

# Patient Experience, Quality & Safety Committee

Tue 16 April 2024, 09:30 - 12:30

## Agenda

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### 09:30 - 09:30 1. PRELIMINARY MATTERS

0 min

 PEQS\_Agenda\_16APR24.pdf (2 pages)

#### 1.1. Welcome and Apologies

#### 1.2. Declarations of Interest

#### 1.3. Minutes from the previous meeting held on the 23 January 2024 for approval

 PEQS\_1.3\_unconfirmed Minutes 2024-01-23.pdf (14 pages)

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

 PEQS\_1.4\_Action Log April 2024.pdf (2 pages)

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### 09:30 - 09:30 2. ITEMS FOR ASSURANCE

0 min

#### 2.1. Integrated Quality Report

 PEQS\_2.1\_Integrated Quality Paper April 2024.pdf (15 pages)

 PEQS\_2.1ai\_App 1 briefing 27 March.pdf (1 pages)


 PEQS\_2.1aii\_App 1 PWLS PREMS data.pdf (3 pages)

 PEQS\_2.1aiii\_App 1 PWLS PREMS data.pdf (2 pages)


 PEQS\_2.1ci\_App 3 HIW Charro Dental Practice Report.pdf (25 pages)

 PEQS\_2.1ci\_App 3 HIW Charro Dental Practice Report cym.pdf (26 pages)

 PEQS\_2.1d\_App 4 HIW MH Hospitals and MH Act Monitoring.pdf (49 pages)

 PEQS\_2.1e\_App 5 Quality and Engagement Act Implementation Plan.pdf (16 pages)

#### 2.2. Mental Health Quality and Safety Review

 PEQS\_2.2\_Mental Health Quality and Safety Review Final.pdf (6 pages)

#### 2.3. Clinical Audit Annual Programme

 PEQS\_2.3\_Clinical Audit Annual Programme\_202425 final.pdf (18 pages)

#### 2.4. Joint Inspection of Child Protection Arrangements Action Plan

 PEQS\_2.4\_JICPA Report PEQS.pdf (6 pages)

 PEQS\_2.4a\_Powys JICPA Report - Final.pdf (26 pages)

#### 2.5. Child Practice Review


 PEQS\_2.5\_Child Practice Review Report.pdf (6 pages)

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09:30 - 09:30 **3. ITEMS FOR APPROVAL**

0 min

**3.1. Committee Annual Report**

 PEQS\_3.1\_Committee Annual Report\_Apr24.pdf (12 pages)

**3.2. Committee Annual Work Programme**

*Oral*

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09:30 - 09:30 **4. ITEMS FOR DISCUSSION**

0 min

*There are no items for discussion.*

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09:30 - 09:30 **5. ESCALATED ITEMS**

0 min


**5.1. Infection Prevention and Control - within Integrated Quality Report**

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09:30 - 09:30 **6. ITEMS FOR INFORMATION**

0 min

**6.1. Annual Internal Audit Plan 2024/25**

 PEQS\_6a\_Internal Audit Plan 2024-25.pdf (29 pages)

**6.2. Board and Committee Effectiveness Internal Audit 2023/2024**

 PEQS\_6b\_IA Report Board& Committee Structure Effectiveness.pdf (10 pages)

**6.3. Infection Prevention and Control Internal Audit**

 PEQS\_6c\_IA Report IPC.pdf (16 pages)

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09:30 - 09:30 **7. OTHER MATTERS**

0 min

**7.1. Committee Risk Register**

 PEQS\_Item\_7.1\_Committee Risk Report\_Feb24.pdf (3 pages)

 PEQS\_Item\_7.1a\_Committee Risk Register\_Feb24.pdf (6 pages)

**7.2. Items to be Brought to the Attention of the Board and/or Other Committees**

**7.3. Any Other Urgent Business**

**7.4. Date of the Next Meeting:**

*To be confirmed*

**7.5. Confidential Items**

*Representatives of the press and other members of the public shall be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest*

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**7.6. Welcome and Apologies**

**7.7. Declarations of Interest**

**7.8. Minutes of the In-Committee meeting held on 23 January 2024**

**7.9. Close**

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



**GIG  
CYMRU  
NHS  
WALES**

Bwrdd Iechyd  
Addysgu Powys  
Powys Teaching  
Health Board

**TUESDAY 16 APRIL 2024  
09:30 – 12:30  
VIA MICROSOFT TEAMS**

**AGENDA**

<b>Time</b>	<b>Item</b>	<b>Title</b>	<b>Attached/Oral</b>	<b>Presenter</b>
	<b>1</b>	<b>PRELIMINARY MATTERS</b>		
09:30	1.1	Welcome and Apologies	Oral	Chair
	1.2	Declarations of Interest	Oral	All
	1.3	Minutes from the previous Meeting held on 23 January 2024	Attached	Chair
	1.4	Committee Action Log	Attached	Chair
	<b>2</b>	<b>ITEMS FOR ASSURANCE</b>		
09:40	2.1	Integrated Quality Report	Attached	Director of Nursing and Midwifery
10:40	2.2	Mental Health Quality and Safety Review	Attached	Director of Nursing and Midwifery/Director of Operations, Community Care and Mental Health
11:00	<b>COMFORT BREAK (15 minutes)</b>			
11:15	2.3	Clinical Audit Annual Programme	Attached	Medical Director
11:30	2.4	Joint Inspection of Child Protection Arrangements Action Plan	Attached	Director of Nursing and Midwifery
11:50	2.5	Child Practice Review	Attached	Director of Nursing and Midwifery
	<b>3</b>	<b>ITEMS FOR APPROVAL</b>		
12:10	3.1	Committee Annual Report	Attached	Chair
12:15	3.2	Committee Annual Work Programme	Oral	Director of Corporate Governance
	<b>4</b>	<b>ITEMS FOR DISCUSSION</b>		
		<i>There are no items for discussion</i>		
	<b>5</b>	<b>ESCALATED ITEMS</b>		
	5.1	Infection Prevention Control – within IQR		
	<b>6</b>	<b>ITEMS FOR INFORMATION</b>		
		Internal Audit Reports (if any) <ul style="list-style-type: none"> <li>Annual Internal Audit Plan (2024/25)</li> </ul>		

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		<ul style="list-style-type: none"> <li>• Board Committee Effectiveness (2023/24)</li> <li>• Infection Prevention and Control</li> </ul>		
	<b>7</b>	<b>OTHER MATTERS</b>		
12.20	7.1	Committee Risk Register	Oral	Director of Corporate Governance
	7.2	Items to be Brought to the Attention of the Board and/or Other Committees	Oral	Chair
	7.3	Any Other Urgent Business	Oral	Chair
	7.4	Date of the next meeting: To be confirmed		
<p>7.5 The Chair, with advice from the Director of Corporate Governance, has determined that the following items include confidential or commercially sensitive information which is not in the public interest to discuss in an open meeting at this time. The Board is asked to take this advice into account when considering the following motion to exclude the public from this part of the meeting:</p> <p><u>Motion under Section 1(2) Public Bodies (Admission to Meetings) Act 1960</u></p> <p><b><i>"Representatives of the press and other members of the public shall be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest"</i></b></p>				
12.25	7.6	Welcome and Apologies		
	7.7	Declaration of Interest		
	7.8	Minutes of the In-Committee meeting held on 23 January 2024	Attached	Chair
12.30	Close			

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

**UNCONFIRMED**

**MINUTES OF THE MEETING HELD ON TUESDAY 23 JANUARY 2024  
VIA MICROSOFT TEAMS**

**Present:**

Kirsty Williams  
Jennifer Owen Adams  
Simon Wright  
Ian Phillips

Vice-Chair (Committee Chair)  
Independent Member  
Independent Member  
Independent Member

**In Attendance:**

Claire Roche  
Claire Madsen  
Kate Wright  
Pete Hopgood  
Joy Garfitt

Director of Nursing and Midwifery  
Director of Therapies and Health Sciences  
Medical Director  
Director of Finance, Information and IT  
Interim Director Operations, Community Care and  
Mental Health  
Assistant Director of Quality and Safety  
Director of Corporate Governance  
Deputy Director Nursing)  
Assistant Director – Innovations and Improvement  
Assistant Director – Mental Health and LD Services  
Director of Corporate Governance (from 10.05)

Zoe Ashman  
Helen Bushell  
Marie Davies  
Amanda Edwards  
Louisa Kerr  
Helen Bushell

**Observing:**

Carl Cooper  
Stuart Bodnam  
Daisy Dee  
Alexandra Jones

Chair PTHB  
Internal Audit  
Health Inspectorate Wales  
Health Inspectorate Wales

**Apologies for absence:**

Hayley Thomas  
Mererid Bowley  
Debra Wood Lawson  
Sarah Diskin

Interim Chief Executive  
Director of Public Health  
Director of Workforce and OD  
Llais

**Committee Support:**

Liz Patterson  
Sue Wilcox

Interim Head of Corporate Governance  
Senior Administrator

PEQS/23/56	<p><b>WELCOME AND APOLOGIES FOR ABSENCE</b></p> <p>The Committee Chair welcomed Members to the meeting. Apologies for absence were noted as recorded above.</p>
PEQS/23/57	<p><b>DECLARATIONS OF INTERESTS</b></p> <p>No interests were declared in addition to those already declared in the published register.</p>
PEQS/23/58	<p><b>MINUTES OF THE EXPERIENCE, QUALITY AND SAFETY COMMITTEE MEETING HELD ON 24 OCTOBER 2023 (FOR APPROVAL) AND MATTERS ARISING FROM THE MINUTES</b></p> <p>The minutes of the previous meeting held 24 October 2023 were AGREED as a true and accurate record.</p> <p>Ian Philips advised the following matters relating to the Pharmacy paper will be taken forward to the Workforce and Culture Committee, which he chairs:</p> <ul style="list-style-type: none"> <li>• Training – Understanding the priorities for essential training, as this links with ‘Powys – a better place to work’.</li> <li>• Fixed Term Contracts – given the high vacancy rates should the Health Board be taking a more calculated risk in temporary funded posts.</li> </ul> <p><i>Should an action be assigned regarding a follow-up paper on point of care testing?</i></p> <p>The Director of Therapies and Health Sciences noted the post of First Point of Care Testing Coordinator has been recently filled on a fixed term basis for 12 months. An initial scoping exercise is being completed looking at the priorities and issues, to enable a status report to be drafted, which will evidence or otherwise the need for this to be substantive role.</p> <p>This will be brought back to Committee in autumn 2024.</p> <p><b>Action: Director of Therapies and Health Sciences</b></p>
PEQS/23/59	<p><b>PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE ACTION LOG</b></p> <p>The Chair presented the action log noting that four items were classed as ‘at risk’, three of which had a change of date request. The Director of Nursing and Midwifery advised the change of date requests were due to</p>

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	<ul style="list-style-type: none"> <li>• <b>PEQS/23/40 The disaggregation of inherited and acquired pressure sore incident</b> –concerns about the quality of the data remain, work is ongoing, and it is anticipated this will be completed for the April Committee.</li> <li>• <b>PEQS/23/23a -The Mental Capacity Act</b> and the backlogs in the system - the team are in the process of drafting a report that is due to go to the Executive Committee in the next few weeks and will be brought to the April Committee.</li> <li>• <b>PEQS/23/84b The Child Practice review</b> is led by the Regional Safeguarding Board. The report is expected in mid-February and once published will be taken through the Safeguarding and Strategic Steering Group and included in the Integrated Quality Report for the April Committee.</li> </ul> <p>The Interim Director Operations, Community Care and MH noted the fourth 'at risk' item (PEQS/23/43) concerning access to the 111 press 2 service from England. England does not have a universal 111 press 2 service although this is being developed as a priority. A caller will need to be in Wales to use the Welsh system; although there are some oddities around the border. Until the English 111p2 system is universal it will be necessary to contact Powys Safeguarding Hub to access this service. This action was closed.</p> <p>The change of date requests were APPROVED.</p>
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**ITEMS FOR ASSURANCE**

<p>PEQS/23/60</p>	<p><b>INTEGRATED QUALITY REPORT:</b></p> <p>The Director of Nursing and Midwifery presented the report and drew attention to the following areas:-</p> <ul style="list-style-type: none"> <li>• Putting Things Right (PTR) management of concerns - maintaining the management of concerns within 30 days. Quarter 1 to quarter 3 compliance was 76%.</li> <li>• Duty of Candour –an increase in cases being triggered, the majority of which are categorised as moderate harm, none of the cases have been referred for readdress. A rise in cases is anticipated, as this process embeds in the organisation and confidence in the Duty of Candour increases.</li> <li>• Reporting returns to the Public Service Ombudsman for Wales (PSOW) – there were a high number of reports from Powys referred to the PSOW in relation to the previous year, partially due to a significant</li> </ul>
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number of backlog complaints being closed. The PSOW referrals have now reduced.

- Incident management – continuing to work on the timely management and closure of incidents across the organisation. The number of patient safety incidents remain stable and appropriately reported as a low or no harm classification.
- Patient experience – work is being undertaken to allow service users/patients and their families voices be heard, informing of improvements that need to be made. The number of responses in Civica are low, so the text notifications and prompts are being reviewed to maximise the opportunity to capture feedback.

Infection Prevention and Control has been escalated to Board by the Committee. Good progress is being made implementing the Year 1 improvement plan with 29 actions completed, 8 on track, 9 where progress has been made and they are likely to be achieved and 1 which will be addressed in Q4. The improvement plan for Year 2 is in development.

Independent Members asked the following questions for assurance:

*Why is there not more success in early resolution?*

The Director of Nursing and Midwifery advised that the number of complaints currently is low. as the backlog of complaints having been cleared, which may affect the data shown in the report. There is a continued focus on maximising the opportunities of staff to have training on effective conversations, to address the issue at source.

*What action has been taken in relation to a theme identifiable within the appendices relating to the standard of record keeping?*

The Director of Nursing and Midwifery advised the standard of record keeping is a consistent theme of concern, any audits undertaken will have a focus on the standard of the record keeping. As records are digitised this will allow for easier monitoring of record keeping than is currently the case with hard copy records.

The Medical Director and Director of Therapies and Health Sciences both confirmed there was an urgent need to press ahead for a unified digital record as needing to complete multiple sets of records was challenging.

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*What is the reason for the high portion of re-grading of incidents?*

The Director of Nursing and Midwifery advised it is not uncommon for incidents to be initially categorised as a high level of harm, when on investigation the incident presented a lower degree of harm.

*Are the low number responses from Civica and the lack of wi-fi performance on the wards linked?*

The Director of Finance, Information and IT noted that improving wi-fi and digital infrastructure is an ongoing action area. This is reported in the Digital First and Infrastructure audits.

*Can it be confirmed that in relation to digital upgrades for wards that Velindre Ward in Bronllys is a priority?*

The Director of Finance, Information and IT advised that the supplier for guest wi-fi is changing which should improve connectivity, reliability, consistency and improved speed.

The Director of Corporate Governance joined the meeting  
10.05

*Is there anything that can help solve or relieve the block on the rate of closing down incident management?*

The Director of Nursing and Midwifery suggested the block may be due to a number of reasons

- Practicalities of understanding of what constitutes as an incident – inappropriate use of the Datix system, where people log an incident which is not an incident. These incidents then remain in the system until closed off.
- Capacity – to deal with the above
- Culture – where some colleagues see this as cumbersome rather than a learning opportunity

*Can a summary of progress on implementation of the Duty of Quality and Candour be brought to Committee?*

The Director of Nursing and Midwifery confirmed the Duty of Quality and Duty of Candour implementation plan will be included in the next IQR to Committee.

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*When with the policy on dealing with vexatious complainant policy be implemented?*

The Director of Nursing and Midwifery advised this policy will be going to the Executive Committee 24 January 2024 for approval, subject to approval it will be implemented immediately.

*In terms of the themes coming from Civica, how do we know if things are getting better or worse?*

The Director of Nursing and Midwifery advised some of the high-level trends and themes have been identified, However, to do this comprehensively, an integrated quality management system needs to be incorporated into the Integrated Performance Report.

The Chair advised that the Planning Team were keen for this to be considered at Board Development.

**Action: Director of Corporate Governance**

*How were the priorities to develop Civica identified?*

The Director of Nursing and Midwifery advised that these were identified by the Patient Experience Steering Group.

*The Living Well team are using the Microsoft 365 appointment function which has been integrated with Civica. How is this system being maximised across the organisation?*

The Assistant Director of Quality and Safety noted that significant progress has been made with Civica, many services are using the appointment functionality, but using it across the whole of the organisation continues to be a challenge. Accessing information for the patients who have received care from a commissioned organisation is the next step. The narrative in the text messages has been re-phrased which it is hoped will prompt greater response rates.

*Are the rates of clinical negligence and general medicine practice indemnity claims at an expected level?*

The Assistant Director of Quality and Safety advised that the Health Board are not an outlier with the numbers of these cases.

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	<p>The Committee:</p> <ul style="list-style-type: none"> <li>RECEIVED the report and take ASSURANCE that Quality and Safety is appropriately monitored and reported and that continued actions are in place to further develop quality and safety monitoring and reporting.</li> </ul>
PEQS/23/61	<p><b>MENTAL HEALTH DEEP DIVE FROM A QUALITY AND SAFETY PERSPECTIVE (ACTIONS PEQS/22/51, PEQS IC/22/73 AND PEQS/23/42)</b></p> <p>The Director of Nursing and Midwifery introduced the report in response to some of the actions on the Action Log and in relation to Chief Executive’s request for a deep dive into Mental Health incident management.</p> <p>A high-level report on nationally reportable incidents is taken to the Executive Committee monthly. It is not a detailed analysis but provides a breakdown of where in the organisation those incidents have occurred and broadly what they relate to.</p> <p>Fifty incidents from all service areas and team in Mental Health were randomly selected on the Datix systems (25 open incidents and 25 closed incidents). These were reviewed, along with the reporting arrangements for identifying and reporting nationally reportable incidents in line with the incident management framework. The review identified some gaps with the management of incidents and the NRI incidents, in addition to identifying some opportunities for improvement, these are being captured in an improvement plan.</p> <p>The next step is to develop a Mental Health Quality and Safety Improvement Plan which will include the findings of the review and emerging improvements, this will be reported through the Executive Committee.</p> <p>The Committee:</p> <ul style="list-style-type: none"> <li>NOTED that an Incident Management Quality and Safety review has been undertaken in Mental Health Services, and</li> </ul> <p>Took ASSURANCE that an improvement plan is being developed which will be received and monitored by the Executive Committee, and an update will be provided to this Committee at its next meeting in April 2024.</p>

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PEQS/23/62	<p><b>MH POWER OF DISCHARGE SIX MONTHLY REPORT INCLUDING MH COMPLIANCE WITH LEGISLATION</b></p> <p>The Interim Director Operations, Community Care and Mental Health introduced the technical report concerned with the processes and legality of how powers are discharged under the Mental Health Act.</p> <p>The Assistant Director – Mental Health and LD Services drew attention to the Health Board’s compliance against the majority of measures. There has not been a significant difference in activity compared to previous years, although there have been minor variations which show a slight increase. This is believed to relate to the acuity in Mental Health.</p> <p>There is ongoing work to improve the Scheme of Delegation, via the Powers Of Discharge Group and the engagement of advocates at hearings.</p> <p>It has been recognised that there is a need to invest in the Mental Health Act administration. The quality and safety of the structure is under review.</p> <p>The Committee RECEIVED the report and took ASSURANCE in relation to administration of the Mental Health Act and compliance with legislation.</p>
PEQS/23/63	<p><b>JOINT INSPECTION ON CHILD PROTECTION ARRANGEMENTS (JICPA)</b></p> <ul style="list-style-type: none"> <li>including update on level 3 safeguarding training - PEQS/23/23b</li> </ul> <p>The Director of Nursing and Midwifery gave a verbal update confirming the final report for the joint inspection of Child Protection arrangements led the Care Inspectorate of Wales and supported by Health Inspectorate Wales, Inspectorate for the Police and Estyn, that was expected to be fully published at the beginning of January will not be published until the beginning of February.</p> <p>A draft report was received in December and responded to in terms of some factual inaccuracies. The draft report did not look significantly different to the verbal feedback already received.</p> <p>This will be an agenda item in the April Committee, where the full JICPA report will be brought to the Committee, supplemented by the narrative to the improvement plan and what has happened on receipt of the report.</p>

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	<p>On receipt of the report, the Director of Nursing and Midwifery along with the Directors of Social Services and senior personnel in Dyfed Powys Police will be charged with drafting a joint improvement plan for Powys.</p> <p>The key learning from this was the Level 3 Safeguarding training compliance. The safeguarding team have an action plan to address this, which was in development prior to JICPA, and will be monitored through the Safeguarding Steering Group whilst reporting to this committee on a regular basis.</p> <p><b>Action: The Director of Nursing and Midwifery</b> to provide details of the Level 3 Safeguarding Training implementation plan and timescales, once the report is received.</p> <p>The Committee NOTED the update.</p>
PEQS/23/64	<p><b>CANCER IMPROVEMENT PLAN</b></p> <p>The Medical Director introduced the item for the Committee to take assurance that a plan is in place, for the period 2023-2026. The national Cancer Plan was approved in 2023 covering all aspects from early diagnosis to living with cancer. The team, working in partnership with commissioning partners, the local authority and third sector have mapped services against the national plan. It is a complex and long term plan and discussions on reporting arrangements are ongoing. It is likely that reporting will take place in Executive Committee with an annual report to this Committee.</p> <p>Independent Members asked the following questions for assurance:</p> <p><i>What is the position regarding Rapid Diagnostic Centres for Powys patients which, are present, can require lengthy travel to access?</i></p> <p>The Medical Director advised Rapid Diagnostic Centres in Powys would not be viable due to low numbers of patients and inability to staff such centres.</p> <p>The Assistant Director of Quality and Safety noted the feedback from a recent survey of patients on Urgent Suspected Cancer pathway had provided learning for the Health Board. A number of patients had said they had received a very prompt service. The findings from the</p>

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	<p>survey will be shared with this committee at the next meeting.</p> <p><i>Is there anything that can be done at a national level which will help drive and improve outcomes for patients?</i></p> <p>The Medical Director noted the Cancer Improvement NHS Wales is the national response, there is a need to get into the preventative phase.</p> <p>The Committee:</p> <p>took ASSURANCE that the Cancer Improvement Plan 2023-2026 is in place and will RECEIVE updates on quality safety and patient experience of the plan.</p>
<p>PEQS/23/65</p>	<p><b>ANNUAL REPORT OF ACCOUNTABLE OFFICER FOR CONTROLLED DRUGS</b></p> <p>The Medical Director presented the Annual report which summarised the work of the Accountable Officer for Controlled Drugs, the Controlled Drugs local intelligence network, and the multi-agency network where learning from incidents to improve safety in the system takes place. It highlights the standards, the Standard Operating Procedures in place and monitoring and audit arrangements, with an emphasis on training and improvement in the prescribing process and incident management.</p> <p>There is ongoing work with Primary Care to prevent and reduce the numbers of controlled drugs prescribed.</p> <p>Independent Members asked the following questions for assurance:</p> <p><i>It appears that the Police are not reporting any incidences in relation to Controlled Drugs. Is this to be expected?</i></p> <p>The Medical Director advised this was likely to be as the Police were less involved in the prescribing and supporting use of Controlled Drugs.</p> <p><i>Attendance at the Local Intelligence network is on occasion less than 50%. Is this of concern?</i></p> <p>The Medical Director advised that whilst it would be preferable for there to be full attendance, the Controlled Drugs Accountable Officer was developing the network with the intention of encouraging greater attendance.</p>

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	<p>The Committee</p> <ul style="list-style-type: none"> <li>• RECEIVED the report recognising the progress that has been made during the last 12 months.</li> <li>• Took ASSURANCE that an annual report is in place and that systems exist to capture, record and report the information.</li> <li>• NOTED that there is still considerable work to be done to strengthen governance arrangements across the Health Board.</li> </ul>
PEQS/23/66	<p><b>WHSSC QUALITY AND SAFETY COMMITTEE CHAIRS REPORT OCTOBER 2023</b></p> <p>The Director of Nursing and Midwifery presented the report that highlighted two news risks within the Women and Children’s portfolio, particularly in neonatal and paediatrics at Cardiff and Vale UHB. This has been escalated to the Joint Committee at WHSSC.</p> <p>The Director of Nursing and Midwifery is receiving regular updates on key matters from the Director of Nursing and Quality at WHSSC. The Maternity and Neonatal network in Wales is working closely with Heads of Midwifery, Paediatric and Neonatal services with improvements in addition to the ongoing Maternity and Neonatal Safety Improvement Programme.</p> <p>The Committee NOTED the report from WHSSC Quality and Safety Committee.</p>
<b>ITEMS FOR APPROVAL</b>	
There were no items for approval	
<b>ITEMS FOR DISCUSSION</b>	
PEQS/23/67	<p><b>ANNUAL ASSESSMENT OF COMMITTEE EFFECTIVENESS</b></p> <p>The Director of Corporate Governance presented the slides which demonstrated the individual views of the effectiveness of the Committee. Moving forward, reviews will be held annually. The main areas for consideration were:</p> <ul style="list-style-type: none"> <li>• Composition and establishment</li> <li>• Effective functioning</li> <li>• Assurance</li> </ul> <p>Positive comments had been received and outlined under ‘areas that work well’, along with key areas for improvement.</p>

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	<p>All the above comments will be fed into next year's planning cycle, which will be presented to this Committee in April 2024.</p> <p>An action plan will be developed which will be consistent against all Committees, this will also be brought back to this Committee for review in April.</p> <p>A collective report with all Committee actions and feedback will be shared with the Board.</p> <p>Members welcomed the opportunity to contribute to the review and requested that consideration be given to how Committees communicate their work to the public.</p> <p>The Committee NOTED the presentation.</p>
PEQS/23/68	<p><b>REVIEW OF TERMS OF REFERENCE</b></p> <p>The Director of Corporate Governance presented the Terms of Reference noting they are dated 2021, when the Committee was meeting bi-monthly. Fundamental changes are not need, although some areas need to be added including The Duty of Quality; Duty of Candour and Speaking up Safely. Consideration needs to be given to the frequency of these meetings, currently meetings are held quarterly.</p> <p>Independent Members asked the following questions for assurance:</p> <p><i>Is it possible to amend the terms of reference to stress the patient centric nature of the Committee?</i></p> <p>The Assistant Director – Quality and Safety noted the inclusion of the Duty of Quality would help ensure quality measures and enablers are captured.</p> <p><i>Would it be possible to structure these meetings to allow enable reporting of quarterly data?</i></p> <p>The Director of Corporate Governance confirmed this suggestion will be considered.</p>
<b>ESCALATED ITEMS</b>	
PEQS/23/69	<p><b>INFECTION PREVENTION AND CONTROL IMPROVEMENT PLAN PROGRESS REPORT (CONTAINED WITHIN THE INTEGRATED QUALITY REPORT)</b></p> <p>The Chair noted this had been considered as part of the Integrated Quality Report and details would be included in her Chair's Report to the Board.</p>
<b>ITEMS FOR INFORMATION</b>	


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<b>OTHER MATTERS</b>	
PEQS/23/70	<p><b>COMMITTEE RISK REGISTER</b></p> <p>The Director of Corporate Governance advised Risk Register was not presented at this meeting as Executive Leads are in the process of updating the Risk Register for presentation at the Board meeting on the 31 January 2024.</p> <p>This will be routinely reported to the Committee in the 2024-2025 cycle.</p>
PEQS/23/71	<p><b>COMMITTEE WORK PROGRAMME</b></p> <p>The Director of Corporate Governance presented the Committee Work Programme for information.</p>
PEQS/23/72	<p><b>ITEMS TO BE BROUGHT TO THE ATTENTION OF THE BOARD AND/OR OTHER COMMITTEES</b></p> <p>There were no new items from the Patient Experience, Quality and Safety Committee to bring to the attention of Board. The Committee will update Board on Infection Prevention and Control.</p> <p>The following items will be taken to the Workforce and Culture Committee</p> <ul style="list-style-type: none"> <li>• Training – Understanding the priorities for essential training, which links with ‘Powys – a better place to work’.</li> <li>• Fixed Term Contracts – given the high vacancy rates should the Health Board be adopting a more calculated risk in temporary funded posts.</li> </ul>
PEQS/23/73	<p><b>ANY OTHER URGENT BUSINESS</b></p> <p>There was no other urgent business.</p>
PEQS/23/74	<p><b>DATE OF THE NEXT MEETING</b></p> <p>16 APRIL 2024, via Microsoft Teams.</p>
PEQS/23/75	<p><b>CONFIDENTIAL ITEM</b></p> <p>The following motion was passed:</p> <p><b><i>Representatives of the press and other members of the public shall be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.</i></b></p>
<b>PRESENT:</b>	

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<p>Kirsty Williams (Chair)  Jennifer Owen Adams (Independent Member)  Simon Wright (Independent Member)  Ian Philips (Independent Member)</p> <p><b>IN ATTENDANCE:</b></p> <p>Claire Madson (Director of Therapies and Health Sciences)  Helen Bushell (Director of Corporate Governance)  Marie Davies (Deputy Director of Nursing)  Zoe Ashman (Assistant Director of Quality and Safety)  Liz Patterson (Interim Head of Corporate Governance)</p> <p><b>APOLOGIES FOR ABSENCE:</b></p> <p>Joy Garfitt and (Interim Director Operations, Community Care and Mental Health)  Pete Hopgood (Director of Finance, Information and IT)  Claire Roche (Director of Nursing and Midwifery)  Kate Wright (Medical Director)  Debra Wood Lawson (Director of Workforce and OD)  Hayley Thomas (Chief executive Officer)</p>	
<p>PEQS IC/23/76</p>	<p><b>SUICIDE REVIEW REPORT (NOVEMBER 2023)</b></p> <p>Rationale for item being held in public: tbc</p> <p>The Committee:</p> <ul style="list-style-type: none"> <li>RECEIVED the report taking ASSURANCE that relevant systems are in place to capture and record relevant information;</li> <li>NOTED the continued actions that the service will continue to develop and implement.</li> </ul>
<p>PEQS IC/23/77</p>	<p><b>MENTAL HEALTH DEEP DIVE FROM A QUALITY AND SAFETY PERSPECTIVE</b></p> <p>Rationale for item being held in private: tbc</p> <p>The recommendation as outlined in PEQS/23/61 was confirmed.</p>

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Liz Patterson													
<b>RAG Status:</b>													
<b>At risk</b>	Red - action date passed or revised date needed												
<b>On track</b>	Yellow - action on target to be completed by agreed/revised date												
<b>Completed</b>	Green - action complete												
<b>No longer needed</b>	Blue - action to be removed and/or replaced by new action												
<b>Transferred</b>	Grey - Transferred to another group												
<b>Patient Experience, Quality and Safety Committee</b>													
<b>Meeting Date</b>	<b>Item Reference</b>	<b>Lead</b>	<b>Meeting Item Title</b>	<b>Details of Action</b>	<b>Update on Progress</b>	<b>Original target date</b>	<b>Revised Target Date</b>	<b>RAG status</b>					
<b>OPEN ACTIONS FOR REVIEW</b>													
24/10/2023	PEQS/23/40a	DoNM	Integrated Quality Report	IPR to include a disaggregation of inherited and acquired pressure sore incidents	<b>23.01.24 update</b> - request to provide this to April 2024 meeting <b>23.01.24 update</b> -This work is on-going to ensure that data is correct. It is anticipated this will be included in the IQR at in April 24. <b>16.04.24 update</b> - update to be provided in the meeting	Jan-24	Apr-24	On track					
04/07/2023	PEQS/23/23a	DoNM	Annual Safeguarding Report	The method of sharing information with the Committee relating to the number of cases and backlogs in the system to be reviewed	<b>24.10.2023 update</b> - A position paper regarding the Mental Capacity Act and Deprivation of Liberty Safeguards is in preparation for Executive Committee at the end of November. Change of date requested <b>23.01.24 update</b> : paper now going to Executive Committee late January. Change of date requested to April 2024. <b>16.04.24 update</b> - MCA report considered by Executive Committee on the 6 March, DoNM to provide an update in the PEQS committee meeting on 16.04.24.	Oct-23	Apr-24	On track					
29/11/2023	PTHB/23/12	DFIT	Llais Director Report	Assurance report requested on the process of off listing and number of patients affected under GP Behavioural Contracts	<b>23.01.24 update</b> - action to be updated during the meeting	Apr-24		On track					
<b>OPEN ACTIONS - IN PROGRESS BUT NOT YET DUE</b>													
23/01/2024	PEQS/23/63	DoNM	Joint Inspection on Child Protection Arrangements (JICPA)	Provide details of the Level Safeguarding Training implementation plan and timescales.	<b>16.04.24 update</b> - update to be provided during the meeting	Apr-24		On track					
23/01/2024	PEQS/23/58	DoTHS	First Point of Care Testing Coordinator	Update on draft status report evidencing or otherwise the need for the First Point of Care Testing Coordinator role	<b>16.04.24 update</b> - action on track	Oct-24		On track					
24/10/2023	PEQS/23/39a	MD	Medicine Management Annual Report	Update on Pharmacy Support to Mental Health Services to be included in the next Medicines Management Report	<b>23.01.24 update</b> - action on track <b>16.04.24 update</b> - action on track	Oct-24		On track					
24/10/2023	PEQS/23/39b	MD	Medicine Management Annual Report	Update on Electronic Prescribing to be included in the next Medicines Management Report	<b>23.01.24 update</b> - action on track <b>16.04.24 update</b> - action on track	Oct-24		On track					
<b>ACTIONS RECOMMENDED FOR CLOSURE (MEETING 16 April 2024)</b>													

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23-Feb-23	PEQS/22/84b	DNM	Child Practice Review	Child Practice Review to be brought back to Committee	<p><b>24.10.2023 update</b> - Date remains to be confirmed.</p> <p><b>25.04.23 update</b> - Added to work programme for Jan 2024, review due to be completed and report received in November</p> <p><b>23.01.24 update</b> Report expected February 2024, publish date is out of the health boards control. report will be shared with committee and reported at the following meeting following being published <b>16.04.2024 update</b> - On meeting agenda</p>	Jan-24	Apr-24	Completed
23/01/2024	PEQS/23/60	DCG	Integrated Quality Report	Due to the high-level trends and themes having been identified, an integrated quality management system needs to be incorporated into the Integrated Performance Report - an item to be considered at Board Development	<b>16.04.24 update</b> - item considered at Board on 20 March and approved.	Apr-24		Completed

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**Patient Experience & Quality  
Committee**

<b>Subject:</b>	<b>Integrated Quality Report</b>
<b>Approved and Presented by:</b>	Claire Roche, Executive Director of Nursing & Midwifery
<b>Prepared by:</b>	Zoe Ashman, Assistant Director Quality & Safety
<b>Other Committees and meetings considered at:</b>	Executive Committee 10 April 2024

**PURPOSE:**

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

**RECOMMENDATION(S):**

The Patient Experience and Quality Committee are asked to:

- **RECEIVE** the report and take **ASSURANCE** that Quality and Safety is appropriately monitored and reported and that continued actions are in place to further develop quality and safety monitoring and reporting.

<b>Approval/Ratification/Decision<sup>i</sup></b>	<b>Discussion</b>	<b>Information</b>
x	✓	✓

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

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

**ACRONYMS**

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

**DETAILED BACKGROUND AND ASSESSMENT:**

**1 Background**

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

**2 Specific matters for consideration by this meeting (Assessment)**

**2.1 Quality & Engagement Act (2023) Implementation**

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

an implementation plan to ensure compliance and maturity was achieved in line with the Duty of Quality and Duty of Candour.

Implementation plan, table of compliance:

	<b>Number of key objectives</b>	<b>Number of actions completed</b>	<b>Number of actions outstanding</b>
<b>Duty of Quality</b>	<b>6</b>	<b>26</b>	<b>4</b>
<b>Duty of Candour</b>	<b>6</b>	<b>18</b>	<b>0</b>

4 outstanding actions are:

1. Processes and systems in place to provide demonstrable evidence that Board decisions have been made through Quality lens.
2. To ensure the Board are assured that DoQ is being considered across system.
3. Review Health & Care Strategy through the lens of the Duty of Quality & Duty of Candour; strengthening existing messages.
4. Create and embed an infrastructure within the organisation through which the QMS is deployed.

Clear and robust plans are in place to ensure the 4 outstanding actions are completed and embedded during Q1 2024/25.

## **2.2 Once for Wales Content Management System (RLDatix)**

The implementation of the Once for Wales Content Management System (OFWCMS) is complete.

PTHB pilot of the risk module commenced in September 2023 within the Nursing Directorate, training has taken place to support roll out across service groups in a staged approach. Taking the opportunity to pilot the module ensures PTHB can use a digital platform to manage risks across the health board, ensuring a more robust structure for risk management visible on one platform.

Data dashboards are available within the datix system and in use by teams across the health board to further support the management of incidents in a timely and proportionate manner.

## **2.3 Supporting learning and improvement**

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

The team have supported learning events to discuss incidents that have occurred with common themes and crossover of learning. 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.

## 2.4 Putting Things Right – Concerns

The management of concerns compliance within 30 working days has been stable Q1-Q4 during 2023/24 with reported compliance nationally of 81.25% 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.

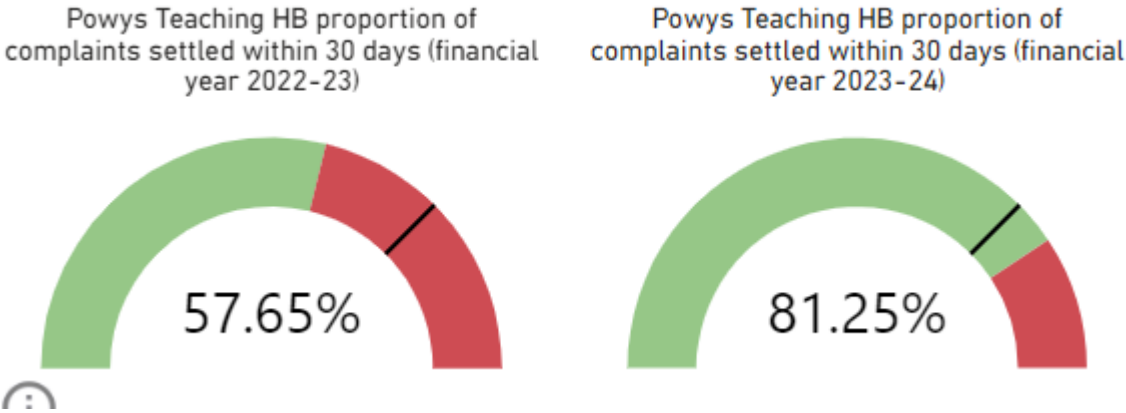
Table below demonstrate the number of concerns managed during 2022/23 & 2023/24, managed through PTR (formally) & Early Resolution.

22/23 - Complaint by Subtype and First received (Year)			
	2022	2023	Total
Managed through PTR	42	16	58
Early Resolution	50	19	69
Total	92	35	127

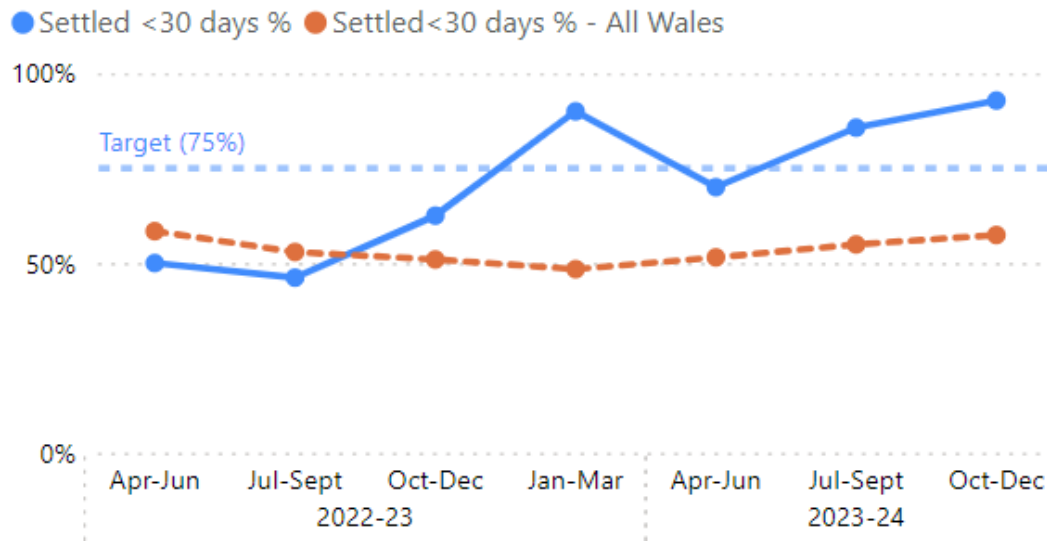
2023/2024 - Complaint by Subtype and First received (Year)			
	2023	2024	Total
Managed through PTR	48	19	67
Early Resolution	66	20	86
Total	114	39	153

**Graph 1 compares compliance 2022/23 with 2023/24 (Data obtained from NHS Executive Beacon Dashboard)**



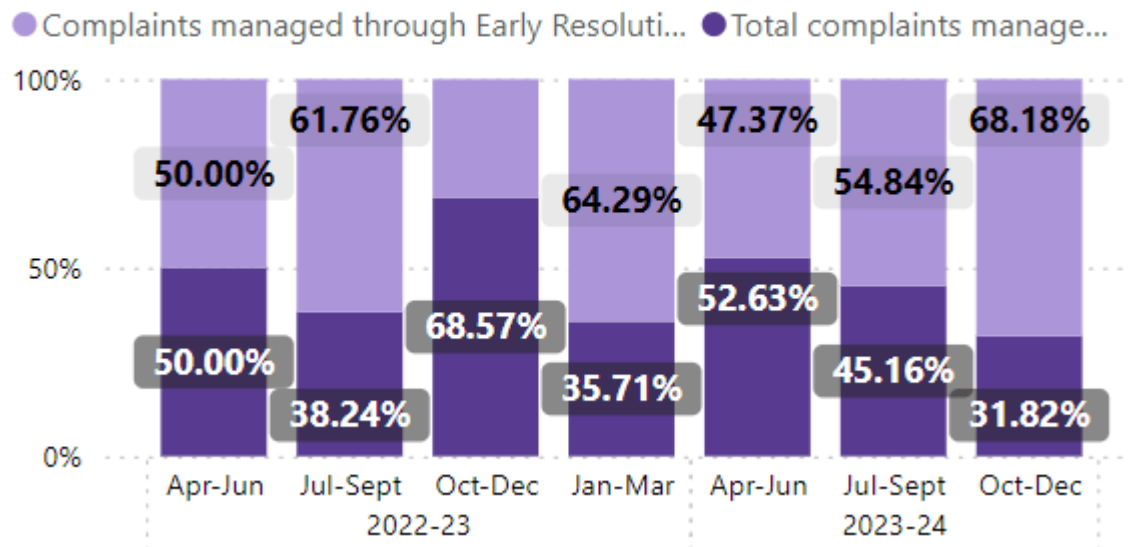
**Graph 2 highlights the Powys quarterly compliance (blue line) against the national position (Orange line) (Data obtained from NHS Executive Beacon Dashboard)**

## PT HB Putting Things Right (PTR)- Total Complaints Settled with Final Reply (Reg24) + % Settled Inside 30 days by Quarter



Graph 3 notes the percentage of concerns managed as early resolution (light purple) and formally (Dark purple) (Data obtained from NHS Executive Beacon Dashboard)

## PT HB New Complaints Settled Proportion



### Themes from concerns (provider) –

- Communication with families.
- Clarity of pathway of care.
- Decision making regarding pathways of care.

### Themes from concerns (commissioning) –

- Waiting time for gynaecology procedures at SaTH
- Attending appointments when results not available.
- Request to move care from one health board to another.

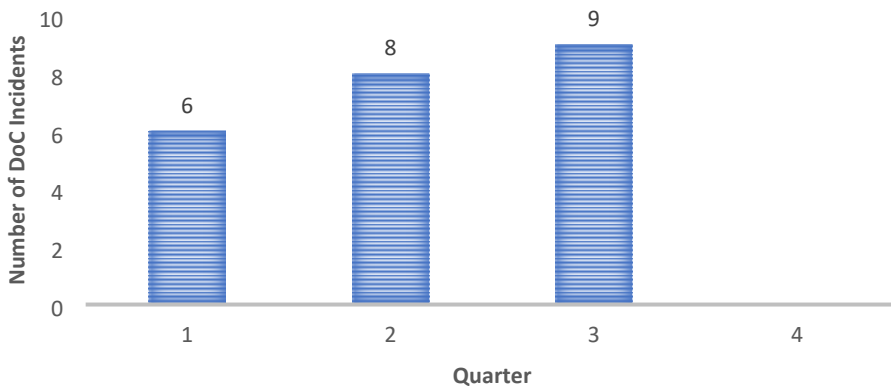
### Themes from enquiries –

- Unable to access dental care following closure of previous practice.
- Misuse of visitors' car park at BWMH.
- Availability of epilepsy equipment in Powys.
- Delay in receiving covid boosters.

### Duty of Candour

There have been 9 duty of candour cases during Q3 2023/24. 4 have been closed with no harm and 5 investigations are ongoing.

### NUMBER OF DUTY OF CANDOR INCIDENTS 23/24



### Claims, Redress & Clinical Negligence Position

#### Redress

5 open cases being managed.  
100% compliance with re-imburement recovery.

#### Clinical Negligence

7 Open files

#### General Medicine Practice Indemnity (GMPI) Claims

4 Open cases

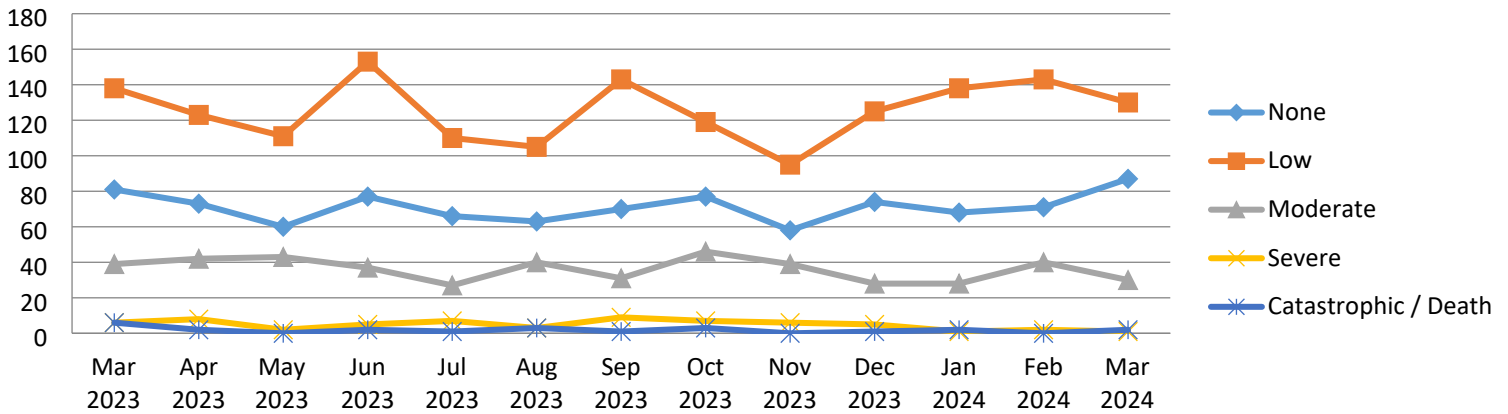
### 2.5 Incident Management

The number of patient safety incidents (**Graph 4**) reported is stable and appropriate with most incidents reported within the Low and No Harm classification.

**Graph 4**

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## Incidents by Reported level of harm

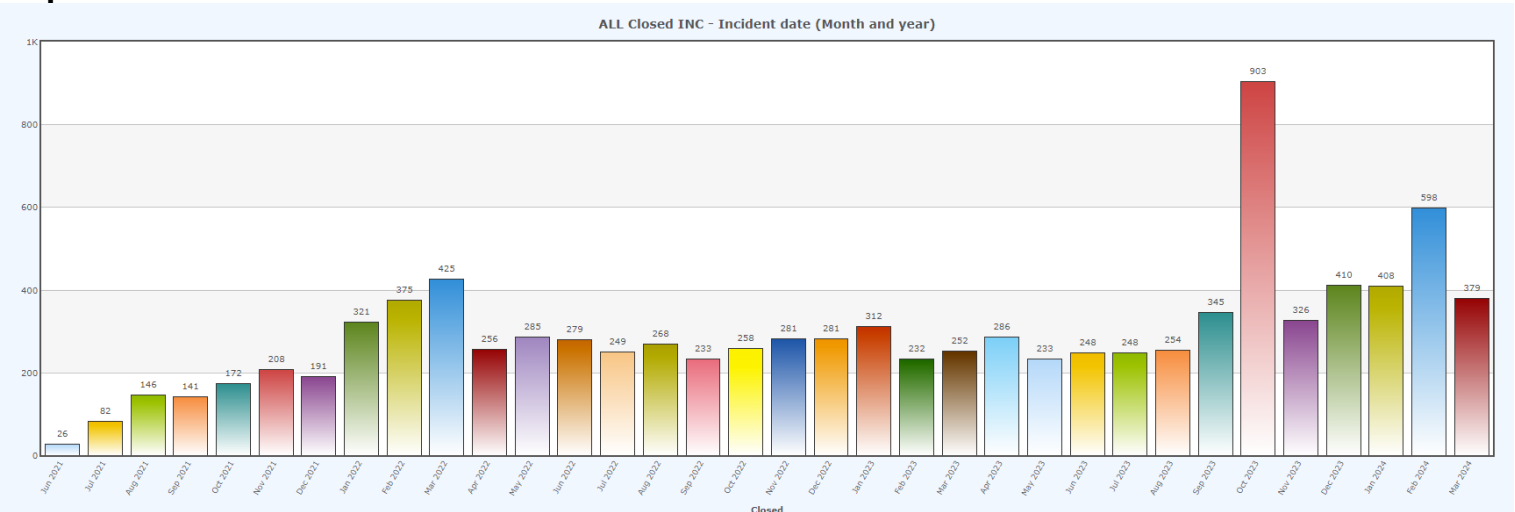


Significant challenge continues with the timely management and closure of incidents by services, although it must be noted that improvements have been made in the number of incidents closed.

**Graph 5** demonstrates the rate of incident closure since June 2021, significant improvement can be seen since September 2023 when the following supportive measures were put in place:

- Implementation of Incident Management Framework, which provides clarity of process and expectations along with templates to support timely investigations.
- Weekly reporting to Heads of Service, Assistant Director and Executive Directors highlighting incidents that remain open/overdue.
- Weekly meetings with service governance leads.
- Additional training sessions to support timely incident management.
- Production of dashboards within Datix for all services.
- Additional resource to support the management of Pressure Ulcer incidents.
- 112 staff members have attended RCA training to further strengthen the ability of teams to appropriately manage, investigate and close incidents of all nature.

**Graph 5: Data source Datix**



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

1 Early Warning Notification has been submitted during Q4 2023/24.

### 2.11 Nationally Reportable Incidents

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

Number open	Number open in time	Number open overdue	Number awaiting final approval
18	4	5	4

The themes for learning and improvement include:

- Standards of record keeping.
- Consent to treatment.
- Ensure appropriate patients are treated in community hospital settings.
- Enhanced care requirements.
- Clinical Guidelines not followed or not present.
- Complex pathway of care.
- Review training requirements for all staff for ward based clinical activities (NEWS, SEPSIS and the Deteriorating Patient).
- WARRN training to be recommenced in 2024.

### 3. Patient Experience

#### 3.1 CIVICA

CIVICA patient experience system continues to evolve and become established across teams with 59 questionnaires available for use, a further 9 surveys in development and 3027 responses.

Your NHS Experience is available for all patients that have accessed healthcare **Graph 6** demonstrates the feedback available as a percentage of all respondents. **Graph 7** provides the same feedback from patients in receipt of care from Wye Valley Trust, this feedback will be shared within the Commissioning Quality Monitoring meetings. Further analysis is required of the narrative 'free text' option to understand what has impacted both positively and negatively to support ongoing learning and service improvement. **Graph 8** is a wordle of the most used words within the 'free text' system.

**Graph 6 – Source CIVICA**

Question:	Survey	2022			2023			2023			2023			2023			2024			2024		
		Nov	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Nov	Dec	Jan	Feb	Mar
2. Did you feel that you were listened to?	Your NHS Wales	100	72	67	75	75	82	80	78	81	82	83	90	88	86	64	59					
3. Were you able to speak in Welsh to staff if you needed to?	Your NHS Wales	0	-	-	100	25	46	25	27	50	35	29	30	41	46	25	25					
4. From the time you realised you needed to use this service, was the time you waited:	Your NHS Wales	75	53	0	63	66	68	63	63	62	67	68	70	70	74	47	50					
5. Did you feel well cared for?	Your NHS Wales	100	55	67	69	80	81	80	80	80	83	81	89	89	87	58	59					
6. If you asked for assistance, did you get it when you needed it?	Your NHS Wales	100	55	50	63	73	79	81	75	80	84	75	90	86	85	42	75					
7. Did you feel you understood what was happening in your care?	Your NHS Wales	100	64	63	75	80	83	82	81	85	87	84	90	90	88	61	59					
8. Were things explained to you in a way that you could understand?	Your NHS Wales	100	77	88	81	81	85	85	82	88	89	86	91	91	88	61	59					
9. Were you involved as much as you wanted to be in decisions about your care?	Your NHS Wales	100	68	88	75	74	81	80	80	80	86	83	86	89	85	56	56					
10. How would you rate your experience? 1-10	Your NHS Wales	100	59	75	55	80	80	77	78	80	86	81	89	89	85	61	55					
Overall:		86	63	63	70	75	79	78	76	79	82	79	86	86	84	57	58					
Respondents:		1	15	3	4	67	68	74	111	130	134	129	139	184	219	9	9					

**Graph 7 – Source CIVICA**

Question:	Survey	2023			2023			2023			2023			2024			Benchmark
		Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar				
2. Did you feel that you were listened to?	Your NHS Wales	75	83	82	80	83	82	83	90	90	88	-	-	85			
3. Were you able to speak in Welsh to staff if you needed to?	Your NHS Wales	14	46	25	25	50	35	32	30	39	50	-	-	85			
4. From the time you realised you needed to use this service, was the time you waited:	Your NHS Wales	65	70	64	65	63	67	69	70	71	76	-	-	85			
5. Did you feel well cared for?	Your NHS Wales	81	82	83	82	81	84	82	90	90	89	-	-	85			
6. If you asked for assistance, did you get it when you needed it?	Your NHS Wales	74	80	85	76	81	84	76	91	86	87	-	-	85			
7. Did you feel you understood what was happening in your care?	Your NHS Wales	81	84	84	83	86	88	84	90	90	89	-	-	85			
8. Were things explained to you in a way that you could understand?	Your NHS Wales	81	87	87	83	88	89	87	90	92	89	-	-	85			
9. Were you involved as much as you wanted to be in decisions about your care?	Your NHS Wales	74	82	83	83	81	87	84	87	90	87	-	-	85			
10. How would you rate your experience 1-10	Your NHS Wales	82	82	80	81	81	87	82	89	89	87	-	-	85			
Overall:		75	81	80	79	80	83	80	86	86	86	-	-				
Respondents:		61	65	68	99	127	128	123	137	175	207	0	0				

**Graph 8 – Source CIVICA**



**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. **(Appendix 1)**

### 3.2 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 Q4 2023/24 and will continue into Q1 2024/25.

Following an Executive portfolio change and movement of staff there is no support or resource to support production of patient stories since Q1 2023/24. However, the Assistant Director of Quality & Safety has purchased equipment to digitally record stories for sharing as required. Support for the patient experience agenda is a key priority for the Nursing Directorate within the IMTP forward plan.

## 4. Infection Prevention and Control (IP&C)

**4.1** IP&C improvement plan continues to progress, with a summary of the delivery outlined below:

Summary Delivery vs Plan			
	Delivery against Plan	RAG Status Definition	%
% of activities which are complete		The action has been completed and there is a record of evidence to support it's completion.	70%
% of progress being made		Progress is good and the action is likely to be achieved within timescale.	9%
% of activities which are late or confirmed as being late		Work is significantly behind schedule and no progress has been made/or progress has been made but the timescale has not been achieved.	2%
% of activities on track		Progress being made and is on track and will be completed on timescale.	18%

- **35 actions have been completed.**
- **8** on track and will be completed within the timescales provided.
- **4** progress is good and is likely to be achieved.
- **1** where no progress has been made (*due to the nature of specialist input required into a specific policy of vCJD*). A plan to achieve by the beginning of May 2024 has been implemented.

### Areas of improvement realised to date:

- The recent internal audit has concluded with positive feedback, demonstrating notable advancements and achievements across various areas, many of which achieved a substantial level of assurance.

- A recent JAG accreditation audit particularly commended the IP&C team for their excellence in IP&C and decontamination efforts.
- Engagement with primary care on post-infection reviews has been fruitful, offering valuable insights into infection patterns, notably with C.difficile, and has helped to guide targeted support initiatives, including antimicrobial prescribing.
- The development, implementation and widespread dissemination of new policies have taken a significant step forward, and in the main all policies identified within the IP&C improvement plan are live across the organisation.
- The introduction of 'Bug Bites' IP&C training sessions across the organisation is addressing audit and post-infection review findings.
- NWSSP Audit taken place During Q3 2023/24 with objective to review the controls and processes in place for Infection Prevention and Control, with specific focus on the IPC Improvement Plan and the C-Diff infection pathway has resulted in Reasonable Assurance. **(Appendix 2)**

**key objectives:**

- Review of IP&C structure, capacity, and resilience, which encompasses extending support to primary care.
- Development of a programme of delivery for 2024-25, including a robust audit programme
- Progressing discussions with commissioning colleagues on the processing of Microbiology results through Welsh laboratories.
- Assisting pharmacy colleagues in a business case for an Antimicrobial Stewardship Pharmacist, which will help efforts in combating antimicrobial resistance and reducing infections.
- Continue to advocate for the adoption of an electronic auditing system, which will greatly reduce staffing hours needed to complete audits and provide real-time and immediate assurance.
- Focus on decontamination practices across the organisation.
- Enhance staff training and education across the Health Board, with plans to revive link worker sessions.

**5. Health and Social Care Inspections Regulatory Recommendations**

**5.1 Health Inspectorate Wales Inspections**

During March 2024, services were tasked with undertaking a robust review of outstanding actions which has resulted in several actions being closed. Processes in place to monitor action plans have been reviewed and updated, along with a dashboard to provide at a glance information regarding numbers of open and closed actions.

The historical actions from 2017-2020 are closed and the oldest outstanding actions now relate to inspections conducted from 2021 to date (shown below).

	Recommendations / Actions Overdue (agreed timescale)	Overdue Recommendations	Recommendations / Actions Not Yet Due
--	--	-------------------------	---------------------------------------

		/ Actions Revised Timescale	
Tier 1 Quality Check Clywedog Ward, Llandrindod Wells		<b>1</b>	
HIW Announced Inspection of community mental health services	<b>6</b>		<b>2</b>
HIW Tawe Ward Unannounced Inspection			<b>3</b>
HIW All Wales Review of discharge arrangements in Mental Health		<b>3</b>	<b>3</b>

All actions outstanding are joint actions for PTHB and PCC colleagues, plans are in place to address through joint working forums. The 6 overdue actions that relate to the CMHT inspection are:

1. The Health Board and Local Authority must further explore and clarify clinical leadership.
2. The Health Board and Local Authority must explore GP engagement in the provision of service to ensure that service users have good access to holistic care.
3. The Health Board and Local Authority must ensure that the social circumstance reports reflected the service user’s wishes and ‘what matters’ conversation.
4. The Health Board and Local Authority must ensure that the social circumstance report includes narrative around the nature of any ongoing risks and the views of other professionals.
5. The Health Board and Local Authority must ensure that all relevant staff have access to Mental Health Act training.
6. The Health Board and Local Authority must continue to ensure that the person centred and empowering approach to the provision of care and support is fully embedded across the service and that care documentation is amended to better capture and reflect service users' views on how they wish to be cared for.

There have been no HIW inspections and 1 CIW inspection since the last reporting period.

- Cottage View, Knighton; 15 February 2024 (Report not published)  
Cottage View is a 15-bed residential home managed by the Health Board within the Knighton Hospital site. There are 10 permanent residential spaces and 5 spaces for reablement and recovery post discharge. The home has been significantly refurbished and modernised to improve the environment for residents and provide a reablement pathway in Mid Radnorshire.

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This most recent inspection by Care Inspectorate Wales has been very positive for the care home with no areas identified for improvements. Feedback from residents and staff has been very encouraging. The refurbishment has included additional lounge spaces, activity areas, a new kitchen and expanded dining area. There is a busy activity schedule and following a successful pilot the care home is successfully supporting residents from the local community with a period of reablement prior to returning home after discharge from hospital.

The Care Inspectorate for Wales were able to provide positive feedback on the four main criteria which are, Wellbeing, Care and Support, Leadership and Management and the environment.

Plans for 2024 include an upgrade to the fire safety systems and a new accessible garden for residents and staff both at Cottage View and the wider Hospital.

- Charro Dental Practice Inspection report published 13 March 2024 (**Appendix 3**)

### 6. Llais

No reports provided for reporting period.

### 7. PAVO

No reports provided for reporting period.

## 8. KEY MATTERS FOR BOARD/COMMITTEE

Resource to support the patient experience along with production of patient's stories requires a focus to ensure the requirements of the organisation in line with Duty of Quality are realised.

**ACTION taken:** Assistant Director Quality & Safety purchased equipment and will be meeting with patients/families to record stories. Administrator within Quality & Safety Team currently supporting administration of CIVICA but limitations to the support being able to be provided due to substantive role requirements.

Timely management of incidents is required to ensure appropriate action is taken.

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

<b>Appendix 1: CIVICA</b>	
<b>Appendix 2: AP&amp;C Audit Report</b>	Included on PEQS agenda Item 6
<b>Appendix 3: HIW Report Charro Dental Practice</b>	
<b>Appendix 4: HIW Annual Report 2022-2023, Mental Health Hospitals, Learning Disability Hospitals and Mental Health Act</b>	

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

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

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/



**1) What is the CIVICA patient experience system?**

CIVICA Experience system enables healthcare organisations to understand real-time patient feedback, and was purchased by Powys Teaching Health Board at the end of 2022. It will allow your service 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 Powys residents (including staff) who have received care in Powys or by one of our providers can give feedback.

**7) Further Initiatives by Outpatients to boost survey use**

The senior administrator in Brecon has also put in place some further initiatives to help staff both use and access the data from the surveys by:

- Sending out weekly emails letting the outpatient teams know the number of surveys completed
- Sending messages via a team WhatsApp group

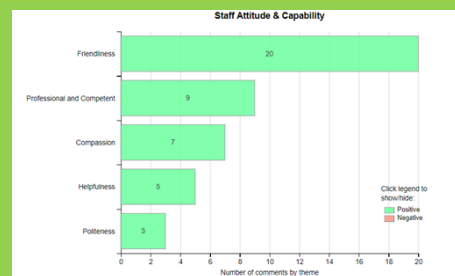
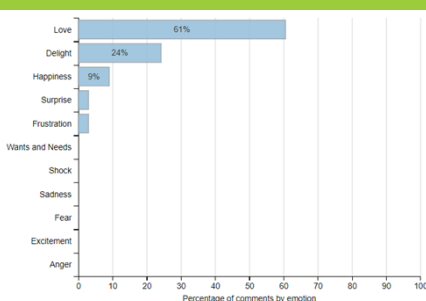
**2) Overview**

- 59 Active Surveys
- 9 surveys currently in development
- 3027 responses across all surveys since 16/12/2022
- Two generic surveys live on PTHB Internet:

[Complete the Family and Friends Survey \(link to external website\)](#)  
[Complete the NHS Experience Survey \(link to external website\)](#)



**6) Outpatient Results**



**3) Focus on Outpatients – surveys completed**

During February 2024, Outpatient Departments across the health board have received 85 responses to their CIVICA survey.

- Brecon – 10
- Llandrindod – 8
- Llanidloes – 7
- Machynlleth – 8
- Newtown – 25
- Welshpool – 27
- Ystradgynlais - 0

**4) How have Outpatient's achieved this?**

The department have achieved this in a number of ways through the use of:

- Paper (although not recommended)
- Posters
- iPads in Brecon and Newtown

**5) Why did Outpatients prioritise?**

As part of an Audit Day in November 23, Outpatient's staff noted that they do not always receive feedback.

Since the audit, staff have been encouraged by the Senior Nurse Manager for Outpatients Development, supported by the Senior Administrator in Brecon, to fully engage with the CIVICA patient experience surveys to be able to obtain feedback, which in turn has boosted staff morale.

# Survey Analysis

## Showing: Full Breakdown Analysis of Survey Results

Total Respondents: 25



### Survey: Powys Living Well Service – Programme Feedback

#### Results from: Powys Living Well Service - PLWS

**Question 1:** Thinking about your overall first impressions of the care you received in the group programme...How likely are you to recommend our service to friends and family if they needed similar care or treatment?

Available Answers	Responses	Score (%)
Extremely likely	19	76.00%
Likely	4	16.00%
Neither likely or unlikely	2	8.00%
Unlikely	0	0.00%
Extremely unlikely	0	0.00%
Don't know	0	0.00%
<b>Total</b>	<b>25</b>	<b>100%</b>



[Create new action](#)

**Question 2:** Did you feel that you were listened to?

Available Answers	Responses	Score (%)
Always	21	84.00%
Usually	3	12.00%
Sometimes	1	4.00%
Never	0	0.00%
<b>Total</b>	<b>25</b>	<b>100%</b>



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# Survey Analysis

## Showing: Full Breakdown Analysis of Survey Results

Total Respondents: 25

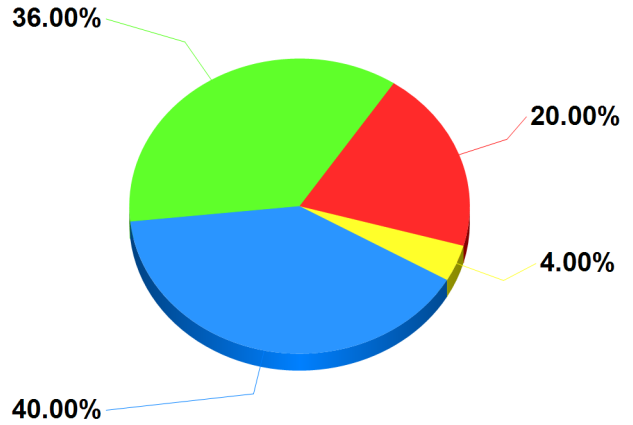


### Survey: Powys Living Well Service – Programme Feedback

**Question 3:** From the time you agreed to take part in this programme, was the time you waited....

Available Answers	Responses	Score (%)
Shorter than expected	10	40.00%
About right	9	36.00%
A bit too long	5	20.00%
Much too long	1	4.00%
<b>Total</b>	<b>25</b>	<b>100%</b>

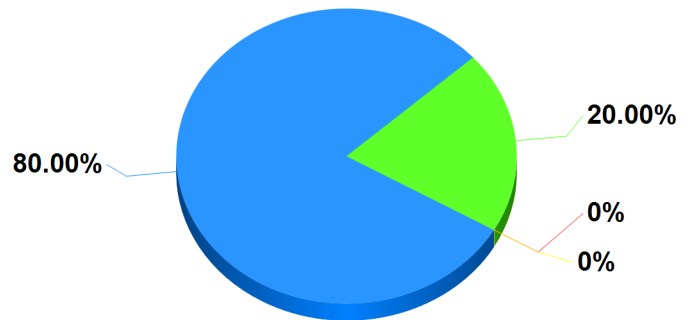
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**Question 4:** Were things explained to you in a way that you could understand?

Available Answers	Responses	Score (%)
Always	20	80.00%
Usually	5	20.00%
Sometimes	0	0.00%
Never	0	0.00%
<b>Total</b>	<b>25</b>	<b>100%</b>

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# Survey Analysis

## Showing: Full Breakdown Analysis of Survey Results

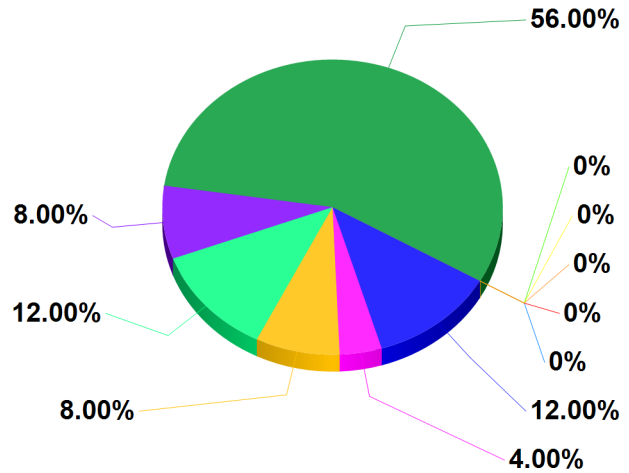
Total Respondents: 25



### Survey: Powys Living Well Service – Programme Feedback

**Question 5:** Your overall experience: Using a scale of 0-10 where 0 is very bad and 10 is excellent, how would you rate your overall experience?

Available Answers	Responses	Score (%)
0 - Very bad	0	0.00%
1	0	0.00%
2	0	0.00%
3	0	0.00%
4	0	0.00%
5 - Average	3	12.00%
6	1	4.00%
7	2	8.00%
8	3	12.00%
9	2	8.00%
10 - Excellent	14	56.00%
<b>Total</b>	<b>25</b>	<b>100%</b>



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#### Available Filters:

Note: The available filter selection is dependent on the report that is being generated.

Filter Option	Selection
Services	Powys Services
Site	Bronllys Hospital/Virtual Services
Location	Powys Living Well Service - PLWS

Survey	Powys Living Well Service – Programme Feedback
Question	All Questions Selected
Response	All Responses Selected
Category	Standard

Start Date	No Start Date
End Date	No Start Date

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# Survey Analysis

## Showing: Full Breakdown Analysis of Survey Results

Total Respondents: 157



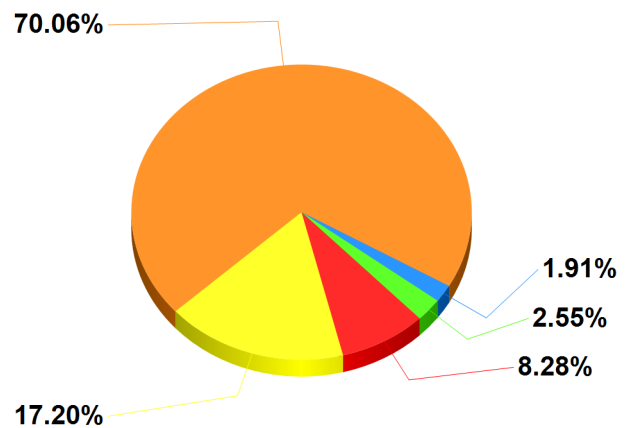
**Survey:** Powys Living Well Service - Feedback on your appointment

**Results from:** Powys Living Well Service - PLWS

**Question 1:** How much effort was made to help you understand your health issues?

Available Answers	Responses	Score (%)
0 - No effort was made	3	1.91%
1 - A little effort was made	4	2.55%
2 - Some effort was made	13	8.28%
3 - A lot of effort was made	27	17.20%
4 - Every effort was made	110	70.06%
<b>Total</b>	<b>157</b>	<b>100%</b>

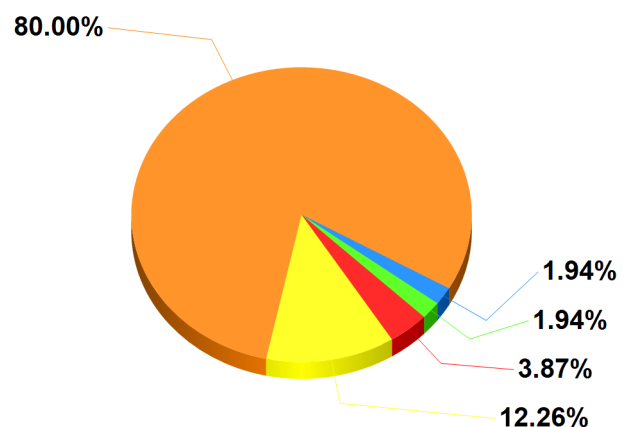
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**Question 1:** How much effort was made to listen to the things that matter most to you about your health issues?

Available Answers	Responses	Score (%)
0 - No effort was made	3	1.94%
1 - A little effort was made	3	1.94%
2 - Some effort was made	6	3.87%
3 - A lot of effort was made	19	12.26%
4 - Every effort was made	124	80.00%
<b>Total</b>	<b>155</b>	<b>100%</b>

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# Survey Analysis

## Showing: Full Breakdown Analysis of Survey Results

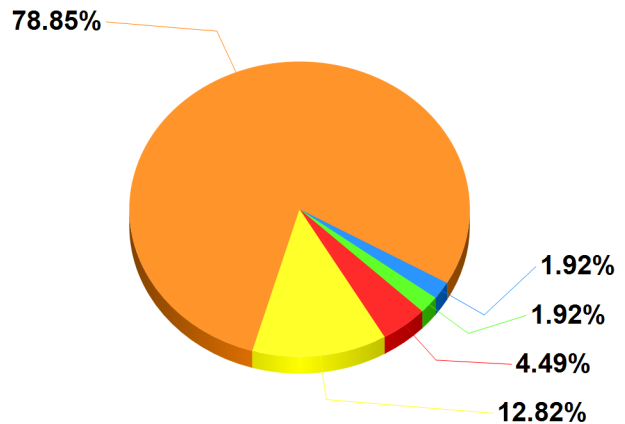
Total Respondents: 157

### Survey: Powys Living Well Service - Feedback on your appointment



**Question 1:** How much effort was made to include what matters most to you in choosing what to do next?

Available Answers	Responses	Score (%)
0 - No effort was made	3	1.92%
1 - A little effort was made	3	1.92%
2 - Some effort was made	7	4.49%
3 - A lot of effort was made	20	12.82%
4 - Every effort was made	123	78.85%
<b>Total</b>	<b>156</b>	<b>100%</b>



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#### Available Filters:

Note: The available filter selection is dependent on the report that is being generated.

Filter Option	Selection
Services	Powys Services
Site	Bronllys Hospital/Virtual Services
Location	Powys Living Well Service - PLWS

Survey	Powys Living Well Service - Feedback on your appointment
Question	All Questions Selected
Response	All Responses Selected
Category	Standard

Start Date	No Start Date
End Date	No Start Date

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# General Dental Practice Inspection Report (Announced)

Charro Dental practice, Powys  
Teaching Health Board

Inspection date: 12 December 2023

Publication date: 13 March 2024



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

Copies of all reports, when published, will be available on our [website](#) or by contacting us:

In writing:

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

## Our purpose

To check that healthcare services are provided in a way which maximises the health and wellbeing of people

## Our values

We place people at the heart of what we do.

We are:

- Independent - we are impartial, deciding what work we do and where we do it
- Objective - we are reasoned, fair and evidence driven
- Decisive - we make clear judgements and take action to improve poor standards and highlight the good practice we find
- Inclusive - we value and encourage equality and diversity through our work
- Proportionate - we are agile and we carry out our work where it matters most

## Our goal

To be a trusted voice which influences and drives improvement in healthcare

## Our priorities

- We will focus on the quality of healthcare provided to people and communities as they access, use and move between services.
- We will adapt our approach to ensure we are responsive to emerging risks to patient safety
- We will work collaboratively to drive system and service improvement within healthcare
- We will support and develop our workforce to enable them, and the organisation, to deliver our priorities.



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# 1. What we did

Full details on how we inspect the NHS and regulate independent healthcare providers in Wales can be found on our [website](#).

Healthcare Inspectorate Wales (HIW) completed an announced inspection of Charro Dental Practice, Powys Teaching Health Board on 12 December 2023.

Our team for the inspection comprised of a HIW Healthcare Inspector and a Dental Peer Reviewer.

During the inspection we invited patients or their carers to complete a questionnaire to tell us about their experience of using the service. A total of 32 were completed. We also spoke to staff working at the service during our inspection. Feedback and some of the comments we received appear throughout the report.

Where present, quotes in this publication may have been translated from their original language.

Note the inspection findings relate to the point in time that the inspection was undertaken.

This (full) report is designed for the setting, and describes all findings relating to the provision of high quality, safe and reliable care that is centred on individual patients.

A summary version of the report, which is designed for members of the public can be found on our [website](#).

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## 2. Summary of inspection

### Quality of Patient Experience

Overall summary:

We found the dignity of patients was upheld and they were treated with respect through their patient journey. All patients told us the service provided by the practice was 'very good'. We saw systems in place to manage patient appointments appropriately, and delays to appointments were communicated in a timely manner. We found areas of improvement regarding the implementation of the 'Active Offer,' but noted the practice made efforts to enable patients to communicate in their preferred language wherever possible. We saw a zero-tolerance approach to the abuse of both patients and staff.

This is what we recommend the service can improve:

- The registered manager must provide HIW with details of the action taken on implementing the 'Active Offer'.

This is what the service did well:

- Patient feedback to the HIW questionnaire was positive.

### Delivery of Safe and Effective Care

Overall summary:

We found a clean and organised practice which promoted the safe and effective care of patients. We saw equipment was in good condition and used appropriately. Infection control was managed effectively and the records we viewed indicated staff were trained to the correct level in IPC and decontamination. All patients who completed the HIW questionnaire told us they thought the practice was 'very clean' and that staff followed infection control procedures.

We saw care was delivered safely and in line with regulatory and statutory guidance, but found some improvements were required in relation to patient records and staff first aid training compliance. All patients told us they thought their medical history was checked appropriately prior to treatment. We found fire risks were managed safely, with equipment maintained to the correct standard.

This is what we recommend the service can improve:

- The registered manager must ensure first aid refreshers take place annually
- The registered manager must ensure patient records accurately reflect risk assessments and treatment provided to the patient

- The registered manager must ensure the language and communication needs of patients are routinely recorded in patient records.

This is what the service did well:

- Medicines were managed correctly and safely
- The management of radiographic treatments was robust.

## Quality of Management and Leadership

Overall summary:

We found the management structures in place supported the effective running of the practice. Staff were friendly and supportive with one another and patients. The records we reviewed evidenced all staff were appropriately trained to perform their roles and that their professional obligations were upheld. The staff we spoke to said they felt confident raising concerns and raising issues with managers. We found a satisfactory system in place for the recording of and response to patient feedback. We noted that improvements were required in respect of compliance with audits.

This is what we recommend the service can improve:

- The registered manager must undertake clinical audits, such as those available through Health Education and Improvement Wales (HEIW)
- The registered manager must undertake a review of their audit and quality improvement policy and procedure.

This is what the service did well:

- The collection, review and response to patient feedback was routine.

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## 3. What we found

### Quality of Patient Experience

#### Patient Feedback

Overall, the responses from patients were positive. All of the patients stated the service provided by the practice was ‘very good’. Some of the comments provided by patients included:

*“I was treated with the utmost respect and dignity and educated about my oral health. I was made fully aware of the treatment required. Excellent!”*

*“After 20 years with this practice, I would recommend to anyone. First class dentist and staff.”*

*“The service in this practice has and is excellent. Thanks everyone.”*

*“I am very impressed with my care and the professional way that I have been dealt with. They have gone above and beyond to make me (a nervous patient) feel welcome and as relaxed as possible.”*

*“Very welcoming, polite and professional. Great!”*

*“At 50 years of age it is the best dental practice I have ever known. Jimmy has humour, expertise and great patient care on his side.”*

*“I have been attending this practice since we retired here in 2011. Probably the best treatment I have ever had.”*

#### Person Centred

##### Health Promotion

We saw information on display in the patient waiting area regarding paediatric dental health, smoking cessation advice and varied NHS patient advice leaflets. We observed clearly displayed information on the fees for NHS and private treatments. The names, photographs and General Dental Council (GDC) numbers for practitioners were also on display in the patient waiting area. We saw the GDC

codes of ethics on display and the opening hours and emergency contact details prominently placed on the front door.

All patients that responded to the HIW questionnaire said staff explained their oral health to them in a manner they could understand throughout their appointment. All patients stated they were also given suitable aftercare instructions on how to maintain good oral health.

### **Dignified and Respectful Care**

We observed patients being treated with dignity and respect. We saw satisfactory arrangements in place to protect the privacy of patients, including frosted glass on windows and solid doors that were kept closed during appointments. The practice had a separate waiting room away from the reception desk, which prevented patient phone calls being overheard. Staff told us sensitive patient discussions could be held in a separate room away from the reception area if required, to protect patient confidentiality.

All of the patients that completed the HIW questionnaire said staff treated them with dignity and respect, that they listened to them during their appointment and answered their questions.

### **Individualised care**

We found treatment planning and options were recorded within the sample of patient records we reviewed. This meant that patients were provided with information which enabled them to make an informed decision about their treatment.

All of the respondents to the HIW questionnaire said they felt involved as much as they wanted to be in decisions about their treatment, with the options available and the risks and benefits explained to them by staff.

The majority of patients said they were given information on how the practice would resolve any post-treatment concerns or complaints (31/32). All but one of the respondents (31/32) to the HIW questionnaire told us they knew what to do in the event of an emergency or infection.

## **Timely**

### **Timely Care**

We found an appropriate system in place for the management of appointments and timely access to care for patients. Appointments were made over the telephone and we saw patients arranging appointments with staff following their treatments. Staff told us emergency appointments were triaged over the telephone in

consultation with dental practitioners, and any emergency patient would be seen within 24 hours.

Staff explained any delays to appointments would be communicated to patients in a timely manner by reception staff, with patients waiting longer than 15 minutes offered an alternative appointment.

Staff outlined patients could be seen for routine appointments usually within a working day, where requested. We were told that appointments were arranged in accordance with patient needs and availability wherever possible.

Patients told us they found it very easy (28/31) or fairly easy (3/31) to get an appointment when they needed one. We saw information on out of hours dental services was suitably displayed on the exterior of the practice and on the practice website. The majority of respondents (25/31) to the HIW patient questionnaire confirmed they would know how to access out of hours dental services if they had an urgent dental problem.

## Equitable

### Communication and Language

Patient information was readily available to patients in English but we found limited information available in Welsh. We saw signs in the practice which were in English only, and there was limited information at the reception desk to encourage patients to communicate in a language of their choice. We saw staff did not wear 'Iaith Gwaith' badges, with staff explaining this was because there were no fluent Welsh speakers at the practice.

Staff told us they could access Language Line to communicate with patients whose first language was not English. Staff confirmed that patient information could be provided in the preferred language of patients upon request.

During our discussions with staff they demonstrated an understanding of the 'Active Offer' and the requirement to provide a bilingual service for patients. However, staff explained they had struggled to obtain assistance from the health board for Welsh language training and implementation of the 'Active Offer'.

**The registered manager must provide HIW with details of the action taken on implementing the 'Active Offer'.**

### Rights and Equality

We found the rights of patients were protected and their equality promoted through a robust diversity policy and a suitable patient acceptance policy. We saw

a 'zero-tolerance to abuse' poster at reception and this approach was reflected in practice policies and procedures.

We saw the use of comprehensive display screen equipment checklists from the Health and Safety Executive were completed for all members of staff. Staff told us that transgender patients were given the option to choose their preferred pronouns on their patient record, demonstrating the commitment to uphold the quality and rights of patients.

All respondents to the HIW questionnaire told us they had not faced any form of discrimination when accessing this service. All patients stated they felt they could access the right healthcare at the right time and a majority (31/32) stated the building was accessible. One respondent indicated they were 'not sure'.

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# Delivery of Safe and Effective Care

## Safe

### Risk Management

We found the practice to be in a good state of repair internally and externally. We saw four spacious surgeries spread across the ground floor, which included a modern, newly built surgery. We saw a suitably sized waiting room with satisfactory heating, lighting, ventilation and signage for the whole practice. We saw and heard working telephone lines and noted staff changing facilities and lockers were available. The ground floor was accessible for patients, including the surgeries and we saw two clean and appropriately equipped disabled toilets.

We observed reusable dental equipment that promoted safe and effective care which was in good condition and single use items being used where appropriate.

We reviewed both a comprehensive health and safety policy as well as a building maintenance policy and we saw a robust business continuity plan. We found suitable risk assessments were in place for health and safety and fire safety. Staff signed a checklist to confirm their knowledge and understanding of all policies.

We noted the practice employer liability insurance certificate and Health and Safety Executive poster on display.

Fire safety and no smoking signs were prominently displayed around the practice. On review of the fire safety equipment and information we found appropriate arrangements were in place in relation to fire safety, including regular maintenance of fire equipment and fire exit signs were clearly displayed.

### Infection, Prevention, Control (IPC) and Decontamination

We found suitable infection control policies and procedures in place to ensure high standards of infection control. Effective cleaning schedules were in place to promote regular cleaning of the practice. We saw hand hygiene facilities and signage were appropriate. Staff had sufficient access to Personal Protective Equipment (PPE) and the environment was in a good state of repair to enable effective cleaning.

All of the patients that responded to the HIW questionnaire said they felt the practice was very clean and stated they felt IPC measures were being appropriately followed by staff. One patient said:

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*“First impressions were the conditions of the building throughout.  
Exceptionally clean!”*

Occupational health services were in place for staff to deal with sharps injuries and we saw the use of safer sharps devices to prevent injuries. We noted a suitable sharps injury protocol in place.

We saw comprehensive arrangements in place to ensure the correct decontamination and sterilisation of reusable equipment. We reviewed records of daily autoclave machine cycle checks and a routine schedule of maintenance. We noted impressions were safely disinfected as appropriate.

The training records we reviewed confirmed all staff had received appropriate training for IPC and the decontamination of equipment. The staff we spoke with were clear about their individual responsibilities in relation to infection control measures.

We saw that all waste was stored securely and disposed of correctly through a suitable waste disposal contract. We found the process for the Control of Substances Hazardous to Health (COSHH) was satisfactory, with the details collated in a comprehensive COSHH folder.

### **Medicines Management**

We saw appropriate procedures were in place to ensure the safe and effective storage, administration and disposal of medicines. Medicines were not routinely dispensed, being stored and used only in the event of an emergency. Within patient notes, we saw any administered medicines were clearly recorded. The practice prescription pad was stored securely.

We reviewed the policy for the management of medical emergencies which was comprehensive and up to date. We noted a robust system in place to monitor the expiry dates of equipment and emergency medicines. All of the emergency and first aid equipment was easily accessible and within their expiry date.

The staff training records we reviewed showed that all staff were trained in cardiopulmonary resuscitation and there were two trained first aiders. However, we saw evidence that the two first aiders had received their three-yearly qualifications, but their annual refresher dates had passed. The risk to immediate patient safety was mitigated by all staff having been trained in advanced life support and managing medical emergencies.

**The registered manager must ensure first aid refreshers take place annually.**

## **Safeguarding of Children and Adults**

We found appropriate and up to date safeguarding policies and procedures in place to promote and protect the welfare and safety of children and adults. The policy and procedures incorporated the All Wales Safeguarding Procedures, identified an appointed safeguarding lead and included contact details for local support services.

We saw all staff were suitably trained in the safeguarding of children and adults. The staff we spoke to demonstrated a satisfactory understanding of safeguarding procedures and said they would feel supported if they were to raise a concern.

## **Management of Medical Devices and Equipment**

We saw clinical equipment was safe, in good condition and fit for purpose. The reusable dental equipment was observed to be in good condition and promoted safe and effective care. Appropriate arrangements were in place for the safe handling and disinfection of dental equipment. The staff we spoke to were confident in using the equipment and the training records we inspected confirmed they had received suitable training for their roles.

We saw the practice radiation protection folder was up to date and comprehensive. On review of patient records, we found the clinical notes for radiographic treatments to be fully complete. Records also indicated patients, and where relevant their comforters, were suitably informed of the risks and benefits of radiation and any exposures were correctly recorded. We noted the local rules were easily locatable. Staff training records indicated all staff were trained to an appropriate level in radiography.

## **Effective**

### **Effective Care**

We found staff made a safe assessment and diagnosis of patients. Patient records evidenced treatments being provided according to clinical need and following professional, regulatory and statutory guidance.

The clinical staff we spoke to demonstrated clear understanding of their responsibilities while being aware of where to seek relevant professional advice, if necessary.

We saw appropriate use of clinical checklists such as the Local Safety Standards for Invasive Procedures (LocSSIPs).

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## Patient Records

We reviewed a total of 10 patient records and found clinical records kept to a satisfactory standard. We found an appropriate records management policy and a robust digital records system in place. We saw all records were stored in line with the General Data Protection Regulations.

We saw comprehensive patient notes covering patient history checks, reasons for attendance and informed consent on the treatment options provided. This was supported by what patients told us in the HIW questionnaire. However, we noted oral cancer screening wasn't always noted in patient records and risk assessments relating to cavities, perio, tooth wear and oral cancer were also missing from 8 of the 10 records we reviewed.

We found that patient referrals were being made but we saw no evidence that referrals were being recorded within patient records.

**The registered manager must ensure patient records accurately reflect risk assessments and treatment provided to the patient.**

We also found the recording of patient language preference and any actions taken in response to this preference were not recorded in any of the records we reviewed.

**The registered manager must ensure the language and communication needs of patients are routinely recorded.**

## Efficient

### Efficient

We found clinicians were delivering a satisfactory service for the needs of their patients in a suitable premises. We saw the use of a robust triage procedure which utilised the slots created by cancellations to use clinicians time effectively.

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# Quality of Management and Leadership

## Leadership

### Governance and Leadership

We found clear management structures in place to support the effective running of the practice. Staff told us they were British Dental Association ‘Expert’ members and we saw evidence of the Good Practice Scheme team development tool being used. We found team meetings were held regularly and discussion topics included resource management, fire safety and NHS policies.

The staff we spoke to were supportive of one another, friendly and approachable. The lead dentist and practice owner confirmed they had received suitable support and training to undertake their leadership role effectively. The practice maintained a register of policies and procedures which were reviewed on an annual basis to provide clear guidance to staff.

## Workforce

### Skilled and Enabled Workforce

We found comprehensive arrangements in place to ensure staff were trained and retained their skills in a timely manner. In five out of the nine staff records we viewed we saw full compliance with all mandatory training courses and evidence of current and routine staff appraisals on file. The staff we spoke to confirmed they felt supported to undertake learning and development and we saw that training days for all staff were held routinely.

An effective rota system was used to manage appropriate numbers of suitably qualified staff working at any one time. We noted a suitable induction procedure and satisfactory systems in place to manage the use of agency workers.

We saw robust systems in place to ensure staff records were kept up to date and appropriate pre-employment checks undertaken. The professional registrations of all staff were up to date and suitably managed by the practice manager.

We found a comprehensive whistleblowing policy in place which described the procedure for staff to raise concerns. Staff confirmed they would feel confident raising a concern, would feel supported by managers in doing so and explained the process they would follow.

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## Culture

### People Engagement, Feedback and Learning

We saw a satisfactory system in place for the submission and management of patient feedback. There was a suggestion box at reception and we noted in meeting minutes that feedback was routinely discussed in practice meetings. A notice board in the waiting area detailed the service response to patient feedback and outlined any changes made as a result.

The complaints policy was clearly displayed in the waiting area for patient awareness. We noted patient complaints were managed in line with the Putting Things Right procedure, and we saw the practice manager was a named contact in the event of a patient seeking to make a complaint. While there were no complaints for us to review, we found a satisfactory complaints folder and draft complaint forms in place. Staff told us that any verbal complaints were recorded and submitted for review to the practice manager.

We noted up to date and suitable Duty of Candour policies and procedures in place. The staff we spoke to demonstrated understanding of their role as part of the duty and told us they felt encouraged to share concerns with the patient when something had gone wrong. Staff training records evidenced recent completion of Duty of Candour training by all staff.

## Learning, Improvement and Research

### Quality Improvement Activities

We noted a policy was in place for clinical audits and on-going quality improvement and we saw peer review between clinical staff was routine. However, we did not find evidence of regular audit activities being conducted in relation to radiographic quality, smoking cessation, antibiotic prescribing nor record keeping. Due to the number of audit omissions, the practice was advised to undertake a review of their audit and quality improvement policy and procedures.

**The registered manager must undertake clinical audits, such as those available through Health Education and Improvement Wales (HEIW).**

**The registered manager must undertake a review of their audit and quality improvement policy and procedure.**

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## Whole Systems Approach

### Partnership Working and Development

Staff outlined suitable means of communication with other health service providers, including the health board.

We saw an appropriate process in place to follow up on any referrals made to other service providers. Staff explained they maintained good working relationships with other primary care services in Powys, including GP services.

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## 4. Next steps

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

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

The improvement plans should:

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

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

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

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

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# Appendix A - Summary of concerns resolved during the inspection

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

Immediate concerns Identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
No immediate concerns were identified on this inspection.			

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# Appendix B - Immediate improvement plan

**Service:** Charro Dental Practice

**Date of inspection:** 12 December 2023

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

Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
No immediate concerns were identified on this inspection.					

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## Appendix C - Improvement plan

**Service:** Charro Dental Practice

**Date of inspection:** 12 December 2023

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

Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
<p>Patient information was readily available to patients in English but we found limited information available in Welsh. We saw signs in the practice which in English only, and there was limited information at the reception desk to encourage patients to communicate in a language of their choice. We saw staff did not wear 'Iaith Gwaith' badges.</p>	<p>The registered manager must provide HIW with details of the action taken on implementing the 'Active Offer'.</p>	<p>Private Dentistry (Wales) Regulations 2017, Section 13 (1) (a)</p>	<p>New Signage in Welsh has been displayed throughout the practice. Staff have been encouraged to participate in Welsh language lessons provided by the health board, and encouraged to greet patients bilingually.</p>	<p>Charlotte Allison</p>	<p>To be in place by 12/2/24</p>

<p>We saw evidence that the two first aiders had received their three-yearly qualifications, but their annual refresher dates had passed.</p>	<p>The registered manager must ensure first aid refreshers take place annually.</p>	<p>Section 17</p>	<p>First aid refresher courses to be completed by all first aiders immediately, and annually thereafter.</p>	<p>Charlotte Allison</p>	<p>12/2/24</p>
<p>We noted oral cancer screening wasn't always noted in patient records and risk assessments relating to cavities, perio, tooth wear and oral cancer were also missing from 8 of the 10 records we reviewed.</p> <p>We found that patient referrals were being made but we saw no evidence that referrals were being recorded within patient records.</p>	<p>The registered manager must ensure patient records accurately reflect risk assessments and treatment provided to the patient.</p>	<p>Section 20 (1)</p>	<p>This information has been relayed to all clinicians, who are responsible for their own clinical notes, and regular audits of the clinical notes will be carried out by the practice manager to ensure the notes are reflecting accurate risk assessments for treatment.</p>	<p>Charlotte Allison</p>	<p>31/3/24</p>
<p>Patient language preference and any actions taken in response</p>	<p>The registered manager must ensure the language and communication needs of</p>	<p>Section 13 (1) (a)</p>	<p>Patients will be asked at the beginning of their appointment</p>	<p>Charlotte Allison</p>	<p>31/3/24</p>

<p>to this preference were not recorded in any of the records we reviewed.</p>	<p>patients are routinely recorded.</p>		<p>(what their language preference is) and their corresponding answer will be recorded on the patient's physical file and clinical notes.</p>		
<p>We noted a policy was in place for clinical audits and on-going quality improvement and we saw peer review between clinical staff was routine.</p> <p>However, we did not find evidence of regular audit activities being conducted in relation to radiographic quality, smoking cessation, antibiotic prescribing nor record keeping. Due to the number of audit omissions, the practice was advised to undertake a review of their audit</p>	<p>The registered manager must undertake clinical audits, such as those available through Health Education and Improvement Wales (HEIW).</p> <p>The registered manager must undertake a review of their audit and quality improvement policy and procedure.</p>	<p>Section 16 (1)</p>	<p>The practice manager will take over responsibility for the clinical audits, and will undertake the HEIW audits without delay.</p> <p>This will be reflected in the practice audit policy.</p>	<p>Charlotte Allsion</p>	<p>30/4/24</p>

and quality improvement  
policy and procedures.

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

**Service representative**

**Name (print):** Charlotte Allison

**Job role:** Practice Manager

**Date:** 7/2/24

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# Adroddiad Arolygu o Bractis Deintyddol Cyffredinol (Lle Rhoddwyd Rhybudd)

Practis Deintyddol Charro, Bwrdd  
Iechyd Addysgu Powys

Dyddiad yr arolygiad: 12 Rhagfyr 2023

Dyddiad cyhoeddi: 13 Mawrth 2024



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Gellir darparu'r cyhoeddiad hwn a gwybodaeth arall gan AGIC mewn fformatau neu ieithoedd amgen ar gais. Bydd oedi byr wrth i ieithoedd a fformatau eraill gael eu cynhyrchu pan ofynnir amdanynt i ddiwallu anghenion unigol. Cysylltwch â ni am gymorth.

Bydd copïau o'r holl adroddiadau, pan gânt eu cyhoeddi, ar gael ar ein [gwefan](#) neu drwy gysylltu â ni:

Yn ysgrifenedig:

Rheolwr Cyfathrebu  
Arolygiaeth Gofal Iechyd Cymru  
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# Arolygiaeth Gofal Iechyd Cymru (AGIC) yw arolygiaeth a rheoleiddiwr annibynnol gofal iechyd yng Nghymru

## Ein diben

Gwirio bod gwasanaethau gofal iechyd yn cael eu darparu mewn ffordd sy'n mwyafu iechyd a llesiant pobl.

## Ein gwerthoedd

Mae pobl wrth wraidd yr hyn a wnawn. Rydym yn:

- Annibynnol - rydym yn ddiuedd, yn penderfynu pa waith rydym yn ei wneud a lle rydym yn ei wneud
- Gwrthrychol - rydym yn rhesymol ac yn deg ac yn gweithredu ar sail tystiolaeth
- Pendant - rydym yn gwneud dyfarniadau clir ac yn cymryd camau i wella safonau gwael ac amlygu'r arferion da rydym yn dod ar eu traws
- Cynhwysol - rydym yn gwerthfawrogi ac yn annog cydraddoldeb ac amrywiaeth drwy ein gwaith
- Cymesur - rydym yn ystwyth ac yn gwneud ein gwaith lle mae o'r pwys mwyaf

## Ein nod

Bod yn llais dibynadwy sy'n ysgogi gwelliant mewn gofal iechyd ac sy'n dylanwadu arno

## Ein blaenoriaethau

- Byddwn yn canolbwyntio ar ansawdd y gofal iechyd a ddarperir i bobl a chymunedau wrth iddynt gyrchu gwasanaethau, eu defnyddio a symud rhyngddynt
- Byddwn yn addasu ein dull gweithredu i sicrhau ein bod yn ymatebol i risgiau i ddiogelwch cleifion sy'n dod i'r amlwg
- Byddwn yn cydweithio er mwyn ysgogi'r gwaith o wella systemau a gwasanaethau ym maes gofal iechyd
- Byddwn yn cefnogi ac yn datblygu ein gweithlu i'w galluogi nhw, a'r sefydliad, i gyflawni ein blaenoriaethau.



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# 1. Yr hyn a wnaethom

Ceir manylion llawn am y ffordd rydym yn arolygu'r GIG ac yn rheoleiddio darparwyr gofal iechyd annibynnol yng Nghymru ar ein [gwefan](#).

Cwblhaodd Arolygiaeth Gofal Iechyd Cymru (AGIC) arolygiad lle rhoddwyd rhybudd o Bractis Deintyddol Charro, Bwrdd Iechyd Addysgu Powys ar 12 Rhagfyr 2023.

Roedd ein tîm ar gyfer yr arolygiad yn cynnwys un Arolygydd Gofal Iechyd AGIC ac Adolygydd Cymheiriaid Deintyddol.

Yn ystod yr arolygiad, gwnaethom wahodd y cleifion neu eu gofalwyr i gwblhau holiadur er mwyn dweud wrthym am eu profiad o ddefnyddio'r gwasanaeth. Cwblhawyd cyfanswm o 32 o holiaduron. Gwnaethom hefyd siarad â'r staff a oedd yn gweithio yn y gwasanaeth yn ystod ein harolygiad. Mae'r adborth a rhai o'r sylwadau a gafwyd yn ymddangos yn yr adroddiad.

Lle bo dyfyniadau yn y cyhoeddiad hwn, mae'n bosibl eu bod wedi cael eu cyfieithu o'u hiaith wreiddiol.

Nodwch fod canfyddiadau'r arolygiad yn ymwneud â'r adeg y cynhaliwyd yr arolygiad.

Mae'r adroddiad (llawn) hwn wedi'i gynllunio ar gyfer y lleoliad, ac mae'n disgrifio'r holl ganfyddiadau sy'n ymwneud â darparu gofal diogel a dibynadwy o ansawdd uchel sy'n canolbwyntio ar gleifion unigol.

Mae fersiwn gryno o'r adroddiad, sydd wedi'i chynllunio ar gyfer aelodau'r cyhoedd, ar gael ar ein [gwefan](#).

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## 2. Crynodeb o'r arolygiad

### Ansawdd Profiad y Claf

Crynodeb cyffredinol:

Gwelsom fod urddas y cleifion yn cael ei gynnal a'u bod yn cael eu trin â pharch drwy gydol eu taith fel claf. Dywedodd pob claf wrthym fod y gwasanaeth a ddarperir gan y practis yn 'dda iawn'. Gwelsom fod systemau ar waith i reoli apwyntiadau cleifion yn briodol, ac roedd unrhyw achosion o oedi i apwyntiadau yn cael eu cyfleu mewn modd amserol. Nodwyd gennym fod meysydd i'w gwella mewn perthynas â rhoi'r 'Cynnig Rhagweithiol' ar waith, ond roedd y practis yn ymdrechu i sicrhau y gallai'r cleifion gyfathrebu yn eu dewis iaith lle bynnag y bo'n bosibl. Gwelsom na fyddai unrhyw achos o sarhau cleifion na'r staff yn cael ei oddef.

Rydym yn argymhell y gall y gwasanaeth wella'r canlynol:

- Rhaid i'r rheolwr cofrestredig roi manylion i AGIC am y camau a gymerwyd i roi'r 'Cynnig Rhagweithiol' ar waith.

Dyma beth roedd y gwasanaeth yn ei wneud yn dda:

- Roedd adborth y cleifion i holiadur AGIC yn gadarnhaol.

### Darparu Gofal Diogel ac Effeithiol

Crynodeb cyffredinol:

Roedd y practis yn lân ac yn drefnus, a oedd yn hyrwyddo gofal diogel ac effeithiol i'r cleifion. Gwelsom fod y cyfarpar mewn cyflwr da a'i fod yn cael ei ddefnyddio'n briodol. Roedd y prosesau ar gyfer rheoli heintiau yn cael eu rheoli'n effeithiol ac roedd y cofnodion a welsom yn dangos bod y staff wedi cael hyfforddiant atal a rheoli heintiau a dihalogi hyd at y lefel gywir. Dywedodd pob claf a gwblhaodd holiadur AGIC wrthym ei fod o'r farn bod y practis yn 'lân iawn' a bod y staff yn dilyn gweithdrefnau rheoli heintiau.

Gwelsom fod gofal yn cael ei ddarparu'n ddiogel ac yn unol â chanllawiau rheoliadol a statudol, ond roedd angen gwneud rhai gwelliannau mewn perthynas â chofnodion cleifion a chydymffurfiaeth staff â hyfforddiant cymorth cyntaf. Dywedodd pob claf wrthym fod y staff wedi cadarnhau ei hanes meddygol yn briodol cyn rhoi triniaeth. Roedd risgiau tân yn cael eu rheoli'n ddiogel, ac roedd y cyfarpar yn cael ei gynnal a'i gadw i'r safon briodol.

Rydym yn argymhell y gall y gwasanaeth wella'r canlynol:

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- Rhaid i'r rheolwr cofrestredig sicrhau y caiff hyfforddiant gloywi cymorth cyntaf ei gynnal bob blwyddyn
- Rhaid i'r rheolwr cofrestredig sicrhau bod cofnodion y cleifion yn adlewyrchu'r asesiadau risg a'r triniaethau a roddir i'r claf yn gywir
- Rhaid i'r rheolwr cofrestredig sicrhau y caiff anghenion iaith a chyfathrebu cleifion eu cofnodi fel mater o drefn yng nghofnodion y cleifion.

Dyma beth roedd y gwasanaeth yn ei wneud yn dda:

- Roedd meddyginiaethau yn cael eu rheoli'n gywir ac yn ddiogel
- Roedd y trefniadau ar gyfer rheoli triniaethau radiograffig yn gadarn.

## Ansawdd Rheolaeth ac Arweinyddiaeth

Crynodeb cyffredinol:

Nodwyd gennym fod y strwythurau rheoli sydd ar waith yn helpu i sicrhau bod y practis yn rhedeg yn effeithiol. Roedd y staff yn gyfeillgar ac yn gefnogol tuag at ei gilydd a thuag at y cleifion. Roedd y cofnodion a welsom yn dangos bod pob aelod o'r staff wedi cael hyfforddiant priodol i gyflawni eu rolau a'u bod yn cyflawni eu rhwymedigaethau proffesiynol. Dywedodd y staff y gwnaethom siarad â nhw eu bod yn teimlo'n hyderus yn codi pryderon ac yn trafod materion â'r rheolwyr. Roedd system foddhaol ar waith ar gyfer cofnodi adborth gan gleifion ac ymateb iddo. Nodwyd gennym fod angen gwneud gwelliannau mewn perthynas â chydymffurfio ag archwiliadau.

Rydym yn argymhell y gall y gwasanaeth wella'r canlynol:

- Rhaid i'r rheolwr cofrestredig gynnal archwiliadau clinigol, fel y rhai hynny sydd ar gael drwy Addysg a Gwella Iechyd Cymru (AaGIC)
- Rhaid i'r rheolwr cofrestredig adolygu ei bolisi a'i weithdrefn archwilio a gwella ansawdd.

Dyma beth roedd y gwasanaeth yn ei wneud yn dda:

- Roedd adborth gan gleifion yn cael ei gasglu a'i adolygu fel mater o drefn ac roedd y practis yn ymateb i'r adborth hwnnw.

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## 3. Yr hyn a nodwyd gennym

### Ansawdd Profiad y Claf

#### Adborth gan Gleifion

Ar y cyfan, roedd yr ymatebion gan y cleifion yn gadarnhaol. Dywedodd pob claf wrthym fod y gwasanaeth a ddarperir gan y practis yn 'dda iawn'. Ymhlith y sylwadau a gafwyd gan y cleifion roedd y canlynol:

*“Cefais fy nhrin â'r lefel uchaf o barch ac urddas a chefais wybodaeth am iechyd fy ngheg. Cefais wybod pob dim am y driniaeth roedd ei hangen arna i. Rhagorol!”*

*“Ar ôl 20 mlynedd gyda'r practis hwn, byddwn yn ei argymhell i unrhyw un. Deintydd a staff o'r radd flaenaf.”*

*“Mae'r gwasanaeth yn y practis hwn yn rhagorol, ac wedi bod erioed. Diolch bawb.”*

*“Rwy'n falch iawn ar y gofal rwy'n ei gael a'r ffordd broffesiynol y mae'r staff yn ymdrin â mi. Maen nhw wedi gwneud mwy na digon i wneud i mi (claf nerfus) deimlo'n gartrefol ac i sicrhau fy mod yn gallu ymlacio cymaint â phosibl.”*

*“Croesawgar, cwrtais a phroffesiynol iawn. Ardderchog!”*

*“Rwy'n 50 oed, a dyma'r practis deintyddol gorau rwyf wedi bod iddo. Mae Jimmy yn llawn hiwmor ac arbenigedd ac yn rhoi gofal arbennig i'w gleifion.”*

*“Rwyf wedi bod yn dod i'r practis hwn ers i ni ymddeol yma yn 2011. Fwy na thebyg mai dyma'r driniaeth orau rwyf wedi'i chael erioed.”*

#### Yn Canolbwyntio ar yr Unigolyn

##### Hybu Iechyd

Gwelsom wybodaeth yn cael ei harddangos yn yr ardal aros i gleifion am iechyd deintyddol pediatrig, cyngor ar roi'r gorau i smygu ac amrywiaeth o daflenni cyngor i gleifion gan y GIG. Roedd gwybodaeth wedi'i harddangos yn glir am y ffioedd ar

gyfer triniaethau'r GIG a thriniaethau preifat. Roedd enwau'r ymarferwyr, lluniau ohonynt a'u rhifau cofrestru â'r Cyngor Deintyddol Cyffredinol hefyd i'w gweld yn yr ardal aros i gleifion. Roedd codau moeseg y Cyngor Deintyddol Cyffredinol wedi'u harddangos ac roedd yr oriau agor a manylion cyswllt mewn argyfwng i'w gweld yn amlwg ar ddrws y ffrynt.

Dyweddodd pob claf a ymatebodd i holiadur AGIC fod y staff wedi esbonio iechyd eu ceg iddynt mewn modd y gallent ei ddeall drwy gydol eu hapwyntiad. Dywedodd pob claf hefyd ei fod wedi cael cyfarwyddiadau ôl-ofal addas ar sut i gynnal iechyd da yn y geg.

### **Gofal Urddasol a Pharchus**

Gwelsom y cleifion yn cael eu trin ag urddas a pharch. Roedd trefniadau boddhaol ar waith i amddiffyn preifatrwydd cleifion, gan gynnwys gwydr barugog ar y ffenestri a drysau soled a oedd yn cael eu cadw ar gau yn ystod apwyntiadau. Roedd gan y practis ardal aros ar wahân i ddesg y dderbynfa, felly nid oedd modd i'r cleifion glywed galwadau ffôn â chleifion eraill. Dywedodd y staff wrthym y gellid cynnal trafodaethau sensitif â chleifion mewn ystafell ar wahân nad oedd yn ardal y dderbynfa pe byddai angen, er mwyn cynnig cyfrinachedd i'r cleifion.

Dyweddodd pob un o'r cleifion a gwblhaodd holiadur AGIC fod y staff wedi eu trin ag urddas a pharch, eu bod wedi gwrandao arnynt yn ystod eu hapwyntiad a'u bod wedi ateb eu cwestiynau.

### **Gofal wedi'i deilwra at yr unigolyn**

Gwelsom fod prosesau cynllunio triniaethau ac opsiynau triniaeth wedi'u cofnodi yn y sampl o gofnodion cleifion a welsom. Roedd hyn yn golygu bod y cleifion wedi cael gwybodaeth i'w galluogi i wneud penderfyniad gwybodus am eu triniaeth.

Dyweddodd pawb a ymatebodd i holiadur AGIC eu bod yn teimlo eu bod wedi cael eu cynnwys cymaint ag yr oeddent am gael eu cynnwys yn y penderfyniadau am eu triniaeth, a bod y staff wedi esbonio'r opsiynau a oedd ar gael a'r risgiau a'r manteision iddynt.

Dyweddodd y rhan fwyaf o'r cleifion eu bod wedi cael gwybodaeth am sut y byddai'r practis yn datrys unrhyw bryderon neu gwynion ar ôl triniaeth (31/32). Dywedodd pob un ond un (31/32) a ymatebodd i holiadur AGIC wrthym eu bod yn gwybod beth i'w wneud pe byddai ganddynt argyfwng neu haint.

**Amserol**

**Gofal Amserol**

Gwelsom fod system briodol ar waith ar gyfer rheoli apwyntiadau a bod cleifion yn cael gofal amserol. Roedd apwyntiadau yn cael eu trefnu dros y ffôn a gwelsom enghreifftiau o'r cleifion yn trefnu apwyntiadau â'r staff ar ôl eu triniaethau. Dywedodd y staff wrthym fod apwyntiadau brys yn cael eu brysbennu dros y ffôn drwy ymgynghori â'r ymarferwyr deintyddol, ac y byddai unrhyw gleifion brys yn cael eu gweld o fewn 24 awr.

Esboniodd y staff y byddai unrhyw achosion o oedi i apwyntiadau yn cael eu cyfleu i'r cleifion mewn modd amserol gan staff y dderbynfa, ac y byddai cleifion a oedd wedi aros mwy na 15 munud yn cael cynnig apwyntiad amgen.

Nododd y staff y gellid trefnu apwyntiadau cyffredin i gleifion o fewn un diwrnod gwaith fel arfer, pe gofynnwyd am hynny. Dywedwyd wrthym fod apwyntiadau yn cael eu trefnu'n unol ag anghenion cleifion ac argaeledd lle bynnag y bo'n bosibl.

Dywedodd y cleifion wrthym eu bod wedi ei chael hi'n hawdd iawn (28/31) neu'n eithaf hawdd (3/31) cael apwyntiad pan oedd angen un arnynt. Gwelsom fod gwybodaeth am wasanaethau deintyddol y tu allan i oriau yn cael ei harddangos yn addas y tu allan i'r practis ac ar wefan y practis. Cadarnhaodd y rhan fwyaf o'r cleifion (25/31) a ymatebodd i holiadur cleifion AGIC y byddent yn gwybod sut i gael gafael ar wasanaethau deintyddol y tu allan i oriau pe bai ganddynt broblem ddeintyddol frys.

## Teg

### Cyfathrebu ac iaith

Roedd gwybodaeth i gleifion ar gael yn hwylus i gleifion yn Saesneg ond prin oedd y wybodaeth a oedd ar gael yn Gymraeg. Gwelsom arwyddion yn y practis a oedd yn uniaith Saesneg, a phrin oedd y wybodaeth wrth ddesg y dderbynfa i annog y cleifion i gyfathrebu yn eu dewis iaith. Nid oedd y staff yn gwisgo bathodynau 'laith Gwaith', gan esbonio mai'r rheswm am hynny oedd nad oedd unrhyw un yn y practis yn siarad Cymraeg yn rhugl.

Dywedodd y staff wrthym eu bod yn gallu defnyddio'r Llinell Iaith i gyfathrebu â chleifion nad Saesneg yw eu mamiaith. Cadarnhaodd y staff y gellid darparu gwybodaeth i gleifion yn eu dewis iaith ar gais.

Yn ystod ein trafodaethau â'r staff, gwnaethant ddangos dealltwriaeth o'r 'Cynnig Rhagweithiol' a'r gofyniad i ddarparu gwasanaeth dwyieithog i gleifion. Fodd bynnag, esboniodd y staff eu bod wedi ei chael hi'n anodd cael cymorth gan y staff wrth dderbynfa i drefnu hyfforddiant Cymraeg ac i roi'r 'Cynnig Rhagweithiol' ar waith.

Rhaid i'r rheolwr cofrestredig roi manylion i AGIC am y camau a gymerwyd i roi'r 'Cynnig Rhagweithiol' ar waith.

### **Hawliau a Chydraddoldeb**

Roedd hawliau'r cleifion yn cael eu hamddiffyn ac roedd eu cydraddoldeb yn cael ei hyrwyddo drwy bolisi amrywiaeth cadarn a pholisi addas ar gyfer derbyn cleifion. Roedd poster yn dangos na fyddai unrhyw achos o ymddygiad sarhaus yn cael ei oddef i'w weld yn y dderbynfa ac roedd y safbwynt hwn wedi'i adlewyrchu ym mholisiau a gweithdrefnau'r practis.

Gwelsom fod rhestrau gwirio cynhwysfawr ar gyfer cyfarpar sgriniau arddangos gan yr Awdurdod Gweithredol Iechyd a Diogelwch yn cael eu cwblhau ar gyfer pob aelod o'r staff. Dywedodd y staff wrthym fod cleifion trawsryweddol yn cael cynnig dewis y rhagenwau a ffefrir ganddynt ar eu cofnod, gan ddangos yr ymrwymiad i gynnal ansawdd a hawliau cleifion.

Dywedodd pawb a ymatebodd i holiadur AGIC wrthym nad oeddent wedi wynebu unrhyw fath o wahaniaethu wrth ddefnyddio'r gwasanaeth hwn. Dywedodd pob un o'r cleifion eu bod yn teimlo eu bod yn gallu cael gafael ar y gofal iechyd cywir ar yr adeg gywir a dywedodd y rhan fwyaf (31/32) ohonynt fod yr adeilad yn hygyrch. Nododd un ymatebydd nad oedd yn siŵr.

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# Darparu Gofal Diogel ac Effeithiol

## Diogel

### Rheoli Risg

Roedd y practis mewn cyflwr da y tu mewn a'r tu allan. Roedd pedair deintyddfa fawr ar y llawr gwaelod, a oedd yn cynnwys deintyddfa fodern a oedd newydd ei hadeiladu. Roedd ystafell aros o faint addas ac roedd gwres, goleuadau, dulliau awyru ac arwyddion boddhaol ym mhob rhan o'r practis. Gwelsom a chlywsom y llinellau ffôn yn gweithio a nodwyd gennym fod cyfleusterau newid a loceri ar gael i'r staff. Roedd y llawr gwaelod yn hygyrch i'r cleifion, gan gynnwys y deintyddfeydd a gwelsom ddau doiled i bobl anabl a oedd yn lân ac yn cynnwys cyfarpar priodol.

Gwelsom gyfarpar deintyddol aml dro a oedd yn hyrwyddo gofal diogel ac effeithiol ac a oedd mewn cyflwr da, ac roedd eitemau untro yn cael eu defnyddio lle y bo'n briodol.

Gwnaethom edrych ar bolisi iechyd a diogelwch cynhwysfawr yn ogystal â pholisi ar gyfer cynnal a chadw'r adeilad a chynllun parhad busnes cadarn. Roedd asesiadau risg addas ar waith ar gyfer iechyd a diogelwch a diogelwch tân. Roedd y staff yn llofnodi rhestr wirio i gadarnhau eu bod yn ymwybodol o bob polisi ac yn ei ddeall.

Gwelsom fod tystysgrif yswiriant atebolwydd cyflogwr y practis a phoster gan yr Awdurdod Gweithredol Iechyd a Diogelwch yn cael eu harddangos.

Roedd arwyddion diogelwch tân a dim smygu i'w gweld yn amlwg o amgylch y practis. Wrth edrych ar y cyfarpar a'r wybodaeth diogelwch tân, gwelsom fod trefniadau addas ar waith o ran diogelwch tân, gan gynnwys trefniadau ar gyfer cynnal a chadw'r cyfarpar tân yn rheolaidd ac arwyddion clir ar gyfer yr allanfeydd tân.

### Atal a Rheoli Heintiau a Dihalogi

Roedd polisiau a gweithdrefnau rheoli heintiau addas ar waith er mwyn sicrhau safonau uchel mewn perthynas â rheoli heintiau. Roedd amserlenni glanhau effeithiol ar waith er mwyn hyrwyddo gweithdrefnau glanhau rheolaidd yn y practis. Gwelsom fod y cyfleusterau hylendid dwylo a'r arwyddion cysylltiedig yn briodol. Roedd digon o Gyfarpar Diogelu Personol (PPE) ar gael i'r staff ac roedd yr amgylchedd mewn cyflwr da er mwyn gallu ei lanhau'n effeithiol.

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Dyweddod pob un o'r cleifion a ymatebodd i holiadur AGIC eu bod o'r farn bod y practis yn lân iawn a bod mesurau atal a rheoli heintiau yn cael eu dilyn yn briodol gan y staff. Dywedodd un o'r cleifion:

*“Gwnaeth cyflwr yr adeilad cyfan argraff dda iawn arna i. Roedd yn eithriadol o lân!”*

Roedd gwasanaethau iechyd galwedigaethol ar gael i'r staff er mwyn ymdrin ag anafiadau offer miniog a gwelsom fod dyfeisiau offer miniog mwy diogel yn cael eu defnyddio er mwyn atal anafiadau. Roedd protocol addas ar waith ar gyfer anafiadau offer miniog.

Gwelsom fod trefniadau cynhwysfawr ar waith i sicrhau bod cyfarpar aml dro yn cael ei ddihalogi a'i sterileiddio'n gywir. Gwnaethom edrych ar y cofnodion o'r gwiriadau ar gylchredau'r peiriant awtoclaf ac amserlen o waith cynnal a chadw rheolaidd. Gwnaethom nodi bod argraffiadau yn cael eu diheintio'n ddiogel fel y bo'n briodol.

Cadarnhaodd y cofnodion hyfforddiant y gwnaethom edrych arnynt fod pob aelod o'r staff wedi cael hyfforddiant priodol ar atal a rheoli heintiau a dihalogi cyfarpar. Roedd y staff y gwnaethom siarad â nhw yn deall eu cyfrifoldebau unigol mewn perthynas â mesurau rheoli heintiau yn glir.

Gwelsom fod yr holl wastraff yn cael ei storio'n ddiogel a'i waredu'n briodol drwy gontract gwaredu gwastraff addas. Nodwyd gennym fod y broses ar gyfer Rheoli Sylweddau Peryglus i Iechyd (COSHH) yn foddhaol, ac roedd y manylion yn cael eu cadw gyda'i gilydd mewn ffolder COSHH gynhwysfawr.

### **Rheoli Meddyginiaethau**

Gwelsom fod gweithdrefnau priodol ar waith i sicrhau bod meddyginiaethau yn cael eu storio, eu rhoi a'u dosbarthu'n ddiogel ac yn effeithiol. Nid oedd meddyginiaethau yn cael eu defnyddio'n rheolaidd. Roeddent yn cael eu storio i'w defnyddio mewn argyfwng yn unig. Yn nodiadau'r cleifion, gwelsom fod unrhyw feddyginiaethau a roddwyd yn cael eu cofnodi'n glir. Roedd pad presgripsiwn y practis yn cael ei storio'n ddiogel.

Gwnaethom edrych ar y polisi ar gyfer rheoli argyfyngau meddygol a oedd yn gynhwysfawr ac yn gyfredol. Roedd system gadarn ar waith ar gyfer monitro dyddiadau defnyddio cyfarpar a meddyginiaethau brys. Roedd yr holl gyfarpar brys a chymorth cyntaf o fewn cyrraedd hawdd i'r staff ac roedd y dyddiadau defnyddio yn gyfredol.

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Roedd y cofnodion hyfforddiant staff a welsom yn dangos bod pob aelod o'r staff wedi cael hyfforddiant dadebru cardio-anadlol ac roedd dau swyddog cymorth cyntaf hyfforddedig. Fodd bynnag, gwelsom dystiolaeth bod y ddau swyddog cymorth cyntaf wedi cwblhau eu cymwysterau bob tair blynedd, ond bod dyddiadau eu hyfforddiant gloywi blynyddol wedi mynd heibio. Cafodd y risg i ddiogelwch uniongyrchol y cleifion ei lliniaru gan y ffaith bod pob aelod o'r staff wedi cael hyfforddiant cynnal bywyd uwch a hyfforddiant i reoli argyfyngau meddygol.

**Rhaid i'r rheolwr cofrestredig sicrhau y caiff hyfforddiant gloywi cymorth cyntaf ei gynnal bob blwyddyn.**

### **Diogelu Plant ac Oedolion**

Gwelsom fod polisiau a gweithdrefnau diogelu priodol a chyfredol ar waith i hybu ac amddiffyn lles a diogelwch plant ac oedolion. Roedd y polisi a'r gweithdrefnau yn cynnwys Gweithdrefnau Diogelu Cymru, yn nodi arweinydd diogelu penodedig ac yn cynnwys y manylion cyswllt ar gyfer gwasanaethau cymorth lleol.

Gwelsom fod pob aelod o'r staff wedi cwblhau hyfforddiant addas ar ddiogelu plant ac oedolion. Dangosodd y staff y gwnaethom siarad â nhw ddealltwriaeth foddhaol o weithdrefnau diogelu gan ddweud eu bod yn teimlo y byddent yn cael eu cefnogi pe byddent yn codi pryder.

### **Rheoli Dyfeisiau a Chyfarpar Meddygol**

Gwelsom fod y cyfarpar clinigol yn ddiogel, mewn cyflwr da ac yn addas at y diben. Gwelsom fod y cyfarpar deintyddol aml dro mewn cyflwr da a'i fod yn hyrwyddo gofal diogel ac effeithiol. Roedd trefniadau priodol ar waith ar gyfer ymdrin â chyfarpar deintyddol a'i ddiheintio mewn modd diogel. Roedd y staff y gwnaethom siarad â nhw yn hyderus o ran defnyddio'r cyfarpar, ac roedd y cofnodion hyfforddiant y gwnaethom edrych arnynt yn cadarnhau eu bod wedi cael hyfforddiant addas ar gyfer eu rolau.

Gwelsom fod ffolder diogelu rhag ymbelydredd y practis yn gyfredol ac yn gynhwysfawr. Wrth edrych ar gofnodion y cleifion, gwelsom fod y nodiadau clinigol ar gyfer triniaethau radiograffig wedi cael eu cwblhau'n llawn. Roedd y cofnodion hefyd yn dangos fod risgiau a manteision ymbelydredd yn cael eu hesbonio i gleifion, a lle y bo'n berthnasol i'w cysurwyr, a bod unrhyw gysylltiadau yn cael eu cofnodi'n briodol. Nodwyd gennym eu bod hi'n hawdd cael gafael ar y rheolau lleol. Roedd cofnodion hyfforddiant y staff yn dangos bod pob aelod o'r staff wedi cael hyfforddiant radiograffeg i lefel briodol.

**Effeithiol**

## **Gofal Effeithiol**

Gwelsom fod y staff yn asesu cleifion ac yn gwneud diagnosis yn ddiogel. Roedd cofnodion y cleifion yn dangos bod triniaethau'n cael eu darparu'n unol ag anghenion clinigol a chan gydymffurfio â chanllawiau proffesiynol, rheoliadol a statudol.

Dangosodd y staff clinigol y gwnaethom siarad â nhw ddealltwriaeth glir o'u cyfrifoldebau ac roeddent hefyd yn gwybod ble i gael gafael ar gyngor proffesiynol perthnasol pe bai angen.

Gwelsom ddefnydd priodol o restrau gwirio clinigol fel y Safonau Diogelwch Lleol ar gyfer Triniaethau Mewnwithiol.

## **Cofnodion Cleifion**

Gwnaethom adolygu cofnodion 10 claf i gyd a gwelsom fod y cofnodion clinigol yn cyrraedd safon foddhaol. Gwelsom fod polisi rheoli cofnodion priodol a system cofnodion digidol cadarn ar waith. Roedd pob cofnod yn cael ei storio'n unol â'r Rheoliad Cyffredinol ar Ddiogelu Data.

Gwelsom enghreifftiau o nodiadau cleifion cynhwysfawr a oedd yn cynnwys cadarnhau hanes y claf, y rhesymau dros yr apwyntiad a chydsyniad ar sail gwybodaeth ar gyfer yr opsiynau triniaeth a ddarparwyd. Ategwyd hyn gan yr hyn a ddywedodd y cleifion wrthym yn holiadur AGIC. Fodd bynnag, nodwyd gennym nad oedd profion sgrinio ar gyfer canser y geg bob amser yn cael eu nodi yng nghofnodion y cleifion ac nid oedd wyth o'r 10 cofnod a welsom yn cynnwys asesiadau risg mewn perthynas â cheudodau, perio, traul dannedd a chanser y geg.

Gwelsom fod cleifion yn cael eu hatgyfeirio, ond nid oedd unrhyw dystiolaeth i'w gweld bod yr atgyfeiriadau yn cael eu cofnodi yng nghofnodion y cleifion.

**Rhaid i'r rheolwr cofrestredig sicrhau bod cofnodion y cleifion yn adlewyrchu'r asesiadau risg a'r triniaethau a roddir i'r claf yn gywir.**

Gwelsom hefyd nad oedd dewis iaith y cleifion nac unrhyw gamau a gymerwyd mewn ymateb i'r dewis hwn wedi cael eu cofnodi yn unrhyw un o'r cofnodion a welsom.

**Rhaid i'r rheolwr cofrestredig sicrhau y caiff anghenion iaith a chyfathrebu cleifion eu cofnodi fel mater o drefn.**

**Effeithlon**

## Effeithlon

Gwelsom fod y clinigwyr yn darparu gwasanaeth boddhaol i ddiwallu anghenion eu cleifion ar safle addas. Roedd gweithdrefn brysbennu gadarn ar waith a oedd yn defnyddio'r slotiau a oedd yn cael eu creu pan fyddai apwyntiadau yn cael eu canslo i ddefnyddio amser y clinigwyr mewn ffordd effeithiol.

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# Ansawdd Rheolaeth ac Arweinyddiaeth

## Arweinyddiaeth

### Llywodraethu ac Arweinyddiaeth

Nodwyd gennym fod strwythurau rheoli clir ar waith er mwyn helpu i sicrhau bod y practis yn rhedeg yn effeithiol. Dywedodd y staff wrthym eu bod yn aelodau 'Arbenigol' o Gymdeithas Ddeintyddol Prydain a gwelsom dystiolaeth fod adnodd datblygu tîm y Cynllun Arferion Da yn cael ei ddefnyddio. Roedd cyfarfodydd tîm yn cael eu cynnal yn rheolaidd ac roedd y pynciau a oedd yn cael eu trafod yn cynnwys rheoli adnoddau, diogelwch tân a pholisïau'r GIG.

Roedd y staff y gwnaethom siarad â nhw yn cefnogi ei gilydd, yn gyfeillgar ac yn hawdd mynd atynt. Cadarnhaodd y deintydd arwain a pherchennog y practis ei fod wedi cael cymorth a hyfforddiant addas i gyflawni ei rôl arwain yn effeithiol. Roedd y practis yn cadw cofrestr o bolisïau a gweithdrefnau a oedd yn cael eu hadolygu bob blwyddyn er mwyn rhoi canllawiau clir i'r staff.

## Y Gweithlu

### Gweithlu Medrus a Galluog

Roedd trefniadau cynhwysfawr ar waith i sicrhau bod y staff yn cael hyfforddiant ac yn diweddarau eu sgiliau mewn modd amserol. Yng nghofnodion staff pump aelod o staff allan o'r naw a welsom, gwelwyd cydymffurfiaeth lawn â'r holl gyrsiau hyfforddiant gorfodol a thystiolaeth o arfarniadau staff cyfredol a rheolaidd yn y ffeil. Cadarnhaodd y staff y gwnaethom siarad â nhw eu bod yn teimlo eu bod yn cael eu cefnogi i ymgymryd â gweithgareddau dysgu a datblygu a gwelsom fod diwrnodau hyfforddiant yn cael eu cynnal yn rheolaidd i bob aelod o'r staff.

Roedd system rota effeithiol ar waith i sicrhau bod niferoedd priodol o staff â'r cymwysterau addas yn gweithio ar unrhyw un adeg. Gwelsom fod gweithdrefn sefydlu addas a systemau boddhaol ar waith i reoli'r defnydd o weithwyr asiantaeth.

Gwelsom fod systemau cadarn ar waith i sicrhau bod cofnodion y staff yn cael eu diweddarau'n barhaus a bod gwiriadau cyn cyflogi priodol yn cael eu cynnal. Roedd cofrestriadau proffesiynol pob aelod o'r staff yn gyfredol ac yn cael eu rheoli mewn ffordd addas gan reolwr y practis.

Roedd polisi chwythu'r chwiban cynhwysfawr ar waith a oedd yn disgrifio'r weithdrefn i'r staff godi pryderon. Cadarnhaodd y staff y byddent yn teimlo'n

hyderus yn codi pryder, y byddent yn teimlo y byddai'r rheolwyr yn eu cefnogi pe byddent yn gwneud hynny a gwnaethant esbonio'r broses y byddent yn ei dilyn.

## Diwylliant

### Ymgysylltu â Phobl, Adborth a Dysgu

Gwelsom fod system foddhaol ar waith ar gyfer cyflwyno a rheoli adborth gan gleifion. Roedd blwch awgrymiadau yn y dderbynfa a gwelsom o gofnodion cyfarfodydd fod adborth yn cael ei drafod yn rheolaidd yn ystod cyfarfodydd y practis. Roedd hysbysfwrdd yn yr ardal aros yn nodi manylion ymateb y gwasanaeth i adborth gan gleifion ac yn amlinellu unrhyw newidiadau a wnaed o ganlyniadi hynny.

Roedd y polisi cwynion wedi'i arddangos yn glir yn yr ardal aros er mwyn sicrhau bod cleifion yn ymwybodol ohono. Nodwyd gennym fod cwynion gan gleifion yn cael eu rheoli'n unol â'r weithdrefn Gweithio i Wella, a gwelsom fod rheolwr y practis wedi'i enwi fel yr unigolyn y dylid cysylltu ag ef pe byddai claf yn awyddus i wneud cwyn. Er nad oedd unrhyw gwynion i ni eu hadolygu, gwelsom fod ffolder cwynion foddhaol a ffurflenni cwyno drafft ar gael. Dywedodd y staff wrthym y byddai unrhyw gwynion a wnaed ar lafar yn cael eu cofnodi a'u cyflwyno i reolwr y practis eu hadolygu.

Gwelsom fod polisiau a gweithdrefnau cyfredol ac addas ar waith mewn perthynas â'r Ddyletswydd Gonestrwydd. Dangosodd y staff y gwnaethom siarad â nhw eu bod yn deall eu rôl o dan y ddyletswydd, gan ddweud wrthym eu bod yn teimlo eu bod yn cael eu hannog i rannu pryderon â'r claf pan fyddai rhywbeth wedi mynd o'i le. Roedd cofnodion hyfforddiant y staff yn dangos bod pob aelod o'r staff wedi cwblhau hyfforddiant ar y Ddyletswydd Gonestrwydd yn ddiweddar.

## Dysgu, Gwella ac Ymchwil

### Gweithgareddau Gwella Ansawdd

Gwelsom fod polisi ar waith ar gyfer archwiliadau clinigol a gweithgareddau gwella ansawdd parhaus ac roedd adolygiadau cymheiriaid rhwng aelodau o'r staff clinigol yn cael eu cynnal yn rheolaidd.

Fodd bynnag, ni welsom dystiolaeth i ddangos bod gweithgareddau archwilio rheolaidd yn cael eu cynnal mewn perthynas ag ansawdd triniaethau radiograffig, rhoi'r gorau i smygu, rhagnodi gwrthfotigau na chadw cofnodion. Gan fod cymaint o archwiliadau ar goll, awgrymwyd y dylai'r practis gynnal adolygiad o'i bolisi a'i weithdrefnau archwilio a gwella ansawdd.

Rhaid i'r rheolwr cofrestredig gynnal archwiliadau clinigol, fel y rhai hynny sydd ar gael drwy Addysg a Gwella Iechyd Cymru (AaGIC).

Rhaid i'r rheolwr cofrestredig adolygu ei bolisi a'i weithdrefn archwilio a gwella ansawdd.

## Dull Systemau Cyfan

### Gweithio mewn Partneriaeth a Datblygu

Amlinellodd y staff ddulliau addas o gyfathrebu â darparwyr gwasanaethau iechyd eraill, gan gynnwys y bwrdd iechyd.

Gwelsom fod proses briodol ar waith i olrhain unrhyw atgyfeiriadau a wnaed i ddarparwyr gwasanaethau eraill. Esboniodd y staff fod ganddynt gydberthnasau gwaith da â gwasanaethau gofal sylfaenol eraill ym Mhowys, gan gynnwys gwasanaethau meddygon teulu.

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## 4. Y camau nesaf

Lle rydym wedi nodi gwelliannau a phryderon uniongyrchol yn ystod ein harolygiad y mae'n ofynnol i'r gwasanaeth gymryd camau yn eu cylch, nodir y rhain yn y ffyrdd canlynol yn atodiadau'r adroddiad hwn (lle y bônt yn gymwys):

- Atodiad A: Yn cynnwys crynodeb o unrhyw bryderon am ddiogelwch cleifion a gafodd eu huwchgyfeirio a'u datrys yn ystod yr arolygiad
- Atodiad B: Yn cynnwys unrhyw bryderon uniongyrchol am ddiogelwch cleifion lle rydym yn gofyn i'r gwasanaeth gwblhau cynllun gwella ar unwaith yn dweud wrthym am y camau brys y mae'n eu cymryd
- Atodiad C: Yn cynnwys unrhyw welliannau eraill a nodwyd yn ystod yr arolygiad, lle rydym yn gofyn i'r gwasanaeth gwblhau cynllun gwella sy'n dweud wrthym am y camau y mae'n eu cymryd i fynd i'r afael â'r meysydd hyn.

Dylai'r cynlluniau gwella wneud y canlynol:

- Nodi'n glir sut yr ymdrinnir â'r canfyddiadau a nodwyd
- Sicrhau bod y camau a gymerir mewn ymateb i'r materion a nodwyd yn benodol, yn fesuradwy, yn gyflawnadwy, yn realistig ac wedi'u hamseru
- Cynnwys digon o fanylion er mwyn rhoi sicrwydd i AGIC a'r cyhoedd yr ymdrinnir â'r canfyddiadau a nodwyd yn ddigonol
- Sicrhau bod y dystiolaeth ofynnol yn erbyn y camau a nodwyd yn cael ei rhoi i AGIC o fewn tri mis i'r arolygiad.

O ganlyniad i ganfyddiadau'r arolygiad hwn, dylai'r gwasanaeth wneud y canlynol:

- Sicrhau nad yw'r canfyddiadau yn systemig ar draws rhannau eraill o'r sefydliad ehangach
- Rhoi'r wybodaeth ddiweddaraf i AGIC pan fydd camau yn dal i fod heb eu cymryd a/neu ar y gweill, er mwyn cadarnhau pan fyddant wedi cael eu cwblhau.

Caiff y cynllun gwella, ar ôl cytuno arno, ei gyhoeddi ar wefan AGIC.

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# Atodiad A - Crynodeb o bryderon a ddatryswyd yn ystod yr arolygiad

Mae'r tabl isod yn crynhoi'r pryderon a gafodd eu nodi a'u huwchgyfeirio yn ystod ein harolygiad. Oherwydd yr effaith/effaith bosibl ar ofal a thriniaeth y cleifion, roedd angen rhoi sylw i'r pryderon hyn ar unwaith, yn ystod yr arolygiad.

Pryderon uniongyrchol a nodwyd	Effaith/effaith bosibl ar ofal a thriniaeth y cleifion	Sut gwnaeth AGIC uwchgyfeirio'r pryder	Sut cafodd y pryder ei ddatrys
Ni nodwyd unrhyw bryderon uniongyrchol yn ystod yr arolygiad hwn.			

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# Atodiad B - Cynllun gwella ar unwaith

Gwasanaeth: Practis Deintyddol Charro

Dyddiad yr arolygiad: 12 Rhagfyr 2023

Mae'r tabl isod yn cynnwys unrhyw bryderon uniongyrchol am ddiffyg cydymffurfio sy'n ymwneud â diogelwch y cleifion a nodwyd yn ystod yr arolygiad lle rydym yn gofyn i'r gwasanaeth gwblhau cynllun gwella ar unwaith sy'n nodi'r camau brys y mae'n eu cymryd.

Risg/canfyddiad/mater	Yr hyn sydd angen ei wella	Safon / Rheoliad	Camau gweithredu gan y gwasanaeth	Swyddog cyfrifol	Amserlen
Ni nodwyd unrhyw bryderon uniongyrchol yn ystod yr arolygiad hwn.					

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# Atodiad C - Cynllun gwella

Gwasanaeth: Practis Deintyddol Charro

Dyddiad yr arolygiad: 12 Rhagfyr 2023

Mae'r tabl isod yn cynnwys unrhyw welliannau eraill a nodwyd yn ystod yr arolygiad, lle rydym yn gofyn i'r gwasanaeth gwblhau cynllun gwella sy'n dweud wrthym am y camau y mae'n eu cymryd i fynd i'r afael â'r meysydd hyn.

Risg/canfyddiad/mater	Yr hyn sydd angen ei wella	Safon / Rheoliad	Camau gweithredu gan y gwasanaeth	Swyddog cyfrifol	Amserlen
<p>Roedd gwybodaeth i gleifion ar gael yn hwylus i gleifion yn Saesneg ond prin oedd y wybodaeth a oedd ar gael yn Gymraeg. Gwelsom arwyddion yn y practis a oedd yn uniaith Saesneg, a phrin oedd y wybodaeth wrth ddesg y dderbynfa i annog y cleifion i gyfathrebu yn eu dewis iaith. Nid oedd y staff yn gwisgo bathodynau 'laith Gwaith'.</p>	<p>Rhaid i'r rheolwr cofrestredig roi manylion i AGIC am y camau a gymerwyd i roi'r 'Cynnig Rhagweithiol' ar waith.</p>	<p>Rheoliadau Deintyddiaeth Breifat (Cymru) 2017, Adran 13 (1) (a)</p>	<p>Mae arwyddion Cymraeg newydd i'w gweld ym mhob rhan o'r practis. Anogwyd y staff i gymryd rhan mewn gwersi Cymraeg a ddarperir gan y bwrdd iechyd, ac i gyfarch y cleifion yn ddwyieithog.</p>	<p>Charlotte Allison</p>	<p>I'w roi ar waith erbyn 12/2/24</p>

<p>Gwelsom dystiolaeth bod y ddau swyddog cymorth cyntaf wedi cwblhau eu cymwysterau bob tair blynedd, ond bod dyddiadau eu hyfforddiant gloywi blynyddol wedi mynd heibio.</p>	<p>Rhaid i'r rheolwr cofrestredig sicrhau y caiff hyfforddiant gloywi cymorth cyntaf ei gynnal bob blwyddyn.</p>	<p>Adran 17</p>	<p>Caiff cyrsiau gloywi cymorth cyntaf eu cwblhau gan bob swyddog cymorth cyntaf ar unwaith, a bob blwyddyn wedi hynny.</p>	<p>Charlotte Allison</p>	<p>12/2/24</p>
<p>Nodwyd gennym nad oedd profion sgrinio ar gyfer canser y geg bob amser yn cael eu nodi yng nghofnodion y cleifion ac nid oedd wyth o'r 10 cofnod a welsom yn cynnwys asesiadau risg mewn perthynas â cheudodau, perio, traul dannedd a chanser y geg.</p> <p>Gwelsom fod cleifion yn cael eu hatgyfeirio, ond nid oedd unrhyw</p>	<p>Rhaid i'r rheolwr cofrestredig sicrhau bod cofnodion y cleifion yn adlewyrchu'r asesiadau risg a'r triniaethau a roddir i'r claf yn gywir.</p>	<p>Adran 20 (1)</p>	<p>Cafodd y wybodaeth hon ei chyfleu i bob un o'r clinigwyr, sy'n gyfrifol am eu nodiadau clinigol eu hunain, a chaiff archwiliadau rheolaidd eu cynnal gan reolwr y practis o'r nodiadau clinigol er mwyn sicrhau eu bod yn adlewyrchu asesiadau risg cywir ar gyfer triniaethau.</p>	<p>Charlotte Allison</p>	<p>31/3/24</p>

dystiolaeth i'w gweld bod yr atgyfeiriadau yn cael eu cofnodi yng nghofnodion y cleifion.					
Nid oedd dewis iaith y cleifion nac unrhyw gamau a gymerwyd mewn ymateb i'r dewis hwn wedi cael eu cofnodi yn unrhyw un o'r cofnodion a welsom.	Rhaid i'r rheolwr cofrestredig sicrhau y caiff anghenion iaith a chyfathrebu cleifion eu cofnodi fel mater o drefn.	Adran 13 (1) (a)	Gofynnir i gleifion ar ddechrau eu hapwyntiad (i nodi eu dewis iaith) a chaiff eu hateb ei gofnodi yn ffeil ffisegol a nodiadau clinigol y claf.	Charlotte Allison	31/3/24
Gwelsom fod polisi ar waith ar gyfer archwiliadau clinigol a gweithgareddau gwella ansawdd parhaus ac roedd adolygiadau cymheiriaid rhwng aelodau o'r staff clinigol yn cael eu cynnal yn rheolaidd. Fodd bynnag, ni welsom dystiolaeth i ddangos bod gweithgareddau	Rhaid i'r rheolwr cofrestredig gynnal archwiliadau clinigol, fel y rhai hynny sydd ar gael drwy Addysg a Gwella Iechyd Cymru (AaGIC).  Rhaid i'r rheolwr cofrestredig adolygu ei bolisi a'i weithdrefn archwilio a gwella ansawdd.	Adran 16 (1)	Bydd rheolwr y practis yn gyfrifol am yr archwiliadau clinigol, a bydd yn cynnal archwiliadau AaGIC ar unwaith.  Caiff hyn ei adlewyrchu ym mholisi archwilio'r practis.	Charlotte Allison	30/4/24

<p>archwilio rheolaidd yn cael eu cynnal mewn perthynas ag ansawdd triniaethau radiograffig, rhoi'r gorau i smygu, rhagnodi gwrthfotigau na chadw cofnodion. Gan fod cymaint o archwiliadau ar goll, awgrymwyd y dylai'r practis gynnal adolygiad o'i bolisi a'i weithdrefnau archwilio a gwella ansawdd.</p>					
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Rhaid i'r adran ganlynol gael ei chwblhau gan gynrychiolydd y gwasanaeth sydd â'r cyfrifoldeb ac atebolrwydd cyffredinol dros sicrhau bod y cynllun gwella yn cael ei roi ar waith.

### **Cynrychiolydd y gwasanaeth**

**Enw (priflythrennau): Charlotte Allison**

**Teitl swydd: Rheolwr y Practis**

**Dyddiad: 7/2/24**

Patterson-Liz  
12/04/2024 09:50:36

# Mental Health Hospitals, Learning Disability Hospitals and Mental Health Act Monitoring

Annual Report 2022-2023



Patterson Liz  
12/04/2024 09:50:36

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

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

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To aid readers, a list and explanation of technical terms used in this report is included as Appendix B.

Mae'r ddogfen yma hefyd ar gael yn Gymraeg.  
This document is also available in Welsh.

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

## Our purpose

To check that healthcare services are provided in a way which maximises the health and wellbeing of people.

## Our values

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

- **Independent** – we are impartial, deciding what work we do and where we do it.
- **Objective** – we are reasoned, fair and evidence driven.
- **Decisive** – we make clear judgements and take action to improve poor standards and highlight the good practice we find.
- **Inclusive** – we value and encourage equality and diversity through our work.
- **Proportionate** – we are agile, and we carry out our work where it matters most.

## Our goal:

- To be a trusted voice which influences and drives improvement in healthcare.

## Our priorities

- We will focus on the quality of healthcare provided to people and communities as they access, use, and move between services.
- We will adapt our approach to ensure we are responsive to emerging risks to patient safety.
- We will work collaboratively to drive system and service improvement within healthcare.
- We will support and develop our workforce to enable them, and the organisation, to deliver our priorities.



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# 1. Executive Summary

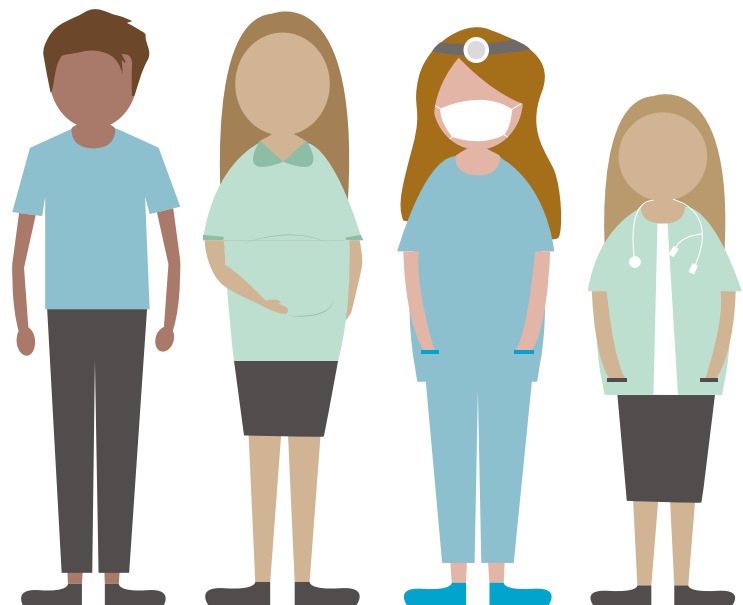
This report sets out Healthcare Inspectorate Wales (HIW) activity and findings for mental health and learning disability services during the period April 2022 to March 2023

Mental health and learning disability services continue to face many challenges that are affecting outcomes for patients. There continues to be severe pressure on in-patient beds and there are many challenges faced by the health boards and independent providers of care in providing a range of diverse services to vulnerable patients. This year we have extended our inspection programme to include community services.

One positive aspect of the vast majority of our inspections was the appreciation by patients and relatives of the quality of staff and patient interaction. Our staff observed patients being engaged in a positive manner with an appropriate level of explanation to ensure patients understood the care and treatment they were receiving. In addition, in the vast majority of our inspections, we found a number of good examples of patients being actively engaged with a range of therapies that they commented positively upon. This is a significant improvement on our previous years of inspection findings where we identified a number of issues with provision of meaningful activities.

However, some areas continue to cause concern for us, particularly where there has been little or no improvement since our 2021-22 report. These areas are:

- Workforce challenges – issues with recruitment and retention of staff.
- Medicines management – a range of issues with the storage, administration, and audit.
- Patient observations – training of staff, lack of effective recording, and the timely review of policies/procedures.
- Patient information – lack of information available for patients on key topics.
- Risk assessments and care planning documentation – including risk assessments not completed and lack of a timely review.
- Environment of care – a lack of audits and the management of environmental ligature risks.
- Governance - a lack of audit and oversight of key areas including training.



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In some of our visits we identified very serious issues that required immediate assurance notices for health boards, or non-compliance notices for the independent providers. The health board/independent provider responds to these notices with an immediate improvement plan that HIW must agree. We issued a total of seven notices between the period 1 April 2022 and the 31 March 2023. This comprised of five for health boards and two for the independent providers.

Chapter 6 of this report identifies the process and areas we focus upon to be assured that services discharge their powers and duties correctly under the Mental Health Act 1983 in Wales.

Our findings are drawn from inspection visits and onsite focussed reviews, analysis of information received through our concerns and notifications processes, and the work of our Review Service for Mental Health (RSMH). During the reporting period we conducted a total of 22 onsite inspections to a range of healthcare settings of both NHS and independent hospitals. The wards inspected accommodated a range of patients that included:

- Adults with mental health issues.
- Older persons.
- Learning Disabilities.
- Child and Adolescent Mental Health Services (CAMHS).

Within the total of 22 onsite inspections, we jointly visited three Community Mental Health Teams (CMHTs) with Care Inspectorate Wales (CIW) and one independent healthcare provider was visited on two occasions because of the nature of the concerns identified.

We reviewed 902 regulatory notifications of incidents that occurred within independent mental health and learning disability healthcare settings.

In addition, we received 694 requests for a visit by a Second Opinion Appointed Doctor (SOAD). This represents a decrease in requests from 759 for the period April 2021 to March 2022.

These requests can be broken down in the following way:

- 640 requests related to the certification of medication.
- 42 requests related to the certification of Electro-Convulsive Therapy (ECT).
- 12 requests related to medication and ECT.

In conclusion, we continue to identify areas of good practice and patients continue to be complimentary about the quality of staff and patient interaction. Our staff observed patients being engaged in a positive manner with an appropriate level of explanation to ensure patients understood the care and treatment they were receiving. However, we continue to identify significant issues with the workforce, medicines management, patient observations, patient information, risk assessments and care and treatment planning documentation, environment of care and governance.

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## 2. Context

Throughout 2022-23 mental health and learning disability hospitals and community services faced many challenges in delivering services post the COVID-19 pandemic. Many individuals have experienced deterioration in their mental health after the stress and social isolation of living through the pandemic.

This unprecedented event has also placed a considerable degree of pressure on staff working in the NHS and independent sector. Workforce challenges in the recruitment and retention of skilled, knowledgeable, and experienced staff is an issue that made delivering effective services very hard, and inevitably, this impacted on individual patient care and treatment. Workforce issues were found in most of our inspections and effected all disciplines of healthcare staff. Shortages of staff were having an impact on the care pathway for patients particularly in terms of taking section 17 leave which is a key part of a patients' care pathway.

During the inspection year we have undertaken some joint working with CIW visiting three CMHTs. This enabled us to effectively case track joint working between in-patient wards and community services. In addition, we undertook a local review of discharge arrangements for adult patients from inpatient mental health services in Cwm Taf Morgannwg University Health Board. This resulted in a number of significant recommendations being made to the health board.

In 2022-23 some key pieces of guidance were introduced, and we assessed, through our inspections, how health boards and independent providers are implementing the guidance. One key piece of Welsh Government guidance was published in October 2022 and was a framework for reducing restrictive practices in childcare, education, health and social care settings.

The Mental Health Act 1983 Code of Practice for Wales (revised 2016) states "In some exceptional circumstances, where the severity of the patient's behaviour leads to an identification of a need for some form of mechanical restraint, such restraint may, in certain circumstances, be agreed by the hospital managers. This will be in circumstances where a high security placement has been assessed as not being suitable and following a recorded multi-disciplinary discussion. This agreement should usually be made in collaboration with Healthcare Inspectorate Wales (HIW)". HIW has been consulted regarding the use of mechanical restraint. The use of such restraint in hospitals is very rare but, in the event, it is being considered, our role is to check that this form of restraint has been thoroughly risk assessed and care planned, and that it is the last option available in managing a patient's extreme challenging behaviour.

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The SOAD service is now a hybrid model with a mixture of remote and face to face contact with patients who require a second medical opinion under the Act. Whether patients are seen remotely or face to face there is still the requirement for health boards and independent providers of care to send key documentation to us to enable the SOAD to have access to key information in relation to the history and treatment for the patient.

We continue to work with a number of stakeholders for mental health and these stakeholders are listed within section 3 of this report. These stakeholders keep HIW well sighted on current developments, within a range of areas, and we use this intelligence to target and enhance our inspections. Following the end of Welsh Government's Together for Mental Health Delivery Plan in 2022, a new mental health strategy is expected from the Welsh Government in Autumn 2023.



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### 3. Our role in mental health and learning disability care

HIW has a number of key roles within healthcare in Wales which are outlined below:

- We inspect all NHS mental health and learning disability services.
- We are the regulator and inspectorate of all independent mental health and learning disability healthcare services.
- We have a statutory responsibility to monitor the use of the Mental Health Act on behalf of the Welsh Ministers.
- We monitor parts 2 and 4 of the Mental Health (Wales) Measure 2010.
- We monitor the implementation of the Deprivation of Liberty Safeguards (DoLS).

#### Inspection and regulation

During this period, within the NHS, we looked at how services met the Health and Care as well as other relevant standards, in order to check that people receive good quality healthcare.

HIW is the registering body for all independent healthcare providers in Wales. We register, inspect, consider intelligence on complaints and concerns and enforce in accordance with the Care Standards Act 2000, the Independent Health Care (Wales) Regulations 2011 and the 25 National Minimum Standards for Independent Health Care Services in Wales.

We made use of a combination of routine on-site and focused inspections during 2022-23. The findings from these inspections are summarised in section 5 of this report. In addition, a list of the activity we undertook and links to the reports for individual settings is included as Appendix A.

#### Monitoring use of the Mental Health Act 1983

The Welsh Ministers have a duty to monitor how services discharge their powers and duties in relation to the Mental Health Act 1983. This duty is undertaken by HIW on their behalf. We have extensively revised our Mental Health Act compliance methodology to assist our reviewers who monitor how the health boards and independent providers discharge their duties under the Act. Our Mental Health Act reviewers examine detention paperwork to ensure legal compliance, and consult with the Mental Health Act administrators, employed by Health Boards and independent providers, to gain an insight into how the Act is administered and the governance processes in place. We also have a specific role in relation to the investigation of certain types of complaints. During our inspections we routinely review a number of key areas as outlined within the Mental Health Act 1983 – Code of Practice for Wales (revised 2016), assessing whether:

- Mental Health Act detention paperwork ensures patients are lawfully detained and well cared for.
- Patients are informed about their rights on admission and at regular intervals under section 132 both verbally and in writing and a record of this is maintained in the patients' file.
- Patients are given respect for their qualities, abilities, and diverse backgrounds as individuals, and that their needs in relation to age, gender, sexual orientation, social, ethnic, cultural and religious backgrounds are taken into account.

- Section 17 leave is routinely utilised when appropriate and to assist patients in their care/rehabilitation pathway.
- The Mental Health Act Code of Practice for Wales (Revised 2016), that has been prepared and issued under section 118 of the Mental Health Act 1983 is being followed.
- Detailed plans are made for patients before they are discharged from hospital and consider key area such as relapse indicators.

In general, the findings from our inspections of the processes and application of the Mental Health Act were positive, however, we did find a number of areas for improvement. Our findings for the period April 2022 to March 2023 are summarised in section 6 of this report.

## Review Service Mental Health

HIW's Review Service for Mental Health (RSMH) covers a number of key areas of the Mental Health Act including:

- The SOAD service for Wales. The SOAD service safeguards the rights of people who, whilst detained under the Mental Health Act, have refused prescribed treatment, or have been assessed as unable to consent to the treatment.
- A review of treatment under Section 61 of the Mental Health Act. When a SOAD has authorised a treatment plan, the doctor responsible for the patient's care and treatment (the Responsible Clinician) must provide a report on the patient's condition and treatment to the RSMH for review.
- The RSMH is also notified of all deaths of detained patients receiving treatment within the NHS. We consider the notifications and the details of events that led up to the death of the patient.

A summary of work undertaken by SOADs and the findings from our section 61 reviews between April 2022 and March 2023 is provided in section 7 of this report.

## Monitoring the Mental Health (Wales) Measure 2010

The Mental Health (Wales) Measure 2010 consists of four distinct parts:

**Part 1** – Primary mental health support services.

**Part 2** – Co-ordination of, and care planning for, secondary mental health service users.

**Part 3** – Assessment of former users of secondary mental health services.

**Part 4** – Mental health advocacy.

During our inspections we routinely review the care and treatment plans for patients and consider the role of the Care Coordinator. Within section 5 of this report, we have detailed our findings on risk assessment and care planning where we consider various aspects of the Measure. We also consider the role and access for patients to advocacy services.

## Monitoring use of the Deprivation of Liberty Safeguards

A separate annual report is published jointly by HIW and CIW on the use of the Deprivation of Liberty Safeguards (DoLS). DoLS is a part of the Mental Capacity Act 2005. The Liberty Protection Safeguards (LPS) was scheduled to replace DoLS in 2024. However, in early April 2023, the UK Government informed Welsh Ministers of a delay to the implementation of LPS. Between April 2022 and March 2023 HIW was a member of the LPS Implementation and Monitoring group with Welsh Government representatives and other key stakeholders. DoLS can be used when

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detention under the Mental Health Act 1983 is not appropriate. The DoLS annual monitoring reports are available on the HIW website.

## UK National Preventive Mechanism

HIW is one of 21 designated bodies of the UK's National Preventative Mechanism (NPM) which was established in March 2009 following the UK ratification of the United Nations Optional Protocol to the Convention against Torture (OPCAT) in 2003. Membership of the NPM comprises of organisations from the four nations that make up the United Kingdom, namely, Wales, England, Scotland and Northern Ireland. The other inspectorate in Wales that is also a member of the NPM is CIW. Other organisations that form the NPM include the Care Quality Commission (CQC), the Independent Custody Visiting Association, Criminal Justice Inspection Northern Ireland and His Majesty's Inspectorate of Constabulary in Scotland. HIW undertakes joint work with His Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) and His Majesty's Inspectorate of Prisons (HMI Prisons).

HIW is a designated body of the UK's NPM because of its role in monitoring places where patients may be detained under the Mental Health Act. This role is further explored within section 6 of this report.

The UK's NPM liaises directly with the United Nations Committee Against Torture (CAT) and the Subcommittee on Prevention of Torture (SPT) which is an international body established by OPCAT.

We attend NPM business meetings and will again rejoin the steering committee later in 2023.

## Youth Justice Services

In April 2022 HIW joined His Majesty's Inspectorate of Probation (HMI Probation) on the joint inspection of Cardiff Youth Justices Services (YJS). Other inspectorates that participated in the joint review include, CIW, Estyn and HMICFRS. HIW's specific remit was to consider the services received by the YJS from a healthcare perspective. The specific areas that we inspected were access to CAMHS, Speech and Language Therapy, substance misuse and access to physical healthcare. Key members of staff employed by the health board were interviewed as part of this process.

## Dementia Partners National Steering Group

We continue to attend the Dementia Partners National Steering Group which has direct links to the Welsh Government Dementia Oversight of Implementation and Impact Group (DOIIG). Within this group each of the health boards provide regional updates to the members of the group, on developments within dementia care for their region.

Attendance at the group provides a rich source of information that we can use to ensure services are implementing the All-Wales Dementia Care Pathway of Standards. It should be noted that the Dementia Action Plan for Wales 2018 – 2022 has been extended following extensive evaluation.

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## Substance Misuse and Mental Health Deep Dive – Co-occurring Meeting

Throughout 2022-23 HIW attended the above group which is organised by Welsh Government. A number of organisations attend this group including, health boards, the National Strategic Clinical network for Mental Health, NHS Executive, representatives of the Royal College of Psychiatrists and Alcohol Change UK. The group is committed to improving the co-ordination between substance misuse, mental health, housing services and a wide range of other operational delivery partners, with a view to improving current pathways of care for individuals with the most complex needs in order to achieve the most positive outcomes possible.

The group will:

- Review the current strategic landscape in relation to Mental Health and substance misuse services, particularly current barriers to seamless integration.
- Consider actions that can be taken at a strategic level across all delivery agencies. This could include all emergency, mental health, and community substance misuse services across both the statutory sector and Third sector, public health interventions and the Criminal Justice system.
- Continue to reinforce the need to integrate housing services and, in particular, homelessness, Housing First and Rapid rehousing principles practices.

- Consider the recommendations stemming from recently published reports.
- Understand barriers, share best practice and identify opportunities for continual service improvement.
- Where required agree task and finish groups to address specific issues.
- Produce an informed comprehensive action plan to take forward across the seven Health Board Areas across Wales.

### Our National Review of Mental Health Crisis Prevention in the Community

published in March 2022 identifies the complexity and challenges of working with individuals who have issues with their mental health and require the support of substance misuse services. The review identified issues of long waiting lists after referral to mental health services, and staff working in substance misuse services raised concerns that referral processes were sometimes overly complicated and inconsistent. In addition, it was recommended that improved co-ordination between substance misuse services and mental health teams was required in some areas of Wales.

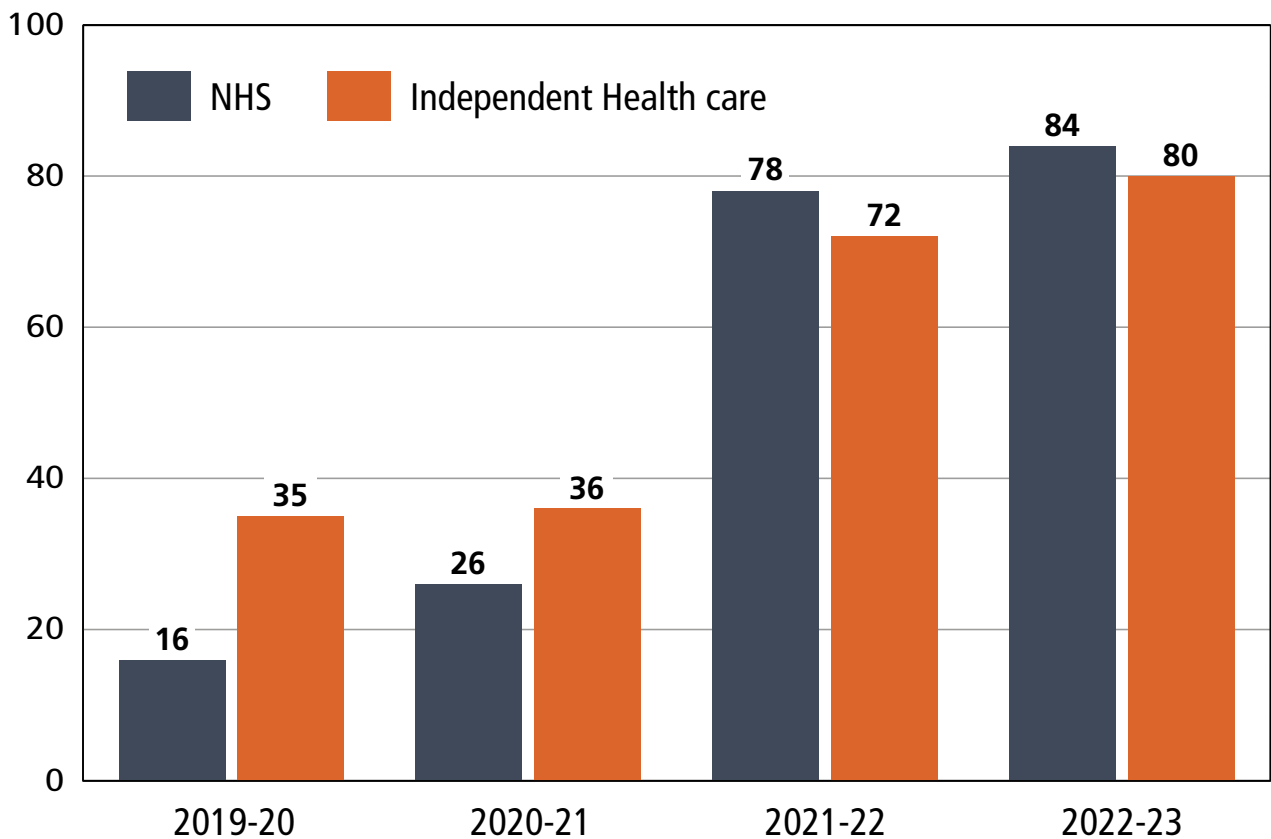
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## 4. Listening to concerns

During the reporting period we received:

- 659 complaints and concerns about healthcare providers in Wales.
- 164 of these were about mental health and learning disability healthcare services. This is a 9% increase compared to the previous year. Of these 164:
  - 84 were in relation to NHS mental health and learning disability services.
  - 80 were in relation to independent mental health and learning disability services.

### Number of patients contacting HIW with concerns and complaints about mental health care



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The following categories are utilised in order to categorise concerns received:

- Access, admission, transfer, discharge (including missing patient).
- Clinical assessment (Including diagnosis, scans, test, assessments).
- Communication.
- Complaints Management.
- Consent and Confidentiality.
- Funding.
- Infection Control Incident.
- Infrastructure (including staff facilities, environment).
- Medical Device/Equipment.
- Medication Management.
- Mental Health Act.
- Other, to capture all concerns that fall outside of existing themes.
- Patient Accident.
- Records Management.
- Safeguarding.
- Self-harming Behaviour.
- Treatment and Procedure.
- Whistleblowing.

The table below shows a breakdown of concern and complaints by their subject – 2022-23.

Subject of Concerns and Complaints	NHS Settings	Independent Healthcare Settings
Access, Admission, Transfer, Discharge (including missing patient)	17	7
Clinical Assessment (Including Diagnosis, scans, tests, assessments)	2	2
Communication	7	5
Complaints Management	1	0
Consent & Confidentiality	0	2
Infrastructure (including staff facilities, environment)	8	19
Medication Management	6	2
Mental Health Act	8	3
Other	3	5
Records Management	6	1
Safeguarding	4	9
Self-harming Behaviour	5	3
Treatment/Procedure	7	6
Whistleblowing	10	16
<b>Total</b>	<b>84</b>	<b>80</b>

The highest category of complaints for the NHS was in relation to:

- Access.
- Admission.
- Transfer.
- Discharge (including missing patient).

Concerns regarding access, admission, transfer, and discharge of mental health patients often revolve around issues of patient rights, informed consent, and compliance with mental health laws and guidance. Patients have the right to timely and appropriate care, and any violations can lead to grievances.

From an NHS viewpoint, managing these aspects of mental health care can be challenging due to the availability of resources, high patient demand, and complex legal and ethical considerations. They may face difficulties in ensuring smooth transitions between care settings and addressing the diverse needs of patients.

From the patient's perspective, concerns can arise when patients experience unfair treatment or feel discriminated against, or lack of communication during the admission, transfer, or discharge process. Many mental health patients already feel vulnerable, so their experiences should be handled with care and empathy.

From an Independent Healthcare Setting perspective, the highest category of concerns received was in relation to infrastructure (including staff facilities, environment).

From the patient's perspective, complaints often emerge when patients experience unfair treatment or feel discriminated against, inadequate treatment, or lack of communication during critical phases of care. These complaints underscore the need for collaborative efforts among healthcare professionals, legal experts, and patient advocates to strike a holistic balance.

## Staff concerns

Whistleblowing is different to making a complaint or a grievance. A 'whistleblower' is somebody who makes a 'qualifying disclosure' about a concern at work. HIW is a 'prescribed body' under whistleblowing laws. This means that a whistleblower can make a 'qualifying disclosure' to us and will have certain employment protections under the Employment Rights Act 1996, which was amended by the Public Interest Disclosure Act (PIDA) 1998.

PIDA protects the public interest by providing a remedy for individuals who suffer workplace reprisal for raising a genuine concern, whether it is a concern about patient safety, safeguarding, financial malpractice, danger, illegality, or other wrongdoing.

Additional information in relation to whistleblowing can be found at our website: [www.hiw.org.uk](http://www.hiw.org.uk)

This year we have seen an increase in the number of whistleblowers raising concerns with HIW compared to last year. Potentially this is due to HIW returning to normal business of undertaking on-site inspections and being more visible following the pandemic. In addition, this may be indicative of the pressures that the healthcare system is experiencing.

- 42 in 2020-21.
- 15 in relation to NHS services.
- 27 in relation to independent services.
- 28 in 2021-22.
- 10 in relation to NHS services.
- 18 in relation to independent services.
- 28 in 2022-23.
- 18 in relation to NHS services.
- 20 in relation to independent services.

## Regulation 30 and 31 Notifications

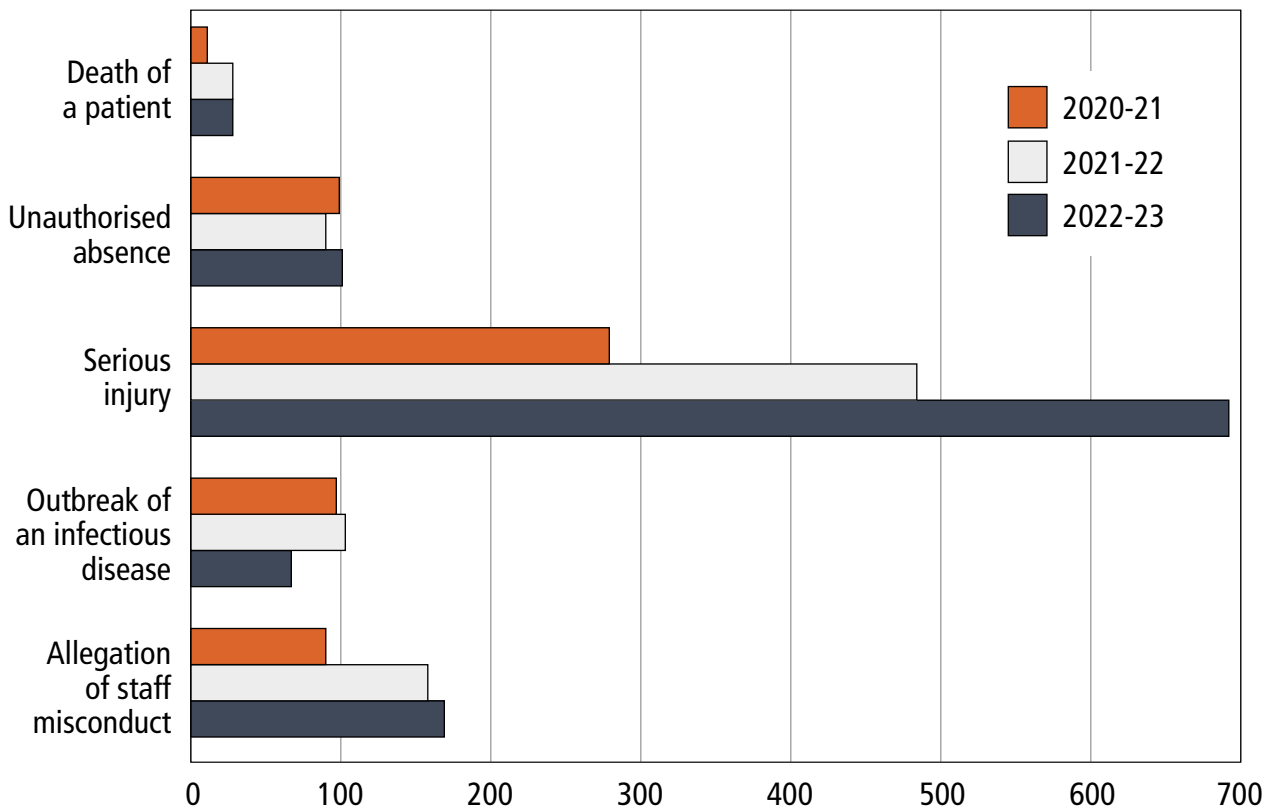
The registered person of an independent hospital, independent clinic, or independent medical agency is required by Regulations 30 and 31 of the Independent Health Care (Wales) Regulations 2011 to notify us of specific patient safety-related events. This is required by law and includes:

- Death of a patient.
- Unauthorised absence.
- Serious injury.

- Outbreak of infectious disease.
- Alleged staff misconduct.
- Deprivation of liberty.

During the reporting period, we received 902 notifications of incidents that occurred within independent mental health and learning disability healthcare settings. This was significantly higher than the number of notifications we received in 2021-22. Notifications were themed as shown in chart below.

### Regulation 30/31 notifications 2020-21 – 2022-23



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The most prominent theme emerging from this year's regulatory notification is the significant increase in the number of notifications in relation to serious injury. We have identified an increase in the numbers of patients self-harming. The range of issues identified within this report, such as a lack of staff, poor risk management plans and care and treatment plans as well as issues with patient observation may be contributory factors in relation to serious injury. In addition, potentially we are seeing this rise as a partial consequence of the COVID-19 pandemic. The extended periods of isolation, economic uncertainties, and heightened anxiety triggered by

the pandemic restrictions contributed to a downturn in the mental health and wellbeing of some people. The closure of essential support systems, such as in-person therapy and social networks, left many individuals struggling to cope with their emotional distress. As a result, self-harm emerged as a coping mechanism for some, reflecting the urgent need for accessible mental health resources and a deeper understanding of the pandemic's impact on mental well-being. Additionally, post pandemic, HIW has increased its inspection, assurance and engagement activities which have all enabled an increased awareness of the requirement to complete regulatory notifications in a timely manner.



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## 5. Inspecting mental health and learning disability healthcare services

In 2022-23 we undertook a total of 22 onsite inspections of a range of healthcare settings of both NHS and independent hospitals. The wards inspected accommodated a range of patients that included:

- Adults with mental health issues.
- Older persons.
- Learning Disabilities.
- CAMHS.
- Considered the diverse range of environments of care, and ensured that risks had been identified and appropriate action taken to mitigate against those risks.
- Reviewed administration of the Mental Health Act and compliance with the Mental Health Code of Practice for Wales (2016).

Within the total of 22 we jointly visited three CMHTs with CIW.

During 2022-23 one independent healthcare provider was visited on two occasions because of the nature of the concerns identified.

During our onsite inspections and focussed reviews, we:

- Spoke with a number of patients to ascertain their thoughts on the quality of care and treatment provided.
- Observed how staff from multi-disciplinary teams interacted with patients and each other.
- Examined how the Mental Health (Wales) Measure 2010 was implemented and reviewed and considered the role of the Care Coordinators and other members of the multi-disciplinary team.
- We also examined individual patient care and treatment plans, any records of restraints, and any seclusion undertaken.
- Considered if there was an effective discharge pathway in place.
- Examined audit findings and governance processes.

A list of the health boards and independent registered providers we inspected is included as Appendix A, along with links to the reports of findings.

### Our findings

Within this section our findings are broken down into three specific areas, **mental health including older and younger persons and CMHTs, learning disabilities and CAMHS**. The findings are drawn from our onsite inspections and focussed reviews we carried out during the year. Where HIW identifies significant issues we send immediate assurance notices for health boards, and non-compliance notices for the independent providers. These notices are sent within 2 days of the inspections being undertaken. The health board/independent provider responds to these notices with an immediate improvement plan that HIW must agree. We issued a total of seven notices between the period 1 April 2022 and the 31 March 2023. This comprised of five for health boards and two for the independent providers.

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## Findings specific to mental health, including older and younger persons and the CMHTs

A positive finding in the vast majority of our inspections was the quality of staff and patient interaction. Our staff observed patients being engaged in a positive manner with an appropriate level of explanation to ensure patients understood the care and treatment they were receiving.

### Least restrictive care

In October 2022, the Welsh Government published **guidance** on a framework for reducing restrictive practices in childcare, education, health and social care settings. This framework is intended to promote measures that will lead to the reduction of restrictive practices in hospitals and other settings. Our inspection methodology reflects this guidance, and compliance with the framework is considered within our inspection process.

Some key areas that are considered within our inspections include, planning care in a person-centred way, appropriate language that ensures patients understand the care and treatment being delivered to them, and staff education and development to ensure a skilled workforce in delivering a holistic plan of care in the least restrictive way. However, this must be balanced with a risk-based approach. Our inspections aim to ensure that blanket restrictions for patients are not being used and where restrictions are necessary, they are individualised and based on a person's risk areas.

However, we did find examples where we were not assured that the least form of restrictive practice was being used. More specific details will be identified in the restraint section.

## Use of restraint

Any form of restraint, whether it is physical, chemical, environmental, or mechanical, should always be a last resort when all other interventions have failed and not had a successful outcome for the patient. All forms of restraint must have a detailed plan of care describing how the restraint can be avoided by staff, understanding any triggers that may necessitate that level of intervention taking place. The Mental Health Act 1983 – Code of Practice for Wales 2016 has a section dedicated to restraint and managing challenging behaviour. The Code is very clear that restraint must only be used as a last resort. In terms of mechanical restraint, the Code stipulates that HIW must be consulted if this is being considered. The use of mechanical restraint in hospitals is very rare but in the event it is being considered, our role is to check that this form of restraint has been thoroughly risk assessed and care planned, and that it is the last option available in managing a patients' extreme challenging behaviour, whether that is violence directed at others or self-injury. This form of restraint, as with all restraints, must be regularly reviewed and be in place for the shortest possible period of time.

During our visits, where restraint is being used, we routinely examine patient records and consider a number of factors including:

- The position of the patient.
- Length of time the patient was restrained for.
- Number of staff involved and that they are suitably trained.
- Triggers that led to the point where a restraint was initiated.
- Ensuring that all restraints are routinely examined any if there is any learning from the restraint.

- Debriefs on the restraint are held for all staff involved.
- Any lessons learnt that need to be considered during the restraint.
- Any restraint undertaken is thoroughly documented.
- A robust governance process of all restraints including analysis of each restraint undertaken.

Generally, restraints were well documented, and systems were in place to monitor any incidents of restraint. However, during one inspection we identified that the 'Use of Restrictive Physical Intervention' policy required a review, as a matter of urgency, to provide clear guidance to staff. In another visit we identified that the health board had not ensured that the Physical Restraint Policy had been reviewed to provide clear guidance to staff. Up to date policies are an essential component to ensure that the latest guidance is being utilised to safeguard patients and staff.

In four of our visits to hospitals, within health boards, we identified a lack of managing aggression/physical intervention training for staff, including bank staff. This is a significant issue because a well trained workforce can help reduce the incidents of patients and staff being injured during a restraint. In addition, we identified on one of our inspections that a health board did not ensure that restraints are recorded in patient records and that patient's notes are updated.

## Use of seclusion

The Mental Health Act 1983 – Code of Practice for Wales 2016 has a section dedicated to the use of seclusion. Seclusion is described within the Code as "the supervised confinement of a patient in a room which may be locked". It is interesting to note that the Code uses the term "may be locked", implying that it is possible for a patient to be secluded within a room behind a door that is closed but not locked. The Code also sets out timeframes for when continued seclusion should be reviewed, these are, "every two hours by two nurses" and "every four hours by a doctor, or a suitably qualified approved clinician". The Code also states that seclusion is used as a last resort and for the shortest possible time. Policies and procedures must be in place for the use of seclusion and should reflect NICE and other guidelines.

It was pleasing to note that no issues relating to seclusion were identified during our inspections throughout 2022-23. However, we did identify, during one of our visits, that there was no structured policy regarding use of the Extra Care Area (ECA) on both wards. We recommended improvement in the documentation and daily records entries for patients who spend time in the ECAs so that a clear picture of their time spent on the ECA can be established. It must be noted that ECAs are not seclusion suites.

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## Section 136 Suites

Section 136 Suites are designated facilities that an individual is taken to by a police officer if they believe it is required in the interests of that person or for the protection of others. The removal of the person is only permitted in a place to which the public have access.

Within our inspections we visited one section 136 suite located within a hospital. During that visit we only identified one issue for the Health Board and that was the provision of appropriate observation mirrors to enable staff to see concealed areas in the section 136 suite.

## Patient Observations

Patients who are in an acute and/or challenging phase of their illness will require a degree of effective observational levels to ensure that their safety and the safety of others is protected. The term enhanced levels of observations can range anywhere from 15 minutes to more intense levels of 1 to 1, 2 to 1 and so on.

During our inspections, we consider the appropriateness of the levels of observations, whether there are sufficient staff to undertake the levels, that a robust care plan and risk assessment is in place, and whether there is a regular review of the effectiveness of these observations. Generally, we observed that patient observations were undertaken appropriately, regularly reviewed and staff understood the importance of effective patient observations.

In some hospitals, we identified a range of significant issues, including, a lack of a review of a Therapeutic Observations Policy which had expired in December 2021. Another example was that observational charts were not completed accurately.

In addition, we found two examples where the observational policy had not been reviewed and updated in line with the timescales identified. We also found issues, on one inspection, with documentation of patient observations including observation records that contained many significant gaps during which they were not updated for extended periods of time. We also saw an example of one record which had not been updated for over six hours and another left entirely blank. Because staff had failed to update patient therapeutic observation records to reflect that they had been conducted, we could not be assured that patients were being monitored and fully protected and safeguarded on the ward.

## Meaningful and therapeutic activities

A key part of our inspection process is to examine the range of meaningful therapeutic, social and recreational activity available to patients. Meaningful activity can promote and have a very positive impact on patient wellbeing and their recovery pathway.

In most of our inspections, we found a number of good examples of patients being actively engaged with a range of therapies that they commented positively upon. This is a significant improvement on our previous years of inspection findings where we identified a number of issues with provision of meaningful activities. Only in one inspection did we identify issues of a health board that was not providing a wide range of therapeutic and physical activities for patients on the ward, including activities outside of weekday working hours and opportunities to exercise. This issue was also identified in a previous recommendation, following an inspection of the ward in 2017.

We continued to identify issues with section 17 leave under the Mental Health Act, but these will be addressed within section 6, Monitoring the Mental Health Act, of this report.

## Medication Management

The safe and effective administration, storage and ordering of medication is an area that our inspection process routinely focuses upon. This section of the report addresses the inspection findings from 15 hospitals and 3 CMHTs. Disappointingly we identified issues in 14 of the 18 visits. This is an area where HIW has previously identified significant issues and it is disappointing that the health boards and independent providers do not have robust systems of audit and governance to address these issues. Issues identified covered many different aspects of medicines management with the most significant being:

- Full sharp boxes not being appropriately disposed of.
- Medication not always stored securely inside the clinic room and being left unattended on the wards.
- Controlled drugs were sometimes not administered correctly and the frequency of stock checks was not aligned with health board policy.
- Medication Administration Records (MAR) not completed correctly.
- Medication trolleys were left unattended and not locked and secure when not in use.
- No system in place to audit medication charts.

- A lack of Consent to Treatments forms attached to MAR charts and regularly reviewed.

- Outdated medicines not always securely stored away from general stocks and arrangements for their timely collection and disposal was not always in place.

The issues listed above demonstrate a range of diverse findings that fail to give HIW a level of assurance that medicine management systems are robust and ensure the necessary checks and audits are in place to ensure patient safety. This has been a reoccurring theme for the past years and health boards and independent providers must strive to do better in this area.

## Patient information

A range of useful and explanatory information that is in a suitable format is essential to inform patients about key areas for their stay in hospital. This information can reduce the risk of any misunderstanding in relation to care and treatment processes that patients can expect during their stay in hospital and/or input from CMHTs.

In some of our inspections we identified issues in relation to the lack of availability of patient/visitor information on display in the following areas:

- Information on making a complaint.
- Advocacy services.
- The NHS Putting Things Right.
- Guidance around mental health legislation.
- Health promotion including healthy eating and well being.
- Healthcare Inspectorate Wales.

In addition, patient information was not always provided in an accessible format for patients with communication difficulties or cognitive impairments.

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## Risk assessment and care planning

A comprehensive approach to risk management and care planning is essential to ensure patients have a robust plan in place to address any risks identified. In terms of care and treatment plans, HIW has a specific responsibility in monitoring part 2 of the Mental Health (Wales) Measure 2010. Part 2 of the Measure requires all patients receiving secondary mental health care to have a care and treatment plan in place. Care and treatment plans should be comprehensive, holistic, and patient focused.

These plans under the Measure cover a number of distinct domains including:

- Finance and money.
- Accommodation.
- Personal care and physical well-being.
- Education and training.
- Work and occupation.
- Parenting or caring relationships.
- Social, cultural, or spiritual.
- Medical and other forms of treatment including psychological interventions.

Care and treatment plans are overseen by Care Coordinators who ensure the timely review of these plans so that they continue to address the key needs of the individual within the domains listed above. In addition to the Measure, there must also be a robust risk assessment process in place that takes account of historical and present risks. Any risks identified must have a robust plan of care in place to mitigate against identified risks and strategies in place to manage these.

Care Coordinators are key individuals, and their input is central to assisting the patient with their journey through secondary mental health services. This is another area that is assessed within our inspections.

During our inspections we consider the role of the Care Coordinators and examine the care and treatment plan documentation. We also interview patients and staff to get an understanding of the effectiveness of the care and treatment plan. We have again this year identified some examples of good practice including, patient care plans being regularly reviewed by staff and updated to reflect current needs and risks and suitable protocols being in place to manage risk, health and safety and infection control. In addition, written evaluations completed by the care staff were found to be comprehensive and reflective of the care provided. Patients were involved in the planning and provision of their own care, as far as possible, and where patients were unable to make decisions for themselves, we saw evidence that relatives were consulted. However, we also identified many areas that required improvement in many of the inspections that we undertook. Issues we identified included:

- The Malnutrition Universal Screening Tool was not completed and regularly reviewed for all patients; this is essential for identifying all patients who may be nutritionally compromised so early dietary intervention can take place.
- A lack of patients' physical conditions, and required interventions, detailed in care plans.
- Care and treatment plans were not always fully completed, kept up to date and completed in accordance with the Mental Health (Wales) Measure 2010.

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- HIW was not assured that all aspects of care are being delivered in a safe and effective manner. For example, in one patient's record we reviewed, the Speech and Language Therapist (SALT) directed staff to implement a puree level 4 diet. The patient's records documented that they were at risk from aspiration and choking if they ingested a normal diet. It is evidenced in the notes post the advice from the SALT that the patient had been given a level 7 diet, contrary to the SALT advice, therefore placing the patient at risk of significant harm.
- Concerns around management of risk were raised following a review of patient records. These highlighted that documentation was not regularly updated, fully completed, specifically suicide risk sections were incomplete or very brief information recorded that lacked specific detail. As a result, we were not assured that the current controls or mitigating actions put in place were effective.
- Patient records were left unattended.
- No evidence of pain assessments being completed in patient records and WARRN risk assessments were not completed and updated in conjunction with the care and treatment plans.
- A lack of detailed information was recorded within the care and treatment plans to reflect patient needs and reasons for interventions in order to ensure safe patient care.

The issues identified above are wide ranging covering a number of different areas of risk and care and treatment documentation. Effective risk, and care and treatment plans, are an essential part of the care delivery for patients and health boards and independent providers must do more to ensure a robust

audit and resulting action plan to address deficits in this key documentation. In every health board hospital and the CMHT inspections, 11 in total, we identified issues in relation to risk and care and treatment plans. In the independent sector we identified issues in four of the seven inspections undertaken.

In relation to care and treatment plans, we required immediate assurance in one of our inspections undertaken in the health boards. This resulted in the health board providing an immediate improvement plan.

## Environment of care

During our inspections we routinely undertake a tour of the wards. This enables us to identify issues and make observations in relation to the appropriateness and safety of the environment for the care and treatment of the patient group.

In five out of eight health board hospitals, that we inspected, we identified a lack of audits and the management of environmental ligature risks. In addition, on one of these visits we identified an issue that required an immediate assurance where HIW was not assured that ligature risks had been rectified. We had identified concerns which could result in significant patient harm in a HIW quality check in 2020 and this has still not been addressed.

We also identified, on some visits, the lack of availability and appropriate storage of ligature cutters.

Other environmental issues identified included, the requirement for redecoration and refurbishment of ward areas, broken furniture, stained and marked carpeting, inaccessible garden areas due to a lack of maintenance, damaged door handles and grab rails, and faulty ceiling lights.

In addition, a number of environmental issues identified were impacting upon patients' privacy and dignity, and included the lack of blinds or curtains for patient bedrooms and a lack of appropriate privacy doors on patient bathrooms.

## Workforce

There are significant healthcare workforce challenges across Wales. Recruiting and retaining sufficient, knowledgeable and well-trained staff is very difficult and is creating challenges for both health boards and independent providers in sustaining services. Well trained, knowledgeable staff in sufficient numbers is key to ensuring patients receive the professional time that an effective care pathway requires. Feedback from patients in most of our inspections was very positive towards staff and many patients appreciated the pressure that workforce shortages was creating. Our staff and reviewers observed many positive interactions by a very busy workforce under pressure.

Workforce issues were identified in 13 out of 18 inspections across a range of disciplines and some of these are outlined below:

- Patients' physical healthcare problems were not assessed in a timely manner.
- High level of agency staff usage and a lack of focus on the recruitment of staff into permanent vacancies on some of our visits.
- A lack of professionals on-site including, occupational therapists, psychologists, physiotherapists, and activities coordinators.

In some of our inspections we identified a lack of review of staffing levels to ensure that they meet the demands of the patient group. Health boards must ensure that substantive medical staff are appointed as far as possible to ensure continuity of care.

- One-to-one psychology waiting times were very long and the health board/ local authority must consider how these times can be reduced to ensure that patients receive the most appropriate level of intervention.
- A health board and local authority must review the duty arrangements in order to ensure that staff are able to fully meet the demands of their substantive roles.
- Enough female staff was not available for enhanced observations in bedroom areas.
- An independent provider did not ensure that a comprehensive and robust risk assessment process had been undertaken regarding nurse staffing requirements.
- An independent provider did not ensure all recruitment follows the open and fair process set out in the safer recruitment and selection policy.

It is evident, from the range of issues identified above, that significant workforce challenges were having a detrimental effect on the care pathway for patients. In addition, workforce challenges were not confined to one discipline of staff, but shortages were identified across all disciplines. All health boards and independent providers must ensure that they have a short and longer-term strategies to address these shortages and that the strategy is regularly reviewed for its effectiveness of both recruitment and retention of a sufficient number of knowledgeable and skilled staff. Where agency and bank staff are used, it is desirable for the same members of staff to be used as opposed to different staff for each shift.

In relation to section 17 and patient leave under the Mental Health Act this area will be further analysed in section 6 of this report.

## Governance

Robust governance and audit processes are key to identifying, at an early stage, where the delivery of a service needs to improve to meet the needs of the patient group more effectively. Unfortunately, many of the issues identified within this section of the report may not have been prevalent if effective audit and governance processes were in place. Audits are key tools to drive improvement and ensure that services meet the needs of vulnerable patients. In addition, when things go wrong, it is vital that lessons are learnt to prevent issues reoccurring. This cycle of continuous improvement ensures a sound and proactive governance framework that achieves more positive outcomes for the patient group. Unfortunately, in 9 out of 18 (50%) of our visits, we identified issues in relation to audit and governance. Some of the areas include:

- A lack of audit/governance for policies; some had not been reviewed within the identified timescales in some cases this was in excess of over a year.
- In one visit, we observed issues with the roles and responsibilities of the Acute Care Clinical Site Manager and a lack of time to ensure that they are able to discharge their duties effectively across all the services that they are responsible for.
- Failure to implement a robust governance program of audit to ensure that access cards issued by the hospital are monitored and accounted for to prevent security breaches and ensure the safety of patients, staff and visitors.
- A health board did not implement a programme of governance oversight in respect of the medicines management system, to ensure that daily checks, areas of non-compliance and areas requiring improvement are identified and addressed appropriately.

- A lack of recording of mandatory training on one system for ease of governance and monitoring.
- A lack of staff awareness of the importance and relevance of audits, and a lack of participation so that they can better understand and improve audit outcomes.
- Audit activities were not reviewed to ensure that they were being completed appropriately and were effective in identifying errors and areas for improvement.
- An independent provider did not have effective and proactive governance arrangements in place to check compliance with relevant regulations and best practice standards to focus on continuous improvement within the service.

In addition, there was a lack of assurance that a health board had a robust governance framework in place, e.g. during the inspection it was difficult to locate and access patient information. Attempting to follow the care and treatment of an individual was complex and time consuming across the individual sources. This would be of particular concern for an agency member of staff attending the ward for the first time where it would be very difficult for them to understand patient behaviours and the appropriate actions to take to manage them. We also identified that no formal minutes were being routinely recorded for patient related meetings, weekly ward rounds, and for MDT meetings. This demonstrates a weakness in the governance processes in place for maintaining patient safety. These areas resulted in us issuing an immediate improvement notice to the health board.

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## Findings specific to Learning Disabilities

During 2022-23 we undertook three inspections of learning disability services. Within these inspections, we noted a range of positive findings including, staff interacting and engaging with patients appropriately and treated patients with respect and dignity. In addition, there was a range of suitable community-based activities available for the patient group.

During one of our three visits we required immediate assurance for a number of significant issues as described below.

We could not be assured that the health, safety and welfare of patients, staff and visitors at the unit was being actively promoted and protected. In addition, potential risks of harm were not being identified, monitored, and where possible, reduced or prevented. The following issues required immediate action by the health board:

- We saw three examples of immediate potential risk to patient safety and advised staff to take action, but only one risk was removed prior to the conclusion of our inspection.
- We reviewed four records of patients who were undergoing therapeutic observations and found that the therapeutic observation records contained many significant gaps during which they were not updated for extended periods of time.
- We reviewed six Datix incidents relating to medication errors and patient restraint incidents, and found there was no investigation update within all six incidents. Senior staff confirmed that they did not understand the correct procedure to follow in order to successfully manage and investigate Datix incidents in accordance with their duties.
- Staff compliance with Positive Behaviour Management (PBM) and Breakaway Training was 79%. Staff were unable to provide HIW with accurate restrictive practices data to determine the number of patient restraints which had occurred within the past three months. Staff could not identify whether members of staff who were not compliant with their restraint training had participated in patient restraints during this period.



## Staff and patient safety

Patients and staff feeling safe, and having systems and processes in place to protect their safety, is key to achieving positive outcomes for patients and staff having confidence in working within a safe environment.

In terms of staff safety, on one of our inspections we identified a lack of access to personal safety alarms, or a policy in place around the use of safety alarms. In another inspection the health board did not provide an effective and appropriate alarm system on the ward to ensure that staff, patients and visitors are able to raise alarms when necessary. Other issues identified included gaps in information being provided to staff when a patient is admitted and COSHH equipment not always being stored correctly. Also, we identified that senior managers did not consider the limitations of the environment and the clinical opinion of MDT when making decisions regarding patient admissions.

Lastly, oxygen cylinders were not appropriately secured to protect the safety of patients, staff, and visitors.

## Medicine management

The safe and effective administration, storage and ordering of medication is a very important area of focus for our inspections. Issues identified, include, a lack of pharmaceutical support to improve medication management, special instructions relating to patient medication not being recorded in patient medication records to ensure that all staff are aware of the correct procedure to follow.

Also, regular pharmacy audits were not undertaken on one ward and there was a lack of pharmaceutical support to improve medication management on two wards. In addition, on some of our inspections there were no photographs of patients attached to MAR charts to assist with patient identification.

## Training

A trained, skilled, and knowledgeable workforce is essential to achieving positive outcomes for patients. During our visits we identified a number of areas of concern, and these included low numbers of staff training for DoLS and low compliance with mandatory training. In one of our inspections one of the health boards had not reviewed and considered any additional training courses which would develop staff and benefit patients on the ward. Value-based training, for all staff, should be considered to ensure that appropriate language is used in relation to patient care; so that patients are actively listened to, acknowledged, and respected on the unit.

Lastly, on one of our inspections, we identified that staff training and monitoring systems, should be reviewed to ensure that current and accurate training compliance figures can be retrieved, for the effective management of staff training levels and the safety of patients and staff.

## Case study for DoLS

On reviewing the care notes for one individual we identified a range of issues in relation to DoLS.

We found that the statutory authorisation paperwork was missing from the patient file. However, when we highlighted this issue to staff, they later produced the authorisation document, but there were significant errors within the form. The form wrongly cited an alternative health board as the supervisory body. The urgent authorisation was authorised for a seven-day period in October 2022, after which it expired, but there was no further DoLS authorisation documentation on file. We discussed this matter directly with the health board's DoLS team, who advised that the incorrectly completed form initially submitted to them by unit was rejected and returned to the unit to be rectified and resubmitted. During the inspection the DoLS

team advised that the unit had never returned the correct documentation to request a further extension of the patient's DoLS authorisation which meant the DoLS authorisation had expired. Following the inspection, we were later advised that the documentation had been amended correctly and sent to the DoLS team therefore authorisation had not expired. We discussed these issues with staff and noted that staff compliance with nonmandatory Mental Capacity Act training was 63 per cent. We were advised that additional Mental Health Act training will be arranged for staff. We recommend that unit staff should be provided with additional training, instruction, and governance with regards to the MHA and DoLS to ensure compliance with legislation and that documents are completed and submitted correctly.

## Patient activities

During one of our visits, we identified that an activity timetable should be kept up to date and made available to patients and the activity room should be decluttered and converted into a protected activity room for patients. In addition, on the same visit, a full time Occupational Therapist (OT) needed to be recruited to assist in the development of a comprehensive therapeutic activity programme.

## Care plans and risk assessments

A patient's care plan must reflect all assessed needs, and have any risks clearly identified and a strategy in place to deal with those risks. Our visits found that patient care plans and individual risk assessments were not always updated to include additional information about how individuals are supported in bathroom and toilet areas so that patients and staff are safeguarded when administering personal care. Also, patient care plans were not always updated to include the frequency of inspection and repair of patient items which are regularly damaged.

In one of our inspections the health board needed to review its processes for transferring relevant information with patients who are transferred to hospital to ensure that sufficient information is retained on the ward to allow for effective communication and MDT review.

There were also issues with a health board needing to review the current health record system with a view to implementing an electronic health record system in future and to support the care and treatment plans. In addition, pen profiles should be attached to patient files for the awareness of staff, particularly agency staff who are not familiar with patients.

Lastly, we identified that a unit was not adhering to the Division of Mental Health and Learning Disabilities Principles for the Management of Mixed Sex Wards, and that safeguarding measures needed to be put in place, and care plans and risk assessments updated accordingly.

## Patient information

Patient information should be in a suitable format to assist individuals in making informed choices. This principle is important to all aspects of care and treatment.

In relation to food and drink patients should be able to view a pictorial and written menu to assist their choices, however, on one of our visits this was not happening.

## Governance

A range of governance issues were identified during our visits. These included:

- A lack of access to governance and audit documents in the absence of ward managers.
- Policies not being reviewed before they expire, resulting in staff not being supported in their roles.

- Training compliance was not clear for ease of governance and monitoring.
- The lack of an audit process to ensure all visitors to the unit are recorded and accounted for.
- A lack of understanding, by some senior staff, on their roles and responsibilities in respect to audit governance.
- A lack of review, by senior management, for clinical audits so that any issues are identified and any opportunities for quality improvement are shared.

## Findings specific to CAMHS

During 2022-23 we inspected one of the three in-patient CAMHS units in Wales. We identified a number of positive findings which included positive feedback from young people about the care they received at the hospital and about their interactions with staff. The young people also felt that they could engage and provide feedback to staff on the provision of care at the hospital in several ways. A mental health advocate was also available to the young people to provide them with support and information. However, our inspection also identified a range of issues. In relation to care and treatment plans, risk and other assessments, physical health assessments undertaken were not tailored to the individual but followed a generic template, and care and treatment plans did not indicate whether each young person should keep their NG tube in situ or whether it is removed after feeding. We ask the service to ensure that the justification for NG feeds is recorded for each young person that it is deemed appropriate for. Care and treatment plans were not always created for identified needs and the service must review the existing care and treatment plans, in place for each young person, and assess whether there are any missing care and identify treatment plans that need to be created.

In relation to restrictive practices the service provided insufficient assurance on their strategy for reducing the number of restraints at the hospital in line with the Reducing Restrictive Practice Framework for Wales. In relation to effective governance the service was required to improve the quality of incident reporting and to improve communication to staff on the outcome of any safeguarding incidents that they have been involved in or raised. Also, the service must ensure there is clearer responsibility in relation to ownership and sign off of any safeguarding concerns that have been raised.

Other issues identified included, a lack of therapeutic activities taking place as scheduled and the service needing to improve its communication to family members and carers of the young people at the hospital in relation to their care and wellbeing (where contact is appropriate). Also, in relation to visiting, the service was required to review its visiting arrangements, including frequency of visits, to ensure they meet the needs of the young people and family members and carers. In terms of training, there were staff, including agency staff, undertaking observations on young people that had not completed their training in therapeutic observations. We also observed a lack of engagement with the young people, from staff undertaking observations, to help best support them while undertaking therapeutic observations.

Lastly, in terms of the environment of care, the service needed to improve the process for identifying and removing blood stains following incidents in a timelier manner and cleaning schedules must be maintained as expected.

## 6. Monitoring the Mental Health Act, 1983

HIW monitors how health boards and independent providers discharge their powers and duties under the Mental Health Act 1983 and amended in 2007, on behalf of Welsh Ministers. Part of our statutory responsibilities is to provide the public with assurance about the quality, safety, and effectiveness of mental healthcare services in Wales.

Individuals who access mental health and learning disability services do so either as an informal patient, liable to be detained, or as a detained patient. Informal patients receive treatment on a voluntarily basis, detained patients are assessed and/or receive treatment through the provisions set out in the Mental Health Act 1983.

The Mental Health Act is the legal framework that provides authority for the detention and treatment of people who have a mental illness and need protection for their own health or safety, or for the safety of others. The Mental Health Act provides a legal framework to protect the rights of patients, and requires that an appropriate level of care, effective treatment, and an environment that promotes recovery is provided.

### How the Mental Health Act, 1983 is monitored

HIW is one of several individuals and organisations with powers and responsibilities under the Mental Health Act. Other individuals and organisations include, officers and the staff of health boards, social services and independent hospitals, Welsh Ministers, courts, police officers, advocates, and relatives of people who are detained. HIW undertakes a number of inspection visits where we consider how healthcare organisations discharge their powers and responsibilities under the Act. This section of the annual report details how the Mental Health Act is being implemented and how the powers granted are being exercised and monitored

in Wales. HIW also operates the SOAD service and consider how health boards and independent providers investigate complaints. In some circumstances, where HIW is not satisfied with an investigation, it can undertake its own investigation.

During our inspection visits in 2022-23 we focused on a number of key areas including:

- Are patients lawfully detained and is the care and treatment appropriate.
- Are patients informed about their rights, at the point of detention, and then at regular intervals. Is it clear if patients understand the significance of their detention or not.
- Does the treatment consider the patient's wishes and do they feel as if they are treated with dignity and respect.

We measure the above areas by talking to detained patients, their relatives, any advocates (if present) and any representatives of the patient if they so wish. We also speak with staff including Mental Health Act administrators and other key individuals. In addition, we examine Mental Health Act detention papers to ensure patients are lawfully detained and the Mental Health Act 1983 Code of Practice for Wales 2016 is taken into consideration. Finally, we consider the robustness of the audit and governance processes in place.

## Mental Health Act Reviewers

Mental Health Act Reviewers were involved in all our inspections and their primary focus is determining whether the Mental Health Act was being lawfully applied and the Mental Health Act 1983 Code of Practice was being adhered to. Within the inspection, detention and care and treatment documentation is examined to ensure compliance with the Act.

The reviewers focus upon a number of key sections of the Act including section 132 which ensures detained patients are informed of their rights at the point of detention and that there is an on-going process of continuing to ensure patients are aware of their right. A patient's understanding is also considered and any leaflets, about their right, are provided in a suitable format and languages to assist understanding. The reviewers also consider the documentation for section 17 leave and whether any leave takes account of the patient's wishes and those of carers, relatives, and friends. Leave must also take into consideration any risks to the patient's and others health and safety. Any conditions for the leave are also scrutinised.

Our reviewers also consider access to legal services and advocacy to assist in the protection of the rights of detained patients. In addition, they consider if patients are aware of their rights to apply to the Mental Health Review Tribunal for Wales (MHRT). They also consider hospital managers' duty to refer cases to the MHRT for Wales.

## Our Findings

### Mental Capacity

A range of good practice was identified and, on many of our inspections, there was evidence that capacity assessments for consenting to treatment were completed upon admission and the mental capacity

of each patient had been assessed and clearly documented. Although not part of the Mental Health Act, a good standard of mental capacity assessments was being undertaken as required, when DoLS referrals were made. There was good evidence of Independent Mental Capacity Advocate (IMCA) and Independent Mental Health Advocacy involvement in patient case work.

However, on some of our visits, we identified that patients records needed clarification and explanation regarding IMCA input when there is no family or lasting power of attorney. The health board must ensure that patient records reflect IMCA input when no lasting power of attorney or family involvement.

In one case, whilst capacity assessments for consenting to treatment were completed upon admission, these should preferably be recorded on an appropriate proforma to ensure a consistent and standardised approach to assessing mental capacity in the decision making process for treatment.

### Lawful detention/treatment

A key component of our inspection process is the review of statutory detention documentation to ensure the patients were legally detained. The detention paperwork we examined had commenced and been renewed within the requirements of the Act. In addition, the records we viewed were generally well organised, easy to navigate and contained detailed and relevant information.

During one of our visits, we identified that a number of consent to treatment certificates had expired, meaning that there was no authority to give medication. In addition, on one of our visits, we found no evidence of Section 62 being recorded in patients notes for those that had expired. We recommended that the health board review its Section 62 forms and ensure

that the forms are received by the mental health team before the end of the working day so that all certificates are up to date and the correct entries documented for medication to be authorised.

In addition, patients' legal status was not always recorded on medicine administration records and errors in Mental Health Act records were not signed and dated appropriately. Other issues identified, included, a lack of copies of detention papers kept with patient records and a lack of consent to treatment certificates kept with patient's drug charts.

## Mental Health Review Tribunal for Wales (MHRT)

We noted that Mental Health Act Tribunal and Review Panels generally took place in a timely manner, although we were informed, on one of our inspections, that there were difficulties recruiting and retaining panel members during the pandemic. We were assured that there are efforts underway to recruit additional panel members to ensure that timely reviews take place.

## Section 17 leave

Section 17 leave was one of the areas where we identified the greatest number of issues during our visits. The issues identified included:

- Section 17 leave forms were not signed by the patients and that patients were not offered a copy.
- Photographs of detained patients undertaking Section 17 Leave were not kept on record.
- Section 17 leave forms were not fully completed.

- Section 17 leave forms did not have a space for patients to sign, and if a patient lacked capacity to consent this was not recorded.
- A lack of patient involvement in the section 17 leave process.

## Ensuring patients' rights

Section 132 and 132A of the Act places a duty upon hospital manager to ensure detained patients understand how the Mental Health Act applies to them and what their rights are. Information must be given to the detained patient both verbally and in writing in accessible formats as a matter of urgency. Accessible formats include, easy read, a language the patient understands, and Braille.

During our inspections we identified, on occasions, that there was no record of ongoing provision of rights as directed by the Mental Health Act Code of Practice for Wales. In addition, on one of our inspections we noted that one patient had not had their rights read to them since March 2022 and the inspection was undertaken in July 2022. Detained patients must have their rights read to them as required by the MHA.

## Statutory consultees

Our SOADs are required to consult two people, called statutory consultees, before issuing any certificates approving treatment. When section 57, 58 or 58A applies, one of the consultees must be a nurse and the other must not be a nurse or a medical doctor. A patient's care coordinator will be particularly well placed to act in the role of a statutory consultee.

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Statutory consultees must know the patient well enough to undertake the role. During the discussion with the SOAD, they should consider commenting on the proposed treatment, the patient's ability to consent to that treatment, the views and wishes of the patient, any other possible treatment options, and the facts of the case.

During one of our inspections, we found, in two patient records, that there was evidence that the Second Opinion Approved Doctor had consulted with the two statutory consultees, however, there was no record of their views and agreement. In addition, there was no associated proforma available for the statutory consultees to record their views and sign and date their conclusions.

## Community Treatment Orders (CTOs)

Within our CMHT inspections we considered how the Mental Health Act was implemented for patients within the community. Within the 2 inspections we undertook of health board CMHTs we identified the issues below;

To fully strengthen compliance with the Act, one of the health boards was asked to ensure that the following information is recorded in CTO documentation:

- Reasons for the conditions.
- A record that the conditions (and reasons) have been explained to the service user.
- The conditions have been explained to other concerned parties.
- Approved mental health professional (AMHP) views on the CTO are recorded.

To ensure compliance with the Mental Health Act, another health board was asked to ensure the following:

- That the appropriate Consent to Treatment (CTT) certificates are used, and that copies of the certificates are kept with medication administration charts.
- That capacity assessments are undertaken as part of the CTT process.
- That changes in medication are reflected in CTT certificates.
- That patients' rights are regularly reviewed.

Other issues included:

- A lack of Section 12 doctors.
- A lack of copies of the Mental Health Act 1983 Code of Practice for Wales (2016) available on some of the units.

## Audit and governance arrangements

Part of our scrutiny of how services discharge their powers and duties in relation to the Mental Health Act 1983 is to consider the audit and governance processes. During our visits we reviewed the systems and processes that mental healthcare providers had in place to ensure oversight, monitoring and audit of their application of the Act. A number of issues were identified in some of our inspections, including the absence of an audit process in respect of consent to treatment forms and no regular audit activity of the records to ensure that records are well maintained, fully completed and easy to navigate.

The findings within this section of the report demonstrate that health boards and independent providers need to ensure a robust audit and governance process is in place.

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## 7. Review Service Mental Health

The Review Service for Mental Health (RSMH) has a number of key functions that this section of the report will consider. The key role of the RSMH is to monitor how services discharged their powers and duties under the Mental Health Act 1983, and the administration of the SOAD service. We undertake this work on behalf of Welsh Ministers, to protect the interests of people whose rights were restricted under the Act.

Our RSMH can also investigate certain types of complaints, and can talk to detained patients, hospital managers and other staff about matters that affect care and treatment of detained individuals.

### Second Opinion Appointed Doctor Service

The Second Opinion Appointed Doctor (SOAD) is a key service to protect the rights of patients who are detained under the Act and who either do not consent or are assessed as unable to consent to the treatment that has been prescribed for their mental illness.

A SOAD is an independent registered medical practitioner, appointed by HIW, who can approve certain forms of treatment. The role of the SOAD, under parts 4 and 4A of the Act is to provide an additional safeguard to protect individual patient's rights.

Certain treatments require patient consent and a second opinion under section 57 of the Act. Section 57 applies to invasive treatments such as psychosurgery or surgical implements for the purpose of reducing male sex drive.

In addition, detained patients of any age who do not consent, or do not have capacity to consent, to medication (section 58) and electroconvulsive therapy (ECT) (section 58A) prescribed for mental disorder, also require a second opinion. All patients under 18 years of age, including those who are not detained and for whom ECT is proposed, also require a second opinion from a SOAD.

SOADs have a responsibility to ensure that the proposed treatment is appropriate, is in the patient's best interests, and that the patient's views and rights have been taken into consideration. If the SOAD is satisfied, he/she will issue a statutory certificate that provides the legal authority for the treatment to be given.

In 2022-23 the SOAD service operated as a hybrid service. Our methodology specified that all SOAD visits should occur in person for the purposes of interviewing the patient. Consultations with Statutory Consultees could, however, still be undertaken remotely.

Due to capacity and operational availability of SOADs, the option for remote certification is still utilised to ensure a timely and prompt certification is provided, which we believe is in the best interests of the patient. All patients, however, are still offered an interview via teams/ or telephone consultation in cases where remote certification is utilised.

In all cases, the SOAD must and will use their professional opinion and discretion to consider whether they can safely and confidently certify in remote cases, and the method of interviewing the patient should always be recorded as part of their reasoning on their Certification (CO) forms.

Full advice on our methodology is available on our website: [www.hiw.org.uk](http://www.hiw.org.uk)

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## SOAD Recruitment

We have advertised the vacant Lead SOAD and Deputy Lead SOAD and anticipate the posts to be filled in the summer of 2023. The creation of a Deputy Lead SOAD as a new post is intended to provide further resilience to the service. We have also recruited three new SOADs to further bolster the resilience and effectiveness of the service, and these new SOADs will be in post by the Summer of 2023. This brings our total to 15 active SOADs operating in Wales.

## SOAD training

We provide a regular annual training programme to all of our SOADs to ensure best practice and continuous improvement in their role. In 2022-3, however, due to unforeseen circumstances, we were unable to provide an official training programme. This has been highlighted as a priority for our new Lead SOAD on appointment, and we will then proceed to make arrangements for training sessions to resume in the Autumn of 2023.

## SOAD activity

During the period April 2022 to March 2023, the RSMH received 694 requests for a visit by a SOAD. This figure is a decrease from the April 2021 to March 2022 requests.

These figures can be broken down as follows:

- 640 requests related to the certification of medication.
- 42 requests related to the certification of ECT.
- 12 requests related to medication and ECT.

In the table below the number of requests for a SOAD visit appears to have stabilised from the peak of 954 visits in 2019-20.

## Requests for visits by a SOAD, 2006-07 to 2022-23<sup>1</sup>

Year	Medication	ECT	Medication & ECT	Total
2006-07	428	106	3	537
2007-08	427	79	5	511
2008-09	545	60	2	607
2009-10	743	57	11	811
2010-11	823	61	17	901
2011-12	880	63	1	944
2012-13	691	59	8	758
2013-14	625	60	5	690

<sup>1</sup> Source: SOAD requests to HIW

Year	Medication	ECT	Medication & ECT	Total
2014-15	739	68	5	812
2015-16	793	60	16	869
2016-17	841	71	2	914
2017-18	830	52	25	907
2018-19	834	51	25	910
2019-20	877	51	26	954
2020-21	693	43	20	756
2021-22	657	66	36	759
2022-23	640	42	12	694

### Timely SOAD assessment

To ensure patients receive appropriate care and treatment it is very important that the SOAD assessment is completed in a timely manner. Therefore, three key performance indicators, with precise timescales, were developed to ensure the assessment is completed as soon as possible, and within:

- 2 working days for a referral in relation to ECT.
- 5 working days for referrals about prescribed medication when the patient is in hospital.
- 10 working days when the referral is in relation to someone subject to a Community Treatment Order.

Whilst we strive to meet the above timescales, there are a number of reasons why sometimes the timescales are not met. Some of these reasons include the availability of the Responsible Clinician

or Statutory Consultees to be consulted with by the SOAD. As reported last year, improvements within the timeliness of the service have been maintained since the introduction of telephone and email consultations with the SOAD. In addition, the requirement for all relevant documentation to be provided to the SOAD in advance of the consultations, has continued to maintain the improved timeliness of the assessment process. However, sometimes delays occur because of the availability of the patient, or it was not clear whether the patient wished to be interviewed or not by the SOAD.

Throughout the pandemic we have continued to work with the Mental Health Act Administrators in local health boards and independent mental healthcare settings, to ensure that the SOAD referral and assessment process was completed in a timely way.

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We have retained a hybrid methodology of remote and on-site visits following the implementation of the COVID-19 safe methodology. This is to maintain the improvements in the referral and assessment timescales seen during the reporting period. This includes, offering the option of telephone or video conference consultations with the Responsible Clinician and Statutory Consultees, and maintaining the requirement for health boards and independent mental health hospitals to provide information for the SOAD in advance.

However, our guidance is first and foremost that all patients should be offered interview on a face to face basis, unless the patient indicates they are content or would indeed prefer a remote consultation. There remain difficulties in assessing the preferences of patients and we intend to consult with relevant stakeholders, notably the Mental Health Act Administrators (MHAA) for all settings to try and ensure improvements in this process next year.

Our guidance to all SOADs is that they should record the method of consultation with the patient on their CO forms under the reasons section.

## Review of treatment (Section 61)

Following the authorisation of a treatment plan by an authorised medical practitioner (SOAD) that has been appointed by HIW, a report on the treatment and the patient's condition must be provided by the responsible clinician in charge of the patient's treatment and given to HIW.

The designated form is provided to the Mental Health Act Administrators office for all local health boards and independent settings for the Responsible Clinician to complete. For the seventh consecutive year, HIW undertook an audit of these forms to ensure that adequate patient safeguards were in place. The treatments are usually reviewed on a monthly basis by our lead SOAD for Wales.

Due to unforeseen circumstances beyond our control, there was a significant impact on this service in this reporting period due to the vacant Lead SOAD post. We appointed an interim Lead SOAD with assistance from Care Quality Commission (CQC) to assist in reviewing treatment whilst we advertised our vacant Lead SOAD post.

As reported last year, there remain very few instances where discrepancies are identified by the reviewer. Further improvements from our previous report continue in relation to the following areas:

There continue to be instances where an additional medication is listed under the treatment description than is authorised on the CO3 form. In these instances, the reviewer highlights the need for a SOAD request to be submitted by the setting.

Further to the appointment of a new Lead SOAD we will look to improve our reporting mechanisms in future reports.

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## 8. Our Data

To prepare this report we analysed data from our work between April 2022 and March 2023, including our Mental Health Act monitoring activities and inspection of mental healthcare services and services for people with learning disability and autism.

We also analysed concerns raised with us by patients, relatives, staff, and members of the public, and statutory notification data submitted by independent providers of mental healthcare and learning disability services.



## Appendix A

### Relevant work 2022-23

Hospital	Link	Date	Type
<b>Health Boards</b>			
1		11-13 July 2022	Inspection
2		5-7 September 2022	Inspection
3		1-2 November 2022	Inspection
4		7-9 November 2022	Inspection
5		14-16 November 2022	Inspection
6		9-11 January 2023	Inspection
7		24-25 January 2023	Inspection
8		31 January – 1 February 2023	Inspection
9		9-11 January 2023	Inspection

Hospital	Link	Date	Type
10 Ward 12 & Ward 16, Mental Health Services for Older Persons, Llandough Hospital, Cardiff & Vale University Health Board		20-22 March 2023	Inspection
11 Learning Disability service Betsi Cadwaladr University Health Board		22-23 March 2023	Inspection
12 HIW & CIW Joint Community Mental Health Team (CMHT) North Monmouthshire CMHT, Maendiff Court Hospital, Aneurin Bevan University Health Board		15-16 November 2022	Inspection
13 HIW & CIW Joint Community Mental Health Team (CMHT) Bridgend North CMHT, Maesteg Community Hospital, Cwm Taf Morgannwg University Health Board		13-14 December 2022	Inspection
14 HIW & CIW Joint Community Mental Health Team (CMHT) Welshpool CMHT, Bryntirion Mental Health Resource Centre, Victoria Memorial Hospital, Powys Teaching Health Board		14-15 February 2023	Inspection
<b>Independent Healthcare Providers</b>			
15 Heatherwood Court Hospital Llantrisant Road, Pontypridd		21-23 June 2022	Inspection
16 Tŷ Grosvenor		25-27 April 2022	Inspection
17 Delfryn House and Delfryn Lodge		4-6 July 2022	Inspection
18 St Peter's Hospital		17-19 October 2022	Inspection
19 Heatherwood Court Hospital, Llantrisant Road, Pontypridd.		8-9 November 2022	Inspection
20 Lanarth Court Hospital		13-15 February 2023	Inspection
21 New Hall Independent Hospital		13-15 March 2023	Inspection
22 Hillview Hospital		15-17 August 2022	Inspection

## Appendix B: Glossary

<b>Advocacy</b>	Independent help and support with understanding issues and assistance in putting forward one's own views, feelings and ideas. See also independent mental health advocate.
<b>Approved Clinician</b>	A mental health professional approved by the Welsh Ministers (or the Secretary of State) to act as an approved clinician for the purposes of the Act. In practice, Local health boards take these decisions on behalf of the Welsh Ministers. Some decisions under the Act can only be undertaken by people who are approved clinicians. A responsible clinician must be an approved clinician.
<b>Assessment</b>	Examining a patient to establish whether the patient has a mental disorder and, if they do, what treatment and care they need. It is also used to mean examining or interviewing a patient to decide whether an application for detention or guardianship should be made.
<b>Capacity</b>	The ability to take a decision about a particular matter at the time the decision needs to be made. Some people may lack mental capacity to take a particular decision because they cannot understand, retain or weigh the information relevant to the decision. A legal definition of lack of capacity for people aged 16 or over is set out in Section 2 of the Mental Capacity Act 2005.
<b>Care Standards Act 2000</b>	An Act of Parliament that provides a legislative framework for independent care providers.
<b>CO2 form</b>	Certificate of consent to treatment (Section 58(3) (a)).
<b>CO3 form</b>	Certificate of second opinion (Section 58(3) (b)).
<b>CO7 form</b>	Certificate of appropriateness of treatment to be given to a community patient.
<b>CO8 form</b>	Certificate of consent to treatment for a community patient.

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**Community Treatment Order (CTO)**

Written authorisation on a prescribed form for the discharge of a patient from detention in a hospital onto supervised community treatment. They are a mechanism to enable individuals detained in hospital for treatment (under section three of the Act or an equivalent part three power without restrictions) to be discharged from hospital to be cared for and treated more appropriately at home or in a community setting. When an individual is subject to a CTO the discharging hospital has the power to recall the patient to hospital for up to 72 hours, which can be followed by release back into the community, an informal admission or revoking the CTO in place and re-imposing the previous detention.

**Compulsory Treatment**

Medical treatment for mental disorder given under the Act.

**Consent**

Agreeing to allow someone else to do something to or for you, particularly consent to treatment.

**Deprivation of Liberty**

A term used in Article 5 of the European Convention on Human Rights to mean the circumstances in which a person's freedom is taken away. Its meaning in practice has been developed through case law.

**Deprivation of Liberty Safeguards**

The framework of safeguards under the Mental Capacity Act for people who need to be deprived of their liberty in their best interests for care or treatment to which they lack the capacity to consent themselves.

**Detained patient**

Unless otherwise stated, a patient who is detained in hospital under the Act, or who is liable to be detained in hospital but who is (for any reason) currently out of hospital.

**Detention/detained**

Unless otherwise stated, being held compulsorily in hospital under the Act for a period of assessment or medical treatment for mental disorder. Sometimes referred to as "sectioning" or "sectioned".

**Discharge**

Unless otherwise stated, a decision that a patient should no longer be subject to detention, supervised community treatment, guardianship or conditional discharge.

Discharge from detention is not the same thing as being discharged from hospital. The patient may already have left hospital or might agree to remain in hospital as an informal patient.

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<b>Doctor</b>	A registered medical practitioner.
<b>Electro-Convulsive Therapy (ECT)</b>	A form of medical treatment for mental disorder in which seizures are induced by passing electricity through the brain of an anaesthetised patient; generally used as a treatment for severe depression.
<b>Guardianship</b>	The appointment of a guardian to help and supervise patients in the community for their own welfare or to protect other people. The guardian may be either a local social services authority (LSSA) or someone else approved by the LSSA (a private guardian).
<b>HIW</b>	Healthcare Inspectorate Wales is the independent inspectorate and regulator of healthcare in Wales.
<b>Hospital managers</b>	<p>The organisation (or individual) responsible for the operation of the Act in a particular hospital (e.g., an NHS Trust or Health Board).</p> <p>Hospital managers have various functions under the Act, which include the power to discharge a patient. In practice most of the hospital managers' decisions are taken on their behalf by individuals (or groups of individuals) authorised by the hospital managers to do so. This can include clinical staff.</p>
<b>Independent Mental Capacity Advocate (IMCA)</b>	Someone who provides support and representation for a person who lacks capacity to make specific decisions, where the person has no-one else to support them. The IMCA service is established under the Mental Capacity Act. It is not the same as an ordinary advocacy service or an independent mental health advocacy (IMHA) service.
<b>Informal patient</b>	Someone who is being treated for mental disorder in hospital and who is not detained under the Act; also, sometimes known as a voluntary patient.
<b>Learning disability</b>	In the Act, a learning disability means a state of arrested or incomplete development of the mind which includes a significant impairment of intelligence and social functioning. It is a form of mental disorder for the purposes of the Act.

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**Leave of absence  
(section 17 leave)**

Formal permission for a patient who is detained in hospital to be absent from the hospital for a period of time; patients remain under the powers of the Act when they are on leave and can be recalled to hospital, if necessary, in the interests of their health or safety or for the protection of others. Sometimes referred to as 'Section 17 leave'.

**Liable to be detained**

This term refers to individuals who could lawfully be detained but who, for some reason, are not at the present time.

**Ligature**

A ligature is an item or items that can be used to cause compression of airways, resulting in asphyxiation and death. A Ligature (Point) Risk Assessment identifies potential ligature points and what actions should be undertaken by the healthcare provider to remove or manage these points for patient safety.

**Mental Health Review  
Tribunal**

The Mental Health Review Tribunal (MHRT) for Wales safeguards patients who have had their liberty restricted under the Mental Health Act. The MHRT for Wales review the cases of patients who are detained in hospital or living in the community subject to a conditional discharge, community treatment or guardianship order.

**Medical treatment**

In the Act this covers a wide range of services. As well as the kind of care and treatment given by doctors, it also includes nursing, psychological therapies, and specialist mental health intervention, rehabilitation, and care.

**Medical treatment for  
mental disorder**

Medical treatment, which is for the purpose of alleviating, or preventing a worsening of the mental disorder or one or more its symptoms or manifestations.

**Mental Capacity Act 2005**

An Act of Parliament that governs decision-making on behalf of people who lack capacity, both where they lose capacity at some point in their lives and where the incapacitating condition has been present since birth.

**Mental illness**

An illness of the mind. It includes common conditions like depression and anxiety and less common conditions like schizophrenia, bipolar disorder, anorexia nervosa and dementia.

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<b>Multidisciplinary Team</b>	A Multidisciplinary Team (MDT) is a group of professionals from one or more clinical disciplines who together make decisions about recommended treatments.
<b>Patient</b>	A person who is, or appears to be, suffering from mental disorder. The use of the term is not a recommendation that the term 'patient' should be used in practice in preference to other terms such as 'service user', 'client' or similar. It is simply a reflection of the terminology used in the Act itself.
<b>Prescribed body</b>	The role of a prescribed person or body is to provide workers with a mechanism to make their public interest disclosure to an independent body where the worker does not feel able to disclose directly to their employer and the body might be in a position to take some form of further action on the disclosure.
<b>Public Interest Disclosure Act</b>	The Public Interest Disclosure Act 1998 provides protection to "workers" making disclosures in the public interest and allows such individuals to claim compensation for victimisation following such disclosures. Further protection was afforded by The Enterprise and Regulatory Reform Act 2013 (ERRA) which came into force in July 2013.
<b>Recall (and recalled)</b>	A requirement that a patient who is subject to the Act return to hospital. It can apply to patients who are on leave of absence, who are on supervised community treatment, or who have been given a conditional discharge from hospital.
<b>Regulations</b>	Secondary legislation made under the Act. In most cases, it means the Mental Health (Hospital, Guardianship, Community Treatment and Consent to Treatment) (Wales) Regulations 2008.
<b>Revocation</b>	This term is used to describe the rescinding of a CTO when a supervised community treatment patient needs further treatment in hospital. If a patient's CTO is revoked, the patient is detained under the same powers of the Act before the CTO was made.
<b>Responsible Clinician</b>	The approved clinician with overall responsibility for the patient's case.

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<b>Restricted patient</b>	<p>A Part 3 patient who, following criminal proceedings, is made subject to a restriction order under Section 41 of the Act, to a limitation direction under Section 45A or to a restriction direction under Section 49.</p> <p>The order or direction will be imposed on an offender where it appears necessary to protect the public from serious harm. One of the effects of the restrictions imposed by these sections is that such patients cannot be given leave of absence or be transferred to another hospital without the consent of the Secretary of State for Justice, and only the Mental Health Review Tribunal for Wales can discharge them without the Secretary of State's agreement.</p>
<b>Second Opinion Appointed Doctor (SOAD)</b>	<p>An independent doctor appointed by the Mental Health Act Commission who gives a second opinion on whether certain types of medical treatment for mental disorder should be given without the patient's consent.</p>
<b>Section 3</b>	<p>Section 3 of the Mental Health Act allows for the detention of a patient for treatment in a hospital and initially for a period of up to 6 months. This can be renewed for a further 6 months and then annually.</p>
<b>Section 12 doctor</b>	<p>See doctor approved under Section 12.</p>
<b>Section 17A</b>	<p>This is a Community Treatment Order.</p>
<b>Section 37</b>	<p>This is a hospital order, which is an alternative to a prison sentence.</p>
<b>Section 41</b>	<p>This is accompanied by a section 37 and only a Crown Court can use a section 37 (41). The patient must have a mental illness that needs treatment in hospital and the patient. Section 41 is a restriction order and is used if a patient is considered a risk to the public.</p>
<b>Section 57 treatment</b>	<p>Section 57 treatments mean psychosurgery or surgical implants to alter male sexual function.</p>
<b>Section 58 &amp; 58A</b>	<p>Section 58 treatments refer to medication for mental disorder and section 58A treatments electroconvulsive therapy for mental disorder. Part 4A of the Act regulates the Section 58 and 58A type treatments of those on community treatment.</p>

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<b>Section 61</b>	This provides for reports to be given in relation to treatments given under section 57, 58, 58A or 62B.
<b>Section 132</b>	This provides a responsibility on the hospital managers to take all responsible steps to ensure all detained patients are given information about their rights.
<b>Section 135</b>	Section 135 allows a police officer the powers of entry using a warrant obtained from a Justice of the Peace. This is used to gain access to a person believed to be mentally disordered who is not in a public place and if necessary, remove them to a place of safety.
<b>Section 136</b>	Section 136 of the Act allows for any person to be removed to a place of safety (section 136 suites) if they are found in a public place and appear to be police officer to be suffering from a mental disorder and in immediate need of care and control.
<b>SOAD certificate</b>	A certificate issued by a second opinion appointed doctor (SOAD) approving particular forms of medical treatment for a patient.
<b>Statutory Consultees</b>	A SOAD is required to consult two people (statutory consultees) before issuing certificates approving treatment. One of the statutory consultees must be a nurse and the other must have been professionally concerned with the patient's medical treatment and neither maybe the clinician in charge of the proposed treatment or the responsible clinician.
<b>The Mental Health (Wales) Measure 2010</b>	Legislation that consists of 4 distinct parts: <b>Part 1</b> – Primary mental health support services. <b>Part 2</b> – Co-ordination of and care planning for secondary mental health service users. <b>Part 3</b> – Assessment of former users of secondary mental health services. <b>Part 4</b> – Mental health advocacy.
<b>Voluntary patient</b>	See informal patient.
<b>Welsh Ministers</b>	Ministers in the Welsh Government.

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## Feedback on this report

If you have any comments or queries regarding this publication, please contact us.

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# Quality and Engagement Act Implementation Plan

## Duty of Quality

6 Steps for the implementation of the Duty of Quality	Objective – What are we trying to achieve?	Actions	Progress & Evidence	Monitoring Arrangements	Responsible person/persons	Deadline date for completion & insert date of completion
1. <b>Secure Board Support</b>	Board members will be aware of the Duty of Quality and the statutory requirements, ensuring that the Duty is embedded across the organisation	Board education and training	<p>Executive committee update provided September 2023</p> <p>IM's provided with PowerPoint briefing session</p> <p>Board development session held April 2023 and July 2023</p> <p>IM's attended national training session.</p>	PTHB Q&EA Implementation Board	Board Secretary EDoN&M	April 2023

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6 Steps for the implementation of the Duty of Quality	Objective – What are we trying to achieve?	Actions	Progress & Evidence	Monitoring Arrangements	Responsible person/persons	Deadline date for completion & insert date of completion
		At least one member of Board trained, knowledgeable and able to influence Board in relation to DoQ	All Board members provided with e-learning module on ESR.  Board development day scheduled 27/04/23	PTHB Q&EA Implementation Board	EDoN	April 2023
	Duty of Quality embedded into Board governance structure	Board & Sub-board committees TOR will be reviewed to account for the Duty of Quality	This will be incorporated into the TOR reviews ready for May 2024 Board, it is a given that legal requirements / changes fall within Committee remit – PEQs is the lead Committee.	PTHB Q&EA Implementation Board	Director of Corporate Governance	April 2023
		Build Quality into the governance work programme	Confirmed – part of PEQs agenda through IQR, part of Board Dev programme and Joint Committee held Oct 2023.		Director of Corporate Governance	April 2023

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6 Steps for the implementation of the Duty of Quality	Objective – What are we trying to achieve?	Actions	Progress & Evidence	Monitoring Arrangements	Responsible person/persons	Deadline date for completion & insert date of completion
2. Assessing Readiness	Leadership and culture	Senior responsible leadership in place and driving implementation work	Executive leads identified	PTHB Q&EA Implementation Board	EDoN&M	November 2023
		All staff recognise and understand the organisation's Quality vision, and their roles within it	Development of the Quality Strategy in progress, consultation Q3 and publishing end Q4  <b>Feb 2024 update</b> – draft Quality Strategy shared with Board Sec and Clinical Execs for comment.	PTHB Q&EA Implementation Board	AD Q&S AD Innovation	April 2024
		Commitment, resources, and infrastructure in place to implement Duty effectively	IQPF will realise the quality measures with the supported quality dashboard.  Quality dashboard in final stages of completion	IQPF implementation  PEQS	Director planning and commissioning	January 2024

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6 Steps for the implementation of the Duty of Quality	Objective – What are we trying to achieve?	Actions	Progress & Evidence	Monitoring Arrangements	Responsible person/persons	Deadline date for completion & insert date of completion
	Decision-making	Processes and systems in place to provide demonstrable evidence that Board decisions have been made through Quality lens	Financial Scenario planning – L1&L2 assessments  Board paper template amended to reflect STEEP.  More work to do here – linked to impact assessment work to be undertaken.	PTHB Q&EA Implementation Board	Director of Corporate Governance	April 2024
	Governance and accountability structures	To ensure the Board are assured that DoQ is being considered across system	Schedule annual report / update for May 2024, PEQS continue to receive assurance reports	PTHB Q&EA Implementation Board	Director of Corporate Governance (DCG)	March 2024
		Routine governance documentation is DoQ-ready	Completed in line with IQPF	Exec committee	DCG EDoN&M	April 2024
	Reporting and information (data to knowledge)	Mechanism and publication schedule / plan in place for sharing DoQ	End of year 1 reporting planned.	PTHB Q&EA Implementation Board	DCG EDoN&M	March 2024

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6 Steps for the implementation of the Duty of Quality	Objective – What are we trying to achieve?	Actions	Progress & Evidence	Monitoring Arrangements	Responsible person/persons	Deadline date for completion & insert date of completion
		progress information externally	DoQ monitored within IQPD meetings for commissioned services			
		Quality-related information escalation mechanisms in place, with plans for review and consideration at appropriate level	IPF will realise the quality measures with the supported quality dashboard. Quality dashboard in final stages of completion	IPF implementation PEQS	Director planning and commissioning	January 2024
	Commissioning	A clear and corporately agreed understanding of changes required to incorporate DoQ requirements into all commissioning arrangements	IPF will realise the quality measures with the supported quality dashboard	CQPRM	Director planning and commissioning	January 2024
	Hosting	A clear and corporately agreed understanding of changes required to incorporate DoQ	Measures in place	PTHB Q&EA Implementation Board	AD Commissioning	April 2023

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6 Steps for the implementation of the Duty of Quality	Objective – What are we trying to achieve?	Actions	Progress & Evidence	Monitoring Arrangements	Responsible person/persons	Deadline date for completion & insert date of completion
		requirements into hosting arrangements				
	Quality Standards	A clear understanding of changes required to existing quality infrastructure and agreed programme of work to align with Quality Standards 2023	Implementation of IQPF	PEQS	EDoN&M	March 2024
	Quality management system – general	A clear understanding of, and commitment to, a quality management system, with plans in place to identify requirements and current gaps	IQPF will realise the quality measures with the supported quality dashboard.  Further maturity is required to ensure alignment to the quality standards is made across the system.	Executive Committee	EDoN/Director of planning/DCG	March 2024

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6 Steps for the implementation of the Duty of Quality	Objective – What are we trying to achieve?	Actions	Progress & Evidence	Monitoring Arrangements	Responsible person/persons	Deadline date for completion & insert date of completion
	Communication and engagement	All staff are aware of key DoQ messages tailored to their organisation	Communication strategy in place, weekly communication agreed.	PTHB Q&EA Implementation Board	AD (Engagement and Communication )	February 2023
			HB sharepoint webpage in place	PTHB Q&EA Implementation Board	AD Q&S	March 2023
		Public are aware of publication of quality metrics as part of wider Duty of Quality requirements	Plan in place for messaging and public awareness linked to publication of Quality Metrics	PTHB Q&EA Implementation Board	AD (Engagement and Communication )	June 2024
3. <b>Securing Wider Organisational Buy-In and Co-Creating a Vision</b>	Strategy	Review Health & Care Strategy through the lens of the Duty of Quality & Duty of Candour; strengthening existing messages	Development of the Quality Strategy in progress, consultation Q3 and publishing end Q4	PTHB Q&EA Implementation Board	AD Q&S AD Innovation	April 2024

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6 Steps for the implementation of the Duty of Quality	Objective – What are we trying to achieve?	Actions	Progress & Evidence	Monitoring Arrangements	Responsible person/persons	Deadline date for completion & insert date of completion
	Ensuring IMTP is aligned to the principles of the Duty of Quality & Duty of Candour	The objectives of IMTP are underpinned by the Quality Domains of STEEP and the associated Quality Standards	IMTP of 2023/24 can align to STEEP (however Quality Standards have not yet been published) IMTP 2024/25 will need to consider the quality standards along with STEEP	Executive Committee	All Executive Directors	March 2023
4. <b>Developing Improvement Skills and Infrastructure</b>	The quality management system (QMS) enables quality improvement and is systemic within the organisation	QMS is an integral component of the organisations IQPF	IQPF will realise the quality measures with the supported quality dashboard. Increased training and awareness to support teams	Executive Committee	EDoN/Director of planning/DCG	March 2023
	Create and embed an infrastructure within the organisation through which the QMS is deployed	Implement an Integrated Quality & Performance Group (IQPG) reporting to the executive committee and onto PEQS.	Review of quality reporting structures within the health board and implementation of IQPF	PEQS	EDoN&M	March 2024

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6 Steps for the implementation of the Duty of Quality	Objective – What are we trying to achieve?	Actions	Progress & Evidence	Monitoring Arrangements	Responsible person/persons	Deadline date for completion & insert date of completion
		Ensure service level Quality groups are in place	Scoping of requirements, ToR and reporting to ensure alignment to organisational structures.	Executive Committee	EDoN&M	March 2023
	Build improvement knowledge skills and expertise within the organisation, building on existing quality improvement capacity	Undertake an organisational TNA	Sport for SCiL programme Alignment of teams to Safecare Collaborative and national approach/support	Learning Group	Medical Director	June 2023
5. <b>Aligning and Co-ordinating Activity</b>	Create and embed an infrastructure within the organisation through which the QMS is deployed	Implement Integrated Quality & Performance Group reporting to the executive committee and onto PEQS.	Structure, purpose, and ToR being agreed and ratified	Executive committee	EDoN&M	March 2024
		Establish local clinical quality groups, reporting to	Structure, purpose, and ToR being agreed and ratified	Executive committee	EDoN&M	May 2024

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6 Steps for the implementation of the Duty of Quality	Objective – What are we trying to achieve?	Actions	Progress & Evidence	Monitoring Arrangements	Responsible person/persons	Deadline date for completion & insert date of completion
		and informing the IQPG				
		Build Quality into the governance work programme	Built into PEQs and W&C work plans	PTHB Q&EA Implementation Board	DCG	April 2023
	Duty of Quality embedded into Executive Committee and its sub-groups	All sub-groups i.e., workforce steering group, finance steering group, clinical quality advisory group etc. co-ordinate their activity supported by IPF and QMS	Executive governance structure reviewed Oct 2023, Executive Committee TOR reviewed Dec 2023 ToRs updated	Executive Committee	DCG	April 2023 (Dec 2024 – on track)
<b>6. Sustaining organisational wide approach</b>	Duty of Quality embedded into Executive Committee and its sub-groups	All sub-groups i.e., workforce steering group, finance steering group, clinical quality advisory group etc. co-ordinate their activity supported by IPF and QMS	Duplicated as above	Executive Committee	DCG	April 2023 (Dec 2024 – on track)

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# Duty of Candour

Recommendation	Objective, what are we trying to achieve?	Action needed	Progress & Evidence	Monitoring Arrangements	Responsible Person/persons	Deadline date for completion & insert date of completion
1. Assessing Readiness	Quality Led Leadership and culture	Senior responsible leadership in place and driving implementation work	Lead identified	PTHB Q&EA Implementation Board	AD Quality & Safety	November 2022
		Strategic led identified and trained (IM or Non-Exec)	Lead identified	PTHB Q&EA Implementation Board	Vice-Chair	November 2022
		Operational lead identified (executive officer level)	Lead identified	PTHB Q&EA Implementation Board	EDoN&M	November 2022
	Governance and accountability structures	Fully developed and signed off Implementation plan for the duty	Implementation plan in place	PTHB Q&EA Implementation Board	AD Quality & Safety	January 2023

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Recommendation	Objective, what are we trying to achieve?	Action needed	Progress & Evidence	Monitoring Arrangements	Responsible Person/persons	Deadline date for completion & insert date of completion
		Implementation of the actions in the implementation plan due to enable duty to be enacted in April.	Action plan monitored	PTHB Q&EA Implementation Board	AD Quality & Safety	January 2023
		Policy-ratified and published	Update to PTR policy in draft, awaiting publication of final Duty of candour guidance	PTHB Q&EA Implementation Board	AD Quality & Safety	May 2023
		Any additional SOP's or policies completed	SOP's in place Template letters completed	PTHB Q&EA Implementation Board	AD Quality & Safety	April 2023
	Reporting and information (data to knowledge)	Training Needs analysis for reporting requirements for the duty	TNA completed and training provided.  Training video also available on HB sharepoint for all staff.  National training materials shared with teams.	PTHB Q&EA Implementation Board	AD Quality & Safety	March 2023

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Recommendation	Objective, what are we trying to achieve?	Action needed	Progress & Evidence	Monitoring Arrangements	Responsible Person/persons	Deadline date for completion & insert date of completion
		Candour-related information validation and mechanisms for escalation in place, with plans for review and consideration at appropriate level	SOP in place	PTHB Q&EA Implementation Board	AD Quality & Safety	March 2023
		Facilities for primary care providers in place and functionality tested	SOP to be agreed and ratified. National training provided Measures in place to align with RLDatix reporting	PTHB Q&EA Implementation Board	AD Primary Care	May 2023
		Mechanism and publication schedule / plan in place for Candour Reporting Requirements.	Monthly reporting dashboard in place	PTHB Q&EA Implementation Board	AD Quality & Safety	March 2023
	Commissioning	A clear and corporately agreed understanding of changes required to incorporate DoC	Commissioning team contacted to raise awareness and requirements of the	PTHB Q&EA Implementation Board	AD planning and commissioning	May 2023

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Recommendation	Objective, what are we trying to achieve?	Action needed	Progress & Evidence	Monitoring Arrangements	Responsible Person/persons	Deadline date for completion & insert date of completion
		requirements into all commissioning arrangements	<p>Duty of Candour, and the impact this will have on commissioned services within Wales and outside Wales</p> <p>A clear and corporately agreed understanding of changes required to incorporated Candour requirements into all commissioning arrangements is required, as well as to hosting arrangements.</p>			
	Communication and engagement	All staff are aware of key DoC messages tailored to their organisation	Communication strategy in place, including regular email bulletins through Q4 to all staff promoting Duty of Candour and raising awareness of forthcoming requirements	PTHB Q&EA Implementation Board	AD (Engagement and Communication )	February 2023

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Recommendation	Objective, what are we trying to achieve?	Action needed	Progress & Evidence	Monitoring Arrangements	Responsible Person/persons	Deadline date for completion & insert date of completion
			Duty of Candour SharePoint site in place	PTHB Q&EA Implementation Board	EDoN&M	February 2023
		Engagement with workforce and key stakeholders e.g. Service Users	Communication strategy in place, including website content and utilisation of national promotional resources	PTHB Q&EA Implementation Board	AD (Engagement and Communication )	February 2023
			Continuing to raise awareness of the Duty of Candour with the public and service users from 1 April, including information available on PTHB website, shared via social media channels, and on PTHB public display screens	PTHB Q&EA Implementation Board	AD (Engagement and Communication )	June 2024
	Engagement with workforce and key stakeholders	Training Needs analysis for the duty	TNA completed and training provided.	PTHB Q&EA Implementation Board	AD Quality & Safety	March 2023

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Recommendation	Objective, what are we trying to achieve?	Action needed	Progress & Evidence	Monitoring Arrangements	Responsible Person/persons	Deadline date for completion & insert date of completion
	e.g. Service Users		<p>Training video also available on HB sharepoint for all staff.</p> <p>National training materials shared with teams.</p> <p>National leaflets and information shared on staff facing and public facing web pages</p>			

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**GIG**  
CYMRU  
**NHS**  
WALES

Bwrdd Iechyd  
Addysgu Powys  
Powys Teaching  
Health Board

**Agenda item: 2.2**

<b>Patient Experience and Quality Committee</b>		<b>DATE</b> <b>16 April 2024</b>
<b>Subject:</b>	Mental Health Services: Quality Governance Update	
<b>Approved and presented by:</b>	Claire Roche: Executive Director of Nursing and Midwifery Kate Wright: Medical Director David Farnsworth: Interim Director of Operations	
<b>Prepared by:</b>	Claire Roche: Executive Director of Nursing and Midwifery	
<b>Other Committees and meetings considered at:</b>	Executive Committee 3 April 2024	
<b>PURPOSE:</b>		
To provide the Committee with an updated position in Mental Health Services, following on from the paper presented at Committee on the 23 January 2024. To inform the Committee of the escalated status of Mental Health Services in Powys and the monitoring, assurance and improvement arrangements in place.		
<b>RECOMMENDATION(S):</b>		
The Patient Experience and Quality Committee is asked to:		
<ol style="list-style-type: none"> <li>1) <b>NOTE</b> the actions that have been taken since 23 January 2024</li> <li>2) <b>NOTE</b> the escalated status of Mental Health Services to Level 2a (in line with the newly approved escalation framework within the Integrated Quality and Performance Framework IQPF)</li> <li>3) Take <b>ASSURANCE</b> of the plans in place to monitor progress in mental health services to ensure effective oversight, assurance and improvement.</li> </ol>		
<b>Approve/Take Assurance</b>	<b>Discuss</b>	<b>Note</b>
Y	Y	Y

<b>ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:</b>		
1. Focus on Wellbeing	Y	
2. Provide Early Help and Support	Y	
3. Tackle the Big Four	Y	
4. Enable Joined up Care	Y	
5. Develop Workforce Futures	N	

6. Promote Innovative Environments	N	
7. Put Digital First	Y	
8. Transforming in Partnership	Y	

## EXECUTIVE SUMMARY

The Executive Committee has agreed that Mental Health Services in Powys Teaching Health Board be placed into an escalated (internal within the Health Board) status.

Weekly Monitoring and Oversight Escalation meetings chaired by the Executive Director of Nursing and Midwifery to monitor progress and gain assurance on improvements commenced on the 2 April 2024

## SITUATION, BACKGROUND AND ASSESSMENT

### SITUATION

The Executive Committee has agreed that Mental Health Services in Powys Teaching Health Board be placed into an escalated (internal within the Health Board) status.

In line with the recently approved Escalation Framework within the revised Integrated Quality and Performance Framework (IQPF) by Board (20 March 2024), the service will be placed into Level 2a.

### BACKGROUND

The Chief Executive Officer commissioned a review into the quality and safety governance arrangements in mental health services in Quarter 3 2023/24. This request was informed by a number of nationally reportable incidents in the service and in response to a number of outstanding actions from the Patient Experience, Quality and Safety (PEQS) Committee.

The review, co-ordinated and led by the Head of Quality and Safety, supported by the Assistant Director of Nursing (Quality and Safety) and in partnership with the Assistant Director Mental Health and the Head of Nursing, Mental Health involved a deep dive into a number of patient safety incidents reported in the DATIX system. The outcome of this review was presented to the Executive Committee on the 17 January 2024 and the Patient Experience and Quality Committee on the 23 January 2024.

Since receiving the outcome of the initial deep dive into incident management, two courses of action have been undertaken. Firstly, regular progress reports have been provided to the Executive Team regarding the management and learning of incidents. Secondly, the Chief Executive requested a further review of

quality and safety arrangements in Mental Health to further understand the arrangements in place for effective quality and safety. This review consisted of a Clinical Systems Audit.

Dr Paul Buss, Director of Clinical Strategy undertook this audit, supported by the Quality and Safety Team and the Mental Health Senior Team. The outcome of this audit was presented to the Executive Team on the 6 March by the Executive Director of Nursing and the Medical Director.

Informed by "safer services: A toolkit for specialist mental health services and primary care" (University of Manchester and Healthcare Quality Improvement Partnership 2023) and the Mental Health (Wales) Measure 2010, the audit consisted of a selection of standards included in the Royal College of Psychiatry standards for in-patient acute mental health (2019), the National Confidential Enquiry of suicide toolkit.

The outcome of this audit identified gaps against standards and therefore, the Executive Team agreed that the Mental Health Service be placed into internal escalation for increased scrutiny, assurance and improvement. It was agreed that the level of escalation would be akin to Level 2a (as described in our proposed new escalation Framework that was intended at that time to take to Board at the end of March 2024).

The paper also updated the Executive Team on the numbers of complaints received into the Health Board regarding mental health services. As can be seen from the table below, in the first 2 months of 2024, nearly half as many formal concerns were received as in the whole of 2023.

Category	2023	2024
Formal	16	7
Early Resolution	27	8
HIW Enquiries/Concerns	2	3

The 3 highest Themes of concerns are as follows:

- Communication
- Attitude and Behaviours of staff
- Medication and Appointments

## ASSESSMENT

The triangulation of information received by the Executive Team as a result of the initial deep dive into patient safety incident management, the outcome of the Clinical Systems Audit and the increased number of complaints/ concerns into the

Organisation led to the Executive Team agreeing that the service should be placed into a status of escalation within the Health Board.

At the same Executive meeting, the team also received a paper proposing a new escalation framework to be included in the revised Integrated Quality and Performance Framework (IQPF). This was recommended to Board and received Board approval on the 20 March 2024.

Therefore, Mental Health Services have been placed into Level 2a escalation. It must be stressed that the purpose of this action is to realise the necessary improvements in the service, embedding a culture of continuous improvement and psychological safety.

To provide support to the mental health team and to establish a robust monitoring process, a weekly assurance meeting will be established. The attendees are:

- EDoN (Chair)
- MD (Vice Chair)
- Director of Operations
- Deputy Director Workforce
- Representation from Performance and Commissioning
- Representation from Quality & Safety
- Mental Health Triumvirate (AD MH, HoN, CD)

The focus of the meeting will be to support and enable the mental health team to make improvements whilst also seeking assurance on the following indicators:

- Appropriate management of patient safety incidents.
- Management of concerns and complaints, along with learning from themes and trends.
- NRI's investigation closure, action plans and learning clearly defined.
- Clear actions in place to RAG rate Policies and policy ratification.
- Clinical audit plan to include application of policies.
- Training & Education plan and compliance, with clear TNA.
- Workforce monitoring inclusive of agency use, sickness/absence, PADR compliance.

This process commenced on 2 April 2024. The Directors involved will be updating the Executive team every two weeks as a minimum and a formal progress paper will be received by the Executive Committee bi-monthly. Reports will also be provided to the Patient Experience, Quality and Safety Committee at each meeting.

## **Health Inspectorate Wales (HIW) Correspondence**

The Committee should also be aware of correspondence received into the Health Board on the 21 March 2024. The letter, received by the Chief Executive Officer (CEO) communicated concerns within HIW regarding Mental Health Services in Powys Teaching Health Board as a result of the increase in Nationally Reported Incidents (NRIs) and a number of concerns and complaints received into HIW in recent months. To note, the Health Board is aware of all reported incidents (as reported by the Health Board) and the complaints as each has been communicated to us, investigated and a response to HIW has been provided.

HIW requested further assurance on how we are managing and learning from our reported NRIs, our progress with the open incidents as well as clarity on our oversight arrangements and our quality governance.

A comprehensive response was submitted to HIW from the CEO on the 27 March 2024.

#### **NEXT STEPS:**

- 1) Weekly Monitoring and Oversight Escalation meetings chaired by the Executive Director of Nursing and Midwifery to monitor progress, gain assurance from the Continuous Improvement plan and identify any barriers to success.
- 2) Fortnightly updates to the Executive team from the Director of Nursing, Medical Director and Director of Operations
- 3) Bi-monthly formal progress reports to the Executive Committee
- 4) Formal Progress reports to Patient Experience and Quality Committee for the duration of the escalation period

## IMPACT ASSESSMENT - NO ASSESSMENT REQUIRED

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

### QUALITY:

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

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.

### EQUALITY:

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

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.

### RISK ASSESSMENT:

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

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.

Patterson, Liz  
12/04/2024 09:50:36

<b>Patient Experience, Quality and Safety Committee</b>	<b>Date of Meeting: 16 April 2024</b>	
<b>Subject :</b>	2024-2025 Clinical Audit Programme	
<b>Approved and Presented by:</b>	Kate Wright, Medical Director	
<b>Prepared by:</b>	David Farnsworth, Assistant Director for Community Services Catherine Arnold, Quality and Risk Manager for Mental Health Louise Turner, Assistant Director for Women and Children’s Services Amanda Waters, Head of Primary Care Jacqueline Seaton, Chief Pharmacist and their respective staff Collated by; Howard Cooper, Safety and Quality Improvement Manager	
<b>Other Committees and meetings considered at:</b>	Executive Committee – 3 April 2024 - who supported the plan and endorsed it to the Patient Experience, Quality and Safety Committee.	
<b>PURPOSE:</b>		
The purpose of this paper is to provide the organisational ambitions for the 2024-2025 clinical audit plan.		
<b>RECOMMENDATION(S):</b>		
The Patient Experience Quality and Safety Committee is asked to: <ul style="list-style-type: none"> <li>• <b>RECEIVE</b> and <b>APPROVE</b> the clinical audit plan 2024-2025.</li> </ul>		
<b>Approval/Ratification/Decision<sup>1</sup></b>	<b>Discussion</b>	<b>Information</b>
✓	x	x
<b>THE PAPER IS ALIGNED TO THE DELIVERY OF THE FOLLOWING STRATEGIC OBJECTIVE(S) AND HEALTH AND CARE STANDARD(S):</b>		

<sup>1</sup> Equality Impact Assessment (EiA) must be undertaken to support all organisational decision making at a strategic level

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

## EXECUTIVE SUMMARY:

This paper presents the PTHB clinical audit programme for 2023-24 for information and approval.

## BACKGROUND AND ASSESSMENT:

Clinical Audit, the systematic review of actual performance against expected standards, remains an important benchmarking tool in determining the level of our clinical standards.

It will provide assurance in areas where procedures are inherently high-risk, or where new processes and policies have been introduced. It may also identify areas of concern where the significant input of resources may be required.

A Clinical Audit Plan has been drafted for 2024/25 which incorporates the following:

- High volume basic activities which require a high level of compliance.
- Areas of concern or themes identified during investigations of Nationally Reportable Incidents or complaints.
- New policies or changes to existing policy / practice to confirm new practice is established and that policies are effective.
- The prioritisation of new and repeat clinical audit projects based on recognised clinical risk.
- Clinical audits required to confirm that practice has improved and that actions have been effectively completed where concern had been raised.
- Areas identified from triangulation of themes in Learning Group.

The plan was developed and approved by the five Assistant Directors with responsibility for;

- **Women and Children's Services**
- **Community Services Group**
- **Mental Health and Learning Disabilities Group**
- **Medicines management**
- **Primary Care**

A copy of the current draft Clinical audit Plan 2024/25 can be found at **Appendix A**. Of note, the clinical audit plan for Mental Health Services has been strengthened. Further audits may be added during the year if further areas of key focus are identified.

### **National Clinical Audit Programme**

The National Clinical Audit Programme is a programme of audits commissioned by the London-based Healthcare Quality Improvement Partnership (HQIP) on behalf of the UK Department of Health.

Welsh Government agrees to pay an annual fee to HQIP to allow Welsh Health Boards to participate in these audits. The agreement for 2024/25 is not yet in place at the time of writing. Any nationally agreed audits will be added to the update reports presented to this committee during the 2024/25 cycle.

Progress against the Clinical Audit Plan will be reported within agreed timeframes to PEQ&S. This will highlight:

- Any significant actions to be taken from needs identified in the audits.
- The sharing of appropriate learning across services.
- The sustainable implementation of any safety improvements made.

### **Internal Audit Report on Clinical Audit**

The Internal Audit team have undertaken an audit of the processes around Clinical Audit examining four measures. Their report, published in September 2023, gave a rating of Substantial Assurance for the development of the Annual Clinical Audit plan, and for the provision of guidance and advice to staff on conducting a Clinical Audit.

They gave a rating of Reasonable Assurance on the provision of adequate resources to undertake Clinical Audit and on the monitoring and reporting of audit outcomes.

As part of the recommended actions from the Internal Audit report audit leads across the organisation have been asked to consider the resources they have available for clinical audit, and to select which of the following statements most closely matches their situation.

The (name of service) feels that;

- 1) We have sufficient capacity to do any audit that we feel is worth undertaking
- 2) We have capacity to do mandatory or important safety audits but lack the internal capacity to do all the audits we would like to
- 3) We struggle to complete even those audits that we feel should be a priority
- 4) Its more complicated – we feel our position is (add reply)

The results of this survey will be included in the future reports and will help identify if more support is needed.

It is planned that a formal audit forum will be established during 24/25 where audit findings and learning can be shared more widely across our MDTs.

### **RECOMMENDATIONS:**

That the Experience Quality and Safety Committee notes and agreed the content of this report.

Patterson Liz  
12/04/2024 09:50:30

## Clinical Audit Plan 2024/25

Nursing (Ward and Community)					
Driver	Audit Title	Start Date		Lead	End Date
Local Audits for Service Improvement	Health & Care Monitoring Tool (Includes Hand hygiene audits & Patient surveys, ward cleaning)	Monthly	Nursing (Wards)	Ward Managers	Quarter 4 2024/25
Local Audits for Service Improvement	NEWS Audit	Monthly	Nursing (Wards)	Ward Managers	Quarter 4 2024/25
Local Audits for Service Improvement	Wristband Audit	Monthly	Nursing (Wards)	Ward Managers	Quarter 4 2024/25
Local Audits for Service Improvement	Dols Audit	Monthly	Nursing (Wards)	Ward Managers	Quarter 4 2024/25
Local Audits for Service Improvement	Environmental Audit	Monthly	Nursing (Wards)	Ward Managers	Quarter 4 2024/25
Local Audits for Service Improvement	Welsh Language Audit	Monthly	Nursing (Wards)	Ward Managers	Quarter 4 2024/25
Local Audits for Service Improvement	DNACPR Audit	Monthly	Nursing (Wards)	Ward Managers	Quarter 4 2024/25
Local Audits for Service Improvement	Multi-factorial Falls Risk Assessment Audit (Inpatients)	Quarter 2 2024		Ward Managers	Quarter 4 2024/25

Specialist Nursing					
Driver	Audit Title	Start Date		Lead	End Date
Other National Audit & Service Evaluation	Parkinson's UK National Audit	2 yearly (Completed Nov 2022)	Specialist Nursing – Parkinson's Disease	Parkinson's Disease ANP	Quarter 4 2024/25
Local Audits for Service Improvement	Pressure Damage Audit	Quarter 2 2024	Specialist Nursing – Tissue Viability Nurse	Senior Nurses	Quarter 4 2024/25
Service Evaluation	Clinic PREM Data	Monthly	Specialist Nursing - Continence	Continence Service Manager	Quarter 4 2024/25
Service Evaluation	Prescribing Data	Quarter 1	Specialist Nursing - Continence	Continence Service Manager	Quarter 4 2024/25

Service Evaluation	Transition Clinic PREM Data	Biannual (New) Quarter 2	Specialist Nursing - Continence	Continence Service Manager	Quarter 4 2024/25
Service Evaluation	Pad PREM	Biennial 2024	Specialist Nursing - Continence	Continence Service Manager	Quarter 4 2024/25
Service Evaluation	COBWEB PREM	Biennial 2024	Specialist Nursing - Continence	Continence Service Manager	Quarter 4 2024/25
Service Evaluation	CIVICA/PREMS clinic data	Monthly	Specialist Nursing - Cardiology	Cardiology Team Lead	Quarter 4 2024/25
Other National Audit & Service Evaluation	National Audit of Cardiac rehab/PROMS	Annually	Specialist Nursing - Cardiology	Cardiology Team Lead	Quarter 4 2024/25
Service Evaluation	CROMS data	Monthly	Specialist Nursing - Cardiology	Cardiology Team Lead	Quarter 4 2024/25
Local Audits for Service Improvement	Quality Assurance Audits for ECHO scans at neighbouring DGH.	Monthly	Specialist Nursing - Cardiology	Cardiology Team Lead	Quarter 4 2024/25

Surgery and Endoscopy					
Driver	Audit Title	Start Date	Service	Lead	End Date
Local Audits for Service Improvement	NEWS Audit	Quarter 1 2024	Theatre/Endoscopy	Theatre/Endoscopy Lead	Quarter 3 2024/25
Service Evaluation	Surgical Performance/DNA/Cancellation data	Monthly	Theatre	Theatre Lead	Quarter 4 2024/25
Service Evaluation	Monthly Surgical Utilisation data	Monthly	Theatre	Theatre Lead	Quarter 4 2024/25
Service Evaluation	Surgical Site Infection data	Monthly	Theatre	Theatre Lead	Quarter 4 2024/25
Service Evaluation	Surgical incidents	Monthly	Theatre	Theatre Lead	Quarter 4 2024/25
Service Evaluation	Hand hygiene Audits	Monthly	Theatre	Theatre staff	Quarter 4 2024/25
Service Evaluation	Bi weekly C4C audit	Bi weekly	Theatre	Facilities	Quarter 4 2024/25
Service Evaluation	Legal and ethical audit	Quarter 2 2024	Theatre	Theatre Lead	Quarter 2 2024/25

Service Evaluation	Data protection and GDPR	Quarter 2 2024	Theatre	Theatre Lead	Quarter 2 2024/25
Service Evaluation	Management/Human Resources	Quarter 2 2024	Theatre	Theatre Lead	Quarter 2 2024/25
Service Evaluation	Education	Quarter 2 2024	Theatre	Theatre Lead	Quarter 2 2024/25
Service Evaluation	Five Steps to Safer Surgery	Quarter 2 2024	Theatre	Theatre Lead	Quarter 2 2024/25
Service Evaluation	Managing Perioperative Normothermia	Quarter 2 2024	Theatre	Theatre Lead	Quarter 2 2024/25
Service Evaluation	Risk Management (Organisational and Environmental)	Quarter 2 2024	Theatre	Theatre Lead	Quarter 2 2024/25
Service Evaluation	Decontamination	Quarter 2 2024	Theatre	Theatre Lead	Quarter 2 2024/25
Service Evaluation	Specimen Management	Quarter 2 2024	Theatre	Theatre Lead	Quarter 2 2024/25
Service Evaluation	Tourniquets	Quarter 2 2024	Theatre	Theatre Lead	Quarter 2 2025
Service Evaluation	Use and Handling of Surgical Instruments	Quarter 2 2024	Theatre	Theatre Lead	Quarter 2 2024/25
Service Evaluation	Preoperative care for Patients with Dementia	Quarter 3 2024	Theatre	Theatre Lead	Quarter 3 2024/25
Service Evaluation	Anaesthesia	Quarter 3 2024	Theatre	Theatre Lead	Quarter 3 2024/25
Service Evaluation	Surgical record keeping audit & consent	Quarter 3 2024	Theatre	Theatre Lead	Quarter 3 2024/25
Service Evaluation	Post anaesthetic Care	Quarter 3 2024	Theatre	Theatre Lead	Quarter 3 2024/25
Service Evaluation	Surgical Patient Satisfaction audit	Quarter 3 2024	Theatre	Theatre Lead	Quarter 3 2024/25
Service Evaluation	Electrosurgery	Quarter 3 2024	Theatre	Theatre Lead	Quarter 3 2024/25
Service Evaluation	Fluid Management	Quarter 3 2024	Theatre	Theatre Lead	Quarter 3 2024/25
Service Evaluation	Foreign body aspiration during intubation, advanced airway management or ventilation	Quarter 3 2024	Theatre	Theatre Lead	Quarter 3 2024/25

Service Evaluation	Surgical patient story	Quarter 3 2024	Theatre	Theatre Lead	Quarter 3 2024/25
Service Evaluation	Pre assessment and Specific Day Case Requirements	Quarter 3 2024	Theatre	Theatre Lead	Quarter 4 2024/25
Service Evaluation	Audit of prosthesis verification data	Quarter 3 2024	Theatre	Theatre Lead	Quarter 4 2024/25
Service Evaluation	Intraoperative Care	Yearly Quarter 1 2024	Theatre	Theatre Lead	Quarter 4 2024/25
Local Audits for Service Improvement	Staff Satisfaction	Yearly Quarter 1 2024	Theatre	Theatre Lead	Quarter 4 2024/25
Service Evaluation	Accountable Items, Swab, Instrument and Sharps Count	Yearly Quarter 1 2024	Theatre	Theatre Lead	Quarter 4 2024/25
Service Evaluation	Individual Endoscopist KPI's	TBC	Endoscopy	Clinical Lead Endoscopy	TBC
Service Evaluation	Gastric ulcers rescoped within 12 weeks	Quarterly	Endoscopy	J Harrison Endoscopy coordinator & S Williams Data/Audit Support	Quarter 4 2024/25
Service Evaluation	Post colonoscopy colorectal cancer rate Links established with Cwm Taf Morgannwg University Health Board MDT. If we are made aware – root cause analysis carried out	TBC	Endoscopy	Clinical Lead Endoscopy	TBC
Service Evaluation	Patient Satisfaction survey	Monthly	Endoscopy	Jane Harrison Endoscopy coordinator & S Williams Data/Audit Support	Quarter 4 2024/25
Service Evaluation	Staff survey	Yearly Quarter 1 2024	Endoscopy	Jane Harrison Endoscopy coordinator & S Williams Data/Audit Support	Quarter 4 2024/25
Service Evaluation	Endoscopist satisfaction survey	Yearly	Endoscopy	Clinical Lead Endoscopy	Quarter 4 2024/25

		Quarter 1 2024			
Service Evaluation	Endoscopy Performance e.g DNA cancellations no of procedures late start early finishes	Monthly	Endoscopy	S Williams Data/Audit Support	Quarter 4 2024/25
Other National Audit Programme	Bowel Screening Wales User Experience Survey results	Yearly Quarter 1 2024	Endoscopy	Clinical Lead Endoscopy	Quarter 4 2024/25
Local Audits for Service Improvement	Record Keeping	Yearly Quarter 4 2024	Endoscopy	Clinical Lead Endoscopy	Quarter 4 2024/25
Service Evaluation	Annual planning & productivity report	Yearly Quarter 1 2024	Endoscopy	Clinical Lead Endoscopy	Quarter 4 2024/25
Service Evaluation	Scope traceability	Currently underway	Endoscopy	Jane Harrison & Tracie Watling	

Therapies and Health Science					
Driver	Audit Title	Start Date	Service	Lead	End Date
Audits performed for accreditation schemes	Compliance with Standard operating procedures	Quarter 1	Radiography	Head of Radiography	Quarter 3
Audits performed for accreditation schemes	Pregnancy Status	Quarter 1	Radiography	Head of Radiography	Quarter 3
Audits performed for accreditation schemes	Correct use of radiographic markers	Quarter 1	Radiography	Head of Radiography	Quarter 3
Audits performed for accreditation schemes	Non Medical Referrals (NMR) Audit of NMR compliance	Quarter 1	Radiography	Head of Radiography	Quarter 3
Audits performed for accreditation schemes	Reject analysis	Quarter 1	Radiography	Head of Radiography	Quarter 3
Audits performed for accreditation schemes	Radiographer commenting audit	Quarter 1	Radiography	Head of Radiography	Quarter 3
Audits performed for accreditation schemes	QA plain film and NOUS / Midwife Sonography	Quarter 1	Radiography	Head of Radiography	Quarter 3

Local Audits for service improvement	QA reporting Audit	Quarter 1	Radiography	Head of Radiography	Quarter 3
Audits performed for accreditation schemes	Monthly Clinispet/Clinel Wipes Audit	Quarter 1	Radiography	Head of Radiography	Quarter 3
Audits performed for accreditation schemes	Sonography Service Audit	Quarter 1	Radiography	Clinical Governance Lead for Sonography	Quarter 3
Audits performed for accreditation schemes	Reporting Radiography Service Audit	Quarter 1	Radiography	Head of Radiography	Quarter 3
Audits performed for accreditation schemes	MIU NMR Audit for appropriate referrals	Quarter 4	Radiography	Head of Radiography	Quarter 4
Audits performed for accreditation schemes	Red Dot Audit	Quarter 3	Radiography	Head of Radiography	Quarter 4
Local Audits for service improvement	Caseload Management	Quarter 1	All AHP and HS	All HOS	Quarter 3
Local Audits for service improvement	Clinical Records audit focusing on consent, goal planning	Quarter 1	Occupational Therapy	Head of OT	Quarter 4
Local Audits for service improvement	Clinical Records audit focusing on consent, goal planning	Quarter 1	SALT	Head of SALT	Quarter 4
Service Evaluation	Quarterly Wax Management	Quarter 1	Audiology	Head of Audiology	Quarter 4
Local Audits for Service Improvement	audiology Inappropriate referrals waiting times/compliance with target	Quarter 2	Audiology	Head of Audiology	Quarter 3
Service Evaluation	Wax Management Audit	Quarter 1	Audiology	Head of Audiology	Quarter 4
Service Evaluation	Inpatient Nutrition Frailty	Quarter 1	Dietetics	Head of Dietetics	Quarter 3
Welsh Government National Audit Programme	Quality Standards Tinnitus Service	Quarter 3	Audiology	Head of Audiology	Quarter 4
Other National Audits	National Diabetes Foot Care Audit	TBC National	Podiatry	Head of Podiatry	TBC National
Local Audits for Service Improvement	Taxonomy compliance audit	Quarter 3	Podiatry	Head of Podiatry	Quarter 4
Local Audits for Service Improvement	Patient Notes	TBC	Podiatry	Head of Podiatry	TBC
Local Audits for Service Improvement	Nail Surgery Consent and Dressing Audit	Quarter 3	Podiatry	Head of Podiatry	Quarter 4
Service Evaluation	Shockwave Podiatry	Quarter 2	Podiatry	Head of Podiatry	Quarter 3

Local Audits for Service Improvement	Implementation of Falls Therapy Practitioner	Quarter 3	Community Therapies	Senior Therapist	Quarter 4
Local Audits for Service Improvement	Implementation of MFA - Falls	Quarter 3	Community Therapies	Senior Therapist	Quarter 4
Service Evaluation	FCP Evaluation - North	Quarter 2	Physiotherapy	Consultant Physio	Quarter 3
Service Evaluation	GTPS Shockwave	Quarter 1	Physiotherapy	Head of Physiotherapy	Quarter 3
Local Audits for Service Improvement	Therapy Outcome Measures Audit	Quarter 1	Speech and Language therapy	Head of Speech and Language therapy	Quarter 4
Other National Audits	National Audit Programme Lymphodema	Quarter 1	Lymphoedema	Team Lead for Lymphoedema services	Quarter 4
Other National Audits	SNAPP Audit	TBC Nationally	Therapies	Head of Service	TBC Nationally
Local Audits following change to policy or procedure	Adherence to clinical supervision policy	Quarter 4	Therapies	Head of Service	Quarter 4

Primary Care Group					
GP Services					
Driver	Audit Title	Start Date	Service	Lead	End Date
	TBC	TBC	GP Surgery	GP Surgery Staff	TBC
	TBC	TBC	GP Surgery	GP Surgery Staff	TBC
	TBC	TBC	GP Surgery	GP Surgery Staff	TBC
Note: The subjects of these audits have been traditionally agreed later in the year.					
Community Dentistry					

Driver	Audit Title	Start Date	Service	Lead	End Date
Local Audits for Service Improvement	Clinical Record Keeping Audit	TBC	Community Dentistry	TBC	TBC
Other National Audit	WHTM01-05 Equipment decontamination audit	TBC	Community Dentistry	Rachel Anwyl	TBC
Local Audits for Service Improvement	Written Consent to treatment audit	TBC	Community Dentistry	TBC	TBC
Local Audits for Service Improvement	Compliance with Acorn and Fluoride application for GDS patients	TBC	Community Dentistry	Heidi Thomas	TBC
Local Audits for Service Improvement	Acorn and contract reform compliance (GDS)	TBC	Community Dentistry	Eva Gough	Sept 2024
Local Audits for Service Improvement	Antimicrobial Stewardship	February 2024	Community Dentistry	Warren Tolley	Sept 2024

Medical Directorate Medicines Management					
Driver	Audit Title	Start Date	Service	Lead	End Date
Identified Risk – Powys has the highest per capita 4C antibiotic prescribing in Wales	4C antimicrobial prescribing in primary care	Quarter 2 2024/25	Medicines Management	Medicines Management Staff	Quarter 3 2024/25
Identified Risk	Allergy status reporting in PTHB community hospitals	Quarter 1 2024/25	Medicines Management	Medicines Management Team	Quarter 3 2024/25
Identified Risk	The completion of Venous thromboembolism (VTE) risk assessments	Quarter 1 2024/25	Medicines Management	Medicines Management Team	Quarter 3 2024/25
Identified Risk	Valproate prescribing Audit of compliance with NatPSA/2023/013/MHRA	Quarter 2 2024/25	Medicines Management	Medicines Management Team	Quarter 3 2024/25

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<b>Nursing Directorate (Corporate Functions)</b>					
<b>Safeguarding</b>					
<b>Driver</b>	<b>Audit Title</b>	<b>Start Date</b>	<b>Service</b>	<b>Lead</b>	<b>End Date</b>
Other National Audit Programme	Safeguarding maturity matrix self-assessment audit	March 24	Safeguarding	Asst. Director of Safeguarding and Public Protection	Sept 24
Local Audits for Service Improvement	Quality of child protection case conference reports audit	Sept 24	Safeguarding	Asst. Director of Safeguarding and Public Protection	Dec 24

<b>Mental Health and Learning Disabilities</b>					
<b>Mental Health</b>					
<b>Driver</b>	<b>Audit Title</b>	<b>Start Date</b>	<b>Service</b>	<b>Lead</b>	<b>End Date</b>
Identified Risk – patients may suffer harm if these assessments are not correctly completed	Audit of Environmental Ligature risk assessments	Quarter 1 2024/25	Mental Health Service	Mental Health Service Staff	Quarter 4 2024/25
Identified Risk – patients may suffer	Audit of WARRN risk assessments	Quarter 1 2024/25	Mental Health Service	Mental Health Service Staff	Quarter 4 2024/25

harm if these assessments are not correctly completed					
Identified Risk – patients may suffer harm if these assessments are not correctly completed	Audit of Security Risk Assessment	Quarter 2 2024/25	Mental Health and Learning Disabilities Service	MH&LD staff	Quarter 4 2024/25
Local Audits for Service Improvement	Audit of Care and treatment plans	Quarter 1 2024/25	Mental Health Service	Mental Health Service Staff	Quarter 4 2024/25
Welsh Government National Audit Programme	NCISH Suicide audit	Quarter 1 2024/25	Mental Health Service	Mental Health Service Staff	Quarter 4 2024/25
Welsh Government National Audit Programme	National review of schizophrenia audit	Quarter 1 2024/25	Mental Health Service	Mental Health Service Staff	Quarter 4 2024/25
Local Audits for Service Improvement	In patient Physical health monitoring audits	Quarter 1 2024/25	Mental Health Service	Mental Health Service Staff	Quarter 4 2024/25
Local Audits for Service Improvement	RCP/NICE quality standards for inpatient care	Quarter 1 2024/25	Mental Health Service	Mental Health Service Staff	Quarter 4 2024/25
Local Audits for Service Improvement	Medicine management audit	Quarter 1 2024/25	Mental Health Service	Mental Health Service Staff	Quarter 4 2024/25
Local Audits for Service Improvement	Hand Hygiene Audit	Undertaken quarterly	In-patient service	Ward Managers	Reported quarterly
Local Audits for Service Improvement	Record Keeping Audit	Quarter 1 2024/25	Mental Health Service	Team Leads	Quarter 4 2024/25
Local Audits for Service Improvement	Did Not Attend Appointment Audit	Quarter 1 2024/25	Mental Health Service	Performance Manager	Quarter 4 2024/25
Local Audits for Service Improvement	Falls Risk Assessment Audit	Undertaken quarterly	In-patient service	Ward Managers	Reported quarterly
Local Audits for Service Improvement	Welsh Language Active Offer Audit	Quarter 1 2024/25	Mental Health Service with Workforce Colleagues		Quarter 4 2024/25
Local Audits for Service Improvement	(Child) Was Not Brought to Appointment Audit	Undertaken quarterly	CAMHS service	CAMHS staff	Reported quarterly
Welsh Government National Audit Programme	Early Intervention in Psychosis Audit	TBC Nationally	CAMHS service	CAMHS staff	TBC Nationally

Local Audits for Service Improvement	Outcome Measures Audit	Quarter 1 2024/25	CAMHS service	CAMHS staff	Quarter 4 2024/25
Local Audits for Service Improvement	LPMHSS Audit	Quarter 1 2024/25	Local Primary Mental Health Support Service (LPMHSS)	Service Manager	Quarter 4 2024/25
Local Audits for Service Improvement	Policy Audit	Quarter 1 2024/25	Mental Health and Learning Disabilities Service	MH&LD staff	Quarter 4 2024/25
Local Audits for Service Improvement	Community Medical Caseload Audit	Quarter 1 2024/25	Mental Health Service	Mental Health Service Staff	Quarter 4 2024/25
Local Audits for Service Improvement	Section 177 Audit	Quarter 1 2024/25	Mental Health Service	Mental Health Service Staff	Quarter 4 2024/25
Local Audits for Service Improvement	Mental Health Act Compliance Audit	Quarter 1 2024/25	Mental Health Service	Mental Health Service Staff	Quarter 4 2024/25
Local Audits for Service Improvement	Adult CMHT MDT Audit	Quarter 1 2024/25	Mental Health Service	Mental Health Service Staff	Quarter 4 2024/25

Women and Children's Service					
Midwifery					
Driver	Audit Title	Start Date	Service	Lead	End Date
Local Audits for Service Improvement	Antenatal Contacts – HCWP (Health Visiting)	Mar 2024	Health Visiting	Assistant Head of Public Health Nursing	Quarter 1
Identified Risk	Was Not Brought - School Nursing.	Jan 2024	Health Visiting	Assistant Head of Public Health Nursing	TBC

Local Audits for Service Improvement	DTP/MenACWY Uptake	Feb 2024	Health Visiting	Assistant Head of Public Health Nursing	Quarter 1
Local Audits for Service Improvement	ChatHealth	Mar 2024 Q4	Health Visiting	Assistant Head of Public Health Nursing	Quarter 1
Local Audits for Service Improvement	Health Visiting & School Nursing CIVICA Audit	Mar 2023 Q3	Health Visiting	Assistant Head of Public Health Nursing	Quarter 1
Local Audits for Service Improvement	Health Visiting CNN Audit	Mar 2023 Q3	Health Visiting	Assistant Head of Public Health Nursing	Quarter 1
Local Audits for Service Improvement	Routine Enquiry (Health Visiting)	April 2024	Health Visiting	Assistant Head of Public Health Nursing	Quarter 1
Local Audits for Service Improvement	HPV Uptake	May 2024	Health Visiting	Assistant Head of Public Health Nursing	Quarter 2
Local Audit for service improvement	Health Visiting CNN Audit	April 2024 Q4	Health Visiting	Assistant Head of Public Health Nursing	Quarter 2
Local Audits for Service Improvement	Health Visiting and School Nursing CIVICA Audit	June 2024 Q4	Health Visiting	Assistant Head of Public Health Nursing	Quarter 2
Local Audits for Service Improvement	ChatHealth	June 2024 Q4	Health Visiting	Assistant Head of Public Health Nursing	Quarter 2
Local Audits for Service Improvement	Routine Enquiry (Health Visiting)	July 2024	Health Visiting	Assistant Head of Public Health Nursing	Quarter 2
Local Audits for Service Improvement	Health Visiting & School Nursing CIVICA Audit	July 2024	Health Visiting	Assistant Head of Public Health Nursing	Quarter 2
Local Audit for service improvement	Health Visiting CNN Audit	July 2024	Health Visiting	Assistant Head of Public Health Nursing	Quarter 2
Local Audits for Service Improvement	Flu Uptake	Oct 2024	Health Visiting	Assistant Head of Public Health Nursing	Quarter 3

Local Audits for Service Improvement	Routine Enquiry (Health Visiting)	Oct 2024	Health Visiting	Assistant Head of Public Health Nursing	Quarter 4
Local Audits for Service Improvement	Health Visiting & School Nursing CIVICA Audit	July 2024	Health Visiting	Assistant Head of Public Health Nursing	Quarter 3
Local Audits for Service Improvement	Record Keeping – Health Visiting and School Nursing	Nov 2024	Health Visiting	Assistant Head of Public Health Nursing	Quarter 4
Local Audit for Service Improvement	Recording Keeping – Sexual Health Services	April 2023	Sexual Health	Sexual Health Clinical Lead	Quarter 1
Local Audit for Service Improvement	Routine Enquiry – (Sexual Health)	April 2024	Sexual Health	Sexual Health Clinical Lead	Quarter 3
Local Audit for Service Improvement	All Wales Handheld Maternity Records	April 2024	Maternity	Clinical Supervisor of Midwives	Quarter 2
Local Audit for Service Improvement	Intrapartum Transfers from Powys to DGH	April 2024	Maternity	Research Midwife Consultant Midwife	Quarter 2
Local Audit for Service Improvement	Clinical Information Sharing Caseload	April 2024	Maternity	Consultant Midwife	Quarter 2
Local Audit for Service Improvement	Record keeping – WCCIS Clinical Assessment form	April 2024	Maternity	Endometriosis Clinical Nurse Specialist	Quarter 3
Local Audit for Service Improvement	ADHD medication monitoring audited against NICE guidelines/new SOP	Quarter 3-4	Community Paediatrician	Paediatrics	Quarter 4
Local Audit for Service Improvement	Monitoring for Children and YP with Down Syndrome	Quarter 2	Community Paediatrician	Paediatrics	Quarter 3
Local Audit for Service Improvement	Children and YP with Cerebral Palsy – monitoring including hips (CPIPs), timely diagnosis. And review	Quarter 4	Community Paediatrician and Physio CPIP lead	Paediatrics	Quarter 4

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Audit Driver Key:

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

Progress Key:

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

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**GIG**  
CYMRU  
**NHS**  
WALES

Bwrdd Iechyd  
Addysgu Powys  
Powys Teaching  
Health Board

**Agenda item: 2.4**

<b>Patient Experience Quality Safety Committee</b>		<b>DATE</b> 16 April 2024
<b>Subject:</b>	<b>Joint Inspection of Child Protection Arrangements (JICPA)</b>	
<b>Approved and presented by:</b>	Executive Director of Nursing and Midwifery	
<b>Prepared by:</b>	Assistant Director of Nursing, Safeguarding	
<b>Other Committees and meetings considered at:</b>	Executive Committee 3 April 2024.	
<b>PURPOSE:</b>		
To update the PEQS Committee on the Joint Inspection of Child Protection Arrangements (JICPA) report and the four specific actions for PTHB.		
<b>RECOMMENDATION(S):</b>		
The Patient Experience, Quality and Safety Committee are asked to;		
<ol style="list-style-type: none"> <li><b>NOTE</b> the Joint Inspection of Child Protection Arrangements (JICPA) report and findings.</li> <li><b>NOTE</b> the improvements identified for PTHB and Take <b>ASSURANCE</b> from the arrangements for monitoring progress.</li> <li><b>NOTE</b> the arrangements for monitoring the multi-agency whole system improvement plan.</li> </ol>		
<b>Approve/Take Assurance</b>	<b>Discuss</b>	<b>Note</b>
N	Y	Y

<b>ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:</b>		
1. Focus on Wellbeing	Y	
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	N	
7. Put Digital First	Y	
8. Transforming in Partnership	Y	

## EXECUTIVE SUMMARY:

Between 16 and 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 scope of the JICPA was to review:

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

The final JICPA Report was published on 1 February 2024 attached as appendix 2.4a and linked here - [PDF Powys JICPA Report - Final.pdf](#)

Strengths and areas for improvement were identified for the partnership and individual agencies. A whole system improvement plan which identifies multi agency and individual agency actions has been submitted by the Head of Childrens Services for Powys County Council to CIW. The plan may inform the lines of enquiry at any future joint or single agency activity by the inspectorates.

The whole system improvement plan will be monitored within Powys Local Multi-Agency Safeguarding Operation Group which reports quarterly to the Mid and West Wales Regional Safeguarding Board. The Assistant Director of Nursing for Safeguarding attends both meetings.

The JICPA identified four specific actions for PTHB which have been translated into a PTHB improvement plan which will be managed within the Safeguarding Operational Group and will report progress quarterly to the Safeguarding Strategic Group. This will then report through to the Executive Committee and Patient Experience and Quality Committee.

## 1. PTHB Improvement Plan

### Improvement No 1

Whilst there is evidence of commitment to a learning culture, compliance with level 3 safeguarding children training is significantly lower than the national target of 85%. (59% at time of JICPA).

Improvement Required	Actions	By when	By whom	BRAG
To achieve the national target of 85% compliance with Level 3 Safeguarding Children Training	Continue to report overall Compliance at quarterly Safeguarding Strategic and operational Group. This can be further broken down to service group level which will help guide a supportive approach where required	March 24	SGT	Completed
	Complete a one-off review of then names and job roles of all staff who have not completed the L3 training. This will be shared will line managers, with an expectation staff will be supported to put a plan in place on how compliance can be achieved within 9 months	March 24	SGT	Completed
	Review Each quarter Who has attended L3 training and not completed a passport within the time scale. Process to be put in place to send a reminder to the staff member and escalate to line manager if no response to email received. There will be an expectation the staff member will be supported to put a plan in place to achieve compliance within 3 months. New process to be shared with operation managers via email and in safeguarding operational group	March 24	SGT	Completed
	Develop a new reporting form into SSG that supports managers' report their individual team's compliance and show the trend over time	May24	SGT	On track

### Improvement No 2

The health board's safeguarding team (SGT) need to raise awareness of the triggers for requesting one-to-one case specific supervision in complex cases, where there is drift or disguised compliance in line with the PTHB safeguarding supervision policy.

Improvement Required	Actions	By when	By whom	BRAG
PTHB Staff to be reminded of the safeguarding supervision trigger list and for its use to become custom and practice.	Trigger list to be promoted within team meeting, via a memo to all staff, during ad-hoc, 1:1 and Group Supervision	March 24	SGT	Completed
	Set up a process to review of all children known to be on the Child Protection Register for 15 months or more. This will commence April 2024 and will be repeated quarterly. Communicate review process across services groups	April 24	SGT	Completed

### Improvement No 3

Owing to its geographical location, children in Powys frequently require access to healthcare services across borders. The different Information Management Systems in place can introduce risks associated with communicating safeguarding information. It is imperative for the health board to incorporate an acknowledgment of these risks, along

with their corresponding mitigation strategies, into both the Safeguarding Maturity Matrix (SMM) improvement plan and the Risk Management Plan.

Improvement Required	Actions	By when	By whom	BRAG
Information and reports regarding children accessing healthcare outside of the health board will be available for staff to view and use to inform their ongoing assessments and plans	Work with PTHB Commissioning dept, Informatics and Service Groups to undertake a gap analysis.	Aug 24	IT, Services Groups, and Commissioning	Not started
	Reference this work within PTHB's 2024/25 Safeguarding Maturity Matrix	June 24	SGT	On track

#### Improvement No 4

Multiple IT recording systems used within the HB can make finding and sharing relevant safeguarding information challenging for staff. This was supported by 40% of the 114 health survey responses. It presents a risk that key information could be missed, or multi agency key decisions might be made without the relevant health information.

Improvement Required	Actions	By when	By whom	BRAG
To review staff views regarding the challenges they face. Await outcome and formulate a plan once review complete.	Undertake sessions with staff to understand the survey results which will inform next steps	July 24	SGT & Service Groups	Not started
	Review guidance to staff regarding how and when to use the significant event tracker, remind staff of the importance to use and review it.	July 24	STG	On track
	Continue quarterly review of staff's use of significant event tracker	April 24	SGT	Completed

#### NEXT STEPS:

1. Take forward the PTHB specific action plan and report progress quarterly to the PTHB Safeguarding Strategic Group, Executive Committee and Patient Experience and Quality Committee

2. Work with our multi agency partners on the whole system improvement plan and report progress to the Mid and West Wales Safeguarding Board via the Powys Local Multi-Agency Safeguarding Operation Group.

## IMPACT ASSESSMENT – ASSESSMENT NOT REQUIRED

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

### QUALITY:

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

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.

### EQUALITY:

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

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.

### RISK ASSESSMENT:

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

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 County Council, Powys Teaching Health Board, Dyfed Powys Police

## Report of Joint Inspection of Child Protection Arrangements

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Mae'r ddogfen yma hefyd ar gael yn Gymraeg.  
This document is also available in Welsh.

## **Introduction**

Between 16 and 20 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 the multi-agency response to abuse and neglect of children in Powys.

This report outlines our findings about the effectiveness of partnership working and of the work of individual agencies in Powys.

### **Scope of the inspection**

The Joint Inspection of Child Protection Arrangements (JICPA) reviewed:

- 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
- protecting 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

We have endeavoured to use plain language to describe the findings from the JICPA. We refer to several terms throughout the report which are defined as follows:

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## **Terms of reference**

**ACEs** - Adverse Childhood experiences

**CAMHS** - Child and Adolescent Mental Health Services

**CASPP** - Care and Support Protection Plan

**CLA** - Children Looked After

**CME** - Children missing in education

**CP/ CPR** - Child Protection/ Child Protection Register

**CRU** - Central referral unit (police)

**DPP** - Dyfed Powys Police

**DSL** - Designated Safeguarding Lead is the person appointed to take lead responsibility for child protection issues in schools.

**EHE** - Elective home education

**ELSA** - Emotional Literacy Support Assistant is a social and emotional intervention programme delivered by trained staff in primary and secondary schools.

**ESR** - Electronic Staff Record

**FCC** - Force Communications Centre (Police)

**FCR** - Force Control Room (Police)

**IAA** - Information, Advice and Assistance

**IRO** - Independent Reviewing Officers

**MARAC** - MARACs are Multi Agency Risk Assessment Conferences. They are regular meetings of professionals who discuss how to help individuals who are most at risk of serious harm due to domestic violence and abuse.

**MIU** - Minor Injuries Unit

**NICHE** - The police intelligence and information system

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**Operation Encompass** - Operation Encompass is a partnership between police and schools, a school can only join if the local police force has already joined Operation Encompass. One of the principles of Operation Encompass is that all incidents of domestic abuse are shared with schools, not just those where an offence can be identified.

**PCC or LA** - Powys County Council or Local Authority

**Philomena protocol** - An agreement between the local authority, the police, and providers of children's residential care about steps to be followed by care staff if they are concerned about children not being at home.

**PPN** - Public Protection Notices

**PTHB** - Powys Teaching Health Board

**PRUDIC** - Procedural Response to Unexpected Death in Childhood

**Section 47 (S47)** - Under Section 47 Children Act 1989, a local authority has a duty to investigate if it appears to them that a child in its area is suffering or is at risk of suffering significant harm.

**SoS** - Signs of Safety approach is a relationship-grounded, safety-organised approach to child protection practice, created by researching what works for professionals and families in building meaningful safety for vulnerable and at-risk children.

**TAC** - Team around the Cluster (TAC) model aims to support schools to identify and support families earlier when the needs arise by collaboration with key partners.

**UASC** - Unaccompanied Asylum-Seeking Children

**WSP** - Wales Safeguarding Procedures detail the essential roles and responsibilities for practitioners to ensure that they safeguard children and adults who are at risk of abuse and neglect.

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## 1. Summary

Safeguarding organisations in Powys have systems and arrangements in place for effective joint working when children are considered at risk of abuse or neglect. Senior leaders in the local authority, police and health boards demonstrate a joint approach to regional safeguarding arrangements. Leaders and managers have established a highly positive culture of joint multi-agency working.

We generally found effective information sharing between agencies resulting in appropriate referrals to children's services. However, the multiple recording systems in the health board can sometimes make the finding, and sharing, of relevant safeguarding information a challenge for staff. The Mid and West Wales Regional Safeguarding Board covers four local authorities and two health boards. Useful regional threshold guidance helps professionals analyse risk when submitting a referral, or duty to report. In general, a shared understanding about how to respond to harm is evident across partner agencies.

Opportunities for partnership working are positively taken up. There is good representation and contribution from key partners at strategy discussions, meetings, and case conferences. Actions usually happen within appropriate timescales, with support and protection in place to meet children's needs. Multi-agency contribution is evident in addressing the child's safety through care and support protection plans (CASPP).

Schools across Powys work well with a wide range of services to support children and families. There is good multi-agency attendance and participation in child protection meetings arranged under the Wales Safeguarding Procedures (WSP). This includes the initial and review child protection case conference and core groups. Parents spoke highly about school support and pupil well-being and safety is a high priority across all schools.

In common with many areas across Wales, the ability to recruit and retain key staff is impacting on children's safeguarding arrangements. This is exacerbated by the high demand on services and the increasing complexity of children and families' needs. In social services, agency staff have bolstered workforce resilience, but there are plans in place, with some success, to safely reduce reliance on agency staff and make permanent appointments.

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## **2. Key findings and evidence**

### **2.1 Well-being**

#### **Partnership Arrangements**

##### **Strengths**

Professionals accurately identify children in need of help and protection. The safeguarding organisations respond promptly and effectively to meet these needs, especially where acute risk is identified. For example, we saw practitioners arranging strategy meetings and visits to children at short notice to ensure their welfare. Healthcare professionals frequently attend initial strategy discussions. The subsequent planning was focused and based on a good exchange of information across agencies.

There is good multi-agency attendance and participation in child protection meetings arranged under the Wales Safeguarding Procedures (WSP). Partners understand their roles and responsibilities in relation to safeguarding children well. Strategy meetings and child protection conferences are effective forums for information-sharing, planning and decision-making. Information from these meetings is recorded on police systems so it can be used in responses to future incidents. This is essential for ongoing monitoring and reviewing safety.

##### **What needs to improve**

There is a clear process in place to support professionals making safeguarding referrals about children. However, referrers are not consistently told about the outcome or the rationale supporting subsequent decisions. Following the conclusion of a Section 47 enquiry, outcome strategy meetings are not always arranged. This can result in missed opportunities to share essential information and discuss the outcome of the enquiry. This doesn't comply with the expectations of the WSP.

Children's voices, wishes and feelings are promoted at child protection conferences by professionals, but rarely through children's direct contribution to the conference.

##### **Strengths**

#### **Powys Teaching Health Board**

The pathway for child protection medical examination is clear and has been shared with relevant professionals. All child protection medical reports are reviewed jointly by the named doctor for safeguarding and senior members of the safeguarding team. This is to ensure consistency of examination from all commissioned services. A new initiative to discuss all child protection medicals in a multi-agency forum is

planned to commence in January 2024. This is in line with the Royal College of Paediatric and Child Health Standards.

School nurses and health visitors are notified of children attending Minor Injuries Units (MIU) and where there are concerns, MIU staff can access recording systems to check if a child's name is flagged as on the child protection register (CPR).

School nurses complete a holistic health assessment when a child's name is placed on the CPR. Health representatives regularly attend and contribute to strategy meetings, conferences, and core group meetings. A child's General Practitioner (GP) is invited to attend child protection conferences and is provided with feedback in relation to registration, recommendations, and conference minutes. GP practices routinely flag the records of children whose names are on the CPR, and the safeguarding team update the out of hours GP system daily. GP's provide reports to conference, though this is often a printout of consultations or immunisations.

The safeguarding team share relevant information they receive from police with key healthcare professionals and GP practices. Overall, GPs know which children are looked after by the local authority or named on the CPR.

The child protection reports we reviewed were timely and appropriate. We found evidence of key safeguarding assessments and subsequent documentation within the clinical records, and these were updated accordingly. Healthcare staff felt well supported by the safeguarding team to challenge decisions on a child's behalf if required.

It was positive to find that when an adult is admitted to the health board's mental health services, as part of the initial assessment process, consideration is given to any children associated to the patient, and whether there is a history of domestic abuse. When the patient is discharged, a Risk Enablement Panel is convened, which includes a discussion as applicable, regarding the safety of any children who may be residing or visiting the patient's home. This demonstrates a proactive approach to risk management.

## **Education**

Parents spoke highly about the support they receive from schools. Schools prioritise pupil well-being and safety. For example, schools support with childcare, pupil's personal hygiene, and provision of free school trips. Teachers plan purposeful activities about the importance of healthy and safe relationships, including how to stay safe online. In all schools visited, pupils felt happy, well cared for, safe and listened to. They all gave relevant examples of how school staff keep them safe and develop their understanding of having positive emotional and mental health.

Schools say they receive valuable support and advice from children's services when referring new concerns. School staff feel listened to and able to challenge decisions. Many schools report that relevant agencies within the local authority are forthcoming in sharing information with them when it is necessary. Schools are well represented in a wide range of multi-agency meetings. The role of the Designated Safeguarding Lead (DSL) in schools is particularly effective in bridging children's services and education. This ensures relevant information is shared with schools and that there is consistent support for headteachers with their queries.

Processes and systems have greatly improved over the last few years. There has been a strengthening of safeguarding culture at a corporate and school level. The schools' service is the strategic link between the local authority as a whole and schools. Local authority education officers at all levels understand their roles and responsibilities in respect of keeping learners safe.

### **Dyfed Powys Police**

The force records allegations of crimes effecting children and assigns them without delay to investigating officers. Investigating officers make effective safeguarding plans and use bail conditions to protect vulnerable children and their families.

The Force Communication Centre (FCC) managers routinely sample calls to make sure the risk assessments are accurate and are responded to appropriately. FCC managers train their personnel to research information on the force's systems to back up their decisions.

The FCC system identifies previous calls and incidents at addresses. The system includes risk markers for vulnerable children, such as those on the CPR. This information helps personnel to assign the right level of response. It means many vulnerable children are identified at an early stage, and relevant information is sent to responding officers to help them assess the risk to children, for example, from domestic abuse. Warning markers on the system alert officers about the locations of persons who are a risk to children, such as registered sex offenders. FCC managers check that these markers are accurate. But we saw some markers for children who were no longer on the CPR were still on the force system.

The specialist intelligence personnel in the FCC use local and national information to support frontline responses when children are thought to be at risk of harm. Such as those who are missing, being trafficked, and exploited.

We found that FCC personnel don't routinely prompt responding personnel to record the voice of the child when they attend a domestic abuse incident. But when we raised this, the FCC manager immediately issued new guidance to staff with instructions, *'Can I remind you to use your body-worn video and please remember to capture the voice of the child'*.

The Force and the Police and Crime Commissioner support a scheme where youth workers complete return home interviews with children who have been missing. The

information the youth workers get from the children is used to update risk management plans for these children.

## **Children's Services**

Skilled practitioners assess situations effectively, balancing what is working well for children with any risks and concerns, and closely tracking change and progress. We saw consistent evidence of direct work with families including well-run family network meetings to support people. Newly created innovative posts such as well-being officers help support the delivery of care and support plans.

Children's assessments are comprehensive and include historical and situational context. Complex family situations are well understood and documented in reports. Care and support plans incorporate a positive use of support services. Practitioners use case summaries and chronologies to develop an understanding of the child's lived experience.

Children's services practitioners use the Signs of Safety approach to child protection. Improvements could be made to support the model, including through more proportionate recording which succinctly captures information about strengths and risks. Plans are in place to review the child protection forms to make them more child friendly and to improve engagement with children and families.

When plans do not sufficiently reduce the risk of harm for children, appropriate decisions are taken to escalate. Parents receive clear letters helping them understand what needs to change for children to remain safely in their care prior to public law outline proceedings.

## **What needs to improve**

### **Powys Teaching Health Board**

Multiple IT recording systems used within the health board can make the finding and timely sharing of relevant safeguarding information challenging for staff. This was supported by 40% of 114 health care staff survey responses. It presents a risk that key information could be missed, or multi-agency decisions might be made without the availability of all relevant health information.

## **Education**

It is positive that schools now complete annual safeguarding audits. The local authority officers have quality assurance processes in place which are at an early stage of development. There is further work to be done to improve the effectiveness

of these school audits to drive improvement. For example, linking fixed-term exclusion figures to the safeguarding audit.

A small number of headteachers noted that they are not routinely invited to take part in strategy discussions or meetings concerning their pupils. A few schools noted that although the police adhere systematically to Operation Encompass to share information about domestic abuse incidences, they do not always share information about offences involving their pupils in the community.

In a very few cases, frontline professionals in children's services do not have a clear enough understanding of how schools work. To this end, beneficial joint professional learning would further strengthen the working relationship of all professionals.

### **Dyfed Powys Police**

Staff working in children's homes make many reports of children missing to the police. Often the same child is reported missing repeatedly. Children's carers are responsible for making the initial enquiries to locate children who have not returned home. But on too many occasions, these basic enquiries are not done before they are reported as missing to the police. The Philomena protocol<sup>1</sup> is inconsistent and underdeveloped in Powys.

Inappropriate reports of missing children can stigmatise looked after children who feel they are treated differently by professionals. It also diverts police time and resources from dealing with other high-risk incidents. In other areas where the Philomena protocol has been implemented, there are reductions of up to one third in looked after children being reported as missing.

The force policy for recording information about missing children on public protection notices (PPNs) is inconsistent. In October 2023, personnel didn't complete PPNs for 43 of the 73 missing children. It means that in too many cases information which can help the force find a child quickly isn't recorded on force systems or shared with safeguarding partners.

### **Children's Services**

Children whose names are on the CPR are not always seen alone in accordance with the expectations set out in the WSP. We found occasions when child protection visits were mainly announced; it is important some visits are unannounced to provide a balanced perspective of the child's quality of life.

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<sup>1</sup>**Philomena protocol:** An agreement between the local authority, the police, and providers of children's residential care about steps to be followed by care staff if they are concerned about children not being at home.

We found limited evidence to confirm that the Welsh active offer is consistently being made, other than at the first point of contact via the automated response. Managers informed us Welsh speaking practitioners are available but further work is required to ensure people's language preference is recorded and facilitated. We found variable practice in relation to recording and considering a child's ethnicity and religion, in addition to recording who has parental responsibility for the child.

## **2.2 People**

### **Partnership arrangements**

#### **Strengths**

Leaders and managers understand the prevalence of need and risk in their area. They have a good understanding of the experiences of children and families who need help, and they work together to plan strategically for this. A child-centred approach is evident at an operational level particularly when children are seen in school.

We found competent and experienced professionals working in child protection in Powys. Despite the context of increasing volume and complexity of work, we found good operational relationships. There is commitment to continuous improvement with robust scrutiny and learning processes in place. This includes thorough child practice reviews, incident reporting, and promoting a culture of continuous learning and openness.

The police and other safeguarding organisations work effectively in several themed multi-agency risk management meetings. Such as the multi-agency risk assessment conferences (MARAC) for domestic abuse, multi-agency public protection arrangements (MAPPA) for sexual and violent offenders, the multi-agency exploitation meeting (MACE) and a weekly meeting to manage the risk for missing children.

#### **What needs to improve**

There has been a large increase in the population of electively home educated (EHE) children in the region and we consider this may represent a risk to some of these children. The EHE guidance<sup>2</sup> from Welsh Government outlines an overriding objective for agencies to ensure that these children's development is protected from significant harm. This area requires a multi-agency response to provide assurance about the safety of children in these arrangements.

The police force contributes to some multi-agency child protection audits. An example is the audit of incidents where children were taken into police protection

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<sup>2</sup> [Elective Home Education Guidance \(gov.wales\)](https://gov.wales/elective-home-education-guidance)

across the Mid Wales area. Multi-agency audits need to be completed routinely to disseminate the good practice we have seen from some agencies in this area.

## **Strengths**

### **Powys Teaching Health Board**

Due to its geographical location, the health board commissions all tertiary care. Within the contract with the commissioned service, the health board's safeguarding team sets out the minimum safeguarding processes expected for its population using cross border services.

The health board demonstrates full commitment to working in partnership in all areas of safeguarding, both at an operational and strategic level. The health board's safeguarding team is a valued resource, offering support, advice, supervision, and training to staff. This was supported by almost 96% of the 114 healthcare staff surveyed, who said they felt supported when they have a concern regarding a child's safety or well-being.

We also found the health board responds proactively to learning from practice reviews, such as, Child, Adult and Domestic Homicide Reviews. Examples of this include newsletters, training videos, and expansion of domestic abuse routine enquiry into sexual health clinics and minor injuries units. All referrals from healthcare staff are sent to the safeguarding team for information and quality assurance. The safeguarding team offer support via a debrief session when staff attend Procedural Response to Unexpected Death in Childhood (PRUDIC) meetings and a referral to external support via the third sector organisation [2Wish](#).

The health board demonstrates a commitment to continuous improvement, which is evident through the scrutiny and learning processes in place. This includes reviews of serious incidents, concerns, reports, and the shared learning from this. Operational and strategic meetings have a clear governance structure, with effective monitoring of improvements and actions, and generally completed within appropriate timescales.

We found the voice of the child; their wishes and feelings were highlighted in the healthcare records. There are several initiatives in place to capture the voice of the child. These include the provision of QR codes for children looked after (CLA) and their carers to access, to feedback on their experiences, and school nurse initiatives including 'CHAT', where young people can text the school nurse for advice and support.

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We found that the children's records seen contained genograms<sup>3</sup> and chronologies, and the healthcare assessments highlighted the religion, ethnicity and first language of a child. There was evidence of staff advocating for the health and social care needs of children, and we found positive efforts to involve family members and wider support networks in decisions being made about children.

## Education

The Director of Education has a clear, strategic, and well considered vision to ensure schools are safe, and supportive learning environments for the children and young people of Powys. This vision is shared effectively across all service areas. The high priority given to safeguarding across the local authority has strengthened the understanding that it is everyone's responsibility.

Senior management restructure has resulted in clear roles and responsibilities. This allows for effective working arrangements which maximise the capacity of the local authority officers well. The interim Chief Executive places a high priority on the safety and well-being of pupils. Together with the Director of Education and heads of service they maintain a clear focus on safeguarding. The lead elected member demonstrates a high priority and commitment to safeguarding as a key focus for the local authority.

There has been beneficial work developed around, for example, Children Missing in Education (CME) which has been underpinned by the CME policy completed in September 2023. The policy has purposeful information which is helping to increase awareness of CME processes and ensure cases are reported and resolved appropriately.

School leaders are confident in the safeguarding support and guidance they receive from the local authority. Partnership working has been strengthened recently, and this allows for more effective sharing of information to support pupils and families. For example, the Team Around the Cluster (TAC) approach is viewed as a strength by schools. Schools highly value the support and advice from the local authority education safeguarding manager and the wider safeguarding team. The capacity of this service has been further strengthened recently and is viewed by schools as extremely positive.

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<sup>3</sup> **Genogram** - This is in effect a family tree covering two to three generations. It is an effective, visual tool that helps practitioners and families understand familial relationships Using established symbols and connecting lines family members work with practitioners to depict develop a graphical representation of their inter-and intra-generational family structure.

[Safeguarding Wales](#)

School staff undertake regular safeguarding training at the appropriate levels, and this normally includes governors. Relevant school staff also have child protection, PREVENT and violence against women, domestic abuse, and sexual violence (VAWDASV) training. School designated safeguarding leads (DSL) highly value the support, guidance, and training opportunities from the local authority. For example, the training to support staff in completing multi-agency referral forms.

The local authority expects all governors and elected members to undertake safeguarding training. As a result, they have a deeper understanding of safeguarding arrangements and are better equipped to offer support and challenge in their schools. Governors are beginning to have an increased involvement in the safeguarding audit tool processes in their schools. Where practice is effective, governors can hold schools to account in meeting the safeguarding audit action plan.

### **Dyfed Powys Police**

Police leaders understand the importance of their personnel speaking to children and recording their voices. Positively we saw no police records with victim blaming language.

A senior police leader chairs the daily management meeting. They check domestic abuse incidents and records for the recording of children's voices. They also scrutinise the recent force responses to high-risk incidents, crime, and vulnerability to make sure that the necessary resources and capability is in place.

Police supervisors audit some investigations and PPNs each month. The results are reviewed by managers and personnel are tasked if additional action is needed. These audits provide a useful insight about the quality of the safeguarding services and the focus on outcomes for children. But currently the small numbers audited limit the positive benefits of this practice.

Specialist personnel in the force's central referral unit (CRU) research force systems to complete risk assessments. The CRU follows the multi-agency threshold policy to make referrals to other safeguarding organisations. This process is effective, and we found no delays in sharing information about children who needed help with other organisations.

When officers place children into police protection there is always a strategy meeting. At night, police inspectors hold these with the local authority emergency duty team staff. This means there is a multi-agency approach to safeguarding these children.

But sometimes there are delays in finding these children suitable accommodation meaning they are kept in police stations for too long. The CRU reviews all these incidents to make sure the children remain safe until the incident is resolved.

CRU supervisors hold timely strategy meetings with local authority and health staff. If joint investigations are agreed, these are allocated to investigators who then hold

further strategy meetings with locally based professionals from the other safeguarding organisations. These meetings are well attended but we saw that some of them lacked a focus on the safeguarding priorities.

Positively most detectives in the force are trained specialist child abuse investigators following the College of Policing specialist child abuse investigators development programme.

## **Children's Services**

Corporate support for children's services has been prioritised amongst competing Council demands. There are effective governance arrangements across children's services. This provides visibility on the delivery of duties and risks, coupled with an understanding of the quality of children's experiences. Leaders and managers have an accurate understanding of the quality of practice as data is used in sufficient depth to scrutinise performance. Senior leaders accurately evaluate the performance of children's services with an effective quality assurance framework. Detailed analysis of performance means leaders can target resources where needed.

Senior managers in children's services are visible and supportive. Practitioners spoke positively about the support offered to each other and the ethos of a team approach. We heard about excellent peer support, informal and formal supervision, and approachable and available managers. There is clear investment in newly qualified social workers, with identified management posts in the structure to target support for these workers. Practitioners have access to a clinical psychologist within the local authority. Complex situations can be discussed as a team with psychology input and oversight to help support and upskill staff to achieve positive outcomes for people.

Supervision occurs frequently and promotes staff induction, development, and well-being. In the best examples supervision is reflective, considers the link between research and practice, and promotes opportunities for professional development.

## **What needs to improve**

### **Powys Teaching Health Board**

Whilst there is evidence of commitment to a learning culture, compliance with level 3 safeguarding children training is significantly lower than the national target of 85%. A recent data cleansing of the electronic staff system (ESR) will support the accuracy in recording of compliance data, however, the availability of the safeguarding team to deliver additional training sessions to meet demand is an issue. Therefore, improving access to and compliance with level 3 safeguarding training should be prioritised.

Safeguarding supervision is a self-identified area for improvement by the health board. Consequently, a recent policy change to reduce group supervision from 3 to 6 monthly has been introduced to align with the wider national picture and to support greater compliance. However, there needs to be a greater focus on ensuring the triggers for individual supervision are used, as outlined in the health board's policy, to ensure the safeguarding team has oversight and scrutiny of individuals who meet this threshold.

The health board acknowledges the continuing expansion of its safeguarding responsibilities, such as the new Serious Violence Duty, and the lifting of the cap on numbers of unaccompanied asylum seeker children (UASC). The impact of these changes will require further monitoring to ensure adequate resourcing to meet these requirements.

The health board's safeguarding team need to raise awareness of the triggers for requesting one-to-one case specific supervision in complex cases, where there is drift or disguised compliance in line with the PTHB safeguarding supervision policy.

## **Education**

Processes for monitoring children and young people who are electively home educated (EHE) involving multi-agency working require strengthening as they are at an early stage of development.

There is currently a lack of regular opportunities, facilitated by the local authority, for school designated safeguarding leads (DSL) to meet to support each other, share effective practice and concerns.

## **Dyfed Powys Police**

The force's audits focus on child protection and domestic abuse investigations. These audits are reviewed by senior leaders. But the force would benefit from developing its qualitative focus further. And embedding a stronger audit culture within its routine management practices.

Not all police personnel have received vulnerability training. Frontline personnel responding to incidents don't always speak to the children. So, they don't always record information about these children's demeanour, lived experiences and wishes.

We found police supervisors didn't always direct investigations effectively. There are supervisory entries on records, but these don't always focus on the risk to children.

Such as from repeated incidents or when safeguarding action should be escalated. Some investigations are closed without information about the risks to all the children being considered and shared with other safeguarding organisations.

We found inconsistency in how personnel record information about children on PPNs. Some included the voice of the child, ethnicity, risk, and vulnerability. But some personnel didn't identify the impact of all vulnerability factors, such as a disability, on the lived experience of the child.

PPNs are not consistently used when children are perpetrators. In one incident, a child who was on the CPR was racially abused by other children. This information was not recorded as a separate crime, or on a PPN and shared with other organisations.

Not recording vulnerability on PPNs also means the CRU do not identify other relevant information and inform other organisations about the risks to a child. Some PPNs didn't include other children in the family who were affected by the incident.

## **Children's Services**

In common with many local authorities across Wales, the challenges in recruitment and retention have affected child protection arrangements. We acknowledge recent successes in appointing to managerial posts permanently but do not underestimate the challenge of moving away from a reliance on agency workers. It is positive workloads are manageable, and no children are left unallocated.

Proportionately only a small number of children and young people are attending their child protection meetings. The reasons for this need to be explored further. There is a welcome focus on the participation agenda, including the Momo App, use of advocacy and family network meetings. At a strategic level, the participation agenda does need to be developed further to provide children with opportunities for meaningful input into the design of services.

## **2.3 Partnership and Integration**

### **Partnership Arrangements**

#### **Strengths**

Powys contributes significantly to the Mid and West Wales Regional Safeguarding Board and leads on many aspects of its work, for example, the regional exploitation strategy and training sub-group. Relationships are now well established with clear leadership responsibility across agencies for child protection. For example, the police assistant chief constable attends the Safeguarding Board executive and chairs the force's strategic vulnerability board. This means strategic decision making is informed by both police and partnership information and in consideration of multi-agency priorities. The Junior Safeguarding Board (CYSUR) represents the views of children and young people by actively contributing children's voices at a strategic level.

There are many examples of innovative multi-agency working in Powys. For example, between the local authority and health board with proactive Child and Adolescent Mental Health Service (CAMHS) arrangements and resource for a new joint therapeutic team. There is also the effective commissioning of an organisation to complete the return home interviews for missing children which are detailed and meaningful.

At all levels we found strong and established professional working relationships in child protection. Within the social care staff survey, 47 practitioners rated partnership working as excellent or good (71%), with 25% recording this as adequate. The local authority has a professional support network from which it can draw expertise, knowledge, support, and constructive challenge. We found record keeping in respect of child protection was detailed across agencies. Key stakeholders share valuable information within strategy meetings, core groups, and conferences.

### **What needs to improve**

The frequency of multi-agency training should be increased to ensure there is a consistent approach to safeguarding practice. Police personnel are not benefitting from more regular multi-agency safeguarding training. They do receive some inputs during continuous professional development training from non-police subject matter specialists, such as domestic abuse, but would benefit from joint training. Recent multi-agency training on subjects such as professional curiosity has been welcomed.

The Safeguarding Board covers four local authorities and two health board areas and has a regional threshold guidance which is due to be reviewed. Ensuring a joint understanding of the threshold for significant harm is an area which requires strengthening. Feedback from the safeguarding team in PTHB reported that there has been little to no need to use the dispute protocol which is in place as these are usually resolved at operational level.

For some families, actions outlined in the CASPP need to be progressed more quickly. This is particularly noted in complex family situations with longstanding neglect. Partners need to consistently work together to ensure measurable actions which improve outcomes for children living in these circumstances. Clear supervisory direction is needed in the police force to ensure child abuse investigations are timely and effective and prioritise all the safeguarding issues affecting the outcomes for the children.

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## **Strengths**

### **Powys Teaching Health Board**

There is evidence that CAMHS teams work in close partnership with multi-agency colleagues to safeguard and engage children. It is noteworthy that the presence of senior CAMHS practitioners with backgrounds in social work has markedly enriched the team dynamics and multi-agency collaboration. In one example, a school was able to contact CAMHS for advice around a child's self-harm and together developed a joint risk management plan. We saw CAMHS making continuing efforts to engage with children, including offering to visit the child in school, if the child felt more comfortable with this location.

We found the health board's perinatal service to be robust. The service actively engages collaboratively with various agencies, internal disciplines, and partner agency professionals such as Police, Probation and Social Care. The proactive approach to discussing complex cases during meetings highlights the service's commitment to comprehensive and inclusive care strategies.

## **Education**

There are strong working practices between schools and other agencies such as health and children's services who work effectively in partnership to plan, implement, and review provision for vulnerable children in Powys. This is well supported through the termly Team Around the Cluster (TAC) meetings where multi-agency professionals attend a workshop style event to discuss common issues and agree interventions and support. These meetings are normally well-attended by education staff, CAMHS, school nursing service, Careers, Police, Youth Service.

Schools when invited, attend, and contribute fully to child protection conferences and reviews. Data on the child's attendance, punctuality and attainment are shared in school reports. Parents' contact with schools provides useful intelligence that supports the care and support planning for pupils well. Schools prioritise the importance of safeguarding their pupils and provide a range of purposeful support. For example, establishing a trusted adult for children to have access to, specific intervention programmes and facilitating rooms for social worker visits. Most schools keep appropriate school records, and information is shared when a child moves school suitably.

### **Dyfed Powys Police**

Police personnel contribute effectively to child protection conferences and supply reports to help the multi-agency decision making. But police personnel are not trained in the Signs of Safety approach used by conferences in Powys.

## **Children's Services**

Opportunities to work in partnership are positively led and taken up by children's services. We saw good working relationships between families and professionals. Parents told us they valued the support of children's services with some of their own vulnerabilities, including understanding how their own adverse experiences impact on their parenting capacity. We also heard of difficulties at times with communication and the adverse impact of changes of social workers.

Independent Reviewing Officers (IRO) have a critical role in overseeing the quality of practice and provide a valuable contribution in challenging delays where necessary. They prioritise visits to children prior to children looked after (CLA) reviews, building meaningful and consistent relationships with them. They consult parents in all cases prior to initial and review conferences.

We found in general effective partnerships are in place to commission and deliver good quality support to children and families in Powys despite the geographical challenges. Positive examples were shared of the good outcomes of this work. Third sector partners are clear and confident in their roles but feel their profile could be enhanced across early help.

## **What needs to improve**

### **Powys Teaching Health Board**

Owing to its geographical location, children in Powys frequently require access to healthcare services across borders. The different Information Management Systems in place can introduce risks associated with communicating safeguarding information. It is imperative for the health board to incorporate an acknowledgment of these risks, along with their corresponding mitigation strategies, into both the Safeguarding Maturity Matrix (SMM) improvement plan and the Risk Management Plan.

### **Dyfed Powys Police**

Supervisors are not consistently recording reviews of investigations and giving clear direction on investigative and safeguarding priorities. They don't always act to escalate changes in risks in ongoing investigations. Review strategy meetings aren't always held in a timely way. It means that some investigations can take too long, and investigators don't always fully consider the long-term outcomes for children.

There is inconsistency in how investigators record information for the victim's codes of practice (VCOP) including a victim's needs assessment and informing the child of the outcome of the investigation.

We found some duplicate records of children and family members on the force's system. These need to be identified and reconciled to make sure the force has a clear understanding of the vulnerability and risk for these people.

## **Children's Services**

Records of child protection meetings, such as conferences and core group minutes, are not consistently shared with parents and key partners. This means agencies may not receive key information to enable them to safeguard and support children and families.

Core groups provide regular updates to evaluate progress against children's plans, but there is inconsistency in this area. The link between risk and safety needs to be more explicit, with plans measuring progress rather than the delivery of services.

Signs of Safety is recognised and well used by practitioners and partner agencies, however, with the appointment of newly qualified social workers this could be an opportunity to ensure a model is embedded in practice.

## **2.4 Prevention**

### **Partnership Arrangements**

#### **Strengths**

For all agencies in the current context of increased demand, it is a challenge to prioritise the preventative agenda in a way which reduces the need for more formal care and support. Despite this, many children in Powys benefit from early help with plans evidencing a wide range of statutory, community and voluntary services which are child-focused and are used well to meet children's needs.

There are good relationships between children's services practitioners at the front door and their partners with regular interface as part of child protection procedures. We saw consideration given in general to identifying the needs of other children and adults at risk who may be affected, such as siblings and/or those children in contact with alleged abusers.

At times the availability of partners can be a challenge. Further work is required to ensure the expectations set out in the WSP are consistently adhered to, and the referrer is invited to participate in strategy discussions and/or meetings. Similarly, practitioners from education should always be invited to contribute to strategy discussions if they have worked, or are working, with the child.

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## **What needs to improve**

Despite a range of preventative services which are highly valued, we heard mixed accounts about their co-ordination. We consider arrangements for early help could be clearer, more streamlined, and consistent across Powys, but we understand there is a programme of work to expand this.

In some files we found gaps in analysis about specific and important areas for assessment. This included disguised compliance, parental motivation to change, the differing needs of siblings, and the impact of long-term and chronic harms. This resulted in cases where the individual needs of siblings were not considered in a timely way, and others where the risk of re-referral was not sufficiently managed.

As stated previously, we saw examples where children's plans were not reviewed nor updated in response to further incidents. This presents a missed opportunity to review the risks to children and to update the CASPP accordingly. For some children who have experienced long-term neglect, planning and interventions are ineffective across agencies, with insufficient focus on the safety and well-being of the child.

## **Strengths**

### **Powys Teaching Health Board**

Health board staff use the Signs of Safety approach to formulate conference reports and in safeguarding supervision sessions. They believed this supports holistic health assessments to identify both emotional and physical health needs, as well as wishes and feelings.

Pre-birth meetings occur between children's services and healthcare services in line with the regional pathway. To facilitate communication, a specialist pre-birth social worker and lead safeguarding midwife attend the meetings to provide additional oversight.

Where there are wider risks, there is evidence to support the efforts in risk management and preventative work. For example, Domestic Abuse, County Lines, and serious organised crime involvement.

### **Dyfed Powys Police**

We found locally based personnel work effectively with other organisations to prevent crime and reduce risks to children and families. These personnel have extensive knowledge of their communities, and they know which local children are at risk. The force's 'Intact' initiative involves police and other organisations working jointly to prevent and disrupt crime and anti-social behaviour in communities.

## Education

Pupils feel listened to in schools, they have a strong voice. Vulnerable pupils are well supported to play an active part in school life. They are encouraged to join clubs and are often named persons such as prefects or ambassadors. There is good use of a one-page profile to ensure that pupils have a voice in the design of their support. Where practice is most effective, pupils have trusted adults in school to whom they can turn for advice and support.

Nearly all schools use a good range of strategies to support pupils with anxiety or anger issues to meet their individual needs. Where practice is effective, schools have a well-planned curriculum which teaches pupils the importance of strong mental health and emotional well-being. This supports their school placement and can help to avoid exclusion.

There is evidence of strong support for families from schools, with many employing family liaison officers. Schools provide children and families with a wide range of beneficial interventions to help support pupils' social, emotional, and behavioural development. This includes practical help such as parenting classes, opportunities to develop skills and support to complete forms. There is evidence of parents being consulted appropriately on decisions that affect them and their children.

Innovative work is led by the Educational Psychology Team to support vulnerable pupils in schools including children with neuro diversity issues, pupils with adverse childhood experiences (ACEs), and trauma. In addition, the development of Emotional Literacy Support Assistant (ELSA) for non-verbal pupils is highly beneficial. Nearly all schools are provided with useful and timely advice from social services front door staff.

## Children's Services

Children's services do not have waiting lists across teams and despite the context of increasing volume and complexity of referrals, staff express positivity about improvements made by the authority over the last couple of years. We heard about the support provided by well-being workers, who support social work practice with direct work to de-escalate need. On many occasions, parenting support, trauma informed practice, and crisis intervention were evident within care plans. Practitioners considered the individual needs of children and monitored complex family dynamics.

Despite the demands on the service, performance indicators in relation to statutory duties such as timely child protection conferences and visits are generally good. In the period March 2023 to August 2023, the performance in relation to the number of section 47 enquires complemented within statutory timescales has consistently improved from a dip in April 2023 at 46% to an upward trajectory of above 80% for

all other months. Whilst it is positive that this is an improving picture, the local authority must ensure that it consistently maintains the improvements made in relation to performance in this area.

## **What needs to improve**

### **Dyfed Powys Police**

We found inconsistency in force managers' knowledge about accessing and using child protection performance information. This is partly because the force information systems were recently changed. And the force is also introducing a new system of cloud-based record storage. It means that previous practices of accessing information no longer work. Not all personnel know how to access the force's information systems to support operational planning. For example, in understanding a child's vulnerability after repeated low level incidents and to plan multi-agency interventions to reduce this risk.

### **Children's Services**

We heard there can be challenges around the progress of referrals which are rated a medium priority by the service as urgent contacts are prioritised. A prudent approach to resource allocation is required to ensure the right help is available at the right time. Senior managers should keep under review the resources within the front door/IAA service to ensure the team has sufficient capacity to consistently and effectively respond in a timely manner and to meet the levels of demand.

## **Next steps**

On behalf of the partnership, the local authority should prepare a written statement of proposed action responding to the findings outlined in this report. This should be a multi-agency response involving Powys Teaching Health Board and Dyfed Powys Police. The response should set out the actions for the partnership and, where appropriate, individual agencies. The head of service for children's services should send the written statement of action to [CIWLocalAuthority@gov.wales](mailto:CIWLocalAuthority@gov.wales) by (date to be confirmed as will be 6 weeks after report publication). This statement will inform the lines of enquiry at any future joint or single agency activity by the inspectorates.

## **Methodology**

### **Fieldwork**

Most inspection evidence was gathered by reviewing the experiences of people through sampling agency records and file tracking children's care and support arrangements. We case sampled ten files and tracked six.

Tracking a child's record includes having conversations with the child where appropriate, their family or carers, key worker, the key worker's manager, and other professionals involved.

We held focus groups with staff and two professional groups focused on the working arrangements and outcomes for two of the tracked files.

We visited a small sample of primary, secondary, and special schools where we conducted meetings with the headteacher, the designated safeguarding lead and groups of children.

We interviewed a range of employees across different agencies.

We interviewed a range of partner organisations, representing both statutory and third sector.

We reviewed supporting documentation sent to the inspectorates for the purpose of the inspection.

We administered surveys to children's services staff, third sector organisations, schools and children and family members.

We observed child protection conferences, a child exploitation strategy meeting and practice as part of our inspection activity.

We evaluated samples of health and well-being schemes of work and looked at samples of pupils' work. This included holding a 'listening to learner' sessions in all schools visited.

## **Acknowledgements**

The inspectorates would like to thank the people, staff, and partners who gave their time and contributed to this inspection.

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**GIG**  
CYMRU  
**NHS**  
WALES

Bwrdd Iechyd  
Addysgu Powys  
Powys Teaching  
Health Board

**Agenda item: 2.5**

<b>Patient Experience Quality Safety Committee</b>		<b>DATE</b> <b>16 April 2024</b>
<b>Subject:</b>	Mid and West Wales Safeguarding Board Concise Child Practice Review (CYSUR 3 2021)	
<b>Approved and presented by:</b>	Executive Director of Nursing and Midwifery	
<b>Prepared by:</b>	Assistant Director of Nursing for Safeguarding	
<b>Other Committees and meetings considered at:</b>	Executive Committee 3 April 2024	
<b>PURPOSE:</b>		
To update the PEQS Committee on the Concise Child Practice Review (CYSUR 3 2021) publication, improvements already undertaken and the arrangements for the implementation and monitoring of the Mid and West Wales Safeguarding Board multi-agency action plan within PTHB		
<b>RECOMMENDATION(S):</b>		
PEQS Committee is asked to:		
<ol style="list-style-type: none"> <li>1) <b>NOTE</b> the recommendations within the Concise Practice Review for PTHB</li> <li>2) <b>NOTE</b> the reviews and improvements undertaken to date.</li> <li>3) <b>NOTE</b> the internal process to implement and monitor the PTHB Specific Practice Review Learning within the Safeguarding Practice Improvement Group which reports to the Strategic Safeguarding Group</li> <li>4) <b>NOTE</b> the expected date for the Mid and West Wales Safeguarding Board CPR Multi Agency Action Plan to be shared with Safeguarding Board members</li> </ol>		
<b>Approve/Take Assurance</b>	<b>Discuss</b>	<b>Note</b>
N	Y	Y

<b>ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:</b>		
1. Focus on Wellbeing	N	
2. Provide Early Help and Support	N	
3. Tackle the Big Four	N	
4. Enable Joined up Care	Y	
5. Develop Workforce Futures	N	

6. Promote Innovative Environments	N	
7. Put Digital First	N	
8. Transforming in Partnership	Y	

**EXECUTIVE SUMMARY:**

**1. Executive Summary**

On the 10 October 2020, a 16-year-old female residing in Powys was found deceased in her home. Due to the unexpected nature of her death and the circumstances in which the child was found a Concise Child Practice Review (CPR) was commissioned by the Mid and West Wales Safeguarding Board (M&WWSB) and managed in accordance with the [Guidance for Child Practice Reviews working-together-to-safeguard-people-volume-2-child-practice-reviews.pdf \(gov.wales\)](https://www.gov.wales/government/publications/working-together-to-safeguard-people-volume-2-child-practice-reviews.pdf)

The Concise Child Practice Review commenced in June 2022, however, due to the criminal trial, the review was immediately suspended and recommenced once both the criminal and coronial matters concluded in May 2023.

On the 14 March 2024, Mid and West Safeguarding Board published the Concise Child Practice Review on their website [Published report and 7MB](#).

The review made nine recommendations for the M&WWSB and its member agencies, five of which make specific reference to Powys Teaching Health Board.

The nine recommendations will be translated into a Mid and West Wales Safeguarding Board CPR Multi Agency Action Plan and shared with the M&WWSB members by the middle of May 2024. While the CPR report is published and in the public domain, the action plan is not.

However, the PTHB specific actions within the M&WWSB CPR Multi Agency Action Plan will be implemented and monitored within the Health Board’s Safeguarding Practice Improvement Group which will provide progress updates quarterly to the Safeguarding Strategic Group. This will subsequently report through to the Patient Experience and Quality Committee.

Progress on the action plan will also be reported quarterly to the Multi-Agency Regional Safeguarding Operational Group and the M&WWSB as owners of the action plan.

**HEADING:**

**2. Powys Teaching Health Board Recommendations**

five recommendations have been made for Powys Teaching Health Board;

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- I. The Local Authority and Health Board to jointly review the systems, processes and pathways that are in place for children with chronic disabilities.
- II. All agencies to undertake a review of their existing training programmes and policy guidance to ensure the duty on all practitioners, regardless of barriers, to speak to and communicate directly with children, is understood. Their responsibility to engage with and accurately record any communications must be explicitly clear and understood by those responsible for delivering and providing services to children and their families.
- III. Powys Teaching Health Board to raise awareness, implement and embed the updated All Wales Weight Management Pathway for children, young people and families published by Welsh Government in 2021.
- IV. Powys Teaching Health Board to review the availability of and access to lymphoedema services for children living in Powys. To clarify or create a protocol regarding the regular monitoring of the skin condition of children with complex health needs and mobility limitations, including spina bifida.
- V. Powys Teaching Health Board to further embed the Was Not Brought policy and to consider cross-border involvement.

### **3. Overview of learning undertaken**

#### **3.1 Practice, Systems and Process Improvements**

Immediately following the child's death, PTHB undertook an internal practice, systems and process review. The themes identified for improvement included:

- Managing children who are not brought for appointments.
- The use of chronologies to record significant events in a child and family's life.
- Supporting practitioners to be professionally curious when managing/coordinating children's care plans where there are multiple health needs and practitioners involved in supporting the child and family.

#### **3.2 Progress made Against the Practice, Systems and Processes Improvement Plan**

The Health Board Policy for Managing Was Not Brought/Did Not Attend/No Access Appointments for Vulnerable People' (SGP 047) has been audited, revised and promoted throughout the health board. The updated Policy now includes a risk assessment and reminds practitioners they must consider the family's needs/circumstances and work with others involved with the child, when

managing and scheduling appointments that support children being brought to appointments.

- Annual audit plan of the policy is in place and was last undertaken in December 2023. Managers/Team Leads also undertake a monthly review of *Children Not Brought* to appointments within their service.
- Significant events chronology for each child has been developed on WCCIS. Practitioners can add to and read all entries on the chronology.
- Staff are reminded during safeguarding supervision of the importance of being '*professionally curious*'. Regional multi agency training on Professional Curiosity including Was Not Brought is available to staff and has been added in PTHB's safeguarding children level 3 passport.
- PTHB Clinical Supervision Policy has been updated and ratified.
- Principles for Managing Discharges process has been developed for use in each service area.
- PTHB Safeguarding Supervision Protocol audited with an action plan developed and completed.
- Process to enable Multi-Disciplinary Team (MDT) meetings has been developed and ratified. Practitioners who have the most involvement with a child with multiple health needs may be asked to be the Lead Practitioner for the MDT process.

Practitioners were also reminded they must:

- I. Adhere to their own professional code/standards and Health Board policies in relation to record keeping and storage of documents.
- II. Use the system agreed within their service area to record case notes, this includes providing a reason why the child is open to the service, an analysis of care/service required and/or being provided and ensure care plans are updated.
- III. Open referrals on WCCIS/WPAS without any activity or evidence the service is being offered should be reviewed and either updated to indicate the child is waiting for an appointment or the contact is closed with a clear rationale why.

#### **4. Taking forward the Mid and West Wales Safeguarding Board Child Practice Review Action Plan**

A meeting between Powys Teaching Health board Senior Managers has been arranged for 11.04.2024 which will enable the Health Board to digest and reflect on the Child Practice Review Report and the recommendations, undertake a

review of the improvements made to date, consider the legislative changes over time and agree how to take forward the Mid and West Wales Safeguarding Action plan once received.

The PTHB specific actions within the M&WWSB CPR Multi Agency Action Plan will be implemented and monitored within the Health Board's Safeguarding Practice Improvement Group which will provide progress updates quarterly to the Safeguarding Strategic Group. This will report to the Patient Experience and Quality Committee.

Progress on the action plan will also be reported quarterly to the Multi-Agency Regional Safeguarding Operational Group and the M&WWSB as owners of the action plan.

#### **NEXT STEPS:**

- I. Arrange a meeting with Heads of Services to consider the recommendations and map the improvements already implemented and the legislative changes since the child's death (meeting arranged for 11.04.24)
- II. Receive the Mid and West Wales Safeguarding Board CPR Action Plan into the health boards Safeguarding Practice Improvement Group and report progress against the PTHB specific actions to the Health Boards Safeguarding Strategic Group.
- III. Work with our multi agency partners on the whole system improvements within the action plan.
- IV. Provide progress reports to both the Executive Committee and Patient Experience, Quality and Safety Committee.

## 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				
Timely				
Effective				
Efficient				
Equitable				
Person Centred				
Workforce				
Leadership				
Culture				
Information				
Learn, Improve, Research				
Whole Systems Approach				

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.

### EQUALITY:

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

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.

### RISK ASSESSMENT:

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

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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**Agenda Item: 3.1**

<b>Patient Experience, Quality and Safety Committee</b>		<b>Date of Meeting: 16 April 2024</b>
<b>Subject:</b>	<b>PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE ANNUAL REPORT TO THE BOARD</b>	
<b>Approved and Presented by:</b>	Director of Corporate Governance / Board Secretary	
<b>Prepared by:</b>	Director of Corporate Governance / Board Secretary Interim Corporate Governance Manager	
<b>Other Committees and meetings considered at:</b>	N/A	

<b>PURPOSE:</b>		
The purpose of this report is to provide the Patient Experience, Quality and Safety Committee Report for 2023/24.		
<b>RECOMMENDATION(S):</b>		
It is recommended that the Patient Experience, Quality and Safety Committee :		
<ul style="list-style-type: none"> <li>• <b>CONSIDER</b> the Patient Experience, Quality and Safety Committee Annual Report for 2023/24 summarising the key areas of business activity undertaken;</li> <li>• <b>RECOMMEND</b> the report to the Board for the 22 May 2024 meeting.</li> </ul>		
<b>Approval/Ratification/Decision</b>	<b>Discussion</b>	<b>Information</b>
X		

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## 1. Introduction

The Patient Experience, Quality and Safety Committee has been established by the Board in order to provide advice and assurance to the Board on the effectiveness of arrangements in place for securing the achievement of the Board's aims and objectives, in accordance with the standards of good governance determined for the NHS in Wales.

This report summarises the key areas of business activity undertaken by the Patient Experience, Quality and Safety Committee ('the Committee') over the past year and highlights some of the key issues which the Committee intend to give further consideration to over the next 12 months.

## 2. Roles and Responsibilities

The Terms of Reference for the Committee were reviewed and agreed by the Board in September 2021. The purpose of the Committee is to:

- provide accurate, evidence based (where possible) and timely advice to the Board and its committees in respect of the development of the following matters, consistent with the Board's overall strategic direction
  - a. Citizen Experience; and
  - b. Quality and Safety of directly provided and commissioned services.
- Committee will seek assurances:
  - a) The robustness of the Board's Clinical Quality Framework;
  - b) the experience of patients, citizens and carers ensuring continuous learning;
  - c) the provision of high quality, safe and effective healthcare within directly provided and commissioned services;
  - d) the effectiveness of arrangements in place to support Improvement and Innovation and
  - e) compliance with mental health legislation, including the Mental Health Act 1983 (amended 2007) and the Mental Capacity Act 2005.

Noting the scope of the Committee extends to the full range of PTHB responsibilities. This encompasses all areas of patient experience, quality and safety relating to patients, carers and service users, within directly provided services and commissioned services. The Committee will embrace the Health and Care Standards as the Framework in which it will fulfil its purpose:

- Staying Healthy
- Safe Care
- Effective Care
- Dignified Care
- Timely Care
- Individual Care
- Staff and Resources

The Committee is responsible for providing advice to the Board and Committees on:

- A. Seek assurance that the Health Board’s **Clinical Quality Framework** remains appropriate, is aligned to the National Quality Framework, and is embedded in practice.
  
- B. Seek assurance that arrangements for capturing the **experience of patients, citizens and carers** are sufficient, effective and robust, including:
  - the delivery of the Patient Experience Plan; and
  - the implementation of Putting Things Right regulations (to include patient safety incidents, complaints, compliments, clinical negligence claims and inquests) reporting trends, with particular emphasis on ensuring that lessons are learned.
  
- C. Seek assurance that arrangements for **the provision of high quality, safe and effective healthcare** are sufficient, effective and robust, including:
  - the systems and processes in place to ensure efficient, effective, timely, dignified and safe delivery of directly provided services;
  - the commissioning assurance arrangements in place to ensure efficient, effective, timely, dignified and safe delivery of commissioned services;
  - the arrangements in place to undertake, review and act on clinical audit activity which responds to national and local priorities;
  - the recommendations made by internal and external review bodies, ensuring where appropriate, that action is taken in response;

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- the arrangements in place to ensure that there are robust infection, prevention and control measures in place in all settings;
- the development of the board's Annual Quality Statement and Annual Quality Priorities; and
- performance against key quality focussed performance indicators and metrics.

D. Seek assurance on the arrangements in place to support

**Improvement and Innovation**, including:

- an overview of the research and development activity within the organisation;
- alignment with the national objectives published by Health And Care Research Wales (HCRW);
- an overview of the quality improvement activity within the organisation.

E. Seek assurance that arrangements for **compliance with mental health legislation** are sufficient, effective and robust, including:

- the Mental Health Act 1983 Code of Practice for Wales and associated regulations;
- the Mental Capacity Act 2005 Code of Practice and associated regulations;
- the Mental Capacity Act 2005 Deprivation of Liberty Safeguards Code of Practice and associated regulations; and
- the Mental Health Measure (Wales) 2010.

3.1 The Committee will consider and recommend to the Board for approval those policies reserved for the Board and delegated to this Committee for review, in-line with the Board's Policy Management Framework and Scheme of Delegation and Reservation of Powers.

3.2 The Committee will seek assurances on the management of strategic risks delegated to the Committee by the Board, via the Corporate Risk Register.

It is expected that the committee will also annually review its own terms of reference and report any changes to the Board for ratification.

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## 2.1 Membership of the Committee

The membership of the Committee during 2023/24 was:

<b>Name</b>	<b>Role</b>	<b>Attendance</b>
Kirsty Williams	Chair	4/4
Jennifer Owen Adams	Vice-Chair	4/4
Ian Phillips	Member	3/4
Simon Wright	Member	4/4
Mark Taylor (to 23 October 2023)	Member	2/2

## 2.2 Others in Attendance

During 2023/24, the following staff attended the Committee:

<b>Name</b>	<b>Role</b>	<b>Attendance</b>
Claire Roche	Director of Nursing and Midwifery	4/4
Kate Wright	Medical Director	3/4
Claire Madsen	Director of Therapies and Health Sciences	3/4
Joy Garfitt	Interim Director of Operations	2/4
Pete Hopgood (from 03/05/2023)	Director of Finance, Information and IT, Interim Director of Primary Care	1/3
Debra Wood Lawson	Director of Workforce and OD	2/4

Other Directors and officers attended during the year to present reports which related to their areas of responsibility as required.

The Chief Executive, Hayley Thomas, was also invited to attend every meeting, and attends at least annually attending once during the year.

The Chair of the Board, Carl Cooper, attended two meetings. The Chair has a standing invite to attend Board Committees.

## 2.3 Meeting frequency

During 2023/24 the Committee met four times and was quorate on all occasions.

Whilst the terms of reference for the Committee require meetings to be held no less than bi-monthly and otherwise, as the Chair of the Committee deems necessary, consistent with the annual plan of Board and Committee Business, it was agreed that the Committee would meet quarterly, and the Terms of Reference require updating to reflect this. The Terms of Reference are due for consideration by the Board in May 2024.

In addition to the scheduled meetings, the Committee met once jointly with the Workforce and Culture Committee on 24 October 2023 to discuss areas of common interest. It is expected that further joint meetings of the two Committees will be held into 2024/25.

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### 3. Activity in 2023/24

#### 3.1 Main Areas of Committee Activity 2023/24

<b>Assurance</b>	
Integrated Quality Report	April 2023
Duties of Quality and Candour presentation	April 2023
WHSSC Quality and Safety Committee Report January 2023	April 2023
Integrated Quality Report	July 2023
Mental Health Power of Discharge Annual Report 2022-2023	July 2023
Clinical Audit Report	July 2023
Annual Safeguarding Report 2022-23	July 2023
WHSSC Quality and Safety Committee Report April 2023	July 2023
Integrated Quality Report	October 2023 (including Public Services Ombudsman for Wales Annual Report 2022/23 and Infection Prevention and Control Plan Progress)
Maternity Services Assurance Paper	October 2023
Mental Health Services Presentation	October 2023
111p2 12 week review	October 2023
Implementation of Welsh Government guidance on Transition and Handover from Children's to Adult's Health Services	October 2023

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Medical Devices and Point of Care Testing Annual Report 2022-2023	October 2023
Integrated Quality Report	January 2024
Mental Health Services Deep-Dive	January 2024
Mental Health Power of Discharge Six Monthly Report	January 2024
Joint Inspection on Child Protection Arrangements	January 2024
Cancer Improvement Plan	January 2024
Annual Report of Accountable Officer for Controlled Drugs	January 2024
WHSSC Quality and Safety Committee Chairs Report October 2023	January 2024
<b>Items for approval</b>	
Statement of Commitment to Infection Prevention and Control	October 2023
<b>Items considered In-Committee</b>	
Infection Prevention and Control	July 2023
Suicide Review Report (November 2023)	January 2024
Mental Health Deep Dive from a Quality and Safety Perspective	January 2024
<b>Escalated Items</b>	
Maternity Services	April 2023 de-escalated to business as usual
Infection Prevention and Control	Escalated in July 2023 – monitoring reports received in October 2023 and January 2024
<b>Corporate Governance</b>	

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Committee Risk Register	April 2023, July 2023 and January 2024
Committee Work Programme	Each meeting
Annual Assessment of Committee Effectiveness	January 2024
Review of Committee Terms of Reference	January 2024

<b>Joint Patient Experience, Quality and Safety Committee and Workforce and Culture Committee</b>	
Duty of Quality and Candour – focus on workforce culture, quality and safety	For discussion – October 2024
Speaking up Safely draft Self-Assessment	For discussion – October 2024

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### **3.2 Work programme and action log**

The Committee Work Plan ensures that the Committee discharges its responsibilities in a planned manner. It assists with agenda planning and is updated during the year to ensure that the Committee considers any additional items which may arise during the year.

In order to monitor progress and any necessary follow up action, the Committee has an Action Log that captures all agreed actions. This provides an essential element of assurance to the Committee and from the Committee to the Board.

The Committee reported to the Board through a Committee Chair's report, providing an overview of items considered by the Committee and highlighting any cross-committee issues / themes or items needing to be brought to the Board's attention. The Committee Chair's report and confirmed minutes are published on the website.

## **4. Assurance to the Board**

The Committee wishes to assure the Board that on the basis of the work completed by the Committee during 2023/24, there are effective measures in place and there are no outstanding issues that the Committee wishes to bring to the attention of the Board over and above the risks and issues already raised in the Committee Chairs report, noted as Escalated Items or those that are already visible in the corporate risk register. The Chair of the Committee reports into the Board via a report from Committee Chairs, where any significant issues are brought to the attention of the Board.

## **5. Committee Effectiveness**

During the year the Committee has continued to review and revise its ways of working to optimise a robust governance approach balancing the need reduce pressure on staff where possible, whilst ensuring the Committee fulfils its responsibilities.

The Committee continued to review its effectiveness thorough the year, to ensure effective use of time and ensure it fulfilled its role to provide assurance to the Board.

The key developments/adaptations made this year included:

- The construct of the Committee meeting agendas remained flexible, and the application of a risk based approach to the selection of agenda items.

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- The continued development and maturing of the Integrated Quality Report as a key tool for a number of areas of the Committees responsibility including the Duties of Quality and Candour.
- The use of verbal updates and presentations where appropriate to ensure the timeliness of information to the Committee given the fast moving pace of some agenda areas.
- The circulation of relevant material outside meetings where appropriate.
- The introduction of the joint meeting with Workforce and Culture Committee.

The Committee has undertaken its annual effectiveness review process. The outcome and recommendations following this review will be reported to the Board in Quarter 1 of 2024/25.

## **6. Planned Activity in 2024/245**

The Committee has developed its annual work programme and is committed to continuing to develop its function and effectiveness as per its terms of reference. The Committee welcomes any feedback from the Board in relation to its annual work programme when it is presented to the Board in May 2024.

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# Annual Internal Audit Plan: Draft Internal Audit Charter

March 2024

Powys Teaching Health Board

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GIG  
CYMRU  
NHS  
WALES

Partneriaeth  
Cydwasaethau  
Gwasanaethau Archwilio a Sicrwydd  
Shared Services  
Partnership  
Audit and Assurance Services



GIG  
CYMRU  
NHS  
WALES

Bwrdd Iechyd  
Addysgu Powys  
Powys Teaching  
Health Board



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### Disclaimer notice - please note

This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared in accordance with the agreed audit brief and the Audit Charter, as approved by the Audit Risk and Assurance Committee.

Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Powys Teaching Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

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# 1. Introduction

This document sets out the Internal Audit Plan for 2024/25 (the Plan) detailing the audits to be undertaken and an analysis of the corresponding resources. It also contains the Internal Audit Charter which defines the over-arching purpose, authority and responsibility of Internal Audit and the Key Performance Indicators for the service.

The Accountable Officer (the Health Board Chief Executive) is required to certify, in the Annual Governance Statement, that they have reviewed the effectiveness of the organisation's governance arrangements, including the internal control systems, and provide confirmation that these arrangements have been effective, with any qualifications as necessary including required developments and improvement to address any issues identified.

The purpose of Internal Audit is to provide the Accountable Officer and the Board, through the Audit, Risk and Assurance Committee, with an independent and objective annual opinion on the overall adequacy and effectiveness of the organisation's framework of governance, risk management, and control. The opinion should be used to inform the Annual Governance Statement.

Additionally, the findings and recommendations from internal audit reviews may be used by Health Board management to improve governance, risk management, and control within their operational areas.

The Public Sector Internal Audit Standards (the Standards) require that 'The risk-based plan must take into account the requirement to produce an annual internal audit opinion and the assurance framework. It must incorporate or be linked to a strategic or high-level statement of how the internal audit service will be delivered in accordance with the internal audit charter and how it links to the organisational objectives and priorities.'

Accordingly, this document sets out the risk-based approach and the Plan for 2024/25. The Plan will be delivered in accordance with the Internal Audit Charter and the agreed KPIs which are monitored and reported to you. All internal audit activity will be provided by Audit & Assurance Services, a part of NHS Wales Shared Services Partnership (NWSSP).

## 1.1 National Assurance Audits

The proposed Plan includes assurance audits on some services that are provided by Digital Health and Care Wales (DHCW), NWSSP and the NHS Wales Joint Commissioning Committee (NWJCC) (the new Joint Committee for Welsh Health Specialised Services Committee (WHSSC), Emergency Ambulance Services Committee (EASC) and the National Collaborative Commissioning Unit (NCCU)) on behalf of NHS Wales. These audits will be included in Appendix A when agreed formally. These audits are part of the risk-based programme of work for DHCW, NWSSP and Cwm Taf Morgannwg UHB (for NWJCC) but the results, as in previous years, are reported to the relevant organisation and are used to inform the overall annual Internal Audit opinion for those organisations.

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## 2. Developing the Internal Audit Plan

### 2.1 Link to the Public Sector Internal Audit Standards

The Plan has been developed in accordance with Standard 2010 – Planning, to enable the Head of Internal Audit to meet the following key objectives:

- the need to establish risk-based plans to determine the priorities of the internal audit activity, consistent with the organisation’s goals;
- provision to the Accountable Officer of an overall independent and objective annual opinion on the organisation’s governance, risk management, and control, which will in turn support the preparation of the Annual Governance Statement;
- audits of the organisation’s governance, risk management, and control arrangements which afford suitable priority to the organisation’s objectives and risks;
- improvement of the organisation’s governance, risk management, and control arrangements by providing line management with recommendations arising from audit work;
- confirmation of the audit resources required to deliver the Internal Audit Plan;
- effective co-operation with Audit Wales as external auditor and other review bodies functioning in the organisation; and
- provision of both assurance (opinion based) and consulting engagements by Internal Audit.

### 2.2 Risk based internal audit planning approach

Our risk-based planning approach recognises the need for the prioritisation of audit coverage to provide assurance on the management of key areas of risk, and our approach addresses this by considering:

- the organisation’s risk assessment and maturity;
- the organisation’s response to key areas of governance, risk management and control;
- the previous years’ internal audit activities; and
- the audit resources required to provide a balanced and comprehensive view.

Our planning takes into account the NHS Wales Planning Framework and other NHS Wales priorities, such as the duties of Quality and Candour, and is mindful of significant national changes that are taking place. In addition, the plan aims to reflect any significant local changes occurring as identified through the Integrated Medium-Term Plan (IMTP) and Annual Plan and other changes within the organisation, assurance needs, identified concerns from our discussions with management, and emerging risks.

We will ensure that the plan remains fit for purpose by recommending

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changes where appropriate and reacting to any emerging issues throughout the year. Any necessary updates will be reported to the Audit, Risk and Assurance Committee in line with the Internal Audit Charter.

While some areas of governance, risk management and control will require annual consideration, our risk-based planning approach recognises that it is not possible to audit every area of an organisation's activities every year. Therefore, our approach identifies auditable areas (the audit universe). The risk associated with each auditable area is assessed and this determines the appropriate frequency for review.

In addition, we will, if requested, also agree a programme of work through both the Directors of Corporate Governance and Directors of Finance networks. These audits and reviews may be undertaken across all NHS bodies or a particular sub-set, for example at Health Boards only.

Therefore, our audit plan is made up of a number of key components:

- 1) Consideration of key governance and risk areas: We have identified a number of areas where an annual consideration supports the most efficient and effective delivery of an annual opinion. These cover Governance, Board Assurance Framework, Risk Management, Clinical Governance and Quality, Financial Sustainability, Performance Monitoring & Management and an overall IM&T assessment. In each case we anticipate a short overview to establish the arrangements in place including any changes from the previous year with detailed testing or further work where required.
- 2) Organisation based audit work – this covers key risks and priorities from the Board Assurance Framework and the Corporate Risk Register together with other auditable areas identified and prioritised through our planning approach. This work combines elements of governance and risk management with the controls and processes put in place by management to effectively manage the areas under review.
- 3) Follow up: this is follow-up work on previous limited and unsatisfactory assurance reports as well as other high priority recommendations. Our work here also links to the organisation's recommendation tracker and considers the impact of their implementation on the systems of governance and control.
- 4) Work agreed with the Directors of Corporate Governance, Directors of Finance, other executive peer groups, or Audit Committee Chairs in response to common risks faced by a number of organisations. This may be advisory work in order to identify areas of best practice or shared learning.
- 5) The impact of audits undertaken at other NHS Wales bodies that impacts on the Health Board, namely NWSSP, DHCW and NWJCC.
- 6) Where appropriate, Integrated Audit & Assurance Plans will be agreed for major capital and transformation schemes and charged for separately. Health bodies are able to add a provision for audit and assurance costs into the Final Business Case for major capital bids.

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These components are designed to ensure that our internal audit programmes comply with all of the requirements of the Standards, supports the maximisation of the benefits of being an all-NHS Wales wide internal audit service, and allows us to respond in an agile way to requests for audit input at both an all-Wales and organisational level.

### 2.3 Link to the Health Board's systems of assurance

The risk based internal audit planning approach integrates with the Health Board's systems of assurance; therefore, we have considered the following:

- a review of the Board's vision, values and forward priorities as outlined in the Annual Plan and three year Integrated Medium Term Plan (IMTP);
- an assessment of the Health Board's governance and assurance arrangements and the contents of the corporate risk register;
- risks identified in papers to the Board and its Committees (in particular the Audit, Risk and Assurance Committee and the Patient Experience, Quality and Safety Committee);
- key strategic risks identified within the corporate risk register and assurance processes;
- discussions with Executive Directors regarding risks and assurance needs in areas of corporate responsibility;
- cumulative internal audit knowledge of governance, risk management, and control arrangements (including a consideration of past internal audit opinions);
- new developments and service changes;
- legislative requirements to which the organisation is required to comply;
- planned audit coverage of systems and processes provided through NWSSP, DHCW and NWJCC;
- work undertaken by other supporting functions of the Audit, Risk and Assurance Committee including Local Counter-Fraud Services (LCFS) and the Post-Payment Verification Team (PPV) where appropriate;
- work undertaken by other review bodies including Audit Wales and Healthcare Inspectorate Wales (HIW); and
- coverage necessary to provide assurance to the Accountable Officer in support of the Annual Governance Statement.

### 2.4 Audit planning meetings

In developing the Plan, in addition to consideration of the above, the Head of Internal Audit has met and spoken with a number of Health Board Executive Directors and Independent Members to discuss current areas of risk and related assurance needs.

The draft Plan has been provided to the Health Board's Executive Committee to ensure that Internal Audit's focus is best targeted to areas of risk.

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### 3. Audit risk assessment

The prioritisation of audit coverage across the audit universe is based on both our and the organisation's assessment of risk and assurance requirements as defined in the Corporate Risk Register.

The maturity of these risk and assurance systems allows us to consider both inherent risk (impact and likelihood) and mitigation (adequacy and effectiveness of internal controls). Our assessment also takes into account corporate risk, materiality or significance, system complexity, previous audit findings, and potential for fraud.

### 4. Planned internal audit coverage

#### 4.1 Internal Audit Plan 2024/25

The Plan is set out in Appendix A and identifies the audit assignments, lead executive officers, outline scopes, and proposed timings. It is structured under the six components referred to in section 2.2.

Where appropriate the Plan makes cross reference to key strategic risks identified within the corporate risk register and related systems of assurance together with the proposed audit response within the outline scope.

The scope, objectives and audit resource requirements and timing will be refined in each area when developing the audit scope in discussion with the responsible executive director(s) and operational management.

The scheduling takes account of the optimum timing for the performance of specific assignments in discussion with management, and Audit Wales requirements if appropriate.

The Audit, Risk and Assurance Committee will be kept apprised of performance in delivery of the Plan, and any required changes, through routine progress reports to each Committee meeting.

The majority of the audit work will be undertaken by our regionally based teams with support from our national Capital & Estates team, in terms of capital audit and estates assurance work, and from our IM&T team, in terms of Information Governance, IT security and Digital work.

#### 4.2 Keeping the plan under review

Our risk assessment and resulting Plan is limited to matters emerging from the planning processes indicated above.

Audit & Assurance Services is committed to ensuring its service focuses on priority risk areas, business critical systems, and the provision of assurance to management across the medium term and in the operational year ahead. As in any given year, our Plan will be kept under review and may be subject to change to ensure it remains fit for purpose.

Consistent with previous years, and in accordance with best professional practice, an unallocated contingency provision has been retained in the Plan

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to enable Internal Audit to respond to emerging risks and priorities identified by the Executive Management Team and endorsed by the Audit, Risk and Assurance Committee. Any changes to the Plan will be based upon consideration of risk and need and will be presented to the Audit, Risk and Assurance Committee for approval.

Regular liaison with Audit Wales as your External Auditor will take place to coordinate planned coverage and ensure optimum benefit is derived from the total audit resource.

## 5. Resource needs assessment

The plan has been put together on the basis of the planning process described in this document. The plan includes sufficient audit work to be able to give an annual Head of Internal Audit Opinion in line with the requirements of Standard 2450 – Overall Opinions.

Under the approach we have adopted for a number of years, the top slice provided to us to undertake the internal audit programme is supplemented by an additional charge for work over and above the top slice. To this end the health board will need to pay an additional £72,635 (£64,325 in 23/24) to cover this additional audit work.

Provision has also been made for other essential audit work including planning, management, reporting and follow-up.

If additional work, support or further input is necessary to deliver the plan, we will look to deliver it from within our resources. It is possible, in exceptional cases, that an additional fee may be charged. Any change to the plan will be based upon consideration of risk and need and presented to the Audit, Risk and Assurance Committee for approval.

The Standards enable Internal Audit to provide consulting services to management. The commissioning of these additional services by the Health Board, unless already included in the plan, is discretionary. Accordingly, a separate fee may need to be agreed for any additional work.

Under the approach we have adopted since the formation of NWSSP we charge for the specialist Capital & Estates work delivered as a part of the agreed plan. Noting the anticipated profile of activity within the Health Board during 2024/25, this additional charge is £34,045 (£14,367 in 23/24).

The audit of major programmes/projects will be facilitated through the Integrated Assurance and Approval Plans agreed at the respective approved business cases with the associated plans funded via the Welsh Government's capital allocations. There are currently no health board projects proposed for review facilitated through the Integrated Assurance and Approval Plan process during 2024/25.

Therefore, the Health Board will be charged an additional amount of £106,680 which is over and above the 'top slice' recharge agreed as part of NWSSP's overall funding for 2024/25.

## 6. Action required

The Audit, Risk and Assurance Committee is invited to consider the Internal Audit Plan for 2024/25 and:

- approve the Internal Audit Plan for 2024/25;
- approve the Internal Audit Charter; and
- note the associated Internal Audit resource requirements and Key Performance Indicators.

Ian Virgill

Head of Internal Audit (Powys Teaching Health Board)  
Audit and Assurance Services  
NHS Wales Shared Services Partnership

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## Appendix A: Internal Audit Plan 2024/2025

Planned output	Audit Ref	Corporate Risk Register Reference	Outline Scope	Executive Lead	Outline Timing
Annual Governance Statement	N/A	N/A	To provide commentary on key aspects of Board Governance to underpin the completion of the statement.	Director of Corporate Governance	Q4
Risk Management & Assurance	1		Review the on-going development, implementation and application of the Health Boards Risk Management and Board Assurance processes.	Director of Corporate Governance	Q4
Board Effectiveness	2		Review and evaluate the operation of the Health Board's Board to ensure effective and efficient reporting, scrutiny and decision making on areas of accountability.	Director of Corporate Governance	Q3
Policy Management	3		Review the arrangements and processes in place for the creation, management and review of Health Board policies.	Director of Corporate Governance	Q3

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Planned output	Audit Ref	Corporate Risk Register Reference	Outline Scope	Executive Lead	Outline Timing
Medicines Management	4		Review of Medicines Management arrangements, potentially including medicines efficiency / prescribing, interfaces with community pharmacies or antimicrobial prescribing. Exact scope of audit to be agreed.	Medical Director	TBC
Cancer Services	5	CRR 005	A review of Cancer Services included for the second half of the plan. Scope could cover the Cancer Tracking Service or Harm Review Process, to be confirmed later in the year.	Medical Director	Q3/4
Patient Flow / Discharge Management	6	CRR 004	Review of the current controls and systems around patient flow, reducing discharge delays and work of the Complex Care and Unscheduled Care Team. Include a focus on the repatriation of patients from other providers.	Director of Operations / Community & Mental Health	Q1/2
Mental Health Care and Treatment Planning	7	CRR 005	Review of the current processes and performance around completion of care and treatment plans within the Mental Health Service and plans in place to improve these.	Director of Operations / Community & Mental Health	Q2/3

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Planned output	Audit Ref	Corporate Risk Register Reference	Outline Scope	Executive Lead	Outline Timing
Local Primary Mental Health Support Services	8	CRR 005	Review of how the Local Primary Mental Health Support Services are structured, managed and delivered.	Director of Operations / Community & Mental Health	Q4
Quality & Safety Governance (Duty of Quality)	9	CRR 003	Review of the implementation and operation of the new arrangements around quality and governance structures and floor to Board reporting. Potentially include a review of the Integrated Quality Report. Exact scope to be agreed.	Director of Nursing & Midwifery	Q4
Deprivation of Liberties Safeguards (DoLS)	10		Review of the arrangements for ensuring compliance with DoLS requirements including role of Best Interest Assessors. Will need to consider potential scope of this audit further.	Director of Nursing & Midwifery	Q3
Staff Retention	11	CRR 006	Review and assessment of the plans and processes in place to enable the Health Board to retain an appropriate workforce to allow for the sustained delivery of high-quality services.	Director of Workforce & Organisational Development	Q2/3

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Planned output	Audit Ref	Corporate Risk Register Reference	Outline Scope	Executive Lead	Outline Timing
Partnership Governance Framework	12	CRR 007	Review of the development and implementation of the Framework.	Director of Performance & Commissioning / Director of Corporate Governance	Q4
IMTP / Annual Plan Development	13	CRR 001 / 008	Review of the processes and assumptions used for developing the IMTP and Annual Plan. Include a focus on assessment of financial plans.	Director of Performance & Commissioning	Q1
Procurement & Contract Management (All Wales Review)	14	CRR 001	To provide assurance that the Health Board has appropriate procurement and contract management arrangements in place. Review of Health Board arrangements along with the interaction and assurance received from NWSSP Procurement Services.	Deputy CEO/Director of Finance Information & IT Services	TBC
Core Financial Systems	15	CRR 001	Review elements of the core financial systems on a cyclical basis. Covering – General Ledger Management / Treasury Management / Accounts Receivable / Capital Asset Management.	Deputy CEO/Director of Finance Information & IT Services	Q2

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Planned output	Audit Ref	Corporate Risk Register Reference	Outline Scope	Executive Lead	Outline Timing
Primary Care – Ophthalmology Contract	16	CRR 008	Review of the processes for managing the ophthalmology contract and monitoring and reporting performance.	Deputy CEO/Director of Finance Information & IT Services	Q3
Information Governance Follow-up	17	CRR 009	Follow-up of 23/24 Limited Assurance report. Will need to agree the timescale for carrying out the follow-up.	Deputy CEO/Director of Finance Information & IT Services	TBC
Records Management	18		Review of arrangements for managing records within the Health Board and ensuring compliance with Standards / regulations.	Deputy CEO/Director of Finance Information & IT Services	Q3
Additional Learning Needs Legislation (Deferred from 23/24 plan)	19	CRR 006	Review the structures and processes in place within the Health Board for ensuring compliance with the requirements of the Additional Learning Needs and Educational Tribunal Act (Wales).	Director of Therapies and Health Science	Q2/3

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Planned output	Audit Ref	Corporate Risk Register Reference	Outline Scope	Executive Lead	Outline Timing
Medical Devices - Mattresses	20	CRR 003	Review of actions taken to address previous incidents that have occurred within the Health Board around mattresses. Provide assurance on whether revised processes and controls are being effectively applied.	Director of Therapies and Health Science	Q4
Cleaning Standards	21		Review of processes and controls in place to ensure compliance with national cleaning standards.	Director of Therapies and Health Science	Q1
Site Co-Ordination	22		Assurance review of the updated arrangements in place, following on from the advisory audit completed in 21/22.	Director of Therapies and Health Science	Q4
Business Continuity Planning	23		Establish if the Health Board has appropriate arrangements in place to ensure effective business continuity across all areas and services. Following on from the 23/24 audit of the corporate level arrangements.	Director of Public Health	TBC
Community Cardiology	24		Review of the structure and delivery of the service implemented in North Powys, to inform further roll-out across Powys.	Director of Public Health	TBC

Planned output	Audit Ref	Corporate Risk Register Reference	Outline Scope	Executive Lead	Outline Timing
Estates Assurance – Energy Management	25	CRR 010	Increased energy tariffs are acknowledged as a key risk, so there is an increased need to ensure appropriate energy management and control arrangements are applied. Energy Management will be the focus of all UHB/Trust estates assurance reviews across NHS Wales during 2024/25, enabling the production of a national summary report on conclusion.	Director of Capital, Estates & property	TBC
Capital Systems	26	CRR 010	A review of the arrangements in place for the selection and award of advisers and contractors at health board projects; to include the use of local, regional, and national framework arrangements, adequacy of contractual arrangements applied etc.	Director of Capital, Estates & property	TBC
Capital Project	27	CRR 010	To assess the THB's processes, procedures and operational management of the delivery of either the proposed new multi-agency wellbeing campus in Newtown or the Llandrindod Wells redevelopment programme.	Director of Capital, Estates & property	TBC

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Planned output	Audit Ref	Corporate Risk Register Reference	Outline Scope	Executive Lead	Outline Timing
Estates Condition Follow-up	28	CR010	Potential follow-up audit if the 23/24 audit is finalised as Limited. Will need to agree the timescale for carrying out the follow-up	Director of Capital, Estates & property	TBC
Follow-up – Recommendation Tracking	N/A	N/A	To review the systems in place to monitor progress with the implementation of actions in response to internal audit reports.	Director of Corporate Governance	Q4
Integrated Audit & Assurance Plans					
Development of Integrated Audit Plans	N/A	CRR 010	In accordance with the NHS Wales Infrastructure Investment Guidance (2018), Audit will work with the health board to “assess the risk profile of the scheme and provide appropriate levels of review”. A small provision of days is included within the 2024/25 plan to enable us to work with the health board to develop audit plans for inclusion within the respective business case submissions for major projects/ programmes.	Director of Capital, Estates & property	See IAAPs

Please note: The national audits undertaken at DHCW, NWSSP and NWJCC will be added later.

## Appendix B: Key performance indicators (KPI)

KPI	SLA required	Target 2024/25
Audit plan 2024/25 agreed/in draft by 30 April	✓	To deliver plan
Audit opinion 2024/25 delivered by 31 May	✓	To deliver opinion
Audits reported versus total planned audits, and in line with Audit Committee expectations	✓	varies
% of audit outputs in progress	No	varies
Report turnaround fieldwork to draft reporting [10 working days]	✓	80%
Report turnaround management response to draft report [15 working days maximum]	✓	80%
Report turnaround draft response to final reporting [10 working days]	✓	80%

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## Appendix C: Internal Audit Charter

### 1 Introduction

- 1.1 This Charter is produced and updated annually to comply with the Public Sector Internal Audit Standards. The Charter is complementary to the relevant provisions included in the organisation's own Standing Orders and Standing Financial Instructions.
- 1.2 The terms 'board' and 'senior management' are required to be defined under the Standards and therefore have the following meaning in this Charter:
- Board means the Board of Powys Teaching Health Board with responsibility to direct and oversee the activities and management of the organisation. The Board has delegated authority to the Audit Committee in terms of providing a reporting interface with internal audit activity; and
  - Senior Management means the Chief Executive as being the designated Accountable Officer for Powys Teaching Health Board. The Chief Executive has made arrangements within this Charter for an operational interface with internal audit activity through the Director of Corporate Governance.
- 1.3 Internal Audit seeks to comply with all the appropriate requirements of the Welsh Language (Wales) Measure 2011. We are happy to correspond in both Welsh and English.

### 2 Purpose and responsibility

- 2.1 Internal audit is an independent, objective assurance and advisory function designed to add value and improve the operations of Powys Teaching Health Board. Internal audit helps the organisation accomplish its objectives by bringing a systematic and disciplined approach to evaluate and improve the effectiveness of governance, risk management and control processes. Its mission is to enhance and protect organisational value by providing risk-based and objective assurance, advice and insight.
- 2.2 Internal Audit is responsible for providing an independent and objective assurance opinion to the Accountable Officer, the Board and the Audit Committee on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control. In addition, internal audit's findings and recommendations are beneficial to management in securing improvement in the audited areas.
- 2.3 The organisation's risk management, internal control and governance arrangements comprise:

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- the policies, procedures and operations established by the organisation to ensure the achievement of objectives;
  - the appropriate assessment and management of risk, and the related system of assurance;
  - the arrangements to monitor performance and secure value for money in the use of resources;
  - the reliability of internal and external reporting and accountability processes and the safeguarding of assets;
  - compliance with applicable laws and regulations; and
  - compliance with the behavioural and ethical standards set out for the organisation.
- 2.4 Internal audit also provides an independent and objective consulting service specifically to help management improve the organisations risk management, control and governance arrangements. The service applies the professional skills of internal audit through a systematic and disciplined evaluation of the policies, procedures and operations that management have put in place to ensure the achievement of the organisations objectives, and through recommendations for improvement. Such consulting work contributes to the opinion which internal audit provides on risk management control and governance.

### 3 Independence and Objectivity

- 3.1 Independence is described in the Public Sector Internal Audit Standards as the freedom from conditions that threaten the ability of the internal audit activity to carry out internal audit responsibilities in an unbiased manner. To achieve the degree of independence necessary to effectively carry out the responsibilities of the internal audit activity, the Head of Internal Audit will have direct and unrestricted access to the Board and Senior Management, in particular the Chair of the Audit Committee and Accountable Officer.
- 3.2 Organisational independence is effectively achieved when the auditor reports functionally to the Audit Committee on behalf of the Board. Such functional reporting includes the Audit Committee:
- approving the internal audit charter;
  - approving the risk based internal audit plan;
  - approving the internal audit resource plan;
  - receiving outcomes of all internal audit work together with the assurance rating; and
  - reporting on internal audit activity's performance relative to its plan.

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- 3.3 While maintaining effective liaison and communication with the organisation, as provided in this Charter, all internal audit activities shall remain free of untoward influence by any element in the organisation, including matters of audit selection, scope, procedures, frequency, timing, or report content to permit maintenance of an independent and objective attitude necessary in rendering reports.
- 3.4 Internal Auditors shall have no executive or direct operational responsibility or authority over any of the activities they review. Accordingly, they shall not develop nor install systems or procedures, prepare records, or engage in any other activity which would normally be audited.
- 3.5 This Charter makes appropriate arrangements to secure the objectivity and independence of internal audit as required under the standards. In addition, the shared service model of provision in NHS Wales through NWSSP provides further organisational independence.
- 3.6 In terms of avoiding conflicts of interest in relation to non-audit activities, Audit & Assurance has produced a Consulting Protocol that includes all of the steps to be undertaken to ensure compliance with the relevant Standards that apply to non-audit activities.

## 4 Authority and Accountability

- 4.1 Internal Audit derives its authority from the Board, the Accountable Officer and Audit Committee. These authorities are established in Standing Orders and Standing Financial Instructions adopted by the Board.
- 4.2 The Minister for Health and Social Services has determined that internal audit will be provided to all health organisations by the NHS Wales Shared Services Partnership (NWSSP). The service provision will be in accordance with the Service Level Agreement agreed by the Shared Services Partnership Committee and in which the organisation has permanent membership.
- 4.3 The Director of Audit & Assurance leads the NWSSP Audit and Assurance Services and after due consultation will assign a named Head of Internal Audit to the organisation. For line management (e.g. individual performance) and professional quality purposes (e.g. compliance with the Public Sector Internal Audit Standards), the Head of Internal Audit reports to the Director of Audit & Assurance.
- 4.4 The Head of Internal Audit reports on a functional basis to the Accountable Officer and to the Audit Committee on behalf of the Board. Accordingly, the Head of Internal Audit has a direct right of access to the Accountable Officer, the Chair of the Audit Committee and the Chair of the organisation if deemed necessary.
- 4.5 The Audit Committee approves all Internal Audit plans and may review any aspect of its work. The Audit Committee also has regular

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private meetings with the Head of Internal Audit.

- 4.6 In order to facilitate its assessment of governance within the organisation, Internal Audit is granted access to attend any committee or sub-committee of the Board charged with aspects of governance.

## 5 Relationships

- 5.1 In terms of normal business the Accountable Officer has determined that the Director of Corporate Governance will be the nominated executive lead for internal audit. Accordingly, the Head of Internal Audit will maintain functional liaison with this officer.
- 5.2 In order to maximise its contribution to the Board's overall system of assurance, Internal Audit will work closely with the organisation's Director of Corporate Governance in planning its work programme.
- 5.3 Co-operative relationships with management enhance the ability of internal audit to achieve its objectives effectively. Audit work will be planned in conjunction with management, particularly in respect of the timing of audit work.
- 5.4 Internal Audit will meet regularly with the external auditor, Audit Wales, to consult on audit plans, discuss matters of mutual interest, discuss common understanding of audit techniques, method and terminology, and to seek opportunities for co-operation in the conduct of audit work. In particular, Internal Audit will make available their working files to the external auditor for them to place reliance upon the work of Internal Audit where appropriate.
- 5.5 The Head of Internal Audit will establish a means to gain an overview of other assurance providers' approaches and output as part of the establishment of an integrated assurance framework.
- 5.6 The Head of Internal Audit will take account of key systems being operated by organisation's outside of the remit of the Accountable Officer, or through a shared or joint arrangement, such as the Digital Health and Care Wales, NHS Wales Shared Services Partnership, and NHS Wales Joint Commissioning Committee.
- 5.7 Internal Audit strives to add value to the organisation's processes and help improve its systems and services. To support this Internal Audit will obtain an understanding of the organisation and its activities, encourage two-way communications between internal audit and operational staff, discuss the audit approach and seek feedback on work undertaken.
- 5.8 The Audit Committee may determine that another Committee of the organisation is a more appropriate forum to receive and action individual audit reports. However, the Audit Committee will remain the final reporting line for all our audit and consulting reports.

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## 6 Standards, Ethics, and Performance

- 6.1 Internal Audit must comply with the Definition of Internal Auditing, the Core Principles, Public Sector Internal Audit Standards and the professional Code of Ethics, as published on the NHS Wales e-governance website.
- 6.2 Internal Audit will operate in accordance with the Service Level Agreement (updated 2021) and associated performance standards agreed with the Audit Committee and the Shared Services Partnership Committee. The Service Level Agreement includes a number of Key Performance Indicators, and we will agree with each Audit Committee which of these they want reported to them and how often.

## 7 Scope

- 7.1 The scope of Internal Audit encompasses the examination and evaluation of the adequacy and effectiveness of the organisation's governance, risk management arrangements, system of internal control, and the quality of performance in carrying out assigned responsibilities to achieve the organisation's stated goals and objectives. It includes but is not limited to:
- reviewing the reliability and integrity of financial and operating information and the means used to identify measure, classify, and report such information;
  - reviewing the systems established to ensure compliance with those policies, plans, procedures, laws, and regulations which could have a significant impact on operations, and reports on whether the organisation is in compliance;
  - reviewing the means of safeguarding assets and, as appropriate, verifying the existence of such assets;
  - reviewing and appraising the economy and efficiency with which resources are employed, this may include benchmarking and sharing of best practice;
  - reviewing operations or programmes to ascertain whether results are consistent with the organisation's objectives and goals and whether the operations or programmes are being carried out as planned;
  - reviewing specific operations at the request of the Audit Committee or management, this may include areas of concern identified in the corporate risk register;
  - monitoring and evaluating the effectiveness of the organisation's risk management arrangements and the overall system of assurance;

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- ensuring effective co-ordination, as appropriate, with external auditors; and
  - reviewing the Annual Governance Statement prepared by senior management.
- 7.2 Internal Audit will devote particular attention to any aspects of the risk management, internal control and governance arrangements affected by material changes to the organisation’s risk environment.
- 7.3 If the Head of Internal Audit or the Audit Committee consider that the level of audit resources or the Charter in any way limit the scope of internal audit or prejudice the ability of internal audit to deliver a service consistent with the definition of internal auditing, they will advise the Accountable Officer and Board accordingly.

## 8 Approach

8.1 To ensure delivery of its scope and objectives in accordance with the Charter and Standards, Internal Audit has produced an Audit Manual (called the Quality Manual). The Quality Manual includes arrangements for planning the audit work. These audit planning arrangements are organised into a hierarchy as illustrated in Figure 1.

**Figure 1: Audit planning hierarchy**

NHS Wales Level	NWSSP overall audit strategy	Arrangements for provision of internal audit services across NHS Wales
Organisation Level	Entity strategic 3-year audit plan	Entity level medium term audit plan linked to organisational objectives
	Entity annual internal audit plan	Annual internal audit plan detailing audit engagements to be completed in year ahead leading to the overall HIA opinion
Business Unit Level	Assignment plans	Assignment plans detail the scope and objectives for each audit engagement within the annual operational plan

8.2 NWSSP Audit & Assurance Services has developed an overall audit strategy which sets out the strategic approach to the delivery of audit services to all health organisations in NHS Wales. The strategy also includes arrangements for securing assurance on the national transaction processing systems including those operated by DHCW and NWSSP on behalf of NHS Wales.

8.3 The main purpose of the Strategic 3-year Audit Plan is to enable the Head of Internal Audit to plan over the medium term on how the

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assurance needs of the organisation will be met as required by the Standards and facilitate:

- the provision to the Accountable Officer and the Audit Committee of an overall opinion each year on the organisation's risk management, control and governance, to support the preparation of the Annual Governance Statement;
- audit of the organisation's risk management, control and governance through periodic audit plans in a way that affords suitable priority to the organisation's objectives and risks;
- improvement of the organisation's risk management, control and governance by providing management with constructive recommendations arising from audit work;
- an assessment of audit needs in terms of those audit resources which 'are appropriate, sufficient and effectively deployed to achieve the approved plan';
- effective co-operation with external auditors and other review bodies functioning in the organisation; and
- the allocation of resources between assurance and consulting work.

8.4 The Strategic 3-year Audit Plan will be largely based on the Board Assurance Framework where it is sufficiently mature, together with the organisation-wide risk assessment.

8.5 An Annual Internal Audit Plan will be prepared each year drawn from the Strategic 3-year Audit Plan and other information and outlining the scope and timing of audit assignments to be completed during the year ahead.

8.6 The strategic 3-year and annual internal audit plans shall be prepared to support the audit opinion to the Accountable Officer on the risk management, internal control and governance arrangements within the organisation.

8.7 The annual internal audit plan will be developed in discussion with executive management and approved by the Audit Committee on behalf of the Board.

8.8 The NWSSP Audit Strategy is expanded in the form of a Quality Manual and a Consulting Protocol which together define the audit approach applied to the provision of internal audit and consulting services.

8.9 During the planning of audit assignments, an assignment brief will be prepared for discussion with the nominated operational manager. The brief will contain the proposed scope of the review along with the relevant objectives and risks to be covered. In order to ensure the scope of the review is appropriate it will require agreement by the

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relevant Executive Director or their nominated lead and will also be copied to the Director of Corporate Governance.

## 9 Reporting

9.1 Internal Audit will report formally to the Audit Committee through the following:

- An annual report will be presented to confirm completion of the audit plan and will include the Head of Internal Audit opinion provided for the Accountable Officer that will support the Annual Governance Statement.
- The Head of Internal Audit opinion will:
  - a) State the overall adequacy and effectiveness of the organisation's risk management, control and governance processes;
  - b) Disclose any qualification to that opinion, together with the reasons for the qualification;
  - c) Present a summary of the audit work undertaken to formulate the opinion, including reliance placed on work by other assurance bodies;
  - d) Draw attention to any issues Internal Audit judge as being particularly relevant to the preparation of the Annual Governance Statement;
  - e) Compare work actually undertaken with the work which was planned and summarise performance of the internal audit function against its performance measurement criteria; and
  - f) Provide a statement of conformity in terms of compliance with the Public Sector Internal Audit Standards and associated internal quality assurance arrangements.
- For each Audit Committee meeting a progress report will be presented to summarise progress against the plan. The progress report will highlight any slippage and changes in the programme. The findings arising from individual audit reviews will be reported in accordance with Audit Committee requirements; and
- The Audit Committee will be provided with copies of individual audit reports for each assignment undertaken unless the Head of Internal Audit is advised otherwise. The reports will include an action plan on any recommendations for improvement agreed with management including target dates for completion.

9.2 The process for audit reporting is summarised below:

- Following the closure of fieldwork and the resolution of any queries, Internal Audit will discuss findings with operational

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managers to confirm understanding and shape the reporting stage;

- Operational management will receive discussion draft reports which will include any proposed recommendations for improvement within 10 working days following the discussion of findings. A copy of the draft report will also be provided to the relevant Executive Director;
- The draft report will give an assurance opinion on the area reviewed in line with the criteria at Appendix B (unless it is a consulting review). The draft report will also indicate priority ratings for individual report findings and recommendations;
- Operational management will be required to respond to the draft report in consultation with the relevant Executive Director within 15 working days of issue, identifying actions, identifying staff with responsibility for implementation and the dates by which action will be taken;
- The Head of Internal Audit will seek to resolve any disagreement with management in the clearance of the draft report. However, where the management response is deemed inadequate or disagreement remains then the matter will be escalated to the Director of Corporate Governance. The Head of Internal Audit may present the draft report to the Audit Committee where the management response is inadequate or where disagreement remains unresolved. The Head of Internal Audit may also escalate this directly to the Audit Committee Chair to ensure that the issues raised in the report are addressed appropriately;
- Reminder correspondence will be issued after the set response date where no management response has been received. Where no reply is received within 5 working days of the reminder, the matter will be escalated to the Director of Corporate Governance. The Head of Internal Audit may present the draft report to the Audit Committee where no management response is forthcoming;
- Internal Audit issues a Final report to Executive Director within 10 working days of receipt of complete management response. Within this timescale Internal Audit will quality assess the responses, and if necessary return the responses, requiring them to be strengthened.
- Responses to audit recommendations need to be SMART:
  - Specific
  - Measurable
  - Achievable
  - Relevant / Realistic

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➤ Timely.

- The relevant Executive Director, Director of Corporate Governance and the Chair of the Audit Committee will be copied into any correspondence.
  - The final report will be copied to the Accountable Officer and Director of Corporate Governance and placed on the agenda for the next available Audit Committee.
- 9.3 Internal Audit will make provision to review the implementation of agreed action within the agreed timescales. However, where there are issues of particular concern provision maybe made for a follow-up review within the same financial year. Issue and clearance of follow up reports shall be as for other assignments referred to above.
- 9.4 Timescales are to be included in all initial scopes sent prior to commencing an audit.

## 10 Access and Confidentiality

- 10.1 Internal Audit shall have the authority to access all the organisation's information, documents, records, assets, personnel and premises that it considers necessary to fulfil its role. This shall extend to the resources of the third parties that provide services on behalf of the organisation.
- 10.2 All information obtained during the course of a review will be regarded as strictly confidential to the organisation and shall not be divulged to any third party without the prior permission of the Accountable Officer. However, open access shall be granted to the organisation's external auditors.
- 10.3 Where there is a request to share information amongst the NHS bodies in Wales, for example to promote good practice and learning, then permission will be sought from the Accountable Officer before any information is shared.

## 11 Irregularities, Fraud & Corruption

- 11.1 It is the responsibility of management to maintain systems that ensure the organisation's resources are utilised in the manner and on activities intended. This includes the responsibility for the prevention and detection of fraud and other illegal acts.
- 11.2 Internal Audit shall not be relied upon to detect fraud or other irregularities. However, Internal Audit will give due regard to the possibility of fraud and other irregularities in work undertaken. Additionally, Internal Audit shall seek to identify weaknesses in control that could permit fraud or irregularity.
- 11.3 If Internal Audit discovers suspicion or evidence of fraud or irregularity, this will immediately be reported to the organisation's

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Local Counter Fraud Service (LCFS) in accordance with the organisation's Counter Fraud Policy & Fraud Response Plan and the agreed Internal Audit and Counter Fraud Protocol.

## 12 Quality Assurance

- 12.1 The work of internal audit is controlled at each level of operation to ensure that a continuously effective level of performance, compliant with the Public Sector Internal Audit Standards, is being achieved.
- 12.2 The Director of Audit & Assurance will establish a quality assurance and improvement programme designed to give assurance through internal and external review that the work of Internal Audit is compliant with the Public Sector Internal Audit Standards and to achieve its objectives. A commentary on compliance against the Standards will be provided in the Annual Audit Report to the Audit Committee.
- 12.3 The Director of Audit & Assurance will monitor the performance of the internal audit provision in terms of meeting the service performance standards set out in the NWSSP Service Level Agreement. The Head of Internal Audit will periodically report service performance to the Audit Committee through the reporting mechanisms outlined in Section 9.

## 13 Resolving Concerns

- 13.1 NWSSP Audit & Assurance was established for the collective benefit of NHS Wales and as such needs to meet the expectations of client partners. Any questions or concerns about the audit service should be raised initially with the Head of Internal Audit assigned to the organisation. In addition, any matter may be escalated to the Director of Audit & Assurance. NWSSP Audit & Assurance will seek to resolve any issues and find a way forward.
- 13.2 Any formal complaints will be handled in accordance with the NWSSP complaint handling procedure. Where any concerns relate to the conduct of the Director of Audit & Assurance, the NHS organisation will have access to the Managing Director of Shared Services.

## 14 Review of the Internal Audit Charter

- 14.1 This Internal Audit Charter shall be reviewed annually and approved by the Board, taking account of advice from the Audit Committee.

Simon Cookson  
Director of Audit & Assurance  
NHS Wales Shared Services Partnership  
March 2024

Patterson, Liz  
12/04/2024 09:50:36

# Board & Committee Structure/Effectiveness Final Internal Audit Report

March 2024

Powys Teaching Health Board



Partneriaeth  
Sydwasaethau  
Gwasanaethau Archwilio a Sicrwydd  
Shared Services  
Partnership  
Audit and Assurance Services



Bwrdd Iechyd  
Addysgu Powys  
Powys Teaching  
Health Board



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Review reference:	PTHB-2324-02
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Fieldwork commencement:	19 <sup>th</sup> December 2023
Fieldwork completion:	14 <sup>th</sup> February 2024
Debrief meeting:	n/a
Draft report issued:	20 <sup>th</sup> February 2024
Management response received:	1 <sup>st</sup> March 2024
Final report issued:	1 <sup>st</sup> March 2024
Auditors:	Jayne Gibbon, Audit Manager Stuart Bodman, Principal Auditor
Executive sign-off:	Helen Bushell, Director of Corporate Governance/Board Secretary
Distribution:	Liz Patterson, Corporate Governance Manager
Committee:	Audit Risk & Assurance Committee



Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

### Acknowledgement

NHS Wales Audit and Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

### Disclaimer notice - please note

This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit Risk and Assurance Committee.

Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services, and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of Powys Teaching Health Board no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with Powys Teaching Health Board. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

## Executive Summary

### Purpose

The overall objective of the audit was to evaluate the Health Board’s Board and Committee structure and assess their operation to ensure effective and efficient reporting, scrutiny and decision making on areas of accountability.

### Overview

We have issued substantial assurance on this area. Noting the following key processes that are in place:

- The Board and its Committees are supported by formally defined governance and assurance arrangements.
- Committee structures in place enables the delivery of efficient and effective scrutiny and decision making.
- Board and Committee Annual Work Programmes align to and facilitate delivery of the organisation’s strategic objectives and monitoring of its key risks.
- Business activity is of good quality, clearly and effectively reported between Committees and the Board, and where appropriate issued in the public domain.

Matters arising concerning the areas for refinement and further development have been noted (see Appendix A).

### Report Opinion

Substantial



Few matters require attention and are compliance or advisory in nature.

**Low impact** on residual risk exposure.

### Assurance summary<sup>1</sup>

Objectives	Assurance
1 The Health Board has clear, defined Board and Committee governance and assurance structures.	Substantial
2 The Committee structure provides for clear, effective, and efficient decision-making and scrutiny on areas of accountability.	Substantial
3 Board and Committee Work Programmes are aligned to the Health Board’s strategic objectives and risks.	Substantial
4 Board and Committee reporting is clear and concise and provides effective triangulation of business activity.	Substantial

<sup>1</sup>The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

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## 1. Introduction

- 1.1 Our review of Board & Committee Structure / Effectiveness was completed in line with the 2023/24 Internal Audit Plan for Powys Teaching Health Board (the 'Health Board').
- 1.2 The overall objective of this audit was to evaluate the Health Board's Board and Committee structure and assess the operation of the Board and Committees to ensure effective and efficient reporting, scrutiny and decision making on areas of accountability.
- 1.3 The current committee structure of the Health Board has been in place since August 2021 with the following committees currently in operation:
- Audit, Risk and Assurance Committee
  - Charitable Funds Committee
  - Delivery and Performance Committee
  - Executive Committee
  - Patient, Experience, Quality & Safety Committee
  - Planning, Partnerships and Population Health Committee
  - Remuneration and Terms of Service Committee
  - Workforce and Culture Committee
- 1.4 Our review focussed its testing on the operation of the following three sampled Committees:
- Delivery and Performance Committee (D&P)
  - Executive Committee
  - Patient, Experience, Quality & Safety Committee (PEQS)
- 1.5 The potential risks considered during this audit are as follows:
- Failure to achieve strategic objectives.
  - Failure to manage risk
  - Financial or reputational damage.
- 1.6 The Executive lead for this review is the Director of Corporate Governance / Board Secretary.

## 2. Detailed Audit Findings

### **Objective 1: The Health Board has clear, defined Board and Committee governance and assurance structures.**

- 2.1 The Board and each Health Board Committee has been established in accordance with the stated requirements of the organisational Standing Orders.

- 
- 2.2 Each Health Board Committees' Terms of Reference (ToR) clearly defines its roles and responsibilities, and there are no overlaps or conflicts within their respective subject areas of accountability.
  - 2.3 All Health Board Committee ToR documents also outline its constituent membership, quoracy, meeting frequency and reporting arrangements.
  - 2.4 Induction processes for new Independent Members are outlined within a Board Member Library held on the Health Board intranet site, and this also acts as a repository that includes comprehensive and regularly updated resources for training and development.
  - 2.5 However, at the time of our fieldwork, the Health Board Standing Orders (including the Board and respective Committee ToRs) within the public domain were out of date, but we acknowledge that these are to be updated after the May 2024 Board meeting. **(Matter Arising 1)**

**Conclusion:**

- 2.6 The Health Board has established and implemented clearly defined governance and assurance structures, but the organisation should ensure that information relating to these within the public domain is current. We have provided **Substantial Assurance** for this objective.

**Objective 2: The Committee structure provides for clear, effective and efficient decision-making and scrutiny on areas of accountability.**

- 2.7 Our attendance at each of the three sampled Committees confirmed that committee Chairs efficiently manage the delivery of Agenda items, and effectively engage with Committee members and attendees.
- 2.8 Our discussions with the three Committee Chairs corroborated and reinforced their approaches in respect of the oversight and scrutiny undertaken within the respective Committee meetings we attended.
- 2.9 Declarations of Interests for all three sampled Committees are discussed as a Standing Agenda item at each meeting.
- 2.10 All three Chairs expressed satisfaction with the managerial and Committee secretariat support, and with the ongoing training and development provided by the Health Board.
- 2.11 Decisions made within these Committees are clearly recorded within their meeting Minutes and are supported by action logs which are subject to ongoing review.

**Conclusion:**

- 2.12 Committee structures and the support provided to Committee Chairs by the Health Board allows the effective and efficient delivery and recording of business decision making and outcomes. We have provided **Substantial Assurance** for this objective.

---

**Objective 3: Board and Committee work programmes are aligned to the Health Board's strategic objectives and risks.**

- 2.13 The content of all three sampled annual Committee Work Programmes for 2023/2024 reflects their respective, prescribed Committee ToR risks and objectives.
- 2.14 Our review of the sampled PEQS and Executives Committee meetings confirms that the items stated on their annual Work Programme were met, and where changes were made these were recorded therein accordingly.
- 2.15 However, the Delivery and Performance Committee Work Programme was not updated to reflect a small number of necessary changes to timetabled items, and the reasons for these changes were not recorded within the relevant Committee Minutes. **(Matter Arising 2)**

**Conclusion:**

- 2.16 We acknowledge that Committee Work Programme items are subject to change, and these changes are largely recorded as a matter of record, however the application of this process is not consistent. We have provided **Substantial Assurance** for this objective.

**Objective 4: Board and Committee reporting is clear and concise and provides effective triangulation of business activity**

- 2.17 All sampled Committee Agendas, Minutes and covering papers were issued to Committee members and the public (where appropriate) via the Health Board internet site within a reasonable timescale in advance of the meetings being held.
- 2.18 Our review of all sampled Committee meeting cover papers and accompanying reports confirm that they are of good quality, detailed and thorough in content.
- 2.19 All sampled Committee Minutes form the basis of their respective Chair's Reports that are submitted to the next Board meeting, and the content reflects the key decision making and outcomes arising from the discussed Agenda items.

**Conclusion:**

- 2.20 Internal and external reporting of Board and Committee activities and outcomes is efficient, clear, and of good quality. We have provided **Substantial Assurance** for this objective.

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## Appendix A: Management Action Plan

Matter Arising 1: Online publication of outdated Health Board Standing Orders (Operation)		Impact
<p>Our review of the Health Board internet site identified that the Health Board Standing Orders (including the Board and Committee ToRs Schedule 4) that are currently in the public domain are dated 2020 and/or 2021.</p> <p>However, subsequent to our inspection we were advised, and have confirmed, that the Health Board internet site has been updated to include the latest iteration of the Standing Orders dated May 2023, and that the latest version of all Committee ToRs are to be ratified by the May 2024 Board meeting before being published online.</p>		<p>Failure to achieve strategic objectives.</p> <p>Failure to manage risk.</p>
Recommendations		Priority
1.1	<p>Management should ensure that the May 2024 Board meeting reviews and ratifies the Health Board Standing Orders, to include the revised and updated iterations of all Health Board Committee Terms of Reference documents. The updated documents should then be published on the Health Board's internet site.</p>	<b>Low</b>
Agreed Management Action		Target Date
1.1	<p><b>Recommendation accepted.</b></p> <p>The revised Standing orders and supporting terms of reference and other documents will be presented to the May 2024 Board meeting and then published to the website.</p>	30 May 2024
		Responsible Officer
		<b>Director of Corporate Governance</b>

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Matter Arising 2: Annual Delivery and Performance Committee Work Programme (Operation)		Impact	
<p>Our review of the two sampled Delivery and Performance Committee meetings held on 17th October and 19th December 2023 confirmed that business items stated on its 2023/24 Work Programme were largely met, and the deviation from stated items (one item 17th October 2023 and two items 19th December 2023) were necessary and justifiable.</p> <p>However, the meeting Minutes or the Committee Work Programme did not state the reasons for the removal of these items from the respective meeting Agendas, nor did they state as to whether they would be deferred to a future meeting.</p>		<p>Failure to achieve strategic objectives.</p> <p>Failure to manage risk.</p>	
Recommendations		Priority	
2.1	<p>The Annual Work Programme should be subject to update and revision to ensure that items of business are accurately timetabled and allocated to Committee meetings.</p> <p>Where timetabled items stated on the Work Programme are subject to change and removed from the respective Committee Agenda, this should be noted within the Minutes stating the reason, and if known, the date of the next Committee meeting to which the item has been rescheduled.</p>	<b>Low</b>	
Agreed Management Action		Target Date	Responsible Officer
2.1	<p><b>Recommendation accepted and completed.</b></p> <p>A revised approach has been implemented since the report, changes to work programmes are recorded on the work programme report to the Committee and the report then noted in the minutes.</p>	N/A as complete	<b>Director of Corporate Governance</b>

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## Appendix B: Assurance opinion and action plan risk rating

### Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

	<b>Substantial assurance</b>	Few matters require attention and are compliance or advisory in nature. <b>Low impact</b> on residual risk exposure.
	<b>Reasonable assurance</b>	Some matters require management attention in control design or compliance. <b>Low to moderate impact</b> on residual risk exposure until resolved.
	<b>Limited assurance</b>	More significant matters require management attention. <b>Moderate impact</b> on residual risk exposure until resolved.
	<b>Unsatisfactory assurance</b>	Action is required to address the whole control framework in this area. <b>High impact</b> on residual risk exposure until resolved.
	<b>Assurance not applicable</b>	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

### Prioritisation of Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

\* Unless a more appropriate timescale is identified/agreed at the assignment.



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Partneriaeth  
Liz  
11/07/2024 09:50:36

# Infection, Prevention & Control Final Internal Audit Report

March 2024

Powys Teaching Health Board



Partneriaeth  
Sydwasaethau  
Gwasanaethau Archwilio a Sicrwydd  
Shared Services  
Partnership  
Audit and Assurance Services



Bwrdd Iechyd  
Addysgu Powys  
Powys Teaching  
Health Board



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Draft report issued:	6 March 2024
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Final report issued:	21 March 2024
Auditors:	Wendy Wright-Davies, Deputy Head of Internal Audit Ian Virgill, Head of Internal Audit
Executive sign-off:	Claire Roche, Executive Director of Nursing & Midwifery
Distribution:	Gareth Thomas, Consultant Nurse Infection Prevention and Control Zoe Ashman, Assistant Director Quality & Safety Claire Roche, Executive Director of Nursing & Midwifery
Committee:	Audit Risk & Assurance Committee



Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

### Acknowledgement

NHS Wales Audit and Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

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# Executive Summary

## Purpose

The overall objective of the audit was to review the controls and processes in place for Infection Prevention and Control, with specific focus on the IPC Improvement Plan and the Clostridioides Difficile infection pathway.

We have issued reasonable assurance on this area.

The matters requiring management attention include:

- The IPC team’s Standard Operating Procedure (SOP) ‘Management and Escalation of C.difficile cases/clusters/outbreaks and cases identified within Primary Care’ should be added as an appendix to the Clostridioides Difficile Policy; and
- IPC Mandatory Training rates could be improved, it is the role of line managers to ensure their staff are compliant. Whilst completion rates are relatively high, mandatory training requires all staff to comply.

Further low priority recommendations / advisory points are within the detail of the report and included at Appendix A.

## Report Opinion

Reasonable



Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

## Assurance summary<sup>1</sup>

Objectives	Assurance
1 Monitoring and reporting of the IPC Improvement Plan	Substantial
2 Clostridioides Difficile policies and procedures	Reasonable
3 Guidance and training	Reasonable
4 Incident reporting and monitoring of Clostridioides Difficile	Substantial
5 Reporting on Clostridioides Difficile performance	Substantial

<sup>1</sup>The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

## Key Matters Arising

	Objective	Control Design or Operation	Recommendation Priority
3	Addition of IPC Team’s SOP to the Clostridioides Difficile Policy	2 Operation	Medium
4	Non-compliance with Mandatory IPC Training	3 Operation	Medium

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## 1. Introduction

- 1.1 Our audit review of Infection, Prevention & Control was completed in line with the 2023/24 Internal Audit Plan for Powys Teaching Health Board (the 'Health Board').
- 1.2 Infection Prevention and Control (IPC) is fundamental in ensuring the provision of a safe environment for staff and service users. The COVID-19 pandemic has emphasised the need for healthcare organisations to have coordinated, collaborative, agile and robust IPC processes and structures in place to ensure an effective and timely IPC response.
- 1.3 Healthcare Associated Infection (HCAI) refers to an infection that occurs because of contact with the healthcare system. A consistent approach and effective leadership within the Health Board is required to prevent HCAI within Health Boards.
- 1.4 The Executive Director for Nursing and Midwifery commissioned a deep dive into IPC processes, policies and procedures across the Health Board between May 2022 and March 2023. The purpose of this deep dive was to assess the Health Board's position against the Welsh Government Code of Practice for the Prevention and Control of Healthcare Associated Infections, identifying gaps and priorities for improvement.
- 1.5 The deep dive was undertaken by the Health Board's Consultant Nurse for IPC and the findings were reported to the Executive PEQS Committee on the 31 May 2023 with the recommendation that an IPC Improvement plan be developed to address the findings of the deep dive.
- 1.6 The IPC Improvement Plan was developed and approved at the Executive PEQS Committee held on 28 June 2023 and was also submitted to the Patient Experience, Quality and Safety In-PEQS Committee (closed session) on 4 July 2023 for assurance and noting as the PEQS Committee was to be the forum for monitoring the delivery of the Improvement Plan.
- 1.7 The Executive Director for Nursing and Midwifery is the lead Executive for this review.

### Audit Risks

- 1.8 The potential risks considered in this review were as follows:
  - Non-compliance with infection control reporting requirements and legislation; and
  - The Health Board fails to prevent the spread of infection.

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## 2. Detailed Audit Findings

### **Objective 1: There are robust monitoring and reporting arrangements in place within the Health Board for the IPC Improvement Plan**

- 2.1 Since the approval of the IPC Improvement Plan in the summer of 2023, delivery against the Plan has been presented to the Patient Experience, Quality and Safety Committee (PEQS Committee). Updates are included within the Integrated Quality Report, with a specific section on Infection Prevention and Control. The updates have demonstrated progress against the two-year plan. Most recently in January 2024 the PEQS Committee were advised that 60% of the actions were complete. We selected a sample of actions marked as complete and were able to evidence the position.
- 2.2 Whilst the PEQS Committee is kept informed of progress against the Improvement Plan, there are opportunities to make minor updates to the papers presented to enhance the clarity of the information presented.  
**(Matter Arising 1 – Low Priority)**
- 2.3 In advance of the PEQS Committee, the Executive Committee have sight of the IPC papers, in addition to the 'Infection Prevention & Control, Decontamination & Antimicrobial Resistance Group' (The IPC Group). The Terms of Reference for the IPC Group refers to the Director of Nursing & Midwifery as Chair, who has the authority to nominate a deputy chair. The IPC Group plays a key role in monitoring the delivery of the Improvement Plan.
- 2.4 The IPC Group was newly formed in July 2023, following an action within the Improvement Plan. A review of the assurance framework and reporting structures found that the former IPC Group and separate Decontamination Committee should be combined, to facilitate regular reporting into the PEQS Committee. Management acknowledge that the IPC Group's Terms of Reference is dated July 2020, and therefore requires a review.  
**(Matter Arising 2 – Low Priority)**

#### Conclusion 1:

- 2.5 There are robust monitoring and reporting arrangements in place within the Health Board for the IPC Improvement Plan, but we have identified minor opportunities to enhance the clarity of reporting to the PEQS Committee. There is also a need for the Infection Prevention & Control, Decontamination & Antimicrobial Resistance Group's terms of reference to be reviewed. *(Substantial Assurance)*

Patterson, Liz  
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**Objective 2: There are up to date policies and procedures in place for the C-Diff infection pathway that align with Welsh Government requirements and relevant legislation**

- 2.6 The Management of Clostridioides Difficile Policy (IPC 003) along with the wider suite of Infection Prevention and Control policies and procedures were reviewed and updated in the summer of 2023.
- 2.7 The review of the Management of Clostridioides Difficile Policy was informed by a number of sources, which include publications by the UK government, The All Wales Medicine Strategy Group, and the National Institute for Health Care Excellence: Clostridioides difficile infection; antimicrobial prescribing (2021). The Policy also aligns to the 2014 Welsh Government Code of Practice for the Prevention and Control of Healthcare Associated Infections (nine minimum standards an organisation is expected to have in place).
- 2.8 The Policy was issued in November 2023 and is available on the Health Board's intranet site (SharePoint). The Policy was approved by the IPC Group, under delegated authority, as detailed within 'CGP 004 – Management of Policies, Procedures and Other Written Control Documents'.
- 2.9 The Policy contains a number of Standard Operating Procedures e.g. Appendix 1: SOP - Collection of stool samples for Clostridioides difficile toxin testing, and Appendix 3: SOP Management and Escalation of C. difficile cases and Periods of Increased Incidence (PII). A further SOP - Management and Escalation of C.difficile cases/clusters/outbreaks and cases identified within Primary Care was provided, but this was not referenced within the Policy. The IPC Consultant Nurse confirmed that this relates to processes solely within the IPC team.

**(Matter Arising 3 – Medium Priority)**

**Conclusion 2:**

- 2.10 There are up to date policies and procedures in place for the Clostridioides Difficile (C. Difficile) infection pathway that align with Welsh Government requirements and relevant legislation, but we have made a recommendation to strengthen the IPC governance framework. Management should consider how standard operating procedures underpin the Policy. (*Reasonable Assurance*)

**Objective 3: There is awareness of the guidance and staff have undertaken appropriate training**

- 2.11 Following the approval of the Management of Clostridioides Difficile Policy an email was circulated to ward managers and service leads to raise the awareness of the revised Policy. The IPC Team offered to speak to teams directly to clarify any queries around the updated policy, in addition to the more general Standard Infection Prevention and Control Precautions (SICPs) Policy.
- 2.12 To further raise awareness with staff, the policies were shared via the Chief Executives video update, and an article added to the Intranet.

2.13 The following policies clarify the training requirements:

- The Management of Clostridioides Difficile Policy notes, "... *Training on the management of Clostridoides difficile will be included in PTHB level 1 Infection Prevention and Control training, which is available via ESR*".
- The Standard Infection Prevention and Control Precautions Policy notes the varying training requirements for the different staff groups, "*Infection Prevention and Control mandatory training is annually for clinical staff to complete level 2, and all other staff level 1, access through ESR learning data base*". The Policy further highlights that it is the responsibility of the Manager to ensure ALL staff complete the training.

2.14 The IPC Group receives a quarterly report at each meeting from the IPC Consultant Nurse, which provides an overview of 'Organisational IPC Training', broken down by level 1 (Non-clinical staff - 3 year renewal) and level 2 (Clinical Staff - Annually).

2.15 As at the meeting on 30 January 2024 compliance rates were reported as follows:

- Non Clinical Staff 89.8% (713 of 794); and
- Clinical Staff 82.82% (1,263 of 1,525).

**(Matter Arising 4 – Medium Priority)**

2.16 Whilst training compliance rates are reported to the IPC Group within the IPC Quarterly Report, the timeliness of the data should be considered.

**(Matter Arising 5 – Low Priority)**

2.17 In addition to ESR Training, the IP&C Team arranged for clinical educators from Gamma (the manufacturer of clinical wipes) to visit Health Board sites. The purpose of these visits was to provide refresher training on the basic principles of cleaning (including equipment, such as beds, commodes etc). The training was undertaken in August 2023 and all community sites in Powys were visited by the representative together with IPC representation.

2.18 The IPC Consultant Nurse confirmed that IPC is included within Corporate Induction from February 2024, as detailed within the IPC Improvement Plan.

### Conclusion 3:

2.19 The IPC team have provided various channels to inform staff of the updated C. Difficile Policy. The majority of staff have undertaken appropriate IPC training, although we note that approximately 10% (81 of 794) of non-clinical staff and 17% (262 of 1525) of clinical staff are not compliant with the mandatory training. It is managements responsibility to ensure their staff are compliant. (Reasonable Assurance)

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**Objective 4: Robust incident reporting and monitoring processes are in place for the accurate and timely identification and recording of C-Diff infections to ensure actions are taken to address the incidents and lessons are learned.**

- 2.20 The Management of Clostridioides Difficile Policy, and supporting Standard Operating Procedures outline the processes in place for recording and actioning C. Difficile infections and thereafter how they are reported and monitored.
- 2.21 It was evident that the Health Board utilises the ICNet system in accordance with Welsh Health Circular (WHC/2019/019), which requires all Health Boards and Trusts to use the ICNet system for local IPC case management and outbreak management.
- 2.22 C. Difficile test results are published on ICNet, the IPC Team also have in place a local spreadsheet for monitoring C. Difficile infections, which expands upon hospital or community onset infections. The spreadsheet also records the circulation and return of a local assessment tool to assist in identifying root causes of infection and lessons to be learned going forward. The tool varies for hospital onset infections and community onset. GP practices are engaging with the IPC Team to complete and return the assessment tool.
- 2.23 Within the current year, 2023-24 through quarters one to three there had been 18 identified C. Difficile infections, two were hospital onset and 16 community onset. We took a sample of positive infections and were satisfied that the Management of Clostridioides Difficile Policy and supporting Standard Operating Procedures had been adhered to. We were able to evidence the timeliness of the circulation of the assessment tool to obtain any learning and to reduce the risk of further spread of infection. We also noted that incidents had been reported on Datix for the hospital onset infections.
- 2.24 Two positive infections within the sample were linked to a potential C. Difficile outbreak, where we noted that in place of a post infection review meeting, a potential outbreak control meeting took place. Clear actions were reported from the meeting, and it was highlighted that epidemiology colleagues thought it unlikely that transmission has occurred within PTHB. A further risk was noted within the meeting notes, that where neighbouring acute trusts are experiencing significant cluster outbreaks of C. Difficile this can leave PTHB vulnerable, given that a large number of patients are repatriated from these trusts and there is a risk of onward transmission within PTHB.
- 2.25 Since the onboarding of the IPC Consultant Nurse we noted the efforts made to enhance relationships and to improve communication with IPC colleagues in Wye Valley NHS Trust and Shrewsbury and Telford Hospital NHS Trust, which we were able to evidence by supporting emails.
- 2.26 As noted within paragraph 2.23, almost all C. Difficile cases to the close of quarter three were community onset. Welsh Health Circular (WHC 2022 Number 14)

highlights that "*Infection Prevention and Control (IP&C) measures have never been so important. The pandemic has demonstrated the need for adequate resources to support IP&C in both hospital and community settings*".<sup>1</sup>

- 2.27 Currently the Health Board's IPC Team has no resource to proactively support IPC in community settings. The IPC Consultant Nurse has highlighted this risk to the executive lead and has prepared an internal business case, which is yet to be decided upon.
- 2.28 The IPC Group meet quarterly and are presented with HCAI data, which includes C. Difficile. The information is presented in a quarterly IPC report. Should there be matters that require escalation, these are raised in the Quality Report presented to the PEQS Committee.

#### Conclusion 4:

- 2.29 There are robust incident reporting and monitoring processes in place for the accurate and timely identification and recording of C. Difficile infections. We were able to evidence that actions had been taken to address the sampled infections and lessons were learned through the post assessment tool, or relevant meeting which were well documented. We make no recommendations within this objective. (*Substantial Assurance*)

#### **Objective 5: There is regular reporting on C-Diff performance and reports are submitted to appropriate management and Board level groups for information and action**

- 2.30 As noted previously there are quarterly IPC reports presented to the IPC Group, which report on C. Difficile cases, split by month, hospital onset, community onset and rate/100,000. Should there be a case for escalating issues within the reports the Executive lead would update the PEQS Committee.
- 2.31 The rater per 100,000 aligns to the Welsh Health Circulars. The current and previous versions of the Welsh Health Circulars titled, 'AMR & HCAI Improvement Goals' have consistently required Health Boards and Trusts to reduce the annual incidence of C. Difficile to 25 cases per 100,000.
- 2.32 The IPC Consultant Nurse confirmed that the Health Board has consistently fallen below these targets and therefore has no target to aspire to achieve. Consideration is being given to setting an additional internal target to have something to work towards and to drive improvement.

#### Conclusion 5:

- 2.33 There is regular reporting on C. Difficile performance to the IPC Group and there is a defined route of escalation to the PEQS Committee if required. At the close of quarter 3, C. Difficile cases were below the Welsh Government target outlined in Welsh Health Circular (WHC 2023/031). (*Substantial Assurance*)

<sup>1</sup> <https://www.gov.wales/sites/default/files/publications/2022-04/amr-hcai-improvement-goals-for-2021-2023.pdf>

## Appendix A: Management Action Plan

Matter Arising 1: Enhancements to papers presented to the Patient Experience, Quality and Safety Committee (Operation)		Impact	
<p>Our review of the papers presented to the Patient Experience, Quality and Safety Committee linked to the IPC Improvement Plan highlighted the following:</p> <ul style="list-style-type: none"> <li>The Infection Prevention Control Improvement Plan referred to Cwm Taf University Health Board within the header, when presented to the PEQS Committee in October 2023; and</li> <li>The Integrated Quality Report presented to the PEQS Committee on 23 January 2024 had not been updated from the Executive Committee, the report date and purpose required an update.</li> </ul>		<p>Potential risk of:</p> <ul style="list-style-type: none"> <li>Non-compliance with infection control reporting requirements and legislation.</li> </ul>	
Recommendation		Priority	
1	Greater attention to detail should be given to the papers presented to the Patient Experience, Quality and Safety Committee in the context of the IPC Improvement Plan.	<b>Low</b>	
Agreed Management Action		Target Date	Responsible Officer
1	Ensure a robust Quality Assurance process is in place within the Nursing Directorate prior to sharing reports with corporate team for publication	01/04/2024	Assistant Director of Quality & Safety

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Matter Arising 2: Infection Prevention & Control, Decontamination & Antimicrobial Resistance Group's Terms of Reference requires review (Design)		Impact	
<p>As noted within the IP&amp;C Improvement Plan, a review of the IP&amp;C assurance framework and reporting structures resulted in a combined IP&amp;C &amp; Decontamination Group, with regular reporting into the PEQS Committee.</p> <p>We reviewed the terms of reference and operating arrangements for the 'Infection Prevention &amp; Control, Decontamination &amp; Antimicrobial Resistance Group', and noted that they are dated July 2020, and therefore requires review.</p>		<p>Potential risk of:</p> <ul style="list-style-type: none"> <li>The Health Board fails to prevent the spread of infection.</li> </ul>	
Recommendation		Priority	
2	To ensure the 'Infection Prevention & Control, Decontamination & Antimicrobial Resistance Group' have a clear purpose the terms of reference and operating arrangements should be reviewed and approved.	<b>Low</b>	
Agreed Management Action		Target Date	Responsible Officer
2	The existing terms of reference will be revised to incorporate some of the actions identified within this audit and the organisations Infection Prevention and Control improvement plan. An updated terms of reference will be presented to the next quarterly group in May 2024 for ratification and approval.	05/05/2024	Consultant Nurse – Infection Prevention & Control

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Matter Arising 3: Addition of IPC Team's SOP to the Clostridioides Difficile Policy (Operation)		Impact	
<p>We reviewed the C. Difficile Policy and the suite of Standard Operating Procedures and make the following observations:</p> <ul style="list-style-type: none"> <li>The management of Clostridioides Difficile Policy (IPC 003) was approved by the 'Infection Prevention and Control Group', under delegated authority, as detailed within 'CGP 004 – Management of Policies, Procedures and Other Written Control Documents'. Whilst the Group has the relevant expertise to scrutinise the Policy, there is potentially a lack of transparency and independent scrutiny when it is approved internally. We also note that CGP 004 is significantly passed its review date of 2018. As these issues are outside the control of the IPC Group, we do not make any recommendation as part of this audit but will take them forward separately with the Health Board's Corporate Governance team.</li> <li>Through the course of the audit we were presented with the Standard Operating Procedure 'Management and Escalation of C.difficile cases/clusters/outbreaks and cases identified within Primary Care' but this was not appended to the Policy where other Standard Operating Procedures were included. The IPC Consultant Nurse advised that the SOP details processes solely for the IPC team.</li> </ul>		<p>Potential risk of:</p> <ul style="list-style-type: none"> <li>Non-compliance with infection control reporting requirements and legislation; and</li> <li>The Health Board fails to prevent the spread of infection.</li> </ul>	
Recommendation		Priority	
3	To strengthen the governance framework which supports infection prevention and control, the IPC Team's SOP on the 'Management and Escalation of C.difficile cases/clusters/outbreaks and cases identified within Primary Care' should be appended to the Policy, in keeping with other SOPs.	<b>Medium</b>	
Agreed Management Action		Target Date	Responsible Officer
3	Infection Prevention & Control policies in the mane align with the Scottish National Infection Prevention & Control manual (NIPCM), which has been adopted for use by all organisations within Wales and adheres to best practice. The IP&C team will work with the corporate governance team to enhance independence and transparency. The SOP on the 'Management and Escalation of C.difficile cases/clusters/outbreaks' will be incorporated into the current policy.	01/04/2024	Consultant Nurse – Infection Prevention & Control

Matter Arising 4: Non-compliance with Mandatory IPC Training (Operation)		Impact
<p>The IPC Policy highlights that it is the role of management to ensure that all staff complete the mandatory IPC training held in ESR. We reviewed the IPC Quarter 3 report, which was presented to the Group on 30<sup>th</sup> January 2024, which noted the following compliance rates:</p> <ul style="list-style-type: none"> <li>• Non Clinical Staff 89.8% (713 of 794) – 3 year renewal of Level 1; and</li> <li>• Clinical Staff 82.82% (1,263 of 1,525) – Annual renewal of Level 2.</li> </ul>		<p>Potential risk of:</p> <ul style="list-style-type: none"> <li>• The Health Board fails to prevent the spread of infection.</li> </ul>
Recommendation		Priority
4	Management should be reminded to ensure that all staff complete their Infection Prevention and Control training held in ESR.	<b>Medium</b>
Agreed Management Action		Target Date
4	The Infection Prevention and Control team will continue to work collaboratively with service leads to ensure the completion of mandatory level 1 & 2 training. Strengthened monitoring of compliance will occur during the quarterly Infection Prevention and Control group, with service leads expected to report on compliance and actions for improvement, if required. The reporting requirements will be strengthened in the groups updated terms of reference.	01/04/2024
		Responsible Officer
		Consultant Nurse – Infection Prevention & Control

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Matter Arising 5: The timeliness of reporting mandatory IPC Training (Operation)		Impact
<p>We reviewed the source data for ESR IPC Training rates which informed the Quarter 3 IPC report. We noted that Workforce and OD confirmed the compliance figures as at 31 October 2023, which were reported on 30 January 2024 meeting (a 3-month gap).</p>		<p>Potential risk of:</p> <ul style="list-style-type: none"> <li>The Health Board fails to prevent the spread of infection.</li> </ul>
Recommendation		Priority
5	<p>Consideration should be given to the timeliness of ESR IPC Training data which informs the IPC Quarterly report.</p>	<p><b>Low</b></p>
Agreed Management Action		Target Date
5	<p>Traditionally reporting periods have covered the previous quarter, but moving forward, we'll strive to provide real-time data on training compliance to the group. This will include integrating the agreed management actions from recommendation 4 above.</p>	<p>05/05/2024</p>
		Responsible Officer
		<p>Consultant Nurse – Infection Prevention &amp; Control</p>

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## Appendix B: Assurance opinion and action plan risk rating

### Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

	<b>Substantial assurance</b>	Few matters require attention and are compliance or advisory in nature. <b>Low impact</b> on residual risk exposure.
	<b>Reasonable assurance</b>	Some matters require management attention in control design or compliance. <b>Low to moderate impact</b> on residual risk exposure until resolved.
	<b>Limited assurance</b>	More significant matters require management attention. <b>Moderate impact</b> on residual risk exposure until resolved.
	<b>Unsatisfactory assurance</b>	Action is required to address the whole control framework in this area. <b>High impact</b> on residual risk exposure until resolved.
	<b>Assurance not applicable</b>	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

### Prioritisation of Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

\* Unless a more appropriate timescale is identified/agreed at the assignment.

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CF15 7QZ

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11/07/2024 09:50:36

**Agenda item: 7.1**

<b>Patient Experience, Quality and Safety Committee</b>		<b>Date of Meeting: 16 April 2024</b>
<b>Subject:</b>	<b>Corporate Risk Register</b> (Relevant to the committee)	
<b>Approved and Presented by:</b>	Director of Corporate Governance and Board Secretary	
<b>Prepared by:</b>	Director of Corporate Governance and Board Secretary PA to Director of Corporate Governance and Board Secretary	
<b>Other Committees and meetings considered at:</b>	Executive Committee – 06 March 2024 PTHB Board – 20 March 2024	

**PURPOSE:**

The purpose of the Committee Risk Register (CRR) is to draw together relevant risks for the Committee from the CRR, to provide a summary of the significant risks to delivery of the health board’s strategic objectives.

**RECOMMENDATION(S):**

It is recommended that the Committee **CONSIDERS** the February 2024 version of the Committee Risk Register, which reflects the risks identified as requiring oversight by this Committee. This copy of the Committee Risk Register is based upon the Corporate Risk Register (CRR) considered by the Board on 20 March 2024.

The Committee is asked to **consider** the corporate risks within the committee’s remit, **discuss** any relevant issues and take **assurance** that risks are being managed in line with the Risk Management Framework.

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Approval/Ratification/Decision	Discussion	Information
x	✓	✓

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

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

**EXECUTIVE SUMMARY:**

The purpose of the Committee Risk Register is to draw together relevant risks for the Committee from the Corporate Risk Register (CRR), to provide a summary of the significant risks to delivery of the health board’s strategic objectives.

**BACKGROUND AND ASSESSMENT:**

The CRR provides a summary of the significant risks to the delivery of the health board’s strategic objectives. Corporate risks also include risks that are widespread beyond the local area, and risks for which the cost of control is significantly beyond the scope of the local budget holder. The CRR is reviewed by the Executive Committee on a bi-monthly basis and is noted by the Board.

The Committee is asked to DISCUSS the risks relating to Patient Experience, Quality and Safety Committee and the risk targets within the Committee Based Risk Register, and to CONSIDER whether the targets identified are achievable and realistic.

The full Committee Risk Register is attached at **Appendix A.**

**NEXT STEPS:**

The group will lead the ongoing development of patient experience, quality and safety risks as set out above.

An updated version of the Corporate Risk Register is due to be presented to the Board on 22 May 2024.

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NHS  
WALES

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Addysgu Powys  
Powys Teaching  
Health Board

# **Patient Experience, Quality and Safety Committee (16 April 2024) Committee Based Risk Register**

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16 April 2024  
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## CORPORATE RISK HEAT MAP:

There is a risk that...

<b>Impact</b>	<b>Catastrophic</b>	<b>5</b>					
	<b>Major</b>	<b>4</b>				<ul style="list-style-type: none"> <li>Citizens of Powys receive poor quality care (quality defined as safety, effectiveness and experience) from one or more of a range of providers</li> </ul>	
	<b>Moderate</b>	<b>3</b>					
	<b>Minor</b>	<b>2</b>					
	<b>Negligible</b>	<b>1</b>					
			<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
			Rare	Unlikely	Possible	Likely	Almost Certain
			<b>Likelihood</b>				

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### CORPORATE RISK DASHBOARD

Risk Lead	Risk ID	Main Risk Category	Risk Description There is a risk that:	SCORE (Likelihood x Impact)	Board Risk Appetite	Risk Target	At Target ✓/✗	Lead Board Committee	Risk Impacts on
DoNM/ MD	CRR 003	<b>Quality</b>	Citizens of Powys receive poor quality care (quality defined as safety, effectiveness and experience) from one or more of a range of providers	<b>4 x 4 = 16</b>	Minimal	6	✗	Patient Experience, Quality and Safety	Organisational Priorities Underpinning WBO 1 to 4

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**KEY**

**Risk Appetite Descriptors and Categories**

Risk Appetite	Description
Averse	Avoidance of risk and uncertainty in achievement of key deliverables or initiatives is key objective. Activities undertaken will only be those considered to carry virtually no inherent risk.
Minimal	Preference for very safe business delivery options that have a low degree of inherent risk with the potential for benefit/return not a key driver. Activities will only be undertaken where they have a low degree of inherent risk.
Cautious	Preference for safe options that have low degree of inherent risk and only limited potential for benefit. Willing to tolerate a degree of risk in selecting which activities to undertake to achieve key deliverables or initiatives, where we have identified scope to achieve significant benefit and/or realise an opportunity. Activities undertaken may carry a high degree of inherent risk that is deemed controllable to a large extent.
Open	Willing to consider all options and choose one most likely to result in successful delivery while providing an acceptable level of benefit. Seek to achieve a balance between a high likelihood of successful delivery and a high degree of benefit and value for money. Activities themselves may potentially carry, or contribute to, a high degree of residual risk.
Eager	Eager to be innovative and to choose options based on maximising opportunities and potential higher benefit even if those activities carry a very high residual risk.

Executive Lead:	
CEO	Chief Executive
DFIT	Director of Finance, Information and IT
D Ops	Director of Operations/Director of Community and Mental Health
DoNM	Director of Nursing and Midwifery
MD	Medical Director
DPH	Director of Public Health
DWOD	Director of Workforce & Organisational Development
DoTHS	Director of Therapies & Health Sciences
DP&C	Director of Performance and Commissioning
ADoEP	Associate Director of Estates and Property
DCG	Director of Corporate Governance

**Risk Scoring**

LIKELIHOOD	IMPACT				
	Insignificant 1	Minor 2	Moderate 3	Major 4	Catastrophic 5
Almost Certain 5	5	10	15	20	25
Likely 4	4	8	12	16	20
Possible 3	3	6	9	12	15
Unlikely 2	2	4	6	8	10
Rare 1	1	2	3	4	5

Very Low	Low	4-8	Moderate	9-12	High	15-25
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RISK APPETITE	
Category	Appetite for Risk
Safety	Averse
Quality	Minimal
Regulation and Compliance	Cautious
Reputation and Public Confidence	Cautious
Performance and Service Sustainability	Cautious
Financial Sustainability	Cautious
Workforce	Cautious
Partnerships	Open
Innovation and Strategic Change	Open

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<b>CRR 003</b> <b>Risk that:</b> citizens of Powys receive poor quality care (quality defined as safety, effectiveness and experience) from one or more of a range of providers		<b>Executive Lead:</b> Director of Nursing and Midwifery, Medical Director  <b>Assuring Committee:</b> Patient Experience, Quality and Safety																												
<b>Risk Impacts on:</b> Organisational Priorities underpinning WBO 1 to 4		<b>Date last reviewed:</b> February 2024																												
<b>Risk Rating</b> (likelihood x impact): Inherent: 4 x 5 = 20 <b>Current: 4 x 4 = 16</b> Target: 2 x 3 = 6	<table border="1"> <caption>Risk Score and Target Score History</caption> <thead> <tr> <th>Month</th> <th>Target Score</th> <th>Risk Score</th> </tr> </thead> <tbody> <tr><td>Sept-22</td><td>6</td><td>16</td></tr> <tr><td>Nov-22</td><td>6</td><td>16</td></tr> <tr><td>Dec-22</td><td>6</td><td>16</td></tr> <tr><td>Feb-23</td><td>6</td><td>16</td></tr> <tr><td>Apr-23</td><td>6</td><td>16</td></tr> <tr><td>Aug-23</td><td>6</td><td>16</td></tr> <tr><td>Dec-23</td><td>6</td><td>16</td></tr> <tr><td>Feb-24</td><td>6</td><td>16</td></tr> </tbody> </table>	Month	Target Score	Risk Score	Sept-22	6	16	Nov-22	6	16	Dec-22	6	16	Feb-23	6	16	Apr-23	6	16	Aug-23	6	16	Dec-23	6	16	Feb-24	6	16	<b>Rationale for current score:</b> <ul style="list-style-type: none"> <li>Intelligence from incidents, concerns and complaints</li> <li>Intelligence from patient engagement</li> <li>Intelligence and communication from all stakeholders and partners</li> <li>Increased pressure on the NHS as a result of multiple factors (aging population, winter pressures, post Covid-19 pandemic)</li> </ul>	
Month		Target Score	Risk Score																											
Sept-22	6	16																												
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Aug-23	6	16																												
Dec-23	6	16																												
Feb-24	6	16																												
<b>Date added to the risk register</b> Risk Updated September 2022	<b>Controls (What are we currently doing about the risk?)</b> <ul style="list-style-type: none"> <li>Integrated Performance Framework</li> <li>Powys Clinical Audit plan</li> <li>Internal Audit annual plan of audits</li> <li>NHS Wales collaborative management groups and associated peer groups</li> <li>Collaboration with the Delivery Unit (NHS Wales)</li> <li>Review of CQC and HIW reports for all providers where Powys residents receive care</li> <li>Triangulation of concerns, complaints (PTR) and incidents</li> <li>Operational arrangements for operational delivery (e.g DCG)</li> <li>Partnership with PCC</li> <li>Communication and engagement with the public and stakeholders</li> </ul>		<b>Mitigating actions (What more will we do?)</b> <table border="1"> <thead> <tr> <th>Action</th> <th>Lead</th> <th>Deadline</th> </tr> </thead> <tbody> <tr> <td>Improve and refine the Integrated Performance Framework</td> <td>DoPP</td> <td>Sept 2022</td> </tr> <tr> <td>Monitor fundamentals of care (provider services)</td> <td>DoNM</td> <td>Ongoing</td> </tr> <tr> <td>Mortality Reviews</td> <td>MD</td> <td>Ongoing</td> </tr> <tr> <td>Address inequalities of access</td> <td>DoPP/ DOMHP PC DoTH</td> <td>Ongoing</td> </tr> <tr> <td>Implement Patient experience system (Civica)</td> <td>DoTH</td> <td>Dec 2022</td> </tr> <tr> <td></td> <td>DoNM/ DoPP</td> <td>June 2024</td> </tr> </tbody> </table>		Action	Lead	Deadline	Improve and refine the Integrated Performance Framework	DoPP	Sept 2022	Monitor fundamentals of care (provider services)	DoNM	Ongoing	Mortality Reviews	MD	Ongoing	Address inequalities of access	DoPP/ DOMHP PC DoTH	Ongoing	Implement Patient experience system (Civica)	DoTH	Dec 2022		DoNM/ DoPP	June 2024					
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	Revisions to IPF to include a strengthened focus of Quality. This will come through to PEQs and Board , will become the IQPF Quality and Performance Escalation Framework in development (QuPEF)		
<b>Current Risk Rating</b>	<b>Update including impact of actions to date on current risk score</b>		
<b>4 x 4 = 16</b>	<p>This risk will continue to be reviewed at PEQs. The integrated Quality Report informs the Committee of triangulated data. Key matters at February meeting include an update of Maternity Services (Powys Provider), preparation for the implementation of the Duty of Quality and Duty of Candour and progress with the National Nosocomial Framework. Focus on concerns/ complaints will now focus on themes and trends identifying priorities for learning, now that process matters have been addressed.</p> <p>Integrated Performance framework - Approved by the Board in September 2022, implementation to be reported through Delivery and Performance Committee. A project group has been established, chaired by the AD Performance and Commissioning, with representatives from commissioning, performance, finance, nursing, workforce and service group colleagues. Duty of Quality and the implementation of a Total Quality Management System as part of the IPF will be Powys THB vehicle for quality control and quality planning.</p> <p>4.09.2023: The scoring of this current risk needs to remain the same presently. There is an acknowledgement that this current risk is multiple risks in one and therefore needs to be fully re-assessed. The Medical Director and Director of Nursing and Midwifery have a meeting planned with the Director of Corporate Governance/ Board Secretary to agree a course of action.</p> <p>01.03.2024: The score of this risk remains the same presently.</p>		

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