Patient Experience, Quality & Safety Committee

Tue 04 July 2023, 09:30 - 12:30

Agenda

09:30 - 09:30
0 min

1. PRELIMINARY MATTERS

PEQS_ Agenda_4 July2023.pdf (2 pages)

1.1. Welcome and Apologies

1.2. Declarations of Interest

1.3. Minutes from the previous meeting held on the 25 April 2023

PEQS_Item_1.3_unconfirmed Minutes 2023-04-25.pdf (13 pages)

1.4. Patient Experience, Quality and Safety Committee Action Log

PEQS_1.4_Action Log 2023-24.pdf (1 pages)

09:30 - 09:30
0 min

2. ITEMS FOR ASSURANCE

2.1. Integrated Quality Report

PEQS_Item_1_Committee-Integrated Quality Paper JULY2023.pdf (15 pages)

2.2. MENTAL HEALTH POWER OF DISCHARGE ANNUAL REPORT INCLUDING MENTAL HEALTH COMPLIANCE WITH LEGISLATION

PEQS_Item_2.2_MHA Compliance Report 2022-23.pdf (11 pages)

2.3. CLINICAL AUDIT PROGRESS REPORT

PEQS_2.3_Clinical Audit Programme22-23 Closure&Q1 update.pdf (40 pages)

2.4. ANNUAL SAFEGUARDING REPORT

PEQS_2.4_Safeguarding Annual Report 2022-22.pdf (8 pages)
PEQS_2.4a_Safeguarding & Public Protection AR 2022-23.pdf (61 pages)

2.5. WHSSC QUALITY AND SAFETY COMMITTEE CHAIRS REPORT APRIL 2023

PEQS_Item_2.5_QPSC Chairs report 18 April 2023.pdf (32 pages)

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09:30 - 09:30
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3. ITEMS FOR DISCUSSION

There are no items for inclusion in this section.

09:30 - 09:30
0 min

4. ESCALATED ITEMS

There are no items for inclusion in this section

09:30 - 09:30
0 min

5. ITEMS FOR INFORMATION

There are no items for inclusion in this section

09:30 - 09:30
0 min

6. OTHER MATTERS

6.1. Committee Risk Register

- PEQS_Item_6.1_Committee Risk Report_Jul23.pdf (3 pages)
- PEQS_Item_6.1a_Appendix A_Committee Risk Register_Jul23.pdf (6 pages)

6.2. Committee Work Programme

- PEQS_Item_6.2_PEQS work plan as at July 2023.pdf (1 pages)

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

6.4. Any Other Urgent Business

6.5. Date of the Next Meeting

24 October 2023

6.6. CONFIDENTIAL ITEM

6.7. INFECTION PREVENTION AND CONTROL

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POWYS TEACHING HEALTH BOARD
PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE

TUESDAY 4 JULY 2023
09:30 – 12:30
VIA MICROSOFT TEAMS

AGENDA				
Time	**Item**	**Title**	**Attached/Oral**	**Presenter**
	1	**PRELIMINARY MATTERS**		
09:30	1.1	Welcome and Apologies	Oral	Chair
	1.2	Declarations of Interest	Oral	All
	1.3	Minutes from the previous Meeting 25 April 2023	Attached	Chair
09.35	1.4	Committee Action Log	To follow	Chair
	2	**ITEMS FOR ASSURANCE**		
09.40	2.1	Integrated Quality Report	Attached	Director of Nursing and Midwifery
10:40	2.2	Mental Health Power of Discharge Annual Report including Mental Health compliance with legislation	Attached	Director of Operations, Community Care and Mental Health
11:00		COMFORT BREAK		
11:10	2.3	Clinical Audit Progress Report	To follow	Medical Director
11:25	2.4	Annual Safeguarding Report	To follow	Director of Nursing and Midwifery
11:40	2.5	WHSSC Quality and Safety Committee Chairs Report April 2023	Attached	Director of Nursing and Midwifery
	3	**ITEMS FOR DISCUSSION**		
		There are no items for inclusion within this section		
	4	**ESCALATED ITEMS**		
		There are no items for inclusion within this section		
	5	**ITEMS FOR INFORMATION**		
		There are no items for inclusion within this section		
	6	**OTHER MATTERS**		
11:45	6.1	Committee Risk Register	Attached	Director of Corporate Governance / Director of Nursing & Midwifery
11:55	6.2	Committee Work Programme	Attached	Director of Corporate Governance
12:00	6.3	Items to be Brought to the Attention of the Board and/or Other Committees	Oral	Chair

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	6.4	Any Other Urgent Business	Oral	Chair
	6.5	Date of the Next Meeting: 24 October 2023		
6.6 The Chair, with advice from the Director of Corporate Governance, has determined that the following items include confidential or commercially sensitive information which is not in the public interest to discuss in an open meeting at this time. The Board is asked to take this advice into account when considering the following motion to exclude the public from this part of the meeting: Motion under Section 1(2) Public Bodies (Admission to Meetings) Act 1960 ***"Representatives of the press and other members of the public shall be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest"***				
12:00	6.7	Infection Prevention and Control	To follow	Director of Nursing and Midwifery

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.

Meetings are currently held virtually, should you wish to observe a virtual meeting of a committee, please contact the Director of Corporate Governance at PowysDirectorate.CorporateGovernance@wales.nhs.uk at least 24 hours in advance of the meeting in order that your request can be considered on an individual basis.

Papers for the meeting are made available on the website in advance and a copy of the minutes are uploaded to the website once agreed at the following meeting.

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

MINUTES OF THE MEETING HELD ON TUESDAY 25 APRIL 2023 VIA MICROSOFT TEAMS

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Present:

Kirsty Williams	Vice-Chair (Committee Chair)
Jennifer Owen Adams	Independent Member
Ian Phillips	Independent Member
Mark Taylor	Independent Member
Simon Wright	Independent Member

In Attendance:

Claire Roche	Director of Nursing and Midwifery
Kate Wright	Medical Director
Joy Garfitt	Interim Director Operations, Community Care and Mental Health
Lucie Cornish	Assistant Director of Therapies and Health Sciences (representing Director of Therapies and Health Sciences)
Marie Davies	Deputy Director Nursing
Zoe Ashman	Assistant Director of Quality and Safety
Amanda Edwards	Assistant Director – Innovation and Improvement
Helen Bushell	Director of Corporate Governance (from XX)

Observing:

Gareth Thomas	Infection Prevention and Control Nurse
Heidi Sinclair	Head of Quality and Safety
Sonia Thomas	Llais
Mitchell Parker	Health Inspectorate Wales
Daisy Dee	Health Inspectorate Wales

Apologies for absence:

Carol Shillabeer	Chief Executive
Hayley Thomas	Director of Strategy, Primary Care and Partnerships/Deputy CEO
Claire Madsen	Director of Therapies and Health Sciences
Merérid Bowley	Director of Public Health

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Debra Wood-Lawson Director of Workforce and OD

Committee Support:
Liz Patterson Interim Head of Corporate Governance

PEQS/23/01	**WELCOME AND APOLOGIES FOR ABSENCE** The Committee Chair welcomed Members to the meeting. Apologies for absence were noted as recorded above.
PEQS/23/02	**DECLARATIONS OF INTERESTS** No interests were declared in addition to those already declared in the published register.
PEQS/23/03	**MINUTES OF THE EXPERIENCE, QUALITY AND SAFETY COMMITTEE MEETING HELD ON 23 FEBRUARY 2023 (FOR APPROVAL)** The minutes of the previous meeting held on 23 February 2023 were AGREED as a true and accurate record subject to the following amendments: • on paragraph 2 of page 7 – The ~~Paint~~ *Pain* Toolkit • on question 1 of page 8 – *given these prescribed medications ~~and~~* are *not illegal*. • penultimate paragraph of page 9 – October ~~2022~~ 2020.
PEQS/23/04	**PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE ACTION LOG** The Action Log recorded updates with the following update was provided during the meeting: PEQS/21/29 – Next Quality Report to include actions taken as a result of the staff survey – The Director of Nursing and Midwifery advised this should be re-assigned the Nursing Directorate. Work would take place with the Director of Workforce and OD to address this. The plan and progress to date would be reported to the July meeting but the inclusion of information with the Integrated Quality Report would be dependent on timeframes of staff survey reports. PEQS/22/63 – Update on Patient Experience Approach to be provided to PEQS – the responsibility for Patient Experience has moved from the Director of Therapies and Health Sciences to the Director of Nursing and Midwifery. The Integrated Quality Report would feature additional

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	information on Patient Experience both from the information provided via the Civica system and the Citizen Voice (Llais). PEQS/22/81 – Report of the National Commissioning Functions Review to be brought to Committee at the appropriate time – the Director of Corporate Governance advised that the groundwork for the review had concluded and a session with Health Board Chairs was expected in approximately 3 weeks to share feedback. The outcome would be reported to Committee in July 2023 with Members briefed if the report was available in the meantime. The Committee RECEIVED the updates on the action log.
ITEMS FOR ASSURANCE	
PEQS/23/05	**INTEGRATED QUALITY REPORT** The Director of Nursing and Midwifery presented the report and drew attention to the following areas: • the partnership between NHS Wales Health Board and Trusts, Improvement Cymru and the Institute for Healthcare Improvement to create the Safe Care Collaborative designed to improve quality and safety of care across all systems; • the national nosocomial work is proceeding at pace, and it is anticipated that work will be completed in Q2 of 2023/24, some six months earlier than planned; • the number of open formal concerns had remained stable at under 10 since October 2022, a considerable improvement since March 2022 when 44 were open. Maintaining this level will allow for a timely response to new concerns; • compliance in responding to concerns within 30 working days had improved, but with the decrease in number of concerns the indicator of responding within 30 working days had become more volatile; • the top three themes of formal concerns were: access to services, complexity of care and delays; • the number of reported low and moderate incidents of harm had recently decreased. This was thought to be due to a programme of training on root cause analysis which enabled colleagues to correctly score potential harm; • there were no No Surprises notifications during Q4 of 2022/23; • the Civica patient feedback system had been implemented during Q3 and Q4 of 2022/23 which it is

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	hoped will provide rich feedback of patient stories; and • Health Inspectorate Wales (HIW) had undertaken reviews at Claerwen Ward, Llandrindod Wells and Tawe Ward, Ystradgynlais. A response to HIW on both reports is in preparation. The Director of Nursing drew to the attention of Committee the following two matters: • Timely management of incidents is required to ensure appropriate action is taken – ACTION taken: Managers and those responsible for managing incidents have been provided with RCA training to manage incidents effectively and in a timely manner. Implementation of the Incident Management Framework will further support the timely and robust management of incidents. • Limitations to the capability of the CIVICA system due to no additional resource aligned to drive the agenda across the health board. ACTION taken: Quality & Safety Team members are being utilised to support the use of the CIVICA system within teams and services, encouraging local service level champions is being considered. *Independent Members sought assurance by asking the following questions:* *Should the Safe Care Collaborative project to reduce people not attending appointments (DNAs) focus on moving away from issuing appointments to Seen On Symptoms?* The Medical Director advised that DNAs were a perceived issue in one staff group and the project would first ascertain if this was an actual rather than a perceived problem. The Assistant Director of Therapies and Health Sciences advised that the Therapies team wished to understand why DNAs were happening and if it was because appointments were not needed. *Is the year 2021/22 correct for the complaints to the Public Services Ombudsman for Wales?* The Director of Nursing and Midwifery confirmed that full year figures for 2021/22 were provided for comparison with the data available for 2022/23 which when the report was compiled was to Q3.

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	The data on incident management appears stable if April 2023 figures are discounted. The Director of Nursing and Midwifery advised that the team are working on an Incident Management Framework to help with identifying an incident. This part of the Integrated Quality Report will be strengthened. **Action: Director of Nursing and Midwifery** *It is concerning to note the use of the Civica system will be limited by a lack of resource. Members regretted that this had not been identified earlier and were concerned that the investment that had been made in Civica would not meet its full potential without additional resource.* The Director of Nursing and Midwifery noted that the implementation of Civica was a welcome addition to the tools available to gather patient experience. It will be necessary to identify what resource is required and align it to maximise usage of the system. The Assistant Director of Quality and Safety advised there were 35 cases on the system with a further 12 awaiting upload. The system is powerful but requires resource to access the data. The Director of Nursing and Midwifery noted that when the resource required was investigated, the ability to gather data on Powys patients held within Patient Experience teams in other organisations would also be considered. This Integrated Quality Report will be strengthened in respect of Patient Experience. **Action: Director of Nursing and Midwifery** *When is it anticipated the Nosocomial cases will be cleared?* The Assistant Director of Quality and Safety confirmed it was expected the cases would be cleared by Q2 of 2022/23 and a Final Report would be prepared. *The HIW Claerwen Report refers to the service not managing pressure sores correctly. Is a deep dive required, what is preventable and what can be improved?* The Director of Nursing and Midwifery confirmed that preventable pressure damage remained a focus for the organisation as a key indicator of avoidable harm. Senior Nursing and Midwifery oversight teams were working with

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	Informatics to improve data collection and dissemination including for pressure sores. The Head of Nursing chairs a Pressure Sore Scrutiny Panel to examine cases of pressure damage to ascertain if it was avoidable and whether the damage had occurred prior to admission. *Does the Health Board consider the HIW reports on Claerwen Ward and Tawe Ward to be fair?* The Interim Director of Operations, Community Care and Mental Health advised that the feedback received orally after the Tawe Ward Inspection commended the quality of care, however, the written report appeared a little less positive. Overall however, the report was good and no urgent recommendations were made. An inspection had also taken place of Bryntirion Ward which is jointly run with the Local Authority. There have been problems staffing the Ward to statutory standards and it had been expected the report would place greater focus on this. The Medical Director noted the Claerwen Ward described areas of good practice but had concerns regarding the resuscitation arrangements. The Health Board have a Service Level Agreement with Cwm Taf University Health Board to provide training but the Health Board would benefit from having an local Resuscitation Officer. The Director of Nursing and Midwifery added that as soon as the HIW Inspection of Claerwen had commenced she had been notified. The Ward Manager and Head of Nursing had started creating an action plan in response to feedback received during the Inspection. Outstanding actions will be monitored via the Integrated Quality Report. *Has there been a recent increase in formal concerns and is the Health Board confident that it is easy for patients to raise concerns?* The Director of Nursing and Midwifery advised staff had been trained to accurately define concerns and the whole process has been made leaner to ensure that unless it is particularly complex it will be possible to respond within 30 working days. The Director of Nursing and Midwifery expressed confidence in the ability of the patients to raise concerns. There had been an increase in patient complaints to the Public

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	Services Ombudsman for Wales (PSOW) which had been expected once the long standing complaints had been closed (a complaint to the PSOW cannot take place until a complaint has been closed). It is expected now the longstanding concerns have closed that complaints to the PSOW will decrease. The Assistant Director of Quality and Safety advised that the Health Board actively sought views on satisfaction with the complaints process. The Integrated Quality Report would include details of complaint process satisfaction in the July Report. **Action: Assistant Director of Quality and Safety** *Is the number of behaviours (including violence and aggression) resulting in harm increasing? What is in place to manage these events?* The Director of Nursing and Midwifery confirmed that a deep dive would be undertaken into the themes and trends relating to behaviours which would be brought back to the Committee. **Action: Director of Nursing and Midwifery** The Health Inspectorate Wales observer thanked the Interim Director of Operations, Community Care and Mental Health for the feedback and invited further feedback from Executives and Members of the Committee. The Chair observed that the action taken in relation to timely management of incidents appeared appropriate, however, the mitigation in relation to the lack of resource and consequent limitations on the capability of the Civica system did not appear appropriate in the longer term and welcomed the Director of Nursing and Midwifery's plan in the first instance to ascertain the resources required to provide this service. The Independent Member (ICT) observed that by highlighting the lack of resource it appeared there had been a lack of planning in the implementation of the Civica system. The Committee agreed to advise Board of their concerns regarding the capacity constraints to fulfil expectations in

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	respect of Patient Experience. The Board would be advised that the issue had been identified, the Director of Nursing and Midwifery would prepare a plan to address the issue, the implementation of which would be monitored by the Committee. **Action: Chair** The Integrated Quality Report was DISCUSSED and ASSURANCE was taken from the information provided within the report. **Duties of Quality and Candour Implementation** The Assistant Director for Quality and Safety gave a presentation on the Implementation of the Duties of Quality and Candour. The Health and Social Care (Quality and Engagement) (Wales) Act 2020 was passed on 17 April 2020 with a statutory implementation date of April 2023. A duty of candour is placed on NHS bodies and primary care, and a duty of quality on NHS bodies and Ministers. The duty of candour is triggered when it appears both of the following conditions are met: • a service user to whom healthcare is being or has been provided by the NHS body has suffered an adverse outcome; and • the provision of the health care was or may have been a factor in the service user suffering the adverse outcome. It also requires 'more than minimal harm' which is undefined in the Act, although under the Putting Things Right process it is defined as 'moderate harm, severe harm and death'. The procedure and monitoring arrangements were outlined. The NHS bodies and Welsh Ministers are required to: • ensure that all strategic decisions are made through the lens of improving the quality of services and patient outcomes; • exercise their functions in a way that considers how they improve quality and outcomes on an on-going basis;

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	• actively monitor progress on the improvement of quality services and patient outcomes and routinely share information on this progress with population; • strengthen governance arrangements by reporting annually on the steps taken to comply with the Duty and assess the extent of improvements in outcomes; • ensure that NHS organisations are operating an interlinked Quality Management System; and • create a quality culture within organisations. Candour cases will be reported to the Committee on a quarterly basis and an Annual Duty of Candour report will be produced. It was confirmed that there had not been a candour case since the implementation of the Act in April 2023. The Director of Nursing and Midwifery advised that the Health Board had established an internal Implementation Board chaired by the Director of Therapies and Health Sciences with representation from all Directorates. This Board meets months and monitors implementation progress providing updates to the national team. The National Implementation Board will cease as of May 2023. *Who decides if the threshold for the duty of candour has been triggered?* The Director of Nursing and Midwifery explained the decision took place after a multi-profession discussion including Executive Directors in the same way that potential incidents of harm are currently identified. *Given the Health Board commission many services how can assurance be gained that the duty of candour is being implemented for all Powys patients?* The Director of Nursing and Midwifery advised the Integrated Performance Framework includes a section on Quality and Safety and it will be necessary to develop this in relation to Commissioned Services. Colleagues from Commissioning are part of the local Implementation Board. The Welsh Ambulance Services Trust are leading national work on the duty of candour where cases involve partner organisations.

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	Does the Health Board know what Excellent looks like or can point to an organisation that models this? The Director of Nursing and Midwifery noted that this was a large area of work and related to leadership, culture, learning systems and psychological safety. Colleagues still talked about a fear of blame and it is a huge shift from a culture of blame to a learning culture. The work of the Safe Care Collaborative will contribute, together with benchmarking within and outside of Wales. *To enable the Committee to be able to monitor implementation progress could a copy of the Implementation Plan be made available?* The Director of Nursing and Midwifery confirmed the Implementation Plan would be shared with Committee Members to enable monitoring of the implementation via the Integrated Quality Report. **Action: Director of Nursing and Midwifery**
PEQS/23/06	**WHSSC QUALITY AND SAFETY COMMITTEE REPORT – JANUARY 2023** The Chair advised that she was a member of the WHSSC Quality and Safety Committee. Discussions were taking place to enable earlier sharing of Chair's Reports as at present these are only shared after the following meeting of the WHSSC Quality and Safety Committee.
	ITEMS FOR DISCUSSION
PEQS/23/07	There were no items for discussion.
	ESCALATED ITEMS
PEQS/23/08	**MATERNITY SERVICES DE-ESCALATION TO BUSINESS AS USUAL** The Director of Nursing and Midwifery presented the report outlining the work that had taken place to enable a decision to be taken at Executive Committee to de-escalate Maternity Services to Business as Usual. Powys provider maternity services had been in local escalation since June 2022 as a response to the identification of three Nationally Reportable Incidents between February and May 2022, findings from a local review of governance in

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	Midwifery services, and concerns around the use of the Perinatal Institutes Gap/Grow programme. A weekly escalation meeting was introduced which reduced to fortnightly following improvements and assurance across the service. The Executive Committee considered the improvements outlined in the paper in February 2023 together with the ongoing monitoring arrangements. The Executive Committee agreed to de-escalate the service to Business as Usual. The Patient Experience, Quality and Safety Committee will receive a six monthly Maternity Assurance Report. *To enable the Committee to be able to monitor progress in Maternity Services could a copy of the Improvement Plan be made available?* The Director of Nursing and Midwifery confirmed the Improvement Plan would be shared with Committee Members to enable monitoring of progress via a six monthly Maternity Assurance Report. **Action: Director of Nursing and Midwifery** *Was it a close decision for Executive Committee to de-escalate the service?* The Medical Director advised that personally she felt sighted on the matter both formally and informally. Improvement and change were noted, it could be seen how the position had been reached and the root cause had been addressed. The Director of Corporate Governance noted there had been an extensive conversation at Executive Committee which covered all the matters, chaired by the Chief Executive prior to the decision been taken. The Committee welcomed the de-escalation of Maternity Services, noted the Improvement Plan would be shared with the Committee and that a Maternity Assurance Report would be brought to Committee on a six monthly basis.

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	The efforts of all involved to return to Business as Usual were recognised and it was suggested that a staff story of their experience be prepared to share at Workforce and Culture Committee. **Action: Director of Nursing and Midwifery** The Committee took ASSURANCE that local escalation measures in Maternity Services has taken place to realise significant improvements resulting in the decision, by the Executive Committee, to de-escalate to business as usual.
ITEMS FOR INFORMATION	
PEQS/23/09	There were no items for information.
OTHER MATTERS	
PEQS/23/10	**COMMITTEE RISK REGISTER** The Director of Corporate Governance presented the Risk Register for risks associated with this Committee. There is one risk on the register: Citizens of Powys receive poor quality care (quality defined as safety, effectiveness and experience) from one or more of a range of providers. The risk was last considered at Board in March 2023 and the score remains at 16. It will be necessary to review the Corporate Risk Register given there will be changes to the 2023/24 Delivery Plan. The refreshed Corporate Risk Register will be brought to Board in July 2023 The Director of Nursing and Midwifery advised the risk was difficult as it was so large it was hard to update in terms of mitigations. It will be necessary to realign the risk in light of the new Quality Standards. *The risk appears wide ranging but does not appear to detail everything (for example the issues in maternity services were not outlined).* The Director of Corporate Governance advised that a Directorate Risk Register and Corporate Risk Register were

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	held. Risks would be escalated from the Directorate Register to the Corporate Register depending on their score. The Committee receive the risks contained within the Corporate Risk Register pertinent to the work of the Committee. The Director of Nursing and Midwifery confirmed Maternity Services were not added to the Corporate Risk Register as they were deemed to be at an operational level. The Committee: • CONSIDERED the corporate risks within the committee's remit, • DISCUSSED any relevant issues; and • took ASSURANCE that risks were being managed in line with the Risk Management Framework.
PEQS/23/11	**WORK PROGRAMME** The Director of Corporate Governance advised that work on the Committee Work Programmes was ongoing and would be presented to Board at the end of May 2023. A meeting with the Chair was planned after which the draft programme would be shared with the Committee for comment.
PEQS/23/12	**ITEMS TO BE BROUGHT TO THE ATTENTION OF THE BOARD AND/OR OTHER COMMITTEES** The Chair noted that the matters discussed would be included in the Chair's Report to Board. Attention would be drawn to: • Concerns regarding capacity constraints in respect of use of the Civica system in patient experience; and • De-escalation of Maternity Services
PEQS/23/14	**ANY OTHER URGENT BUSINESS** There was no other urgent business.
PEQS/23/15	**DATE OF THE NEXT MEETING** 4 July 2023, via Microsoft Teams.

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Liz Patterson
RAG Status:

At risk	Red - action date passed or revised date needed
On track	Yellow - action on target to be completed by agreed/revised date
Completed	Green - action complete
No longer needed	Blue - action to be removed and/or replaced by new action
Transferred	Grey - Transferred to another group

Meeting Date	Item Reference	Lead	Meeting Item Title	Details of Action	Update on Progress	Original target date	Revised Target Date	RAG status
Patient Experience, Quality and Safety Committee								
OPEN ACTIONS FOR REVIEW								
OPEN ACTIONS - IN PROGRESS BUT NOT YET DUE								
13/09/2022 and 24 Nov 2022	PEQS/22/51 and PEQS IC/22/73	DOCC&MH	Mental Health Services	A further report on Mental Health Services to be brought to the December 2022 Committee meeting	**25.04.23 update** - This item has been rescheduled due to changes in staff structures	Dec-22	Jul-23	On track
24-Nov-22	PEQS/22/59	MD	Clinical Audit Progress and Learning	Revise the Terms and Reference of the Learning Group to reflect changes in reporting of National Audits	**25.04.23 update** - The Terms of Reference have been revised and will be considered for approval at the next Learning Development Meeting	Jul-23		On track
31-Jan-23	ARA/22/109	DNM	LOSSES AND SPECIAL PAYMENTS UPDATE REPORT (transferred from Audit Committee)	Trends and lessons learnt from rebutting negligence claims to be included in the Integrated Quality Report to the Patient Experience, Quality and Safety Committee	**25.04.23 update** - Action has been reviewed and given the low number of claims, data could become individually identifiable. DCN to reconsider how to achieve the action and report back	Oct-23		On track
23-Feb-23	PEQS/22/81	DCG	National Commissioning Functions Review	The Report of the National Commissioning Functions Review be brought back to Committee at the appropriate time	**25.04.23 update** - Added to work programme, date to be confirmed			On track
23-Feb-23	PEQS/22/82	DOCC&MH	Mental Health Services 111 press 2 project	The 12 week review into NHS 111press2 to be brought to Committee	**25.04.23 update** - Added to work programme	Sep-23		On track
23-Feb-23	PEQS/22/84b	DNM	Child Practice Review	Child Practice Review to be brought back to Committee	**25.04.23 update** - Added to work programme, date to be confirmed			On track
25-Apr-23	PEQS/23/05	DNM	Integrated Quality Report	Integrated Quality Report to be strengthened in tems of Incident Management	**04.07.23 update** - a revised incident management framework has been drafted and is currently out to consultation. This will be reported on in greater detail at the October PEQS.	Jul-23	Oct-23	On track
25-Apr-23	PEQS/23/05	DNM	Integrated Quality Report	Integrated Quality Report to be strengthened in terms of themes and trends relating to behaviours resulting in harm	**04.07.23 update** - DoNM is currently liaising with DoTHs (with current responsibility for Health and Safety) to review non-patient safety incidents, themes and trends	Jul-23	Oct-23	On track
25-Apr-23	PEQS/23/05	DNM	Duty of Candour and Quality	The Duty of Candour and Quality Implementation Plan to be shared with Committee	DoNM to update in the meeting.	May-23		
ACTIONS RECOMMENDED FOR CLOSURE (MEETING 4 JULY 2023)								
02-Dec-21	PEQS/21/29	DNM	Audit Wales Review: PTHB Quality Governance Arrangements	Next Quality Report to include details of actions taken as a result of staff survey	**28.06.23 update-** Narrative included in integrated quality report **25.04.23 update** - The DNM accepted this action. An update would be presented at July 2023 meeting.		Jul-23	Completed
24-Nov-22	PEQS/22/63	DNM	Patient Experience Approach	Patient Experience Approach to be reconsidered at Executive Committee and an update be provided to PEQS	**28.06.23 update** - Additional information inlcuded in the IQR to be presented at July Committeee this will be followed by a focus on patient experience in the October PEQS. **25.04.23 update** - The IQR will contain additional information on patient experience both from information provided by Civica and via the Citizen Voice.		Jul-23	Completed
25-Apr-23	PEQS/23/05	DNM	Integrated Quality Report	Integrated Quality Report to be strengthened in tems of Patient Experience	**28.06.23 update -** Additional information inlcuded in the IQR to be presented at July Committeee this will be followed by a focus	Jul-23		Completed
25-Apr-23	PEQS/23/05	DNM	Integrated Quality Report	Integrated Quality Report to include details of complaint process satisfaction in the July Report	**04.07.23 update** - included in IQR on this occasion	Jul-23		Completed
25-Apr-23	PEQS/23/05	Chair	Integrated Quality Report	Chair to bring to the attention of Board concerns regarding the capacity constraints to fulfil expectations in relation to Patient Experience	**04.07.23 update** - reported to Board on 24 May 2023	May-23		Completed

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Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 2.1

Patient Experience and Quality Committee	**04 July 2023**
Subject:	**Integrated Quality Report**
Approved and Presented by:	Claire Roche, Executive Director of Nursing & Midwifery
Presented by	Claire Roche, Executive Director of Nursing & Midwifery
Prepared by:	Zoe Ashman, Assistant Director Quality & Safety
Other Committees and meetings considered at:	Executive Committee – 14 June 2023

PURPOSE:

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

RECOMMENDATION(S):

The Patient Experience and Quality Committee are asked to take **assurance** that Quality and Safety is appropriately monitored and reported and that continued actions are in place to further develop quality and safety monitoring and reporting.

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

Patterson,Liz 03/07/2023 08:33:07

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

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

DETAILED BACKGROUND AND ASSESSMENT:

1 Background

The purpose of this report is to provide the Patient Experience and Quality Committee with an update on the quality and safety agenda for Powys Teaching Health Board (PTHB).

2 Specific matters for consideration by this meeting (Assessment)

2.1 Quality & Engagement Act (2023) Implementation

The Health and Social Care (Quality and Engagement) (Wales) Act ('the Act') became law on 1 June 2020 and full implementation commenced on 1 April 2023.

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An Implementation Group is in place to monitor compliance and ensure the implementation plan is realised.

During April and May 2023, the duty of candour has been triggered 3 times in the Health Board. Where this has been triggered, investigations are undertaken to identify a root cause analysis and priorities for learning and improving. Where the duty has been triggered, communication and points of contact with patients and/or families has been established.

The final national Duty of Quality and Candour Implemention Board was held on 20 June 2023. The Health Board will now be required to report its progress with the Duty of Quality and the Duty of Candour to the Integrated Quality Performance and Delivery (IQPD) meetings with Welsh Government.

2.2 Once for Wales Content Management System (RLDatix)

The implementation of the Once for Wales Content Management System (OFWCMS) is complete. However, this excludes the final risk module which continues to be delayed.

The draft Incident Management Framework (IMF) has been developed with approval and rollout anticipated during Q2. Data dashboards are available and in use for teams across the health board to further support the management of incidents in a timely and proportionate manner.

2.3 Supporting learning and improvement

The Learning Group is supported by all Clinical Directors and their teams. This forum is a key enabler to the reporting and monitoring process further supported by the implementation of the Incident Management Framework.

The team have supported learning events to discuss incidents that have occurred with common themes and crossover of learning. A recent event focussing on the incidents that occurred in Planned Care was well attended by key individuals within the services to further strengthen the actions for improvement that are required. It is envisaged that these events will ensure that teams develop a safe culture to learn, improve and celebrate their successes.

The final investigation training session, inclusive of human factors and psychological safety has been delivered during Q1, with 94 health board staff members having attended from across all services over the past 9 months. A continuous programme of training has been planned for Q3 2023/24, which will be further informed by the implementation of the incident management framework.

Safe Care Collaborative

The Safe Care Collaborative is part of the Safe Care Partnership, which is a collaboration between NHS Wales health boards and trusts, Improvement Cymru and the Institute for Healthcare Improvement (IHI).

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The partnership's aim is to coach and support health boards and trusts to improve the quality and safety of care across their systems. The Safe Care Collaborative creates a learning system where organisations test and measure practice innovations and share their experiences to accelerate learning and widespread implementation of best practices for safe care. It brings together teams, coaches, executives, and senior leaders for safety from across all the health boards and trusts in Wales to focus on a common aim.

At organisational level an aim of this work is to achieve a locally owned and managed safety programme with the infrastructure to support a sustainable learning system that will work towards achieving results at scale.

Health Board representatives, consisting of front-line staff, senior managers, Assistant Directors, the Executive Director of Nursing and Midwifery and the Medical Director attended the collaborative event during June 2023 and presented their journey of improvement thus far (Appendix 1). The event enabled learning and networking, facilitating joint working with other Organisations for some of the improvement projects.

A follow up visit from IHI and Improvement Cymru colleagues will take place in July 2023 to further strengthen our quality improvement journey.

Learning from the experience of our people

The national (NHS Wales) staff survey is due to be launched in September with the last survey being 2020. However, currently Powys THB have a staff wellbeing survey out, which will close on Friday 30th June. The Workforce and Organisational Development team within the HB are currently working on an approach to triangulate the range of soft and hard workforce data and information as part of the development of the Integrated Performance Framework (IPF) in the workforce quadrant. This will support a holistic assessment of quality and performance, ensuring that workforce, leadership and culture are central to an effective quality management system.

This initial proposal will be discussed at Workforce and Culture Committee in September with an aim of understanding the indicative 'health' of a team. The psychological safety within teams is recognised as fundamental to team effectiveness, quality and safety and required for a culture of learning. There will be an approach to undertaking Team Climate surveys, which will involve teams completing the survey and feedback sessions with the OD team. This is currently being utilised in Women and Children's service, having been trialled in WOD.

2.4 National Nosocomial Framework

In March 2021, the Framework into the 'Management of patient safety incidents following nosocomial transmission of COVID-19' was published. Any hospital acquired infection, including COVID-19, is considered a patient safety incident and therefore the provisions of the Putting Things Right Regulations (PTR) apply.

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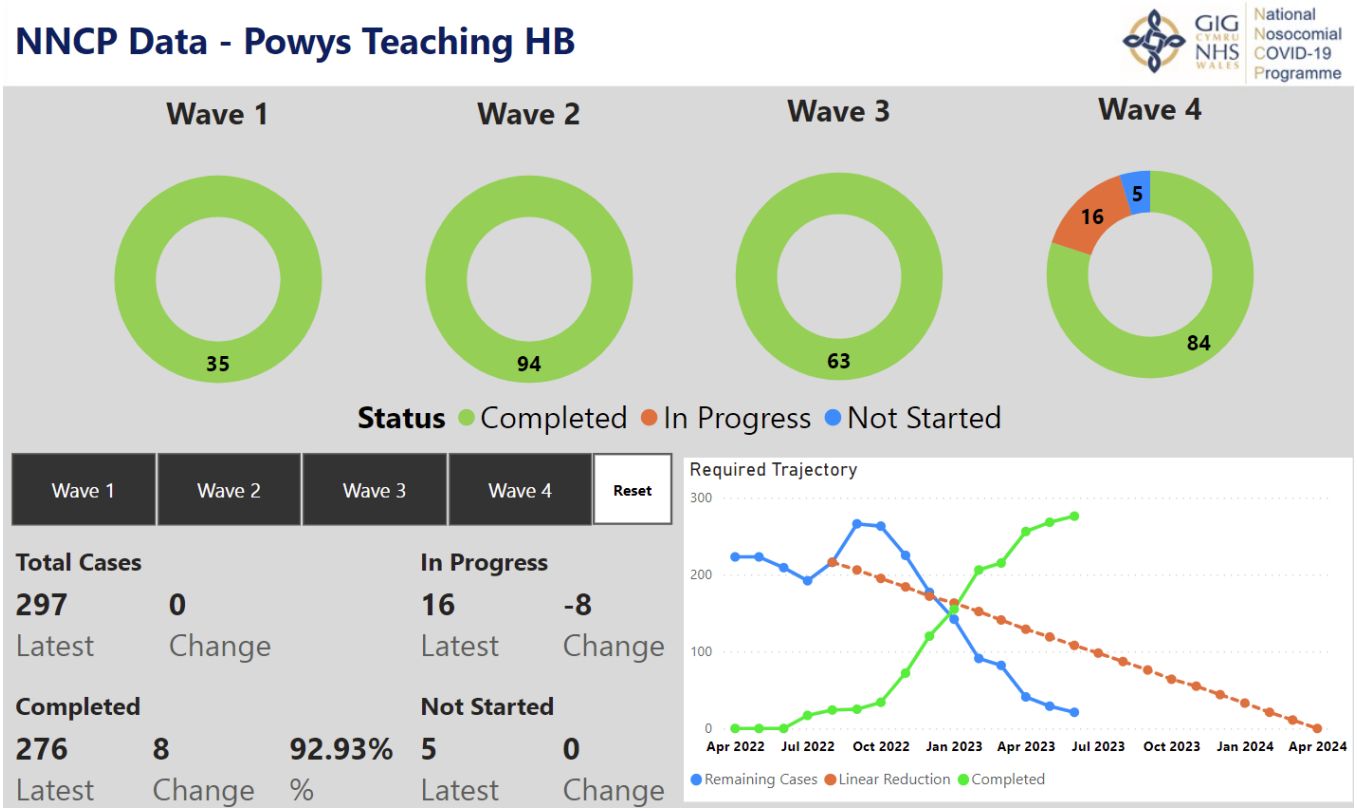
To date, the Health Board has not received any concerns from families or patients affected by nosocomial transmission of Covid-19. No identified cases where severe harm or death have occurred have been identified thus far and therefore, duty of candour conversations with patients and/or families have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

Data updated 22/06/23



The graph above demonstrates that the Health Board has progressed the pace of the programme significantly during Q4 2022/23 with completion anticipated during Q2 2023/24.

2.5 Putting Things Right – Concerns

The management of concerns continues to improve with the target of 75% compliance to responses within 30 working days being realised (Graph 1 below) Continued focus is maintained to ensure concerns re managed in a timely manner with the appropriate investigation and response.

With the use of the CIVICA patient Experience system, the team sought to obtain feedback from those that have raised a concern which has since been closed. An overwhelming response was received with over 79% very happy with the process, standard of communication and engagement with the team; PTHB are the first health board in Wales to have taken this approach for feedback from people who have raised a complaint with us.

Graph 1

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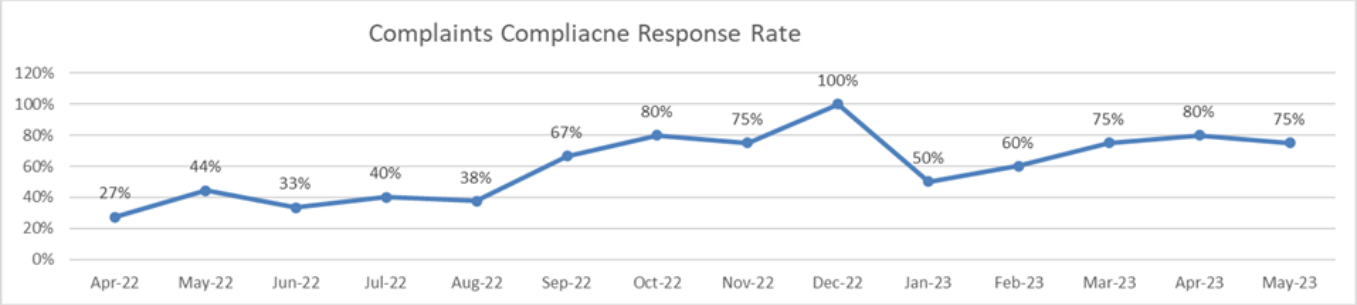

Concerns Validation: Substantial Assurance

The Welsh Risk Pool (WRP) at the request of Welsh Government, have undertaken a validation exercise of the 2022-23 quarterly complaints data prepared for submission by each health body. Following analysis of Q2 data, a supportive exercise was agreed with the Heads of Patient Experience Safety & Learning Network – with the WRP providing support to validate and reconcile data for Q1, Q2 and Q3.

A validation exercise is now completed in respect of Q4 data. The validation exercise is intended to provide support to each health body in relation to the assurance of local processes for the application of the requirements of the Putting Thing Right regulations, published definitions and guidance and the maintenance of accurate and consistent information within the Datix Cymru system.

The validation exercise consisted of verifying source data provided by the health board and comparing this to the prepared proforma, addressing variances or queries through liaison with staff within the organisation.

The validation report is presented using the standard approach to audit assurance ratings and contains recommendations to enhance local processes. We were pleased to receive a Substantial Assurance rating and the report can be found in Appendix 2.

The top 3 themes of formal concerns are:

- Access to services, clinical treatment/ assessment
- Complexity of care due to commissioning arrangements and pathways of care
- Delays: Patients waiting longer than expected for appointments, delay in discharge, delay in transfer.

2.6 Public Service Ombudsman for Wales (PSOW)

The Health Board position for 2022/23 with complaints escalated to the PSOW is noted in table 1. The data demonstrates that the health board support and resolve concerns raised to PSOW proactively, which has resulted in 22% early resolution/voluntary settlements. No concerns have been upheld by PSOW during Q2-22/23:

Table 1

Out of Jurisdiction	Premature	Closed after consideration	Early resolution/voluntary settlement	Upheld	Total

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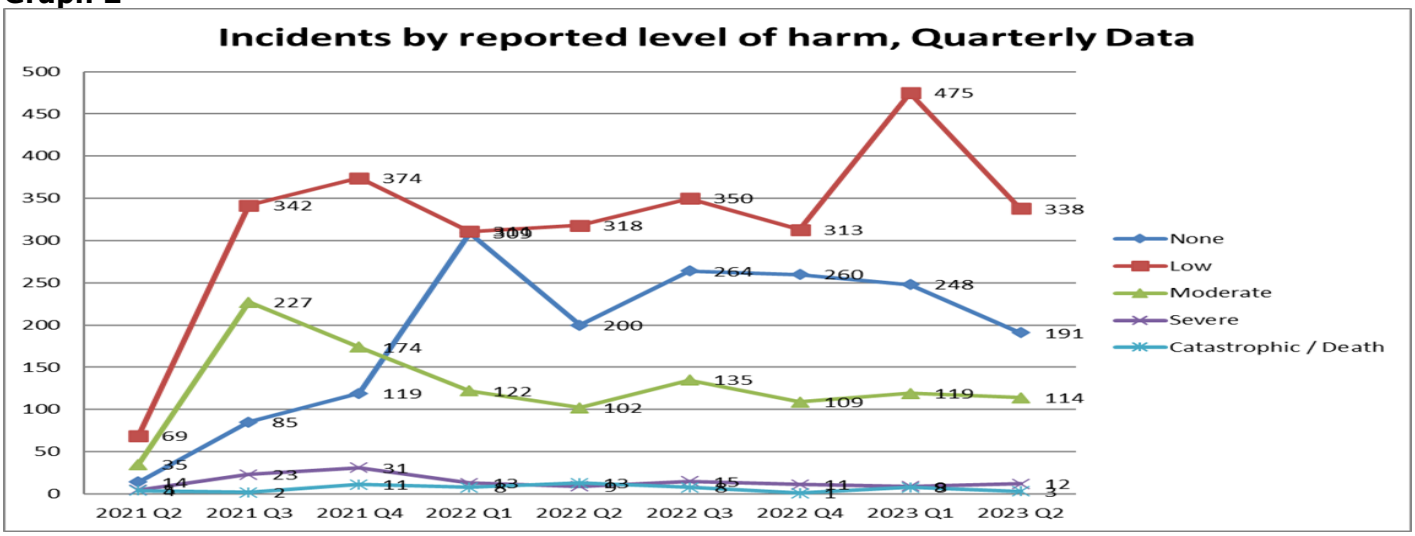
22% (n5)	4% (n1)	52% (n12)	22% (n5)	0%	23

2.7 Incident Management

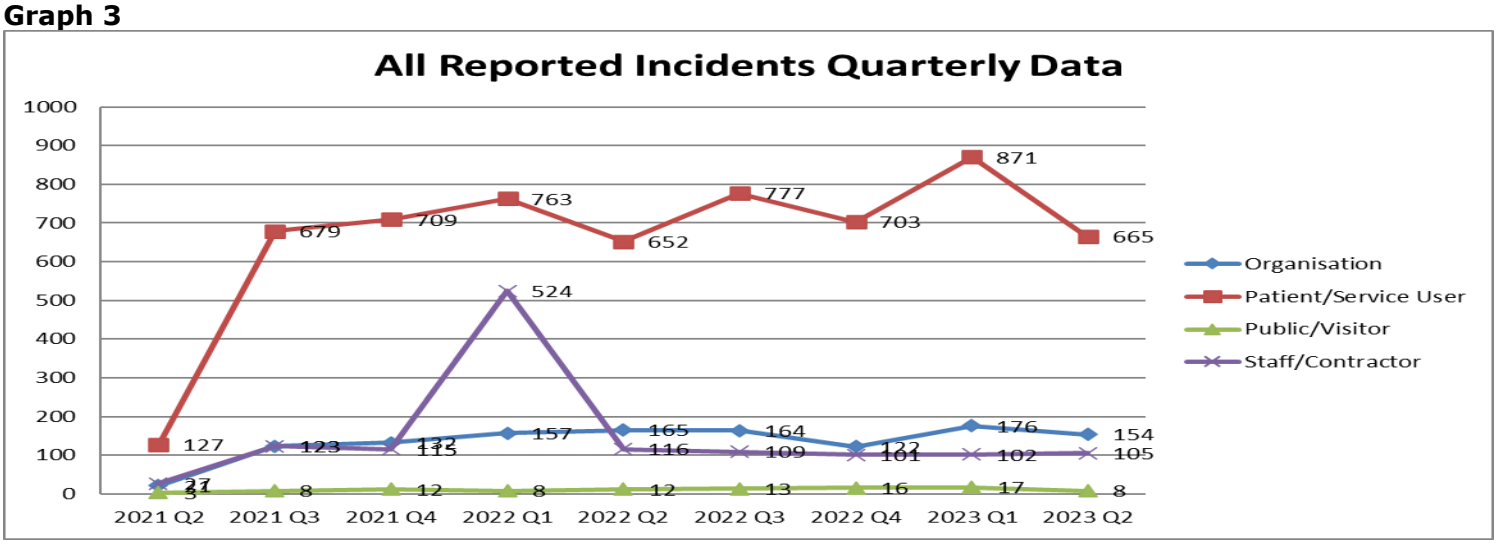
The number of patient safety incidents (**Graph 2**) reported is stable and appropriate with most incidents reported within the Low and No Harm classification. All patient safety and non-patient safety incidents are demonstrated in **Graph 3**.

It must also be recognised that the number of moderate harm incidents has reduced which may be attributed to the increased education and training regarding the classification of harm and incident management.

Graph 2



Graph 3



The highest reported incident themes during Q4:

- Pressure or moisture damage

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Action: All grade 3 pressure ulcers and above are reviewed through the multidisciplinary scrutiny panel process for wider organisational learning and improvement.

- Slip, trip or fall
  Action: Fall's scrutiny panel has commenced during Q3 to assess the themes and trends of falls to inform improvements required within the falls framework. This work will be further supported through the Safe Care Collaborative quality improvement project guided by Improvement Cymru & IHI.

- Behaviour (including violence & aggression) (n91)
  Action: Deep dive to review themes and trends of reporting by the Head of Quality & Safety

2.11 Early Warning Notifications (previously No surprises notifications)

2 Early Warning Notifications have been submitted during Q1 2023/24 to date (12/06/23).

2.12 Nationally Reportable Incidents

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

Reported period	Number open in time	Number open overdue	Number awaiting final approval	Closed	Total
Q1	**5**	**3**	**3**	**1**	**9**

The themes for learning and improvement include:

- Standards of record keeping
- Consent to treatment
- Ensure appropriate patients are treated in community hospital settings.
- Enhanced care requirements
- Clinical Guidelines not followed or not present.
- Complex pathway of care

3. Patient Experience

CIVICA patient experience system continues to evolve and become established across teams with 35 questionnaires available for use. Key priorities for Q2 are:

- Roll out of questionnaires on a monthly 'push notification' to those that have received commissioned care.
- Implementation of District Nursing feedback process.
- Commence audit visits across community hospitals with the inclusion of feedback from patients, Next of Kin (NOK) and carers.

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Several patient experience measures are in place across services which include:

- Implementation of 'How we are doing boards' within clinical areas.
- Consideration needs to be given for those with a hearing impairment and how they access services.
- Age-appropriate feedback mechanisms are in place for young people withing PTHB.

Some examples of recent feedback received by patients and service users has been captured below:

Email received from patient attending the DAFNE (Dose Adjustment For Normal Eating)
"I just wanted to drop a note to say a huge thank you for the last few week's and for the time and knowledge you've been able to share with us as part of the DAFNE course. I don't generally consider myself to be a particularly emotional person but the day of our first training session I cried because I realised, after completing the online work, how little I knew about my illness and for many years it is something I've been embarrassed of and seen as a weakness. However, following Thursday's session, I had a few tears in my eyes because I'm so grateful for the time you've given to help educate me and help me to manage and feel in control of my diabetes."

Compliment received following experience at X-Ray, Brecon
"I wanted to drop you a message to say how fantastic the service at Brecon hospital has been as I've recently attended for two chest x-rays.
The first one was booked over the phone and when I was asked when I could attend, I explained that I was a teacher and was instantly offered a Saturday appointment. This was a welcome surprise.
The second one came via letter and was originally for a Friday but I rang the department and they were able to rearrange and again see me on a Saturday.
The radiographers were both very professional and friendly during the process.
I'm really grateful to the staff for making things so easy for me and really wanted to feed this back".

4.1 Medical Device Regulations

Background

As a consequence of Brexit, the Medicines and Healthcare products Regulatory Agency (MHRA) has had to develop new Medical Device Regulations. In May 2017, the new Medical Device Regulations were published. The date of application for the new regulations was originally May 2020, however, timescales were impacted upon following a delay due to COVID-19. Further delays have followed, with the MHRA now advising they have extended the standstill period for the new regulations and are now aiming to bring them in to force by July 2024.

An all-Wales group, including representation from PTHB, has been set up to ensure compliance with new Regulations. The MHRA has organised focus groups to work on the planned new regulations. Dates for the focus groups have yet to be released.

What do the Regulations mean for PTHB?

The main impact of the regulations for the health board are within therapy services and include Physiotherapy, Occupational Therapy, Podiatry, Audiology and Orthotic Services, particularly in relation to device modifications.

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The health board does not have an in-house Medical Engineering Service and Central Sterile Services Department (CSSD), these are currently outsourced to Avensys Ltd and Cwm Taf Morgannwg University Health Board respectively.

PTHB's position is different from other health boards in Wales in that there are no manufacturing laboratories producing devices/appliances for patients. The health board does not employ any technicians who would fill that role. The manufacture of appliances, insoles and similar devices is undertaken by an external provider, Dacey's, under an all-Wales contract.

The devices made by clinicians in PTHB are, therefore, custom-made using materials supplied by external suppliers, specifically for that purpose. However, there are ongoing discussions as to whether this constitutes in-house manufacturing. The outcome of these discussions is important as it will determine whether the health board is required to put a Quality Management System in place and what expertise are required to support this. There is work taking place on an All-Wales basis, exploring a collaborative approach to support the implementation of the Medical Device Regulations and therefore Quality Management Systems, where required.

A recent communication from MHRA (May 2023) has now confirmed that they have laid legislation before Parliament, subject to approval, which will ensure that all medical devices, including custom made devices that were compliant with EU MDR previously, will be covered until 30 June 2030.

Compliance

All suppliers who provide PTHB with devices and materials for the manufacture of custom-made devices have been questioned to determine their compliance with regulations including ISO 9001, ISO 13485 or CE marked. All were found to be fully compliant. The table below provides this detail.

Service	Relevant Activity	ISO 13485 status	ISO 9001 status	Notes/other
Occupational Therapy	The purchase of products that are onward supplied to the patient are procured from approved suppliers.			Confirmation of compliance received from suppliers. However, products can change according to new prices / properties. All purchases made via Oracle.

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	All materials that may come into direct contact with the patient are procured from CE approved suppliers.			
Physiotherapy	The purchase of products that are onward supplied to the patient are procured from approved suppliers. All materials that may come into direct contact with the patient are procured from CE approved suppliers.			Confirmation of compliance received from suppliers e.g.Benecast, Delta-Cast, Scotchcast. All purchases made via Oracle.
Prosthetics	N/A			
Maxillo-facial	N/A			
Podiatry	The purchase of products that are onward supplied to the patient are procured from approved suppliers. All materials that may come into direct contact with the patient are procured from CE approved suppliers.			Confirmation of compliance received from suppliers e.g., Benecast, Scotchcast, X-Line. All purchases made via Oracle.

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	The Podiatry Department maintains a system to assess the approved status of suppliers who should be CE or ISO approved.			
Rehabilitation Engineering	N/A			
Medical Physics	N/A			
Clinical Engineering	Provided by Avensys Ltd.	Certified (May 2022 – May 2025)	Certified (May 2022 – May 2025)	Certificates provided as evidence
Software as Medical Device	Seeking further clarification on requirements.			
Orthotics	Provided by Dacey Ltd	Certified (May 2021 – May 2024)		Certificates provided as evidence
Audiology	Hearing equipment supplied by Minerva UK. Ear moulds manufactured from Otoform silicone manufactured by Dreve. Ear moulds manufactured from Detax silicone.	Certified (May 2022 – May 2025) Certified (Oct 2022 – May 2024) Certified (May 2022 –June 2023)	Certified (May 2022 – May 2025) Certified (Oct 2022 –Oct 2025)	All earpieces are manufactured in the UK and tested to EN352-2 standards. Dreve Otoform products only consist of approved silicone polymers according to ISO 9001 and ISO 13485. Detax products conform to MDR QM Certificate and EG-Certification 93/42/EEC

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CSSD	Sterile Service provision	Certified (Jan 2022 – May 2024)	Certified (Jan 2022 – May 2024)	Certificate GB22/969347 provided as evidence

In summary, the health board has reasonable assurance it will be able to fulfil the requirements of any new regulations produced by the MHRA. PTHB does not have any manufacturing laboratories and all contracted supplier and materials are compliant with regulation. National discussions as to what constitutes in-house manufacturing will determine whether the health board is required to put a Quality Management System in place and what expertise are required to support this. There is work taking place on an All-Wales basis, exploring a collaborative approach to support the implementation of the Medical Device Regulations and therefore Quality Management Systems, where required. A further update will be provided once appropriate action has been agreed and, where appropriate, progressed.

5. Health and Social Care Inspections Regulatory Recommendations

5.1 Health Inspectorate Wales Inspections

HIW undertook an unannounced visit to Adelina Patti Ward in Ystradgynlais on the 20 June 2023. The Health Board will now receive their report and recommendations and compile ab action plan for any improvements identified. It should be noted that the HIW Inspection team commented positively on the warm welcome they received from the Ward team and the engaged and collaborative manner in which the team responded to the inspection.

<u>HIW & CIW Joint Community Mental Health Team (CMHT) Inspection Report (Announced)</u>

The published report and action plan can be found (Appendix 3). The overall summary noted that Service users were provided with a person centred and dignified experience. The feedback received from service users and their relatives/carers about the care they receive was generally positive and no immediate concerns were identified.

<u>HIW Review Report: Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Services within Cwm Taf Morgannwg University Health Board</u>

On 23 March 2023 HIW shared their report "Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Services within Cwm Taf Morgannwg University Health Board" with all health boards. All health boards were required to complete and submit an action plan by 5 May 2023. Reporting on this action plan will begin in the next reporting period (Appendix 4).

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5.2 Health and Social Care Regulatory Reports

2 actions remain outstanding 2017-2020. Updates against these are provided below:

HIW Review of Healthcare Services for Young People	Health boards must ensure that children and young people can consistently be treated within designated areas.	Discussion on adult OPD environment with scheduled care managers held, consideration given to move some OPD clinics to children's centres- currently being reviewed re capacity and staffing.
HIW Review of Healthcare Services for Young People	Health boards must ensure there are robust systems to monitor transition policies and pathways across healthcare services to ensure approaches are effective.	Benchmarking against "let me flourish" report 2021 is being undertaken by the Startwell Complex Needs workstream in addition to this being progressed through PTHB transition guidance group

6 KEY MATTERS FOR BOARD/COMMITTEE

6.1 Timely management of incidents is required to ensure appropriate action is taken. **ACTION taken:** Managers and those responsible for managing incidents have been provided with RCA training to manage incidents effectively and in a timely manner. Implementation of the Incident Management Framework will further support the timely and robust management of incidents.

Appendices (Background papers)

Appendix 1: Safecare Collaborative Presentation
Appendix 2: WRP Concerns Validation Report
Appendix 3: HIW Bryntirion Report
Appendix 4: HIW Review of Quality of Discharge Arrangements from Adult Inpatient Mental Health Services within Cwm Taf Morgannwg University Health Board (CONFIDENTIAL)

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

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

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Powys Teaching Health Board

Agenda item: 2.2

Patient Experience, Quality and Safety Committee	**Date of Meeting: 14 June 2023**
Subject:	**Mental Health Act Compliance Report for the 12 month period :** **1 April to 30 June 2022 (Q1)** **1 July to 30 September 2022 (Q2)** **1 October to 31 December 2022 (Q3)** **1 January to 31 March 2023 (Q4)**
Approved by, **and presented by:**	Joy Garfitt (Executive Director of Operations. Director of Community and Mental Health) Louisa Kerr (Head of Mental Health Operations)
Prepared by:	Paul Hanna, Mental Health Head of Nursing and Melissa Brooks, Mental Health Act Administrator
Other Committees and meetings considered at:	Executive Committee 14 June 2023
References	*Monitoring the Mental Health* 2018/19 (2020). **www.cqc.org.uk/mhareport** *Mental Health, Learning Disability Hospitals and Mental Health Act Monitoring Annual Report* 2018/19 (2020)Healthcare Inspectorate Wales **www.hiw.org**

PURPOSE:

The purpose of this paper is to provide **ASSURANCE** to the committee that Powys Teaching Health Board is compliant with the legal duties under the Mental Health Act 1983 (MHA).

Patterson, Liz 03/07/2023 09:03:07

RECOMMENDATION(S):

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

Approval	Discussion	Information
	✓	

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

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

EXECUTIVE SUMMARY:

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

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

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DETAILED BACKGROUND AND ASSESSMENT:

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

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

Mental Health Act, 1983 - Data Collection and Exception Reporting

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

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

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

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

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

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

	2021/2022 (12 months)	2022 / 2023 (12 months)
Sec 5 (4)	**5**	**3**
Sec 5 (2)	**23**	**16**

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The use of both Section 5(4) and Section 5(2) powers has decreased over the last two years and the service will continue to monitor the use of s5(2) powers closely during 2023/24.

ii) Section 2 – Admission for Assessment

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

Section 2 was used on 88 occasions during this 12-month period. The majority of patients reverted to voluntary status following this period of detention under the Act. For the same period last year, section 2 was used on a total of 92 occasions.

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

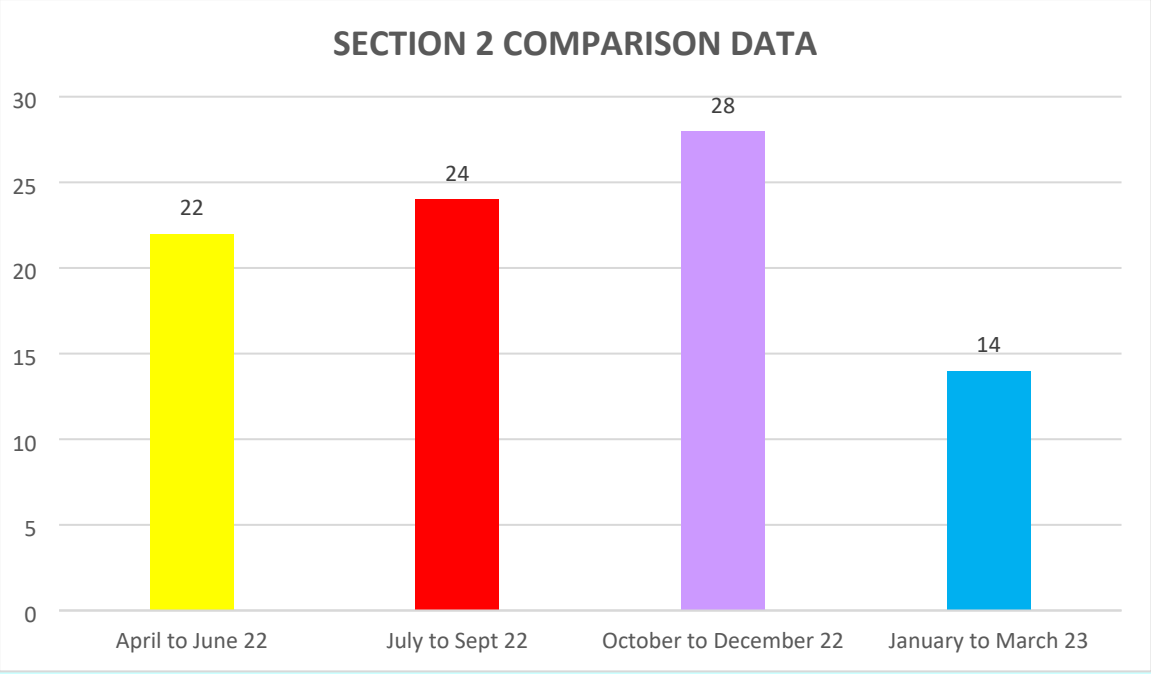

Table 1: Use of Section 2 over the last 12-month period

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iii) Section 3 – Admission for Treatment

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

During this 12-month period section 3 was used on 30 occasions.
For the same period last year, section 3 was used on a total of 38 occasions. This decrease may be linked to COVID restrictions being lifted and services being able to engage with clients at home with support as restrictions eased.

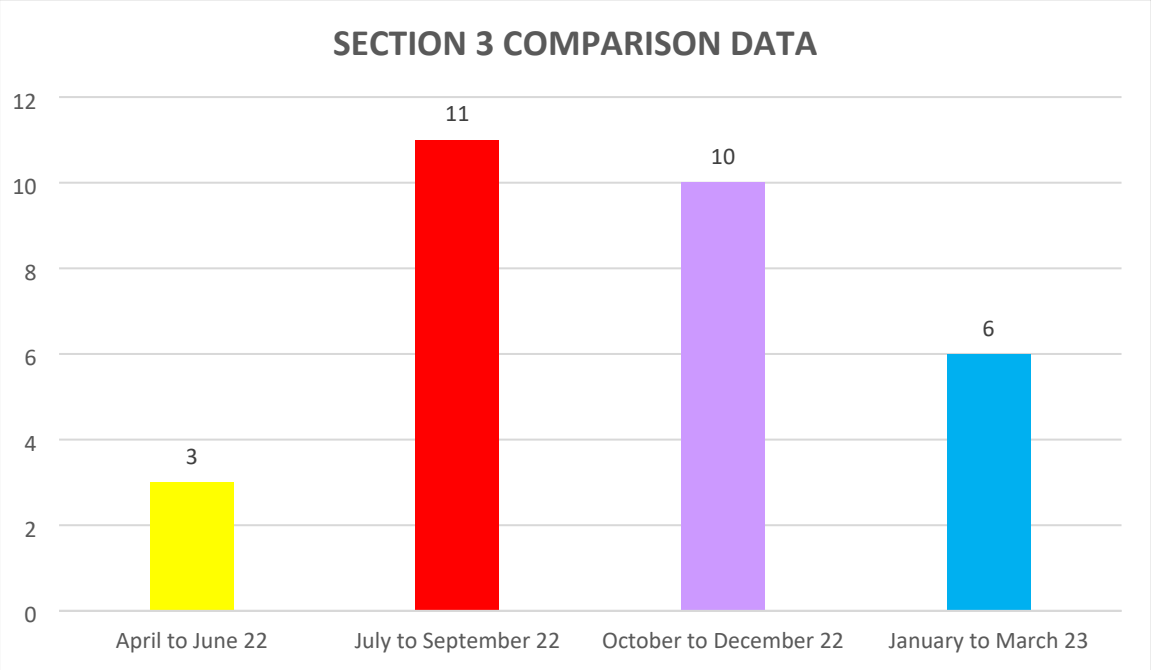

Table 2: Use of Section 3 over the last 12 month period

iv) Section 4 – Emergency Admission for Assessment

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

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

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

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

A CTO can only be used for a patient who has already been detained in hospital (under a section 3) and there will be conditions that the patient must comply with regarding their treatment within the community. If the patient does not adhere to the conditions of the CTO, they can be recalled to hospital for up to 72 hours to enable an assessment of their mental health. CTO's are used for patients who have serious mental illness and have experienced admission to hospital under the Act. It is likely that they would need the support of a CTO to accept treatment that will help them to remain well outside of a hospital setting.

In PTHB, there were fifteen community treatment orders (CTO) in place as at 8th April 2023. CTO activity during the 12-month period 1 April 2022 to 31 March 2023 includes 5 new CTO's, and three patients were recalls/revocations and two discharged from the CTO. No patients were discharged from their CTO by the Mental Health Review Tribunal. By comparison on 8 April 2022 there were eleven community treatment orders in place.

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

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

Section 136 was used during the twelve-month period 1 April 2022 to 31 March 2023 on twenty-two occasions. During the reporting period the majority of those assessed did not result in the admission or further detention of the person. The number of assessments undertaken under s136 powers, was a little higher than in the previous 12-month period when it was used on a total of nineteen occasions (over the last five years approximately twenty-seven s136 assessments are undertaken per year), however all assessments referred and conducted were appropriate.

A multi-disciplinary sub-committee of the Mental Health Planning & Development Partnership is reviewing the use of s136 powers and meets regularly to discuss cases and identify areas for improvement and learning.

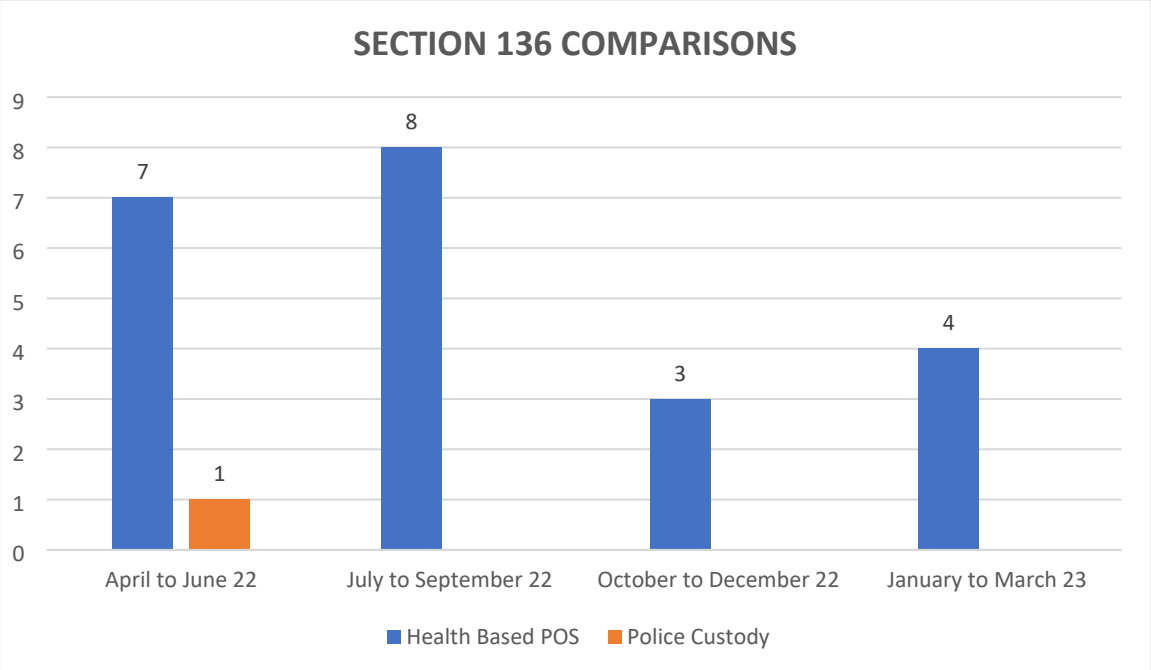

Table 3: **Location of completed Section 136 assessments highlights that police cells were used on one occasion as a place of safety during the period.**

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vii) Scrutiny of Documents

Hospital managers must ensure that Mental Health Act admission documents are received and scrutinised correctly by formally delegated officers. Section 15 of the Act provides for certain admission documents, (which if found to be incorrect or defective) must be rectified within fourteen days of the patient's admission. Rectification or correction is mainly concerned with inaccurate recording (e.g., spelling of a patient's name) and it cannot be used to enable a fundamentally defective application to be retrospectively validated. For example, a spelling error on a document, if corrected ensures the detention remain valid. For this 12-month period there were ten rectifications which is down from 12 the previous year. Error types are spelling error in patients name, spelling error in name of local authority, spelling error in address, incomplete address of Approved Mental Health Professional. There was one fundamentally defective detention where the patient was detained to a different hospital within the county to that named on the application.

Errors found that were required to be rectified within the fourteen days statutory time limits under section 15 of the Act were:

Rectifications		**Number of Errors**
Quarter 1	1 Apr to 30 June 22	**Five occasions**
Quarter 2	1 July to 30 Sept 22	**Less than 5 occasions**
Quarter 3	1 Oct to 31 Dec 22	**Less than 5 occasions**
Quarter 4	1 Jan to 31 Mar 23	**None**
Fundamentally Defective Detentions		
Quarter 1	1 Apr to 30 June 22	**None**
Quarter 2	1 July to 30 Sept 22	**One**
Quarter 3	1 Oct to 31 Dec 22	**None**
Quarter 4	1 Jan to 31 Mar 23	**None**

viii) Deaths of detained patients

During the period there were two deaths of patients who were subject to detention under the Mental Health Act 1983. One was an older adult patient who passed away after becoming acutely physically unwell. The second case was an Adult patient who passed away on Felindre.

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

During the 12-month reporting period reporting period, 24 applications applications/referrals were made to the MHRT:

- One patient was discharged

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Fifteen Hospital Managers Hearings were held during the period. By comparison there were 19 Hospital Managers Hearings for the same period in the previous year

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

This is reviewed by the quarterly Powers of Discharge Committee which is satisfied those patients are being made aware of their rights and have sufficient information to appoint an advocate if they want one.

5. Hospital Managers Power of Discharge Committee

Meetings for the above committee made up of the Hospital Managers and Independent Members was held during the year and quarterly performance was reported, scrutinised and discussed. Attached are the minutes of the meetings held within the period.

6. Healthcare Inspectorate Wales (HIW) Visits to Mental Health & Learning Disabilities Units

During the reporting period there was two visits by HIW. The first visit was to Tawe ward in January 2023 and the second was to Bryntirion CMHT in March 2023. No urgent recommendations were made by HIW.

From the Tawe action plan the health board were asked to ensure that the Mental Health Act office undertake regular audit activity of the records to ensure that records are well maintained, fully completed and easy to navigate. An SBAR is being formulated to support adding resource to the MHA office as currently this work is undertaken by a lone practitioner.

RECOMMENDATION:

The committee is asked to note the contents of this report and receive assurance that the performance of the service in relation to the administration of the Mental Health Act 1983 has been compliant with legislation.

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Appendix

KEY TO MENTAL HEALTH ACT SECTIONS

Part 2 – Compulsory Admission to Hospital or Guardianship

- Section 5(4) Nurses Holding Power (up to 6 hours)
- Section 5(2) Doctors Holding Power (up to 72 hours)
- Section 4 Emergency Admission for Assessment (up to 72 hours)
- Section 2 Admission for Assessment (up to 28 days)
- Section 3 Admission for Treatment (6 months, renewable)
- Section 7 Application for Guardianship (6 months, renewable)
- Section 17A Community Treatment Order (6 months, renewable)

Part 3 - Patients Concerned with Criminal Proceedings or Under Sentence

- Section 35 Remand for reports (28 days, maximum 12 weeks)
- Section 36 Remand for treatment (28 days, maximum 12 weeks)
- Section 38 Interim Hospital Order (Initial 12 weeks, maximum 1 year)
- Section 47/49 Transfer of sentenced prisoner to hospital
- Section 48/49 Transfer of un-sentenced prisoner to hospital
- Section 37 Hospital or Guardianship Order (6 months, renewable)
- Section 37/41 Hospital Order with restriction (Indefinite period)
- Section 45A Hospital Direction and Limitation Direction
- CPI 5 Criminal Procedure (Insanity) & Unfitness to Plead (Indefinite period)

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Part 10 – Miscellaneous and Supplementary

- Section 135(1) Warrant to enter and remove (up to 24 hours)
- Section 135(2) Warrant to enter and take or retake (up to 24 hours)
- Section 136 Removal to a place of safety (up to 24 hours)

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Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 2.3

Patient Experience, Quality and Safety Committee	**Date of Meeting: 4 July 2023**
Subject:	Closure Report of the 2022-2023 Clinical Audit Programme and update on progress for Q1 2023-2024
Approved and Presented by:	Kate Wright, Medical Director
Prepared by:	David Farnsworth, Assistant Director for Community Services Joy Garfitt, Assistant Director for Mental Health Louise Turner, Assistant Director for Women and Children's Services Jayne Lawrence, Assistant Director for Primary Care Jacqueline Seaton, Chief Pharmacist Howard Cooper, Safety and Quality Improvement Manager
Other Committees and meetings considered at:	N/A

PURPOSE:

This paper provides the committee with a closure report of the 2022/23 Clinical Audit Programme and update of quarter one activity for 2023/24.

RECOMMENDATION(S):

The Patient Experience Quality and Safety Committee is asked to:

- **NOTE** the end of year clinical audit programme position (see also appendix A); and
- Take **ASSURANCE** on quarter one progress against the 2023/24 programme.

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

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

Closure of the 2022-23 Clinical Audit Programme

This section of the report details the status of the audits included in the 2022-23 Clinical Audit Programme as of Friday 31 March 2023.

The Clinical Audit Plan 2022/23 comprised the following types of audits:

	Women & Children's Service Group	Community Service Group	Mental Health & LD Service Group	Medical Directorate	Corporate Nursing
National Audit Programme	3	6	-	-	-
Non-Programme National Initiatives	5	1	-	1	
Local Service Improvement Initiatives	9	53	2	2	3

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

Audits required for Accreditation of Services	-	8	-	-	-
Response to Incident of identified Risk	-	1	1	1	
Evaluation of introduction of new policy or process	2	1	-	-	-
Others	1	-	-	-	-

End of Year summary for audit activity

COMPLETED AUDITS	ONGOING AT YEAR END	POSTPONED TO 23/24	DID NOT PROCEED
66	**16**	**15**	**3**

Community Service Group audit activity

The clinical audit plan for the Community Service Group for 2022/23 comprised the following:

	Community Service Group
National Audit Programme	6
Non-Programme National Initiatives	1
Local Service Improvement Initiatives	53
Audits required for Accreditation of Services	8
Response to Incident of identified Risk	1
Evaluation of introduction of new policy or process	1
Others	-

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End of Year summary for Community Services Group audit activity

COMPLETED AUDITS	ONGOING AT YEAR END	POSTPONED TO 22/23	DID NOT PROCEED
51	**12**	**6**	**1**

One audit in Physiotherapy did not proceed as the clinical priorities changed during the course of the year and other work was prioritised.

Women and Children's Service audit activity

The clinical audit plan for the Women & Children's Service for 2022/23 comprised the following:

	Women & Children's Service Group
National Audit Programme	3
Non-Programme National Initiatives	5
Local Service Improvement Initiatives	9
Audits required for Accreditation of Services	-
Response to Incident of identified Risk	-
Evaluation of introduction of new policy or process	2
Others	1

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

COMPLETED AUDITS	ONGOING AT YEAR END	POSTPONED TO 22/23	DID NOT PROCEED
11	**2**	**5**	**2**

Two audits did not proceed. One audit on adoption documentation was cancelled because illness severely reduced staff capacity and it was felt that there was very low risk if the audit was not undertaken.

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The second audit was cancelled as the measure it was due to audit was delayed and has not yet been fully introduced.

Mental Health and Learning Disabilities Service audit activity

The clinical audit plan for the Mental Health and Learning Disabilities Service for 2022/23 comprised the following:

	Mental Health & LD Service Group
National Audit Programme	-
Non-Programme National Initiatives	-
Local Service Improvement Initiatives	2
Audits required for Accreditation of Services	-
Response to Incident of identified Risk	1
Evaluation of introduction of new policy or process	-
Others	-

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

COMPLETED AUDITS	ONGOING AT YEAR END	POSTPONED TO 22/23	DID NOT PROCEED
1	**0**	**2**	**0**

Medical Directorate audit activity

	Medical Directorate
National Audit Programme	-
Non-Programme National Initiatives	1
Local Service Improvement Initiatives	2
Audits required for Accreditation of Services	-
Response to Incident of identified Risk	1
Evaluation of introduction of new policy or process	-
Others	-

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COMPLETED AUDITS	ONGOING AT YEAR END	POSTPONED TO 22/23	DID NOT PROCEED
1	0	3	0

Corporate Nursing audit activity

	Corporate Nursing
National Audit Programme	-
Non-Programme National Initiatives	
Local Service Improvement Initiatives	3
Audits required for Accreditation of Services	-
Response to Incident of identified Risk	
Evaluation of introduction of new policy or process	-
Evaluation of a new service	-

COMPLETED AUDITS	ONGOING AT YEAR END	POSTPONED TO 22/23	DID NOT PROCEED
2	0	1	0

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Section 2 - This section of the report provides an update on clinical audits reported in Quarter 1 of 2023-24

Of the seven audits due to be reported for quarter one, 5 have been completed. Appendix B provides a copy of the clinical audit programme for 2023/24 as agreed by the Committee in April 2023.

Changes to the Audit Programme.

Nursing Fundamentals audit has been added.

Two Endoscopy audits have been delayed.

It is recognised that a high proportion of the clinical audits for 2023/24 are due to report in later quarters. In some instances, this is planned to fit with the rhythm of work, however it will be suggested that service groups bring some audits forwards.

Additional Audit undertaken.

None.

Audits Delayed.

Planned Care reports a delay to both the Annual planning and productivity report and the Endoscopist satisfaction survey due to there being no lead endoscopist or senior clinician in post. Recruitment is underway and plans are being developed to progress these audits in the meantime.

No Clinical Audits were due to report in this period from;

- Mental Health and Learning Disabilities Group
- Medicines Management
- Primary Care

Maturing the clinical audit plan, learning and future planning

The following are some instances when a new clinical audit may be considered:

- The learning from experience group considers themes from concerns and incidents and clinical audits. Where additional assurance is needed, specific clinical audits are requested.

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- In considering action plans following an incident investigation, clinical audits have been included for key areas. This will help to provide additional confidence and assurance that actions and interventions have been effective.

- Where new clinical policies and procedures are implemented, clinical audits have been suggested to assess effectiveness.

- Where there is learning from wider system wide reviews indicating the need for additional assurance.

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Appendix A - Closure Status of Audits from the Clinical Audit Plan 2022/23

Medical Directorate Audits				
Medicines Management Team				
Driver	**Audit Title**	**Start Date**	**Lead**	**End of Year Status**
Tier 2 Service Improvement	Audit of authorisation process for staff to use Patient Group Directions (Brought forward from 21/22).	Quarter 3 2022	Medicines Management Staff	AUDIT UNDERWAY BUT NOT COMPLETED
Tier 2 Service Improvement	Record keeping and correct use of Patient Group Directions across the Health Board (Brought forward from 21/22).	Quarter 3 2022	Medicines Management Staff	AUDIT UNDERWAY BUT NOT COMPLETED
Tier 2 – Identified risk	Controlled Drugs Register Audit. (Brought forward from 21/22).	Quarter 3 2022	Medicines Management Staff	MOVED TO 23/24 PROGRAMME
Safety and Quality Improvement				
Driver	**Audit Title**	**Start Date**	**Lead**	**End of Year Status**
Tier 1 - Other National Audits	All Wales audit of completion of DNACPR forms	Quarter 3 2022	Safety & Quality Improvement Manager	COMPLETED
Community Services Group Audits				
Dentistry				

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Driver	Audit Title	Start Date	Lead	End of Year Status
Tier 2 - Service Improvement	Retrospective audit of e-referral form completeness for Oral Surgery services in north Powys Oct during March 2020 - June 2022	Quarter 3 2022	Dental Staff	MOVED TO 23/24 PROGRAMME
Tier 2 -Changes to Policy and Practice	Audit of staff acceptance of pre- and post-clinic briefings introduced in the Community Dental Service in Powys	Quarter 3 2022	Dental Staff	COMPLETED
Tier 2 - Service Improvement	Audit of subjective image quality ratings of dental radiographs in the Community Dental Service	Quarter 3 2022	Dental Staff	COMPLETED
Tier 2- Audit for accreditation scheme	WHTM01-05 (equipment decontamination) audit	Quarter 3 2022	Dental Staff	COMPLETED
Tier 2 - Service Improvement	Audit of E-referral form completeness for Oral Surgery services in north Powys	Quarter 3 2022	Dental Staff	MOVED TO 23/24 PROGRAMME
Tier 2 - Service Improvement	Audit of Clinical Record Keeping	Quarter 3 2022	Dental Staff	COMPLETED
Tier 2 - Service Improvement	Audit of IPC& Decontamination and Hand Hygiene Protocol	Quarter 3 2022	Dental Staff	COMPLETED
Primary Care				
Driver	**Audit Title**	**Start Date**	**Lead**	**End of Year Status**
Tier 2 Service Improvement	Near Patient Testing of intrinsically high-risk drugs	Quarter 3 2022	GP Surgery Staff	COMPLETED
Tier 2 Service Improvement	Audit of care provided to patients with diabetes	Quarter 3 2022	GP Surgery Staff	COMPLETED

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Tier 2 Service Improvement	Audit of the use of Novel Oral Anti-Coagulants	Quarter 3 2022	GP Surgery Staff	COMPLETED
Tier 1- National Audit Programme	National Diabetes Core Audit	On Demand	Data automatically extracted from Practice database by National Audit team.	COMPLETED

Therapies and Health Sciences				
Driver	**Audit Title**	**Start Date**	**Lead**	**End of Year Status**
Tier 2-Service Improvement	Notes Audit (re-audit of 2020 audit) (Brought forward from 21/22).	Quarter 2 2022	Occupational Therapy staff	COMPLETED
Tier 2-Service Improvement	Notes Audit (re-audit of 2020 audit) (Brought forward from 21/22).	Quarter 2 2022	Physiotherapy staff	AUDIT UNDERWAY BUT NOT COMPLETED
Tier 2-Service Improvement	Notes Audit (Brought forward from 21/22).	Quarter 2 2022	Speech and Language staff	COMPLETED
Tier 2 – Identified risk	Waiting times/compliance with targets (Brought forward from 21/22).	Quarter 2 2022	Audiology staff	COMPLETED
Tier 2-Service Improvement	Spasticity against National Standards (Brought forward from 21/22).	Quarter 2 2022	Physiotherapy staff	MOVED TO 23/24 PROGRAMME

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Tier 2- Audit for accreditation scheme	Compliance with Standard operating procedures	Quarter 1 2022	Head of Radiography	COMPLETED
Tier 2- Audit for accreditation scheme	Pregnancy Status	Quarter 1 2022	Head of Radiography	COMPLETED
Tier 2- Audit for accreditation scheme	Correct use of radiographic markers	Quarter 1 2022	Head of Radiography	COMPLETED
Tier 2- Audit for accreditation scheme	Non Medical Referrals (NMR) Audit of NMR compliance	Quarter 1 2022	Head of Radiography	COMPLETED
Tier 2- Audit for accreditation scheme	Reject analysis	Quarter 1 2022	Head of Radiography	COMPLETED
Tier 2- Audit for accreditation scheme	Radiographer commenting audit	Quarter 1 2022	Head of Radiography	COMPLETED
Tier 2- Audit for accreditation scheme	QA plain film and NOUS / Midwife Sonography	Quarter 1 2022	Head of Radiography	COMPLETED
Tier 2- Service Improvement	QA reporting Audit	Quarter 1 2022	Head of Radiography	AUDIT UNDERWAY BUT NOT COMPLETED
Tier 1- National Audit Programme	National Quality Standards Adult Audiology	Quarter 2 2022	Head of Audiology	AUDIT UNDERWAY BUT NOT COMPLETED
Tier 2- Service Improvement	Inappropriate Referrals audit	TBC	Head of Audiology	COMPLETED
Tier 2- Service Improvement	Notes Audit	Quarter 3 2022	Head of Adult Speech and Language Therapy	COMPLETED
Tier 2- Service Improvement	Notes Audit	Quarter 2 2022	Team Leader, Dietetics	AUDIT UNDERWAY

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				BUT NOT COMPLETED
Tier 2- Service Improvement	Notes Audit	Quarter 1 2022	Head of Occupational Therapy	COMPLETED
Tier 2- Service Improvement	Notes Audit	Quarter 2 2022	Head of Physiotherapy	AUDIT UNDERWAY BUT NOT COMPLETED
Tier 2- Service Improvement	Notes Audit	Quarter 4 2022	Head of Podiatry	AUDIT UNDERWAY BUT NOT COMPLETED
Tier 1- National Audit Programme	National Diabetes Foot Care Audit	Quarter 1 2022	Head of Podiatry	AUDIT UNDERWAY BUT NOT COMPLETED
Tier 1- National Audit Programme	National Stroke Audit (SNAPP)	Quarter 1 2022	Consultant Therapist	COMPLETED
Tier 2- Service Improvement	Audit of CMATS Osteo arthritis Knee care based on NICE guidance	Quarter 1 2022	Head of Physiotherapy	ABANDONED
Tier 1 - Other National Audits	Parkinson's Care	TBC Nationally	Head of Speech and Language Therapy	AUDIT UNDERWAY BUT NOT COMPLETED
Tier 2- Service Improvement	Spasticity care against National Standards	Quarter 3 2022	Consultant Therapist	MOVED TO 23/24 PROGRAMME

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Tier 2- Service Improvement	Taxonomy Audit	Quarter 3 2022	Head of Podiatry	AUDIT UNDERWAY BUT NOT COMPLETED
Tier 2- Service Improvement	Paediatric Dietetic Service	Quarter 3 2022	Head of Dietetics	MOVED TO 23/24 PROGRAMME
Tier 2- Service Improvement	Diabetes Prevention - Primary Care	Quarter 4 2022	Head of Dietetics	MOVED TO 23/24 PROGRAMME
Unscheduled Care				
Driver	**Audit Title**	**Start Date**	**Lead**	**End of Year Status**
Tier 2-Service Improvement	Missed Fractures Audit	Quarterly	Senior Nurse Unscheduled Care	COMPLETED
Tier 2-Service Improvement	Mattress audit	Quarterly	Senior Nurse Unscheduled Care	COMPLETED
Tier 2-Service Improvement	Hand Hygiene Audit	Quarterly	Senior Nurse Unscheduled Care	COMPLETED
Tier 2-Service Improvement	Primary Care Attenders	Bi Yearly 2021	Senior Nurse Unscheduled Care	COMPLETED
Tier 2-Service Improvement	Paramedic/downgrade ambulance audit	Bi yearly 2021	Senior Nurse Unscheduled Care	COMPLETED
Tier 2-Service Improvement	PGD Audit	Monthly	Senior Nurse Unscheduled Care	COMPLETED

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Tier 2-Service Improvement	Paeds under five audit – scrutiny of every attender under five	Bi yearly 2021	Senior Nurse Unscheduled Care	COMPLETED
Nursing (Ward and Community)				
Driver	**Audit Title**	**Start Date**	**Lead**	**End of Year Status**
Tier 2-Service Improvement	Fundamentals of care	Monthly	Senior Nurses	COMPLETED
Tier 2-Service Improvement	Pressure Damage Audit	Quarter 4 2022	Senior Nurses	AUDIT UNDERWAY BUT NOT COMPLETED
Tier 2-Service Improvement	In-Patient Falls Audit	Quarter 4 2022	Senior Nurses	AUDIT UNDERWAY BUT NOT COMPLETED
Tier 2-Service Improvement	Hydration and Nutrition Audit	Quarter 4 2022	Senior Nurses	AUDIT UNDERWAY BUT NOT COMPLETED
Tier 1- National Audit Programme	National Cardiac Rehabilitation Audit	TBC Nationally	Rehabilitation Nursing Staff	COMPLETED
Tier 1- National Audit Programme	National Pulmonary Rehabilitation Audit	TBC Nationally	Rehabilitation Nursing Staff	COMPLETED
Surgery and Endoscopy				
Driver	**Audit Title**	**Start Date**	**Lead**	**End of Year Status**

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Tier 2-Service Improvement	Five Steps to Safer Surgery	Quarter 1 2022	Surgery and Endoscopy Team	COMPLETED
Tier 2-Service Improvement	Managing Perioperative Normothermia	Quarter 1 2022	Surgery and Endoscopy Team	COMPLETED
Tier 2-Service Improvement	Decontamination	Quarter 1 2022	Surgery and Endoscopy Team	COMPLETED
Tier 2-Service Improvement	Specimen Management	Quarter 1 2022	Surgery and Endoscopy Team	COMPLETED
Tier 2-Service Improvement	Tourniquets	Quarter 1 2022	Surgery and Endoscopy Team	COMPLETED
Tier 2-Service Improvement	Use and Handling of Surgical Instruments	Quarter 1 2022	Surgery and Endoscopy Team	COMPLETED
Tier 2-Service Improvement	Preoperative care for Patients with Dementia	Quarter 2 2022	Surgery and Endoscopy Team	COMPLETED
Tier 2-Service Improvement	Anaesthesia	Quarter 2 2022	Surgery and Endoscopy Team	COMPLETED
Tier 2-Service Improvement	Surgical record keeping audit & consent	Quarter 2 2022	Surgery and Endoscopy Team	COMPLETED
Tier 2-Service Improvement	Post anaesthetic Care	Quarter 2 2022	Surgery and Endoscopy Team	COMPLETED
Tier 2-Service Improvement	Surgical Patient Satisfaction audit	Quarter 2 2022	Surgery and Endoscopy Team	COMPLETED
Tier 2-Service Improvement	Electrosurgery	Quarter 2 2022	Surgery and Endoscopy Team	COMPLETED
Tier 2-Service Improvement	Fluid Management	Quarter 3 2022	Surgery and Endoscopy Team	COMPLETED
Tier 2-Service Improvement	Foreign body aspiration during intubation, advanced airway management or ventilation	Quarter 3 2022	Surgery and Endoscopy Team	COMPLETED

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Tier 2-Service Improvement	Pre assessment and Specific Day Case Requirements	Quarter 3 2022	Surgery and Endoscopy Team	COMPLETED
Tier 2-Service Improvement	Audit of prosthesis verification data	Quarter 3 2022	Surgery and Endoscopy Team	COMPLETED
Tier 2-Service Improvement	Intraoperative Care	Quarter 4 2022	Surgery and Endoscopy Team	COMPLETED
Tier 2-Service Improvement	Accountable Items, Swab, Instrument and Sharps Count	Quarter 4 2022	Surgery and Endoscopy Team	COMPLETED
Women's and Children's Service				
Maternity Services				
Driver	**Audit Title**	**Start Date**	**Lead**	**End of Year Status**
Tier 1 - National Audit Programme	National Maternity and Perinatal Audit	April 2022	Head of Midwifery & Sexual Health Services & W&C Governance Lead	MOVED TO 23/24 PROGRAMME
Tier 2-Service Improvement	Audit of Compliance with Pool Evacuation Policy	April 2022	Clinical Supervisor of Midwives	COMPLETED
Tier 1 - UNICEF BFI	BFI Infant feeding audits	TBC	Infant Feeding Coordinator	MOVED TO 23/24 PROGRAMME
Tier 1 - Other National Audits	SGA Audit Compliance with GAP/GROW fetal surveillance programme at detecting SGA babies (Brought forward from 21/22).	April 2022	Head of Midwifery & Sexual Health Services	COMPLETED

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Tier 2-Service Improvement	WAST Transfer Audit - Implementation of new transfer flow chart. (Brought forward from 21/22).	Quarter3 2022	Shelly Higgins Consultant Midwife / Kate Evans	COMPLETED
Tier 2-Service Improvement	Clinical Supervision Policy (Brought forward from 21/22).	Autumn 2022	TBC	AUDIT UNDERWAY BUT NOT COMPLETED
Tier 2-Service Improvement	Infection Control Audits (Environmental, Hand Hygiene) (Brought forward from 21/22).	Quarter3 2022	W&C Risk and Governance Lead	MOVED TO 23/24 PROGRAMME
Tier 2-Service Improvement	Annual Record Keeping Audit of Clinical Records	April 2022	All service leads	AUDIT UNDERWAY BUT NOT COMPLETED
Tier 2-Service Improvement	Audit of Access to DAU Service And Care Against DAU Guideline	April 2022	Assistant Head of Midwifery & Sexual Health Services	MOVED TO 23/24 PROGRAMME
Tier 2-Service Improvement	Midwifery Sonography Audit to validate findings of local scans	Quarter3 2022	Consultant Midwife	COMPLETED
Tier 2-Service Improvement	Antenatal and intrapartum transfer audits	Quarter3 2022	Consultant Midwife	COMPLETED
Community Paediatrics				
Tier 3- Audit suggested by FOI request	Recording of Antenatal Alcohol Exposure on Adoption Medical Reports. (Brought forward from 21/22).	TBC	Consultant Community Paediatrician	ABANDONED
Tier 2 -Changes to Policy and Practice	Melatonin Use Re-Audit (Brought forward from 21/22).	Quarter 1 2022	Consultant Community Paediatricians	COMPLETED

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Tier 1 - National Audit Programme	National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)	TBC	Consultant Community Paediatricians	COMPLETED
Tier 1 - Child Protection Quality Standards (UK)	Child Protection Medicals in Powys (Trends over last 3 years) (Brought forward from 21/22).	Quarter 1 2022	Consultant Community Paediatricians	COMPLETED
Children's Therapies				
Tier 1 - National Audit Programme	Audit of Quality Standards for Paediatric Audiology	Quarter 2 2022	Professional/Medical Lead for Paediatric Audiology	COMPLETED
Tier 2 -Changes to Policy and Practice	Using TOMS to measure virtual therapy practices (Brought forward from 21/22).	Quarter 3 2022	Head of Children's Speech and Language Therapy/Team Leader North	ABANDONED
Tier 2-Service Improvement	NICE Guidance – Neurodevelopment Service (Brought forward from 21/22).	Quarter 3 2022	ND service	MOVED TO 23/24 PROGRAMME
Children's Nursing/Health Visiting				
Tier 1 - Other National Audits	Health Care Standards Audit (Brought forward from 21/22).	April 2022	Health Visiting	COMPLETED
Tier 1 - Other National Audits	SN Framework and Special School Nursing Framework (Brought forward from 21/22).	April 2022	School Nursing	COMPLETED

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Mental Health and Learning Disabilities				
Driver	**Audit Title**	**Start Date**	**Lead**	**End of Year Status**
Tier 2 – Identified risk	Audit of assessments conducted using the Wales Applied Risk Research Network (WARRN) tool	Quarter 1 2022	Mental Health Staff	COMPLETED
Tier 2-Service Improvement	Audit of Admission Documentation	Quarter 3 2022	Mental Health Staff	MOVED TO 23/24 PROGRAMME
Tier 2-Service Improvement	Audit of Care and Treatment Plan Documentation	Quarter 3 2022	Mental Health Staff	MOVED TO 23/24 PROGRAMME
Corporate Nursing Team				
Safeguarding				
Driver	**Audit Title**	**Start Date**	**Lead**	**End of Year Status**
Tier 2-Service Improvement	Safeguarding Maturity Matrix	September 2022	Assistant Director Safeguarding	COMPLETED
Tier 2-Service Improvement	Audit of child exploitation safeguarding procedures	Quarter 4 2022	Assistant Director Safeguarding	COMPLETED
Tier 2-Service Improvement	Audit in the Recording of Safeguarding Advice	Quarter 4 2022	Assistant Director Safeguarding	MOVED TO 23/24 PROGRAMME

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Audit Driver Key:

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

Progress Key:

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

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Appendix B

Clinical Audit Plan 2023/24

Community Services Group					
Unscheduled Care					
Driver	Audit Title	Planned Reporting Date	Service	Lead	Audit Status
Local Audits for Service Improvement	Missed Fractures Audit	Quarter 4	Unscheduled Care	Senior Manager	Not Yet Due
Local Audits for Service Improvement	Mattress audit	Quarter 4	Unscheduled Care	Senior Manager	Not Yet Due
Local Audits for Service Improvement	Hand Hygiene Audit	Quarter 4	Unscheduled Care	Senior Manager	Not Yet Due
Local Audits for Service Improvement	Primary Care Attenders	Quarter 4	Unscheduled Care	Senior Manager	Not Yet Due
Local Audits for Service Improvement	Paramedic/downgrade ambulance audit	Quarter 4	Unscheduled Care	Senior Manager	Not Yet Due
Local Audits for Service Improvement	PGD Audit	Quarter 4	Unscheduled Care	Senior Manager	Not Yet Due
Local Audits for Service Improvement	Paeds under five audit – scrutiny of every attender under five	Quarter 4	Unscheduled Care	Senior Manager	Not Yet Due

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Nursing (Ward and Community)					
Driver	Audit Title	Planned Reporting Date	Service	Lead	Audit Status
Local Audits for Service Improvement	Health & Care Monitoring Tool (Includes Hand hygiene audits & Patient surveys, ward cleaning)	Quarter 4	Nursing (Wards)	Ward Managers	Not Yet Due
Local Audits for Service Improvement	NEWS Audit	Quarter 4	Nursing (Wards)	Ward Managers	Not Yet Due
Local Audits for Service Improvement	Wristband Audit	Quarter 4	Nursing (Wards)	Ward Managers	Not Yet Due
Local Audits for Service Improvement	Dols Audit	Quarter 4	Nursing (Wards)	Ward Managers	Not Yet Due
Local Audits for Service Improvement	Welsh Language Audit	Quarter 4	Nursing (Wards)	Ward Managers	Not Yet Due
Local Audits for Service Improvement	DNACPR Audit	Quarter 4	Nursing (Wards)	Ward Managers	Not Yet Due
Local Audits for Service Improvement	Multi-factorial Falls Risk Assessment Audit (Inpatients)	Quarter 2	Nursing (Wards)	Ward Managers	Not Yet Due
Local Audits for Service Improvement	Hydration and Nutrition Audit	Quarter 4	Nursing (Wards)	Senior Nurses	Not Yet Due

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Specialist Nursing					
Driver	Audit Title	Planned Reporting Date	Service	Lead	Audit Status

Other National Audit & Service Evaluation	Parkinson's UK National Audit	Quarter 4 2024	Specialist Nursing – Parkinson's Disease	Parkinson's Disease ANP	Not Yet Due
Local Audits for Service Improvement	Pressure Damage Audit	Quarter 4 2024	Specialist Nursing – Tissue Viability Nurse	Senior Nurses	Not Yet Due
Service Evaluation	Clinic PREM Data	Quarter 4 2024	Specialist Nursing - Continence	Continence Service Manager	Not Yet Due
Service Evaluation	UTI Safety Data	Quarter 4 2024	Specialist Nursing - Continence	Continence Service Manager	Not Yet Due
Service Evaluation	Prescribing Data	Quarter 4 2024	Specialist Nursing - Continence	Continence Service Manager	Not Yet Due
Service Evaluation	Transition Clinic PREM Data	Quarter 4 2024	Specialist Nursing - Continence	Continence Service Manager	Not Yet Due
Service Evaluation	Pad PREM	2025	Specialist Nursing - Continence	Continence Service Manager	Not Yet Due
Service Evaluation	COBWEB PREM	2025	Specialist Nursing - Continence	Continence Service Manager	Not Yet Due

Surgery and Endoscopy					
Driver	**Audit Title**	**Planned Reporting Date**	**Service**	**Lead**	**Audit Status**
Service Evaluation	Surgical Performance/DNA/Cancellation data	Quarter 4	Theatre	Theatre Lead	Not Yet Due
Service Evaluation	Monthly Surgical Utilisation data	Quarter 4	Theatre	Theatre Lead	Not Yet Due
Service Evaluation	Surgical Site Infection data	Quarter 4	Theatre	Theatre Lead	Not Yet Due

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Service Evaluation	Surgical incidents	Quarter 4	Theatre	Theatre Lead	Not Yet Due
Service Evaluation	Hand hygiene Audits	Quarter 4	Theatre	Theatre staff	Not Yet Due
Service Evaluation	Bi weekly C4C audit	Quarter 4	Theatre	Facilities	Not Yet Due
Service Evaluation	Legal and ethical audit	Quarter 2	Theatre	Theatre Lead	Not Yet Due
Service Evaluation	Data protection and GDPR	Quarter 2	Theatre	Theatre Lead	Not Yet Due
Service Evaluation	Management/Human Resources	Quarter 2	Theatre	Theatre Lead	Not Yet Due
Service Evaluation	Education	Quarter 2	Theatre	Theatre Lead	Not Yet Due
Service Evaluation	Five Steps to Safer Surgery	Quarter 2	Theatre	Theatre Lead	Not Yet Due
Service Evaluation	Managing Perioperative Normothermia	Quarter 2	Theatre	Theatre Lead	Not Yet Due
Service Evaluation	Risk Management (Organisational and Environmental)	Quarter 2	Theatre	Theatre Lead	Not Yet Due
Service Evaluation	Decontamination	Quarter 2	Theatre	Theatre Lead	Not Yet Due
Service Evaluation	Specimen Management	Quarter 2	Theatre	Theatre Lead	Not Yet Due
Service Evaluation	Tourniquets	Quarter 2	Theatre	Theatre Lead	Not Yet Due
Service Evaluation	Use and Handling of Surgical Instruments	Quarter 2	Theatre	Theatre Lead	Not Yet Due
Service Evaluation	Preoperative care for Patients with Dementia	Quarter 3	Theatre	Theatre Lead	Not Yet Due
Service Evaluation	Anaesthesia	Quarter 3	Theatre	Theatre Lead	Not Yet Due

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Service Evaluation	Surgical record keeping audit & consent	Quarter 3	Theatre	Theatre Lead	Not Yet Due
Service Evaluation	Post anaesthetic Care	Quarter 3	Theatre	Theatre Lead	Not Yet Due
Service Evaluation	Surgical Patient Satisfaction audit	Quarter 3	Theatre	Theatre Lead	Not Yet Due
Service Evaluation	Electrosurgery	Quarter 3	Theatre	Theatre Lead	Not Yet Due
Service Evaluation	Fluid Management	Quarter 3	Theatre	Theatre Lead	Not Yet Due
Service Evaluation	Foreign body aspiration during intubation, advanced airway management or ventilation	Quarter 3	Theatre	Theatre Lead	Not Yet Due
Service Evaluation	Surgical patient story	Quarter 3	Theatre	Theatre Lead	Not Yet Due
Service Evaluation	Pre assessment and Specific Day Case Requirements	Quarter 4	Theatre	Theatre Lead	Not Yet Due
Service Evaluation	Audit of prosthesis verification data	Quarter 4	Theatre	Theatre Lead	Not Yet Due
Service Evaluation	Intraoperative Care	Quarter 1	Theatre	Theatre Lead	Completed
Local Audits for Service Improvement	Staff Satisfaction	Quarter 1	Theatre	Theatre Lead	Completed
Service Evaluation	Accountable Items, Swab, Instrument and Sharps Count	Quarter 1	Theatre	Theatre Lead	Completed
Service Evaluation	Individual Endoscopist KPI's	Quarter 4	Endoscopy	Clinical Lead Endoscopy	Not Yet Due

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Service Evaluation	Gastric ulcers rescoped within 12 weeks	Quarter 4	Endoscopy	J Harrison Endoscopy coordinator & S Williams Data/Audit Support	Not Yet Due
Service Evaluation	Post colonoscopy colorectal cancer rate Links established with Cwm Taf Morgannwg University Health Board MDT. If we are made aware – root cause analysis carried out	Quarter 4	Endoscopy	Clinical Lead Endoscopy	Not Yet Due
Service Evaluation	Patient Satisfaction survey	Quarter 4	Endoscopy	Jane Harrison Endoscopy coordinator & S Williams Data/Audit Support	Completed but not yet presented to management team.
Service Evaluation	Staff survey	Quarter 1	Endoscopy	Jane Harrison Endoscopy coordinator & S Williams Data/Audit Support	Completed but not yet presented to management team.
Service Evaluation	Endoscopist satisfaction survey	Quarter 1	Endoscopy	Clinical Lead Endoscopy	Delayed
Service Evaluation	Endoscopy Performance e.g DNA cancellations no of procedures late start early finishes	Quarter 4	Endoscopy	S Williams Data/Audit Support	Not Yet Due

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Other National Audits	Bowel Screening Wales User Experience Survey results	Quarter 1	Endoscopy	Clinical Lead Endoscopy	Completed
Local Audits for Service Improvement	Record Keeping	Quarter 4	Endoscopy	Clinical Lead Endoscopy	Not Yet Due
Service Evaluation	Annual planning & productivity report	Quarter 1	Endoscopy	Clinical Lead Endoscopy	Delayed
Service Evaluation	Scope traceability	Quarter 4	Endoscopy	Jane Harrison & Tracie Watling	Not Yet Due

Therapies and Health Science					
Driver	Audit Title	Planned Reporting Date	Service	Lead	Audit Status
Audits performed for accreditation schemes	Compliance with Standard operating procedures	Quarter 3	Radiography	Head of Radiography	Not Yet Due
Audits performed for accreditation schemes	Pregnancy Status	Quarter 3	Radiography	Head of Radiography	Not Yet Due
Audits performed for accreditation schemes	Correct use of radiographic markers	Quarter 3	Radiography	Head of Radiography	Not Yet Due
Audits performed for accreditation schemes	Non Medical Referrals (NMR) Audit of NMR compliance	Quarter 3	Radiography	Head of Radiography	Not Yet Due

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Audits performed for accreditation schemes	Reject analysis	Quarter 3	Radiography	Head of Radiography	Not Yet Due
Audits performed for accreditation schemes	Radiographer commenting audit	Quarter 3	Radiography	Head of Radiography	Not Yet Due
Audits performed for accreditation schemes	QA plain film and NOUS / Midwife Sonography	Quarter 3	Radiography	Head of Radiography	Not Yet Due

Local Audits for Service Improvement	QA reporting Audit	Quarter 3	Radiography	Head of Radiography	Not Yet Due
Audits performed for accreditation schemes	Monthly Clinispet/Clinel Wipes Audit	Quarter 3	Radiography	Head of Radiography	Not Yet Due
Audits performed for accreditation schemes	Sonography Service Audit	Quarter 4	Radiography	Clinical Governance Lead for Sonography	Not Yet Due
Audits performed for accreditation schemes	Reporting Radiography Service Audit	Quarter 3	Radiography	Head of Radiography	Not Yet Due
Welsh Government National Audit Programme	National Diabetes Foot Care Audit	TBC National	Podiatry	Head of Podiatry	Not Yet Due
Local Audits for Service Improvement	Taxonomy compliance audit	Quarter 4	Podiatry	Head of Podiatry	Not Yet Due

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Local Audits for Service Improvement	Patient Notes	Quarter 4	Podiatry	Head of Podiatry	Not Yet Due
Local Audits for Service Improvement	Nail Surgery	Quarter 4	Podiatry	Head of Podiatry	Not Yet Due
Welsh Government National Audit Programme	Quality Standards Tinnitus Service	Quarter 4	Audiology	Head of Audiology	Not Yet Due
Local Audits for Service Improvement	Audiology Inappropriate referrals	Quarter 3	Audiology	Head of Audiology	Not Yet Due
Service Evaluation	waiting times/compliance with target	Quarter 3	Audiology	Head of Audiology	Not Yet Due
Local Audits for Service Improvement	Carpal Tunnel	Quarter 4	Physiotherapy	Consultant MSK Physio	Not Yet Due
Local Audits for Service Improvement	Case Notes	Quarter 4	Physiotherapy	Head of Physiotherapy	Not Yet Due
Local Audits for Service Improvement	Caseload Management	Quarter 3	All AHP and HS	Al HOS	Not Yet Due
Local Audits for Service Improvement	DNA Rate	Quarter 4	Physiotherapy	Head of Physiotherapy	Not Yet Due
Local Audits for Service Improvement	Dietetic record card audit	Quarter 3	Dietetics	Clinical lead Dietitian	Not Yet Due
Local Audits for Service Improvement	Case note audit	Quarter 3	Speech and Language Therapy	Head of SLT and Clinical Leads	Not Yet Due
Local Audits for Service Improvement	Caseload Management	Quarter 3	Speech and Language Therapy	Head of Speech and Language Therapy	Not Yet Due

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Local Audits for Service Improvement	DNA Rates, CBH and CBP rates	Quarter 3	Speech and Language Therapy	Head of Speech and Language Therapy	Not Yet Due
Local Audits for Service Improvement	Was Not Brought Audit	Quarter 3	Speech and Language Therapy	Head of Speech and Language Therapy	Not Yet Due
Local Audits for Service Improvement	Use of Virtual/Attend anywhere in Adult service	Quarter 2	Speech and Language Therapy	Locum SLT	Not Yet Due
Local Audits for Service Improvement	Clinical Records audit focusing on consent, goal planning and discharge	Quarter 3	Occupational Therapy	Head of OT	Not Yet Due
Welsh Government National Audit Programme	The Sentinel Stroke National Audit Programme	Quarter 4	All AHPs	Consultant Therapist for Stroke	Not Yet Due
Service Evaluation	Quarterly Wax Management	Quarter 4	Audiology	Head of Audiology	Not Yet Due
Local Audits for Service Improvement	TImely Discharges	Quarter 4	All AHP and HS	HOS	Not Yet Due
Service Evaluation	First Contact Practitioner	Quarter 3	Physiotherapy	Consultant MSK Physio	Not Yet Due

Primary Care Group
GP Services

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Driver	Audit Title	Planned Reporting Date	Service	Lead	Audit Status
Local Audits for Service Improvement	Several audit topics will be identified based on the Local Enhanced Service agreements held with the Powys GP surgeries	Quarter 4	GP Surgeries	Powys GP's and Practice Managers	Not Yet Due
Service Evaluation	Audit of the GP with a Specialist Interest in Cardiology Service	Quarter 4	Cardiology	Dr French WVT Consultant Cardiologist	Not Yet Due
Community Dentistry					
Driver	**Audit Title**	**Planned Reporting Date**	**Service**	**Lead**	**Audit Status**
Local Audits for Service Improvement	Radiography grading - Annual subjective image quality ratings of dental radiographs in the Community Dental Service	Quarter 4 2023	All Community Dental Sites	Dental Director	Not Yet Due
Local Audits for Service Improvement	FGDP record keeping guideline audit	Quarter 4	All Community Dental Sites	Senior Dentist	Not Yet Due
Local Audits for Service Improvement	Consent to Treatment Audit	Quarter 4	All Community Dental Sites	Senior Dentist	Not Yet Due
Local Audits for Service Improvement	WHTM01-05 instrument decontamination audit	Quarter 4	All Community Dental Sites	Senior Dentist	Not Yet Due
Local Audits for Service Improvement	E-referral form completeness for Oral Surgery services audit	Quarter 4	North Powys Locations	Senior Oral Surgeon	Not Yet Due

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Local Audits for Service Improvement	Staff acceptance of pre- and post-clinic briefings introduced in the Community Dental Service (Reaudit)	Quarter 4	All Community Dental Sites	Senior Oral Surgeon	Not Yet Due

Medicines Management Group					
Medicines Management					
Driver	**Audit Title**	**Planned Reporting Date**	**Service**	**Lead**	**Audit Status**
Local Audits for Service Improvement	**Antimicrobial Stewardship: Start Smart Then Focus**	Quarter 4 2023/24	Medicines Management	Medicines Management Staff	Not Yet Due
Local Audits for Service Improvement	**Patient Safety Notice 055 (PSN055) Safe Storage of Medicines**	Quarter 3 2023/24	Medicines Management	Medicines Management Staff	Not Yet Due
Local Audits for Service Improvement	**Patient Group Directions** • Audit of authorisation process for staff to use PGDs • Record keeping regarding the use of PGDs Use of PGDs across the health Board	Quarter 4 2023/24	Medicines Management	Medicines Management Staff	Not Yet Due

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Local Audits for Service Improvement	**Medical Gases: Storage, Supply and Usage**	Quarter 4 2023/24	Medicines Management	Medicines Management Staff	Not Yet Due
Local Audits for Service Improvement	**Controlled Drugs: Safe Use and Management baseline audit** Tools and resources | Controlled drugs: safe use and management | Guidance | NICE	Quarter 2 2023/24	Medicines Management	Medicines Management Staff	Not Yet Due

Mental Health and Learning Disabilities					
Mental Health					
Driver	**Audit Title**	**Planned Reporting Date**	**Service**	**Lead**	**Audit Status**
Identified risk	Audit of assessments conducted using the Wales Applied Risk Research Network (WARRN) tool	Quarter 2 2023	Mental Health	Mental Health Staff	Not Yet Due
Local Audits for Service Improvement	Audit of Admission Documentation	Quarter 4 2023	Mental Health	Mental Health Staff	Not Yet Due
Local Audits for Service Improvement	Audit of Care and Treatment Plan Documentation	Quarter 4 2023	Mental Health	Mental Health Staff	Not Yet Due

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Local Audits for Service Improvement	Mattress audit	Quarter 4 2022	Mental Health	Mental Health Staff	Not Yet Due
Local Audits for Service Improvement	Hand Hygiene Audit	Quarter 3 2023	Mental Health	Mental Health Staff	Not Yet Due
Local Audits for Service Improvement	Hydration and Nutrition Audit	Quarter 3 2023	Mental Health	Mental Health Staff	Not Yet Due
Local Audits for Service Improvement	Audit of referrals to the Complex Trauma Service	Quarter 4 2023	Mental Health	Trainee Clinical Psychologist	Not Yet Due

Women and Children's Service					
Midwifery					
Driver	**Audit Title**	**Planned Reporting Date**	**Service**	**Lead**	**Audit Status**
Local Audits for service improvement	Audit of Access to DAU Service And Care Against DAU Guideline	Quarter 2 2023	Midwifery	Assistant Head of Midwifery & Sexual Health Services	Not Yet Due
Local Audits for service improvement	Audit against NICE Guidance – Neurodevelopment Service	Quarter 4 2023	Neurodevelopment Service	ND service lead	Not Yet Due

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UNICEF BFI	BFI Infant feeding audits	Quarter 4 2023	Midwifery	Infant Feeding Coordinator	Not Yet Due
Local Audits for service improvement	Infection Control Audits (Environmental, Hand Hygiene)	Quarter 4 2022	Midwifery	W&C Risk and Governance Lead	Not Yet Due
Local Audits for service improvement	Audit of Compliance with Pool Evacuation Guideline – a re-audit	Quarter 4 2022	Midwifery	Clinical Supervisor for Midwives	Not Yet Due
Local Audits following change to policy or procedure	Audit of clinical information sharing process in maternity	Quarter 3 2023	Midwifery	Consultant midwife / clinical supervisor for midwives	Not Yet Due
Local Audits for service improvement	Annual Record Keeping Audit	March 2024	Midwifery	Clinical Supervisor for Midwives	Not Yet Due
School Nursing and Health Visiting					
Driver	**Audit Title**	**Planned Reporting Date**	**Service**	**Lead**	**Audit Status**
Local Audits for service improvement	Annual Record Keeping Audit	Quarter 4	Health Visiting	Health Visiting Team Leaders	Not Yet Due
Local Audits for service improvement	Annual Record Keeping Audit	Quarter 4	School Nursing	School Nursing Team Leaders	Not Yet Due

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Local Audits for service improvement	Chat Health	Quarter 2	School Nursing	School Nursing Team Leaders	Not Yet Due
Local Audits for service improvement	Flu Vaccine Uptake	Quarter 3	School Nursing	School Nursing Team Leaders	Not Yet Due
Local Audits for service improvement	Use of Gastronomy Enplugs Audit	Quarter 3	Children's Community Nurse Team	Children's Community Nurse Team Lead	Not Yet Due
Service wide and specialist audits					
Driver	**Audit Title**	**Planned Reporting Date**	**Service**	**Lead**	**Audit Status**
Local Audits in response to a Serious Incident/Identified Risk	Was Not Brought – Annual Learning	Quarter 4	Whole Service	All W&C Team Leaders	Not Yet Due
Local Audits for service improvement	Baseline assessment tool for Challenging behaviour and learning disabilities (NICE clinical guideline NG11)	Quarter 3	Paediatric Learning Disabilities	Clinical Behaviour Specialist for Children with Learning Disabilities	Not Yet Due
Paediatric Therapy audits					

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Driver	Audit Title	Planned Reporting Date	Service	Lead	Audit Status
Local Audits following change to policy or procedure	Liberty Protection Safeguards	TBC	Children's Therapies Teams	HOS Paediatric, Transition & LD OT & Physio	Not Yet Due
Local Audits following change to policy or procedure	ALN health referrals	TBC	Additional Learning Needs (ALN) team	Senior administrator ALN	Not Yet Due
Local Audits in response to a Serious Incident/Identified Risk	Bone health – identification of risk.	Quarter 3	Children's Therapies Teams	HOS Paediatric, Transition & LD OT & Physio	Not Yet Due
Local Audits for service improvement	Case Note Audit	Quarter 3	Speech and Language Team	Head of SLT and Clinical Leads	Not Yet Due
Local Audits for service improvement	Caseload Management	Quarter 3	Speech and Language Team	Head of Speech and Language Therapy	Not Yet Due
Local Audits for service improvement	DNA Rates	Quarter 3	Speech and Language Team	Head of Speech and Language Therapy	Not Yet Due
Local Audits in response to a Serious Incident/Identified Risk	Was Not Brought	Quarter 3	Speech and Language Team	Head of Speech and Language Therapy	Not Yet Due

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Audit Driver Key:

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

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Progress Key:

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

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Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda Item 2.4

Patient Experience and Quality Committee	**Date of Meeting: 4 July 2023**
Subject:	**Safeguarding Update: Safeguarding and Public Protection Annual Report 2022-23**
Approved and presented by:	Claire Roche - Executive Director of Nursing and Midwifery
Prepared by	Jayne Wheeler Sexton - Assistant Director for Safeguarding and Public Protection
Other Committees and meetings considered at:	Executive Committee 28 June 2023

PURPOSE:

The purpose of this paper is to:

To present the 2022-23 Safeguarding and Public Protection Annual Report to the Patient Experience, Quality and Safety Committee July 2023.

RECOMMENDATION:

The Patient Experience and Quality Committee are asked to:

- **RECEIVE** the Annual Safeguarding Report 2022/23 and take **ASSURANCE** the health Board are delivering their statutory requirements.

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

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

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

EXECUTIVE SUMMARY:

PTHB Safeguarding and Public Protection Annual Report presents the key areas of development and achievement which have supported the Health Board to meet its statutory responsibilities in safeguarding the people of Powys during 2022/23. The report is aligned to the Standards of the Safeguarding Maturity Matrix (SMM); a self-assessment tool which addresses the interdependent strands regarding safeguarding; service quality improvement, compliance against agreed standards and learning from incidents and reviews.

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

The Safeguarding Team has been both visible and accessible across the whole Health Board driving change and improvements throughout 2022/23. The challenges for 2023/24 are also noted.

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1. Introduction

1.1 NHS Wales has an essential role in ensuring that all adults and children receive the care, support and services they need to promote a healthy, safer

and fairer Wales. However measuring the effectiveness of health services and their contribution to safeguarding adults and children is difficult and complex.

Powys Teaching Health Board is committed to ensuring safeguarding is part of its core business. The Health Board recognises that safeguarding children and adults at risk is a shared responsibility that requires all our employees to have the competencies to safeguard people and be able to develop strong and effective joint working relationships with our partner agencies and colleagues. Our vision is that Powys residents live their lives free from violence, abuse, neglect and exploitation. The Health Board will promote the United Nations Convention on the Rights of the Child, Human Rights and the United Nations principles for Older Persons in all its work.

1.2 The Annual Report outlines, with some examples, how the safeguarding service is performing and innovating to deliver an accessible, research led service. It provides an update on safeguarding practice improvements and challenges during 2022/23 and identifies safeguarding priorities in 2023/24. The Safeguarding Team acknowledges the need to build on what has already been achieved to ensure PTHB and all contracted services, fully meet their statutory responsibilities for preventing harm, and act in a timely way on concerns raised about the welfare of people who reside, work within or visit Powys.

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

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

- Governance and Rights Based Approach,
- Safe Care,
- ACE's Informed (Adverse Childhood Experiences)
- Leaning Culture and Multiagency Partnership Working.

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PTHB's 2022-23 overall SMM self-assessment score was 4/5, ACE Informed increased from the 2021 submission as improvements had been made regarding Ask & Act compliance, raising awareness of exploitation and completion of the LAC action plan within the renewal workstream. A Maturity score of 4/5 indicates comprehensive assurance is in place with 75% or more of the indicators being evidenced.

2. Key Highlights

2.1 Safeguarding HUB

PTHB Safeguarding Hub is available to give advice, support and guidance on an ad hoc basis Monday to Friday 9am to 5pm. During 2022/23 there were 940 calls into the PTHB Safeguarding Hub which is a 28% increase from the previous year. Safeguarding Leads on the Hub attended 435 Strategy Discussions with the Local Authority and Police Colleagues.

2.2 Looked After Children

Looked After Children Health Assessment Audit undertaken by NWSSP gave Substantial Assurance. There was one recommendation; to consider updating the LAC data base. With the support of Informatics, a new system has been developed and launched.

The looked after children's team have developed and designed a leaflet that is shared with the children and their carers at each contact. The leaflet starts off by explaining who the Clinical Nurse Specialist Looked After Children are, there is a photograph of both nurses and explains why children looked after are offered a health assessment, who the information is shared with, the frequency of their health assessments, the Children's Pledge and the team's contact details. The team have developed a process whereby feedback, compliments and ideas for improvement from both children and foster carers could be shared via three surveys designed by the nurses and embedded within the leaflet using QR codes. There are three separate codes, one for children aged 5-8 years, 9-17 years and for foster carers.

2.3 Safer Sleep

In response to several unexpected child deaths over the last 18 months where risk factors associated with unsafe sleep have been present, a task and finish group was formed with colleagues from Midwifery, Health Visiting and Safeguarding. The group produced a detailed SOP document for

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practitioners to support the delivery of clear, consistent, tailored advice to parents and carers regarding Safer Sleep, this was launched in October 2022 A presentation has been shared widely across the Health Board including at team meetings, General Practices, to Local Authority colleagues & domestic abuse services. PTHB midwifery documentation has also been updated to include a page within the postnatal pathway which specifically focuses on Safer Sleep.

Lullaby Trust QR codes have also been used within a poster presentation that can be displayed in healthcare settings & made into stickers which can be placed within each Child Health record giving parents and carers easy access to information, advice and support.

2.4 Strengthening knowledge of the Mental Capacity Act 2005 fundamentals.

Significant effort has been made to develop training resources and experiential training to front line staff which include an MCA Competency Framework and booklet for practitioners. An MCA and DoLS intranet tile that gives practitioners easy access to; MCA and DoLS resources with links to the code of practice, forms and policies has been developed, it is reviewed & updated regularly, supporting uniformity across PTHB.

PTHB has successfully recruited to the MCA/DoLS Senior Practitioner post. Weekly meetings with PCC DoLS office support working together, identify areas of improvement to target to enable the safeguards to be most effectively administered. This includes follow-up with wards (managing authority) maintaining focus on the patient and their rights being central to the process.

A DoLS Tracker has been developed to support Managing Authorities in applying the DoLS process. This is in testing phase supported by Graham Davies Ward. The objective is to achieve timescales and have clarity for managing authorities in their responsibilities. The tracker includes automates prompting actions at the required points of a patient's journey, including responsibilities of supporting patient's understand their rights. This will also aim to have effective monitoring of those without authorisation of a DoL.

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2.5 Operation Jasmine

Operation Jasmine was a wide-ranging investigation carried out by Gwent police between 2005–2013, into the deaths of 63 people living in care homes

in South East Wales. The Flynn Review was commissioned in December 2013 and the report 'In Search of Accountability' was published in May 2015. It made 12 recommendations, including that inquests should be held which took place between January & March 2021.The coroner concluded the deaths of five people were contributed to by neglect.

Much has changed since these tragic events both through legislation and in our ways of working. However, we should never become complacent and must continue to reflect, learn and improve. This is particularly important as we respond to the continued impact and pressures on the health and social care sector arising from the COVID-19 pandemic.

In April 2022, CIW wrote to health boards to ask they consider Watching the Operation Jasmine: learning and reflection event webinar held in December 2021, and follow this up with a group discussion and reflection on; is practice, recording and organisational culture outcome focused? how effective are we at communicating with other agencies? do we ensure actions are explained, noted and acted on? how well do we currently respond to fluctuating performance?

PTHB responded by; during October 2022 a Task & Finish group was formed and in early 2023 a day focusing on watching the webinar and discussing and reflecting on the questions took place. The event was well attended and noted there have been many improvements since 2015, however, opportunity to develop an Improvement Plan was identified and this will be monitored by the Practice Improvement Group. Themes from the focus day include; training, improved communication, extend the MTD SOP to adults & role out of the observation form to keep record of low level concerns in nursing homes.

2.6 Child & Adults who Was Not Brought to Appointments

Robust arrangements must be in place to manage all child & adults at risk who are not brought for appointments in PTHB, or for whom there is a failed contact/access. There are occasions when a patient's non-attendance is an indicator that they are at risk, it is important that this is recognised and risk considered for every failed contact.

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Following several audits, SGP 047 Policy for Children and Adults Who Was Not Brought to Health Appointments has been rewritten and re launched within all services groups. A short WEBINAR has also been produced to share

the importance of the document Bitesize Power point presentation for Launch of WNB - Final.mp4 (sharepoint.com)

A significant events chronology that can be used for each child has been developed on WCCIS. All practitioners can add to and read all entries on the chronology. Team Leads can view all children added to the chronology as Not Seen due to WNB/NAV on their Dash Boards. Monitoring already in place includes;

- Annual audit of the policy
- Monthly audits by Team Leads of their service dash boards.

2.7 Launch of the Do's & Don'ts of Caring Animation – Young People's Animation

The launch and celebration of 'The Do's and Don'ts of Caring' an animated safeguarding training resource, took place at Parc-y–Scarlets Stadium in Llanelli on Friday 18th November 2022. The video animation had been created by children and young people from Pembrokeshire, Carmarthenshire, Ceredigion and Powys as part of the work of CADW (Children taking Action Differently in Wales), the Junior Safeguarding Board. The animation was launched alongside a video that captured the reactions of CADW members when they viewed the resource for the first time.

Following a screening of both videos and an address by the new Children's Commissioner, Ms Rocio Cifuentes, Senior Leaders for statutory agencies pledged to promote and share the webinar across their organisations and consider a series of questions posed by the children. https://youtu.be/bhm_yFLV84Y

PTHB Actions so far;

- Video's shared at both strategic & operational safeguarding groups & distributed to teams via managers, a memo, during team meetings & housed on PTHB Safeguarding and Public Protection Intranet Page
- Video included in Level 3 Safeguarding Training Competency Framework
- Video added to Corporate Induction Day for all new employees into the Health Board
- Children Participation Strategy to be added to 2023-24 work plan

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3. Safeguarding & Public Protection; Challenges and a Look Ahead into 2023/24

- ❖ Progress PTHB's 2023/24 Safeguarding Maturity Matric Improvement Plan
- ❖ Completion of Child Practice Review and progress learning once completed.
- ❖ Introduction of the Serious Violence Duty (2022)
- ❖ Uncertainty around implementation of LPS
- ❖ Introduction of the Single Unified Safeguarding Review (SUSR)
- ❖ Expanding Safeguarding Agenda
- ❖ IRIS model and the next steps
- ❖ Work with partner agencies to consider Welsh Government VAWDASV Blueprint

In summary, the Safeguarding and Public Protection Annual Report highlights the vast and varied safeguarding and public protection agenda, how the Safeguarding Team continues to engage with our partners locally, regionally and at a national level. The service is both visible and accessible across the whole Health Board and has been able to drive change throughout 2022/23.

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Powys Teaching Health Board Safeguarding & Public Protection Annual Report 2022-2023

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

Safeguarding and Public Protection
Diogelu ac Amddiffyn y Cyhoedd

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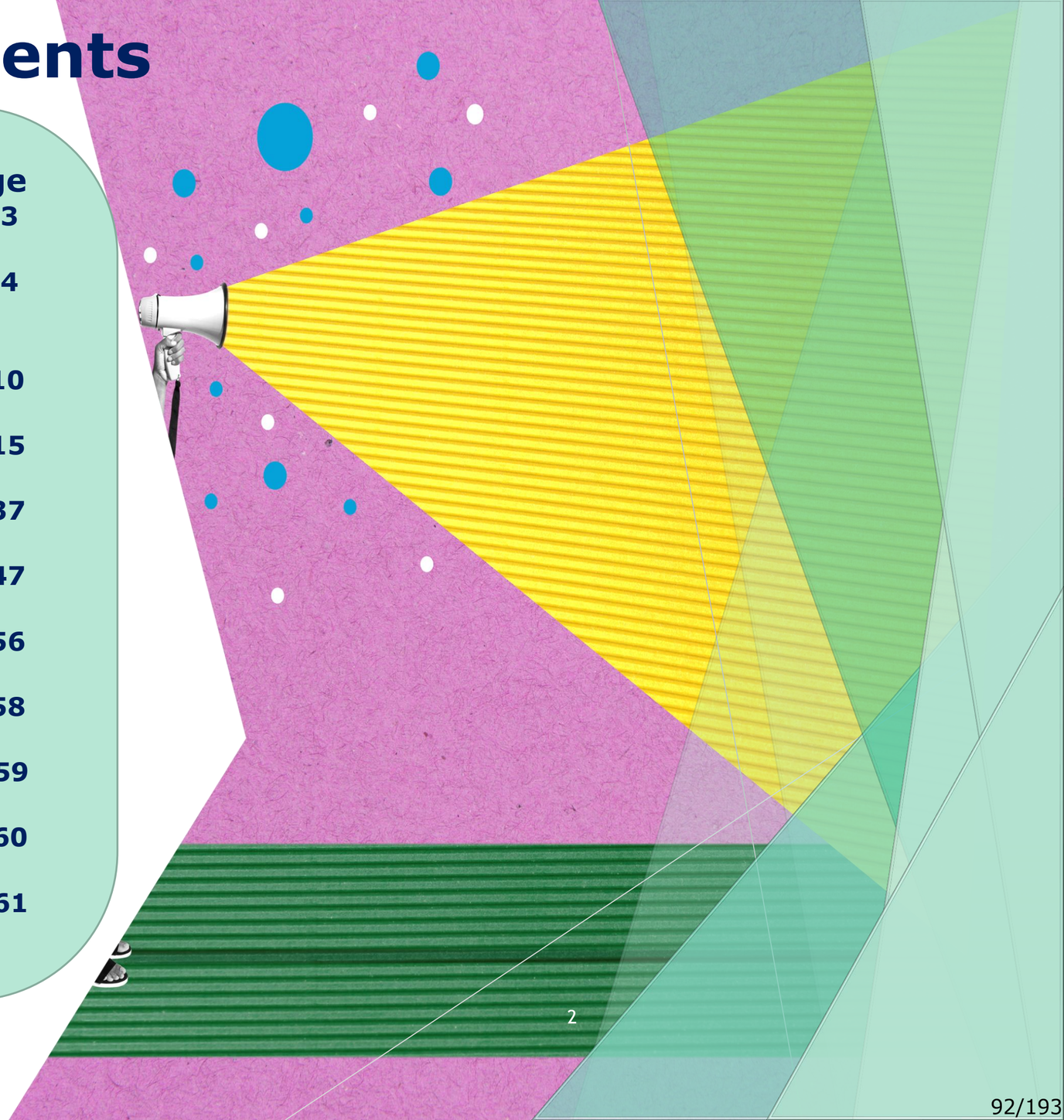

Introduction

Powys Teaching Health Board (PTHB) is responsible for providing health care and well-being services for approximately 133,000 people living throughout the area of Powys, this includes health services both provided by and commissioned on behalf of PTHB.

PTHB employs 2952 members of staff which include 409 bank staff. Care is delivered across a network of services and practitioners. The geography and rurality can make access to some services a challenge, and requires the Health Board to be innovative and creative to ensure Powys residents have timely access to high quality services to meet their needs. PTHB is uniquely positioned as Powys accounts for a quarter of the land mass in Wales and borders a number of other Welsh and English Health Boards.

Powys Teaching Health Board is committed to ensuring safeguarding is part of its core business. The Health Board recognises that safeguarding children and adults at risk is a shared responsibility that requires all our employees to have the competencies to safeguard people, and are able to develop strong, effective joint working relationships with our partner agencies and colleagues.

Our vision is that Powys residents live their lives free from violence, abuse, neglect and exploitation. The Health Board will promote the United Nations Convention on the Rights of the Child, Human Rights and the United Nations Principles for Older Persons in all its work.

This annual report outlines, with examples, how the safeguarding service is performing and innovating to deliver an accessible, research led service. It provides an update on safeguarding developments during 2022-2023 and identifies safeguarding key priorities for 2023-2024.

The Safeguarding Service acknowledges the need to build on what has already been achieved, to ensure PTHB and all contracted services fully meet their statutory responsibilities for preventing harm and act in a timely way on concerns raised about the welfare of people who reside, work or visit Powys.

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Powys Teaching Health Board Safeguarding Team

Safeguarding & Public Protection team

Assistant Director of Safeguarding & Public Protection
1WTE

Senior Nurse Safeguarding
1WTE

Senior Practitioner MCA
1WTE

Clinical Nurse Specialist Looked After Children
1.8 WTE

Safeguarding Business Support Manager
1WTE

Lead Nurse/Practitioner Safeguarding
2.6 WTE

Lead Midwife Safeguarding
0.4 WTE

Best Interest Assessor
1 WTE

Clerical Officer Looked After Children
0.6WTE

Safeguarding Administrator
0.6WTE

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NHS Safeguarding Maturity Matrix

NHS Wales has an essential role in ensuring that all adults and children receive the care, support and services they need in order to promote a healthier, safer and fairer Wales, however measuring the effectiveness of health services and their contribution to safeguarding adults and children is difficult and complex.

The Safeguarding Maturity Matrix (SMM) is a self-assessment tool which addresses the interdependent strands regarding safeguarding; service quality improvement, compliance against agreed standards and learning from incidents and reviews.

Powys Teaching Health Board's SMM self assessment & improvement plan is completed annually and returned to the National Safeguarding Service, where it contributes to a National Safeguarding Report to the Chief Nursing Officer in Welsh Government. Capturing a National overview of safeguarding helps drive improvement, inform the Nations Safeguarding Services key priorities, annual plan, and shares best practice.

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Powys Teaching Health Boards Safeguarding Maturity Matrix 2022-23 Assessment

In 2022-23 PTHB's overall Safeguarding Maturity Matrix (SMM) self assessment score was **4/5,** ACE Informed (Adverse Childhood Experience) increased from the 2021 submission as improvements made regarding Ask & Act compliance, raising awareness of exploitation and completion of the Looked After Children (LAC) action plan within the renewal workstream. A **Maturity Score** of **4/5** indicates comprehensive assurance is in place with 75% or more of the indicators being evidenced. During the Autumn PTHB attended a SMM Peer review with most of the other health boards & trusts in Wales

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PTHB Safeguarding Maturity Matrix Improvement Plan 2022-23

Powys Teaching Health Board's 2022/23 Safeguarding Maturity Matrix Improvement Plan has been reported quarterly to PTHB Safeguarding Strategic Group. Most of the actions have been completed, any that remain incomplete will be carried over into 2023-24

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PTHB Safeguarding Maturity Matrix Improvement Plan 2022-23

Governance & Rights Based Approach

We Said	We Achieved	We need to progress
Children Rights/Children's Pledge must be embedded throughout the Health Board	LAC Nurses share The Childrens Pledge with children who are looked after and their carers at their first contact The Do's& Don'ts of Caring shared across organisation, added to staff induction & housed on safeguarding intranet page	Further work required to develop a children's participation group
LAC Commissioning to move into Safeguarding & Public Protection Team	completed	
PTHB to be assured professionals are aware of and using PTHB's Was Not Brought Protocol	Webinar produced & promoted across the health board Team leads review monthly Was Not Brought to appointments on dashboards	Continue to promote Policy and support staff

Safe Care

We Said	We Achieved	We need to progress
Review process for Sharing Information in Pregnancy	Process developed with support from Informatics.	Role out across organisation
Reintroduce coping with crying resources	Completed	
PTHB to be assured GNP036 Policy for Managing, and Preventing Falls is being implemented	Falls scrutiny panel established & falls reporting via Datix commenced Safeguarding invited to Falls Panel when appropriate	

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PTHB Safeguarding Maturity Matrix Improvement Plan 2022-23

Safe Care

We Said	We Achieved	We need to progress
PTHB continue to prepare for the implementation of Liberty Protection Safeguards	Upskilling of staff knowledge & skills re MCA & DoLS continued Responded to MCA/LPS consultation Appointed MCA Senior Practitioner	Continue MCA Operational Group
Review and consider models to support staff following a traumatic event	Models reviewed & PTHB have access to a number or services/options which require promoting	Resources to be linked into safeguarding intranet page

Ace Informed

We Said	We Achieved	We need to progress
Develop a QR Code that will enable Care Leavers to have their essential health information readily available to them and have links to local health and wellbeing services	Worked progressed to final version, approved by IG	Awaiting Informatics to be available to complete final part of process
Consider the Bright Spots Survey completed by CORAM BAFF, with particular interest in to the Childrens views on their own health	Care leaver pack developed CAMHS recruited to a LAC CAMHS post LAC leaflet introducing service and nurses completed Feedback QR codes developed for children and foster carers	Encourage use of QR codes & monitor feedback from both children and foster carers
Develop a suicide review group	Group established	Monitor & review themes
Sudden Unexpected deaths nationally remain one of the main causes of infant deaths. PTHB have a Standard Operation Process (SOP) in place and working to promote Safer Sleep/Safe Environment however, there remains a gap in the information available from WG	Raised within the NHS National Safeguarding Service Group Poster and other resources developed Resources shared regionally	Await outcome of rapid child death review by Public Health Wales (PHW) & continue to raise with Welsh Government

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PTHB Safeguarding Maturity Matrix Improvement Plan 2022-23

Learning Culture

We Said	We Achieved	We need to progress
Work with the NHS National Safeguarding Service to update Violence, Against Women, Domestic Abuse & Sexual Violence (VAWDASV) Group 2 Training package to ensure it considers Domestic Abuse to older people, LGBTQ+, Ethnic Minority groups & the changes brought in with the new Domestic Abuse Act	Pack developed and roll out commenced within PTHB	Continue to evaluate training, monitor and report compliance
Commence the role out of VAWDASV Group 3 Training	Targeted training commenced	Continue to offer Group 3 into 23-24
Safeguarding Level 3 training compliance requires improvement	Blended approach to safeguarding training & promote passport Safeguarding presents at Corporate Induction Day to all new recruits	Understand why the challenges continue in achieving compliance. Cleanse ESR, update passport

Multi Agency Partnership Working

We Said	We Achieved	We need to progress
Support the Mid & West Wales Regional Safeguarding Board's Work to develop an Immediate Response Group to a Significant Event	Rapid Response Group commenced Sept 2022. PTHB have an operating process in place and cooperates fully with the process.	Continue to engage in the pilot, monitor & report activity, themes & consider learning
With our partners re introduce Independent Provider Forums	Meeting recommenced Spring 2023	Support agenda setting and attendance at the meeting
Present the Identification & Referral to Improve Safety (IRIS) to Primary Care	Presented to the 3 GP Collaboratives	Consider costings and appetite to take forward this model

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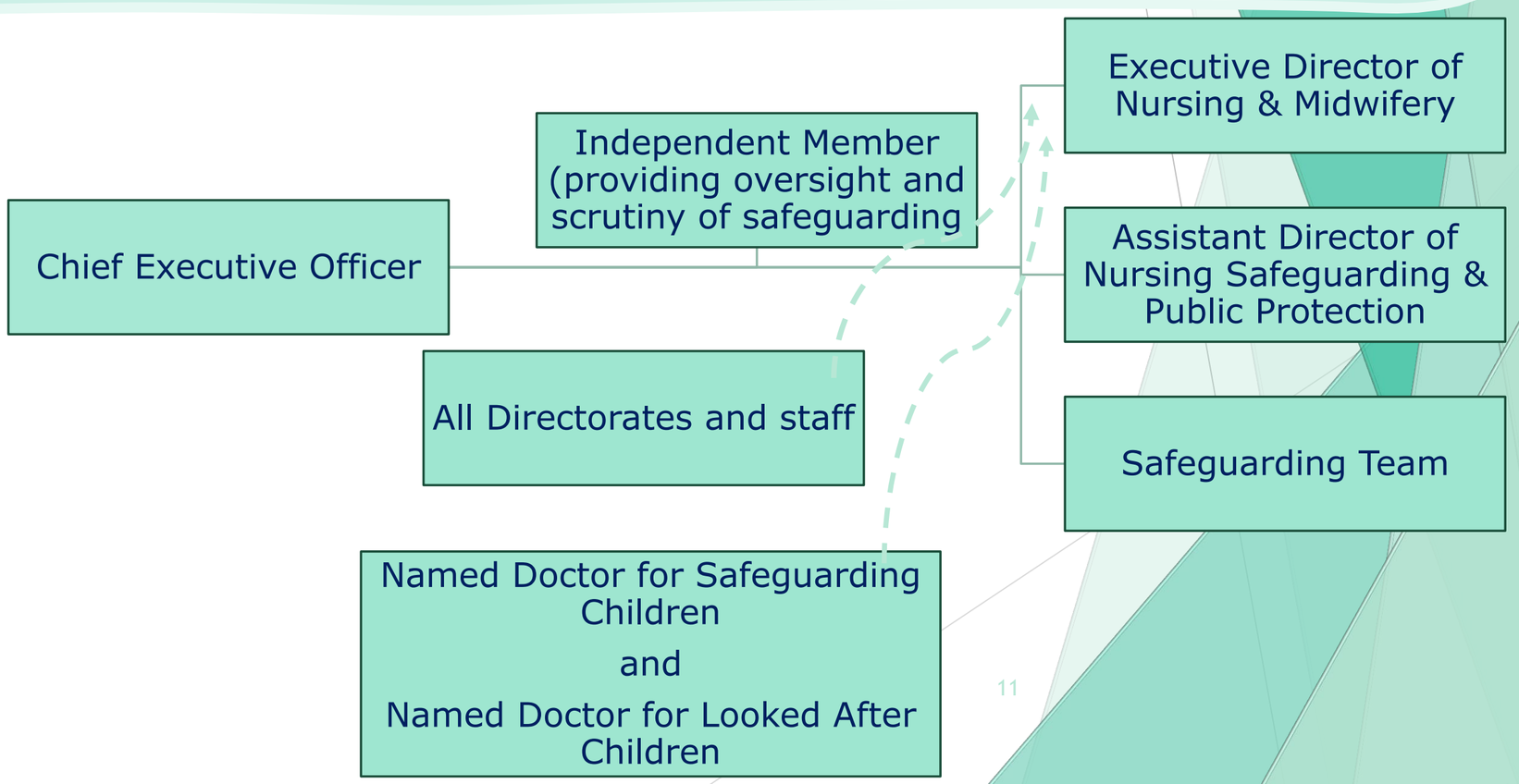
PTHB Safeguarding Lines of Accountability

GOVERNANCE & Rights Base Approach

The Chief Executive assumes overall responsibility for safeguarding and the Executive Director of Nursing & Midwifery is the delegated Executive Lead for Safeguarding and Public Protection. The Health Board's Vice Chair is the designated Lead Independent Member for children's and young people's services with responsibility for providing oversight and scrutiny of the broader safeguarding agenda.



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PTHB Safeguarding & Public Protection Reporting arrangements

PTHB has clear reporting structure in place regarding its safeguarding and public protection arrangements. The Executive Director of Nursing and Midwifery as lead Executive Officer provides strategic direction and reports on safeguarding and public protection matters to the Board.

Governance Reporting Structure

- Board
- Patient Experience, Quality and Safety Committee
- Safeguarding Strategic Group
- Safeguarding Operational Group
- Team/Service Meetings

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PTHB Safeguarding Strategic Group

PTHB Safeguarding Strategic Group is chaired by Executive Director of Nursing and Midwifery, the group supports the Health Board to execute its duties to safeguard children and adults at risk within the statutory frameworks (Social Services & Well-being (Wales) Act 2014, Children Act 1989, 2004). It also aims to ensure that the Health Board promotes and protects the welfare and safety of children and adults who become vulnerable or at risk at any time.

The Safeguarding Strategic Group has an Independent Board Member within its membership and each Service Area is represented by a Senior Manager. The group ensures there is scrutiny of the data being presented, the implementation, monitoring and audit of relevant guidance, receives the reports from Domestic Homicide Reviews, Adult and Child Practice Reviews and monitors the implementation of recommendations across the organisation.

The Safeguarding Strategic Group provides a link between PTHB, the Regional Safeguarding Board, the Violence Against Women, Domestic Abuse and Sexual Violence Strategic Group and NHS Wales Safeguarding Service

During 2022-23

NHS Safeguarding Maturity Matrix and Improvement Plan completed

Safeguarding Operational Group & Practice Improvement Group combined

Safeguarding Strategic & Operational Group met quarterly

NHS Wales Audit & Assurance Services; Looked After Children Audit completed with Substantial Assurance

PTHB represented at the Mid & West Wales Safeguarding Board, NHS Safeguarding Network & Violence Against Women Domestic Abuse & Sexual Violence Board

PTHB Safeguarding Intranet Page hosts a suite of National, Regional & PTHB Policies and documents

Safeguarding Audits completed: Was Not Brought/No Access Visits

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Safeguarding & Public Protection Legislation

Legislation and associated guidance details the roles and responsibilities of agencies in relation to safeguarding and public protection and include levels of accountability; responsibilities and duties of staff; the skills and competencies required by staff to perform their duties; handling individual cases and effective interagency working at all levels. These include;

Children Act 1989 & 2004

United Nations Convention on the Rights of the Child UNCRC

Wales Safeguarding Procedures (2019)

Working Together to Safeguard Children (2018)

Protecting Children & Young People, GMC (2012)

Safeguarding Children & Young People Intercollegiate Document: Roles & Responsibilities for Health Care Staff – January 2019 4th Edition

Adult Safeguarding: Roles and Competencies for Health Care Staff – August 2018 1st Edition

Social Services & Well-being (Wales) Act 2014

The Well Being of Future Generations (Wales) Act 2015

NSF, Health Inspectorate Wales, Vulnerable Groups Act (2006)

NICE 16, Standard 13 (Vulnerable Groups)

Mental Capacity Act 2005

Dignified Care: Two Years On (2014): Older People

Violence Against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015

Mental Health Act, 1983

Health and Care Standards (April 2015) Standards 2.7

Counter Terrorism and Security Act 2015

Children Wales Act 2020

Domestic Abuse Act 2021

WG National Strategy on VAWDASV 2022-26

Serious Violence Duty 2022

PTHB Polices, Protocols & Guidance Documents

Powys Teaching Health Board has a number of Policies, Protocols and Guidance documents to support the Safeguarding and Public Protection processes within the Health Board. These include:

- **SGP002 – Safeguarding Supervision Protocol**
- **SGP011 Child Protection Medical Policy**
- **SGP012 Looked After Children Guidance for Health Professionals**
- **SGP034 PREVENT Policy**
- **SGP035 Child Exploitation Guidance**
- **SGP036 Safeguarding Policy**
- **SGP041 Managing Allegations of Abuse & Neglect**
- **SGP042 Deprivation of Liberty Safeguards Policy & Procedure**
- **SGP047 Policy for Children & Adults who "Was Not Brought" to health appointments**
- **SGP049 Mental Capacity Act**
- **SGP050 DoLS Signatory SOP**
- **SGP051 Significant Event Chronology SOP**

Safeguarding and Protecting People

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

PTHB Safeguarding Hub is available to give advice, support and guidance on an ad hoc basis Monday to Friday 9am to 5pm

- During 2022 -23 there were **940** calls into the PTHB Safeguarding Hub.

Trend: this is an increase of **28%** from 2021-22

Safeguarding Leads on the Hub attended **435** Strategy Discussions with the Local Authority and Police Colleagues

Safeguarding Children at Risk

179 **child Safeguarding reports were made by PTHB staff in 2022-2023**
All reports are quality assured by the Safeguarding Team

Trend: this is an decrease of **6.2%** from 2021-22

38% **related to concerns about neglect**

12% **related to concerns about emotional abuse**

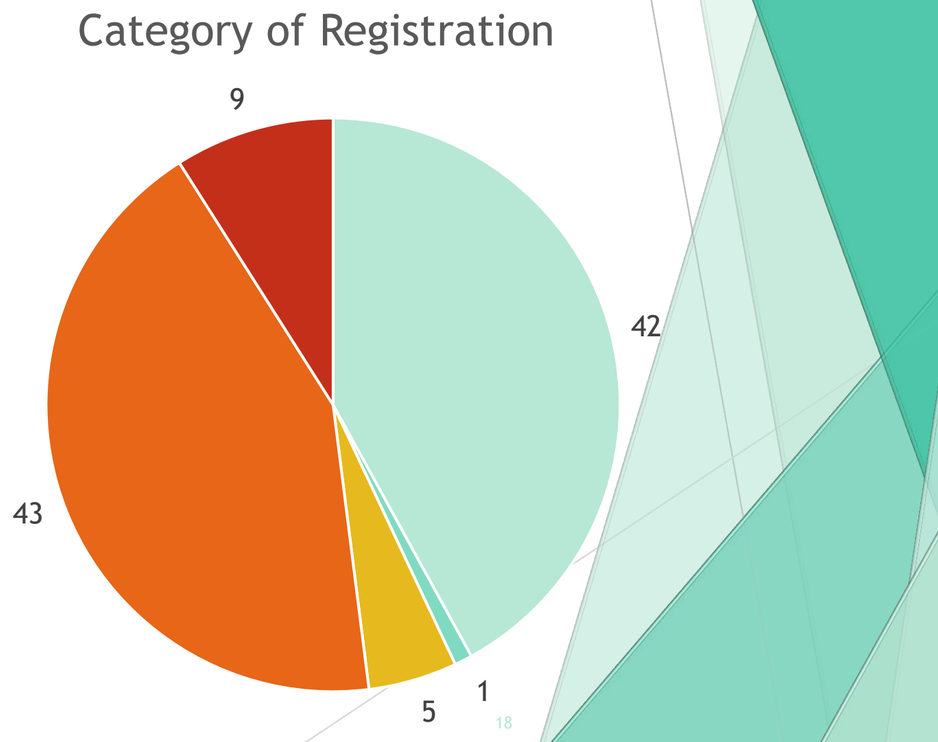
12% **related to concerns about domestic abuse**

Living a life that is free from harm and abuse is a basic right for every child within Wales

Powys Children on Child Protection Register

The number of children on Powys Child Protection Register has been stable over the past 12 months. As of 31.03.23 there were **100** children with a care, support and protection plan. Health practitioners have a duty to work with our partners in all parts of the Child Protection Registration process

Trend: this is an increase of **3%** from 2021-22



Child Protection Medicals

National reviews have indicated that practitioners have sometimes underestimated the significance of the presence of bruising or minor injuries in children, especially those who are not independently mobile. It is very important to recognise that minor injuries can be an indicator or precursor to significant injuries or death of a child. Early recognition and action in such cases is key to preventing further injuries.

PTHB Safeguarding leads attend most strategy discussions to support multi agency decision making regarding Child Protection Medicals.

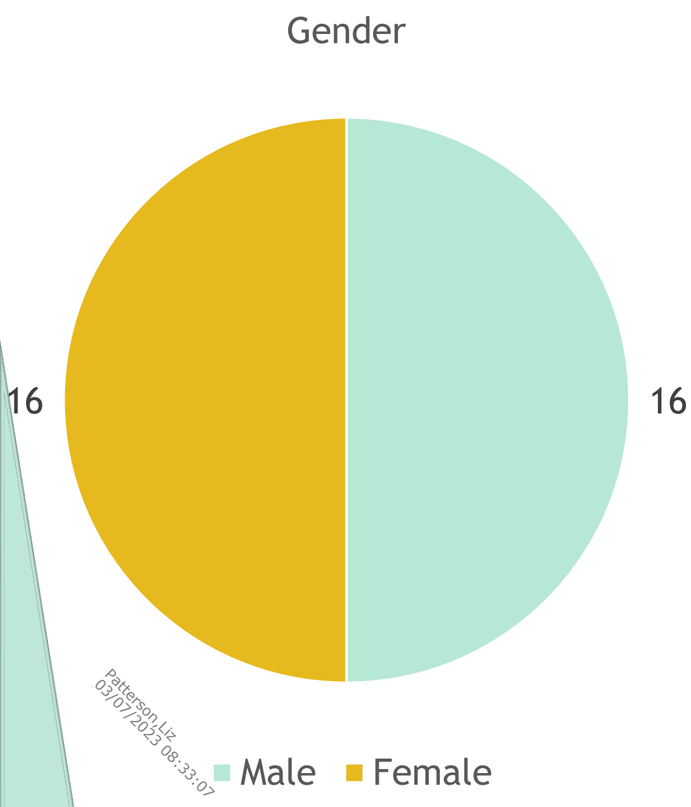
PTHB Named Doctor for Child Protection attends Cwm Taff Morgannwg University Health Boards Child Protection Peer Review Group

PTHB Named Doctor for Child Protection & Assistant Director of Nursing for Safeguarding review all Child Protection Medical Reports.

PTHB Operational Policy for Child Protection Medicals was updated in September 2022 SGP 011 Operational Policy for Child Protection Medicals.pdf

32 Child Protection medicals were undertaken during 2022-2023

Trend: this is an decrease of **8%** from 2021-22



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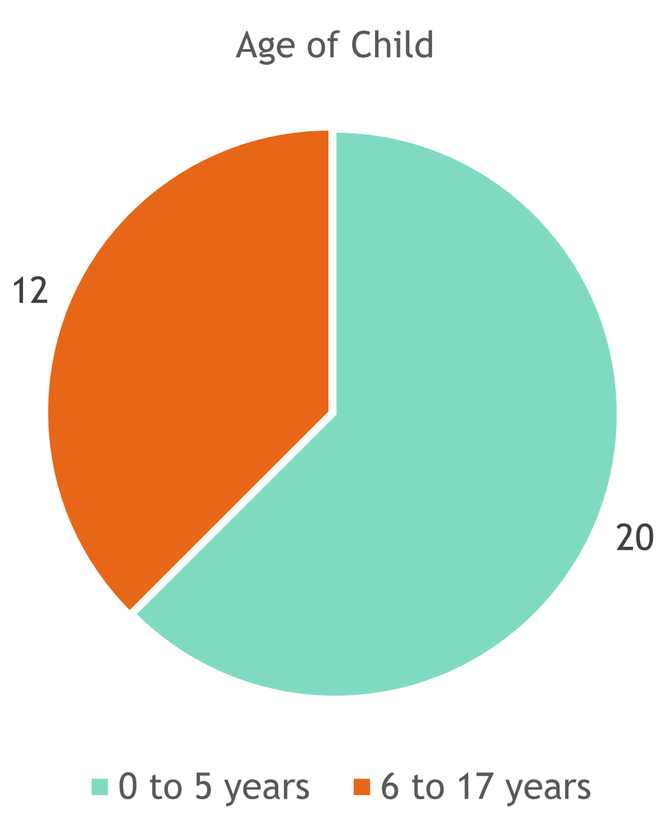

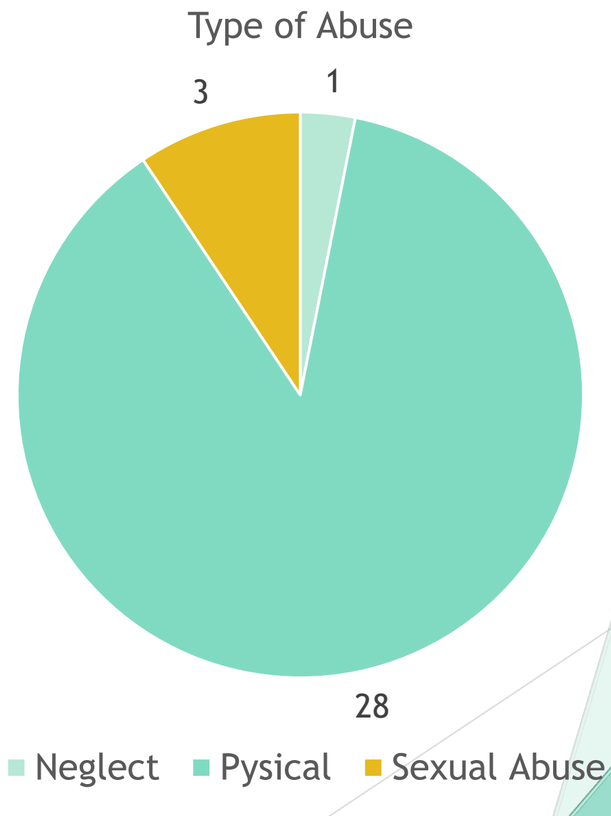

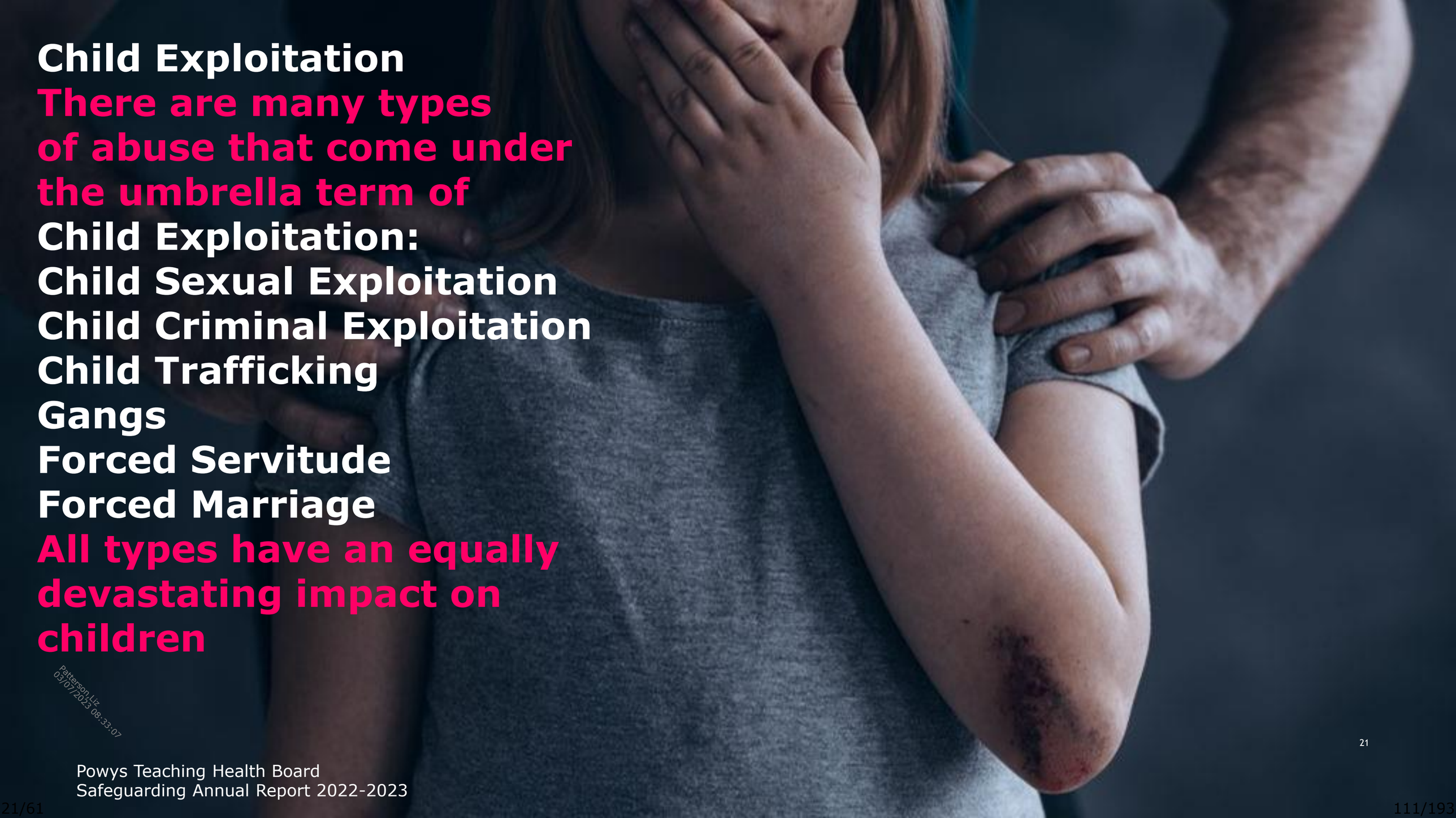

Child Exploitation

There are many types of abuse that come under the umbrella term of

Child Exploitation:

Child Sexual Exploitation

Child Criminal Exploitation

Child Trafficking

Gangs

Forced Servitude

Forced Marriage

All types have an equally devastating impact on children

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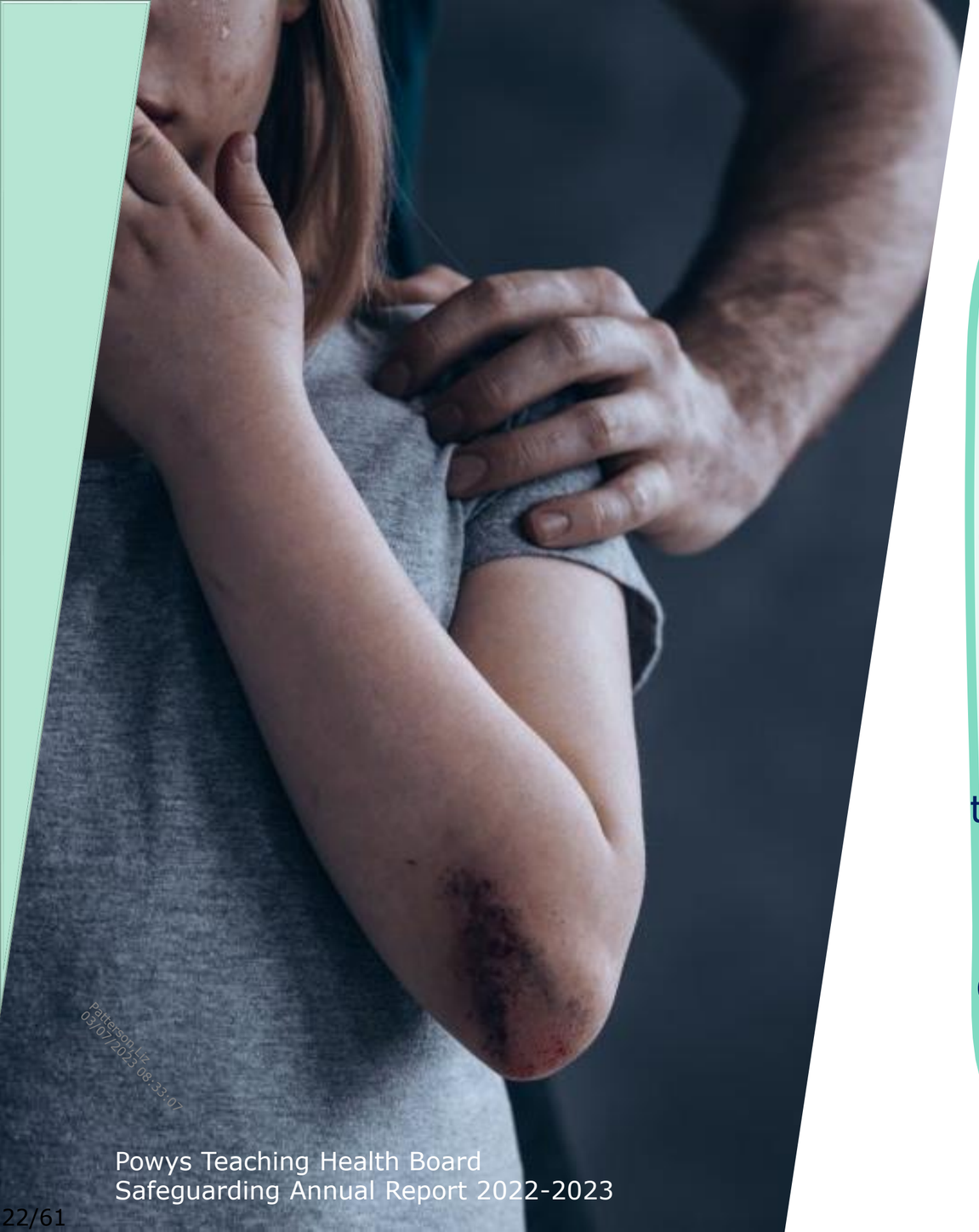

Child Exploitation Practice Development

In October 2022 the Mid & West Wales Safeguarding Board launched their Child Exploitation Strategy

child-exploitation-strategy-document.pdf (cysur.wales)

The strategy sets out the regional priorities and makes an explicit commitment to prevent and tackle child exploitation. It references the serious impact child exploitation can have on children, their families and communities.

There is no single solution to tackling child exploitation and interventions require coordinated multi agency responses that are based on current evidence which is child centred and grounded in children's rights.

This strategy is overseen and driven by the Multi Agency Child Exploitation (MACE) meetings. PTHB Safeguarding eam attend all MACE Meeting in 2022-23

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Children Looked After

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

Improving the health of children who are looked after is a multi-agency responsibility involving local authorities and health agencies. PTHB have a duty to comply with the statutory legislation: Part 6, Social Services & Wellbeing (Wales) Act 2014 – Looked After & Accommodated Children

Throughout 2022-2023 PTHB Clinical Nurse Specialist for Children Looked After and Health Visitors continued to Work flexibly around the needs of the child offering advice and support to both children and professionals. This includes completing LAC health assessments, attending LAC reviews, Pathway Plans for 16+children and strategy meetings. The views of the children are captured during their statutory health assessment and help to shape the child's LAC Health Plan

Children Looked After

During 2022-2023

300 **LAC Health Assessments were completed by Powys Looked After Children Nurses & Health Visitors, all assessments aim to capture the voice of the child, all assessments undergo a Quality Assurance process**

78% **were completed within statutory timescales, delays were mainly due to accommodating the needs of the children and Foster carers availability. There has been a significant improvement in receiving timely consent for Powys Local Authority**

199 **Health Assessments were with children from Powys**

101 **Health Assessments were with children from other Local Authorities placed in Powys**

14 **Unaccompanied Asylum Seeker Children (UASC) are currently being supported by PTHB LAC Team. The cap on how many children are placed in each Local Authority is being lifted in the summer of 2023**

Children Looked After Achievements & Improvements 2022 -2023

Looked After Children Health Assessment Audit undertaken by NWSSP gave Substantial Assurance. There was one recommendation; to consider updating the LAC data base. With the support of Informatics, a new system has been developed and launched

LAC Commissioning moved into the Safeguarding and Public Protection Team during 2022, a new app has been built to support this work

PTHB meet quarterly with Powys County Council Through Care Manager, this has supported communication, shared ideas & improved the timelines of health receiving signed consent forms

Care Leavers Health Pack

PTHB Clinical Nurse Specialist for LAC identified a gap and therefore an opportunity to develop a care leavers health pack for young people who leave care/turn 18. The health pack provides children with links to useful websites, information regarding sexual health, mental health and emotional support

PTHB worked with the Local Authority to recommence after many years the Children Looked After Provider Forum

Children Looked After Achievements & Improvements 2022 -2023

The looked after children's team have developed and designed a leaflet that is shared with the children and their carers at each contact. The leaflet starts off by explaining who the Clinical Nurse Specialist Looked After Children are, there is a photograph of both nurses and explains why children looked after are offered a health assessment, who the information is shared with, the frequency of their health assessments, the children's pledge and the teams contact details.

To support the looked after children's team to continually respond to the needs of children, the team have developed a process whereby feedback, compliments and ideas for improvement from both children and foster carers could be shared. The nurses designed three surveys that are embedded within the leaflet using QR codes. There are three separate codes, one for children 5-8 yrs, 9-17 yrs and for foster carers feedback can be anonymous if they wish.

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Procedural Response to Unexpected Death in Childhood (PRUDiC) 2023

PRUDiC sets a minimum standard for a response to unexpected deaths in infancy and childhood. It describes the process of communication, collaborative action and information sharing following the unexpected death of a child.

The aim of the PRUDiC is to ensure that the response is safe, consistent and sensitive to those concerned, and that there is uniformity across Wales in the multi-agency response to unexpected child deaths

During 2022 to 2023, 7 unexpected child deaths were managed under the PRUDiC Procedure

PTHB worked with Dr Claire Thomas Designated Doctor, National Safeguarding Service to contribute to the revised PRUDiC (2023)

Procedural Response to Unexpected Deaths in Childhood (PRUDiC) 2023 E(4) (003).pdf

PTHB have established a link with the charity 2 Wish 2wish Support for those affected by death in young people who in addition to offering support to bereaved parents and their family of a child who dies unexpectedly, also offer support any professional involved with a child.

Strengthening Practice

In response to a number of unexpected child deaths over the last 18 months where risk factors associated with unsafe sleep have been present, a task and finish group was formed with colleagues from Midwifery, Health Visiting and Safeguarding.

The group produced a detailed document for practitioners, to support the delivery of clear, consistent, tailored advice to parents and carers regarding Safer Sleep.

Powys Teaching Health Board's Safer Sleep Standard Operating Procedure and Safer Sleep Presentation was launched in October 2022

The presentation has been shared widely across the Health Board including at team meetings, General Practices, to Local Authority colleagues & domestic abuse services.

Link to SOP & Safer Sleep Presentation

SGP 052 Safer Sleeping Standard Operating Procedure.pdf

https://youtu.be/aaF2sXV4vqg

PTHB midwifery documentation has also been updated to include a page within the postnatal pathway which specifically focuses on Safer Sleep.

Lullaby Trust QR codes have also been embedded into the postnatal pathway, used within a poster presentation that can be displayed in healthcare settings & made into stickers which can be placed within each Child Health record giving parents and carers easy access to information, advice and support.

PTHB Keeping Baby Safe Poster

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

the lullaby trust

Keeping Baby Safe

Safer Sleep : How to sleep your baby more safely to reduce the risk of sudden infant death syndrome (SIDS)

Dad's Zone :

A dedicated safer sleep page for new and expectant dads and partners filled with everything you need to know.

Safer Sleep Awareness :

A guide for Childminders, Foster Carers, Nannies and Nursery Settings

NSPCC

NSPCC—Handle with care: A guide to keeping your baby safe and advice on ways of holding and caring for your baby

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Safeguarding Adults at Risk

154 adult reports were made by PTHB staff in 2022-2023

All reports are quality assured by the Safeguarding Team

Trend: this is an increase of **50.9%** from 2021-22

27% were in relation to **neglect**

12% were in relation to **financial** abuse

3% were in relation to **emotional** abuse

Living a life that is free from harm and abuse is a basic right for every adult within Wales

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The Mental Capacity Act 2005

The Mental Capacity Act 2005 (MCA) provides the statutory framework for acting and making decisions on behalf of people who lack the capacity to make decisions for themselves. The MCA sets out who can make decisions for a person who lacks capacity, when and how. It ensures decisions are made in the person's best interest and the person is involved in the decision as much as possible. Deprivation of Liberty Safeguards (DoLS) were introduced as an amendment to the MCA and came into force in April 2009, providing a legal framework for situations where someone may be deprived of their liberty within the meaning of article 5 of the European Convention on Human Rights (ECHR).

In 2014 a Supreme Court ruling resulted in a very large increase in the number of applications for DoLS authorisations, this was followed by a scrutiny report (2014) of the MCA that recommended DoLS be replaced. Liberty Protection Safeguards (LPS) were introduced by the Mental Capacity (Amendment) Act 2019, to replace DoLS as the system to lawfully deprive someone over the age of 16 of their liberty.

The Mental Capacity Act 2005

July 2022, the UK Government consulted on the draft Liberty Protection Safeguards (LPS) Code of Practice which applies to both England and Wales. At the same time the Welsh Government consulted on the draft regulations supporting the implementation of the LPS in Wales. During 2022-23 the health board received additional funding from Welsh Government to address the number of Deprivation of Liberty Safeguards (DoLS) applications and provide additional training, to promote and embed the principles of the Mental Capacity Act 2005 in preparation for the implementation of LPS.

After much speculation, on the 6th April 2023 the UK and Welsh Governments advised that the proposed Mental Capacity (amendment) Act 2019 would not be considered until at least the next parliament. In addition to this there is no clarity regarding the publication of the responses to the consultation on the MCA and LPS code of practice and relevant regulations. This means there are no changes to the Mental Capacity Act 2005 and the current DoLS legislation remains in place, it is important that the health board continues to follow the DoLS process to ensure people's rights are protected and care and support amounting to a deprivation of liberty is appropriately authorised.

PTHB Deprivation of Liberty Protection Safeguards (DoLS) Activity 2022-23

PTHB DoLS Applications	Q1	Q2	Q3	Q4
No. of urgent referrals for the period	81	83	57	81
No. of standard/renewal referrals for the period	10	5	8	2
No. withdrawn/not granted	74	61	45	44
No. allocated to internal BIA's	14	24	27	28
No. allocated to external BIA's	23	51	29	27
No. granted	17	17	21	12
Total outstanding applications	37	26	26	34

Trend: DoLS Applications this is an decrease of **29%** from 2021-22

Mental Capacity Act (MCA) Training Compliance as of 31.03.23

MCA Level 1	**85%**
MCA Level 2	**94%**

2022-23 MCA Practice Improvements

Strengthening knowledge of the Mental Capacity Act 2005 fundamentals by; developing training resources for front line staff which include a booklet for practitioner's Mental Capacity What Practitioners Need to Know.pdf , and an MCA Competency Framework

Specific Intranet tile that gives practitioners easy access to; MCA and DoLS Resources with links, e.g. code of practice, forms and policies. This information is reviewed & updated, supporting uniformity across PTHB.

Providing targeted experiential training

Recruitment to the MCA/DoLS Senior Practitioner post

Weekly meetings with DoLS office to identify; areas of improvement to enable the safeguards be most effectively administered. This includes follow-up with wards (managing authority) maintaining focus on the patient and their rights being central to the process.

Updated Form 3 and 3a to be used by BIA's to reflect current case law

Additional authoriser's have been supported through training and shadowing opportunities to achieve confidence and the necessary skills required for this role alongside a more robust panel decision-making process.

Development of a DoLS Tracker to support Managing Authorities in applying the DoLS. This is in testing phase supported by Graham Davies Ward. The objective is to achieve timescales and provide clarity for managing authorities in their responsibilities. The tracker includes automates prompting actions at the required points of a patient's journey including responsibilities of supporting patient's understand their rights. This will also aim to have effective monitoring of those without authorisation of a DoL

Mental Capacity Act 2005; What's Next…

Following a statement from both National & Welsh Government which informed that LPS will not be implemented in the near future, there is a need for PTHB to refocus and change direction for the MCA application

The Health Board is waiting for the outcome of a Welsh Government Grant for 2023/24 which will support in the development of PTHB's Mental Capacity 23-24 Action Plan. The plan will be directed by objectives identified by WG that focuses on addressing the DoLS backlog, delivering mental capacity training, to improve monitoring and reporting on DoLS, supporting systems and processes, embed mental capacity principles across care, support and treatment planning and necessary work to improve the application of DoLS. PTHB aim to build on what has been achieved so far and move forward with certainty following resource funding confirmation.

The action plan aims to include embedding training into practice across the Health Board, identifying specialist knowledge areas that need development, such as the application of DoLS, and the interface of this with the Mental Health Act 1983. A training plan will be developed and delivered, with bespoke training in response to identified challenges. Resources will be promoted to frontline staff alongside the recently developed MCA competency Framework and updated intranet page.

PTHB wish to promote efficiency in processes for DoLS at Managing Authority and Supervisory Body level. There is an existing backlog and increased volume of referrals year on year for PTHB. The aim is to review the current application and processes and make changes where applicable. This will promote assurance regarding operational compliance and reduce burden in systems. This will include the implementation of a tracker system across PTHB wards and reflect developments in clear processes.

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Practice Process

Safe Recruitment

- Powys Teaching Health Board recognises the importance of pre-employment disclosure checks on newly appointed employees and those who change position within the Health Board, in accordance with the relevant legislation and codes of practice. There is a Disclosure and Barring Service Policy and Procedure in place which sets out the process for DBS
- Recruitment data is reported to the Safeguarding Strategic Group quarterly

HR 019 Disclosure and Barring Service Policy and Procedure V5 Review Date June 2025.pdf

Position of Trust

All allegations and/or concerns of abuse of a child or an adult at risk by a HB employee must be taken seriously and treated in accordance with the appropriate policies and legislation. The WSP(2019) sets out arrangements for responding to safeguarding concerns about those whose work, either in a paid or voluntary capacity, which brings them into contact with children or adults at risk. It also includes individuals who have caring responsibilities for children or adults in need of care and support and their employment or voluntary work brings them into contact with children or adults at risk

SGP 041 Managing allegations of abuse or neglect made against professionals and members of staff.pdf

Pressure Care

PTHB has a policy in place to support the prevention & management of pressure damage.

The policy objective is to ensure appropriate care & management is provided to individuals at risk of or with pressure ulcers.

All pressure damage found must be reported via RL Datix clinical incident reporting. PTHB Pressure Damage Scrutiny Group meet monthly, a member of the safeguarding team attends the panel.

GNP 026 Prevention and Management of Pressure Damage.pdf

Falls

PTHB has a policy in place for reducing & managing in patient falls which sets out a systematic process for the prevention & management of in patients falls. Policy aims are;

Reduce preventable fall in hospital by providing an evidence based, patient centred approach to reducing the risk of harm & promoting patient safety

Heighten awareness & knowledge to staff & carers on the prevention & causes of falls, slips & trips

Provide guidance for the action to be taken when a patient has fallen

All falls are reported via RL Datix clinical incident reporting. PTHB has put in place a Falls Scrutiny Panel

GNP 036 Policy for Reducing and Managing Inpatient Falls.pdf

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Practice Improvement Child & Adults who Was Not Brought to Appointments

Robust arrangements must be in place to manage all child & adults at risk who are not brought for appointments in PTHB, or for whom there is a failed contact/access. There are occasions when a patients non-attendance is an indicator that they are at risk, it is important that this is recognised and risk considered for every failed contact.

Following several audits, SGP 047 Policy for Children and Adults Who Was Not Brought to Health Appointments has been rewritten and re launched within all services groups Policies & Written Control Documents - SGP 047 Policy for Children and Adults Who Was Not Brought to Health Appointments.pdf - All Documents (sharepoint.com)

A short WEBINAR has been produced to share the importance of the document

Bitesize Power point presentation for Launch of WNB - Final.mp4 (sharepoint.com)

A significant events chronology that can be used for each child has been developed on WCCIS. All practitioners can add to and read all entries on the chronology. Team Leads can view all children added to the chronology as Not Seen due to WNB/NAV on their Dash Boards. Monitoring in place includes;

- Annual audit of the policy
- Monthly audits by Team Leads of their service dash boards

Adverse Childhood Experiences

ACE Informed

Adverse Childhood Experiences (ACEs) are traumatic events, particularly those in early childhood that significantly affect the health and wellbeing of people in Wales, the rest of the UK and the world.

We can break the cycle of ACEs at any stage; it's never too late. Preventing ACEs in a single generation or reducing their impact can benefit not only those children but also future generations here in Wales.

Adverse Childhood Experiences range from children suffering from or being in a household where there is;

Alcohol Abuse
Parental Separation
Sexual Abuse
Drug Use
Emotional Abuse
Physical Abuse
Mental Illness
Incarceration
Drug Use
Sexual Abuse
Alcohol Abuse
Emotional Abuse

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Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV)

VAWDASV is a major public health problem in Wales and globally, and is a violation of human rights, it has far reaching consequences for families, children, communities and society.

All forms of violence and abuse are unacceptable, anyone who experiences violence against women, domestic abuse and sexual violence deserves an effective and timely response from all public services, who must work together in a consistent and cohesive way, to improve the outcomes for individuals and their families subjected to violence against women, domestic abuse or sexual violence

Through taking a public health approach to VAWDASV, we can make progress towards achieving our vision: a Wales that is free from violence against women, domestic abuse and sexual violence

Violence Against Women, Domestic Abuse and Sexual Violence

Powys Teaching Health Board receives Daily Domestic Abuse Notifications from Dyfed Powys Police following a report of Domestic Abuse when an individual involved is pregnant or there are children associated with the victim or perpetrator

During 2022-2023 there were

1,022 Daily Domestic Incident Notifications received into PTHB Safeguarding Hub from the Police which were shared with the appropriate GP, HV Hub, School Nurse Hub and Midwifery

Trend: this is an increase of **7.2%** from 2021-22

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Sexual Violence Physical Child to Parent Abuse Modern Slavery FGM
Forced Marriage Coercion & Control Financial Cuckooing Exploitation

Violence Against Women, Domestic Abuse and Sexual Violence

Domestic Abuse Daily Discussion (DADD) is a multi-agency conference call where all high risk victims of domestic abuse are discussed within 48 hours of a domestic incident, enabling earlier intervention, joint decision making and timely decisions around the Domestic Violence Disclosure Scheme. If a high risk case requires additional safety planning via the MARAC (Multi Agency Risk Assessment Conference) process, the MARAC is better informed regarding risk and risk management

During 2022-2023 there were

152 daily discussions where ***512*** cases were discussed and risk assessed

Trend: this is an increase of **10.9% and 9.8%** from 2021-22

Violence Against Women, Domestic Abuse and Sexual Violence

Domestic Abuse Multi Agency Risk Assessment Conferences (MARAC) are held every two weeks. MARAC meetings are victim-focused, agencies share information on the highest risk cases of domestic abuse. A safety plan for each victim is developed

PTHB Safeguarding Team actively participate in all aspects of the MARAC process. A representative from the Safeguarding Team attends all MARAC meetings along with our colleagues in Mental Health

PTHB are represented at the MARAC Steering group by the Senior Nurse for Safeguarding & Public Protection

During 2022-2023 there were *25* MARAC *meetings*

which developed safety plans for ***43*** high risk victims

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Physical
Modern Slavery
Exploitation
Forced Marriage
Child to Parent
FGM
Sexual Violence
Financia
Cuckooing
Coercion & Control

Violence Against Women, Domestic Abuse and Sexual Violence

Modern Slavery is the illegal exploitation of people for personal or commercial gain. Victims are trapped in servitude, which they have been deceived or coerced into, and cannot leave.

Slavery in Wales is on the rise. In 2016, 123 referrals of potential victims of slavery were reported. This is an 8.2% increase on the previous year and represents 3.2% of all UK referrals.

Men, women and children may be forced into various types of slavery, including: forced prostitution child trafficking criminal exploitation domestic servitude forced labour organ harvesting sexual exploitation. During 2022-23 19 children were referred into the NRM (National Referral Mechanism) process

The All Wales **FGM Clinical Pathway (Female Genital Mutilation)** has been updated to support diagnosis, referral and treatment of FGM victims.

FGM information is available on the PTHB Safeguarding intranet page

PTHB is represented at the NHS Safeguarding Service meeting and will be supporting the development of a FGM Audit Tool in 2023-24.

Quarterly mandatory reporting to the Violence Prevention Unit (VPU) commenced April 22, there have been **no** cases of FGM in Powys during 2022-23

ACE Related Progress & Achievements in 2022 - 2023

- Commenced targeted roll out of VAWDASV Group 3 training
- Contributed within a multi agency group to the rewrite of the NHS VAWDASV Group 2 training pack
- Roll out of new VAWDASV Group 2 training pack
- Contributed to the development of the new Regional VAWDASV Strategy 2023-2027
- With VAWDASV regional funding, PTHB commissioned a series of Webinar Training videos on Domestic Abuse Risk Assessments, MARAC & Safety Planning. These will be launched and embedded during 2023-24
- Safeguarding Midwife has developed a SOP which supports midwives to have a consistent approach to the Routine Enquiry and a process for quarterly audits to be undertaken. This will be replicated within Health Visiting and Minor Injury Units in 2023-24
- Continued engagement in the Wales Sexual Assault Service development
- Development of Regional Survivor Advisory Panel
- Identification & Referral to Improve Safety (IRIS) Model presented to the 3 GP Collaboratives

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Multi Agency Public Protection Arrangements (MAPPA)

MAPPA are a set of arrangements to manage the risk posed by the most serious sexual and violent offenders under the provisions of sections 325 - 327B of the Criminal Justice Act 2003. They bring together the Police, Probation and Prison Services in each of the 42 Areas in England and Wales into what is known as the MAPPA Responsible Authority. Several other agencies are under a Duty to Co-operate (DTC) with the Responsible Authority. These include Local Authorities, Health Boards, Youth Offending Teams, Local Housing and Education Authorities.

There are 3 categories of MAPPA-eligible offender:

Category 1 - registered sexual offenders

Category 2 – violent offenders sentenced to imprisonment for 12 months or more.

Category 3 – offenders who do not qualify under categories 1 or 2 but who currently pose a risk of serious harm

MAPPA is attended by representatives from PTHB Adult Mental Health & Safeguarding Team

2023/23		Q1	Q2	Q3	Q4
MAPPA 2	Initials	4	3	1	1
	Reviews	9	7	8	9
	M2 Total	13	10	9	10
MAPPA 3	Initials	0	1	0	0
	Reviews	1	1	5	5
	M3 Total	1	2	5	5

Channel Multi Agency Panel

In England & Wales Channel is the process that focuses on providing support at an early stage to people who are identified as being vulnerable to being drawn into terrorism. Channel uses a multi-agency approach to:

- identify individuals at risk
- assess the nature and extent of that risk
- develop the most appropriate support plan for the individuals concerned

There is a Channel process in every local authority in England and Wales which addresses all types of extremism, including extreme right-wing and Islamist-related.

Participation in Channel is entirely voluntary. People who do not consent to receive support through Channel, or who decide to leave the programme, may be offered alternative forms of support by the local authority or other providers, and any terrorist risk is managed by the police.

PTHB Safeguarding Team attended all 12 Channel Panels during 2022 - 23

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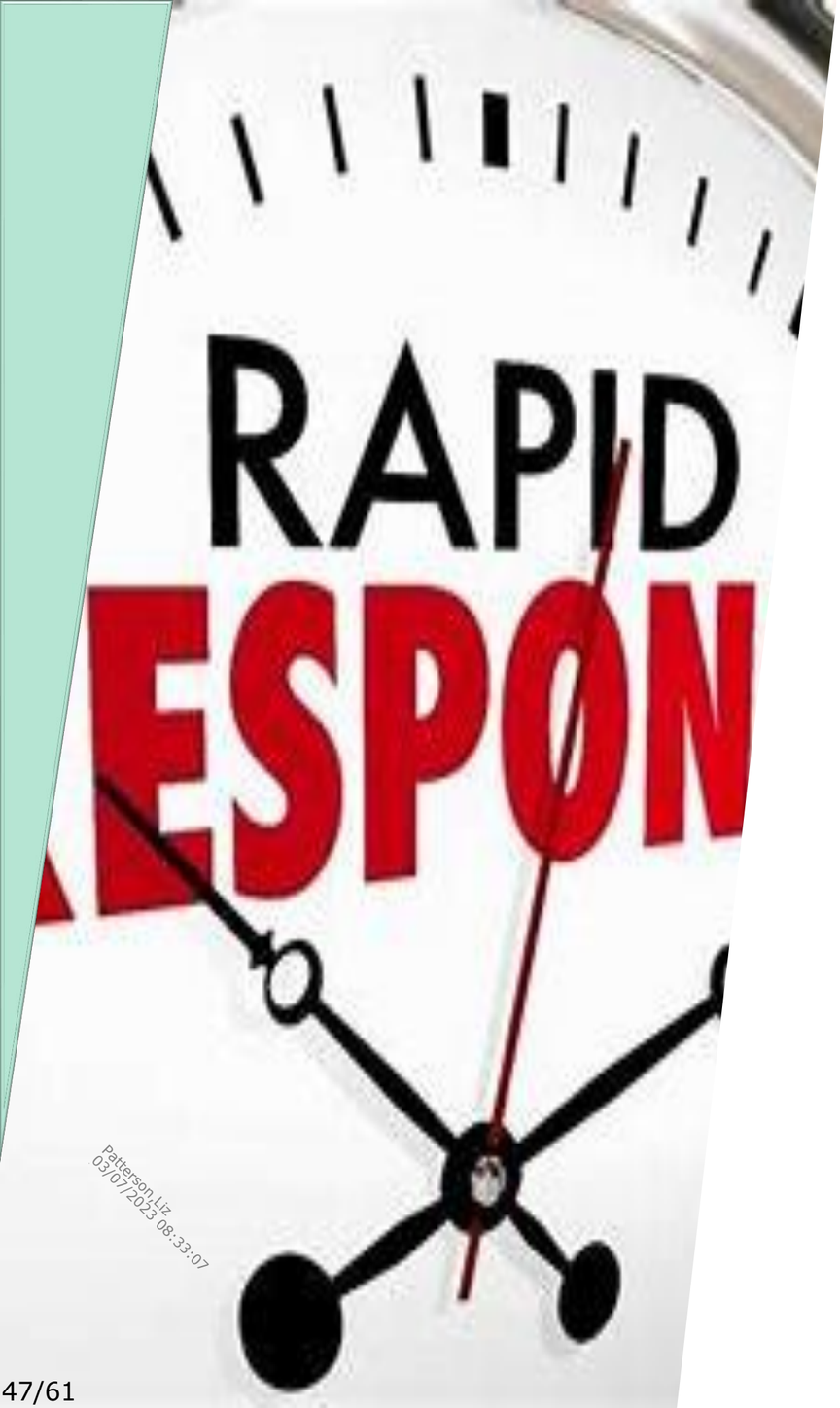
Rapid Response to Incidents of Suspected Suicide



In September 2022, the Mid & West Wales Safeguarding Board launched the **Rapid Response to Incidents of Suspected Suicide Protocol**

The aim of the ***Rapid Response to Incidents of Suspected Suicide Protocol*** is to set out the regional arrangements to provide a rapid, multi-agency response to managing the consequences and impact of incidents of suspected suicide for children and adults across the Mid and West Wales region

The model is implemented on an initial 12-month pilot/trial period. Progress will be reviewed by a regional task and finish group every 3-months throughout the pilot phase. The protocol is complementary and supportive of, but does not replace, other protocols and processes

Since September 2022, **6** suspected suicides have been managed using the **Rapid Response to Incidents of Suspected Suicide Protocol**. PTHB are represented by the Safeguarding Team and Suicide Prevention, Harm Reduction Manager

Resources are available to support the bereaved and promote post vention work. To support this CAMHS developed a safety advice leaflet Safety Advice leaflet FINAL Powys .docx

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Training & Development

Learning Culture

Powys Teaching Health Board has a responsibility to support their employees develop knowledge, skills and the competencies to perform effectively in their role and know how to respond to safeguarding concerns in line with local and national polices and processes.

PTHB signed up to the National Safeguarding Training Framework co-produced by the National Safeguarding Service, Health Boards & Trusts. The framework is aligned to and benchmarked against the;

Intercollegiate guidance, national workforce competencies such as the UK Core Skills Training Framework for adults (2018) & children (2019)

National Training Framework for Violence Against Women Domestic Abuse and Sexual Violence (2016)

Adverse Childhood Experiences (ACEs) Skills and Knowledge Framework for Wales (March 2019)

3 VAWDASV Group 3 training sessions delivered to 31 staff

12 Ask & Act Training sessions delivered to 347 staff

During 2022-2023 the Safeguarding Team delivered a variety of training opportunities over MS Teams to PTHB Practitioners with further resources available on PTHB Safeguarding Intranet Page

Safeguarding Training (sharepoint.com)

3 Safeguarding Children Level 3 sessions delivered to 36 staff

4 Safeguarding Adults Level 3 sessions delivered to 78 staff

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Safeguarding Training Compliance 2022-2023

Indicator	National Target guideline	Q1	Q2	Q3	Q4
Safeguarding Adults Level 1	85%	91.93%	91.43%	91.31%	86.01%
Safeguarding Adults Level 2	85%	95.43%	93.87%	93.61%	87.16%
Safeguarding Adults Level 3	85%	45.22%	45.84%	46.46%	46.53%
Safeguarding Adults Level 4	85%	75%	100%	100%	100%
Safeguarding Children Level 1	85%	89.61%	88.81%	89.37%	86.67%
Safeguarding Children Level 2	85%	90.24%	89.78%	88.51%	87%
Safeguarding Children Level 3	85%	67.88%	69.90%	68.66%	67.33%
Safeguarding Children Level 4	85%	71.43%	85.71%	85.71%	85.71%
VAWDASV Group 1	85%	87.06%	87.13%	87.34%	85.71%
VAWDASV – Ask & Act Group 2	85%	79.47%	71.02%	71.32%	63.09%
VAWDASV Group 6 IM's	85%				91%

Safeguarding training compliance is reported quarterly to both the Strategic & Operational Safeguarding Groups

Monitoring training compliance against the national targets is vitally important as it supports the Health Board demonstrate areas of good compliance and those where a more targeted approach is required.

Level 3 adult and child safeguarding training has stagnated in 2022/23. An action is required to understand the challenges practitioners face in achieving Level 3 & how these can be overcome

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Learning from Safeguarding Reviews, Incidents & PRUDiC's

To support learning from safeguarding reviews, incidents & PRUDiCs, PTHB's Practice Improvement Group meets quarterly & is attended by Senior Managers from across the organisation. **The objectives of the group include to;**

- Receive reports from regional and national reviews & PTHB incidents & PRUDiCs
- Ensure all action plans from reviews, incidents & PRUDiCs are monitored until completed.
- Review and scrutinise all health records following a serious safeguarding incident to identify immediate learning and develop an action plan to improve practice if needed. Actions should not wait until the outcome of a practice review.
- Identify specific audits & share learning in practice.
- Identify & develop policies or guidance in response to any learning or change in practice as the result of a review.
- Ensure that the dissemination of learning and themes identified from reviews are shared in a way that engages all relevant staff groups, for example, use of briefings, posters, learning events, MS Teams.
- In 2022-2023, 7 Action Plans were completed & closed, all open action plans are on track

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Safeguarding Supervision, Advice & Support

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

Types of Safeguarding Supervision available to PTHB staff include;

- Immediate telephone supervision
- Requested Individual Safeguarding Supervision
- Group supervision
- Professionals who access 3 monthly group supervision; Health Visitors, School Nurses, Midwives, CAMHS registrants, Community Paediatric Nurses, Children with Learning Disability Nurses
- Professionals who access 6 monthly group supervision; Paediatric Allied Health Professionals, Adult Learning Disability Nurses, District Nurses
- Minor Injury Unit Staff, Continuing Health Care Staff, Adult Mental Health Professionals
- Debrief sessions
- Peer Review for Medical Paediatric Staff

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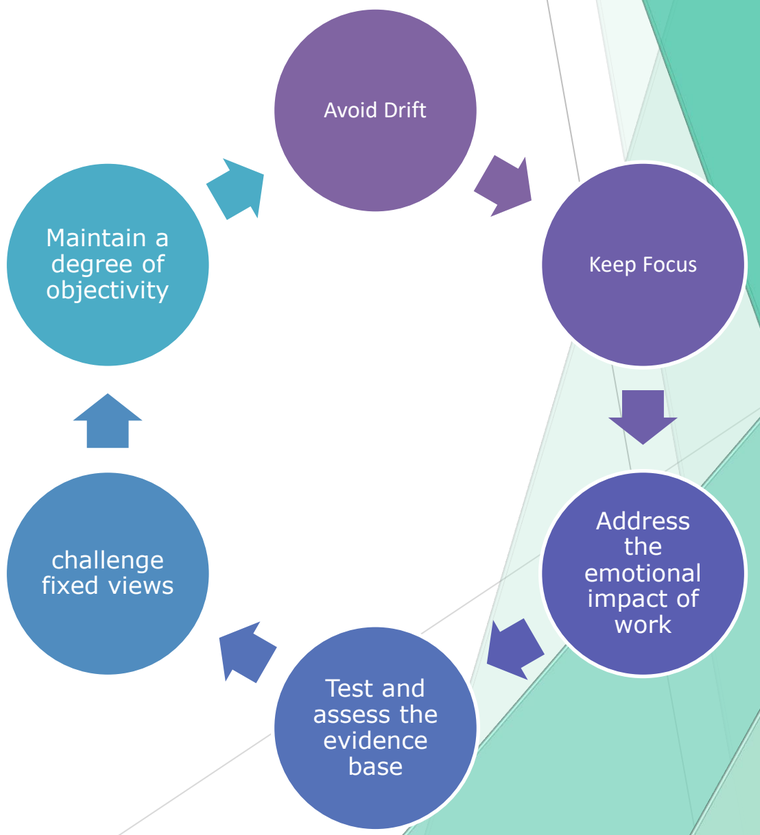
Good quality safeguarding supervision can help to;



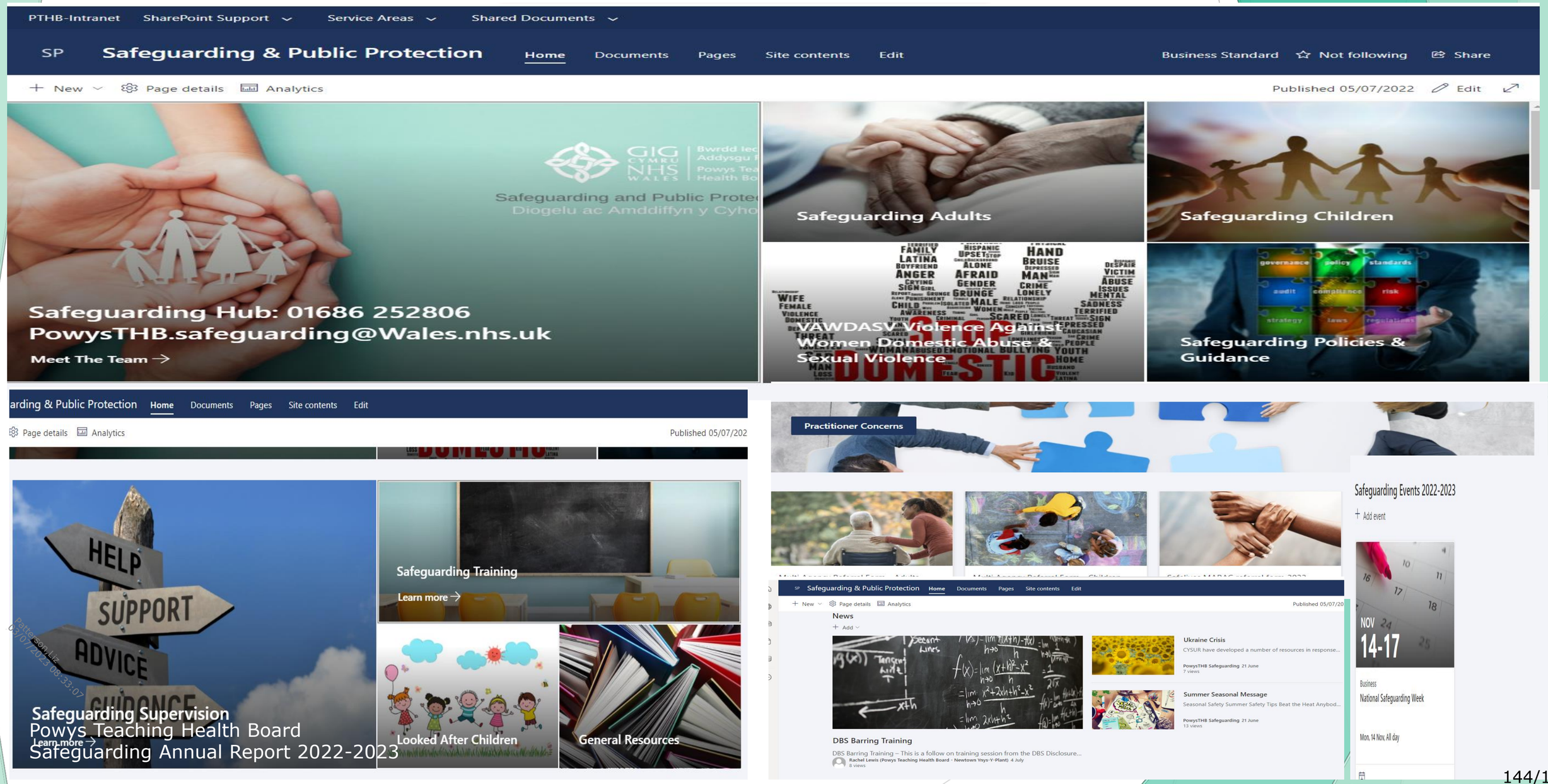
Safeguarding Supervision, Advice & Support During 2022 to 23

PTHB Safeguarding Team offered; 152 Group Supervision Sessions which were attended by **448** practitioners. Themes from supervision are reviewed quarterly by the Safeguarding team and help improve resources and targeted support

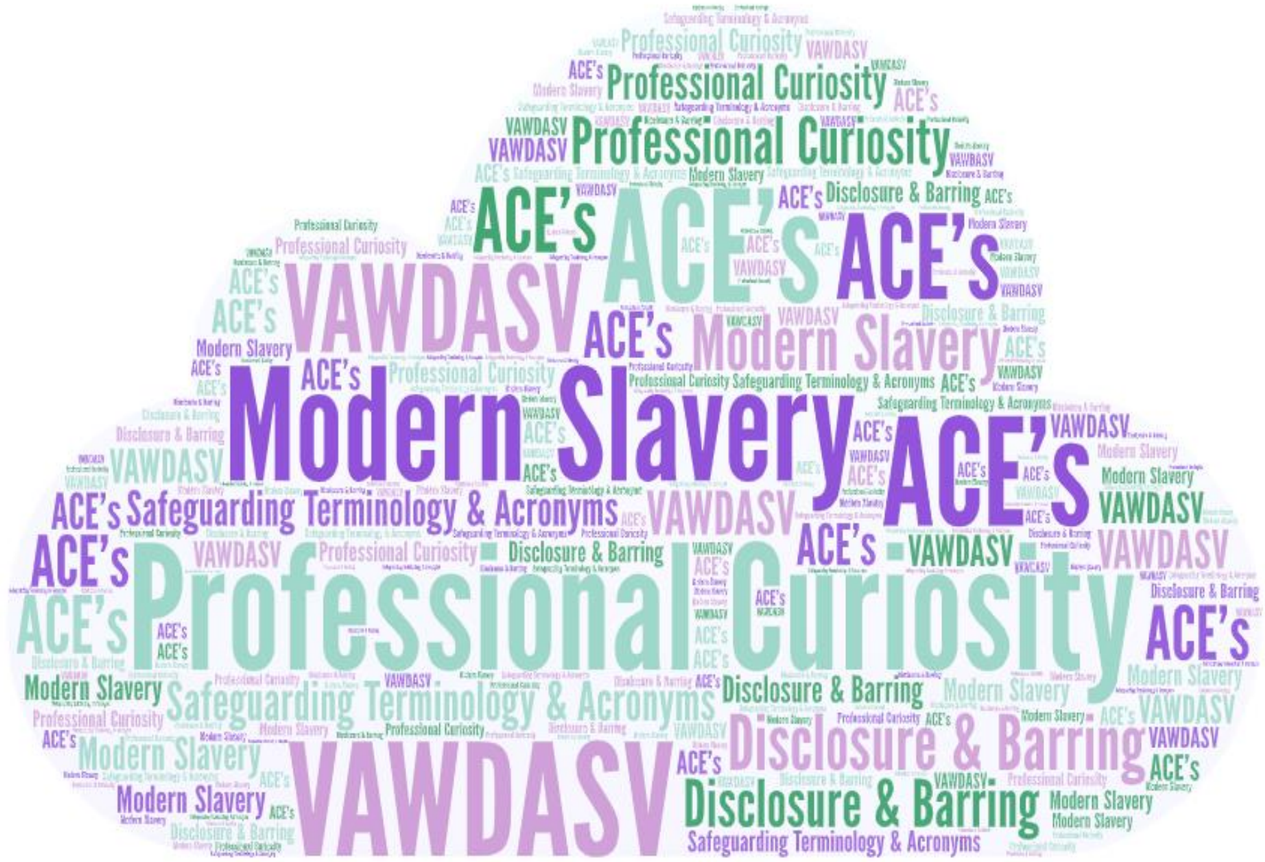
Following a review of safeguarding group supervision compliance & the expanding number of practitioners requiring Group Supervision, a recommendation was made to offer all staff groups 6 monthly safeguarding group supervision which will be complimented with the safeguarding team attending team meetings 6 monthly, this will be embedded during 2023-24 Compliance will continue to be monitored at the Safeguarding Strategic Group.

The PTHB Safeguarding Hub received; 940 Calls for supervision, advice & support, this is an increase of **28%** from the previous year

PTHB Safeguarding and Public Protection Intranet Page is packed full of resources [Safeguarding & Public Protection - Home (sharepoint.com)]



Throughout 2022-2023 PTHB Safeguarding Team shared themed newsletters including;



Advocacy & Rights

Links have been made with the IMCA (Independent Mental Capacity Advocate) and Specialist Mental Health Advocacy Service.

This has enabled an intranet resource to be hosted within the Safeguarding Team intranet page.

It provides information on advocacy with guidance to support how to use the information

Links have begun to be developed to enable opportunities to embed the offer of advocacy into everyday care so it becomes custom and practice throughout a patient's journey.

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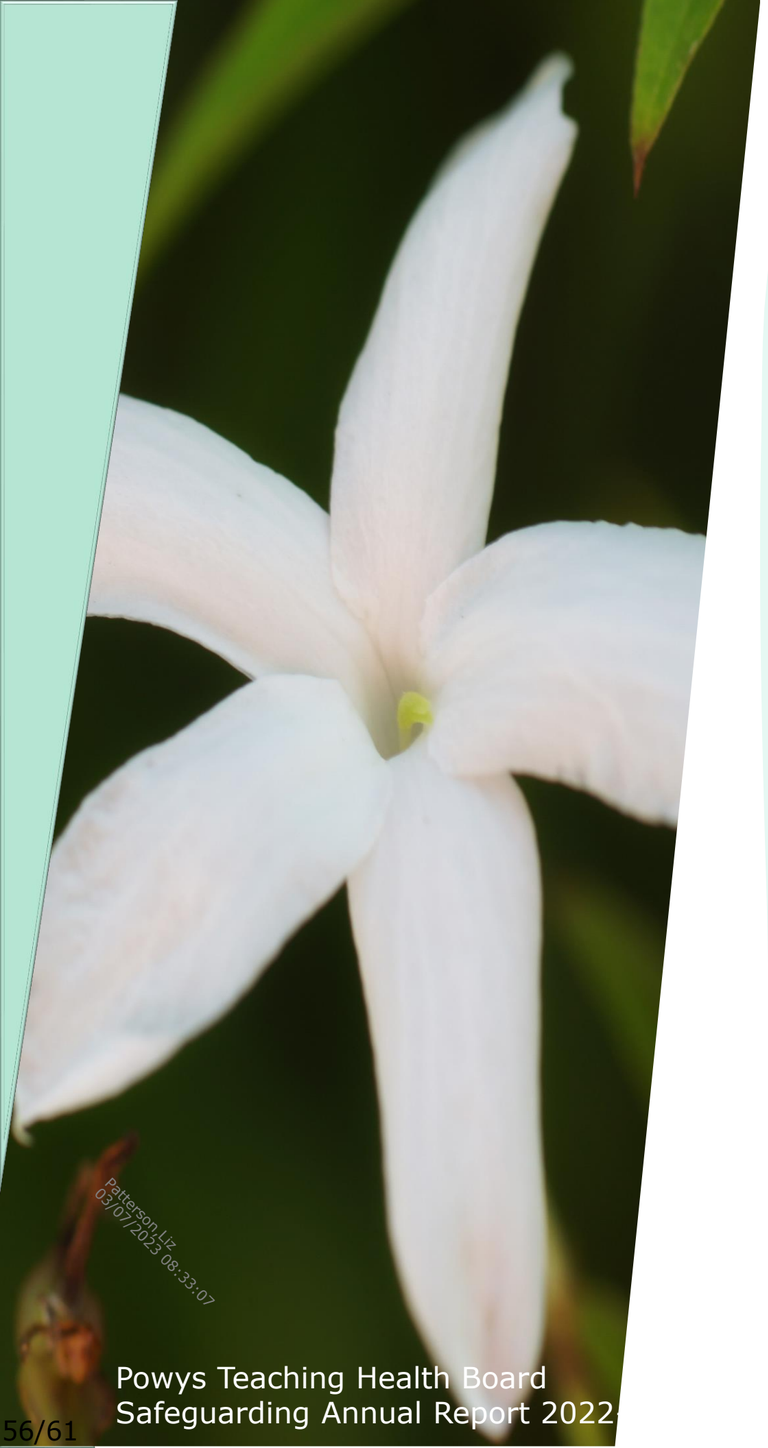

Operation Jasmine

Operation Jasmine was a wide-ranging investigation carried out by Gwent police between 2005–2013, into the deaths of 63 people living in care homes in South East Wales.

The Flynn Review was commissioned in December 2013 and the report 'In Search of Accountability' was published in May 2015. It made 12 recommendations, including that inquests should be held which took place between January & March 2021.

The coroner concluded the deaths of five people were contributed to by neglect. Much has changed since these tragic events both through legislation and in our ways of working. However, we should never become complacent and must continue to reflect, learn and improve. This is particularly important as we respond to the continued impact and pressures on the health and social care sector arising from the COVID-19 pandemic.

In April 2022, Care Inspectorate Wales (CIW) wrote to health boards to ask they consider Watching the **Operation Jasmine: learning and reflection event webinar** held in December 2021, and follow this up with a group discussion and reflection on; is practice, recording and organisational culture outcome focused? how effective are we at communicating with other agencies? do we ensure actions are explained, noted and acted on? how well do we currently respond to fluctuating performance?

PTHB has responded by; During October 2022 a Task & Finish group was formed and in early 2023 a day focusing on watching the webinar and discussing and reflecting on the questions took place. The event was well attended and noted there have been many improvements since 2015, however, opportunity to develop an Improvement Plan was identified and this will be monitored by the Practice Improvement Group

Themes from the focus day include; training, improved communication, extend the Multi Disciplinary Team SOP to adults & role out of the observation form to keep record of low level concerns in nursing homes

Multi Agency Partnership Working

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

PTHB are committed to working alongside our partners at a National, Regional and Local level

Examples of working together during 2022-23;

- Contribution to Safeguarding Week https://www.cysur.wales/national-safeguarding-week-2022/
- Updating adult & child Multi Agency Referral Form (MARF)
- Various Consultations
- PRUDiC Guidance 2023
- Regional Rapid Response Model
- Co delivery of Professional Curiosity Training
- Completion of the National Action Plan on Child Sexual Abuse Social Services and Well-being (Wales) Act 2014 (gov.wales)
- Multiagency collaboration on the new Serious Violence Duty (2022) Serious Violence Duty - Statutory Guidance (publishing.service.gov.uk)

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Safeguarding & Public Protection Partnership Working

PTHB Safeguarding Team attends & contributes to meetings and groups in the Safeguarding & Public Protection Arena

National Meetings

- NHS Safeguarding Service
- SARC Project Board & Implementation Group
- Safeguarding Maturity Matrix
- NHS VAWDASV Steering Group
- NHS Network LAC Steering Group
- NHS Training Sub-group
- NHS DOLS/LPS/MCA Task & Finish Group
- LAC Cymru (Peer Group)
- WG LPS Implementation Group

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Regional Meetings

- M&WWSB Board
- M&WWSB CPR/APR/MAPF Sub-Group
- VAWDASV Strategic Group
- VAWDASV Training Sub-Group
- VAWDASV Delivery group
- VAWDASV Commissioning Group
- M&WWSB Appeal Panel
- M&WWSB Training Sub-Group
- M&WWSB Policy and Procedure Sub-Group
- Regional DoLS/LPS and MCA Forum
- M&WWSB Safeguarding Child working Group
- M&WWSB Safeguarding Adult working Group
- Regional Anti-Slavery Group
- Serious Violence Duty Group
- SVOC Board
- MCA Forum

Local Meetings

- PLOG
- Corporate Parenting Group
- CPR/APR/DHR/MAPF Panel
- Youth Justice Board
- Start Well Board
- MARAC Steering Group
- MARAC
- PRUDiC
- DDAC
- Channel Panel
- MAPPA
- MASE
- National Safeguarding Week Planning Group
- Community Safety Partnership (CSP)
- Practitioner Concerns Strategy meetings
- Complex Strategy meetings
- Rapid Response Meetings

Health Board

- Pressure Ulcer Scrutiny Panel
- Heads of Nursing/Midwifery
- DoLS Signatory
- Maternal & Child Death Review Group
- Safeguarding Strategic Group
- Safeguarding Operational & Practice Improvement Group
- MCA Improvement Group
- JIMP
- Practitioners Concerns Meetings
- Royal Welsh Planning

Practice Improvement; Launch of the Do's & Don'ts of Caring Animation – Young People's Animation

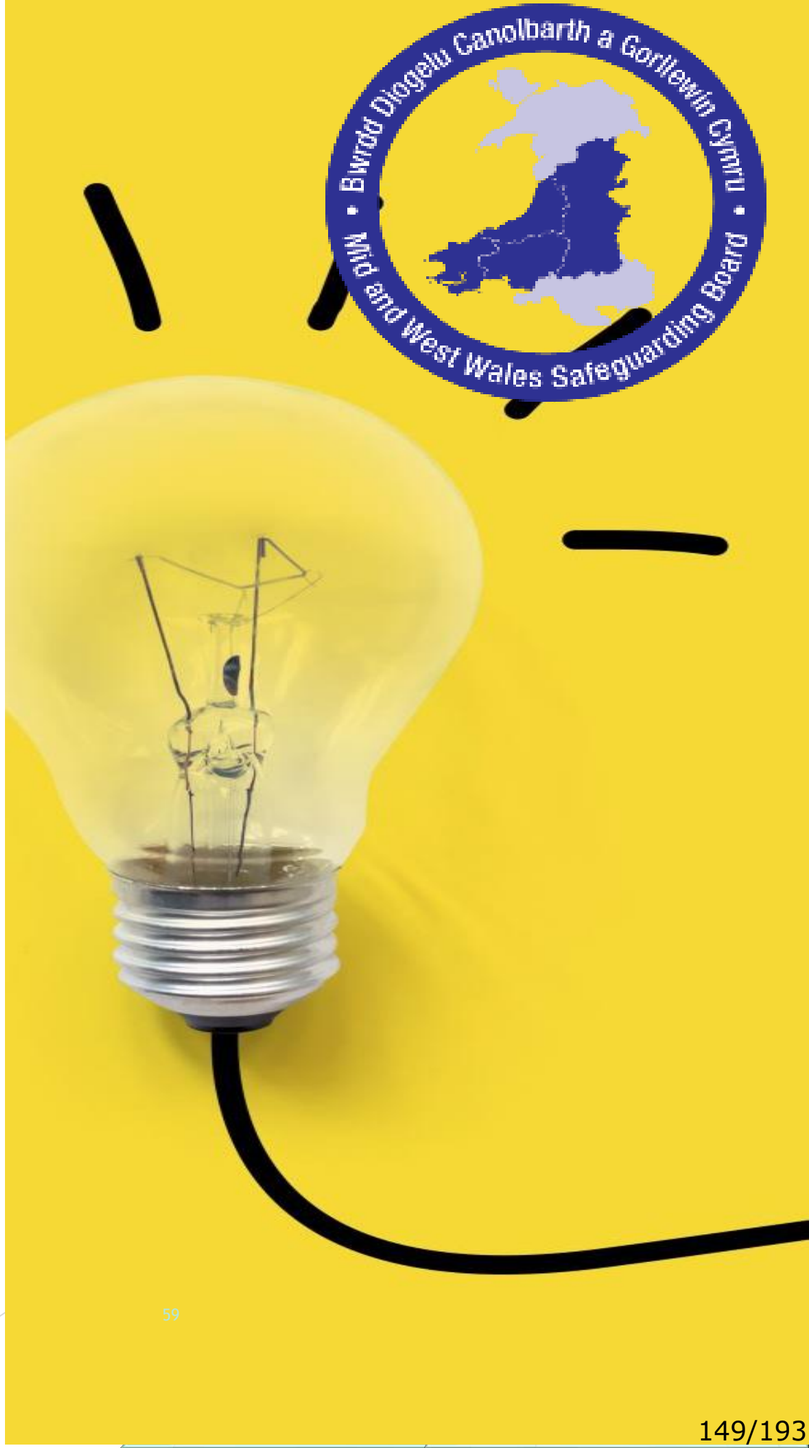
The launch and celebration of 'The Do's and Don'ts of Caring' an animated safeguarding training resource, took place at Parc-y–Scarlets Stadium in Llanelli on Friday 18th November. The video animation had been created by children and young people from Pembrokeshire, Carmarthenshire, Ceredigion and Powys as part of the work of CADW (Children taking Action Differently in Wales), the Junior Safeguarding Board. The animation was launched alongside a video that captured the reactions of CADW members when they viewed the resource for the first time.

Following a screening of both videos and an address by the new Children's Commissioner, Ms Rocio Cifuentes, Senior Leaders for statutory agencies pledged to promote and share the webinar across their organisations and consider a series of questions posed by the children.

https://youtu.be/bhm_yFLV84Y

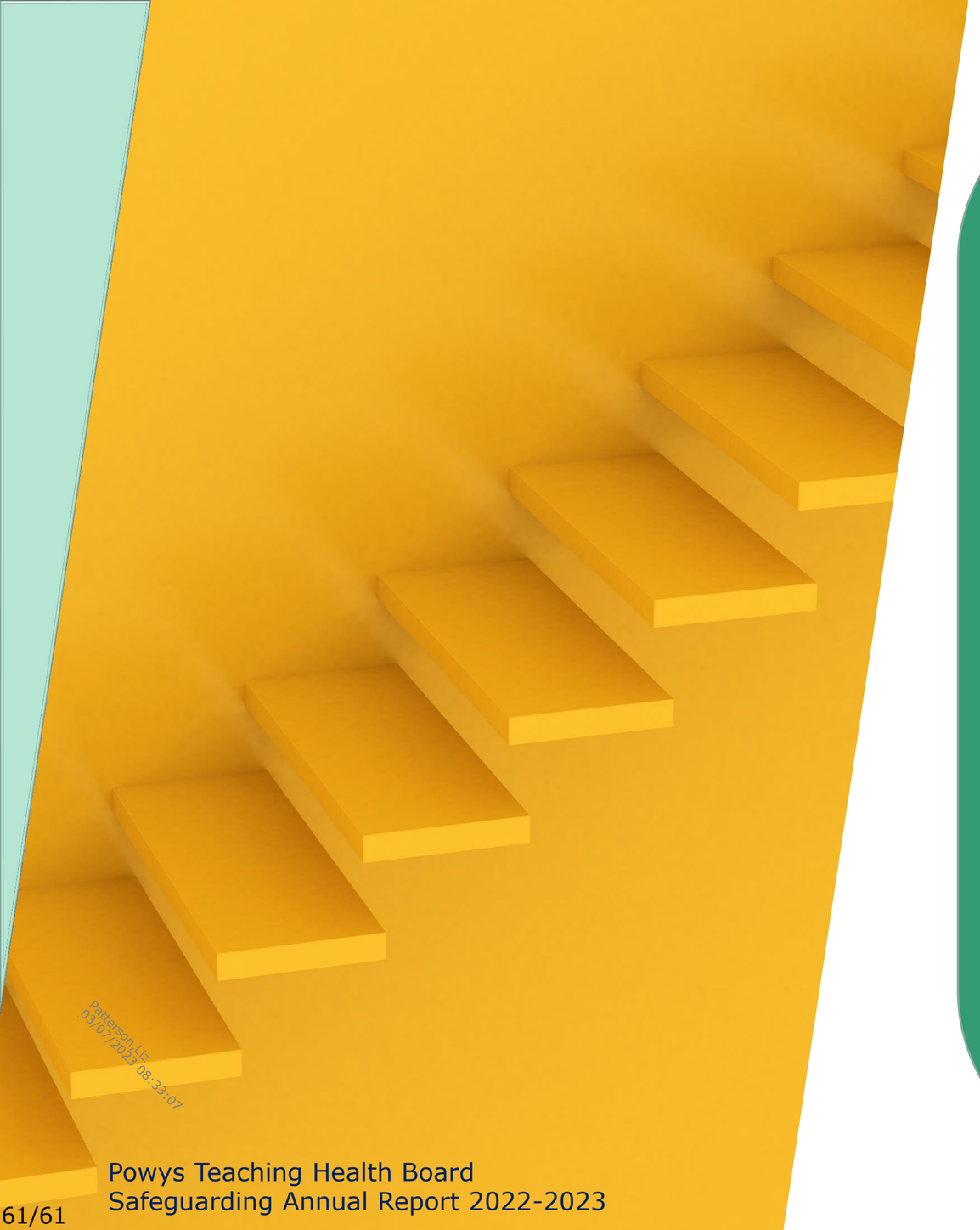
PTHB Actions so far;

- Video's shared at both strategic & operational safeguarding groups & distributed to teams via managers, a memo, during team meetings & housed on PTHB Safeguarding Intranet Page
- Video included in Level 3 Safeguarding Training Competency Framework
- Video added to Corporate Induction Day for all new employees into the Health Board
- Children Participation Strategy to be added to 2023-24 work plan



Safeguarding & Public Protection; Challenges Ahead into 2023-24

- Completion of Child Practice Review
- Introduction of Serious Violence Duty
- Uncertainty around implementation of Liberty Protection Safeguards (LPS)
- Introduction of the Single Unified Safeguarding Review (SUSR)
- Expanding Safeguarding Agenda
- Identification & Referral to Improve Safety (IRIS) model and the next steps



Next Steps in 2023 -24

- Update the Safeguarding Level 3 Training Passport
- Improve Safeguarding Level 3 Training Compliance
- Develop bespoke training for volunteers that is delivered in person
- Develop and deliver Childhood Injuries training
- Continue to role out VAWDASV Group 3
- Work with the Wales Violence Prevention Unit (VPU) to develop a system to share violent incident data to support vulnerability mapping
- Work with Minor Injury Units to strengthen the Routine Enquiry, data collection and audit
- Share learning from Child Practice Review
- Improve Internet Safeguarding Page
- Completion of annual Safeguarding Maturity Matrix and development of improvement plan
- Develop Mental Capacity Act Action Plan
- Implementation of DoLS tracker
- Implementation of the LAC Database
- Work with partners to implement the Serious Violence Duty
- Respond to Welsh Government consultation on the Single Unified Safeguarding Review process
- Work with partner agencies to consider WG VAWDASV Blue Print
- Consider the RLDatix Safeguarding Management System
- Work with the NHS National Safeguarding Service to produce a high level safeguarding strategy
- Review how a child's voice is reflected in assessments & contacts
- Consider IRIS in Primary Care

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