and Health Visiting teams are tailoring the Antenatal Education package to meet the needs of our families to be launched in September 2021

11.0 Next Steps

- 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
- 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.

COMMUNITY SERVICES GROUP

Further to reports to the Quality Governance Group July 2021 and Experience, Quality and Safety Committee July 2021 outlining the quality and safety processes within the Community Services Group, a range of priority quality metrics have been developed.

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 Group
- 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

Group Assurance

Community Services Group Quality Governance and Patient Safety Structure (QGPSS) has been in place since April 2021.

The Group has designed its structure with the support of the Director of Nursing and Midwifery, and by sharing best practice across the Directorate, aligning with the Clinical Quality Framework to help achieve the following outcomes:

- People who receive care, their families and the people who provide it, can identify where change is needed and take action to shape change
- Culture and practice that promotes and facilitates continuous improvement by listening and learning
- Underpinning the delivery of safe, effective, efficient, equitable, timely and person-centred care
- Help to consolidate an honest, just and open culture, and actively support the duty of candour
- Increase the level of assurance for all stakeholders through its implementation, with the aim of increasing public trust and confidence

- Articulate the expectations of the Board in relation to quality and patient safety
- Better inform and shape the Health Board's Annual Quality Statement by ensuring the work of established quality improvement working groups, demonstrate a learning and quality improvement focus
- Improve the opportunity for the provision of safe care through clear lines of communication and reporting from ward to Board and Board to ward
- Support clarity in roles, responsibilities and lines of reporting

This report provides an update on key quality indicators outlined in the Group Governance structure.

Patient Quality and Experience group

The group continues to hold bi monthly formal Quality and Patient Experience Meetings where the senior team review the risk register, quality reports, trends, harms, external audits and oversees the work of the scrutiny groups. This group acts as the main formal forum for monitoring quality within the Service group.

To strengthen the clinical oversight and liaison with corporate Clinical Directorates the meeting is also attended in rotation by the Deputy Director of Nursing, Assistant Director of Therapies and the Assistant Medical Director.

Current Community Services Group Reporting Arrangements

Quality Monitoring	Report Type	Report Through
Healthcare Associated Infections (HCAI)	Infection Prevention & Control (IPC) Report for IPC Group and Decontamination Group	Patient Quality and Experience Group Quarterly Senior Management Meeting Weekly Operations Meeting by exception
Patient Experience	4 Quadrant Report for Patient Experience group	
Pressure Ulcers	Pressure Ulcer scrutiny Panel	
Falls	Serious Incident review Group	
Serious Incidents	Serious Incident Review group	

Clinical Audit	Group Clinical Audit Improvement Meeting	

A monthly highlight report is submitted to the Directorate Management team outlining key issues and there are weekly opportunities to raise quality and governance issues.

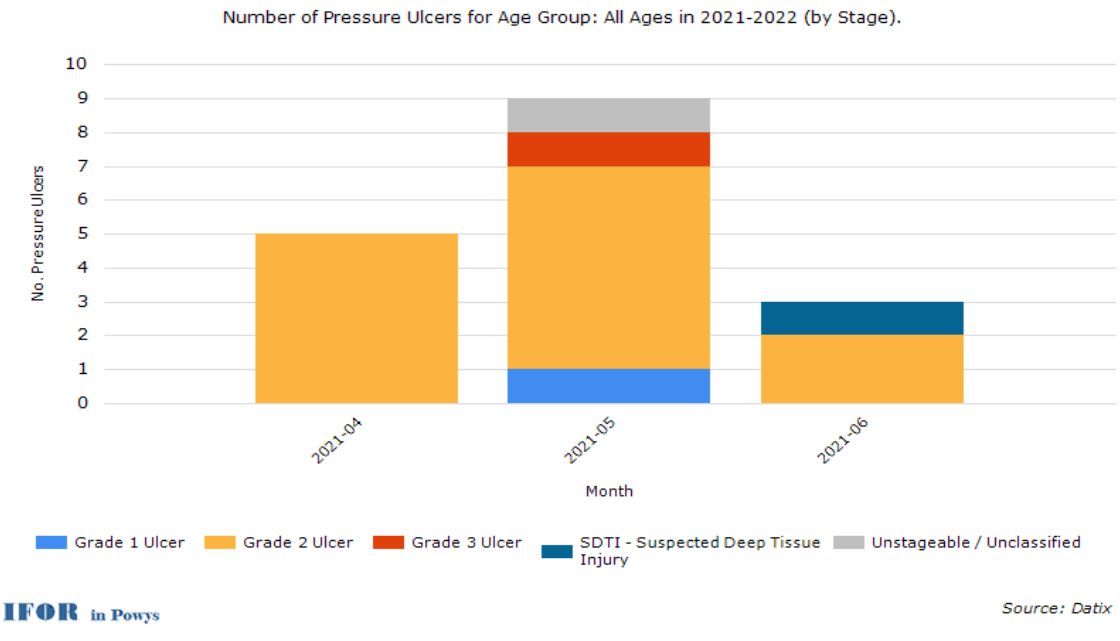
Hospital Acquired Pressure Ulcers

A combined total of 34 pressure ulcers were recorded from in-hospital and from the Community between April to June 2021.

The International Pressure Ulcer Classification System used by the National Pressure Ulcer Advisory Panel (NPUAP) and European Pressure Ulcer Advisory Panel (EPUAP) identifies the following stages of pressure ulcers:

Category/Stage I: Non-blanchable Erythema
Category/Stage II: Partial Thickness Skin Loss
Category/Stage III: Full Thickness Skin Loss
Category/Stage IV: Full Thickness Tissue Loss
Unstageable: Depth Unknown
Suspected Deep Tissue Injury: Depth Unknown

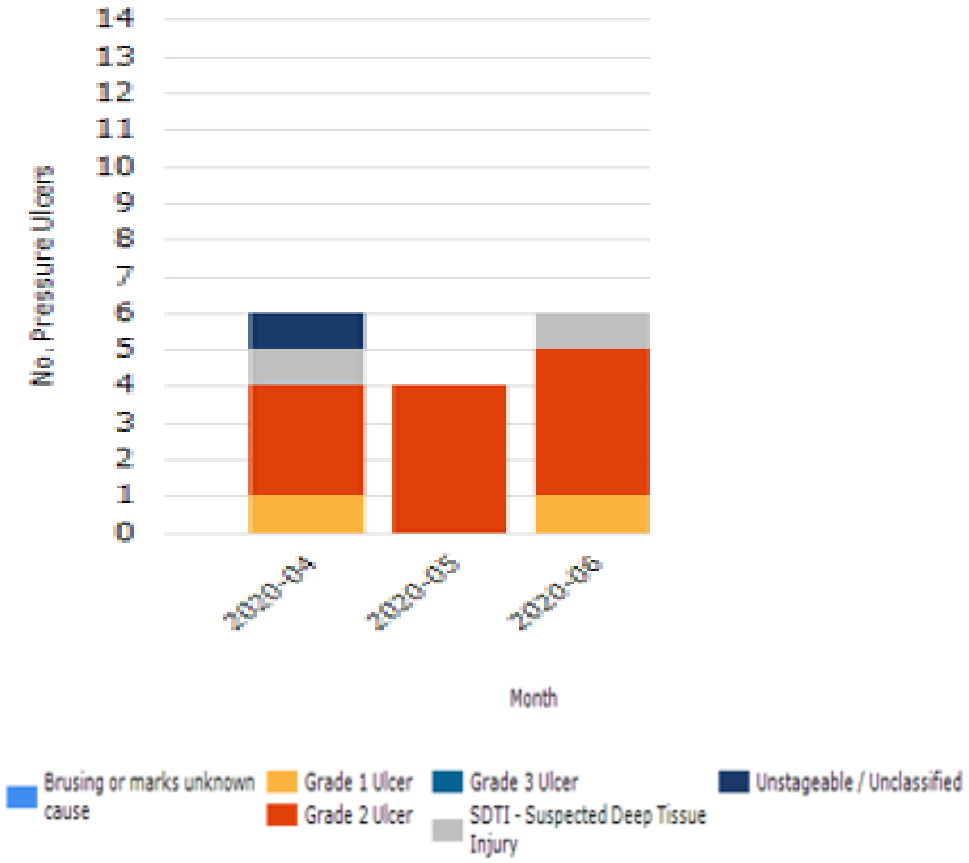
In-hospital incidence of pressure ulcers by Stage

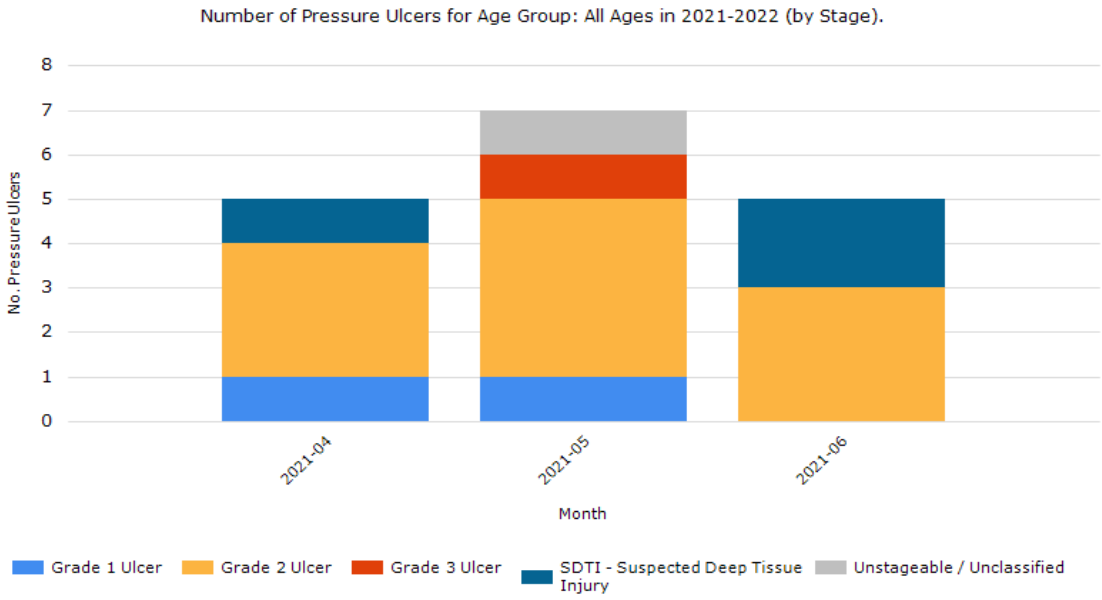


A total of 17 pressure ulcers were reported from the in-hospital setting between April and June 2021 of which over three-quarters were categorised as Stage II pressure ulcers (76%, n=13). This was followed by one at Stage

1, Stage III, Unstageable and Suspected Deep Tissue Injury (SDTI) respectively.

A 12-month comparison to the same period of April to June 2020 reveals that a similar number were reported (n=16), that the majority were Stage II pressure ulcers (68.7%) and with similar numbers in other stages with two Stage I, one Unstageable and two SDTI. Please note the difference in legend to Stages in both charts when comparing.





IFOR in Powys

Source: Datix

A total of 17 pressure ulcers were also reported from the Community setting between April and June 2021 of which again, the majority were Stage II pressure ulcers (58.8% n=10) followed by three SDTI, two Stage I, and one at Stage III and Unstageable respectively.

The data does not provide a direct comparison for the Community for 2020/21 however manual extraction of the data to provide a 12-month comparison of the same period of April to June 2020 reveals that a similar number were reported (n=16), that the majority were Stage II pressure ulcers (50% n=8) and with similar numbers in other stages with three Stage I and Stage III respectively and one Stage VI and Unstageable respectively.

Number of Pressure Ulcers for Age Group: All Ages in 2020-2021 (by Stage).

Pressure Damage	2020-04	2020-05	2020-06
Grade 1 Ulcer	2	1	
Grade 2 Ulcer	3	1	4
Grade 3 Ulcer		1	2
Grade 4 Ulcer			1
SDTI - Suspected Deep Tissue Injury			
Unstageable / Unclassified			1
Total	5	3	8

The above data provided does not include analysis of which pressure ulcers may have been avoidable and which may have been unavoidable. The Pressure Ulcer Scrutiny Panel reviews each case with the ward manager and tissue viability nurse specialist to determine causation, management and if the pressure ulcer was preventable. The Pressure Ulcer Scrutiny Group provides assurance to the service group by monitoring trends, incidence and training needs, including the sharing of learning across all inpatient wards.

PTHB intention is to reduce the risk of avoidable pressure damage by the implementation of timely, targeted, appropriate interventions for all those at risk of pressure damage. The PTHB Pressure Damage Scrutiny Panel is well-established and provides scrutiny of avoidable pressure damage as a result of NHS funded care, with the aim to determine causal factors, lessons to be learnt and to inform cases for redress.

Inpatient Falls

Over the period April to June 2021, a total of 76 falls were reported from in-patient settings. The lower figure reported for June can be explained by the change in reporting system to the 'Once for Wales Concerns Management System' (OFWCMS) from 14th June, therefore this figure will be higher in reality than reported here.

In-patient Falls April – June 2021

2021-04	2021-05	2021-06	Unique Period Total
29	34	13	**76**

In-patient Falls April – June 2020

2020-04	2020-05	2020-06	Unique Period Total
31	26	22	**79**

A comparison of figures from the same period in 2020 reveals similar numbers over the 3-month period, noting that June 2021 may be affected by the move to the OFWCMS from 14th June. There is a potential impact with the implementation of the new OFWCMS which has been escalated to the Governance Team.

Multiple Fallers

The service group monitors fallers and distinguishes multiple fallers. It is important to note that the total number of falls may account for one patient falling more than once or be classed as a 'multiple faller'. 8 fallers have fallen twice, 5 fallers have fallen three times and less than 5 fallers have fallen four times. The assessment of patients who have fallen more than once identified the increased level of risk associated with comorbidities and poor cognition. Strategies including cohorting and 'bay watch' are used to support patients who may be at risk of multiple falls. These include the use of enhanced care support with rostering additional staff. Assurance is provided by the review of individual cases at the Falls Scrutiny Panel.

Severity of Falls

Number of In-Patient Falls by Severity in 2021-2022

Location	Total by Severity
Severity of Fall	
(1) No Injury	10
(2) Very Low	16
(3) Low	38
(4) Moderate	11
(5) Severe	1
Total 2021-2022	76

The number of in-patient falls by severity provides the total to date for FY2021-2022 (i.e. April to June 2021). The majority of in-patient falls are graded as either Low injury (50%, n=16) or No Injury/Very Low injury (34%, n=26).

Despite there being a smaller number of falls graded as Moderate and Severe, Powys Teaching Health Board (PTHB) intention is to reduce the risk of unnecessary harm from falls through the implementation of timely, targeted and appropriate interventions for all those at risk of falls. The PTHB In-Patient Falls Prevention Scrutiny Panel which is chaired by the Head of Nursing has recently been established and Terms of Reference agreed. It provides scrutiny of harm caused by any falls occurring within a PTHB in-patient hospital setting. The Panel meets bi-monthly with the aim to determine the causal factors and lessons to be learnt, as well as to promote further awareness, education and improvement in preventing in-patient falls in PTHB.

There is on-going work regarding how we share learning regarding falls. The concept of a rapid instant review of the incident by local and senior staff called a 'Hot Debrief' is being planned and will be introduced to the wards to ensure an interactive and structured team dialogue takes place either immediately or very shortly after a fall. We aim to ensure that the whole team learn from the experience and are able to reflect on what went well, identify team strengths or difficulties and consider ways to improve future performance.

The Professional Head of Nursing and Lead Clinician for Quality and Safety have joined the All Wales Inpatient Falls Network. The network first met on 30th March 2021, will meet quarterly and aims to review and analyse all available data and information in relation to inpatient falls resulting in inpatient hip fracture (IHF), cervical spine injury or inpatient death. The network will also establish pathways for post fall management.

Infection Prevention and Control (IPC) data

COVID positive cases are complex to report. Less than five in-patients have tested positive during the period April to June 2021, however none of these have been classed as a true new infection. After review by a Microbiologist they were felt to be a false positive given their history and lack of symptoms.

Clostridium difficile, also known as C. difficile or C. diff, must be reported to Public Health Wales. As this data involves small numbers developing a trend

analysis is not possible. The table below shows all cases that have occurred in Powys residents, located in Powys at the time of the sample either as in-patients or out of hospital.

Norovirus There have been no confirmed cases of Norovirus since April 21.

Catheter Associated Urinary Tract Infection (CAUTI) Patients with an indwelling urinary catheter, are more at risk of developing a urinary tract infection (UTI) in their bladder or kidneys. Many types of bacteria or fungi can cause a catheter-related Urinary Tract Infections. In the in-patient settings, the Continence team collate data on CAUTI as well as catheter numbers. Unfortunately, COVID has affected data gathering however this will improve for the next quarter as the Link Nurse forum becomes re-established. Data in the community is not collected as there is no reliable way of this being accurate - District Nurse's may not always be aware of CAUTI's and not everyone with a catheter sees a District Nurse. Data from the community captures the number of in-dwelling catheters and compliance with use of a catheter passport.

Pandemic work, and staff shortages in the IPC team, have meant that CAUTI prevention beyond what the Continence Team are doing, and the related Gram-Negative Bacteraemia prevention work that would be considered Business as Usual have been postponed. It has been identified as a risk within the IPC Team having been RAG rated 'red' in their work plan. Realistically they are not going to be able to start looking at the preventative work until Spring 2022.

Patient Experience Report
The CSG Patient Experience Quadrant for Q1 2021-2022 was reviewed at both the Service Group Management Team and the Directorate Management Team.

To support the Patient Experience Strategy and to demonstrate improvement and share learning, the four-quadrant approach has been revalidated by the Health Board as a mechanism to capture the patient experience activity, outcomes and to incorporate "You said, We did". The detail of this was discussed at the DMT. The aim of this approach is to list the key areas of learning from the real time, retrospective, proactive/reactive and balancing elements of the report. Patient experience remains a standing agenda point on the CSG Group meeting.

Updates on audits reported presented through Learning Group
The CSG Audit Feedback and Learning Sessions are chaired by the Head of Therapies and Health Sciences and were introduced on 27th April 2021 and meet every 6 weeks. There have been three sessions to date that have included:

- Occupational Therapy Notes Audit
- Safeguarding Audit on Consent

- Implementation of the Radiography Imaging Optimisation Team (RIOT)
- Endoscopy: Patient Satisfaction Audit 2021
- Referrals into Audiology
- Anti VEGF Intravitreal Treatment Audit
- Admission assessment/documentation in Brecon Hospital
- Podiatry Notes Audit
- MIU - patient triaging system
- SNAPP Audit

The next session is due 7th September.

The audit and feedback process comprise one or more cycles of establishing best practice criteria, measuring current practice, feeding back findings, implementing changes, and further monitoring. Learning and outcomes are discussed at the end of each presentation and if any change or improvement is required this is identified. Feedback to date has been positive and the group are finding the session beneficial and making them think about audits in their areas more.

The sessions are open to all within the CSG however work is required to support and encourage all clinical staff groups to attend sessions, to present and to share learning within their respective areas.

Health Inspectorate Wales (HIW) and Care Inspectorate Wales (CIW) inspections

No Healthcare Inspectorate Wales (HIW) or Care Inspectorate Wales (CIW) visits were conducted between April to July 2021 to facilities within the CSG.

The Annual Cottage View Quality of Care Review for 2020/21 was presented to the Quality Governance Group on 6th July 2021. The report provides an overview of the arrangements and services delivered in line with the Regulation and Inspection Social Care (Wales) (RISCA) Act 2016 and the Community Services Group (CSG) Governance and Safety Structure. Regulation 80 requires the Responsible Individual to demonstrate through an annual report they have put into place systems and processes to monitor the service in respect to quality and governance.

The paper outlines the systems and process that are in place and provides an overview of the 2020/2021 position.

The inspection undertaken in July identified the level of care was of a high standard. There were however a number of areas regarding the documents required for Statement of Purpose and Standard Operating Procedures which did not meet the required standard and required an immediate improvement action. This is being managed by the Care Home Management and the Responsible Individual roles who will liaise with CIW directly with the update documents.

Elective Waiting Times
The monitoring of quality for patients on a Referral to Treatment Times (RTT) waiting list is managed through a risk stratification process in line with the Surgical Services Forum Association Guidance. This ensures that waiting lists are clinically validated and the team are also working with the Welsh Government Risk Stratification Work Stream including communication with patients who are considered long waiters to offer support and advice for patients who are on the waiting list. Detailed reporting on RTT is provided through Delivery and Performance forum.

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.

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.

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.

Delayed Transfers of Care (DTOC)
DTOC reporting was stepped down in April 2020 with interim reporting measures introduced that were to temporarily replace DTOC's. This was required due to new Covid discharge guidance that emerged and because of this we do not have a comparative data set to use currently.

DTOC's will be stepped back up in October/November 2021 however we are awaiting confirmation from Welsh Government for this to happen.

Delays are largely contributed to a lack of domiciliary care in Powys which is a Welsh-wide issue due to the care market being severely depleted. We anticipate interim placements in care homes will absorb this but this does then cause the issue of having a large number of patients being placed in care homes and the potential for de-conditioning.

There is a recognition from the Welsh Government that despite Covid discharge guidelines being issued, the Discharge to Recover and Assess (D2RA) pathway in the community is not sufficient to support every patient needing this pathway and the current reporting delay system does not sufficiently capture the delay reasons and the issues local authorities and health are facing with community capacity.

Serious Incident Report, themes

- **Patient Safety Incidents**

To improve and facilitate management of Patient Safety Incidents (PSIs), particularly during the transition of systems, a local tracker records all PSI reported since 14th June and also any that remained open prior to this date. Of the 16 currently held, <5 remain open but are overdue. With the introduction of the new role of Lead Clinician for Quality and Safety who will co-ordinate the management and track PSIs more closely, it is anticipated that reports becoming overdue through administrative reasons will now be prevented.

The majority of PSIs reported are from Nursing and most are due to Falls or Pressure Damage which are investigated in scrutiny panels.

Service Area	Number of PSIs reported
Nursing	15 (94%)
Therapies	0
Planned Care	1 (6%)
Unscheduled Care	0
Total	**16**

- **Concerns**

The local tracker also records all Concerns submitted since 14th June and includes any outstanding Concerns transferred over prior to this date. Each Concern is investigated and where required departmental Action Plans are

devised to improve patient experience and service delivery and to also provide assurance to the complainant that their Concern has been taken seriously. Whilst over half are responded to within the due date there is still improvement required to ensure we provide a timely response to all Concerns raised. The Lead Clinician for Quality and Safety now co-ordinates the management and tracking of Concerns which will facilitate communication between the Quality and Safety team and the service areas / investigating officers who are required to draft the response.

Number of Concerns held on tracker	Response submitted on time or still in date	Response submitted late or now overdue
14	8 (57%)	6 (43%)

The majority of Concerns raised are from in-patients or relatives acting on their behalf. Following closure, each Concern is discussed in a scrutiny panel to monitor any emerging themes and identify any lessons that can be shared for shared learning, development and improvement.

Service Area	Number of Concerns received
MENTAL HEALTH	
Nursing	7 (50%)
Therapies	2 (14%)
Planned Care	4 (29%)
Unscheduled Care	1 (7%)
Total	**14**

- **Lessons learned**

Learning and Development is now embedded within the Patient Safety Incident, In-patient Falls and Pressure Damage Scrutiny Panels however further work is required to ensure it is shared widely across the Community Services Group and also across PTHB. Work now must concentrate on sharing information across all areas that include Concerns, Audit and Action Plans from investigation reports as well as consideration whether it should be shared across PTHB or whether local learning is sufficient and is not required to be shared widely.

Reports to Quality Governance Group in June and Experience and Quality Safety Committee in July 2021 outlined the mechanisms for monitoring quality and safety, the report outlines specific metrics for the Mental Health and Learning Disabilities (MHLD) service group.

Previous reports have focussed on 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. This reflects the progress of the service against the Mental Health (Wales) Measure 2010. This report builds on the CAF and opens up the indicators outside of the Mental Health Measure to consider other performance and quality components built into the MHLD services.

The MHLD CAF analysis describes the wider outcomes collected and monitored by the Health Board.

Commissioning Assurance Framework Highlights for the period

MH Measure: Part 1
Both Assessment and Intervention targets achieved in June 2021 (Target 80% within 28 days):

MH Measure: Part 2
Target achieved overall - 91.8%. North Adult and Older Adult Teams are reviewing and addressing the shortfalls in their Care & Treatment Plan (CTP completion).

MH Measure: Part 3
100% - No issues. There has been a total of 20 assessments conducted across Powys in the last 12-month period (July 2020–June 2021), an average of 1.66 assessments per month of those patients re-referred into mental health services.

Psychology
In March 2020 at the start of the Covid 19 pandemic, referrals into the Psychology service were around 9 per week. Less referrals are being received (average 2.5 for June 2021) compared to pre-pandemic levels. There were 5 breaches over 26 weeks as at 9/8/21. Some patients are awaiting face to face appointments, so their waiting time has extended due to their choice of contact. The breaches are continuing to fall due to the reductions in the time spent engaged in therapy. By reducing the time in therapy, more service users can be seen and the waiting time for others reduces. There is an issue with adding group contacts on Wales Patient Access Scheme (WPAS), hence some contacts on waiting lists have been seen, but group therapy sessions currently cannot be updated to take these waiters off waiting lists. The Information Team are currently trying to resolve this issue with national colleagues.

Delayed Transfer of Care (DTOC)

In line with the update by Community Service Group, formal reporting of DTOCs has been paused. A common delay will be the ability to transfer patients once Nursing/Residential homes are open to new residents and when the patients have been evidenced as not having Covid 19. The comparison of Powys' performance against all Wales figures has not been possible since Stats Wales suspended producing the updates in February 2020.

Background

A number of potential indicators have been considered with the aim of demonstrating a wide range of metrics that will illustrate how the performance activity supports quality governance. There will need to be review and evaluation as part of a developmental process. This is the starting point and builds on the CAF, which has been in place since 2017.

Period: April to June 2021

		Quarter Ending:		
Tier 1 targets and RTT	**Measure**	**Mar-21**	**Jun-21**	**Comment**
Timeliness of care and access to service	MH Measure Part 1 - Assessments (Target 80%)	92.80%	93.90%	Target achieved
	MH Measure Part 1 - Interventions (Target 80%)	81.10%	85.60%	Target achieved
	MH Measure Part 2 - CTP Completion (Target 90%)	91.40%	92.50%	Target achieved
	MH Measure Part 3 - Self Referral Patients sent their Outcome Assessments within 11 days (target 100%)	100%	100%	Target achieved
	Overall staff sickness levels for front-facing staff group (Ward Nursing) at quarter end/Rolling Sickness Rate at Quarter End	<5 WTE	6.7 WTE	The effect of C-19 isolating and illness is impacting upon general service sickness levels.

	Overall staff sickness levels at quarter end/Rolling Sickness Rate at Quarter End	4.45% / 5.37%	6.02% / 5.43%	Since the start of Q1, sickness within the MHLD service group has continued to rise – mainly attributed to isolating and C19
	Average % of DNA appointments for community-based services within the quarter/Total DNAs in Quarter - ADULT	9% / 69	12% / 90	The service continues to seek to reduce (Did Not Attend) DNA, specifically amongst Adult Mental Health clients-. We are actively exploring introducing a text reminder alert to patients and options are being investigated.
	Average % of DNA appointments for community-based services within the quarter/Total DNAs in Quarter - OLDER ADULT	2.4% / 23	2.8% / 27	The number/% of older adults who DNA remains low. This is because a carer or relative usually accompanies patients to appointments.
	Average % of DNA appointments for community-based services within the quarter/Total DNAs in Quarter - LEARNING DISABILITIES	8% / 9	6.8% / 9	In a similar way to Older Adults, most LD patients are accompanied to appointment, although the effect of isolating has increased Learning Disability (LD) DNA's during 21/22. It should be noted that most LD appointments in 21/22 were conducted in patients own homes due to C19.
	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) YTD	Although Delayed Transfer of Care (DTOC) numbers aren't currently reported to WG. The MHLD service group has continue to monitor DTOC. The vast majority of these DTOC are due to Social Care; allocation of a Social Worker or awaiting a package of care. This is impacting on patient flow and availability of Mental Health beds within Powys.
	WTE Bank/Agency Staffing - Ward Nursing	3.7/0.8 WTE	7.8/4.9 WTE	The 1st quarter 2021/22 has experienced an unprecedented level of bed occupancy and patient acuity requiring enhanced observation.
	WTE staff vacancies - Ward Nursing - RN/HCSW	-7.3/-3.8 WTE	-7.9/-7.8 WTE	Recruitment is underway regarding these vacancies.
Suitably skilled and	% of mandatory training that reaches the required health	Not available	74%	The Service continues to make progress towards achieving the 80% target.

qualified staff	board target level within the quarter			
	Percentage of staff who have an up to date PADR at the end of the Quarter	Not available	63%	This is an improvement on 20/21 achievement, and the service is focused on achieving the 80% target as a minimum.
Use of restrictive powers	Number of Patients discharged at Hospital Manager hearing and Tribunal during the Quarter	<5	<5	These are Patients discharged from a Tier 2 MH Review Tribunal. As a service we always seek the least restrictive means possible to provide treatment to patients, and this includes discharging patients from the Mental Health Act (MHA) when this is in their best interest. Although not reportable in this paper the number in June is lower than March position.
	Number of patients detained under the Mental Health Act during the quarter.	51	47	Numbers of patients detained and admitted to Powys MH beds remains higher than average for the service. Following a relatively low numbers of detentions over winter 20/21, it is likely that the impact of C19 lockdown is impacting on acuity of mental health symptoms.
	Number of uses of s136 Powys and the number of patients detained following an arrest under s136.	<5	6	The use of s136 powers (Police Powers to detain under the Mental Health Act) during Q1 Is within normal variation for Powys. On average, we expect the use of approx. 20-26 s136 powers p.a.
Patient Voice	Number of new qualifying people accepted in Advocacy services within the quarter	46	56	The number of patients eligible for advocacy receiving support from an Independent Mental Health Advocate (IMHA) is due to increases in Mental Health Act detentions in Q1 and bed occupancy.
	Total number of Qualifying patients currently in receipt of IMHA Services at the end of the Quarter	28	48	We are encouraged that the number of patients accepting advocacy services has increased in Q1.

Mental Health Service User and Carer Involvement Framework

Mental Health services have a service user carer involvement framework in place. The objective of the framework is to ensure that people using services are involved in decision making, and have the appropriate assistance from services, and those who support them, to be part of the selection of staff process and to meaningfully participate and contribute to service development work.

The Mental Health Planning and Development Partnership Board Sub-group, Engage to Change, is also working closely with the All Wales Mental Health and Wellbeing National Forum who are developing national guidance on coproduction in mental health services. Significant engagement has taken place with the Forum over the Summer of 2021, and it is anticipated that the completed guidance will be published by the Forum in December 2021. Following publication, PTHB's Engage to Change group will be developing a coproduction strategy for Powys mental health services.

Together for Mental Health Delivery Plan 2019 - 2022

Together for Mental Health Delivery Plan is in its final stages of delivery. It was delayed in being finalised and circulated due to the Covid-19 pandemic. The plan is aligned with the Together for Mental Health Strategy for Wales and this 10-year strategy, also in final stages, will shortly be evaluated for outcomes/impact. The plan has been widely consulted with local Powys partners and a final version of the plan has been aligned with local priorities across all partners in respect of mental health service delivery through the Mental Health Officer's Group, sitting within the governance of the Mental Health Partnership Board's remit. The Partnership Board will endorse the final plan and contribute final comments in readiness for consultation and engagement, both in terms of current needs, priorities, outcomes, and in preparation for the upcoming consultation on the 10-year strategy.

Key priority areas of focus within the current plan:

- Delivering NHS 111 (Mental Health) point of access and commissioning Third Sector Sanctuary Services (out of hours support)
- Working across partners to support people with current and emerging complex needs as a result of Covid-19, which includes people who are at risk of being homeless, living with mental health and substance misuse issues – developing new Dual Diagnosis and Complex Needs officers in support across partners
- Analysing Suicide and Self-Harm data over the last five years, looking at emerging trends and themes and developing related services to support needs
- Ensuring our Drug Related Death investigation process is aligned with our Serious Incident reporting/investigation and contributes to learning for Harm Reduction in respect of Substance Misuse reduction
- Reviewing Adult mental health provision and looking at transforming services

- Working across partners in Children and Young People's services supporting access to mental health support within schools, both face to face and on-line with tiered commissioned support across Third Sector
- Ensuring all partners are aware of and aligned in our priorities in relation to mental health, with a whole system approach to understanding population needs and developing a consistent response – we are focused on this as part of the work of our revitalised Mental Health Officer's Group reporting into the Mental Health Partnership Board

Patient Safety Incidents and Concerns

Between January 2021 and August 12th 2021 there have been less than five Patient Safety Incidents (PSI), all of these relate to the death of a patient. Less than five were placed in an external setting. Less than five of these patient safety incidents are being treated as a suspected suicide and are pending the outcome of inquests with HM Coroner.

The service has received eight concerns in the same period. A number have been resolved at a local level and have not progressed to formal investigation. No themes have been highlighted from these concerns and where there is learning, this is reflected at the local team level. All investigations have been completed and progressed.

There are less than 5 historic concerns remaining within the direction of the Public Service Ombudsman for Wales, with both of these having current activity to progress resolution, included the redress panel.

It remains challenging to identify Investigating Officers (IO) at times and the service is working with the corporate team to address training and development. Alongside capacity, confidence and competence are fundamental to having a pool of IO's to allocate investigations to for both PSI's and concerns so that we are able to respond in a timely manner. Timeliness is critical to achieving the best outcomes for patients and family members, particularly those who have suffered a bereavement and seek understanding of what has happened. Identification of the learning from both concerns and PSI's and HIW inspection episodes is embedded into the quality agenda of MHLD services.

National Work: Patient Safety Planning

Patient Safety Planning is a core indicator of service quality in mental health. We are engaged in national work around patient safety planning. A piece of research commissioned by the Delivery Unit and undertaken by Professor Michael Coffey, Faculty of Medicine, Health and Life Science, Swansea University, alongside the person-centred safety planning group established in early 2020 is in progress currently. We are anticipating the learning from this by autumn 2021 and it will offer mental health services in Wales the most up to date outcomes from research. The objective of the group and academic research is to enable mental health services to develop new approaches in understanding and delivering the best patient safety plans for risk and

safeguarding. One aim of this work is to establish how patient safety planning can be managed in a meaningful way that includes co-production within mental health care. This national working group includes representation from all health board's and relevant national agencies, therefore making best use of the existing professional knowledge, research and practice in relation to risk assessment, risk management and safety planning. The principles supporting this valuable work include:

- Ensuring safety is the central thread of risk assessment and risk management
- Ensuring opportunities for involvement, contribution and co-production are given at each step of the process used
- Avoiding simplistic approaches to risk assessment and management processes whilst reducing the complexity within them

Outcome Measurement in Wales

There has been a programme of extensive national work focussing on what is important to service users, families and carers. This has been identified within Together for Health2 (T4MH), the Welsh Government's 10-year cross-sector strategy for improving mental health services in Wales, reiterating that services should offer evidence-based interventions that are timely, proportionate and do no harm.

An all Wales framework for the use of outcome tools in mental health and learning disabilities has now started its implementation journey. PTHB staff were among the first to undertake the training and this was complemented by a wider presentation to staff at the Learning & Development Group on August 4th. The three outcome groups of *Improving My Wellbeing, Being Able to Set My Own Goals and Aspirations and My Experience and Satisfaction;* will enable all practitioners to ultimately use outcome tools in their practice routinely. MHLD has set up a steering group to support this ongoing roll out with staff due to be trained in October 2021 by Improvement Cymru. Welsh Government expects these outcome measures to be in place by March 2022, and technical work is underway with NWIS to enable the WCCIS system to capture this data on an all-Wales basis.

Ligature Risk Management

NHS Wales Patient Safety Solutions issued an alert (PSA013) on 26th June 2021 Formally requesting compliance around *Ligature and ligature point risk assessment tools and policies.* Compliance has been reported and further work to support a second component of compliance has been directed by the Deputy Director of Nursing for completion.

Deputy Director of Nursing	Response
The policy needs to be reviewed in relation to formatting of appendices	Completed. There is a national workstream facilitated by the Delivery Unit with the objective of agreeing an All Wales Policy currently ongoing and this national work is included in the Head of Nursing's workplan
There is no reference in the Policy to having easy access to ligature cutters and which is a requirement in the PSA.	All wards have accessible ligature cutters. This is now specified and included in the policy
The policy refers to taking reports to Health and Safety meetings but there isn't a responsibility for the H&S Officer.	Raised with Health & Safety colleagues. There is close working between all parties at the point of HSE visits and improvement plans evidenced through the Health & Safety Working Group. Links to Health & Safety colleagues now included within the updated policy
It has been requested that as part of the assurance required prior to submission, that a multidisciplinary audit/walk-round is undertaken with health and safety/estates and a written report submitted to provide assurance/evidence	Completed on August 20th 2021 and August 27th 2021 by the Head of Nursing, Estates and Health & Safety colleagues

Health Inspectorate Wales Care /Inspectorate Wales Inspections

In June 2021, the service participated in an unannounced two-day inspection episode on Felindre ward which raised no requirement for immediate assurances. The inspection was based around the broad themes of Dignified Care; Quality of Patient Experience; Delivery of Safe and Effective Care including managing risk; and Quality of Management and Leadership. There were twenty-seven improvement points highlighted, fifteen of which have been completed or resolved. The outstanding improvement points are not yet due and mainly relate to Estates work which is underway. It was pleasing to note that patient views sought by the inspection team were positive and a dedicated staff team who were committed to providing a high standard of patient care was noted by the inspectors.

RECCOMMENDATIONS

The Committee is asked to discuss and note the contents of this report including the planned work to scope additional metrics relating to quality and safety in specific areas for future reporting.

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 3.2

Patient Experience, Quality & Safety Committee	**7 October 2021**
Subject :	**PUTTING THINGS RIGHT, COMPENSATION CLAIMS REPORT**
Approved and Presented by:	Alison Davies, Director of Nursing & Midwifery Wendy Morgan, Assistant Director Quality & Safety
Prepared by:	Wendy Morgan, Assistant Director Quality & Safety Alison Davies, Director of Nursing & Midwifery
Other Committees and meetings considered at:	**Executive Committee 22 September 2021**

PURPOSE:

The purpose of this report is to provide the 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 April 2021 to 31 July 2021.

The report also provides the opportunity to share the Quarter 1 findings of the new audit programme cycle for Putting Things Right.

RECOMMENDATION(S):

The Patient Experience, Quality & Safety Committee is 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 support 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 April 2021 to 31 July 2021, including trends.

2 Assessment

2.1 National Strategic development

The national picture is developing in terms for the strategic direction for quality in Wales, recently enhanced by the publication in September 2021 of Welsh Government's Quality and Safety, Improvement and Learning Framework, which will assist in the health board's preparedness for implementation of the Health and Social Care (Quality and Engagement) (Wales) Act, including duties of quality and candour, in force from April 2023.

Additionally, Improvement Cymru have recently launched its new Improvement Cymru Strategy 2021-2026 to enable everyone to work together with health and

care systems in Wales to ensure that everyone has access to safe, effective and efficient care in the right place at the right time.

The health board's Clinical Quality Framework will be benchmarked and revised in light of both documents to ensure the local direction compliments that of the national direction. Further information will be provided to the Committee in due course.

2.2 External scrutiny and assurance

The heath board have been subject to a quality governance review recently undertaken by Audit Wales. The audit examined whether the health board's governance arrangements support delivery of high quality, safe and effective services. The focus was on both the operational and corporate approach to quality governance, organisational culture and behaviours, strategy, structures and processes, information flows and reporting.

The report received by the health board summarises the findings from the audit carried out between April and July 2021 which tested the 'floor to board' perspective, by examining the arrangements for Community Services as well as reviewing high-level arrangements for assuring quality of provider services.

A draft reported has been received, comments related to factual accuracy are being collated and population of the management response is underway. The final report is expected thereafter and will be presented to next Committee.

2.3 Improving health board wide systems and processes, Putting Things Right

As previously reported, a deep dive into the health board's approach to Putting Thins Right commenced during November 2020, and is nearing completion. The deep dive has been undertaken in as a phased approach and the lessons learned have either been incorporated into the improvement plan (**appendix 1**), or preferably, resolved in real time, wherever possible. The deep dive as also helped to identify the optimum form to fulfil the function hence any redesign of the team will be predicated on this. The plan has been updated to demonstrate progress and there are no items to escalate at present.

2.2 Putting Things Right Audit and Assurance Plan

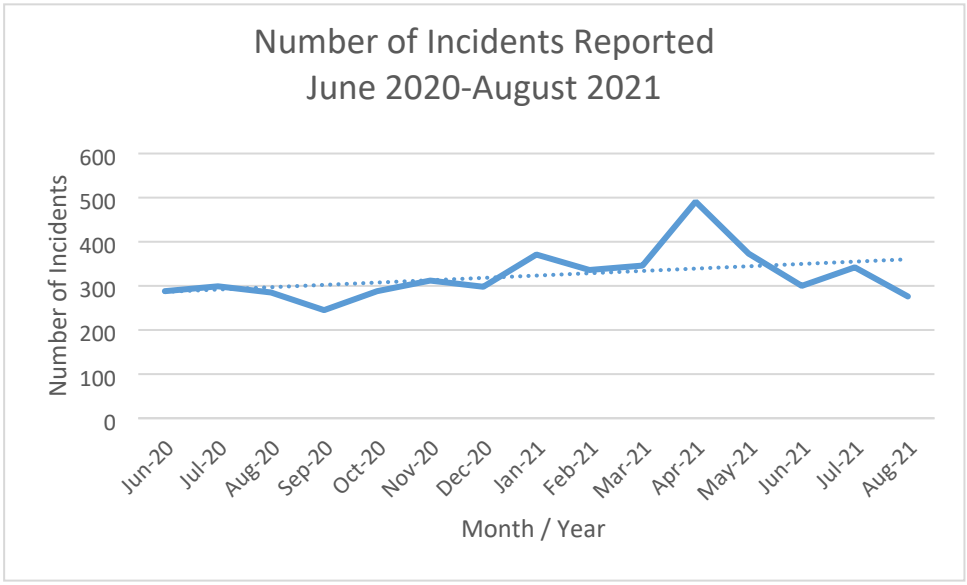
The audit and assurance plan have been presented in previous papers and the first quarter audit has been completed as scheduled (**appendix 2**). The audit has further assisted in identifying areas for improvement including communication with complainants, managing complainant's expectations with regards to response timeframes, timely management of concerns, timely obtaining of consent, and record keeping on all platforms used. The key areas relating to serious incidents

mainly relate to timeframes for notification reporting to the Delivery Unit, early engagement of patients, carer and their families in incident investigation. Further work is required to capture complainant experience. The Concerns Team are working with service groups to progress areas for improvement and where the improvements relate to the central concerns team, these have been added to the Putting Things Right improvement plan to ensure there is a single aggregated plan to maximise improvement.

2.3 Once for Wales Content Management System

The Once for Wales Content Management System (RLDatix) has been in use for concerns management since May 2021, the incident module was launched 14 June 2021. Initial issues identified have settled albeit new issues are raised the more the system is used; working with the national team the issues are being worked through. Monitoring of incident reporting across the health board has not shown any decline in the number of incidents reported since introduction of the new system.

Graph 1: Powys total number of incidents reported monthly



There are limitations with regards to extracting data from the system at present, whilst the national team finalise the new business intelligence and reporting system. The health board have been informed reports /dashboards will be available by 1st October 2021. Training for the Datix Administrators on the use of the Business Intelligence Tool is scheduled for 1st and 2nd November 2021, following which the health board will then receive the related tool for use. This is adversely impacting on the availability of data that can be extracted from the system for the purpose of this paper. As an interim measure, Datix administrators are setting up some standard templates on compliments, concerns and national reported patient safety incidents.

2.4 Patient Safety Incident Policy – changes to national reporting

As previously shared, reporting arrangements for nationally reportable patient safety incidents (previously often described as serious incidents) changed from the 14 June 2021. A group of assistant directors, now led by the Assistant Director Quality and Safety was formed and an implementation plan developed. The plan is being implemented and thus far includes increased service group ownership in reviewing all incidents regularly to identify any that are reportable nationally, and the production of a patient safety incident huddle guide, to assist staff in decision making which includes a 72-hour review template and national grading criteria enabling assessment based on level of potential harm caused, and likelihood or risk of recurrence (**appendix 3**). Early signs are encouraging indicating the approach to be effective. All incidents reported continue to be monitored via the Quality & Safety Unit. There is regular feedback from the Delivery Unit in terms of performance and the new system is becoming embedded. Whilst there are distinct differences in the requirements between the previous and new system, the number of reported incidents is being reported through the implementation group enabling observation of patterns of reporting.

Phase 2 of the national work has commenced. A National Reporting Incident Implementation Collaborative (NRIIC) is now established, and using a co-production approach, the collaborative enables representation from all Welsh NHS organisations into all relevant aspects of the national incident reporting approaches. The second phase focusses on:

- Capturing learning from events which has been developed to align with the current process used by the Welsh Risk Pool Services for the purposes of redress and compensation claims. This is aimed at avoiding duplication of submission of information. A draft version will be piloted by Swansea Bay University Health Board in the next weeks prior to roll out across all health boards and NHS Trusts.
- The introduction of early warning notifications to replace no surprises notification, used in circumstances to alert Welsh Government to issues of concern. It was agreed this will be a separate process to the national reported patient safety incidents currently reported to the Delivery Unit. Information will be provided through separate guidance in the near future. Until such time, the health board are required to continue using the no surprise notification forms.
- In developing new thematic ways of reporting certain incident types across a number of specialities, representatives of the Delivery Unit are currently working with specialist All Wales groups, such as maternity, mental health, falls and pressure damage, to discuss the information to be captured and how it will be used, the aim to support learning and improvement. Further information will follow.

2.5 Supporting learning and improvement

The quarterly newsletter of Welsh Risk Pool's learning Advisory Panel was shared in August 2021 via Powys Announcements (**appendix 4 & 4a), and** focuses on learning generated from 200 new redress and clinical negligence cases across Wales.

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 committee.

2.6 Outputs and outcomes of Putting Things Right

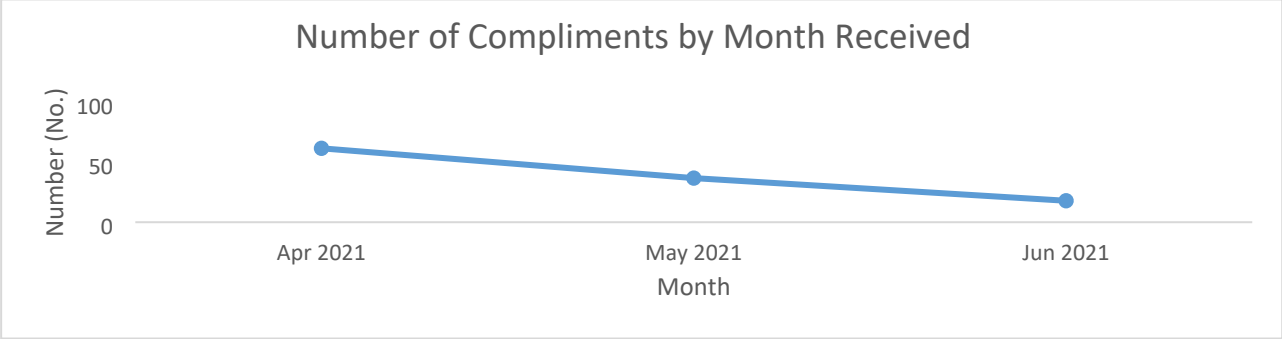
The data used within this report has been extracted from the new Once for Wales Content Management System (RLDatix). This paper represents the corporate oversight, and there is a need to cross reference this paper with that of the service groups paper for more detail on outputs and outcomes, including learning and improvement.

As explained earlier, there are limitations with regards to extracting data from the system at present, whilst the national team finalise the new business intelligence and reporting system. The health board have been informed reports /dashboards will be available by 1st October 2021. Training for the Datix Administrators on the use of the Business Intelligence Tool is scheduled for 1st and 2nd November 2021, following which the health board will then receive the related tool for use. This is adversely impacting on the availability of data that can be extracted from the system for the purpose of this paper. As an interim measure, Datix administrators are setting up some standard templates on compliments, concerns and national reported patient safety incidents. **Please note data for this paper has been taken from the old and new systems, and therefore, two run charts exist for each section reported.**

2.6.1 Compliments

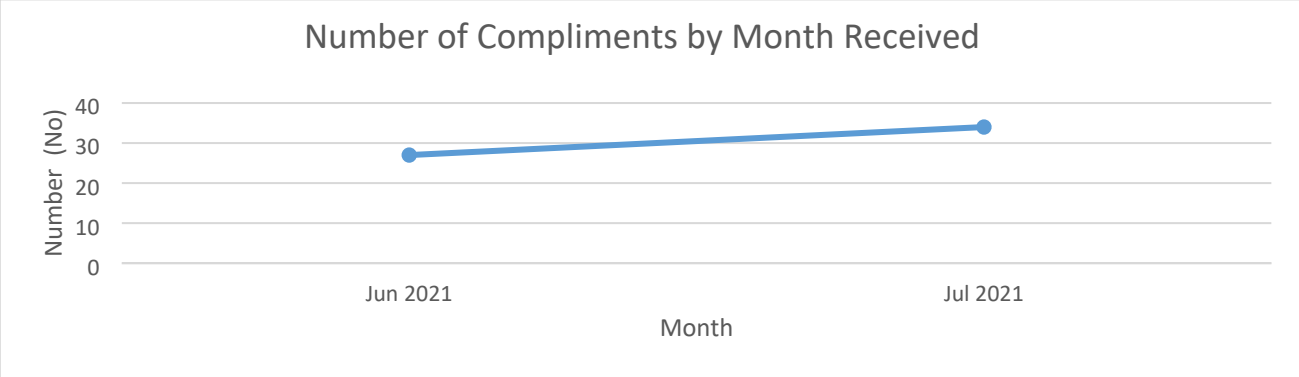
Between 01 April 2021 to 31 July 2021, a total of 180 compliments received. This is a greater number of compliments received month on month the previous year, the range 18-62 per month, this may be because of the adverse impact of the covid19 pandemic on service provision last year. It is not possible to provide a breakdown of specialities recording compliments for this report.

Graph 2 – Total number of compliments received between 01 April 2021 to 31 July 2021 recorded via the old Datix system



Source: Datix (old system) data recorded until 14 June 2021

Graph 3 – Total number of compliments received between 01 April 2021 to 31 July 2021 recorded via the OFWCMS RLDatix system



Source: OFWCMS RLDatix data recorded from 14 June 2021-31 July 2021

2.6.2 Concerns (complaints) Summary Position

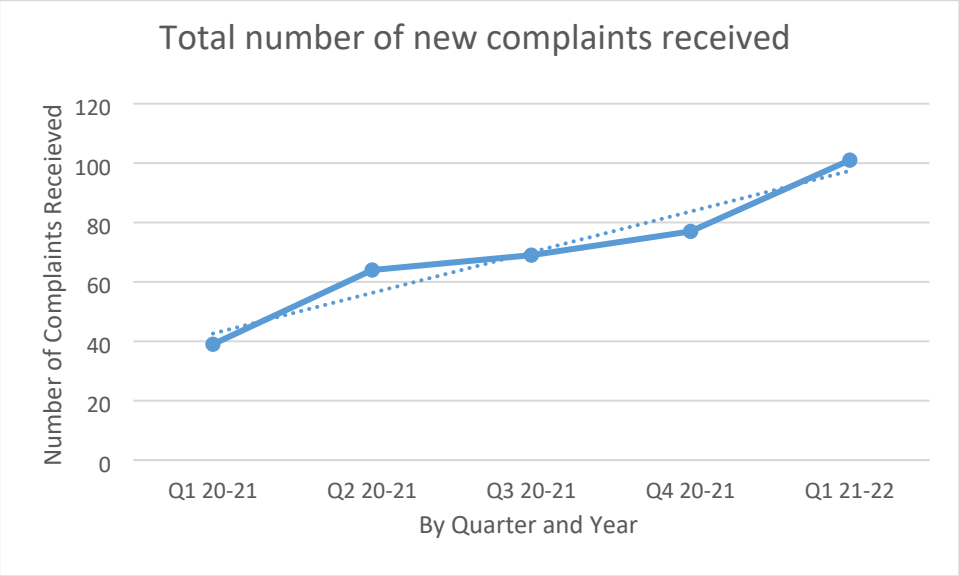
For the purpose of this report, the concerns data is taken from the quarterly validated return (**appendix 5**) provided to Welsh Government. Between 01 April 2021 and 30 June 2021, the health board received 101 new complaints (both those managed through Putting Things Right Regulations and through Early Resolution).

The primary subject areas related to access to services (n26) and appointments (n16). Issues of access remains focussed on dental and primary care services. The number of complaints by staff group are in the main nursing, midwifery and health visiting (n62) and medical and dental (n28).

A total of 47% of concerns closed within this quarter were within 30 working days. 47% were within 30 working days to 6 months, and the majority of these were concerns that had exceeded the expected 30 working day timeframe and hence closed at a later date. A further 6% of concerns were closed after a period of being open for more than 6 months. This reflects the improvement work targeted on clearing historical open concerns.

Alongside this, there is clear increase in the number of informal and formal concerns received each quarter, as per graph 4 below:

Graph 4 – Total number of new complaints received each quarter, 2020/21 to 2021/22



Source: OFWCMS RLDatix data reported via the quarterly NHS Concerns data returns to Welsh Government (example at Appendix 5)

A continued downward trend in numbers of concerns relating to the mass vaccination programme continues. Most enquiries now relate to travel certificates. A total of 137 enquiries recorded since January 2021 to date. All enquiries are now directed to the contact line and Powys Covid vaccination email address.

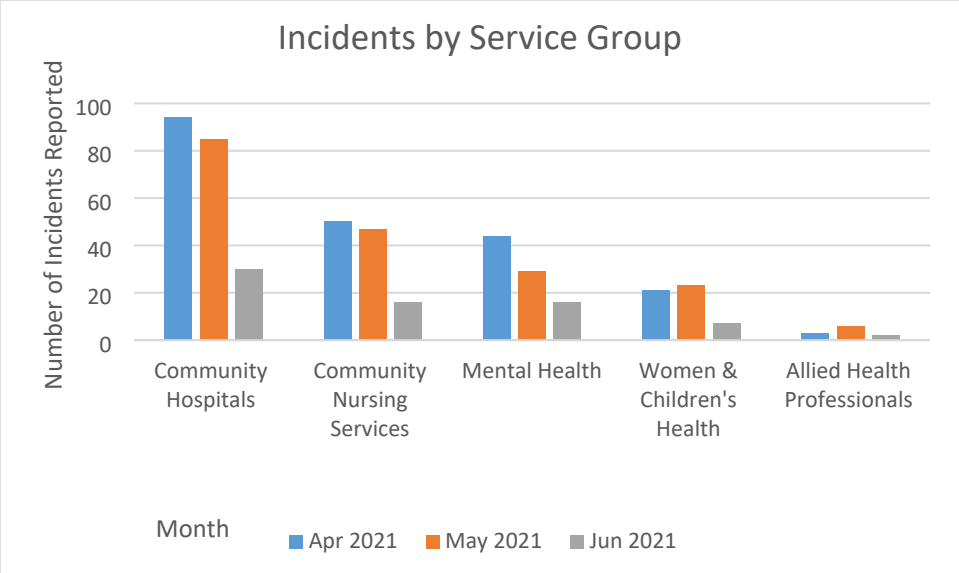
There has been a steady increase in concerns since January 2021, noting numbers reduced during 2020 reflective of the pandemic situations. Current numbers of concerns received show a slightly higher than our average pre-pandemic (25-30 per month) position. Many of the new concerns relate to care and treatment and access to services, across both primary and secondary care.

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. During the period of 1 June 2021 to 31 July 2021 the health board reported 2 national reportable patient safety incidents to the Delivery Unit both relating to mental health services. As explained in section 2.4 above the approach to reporting has changed and the plans to introduce thematic reporting will include a range of incidents that we previously reported as serious incidents, for example, falls. As the new reporting system becomes embedded, this report will articulate incidents that are nationally reportable along with those thematically reported.

Graph 5 shows the service groups reporting the highest number of incidents for the period 01 April 2021-14 June 2021 via the old Datix system, with Community Hospitals (n209), Community Nursing Services (n113), Mental Health Services (n89), Women & Children's Services (n51) and Allied Health Professionals (n11) displayed. The numbers reported are consistent with previous years data.

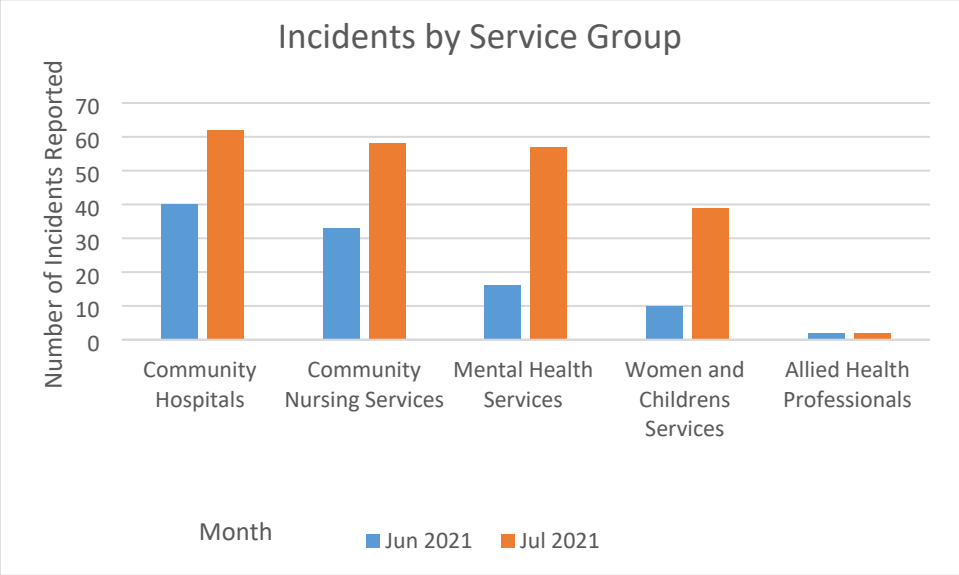
Graph 5: Incidents reported by Service Group 01 April 2021-14 June 2021



Source: Datix (old system) data recorded until 14 June 2021

Graph 6 shows the service groups reporting the highest number of incidents for the period 14 June 2021-31 July 2021 via the new OFWCMS RLDatix system, with Community Hospitals (n209), Community Nursing Services (n102), Mental Health Services (n73), Women & Children's Services (n49) and Allied Health Professionals (n4) displayed. Once again, the numbers reported are consistent with previous years data and indicates there has not been a reduction in reporting of incidents during the change of systems.

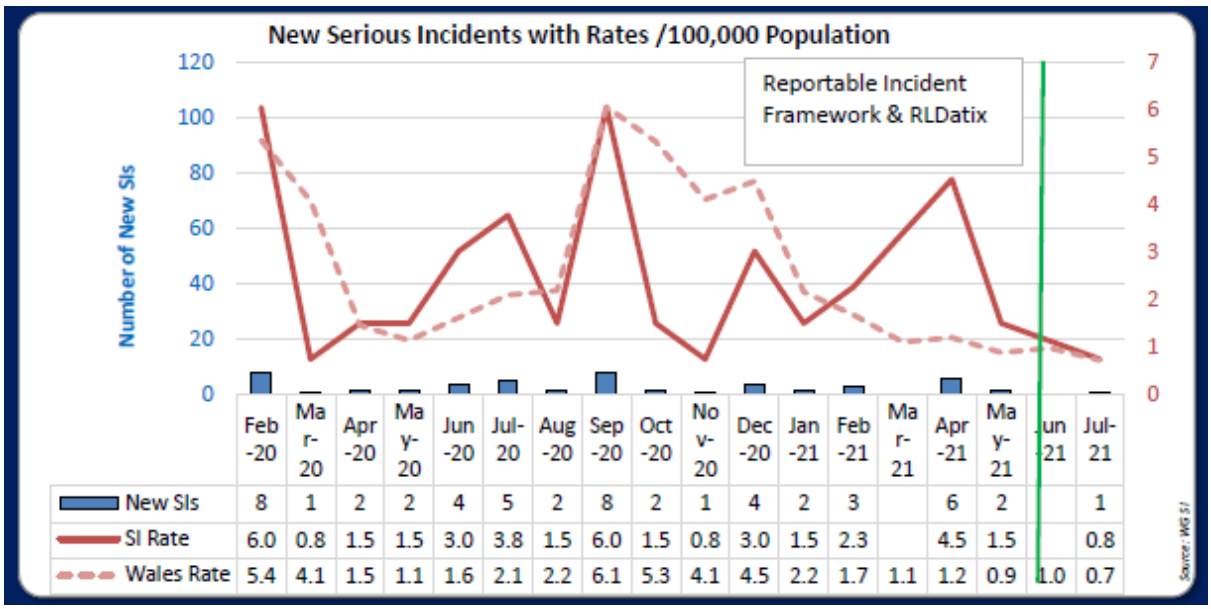
Graph 6: Incidents reported by Service Group 14 June 2021-31 July 2021



Source: OFWCMS RLDatix data recorded from 14 June 2021-31 July 2021

With regards reporting of patient safety incidents at national level, graph 7 below provides the position as at July 2021 on Powys' position reference All Wales reporting of new serious incidents per 100,000 population. As you will note, the health board are reporting broadly in line with reporting rates across other health boards and NHS Trusts in Wales.

Graph 7: Powys Serious Incident Reporting Rate reference All Wales Reporting Rate



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 June 2021 to 31 July 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 June 2021 to 31 July 2021 there have been less than 5 HM Coroner enquiries opened, and further 5 cases closed with no learning identified for the health board. A new policy has been developed to support our staff when attending inquests, 'PEP005 Statement Writing, Inquests, Attending Court and Assisting with Police Investigations (April 2021)'.

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 June 2021 to 31 July 2021, the health board has not received any PSOW enquiries, and received less than 5 decision letters, 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 14 open, inclusive of clinical negligence, personal injury and General Medical Practitioner Indemnity (GMPI) claims (**appendix 6**). The Scheme for General Medical Practice Indemnity (GMPI) is a discretionary state-backed scheme of indemnity provision for General Practitioners on Welsh Medical Performers Lists, their staff and those engaged by the General Practice, in place from the 1 April 2019. The health board has recently seen its first request for indemnity under this scheme.

Following review of the claims for the health board, there have been no identified themes and trends.

2.8.7 Patient Safety Solutions

Performance for all Health Boards and Trust in Wales can be found at **http://www.patientsafety.wales.nhs.uk/safety-solutions-compliance-data**
In line with goal 1 priorities within the Clinical Quality Framework, local improvement work is progressing to change the way in which patient safety alerts and notices are managed within the health board, the alerts policy is currently being reviewed with a key focus on strengthening roles and responsibilities, seeking assurance and reporting compliance with alerts issued. Action is also being taken to limit the distribution of alerts to a wide range of staff across the health board to a more

structured and dedicated mailbox process for each department, whereby two people have responsibility for managing the further distribution at service group level and providing evidence/ assurance to the corporate team. The model has been trialled with the mental health services and is being rolled out across all service groups.

Compliance with one overdue patient safety solution continues to be indicated as non-compliant 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.

Compliance with PSN056: Foreign body aspiration during intubation, advanced airway management or ventilation, has been declared, confirmation of acceptance from Welsh Government received 6 September 2021.

The All Wales Patient Safety Solutions Group led by the Delivery Unit, Welsh Government, held their second meeting in August. The discussions focussing on a centralised system for all alerts, priority notices to address which included PSN034 as above, to look at solutions across Wales and receipt of English alerts and actions required in response. A day is planned in the Autumn/ Winter 2021 focussing on sharing good practice across Wales.

APPENDIX 1

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

High Level Implementation Plan

Putting Things Right

for the period: Quarter 2 (April - June) 2021

Version 1 01/07/21

Complete
On track
Delayed

Theme	Learning and Action Taken	Executive Lead	AD / Operational lead(s)	Update June 2021	Actions Remaining	Deadline	Status	Comments
Concerns are not consistently processed by the simplest path	Ongoing development with service group leads. Where a short turnaround is identified this is actively followed up by the concerns team	Director of Nursing & Midwifery	AD for Quality and Safety	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.	(1)Maintain triage process (2)Increased focus on early resolution across all specialties/ services.	30 September 2021		(1) Triage processes well embedded. Mental Health Services is well established; Women and Children's services improved as a responsive group, part of their journey is to focus on all staff members understanding this process. (2) Recognition by service groups that families/carers need to be engaged from day one. Working with the Concerns team, the service groups are identfying concerns for early resolution.
Process pathways for responding to complaints need clarification and simplification	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	Director of Nursing & Midwifery	AD for Quality and Safety	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.	(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		(1) Putting Things Right Policy currently being reviewed to take account of template changes. (2) The trackers are reviewed as part of the PtR audit programme and areas for improvement identified.
Service group governance needs strengthening to ensure capacity and capability at a local level	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	Director of Primary, Community & Mental Health Services	AD for Primary Care, Mental Health and Women and Children's Services	Governance leads in place in each Service Group as from June 2021.	(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) Governance arrangements presented to EQS Committee.
					(2) Improvement trajectories to be agreed with each service group - in line with Section 1.6	31 October 2021		(2) Weekly meetings with Community Hospital Servcie Group to monitor all concerns activity and follow up of cases. Monthly meetingws with W&CS. Mental Health Services submit weekly trackers which are followed up.
					(3) Develop dashboard to monitor performance within service groups and use of CAF process by corporate team to provide assurance of performance	30 November 2021		(3) Dashboard develpoment in progress involving representatives from all areas.
Corporate concerns team structure review	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.	Director of Nursing & Midwifery	AD for Quality and Safety	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.	(1) Report the outcome of the options appraisal.	31 October 2021		The model is developing based on learning from the deep dive work.
Capability needs further development to include a structured training Programme	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"	Director of Nursing & Midwifery	AD for Quality and Safety	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.	(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		In progress. Where it is identified a definitive need cannot be met internally, procurement of external training to meet this need will be explored.

Performance monitoring including quality assurance	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.	Director of Nursing & Midwifery	AD for Quality and Safety	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	(1) Development of dashboards on the new OFWCMS to support monitoring. (2) Weekly overview meetings continued. (3) Report Quarter 1 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) The Business Intelligence Tool for OFWCMS is indicated as available from 1 October 2021. At this time dashboards will be made availabe for use and training provided to support staff in how to use them. (2) The Health Board is on track for delivery of plans to improve performance. (3)&(4) Quarter 1 audit findings reported-actions incorporated into this action plan, as at 1.9 below. (5) As part of the CAF process, although concerns are addressed, it has been requested an explicit agenda item be added to every and all CQRM meetings for concerns.
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	This panel would maintain oversight of formal complaints, serious incidents, coroner cases and Public Health Ombudsman cases including driving performance with service groups.	Director of Nursing & Midwifery	AD for Quality and Safety	The patient safety incident implementation group are currently considering this approach.	(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) The new incident framework is formally in place from April 2022 and the Health Board is working towards compliance in 2021-22. (2) Action being taken as part of combined service / coproate team group work on PtR improvement plan to develop examples, first meeting was held 31/08/2021.
Learning from concerns, complaints and incidents	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.	Director of Clinical Strategy		Learning from concerns and compensation claims to be reported through this group.	(1) Active reporting through QGG; EQS; Service Group Quality and Safety arrangements; Internal bulletins	31 March 2021		In place. Quality Governance Group temporarily stood down and reporting through Executive Committee.
Improvements in response to the PTR Audit programme	The Concerns Team working with Service Groups/ Directorates will address required improvements that result from the quarterly PtR audits.	Director of Nursing & Midwifery/ Director of Primary, Community & Mental Health Services	AD for Quality and Safety / AD for Primary Care, Mental Health and Women and Children's Services	Improvements made in response to the PtR audit to be reported .	(1) assurance on PtR audit improvements to be provided through each concerns paper to Executive Committee and EQS Committee.	31-Mar-22		First results from audit provided to Executive and EQS Committee September / October. Improvement work commenced, monthly validation of all concerns taking place and improvements simultaneously addressed. Also feedback to service group representatives as part of discussions on PtR improvement plan.

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

Putting Things Right
Audit Report
Quarter 1
April – June 2021

Introduction

The Putting Things Right Audit Programme Cycle (**appendix 1**) for 2021-2022 focuses on three key areas: process compliance, listening and learning and duty of candour.

A phased approach throughout this first year, the first quarter focuses on concerns management, children and adults at risk, commissioned services concerns, cross border and multiagency concerns, serious concerns and never events.

The following detail outlines the findings from Quarter 1.

A total of 101 new concerns were received for the period 1 April – 30 June 2021.

Concerns

A 10% random sample audit comprising 10 concerns inclusive of the 3 concerns that relate to children and adults at risk.

The standard set (**appendix 2**) audits related timeframes and processes in place.

The main findings are:

- Consent not received from complainant, primary care asked to provide a general response only.
- A number of iterations of a draft response.
- The incorrect acknowledgement template used for a primary care complaint.
- A firewall issue prevented an acknowledgement letter being issued timely, resent 2 weeks later.
- Timeframe for response not accurate, Datix stated assessed as 30 working days to 6 months not 30 working days as per the letter to the complainant.
- Issues with obtaining written consent impacting timely management.
- No evidence of communication to complainant.
- No evidence of Mail Marshall the first time the acknowledgement letter was issued, which delayed receipt of communication to the complainant.
- No evidence of escalation noted when no response received.
- No update to the complainant in relation to the delay in receiving the concerns response. The response should have been received the 1st June 2021 but was delayed in the sign off process.

- The initial concerns response was received in good time but has had various amendments and absence of documentation on the new Datix system to reflect this.
- Awaiting a concerns response from the service, escalated but no response received.
- Holding letter was not sent out to complainant until after the 30 working days had passed, resulting in delayed communication to the complainant as to when they will receive their response.
- No timely response to a complainant, not updated regarding the progress of the response and exceeded expected timeframes for responding.
- Concern was not shared with a General practitioner timely, delayed by 1 month.
- No holding letter or update provided to complainant

Good Practice:

- Assessed as 30 working days – 6 months, managed in good time and complainant kept updated.

Improvements:

- At time of closing a concern, there is a need to complete:
  - final grading of the concern; and,
  - the timeframe for response.
- Use the correct template at all times.
- Record timeframes accurately on Datix and the reasons they are changed.
- Always write out a courtesy letter to the complainant to close the complaint if inaction evident as a result of details/ obtaining consent.
- More proactive use of delivery and read receipts.
- Courtesy follow up if no response within 5 working days.
- Record where escalation takes place.
- Write to complainant if there may be a slight delay in them receiving their concerns response to keep them updated.
- Ensure complainants are written to, prior to, the passing of the expected date for receipt of response, so that they are updated accordingly and in a timely manner.
- Ensure concerns are sent to the General Practitioner following receipt of consent.

There are clearly improvements to be made which can enhance the timely management of concerns and contribute to a more positive experience for complainants involved.

Children and Adults at Risk

A random sample, a total of 3 cases reviewed. Two responses were not due until the start of the second quarter, so timeframes for responses not able to be calculated.

Main findings:

- Complainant did not receive their response within expected 30 working days.
- A post response meeting took place, no record of what happened at the meeting, despite a request to the service.
- Consent not received.

Improvements:

- Timely follow up of consent.
- Timely follow up to investigation officers requesting update and whether response will be completed within expected timeframe.
- Consider use of holding letters timely.

Commissioned Services

A random sample audit of 10%, with 5 concerns reviewed. These were also reflective of cross border concerns and multi-agency concerns.

Main findings:

- Issue with the consent form provided by the complainant, did not enable Powys Teaching Health Board to request a copy of the final concerns' response provided by a provider organisation.
- Significant delay in receiving the concerns response from the other health board, could have been escalated for a quicker response time.
- Subject of complaint not completed on Datix, the matter also not been closed.
- Complainant was informed that Powys Teaching Health Board could no directly re-investigate the concerns raised and after liaising with the General Practice, the complainant was advised to seek advice from the Public Service Ombudsman for Wales. Datix not updated to reflect this.

- The concern was an informal complaint and although the complainant had been provided with the information, there was no information recorded for some weeks to suggest that they wished to pursue the complaint. The concern was not recorded on the new Datix system.

Improvements:

- Ensure accurate record keeping, and on all platforms.
- Ensure consent forms accurately completed.
- Consider follow up of concerns within a 7-day timeframe and keep the complainant updated.
- When concerns raised via Members of Senedd, ensure they are kept updated on progress of concerns.

As for the management of standard concerns, there are clearly improvements to be made which can enhance the timely management of commissioned concerns involving cross border organisations and multi-agency concerns, contributing to a more positive experience for complainants.

Serious Incident Reporting

(now called national reported patient safety incidents)

The criteria (**appendix 3**) used to audit a 10% sample of serious incidents open at that time of the audit, and was based on the current timeframes for their management. The timeframes were taken from the PTHB / PEP004 Serious Incident Policy: Reporting, Investigating and Assurance Processes (October 2020). The stated process for managing the serious incidents once notified to the Delivery Unit and tracking the investigation through to completion was not complied with. This is mainly due to the fact that the process outlined and used up until the Covid-19 pandemic started was not being deployed in the way intended, likely due to a number of reasons, such as reporting of serious incidents to Welsh Government was changed during this period, staff were deployed into different roles and everyone was working differently. This did not however detract from their robust management ensuring immediate make safes were put in place, and there was mitigation of identified risks with actions, recommendations and improvements actively progressed.

During quarter 1 national reporting of patient safety incidents has changed and this will be reflected in the quarter 3 audit work.

Findings:

- Delays in notification of incidents to submission to the Delivery Unit (9 days, 12 days and 6 days recorded). Assurance timeframe of 60 working days for completed investigation to Welsh Government not complied with.
- Service responded unwilling to share investigation outcome until all quality assurance processes had been completed, indicated they would then approach the family asking if they wished to see the investigation report.

Improvements:

- The need for timely action for notification and assurance.
- The need for service groups to focus on being open and engaging patients, families and carers in the investigation process. The need to be mindful of the forthcoming Duty of Candour to be emphasised.

The current serious incident policy will be updated to take account of the changes associated with the new national reporting of patient safety incidents. This work will align to the current Putting Things Right improvement plan which is being progressed and will focus on robust systems and processes supporting effective management, investigation, and learning from national reporting of patient safety incidents.

Never Events

There were no never events recorded during quarter 1 2021/2021.

Complainant Experience

A survey to ascertain complainant experience is not currently in use. As a result, this was not audited during Quarter 1.

It has been agreed that for quarter 2, cases where a complainant has further complained and raised dissatisfaction will be looked at, the aim to understand the underlying reasons as to why. This will also be balanced with positive feedback received where concerns have been managed well, the aim to identify what has worked well and what did not work well.

Appendix 1: audit programme cycle

Area		Activity	Delivery timeframe for internal activity				
			Q1	Q2	Q3	Q4	External Audit (EA)
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					

Appendix 2

Standard for audit of concerns

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))
Received
Date Sent

Appendix 3

Timeframes for management of serious incidents

Timeframe	Action
24 hours	Report serious incident to Welsh Government
1-2 working days	Internal PTHB serious incident audio meeting Initial scoping / Terms of Reference
3-25 working days	Investigation led by assigned Investigation Officer (IO)
26-30 working days	Executive Lead Review
31-36 working days	Additional work as required
37-42 working days	Executive Lead Sign off investigation report and closure form
42-47 working days	Serious incident Panel review and approval/ concerns team involvement Written draft responses to patient / families (Regulation 24/ 26 letter) Signed off by CEO via the Concerns Team.
Within 60 working days	Assurance to Welsh Government

Patient Safety Incident Huddle Guide

Date:	
Time:	
Dial-in Details:	

Case Ref:	WEB*****
Participants	Governance Lead Ward Manager Head of Service/ Community Service Managers

Please turn page for Huddle Guide

CHECKLIST

1	Purpose of Huddle
2	Patient Safety Incident Brief
3	Determine Grading of Incident Rationale given *If agreed not for national reporting, then please go to Step 7 to ensure lessons are learnt and shared from all incidents where indicated.*
4	Immediate Actions Taken • Patient support • Staff support • Family support • Onsite Gold/ Silver notification
5	Consider in context of patient safety incident: • Is the incident RIDDOR reportable • Safeguarding • Information Governance Office • MHRA • HIW • CIW • Professional bodies • Coroner/ Police • National Reporting – Delivery Unit/ Welsh Government – complete related forms • Media
6	Investigation • Select Investigation Officer (IO) • Scope of investigation • Administration support • IO support • Joint Investigation • Medical records / documentation • Timescales • Draft Report & Action Plan • Final Report & Action Plan • Learning and lessons for sharing • Sign off final report • Completion of any forms for national reporting • Debrief for all staff involved • Communication
7**	Lessons learnt and lessons for sharing
8	Agree further actions required
9	Next Huddle

**Capture lessons learnt at every stage, where applicable

Powys Teaching Health Board 72-hour Patient Safety Incident Update Brief			
Datix Ref:		**Incident Category:**	
Date of Incident:		**Date Incident Identified:**	
Date Delivery Unit/ Welsh Government Notified:		**Location of Incident:**	
Details of contact with or planned contact with patient/family or carers			
Summary of Incident: (situation)			
72-hour update information			
Summary of immediate actions taken to ensure safety of patients/ staff			
Agreed level of investigation			
Completed by:			
Approved by:			

Grading of Concerns

Grade	Examples of Concern	Potential for Qualifying Liability / Redress
1 **No Harm**	• Concerns which normally involve issues that can be easily/speedily addressed, with no harm having arisen (e.g. outpatient appointment delayed but no consequences in terms of health, difficulty in car parking etc.) but have impacted on a positive patient experience. • Labelling error in Pathology detected pre-analytically.	Highly Unlikely.
2 **Low Harm**	• Concerns regarding care and treatment which span a number of different aspects/specialties. • Increase in length of stay by 1-3 days. • Patient fall - requiring minor treatment. • Requiring time off work - 3 days. • Concern involves a single failure to meet internal standards but with minor implications for patient safety. • Return for minor treatment, e.g. requiring local anaesthetic, further treatment/monitoring by GP. • Samples taken from the wrong patient – not acted upon but require repeat venepuncture. • Pathology labelling error detected post analytically before further intervention	Unlikely.

Grade	Examples of Concern	Potential for Qualifying Liability / Redress
3 **Moderate Harm**	• Clinical process/issues that have resulted in avoidable, semi-permanent injury or impairment of health or damage that requires intervention. • Additional interventions required or treatment/appointments needed to be cancelled. • Re-admission or return to surgery, e.g. requiring general anaesthetic. • Necessity for transfer to another centre for treatment/care (e.g. for and incident in a GP Practice, admission to hospital). • Increase in a length of stay by 4-15 days. • RIDDOR reportable incident (moderate harm). • Requiring time off work – 4-14 days. • Concerns that outline more than one failure to meet internal standards. • Moderate patient safety implication. • Concerns that involve more than one organisation (e.g. cross border incidents that may involve English Providers or other Health Boards, incidents involving interface with Local Authority or Ambulance Trusts).	Possible in some cases.
4 **Severe Harm**	• Clinical process issues that have resulted in avoidable, semi-permanent harm or impairment of health or damage leading to incapacity or disability. • Additional interventions required or treatment needed to be cancelled. • Unexpected re-admission or unplanned return to surgery. • Increase in length of stay by more than 15 days. • Necessity for transfer to another centre for treatment/care. • Requiring time off work – more than 14 days.	Likely in many cases.

Grade	Examples of Concern	Potential for Qualifying Liability / Redress
	• A concern outlining noncompliance with national standards, with significant risk to patient safety. • RIDDOR reportable incident (significant harm). • Pathology: Specimen loss, labelling error detected post analytically following further intervention. • 'Wrong Blood' transfusion	
5 Catastrophic Harm	• Concern leading to unexpected death, multiple harm or irreversible health effects. • Concern outlining gross failure to meet national standards. • Clinical/process issues that have resulted in avoidable, irrecoverable injury or impairment of health, having a lifelong adverse effect on lifestyle, quality of life, physical and mental wellbeing. • Clinical process or issues that have resulted in avoidable loss of life. • RIDDOR reportable incident (catastrophic harm). • Significant/consistent reporting errors i.e. malignant as benign.	Very likely.

Doctrina

Doctrina meaning learning
Edition 3
Summer 2021

The quarterly newsletter of the Welsh Risk Pool's Learning Advisory Panel (LAP)

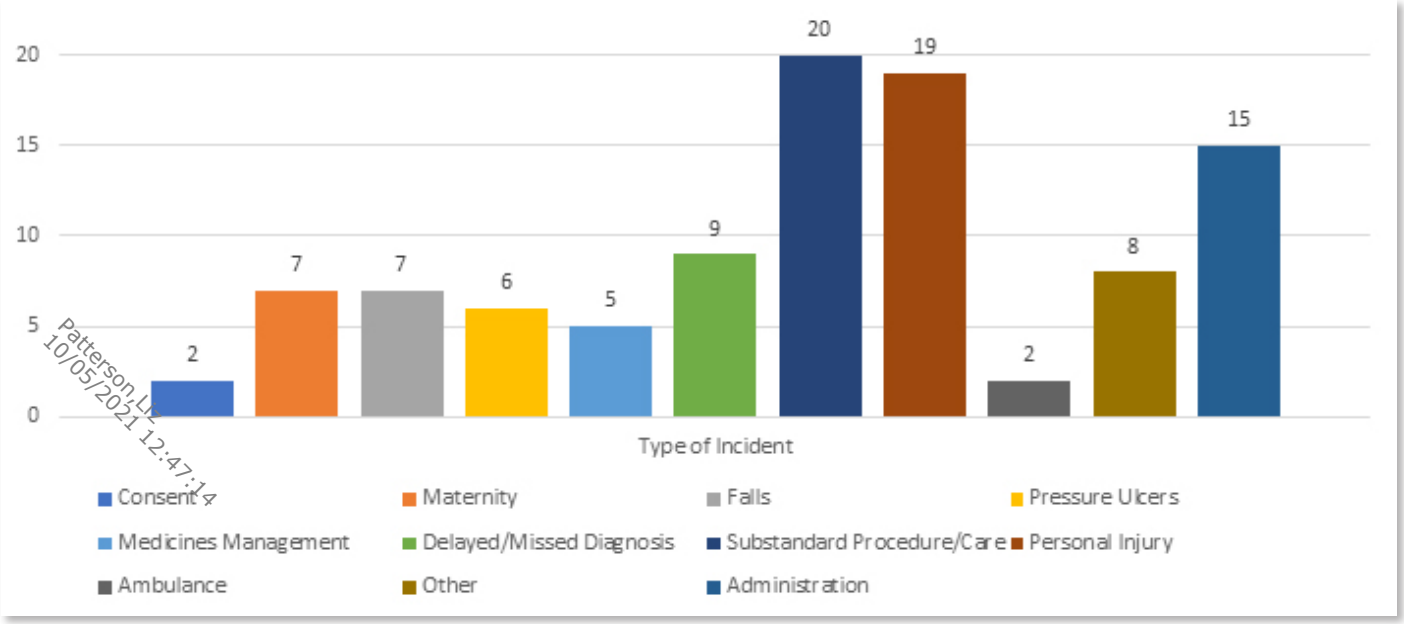
Trends

During the last quarter, the LAP has reviewed the learning implemented by health bodies, for 200 new redress or clinical negligence cases, across Wales. This a reduction of 24% compared with the last quarter. We have been noting an obvious reduction in case submissions to the Welsh Risk Pool, during the last few months, however, we are expecting numbers to rise as we approach the Autumn with school holidays ending and normal working practices hopefully resuming, following the pandemic.

Interestingly, we have seen a sharp increase in the number of personal injury cases being reviewed by the LAP. As shown in the graph below, personal injury cases accounted for 19% of all cases this quarter which is almost double to the previous quarter. These cases are commonly related to slips, trips and falls, though there has been a notable number of cases relating to site maintenance.

We are always looking for doctors, nurses or anyone involved with governance, to participate in a panel. Please contact the email address at the end of this newsletter for more information.

A Graph to Show the Percentage of Clinical Negligence and Redress Claims Reviewed by the Learning Advisory Panel for the Quarter to July 2021:



The Slip

A staff member was returning her plate to the plate racking area of a coffee shop within hospital, when she slipped on a discarded banana peel that was on the floor. As a result of the slip, she ruptured the anterior cruciate ligament in her right knee and consequently, needed a surgical repair.

Unfortunately, inspection records were not available, as Environmental Health require them to only be kept for 6 months.

Following this incident, records are now kept longer than the period prescribed by Environmental Health, a Safe System of Work for cleaning the area, including emptying rubbish bins, was devised and staff underwent additional training.

The Trip

A 46-year-old patient was walking from the bathroom to his living area, when he tripped over damaged flooring and a raised area of carpet. As a result, he sustained a chip fracture to one of his cervical vertebrae, whiplash and lower back strain.

It was identified that the damaged floor area had first been reported nine months earlier but the Estates Department had not been instructed to repair the floor and carpet.

Since this incident, the flooring has been repaired and the carpet replaced. It has also been requested that the Health Board instigate a regular system of inspection, rather than rely solely on faults being reported.

And the Fall

A 40-year-old patient, with alcohol dependency and mental health issues, was admitted to hospital having suffered a fit due to alcohol withdrawal. He was confused and agitated, making several attempts to leave the ward.

Unfortunately, he gained access to a window, overcame the window restrictor, jumped out and fell down two floors. Multiple injuries were sustained including a fractured left proximal humerus, fractured ribs, fractured pelvis, brachial plexus injury and a fractured calcaneus.

A review of window restrictors was undertaken and remedial works carried out as necessary. Load bearing tests were undertaken on all restrictors. All window restrictors procured now meet or exceed British Standards guidance.Regular inspections are undertaken and a safety notice was issued for wider learning.

Damages settled for £315,000. Costs are still being negotiated.

More About Maintenance – Doorknobs, Gates and Potholes!

A Health Care Support Worker (HCSW) was undertaking a 'door hold' to prevent a patient with learning difficulties from leaving the room. The patient who was attempting to open the door, suddenly let go and the door slammed against the HCSW's hand causing a crush injury to her tendons. It was identified that the handle was too near to the door flame and that this had contributed to the injury. The door handle was moved within two days. Other doors within the unit were of a different style and not an issue.

Elsewhere, a porter was opening the entrance gate to the hospital, when it came away from the fixtures, falling on top of him. He sustained soft tissue injuries to his head, chest and left arm together with an open fracture of his left tibia. The gate should have had wheels at the bottom but they had previously been removed and the hinges had consequently bent 90 degrees over a period of time. All gates within the Health Board have now been replaced with those that have a rolling mechanism and a Planned Preventative Maintenance Program is now in place.

Finally, a patient fell down a pothole in the carpark sustaining soft tissue injuries to her right ankle and groin. It was identified that there were numerous potholes in the carpark and that routine maintenance inspections were not being undertaken. The potholes have been repaired and it has been requested that the Health Board commence regular inspections and introduce a Planned Preventative Maintenance Program.

Administrative Errors

We see a steady number of cases each quarter, where patient records or confidential information has been incorrectly disclosed. In each case, processes have not been followed when external bodies such as the Police or housing associations have requested information.

Other incidents have arisen when confidential personal information has been sent to the wrong address. These incidents result in a breach of GDPR (General Data Protection Regulations) which can lead to fines or reputational risk for the Health Board, together with considerable amounts of stress and anxiety for the patient involved.

Other administrative cases arise due to waiting list errors or patients being lost to follow up. Many departments have improved their follow up booking process by reviewing policies, updating guidelines or by encouraging the patient to take a more proactive role, however, we are still seeing cases where patients have been 'lost' with terrible consequences.

The Case of the Glaucoma Patient

A 72-year-old female with glaucoma in her right eye was stable on treatment for five years up to June 2017, during which time she was monitored regularly. Her intraocular pressure remained controlled and she had no significant reduction in vision.

At her review in June 2017, the intraocular pressure had increased and consequently her medication was altered. A review was planned for three months later but the appointment was never made and she was lost to follow up. The patient continued to see her optician yearly. She initially remained stable but by March 2019 her vision was deteriorating and a referral for an ophthalmology review was made.

Despite treatment, the patient experienced pain and continued loss of vision. By the end of the year, she was irreversibly blind.

Following this case, the Health Board appointed a Glaucoma Co-ordinator to oversee clinics and track patients through the pathway. A regional Glaucoma Service was developed and an additional ophthalmologist was recruited.

NEWS Cymru

A recent LAP identified that there was some confusion across Wales in relation to NEWS, NEWS Cymru and NEWS2.

During 2019, in response to the Royal College of Physician's NEWS2 guidance, a RRAILS Steering Group set up a collaborative to undertake a review of NEWS charts in Wales. The collaborative worked with clinicians within Health Boards, professional bodies and the Welsh Government to achieve a consistent approach across Wales.

Several areas of refinement were suggested in NEWS2. One area was related to oxygen stats/observations. No real evidence was found to conclude that including these extra observations were of benefit. If anything, they made the chart over complex. The original NEWS was therefore refined into NEWS Cymru.

The Steering Group disbanded and given there is no network for this topic, it appears that confusion has resulted and not all Health Boards adopted NEWS Cymru.
Welsh Government plan to hold a workshop to look into the matter.

Contact us

If you have any questions about the Learning Advisory Panel or would like to participate in one, please contact the Safety and Learning Team via email at welsh.riskpool@wales.nhs.uk.

Guidance Notes

General Points

(1) Organisations to provide one completed template for all complaints in their organisation.

(2) Redress cases on the Closed COMPLAINTS sheet will be supplied separately by the Welsh Risk Pool.

(3) The submission requirements for 2021/22 are quarterly as follows (if the submission date falls on a weekend, please submit on the next working day following the weekend):

Data relating to	Submission Date
April - June 2021	31st July 2021
July - September 2021	31st October 2021
October - December 2021	31st January 2022
January - March 2022	30th April 2022

(4) All submissions should be e-mailed to the Welsh Government Delivery & Performance Division inbox at:
HSS.Performance@gov.wales

ORGANISATION (select from drop down)			Powys Teaching HB				
NEW COMPLAINTS - 2021/22			Q1	Q2	Q3	Q4	Total
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				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				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				13
		Outpatient	9				9
		Emergency Department	4				4
		Community Hospital					
		Inpatient	5				5
		Outpatient	13				13
		Mental Health and Learning Disabilities					
		Inpatient	5				5
		Outpatient	0				0
		Community Mental Health	7				7
		Minor Injurys Unit (Acute or community based)	6				6
		Out of Hours GP services	1				1
		Ambulance service					
		Emergency and general transport	2				2
		111 services	1				1
		Welsh Blood Services	0				0
		Public Health Services	0				0
		Primary Care Services					
		General Practice (Independent Services)	20				20
		General practice (Health Board Managed Practices)	1				1
		NHS Dentists	8				8
		NHS Opticians	0				0
		NHS Pharmacies	3				3
		NHS Health Care provided in the Community					
		Inpatient setting eg nursing home	0				0
		patient's own home	0				0
		Externally Commissioned Services non NHS Wales	0				0
		Prison	0				0
		Other	3				3

NEW COMPLAINTS - 2021/22			Q1	Q2	Q3	Q4	Total
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				28
		Nursing, midwifery and health visiting staff	62				62
		Maintenance & Auxiliary Staff	0				0
		Clerical and Admin Staff	1				1
		Scientific, therapeutic and technical staff	2				2
		Healthcare assistants and support staff	0				0
		Ambulance Clinical Staff	0				0
		Concern not related to a profession	3				3
		Other	3				3
		Staff Not employed by the organisation	2				2
		Unknown	0				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				26
		Accident / falls	0				0
		Admissions	1				1
		Appointments	16				16
		Attitude / behaviour	9				9
		Assault	0				0
		Post death issues	1				1
		Catering	0				0
		Cleanliness	0				0
		Clinical treatment / assessment	7				7
		Communication issues (including language)	6				6
		Concerns handling	2				2
		Confidentiality	7				7
		Consent	0				0
		Discharge issues	5				5
		Equality	0				0
		Equipment	2				2
		Environment / facilities	5				5
		Infection control	0				0
		Medication	7				7
		Monitoring / observation issues	0				0
		Nutrition / hydration issues	0				0
		Patient care	1				1
		Personal property / finance	0				0
		Privacy / dignity	0				0
		Referrals	4				4
		Record keeping	1				1

NEW COMPLAINTS - 2021/22			Q1	Q2	Q3	Q4	Total
		Resources	0				0
		Skin damage	0				0
		Test and investigation results	0				0
		Other	1				1
6	**Total number of written compliments received in the quarter**		61				61
7	**Total number of previously closed complaints that were reopened during the quarter**		2				2

Patterson,Liz
10/05/2021 12:47:14

ORGANISATION (select from drop down)							
CLOSED COMPLAINTS - 2021/22 **NOTE - ALL REDRESS CASE INFORMATION WILL BE SUPPLIED BY THE WELSH RISK POOL**			Q1	Q2	Q3	Q4	Total
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				49
		Complaints Managed as INFORMAL COMPLAINTS	12				12
		Total number of complaints managed through PTR Regs	61	0	0	0	61
		Complaints managed through Early Resolution	0				0
		Total number of Complaints Closed during the quarter	61	0	0	0	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				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				23
		After 127 working days (6 months) of the date the Complaint was first received by the organisation	3				3
		Total number of Regulation 24 Complaints settled and received a final reply during the quarter	49	0	0	0	49
10	**Closed Complaints with SERIOUS INCIDENT INVESTIGATION** **Of the Complaints managed through the PTR Regulations closed during the quarter, how many had a Serious Incident investigation undertaken which was notified to Welsh Government**		0				0
11	**Closed Complaints by GRADING** **Of the Complaints managed through the PTR Regulations closed during the quarter, how many formal Complaints had a final grading as follows:**	Grade 5	0				0
		Grade 4	0				0
		Grade 3	0				0
		Grade 2	3				3
		Grade 1	58				58

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

Scheme for General Medical Practice Indemnity (GMPI) Guidelines

In 2018 the Welsh Government established a discretionary state-backed scheme of indemnity provision for General Practitioners on Welsh Medical Performers Lists, their staff and those engaged by the GP practice from 1 April 2019.

The main change for General Medical Practices is that in relation to incidents occurring on or after 1 April 2019, the health boards in Wales will provide an indemnity arrangement and will be the named Defendant for clinical negligence litigation rather than the General Medical Practices. Legal & Risk Services (NWSSP) will act on behalf of and seek instructions from the Health Boards in relation to the litigation and will seek evidence and views on the proposed strategy from General Medical Practices. Although the health boards will be the client for the purpose of the litigation, the views of all individuals involved will be

The scheme will include the provision of guidance and support for General Medical Practices in Wales and their employed or contracted staff, for actual or potential clinical negligence litigation arising from the provision of NHS Primary Medical Services. Some aspects of GP work will not be covered by the scheme, for which membership of a Medical Defence Organisation will remain necessary.

Examples of such 'out-of-scope' activity will include private work, inquests, disciplinary issues, issues with the General Medical Council or other Regulators and any non-clinical elements of Ombudsman referrals. The Scheme Regulations set out the scope of the scheme, namely "primary medical services" which are defined as health services provided under a contract, arrangement or agreement made under or by virtue of the following sections of the National Health Service (Wales) Act 2006: 4 (a) section 41(2) (primary medical services); (b) section 42(1) (general medical services contracts); (c) section 50 (arrangements by Local Health Boards for the provision of primary medical services). There is an All Wales Locum Register ('AWLR') for Wales which GP locums must join in order to be captured by GMPI. There are specific requirements with which GP locums must comply in order to benefit from GMPI.

Ombwdsmon Ombudsman
OMBWDSMON GWASANAETHAU CYHOEDDUS CYMRU
PUBLIC SERVICES OMBUDSMAN FOR WALES

Ask for: Communications

01656 641150

communications@ombudsman.wales

Date: September 2021

Professor Vivienne Harpwood
Powys Teaching Health Board

By Email only: vivienne.harpwood@wales.nhs.uk

Annual Letter 2020/21

Dear Vivienne

I am pleased to provide you with the Annual letter (2020/21) for Powys Teaching Health Board.

This letter discusses information from a year unlike any other in recent memory, and as such may not be useful for establishing trends or patterns. Information received during this remarkable year will, however, bring insights on how Public Services reacted in the face of unprecedented demand and the most difficult of circumstances.

Despite the challenges brought by the Covid 19 pandemic, I'm pleased with the engagement shown by the Health Board and the number of training sessions delivered by my complaints standards staff.

During the past financial year, we have intervened in (upheld, settled or resolved at an early stage) the same proportion of complaints about public bodies, 20%, compared with 2019/20.

Last year, we saw a 22% reduction in new complaints relating to Health Boards – a predictable reduction given the circumstances of the year. However, my Office intervened slightly more frequently in complaints involving Health Boards, 33% compared to 31% in 2019/20.

During 2020/21, despite challenges caused by the pandemic, my office made great strides in progressing work related to Complaints Standards and Own Initiative Investigations. The theme and consultation period of the first wider Own Initiative Investigation – into Local Authority Homelessness Assessments - was launched in September 2020 and the report is due in the coming months. We

also commenced 4 extended Own Initiative Investigations, where we extended the scope of our work on a complaint already under investigation.

Last year, my office also pushed ahead with two new publications – 'Our Findings' and our first Equality Report.

'Our Findings' will be accessed via the PSOW website and replaces the quarterly casebooks. Our Findings will be updated more frequently and will be a more useful tool in sharing the outcomes of investigations. Our first Equality Report highlights the work done to improve equality and diversity, and to ensure that our service is available to people from all parts of society.

A summary of the complaints of maladministration/service failure received relating to your Health Board is attached.

I ask that the Health Board takes the following actions:

- Present my Annual Letter to the Board to assist Board members in their scrutiny of the Health Board's complaints performance and their consideration of any actions to be taken as a result.
- Engage with my Complaints Standards work, accessing training for your staff and providing complaints data.
- Inform me of the outcome of the Health Board's considerations and proposed actions on the above matters by 15 November.

This correspondence is copied to the Chief Executive of your Health Board and to your Contact Officer. Finally, a copy of all Annual Letters will be published on my website.

Yours sincerely,

Nick Bennett
Ombudsman

cc. Carol Shillabeer, Chief Executive, Powys Teaching Health Board
By Email only: carol.shillabeer2@wales.nhs.uk

Factsheet

Appendix A - Complaints Received

Health Board	Complaints Received	Received per 1000 residents
Aneurin Bevan University Health Board	96	0.16
Betsi Cadwaladr University Health Board	184	0.26
Cardiff and Vale University Health Board	62	0.12
Cwm Taf Morgannwg University Health Board	86	0.19
Hywel Dda University Health Board	64	0.17
Powys Teaching Health Board	16	0.12
Swansea Bay University Health Board	79	0.20
Total	587	0.19

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01656 641150 01656 641199 ask@ombudsman-wales.org.uk | holwch@ombwdsmon-cymru.org.uk

Appendix B - Received by Subject

Powys Teaching Health Board	Complaints Received	% Share
Ambulance Services	0	0%
Appointments/admissions/discharge and transfer procedures	0	0%
Clinical treatment in hospital	6	38%
Clinical treatment outside hospital	4	25%
Complaints Handling	3	19%
Confidentiality	0	0%
Continuing care	0	0%
COVID19	1	6%
Disclosure of personal information / data loss	0	0%
Funding	0	0%
Medical records/standards of record-keeping	0	0%
Medication> Prescription dispensing	0	0%
NHS Independent Provider	0	0%
Non-medical services	0	0%
Other	2	13%
Patient list issues	0	0%
Poor/No communication or failure to provide information	0	0%
Rudeness/inconsiderate behaviour/staff attitude	0	0%
	16	

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Appendix C - Complaint Outcomes
(* denotes intervention)

Local Health Board/NHS Trust	Out of Jurisdiction	Premature	Other cases closed after initial consideration	Early Resolution /voluntary settlement *	Discontinued	Other Reports- Not Upheld	Other Reports - Upheld*	Public Interest Report*	Total
Powys Teaching Health Board	3	4	5	4	0	0	1	0	17
% share	18%	24%	29%	24%	0%	0%	6%	0%	

Appendix D - Cases with PSOW Intervention

	No. of Interventions	No. of Closures	% Of Interventions
Aneurin Bevan University Health Board	38	106	36%
Betsi Cadwaladr University Health Board	68	194	35%
Cardiff and Vale University Health Board	21	72	29%
Cwm Taf Morgannwg University Health Board	19	83	23%
Hywel Dda University Health Board	33	74	45%
Powys Teaching Health Board	5	17	29%
Swansea Bay University Health Board	25	80	31%
Total	**209**	**626**	33%

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Ombwdsmon Ombudsman
OMBWDSMON GWASANAETHAU CYHOEDDUS CYMRU
PUBLIC SERVICES OMBUDSMAN FOR WALES

Information Sheet

Appendix A shows the number of complaints received by PSOW for all Health Boards in 2020/2021. These complaints are contextualised by the number of people each health board reportedly serves.

Appendix B shows the categorisation of each complaint received, and what proportion of received complaints represents for the Health Board.

Appendix C shows outcomes of the complaints which PSOW closed for the Health Board in 2020/2021. This table shows both the volume, and the proportion that each outcome represents for the Health Board.

Appendix D shows Intervention Rates for all Health Boards in 2020/2021. An intervention is categorised by either an upheld complaint (either public interest or non-public interest), an early resolution, or a voluntary settlement.

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Agenda item: 3.3

PATIENT EXPERIENCE, QUALITY & SAFETY COMMITTEE	7 October 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 22 September 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 is asked to

- DISCUSS the contents of this report
- Agree the revised timeframes for the National Maternity Improvement Plan priorities 2021.

Approval/Ratification/Decision	Discussion	Information
x	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	✓
	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 provides assurance on progress with Tier 1 and unannounced inspections. Quality check summary reports for dental practices are now highlighted within this report, with the primary care team leading the assurance monitoring arrangements.

An update on the National Maternity improvement plan priorities 2021, seeks agreement to extend the timeframe for 5 actions. HIW have confirmed their decision not to progress with phase 2 of the review.

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

1.1 Tier 1 Quality Checks

Clywedog Ward, LLandrindod Wells Memorial Hospital

Healthcare Inspectorate Wales (HIW) responded to the receipt of the 3-month review of progress made in terms of the improvement plan, following the quality check of Clywedog ward on the 23 March 2021. HIW concluded that sufficient assurance was provided by the health board (**appendix 1**). The updated improvement plan is unpublished and used by HIW to inform any future inspection and assurance activity.

1.2 Unannounced Inspections

An unannounced inspection took place 15 June 2021 on Felindre Ward, Bronllys Hospital. There were no immediate improvements issued. The final report **(appendix 2)** was published 20 September 2021 - Bronllys Hospital | Healthcare Inspectorate Wales (hiw.org.uk).

Evidence is required to demonstrate that actions in the improvement plan have been completed. At this time 13 of the 27 actions are completed, with 3 red and 11 amber.

1.3 Dental Practice Inspections

There have been a number of dental practice inspections recently reported (**appendix 3a, b & c)**:

- 12th May 2021: Ystradgynlais Dental Practice Quality Check Summary Report, published 16th June 2021. The report was discussed at the recent General Dental Service (GDS) governance group and noting the report was positive, no further actions were identified.
  Ystradgynlais Dental Practice | Healthcare Inspectorate Wales (hiw.org.uk)

- 29th June 2021 MyDentist, Welshpool Quality Check Summary Report, published 3 August 2021.
  MyDentist – Severn Street, Welshpool | Healthcare Inspectorate Wales (hiw.org.uk)

- 14th July 2021 MyDentist, Newtown Quality Check Summary Report, published 16 August 2021
  MyDentist – New Road, Newtown | Healthcare Inspectorate Wales (hiw.org.uk)

Improvement activity will be monitored through the Primary Care governance and assurance monitoring arrangements.

1.4 Welsh Ambulance Services Trust: Review of Patient Experience whilst Waiting in Ambulances during Delayed Handover

Healthcare Inspectorate Wales completed a local review of the Welsh Ambulance Service Trust (WAST). The focus of the review was to consider the impact of ambulance waits outside Emergency Departments on patient safety, privacy, dignity and their overall experience. Powys Teaching Health Board were invited to provide feedback as part of this review.

A draft report has been received and the health board was invited to review the local review report for factual accuracy providing feedback by Friday 20 August 2021. The health board are also invited to complete a joint management response action plan, in collaboration with WAST and Welsh Government, by Friday 25 September 2021 (**Appendix 4a and b)**.

2 Care Inspectorate Wales

The inspection report for Cottage View was published 3 August 2021 attached in **appendix 5**. Progress on the areas for improvement will be reported in future papers. Cottage View | Care Inspectorate Wales

3 National Maternity Improvement Plan 2021 Priorities

Maternity services are making good progress with regard to the National Maternity Improvement Plan 2021 priorities. However, there are five areas where they are requesting revised timeframes. The Patient Experience, Quality & Safety Committee is asked to note the requirement for revised timelines. These are:

HIW Maternity Improvement action ***Improvement needed***	**Context / Narrative** ***Current Position***
Action 9- CO Monitoring ***The Health Board must ensure smoking cessation and healthier lifestyles are continued to reduce risk of stillbirth and improve the health and wellbeing of Powys families.***	RCOG COVID19 version 14 (August 2021) recommends that Pregnant women should be offered CO Monitoring. A paper is being prepared for September Prevent and Response Committee for Powys Midwifery and Health Visiting services to resume CO Monitoring in line with evidence-based guidance. This will require the support of Powys Public Health team. Risk Assessment tools for staff and client safety which have been adapted by other health boards in Wales will be part of the paper.

Action 14- Maternity Support worker skill mix for continuity teams ***The Health Board to support the implementation of full roll of Continuity of Care in Powys by 8 teams across Powys to commence in May 2021 and explore pathways with commissioned services to enhance continuity with obstetric colleagues to include named consultant for PTHB and use of virtual means such as Attend Anywhere.***	Powys Continuity teams fully rolled out in June 2021. Business Case to be developed for additional resource of Maternity Support Worker to be developed as part of the Evaluation and Sustainability of Healthier Lifestyle roles which are funded until March 2022.
Action 15 - Infant Feeding group to resume ***The Health Board to ensure the appropriate level of breastfeeding advice, guidance and support is provided at all times***	Welsh Government Infant Feeding Action remains on hold due to COVID19 service pressures. Powys Infant Feeding Action Plan will be resumed as part of the Start Well / Partnership renewal priorities. Infant Feeding. A business case will need to be developed to Regional Partnership Board via Start Well Programme Board for the implementation Welsh Government Recommendation 4 for the All Wales Breastfeeding Action Plan for Strategic Lead for Breastfeeding.
Action 21- Welshpool Birth Pool Installation ***The Health Board to review how Waterbirth options can be made available across all services***	The installation of Welshpool Birth Pool was delayed due to supply of taps and re-sourcing of the Pool. Pool now on schedule to be installed in September with a soft launch / formal opening of the Pool scheduled for October 2021.
Action 24 -Digital Maternity Cymru – awaiting Welsh Government Scoping paper ***The Health Board to prepare for the timely implementation of a single maternity dashboard for Maternity services in Wales***	Welsh Government have been undertaking a scoping paper to prepare for the implementation of a single maternity dashboard for Wales (Maternity Digital Cymru) which is expected to report to NHS Collaborative in Autumn 2021. The delay in implementation is adding a risk with Cross Border commissioned services who are implementing Badgernet as their preferred Maternity system. Once the Welsh Government scoping paper has been approved the health board are expecting Welsh Government resource for implementation to support Digital Midwife to help support with the implementation of a single maternity dashboard for Powys.

National Review of Maternity Services – Phase Two and Follow Up

Healthcare Inspectorate Wales communication received 25 August 2021 (**Appendix 6**) confirmed their decision not to progress with phase 2 of the review as set out in their published terms of reference. Instead, for issues

identified in relation to aspects of maternity care that were outside the original scope of the national review, they will seek assurances through their follow up work.

It is further indicated HIW In February 2021, commenced stage one of their formal reviews follow up process, and wrote to each health board to request an update on progress against the national recommendations, receiving a satisfactory response from each health board.

Summer 2022, they will commence stage two of their follow up process to request a further update on progress against the national recommendations. In addition to their formal reviews follow up process, their review, inspection and intelligence teams, along with their Relationship Managers, will continue to gather intelligence and will work with health boards, Welsh Government and other stakeholders where appropriate, to follow up on phase one activity, and to gain assurance where they feel necessary for antenatal and postnatal care services.

Powys Maternity Services are maintaining their momentum outstanding actions, and in providing assurance on progress an update on the Powys Maternity Improvement actions is provided below:

HIW Powys Maternity Improvement action ***Local Improvement needed***	**Context / Narrative** ***Current Position***
Action 13- ***The health board must ensure that a review of the facilities within Llanidloes War Memorial Hospital and Knighton Hospital takes place to ensure that infection prevention and control measures are in line with health board policy.***	Maternity services are working in partnership with Capital Estates for review of Llanidloes War Memorial Hospital and Knighton Hospital to improve facilities for the environment. Plans for Phase 1 (redecoration), 2 (bathroom improvement) and 3 (Pool Hoist insertion and Double Bed) have been developed for Knighton Birth Centre). Llanidloes Birth Centre improvement plan is being developed with the Capital Estates team and funding in discussion with League of Friends. Plans have been slightly delayed due COVID19 pressures but will be scheduled to be progress in Q2 (September – December 2021)
Action 14- ***The health board must ensure that policies and procedures are reviewed and updated within appropriate timescales to ensure consistency in care.***	Women's and Children's Policy and Procedures group has an action plan that lists all policies and guidelines developed, which include revision dates and priority list for completion. This work is on track to complete.

	All policy / guideline authors are approached by the appropriate forums within the Health Board when policy review is required.

4 Health and Social Care Regulatory Reports: Recommendations and Tracker

The dashboard at **appendix 7** provides an overview of the current position relating to the implementation of recommendations following Health and Social Care Regulatory visits. Validation of the tracker continues to ensure a current position on progress against all recommendations is captured.

The table below sets out the inspections where all actions have been completed which is unchanged since the previous report:

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

Inspections added to the tracker since the last report, featured in Table 2 below, support ongoing monitoring and assurance on actions as they are implemented.

Table 2: Inspections added to the tracker

2021/22	212208	Tier 1 Quality Check Felindre Ward, Bronllys Hospital; an unannounced visit.

5. Community Health Council

There have been no recent inspections. Work is underway in partnership with the Community Health Council to establish a virtual visiting arrangement, which will be reported upon in future papers.

6. Environmental Health Services

Environmental Health Officers visited Ystradgynlais Hospital on 1st June 2021 and Brecon War Memorial Hospital on the 24th August 2021. Both hospital sites gained a score of 5 meaning that there were no actions required. There have been no further inspections in the current reporting period.

APPENDIX 1

Direct Line: 0300 062 8163
E-mail: HIW.Inspections@gov.wales

Carol Shillabeer

Powys Teaching Health Board

16 July 2021

Dear Ms Shillabeer

Healthcare Inspectorate Wales (HIW) Quality Check – Clywedog Ward, Llandrindod Memorial Hospital: - Improvement Plan – 3 month review

Thank you for taking the time to submit your completed improvement plan and associated evidence following the quality check of Clywedog Ward on 23 March 2021.

HIW has evaluated your response and concluded that it provides us with sufficient assurance. This is because the improvements we identified have either been addressed and/or progress is being made to ensure that patient safety is protected.

Please note that the updated improvement plan will not be published. HIW uses this information to inform any future inspection and assurance activity and where actions remain outstanding we will follow these up in line with the timescales proposed in your improvement plan.

Please contact me should you wish to discuss this letter.

Yours sincerely

Mitchell Parker
Healthcare Inspector
Healthcare Inspectorate Wales

Gwirio bod pobl yng Nghymru yn derbyn gofal da

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Healthcare Inspectorate Wales • Arolygiaeth Gofal Iechyd Cymru
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CF48 1UZ
Tel • Ffôn 0300 062 8163
www.hiw.org.uk

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

NHS Mental Health Service Inspection (Unannounced)

Bronllys Hospital

Felindre Ward

Powys Teaching Health Board

Inspection date: 15 – 17 June 2021

Publication date: 20 September 2021

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

Copies of all reports, when published, will be available on our website or by contacting us:

In writing:

Communications Manager

Healthcare Inspectorate Wales
Welsh Government

Rhydycar Business Park

Merthyr Tydfil

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

Our purpose

To check that people in Wales receive good quality healthcare

Our values

We place patients at the heart of what we do. We are:

- Independent
- Objective
- Caring
- Collaborative
- Authoritative

Our priorities

Through our work we aim to:

Provide assurance:	Provide an independent view on the quality of care
Promote improvement:	Encourage improvement through reporting and sharing of good practice
Influence policy and standards:	Use what we find to influence policy, standards and practice

1. What we did

Healthcare Inspectorate Wales (HIW) completed an unannounced mental health inspection of Bronllys Hospital within Powys Teaching Health Board on the evening of 15 June 2021 and the following days of 16 and 17 June 2021. The following sites and wards were visited during this inspection:

- Felindre Ward

Our team, for the inspection comprised of two HIW inspectors and one clinical peer reviewer. A HIW inspection manager led the inspection.

Further details about how we conduct NHS mental health service inspections can be found in Section 5 and on our website.

2. Summary of our inspection

We found a dedicated staff team that were committed to providing a high standard of care to patients. We observed staff interacting with patients respectfully throughout the inspection.

Patients we spoke to told us they were happy and stated that they were receiving good care at the hospital.

The high number of maintenance issues that were unresolved on the ward concerned us, this is impacting negatively on patient experience. Significant improvements are required in relation to reviewing and updating policies.

This is what we found the service did well:

- We observed that staff interacted and engaged with patients respectfully
- Good team working and motivated staff
- Patients were provided with a good range of therapies and activities.

This is what we recommend the service could improve:

- The general maintenance of the hospital facilities
- The provision of information on the ward for patients
- Organisation and completion of care plans
- Review and update of policies
- Completion and monitoring of mandatory training.

There were no areas of immediate assurance requiring urgent remedial action identified at this inspection.

3. What we found

Background of the service

Bronllys, Felindre Ward provides NHS mental health services at Brecon Road, Bronllys, Powys LD3 0LU, within Powys Teaching Health Board.

Felindre is a 16 bedded acute adult mental health admission ward, with the addition of two crisis beds, serving the population of Powys.

The service is a mixed gender ward, however gender separation is afforded careful consideration. At the time of inspection, there were ten patients at the hospital. HIW last inspected the hospital in November 2019.

The service employs a staff team which includes a team of registered mental health nurses and health care support workers. The multi-disciplinary team consists of two consultant psychiatrists, an occupational therapist and an assistant occupational therapist.

Dedicated teams of administration staff, maintenance, catering and domestic staff support the day-to-day operation of the hospital.

The health board's clinical and administrative structures support the hospital.

Quality of patient experience

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

We observed staff interacting and engaging with patients appropriately and we observed staff treating patients with dignity and respect.

Patients we spoke to told us they were happy and receiving good care at the hospital.

There were a range of suitable activities and therapies available on Felindre Ward, to aid patient rehabilitation. However, we have made a number of recommendations on the physical environment of care.

Staying healthy

Bronllys had a range of facilities to support the provision of therapies and activities along with regular access to the community for patients that were authorised to leave the hospital. However, due to the restrictions of the coronavirus (COVID- 19) pandemic, patients have been accessing leave less frequently following government and organisational guidance.

We observed patients and staff taking part in a range of activities throughout the inspection. These activities included pottery classes, playing board games and table tennis, and reading and watching television.

The hospital had a designated games room for patients which contained arts and crafts resources and an occupational therapy kitchen. This was an improvement since our last inspection. Occupational therapists had been appointed, which improved patient activities by enabling patients to engage in daily life activities on the ward, allowing them to develop routines and lifestyle skills.

The ward had a dedicated smoking room; it was clean, and staff kept the room shut so the smell did not spread onto the ward. We were told that plans were in

place to change the smoking room into a gym facility. This will be a positive change for patients as the ward will then be compliant with smoke free legislation and requirements and ensure that patients who cannot leave the ward have an opportunity to exercise. The health board must notify HIW of when this change has occurred.

Patients did have access to an enclosed garden area and during our inspection we saw patients using the garden during the day and at night. However staff told us that the garden light was not working. The broken garden light was an area of improvement required by the health board during our last inspection. The health board must ensure that the garden light is fixed so patients can use the garden area safely.

The ward had designated times for providing patients with drinks throughout the day. They served hot drinks on a two hourly basis from 6am through till 10pm. Patients told us that if they wanted hot drinks outside of the stipulated hours, staff would aim to provide them. The health board must explore options to support patients in accessing hot drinks throughout the day to lessen this institutional practice of designated times for hot drinks.

A water fountain is also available in the lounge area so that patients could readily access drinking water.

Improvement needed

The health board must make sure that :

- The plans to replace the smoking room with a gym are completed
- Light fixtures in garden are fixed
- Patients are able to easily access hot drinks throughout the day.

Dignified care

We noted that all employees; ward staff, senior management and administration staff, interacted and engaged with patients appropriately and treated patients with dignity and respect.

The staff we spoke with were passionate about their roles and enthusiastic about how they supported and cared for the patients. We observed most staff taking time to speak with patients and address any needs or concerns the patients raised, this demonstrated that staff had responsive and caring attitudes towards the patients.

Locked doors and an intercom system on the ward prevented any unauthorised access. The ward provided mixed gender care and although gender separation is given careful consideration, this presented challenges around aspects of dignified care. Most patients had access to their own bedroom, however there was one shared bedroom on the male corridor, the two beds within this area had curtains between them. These only afforded the basic level of privacy for patients, and do not reflect modern mental health care provision.

Patients were not able to lock their bedrooms unless they asked staff. Patients told us that staff generally respected their privacy and dignity. During the course of our inspection we saw many examples of staff knocking on patients doors before entering the bedrooms.

The bedrooms offered limited storage and patients were not able to personalise their room with pictures and posters. We noted that there were no vision panels on the bedroom doors, which enable staff to do hourly observations without opening doors and disturbing patients sleeping. The health board told us they had considered other options and were awaiting delivery of new doors which would enable staff to check on the well-being of patients with minimal disruption. The health board must ensure that these new doors are fitted.

Patient bedrooms did not have en-suite facilities; there were gender specific shared toilets, and shower facilities located on the ward corridors. The two crisis rooms did have en-suite facilities and appeared more welcoming than the ward bedrooms.

One shared female bathroom was out of use because the shower was broken. We were told that this issue had been raised over a week before the inspection with the health board maintenance and facilities team. The health board must ensure that the shower facilities are fixed to improve dignified care for patients.

There were laundry facilities at the hospital that the patients were encouraged to use, with support from staff where required.

In the nurse's office, there was a patient status at a glance board[1] displaying confidential information regarding each patient being cared for on the ward. The boards were designed in such a way that they could cover confidential information when the boards were not in use. This meant that the staff team were making every effort to protect patient confidentiality.

Hospital policies and the staff practices we observed, contributed to maintaining patient dignity and enhancing individualised care at the hospital. There were regular ward meetings to review and discuss practices to minimise the restrictions on patients based on individual patient's risks.

Improvement needed

The health board must ensure that :

- Improvements are made to the environment to ensure patient have a level of privacy in bedroom areas
- They consider options on ensuring staff can check on the well-being of patients with minimal disruption
- Shower in female bathroom is fixed.

Patient information

There were some information boards were on the ward protected by Perspex. They included religious information, activity timetable, and bus timetables. The ward appeared very clinical and although some information was available, we noted that there was no information displayed in the hospital to help patients and their families understand their care, nor details about organisations that can provide help and support to patients affected by mental health conditions. Advocacy information was available and it was positive to note that information on display was also available in welsh.

[1] A board that provides staff with a quick reference to essential information about the individual patients being cared for on the ward.

There was no information available on the role of HIW and how patients can contact the organisation. This is required by the Mental Health Act 1983 Code of Practice for Wales[2].

There was no information displayed about how patients could raise a concern about their care which includes NHS Wales Putting Things Right[3] arrangements.

Staff provide patients with a welcome pack on admission which included smoking cessation advice and other appropriate information, such as mealtimes. In addition essential items such as toothbrushes and hygiene products were also included in the packs.

A smoking cessation officer also attends the hospital on a weekly basis to provide patients with information and support.

Improvement needed

The health board must ensure that a range of information for patients is displayed on the ward that includes:

- The NHS Putting Things Right process
- Guidance around mental health legislation
- Healthcare Inspectorate Wales.

Communicating effectively

All patients we spoke with stated that they felt safe and able to speak with a staff member should they need to. Patients told us they were happy at the hospital

[2] Mental Health Act 1983 Code of Practice for Wales (Revised 2016) provides guidance to professionals about their responsibilities under the Mental Health Act 1983. As well as providing guidance for professionals, the Code of practice also provides information for patients, their families and carers. https://gov.wales/topics/health/nhswales/mental-health-services/law/code-of-practice/?lang=en

[3] Putting Things Right is the process for managing concerns in NHS Wales. http://www.wales.nhs.uk/sites3/home.cfm?orgid=932

and that staff were kind and helpful. There was clear mutual respect and strong relational security between staff and patients.

For individual meetings, patients could have assistance from external bodies to provide support and guidance, such as solicitors or advocacy. With patients' agreement, wherever possible, their families and carers were also included in some meetings.

There were a number of meetings involving patients and staff. These meetings included formal individual care planning meetings and group community meetings.

Staff and patients told us about the patients' council, this is a positive initiative where previous service users attend the ward and listen to patient views to help improve the experience on the ward. We saw evidence of regular patient meetings and it was pleasing to hear staff and patients speaking about the patient council in a positive way.

Timely care

The ward held a bed status weekly management meeting to establish the bed occupancy levels. They also held meetings to discuss patients who had been placed in services in other health boards or independent providers.

Felindre ward has a designated Section 136 suite[4] which facilitates the south Powys area. The Section 136 suite complied with the National Institute for Health and Clinical Excellence (NICE) standards, and the hospital ward and police had an agreed protocol on the use of the suite.

We were also told that meetings took place between the police and ward staff to evaluate admissions and frequency of use of the suite. It was positive to hear that any lessons learnt and organisational feedback would be discussed during these sessions and fed back to staff from both organisations. Close partnership

[4] Section 136 gives the police the power to remove a person from a public place, when they appear to be suffering from a mental disorder, to a place of safety. A Section 136 Suite is a designated place of safety

working with the police and effective use of the Section 136 suite is crucial to ensure that people presenting with mental health issues are getting the right care in the right setting.

People's rights

Legal documentation we saw to detain patients under the Mental Health Act was compliant with the legislation.

Information was displayed on the wards to inform patients, who were not restricted by the Act[5], about their rights to leave the ward.

Established hospital policies and systems ensured that patients' equality, diversity and rights are maintained.

Depending on individual risk assessment, patients could have access to their mobile phone but are prevented from using them in communal areas. Patients also had access to a pay phone located in a private booth within the hospital to enable patients to make contact with family and friends.

Due to Welsh Government restrictions associated with COVID-19 legislation, visitors were not allowed on to the hospital ward. However, some patients could meet with family and friends within the spacious hospital grounds. Other patients could maintain contact with family and friends by telephone and video calls.

Facilities were available for patients to spend time with family and friends; a visitor room was available when government restrictions eased, however there was limited information available for families and visitors in this room.

[5] Commonly referred to as "informal patients", where the patient has capacity to agree to remain in hospital to receive care for their mental health.

Improvement needed

The health board must ensure that information is available for visitors in the visitor's room.

Listening and learning from feedback

There were regular patient meetings where patients had the opportunity to provide feedback on the care that they receive at the hospital and discuss any developments or concerns. However, during our inspection we identified issues raised in meetings by patients were not being dealt with and being carried forward for several months with no action being taken. Patient minutes of meetings indicated that easily resolved issues were carried forward over several months; for example nurses protected time with patients had not been taking place from February to June. This was repeatedly raised in patient meetings and still remained unresolved. The health board must ensure that patients' requests are dealt with promptly and in a timely manner.

Senior ward staff confirmed that wherever possible they would try and resolve complaints immediately. The health board also had a process in place where patients could escalate concerns via the health boards' Putting Things Right complaints procedure. Patients could also provide anonymous feedback and suggestions on improvements for the ward via anonymous forms placed in a suggestion boxes located in the recovery room.

Improvement needed

The health board must ensure that patient requests are dealt with and in a timely manner.

Delivery of safe and effective care

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

We found that staff were generally completing clinical processes and documentation as required.

There were established processes and audits in place to manage risk, health and safety and infection control. This enabled staff to continue to provide safe and clinically effective care.

We made some recommendations on some areas of infection control and medications management.

Safe care

Managing risk and promoting health and safety

During the course of our inspection we noted that there was damage to three fire doors within the hospital, the glass panes on all 3 fire doors had been broken and boarded up. We were concerned that the integrity of the fire door was compromised which would reduce the effectiveness of the fire door in the case of fire.

The health board provided us with documentary evidence from a fire safety officer, who confirmed that the doors gave adequate fire security precautions. We were told by the health board and provided with additional evidence which confirmed that new doors had been ordered and were due to be fitted. The health board must ensure that the fire doors are replaced and HIW are informed when this work has been completed.

Access to the wards was direct from the hospital car park which provided suitable access for people who may have mobility difficulties. Entry to the mental health unit and ward was secure to prevent unauthorised access.

There were no nurse call points around the ward corridors. The bedrooms with en-suite bathrooms and the crisis beds did have nurse call points within the bathroom areas, however there were no nurse call points in the remaining patient bedrooms. If a patient was in difficulty or distress within their bedroom, then they could not attract the attention of staff promptly. This issue needs to be reviewed

as we commented upon this during our previous inspection. The health board must provide clarity on how a patient should call for assistance if there are no nurse call points within bedrooms.

Staff had access to personal alarms to call for assistance if required. They also linked the alarm system to the community teams in a separate area of the building. This meant if activated the community team would provide additional support if present at the hospital.

The furniture, fixtures and fittings at the hospital were appropriate for the patient group. Some furniture had been replaced since our last inspection. The new furniture created a pleasant, comfortable and welcoming atmosphere on the ward.

Several areas of the ward needed a paint refresh, the corridor to the garden, the wooden frame of the medication room door, and the ceiling in the games room.

There was no Psychiatric Intensive Care Unit[6] (PICU) at Bronllys Hospital. If a PICU was required, then patients would be transferred to another service which provided this facility. Staff we spoke with did not raised any concerns about this arrangement.

Improvement needed

The health board must make sure that:

- Patients can alert staff that they require assistance from their bedrooms.
- Ward areas are painted.

[6] A Psychiatric Intensive Care Unit is an in-patient mental health ward that provides greater support and lower risk for patients with a more restrictive environment and increased staffing levels than an acute ward. PICUs are designed to look after patients who cannot be managed on acute psychiatric wards due to the level of risk the patient poses to themselves or others. The aim is for the patient's length of stay to be as short as possible to manage the increased challenging behaviours and then returned to an acute ward as soon as their mental state has stabilised to what can be safely managed there.

Infection prevention and control

The health board employed dedicated housekeeping staff for the wards. They described a system of regular audit of infection control arrangement. This was completed with the aim to identify areas for improvement so that they could take appropriate action where necessary.

Staff confirmed that cleaning schedules were in place to promote regular and effective cleaning of the hospital. Staff were aware of their responsibilities around infection prevention and control, and we observed staff undertaking cleaning duties.

Cleaning equipment was stored and organised appropriately. There were suitable arrangements in place for the disposal of clinical waste. Bins were available to dispose of medical sharp items and these were not over filled.

We saw evidence to confirm that the health board conducted necessary risk assessments and updated relevant policies and procedures to meet the additional demands of the COVID-19 pandemic. Staff we spoke to were aware of infection control obligations. We also examined COVID-19 documents, which supported staff to ensure they remained compliant with policies and procedures.

Felindre ward had areas set aside an area where if a patient became symptomatic they could be isolated and barrier nursed in a bedroom within a protected area. None of these areas were in use at the time of inspection.

Regular communication via meetings and emails ensured everyone has up to date advice and guidance on COVID-19.

During our discussions, staff highlighted did not highlight any issues relating to access to Personal Protection Equipment (PPE). PPE, including masks and gloves, was available at the ward entrance and they provided bins for the disposal of equipment. Staff wear masks in communal areas and on the ward and anyone attending the ward have their temperature checked before admission.

Hand gel dispensers are available on entry to the ward but we did not see any in the communal areas of the ward. In addition hand hygiene audits completed on 7 June 2021 indicated compliance of only 68.75%. The health board must ensure that improvements are made to current hand hygiene compliance rates.

Improvement needed

The health board must make sure that:

- Appropriate hand hygiene products are available in the communal areas of the ward
- Improvements are made in hand hygiene audit results.

Nutrition and hydration

The hospital provided patients with meals on the ward, making their choices from the hospital menu. We were told that specific dietary requirements were accommodated and if patients missed mealtimes, they would be provided with sandwiches. Staff said patients make their food choices in advance and stated if a patient changes their mind they can usually be accommodated with another option.

The dining room was clean and tidy and provided a suitable environment for patients to eat their meals.

Patients with leave could access the community to purchase food items and ingredients to cook in the occupational therapy kitchen with supervision.

Medicines management

Overall, we noted that medication was securely stored. Staff locked the clinic room and medication cupboards to prevent unauthorised access. Medication trolleys were also secured to the clinic room, to prevent them being removed by an unauthorised person. Staff locked medication fridges when not being accessed. On the first night of the inspection we noted that the medication fridge in the clinical room was not working. We were told all current medication was being stored on another ward. When we attended the hospital the following day, the fridge had been repaired.

There were appropriate arrangements in place on the ward for the storage and use of Controlled Drugs and Drugs Liable to Misuse. The temperatures of medication fridge was being recorded, however we noted that no temperature checks had been monitored or recorded for the clinical room. It is important that temperature checks of the clinical room are taken and recorded to ensure that medication does not change due to the temperature of the room.

There was a regular pharmacy input, and audits were undertaken which assisted the management, prescribing and administration of medication. We observed a number of medication rounds, and saw that staff undertook these appropriately and professionally, and interacted with patients respectfully and considerately.

The Medication Administration Records (MAR Charts)[7] reviewed were not always fully completed by staff. Staff recorded patient names and identifications on front pages of charts but were missing on several of the other pages. This was common across all MAR Charts viewed.

Staff were recording the administration of medication, or the reason it had not occurred, however, there was little evidence of patient engagement in medication management. It is important that patients are involved in decisions on prescribed medication and that these discussion are recorded in patient notes.

We noted that over the counter medication to treat minor ailments (topical homely remedies) were stored in a shelf under the medication trolley. Staff lock the clinical room when not in use, however patients accessed this area for physical health checks. The health board policy states at section 5 ‘All medicinal products issued for use shall be safeguarded against loss or improper use’ (with the exception of emergency drugs boxes) be stored in a locked cupboard, trolley, refrigerator, patients own locker or other secure receptacle. The health board must ensure that homely remedies are stored correctly and in line with health board policy.

Improvement needed

The health board must ensure that:

[7] A Medication Administration Record is the report that serves as a legal record of the drugs administered to a patient by a health care professional. The Medication Administration Record is a part of a patient's permanent record on their medical chart.

- Temperature checks on the clinical room are consistently taken and recorded
- MAR charts are completed correctly.
- Discussions about medications are recorded in patient notes
- Homely remedies are stored correctly and in line with health board policy.

Safeguarding children and adults at risk

There were established health board policies and processes in place to ensure that staff safeguarded vulnerable adults and children, with referrals to external agencies as and when required.

Ward staff had access to the health board's safeguarding procedures via its intranet. Senior ward staff confirmed they were confident that staff were aware of the correct procedure to follow should they have a safeguarding concern. During discussions with staff they were able to demonstrate knowledge of the process of making a safeguarding referral.

Medical devices, equipment and diagnostic systems

There were regular clinical audits undertaken at the hospital and we saw evidence of regular auditing of resuscitation equipment. Staff had documented when these had occurred to ensure that the equipment was present and in date.

During staff discussions, it was evident that staff were aware of the locations of ligature cutters in case of an emergency.

Effective care

Safe and clinically effective care

Staff described strategies for managing challenging behaviour to promote the safety and well-being of patients. We were told that preventative techniques were used and where necessary staff would observe patients more frequently if their behaviour was a cause for concern. Senior staff confirmed that the safe physical

restraint of patients was used, but this was rare and only used as a last resort. Data we viewed on inspection confirmed that physical restraint is used as a last resort and verbal de-escalation used more often.

The ward had a specific area for staff to redirect patients, to manage their challenging behaviours. Staff used the extra care suite to take patients who were agitated and distressed, in order to de-escalate their behaviour. This suite enables staff to protect the patient's privacy and dignity and to prevent other patients becoming distressed. The health board had removed the sofa from this area due to damage being caused during a previous incident. The health board told us that a new one had been ordered and they were awaiting its arrival.

The health board completed the last ligature risk assessment in 2019. This document identified potential ligature points and what actions they had taken to remove or manage these. The health board must review the ligature audit assessment when any new furniture, fittings and doors are replaced to ensure that the ligature risk assessment document is accurate and up to date.

We requested to view a selection of clinic room polices however, upon review most of the versions we received had passed their review date. We found the following policies were out of date:

- Management of Adults with Methicillin Resistant Staphylococcus Aureus (MRSA) – Review due date August 2016
- Medication Management policy had expired – Review date March 2016
- Transcribing/amending inpatient charts – Review due date July 2017
- Resuscitations policy – Review due date August 2017
- Remote prescribing – Review due date November 2018.

We were not assured that staff were obtaining or being provided with the most up to date guidance to direct their professional practice. We highlighted some outdated policies on a previous inspection. It was disappointing to see that the health board had not renewed these. The health board must make sure that all policies are updated and reviewed.

Improvement needed

The health board must make sure:

- The ligature points risk assessment is updated
- All policies are reviewed and updated
- There is a routine audit of policies to ensure that ward staff have access to, and are referring to, the most recent version.

Quality improvement, research and innovation

During our discussions with ward staff and senior managers, we were provided with many examples where they were reviewing the provision of service on the ward and the wider health board. This was to assist in the modernisation of care and implement innovation to develop the service. Since our last inspection the health board had created additional beds on the ward, therefore increasing the provision of inpatient mental health services to support the needs of the health board's population.

It was also positive to hear of the ongoing developing plans for the smoking room to be converted into a gym for patients use. This will provide an additional activity option for patients and will support their health and well-being.

Record keeping

Patient records were mainly paper files that were stored within the locked nursing office. We observed staff storing the records appropriately during our inspection.

Staff completed factual entries where they documented patient daily routines, which provided clear information regarding each patient's care.

We reviewed a sample of patient records. It was evident that staff from across the multidisciplinary teams were writing detailed and regular entries.

Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision

We reviewed the care plans of a total of three patients.

We reviewed a sample of care files and found they were generally maintained to a good standard. However, some notes within files were not filed correctly and appeared to be disorganised.

The Wales Applied Risk Research Network (WARRN) assessments provided good summaries of personal and historical factors associated with risk. This helped to manage the risks of individual patients. However in some records we did identify that there was limited evidence of physical health monitoring. One set of notes viewed highlighted that they had not undertaken a physical health assessments since admission.

In addition, we also noted that the unmet needs of patients in some care plans were not recorded in the notes we viewed. It is important that unmet needs are documented so that these can be reviewed by the multidisciplinary team to look at options for meeting those needs.

We also noted that some patients refused to collaborate with their care and treatment plan (CTP) and would not sign it. The CTP is the patient's own personal plan and offers an opportunity to promote engagement with care and treatment, exploring and including the patient's perspective as far as is possible. It is therefore important that staff document any refusal by a patient to sign a plan, and that they record the reason for the refusal within patients' care notes.

We also found that had Section 17[8] leave paperwork in three patient records had not been signed by the patient to evidence that they patient understood their responsibilities and agreed conditions of leave.

Improvement needed

The health board must ensure that:

- Notes are filed correctly and that patient files are organised
- Physical health monitoring and assessment records are completed

[8] Section 17 leave allows the detained patient leave from hospital

- Unmet needs are evidenced and documented within patient care plans
- Any refusal by a patient to sign a plan is documented along with the reason for refusal
- The patient has signed section 17 leave to evidence that the patient understands the agreed condition of leave.

Quality of management and leadership

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

We observed a committed staff team who had a good understanding of the needs of the patients at the hospital.

We found that staff were committed to providing patient care to high standards. Throughout the inspection, staff were receptive to our views, findings and recommendations.

Staff were positive about the support they received from their colleagues and management teams. However, the health board must address the maintenance issues on the ward to improve the quality of patient experience.

Improvements are also required in the completion of mandatory training.

Governance, leadership and accountability

There was a clear organisational structure for the hospital, which provided clear lines of management and accountability. They defined these arrangements during the day, with senior management and on-call systems in place for the night shift.

There was dedicated and passionate leadership from senior ward staff, who are supported by committed ward multidisciplinary teams and senior health board managers. We found a friendly, professional staff team who demonstrated a commitment to providing high quality care to patients. Staff were able to describe their roles and appeared knowledgeable about the care needs of most patients they were responsible for.

During our time on the ward we observed a positive culture with good relationships between staff who we observed working well together as a team.

It was clear to see that staff were striving to provide high levels of care to the patient groups to expedite recovery and minimise the length of time in hospital. Close and productive working with the community mental health teams supported this.

Arrangements were in place to disseminate information and lessons learnt to staff from complaints and incidents at the hospital and the wider organisation. This helps to promote patient safety and continuous improvement of the service provided.

There was an established electronic system in place for recording, reviewing and monitoring incidents. Incidents were entered on to the health board's incident reporting system (DATIX) that included the names of patient and staff involved, a description, location, time and length of the incident. Any use of restraint was documented.

Senior managers of the health board engaged openly during the inspection, and acknowledged that some environmental changes had been delayed since the last inspection due to the COVID -19 situation.

Staff and resources

Workforce

The staffing levels appeared appropriate to maintain patient safety within the ward at the time of our inspection.

The health board reviewed staffing resources daily. This helped to ensure sufficient staff numbers were on shift to meet the care needs of the patients at the hospital.

We noted a number of registered nurse vacancies, which the health board was attempting to recruit into. Where possible the ward utilised its own staff and regular staff from the health board's staff bank to temporarily fill these shortfalls. Daily meetings on staffing levels and patient flow and demand took place to immediately resolve any shortfalls. The health board must continue to ensure it has sustainable and sufficient capacity to provide safe and effective care to patients.

The patients did not have access to psychological therapies as there is no psychologist in post. It is important that patients have access to a therapist to help support them. We have recommended the health board fill this vacancy.

Staff told us that the health board management team were approachable and visible. During interviews with staff they told us they had confidence to speak with management if they needed to raise issues or concerns.

We saw evidence of staff annual appraisals in staff files and compliance rates were high. These appraisals provide staff with a platform to discuss their employment and professional development and an opportunity for managers to give feedback to staff about their work.

There was a programme of training so that staff would receive timely updates on what training required completion. The electronic records provided the senior managers with details of the course completion rates and individual staff compliance details.

We reviewed the mandatory training and found that completion rates were low in some areas. For example, the compliance rates for Basic Life Support was 65.2% and Immediate Life Support was 63.64%. Safeguarding level 1 was 50%. This is of concern, because the ward on rare occasions has provisions for emergency admissions for children and adults.

We recognise that face to face training has been difficult due to the pandemic, however improvements are still required in these areas and senior management need to scrutinise training compliance on a regular basis.

It was reassuring to see that the completion rates for training had already been identified, and the health board was arranging this training.

It was positive to see that the health board had trained healthcare support workers to undertake general medical checks such as taking blood and ECG readings, this training enabled the healthcare support workers to provide additional support to the nurses. In addition one member of staff was supporting the occupational therapist to delivery activities to the patients.

There were good systems in place to support staff welfare, which comprised of online CBT services, and confidential counselling services. The health board must continue to monitor, promote, and invest in staff welfare and well-being.

Improvement needed

The health board must ensure that:

- Staff vacancies are filled and future initiatives are explored to encourage recruitment into the hospital.

- Mandatory training rates are improved.

4. What next?

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

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

The improvement plans should:

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

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

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

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

5. How we inspect NHS mental health services

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

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

HIW inspections of NHS mental health services will look at how services:

- Comply with the Mental Health Act 1983, Mental Capacity Act 2005, Mental Health (Wales) Measure 2010 and implementation of Deprivation of Liberty Safeguards
- Meet the Health and Care Standards 2015

We also consider other professional standards and guidance as applicable. These inspections capture a snapshot of the standards of care within NHS mental health services.

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

Appendix A – Summary of concerns resolved during the inspection

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

Immediate concerns identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
Fridge in medication room was not working on first night of inspection	Patient medication was being stored on another ward in the hospital, however the medication was not easily accessible.	Night staff advised that the situation needed to be resolved by the morning.	Fridge was fixed and medication was being stored safely on the ward.

Appendix B – Immediate improvement plan

Service: Bronllys Hospital

Ward/unit(s): Felindre Ward

Date of inspection: 15 – 17 June 2021

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

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
No Immediate assurance issues were identified during the inspection.				

Appendix C – Improvement plan

Service: Bronllys Hospital

Ward/unit(s): Felindre Ward

Date of inspection: 15 – 17 June 2021

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

Improvement needed	Standard	Service action	Responsible officer	Timescale
Quality of the patient experience				
The health board must ensure that the smoking room is replaced with a gym.	1.1 Health promotion, protection and improvement	The service will work with estates to undertake any essential painting of the room. Gym equipment will be identified, ordered following an application to charitable funds and installed. We will set up a co-production focus group to oversee the development of the gym. The mandatory date for closure of the smoking room is September 2022, but	Ward manager & Head of mental health operational services	March 31st 2022

Improvement needed	Standard	Service action	Responsible officer	Timescale
		the service has set a date of March 31st 2022 to complete this.		
The health board must ensure that light fixtures in garden are fixed	1.1 Health promotion, protection and improvement	This has been requested and is pending completion.	Head of estates	September 30th 2021
The health board must ensure that patients are able to easily access hot drinks throughout the day	1.1 Health promotion, protection and improvement	Hot drinks are available on a two hourly basis and on request to staff at any time outside of these times due to health and safety on the ward. The service will explore the possibility of a vending system to offer more independence to patients.	Service manager & deputy ward manager	Completed and in place
The health board must ensure that improvements are made to the environment to ensure patient have a level of privacy in bedroom areas	4.1 Dignified Care	The two-bedded room is being separated into two rooms ensuring the privacy of all patients. This work is currently out to tender.	Head of estates & Head of mental health operational services	March 31st 2022
The health board must ensure that staff can check on the well-being of patients with minimal disruption	4.1 Dignified Care	New Doors have been ordered and this work is currently out to tender for fitting.	Head of estates &	March 31st 2022

Improvement needed	Standard	Service action	Responsible officer	Timescale
			Head of mental health operational services	
The health board must ensure that the shower in female bathroom is fixed	4.1 Dignified Care	All showers are now in working order	Head of estates	Completed 02.07.2021
The health board must ensure that a range of information for patients is displayed on the ward that includes: • The NHS Putting Things Right process • Guidance around mental health legislation • Healthcare Inspectorate Wales.	4.2 Patient Information	New anti-ligature leaflet display/holders have been ordered and these will enable all leaflets to be accessible to patients and relatives.	Service manager & deputy ward manager	September 30th 2021
The health board must ensure that information is available for visitors in the visitor's room.	6.2 Peoples rights	As above	Service manager & deputy ward manager	September 30th 2021
The health board must ensure that patient requests are dealt with and in a timely manner.	6.3 Listening and Learning from feedback	Weekly patient meetings ensure that patients are able to feedback formally, in addition to personal time with their clinician. Monthly patient council meeting	Service manager & deputy ward manager	Completed and in place

Improvement needed	Standard	Service action	Responsible officer	Timescale
		sends out an action plan that goes to the ward manager for action. The action plan is monitored and reviewed at the subsequent meeting to ensure completion of all actions. The service manager, in the absence of a ward manager currently, will address the timeliness of responses in the monthly Band 6 meetings, recognising that some actions may require realistic timescales. The Terms of Reference for the Patient Council will be reviewed by the co-production group, guided by the new ward manager as part of their induction to ensure that patient views are clearly reflected within the TOR.	Ward manager	September 30th 2021
Delivery of safe and effective care				
The health board must ensure that patients can alert staff that they require assistance from their bedrooms.	2.1 Managing risk and promoting health and safety	The model of care is based on recovery and building on individual strengths to support this. Each patient has identified needs addressed in their Care and Treatment plan (CTP). Outside of this, a patient requiring additional assistance	Head of mental health operational services &	Completed and in place

Improvement needed	Standard	Service action	Responsible officer	Timescale
		would be expected to go to a staff member and request it. There may be exceptional circumstances where patients admitted to Felindre ward would be unable to alert staff for assistance from their bedroom. In the case where the patient may have reduced mobility, an individual care plan will address how they may summon help if required. High risk patients will be on enhanced observation levels.	Head of mental health nursing, quality & safety	
The health board must ensure that ward areas are freshly painted.	2.1 Managing risk and promoting health and safety	Decoration is undertaken on a rolling programme of maintenance.	Head of mental health operational services & head of estates	March 31st 2022
The health board must ensure that appropriate hand hygiene products are available in the communal areas of the ward	2.4 Infection Prevention and Control (IPC) and Decontamination	Hand hygiene products are available at the entrance to the Felindre ward. We will implement hand gel for use at every meal time. We will work with the IP&C team to undertake a detailed audit of the area and identify any recommendations and	Service manager & deputy ward manager	July 31st 2021

Improvement needed	Standard	Service action	Responsible officer	Timescale
		implement these accordingly. The use of non-alcohol-based products will be actively pursued.	Service manager & deputy ward manager	August 31st 2021
The health board must ensure that improvements are made in hand hygiene audits.	2.4 Infection Prevention and Control (IPC) and Decontamination	Audits have been implemented, initially on a twice monthly basis, the results of which will feed into the Health & Care Standards audits and reported quarterly via highlight reports to the quarterly Infection Prevention and Control Committee.	Service manager & deputy ward manager	Completed and in place
The health board must ensure that temperature checks in clinical room are taken and recorded consistently.	2.6 Medicines Management	A wall thermometer for the clinic room has been ordered and temperature checks will be incorporated into daily clinic checks.	Service manager & deputy ward manager	July 31st 2021
The health board must ensure that MAR charts are completed correctly.	2.6 Medicines Management	Medicines Management audit is scheduled for August 2nd. We will incorporate this into a monthly audit to reinforce correct completion of the Medication Administration Record charts.	Service manager & deputy ward manager	August 2nd 2021

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must ensure that they record discussions on medication in patient notes.	2.6 Medicines Management	Weekly case note audit is in place. Case note management and supervision for qualified staff is now in place to reinforce record keeping.	Clinical director, service manager & deputy ward manager	Completed and in place
The health board must ensure that homely remedies are stored correctly and in line with health board policy.	2.6 Medicines Management	Topical homely medicines are now locked away.	Service manager & deputy ward manager	Completed and in place
The health board must ensure that the ligature point audit is updated.	3.1 Safe and Clinically Effective care	The ligature audit was reviewed and revised on May 10th 2021. There is a Ligature Risk Management Group in place, meeting quarterly and reporting to Mental Health Learning Disability (MHLD) senior management team. The group had been paused during the pandemic, but was brought back into operational activity in May 2021. The next meeting is scheduled for August 9th 2021.	Service manager and head of nursing, quality & safety	Completed and in place
The health board must ensure that all policies are updated and reviewed.	3.1 Safe and Clinically Effective care	The service will engage with other service areas to progress the relevant out of date policies and feed into the Policy Group led by the deputy nurse director.	Clinical lead quality & safety	March 31st 2022

Improvement needed	Standard	Service action	Responsible officer	Timescale
		Planned review of all mental health policies to ensure the policies are up to date. The service will ensure there is a mental health representative on the health care clinical policies group.		
The health board must ensure that there is a routine audit of policies to ensure that ward staff have access to, and are referring to, the most recent version.	3.1 Safe and Clinically Effective care	As above The service quality and safety team have a work plan setting meeting scheduled for August 18th. The action plan will feed into senior management team (SMT) in September for review and finalisation.	Clinical lead quality & safety	March 31st 2022 September 15th 2021
The health board must ensure that notes are filed correctly and that patient files are organised	3.5 Record keeping	Ward clerk role has now been appointed to and an interim staff member is in place to maintain files. Audit will be undertaken following new post holder start date to confirm compliance.	Service manager & deputy ward manager	Complete and in place
The health board must ensure that physical health monitoring and assessment records are completed	3.5 Record keeping	We will ensure that this is clearly documented. This has been raised at the Band 6 meeting and will be captured in the file audit. This will be included in the ward audit.	Service manager & deputy ward manager	Complete and in place

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must ensure that unmet needs are evidenced and documented in patient care plans.	3.5 Record keeping	There is a process to record unmet needs outside of patient records. We will ensure individual unmet needs are recorded on a patient file. This will be monitored through case file audit and frequency will be revised if the evidence of the audits indicates that unmet needs are not being recorded as a matter of routine practice.	Service manager & deputy ward manager	Completed and in place
The health board must ensure that document any refusal by a patient to sign a plan along with the reason for refusal.	3.5 Record keeping	As above	Service manager & deputy ward manager	Completed and in place
The health board must ensure that patient has signed section 17 leave to evidence that the patient understands the agreed condition of leave.	3.5 Record keeping	Clinical director will raise this with medical team and it will be captured in the file audit.	Clinical director	July 31st 2021
Quality of management and leadership				
The health board must ensure that vacancies are filled and future initiatives are explored to encourage recruitment into the hospital.	7.1 Workforce	Mental health services actively engage in workforce futures and health and care academy in the health board.	Service manager, workforce business partner &	Completed and in place

Improvement needed	Standard	Service action	Responsible officer	Timescale
			Head of mental health operational services	
The health board must ensure that mandatory training rates are improved.	7.1 Workforce	Service manager will undertake an audit and ensure that this is included in the new ward manager's induction programme. The health board target is 85% and the Felindre is currently reaching 82%.	Service manager	September 30th 2021

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

Service representative

Name (print): **Ruth Derrick**

Job role: **Head of Nursing, Quality & Safety**

Date: **28.07.2021**

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Quality Check Summary
Ystradgynlais Dental Practice
Activity date: 12 May 2021

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Digital ISBN 978-1-80195-511-9

Quality Check Summary

Our approach

Healthcare Inspectorate Wales (HIW) undertook a remote quality check of Ystradgynlais Dental Practice as part of its programme of assurance work. The practice offers a range of NHS and private dental treatments.

HIW's quality checks form part of a new tailored approach to assurance and are one of a number of ways in which it examines how healthcare services are meeting the Health and Care Standards 2015 (and other relevant regulations). Feedback is made available to service representatives at the end of the quality check, in a way which supports learning, development and improvement at both operational and strategic levels.

Quality checks are a snapshot of the standards of care within healthcare services. They are conducted entirely offsite and focus on three key areas; infection prevention and control, governance (specifically around staffing) and the environment of care. The work explores arrangements put in place to protect staff and patients from COVID 19, enabling us provide fast and supportive improvement advice on the safe operation of services during the pandemic. More information on our approach to assurance and inspections can be found here.

We spoke to the registered manager on 12 May 2021 who provided us with information and evidence about their service. We used the following key lines of enquiry:

- What changes have you implemented in light of COVID-19 to ensure infection prevention and control standards are maintained?
- How are you ensuring that all patients (including vulnerable/at risk groups) are able to access services appropriately and safely?
- How has the practice and the services it provides adapted during this period of COVID-19?

Environment

During the quality check, we considered how the service has responded to the challenges presented by COVID-19 and how the service has designed and managed the environment of care to keep it as safe as possible for patients, staff and visitors.

The key documents we reviewed included:

- the practice risk assessment for COVID-19 resuming dental services
- most recent fire risk assessments action plan
- most recent health and safety risk assessment action plan

We also questioned the service representative on the changes they have made to make sure patients continue to receive care and treatment according to their needs.

The following positive evidence was received:

We were told about the changes that had been made to the practice environment as a result of the pandemic. Personal Protective Equipment (PPE) for staff and patients is available as well as hand sanitizing stations throughout the practice. Cleaning schedules had been amended to enable more frequent cleaning. We were told that the practice were updating their own Standard Operating Procedure (SOP) in line with updates and advice from external bodies. This included the guidance issued within the Standard Operating Procedure for the dental management of non-COVID-19 patients in Wales. We were told that where possible, staff teams would remain consistent to minimise unnecessary contact between other staff members to help maintain services.

We were told about the changes made to the environment to minimise the risk of COVID-19 transmission within the communal areas and treatment rooms. These included social distancing measures and only patients with pre-arranged appointments could visit the practice. Furniture and seating had been removed from the waiting areas. Treatment rooms had been cleared of all unnecessary items.

We were told that patients are asked to attend their appointments on time and not arrive earlier due to the lack of patient waiting areas. The doors to the practice remain closed until the surgery in which the patient being treated is ready to receive them. On entering the practice, staff undertake temperature checks which are recorded, a new face mask is provided (if required) and hand sanitizer given. A dedicated member of staff escorts all patients to and from the treatment rooms.

We were told that COVID-19 risk assessments had been completed for all staff. Depending on the outcome of the assessment, the practice would determine if the staff member needed

to shield[1] or undertake a different role within the practice.

We were told that all surgeries were equipped to perform Aerosol Generating Procedures (AGP)[2]. Mechanical ventilation had been installed to facilitate the removal of contaminated air. Where possible, patients requiring AGP treatments were given appointments in the same treatment room, so that additional cleaning could be carried out with minimal disruptions to appointment times.

In order to allow adequate time to disinfect the surgery between patients, a reduced amount of appointments were available. Staff stated that this had impacted on availability of appointments, but this was being managed effectively to ensure patients could still access the care that they needed. The registered manager stated that they felt staff worked and adapted well within the restrictions and guidelines.

We saw evidence of a COVID-19 specific risk assessment which had been completed in March 2021, and an environment risk assessment that had been updated in January 2021. Existing controls or action required were documented within the assessment, along with the actions taken to address these risks.

No areas for improvements were identified.

Infection prevention and control

During the quality check, we considered how the practice has responded to the challenges presented by COVID-19. We considered how well the practice manages and controls the risk of infection to help keep patients and staff safe.

The key documents we reviewed included:

- COVID-19 policy
- Infection control policy
- the most recent Welsh Health Technical Manual (WHTM) 01-05[3] decontamination audit and the action plan to address any areas for improvement
- surgery cleaning schedules
- records of daily checks of autoclaves

[1] This word is used to describe how people at high-risk should protect themselves by not leaving their homes and minimising all face-to-face contact.

[2] An aerosol generating procedure (AGP) is a medical procedure that can result in the release of airborne particles (aerosols) from the respiratory tract when treating someone who is suspected or known to be suffering from an infectious agent transmitted wholly or partly by the airborne or droplet route.

[3] WHTM 01-05 includes information on an audit of compliance with decontamination. The audit has been developed by dentists in Wales and is supported by the Dental Section, HEIW.

- records of daily checks of ultrasonic bath and washer disinfector

The following positive evidence was received:

We were provided with various documents for the prevention and control of infection, which included Protocols and Risk Assessments for Working during the Coronavirus Pandemic. We saw evidence of an Infection Prevention and Control (IPC) audit, together with practice cleaning schedules and records for the decontamination of instruments and dental equipment.

We were told about the systems that are in place to ensure all staff were aware of, and discharged their responsibilities for preventing and controlling infection. This was evidenced in the practice's SOP document which set out the actions and responsibilities of management and staff in order to prevent the spread of the virus. In addition, we were told that PPE training, including mask training and donning and doffing of PPE had been delivered to all staff. Due to social distancing, staff meetings had been moved to video calls during the height of the pandemic, and were still continuing. Calls were held on a weekly basis and would follow a weekly brief, to ensure all staff had access to the most up to date procedures for working during the pandemic.

We were told that before each treatment session, dental nurses were responsible for arranging the equipment required for all appointments and boxing them up ready to be easily accessed. This is designed to minimise staff entering or leaving the surgery during the procedure. Staff told us that a nurse is on duty to escort patients to and from the surgery. These practises ensure that infection risk is minimised during procedures.

We were told that staff at the practice had received COVID-19 vaccinations, with some staff having received both the doses required.

Staff explained that patients were contacted prior to their appointment and asked a series of questions to determine whether they were at risk of transmitting the virus. On arrival at the practice, patients have their temperature taken and follow the procedure set out in the SOP for ensuring staff and patient safety when entering the practice. Patients who were displaying symptoms or were awaiting results of a COVID-19 test were instructed to stay home and not attend the practice.

The practice stated they had sufficient stock of PPE and that regular stock checks are undertaken. We were told that a member of staff oversees the central stocks and orders are placed via an online system on a regular basis.

No areas for improvements were identified

Governance / Staffing

As part of this standard, HIW questioned the service representatives about how, in the light of the impact of COVID-19, they have adapted their service. We explored whether management arrangements ensure that staff are suitable in their roles and are appropriately trained in order to provide safe and effective care.

The key documents we reviewed included:

- Statement of Purpose
- Patient Information Leaflet
- Ionising Radiation (Medical Exposure) Regulations (IRMER) audit
- Record card audit
- Informed consent policies / procedures
- COVID-19 policy
- Business continuity plan
- Mandatory training completion rates for all staff

The following positive evidence was received:

We saw evidence of training records, which showed compliance with mandatory training. Staff also explained the process for ensuring training was up to date. Staff continued to use e-learning[4] packages for Continued Professional Development (CPD). In addition, small group face to face training was being arranged for staff to ensure skills and knowledge remain up to date.

We were told that the practice did not close during the initial stages of the pandemic. Throughout the pandemic the practice has maintained a system of taking calls for remote triage[5] by a clinician. This ensures patient care can be delivered according to their needs.

The practice has maintained their processes for the reporting of any incidents, with the principal dentist and registered manager having an oversight of any incidents. We were told that staff were aware of their roles and responsibilities in reporting incidents to regulatory agencies including Healthcare Inspectorate Wales (HIW), and this process was explained in detail. Any updated guidance for healthcare professionals was delivered in regular staff meetings and emails.

The process of checking emergency equipment and medicines was explained. One member of staff has responsibility for performing the checks and recording the findings in online software. The software used also allowed the practice to receive electronic updates when items were coming to the end of their shelf life, providing the practice with a second layer of protection.

[4] Learning conducted via electronic media, typically on the internet.
[5] The assignment of degrees of urgency to decide the order of treatment of a number of patients.

We reviewed the patient information leaflet[6] and statement of purpose[7], which contained all the required information and are available from the practice upon request.

What next?

Where we have identified areas for improvements during our quality check and require the service to tell us about the actions taken to address these, an improvement plan providing details will be provided at the end of this quality check summary.

Where an improvement plan is required, it should:

- Ensure actions taken in response to the issues identified are specific, measurable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the areas for improvements identified will be sufficiently addressed
- Ensure required evidence against stated actions is provided to HIW within three months of the quality check.

As a result of the findings from this quality check, the service should:

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

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

If no areas for improvement were identified during this quality check, an improvement plan will not be required, and only the quality check summary report will be published on HIW's website.

[6] Information as required by Schedule 2 of the Private Dentistry (Wales) Regulations and Schedule 1.
[7] "Statement of purpose" means the statement compiled in accordance with regulation 5(1) of the Private Dentistry (Wales) Regulations and Schedule 1.

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Quality Check Summary
{my}dentist, Welshpool
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Quality Check Summary

Our approach

Healthcare Inspectorate Wales (HIW) undertook a remote quality check of {my}dentist (Welshpool) as part of its programme of assurance work. The practice provides a range of NHS and private treatment and forms part of the dental services provided within the area serviced by Powys Teaching Health Board.

HIW's quality checks form part of a new tailored approach to assurance and are one of a number of ways in which it examines how healthcare services are meeting the Private Dentistry (Wales) Regulations 2017 (and other relevant regulations and standards). Feedback is made available to service representatives at the end of the quality check, in a way which supports learning, development and improvement at both operational and strategic levels.

Quality checks are a snapshot of the standards of care within healthcare services. They are conducted entirely offsite and focus on three key areas; infection prevention and control, governance (specifically around staffing) and the environment of care. The work explores arrangements put in place to protect staff and patients from COVID 19, enabling us provide fast and supportive improvement advice on the safe operation of services during the pandemic. More information on our approach to assurance and inspections can be found here.

We spoke to the registered manager[1] and regulatory officer on 29 June 2021 who provided us with information and evidence about their service. We used the following key lines of enquiry:

- What changes have you implemented in light of COVID-19 to ensure infection prevention and control standards are maintained?
- How are you ensuring that all patients (including vulnerable/at risk groups) are able to access services appropriately and safely?
- How do you meet the needs of Welsh speaking patients when accessing healthcare services in the medium of Welsh?
- How has the practice and the services it provides adapted during this period of COVID-19?
- How do you ensure that equality and a rights based approach are embedded across the service?

[1] "registered manager" means a person who is registered under Part 2 of the Private Dentistry (Wales) Regulations 2017 as the manager of a private dental practice.

Environment

During the quality check, we considered how the service has responded to the challenges presented by COVID-19 and how the service has designed and managed the environment of care to keep it as safe as possible for patients, staff and visitors.

The key documents we reviewed included:

- The most recent environment health and safety risk assessment
- The most recent fire safety risk assessment

We also questioned the service representatives on the changes they have made to make sure patients continue to receive care and treatment according to their needs.

The following positive evidence was received:

The registered manager provided details of the changes that have been made to the practice environment to allow for patients to be seen throughout the pandemic. In order to protect staff and patients within the practice, we were informed that the front door is locked to prevent individuals from entering the building unattended and/ or without an appointment. All patients must pre-book an appointment with a dentist before attending the practice.

Patients are asked to attend their appointments alone wherever possible. However, appointments are arranged accordingly for vulnerable patients identified during telephone triage.

We were informed that clear plastic barriers have been installed within the reception area to protect staff and patients. On arrival, patients are welcomed into the practice by a staff member and they are then escorted to the relevant waiting area. The waiting areas within the practice have been reorganised to allow for social distancing, a one-way system has been implemented within the building and clear markers setting out social distancing requirements are displayed. Following the appointment, patients are escorted out of the building via a different door.

We were informed that hand hygiene facilities are available in all toilets, surgeries and the decontamination room. Additionally, hand sanitiser stations have been installed throughout the practice.

The registered manager confirmed that following the booking of an appointment, information is emailed to the patient to ensure that they are fully aware of what to expect when they arrive, in regards to the arrangements in place. Additionally, we were informed that regular updates have also been sent out to all patients via email, to keep them up to date with the relevant procedures in place and to ensure they know how to access the service if required.

The following areas for improvement were identified:

We were provided with copies of the practice's health and safety risk assessment and fire safety risk assessment documentation. Following review of these documents it was highlighted that the most recent assessments were completed in October 2019, with no evidence to confirm that subsequent reviews had taken place. Additionally, evidence reviewed did not provide assurance that the required remedial actions had been taken to address the issues identified in the risk assessments.

As a result of these concerns and the associated risks to patients and staff, a non-compliance notice was sent to the registered provider to request assurance in relation to the actions that have been or will be taken, to address the concerns highlighted and to ensure patient and staff safety is protected. Subsequently, a response was received from the practice within the set deadline, which provided assurance and set out the actions that will be taken to address the issues highlighted.

Infection prevention and control

During the quality check, we considered how the service has responded to the challenges presented by COVID-19, and how well it manages and controls the risk of infection to help keep patients, visitors and staff safe.

The key documents we reviewed included:

- A copy of the most recent WHTM01-05 decontamination audit and the action plan to address any areas for improvement.
- Generic infection control policies and Covid-19 specific policies
- Most recent infection control risk assessments / audits
- Cleaning schedules including autoclave and ultrasonic checks.

The following positive evidence was received:

The registered manager described the processes in place to minimise the infection risks to staff and patients when aerosol generating procedures (AGP)[2] were being carried out within the practice. These arrangements were also set out in the Standard Operating Procedure (SOP). The registered manager confirmed that mechanical air filtration units have been installed which means that the practice has been able to reduce the fallow time[3] following AGP procedures to 10 minutes.

We saw evidence of a COVID-19 risk assessment in place, which set out the risks and control

[2] An aerosol generating procedure (AGP) is a medical procedure that can result in the release of airborne particles (aerosols) from the respiratory tract when treating someone who is suspected or known to be suffering from an infectious agent transmitted wholly or partly by the airborne or droplet route.
[3] Fallow time is the downtime in the surgery following an aerosol generating procedure (AGP) taking place.

measures in place for relevant areas throughout the practice. The registered manager confirmed that this assessment was reviewed on a six monthly basis which correlated with the detail included on the document.

The process followed to ensure that patients were routinely screened for COVID-19 symptoms prior to their appointment was discussed. We were informed that prior to any patient appointment a telephone triage is undertaken 24 hours before. We were told that relevant staff have received training in regards to triaging patients and instructions were detailed within the SOP. Additionally, the registered manager confirmed that on arrival at the practice for the appointment, the patient is also asked further triage questions to check for any COVID-19 symptoms. The information obtained as part of this triage process is recorded within the relevant patients' health record.

The registered manager confirmed that should patients notify staff that they have tested positive or they are awaiting results of a COVID-19 test, they would be signposted to one of the health board's Urgent Dental Clinics (UDC).

We were told that regular temperature checks are completed for staff and there were plans to obtain lateral flow tests for staff to routinely complete.

Evidence of the completed Welsh Health Technical Memorandum (WHTM) 01-05[4] decontamination audit and action plan to address any areas for improvement was provided. Additionally, copies of the cleaning policy and completed surgery cleaning checklists were provided, as well as daily check records for each autoclave and ultrasonic bath.

We were informed that all relevant staff members have been fit tested for the required personal protective equipment (PPE) with the exception of one member of staff who recently joined the practice. We were told that plans were in place to action this. The registered manager also confirmed that a PPE 'donning and doffing[5]' room has been set for staff within the practice.

The registered manager confirmed that all staff are required to complete mandatory IPC training and additional training and guidance has been provided staff to ensure that they felt confident and competent about PPE requirements. We were informed that arrangements were in place to ensure that there were no issues with the provision of PPE for staff; weekly stock checks are completed and the practice has access to the health board stock when required.

No areas for improvements were identified.

[4] Scope, status and structure of WHTM 01-05 Welsh Health Technical Memorandum (WHTM) 01-05 is intended to progressively raise the quality of decontamination work in primary care dental services by covering the decontamination of reusable instruments within dental facilities.

[5] Donning – putting on personal protective equipment (PPE); Doffing – taking off personal protective equipment (PPE)

Governance / Staffing

As part of this standard, HIW questioned the service representatives about how, in the light of the impact of COVID-19, they have adapted their service. We explored whether management arrangements ensure that staff are suitable in their roles and are appropriately trained in order to provide safe and effective care.

The key documents we reviewed included:

- Informed consent policies / procedures
- Escalation policies
- Business continuity plans
- Mandatory training records for all staff
- Risk assessments undertaken in relation to infection prevention and control, environment and staff health and safety
- Record card information
- IR(ME)R audit
- Copy of the latest statement of purpose[6]
- Copy of the latest patient information leaflet[7].

The following positive evidence was received:

We were informed that the practice remained open throughout the pandemic. However, in the early stages, clinical remote triage was undertaken with each patient before an onsite appointment was scheduled. This was to ensure that the patient needed to be seen at the practice or if other options could be considered.

We were provided with a copy of the statement of purpose and patient information leaflet which included relevant information about the services being offered. Additionally, we were provided with a sample of policies and procedures. We were informed that all policies are managed centrally within the organisation; they are drafted by the head of the relevant department and then circulated to each practice. There is a system in place to monitor and provide notifications in regards to scheduled review dates for all policies and procedures in place.

We were informed that arrangements are in place to ensure that staff have been routinely

[6] The statement of purpose is the information required in accordance with Schedule 1 to the Private Dentistry (Wales) Regulations. This includes the practice aims and objectives and the names and qualifications of the dentists and dental staff. Additionally is should list the kinds of treatment, facilities and all other services provided in or for the purposes of the private dental practice, including details of the range of needs which those services are intended to meet.

[7] The patient information leaflet is supplied to patients and includes the information required by Schedule 2 to the above regulations. The information included a summary of the statement of purpose, arrangements seeking patients' views, access to the premises and keeping appointments.

kept up to date with the relevant changes to guidance and the procedures in place within the practice. Team meetings are held on a monthly basis currently, with ad-hoc meetings held when required. The registered manager confirmed that during the early onset of the pandemic meetings were being held on a daily/weekly basis to ensure that staff were fully aware of the guidance and requirements to follow. Information is also detailed on the company intranet site and regular email updates are also circulated to staff outlining any changes to guidance, policies and procedures.

The registered manager confirmed that translation service support is available for patients wishing to converse in Welsh. We were also informed that written information could be provided in Welsh when required.

We were informed that audit processes in place have remained the same throughout the pandemic, with additional COVID-19 audits implemented for the environmental cleaning and COVID-19 triaging into the record card audit. Each completed audit is logged onto the company governance system to ensure that adequate compliance levels are achieved. Clinical audits are required to be above 80 percent, failure to achieve this results in a review from the clinical support manager.

The regulatory officer confirmed that the practice's responsible individual is scheduled to undertake a visit on 30 July 2021. This visit relates to the regulation 23 within The Private Dentistry (Wales) Regulations 2017, to assess the quality of service being provided against regulations and relevant standards. Following completion of the visit, a report is generated which must subsequently be submitted to the registered manager and HIW.

The following areas for improvement were identified:

The registered manager confirmed that mandatory training compliance is regularly monitored to ensure that staff are compliant with relevant training requirements. A copy of the mandatory training compliance document was provided as evidence which detailed that the majority of staff had completed the training required. However, there were some gaps highlighted, which indicated that not all staff members had completed the required training. Therefore, the registered provided is required to ensure that all staff are fully compliant with all relevant mandatory training.

What next?

Where we have identified areas for improvements during our quality check and require the service to tell us about the actions taken to address these, an improvement plan providing details will be provided at the end of this quality check summary.

Where an improvement plan is required, it should:

- Ensure actions taken in response to the issues identified are specific, measurable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the areas for improvements identified will be sufficiently addressed
- Ensure required evidence against stated actions is provided to HIW within three months of the quality check.

As a result of the findings from this quality check, the service should:

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

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

If no areas for improvement were identified during this quality check, an improvement plan will not be required, and only the quality check summary report will be published on HIW's website.

Improvement plan

Setting: {my}dentist Welshpool

Service: Dental

Date of activity: Quality Check

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

Please note, all actions are expected to be complete within three months of the Quality Check and the final version of the Improvement Plan is to be submitted via Objective Connect once complete.

Reference Number	Improvement needed	Standard/ Regulation	Service Action	Responsible Officer	Timescale
1	The Registered Provider must take appropriate action to ensure that there are no outstanding actions associated with the health and safety risk assessment completed in October 2019.	Regulations 8(1)(c)(e)(k)(o) of the Private Dentistry (Wales) Regulations Health and Care Standards, Standard 2.1	A full review of the existing action is currently taking place by the registered manager and will be completed by the 16th July 2021 which was accepted on the initial immediate improvement plan	Practice manager	16/07/2021

		Managing Risk and Promoting Health and Safety			
2	The Registered Provider must take appropriate action to ensure that an updated health and safety risk assessment is undertaken as soon as possible.	Regulations 8(1)(c)(e)(k)(o) of the Private Dentistry (Wales) Regulations Health and Care Standards, Standard 2.1 Managing Risk and Promoting Health and Safety	A member of the Health & Safety team attended practice 14/07/2021 to carry out a new Health & Safety risk assessment. A risk assessment will be generated and issued to the practice with the action plan uploaded to the internal works tracker with task appropriate deadline dates to review and complete the outstanding actions. Any building work actions will be immediately reported to the facilities help desk to arrange for a contractor to attend site for the completion of any outstanding work	Practice Manager Health & Safety team	31/08/2021
3	The Registered Provider must take appropriate action to ensure that there are no outstanding actions associated with the fire safety risk assessment completed in October 2019.	Regulation 22(4)(f) of the Private Dentistry (Wales) Regulations Health and Care	A full review of the existing action is currently taking place by the registered manager and will be completed by the 16th July 2021 which was accepted on the initial immediate improvement plan	Practice Manager	16/07/2021

		Standards, Standard 2.1 Managing Risk and Promoting Health and Safety			
4	The Registered Provider must take appropriate action to ensure that an updated fire safety risk assessment is undertaken as soon as possible.	Regulation 22(4)(f) of the Private Dentistry (Wales) Regulations Health and Care Standards, Standard 2.1 Managing Risk and Promoting Health and Safety	A member of the Health & Safety team attended practice 14/07/2021 to carry out a new Health & Safety risk assessment. A risk assessment will be generated and issued to the practice with the action plan uploaded to the internal works tracker with task appropriate deadline dates to review and complete the outstanding actions. Any building work actions will be immediately reported to the facilities help desk to arrange for a contractor to attend site for the completion of any outstanding work	Practice Manager Health & Safety team	31/08/2021
5	The registered provided is required to ensure that all staff are fully compliant with all relevant mandatory training.	Private Dentistry Regulations (Wales) 2017 17(3)(a)	All staff have been given a deadline of 30th July 2021 to complete all mandatory training.	Practice Manager	30/07/2021

		Health and Care Standards, Standard 7.1 Workforce			

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

Name:
Corryne McNeil

Date:
14/07/2021

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Quality Check Summary
{my}dentist, Newtown
Activity date: 14 July 2021

Publication date: 16 August 2021

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

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Website: www.hiw.org.uk

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Quality Check Summary

Our approach

Healthcare Inspectorate Wales (HIW) undertook a remote quality check of {my}dentist (Newtown) as part of its programme of assurance work. The practice provides a range of NHS and private treatment and forms part of the dental services provided within the area serviced by Powys Teaching Health Board.

HIW's quality checks form part of a new tailored approach to assurance and are one of a number of ways in which it examines how healthcare services are meeting the Private Dentistry (Wales) Regulations 2017 (and other relevant regulations and standards). Feedback is made available to service representatives at the end of the quality check, in a way which supports learning, development and improvement at both operational and strategic levels.

Quality checks are a snapshot of the standards of care within healthcare services. They are conducted entirely offsite and focus on three key areas; infection prevention and control, governance (specifically around staffing) and the environment of care. The work explores arrangements put in place to protect staff and patients from COVID 19, enabling us provide fast and supportive improvement advice on the safe operation of services during the pandemic. More information on our approach to assurance and inspections can be found here.

We spoke to the registered manager[1] and two regulatory officers on 14 July 2021, who provided us with information and evidence about their service. We used the following key lines of enquiry.

- What changes have you implemented in light of COVID-19 to ensure infection prevention and control standards are maintained?
- How are you ensuring that all patients (including vulnerable/at risk groups) are able to access services appropriately and safely?
- How do you meet the needs of Welsh speaking patients when accessing healthcare services in the medium of Welsh?
- How has the practice and the services it provides adapted during this period of COVID-19?
- How do you ensure that equality and a rights based approach are embedded across the service?

[1] "registered manager" means a person who is registered under Part 2 of the Private Dentistry (Wales) Regulations 2017 as the manager of a private dental practice.

Environment

During the quality check, we considered how the service has responded to the challenges presented by COVID-19 and how the service has designed and managed the environment of care to keep it as safe as possible for patients, staff and visitors.

The key documents we reviewed included:

- The most recent environment health and safety risk assessment
- The most recent fire safety risk assessment

We also questioned the service representatives on the changes they have made to make sure patients continue to receive care and treatment according to their needs.

The following positive evidence was received:

The registered manager provided details of the changes that have been made to the practice environment to allow for patients to be seen throughout the pandemic. In order to protect staff and patients within the practice, the front door is locked to prevent individuals from entering the building unattended and/or without an appointment. All patients must pre-book an appointment with a dentist before attending the practice.

We were informed that clear plastic screens have been installed within the reception area to protect staff and patients. On arrival, patients are welcomed into the practice by a staff member and then escorted to the waiting area or if possible straight to the relevant surgery. The waiting area has been reorganised to allow for social distancing and now only contains two chairs for patients. No more than two patients are permitted to wait inside the surgery at one time. Additionally, a one-way system has been implemented within the building and we were told that arrow signs are displayed. Following the appointment, patients are escorted out of the building via a different door.

We were informed that hand hygiene facilities are available in all toilets, surgeries and the decontamination room. The registered manager also confirmed that hand sanitiser stations have been installed throughout the practice.

The registered manager explained that following the booking of an appointment, information is shared with the patient regarding the arrangements in place at the practice, to ensure that they know what to expect when they arrive. Additionally, we were informed that efforts have been made to ensure that all patients have been routinely updated on the changes which have been implemented in the practice as a result of COVID-19. Emails and letters have been sent out to provide updates on the relevant procedures in place and to ensure that patients know how to access the service if required.

We were provided with copies of the practice's health and safety and fire safety risk

assessment documentation. These documents listed various risks, control measures and precautions that were in place to mitigate the highlighted risks. We were informed that reviews of the assessments and associated action plans take place on an annual basis. Additionally, we were told that required remedial actions are inserted onto an internal works tracker to monitor progress. The registered manager confirmed that all required actions had been completed to address the issues identified in the risk assessments.

No areas for improvements were identified.

Infection prevention and control

During the quality check, we considered how the service has responded to the challenges presented by COVID-19, and how well it manages and controls the risk of infection to help keep patients, visitors and staff safe.

The key documents we reviewed included:

- A copy of the most recent WHTM01-05 decontamination audit and the action plan to address any areas for improvement
- Generic infection control policies and Covid-19 specific policies
- Most recent infection control risk assessments / audits
- Cleaning schedules including autoclave and ultrasonic checks.

The following positive evidence was received:

The registered manager described the processes in place to minimise the infection risk to staff and patients when aerosol generating procedures (AGP)[2] were being carried out within the practice. These arrangements were also set out in the Standard Operating Procedure (SOP). The registered manager confirmed that an extractor fan and air conditioning is available in the designated surgery room, which means that fallow time[3] following treatment is 10 minutes. We were also informed that a "runner nurse" has been introduced to assist with AGP procedures. The nurse is available to escort the patient to and from the surgery, kept free to provide assistance when required and also helps with the required cleaning of the room following the procedure.

We saw evidence of a COVID-19 risk assessment in place, which set out the risks and control measures in place for relevant areas throughout the practice. The registered manager confirmed that this assessment is reviewed on a six monthly basis, or on an ad-hoc basis as and when required.

[2] An aerosol generating procedure (AGP) is a medical procedure that can result in the release of airborne particles (aerosols) from the respiratory tract when treating someone who is suspected or known to be suffering from an infectious agent transmitted wholly or partly by the airborne or droplet route.
[3] Fallow time is the downtime in the surgery following an aerosol generating procedure (AGP) taking place.

The process followed to ensure that patients were routinely screened for COVID-19 symptoms prior to their appointment was discussed. We were informed that a telephone triage is undertaken 24 hours prior to any appointment. We were told that relevant staff have received training and guidance in regards to triaging patients, and instructions were also detailed within the SOP. The registered manager confirmed that on arrival at the practice for their appointment, the patient's temperature is taken, they are given hand sanitiser and a disposable mask if required. The patient is also asked further triage questions, to check for any COVID-19 symptoms. We were informed that that information obtained as part of the triage process is recorded within the relevant patients' health record.

The registered manager confirmed that should patients notify staff that they have tested positive or they are awaiting results of a COVID-19 test, they would be signposted to one of the health board's Urgent Dental Clinics (UDC). We were also told that regular temperature checks are completed for staff working in the practice.

Evidence of the completed Welsh Health Technical Memorandum (WHTM) 01-05[4] decontamination audit and action plan to address any areas for improvement was provided. Additionally, copies of the cleaning policy and completed surgery cleaning checklists were provided, as well as daily check records for each autoclave and ultrasonic bath.

The registered manager confirmed that the lead nurse for the practice is the IPC lead and responsible for ensuring that regular audits are being completed, and IPC requirements are being adhered to by staff.

We were informed that all staff are required to complete mandatory IPC training. Training and guidance information has also been provided to ensure that staff are confident and competent in regards to personal protective equipment (PPE) requirements, including 'donning and doffing[5]'. The registered manager confirmed that all relevant staff members have been fit tested for the required PPE. Additionally, arrangements were in place to ensure that there were no issues with the provision of PPE for staff; weekly stock checks are completed and the practice has access to the health board stock when required.

No areas for improvements were identified.

[4] Scope, status and structure of WHTM 01-05 Welsh Health Technical Memorandum (WHTM) 01-05 is intended to progressively raise the quality of decontamination work in primary care dental services by covering the decontamination of reusable instruments within dental facilities.

[5] Donning – putting on personal protective equipment (PPE); Doffing – taking off personal protective equipment (PPE)

Governance / Staffing

As part of this standard, HIW questioned the service representatives about how, in the light of the impact of COVID-19, they have adapted their service. We explored whether management arrangements ensure that staff are suitable in their roles and are appropriately trained in order to provide safe and effective care.

The key documents we reviewed included:

- Informed consent policies / procedures
- Escalation policies
- Business continuity plans
- Mandatory training records for all staff
- Risk assessments undertaken in relation to infection prevention and control, environment and staff health and safety
- Record card information
- Ionising Radiation (Medical Exposures)Regulations (IR(ME)R) audit
- Copy of the latest statement of purpose[6]
- Copy of the latest patient information leaflet[7].

The following positive evidence was received:

The registered manager confirmed that the practice remained open throughout the pandemic. However, since there outbreak there have only been two surgeries operating, whereas prior to the pandemic there were three.

We were provided with a copy of the statement of purpose and patient information leaflet which included relevant information about the services being offered. The registered manager confirmed that the statement of purpose is reviewed on an annual basis. However, this did not reflect the review date information detailed on the document. This was discussed and we were informed that the document would be updated accordingly.

A sample of policies and procedures in place were provided. We were informed that all policies are managed centrally within the organisation; they are drafted by the head of the relevant department

[6] The statement of purpose is the information required in accordance with Schedule 1 to the Private Dentistry (Wales) Regulations. This includes the practice aims and objectives and the names and qualifications of the dentists and dental staff. Additionally is should list the kinds of treatment, facilities and all other services provided in or for the purposes of the private dental practice, including details of the range of needs which those services are intended to meet.

[7] The patient information leaflet is supplied to patients and includes the information required by Schedule 2 to the above regulations. The information included a summary of the statement of purpose, arrangements seeking patients' views, access to the premises and keeping appointments.

and then circulated to each practice. We were told that on the occasions where any key changes have been made to a policy or procedure, awareness sessions have been undertaken to ensure that staff are fully informed. Arrangements are in place to monitor and provide notifications in regards to scheduled review dates for all policies and procedures in current operation.

We were informed that arrangements were in place to ensure that staff have been routinely kept up to date with changes to guidance and the procedures in place. Team meetings have been held on a weekly basis to discuss any changes or issues. Additionally, we were told that information has also been circulated via email and detailed on the company intranet site. The registered manager stated that the corporate team within the organisation has been very good at ensuring key information has routinely been shared with the practice, as and when required throughout the pandemic.

The registered manager confirmed that translation service support is available for patients wishing to converse in Welsh via the health board. We were also informed that written forms and leaflets were available in Welsh.

We were told that regular audits and management spot checks are completed to ensure compliance with the relevant policies and procedures in place. Each completed audit is logged onto the company governance system to ensure that adequate compliance levels are achieved. We were informed that for any audit result below 80 percent, the registered manager is required to contact the clinical support manager for further guidance and support to be made available.

The registered manager confirmed that arrangements were in place to ensure that regular checks of the emergency equipment and medication took place. We were also informed that expiry dates of medication are monitored via the company internal governance system.

The registered manager confirmed that the practice responsible individual completed their visit on 8 July 2021 and was in the process of completing the associated report. This visit relates to the regulation 23 within The Private Dentistry (Wales) Regulations 2017, to assess the quality of service being provided against regulations and relevant standards. Following the completion of the report, it must subsequently be submitted to the registered manager and HIW.

The registered manager confirmed that mandatory training compliance is regularly monitored to ensure that staff are compliant with relevant training requirements. A copy of the mandatory training compliance document was provided as evidence. With the exception of a few anomalies in the training record for one member of staff, the information detailed within this document demonstrated that all other staff were fully compliant with mandatory training requirements.

No areas for improvements were identified.

What next?

Where we have identified areas for improvements during our quality check and require the service to tell us about the actions taken to address these, an improvement plan providing details will be provided at the end of this quality check summary.

Where an improvement plan is required, it should:

- Ensure actions taken in response to the issues identified are specific, measurable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the areas for improvements identified will be sufficiently addressed
- Ensure required evidence against stated actions is provided to HIW within three months of the quality check.

As a result of the findings from this quality check, the service should:

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

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

If no areas for improvement were identified during this quality check, an improvement plan will not be required, and only the quality check summary report will be published on HIW's website.

OFFICIAL SENSITIVE

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12 August 2021

Sent by secure email

Dear Carol

RE: Welsh Ambulance Service Trust: Local Review - next steps

As you are aware, as part of Healthcare Inspectorate Wales' (HIW) annual reviews programme for 2020-21, it committed to undertake a local review of the Welsh Ambulance Service Trust (WAST). The focus of the review was to consider the impact of ambulance waits outside Emergency Departments (ED) on patient safety, privacy, dignity and their overall experience. Whilst we did not require you to complete a self-assessment document as part of our review, we would like to give you the opportunity to comment on the factual accuracy of the report and to work collaboratively with other health boards, WAST and Welsh Government in considering the recommendations from our review.

This letter sets out the next steps you are required to take following the review.

Please read this letter carefully and respond by taking the following actions:

1. **Review the local review report for factual accuracy:** This is your opportunity to ensure the report (**Attachment 1**) is factually accurate before its publication on HIW's website. If you find any issues of factual accuracy within the report, please state these by completing the enclosed form (**Attachment 2**). Please note that this form is for factual accuracy issues only. If we do not receive a response from you by **Friday 20 August 2021**, we will assume you are content with the factual accuracy of the report and we will arrange for the report to be published on our website. Factual accuracy comments will not be accepted after this time.

2. **Complete the management response action plan:**

3. You are required to complete the management response action plan, to tell us how you will address the recommendations from the local review. Whilst some recommendations are specifically directed towards WAST, in view of the nature of the improvements that are required, we would like you to complete a **joint management response action plan**, in collaboration with WAST and Welsh Government, by **Friday 25 September 2021**. Please edit the document attached **(Attachment 3)** and return it to HIW electronically via our secure portal in Word doc format. Currently, we cannot accept action plans in any other format. Guidance about completing your action plan has been enclosed **(Attachment 4).** You must not use the action plan to comment on any issues of factual accuracy. Please do not send any other documents to HIW, unless we have asked you to. The jointly completed action plan will be published separately to the published report.

4. **Send us your feedback:**

   If you would like to share your feedback on your experience of the local review, please send an email to HIW@gov.wales Please remember to include the name of your service and the title of the review in any correspondence. Your feedback will help us to ensure the quality and effectiveness of our work, and will help us to improve future reviews.

We look forward to receiving your response to this letter with the completed factual accuracy form by no later than **20 August 2021**.

If you have any queries or concerns about the content of this letter please e-mail HIWInspections@gov.wales or telephone 0300 062 8163.
Further information about HIW's inspections, including how we inspect the NHS and how we inspect independent services is available on our website .

Please do not hesitate to contact me should you wish to discuss this letter further.

Yours sincerely

V. L. Davies

Vanessa Davies
Head of Reviews
Healthcare Inspectorate Wales

Enclosed:

Attachment 1 – Local review report
Attachment 2 - Factual accuracy comments form
Attachment 3 - Management response action plan (Word document)
Attachment 4 - Guidance on completing your action plan

cc:
Professor Vivienne Harpwood - Chair

Healthcare Inspectorate Wales • Arolygiaeth Gofal Iechyd Cymru
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Welsh Ambulance Services Trust

Review of Patient Experience whilst Waiting in Ambulances during Delayed Handover

Review date: 2021

Publication date: Insert date

EMBARGOED UNTIL PUBLICATION

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

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Digital ISBN XX

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

Our purpose

To check that people in Wales receive good quality healthcare

Our values

We place patients at the heart of what we do. We are:

- Independent
- Objective
- Caring
- Collaborative
- Authoritative

Our priorities

Through our work we aim to:

Provide assurance:	Provide an independent view on the quality of care
Promote improvement:	Encourage improvement through reporting and sharing of good practice
Influence policy and standards:	Use what we find to influence policy, standards and practice

Foreword

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales. We are responsible for inspecting, reviewing and investigating NHS services and independent healthcare services throughout Wales against a range of standards, policies, guidance and regulations to highlight areas requiring improvement. In our role, it is important that we maintain an overview of each of the NHS health boards and Trusts in Wales.

The COVID-19 pandemic has introduced unique and unprecedented pressures on the healthcare system, however, it is our continued commitment and goal to check that people in Wales are receiving good quality care, which is provided safely and effectively, in line with recognised standards.

As part of the HIW annual reviews programme for 2020-21, we committed to undertake a local review of the Welsh Ambulance Services Trust (WAST). This was due to concerns identified with long handover delays during a previous WAST local review carried out in 2019-20, where we explored how the risks to patients' health, safety and well-being were being managed, whilst they were waiting for an ambulance to arrive. A copy of this report can be found on our website[1].

This review set out specifically to consider what the impact of ambulance waits outside of Emergency Departments is having on the overall experience of patients, which included their safety, care, privacy and dignity. We considered the period between 1 April 2020 and 31 March 2021.

We would like to express our thanks to all of the patients who helped inform our review by completing our survey and sharing their experiences with us. We also convey our gratitude to staff working within WAST and health boards across Wales who participated in this review, which included completing our professional surveys and participating in interviews with the HIW review team.

[1] https://hiw.org.uk/sites/default/files/2020-09/20200923 - WAST Review - FINAL ENGLISH.pdf

In addition, we wish to thank the Community Health Councils[2] in Wales, which provided their support in developing our questionnaire and with obtaining patient views.

[2] Community Health Councils (CHCs) are independent bodies who listen to what individuals and the community have to say about the health services with regard to quality, quantity, access to and appropriateness of the services provided for them. They then act as the public voice in letting managers of health services know what people want and how things can be improved.

Summary

This report highlights the findings of our review of the experience of patients waiting on board an ambulance outside emergency departments during delayed handovers. The key findings of our review are outlined below.

It is clear from our review that the issue of prolonged handover delays is a regular occurrence outside emergency departments (ED) across Wales. Whilst patients were positive about their experience with ambulance crews, it is clear that handover delays are having a detrimental impact upon the ability of the health care system to provide responsive, safe, effective and dignified care to patients.

Whilst there are clear expectations and guidance for NHS Wales[3] in relation to hospital handovers, and a clear and apparent will to meet and achieve these, there are substantial challenges inhibiting the ability of the NHS in Wales to do so. The problem of delayed handovers is symptomatic of the wider issue of patient flow throughout the NHS, with consequent increased risks to patients associated with prolonged waits on ambulance vehicles outside EDs, impacting the ability of WAST to coordinate responses for patients waiting in the community for an ambulance.

Our review has noted that whilst work is ongoing to try and tackle this issue, with various approaches and initiatives in progress at a national level, it is unclear how effective these activities have been to date. This is not a problem that WAST can resolve by itself, it is a challenge that requires WAST, health boards, and Welsh Government to work together and consider whether a different approach is required to ensure reinvigorated, strengthened and concerted action is taken to make sure that these issues are overcome.

Whilst we found that overall, handover processes at EDs across Wales are broadly similar, some variations exist in processes between individual EDs within health board areas. This was due to a number of local joint Standard Operating Procedures (SOPs) being in place with WAST, due to geographical

[3] Wales Hospital Handover Guidance 2016 click here

layouts of ED environments, staff roles and levels of staffing available. This inconsistency can introduce risk, with our findings indicating that some WAST staff may be unfamiliar with SOPs specific to the ED that they are handing over to.

Further to this, feedback suggests that local handover processes can differ from day to day, depending sometimes on the clinician and or member of ED staff being dealt with. Again, we are concerned that this inconsistency could have a detrimental impact on patient care and safety and requires attention.

It is concerning that our review found that only 41% of WAST staff clearly understood who has responsibility and accountability for the patient at all times. This is despite three quarters of ED staff reporting that they clearly understood who is responsible for the patient. Ensuring absolute clarity over who has responsibility for patient care on board an ambulance following triage, until transferred in to the ED, is an important issue requiring attention to ensure safety of care.

Some health boards have introduced specific roles with the purpose of improving handover processes, such as Ambulance Patient Flow Co-ordinators or Hospital Ambulance Liaison Officers (HALO); these have reportedly had a beneficial impact on handover, and on patient experience by ensuring better coordination of the process. However, these roles aren't in place across all EDs, and we believe that all health boards should consider the benefits that these roles may bring.

Attention is required from WAST and health boards regarding some of the specific operational challenges faced by staff during the handover process. This includes the need to address some of the procedural challenges associated with timeliness of handover process. There is also a need to ensure that procedures to provide timely investigations, such as blood tests and x-rays, for patients on board ambulances awaiting handover are strengthened. This would have the benefit of enabling ambulance crews to be released, to undertake their primary role of providing on scene urgent or emergency care.

More work is required from WAST in regards to its own workforce. For instance, in relation to ensuring escalation processes are in place should a patient's condition deteriorate whilst they are on board an ambulance awaiting handover. Only 49% of WAST staff we engaged with said there was a robust process to alert ED staff to such a situation. This is a concerning figure requiring attention.

WAST also needs to ensure that its workforce is adequately supported, and that staff wellbeing is maintained, when they wait for long periods on board an ambulance due to delayed handovers. Some approaches have improved the

situation, for instance the introduction of the Duty Operational Manager which has facilitated crews to take their allocated breaks, and to finish their shift on time wherever possible, by taking over the care of patient. However, work remains on WAST's behalf to ensure that it adopts a consistent approach across Wales to support its workforce.

Improvements are also needed to strengthen collaborative working between WAST and health boards in relation to communication and the management of serious incidents arising from delayed handover. This includes the need to ensure health board representatives attend WAST Serious Clinical Incident Forum (SCIF) meetings, to enable timely management of concerns, development of action plans and ensure learning via feedback throughout the organisations.

Concerns were also highlighted to us around the consistency of feedback from incident reporting within WAST. Our findings highlight the need for WAST to identify more effective processes for sharing feedback and learning from incidents with ambulance crew following incident investigations, to improve quality and safety of patient care. In addition, WAST needs to do more to ensure that its staff feel confident that any concerns they raise would be addressed.

Patients were generally positive about their experiences and provided good feedback about ambulance crews, particularly in relation to their kindness, overall communication and management of distressing situations. Patients reported that they were treated with dignity and respect by ambulance crews, and felt safe and cared for. Patients also indicated that they were satisfied with the care and treatment from ED staff. Overall, our findings indicate that the severe impact of the pandemic did not negatively affect the experience of patients who used emergency ambulances services across Wales, and that on the whole patients were satisfied with the care provided.

Whilst patient feedback has been positive, this should not detract from the issues associated with delayed handover. It is clear that there are genuine frustrations held by WAST and health board staff regarding their inability to effectively carry out their roles as a consequence of this issue. The positive experiences shared by patients should also not detract from areas of concern regarding patient care, including the difficulties in facilitating patients to access a toilet during their wait, the risk to patients of sustaining skin tissue pressure damage, and the problems faced in providing them with food and drink. In addition, a number of staff raised concerns about their ability to appropriately achieve and appropriately maintain high standards of hygiene and infection, prevention and control measures on board the ambulance.

We have found that whilst WAST has developed clear systems, which identify risks, provide mitigation and escalate concerns, it is clear that these systems alone are not enough and more collaborative work with health boards is required to resolve the issue of prolonged handover delays.

[redacted]

The Welsh Ambulance Services Trust (WAST) is the primary frontline service delivering ambulance transport in Wales. The Trust was formed in 1998, and serves a population of around 3.2 million people across seven health boards in Wales.

WAST responds to more than 1800 emergency calls a day across the country. It operates 24 hours a day, 365 days a year, and provides emergency medical services, advice and appropriate signposting to other healthcare services. In addition to emergency transport, WAST also provides a Non-Emergency Patient Transport Service (NEPTS)[4], as well as hosting the 111[5] service, which consists of the NHS Direct Wales[6] and clinical triage elements of the GP out-of-hours services[7].

The workforce is made up of over 3,500 staff who contribute to the delivery of patient care across Wales. In addition, it has over 300 vehicles based in 90 ambulance stations across Wales which work collaboratively with the three Emergency Medical Service Clinical Contact Centres (EMSCCCs) in Wales.

WAST ambulance crews are highly skilled professionals who are able to treat and stabilise patients before taking them, if necessary, to the most appropriate hospital. The ambulance vehicles hold a wide range of emergency care

[4] Non-Emergency Patient Transport Services are provided to get patients, who are unable to transport themselves due to medical reasons, to and from hospital and clinic appointments.

[5] The 111 service is an online or free telephone number available 24 hours a day, providing health information, advice and access to urgent out-of-hours primary care.

[6] NHS Direct Wales is a health advice and information service available 24 hours a day. It has operated across Wales for many years and forms the backbone of the 111 service which is currently operating in four of the seven health board areas in Wales and will, over time, be replaced by 111 entirely.

[7] The GP out of hours service is for people who need urgent medical treatment but cannot wait until their doctor's practice is open.

equipment including oxygen, a defibrillator, advanced life-saving equipment and emergency drugs including pain relief.

A range of information sources indicate that ambulance waiting times, outside hospital Emergency Departments, can be excessive, particularly when the healthcare system is under pressure. These information sources include Welsh Government ambulance monthly performance indicators, Serious Incident notifications to Welsh Government, intelligence held by WAST, media reports, and discussions between HIW and senior staff within both WAST, and health boards. In addition, delays in the handover process with Emergency Departments resulting in reduced ambulance availability, were highlighted during HIW's local review of WAST during 2019-20.

In response to these issues, our review set out to consider the impact of ambulance waits outside of Emergency Departments on patient safety, privacy, dignity and overall experience. The review set out specifically to consider the impact that ambulance waits outside EDs are having on the overall experience of patients, and considered the period between 1 April 2020 and 31 March 2021.

As part of our review, we also engaged with all health boards across Wales providing emergency care. This included Aneurin Bevan, Betsi Cadwaladr, Cardiff and Vale, Cwm Taf Morgannwg, Hywel Dda and Swansea Bay University Health Boards. Each of the health boards have between one and three EDs within their localities, with a total of 12 across Wales.

Powys Teaching Health Board does not provide an emergency care service, although does provide minor injury care within its three Minor Injury Units (MIUs) across its localities.

The map below details the location of each ED and MIU across Wales:

WALES
A&E HOSPITALS AND MINOR INJURY UNITS

What we did

Focus of review

We reviewed how patient safety, privacy, dignity and their overall experience was managed by WAST ambulance crews and health board ED staff, whilst they waited on-board ambulances during delayed handover to ED staff. To achieve this, we explored the following five areas:

- **Patient handover** - to consider the procedures in place between the WAST and each acute hospital emergency department for accepting patients from ambulances into the care of health board staff
- **Patient experience** - to assess the overall experience of patients whilst waiting in an ambulance to include their safety, care and any impact on their wellbeing. We also considered how patient dignity is maintained and needs are met, to include nutritional, hydration and toilet needs
- **Workforce** – to consider the impact of the delays on ambulance crew to include their welfare and support
- **Escalation processes** - to consider the risk management and escalation arrangements of WAST during periods of high pressure as a result of delayed handovers
- **Governance arrangements** – to consider incident reporting, investigation of incidents of patient harm due to delayed handovers and learning from incidents.

Scope and methodology

The pandemic introduced unique and unprecedented pressures on the healthcare system; in view of this, we considered patient experiences between 1 April 2020 and 31 March 2021 in order to understand what impact the pandemic had on this issue.

To review the areas detailed above, we requested relevant documentation alongside and issued a self-assessment document to WAST and each health board. We also considered local and national performance data and statistics.

We held interviews with a variety of WAST staff, and conducted a survey for both WAST and health board staff.

In addition, we conducted a survey of people who used the emergency ambulance service in the 12 month period highlighted above.

Self-assessment

We asked six of the seven health boards across Wales to complete and return a self-assessment document. This helped us to understand the degree of insight each health board has of its strengths and areas for improvement with the process in place for ambulance patient handover, and the management of patients awaiting handover.

We wanted to understand the views of the public and staff on ambulance handover delays, and developed and launched two national surveys to help capture this information.

Staff survey

We developed and launched a staff survey to obtain the views of WAST and health board staff on the patient handover processes in place between ambulance crew and ED staff. This was to help us understand the impact of delays in the process may have on staff well-being, and to identify any areas for improvement.

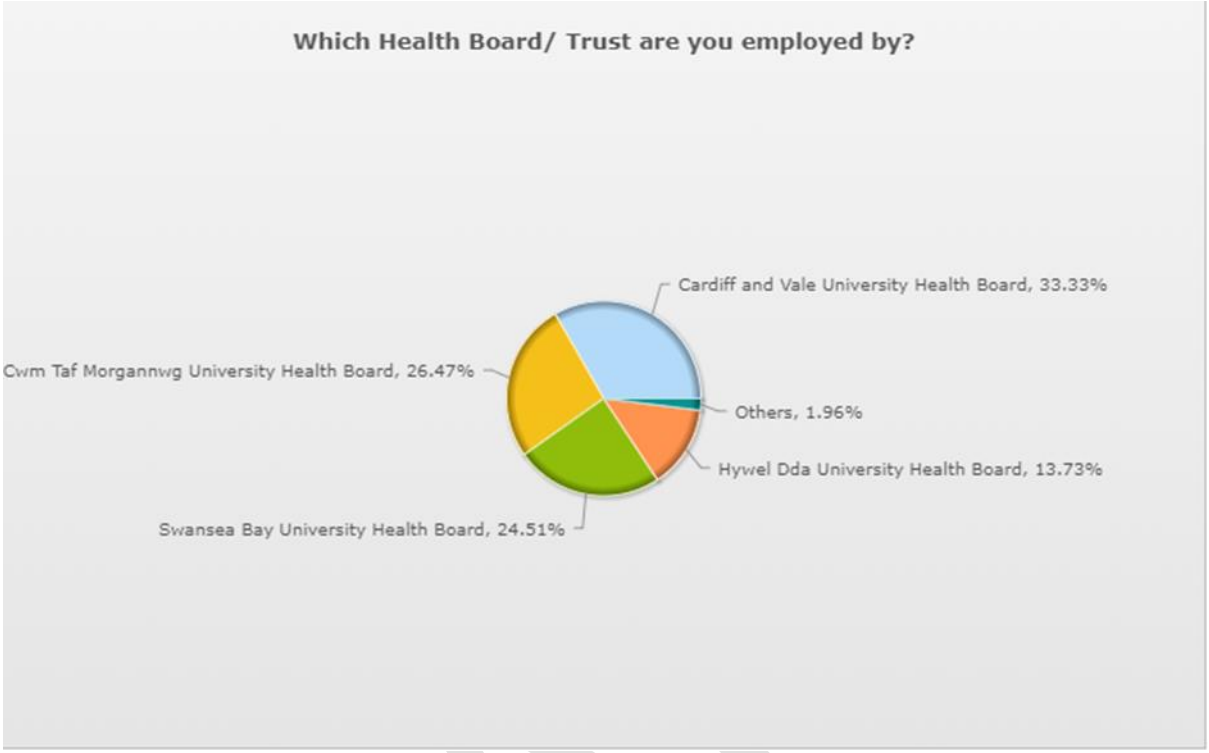
We asked WAST and health boards to distribute our online smart survey details to relevant staff, and we also promoted the survey through our social media channels.

We received a total of 438 responses, which covered a range of staff across Wales, which included:

- 271 WAST Paramedics and Ambulance Technicians
- 64 ‘other’ WAST staff, which included First Responders, Duty Operational Managers and Urgent Care Assistants
- 98 health board ED staff and ED managers
- 5 ‘other’ ED staff which included Patient Flow Managers.

Despite engagement with the six health boards providing emergency services, only staff within four health boards provided a response. We therefore did not receive the opinions from ED staff working within Aneurin Bevan and Betsi Cadwaladr University Health Boards, who cover four of the 12 EDs across Wales.

Breakdown of staff responses per health board

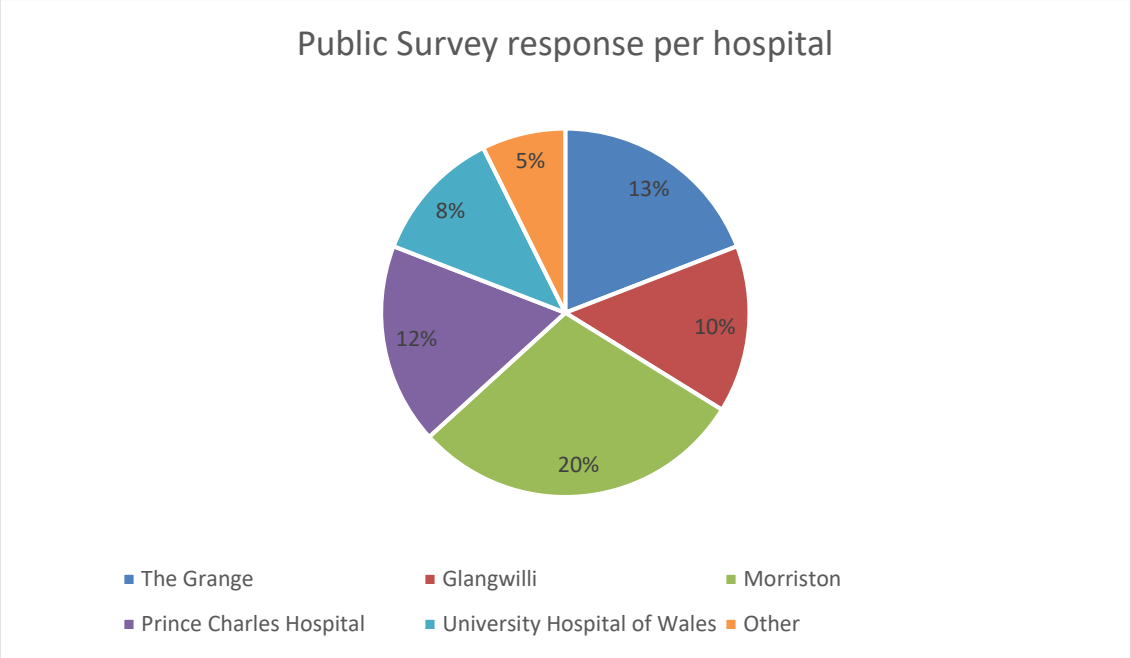


Public survey

In parallel with the staff survey, we also launched a national public survey, to capture the views of patients who had used an emergency ambulance. This was to gain an understanding of their experiences whilst waiting on board an ambulance outside an ED.

The survey was distributed via smart survey and was open to all people in Wales to capture the views of those who used WAST emergency services between March 2020 and April 2021. We engaged with WAST, health boards, and also the Community Health Councils in Wales, who provided their support with obtaining patient views.

We received a total of 137 responses, with 85% having used WAST emergency services within the last 12 months. Representation was from patients who had attended EDs across health boards in Wales.



Staff Interviews

Due to restrictions in place relating to the COVID-19 pandemic, the majority of our fieldwork was completed remotely, including most of our staff interviews. Where we completed site visits, each was individually risk assessed to minimise the risks to our staff and healthcare providers.

We held a number of interviews with ambulance crews from across Wales. This included Paramedics, Ambulance Technicians, Duty Operational Managers and Urgent Care Assistants. Staff we interviewed shared their views and experiences of working within the service, which included the main challenges they faced with handover delays.

As part of our fieldwork, we also interviewed senior staff from within the Trust, including members of the Executive Team. We completed a total of 31 interviews and our findings will be highlighted throughout the report.

What we found

The handover process

It is a regular occurrence across Wales for multiple ambulances to be stationary outside hospitals for prolonged periods, waiting to hand over their patients to the health board.

Wales Hospital Handover Guidance 2016[8]

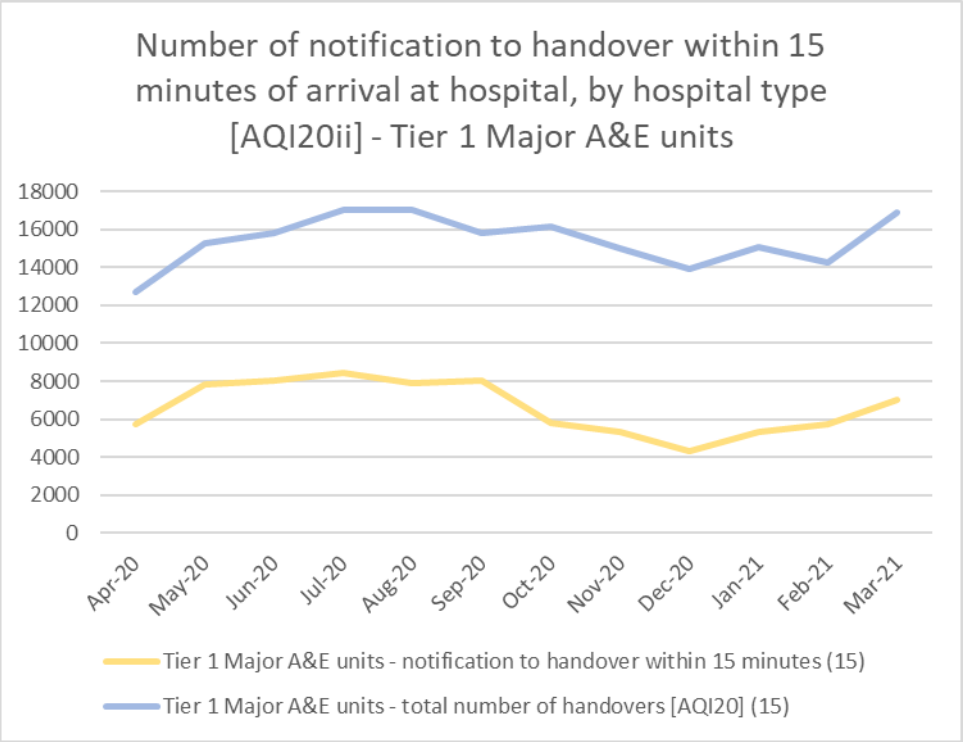
The hospital handover guidance issued by Welsh Government in 2016 stipulates the need for timely handover of patients from ambulance crew to hospital staff, to optimise performance and patient care. The guidance highlights that health boards are responsible for arranging the safe emergency transfer and timely treatment of citizens in their local area.

The statement of intent within the guidance indicates that the safety, effectiveness and patient dignity must be at the forefront of systems of emergency care. In addition, that the best care is provided to patients in the correct care environment. Therefore, when an ambulance crew takes a patient to hospital, it is essential that they are released promptly so they can continue to provide a safe and efficient service to the local community.

According to the above guidance, when a patient is conveyed to a hospital by ambulance, care must be handed over to the hospital team within 15 minutes. Health boards are responsible for ensuring this happens reliably. Hospital clinical staff must ensure that any patient waiting more than 30 minutes has been assessed and moved immediately into hospital if there is a risk to patient safety. Management of delays of over 60 minutes are unacceptable, and Welsh Government states that they should be the exception.

[8] Wales Hospital Handover Guidance 2016 click here

Data published by Welsh Government on the StatsWales[9] website, highlights that between April 2020 and March 2021 there were approximately 185,000 handovers at acute EDs throughout Wales. Of which, just over 79,500 occurred within the target of 15 minutes. This is highlighted in the chart below and relates to over 105,000 handovers falling outside of the Welsh Government target.



The impact of handover delays is that there are occasions where multiple ambulances are waiting together outside EDs for long periods of time. This can often affect the service to the extent that there are no ambulance resources available to respond to new emergencies within the community, thus increasing the risk to patient safety or life.

WAST data demonstrates that between April 2020 and March 2021, there were 32,699 incidents recorded across Wales, where handover delays were in excess of 60 minutes, of which, 16,405 involved patients over the age of 65. This is a concern since many older adults can be considered more vulnerable

[9] Ambulance Quality Indicators - Number of notification to handover within 15 minutes of arrival at hospital Tier 1 Major A&E units (AQI20ii) click here

and at risk of unnecessary harm due to frailty and pre-existing health conditions which are more common with older age.

Data published by Welsh Government of the recorded number of lost hours as a result of hospital handover delays, highlight that in December 2020, a total of 11,542 hours were lost due to handover delays. This is the equivalent to 1,004 ambulance shifts (based on an 11.5 hour shift duration). These delays have serious implications on the ability of the service to provide timely responses to patients requiring urgent and life threatening care.

Patient flow issues, such as system bottlenecks and discharge problems can negatively impact on the availability of beds within EDs, since the departments cannot transfer patient to wards due to insufficient ward bed availability. These concerns were echoed by numerous WAST and ED staff within our survey. Patient handover delays are not directly a WAST problem, but are a consequence of wider systemic patient flow issues through NHS healthcare systems and social care services. Concerns were also highlighted to us of severe overcrowding within EDs, which leads to the inability to offload patients from ambulances. This is consistent within a number of our findings during previous HIW inspections of EDs across Wales.

We found handover delays impact on the ability of ambulance crew to provide a positive experience for patients. It may also increase the risk to patient safety, through delays in diagnosis and receiving treatment, as well as to the risk to people awaiting an ambulance in the community, with fewer ambulances available to respond to their needs.

During our review of WAST in 2019-20, we made a recommendation to WAST to consider a holistic review with stakeholder engagement, of the handover arrangements in place across Wales, to help address the patient flow issues through NHS healthcare systems.

The Trust has been working on actions to make improvements in this area and with its stakeholders since 2020. However, our review has found ongoing issues in relation to patient flow within each health board across Wales. We have therefore recommended that Welsh Government considers how this broader issue can be tackled, and to coordinate a collaborative approach to ensure consistency across Wales.

Recommendation: *Health boards, and Welsh Government should consider what further actions are required to make improvements regarding the patient flow issues impacting on delayed patient handover. This may include consideration of whether a different approach is required by WAST, health*

boards, and social care services within Wales, to that taken to date in tackling this system-wide problem.

Ambulance arrival at ED

Six health boards were asked to complete a self-assessment regarding ambulance patient arrival and handover procedures within their EDs. The assessment responses helped us to understand the degree of insight each health board has into its own strengths and areas for development with ambulance patient handover.

Overall, we found that handover processes across Wales were broadly similar. There were, however, some variations in processes between each individual EDs within health board areas, and some disparities with the processes in place across health boards in Wales. This was due to local joint Standard Operating Procedures (SOPs) being in place with WAST, due to geographical layouts of ED environments, staff roles and levels of staffing available. We will elaborate further on these inconsistencies and the risks associated later within the report.

Since the start of the pandemic, we found that handover processes were consistently reviewed to meet the evolving national COVID-19 guidance. This included social distancing guidance and admission routes into EDs to support Red and Green pathways, and processes were changed to align with this to maintain patient and staff safety.

Pre-alert calls

In emergency and life threating situations, there are consistent arrangements in place across Wales for ambulance crew to provide pre-alert calls to a dedicated phone in ED, to notify staff of inbound patients who require immediate attention. For example, with patients experiencing cardiac arrest, difficulty breathing or heavy bleeding.

Pre-alert calls allow time for ED staff to prepare and prioritise for the arrival of the patient. Upon arrival to ED, ambulance crew immediately transfer the patient to an allocated space for assessment and treatment by the ED team. Once the patient transfer from ambulance stretcher to an ED trolley is

complete, a formal dual pin handover[10] is completed between ED staff and ambulance crew, and is documented on the Hospital Arrival Screen (HAS).

We were informed that ED staff regularly monitor the HAS for inbound ambulances. When patients arrive by ambulance (not requiring a pre-alert), an ambulance crew member registers the patient either at the ED reception, or with a dedicated ambulance receptionist, which in some EDs is a dedicated role. Patients are triaged[11] (assessed) either on board the ambulance or within a designated triage area of the ED, dependent upon capacity.

Dual pin handover process

The handover process involves both a paramedic and ED staff nurse communicating the formal handover with each entering their pin number into the hospital arrival screen. Welsh Government statistics relating to handover times are generated as a result of the timings of the dual pin handover process.

We received negative comments from ambulance crew in our survey regarding the timing of the formal handover to ED staff. They stated that at times, ED staff may complete the dual handover process and patients would be classified as handover complete whilst the formal handover was still taking place. In addition, we received 15 comments from ED staff who provided an insight from their perspective, around the difficulties that hospital staff are facing with the dual pin process. One comment included:

> *'As ED staff - once the ambulance verbal handover is complete and a patient is in the care of the ED in an appropriate area, I find it very frustrating to have to spend extra time chasing the ambulance crew, often back outside for their PIN number to clear the crew from the HAS handover screen. Ambulance crew are also sometimes reluctant to*

[10] Dual Pin Handover refers to an element of the handover process where both a paramedic and ED staff nurse communicate the formal handover of care, with each entering their pin number into the hospital arrival screen. Welsh Government statistics relating to handover times are generated as a result of the timings of the dual pin handover process.

[11] Triage is the process of determining the priority of patients' treatments by the severity of their condition or likelihood of recovery with and without treatment.

provide their PIN number to ensure a timely handover. This takes extra time which removes nurses from providing care to patients'.

In response to our self-assessment evidence from WAST, we were told that the dual pin handover process has led to improved data quality when examining the lost hours due to hospital handover delays. However, during our fieldwork interviews with ambulance crew, the issue of inaccurate handover recordings was repeatedly highlighted, which supported our findings from the staff survey. Correct application of the dual pin process will ensure that accurate timings of handovers are recorded and reported on by Welsh Government.

We also received a number of concerns around the process for dual pin handover from health board self-assessments, where the process is not consistent between hospitals or across health boards. Some said that the processes in place does not always provide an accurate picture of handover timings.

Recommendation *- WAST should engage with health board representatives to ensure there is improvement in practice between ambulance crew and emergency department staff to ensure the dual pin process is consistently followed, and ensure Welsh Government reporting data is accurate.*

Patient triage

We found variation across Wales in the staff roles that undertake triage assessments. This ranged between dedicated ED Triage Nurses, dedicated Ambulance Triage Nurses, the Nurse in Charge, or a Rapid Assessment Team (which may include a registered nurse, ED doctor and Healthcare Support Worker).

Across Wales, it is the aim is to commence triage within 30 minutes of patient arrival at ED, in line with the Welsh Government target. Patients are triaged

using the Manchester Triage System[12], which enables the triage clinician to assign a clinical priority, according to the patient's presenting signs and symptoms.

If, following triage, patients are deemed as 'Fit to Sit', meaning people are well enough to sit within the ED waiting area, they are transferred from the ambulance and escorted to the ED waiting area, and a dual pin handover between ambulance crew and ED staff takes place.

When patients are not considered to be suitable to stay in the waiting room, the patients are usually offloaded from an ambulance and transferred to an appropriate area according to clinical priority. If there is no capacity within the ED to accept patients from the ambulance crew, they will remain on board the ambulance until a space becomes available.

Following triage, we found a commonality across Wales where patient investigations commence, such as blood tests, X-rays or Computerised Tomography (CT) scans. Where appropriate, other time critical procedures and/or treatments are also commenced, such as Sepsis and Stroke pathways. This will commence regardless of ED space, and will include patients located on board ambulances.

Mitigating risks for patients arriving by ambulance

We asked health boards how they identify, manage, and mitigate any risks associated with patients arriving on ambulances. Each response highlighted the aim to achieve a 15 minute handover time for patients arriving at ED. When this is achieved, and an ambulance is released, it is beneficial to the patients' condition, positively impacts on their experience, and further benefits those awaiting an ambulance resource within the wider community. However, our review has found that this target is not often met across Wales.

[12] The Manchester triage system is an algorithm based on flowcharts and consists of 52 flowchart diagrams (49 suitable for children), that are specific for the patient's presenting problem. The flowcharts show six key discriminators (life threat, pain, haemorrhage, acuteness of onset, level of consciousness, and temperature), as well as specific discriminators relevant to the presenting problem. Selection of a discriminator indicates one of the five urgency categories, with a maximum waiting time ("immediate" 0 minutes, "very urgent" 10 minutes, "urgent" 60 minutes, "standard" 120 minutes, and "non-urgent" 240 minutes)

During times of increased pressure and numerous ambulances waiting to hand over the care of their patients to ED staff, a WAST Duty Operational Manager (DOM), may attend the hospital site, to provide welfare support to ambulance crews who are unable to offload and handover their patients. This is a new role that has been introduced by WAST. The DOM will provide cover for ambulance crew to take their breaks, and/or help enable crews to finish their shift on time, by taking over the care of the patient. The DOM will also liaise closely with ED staff and the hospital site managers, to plan what action is required to progress and facilitate the handover of patients to the care of the ED staff.

Health boards also highlighted to us the benefits of the role of Ambulance Patient Flow Co-ordinators or Hospital Ambulance Liaison Officers (HALO) within the EDs. Their role is to assist in achieving a timely handover, and to maintain effective communication between ambulance crew, ED staff and patients. In addition, they aim to reduce delays by helping to mitigate risks to patient safety on board an ambulance, by minimising long waits outside ED, which in turn will benefit those waiting in the community for emergency care. Furthermore, the role also aims to improve the overall experience for patients, by working with ambulance crew in providing care. Our review has found that where these roles have been introduced, they have helped to ease some of problems associated with the handover process and have been beneficial to patient experience as a consequence.

During times of delayed handover, we identified that ambulance crews monitor the patient condition and escalate any concerns to the ED nurse in charge. In the event of a patient's condition deteriorating further, ambulance crew will enact a formal process for escalating a clinical concern with a deteriorating patient outside the ED. We will elaborate further on the effectiveness of this process later within the report.

We also found consistently across Wales, that during periods of high demands on the service, such as multiple delays with handover, each hospital has an internal escalation plan which is actioned, and plans are implemented with the to aim to reduce ambulance offload delays.

Other consistent measures in place across Wales are regular hospital patient flow meetings and hospital bed management meetings. The meetings allow staff to assess the availability of hospital beds, and to monitor the capacity within ED and the number of ambulances waiting to handover. However, despite these measures, the problem of prolonged handover remains an issue.

Strengths with handover processes

Health boards were asked to tell us about the strengths they have identified as part of their handover processes. Across Wales, there was unanimous agreement that EDs have introduced an effective COVID-19 point of contact testing, where patients are tested for the virus at their point of entry, and are allocated a waiting area based on their expected or predicted status for the virus. Some health boards highlighted an improvement with patient flow, as a result of point of contact testing particularly during the height of the pandemic, which resulted in reduced delays with transferring patients to wards.

During our interviews with ambulance crew, they spoke of the positive impact on handover, as a consequence of the roles of the dedicated Ambulance Triage Nurses or Ambulance First Point of Contact. As mentioned, staff in these roles determine the level of acuity of patients arriving by ambulance, and assist in helping to achieving 15 minute handover targets and to commence triage within 30 minutes of arrival.

Ambulance crew also highlighted that dedicated ambulance receptionists help make the handover process more efficient in enabling them to register patients upon their arrival. The role of the HALO or Ambulance Flow Co-ordinator was also reported to help assist with handover and relieve pressure from the Ambulance Triage Nurse. We found that the introduction of these roles assists in improving the patient experience and welfare by providing positive links for effective communication between ambulance crew and emergency department staff. However, the presence of these receptionist, liaison, and patient flow roles isn’t consistent across each ED in Wales.

We were told that patients are re-triaged once clinical interventions have been initiated on board ambulances. As a consequence, any improvements in a patient's clinical condition could expedite their admission to the department, for example if they are assessed as 'Fit to Sit' in the ED waiting area. In addition, in some instances, patients may be well enough for discharge, to recover at home.

Areas that require improvement

Health boards highlighted some areas that require strengthening with handover. There was unanimous agreement across Wales that improvement is required with patient flow through hospitals, in order to improve bed availability and trolley space capacity within EDs. This included improvement in the timely discharge of patients from hospitals, to assist with patient flow. This would lead to improved patient handover times from ambulance crew to ED staff, an improvement in the overall patient experience, and benefits to timely care with emergency responses in the community.

We found that improvements need to be made in relation to collaborative working between WAST and health boards, particularly in regards to communication and the management of serious incidents arising from delayed handover. There is a need to ensure health board representatives regularly attend WAST Serious Clinical Incident Forum (SCIF) meetings, to enable timely management of concerns and to develop action plans and feedback throughout the organisations. This is referred to in more detail later within this report. Whilst there appear to be robust processes in place for triage, initiating treatment and handover process, issues remain with delayed handover due to the lack of bed space within ED and the wider hospitals, which significantly affects patient flow.

***Recommendation**: Health boards should consider the benefits of the introduction of specific roles within their EDs that have the aim of improving process the handover of patients from ambulances.*

***Recommendation**: Health boards must ensure that appropriate representation is present at WAST Serious Clinical Incident Forum meetings, to aid with the timely management of concerns and service improvement.*

Staff perceptions of the handover process

We considered the perspective of ambulance crew and ED staff of the handover process. This was achieved through our staff survey and our interviews with ambulance crew.

Through our staff survey, we found that 90% of ED staff were familiar with the handover policy for their hospital. This was slightly less for ambulance crews, with just over three quarters of them aware, although with a slight increase in number for their most frequented hospital. These numbers give rise to concern, as it is suggestive that some ED staff and ambulance crews are unfamiliar with handover policies.

The majority of ambulance crew respondents also expressed frustrations of their experience of waiting outside hospitals and their dissatisfaction with the handover process in place both at a local level and nationally. We had a strong response on the comment section for this area with almost half of WAST respondents providing additional detail when sharing their experiences.

The comments enabled us to identify some key themes such as, some ambulance crews told us that handover processes frequently change and they are not familiar with current practices. Ambulance crew who regularly attend more than one ED also face the challenge in different local practices. Some said that processes differ day to day, and that each clinician and member of ED staff implements them in different ways therefore, making it difficult for staff to

remain up to date with current processes. There are variations in processes due to local SOPs, geographical layout of each environment, job roles and levels of staffing. It was also highlighted to us that the impact of the pandemic on practices has been that it is challenging for staff to stay up to date with current processes.

***Recommendation**: If and where local standard operating procedures are absolutely necessary, WAST and health boards must work together ensure that ambulance crew are familiar with the handover policy for that ED.*

Ambulance crews also provided their comments in our survey on their view of the effectiveness of the handover hospital handover guidance issued by Welsh Government in 2016 process. These included:

> *'The process seems to be centred around ambulance turnover rather than a focus on patient care. This in turn creates more delays for ambulances as the processes put in place differ day by day, nurse by nurse as there is no full understanding of what the procedure should be. My experience has been waiting upwards of 30 mins just to notify the hospital of our patient. That's before they are booked into the department and triaged*.
>
> *ED staff are excellent and do as much as they can to assist/handover patients however they cannot do this when there are not beds available. It is not appropriate to manage patients on the back of an ambulance for several hours and should be avoided where possible.*
>
> *There is a reluctance to follow the "Fit to Sit" agreements that the Welsh ambulance service have in place'.*

Our staff survey responses noted ambulance crew sometimes attend EDs within England. Concerns were highlighted that handover delays have become routine in Welsh hospitals, and are less frequent in England. A number of ambulance crew provided their opinions to us during interview, that handover processes within EDs in England are more efficient than the processes in place in Wales, which compound the frustrations with handover delays across Wales. Comments from ambulance crew included:

> *"Patients waiting in the community are coming to a wide range of harm due to no ambulances to send to them due to the ambulances being queued outside hospitals. I've recently transferred to Wales from England and this problem very rarely happens in England but is a daily problem in Wales. Very poor.*

When I visit other ED outside of Wales, we take the PT straight in to EDs, even large City EDs. But for some reason Welsh EDs struggle with this'.

Relationship between ambulance crew and emergency department staff

Throughout our interviews, ambulance crew told us that in general, positive relationships had been formed with ED staff across Wales. We were told that both parties were working towards the same goal of achieving early handovers to release ambulance crews to respond to emergencies. However, this was not consistent with our survey results, with 71% of ambulance crew stating that they did not feel ED staff and the service provided by ambulance crew worked together to provide seamless patient treatment and care. However, 69% of ED staff felt they work together with ambulance crew to provide seamless patient care.

One comment received from a member of ED staff highlighted:

'There is no single issue which would resolve the problem, neither is it solely a problem of a specific group. Again, I would like to reiterate that ED is locked between a rock and a hard place; trying our best but with many obstacles in our way. We used to have a really positive working relationship with our WAST colleagues which has deteriorated over time'.

The findings from our survey and interviews suggests a mixed relationship, and issues can occur on a case by case basis. We recognise the pressure and intensity that handover delays must have on both ambulance crew and ED staff to minimise risks to patients, and that working relationships may be strained as a consequence. However, this can have a negative impact on the overall patient experience.

We also found through our interviews and staff survey that ambulance crew feel their vehicles are used inappropriately, and as an extension of the ED. The term ‘warding’ was commonly used to refer to this. Ambulance crew told us that ambulances are used as waiting rooms or additional beds, with many staff elaborating that a bed shortage within ED is the reason for this.

We also learned that patients are often taken off an ambulance for scans or other investigations, and returned to the ambulance due to no capacity in the EDs. We were also told about occasions when following investigations and treatment, patients who did not require hospital admission, were transported home by the same ambulance crew who had responded to the initial emergency call. Some ambulance crew also said that hospitals manage their

own risks by keeping patients on the ambulance. Comments from ambulance crew included:

> *'The feeling that the patient isn't the problem of the hospital until they get in through the front doors is widespread. We are extended waiting rooms for the hospitals and this shouldn't be the situation.*
>
> *The current system is not working, emergency departments are using ambulances to treat patients in and this is not what they are intended to do. While this is happening and we are waiting to handover our patients there is patients within the community not getting the medical help needed for many hours'.*
>
> *'The problems with handover are not due to WAST. The issue is severe overcrowding of the EDs which then leads to lack of ability to offload. The systems in the hospitals prioritise patients who have been seen and treated (inpatients) over patients who have not been seen or treated by the ED which is wrong and unsafe. As well as this, having ambulances stacked outside causes there to be increased response times by WAST. So in turn, we are prioritising seen and treated patients (inpatients) over those waiting for an ambulance…..The subsequent problems of even more overcrowding that will cause, will lead to innovation within the hospital. Unless we bring the problem into the hospital, the hospital will not solve it*'.

As highlighted earlier, the role of ambulance crew is to provide an emergency response and transportation for patients to EDs. Welsh Government guidance is clear that patient care should be handed over to hospital staff within 15 minutes of their arrival, but most certainly before 60 minutes.

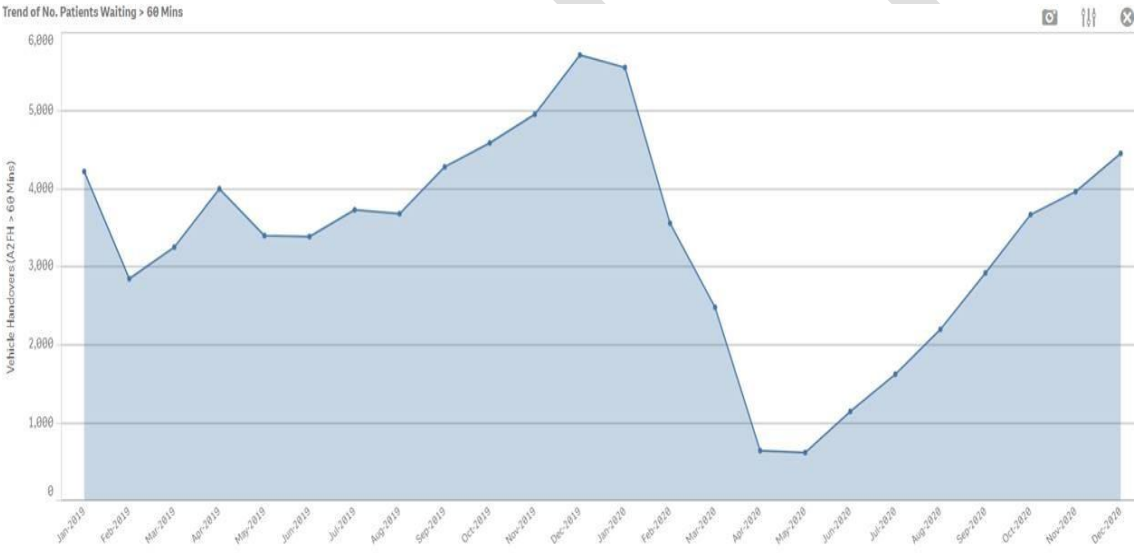
Ambulances are designed as a pre-hospital environment and are equipped to transport ambulance crew and other first responders to the waiting patient. The vehicles carry equipment for administering emergency care to treat patients at the scene, and transport patients when necessary to EDs for advanced treatment. They are not designed and equipped for patients to be cared for during periods of extensive waits outside EDs. The impact of patients remaining within the back of an ambulance can negatively impact on the patients' experience and their safety.

Patient experience

Impact of the pandemic on patient experience

The NHS Wales activity and performance summary highlights fewer attendances to all NHS Wales EDs during the first wave of the pandemic, with April 2020 seeing the lowest number of attendances at ED since current reporting began in 2012.

Handover delays during the first wave of the pandemic were substantially lower. We were informed that this was the result of a significant decrease in demand, and an initial pandemic response to improve hospital capacity. This is highlighted in the chart below, which reflects the number of patients who experienced handover delays over 60 minutes across all health boards in Wales.



We considered the views of patients on whether the pandemic impacted on their experience of attending the ED. In the public survey responses, the majority said they were not displaying COVID-19 symptoms, and were not attending ED due to suspected COVID-19.

It was positive to learn that the majority of respondents felt that measures to minimise the spread of COVID-19 were being followed by both ambulance crew and ED staff. The majority of respondents said all staff wore PPE on the ambulance and at hospital, their temperatures were taken on arrival at hospital, and they were transferred to a designated green areas away from suspected or positive COVID-19 patients. However, we did find in a small minority, where some concerns were highlighted in the survey, as highlighted below:

'Unfortunately dad was infected with COVID in hospital'

'We were all asked to wear masks in the house whilst the paramedics were there. However, I noticed that although the crew were wearing masks they weren't wearing any other form of PPE'.

Overall, our findings reflect that despite the severe impact of the pandemic, it did not negatively affect the patient experience who used emergency ambulances services across Wales, and on the whole patients were satisfied with the care provided. Our COVID-19 themed national review report[13] highlights further our understanding of how healthcare services across Wales met the needs of people and maintained their safety during the pandemic.

Patients awaiting ambulances in the community and their arrival at the ED

Standard 5.1 within the Health and Care Standards 2015[14] states that all aspects of care should be provided in a timely way, ensuring people are treated and cared for in the right way, at the right time, in the right place and with the right staff.

Of the 137 responses to our public survey, approximately half waited under an hour in the community for an ambulance to arrive, with most waiting less than 30 minutes. However, 26% of respondents waited between one and four hours, and 22% waited over four hours. For those who waited over four hours, each commented that they felt their health condition deteriorated over this time. Around a third of these patients were admitted immediately into the hospital on arrival, however, another third had a further wait of over two hours on-board an ambulance following arrival at the hospital.

We received several concerning comments from people about prolonged ambulance waits, despite the possibility of them experiencing a stroke, heart attack or other serious health concerns. Comments included:

[13] HIW COVID-19 National Review Report

[14] The Health and Care Standards 2015

'I waited over 2 hours for an ambulance after having a stroke. Ambulance never showed. First responder arrived at 2 hours and tried to get an ambulance and was told none available.

'Things could have been a lot worse as Dr said by rights my dad should not still be here after having to wait 3hrs whilst having a major heart attack'.

Several people in response to our public survey highlighted long waits of between four and 13 hours for an ambulance after sustaining an injury due to falls at home, particularly in relation to older adults. Long waits in the community were also substantiated by ambulance crew in response to our staff survey and during our fieldwork interviews. Staff highlighted that the risk from handover delays is not only to the patients waiting in ambulances but also to patients in the community, who are waiting for an emergency response. Comments included:

'Patients queuing up in ambulances probably have the same outcomes as patients in the ED, as HB clinicians will always see and treat our patients. It's the patients that are waiting for ambulances that are most at risk.

Handover delays impact me and my patients negatively as I am often on scene with an unwell patient waiting for an ambulance to become available. It is common to have to wait 2-4 hours for 'emergency' backup. This can be very detrimental to patients and is hugely stressful for me. I have been on my own with patients having multiples seizures, heart attacks or severe breathing difficulties for 1-2 hours. As well as patients likely to come to harm, this is very stressful for me and affects my mental health.'

Throughout our fieldwork, the majority of ambulance crew interviewed expressed their frustrations of waiting outside EDs to handover patients, in the knowledge that patients are waiting in the community in need of an emergency response. These patients have not been physically assessed by a clinician and therefore, their clinical condition is unknown. This is particularly concerning for conditions such as strokes or heart attacks, where time critical treatment is essential due to specific therapeutic window timescales, and any delays to treatment may negatively impact on their clinical outcome, future rehabilitation or even their life.

People indicated in the survey comments, that due to long ambulance waits they sometimes had to arrange alternative transport, such as driving their loved one to the hospital or arrange a taxi. Comments included:

'Ambulance wait time over 2 hours. This was not made clear at 999 call only that an ambulance has been requested. After 2nd call to 999 after half an hour I was told it could be 2 hours. Took him in the car and hospital was excellent. Could and should have gone sooner if wait time had been honest in the first place'.

The risk to patients in the community was a key finding from our previous review of WAST in 2019/2020, and has been repeatedly highlighted by staff throughout this review.

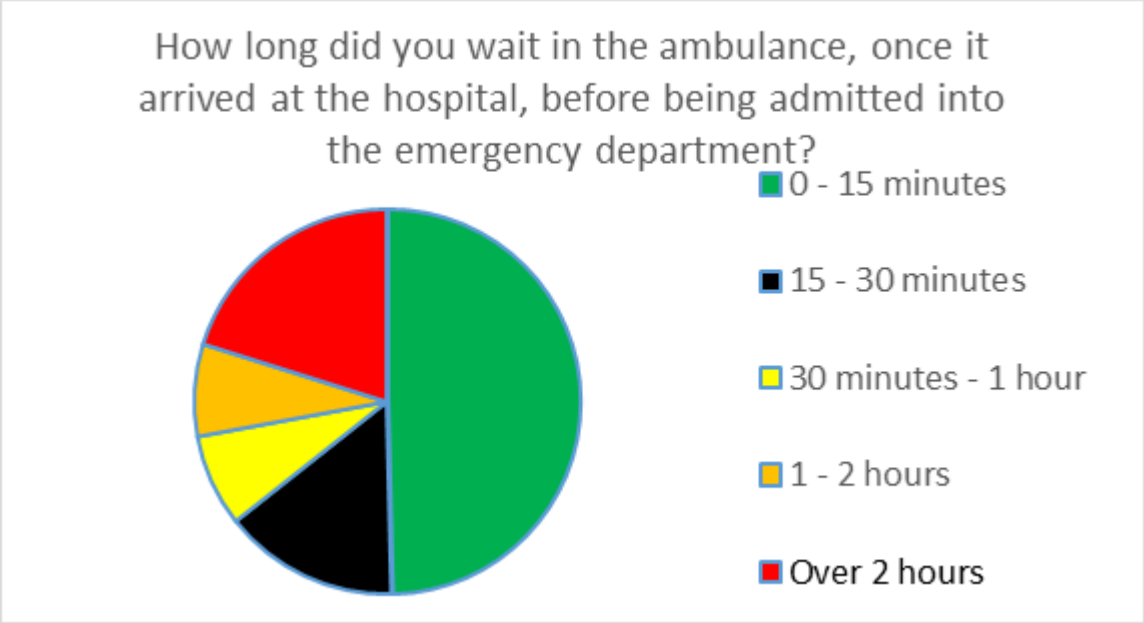
As referred to earlier in this report, a recommendation was made in our previous report that WAST should consider a holistic review with stakeholder engagement, of the current handover arrangements in place, which should include current escalation arrangements during periods of high demand. Whilst we are satisfied that progress has been made, this re-iterates the need for Welsh Government to ensure a prompt collaborative approach between WAST, health boards, and social care services within Wales, to make improvements with the ongoing patient flow issues.

Patient experience with handover and triage

We asked patients in our public survey to tell us about their experience during handover between ambulance crew and ED staff. As highlighted earlier, the Welsh Government target for patient handover to the ED team, is within 15 minutes of arrival at the hospital.

Our public survey identified that only half the respondents said they were admitted to ED within 15 minutes. A further 15% waited between 15 to 30 minutes, and a minority waited between 30 minutes to 2 hours. However, 1 in 5 patients told us they waited over two hours in the ambulance, before being handed over to the care of ED staff.

'I had a four and a half hour wait for the ambulance which had been requested (highest priority) by my GP in the surgery. On arrival at the hospital there were 17 ambulances waiting to hand over the patients. I was waiting for a further three and a quarter hours'



As highlighted earlier in the report, any delay over 60 minutes should be the exception. Prolonged patient waits on board an ambulance are not acceptable, in particular for those who may have already waited for long periods for an ambulance in the community.

Our public survey highlighted that the majority of people who engaged with us were triaged within 30 minutes of arrival at the hospital. This is in line with Welsh Government targets. However, around a quarter reported that it took longer than 30 minutes. Whilst most patients were assessed in hospital, 30% reported that assessment took place on board the ambulance. Only a few patients told us they had been assessed in hospital and then taken back to the ambulance.

We received one comment from a patient who reported 17 ambulances were outside the ED at the time that they attended, waiting to handover patients to hospital staff. This is concerning and reflective of the difficulties ambulance crews and ED staff are frequently facing.

A quarter of patients told us they received treatment from ED staff whilst on board the ambulance, but most remained under the care of the ambulance crew. One patient told us that no ED staff assessed them for the duration of their time on board the ambulance, whilst another said:

> *'I was in the ambulance from 8.30am to sometime around 4pm. A doctor paid a number of visits and also nursing staff to take blood and to give me painkillers'.*

We asked patients to provide their views on the triage/assessment process upon their arrival at the hospital. Comments we received were mixed, with some stating that it worked efficiently and they were seen immediately, however, there were a number of comments about how long it took to be seen upon their arrival at hospital. One commented included:

> '*After assessment and excellent care and treatment by ambulance personnel I was treated almost immediately after arriving at hospital by a superb team'.*

Whilst it is positive that most patients were triaged within 30 minutes, it is concerning that not all patients were assessed by a health board clinician in the appropriate timeframe. This can negatively impact on the patient experience and clinical condition, when they are not reviewed in a timely manner.

As part of our review, we also considered communication with patients' relatives/carers. We found a clear divide, with half stating that relatives were kept updated, and half stating they were not. Comments indicated that ambulance crew communicated well with relatives, to update them on what was happening. However, only half of the survey respondents said they were kept informed about how long the wait on board the ambulance would be. Our survey highlighted that communication once the person was admitted to hospital was experienced as variable.

Our interviews with ambulance crew indicate that they always endeavour to engage with and build a positive rapport with patients. However, they said that during periods of long delays, there are limitations to the number of times they can apologise to patients and their loved ones, either for the delays they experience whilst waiting for an ambulance in the community, delays outside the hospital, or at both locations.

The hospital handover guidance issued by Welsh Government in 2016 is clear, that when delays occur patients and their relatives or carers should be kept fully informed of the reasons and the progress being made in resolving them. We recognise that it may not always be possible to provide accurate timescales to people, since the clinical priority of patients for handover to ED is continuously assessed and changing. However, the importance of clear communication with patients to ensure they are informed of the reasons for delay, is key in alleviating their anxieties or frustration with waiting.

Recommendation*: WAST and health boards need to ensure that when delays occur, patients and their relatives or carers should be kept fully informed of the reasons and the progress being made in resolving them.*

***Recommendation**: WAST and health boards across Wales should ensure patient feedback is obtained regularly to understand their experiences of long waits on board an ambulance, in order to inform improvement.*

Delayed diagnosis and treatment

Although a minority, several views were communicated to us from people in our public survey regarding ineffective diagnoses made by both ambulance and ED staff. It also included a few dissatisfied comments about ineffective diagnosis and treatment of conditions once admitted.

> *'If there's a documented history of sepsis. Surely the sepsis protocols could be followed'.*

We also received comments from ambulance crew relating to the delays in treatment and diagnosis for patients by ED staff. The comments included concerns where a patient's health could deteriorate whilst on board the ambulance, such as a patient experiencing chest pain.

Other comments from WAST staff suggested that they believe diagnosis should commence whilst the patient is waiting on board the ambulance, such as blood tests and x-rays. This somewhat contradicts the self-assessments completed by health boards which suggest that ED staff do commence investigations, diagnosis and treatment while the patient is on board the ambulance. This suggests that the commencement of investigations whilst the patient is on the back of the ambulance does not consistently happen across all EDs. The comments included:

> *'Our patients are left stuck on ambulances without having bloods etc. done which could speed up the process for them to discharge patients. There should be a system for WAST staff to take bloods and take patients for x-rays or appropriate investigations whilst waiting outside hospitals as it benefits the patient and the staff at the hospital'.*

We believe that commencing investigations whilst the patient is on board an ambulance has a benefit of earlier diagnosis, admission or even discharge of some patients, which could enable ambulance crews to be released, to undertake their primary role as providing on scene urgent or emergency care, and urgent or emergency transport of patients to hospitals.

***Recommendation**: WAST and all health boards across Wales must work together to identify a consistent approach in providing timely investigations and treatment for patients on board ambulances, to enable ambulance crews to be released quickly.*

Patient privacy and dignity

Standard 4.1 within the Health and Care Standards 2015, states that people's experience of care is one where everyone is treated with dignity, respect, compassion and kindness and which recognises and addresses individual physical, psychological, social, cultural, language and spiritual needs.

In its handover guidance, Welsh Government states that the safety, effectiveness and dignity of care of patients must be at the forefront of systems of emergency care.

As highlighted earlier, our review considered how delayed handovers impacted on the privacy and dignity of patients on board the ambulance. This included the toilet needs of the patient either within the ED, or on board the ambulance.

Overall, our patient survey highlighted that patients were very positive about their experience waiting on board an ambulance due to delayed handovers. We received very positive feedback about ambulance crew, particularly in relation to their kindness, overall communication and managing of distressing situations. Patient comments included:

> *'The ambulance service went above and beyond'*
>
> *'They were excellent, really helped with my mother-in-law's anxiety and kept us fully informed throughout'.*

Nearly all who engaged in our public survey said they were treated with dignity and respect by ambulance crew, and felt safe and cared for, and that staff were knowledgeable. Most also said they felt ambulance crew treated their condition effectively. Patients also indicated that they were satisfied by the care and treatment from ED staff.

The results of our staff survey, however, were not as positive in relation to their ability to maintain patients' dignity during delayed handovers. For ED staff, whilst 78% felt that patients were well cared for on board ambulances, only 68% said that the patient's privacy and dignity is maintained. In addition, only 62% of ambulance crew were felt that patient privacy and dignity is maintained. This was also highlighted in our interviews with ambulance crew, with some specifically raising concerns with their ability to maintain the privacy and dignity of patients. The comments included:

'Patients never provided with reason as to why they are waiting on an ambulance or have to endure the indignity of using a commode on an ambulance.

'The biggest issue I have come across resulting from patients waiting for many hours on the back of an ambulance is that comfort and dignity is compromised. The ambulance stretcher is not designed for patients, especially elderly patients with thin skin to be laying on them for hours. Also, during long waits patients often need to go to toilet and as a result of very poor mobility end up soiling themselves. So to preserve their dignity we clean them up as best we can with very limited items as it's an ambulance and not a hospital ward'.

One area of concern consistently highlighted by ambulance crew, was the difficulty in facilitating patients to access a toilet during their wait. Whilst most patients told us they were able to access a toilet, it is concerning that some patients reported they did not have access to facilities. In addition, during our staff interviews, concerns were highlighted by numerous ambulance crew with the difficulties encountered in assisting patients to use a commode or a bedpan on board an ambulance, due to the limited space available. Some also expressed concern over appropriateness, when two male ambulance crew were required to assist female patients with their toileting needs.

Wherever possible, ambulance crew told us they take patients inside the ED to use the department's toilet facilities, and request nursing staff assistance as appropriate. Overall, staff highlighted the issues with accessing toilet facilities as having a negative impact on patient privacy and dignity. Whilst ambulance crew told us that every effort is made to help maintain patient dignity, they described this as not always possible.

It was positive to note in one ED, that the ED sister attends the ambulance bays to enquire whether patients require the use of a toilet, and ensures staff are available to assist them. Patients are taken inside the ED whenever possible, or assistance is provided on board the ambulance.

Good practice in toilet management can help patients to maintain their dignity. Whilst we acknowledge the efforts made by ambulance crew to protect patient dignity, further efforts are required by both ED staff and ambulance crew to ensure all patients can access appropriate toilet facilities to maintain their privacy and dignity at all times.

Recommendation: *Both WAST and health boards must ensure that ambulance crew and ED staff work collaboratively to ensure patient privacy and dignity is maintained, and patients are always provided with the opportunity to*

use private toilet facilities where appropriate, in a dignified manner whilst waiting on board an ambulance during delayed handovers.

Preventing pressure and tissue damage

It is highlighted within Standard 2.2 of the Health and Care Standards 2015 that people should be helped to look after their skin, and every effort should be made to prevent people from developing pressure and tissue damage.

In response to our staff survey, ambulance crew raised concerns around the suitability of ambulance stretchers for patients who experience long handover waits. In particular, for patients who are immobile and lying on a trolley on board an ambulance are at an increased risk of sustaining skin tissue pressure damage. We received numerous comments from ambulance crew which included:

> *'Patients are regularly suffering due to excessive handover delays. Ambulance stretchers are not designed for prolonged use and vulnerable patients are being put at risk of pressure sores and other tissue viability issues despite the efforts of ambulance staff to turn and adjust their positions.*
>
> *Often waiting outside with a patient for extended hours anywhere from 2 to 12 hours with a patient on an ambulance stretcher that is not designed for. Hard to give pressure relief to patients especially the heavier ones'.*

We were told during our interviews with ambulance crew that they are required to undertake an on-line clinical training module on the risk of pressure damage and pressure relief. However, despite their knowledge and understanding of the risks, and crew efforts to mobilise patients where appropriate, staff told us it can be very difficult to prevent skin tissue pressure damage for all patients. This in particular is an issue patients, such as those with a suspected fractured neck of femur or spinal injury, who cannot be appropriately moved.

In addition, there is an increased risk of skin tissue damage with patients over 70 years of age, as a result of frailty and/or decreased mobility and/or poor nutrition and hydration on board an ambulance. Given the patient demographics provided to us by WAST, the majority of patients taken to EDs by ambulance are aged 65 and above, which highlights additional concerns associated with long patient waits outside ED.

We acknowledge the efforts made by both ambulance crew, and ED staff who support them, to help provide pressure relief and assess patients' skin for signs

of pressure damage on arrival to ED. However, we are concerned that the risk of skin tissue damage remains for all patients experiencing long handover delays, in particular older adults, and will continue until prolonged handover delays are resolved.

***Recommendation**: During prolonged handover delays, WAST and health boards must work collaboratively and consistently, to minimise the risk of skin tissue damage for patients.*

Nutrition and Hydration

Standard 2.5 of the Health and Care Standards highlights that that people should be supported to meet their nutritional and hydration needs, to maximise recovery from illness or injury.

During our review, we considered how patients' nutritional and hydration needs are met whilst they wait on board an ambulance.

As highlighted earlier in the report, the purpose of ambulance crew is to provide urgent or emergency care to patients in the community and where necessary, to transport them to hospital on board an ambulance. Ambulances are therefore not equipped to provide food and drinks to patients. One member of ambulance crew commented:

> *'Hospital delays have been allowed to happen without any care or thought to keeping patients hydrated, fed and toileted appropriately whilst in the Ambulance. Ambulance Staff are not provided for, and often left hours without access to food and drink'.*

In our public survey, it was concerning to find that half of the respondents said they did not receive sufficient food and drink during their wait for handover to the ED. However, we are mindful that there are occasions when patients are designated as 'Nil by Mouth' due to their clinical condition, and therefore cannot consume food or drink, unless assessed as safe to do so. This may include examples with patients with gastric complaints, such as diarrhoea and vomiting, or severe abdominal pain, or for those who are suspected as required urgent surgery.

We found positive examples during our interviews with staff, where the majority told us that patients were supported by British Red Cross workers, who were contracted to work within EDs, who provided assistance to patients with food and drinks, and offered emotional support through engagement with patients.

It is concerning that patients who are waiting on board an ambulance are reliant on others for the provision of food and drink, to ensure their nutritional and hydration needs are met. We also acknowledge the difficulties that ambulance crew and ED staff face in providing food and drink for patients. The uncertainty of when patients may be able to eat and drink will negatively impact on them physically, especially given the uncertainty around timescales of when they may be handed over to hospital staff.

Recommendation: *WAST should work with health boards to ensure that patients' nutritional and hydration needs are consistently met whilst waiting in the back of an ambulance due to delayed handovers.*

Pain Management

During the review, we considered how patients' pain was managed on board the ambulance during triage and thereafter. Our public survey provided mixed comments, though overall, patients reported that ambulance crew managed their pain well. There was also a good response from ambulance crew in relation to the management of the patient's pain, with 81% stating they had access to pain relief should the patient require it. However, this was not consistent with their hospital experience, where patient comments indicated that their pain was at times not managed well once admitted to the ED. The comments included:

> '*The paramedics ensured I received additional pain relief in the ambulance on arrival'*
>
> *'Unfortunately the hospital left me in a great deal of pain for quite some time.'*

It is reassuring that ambulance crew are acting positively in managing patients' pain. This is imperative, given the uncertainty of the length of handover delays. This may be reflective of the one to one care patients receive from the ambulance crew in comparison to staff-patient ratio in the ED. Health boards should reflect on these findings, and consider how pain management can be appropriately maintained, for patients experiencing pain once admitted in to the ED.

Infection prevention and Control (IPC)

Standard 2.4 of the Health and Care Standards 2015, highlights that effective IPC is everybody's business, and must be part of everyday healthcare practice and based on best available evidence, so that people are protected from preventable healthcare associated infections.

Our staff survey highlighted a generally positive response to IPC from ED staff. Whilst 83% said that IPC procedures are followed, almost all said there is a sufficient supply of PPE, and 89% highlighting decontamination arrangements are in place for used equipment and relevant areas.

However, the survey response from ambulance crew was less assuring with 79% saying that IPC procedures were followed, and only 70% highlighting they felt there are adequate decontamination arrangements in place on the vehicle.

During our interviews with ambulance crew, concerns were highlighted by a number of staff regarding their ability to appropriately maintain safe IPC measures on board the ambulance. They provided examples with patients requiring a commode on board the ambulance, and with patients needing to eat and drink within the vehicle during long delays. In addition, crew members who may assist patients with enabling a patient to use a commode or bed pan are unable to change their uniform (if required), and may attend further emergency calls during their shift.

These examples highlight the difficulty in maintaining a safe and infection free clinical environment. The vehicles are a confined environments, and are not appropriate to provide adequate care for patients during periods of long delays with handover. This not only increases the risks with maintaining IPC, but can be considered detrimental to the patient experience.

***Recommendation**: WAST should consider how ambulance crew and patients can be supported to achieve and maintain high standards of hygiene and IPC, in particular during periods of delayed handovers for patients on board an ambulance.*

Safe Care

People's health, safety and welfare actively promoted and protected. Risks are identified, monitored and where possible, reduced or prevented.

Within our staff survey, we asked whether staff were satisfied with the quality of care, treatment and diagnosis they give to patients during periods of handover delays. It was positive to find that 89% of ambulance crew said they were satisfied with the care they give to patients, although only 74% of ED staff were satisfied with this.

We asked ambulance crew in our survey if patients were monitored and assessed for acute illness; 87% confirmed they were, and this was also reflected our findings from the ED staff. In addition, more than three quarters of

ambulance crew said there was access to higher clinical support should it be required.

We also asked staff whether patients were involved in decisions about their care. Three quarters of ambulance crew and ED staff confirmed they were, however, we identified some negative comments from ED staff in relation to this question. Once comment included:

> *'There are issues with regards to ongoing care of patients who remain on vehicles for long periods of time; as a department we are trying to look after patient's both physically in and out of the ED, sometimes with little support from the crew.'*

Despite receiving positive responses regarding the quality of care provided to patients from ambulance crew, it was very concerning that only 41% of ambulance crew said it was clearly understood who has responsibility for the patient at all times. However, three quarters of ED staff said it is clearly understood who has responsibility for the patient at all times. The hospital handover guidance highlights that ambulance crew should not routinely be responsible for monitoring patients for prolonged periods outside ED.

During our interviews with ambulance crew we identified that the lines of responsibility for patients on board an ambulance are blurred, due to ED staff going on board ambulances to assess and treat patients, and ambulance crews moving patients around hospitals for X-rays, CT scans and other investigations.

Overall, we identified from our interviews and staff survey that ambulance crew are not clear at all times as to who has responsibility for the patient prior to the formal handover taking place to ensure the safety of patients.

Recommendation: *WAST and health boards must ensure there is absolute clarity, consistency and understanding between both ambulance crew and ED staff, as to where the responsibility and accountability lies for patient care on board an ambulance following triage, until transferred into the ED.*

Discharge planning

During our interviews, a theme emerged from both ambulance crew and senior WAST managers that discharge planning could be improved. We were told that the anticipated date and time of patient discharge often appeared to be a ‘last minute’ decision in some EDs. The implication of this on the system is that a decision to discharge a patient may not take place until later during the day, which results in less time to obtain patient medication from pharmacy to take

home, to arrange take home transport, thus impacting on delayed bed availability for patients in ED.

As referred to earlier within the report, the role of patient flow coordinators at some hospitals is seen as having a positive impact on this issue. On a day to day basis, their role includes co-ordinating a discharge time for a patient to understand the time their bed will become available for patients in ED. Some hospitals also provide the service of a discharge lounge, where patients can wait for their take home medication, and transport home. This means that their hospital bed is made available sooner and helps improve patient flow within the hospital.

Earlier patient discharge planning could result in more timely bed availability within the hospital. This could result in improved patient flow and improved ambulance patient handover times. Consequently this could release more ambulances to respond to emergency calls to patients waiting within the community.

Whilst overall we found that patient privacy and dignity may be compromised when patients are confined to excessive waits on ambulances, people who engaged with our survey were generally positive about their overall experiences. The outcome from our public survey is a positive reflection on the professionalism and caring attitude of the ambulance crews towards their patients.

Workforce

Within the Health and Care Standards, standard 7.1 highlights that healthcare services should ensure there are enough staff with the right knowledge and skills available at the right time to meet needs of patients.

Staff numbers and staff pressures

We received a number of comments from ambulance crew relating to perceptions that EDs are under staffed and under pressure, comments included:

> *'Due to low staffing, there can be long delays waiting to hand over. During busy times it feels like the staff aren't listening to us when handing over.*
>
> *Slow ... ED staff under too much pressure often short staffed or lack of bed spaces'.*

This was supported in our findings from ED staff, with only a fifth (23 of 103) of respondents saying there are enough staff for them to carry out their role safely and effectively. This is also consistent with our findings of previous ED inspections across Wales.

These findings are a concern, since insufficient staff numbers within EDs will have an impact on the quality and safety of patient care, and the ability to facilitate a timely ambulance patient handover, thus affecting people waiting for an ambulance in the community. Whilst the scope of our review did not include consideration staffing levels within EDs across Wales, health boards should review, and continue to monitor their staff establishments in EDs, and take action to improve the ongoing issues identified with staffing during our review and in our previous ED inspections.

It was concerning to find that in response to our survey, only 31% of ambulance crew said there were adequate staff for them to do their job properly. Only 65% said they were able to meet the demands on their time at work.

Recommendation*: WAST and health boards must review and continuously monitor their staff establishments, in order to ensure appropriate levels of staff are maintained at all times*.

Impact of hospital handover delays on staff

We asked ambulance crew in our survey whether there was sufficient support available when they wait for long periods on board an ambulance due to delayed handovers. It was disappointing to find that 93% of respondents said there was insufficient support available to them.

Only 36% of ambulance crew said their working pattern allows for appropriate breaks throughout their shift, and that their working pattern allows for a good work life balance. Ambulance crew we interviewed reported that shifts overrunning have become a normal part of their work. The term overruns refers to crews who have no option other than to work beyond their shift end time.

We identified that staff welfare in urban areas is easier to manage than rural areas, since crews are stationed closer to the ED they most often attend with patients, and are therefore able to return to their base station during their breaks and sooner at end of shift times.

In rural areas, we were told that it is not uncommon for shifts to overrun by two to three hours. The impact of delayed handovers is also increased in areas where a high number of tourists arrive during peak holiday times. If ambulance crews are late leaving the ED at the end of their shift whilst awaiting the arrival of a relief crew, at times, crews may be delayed by up to a further two hours before they arrive back at their base station.

These delays mean they have to start their shift the following day at a later time, to ensure they have sufficient down time between shifts. This can have a knock on effect to staff availability in the earlier part of their next shift.

It was positive to find that that ‘pool cars’ have been implemented at some ambulance stations, to help alleviate the impact of overruns on crew. They are used to transport ambulance crews to return to base for their breaks, and at the end of their shift, once the new crew arrive to take over the patient care on board the ambulance, waiting outside the ED to handover.

As referred to earlier within the report, the role of a Duty Operational Manager (DOM) has been implemented across Wales. Part of their role, facilitates crews to take their allocated breaks, and to finish their shift on time wherever possible, by taking over the care of patients, therefore providing relief to crew members. We learned that the role is a relatively new initiative within WAST, and a number of DOMs had only recently been appointed at the time of our fieldwork interviews. The positive impact of this role in supporting ambulance crews is welcomed by those who have experienced this support.

Staff access to food and drink

Our review considered whether ambulance crews have reasonable access to food and drink during their shifts and prolonged waits outside of EDs. Only two in five said they had reasonable access to food and drink.

We established that ambulance crew who attend EDs in rural areas, or those whose ambulance base station is a great distance from their most frequented EDs, have more issues in accessing food and drink, especially during night shifts. This is because they cannot store their food at their base station and return to get it during their breaks, and there are no facilities for them to purchase food, either within the hospital or nearby vicinity. Ambulance crew working within urban areas said access to food was easier, since their base station was near the hospital, which allowed them to return either to their base station, or access food within the vicinity of the hospital, when relieved by Duty Operational Managers. Staff comments included:

> *"Food or a hot beverage is not available on nights and when working with a less experienced individual you cannot leave the patient when stuck outside hospital for hours on end. Only some hospitals offer the concession of £5. The patient does not get a warm drink or food whilst waiting.*
>
> *During night shifts access to food and drink becomes much more difficult and wish this should be addressed."*

Staff well-being

Our review has highlighted a number of key issues discussed above, which impact on the health and well-being of ambulance crews, as a direct result of delayed handovers and their knock on effect on crews' working conditions. During interviews, a number of ambulance crew told us that handover delays have a direct impact on their own health and well-being, comments included:

> *"Hospital handover delays are having significant impact not only on patients but on WAST as an organisation, and also on morale, since they [staff] feel they are unable to provide the best service possible to the community that they serve.'*

In addition to these issues, staff highlighted further concerns regarding the poor ventilation on board an ambulance. We were told this has had a significant impact during the pandemic, where crews have spent prolonged periods on board ambulances waiting to handover to ED, and were required to wear full PPE whilst caring for suspected COVID positive patients. Furthermore, other

concerns were highlighted regarding exposure to exhaust emissions from older ambulance vehicles when waiting outside EDs, where engines must run to maintain power to the vehicle.

During interview, some senior WAST staff highlighted their concerns with the impact handover delays have on ambulance crews. Consequently, actions have been implemented to support patients and staff. These include the initiatives highlighted earlier, such as Red Cross teams supporting patients, DOMs and pool vehicles supporting crews and the provision of concessions at hospital canteens for staff meals, when delayed with handover.

The crews we interviewed expressed their support and gratitude for the initiatives, however not all the measures are available consistently across Wales.

In response to our staff survey, 84% of ambulance crew said they were aware of the occupational health support available to them to support their health and well-being, and around 65% said their work place provides support for their mental health. However, it was disappointing to find that only 39% of ambulance crew said their organisation takes positive action on staff health and well-being, and just over 25% said that their employer provides support for their physical health.

Our survey findings also highlighted that just 73% of ambulance crew feel safe at work, and only 47% were content with the efforts of the organisation to keep them and patients safe. Staff repeatedly expressed their frustrations with the impact of handover delays on the experience of patients, and on their own well-being. Further comments in our staff survey included:

> *'The effects of waits and frustrations are impacting on staff wellbeing.*
>
> *We are expected to have a good level of fitness to perform our roles yet no access to gyms/PTs/equipment is made.*
>
> *WAST have improved in helping with mental well-being but they are very poor at ensuring staff are able to meet the physical requirements of the role. We should have access to gym facilities, discounted gym memberships, a sports club and easy access to physiotherapy. There should be a regular assessment of staff fitness.*
>
> *I feel all efforts to improve wellbeing are paper exercises only and there is no real support.'*

Our staff interviews identified positive comments from ambulance crew regarding access to mental health support at work. The support included referral to TRiM[15], access to the 'Headspace' mindfulness app, and mental health awareness weeks, which promote the services available to staff. Crews also highlighted that following attendance at a serious incident, staff are automatically referred to the TRiM process.

Whilst, in general ambulance crew said that the Trust provides support for their mental health, the majority of DOMs we interviewed said that the support offered to them is limited. They also highlighted that as peers, they provide support to each other, but are not always considered for referral if they have attended the scene of a serious incident, which may have been stressful and upsetting.

Recommendation: *WAST should consider how initiatives already introduced can be made consistently available to all ambulance crew across Wales. In addition, consideration should be given to how the welfare and support available to ambulance crews can be further improved.*

Recommendation: *WAST must ensure that the support for staff mental well-being is consistent across Wales, and that staff are routinely referred when appropriate and aware of how to access support if required.*

Training and development

We considered the training and development of WAST staff. 85% of our survey respondents said they had received relevant training to allow them to undertake their role with confidence. Some ambulance crew comments suggested that despite caring for patients for prolonged periods on board an ambulance awaiting handover, training is not provided to support staff with this. This training issue was also highlighted by the ambulance crew we interviewed. Comments included:

[15] TRiM is a trauma-focused peer support system designed to help people who have experienced a traumatic, or potentially traumatic event.

"We are not nursing staff, but are expected to look after patients as though they are in the department, this includes having to try and toilet patients."

Recommendation: *WAST should ensure that appropriate training is provided to ambulance crew in providing care to patients on board an ambulance, during prolonged periods of handover delays.*

Escalation arrangements

Escalating a clinical concern with a deteriorating patient

Our review considered the escalation process in place should a patient's condition deteriorate whilst they are on board an ambulance awaiting handover to the care of ED staff.

In 2018, following the sad death of a patient who had endured a delay with handover from WAST to an ED, the Coroner, issued the Trust with a Regulation 28[16] letter in December 2019 to implement an escalation process for delayed handover. The process was implemented in February 2021 and stipulates circumstances when escalation is required, and what actions must be taken by ambulance crew and ED staff. As part of the escalation process, a Datix incident (electronic incident reporting system) will be completed. This will flag the incident with senior health board and WAST staff to investigate jointly the delay, to help prevent reoccurrence.

In response to our staff survey, only 49% of ambulance crew said that there was a robust system to alert ED staff should a patient's health deteriorate. This was concerning given that a clear process has already been implemented. In addition, not all the staff that we spoke with during our interviews were aware of the process. One comment received by a member of ambulance crew said:

> *'We have patients who regularly take the turn for the worse and are waiting outside, we raise with hospital staff and management and it's a slow process to get the patient into the department'.*

Ambulance crew who had an awareness of the new escalation process told us that it is available on the Trust's intranet which is accessible to all ambulance crew via their iPads.

During our interviews, we spoke with a senior manager within the Trust who said that since its implementation, the impact of the escalation process was

[16] The Coroner has a legal power and duty to write a report following an inquest if it appears there is a risk of other deaths occurring in similar circumstances. This is known as a 'report under regulation 28' or a Preventing Future Deaths report because the power comes from regulation 28 of the Coroners (Inquests) Regulations 2013.

being monitored. The process had been presented to the Trust's scrutiny panel and an all Wales audit had commenced with Datix incidents being dip-sampled. The effectiveness of the process is to be gauged within the first six months since its implementation. At the time of our interviews, we were told that it was too early to gauge the effectiveness of the escalation process. As part of HIW's review action plan follow up processes, we seek an update on the Trust's assessment of the effectiveness of the escalation process.

Recommendation *- WAST must ensure all relevant staff are fully aware of the escalation process in place should a patient's health deteriorate, in order to minimise risks to patient safety.*

Recommendation *– WAST must provide HIW with evidence of its assessment of the effectiveness of the escalation process.*

Escalation arrangements at a strategic level

Our review also considered how WAST manages escalation arrangements at a strategic level during periods of high pressure and demand during delayed handovers, and the subsequent lack of vehicle resource. In addition, how risks are identified, managed, and mitigated to ensure patient safety is maintained on board the ambulance during delayed handover.

To explore this, we attended the Trust's Operational Delivery Unit (ODU) in Cwmbran. This is the central hub and support network which provides leadership and co-ordination for the unscheduled care system in Wales. The ODU provides a single point of access for the identification and mitigation of risks in relation to hospital handover delays. Where ambulance crews are delayed, early escalation will occur via the ODU to the site manager and senior manager on call when necessary.

National Delivery Managers located within the ODU work collaboratively with health boards, WAST, Welsh Government and wider organisations and networks. Their role is to monitor WAST's status across all health boards in Wales, which includes the number of ambulances delayed outside each hospital, the hours they have been delayed, and the number of calls from patients who are waiting for an ambulance within the community.

We observed a live intelligence led integrated unscheduled care dashboard, which displays the data highlighted above, and provides a clear visual representation of the situation across Wales. The ODU currently operates seven days a week from 08.00am to 08.00pm or 02.00am during peak periods, and planning is in progress for the ODU to be operational 24 hours a day, 7 days a week.

We observed the daily WAST Risk and Safety Huddle, which is a video call chaired by the National Delivery Manager, with representatives of each directorate present to assess and plan the day ahead. The huddle, includes discussions about the national status across Wales, the current pressures and any risks and plans for mitigation.

We also observed the daily National Risk and Safety Huddle, which is a video call with senior hospital managers within each health board and Welsh Government leads. This is chaired by the WAST Strategic Lead or the Head of the ODU. During the huddle, we observed how intelligence is gathered, performance and risk information is shared nationally, and the regional health system plans for the day are set to maintain the public and patient safety and identify risks, and plan for mitigation of these.

Information is submitted by health boards prior to the meeting which includes hospital escalation status and risk level, hospital bed capacity, and speciality bed numbers, such as those available in critical care. During the call, WAST provides an update on the levels of activity, demand, performance, escalation status and pressures within the unscheduled care system. Areas with significant handover delays, and areas within the community experiencing lengthy patient ambulance response times are prioritised, and health boards report the risks and their plans for mitigation of handover delays. Risks and action plans are agreed and a regional escalation stage is agreed based on demand.

The development of regional escalation protocols has ensured risk is balanced across the healthcare systems. When hospital handover delays are causing issues with vehicle resource and the demand for beds at a hospital has reached maximum capacity, decisions can be made dynamically to divert ambulance resources across geographical borders, to help maintain patient safety. Each health board will take responsibility for ensuring that all appropriate actions have been taken to manage demand within their own boundaries before cross border or regional actions are implemented in line with those defined within their own escalation plans, supported by regional escalation stages.

During periods of high demand on WAST emergency services, ambulance waiting times will inevitably increase. During these periods, WAST utilises the Demand Management Plan (DMP) framework. The DMP is used to deal with real time acute operational issues, which are not likely to have any long term service impact. There are four DMP levels (DMP-1 to DMP-4) which are reflective of the scale of demand experienced by the service. The DMP aims to reduce demand and increase capacity of the service, which requires decisions at operational, tactical and strategic command level, in-line with the DMP level.

During any handover delay of more than six hours, alerts are automatically generated to the WAST Director of Operations and Chief Executive, to ensure key organisational leads can act on the issues identified and plan to mitigate the risks to patient safety.

During late 2020, WAST commissioned a Quality Governance Report associated with hospital handover delays. The report detailed the background, complexity, and significance of handover delays with the aim to embed robust governance processes, to monitor and manage the issues. The report also provided an account of activities undertaken to promote improvement, an assessment of the likely outcome of improvement actions being undertaken and significance of negative patient experience or patient harm.

WAST also has a Notification and Escalation Procedure, which provides guidance on the incident notification procedures followed within WAST. It also articulates the escalation process for hospital delays and/or patients awaiting an ambulance response within the community. To provide a consistent process, as to when, and to who, hospital handover delays need to be escalated.

In order to ensure the safe handover of patients to secondary care, WAST has developed systems, which identify risks, provide mitigation and escalate concerns, through timely, efficient and safe processes. The development of the ODU has had a significant impact in providing system oversight, and enabling effective management and practice across the healthcare system. The ODU is able to focus on immediate 'red release requests of ambulances from hospitals, hospital diversions to less busy sites, and enabling ambulance crews to handover patients in a timely manner.

Governance Arrangements

The Health and Care Standards stipulate that governance, leadership and accountability should be in keeping with the size and complexity of the healthcare service, are essential for the sustainable delivery of safe, effective person-centred care.

Reporting handover incidents

We found a robust process in place for managing handover incidents which may result in patient harm or death. Daily reviews of the Trust's electronic clinical incident system 'Datix' is undertaken by patient safety officers and managers. The Trust's Serious Case Incident Forum (SCIF), also meets twice weekly to review any serious incident reports, for investigation, and to identify any actions, lessons learnt and themes or trends.

WAST local management teams meet regularly with health board clinical leads to escalate any concerns, present data and discuss local mitigation. A Joint Investigation Framework process is also in place, and guides the Trust and health boards across Wales to review and investigate serious patient safety incidents identified within SCIF.

The process involves a collaborative investigation between WAST and the relevant health board. WAST staff highlighted issues with inconsistency in engagement in the joint process from all health boards, where identifying and sharing of learning from incidents is inconsistent across Wales. However, they did acknowledge that positive steps have been made, to improve engagement from all health boards.

Within our staff survey, only 63% of WAST respondents said they felt secure in raising concerns about unsafe clinical practice, although almost all staff knew how to report it. In relation to patient safety incidents, 64% of WAST respondents said they had seen a patient safety incident, near miss or an error, and of these almost all said they or a colleague had reported it.

It was disappointing to find that only 41% of WAST respondents said they believed their organisation would address their concerns. Our staff interviews supported this finding, with some staff highlighting that any response or feedback they receive as a result of reporting an incident, is a generic response. This therefore does not provide the reporting person with any action plan or learning as the result of a reported incident. Comments included:

'Items are reported, there is no feedback and the issue is recurrent.

Handover delays and long response times are not seen as near misses anymore. They are normal.

Not confident in reporting any concerns due to backlash.'

Despite an overall negative response to incident reporting management, good practice was reported from staff from one ambulance base, which reported a process in place for a designated member of staff to provide feedback to the teams regarding Datix incidents and reports. This has a positive impact on staff, with the feedback encouraging teams to report any incident that occurs.

Our findings highlight the need for WAST to identify more effective processes for sharing feedback from incidents. This was discussed with senior staff who acknowledge improvements can be made to ensure incident investigation outcomes are effectively shared with staff, to help improve the quality and safety of care.

***Recommendation**: WAST must do more to ensure that its staff feel able to, and are confident in raising concerns. It must also ensure that robust processes are in place to share the learning with staff following incident investigations, in order to improve quality and safety of patient care.*

Risk Registers

Hospital handover delays are identified by WAST as a significant corporate risk, which has been assessed at the highest score on its risk register. The risk relates to patients not being able to access secondary care assessment and treatment due to prolonged handover delays. In addition, the consequence of emergency response vehicles unable to attend patients requiring and ambulance in the community.

Such situations place WAST in a position where it is managing the consequence of handover delays. These delays are generally caused by a wider set of factors within the hospital setting including patient flow issues.

It is clear that WAST cannot, alone, improve patient flow through hospitals, to support the prompt transfer of patient care in to EDs. The significant level of risk to patient safety associated with delays handovers including the risk to patients in the community, cannot be one that is accepted any longer. It is essential that WAST, each health board across Wales, including Powys Teaching Health Board, consider whether actions taken to date have gone far enough to resolve this issue.

Conclusion

The aim of our review was to consider the experience of patients, including their safety, care, privacy and dignity whilst waiting on board an ambulance outside emergency departments during delayed handovers.

Despite finding that patients were, on the whole, positive about their experience, we have identified a wide range of evidence that handover delays have a significant impact on the ability of ambulance crew to provide a positive experience for patients. This included negative impact on the dignity of patients, and potential increased risks to patient safety.

It is clear that the issue of delayed handover has a hugely negative impact on the unscheduled care system as a whole. Each ambulance that encounters a prolonged stay at an ED potentially means fewer ambulances available to respond to emergency situations elsewhere.

National guidance is clear on the targets and expectations regarding handover and there is an apparent clear will to meet and achieve these expectations. However, it is clear that the issues around handover have not been resolved to date, with inconsistency in approaches apparent across Wales introducing risks to patient safety.

Whilst WAST has a role to play in addressing the issues described within this report, it does not have the ability to unilaterally resolve these problems. The whole healthcare system has a role and part to play in addressing the issues that we have highlighted in our report, and it is imperative that a reinvigorated, strengthened and concerted approach is taken to ensure that these problems are overcome.

HIW plans to undertake a National Review during 21-22 which will focus in more detail on the issue of patient flow, examining in greater depth the cause and impact of patient flow issues.

What next?

We expect the Welsh Ambulance Services Trust, health boards, and Welsh Government to carefully consider the findings from this review and the recommendations set out in Appendix A. We hope that this information will be used to further improve the service being provided by the Trust, and to inform further work and investigation across Wales, as highlighted within the report.

The Trust, health boards and Welsh Government will be required to submit a joint action plan in response to the recommendations highlighted within our report. HIW will undertake follow-up activity on recommendations made. This is to ensure that the Trust, health boards and Welsh Government are being vigilant in addressing the matters raised and taking all necessary action to improve the issues highlighted in our review.

Appendix A – Recommendations

As a result of the findings from this review, we have made the following recommendations in the table below.

Recommendations	Action
Health boards, and Welsh Government should consider what further actions are required to make improvements regarding the patient flow issues impacting on delayed patient handover. This may include consideration of whether a different approach is required by WAST, health boards, and social care services within Wales, to that taken to date in tackling this system-wide problem .	x
WAST should engage with health board representatives to ensure there is improvement in practice between ambulance crew and emergency department staff to ensure the dual pin process is consistently followed, and ensure Welsh Government reporting data is accurate.	x
Health boards should consider the benefits of the introduction of specific roles within their EDs that have the aim of improving process of the handover of patients from ambulances.	x
Health boards must ensure that appropriate representation is present at WAST Serious Clinical Incident Forum meetings, to aid with the timely management of concerns and service improvement.	x
If and where local standard operating procedures are absolutely necessary, WAST and health boards must together ensure that ambulance crew are familiar with the handover policy for that ED.	x
WAST and health boards need to ensure that when delays occur, patients and their relatives or carers should be kept fully informed of the reasons and the progress being made in resolving them.	x

Recommendations	Action
WAST and health boards across Wales should ensure patient feedback is obtained regularly to understand their experiences of long waits on board an ambulance, in order to inform improvement.	x
WAST and all health boards across Wales must work together to identify a consistent approach in providing timely investigations and treatment for patients on board ambulances, to enable ambulance crews to be released quickly.	x
Both WAST and health boards must ensure that ambulance crew and ED staff work collaboratively to ensure patient privacy and dignity is maintained, and patients are always provided with the opportunity to use private toilet facilities where appropriate, in a dignified manner whilst waiting on board an ambulance during delayed handovers.	x
During prolonged handover delays, WAST and health boards must work collaboratively and consistently, to minimise the risk of skin tissue damage for patients.	x
WAST should work with health boards to ensure that patients nutritional and hydration needs are consistently met whilst waiting in the back of an ambulance due to delayed handovers.	x
WAST should consider how ambulance crew and patients can be supported to achieve and maintain high standards of hygiene and IPC, in particular during periods of delayed handovers for patients on board an ambulance.	x
WAST and health boards must ensure there is absolute clarity, consistency and understanding between both ambulance crew and ED staff, as to where the responsibility and accountability lies for patient care on board an ambulance following triage, until transferred into the ED.	x
WAST and health boards must review and continuously monitor their staff establishments, in	x

Recommendations	Action
order to ensure appropriate levels of staff are maintained at all times.	
WAST should consider how initiatives already introduced can be made consistently available to all ambulance crew across Wales. In addition, consideration should be given to how the welfare and support available to ambulance crews can be further improved.	x
WAST must ensure that the support for staff mental well-being is consistent across Wales, and that staff are routinely referred when appropriate and aware of how to access support if required.	x
WAST should ensure that appropriate training is provided to ambulance crew in providing care to patients on board an ambulance, during prolonged periods of handover delays.	x
WAST must ensure all relevant staff are fully aware of the escalation process in place should a patient's health deteriorate, in order to minimise risks to patient safety.	x
Recommendation – WAST must provide HIW with evidence of its assessment of the effectiveness of the escalation process.	x
WAST must do more to ensure that its staff feel able to, and are confident in raising concerns. It must also ensure that robust processes are in place to share the learning with staff following incident investigations, in order to improve quality and safety of patient care.	x

Arolygiaeth Gofal Cymru
Care Inspectorate Wales

Inspection Report on

Cottage View

Powys Teaching Health Board
Knighton Hospital
Ffrydd Road
Knighton
LD7 1DF

Date Inspection Completed

03/06/2021

About Cottage View

Type of care provided	Care Home Service Adults Without Nursing
Registered Provider	Powys Teaching Health Board
Registered places	10
Language of the service	English
Previous Care Inspectorate Wales inspection	12 March 2020
Does this service provide the Welsh Language active offer?	This is a service that does not provide an 'Active Offer' of the Welsh language. It does not anticipate, identify or meet the Welsh language needs of people who use or intend to use the service. We recommend the service provider considers Welsh Government's 'More Than Just Words follow on strategic guidance for Welsh language in social care.

Summary

People are happy with the care and support they receive. They have good relationships with the care staff who treat them with kindness and respect. People have opportunities to take part in activities and are able to share ideas on how the service can be improved. Care documentation needs improvement. Care staff must have accurate information about people so they can provide them with the right care and support. The management oversight of the service has changed since the last inspection but further improvements are needed to make sure the requirements of the regulations are met.

Well-being

People have choice over day-to-day life. People are comfortable with care staff who take time to sit and speak with them. They told us "*staff are great*" and "*will do anything for you*". People are able to choose where they spend their time during the day. Menus are on the dining tables. People choose their meals and are complimentary of the food served. Comments include "*food is plentiful*" and *"we can have almost anything we want".* Improvements are being considered to the activities programme. This is as a result of feedback given to the responsible individual (RI) by people who live in Cottage View. People do not have up to date information about the service so they do not know what to expect if or when they move in. Information on the complaints process is not always accurate or accessible but people feel issues raised with the provider will be considered promptly. Whilst bilingual signage is around the home, the statement of purpose (SOP) states people cannot receive their service in Welsh.

The service promotes people's physical and mental health. Health professional visits or advice is requested when needed. Care staff and people using the service confirm this. Care staff treat people with respect and have positive relationships with them which helps support emotional health. They facilitate visits with family members. People told us they look forward to the visits.

Processes to protect people and make sure they get the right care and support would benefit from some improvement. Records show recruitment practices and training for care staff help to keep people safe. Policies to guide care staff are accessible. Information in risks assessments and personal plans are not always accurate to make sure people get the right care and support and keep them as safe as they can be.

Accommodation allows for people to be as independent as possible. Communal areas are comfortable and people's bedrooms are personalised.

Care and Support

People and their relatives comment positively about the service. Interactions between care staff and people are positive and caring. Care staff are kind in their approach to people, creating a relaxed, friendly atmosphere. People look happy, talking and laughing with care staff showing they are clearly at ease with them. People have choices about activities, meals and daily routines. Signage around the home is displayed bilingually but people cannot have their service in Welsh.

Pre service assessments show people's needs are assessed before they move in. There are no provider assessments in place to demonstrate people's needs are continually assessed and no policy to follow for admissions and commencement of service. While no immediate action is required, this is an area for improvement and we expect the provider to take action.

Personal plans are reviewed regularly and show people's involvement with this. The manager is changing the format of personal plans to make sure they accurately reflect people's needs. Care staff we spoke with are clear about people's care and support needs and how to meet them.

Risk management plans are not always in place to manage identified risk to people. Records seen including health notes and personal plans identified health needs which could impact on people's health and well-being. There are no risk management plans in place to manage this. The manager said this is being addressed and provided evidence. This is an area for improvement and we expect the provider to take action.

Measures are in place to manage hygiene and infection control. A recent infection control audit of the service identified areas for improvement. The RI told us this is being addressed. Records show staff have infection control training and regular audits of the cleaning arrangements take place. Processes are in place to make sure people can safely meet with their relatives. However, we were not checked for COVID 19 in line with the providers risk assessment. We raised this with the RI to make sure care staff follow correct procedures for all visitors to the home.

Measures are in place to manage medication. Regular audits take place and identified issues are addressed quickly. Care staff demonstrate a good understanding of the process. They liaise with health professionals as needed.

Environment

The layout of the home means people can move freely around maximising their independence. We saw people independently walking around the home, stopping to chat with care staff. Others spend time in the lounges or their bedrooms. Signage around the home is bilingual. The home is clean, regular audits of the cleanliness of the home are made. People are happy with their personal space. Bedrooms are personalised with photos, ornaments and items important to people. The care home is attached to the hospital and so shares some facilities including the main kitchen. There is a small kitchen in the care home so people can get snacks and drinks when they want them.

Arrangements are in place to ensure risks to people's health and safety are identified and addressed. Call bells allow people to alert care workers when they need help. People confirm they are answered promptly when they use them. Equipment including mobility aids is regularly serviced. Health and safety is covered in the monthly management audits of the home so issues can be addressed quickly.

Leadership and Management

At the last inspection in March 2020, the SOP was not an accurate reflection of the service provided. We informed the provider this was an area for improvement. During this inspection, we acknowledge the document has been reviewed but it still does not contain all the required or correct information. We have therefore issued a priority action notice. The provider must take immediate action to address this issue.

At the last inspection in March 2020, the guide to the service did not contain all the required information. At this inspection, we did not evidence it had been reviewed. It still does not contain all the required information. We have therefore issued a priority action notice. The provider must take immediate action to address this issue.

Care staff and people living in the home are confident their views will be considered and they are listened to. The complaints policy is in the process of being reviewed to make sure people have accurate up to date information which is accessible to them.

Care staff are positive about the home and the support they receive from the manager. They confirm they have regular one to one meetings with them and an annual appraisal of their work. Records support this but the frequency of supervision is not always in line with regulations. Care staff told us training opportunities are good but a lot of training is on line which some care staff are not so confident completing. Recruitment records show processes are in place to protect people. Care staff confirm they have a good induction with support from the manager and colleagues.

Improvements have been made to the oversight and governance of the service. The provider has appointed a new RI. Records show they visit the home regularly. They meet people living in the home and care staff. Notifications are sent to CIW as required. Further improvements to the audit systems will help to identify areas where the service is not meeting the requirements of the regulations. A review of the quality of care and support is carried out but not as frequent as it should be. While no immediate action is required, this is an area for improvement and we expect the provider to take action.

Areas for improvement and action at, or since, the previous inspection. Achieved	
The service provider does not notify the service regulator of events in line with the legal requirements.	Regulation 60(1)
The provider has failed to ensure the person designated as responsible individual has carried out thier role effectively.	Regulation 9(2) Regulation 9(2)(a) Regulation 9(2)(b) Regulation 9(3)(a) Regulation 9(3) Regulation 9(3)(b) Regulation 9(4)(a) Regulation 9(4)(b) Regulation 9(4)(c) Regulation 9(5)(a) Regulation 9(5)(b)

Areas for improvement and action at, or since, the previous inspection. Not Achieved	
The SOP is not an accurate reflection of the service and does not contain information required in regulations.	Regulation 7 (1)
The guide to the service does not contain all the information required in the regulations and guidance.	Regulation 19(2)

Where providers fail to improve we will escalate the matter by issuing a priority action notice. Where providers fail to take priority action we may escalate the matter to an Improvement and Enforcement Panel.

Areas where priority action is required	
The statement of purpose does not contain all the required, or correct information.	Regulation 7(1)
The registered provider has not ensured the guide to the home contains all the required information.	Regulation 19(2) Regulation 19 (3)

We have issued a priority action notice and expect the provider to take immediate steps to address this and make improvements.

Areas where improvement is required	
The registered provider has not ensured there is a clear policy in relation to the admission and commencement of service.	Regulation 14(2)

There is no evidence of provider assessments carried out within 7 days of the commencement of the service.	Regulation 18(1) Regulation 18(2) Regulation 18(5) Regulation 18(6) Regulation 18(7)
The registered provider has not ensured that risk management plans are in place to manage all identified risks to people.	Regulation 15(1)(c)
The registered provider has not ensured quality of care reviews are carried out every six months as required.	Regulation 80(1) Regulation 8(2)

The area(s) identified above require improvement but we have not issued a priority action notice on this occasion. This is because there is no immediate or significant risk for people using the service. We expect the registered provider to take action to rectify this and we will follow this up at the next inspection.

Date Published 03/08/2021

Direct Line: 0300 062 8163
E-mail: vanessa.davies008@gov.wales

Chief Executives and Chairs
NHS Health Boards Wales
Via Email

25 August 2021

Dear Chief Executive & Chair

National Review of Maternity Services – Phase Two and Follow Up

We wrote to you in January 2021 setting out HIW's intention to delay phase two of our national review of maternity services across Wales for a period of six months, at which point we would again review the position of services and our work in this area. The decision to delay was predominantly down to healthcare services having to meet the challenges of a global pandemic, which introduced unique and unprecedented pressures on the system, as well as the impact of the pandemic on our ability to carry out phase two plans and fieldwork.

In July 2021, we reviewed our position for phase two plans alongside our risk based inspection and reviews programme for 2021-22 and our resources. Following careful consideration, we have taken the decision not to progress with phase 2 of the review as set out in our published terms of reference. Instead, for issues identified in relation to aspects of maternity care that were outside the original scope of the national review, we will seek assurances through our follow up work.

In February 2021, we commenced stage one of our formal reviews follow up process, and wrote to each health board to request an update on progress against the national recommendations, and received a satisfactory response from each health board. By summer 2022, we will commence stage two of our follow up process to request a further update on progress against the national recommendations, and will write again in this regard in due course.

In addition to our formal reviews follow up process, our review, inspection and intelligence teams, along with our Relationship Managers, will continue to gather intelligence and will work with health boards, Welsh Government and other stakeholders where appropriate, to follow up on phase one activity, and to gain assurance where we feel necessary for antenatal and postnatal care services.

We would like to thank you and your maternity teams for their ongoing contribution and support during this important piece of the work, and request that you inform your maternity services teams within both secondary and primary and community care of our decision.

If you have any queries or questions relating to this correspondence, please e-mail vanessa.davies008@gov.wales or telephone 0300 062 8163.

Further information regarding all of the inspections carried out as part of this review, including how we inspect the NHS is available on our website.

Yours sincerely,

Stuart Fitzgerald
Deputy Chief Executive
Healthcare Inspectorate Wales

Gwirio bod pobl yng Nghymru yn derbyn gofal da

Checking people in Wales are receiving good care

Llywodraeth Cymru / Welsh Government
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Appendix 7-DASHBOARD OF IMPLEMENTATION OF HEALTH AND SOCIAL CARE REGULATORY REPORT RECOMMENDATIONS

Health and Social Care Regulatory Report Recommendations Dashboard July 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		2		
	192004	Unannounced Twymyn Ward, Machynlleth Community Hospital & Graham Davies Ward, Llanidloes Hospital Inspection	20	19		1		
	192006	Unannounced Hospital Inspection: Llewellyn Ward, Bronllys Hospital	13	12		1		
	192007	Birth Centres (Free Standing Midwifery Led Unit) Across Powys	9	6		3		
	192008	NHS Mental Health Service Inspection (Unannounced): Felindre Ward, Bronllys Hospital	23	21		2		
	192009	HIW Review of Healthcare Services for Young People	37 (**32**-5N/A)	31		1		
	TOTAL		120	110		10		
2020/21	20050	Tier 1 Quality Check: Maldwyn Ward, Welshpool Hospital	2	1		1		
	TOTAL		2	1		1		
2021/22	212201	HIW National Maternity Improvement Plan 2021 Priorities	25	3	7		15	
	212202	Tier 1 Quality Check Clywedog Ward, Llandrindod Wells	2	1			1	
	212207	CIW Inspection of Cottage View	Outcome awaited					
	212208	HIW Tier 1 Quality Check: Felindre Ward, Bronllys Hospital	27	13	3	11		
	TOTAL		54	17	10	11	16	
	GRAND TOTAL		185	136	10	23	16	

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 3.4

Patient Experience, Quality and Safety Committee	**Date of Meeting: 7 October 2021**
Subject:	**Infection Prevention and Control Update**
Approved by:	Alison Davies – Director of Nursing and Midwifery
Presented by:	Marie Davies – Deputy Director of Nursing
Prepared by:	Marie Davies – Deputy Director of Nursing Jason Crowl – Assistant Director Community Services and Operational Lead for Decontamination
Other Committees and meetings considered at:	• Infection, Prevention and Control Group 14th September 2021 • Executive Committee 22nd September 2021

PURPOSE:

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

Specifically, this paper presents the Powys Teaching Health Board Annual Report for Infection, Prevention and Control and the Annual Authorised Engineer Report into Decontamination Services.

RECOMMENDATION(S):

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

1. DISCUSS and NOTE the annual report
2. DISCUSS and NOTE the planned approach to address the improvement actions required by the Annual Authorised Engineer Report into Decontamination Services
3. RECEIVE the update provided in investigation of COVID-19 infection within hospital settings in Powys.

Approval/Ratification/Decision	Discussion	Information
✓		

DETAILED BACKGROUND AND ASSESSMENT:

1. Background

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

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

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

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

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

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

2. Infection, Prevention and Control Annual Report

2.1 Development of the IPC Annual Report

The annual report, outlining the activities and arrangements for IPC in Powys Teaching Health Board in 2020 -21 is shown at **Appendix 1.**

This annual report provides an overview of the governance arrangements for Infection, Prevention and Control activities; analysis of the surveillance data, quality assurance through audit and oversight of structures supporting IPC activities, education and training, and policies developed to support and direct patient care. This data has been collected and produced by the Infection Prevention & Control Team (IPC) for the time period from April 2020 – March 2021 with assistance from the chairs of the task groups supporting this programme of work (Figure 1).

Figure 1: Chairs of the IPC Task Groups

Sub Group	Chair
Antimicrobial Stewardship Group (AMR)	Chief Pharmacist
Environmental Cleanliness & Operational Guidance (ECOG)	Service Improvement Manager: Compliance and Quality
Water Safety and Ventilation (WSV)	Responsible Person Water & Authorised Person Ventilation Assistant Director Property & Estates (Chair)
Decontamination Group	Assistant Director: Community Services Group
Medical Devices (MD)	Medical Devices & Point of Care Testing Manager
Nosocomial Group	Deputy Director of Nursing

3. Authorising Engineer Decontamination Annual Report

3.1 Overview

Powys Teaching Health Board manages the decontamination of equipment used in a range of services delivered by the Community Services Group and the Primary Care Service Group namely:

- Community Dental Services
- Theatre and Endoscopy Services
- Invasive Ultrasound Procedures

Decontamination services are subject to an annual review by the authorised engineer who will make recommendations in line with best practice standards and existing regulations.

An action plan is then drawn up by the Operational Decontamination Group which has the responsibility to oversee services in and their delivery of the improvement actions.

3.2 Annual Audit

A report into decontamination compliance and service review is undertaken by the Authorising Engineer for Decontamination (AE (D)) appointed by the Powys Health Board (PTHB).

This report is in accordance with the guidance set out in Welsh Health Technical Memorandum 00 - which stipulates the requirement for the Authorising Engineer to produce an annual audit (WHTM 00 Best practice guidance for healthcare engineering paragraph 3.15).

This role is fully independent of the health boards' and healthcare facilities' structure for maintenance, testing and operational management of the decontamination equipment and services.

The overall assurance rating given for the Health Board is 'Reasonable Assurance'. A copy of the report is in **Appendix 2** and makes several recommendations which are embedded in the narrative of the document.

These have been developed into an action and improvement plan which will be overseen by the Operational Decontamination Group and will form part of the highlight report it submits to the Infection Prevention Group.

No immediate actions where identified and no specific timelines were suggested in the recommendations. The timelines therefore, have been added at the discretion of the Service leads.

3.3 Recommendations and Next Steps

The report makes 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: **This has been completed**

- Decontamination centres that undertake 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 represents best practice and a policy should be in place for the health board to work towards this standard.

  Status: **Work is ongoing towards completion at this time.**

- The management structure is in place across the organisations. However, interviews indicated concerns with resource time allocation needed to undertake the management of decontamination across the organisation. It is recommended the structure is reviewed and appropriate resource allocated.

  Status: **Estates will assess this role and if there is a case to increase capacity.**

A comprehensive action and improvement plan have been drawn up as shown in **Appendix 3** and will form part of the work programme for the Operational Decontamination Group for 2021/22.

4. Nosocomial Infection Investigations Update

4.1 Overview

Hospitals and care settings are high-risk sites for potential COVID-19 transmission. Nosocomial infections are **infections that have been caught in a hospital, or health care setting.** Surveillance and monitoring of COVID-19 infections acquired within hospitals is essential to identify sources minimise risk of further transmission.

The Health and Safety Executive (2020) require reports to be made under RIDDOR (Reporting of Injuries, Diseases, and Dangerous Occurrences Regulations 2013):

- If an accident or incident at work has, or could have, led to the release or escape of coronavirus (SARS-CoV-2)
- A person at work (a worker) has been diagnosed as having COVID-19 attributed to an occupational exposure to coronavirus.
- A worker dies as a result of occupational exposure to coronavirus.

Building on existing reporting systems, it was identified on an All Wales basis that a standardised approach to the reporting and investigation of possible hospital and work acquired COVID-19 infections would help determine if additional infection prevention and control measures are required, to reduce the risk of further transmission between staff, patients and visitors.

The toolkits for both staff and patients have been developed on an All Wales basis and Powys have adopted these with some minor adaptations to the staff toolkit in order to capture some additional information. The aim of the toolkits is to help prevent the transmission of COVID-19 in hospital settings in Powys by reviewing potential nosocomial transmission in patients and staff, identifying and addressing underlying issues and ensuring rapid dissemination of any learning identified.

To support NHS Wales approach and enable continuity, the draft NHS Wales National Framework - Management of Patient Safety Incidents following Nosocomial Transmission of COVID-19 (Delivery Unit, 2021), has been developed in partnership and widely consulted upon. There are discussions still ongoing in respect of the overall national co-ordination, and the required resources, to implement the framework.

4.2 Nosocomial Investigations Group

The Nosocomial Investigation Group oversees the investigation of all positive cases of COVID-19 in patients and staff. The Group reports to the Prevent and Respond Group through the Incident Management Team (IMT) meetings, and currently provides monthly updates. The engagement in the IMT meetings has helped to connect work across the health and social sector, in particular between hospitals and care homes.

Nationally agreed templates are completed for each patient and staff positive COVID-19 case and this is reviewed through a scrutiny panel process.

The learning through this approach has been drawn together and shared with the Prevent and Respond Group. As a result, clear communications have been shared around the importance of opening windows if only for a short period of time in order to increase air flow, and the need to maintain social distancing and to maximise air circulation if sharing a room at break time with a colleague. These messages have been supported through the Social Distancing Group which was established to bring together operational, workforce and staff side partners to develop supportive advice for staff, and internal communications.

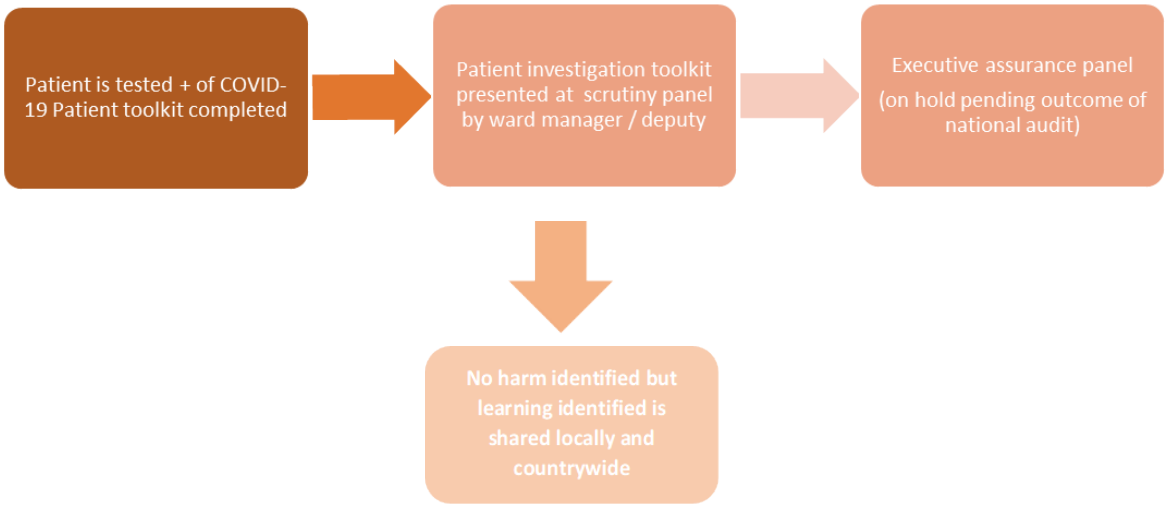
4.3 Patient investigations and presentation at scrutiny panel

The patient scrutiny panel is chaired by the Professional Head of Nursing for Community Services and follows the NHS Wales National Framework - Management of Patient Safety Incidents following Nosocomial Transmission of COVID-19. The general principles of the national investigation process are supported within the Health Board where the detection of instances reaching the threshold for investigation are investigated at ward level and presented at a scrutiny panel. All cases are investigated and presented to scrutiny panel that are classified as, indeterminate, probable or definite hospital onset as shown in **Figure 2 and Figure 3.**

Figure 2: Definitions of HCAI Categories

HCAI category	Criteria
Community onset	Positive specimen date ≤2 days after admission to Trust
Indeterminate healthcare-associated	Positive specimen date 3-7 days after admission to Trust
Probable healthcare-associated	Positive specimen date 8-14 days after admission to Trust
Definite healthcare-associated	Positive specimen date 15 or more days after admission to Trust

Figure 3: Process for investigation of patient nosocomial infections



As of the week commencing 30th August 2021, in relation to patients identified as requiring investigation, 100% of the patient investigation toolkits have been completed and reviewed via 13 patient scrutiny panels.

The patient scrutiny panel is temporarily stood down there is an expectation that following any new positive cases it will be re-instated in order to have the case presented within 35 days of the positive result.

To ensure investigations are completed and available to present at scrutiny panel, a standard has been introduced with support to services to help achieve it, that is: if a completed toolkit is not received by day 5, escalation email will be sent to the Community Services Manager / Operation Manager, if not received by day 10, an escalation email will be sent to the Professional Head of Nursing.

Following the National Nosocomial COVID-19 strategy meeting in July 2021, all health boards across Wales were asked to provide ten individual patient nosocomial transmission cases in keeping with a set selection criteria. The Health Board submitted sample cases as requested in August 2021, alongside investigation reports which included the All Wales COVID-19 Patient Investigation toolkit and relevant Investigation Reports completed. The Health Board is awaiting the outcome of the Technical Advisory Group (TAG) that was established by the Delivery Unit to assess the quality of the available data in order to establish future requirements for The NHS Wales (2021) National Framework for the

Management of Patient Safety Incidents following Nosocomial Transmission of Covid-19.

4.4 Staff investigations and presentation at scrutiny panel

The staff investigation toolkit has been developed on an All Wales basis, minor adjustments have been made locally in order to gain more information whist conducting the investigation.

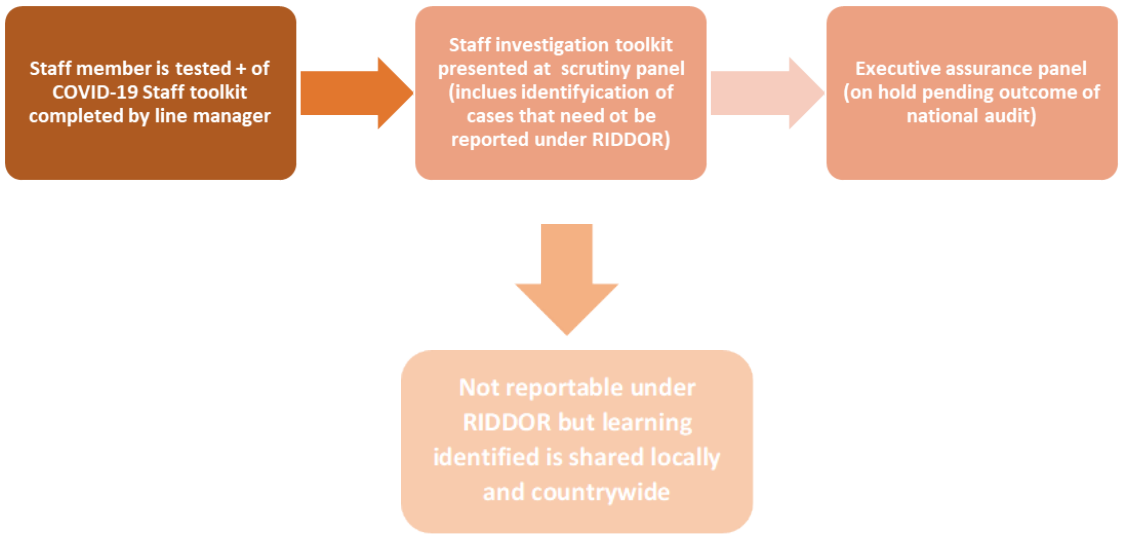
The Chair of the Staff Scrutiny Panel is the Assistant Director of Support Services. Prior to this panel being in place, in September 2020 a number of staff cases were investigated by a Senior Nurse and subsequently scrutinised by representatives of the Executive Team, as a result, a number were reported under RIDDOR to the Health & Safety Executive (HSE). These cases were later reviewed in line with current reporting criteria resulting in further cases being reported under RIDDOR.

After excluding staff who did not work within the health board for at least 14 days prior to being tested and therefore would not be classed as having a nosocomial infection, at week commencing the 30th August 2021

- 8 staff scrutiny panels have been held
- Over 90% of staff investigation toolkits have been completed and reviewed at the panel.

There have been a number of COVID-19 positive staff, and zero staff deaths. The staff scrutiny panel have weekly meetings scheduled in order to adhere to the HSE reporting timeframe if the case needs to be reported under RIDDOR. Throughout the summer period there have been issues with lack of quoracy in scrutiny panels resulting in a delay in reviewing. However, the panel aim to be working to a measure of >95% of staff cases investigated at any time. In order to ensure investigations are completed and available to present at scrutiny panel there has been a standard introduced and there is work ongoing with services to support this i.e.: if there is no completed toolkit received by day 5, an email is sent to the member of staff's line manager, if not received by day 10 an escalation email is sent to the service manager. It is envisaged that the staff toolkit will become a standard process for management of COVID-19 sickness, however this will have to be managed closely. This is summarised in **Figure 4**.

Figure 4: Process for investigation of staff nosocomial infections



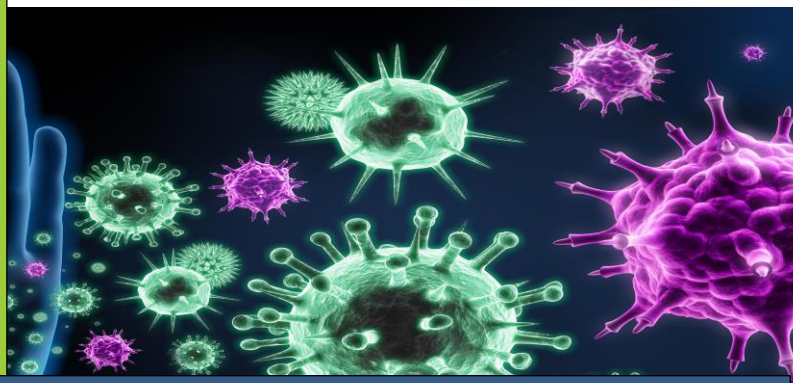
NEXT STEPS:

Going forward a quarterly update will be provided in regard to Infection, Prevention and Control work programme activities including decontamination and nosocomial infections.

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	✓

Appendices:
1: IP&C Annual Report 2020-21
2: Authorising Engineer Decontamination Annual Report 2020-21
3: AED Action and Improvement Plan

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board



Powys Teaching Health Board

Infection Prevention and Control Annual Report

2020-2021

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1 Executive Summary

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

Last year was like no other for Infection, Prevention and Control related work. The pandemic has greatly impacted on health and social care services for both patients and staff alike. Powys Teaching Health Board has worked with national, regional and local services to ensure that the national approach to the pandemic has been adopted, and in implementing systems to ensure safety for patients, carers and families, and staff.

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

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

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

This annual report is produced to provide an overview of the governance arrangements for Infection, Prevention and Control activities; analysis of the surveillance data, quality assurance through audit and oversight of structures supporting IPC activities, education and training, and policies developed to support and direct patient care. This data has been collected and produced by the Infection Prevention & Control Team (IPC) for the time period from April 2020 – March 2021 with assistance from the wider team supporting this programme of work. It should be noted that the national case management and clinical surveillance software system in use in Wales - ICNet is not compatible with certain English laboratories, resulting in the absence of data for quarter 1 and 2 for samples that were not processed within Wales. However, the IPC team have worked extensively with bordering health boards to establish a method of collating these results so the data for quarters 3 and 4 is included in this report.

Due to the pandemic, COVID-19 preparedness and response has been the main focus for the IPC team for the past year and therefore some elements of the IPC work have not been completed fully and will be included in the 2021-22 work programme.

2 Key achievements

- Two new Senior IPC Nurses have been recruited to provide an IPC service across primary and community care, including specific work supporting care homes.
- The IPC Team have been integral to the planning and response to the COVID-19 pandemic, working collaboratively with a range of multi-professional colleagues, including national bodies Welsh Government and Public Health Wales, and regional partners: Powys County Council, Powys Primary Care and the independent sector, significantly those in care home provision.
- The IPC Link Workers programme has been established to have staff representation from every department in PTHB, clinical and non-clinical, in order to be able to cascade new guidance easily and quickly, and to learn about IPC issues on the ground. There were 70 IPC Link Workers in place and meetings were held monthly - a decision made by the IPC Link Workers themselves as they expressed a need for regular support due to the frequently changing COVID-19 guidance.
- Multi-professional relationships were key to responding to the demands of the pandemic. The IPC team acknowledge the diligence and hard work of all staff both clinical and non-clinical who play a vital role in improving the quality of patient and stakeholder experience as well as helping to reduce the risk of infections. Additionally, the Health Board works collaboratively with outside agencies as part of its IPC governance arrangements including:

- Public Health Wales
- Powys County Council
- Environmental Health Office (EHO)

The newly formed senior nursing team provided IPC support to frontline staff at weekends on an on-call basis which enhanced working relationships across estates and facilities as well as clinical and managerial staff.

This data in this report has been collected and produced by the Infection Prevention & Control Team (IPC) for the time period from April 2020 – March 2021 with assistance from the chairs of the task groups supporting this programme of work (Figure 1). It represents a point in time and notes the significant journey travelled in 2020-21 and the challenges that lie ahead.

Figure 1: Chairs of the IPC Task Groups

Sub Group	Chair
Antimicrobial Stewardship Group (AMR)	**Chief Pharmacist**
Environmental Cleanliness & Operational Guidance (ECOG)	**Service Improvement Manager: Compliance and Quality**
Water Safety and Ventilation (WSV)	**Responsible Person Water & Authorised Person Ventilation** **Assistant Director Property & Estates (Chair)**
Decontamination Group	**Assistant Director: Community Services Group**
Medical Devices (MD)	**Medical Devices & Point of Care Testing Manager**
Nosocomial Group	**Deputy Director of Nursing**

3 Healthcare associated infections (HCAI): statistics and performance

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

4 Welsh Government (WG) reduction expectations for April 2020 – March 2021

PTHB is not benchmarked at an All Wales level, due to the nature of our services however, the Health Board is committed to reducing infections in line with national

expectations. Due to the COVID-19 pandemic, the reduction expectation set for 2019/20 was extended for 2021/21.

Figure 2: Number and rate of *C. difficile, S.aureus* bacteraemia, *E. coli* bacteraemia, Klebsiella sp. bacteraemia and Pseudomonas aeruginosa bacteraemia per 100,000 population, April 2020 – March 2021.

	Rate of C. difficile/ 100,000 population		Rate of MRSA bacteraemia/ 100,000 population		Rate of MSSA bacteraemia/ 100,000 population		Rate of E. coli bacteraemia/ 100,000 population		Rate of Klebsiella sp. bacteraemia/ 100,000 population		Rate of Pseudo aer bacteraemia/ 100,000 population	
	No. of cases	Rate	No. of cases	Rate	No. of cases	Rate	No. of cases	Rate	No. of cases	Rate	No. of cases	Rate
Powys Teaching Health Board	7	5.26	0	0	1	0.75	5	3.76	2	1.5	1	0.75
All Wales	880	28.04	47	1.50	733	23.35	1882	59.96	620	19.75	148	4.72

(A) *Clostridium difficile* Infection (CDI):

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

Figure 3: Definitions of C. difficile cases:

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

Monthly numbers of C.difficile for April 2020 – March 2021

Monthly numbers for equivalent period 2019-20.

Figure 4: C.Difficile Cases 2020/21

C.difficile cases 2020/21	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	No pts
HOHA - PTHB	1	0	0	0	1	0	2	0	1	0	0	1	6
Pre-48hr cases*	1	0	0	0	0	0	0	0	0	0	0	0	1
GP sample	0	1	0	0	0	1	1	1	0	0	0	0	4
YTD cases 2020/21	2	3	3	3	4	5	8	9	10	10	10	11	11
C.difficile cases 2019/20													
HOHA - PTHB	0	0	0	0	0	0	0	1	0	1	2	0	4
Pre-48	1	0	0	0	1	0	0	0	0	0	0	0	2
Cases in GP	2	1	0	0	1	2	2	0	2	3	0	2	15
Cases YTD 2019/20	3	4	4	4	6	8	10	11	13	16	18	20	20

Hospital acquired cases remained similar in 20-21, there was a noted reduction (70%) reported in General Practice cases. The pandemic may have had some effect on the prevention of transmission but demonstrates the impact of prevention that can be made in primary care. During the pandemic post infection reviews were paused in order to add capacity to responding to COVID-19 impacts and were reinstated in April 2021. Reducing C. difficile infection in primary care is key to reducing the overall C. difficile rate in Powys. Work with primary care to further prevent C. difficile has been outlined in the 2021-222 work programme.

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

Powys had zero cases of MRSA blood stream infections and 1 case reported of an MSSA blood stream infection.

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

Reducing gram-negative blood stream infections is a key part of the Government's UK AMR (Antimicrobial Resistance) strategy and is monitored nationally. A gram-

negative blood stream infection is only considered as hospital onset if the sample is taken 48 hours after admission, any sample taken before this point is considered as community-onset.

Figure 5: Number of GNBBI's:

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	No pts
E. coli													
2020/21	0	1	0	0	0	0	0	0	0	1	1	1	4
2019/20	0	0	0	1	1	0	1	0	0	0	0	0	3
Klebsiella Pneumoniae													
2020/21	1	0	0	0	0	0	0	0	0	1	0	0	2
2019/20	0	0	1	0	0	0	0	0	0	0	0	0	1
Psudomonas aeruginosa													
2020/21	0	0	1	0	0	0	0	0	0	0	0	0	1
2019/20	0	0	0	0	0	0	0	0	0	0	0	0	0
Total GNBSI YTD 20/21	1	2	3	3	3	3	3	3	3	5	6	7*	
Total GNBSI YTD 19/20	**0**	**0**	**1**	**2**	**3**	**3**	**4**	**4**	**4**	4	4	4	

All gram-negative blood stream infections reported were hospital acquired. Although numbers remain low, they almost doubled in 20/21 (7 vs 4). Local improvement work has commenced in order to strengthen the investigation process and learning opportunities, with a multi-disciplinary approach. The IPC team will lead post-infection reviews acknowledging that clinical engagement is critical to provide opportunities for multi professional learning.

5 Outbreaks of other infectious diseases incidents and other communicable diseases

In 2020-21 there were no outbreaks other than those related to COVID-19.
Other infections to note include one reported case of a single staff member contracting scabies, and one isolated patient case of shingles.

COVID-19

Public Health Wales released a briefing in January 2020 alerting the health board to cases of pneumonia of unknown microbial aetiology associated with Wuhan City, Hubei Province, China. A cluster of cases had been identified which represented the emergence of a novel pathogen – COVID-19. As the pandemic developed over 2020/21, Public Health Wales published regular briefings, IPC guidance, clinical and epidemiological criteria and testing strategies to promote standardisation across Wales. The IPC team worked collaboratively to deliver a robust multi professional response to COVID-19 across PTHB.

Hospitals and care settings have been identified as high-risk sites for potential COVID-19 transmission. Nosocomial infections are infections that have been caught in a hospital, or health care setting. Building on existing reporting systems, it was agreed that a standardised national approach to the reporting and investigation of possible hospital and work acquired COVID-19 infections would help determine if additional infection prevention and control measures are required, aiming to reduce the risk of further transmission between staff, patients and visitors. Toolkits for both staff and patients have been developed on an All Wales basis and Powys have adopted these with some minor additions in order to capture some additional information on the staff toolkit. There is a process in place within the Health Board to investigate cases which includes a scrutiny panel with multidisciplinary membership.

A 16-point plan was devised by Public Health colleagues which described the gold standard PTHB should work towards. A robust testing strategy was developed and patients managed suitably depending on their test results/symptoms. Regular Incident Management Team meetings were held with Health, Local Authority and Public Health Wales colleagues to discuss individual COVID cases and manage the evolving outbreak situation across all hospital sites as well as care homes. The Health Board will continue to work together with the Delivery Unit which is shaping the future approach for COVID-19 Nosocomial work.

The increased cases/outbreak situations seen across hospital sites and care homes reflected the situation in our communities. Learning from experience within other health boards and across the United Kingdom has been considered and learning built into clinical practice where appropriate to do so. This has included an approach to reduce beds across the estate to comply with national guidance on distancing and designate ward areas to zones according to the risk or presence of COVID-19. This has impacted on patient flow through the hospital sites and discharge to care homes. Close partnership working across the Powys health and social sector helped to minimise this impact.

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

The work of the IPC team was significantly impacted by the COVID-19 pandemic from February 2020, with the management of potential cases of COVID-19 and

then later as the number of cases rose within the health board and care homes. The IPC team continue to offer a rolling programme of updates via a virtual platform as well as updating written guidance alongside policies and operating procedures as situations change and evolve.

The IPC Team has visited wards on both a proactive basis and where outbreaks have been confirmed, in order to support staff and ensure compliance with IPC procedures, and use of Personal Protective Equipment (PPE). For each outbreak an investigating officer was also appointed to carry out an independent review and root cause analysis, which is part of the Serious Incident framework followed in the Health Board. The IPC team has also supported the Local Authority by attending care homes together with the Environmental Health Officer (EHO). The Health Board and the Local Authority worked together during the pandemic and this positive way of working enabled good communication and further strengthened relationships working collaboratively together. Learning included the value of joint visits to care homes; developing bespoke support actions for the care homes, development of an individual staff assessment for donning and doffing in the home and strengthening business continuity alongside local authority partners.

6 Incidents and Adverse Events

All adverse incidents are reported to a National Incident Reporting System. There were nine reported incidents relating to clostridium difficile, highlighting good practice from wards, as this is higher than actual hospital cases. This identifies proactive reporting from wards of suspected cases. There were four incidents reported concerning positive MRSA screening results in comparison to ten cases identified on ICNet. This identified a need to remind operational leads and clarify the reporting process.

7 IPC Policies Approved in 2020/21

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

Figure 6: IPC Guidance Approved in 2020/21

	Title
7.2.1	Infection Prevention & Control Policy Part D – Visiting arrangements for inpatient units.
7.2.3	Infection Prevention & Control Policy Part C – Managing Outbreaks

7.2.4	Mental Health Infection Prevention Control During COVID19 Policy
SOP	Mass Vaccination Centres IPC, PPE and cleaning advice
SOP	Supplemental guidance for Mass Vaccination Centres on what to do if a person with a suspected case of COVID-19 enters the building
Action Card	Ward Visitors
Action Card	Reopening Outpatient Departments
Action Card	Transportation of patient by staff from hospital for a therapy assessment in the patient home
Action Card	Staff undertaking community visits
Action Card	Staff undertaking face to face training due to the nature of the training

8 Internal Audit Programme and Performance

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

The IPC Team has a rolling annual audit programme including all clinical areas and departments for independent verifications. As stated, the IPC team were unable to fully complete the audit programme in 2019/20 due to the pandemic but unannounced spot checks were carried out regularly during ward visits and non-compliance with IPC policies addressed at the time of the visit. The audit programme has now restarted and monthly IPC and Cleaning "Efficacy" audits scheduled for 2021/22. This brings together a rounded approach to assessing the effectiveness of cleaning and infection perfection arrangements and processes. Outcomes from these audits will be provided to the respective reporting groups to enable a collective understanding and assurance of each site's performance.

The completion and roll-out of a new Cleanliness Monitoring tool project will further enhance cleanliness auditing. This has been enabled with improved handheld auditing devices and new software with real-time reporting of audit outcomes. This new system offers superior functionality, not only in the auditing process but also providing a higher level of intelligence within the reports. The importance of clear, transparent reporting has proved to be essential during this period of COVID-19, to not only assist in managing cleaning effectively, but also to inform working groups undertaking nosocomial investigations.

9 Audit Results

9.1 Hand Hygiene Audits

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

- Before touching a patient
- Before a clean procedure
- After a dirty procedure
- After touching the patient
- After touching the patient's environment.

Hand hygiene is the single most important measure to prevent cross infection, and clinical engagement is paramount in improving compliance with hand hygiene practice. Infection prevention and control is everybody's business and all staff must practice infection prevention and control precautions at all times. It has been acknowledged that there are data quality issues with the reporting of hand hygiene audit scores completed within the inpatient wards. Areas that have reported show compliance ranging from 93.3% to 100%. The IPC team also supported the development and audit of practice within the Mass Vaccination Centres and these have been incorporated into the future audit programme.

The IPC team acknowledge that there is a need to ensure all clinical settings are reporting consistently and through one system, this will be further developed in 2021/22. The team will also review the hand hygiene audit tool.

9.2 Environmental Cleanliness Audits

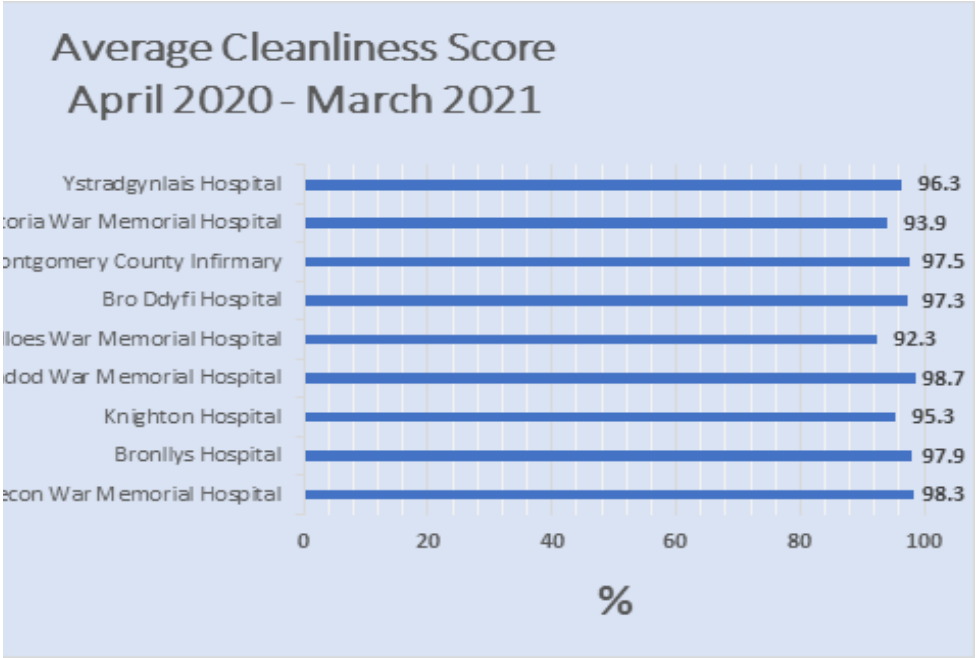
Environmental audits have shown consistent levels of cleaning in the majority of the areas across the health board. Resources have been utilised to ensure they are equally applied to all clinical areas. Outcomes are reported through the monthly Support Services Management Team, the bi-monthly Environmental Cleanliness and Operational Guidance Group and the Infection Prevention and Control Group.

The management of maintaining clean environments requires a breadth of knowledge, skills and experience to plan and execute the right frequency of cleaning in the right place, at the right time and to the expected standard. During 2020/21, cleaning in a COVID-19 Environment added a further dimension for cleaning in areas of the hospitals where they had previously been cleaned at the frequency dictated by the allocated risk level for the area. COVID-19 guidance

changed the cleaning processes but also a revaluation and allocation of risk areas. These changes were managed quickly as changing advice was received and implanted through new safe systems of work, information and training. A monthly dashboard report on cleaning standards performance was introduced and used widely for reporting on the outcomes of cleanliness audits.

Looking forward to 2021/22 a new Information and Communication Technology (ICT) capability for monitoring the standards of cleanliness in PTHB environments will be rolled out. This enhancement supports more effective monitoring of environmental cleanliness through several handheld tablets and allows live reporting into the new software. This will ease the process of managing cleanliness audit data and provide greater capability for reporting and informing stakeholders.

Figure 7: Cleanliness Audits of In-Patient Settings



10 Education and Training Activities

10.1 Statutory and Mandatory Training

Training, where possible was converted to a virtual platform although essential face to face activities such as face mask fit testing continued. It is noted that overall compliance for Level 1 training of 88.51% remained above the compliance target of 85%. Level 2 compliance fell to 78%, work is continuing with staff groups to promote the importance of completion through regular communication via internal Powys Announcements and Link Worker meetings.

Figure 8: Annual compliance for IPC Mandatory Training, levels 1 & 2

Staff Group	Infection Precaution Level 1			Infection Precaution Level 2		
	Required	Achieved	Compliance %	Required	Achieved	Compliance %
Add Prof Scientific and Technic	4	1	25.00%	90	63	70.00%
Additional Clinical Services				475	370	77.89%
Administrative and Clerical	549	487	88.71%	13	11	84.62%
Allied Health Professionals	15	14	93.33%	158	136	86.08%
Estates & Ancillary	231	205	88.74%			
Healthcare Scientists				4	4	100.00%
Medical and Dental	2	2	100.00%	51	30	58.82%
Nursing and Midwifery Registered				698	560	80.23%
Students				2	1	50.00%
Grand Total	801	709	88.51%	1491	1175	78.81%

10.2 PPE and FFP3 training

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

During April 2020 staff training was available through scheduled and 'drop in' sessions for FFP3 mask fit testing, and attend work stations for donning and doffing, hand hygiene, insertion of cannula and venepuncture. This was positively received by staff who attended and their attendance was recorded on ESR.

Face to face or online sessions were organised between March and October 2020, offering a comprehensive update on COVID-19 and the IPC/PPE requirements to manage it. 152 sessions were offered, with 1200 staff attending. A donning and doffing competency assessment document was created in line with other Health Boards across Wales, to give assurance that clinical staff were competent.

The IPC team staff members continued to provide opportunistic training while on the wards and other hospital sites alongside maintaining sessions via a virtual platform where a further 110 staff attended, from across PTHB and multiple disciplines.

FFP3 mask fit testing was completed across the organisation (An FFP3 mask is used to protect against respiratory borne pathogens. To use these masks, relevant staff

must be 'face fit tested' to ensure that they can achieve a suitable face fit of the mask and that it operates at the required efficiency). The IPC team supported colleagues in the Local Authority by conducting face mask fit testing for staff working in care homes and some domiciliary care agencies. The Local Authority has since arranged alternative methods of continuing to mask fit staff. In February 2021 the remit for mask fit testing moved to the portfolio of the Health & Safety team.

10.3 Aseptic Non-Touch Technique (ANTT)

Aseptic Non-Touch Technique (ANTT) is a comprehensive practice framework for aseptic technique used for all invasive procedures. All health board employees, who perform aseptic procedures as part of their role, must complete the ANTT e-learning package which is available via NHS learning Wales. Staff are then competency assessed in their areas by designated ANTT trainers for the organisation.

The health board has progressed this programme with 34 clinical staff who attended the ANTT Assessor Training in August and September 2020. Clinical staff must complete the online ANTT training before being assessed as competent by one of the newly trained assessors. Due to capacity issues the IPC team has not been able to assist with assessments and the practical element has been postponed with an aim to re-commence in 2021.

11 Strategic Decontamination Group

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

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

Community Dental Services benefitted from the installation of improved ventilation and decommissioning of obsolete bench top sterilisers.

A site visit to Llandrindod Endoscopic Decontamination system was undertaken in February 2021 and this demonstrated improvements in the services delivered. Learning from incidents from other NHS organisations included an incident

involving a minor spillage of peracetic acid (peracetic acid is an organic compound and is best known for its ability to sanitise surfaces and objects), this led to a review of strategies and systems for dealing with this sort of spillage.

The Authorised Engineer Decontamination Report 2021 provided the Health Board with an overall assurance rating of Reasonable Assurance. An action plan has been subsequently developed, and will be monitored through the health board Decontamination Group. It was recommended that Powys Teaching Health Board should be represented at the All Wales Decontamination and Sterilisation Group, a PTHB nomination has commenced attending.

12 Legionella/Water

The Estates Team has a proactive sampling regime that identifies and resolves water quality issues along with a management system. New risk assessments have been completed for all buildings, including all recently acquired or leased premise due to the needs of the COVID-19 pandemic.

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

13 Challenges this year and priorities for 2020/21

Challenges faced in the past year:

- IPC work has been prioritised on a day to day and week by week basis to ensure the team is focused on the preparedness and response agenda for COVID-19.
- Increased workload due to the pandemic and responding/supporting to the COVID outbreaks across PTHB.
- Reduced staffing levels.
- Unable to achieve a full audit programme.
- Unable to progress with all planned improvement work.
- The Health Board has been subject to external review through this period by HIW and no concerns raised in regard to IPC arrangements.
- The Link Worker is a strategy to develop key links with wards and provide those identified as Link Workers with further educational opportunities to build capacity in operational areas.

Priorities for 2021/22

Plans for the next financial year:

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

- Developing a work plan that balances the requirements of the Welsh Government/PHW and local PTHB needs with the capacity of the team.
- Completion of the 2021/22 work plan (see Appendix Four for the draft plan).
- Forward planning for a potential increase in COVID19 cases/winter pressures including Influenza.
- Maintaining the PPE & IPC Update training, to be delivered online and face-to-face.
- Reintroduction of routine IPC audits across the inpatient wards.
- Reintroduction of post-infection reviews for C. difficile and Gram-negative bacteria BSIs, to enable learning to be identified. Focusing on prevention of C. difficile in Primary care.
- Ongoing PPE training and IPC Link Worker meetings. Developing the role and knowledge of the IPC Link Worker to support PTHB in meeting All Wales directives regarding AMR and HCAIs.
- Continuing to meet departments and work with/provide support to colleagues.
- Providing support to all departments with regards to returning to 'Business as Usual' and ongoing IPC requirements
- Contribution to the All Wales groups on ANTT development and the digitalisation of patient records
- Continuation of the joint visiting of Care Homes with the EHOs and development of the programme of support offered to Care Homes with respect to IPC and other relevant issues.
- Provide bespoke placements with the IPC team for student nurses.

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Shared Services Partnership
Specialist Estates Services

Authorising Engineer (Decontamination) Annual Report For Powys Teaching Health Board

Authorising Engineer
(Decontamination) Annual Report
For
Powys Teaching Health Board

NWSSP-SES Job No: PO/AG/001

Report Date: July 2021

Author: **John Prendergast**

Signed: .....

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Signed: .....

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1.0 EXECUTIVE SUMMARY

1.1 National decontamination surveys, organised by NWSSP-SES between 2014 and 2019 on behalf of Welsh Government (WG), have been carried out for nominated disciplines of decontamination (sterile services, endoscope services and community dentistry).

1.2 It is recommended that draft action plans should be developed in response to the surveys, to include the WG 2019 survey carried out within the Community Dentistry Service (CDS). The action plans should be discussed at the Strategic Decontamination group and assessment of risks considered and improvements actioned where appropriate.

1.3 NWSSP-SES recommends the health board (HB) explore the possibilities of transferring community dental services decontamination activities to accredited Sterile Service Units. It is suggested that the transfer of service be carried out on a trial basis to assess the impact on service. Such practicalities of service transfer should be dependent on patient volume, strategic location and device turnaround.

1.4 The 2018 national survey identified areas where improvement was recommended with the services to decontaminate endoscopic devices. There has been investment and improvement, at both Brecon War Memorial (BWMH) and Llandrindod Wells Memorial Hospital.

Further improvements have been recommended as part of the annual JAG assessment at BWMH. An action plan has been developed and it is essential that such improvements are completed in alignment with JAG requirements.

1.5 The HB should instigate electronic methods of trace-ability to document and record key stages of decontamination processes for medical devices. It is a requirement identified in WHC 2015 (050) that organisations implement track and trace systems link device usage to individual patients. Recording methods should be as robust as possible and all relevant information maintained throughout the process. Such systems within the PTHB facilities have historically been manually controlled (Endoscopy and Community Dentistry).

1.6 Discussions indicated a lack of assurance in regards ENT provision at satellite locations. The Operational Decontamination Lead must ensure there is no satellite decontamination of scopes outside of the dedicated facilities (BWMH and LWMH) for any endoscopes used for outpatient activity. The recommendation is that full automation is required for all such processes, this has been the preferred route with historic service transfers implemented within the health board, as recommended in WHTM 01/06 par C paragraph 3:57.

1.7 Concerns have been noted with levels of decontamination competencies for ENT staff using the facility with main Endoscopy to decontaminate ENT scopes at the end of list. It is a recommendation that a service review is carried out, and the ENT scopes are decontaminated by the dedicated staff positioned within the Endoscopy Unit (who are appropriately trained). WHTM 01-06 Part A requires that all staff are trained and educated in cleaning and decontamination processes.

1.8 From information presented it is understood PTHB is generally in compliance with WHC (2020) 15. The circular require that all laryngoscope devices (handles and blades) should be either single use application or devices designed for re-usable applications using validated equipment. The circular sets a timescale of one

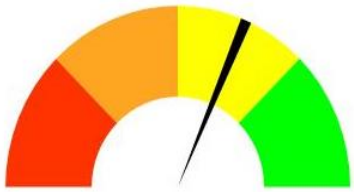
calendar year for organisations to meet the requirements WHC 2015 (050). The Operational Decontamination Lead should monitor systems in place and ensure that all areas within PTHB meet requirements of the WHC.

1.9 Engineering support is provided within PTHB, however there is only one Authorised Person (Decontamination) to manage the activities across the whole area, with minimal time resource and no resilience. It is a requirement in WHTM 01/01 part A, WHTM 01/06 and WHTM 01/05 that AP(D) s' are in place to represent a health care organisation and be responsible for the routine implementation and operation of Management's safety policy and procedures relating to the engineering aspects of decontamination equipment.

1.10 Validation reports supplied for the sterilizers within the community dental service do not present accountable evidence of sterilizer performance. The reports are produced to manufacturer's bespoke standards and not to requirements of WHTM 01-05, therefore not providing sufficient governance to the practice or HB.

Yellow – Reasonable Assurance

(with improvement plans necessary)



- Commitment to continual improvement evident, but needs further progression.
- Risks identified with limited action (Ref Executive Summary)
- Lack of compliance with documentation (validation/permit to work)
- Lack of resource to support compliant AP(D) provision
- Electronic trace-ability systems recommended

Figure 1 Overall Compliance Rating

2.0 BACKGROUND

2.1 The following report is a compliance and service review undertaken by the Authorising Engineer for Decontamination (AE (D)) appointed by the Powys Health Board (PTHB).

2.2 This report is in accordance with the guidance set out in Welsh Health Technical Memorandum 00 - which stipulates the requirement for the Authorising Engineer to produce an annual audit (WHTM 00 Best practice guidance for healthcare engineering paragraph 3.15).

2.3 Healthcare organisations have a duty of care to patients, their workforce and the public. This is to ensure that a safe and appropriate environment for healthcare is provided, which is a requirement identified in a wide range of legislation.

2.4 The role of the AE (D) is detailed within WHTM 01-01 part A and specifies the principle duties (WHTM 01/01 part A paragraph 7:26 to 7:32). This role is fully - independent of the health boards' and healthcare facilities' structure for maintenance, testing and operational management of the decontamination equipment and services.

NWSSP-SES and the AE (D) service within, has a reporting route to the Decontamination Lead and provides professional and technical advice to the Welsh Government, AP (D)s, CP (D)s, users and other key personnel involved in the control of decontamination processes in health boards/Trusts.

The structure for health boards within Wales is clearly identified in within WHTM 0-01 part A chapter 7.0 figure 3.

The AE (D) appointed for Powys Teaching Health Board is Mr John Prendergast on behalf of NWSSP-SES

3.0 OPERATIONAL MANAGEMENT STRUCTURE

3.1 Systems are in place to ensure the governance and accountability systems are in accordance with WHTM 01-01 part A. The strategic decontamination committee meets routinely and the AE (D) attends as part of the group. The committee presents an active group to escalate incidents and concerns as appropriate.

There is an Infection Prevention and Control report presented to the board on an annual basis; however, this was not submitted 2020 because of pandemic pressures. It is our understanding the report for 2021 is to be presented at the summer meeting of executive committee.

3.2 The health board has a designated decontamination lead at executive level, a newly appointed operational lead has been designated to manage operational issues. It is recommended that any nominated lead has undertaken formal training for this role.

Microbiologist advice is available and there is one AP (D) to cover the whole organisation (see executive summary).

Competent Person (Decontamination) provision is provided by external suppliers who carry out service/validation activities on the Endoscope reprocessing equipment and Community Dental provision.

4.0 DECONTAMINATION FACILITIES/INFRASTRUCTURE

4.1 Sterile service provision is outsourced to Cwm Taf University Health Board. It is imperative that transport and logistic services are optimised to ensure devices are transferred to SSD within a 24 hour period. Where such timescales are not possible, instruments sets should be maintained within a moist environment (Ref' WHTM 01-01 part A paragraph 4.8). The compliance of service returns should be reviewed and audited periodically and process improvements installed where consistent delays are acknowledged.

4.2 The facility dedicated to decontamination of endoscopes at Brecon War Memorial Hospital meets the requirements of JAG (a nationally recognised audit tool developed through IHEEM). There is scope for moderate investment to improve the infrastructure and develop the decontamination environment. Additionally there is need to expand the service to meet the anticipated growth in diagnostic services in coming years.

4.3 A major redevelopment of the Endoscopy Unit has been completed at Llandrindod Wells Hospital, however delays have prevented the unit opening since original project completion. The unit has now been accepted and is used as an operational facility. This re-development has included a new area to decontaminate flexible endoscopes used within the hospital and subsequent satellite areas. This unit has been designed to principles of HBN 13 and standards highlighted in WHTM 01-06.

4.4 Generally the WG national surveys have identified premises dedicated for decontamination within Community Dental Service in need of investment as part of continual improvement (Ref' WHTM 01/05 paragraph 1.5). The health board should assess relocation to the dedicated decontamination service centres (SSD's) where transport, strategic position or workload deem possible.

'It is a strong recommendation PTHB explore the possibility/feasibility of such transfer of decontamination service as part of reconfiguration of decontamination services. As a guide it is recommended transfer of service, on a trial basis for chosen centres close to accredited SSD's e.g. Machynlleth Clinic to Bronglais SSD.

5.0 DECONTAMINATION EQUIPMENT

5.1 Brecon War Memorial Hospital

Equipment	Number/Date of manufacture	Estimated life expectancy of equipment
Endoscope Washer/Disinfector	1 x Wassenburg 440 PT (2012)	Reaching end of projected life.
Controlled Environment Storage Cabinets	Cantel ESC 10T – 2012 Cantel ESC 10T – 2015	

5.2 Llandrindod Wells War Memorial Hospital

Equipment	Number/Date of manufacture	Estimated life expectancy of equipment

Endoscope Washer/Disinfectors (Endoscopy Unit)	2 x Cantel RapidAER (2019)	

Equipment	Number/Date of manufacture	Estimated life expectancy of equipment

Guide	Within projected service life	Equipment should be placed on equipment replacement register	Equipment deemed past anticipated service life expectancy
RAG Rating	<10 years from manufacture	>10 and <15 years from manufacture	>15 years from manufacture
	Note – this is a guide only, assessment should be based upon service-ability, recorded reliability, manufacturers guidance and individual design obsolescence. • Equipment design deemed obsolete - * • Incomplete/inaccurate as a result of lack of information returned - **		

5.3 Currently the community dental services operate from 13 premises and additional mobile units (information presented for 2019 survey). The management of the equipment used for decontamination of medical devices at each premises, should include periodic validation, routine maintenance/service, repair and pressure vessel certification (in accordance with requirements of the Pressure Systems Safety regulations) for each relevant machine. If carried out to best practice, this would equate to a significant financial resource.

6.0 VALIDATION COMPLIANCE

6.1 Validation of equipment used for flexible endoscope decontamination is undertaken by the manufacturers at the two current sites (BWMH and LWMH). Weekly testing of endoscope washer disinfectors is not currently carried out to the requirements of WHTM 01-06.

6.2 Reports are supplied and reviewed by the AE (D) upon request or when on-site, and comments passed back. The AP (D) and users should ensure that these comments are passed on to the relevant service supplier or CP (D). General standards are satisfactory.

6.3 Routine audit of the validation reports supplied for the sterilizers within the community dental service do not present accountable evidence of sterilizer performance. The sample presented indicate the reports presented for the washer/disinfectors are to a satisfactory standard.

6.4 Validation reports for Trophon systems should be periodically presented to the Operational Decontamination Lead and AE(D) for review.

7.0 EQUIPMENT SERVICE RECORDS

7.1 Service arrangements for equipment, used for flexible endoscope decontamination, is undertaken by the manufacturers at the three sites.

7.2 Decontamination equipment must be maintained in accordance with basic principles of manufacturers' recommendations. Regimes should be implemented and documentation retained by Users, to record replacement, safe operation and maintenance review of all critical components. Such areas include Endoscopy units and Community Dental practices. The AP(D) should check that all equipment is serviced to a satisfactory standard.

8.0 ENGINEERING GOVERNANCE - DECONTAMINATION

8.1 Equipment governance is in place within PTHB. Estates management team has systems in place in accordance with WHTM 00 and WHTM 01-01 part A chapter 7:0, WHTM 01/06 part C chapter 1.0 and WHTM 01/05 chapter 9.0. A nominated AP (D) is in place. Concerns have been noted with the ability of the one nominated person to cover the required duties of the AP(D) role (both from a geographic and volume of work basis).

Hospital	AP(D) for designated site	Date of Appointment	Appointment expires
HB Wide	Stuart Lewis	9th October 2020	9th October 2023

Guide	Within projected appointment period	Approaching appointment period	service life expectancy
RAG Rating	< 3 years since last assessment	> 2.5 and 3.5 years from last assessment	>3.5 years since last assessment

8.2 It is recommended that the AP (D) within PTHB develop a register of competency records for all engineers (internal/external) working on decontamination equipment and associated ancillary services. The AP (D) should maintain the responsibility for validation of competency of all CP (D) s' working under the responsibility of the organisation (Ref WHTM 00 paragraph 3:18). All CP (D) s' must work under the authorisation of the AP (D) and in accordance with the HB operating policies.

8.3 There is no formal permit to work system in place for decontamination equipment, it is recommended this system is put in place to cover all units decontaminating medical devices and critical ancillary services that supply the decontamination facilities (e.g. ventilation/water services).

In conjunction with the permit to work, it is recommended formal logbooks be developed for each item of decontamination equipment and ancillary service.

9.0 COMPLIANCE WITH WELSH GOVERNMENT GUIDANCE

9.1 Welsh Government has set a target that all main Endoscopy centres achieve JAG accreditation by March 2023. To achieve accreditation each decontamination facility/equipment should meet the standards set out in the JAG/IHEEM audit tool.

NWSSP-SES have carried out audits, using the JAG recognised IHEEM audit tool at Brecon War Memorial Hospital. Recommendations for continual improvement have been identified that will act as an action plan to ensure the decontamination systems meet JAG standards.

The unit at Brecon WMH has been accredited since 2018, and is scheduled for its 5-year assessment in 2023.

After a number of design and process issues, the new decontamination centre at Llandrindod Wells War Memorial Hospital is now operational. It is the intention for the AE (D) to undertake a JAG standard assessment at some point in 2021.

9.2 The HB should ensure full trace-ability systems are in place to document and record key stages of the decontamination processes. It is a requirement identified in WHC 2015 (050) that organisations implement track and trace systems and link device usage to individual patients. Recording methods should be as robust as possible and all relevant information maintained throughout the process.

It is recommended trace-ability of activity be recorded using life cycle electronic systems as operated within both Endoscopy Units. systems to record process.

A review of trace-ability systems within Community Dental Services should be undertaken, with a progression to electronic systems. Robust manual systems, routinely audited, should be in place until the progression is complete.

The Consumer Protection Act in particular, has implications for reprocessing of instruments for patient care. All practices should have the ability to demonstrate how particular instruments have been processed.

9.3 Technological advancement has seen ‘Trophon’ systems for ultrasound probes. It is recommended continued progress be made for any remaining practices not using validated solutions.

10.0 ASSISTANCE WITH INCIDENTS

10.1 There have been no significant issues escalated to the Authorising Engineer (Decontamination).

11.0 RECOMMENDATIONS

11.1 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.

11.2 Decontamination centres that undertake 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 represents best practice and a policy should be in place for the health board to work towards this standard.

The accreditation for endoscope decontamination facilities is a requirement of WHC (2015) 050 and on the revised Medicines and Healthcare Regulatory Agency

`Top ten tips` on endoscope decontamination. Within NHS Wales, there are currently examples of departments achieving, or working towards such ISO registration.

11.3 The management structure is in place across the organisations. However, interviews indicated concerns with resource time allocation needed to undertake the management of decontamination across the organisation. It is recommended the structure is reviewed and appropriate resource allocated.

If the Designated Person or their representatives would like to discuss this report, further please contact the AE (D) using the details below:

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AED Report Operational Decontamination Group Action and Improvement Plan

Actions relating to AED Annual Report August 2021 (BRAG REPORT)

Review Cycle: Via Operational Decontamination Group

All Actions complete actions will be review for sustainability every 12 months.

Report Recommendation	Lead	Target Date	Update	Status
1.2 It is recommended that draft action plans should be developed in response to the surveys, to include the WG 2019 survey carried out within the Community Dentistry Service (CDS). The action plans should be discussed at the Strategic Decontamination group and assessment of risks considered and improvements actioned where appropriate.	Service leads	1/8/2021	Action plans are in place for Dental, including annual audit in line with CDS specific Decontamination and IPC requirements. (2021) Institute Health Care Engineering and Estate Management (IHEEM) assessment (2021) and associate action plan in place. Community dental Services have agreed improvement plan AED Report (2021 Improvement plan in place. All plans are due for review at the September Decontamination Operational Group	Complete
1.3 NWSSP-SES recommends the health board (HB) explore the possibilities of transferring community dental services decontamination activities to accredited Sterile Service Units. It is suggested that the transfer of service be carried out on a trial basis to assess the impact on service. Such practicalities of service transfer should be dependent on patient volume, strategic location and device turnaround.	Clinical Director Dental Services	1/8/2021	The options of exploration and discussions have been considered in 2020 and 2021. The current Health Board Position is to retain and maintain in house CDS decontamination. Clinical Director for Dental Services has reviewed options and has linked to the All Wales Dental Decontamination and IPC Group. No further plans to consider transfer of CDS decontamination arrangements have been agreed for 2021/22	Complete
1.4 The 2018 national survey identified areas where improvement was recommended with the services to decontaminate endoscopic devices. There has been investment and improvement, at both Brecon War Memorial (BWMH) and Llandrindod Wells Memorial Hospital. Further improvements have been recommended as part of the annual JAG assessment at BWMH. An action plan has been developed and it is essential that such improvements are completed in alignment with JAG requirements	Service leads	1/1/2021	Submission for funding to replace the washers has been successful. This will strengthen the JAG accreditation process and safeguard the service. Work is planned for the installation of washers in 2021. This action is being reviewed by the service and will be reviewed at Septembers Operational Decontamination Meeting	Ontrack

AED Report Operational Decontamination Group Action and Improvement Plan

1.5 The HB should instigate electronic methods of trace-ability to document and record key stages of decontamination processes for medical devices. It is a requirement identified in WHC 2015 (050) that organisations implement track and trace systems link device usage to individual patients. Recording methods should be as robust as possible and all relevant information maintained throughout the process. Such systems within the PTHB facilities have historically been manually controlled (Endoscopy and Community Dentistry).	Service Leads	1/1/2021	This action is being managed though the IHEEM action plan. Plan is linking in several providers, shared services and IT and is currently ongoing This action is being reviewed by the service and will be reviewed in Septembers Operational Decontamination Meeting	Behind track
1.6 Discussions indicated a lack of assurance in regards ENT provision at satellite locations. The Operational Decontamination Lead must ensure there is no satellite decontamination of scopes outside of the dedicated facilities (BWMH and LWMH) for any endoscopes used for outpatient activity. The recommendation is that full automation is required for all such processes, this has been the preferred route with historic service transfers implemented within the health board, as recommended in WHTM 01/06 par C paragraph 3:57.	Service Leads	1/11/2021	ENT scopes are sent to Llandrindod for processing after OPD clinics from Ystradgynlais and Welshpool. This process will be reviewed with the AE to understand specific concerns and risk ass is these clinics can continue and what changes are required This action is being reviewed by the service and will be reviewed at Septembers Operational Decontamination Meeting	Ontrack
1.7 Concerns have been noted with levels of decontamination competencies for ENT staff using the facility with main Endoscopy to decontaminate ENT scopes at the end of list. It is a recommendation that a service review is carried out, and the ENT scopes are decontaminated by the dedicated staff positioned within the Endoscopy Unit (who are appropriately trained). WHTM 01-06 Part A requires that all staff are trained and educated in cleaning and decontamination processes.	Service	1/11/2021	OPD staff in Brecon and Llandrindod have received all appropriate yearly training which has been delivered by the relevant companies. Follow up review with AE to be requested to assess if action has been achieved. This action is being reviewed by the service and will be reviewed in Septembers Operational Decontamination Meeting	On Track
1.8 From information presented it is understood PTHB is generally in compliance with WHC (2020) 15. The circular require that all laryngoscope devices (handles and blades) should be either single use application or devices designed for re-usable applications using validated equipment. The circular sets a timescale of one calendar year for organisations to meet the requirements WHC 2015 (050). The Operational Decontamination Lead should monitor systems in place and ensure that all areas within PTHB meet requirements of the WHC.	Service Leads	1/7/2021	We only use single use laryngoscope blades and handles within theatre and there had been confirmation that the blades and handles on the resus trollies are single use as well.	Complete

AED Report Operational Decontamination Group Action and Improvement Plan

1.9 Engineering support is provided within PTHB, however there is only one Authorised Person (Decontamination) to manage the activities across the whole area, with minimal time resource and no resilience. It is a requirement in WHTM 01/01 part A, WHTM 01/06 and WHTM 01/05 that AP(D) s' are in place to represent a health care organisation and be responsible for the routine implementation and operation of Management's safety policy and procedures relating to the engineering aspects of decontamination equipment.	Service Leads	1/10/2021	Capacity to be reviewed by Estates Team. This action is being reviewed by the service and will be reviewed in Septembers Operational Decontamination Meeting	On Track
1.10 Validation reports supplied for the sterilizers within the community dental service do not present accountable evidence of sterilizer performance. The reports are produced to manufacturer's bespoke standards and not to requirements of WHTM 01-05, therefore not providing sufficient governance to the practice or HB.	Service Leads	1/11/2021	Meetings have been held with the manufacturer, additional evidence has been provided. CDS and Manufacturer are able to provide evidence. Meetings have been held with AE and further meetings are planned. All evidence has been provided. This action is being reviewed by the service and will be reviewed in Septembers Operational Decontamination Meeting	On Track
3.2 The health board has a designated decontamination lead at executive level, a newly appointed operational lead has been designated to manage operational issues. It is recommended that any nominated lead has undertaken formal training for this role.	Executive Lead	1/11/2021	The Decontamination lead is enquiring re options for formal training in this area. Theatre Manager has attended the Management of flexible endoscope decontamination (to NHS guidance) course at Eastwood Park training center and this is a C&G certified course. This action is being reviewed by the service and will be reviewed in Septembers Operational Decontamination Meeting	On Track
4.1 Sterile service provision is outsourced to Cwm Taf University Health Board. It is imperative that transport and logistic services are optimised to ensure devices are transferred to SSD within a 24 hour period. Where such timescales are not possible, instruments sets should be maintained within a moist environment (Ref' WHTM 01-01 part A paragraph 4.8). The compliance of service returns should be reviewed and audited periodically and process improvements installed where consistent delays are acknowledged	Service Leads	1/11/201	All of theatre instrument trays are sent to PCH in Humipak bags, which are then placed into a sealed box. The Humipak bags keep all the instruments moist until they are processed.	Complete

AED Report Operational Decontamination Group Action and Improvement Plan

4.2 The facility dedicated to decontamination of endoscopes at Brecon War Memorial Hospital meets the requirements of JAG (a nationally recognised audit tool developed through IHEEM). There is scope for moderate investment to improve the infrastructure and develop the decontamination environment. Additionally there is need to expand the service to meet the anticipated growth in diagnostic services in coming years.	Service Leads	1/1/2021	Submission for funding to replace the washers has been successful. This will strengthen the JAG accreditation process and safeguard the service. Work is planned for the installation of washers in 2021. This action is being reviewed by the service and will be reviewed in Septembers Operational Decontamination Meeting	Ontrack
4.4 Generally the WG national surveys have identified premises dedicated for decontamination within Community Dental Service in need of investment as part of continual improvement (Ref' WHTM 01/05 paragraph 1.5). The health board should assess relocation to the dedicated decontamination service centres (SSD's) where transport, strategic position or workload deem possible. 'It is a strong recommendation PTHB explore the possibility/feasibility of such transfer of decontamination service as part of reconfiguration of decontamination services. As a guide it is recommended transfer of service, on a trial basis for chosen centres close to accredited SSD's e.g. Machynlleth Clinic to Bronglais SSD.	DPCCMH	1/11/2021	Outline discussions have not identified need to develop a workstream to outsource CDS decontamination. In light of this request further discussions at Directorate level will take place. This action is being reviewed by the service and will be reviewed in Septembers Operational Decontamination Meeting	On Track
5.1 Brecon Endoscope Washer Disinfector, Wassenburg 440 PT is approaching the end of its projected life span	Service Leads	1/11/2021	Submission for funding to replace the washers has been successful. This will strengthen the JAG accreditation process and safeguard the service. Work is planned for the installation of washers in 2021. This action is being reviewed by the service and will be reviewed in Septembers Operational Decontamination Meeting	On Track
5.3 Currently the community dental services operate from 13 premises and additional mobile units (information presented for 2019 survey). The management of the equipment used for decontamination of medical devices at each premises, should include periodic validation, routine maintenance/service, repair and pressure vessel certification (in accordance with requirements of the Pressure Systems Safety regulations) for each relevant machine. If carried out to best practice, this would equate to a significant financial resource.	Service Leads	1/11/2021	This action is being reviewed by the service and will be reviewed in Septembers Operational Decontamination Meeting	On Track

6.1 Validation of equipment used for flexible endoscope decontamination is undertaken by the manufacturers at the two current sites (BWMH and LWMH). Weekly testing of endoscope washer disinfectors is not currently carried out to the requirements of WHTM 01-06.	Service Leads	1/11/2021	This action is being reviewed by the service and will be reviewed in Septembers Operational Decontamination Meeting	On Track
6.3 Routine audit of the validation reports supplied for the sterilizers within the community dental service do not present accountable evidence of sterilizer performance. The sample presented indicate the reports presented for the washer/disinfectors are to a satisfactory standard.	Service Leads	1/11/2021	This action is being reviewed by the service and will be reviewed in Septembers Operational Decontamination Meeting	On Track
6.4 Validation reports for Trophon systems should be periodically presented to the Operational Decontamination Lead and AE(D) for review.	Service Leads	1/11/2021	This action is being reviewed by the service and will be reviewed in Septembers Operational Decontamination Meeting	On Track
8.2 It is recommended that the AP (D) within PTHB develop a register of competency records for all engineers (internal/external) working on decontamination equipment and associated ancillary services. The AP (D) should maintain the responsibility for validation of competency of all CP (D) s' working under the responsibility of the organisation (Ref WHTM 00 paragraph 3:18). All CP (D) s' must work under the authorisation of the AP (D) and in accordance with the HB operating policies.	Service Leads	1/11/2021	This action is being reviewed by the service and will be reviewed in Septembers Operational Decontamination Meeting	On Track
8.3 There is no formal permit to work system in place for decontamination equipment, it is recommended this system is put in place to cover all units decontaminating medical devices and critical ancillary services that supply the decontamination facilities (e.g. ventilation/water services). In conjunction with the permit to work, it is recommended formal logbooks be developed for each item of decontamination equipment and ancillary service.	Service Leads	1/11/2021	This action is being reviewed by the service and will be reviewed in Septembers Operational Decontamination Meeting	On Track
9.2 The HB should ensure full trace-ability systems are in place to document and record key stages of the decontamination processes. It is a requirement identified in WHC 2015 (050) that organisations implement track and trace systems and link device usage to individual patients. Recording methods should be as robust as possible and all relevant information maintained throughout the process. It is recommended	Service Leads	1/11/2021	This action is being reviewed by the service and will be reviewed in Septembers Operational Decontamination Meeting	On Track

AED Report Operational Decontamination Group Action and Improvement Plan

trace-ability of activity be recorded using life cycle electronic systems as operated within both Endoscopy Units. systems to record process.				
9.3 A review of trace-ability systems within Community Dental Services should be undertaken, with a progression to electronic systems. Robust manual systems, routinely audited, should be in place until the progression is complete.	Service Leads	1/11/2021	This action is being reviewed by the service and will be reviewed in Septembers Operational Decontamination Meeting	On Track
11.1 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.	Service Leads	1/8/2021	Operational decontamination leads now in place and on the attendance list for the All-Wales decontamination group.	Complete
11.2 Decontamination centres that undertake 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 represents best practice and a policy should be in place for the health board to work towards this standard. The accreditation for endoscope decontamination facilities is a requirement of WHC (2015) 050 and on the revised Medicines and Healthcare Regulatory Agency `Top ten tips` on endoscope decontamination. Within NHS Wales, there are currently examples of departments achieving, or working towards such ISO registration.	Service Leads	1/8/2021	The endoscopy unit in Brecon is JAG accredited and has an annual IHEEM decontamination audit undertaken. A working party, which meets quarterly, has been set up with the aim to discuss the action plan and also move PTHB into a position to gain ISO 13485.	Complete
11.3 The management structure is in place across the organisations. However, interviews indicated concerns with resource time allocation needed to undertake the management of decontamination across the organisation. It is recommended the structure is reviewed and appropriate resource allocated.	Service Leads	1/11/2021	Llandrindod endoscopy unit is scheduled to have a JAG standard assessment in September 2021 and any actions following this will be placed into an action plan and again discussed at the quarterly meetings. This action is being reviewed by the service and will be reviewed in Septembers Operational Decontamination Meeting	On Track

Agenda Item: 3.5

Patient Experience Quality & Safety Committee	**7 October 2021**
Subject:	**Maternity Assurance Report**
Approved by:	Alison Davies, Director of Nursing and Midwifery
Prepared and presented by:	Julie Richards, Head of Midwifery and Sexual Health Clare Lines, Assistant Director for Transformation Alison Davies, Director of Nursing and Midwifery
Other Committees and meetings considered at:	Executive Committee 22nd September 2021 Women and Children's Senior Leadership meeting 30th September Midwifery Management and Leadership Governance meeting 4th September 2021

PURPOSE:
The purpose of this paper is to provide the Patient Experience Quality Safety Committee (PEQS) with the current position related to the maternity pathway for the women of Powys.
RECOMMENDATION:
The PEQS Committee is asked to DISCUSS and NOTE the report.

Approval/Ratification/Decision	**Discussion**	**Information**
	✓	✓

THE PAPER IS ALIGNED TO THE DELIVERY OF THE FOLLOWING STRATEGIC OBJECTIVES AND HEALTH AND CARE STANDARDS:		
Strategic Objectives:	Focus on Wellbeing	✓
	Provide Early Help and Support	✓
	Tackle the Big Four	✓
	Enable Joined up Care	

	Develop Workforce Futures	
	Promote Innovative Environments	
	Put Digital First	
	Transforming in Partnership	
Health and Care Standards:	Staying Healthy	✓
	Safe Care	✓
	Effective Care	✓
	Dignified Care	✓
	Timely Care	✓
	Individual Care	✓
	Staff and Resources	✓
	Governance, Leadership & Accountability	✓

EXECUTIVE SUMMARY:

This paper provides the Patient Experience Quality Safety Committee (PEQS) with a position in terms of the maternity pathway for the women of Powys, focusing on the following:

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

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DETAILED BACKGROUND AND ASSESSMENT:

1. Maternity Commissioning Assurance framework

Whilst the health board's commissioning assurance processes have been adversely impacted upon by the covid 19 pandemic with interim arrangements put in place nationally in terms of contracting, the first 2 quarter's maternity assurance framework discussions have been informed via monthly verbal reports to the Internal Commissioning Assurance Meetings. The findings are included within the commissioning performance report, present to the Performance and Resources Committee, with the quality and safety component regularly reported to this Committee.

Emerging themes include increased workforce pressures, increased acuity and issues of access to maternity and neonatal services across all Health Boards and commissioned cross border services. Mitigation includes monthly all Wales monitoring of emerging incidents including obstetric service access and WAST has been commenced supported by collaborative discussion on a weekly basis through the all Wales Maternity and Neonatal Network. Locally,

a no surprises notification has been made to Welsh Government during his period in relation to one episode of non-accessibility of services in Wye Valley.

In line with an increased national focus on neonatal services, the maternity assurance framework will aim to establish a specific neonatal focus, which will be negotiated with health boards and NHS Trusts as part of arrangements for the next finical year. This will assist the health board in understanding, and influencing, the quality and safety of neonatal services accessed by babies and families in Powys.

In terms of service group's assurance and oversight in relation to the whole pathway experienced by pregnant women, governance arrangements continue to strengthen, with regular reporting into Committees as scheduled.

2. Commissioned maternity services subject to special measures

2.1 Shrewsbury & Telford NHS Trust (SaTH):
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.*" https://www.england.nhs.uk/publication/ockenden-review-of-maternity-services.

The actions noted as off track at the moment are listed below:

LAFL 4.59 - The maternity department clinical governance structure and team must be appropriately resourced so that investigations of all cases with adverse outcomes take place in a timely manner. *This governance review has not yet been completed.*

LAFL 4.60 - The maternity department clinical governance structure must include a multidisciplinary team structure, trust risk representation, clear auditable systems of identification and review of cases of potential harm, adverse outcomes and serious incidents in line with the NHS England Serious Incident Framework 2015. *This action is linked to 4.59 above.*

LAFL 4.73 - Women with pre-existing medical co-morbidities must be seen in a timely manner by a multidisciplinary specialist team and an individual management plan formulated in agreement with the mother to be. This must include a pathway for referral to a specialist maternal medicine centre for consultation and/or continuation of care at an early stage of the pregnancy. *This is a complex action, some of which is taking longer than anticipated to address and, also, is awaiting national action regarding specialist maternal medicine centres, which is out of the Trust's control.*

LAFL 4.100 - There was some evidence of outdated neonatal practice at The Shrewsbury and Telford Hospital NHS Trust. Consultant neonatologists and ANNPs must have the opportunity of regular observational attachments at another neonatal intensive care unit. *This action is dependent upon the recruitment of an additional NICU consultant so that staff can be released from the unit. Funding is now in place but the recruitment has not taken place yet; hence this is now off track against its original target date. The delivery date will be revised.*

IEA 1.4 - An LMS cannot function as one maternity service only. *Work is underway to set up a formal partnership with another LMNS and discussions are still taking place on the future arrangements.*

LAFL 4.66 - The Lead Midwife and Lead Obstetrician must adopt and implement the National Bereavement Care Pathway. *The reason for this not yet being implemented fully is that that the Trust is awaiting an on-site review of the pathway by the Stillbirth and Neonatal Death Society (SANDS), which has been delayed due*

An NHS England and Improvement (NHSEI) letter on the 14th December, 2020, set out the requirement for all Trusts to receive the report at public meetings. An assurance statement also had to be completed. NHS Trusts in England have submitted reports to the NHSEI regions and it is understood that these are being risk assessed. PTHB will provide a separate internal report when these have been collated and assessed.

SaTH has established a committee to drive forward actions arising from the report. The Ockenden Report Assurance Committee (ORAC) meets monthly in public. PTHB is represented through the Director of Nursing and Midwifery. The Powys Community Health Council is also represented. The purpose of the Committee is to obtain and provide assurance in relation to the delivery, evidence, sustainability and impact of the implementation of the actions arising from the Ockenden report.

A comprehensive account of progress and areas of challenge in terms of implementing the recommendations of the Ockendon Review was presented at the OCKENDEN REPORT ASSURANCE COMMITTEE (ORAC), held in public on 23 September 2021 included in **appendix 1**. To note, the presentation incorporated the approach in totality being undertaken to improve maternity services provided by SaTH, some, but not all of which, has been informed by the Ockendon Report. Assurance was provided in terms of the acceptability of SaTHs practice in terms of neonatal referral previously queried by Okendon.

The final Ockendon Report, expected at the end of 2021, may generate further learning and improvement.

2.2 Cwm Taf Morgannwg University Health Board

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 2nd September, 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. Neonatal reviews are underway and as the learning emerges it will be fed into the wider improvement programme.

The panel is also conducting 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.

On the 7th September, 2021, the Minister for Health and Social Services issued a further statement in relation to CTMUHB. The statement may be read in full through this link: https://gov.wales/written-statement-cwm-taf-morgannwg-university-health-board-interim-findings-independent-maternity

The IMSOP deep dive of neonatal services at Prince Charles Hospital, in Merthyr Tydfil, began in May 2021. This comprehensive exercise is being informed by evidence gathered from a range of sources including: feedback from families who have experienced neonatal care; conversations with staff and wider stakeholders; case reviews of the sickest infants presenting to the neonatal unit during 2020; and a review of a wide range of documentation relating to clinical outcomes, safety and effectiveness data as well as clinical governance and assurance.

From the evidence reviewed to date, the panel has identified some areas, which it determined were impacting on the consistent provision of safe and

effective care that would be expected of such a unit in the UK. It took the decision to advise the health board of its interim findings and escalate a range of issues for immediate and short-term action. It has worked closely with the health board and Welsh Government officials to ensure appropriate steps are taken at pace. The issues for immediate and short-term action include:

- Immediate improvements to medicines prescribing and administration with pharmacy support and daily checking of prescriptions. Further work will be carried out over the next month to develop a standard operating procedure, checklists and audits.
- An audit has been initiated to ensure the timely transfer of babies needing referral to a tertiary unit and reducing inappropriate admissions to the Prince Charles Hospital unit.
- Increasing the intensity of consultants overseeing the unit and increased time allocated to the unit. Closer working with and support from the specialist neonatal unit in Cardiff. The recruitment of an additional two consultant posts is already underway, with one taking up post in November.
- Establishing a specialist centre support programme for neonatal nursing staff. Improving specific aspects of clinical practice, including urgent review of the approach to therapeutic cooling of babies and for those requiring intubation.
- Improvements to the standard of documentation, including the introduction of a revised observation chart.
- Securing closer working with the Wales maternity and neonatal network and support from neighbouring units, will be key in helping to embed these improvements.

It is recognised that these findings will be concerning for families using the service, however many of the improvements in train have been informed by their feedback. CTMUHB will work to ensure that communication and support is improved and that parents have greater involvement in decisions about their baby's care. The importance of staff being supported to make these improvements and their wellbeing is also a key consideration in the health board's improvement plan.

The panel and Welsh Government officials will be working closely with the health board to support and monitor the improvements. The panel will be producing a report when this part of their work is concluded, which will be made available later this year. There will also be a further progress report from IMSOP on all aspects of its work and its assessment of CTMUHB's overall progress. The panel is finalising its analysis and findings from the second element of the clinical review look back programme, involving babies who sadly were stillborn. This report will also be made available.

3. South Powys Programme Maternity and Neonatal Workstream

As previously reported to the PEQS Committee a Maternity and Neonatal Workstream is in place under the South Powys Programme chaired by the PTHB Director of Nursing and Midwifery, involving clinicians from PTHB, Aneurin Bevan University Health Board (ABUHB) and Cwm Taf Morgannwg University Health Board (CTMUHB). Following the statement made by the Minister for Health and Social Services on the 7th September 2021 detailed above, the right timing for a future strategic change in pathway remains subject to PTHB Board approval based on assurances about quality, safety, patient experience and governance and an assessment of readiness including factors such as capacity and capability.

4. Powys provided maternity services - Improvement Plan

The Powys Maternity Improvement Plan is informed by the:

- National Report for Healthcare Inspectorate Wales (HIW) recommendations for Maternity services (March 2021)
- Reactive national and local work resulting from the covid 19 pandemic Safe and Sustainable Maternity and Neonatal services in Wales
- The Ockenden Report (December 2020) immediate and essential actions
- RCOG & RCM recommendations following the review of Cwm Taf Morgannwg University Health Board, published April 2018 and subsequent findings of the IMSOP
- MBRRACE recommendations
- The Vision for Maternity services in Wales
- Recommendations from other key reports and audits
- Recovery and renewal priorities articulated within the health board's annual plan

Based on the above, focus has been given to the following areas:

4.1 Sustainable workforce including staff wellbeing

Support and sustainability of the Powys midwifery workforce continues to be key priority, the service has maintained safe staffing levels with below 5% absence over the last 18 months. However, the level of flexibility required and the challenges that midwifery staff have faced is impacting upon staff wellbeing, in terms of morale and some notable anxiety levels, along with pressures recognised more widely for maternity services in Wales and England and on WAST. The situation is regularly reviewed and is subject to all Wales weekly scrutiny at present. in terms of supporting and enhancing the staffing model:

- An increase in Clinical Supervisor of Midwives resource is being considered as an additional support mechanism and to enhance the

governance and safety focus within the service.

- Fragilities in terms of long-term sickness has an improved position from September 2021
- Substantive Assistant Head of Midwifery post is being recruited.
- Additional administrative and project support has been arranged to maintain progress of the maternity improvement plan priorities.
- The additional 2.4 wte newly qualified midwives through midwifery streamlining supports sustainability supported with a robust 12 month all Wales preceptorship programme
- Appointment of a perinatal mental health specialist midwife to the perinatal mental health service
- Via Charitable funds, the appointment of 2-year fixed term research midwife to build and grow capacity as part of the women and children's service group renewal priorities.
- Training and learning continue using all Wales PROMPT methodology with a continued focus on the importance of respectful team working building a supportive work culture. Three additional Powys PROMPT faculty trainers have been trained to enhance the Powys PROMPT team with pending retirements.
- With the Medical Director, review and enhancement of multidisciplinary working is being strengthened.

4.2 Implementation of Continuity of Care

The Future Vision for Maternity Care highlighted the need for continuity throughout low risk and complex care, with shared decision making and collaborative working across specialities. In Powys:

- Continuity of care has been fully rolled since June 2021
- Ongoing engagement with other health boards to ensure that a dedicated obstetrician link is established to each community midwifery team to ensure consistency with medical engagement for women with additional needs for pregnancies requiring obstetric input.
- A business case will be developed for additional resource of maternity support worker to be developed as part of the evaluation and 'Sustainability of Healthier Lifestyle' roles which are currently funded until March 2022. This will provide support to the continuity of care teams and the First 1000 days pathway.

4.3 Digital Maternity Cymru, electronic record

Welsh Government are undertaking a scoping paper to prepare for the implementation of a single maternity dashboard for Wales (Maternity Digital Cymru) which is expected to report to NHS Collaborative in Autumn 2021.

- The all Wales Maternity and Neonatal Network Safety Action Plan has identified the importance of real time essential data to understand and evidence capacity issues. Some of the emerging concerns through the

Safety and Sustainability of Maternity Services Group highlight the challenge in paper-based systems when cross border commissioned services are now proactively using electronic records.

- SatH, ABHB and Wye Valley have already implemented Badgernet as their preferred maternity and neonatal systems. In the meantime, communication with cross border commissioned services is risk assessed
- Once the Welsh Government scoping paper has been approved PTHB are expecting resource for implementation of a maternity dashboard for Powys and this work will need support of the PTHB Digital Transformation team.

4.4 Birth Centre Environments

The Powys Maternity Improvement Plan includes a focus on profiling the birth options including Birth Centres, further promoting the availability of waterbirth options.

Working with the Capital Estates Team reviewing Llanidloes War Memorial Hospital and Knighton Hospital to improve facilities for the environment include phased plans for redecoration, bathroom improvement, pool hoist and Double Bed provision. A Llanidloes Birth Centre improvement plan is being developed with the Capital Estates team and funding in discussion with League of Friends. Plans have been slightly delayed due COVID19 pressures.

The Welshpool birth pool installation and refurbishment of the birth room is was further delayed for implementation due to supplies of the pool and taps. The pool was successfully installed in September 2021 with a formal launch planned for October 2021. HIW highlighted the need for modernisation of Llanidloes and Knighton Birth Centre environments and plans are currently in development to present to the Health Board Capital Control Group in October 2021.

4.5 Public health, pregnant women and families

4.5.1 In response to a Chief Medical Officer letter (9th August 2021), re. all pregnant and breastfeeding women being offered the Covid-19 vaccination, a work programme has been developed and is monitored through the weekly maternity and health visiting Covid-19 vaccination working group, reporting internally to the PTHB Mass Vaccination Operational Delivery Group and Strategic Oversight Group. The programme has focused on the key areas raised in the letter:

- Pregnant and breastfeeding women to have the opportunity

to read and view reliable information
- Data for uptake for pregnant women
- Pregnant and breastfeeding women access to vaccination
- Social media information
- Maternity Parent Voices Partnerships
- Staff vaccination uptake has been confirmed as more than 95% of Powys Midwives vaccinated which is above the all Wales percentage of 84%

2020-2021 Flu vaccination for Pregnant women- end of Flu season data was suggestive of over 70% of Pregnant women Powys accessed Flu Vaccination

Midwife Led Vaccination	65%
Vaccinated elsewhere	5%
Declined	13%
Unknown	16%

Current COVID19 vaccination data continues to be validated from WIS data provided from Mass Vaccination Centre team against the current Maternity data. Data in August was suggesting 42% of Powys Pregnant women have received both doses of vaccination and 39% of Pregnant women unvaccinated. A Midwifery caseload database has been set up as part of the Powys programme of work so unvaccinated women are highlighted at the Midwife and Health Visitor sharing of information as behavioural insights information is suggestive that Pregnant women remain hesitant to have vaccination until the baby has been born.

4.5.2 The most recent RCOG COVID19 version 14 (August 2021) recommends that pregnant women should be offered CO Monitoring. A paper will be prepared for the October 2021 Prevent and Response Oversight Group requesting consideration that midwifery and health visiting services resume CO monitoring in line with evidence-based guidance. The service will require the support of Powys Public Health team. Risk Assessment tools for staff and client safety have been adapted by other Health Boards in Wales and will be part of the implementation.

4.5.3 The HIW National Report and Maternity Vision references the need for appropriate levels of breastfeeding advice, guidance and support at all times. The Welsh Government Infant Feeding Action Plan has been on hold due to the COVID19 pandemic. As part of Start Well Partnership renewal priorities the Powys Infant Feeding Action Plan will be resumed. A business case will need to be developed for consideration for the implementation Welsh Government Recommendation 4 for all Wales Breastfeeding Action Plan for Strategic Lead for Breastfeeding.

5. External scrutiny

The Welsh Government Maternity and Neonatal Performance Board was held in July 2021, chaired by the Interim Chief Nursing Officer for Wales. The outcome letter is anticipated during the autumn 2021, will further inform the development of the Powys Maternity Improvement Plan.

In terms of regulator engagement for provided services, HIW have accepted the health board's improvement plan, developed using self-assessment against the national recommendations. HIW have stated that the previously planned phase 2 has been reconsidered and a risk-based inspection and review programme will be progressed, seek assurances through follow up work. The correspondence advises by summer 2022, HIW will commence stage two requesting updates on progress against the national recommendations.

Next Steps

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

Ockenden Report Assurance Committee

Ockenden Report Action Plan: Progress to Date

Date: 23 September 2021

Presenters:

Martyn Underwood

- *Medical Director, Women's & Children's Division*
- *Senior Responsible Officer, Maternity Transformation Programme*

Guy Calcott

- *Consultant, Obstetrics and Gynaecology*
- *Workstream Lead: Clinical Quality & Choice*

Background to the plan: The 52 action items

Summary of the requirements set out in the Ockenden Report

Background to the First Ockenden Report

The Shrewsbury and Telford Hospital NHS Trust

- Independent review established following a number of serious clinical incidents beginning, in 2009.
- Commissioned by the then-Secretary of State for Health.
- Led by an independent Chair, Donna Ockenden, supported by a multi-disciplinary Review Team.
- Direct contributions from the affected families.
- Report and action plan based on 250 clinical reviews.
- Published in December 2020.
- Final report expected end of 2021.

Background to plan: The 52 action items

The Shrewsbury and Telford Hospital NHS Trust

Ockenden Report Action Plan	Local Actions for Learning (LAFL)	4 Themes	1. Maternity care	27 Actions	52 Total Actions
			2. Maternal deaths		
			3. Obstetric anaesthesia		
			4. Neonatal service		
	Immediate and Essential Actions (IEA)	7 Themes	1. Enhanced safety	25 actions	
			2. Listening to women & families		
			3. Staff training & working together		
			4. Managing complex pregnancy		
			5. Risk assessment throughout pregnancy		
			6. Monitoring fetal wellbeing		
			7. Informed consent		

Local Actions for Learning (LAFL) summary

The Shrewsbury and Telford Hospital NHS Trust

LAFL (4 themes) ***Only applicable to SaTH***	1. Maternity care *13 Actions*	Risk assessment, supporting and enabling informed choice, resourcing of fetal monitoring and governance teams *Actions 4.54 - 4.66 inclusive*	27 Actions
	2. Maternal deaths *3 Actions*	Escalation and referral pathways, multi-disciplinary specialist input and planning, named consultant overseeing care *Actions 4.72 - 4.74 inclusive*	
	3. Obstetric anaesthesia *7 Actions*	Inclusion and input of obstetric anaesthetists in the wider maternity team, including training, incident review and audits *Actions 4.85 - 4.91 inclusive*	
	4. Neonatal service *4 Actions*	Combined notes, consultation with tertiary units, staff resourcing and observational attachments *Actions 4.97 - 4.100 inclusive*	

Immediate and Essential Actions (IEA) summary

The Shrewsbury and Telford Hospital NHS Trust

IEA (7 themes) ***All NHS Providers of Maternity Services***	1. Enhanced safety *6 Actions*	Incident Investigation: working with LMNS and Trust Board to review all serious incidents *IEA 1.1, 1.2, 1.3, 1.4, 1.5 & 1.6*	25 actions
	2. Listening to women & families *4 Actions*	Maternity Voice Partners (MVP): Working with MVP to ensure women and families are listened to *IEA 2.1, 2.2, 2.3 & 2.4*	
	3. Staff training & working together *3 Actions*	Multidisciplinary training: Ensure that staff train and work together efficiently *IEA 3.1, 3.2 & 3.3*	
	4. Managing complex pregnancy *4 Actions*	Named consultants: Ensure there is a robust pathway for complex pregnancies *IEA 4.1, 4.2, 4.3 & 4.4*	
	5. Risk assessment throughout pregnancy *2 Actions*	Antenatal care pathways: Ensure thorough risk assessments are in place *IEA 5.1 & 5.2*	
	6. Monitoring Fetal Wellbeing *3 Actions*	Saving Babies Lives v2: Appoint fetal monitoring leads and implement SBLv2 *IEA 6.1, 6.2 & 6.3*	
	7. Informed consent *3 Actions*	Respect of choice: Ensure all information is available to women in different formats (leaflets, video, web, etc.) *IEA 7.1, 7.2 & 7.3*	

Delivery and Progress Rates to Date

The latest statuses as accepted by the Maternity Transformation Assurance Committee at their monthly meeting 14/09/21

Colour coding: delivery & progress reverse RAG rating

The Shrewsbury and Telford Hospital NHS Trust

Delivery Status

Colour	Status	Description
	Not yet Delivered	Action is not yet in place, there are outstanding tasks to deliver.
	Delivered, not yet Evidenced	Action is in place with all tasks completed, but has not yet been assured/evidenced as delivering the required improvements.
	Evidenced and Assured	Action is in place; with assurance/evidence that the action has been/continued to be addressed.

Progress Status

Colour	Status	Description
	Not Started	Work on the tasks required to deliver this action has not yet started.
	Off Track	Achievement of the action has missed or the scheduled deadline. An exception report must be created to explain why, along with mitigating actions, where possible.
	At Risk	There is a risk that achievement of the action may miss the scheduled deadline or quality tolerances, but the owner judges that this can be remedied without needing to escalate. An exception report must nonetheless be created to explain why exception may occur, along with mitigating actions, where possible.
	On Track	Work to deliver this action is underway and expected to meet deadline and quality tolerances.
	Complete	The work to deliver this action has been completed and there is assurance/evidence that the action is being delivered and sustained.

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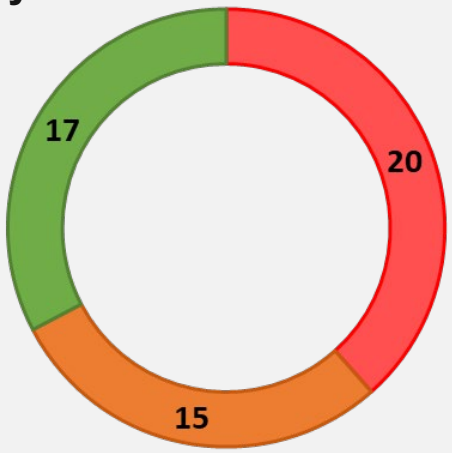
Delivery & Progress of the 52 Actions (Sep 21)

The Shrewsbury and Telford Hospital NHS Trust

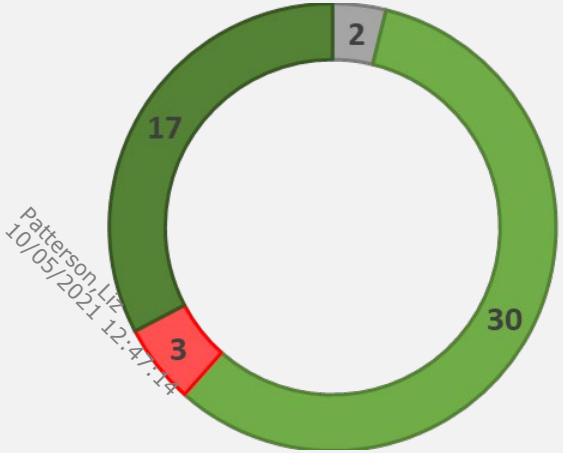
Delivery Status



- Evidenced & Assured
- Delivered, Not Yet Evidenced
- Not Yet Delivered

32 Actions Delivered (62% overall):
- 17 (33%) Evidenced & Assured
- 15 (29%) Delivered, Not Yet Evidenced

Progress Status



- Complete
- On Track
- At Risk
- Off Track
- Not Started

32 Actions Implemented (62% overall):
- 17 (33%) Complete
- 30 (58%) On Track
  - 15 On Track (Embedding)
  - 15 On Track (Delivery)

Assurance and Governance

How is SaTH providing assurance that the actions are fully implemented, and embedded so that they will continue to be adhered to and sustained?

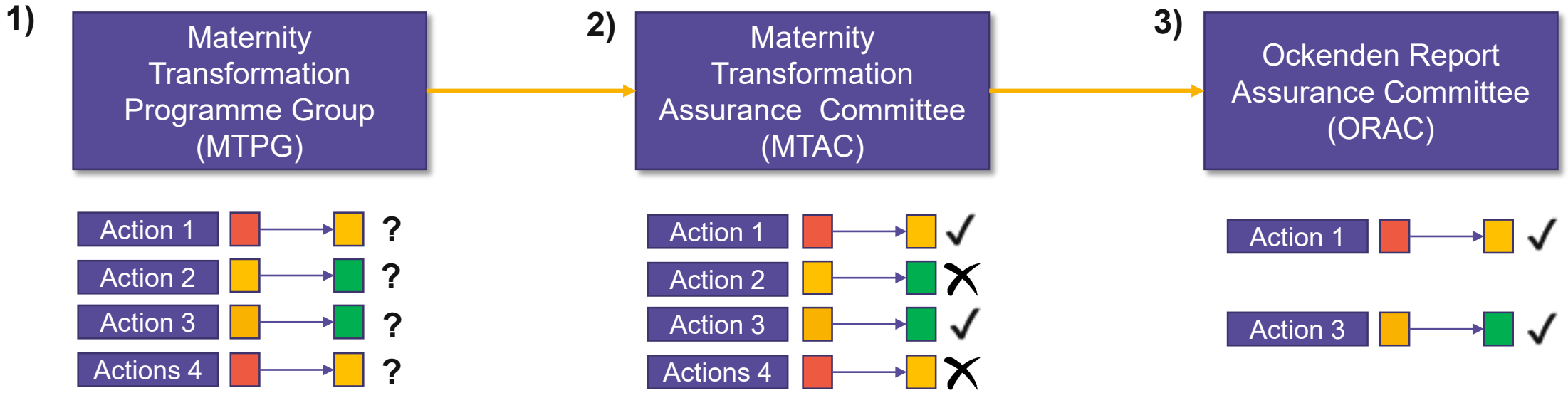
Ockenden Actions split into 6 workstreams

The Shrewsbury and Telford Hospital NHS Trust

1. Clinical Quality & Choice	2. People & Culture	3. Governance & Risk	4. Learning, Partnerships & Research	5. Communications & Engagements	6. Maternity Improvement Plan
					
Guy Calcott Consultant – Obstetrics and Gynaecology	**Vicki Robinson** HRBP Women and Children's Division	**Shirley Jones** Interim Head of Midwifery	**Will Parry-Smith** Consultant – Obstetrics and Gynaecology	**Mei-See Hon** Clinical Director – Obstetrics	**Shirley Jones** Interim Head of Midwifery

Assurance and Governance process

The Shrewsbury and Telford Hospital NHS Trust



- Raise, manage and escalate risks & issues
- Oversee finance
- Document lessons learnt & best practice
- Review & propose status changes

- Review completion evidence
- Accept/Reject status change proposals
- Review and agree exception reports/change requests
- Act upon escalated risks & issues
- Provide forum for stakeholder input & discussion
- Agree key assurance topics for discussion at ORAC

- To provide assurance of Ockenden completion
- Sub committee of Board of Directors
- Independent co-chair
- Stakeholder involvement
- Live-streamed to public

The Ockenden Report Assurance Committee

Review of topics covered to date, reminder of the initial concept of the Committee, and reflections on assurance provided to date

ORAC: why was it established?

The Shrewsbury and Telford Hospital NHS Trust

- The Ockenden Report Assurance Committee is designed to improve accountability and transparency.

  - ✓ Provides dedicated time, specific to the completion of Ockenden Actions.
  - ✓ Is a subcommittee of the Board of Directors.
  - ✓ Has an independent co-chair (alongside the Trust's Chair).
  - ✓ Ensures stakeholder involvement:
    - Maternity Voices Partnership
    - Healthwatch
    - Local Maternity and Neonatal System and Clinical Commissioning Group
    - Sherwood Forest Hospitals NHS Foundation Trust
    - Richard Kennedy – Associate Medical Director, NHSE/I Midlands Region
  - ✓ Is live-streamed to the public.
  - ✓ Invites questions from the public.

- Five ORAC meetings have been held so far, with this being the 6th Meeting.

ORAC: Topics discussed so far

The Shrewsbury and Telford Hospital NHS Trust

Month	Topic	Presenter(s)
25 March 2021	• LAFL Theme 1: Maternity Care	Dr Mei-See Hon Mr Martyn Underwood
22 April 2021	• IEA 1: Enhanced Safety • LAFL Theme 2: Maternal Deaths • LAFL Theme 4: Neonatal Services	Dr Mei-See Hon Mr Martyn Underwood
27 May 2021	• Review of the Ockenden Report Action Plan and current progress status • IEA 2: Listening to Women and Families • IEA 3: Staff Training and Working Together • IEA 4: Managing Complex Pregnancies • IEA 5: Risk Assessment Throughout Pregnancy • IEA 6: Managing Complex Pregnancies • IEA 7: Informed Consent	Mr Guy Calcott
24 June 2021	• Saving Babies' Lives (LAFL 4.57) : Background and SaTH's progress in implementing the Care Bundle	Ms Lindsey Reid Mr Guy Calcott
22 July 2021	• Obstetric Anaesthesia	Dr Lorien Branfield

Tangible benefits so far delivered as a result of implementing the Ockenden Report's actions

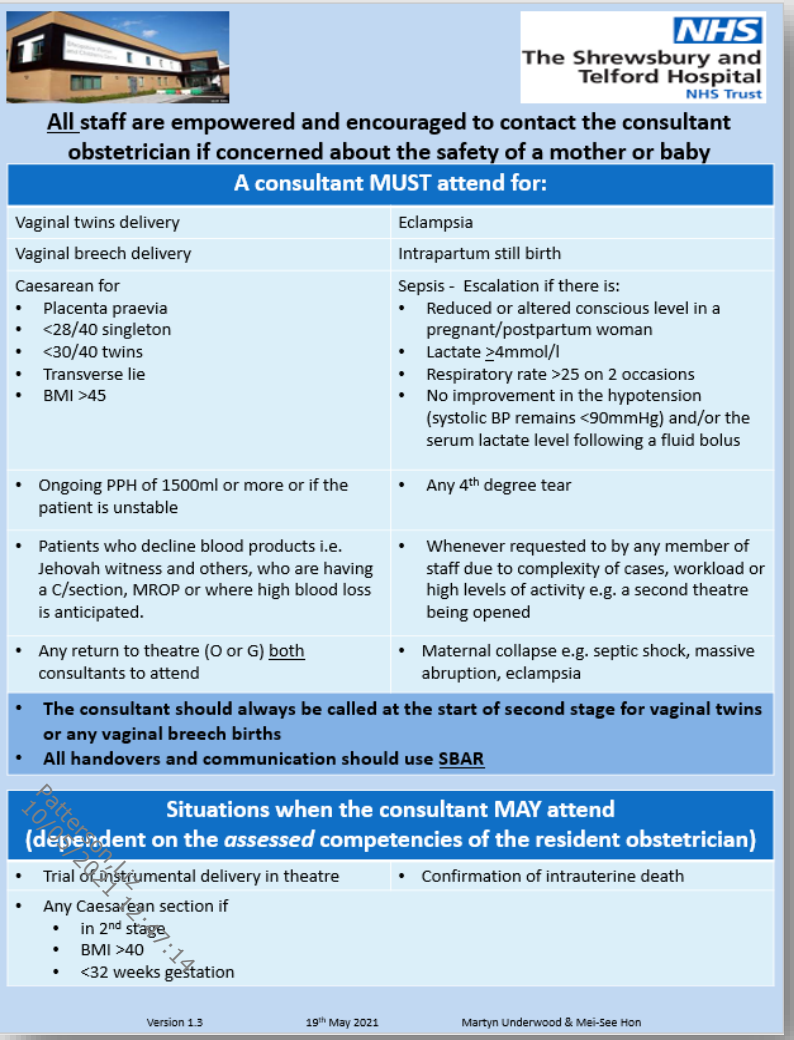
LAFL Theme 1 – Maternity Care

The Shrewsbury and Telford Hospital NHS Trust

- ✓ Clinical Referral Team established.
- ✓ Updated birth information introduced.
- ✓ Two fetal monitoring champion midwives brought into post.
- ✓ Full delivery of Saving Babies' Lives care bundle.
- ✓ Cardio Tocography (CTG) guidelines validated by Clinical Network and audit completed to prove compliance.
- ✓ Partnered Clinical Governance review started, and three additional specialist midwives recruited to the team (in post in next few weeks).
- ✓ Multi-disciplinary twice-daily ward rounds are in place.

LAFL Theme 2 – Maternal Deaths

The Shrewsbury and Telford Hospital NHS Trust



The Shrewsbury and Telford Hospital NHS Trust

All staff are empowered and encouraged to contact the consultant obstetrician if concerned about the safety of a mother or baby

A consultant MUST attend for:	
Vaginal twins delivery	Eclampsia
Vaginal breech delivery	Intrapartum still birth
Caesarean for • Placenta praevia • <28/40 singleton • <30/40 twins • Transverse lie • BMI >45	Sepsis - Escalation if there is: • Reduced or altered conscious level in a pregnant/postpartum woman • Lactate ≥4mmol/l • Respiratory rate >25 on 2 occasions • No improvement in the hypotension (systolic BP remains <90mmHg) and/or the serum lactate level following a fluid bolus
• Ongoing PPH of 1500ml or more or if the patient is unstable	• Any 4th degree tear
• Patients who decline blood products i.e. Jehovah witness and others, who are having a C/section, MROP or where high blood loss is anticipated.	• Whenever requested to by any member of staff due to complexity of cases, workload or high levels of activity e.g. a second theatre being opened
• Any return to theatre (O or G) both consultants to attend	• Maternal collapse e.g. septic shock, massive abruption, eclampsia
• **The consultant should always be called at the start of second stage for vaginal twins or any vaginal breech births** • **All handovers and communication should use SBAR**	
Situations when the consultant MAY attend (dependent on the *assessed* competencies of the resident obstetrician)	
• Trial of instrumental delivery in theatre	• Confirmation of intrauterine death
• Any Caesarean section if • in 2nd stage • BMI >40 • <32 weeks gestation	

Version 1.3 19th May 2021 Martyn Underwood & Mei-See Hon

- ✓ Escalation policy for junior obstetric staff and midwives on when to involve the consultant have been updated.
- ✓ Engagement with the soon-to-be-established specialist maternal medicine centres is in place and will inform referral pathways.
- ✓ More than 100 midwife and obstetrician places secured (25 booked for November) in Baby Lifeline's 'Recognition and Management of the Sick and Deteriorating Woman' course.

LAFL Theme 3 – Obstetric Anaesthesia

The Shrewsbury and Telford Hospital NHS Trust

- ✓ Anaesthetists involved in the multi-disciplinary ward rounds.
- ✓ Obstetric Anaesthetic lead playing key role in development of ‘enhanced maternity care’ proposal and guideline.
- ✓ Anaesthetic audit requirements included in the bespoke Ockenden Report case notes audit tool (LAFL 4.89).
- ✓ Anaesthetic consultants >90% compliance with online PROMPT training achieved.
- ✓ Multi-disciplinary skills-drills and simulation training taking place.
- ✓ Evidenced compliance with anaesthetics-related sections of Clinical Negligence Scheme for Trusts Safety Action 8.

Dr Prafulla Gulati – Anaesthetic Consultant

LAFL Theme 4 – Neonatal Service

Dr Sanjeev Deshpande – Clinical Director, Neonatal Unit

- ✓ Combined nursing and medical notes implemented.
- ✓ 7th consultant recruited; intended start date of January 2022.
- ✓ Rotational attachments to tertiary units to commence in October 2021.
- ✓ Escalation policy to tertiary units in line with Neonatal Operational Delivery Network, British Association of Perinatal Medicine and NHSE guidelines; externally checked and validated (by NHSE/I regional colleagues).

IEA Theme 1 – Enhanced Safety and IEA 2 – Listening to women & families

Ms Emily Evans – MVP Chair

IEA 1

- Audit confirms appropriate involvement of external experts in investigations.
- Strong links with LMNS/CCG include membership of Senior Quality Lead and Patient Safety Specialist in SaTH's Maternity & Neonatal Safety Champions Group.

IEA 2

- Maternity Voice Partnership (MVP)-SaTH co-produced 'User Experience (UX) System' now in its second cycle with more than 80 inputs received from staff and service users.
- Active Non-Executive Director and Board-level Executive participation in Safety Champions group.
- Improvements underway to SaTH's digital offering.

IEA Theme 3 – Staff training together and working together

The Shrewsbury and Telford Hospital NHS Trust

IEA 3

- ✓ LMNS-funded £360k investment includes simulation kit for multi-disciplinary training – significant quantity already acquired.
- ✓ SaTH investment of £190k in external training, including care and management of sick/deteriorating women, learning from adverse events, CTG masterclass and more. Multiple places already booked / attended.
- ✓ PROMPT yearly package, including 'train-the-trainer' acquired.
- ✓ Ring-fenced funding for MDT and EFM training.

Mr William Parry-Smith
Consultant, Obstetrics and Gynaecology

IEA Theme 4 – Managing Complex Pregnancies & IEA Theme 5 – Risk Assessment throughout Pregnancy

The Shrewsbury and Telford Hospital NHS Trust

IEA 4

- ✓ Recruitment of eight additional obstetric consultants – six in post, two more yet to be appointed – with the aim of providing 24/7 residential consultants.
- ✓ Ongoing liaison with new regional specialist maternal medicine centres to inform referral pathways.
- ✓ SaTH successful early adopter of Perinatal Mental Healthcare Clinic; successful bid and ongoing rollout achieved by Transformation Midwife.

IEA 5

- ✓ Bespoke audit tool in development to monitor compliance with risk assessment processes at antenatal appointments and during intrapartum phase.
- ✓ First bookings commenced via Badgernet EPR system in August 2021.

Dr Mei-See Hon
Clinical Director, Obstetrics

IEA Theme 6 – Monitoring Fetal Wellbeing

Ms Becky Hanlon
Midwife

IEA 6

- ✓ Named consultant plus two specialist midwife champions in post.
- ✓ Active delivery of training and improving practice.
- ✓ Multiple places booked for clinical staff on Baby Lifeline's 'CTG Masterclass' course.
- ✓ Ongoing audits of compliance with CTG guidelines.

IEA Theme 7 – Informed Consent

The Shrewsbury and Telford Hospital NHS Trust

IEA 7

- ✓ Promotion of BabyBuddy app v2.0 in partnership with MVP; co-production of ‘My Personal Care and Support Plan’
- ✓ Co-produced MVP / SaTH ‘User Experience (UX) System’ yielding significant service user and staff input
- ✓ New Badgernet system is providing digitalised content and provides prompts where information has not been accessed, triggering staff to offer additional support
- ✓ Birth Options clinic up and running

Actions currently off-track

Actions that have missed their (internally imposed) deadlines, the reasons for this delay, the mitigations put in place and the plans to get them back on track

Actions Currently Off-track (1 of 2)

The Shrewsbury and Telford Hospital NHS Trust

Reference	Description	Reason for delay	Mitigation / Recovery Plan
LAFL 4.59	The maternity department clinical governance structure and team must be appropriately resourced so that investigations of all cases with adverse outcomes take place in a timely manner.	Recent staff turnover in the divisional clinical governance team put back the delivery of this action.	The Trust has appointed a new Head of Clinical Governance. The divisional Clinical Governance team has appointed a new Risk and Governance lead midwife, with two specialist deputies – funded by NHSE/I.

Actions Currently Off-track (2 of 2)

The Shrewsbury and Telford Hospital NHS Trust

Reference	Description	Reason for delay	Mitigation / Recovery Plan
LAFL 4.60	The maternity department clinical governance structure must include a multidisciplinary team structure, trust risk representation, clear auditable systems of identification and review of cases of potential harm, adverse outcomes and serious incidents in line with the NHS England Serious Incident Framework 2015.	The initial internally-set deadline for this action did not allow for the complexity of its implementation.	SaTH is compliant with Safety Action 1 of CNST and working towards full compliance with Safety Action 10. The divisional clinical governance team has been enhanced with the inclusion of three specialist midwives. A governance review, partnered with Sherwood Forest Hospitals NHS Foundation Trust is underway.

Note: LAFL 4.73 is also Off Track: this is covered in the 'External Dependencies' section of this presentation.

Next steps

Next steps

The Shrewsbury and Telford Hospital NHS Trust

Milestone	Area affected	Date
Completion amendments to the Case Notes Audit tool, and launch second audit round	All workstreams	Oct 2021
Implementation of split Tier 2 rotation and first round of observational attachments at Tier 3 Units Oct	Neonatal staff	Oct 2021
Sands review, to inform National Bereavement Care Pathway adoption	Bereavement Care	Nov 2021
Prepare to receive and plan the implementation of the Final Ockenden Report	All workstreams	Winter 2021
Review of Ockenden actions related to integration of Obstetric Anaesthesia in wider maternity team, to test level of completion	Obstetric Anaesthesia	Mar 2022
Evidenced completion of the partnered Governance Review	Governance & Risk	Spring 2022

Ockenden Actions with external dependencies

These actions are not within SaTH's control to implement independently.

Further clarity / action is needed from external parties in order to proceed.

Any sub-actions that can be completed internally, are underway

Ockenden Actions with External Dependencies (1 of 2)

The Shrewsbury and Telford Hospital NHS Trust

Reference	Description
LAFL 4.73	Women with pre-existing medical co-morbidities must be seen in a timely manner by a multidisciplinary specialist team and an individual management plan formulated in agreement with the mother to be. This must include a pathway for referral to a specialist maternal medicine centre for consultation and/or continuation of care at an early stage of the pregnancy.
IEA 1.3	LMS must be given greater responsibility and accountability so that they can ensure the maternity services they represent provide safe services for all who access them.
IEA 1.4	An LMS cannot function as one maternity service only.
IEA 2.1	Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards.

Ockenden Actions with External Dependencies (2 of 2)

The Shrewsbury and Telford Hospital NHS Trust

Reference	Description
IEA 2.2	The advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome.
IEA 2.4	CQC inspections must include an assessment of whether women's voices are truly heard by the maternity service through the active and meaningful involvement of the Maternity Voices Partnership.
IEA 4.3	The development of maternal medicine specialist centres as a regional hub and spoke model must be an urgent national priority to allow early discussion of complex maternity cases with expert clinicians.

Thank you

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

AGENDA ITEM: 3.6

Patient Experience Quality and Safety Committee	**7 October 2021**
Subject:	**COMMISSIONING ESCALATION REPORT**
Approved and Presented by:	Director of Planning and Performance Director of Nursing and Midwifery
Prepared by:	Assistant Director Transformation and Value
Other Committees and meetings considered at:	Executive Committee 22 September 2021 Scores were considered on the 18th August 2021 at the Internal Commissioning Assurance Meeting; the Executive Committee Delivery and Performance Group on the 26th August; and the Delivery and Performance Committee on the 2nd September 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 and Safety Committee the providers in Special Measures or scored as Level 4 under the PTHB Commissioning Assurance Framework.

RECOMMENDATION(S):

It is recommended that the Patient Experience, Quality and Safety Committee DISCUSSES this Commissioning Escalation 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	✓

EXECUTIVE SUMMARY:

This report highlights providers in Special Measures or scored as Level 4 and above following the 18th 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 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).

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 Service Group 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 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, widespread elective care delays are at an unprecedented level due to the pandemic. The Public Health support assisting with the interpretation of the Clinical Health Knowledge System results, which was diverted to COVID 19 outbreak work, is being restarted focusing on maternity services.

Special Measures					
Provider	**Area of Measure**	**June 2021**	**July 2021**	**August 2021**	**Change in Status**
Shrewsbury and Telford Hospital NHS Trust	Quality & Safety				↔
	Patient Experience				
	Access				
	Finance	BLOCK AGREEMENT			
	Governance & Strategic Change	NOT RATED			
Cwm Taf Morgannwg University Health Board (Maternity)	Quality & Safety				↔
	Patient Experience				
	Access				
	Finance	BLOCK AGREEMENT			
	Governance & Strategic Change	NOT RATED			

Level 4					
Provider	**Area of Measure**	**June 2021**	**July 2021**	**August 2021**	**Change in Status**
Wye Valley NHS Trust	Quality & Safety				↔
	Patient Experience				
	Access				
	Finance	BLOCK AGREEMENT			
	Governance & Strategic Change	NOT RATED			

1. Shrewsbury and Telford Hospitals NHS Trust (SATH)

Special Measures					
Provider	**Area of Measure**	**June 2021**	**July 2021**	**August 2021**	**Change in Status**
Shrewsbury and Telford Hospital NHS Trust	Quality & Safety				↔
	Patient Experience				
	Access				
	Finance	BLOCK AGREEMENT			
	Governance & Strategic Change	NOT RATED			

As previously reported to the Experience, Quality and Safety Committee (EQS) 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:

- Maternity Services, current status reported to Committee separately
- 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
- the oversight of audits and the improvement of outcomes
- the culture.

Reports on these matters have been considered by EQS this year on the 4th February 2021, 15th April, 2021, 3rd June, 2021 and 15th July 2021. The Performance and Resources Committee has also been updated, most recently on the 2nd September, 2021. Key issues reported to the SaTH Board on 5th August, 2021, are summarised below.

- The Trust is continuing to focus on the implementation of its quality strategy and the delivery of its quality improvement plans, ensuring that those plans fully respond to the findings of recent reviews (including the Independent Review of Maternity Services).
- During July the CQC has carried out further inspections and the Trust is working to address the feedback and the formal inspection reports are awaited.
- The Trust reports that it has received positive feedback from GIRFT (Getting It Right First Time) on its acute medicine service and was commended for its length of stay and low readmission rates.
- The Trust is attempting to improve its response to patients when concerns are raised and is introducing a new simplified process with the aim of reducing delays.

- During June attendances at the Emergency Department have exceeded those seen prior to the pandemic. This is putting pressure on the ED and on ambulance handovers. The Trust has been maintaining infection control measures, but as a result has not been able to safely increase the occupancy in clinical areas to support the increased activity.
- There has been an increase in the restoration of elective activity and orthopaedic surgery has recommenced.
- Early indications are that the Trust's recovery across Outpatients, In-Patients and Day cases exceeded the 80% threshold set by NHSEI for June.
- A Vanguard theatre is being used to increase surgical capacity. There are theatre staffing shortages and in-sourcing is being secured. Recruitment is also underway and theatre apprentices are being developed for longer term sustainability.
- Expanded elective inpatient capacity was implemented at the end of June; which will put additional pressure on emergency care capacity but is vital to reduce waiting lists.
- The regional mobile CT scanner left SATH at the start of June, and the service is prioritising urgent and cancer activity (and any routine activity where possible) until new capacity comes on line at the start of September 2021. Radiology staffing is also pressured, and is limiting some restoration of services.
- Cancer activity has also returned to above pre-Covid-19 levels, and a number of specialty areas are challenged. The Breast service is steadily returning to a two week wait time (although it was at 16 days at start of June). Pressure remains in Urology, Colorectal and Lung services.
- The Trust's view is that diagnostic recovery is progressing well despite recruitment challenges. As well as a new CT and MRI pod, which is due to open, improvements are being made to increase endoscopy capacity.
- During 2020/21 there were 13 confirmed inpatient deaths of people diagnosed with learning disabilities. The cases have undergone an internal speciality mortality review and have additionally been reviewed through the "Learning from Deaths" process. No preventable factors were identified through these reviews.

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.

"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".

The Clinical Negligence Scheme for Trusts (CNST) in England sets out ten maternity safety standards which have to be met in full in order to receive an Maternity Incentive Scheme payment. There are four standards with which the Trust is not yet compliant.

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 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 NHS partners in England 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.

Special Measures					
Provider	**Area of Measure**	**June 2021**	**July 2021**	**August 2021**	**Change in Status**
Cwm Taf Morgannwg University Health Board (Maternity)	Quality & Safety				↔
	Patient Experience				
	Access				
	Finance	BLOCK AGREEMENT			
	Governance & Strategic Change	NOT RATED			

Whilst PTHB transferred emergency pathways for the majority of South Powys to PCH, in line with the outcome of public consultation on the findings of the South Wales Programme, approved by boards and WAST in 2014, it has not transferred obstetric and neonatal pathways. Detailed information in relation to maternity and neonatal services provided by CTMUHB is included within the maternity services paper, presented at today's Committee, including further work being undertaken by the Independent Maternity Oversight Panel (IMSOP) and the actions required to ensure neonatal services are safe, effective, well led and importantly integrated with the maternity service to provide a seamless service for women and babies.

PTHB provides maternity services within county. At present in South Powys, when obstetric and neonatal care is needed, pathways predominantly involve Aneurin Bevan University Health Board (although there remains a small pre-existing flow to CTMUHB).

Under Phase 2 of PTHB South Powys Programme a Maternity and Neonatal workstream is in place, chaired by the Executive Director of Nursing and Midwifery for PTHB, with senior clinical involvement from CTMUHB and ABUHB. PTHB continues to monitor the situation and pathways carefully. A Maternity Assurance Framework is in place and assurance information in relation to neonatal services will be further strengthened. Recommendations to the Board in relation to strategic maternity and neonatal pathways will need to be informed by the reports above when available.

Whilst it is recognised that CTMUHB are in special measures for maternity services only, given the transfer of emergency pathways to PCH, a more detailed overview in terms of the wider offer will be provided to the next Committee.

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.

Immediate and short-term actions are required as a result of the interim findings of a deep dive into neonatal care by the Panel. 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 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.

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 3.7

Patient Experience, Quality & Safety Committee	**Date of Meeting: 7 October 2021**
Subject :	**Clinical Quality Framework: Goal 5, Intelligence**
Approved and Presented by:	**Director of Public Health**
Prepared by:	**Director of Public Health**
Other Committees and meetings considered at:	**Executive Committee (22/09/21)**

PURPOSE:
This paper provides a briefing on Goal 5 of the Health Board's *Improving Clinical Quality Framework*. The title of Goal 5 is to "Develop Excellent Information and Intelligence Systems, to Enable High Quality Clinical Care".
RECOMMENDATION(S):
The PEQS Committee is asked to NOTE and DISCUSS the content 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	
	6. Promote Innovative Environments	✓

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

EXECUTIVE SUMMARY:

This paper provides a summary of progress in implementing the actions set out under Goal 5 of the Health Board's *Improving Clinical Quality Framework.* There are four actions under Goal 5, two of which have had work taken forward, and two of which require further work to define and describe their scope. The paper also notes two more recent developments; a draft report from Audit Wales and a Welsh Government quality framework, recognising that there is a need to align elements of these two documents under Goal 5 to recognise their contribution to the aim of this goal.

DETAILED BACKGROUND AND ASSESSMENT:

In the Health Board's *Improving Clinical Quality Framework*, the title of Goal 5 is to "Develop Excellent Information and Intelligence Systems, to Enable High Quality Clinical Care". Within the action plan, this aim is broken down into four actions:

PTHB Improving Clinical Quality Framework (Goal 5)

1. Review and develop performance monitoring arrangements for clinical services; aligning to work undertaken on [the] Commissioning Assurance Framework(s).
2. Review and develop ward/department and service-level dashboards.
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.
4. Develop/integrate a valid and robust organisational benchmarking approach, using national/international comparators where available.

The current position in relation to each of these actions is described below.

In respect of the first action, 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.

The second action 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.

The scope of actions 3 and 4 are extremely broad and wide ranging, and need to be described further in relation to deliverable outcomes. This is a piece of work that is still to be done.

Subsequent to the PTHB *Improving Clinical Quality Framework* being developed, PTHB participated in an Audit Wales review of quality and safety arrangements during April-June 2021. Through the review, Audit Wales found a clear commitment in PTHB to ensure the provision of safe and high-quality services, supported by corporate frameworks and improving risk management. Some scope was identified to develop clearer quality priorities and success measures to measure impact and improvement. The Audit Wales review is draft at the time of writing, but it does contain recommendations which directly relate to Goal 5:

Audit Wales Review of Quality Governance Arrangements

Commissioning Assurance Framework
R1 Review the Commissioning Assurance Framework to include measures on the standards of care provided or patient outcomes.

Performance Measures
R5 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.

Data Analytics
R8 Ensure that there is sufficient data analytics capacity for analysing and interpreting data on quality and safety both corporately and operationally.

The review is still draft, however, the recommendations are unlikely to change and work now needs to be done aligning the response with Goal 5, recognising the contribution these recommendations will make to information and intelligence about quality.

More recently, on the 17th September, Welsh Government published a *Quality and Safety Framework* for the NHS with the stated aim of ensuring quality and safety is firmly placed at the heart of NHS healthcare provision. The document contains a total of 15 actions, two of which directly relate to the aim of Goal 5:

Welsh Government. Quality and Safety Framework: Learning and Improving

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.

Given both the local recommendations arising from the Audit Wales review and a new national framework document, a re-alignment and re-statement of the actions under Goal 5 will be a next step to reflect these more recent developments.

NEXT STEPS:

1. Align both Audit Wales and Welsh Government actions to Goal 5 to better describe the range of actions taking place, and to re-define existing actions 3 and 4.
2. Continue to refine the internal performance monitoring arrangements underpinned by the CAF.
3. Continue work with Improvement Cymru to implement a ward level programme of quality surveillance and improvement.

PATIENT EXPERIENCE, QUALITY & SAFETY COMMITTEE
PROGRAMME OF BUSINESS AUGUST 2021- MARCH 22

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

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

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

Throughout the COVID-19 pandemic, the Board has continued to review its governance arrangements to ensure that they remain appropriate whilst agile enough to meet the demands placed upon the organisation. The Board is aware of the increasing pressures that have been placed on the health and social care system over the last few months. The Board is therefore committed to ensuring that, as we move into Quarters 3 & 4 of 2021/22, Board's business, and that of its committees, remains focussed on its key priorities and strategic risks.

The Committee was constituted at the meeting of Board in July 2021 and the programme of business has been set for the remainder of the Corporate Year.

MATTER TO BE CONSIDERED BY COMMITTEE	EXEC LEAD	SCHEDULED COMMITTEE DATES 2021-22					
					07 Oct	02 Dec	03 Feb
Annual Reports							
Putting Things Right Annual Report	DNM				✓		
Public Services Ombudsman Annual Report	DNM				✓		
Annual Report of the Accountable Officer for Controlled Drugs	MD						✓
Safeguarding Annual Report	DNM					✓	
Annual Report of the Caldicott Guardian	MD						✓
Annual Quality Statement	DNM						Dependent on WG timeframes
Quality & Safety Assurance Reports							
Clinical Quality Framework Implementation Plan	DNM				✓ (Goal 5)		✓
Annual Clinical Audit Programme	MD/DPCCMH						
Clinical Audit Report	MD						✓
Pharmacy & Medicines Management Assurance Report	MD						✓
Quality Performance Report (Provided and Commissioned Services)	DNM				✓	✓	✓

MATTER TO BE CONSIDERED BY COMMITTEE	EXEC LEAD	SCHEDULED COMMITTEE DATES 2021-22					
					07 Oct	02 Dec	03 Feb
Integrated Quality Report, Directorate of Primary, Community Care and MH					✓		✓
Quality Governance Oversight Arrangements in Primary Care						✓	
Serious Incidents and Concerns Report	DNM				✓	✓	✓
Inspections and External Bodies Report and Action Tracking	DNM				✓	✓	✓
Mortality Reporting	MD					✓	
Mental Health Act Compliance & Powers of Discharge	DPCCMH						✓
Quality Improvement Programme	MD					✓	
Infection Prevention & Control Report	DNM				✓		✓
Safeguarding Report	DNM						✓
Audit Wales Review: Quality Governance and PTHB Management Response	DPCCMH					✓	

MATTER TO BE CONSIDERED BY COMMITTEE	EXEC LEAD	SCHEDULED COMMITTEE DATES 2021-22					
					07 Oct	02 Dec	03 Feb
Additional reports Scheduled as an Organisational Priority/Strategic Risk							
Maternity Services Assurance Framework	DNM				✓		✓
Commissioning Arrangements: Shrewsbury & Telford Hospitals NHS Trust	DNM				✓	✓	✓
Maternity Update Report (SATH, Ockenden Review and HIW)	DNM				✓		✓
Once for Wales Complaints Management System (DATIX) Implementation Update	DF&IT					✓	
Refreshed Patient Experience Framework	DNM						✓
Quality & Engagement (Wales) Act: Implementation Update	DNM						✓
Approach to assessing harm from COVID-19	MD					✓	
Research and Innovation Report	MD					✓	
Committee Governance Reports							
Policies Delegated from the Board for Review and Approval	BS	**As and when identified**					

MATTER TO BE CONSIDERED BY COMMITTEE	EXEC LEAD	SCHEDULED COMMITTEE DATES 2021-22					
					07 Oct	02 Dec	03 Feb
Review of Committee Programme of Business	BS				✓	✓	✓
Committee Requirements as set out in Standing Orders							
Development of Committee Annual Programme Business	BS					✓	✓
Annual Review of Committee Terms of Reference 2021-22	BS					✓	✓
Annual Self-assessment of Committee effectiveness 2021-22	BS						✓
The Committee will meet in a closed session to discuss any matters deemed of a confidential and/or sensitive nature, including where reports include patient identifiable information							

KEY:

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

POWYS TEACHING HEALTH BOARD
EXPERIENCE, QUALITY & SAFETY COMMITTEE

CONFIRMED

MINUTES OF THE MEETING HELD ON THURSDAY 15 JULY 2021 VIA MICROSOFT TEAMS

Present:	
Melamine Davies	Vice-Chair (Committee Chair)
Trish Buchan	Independent Member
Frances Gerrard	Independent Member
Susan Newport	Independent Member
In Attendance:	
Carol Shillabeer	Chief Executive Director
Alison Davies	Director of Nursing and Midwifery
Kate Wright	Medical Director
Claire Madsen	Director of Therapies and Health Sciences
Wendy Morgan	Assistant Director of Quality and Safety
Jamie Marchant	Director of Primary, Community Care and Mental Health.
Rani Mallison	Board Secretary
Joy Garfitt	Assistant Director for Mental Health Services (Item 3.1 only)
Jayne Lawrence	Assistant Director of Primary Care Services (Item 3.2 only)
Marie Davies	Deputy Director of Nursing
Observers:	
Sara Utley	Audit Wales
Rebecca Collier	Healthcare Inspectorate Wales (HIW)
Ian Virgil	NWSSP – Head of Internal Audit
Apologies for absence:	
Julie Rowles	Director of Workforce, OD and Support Services
Stuart Bourne	Director of Public Health
Ruth Derrick	Head of Nursing, Quality & Safety, Mental Health
Vicky Malcomson	Improvement & Efficiencies

EQS/21/43	**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.
EQS/21/44	**DECLARATIONS OF INTERESTS** No interests were declared.
EQS/21/45	**MINUTES OF THE EXPERIENCE, QUALITY AND SAFETY COMMITTEE MEETING HELD ON 3 JUNE 2021** The minutes of the previous meeting held on 3 June 2021 were AGREED as being a true and accurate record.
EQS/21/46	**MATTERS ARISING FROM PREVIOUS MEETINGS** One query was raised relating to the answer contained in the minutes to the following question where the second part of the question did not receive an answer. The answer to the second part of the question was provided as follows. *EQS/21/33 Serious Incidents and Concerns Report – Do the complaints team investigate complaints regarding long waits? And if so, do patients know that this was the method that could be used?* The Director of Nursing and Midwifery explained that there were a number of elements that inform residents and patients on how to make a complaint, including information on the website. Community Health Council (CHC) and Health Inspectorate Wales (HIW) inspect premises to see if information was available for people on premises advising of how to make a complaint. Publicity on how to make complaints can be undertaken and the Health Board could look to strengthen that element. *Could more clarification be given to the public on where they can go to make a complaint.* The Chief Executive further explained that individuals do write to the Health Board about the access issues. However, it was be difficult to understand if people were aware and able to use

	this form of communication. A solution to this would be to highlight this method through the networks and particular the CHC. As part of the Health Boards renewal portfolio there was a programme called Advice, Support and Rehabilitation. That would move the Health Board into a position where the organisation was more proactive in contacting people who were delayed on the waiting lists.
EQS/21/47	**COMMITTEE ACTION LOG** The Committee received the action log and there were no updates provided.
ITEMS FOR APPROVAL/RATIFICATION/DECISION	
EQS/21/48	*There were no items for inclusion in this section*
ITEMS FOR DISCUSSION	
EQS/21/49	**SERVICE GROUP, QUALITY GOVERNANCE REPORTING: MENTAL HEALTH** The Director of Primary Care, Community and Mental Health Services introduced the previously circulated report. The Assistant Director for Mental Health Services presented the paper which highlighted a number of the quality and governance mechanisms which had deployed within the mental health and learning disabilities (MHLD) service group. The use of the Commissioning Assurance Framework (CAF) was the foundation for MHLD Service Group, a quality assurance and performance process within the Health Board reflecting the progress the Mental Health (Wales) Measure 2010. The CAF includes details of Powys Teaching Health Board (PTHB) as a provider of 90% of mental health services with 10% provided via commissioned services through other NHS bodies or through the private sector. The priority during COVID-19 pandemic was continuity of care to ensure that the Health Board were picking up individuals with escalating presentations concerning any risks. The service culture was highlighted as transparent and accessible leadership. The size of the Mental Health team was noted with currently 400 members of staff and approximately 4,000 patients.

	The outcome measures had presented a difficulty in getting to a core data set across Wales. Welsh Government had undertaken some work regarding this, to bring together approximately 10-12 quality and outcome measures, which would be used. The new outcomes would be centred around improving wellbeing from a patient perspective, ability to get own goals and recovery aspirations, experience and satisfaction. This demonstrated a move from a quantitive to a qualitive process. The management of Concerns and Serious Incidents was a robust management system within the group and there was a small team focused around this area. There was an aim to improve and prioritise work surrounding mandatory training and appraisal rates. The Once for Wales system had been introduced and there was continued engagement with national working groups from Welsh Government, particularly around outcome performance measures. *The quality governance framework cannot be populated due to identifiable information and issues. Could this information be given to the In-Committee in order for members to be fully sighted on information presented.* The Director of Primary, Community Care and Mental Health explained that the information provided to committee was to inform members of the process. The paper outlined the learning and how the assurance was based upon the process itself, how information was pulled together, analysed and supported by the local service areas. Therefore, it was to understand what was discussed rather than the detail under discussion. *How were the mental health staff?* The Assistant Director for Mental Health Services explained a recent visit to staff within North Powys highlighted they had become fatigued. Staff members were taking annual leave which was important and this was supported. There was an increase in number of patients referring to the mental health service. There had been a 25% increase in primary mental health services referrals and there was a greater number of patients in secondary care and living with a complex trauma. It was not only staff who were fatigued but patients also. *The framework presented to the Committee highlighted that the Health Board had a responsibility for all patients in learning disability and mental health. Was this inclusive of those learning disability patients and people who were based*

	out of county? Was it comprehensive? Did it include children and adolescents as well as older people within all these settings? The Assistant Director for Mental Health Services confirmed that the Mental Health Service was looking at all of these groups identified. It was explained that the figure provided to committee of 4,000 patients fluctuates regarding patients who were eligible for assessment, treatment, ongoing support or post diagnostic support. As an example, if the service was treating an individual with a learning disability, there would be an investment in providing support for families and carers who deliver care in an informal care perspective. Out of county placements have a number of patients who were in specialist provision and during COVID-19 those visits have been kept up via calls or in-person. *The physical health of individuals with a learning disability and with mental health issues is an area of concern. There was no information provided on the current reporting system regarding the physical health of these patients and if that was being looked after. Could this information be provided in future reports?* The Assistant Director for Mental Health Services explained that GP annual checks have suffered during COVID-19 as less patients have been attending clinics. This was the only formal measure relating to the physical health of these patient. The community learning and disability team have gone out, for example to ensure that their patients have been double vaccinated and have also undertaken basic observations and health screening when completing medication reviews. The Experience, Quality & Safety Committee DISCUSSED and NOTED the report. *The Assistant Director for Mental Health Services left meeting.*
EQS/21/50	**GP ACCESS STANDARDS TO INCLUDE:** **a) PERFORMANCE REPORT** The Director of Primary Care, Community and Mental Health Services introduced the previously circulated report to the committee. The Assistant Director of Primary Care Services presented the report which focused on General Medical Services (GMS) access which included opening hours, appointment availability and Access Standards achievement for 2020/2021. It included the findings of a Powys Community Health Council (CHC) access report following an access survey in autumn 2020.

	The GMS regulations allowed practices to self-regulate their provision of services, to meet the 'reasonable' needs of patients. It was noted that theses reasonable needs were required to be met between the hours of 8am to 6:30pm, Monday to Friday. However, it did not mean that the doors require to be open throughout this period, telephone access could be classed as reasonable needs. This presented challenges in defining 'reasonable' and collecting data to assess this. However, there was a variety of information captured to gain assurance around the various access components in general practice. 100% of the 16 Powys Practices were accessible during core hours, Monday to Friday excluding bank holidays. 100% of practices did not undertake half day closures or lunchbreaks. At some multi-site practices, access to either the main or branch site would be available to patients. During the COVID-19 pandemic all practices maintained core opening hours, although there were some closures due to outbreaks or self-isolating staff. The model of delivery for access to general practice had to adapt quickly due to COVID-19. Some were not fully incorporated within the triage model however, overnight practices moved to telephone triage and telephone contact. All practices have an open list, this means that as long as a patient resides within a practice area, they were entitled to register with the practice. PTHB had an Access Forum which was conducted quarterly and the representation within that group included the Local Medical Committee (LMC), Community Health Council (CHC) and assistant directors from across the Health Board. Access standards and general access to general medical services were discussed within this forum and were reported through the General Medical Services Commissioning Assurance Framework (CAF) reporting. The CAF would be reported through PTHB groups and committees once year end data was available. The access standards had been in place for the last two years and although it was not a mandatory contractual requirement, 100% of Powys practices were committed to aspire to achieved the standards. There was one GP practice that chose not to implement one of the standards however, overall the compliance and achievement of standards was above the national average of 76%. PTHB provided a supportive role in assisting practices with achievement of the standards and improve accessibility.

	During 2020/21, NHS Wales Shared Services Partnership Audit and Assurance Services Internal Audit undertook a review of the Access Standards with the conclusion 'substantial' assurance was in place regarding the Health Board's method and approach to monitoring standards. Powys Community Health Council (CHC) undertook an access survey during September 2020. The sample was small with 116 participants. The survey was set against the context of the COVID pandemic and individual experiences of accessing general practice services. The report recommendations offered practices further considerations when planning future access models. The Experience, Quality & Safety Committee DISCUSSED and NOTED the report. *The Assistant Director of Primary Care Services left the meeting.*
EQS/21/51	**MORTALITY REPORT** The Medical Director presented the previously circulated report which provided an update on the mortality data for the period 1 January 2021 to 30 April 2021 and developments in the mortality review process. The mortality report was reviewed every six months and was aligned to the medical examiners service and the methodology that will be used when this service commences. The latest mortality review took place in April and May 2021 and 86 cases from across the community hospitals within Powys was reviewed. This paper provided a summary on deaths of Powys residents occurring both in Powys community hospitals and in the services commissioned in out of county District General Hospitals during the period 1st January 2021 to 30th April 2021. The findings of the second round of independent reviews of deaths occurring in Powys Community Hospitals were detailed. The paper also provided an update on the Datix Mortality Module and the roll out of the Medical Examiner project. The previous mortality reviews highlighted an issue regarding the recording of cause of death within case notes and it was noted that this had improved. The medical examiner service was due to commence by April 2022. It was planned to look at cases from community hospitals during late summer/early autumn. Therefore, it was important to ensure that the mechanisms were in place to provide documentation in a timely manner.

	The Experience, Quality & Safety Committee DISCUSSED and NOTED the report.
EQS/21/52	**RESUSCITATION GROUP REPORT** The Medical Director presented the previously circulated report which informed the Committee of the three main areas that were discussed namely equipment, training and policy and governance. There was a Service Level Agreement (SLA) in place with Cwm Taf Morgannwg regarding equipment and training. Cwm Taff was to review the defibrillators and equipment ten times throughout the year, and there would be an annual inspection from the Electro-Biomedical Engineering (EBME) team, and daily checks done by the ward staff. There were three levels of resuscitation training, basic life support, intermediate life support and advanced life support. Basic and intermediate training was appropriate for the majority of the Powys Teaching Health Board staff. This was delivered within Powys and staff were up to date with this training. The Advanced Life Support was harder to provide as it required face to face training. In respect of policy and governance, it was noted that Powys did not have a Resuscitation Officer. There was an understanding that Cwm Taf Morgannwg would provide that role, which may no longer be the case. There was a discussion around appointing someone to this role within Powys Teaching Health Board. The following roles of the Resuscitation Sub-Group were noted: • Act as a liaison forum for the parties with an interest in supporting good clinical practice to meet and discuss quality and improvement. • Act as an advisory body to assist the Medical Director in determining policy and practice for the organisation with respect to resuscitation. Historically the Sub-group had met twice per year, under the Chairmanship of the Medical Director, but could be called on to provide advice outside of a meeting if required. *Support was shown for an appointment of a resuscitation officer within Powys Teaching Health Board. It was noted that it was a very important missing link within Powys Teaching Health Board.* The Experience, Quality & Safety Committee DISCUSSED and NOTED the report.

EQS/21/53	**COMMISSIONING ESCALATION REPORT** The Director of Nursing and Midwifery presented the previously circulated report which highlighted providers in Special Measures or scored as Level 4 and above following the 27 May 2021 PTHB Internal Commissioning Assurance Meeting (ICAM). There were two providers, Cwm Taf Morgannwg and Shrewsbury and Telford Hospital NHS Trust (SaTH) in Special Measures. There was one provider at Level 4, Wye Valley. The report provided a high-level summary of key issues in relation to the two providers with services in special measures. It was noted that the commissioning assurance framework established within PTHB looked at a number of elements including patient experience, quality and safety, access, activity, finance, governance and strategic change. This considered the intelligence, which was key for triangulation and a more formalised reports provided by regulators and independent organisations. The key elements that were highlighted to the Committee includedthe issues and assurances escalated to SaTH's own Trust Board in June 2021. SaTH's focus had been on restoring services, consideration of the mortality rate. Alerts made to SaTH's own Board include delays in implementation of IT system, reliance on funding surround COVID related initiatives. The report identified the work been done to re-introduce the commissioning assurance framework and escalation reports which identified issues that exist with the commissioned services in Special Measures. *A delay in implementation of IT was mentioned, was this regarding IC net? Or wider?* The Director of Nursing and Midwifery confirmed that the IT delay was wider. *The Health Board was hopeful that when the University Hospitals Birmingham NHS Trust took over, it would strengthen the governance aspects and would have a significant impact. Had that been noted?*

	The Chief Executive explained there were key conversations that needed to take place with system leaders and experts that were supporting the Trust, in particular the University Hospitals Birmingham NHS Trust. The University Hospitals Birmingham NHS Trust were in a formal alliance with SaTH therefore, the Chief Executive had requested a meeting with the UHB Chief Executive or suitable member of his team to understand where there had been progress and in what areas progress was lacking. The Chief Executive had also approached the Medical Director for the NHS England and NHS Improvement, to ask similar questions. There had been contact made with the Care Quality Commission (CQC) regarding this matter and it had been agreed to keep open communication regarding this. The Experience, Quality & Safety Committee DISCUSSED and NOTED the report.
EQS/21/54	**PUTTING THINGS RIGHT, COMPENSATION AND CLAIMS REPORT** The Director of Nursing and Midwifery presented the previously circulated report which set out an overview of the way in which Putting Things Right (PTR) was discharged within the Health Board and compensation claims activity for the period 1 April 2021 to 31 May 2021. The report provided opportunity to share the internal review undertaken following the publication of a Special Report by the Public Service Ombudsman for Wales in October 2020, and the accompanying improvement plan. The assessment element of the paper was divided into two elements, system and processes that support the PTR function. Some of the improvements gained were a result of a deep dive. The Audit Wales quality governance report was expected in the coming weeks, which would give more context to areas which need further improvement and development. The PTR policy had been revised and approved by Board and an increase training was noted. The Health Board was aware there needed to be a structured approached to training, education and learning around the level of investigative analysis, and the ability to translate those findings into meaningful improvements. The audit and assurance plan had been previously presented to this Committee and assurance provided that the first quarter actions had commenced. The findings and lessons learned were due to be reported at the following EQS Committee. The Once for Wales management system had been introduced on the 7 May 2021, with staged introductions following. PTHB

	was waiting for the mortality and safeguarding modules to be established. The application and implementation to date had been successful due to a number of key individuals. During implementation and the change from the old to the new system, risks were identified therefore weekly monitoring of incident reporting patterns and trends had been implemented. This ensured that any areas that demonstrate lower than expecting reporting or an unplanned change reporting patterns would receive an additional level of support when needed. Reporting across Wales had identified that the new system, despite the concerns, was more user friendly. The new patient safety incident policy that had been provided in May 2021 had received a significant amount of work at All Wales level, as well as locally in order to be in a position to implement the changing policy by the end of the financial year. It was noted that the informal concerns target was 100% and within the last reporting period that was achieved. Formal concerns narrowly missed that target. The key area for formal concerns was surrounding access to primary and dental services. *How was the new IT system functioning?* The Director of Nursing and Midwifery explained that there was some anxiety around bringing in this system during the pandemic. There had been a large amount of work locally and at an All Wales level to try and incorporate this system in a safe and effective way. Any new system will have issues, but the work conducted by the Director of Finance and IT, and his team helped to address and find solutions efficiently. The system was intuitive therefore, was likely to be better at providing for PTHB needs. *Regarding the inquests, could an explanation be given to how the Health Board analyses anything that had less than five particular individuals. Therefore, individuals reading the paper would understand that it was not a lack of information but the requirement not to report actual figures where less than five.* The Director of Nursing and Midwifery agreed it was frustrating, and although well recognised in healthcare, the use of the phrase less than 5 is required when numbers are so small there is a risk of sharing person identifiable information in the public domain. The Experience, Quality & Safety Committee DISCUSSED and NOTED the report.

EQS/21/55	**REGULATORY INSPECTIONS REPORT** The Director of Nursing & Midwifery presented the previously circulated 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. Healthcare Inspectorate Wales (HIW) had stated that they would be recommencing a face-to-face visit programme. Recent activity which related to HIW inspections included the submission of an updated improvement plan relating to a Tier 1 Quality Check report. An unannounced inspection of a mental health ward was carried out on 15 June 2021, with no immediate improvements identified. A dashboard overview of the current position was provided, relating to the implementation of actions in response to recommendations from the Health and Social Care Regulators. The report highlighted any inspections that can been closed since the previous report. No inspections have been closed but there have been inspections added. *Could more information be provided regarding the Deprivation of Liberty Safeguards (DoLS) report.* The Director of Nursing and Midwifery explained that previously there was a limited assurance audit in relation to deprivation of liberty saf, approach and opportunity to take that forward. Work had been undertaken to strengthen PTHB's position in relation to *DoLS.* There were pending Liberty Protection Safeguards which were potentially coming in at the end of this financial year. PTHB had undertaken a significant amount of internal strengthening focused on re-training and learning. There had been a steady increase in requests for *DoLS'* best interest assessment and the Executive Committee were looking at ways to best steady the increase in demand along with what will be required in relation to the new LPS. Currently it was awaiting clarity from a UK wide level of what will be required for LPS. The Experience, Quality & Safety Committee DISCUSSED and NOTED the report.
EQS/21/56	**CLINICAL QUALITY FRAMEWORK, PATIENT EXPERIENCE: REVISED PRIORITIES** The Director of Therapies & Health Sciences presented the previously circulated report which articulated service user/ patient experience activity over the past year and current work in progress, and reflected Goal 1 of the Clinical Quality Framework.

	It was noted that there was not a dedicated team that collects patient experience. It required staff that were engaging with patients and users. The paper shared new ways of working that had contributed to positive experiences through the recent pandemic. A focus was on the improvements identified through the Health Board's Clinical Quality Framework. The paper set out the main priorities for the first quarter of 2021/22. The Experience, Quality & Safety Committee NOTED the report.
EQS/21/57	**MEDICAL DEVICES AND POINT OF CARE TESTING REPORT** The Director of Therapies and Health Science presented the previously circulated report which provided an update on the current position in terms of Medical Devices and Point of Care Testing. It included background information in relation to recent organisational changes, the current structure which supported this area of work and briefly outlined the functions of the team. Information on key activities, progress and risks associated with Medical Devices and Point of Care Testing (PoCT) was included. Capacity to progress with the PoCT Work Plan and Medical Devices Improvement Plan was challenged by additional unplanned workload. Urgent equipment requirements could be avoided through better management of local equipment replacement programmes. There were some grey areas in terms of responsibility and leadership which created confusion and delays. These areas should be managed in collaboration as opposed to responsibility sitting within one area. *Financially how were the contracts managed and arranged by the Medical Devices and Point of Care testing manager. There was no designated medical device or equipment budget. Was that the easiest way to finance this?* The Director of Therapies and Health Science confimred that this presented a challenge in relation to the requirement to charge back to each area. The Experience, Quality & Safety Committee DISCUSSED and NOTED the report.

EQS/21/58	**REPORT OF THE LEARNING FROM EXPERIENCE GROUP** The Medical Director presented the previously circulated report which informed the Experience, Quality and Safety Committee of the work of the Learning from Experience Group. The Group comprised of the Executive Clinical Directors for Medicine, Nursing and Therapies & Health Sciences together with the Chief Pharmacist. The Group meet quarterly under the Chairmanship of the Director of Clinical Strategy and Medical Director. 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 Experience, Quality & Safety Committee NOTED the report.
ITEMS FOR INFORMATION	
EQS/21/59	There were no items for inclusion in this section.
OTHER MATTERS	
EQS/21/60	**ITEMS TO BE BROUGHT TO THE ATTENTION OF THE BOARD AND OTHER COMMITTEES** There were no items for inclusion in this section.
EQS/21/61	**ANY OTHER URGENT BUSINESS** No urgent business. The Committee Chair thanked all members.
EQS/21/62	**DATE OF THE NEXT MEETING** 7 October 2021, at 10:00, via Microsoft Teams.

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

Patient Experience, Quality and Safety Committee

Terms of Reference & Operating Arrangements

September 2021

1. INTRODUCTION

1.1 Section 2 of the Standing Orders of the Powys Teaching Health Board (referred to throughout this document as 'PTHB', the Board' or the 'Health Board') provides that:

"*The Board may and, where directed by the Welsh Government must, appoint Committees of the Health Board either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of its business extends equally to the work carried out on its behalf by committees*".

1.2 The Health Board has established a committee to be known as the **Patient Experience, Quality and Safety Committee** (referred to throughout this document as 'the Committee'). The Terms of Reference and operating arrangements set by the Board in respect of this committee are provided below.

2. PURPOSE

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

- Staying Healthy
- Safe Care
- Effective Care
- Dignified Care
- Timely Care
- Individual Care
- Staff and Resources

2.1 ADVICE

The Committee will provide accurate, evidence based (where possible) and timely advice to the Board and its committees in respect of the development of the following matters, consistent with the Board's overall strategic direction

- Citizen Experience; and
- Quality and Safety of directly provided and commissioned services.

2.2 ASSURANCE

In respect of the achievement of the Boards' strategic aims, objectives and priorities, the Committee will seek assurances on:

a. The robustness of the Board's Clinical Quality Framework;
b. the experience of patients, citizens and carers ensuring continuous learning;
c. the provision of high quality, safe and effective healthcare within directly provided and commissioned services;
d. the effectiveness of arrangements in place to support Improvement and Innovation and
e. compliance with mental health legislation, including the Mental Health Act 1983 (amended 2007) and the Mental Capacity Act 2005.

3 DELEGATED POWERS AND AUTHORITY

3.1 With regard to the powers delegated to it by the Board, the Committee will:

A. Seek assurance that the Health Board's **Clinical Quality Framework** remains appropriate, is aligned to the National Quality Framework, and is embedded in practice.

B. Seek assurance that arrangements for capturing the **experience of patients, citizens and carers** are sufficient, effective and robust, including:

- the delivery of the Patient Experience Plan; and
- the implementation of Putting Things Right regulations (to include patient safety incidents, complaints, compliments, clinical negligence claims and inquests) reporting trends, with particular emphasis on ensuring that lessons are learned.

C. Seek assurance that arrangements for **the provision of high quality, safe and effective healthcare** are sufficient, effective and robust, including:

- the systems and processes in place to ensure efficient, effective, timely, dignified and safe delivery of directly provided services;
- the commissioning assurance arrangements in place to ensure efficient, effective, timely, dignified and safe delivery of commissioned services;
- the arrangements in place to undertake, review and act on clinical audit activity which responds to national and local priorities;

- the recommendations made by internal and external review bodies, ensuring where appropriate, that action is taken in response;
- the arrangements in place to ensure that there are robust infection, prevention and control measures in place in all settings;
- the development of the board's Annual Quality Statement and Annual Quality Priorities; and
- performance against key quality focussed performance indicators and metrics.

D. Seek assurance on the arrangements in place to support **Improvement and Innovation**, including:
   - an overview of the research and development activity within the organisation;
   - alignment with the national objectives published by Health And Care Research Wales (HCRW);
   - an overview of the quality improvement activity within the organisation.

E. Seek assurance that arrangements for **compliance with mental health legislation** are sufficient, effective and robust, including:
   - the Mental Health Act 1983 Code of Practice for Wales and associated regulations;
   - the Mental Capacity Act 2005 Code of Practice and associated regulations;
   - the Mental Capacity Act 2005 Deprivation of Liberty Safeguards Code of Practice and associated regulations; and
   - the Mental Health Measure (Wales) 2010.

3.2 The Committee will consider and recommend to the Board for approval those policies reserved for the Board and delegated to this Committee for review, in-line with the Board's Policy Management Framework and Scheme of Delegation and Reservation of Powers.

3.3 The Committee will seek assurances on the management of strategic risks delegated to the Committee by the Board, via the Corporate Risk Register.

Authority

3.4 The Committee is authorised by the Board to investigate or have investigated any activity within its terms of reference. In doing so, the Committee shall have the right to inspect any books, records or documents of the Health Board relevant to the Committee's remit and ensuring patient/client and staff confidentiality, as appropriate.

The Committee may seek any relevant information from any:
- employee (and all employees are directed to cooperate with any reasonable request made by the Committee); and
- any other committee, sub committee or group set up by the Board to assist it in the delivery of its functions.

3.5 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary (subject to the Board's procurement, budgetary and any other applicable standing requirements).

Access

3.6 The Head of Internal Audit shall have unrestricted and confidential access to the Chair of the Committee.

3.7 The Chair of the Committee shall have reasonable access to Executive Directors and other relevant senior staff.

Sub Committees

3.8 The Committee may, subject to the approval of the Board, establish sub committees or task and finish groups to carry out on its behalf specific aspects of Committee business.

3.9 The Committee has established a sub-committee, named the **Mental Health Act Power of Discharge Group.** The purpose of this group is to review and monitor how the operation of the delegated functions under Section 23 of the Mental Health Act 1983 are being exercised. This group will report through to the Patient Experience, Quality & Safety Committee providing assurance in-line with its agreed Terms of Reference.

Committee Programme of Work

3.10 Each year the Board will determine the Committee's priorities for its annual programme of work, based on the Board's Assurance Framework and Corporate Risk Register. This approach will ensure that the Committee's focus is directed to the areas of greatest

assurance needs. This will therefore mean that these Terms of Reference are provided as a framework for the Committee's annual programme of work and is not an exhaustive list for full coverage. This approach recognises that the Committee's programme of work will be dynamic and flexible to meet the needs of the Board throughout the year.

4 MEMBERSHIP

Members

4.1 Membership will comprise:

Chair	Vice Chair of the Board
Vice Chair	Independent member of the Board
Members	Independent member of the Board x3
	The Committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise.

Attendees

4.2 In attendance: The following Executive Directors of the Board will be regular attendees:

- Director of Nursing and Midwifery (Officer Lead)
- Director of Therapies and Health Sciences
- Medical Director
- Director of Public Health
- Director of Primary, Community Care and Mental Health

4.3 By invitation:
The Committee Chair extends an invitation to the PTHB Chair and Chief Executive to attend committee meetings.

The Committee Chair will extend invitations to attend committee meetings, dependent upon the nature of business, to the following:

- other Executive Directors not listed above;
- other Senior Managers and
- other officials from within or outside the organisation to attend all or part of a meeting to assist it with its discussions on any particular matter.

Secretariat

4.4 The Office of the Board Secretary will provide secretariat services to the Committee.

Member Appointments

4.5 The membership of the Committee shall be determined by the Board, based on the recommendation of the Chair of PTHB - taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government.

4.6 Members shall be appointed to hold office for a period of one year at a time, up to a maximum of their term of office. During this time a member may resign or be removed by the Board.

4.7 Terms and conditions of appointment, (including any remuneration and reimbursement) in respect of co-opted independent external members are determined by the Board, based upon the recommendation of the Chair of PTHB.

Support to Committee Members

4.8 The Board Secretary, on behalf of the Committee Chair, shall:

- arrange the provision of advice and support to committee members on any aspect related to the conduct of their role; and
- ensure the provision of a programme of development for committee members as part of the Board's overall Development Programme.

5 COMMITTEE MEETINGS

Quorum

5.1 At least **three** members must be present to ensure the quorum of the Committee, one of whom should be the Committee Chair or Vice Chair.

5.2 Where members are unable to attend a meeting and there is a likelihood that the Committee will not be quorate, the Chair can invite another independent member of the board to become a temporary member of the Committee.

Frequency of Meetings

5.3 The Chair of the Committee shall determine the timing and frequency of meetings, which shall be held no less than **bi-monthly**, and in line with the Health Board's annual plan of Board Business.

5.4 The Chair of the Committee may call additional meetings if urgent business is required to be taken forward between scheduled meetings.

Openness and Transparency

5.5 Section 3.1 of PTHB Standings Orders confirms the Board's commitment to openness and transparency in the conduct of all its business and extends equally to the work carried out on its behalf by Committees. The Board requires, wherever possible, meetings to be held in public. The Committee will:

- hold meetings in public, other than where a matter is required to be discussed in private (see point 5.6);
- issue an annual programme of meetings (including timings and venues) and its annual programme of business;
- publish agendas and papers on the Health Board's website in advance of meetings;
- ensure the provision of agendas and minutes in English and Welsh and upon request in accessible formats, such as Braille, large print, and easy read; and
- through PTHB's website, promote information on how attendees can notify the Health Board of any access needs sufficiently in advance of a proposed meeting, e.g., interpretation or translation arrangements, in accordance with legislative requirements such as the Equality Act 2010 and Welsh Language Standards 2018.

Withdrawal of individuals in attendance

5.6 There may be circumstances where it would not be in the public interest to discuss a matter in public, e.g., business that relates to a confidential matter. In such cases the Chair (advised by the Board Secretary where appropriate) shall schedule these issues accordingly and require that any observers withdraw from the meeting. In doing so, the Committee shall resolve:

That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960 (c.67).

In these circumstances, when the Committee is not meeting in public session it shall operate in private session, formally reporting any decisions taken to the next meeting of the Committee in public session.

6. RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

6.1 Although the Board has delegated authority to the Committee for the exercise of certain functions (as set out within these terms of reference), the Board retains overall responsibility and accountability for all matters relating to performance and resources.

The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.

6.2 The Committee will work closely with the Board's other committees, joint and sub committees and groups to provide advice and assurance to the Board through the:

- joint planning and co-ordination of Board and Committee business;
- sharing of appropriate information; and
- applicable escalation of concerns.

in doing so, this contributes to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.

6.3 The Committee shall embed the Health Board's agreed Values and Behaviours, as set out in the Board's Values and Behaviours Framework, through the conduct of its business.

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

- report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes verbal updates on activity, and the submission of Committee minutes and written reports;
- bring to the Board's specific attention any significant matters under consideration by the Committee;
- ensure appropriate escalation arrangements are in place to alert the Chair of PTHB, Chief Executive or Chairs of other relevant committees/groups of any urgent/critical matters

that may affect the operation and/or reputation of the Health Board.

7.2 The Board may also require the Committee Chair to report upon the Committee's activities at public meetings, e.g., Annual General Meeting, or to community partners and other stakeholders, where this is considered appropriate, e.g., where the committee's assurance role relates to a joint or shared responsibility.

7.3 The Board Secretary shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation including that of further committees established.

7.4 The Committee shall provide a written annual report to the Board on its activities. The report will also record the results of the Committee's self-assessment and evaluation.

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

8.1 The requirements for the conduct of business as set out in PTHB's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum
- Issue of Committee papers

9. CHAIR'S ACTION ON URGENT MATTERS

9.1 There may, occasionally, be circumstances where decisions which would normally be made by the Committee need to be taken between scheduled meetings, and it is not practicable to call a meeting of the Committee. In these circumstances, the Chair of the Committee, supported by the Board Secretary as appropriate, may deal with the matter on behalf of the Committee - after first consulting with at least two other Independent Members of the Committee. The Board Secretary must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.

9.2 Chair's action may not be taken where the Chair has a personal or business interest in the urgent matter requiring a decision.

10. REVIEW

10.1 These Terms of Reference shall be reviewed annually by the Committee. The Committee Chair will report any changes to the Board for ratification.

Archwilio Cymru
Audit Wales

Welsh Health Specialised Services Committee Governance Arrangements

Report of the Auditor General for Wales

May 2021

This report has been prepared for presentation to the Senedd under the Public Audit (Wales) Act 2004 and the Government of Wales Act 1998

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Mae'r ddogfen hon hefyd ar gael yn Gymraeg.

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Summary report

Background

1 The Welsh Health Specialised Services Committee (WHSSC) is a joint committee of each local health board in Wales, established under the Welsh Health Specialised Services Committee (Wales) Directions 2009 (2009/35). The remit of the Joint Committee is to enable the seven health boards in Wales to make collective decisions on the review, planning, procurement, and performance monitoring of agreed specialised and tertiary services.

2 The Joint Committee is hosted by Cwm Taf Morgannwg University Health Board and is responsible for the joint planning and commissioning of specialised services on behalf of local health boards in Wales. WHSSC is made up of, and funded by, the seven local health boards with an overall annual budget of £680 million with the financial contributions determined by population need. Some health boards in Wales provide specialised services. In particular, Cardiff and Vale and Swansea Bay University Health Boards receive significant funding for the services that they provide.

3 On a day-to-day basis, the Joint Committee delegates operational responsibility for commissioning to Welsh Health Specialised Services (WHSS) Officers, through the management team (**Exhibit 1**) and supported by six multidisciplinary commissioning teams. These teams commission specialised services, including:

- Cancer and Blood
- Cardiac
- Mental Health and Vulnerable Groups
- Neurosciences and long-term conditions
- Renal
- Women's and children's

Exhibit 1: WHSS management structure

Source: Welsh Health Specialised Services Standing Orders

4 In 2015, two separate reviews highlighted issues with WHSSC's governance arrangements. The Good Governance Institute highlighted concerns relating to decision making and conflicts of interest, and identified the need to improve senior level clinical input as well as the need to create a more independent organisation that is free to make strong and sometimes unpopular (to some) decisions in the best interest of the people of Wales. In the same year, Healthcare Inspectorate Wales (HIW) conducted a review of clinical governance at WHSSC. That review found that WHSSC was beginning to strengthen its clinical governance arrangements but needed to strengthen its approach for monitoring service quality and also improve clinical engagement.

5 Time has now passed since these reviews. Considering the increasing service and financial pressures, and the potentially changing landscape of national collaborative commissioning and NHS Executive as set out in A Healthier Wales, the Auditor General felt it was timely to review WHSSC's governance arrangements. This report considers the extent to which there are effective governance arrangements and whether the planning approach effectively supports the commissioning of specialised services for the population of Wales. Given the impact of COVID-19 on the capacity and productivity of services, we have also highlighted some specific challenges which relate to recovery.

6 Much of our review was carried out between March and June 2020, but as a result of the pandemic, we paused aspects of the review, restarting in July with a survey to all health boards and concluding the fieldwork in October. The delivery of our work included interviews with WHSS officers and WHSSC independent members, observations of Joint Committee and sub-committee meetings, questionnaires of health board chief executives and chairs and a review of documentation.

Key findings

7 Overall, we found **since the previous reviews in 2015, governance, management and planning arrangements have improved, but the impact of COVID-19 will now require a clear strategy to recover services and there would still be benefits in reviewing the wider governance arrangements for specialised services in line with the commitments within A Healthier Wales**.

Governance arrangements have improved but decision making is likely to become more challenging as a result of COVID-19

8 Our work has found improvements in the overall governance arrangements in WHSSC since 2015. WHSSC is formed of a mix of independent members, health board chief executives, and WHSS officers who work in collaboration to lead specialised services commissioning on behalf of the population of Wales. There are benefits to this system of governance which provides partners with the opportunity to collaborate on service developments. In general, we found that the Joint Committee operates well and there is normally a healthy working relationship between Joint Committee members. There are, however, occasions when this has become more challenging, such as discussions around new service models for major trauma and thoracic surgery. This tends to occur when new services are commissioned from providers who are Joint Committee members. This can present a risk of conflict of interest but the negative impact of this has been reduced through the introduction of a new majority voting system. These conflict-of-interest issues will remain a live risk, particularly when considering post-pandemic service recovery.

9 The agenda of the Joint Committee meetings appears appropriate and proportionate. However, our observations highlighted opportunities to increase the attention given to finance, performance, and quality reporting at Joint Committee. We also identified a need to review the independent member recruitment arrangements and the level of remuneration that they receive to help deal with the challenges of independent member turnover.

10 The Joint Committee's sub-committees and groups are well-chaired and administered, although there is a need to strengthen the Integrated Governance Committee to ensure it discharges its terms of reference. WHSSC is hosted by Cwm Taf Morgannwg University Health Board which provides administrative support such as ICT, HR, Facilities, and Communications. WHSSC also forms part of the governance and accountability framework of the Health Board via the Audit and Risk Committee and requirement for financial disclosure in annual reports and accounts. Work is ongoing to strengthen the role and function of the Health Board's Audit and Risk Committee in respect of its hosted statutory joint committees.

11 WHSSC has developed good risk management processes using a corporate risk assurance framework. The risks are regularly scrutinised at corporate and Joint Committee levels with a specific arrangement to capture COVID-19 risks since the onset of the pandemic. Likewise, performance management arrangements provide a good foundation, adopting a tiered model for service escalation and appropriate operational monitoring. WHSSC has adapted these arrangements as a result of the pandemic but may need to become more robust in future to ensure specialised services minimise the risk of harm as a result of delays in treatment.

12 After an initially slow response, WHSSC has responded to the recommendations made in 2015 relating to the need to strengthen quality assurance arrangements. In 2019, WHSSC established a Quality Assurance Team, which is embedding well and is now taking steps to update its quality assurance framework.

Planning arrangements provide a good foundation but there is a need for a clear strategy to respond to the challenges presented by COVID-19

13 Annual planning arrangements are generally effective. Year on year, development and approval of the Integrated Commissioning Plan has become timelier and there are clear formal arrangements for the identification and prioritisation of emerging specialised care services and treatments. Welsh Government officials told us of the additional capacity and capability they received from WHSSC planning officers to help drive through review of health board and trust quarterly plans during the first wave of the pandemic. This provides a good indication of the expertise within the team. Information to support planning and commissioning is improving and this is supported by a performance information system which continues to develop. Delivery of existing commissioned service plans is well managed, but elapsed time for the introduction of new services such as new service models for major trauma and thoracic surgery in South Wales has been slow. This is not within the sole remit of WHSSC but indicates the need for wider 'end to end' programme management at regional levels.

14 Financial planning arrangements are sufficiently robust and linked appropriately to the Integrated Commissioning Plan. COVID-19 has significantly reduced access to some specialised services, and recovery will have some significant financial consequences. There is a need to understand the financial consequences resulting from the pandemic in terms of service recovery. Value-based commissioning approaches are improving, but to maximise recovery with finite resources, this now needs to become more ambitious and more strongly linked to patient outcomes, prioritisation, and decommissioning (where there isn't good evidence that services/interventions are leading to improved outcomes).

15 COVID-19 has delayed specialised services strategy development and will no doubt continue to impact on the timeline for the development of the strategy. Specialised service officers can start to shape a strategy that focusses on the impacts of COVID-19 alongside advances in technological, therapeutic and policy developments. Strategy renewal is more crucial than ever and will need to be shaped around the changing risks and opportunities for specialised services taking consideration of the issues and opportunities identified in this report.

Future arrangements for commissioning specialised services

16 **A Healthier Wales**, the Welsh Government's plan for health and social care in Wales, signalled an intention to review a range of hosted national functions, including WHSSC, with the aim of consolidating national activity and clarifying governance and accountability. Whilst the governance arrangements for WHSSC have continued to evolve positively in the main, there would still be benefits in the Welsh Government including WHSSC in the planned review of national hosted functions. In looking at potential future governance and accountability arrangements for specialised services, it should be recognised that the current collaborative commissioning model has strengths in that it creates a collective and jointly owned approach to the planning and delivery of specialist services. However, it also has some inbuilt risks that see individual Joint Committee members having to balance all-Wales needs with those of their population and the individual NHS bodies they lead.

The Welsh Health Specialised Services Committee (WHSSC) commissions around £680 million of specialised services on behalf of the population of Wales and is a vital component of the Welsh healthcare system. Given this level of responsibility and investment, I'm encouraged by the progress WHSCC has made to improve its governance, management, and planning arrangements over recent years.

An immediate challenge for WHSSC is to develop a clear strategy to address the challenges associated with recovering specialised services following the Covid-19 pandemic. My report also shows that there is still a need to take a more fundamental look at the model for commissioning specialised services, in line with the commitment set out in the Welsh Government's NHS Plan 'A Healthier Wales'. It is important that this commitment is taken forward and I hope that the findings set out in this report can helpfully inform that debate.

Adrian Crompton
Auditor General for Wales

4 Recommendations

17 Recommendations arising from this audit are detailed in **Exhibits 2 and 3**.

Exhibit 2: recommendations for the Welsh Health Specialised Services Committee

Recommendations

Quality governance and management

R1 **Increase the focus on quality at the Joint Committee.** This should ensure effective focus and discussion on the pace of improvement for those services in escalation and driving quality and outcome improvements for patients.

Programme management

R2 **Implement clear programme management arrangements for the introduction of new commissioned services.** This should include clear and explicit milestones which are set from concept through to completion (ie early in the development through to post-implementation benefits analysis). Progress reporting against those milestones should then form part of reporting into the joint committee.

Recommendations

Recovery planning

R3 In the short to medium term, the impact of COVID-19 presents a number of challenges. WHSSC should undertake a review and report analysis on:

a the backlog of waits for specialised services, how these will be managed whilst reducing patient harm.

b potential impact and cost of managing hidden demand. That being patients that did not present to primary or secondary care during the pandemic, with conditions potentially worsening.

c the financial consequences of services that were commissioned and under-delivered as a result of COVID-19, including the under-delivery of services commissioned from England. This should be used to inform contract negotiation.

Recommendations

Specialised services strategy

R4 The current specialised services strategy was approved in 2012. WHSSC should **develop and approve a new strategy during 2021**. This should:

a embrace new therapeutic and technological innovations, drive value, consider best practice commissioning models in place elsewhere, and drive a short, medium, and long-term approach for post-pandemic recovery.

b be informed by a review of the extent of the wider services already commissioned by WHSSC, by developing a value-based service assessment to better inform commissioning intent and options for driving value and where necessary decommissioning. The review should assess services:

- which do not demonstrate clinical efficacy or patient outcome (stop);
- which should no longer be considered specialised and therefore could transfer to become core services of health boards (transfer);
- where alternative interventions provide better outcome for the investment (change);
- currently commissioned, which should continue (continue).

Exhibit 3: Recommendations for the Welsh Government

Recommendations

Independent member recruitment

R5 Review the options to recruit and retain WHSSC independent members. This should include considering measures to expand the range of NHS bodies that WHSSC members can be drawn from, and remuneration for undertaking the role.

Sub-regional and regional programme management

R6 This is linked to **Recommendation 2** made to WHSSC in this report. When new regional or sub-regional specialised services are planned which are not the sole responsibility of WHSSC, ensure that effective multi-partner programme management arrangements are in place from concept through to completion (ie early in the development through to post-implementation benefits analysis).

Future governance and accountability arrangements for specialised services

R7 **A Healthier Wales** included a commitment to review the WHSSC arrangements along with other national hosted and specialist advisory functions. COVID-19 has contributed to delays in taking forward that action. It is recommended that the Welsh Government set a revised timescale for the action and use the findings of this report to inform any further work looking at governance and accountability arrangements for commissioning specialised services as part of a wider consolidation of current national activity.

Main report

Governance and assurance

18 Our review has examined WHSSC's governance and assurance arrangements, such as the way the Joint Committee and its sub-committees conduct business, systems for managing performance and risk, and arrangements to ensure probity and propriety. We found that **governance arrangements have improved but decision making is likely to become more challenging as a result of COVID-19**.

Conducting business effectively

19 We looked at the clarity of governance structures, decision-making arrangements and conduct at the Joint Committee and its sub-committees. We found that **committee arrangements have improved, although challenges around conflicts of interest remain and there is a need for stronger focus on quality, finance, and performance at Joint Committee meetings**.

The Joint Committee is well administered with a healthy relationship between members. However, there is scope for greater scrutiny of service quality and routine finance and performance reports, and an opportunity to look afresh at independent member recruitment arrangements

20 The Joint Committee is made up of 15 voting members and three associate members. The voting members include the chief executives of the seven health boards, four independent members (three of whom are drawn from health boards), including the Chair (a Ministerial appointment) and Vice Chair, and four WHSS officers. In October 2020, a new Chair was appointed, taking over from the Interim Chair who had been in post for a little over three years. WHSSC is expecting turnover of independent members in the coming months which will present both capacity and recruitment challenges. It was reported that recruiting independent members is difficult, especially since the pool from which they can be recruited is limited to health boards only. Consideration should be given to widening the recruitment pool to include all NHS Wales organisations, not just health boards. In addition, there is no additional remuneration for independent members of WHSSC, which makes the position less attractive. Thought, therefore, should be given to whether the current remuneration arrangements reflect the commitment expected of independent members of WHSSC.

21 We observed the Joint Committee both before and during the pandemic. Meetings were well attended and the relationship between members was respectful with a healthy level of challenge. Due to the pandemic, WHSSC moved to holding virtual meetings from March 2020. At this time, the Joint Committee's agenda had a COVID-19 focus with updates on commissioning independent hospitals, which the WHSS team was responsible for, risk management and delivering specialised services during the pandemic. WHSS officers fed back that the revised arrangements improved meeting efficiency and engagement and created better approaches for responding to questions. Moving forward, we would encourage WHSSC to review and consider the advantages of retaining these arrangements.

22 Those we interviewed were positive about the Joint Committee, indicating that it had matured in the past one to two years. Generally, it was felt the Joint Committee works effectively, is open and transparent, that chief executives are supportive of each other, and that roles and responsibilities are clear. Our observations at Joint Committee indicated a tendency to focus on new service modelling which resulted in a south Wales focus in meetings. We also saw limited discussion about the performance of commissioned services. Despite good systems for quality assurance at an operational level within WHSSC, there is a lack of sufficient oversight at Joint Committee. These need to be strengthened as part of a focus on service recovery.

Decision making arrangements have improved, but conflicts of interest remain a risk

23 WHSSC commissions specialised health services for Wales as a whole. Whilst membership of the Joint Committee is drawn from existing health boards, the members are supposed to be independent. However, decision-making for some members poses a potential conflict of interest. This is because the larger Welsh health boards are substantial providers of specialised services, especially in south Wales. Those we spoke to reported that there can be some tensions around negotiations, citing the major trauma centre and thoracic surgery, and potential to draw attention on these specific issues at committee meetings at the expense of wider aspects of the agenda.

24 As a result of previous challenges in decision making, WHSSC's voting arrangements changed from 100% agreement required to a two-thirds majority vote in accordance with a Ministerial direction dated 12 November 2018. This was subsequently reflected in an amendment to WHSSC's standing orders. The new voting system is more pragmatic and ensures quicker decision-making, but this was introduced relatively recently, so WHSSC should keep this new arrangement under review. The governance arrangements mean that chief executives and independent members take part in votes on commissioning services from their own health board. As a result, the previous interim Chair of WHSSC reinforced the need to act on behalf of the all-Wales position when making decisions. Moving forward, the difficulties presented by the pandemic are likely to be challenging. When acting on behalf of 'all-Wales' and to minimise patient harm as a result of delays in receiving specialised care, shifts in investment may be necessary. This again may increase the risk of conflicts of interest if chief executive members are required to vote on diverting investments from their own health boards.

Flows of assurance between the Joint Committee and individual health boards are variable

25 As the Joint Committee commissions specialised services on behalf of the seven health boards, we would expect to see clear lines of assurance from the Joint Committee to individual Boards. On reviewing health board papers[1] we found that as a minimum all seven health boards had approved their own standing orders, which set out their responsibilities regarding WHSSC, and WHSSC's standing orders. All health boards report WHSSC's assurance reports and minutes of the Joint Committee meetings (or provide a link to the minutes).

26 However, health board minutes show some variability in the extent of discussions of WHSSC services. For example, the programme business case approval for major trauma and thoracic surgery prompted extensive papers and good discussion at health boards. But at other times WHSSC papers were just noted with limited discussion. We found that Board level oversight of quality and escalated specialised services appears limited, but we note that this is something WHSS officers are working to improve through their engagement work with health boards across Wales.

1 For each health board, we reviewed its Board papers and papers for its quality and safety, finance and performance meetings.

WHSSC's hosting arrangements function largely as intended, albeit there are occasional operational challenges and an opportunity to strengthen the governance role of the host health board's Audit and Risk Committee

27 WHSSC is hosted by Cwm Taf Morgannwg University Health Board which provides administrative support such as ICT, HR, Facilities and Communications. WHSSC employees have a contract of employment with Cwm Taf Morgannwg University Health Board and WHSSC's Managing Director has a line of accountability to its Chief Executive. Interviewees indicated that in general these arrangements operated sufficiently, but there were some concerns expressed about Cwm Taf Morgannwg University Health Board's capacity to support WHSSC, particularly in relation to HR and ICT support services. In addition, it was noted that Cwm Taf Morgannwg University Health Board is a provider of specialised services commissioned by WHSSC, which could provide further conflicts of interest over and above the inherent provider/commissioner tension at Joint Committee.

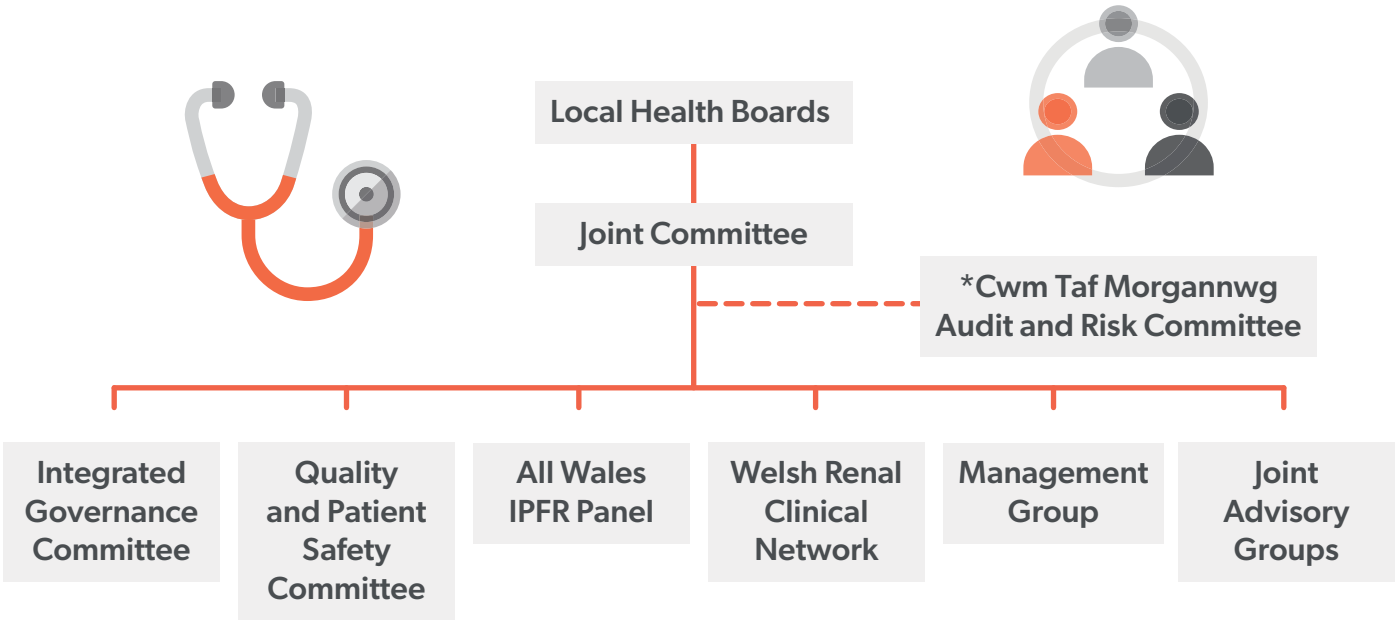
28 A hosting agreement exists between WHSSC and the seven Welsh health boards which includes provision for Cwm Taf Morgannwg University Health Board's Audit and Risk Committee to assist in the discharge of WHSSC's governance and assurance responsibilities. However, the existing hosting agreement has limited detail on how these arrangements should work, and the degree of scrutiny of WHSSC business at the committee can be fairly limited. Hosted organisations are considered at Part 2 of Audit and Risk Committee meetings. Cwm Taf Morgannwg University Health Board is working to clarify the assurance requirements of the hosted bodies[2] through developing an assurance framework. The new framework aims to define the role, function, responsibilities and accountabilities of the Audit and Risk Committee, the host, the all-Wales statutory joint committees and the directors involved. We understand that this work is ongoing and will require further engagement across all bodies affected.

2 Cwm Taf Morgannwg University Health Board is also the host for the Emergency Ambulance Services Committee (EASC) and the NHS National Imaging Academy.

WHSSC's sub-committees and groups generally operate well, although there is a need to ensure that all aspects within terms of reference are appropriately covered

29 WHSSC is required through its standing orders to have committees responsible for quality and safety, and audit. As identified earlier, the Audit and Risk Committee is facilitated through hosting arrangements. However, the Joint Committee is also supported by a range of its own sub-committees and groups (**Exhibit 4**). Some provide scrutiny and receive assurances, while others are more focussed on delivery and decision making. The Quality and Patient Safety Committee, forms part of WHSSC's own committee and group structure. The Joint Committee also has three advisory groups, which at the time of our fieldwork were under review.

Exhibit 4: WHSSC Governance Structure[3]



* Functions as both the Health Board's Audit and Risk Committee and WHSSC's Audit Committee.

Source: WHSSC

3 See section 2.3 of the 2019/20 WHSSC Annual Governance Statement for more information on the arrangements for Cwm Taf Morgannwg's Audit and Risk Committee and Quality and Patient Safety Committee in relation to WHSCC governance.

30 Most of our observations took place prior to the pandemic. Generally, we found that the meetings had a clear agenda, were well administered with formal procedures observed as expected, such as declarations of interest and review of previous minutes. Meeting papers were clearly written with a templated cover report detailing the purpose of the paper such as for approval, noting and assurance. The sub-committees have an up-to-date work programme and terms of reference.

31 WHSSC's Quality and Patient Safety Committee effectively scrutinises assurance reports from all of its commissioning teams on escalated services, service risks, quality visits, inspections and any incidents or concerns. The committee also receives reports on concerns, serious incidents, ombudsman reports, clinical policy review and COVID-19. WHSS officers are also aiming to improve the flow of information between WHSSC and the quality and safety committees of health boards.

32 During 2019-20, the Integrated Governance Committee met infrequently, leaving a six-month gap between the October 2019 and April 2020 meetings. However, the number of meetings was still in line with the committee's terms of reference and, since April 2020, the frequency of meetings has increased. Our work indicates that there needs to be greater clarity on the role and function of this committee. At present, part of the Integrated Governance Committee's remit is to maintain oversight of the work of the Quality and Patient Safety Committee, Audit and Risk Committee, and the Welsh Renal Network. The Integrated Governance Committee is also responsible for scrutinising delivery and performance of the Integrated Commissioning Plan. Whilst there was good oversight of the plan's development by the committee, we found that with the exception of a routine report on escalated services, there was no evidence of wider scrutiny of delivery against the plan.

33 Our observations found that Management Group, an officer-level group which makes recommendations to the Joint Committee, is well chaired, and in general papers are well discussed. But, as with Joint Committee, we saw a need for better discussion of performance, finance, and service quality and patient safety.

Systems of assurance

34 We examined whether the Joint Committee has an effective system of internal controls to support assurance systems. We found that **in recent years there has been notable strengthening of systems of assurance, but there is scope to strengthen them further**.

Arrangements to promote probity and propriety are in place

35 WHSSC's governance and accountability framework was last fully reviewed in September 2019. This version reflects the amended voting arrangements and includes:

- Standing Orders
- Memorandum of Agreement
- Hosting Agreement
- Joint Committee Business Framework

36 To help ensure probity and propriety, WHSSC maintains registers for declarations of interest and gifts, hospitality, and sponsorship. The registers are appropriately updated, with records available on the WHSSC website and declared within the Annual Governance Statement.

37 WHSSC keeps an internal audit recommendation tracker, which is clearly formatted and reviewed at each Audit and Risk Committee meeting. There were no external audit recommendations on the tracker when we conducted our review, but we are told that historically recommendations have been listed on the tracker and they were scrutinised in the same way as they were for the host. We would particularly expect the recommendations made in this review to appear on the tracker and be subjected to scrutiny.

38 WHSSC also monitored progress against the 2015 Good Governance Institute and HIW reviews. WHSSC developed a governance action plan and most actions are closed. The Integrated Governance Committee received six-monthly updates on the outstanding actions, the last of which was in March 2019.

Good risk management processes are in place, with risks regularly scrutinised at corporate and Joint Committee level, and systems in place to capture risks arising from COVID-19

39 WHSSC has a Corporate Risk Assurance Framework (CRAF) which identifies high-level risks to commissioned services. Each of the commissioning teams has a risk register. Risks rated 15 or above after controls are put in place are escalated to the CRAF. The Joint Committee has sight of the CRAF twice a year and it is reviewed regularly by the sub-committees and the Corporate Directors Group Board. The CRAF is clearly presented and includes the information we would expect to see on a corporate risk register including a lead director and assuring committee for each risk.

40 WHSSC has recently updated its integrated risk management framework including reviewing existing risk registers, developing a new risk register template, and training staff. The framework sets out accountabilities, responsibilities, and the organisation's risk appetite. WHSSC is seeking further improvements to tighten escalation and de-escalation processes and by introducing an electronic risk management system. It hopes to roll out new risk processes in spring 2021.

41 During the pandemic, a separate risk assessment and register was completed to assess how essential specialised services were impacted by COVID-19. The assessment is a live document which is updated as providers supplied more information. The Joint Committee continues to review both the COVID-19 risk register and the CRAF.

WHSSC is taking necessary action to strengthen its performance management arrangements but will need to consider how these are adapted to monitor and manage the post-pandemic recovery of services

42 WHSSC predominantly monitors a service's performance through national key performance indicators. The measures are set out in contracts and service specifications. Underperformance is managed through WHSSC's escalation framework, which has four levels of escalation, with level four being the highest. The WHSS team holds regular Service Level Agreement (SLA) meetings with Welsh providers, and at least an annual contract meeting with English providers. Escalated services are subject to enhanced performance management arrangements until significant improvement can be demonstrated to allow de-escalation.

43 During the height of the pandemic, WHSSC stood down SLA monitoring in line with the Welsh Government's practice. At this point only essential specialised services were being delivered. During this time, the WHSS team found it difficult to engage with both Welsh and English providers who were heavily focussed on the pandemic. Pragmatically, to overcome this they adopted a direct monitoring system, reviewing available performance data and challenging providers on the findings. WHSSC is still 'direct monitoring' services and is sharing information with the Welsh Government. Where the WHSS team has been able to proactively engage with providers they have been able to negotiate the continuation of some services. WHSSC reported that despite the pandemic, escalation arrangements continued to work well, and it has helped to highlight differences in activity and productivity between different providers.

44 The pandemic has also highlighted the need to review performance management arrangements and metrics. For example, performance against referral to treatment (RTT) waiting times was often used to determine escalation levels[4]. But in the current climate where RTT waiting times have risen across the NHS, it is difficult to differentiate risk of harm or patient outcome when so many patients are delayed and waiting. As a result, WHSSC is currently in the process of reviewing each service in escalation to see if it is still relevant. WHSSC does not currently have an overarching Performance Management Framework, although it has developed a performance analysis system called 'MAIR' (My Analytics and Information Reports). However, the team is developing a Commissioning Assurance Framework. The framework will set out a new performance assurance process alongside more outcome focussed performance measures. It also proposes an annual meeting between WHSSC executives and health board executives to understand commissioner priorities to feed into the Integrated Commissioning Plan development process. It is hoped the new framework will be launched alongside the refreshed Integrated Commissioning Plan. This is a positive development as monitoring services as they recover from the pandemic will need a different approach. Reviewing data on patient outcomes and harm will need to be an important part of these developing arrangements.

45 WHSSC's integrated performance dashboard is presented to the Corporate Directors Group Board and Management Group monthly, and to the Joint Committee bi-monthly. While there is discussion and challenge at commissioning team meetings, as stated earlier, we observed little scrutiny of this report at Joint Committee. The existing reports do not have a breadth of measures, reporting mainly on waiting times and RTT performance and there is opportunity to refresh these as part of post-pandemic recovery and the new Commissioner Performance Assurance Framework.

4 The escalation framework works on a four-tier basis with level four being the highest level of escalation. Services can be escalated for performance and/or quality issues.

WHSSC is driving quality improvement through its Quality Assurance Team and quality assurance framework

46 In 2015, the Good Governance Institute and HIW made several recommendations related to quality governance. Since these reviews, WHSSC has made good progress in improving quality governance. The Joint Committee has senior clinical representation, the Director of Nursing and Quality Assurance is a member of the Joint Committee and the Medical Director attends the meeting. At an operational level, each of the six multidisciplinary commissioning teams has an associate medical director for clinical advice and guidance.

47 A Quality Assurance team, led by the Director of Nursing and Quality Assurance, was established in 2019. The team is responsible for monitoring and learning from quality and patient experience to help improve commissioned services. Specifically, this includes managing and responding to complaints, near misses, serious incidents and never events. The team is also part of the multidisciplinary commissioning teams and is involved in planning and quality assuring commissioned services. In addition, WHSSC has updated its Quality Assurance Framework which was agreed in 2014 and will form part of the new Commissioning Assurance Framework.

48 To share intelligence and reduce duplication, the Quality Assurance team maintains good relationships with providers and regulators. For example, the team holds quarterly meetings with the quality leads at provider health boards to review a range of quality measures and information. They also use intelligence from regulators, clinical audit, and the National Collaborative Commissioning Unit (mental health services) to feed into planning and monitoring of services. There is a different system for English providers. NHS England has a quality assurance portal, which WHSSC accesses. Information on the portal is detailed and benchmarked against similar NHS England providers. WHSSC plans to replicate this approach for Swansea and Cardiff and Vale University Health Boards.

Strategic planning

49 Our work examined whether WHSSC has a clear and robust approach to strategic and financial planning. As a result of the pandemic, the specialised services environment has changed, with some services, particularly surgical, stopping or significantly curtailed. Our review found that **planning arrangements provide a good foundation but there is need for a clear strategy to respond to the challenges presented by COVID-19**.

Annual planning arrangements are generally effective, but recovery of services will be challenging

50 WHSSC currently undertakes planning each year culminating in a rolling three-year Integrated Commissioning Plan. This plan is agreed annually and has become increasingly timely and mature in recent years. There are clear stages of development and engagement with health boards as part of the approval process, prior to formal ratification/approval at the WHSSC Joint Committee. There is also a clear process and accountability for different stages of preparation and approval and, if necessary, consultation with relevant stakeholders.

51 WHSSC consults key stakeholders and the public on new commissioning policies, service specifications and revised commissioning policies where there are material changes to the service. There are good examples of this in relation to major trauma and thoracic surgery with the relevant community health councils actively engaging in stakeholder feedback and analysis. Community health council feedback informs both WHSSC planning and the relevant health boards whose population may be affected by proposed service changes.

52 The extent that health boards incorporate specialised services within their own integrated medium-term plans is variable across Wales. For example, Powys Teaching Health Board and Hywel Dda University Health Board rely more significantly on externally commissioned specialised services and we see these featuring in their plans more so than in the plans of the health boards that are specialised service providers.

53 Our work indicates that WHSSC has sufficient capacity and capability to support planning. That capacity and capability was drawn upon in 2020 to help support the Welsh Government's NHS Planning Team's review of health boards' quarterly plans, using their knowledge and experience of complex service planning. WHSSC's planning arrangements include significant contribution from each of the specialised services commissioning teams, clinical impact advisory group and WHSSC Management Group. Clinical advice helps to shape specialised services and WHSSC intends to increase the level of internal 'consultant-level' expertise further.

54 WHSSC has adopted a continuous approach for identifying and evaluating new research, treatments and using NICE[5] guidance to shape commissioned services. This 'horizon scanning' is supported by a consistent and transparent prioritisation process (**Exhibit 5**) to help ensure that investment decisions are affordable, offer value for money and are supported by convincing evidence of safety and effectiveness. The robustness of the approach helps to secure agreement of new proposals at the Joint Committee.

Exhibit 5 – key principles of the prioritisation process adopted by WHSSC

- Scoring and ranking of interventions by the WHSSC Prioritisation Panel is carried out using formal and agreed methodology
- The prioritisation process is intended not to duplicate work already completed (for example by NICE)
- There must be appropriate and timely engagement with NHS Wales as part of the process
- There are clear and agreed scoring criteria and voting technology is utilised during assessment. The criteria include:
  - Strength of clinical evidence
  - Patient benefit
  - Economic assessment
  - Burden of disease (severity of condition and also impact on the population)
  - Reducing inequalities of access

Source: Audit Wales fieldwork

5 National Institute for Health and Care Excellence https://www.nice.org.uk/

55 COVID-19 has significantly affected the delivery of specialised services across Wales and England. After the first wave of the pandemic, we understand that variation in service productivity between providers was increasing, with some providers able to restart specialised services earlier and with greater degrees of success than others. This creates a commissioning challenge as WHSSC looks to develop post-pandemic recovery plans on behalf of the population of Wales.

Information to support planning and commissioning is improving and will need to adapt to the challenges brought about by the pandemic

56 WHSSC's development of My Analytics and Information Reports (MAIR) in 2018-19 was a notable improvement on previous arrangements. WHSSC has worked closely with health board teams to ensure that health boards now have access to the comprehensive information sets now available. Reports can be tailored by health board or provider, by specialty and point of delivery. Results can also be made available using a variety of visualisation tools including maps, charts, tables, and pathways. This has enabled health boards to gain a deeper understanding of their demand patterns for specialised services and compare their own access rates to other health boards and inform areas for targeted review.

57 Plans for further development of MAIR include:

- Producing performance management dashboards and heat mapping
- Improving the timeliness of performance reporting
- Exploring how quality and outcomes data can be incorporated
- Improving the familiarisation of health boards with the variety of WHSSC's contracts by the production of deep dive reports.

58 Commissioning and contracting services can only be effective if there is robust information to inform operational and strategic decisions. Our work has identified that prior to the COVID-19 pandemic, there was a good track record of analysis of demand and capacity of services both in Wales and England. This will become even more important post-pandemic, to help provide options for recovering service performance and reducing risk of harm as a result of delays in access to care.

Delivery of Integrated Commissioning Plans is effective, but development and implementation of new services can be slow

59 For services that are already commissioned and being delivered, the necessary arrangements are in place to ensure they are resourced and being delivered as intended, with arrangements to escalate matters should there be any concerns.

60 Commissioning of new services from first consideration through to the launch of new services can, however, be a lengthy process, particularly for services provided in Wales. For example, the major trauma network in south Wales was launched in September 2020, after having been originally identified as necessary back in 2013, although WHSSC's involvement only commenced in 2018-19. Similarly, the improvements to thoracic surgery services, identified as necessary by the Royal College of Surgeon's report in 2016, are not expected to go live until 2024, and this is subject to a capital business case requiring Welsh Government funding.

61 Whilst introduction of new services is by no means simple, there has been protracted debate on where the new developments mentioned above should be housed, although the statutory engagement and consultation process, which is integral to this, can consume considerable time. The roll out of such schemes is not the sole domain of WHSSC and depends upon the wider architecture that supports regional service development within the NHS in Wales. There is scope, however, to strengthen end-to-end programme management of such schemes to improve timeliness of service development. The pandemic has created a common sense of urgency amongst providers. This momentum needs to be maintained to identify and rapidly develop or reshape services to accelerate recovery.

Financial planning arrangements are sufficiently robust and linked appropriately to the Integrated Commissioning Plan but will need to ensure value for money as services restart and aim to recover

62 Financial planning is an integral element of the Integrated Commissioning Plan. Health boards are fully engaged in discussions on costs and projected cost growth for the coming financial year during planning and agreement stages, prior to ratification of the plan. Cost growth is explicitly defined in the plan and justified through the agreed process for horizon scanning and prioritisation. Financial planning has two distinct elements:

- determining overall specialised services costs and the apportionment of these costs to health boards; and
- contracting and commissioning health boards and trusts in relation to provision of specialised services.

63 These are managed through financial risk-sharing agreements. These agreements set out who pays for what in relation to the provision and receipt of services. The risk sharing agreements are based on a financial formula and this is used both as part of planning and at the year-end to look at variance in activity against plan and determine distribution of under and overspends. There are different models for risk sharing designed to suit different types of commissioned services. For most services, planning is based on actual utilisation and a two-year average of activity. This is designed to smooth some peaks and troughs but also create incentive for efficiency. Highly specialised services which are not utilised often are funded using a population-based formula which is designed to provide continuity of income. This is to ensure services are sustainable, but also to protect against peaks of extreme costs when services are required.

64 Our review of health board expenditure on specialised services for the period 2014-15 to 2020-21[6] indicates the overall costs have increased above inflation. We understand that this is typical when new specialised therapies and treatments are developed and adopted into commissioning agreements.

65 In the short to medium term, however, the impact of COVID-19 on finances presents a number of challenges, including:

- payments to providers have continued in Wales and England albeit recent negotiations have resulted in rebates/reductions where there is under-delivery by providers;
- lack of service delivery during the pandemic has created a backlog of waits for some specialised services; and
- lack of patients presenting to primary and secondary care with symptoms during the pandemic may mean that there is greater hidden demand, and that conditions may have exacerbated, requiring more costly intervention downstream.

66 The Joint Committee should seek to understand the short and medium term financial impacts of COVID-19 to determine what this means for service recovery plans.

6 2019-20 data is taken from the Month 12 Health Board expenditure on Welsh Health Specialised Services. 2020-21 costs are based on forecast expenditure budgeted within the 2020-21 integrated commissioning plan. We acknowledge that 2019-20 data is currently unaudited, and 2020-21 data is subject to significant variation as a result of the COVID-19 outbreak.

Value-based commissioning approaches are improving, but to maximise recovery with finite resources, this now needs more strongly to link to patient outcomes, prioritisation, and de-commissioning

67 Prudent and value-based care is a core aspect of the 2020-2023 Integrated Commissioning Plan. This focussed on increasing the value achieved through improvement, innovation, use of best practice and eliminating waste. The value-based commissioning approach adopted by WHSSC is logical and methodical. This includes identifying commissioning opportunities, refining these, and engaging the WHSSC Management Group members and wider teams. WHSSC has developed thematic areas for value-based commissioning. Some of these will be easier to achieve than others and some may need to be pursued over a multi-year period. The areas include procurement, efficiency, service rationalisation, disinvestment, and assessing access criteria.

68 While COVID-19 has changed the position significantly, the extent of the original value-based commissioning savings for 2020-21 was around £2.75 million. Overall, our review has identified that WHSSC's value-based approach is developing and there is opportunity to exploit this further. In doing so, we expect there will need to be a clear and strong focus on collecting patient outcome information to inform the development of opportunities to reduce waste and maximise the benefit of investment in specialised care. For example, there remains greater opportunity to assess services:

- which do not demonstrate clinical efficacy or patient outcome (**stop**);
- which should no longer be considered specialised and therefore could transfer to become core services of health boards (**transfer**);
- where alternative interventions provide better outcome for the investment (**change**);
- currently commissioned, which should continue (**continue**).

COVID-19 has delayed the development of a new specialised services strategy, but this now provides the opportunity to shape the direction to focus on recovery, value and to exploit new technology and ways of working

69 A key function of commissioning relates to planning of services to meet population need. The specialised services strategy provides a framework for commissioning services, but the current version is dated 2012. Senior specialised services officers had intended to refresh the strategy in 2020, but this has been delayed by the pandemic. However, this gives specialised service officers the opportunity to shape the strategy to focus on COVID-19 recovery arrangements alongside routine technological, therapeutic and policy developments.

Future arrangements for commissioning specialised services

70 Our review, in examining both WHSSC's governance and planning arrangements indicates that **there would still be merit in reviewing the future arrangements for commissioning specialised services in line with the commitments of A Healthier Wales.**

71 **A Healthier Wales**, the Welsh Government's plan for health and social care in Wales signalled an intention to create a national executive to strengthen national leadership and strategic direction across a range of areas. Linked to this, **A Healthier Wales** signalled an intention to review a range of hosted national functions, including WHSSC, with the aim of consolidating national activity and clarifying governance and accountability.

72 Whilst the findings in this report show that the governance arrangements for WHSSC have continued to evolve positively in the main, they do also point to a need still to undertake the wider review signalled within **A Healthier Wales**. The current collaborative commissioning model has strengths in that it creates a collective and jointly owned approach to the planning and delivery of specialist services. However, it also has some inbuilt risks that sees individual Joint Committee members having to balance all-Wales needs with those of their population and the individual NHS bodies they lead.

73 The Good Governance Institute's report in 2015 questioned the hosting arrangements for WHSSC, suggesting that a more national model might be appropriate. WHSSC's hosting arrangements have remained unchanged since that report and our work has shown that in respect of WHSSC's governance, the use of the hosting health board's Audit and Risk Committee needs to be reviewed to ensure there is sufficient depth of debate and scrutiny (see **paragraphs 27** and **28 above**).

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

		Agenda Item	4.5
Meeting Title	**Joint Committee**	Meeting Date	13/07/2021
Report Title	WHSSC Committee Governance Arrangements – Management Response		
Author (Job title)	Committee Secretary & Head of Corporate Services		
Executive Lead (Job title)	Committee Secretary & Head of Corporate Services	Public	Public

Purpose	The purpose of this report is to present the management response to the Audit Wales report WHSSC Committee Governance Arrangements.			
RATIFY ☐	APPROVE ☐	SUPPORT ☐	ASSURE ☒	INFORM ☐

Sub Group /Committee	Audit Committee	Meeting Date	09/06/2021
Recommendation(s)	Members are asked to: • **Note** the report and the proposed WHSSC management response to the Audit Wales recommendations outlined in the WHSSC Committee Governance Arrangements report, • **Note** the Welsh Government response to the Audit Wales recommendations outlined in the WHSSC Committee Governance Arrangements report.		

Considerations within the report (tick as appropriate)

	YES	NO		YES	NO		YES	NO
Strategic Objective(s)	✓		Link to Integrated Commissioning Plan			Health and Care Standards		
Principles of Prudent Healthcare			IHI Triple Aim			Quality, Safety & Patient Experience		
Resources Implications			Risk and Assurance			Evidence Base		
Equality and Diversity			Population Health			Legal Implications		

Commissioner Health Board affected

Aneurin Bevan	✓	Betsi Cadwaladr	✓	Cardiff and Vale	✓	Cwm Taf Morgannwg	✓	Hywel Dda	✓	Powys	✓	Swansea Bay	✓

Provider Health Board affected (please state below)

WHSSC COMMITTEE GOVERNANCE ARRANGEMENTS – MANAGEMENT RESPONSE

1.0 SITUATION

The purpose of this report is to present the management response to the Audit Wales report WHSSC Committee Governance Arrangements.

2.0 BACKGROUND

In 2015, the Good Governance Institute (GGI) and Healthcare Inspectorate Wales (HIW) undertook two separate governance reviews for WHSSC which highlighted issues with WHSSC's governance arrangements. The GGI highlighted concerns relating to decision making and conflicts of interest, and identified the need to improve senior level clinical input as well as the need to create a more independent organisation that is free to make strong and sometimes unpopular (to some) decisions in the best interest of the people of Wales. HIW) conducted a review of clinical governance and found that WHSSC was beginning to strengthen its clinical governance arrangements but needed to strengthen its approach for monitoring service quality and also improve clinical engagement.

Since then, considering the increasing service and financial pressures, and the potentially changing landscape of national collaborative commissioning and NHS Executive as set out in Welsh Government's "A Healthier Wales", the Auditor General for Wales felt it was timely to undertake a review WHSSC's governance arrangements.

The Audit Wales review into Committee Governance arrangements at WHSSC was undertaken between March and June 2020, however as a result of the COVID-19 pandemic, aspects of the review were paused, and re-commenced in July. A survey was issued to all Health Boards and the fieldwork was concluded in October 2020.

The scope of the work included interviews with officers and independent members at WHSSC, observations from attending Joint Committee and sub-committee meetings, feedback from questionnaires issued to Health Board Chief Executive and Chairs and a review of corporate documents.

The findings were published in May 2021 in the Audit Wales Committee Governance Arrangements at WHSSC report.

The report outlined 4 recommendations for WHSSC and the 3 recommendations for Welsh Government.

3.0 MANAGEMENT RESPONSE

3.1 WHSSC Management Response

The report outlined 4 recommendations for WHSSC and the draft management response has been circulated to Health Board CEO's, Welsh Government and Audit Wales for comment and feedback.

The feedback received has been reviewed and the updated WHSSC management response is presented at ***Appendix 1*** for information and assurance.

Progress against the actions outlined within the management response will be monitored through the Integrated Governance Committee (IGC) on a quarterly basis, and a full progress report will be presented to the Joint Committee 18 January 2022, once the actions related to the Integrated Commissioning Plan (ICP) process and engagement events have been completed.

3.2 Welsh Government Management Response

The report outlined 3 recommendations for Welsh Government (WG) and the management response is outlined in the letter from Dr Andrew Goodall, Director General Health & Social Services/ NHS Wales Chief Executive to Mr Adrian Crompton, Auditor General for Wales which is presented at ***Appendix 2*** for information and assurance.

Progress against the WG management response will be monitored through discussions between the Chair, the WHSSC Managing Director and the Director General Health & Social Services/ NHS Wales Chief executive.

4.0 GOVERNANCE & RISK

Audit Wales undertake an annual programme of independent external audits on NHS services, and NHS bodies are required to present a formal management response to recommendations through a public report.

5.0 RECOMMENDATIONS

Members are asked to:

- **Note** the report and the proposed WHSSC management response to the Audit Wales recommendations outlined in the WHSSC Committee Governance Arrangements report; and
- **Note** the Welsh Government response to the Audit Wales recommendations outlined in the WHSSC Committee Governance Arrangements report; and
- **Note** the proposed arrangements for monitoring progress against the actions outlined in the management responses.

6.0 APPENDICES / ANNEXES

Appendix 1 - WHSSC Management Response to the Audit Wales Report Committee Governance Arrangements at WHSSC
Appendix 2 – Letter from Welsh Government to Audit Wales – Welsh Government's Management Response

Link to Healthcare Objectives	
Strategic Objective(s)	Governance and Assurance Choose an item. Choose an item.
Link to Integrated Commissioning Plan	Implementation of the agreed ICP
Health and Care Standards	Safe Care Effective Care Governance, Leadership and Accountability
Principles of Prudent Healthcare	Only do what is needed Reduce inappropriate variation Choose an item.
Institute for HealthCare Improvement Triple Aim	Improving Patient Experience (including quality and Satisfaction) Choose an item. Choose an item.
Organisational Implications	
Quality, Safety & Patient Experience	The Management responses outline activities to strengthen and develop WHSSC's impact on quality, safety and patient experience.
Resources Implications	Some improvement actions may require the application of additional resources.
Risk and Assurance	Risk management is a key element of developing WHSSC's services and risk assessments will be undertaken as required.
Evidence Base	-
Equality and Diversity	There are no equality and diversity implications.
Population Health	There are no immediate population health implications.
Legal Implications	There are no direct legal implications.

Report History:		
Presented at:	**Date**	**Brief Summary of Outcome**

Response to the Recommendations from the Audit Wales Report Welsh Health Specialised Services Committee Governance Arrangements

In May 2021, Audit Wales published the "Welsh Health Specialised Services Committee Governance Arrangements"[1] which found that the governance, management and planning arrangements at WHSSC have improved, however the impact of COVID-19 will require a clear strategy to recover key services and that the Welsh Government's long-term model for health and social care 'A Healthier Wales', and the references made to WHSSC should be re-visited.

Audit Wales made a number of recommendations for both WHSSC and Welsh Government and the management response to the WHSSC recommendations are outlined below:

Recommendation	Response/ Action	By when	By whom
Quality governance and management			
R1 Increase the focus on quality at the Joint Committee. This should ensure effective focus and discussion on the pace of improvement for those services in escalation and driving quality and outcome improvements for patients.	We accept the recommendation and intend to take the following actions. We will include in our routine reports to Joint Committee (JC) on quality, performance and finance a section highlighting key areas of concern to promote effective focus and discussion. We will develop a revised suite of routine reports for JC that will include elements of the activity reporting, that we introduced during the pandemic, and will take into account the quality and outcome reporting that is currently being developed by Welsh Government (WG).	Sept 2021 Mar 2022	WHSSC Executive leads WHSSC Executive leads

[1] Welsh Health Specialised Services Committee Governance Arrangements (audit.wales)

Recommendation	Response/ Action	By when	By whom
	We will encourage members of the JC to engage in consideration and discussion of key areas of concern that are highlighted. We will include routinely at JC an invitation for an oral report to be delivered by, or on behalf of, the Chair of the WHSSC Quality & Patient Safety Committee (Q&PSC) based on the written report from the Chair of Q&PSC.	Sept 2021 Sept 2021	Chair of WHSSC Chair of WHSSC
Programme Management			
R2 Implement clear programme management arrangements for the introduction of new commissioned services. This should include clear and explicit milestones which are set from concept through to completion (i.e. early in the development through to post implementation benefits analysis). Progress reporting against those milestones should then form part of reporting into the Joint Committee.	We accept the recommendation and intend to take the following actions. **a) Building Programme Management competency/capacity** A number of new staff have recently joined WHSSC in senior positions in the planning team who bring with them strong programme and project management skills. There are 'lunch and learn' sessions planned to share this approach, and the use of common templates is embedding, it is anticipated that this approach will grow programme management competency and capacity within the organisation. The approach is already starting to embed in the way the planning team operates, with programme management approaches already	To commence Sept 2021	WHSSC Director of Planning

Recommendation	Response/ Action	By when	By whom
	applied to the two strategic pieces committed to through the 2021 ICP (namely paediatrics and mental health) and to the management of the CIAG prioritisation process. Common templates apply to highlight and exception reporting, risk logs and timelines/milestones. **b) Programme management on WHSSC commissioned services.** Programme arrangements have previously been used for strategic service reviews and the development of the PET (positron Emission Therapy) business case. We will further develop this approach as outlined above, i.e. through a common approach to programme management across the organisation and to and the use of common templates. These will become the basis of reporting through programme structures and as necessary to joint committee. **c) HB Commissioned Services** – when services are not the sole responsibility of WHSSC, and where the senior responsible officer is outside of WHSSC, we will contribute to the programme arrangements, offering clarity about the role of WHSSC and		

Recommendation	Response/ Action	By when	By whom
	the scope of the responsibilities it has within the programme. We will seek to deliver against any key milestones set, and report progress, risk and exception accordingly.		
Recovery Planning			
R3 In the short to medium term, the impact of COVID-19 presents a number of challenges. WHSSC should undertake a review and report analysis on: a. the backlog of waits for specialised services, how these will be managed whilst reducing patient harm. b. potential impact and cost of managing hidden demand. That being patients that did not present to primary or secondary care during the pandemic, with conditions potentially worsening. c. the financial consequences of services that were commissioned and under-delivered as a result of COVID-19, including the under-delivery of services commissioned from England. This should be used to inform contract negotiation.	We accept the recommendation and recognise the post COVID-19 recovery challenges. We intend to take the following actions. **a) Managing backlog of waits whilst reducing harm** i. Introduction of real-time monitoring and reporting of waiting times to Management Group and Joint Committee ii. Review of recovery plans with Welsh provider Health Boards, iii. Regular Reset and Recovery meetings with services to monitor performance against plans. Significant variance from plans will be managed through the WHSSC escalation process iv. Introduction of the WHSSC Commissioner Assurance Framework (CAF), v. Workshop with Joint Committee members on how to deliver 'equity' in specialised services. Report shared with HBs and WG.	Sep 2021 Jul 2021 From Apr 2021 In place In place Completed May 2021	WHSSC Executive leads WHSSC Executive leads

Recommendation	Response/ Action	By when	By whom
	b) Potential impact and cost of managing hidden demand. i. Introduction of demand monitoring compared to historical levels for high volume specialties, findings to be reported to the WG Planned Care Board and HBs to inform non-WHSSC commissioned pathway development. ii. Appointment of an Associate Medical Director for Public Health to work with Health Board Directors of Public Health to assess impact. **c)Financial consequences of services that were commissioned and under-delivered as a result of COVID-19** i. This information is already captured through our contract monitoring process and compared against the national block contract framework implemented to maintain income stability through COVID-19. This will inform future planned baselines and contract negotiation, where the negotiation is within our control. WHSSC is working with contracted providers across Wales and England to establish their specialised recovery trajectories	In Place Q3/Q4 2021/22 In Place	WHSSC Executive leads

Recommendation	Response/ Action	By when	By whom
	and where appropriate will secure recovery funding from WG to direct to providers for recovery performance if above established contracted baseline levels. **d) Reporting Analysis** We will review and analyse the business intelligence gathered from the actions outlined in points a,b and c above and use the real-time and historical data to inform our decision making on managing existing, and developing new specialised commissioned services. We will report our analysis and outcomes to the Joint Committee, Welsh Government and the Management Group as appropriate.	Sept 2021	
Specialised Services Strategy			
R4 The current specialised services strategy was approved in 2012. WHSSC should develop and approve a new strategy during 2021. This should: a. embrace new therapeutic and technological innovations, drive value, consider best practice commissioning models in place elsewhere, and drive a short, medium, and long-term approach for post pandemic recovery. b. be informed by a review of the extent of the wider services already commissioned by WHSSC, by	We accept the recommendation and work had begun on developing a new Commissioning strategy, however the COVID-19 pandemic delayed progress. To move forward the new specialised services strategy will be informed by the WG policy for reset and recovery. We intend to take the following actions. **a. Embrace New Innovations** i. We will continue to utilise our well-established horizon scanning	Q4 2021/22 In place Jul 2021	WHSSC Managing Director

Recommendation	Response/ Action	By when	By whom
developing a value-based service assessment to better inform commissioning intent and options for driving value and where necessary decommissioning. The review should assess services: • which do not demonstrate clinical efficacy or patient outcome (stop); • which should no longer be considered specialised and therefore could transfer to become core services of health boards (transfer); • where alternative interventions provide better outcome for the investment (change); • currently commissioned, which should continue (continue).	process to identify new therapeutic and technological innovations, drive value and benchmark services against other commissioning models to support , short, medium, and long-term approach for post pandemic recovery ii. We will continue to develop our relationship with NICE, AWMSG and HTW in relation to the evaluation of new drugs and interventions, iii. We will engage with developments for digital and Artificial intelligence (AI), iv. We will continue our regular dialogue and knowledge sharing with the four nations' specialised services commissioners, v. We will continue to build upon our existing relationships with the Royal Colleges, vi. We will continue to develop our work on value-based commissioning, vii. We will develop a communication and engagement plan to support and inform the strategy. viii. As previously agreed with Joint Committee a stakeholder engagement exercise will be undertaken to gain insight on long term ambitions and to inform how	Q3 2021/22 In place Dec 2021 Dec 2021	

Recommendation	Response/ Action	By when	By whom
	we shape and design our services for the future. This will inform the Specialised Services Strategy and the supporting the 3 year integrated commissioning plan. **b. Approach to Review of Services will be considered in strategy engagement** i. The draft strategy will consider our approach to the review of the existing portfolio of commissioned services and undertake a value based services assessment to assess if existing services are still categorised as specialised, ii. We will continue to undertake our annual prioritisation panel with HB's to assess new specialised services that could be commissioned, iii. We will continue to undertake a process of continuous horizon scanning to identify potential new and emerging services and drugs, and to focus on existing and new hyper-specialised services, iv. WHSSC will investigate opportunities for strengthening its information function through internal re-organisation and investment. This will include the development of an outcome	Sept 2021	

Recommendation	Response/ Action	By when	By whom
	manager post to support both the WHSSC strategic approach to outcome measurement as well as a feasibility analysis of currently available tools. We will pursue our planned investment to utilise the SAIL database with a view to assessing the population impact of services in a number of pilot areas. As previously agreed with the Joint Committee a stakeholder engagement exercise will be undertaken to gain insight from our stakeholders on long term ambitions and to inform how we shape and design our services for the future. This will inform transferring commissioned services into and out of the WHSSC portfolio to meet stakeholder and patient demand.		

Cyfarwyddwr Cyffredinol Iechyd a Gwasanaethau Cymdeithasol/
Prif Weithredwr GIG Cymru
Grŵp Iechyd a Gwasanaethau Cymdeithasol

Director General Health and Social Services/
NHS Wales Chief Executive
Health and Social Services Group

Llywodraeth Cymru
Welsh Government

Mr Adrian Crompton
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c/o Dave.Thomas@audit.wales

2 June 2021

Dear Adrian

Welsh Health Specialised Services Committee (WHSSC) Governance Arrangements: Report of the Auditor General for Wales, May 2021

Thank you for the above Audit Wales report, published on 12 May.

I welcome your conclusion that governance arrangements and decision making at WHSSC have improved since previous reviews. The WHSSC team has worked hard to make these changes and I will expect them to make further progress by addressing your recommendations in relation to an increased focus on quality, programme management, COVID-19 recovery and the specialised services strategy. My officials will be following up on these areas at their regular meetings with WHSSC.

In terms of your recommendations to the Welsh Government, I set out my initial response below, although these may well be subject to any views from the new Minister in light of her priorities.

Recommendation 5: Independent Member recruitment – accepted and action in train

I am aware there have been challenges in securing nominations from health boards to undertake the independent member role at WHSSC. My officials have been looking at options in relation to recruitment, remuneration and retention of independent members and I am currently considering their advice before the matter is raised with the Minister. There are a number of options, some of which could be achieved relatively simply and others which would require changes to the legislation. I will write to you again when we have a clear way forward.

BUDDSODDWYR MEWN POBL | INVESTORS IN PEOPLE

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Recommendation 6: Sub-regional and regional programme management (linked to recommendation 2 directed to WHSSC) – accepted

As you have highlighted, whilst some key service areas like major trauma have been developed successfully and with good collaboration across organisations, the timelines around such changes have been slow and often hampered by a lack of clarity on who is driving the process. I agree with your view that end-to-end programme management of such schemes, which are not within the sole remit of WHSSC, should be strengthened. The National Clinical Framework which we published on 22 March, sets out a vision for a health system that is co-ordinated centrally and delivered locally or through regional collaborations. Implementation will be taken forward through NHS planning and quality improvement approaches and our accountability arrangements with NHS bodies.

Recommendation 7: Future governance and accountability arrangements for specialised services – accepted in principle

A Healthier Wales committed to reviewing the WHSSC arrangements alongside other hosted national and specialised functions, in the context of the development of the NHS Executive function. The position of WHSSC within this landscape needs to be carefully considered. On the one hand, there are strengths in the current system whereby health boards, through the joint committee, retain overall responsibility for the commissioning of specialised services. This requires collaboration and mature discussion from both the commissioner and provider standpoint. However, I recognise the inherent risk of conflict of interest in this arrangement and note the reference made in your report to the Good Governance Institute's report of 2015 which suggested a more national model may be appropriate.

In my letter to health boards of 14 August 2019, I indicated that, as recommended by the Parliamentary Review, the governance and hosting arrangements for the existing Joint Committees would be streamlined and standardised. I also said that it was intended the NHS Executive would be become a member of the Joint Committees' Boards in order to ensure there is a stronger national focus to decision making. However, the thinking at the time was that the joint committee functions would not be subsumed into the NHS Executive function. We will continue to look at this as the NHS Executive function develops further and I will update you should there be any change to the direction of travel I indicated in 2019.

Yours sincerely

Dr Andrew Goodall CBE

cc: Chair of the Senedd Public Accounts Committee.

Reporting Committee	**Quality Patient Safety Committee**
Chaired by	**Ceri Phillips**
Lead Executive Director	**Director of Nursing & Quality**
Date of Meeting	**10 August**

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

- **Update from the Welsh Renal Clinical Network**

The report from the Welsh Clinical Renal Network was received and considered. The Network Lead highlighted the National Renal Audit Day taking place on 24 September 2021 and extended an invitation to Members to attend if wished to do so. Members noted the Home Dialysis Peer Review completed in July 2021 and noted that the process had identified several areas of excellent performance in each of the 5 Renal Units reviews, as well as highlighting areas for improvement/action.

- **Presentation – QAIS – Summary of the Review of the NHS Wales CAMHS In-Patient Services Report**

Members received a presentation for information from Shane Mills, Director of Quality and Mental Health, NCCU who introduced slides on the following:

- Latest Benchmarking information for children and young people:
- Review of the two Tier 4 CAMHS Units that WHSSC commission:
- Review of designated beds for children and young people on adult wards requested by Welsh Government:
- Pandemic: Expected impact on Children and Young People's Mental Health:
- Actions; and
- Overview of the issues.

A copy of the review of designated beds for children and young people on adult wards report commissioned by Welsh Government is available to Joint Committee members upon request.

Members noted the increase in children with eating disorders and that WHSSC had undertaken a piece of work to understand the increase in demand, the outcome of which was being reviewed and would be reported back to the Committee in due course.

- **Patient Story – Rookwood Hospital Prosthetics Service**

Members received a patient story and update from Gwen Griffith, Prosthetist at C&VUHB and her patient DB who had been fitted with a microprocessor controlled

prosthetic knee (MPK) 3 years after having his leg amputated above the knee aged 59. Members agreed the impact on emotional health of the MPK recipient was unquantifiable and noted that financial impact should never be the most important consideration in such a situation.

- **Commissioning Assurance Framework**

Members received and considered the report the purpose of which was to present the Commissioning Assurance Framework and suite of documents prior to submission to the Joint Committee on 07 September 2021 for final approval It was noted that the Patient Engagement & Experience Framework had recently been discussed at Corporate Directors Group Board (CDGB) and following feedback the document would be strengthened to incorporate some additional information and that those minor amendments would be made prior to requesting final approval from Joint Committee in September 2021.

Members welcomed the inclusion of patient feedback and engagement in the CAF. Members were assured that whilst the CAF had a review date of 2024 it would be kept under constant review and updated as and when necessary.

- **Commissioning Team and updates**

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

- **Cancer & Blood**

Members received the Cancer & Blood report and noted the progress made.

- **Cardiac**

Members received an update on the Getting It Right First Time (GIRFT) review of cardiac services and noted that cardiac services in SBUHB had been escalated to Level 4 of the WHSSC escalation process and that Cardiac services in CVUHB had been escalated to Level 2.

Members discussed the report and noted that a report had been presented to the Joint Committee's "in committee" meeting on the 13 July 2021, and noted that reassurance had been provided to the Committee that a number of immediate actions had been taken, and that it had been agreed that progress on the recommendations made would be monitored through the Q&PS Committee.

- **Mental Health & Vulnerable Groups**

Members noted that Ty Llidiard had been escalated to Level 4, a joint decision taken by both the Health Board and WHSSC as Commissioner.

Members also noted that Cefn Carnau a low secure provision had served notice on a complex patient requiring a medium secure placement. Despite extensive searching by the Case Managers and the Health Board of residency supported by

QAIS a placement had yet to be secured. Ongoing work with providers such as Llanarth Court was in progress alongside the development of a possible bespoke placement.

Members noted that WHSSC had placements for two of the NHS Wales patients currently at the St Johns Priory Group being decommissioned on 31 August. The WHSS Team are waiting to confirm a placement for the third and the matter had been escalated to the Chief Executive Officers of the affected Health Boards including the need to have a contingency plan in place in case WHSSC were unable to place any of the patients. SL reported the WHSS Team were working with medium secure providers to develop an All Wales response to this situation. Members agreed an update on the St John's patients would be provided at the next meeting.

- **Neurosciences**

Members noted the Cochlear Implant Service risk score had been lowered from 25 to 16 and that a programme of work had been developed including work streams to define the scope of service change and undertake an option appraisal on the delivery of the service. Workshops would take place in September 2021 with a view to preparing and approving the relevant documentation by the end of 2021 and proceeding to consultation early 2022.

- **Women & Children**

Members noted the following:

- There are a number of fragile paediatric services in sub-specialty areas but that there was some recruitment funding available that would reduce some of the risks. WHSSC developing a paediatric specialist service strategy;
- Serious concerns around staffing in neonatal services as a result of absence from work, in particular as a result of staff being pinged by the NHS COVID app, which may be alleviated in October as newly qualified nurses take up their posts. NHS England similarly affected;
- A number of pregnant women delivering early as they have been admitted to hospital with COVID-19 and are in the unvaccinated community;
- An increase in the number of children in hospital with respiratory viruses, expected over winter but presenting earlier than anticipated.

- **Intestinal Failure**

Members noted WHSSC intended to undertake a review of intestinal failure services and that the WHSS Team had already engaged with the providers and the review was welcomed by all parties.

- **Other Reports received**

Members received reports on the following:

- **Services in Escalation Summary**
- **CRAF Risk Assurance Framework**
- **WHSSC Policy Group**
- **CQC/HIW Summary Update**

- **Incidents and Complaints Report**

- **Items for information**

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

- Chair's Report and Escalation Summary to Joint Committee 13 July 2021;
- National Patient Safety Incident Reporting Policy – Implementation Group;
- National Framework for Managing Patient Safety Incidents following Nosocomial COVID-19;
- NHS Wales Quality Assurance Improvement Service 2021 9th Annual Position Statement 2020-2021;
- NHS Wales Executive Board – Duty of Quality and Candour; and
- Health Board QPS Leads Contacts

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

Cardiac Service – The GIRFT report and escalation of these services.
Ty Llidiard escalation to Level 4

Summary of services in Escalation (Appendix 1 attached)

Matters requiring Committee level consideration and/or approval

The Committee are asked to note the concerns raised regarding adult Cleft Lip and Palate Services and the actions requested.

Matters referred to other Committees

None

Confirmed Minutes for the meeting are available upon request

Date of next scheduled meeting:	12 October 2021

SERVICES IN ESCALATION

Date of Escalation	Service	Provider	Level of Escalation	Reason for Escalation	Current Position	Movement from last month
November 2017	North Wales Adolescent Service (NWAS)	BCUHB	2	• Medical workforce and shortages operational capacity • Lack of access to other Health Board provision including Paediatrics and Adult Mental Health. Number of Out-of-Area admissions	• QAIS report outlined key areas for development including the recommendation to consider the location of NWAS due to lack of access on site to other health board provision. • Participation in weekly bed management panel meeting • Environmental works complete. Unit currently able to accommodate full 12 bed establishment.	

Date of Escalation	Service	Provider	Level of Escalation	Reason for Escalation	Current Position	Movement from last month
March 2018 Sept 2020 June 2021	Ty Llidiard	CTMUHB	4	• Unexpected Patient death and frequent SUIs revealed patient safety concerns due to environmental shortfalls and poor governance • SUI 11th September • Culture & Leadership issues raised by CTMUHB	• Concerns raised by CTMUHB re culture & leadership issues in the unit which were being investigated • Emergency Response to the unit remain outstanding from March 2018 • Paper to CDGB on 28th June 2021 decision made to escalate to level 4. Mr Stuart Davies identified as Executive Lead • Letter to Health Board explaining decision • Meeting with Health Board 12th July 2021 with agreed actions going forward • Letter from CEO CTMUHB with actions to be taken against 8 agreed action points • Letter from WG 9thJuly 2021 concerning Ty Llidiard	

					• Next escalation meeting 10th August 2021	
Date of Escalation	**Service**	**Provider**	**Level of Escalation**	**Reason for Escalation**	**Current Position**	**Movement from last month**
September 2019	Cochlear Implant Service	South Wales	4	• Quality and Patient Safety concerns from C&V Cochlear Implant team, from the patients who were immediately transferred to the service in Cardiff following the loss of audiology support from the Bridgend service.	• C&VUHB treating all patients • Interim CHC arrangements agreed • Following further discussions with WHSSC Corporate Directors, it was agreed that an initial key piece of work, which was started prior to the concerns raised about the Bridgend service should be re-established before the commencement of the engagement process. • It is anticipated that the first 2 workshops will take place in September. The aspiration is that documentation can be prepared and approved by the end of the calendar year, with a view to commencing consultation early 2022, subject to capacity within the Planning team.	

Date of Escalation	Service	Provider	Level of Escalation	Reason for Escalation	Current Position	Movement from last month
February 2020	TAVI	SBUHB	2	• Quality and Patient Safety concerns due to the lack of assurance provided to the WHSS team regarding the actions taken by the HB to address 4 Serious Incidents relating to vascular complications.	• Action Plan completed • Service sustainability being monitored through the bi-monthly Risk, Assurance and Recovery meetings (next Meeting July 2021) • WHSSC Quality Team to monitor PROMS and PREMS on a quarterly basis	
July 2021	Cardiac Surgery	SBUHB	4	• Lack of assurance regarding current performance, processes and quality and patient safety based on the findings from the Getting It Right First Time review	• QPS agreed the monitoring arrangements in place, with 6 weekly meetings • Further discussions to be held with both South Wales centers regarding the future pathways for aorto-vascular cases	

Date of Escalation	Service	Provider	Level of Escalation	Reason for Escalation	Current Position	Movement from last month
July 2021	Cardiac Surgery	C&VUHB	2	• Lack of assurance regarding processes and patient flow which impact on patient experience	• C&VUHB in process of agreeing a Programme of improvement work to address the recommendations set out in the GIRFT report • Outline programmed to be shared with WHSSC • Bi- monthly meetings agreed for monitoring purposes	
September 2020	FACTS	CTMUHB	3	• Workforce issue	• 5 CQV meetings have now been held. Still waiting for substantive. Consultant Psychiatrist role to be advertised. Plans in place for all other roles. FACTS service specification is still in development. Next CQV meeting is planned for 2nd August.	

Level of escalation reducing / improving position

Level of escalation unchanged from previous report/month

Level of escalation increasing / worsening position

The Health and Social Care (Quality and Engagement) (Wales) Act 2020

Implementation Update – Summer 2021

Welcome to the first edition of our newsletter. These newsletters will be an opportunity to share updates with you on our progress in implementing the Health and Social Care (Quality and Engagement) (Wales) Act 2020.

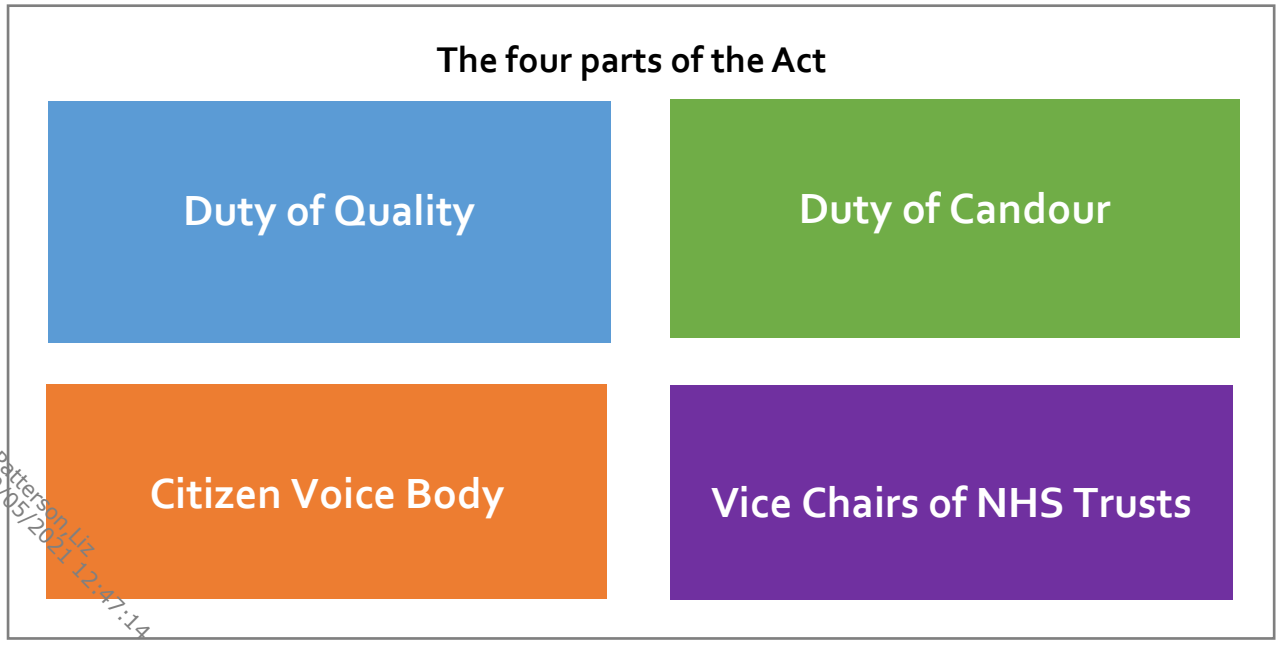
This first newsletter sets the scene by summarising the key aims of the Act; beginning to describe what it will mean in practice and setting out the initial work we are undertaking in relation to each part of the Act.

The Act is a lever for improving and protecting the health, care and well-being of the current and future population of Wales.

It builds on our existing health and social care systems. It aims to ensure a stronger citizen voice and to improve the accountability of services, to deliver a better experience and quality of care. Doing so contributes to a healthy and more prosperous country.

In totality , the parts of the Act are intended to have a cumulative positive benefit for everyone in Wales; supporting a culture and the conditions that focus on driving improvements in health and social care.

The Welsh Government aims to bring all of the Act into force by April 2023.



Duty of Quality

What is it?

Health services will need to show that delivering excellent quality of care is at the heart of all they do. They must ensure **a system-wide approach to achieve quality of care in a way that secures continuous improvement** in quality and improved outcomes for the population.

The Duty of Quality focuses on the **6 domains of quality**: Safe, Effective, Person-centred, Timely, Efficient, Equitable care. It seeks to strengthen these domains across a maturing **Quality Management System.**

Components of a Quality Management System.

The Duty of Quality applies to **all clinical and non-clinical health service functions** in Health Boards, NHS Trusts and Special Health Authorities.

It **also applies to the Welsh Ministers** in their health related functions.

What will it mean?

Ministers and NHS organisations will have to **actively consider** whether decisions they make will improve the quality of services and lead to improved outcomes for people.

Ministers and NHS organisations will also need to **publish an annual report** that describes how they have complied with the Duty. This will include an assessment of any improvement in outcomes achieved for people. The assessment must be supported with evidence.

How will it happen?

To support the implementation programme there will be:

- A digital awareness campaign and training for NHS and Welsh Government staff.
- Enhanced training for Welsh Ministers and Board members of NHS organisations.
- Statutory Guidance will be published about how assessments of any improvement should be undertaken and the types of evidence to use.
- Supporting resources will be produced.

Several **work streams** will support the implementation programme:

Work stream 1: Duty of Quality Overarching principles and guidance development	Work stream 2: Quality Reporting Framework	Work stream 3: Health and Care Standards review
Work stream 4: Communication and Engagement		
Work stream 5: Education		

Duty of Candour

What is it?

The duty applies when a person who is in receipt of health care suffers an adverse outcome and the health care provided was or may have been a factor.

A person suffers an adverse outcome if they experience, or could experience, any unintended or unexpected harm that is more than minimal.

The duty will apply to NHS bodies (Health Boards, Trusts, Welsh Special Health Authorities and NHS Blood and Transplant, in relation to their Welsh functions) and to primary care providers in Wales (in respect of services they provide under arrangements with a Health Board).

The introduction of the duty at an organisational level, highlights the Welsh Government's commitment to safe, effective and person-centred health services. It will also support health professionals to comply with the duties of candour that apply to them as part of their professional regulation.

We also plan to make regulations under the Care Standards Act 2000, to place a duty of candour on regulated independent healthcare providers.

What will it mean?

The key intention of the duty is to promote a culture of openness, learning and improving that is owned at organisational level.

The duty will mean that NHS bodies and primary care will be required to follow a procedure when the duty is triggered. There is also a duty to prepare an annual report. Triggering the duty does not mean an NHS body accepts any fault or blame.

How will it happen?

To support implementation of the duty, the Welsh Ministers will:

- **Publish statutory guidance**, which aims to provide a framework of best practice.
- **Hold stakeholder workshops** from October to December 2021, to co-develop the guidance.
- **Make Regulations** that will set out the procedure to be followed when the duty is triggered.

There will be full public consultation in Spring 2022, with the aim of finalising the guidance and Regulations in October 2022, in readiness for the duty coming into force in April 2023.

E-learning packages will be developed to cascade training and ensure awareness. There will also be a campaign to increase public awareness of the duty of candour. Easy read leaflets will be developed and engagement will take place across Wales.

Essentially, we will do whatever we can to ensure the duty is embedded and owned by the NHS in Wales.

The Citizen Voice Body for Health and Social Care

What is it?

From April 2023, the Citizen Voice Body ('the CVB') will independently represent the interests of the public in relation to health and social care, and replace Community Health Councils ('CHCs'). Its role will be to:

- **actively seek and listen** to the views of service users, carers and wider public;
- **support individuals** throughout Wales with advice and assistance when making a complaint about their care;
- **make representations to NHS bodies and local authorities** about the provision of health or social services;
- **help ensure people's experiences drive continuous improvement** – local, regional and national plans and policy.

What will it mean?

Creating the CVB reflects the Welsh Government's commitment to support integration of health and social services. It will be at the heart of conversation with the Welsh public, working together with NHS bodies and local authorities, and alongside other public, independent and volunteer organisations to strengthen the voice of citizens: building greater connections; leading to better outcomes.

Alongside NHS bodies and local authorities, the CVB must promote public awareness of its objectives and activities. They will work together in this and support the CVB to seek people's views about health and social care.

NHS bodies and local authorities must take into consideration any representations made to them by the CVB about their services and follow statutory guidance. They will supply the CVB with information it reasonably requests and all must have regard to a code of practice on access to premises. The guidance and code are in development and will be consulted upon.

As a national organisation the CVB must represent the interests of; be accessible to; and engage effectively with people in all parts of Wales. It will recognise the importance of face-to-face engagement when seeking individuals' views and providing complaints advocacy; for children and adults in relation to NHS complaints and on a wide range of social care matters, excluding only those where young people have existing rights to assistance.

How will it happen?

Work to establish and integrate the new body, managing the transition from CHCs, is underway. It is led by the CVB Steering Group and its work streams: People and HR; Locations; Digital and ICT; Governance and Finance; Legislation; Communications; Training. The CVB Board will be established during 2022-23 to enable its engagement in making critical decisions.

Public, independent and voluntary sector partners across health and social care will remain informed and involved, as part of a Stakeholder Reference Network. This will be set up in the autumn to engage organisations – as a collective or those most concerned – seeking their views and expertise at key milestones.

Vice Chairs of NHS Trusts

This element will allow the public appointment of statutory Vice Chairs of NHS Trusts.

This will improve their governance arrangements and bring them into line with those of Local Health Boards.

Following engagement with Chairs, Chief Executives and Board Secretaries, Dr Andrew Goodall, Director General for Health and Social Services and NHS Wales Chief Executive, wrote to NHS Trusts in April to confirm our intention that Regulations will be in place by the end of 2021.

Have you seen the Welsh Government website on the Quality and Engagement Act?

For more information and to view the Act, head to our website:

https://gov.wales/health-and-social-care-quality-and-engagement-wales-act

Newsletter feedback

- Do you have any comments about this newsletter?
- Are there areas of the Act you would like future newsletters to cover?

You can contact us at:
HSCQualityandEngagement@gov.wales