

# Patient Experience, Quality and Safety Committee 5 September 2024

Thu 05 September 2024, 15:30 - 16:15

## Agenda

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### 15:30 - 15:30 1. PRELIMINARY MATTERS

0 min

📎 PEQS\_Agenda\_05Sept24.pdf (1 pages)

#### 1.1. Welcome and Apologies

#### 1.2. Declarations of Interest

#### 1.3. Minutes from the previous meeting held on the 30 July 2024 for approval

📎 PEQS\_1.3\_unconfirmed PEQS Minutes 2024-07-30.pdf (10 pages)

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### 15:30 - 15:30 2. ITEMS FOR ASSURANCE

0 min

#### 2.1. Duty of Quality Annual Report 2023/24

Attached Claire Roche

📎 PEQS\_2.1\_Duty of Quality AR cover paper.pdf (3 pages)

📎 PEQS\_2.1a\_Duty of Quality Annual Report.pdf (19 pages)

#### 2.2. Safeguarding Annual Report 2023/24

Attached Claire Roche

📎 PEQS\_2.2\_Safeguarding Annual Report cover.pdf (6 pages)

📎 PEQS\_2.2a\_Safeguarding Annual Report\_23-24.pdf (75 pages)

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### 15:30 - 15:30 3. OTHER MATTERS

0 min

#### 3.1. Items to be Brought to the Attention of the Board and/or Other Committees

#### 3.2. Any Other Urgent Business

#### 3.3. Date of the Next Meeting: 07 November 2024

#### 3.4. Welcome and Apologies

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**POWYS TEACHING HEALTH BOARD  
PATIENT EXPERIENCE, QUALITY AND  
SAFETY COMMITTEE**



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**THURSDAY 05 SEPTEMBER 2024  
15.30 – 16.15  
VIA MICROSOFT TEAMS**

**AGENDA**

<b>Time</b>	<b>Item</b>	<b>Title</b>	<b>Attached</b>	<b>Presenter</b>
	<b>1</b>	<b>PRELIMINARY MATTERS</b>		
15.30	1.1	Welcome and Apologies	Verbal	Chair
	1.2	Declarations of Interest	Verbal	All
	1.3	Minutes from the previous Meeting held on 30 July 2024	Attached	Chair
	<b>2</b>	<b>ITEMS FOR ASSURANCE</b>		
15.35	2.1	Duty of Quality Annual Report 2023/24	Attached	Executive Director of Nursing, Quality, Women and Family Health
15.50	2.2	Safeguarding Annual Report 2023/24	Attached	Executive Director of Nursing, Quality, Women and Family Health
	<b>3</b>	<b>OTHER MATTERS</b>		
	3.1	Items to be Brought to the Attention of the Board and/or Other Committees	Verbal	Chair
	3.2	Any Other Urgent Business	Verbal	Chair
16.15	3.3	Date of the next meeting: <ul style="list-style-type: none"> <li>PEQS 07 November 2024 – in person, venue tbc</li> </ul>		

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

**UNCONFIRMED**

**MINUTES OF THE MEETING HELD ON TUESDAY 30 JULY 2024  
VIA MICROSOFT TEAMS**

<b>Present:</b>	
Kirsty Williams (KWi)	Vice-Chair (Committee Chair)
Jennifer Owen Adams (JOA)	Independent Member
Simon Wright (SW)	Independent Member
Ian Phillips (IP)	Independent Member
<b>In Attendance:</b>	
Kate Wright (KW)	Medical Director
Claire Madsen (CM)	Executive Director of Allied Health Professionals, Health Sciences and Digital
Marie Davies (MD)	Deputy Director of Nursing
Gareth Thomas (GT)	Consultant Nurse – Infection Prevention and Control
Zoe Ashman (ZA)	Interim Assistant Director of Women’s and Childrens
Jason Crowl (JC)	Assistant Director Health and Safety and Support Services
Hayley Thomas (HT)	Chief Executive
Helen Bushell (HB)	Director of Corporate Governance
Amanda Edwards (AE)	Assistant Director – Innovations and Improvement
Heather Wenban (HW)	Dementia Lead Nurse
Francis Issacs (FI)	Dementia Services – Patient with Lived Experience
<b>Observing:</b>	
Carl Cooper (CC)	Chair PTHB
Simeon Foreman (SF)	Deputy Board Secretary
Heidi Sinclair (HS)	Head of Quality and Safety
Toboline Mupita (TM)	Mentee of Vice Chair Kirsty Williams
Bethan Hopkins (BH)	Audit Wales
<b>Apologies for absence:</b>	
Claire Roche (CR)	Executive Director of Nursing, Quality, Women and Family Health
Joy Garfitt (JG)	Interim Director Operations, Community Care and Mental Health
<b>Committee Support:</b>	
Liz Patterson (LP)	Interim Head of Corporate Governance

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PEQS/24/21	<p><b>WELCOME AND APOLOGIES FOR ABSENCE</b></p> <p>KWi welcomed all to the meeting. Apologies for absence were noted as recorded above.</p>
PEQS/24/22	<p><b>DECLARATIONS OF INTERESTS</b></p> <p>No interests were declared in addition to those already declared in the published register.</p>
PEQS/24/23	<p><b>MINUTES OF THE EXPERIENCE, QUALITY AND SAFETY COMMITTEE MEETING HELD ON 16 APRIL 2024</b></p> <p>The minutes of the previous meeting held 16 April 2023 were <b>AGREED</b> as a true and accurate record.</p>
PEQS/24/24	<p><b>PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE ACTION LOG</b></p> <p>HB presented the action log noting that seven actions were on track, four were at risk with date changes requested (all relating to content of the Integrated Quality Report), and the following item was due a verbal update to the meeting:</p> <ul style="list-style-type: none"> <li>PEQS/24/09a – an update to Was Not Brought Audit of December 2023 was provided to the Committee and circulated to Members after the meeting.</li> </ul> <p>Independent Members asked the following questions for assurance: <i>Can assurance be given that the change of date requests will not increase risk for the organisation?</i></p> <p>MD confirmed that actions outlined in the four areas when amended dates were requested were all in train, but it had not been possible to implement in the Integrated Quality Report to this meeting due to staff absence.</p> <p><i>PEQS/23/40a has been open since October 2023. How concerned should Committee be that this is not progressing?</i></p> <p>ZA advised that work had been taking place in relation to pressure sores, but staff absence had meant that it had not been possible to report to this meeting.</p> <p>The Committee <b>NOTED:</b></p> <ul style="list-style-type: none"> <li>the update given in relation to PEQS/24/09c (Was Not Brought). This action to be closed.</li> <li>that seven actions remained on track.</li> <li>that four actions were at risk and <b>AGREED</b> the request for a date change to November 2024, noting that PEQS/23/40a had been open since October 2023 and whilst understanding extenuating circumstances it is expected that this action will be in a position to be closed at the November 2024 meeting.</li> </ul>
PEQS/24/25	<p><b>PATIENT STORY</b></p> <p>HW introduced FI who spoke about her experiences of visiting a Memory Clinic and how challenging the environment had been. FI had been consulted on the refurbishment of Outpatient areas in</p>

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	<p>Bronllys and advised on clear signage for people with dementia and with colour coding for people with sight loss. FI shared other examples where improvements could be made under the Patient Friendly Charter.</p> <p>MD advised that FI's input had been invaluable on the Dementia Steering Group, and this would be maximised when work commenced on the Ready To Go units.</p>
<b>ESCALATED ITEMS</b>	
<p>PEQS/24/26</p>	<p><b>INFECTION PREVENTION AND CONTROL (IPC) ANNUAL REPORT</b></p> <p>GT presented the report which included updates on the Infection Prevention and Control Improvement Plan year one, year two objectives and the 2023/24 Infection Prevention and Control Annual Report. Attention was drawn to the following matters:</p> <ul style="list-style-type: none"> <li>• Since the report was written a further two actions have been completed meaning one action remains on track to be completed within timescales and three actions where good progress is being made.</li> <li>• Funding has been accessed for an additional post which due to unsuccessful recruitment will now be advertised as a development role.</li> <li>• An Antimicrobial Stewardship Officer will take up post in September 2024.</li> <li>• Rates of Clostridioides Difficile (CDI) have increased locally.</li> <li>• The majority of cases are community acquired infection with no identifiable contributing factors.</li> <li>• There have been challenges with obtaining cross border information which has been resolved for Wye Valley NHS Trust and is likely to be resolved for Shrewsbury and Telford Hospitals NHS Trust in quarter 3.</li> </ul> <p>Independent Members asked the following questions for assurance: <i>In relation to the cleanliness audit where figures of over 95% are recorded, what would be considered to be a good score?</i> GT advised that this is a reassuring result, it is known that there is more work to be done in respect of cleanliness, but a perfect score would raise other questions.</p> <p><i>Are the rising rates of CDI of concern, is the Health Board an outlier in this respect?</i> GT advised that rates of CDI were rising across Wales and the Health Board was not an outlier. Small numbers of cases in the Health Board area mean percentage changes can appear skewed. However, improvements in respect of Antimicrobial Stewardship are required.</p> <p><i>What is the issue in respect of General Practitioner (GP) prescribing rates?</i></p>

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	<p>KW advised that the Health Board were working with Primary Care to implement MicroGuide, an application which advises of the best antibiotic for each condition. This is recently available to all GPs, and it is expected will lead to improved prescribing practice.</p> <p><i>The Health Board is consulting on temporary changes which will result in patients moving between hospitals. Will this result in an increased risk of infection?</i></p> <p>GT advised that patient movement can result in increased rates of infection, however, the standards of IPC have improved, and robust arrangements are in place to address this.</p> <p>The Committee:</p> <ul style="list-style-type: none"> <li>• <b>RECEIVED</b> and <b>DISCUSSED</b> the Infection Prevention and Control improvement plan at the end of year one (2023/24) took <b>ASSURANCE</b> of substantial progress against plan.</li> <li>• <b>NOTED</b> the objectives set for year two and the contents of the 2023/24 Annual Report.</li> </ul>
PEQS/24/27	<p><b>MENTAL HEALTH SERVICES ESCALATION ASSURANCE REPORT</b></p> <p>KW presented the Committee with an update on progress in respect of Mental Health Services which had been placed in local escalation in April 2024. Since then, the Escalation Oversight Group had meet, initially weekly but after improvements have been recorded this has moved to fortnightly.</p> <p>Concern had initially been raised regarding the incident management with 480 overdue Datix incidents. This has reduced to 61 open cases in the context of around 70-80 cases a month which demonstrates the historic cases are largely cleared and new cases are dealt with in a timely manner. What is necessary now is to demonstrate this improvement is sustainable. Multi-Disciplinary Team working has been strengthened. Out of date policies have been reviewed. Some have been updated and this work continues. A de-escalation plan is being drawn up which will be reliant on evidence of sustained improvement.</p> <p><i>How are the team responding during this period of escalation?</i></p> <p>KW confirmed the team had gone through a challenging time during a period of workforce fragility and having a number of difficult cases. The team have found it hard but remain positive, there have been difficult times, but the constructive support has been welcomed.</p> <p><i>Can a message be sent from Board Members to the team to recognise and thank them for the progress make?</i></p> <p>CC advised that following discussion with HT he would visit the team with KW to check in from a Board perspective and ask how escalation had been experienced by the team. It was noted that</p>

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local escalation had been put in place as a result of concerns raised by this Committee to the Chief Executive which provided assurance good governance processes were in place.

*How will it be known when the improvements are sustainable?*

KW confirmed that de-escalation would take place gradually to ensure the changes are fully embedded.

*What is different this time, how will assurance be given the changes are being sustained when the level of scrutiny is removed?*

KW confirmed that concerns related to workforce fragility in the system. This led to a lack of focus on core governance arrangements which have been addressed during the period of escalation. A plan is being put in place to prevent this happening again.

*Are the numbers of Datix reports received around the levels expected?*

KW advised that a low threshold for reporting is in place and the majority of cases are closed without further action. It is good practice to report concerns, and this is encouraged.

*How is patient voice heard in this service?*

ZA advised PAVO were facilitating a group on Velindre Ward to provide this information. Further work is necessary to gain the views of patients being cared for in the community.

*What progress is being made in relation to capital works on Velindre Ward?*

HT advised the work is due for completion in October 2024.

HT added that the Executive Committee had been pleased with progress to date and would be having a further report in September 2024. Once de-escalation criteria had been met the service would still be monitored via regular reporting mechanisms. It was the first time the Integrated Quality and Performance Framework has been used in relation to local escalation and once de-escalation had been confirmed it would be appropriate to invite the service to attend Committee to share their experience.

**Action: Director of Corporate Governance**

The Committee:

1. Took **ASSURANCE** that the implementation of the IQPF Escalation Oversight mechanism is providing robust oversight of the quality improvement and risk mitigation work being undertaken within Mental Health Services.
2. **NOTED** and **DISCUSSED** the contents of the report including the action plan, progress that has been made and updated maturity assessment.

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## ITEMS FOR ASSURANCE

PEQS/24/28

### INTEGRATED QUALITY REPORT QUARTER 1

ZA presented the report and drew attention to the following areas:

- Compliance with responses in 30 days for Putting Things Right (PTR) has risen from 27.5% to 85.25% in two years.
- Incident reporting has reached a steady state with a high level of cases of moderate harm reported, but a decreasing number of severe harm cases reported.
- A number of Nationally Reportable Incidents have been closed with five remaining open and overdue (these can be complex and circumstances outside of the Health Board may prevent earlier closure).
- Patient feedback this quarter has been more negative than previously, the reasons for this will be examined.
- Collation of patient stories remains challenging, but it is hoped a library of stories will be available in the next two months.
- Feedback from the Medical Examiner work outlined that families did not feel they had been contacted early enough when end of life was near

Independent Members asked the following questions for assurance:

*To what extent is Datix used across the organisation and how can assurance be given that a timely response to incidents is achieved?*

ZA advised that Datix is used across all teams in the Health Board. Continual support needs to be applied to ensure incidents are investigated in a timely way.

*Should Members be concerned with the reduction in compliance with management of concerns from 86% in 2023/24 to 68% in Q1 of 2024/25?*

ZA advised that the small number of concerns meant that large swings in compliance were seen, and this was not a cause for concern.

*The Committee have escalated to Board capacity restraints with Civica in relation to patient experience and an inability to process the high level of responses received. The Audit, Risk and Assurance Committee received an Internal Audit on patient experience in the Therapies Service which found patient response rates were low. These appear to be conflicting positions.*

CM advised that the method of collecting patient experience had changed from a paper focussed method to Civica. During the transition it was to be expected that response rates would not truly reflect the levels of response.

MD advised that a Business Case was in preparation to provide capacity to support patient experience.

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	<p><i>Will the addition of investigating deaths in the Community which the Medical Examiner is taking over from September 2024 result in additional workload for the Health Board?</i></p> <p>KW advised that additional workload would be expected with appropriate feedback and shared learning essential.</p> <p><i>Why are Health Inspectorate Wales historical actions from 2017-2020 referenced if they are closed?</i></p> <p>MD advised that the service is examining what actions can be taken to close outstanding recommendations. Any recommendations outstanding for over 12 months will be highlighted within the report.</p> <p><b>Action: Director of Nursing, Quality, Women and Family Health.</b></p> <p>The Committee <b>RECEIVED</b> the report and took <b>ASSURANCE</b> 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.</p>
PEQS/24/29	<p><b>CARE INSPECTORATE WALES REPORT – COTTAGE VIEW, KNIGHTON</b></p> <p>JC introduced the report outlining the Health Board were responsible for a 15 bedded care home which is subject to different regulatory arrangements to the NHS. It is regulated under the Care Inspectorate Wales and for the first time since 2016 has received a clean inspection in all areas with the previously raised concerns relating to governance and organisational arrangements addressed. Thanks were expressed to the Registered Manager Chris Creemer.</p> <p><i>What learning can be taken from this experience and applied elsewhere in the organisation?</i></p> <p>JC advised this was being examined, both from the perspective of providing residential services, but also for potentially providing day care services.</p> <p>The Committee <b>DISCUSSED</b> and took <b>ASSURANCE</b> from the Inspection Report.</p>
PEQS/24/30	<p><b>HEALTH INSPECTORATE WALES (HIW) – DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION (DNACPR) REVIEW</b></p> <p>KW presented the action plan drawn up in response to the national HIW DNACPR review. The report identified the following themes:</p> <ul style="list-style-type: none"> <li>• Communication</li> <li>• Public awareness and understanding of DNACPR.</li> <li>• Accessibility of information</li> <li>• Timing of discussions</li> <li>• Documentation and review</li> </ul> <p>Actions to address the findings include:</p>

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	<ul style="list-style-type: none"> <li>• Multi-Disciplinary Team discussion and review of recommendations triangulated with learning from local DNACPR audit.</li> <li>• Majority of actions would be best achieved by training, initially of medical staff.</li> <li>• Topic has been addressed in Primary Care Protected Learning Time.</li> <li>• Further education events to be planned with Macmillan GPs.</li> </ul> <p>Independent Members asked the following questions for assurance: <i>What triggered the need for this report?</i> KW advised that there had been concern during the pandemic that the threshold for DNACPR had been reduced and it was time for a review.</p> <p><i>What support is available for social care settings?</i> KW advised that this is a focus for Future Care Planning. When patients enter a social care setting a conversation takes place regarding future wishes but there is no consistent way of recording or reviewing this. Joint work is also taking place with the ambulance service on this matter.</p> <p>The Committee took <b>ASSURANCE</b> that the Health Board are responding appropriately to the HIW DNACPR report.</p>
<b>CONSENT AGENDA</b>	
PEQS/24/31	<p><b>MENTAL HEALTH POWER OF DISCHARGE ANNUAL REPORT INCLUDING MENTAL HEALTH COMPLIANCE WITH LEGISLATION</b></p> <p>KW requested that in future the trend data included within the report covers several years, rather than the single year shown in this report.</p> <p><b>Action: Executive Director of Primary Care, Community Care and Mental Health</b></p> <p>The Committee <b>RECEIVED</b> the contents of this report and took <b>ASSURANCE</b> that the performance of the service in relation to the administration of the Mental Health Act 1983 has been compliant with legislation.</p>
<b>ITEMS FOR APPROVAL</b>	
There were no items for approval.	
<b>ITEMS FOR DISCUSSION</b>	
There were no items for discussion.	
<b>ITEMS FOR INFORMATION</b>	
PEQS/24/32	<p>The following items were received for information:</p> <ul style="list-style-type: none"> <li>• Internal Audit Report – Continuing Health Care</li> <li>• Internal Audit Report – Patient Experience</li> </ul>

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	<p>HB advised that the Audit, Risk and Assurance Committee (ARAC) received Internal Audit Reports and monitored the implementation of audit recommendations. Should ARAC have particular concerns regarding a specific matter, this can be referred to a committee for their attention.</p> <ul style="list-style-type: none"> <li>• WHSSC Quality Patient Safety Committee Chairs Report</li> </ul>
<p><b>OTHER MATTERS</b></p>	
<p>PEQS/24/33</p>	<p><b>COMMITTEE RISK REGISTER</b></p> <p>HB presented the report which drew together the relevant risks from the Corporate Risk Register which had been presented to Board in July 2024. A planned update will be presented to Board in September 2024.</p> <p>Independent Members asked the following questions for assurance:  <i>Can consideration be given to including a risk on the availability of digital information at the point of care?</i></p> <p>HB confirmed that this request would be fed into the Risk and Assurance Group for active consideration.</p> <p><b>Action: Director of Corporate Governance</b></p> <p>The Committee:</p> <ul style="list-style-type: none"> <li>• <b>CONSIDERED</b> the corporate risks within the committee’s remit,</li> <li>• <b>DISCUSSED</b> any relevant issues, and</li> <li>• Took <b>ASSURANCE</b> that risks are being managed in line with the Risk Management Framework.</li> </ul>
<p>PEQS/24/34</p>	<p><b>COMMITTEE WORK PROGRAMME</b></p> <p>HB introduced the work programme and confirmed that research and innovation would be included in the Work Programme. The work programme was agile and would be reviewed to ensure that the proposed temporary service change was appropriately considered by the organisation.</p> <p><b>Action: Director of Corporate Governance</b></p>
<p>PEQS/24/35</p>	<p><b>ITEMS TO BE BROUGHT TO THE ATTENTION OF THE BOARD AND/OR OTHER COMMITTEES</b></p> <p>HB presented the report which gave an overview of the current items escalated to Board namely:</p> <ul style="list-style-type: none"> <li>• Concerns regarding capacity constraints in the use of Civica for patient experience – the meeting had heard that a plan was in place to increase capacity and that the Patient Experience Framework would be brought to Committee in November 2024 when the escalation to Board would be reviewed.</li> <li>• Infection Prevention and Control – progress has been demonstrated but the Committee still wish this to remain escalated to Board where an update will be given.</li> <li>• Mental Health Services in local escalation – an update has been received and will be given to Board</li> </ul>

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PEQS/24/36	<p><b>ANY OTHER URGENT BUSINESS</b></p> <p>There was no other urgent business.</p>
PEQS/24/37	<p><b>COMMITTEE FEEDBACK</b></p> <p>The following observations were made:</p> <ul style="list-style-type: none"> <li>• Operational colleagues welcomed attendance to understand Committee requirements.</li> <li>• A good balance between support and scrutiny</li> <li>• Committee work does not feel siloed.</li> <li>• Patient stories are powerful.</li> <li>• Documents included from outside sources (HIW report) enable triangulation.</li> <li>• Reports are of good quality and accessible</li> </ul>
PEQS/24/17	<p><b>DATE OF THE NEXT MEETING</b></p> <ul style="list-style-type: none"> <li>• PEQS 5 September 2024</li> <li>• Joint PEQS and Workforce and Culture 10 October 2024</li> <li>• PEQS 7 November 2024 – in person venue to be confirmed</li> </ul>

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**Agenda item: 2.1**

**PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE** **5 SEPTEMBER 2024**

<b>Subject:</b>	<b>Annual Duty of Quality Report 2023-24</b>
<b>Approved and presented by:</b>	Claire Roche, Executive Director of Nursing, Quality, Women and Family Health
<b>Prepared by:</b>	Zoe Ashman, Interim Assistant Director Women & Children
<b>Other Committees and meetings considered at:</b>	Executive Committee 21 August 2024

**PURPOSE:**

To present to the Patient Experience, Quality and Safety Committee the Powys Teaching Health Boards Annual Duty of Quality Report 2023-24.

**RECOMMENDATION(S):**

The Committee is asked to **DISCUSS** the content of the Annual Quality Report and **APPROVE** for publication.

Approve/Take Assurance	Discuss	Note
<b>Y</b>	<b>Y</b>	<b>N</b>

**ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:**

1. Focus on Wellbeing	Y/N
2. Provide Early Help and Support	Y/N
3. Tackle the Big Four	Y/N
4. Enable Joined up Care	Y/N
5. Develop Workforce Futures	Y/N
6. Promote Innovative Environments	Y/N
7. Put Digital First	Y/N
8. Transforming in Partnership	Y/N

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## EXECUTIVE SUMMARY:

This Quality report is intended to summarise and reflect the Health Board's progress to improve the quality of our services and population outcomes during the last year.

The Duty of Quality (Health and Social Care (Quality and Engagement) (Wales) Act 2020) applies to all health care service function, and not just clinical functions in NHS Wales. Ministers and NHS bodies will have to actively consider whether their decisions will improve service quality and secure improvement in outcomes. This approach supports the five ways of working in The Well-being of Future Generations (Wales) Act 2015 to achieve a healthier Wales. The Duty aims 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.
- 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.
- Create a quality culture within organisations.

## DETAILED BACKGROUND AND ASSESSMENT:

Following the implementation of the Health and Social Care (Quality and Engagement) (Wales) Act 2020, which came into force in April 2023, it is a requirement for health boards to publish an annual quality report. Given the Act and its implementation is 'new' in Wales health boards have been afforded the opportunity to have a 'light' touch for the first report with expectations it will evolve and develop over proceeding years.

This first report provides an overview of the Health Board's development and progression within the quality sphere and alignment of a quality management system which will further mature during 2024/25.

## NEXT STEPS:

Publication of the Annual Duty of Quality Report.

## IMPACT ASSESSMENT

This section must be completed for all strategic organisational decisions including approval of health board policies.

### QUALITY:

	No impact	Negative	Positive	Both
Safe			X	
Timely			X	
Effective			X	
Efficient			X	
Equitable			X	
Person Centred			X	
Workforce			X	
Leadership			X	
Culture			X	
Information			X	
Learn, Improve, Research			X	
Whole Systems Approach			x	

Following the implementation of the Health and Social Care (Quality and Engagement) (Wales) Act 2020, a requirement of the Act is for all health boards to publish an annual report in line with the Duty of Quality. This Quality report is intended to summarise and reflect progress to improve the quality of our services and population outcomes during the last year.

### EQUALITY:

	No impact	Negative	Positive	Both
Age	X			
Disability	X			
Gender reassignment	X			
Marriage / civil partnership	X			
Pregnancy / maternity	X			
Race	X			
Religion or Belief	X			
Gender	X			
Sexual Orientation	X			
Welsh Language			x	
Socio-economic status	X			
Social exclusion	X			
Carers	x			

The proposal will not disproportionately affect any of the protected characteristics

### RISK ASSESSMENT:

	Level of risk identified			
	Very Low (0-3)	Low (4-8)	Moderate (9-12)	High (15-25)
Clinical		x		
Financial			x	
Corporate		x		
Operational		x		
Reputational		x		

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# Annual Duty of Quality Report 2023- 2024



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PEQS Committee  
05 September 2024  
Item 2.1a

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## 1.0 Foreword

Powys Teaching Health Board has a whole range of responsibilities for healthcare for the people of Powys, both as a provider and a commissioner of services. It can therefore be a broad, complex arena to navigate for both health care professionals along with the citizens of Powys.

The Health Board continues to focus on the medium-to-long term strategic goals set out in our Health and Care Strategy:

*Focus on Wellbeing, Early Help and Support, Tackling the Big Four, Joined Up Care;* enabled through

*Workforce Futures, Digital First, Innovative Environments, Transforming in Partnership*

We are really pleased to provide you with the Health Boards first Duty of Quality Annual Report. We hope this report provides you with an overview of what we have been doing over the last year to improve the quality oversight and infrastructure across Powys as well as some of the improvements we have made. We will continue to work with LLAIS along with the communication and engagement team to further enhance our report next year by, taking feedback on this years' report and asking what, in addition our citizen's would like to see in future reports.

Our Quality and Safety Vision is to ensure that quality, patient safety, and experience are central to all our actions. Every decision we make aims to actively involve both those who receive care or access services and those who provide it, while maintaining a persistent commitment to learning and improvement.

To successfully realise this vision, establishing a just safety culture and embracing compassionate leadership approaches are crucial. This first Duty of Quality Annual Report will review our achievements in improving the quality of our service.

## 2.0 Introduction

This Quality report is intended to summarise and reflect the Health Board's progress to improve the quality of our services and population outcomes during the last year.

The Duty of Quality applies to all health care service function, and not just clinical functions in NHS Wales. Ministers and NHS bodies will have to actively consider whether their decisions will improve service quality and secure improvement in outcomes. This approach supports the five ways of working in The Well-being of Future Generations (Wales) Act 2015 to achieve a healthier Wales. The Duty aims 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.
- 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.
- Create a quality culture within organisations.

### 3.0 Quality Governance

As an NHS Wales organisation, there are clear expectations set out for the quality standards we must maintain. These are set out through the:

- Health and Social Care (Quality and Engagement) (Wales) Act 2020;
- A Healthier Wales;
- Core Commissioning Requirements.

With our aims to continuously improve and learn, new legislative requirements support the quality governance framework during 2023/2024. The Health and Social Care (Quality and Engagement) (Wales) Act 2020 has placed increased responsibility on health and care organisations in Wales. Enhancing quality, honesty and transparency, the legislation provides the Health Board with a Duty of Quality, Duty of Candour, and establishes a Citizen Voice Body. Thus, enriching engagement with our citizens and wider communities. Developing our organisational culture and embedding the Duty of Candour have been critical in being open and honest with our citizens and service users where our services have not met expectations or caused harm. Candour will be utilised to drive improvement whilst embracing innovation opportunities.

The existing quality governance structure has been maintained. The Patient Experience, Quality and Safety Committee continued to receive reports on assurance and escalated risks linked to patient experience, quality, and safety.

The key aspects of the quality governance arrangements in the Health Board are:

- Commissioning Assurance Framework:
  - Quality
  - Access
  - Cost/Finance
  - Governance & strategic change
- Putting Things Right (Concerns, Incident, Redress and Clinical Negligence)
- Clinical Audit
- Data – CHKS – healthcare intelligence and quality improvement, benchmarking
- External Reviews – e.g., Getting It Right First Time
- Professional practice supervision/regulation
- Staff Surveys
- Organisational Development Framework
- Relationships/Escalations – Care Quality Commission, Healthcare Inspectorate Wales etc

A focus on quality has been maintained through the following activity in 2023/2024:

- Continued work to address the recommendations from the Audit Wales Review of Quality Governance (October 2021). The Review was positive overall with helpful areas for improvement identified.

- A focus on improving quality metric reporting which has been supported by the implementation of the Integrated Quality Performance Framework (IQPF).
- Implementation of the Medical Examiner Service.
- Completion of the National Nosocomial COVID-19 Programme (NNCP).
- Safeguarding & public protection annual report presentation to the Patient Experience, Quality and Safety in December 2023; and

There has been continued focus on the Health Board’s formal process, in line with the NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 also known as Putting Things Right, which aims to address concerns in a proactive, timely and open manner.

Learning from concerns has continued to mature, ensuring lessons are learned and both patient and staff experiences are heard, along with influencing change if required.

### 3.1 Health and Care Standards

The Health and Care Quality Standards replace the 2015 Health and Care Standards as set out in [WHC/2023/013](#). The inclusion of quality directly aligns the standards with the [Duty of Quality](#) introduced in April 2023 through the [Health and Social Care \(Quality and Engagement\) \(Wales\) Act 2020](#). The standards set out the expectations for services in both a provider and commissioned basis for local citizens. They are aligned to the health board Quality Management System and cross referenced as part of Committee reporting, with associated risks and escalation raised.

Decisions should be based on the 12 Health and Care Quality Standards 2023: Safe, Timely, Effective, Efficient, Equitable and Person-centred (STEEP) care delivered through: Leadership, Workforce, Culture and Valuing People, Information, Learning, improvement and research, Whole systems approach.

The diagram illustrates the standards:

The 12 standards are made up of six domains of quality (a domain is a particular area or things we want to have good quality health care) as highlighted in the diagram.



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## 4.0 The quality journey

### 4.1 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).

The partnership's aim was to coach and support health boards and trusts to improve the quality and safety of care across their systems. The Safe Care Collaborative created a learning system where organisations tested and measured practice innovations and shared their experiences to accelerate learning and widespread implementation of best practices for safe care. It brought 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.

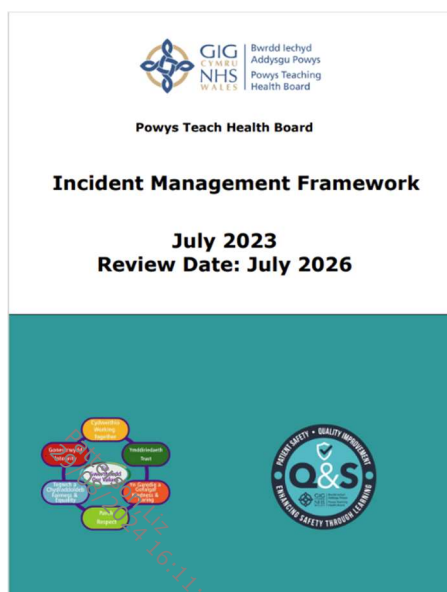
Improvement Cymru colleagues were invited to our local Safe Care collaborative meetings. The team focussed on the completion of level 2 Quality Impact Assessments required by Welsh Government to support the cost saving projects. The health board priority projects focussed on:

- Reducing numbers of patients not attending for outpatients' appointments (DNA).
- Care of the deteriorating patient

### Leading Patient Safety Programme 2023/2024

In August 2023 two additional employees were successful in securing a place on the second cohort of the Leading Patient Safety Programme. They joined 30 other leaders in patient safety from across the NHS Wales system, focusing on building a system of safety within their organisations. At the end of the programme, they will join the Leading Patient Safety network.

## 5.0 Examples of how we have improved the quality of our services



### 5.1 Implementation of Incident Management Framework

The framework will support and further enhance the response to the management of incidents. There is a robust focus on compassionate leadership, management and engagement to ensure appropriate involvement for all those affected by safety incidents, including staff, service users/patients, carers/family.

Learning following an incident to reduce or prevent recurrence is paramount and reinforces improvements are key to a high-quality organisation.

### 5.2 Learning Group

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.

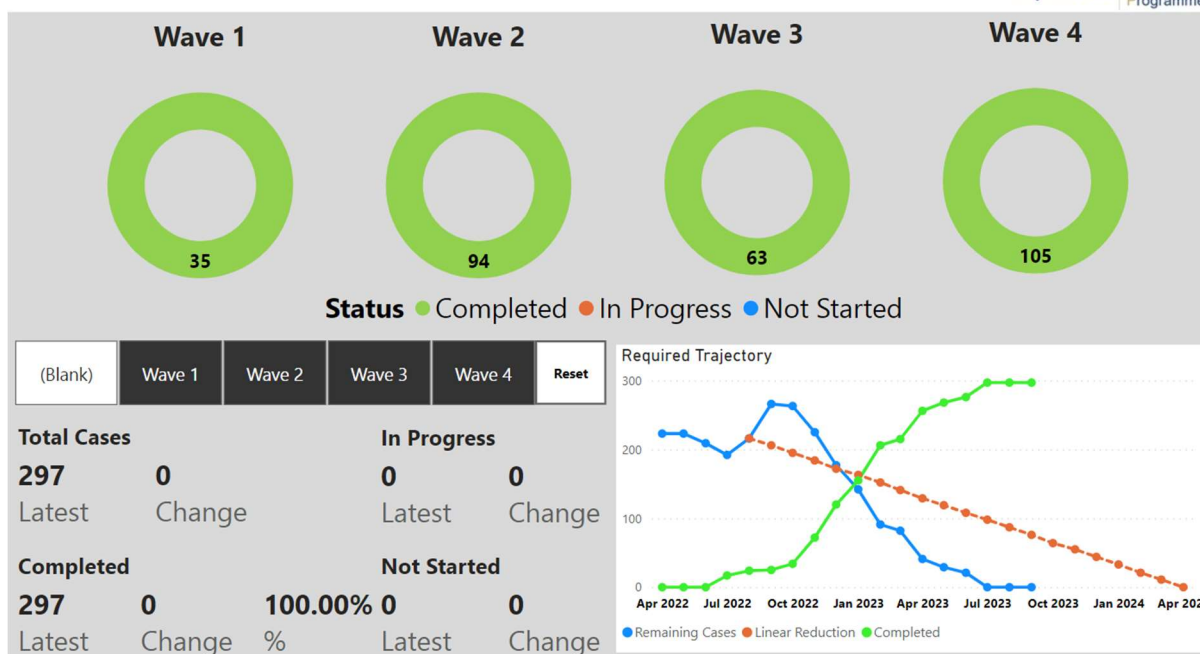
The team have supported learning events to discuss incidents that have occurred with common themes and crossover of learning. The learning events have been well attended by key individuals within the services to further strengthen the actions for improvement that are required. It is envisaged that these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

### 5.3 National Nosocomial Framework

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

To date, the Health Board has not received any concerns from families or patients affected by nosocomial transmission of Covid-19. No identified cases where severe harm or death have occurred have been identified thus far and therefore, duty of candour conversations with patients and/or families have not been required. The programme completed all cases during July 2023 and will be providing information to the national team for an end of programme report regarding learning.

#### NNCP Data - Powys Teaching HB



Learning identified within the Nosocomial Framework specifically for Powys includes:

- With the restrictions to visiting and flow numbers of nosocomial cases were low, Health Board had an advantage of planned admissions following strict guidance.
- Clear tracking of patients i.e., location of bed on ward, would have been helpful to identify learning during outbreaks.
- Increased visibility of IP&C team and presence in clinical areas to provide support to teams could have been improved

- Outbreak meetings could have been better structured and communicated more effectively The Learning from outbreaks did not always effectively inform care planning or future actions.
- Training has been provided by the nosocomial team to support ward managers and team leads to manage incidents associated with Nosocomial infections.

## 5.4 Medical Examiner Service

During 2023 the Medical Examiner Service took over the review of all in-patient deaths. The Medical Examiner Service began as a pilot at Brecon and Bronllys hospitals in April 2022 being followed by Ystradgynlais hospital who joined the programme in July of 2022.

The remaining sites, Llandrindod, Machynlleth, Llanidloes, Newtown and Welshpool went live in February of 2023.

Between the beginning of the Medical Examiner Pilot and the end of February 2024 a total of 318 Community Hospital in-patient deaths have been reported to, and reviewed by, the Medical Examiner Service.

Of these 318 cases a total of 77 cases have been referred back to the Health Board by the Medical Examiner Service. A referral by the Medical Examiner Service does not necessarily mean that there has been an identified problem with the care provided. The Medical Examiner will comment on anything they consider might be interesting or beneficial for the Health Board to be informed of, or to review. The Medical Examiner Service also talks to the next of kin of the deceased and gives them the opportunity to raise any issues in the care of the deceased. This can include care received at out of county District General Hospitals, Social Services interactions, GP care or experience with the Ambulance Service.

All 77 cases have been reviewed by the Health Board and no causes for concern over the care provided by the Health Board have been identified.

Learning identified:

- Ensure families/NOK are notified when a patient's condition changes during the night.
- Ensure all documentation (including digital records) are shared with the ME.
- Improved communication is required for families/NOK when patients are at the end of life.

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## 6.0 Duty of Candour

The duty of candour is a legal requirement for NHS bodies in Wales to be open and honest with service users receiving care and treatment. The duty stems from the Health and Social (Quality and Engagement) (Wales) Act which became law in 2020, and became operational from 1 April 2023.

Within the health board, we strive to provide high quality, safe and compassionate care to all of our service users. However, even when we do our best, people may sometimes experience harm. That's why we have the Duty of Candour.

Our goal is to create a culture of trust and openness, so that service users feel confident in the care you receive from us.

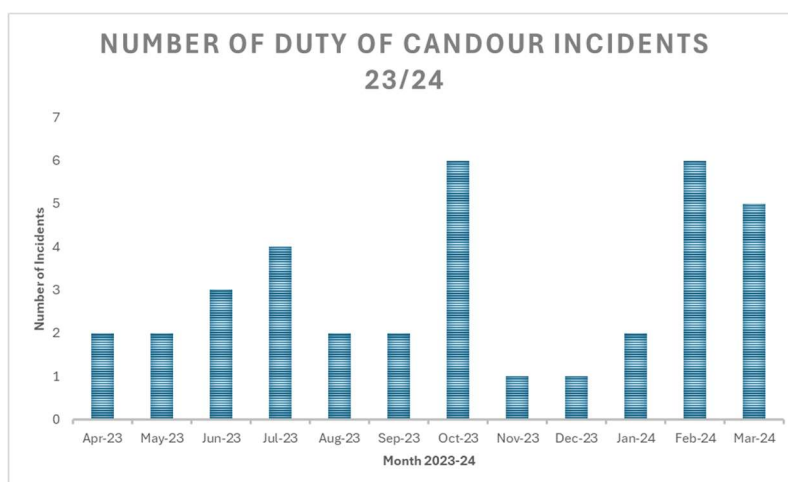
To follow Duty of Candour the health board will:

1. On first becoming aware that the duty of candour applies, notify the service user or a person acting on their behalf. This contact should be 'in person', which means by telephone, video call or face to face.
2. The purpose of the 'in person' notification is to offer an apology, provide an explanation of what is known at that time, offer support, explain the next steps and provide point of contact details
3. The service user or person acting on their behalf will be sent a letter within five working days, confirming what was said in the 'in person' notification.
4. Undertake an investigation to find out what happened and why, and how we can prevent it from happening again
5. This will take place according to the NHS Wales 'Putting Things Right' Procedure.

The number of times the Duty has been triggered is demonstrated in the graph, no cases during 2023/24 have required Redress.

Learning from Duty of Candour:

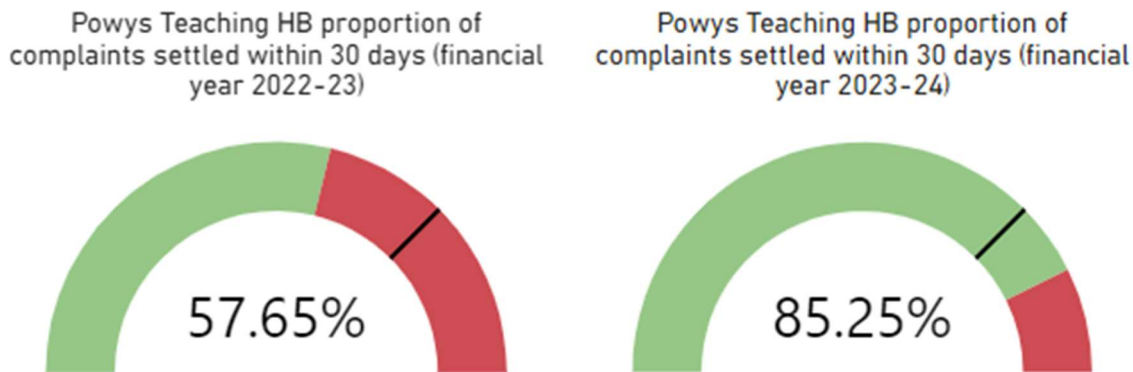
- Review staff training compliance regarding manual handling.
- Ensure all patient risk assessments are completed on admission to hospital.
- Management of the deteriorating patient; management of NEWS & Sepsis 6.
- Pain management.
- Management of staff allocated to provide 1:1 care.



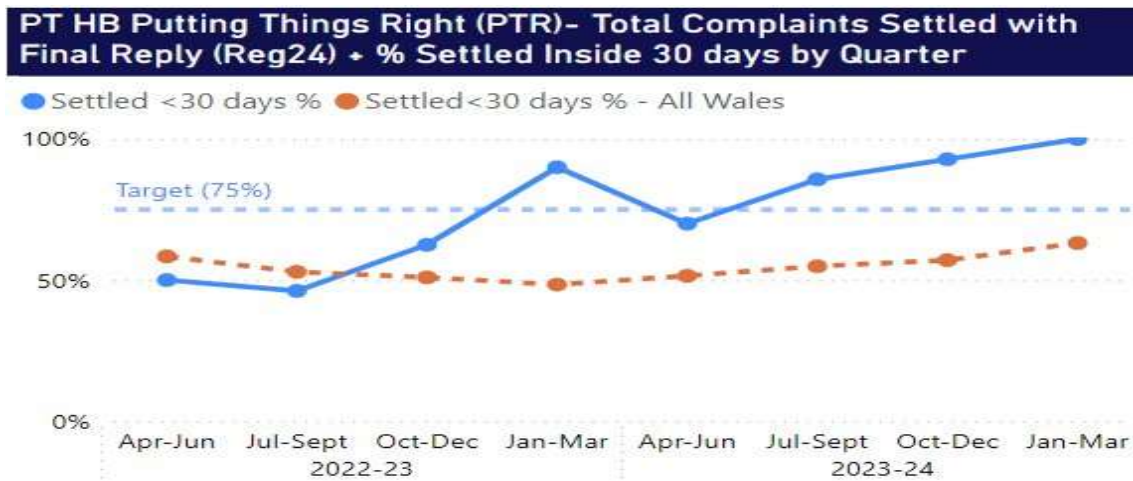
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## 6.1 Putting Things Right – Concerns Management

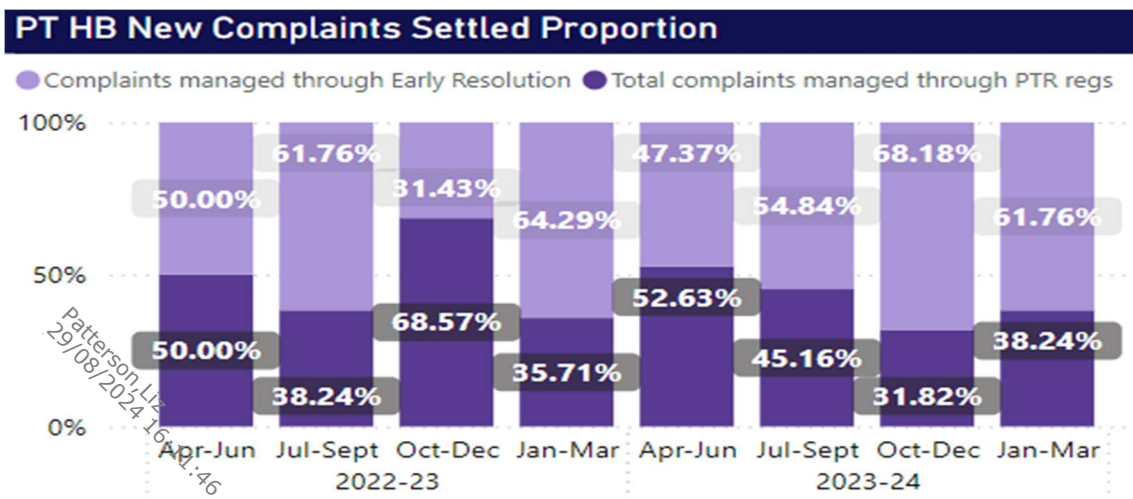
The management of concerns compliance within 30 working days reported nationally at the end of 2023/24 85.25% (2<sup>nd</sup> position nationally) which is a significant improvement 2022-23 of 57.65%. Continued focus is maintained to ensure concerns are managed in a timely manner with the appropriate investigation and response.



Graph below highlights the Powys quarterly compliance (blue line) against the national position (Orange line) (Data obtained from NHS Executive Beacon Dashboard)



The health board has continued throughout 2023/24 to manage concerns in a proactive way with a larger percentage managed as yearly resolution rather than as a formal concern where appropriate. Thus achieving early and appropriate resolution for those raising a concern or issue.



## 7.0 Patient experience

Receiving real-time feedback from our patients/carers/family, whether good or bad, supports continual improvement in the services we provide. Ensuring service decisions are made inclusive on these thoughts and experiences.








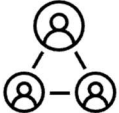
The health board implemented CIVICA Experience system at the end of 2022, the system enables healthcare organisations to understand real-time patient feedback. Services are able to:

- Prioritise risk areas.
- Drive Service improvement.
- Highlight positive & negative comments.
- Analyse comments.

Since the beginning of 2023 we have been building on the number of active surveys, the launch of a "record your own compliments" survey, and advertising via social media (including an animated version – the first in Wales).

All patients/carers/family who have received care in Powys or by one of our providers can share their feedback.

The All-Wales Patient Experience survey includes a suite of standard experience survey questions, including the Friends and Family Test. Infographic below provides an overview of responses during 2023/24 for all services either provided or commissioned.

<b>A total of 1649 surveys returned (1<sup>st</sup> April 2023 to 31<sup>st</sup> March 2024)</b>			
	<b>91.64% scored their experience as "Excellent" (5 and above)</b>		<b>66.73% stated they always felt cared for</b>
	<b>68.55% felt they were always listened to</b>		<b>74.89% said that the time they waited was either shorter than expected or about right</b>
	<b>39.72 % felt they always had assistance when they needed it</b>		<b>68.24% always understood what was happening with their care</b>
	<b>72.73% said explanations were always given in a way they could understand</b>		<b>66.80% always felt they were involved as much as they wanted to be in decisions about their care</b>

Individual service areas have also implemented more in-depth and targeted surveys to gain feedback within service areas and projects. This allows for an adaptable approach to gathering information on performance; some of these are highlighted below:

### 7.1 Powys Maternity Service



Powys Maternity service has embedded the Civica PREMS (Patient Reported Experience Measure) data collection platform in their work, with six surveys currently active to collect feedback relating to care at various stages of the pregnancy journey from booking until discharge, a survey for partner/co-parent as well as a survey for the provision of Solihull antenatal classes. Invitations to complete four the surveys are automatically text to individuals at certain points in their care, and two others are optional surveys. In addition to the Civica surveys, feedback is also collected from women who transfer in labour or shortly after birth via a separate Forms survey.

#### Newtown Birth Centre

*I have/ are enjoying every moment under Newtown midwifery services. I have felt supported through all three of my pregnancies and my current pregnancy. I couldn't be happier, and my midwife is amazing. Definately would recommend this service they have listened to me and support me through pregnancy, labour and post baby. They have treated me like an individual and made me and my husband feel like we are important and listen to.*

#### Canolfan eni Drenewydd

*Rwyf wedi'yn mwynhau pob eiliad dan wasanaethau bydwreigiaeth y Drenewydd. Rwy'n teimlo fy mod wedi cael fy nghefnogi trwy'r tri beichiogrwydd a'm beichiogrwydd presennol. Ni allwn fod yn hapusach, ac mae fy mydwraig yn anhygoel. Byddaf yn sicr yn argymhell y gwasanaeth hwn, maen nhw wedi gwrandio arnaf ac yn wedi fy nghefnogi trwy'r beichiogrwydd, yr enedigaeth ac ar ôl y babi. Maen nhw wedi fy nhrin fel unigolyn ac wedi gwneud i mi a fy ngŵr deimlo ein bod ni'n bwysig ac yn gwrandio arnom.*

The surveys consistently show that people feel listened to, and that their care reflects what is important to them – 98% of respondents have said they were treated with kindness and understanding during their pregnancy, 96% have had enough information to make decisions about labour and birth and 91% were extremely likely or likely to recommend the service to others. The service is exploring with Civica the ability to pull responses straight through to the service dashboard for review. The service will also be developing 'You said, we did' responses to demonstrate learning from feedback received. Results from all surveys, including any comments provided, which are now shared monthly to teams and on social media as posters.

### 7.2 Powys Living Well Service (PLWS)

Powys Living Well Service (PLWS) have embedded the Civica PREMS (Patient Reported Experience Measure) data collection platform in their work, with four surveys currently active to collect feedback relating to one-to-one appointments, group programmes, digital support sessions and experience of e-learning. Invitations to complete the

surveys are automatically emailed to individuals after their one-to-one appointments, and we see a strong response rate.

The surveys consistently show that people feel listened to, and that their care reflects what is important to them – over 80% of respondents have said that every effort was made to listen to the things that matter most to them about their health issues. Surveys are promoted alongside PROMS collection at the end of group programmes and have proved to be valuable in understanding how people feel about the content and delivery style, with feedback influencing future development work. Results from all surveys, including any comments provided, are shared at regular team meetings.

### **7.3 Patient Stories**

Development of a library of patient stories to support learning, improvement along with team meetings, Board and Committee has been an area of focus during 2023/24. NHS Executive have provided national training which PTHB were fortunate to be selected to attend. The production of patient stories will support further insight to staff/patients/carers/Board members of the experiences both negative and positive that impact those in receipt of care along with close to them. Triangulation of experience intelligence will continue to support and influence decisions made in the health board.

### **8.0 Recommendations from external reviews and inspections**

Thematic review of HIW Inspections carried out during 2023/24 has been completed. Findings outlined thematic learning which has been shared across all wards within the community Hospitals.

In summary from the inspections for Claerwen, Adelina Patti, Epynt, Y Bannau, Bryn Heulog and Graham Davies Ward, the following was identified:

#### Quality of Patient Experience

- Staff provided respectful and dignified care.
- Patients were encouraged to be active and were given equipment to help them walk and move.
- Occupational therapists and assistants worked well with patients.
- Initiatives were introduced to help care for patients living with dementia.
- Patients expressed satisfaction with the care and treatment received.
- Staff interactions with patients were dignified and respectful.
- Some aspects of the environment required improvement.

#### Delivery of safe and effective care

- Staff demonstrated commitment to providing safe and effective patient care.
- Suitable equipment was available and used to prevent pressure sores and falls.
- Medication management and storage were handled safely and effectively.
- A pharmacy technician provided valuable support to the ward staff.
- The All-Wales Hospital Nutrition Care pathway standards were generally met.
- On-site food preparation was well-presented and appetizing.
- Patient records were up-to-date and well-completed.

- Weekly checks on emergency equipment were conducted.
- The ward environment was clean and accessible, with appropriate equipment.

Areas for improvement:

- Infection control, medication management, and record keeping required attention.
- Storage space was lacking, and better communication between staff was necessary.
- Blood transfusion policy was out of date and staff required training in some areas.
- Education in the areas of Sepsis, NEWS scoring, care of the deteriorating patient, blood transfusion and inpatient falls was noted to require focus by the health board.

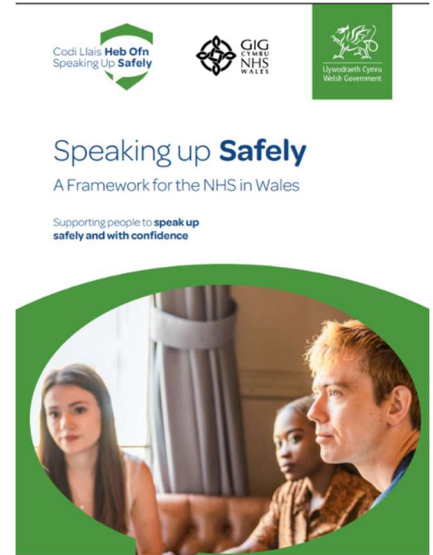
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## 9.0 Speak up Safely Framework

The Speaking up Safely Framework was circulated to NHS Wales Chief Executives at the end of August. The purpose was to support health boards to reflect on their quality and safety systems in light of high profile cases, which served as a stark reminder of the requirement to ensure that everyone working in the NHS feel safe and confident to speak up about anything that gets in the way of delivering safe, high-quality care.

In response the health board established a working group to undertake a self-assessment using the framework and benchmarking against current processes in place. The following actions have been undertaken by the group:

1. Getting Feedback from staff through the chat to change group along with Microsoft forms.
2. Intranet page providing further guidance and support to staff to raise a concern anonymously if required. Along with signposting for support.
3. The Task and Finish Group includes membership of staff side representatives.
4. An Independent Member of our Board has been selected as a Speaking Up Safely Champion.



## 10.0 Quality Management System: Integrated Quality & Performance Framework (IQPF)

Powys Teaching Health Board (PTHB) is responsible for planning, providing and commissioning healthcare services to improve the health and wellbeing of the people of Powys. To ensure that the best possible health and wellbeing outcomes are achieved for Powys residents and responsible patients. To achieve this the health board strategically integrates various components to enhance quality and performance while aligning with the vision of "A Healthier Wales.", these components are:



Integrated Medium Term Plan (IMTP):

- The IMTP 2023-2026 serves as a statutory duty for all Welsh health boards. It spans three years and aims to achieve a financial break-even position while improving health and well-being for the Powys population.
- The IMTP aligns performance, service, workforce, and financial planning, ensuring a holistic approach to healthcare delivery.

## NHS Wales Duty of Quality:

The Duty of Quality, mandated by the Health and Social Care (Quality and Engagement) (Wales) Act 2020, compels NHS organisations to:

- Foster a culture of quality within their operations.
- Improve health services and outcomes continually.
- Actively monitor progress in quality improvement efforts and share this information transparently with the population.

## Welsh NHS Performance Framework:

- The NHS Wales Performance Framework provides a structured approach to measuring and reporting performance in healthcare.
- It sets expectations for health boards, including Public Health Wales, to report progress against key corporate-level information, service delivery, and their role in supporting the wider NHS system.

## Minimum Data Set (MDS):

- Health organisations, including PTHB, are required to complete an MDS comprising service, financial, and workforce information.
- The MDS provides assurance on the robustness of plans and ensures alignment with statutory duties and ministerial targets.

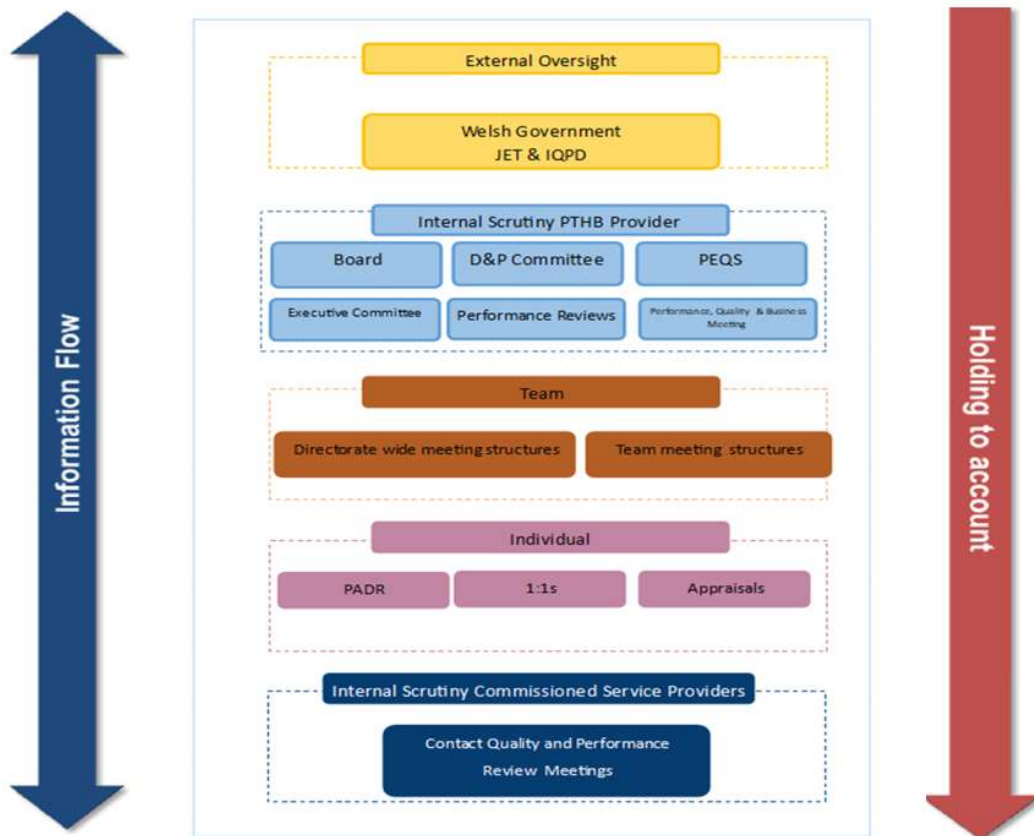
## Strategic Alignment:

- PTHB's plan takes a whole-system approach, recognizing collaboration with partners, including the third sector, primary care contractors, social care colleagues, and other healthcare providers across Wales and England.
- By integrating these frameworks, PTHB aims to balance quality, performance, and financial duties, ultimately working towards the Welsh Government's vision of "A Healthier Wales" and improved patient outcomes.

Our existing quality, performance, and planning arrangements provide a solid foundation for managing performance effectively. This revised framework aligns and emphasises the principles of the Duty of Quality, aiming for a significant improvement in informed performance management. It fosters a culture of positive performance improvement, supports the Integrated Medium-Term Plan (IMTP), manages risks, and assures the Board of successful delivery. Ultimately, the framework assesses quality and performance across key domains, including access, finance, workforce, culture, safety, and patient experience.

The key to the success of our Quality Management System is ensuring and enabling everyone across the health board to be engaged and dynamic in ensuring quality is at the heart of everything we do:

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Through the development of our Quality Management System, we aim to:

- Enable a positive, psychologically safe and Just quality culture through the provision of compassionate leadership.
- Enable a shared responsibility and voice for Quality to ensure the provision of safe, timely, effective, efficient, equitable and person-centred care.
- Embed Quality Driven Decision Making at all levels of the health board.
- Demonstrate a quality approach based upon learning and continuous improvement.

### 10.1 Integrated Quality and Performance Group

The Integrated Quality & Performance Group (IQPG) has been created to provide assurance using a variable meeting frequency approach dependent on directorate health board service provision.

Key approach is that Directorates are engaged with a variable timescale dependant on service provided with the aim to reduce demand on their capacity.

Directorates with patient responsible provider services will provide assurance via monthly engagement.

- Directorate of Primary Care, Community and Mental Health
- Directorate of Nursing, Quality, Women and Family health

Quarterly assurance review meetings schedule will include:

- Directorate of Allied Health Professions, Health Sciences and Digital

- Directorate of Planning, Performance and Commissioning
- Directorate of Public Health.

Six-monthly IQPG assurance review meetings encompass all health board directorates including those with corporate only functions and replaced the 2023/24 bi-annual directorate review approach.

To provide enhanced assurance of historic and future quality and performance an annual review meeting will be undertaken (Q1 of the FY) this will provide a summary of achievement and challenge for the previous year assessing progress of delivery including risks and escalations. Further it will encompass celebrations, achievements, and a look forward to the current year.

## 10.2 Commissioned Services - Commissioning Performance & Assurance via Clinical Quality Performance and Review Meetings (CQPRM)

For services PTHB commissions, the Clinical Quality Performance and Review Meetings (CQPRMs) are a vital mechanism to the way in which the health board seeks assurance on the performance of its commissioned services. This revised framework, now incorporating the previous Commissioning Assurance Framework (CAF), will monitor performance monthly against the core areas of this framework:

	Coverage	Description
Core Areas	Access to Care and Timeliness	Assurance on timely and appropriate access to health care services to achieve the best health outcomes within agreed targets.
	Quality & Safety *	Assurance against national and locally set quality and safety measures of care ensuring services are safe, personal, effective and continuously improving.
	Finance & Activity	Assurance that services are improving efficiency and productivity and financial plans are being delivered.
	Patient Experience * & Effectiveness *	Assurance through listening and responding to patient and carer feedback along with complaints and concerns and the development of PROMS and PREMS.
	Finance & Value	Prudent or value-based health care
	Governance & Risk Management	Reporting progress against audit recommendations, the management of risk registers and links to Board Assurance Framework (BAF).
<b>* Alignment to Clinical Quality Framework Approach (Darzi approach)</b>		

Through the CQPRM process, the following are examples of issues that have been highlighted:

Provider	Specialty	Description
CTM SLA in-reach	Endoscopy and General Surgery	Severe reduction in capacity delivered which has adverse impact on JAG accreditation. Mitigating actions being explored at Executive level between PTHB and CTMUHB.

WVT	Cataract pathway	Worcestershire Acute Hospitals NHS Trust providing mutual aid to support cataract pathways in WVT.
	Multiple specialties	CQC inspection December 2023 highlighted overall rating of requires improvement.
SATH	Cancer	SATH in NHSE Tier 1 – weekly monitoring calls with NHSE.
	Multiple specialties	CQC report 2021 highlighted overall rating of Inadequate. Reports presented to SATH Quality and Assurance Committee and discussed at CQPRMs.
	Maternity Services	Independent Maternity Services review at SATH led by Donna Ockenden published in Dec 2020. Committee of SATH Board meets monthly to discuss progress against action plan which is noted and discussed at CQPRM.

All elements of the performance information sought and reported through the CQPRM meetings will be utilised within organisational performance management processes. A monthly commissioning report is produced to provide an integrated performance update across each provider the health board commissions from. A dashboard will be created for each provider that will feature overall performance information across the core access domains selected alongside a Powys specific sub-set where information allows. This will give greater insight into the services residents are receiving out of county versus the resources deployed. It will also provide an update to report progress against strategic plans.

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Health Board

**Agenda item: 2.2**

<b>Patient Experience, Quality &amp; Safety Committee</b>		<b>DATE:</b> <b>05 September 2024</b>
<b>Subject:</b>	Powys Teaching Health Board Safeguarding Annual Report 2023-2024	
<b>Approved and presented by:</b>	Claire Roche Executive Director of Nursing, Quality, Womens and Family Health	
<b>Prepared by:</b>	Jayne Wheeler Sexton Assistant Director of Nursing, Safeguarding	
<b>Other Committees and meetings considered at:</b>	PTHB Safeguarding Strategic Group PTHB Executive Committee	
<b>PURPOSE:</b>		
To present to the Patient Experience, Quality & Safety Committee Powys Teaching Health Board's Safeguarding Annual Report for 2023-2024.		
<b>RECOMMENDATION(S):</b>		
The Patient Experience, Quality & Safety Committee is asked to <b>APPROVE</b> the report for publication on the Health Board's website.		
<b>Approve/Take Assurance</b>	<b>Discuss</b>	<b>Note</b>
Y	N	N

<b>ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:</b>		
1. Focus on Wellbeing	Y	PTHB Safeguarding Annual Report presents the key areas of development and achievement which have supported the Health Board to meet its statutory responsibilities for safeguarding during 2023/24, including training and support of staff in meeting these obligations.
2. Provide Early Help and Support	Y	
3. Tackle the Big Four	N	
4. Enable Joined up Care	Y	
5. Develop Workforce Futures	N	
6. Promote Innovative Environments	Y	
7. Put Digital First	Y	
8. Transforming in Partnership	Y	

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## EXECUTIVE SUMMARY:

PTHB Safeguarding Annual Report presents the key areas of development and achievement which have supported the Health Board to meet its statutory responsibilities for safeguarding during 2023/24. 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 are highlighted throughout 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 Health Board driving change and improvements throughout 2023/24.

## DETAILED BACKGROUND AND ASSESSMENT:

### 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 Safeguarding 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 2023/24 and identifies safeguarding priorities for 2024/25. 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 to act in a timely way on concerns raised about the welfare of people who reside, work or visit Powys.

### 2. The Safeguarding Maturity Matrix

2.1 The Safeguarding Maturity Matrix is a self-assessment tool which enables scrutiny of the effectiveness, innovation, quality, learning and risks within safeguarding. There are 6 Standards within the assessment tool;

- i. Well Led, Effective Leadership & Governance.
- ii. Confident & Competent Workforce.
- iii. Person Centred.
- iv. Learning Culture.

- v. Multi agency Partnership Working.
- vi. Responsive, Resilient & Purposeful.

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, horizon scan, informs the National Safeguarding Service key priorities, annual plan, and shares best practice.

Powys Teaching Health Board's 2023-2024 Safeguarding Maturity Matrix Improvement Plan is reported on quarterly in PTHB Safeguarding Strategic Group. Most of the actions have been completed, any that remain incomplete will be carried over into 2024-2025.

### **3. Key Highlights**

#### **3.1 Joint Inspection of Child Protection Arrangements (JICPA)**

Between 16 - 20 of October 2023, Care Inspectorate Wales (CIW), His Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS), Healthcare Inspectorate Wales (HIW) and Education and training inspectorate for Wales (Estyn) carried out a Joint Inspection of Child Protection Arrangements (JICPA) in Powys. The inspection focused on multi-agency responses to abuse and neglect of children in Powys.

The final JICPA Report was published on 1 February 2024 and can be accessed via the Healthcare Inspectorate Wales website: <https://www.hiw.org.uk/>

Strengths and areas for improvement were identified for the partnership and individual agencies. A whole system improvement plan has been developed and being monitored within Powys Local Multi-Agency Safeguarding Operation Group which reports quarterly to the Mid and West Wales Regional Safeguarding Board.

The JICPA identified four specific Actions for PTHB, these are being monitored within the Safeguarding Operational Group which reports quarterly to the Safeguarding Strategic Group.

Throughout the JICPA all services within the health board fully cooperated and worked to meet the tight deadlines. Positive working relationship with the other agencies involved in the JICPA enabled the coproduction and delivery of a multi-agency presentation to the inspectors, analysis of the deep dive safeguarding cases and full participation in the practitioner focus groups.

#### **3.2 Restorative Safeguarding Supervision**

During 2023, four PTHB Safeguarding Lead Practitioners attended a four-day Restorative Supervision course, with the aim of improving their knowledge and skills around how best to support and advise those they work with by; providing effective safeguarding supervision, promoting a safe and supportive environment, while being able to respond to the increasing demands on the safeguarding team for quality safeguarding supervision in various formats.

Attending the course inspired our team to review current practice and make changes using their new skills and knowledge.

### **3.3 Unaccompanied Asylum-Seeking Children (UASC)**

As part of the Looked After Childrens Nurse role, they are actively involved in the resettlement programme for our unaccompanied asylum-seeking children. We have identified addition support is required to ensure the children are registering with a General Practice, have access to preliminary blood screening and the immunisations they require. We have developed documents to support the carers and share information with GPs as outlined in Welsh Government Guidelines. Resource packs have also been developed to support these vulnerable children around healthy lifestyle choices, meal planning, budgeting and sleep support.

Many of our unaccompanied children travel in groups at night and sleep during the day, when they arrive in the UK most are unable to settle and frequently suffer from nightmares. Those who have spent time in detention centres or makeshift camps also experience disturbed sleep. These children have difficulties in falling and staying asleep at night, in waking in the morning and staying awake during the day. This contributes to poor concentration and a lack of emotional stability. We identified a children's charity in London that provided sleep packs for our children and collaboratively with Childrens Services we collected 40 packs for distribution across Powys.

### **3.4 Rolling out Routine Enquiry in PTHB Minor Injury Units (MIU)**

PTHB Safeguarding Team & MIU staff have worked together to introduce Routine Enquiry into all MIUs in Powys, which was launched in March 2024. Routine Enquiry sets a minimum standard of enquiry about domestic abuse which registrants must ask all adults who attend Powys MIUs.

A standard operating process has been developed and promoted within each MIU. New paperwork enables the team to undertake quarterly audits to monitor compliance with the standards.

Domestic abuse posters have been created and are visible in all MIUs. All staff have received new lanyards to enable easy access to domestic abuse information. MIU Staff felt that the lanyards were particularly helpful in practice and thought the posters being displayed in toilets pan Powys is an excellent resource for both staff and the public.

## **4. Safeguarding Priorities for 2024/25**

- i. Maintain the level of access staff have to the Safeguarding Team
- ii. Continue to work on improving compliance with Level 3 safeguarding training
- iii. Continue to work with Informatics to develop systems to improve the efficiencies and effectiveness of data collection and analysis
- iv. Implement the learning from the JICPA and Child Practice Review
- v. Implement the new RL Datix Once for Wales Management System to Report Safeguarding Concerns to the Local Authority.
- vi. Develop a Business Case to enable the MCA improvement work to continue, including developing our own Best Interest Assessors

- vii. Work with the Regional VAWDASV Survivor Panel to ensure survivor experiences help shape existing and new VAWDASV processes within the health board.
- viii. With the NHS Safeguarding Service develop a Safeguarding Strategy that can be adapted to each health board and trust
- ix. Audit service users regarding experiences of health involvement in the safeguarding process.
- x. Complete process mapping of the management of sexual & violent offenders using healthcare.
- xi. Continue to influence the safeguarding agenda at a local, regional and national level.

In summary, the Safeguarding Annual Report highlights the vast and varied safeguarding agenda and how the Safeguarding Team continue to engage with our partners locally, regionally and at a national level. The service is both visible and accessible across the Health Board and has been able to drive improvements throughout 2023/24.

**NEXT STEPS:**

Publication on the website.

**IMPACT ASSESSMENT**

This section must of completed for all strategic organisational decisions including approval of health board policies.

**QUALITY:**

	No impact	Negative	Positive	Both	
Safe	x				A Quality Impact Assessment must be undertaken for all reports requesting approval, ratification or decision in line with health board Duty of Quality processes (under development). In this space you should provide supporting narrative to explain the potential adverse and positive impacts that may arise from a decision being taken, and the steps being taken to mitigate adverse impacts. Where required, the full Quality Impact Assessment should be available as a supporting document to inform the decision making process.
Timely	x				
Effective	x				
Efficient	x				
Equitable	x				
Person Centred	x				
Workforce	x				
Leadership	x				
Culture	x				
Information	x				
Learn, Improve, Research	x				
Whole Systems Approach	x				

**EQUALITY:**

	No impact	Negative	Positive	Both	
Age	x				An Equality Impact Assessment must be undertaken for all reports requesting approval, ratification or decision in line with health board Equality Impact Assessment policies and procedures (CGP009). In this space you should provide supporting narrative to explain the potential adverse and positive impacts that may arise from a decision being taken, and the steps being taken to mitigate adverse impacts. Where required, the full Equality Impact Assessment should be available as a supporting document to inform the decision making process.
Disability	x				
Gender reassignment	x				
Marriage / civil partnership	x				
Pregnancy / maternity	x				

Race	x			
Religion or Belief	x			
Gender	x			
Sexual Orientation	x			
Welsh Language	x			
Socio-economic status	x			
Social exclusion	x			
Carers	x			

**RISK ASSESSMENT:**

	Level of risk identified			
	Very Low (0-3)	Low (4-8)	Moderate (9-12)	High (15-25)
Clinical	x			
Financial	x			
Corporate	x			
Operational	x			
Reputational	x			

A Risk Assessment should be undertaken for all reports requesting approval, ratification or decision in line with health board Risk Management Framework CGP005. In this space you should briefly describe the key risks and the steps being taken to manage them, and also how these risks relate to the Board's stated Risk Appetite.

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# Powys Teaching Health Board Safeguarding Annual Report 2023 - 2024



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# Foreword

I am delighted to present the Safeguarding Annual Report 2023/24 for Powys Teaching Health Board.

The report illustrates our commitment to Safeguarding as an Organisation and the dedication and professionalism of our staff. This was particularly evident during the Autumn of 2023, when we were subject to a Joint Investigation into Child Protection Arrangements. I want to take this opportunity to thank the many teams in the Health Board who supported the Inspectorates and enabled a positive learning opportunity.

While the report highlights safeguarding performance, achievements and challenges during 2023/24, it also illustrates the Health Boards maturing safeguarding journey over several years. This includes strengthening our safeguarding processes, building and supporting a confident and competent workforce, ensuring safeguarding support and advice is available to all our staff, building and maintaining key multiagency partnerships and embracing the health boards overarching learning culture by sharing safeguarding messages and learning with a focus on quality improvement.

As the safeguarding landscape continues to change and grow, the safeguarding service will evolve to ensure safeguarding remains part of the Health Boards core business

Claire Roche

Executive Director of Nursing, Quality, Women & Family Health



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## Introduction

Powys Teaching Health Board (PTHB) is responsible for providing health care and well-being services for approximately 133,600 people living throughout the area of Powys, this includes health services both provided by and commissioned on behalf of PTHB.

PTHB employs 2544 members of staff which include 513 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 several 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 can 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 2023-2024 and identifies safeguarding key priorities for 2024-2025. The report is aligned to the NHS Wales Safeguarding Maturity Matrix six Standards.

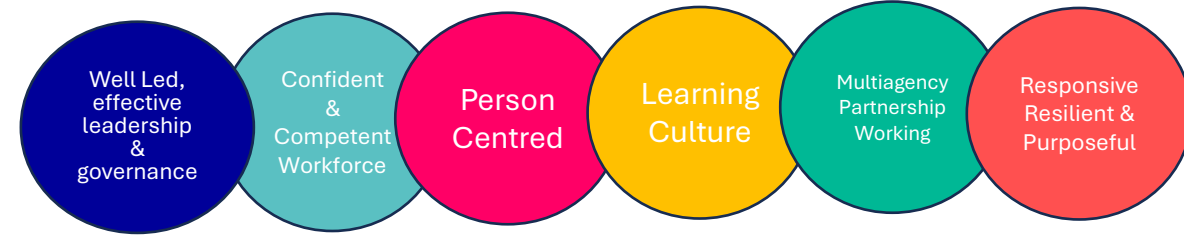
The Safeguarding Service acknowledges the need to build on what has already been achieved, to ensure PTHB and all contracted services fully meet their statutory responsibilities for preventing harm and act in a timely way on concerns raised about the welfare of people who reside, work or visit Powys.

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# NHS Wales Safeguarding Maturity Matrix

NHS Wales has an essential role in ensuring that all adults and children receive the care, support and services they need 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 enables scrutiny of the effectiveness, innovation, quality, learning and risks within safeguarding. There are 6 Standards within the assessment tool;



- Well Led, Effective Leadership & Governance.**
- Confident & Competent Workforce.**
- Person Centred.**
- Learning Culture.**
- Multi agency Partnership Working.**
- Responsive, Resilient & Purposeful.**

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, horizon scan, informs the NHS Wales National Safeguarding Service key priorities, annual plan, and shares best practice.

Powys Teaching Health Board's 2023-2024 Safeguarding Maturity Matrix Improvement Plan has been reported on quarterly to PTHB Safeguarding Strategic Group. Most of the actions have been completed, any that remain incomplete will be carried over into 2024-2025



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## Well Led, Effective Leadership & Governance

### **SMM Standard; Well Led- Effective Leadership & Governance**

Safeguarding is well led and governed in the organisation with evidence of visible and approachable leadership, that is structured at every level. There is a clear safeguarding strategy with well-defined quality objectives that evidences areas of strength and risk and is underpinned by feedback from team members and people who use the services.

#### **Within this section;**

Governance and Lines of Accountability

Powys Teaching Health Board Safeguarding Team Structure

Powys Teaching Health Board Safeguarding Strategic Group Governance

Safeguarding Legislation and Drivers

PTHB Safeguarding Policies, Protocols & Guidance Documents

Inspections and Audits

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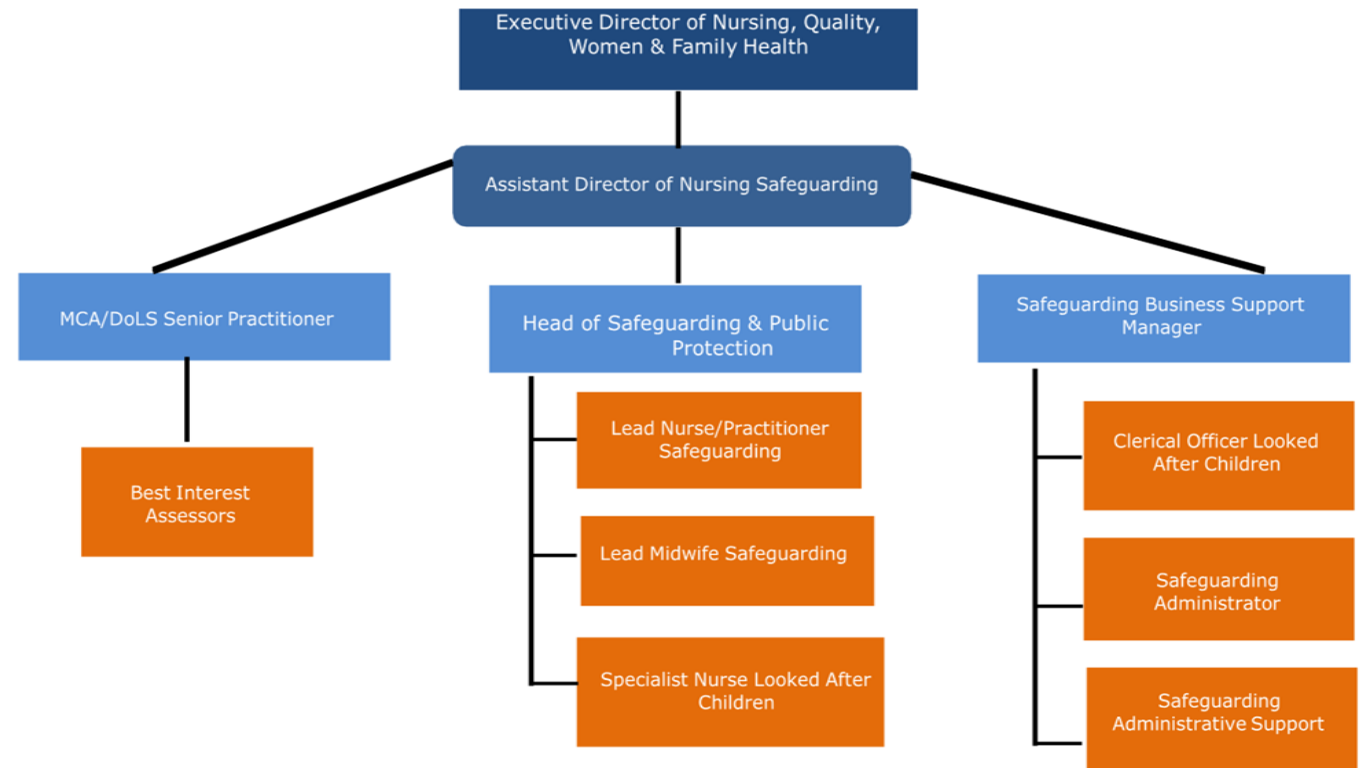
## Governance & Lines of Accountability

The Chief Executive assumes overall responsibility for safeguarding and the Executive Director of Nursing, Quality, Women & Family Health is the delegated Executive Lead for Safeguarding and Public Protection. The Health Board's Vice Chair is the designated Lead Independent Member for children and young people services with responsibility for providing oversight and scrutiny of the broader safeguarding agenda. PTHB has in place a clear reporting structure for safeguarding arrangements. The Executive Director of Nursing, Quality, Women & Family Health as Lead, provides strategic direction and reports on safeguarding and public protection matters to the Board

### PTHB Governance Reporting Structure

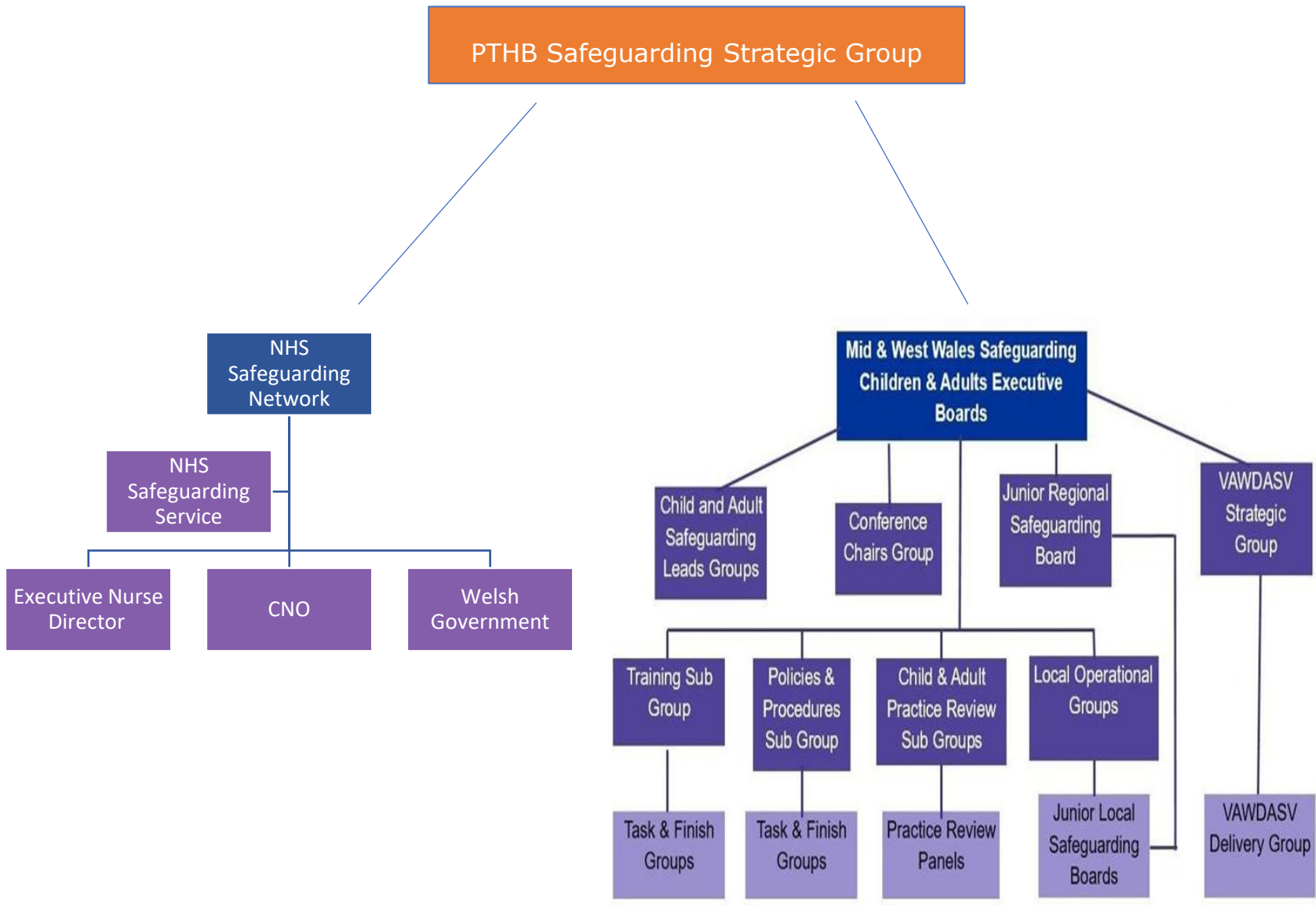


### Powys Teaching Health Board Safeguarding Team Structure



# Powys Teaching Health Board Safeguarding Strategic Group

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



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## Safeguarding Legislation and Drivers

Duties and responsibilities for safeguarding are enshrined in international and national legislation which must be incorporated into NHS organisations and safeguarding practice. These include;

Violence Against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015	Mental Health Act 2007	Mental Capacity Act 2005	Disclosure & Barring Service Code of Practice	Mental Capacity Act 2005	Serious Violence Duty 2022
Children Act 1989 & 2004	United Nations Convention on the Rights of the Child UNCRC	Wales Safeguarding Procedures 2019	Domestic Abuse Act 2021	WG National Strategy on VAWDASV 2022-26	Modern Slavery Act 2015
Working Together to Safeguard Children 2018	Protecting Children & Young People, GMC 2012	Safeguarding Children & Young People Intercollegiate Document: Roles & Responsibilities for Health Care Staff 2019	PREVENT Duty 2023	FGM Act 2003	Duty of Quality 2023
Adult Safeguarding: Roles and Competencies for Health Care Staff 2018	Social Services & Well-being (Wales) Act 2014	The Well Being of Future Generations (Wales) Act 2015	Counter Terrorism and Security Act 2015	Human Rights Act 1998	Children Wales Act 2020

## PTHB Safeguarding Polices, Protocols & Guidance Documents

Powys Teaching Health Board has Policies, Protocols and Guidance documents that support and underpin safeguarding processes within the Health Board. All are reviewed annually to ensure they remain up to date. [PTHB Safeguarding Policies and Guidance](#)



SGP051 Significant Event Chronology SOP	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
SGP002 – Safeguarding Supervision Protocol	SGP049 Mental Capacity Act	SGP047 Policy for Children & Adults who “Was Not Brought” to health appointments	

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## Inspections and Audits: Joint Inspection of Child Protection Arrangements (JICPA)

Between 16th and 20<sup>th</sup> of October 2023, Care Inspectorate Wales (CIW), His Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS), Healthcare Inspectorate Wales (HIW) and Education and training inspectorate for Wales (Estyn) carried out a Joint Inspection of Child Protection Arrangements (JICPA) in Powys. The inspection focused on multi-agency responses to abuse and neglect of children in Powys.

### The scope of the JICPA was to review:

- ❖ the response to allegations of abuse and neglect at the point of identification
- ❖ the quality and impact of assessment, planning and decision-making in response to notifications and referrals.
- ❖ the protection of children aged 11 and under at risk of abuse and neglect.
- ❖ the leadership and management of this work
- ❖ the effectiveness of the multi-agency safeguarding partner arrangements in relation to this work

### The final JICPA Report was published on 1st February 2024 [Powys JICPA Report - Final.pdf](#)

Strengths and areas for improvement were identified for the partnership and individual agencies. A whole system improvement plan was developed and will be monitored within Powys Local Multi-Agency Safeguarding Operation Group which reports quarterly to the Mid and West Wales Regional Safeguarding Board.

The JICPA identified four specific actions for PTHB which will be managed within the Safeguarding Operational Group and will report progress quarterly to PTHB Safeguarding Strategic Group.

Throughout the JICPA all services within the health board fully cooperated and worked to meet the tight deadlines. Positive working relationship with the other agencies involved enabled the coproduction and delivery of a multi-agency presentation to the inspectors, analysis of the deep dive safeguarding cases and full participation in the practitioner focus groups

## Inspections and Audits: Annual Safeguarding Audit of Children Not Brought to Appointments

### Aim

To provide assurance that Heads of Service and Operational Managers are auditing/monitoring the use of the WNB/No Access Visits Policy SGP 047 Policy for Children and Vulnerable Adults/Adults at risk who "Was Not Brought" to Health Appointments

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### Background

A version of the Policy for Children and Vulnerable Adults/Adults at Risk who "Was Not Brought" (WNB) to health appointments, previously referred to as Did Not Attend (DNA) health appointments to include No access Visits (NAV) has been in place since 2013. There was a significant rewrite and relaunch of the Policy in November 2021 which clarified the responsibility for addressing a missed appointment is placed on the staff member whose appointment was missed. A risk assessment was added to help staff identify the impact of the missed appointment on the child or adult at risk.

Practitioners are reminded of the policy in all safeguarding supervision sessions, it has been promoted in all team meetings attended by PTHB Safeguarding Team & there is a modular learning video on PTHB safeguarding intranet page, along with guidance to support practitioners in documenting a "Was Not Brought" episode. The Policy states that Heads of Service and Operational Managers have a responsibility to Audit WNB and No Access Visits monthly. Service leads will need to give assurance to the Strategic Safeguarding Group that this Audit process is in place.

### Results

15 Managers/Heads of Service were approached and 12 responded confirming they are completing an audit of WNB. 10 groups reported using a 365-audit tool which counts the number of WNB entries in the record. 2 were using a manual trawl through records in addition to the audit tool.

An issue with the audit tool only counting recorded WNB was identified by some Heads of Service/Operational Managers with 2 following this up with a quarterly manual trawl through their records. Others were examining how best to address this issue.

### Actions

Audit shared with Safeguarding Operational Group for discussion. Contact those who did not respond to the audit and explore if they were having challenges in developing this audit was actioned. The WNB Policy to be updated explaining the process for documenting the WNB/No Access appointment and re shared in the Safeguarding Operational Group. WNB to continue to be raised at any opportunity by the Safeguarding Team allowing staff to ask questions and clarify any areas they feel unclear about. WNB Document to be reviewed and updated to reflect issues identified by staff or where further clarity is required.

## Inspections and Audits: Quarterly Safeguarding Team Audits, Reviews and Spot Checks

During each quarter throughout 2023–2024 the safeguarding team completed quarterly audits, reviews and spot checks. The outcome of this activity informs what is working well and where improvements, developments or changes can be made. The Audits, reviews and spot checks include;

Themes from Supervision

Mental Capacity Audit

DoLS Audit

Significant Event Chronology

Routine Enquiry in Health Visiting

Routine Enquiry in Midwifery

Quality Assure LAC Health Assessments

Multi Agency Risk Assessment Conference Information Request

Training Evaluation

Safeguarding Advice Tracker

Practitioners Feedback about Safeguarding Services

Children Looked After & Foster Carer Feedback

Safer Sleep Audit

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## Inspections and Audits:

Care Inspectorate Wales (CIW) Rapid Review of Child Protection 2023 Final Report Sept 2023 [Link](#)

National Independent Safeguarding Board National Thematic Review of 33 Child Practice Reviews Undertaken in Wales [Link](#)

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### CIW Rapid Review of Child Protection

In December 2022 Welsh Government asked CIW to review child protection arrangements across Wales. Working alongside colleagues in Healthcare Inspectorate Wales and Estyn, the review focused specifically on the **extent to which current structures and processes in Wales ensure that children's names are appropriately placed on, and removed from the Child Protection Register when sufficient evidence indicates that it is safe to do so.**

### National Independent Safeguarding Board National Thematic Review of 33 Child Practice Reviews Undertaken in Wales

The NISB commissioned this review. The report provides a robust basis for national shared learning and constructive debate about how best to strengthen safeguarding effectiveness for children at risk across Wales and to further reduce the likelihood of significant harms occurring in future. We also believe that the learning it identifies, is highly transferrable to the other nations of the UK.

**Both reviews make several recommendations across the partnership.**

**PTHB Safeguarding Team have undertaken a review of the recommendations and where gaps are evident developed an improvement plan which is implemented and monitored within the PTHB Safeguarding Practice Improvement Group**

## 2023/24 Improvement and Development


- ❖ Safeguarding Supervision App developed, and compliance moved onto ESR
- ❖ Development of an APP to collate and report Child Protection Medical Data
- ❖ Safeguarding Internet page updated [Safeguarding & Public Protection - Powys Teaching Health Board \(nhs.wales\)](https://www.nhs.uk/healthboards/powys-teaching-health-board)
- ❖ Safeguarding Team feedback QR Code developed
- ❖ Safeguarding Team linked with Workforce & Organisational Development to support Inspiring Nurses Programme

## 2024/25 Improvement Plan

- ❖ With the continued support from Informatics develop a Safeguarding Data APP to improve the efficiency and effectiveness of data
- ❖ Progress Actions from the JICPA
- ❖ Progress Actions from all Reviews
- ❖ In collaboration with the NHS Safeguarding Service develop a Safeguarding Strategy that can be adapted to each health board and trust
- ❖ Work with the RL Datix Team and the National Safeguarding Service to implement the Once for Wales Safeguarding Reporting process

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## Confident & Competent Workforce

### **SMM Standard; Confident and competent Workforce**

There is evidence of a confident and competent workforce that are safe to work with vulnerable people. DBSs are completed and monitored. Safeguarding training and supervision is in place. Individuals know how to report and escalate safeguarding concerns, and concerns about safe practice.

#### **Within this section;**

Safeguarding Supervision, Advice and Support

Safeguarding Training and Development

Safeguarding Processes

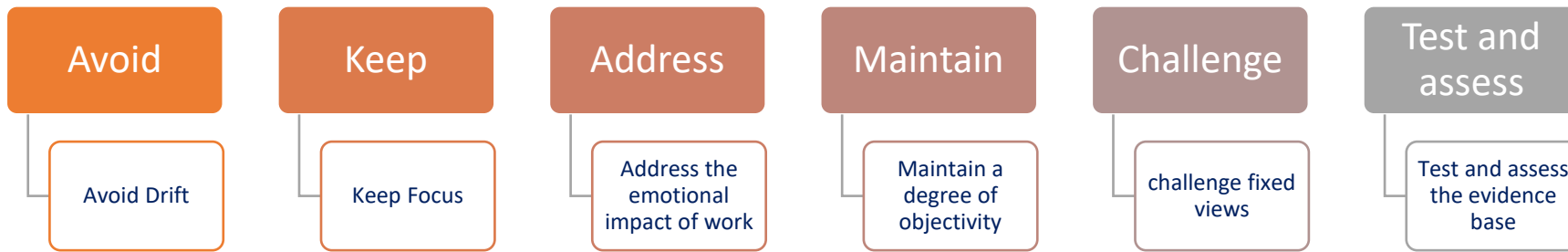
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# Safeguarding Supervision, Advice & Support

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

## Safeguarding Supervision should support to;



## Types of Safeguarding Supervision available to PTHB staff include;

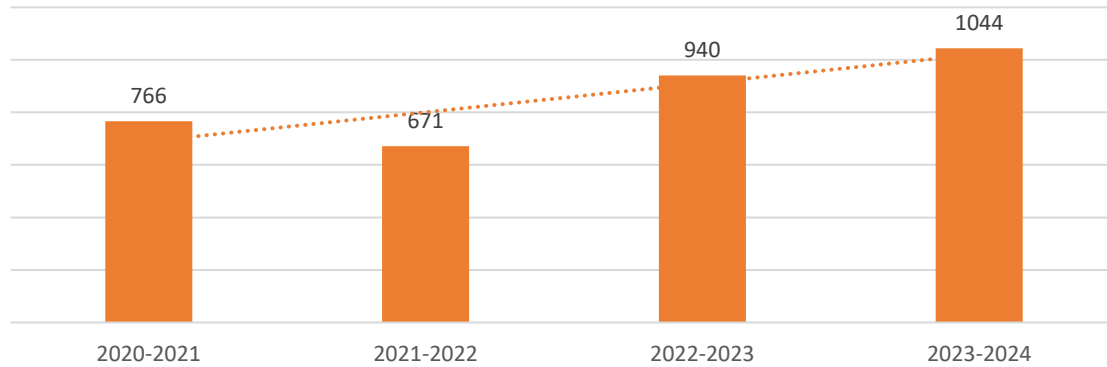


## Safeguarding Supervision, Advice & Support

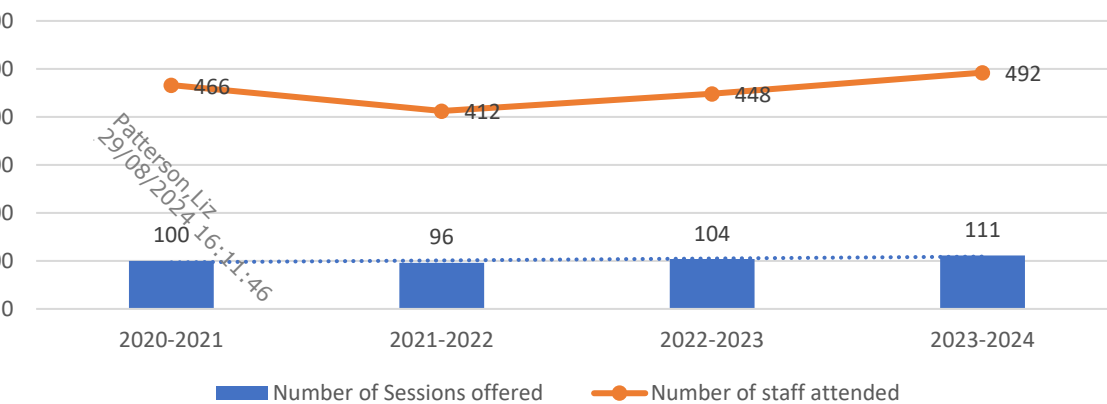
PTHB Safeguarding Hub is available to give supervision, advice, support and guidance on an ad hoc basis Monday to Friday 9am to 5pm

During 2023-2024, **1,044** calls were received into the Safeguarding HUB, this is a 27% increase since the HUB was introduced in 2021. The Safeguarding Leads on the HUB attended **378** Strategy Discussions with the Local Authority and Police Colleagues.

### Calls to PTHB Safeguarding Hub



### Safeguarding Group Supervision: Sessions offered & No of Staff Attended



## Practice Improvement: Safeguarding Supervision

### Restorative Safeguarding Supervision

During 2023, four PTHB Safeguarding Lead Practitioners attended a four-day Restorative Supervision course, with the aim of improving their knowledge and skills around how best to support and advise those they work with by, providing effective safeguarding supervision, promoting a safe and supportive environment, while being able to respond to the increasing demands on the safeguarding team for quality safeguarding supervision in various formats.

#### The Course Aims supported the Safeguarding Leads to:

- ❖ learn how to empower teams and individuals through coaching and supervision techniques.
- ❖ look at the quality of relationships to assist with the success and well-being of supervisees.
- ❖ explore the techniques to overcome barriers in communication
- ❖ be able to promote safeguarding as core business and offer supervision in an accountable process which supports, assures, and develops the knowledge, skills and values of an individual, group or team.

### Implementing a Change to Improve Quality

Attending the course inspired our team to review current practice and make changes using their new skills and knowledge. This includes:

- ❖ Reminding practitioners to prepare to share ongoing cases and/or previous experiences of safeguarding situations in group supervision & promote and use of the signs of safety model.
- ❖ Develop scenarios from Child & Adult & Domestic Homicide Reviews for use in group supervision when practitioners may not provide cases. This enables the process of learning from sharing cases and situations to be demonstrated, whilst also sharing lessons learnt from reviews.
- ❖ Encourage practitioners to share and reflect on the emotional aspects of working within safeguarding.

#### Feedback received from PTHB practitioners following Safeguarding Supervision:

*'I appreciate you using our safeguarding supervision session to breakdown my case. This helped me get a clear understanding of my client's situation and what steps I needed to make. It was also good to hear from others in the safeguarding group such as the lady from perinatal, who advised how their service could be of use, as well as the general support from others and acknowledgement of how difficult and complex this situation was'*

*Just a note to thank you for your time and for the clear and concise safeguarding advice, which was helpful in many ways.*

*Thank you (), your assistance is greatly appreciated.*

*It was an interesting and very informative group supervision session which has caused me to reflect and re-evaluate current cases.*

*I was particularly alerted to the reference to behaviour of carers - in not supporting pt's access to care, including attendances with remote working.*

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# Safeguarding Training & Development

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

During 2023-2024 the Safeguarding Team delivered a variety of training sessions over MS Teams

Additional multi agency training is circulated fortnightly across PTHB & further resources available on PTHB Safeguarding Intranet Page: [Safeguarding & Public Protection - Home \(sharepoint.com\)](#)

**4** Safeguarding Adults Level 3 sessions delivered to **191** staff

**17** Ask & Act training sessions delivered to **468** staff

**3** VAWDASV Group 3 training sessions delivered to **31** staff

**4** Safeguarding Children Level 3 sessions delivered to **146** staff

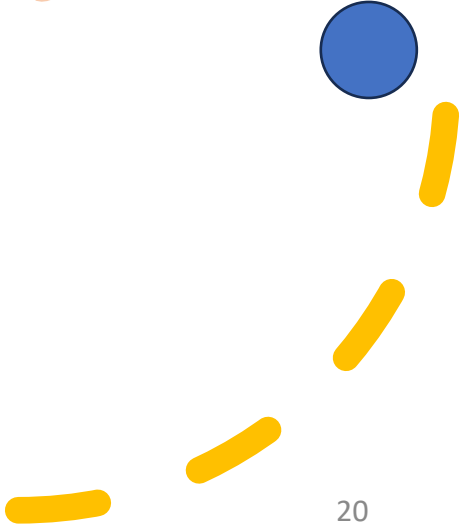
**2** Practice Learning Days delivered to **208** primary care staff (A&A)

**1** Childhood Injury sessions delivered to **28** multi agency staff

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

Level 3 adult and child safeguarding training has been reviewed in 2023 -24 with action taken to realign ESR, redesign the Safeguarding Level 3 Passport & put a system in place to send reminders to staff regarding non-compliance & an escalation pathway to managers

Indicator	Target	Q1	Q2	Q3	Q4
Safeguarding Adults L 1	85%	81%	87%	89%	89%
Safeguarding Adults L 2	85%	74%	85%	88%	90%
Safeguarding Adults L 3	85%	34%	33%	34%	40%
Safeguarding Children L 1	85%	83%	89%	89%	89%
Safeguarding Children L 2	85%	82%	86%	88%	90%
Safeguarding Children L 3	85%	55%	59%	62%	63%
VAWDASV Group 1	85%	84%	85%	86%	87%
VAWDASV Ask & Act	85%	59%	62%	65%	70%



# Safeguarding Process

## Safe Recruitment

Allegations Made Against Staff in a Position of Trust

Resolution of professional Differences

Pressure Care

Falls

## 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](#)

## Allegations Made Against Staff in a Position of Trust

All allegations of abuse of children or adults, and/or concerns raised regarding the conduct in the private or professional life of a PTHB employee, temporary staff, contractor or volunteer, which may pose a risk to children or adults will be taken seriously and treated in accordance with policy and legislation as laid out in the Wales Safeguarding Procedures (2019)

PTHB have a clear process in place for managing these type of concerns. [SGP 041 Managing allegations of abuse or neglect made against professionals and members of staff.pdf](#)

## Resolution of Professional Differences

Mid & West Wales Safeguarding Board Multi Agency Protocol for the Resolution of Professional Differences. [media\\_bjpprbqn\\_resolution-of-professional-differences-protocol-approved-20230124 \(1\).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 to those who have sustained pressure damage. All pressure damage found must be reported via RL Datix clinical incident reporting system. 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 inpatient falls. Policy aims to; 1.Reduce preventable fall in hospital by providing an evidence based, patient centred approach to reducing the risk of harm & promoting patient safety. 2. Heighten awareness & knowledge to staff & carers on the prevention & causes of falls, slips & trips. 3. Provide guidance for the action to be taken when a patient has fallen.

All falls are reported via RL Datix clinical incident reporting system. PTHB in place a Falls Scrutiny Panel. [GNP 036 Policy for Reducing and Managing Inpatient Falls.pdf](#)

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## 2023/24 Improvement and Development

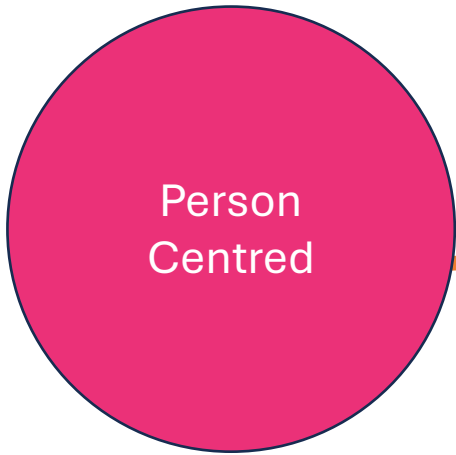
- ❖ Review of the safeguarding training offered to PTHB Volunteers completed, training sessions from PTHB safeguarding team made available to volunteers
- ❖ Safeguarding Level 3 & 4 Competency Passport updated
- ❖ Childhood Injuries training developed and delivered
- ❖ Contributed to a Regional Practitioner Concerns leaflet
- ❖ Survey completed on the dissemination of Safeguarding newsletters and training flyers
- ❖ Safeguarding Leads have been able to learn, reflect and implement changes to our safeguarding supervision process

## 2024/25 Improvement Plan

- ❖ Contribute to the National review of the Safeguarding Level 3 Intercollegic Document
- ❖ Continue to monitor Level 3 Safeguarding Training Compliance



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### **SMM Standard; Person Centred**

Safeguarding is focused on the needs of individuals and the local community, and safeguarding activity data can be used to help demonstrate the needs of the community. There is evidence of policy, process and partnership working for safeguarding issues such as mental capacity, domestic abuse, female genital mutilation (FGM). There is a lifespan approach for vulnerable people where their needs are personalised as they progress through health services as they grow older. This includes being ACE and trauma informed throughout child and adult services. There is a range of services offered using digital approaches and in a variety of languages

#### **Within this section;**

Safeguarding Children

Child Protection Register

Child Protection Medicals

Child Exploitation

Looked After Children

Corporate Parenting Charter

PRUDiC (Procedural Response to Unexpected Death in Childhood)

Safeguarding Awards for the Development of Safe Sleep Information

Safeguarding Adults

Mental Capacity Act 2005



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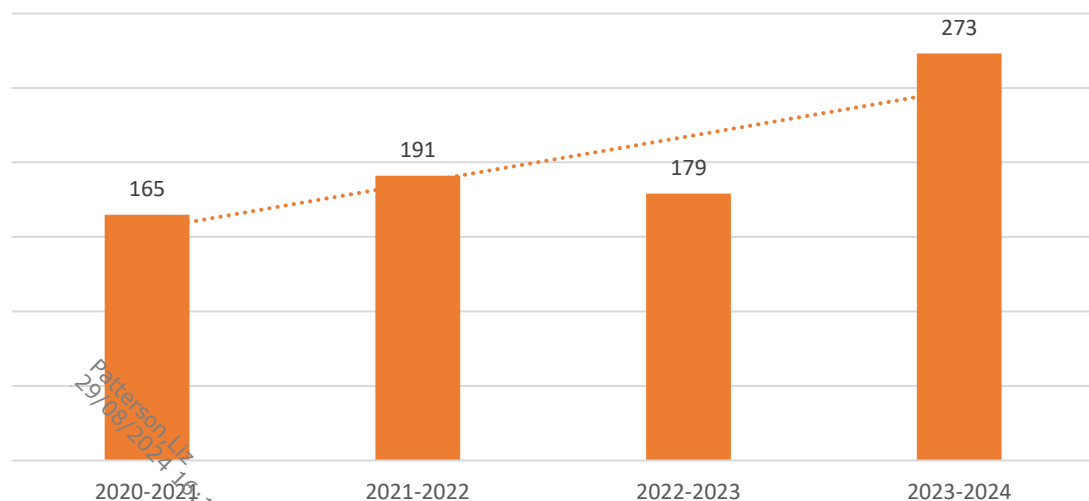
# Safeguarding Children

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 who is (a) experiencing or is at risk of abuse, neglect or other kinds of harm, and (b) has needs for care and support .

273 Safeguarding reports were made by PTHB staff in 2023-2024. This is a rise of 40% over the last 4 years. This rise may be due to several factors including improved data collection and reporting, a more visible and accessible Safeguarding Team including the Safeguarding HUB. Post pandemic reports increased when children & family's re engaged with services and the impact of the cost-of-living crisis.

34% of reports were for concerns about Neglect

Number of Child Safeguarding Reports



All reports are quality assured by the Safeguarding Team



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

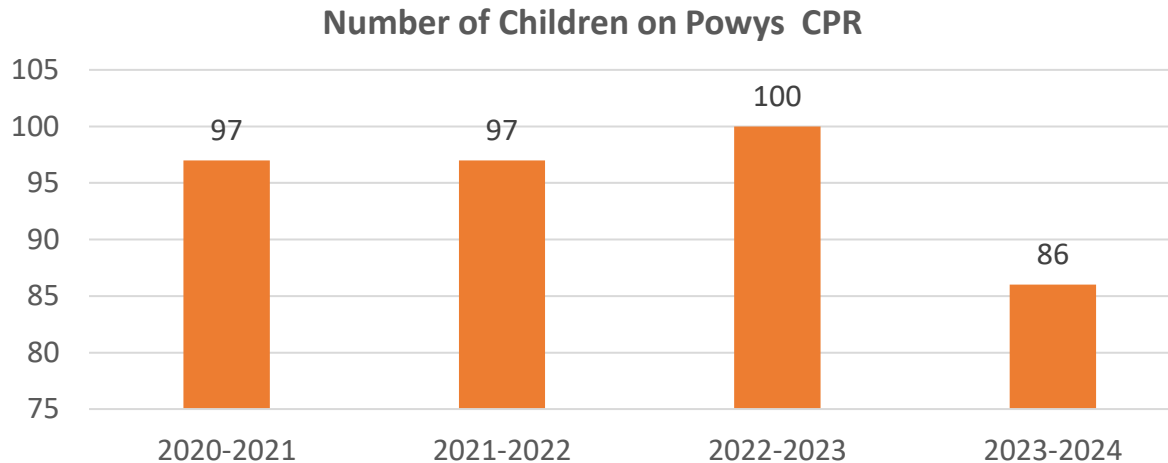
## Child Protection Register

When the outcome of a child protection case conference is a child is assessed as suffering or likely to suffer significant harm from abuse and or neglect their name can be added to the Local Authority's Child Protection Register. This is always a multi agency decision which is made during a child protection case conference.

The Safeguarding Team receive daily updates of all children whose names have been added to or removed from Powys Local Authority Child Protection Register. In addition to this information being shared with practitioners we also provide updates to GP'S and Shrop Doc.

## Child Protection Register

The number of children on Powys Children Protection Register children with care and support and protection plans was 86 as of 31.03.24 representing a reduction in the past 12 months. When benchmarked against the most recently published Welsh data, the numbers of Powys children on the CPR per 10k population is half of that of the National Average.



The categories of harm for children names being added to the Child Protection Register include Neglect, Sexual Abuse, Physical Abuse, Emotional or Psychological Abuse or a combination of two or more categories.

The highest category of registration at the 31.03.2024 was Neglect (41 children), followed by Emotional or Psychological Abuse (26 children)

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## Child Protection Register Learning from the Joint Inspection of Child Protection Arrangements (JICPA)

### Learning & Practice Improvement

Learning from the JICPA has led to the development of the safeguarding team each month reviewing all children who have been subject to a care and support and protection plan for 15 months or more. This information will trigger a Safeguarding Lead Practitioner to offer health staff who are providing services to the child and family a 1:1 safeguarding supervision session, which enables a review of the care and support and protection plan using the signs of safety model.



# 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 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.

The decision to progress to a Child Protection Medical is usually made within a multi-agency strategy discussion regarding the presenting concerns.

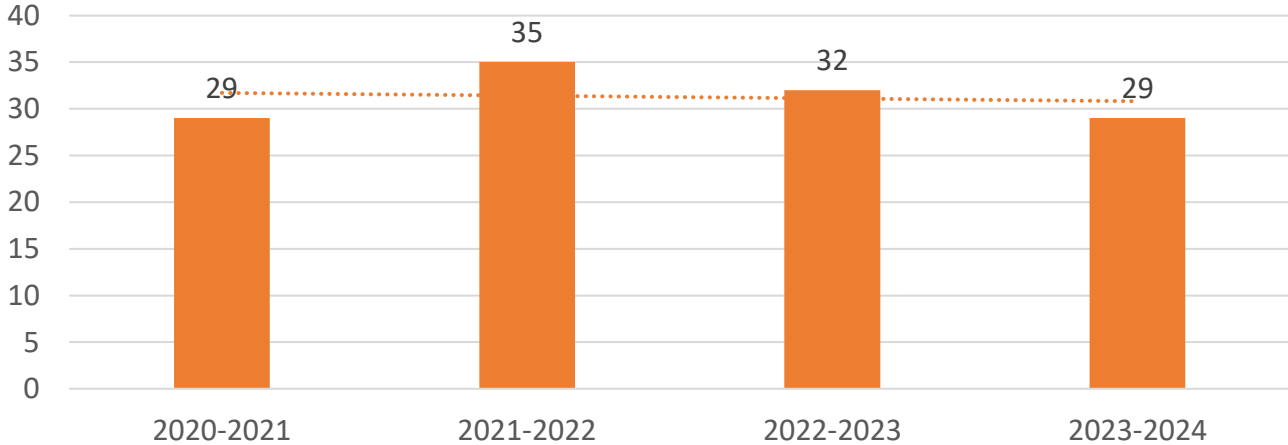
A PTHB Safeguarding Lead Practitioners attends most strategy discussions and will contribute to the decision making. This is supported by PTHB's Named Dr for Child Protection

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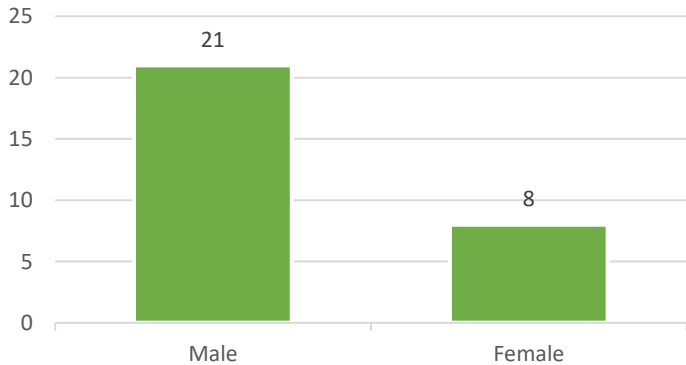
# Child Protection Medicals

Throughout 2023-2024 there were 29 Child Protection Medicals undertaken on Powys Children. This is comparable to the numbers undertaken each year since 2020. 21 were male and 8 female. 17 were under 5 years of age and 12 aged between 5 and 17 years.

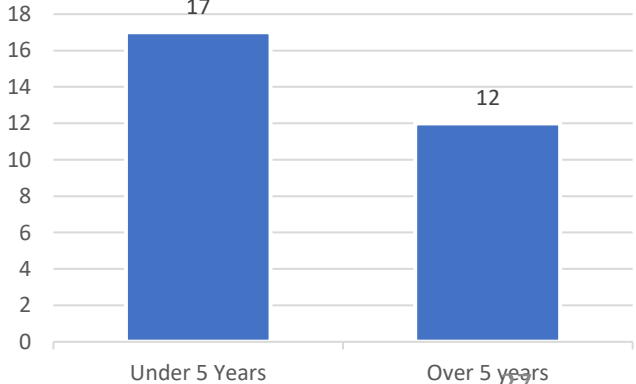
### Number of Child Protection Medicals



### Gender



### Age of Child



## Child Protection Medicals

19 of the 29 medicals undertaken were due to concerns regarding physical abuse, followed by 10 for other reasons

PTHB have a Child Protection Medical Pathway in place and commission medicals dependent on where the child resides and the type of medical required.

PTHB Named Doctor for Child Protection attends Child Protection Peer Review Group

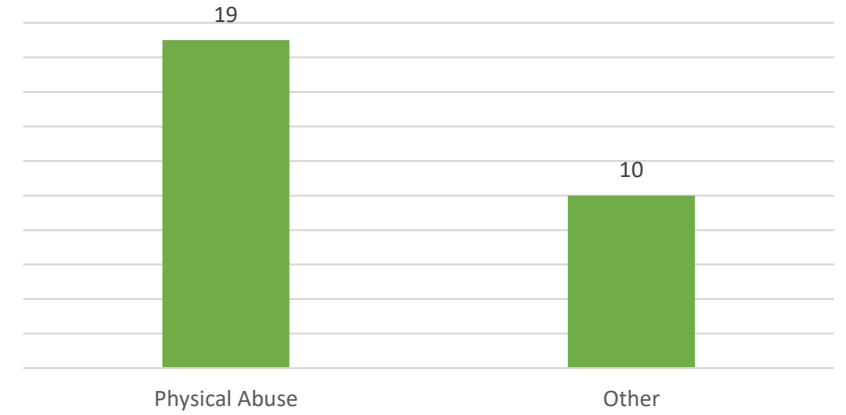
PTHB Named Doctor for Child Protection, Assistant Director of Nursing for Safeguarding and the Head of Safeguarding Quality Assure all Child Protection Medical Reports

### Learning & Practice Improvement

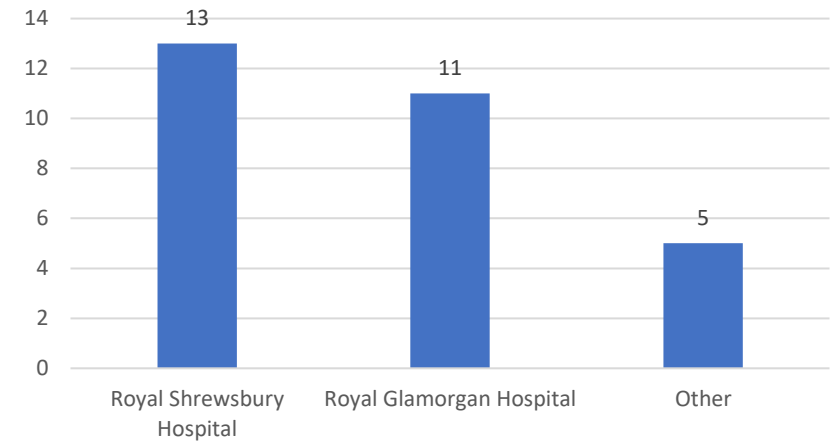
Safeguarding have worked with Informatics to develop a Child Protection Medical APP to house all child protection medical data and reports in one place. This has enabled the monitoring of compliance with the Royal College of Paediatricians Child Protection Medical Standards.

The Named Dr for Child Protection and the Safeguarding Team have developed and delivered Childhood Injury Training. The first session was attended by health, social care, police and education colleagues and received positive feedback. 3 further sessions are planned during 2024-25

Reason for Child Protection Medical



Place of Medical Undertaken



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## Child Exploitation



Child Exploitation is an umbrella term used to describe child sexual exploitation, child criminal exploitation, child trafficking, forced servitude and forced marriage. Like any other form of child abuse, child exploitation can have long-lasting consequences that can impact on every part of a child's life and their future outcomes. This magnifies the need for a coordinated multi-agency approach to ensure that children are 'children first', and that we deliver a trauma informed response to support which promotes their safety and future wellbeing. In the absence of effective safeguarding responses, children can be criminalised or abused further (Jay, 2014).

Multi Agency Child Exploitation (MACE) meetings are held quarterly and provide a framework to facilitate regular information sharing, data analysis, quality assurance, performance and professional challenge on information and intelligence relating to Victims, Offenders, Locations and Themes. The MACE Panel will:

- Use this analysis to direct resources under the four strands of Prevent, Pursue, Prepare and Protect.
- Identify broader themes and best practice in relation to interventions.
- Provide evidence towards outcomes and actions from the National Action Plan to Tackle Child Sexual Exploitation (Wales) on behalf of the Mid and West Safeguarding Board

A PTHB Safeguarding Lead attends all MACE meetings

During 2023-24, 19 children were referred into the NRM (National Referral Mechanism) process

## 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)

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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 2023-2024 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, foster carers 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



# Looked After Children Performance Data 2023-2024

344 LAC Health Assessments completed by Powys Looked After Children Clinical Nurse Specialists & Health Visitors

all assessments aim to capture the voice of the child, all assessments undergo a Quality Assurance process.

86% 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

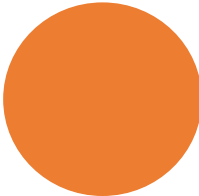
221 Health Assessments were with children from Powys

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

74 were completed by other health board Child Looked After Teams

100% of children were registered with a GP prior to the LAC health assessment

11 Unaccompanied Asylum Seeker Children (UASC) are being supported by PTHB LAC Team.



# Clinical Nurse Specialist for Looked After Children Powys Teaching Health Board

## Rosie Cox and Helen Wear

### Unaccompanied Asylum-Seeking Children (UASC)

As part of our role, we are actively involved in the resettlement programme for our unaccompanied asylum-seeking children. We have identified the need to support them with GP registration, preliminary blood screening and the immunisations they require, we have developed paperwork to support the carers and share information with GP's as outlined in Welsh Government Guidelines.



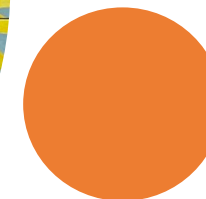
We have also developed a pack to support these vulnerable children around healthy lifestyle choices, meal planning, budgeting and sleep support.



Many of our unaccompanied children travel in groups at night and sleep during the day, when they arrive in the UK most are unable to settle and frequently suffer from nightmares. Those who have spent time in detention or makeshift camps also experience disturbed sleep. These children have difficulties in falling and staying asleep at night, in waking in the morning and staying awake during the day. This contributes to poor concentration and a lack of emotional stability.



We identified a children's charity in London that provided sleep packs for our children and collaboratively with Children Services we collected 40 packs for distribution across Powys.



A Sleep Pack is a pouch that contains: a night shirt, a plug-in night light, a lavender bag, a specially created 'Sweet Dreams' card, an eye mask, ear plugs, tissues, and a stress ball.



## Introducing the new CAMHS Looked After Children Highly Specialised Practitioner role

The CAMHS Looked After Children Highly Specialised Practitioner role was developed and recruited into during 2023.

The CAMHS Child looked after specialist provides a rapid, proactive, and responsive mental health support to all professionals and carers supporting children and young people who are looked after or care experienced.

This includes advising on the best type of approach for the child and advising staff on managing symptoms and behaviours related to emotional or mental health.

Working collaboratively with colleagues in the multi-agency arena is key to improving mental health outcomes and to ensure that all children looked after / care experienced are supported to fulfil their potential and are provided with opportunities to enhance their life chances.

*Vulnerability and inequality that effects our children looked after is well documented.*

*"The majority of children who become looked after do so because of abuse, neglect or family dysfunction that causes acute stress among family members. Entry into care is usually a traumatic experience and brings with it a significant sense of loss that can be insufficiently recognised in care planning. Older children in care may also experience significant problems at school. For those children and young people who remain in long-term care creating a sense of belonging and emotional security is vital to their health and wellbeing." (NICE Guidance)*

Having a CAMHS Child looked after specialist within the team is one way, we are addressing the inequalities and prioritising the health care needs of the children looked after in Powys.

### Head Teacher- High School

The CAMHS Child looked after specialist provides us as an Education Setting with a unique support mechanism for our pupils that are in care. This provision allows us as educational professionals to gain a perspective from a mental health professional around in school behaviours related to a pupils emotional or mental health. This provision gives educational professionals a sounding board to explore our strategies with dealing with these behaviours on the ground and in supporting the foster carers.

This support has lowered our exclusion rate for CLA pupils and ensured that our approach is trauma informed. This support has allowed us to build positive relationships with pupils, where pupils now openly approach staff to discuss their needs in a preventive and reflective manner. Having CAMHS specialist involved in our multi agency meetings allows us to work collaboratively with a pupil centred approach.

Access to this provision ensures that children in care achieve the educational outcomes that they are capable of whilst supporting their emotional needs.

### Fostering Social worker

"Having a direct link to a CAMHS specialist for Children' Looked after is vital for myself working within the Through Care 0-14 team. This service has enabled me to access some helpful support and advice myself and for carers who have received a consultation when discussing the needs of children in their care. In addition, this service has also helped in respect of linking to health services within different areas where there have been some challenges"

### LAC Social worker

Having worked within Powys Children Services for several years, there had always been a disconnect between us and CAMHS, despite the ever-increasing complexities with young people and poor mental health and wellbeing. Since the introduction of this role, it has provided a direct route for not only our young people but also the whole professional network in terms of support and guidance. Katy's role has benefitted the service and our young people massively, even if the young people are not willing to engage, Katy is always there to support from that long arm approach and provide us with the tools we need to provide positive results.

## Corporate Parenting Charter

The Corporate Parenting Charter has been developed to support the delivery of the Welsh Government programme to strengthen public bodies in their role as Corporate Parents. It should help public bodies to understand and develop their responsibilities towards care-experienced children and young people, and to ensure they have the same life chances as all children living in Wales.

The Corporate Parenting Charter is a set of **principles** and **promises** which has been developed in collaboration with care-experienced children and young people.



They align to the United Nations Convention on the Rights of the Child (UNCRC). They also reflect the Wellbeing of Future Generations (Wales) Act 2015 and the Social Services and Well-being (Wales) Act 2014, Part 6 Code of Practice (Looked After and Accommodated Children).



At the public launch of the Corporate Parenting Charter on 22<sup>nd</sup> of September 2023, both the First Minister and the Permanent Secretary signed the Charter on behalf of Welsh Ministers and Welsh Government, respectively.



Support for the Charter was sought from all organisations and senior public sector leaders by signing up to the Charter and making a clear public commitment to become "corporate parents" and deliver on the principles and promises outlined in the Charter.



In March 2024, PTHB signed the Charter. PTHB will continue to be represented at the Local Corporate Parenting Group where, with our partners, the Charter can begin to be embedded and referenced in the work of the Corporate Parenting Group, where agencies can demonstrate and challenge each other's commitment to the Charter.



## Corporate Parenting Charter – A Promise from Wales

“A SHARED PARENTING PLEDGE”

gov.wales

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## Procedural Response to Unexpected Death in Childhood (PRUDiC)

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 an agencies 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 2023 to 2024, all unexpected child deaths were managed under the PRUDiC Procedure.



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

## Mid & West Wales Safeguarding Board Award

At the Mid & West Wales Safeguarding Board Award Ceremony in June 2023, PTHB Safeguarding Lead Practitioners were winners in the **Achievement, Innovation &/or Improving Safeguarding Practice for Children** category.

In response to several unexpected baby deaths over the last 18 months, where risk factors associated with unsafe sleep were present, the Safeguarding Lead Practitioners produced a detailed document for practitioners to support the delivery of clear, consistent, tailored advice to parents and carers regarding Safer Sleep.

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**NSPCC**

## Multi Agency Pre- Birth Pathway

Throughout 2023/24 our Lead Midwife for Safeguarding has worked with Powys Local Authority & partners to ensure the Mid & West Wales Pre-Birth Pathway is embedded into practice. As part of this work the safeguarding midwife meets with the Local Authority every 2 weeks to share information, track cases and provide professional challenge to improve outcomes for babies and their families.

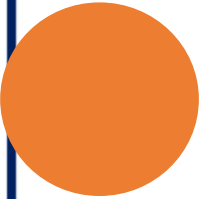
The Pathway sets out *Triggers* which support professionals' decision-making as to when to refer parents for a pre- birth assessment/risk assessment. [Cysur Regional Policies & Procedures](#)

Hart (2000) indicates that there are two fundamental questions when deciding whether a pre-birth assessment is required:  
Will the new-born baby be safe in the care of these parents/carers?  
Is there a realistic prospect of these parents/carers being able to provide adequate care throughout childhood?

The pre-birth assessment must be of sufficient depth to inform future care planning. It must consider family strengths as well as the risk factors to ensure that the new-born baby receives the necessary level of support to achieve their full potential and be protected from immediate and future harm.

### Feedback from Pre-Birth Principal Social Worker on the Lead Safeguarding Midwife Role;

Having you attend the meetings has been invaluable for you to share information and provide health input in the case discussions. Overall, having your attendance is improving the outcomes for the babies and their families through sharing information, tracking the referrals and providing feedback on the development of cases. It is making sure that the multi-agency team is aware of the worries and can provide support to address the risks that have been identified by professionals. It has meant that we have identified cases that need more urgent attention. We have also seen you provide further information about a case which has meant that things can be monitored and addressed promptly by the multi-agency teams. I also believe it has positively developed the working relationship between health and the social work teams.



Version	Revision Date	Owner
V1	15/10/2021	Mid and West Wales Safeguarding Board
V2	October 2022	Mid and West Wales Safeguarding Board (Powys)



Dogs are valued companions and play an important part of life for thousands of families throughout Wales.

Over time there have been several reports from all over the UK where dogs have attacked babies and children resulting in bites and in some cases death.

Within the area covered by Dyfed-Powys Police, there were more than 20 dog attacks involving children under the age of 18, over a six-month period.

Public Health Wales Child Death Review Programme completed a Rapid Review which concluded that the single, most important advice for members of the public is:

***'Never leave a baby or young child unsupervised with a dog, even for a moment, no matter how well you know the dog.'***

We have produced a leaflet to aid discussion and provide advice to families with pets within the home. These conversations need to start early in the antenatal period and continue as the child grows.

Parents and carers must be made aware of how they can reduce the risk of harm and to ensure pets and children live together happily. We have also produced a 7-minute briefing which includes actions to take if a dog bites a child.

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**Keeping babies and children safe around pets in the home and community**



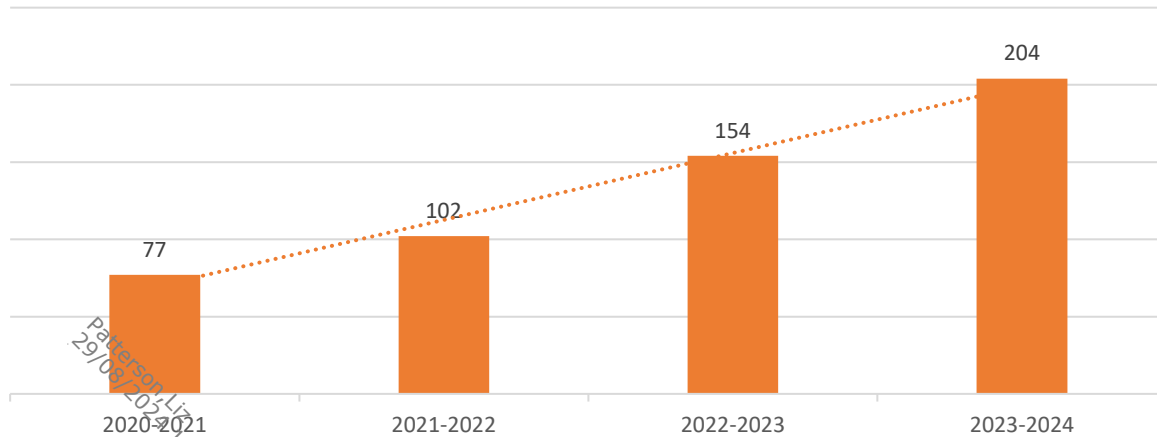
## Safeguarding Adults

In accordance with the Social Services and Well-being (Wales) Act 2014, the Health Board has a statutory duty to report an adult as risk who is (a) experiencing or is at risk of abuse, neglect or other kinds of harm, (b) has needs for care and support (whether or not the authority is meeting any of those needs), and (c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

204 Safeguarding reports were made by PTHB staff in 2023-2024. This is a rise of 62% over the last 4 years. This rise may be due to several factors including improved data collection and reporting, a more visible and accessible Safeguarding Team including the Safeguarding HUB. Post pandemic reports increased when adults and family's re engaged with services and the impact of the cost-of-living crisis.

26% of reports were for concerns about Neglect followed by 10% for concerns relating to domestic abuse

Number of Adult Safeguarding Reports



All reports are quality assured by the Safeguarding Team

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

## 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 when, how and who can make decisions for a person who lacks capacity. It ensures decisions are made in the person's best interest and the person is involved in the decision as much as possible.

MCA DoLS (Mental Capacity Act Deprivation of Liberty Safeguards) 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).

The Safeguards help to ensure the correct process is used to protect people's human rights if they lack the capacity to consent to the arrangements for the care they need; are under continuous supervision and control; and are not free to leave. The DoLS legislation aims to protect people in hospitals who may need to be deprived of their liberty. Hospitals are called managing authorities. The bodies that authorise DoLS applications are called Supervisory Bodies.

In 2014 the House of Lords undertook a review of the MCA which concluded while both pieces of legislation were visionary with the potential to transform lives, they did not work well, due to lack of awareness and understanding and commented that: "[f]or many who are expected to comply with the Act it appears to be an optional add-on, far from being central to their working lives. The evidence presented to us concerns the health and social care sectors principally. In those sectors the prevailing cultures of paternalism (in health) and risk-aversion (in social care) have prevented the Act from becoming widely known or embedded. The empowering ethos has not been delivered. The rights conferred by the Act have not been widely realised. The duties imposed by the Act are not widely followed."

The Lords review led to the Mental Capacity (Amendment) Act 2019 which received Royal Assent on 16th May 2019, and once implemented would repeal the MCA DoLS and replace them with the Liberty Protection Safeguards (LPS).

Significant work was undertaken to consult on the updated code of practice and consider its impact. However, on the 5<sup>th</sup> of April 2023 the UK Government announced the MCA Amendment Act 2019 would not be implemented and as such the current Mental Capacity Act 2005 and MCA DoLS 2019 would remain current statute that must be adhered to.

Compliance with both the MCA 2005 and MCA DoLS 2019 is reiterated through inspection reports, ombudsman findings, and Court of Protection judgements which identify any non-adherence leaves patients outside of the protections afforded by the safeguards, the impact of which is an illegal deprivation of liberty occurs, which is in breach of Article 5 of the Human Rights Act (HRA) 1998.



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# Mental Capacity Act (2005); PTHB MCA Improvement Plan

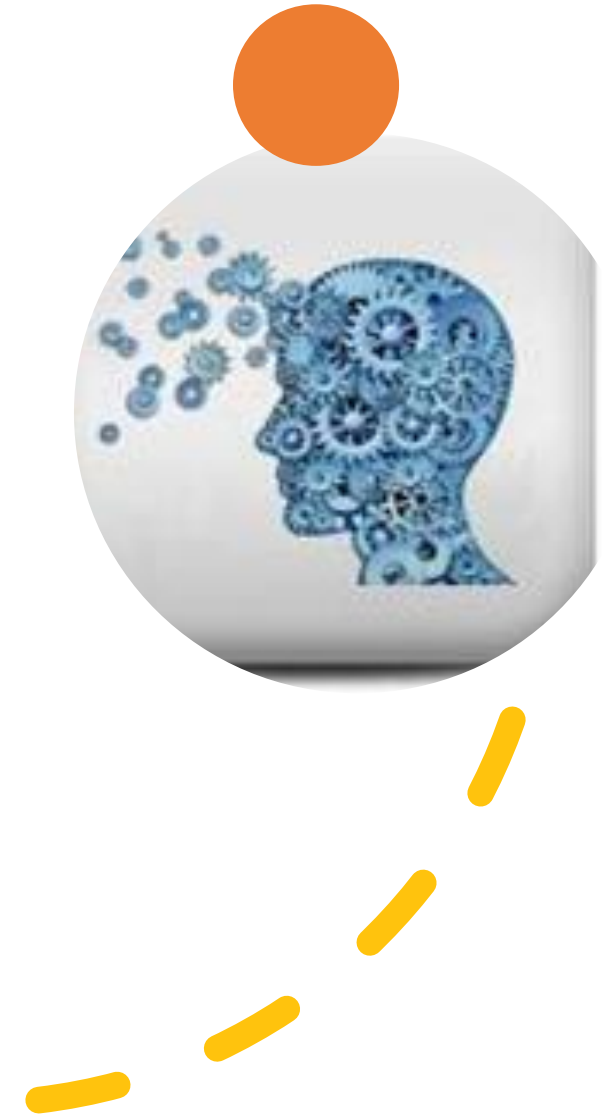
During 2023–24 PTHB have worked to deliver the actions within PTHB’s Mental Capacity Action Plan (2024-2026). The plan has been shaped by the objectives identified by Welsh Government that focus on addressing the Act Deprivation of Liberty Safeguards (DoLS) backlog, delivering mental capacity training, 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.

## Actions Completed include;

- ❖ MCA Policy updated
- ❖ Updated record of capacity assessment and best interest decision recording forms
- ❖ Review of a policies to ensure MCA compliance
- ❖ The Safeguarding Hub can now be accessed to provide support and advice around mental capacity issues
- ❖ Advocacy database and recording governance improved
- ❖ MCA and MCA DoLS training plan until March 24.
- ❖ Awareness raising session at Preceptorship sessions
- ❖ Outpatient audit day
- ❖ General Practice MCA Awareness raising
- ❖ MCA and DoLS Audit to raise governance of delivering care that is MCA compliant and promotion throughout the health board.
- ❖ MCA gap/analysis presented to the Health Board Executives
- ❖ Process for MCA DoLS documents updated for example; MCA DoLS care plan for wards, Process flow, MCA DoLS Form 1 exemplar.

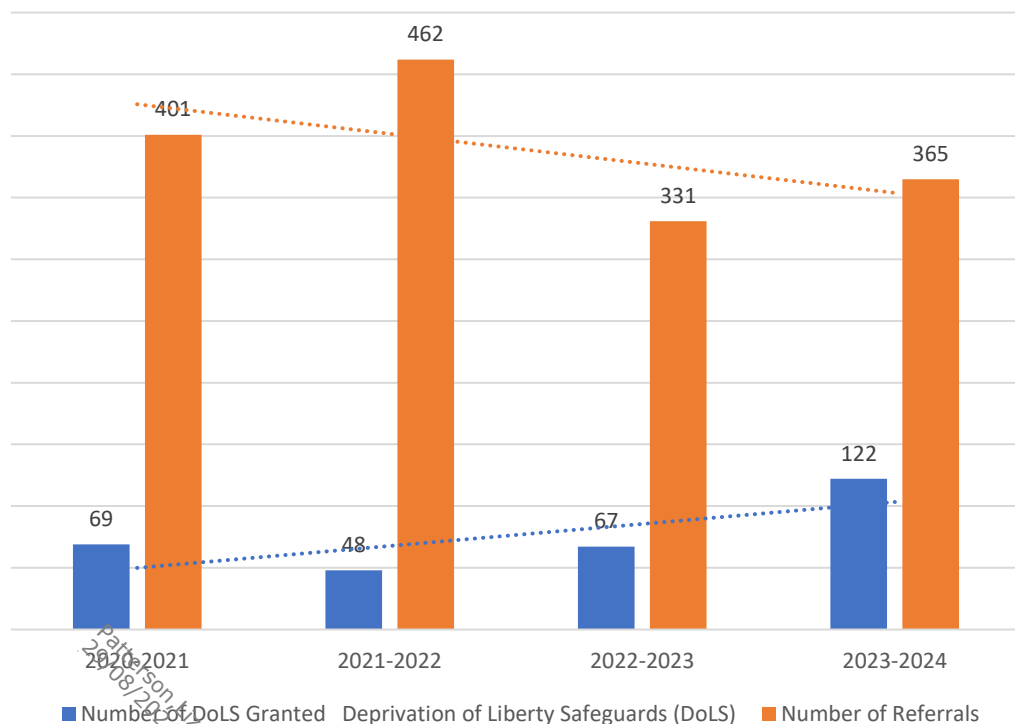
In addition to the improvements made within the plan, the appointment of a Senior Practitioner for Mental Capacity has enabled appraisal of how MCA/MCA DoLS is delivered across the health board, which are reflected in a MCA Gap Analysis undertaken within the Health Board. As awareness of MCA increases, so has the identification of issues; for example the increased number of court appointed deputy, MCA and Mental Health Act interface and the need to reflect Welsh Government Reducing Restrictive Practices policy. PTHB also participate in the NHS Wales Safeguarding Network considering MCA post the non-implementation of Liberty Protection Safeguards.

Initial steps to identify the organisation and delivery of MCA DoLS for PTHB as a Supervisory Body will be a focus for the team in 2024/25.



## PTHB Deprivation of Liberty Safeguards (DoLS) Activity 2020-24

The number of DoLS applications have fluctuated since 2020.



## PTHB Deprivation of Liberty Safeguards (DoLS) Activity 2023-24

PTHB DoLS Applications	Q1	Q2	Q3	Q4
No. of referrals for the period	89	85	106	85
No. granted	28	36	35	23
No. allocated to external BIA's	15	35	36	43
No. allocated to internal BIA's	23	21	8	12
No. withdrawn/not granted	57	61	56	62
No. of standard/renewal referrals for the period	8	8	8	3
No. of urgent referrals for the period	80	75	98	79
No. objecting	10	8	21	18
Total outstanding applications	38	25	37	20

An example of the resources produced by PTHB Safeguarding Team, Mental Health Advocate's and a service users relative

**Powys Mental Health Advocacy Service**

**About Us**

If you are over the age of 18 and in receipt of secondary Mental Health Services, the Advocacy Service is here to assist, in a variety of ways. You can discuss your concerns and worries confidentially about any aspect related to your problem. These may include medication, support service provision or other issues that affect you.

North & South Powys  
Specialist  
Community  
Mental Health  
Advocacy Service

<https://pthb.nhs.wales>

**A Community Mental Health Advocate will:**

- advocacy** Put forward your point of view to others and/or act on your behalf.
- listen** Listen to your concerns.
- understand** Will help you to understand policy and procedures.
- respect** Treat you with respect and fairness.
- rights** Can provide information on your rights' concerning aspects of your care.

Development of patient rights leaflet to support statutory rights information for those subject to Mental Capacity Act Deprivation of Liberty Safeguards.

**Deprivation of Liberty Safeguards (DoLS) and you**

**mental capacity**

**rights**

**What are your Rights?**

All images copyright LYPFT

easy on the eye



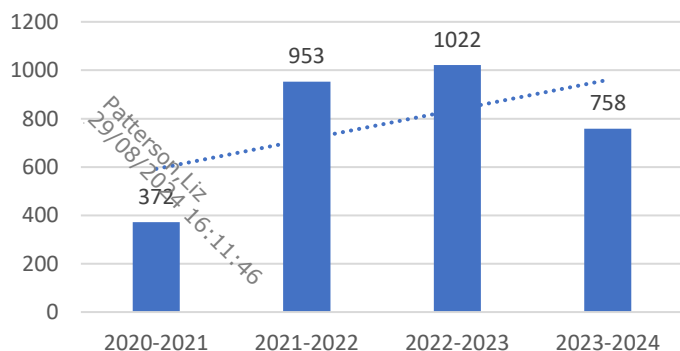
# PTHB Domestic Abuse Data

Powys Teaching Health Board receives daily **Public Protection 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 2023-2024** there were **758** Public Protection Notifications received into PTHB Safeguarding Hub from the Police which were shared with the appropriate GP, Health Visitor & School Nurse Hub and Midwifery

**Trend:** this is a decrease of **25%** from 2022-23

Number Public Protection Notifications Received

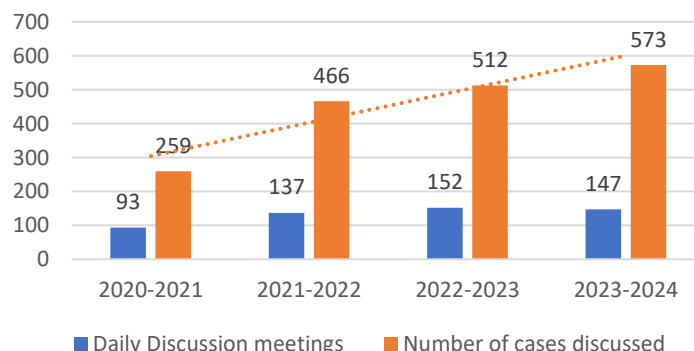


**Domestic Abuse Discussion (DAD)** is a multi-agency conference call where all high-risk victims of domestic abuse are discussed within 48 hours of a domestic incident, enabling earlier intervention, joint decision making & a timely response around the Domestic Violence Disclosure Scheme. If a high-risk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

**During 2023-2024** there were **573** Domestic Discussions. PTHB Safeguarding Hub contributed to them all

**Trend:** this is an increase of victims discussed of **12%** from 2022-23

Number of Discussion Meetings and Cases discussed

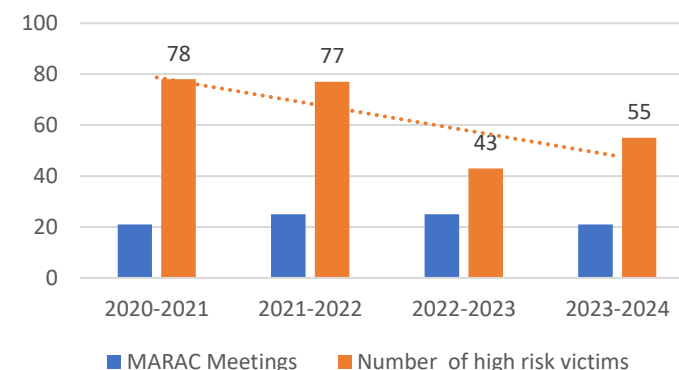


**Domestic Abuse Multi Agency Risk Assessment Conferences (MARAC)** are held every two weeks, they are victim focused, agencies share information on the highest risk victims of all types of abuse. A safety plan for each victim is developed.

**During 2023-2024** there were **55** high risk victims. PTHB Safeguarding Leads attended all MARAC's

**Trend:** this is an increase of victims discussed of **28%** from 2022-23

Number of MARAC meetings and Number of High Risk victims



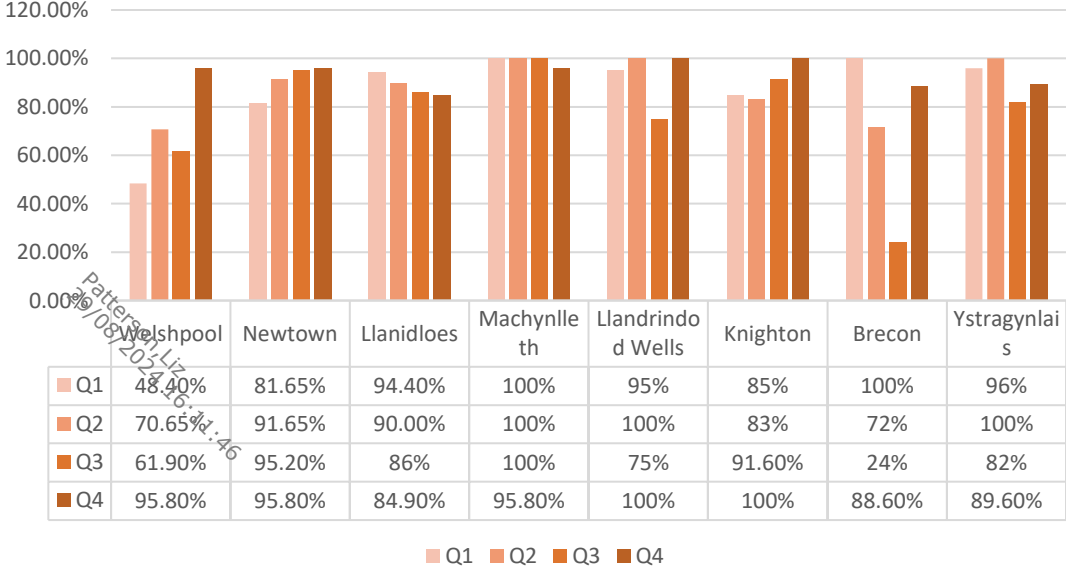
# Routine Enquiry in Midwifery

**Routine Enquiry** is a term used to describe asking all pregnant women about domestic abuse, violence against women and sexual violence irrespective if there is any evidence or suspicions of abuse.

The **Routine Enquiry should** be asked at every antenatal appointment when a pregnant woman attends alone, and it is safe to do so. This is part of the National Standards for Routine Enquiry and in PTHB we launched MAT 081 Maternity Routine Enquiry standard operating process (SOP) in January 2023 to comply with these standards.

As part of this SOP we have embedded a new documentation key to standardise completion of the **Routine Enquiry**. An audit tool has also been developed to measure compliance to the national routine enquiry standards, audit will be undertaken within each midwifery team quarterly to ensure robust monitoring and any learning is acted upon timely.

Percentages of Routine enquiry asked at appropriate appointments based on midwifery team:



# Routine Enquiry in Health Visiting and Sexual Health

**Routine Enquiry in Health Visiting** was first launched in Wales in 2005. During 2023 the National Standards for Routine Enquiry were updated which gave an opportunity to relaunch the Standards.

Similarly to Midwifery, a SOP, which includes a quarterly audit tool has been developed to ensure the standards are applied consistently across the health visiting service and learning is acted upon timely.

At the end of the 2024/25 financial year, we will be able to compare compliance over time. Learning is already emerging regarding record keeping and for all women to be included in the enquiry regardless of their relationship status.

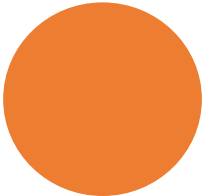
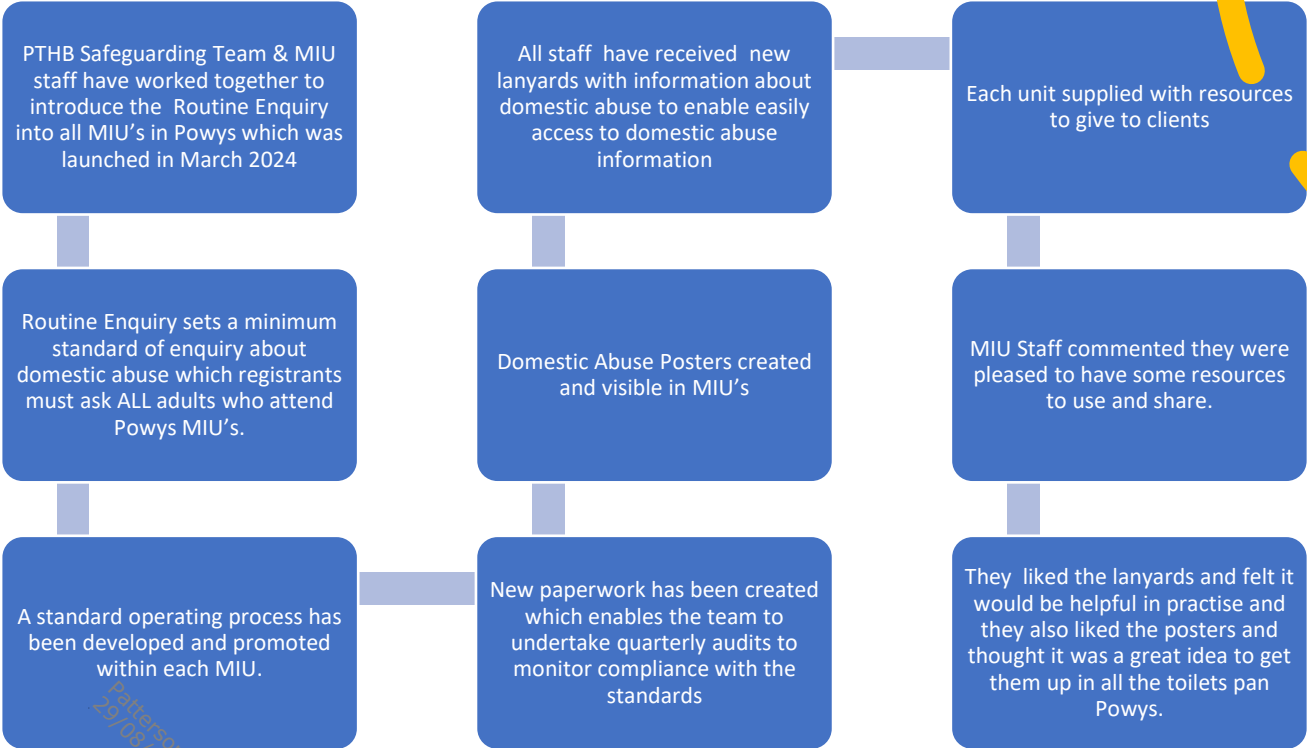
**Routine Enquiry in Sexual Health.** To ensure a consistency and audit across the service and to have a health board approach to Routine Enquiry, Sexual Health have also developed their own SOP and audit tool.

Audits will run 6 monthly with the first due in October 2024

## Next Steps

During 2024/25, following feedback from the Violence Against Women, Domestic Abuse & Sexual Violence (VAWDASV) Survivor Advisory Panel and the outcome of a regional thematic review into domestic homicide reviews, we will work with **Mental Health** to explore opportunities to expand the Routine Enquiry which will be in addition to Ask & Act.

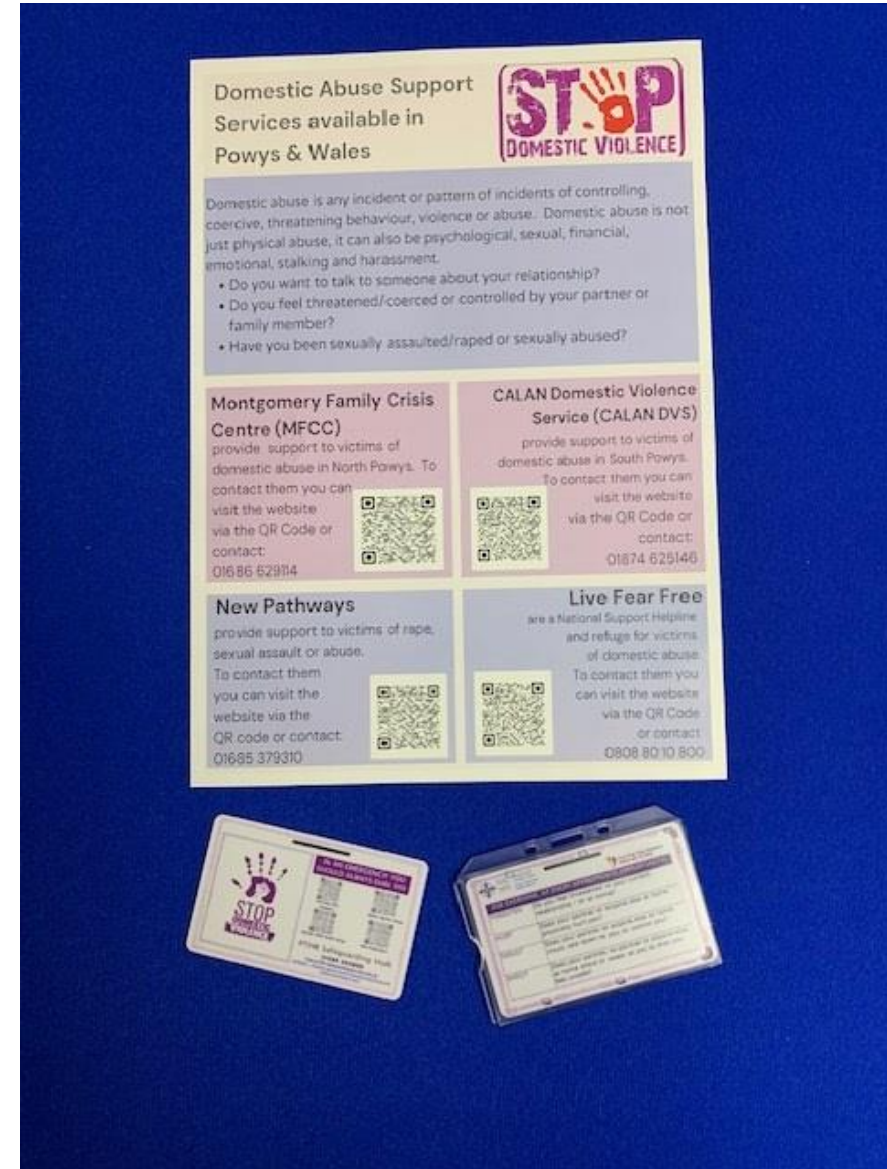
# Rolling out Routine Enquiry in PTHB Minor Injury Units



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An example of the resources produced for PTHB MIU Staff to use and display within their departments, and the Violence Against Women, Domestic Abuse & Sexual Violence poster displayed in all staff and public toilets across PTHB sites.

A huge thank you to facilities staff who went above and beyond to help achieve this.



## Rapid Response to Incidents of Suspected Suicide

Since September 2022, the Mid & West Wales Safeguarding Board have been piloting a **Rapid Response** approach to incidents of Suspected Suicide

The aim of the Rapid Response to Incidents of Suspected Suicide is to provide an immediate, 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 protocol is complementary and supportive of, but does not replace other protocols and processes

The model has exceeded the initial pilot phase of 12 months. A workshop to review the pilot is planned for 2024

Throughout this process the region has been working closely with Welsh Government who are developing national guidance.

Since September 2022, **18** 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. [Mental Health – Help With Suicidal Thoughts - Powys Teaching Health Board \(nhs.wales\)\)](#)

[Safety Advice leaflet FINAL Powys .docx](#)

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## Public Protection and Offender Management

Public Protection and Offender Management is how we create safer communities and reduce crime by multi agency working together to plan, commission and deliver community safety related services and activities.

PTHB must comply with the related legislation:

- Serious Violence Duty 2023
- Counter Terrorism & Security Act 2015
- Criminal Justice Act 2003 – duty to cooperate in Multi-Agency Public Protection Arrangements (MAPPA)

Statutory Agencies have worked together under the new **Serious Violence Duty (SVD) 2023** to produce a Dyfed-Powys SVD Strategic Needs Assessment and a Mid and West Wales Serious Violence Strategy [Link](#). Both will inform the delivery plan for 2024-25.

### **Contest is the UK's overarching response to Terrorism** [CONTEST 3.0](#)

([publishing.service.gov.uk](https://publishing.service.gov.uk)) its aim is to reduce the risk to the UK, overseas interests and UK Citizens from terrorism. CONTEST provides a strategic framework of four work strands known as the 4 P's:

- Prevent: to stop people becoming terrorists or supporting terrorism.
- Pursue: to stop terrorist attacks.
- Protect: to strengthen our protection against a terrorist attack.
- Prepare: to mitigate the impact of a terrorist attack

The main involvement from a health perspective is in PREVENT. **Prevent Duty Guidance (2023) outlines the specific responsibilities placed on health boards.** [Prevent duty guidance: Guidance for specified authorities in England and Wales \(publishing.service.gov.uk\)](#)

It sits alongside long-established safeguarding duties on professionals to protect people from a range of other harms, such as substance abuse, involvement in gangs, and physical and sexual exploitation. The duty helps to ensure that people who are susceptible to radicalisation are supported as they would be under safeguarding processes.

PREVENT training is not mandatory in Wales, however PTHB have added Prevent awareness into our Level 3 Safeguarding Training Passport

The Safeguarding Team represent PTHB at key strategic & operational meetings regarding public protection and offender management including:

- Powys Community Safety Partnership
- Serious Violence and Organised Crime Board
- Serious Violence Duty Board
- MAPPA (Multi Agency Public Protection Arrangement) Senior Management Board
- Violence Against Women, Domestic Abuse & Sexual Violence (VAWDASV) Board
- Contest Board
- MAPPA meetings

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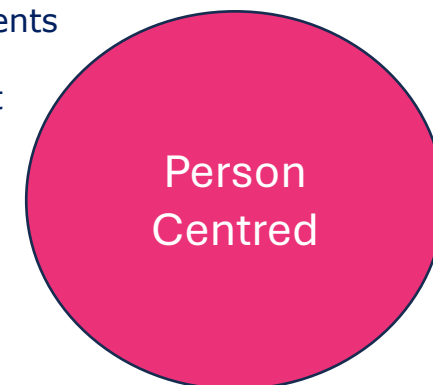
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## 2023/24 Improvement and Development

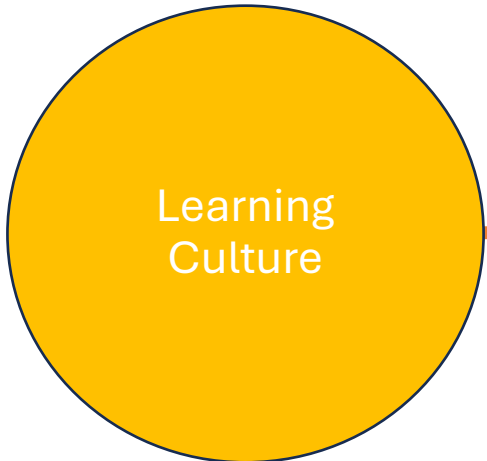
- ❖ Information Sharing Agreement put in place with the Violence Prevention Unit
- ❖ Roll out Routine Enquiry and audit process in PTHB Minor Injury Units
- ❖ Standard for Routine Enquiry and audit process put in place within Health Visiting
- ❖ Due to the reported deaths/serious injuries from dog attacks in the UK, a resource to share with parents/carers around caring for children and pets safely has been developed
- ❖ Survivor of Domestic Abuse shared her voice at PTHB Safeguarding Strategic Group and attended Ask & Act Training to give feedback on content and delivery
- ❖ Ask & Act delivered to 208 Primary Care staff
- ❖ Sharing Information in Pregnancy process strengthened along with strengthening of pre-birth planning with our partners
- ❖ Mental Capacity Act map and gap exercise undertaken

## 2024/25 Improvement Plan

- ❖ Consider Routine Enquiry within Mental Health
- ❖ Review the research regarding DA and menopause and how this can inform practice in the HB
- ❖ Continue to link with the VAWDASV Survivor Panel
- ❖ Following the publication of When we are at Our Most Vulnerable written by the Women's Rights Network (WRN), PTHB to implement a Task & Finish Group to map position and report back to Executives
- ❖ Consider the findings of a recent regional thematic review into 16 Domestic Homicide Reviews and wider research into the link between Mental Health & Domestic Abuse/homicide
- ❖ Audit service users regarding experiences of health involvement in the safeguarding process
- ❖ Progress to the next stage of the Mental Capacity Act gap analysis to work towards meeting the legislative requirements
- ❖ Complete process mapping of the management of sexual & violent offenders using healthcare



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**SMM Standard; Learning Culture**

There is evidence of a culture that promotes candour, learning and avoids blame. This is supported by a reporting system for safeguarding concerns, incidents and litigation where they can be monitored, addressed and trends understood. There is evidence of learning from safeguarding incidents and Practice Reviews that reaches frontline team members. Multi agency learning is promoted to share knowledge across the safeguarding community. Feedback from those who use services is used to shape and improve the quality-of-service provision.

**Within this section;**

- Incident Management System and Processes
- Management of Learning from Reviews
- Themes and Learning from the Reviews during 2023 - 2024



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## Incident management system and Process

PTHB has an established Incident Management Framework (IMF), which is underpinned by the principles of both “Putting Things Right” (requirements of the NHS (concerns, complaints, and redress arrangements) Regulations Wales (2011) and Duty of Candour, as part of the Quality and Engagement Act 2020.

The IMF is essential for robust processes and timely action to support teams within the health board.

The IMF sets out structures and process for the reporting of a patient safety incident via Datix and triggering mechanisms for incidents over moderate and above and the Duty of Candour requirements to be met with informing patients and families of the Health Boards intention to review an incident and the proportionate requirement to report to either the Welsh Government or the NHS Executive.

Upon closure of an incident, which has been through a serious incident process or Root Cause Analysis (RCA), the service will meet with the family/patient involved to go through the RCA report and this will be followed up with a Duty of Candour letter, summarising the review process, any learning for the organisation and if the test for qualifying liability has been met.

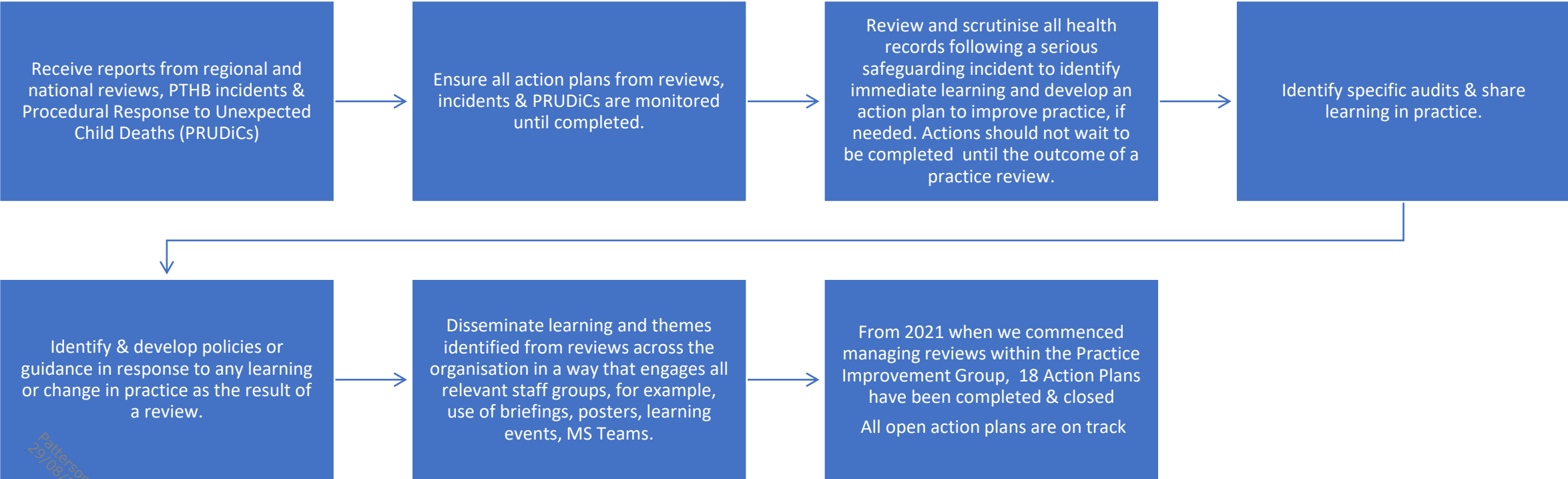
The IMF follows the principles of a “Just Culture” guide, ensuring that all processes avoid blame in the investigation process. The IMF also explores human factors and psychological safety to ensure that staff are supported to engage throughout the process (including with safeguarding, practice reviews and the Coronial process).

Upon closure of an incident, the learning outcomes are shared with the NHS Executive and each service will take the learning to their respective departmental learning and development group and cascading through 7-minute briefings. Following incidents where cases meet redress, this learning is then shared to Welsh Risk Pool through the Learning From Events Report (LFER) process.

The Quality and Safety team work with service groups to complete service reviews, identifying themes in incidents and areas for improvement from learning. Services are supported through Datix with the creation of dashboards, enabling them to keep track and monitor themes from patient incidents and their timely investigation and closure. This is also followed up with a weekly email from the Head of Quality and Safety informing Heads of Service of the live position for moderate and above incidents, reporting requirements and up to date training dates for managers and new users of Datix.

# Management of Learning from Reviews

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



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## Themes and Learning

- ❖ Managing Was Not Brought
- ❖ Improving Routine Enquiry
- ❖ Sharing Information in Pregnancy
- ❖ Documenting Significant Events
- ❖ Safer Sleep
- ❖ Perinatal Pathway
- ❖ Flagging Children at Risk of Harm in General Practice and Out of Hours
- ❖ Promotion of Advocacy Services
- ❖ Multi-Disciplinary Team Process
- ❖ Professional Curiosity

## How the Themes and Learning is shared

- ❖ Training Packs updated
- ❖ Use of short Videos
- ❖ Safeguarding attend Service Group meetings
- ❖ 7 minute briefings
- ❖ Safeguarding Newsletter
- ❖ Safeguarding Intranet Page
- ❖ Safeguarding Newsfeed
- ❖ Promote Regional Training Opportunities

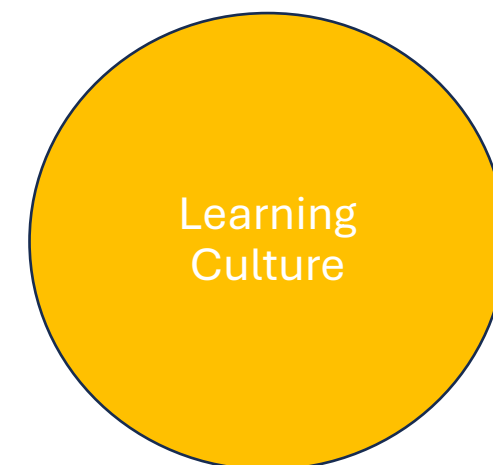
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## 2023/24 Improvement and Development

- ❖ Safeguarding Operational Group and Practice Improvement Group continues to have in attendance representation from across the organisation, the group is progressing all action plans from safeguarding reviews
- ❖ Contribution to the consultation on the proposed Single Unified Safeguarding Review Process – several PTHB practitioners have undertaken the panel member, Reviewer and Chair Training.

## 2024/25 Improvement Plan

- ❖ Extend the reach of the safeguarding services by using podcasts
- ❖ Consider the findings of a Regional Thematic Review of Domestic Homicide Reviews undertaken by the Violence Against Women Domestic Abuse & Sexual Violence (VAWDASV) Strategic Group



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Multiagency  
Partnership  
Working

**SMM Standard; Multi Agency Partnership working**

There is a safeguarding strategy that is aligned to local plans in the wider health and social care economy, and services are planned to meet the needs of the relevant population. The organisation actively contributes to the multi-agency approaches to safeguarding issues. There is appropriate participation in the Regional Safeguarding Boards and involvement in processes such as MARAC and MAPPA. There is evidence of strong connections and referral mechanisms with local services that can prevent harm, support and protect vulnerable people.

**Within this section;**

- Mid and West Wales Safeguarding Board
- VAWDASV Strategic Group
- NHS Wales Safeguarding Network
- Multi Agency Partnerships: Working in Collaboration



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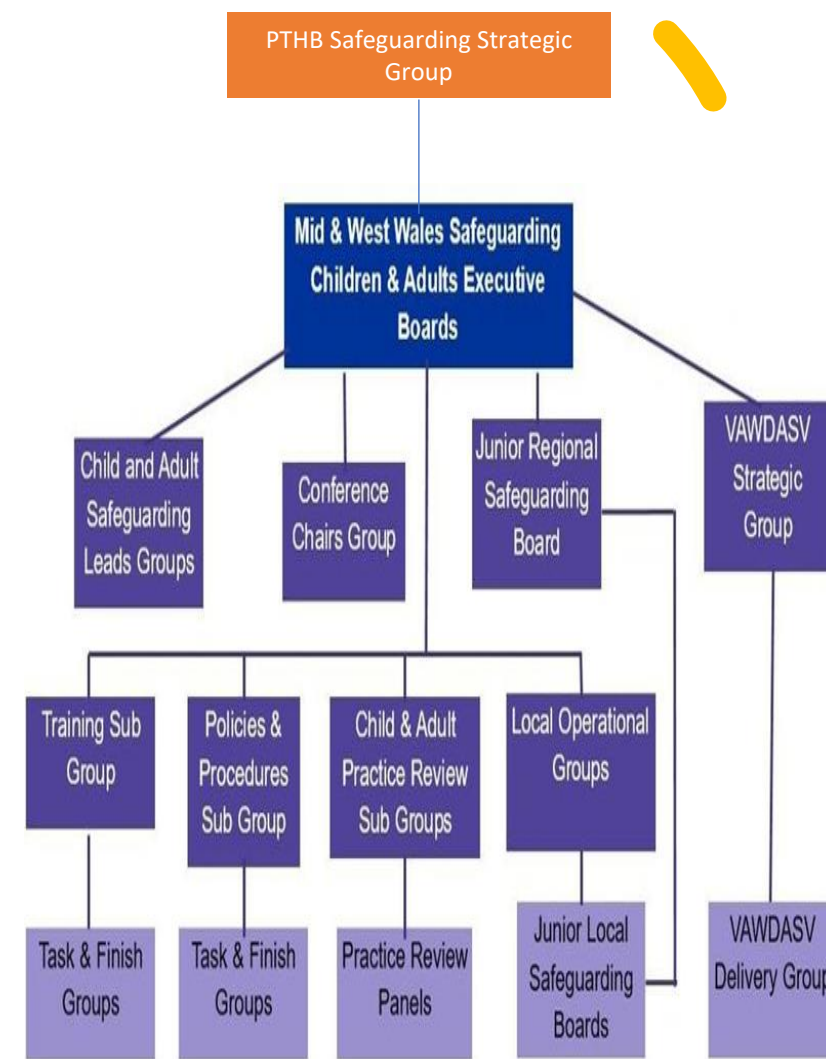
# Mid and West Wales Safeguarding Board (M&WWSB)

The Mid and West Wales Regional Safeguarding Board (Children and Adults) was established to meet the requirements of the Social Services and Well-being (Wales) Act 2014 and is a key Vehicle for agreeing how statutory agencies will cooperate to safeguard and promote the welfare of children and adults at risk, and for ensuring the effectiveness of those agencies both regionally and at a local level.

The regional purpose is to coordinate the strategic direction, collaboration, consistency and improvement of practice across the region. The local purpose is to coordinate local practice, and work towards ensuring effectiveness of safeguarding local arrangements.

## Powys Teaching Health Board is represented on the listed groups with information flowing between the Executive Board and PTHB Strategic Group;

- **The Executive Boards** consist of senior managers from key statutory agencies. The Executive Boards' aim is to provide leadership and guidance to all its constituent agencies through the delivery of a series of strategic priorities for safeguarding activity and practice.
- **Local Operational Group** membership and structure of the LOGs mirror that of the Executive Boards. However, the primary objective of LOGs is to share, monitor and analyse safeguarding practice locally, in an open and transparent environment. LOGs seek to share and acknowledge examples of good safeguarding practice; in addition, they will professionally challenge and hold agencies to account when safeguarding practice falls below expected standards.
- **Regional Training Sub-Group** operates collaboratively and in conjunction with the Executive Boards. It seeks to support and guide the delivery of safeguarding training and learning. The group can commission specialist, bespoke safeguarding training across the region and works closely with other sub-groups, such as the Practice Review Sub-Group, to ensure any learning outcomes identified in Child/Adult Practice Reviews are disseminated to staff.
- **Regional Policies & Procedures Sub-Group** operates collaboratively and in conjunction with the Executive Boards. The Group seeks to provide guidance to professionals via the development of regional safeguarding policy and procedure.
- **Through-Age Practice Review Sub-Group** considers referrals from agencies where a child or adult at risk has either died or suffered significant impairment of health and development as a result of abuse and/or neglect. Practice Reviews are undertaken by a multiagency group of professionals who collectively analyse information and identify any practice themes and lessons to learn. The report is then published as a Child/Adult Practice Review on the Boards' website.



## The Violence Against Women Domestic Abuse & Sexual Violence (VAWDASV) Strategic Group

The VAWDASV Strategic Group is a multiagency collaboration that is driving forward the requirements of the VAWDASV Act, including the implementation of the new Mid and West Wales Violence Against Women, Domestic Abuse and Sexual Violence Strategy 2023-27 [media.20gh4vhu.mww-vawdasv-strategy-2023-28-final.pdf](https://media.20gh4vhu.mww-vawdasv-strategy-2023-28-final.pdf).

The Strategy has been developed through consultation with stakeholders and survivors of domestic abuse and the objectives have been aligned to the Welsh Governments VAWDASV Strategy 2022-2026

The VAWDASV Delivery Group supports the Strategic Group on the progression and implementation of regional priorities, as well as maintaining key links with specialist providers.

### The 6 Priorities of the Strategy are;

1. Challenge public attitudes towards violence against women, domestic abuse and sexual violence across the Welsh population through awareness raising and a space for public discussion with the aim to decrease its occurrence.
2. Increase awareness in children, young people and adults of the importance of safe, equal and healthy relationships and empowering them to make positive personal choices
3. Increase focus on holding to account those who commit or may carry out abusive or violent behavior to change their behavior and avoid offending/reoffending
4. Make early intervention and prevention a priority
5. Relevant professionals are trained to provide effective, timely and appropriate response to victims and survivors
6. Provide all victims with equal access to appropriately resourced, high quality, needs-led, strengths based, intersectional and responsive services.

# MID AND WEST WALES VIOLENCE AGAINST WOMEN, DOMESTIC ABUSE AND SEXUAL VIOLENCE STRATEGY 2023 - 2027





The NHS Wales National Safeguarding Service (NSS) drives and delivers strategic improvements across the NHS in Wales through leadership and collaboration, improvement tools and upskilling of the workforce, as well as embedding policy and research into practice. The NSS also coordinates the NHS Wales Safeguarding Network & its subgroups that include representatives and stakeholders from health boards and trusts, the office of the Chief Nursing Officer, the Children's and Older Peoples Commissioners Office and Welsh Government.

The Network provides a platform for a '**community of practice**' a rich environment for collaboration, learning and creating new knowledge, horizon scanning, sharing challenges, problem solving, innovation and sharing best practice. As safeguarding experts, **the Network** is well placed to support **quality improvement in safeguarding** across NHS Wales, drive positive change by facilitation, challenge and system leadership.

To enable this work and to deliver against a yearly work plan, strong partnerships are key.



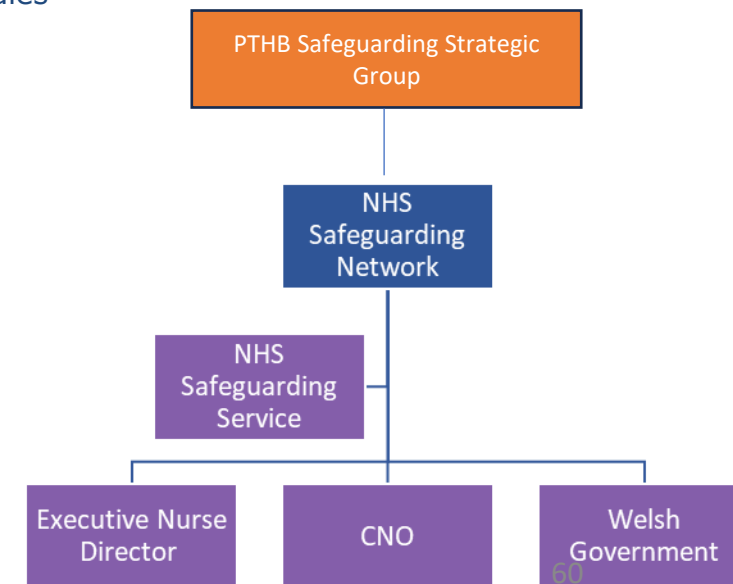
The 2023/24 the Network Work Plan developed 29 Deliverables under 5 themes;

- Quality, Performance & Assurance
- Training & Learning
- Network Leadership
- Network Business & Report Cycle
- Audit

**18** of the 29 deliverables completed within delivery timescales

**7** Paused/Ongoing – to continue into year 24/25

**4** Not delivered within timescales



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

During 2023-24 PTHB worked in collaboration and contributed to;



M&WWSB Strategic Plan 2023-2024 <https://www.cysur.wales/our-annual-plan-2023-24-is-now-live/> and Annual Report <https://www.cysur.wales/our-annual-report-2022-23-is-now-live/>

Safeguarding Week (November 2023) [Cysur | National Safeguarding Week 2023](#)

Various Consultations including the Single Unified Safeguarding Review

Continued Support of the Regional Rapid Response Model

Publication of Regional VAWDASV Strategy 2023 – 2027 & Action Plan [MWWStrategicPlanV2 3 \(cysur.wales\)](#)

Co delivery of Regional Professional Curiosity Training

The National Safeguarding Training Standards

Multiagency collaboration on the new Serious Violence Duty (2022) [Serious Violence Duty - Statutory Guidance \(publishing.service.gov.uk\)](#)

JICPA Inspection, regional and local audits

VAWDASV Survivor Advisory Panel

Continued engagement in the Wales Sexual Assault Service development



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**PTHB Safeguarding Team represent the health board at a wide range of boards, groups, forums and meetings**

### **National Meetings**

- ❖ NHS Wales Safeguarding Network
- ❖ Wales Sexual Assault Project Board & Regional Group
- ❖ Safeguarding Maturity Matrix Group
- ❖ NHS VAWDASV Steering Group
- ❖ NHS Network Looked After Children (LAC) Steering Group
- ❖ NHS Training Sub-group
- ❖ NHS MCA Group
- ❖ LAC Cymru (Peer Group)

### **Regional Meetings**

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

### **Local Meetings**

- ❖ Powys Local Operational Safeguarding Group
- ❖ Corporate Parenting Group
- ❖ CPR/APR/DHR/MAPF Panel
- ❖ Youth Justice Board
- ❖ Start Well Board
- ❖ Multi agency risk assessment Steering Group & meeting
- ❖ PRUDiC
- ❖ Daily Domestic Discussions
- ❖ Channel Panel
- ❖ MAPPA
- ❖ MACE
- ❖ National Safeguarding Week Planning
- ❖ Community Safety Partnership
- ❖ Strategy meetings
- ❖ Rapid Response Meetings

### **Health Board**

- ❖ Pressure Damage Scrutiny Panel
- ❖ Maternal & Child Death Review Group
- ❖ Safeguarding Strategic Group
- ❖ Safeguarding Operational & Practice Improvement Group
- ❖ MCA Improvement Group
- ❖ JIMP
- ❖ Position of Trust Strategy meetings

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## 2023/24 Improvement and Development

- ❖ Worked in collaboration with partners to undertake a Strategic Needs Assessment and develop a Strategy in response to the new Serious Violence Duty 2023
- ❖ Improved Multiagency working where parents are identified antenatally as requiring extra support from multiple agencies
- ❖ DASHRIC & MARAC & Safety Planning Videos (how to undertake a risk assessment when concerned about domestic abuse) made available to staff
- ❖ Worked with partners to have an improved understanding of the level of prostitution within Powys and what this means for services going forward

## 2024/25 Improvement Plan

- ❖ Dyfed Powys Police are rolling out MATAC (Multi Agency Tasking And Coordination). MATAC is a multi-agency approach that focuses on identifying serial perpetrators of domestic violence. It is a whole system approach that works with partners with a focus on multi agency victim support and strong innovative perpetrator management
- ❖ Consider the improvement required following a regional piece of work commissioned to review the level of prostitution in Powys and the knowledge and skills of multiagency workers



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Responsive,  
Resilient &  
Purposeful

### **SMM Standard; Responsive, Resilient and Purposeful**

There is evidence that the organisation is agile and has business continuity plans for safeguarding to ensure children and adults-at-risk remain safe and supported in times of national/local crisis. The impact of changed working practices such as remote working must be evaluated and undertaken in line with local protocols to ensure there is no delay in the identification of risk, harm, need and vulnerability.

#### **2023/24 Improvement and Development**

- ❖ The Safeguarding HUB is developing to include specialist support regarding Mental Capacity. This ensures there is increased knowledge and skills within the team and moves away from a single point of contact for MCA advice and support
- ❖ The Safeguarding Team have supported a Health Visitor and Team Lead to deliver Ask & Act training which increases capacity and enables the practitioners to acquire new skills
- ❖ The health board has nominated 6 practitioners to undertake Practice Review Chair, Reviewer and Panel member training.
- ❖ There has been an opportunity to redesign a safeguarding position for a fixed term 12-month period and recruit a practitioner to experience working within the Safeguarding Service. This will bring fresh ideas into the team and give the practitioner new skills to take back into their substantive post

#### **2024/25 Improvement Plan**

- ❖ Safeguarding to meet with the Digital Transformation Team around the work underway regarding Virtual Consultations
- ❖ In collaboration with workforce colleagues and clinical teams consider options to develop and offer current practitioners Best Interest Assessors training and to undertake a signatory role to move towards a more sustainable model.

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## Service Group Safeguarding Updates

Therapies and Health Sciences

CAMHS

Community Services Group

Women and Family Health

Mental Health

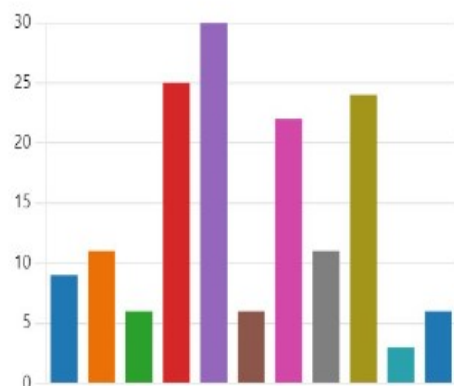
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## Professional Curiosity Awareness

1. Which service area do you work for?

[More Details](#)

Audiology	9
Dietetics	11
Lymphoedema	6
Occupational Therapy	25
Physiotherapy	30
Podiatry	6
Radiography	22
Respiratory	11
Speech and Language Therapy	24
Stroke/Neuro	3
Other	6

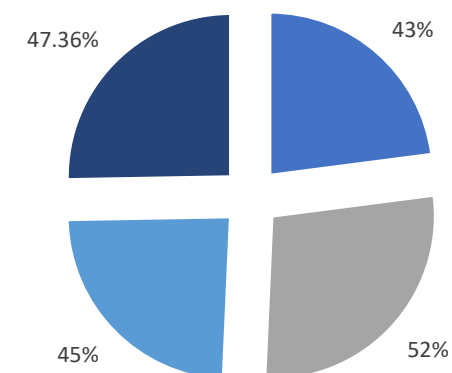


Therapies & Science have completed an audit on Professional Curiosity Training with all clinical staff. There was a 70% response rate (153 staff) and 92% reported they had watched the Professional Curiosity Training video.

## Training and Safeguarding Update Sessions

Therapies and Healthcare Science Services have arranged quarterly "safeguarding update" sessions, these sessions have been well attended and will continue into 2024/25. Safeguarding Supervision sessions for children services continue. During 2023/24, we implemented sessions for the Therapy Adult Services.

### Adult Safeguarding Supervision Compliance Rate



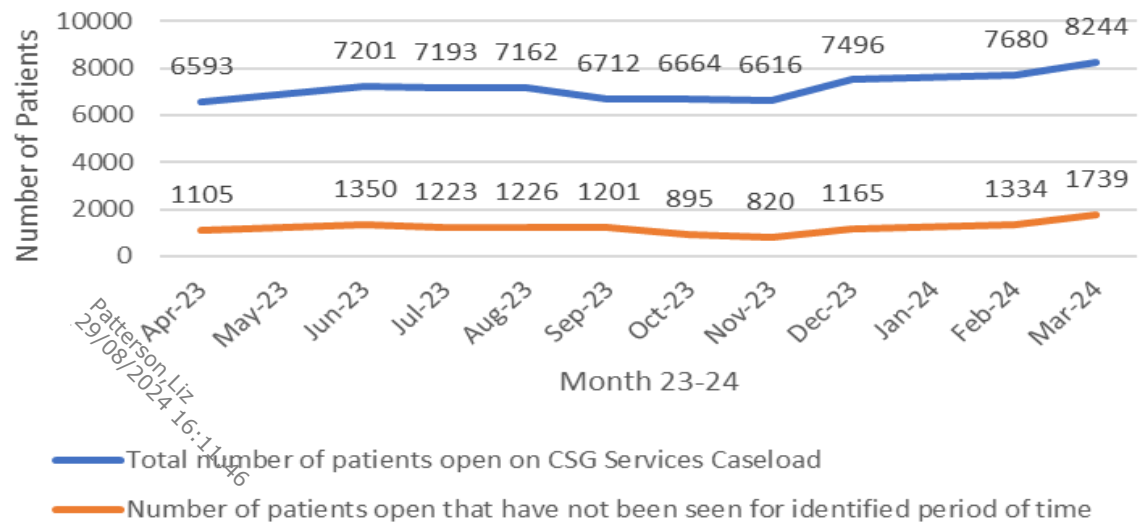
■ Quarter 1 2023-2024 ■ Quarter 2 2023-2024 ■ Quarter 3 2023-2024 ■ Quarter 4 2023-2024

## Caseload Management

In June 2022, Therapy Services identified there were over 19,000 patients open within the Community Service Group, 3,768 of which had been open and not been seen for at least 12 months.

Following significant work with practitioners on Case Load Management and Operational Procedures, the service is now in a position where open cases on caseloads which have no activity for 3 months are regularly reviewed.

CSG Therapy Services Caseloads



To support and maintain this improvement a Caseload Management Standard Operating Process (SOP) for Allied Health Professionals and Health Scientists was ratified in January 2023.

The SOP clarifies:

- ❖ professional practice expected by the workforce
- ❖ roles and responsibilities
- ❖ standards for caseload management to ensure safe and legal services for patients
- ❖ how practitioners will maintain their duty of care to the population
- ❖ Health & Care Professional Council standards relevant to caseload management

During 2024/25 the service is due to carry out an audit on the SOP to review the compliance.

## Was Not Brought Policy (WNB)

Audit tool developed for clinicians to complete when a patient is identified as WNB to an appointment, this is to ensure the WNB policy is being followed. The tool has evolved as it wasn't providing the required assurance.

Monthly audit results are now a Key Performance Indicator that Heads of Service must monitor and report on.

## Missed Appointments

In July 2023, as part of the Safer Care Collaborative, MSK Physiotherapy reviewed the level of Missed Appointments and established this was running at 16%. Some work had already been undertaken with the introduction of 1 way text reminders, and in March 2023 this was further developed to **Two Way Text Reminders**, which enables the patient to select options to cancel or rebook appointments which has had a positive impact with a reduction in the number of missed appointments dropping to 9%.

In January 2024, the service worked with the Communication Team and designed a poster for use in all MSK Physiotherapy waiting areas to raise the awareness of missed appointments and the implications to the patient and service. Currently the service is at a 6% rate, 1% off the internal target of 5%.

The learning from the project can be shared across services, other therapy services are implementing the text reminders and seeing a reduction in their missed appointment rates.



Powys CAMHS does not have its own Crisis provision or its own District General Hospital with an A&E department. PTHB relay on our neighbouring Health Boards to carry out mental health assessments on children presenting at A&E due to mental/emotional health distress.

In September 2023 Powys CAMHS were successful in securing 1 year funding via the NHS Executive to provide a service for Children who require mental health services as an alternatives provision to admission and the attendance at A&E for mental health issues.

This money has aided the development of a Crisis & Intervention Team and a Crisis HWB in the heart of Powys. Staff based at the HWB but can be deployed throughout Powys to offer an assessment in the most appropriate environment for the child.

CAMHS Crisis is now up and running, providing support 7 days a week, 9am until 9.30 pm. It is operating a responsive approach to children in mental health distress, eliminating the need to attend A&E which may result in long waits for a mental health assessment.

The Crisis HWB will be ready for the team to accept children and their families and carers in May 2024. The service will be a safe space to assess a child's mental health needs and provide space for families to share issues with the team.

The HWB also has a Cwtch area, a space where a child can have some safe time out to discuss mental health needs and concerns with staff, and in time there will be an opportunity for staff to facilitate group and 1-1 evidence based interventions.

This new service will prevent the need for admissions to acute mental health wards for short assessments, whilst also offering home treatment & an assertive outreach approach for children in crisis and for those who struggle to engage with services. The service works closely with 111 press 2 and our Local Authority partners.

The team consists of a team leader, nurse therapist, crisis practitioners & healthcare support workers. The service will be subject to ongoing evaluation.



**Initial feedback has been positive**

*We were all very impressed with the session yesterday. E. felt very safe with you, thank you! Thank you for looking after him so well!! It's a shame you can't continue working with him. " (parent) (child turned 18)*

*"Felt that it was going to be a challenge to get into CAMHS but we have been impressed with the whole process and the support offered. (Parent)*

Following 6 Visits from HIW there is a focus on improving learning in Mental Capacity Act and Safeguarding Training. Good progress has been achieved in all areas, with one requiring some focussed support to reach the 85% required target. This is an overall improvement of an average of 50% at the time of the visits. Monitoring continues within the Service Group and at the quarterly Safeguarding Strategic Group.

## Mental Capacity Act Mandatory Training

Org L6	Assignment Count	Required	Achieved	Compliance %
070 5 Hospital Nursing (BRO) E501	28	28	27	96.43%
070 5 Hospital Nursing (LWH) F001	32	32	29	90.63%
070 5 Hospital Nursing (MAC) G501	26	26	23	88.46%
070 5 Hospital Nursing (MCI) H001	31	31	23	74.19%
070 5 Hospital Nursing (VMW) H501	30	30	22	73.33%
070 5 Hospital Nursing Epynt E001	26	26	21	80.77%
070 5 Hospital Nursing LND G001	31	31	29	93.55%
070 5 Hospital Nursing Y Bannau - E007	27	27	25	92.59%
070 5 Hospital Nursing YCH D002	33	33	22	66.67%

## Safeguarding Level 1 and 2 Mandatory Training

Org L6	Assignment Count	Required	Achieved	Compliance %
070 5 Hospital Nursing (BRO) E501	15	15	14	93.33%
070 5 Hospital Nursing (LWH) F001	20	20	18	90.00%
070 5 Hospital Nursing (MAC) G501	17	17	16	94.12%
070 5 Hospital Nursing (MCI) H001	17	17	17	100.00%
070 5 Hospital Nursing (VMW) H501	16	16	14	87.50%
070 5 Hospital Nursing Epynt E001	15	15	13	86.67%
070 5 Hospital Nursing LND G001	20	20	19	95.00%
070 5 Hospital Nursing Y Bannau - E007	17	17	17	100.00%
070 5 Hospital Nursing YCH D002	18	18	14	77.78%

## Review of Learning Outcomes from the Inpatient Falls Panels

Every fall that takes place in a ward setting is reported on Datix and reviewed at a PTHB Falls Panel. The Quality & Safety Team, a Community Service Manager and a representative from the ward where the fall occurred all attend.

The objectives of the panel are to establish whether the fall was avoidable or unavoidable, is Duty of Candour is triggered; whether any harm occurred to the patient; has the Falls pathway been followed correctly and to identify and share any learning with the overall aim to reduce avoidable falls.

Since the Falls Panel commenced there has been a 14% reduction in reported falls. Continued monitoring will help to interpret this drop

## Emerging Themes

Many patients who require assistance wish to preserve their dignity and independence when using the bathroom and this is a common area for falls.

Patients with specific needs are at higher risk of falls

Lying and standing blood pressure is not consistently recorded

Although compliance with the falls assessment is good, they are not consistently updated with all falls

Patients sometimes fall because they have used a bedside table to assist them to stand

Bedrails are not always put back into place when visitors leave

Medication can increase the risk the risk of falls

## Good Practice

The management of falls has improved with the implementation of the Falls Panel. Ward Managers are becoming more engaged which is leading to professional discussions and sharing best practice.

The incidence of alarm mats has been reduced as recommended by the All Wales Falls Network.

The quality of documentation & compliance with the Falls pathway is improving

Staff are promoting independence

The proportion of avoidable falls is low, suggesting that the staff are appropriately assessing and mitigating risk.

RITA's are available on all wards (a tool to promote positive interaction between ward patients and helps build trust and rapport between patients, staff and volunteers.)

## Recommendations

Bathrooms are high risk areas, any future refurbishment work must consider the needs of the older adult, this includes the design of the bins which appear to be a falls risk.

Undertake an annual documentation audit to monitor compliance with the Falls Pathway

The Falls Panels work well, however, consideration to be given to new ways to maximise the learning

Lying and standing blood pressure can be a useful indicator of falls. The Welsh Nursing Care Record could be amended to add this to the admission document

The Safeguarding Team are currently unable to attend Falls Panel due to capacity, however, are contacted for advice when required. A new format for panel is being considered which may give an opportunity for this to be revisited.

# Women and Family Health

## Level 3 Training Compliance broken down into each discipline

- ❖ **Health Visiting:** compliance 63.16% - all outstanding staff have booked onto training
- ❖ **School Nursing:** compliance 90.19% - the one SN not trained is a new starter
- ❖ **Speech & Language Therapy:** compliance 60% (3 new starters)
- ❖ **Maternity Services:** compliance 90%
- ❖ **CCN/LD/ND:** compliance 75%

There is a high level of safeguarding activity within the service based on safeguarding reports & calls to the safeguarding hub

**Chathealth** an application where school age children can communicate with PTHB School Nursing Service has been nominated for a PTHB internal innovation award. The services is being widely promoted with a recent increase in use.

## Standard Operating Processes updated, finalised & ratified include;

Adoption SOP, Caseload Management SOP, Multi-Disciplinary Team SOP, Health Visitor Routine Enquiry SOP.

## Audits undertaken and action taken to learn when required. Audits include;

Was Not Brought, Routine Enquiry in Health Visiting, Midwifery & Sexual Health & Safer sleep information sharing in Midwifery

Service fully engaged in the JICPA and Child Practice Review process and working to progress the action plans

Perinatal and child death review meetings held monthly with annual presentation of learning





## NHS 111 Press 2

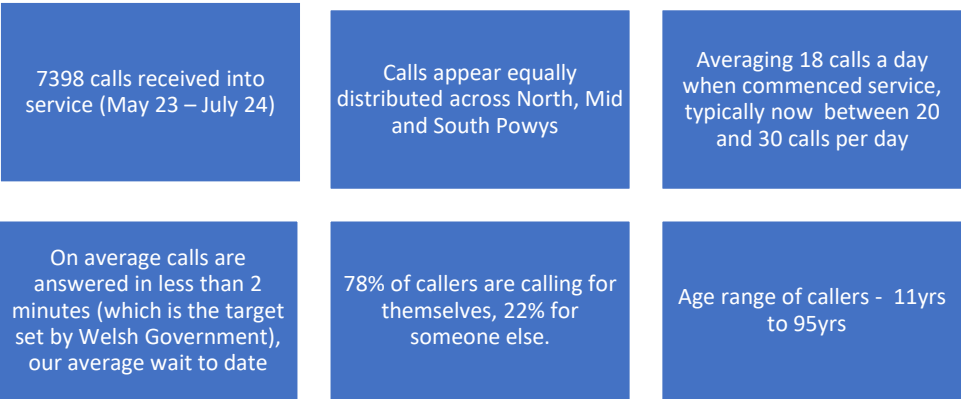
May 2023 saw the National launch of NHS 111 Press Option 2, a service for urgent mental health support which is available 24 hours a day, 7 days a week for all ages if someone had an urgent mental health concern themselves or about someone they know.

By providing access to a mental health professional, without the need for a GP referral, it can help support people to manage a mental health crisis and in many cases be an alternative to attending emergency departments or calling the police.

Callers will be transferred to a dedicated member of a mental health team in their local health board area. It includes an assessment of needs and telephoned based intervention to reduce distress. Where appropriate individuals can be referred to mental health services, given self-care advice or signposted to other support.

In addition to the national campaigns the services is being promoted in Police Stations, Supermarkets, Leisure Centres, Hospitals, Third Sector Organisations, GP Surgeries, Job Centres, Citizens Advice, Restaurants and awareness raising in schools by our CAMHS colleagues

## 111 Press 2



## Incidents and Reviews

Following learning from several incident and reviews within Mental Health the service are commissioning training for staff regarding trauma informed care.

There are currently 2 Domestic Homicide reviews underway which Mental Health are actively participating in.

All open National Reportable Incidents (NRI's) have clear timelines for completion.

The service has developed trackers to support with timely audit and policy updates.

Mental Health have been in escalation since March 2023. This has been a difficult but positive experience, at the time of escalation the service had 660 Datix going back to 2021. The introduction of twice weekly Datix huddles has had a significant impact in supporting the service maintain oversight of incidents and enabled the learning is shared quickly. At the time of writing there were 57 Datix's waiting to be investigated.

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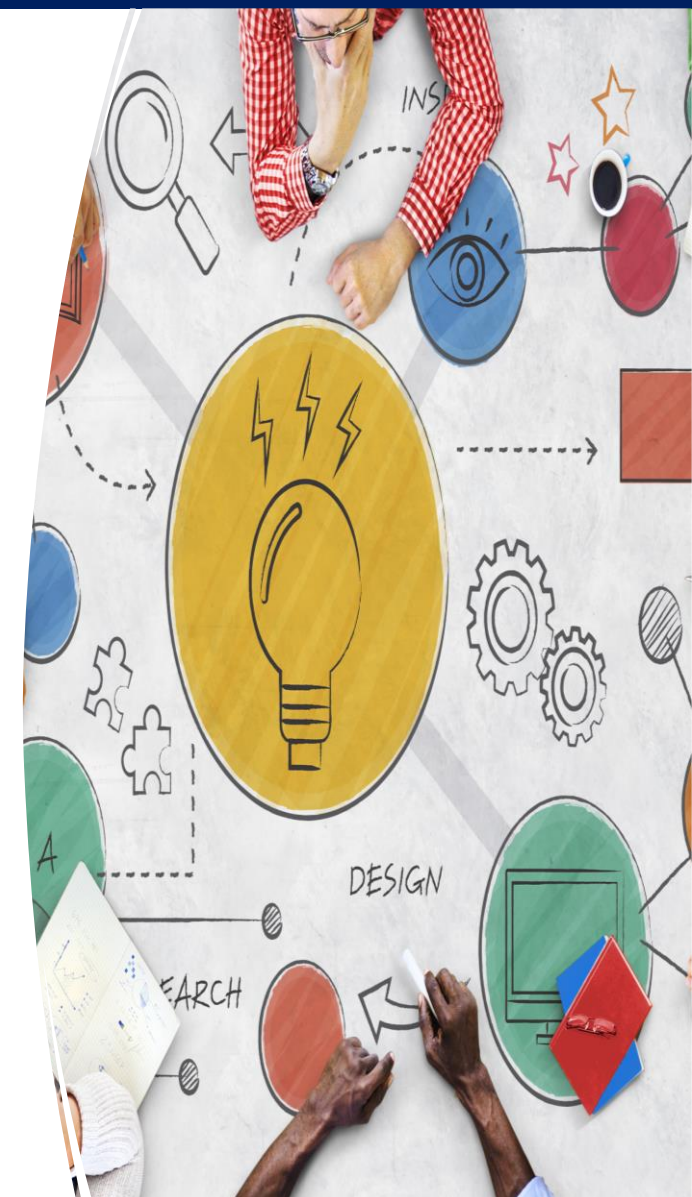
## What's in development

### Single Point of Access

A Single Point of Referral into Mental Health Services will launch later in the year. This will ensure a robust and timely mental health assessment and will streamline patient's experiences.

### Suicide Prevention Risk Assessment Tool

Mental Health are going to be a pilot site in Wales for a new Suicide Prevention risk assessment tool. This will commence with a two-day training course for 20 staff which is being organised for September 2024.



# Powys Teaching Health Board Safeguarding Priorities 2024-2025



## Our Priorities for 2024-2025;

- ❖ Maintain the level of access staff have to the Safeguarding Team
- ❖ Continue to work on improving compliance with Level 3 safeguarding training
- ❖ Continue to work with Informatics to develop systems to improve the efficiencies and effectiveness of data collection and analysis
- ❖ Implement the learning from the JICPA and Child Practice Review
- ❖ Implement the new RL Datix Once for Wales Management System to Report Safeguarding Concerns to the Local Authority.
- ❖ Develop a Business Case to enable the MCA improvement work to continue, including developing our own Best Interest Assessors
- ❖ Work with the Regional VAWDASV Survivor Panel to ensure survivor experiences help shape existing and new VAWDASV processes within the health board
- ❖ In collaboration with the NHS Safeguarding Service develop a Safeguarding Strategy that can be adapted to each health board and trust
- ❖ Audit service user's experiences of health involvement in the safeguarding process
- ❖ Complete process mapping of the management of sexual & violent offenders using healthcare
- ❖ Continue to influence the safeguarding agenda at a local, regional and national level