Patient Experience, Quality and Safety Committee

Tue 29 April 2025, 09:00 - 12:30

Agenda

09:00 - 09:00
0 min

1. PRELIMINARY MATTERS

PEQS_ Agenda_29April25 FINAL.pdf (3 pages)

1.1. Welcome and Apologies

1.2. Declarations of Interest

PEQS_1.2_Register of Interests Board Members 2024-25Feb.pdf (4 pages)

1.3. Patient Story

09:00 - 09:00
0 min

2. CONSENT AGENDA BUSINESS

The Chair will ask if there are any items from the Consent Agenda (Item 6) that Committee Members wish to bring forward to the main agenda.

09:00 - 09:00
0 min

3. ITEMS FOR APPROVAL / DECISION / RATIFICATION

3.1. Minutes of the previous meeting: 11 February 2025

PEQS_3.1_Minutes 2025-02-11 PEQS unconfirmed.pdf (14 pages)

3.2. Committee Action Log

PEQS_3.2_Action Log Apr25.pdf (1 pages)

3.3. Committee Annual Work Programme 2025/26

PEQS_3.3_Work Programme 2025-26.pdf (1 pages)

3.4. Committee Annual Report

PEQS_3.4_PEQS Committee Annual Report 2024-25 FINAL.pdf (13 pages)

09:00 - 09:00
0 min

4. ESCALATED ITEMS

4.1. Children's Neurodiversity Services update

Attached *Executive Director of Planning, Performance and Commissioning*

PEQS_4.1_ND Exec Committee 30 April 2025.pdf (2 pages)
PEQS_4.1a_ND progress report April 2025.pdf (6 pages)
PEQS_4.1c_Appendix 2 IQPAF.pdf (9 pages)
PEQS_4.1d_Appendix 3 Conditions for Sustainability.pdf (6 pages)

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4.2. People Experience Framework

4.3. Infection Prevention and Control

- PEQS_4.3_IP&C Improvement Plan Update Position.pdf (5 pages)

09:00 - 09:00
0 min

5. ITEMS FOR ASSURANCE

5.1. Integrated Quality Report

- PEQS_5.1_Integrated Quality Report April 2025 (003).pdf (25 pages)
- PEQS_5.1a_Appendix 1.pdf (35 pages)
- PEQS_5.1b_Appendix 2.pdf (47 pages)
- PEQS_5.1d_Appendix 4.pdf (73 pages)
- PEQS_5.1e_Appendix 5.pdf (3 pages)

5.2. Annual Programme Clinical Audit

- PEQS_5.2_Clinical Audit Programme 2025-26.pdf (26 pages)

5.3. Monitor Health Board actions of Joint Inspection of Child Protection Arrangements

- PEQS_5.3_JICPA Update Report.pdf (6 pages)

5.4. Staff Experience of MH and LD services in escalation

5.5. Annual Assessment of Committee Effectiveness

- PEQS_5.5_PEQS Committee effectiveness_2024-25.pdf (27 pages)

5.6. Review of Terms of Reference

- PEQS_5.6_Patient Experience, Quality and Safety Terms of Reference Review.pdf (2 pages)
- PEQS_5.6a_ToR Review_2025 (Draft).pdf (11 pages)

5.7. Committee Risk Register

09:00 - 09:00
0 min

6. ITEMS FOR DISCUSSION

There are no items for discussion

09:00 - 09:00
0 min

7. CONSENT AGENDA

7.1. Internal Audit Reports:

7.1.1. Patient Flow and Discharge Management

- PEQS_7.1a_PTH-2425-06 Patient Flow and Discharge Management Final report.pdf (17 pages)

7.1.2. Additional Learning Needs

- PEQS_7.1b_Additional Learning Needs Final Report.pdf (10 pages)

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7.2. Audit Wales Report - Cancer Services

- PEQS_7.2a_AW Cancer Services in Wales - English_0.pdf (72 pages)
- PEQS_7.2b_Cancer - Policy - Audit Wales - Management Response Form - Cancer Services - (English).pdf (9 pages)

7.3. Joint Commissioning Committee Quality Patient Safety Committee Summary Report

- PEQS_7.3_JCC QSO Highlight Report Feb 25.pdf (6 pages)

7.4. Glossary

- PEQS_7.4_Glossary.pdf (5 pages)

09:00 - 09:00
0 min

8. OTHER MATTERS

8.1. Any Other Urgent Business

8.2. Items to be brought to the attention of the Board and/or other Committees

8.3. Committee reflections

8.4. Date of the Next Meeting: 31 July 2025

8.5. 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 interes

8.6. Welcome and Apologies

8.7. Declarations of Interest

8.8. Briefing on suicides

8.9.

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POWYS TEACHING HEALTH BOARD
PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE

TUESDAY 29 APRIL 2025
09.00 – 12.30
The Board Room, Machynlleth Hospital

AGENDA

Time	Item	Title	Attached/Oral	Presenter
	1	**PRELIMINARY MATTERS**		
09.00	1.1	Welcome and apologies	Verbal	Chair
	1.2	Declarations of interest	Verbal	All
	1.3	Patient Story	Video	Executive Director of Nursing, Quality, Women and Family Health
	2	**CONSENT AGENDA BUSINESS**		
The Chair will ask if there are any items from the Consent Agenda (Item 7) that Committee Members wish to bring forward to the main agenda.				
	3	**ITEMS FOR APPROVAL / DECISION / RATIFICATION**		
09.20	3.1	Minutes of previous meeting: • 11 February 2025	Attached	Chair
	3.2	Committee Action Log	Attached	Chair
	3.3	Committee Annual Work Programme 2025/26	Attached	Chair
	3.4	Committee Annual Report	Attached	Chair
	4	**ESCALATED ITEMS**		
09.35	4.1	Children's Neurodiversity Services update	Attached	Executive Director of Planning, Performance and Commissioning
	4.2	People Experience Framework update - (within Integrated Quality Report)	Verbal	Executive Director of Nursing, Quality, Women and Family Health
09.55	4.3	Infection Prevention Control	Attached	Executive Director of Nursing, Quality, Women and Family Health
	5	**ITEMS FOR ASSURANCE**		
10.05	5.1	Integrated Quality Report	Attached	Executive Director of Nursing, Quality, Women and Family Health
10.45	5.2	Annual Programme Clinical Audit • Review of 2024/25 Programme • Planned Programme 2025/26	Attached	Executive Medical Director
11.00		**COMFORT BREAK (15 minutes)**		

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11.15	5.3	Monitor Health Board actions of Joint Inspection of Child Protection arrangements	Attached	Executive Director of Nursing, Quality, Women and Family Health
11.25	5.4	Staff Experience of Mental Health and Learning Disability Services in escalation	Presentation	Executive Director of Primary, Community Care and MH
11.40	5.5	Annual Assessment of Committee Effectiveness	Attached	Director of Corporate Governance
11.50	5.6	Review of Terms of Reference	Attached	Director of Corporate Governance
12.00	5.7	Committee Risk Register	Verbal	Director of Corporate Governance
	6	**ITEMS FOR DISCUSSION**		
		There are no items for discussion		
	7	**CONSENT AGENDA**		
12.05	7.1	Internal Audit Reports: • Patient Flow and Discharge Management Final Report • Additional Learning Needs Legislation **Purpose**: Information	Attached	Director of Corporate Governance
	7.2	Audit Wales Report: • Cancer Services **Purpose**: Information	Attached	Executive Medical Director
	7.3	Joint Commissioning Committee Quality Patient Safety Committee Summary Reports 03 February 2025 (see also Integrated Quality Report)	Attached	Director of Corporate Governance
	7.4	Glossary **Purpose**: Information	Attached	Director of Corporate Governance
	8	**OTHER MATTERS**		
	8.1	Any Other Urgent Business	Oral	Chair
	8.2	Items to be brought to the attention of the Board and/or other Committees	Verbal	Chair
	8.3	Committee Reflections	Verbal	Chair
12.15	8.4	Date of the next meeting: 31 July 2025 via Teams		

8.5 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:
Motion under Section 1(2) Public Bodies (Admission to Meetings) Act 1960

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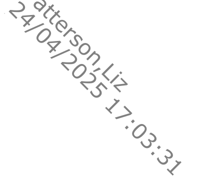
"Representatives of the press and other members of the public shall be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest"				
12.15	8.6	Welcome and Apologies	Verbal	Chair
	8.7	Declaration of Interest	Verbal	Chair
	8.8	Briefing on suicides	Verbal	Executive Director of Nursing, Quality, Women and Family Health
12.30	Close			



POWYS TEACHING HEALTH BOARD - REGISTER OF DECLARATION OF INTERESTS 2024/25								Updated: February 2025	
Position	Name	Nature of Interest	Nature of Declaration	Relevant Dates from	Relevant Dates to	Description of Declaration	Comment	Date Returned	Last day in Powys Teaching Health Board
INDEPENDENT MEMBERS									
PTHB Chair	Carl Cooper	Personal	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	2017	2025	Board Member, Social Care Wales	Remunerated Public Appointment	03/02/2025	
		Spouse/Partner/Other	Ownership or part ownership, of private companies, businesses or consultancies likely or possibly seeking to do business with PTHB.	2018	Ongoing	Sole Trader, Mandy Williams, Consulting	NIL		
			A personal or departmental interest in any part of the Pharmaceutical / healthcare industry that could be perceived as having an influence on decision making or on the provision of advice to members of the team	2025	Ongoing	Stepdaughter's partner is a Pharmaceutical Control Analyst employed by Cardiff & Vale Health Board.	Nil		
Vice Chair	Kirsty Williams	Personal	A position of authority in a Charity of Voluntary Body in the field of health and/or social care	May-22	Current	Deputy Director Samaritans Powys	None	22/05/2024	
			Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	Nov-22	Current	ILEP- A Subsidory of Cardiff University	None		
			Employment by any other body where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice	Feb-24	Ongoing	Commissioner for South Wales Fire and Rescue	Ministerial Appointment		
		Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		
Independent Member (General)	Rhobert Lewis	Personal	Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests.	Nov-21	Current	Chair NPTC Group of Colleges	NIL	08/04/2024	
				Sep-23	Current	Chair Confederal Governance UWTSD	NIL		
				Nov-21	Current	Member of National Assesmbly of Wales Cross-Party Group on STEMM	NIL		
		Spouse/Partner/Other	NIL	NIL	NIL	NIL			
Independent Member (Trade Union)	Cathie Poynton	Personal	NIL	NIL	NIL	NIL	NIL	02/04/2024	
		Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		
Independent Member (Information and Technology)	Ian Phillips	Personal	Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests.	01-Aug-21	Current	Independent Chair Welsh Kidney Network	Remunerated	08/04/2024	22/08/2024
		Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		
Independent Member (finance)	Steve Elliot	Spouse/Partner/Other	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	04/02/2024	Current	Director of Oshi's World Private Limited Company	NIL	19/08/2024	
		Personal	Ownership or part ownweship of private companies, businesses or consultancies likely or possibly seeking to do business with PTHB	22/09/2023	31/03/2024	Special Advisor (Finance) to Powys tHB Audit and Delivery and Performance Committees	Yes		
		Spouse/Partner/Other	A position of authority in a Charity or Voluntary Body in the field of health and/or social care	04/02/2024	Current	Trustee of Oshi's World Charity	NIL		
Independent Member (General)	Ronnie Alexander	Personal	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	2012	Current	Director of RA and CJ Consulting Limited	Dividend Payment only	15/08/2024	
			A position of authority in a Charity or Voluntary Body in the field of health and/or social care.	2017	Current	Member of Finance, Risk and Audit Committee Hafod/Hendre Housing Association	£2500.00 per annum		
			Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests	Mar-21	Current to Dec-27	Personal: Independent Monitoring Authority (IMA) – Non Executive Director	£7500.00 per annum		
		Spouse/Partner/Other	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	2017	Current	Director of RA and CJ Consulting Limited	Dividend Payment only		
Independent Member (University)	Simon Wright	Personal	Employment by any other body where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice.	2015	Current	Personal: Academic Registrar, Cardiff University- Various Healthcare Programmes	Salaried Employment		

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		Spouse/Partner/Other	A personal or departmental interest in any part of the Pharmaceutical / healthcare industry that could be perceived as having an influence on decision making or on the provision of advice to members of the team	2001	Current	Sister: Senior Operational Manager, Milestone Trust, Bristol	Salaried Employment	08/07/2024	
			Employment by any other body where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice.	2021	Current	Spouse: District Nurse, Cardiff and Vale UHB	Salaried Employment		
Independent Member (Third Sector)	**Jennifer Owen Adams**	Personal	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	Jun-16	Ongoing	Member (not a NED) of Glas Cymru the holding company of Dwr Cymru/Welsh Water	None	30/04/2024	
			Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests	Apr-14	Ongoing	Trustee of Impelo Dance CIO	None		
				Jul-05	Ongoing	Chair Public Services Board Scrutiny Committee	None		
		Spouse/Partner/Other	Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests	2013	Ongoing	Brother - Senior Manager Freedom Leisure (Lead responsibility for Swansea and South Powys).	NIL		
Independent Member (Local Authority)	**Christopher Walsh**	Personal	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.			Member of Community Speed Wath Group Member of Society Genealogists Associate Member of the Association of Genealogists and Registered Archivists	NIL	09/09/2024	
			Ownership or part ownweship of private companies, businesses or consultancies likely or possibly seeking to do business with PTHB		Ongoing	Sole Trader/Owner of Celebratory Gifts Heraldic Names Sole Trader/Owner:CTW Genealogy Research and	NIL		
			A position of authority in a Charity or Voluntary Body in the field of health and/or social care.		Ongoing	Elected Member Powys County Council •Trustee/Chair: Brecon University Scholarship Fund •Brecon Town Council Elected Member •Governor of Priory Church in Wales School •Member Brecon Beacons National Park Authority SDF & Grant Advisory Panel	NIL		
			Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests.		Ongoing	•Member of Royal College of Nursing •Registered Member of Nursing and Midwifery Council	NIL		
			Employment by any other body where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice.		Ongoing	Labour Party	NIL		
Independent Member (Capital)	**Michael Giannai**	Personal	Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests.	2019	Current	Chair of the Board of Social Care Wales (Welsh Government Sponsored Body).	Remunerated	01/04/2024	
		Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		
Independent Member	**Ian Thomas**	Personal	Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests.	Jan-23	Current	Family Fund (UK Charity)	NIL	09/01/2025	
				Jun-24	Currne t	Family Fund Business Services (FFBS)	NIL		
EXECUTIVE MEMBERS									
Chief Executive Officer	**Hayley Thomas**	Personal	NIL	NIL	NIL	NIL	NIL	30/05/2024	
		Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		
Executive Director of Planning, Performance & Commissioning	**Stephen Powell**	Personal	NIL	NIL	NIL	NIL	NIL	03/07/2024	18/10/2024
		Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		
Executive Director of Finance, Capital	**Pete Hopgood**	Personal	NIL	NIL	NIL	NIL	NIL		

and Support Services		Spouse/Partner/Other	A personal or departmental interest in any part of the Pharmaceutical / healthcare industry that could be perceived as having an influence on decision making or on the provision of advice to members of the team	Ongoing	Ongoing	Partner is Finance Manager working in SBUHB	Not Relevant	22/05/2024	
Executive Director of Allied Health Professions, Health Science and Digital	**Claire Madsen**	Personal	Employment by any other body where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice.	07-Jan-19	Current	Occasional Lecturer for University of West of England.	Hourly rate	02/04/2024	
			Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	10-Jun-05	Current	Member of the The Chartered Society of Physiotherapy	NIL		
		Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		
Executive Director of Nursing, Quality, Women and Family Health	**Claire Roche**	Personal	A personal or departmental interest in any part of the Pharmaceutical / healthcare industry that could be perceived as having an influence on decision making or on the provision of advice to members of the team	2018	Current	Member of the Royal College of Nursing	NIL	22/08/2024	
				1994	Current	Member of the Royal College of Midwifery			
		Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		
Executive Medical Director	**Kate Wright**	Personal	Employment by any other body where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice.	01-Aug-91	Current	Member of the British Medical Association		12/08/2024	
		Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		
Executive Director of People and Culture	**Debra Wood Lawson**	Personal	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	01-Nov-24	Current	Non Executive Board Director - Cadarn Housing Group Limited (Powys is a zonal partner)	NIL	18/11/2024	
		Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		
Executive Director of Public Health	**Mererid Bowley**	Personal	Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests.	NIL	NIL	Member of Faculty of Public Health	NIL	23/05/2024	
		Spouse/Partner/Other	Ownership or part ownership, of private companies, businesses or consultancies likely or possibly seeking to do business with PTHB.	NIL	NIL	Husband works for Mitie Engineering who hold contracts/work with some NHS bodies/organisations. Shares held by husband and myself and Mitie Company	NIL		
Interim Executive Director of Operations	**Joy Garfitt**	Personal	NIL	NIL	NIL	NIL	NIL	No change from 2023 submission	30/09/2024
		Spouse/Partner/Other	A personal or departmental interest in any part of the Pharmaceutical / healthcare industry that could be perceived as having an influence on decision making or on the provision of advice to members of the team	2012	Current	Spouse employed by PTHB within Mental Health Department	NIL		
Director of Corporate Governance/ Board Secretary	**Helen Bushell**	Personal	Employment by any other body where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice.	Nov-21	Current	School Governor – primary school (Bridgend Local Authority)	Not remunerated	03/06/2024	
		Spouse/Parter or other Relative	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	Sep-16	Current	Board Diretor and Chair of the Board Cadarn Housing Ltd (Powys is a zonal partner)	Remunerated part time role, 2-4 days per month		
			A personal or departmental interest in any part of the Pharmaceutical / healthcare industry that could be perceived as having an influence on decision making or on the provision of advice to members of the team	Jul-24	Oct-24	Spouse member of the PTHB Bank working occasionally for the Health Board	Paid per hour/day of work		
			Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests.	Sep-22	Current	Public Appointment - Youth Work strategy and implementation Board - Oct 22 - Sept 24	Remunerated 2-4 days per month		
Associate Director of Capital and Estates	**Wayne Tannahill**	Personal	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	1996	2016	Director of Pembrokeshire Surveyors Ltd. Sole proprietor, small architectural business, made dormant April 2016 (formally closed April 2017)		24/04/2024	
		Spouse/Parter or other Relative	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	1996	2016	Daughter Kate was Company Secretary			
Director of Strategic	**Lucie Cornish**								

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Improvement and Transformation		Nil	Nil	Nil	Nil	Nil	Nil	13/11/2024	
Executive Director of Planning, Performance & Commissioning	**Nicola Johnson From 07/10/24**	Nil	Nil	Nil	Nil	Nil	Nil	16/10/2024	
Executive Director of Primary, Community Care and Mental Health	**Elaine Lorton From 30/09/2024**	Personal	A position of authority in a Charity or Voluntary Body in the field of health and/or social care.	Nov-19	Current	Chair – West Wales Care & Repair	Nil	17/10/2024	
				Apr-24	Current	Independent Member – ateb	£2,960 Per Annum		

PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE

UNCONFIRMED MINUTES OF THE MEETING HELD ON 11 FEBRUARY 2025 at 13:00 VIA MICROSOFT TEAMS

MEMBERS		
Kirsty Williams	KWi	Vice Chair (Committee Chair)
Jennifer Owen Adams	JOA	Independent Member (Third Sector)
Ian Thomas	IA	Independent Member (General)
IN ATTENDANCE		
Zoe Ashman	ZA	Interim Assistant Director Women & Children
Katie Blackburn	KB	Llais
Helen Bushell	HB	Director of Corporate Governance / Board Secretary
Lucie Cornish	LC	Director of Improvement and Transformation (for Item 5.7)
Susan Dinsdale	SD	Head of Nursing for Children (for Items 4.1 and 5.7)
Amanda Edwards	AE	Assistant Director Innovation and Improvement
Kate Evans	KE	Women's and Childrens Risk Governance Lead
Pete Hopgood	PH	Executive Director Finance, Capital and Support Services
Louisa Kerr	LK	Assistant Director Mental Health (for Items 5.2 and 5.4)
Elaine Lorton	EL	Executive Director of Primary Care, Community and Mental Health
Claire Madsen	CM	Executive Director of Allied Health Professionals, Health Sciences and Digital
Jacqui Seaton	JS	Chief Pharmacist (for Items 5.5 and 5.6)
Heidi Sinclair	HS	Head of Quality and Safety
Kate Wright	KW	Executive Medical Director
APOLOGIES FOR ABSENCE:		
Carl Cooper	CC	Chair of PTHB Board
Nicola Johnson	NJ	Executive Director of Planning, Performance and Commissioning
Claire Roche	CR	Executive Director of Nursing, Quality, Women and Family Health
Hayley Thomas	HT	Chief Executive
Jayne Wheeler-Sexton	JWS	Assistant Director of Nursing, Safeguarding
Simon Wright	SW	Independent Member

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1. PRELIMINARY MATTERS

1.1 WELCOME AND APOLOGIES (PEQS/24/70)

The Chair welcomed everyone to the meeting. Apologies for absence were received as recorded above.

1.2 DECLARATIONS OF INTEREST (PEQS/24/71)

No declarations of interests were received in addition to those already recorded on the register.

2. CONSENT AGENDA BUSINESS

The Chair asked members if they wished to bring forward any items from the Consent agenda to the main agenda.

HB advised that the Consent Agenda contained an Internal Audit Report on the Deprivation of Liberty Safeguards which had been received at the Audit, Risk and Assurance Committee (ARAC). Internal Audit Reports are then shared with relevant Committees for information. In the case of this Internal Audit Report ARAC have transferred an action which requests that this Committee monitor implementation of agreed management actions (see Item 3.2). This will be scheduled into the work programme.

No items were raised by Committee Members.

3. ITEMS FOR APPROVAL / DECISION / RATIFICATION

3.1 MINUTES OF PREVIOUS MEETING (PEQS/24/72)

The minutes of the meeting held on 07 November 2024 were **CONFIRMED** as an accurate record.

3.2 COMMITTEE ACTION LOG (PEQS/24/73)

HB outlined the Action Log recorded updates with the following information provided:

- Six actions had been completed and closed
- Two actions were on track
- Four actions have been transferred into this Committee from other Committees:
    - From Planning, Partnerships and Population Health Committee - to agree frequency of updates in relation to antibiotic resistance. KW undertook to meet with the antimicrobial team to confirm a suggested six-month cycle **Action: Executive Medical Director**
    - From Delivery and Performance Committee – to examine how quality is measured in general and community dental services. EL agreed to bring this to the July 2025 meeting. **Action: Executive Director Primary Care, Community and Mental Health**
    - From Audit, Risk and Assurance Committee to monitor implementation of agreed management actions in relation to the Internal Audit Report on Deprivation of Liberty Safeguards. HB undertook to confirm with CR if the report should be presented in April or July 2025. **Action: Director of Corporate Governance**
    - From Delivery and Performance Committee to reflect on quality elements in relation to JAG (Joint Advisory Group on gastrointestinal

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endoscopy) accreditation – scheduled for July 2025 meeting. **Action: Executive Director Primary Care, Community and Mental Health**

There appears to be an increasing number of actions from other Committees to this Committee to monitor. Is this a proportionate level of action transfers?
HB advised this was a timely question as the team were undertaking reviews on Committee effectiveness and Terms of Reference alongside work planning. This will be shared at the Joint Chair's Group to ensure a balanced, appropriate risk-based plan for the year.

KWi observed the necessity to consider the particular focus that this Committee has on quality when work planning.

4. ESCALATED ITEMS

4.1 CHILDREN'S NEURODIVERSITY SERVICES (PEQS/24/74)

KW presented the report on behalf of NJ advising that Children's Neurodiversity Services had been put into Level 3 local escalation under the Integrated Quality and Performance Framework in October 2024 after a significant increase in the number of referrals into the service and a number of identified performance and quality concerns namely:

- A continued and consistent failure to meet agreed improvements, including failure to deliver Ministerial Priority measures,
- Performance for Neurodevelopmental assessment continued to fall outside of the lower control limit, with performance flagged as a special cause for concern due to the consecutive decreasing trend.
- Challenge that the Referral to Treatment backlog not resolved as expected.

An Executive Oversight Group was established which first met on 29 October 2024.

An Improvement Plan was agreed with 43 actions of which:

- 15 have been completed
- 9 with progress being made and on track and will be completed within timescale
- 18 with progress being made, action likely to be achieve within timescale
- 1 is significantly behind schedule with no progress made / or progress made but timescale not achieved. This action is being addressed to support job planning with support of an Assistant Medical Director
- All 8 Welsh Government (WG) standards are met within current service delivery model.

Details of focussed actions were outlined as shown in the report along with next steps. KW cautioned that despite the progress made, the position remains challenging.

ZA drew attention to the following:

- a welcome reduction in Did Not Attend rates to below the Welsh average,
- that the week-long multi-disciplinary team focus had been effective,
- that there had been a reduction in long waits for assessment – with no patients now waiting beyond three years, and the intention that no patients

would wait more than two years, although a small number are expected to be waiting over 2 years as of 31 March 2024.
- The intention to have no more than 300 patients waiting over a year will not be met, as the original trajectory only took into account first assessments, not those patients who required more than one assessment. A revised 'committed' target has been calculated to include all patients on the pathway.
- It will be necessary to get to a position where pathways are closed in a timely way, therefore pathways will not be opened until cases are ready to be seen as previously pathways were opened and this resulted in patients waiting years for the pathways to be closed.
- Co-production is working well with monthly evening meetings where the following activity has taken place; a logo for the service has been agreed, a template letter for assessment conclusion agreed, production of literature for 0-5 years and 5-11 years, plans for a digital story in quarter 4, questionnaires for CIVICA agreed, and uniform preferences outlined.

EL left the meeting 13.25

Independent Members asked the following questions for assurance:
Is this a team particularly affected by staff turnover?
SD confirmed that the increasing numbers of staff were reflective of an increase in demand. When the service had been established it was expecting to receive 60 referrals a year, it is now receiving over 60 referrals a month.

Is the service on a trajectory which will lead to de-escalation and what will be required to reach this position given the challenges outlined within the report?
KW advised that de-escalation would be appropriate when the service was able to demonstrate that the systems and processes were in place to enable sustained performance and quality. Improving performance was likely to remain challenging for some time and was linked to resource availability.

To what extent does the service work with the local authority, and are there opportunities to pool resources?
ZA advised that the service worked closely with the local authority who were producing an Additional Learning Needs Strategy during summer 2025 which was an important link to neurodiversity. A shared platform is used to undertake multi-disciplinary team assessments. In addition, the Start Well programme under the Regional Partnership Board had a strong focus on neurodiversity. Mapping of the offer from health, social care and education has been completed to ensure appropriate links are in place, and the co-production work is attended by colleagues from early years and education.

Are there any opportunities for the team to learn from the experience of the Midwifery team who were previously in escalation?
AE advised that a member of the Midwifery Team had previously attended the learning from experience group and consideration will be given to how this experience could be shared with the Neurodiversity Team.

In relation to the one area which is significantly behind schedule (job planning for consultant Paediatricians) what action is being taken to address this?

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KW advised that the Assistant Medical Director is working with the Paediatricians to ensure the Job Plans are written.

Can assurance be given that there is an appropriate focus on improvement both in the performance and quality realm?
ZA confirmed a weekly meeting is held with the NHS Executive in relation to the additional funding provided and the team have been explicit that the intention is to shorten pathways, reduce waiting times and to improve the position for new patients as well as those part way through the system.

KB observed that neurodiversity is a priority for Llais and a challenge nationally.

KWi noted that whilst considerable progress had been made, and thanked the team for all their work, there were still a number of families waiting over two years for an assessment and there remained much work to be done to ensure a quality sustainable service was in place.

The Committee:

- **TOOK ASSURANCE** that the implementation of the IQPF Escalation Oversight mechanism is providing robust oversight of the quality improvement and risk mitigation work being undertaken within Neurodevelopmental Services, and
- **NOTED** and **DISCUSSED** the contents of the report and including the action plan and progress report.

4.2 CIVICA – PATIENT EXPERIENCE SYSTEM (PEQS/24/75)

CM presented the report on behalf of CR advising that publication of the Wales Patient Experience Framework was expected imminently ahead of implementation in April 2025. It will be necessary to undertake an assessment of the data held against the data required during March. The team already understand where gaps might be, and it is hoped the appointment of a colleague will enable implementation to be supported.

KWi confirmed this item would remain as an escalated item.

4.3 INFECTION PREVENTION CONTROL (PEQS/24/76)

KWi noted this item was escalated to the Board, however, would be addressed under item 5.1 Integrated Quality Report.

5.ITEMS FOR ASSURANCE

5.1 INTEGRATED QUALITY REPORT (PEQS/24/77)

KW introduced the paper and drew attention to the following areas:

- Concerns management continues to perform well with an average of 80% responded to within 30 days
- Themes of concerns included communication issues, clinical treatment and attitude and behaviour which was disappointing although small numbers of concerns meant caution should be applied to themes
- Duty of candour cases continue to rise as a result of increased awareness, but no redress cases have been triggered
- Incident management are showing a high number of low to medium harm with an increasing number of timely incident closure

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- 52% of Nationally Reportable Incidents remain open due to a number of complex mental health cases which take longer to investigate
- In relation to Civica responses it should be noted that some months have low responses, particularly for provider services
- 46 actions have been completed on the Infection Prevention and Control improvement plan with one expected to be completed by February 2025 and one expected to be completed within the planned timeframe
- There remain a small number of outstanding actions from Health Inspectorate Wales (HIW) inspections to complete

EL joined the meeting 13.55

EL advised that HIW were currently undertaking an unannounced inspection of Clywedog Ward.

Members asked the following questions for assurance:
How prepared are the Health Board to take part in single unified safeguarding reviews?
KW advised that a response to this query would be sought and provided to the Committee.
Action: Executive Medical Director

Why is there a dramatic reduction in responses to your NHS experience between June and July 2024?
ZA advised that this related to a data lag when seeking information relating to external providers.

Infection prevention and control is currently escalated from the Committee to Board. What is the process for de-escalating this item?
HB advised that CR was intending to bring a paper to the Executive Committee and then this Committee giving assurance on actions taken in relation to infection prevention and control with a recommendation that the Committee can advise Board that this is de-escalated.

Are the number of overdue nationally reportable incidents (NRIs) proportionate to the size of population the Health Board serves?
KW advised that the small numbers dealt with in the Health Board meant fluctuations were more marked. There were a number of complex mental health cases which took time to investigate.

Is the number of overdue NRIs an early indicator of a deterioration in performance in this area?
KW advised that the team operate in a busy environment but were aware of the need to ensure that these matters were attended to promptly and improve the response times.

The Chair noted that the Committee would monitor the position and would not wish to see a further deterioration in timeliness of responses.

The Committee:

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- **RECEIVED** the report and took **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.

5.2 ADULT MENTAL HEALTH SERVICES MONITORING POST LOCAL ESCALATION (PEQS/24/78)

LK joined the meeting and presented the Adult Mental Health Services post local escalation monitoring report and drew attention to the following areas:

- In relation to incident management, when the service was escalated in March 2024 there were 480 overdue incidents going back up to two years. This has reduced and stabilised to between 60-100 incidents
- The Nationally Reportable Incident position has improved significantly
- Policy and audit trackers have been prioritised with the most important policies updated first and a system to identify those policies about to go out of compliance
- A review of audits has identified themes for learning including in relation to training
- Senior Management meet quarterly to ensure improvement is sustained and continues to be made

Members asked the following questions for assurance:
Are any of the outstanding overdue incidents from the cohort of overdue incidents that were identified in March 2024, and if so, do they create a particular threat to patient safety or the Health Boards reputation?
LK confirmed that the majority of incidents identified in March 2024 had been investigated and closed, and any that remained open were associated with awaited Coroner findings. The process for investigating incidents had been strengthened and the three teams were working closely to close incidents in a timely manner but also identify incident themes and share learning to make improvements across the service.

Now this service has been de-escalated from local escalation how do the Executive Committee receive assurance that the improvements are sustained and ongoing?
EL advised that Adult Mental Health Services have reported through the usual assurance mechanisms since de-escalation. These mechanisms include a Directorate Management Team which meets monthly to receive assurance on all areas within the Directorate including the financial position, planning and performance, and quality and safety matters. Any items requiring escalation are directed to Executive Committee and onwards to a Board Sub-Committee where appropriate. Within the Mental Health Services division reporting frameworks have been strengthened and aligned to the organisational integrated quality and performance framework to ensure that appropriate information is shared with the Directorate Management Team to provide assurance on the service.

The post escalation period is a potential area of risk as the intense focus on a service area is removed. What actions are being taken to ensure that the investment and attention on this service are appropriate to ensure improvement continues?
EL advised that one of the first challenges as a new Director was to review staffing models to ensure they were appropriate to provide safe, high-quality

delivery. This review is approximately 80% complete and there may be opportunities, particularly within Mental Health and Learning Disability services to make significant spend to save arrangements. It is not anticipated that there will be savings within the operational structure, and it is likely that modest workforce investment will be required to generate a sustainable model.

KW concurred that workforce fragility had led to the need for local escalation and the team were working hard to make substantive appointments. There was also a focus on putting in place strong systems and processes which will help maintain improvements and identify emerging issues much earlier which can be addressed before the service deteriorates.

EL concluded by noting that de-escalation of this service had happened comparatively quickly but rather than meaning the improvements had been concluded, it meant that the team had mitigated to a satisfactory level the issues that had been identified. It will be necessary to substantiate the largely interim staffing arrangements to ensure a sustainable position and that a continuous improvement cycle is embedded.

The Committee:

1. Took **ASSURANCE** that MH&LD Services are maintaining good practice achieved through delivery of the continuous improvement response plan in relation to measures for which they were escalated.
2. **NOTED** and **DISCUSSED** the contents of the report.
3. Took **ASSURANCE** from the ongoing monitoring and evaluation mechanisms in place as part of the Integrated Quality and Performance Framework (IQPF).

LK left the meeting 14.45

5.3 MATERNITY SERVICES ASSURANCE REPORT (PEQS/24/79)

ZA presented the Maternity Services Assurance Report and drew attention to the following areas:

- A low number of formal concerns recorded the majority of which are being managed as early resolutions
- Intrapartum transfer rates remain static which each case being reviewed
- Home birth rates are 9% of all births which is higher than the all Wales rate of 3%
- Regular meetings take place with commissioned service partners
- Cwm Taf Morgannwg have moved maternity services from the Prince Charles Hospital in Merthyr Tydfil to Bridgend. Powys women are able to access care in Hereford as an alternative to Bridgend.
- Monitoring of gap and grow has improved significantly
- Training compliance is 100%
- Improvements have been made to the triage process
- Data quality has improved
- Women’s health is getting more complex, and it is necessary to work with obstetric partners to manage increased health needs

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Members asked the following questions for assurance:
Is the trajectory for home births in Powys increasing and are Powys mothers encouraged to birth at home?

KE advised that during the period of local escalation the numbers of births in Powys (both home births and in birth centres) decreased but this has increased over recent months as psychological safety of staff has improved and women are empowered to choose where to give birth.

Much improvement is evidenced in the report, what checks and balances are in place to ensure this improvement is sustained?
KE confirmed the Improvement Plan will be renamed the Continuous Improvement Plan which will be amended to include new actions that arise going forward.

Given the financial pressures facing the Health Board, what impact will the workforce review have on maternity service provision?
KE advised that the service is seeking to utilise existing staff in the best way which may involve splitting some roles as not all posts are required to be full time in Powys in this small service.

Given that Powys commission maternity care from a large number of partner organisations, what processes are in place should there be problems in one of the commissioned services?
KE advised that quarterly meetings take place with senior partners in commissioned services where all cases are tracked, and issues can be escalated if necessary.

Have the issues relating to gap and grow compliance been fully resolved?
KE advised that maternity services across Wales were working hard to ensure that arrangements for viewing growth charts when care was shared between providers (including in England) was in place. It is hoped that this issue will be resolved in the coming year.

Given the known issues in ambulance services do Powys maternity services experience problems accessing intrapartum transfers?
KE advised that unexpected transfers do happen for women who decide to birth locally outside of guidelines. However, local midwifes monitor women during and post birth to identify any signs that the women or baby need to be transferred to hospital. Maternity calls trigger an immediate amber call to ambulance services and response times have been monitored and are found to be between 9 and 32 minutes.

The Committee:

- **RECEIVED** the report and took **ASSURANCE** about the quality and safety governance mechanisms in place within maternity services.

JS joined the meeting 15.00

5.4 MENTAL HEALTH POWER OF DISCHARGE ANNUAL REPORT INCLUDING COMPLIANCE WITH LEGISLATION (PEQS/24/80)

LK joined the meeting and presented the Mental Health Power of Discharge Annual Report drawing attention to the following areas:

- No non-compliance was identified in relation to the use of sections of the Act

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- Slightly reduced numbers were recorded in comparison to previous years which may be due to a reduced bed base because of environmental works
- A review of length of stay of patients under the Act is in progress
- Trend data had been provided to Committee members
- Police Stations will now no longer be places of safety, in the past year custody has only been used once
- A Health Inspectorate Wales (HIW) inspection of Newtown Community Mental Health Team had a positive outcome although noted a lack of administrative capacity which the service is working to address through the Admin review
- An unannounced inspection is currently taking place on Clywedog Ward

Members asked the following questions for assurance:
What plans are in place for a place of safety when police custody is no longer available?
LK confirmed that not being able to use police custody as a place of safety may result in a delay between assessing a person and finding an appropriate placement. However, police custody is rarely used, and this would not be a common occurrence.

The lack of fundamentally defective detentions is welcomed. What action is being taken to address the minor administrative errors which have been recorded?
LK confirmed that minor administrative errors could be for example spelling a name with an E rather than an A. Checking ensures these errors are picked up quickly and rectified. If errors are more fundamental, then a review meeting would take place with partners, however, these it is rare for fundamental errors to occur.

What plans are in place to encourage take up of Independent Mental Health Advocates (IMHAs)?
LK explained that IMHAs are proactively offered to all patients but take up is low with data available to demonstrate the offer has been made which is shared with the Power of Discharge Committee. The new Mental Health Act will alter the position to ensure that patients must proactively opt to not have an IMHA. This may alter demand for an IMHA, and this will be monitored and reported to the Power of Discharge Committee.

The HIW Inspection report for Newtown notes a lack of administrative capacity. What actions are being taken to address this finding?
LK noted there was one Mental Health Administrator post and with the increase in demand in the service, capacity and cover was an issue. Cover arrangements are in place, but further capacity is required to enable resilience in the service. A job description has been through job evaluation and will now go through the recruitment authorisation process.

The Committee:
- **RECEIVED** the report and took **ASSURANCE** that the performance of the service in relation to the administration of the Mental Health Act 1983 has been compliant with legislation.

LK left the meeting 15.20

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5.5 MEDICINES MANAGEMENT ANNUAL REPORT (PEQS/24/81)

KWi welcomed JS to the meeting noting this was JS' last meeting before retirement. KWi thanked JS for all the work she had undertaken in this area and wished her well for the future.

JS presented the Medicines Management Annual Report and drew attention to the following areas:

- Electronic prescribing and Medicines Administration (EPMA) has been implemented in Builth Wells, Llandrindod Wells, Presteigne and Knighton and will be starting in Rhayader, Ddyfi Valley, Ystradgynlais and Llanfyllin after April 2025.
- Electronic prescribing for hospital services (wards and outpatients) will be rolled out in early summer starting in the South Cluster area then out to the rest of Powys
- The Medicines Safety Officer works with the Community Pharmacy Service to share learning from medicine safety incidents across the organisation
- Opportunities to take efficiencies from the medicines budget are continually sought for example via windfall savings when drugs come off patent. A team member uses Power BI which primary care can always refer to for up-to-date information on prescribing and comparative prescribing data between practices
- Workforce pressures continue to be prevalent with difficulties recruiting in North Powys and to pharmacy posts with mental health specialisms. Opportunities to train existing team members could be considered
- Access to wider data needs to be improved, for example when in discussions with practices in relation to antimicrobial activity, access to admission for infection data would help provide a full picture
- 56-day prescribing remains a challenge with 79% of Powys patients registered with a dispensing practice who will not move to 56-day prescribing
- Work is ongoing to improve arrangements in relation to high-cost prescribing

Members asked the following questions for assurance:

What progress is being made in reducing inappropriate prescribing?

JS noted that central messages from Welsh Government in relation to inappropriate prescribing would be of great help to Health Boards, but these have not been forthcoming. The team write letter templates for practices to use when items are deemed inappropriate (for example removing bath and shower emollients). The 'easy' items have been removed, and it is time to tackle those items that people have been receiving for a long time and do not want to change. The formulary is being strengthened and made more user friendly, and clinicians are encouraged to use it.

What will the new Chief Pharmacist need to focus on in their first 100 days?

JS recommended a focus on finance and the efficiency plan, then windfall savings, such as in relation to a particular drug that has recently come off patent and could save £0.5m a year. However, dispensing practices have a dispensing deal and this is a challenge for the Health Board.

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The Committee:

- **RECEIVED** the report and took **ASSURANCE** that the necessary responsibilities in relation to Medicine Management are being met.

5.6 ANNUAL REPORT OF ACCOUNTABLE OFFICER FOR CONTROLLED DRUGS (PEQS/24/82)

JS presented the report which was taken as read.

The Committee:
- **RECOGNISED** the progress that has been made during the last 12 months **NOTING** that there is further work required to strengthen some arrangements across the health board and through collaborative working with partners., as outlined in the report.
- Took **ASSURANCE** that future actions have been identified to address the further work.

JS left 15.40

5.7 TRANSITION OF CARE ANNUAL REPORT 2023/24 (PEQS/24/83)

ZA presented the report and drew attention to:
- This was the 2023/24 report which had been delayed with the 2024/25 report expected to the July meeting of the Committee. Apologies were offered for the late production of the report and bi-annual updates were offered on this item
- An Oversight Group is in place to manage and oversee transitions across all services from age 14 onwards
- A gap analysis has been undertaken and submitted to Welsh Government. The gaps and challenges identified are being addressed including working with commissioned colleagues

KWi observed the late production of the report noting the Committee expected timely production of Annual Reports. Members agreed to receive the Transition of Care Annual Report 2024/25 to the July meeting of the Committee and review the frequency that this item should be monitored at this time.
Action: Director of Nursing, Quality, Women and Family Health

Members asked the following questions for assurance:
How does the service work with schools in the area of transition, including in relation to the ALN act which covers young people up to the age of mid 20s?
ZA advised there is a quarterly in-house monitoring meeting, and a bi-monthly multi-disciplinary complex case meeting including social care and education. It should be noted that complex case numbers are not large.

The Committee:
- **RECEIVED** and took **ASSURANCE** against the progress being made across the Health Board in relation to Welsh Government Transition and Handover Guidance (2022).

5.8 COMMITTEE RISK REGISTER (PEQS/24/84)

HB presented the report advising that the Corporate Risk Register had been taken to Board in January 2025. Two risks fall under this Committee:
- Risk 004: Increase in demand, inequality of access, complexity of patient needs, or failure to respond to demand pressures for PTHB provided

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services results in poorer outcomes and experience for the citizens of Powys, and

- Risk 005: Increase in demand, inequality of access, complexity of patient needs, or failure to respond to demand pressures for commissioned services results in poorer outcomes and experience for the citizens of Powys. Commissioned services may include urgent and emergency health and social care system.

Both risks are owned by the Executive Director of Planning, Performance and Commissioning and there has been no change in the risk scoring.

The Committee:

- **RECEIVED** and **DISCUSSED** the corporate risks within the Committee's remit and any relevant issues
- **TOOK ASSURANCE** that risks are being managed in line with the Risk Management Framework.

6. ITEMS FOR DISCUSSION

There were no items for discussion

7. CONSENT AGENDA

7.1 INTERNAL AUDIT REPORTS (PEQS/24/85)

The Committee **RECEIVED** the Internal Audit Report on Deprivation of Liberty Safeguards which had been received by the Audit, Risk and Assurance Committee on 14 January 2025. This internal audit had reported Limited Assurance, and the Audit, Risk and Assurance Committee had requested that the Patient Experience, Quality and Safety Committee monitor progress against recommendations (Action ARAC/24/75).

The Committee also received the Board and Committee Effectiveness Internal Audit which had received Substantial Assurance for information.

Further Internal Audits would be received where relevant to the remit of the Committee.

7.2 WORK PROGRAMME (PEQS/24/86)

The Committee **RECEIVED** the Committee Work Programme as of February 2025.

8. OTHER MATTERS

8.1 ANY OTHER URGENT BUSINESS (PEQS/24/66)

There were no items of any other business.

8.2 ITEMS TO BE BROUGHT TO THE ATTENTION OF THE BOARD AND/OR OTHER COMMITTEES (PEQS/24/67)

It was noted that the Chair would provide updates on those items escalated to Board.

8.2 COMMITTEE REFLECTION (PEQS/24/68)

The following summary of business and reflections were provided by members:

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- A challenging meeting due to a number of staff absences, thanks were recorded to those colleagues who had covered for absent staff members
- The detail presented at Committees is wide ranging and consideration may need to be given to the level of detail that is provided, however, it is likely it will be needed given the remit of the Committee
- Without being complacent good progress is being made in some areas which should be noted
- The Committee provides an opportunity to challenge the organisation where problems are identified and monitor progress to address any such issues
- Transitions is an area that Llais receives concerns on, and the Transitions Annual Report gave insight into the work ongoing in this area
- The questions raised were all relevant providing honest communication and scrutiny. It is clear Committee Members have read and understood the papers and are able to question colleagues on what the information presented means for the people of Powys. The meeting felt inclusive and functional.

8.3 DATE OF NEXT MEETING (PEQS/24/69)

The date of the next meeting is scheduled on 29 April 2025 at 10.00 in Machynlleth. Microsoft Teams.

Meeting closed at 16.00

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Liz Patterson

RAG Status:

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

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Patient Experience, Quality and Safety Committee

Meeting Date	Item Reference	Lead	Meeting Item Title	Details of Action	Update on Progress	Original target date	Revised Target Date	RAG status
OPEN ACTIONS FOR REVIEW - NONE								
OPEN ACTIONS - IN PROGRESS BUT NOT YET DUE								
05-Dec-24	D&P/24/086a	Executive Medical Director / Executive Director Primary, Community Care and Mental Health	In-reach Fragility	It was agreed that an update report regarding JAG accreditation would be considered to the Patient Experience, Quality and Safety Committee to reflect on quality elements to provide further assurance on what is being done to regain the accreditation.	**Transfered to PEQS Committee.** **11.02.25 update** - scheduled to July 2025 meeting. PPPH and D&P are considering a JAG accreditation update w/c 3 Feb 2025	Jul-25		On track
05-Dec-24	D&P/24/083c	Executive Director of Primary, Community Care and Mental Health.	Primary Care: GDS	It was agreed that a report would be considered at the Patient Experience, Quality and Safety Committee in the near future to fully understand how quality is measured from a general and community dental perspective.	**Transferred to PEQS Committee** **Update 11.02.25:** Item will be added to the 2025/26 work programme, date to be confirmed - in meeting date agreed as July 2025	Jul-25		On track
14-Jan-25	ARAC/24/075	Executive Director of Nursing, Quality, Women and Family Health	Items to be brought to the attention of other Committees	Deprivation of Liberty Safeguards to be transferred to PEQS for monitoring progress against recommendations	**Transferred to PEQS Committee** **Update 11.02.25:** Item added to work programme for 2025/26. The internal audit report has been shared for information within the agenda and papers for the 11.02.25 meeting DCG undertook to confirm date for this to be considered with EDNQWFH **-**	Jul-25		On track
11-Feb-25	PEQS/24/83	Executive Director of Nursing, Quality, Women and Family Health	Transition of Care Annual Report	Transition of Care Annual Report to be brought to July meeting where a review of the frequency of monitoring will take place		Jul-25		On track
14-Nov-24	PPPH/24/012	Executive Director of Nursing, Quality, Women and Family Health	Antibiotic Resistance	Antibiotic Resistance is of Public Health significance, clarity as what frequency would committee expect to see report updates would be confirmed in February 2025	**02.02.2025 update** - The Director of Nursing, Quality, Womens and Family Health confirmed that reporting would be placed at the PEQS Committee given its remit**:** Item will be scheduled into the 2025/26 work programme. During meeting proposed a provisional six month schedule (MD to confirm)	Feb-25	Jul-25	On track
07-Nov-24	PEQS/24/52b	Executive Director of Nursing, Quality, Women and Family Health	Mental Health Services Update	An review of the Integrated Quality and Performance Framework be brought to a future meeting of PEQS	**Update 11.02.25**: The has been scheduled to be completed by 30 April 2025	Jul-25		On track
ACTIONS RECOMMENDED FOR CLOSURE (MEETING 29 APRIL 2025)								
16/04/2024	PEQS/24/10	DCG	Committee Annual Report	Consider including on the work programme an item on areas with high vacancy/high agency use in relation to the quality and sustainability of services	**30.07.24 update** - discussion planned with Chair and lead executive to explore and determine work programme **11.02.25 update:** Item will be scheduled into the 2025/26 work programme **29.04.25 update:** scheduled into work	Feb-25	Timescales TBC within 2025/26	Completed

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Patient Experience, Quality and Safety Committee 2025-26					
Theme	**Item Title**	**April 29/04/2025**	**July 31/07/2025**	**October 23/10/2025**	**February 05/02/2026**
Governance	Minutes of previous meeting	✓	✓	✓	✓
Governance	Declaration of Interests	✓	✓	✓	✓
Governance	Action Log	✓	✓	✓	✓
Governance	Committee Risk Register	✓	✓	✓	✓
Governance	Annual Work Programme	✓			
Governance	Committee Work Programme (updated through year)		✓	✓	✓
Governance	Items to be brought to the attention of the Board and/or other Committees	✓	✓	✓	✓
Governance	Annual Assessment of Committee Effectiveness	✓			
Governance	Committee Annual Report	✓			
Governance	Review of Terms of Reference PEQS	✓			
Quality	Integrated Quality and Performance Report to include:	✓	✓	✓	✓
	Once for Wales Content Management System	✓			
	Putting Things Right - Concerns	✓			
	Duty of Candour	✓			
	Claims, Redress and Clinical Negligence Position	✓			
	Incident Management	✓			
	Early Warning Notifications	✓			
	Nationally Reportable Incidents	✓			
	Mental Health Review of Suicides	✓			
	Welsh Risk Pool Assurance Report	✓			
	Peoples Experience - Civica	✓			
	Llais Activity	✓			
	Infection Prevention and Control	✓			
	Health Inspectorat Wales Inspections	✓			
	PAVO reports	✓			
	Bereavement Framework	✓			
	Venous Thrombiembolism Scroping Review	✓			
	Strengthening Safeguarding in Health Review	✓	✓		
	QUAILS reports from Service Groups				
	PSOW Annual Letter (within IQR - when received)			✓	
	National Programmes and Initiatives		✓	✓	✓
Quality	High vacancy/high agency use in relation to the quality and sustainability of services				
Research, Development and Improvement	Quality based improvement / learning				
Research, Development and Improvement	Research, Development and Onnovation				
Patient Experience	Patient Experience Framework		✓		
	Patient Story	✓	✓	✓	✓
	Patient Experience in Primary Care (deep dive)		✓		
MH Compliance	MH Power of Discharge Annual Report including MH compliance with legislation and update		✓		✓
Clincial Audit	Annual Programme Clinical Audit	✓			
	Progress Report Clinical Audit			✓	
Audit Reports	Any Internal Audit/Wales Audit reports received - for information	✓	✓	✓	✓
Medicines Management	Annual Report of Accountable Officer for Controlled Drugs				✓
Annual Reports	Medicines Management Annual Report			✓	
	Safeguarding Annual Report		✓		
	Duty of Quality Annual Report		✓		
	Annual Report Medical Devices and Point of Care Testing			✓	
	Transition of Care Annual Report		✓		
Infection Prevention and Control	IPC Annual Assurance Report		✓		
	IPC progress/focus				✓
Comms and Engagement	Comms and Engagement Report for PEQS			✓	
Other	Monitor Health Board actions of Child Pratice Review		✓		
	Monitor Health Board actions of JICPA	✓			
	Corporate Parenting Charter				✓
	Staff experience of MH&LD Services in escalation	✓			
	Staff experience of ND Services in escalation		✓		
	AW Cancer services report and WG response		✓		
	JCC Quality Safety and Outcomes Sub-Committee Hightlight Report	✓			
Actions	Monitor implementation of management actions for DoLS IA report	✓	✓		
	Six-monthly update on Antimicrobial resistance		✓		✓
	How quality is measure in general and community dental services	✓	✓		
	Quality elements in JAG to regain accreditation				
Escalated Items:	IP&C	✓			
	Civica (Patient Experience - see above)	✓	✓	✓	✓
	Neurodiversity (referred from D&P Oct 2024)	✓	✓	✓	✓
KEY					
Added to draft agenda					
Date to be confirmed					

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Agenda Item: 3.4

Patient Experience, Quality and Safety Committee	Date of Meeting: 29 April 2025
Subject:	**PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE ANNUAL REPORT TO THE BOARD**
Approved and Presented by:	Helen Bushell, Director of Corporate Governance / Board Secretary
Prepared by:	Head of Corporate Governance
Other Committees and meetings considered at:	N/A

PURPOSE:

The purpose of this report is to provide the Patient Experience, Quality and Safety Committee Report for 2024/25.

RECOMMENDATION(S):

It is recommended that the Patient Experience, Quality and Safety Committee :

- **CONSIDER** the Patient Experience, Quality and Safety Committee Annual Report for 2024/25 summarising the key areas of business activity undertaken;
- **RECOMMEND** the report to the Board for the 21 May 2025 meeting.

Approval/Ratification/Decision	Discussion	Information
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 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:

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- 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.

The committee annually review their 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 2024/25 was:

Name	Role	Attendance
Kirsty Williams	Chair	5/5
Jennifer Owen Adams	Vice-Chair	4/5
Ian Phillips (to 20/08/2024)	Independent Member	2/2
Simon Wright	Independent Member	4/5
Steve Elliot	Independent Member	1/1
Mick Giannasi	Independent Member	1/1
Ian Thomas	Independent Member	1/1

2.2 Others in Attendance

During 2024/25, the following staff attended the Committee:

Name	Role	Attendance
Claire Roche	Executive Director of Nursing, Quality, Women and Family Health	3/5
Kate Wright	Executive Medical Director	4/5
Claire Madsen	Executive Director of Allied Health Professions, Health Science and Digital	3/5
Joy Garfitt (to 30/09/2024)	Interim Director of Operations	0/3
Pete Hopgood (to 01/05/2024)	Executive Director of Finance, Capital and Support Services, Interim Director of Primary Care	1/1
Elaine Lorton (from 30/09/2024)	Executive Director Primary Care, Community and Mental Health	2/2
Nicola Johnson (from 07/09/2024)	Executive Director of Planning, Performance and Commissioning	1/2
Helen Bushell	Director of Corporate Governance / Board Secretary	5/5

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Other 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 2024/25 the Committee met five times and was quorate on all occasions.

The terms of reference for the Committee require meetings to be held four times a year and otherwise, as the Chair of the Committee deems necessary, consistent with the annual plan of Board and Committee Business. The Committee held an additional meeting in September 2024 to consider matters that were not fully prepared for the July meeting.

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3. Activity in 2024/25

3.1 Main Areas of Committee Activity 2024/25

ITEMS FOR ASSURANCE	
PATIENT STORIES	
Francis Isaacs – Memory Clinic	July 2024
Meggie's Story – Physio	Nov 2024
Quality, Safety and Patient Experience	
Integrated Quality Report	At every meeting November 2024 (including Public Services Ombudsman for Wales Annual Letter 2023/24)
Duty of Quality Annual Report 2023-24	September 2024
Infection Prevention and Control Annual Report	July 2024
Medical Devices and Point of Care Testing Annual Report 2023-2024	November 2024
Medicines Management Annual Report	February 2025
Annual Report of Accountable Officer for Controlled Drugs	February 2025
Transition of Care Annual Report	February 2025
Health and Safety Q1 and Q2 report	November 2024
Child Protection / Safeguarding	
Child Practice Review	April 2024

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Joint Inspection on Child Protection Arrangements	April 2024
Annual Safeguarding Report 2023-24	September 2024
Child Practice Review	November 2024
Services previously in local escalation	
Maternity Service assurance report	February 2025
Mental Health	
Adult Mental Health Post-escalation monitoring	February 2025
Mental Health Power of Discharge Annual Report 2023/24	July 2024
Mental Health Power of Discharge Six Monthly Report	February 2025
Clinical Audit and Regulatory Reports	
Clinical Audit Annual Programme	April 2024
Clinical Audit Progress Report	November 2024
Health Inspectorate Wales – Do Not Attempt Cardio-Pulmonary Resuscitation Inspection Report	July 2024
Care Inspectorate Wales – Cottage View Knighton Inspection Report	July 2024
ITEMS FOR APPROVAL	
There were no items for approval	
ITEMS CONSIDERED IN-COMMITTEE	
No items were considered In-Committee	
ESCALATED ITEMS	

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Infection Prevention and Control	Committee escalated to Board in July 2023 – monitoring reports received in April 2024 and, within Integrated Quality Report in July 2024, November 2024
Civica – Patient Experience	Committee escalated to Board in May 2023 – Patient experience included in Integrated Quality Report in April 2024 and July 2024. Separate reports on Patient experience received in November 2024 and February 2025
Mental Health Services	Escalated by Executive Committee in March 2024 – Committee advised in April 2024 - monitoring report received in July 2024 Committee advised in November 2024 that Executive Committee had de-escalated this service. The Committee to continue to receive post-escalation monitoring reports
Children's Neuro Developmental Services	Escalated by Executive Committee in October 2024 – Committee advised in November 2024 and monitoring report received in February 2025
CORPORATE GOVERNANCE	
Committee Annual Report	April 2024
Committee Annual Work Programme	April 2024
Committee Risk Register	Each meeting
Committee Work Programme	Each meeting
ITEMS FOR INFORMATION	
Internal Audit Reports: • Annual Internal Audit Plan (2024/25) • Board Committee Effectiveness (2023/24) • Infection Prevention and Control	 April 2024 April 2024 April 2024

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• Continuing Health Care • Patient Experience • End of Life Care • Deprivation of Liberty Standards • Board and Committee Effectiveness	July 2024 July 2024 November 2024 February 2025 February 2025
WHSSC/JCC Quality Patient Safety Committee Chairs Report: • 19 February 2024 • 24 June 2024 • 02 September 2024	 July 2024 November 2024 November 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 2024/25, 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. The reporting template was developed in year and made consistent across all Committees.

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:

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- The construct of the Committee meeting agendas remained flexible, and the application of a risk-based approach to the selection of agenda items.
- 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 organisation of the joint meeting with Workforce and Culture Committee.

The Committee is in the process of undertaking its annual effectiveness review process. The outcome and recommendations following this review will be reported to the Board in Quarter 1 of 2025/26.

6. Planned Activity in 2025/2026

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.

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Agenda item: 4.1

PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE	29 APRIL 2025
Subject:	Integrated Quality & Performance Framework – CYP Neurodevelopmental Services Escalation Oversight Group
Approved and presented by:	Nicola Johnson, Executive Director of Planning, Performance and Commissioning
Prepared by:	Claire Roche, Executive Director for Nursing, Quality, Women and Family Health Assistant Director, Women and Children Assistant Director of Performance and Commissioning
Other Committees and meetings considered at:	Executive Committee 2nd October 2024; 13th November 2024; 11th December 2024; 5th February 2025; 19th March 2025 and 23 April 2025. Patient Experience, Quality and Safety Committee – 7 Nov 2024, 11 Feb 2025.

PURPOSE:

In October 2024 the Executive Committee agreed that Children and Young People's (CYP) Neurodevelopmental Services in Powys Teaching Health Board (PTHB) be placed into PTHB's internal 'escalated' status.

The PTHB Integrated Quality & Performance Framework (IQPF) came into effect from the 1st April 2024. In the context of the IQPF, an Escalation Oversight Group (EOG) for Neurodevelopmental Services has been established.

The purpose of this paper is to provide the Executive Committee with an update on current progress.

RECOMMENDATION(S):

The Patient Experience, Quality and Safety Committee is asked to:

1. **TAKE ASSURANCE** that the implementation of the IQPF Escalation Oversight mechanism is providing robust oversight of the quality improvement and risk mitigation work being undertaken within Neurodevelopmental Services.

Approve/Take Assurance	Discuss	Note
Y	Y	N

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ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:

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

EXECUTIVE SUMMARY
A detailed progress report has been prepared (see Appendix One) which provides an update on current progress and escalation status.

IMPACT ASSESSMENT – NOT REQUIRED FOR THIS REPORT

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Neurodevelopmental Services Escalation Progress Report April 2025

Claire Roche, Executive Director for Nursing, Quality, Women and Family Health
Assistant Director, Women and Children
Assistant Director of Performance and Commissioning

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1. Background and Context

The PTHB CYP ND service was launched in February 2018. This service superseded the virtual Social Communication Assessment Teams (SCAT) who were responsible for the assessment and diagnosis of CYP with suspected Autistic Spectrum Disorder (ASD). The new Neurodevelopmental national pathway and its standards now offer CYP diagnostic assessment for both ASD and Attention Deficit Hyperactivity Disorder (ADHD).

Since its inception, the CYP ND service has experienced increased and sustained demand with capacity constraints in the service adversely impacting on the ability to achieve the Welsh Government Referral to Treatment (RTT) targets of 80% of CYP waiting less than 26 weeks to start an ADHD or ASD neurodevelopment assessment. It has been identified that the service is not compliant with recommendations from:

- National Institute for Health and Care Excellence (NICE) guidelines.
- Welsh Government delivery of Neurodevelopmental service standards.
- Wales Code of Practice on the Delivery of Autism Servies (Sept 2021).

In October 2024, the PTHB Executive Committee agreed that, within the context of the Health Board Integrated Quality and Performance Framework (IQPF), Children and Young People (CYP) Neurodevelopmental (ND) Services in PTHB be placed into an escalated (internal within the Health Board) status.

Escalation is considered against the 4 IQPF domains and 3 levels of escalation:

Domains	Escalation levels
Access and Activity Finance and Value Quality, Safety and Patient Experience Workforce and Culture	Level 1: Normal arrangements Level 2a: Failure to achieve/maintain delivery in more than 1 key deliverable/area of performance; Sustained deterioration on 1 or more deliverable/area of performance. Level 2b: Corporate Directorate or Clinical Service area level budget is overspending by more than £0.5m year to date or £1m forecast. Level 3: Serious concerns on quality and governance; Continued and consistent failure to meet agreed performance improvements and trajectories across a number of objectives.

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In line with the performance triggers for escalation within the IQPF, the CYP ND service has been escalated to level 3, the reason for the escalation being:

- Continued and consistent failure to meet agreed performance improvements, including failure to deliver Ministerial Priority measure.
- Performance for Neurodevelopmental assessment continues to fall outside of the lower control limit, with performance flagged as special cause concern due to consecutive decreasing trend.
- Challenge on RTT backlog not resolved as expected.

2. Escalation Oversight

An Escalation Oversight Group (EOG) has been established which describes the process of escalation, de-escalation and intervention process; the levels of escalation; and the four domains of the IQPF against which each service in escalation will be assessed. Services can be in escalation for any or all of these four domains.

The aim of the EOG is to:

- Provide assurance to the Health Board on the provision of safe and high quality care to the population we serve;
- Support an ethos of continuous quality improvement, listening, learning and acting, seeking continual improvement in communication and openness within and across Health Board to enable positive outcomes and shared learning;
- Provide support to the PTHB service placed in escalation and establish a robust monitoring process to gain assurance of improvements being realised and to establish where progress is not being made, ensuring remedial action and/or escalation to the Executive Team;
- Support and enable the service placed in escalation to make improvements and to provide assurance against the four domains of the IQPF.

As per the IQPF, an EOG for CYP ND Services has been established with the first formal of the weekly meetings being held on 29th October 2024. The group is chaired by the Executive Director of Planning, Performance and Commissioning with membership drawn from Executive Directors, Women and Children's Services and Corporate Directorates.

In response to being placed in level 3, the CYP ND service has developed an Improvement Plan (see Appendix One) with actions identified to address the long term commitment in addressing performance requirements in:

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- Address assessment backlogs prioritising longest waits initially; Meeting RTT waits and reduce breaches (Waiting list recovery project).

- Establishing a parents and carers group focussed on 0-5 and 5-11 year olds and address IG requirements to co-produce a padlet as a shared platform for centrally approved resources.

- Meet increased and sustained demand through a robust and sustainable workforce plan for PTHB and consider partnership roles with Powys County Council where appropriate.

- Provide a pre and post diagnostic service as set out in Welsh Government Standards and respective NICE guidance.

3. Current Progress

The CYP ND service in implementing the Improvement Plan has achieved considerable progress:

- All 8 Welsh Government standards met within current service delivery model.
- 43 improvement plan actions, all bar one either completed or will be completed within timescales:
  - Complete job planning for Consultant Paediatricians supported by an AMD, anticipated completion by end May 2025.

The service has undertaken an assessment of progress against the performance escalation triggers:

<table>
<tr><th>Area of Improvement</th><th>Current position</th></tr>
<tr><td>Continued and consistent failure to meet agreed performance improvements, including failure to deliver Ministerial Priority measure.</td><td rowspan="2">• All children previously managed on list have been seen for a first clinical appointment, total 558 since June 2024.
• Appropriate management of RTA since March 2025 with children being seen for first clinical appointment triggering removal from RTA.
• All appointments from 1/3/25 from RTA for clinical assessment – first time this has occurred for > 2 years.
• Run chart demonstrates the targeted work to address the backlog of longest waits.
• Work continues to ensure waits remain below 104weeks.</td></tr>
<tr><td>Performance for Neurodevelopmental assessment continues to fall outside of the lower control limit, with performance</td></tr>
</table>

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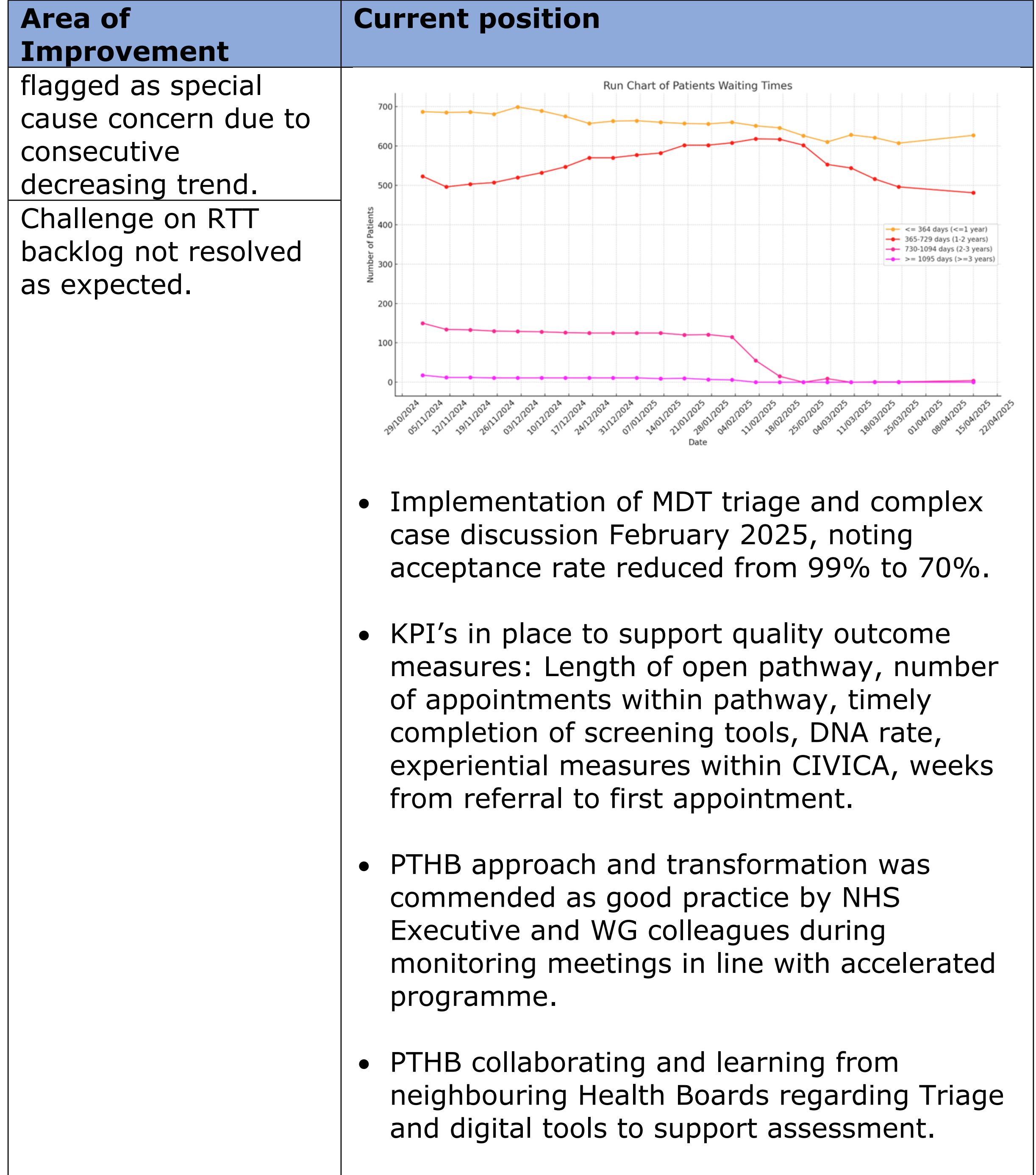
<table>
<tr><th>Area of Improvement</th><th>Current position</th></tr>
<tr><td>flagged as special cause concern due to consecutive decreasing trend.</td><td rowspan="2">

Implementation of MDT triage and complex case discussion February 2025, noting acceptance rate reduced from 99% to 70%.
KPI’s in place to support quality outcome measures: Length of open pathway, number of appointments within pathway, timely completion of screening tools, DNA rate, experiential measures within CIVICA, weeks from referral to first appointment.
PTHB approach and transformation was commended as good practice by NHS Executive and WG colleagues during monitoring meetings in line with accelerated programme.
PTHB collaborating and learning from neighbouring Health Boards regarding Triage and digital tools to support assessment.
</td></tr>
<tr><td>Challenge on RTT backlog not resolved as expected.</td></tr>
</table>

As part of the EOG process, two tools have been developed to provide assurance that the services are improving:

a) <u>IQPF Assessment Framework (IQPAF) self-assessment tool</u>: designed to be used for self-assessment of service maturity seeking to answer three key questions.
   1. How safe and effective are services?
   2. How person centred are services?
   3. How well led and effectively managed are services?

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The service completed a baseline assessment in November 2024 and have undertaken an assessment review in March 2025 (see Appendix Two) from which the service has identified that whilst there has been progress against the reasons for escalation, there has not been a change in the maturity due:

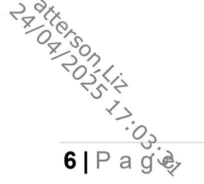
- Additional investment required to support transformation and sustainability.
- Service delivery very fragile and dependent on significant level of senior team member's support. This has been further impacted by sub-optimal processes to manage caseloads across the ND and community children's / paediatric service.

b) Conditions for Sustainability self-assessment tool: designed to be used for self-assessment of the service against a number of domains identified as essential for a sustainable service. The service has undertaken an assessment review in April 2025 (see Appendix Three).

4. Conclusion and Next steps

There has been considerable progress within the service in addressing the performance triggers that resulted in being placed into internal escalation within PTHB in October 2024 including:

- Of the 43 improvement plan actions, all either completed or on course for completion, with mitigating action to address.
- All children previously managed on internal list have been seen for a first clinical appointment, total 558 since June 2024.
- Appropriate management of RTA since March 2025 with children being seen for first clinical appointment triggering removal from RTA.
- Ministerial priority for 0 waits > 2 years achieved.
- Business case being developed with submission planned to IBG in May 2025 to consider robust structure in place informed by clear demand and capacity planning.
- Sustainable workforce with a permanent structure is key to the continued transformation of the ND service.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POWYS TEACHING HEALTH BOARD INTEGRATED QUALITY AND PERFORMANCE FRAMEWORK: ASSESSMENT FRAMEWORK (IQPAF)

Introduction

This IQPAF is one element of a wider range of activities that seek to generate assurance for the Health Board that Neurodevelopmental Disorder services are improving and that these improvements are sustained.

It is designed to be a tool used for self-assessment of service maturity using a simple matrix, which is subjective, but requires service leaders to demonstrate their subjective assessment with evidence.

At the time of writing, the plan is to undertake the IQPAF exercise every 2 months for Neurodevelopmental Disorder Services.

Purpose

The primary purpose of IQPAF is for the leaders of the Neurodevelopmental Disorder Services to self-assess the maturity of their service, how it is progressing and identify what is required to keep improving the service.

The value of this tool is in the quality of the leader discussions to determine maturity and in the challenge discussions with Health Board leaders to demonstrate the assessment made.

The secondary purposes are to:

- Inform a wider group of stakeholders, including PTHB Board, to see evidence of the progress the service is making.
- Demonstrate the service ability to identify and sustain improvements.

The tool is seeking to answer 3 key questions about the maturity of the service:

- How Safe and Effective are services?
- How Person Centred are services?
- How well led and effectively managed are services?

These three questions will be considered within the context of:

- Duty of Quality, mandated by the Health and Social Care (Quality and Engagement) (Wales) Act 2020:
    - Foster a culture of quality within their operations.
    - Improve health services and outcomes continually.
    - Actively monitor progress in quality improvement efforts and share this information transparently with the population.

- PTHB Integrated Quality and Performance Framework domains (referencing Duty of Quality Measures and Enablers:

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Duty of Quality Measures and Enablers	
Domains	
Safe	Our healthcare system is a high quality, highly reliable and safe system that avoids preventable harm, maximising the things that go right and learning from when things go wrong to prevent them occurring again. People's health, safety and welfare are actively promoted and protected; risks are identified and monitored and where possible, risks to safety are reduced or prevented. We promote and protect the wellbeing, and safety of children and adults who become vulnerable or at risk at any time. Where children or adults may be experiencing or are at risk of abuse or neglect, we take appropriate, timely action and report concerns.
Timely	Our healthcare system ensures people have access to the high-quality advice, guidance and care they need quickly and easily, in the right place, first time. We care for those with the greatest health need first, and where treatment is identified as necessary, we treat people based on their identified and agreed clinical priority.
Effective	Our healthcare system ensures decision-making, care and treatment reflects evidence-based best practice, to ensure that people receive the right care to achieve the optimal and possible outcomes that matter to them. We design transformative, evidenced-based, whole-of-life pathways that cover prevention, care and treatment, rehabilitation and embed these into local service delivery.
Efficient	Our health care system takes a value-based approach to improve outcomes that matter most to people in a way that is as sustainable as possible and avoids waste. We make the most effective use of resources to achieve best value in an efficient way. We only do what is needed and undertake treatments that ensure any interventions represent the best value that will improve outcomes for people.
Equitable	Our health care system provides everyone with an equal opportunity to attain their full potential for a healthy life which does not vary in quality by organisation providing care, location where care is delivered or personal characteristics (such as age, gender, sexual orientation, race, language preference, disability, religion or beliefs, socio-economic status or political affiliation). We embed equality and human rights in our health care system.
Person Centred	Our health care system meets people's needs and ensures that their preferences, needs and values guide decision-making that is made in partnership between individuals and the workforce. We care about the well-being of individuals, their families, carers and our staff. We ensure that everyone is always treated with kindness, empathy and compassion and we respect their privacy, dignity and human rights. We are committed to working better together to put people and their families at the centre of decisions, seeing them as experts working alongside professionals to get the best outcome and experience.
Enablers	
Leadership	Our health care system has visible and focused leadership at all levels, with its activities driven by the organisations' vision and values for quality. Our leaders and managers take a long-term, stakeholder-centric view to develop a clear organisational vision. They have the appropriate skills and capacity to create the conditions for a functioning quality management system. We ensure our governance, leadership and accountability is effective in sustainably delivering care.
Workforce	Our healthcare system recruits, retains, develops and extends roles to ensure we have enough, confident people with the right knowledge and skills available at the right time to deliver safe care. We value our people and the commitment and resilience they demonstrate in the care they provide. We care about their wellbeing, protect their rights and support them to feel well and happy at work; and provide them with the tools, systems and environment to work safely and effectively. Our workforce planning focuses on investing in our people and nurturing, growing and transforming our workforce to create a sustainable workforce for the future.
Culture	Our healthcare system creates the right climate and culture to nurture and encourage quality and system safety, valuing people in a supportive, collaborative and inclusive workplace so that our people feel psychologically safe to raise concerns and try out new ideas and approaches. Relationships within teams and with the people we serve are effective and based on transparency, accountability, ethical behaviour, trust and just culture, where people can thrive.
Information	Our healthcare system ensures information is available and shared appropriately for all who need it. We turn data to knowledge by triangulating quantitative and qualitative performance, experience and outcome measures to understand the quality of services, efficacy of improvement work and impact of decisions made. We monitor, report and escalate indicators through our governance structures to ensure that appropriate action is taken at every level in terms of learning, improvement and accountability.
Learning, improvement and research	Our healthcare system creates the conditions and capacity for an organisation and system-wide approach to continuous learning, quality improvement and innovation, which it actively promotes. We use new knowledge to influence improvements in practice and to inform our decision-making. We ensure our learning and improvement activity is linked to our strategic vision to deliver transformational, organisation-wide change. We commit to participating in research because research-active organisations provide improved quality of care and outcomes for people.
Whole system approach	Our healthcare system ensures safety in healthcare goes beyond individual patient safety. We will look within and beyond our organisational boundaries to learn how we can continually, reliably and sustainably meet the evolving needs of people. We will strengthen relationships and work with all our partners to achieve good outcomes. Our policies incorporate the broader ambitions within the seven well-being goals and five ways of working in the Well-being of Future Generations Act.

- Access and Activity – Assurance on **Timely, Equitable** and appropriate access to health care services to achieve the best outcomes within agreed targets.
- Quality, Safety and Patient Experience – Assurance against national and locally set quality and safety measures of care ensuring services are **Safe, Effective, Patient Centred** and continuously improving. Assurance through listening and responding to patient and carer feedback along with complaints and concerns and development of PROMS and PREMs.
- Finance and Value – Assurance that services are improving **Efficiency**, based on Prudent and Values Based Healthcare principles.
- Workforce – Assurance that PTHB recruits, retains, develops and empowers staff to ensure the PTHB has a sustainable workforce that has the right people with the right skills, abilities, knowledge and experience to deliver safe care.

Process

A baseline assessment will need to be undertaken. By adopting this baseline assessment, this process can then focus on changes since the last baseline. Each time the process is completed a new baseline will be created.

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The IQPAF process will follow a 2 month cycle described below:

1. Directorate SMT review service against the Maturity Matrix.
2. Challenge session via Escalation Oversight Group.

3. Challenge Session with Executive Team.
4. Submit final assessment for Executive/Board assurance.

A visual representation of the process in shown below:

1 - Directorate Review against Maturity Matrix

The service senior leadership will consider the service against the Maturity Matrix. Seeking to evidence changes and showing progress or regression in maturity. Key metrics outlined later in this document will be an important part of making the assessment.

2. Challenge Session via Escalation Oversight Group

This would be a meeting where the service senior leadership would present their case to the Escalation Oversight Group, with supporting evidence, of their service maturity assessment.

3. Challenge Session with the Executive Team

This would be a session where the service senior leadership would present the assessment and expect to be challenged on this by the Executive Team. The outcome of this meeting would be submitted to the appropriate Board/Committee (TBC).

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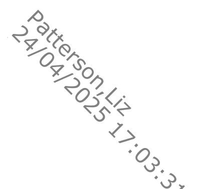
Progress Levels	**BASIC LEVEL** Principle accepted and commitment to action	**EARLY PROGRESS** Early progress in development	**RESULTS** Initial achievements achieved	**MATURITY** Results consistently achieved	**EXEMPLAR** Others learning from our consistent achievements
SAFE AND EFFECTIVE CARE DOMAINS: SAFE, EFFECTIVE, EQUITABLE, EFFICIENT ENABLERS**:** ALL	The health board recognises that improvements are required to the delivery of safe and effective care. There is a commitment to develop systems and processes to facilitate this improvement.	The health board has a developing quality governance structure and has full engagement. The health board has a developing quality dashboard and monitors key indicators. Clinical incidents are reported and investigated appropriately and learning is focussed on individual incidents. Changes in practice are recommended but there is limited evidence that these changes are implemented and/or impact on future safety. Responsibility for patient safety and governance is limited to a few key individuals in the service. The Health Board recognises the importance of support required for bereaved families. Monthly support group meetings taking place.	There is evidence that there is thematic analysis of clinical incidents and that clinical practice is influenced by this learning. There is evidence that changes in practice prevent future incidents of a similar nature. Learning from incidents is shared widely across the service and both clinicians and managers can evidence how this learning influences their own practice. There is a management led audit programme and clinicians are involved in conducting audit. There is evidence that the health board takes corrective action where care is not delivered to accepted standards of practice. There is an emerging interest in quality improvement.	There is recognition that systems contribute to clinical incidents and the service evidence human factors and system changes to prevent incident repetition. The service is outward looking and can evidence that it learns from the experience of other services. The health board recognises good practice and amplifies and spreads this across all aspects of the service. There is a strategic approach to quality improvement and evidence that QI initiatives are impacting on key metrics. All staff recognise that patient safety and quality improvement is part of their role. Clinical audits consistently demonstrate that health board practice delivers care to accepted standards of practice.	A culture of continuous quality improvement is embedded within the health board and is integral to decision making at all levels. The service is a centre of excellence, continually assessing and comparing its performance against others both within and outside the health service. Clinicians in the health board are engaged in local and national research. Teams design and conduct their own audit and QI programmes, which are outcome focussed and in collaboration with patients, families and the public. The need for protocols and policies is reduced as evidence based practice becomes second nature and staff are alert to safety risks.



Progress Levels	**BASIC LEVEL** Principle accepted and commitment to action	**EARLY PROGRESS** Early progress in development	**RESULTS** Initial achievements achieved	**MATURITY** Results consistently achieved	**EXEMPLAR** Others learning from our consistent achievements
QUALITY OF PATIENT AND FAMILIES EXPERIENCE DOMAINS: EQUITABLE, PATIENT CENTRED ENABLERS: ALL	The health board recognises that that engagement and involvement extends from receiving information through to involvement in an individual's direct care planning through to the planning of services. The health board recognises that it has an under-developed approach to engagement and is developing a plan to improve.	The health board informs patients and families of issues related to their care or planned changes to service delivery. The health board seeks the views of patients and families at key points in the care pathway and works to address their individual issues. Learning from experience is largely focussed on Putting Things Right.	The health board has multiple and sophisticated means of seeking the views of patients and families and aggregates and analyses these views to inform service delivery. The health board can evidence that service user engagement has impacted on the delivery of the service. The health board has an appreciative enquiry approach and amplifies good practice across the service.	The health board proactively works with patients and families in all aspects of service delivery and patients and families are actively involved in health board activity, such as recruitment, committee meetings etc. There is evidence that patient stories are used extensively across all activities e.g. training, supervision etc. Patients and families who complain about their experience are satisfied that that their experience impacts on future practice. Fewer patients choose to ask for their complaints to be reviewed by the Public Services Ombudsman.	The health board shares innovate engagement and involvement practices with others. These engagement and involvement practices are co-produced with people with lived experience. Even though feedback from patients and families is consistently positive, the health board proactively engages patients and families to consider further improvements and enhancements to the service, asking not 'what does good look like?' but 'what would outstanding look like?'

Progress Levels	**BASIC LEVEL** Principle accepted and commitment to action	**EARLY PROGRESS** Early progress in development	**RESULTS** Initial achievements achieved	**MATURITY** Results consistently achieved	**EXEMPLAR** Others learning from our consistent achievements
QUALITY OF MANAGEMENT AND LEADERSHIP ENABLERS: ALL	The health board recognises that it needs to improve staff experience, staff development and leadership direction. The health board is developing a plan to address the quality of leadership and management.	The health board monitors staffing levels and takes action to address shortfalls. The health board has a plan to improve recruitment and retention. Training compliance and PADR/appraisal rates are monitored. There are plans in place to improve compliance. The health board responds reactively to external oversight. There is evidence that the plan to improve the quality of management and leadership is accepted and endorsed by services staff and staff side representatives.	The health board is compliant with staffing levels recommendations from professional bodies. There are escalation procedures when staffing levels fall below required standards. The health board is able to release staff for training and mandatory/statutory and other core training compliance rates are consistently good. The health board understands the key components of psychological safety, patient safety culture and good staff experience and is beginning to demonstrate improvements. The health board recognises that it needs to develop the leadership potential of its existing workforce and has emerging leadership programmes in development. There are clear roles, responsibilities and lines of accountability across the service. There is evidence of teamwork across professional disciplines There is an emerging staff engagement strategy and multiple means for staff to share their views and experiences. The health board is proactive in providing assurance.	There is a strategic approach to workforce planning and evidence of well-established plans to meet clinical requirements in the future. There are well developed in-house training programmes. The health board training needs analysis is reviewed annually in line with changes to clinical evidence and there is a robust training infrastructure to ensure that clinical staff are well developed. Staff feel confident to constructively challenge their peers and the organisational culture when they recognise that there are practices that impact on psychological safety and staff experience. Leaders are well supported, outward looking and committed to continuous learning. There are well developed peer networks and constructive challenge and feedback is commonplace. There is robust evidence that staff feedback informs service planning and changes in practice. Managers have constructive working relationships with staff side partners and work in partnership to deliver workforce improvements.	There is evidence that clinicians choose to work in PTHB due to its reputation for high quality care and staff experience. Staff turnover is low. Quality improvement initiatives are also focussed on continuously improving staff experience. PTHB's approach to staff experience is shared widely with other services. The annual staff survey consistently demonstrates high satisfaction rates.

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When using this matrix, PTHB leaders will need to draw on information and evidence to support the subjective assessment.

Assessment Areas – Scope

The scope of the assessment areas, underpinned by the Duty of Quality Domains and Enablers, are as follows:

Safe and Effective Care	Quality of Patient and Families Experience	Quality of Leadership and Management
• Guideline Management • Audit • Job Planning / Rotas / Staffing levels • Clinical Supervision • Governance • SI Process and Learning • Clinical Pathways • Patient Safety • Risk Management • MDT working	• Engagement of patients • Experience Driven Improvement • Service Experience • Complaints Handing • Communications with patients / public • Environment – privacy and dignity	• Quality Improvement • Training and Learning • Staff Experience • Decision Making • Clinical Leadership • Culture • Data (quality, use and timeliness) • Leadership development • Induction • Capacity Management

All three elements of the assessment are underpinned by the Duty of Quality Domains and Enablers

To inform the assessment process, a range of data and information sources are available, both inside and outside the Health Board.

Examples of information sources are:

Internal	External
• Service Performance Reports • Clinical Audit Reports • Complaints/Concerns Data • Staff surveys and other staff experience data • Internal data reports • Learning from SI's, incidents and events • Clinical Reviews • Improvement Work Programme	• HIW, HEIW, Delivery Unit and other external reviews • Audit Wales reports • Public Health (Observatory) • Experience data from patient and family engagement activities • Benchmarking reports • External Clinical Reviews • Llais

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Assessment Template

Date	12/3/25
Assessment	Neurodevelopmental Disorder Services

Baseline Assessment (November 2024)	**Basic Level**	**Early Progress**	**Results**	**Maturity**	**Exemplar**
Safe and Effective Care					
Quality of Patient and Family Experience					
Quality of Leadership and Management					

Proposed Assessment (March 2025)	**Basic Level**	**Early Progress**	**Results**	**Maturity**	**Exemplar**
Safe and Effective Care					
Quality of Patient and Family Experience					
Quality of Leadership and Management					

Evidence to support this assessment – since the previous assessment (see also Improvement Plan)		
	Decreasing Maturity	**Increasing Maturity**
Safe and Effective Care	No change in maturity across all domains due to fragility of service delivery model without additional investment to support transformation and sustainability. The service delivery model is very fragile and dependent on significant level of senior team member's support. This has been further impacted by sub-optimal processes to manage caseloads across the ND and community children's/paediatric service. Wider service transformation is required to ensure a sustainable, high-quality system is in place across children's services to ensure that ND is not viewed in isolation as is co-dependent on all other disciplines that service children's needs.	
Quality of Patient and Family Experience		
Quality of Leadership and Management		

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Appendix Three: Conditions for Sustainability Assessment (April 2025)

Area	Description	Success criteria	Service Assessment April 2025
Corporate Governance	Effective oversight and scrutiny of service provision consistently being provided by the Directorate / PEQs / Delivery and Performance Committee / Board.	• Submission of clear evidence based information triangulated with qualitative feedback to inform Board oversight and scrutiny. • Service risk registers reviewed and updated on regular basis.	• Service report presented within directorate Quality & Performance meeting. • Monthly monitoring of performance within Community paediatrics group. • Risk register and improvement plan updated monthly or as necessary. • Presentation to Executive Committee and PEQS committee monthly and quarterly respectively until April 2025.
Leadership (clinical and non-clinical)	Robust oversight of quality and performance of services.	• Leadership is visible. • Create unity of purpose. • Leadership development support in place. • Shared leadership responsibilities. • Empowerment of staff and teams. • Authentic, collective and compassionate leadership. • Active engagement in driving forward service improvement.	• Substantive clinical leadership structure in place (HoN, Consultant Paediatrician), with structured meetings and foundations developed for service delivery and sustainability. • Substantive clinical structure to be demonstrated within a business case for consideration by IBG and executive committee. • Programme of work supported by OD colleagues to support current and ongoing needs of the team during a period of transformation and improvement.
Culture and Values	Evidence of culture of improvement.	• Shared sense of pride around performance. • Staff aware of and actively participate in improvement work. • Staff view maintaining quality as part of their job, that they have a stake in continually enhancing their performance and are clear on the performance improvement activity and can explain their role in it. • Psychologically safe working environment is actively supported and maintained.	• Quality & Performance are intrinsic to all reporting mechanisms and discussions. • Clear KPI's to support wider quality targets along with RTA. • Clinical support structure (open forums for discussions, forums to raise concerns or inform change and improvements) in place to support a culture of psychological safety. • Working with OD colleagues for some targeted areas of work.
Strategic Vision <u>and</u> Collaboration & engagement	Service has clear agreed vision communicated to relevant stakeholders including the public. All stakeholders share understanding of processes and systems seeking to improve and clear on their contribution.	• Shared vision, goals, strategies. • Actions being delivered providing confidence that sustainable long term continuous improvement is achievable. • Organisation to promote strong partnerships with both internal and external stakeholders. • Supportive structures to ensure involvement of patients, families, public, clinical and non-clinical staff at all levels of the organisation. • Well defined roles and responsibilities. • Clearly agreed and defined outcome measures (quantitative and qualitative).	• Co-production information service change and development. • Open dialogue with PCC and third sector colleagues. • Collaboration for improvements with PCC colleagues both in Social Care and Education. • Clear vision and strategy in place which will be further supported with substantive workforce structure-alignment with PCC along with standard operating procedures aligned with best practice and evidence-based decision making.

Area	Description	Success criteria	Service Assessment April 2025
Quality Management System approach. (refer to PTHB QMS)	Continuous focus on understanding of what a quality service looks like; knowing whether we are delivering the services that our population needs; learning and improving; with leadership for quality owned and driven by the Health Board.	• Quality Planning o Understanding population need & design of services, policies, structures, systems to meet those needs. o Reflect government strategies and targets. • Quality Control o Processes in place to monitor performance in real time & take action when required standards not met. o Control processes owned by those directly providing the service with skills and permission to address performance issues within their control. o Quantitative and qualitative measures with appropriate escalation measures. • Quality Improvement. o Staff provided with right skills to deliver improvement. o QI plan and active QI projects in place with evidence that changes are being delivered. o Programme Management support in place to deliver the improvement plan with open and transparent reporting with effective Board oversight. • Quality Assurance. o Verify that quality control is maintained, and that performance is evaluated. o Effective structures, systems and standards to provide clear line of sight across the Health Board to give assurance internally and externally to stakeholders, that desired improvements to services and population outcomes are being achieved and sustained. • Principles: o Patient centred care – meet patient and stakeholder requirements. Essential is understanding of current and future needs of patients and public through co-production, consultation and two way communication. o Evidence based decision making – decisions based on robust best practice, analysis and evaluation of data and information. o Population and stakeholder engagement (see above). o Clear vision and purpose (see above). o Education and Training.	• Production of a population demand report from PH colleagues to provide insight into prevalence. • Service delivery plan aligned to demand and capacity to ensure <104week waits. • Power BI dashboard reviewed and available with current and up to date data to support oversight of service. • Qualitative measures being address within CIVICA and created through co-production. • TNA completed and training plan in place to support service delivery. • QI driven transformation with robust structures in place to monitor improvements and outcomes. • Data driven service to ensure compliance, performance and outcome is captured. Information shared within team meetings, directorate meetings, committee and board as required. • Co-production agenda and outcomes in place to ensure all transformation and change is driven and supported by both staff and service users. • SOP revised and implemented based on best practice and evidence-based decision making. • Clear and robust management of concerns, incidents and investigations to ensure triangulation of data and information is evident. • Demand and capacity workforce planning to inform sustainable workforce plan supported by business case for consideration by executive committee. • The PTHB Executive Team has agreed for the continuation of the posts to support additional activity at a cost of £203,349.

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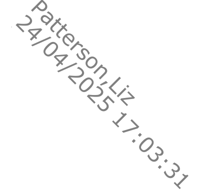
Area	Description	Success criteria	Service Assessment April 2025
		▪ Formal capability programmes in place to build skills across clinical and non-clinical colleagues. ▪ Build organisational wide skill in application of modern quality improvement methods. ▪ Aligned with culture where improvement work is seamlessly integrated into day to day work. o Incident and complaints management. ▪ Effective investigations being conducted on business as usual basis. ▪ Language used in investigation reports is easy to understand for families. ▪ Lessons from clinical incidents must inform delivery of the multi-disciplinary training plan. ▪ Actions arising from serious incident investigation that involve a change in practice must be audited to ensure a change in practice has occurred. ▪ Change in practice arising from a serious incident investigation must be seen within 6 months after the incident occurred. ▪ Ensure that all complaints that meet the serious incident threshold are investigated as such. ▪ Complaints themes and trends to be monitored by the service. o Workforce. ▪ Safe and Sustainable workforce. ▪ Demand and capacity workforce planning to inform sustainable workforce plan supported by a business case for consideration by executive committee.	
Integrated Quality & Performance Assessment Framework (IQPAF)	The IQPAF is used effectively at service and Board level to regularly reflect upon and evaluate progress.	• Regular assessments of 'maturity' level for safe and effective care; quality of leadership and management; and quality, safety and patient experience. • Progression of the domains towards maturity with evidence of progress against agreed key metrics.	• Regular IQPAF assessments undertaken within the service and presented to EOG and Executive Committee.
Guidance on the delivery of Neurodevelopmental Services in Wales	Guidance on functions of Neurodevelopmental (ND) services in Wales (inclusive of children who may also have learning disabilities and additional learning needs)	• Standard 1 Access • Standard 2 Referrals – additional information • Standard 3 & 4 Assessment – additional information • Standard 5 Consolidation and Interpretation of findings • Standard 6 Feedback of Assessment • Standard 7 Post assessment considerations • Standard 8 Post assessment interventions	• All 8 Welsh Government standards met within current service delivery model (see table below).



WG 8 Standards

Standard	Quantitative	Qualitative	Quantative	Qualitative	Lead
Standard 1 - There is a single point of access for diagnostic assesment of all ND disorders	Do you have a single point of acess (SPOA) for the receipt of referrals?	How has the SPOA process been experienced by the referer?	Direct, self and PIP		Katie Higgins
	What number/ % of people were referred directly to the ND team? By GP/school/parent/other source		IFOR, WCCIS		Rebecca James

Standard	Quantitative	Qualitative	Quantative	Qualitative	Lead
Standard 2 - The decision as to whether to accept a referral or not is made on the quality of information provided. Where there is adequate Information to supportconcern, access should not be subject to permitted referrers, the use of screening questionnaires or other specifications	Number/% of referrals accepted and rejected	How has the referral process been experienced by the referrer (e.g. where referrals not accepted)?	IFOR - Query acceptance rate		Rebecca James
	Number/% of referrals not accepted and reasons/time delay on rejected referrals being resent	How has the referral process been experienced by the child and/or family?	Query quality of information		Rebecca James

Standard	Quantitative	Qualitative	Quantative	Qualitative	Lead
Standard 3: When referrals are not expected, the referrer is provided with rationale along with advice to improve referral. Standard 4: Assessment are planned in a child centred way	Waiting times for assessment being collected by Welsh Government (standard RTT times - from GP referral to when? How to capture non GP referrals?)	Parent (and child) experience of assessment	IFOR, not U 5's (WPAS)		Rebecca James
	Evidence of multidisciplinary child centered assessment (how assessed?)	Feedback using CIVICA	WPAS - query quality information and 2nd opinion. Name clinicans and map		Catrin Davies
	Evidence of assessment of co-exisiting physical health conditions and mental health problems as appropriate	Feedback using CIVICA	In place but not robust		Catrin Davies

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Standard	Quantitative	Qualitative	Quantative	Qualitative	Lead
Standard 5 - Timely MDT discussion for those involved with assesment, a profile of child's strngths and difficulties and agreement on future (local determination of process)	Of assessments undertaken number/% of completed reports timescale?	Staff experience of assessment and multidisciplinary discussion inclusing timelines	WPAS - Discharge.		Rebecca James
	Number/% of reports which details evidence for the outcome of assessment	Family experience of process			
	Evidence of multidisciplinary involvement				Catrin Davies

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	Quantitative	Qualitative	Quantative	Qualitative	Lead
Standard 6 - Feedback of Assesment, followed up in writing along with consent sharing with professionals supporting the child.	Number/% of post assessment face to face discussions undertaken	Child and/or families experience of assessment, follow up and forward plan			Catrin Davies
	Number/% of families offered and taking up the follow up appointment	Staff experience of assessment, follow up and forward plan			Rebecca James
	Of assessments undertaken number/% of completed profiles	Narrative on feedback not face to face	IFOR - Data quality		Rebecca James
	Number/% of completed profiles shared with family				Rebecca James
	Evidence of consent to share information given				Catrin Davies

	Quantitative	Qualitative	Quantative	Qualitative	Lead
Standard 7 - Post assessment considerations discussed with family and where appropriate the child	Number/% of parents whose children received a diagnosis of either ADHD or ASD provided with information and education on the core features of the childs assessment and or diagnosis	Child and/or families experience of assessment, follow up and forward plan			Catrin Davies
	Number/% of parents whose children did not receive a diagnosis who were provided with relevant information				Catrin Davies
	Number/% of parents whose children received a diagnosis of either ADHD or ASD who have: Been informed of parenting training courses and attended parenting training courses				Catrin Davies

	Quantitative	Qualitative	Quantative	Qualitative	Lead
Standard 8 - Post assesment interventions should be based on best possible evidence	What evidence based interventions does your service provide?	What has been the impact of those interventions? How have these been measured?		IAS feedback is available	Catrin Davies
		Families and, as appropriate, children's experince of interventions?			

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Agenda item: 4.3

PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE	29 APRIL 2025
Subject:	**Infection Prevention & Control (IP&C) Improvement Plan (2023-25) Update**
Approved and presented by:	Claire Roche Executive Director of Nursing, Quality, Womens and Family Health
Prepared by:	Jayne Wheeler Sexton Assistant Director of Nursing, Safeguarding
Other Committees and meetings considered at:	Executive Committee - 16 April 2025

PURPOSE:

The purpose of this paper is to present the Executive Committee with an updated position at the end of year two of the Infection Prevention and Control improvement plan (IP&C) (2023-2025)

RECOMMENDATION(S):

The Patient Experience, Quality and Safety Committee is asked to:

- Take **ASSURANCE** from the progress and achievements within the Infection Prevention and Control improvement plan
- **NOTE** the plan has been de-escalated by Executive Committee.

Approve/Take Assurance	Discuss	Note
Y	Y	N

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:	
1. Focus on Wellbeing	N
2. Provide Early Help and Support	N
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	N
8. Transforming in Partnership	N

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EXECUTIVE SUMMARY:

The report provides an update on the status of the Infection Prevention and Control improvement plan (2023-25). When initiated there were 24 recommendations made within the improvement plan with 47 associated actions.
Currently 45 of the actions are complete. The outstanding actions of the improvement plan will be completed within the next 3 to 6 months.

1. IP&C Improvement Plan Progress

In May 2023, the IP&C team conducted a comprehensive GAP analysis of Infection Prevention and Control services across the Health Board, leading to the development of an organisational wide IP&C improvement plan which would be led by the IP&C team, with collaboration from services and departments to ensure IP&C is everyone's business and is owned by all.

The plan was evaluated against the nine standards, as set out in the 2014 Code of Practice for the Prevention and Control of Healthcare Associated Infections, and subsequently reviewed and approved by the Patient Experience, Quality & Safety Committee (PEQS).

To ensure the actions required were prioritised the IP&C improvement plan was integrated into the Health Boards Medium Term Plan (IMTP) for 2023-2026. In affirming its commitment to the zero-tolerance stance on Healthcare Associated Infections, the Board approved a statement outlining its collective responsibility to the reduction of Healthcare Associated Infections and improvements in Infection Prevention and Control standards across Powys Teaching Health Board.

There are 24 overall recommendations within the IP&C improvement plan; within these recommendations there are 47 associated actions:

At the time of completing this report 45 actions have been completed. The two outstanding actions are in progress and will be achieved within the next six months.

Highlights of key achievements from the improvement plan in year 1 (2023/4):

- A Board level statement outlining its collective responsibility towards the prevention of Healthcare Associated Infections

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- PHW dashboards on Tier 1 surveillance organisms, now aligns with PTHB internal data, at present, providing a true reflection of infection data in Powys.
- The Health Board has continued to maintain a record of zero cases of MRSA bacteraemia since 2013/14.
- Internal audit during Q4 provided reasonable assurance overall, with a proportion of areas gaining substantial assurance.
- The IP&C team has responded effectively and efficiently, overcoming the challenges and increased workload, as a result of the IP&C improvement plan
- The team have successfully implemented and maintained several crucial policies, processes, and standard operating procedures across the organisation, enhancing awareness, understanding and safety for both staff and patients.
- Relationships across the Health Board have significantly improved as awareness and understanding of the IP&C team's roles and responsibilities have become more widely recognised.
- Compliance for mandatory and statutory IP&C training levels one and two have continued to increase over the year, currently exceeding 85%.

Highlights of the key achievements from the improvement plan in year 2 (2024/25):

- The team continues to build of the achievements in year 1.
- IP&C team recruited to a vacant position.
- Dedicated Antimicrobial Stewardship Pharmacist recruited.
- Implementation of an electronic auditing system, which will support improved compliance with standards and consistency, along with providing at a glance assurance has commenced.

2. Outstanding Actions

Standard 5: All staff employed to provide care in all settings are fully engaged in the process of IPC.

Outstanding Action: Improve the number of staff across the organisation who have:
1. Been assessed as an Aseptic Non-Touch Technique (ANTT assessor)
2. Undertaken training in ANTT prior to undertaking clinical procedures

Progress: Progress is being measured by the steps required for the Health Board to achieve Bronze Accreditation in ANTT Patient Protection Accreditation Programme

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for Healthcare Providers. It is anticipated this will be realised in the next 3 to 6 months.

Standard 7: Policies on IPC must be in place and made readily accessible to all staff.

Outstanding Action: Develop a Health Board specific policy on Multi-Drug-Resistant Organisms (MDRO) (Clinically significant anti-microbial resistant organisms (CSARO)

Progress: This is almost complete, however, there is an All Wales Policy in use which the Health Board applies in practice.

3. Internal Audit

In addition to the IP&C improvement plan, an IP&C internal audit undertaken as a component of the Health Boards annual internal audit programme. This evaluation specifically aimed to examine the protocols and measures in place across the IP&C portfolio, with a particular emphasis on the management of CDI and the Infection Prevention and Control improvement plan.

The audit filed work was conducted in the fourth quarter of 2023/24, the audit provided a reasonable level of assurance overall, with substantial assurance gained in several key areas including the management of CDI within the organisation and the effective oversight and reporting of the IP&C improvement plan. The audit identified a number of actions which have been fully implemented.

To conclude, a considerable amount of work has been undertaken by the Infection Prevention and Control team in conjunction with colleagues across the Health Board to achieve the requirements of the Infection Prevention and Control improvement plan.

The Committee is asked to acknowledge and take assurance from the significant work and progress made on Infection Prevention and Control across the Health Board. 45 of the 47 actions are complete, the remaining two actions will continue to be progressed and monitored until completed within the IP&C Committee. It is, therefore recommended the IP&C improvement plan can be de-escalated.

NEXT STEPS:
1. Continue to build on the improvements made across the Health Board

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II.	The IP&C Committee will continue to monitor the remaining two outstanding actions until completed**.**
III.	Complete the IP&C Annual Report for 2024/25 which will add context to each improvement and further inform of the achievements and challenges within IP&C.

IMPACT ASSESSMENT
Not required

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Agenda item: 5.1

PATIENT EXPERIENCE AND QUALITY COMMITTEE	29 APRIL 2025
Subject:	**Integrated Quality Report: Quarter 4**
Approved and presented by:	Claire Roche, Executive Director Nursing, Quality, Women & Family Health
Prepared by:	Head of Quality and Safety
Other Committees and meetings considered at:	Executive Committee - 16 April 2025

PURPOSE:

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

RECOMMENDATION(S):

The Patient Experience, Quality and Safety 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.

Approve/Take Assurance	Discuss	Note
N	Y	Y

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:		
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	N	

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EXECUTIVE SUMMARY:

1 Background

The purpose of this report is to provide the Executive Committee with an update on the quality and safety agenda for Powys Teaching Health Board (PTHB). This report is commensurate with our Duty of Quality and Duty of Candour as per the Health and Social Care (Quality and Engagement) (Wales) Act 2020.

2 Specific matters for consideration by this meeting (Assessment)

2.1 Once for Wales Content Management System (RLDatix)

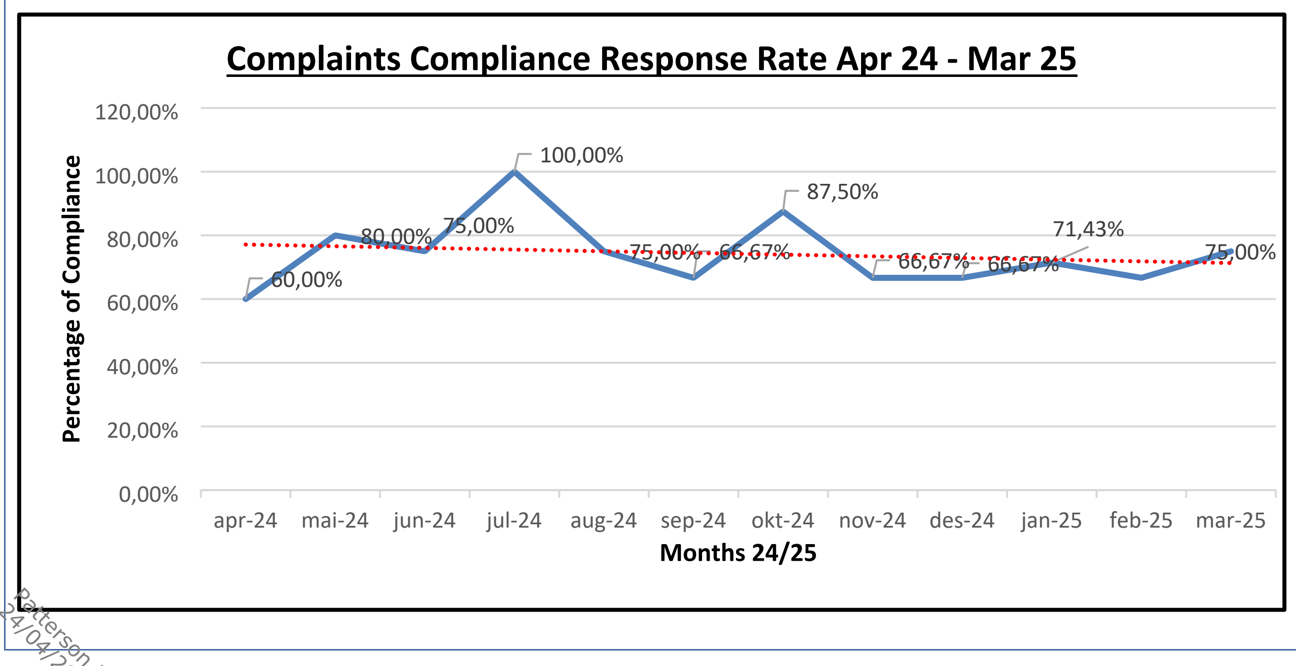
The RLDatix system – Risk Register hierarchy continues to be built through Q4 to include high level services. The aim is still that the risk register will be live in the Health Board by the end of summer 2025.

2.2 Putting Things Right – Concerns

The management of concerns compliance within 30 working days reported nationally at the end of 2024/25 is 80%. We have maintained our performance above 75%. There is continued focus to ensure our concerns are managed in a timely manner with the appropriate investigation and response.

The reported compliance for Q4 2024/25 is 71.5%.

Graph 1 – Complaints compliance Response Rate – Datix Source.



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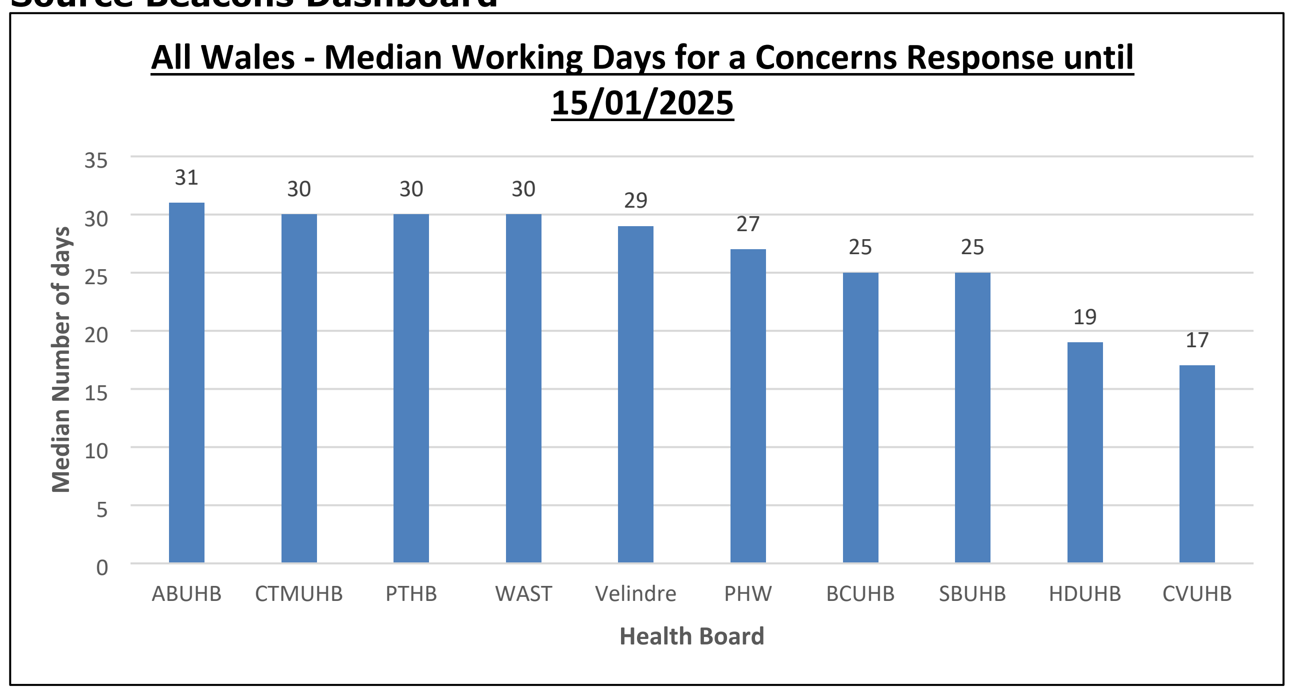
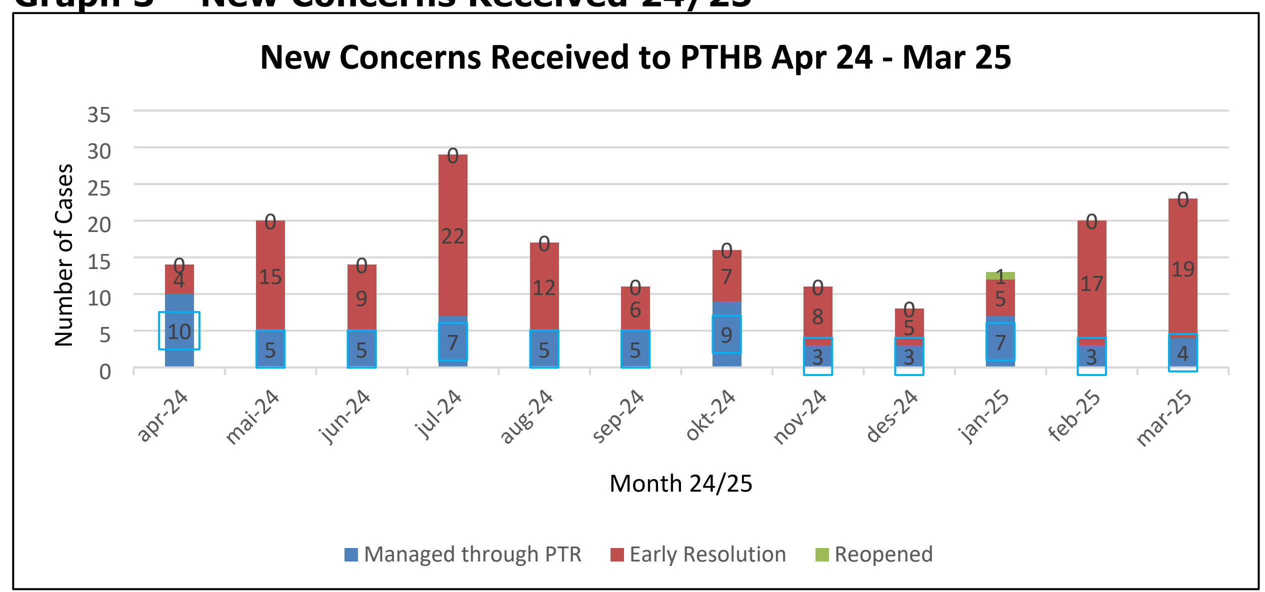
Within PTR, formal concerns should be responded to within 30 working days. **Graph 2** shows that while PTHB meets compliance with responses for 30 working days, there is still room for improvement in providing responses earlier as demonstrated by those health boards achieving concerns responses in under 30 working days.

Graph 2 – All Wales Median Working days for Concerns Response – Source Beacons Dashboard



Graph 3 – New Concerns Received 24/25



15 formal concerns have been raised through PTR. Themes for Quarter 4 include:

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- Clinical & assessment.
- Attitude & behaviour of staff.
- Availability of rehabilitation equipment.
- Communication with relatives/family/next of kin.
- Discharge issues

Challenges to compliance:

- Concern complexity.
- Multiple agency involvement requiring longer than 30wd.

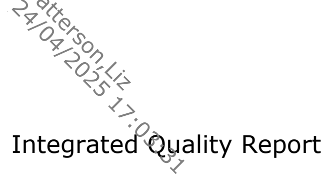
2.3 Duty of Candour (DoC)

There have been 16 Duty of Candour cases during Q4 2024/25. All cases are at various points of investigation. There was an increased number of cases in Q4 compared to the first 3 quarters due to an increase in unexpected deaths in Mental Health services between January and February 2025. The number of Candour cases have increased throughout the year, this is attributed to colleagues increased awareness and understanding of the requirements of the Act; Duty of Candour has had no impact on number of Redress cases to date.

There are currently 29 open DoC case in various stages of investigation. Themes include:

- Avoidable falls
- Unexpected death of a patient known to mental health services
- Administration errors with vaccinations
- Avoidable pressure damage

Graph 4 - Numbers Incidents reported as Duty of Candour Apr 24- Mar 25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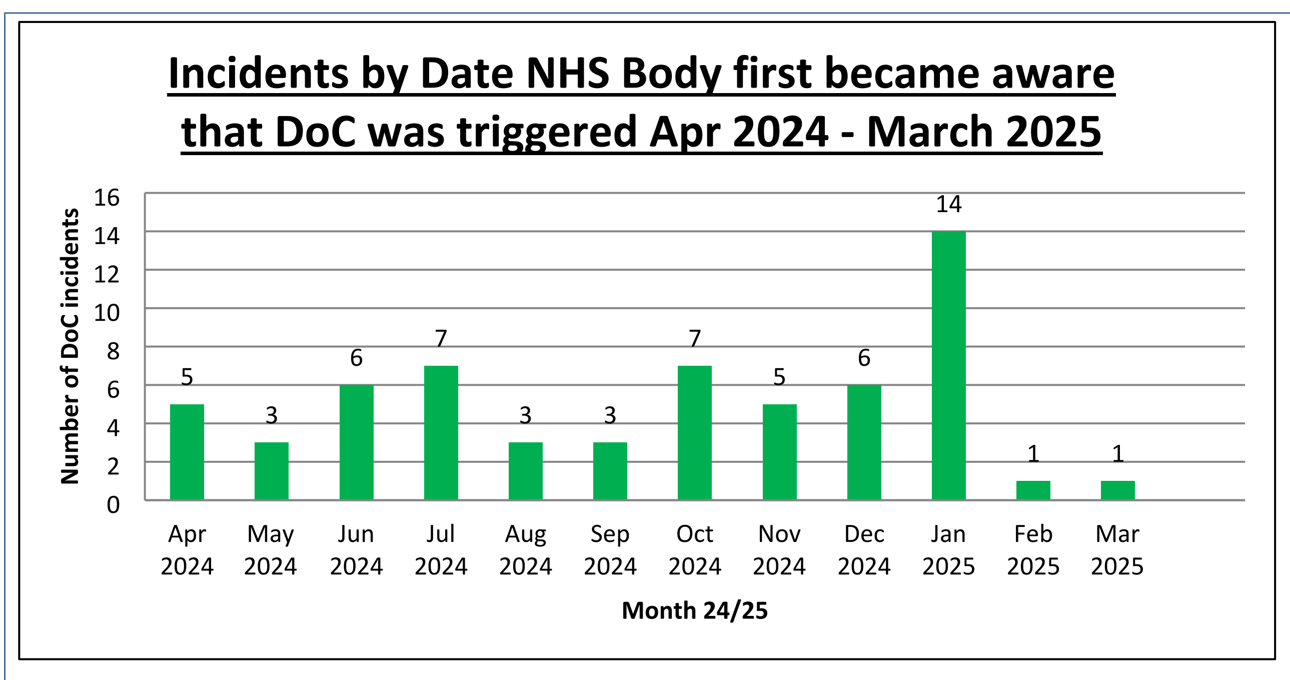

Learning from Duty of Candour

Learning from Q4 has included the following actions:

- Interpretation services should have been offered for all of your antenatal appointments as English is not the patient's first language.
- Electronic Tablets have been placed in every birth centre to ensure interpretation services are easily accessible.
- A document published by Antenatal Screening Wales called 'Rashes and Infections in Pregnancy' has been shared with all midwives to remind them of what to do if a woman shares that she has been in contact with parvovirus.
- A reminder to all ward staff of responsibilities surrounding patients with 1:1 care and the importance of maintaining these observations to prevent falls.
- Ward staff have been reminded to complete agency induction which includes information about roles and responsibilities regarding enhanced care patients.
- Nurses with the role of 'Nurse in Charge' of the shift must understand the importance of planning to ensure the correct allocation of staff to duties throughout the shift.
- All medication rounds must be completed in the ward treatment room, ensuring that the administering nurse has protected time to complete this to avoid distractions to prevent medication errors occurring.
- Mental Health wards will discuss medication errors in their ward meeting to support this learning and prevent similar incidents from occurring in the future.

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- All reports and covering letters are now cross checked by an additional administrative member of staff prior to posting to prevent errors in correspondence communication in the Integrated Autism Service.

2.4 Claims, Redress & Clinical Negligence Position

Redress

9 confirmed cases, 1 potential cases.

Currently have 1 redress case amber deferred, outstanding information is being requested from service.
The next redress panel is arranged for 23rd April 2025, in which three cases are to be presented.

Clinical Negligence

10 confirmed cases, 4 potential cases
General Medicine Practice Indemnity (GMPI) Claims

4 confirmed cases, 4 potential cases.
Personal Injury

4 confirmed cases, 0 potential

2.5 Incident Management

The number of patient safety incidents (**Graph 5**) reported is stable and appropriate with most incidents reported within the Low and No Harm classification.

Graph 5 Incidents Reported by Actual Level of Harm April 2024-Mar 2025

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Incidents by Date Reported and Post Investigation harm assessment Apr 2024- March 2025

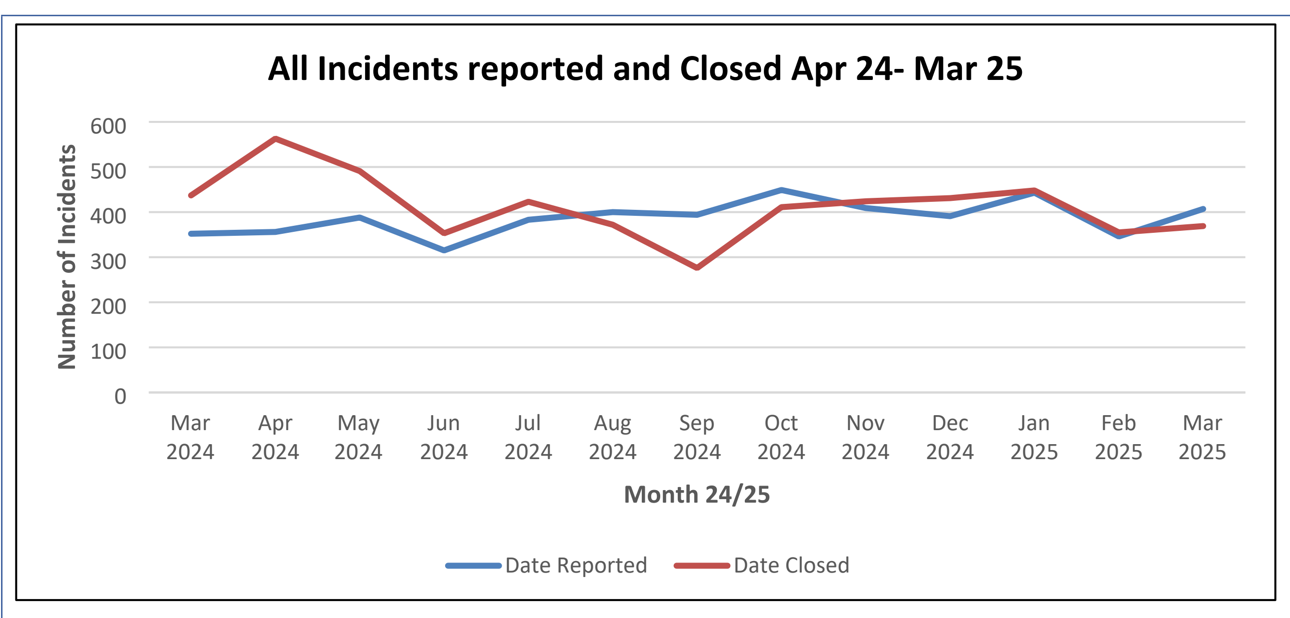
Number of Incidents (0–350) by Month 24/25

Month	Data labels
Apr 2024	210, 103, 4, 0
May 2024	242, 109, 3, 0
Jun 2024	178, 105, 0, 1
Jul 2024	251, 86, 3, 0
Aug 2024	263, 88, 0, 0
Sep 2024	231, 105, 1, 0
Oct 2024	292, 109, 1, 1
Nov 2024	247, 97, 1, 1
Dec 2024	242, 89, 1, 0
Jan 2025	239, 78, 2, 0
Feb 2025	166, 63, 1, 0
Mar 2025	165, 64, 0, 0

None, Low, Moderate, Severe, Catastrophic / Death

Graph 5 demonstrates stability in reporting across the year and that the majority of incidents are reported as low or no harm.
Improvements have been realised with regards to the timely investigation and closure of incidents. It is visible in **Graph 6** below that the number of incidents closed has mirrored the live position of reporting during Q4, following proactive and supportive measures which continue with incident position emails to service leads on a weekly basis, with particular emphasis on moderate and above incidents that trigger Duty of Candour.

Graph 6: Data source Datix



2.6 Early Warning Notifications (previously No surprises notifications)

7 Early Warning Notifications have been submitted during Q4 2024/2025. These are submitted to Welsh Government and should be used in circumstances where the Welsh Government needs to be alerted to an immediate issue of concern or prior warning of something due to happen which might relate to the following:

- has the potential to affect a number of patients/ staff / communities etc
- has a significant impact on service provision;
- may have an adverse impact in the media;
- might cause national or political embarrassment;
- following an inquest which has resulted in a Regulation 28 or public interest in a Public Services Ombudsman for Wales (PSOW) report OR
- a positive good news story.

2.7 Nationally Reportable Incidents

The current position for open Nationally Reportable Incidents (NRI's) is reported in the table below. Improved timeliness of investigations is a focus for 2024/25 as currently 55.2% of investigations remain open for >90 working days with the average completion time of 181days, which is an improvement on Q3 which was 190days (the All-Wales median is 132days). This can be attributed to complex mental health cases which are anticipated to be completed by 120days. With the consideration of the most complex cases, investigation timeliness requires improvement to ensure investigations are shared with families and learning consolidated.

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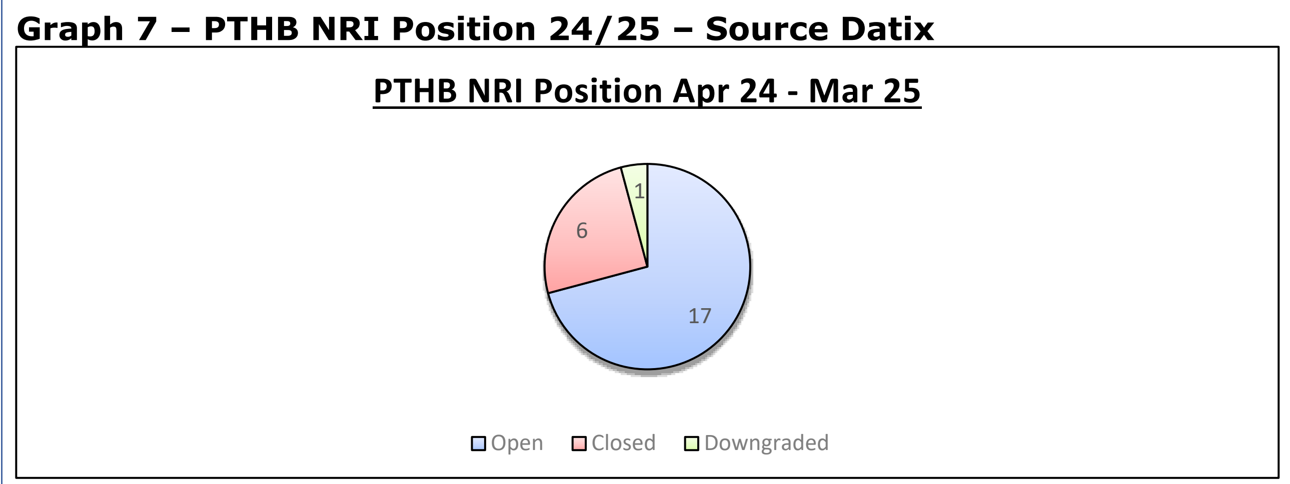
Graph 7 – PTHB NRI Position 24/25 – Source Datix



This is not including 7 incidents that are awaiting closure from 2022 and 23/24.

- 4 NRIs have been closed during Q4.

2.8 Mental Health Review of Suicides

During Q4 19 unexpected deaths were reported in Mental Health Services. The Health Board has reviewed all incidents, and 9 incidents have been reported as Nationally Reportable Incidents. Mental Health Services have collaborated with NHS Executive, Public Health Wales, Safeguarding and Dyfed Powys Police to complete a review of all deaths in 24/25, with focus on Q4. A comprehensive report will be presented to Executive Committee for 09/07/2025, ready for PEQS on 31/07/2025.

2.9 Welsh Risk Pool Assurance Report – Appendix 2

The WRP Assessment process provides a framework for the analysis of an organisation's compliance with the WRP Reimbursement Procedures, the requirements of the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011, the Health & Social Care (Quality & Engagement) (Wales) Act 2020 and other national policies and procedures related to the Putting Things Right sector. Following a review in 2023, the 2024 programme of WRP assessments includes a specific area for assessment in relation to Inquests - in acknowledgement of the increased work in this area. The scope of the review related to policies and procedures in force and matters opened, under investigation, or closed between 1st January 2024 to 31st March 2024 which included 1010 incidents reported and:

- Management of Concerns (Incidents)
- Management of Concerns (Complaints & Enquiries)
- Redress Case Management

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- Claims Case Management
- Inquest & Coronial Inquiry Management
- Organisational Learning
- WRP Reimbursement Process

The review found that there were still challenges in the timely closure of NRI and DoC incidents, though the quality of the outcomes were definitely improved. The Assessment Team also found recommendations from the previous review that had not been addressed. However, overall, The Assessment Team were pleased to note that the changes in practice which had preceded the previous WRP Assessment had been sustained. The operation of Putting Things Right (PTR) was considered to be led by the small corporate team to a high standard, where it was recognised that withing the organisation demand and capacity, the Quality and Safety Team are working efficiently and effectively. A number of areas of exemplar practice were identified.

10 recommendations were made (including 3 historical recommendations yet to be completed), which have been incorporated into an action plan (Appendix 5) that was sent completed to Welsh Risk Pool on 9 January 2025.

Table 8 is the overall assurance from WRP in their Assurance Report

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Management of Concerns (Incidents)	REASONABLE ASSURANCE	
Management of Concerns (Complaints & Enquiries)	SUBSTANTIAL ASSURANCE	
Redress Case Management	SUBSTANTIAL ASSURANCE	
Claims Case Management	SUBSTANTIAL ASSURANCE	
Inquest Case Management	SUBSTANTIAL ASSURANCE	
Organisational Learning and Learning from Events	SUBSTANTIAL ASSURANCE	
WRP Reimbursement Process	SUBSTANTIAL ASSURANCE	
NOTES The Assessment Team were pleased to note that the changes in practice which had preceded the previous WRP Assessment had been sustained. The operation of PTR was considered to be led by the small corporate team to a high standard. While there is a smaller volume of each type of matter in this organisation, the corresponding resources are equally limited and therefore the team are working efficiently and effectively. There are a number of areas of exemplar practice. Through embedding of further processes, outlined in the existing recommendations to monitor compliance with incident management principles, the Health Board can expect to increase assurance in this area also.		

3. People's Experience
3.1 CIVICA

Your NHS Experience survey is available for all patients that have accessed healthcare is available on the Health Board's website, together with a shorter Friends and Family test survey. The CIVICA system administrator receives a notification each time a Friends and Family test is completed, the feedback from which is shared with the service area highlighted in the feedback. **Graphs 9** and **10** are heat maps, the data for which builds over time and gives an overview of responses to specific questions. The heat maps below are for the current financial year but area available from the installation of CIVICA. The 'heat map' approach to data is described as:

- Green >85%
- Amber 75-84%
- Red <75%

Narrative analysis of responses remains an area for development to further inform ongoing learning and service development.

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Graph 9 – Source CIVICA
Your NHS Experience Survey Heat Map across all services, internal and external

Question:	Survey	2024 Apr	2024 May	2024 Jun	2024 Jul	2024 Aug	2024 Sept	2024 Oct	2024 Nov	2024 Dec	Benchmark
2. Did you feel that you were listened to?	Your NHS Wales Experience	85	89	85	68	35	71	56	67	39	85
3. Were you able to speak in Welsh to staff if you needed to?	Your NHS Wales Experience	45	39	44	-	-	25	10	25	25	85
4. From the time you realised you needed to use this service, was the time you waited:	Your NHS Wales Experience	71	70	66	53	35	63	45	42	50	85
5. Did you feel well cared for?	Your NHS Wales Experience	86	89	85	65	40	71	56	50	54	85
6. If you asked for assistance, did you get it when you needed it?	Your NHS Wales Experience	81	85	85	63	25	65	50	25	38	85
7. Did you feel you understood what was happening in your care?	Your NHS Wales Experience	86	86	87	72	40	75	58	50	40	85
8. Were things explained to you in a way that you could understand?	Your NHS Wales Experience	90	87	89	67	40	65	63	50	45	85
9. Were you involved as much as you wanted to be in decisions about your care?	Your NHS Wales Experience	85	85	86	67	40	75	59	50	40	85
10. How would you rate your experience 1-10	Your NHS Wales Experience	86	86	86	69	34	68	57	40	56	85
Overall:		83	84	83	65	36	68	54	47	45	
Respondents:		131	215	211	10	5	6	16	3	7	

Graph 10 – Source CIVICA
Your NHS Experience Heat Map for Powys Teaching Health Board Services only

Question:	Survey	2024 Apr	2024 May	2024 Jun	2024 Jul	2024 Aug	2024 Sept	2024 Oct	2024 Nov	2024 Dec	Benchmark
2. Did you feel that you were listened to?	Your NHS Wales Experience	92	100	-	100	100	100	96	-	100	85
3. Were you able to speak in Welsh to staff if you needed to?	Your NHS Wales Experience	25	25	-	-	-	25	-	-	-	85
4. From the time you realised you needed to use this service, was the time you waited:	Your NHS Wales Experience	67	83	-	83	100	92	75	-	100	85
5. Did you feel well cared for?	Your NHS Wales Experience	100	100	-	92	100	100	96	-	100	85
6. If you asked for assistance, did you get it when you needed it?	Your NHS Wales Experience	63	100	-	100	100	100	95	-	-	85
7. Did you feel you understood what was happening in your care?	Your NHS Wales Experience	92	100	-	100	100	100	96	-	100	85
8. Were things explained to you in a way that you could understand?	Your NHS Wales Experience	100	100	-	100	100	100	96	-	100	85
9. Were you involved as much as you wanted to be in decisions about your care?	Your NHS Wales Experience	92	100	-	100	100	100	93	-	100	85
10. How would you rate your experience 1-10	Your NHS Wales Experience	90	97	-	100	100	100	94	-	100	85
Overall:		85	94	-	97	100	96	93	-	100	
Respondents:		3	3	0	3	1	3	7	0	1	

Graph 11 and 12– Source CIVICA
A wordle of negative words around waiting on the left and the number of times each word appears on the right.

"wasting staff time"
"took 5 weeks" "took a very long"
"hour before i was"
"took a further hour" "wasted appointment time"
"further hour" "for hours" eventually "hours later"
"for 5hrs" "took a long" "running late" "taking so long"
"in a queue" "minutes late" waited ages "for an hour"
"after 24 hours" lengthy chase wait finally delays postponed
"take so long" waits queue "waste time"
"put off" delayed waiting delay "hour to get"
"for 65hours" cancelled chased
"hour late" "waste of time" "for 48 hours"
"wasting there time" "wasnt seen"
"running very late" "wasting her time"
"another 24 hours" "took 3 weeks"
"for several hours" "took 4 hours"
"wasting everyone time"

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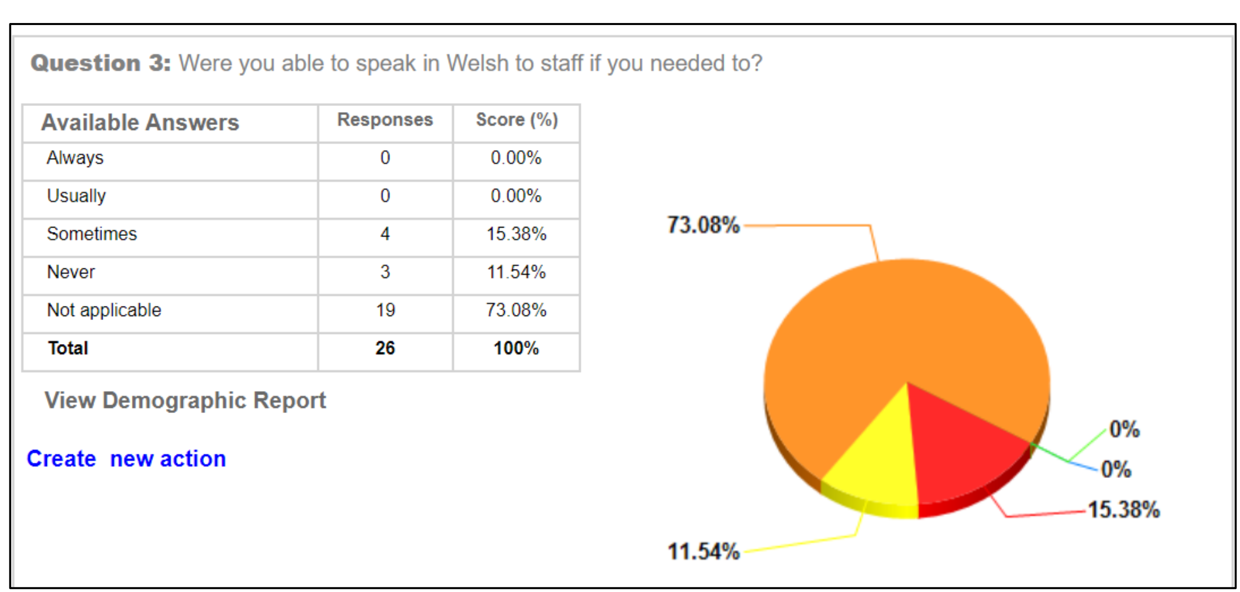
Graph 13 – Source CIVICA
Your NHS Experience – Were you able to speak Welsh if you need to?



Question 3: Were you able to speak in Welsh to staff if you needed to?

Available Answers	Responses	Score (%)
Always	0	0.00%
Usually	0	0.00%
Sometimes	4	15.38%
Never	3	11.54%
Not applicable	19	73.08%
Total	**26**	**100%**

View Demographic Report

Create new action

3.2 Patient Stories

The Quality and Safety Team have been working with services across the Health Board to encourage active engagement on patient story creation. Maternity and Neurodevelopment Services have both produced stories, while Mental Health have produced Good News Stories from patients at their Learning and Development Forum. Following recruitment, obtaining and presenting patient stories to Board will be the People's Experience Lead's coordinated function.

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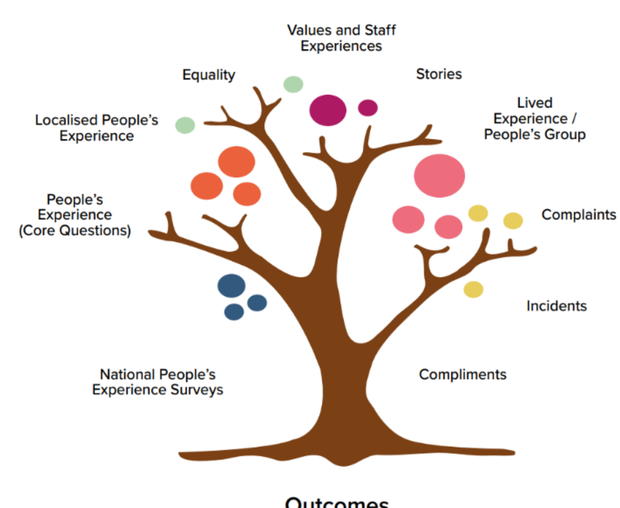
3.3 People's Experience Framework (PEF)

On 2 April 2025, the Health Board received WHC/2024/015 (**Appendix 1**) People's Experience Framework and People's Experience Survey. This framework is a self-assessment maturity matrix, aimed at empowering organisations to evaluate their current position and to develop an ambitious improvement plan for people's experience through a Value lens.

This framework will encompass all services provided by NHS Wales organisations, including commissioned services. Quality and experience indicators must be integrated into all commissioned services arrangements and the data gathered used as part of contractual monitoring and compliance. The People's Experience Framework aligns with various regulations and acts where listening and learning from people's experiences is an integral element.

People's experience is 'the sum of all interactions, shaped by the culture of the organisation, staff and systems' and can be described as how people feel when using any services and programmes offered by NHS in Wales.

The Framework outlines numerous listening, learning and improvement opportunities as depicted in the Listening, Learning and Improving Tree:



The definition of People's Experience is fundamental to Person and Population centredness. The integration of all strands of experience feedback relies on local expertise and resource and indicative of an organisation committed to quality.
With the launch of the Framework the next steps for the Health Board include

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- Undertake the recommended Self-Assessment within the Framework
- Consider the Health Boards approach on how to execute the People's Experience Surveys
- Develop a Patient Experience Framework (PEF) action plan and steering group.
- Recruit a Patient Experience Lead to oversee implementation of the required work
- Review the ToR of the Patient Experience Steering Group so that is aligns with the Framework.

The Quality and Safety Team will be rolling out the framework in the coming weeks, with a communication on their intranet page and a planned engagement roadshow during summer 2025.

3.4 Llais Activity

Llais continue to meet with the Health Board fortnightly and during April they will be completing engagement in Newtown. The Engagement Plan is available in **Appendix 5.**

4. Infection Prevention and Control (IP&C)

The IP&C improvement plan is almost accomplished with 2 ongoing actions remaining. As progress is almost complete discussions are imminent at an Executive Level to consider de-escalation.

Key developments since the previous update:

- Recruitment completed within IP&C Team. Team potentially at full capacity, however long-term sickness within the team is currently impacting the team's capacity.
- The implementation of an electronic auditing system known and MEG.

MEG Audit System

MEG is an intuitive, cloud-based digital quality management system. The system has been implemented within the IP&C service to monitor and measure care quality, drive improvement and support quality assurance.
The IP&C team were onboarded with MEG in January 2025 and have utilised the system to undertake the annual IP&C Environmental Audit in all inpatient areas across PTHB.

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The IP&C team are piloting the system and working through some system, organisation and development issues to perfect MEG. Ongoing work continues to roll out across services in the Health Board to enable them to utilise MEG.

Audit
The annual IP&C environmental audits for 2024-2025 have been undertaken in all inpatient areas the Health Board

A Snapshot of findings and themes utilising MEG to complete the audits include:

- Cleanliness of the environment
- Cleanliness of patient equipment
- Documentation
- Chemical Compliance
- Sharps Safety Standards

Work is underway in conjunction with colleagues in facilities via an Infection Prevention and Environmental Cleanliness Improvement Plan to address the issues, the plan will be communicated widely at the next IP&C Committee in April 2025.

The remainder of the audit findings will be addressed via an IP&C action plan which will for part of the IP&C workplan for 2025-2026.

Clostridioides difficile Framework for Wales 2025-2027
The IP&C team and AMS Pharmacist continue to work on reviewing the recommendations within the framework against the existing resources within the Health Board. These findings, when complete along with proposed recommendations, will be submitted to the IP&C Committee for further discussion.

5 Health and Social Care Inspections Regulatory Recommendations

5.1 Health Inspectorate Wales Inspections

The oldest outstanding actions now relate to inspections conducted from 2021 to 2023, of which 4 relate to the CMHT inspection 21/22). These 4 actions require a response from our colleagues in Powys County Council and we are in the process of liaising with them to conclude these actions. Moving forward we will seek to separate out the actions so that it is clear we are reporting fully against PTHB actions.

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Mental Health have undertaken a deep dive during December 2024 of all outstanding actions and have made significant progress with closure. All outstanding actions will now be tracked and progressed through the QuAILS group (Quality Assurance Integrated Learning and Safety).

The two outstanding actions for Epynt Ward during an inspection in 23/24 relate to flooring. Two areas have been repaired but funding is required to complete the rest.

Graph 14 Historical Inspections 2021-2023

Historical Inspections up to September 2023

Ref	Inspection Title	Recommendations Made / Actions	Recommendations / Actions Complete	Recommendations / Actions Overdue (agreed timescale)	Overdue Recommendations / Actions Revised Timescale	Recommendations / Actions Not Yet Due	All recommendations / Actions implemented
Mental Health							
212202	Tier 1 Quality Check Clywedog Ward, Llandrindod Wells	2	2				Yes
212215	HIW Announced Inspection of community mental health services	55 (4 of which PCC led)	50	4	1		
222307	HIW Tawe Ward Unannounced Inspection	26	26				Yes
232401	HIW All Wales Review of discharge arrangements in Mental Health	40	40				Yes
Wards							
232402	HIW Inspection Epynt and Y Bannau Wards, Brecon Hospital	99	97		2		
TOTALS		222	215	4	3		

Actions since 2023/2024 to date:

There are currently 2 actions open outside of the HIW timescale across Community Services, CAMHS, Mental Health, Patient Flow along with a review for DNACPR.

Graph 15 Current Open Actions from External Inspections.

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NEW Process including inspections from October 2023

Ref	Inspection Title	Recommendations Made / Actions	Recommendations / Acctions Complete	Recommendations /a Actons Paritally complete or overdue (agreed timescale)	All recommendations / Actions implemented
Mental Health					
242503	CMHT Newtown	25	24	1	
Wards					
232403	HIW Inspection Graham Davies Ward	31	29	2	
232404	HIW Inspection of Brynheulog Ward	15	12	3	
National Reviews - Improvement Plans					
232405	HIW National Review of CAMHS	Action plan due for submission to HIW 03/02/25			
232406	HIW National Review of Patient Flow	9 Recommendations requiring further information	8	1	
242501	HIW National Review MH Crisis Prevention	19	12	7	
242502	HIW National Review DNACPR - further updates requested	16 (+1 recommendation N/A)	12	4	
		115	97	18	

Graph 16 Summary Position of all inspections

Year/ Reference No	Inspection Title	Recommendations Made / Actions	Recommendations / Actions Complete	Recommendations / Actions Overdue (agreed timescale)	Overdue Recommendations / Actions Revised Timescale	Recommendations / Actions Not Yet Due
212202	Tier 1 Quality Check Clywedog Ward, Llandrindod Wells	2	2			
212215	HIW Announced Inspection of community mental health services	55 (4 of which PCC led)	50	4	1	
222307	HIW Tawe Ward Unannounced Inspection	26	26			
232401	HIW All Wales Review of discharge arrangements in Mental Health	40	40			
232402	HIW Inspection Epynt and Y Bannau Wards, Brecon Hospital	99	97		2	
232403	HIW Inspection Graham Davies Ward	31	29	2		
232404	HIW Inspection of Brynheulog Ward	15	12	3		
232406	HIW National Review of Patient Flow	9	8	1		
242501	HIW National Review MH Crisis Prevention	19	12	7		
242502	HIW National Review DNACPR - further updates requested	16	12	4		
242503	CMHT Newtown	25	12	13		
Totals		**232**	**300**	**21**	**3**	

6 PAVO

No reports provided for reporting period.

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7 Bereavement Framework

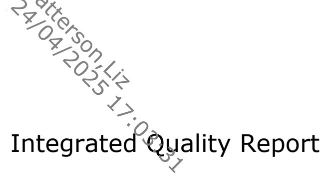
The Bereavement Lead has been completing the objectives of the National Bereavement Framework (NBF). Following reporting for the period 01/04/2024-30/09/2024 feedback has asked for assurance on the following:

- The assessment of the local population's bereavement needs including the needs of those with protected characteristics
- Commissioning of bereavement support from external providers and their progress in providing this.
- Activities undertaken to support the roll-out of the pathways and to support child bereavement in Children's Services and CAHMS.
- Health Board progress in obtaining feedback from bereaved people on the service received from all bereavement services in the HB.
- Bereavement provision out of hours, at weekends, and Bank Holidays.

The BAF has been completed for October 2024 to March 2025 where all assurance was completed and provided with the exception of provision of Bereavement support out of hours, weekends and Bank Holidays. This will continue to be a focus for 25/26.

Alongside this, the Bereavement Lead has achieved the following:

- Commissioning Grief First Aid training to establish Grief Awareness Champions throughout the Health Board.
- Mortality review – since the introduction of the Medical Examiner reviewing all deaths, there has been an expected increase in cases being forwarded to the Health Board for review. 19 cases were forwarded in Q4 with the following themes:
    - Delays in clinical information being shared with the ME
    - Delays in patients receiving diagnosis
    - Concerns regarding lack of bereavement information – This has been addressed with the ward in question as Bereavement Packs are well established across the Health Board.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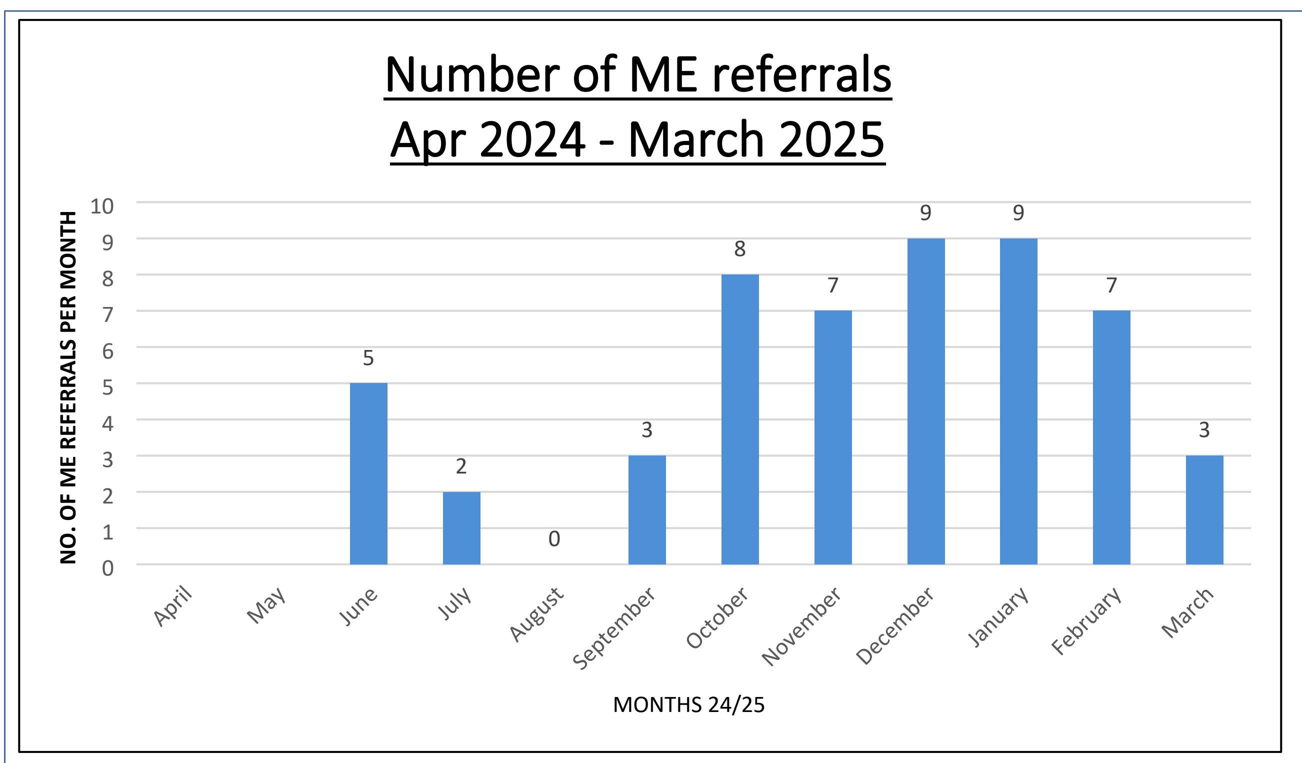
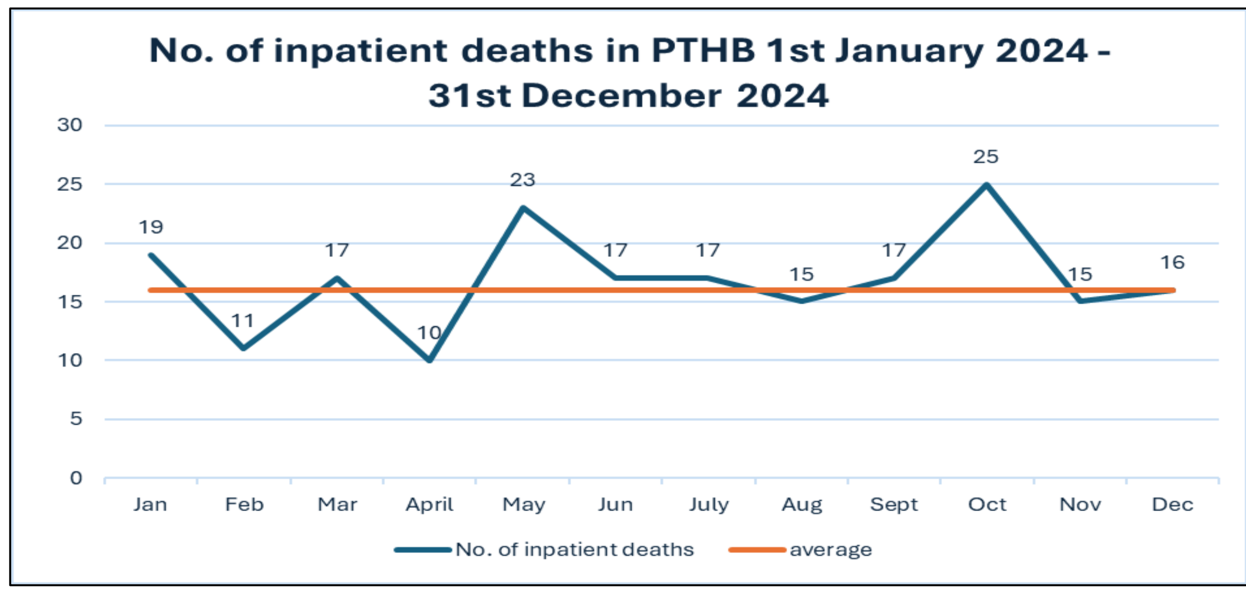


Mortality review

The total number of deaths among Powys residents from 1 January 2024 – 31 December 2024 was 2,107. Of these 1,511 occurred in the community while 202 were inpatient deaths within PTHB wards.



The average number of in-patient deaths in PTHB community hospitals for 2024 is 16 patients dying during each calendar month, this number is significantly lower compared to previous years with an average of 21 patients each calendar month in 2022 and 2023.

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The remaining deaths took place in neighbouring Health Boards across England and Wales. The table below provides a detailed breakdown of these figures.

ProvidersMainGroup	2024-2025	Total
Non inpatient	1,511	**1,511**
Welsh - Powys Teaching Local Health Board	195	**195**
English - Wye Valley NHS Trust	125	**125**
Welsh - Cwm Taf Morgannwg University Local Health Board	56	**56**
Welsh - Swansea Bay University Local Health Board	54	**54**
Welsh - Hywel Dda Local Health Board	49	**49**
English - Shrewsbury & Telford Hospital NHS Trust	44	**44**
Welsh - Aneurin Bevan Local Health Board	31	**31**
English Other	17	**17**
Welsh - Cardiff & Vale University Local Health Board	9	**9**
Welsh - Betsi Cadwaladr University Local Health Board	8	**8**
English - Gloucestershire Hospitals NHS Foundation Trust	5	**5**
English - Worcestershire Acute Hospitals NHS Trust	2	**2**
English - Robert Jones & Agnes Hunt Orthopaedic & District Trust	1	**1**
Total	**2,107**	**2,107**

8. Venous Thromboembolism (VTE) Scoping Review

The Quality and Safety Team met with the All-Wales Lead for VTE to complete a VTE scoping review of all the health boards. The purpose of an all Wales VTE scoping review is to identify any variation in practice within specialities and the health boards at large, which may lead to the development of a standardised approach to VTE prevention. A standardised approach could include the assessment of VTE risk, VTE educational package, sharing of best practice and innovations in VTE prevention and practice, reporting of Hospital Acquired Thrombosis and adaptation of guidelines and policies. Having a standardised approach would be beneficial in many ways including increased patient safety and experience, ease of movement of staff between departments and Health Boards, reduction in variation in practice and comparable data to show trends. It is hoped that the results of the review will be available Autumn 2025.

9. Quality Safety and Outcomes Sub-Committee Highlight Report

Appendix 3 The report had been prepared to provide a summary of the key issues considered by the Joint Commissioning Committee Quality, Safety and Outcomes sub-committee at its meeting on 3 February 2025. Also presented were the Terms of Reference and the Way Forward Plan and Members were informed about the Risk approach and noted that by March 2025, risks related to quality and safety will be reported to this sub-committee for review

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and assurance. **Appendix 3** also contains links to reports highlighted February 2025 – NHS Wales JCC QSO.

10. Strengthening Safeguarding in Health Review

The Strengthening Safeguarding in Health Review final report was received in January 2025.

The **Safeguarding in Health Review** was commissioned by Welsh Government to review of the effectiveness of safeguarding arrangements in NHS Wales, thus ensuring that the Welsh Government (the CNO, Director General/Chief Executive NHS Wales and Ministers) have sufficient, meaningful assurance that the NHS in Wales is delivering against its statutory safeguarding duties.

With the establishment of the NHS Executive and the enactment of the Health Social Care (Quality and engagement) (Wales) Act 2020, it is considered now is the right time to reflect on how arrangements could be strengthened and /or enhanced giving particular focus on developing a safeguarding quality management system with supporting architecture in the NHS in Wales, which will provide oversight on the effectiveness of Safeguarding arrangements in health, at a system level.

Background

Over the past ten years throughout Wales, several high-profile safeguarding Adult and Child Practice Reviews, inspection reports and safeguarding publications have been published, however, assessing whether the recommended interventions and actions have been effectively implemented is a challenge. Additionally, ensuring that significant lessons are consistently applied across all relevant health settings, rather than just where the issue was first identified, is equally complex which presents a risk.

Findings

The final Safeguarding in Health Review report acknowledges the remit of safeguarding is vast and challenging within the NHS, which is complex and where there are thousands of touch points with the public every year, some of whom will already be vulnerable to abuse or neglect or who may become vulnerable by virtue of presenting to health services.

The review provides well-informed insights and a total of 28 recommended changes, including structural adjustments and other modifications that may be necessary to improve systems and practices within NHS Wales.

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A Safeguarding in Health Steering Group has been established and categorised/prioritised the recommendations.
9 recommendations were accepted; however, 5 were agreed to be duplicates.9 recommendations were identified for further consideration, but 3 of these were duplicates.
10 recommendations were determined to be out of scope.

The NHS Executive have been given to mandate to progress the recommendations and will now establish a National Safeguarding in Health Delivery Group to oversee their implementation**.** The First meeting will take place in April 2025

Safeguarding in Health Review

	Primary Findings & Recommendations	**Time frame**
1	**The establishment of the Safeguarding Oversight Group:** NHS Executive to establish oversight group to implement the agreed recommendations.	Within 2 months
2	**Safeguarding Quality & Safety/learning Framework**: Establish a robust system for continuous learning and improvement in safeguarding arrangements in health. This framework will include mechanisms for sharing best practices, learning from incidents, and ensuring that all staff are adequately trained and supported in their safeguarding roles managing and overseeing safeguarding practices within NHS Wales.	Within 12 months
3	**Safeguarding Quality, Assurance & Accountability Framework**: Ensure that safeguarding practices are effectively implemented, monitored, and evaluated for continuous improvement. Framework focuses on ensuring that safeguarding practices are not only implemented effectively but also monitored and evaluated for continuous improvement. This framework will include mechanisms for accountability and assurance, ensuring that health boards and trusts are held responsible for their safeguarding duties reporting to IQPD and JET meetings.	Within 12 months
4	**Quality Statement & Safeguarding Metrics**: Provide clear guidelines on safeguarding objectives and expected outcomes and develop metrics to monitor and evaluate	Within 6 months

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	the effectiveness of safeguarding practices. The Quality Statement & Safeguarding Metrics will provide a clear and concise description of what good quality safeguarding should look like within NHS Wales. This statement will be accompanied by a set of metrics that can be used to monitor and evaluate the effectiveness of safeguarding practices, providing early warning signals for any issues.	
5	**Explore the development and implementation of a Digital Tracking: System** to track actions from reviews, inspections, and reports at both organizational and national levels in NHS Wales. This three-year digital programme will involve key statutory partners and address the need for improved information sharing between agencies.	With in 36 months

NEXT STEPS:

Key Matters for Board/Committee

1. Timely management of Duty of Candour investigations and delivery outcomes to all families.
   ACTION taken: Additional focus and support is being provided by the Head of Quality and Safety to ensure investigations are managed in a timely manner and learning identified and shared throughout the process. The Quality and Safety Team has completed a deep dive of all Duty of Candour incidents since implementation in April 2023 and will be working with services to ensure all incidents are complete.

2. Ensure the required support and resource is available to support the Patient Experience priorities and agenda.
   ACTION taken: Patient experience has been a key focus for the Health Board during Q1-Q4. The Head of Quality and Safety has undertaken a national scoping exercise to understand the Health Board requirements in terms of development and needed resources in line with the National Patient Experience Framework. Active recruitment for the People's Experience Lead is underway and the Q&S Team will be rolling out the Framework in Q1&2 of 25/26.

Appendix 1: People's Experience Framework	
Appendix 2: WRP Assurance Report	

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Appendix 3: Quality Safety and Outcomes Sub-Committee Highlight Report - NHS Wales JCC QSO	See Item 5.5 on agenda
Appendix 4: Strengthening Safeguarding in Health Review	
Appendix 5: Llais Engagement Plan	

IMPACT ASSESSMENT – NOT REQUIRED FOR THIS REPORT

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People's Experience Framework

Review date: August 2028

gov.wales

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Mae'r ddogfen hon ar gael yn Gymraeg hefyd / This document is also available in Welsh
Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg / We welcome correspondence and telephone calls in Welsh

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Aim

This framework is a self-assessment maturity matrix, aimed at empowering organisations to evaluate their current position and to develop an ambitious improvement plan for people's experience through a Value lens.

Scope

This framework will encompass all services provided by NHS Wales organisations, including commissioned services. Quality and experience indicators must be integrated into all commissioned services arrangements and the data gathered used as part of contractual monitoring and compliance.

The People's Experience Framework aligns with various regulations and acts, including the Health and Social Care (Quality and Engagement) (Wales) Act 2020, the National Health Service (Concerns, Complaints, and Redress Arrangements) (Wales) Regulations 2011, the Public Services Ombudsman (Wales) Act 2019, the Well-being of Future Generations (Wales) Act 2015, the Equality Act 2010, the Value Based Health Care Strategy and the Socio-economic Duty. Listening and learning from people's experiences is an integral element of these regulations.

What is 'People's Experience'?

People's experience is 'the sum of all interactions, shaped by the culture of the organisation, staff and systems'. People's experience can be described as how people feel when using any services and programmes offered by NHS in Wales. Whether it be in a hospital ward, outpatient appointment, participation in national screening programs, engagement with primary care services (such as GP, Optometrist, Pharmacist, Dentist), interaction with health promotion practitioners, or attendance at any event hosted by an NHS Wales Organisation.

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In essence, the definition of People's Experience is fundamental to Person and Population-centredness.

The integration of all strands of experience feedback relies on local expertise and resources. However, the triangulation of experience feedback data alongside other metrics, e.g. outcomes, as depicted on the Listening and Learning Tree is indicative of an organisation committed to quality.

Health and Care Quality Standards

To help us understand what excellent quality means and how we can apply it in practice, 12 Health and Care Quality Standards have been developed.

The Standards include the six domains of quality and six quality enablers. The Health and Care Quality Standards are intended to apply broadly to the wide range of services provided by the NHS in Wales.

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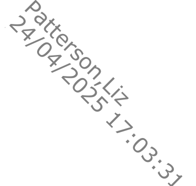
Duty of Quality – Person Centred quality standard

Our health care system meets people's needs and ensures that their preferences, needs and values guide decision-making that is made in partnership between individuals and workforce. We care about the well-being of individuals, their families, carers and our staff. We ensure that everyone is always treated with kindness, empathy and compassion and we respect their privacy, dignity and human rights. We are committed to working better together to put people and their families at the centre of decisions, seeing them as experts collaborating with professionals to get the best outcome and experience.

People's Experience principles should be considered in line with the Duty of Quality

- All people who use NHS Wales services, programmes or functions have the right to provide anonymous feedback quickly and easily when they want to.
- 'People's experience' is a continuous feedback stream.
- At times of distress there may be sensitivities in gathering feedback. However, people should still be able to give feedback if they choose to.
- The feedback should be used to celebrate and build on what is working well, and to identify areas where improvements could be made.
- People's experience feedback should be made readily available to the public in an accessible format.
- Information should show that feedback is being listened to and acted upon, e.g. 'You said, we did' and the Duty of Quality report.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The use of and the difference between People's Experience, Engagement, Patient Reported Experience Measurements (PREMS), Patient Reported Outcome Measurements (PROMs)

Engagement with people is different from People's experience and feedback. Although the two activities are related and overlap, engagement is the active participation of members of the public, communities or other stakeholders in service planning, delivery, and evaluation.

To ensure the prioritisation of people's experience, it is recommended that all NHS Wales organisations have in place a People's Experience Strategy.

Use of Patient Reported Experience Measurements (PREMs)

PREMs (Patient Reported Experience Measures) use a series of questions which require an overall rating or another quantifiable value. PREMs can be classified as either relational or functional. Relational PREMs show the patient's experience of their relationships during treatment, and can be disease specific e.g., did they feel listened to? Functional PREMs examine more practical issues, such as the facilities available.

As an example, the CARE measure, a relational questionnaire, is an example of a PREMs tool. PREMs require a large sample of respondents, to generate standardised aggregated and validated measurements and a supporting system which enables clinicians to view and react to individual PREMs feedback. Alongside People's Experience feedback, PREMs also support clinical effectiveness, safety, and quality improvement, and can support a Value-Based approach by combining specific disease specific PREMs with PROMs, but should not be viewed as a replacement for the 'How it felt to use any of the services, functions, and programs of NHS in Wales,' conversation.

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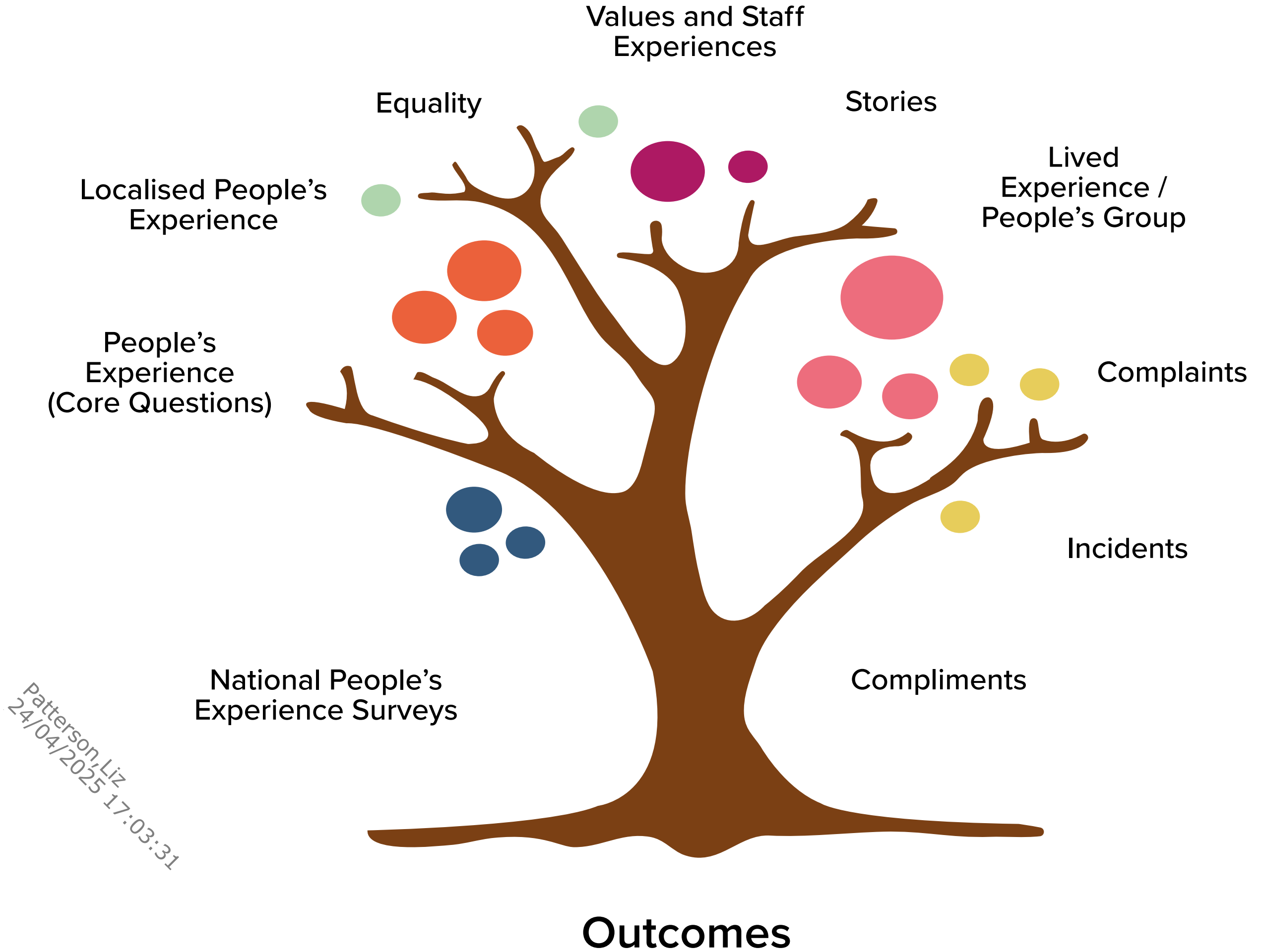
Patient Reported Outcome Measurements (PROMs)

PROMs (Patient reported outcome measures) assessments are essentially a structured communication assessment between a person receiving care and their clinical team, delivering standardised responses about symptom burden and quality of life. PROMs are one of the tools used within a wider toolkit, to evidence Value-Based healthcare, to better understand outcomes which matter most to people and patients. PROMs are designed and evaluated for symptoms relating to specific conditions or around general health and quality of life.

In addition to PREMs and PROMs there is ongoing development of added measures including CROMs (Clinician Reported Outcome Measures) and SROMs (Staff Reported Outcome Measures).

Listening, Learning and Improving Tree



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Outcomes

National People's Experience Surveys

National surveys are developed at the request of clinical areas of work and in conjunction with the NHS Wales Executive Team. There is an approval process set up, (please see Appendix A) to support the development and inclusion of national surveys within the Once for Wales Experience System. Where applicable, all organisations will engage in the national survey approach in line with the Duty of Quality 'always-on' reporting and share with people and communities via local websites, the feedback received and any service improvements that have been undertaken because of the feedback.

Information collected via national surveys will remain the responsibility of clinical areas and organisations supporting the collection. The information will also be used to populate the NHS Wales Executive Quality Dashboard.

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People's Experience (core questions)

A Welsh people's experience core set of questions has been developed. Every effort should be made to use the people's experience core set of questions in all experience and feedback surveys, the core set of questions are listed below. In circumstances where people in receipt of services cannot directly provide feedback, consideration should be made for the views of family, friends, and carers (unpaid) to be gathered.

1. How would you rate your overall experience?

☐ Very poor ☐ Poor ☐ Neither good nor poor

☐ Good ☐ Very good

2. Was there anything particularly good about your experience you would like to tell us about?

3. Was there anything particularly bad about your experience you would like to tell us about?

4a Which language would you prefer to communicate in?

☐ Welsh ☐ Urdu ☐ Gujarati

☐ English ☐ Portuguese ☐ Italian

☐ Polish ☐ Spanish ☐ British Sign Language

☐ Romanian ☐ Arabic ☐ Other, please specify

☐ Panjabi ☐ Bengali

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4b Were you able to communicate in your preferred language?

☐ Always ☐ Usually ☐ Sometimes ☐ Never

Scoring and benchmarking

An All-Wales scoring structure has been agreed upon for the Likert-based question 1, which organisations should use to benchmark, learn from each other, and make publicly available in the spirit of the Duty of Quality.

Response	Weight
Very good	10
Good	7.5
Neither good nor poor	5
Poor	2.5
Very poor	0
I don't know (if included)	N/A

Localised People's Experience Feedback (Service Specific)

Locally requested surveys should reference the National People's Experience question set, included in Appendix B (where appropriate). At a minimum, all local experience and feedback surveys are required to include the people's experience (core questions) question set.

Carers/Families

Carers/Families play a valuable role in the health and well-being of their loved ones and their contribution often goes beyond the cared for and impacts wider society and services. The contribution and role the carers play in the health and well-being of a loved one is sometimes not fully acknowledged. It is often the carer who organises appointments, arranges transportation, plays a role in explaining information to the patient, assists with medication, as well as helping with a host of other important tasks. This level of involvement places carers in a unique position to share their experiences of services and People's Experiences surveys should be developed to allow carers to offer their feedback.

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In addition, the impact of a patient's Illness on a carer/family member's own health and well-being has proven to be both widespread and severe and organisations should consider the availability of a FROM (Family Reported Outcomes Measure) type questionnaire. The development and availability of such questionnaires should always be linked to the organisational ability to provide signposting and support.

Equality Monitoring

Health outcomes and experiences are often influenced by the protected characteristics of our people and communities. To support the identification of varying experiences, **all** experience and feedback surveys across NHS Wales should include a nationally agreed set of demographic and diversity (through a quality lens) questions which are included in Appendix C.

These questions should not be compulsory to answer and a clear explanation of how the data will be used and stored should be set out in the survey/questionnaire introduction. Robust processes to support the analysis of information should be developed at a local level and ensure the information provided does not affect individual access to services or care.

Organisations should also develop processes which help the capture of the demographic and diversity information of those people who have raised a complaint (at a time most appropriate).

It is expected that each organisation will have processes in place to support the analytics of information being collected to provide an extra layer to the experience data and be used to support wider quality, improvement, and engagement of communities.

Values and staff experiences

People's experience is 'the sum of all interactions, shaped by the culture of the organisation, staff and systems. The same definition can be applied to staff and put simply, staff and people's experiences are two sides of the same coin. Organisational culture and staff experiences are intrinsically linked to people's experiences. Staff are proud to work for the organisation and speak highly of the culture. Staff throughout the organisation feel able to raise concerns and believe they will be listened to and supported.

We understand that asking people 'What matters to you' instead of 'What's the matter with you' makes a significant difference to their overall experiences of NHS Wales services. How much more difference could we make if we started asking our staff a similar question: 'What matters most to you?' We should remind ourselves that this relationship could be one of the most important moves the NHS Wales makes to drive better productivity and improve experiences of care for the entire population of Wales.

The expectation is that organisations will work with Human Resources, Finance Organisational Development and Planning, Value-Based Healthcare and Data and Analytical teams to establish a work programme, which includes triangulation of data to drive improved outcomes and experiences for people through improving staff experience.

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Stories

We cannot ignore the importance of conversations and narrative-based contributions in supporting quality and improvement. The use of people, communities and staff narratives should be embedded across all NHS Wales organisations.

There is an expectation that organisations will have processes in place to allow them to capture and listen to people's stories. These stories should be shared at Committees and Board meetings, in addition to being used as part of staff training and organisational awareness.

To support the collection and thematic analysis of stories from across NHS Wales, it is expected that all organisations contribute to the All-Wales NHS Digital Story Library. To support organisations the NHS Wales Digital Story toolkit is included in Appendix D.

Lived experience/people's groups

Lived experience refers to the unique and personal encounters, perspectives, and insights that individuals gain through direct involvement in particular situations or circumstances. It encompasses the real-life experiences, emotions, challenges, and lessons learned by individuals as they navigate various aspects of their lives. Lived experience is deeply subjective and can be influenced by a person's background, culture, beliefs, and personal circumstances. In various contexts, such as healthcare, social services, or advocacy, lived experience is valued for its authenticity and its potential to offer valuable insights and inform decision-making processes.

It is expected that all organisations consult with their lived experience/people's groups, and this is triangulated as part of their people's experience feedback.

Complaints

Complaints are a part of the experience feedback family and are an expression of dissatisfaction, which is significant enough to prompt the person to raise the matter.

An exemplary organisation will include experience and other sources of feedback so that action can be taken quickly where required. Hotspots can be easily shown and reported to senior leadership, Committees, Board meetings and the public in an accessible format.

Complaints are managed through the robust policy framework and processes of 'Putting Things Right Regulations'. The principles of 'Always on' should be aligned to the sphere of complaints.

Incidents

Clinical incidents refer to unintended or unexpected events that occur during the provision of healthcare services and have the potential to cause harm to patients, staff, or visitors. These incidents can range from errors in medication administration to communication breakdowns, equipment malfunctions, or adverse reactions to treatments. Clinical incidents are typically analysed to understand their causes, prevent recurrence, and improve patient safety and quality of care. Incident reporting and investigation systems are commonly used in healthcare settings to find and address clinical incidents promptly. Incidents should be considered in the triangulation of feedback methods.

Compliments

Compliments are an unsolicited expression of gratitude. People invest their time to leave a compliment in the hope that the behaviours they experience are repeated and routinely available to others. The comparison of compliment and complaint numbers in isolation from the contextual narrative has minimal benefit when looking to support quality and improvements. To support a mutual understanding of what constitutes a compliment and to ensure all NHS Wales Bodies maximise the capturing of compliments, common definition of a compliment is provided below:

> *'A positive or appreciative statement about any individual NHS Wales staff member, services, programme, or function, which includes the expression of praise, admiration, or congratulations which goes beyond common courtesy. This can be received through a variety of means including verbal and written'.*

It is expected that all NHS Wales Bodies develop and implement a robust 'Always on' system for the collection of compliments within easy reach for all people and communities. Organisations should also develop processes which support learning from compliments, processes to recognise areas and staff who are mentioned in the compliment, processes to share good practices highlighted within compliments wider in the organisation.

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Good Practice Local Self-Assessment Tool Recommendation

It is recommended that all NHS Wales Bodies complete a local self-assessment Red Amber Green (RAG) rating score for each element of the framework as a basis for local quality and improvements.

National assurance is overseen by NHS Executive Wales.

1. Review each criteria statement and identify the range of evidence available which supports each statement. Ask yourself questions such as:

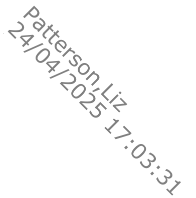
a. How embedded is the process which supports this criterion?

b. Are we consistent across the organisation/ service as a whole?

2. Then judge the strength of the evidence through a RAG rating –

Red	**No / insufficient evidence.**
Amber	**Evidence available but may need further development.**
Green	**Sufficient relevant evidence.**

Where you have judged the evidence available to support the criteria as **Red**, then this is an area for development/exploration and should be included in your organisation's development plan. The **Amber** criteria will also need to be addressed before assessment, **but if you have ten or more Red criteria focus on these first before adding the Amber criteria to your improvement plan.**



Criteria	Name of person/team completing the self-assessment	Date self-assessment undertaken	What we have in place	Our Rating Red Amber Green	Areas for focus/ improvement in next 12 months	Date of reassessment	Name of group/ committee to receive self-assessment outcome
Leadership							
Capacity and capability to effectively collect feedback							
Analysis and triangulation							
Using people's feedback to drive quality improvement and learning							
Reporting and publication							

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Areas for Local Self-Assessment

Leadership

The Board and senior leadership show their dedication to prioritising people's experience in all their initiatives. They work towards enhanced collaboration, ensuring that all individuals play a crucial role in the decision-making processes, to achieve the best possible outcomes and experiences.

Leadership promotes a culture defined by compassion, empathy, and kindness while upholding principles of privacy, dignity, and human rights. These values and behaviours are actively embraced by all members of the workforce.

Characteristics	Suggested requirement needed to meet the characteristic	What will good look like?
The organisation has a strategically endorsed document by the Board aimed at enhancing people's experiences. This document advocates for a system-wide strategy emphasising quality, continuous improvement, and ongoing learning.	The organisation has a People's Experience Document, collaboratively developed with input from individuals and communities, with consultations involving all staff and relevant stakeholders. This document undergoes approval through the organisation's governance process. The People's Experience Framework is designed to be seamlessly aligned with and integral to the Duty of Quality, Health and Care Quality Standards, and Duty of Candour. This approach reflects a commitment to value-based healthcare.	The organisation aims to establish an approved document outlining people's experiences. This document should be easily comprehensible for individuals, communities, and staff. The People's Experience Document is expected to exhibit harmony with other essential policy documents and plans, such as the Quality Strategy, Equality Plan, and others.
The Board can show evidence of actively listening to feedback from individuals and undertaking measures where appropriate to enhance both the experience and the quality of service.	A variety of feedback and engagement methods are in place, actively promoted and widely disseminated. Every staff member is involved, contributing their insights to the development of services and efficiency changes, with a focus on understanding how these changes impact individuals, communities, and staff.	Evidence in public reports of listening, reporting, and acting upon feedback e.g., 'you said, we did,' in line with the Duty of Quality.

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Characteristics	Suggested requirement needed to meet the characteristic	What will good look like?
People's experience is integrated into all leadership development initiatives, encompassing efforts by everyone involved. This fosters a culture dedicated to continuous learning and improvement, prioritising quality, safety, and experience.	All leaders and senior managers actively contribute to an efficient quality management system, possessing the requisite skills, knowledge, and values to provide person-centred services. In addition, leaders and senior managers take proactive steps to incorporate learning, quality, and experience into leadership development, staff objectives, appraisals, and other relevant processes.	The organisation can show the use of Peoples Experience feedback in decision-making and planning and delivery of services. The organisation can provide tangible evidence of incorporating people's experience into the decision-making process and the planning, and delivery of services.
The senior leadership team is visible, with a designated Executive Director taking accountability for leading quality, and people's experience to ensure that the organisation fulfils its Duty of Quality and obligation to promote active listening and learning from experiences and feedback.	The Executive Lead or nominated deputy for people's experience consistently helps discussions on experience and regularly presents comprehensive reports to the Board. Proactively taking charge of this domain within the organisation, the nominated lead ensures that people's experiences (including stories) become a routine feature in various meetings, including those held by the Board and its sub-committees.	People's experiences and the corresponding actions are disclosed in the Board and other published reports. People's experience reports cross-reference various experience/ feedback sources, including compliments, general feedback, satisfaction ratings, complaints, and Value-Based healthcare. Information e.g. (PROMS/PREMS), incorporating both goals and shared decision making tools Lived experiences of people along with associated learnings and actions, are shared both internally and externally. This information is balanced with staff experiences and stories.
The organisational development strategy and implementation plans are underpinned by a commitment to improve people's experiences.	People's experience is integrated into the organisational development strategies. This should also include ensuring that our staff are trained and equipped to engage and work collaboratively with our public and communities.	There is recognition that staff experience is critical to people's experience and service quality. This should be referenced in key documents such as IMTPs, and Patient Experience (People's Experience) Strategies.

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Characteristics	Suggested requirement needed to meet the characteristic	What will good look like?
The organisation values and celebrates innovation by staff that demonstrates a consistent approach to people's experience and quality improvements.	Staff are supported by senior managers and colleagues to listen and act locally as a response to feedback and the organisation routinely captures, analyses and reports on the outcomes from any quality improvement work. Monitoring takes place against the results of the staff and people experience surveys. Staff behaviour is compassionate, involves people and communities in decision-making and provides good emotional support to people.	Innovations are recognised within a wide range of policies, procedures, and reports to the Board. Also celebrated and recognised at staff awards; appraisal; Research and quality improvement programmes. There are opportunities for shared learning throughout the organisation and wider, including the opportunity to share good practices and learn from mistakes. Staff training includes opportunities to understand and embed: • compassionate leadership and culture within the organisation • positive feedback – learning from compliments. People and communities are involved in staff training through a variety of means including lived experience stories to delivering the training. Active involvement of people and communities at NHS Wales meetings can positively impact outcomes and contribute towards raising staff awareness.

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Characteristics	Suggested requirement needed to meet the characteristic	What will good look like?
Organisational culture and staff experiences are intrinsically linked to people's experiences. Staff are proud to work for the organisation and speak highly of the culture. Staff throughout the organisation feel able to raise concerns and believe they will be listened to and supported.	The organisation has developed, with people and staff, a set of values, articulated through all corporate documents, which reflect the values of NHS Wales. The organisation has a process for ensuring values are owned by staff. The organisation has in place a values-based recruitment and appraisal system.	Organisations have an agreed and published Values and Behaviour Framework that has been developed with staff, people, communities, and all relevant stakeholders. Person-centred care/provision (population-centredness) is a core element of the organisation's values and promotes a co-productive way of working. Standards for values and behaviours are part of recruitment, interview processes, staff Job descriptions, role profiles and appraisal.
The organisation expresses its commitment to engaging with people and communities through all its communications. This is per the Duty of Quality.	The organisation's website and other externally facing communications are accessible and clear and people would judge them to be user-friendly. They also articulate a commitment to person or population-centred services and programmes. People and communities are actively involved in the development, production, and review of all public-facing health (including promotion) and well-being information. People and communities can access correspondence relating to their health or care in an accessible format suitable for their needs.	Communication is available bilingually in a range of formats (Welsh and English) but should also include user-friendly and jargon-free easy-to-read information, BSL, audio and language of choice. Organisational websites are designed to use language that is clear in meaning and jargon-free. Public-facing information relating to an individual's or community's health and well-being is developed in line with good practice and is subject to stakeholder review before publication. Stakeholder review is inclusive and relevant to the people and communities who would access the information.

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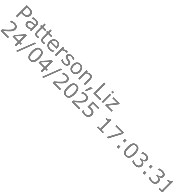
Characteristics	Suggested requirement needed to meet the characteristic	What will good look like?
		Organisations compliance in line with the Accessible Information and Health Care and Quality Standards. Every organisation shows how they will implement, comply, and monitor the Accessible Information Standards. Feedback from staff, people and communities is routinely gathered and includes feedback on whether information and communication are accessible.



Capacity and Capability to effectively collect feedback

The organisation has several routes through which People and Communities can provide feedback.

Characteristics	Suggested requirement needed to meet the characteristic	What will good look like?
The organisation ensures that people's experiences and overarching themes are at the core of all surveys, including post-discharge surveys. It collaborates with teams to devise and execute rapid, real, or near-real time feedback processes.	The organisation fully adheres to all mandated mechanisms and has a comprehensive programme dedicated to looking for rapid, real-time experience and feedback from individuals, utilising the most up to date technology available to them.	A unified system for Wales should facilitate benchmarking across organisations and support real-time feedback through various channels, such as SMS, IVR, online platforms, paper, etc. Organisations are encouraged to consider reframing the question from 'What's the matter?' to 'What matters to you?' This shift in focus aims to prioritise and address the individual's concerns and preferences.

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Characteristics	Suggested requirement needed to meet the characteristic	What will good look like?
The organisation has established an accessible experience and feedback process that aligns with national guidance and regulations.	The organisation has implemented accessible and user-friendly feedback processes, enabling individuals to easily submit compliments, provide feedback, or raise concerns in their language of choice. Information related to these processes is prominently displayed and accessible across all locations and formats (website and display screens etc). Organisations have in place a systematic process for capturing experiences, feedback, and concerns specifically about how complaints are handled and the overall process. There is unambiguous evidence that feedback is consistently collected, and the organisation has implemented changes in practice. Moreover, these improvements have been sustained over time.	There is robust national guidance and widespread awareness of experience and feedback systems throughout the organisation, both internally and externally, with a particular focus on reaching seldom-heard communities. Clear visibility is ensured through the availability of leaflets and posters in bilingual formats (Welsh and English), and other languages in line with local population needs. In additional accessible formats, including Easy Read, British Sign Language (BSL), audio should also be made available. The organisation can provide evidence of collecting experience and feedback regarding the concerns process. Furthermore, they can demonstrate tangible improvements made because of the gathered experience and feedback. Feedback is systematically collected monthly, and there is documented evidence of improvement (where appropriate). This information is presented within the organisation and externally to the public.
All staff take ownership of and promptly address feedback and concerns at the earliest opportunity. Clear information is provided, and support is extended when individuals express a desire to provide feedback or raise a concern.	All staff are supported by their colleagues in addressing concerns raised by individuals, and there is a structured process for teams and the broader organisation to share and learn from these experiences.	All staff are empowered to reflect on all feedback and receive support to enhance the experiences of individuals. The organisation has clear processes in place to escalate, share, and learn from all feedback.

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Characteristics	Suggested requirement needed to meet the characteristic	What will good look like?
Duty of Candour	Staff comprehend and act upon the Duty of Candour as outlined in the Health and Social Care (Quality and Engagement) (Wales) Act 2020. The significance of experience and feedback is integrated into the organisation's approach to staff training.	All staff members, including those who are front facing or involved in service development, have completed Duty of Candour training. The organisation can provide evidence of being open and honest with people and communities when things go wrong. Training on experience feedback is incorporated into all sides of the organisation, including induction processes, leadership development programs, and staff appraisals.
People are provided with information about the various avenues via which they can leave feedback, encompassing paper-based surveys, comment cards, web platforms, text messages, devices, kiosks, and apps. Staff support individuals in utilising these approaches, ensuring consideration for the needs of those who may be less able or less willing to provide feedback.	The organisation disseminates information to individuals in multiple ways to provide feedback. People are informed about various avenues available to them as routes for sharing their experiences and feedback. The organisation utilises a variety of methods to collect feedback from people, tailoring these approaches based on individuals' needs and preferences. Staff members are well-versed in these methods and actively encourage and support people in providing feedback. Organisations are encouraged to establish experience/feedback Quality Indicators (QIs) for all public-facing services, and programmes in alignment with the People's Experience Framework. These should support quality improvements and be reported internally within the organisation while also being made available externally to the public.	The organisation can demonstrate it has in place various accessible methodologies and routes for the capture of people's experiences. Organisations can demonstrate a quality improvement approach to introducing new routes for capturing people's experience and evidence learning which has resulted in improvements. Staff can direct people and communities to a variety of feedback routes. The QIs along with all performance-related information should be made available on websites and in reports in a format which is easily understood. Also, in the case of online, the information should be easy to find.

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Analysis and Triangulation

The Organisation has a systematic and consistent approach to analysing and making sense of feedback (qualitative and quantitative) and considers it alongside safety and outcomes data.

Characteristics	Suggested requirement needed to meet the characteristic	What will good look like?
The organisation has implemented a systematic method for analysing feedback and experiences gathered in various forms. Additionally, the organisation has dedicated analytics and intelligence support for its experience data, generating clear and helpful reports.	The organisation routinely and systematically analyses all forms of feedback and experience, consolidating all strands and identifying themes upon which it acts.	The organisation employs real-time sentiment analysis to identify opportunities for early resolutions. All forms of feedback and experience undergo triangulation with various other outcome measures and are included in quality and assurance reports across the organisation, as well as in other public reports. Quantitative data, when available, is graphically plotted over time to provide a visual representation of trends. Demographic and diversity information is analysed aligned to the experiences themes to identify any variation and support improvement or engagement work (as required). The data is translated into business intelligence, informing meaningful quality improvement actions and engagement (where appropriate).
The organisation generates reports displaying the correlation between enhancing outcomes, safety, and the experience of people. This information is routinely triangulated with data from staff surveys, providing a comprehensive perspective on overall performance.	Reports explicitly highlight themes where people's experiences correlate with other quality measures. Organisational reports clearly articulate these relationships and outline the quality improvement actions that result from the analysis.	All forms of feedback and experience undergo triangulation with a variety of other outcome measures and are incorporated into organisational quality and assurance reports. This information is also included in other public reports. A robust relationship is maintained with services and teams to ensure that feedback, wherever feasible, translates into improvements. This collaboration involves staff from a range of disciplines across the organisation.

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Characteristics	Suggested requirement needed to meet the characteristic	What will good look like?
The organisation adeptly employs experience data to efficiently identify and pinpoint areas of deteriorating performance, facilitating prompt action to address the underlying causes.	The organisation proficiently utilises experience and feedback data as an early warning system for declining standards. This enables leaders at various levels to detect concerns and implement quality improvement approaches promptly. The organisation utilises data related to experience and engagement to comprehend variations. Experience is fully aligned with and integral to quality improvement efforts.	Trend graphs are employed to identify abnormal activity within the feedback system. Additionally, alerts are set up to trigger actions promptly in response to key concerns. This system helps in staying vigilant to emerging issues and taking timely corrective actions. All quality improvement processes unequivocally demonstrate the utilisation of experience data. The insights derived from the data play a leading role in shaping and enhancing the organisation's quality improvement initiatives.
Experience and feedback information is routinely taken into consideration and acted upon by all teams. When a larger scale service redesign is necessary, such feedback is appropriately escalated and incorporated into the decision-making process.	Services, programmes, and functions receive feedback promptly and in a format that is suitable for their users. Organisations regularly engage in discussions about the data and leverage it for quality improvements. The organisation has an effective approach to celebrating and sharing local learning.	The organisation should have access to a quality management system where data is live and in real-time, providing them with immediate and up-to-date insights. The quality management system should encompass all sources of experience and feedback.

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Using People's Feedback to Drive Quality Improvement and Learning

The organisation actively and consistently seeks experiences and feedback from people to foster a learning culture underpinned by quality and service improvement initiatives.

Characteristics	Suggested requirement needed to meet the characteristic	What will good look like?
The organisation actively and consistently seeks people's experiences to foster a learning culture underpinned by quality and service improvement initiatives. There is evidence that the organisation uses these experiences and feedback, and staff are aware that people's experiences are central to influencing quality improvement. Moreover, people are actively engaged as equal partners in the decision-making processes, service plans and evaluation.	Staff demonstrate a good understanding of the theory and practice of shared decision-making with people, and its principles are reinforced through education and training programmes. People are actively involved in all aspects of their health and possess an understanding of the expectations related to their health and well-being. The organisation has a mechanism in place to capture whether people felt involved in decisions about their own or their communities' health and well-being. The organisation has a mechanism in place to capture whether people felt involved in service, programme design or evaluation.	Staff, including those who are front-facing or involved in planning, service development or quality improvement, have undergone education and training for shared decision-making. Public information incorporates health decision information. Clinical and public information are designed to reflect shared decision-making principles, emphasising collaboration between healthcare professionals and the public in the decision-making process. The organisation can evidence and make public, people's involvement right from the outset, highlighting a commitment to hearing and listening.

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Characteristics	Suggested requirement needed to meet the characteristic	What will good look like?
The organisation employs quality improvement methodology and tools as part of an ongoing process to enhance services, programmes, and functions continuously.	Staff actively engage in quality improvement skills to identify problems, carry out tests of change, measure their impact, and act on the results. The organisation empowers all staff by providing the opportunity to contribute and act on ideas for quality improvement, with a clear process for measuring their impact through experiences and feedback. The organisation actively benchmarks and can demonstrate the utilisation of people's experience to make informed decisions. This involves comparing its practices and outcomes to identify areas for improvement and implement informed decision-making processes. (e.g., National People's Experience Surveys, Core Questions or Lived Experiences/People's groups).	There is evidence of education and training courses designed to support Quality Indicators (QI's) in service improvement, in line with the Duty of Quality. Organisations should have a process in place to ensure the public is informed about how their experiences and feedback have influenced change. This involves transparent and accessible communication to demonstrate the impact of public input on organisational decisions, evaluations, and improvements. Organisations can evidence how their Lived Experience or People's groups have supported the identification of shared learning and quality improvements. This should be included in the Duty of Quality report, and all other appropriate reports and made available to the public in an easy-to-find and accessible format.

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Reporting and Publication

The organisation regularly reports and publishes its people's experience data and co-produces its quality improvement plans with a range of stakeholders including the public, statutory and voluntary organisations, and the organisation's staff group.

Characteristics	Suggested requirement needed to meet the characteristic	What will good look like?
People's experience should be a key component of organisational reports in line with the Duty of Quality.	Relevant reports include information about people's experiences and how the organisation has encouraged feedback, listened to, and is responding to people's experiences, including examples of improvements.	The organisation's Annual Quality report, Improvement, engagement, equality report, Duty of Candour and Putting Things Right reports include examples of how the organisation responds to experiences and feedback. In the case of Incidents/Complaints/ Duty of Candour/Inquests, this would include the post-experiences of the handling process.
The organisation routinely publishes transparent and publicly accessible information within easy reach (e.g. 2 clicks) about people's experiences and the organisation's response to feedback (and ensures this information is accessible through multiple routes).	Information is available and accessible via a range of formats and platforms. This should include the accessibility requirements of seldom-heard communities and communities with low socio-economic backgrounds and communities with sensory loss.	The Annual Quality reports, Improvement, Engagement, Equality report, Duty of Candour and Putting Things Right reports should be available via a range of appropriate formats and platforms.
The organisational reports reflect the feedback offered via all external bodies e.g., Llais (Citizens Voice Body), Health Inspectorate Wales, Public Service Ombudsman Wales, and any other regulatory/ statutory body.	Reporting demonstrates that representations made on behalf of the public and feedback to the organisation have been incorporated and considered.	The organisation will review its communication channels to ensure it promotes the role of all regulatory/ statutory bodies in producing reports.

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Appendix A: National Surveys Process Document

National Surveys are overseen by the NHS Executive in line with the national survey road map. The governance process for national surveys is facilitated by the Once for Wales Concerns Management System Central (OfWCMS) team.

- The person or group proposing the national survey is responsible for liaison and engagement with the appropriate Executive Director in each organisation to gain support for the national survey to be undertaken.
- The person or group proposing the national survey will attend the Safety & Learning WRP People's Experience Feedback Network meeting to present their survey.
- A national survey request form must be completed and submitted, with the relevant survey questions, to the Once for Wales Concerns Management System Central (OfWCMS) team via email: **OnceForWales.CMS@wales.nhs.uk**.
- The OfWCMS team will acknowledge receipt of the request form and survey and arrange for the person or representative of the group proposing the national survey to attend a National Editorial Board meeting.
- All proposed national surveys will be presented to the National Surveys Editorial Board.
- Once approved by the National Surveys Editorial Board the national survey request form will be signed by the National System lead for Experience Feedback Wales System and stored by the OfWCMS Central team.
- The person or group proposing the national survey will need to have the survey translated into Welsh and any other language that they wish the survey to be deployed.
- The OfWCMS Central team will liaise with Feedback Experience System Leads and the supplier to progress the various stages required.
- The person or group proposing the national survey will be responsible for identifying and liaising with the teams within the organisations who will roll out the survey locally.
- The teams who will roll out the survey locally will be responsible for liaising with the Feedback Experience system lead within the organisations to ensure weekly feedback reports are set up correctly.
- The OfWCMS Central team, Feedback Experience System Leads, supplier, the person or group proposing the national survey and the teams responsible for the roll out of the survey locally, will agree a launch date.
- The supplier will, at an agreed time, facilitate the transfer of the data received from the survey held in organisations systems, to the national analytical tool.
- Access to the national analytical tool and to the data generated from this system will be managed by the OfWCMS Central team in accordance with the arrangements agreed by the National Surveys Editorial Board and following GDPR Principles.
- The OfWCMS Central team, will work with the Feedback Experience System Leads, supplier, the person or group proposing the national survey and the teams responsible for the roll out of the survey locally, to agree data sets for national reports to be generated both in the national analytical tool and in local systems.

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Appendix B: People's Experience Survey

Your NHS Wales Experience

The experience that you have of care is important to us. This might be an appointment with your doctor or health visitor, a hospital stay, an outpatient visit or something else. We would be grateful if you could complete this survey so that we can understand this better.

The questions are based on the things that patients have said matter most. We will ask you questions about **your latest experience of healthcare**. Please help us by giving your honest opinion.

The questions mostly have four options and you are asked to tick the answer that you feel best describes how you feel.

How recent was the experience you are thinking of?

- ☐ In the last week
- ☐ Between 1 month and 6 months ago
- ☐ Between a week and a month ago
- ☐ More than 6 months ago

Thinking about this experience:

1. Was the time you waited:

- ☐ Much shorter than expected
- ☐ A bit shorter than expected
- ☐ About right
- ☐ A bit longer than expected
- ☐ Much longer than expected

2. Did you feel well cared for?

- ☐ Always
- ☐ Usually
- ☐ Sometimes
- ☐ Never

3. Were you treated with dignity and respect?

- ☐ Always
- ☐ Usually
- ☐ Sometimes
- ☐ Never

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4a. Which language would you prefer to communicate in?

- [ ] Welsh
- [ ] Urdu
- [ ] Gujarati
- [ ] English
- [ ] Portuguese
- [ ] Italian
- [ ] Polish
- [ ] Spanish
- [ ] British Sign Language
- [ ] Romanian
- [ ] Arabic
- [ ] Other, please specify
- [ ] Panjabi
- [ ] Bengali

4b. Were you able to communicate in your preferred language?

- [ ] Always
- [ ] Usually
- [ ] Sometimes
- [ ] Never

5. Did you feel that you were listened to?

- [ ] Always
- [ ] Usually
- [ ] Sometimes
- [ ] Never

6. Were you involved as much as you wanted to be in decisions about your care?

- [ ] Always
- [ ] Usually
- [ ] Sometimes
- [ ] Never

7. Were things explained to you in a way that you could understand?

- [ ] Always
- [ ] Usually
- [ ] Sometimes
- [ ] Never

Thinking of your overall Experience

8. How would you rate your overall experience?

- [ ] Very poor
- [ ] Poor
- [ ] Neither good nor poor
- [ ] Good
- [ ] Very good

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9. Was there anything particularly good about your experience you would like to tell us about?

10. Was there anything particularly bad about your experience you would like to tell us about?

Thank you for taking the time to answer these questions

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Appendix C

Equality Monitoring

We are committed to ensuring that everyone receives fair and equal respect.

Whatever your age, disability, ethnicity, faith, gender reassignment or sexual identity, you can expect to be treated with dignity. We can only achieve this with your help by providing the information below.

Data will be used for monitoring purposes only and held in strictest confidence. Your identity will not be disclosed to anyone.

1. What is your age?

- ☐ 0-15 years
- ☐ 35-44 years
- ☐ 55-64 years
- ☐ 75+ years
- ☐ 16-24 years
- ☐ 45-54 years
- ☐ 65-74 years
- ☐ I prefer not to say

2. What is your gender?

- ☐ Male
- ☐ Female
- ☐ Other
- ☐ I prefer not to say

3. At birth, were you described as:

- ☐ Male
- ☐ Female
- ☐ Other
- ☐ I prefer not to say

4. Are your day-to-day activities limited because of a health problem or disability which has lasted, or is expected to last, at least 12 months?

- ☐ Yes, a lot
- ☐ Yes, a little
- ☐ Not at all
- ☐ I prefer not to say

5. Which of the following options best describes how you think of yourself?

- ☐ Heterosexual or straight
- ☐ Gay or lesbian
- ☐ Bisexual
- ☐ Other
- ☐ I prefer not to say

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6. What is your religion?
(Please choose one option that best describes your religion)

- ☐ No religion
- ☐ Hindu
- ☐ Muslim
- ☐ Any other religion
- ☐ Christian (all denominations)
- ☐ Jewish
- ☐ Sikh
- ☐ I prefer not to say
- ☐ Buddhist

7. What is your ethnic group?
(Please choose one option that best describes your ethnic group or background)

White:

- ☐ Welsh
- ☐ English
- ☐ Scottish
- ☐ British
- ☐ Irish
- ☐ Northern Irish
- ☐ Gypsy or Irish Traveller
- ☐ Any other white background

Mixed / multiple ethnic groups

- ☐ White and Black Caribbean
- ☐ White and Black African
- ☐ White and Asian
- ☐ Any other Mixed / multiple ethnic background

Asian / Asian British

- ☐ Indian
- ☐ Pakistani
- ☐ Bangladeshi
- ☐ Chinese
- ☐ Any other Asian background

Black / African / Caribbean / Black British

- ☐ African
- ☐ Caribbean
- ☐ Any other Black / African / Caribbean background

Other ethnic group

- ☐ Arab
- ☐ Any other ethnic group
- ☐ I prefer not to say

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Thank you for taking the time to answer these questions

Appendix D

The Digital Stories Toolkit – Using Stories to Improve Quality

In September 2021 it was agreed by the Welsh Directors of Nursing that digital storytelling would form a keyway of capturing feedback and learning to improve our services. This toolkit covers the methodology and information needed by everyone who is digitally recording stories, related to individual feedback and personal experiences of any of the health services provided via NHS Wales.

This toolkit has been developed in partnership with all NHS Wales organisations. It is for use across all programmes, services, and functions provided under the NHS Wales umbrella where quality and improvement are a priority.

This toolkit can be accessed via the following link: **Digital Story Toolkit (sharepoint.com)**

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Welsh Risk Pool Concerns Assessment

A Report by the Welsh Risk Pool Safety and Learning Team

Powys Teaching Health Board

Final Report January 2025

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WRP Concerns Assessment
A Report by the Welsh Risk Pool Safety and Learning Team

January 2025

About this Report

This report is intended to support health bodies within NHS Wales to continuously improve the operation of their Putting Things Right processes and provide assurance in relation to current policies, procedures and practice.

This report outlines the findings in relation to each area for assessment following field work and matter scrutiny undertaken by the independent assessment team. The report has been circulated for comments, factual accuracy considerations, and the development of actions arising from recommendations.

The report identifies a number of proposed recommendations. The organisation has developed an action plan which addresses the findings and supports the prioritisation of improvement activity in this sector. A copy of the organisation's action plan, addressing the recommendations, is embedded within this report to ease future analysis.

Along with the draft report, each health body has received a separate summary which detailed the analysis of the matters scrutinised as part of the assessment process. This enables the organisation to consider the comments in the context of the information that the reviewers analysed.

This report is now finalised and will be shared with the Welsh Risk Pool Committee.

Assessment Field Work	May - Jun 2024
Matter Scrutiny	May - Aug 2024
Draft Findings shared	Dec 2024
Action Plans Received	Jan 2025
Final Report Published	Jan 2025

Version

Powys Teaching Health Board WRP Concerns Assessment Report VFinal1b

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WRP Concerns Assessment

A Report by the Welsh Risk Pool Safety and Learning Team

January 2025

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Appendices

Appendix 1 NHS Wales Assurance Framework

Appendix 2 Areas for Assessment

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1.0 Outline of Review

1.1 The Welsh Risk Pool (WRP) undertakes assessments of member organisations' policies, procedures, and practice as part of its oversight duties – with the aim of gathering assurance on local processes for the Welsh Risk Pool Committee, Welsh Government and the NHS Wales Executive; and to provide recommendations to support organisations in continuous improvement in this important area of governance.

1.2 The WRP Assessment is used by the Welsh Risk Pool Committee when determining members' contributions to the fund as part of the risk sharing agreement. The risk sharing calculations for *Managing Concerns* and *Lessons Learned* will include a measure which ranks organisations in each area of assessment.

1.3 The WRP Assessment process provides a framework for the analysis of an organisation's compliance with the WRP Reimbursement Procedures, the requirements of the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011, the Health & Social Care (Quality & Engagement) (Wales) Act 2020 and other national policies & procedures related to the Putting Things Right sector. Following a review in 2023, the 2024 programme of WRP assessments includes a specific area for assessment in relation to Inquests - in acknowledgement of the increased work in this area.

1.4 The review involves analysis of individual case management against both legal requirements and policy criteria. It also examines compliance with the application of the Once for Wales Concerns Management System workflows and essential data fields.

1.5 The review further facilitates analysis of the efficacy of the Learning from Events process within the organisation and examines how a health body shares and implements good practice across the health body and more widely.

1.6 The methodology for assessment has evolved during the last few years in line with national policies. The approach is focussed on peer-review, with senior leaders within the Putting Things Right sector in other organisations joining staff from the WRP in conducting the assessment.

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1.7 Specialist advisors and legal experts have been invited to join the assessment team as required. This approach is considered to promote sharing of best practice and enable the assessment team to recognise the application of the areas for assessment in operational practice.

1.8 For each area for assessment, the Assessment Team considers the available evidence and reports assurance to the organisation using the NHS Wales Internal Audit Assurance Framework. Details of the framework are shown in Appendix 1.

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2.0 Scope of Review

2.1 The review considers a number of areas for assessment, each focussed on a different aspect of the Putting Things Right process.

- Management of Concerns (Incidents)
- Management of Concerns (Complaints & Enquiries)
- Redress Case Management
- Claims Case Management
- Inquest & Coronial Inquiry Management
- Organisational Learning
- WRP Reimbursement Process

2.2 The report considers the same period for each health body that underwent a WRP Assessment. The periods used within the assessment were selected and agreed with the assistance of the Head of Patient Experience Safety & Learning Network.

2.3 The period used for the assessment related to policies and procedures in force and matters opened, under investigation, or closed between 1st January 2024 to 31st March 2024. This period was chosen as it is considered that cases would be sufficiently progressed from initial report and commencement of investigations to facilitate a thorough review but remain relatively current at the time of the assessment. When considering the *performance of quality* data in respect of compliance with the WRP Reimbursement Procedures, data from the financial year 2023/24 was used.

2.4 The WRP recognises that the most frequently occurring clinical specialties seen in claims and redress cases are *Maternity Services*, *Care in Emergency Departments & Units* and *Trauma & Orthopaedics.* The Assessment Team have focussed on these specialties, where they are provided by the health body, as part of the drive towards continuous improvement in relation to the NHS Wales litigation profile. In addition to the clinical specialties which have been subject to enhanced focus, the Assessment Team have selected other matters on a random basis to ensure that assurance is provided across as broad range of areas as possible.

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3.0 Assessment Team

3.1 The WRP Assessments are conducted by a small group of specialist practitioners who are drawn from the Putting Things Right sector.

3.2 The Coordinator for each Assessment is a member of the WRP team, with the Chair of the Assessment Team drawn from a member of the Heads of Patient Experience Safety & Learning Network – providing realistic advice on the practicalities in achieving the standards in practice.

3.3 To provide specialist advice in relation to compliance with the legislation, a lawyer from the Legal & Risk Service is included in the Assessment Team and this colleague focusses on compliance with redress case handling.

3.4 As the assessment process focusses greatly on the use of the Datix Cymru system, a member of the Once for Wales Concerns Management System central team is included in the Assessment Team.

3.4 The Assessment Sponsor coordinates the formation of fieldwork teams and oversees any queries which arise, along with signing off the Assessment Report.

3.5 The Assessment Team for this review was:

Sponsor: Jonathan Webb, Head of Safety & Learning
Welsh Risk Pool

Field Work: Nigel Downes, Assistant Director of Quality & Safety
Cwm Taf Morgannwg University Health Board

Gemma Cooper, Senior Solicitor
Legal & Risk Services

Rachel Roberts, Solicitor
Legal & Risk Services

Christine Buckland, Safety & Learning Advisor
Welsh Risk Pool

Maria Stolzenberg, Principal Systems Lead
Once for Wales Concerns Management System

Gethin Bateman, Serious Clinical Incident Investigation Manager
Digital Health & Care Wales

Eleri Wright, Safety & Learning Advisor
Welsh Risk Pool

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4.0 Previous Findings

4.1 Summary of the 2023 WRP Assessment

4.1.1 During 2023, a programme of assessments was conducted, and the report was accepted by the health body. This report contained a number of recommendations, to which the health body developed an action plan. The Assessment Team have sought evidence for progress with, or completion of, the proposed actions and this is shown in Table1.

Table1: Update on Actions from 2023 Assessment Report			
REF	Recommendation 2023	Position Update	Status
R01	PTHB should ensure that investigation outcomes for incidents are recorded accurately on Datix Cymru, with a validation / audit process established to ensure this is monitored.	The Assessors were not able to identify any evidence of progress against this recommendation.	Outstanding
R02	PTHB should introduce a KPI for incident reporting, regularly reviewing and scrutinising cases to ensure that records are closed efficiently and that all investigation outcomes are completed on the system.	The Assessors were not able to identify any evidence of progress against this recommendation.	Outstanding
R03	PTHB should ensure decisions in terms of consent in respect of concerns are clearly recorded on Datix Cymru.	The Assessors noted that the fields relating to consent have been amended on Datix Cymru which simplified the recording of consent and is working well.	Complete
R04	PTHB should ensure responses include consideration of qualifying liability, where appropriate, and that this is recorded clearly within the system.	Good drafting of Interim response – appropriately sensitive, concise and clear; correct description of legal tests and terminology.	Complete
R05	PTHB should map out the process for the transition of an incident and a complaint into a redress case and consider introducing a Standard Operating Procedure (SOP) to support practice in these areas.	The Assessment Team were provided with a Standard Operating Procedure for the screening of incident and complaints as potential redress matters which provided assurance that all cases are reviewed and actioned appropriately in terms of the Putting Things Right (PTR) Regulations.	Complete
R06	PTHB should ensure responses to concerns are uploaded to Datix Cymru in a timely manner and are clearly identifiable on the system, with no secondary password applied to documents held.	The Assessors were advised that the practice of password protecting documents prior to uploading to Datix Cymru has ceased and they were able to access all required documents.	Complete
R07	PTHB should consider the timing of the process for the consideration of the value of a concern (and whether it is likely to exceed £25,000), as this should be done at the outset.	It was explained that there is not a process in place for screening cases at the outset; they have not had any cases that would have exceeded it recently but if there were concerns, they discuss within the team and refer to JSB guidelines.	Ongoing

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R08	PTHB to ensure there is a clear process in place for the management of cases involving commissioned care in line with PTR.	The Assessors are assured that there is now a clear process in place and cases are managed appropriately.	Complete
R09	PTHB should consider development of a SOP for claims management to build on the good process seen and ensure consistency in operational practice and sustained procedures. This would be seen as presenting the good practice currently in place as a model approach for Wales.	Draft SOP prepared.	Ongoing
R10	PTHB should review its processes for managing financial payments in claims and concerns as any delays could have financial consequences.	Process considered but amendments not implemented as system is believed to work well and without delay at present.	Complete

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5.0 Organisational Performance

5.1 Performance data - Management of Concerns & Lessons Learned

5.1.1 As part of the information gathered with each health body, data relating to the performance against the standards and timescales outlined in the WRP Reimbursement Procedures is collated.

Table 2: Timeliness of LFER submission – 2023/24					
No of LFERs submitted	No of missed standard deadlines	% missed standard deadlines	No of extensions granted	No of missed revised deadlines	% missed revised deadlines
6	2	33.33%	0	0	0%

Table 3: Approval of Learning by Learning Advisory Panel – 2023/24						
No of LFERs considered	No Approved	% Approved	No Amber Deferred	% Amber Deferred	No Red Deferred	% Red Deferred
11	10	90.91%	1	9.09%	0	0.00%

Table 4: Timeliness of CMR submission – 2023/24					
No of CMRs submitted	No of missed standard deadlines	% missed standard deadlines	No of extensions granted	No of missed revised deadlines	% missed revised deadlines
13	2	15.38%	0	0	0%

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6.0 Review Findings

6.1 Management of Concerns (Incidents)

6.1.1 The Assessment Team noted that there were 1010 incidents reported in the period 1st January 2024 to 31st March 2024.

6.1.2 The Assessment Team were provided with evidence of a comprehensive incident management framework document dated which was originally drafted in July 2023 and is next due for review in July 2026.

6.1.3 This document provides clear guidance on the Health Board's arrangement for the management of incidents covering their reporting, review, and escalation (including reporting as a Nationally Reportable Incident (NRI)) and covered the implementation of the Duty of Candour (DoC).

6.1.4 There was also specific guidance on the review of Pressure Ulcer and Falls related incidents as well as a significant level of detail around Putting Things Right including Redress and Qualifying Liability and Learning from Events.

6.1.4 The framework also provides staff with guidance around the provision of support for both families and staff members involved in events which are being managed as incidents.

6.1.5 The Assessment Team were pleased to note that there are clear and established links between the Governance leads within the Directorates & services and the central quality & safety team.

6.1.6 Evidence was provided to the Assessment Team of the implementation of: -

- 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 Cymru for all services.

6.1.7 Within various pieces of documentation & information reviewed, it was evident that the initial management/assessment of incidents was managed at a local/service level with the central team available to provide advice and support.

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6.1.8 However, all incidents undergo a screening process upon reporting based on the severity of the incident.

6.1.9 Within the Incident Management Framework, there is comprehensive guidance (including flow charts) for the management of incidents that are either to trigger the Duty of Candour or be reported as Nationally Reportable Incidents; and a robust process in place for the review and escalation of potential NRIs along with a defined approval and sign off process for notifications.

6.1.10 There are defined timescales identified for the Rapid review of these types of cases and a timescale of within 7 days for the closure of no harm/low harm incidents.

6.1.11 Investigations are undertaken by trained investigators from within the services with support from their governance teams. The Assessment Team were informed that since September 2023, circa 112 staff members have attended the Root Cause Analysis (RCA) training – with the aim to further strengthen the ability of teams to appropriately manage, investigate and close incidents of all nature. The team also utilise pre and post training surveys to allow for the gathering of feedback and improvement of the package.

6.1.12 Evidence was provided to the Assessment Team in regard to the training packages provided to staff which are published on the Health Boards intranet and discussions were held around the investigation training provided along with monthly 2-hour long managers Datix Cymru training meetings covering off both the use of the system and clinical or operational issues.

6.1.13 Evidence was also provided to the Assessment Team to demonstrate that there was sharing of learning from concerns by way of a monthly Learning newsletter.

6.1.14 The Assessment Team scrutinised a number of incident records and undertook a review of the detail of ten incident records on the Datix Cymru system

The following was noted: -

- 90% of incidents were reported within 48hrs of the event.
- 70% of incidents had an Initial Management Review undertaken although the timescales for this varied from 14 days from date of reporting to in some cases over 60 days.

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- In 1 of the 3 incidents where no Management Review was completed it was noted that the incident had in fact been escalated as an NRI and had triggered the Duty of Candour. Upon further review this report did contain significant detail within the progress notes and documents sections.
- It was noted that there was good utilisation of the progress notes section in the majority of reports.
- None of the incidents reviewed that were graded no harm or low were closed within 7 days as per the health boards defined timescales.
- 90% of the incidents reviewed were not closed within 30 days.
- Where deemed appropriate, focussed reviews had been undertaken (e.g, falls review). Additionally, where this was not required despite the initial report suggesting it was, a rationale was provided for this.
- Rationales were always documented in cases where there was a change in grading from initial report to closure.
- In 40% of cases, it was noted that the "*ready to start management review*" question had not been answered which meant that data was hidden from the Assessment Team and any other corporate staff undertaking a record review.
- Where required, the linking of records and completion of NRI and DoC fields was undertaken.
- Any commentary required to clarify why no Qualifying Liability (QL) was identified was provided in all cases.

6.1.14 Evidence was provided to the Assessment Team in respect of the reports that are generated and shared within the Health Board to inform on incident management. One example was the Patient Experience and Quality Committee- Integrated Quality report, which the Assessment Team found to be a very robust report covering incident management, NRIs, DoC providing both graphic information, comparisons and commentary which were both informative and candid.

6.1.15 It was noted that the challenges in respect of incidents found during the assessment were noted within the report.

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"*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"*

Whilst this does provide some assurance that the Health Board is looking to address these issues, it is clear that these same challenges were noted during the last assessment and still remain.

6.1.16 The other recommendation from the last assessment in respect to incident closure validation processes remains outstanding. There are clear issues with the timeliness of both review and closure of reports especially those where other processes i.e, NRI/DoC are not triggered. However, the quality of record completion had definitely improved.

6.1.17 In summary, the Assessment Team found limited evidence that the previous WRP assessment recommendations had been effectively addressed. It is therefore strongly recommended that these previous recommendations are fully addressed and that realistic KPIs are defined and implemented for incident management with a specific requirement for these to relate to both the undertaking of the Initial Management Review and closure of incidents.

6.1.18 It was noted by the Assessment Team that PTHB have now launched an Integrated Quality & Performance Framework (IQPF) to drive continuous improvement and enhance service delivery utilising data such as that shared with the Assessment Team. This data will be shared at all levels of the organisation (Board, Executives Etc) to allow for the monitoring and evaluation of organisational performance and to stimulate timely intervention.

6.1.19 Overall, the Assessment Team found significant improvement in the completion of information regarding incidents and this process is underpinned by a high-quality framework. Further work to fully embed the process and monitor compliance by busy teams will most likely raise the assurance in this area of assessment further.

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Management of Concerns (Incidents)		
REASONABLE ASSURANCE		The organisation can take **reasonable assurance** that arrangements to secure governance, risk management and internal control in relation to the Putting Things Right areas of assessment are suitably planned and applied effectively. Some matters require management attention in control design or compliance with low to moderate impact on residual risk exposure until resolved.

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6.2 Management of Concerns (Complaint and Enquiries)

6.2.1 The Assessment Team noted that there were 39 complaints reported in the period 1st January 2024 to 31st March 2024. The Assessment Team reviewed four matters opened on the Datix Cymru System. It was generally found that data entry compliance was strong.

6.2.2 On reviewing the cases analysed, it was noted that in the majority of matters, not all complaint subjects were included. It is important that all subjects raised by a complainant are specifically recorded as this enables reporting to be in accordance with the expectations of the Complaints Standards Authority.

6.2.3 The review identified that in some early resolution matters there was a lack of detail recorded. In one example, which involved a problem with attendance at an appointment, it was simply recorded that the complainant was “happy now”. The Assessment Team discussed this with the corporate team, and it was agreed that there needed to be greater detail noted in relation to the nature of the discussion which had been held with the complainant.

6.2.4 The Assessment Team identified that not all relevant staff were added to the complaint record routinely. Staff involved in the management of the complaint and also involved in patient care surrounding the complaint should be added to the record. The Health Board agreed to adopt this approach moving forward.

6.2.5 The Assessment Team discussed the risk of confusion between the Health Board and a Complainant if the subjects and issues being raised are not set out and agreed. It is considered good practise for the Complaints Teams to ensure that the issues they feel are being raised by the complainant are detailed in the acknowledgement letter. The Health Board team agreed to adopt this approach and has provided evidence of this following the assessment visit.

6.2.6 The quality of response letters was determined to be of a very high standard and whilst there are opportunities to improve consistency in data collection and documentation, the standards for Putting Things Right complaint handling were considered to be met through the procedures and processes adopted by the Health Board.

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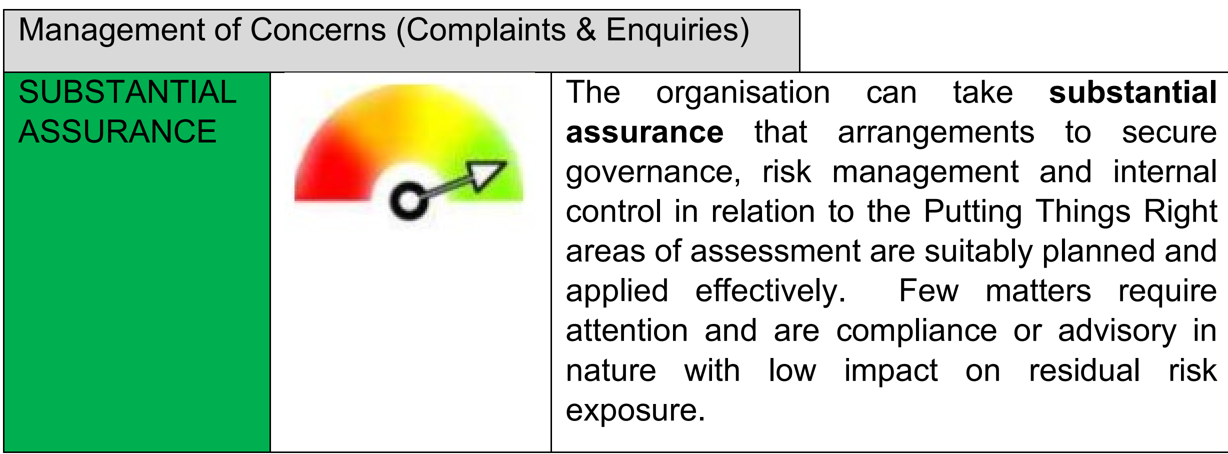
6.2.7 The Assessment Team recognised the work done by the corporate team in this area since the previous assessment.



Management of Concerns (Complaints & Enquiries)		
SUBSTANTIAL ASSURANCE		The organisation can take **substantial assurance** that arrangements to secure governance, risk management and internal control in relation to the Putting Things Right areas of assessment are suitably planned and applied effectively. Few matters require attention and are compliance or advisory in nature with low impact on residual risk exposure.

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6.3 Redress Case Management

6.3.1 The Assessors reviewed three matters opened during the assessment period on the Datix Cymru system. There was clear evidence from the files of excellent inputting of information onto Datix Cymru. Files clearly showed the current position and background, and all relevant documents appeared to have been uploaded. There is generally additional and relevant information contained within progress notes, redress page and quantum pages.

6.3.2 The Redress Lead has a mixed portfolio, also dealing with Claims, Inquests and Learning from Event Report's. The Redress caseload is manageable with the number of Redress cases experienced by the Health Board.

6.3.3 As was noted during the previous Assessment, the Assessors noted that the Health Board has a good structure in place to manage redress cases with minimal input required from Legal & Risk Services. There is a clear process for complaints to move to being managed by the Redress Team. However, there is a slightly less defined process with regards to matters which trigger via an incident. The Health Board assured the Assessment Team that this is being considered and no cases were identified during the review where matters had been missed.

6.3.4 Evidence of continued good practice was noted by the Assessors, where draft responses were flagged with the Redress Team and a review of the draft responses is then undertaken by Redress Leads.

6.3.5 The Assessment Team also noted evidence of good practice - with a clear and robust authority process ahead of making admissions of Breach of Duty and Qualifying Liability and in terms of quantum research and offers.

6.3.6 The Assessment Team were provided with a Standard Operating Procedure (SOP) for the screening of matters escalated as potential redress matters - which provided assurance that all cases are reviewed and actioned appropriately in terms of the Putting Things Right Regulations. The SOP describes interaction with the Redress panel, the process for investigating concerns and the framework for finalising response.

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6.3.7 The PTR responses reviewed were well written and tailored specifically to the cases and the issues raised within them. Some cases were considered

exemplars which could be shared for improvement purposes with other organisations.

6.3.8 Potential cases are managed appropriately on Datix Cymru. The issue identified during the previous WRP Assessment has been addressed - relating to the recording of potential Redress cases on Datix Cymru when the Legal Services Team are asked to assist with the review of matters.

6.3.9 The Assessors noted that there is no formal process to consider the value of a concern and whether it exceeds £25,000. This is a key aspect of the PTR process and should be done at the outset of a matter to provide a clear structure for the investigation and the type of response to be sent to the complainant. Whilst the majority of cases experienced by the Health Board are of low value, it is essential that this review is undertaken and documented.

6.3.10 The Assessment Team reviewed the Management of compensation claims clinical negligence and personal injury policy which was issued in February 2024.

6.3.11 Good use of the Datix Cymru System was noted with the Redress page, Progress notes, and quantum pages being completed appropriately. Documents were also correctly uploaded and noted.

6.3.12 Documents in cases are solely saved to the Datix Cymru System. Only templates are kept on a shared drive, which was noted as good practice. The Assessment Team identified that most of the relevant documentation in cases had been saved to Datix Cymru. In two cases, there were gaps in Interim and Final Response letters.

6.3.13 Whilst there is a good level of completion of the fields throughout the Datix pages, there are some unexplained gaps, such as dates for Breach of Duty, offer amount on Quantum, one case says No to QL, where this was actually confirmed, and one did not have a date for Final Response despite a combined Regulation 26 / Regulation 33 having been served.

6.3.14 These occasional gaps in data completion standards and missing attachments could be resolved by the introduction of a file review on closure of a record and the Health Board agreed to undertake this approach.

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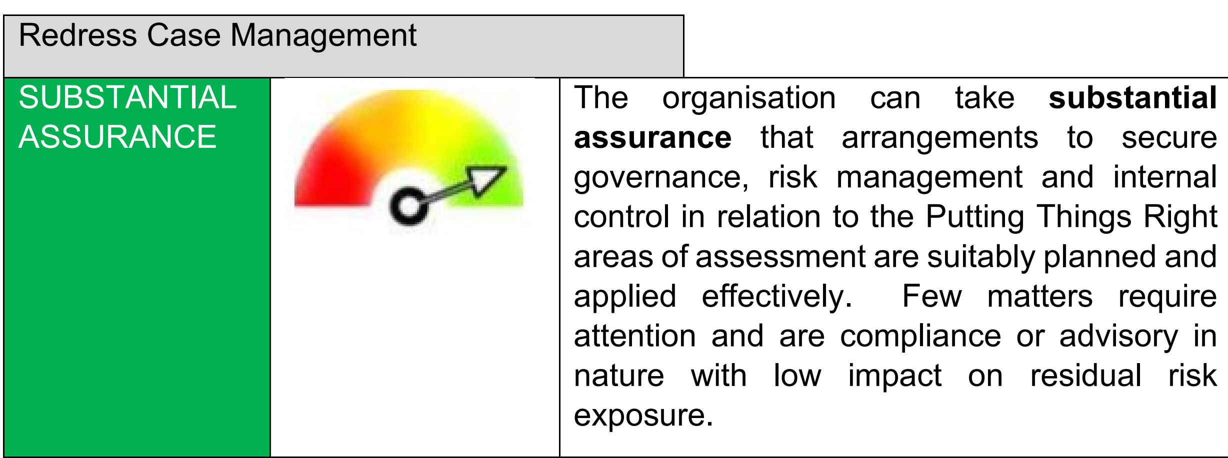
6.3.15 Good engagement with clinicians was noted. Appropriate engagement with Legal & Risk Services was also noted and in regard to value/Quantum considerations.

6.3.16 Good standards of communication with Claimants was also noted and there was evidence of effective drafting of final responses. These documents conveyed sensitivity when required along with sufficient, but not excessive, detail. The correct description of legal tests and terminology was also noted.

6.3.17 The Oracle system continues to be used to process payments which can prove a lengthy process with payments taking up to fourteen days to be approved and paid. The previous assessment recommended that the process and system for processing payment requests be reviewed as delayed payments can have significant financial consequences and this was again reiterated. It was noted however, that there is a close working relationship with finance colleagues which works well but it is a lengthy process to raise an invoice.

6.3.18 The Assessment Team noted that, overall, Redress matters are managed efficiently, and final responses are often served many months in advance of the deadline. There is good compliance in all Regulation 26/33 responses reviewed.



Redress Case Management		
SUBSTANTIAL ASSURANCE		The organisation can take **substantial assurance** that arrangements to secure governance, risk management and internal control in relation to the Putting Things Right areas of assessment are suitably planned and applied effectively. Few matters require attention and are compliance or advisory in nature with low impact on residual risk exposure.

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6.4 Claims Case Management

6.4.1 The Assessment Team noted that there were 2 claims opened (there were 3 opened but one was rejected the same day it was opened) in the period from 1st January 2024 to 31st March 2024.

6.4.2 There was good evidence of clear claims management processes in place for both Clinical Negligence and Personal Injury Claims. A Policy for the management of compensation claims for Clinical Negligence and Personal Injury was in place and had been issued in February 2024 and approved by the Executive Committee.

6.4.3 The Assessment Team were also advised that a SOP for Claims Management had also been drafted following a recommendation made in the previous WRP Assessment Report.

6.4.4 Training continues to be on an ad hoc basis as and when requested by the services. Assurance was provided that there is a close working relationship established with the services who are able to contact the Claims Co-ordinator to discuss any queries and ask for advice.

6.4.5 Executives are sighted on all claims and details are shared with relevant Heads of Nursing when matters are confirmed as progressing on the Datix Cymru System. Local governance leads are also sighted, and assurance was provided that they undertake the investigations and also contact relevant colleagues as they appreciate it can be daunting to be contacted directly by the Claims co-ordinator in such circumstances.

6.4.6 There continues to be a clear process in place for the application of Standing Financial Instructions with timely authorisation for admissions and settlement of matters. Timely instructions are provided from senior colleagues as they are already sited on the claims, they are able to provide authority efficiently agreeing proposed ways forward as advised by Legal and Risk Services. The Assessors noted this as continued good practice which further assists in maintaining close working relationships with the Services.

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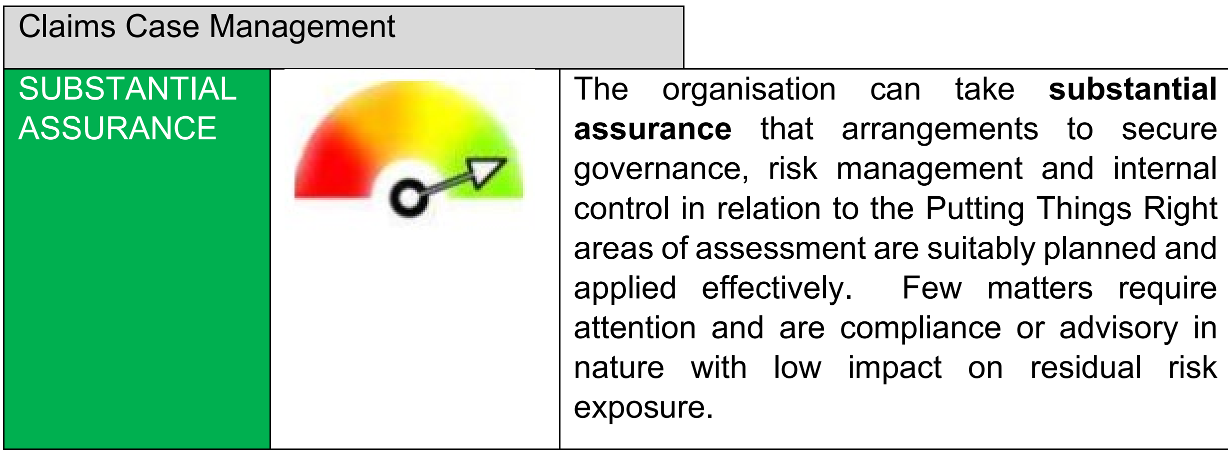
6.4.7 The Assessment Team reviewed one of the matters opened on the Datix Cymru system during the relevant period, along with other records due to the limited

volume of cases. Noting excellent use of the system, the Assessors noted case and claim details were completed and the current stage field was updated as necessary. The Progress Notes section is also used and updated, with relevant documents uploaded and saved clearly.

6.4.8 The Oracle system continues to be used to process payments which can prove a lengthy process with payments taking up to fourteen days to be approved and paid. The previous assessment recommended that the process and system for processing payment requests be reviewed as delayed payments can have significant financial consequences and this was again reiterated. It was noted however, that there is a close working relationship with finance colleagues which works well but it is a lengthy process to raise an invoice.

6.4.10 In summary, the Assessors noted a timely and efficient claims process within the organisation.



Claims Case Management		
SUBSTANTIAL ASSURANCE		The organisation can take **substantial assurance** that arrangements to secure governance, risk management and internal control in relation to the Putting Things Right areas of assessment are suitably planned and applied effectively. Few matters require attention and are compliance or advisory in nature with low impact on residual risk exposure.

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6.5 Inquest Case Management

6.5.1 The Assessment Team noted that the organisation had a good process for coronial enquiries and inquests, with cases managed efficiently and without delay. The Health Board receives requests from a number of coronial areas due to its geography.

6.5.2 It was explained that medical records are requested on receipt of a notification from HM Coroner. Appropriate action is then taken with the Service being advised and Datix being reviewed for any incident or concern information.

6.5.3 The timeliness of information was assured from the evidence seen and there no significant delays observed. The Health Board reported that it had received a Schedule 5 request (formal requirement to provide information) but on review this appeared to have originated due to confusion and the information was provided in a timely manner in this case.

6.5.4 Inquests are RAG rated from the outset within the organisation and only sent to Legal & Risk Servies if the necessary criteria are met. Legal & Risk Services are only instructed if significant issues are highlighted within the draft statements when returned by clinicians.

6.5.5 The Assessors noted good practice with statement requests being sent to Heads of Service and Clinical Governance Leads and not directly to individuals. This is to ensure that staff are provided with appropriate support throughout the inquest process. Inquest guidance and statement templates are sent out with the initial request. Further good practice was also noted with staff being offered a debrief meeting following the conclusion of an inquest hearing.

6.5.6 The Assessment Team reviewed three inquest matters recorded on the Datix Cymru System during the relevant period and noted that case details were completed appropriately as well as the current stage completed and updated which allowed for an efficient review.

6.5.7 Inquest data fields are also completed as well as the investigation section used. As progress notes are used and updated as matters progressed it allowed for an efficient review. Documents were uploaded and easily identifiable and linked to relevant records.

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Inquest Case Management		
SUBSTANTIAL ASSURANCE		The organisation can take **substantial assurance** that arrangements to secure governance, risk management and internal control in relation to the Putting Things Right areas of assessment are suitably planned and applied effectively. Few matters require attention and are compliance or advisory in nature with low impact on residual risk exposure.

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6.6 Organisational Learning and Learning from Events Reports

6.6.1 The Health Board explained that they are very proactive in terms of learning within the organisation with Learning from Events Reports (LFER) being drafted in advance of the deadlines, with a careful tracking process demonstrated. There was also evidence of Services being engaged with the completion of the documents and being aware of the importance of timely submissions to the WRP.

6.6.2 As there has been increase in staff engagement with the learning process, the overall quality of the LFER's has improved as well as the quality of the investigation. LFER's are shared widely within the Services to ensure wider learning. The possibility of sharing the completed LFER with other services and corporately was discussed in an attempt to improve learning further.

6.6.3 The Assessment Team noted that over 90% of LFERs submitted were approved on first presentation to the National Learning Advisory Panel. Additionally, no matters were red deferred which indicates that the learning information submitted clearly addresses the issues in the matter. The Assessment Team felt that must be commended.

6.6.4 The Health Board explained that matters are discussed at a Redress / Case Panel, where actions from lessons learnt are taken forward by key staff. Whilst the Assessment Team noted the relatively low number of matters handled by the organisation, this is excellent practice and demonstrates strong engagement.

6.6.5 Continued good practice was noted with the corporate team drafting the LFER and sometimes completing the issues and actions sections for the Services to sign and take accountability for. The Assistant Director of Quality & Safety as well as the Heads of Nursing and the Governance Leads continue to review the LFER's and agree the learning which assured the Assessment Team that learning from concerns is a priority to the Health Board.

6.6.6 From a review of the data in respect of compliance with the submission deadlines for LFER, this is skewed as the team identified cases from 2018 which had not been submitted at all previously. Whilst the Assessment Team recognise that these cases were clearly submitted well past the deadline, it is

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not indicative of current practice or standards and have therefore been excluded for the purpose of this assessment.

Organisational Learning and Learning from Events		
SUBSTANTIAL ASSURANCE		The organisation can take **substantial assurance** that arrangements to secure governance, risk management and internal control in relation to the Putting Things Right areas of assessment are suitably planned and applied effectively. Few matters require attention and are compliance or advisory in nature with low impact on residual risk exposure.

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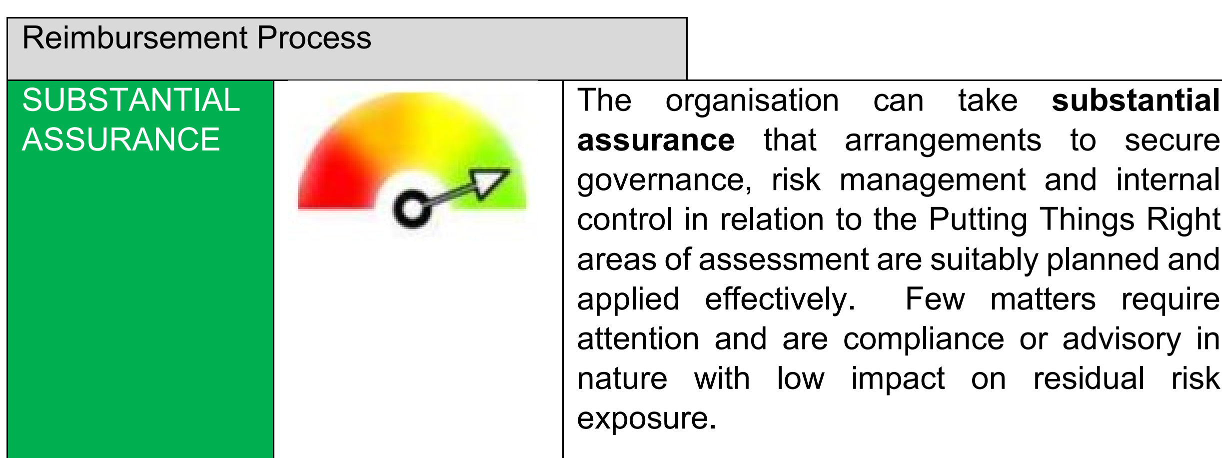
6.7 Reimbursement Process

6.7.1 The Assessment Team were assured that there continues to be a close working relationship within the Finance Department who monitor and track the cases ensuring timely submission of cases for reimbursement to the WRP.

6.7.2 There is an effective process for monitoring WRP submission deadlines. Cases are tracked on Datix Cymru to ensure deadlines are not missed. The WRP section on the Datix Cymru system is fully utilised to ensure effective tracking of cases and deadline dates.

6.7.3 WRP Procedures are closely followed and adhered to. It is usual practice for Case Management Report's (CMR's) to be submitted on the same day the last payment is raised which is evidence of the efficient process in place.

6.7.4 From a review of the data in respect of compliance with the submission deadlines for CMR's, this is skewed as the team identified cases from 2018 which had not been submitted. Whilst the Assessment Team recognise that these cases were clearly submitted well past the deadline, it is not indicative of current practice or standards and have therefore been excluded for the purpose of this assessment.



Reimbursement Process		
SUBSTANTIAL ASSURANCE		The organisation can take **substantial assurance** that arrangements to secure governance, risk management and internal control in relation to the Putting Things Right areas of assessment are suitably planned and applied effectively. Few matters require attention and are compliance or advisory in nature with low impact on residual risk exposure.

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7.0 Areas of Good Practice

7.1 Good redress process in place.

7.2 Clear structure in place to manage and respond to concerns raised by service users or their representatives.

7.3 Good Claims process in place.

7.4 Effective communication channels with Executive Teams.

7.5 Evidence of continued close working relationship with Finance teams.

7.6 Statement requests sent to Heads of Service and Clinical Governance Leads.

7.7 Debrief meeting offered to staff following conclusion of an inquest matter.

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8.0 Assurance Summary

Area	Assurance	
Management of Concerns (Incidents)	REASONABLE ASSURANCE	
Management of Concerns (Complaints & Enquiries)	SUBSTANTIAL ASSURANCE	
Redress Case Management	SUBSTANTIAL ASSURANCE	
Claims Case Management	SUBSTANTIAL ASSURANCE	
Inquest Case Management	SUBSTANTIAL ASSURANCE	
Organisational Learning and Learning from Events	SUBSTANTIAL ASSURANCE	
WRP Reimbursement Process	SUBSTANTIAL ASSURANCE	

NOTES

The Assessment Team were pleased to note that the changes in practice which had preceded the previous WRP Assessment had been sustained. The operation of PTR was considered to be led by the small corporate team to a high standard. While there is a smaller volume of each type of matter in this organisation, the corresponding resources are equally limited and therefore the team are working efficiently and effectively. There are a number of areas of exemplar practice.

Through embedding of further processes, outlined in the existing recommendations to monitor compliance with incident management principles, the Health Board can expect to increase assurance in this area also.

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9.0 Recommendations

One recommendation from the 2023 assessment was noted as being incomplete:

2023-R01 PTHB should ensure that investigation outcomes for incidents are recorded accurately on Datix Cymru, with a validation / audit process established to ensure this is monitored.

2023-R02 PTHB should introduce a KPI for incident reporting, regularly reviewing and scrutinising cases to ensure that records are closed efficiently and that all investigation outcomes are completed on the system.

2023-R09 PTHB should consider the development of a SOP for claims management to build on the good process seen and ensure consistency in operational practice and sustained procedures. This would be seen as presenting the good practice currently in place as a model approach for Wales.

A small number of recommendations have been identified which are considered to enhance practice in the management of PTR:

R01 PTHB should ensure that all complaint subjects are fully completed within the Datix Cymru record and a process for review of this on record closure should be established.

R02 PTHB should ensure that there is clear documentation in relation to the contact and discussions with a complaint, including in cases managed through early resolution. This could be assured through the introduction of an audit of a complaint record at file closure stage.

R03 PTHB should ensure that staff involved in the management of the complaint and also those involved in patient care surrounding the complaint are added to the Datix Cymru record.

R04 PTHB should review the process for ensuring matters which originate as an incident that should be considered as part of the redress process to ensure all cases are included.

R05 PTHB should ensure a process for documenting the review of potential quantum (within the progress notes or via an email attached to the record) at the commencement of a Redress matter, so there is some evidence on Datix that it has been considered.

R06 PTHB should introduce a file review process on closure of a redress record, to ensure data completion and completeness of attachments.

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R07 PTHB should continue to monitor the process, and associated time taken, to request, approve and make payments in redress and claims matters.

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10.0 Health Body Action Plan

10.1 The Health Boady has developed an action plan which addresses the findings of the report and responds to the recommendations made. A copy of this is provided for future reference.

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ACTION PLAN FOR IMPROVEMENT	
Reference	WRP Concerns Assessment
Directorate	Quality and Safety
Lead Officer for Action Plan	Heidi Sinclair
Date action plan commenced	December 2024

	Recommendation	Risk rating	Action needed	Progress & Evidence	By who	**Deadline date for completion** (Use traffic light system to indicate status) **& insert date of completion**
2023 – R01	1. PTHB should ensure that investigation outcomes for incidents are recorded accurately on Datix Cymru, with a validation / audit process established to ensure this is monitored.		PTHB will liaise with colleagues in other health boards regarding their auditing processes and consider whether MEG (audit management system) can provide assistance. Weekly reports are run from Datix on incident status and sent to Heads of Service by the Head of Quality and Safety, updating them of service/Health Board position.	Links made with Velindre Cancer Trust currently using AMaT to capture audit processes for incident management.	Head Quality & Safety	Complete
2023 – R02	2. PTHB should introduce a KPI for incident reporting, regularly reviewing and scrutinising cases to ensure that records are closed efficiently and that all investigation outcomes are completed on the system.		Weekly reports are run from Datix on incident status and sent to Heads of Service by the Head of Quality and Safety, updating them of	Evidence of weekly emails sent to Heads of Service. Process outlined in the Incident		March 2025

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	Recommendation	Risk rating	Action needed	Progress & Evidence	By who	Deadline date for completion (Use traffic light system to indicate status) & insert date of completion
			service/Health Board position. Care Service Groups have structures in place to review the closure of incidents, correct documentation of outcomes on the datix record and, where necessary, escalate if that is required. Upon review of the Incident Management Framework, development of a KPI to be considered.	Management Framework. Care Service Groups complete closure meetings for incidence where appropriate and report on incident closure rates and outcomes in their locally held Quality, Safety and Patient Experience forums.		
2023 – R09	3. PTHB should consider the development of a SOP for claims management to build on the good process seen and ensure consistency in operational practice and sustained procedures. This would be seen as presenting the good practice currently in place as a model approach for Wales.		SOP has been drafted and going through approval	Drafted by Redress, Compensation Claims & Inquest Case Coordinator. With Head Quality & Safety for review	Redress, Compensation Claims & Inquest Case Coordinator.	Completed
R01	4. PTHB should ensure that all complaint subjects are fully completed within the Datix Cymru record and a process for review of this on record closure should be established.		This is currently being done manually at the point of data being required for the NHS Executive	Validation for submission of monthly WG data on or before 15th of every month	Concerns and Public Service Ombudsman Wales Coordinator	Completed

	Recommendation	Risk rating	Action needed	Progress & Evidence	By who	Deadline date for completion (Use traffic light system to indicate status) & insert date of completion
R02	5. PTHB should ensure that there is clear documentation in relation to the contact and discussions with a complaint, including in cases managed through early resolution. This could be assured through the introduction of an audit of a complaint record at file closure stage.		This is currently being done manually at the point of data being required for the NHS Executive	Validation for submission of monthly WG data on or before 15th of every month – ensure progress notes are updated with regards to conversations.	Concerns and Public Service Ombudsman Wales Coordinator	Completed
R03	6. PTHB should ensure that staff involved in the management of the complaint and also those involved in patient care surrounding the complaint are added to the Datix Cymru record.		Update flowchart and shared via Sharepoint	SOP and flowchart currently being considered for approval	Concerns and Public Service Ombudsman Wales Coordinator	Completed
R04	7. PTHB should review the process for ensuring matters which originate as an incident that should be considered as part of the redress process to ensure all cases are included.		Ensure incidents are reviewed timely by the redress coordinator	To be added to the IMF upon review to ensure this process is captured	Head of Quality and Safety	March 2025
R05	8. PTHB should ensure a process for documenting the review of potential quantum (within the progress notes or via an email attached to the record) at the commencement of a Redress matter, so there is some evidence on Datix that it has been considered.		Document that case can be considered under redress due to the potential value	Flowchart of the redress process has been drafted, and being considered for approval	Redress, Compensation Claims & Inquest Case Coordinator	Completed
R06	9. PTHB should introduce a file review process on closure of a redress record, to ensure data completion and completeness of attachments.		Add to redress flowchart ensure progress note corelate with the documentation	Flowchart of the redress process has been drafted, and being considered for approval	Redress, Compensation Claims & Inquest Case Coordinator	Completed

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	Recommendation	Risk rating	Action needed	Progress & Evidence	By who	**Deadline date for completion** (Use traffic light system to indicate status) **& insert date of completion**
R07	10. PTHB should continue to monitor the process, and associated time taken, to request, approve and make payments in redress and claims matters.		Will be considered further at the point of the redress regulations changing.	Awaiting amended regulations	Head of Quality & Safety	In progress until the change in regulations.

Status of action:

GREEN	Complete
AMBER	In progress
RED	Missed deadline for completion - escalate

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Appendix 1
NHS Wales Assurance Framework

The WRP Assessment Programme utilises the NHS Wales Internal Audit Framework for Assurance:

SUBSTANTIAL ASSURANCE		The organisation can take **substantial assurance** that arrangements to secure governance, risk management and internal control in relation to the Putting Things Right areas of assessment are suitably planned and applied effectively. Few matters require attention and are compliance or advisory in nature with low impact on residual risk exposure.
REASONABLE ASSURANCE		The organisation can take **reasonable assurance** that arrangements to secure governance, risk management and internal control in relation to the Putting Things Right areas of assessment are suitably planned and applied effectively. Some matters require management attention in control design or compliance with low to moderate impact on residual risk exposure until resolved.
LIMITED ASSURANCE		The organisation can take **limited assurance** that arrangements to secure governance, risk management and internal control in relation to the Putting Things Right areas of assessment are suitably planned and applied effectively. More significant matters require management attention with moderate impact on residual risk exposure until resolved.
NO ASSURANCE		The organisation has **no assurance** that arrangements to secure governance, risk management and internal control in relation to the Putting Things Right areas of assessment are suitably planned and applied effectively. Action is required to address the whole control framework in this area with high impact on residual risk exposure until resolved.

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Appendix 2

WRP Concerns Assessment – Areas for Assessment

The WRP Assessment Programme uses a series of Areas for Assessment to guide the Assessment Team in the aspects and criteria to be examined. These cover the areas of activity which directly impact on matters which may cause a request for reimbursement from the Welsh Risk Pool.

The Areas for Assessment provide a framework for the Assessment Team to gather information, evidence and collate data to support the identification of findings and the establishment of recommendations.

Assessment Criterion

AREA FOR ASSESSMENT	
A	Management of Concerns (Incidents)
B	Management of Concerns (Complaint and Enquiries)
C	Redress Case Management
D	Claims Case Management
E	Inquest Case Management
F	Organisational Learning and Learning from Events Reports
G	Reimbursement Process

Area for Assessment A: Management of Concerns (Incidents)	
A1-01	Is the timescale between index events and incident reporting reasonable?
A1-02	Did the incident have a Management Review?
A1-03	Is the timescale between reporting and Management Review reasonable?
A1-04	Did the incident have a proportionate investigation completed, where appropriate?
A1-05	Was the incident record closed within 30 days? If not, is there information to explain the reason for any delays or actions being taken?
A1-06	Was the incident reportable as a Nationally Reportable?
A1-07	Did the post incident investigation indicate there was harm caused, and that Qualifying Liability was considered?
A1-08	Based on the reporters view of harm (moderate or above) have the Duty of

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	Candor fields been completed and if not, is a rationale provided for the non-completion?
A1-09	Is there training for staff reporting and investigating incidents?

Area for Assessment A:	
Management of Concerns (Incidents) Policy and Procedure	
A2-01	Is there a policy or procedure in place for Incident Management within the Health Body? Is it in date? Is there a review date? How is it reviewed/ratified?
A2-02	Does the policy or procedure cover the requirements as set out in PTR guidance and associated national policy?

Area for Assessment A:	
Management of Concerns (Incidents) Information, Reporting & Governance Arrangements	
A3-01	Are there effective governance arrangements for the management of incidents?
A3-02	Is there a screening process in place for monitoring accuracy of information submitted in incident reports? Is it timely?
A3-03	How are incidents reported within the Health Body and to what meetings/ committees are they reported? Are they reported at Board level or Sub-Committee? Are these arrangements proportionate?

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Area for Assessment B:	
Management of Concerns (Complaint and Enquiries)	
B1-01	Does the record include details of the 'Person Providing Feedback' (Complainant) and has the Complainant Chain been triggered
B1-02	Have details of the original contact with the Complainant been recorded and supporting information available for review. This may be an email or letter from the Complainant or notes from a telephone discussion.
B1-03	If the complaint is in relation to a third party, has consent been requested
B1-04	Does the Date received (Complainant Chain) match the date the Complaint was first received (Key Dates)
B1-05	Have the following essential data fields in Datix Cymru been completed accurately and up to date: • Is the Complainant Chain available and completed where possible • Has an investigator been identified
B1-06	Has the type of complaint been changed? If yes, has the Complainant Chain be reset to meet the PTR Reg timescale of the new type of complaint
B1-07	Does the Description field contain identifiable information i.e. names of persons or locations
B1-08	Have all the relevant points raised in the complaint been recorded in the 'Complaint Subjects' section
B1-09	If applicable, has a holding letter been sent to the Complainant
Closed records only:	
B1-10	Where a complaint was dealt with as Early Resolution, is this appropriate?
B1-11	Has a response been provided to the person notifying the concern within 30 days. Where it has not been possible to provide the report within 30 days, has the person notifying the concern been advised within 30 working days, an explanation provided, and a proposed timescale agreed?
B1-	Did the response respond to all the relevant points raised in the complaint and the

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12	investigation outcome of each point recorded
B1-13	If no response letter has been sent, has the reason why no response letter was sent provide an adequate explanation e.g. evidence of verbal discussion with complainant
B1-14	If a Regulation 26 or Regulation 33 Response has been sent, has a Redress record been created and have the records been linked
B1-15	Does the complaint response comply with the content requirement as set out within the guidance? - Reg 24 response prepared for the concern reviewed which has been investigated and in respect of which the Responsible Body considers there is no QL in tort? - Reg 24 response prepared for the concern which has been investigated and in respect of which the Health Board considers the claim to be over £25,000 in value? (no reference to BOD and QL if considered over £25,000 and advice re Solicitors etc?) - Reg 26 response prepared advising may be BOD & QL with explanation provided regarding Redress and next steps - Reg 33 response prepared advising there is/was BoD & QL explanation provided regarding Redress and offer made
B1-16	Has the Complainant Chain been fully completed and is the date of response accurately recorded in the Complainant Chain

Policy and Procedure	
B2-01	Is there a policy or procedure in place for Complaint Management within the Health Board? Is it in date? Is there a review date? How is it reviewed/ratified?

Information, Reporting & Governance Arrangements	
B3-01	What are the governance arrangements for the management of complaints and enquiries?
B3-02	How are complaints reported and monitored within the Health Body and to what meetings/Committees are they reported? Are they reported at Board level or Sub-Committee?
B3-03	Is there a training package in place for staff for complaints handling?

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Area for Assessment C:	
Redress Case Management	
C1-01	Is there an appropriate process for determining when a matter should be handled by Redress specialists? Is there a clear process for transition from incident teams and complaints teams?
C1-02	Is the redress record complete? Is all correspondence, advice and supporting information available for review?
C1-03	Is there evidence of the case being screened for potential value at the outset?
C1-04	Has an interim report (Reg 26 letter) for the concern reviewed and investigated been prepared where the Health Body considers there may be a QL?
C1-05	Has the interim report been provided to the person notifying the concern within 30 days?
C1-06	Does the response letter comply with the content requirement set out in the Regulations & associated Guidance? E.g., explaining QL, advice re Solicitors, addresses all concerns raised etc
C1-07	In circumstances where a Reg 26 interim response was provided, have independent experts been instructed? Has this been done in line with the requirements in the Regulations (i.e. jointly) and appropriately?
C1-08	Has a Regulation 33 report been sent for every concern reviewed and investigated in respect of which the Responsible Body has not sent a Regulation 24 response?
C1-09	Has the Regulation 33 report been provided within a maximum of 12 months of the concern being notified to it?
C1-10	Does the Regulation 33 Response comply with the requirements of the Guidance? E.g. clearly sets out the basis for the final decision as to QL and the offer made.
C1-11	Where financial compensation has been paid, has an appropriate contract been entered into between the recipient of the financial compensation and the organisation?
C1-12	Has Legal and Risk Advice been requested? Was this request proportionate?
C1-13	Who authorised QL and on what basis? Was this appropriate?
C1-14	Have all essential data fields been completed correctly within the case management record?

WRP Held Data Review	
C1-14	How many LFER's submitted in relevant period?
C1-15	How many requests for reimbursement submitted to WRP?
C1-16	What is the performance for WRP submission deadlines?
C1-17	How may extensions were requested for submission to WRP?
C1-18	How many cases were approved at the first Learning Advisory Panel?

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Policy and Procedure	
C2-01	Is there a policy or procedure in place for Redress Case Management within the Health Board? Is it in date? Is there a review date? How is it reviewed/ratified?
C2-02	Is there a clear process for the application of Standing Financial Instructions and authorisation of admissions & settlement of matters?
C2-03	Is there a process in place to review admission/denial decisions?

Information, Reporting & Governance Arrangements	
C3-01	What are the governance arrangements for the management of redress cases?
C3-02	How are they reported within the Health Board and to what meetings/Committees are they reported? Are they reported at Board level or Sub-Committee?
C3-03	Is there a training package in place for staff?
C3-04	There is a system for learning lessons from events including concerns (incidents, complaints, claims under redress) compensation claims, claims reviews etc which are used to improve services

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Area for Assessment D:	
Claims Case Management	
D1-01	Is there an effective process for receiving and processing requests for disclosure of medical records in matters where a claim is being considered against the health body?
D1-02	Where disclosure of records is requested, is there a process to ensure appropriate release of information is managed and redaction of relevant information undertaken as required?
D1-03	Is there an effective process for the oversight of disclosure of information in matters where a claim is being considered against the health body?
D1-04	Is there a clear process for referral of relevant matters to Legal & Risk? Is the referral to Legal & Risk being utilised? Is the timescale for referral of claims to Legal & Risk appropriate?
D1-05	Is there a clear process for receipt of advice in a matter and analysis of requests for instructions? Are the timescales for receiving advice and providing instructions appropriate and proportionate?

Policy and Procedure	
D2-01	Is there a policy or procedure in place for Claims Case Management within the Health Board? Is it in date? Is there a review date? How is it reviewed/ratified?
D2-02	Is there a clear process for the application of Standing Financial Instructions and authorisation of admissions & settlement of matters?

Information, Reporting & Governance Arrangements	
D3-01	What are the governance arrangements for the management of claims cases?
D3-02	How are they reported within the Health Board and to what meetings/Committees are they reported?
D3-03	Are they reported at Board level or Sub-Committee?
D3-04	Is there a training package in place for staff responsible for managing claims?

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Area for Assessment E: Inquest Case Management	
E1-01	Is there an effective process for receiving and processing requests from the Coroner?
E1-02	Where staff statements are requested, is there a process to ensure appropriate release of information and statements drafted correctly?
E1-03	Is there an effective process to support staff who are asked to provide statements for the Coroner and to attend the Inquest?
E1-04	Is there a clear process for referral of relevant matters to Legal & Risk? Is the referral to Legal & Risk being utilised? Is the timescale for referral of inquests cases to Legal & Risk appropriate?
E1-05	Is there a clear process for review of Regulation 28 notices from the Coroner? How are staff and Services informed? What is the process for monitoring the request for information and ensuring it is actioned and information submitted in time?

Policy and Procedure *To be completed by Assessors*	
E2-01	Is there a policy or procedure in place for Inquest Management within the Health Board? Is it in date? Is there a review date? How is it reviewed/ratified?

Information, Reporting & Governance Arrangements	
E3-01	What are the governance arrangements for the management of inquest matters?
E3-02	How are they reported within the Health Board and to what meetings/Committees are they reported?
E3-03	Are they reported at Board level or Sub-Committee?
E3-04	Is there a training package in place for staff responsible for managing inquests?

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Area for Assessment F:	
Organisational Learning	
F1-01	Has the locally adapted 'All Wales Learning from Events Framework' been approved through the Health Body's governance processes?
F1-02	Is the Health Body progressing the implementation of the locally adapted 'All Wales Learning from Events Framework'?
F1-03	Is the Health Body considering the importance of psychological safety to being a learning organisation?
F1-04	Are there effective governance arrangements in place to enable oversight by the Health Body's Board and Board subcommittee's that the approach to organisational learning is improving?
F1-05	Are there effective governance arrangements in place to enable oversight by Directorates / Divisional / Groups senior management teams that local learning is improving?
F1-06	Are staff, service users, families and stakeholders involved in determining what the learning should be following an event?
F1-07	Has it been determined how staff across the organisation wish to receive learning?
F1-08	Is the organisation able to demonstrate examples of organisational learning from events (examples may include what goes well, incidents, complaints, claims, inquests, ombudsman, internal reviews, networks, external independent reviews, and Public Inquiries) being discussed from Operational level to the Health Body's Board?
F1-09	Is there a clear process relating to the approval of the Welsh Risk Pool (WRP) Learning from Events Reports locally and corporately prior to submission to the Welsh Risk Pool, including the provision of additional information if the case is deferred?
F1-10	In respect of organisational learning what is the Health Body's approach to knowledge management (practice of organising, storing and sharing vital information) so that everyone can benefit from its use?
F1-11	What proportion of LFER reports were submitted in accordance with the WRP Reimbursement Procedures? E.g. timeliness, completeness, extension requirements?
F1-12	What proportion of LFER reports were approved by the Learning Advisory Panel?

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Area for Assessment G:	
Reimbursement Process	
G1-01	Does the Health Body have in place a defined and formalised process or procedure through which it sets out its objectives and provides assurance for the accounting of losses & special payments which are subject to WRP Reimbursement?
G1-02	Does the Health Body have a process for tracking and ensuring submission to WRP for reimbursement? E.g. timeliness?
G1-03	Does the Health Body have a process for identifying and submitting post-closure reimbursement requests in a timely manner?

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Strengthening Safeguarding in Health Review Report

Review undertaken and report written by: Rhiannon Beaumont-Wood (RN, Dip HV, Dip Child Protection, MSc Econ)

Sponsored/Commissioned by: Sue Tranka Welsh Government Chief Nursing Officer/Nurse Director NHS Wales.

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May 2024

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1.Introduction

This review was commissioned by the Chief Nursing Officer for Wales and Nurse Director of NHS Wales, in response to a paper presented internally to Welsh Government recommending that Welsh Government (the CNO, Director General/Chief Executive NHS Wales and Ministers) have sufficient and meaningful assurance that the NHS in Wales is delivering against its statutory Safeguarding duties. This paper concluded that there is insufficient effective oversight and assurance and joined up delivery of coherent policy across health and social care.

The title of the 'Terms of reference' (see **Appendix 1**), '*Strengthening Safeguarding in Health Review'*, contains the key word 'strengthening', opportunities to strengthen arrangements in NHS Wales has been the focus of this review. This review is not intended as an inspection; rather, it aims to provide an overview to identify opportunities for strengthening or enhancing current arrangements. While this review primarily focuses on health, it fully acknowledges that multiagency and partnership collaboration is essential, as outlined in legislation and associated legislation. (*Social Services and Well-being (Wales) Act 2014)*

The reviewer has been appointed to undertake the review with the knowledge that until the end of June 2023 they served as Executive Director of Quality, Nursing and Allied Health Professionals in Public Health Wales. During this time held the delegated responsibility for corporate safeguarding within the organisation and for a period had the National Safeguarding Service/Team within the portfolio. The reviewer has had a longstanding career in the NHS spanning forty years, and historically held specific roles in Safeguarding within NHS Wales.

Any potential conflicts of interest have been disclosed to Welsh Government.

It is worth noting that a short timeline between January 2024 and the end of May 2024, was allocated to this review with resources for one part time reviewer. It is important to acknowledge unlike previous safeguarding reviews there were no additional supporting reviewers resourced and allocated to this review to bring additional objectivity to the process. (Aylward et al., 2010) Therefore, this review is not positioned as an academic piece of research although does hope to offer some insights and recommendations that could help to strengthen current arrangements. A steering group (**Appendix 2**) was established to oversee the process and approach to the review.

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2. Background and context

The European Convention on Human Rights (ECHR) (Council of Europe 1950), the United Nations Principles for Older Persons (UN, 1991), and the United Nations Convention on the Rights of the Child (UNCRC) (UN, 1989), provide essential frameworks for safeguarding individuals within the NHS and broader health and social care sectors. These instruments emphasise the protection of human rights and the provision of care with dignity, respect, and fairness.

The word 'Safeguarding' is often used as shorthand and conceals a complex legislative multiagency operating environment. A useful definition is found in the Social Services and Well-being (Wales) Act 2014 guidance, Working Together to Safeguard People: Code of Safeguarding Practice, which identifies safeguarding as meaning: **"keeping people safe from abuse, neglect or harm and knowing what to do if you think a child or adult is at risk of abuse, neglect or harm"**. (page 2 Welsh Government, 2022)

NHS Wales organisations, are key multiagency partners with statutory responsibilities under various legislations, including but not limited to the Social Services and Well-being (Wales) Act 2014, the Children Act 2004, and associated guidance. (pages 21,22 and 9, Welsh Government, 2016). These responsibilities include reporting and sharing information to safeguard vulnerable adults and children and ensuring the effective operation of Reginal Safeguarding Boards. (page 24, Welsh Government, 2016)

Figure 1 illustrates some of the legislative framework impacting NHS organisations in Wales concerning their safeguarding responsibilities, as well as other relevant laws that contribute to fostering an environment conducive to meeting the health, wellbeing, and safety requirements of individuals accessing healthcare services and interventions.

Figure 1 Legislative Framework

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The timing of this report and the resource allocation means it will not be possible to reflect all that is currently happening in safeguarding, the remit of safeguarding is vast and the terms reference for the review were broad. Work is ongoing within the NHS in Wales and there are likely to be findings and recommendations which have recently started or are in progress.

The review, as confirmed with Welsh Government officials and the Steering Group, acknowledges that it cannot encompass all aspects of safeguarding. It is being conducted at a time when other reviews may be underway by different departments within the Welsh Government. Additionally, the NHS in Wales is currently working on establishing agreed assurance measures for safeguarding. Key national initiatives, such as the 'Single Unified Safeguarding Review guidance' (Welsh Government, 2023), are also being finalised and will be implemented in due course.

Sexual safety is a topic which has recently gained significant attention, falls outside the remit of this review. The review does not intend to provide commentary on specific topics under the Safeguarding umbrella, adopting a broader overview on the arrangements in the NHS in Wales approach.

The last review to consider an all-Wales view of Safeguarding in the NHS in Wales was in 2010, titled The Safeguarding and Protecting Children in Wales: A Report, led by: Professor Sir Mansel Aylward CB, this previous report is often referred to as the Aylward report. The focus of the report was on arrangements for Safeguarding and protecting children, which was the predominant legislative and policy focus at the time. The distance travelled during the intervening years recognises that Safeguarding applies across the life course and encompasses both adults and children who are or may become at risk of abuse and neglect.

The Aylward (2010) report recommendations were implemented to varying degrees of success, not necessarily achieving the full intended impact. For instance, while the Safeguarding Network was meant to involve Executive leads and Independent Board members, this level of leadership has not been consistently evident. Nonetheless, some important progress not addressed in the report at that time has been made, namely the expansion of the remit of the Safeguarding Network and National Safeguarding Service to cover both adults and children, which evolved in response to legislative and policy shifts towards a broader Safeguarding perspective.

The NHS is complex even for those working within it and it is important to recognise that there are thousands of touch points with the public (patients, service users, their friends and families) every year. Some of whom will already be vulnerable to abuse or neglect or who may become vulnerable by virtue of their presenting health and care needs.

In 2009/2010, the Aylward report aimed in part to respond to concerns raised by the National Society of Prevention Cruelty to Children (NSPCC) in relation to the 2009 reforms in NHS Wales. One of the key concerns was the destabilisation of the national child protection service which had previously sat within the National Public Health Service (NPHS). This was a recommendation which originated from the Carlile Report (2002), which recommended there was a need for a national child protection service within the NHS. The National Child Protection Service, having sat within the National Public Health Service (NPHS) subsequently moved to the newly formed Public Health Wales NHS Trust in 2009, as part of NHS Wales reforms. The

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provision of Child protection services is still included in the Public Health Wales establishment orders.

The National Safeguarding Service in Wales has not always been a natural fit within a public health agency and encountered some challenges integrating into a public health focused organisation. There are philosophical and methodological differences in approach between population and individual health strategies, yet the service has made some strides in bridging the gap between population health approaches and safeguarding individuals. There have been some fruitful collaboration and contributions to population health particularly regarding children and young people, for example, contributing to the previously established 'First 1000 days programme board' and the Child Death Review programme. Expectations between the National Safeguarding Service function and other functions, such as the Violence Prevention Unit and Adverse Childhood Experiences hub that also sit in Public Health Wales have been less clear and there is some degree of confusion around roles and responsibilities.

The function has sat in two different Directorates during the lifetime of Public Health Wales, most recently it has sat in the Quality, Nursing and Allied Health Professionals Directorate.

The Aylward review recommendations have not all been achieved and with the benefit of hindsight, it is arguable whether the infrastructure was set up with the right design and authority to deliver on all the original intentions. However, it is important to recognise that despite the lack of progress on some recommendation's the key recommendations to establish a safeguarding network was achieved. There are numerous examples of safeguarding improvement projects led by the National Safeguarding Service in collaboration with all Wales Safeguarding Network, having been completed over the past fourteen years. Unfortunately, the impact of those improvements has not been sufficiently well evaluated to fully understand the impact of these pieces of work and could have been more widely promoted for key stakeholders to be fully aware of the work achieved, recognising that corporate memory is lost as leadership changes. However, many achievements are recorded and published in the Safeguarding Network annual reports (NHS Wales, 2022/23).

It can be argued that some of the recommendations were for Welsh Government to address, such as setting the expectation and allocation of resources for retrospective Disclosure and Barring.

With the establishment of the NHS Executive and the enactment of the Health Social Care (Quality and engagement) (Wales) Act 2020, it is now an appropriate time to pause and reflect on how arrangements could be strengthened through a more purposefully designed approach and strengthening the mandate of the Safeguarding Network and National Safeguarding Service. To date, there has not been a purposefully designed safeguarding quality management system with supporting architecture in the NHS in Wales, to provide oversight on the effectiveness of Safeguarding arrangements in health, at a system level. This review is timely and aims to provide recommendations with the aim of strengthening current Safeguarding arrangements in NHS Wales.

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3. Scope and approach

The reviewer interprets the scope of the review to involve identifying opportunities to strengthen Safeguarding arrangements within the NHS in Wales, and to improve oversight and assurance mechanisms for both the NHS and the Welsh Government. Due to resource constraints, the main focus is limited to NHS Wales rather than encompassing a broader definition of health.

The terms of reference also specifically stipulate that opportunities to update the remit of the National Safeguarding Service should be identified.

The scope of this review is not intending to report on any individual organisations or services, nor will it focus in detail on any specific topic areas under the umbrella of safeguarding. The approach is a more general look at safeguarding arrangements in NHS Wales, looked at through a lens of seven themes agreed by the Strengthening Safeguarding in Health Review Steering Group. The seven themes seen at **Figure 2** are interdependent and therefore there will be some degree of overlap between the themes.

Figure 2. The Seven Themes

The reviewer received copies of several reports which were Safeguarding related and authored by people either from or on behalf of different organisational bodies. The full list of reports is included in reference list at the end of the report.

In addition, it was agreed that insights would be gathered from a range of stakeholders both within NHS Wales and from key roles outside the NHS in Wales. Information on the roles of people interviewed or organisations who participated is also available in the appendices. See **Appendix 3**. Some additional potential participants were considered for inclusion, however there was no availability identified within the project timeline.

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Welsh Government established a Safeguarding in Health Review steering group (2024) at the end of January chaired by Richard Desir (Nursing Officer Welsh Government), the main purpose of the steering group was to provide advice and guidance and contribute to the final report prior to implementation. **Appendix 2**

The steering group considered and agreed seven themes as seen in **figure 2**, which formed the basis for semi structured interviews to be used with a range of key stakeholders, the aim of which was to gather their perspectives and insights. There were sixty-seven stakeholders interviewed in total. See **Appendix 3**.

The interim report, was submitted according to the Terms of Reference of the Review and project plan agreed upon by the Steering Group, indicating that further interviews and research were needed for phase two. Some emerging findings from the interim report are not included in this report, as they became less relevant by the end of phase two. Additionally, the final report may introduce new findings that emerged during the final phase.

For continuity and a consistent approach, this report has been set out using the agreed theme headings at the commencement agreed in the Steering Group and used in the Interim Report.

4. Methods

This review deployed a three-pronged approach to gather a range of data to understand current safeguarding arrangements in health. This approach comprised:

1. Steering group as described in the above section convened, considered, and agreed seven key themes that could function as the lens through which to review Safeguarding arrangements in NHS Wales.

2. Literature review of available open-source evidence produced by recognised experts in Safeguarding, Regional Safeguarding Board practice reviews or inspection.
3. Semi-structured interviews conducted via Teams with stakeholders across the health and social care landscape in Wales.
4. Data from these three elements has been used to develop a picture of where some of the opportunities lay to strengthen Safeguarding arrangements and inform how improved oversight and assurance within the NHS in Wales could be arranged.

4.1. Steering Group

Welsh Government established a Steering Group, the main purpose of the steering group was to provide advice and guidance and contribute to the final report prior to implementation.

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The steering group agreed on seven themes which informed the line of questioning for both the semi-structured interviews and literature review. See **figure 2**.

4.2. Literature Review

Evidence relating to Safeguarding was gathered using open-source information, such as reports produced by subject matter experts, Regional Safeguarding Board practice reviews, Inspectorate bodies, Google Scholar. Evidence was read and formed part of the analysis, in relation to the seven key themes agreed by the steering group.

4.3. Semi Structured Interviews

To supplement the literature review and to provide greater detail and in-depth insight, semi-structured interviews were utilised.

The Interviews were conducted with sixty-seven stakeholders from across the NHS and social care landscape in Wales, (see **Appendix 3** for full list of interviewees). The interviews were selected by identifying key stakeholders both within and outside of the NHS in Wales, based on advice from the steering group and nominations were provided in relation to front line staff. A small number of additional stakeholders were suggested by stakeholders interviewed in phase one. The stakeholders provided a broad range interview sample. This included those with specific responsibilities in Safeguarding and a small sample of front-line staff, together with nominations from other agencies or functions from a multi-agency perspective, inspectorates and relevant Commissioner's departments, and colleagues working in the NHS in Safeguarding from two other nation countries.

These interviews were conducted via Microsoft Teams and ran for approximately 60 minutes on average. The interviews were recorded, and deductive analysis was undertaken against the seven themes to identify patterns and sub-themes in the data.

Interviewees were asked about their experiences of Safeguarding and current arrangements in the NHS in Wales. Initial questions focused on the effectiveness of current arrangement, as well as current interventions in place to drive the desired outcomes. Example questions such as ***"What is currently working well to support staff?"*** Other questions aimed to understand the structures in place with regards to Safeguarding in health, along with the interplay between health and social services and the wider multiagency arena. Example includes, ***"What barriers are experienced when interacting with multi-agency partners?"*** Interviewees were also asked about individual and organisational behaviour, assurance, and enablers ***"What do you think are the key enablers in safeguarding?"*** The reviewer used prompts when they felt further detail was required, examples include, ***"Can you tell me more about supervision arrangements in your organisation?"***

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4.4. Analysis

Themes were analysed using the qualitative data gathered from the semi-structured interviews. Notes were transcribed from the original audio recordings and the data was read for familiarisation. Notes detailing initial meaning, patterns and ideas were also recorded. Data was then colour coded deductively against the seven agreed themes to facilitate a more refined analysis. Findings were defined based on the frequency of insights being shared by the stakeholders, and its relevance to strengthening Safeguarding in health as they related to the themes.

5.Theme One. Defining strengthening Safeguarding in the NHS is Wales. (Are current arrangements effective?)

This theme generated a lot of discussion as it encapsulated a big open question about the effectiveness of current arrangements. The stakeholders were not asked to define strengthening Safeguarding but were asked broadly about their views on the effectiveness of Safeguarding arrangements at an organisational and national level.

Those in key leadership roles for Safeguarding within the NHS, were able to describe organisational structural and governance arrangements in detail. The question around effectiveness appeared more challenging to confirm.

This theme will highlight some of the key points raised as they relate to Safeguarding effectiveness.

The NHS is notoriously complex and has many moving parts and relationships within organisations, beyond organisational boundaries and the wider system. The workforce is not static and is impacted by systems, processes, internal and external pressures, as well as the physical and cultural environment people are working in to deliver health and care services to the population every day. The multi-agency policy context is the way that collectively the workforce can strive to keep vulnerable children and people across the life course safe from abuse and neglect. However, a number of points and themes came through from the interviews and the literature. These relate to the intra-operability within and between sectors, professionalisation of distinct workforce groups, use of language and perspectives on thresholds and levels of risk adding to already complex working environments. These challenges do not diminish organisational and individual responsibility and accountability; however, it is incumbent upon policy leaders, senior leaders, and leaders at all levels to create environments that enable organisations and individuals to work effectively in line with agreed policies and procedures.

This quote has been attributed to Batalden et al.,(2007) ***"Every system is perfectly designed to get the results it gets"****, (JAMA 2007)* in the world of Quality Improvement there is an understanding that unintended consequences are often designed into our systems, therefore systems and processes need to be designed with more attention paid to co-creating them with those people who are expected to use them.

The systems and arrangements implemented at a particular point in time, would have been deemed right for then. However, the landscape for the NHS in Wales continues to evolve and change. NHS Wales reforms were implemented fifteen years

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ago, and in 2023 the NHS Executive was introduced. This appears to be an appropriate time to consider any changes which could support an onward journey of improvement.

There are Safeguarding people related gaps identified within the NHS, as evidenced by several recent reviews referred to in the Terms of Reference for this review, (see **Appendix 1**). However, the reviewer has not been limited to looking at recommendations identified in recent safeguarding reports to address risks and gaps but has also looked for strategic opportunities to strengthen approaches to Safeguarding People through the wider health policy landscape. For instance, the Health and Social Care (Quality and Engagement) (Wales) Act (2023), this warrants attention as there is potential to use this legislation and policy context to create more focus on improvement in safeguarding arrangements within the NHS in Wales. There were several stakeholders from within the NHS and NHS Executive who thought it was important to apply this area of legislation and policy to Safeguarding People in relation to the NHS.

The Organisation for Economic Co-operation and Development (OECD, 2016), describes the focus of improvement systems and architecture ***"should be, first, on ensuring that appropriate mechanisms for identifying shortcomings early are in place and fit for purpose. These include comprehensive data systems and quality indicators which are regularly reviewed"*** (page 201, OECD, 2016).

Recent reviews have identified gaps in the Safeguarding system within the NHS in Wales, these include but are not limited to, issues with inter-team and interagency communication, findings which are repeatedly made in reviews and other reports. Together with weaknesses in the interoperability of digital systems both within the NHS and across organisation boundaries. (More will be said about inter-departmental and interagency working in theme four and more focus on digital systems in the Enabling section)

There were several views shared during the interviews, that it would be beneficial to integrate Safeguarding people into a Quality Management System approach and incorporate it into integrated quality performance arrangements. There was recognition that there are gaps at a national level in terms of quality planning, control, and improvement processes which would benefit from being strengthened.

It was considered by some who were involved historically with self-assessment against the *Welsh Risk Pool Standard 39*, that assessment processes for Safeguarding were previously more detailed. The Health and Care Standards (Welsh Government, 2015) was until recently used for overall annual organisational governance reporting, included Standard 2.7 *Safeguarding Children and Safeguarding Adults at Risk,* asking health services to consider how it met the standard against a criteria provided in the guidance.

More recently peer assessment sessions to consider organisational self-assessment against the *Safeguarding Maturity Matrix* (NHS Wales, 2019), have also been used. The reviewer was informed that these have been less well attended since Covid 19. There appears to be limited external scrutiny on Safeguarding effectiveness placed on organisations in NHS Wales, indicating a need for a revision of agreed national standards which organisations can assess against and provide assurance on

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effectiveness of arrangements to their Boards. Reporting arrangements to the NHS Executive on behalf of Welsh Government and Regional Safeguarding Boards, also needs further consideration. There was a recognition that data visualisation at an NHS Wales level is currently lacking, and data could be better used to inform improvement priorities.

Stakeholders identified that sharing learning is not currently systematised. Although the insights gathered from interviews, advised that there are processes used to share learning within the National Safeguarding Network, through ad hoc presentations, newsletters, and conferences. There was no systematic approach identified to share organisational learning between organisations and limitations on how learning is shared with wider staff groups across organisations, other than adding in new points into training sessions and newsletter's such as seven-minute briefings being shared. There is no apparent formal mechanism for sharing learning from joint inspection reports of individual organisations, although it is recognised that some willing colleagues will seek to share findings and action plans between Heads of Safeguarding. This is a potential rich source of information which could help to identify national themes for the NHS, which if not shared may not be captured and analysed to drive improvement. Health Inspectorate Wales reported that they do consider if there are any themes arising from inspections.

From the discussions held with stakeholders working within the NHS in Wales, there are apparent inconsistencies with which systems are used for reliable methods for monitoring and tracking Safeguarding related actions arising, for example from reviews and inspections. There is currently no national tracking mechanism in place for NHS Wales for oversight. Discussions held with NHS England identified that there was a national tracking system in place for oversight in NHS England.

In considering this theme from a national perspective, there were some views expressed that there was a need for greater clarity on roles and responsibilities of the National Safeguarding Service (NSS), and some working within the NSS advised that they would welcome a clearer mandate.

There were a number of concerns expressed both from within and outside the NSS, about the need for a balance of the ratio between medical and non-medical roles in the service, this was expressed as a current risk to the wider medical safeguarding workforce.

Insights gathered from Welsh Government, the NHS Executive and other stakeholders identified that there are currently insufficient arrangements for oversight on Safeguarding at a national level. There were also views expressed from stakeholders that safeguarding priority setting needed wider strategic involvement.

There were a range of stakeholder views that the current Safeguarding network was not operating at a sufficiently strategic level and had limits on the level of influence it currently has. There were also insufficient evaluation methods to assess the impact of national pieces of work. In addition, that there was a need to have greater strategic influence and more effective arrangements for sharing learning. Current membership does not appear to attract a sufficiently broad and diverse range of professionals and experts.

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The voice of the person does not appear to be sufficiently visible from discussion and information observed in relation to the work of the Wales Safeguarding Network and NSS. Llais were interviewed as stakeholders and were not aware of the work of the Safeguarding Network or the National Safeguarding Service.

Points relating to the National Safeguarding Service and Safeguarding Network, will be discussed further in the structural theme section.

In summary, while there are Safeguarding governance arrangements in place at an organisational level, with some level of reporting to the Board and Board Committees, and progress is reported on all Wales pieces of work in the Safeguarding Network annual report, there is limited assessment and therefore not a clear understanding of overall effectiveness of Safeguarding people in NHS Wales. The main points identified in this theme, which could benefit from strengthening relate to strategic influence, impact, governance, oversight, data driven quality assurance, medical workforce availability and person centredness. Some of these points are considered further in the section below and other points will be addressed in some of the other themes. For example, in the Structure and Assurance themes.

Strengthening opportunities

There is currently an absence of a purposefully designed NHS Wales safeguarding quality management system at a national level, that can drive improvement in safeguarding people arrangements across NHS Wales, utilising the levers of the duties of Quality and Candour through the *Quality and Safety Framework: Learning and Improving (2021)*. In addition to this the *National Clinical Framework: A Learning Health and Care System* (2021). The NHS Executive was established in 2023, made up of national support functions the main purpose of which is described as **'to drive improvements in the quality and safety of care to achieve better healthcare outcomes for the people of Wales"** (NHS Wales, 2023).

There are opportunities to set clearer expectations nationally with a focus on Safeguarding people through Quality planning, Quality control, Quality Improvement and Quality Assurance with scrutiny weaved into local and national planning and governance arrangements, such as Integrated Medium-Term Plans (IMTP's), Integrated Quality, Planning and Delivery meetings, (IQPD) Joint Executive Team meetings (JET) and annual objectives set for Chairs of NHS organisations.

There is also a need for a higher level of national oversight supported through the NHS Executive. Additionally, a function that brings key strategic experts from outside the NHS, to contribute to setting strategic priorities with Welsh Government notably with the Chief Nursing Officer as the lead Executive within NHS Wales for Safeguarding people in health.

There are currently gaps in the visualisation of national real- or right-time data to drive improvements and provide assurance locally and nationally on the effectiveness of arrangements for Safeguarding people. Data appears to be currently focused on activity and compliance data, with outcome data seen as more challenging to obtain.

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The context of arrangements for NHS Wales as referred to earlier have changed with the establishment of the NHS Executive. This review is therefore timely in terms of the opportunity to bring the National Safeguarding Service functions into the NHS Executive, together with other national functions such as, Improvement Cymru, the Health Collaborative, Delivery unit and Finance Delivery unit. Recognising that there are different structural arrangements akin to Directorates within the NHS Executive itself. A national safeguarding function would appear to have a better fit providing leadership, support, and a guiding hand to the NHS in Wales. The additional benefit is that there can be cross fertilisation and capability building between all the functions in the NHS executive. For example, experience from Improvement Cymru to support improvement programmes, establishing data sets and measurement processes in Safeguarding quality will be highly beneficial as will experience from the collaborative in the establishment, coordination and running of clinical networks. The National Safeguarding service are well placed to provide expertise to some of the improvement programmes which have patient or client groups where elements of safeguarding will feature. For example, Learning Disabilities, Maternity Care transformation programmes.

The NHS Quality and Safety Framework requires Quality Statements to be developed and should include the provision of a description of what good quality safeguarding should look like in the NHS. This needs to be informed by good quality research evidence, agreed revised national standards, a more rounded understanding of current gaps and a rigorous analysis of the themes arising from reviews, inspections, and understanding of the risks. There needs to be a risk-based and impact approach to prioritisation which includes a wider range of stakeholder perspectives (not just from those working within the NHS) at both a strategic and operational level. Current prioritisation arrangements could benefit from the use of a recognised methodology and to involve wider stakeholder perspectives to provide greater check and balance. Safeguarding quality statements have the potential to allow for a higher level of ambition to be set for Safeguarding people in the context of NHS in Wales.

A quality statement for safeguarding should now be developed and agreed, together with a small suite of metrics that can provide assurance at a local and national level, taking account of any national Safeguarding guidance. The measures need to take account of the domains of quality in the application of Safeguarding requirements and provide early warning signals which can alert abnormal variation in the effectiveness of Safeguarding arrangements. This can be implemented as part of the arrangements under the *Quality and Safety Framework (Welsh Government, 2021)* setting a higher level of ambition and impact on closing identified gaps in arrangements and improving quality and safety outcomes in relation to Safeguarding people.

There are opportunities to strengthen the focus on the 'voice of the person' in learning and co-creating approaches to national pieces of work. A starting point could be for the NSS to engage with Llais and identify third sector organisations that may already be working with them, to provide expertise on how the 'voice of the person' could be made more central to developing and implementing all Wales pieces of work.

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The recommendations identified below seek to take advantage of the opportunities brought about by the legislative and policy changes in relation to quality and safety, in the anticipation that Safeguarding people arrangements in the NHS in Wales would be strengthened by moving in this direction. The structural components of any necessary changes will be discussed further in the theme three section, and workforce issue will be discussed further in the theme seven section.

Recommendation 1

It is recommended that Welsh Government through the NHS Executive establish a Safeguarding Quality Management and Learning system, underpinned by the *Health and Social Care* (Quality and *Engagement) (Wales) Act* 2020 and *Social Services and wellbeing Act 2014*, utilising the principles in the *Quality and Safety framework* and *National Clinical Framework* to guide the implementation. This should include: -

- Safeguarding Quality Statement and metrics.
- Development of an NHS Safeguarding Assurance and Accountability Framework.

Recommendation 2

NHS Health Boards and Trusts should ensure there is robust oversight and governance arrangements in place, to ensure actions arising from practice reviews and inspections are completed and meaningful learning is being applied across all relevant health settings and not limited to where the gap or incident was initially identified.

6.Theme Two. Current interventions to drive the desired outcomes.

This theme will consider whether there is a shared understanding of desired outcomes, whether current approaches for Safeguarding people support those outcomes and whether there is evidence to demonstrate this.

Stakeholders were asked initially to describe what they perceived to be desired outcomes. Examples of responses were. It is essentially through ***"to protect vulnerable people and children from harm," "to protect vulnerable people from abuse and neglect and to protect the organisation", and "to have competent confident staff who can recognise a concern and act upon it and record or inform what action needs to be taken"*** the actions of staff working in partnership with others, that safeguarding and protecting people is achieved. Organisational focus on systems, processes and governance arrangements need to ensure staff and line managers are supported to do their jobs well and can get things right first time. Furthermore, there are national and local policies and procedures, corporate safeguarding teams, national teams, education, and training and for some staff groups access to supervision, all focused on driving and supporting the desired outcome, to Safeguard vulnerable people.

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Governance arrangements and Safeguarding specialist resources are evident across Health Boards and Trust's in Wales. What is less evident is whether arrangements and interventions currently in place are achieving the intended outcomes and impact. If staff having the right level of knowledge, confidence and competence is a key

requirement to achieving desired Safeguarding outcomes, it would seem reasonable that the effectiveness of the impact of policies, procedures and training should be better understood.

During the interviews the reviewer was not made aware of any specific work underway to test assumptions of the intended impact of policies and training on staff.

The interviews did however identify that there are safeguarding audits being undertaken within organisations which is positive, however there is variability across NHS Wales in the amount of audit activity which was said to be dependent on safeguarding team resourcing levels.

The importance of learning from incidents is recognised by Safeguarding professionals, the same is also evident in the arena of improvement science methodology. There is also emphasis placed on the importance of learning from what has gone well. During the interviews there were views shared that there is not enough time spent on sharing and learning from what has gone well. Acknowledging that practice reviews and inspection reports include areas of good practice in reports, these may not be getting sufficient airtime. From the interviews undertaken it appears there are only partial mechanisms in place within NHS Wales for sharing Safeguarding related learning across organisational boundaries. For example, findings from Joint Inspection reports.

In considering learning from child and adult practice reviews, examples shared were limited in initiatives to reach wider staff groups, beyond those directly involved with reviews. It is reasonable to suppose that those who have been part of a practice review learning process would be less likely to make the same mistake again. The reach of the learning from adult and child practice reviews does not appear to be sufficiently wide, beyond those directly involved and the implementation of learning appears to be unevaluated.

6.1. Corporate Safeguarding Teams

Heads of Corporate safeguarding teams who were interviewed, described a key part of their role and function as being accessible for support and advice to managers and staff. There were some differing views from the insights, on whether the function was to enable others or whether to step in and 'do for,' staff, particularly at busy times. While it is understood that 'doing for' may be appreciated it could give rise to unintended consequences, as staff may not acquire the confidence to take the right action the next time a situation arises, or they may delay acting, preferring to wait until the corporate team are available. Most teams provide weekday office hours, needs led Safeguarding support and advice usually through some sort of hub arrangement. Some areas depending on the geography provide a Safeguarding professional resource from health in to 'Multi-Agency Safeguarding Hub' (MASH), this is to work more closely with multi-agency colleagues. While health's role in the MASH were reported as valuable, opportunity costs were also identified, time allocated to one activity impacting on other tasks. An example given was being able to have sufficient time to conduct audits. Corporate Safeguarding teams are also heavily involved in providing targeted supervision to staff groups predominantly those involved with children and case work, such as Health Visitors. The corporate team are also providing a range of Safeguarding training as well as providing

strategic level advice and Safeguarding reporting into organisational governance arrangements.

From the small number of front-line staff interviewed as part of the insights gathering, corporate safeguarding teams were well respected and found to be accessible. Further discussion points in relation corporate safeguarding teams will be referred to in the Structure theme 3 section in this report.

6.2. The NHS Wales Safeguarding Network and the National Safeguarding Service.

These two entities are different although interdependent, the National Safeguarding Service providing leadership, collaboration and support to the Safeguarding Network in driving improvement initiatives in safeguarding across NHS Wales. The need for a National Child Protection Services is referenced by Carlile (2002), however he further amplified the importance for such a function in his recommendations with Recommendation 34 **"*We recommend that all designated and named professionals should, for the child protection part their work, be managed by an All-Wales NHS Child Protection Service. This Service should be ultimately accountable to the National Assembly, with a dedicated management group having few competing priorities. There should be a Director of the Service, a consultant in public health medicine. The Director should be required to prepare an annual report on child protection for the National* Assembly"** (Carlile 2002).

The NHS Child Protection Service pre-dates the National Safeguarding Service and was in the National Public Health Service (NPHS) as described earlier in this report. Despite the recommendation in the fullest sense was not implemented, the NHS Child Protection service became part of Public Health Wales and is referenced in the current Standing Orders. The team/service have kept pace with the external safeguarding environment by expanding the focus of the team to include safeguarding across the whole life course and includes 'Looked After Children.' The team is made up of Designated Doctors and Nurses and more will be discussed about this in the 'Structural theme' in this report. The National Safeguarding Service have absorbed the ever-expanding safeguarding remit and have continued to horizon scan and increase a collective body of knowledge to maintain a level of expertise which can contribute to both the NHS, policy landscape and multiagency strategic and operating context.

The Safeguarding Children Network: was originally established in response to the Aylward report recommendation**.** 6.5 ***"The establishment of an all-Wales NHS Child Protection and Safeguarding Network is proposed. Among others, this would include executive leads, independent board members who champion children and young people and representatives of the Safeguarding Children Service. The Network should provide a vital bridge between strategies and arrangements at local level and national policy developments, develop the champion role and promote engagement among key players"*** (page 38, Aylward, 2010). The then Safeguarding Children Network was established at the request of the then Chief Nursing Officer for Wales, with leadership and support functions provided through the Safeguarding Children Service. Terms of reference have iterated over the years the main change being a widening of scope to include

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safeguarding across the life course to be in step with changes happening in the multi-agency landscape at that time. The current terms of reference still use the phrasing of providing a vital bridge as referred to in the original recommendation from the Aylward review (2010).

In terms of this theme, which is about current interventions to drive desired outcomes, the Safeguarding network led by the National Safeguarding Service, has achieved consistent and reliable engagement with key stakeholders such as Heads of Safeguarding, Commissioners, and policy leads. The network led by the NSS has also delivered consistently on agreed workplans; however, the impact is less well captured.

There is a recognition the membership of the network has not been consistently at the level originally intended by the Aylward recommendations. For example, executive leads who have many competing priorities have not been a regular presence at the network and Independent Board members have not been meaningfully involved with the network. This has meant the network appears to have more in common with a community of practice similar to the description identified in the *National Clinical Framework Implementation Programme (NHS Wales, 2021).* This is not to devalue the current network, as engaging and collaborating has been an important mechanism on a once for Wales basis for driving national Safeguarding improvements in the NHS.

The governance arrangements have been in place since the establishment of the Safeguarding Network, the Terms of Reference describe the network as reporting to the CNO and Executive Nurse Directors. The Terms of reference are silent on how all Wales priorities are identified, proposed, and signed off, which is a gap currently. The custom and practice for signing off annual work plans has been through gaining initial agreement within the Safeguarding network, for pieces of work proposed for inclusion on an annual workplan, this is then presented in draft format by the National Safeguarding Service Director and/or deputy, to the CNO meeting held with the Executive Directors of Nursing (EDON'). There were some views raised in the insight gathering that there had recently been less visibility and clarity within the Safeguarding network, about how items on the work plan are collectively identified and agreed prior to being proposed to CNO and EDONs for sign off.

It is unclear whether all Wales pieces of work are identified as national NHS safeguarding priorities and what prioritisation methods and criteria are used. This seems to be an important starting point to understand whether the right priorities are being selected, informed by current available information, the consideration of recorded risks and the available evidence base.

The interview discussions and material reviewed has not identified a national register of strategic risks for NHS Wales Safeguarding. If this does not yet exist, the development would require a broad perspective on the identification of national Safeguarding risks for the NHS in Wales.

This theme explored what is in place currently to drive desired outcomes, in terms of supporting and equipping the workforce with knowledge and information and supporting organisations to discharge their responsibilities.

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There are arrangements in place in Health Boards and Trusts which provide a range of functions to support staff and the organisations to discharge statutory responsibilities. There were views expressed to the reviewer that access and support from corporate safeguarding teams is good. It is not possible to quantify the effectiveness and optimal resource requirements of corporate functions from this review.

More evaluation is required to better understand whether staff do feel knowledgeable, confident, and competent in Safeguarding responsibilities from current interventions. For example, training.

The all-Wales Safeguarding Network, led by the National Safeguarding Service has provided national leadership on delivery of work plans over several years, most of which are documented in annual reports produced by the NSS on behalf of the Safeguarding network. The NSS has been instrumental in providing annual Safeguarding conferences, master classes, expert advice, supervision, development of tools and standards, has undertaken commissioned bespoke pieces of work, facilitation and engagement focused on improvement, horizon scanning and contributed to international research to list a few of the areas which the NSS has contributed to in relation to Safeguarding in Wales. However, there have potentially been opportunities missed to provide evaluation of the impact on the range of work delivered and prioritisation processes are not sufficiently clear.

In summary, this section has identified that there are opportunities to strengthen processes and arrangements currently in place in the NHS in Wales. The next section will seek to identify or confirm the opportunities for strengthening safeguarding arrangements in NHS Wales, within the context of this theme. There may be some opportunities which have a better fit under other themes and will be reflected in those sections.

6.3. Opportunities to strengthen

When considering the insights gathered and how they relate to this theme, Safeguarding architecture and governance arrangements are in place in NHS Wales, at operational and organisational levels. What is less certain is the evidence to determine whether these arrangements are sufficiently strategic, and resources and plans are successfully helping to drive and achieve 'desired' outcomes.

There is an opportunity to revise the approach to prioritisation by considering broader strategic and operational levers and drivers, identifying and addressing key risks, and ensuring that programmes of work are evaluated for their impact. This will require a more rigorous approach, utilising tools and expertise in evaluation methods, and incorporating diverse sources of research and evidence. Additionally, a wider group of stakeholders should be included to inform proposals on national Safeguarding priorities in NHS Wales.

Education and training are discussed further in Theme Seven, however this is an area where it is unknown how successfully safeguarding knowledge transfer is being applied in the workforce and would benefit from further evaluation.

There does not appear to be a national safeguarding risk register for Safeguarding for the NHS in Wales. To consider more of a risk informed approach to priorities

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national risks would need to be identified through analysing data, available documented information and national trends and themes in the NHS in Wales.

It is currently unknown what opportunities may present from the Wales Safeguarding Repository development, aligned to the work being progressed on the Single Unified Safeguarding Review. It may be able to offer the NHS in Wales information relating to national themes and potentially trends in health which could also be used to inform priorities.

Recommendation 3

The NHS Executive with the National Safeguarding Service should ensure there is a revised approach to prioritisation of NHS all Wales Safeguarding priorities and delivery plans. Informed by strategic and operational levers and drivers, identified and recorded risks, wider perspectives of strategic level stakeholders. For example, Welsh Government policy leads, Regional Safeguarding Board Chairs, Safeguarding Advisory Group (see Theme 3) and views of the broader clinical executive roles, for example Executive Medical Directors and Executive Directors of Therapies in addition to Executive Directors of Nursing. The following should be incorporated (but not limited to) the approach.

- Prioritisation tools
- National NHS Safeguarding Risk register
- Evaluation of impact with methods informed by evaluation experts
- Research and evidence informed

7.Theme Three Structural

NHS Wales safeguarding structures have been in place for some time, albeit they continue to adapt and change to external and internal drivers, some of which have been described in the background and other sections of this report. There are key responsibilities placed on Regional Safeguarding Boards and multiagency partners to address risks and gaps in Safeguarding systems. However, there is also a need to ensure that individual organisations within the NHS discharge Safeguarding responsibilities and at a NHS Wales system level, that there is a consistent approach and focus on continuous improvement to reduce unwarranted variation and to support overall effectiveness in the NHS in Wales.

The NHS in Wales has also changed significantly since the Aylward review (Fourteen years ago). Most recently the establishment of the NHS Executive a formal structure with a key role to **"*provide a guiding hand, working in partnership for and on behalf of and Welsh Government in and with the NHS in Wales*"**. The role of the NHS Executive is also described as **"*providing strong leadership and strategic direction; to enable, support and, where necessary, intervene to ensure delivery of national priorities and standards and safeguard and improve the quality and safety of care*"** (NHS Wales, 2023).

The principal areas of focus for this theme will be on the NHS Wales Safeguarding Network and the National Safeguarding Service, there will be some limited

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discussion point on organisational corporate safeguarding teams, and on the Child Death Review Programme.

7.1. National Safeguarding Service

The National Safeguarding Service (NSS) describes its current role as ***"providing coordinated, strategic leadership to improve safeguarding across the NHS in Wales"*** (Public Health Wales, 2024) There are similarities between what the National Safeguarding Service seeks to achieve, and the remit of NHS Executive. However, there has not been a clear mandate for the National Safeguarding Service to undertake its role and the service has relied on collaboration and influence to deliver safeguarding improvement plans. Collaboration is a fundamental way of working in Wales, as reflected in the 'Five ways of Working' in supporting 'The Well-being of Future Generations (Wales) Act 2015, (Welsh Government, 2015), However, without a clear mandate for the National Safeguarding Service function there are some limitations to the function.

Other national functions have also become part of the NHS Executive, such as Improvement Cymru, the Collaborative and Delivery unit to name a few functions now in the NHS Executive. It was suggested that this could allow for cross function collaboration, for example benefiting from improvement expertise to build improvement capability within NSS and advise on the running of clinical networks from the collaborative. Additionally, it was suggested during the interviews by Improvement Cymru that the NSS would also be well positioned to provide safeguarding advice and expertise to relevant Improvement programmes such as Learning Disability and maternity programmes.

The National Safeguarding Service is predominantly made up of Designated Doctors, Designated Nurses, a programme manager, and support staff.

The role of Designated professionals in the National Safeguarding Service was raised by stakeholders in the insight gathering and has been debated historically. The purpose of the role links back to the Carlile review (2002), referred to previously in this report, and the role has expanded across the life courses. The Intercollegiate Document (RCN, 2019) also describes the Core Competencies of Designated professional roles, however, there are aspects of these not fully translated into the NHS Wales current context. Clarity on the Designated role is not unique to Wales as this was explored in the insight gathering interviews with representatives working in the English NHS system. There was a specific opportunity to speak to a Head of Safeguarding working in an Integrated Care Board (ICB), which is where Designated professionals are employed in England. The ICB in brief are statutory organisations established in July 2022 providing leadership to Integrated Care Systems, and is responsible for developing plans, commissioning, and managing budgets to meet the needs of the population and to improve population health, tackle inequalities, enhance productivity and support broader social and economic development of a particular geographical area. (NHS England, 2023). The reviewer was informed that the ways of working between ICB safeguarding teams including Designated Professionals and provider organisations is still evolving since the change from Clinical Commissioning Groups to ICB's. Getting the balance of oversight and collaboration between the ICB, and providers is not straightforward. The Designated

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professionals are also part of multi-agency arrangements. There is also oversight, assessment and assurance reporting at NHS England regional level and oversight and monitoring at a national level. Wales as a devolved nation, and as NHS Wales is arranged very differently to England, although it is recognised some regions in England are a comparable size to Wales. Because arrangements are so different at a regional and ICB level, there did not appear to be any real standout approaches to be lifted and applied in Wales about how Designated Professionals perform their role.

There were also discussions held with Scottish government in relation to Safeguarding arrangements at a policy level, however these discussions were focused on strategic policy and did not get into levels of detail on arrangements within NHS Scotland, as officials were unavailable at the time of the interviews.

The Intercollegiate Document (ICD) identifies Core Competencies for Designated Professionals including but are not limited to; supervision, advice to other safeguarding specialists, Training Needs analysis, commissioning, designing, and delivering training, quality assurance and improvement, innovation and learning lessons where children and young people die or are seriously harmed from neglect or maltreatment.

While the ICD is a helpful framework to inform NHS Wales, it needs to be applied in the context of arrangements in Wales. For example, Designated Professionals provide some bespoke training or knowledge provision commensurate with their knowledge, skills, and experience. These have included annual conferences, masterclasses and recently training for Medical Directors. There would not be sufficient resource and capacity for Designated Professionals to routinely provide training for Local Health Boards and Trusts unless a specific topic needs commissioning. However, specific topics areas are likely to be relevant across NHS Wales. Therefore, to be more efficient with limited resources, Master Classes may be better provided on an all-Wales basis to a specific group of professionals.

In addition, there could be opportunities especially for Designated professionals who are not directly clinical, i.e. Designated Nurses, to provide a proportionate and agreed amount of time working more closely with LHB's and Trusts.

From the insights gathered, the provision of supervision from Designated Professionals for those working in corporate safeguarding functions within LHBs and Trusts, is generally accepted. However, some issues were raised about how Designated Professionals remain conversant with experiences of those working in LHBs and Trusts, there were views expressed that things have changed and continue to change the time in operational settings. This does pose a question how Designated Professionals retain credibility and exposure to the experiences closer to the front line. This is less of an issue for Designated Doctors and the lead GP who continue to perform clinical duties in Health Boards and primary care as well as their duties in the NSS (More will be discussed in section seven about safeguarding supervision).

There were concerns raised from stakeholders about the imbalance which has emerged recently, due to retirement and other retention challenges, impacting on the ratio of medical to non-medical staff within the NSS. It was suggested this limits the opportunity for broader perspectives within the NSS, recognising the value all

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professional backgrounds bring and diversity of thinking is an important feature of high performing teams. Some stakeholders from the wider NHS were concerned that there was also a knock-on effect on the Named Doctor Safeguarding Children roles, who require external clinical expert advice and to feel confident in considering different career options knowing they can access the right level of support and mentorship. There were some views that Named Doctors could be discouraged from going forward for national Designated Doctor roles, if they did not observe visible medical leadership within the NSS.

Primary Care is an essential part of core health service delivery to individuals and families needing to access a range of services to meet their health needs. It is also understood that there are pressures on primary care services currently with additional workforce challenges. Interviews with primary care were limited for the review. The role of the lead GP in safeguarding has been a key step forward and there have been national discussions in relation to Safeguarding in primary care. However, from the limited discussions there remains work to do in terms of awareness raising and understanding the barriers to effective communication and improving systems and processes for Safeguarding arrangements within primary care. Recognising there are many competing priorities which also pose risks to health and life. There is only one lead GP role in the National Safeguarding service contracted for four sessions a week, which equates to two days a week.

Discussions with Designated professionals confirmed involvement at LHB and Trust Safeguarding Committees or equivalent. Heads of Safeguarding and Executive Directors of Nursing representatives interviewed from Health Boards and Trusts, welcomed the involvement and contribution of Designated Professionals at organisational Safeguarding Committees/Groups. There are also recent examples of Designated Doctors and Nurses being commissioned to provide specific assessments or views on services or standards on behalf Health Boards. These are examples of providing benefits to NHS organisations by providing them with opportunities for more objective external assessments and/or assessment against best practice standards.

Some of the interview discussions identified that there is a lack of join up between national Safeguarding and national midwifery structures and Named Midwife roles. There were some views expressed that there is currently a national gap in focus and leadership for Safeguarding in Midwifery, created by the absence of a Designated Midwife for Safeguarding role within the National Safeguarding Service and representation at the Safeguarding Network. There was not an opportunity to speak to the Heads of Midwifery during the interview phases of the review, however relevant government officials and other stakeholder were interviewed. Named Midwives in Safeguarding do not appear to attend all Wales Safeguarding Network. The role of midwives during the antenatal and postnatal period working with parents, newborn infants, and with the wider family have a key role to recognise and respond to safeguarding risks, such as Domestic abuse and child protection concerns (Welsh Government, 2001). This appears to be an important area where collaboration nationally between midwifery leaders and the NSS needs to be strengthened.

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There was also feedback given separately from the National Safeguarding Service and other national functions, such as Health Inspectorate Wales and the Commissioning unit that they were not clear on each other's different priorities and

arrangements, and therefore were unaware of opportunities for collaboration and sharing intelligence and professional perspectives.

The role of Designated Professionals involvement at Regional Safeguarding Boards had little commentary from the stakeholder interviews. However, there were some views expressed by one Chair of a Regional Safeguarding Board about Designated Professionals no longer being operationally involved with Child Practice Reviews, Adult Practice Reviews, and Domestic Homicide Reviews. This change was made due to the limited national resource and refocusing on driving national improvements to improve quality, standards, and consistency across NHS Wales. There were also concerns at the time relating to data protection in terms of data retention and data processing of Health Board records, which the NSS had no lawful role in. However, contribution from Designated Professionals as an independent voice for health at Regional Safeguarding Boards (RSBs) continued. The Chair of this RSB had a view that further clarity was needed on the role of Designated Professionals at Regional Safeguarding Boards. There was an additional point made that there were opportunities to have more focus on population approaches to safeguarding which required more focus. This is currently seen as a gap in terms of the right health knowledge and expertise being available. It was anticipated that Directors of Public Health and/or Public Health Consultants would be best placed to offer this area of knowledge and skills.

The role of Designated Professionals at Regional Safeguarding Boards warrants further discussion beyond this review, as considerations will need to be given to any recommendations from this review which may be implemented. However, a broader point is that Designated Professionals in their strategic national roles will need to have a good ongoing understanding of RSBs and this is best achieved through participation. The balancing of national work against regional work will always need to be fully considered.

This section has highlighted some of the structural and leadership gaps at a national level, particularly in midwifery and primary care, it also questions the level of connectedness between national functions.

There appears to be a current risk in the ratios of medical and non-medical roles in the NSS, impacting on the wider system. There will need to be further consideration of the roles of Designated professionals in RSB's, balanced against current and potential national role functions.

7.2. Opportunities to Strengthen

This section seeks to identify opportunities to strengthen the National Safeguarding Service.

As the NHS Executive is now established and has an important strategic leadership role as described more fully in the earlier section, there is a strong rationale for the National Safeguarding Service to move into the NHS Executive. The remit of the NHS Executive is likely to bring a strengthened mandate to the work of the NSS which in turn will provide opportunities for greater oversight for Welsh Government and bring benefits to NHS Wales. The NSS will need to have access to the data and

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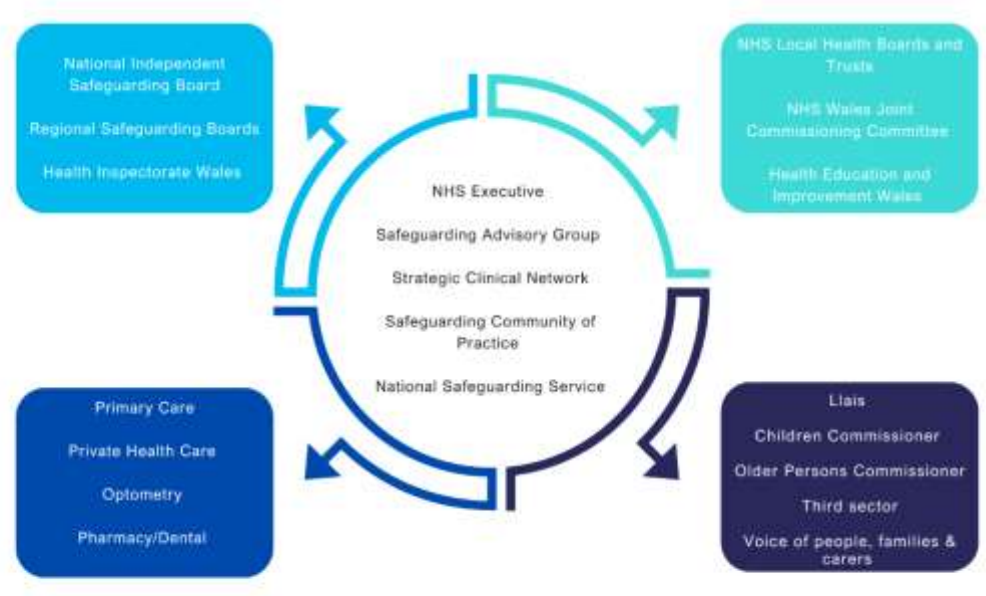
support with data analytics to be able to visualise and interrogate the data in order to inform actions.

Integrating the National Safeguarding Service (NSS) into the NHS Executive will enhance strategic leadership and oversight, benefiting NHS Wales. NSS needs robust data access and analytics to inform actions. Designated professionals should work closely with NHS organisations for deeper insights and provide expert, objective feedback. A review of resource allocation is necessary to ensure equitable distribution across regions. Enhanced succession planning, recruitment for safeguarding specialists, and better collaboration with national functions and public health experts will further strengthen the NSS.A core role of a strengthened NSS would be to support the NHS executive in achieving greater national oversight. This would require Designated professionals to provide a greater scrutiny role. The NSS would also help the NHS Executive to support any revised network and associated arrangements. **Figure 3** provides an illustration of strengthened key stakeholder relationships for the NSS.

Figure 3 NSS key stakeholder relationships



The role of the Designated Professional in response to some of the comments shared from stakeholders could be strengthened by working more closely with NHS organisations, having a greater understanding of some of the organisational challenges and issues of the organisation through regular updates with the Executive Directors of Nursing (EDON) and Heads of Safeguarding. Designated Professionals can offer a combination of expert knowledge, greater objectivity than internal scrutiny alone, and provide a national perspective. EDON's could request areas where objective feedback on specific safeguarding issues would be welcomed, together with suggestions for improvement.

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This arrangement would not prevent any additional pieces of work being commissioned by LHBs or Trusts, to be undertaken by a Designated Professional with a skillset that matches an identified need.

The NSS employs a mix of part-time, full-time, and sessional Designated Professionals. To ensure equitable resource distribution, it would be beneficial to review the current assignment of these professionals to Health Boards and Trusts. This should focus on ensuring assignment is equitable across North, Mid and West, South, and Southeast Wales, as well as national organisations, considering the workforce size of each organisation.

There are opportunities to promote and focus efforts on improvements in succession planning and recruitment particularly for medical Safeguarding specialists, with support and advice from workforce specialists and Health Education and Improvement Wales. There is also opportunity to consider whether the NSS primary care resource is sufficient, given that, *A Healthier Wales*, (2021) aims to shift health and care from acute based care, to home and community-based health and care.

There was a general recognition that the support for adult safeguarding in the NHS system is less well developed than that of safeguarding children, young people and Looked After Children. The NSS has limited resource with expertise in adult safeguarding, the mental capacity act and deprivation of liberty safeguards. This limits what can be offered to the Health Boards and Trusts in terms of expertise. Therefore, there are opportunities to strengthening knowledge and expertise in this area.

In the previous section it was identified that other national functions were not currently working collaboratively. Therefore, there are opportunities for better collaboration between national functions that are relevant to safeguarding and quality and safety, whereby perspectives on priorities, best practice standards, intelligence, and learning can be shared. For example, Health Inspectorate Wales.

There is opportunity to explore contribution from Directors of Public Health or Public Health Consultants to providing population and public health approaches to the work of Regional Safeguarding Boards.

In summary, moving the National Safeguarding Service (NSS) into the NHS Executive to enhance strategic leadership, scrutiny, and oversight, is likely to strengthen overarching Safeguarding arrangements in NHS Wales. The NSS will need access to data and data analytical support for analysis which can be used to inform actions. Designated Professionals should work closely with NHS organisations for deeper insights and provide expert, and objective assessment and feedback. NSS resource alignment to LHBs and Trusts should be reviewed to ensure equitable distribution across Wales. Enhanced succession planning, recruitment of medical Safeguarding specialists, and improved collaboration with national functions and public health experts will further strengthen the NSS.

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Recommendation 4

The National Safeguarding Service should transition to the NHS Executive along with other national functions providing leadership, scrutiny, oversight, and advice to

Welsh Government officials. It will also provide support to NHS Wales and any revised national Safeguarding network arrangements. This may require an amendment to the Public Health Wales Standing Orders and the NHS Executive remit letter. The roles and responsibilities of the NSS and Designated Professionals should include but not be limited to:

- NSS supporting the NHS Executive to have in place effective scrutiny, system learning and evaluation arrangements for NHS Wales.
- Designated professionals working in collaboration with LHB's and Trusts to provide leadership, supervision, support, assessment, and feedback working with NHS organisations and Executive Directors, utilising approved and published Safeguarding Quality Standards and other evidence-based information and tools.
- The NSS working routinely with Health Inspectorate Wales, Llais and the Welsh Health Specialised Services, particularly the Commissioning Unit and National Independent Safeguarding Board and arrangements to meet with Regional Safeguarding Board Chairs on an all-Wales basis. Arrangements for sharing expertise, knowledge, evidence, person centred approaches and intelligence, to be on a regularised basis.
- The NSS providing a horizon scanning function and, undertaking, participating in or commission Safeguarding research.
- The National Safeguarding Service should identify strategies within existing resources, to address workforce implications for the service and broaden the diversity and range of skills required to maximise innovation and impact.
- focused effort to ensure that there is more balance in the ratio of Medical to Non-Medical Designated professionals, including resourcing for lead GP roles and those with knowledge and experience in adult safeguarding. and those with knowledge and experience in adult safeguarding.
- At the earliest opportunity create a Designated Midwife role.
- A widening of professional disciplines to broaden experiences within the service.
  For example, from Allied Health Professionals and Social Care Professionals.
- Identify how the NSS acquires access to knowledge and skills in data science, improvement science, behavioural science and evaluation to increase capability in these areas and accelerate opportunities for impact.

Recommendation 5

The Welsh Government health and social services policy leads, Directors of Public Health and Chairs of Regional Safeguarding Board should explore what mechanisms can be introduced (or shared if arrangements already exist in other RSB's) to provide public health and population health knowledge, skills, and expertise to Regional Safeguarding Boards.

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7.3. NHS Safeguarding Network

The background to the NHS Wales Safeguarding Network has been detailed in the Background and Context section of this report and will therefore not be repeated in this section. Points have also been explored and made in Theme 2, in relation to prioritisation approaches and methods which the Network is involved with and will not be repeated in this section.

This section instead will explore some of the views of stakeholders who were interviewed and asked about their knowledge and views of the Network. This section will also consider how the Network aligns to current guidance on networks in NHS Wales.

The interview discussions included stakeholders who are not currently involved with the Network and were unclear about the purpose and arrangements of the Safeguarding Network, which could suggest it has not been sufficiently well promoted and/or the membership configuration has limitations in relation to stakeholder reach and impact.

Relevant information was reviewed and included the *National Clinical Framework Implementation Programme (pages 5,9,11, NHS* Wales, 2021), identifying that the current Safeguarding Network could be most closely described as a hybrid arrangement, between an NHS Wales Community of Practice and an NHS Wales Safeguarding Implementation Network as identified in the Framework. The current Network does not appear to be operating at the level and criteria of a National Strategic Clinical Network. The main gaps relate to quality statements with identified service standards and outcomes, together with access to meaningful data, and having an upstream focus. Strategic Clinical Networks are also intended to be **"organisation and profession agnostic"** (NHS Wales, 2021).

The key reason of a National Strategic Clinical Network to exist is to (NHS Wales 2021 pg. 10 and 11): -

- "Provide a clinically led and informed, evidence-based national perspective for their respective areas of scope
- bring clinicians, and other stakeholders, together to develop nationally consistent principles and pathways of care, agnostic of local organisation, in support of Quality Statements
- support metrics for monitoring, reporting and escalating issues where necessary".

National Strategic Clinical Networks are defined usually by one of the following criteria (page 10, NHS Wales, 2021).

- "Major conditions (e.g. cancer)
- Categories of service (e.g. maternity and neonatal care)
- Target population segments (e.g. women's health)"

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It is reasonable to see how there is scope and opportunity to align Safeguarding People with one or more of the above criteria.

The current Network membership according to the Terms of Reference (See **Appendix 4**), is currently made up of the NSS including Designated Professionals and the Lead GP national role, Executive Leads for Safeguarding LHBs and Trusts (where necessary Executive Leads may delegate to a suitably senior colleague), Assistant/Associate Directors with Safeguarding responsibilities in LHBs and Trusts, LHB GP safeguarding leads, Observers from Welsh Government, CNO, CMO, Social Services and Integration Directorate (part 2) and observers from the Children's Commissioner for Wales and Older Peoples Commissioner and National Advisors for VAWDASV (Part 2).

From the membership list, it is evident that the expectation is for more senior level of involvement. The reviewer was informed that attendance by Executive level professionals, Primary Care GP leads, Named Doctors and Named Midwives from Health Boards has been minimal. This will have an impact on the range of discussion. For example, it would be impossible to replicate the wider lens and perspective of executive level contribution as the role predisposes them to having a more in-depth understanding of the competing risks, priorities, and challenges which health bodies are grappling with. What is more is that the perspective of primary care safeguarding is best understood by those with lead roles in that setting. However, there is a considerable challenge of competing demands for executives and primary care professionals in terms of available capacity.

The network appears to currently work within its sphere of influence and may not have direct access to some of the levers of change. For example, digital transformation.

Discussions were held with two of the other UK nations in relation to understanding more about the safeguarding related systems and arrangements in place in the different NHS administrations. Due to the time constraints of this review and available diary capacity of colleagues in the other nations, the more detailed discussions were held with NHS England. Although there was some useful learning to take from the discussions, there are significant differences and divergence which exist between the two administrations which makes it difficult to adopt approaches on a like for like basis. However, with the NHS Executive now in place in Wales, there are options of adapting some of the national assurance arrangements in a context for NHS Wales. For example, more reliance on standards and metrics for oversight. NHS Wales could go further to aim for access to real or right-time data, visualised on a dashboard for local and national utilisation. This would drive improvements and inform strategic priorities.

Several stakeholders who were interviewed offered views that the current Safeguarding Network would benefit by being strengthened. There were also suggestions made that there would be added benefit to also having a Strategic Advisory Group chaired by the Chief Nursing Officer. The purpose of the Advisory Group would be to bring additional strategic knowledge and critical thinking from outside of the NHS and government. Suggested examples of membership of a Strategic Advisory Group were, the National Independent Safeguarding Board, the Children and Older Person's commissioners, the Chief Executive of Llais, plus

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representation from the Chairs of Regional Safeguarding Boards. Stakeholders with views on membership of any proposed new network, envisioned that a Strategic Safeguarding Clinical Network would have a broader range of senior clinicians and senior professionals with expertise in Safeguarding vulnerable children and young people, Looked After Children and Safeguarding Adults and Older People or expertise which would be complimentary. In addition, representation by those who can provide external perspectives on person centred approaches or other relevant fields. The Strategic Network would also benefit by support from Digital Health Care Wales, Improvement Cymru and the Collaborative to provide the necessary expertise for developing digital pathways, developing real time indicators and outcome measures and improvement approaches and advice on establishing and running a network as described in the network framework.

There was also the suggestion arising from stakeholders that an all-Wales *Safeguarding Community of Practice* could also be established, building on the current Safeguarding Network but open to a wider group of professionals from the health sector and could potentially include social care. This could include the private health sector and representatives from care homes, the focus would be on sharing and learning from practice and improving quality and safety in safeguarding. The reviewer was informed about other 'Communities of Practice,' which were being successfully run which could offer valuable suggestions.

7.4. Opportunities to strengthen.

To set a new expectation with greater scrutiny and accountability for delivery and a broader perspective in contributing to setting priorities, approaches, outcomes and impact, the *National Clinical Framework Implementation Programme* document has been used as a basis to provide a proposed outline revised structures for how NHS Wales could be organised to build upon and strengthen current arrangements.

As discussed in the previous section, the criteria for a Strategic Clinical Network appears to have been met.

Figure 4 proposes a model of an all Wales proposed governance structure which is anticipated to support a strengthened approach to NHS Wales Safeguarding arrangements.

The governance model is a three-tiered structure with a *Strategic Advisory Group*, the membership of which would include a range of key senior officials who are well regarded from outside of the NHS, to provide Welsh Government with strategic thinking in the field of Safeguarding and will also provide some externality and appropriate challenge to NHS in Wales.

The second tier provides a *Strategic Clinical Safeguarding Network*, to provide an expert and clinically led and informed, evidenced based national perspective in safeguarding in NHS Wales, which will bring together key stakeholders including relevant clinicians to develop nationally consistent principles and pathways and arrangements for effective safeguarding in NHS Wales, in support of agreed Safeguarding Quality Statements.

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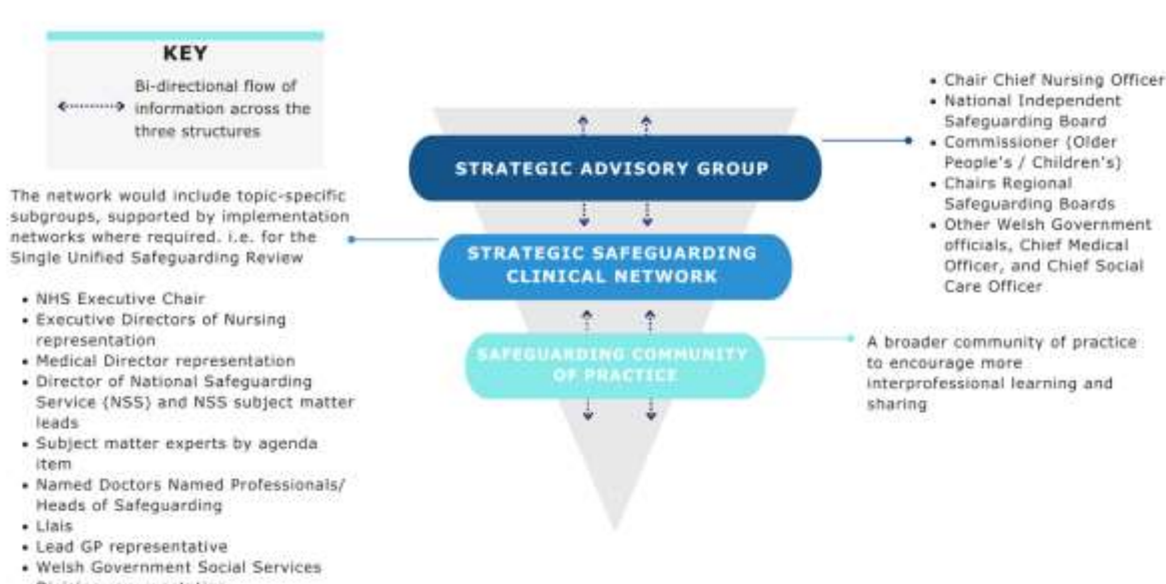
The third tier proposed is a *Community of Practice* providing a forum for clinicians and stakeholders with a broader definition of health to come together and agree areas to improve safeguarding outcomes. The functions are described in section 4.4 of the National Clinical Framework Implementation Programme (NHS Wales, 2021).

Implementation Networks can also be established to implement specific programmes of work, an example could be the implementation of the Single Unified Safeguarding Review.

Information flows are intended to flow up and down between the structures.

Figure 4. Three tier NHS Wales Safeguarding Governance Structure



In summary, this section has explored stakeholder views and relevant information to consider how the NHS Safeguarding Network could be strengthened. An outline conceptual model has been provided with an illustrative diagram to support the narrative. This proposed model will provide a broader set of strategic stakeholders, which is anticipated to widen the sphere of influence, providing suggestions for approaches that can gain traction and achieve impact and outcomes on identified Safeguarding priorities in NHS Wales. This will also bring benefit to addressing gaps and risks identified at regional levels.

Recommendation 6

The Welsh Government overseen by the NHS Executive should implement a new three tier NHS Wales Safeguarding governance structure to include a 1) Safeguarding Advisory Group, a 2) Safeguarding Strategic Clinical Network and a 3) Safeguarding Community of Practice. Guided by the *National Clinical Framework Implementation Programme* and implementation supported by the NHS Wales Collaborative.

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An assessment of the current Safeguarding Network should be undertaken to identify what elements should transition to the Clinical Network and the Community of Practice.

Structures to be implemented: -

- (1) Safeguarding Advisory group
- (2) Safeguarding Strategic Clinical Network
- (3) Safeguarding in Community of Practice

7.5. Child Death Review Panel

It was suggested by some stakeholders that it was important to include and hold a discussion with those involved with the 'Child Death Review Programme'(Public Health Wales, 2024). Although the programme is not focused directly on Safeguarding, it has a focus on child deaths which sadly does include children who have died from abuse and neglect. One of the aims of the programme is to identify learning and publish reports with relevant findings to help to prevent future avoidable deaths. The reviewer was only able to consider the 'Child Death Review Programme' briefly, recognising this is an important function for learning.

The Child Death Review panel process in Wales is not a statutory process. However, in England, the arrangements are on a statutory footing called 'Child death overview panels (CDOP). The reviewer was informed despite mechanisms being in place, there are some difficulties in receiving all information required by the review programme panels and information was often slow in being obtained. This means that not all available is consistently received, this could lead to important learning being missed.

Reports are published by Public Health Wales regularly and include Thematic Reviews, Rapid Reviews and Annual Reports.

In addition to the reports being published there are arrangements in place to ensure that any identified specific clinical performance and standard issues are fed back to relevant health professionals.

7.6. Opportunities to strengthen

Despite additional processes having been implemented to improve relevant information being submitted to the 'Child Death Review Programme', and the update of the *Procedural Response to Unexpected Deaths in Childhood* (2023) by the NSS, those involved closely with the programme are of the view that if the process was placed on a statutory footing it would improve compliance, and therefore, improve the quality of the findings and opportunities to learn. A paper was previously submitted to Welsh government on this matter; however, this predated Covid 19, and policy leads have now changed.

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Recommendation 7

The Welsh Government should consider placing the *'Child Death Review Programme'* on a statutory basis, to improve the quality of learning from child deaths, which could also contribute to learning in the context of safeguarding children and young people.

7.7. Corporate Safeguarding Teams

Interviews revealed that Corporate Safeguarding Teams in NHS Wales vary in size and structure, though most adopt a centralised model with some decentralised elements. These teams are led by Heads of Safeguarding or equivalent roles, who oversee a broad range of safeguarding responsibilities. Some teams include 'Looked After Children' in their structure, while others do not. The teams generally possess the skills and knowledge to advise on safeguarding children, young people, and adults at risk, as well as issues related to Violence Against Women and sexual violence.

Heads of Safeguarding emphasised the importance of good communication whether a centralised model or a hub and spoke model.

Continuous feedback loops and opportunities to share experiences and for the corporate team to be exposed to different operational environments experienced by staff was said to be important during some of the interviews. This was said to help corporate teams to better understand the challenges faced by staff.

Stakeholders expressed concerns in interviews about the insufficient number of sessions allocated to the Named Doctor role, with most Health Boards providing only three sessions a week, equating to a day and a half. This level of resourcing was considered inadequate for fulfilling the role's responsibilities. In contrast, one Health Board had a full-time Named Doctor, several assistant Named Doctors, and additional medical resources for child safeguarding, allowing for more involvement in multi-agency meetings and a strong audit program. The feedback highlighted inconsistencies across NHS Wales in resourcing for this role.

Although the remit of this review did not include Looked After Children, there were stakeholders who wished to feed in perspectives on this critical area. There was a view that the arrangements for Nursing leadership for Looked After Children (LAC) was well resourced. However, this was not said to be the case for Lead Doctor roles for LAC, suggesting this area was under resourced and a bigger gap was described in relation to contributing to non-statutory panels for fostering and kinship carers. The reviewer heard that reports for these panels were frequently completed outside of contracted hours, as it was deemed important to provide a health perspective.

The interviews indicate that a Named Doctor role for Safeguarding adults at risk has not been established. Concerns were raised by some stakeholders that NHS organisations do not allocate the same resources and commitment to adult Safeguarding as they do for children. It is important for all health practitioners to understand their responsibilities in protecting adults and considering mental capacity and deprivation of liberty safeguards, this has not led currently to the creation of a specific Named Doctor role for adults. The concern being without dedicated clinical

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roles to lead adult safeguarding efforts, there is a risk of inconsistent application of standards and a lack of focused improvement efforts, potentially creating disparities between the safeguarding practices for adults and those for children and young people.

Given that adults constitute a larger portion of NHS Wales patients and service users, there is an opportunity for Health Boards and Trusts to reassess current adult safeguarding arrangements, including medical resourcing to see whether there is sufficient strategic focus to drive improvement to prevent harm and reduce it's impact.

Stakeholders from NHS England who were interviewed, informed that there were no plans currently to introduce a Named Doctor role in health settings.

7.8. Opportunities to Strengthen

The variation of resources allocated to corporate Safeguarding teams, may be explained by differing needs of the population and organisation. It is beyond the remit of this review to give specific views on models and workforce establishments for Corporate Safeguarding functions. However, there is an opportunity for the Safeguarding network to undertake a benchmarking exercise against population and workforce numbers for Health Boards and Trusts if this has not been carried out.

There was sufficient concern expressed in the interviews with stakeholders, that there are specific challenges around medical resourcing for Named Doctors and Looked After Children and the medical support structures for Safeguarding. This deserves closer attention. The issue of medical resourcing in the context of Safeguarding is also referred to in Theme Seven.

Recommendation 8

The NHS Wales Safeguarding Network led by the NSS, in collaboration with Heads of Safeguarding, should undertake a detailed benchmarking exercise, taking into account population and workforce size of organisations or geographic markers in the data set.

to include:

- Corporate Safeguarding human resources (Medical/Non-Medical)
- Looked After Children human resources personnel,
- Medical sessions allocated to Safeguarding, LAC and Adoption

The findings should be shared with relevant Board level Committees to inform overall assurance and address any identified risks.

8. Theme four: System interaction

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The term system in this context refers to the NHS in Wales, health and social care and Welsh Government.

The theme of System interaction explored with stakeholders their perspectives and experience when interacting with different parts of the Safeguarding system. This included interaction within organisational departments and teams, with other NHS organisations, with relevant agencies such social services duty/contact teams and also extended to interaction Welsh Government.

"A bad system will beat a good person every time" Deming (1993). This quote highlights the futility of trying harder within a current system, and that success needs to be built into the system.

Digital systems will be discussed further in Theme Seven, however, digital systems were discussed in relation to this theme also, specifically how they can act as a barrier to effective communication and interaction. Digital systems in NHS organisations do not interact between organisations and there are limited examples of interaction between health and social care, which builds in inefficiencies and can impact on timeliness of communication.

8.1. Sharing information

Sharing information appropriately and lawfully to keep people safe from abuse and neglect is a key expectation in safeguarding people policies and procedures. E.g. Welsh Government 2019. Safeguarding training regularly emphasises the point that different teams and services hold different pieces of information. In isolation, this may not appear to be a risk to safeguard people from harm. However, when information is shared appropriately it provides a fuller picture which is fundamental to informing assessments and keeping both children and adults safe from abuse and neglect.

There were examples of good interaction identified during the interviews. For instance, health visitors meeting with social workers to discuss shared cases.

In the literature read and in the stakeholder interviews there were historical examples identified whereby there were barriers to effective information sharing across different departments and teams within organisations. For example, between Accident and Emergency and Child Adolescent Mental Health or between midwifery and health visiting, the interviews provided insights that highlighted a number of barriers to effective interaction and communication. These included different record systems and busy caseloads.

Information sharing usually relies on individual members of staff speaking to each other in person or by phone, and ensuring records are updated with contemporaneous information. For systems and processes to work well they need to consider human factors and be co-created with the staff who need to use them. It is cited by Brennan and Oeppen (2022) that humans make up to seven mistakes a day and healthcare environments are directly impacted by human factors.

Safeguarding related reports often cite examples of information not being shared appropriately (McManus et al., 2023) Both within health and across agency boundaries social care and the multi-agency context.

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The lack of a single digital patient record and efficient digitally enabled information sharing, has an impact on timeliness and robustness. As well as this, it was described as inhibiting efficient reporting capability.

There were examples shared where digital processes have been created within some organisations to provide an electronic audit trail of referrals. The reviewer was informed that the upgrade of the Wales Datix system safeguarding module, was intended to allow referrals to be made and recorded on the system with confirmation of receipt of referrals. However, the implementation of this has faltered.

During the interviews, front line staff spoke favourably of the access and support provided by corporate safeguarding teams. Stakeholders described arrangements in place for staff to get advice and support from corporate Safeguarding teams, which was predominantly available Monday to Friday and a front desk-type arrangements for staff seeking ad-hoc support and advice within the Health Boards.

Relationships with multi-agency partners are reported in some reports as generally positive (Joint Inspection Review of Child Protection Arrangements, 2023). In the interviews for this review, there were many examples given during the interviews of NHS staff in various parts of Wales, describing challenges with different interpretations of referral thresholds between health and social care. This includes an example shared in a CAMHs context, where the corporate safeguarding team would be contacted to assist the CAMH's team in identifying keywords to use in a referral, which would be more likely to be accepted as a referral and for a concern being raised to be acted upon.

There were only two stakeholders interviewed who worked in Primary Care. One of the primary care stakeholders described a recent negative experience when interacting with social services. The example given was one of having difficulty in getting a referral accepted by social services. This created frustration particularly as the importance of taking action to report a concern to social services, was always emphasised strongly in training, this experience was seen as a contradiction.

A system approach acknowledges that human beings are fallible and will be susceptible to errors. Therefore, digital, and other systems and solutions need to be co-created with staff.

8.2. Partnership working at Director and Senior levels.

Views provided in the interviews with very senior health professionals, identified concerns in understanding how different thresholds and procedures are applied by social services regarding professional concerns. For example, when a member of staff is subject to concern under part five of the *Wales Safeguarding Procedures* (Welsh Government, 2023) Although procedures are available to inform how processes work, there were views expressed that procedures for these situations may be applied in a binary way, when concerns which arise are often more nuanced. There were examples given that the views of health professionals were at times overlooked. Inconsistency and unpredictability in responses caused confusion, with similar scenarios receiving different responses. Participants noted that safeguarding decisions often involved nuances, while the application of procedures was at times experienced as binary. Health professionals also highlighted other risks, such as

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referrals to regulatory bodies and service delivery SUSR considerations which also need to be managed. While there are procedures for handling professional differences, these examples appeared to warrant a more interpersonal approach.

There were good examples of system interaction between some of the Heads of Safeguarding collaborating with neighbouring health boards. For example, developing a supervision training package. There were also some views expressed that there was not enough sharing between NHS organisations, in sharing products such as training packages and policies. The Safeguarding Network may not currently have sufficient time allocated to leveraging the sharing and learning opportunities between NHS organisations.

Regarding national functions charged with support and scrutiny roles for NHS Wales, the interviews revealed that there is no established mechanism for information exchange, sharing of knowledge assets and collaboration between the National Safeguarding Service, Health Inspectorate Wales (HIW), and the Commissioning unit. The reviewer was informed that the NSS did historically meet with HIW, however, this seems to have dissipated in recent years and the HIW representative did not have knowledge of this historical arrangement.

Views of Regional Safeguarding Board Chairs described interaction with 'health' as generally good, particularly in relation to those in regular attendance, which included those in deputising roles for the Executive Director of Nursing.

There were several views expressed by executive level leaders from NHS Wales (health), that as health partners they did not always feel like equal partners at RSBs. This was suggested to be in part because social services always hold the RSB Chair role. There were some examples given that in some cases this has led to executives regularly delegating attendance at RSB meetings to deputies. There were some views shared that this could impact on the level of discussion at the Regional Safeguarding Board. It was also suggested that executives are not having sufficient exposure to multi-agency decision making and learning. Although only a small number of RSB Chairs were interviewed, they expressed being open to discussion on different chairing arrangements, however it was highlighted there was a high level of time commitment required. There was also an interest expressed in having different skills and knowledge from health around the RSB table, such as Public Health Consultants to bring more awareness on potential population approaches to safeguarding and to consider the role of the RSB in the prevention of abuse and neglect, for example interventions in Adverse Childhood Experiences.

8.3. Opportunities to strengthen

This theme considered a broad high-level overview of experiences of system interaction, this section aims to identify specific opportunities to strengthen system interaction.

Having a better understanding of human factors and what can potentially go wrong needs to inform improvement approaches to systems, processes, and pathways to improve system interaction to reduce preventable errors. This also requires improvements in digital and technological solutions to better connect the health and care system, co-created by those who need to use the systems and processes.

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Theme seven will also refer to the need for digital improvements. Regarding Datix development, the reviewer has been informed further progress is being explored.

There is opportunity to form a greater shared understanding about how thresholds for referrals and interventions are applied between health and social services. Good system interaction between individuals, teams and organisations requires the building and maintaining of positive interpersonal relationships. Multi-agency training is often referred to as best practice and provides opportunities to understand different agency and professional perspectives and for networking. (McManus et al 2023) However, like any relationships they require time and effort to build and maintain. With busy workloads this is an area which is likely to be negatively impacted, therefore it is important that these opportunities are fostered.

It may be useful to consider approaches in other examples of partnership working such as emergency planning. In this example Directors or senior level partners from different agencies undertake gold command training together. This provides an opportunity to form and build relationships and experience shared learning specifically geared towards senior and executive leaders usually from the same region. This idea was discussed with a Chair of one of the Safeguarding Boards during the interviews and was thought to be worth considering. This could also incorporate opportunities for Chairs of RSB's to have discussions and explore the benefits and risks associated with the potential of different approaches to Chairing RSB's.

There are also opportunities to firm up arrangements for information exchange between the NSS, Health Inspectorate Wales and the Welsh Health Specialised Services Committee, specifically the Commissioning Unit function. This could also include involvement from NSS at the HIW health summit.

In summary to reduce preventable errors, understanding human factors and improving digital solutions is essential. This involves co-creating systems with users and enhancing tools like Datix. Effective system interaction requires a shared understanding of referral thresholds and strong interpersonal relationships, supported by multi-agency training. Learning from emergency planning, where senior leaders train together, can also be beneficial. Additionally, improving information exchange between the National Safeguarding System, Health Inspectorate Wales, and the Welsh Health Specialised Services Committee is recommended.

Recommendation 9

Welsh Government policy leads, the multiagency Inspectorates and the Independent Safeguarding Board should work with Regional Safeguarding Board Chairs, to ensure that thresholds for Safeguarding People interventions are transparently, consistently, and equitably applied.

Recommendation 10

Regional Safeguarding Board Chairs and their partners should ensure there is multi-agency training available for the workforce commensurate with roles and responsibilities.

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Recommendation 11

Regional Safeguarding Boards should create the opportunity for a facilitated discussion with all partners to explore the benefits and risks of a broader range of partners being considered for the chairing role in RSB's.

Recommendation 12

The NHS Executive should ensure that Health Inspectorate Wales and the NHS Wales Joint Commissioning Committee (JCC) are members of the NHS Wales Safeguarding Advisory Group, and that there are arrangements in place for regular information exchange between the NSS, HIW and JCC.

Recommendation 13

NSS and Shared Services should continue to collaborate on the development and optimisation of the Datix safeguarding module capability. Implementation plans should be developed in conjunction with NHS organisations.

9.Theme 5 Individual and Organisational Behaviour

Organisational culture plays a significant role in safeguarding people and requires organisational cultures which are psychologically safe. Psychological **"safety has been described as *the shared belief that the team is safe for interpersonal risk taking"*** (Grailey et al., 2021 page 1) In health care environments psychological safety is described as an antecedent to quality improvement, and ability to speak up to minimise poor practice. (Grailey et al., 2021 pages 2 and 3).

To create such cultures, it requires leadership at all levels to continuously be striving for this. There needs to be a focus on compassionate and inclusive leadership and people-centredness. (West, 2021). Health Boards in Wales have large workforces, and all Wales Trusts have a workforce that is geographically dispersed. The Boards of organisations play a significant role in visibly setting the organisational culture and tone, with the aim through leaders and managers to reach all employees who make up the workforce.

Diversity and inclusion are important for the overall culture of an organisation, and a more ethnically diverse workforce can bring new knowledge and experience including lived experience, to ensure the NHS provides equitable services which are culturally appropriate. (Welsh Government, 2021) This awareness is equally important in the context of Safeguarding people in NHS Wales. Ensuring there is focus and attention on actively progressing diversity and inclusion strategies within organisations which adds to the creation of psychological safe environments overall. Ross (2020) identifies that the NHS has difficulty in sustaining people-centred inclusive cultures. The associated research suggests **"*that it is local action in teams, departments and organisations, where the work to create these types of cultures is most effective, because that is where the people are"*** *(Ross et al., 2020).*

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There are specific frameworks and guidance designed to support cultures which can help to make organisations safer for those receiving care, for their friends and families, and for those working in the NHS. The *'Speaking up Safely, A Framework*

for the NHS in Wales' (2023), recently published aims to create a speaking up culture in health. Although Safeguarding people is not explicit in the framework, promoting a culture of 'speaking up' feeds into creating environments which help to prevent or reduce the impact of abuse and neglect.

In this theme the reviewer attempts to explore some aspects of behavioural factors which can impact on safeguarding people at individual employee and organisational levels, by drawing out perspectives of those interviewed and consideration of additional supporting materials. This section of the report also considers the role of leadership in Safeguarding and how organisations signal what is important among competing priorities. This section will also consider some of the issues of cultural awareness, cultural competency, and unconscious bias in the context Safeguarding People and finally will consider Adverse Childhood Experiences, in considering upstream approaches to Safeguarding people.

Organisational

There were pertinent points made during the interviews with Executive Directors of Nursing about the correlation between staff wellbeing and safeguarding people. The importance of staff wellbeing and how it links patient safety is well documented (Hall et al., 2016)

There were some examples given during the interview of organisations investing time and attention on programmes to improve care environments focused on culture, team dynamics and psychological safety. This includes a focus on staff wellbeing, recognising sometimes challenging situations which staff are working in. Moreover, leadership in supporting staff was expressed as being important.

Other examples provided in the interviews related to the concept of a 'no blame' culture in healthcare. This is an important feature of patient safety principles and focuses on the learning. Views were expressed that the approach to adult and child practice reviews did not seem to offer the same principle of 'no blame' in terms of the application of the review processes. However, Chairs of Regional safeguarding Boards who were interviewed, did not share the same view and perspective seeing the process also focused on learning.

Stakeholders working in the NHS were asked how their Boards and organisations demonstrated to all employees that Safeguarding people was an important organisational commitment. There were mixed responses, some people felt their organisation had a lot of information visible within organisations, such as information placed on the intranet, while others thought that Safeguarding people Board level commitment could be more visible to staff within organisations.

9.1. Opportunities for Learning

The different views on the approach to child and adult practice reviews, suggests there is opportunity to share learning methods between health and social care. Timing seems opportune with ongoing work on the guidance development and implementation of the Single Unified Safeguarding Review.

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The reviewer did not hear about whether NHS organisations are sharing information about approaches to creating psychologically safe environments in different organisations across NHS Wales, if not then it presents a good opportunity to do so.

There appears to be some variation across NHS organisations on the visibility of organisational commitment to Safeguarding people, there is an opportunity for organisations to review this and make any changes for greater visibility.

Recommendation 14

Welsh Government in implementing the SUSR, should consider whether there is sufficient emphasis on a ‘no blame culture’ in the guidance and planning approaches for implementation.

Recommendation 15

NHS Organisations should ensure there is visibility to the workforce, of organisational and Board commitment to Safeguarding people.

Individual

The phrase ‘Safeguarding is everybody’s responsibility’ (Welsh Government, 2017), is often used. This is an important emphasis however, it requires individual employees to read policies and procedures, to undertake relevant training, and to recognise a safeguarding concern and intervene where they know or suspect that an adult/s, child/children, are at risk of abuse or neglect. The law in Wales now requires staff working in the NHS to report children and adults at risk of abuse and neglect to the relevant authority. It is important to emphasise that there are a wide range of roles in the NHS with various levels of knowledge, skills, experiences, and competencies. For example, those who routinely work with infants, children and their families such as midwives and health visitors, who are likely to be more familiar with safeguarding responsibilities. However, the NHS as a statutory partner for safeguarding people requires all staff to be able to recognise and report abuse and neglect.

McManus et al, (2023) highlights the term lack of professional curiosity features in reports. There does not appear be a shared understanding of what is meant by professional curiosity, and what barriers may exist to achieving sufficient professional curiosity. There are clearly behavioural elements to being or not being professionally curious. To this end there is more to understand on this subject and behavioural science and research can offer a valuable perspective on how staff could be supported in becoming appropriately curious, if that is what is required to strengthen safeguarding practice.

Behavioural science methods were used during the pandemic when there was a need to understand more about human motivation, in the context of getting people to comply with health protection policies and rules.

There was limited recognition of the potential benefits of using behavioural science to improve or strengthen safeguarding in health. However, some of the interviews did support the need to explore this further and those with expertise in this area could see the relevance of its application.

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There are several tools which could assist in understanding how to increase engagement and compliance in safeguarding requirements. The COM B model (Michie, van Stralen & West, 2011) suggests there are three conditions which need to be met before a behaviour takes place: capability, opportunity and motivation. This model is used extensively by the Behaviour Science Unit in Public Health Wales, and the unit is keen to increase knowledge of the model used in behavioural science often referred to *who, what, why not.*

During the background reading for this review, MINDSPACE (Dolan et al., 2010) was also identified as a tool to provide some different ways of thinking. This tool is used by the *Institute for Government* when considering approaches to introducing policy challenges. The pneumonic of the model is a checklist of influences on behaviour which can impact on policy implementation. Safeguarding people is such an important policy area that it seems sensible to consider different tools when seeking to improve or introduce new policies and procedures.

Figure 5

MINDSPACE

Messenger	We are heavily influenced by who communicates information
Incentives	Our responses to incentives are shaped by predictable mental shortcuts such as strongly avoiding losses. (loss could mean the loss of time, undertaking training)
Norms	We are strongly influenced by what others do
Defaults	We go with the flow of pre-set options
Salience	Our attention is drawn to what is novel and seems relevant to us
Priming	Our acts are often influenced by sub-conscious cues
Affect	Our emotional associations can powerfully shape or actions
Commitments	We seek to be consistent with our public promises and reciprocate acts
Ego	We act in ways that make us feel better about ourselves.

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This tool identifies two ways of thinking, automatic and reflective, sometimes referred as system 1 and system 2 thinking. Understanding more about how the different thinking styles impact on workforce behaviours in relation to training compliance for

example could be useful. Accessing expert behavioural science knowledge and skills to consider some of the challenges in safeguarding, could offer alternative and complimentary ways of looking at persistent challenges. The Reviewer was made aware there has been some exploration of the application of behaviour science to look at aspects of training in one of the Regional Safeguarding Boards.

Opportunities

There are opportunities to explore the contribution that behavioural science methodologies could make to improving the understanding of barriers to workforce compliance in Safeguarding People and make recommendations of how this could be improved.

Recommendation 16

The National Safeguarding Service should collaborate with the Behaviour Science Unit to explore opportunities to learn new and novel approaches, to persistent barriers in Safeguarding people.

9.2. Equality, Cultural competency, and unconscious bias

These are important subjects, and this review is limited by capacity in identifying comprehensive insights. However, the report seeks to drawer out a couple of points that could be considered.

NHS Wales organisations and other public bodies are bound by the Equality Act (2010) (Welsh Government, 2022) and must comply with the Public Sector Equality Duty.

This requires organisations to: -

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.
- Advance equality of opportunity between people who share a protected characteristic and those who do not,
- Foster good relations between people who share protected characteristics and those who do not.

Representatives from the Older persons Commissioners office and Children's Commissioner office were included in stakeholder interviews. They emphasised the importance of NHS organisations visibly taking a rights-based approach to working with and delivering services to children and older people. For example, visibly demonstrating a Children's rights approach in organisations in NHS Wales through *The* Right Way a Children's Rights Approach in Wales Children's Commissioner for Wales (2017). Plus, the Older people's Commissioner for Wales has two priorities which relate directly to Safeguarding older people, namely, stopping the abuse of older people and protecting and promoting Older People's rights, and asking for an end to ageism and age discrimination. The Welsh Government has also published the National Action Plan aimed at preventing the abuse of older people (February

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2024), which identifies a number of actions one of which is focused on workforce training standards to be approved by RSB's.

During the interviews there were a small number of people posing a question on whether Safeguarding adults was equally weighted to Safeguarding children and young people in resource investment in NHS Wales. Many policies take a life course approach to safeguarding people from abuse and neglect, this review cannot answer whether policies are applied consistently equally across the age ranges. However, it can be noted that a Named Doctor for adult safeguarding does not appear to currently exist, although there are non-medical professionals providing leadership. Some comments were made that without dedicated medical leadership there was inequity in having sufficient focus on driving improvements, including the quality and consistency of the application of the Mental Capacity Act and Deprivation of Liberty Safeguards. There were other views held that a dedicated Named Doctor role was not necessary as safeguarding adults should be part of the core competency of all health professionals.

One regional lead in England with a remit for safeguarding, informed that there was no appetite to create a Named Doctor role for adults/Older People at this time.

Named Doctors for children who were interviewed, informed that this subject was gathering momentum and multi-agency partners had expressed the need for a Named Doctor role who could assess non-accidental injuries in adults and older people at risk of abuse and neglect.

This subject will require further exploration and debate, beyond this review.

9.3. Cultural competency in safeguarding

There does not appear to have been much focus in NHS Wales, on training in cultural competency as it relates to safeguarding effectiveness. The reviewer was informed that some Regional Safeguarding Boards have provided some training on this. It appears from the discussions that further education and training in this topic is required, particularly with those more directly involved in safeguarding people.

Diversity of the workforce in the National Safeguarding Service and those representing NHS organisations at the NHS Safeguarding Network appears limited. Increasing diversity in this speciality is likely to broaden the range of experiences and perspectives.

Opportunities for learning

There are opportunities to explore arrangements in place for adult safeguarding specialist functions within NHS organisations, including if there would be equity, value and quality benefits to introduce a new role of Named Doctor for adult safeguarding into NHS Wales.

There is an opportunity to explore and identify plans to increase the levels of diversity in the speciality of safeguarding in the NHS. This is likely to require some collective national thinking in terms of establishing an approach designed to nurture a greater diversity of people going into safeguarding career pathways. This also aligns with the *Anti Racist Wales Action Plan.* (Welsh Government, 2021)

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Recommendation 17

The NSS should explore with NHS organisations whether a Named Doctor for adult Safeguarding would bring added benefits to the equity, value, quality and safety of current specialist workforce arrangements in adult Safeguarding.

Recommendation 18

The NSS and NHS organisations should seek advice from diversity and inclusion experts to scope opportunities to attract a more diverse workforce in to Safeguarding career pathways.

Adverse Childhood Experiences

Adverse Childhood Experiences (ACEs) includes violence, abuse or neglect in childhood and exposure to domestic violence within a child's home. The cycle of adversity can have an impact on multiple generations. Public Health Wales in (2016) reported that 47% of adults in Wales experienced at least one ACE and 14% experienced four or more, ACEs have an impact on, health harming behaviours such as smoking, alcohol and drugs, risk of chronic diseases such as cardio-vascular disease and cancer and consequently, can substantively impact health and wellbeing across the whole life course.

As the NHS is one of the largest employers in Wales, it is likely that many of NHS workforce have themselves been impacted by ACEs. In fact, some studies suggest those with greater firsthand experiences of ACEs are drawn more into caring professions resulting in even greater numbers of people in health and care professions having a history of ACEs. Consequently, many NHS staff are likely to have some impacts on their health and wellbeing that originate from ACEs.

We do not know the impact on staff who may have experienced ACEs, or whether it has an impact on their resilience at work, their values, and behaviours or whether it has any impact on their ability to respond to safeguarding issues. This could benefit from research.

There has been a coordinated approach to implementing ACEs in policing in South Wales through the project "Early Intervention and Prompt Positive Action: Breaking the Generational Cycle of crime (2018). Evaluation of the project suggests that the training police personnel received improved awareness and confidence of police officers and allowed them to intervene earlier and better meet the needs of vulnerable individuals. Positive perceptions of the police by the public also increased over the period of the intervention.

NHS Wales does not appear to have taken a sufficiently coordinated approach to ACEs, although some elements have been incorporated into training from an awareness raising perspective. The uncoordinated approach in the NHS is surprising given the number of touch points with the public and opportunities to intervene during episodes of care and service delivery.

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Further, the prevention of ACEs and action taken to support those affected by ACEs should help to reduce the numbers of safe-guarding related issues from escalating. It seems appropriate that the NHS could play a key role in preventing and reducing the impact of Adverse Childhood Experiences, particularly as this would also help to reduce the national burden of disease and health inequalities and consequent pressures on the NHS. Intervening in ACEs is part of a prevention to safeguarding and by intervening at this stage usually reduces the need for safeguarding escalation.

Responding to ACE's was discussed in the interviews and in general thought to be an important area which needs addressing. There were views shared that it has not been sufficiently clear what the role of health is in response to ACE's.

9.4. Opportunities to strengthen

Having more impact on ACEs requires a critical mass of trained people in the NHS, so that they can recognise and provide appropriate, typically low-level interventions. An ACEs E-learning training product is currently in development which could potentially provide an opportunity for a more coordinated approach across the NHS in Wales. Whilst ACEs interventions do not generally require escalation, training will help to ensure that people feel confident and can distinguish when safeguarding interventions may be required.

Further discussions will be required with the ACE hub to explore what approaches could be taken to maximise the role and impact of the NHS on the ACE agenda.

Recommended 19

Welsh Government, Public Health Wales ACE hub and the National Safeguarding Network should explore options for a clear and coordinated approach to ACEs in the NHS in Wales.

In Summary, this section emphasises the need to increase diversity and cultural competency within the NHS safeguarding and broader workforce. Additionally, it highlights the importance of a more upstream and coordinated approach to tackling Adverse Childhood Experiences.

10.Theme Six Assurance

This theme should be read in conjunction with Theme One, as there is a degree of overlap between the two themes. Therefore, this section will attempt to address the assurance elements not covered in chapter one.

The NHS Wales Quality and Safety Framework describes good quality as; Safe, Timely, Effective, Efficient, Equitable and Person Centred. These six domains can also be seen as relevant and applicable in the context of the quality of Safeguarding people in NHS Wales.

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One of the aims of this review was for Welsh Government to receive greater assurance on safeguarding arrangements in NHS Wales.

During the semi structured interviews information was provided that NHS organisations provide annual Safeguarding Reports as part of their Board assurance processes. Some organisations have taken steps to integrate some elements of safeguarding reporting into their integrated quality performance arrangements. Organisations continue to use self-assessment of the Safeguarding Maturity Matrix (SMM) (NHS Wales Safeguarding Network, 2019) REF as part of their assurance reporting.

The SMM was introduced in 2019 replacing the Safeguarding Children Quality Outcome Framework and subsequent all age frameworks. Developed based on robust evidence, the SMM emphasises service improvements against standards and continuous learning. A notable strength of the SMM is its peer review process, which provides Safeguarding leads with a platform to share insights and learn collaboratively in a positive environment, fostering constructive and supportive challenge.

However, in recent years, participation in the peer review process has declined compared to previous levels. Despite this decline, the approach still offers significant benefits, including organisational learning, shared learning, and the identification of thematic trends which can inform national priorities. Peer review arrangements can form part of the effectiveness of clinical networks.

One of the areas where governance could be more consistently strengthened is by introducing more regularised organisational Board reporting arrangements. Insights gathered suggest that safeguarding assurance was gained mainly at the Quality and Safety Committees or equivalent. Annual organisational safeguarding reports are produced as a key source of assurance. There was broad support for incorporating Safeguarding reporting into an integrated quality and performance reporting frameworks, and in some cases, this is already happening. This potentially allows safeguarding to be seen as part of the broader quality and safety agenda.

It was thought by some that if safeguarding performance were framed in this way it could help to make safeguarding more visible at Board level.

It is therefore essential to establish a set of national metrics capable of enhancing both national and local assurance regarding the effectiveness of safeguarding arrangements in NHS Wales. These metrics should be visualised through a dashboard and the right level measures accessible to both the Welsh Government and local entities. Furthermore, the measures developed for use in the NHS must align with the reporting requirements of the Regional Safeguarding Boards and the recently introduced 5 Key Elements to Safeguarding Effectiveness by the National Independent Safeguarding Board.(NISB)

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The reviewer has been made aware that draft measures have been developed by the NSS in collaboration, which appear to be mainly activity measures. Before approving the measures, it is useful to consider if the measures will provide

assurance on the quality of safeguarding and whether they provide any outcome measures. It is useful to consider the following questions:

- What is the problem that needs to be addressed i.e. What is the performance question?
- Who is the audience for the measure?
- How will the measure be used, what insights will it generate?
- Where will the data come from?
- What will the upper and lower control limits be?

For example, one measure is focused on achieving health assessments for 'Looked After Children' (LAC) being completed in 28 days, this tells the intended audience about timeliness of health assessments, however it does not inform Boards about whether the overall quality of the health assessment was good.

On a separate note, there was anecdotal information shared with the reviewer that there may be increasing numbers of allegations of professional concerns within the NHS in Wales. It is important to look at this more closely, to understand the data and identify any trends which may require a national response or action.

There did not appear from the insights gathered to be a consistent approach across Wales to tracking and monitoring safeguarding improvement actions arising from Case Reviews, Inspection reports and Serious Incidents. There also appears to be some limitations on the effectiveness of inter organisational learning. There would be a benefit to using an agreed national system for use in the NHS in Wales, to monitor progress on completing actions and additionally to gain assurance on how well learning has been disseminated both within and across organisational boundaries in the NHS in Wales. Current or developing digital systems should be explored to identify what will work best. NHS Wales should also have access to this digital system, for scrutiny and greater assurance on progress across the system. NHS England safeguarding lead advised they have in place a national tracking system.

Complaints, serious incidents, incidents, mortality reviews together with proactive and reactive feedback in the context of safeguarding people, are important sources of learning. From the interviews held there were mainly ad hoc arrangements described for quality and safeguarding teams to scrutinise and challenge perspectives on incidents through a safeguarding and quality lens. There were a couple of organisations who described having more formal arrangements in place for this. In addition, some interview participants shared that child mortality review and learning processes were not previously in place and since the commencement of the 'Thirwall Inquiry' this was starting to be addressed. It is not known whether this is happening across all Health Boards in Wales.

There were also views shared that there is a need to create more of a reporting culture in NHS Wales, to include both safeguarding incidents and near misses, to better understand where organisations may have blind spots or gaps in systems which may require focus to improve.

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10.1. Opportunities for Strengthening

In looking at safeguarding through a quality lens the whole quality cycle needs to be considered. Safeguarding quality needs to be driven from the top of organisations, with a clear vision for safeguarding people which is communicated by Welsh Government, the NHS Executive, Boards of NHS organisations, executive leadership teams, corporate teams, and those leading teams at operational levels.

The quality management cycle for safeguarding described below is potentially an opportunity to strengthen safeguarding arrangements in NHS Wales.

Safeguarding people: Quality planning

Welsh Government through the NHS Executive would set an expectation that planning rounds include a focus on improving arrangements for safeguarding people in the NHS. This would be through a small number of impactful national priorities, with some flexibility for any in year national improvement requirements. In addition, the NHS Wales planning guidance for Integrated Medium-Term Plans would address safeguarding gaps in individual organisations and as identified in Regional Safeguarding Board annual plans.

Safeguarding People: Quality Improvement

At a national level and through closer proximity within the NHS Executive, Improvement Cymru could provide support to the National Safeguarding Service and the Safeguarding Clinical Network, building capability to drive national safeguarding improvement programmes with visualised data which measure progress. This would be informed by a national learning system and mechanisms for regularised feedback from key stakeholders such as the public, staff, Regional/National Safeguarding Boards, and other key stakeholders. At a local level Heads of Safeguarding and Named professionals need to be supported by their organisational improvement advisors and data analysts to apply improvement methodologies to deliver safeguarding improvement plans informed by local and national learning and feedback.

Safeguarding People: Quality Control

To progress effective quality control in NHS Safeguarding arrangements, the NHS Executive will need to gain approval of nationally agreed safeguarding quality standards and measures as referred to in theme one and earlier in this section.

At the time of writing this report the reviewer is aware that work is underway developing a suite of measures referred to as Quality Priorities, which have been linked to different rationales drawn from a range of sources and drivers, including legislative, policy, guidance, and reports. The measures have been split into two categories i.e. quantitative and qualitive. The quantitative measures appear to be activity measures and appear to also include specific audits. It may be preferable to leave organisations to determine their own audit subjects in the main. There is a potential risk if audits are dictated nationally that they will be completed at the expense of local audits, which may be more important for individual organisations. In

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year national audits could be agreed on a need led basis for example, Routine Enquiry into Domestic Abuse audits.

What have been described as qualitative measures have been identified, some of which appear to focus on governance arrangements being in place. One of the key elements for effective safeguarding arrangements is to have staff who feel competent and confident in their safeguarding responsibilities. Therefore, it seems important to have measures which seek to obtain feedback from staff and ideally service users, this is an essential element of quality improvement. It is understood that these types of measures are more difficult to obtain however this does not mean that they should not be included in national and local data sets, support from 10.24. Improvement Cymru and potentially those involved with digital platforms such as CIVICA could collaborate with the NSS and the safeguarding network to further refine the measures. Testing draft measures with a broader multi-disciplinary workforce would also help to test the measures with different audiences.

During the interviews there were some views expressed that having too many measures runs a risk of people spending a disproportionate amount of time obtaining the data, rather than working on actions on improvements. This risk could be mitigated if digital platforms operate efficiently and effectively and by focusing on fewer but informative measures.

Quality Control is referred to in the guidance as being applied at the front line of services and therefore at a local level, staff need to have consistent communication, leadership and data which can inform them on how they are performing in achieving good quality in safeguarding.

Quality Assurance

To date the emphasis has been on providing assurance on safeguarding arrangements based on available information such as training compliance and progress on improvements. However, to gain more robust assurance informed by evidence, the whole quality planning cycle needs to be implemented and applied. This will require a revised approach at a national and local level.

To have an integrated performance report which includes safeguarding would need to have nationally agreed Board level measures (a minimum data set) and to agree frequency of reporting. Safeguarding performance should also be included in Quality and Performance meetings and Joint Executive Team meetings with the NHS Executive and Welsh Government.

Assurance reporting would also be provided to the NHS Executive, utilising meaningful real time (or as close to real time data as possible) data, and a report once and use many times principle.

There is an opportunity to strengthen and have in place a consistent digital approach for monitoring and tracking actions from reviews, inspections and reports issued to NHS Wales organisations, and in addition for an NHS Wales to have a national tracking system, which monitors progress and can be used to identify any national trends and themes.

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A piece of work which would benefit current and future learning opportunities and to avoid future corporate memory loss would be to introduce coding for health actions arising from reviews or incidents. The coding could then be used to generate thematic learning. It is not yet known whether this is a function that will be available from the learning tool in development as part of the implementation of the Single Unified Safeguarding Review.

Organisationally determined safeguarding audits need to be part of general assurance arrangements. Where corporate safeguarding teams lack resilience, there could be a risk that this will impact on the ability to complete important organisational audits. Internal audit can also be utilised to allocate some of the annual quota to safeguarding related audit.

There is an opportunity to explore data on national basis, on the reporting of professional concerns from the NHS in Wales. Identifying an initial national base line and monitor for any potential trends relating to professional concerns.

There is also an opportunity for Chairs of LHB's and Trusts to have Safeguarding people related objectives set, which can be assessed as part of annual appraisal arrangements.

Recommendation 20

The NHS Executive should ensure that there is a Quality Management System approach to safeguarding arrangements for gaining assurance in NHS Wales, as per the NHS Wales Quality and Safety Framework, which incorporates quality planning, control, improvement, and assurance. (Cross references with Recommendation 1)

Recommendation 21

The NHS Executive should agree and approve Safeguarding quality statements and meaningful safeguarding measures which: -

- monitor safeguarding performance locally and provides assurance as part of an integrated performance report at Board level and to Regional Safeguarding Boards as relevant.
- provides oversight of data to the NHS Executive.
- measures to include outcome, process (activity measures) and balancing measures and there should be a clear rationale for the measures aligned to the quality domains and be cognisant of the requirements of Regional Safeguarding Boards. Measures should include outcome and experience measures.

Recommendation 22

Welsh Government through the NHS Executive should set an expectation that planning rounds include a focus on improving arrangements for safeguarding people. This would be through:

- a small number of impactful national priorities

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- flexibility for additional national improvements required
- integrated Medium-Term Plans should address safeguarding gaps in individual organisations (with a national approach where appropriate) and as identified in Regional Safeguarding Board annual plans.
- Safeguarding delivery or improvement plans should be monitored through regular Quality Performance and Delivery meetings and Joint Executive Meetings.
- Chairs of LHB's and Trusts should have Safeguarding people objectives set in their annual appraisal.

Recommendation 23

The NHS executive should ensure there is development and implementation of a digital tracking system which can be used at organisational and national levels in NHS Wales, to track actions issued to NHS Wales from reviews, inspections, and reports. A coding system should be introduced to support the identification of themes and to access and utilise information from past learning. (It is not yet known what role and function the Single Unified Safeguarding Review repository in development can offer) (Welsh Government, 2023).

In Summary, this section highlights the importance of robust arrangements to ensure the CNO, DG and Ministers have sufficient, meaningful assurance on the NHS is delivering against its safeguarding statutory responsibilities.

11. Theme 7: Enablers

When gathering insights for this theme several potential enablers were briefly touched upon, however the ones which have featured in the report are the enablers which the stakeholders specially identified as the most important or spoke more about.

The role of culture and leadership is an important enabler, however this topic has been discussed in Theme Five, when looking in to individual and organisational behaviour. Therefore, there are three enabling areas which are discussed under this theme heading: Safeguarding workforce development and Supervision, Education and Training and Digital.

11.1. Safeguarding Workforce Development and Supervision

Developing the health and social care workforce can be described as a key enabler. The 'Healthier Wales, health and social care workforce strategy' was published in 2020. The ambition is for a ***"motivated, engaged and valued, health and social care workforce, with capacity, competence and confidence to meet the needs of the People of Wales."*** *(Health Education and Improvement Wales (HEIW) and Social Care Wales 2020)*. There are seven themes in the strategy, all of which are pertinent to the current and future safeguarding specialist workforce and the

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workforce more broadly. However, this section will highlight a few specific safeguarding workforce issues which relate to the themes in the strategy. The National Safeguarding Service has several Designated professionals who are between 55 and 65 years of age. Succession planning needs further attention and to explore different options, including approaches to increase diversity and inclusion. As discussed in other sections of this report, there is also the need to retain a balance between Medical and Non-Medical roles working in the NSS. There were concerns expressed that career pathways for Named Doctors becoming Designated Doctors were not clear. This was further expanded to inform the reviewer that Named

Doctors would need to feel confident that they would be well supported through any career progression, with access to expert medical knowledge skills and experience and mentoring required to meet clinical and leadership development. Moreover, it is identified as important to be available at any time, not just in relation to career progression.

There were also views expressed about the importance of supporting the ongoing development of non-medical safeguarding specialists, not only in their knowledge of safeguarding but also in developing other skills such as facilitation, and leading change. Having access to coaching and mentoring was also referred to as important by a number of people in specialist roles. The reviewer is aware there are currently aspiring leadership programmes available through Health Education and Improvement Wales, it is not clear whether these programmes would be suitable or available to both medical and non-medical health professionals working in the specialty of safeguarding. It seems likely that programmes would be sufficiently broad and therefore would be transferable.

Supervision:

Safeguarding supervision is seen as a key pillar of safeguarding practice. The British Association of Social Work defines supervision as ***"a regular, planned, accountable."*** From the interviews undertaken, the reviewer was informed that both planned and needs led safeguarding supervision arrangements are typically in place, for health visitors and school nurses, usually provided by corporate safeguarding teams or by safeguarding children specialists at a service level. There are a couple of different arrangements for safeguarding supervision that were referred to, which included one to one and group supervision models.

The reviewer was made aware that an academic piece or work is being undertaken exploring Safeguarding supervision in health visiting, to include restorative supervision principles. (Moseley, 2020) The reviewer is not aware of any plans to implement any policy changes currently. There is an evidence base for both Safeguarding supervision and restorative Clinical Supervision, (Petit et al 2015). While it is understood that Health Visitors are working with families and children who may become vulnerable and subject to Safeguarding and child protection plans, it was suggested during the interviews there are other health professionals who would benefit by having access to Safeguarding or clinical supervision with a focus on Safeguarding.

Currently there does not appear to be formal accredited Safeguarding supervision training available in Wales, and there does not appear from the discussions to be an up to date nationally agreed safeguarding supervision training package currently for

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use in NHS Wales. The reviewer was informed that a few 'Heads of Safeguarding' are collaborating to develop a package for use within their own organisations. There were no expressed plans to seek to gain accreditation for this training package.

In relation to Community Adolescent Mental Health Services (CAMHS) there was an example shared that supervision is built into everyday practice within this service setting, with one Health Board informing that they had no planned supervision with the corporate team. There was a view shared that in the CAMHS, accessing supervision was seen as an important part of assessing the risk management of children and young people often with complex conditions. In addition, there were specific examples of safeguarding advice being accessed and provided by the corporate safeguarding team. The example given was where the CAMHS team are having difficulty in getting involvement from Social Services, in these situations they would request specific advice. There was another Health Board CAMHS team who informed they received six-monthly safeguarding supervision from the corporate safeguarding team. This suggests the arrangements for CAMH's supervision vary across NHS Wales. This area of practice is potentially challenging and complex, often with high-risk situations for children and young people and warrants a deeper dive.

There were no examples identified from those who were interviewed, of regularised safeguarding supervision being provided to other community teams such as district nursing and other disciplines such as physiotherapists, occupational therapists to name a few roles who also work with individuals and families in community settings. Likewise, the reviewer was not made aware of any regularised safeguarding supervision identified for those working in a ward environment, considering those working with older adults who may be vulnerable or become vulnerable and those adults with additional learning needs. Safeguarding supervision appears currently weighted towards children.

It is highly unlikely that corporate safeguarding teams would have the capacity to sustain a broader cohort of safeguarding supervision, therefore if safeguarding supervision were to extend to a wider group of professionals it would require a different model of delivery.

An area of immediate concern and potential risk is access to safeguarding peer supervision for Safeguarding Children Named Doctors, Looked After Children (LAC) lead doctors and paediatricians more generally. Insights gathered from Named Doctors informed the reviewer that there are not any regularised formal arrangements in place for planned safeguarding supervision, to reflect on cases and to support those who are working with children and young people in need, at risk of harm or have suffered abuse and neglect. Arrangements are currently on a voluntary basis and not built into medical sessional arrangements. In addition, the sessional basis for Named Doctors was reported to be insufficient (typically three sessions a week which equates to one and half days a week). This group of health professionals which includes paediatricians who are not 'Named Doctors,' specialists in safeguarding and those involved in front line clinical assessment safeguarding work, need to use a high-level judgement and decision making often with complex cases. These assessment and decision-making skills are used to inform plans to protect and reduce the impact of harm to children and young people. In addition to this both qualified experienced medical staff and trainees described themselves as

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being exposed to vicarious trauma and often needing to have challenging discussions with multi-agency partners who may not always demonstrate an understanding of wider clinical pressures. While there were examples given of medical colleagues accessing needs led supervision from Named Doctors and Named Doctors accessing supervision from Designated Doctors within the NSS, these were described currently as insufficient. They also highlighted problems with diminished number of Designated Doctors with expertise in Safeguarding children and challenges with succession planning for Named Doctors.

There were no formal arrangements identified to the reviewer in relation to access to adult safeguarding supervision for medical professionals. There is also limited capacity in terms expert medical knowledge in the NSS in relation to primary care, with only the lead GP role in the service working four sessions a week. The access to supervision for lead GPs for safeguarding in primary care practices was not explored due to time constraints.

Opportunities to Strengthen

There are opportunities to strengthen career pathways and succession planning across all safeguarding specialists' disciplines. There is opportunity to explore with Health Education and Improvement Wales the programmes for Safeguarding health professionals in relation to leadership development and coaching and mentoring could access.

There is an immediate gap in access to sufficient medical sessions at Named and Designated Doctor levels for Safeguarding Children, and strengthening of overall medical resilience in the NSS is required.

There is opportunity to better understand the safeguarding supervision requirements for a broader range of health professionals, which also considers the needs of those working with vulnerable adults who may become at risk of abuse and neglect and abuse. There will inevitably be a balance between levels of risk and available resource. Approaches will need to be proportionate and a risk-based approach.

There are opportunities to negotiate with affiliated Universities, where Schools of Health Science could develop programmes.

Recommendation 24

It is recommended further work is required to better understand safeguarding people supervision needs across the NHS organisations in Wales. A supervision needs analysis should be completed led by the NSS, to develop a more informed understanding of the picture across NHS Wales. The Intercollegiate Document (RCN 2019) could be a useful framework to help determine which roles could benefit from safeguarding supervision, recognising that an adult safeguarding Intercollegiate Collegiate Document is due to be published by the Royal College of Nursing.

Recommendation 25

It is recommended that the NHS Executive in collaboration with LHB's ensures that a safeguarding supervision model for Named Doctors for safeguarding children and

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paediatricians, is prioritised for development and implementation. Implementation will need to take account of medical staffing arrangements in this speciality.

Recommendation 26

The NHS Executive should request from *Health Education and Inspectorate Wales* access to programmes for ongoing development of career pathways for those working in the speciality of Safeguarding, ensuring that there are arrangements in place for access to leadership development, mentoring and coaching. This should be prioritised with alignment to competency levels as identified in the Inter Collegiate Document (RCN 2019).

11.1. Education and training

Education and training are an important investment in the NHS workforce, there are a wide range of subjects which employees are required to gain knowledge in, often referred to statutory and mandatory training. (Core Skills Training Framework 2013). Safeguarding Children and Adults are two of the eleven core subjects identified as statutory and mandatory training requirements. This investment in time and resource is intended to equip people working in the NHS with relevant skills, knowledge, and competencies together with knowledge of policies and procedures. If training is effective, it could be described as an enabler, however this does depend on the quality of the training and there can be other barriers to learning in the workplace. Knowing whether learning has been acquired and knowledge retained is not routinely measured. (Creedy et al 2021)

The Intercollegiate document (ICD) *Royal College of Nursing* (2019) is a source of guidance which is written collaboratively by the Royal Colleges and other key stakeholders to provide guidance for health and care settings in the UK. The ICD is a framework which identifies five levels of competence aligned to staff groups, with an additional Board level. (RCN 2019)

In general, some insights received from the interviews suggested the ICD appears to be accepted as relevant guidance for NHS Wales, with some different perspectives potentially arising in primary care. The ICD is currently in the process of being updated. Two Designated Professionals from the NSS have been representing Wales on the ICD update group and have been close to the ongoing development and support the general direction the draft guidance is taking, advising the guidance appears sufficiently flexible in terms of how competencies can be achieved. Levels of training described in safeguarding training modules in NHS Wales are taken from the ICD framework.

The reviewer identified through available information that several safeguarding modules are provided via E-learning available through the Electronic Staff Record (ESR) portal or Learning@NHSWales website. These modules include: -

- Safeguarding People (Adults and Children) Level 2
- Safeguarding Children Level 2
- Safeguarding Adults Level 2

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- Violence Against Women, Domestic Abuse and Sexual Violence
- Mental Capacity Act Level 1 and Level 2
- Female Genital Mutilation Basis Awareness
- Identifying and Supporting Victims of Modern Slavery

The reviewer was not able to access these modules due to the permissions criteria and therefore is not intending to comment on modules themselves, the focus was on understanding the views of the stakeholders more broadly. The reviewer heard that there were some challenges with compliance in some of the NHS organisations. Some comments from front line staff suggested that E-learning was 'ok,' although not a very engaging method of learning and may impact on staff motivation in undertaking the modules. There were examples of Accident & Emergency (A&E) staff being keen to learn more about safeguarding at a higher competency level, as they suggested they were interested to learn more than received to date; those spoken to did not seem to be aware of how to access level 3 multi-agency training which is the level identified for A & E staff.

The reviewer was informed that staff who are required to be level three trained, have access to multi-agency training and bespoke training was provided by specialists working in the NHS, for different clinical groups or settings. Safeguarding specialists providing face to face level 3 training reported that their audience were very engaged with the sessions and shared their views that this method of training optimised learning.

There were specific views expressed that there needed to be some additional and different training for executives, particularly clinical executives as they needed to have a better understanding of their roles and responsibilities and better knowledge of multi-agency arrangements and of the senior level partners working in different organisations. It was noted for Emergency Planning and Business Continuity training there are specific levels of training provided jointly for those in very senior leadership positions. It was thought that something similar could be developed in the context of statutory partners to deepen a collective understanding of roles and responsibilities of safeguarding arrangements. One Regional Safeguarding Board Chair thought this was an innovative idea and is one to explore.

The reviewer was not made aware of any evaluation of how well the learning from training has been translated and applied into everyday practice of the workforce. Given that there is a significant reliance on training to equip people with safeguarding knowledge and skills and that there are known challenges with training compliance in some areas, to develop a better understanding of the effectiveness of knowledge transfer seems important.

Interviews with some stakeholders, provided an important reminder that for some staff raising a concern about a person at risk is not a common occurrence, and requires a certain level of confidence and knowledge about how to access support and advice. Even for staff who are more conversant in working with multiagency partners it was suggested a situation can still be challenging. There were difficulties expressed in relation to different professional perspectives and being prepared for

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respectful challenge. Multiagency training provides opportunities to learn together and form a better understanding of different professional roles and perspectives.

Recommendation 27

The NHS executive should commission research to understand whether the current state of knowledge dissemination and application of safeguarding principles is effectively absorbed and implemented, identifying any barriers and gaps.

11.2. Digital

Issues with communication have been referenced repeatedly in various reviews over many years. Barriers to effective communication often cite digital systems (CIW, Estyn, HIW 2023) which do not talk to one another both within organisations and across organisational boundaries, including important multiagency interactions for effective safeguarding. Digital enablers were also referred to in the System Interaction theme 4 section. Effective digital systems can be a key enabler, and digital advancements have the potential to significantly improve organisational communication and information flows, both within and across organisational boundaries. (i.e. between the NHS including the NHS Executive) Interagency communication and information flows, including access to pertinent safeguarding information could be aided by a single patient record held for each person, it is speculated that this could transform Safeguarding efficiency.

Digital systems within organisations overall were described as inefficient often requiring workarounds to limit risk in relation to safeguarding people. During the insight gathering, people working in the NHS described at times that they did not have access to essential information needed to provide complete health assessments. Information held within different agencies is generally accepted as being vital to help to keep vulnerable children, young people, and adults safe.

An example given, was movements of children who may be vulnerable and at risk, including Looked After Children, across different sites within one NHS organisation or moving between organisational boundaries, often these records are not available at the time assessments need to be carried out.

The reviewer was also informed that in many NHS Wales organisations there is no access to Local Authority Child Protection Registers in Accident and Emergency departments, which could put a child at further risk if health staff have a limited picture of the child's situation. There is often a delay in having relevant information available to address the health and care needs of Looked After Children in a timely fashion, which includes relevant information from Primary Care as well as Social Care.

Other examples of digital inefficiency and ineffectiveness given, was in relation to the inclusion of health information required for case conference reports, information is rarely held in one place and requires searches of different data bases to pull information together.

One of the benefits expressed in relation to Multi agency Safeguarding Hubs or MASH models, is the health professional working in the hub or MASH can access

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the health information. This still requires valuable resource which could be utilised more efficiently if digital systems were more effective.

Although examples have not been provided for adult safeguarding barriers to information flows and information sharing, there will inevitably be similar challenges for safeguarding adults at risk of abuse and/or neglect including Domestic Abuse.

One of the perceived barriers aside from the digital systems themselves, are concerns expressed about information sharing in relation to the data protection and the General Data Protection Regulation (Gov.UK 2018). Safeguarding specialists and Information governance experts and digital or IT experts, can collaborate on how information can be shared lawfully so that digital systems can be created and perceived barriers can be overcome. The IT experts in these areas advised in the interviews, that they need to be brought in at the beginning of digital projects, to advise and guide on digital end to end pathways working in collaboration with users of systems and those with safeguarding expertise.

Opportunities for Strengthening

The publication of the *Digital and Data strategy for health and social care in Wales,* (Welsh Government 2023) in theory provides good timing to make digital improvements which could impact positively on safeguarding effectiveness. One of the principles identified in the strategy is to "***use open, interoperable, and resilient infrastructure" "that allow people's health and social care data to be shared efficiently across health and social care providers."*** The strategy identifies there is a need to establish trust about how data is used, legally and securely. (Welsh Government 2023 page 7).

Strengthening safeguarding across health and social care requires significant digital enhancement and transformation and is overdue.

Recommendation 28

Over the next three years the NHS Executive should ensure that there are programmes of work between Digital Health Care Wales, and the wider NHS in Wales, officers from the Welsh Government Chief Social Care Officer for Wales and office of the Welsh Government Chief Nurse for Wales, safeguarding experts and users of systems. This is to ensure investment and a phased approach to improving digital systems, with the aim of seamless communication and reducing the risk of ineffective safeguarding communication within and across organisations. This should include a focus on but not limited to: -

- Robust digital systems for referrals and other important safeguarding related information and feedback, between health and social care.
- Access for health professionals to Child Protection registers, Looked After children information and other important safety alerts on a need-to-know basis.
- Harmonisation of different data bases working incrementally towards a single patient record.

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- Digital systems must also be able to communicate effectively and transfer information appropriately between different NHS departments and teams in relation to safeguarding related information and risks.

- NHS organisations have reciprocal arrangements between health and social care for relevant safeguarding information sharing. Systems for performance monitoring of safeguarding arrangements must also be made efficient and effective.

- Ensure there are effective digital systems in place for monitoring and reporting of Safeguarding performance and timely identification of areas needing improvement and provide assurance on safeguarding effectiveness.

In Summary, this section highlights the importance of having effective enablers in place to support staff to improve quality and outcomes in safeguarding.

12.Conclusions

The scope of this review centred on strengthening Safeguarding in NHS Wales. The term “strengthening” was a guiding principle in helping to identify opportunities for enhancing current arrangements and introducing new approaches where necessary. The review’s terms of reference highlighted two key objectives: maintaining effective oversight and assurance and delivering joined up and coherent policy across health and social care.

These aims were considered through the lens of seven themes agreed by the steering group shaping the interview questions and document analysis.

The aim of the recommendations is to establish strengthened oversight and scrutiny mechanisms, while integrating the benefits of various policy and legislative areas pertinent to NHS Wales. Although progress has been made since the previous Aylward review, the current review proposes several structural changes and updated governance arrangements to align with the NHS Executive, with a view to achieving greater measurable impacts.

The workforce is pivotal in safeguarding individuals, and several recommendations focus on enhancing the resilience of the current and future specialist workforce. This includes supporting them in their roles and adopting new behavioural methodologies to address persistent challenges. Investing in a more digitally enabled NHS Wales will also contribute to greater efficiency and effectiveness.

The report emphasises the importance of building and maintaining effective relationships within and across organisational boundaries, which requires dedicated time and effort. Multi-agency collaboration is crucial in an effective health and social care system. Each agency needs to listen better to one another and seek first to understand the others perspective.

Unfortunately, safeguarding failures still occur, there have been numerous UK-wide, national, regional, and organisational reviews Victoria Climbie Inquiry (2003), Rees

et al (2021), spanning several decades. All identify recommendations aimed at improving outcomes for vulnerable people, including children and young people, at risk of abuse and neglect. Often, these reviews highlight recurrent findings or recommendations. At the time of writing this report, the Thirwall Inquiry (2024) is preparing for hearings in September this year, which is expected to identify important findings and lessons for the NHS. This tragic case underscores the NHS's crucial role in continuously improving safeguarding arrangements to protect people of all ages and contribute to broader efforts to eradicate harm, abuse and neglect through policy implementation, collective leadership, and individual actions.

Every day, dedicated NHS staff in Wales work tirelessly to safeguard vulnerable individuals and those at risk of abuse and neglect. It is essential for leaders to value, nurture, and express gratitude to their teams, fostering a culture that prioritises patient and individual safety and enables the workforce to thrive. This review aims to provide a short to medium-term road map to strengthen safeguarding in NHS Wales, to create a robust, accountable, and more effective system for protecting people across the life course who are most vulnerable.

13.Thank-you

The Reviewer would like to take the opportunity to thank all the participants who agreed to be interviewed and provide their perspectives and insights to contribute to this review.

14.Recommendations:

Theme 1: Effectiveness - defining strengthening Safeguarding in the NHS is Wales.

Recommendation 1

It is recommended that Welsh Government through the NHS Executive establish a Safeguarding Quality Management and Learning system, underpinned by the *Health and Social Care* (Quality and *Engagement) (Wales) Act* 2020 and *Social Services and wellbeing Act 2014*, utilising the principles in the *Quality and Safety framework* and *National Clinical Framework* to guide the implementation. This should include: -

- Safeguarding Quality Statement and metrics.
- Development of an NHS Safeguarding Assurance and Accountability Framework.

Recommendation 2

NHS Health Boards and Trusts should ensure there is robust oversight and governance arrangements in place, to ensure actions arising from practice reviews and inspections are completed and meaningful learning is being applied across all relevant health settings and not limited to where the gap or incident was initially identified.

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Theme 2: Current interventions to drive desired outcomes.

Recommendation 3

The NHS Executive with the National Safeguarding Service should ensure there is a revised approach to prioritisation of NHS all Wales Safeguarding priorities and delivery plans. Informed by strategic and operational levers and drivers, identified and recorded risks, wider perspectives of strategic level stakeholders. For example,

Welsh Government policy leads, Regional Safeguarding Board Chairs, Safeguarding Advisory Group (see Theme 3) and views of the broader clinical executive roles, for example Executive Medical Directors and Executive Directors of Therapies in addition to Executive Directors of Nursing. The following should be incorporated (but not limited to) the approach.

- Prioritisation tools
- National NHS Safeguarding Risk register
- Evaluation of impact with methods informed by evaluation experts
- Research and evidence informed

Theme 3: Structural

Recommendation 4

The National Safeguarding Service should transition to the NHS Executive along with other national functions providing leadership, scrutiny, oversight and advice to Welsh Government officials. It will also provide support to NHS Wales and any revised national Safeguarding network arrangements. This may require an amendment to the Public Health Wales Standing Orders and NHS Executive remit letter. The roles and responsibilities of the NSS and Designated Professionals should include but not be limited to:

- NSS supporting the NHS Executive to have in place effective scrutiny, system learning and evaluation arrangements for NHS Wales.
- Designated professionals working in collaboration with LHB's and Trusts to provide leadership, supervision, support, assessment and feedback working with NHS organisations and Executive Directors, utilising approved and published Safeguarding Quality Standards and other evidence-based information and tools.
- The NSS working routinely with Health Inspectorate Wales, Llais and the Welsh Health Specialised Services, particularly the Commissioning Unit and National Independent Safeguarding Board and arrangements to meet with Regional Safeguarding Board Chairs on an all-Wales basis. Arrangements for sharing expertise, knowledge, evidence, person centred approaches and intelligence, to be on a regularised basis.

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- The NSS providing a horizon scanning function and, undertaking, participating in or commission Safeguarding research.
- The National Safeguarding Service should identify strategies within existing resources, to address workforce implications for the service and broaden the diversity and range of skills required to maximise innovation and impact.
- A focused effort to ensure that there is more balance in the ratio of Medical to Non-Medical Designated professionals, including resourcing for lead GP roles and those with knowledge and experience in adult safeguarding.
- At the earliest opportunity create a Designated Midwife role.
- A widening of professional disciplines to broaden experiences within the service.
  For example, from Allied Health Professionals and Social Care Professionals.
- Identify how the NSS acquires access to knowledge and skills in data science, improvement science, behavioural science and evaluation to increase capability in these areas and accelerate opportunities for impact.

Recommendation 5

The Welsh Government health and social services policy leads, Directors of Public Health and Chairs of Regional Safeguarding Board should explore what mechanisms can be introduced (or shared if arrangements already exist in other RSB's) to provide public health and population health knowledge, skills, and expertise to Regional Safeguarding Boards.

Recommendation 6

The Welsh Government overseen by the NHS Executive should implement a new three tier NHS Wales Safeguarding governance structure to include a 1) Safeguarding Advisory Group, a 2) Safeguarding Strategic Clinical Network and a 3) Safeguarding Community of Practice. Guided by the *National Clinical Framework Implementation Programme* and implementation supported by the NHS Wales Collaborative.

An assessment of the current Safeguarding Network should be undertaken to identify what elements should transition to the Clinical Network and the Community of Practice.

Structures to be implemented: -

- (1) Safeguarding Advisory group
- (2) Safeguarding Strategic Clinical Network
- (3) Safeguarding in Community of Practice

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Recommendation 7

The Welsh Government should consider placing the *'Child Death Review Programme'* on a statutory basis, to improve the quality of learning from child deaths, which could also contribute to learning in the context of safeguarding children and young people.

Recommendation 8

The NHS Wales Safeguarding Network led by the NSS, in collaboration with Heads of Safeguarding, should undertake a detailed benchmarking exercise, considering population and workforce size of organisations or geographic markers in the data set.

to include:

- Corporate Safeguarding human resources (Medical/Non-Medical)
- Looked After Children human resources personnel,
- Medical sessions allocated to Safeguarding, LAC and Adoption

The findings should be shared with relevant Board level Committees to inform overall assurance and address any identified risks.

Theme 4: System interaction

Recommendation 9

Welsh Government policy leads, the multiagency Inspectorates and the Independent Safeguarding Board should work with Regional Safeguarding Board Chairs, to ensure that thresholds for Safeguarding People interventions are transparently, consistently, and equitably applied.

Recommendation 10

Regional Safeguarding Board Chairs and their partners should ensure there is multi-agency training available for the workforce commensurate with roles and responsibilities.

Recommendation 11

Regional Safeguarding Boards should create the opportunity for a facilitated discussion with all partners to explore the benefits and risks of a broader range of partners being considered for the chairing role in RSB's.

Recommendation 12

The NHS Executive should ensure that Health Inspectorate Wales and the NHS Wales Joint Commissioning Committee (JCC) are members of the NHS Wales Safeguarding Advisory Group, and that there are arrangements in place for regular information exchange between the NSS, HIW and JCC.

Recommendation 13

NSS and Shared Services should continue to collaborate on the development and optimisation of the Datix safeguarding module capability. Implementation plans should be developed in conjunction with NHS organisations.

Theme 5: Individual and Organisational Behaviour

Recommendation 14

Welsh Government in implementing the SUSR, should consider whether there is sufficient emphasis on a 'no blame culture' in the guidance and planning approaches for implementation.

Recommendation 15

NHS Organisations should ensure there is visibility to the workforce, of organisational and Board commitment to Safeguarding people.

Recommendation 16

The National Safeguarding Service should collaborate with the Behaviour Science Unit to explore opportunities to learn new and novel approaches, to persistent barriers in Safeguarding people.

Recommendation 17

The NSS should explore with NHS organisations whether a Named Doctor for adult Safeguarding would bring added benefits to the equity, value, quality and safety of current specialist workforce arrangements in adult Safeguarding.

Recommendation 18

The NSS and NHS organisations should seek advice from diversity and inclusion experts to scope opportunities to attract a more diverse workforce in to Safeguarding career pathway.

Recommendation 19

Welsh Government, Public Health Wales ACE hub and the National Safeguarding Network should explore options for a clear and coordinated approach to ACEs in the NHS in Wales.

Theme 6: Assurance

Recommendation 20

The NHS Executive should ensure that there is a Quality Management System approach to safeguarding arrangements for gaining assurance in NHS Wales, as per the NHS Wales Quality and Safety Framework, which incorporates quality planning, control, improvement, and assurance. (Cross references with Recommendation 1)

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Recommendation 21

The NHS Executive should agree and approve Safeguarding quality statements and meaningful safeguarding measures which: -

- monitor safeguarding performance locally and provides assurance as part of an integrated performance report at Board level and to Regional Safeguarding Boards as relevant.
- provides oversight of data to the NHS Executive.
- the measures should include outcome, process (activity measures) and balancing measures and there should be a clear rationale for the measures aligned to the quality domains and be cognisant of the requirements of Regional Safeguarding Boards. Measures should include outcome and experience measures.

Recommendation 22

Welsh Government through the NHS Executive should set an expectation that planning rounds include a focus on improving arrangements for safeguarding people. This would be through:

- a small number of impactful national priorities
- flexibility for additional national improvements
- integrated Medium-Term Plans should address safeguarding gaps in individual organisations (with a national approach where appropriate) and as identified in Regional Safeguarding Board annual plans.
- Safeguarding delivery or improvement plans should be monitored through regular Quality Performance and Delivery meetings and Joint Executive Meetings.
- Chairs of LHB's and Trusts should have Safeguarding people objectives set in their annual appraisals.

Recommendation 23

The NHS executive should ensure there is development and implementation of a digital tracking system which can be used at organisational and national levels in NHS Wales, to track actions issued to NHS Wales from reviews, inspections, and reports. A coding system should be introduced to support the identification of themes and to access and utilise information from past learning. (It is not yet known what role and function the Single Unified Safeguarding Review repository in development can offer) (Welsh Government, 2023).

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Theme 7: Enablers

Recommendation 24

It is recommended further work is required to better understand safeguarding people supervision needs across the NHS organisations in Wales. A supervision needs analysis should be completed led by the NSS, to develop a more informed understanding of the picture across NHS Wales. The Intercollegiate Document (RCN 2019) could be a useful framework to help determine which roles could benefit from safeguarding supervision, recognising that an adult safeguarding Intercollegiate Collegiate Document is due to be published by the Royal College of Nursing.

Recommendation 25

It is recommended that the NHS Executive ensures that a safeguarding supervision model for Named Doctors for safeguarding children and paediatricians, is prioritised for development and implementation. Implementation will need to take account of medical staffing arrangements in this speciality.

Recommendation 26

The NHS Executive should request from *Health Education and Inspectorate Wales* access to programmes for ongoing development of career pathways for those working in the speciality of Safeguarding, ensuring that there are arrangements in place for access to leadership development, mentoring and coaching. This should be prioritised with alignment to competency levels as identified in the Inter Collegiate Document (RCN 2019).

Recommendation 27

The NHS executive should commission research to understand whether the current state of knowledge dissemination and application of safeguarding principles is effectively absorbed and implemented, identifying any barriers and gaps.

Recommendation 28.

Over the next three years the NHS Executive should ensure that there are programmes of work between Digital Health Care Wales, and the wider NHS in Wales, officers from the Welsh Government Chief Social Care Officer for Wales and office of the Welsh Government Chief Nurse for Wales, safeguarding experts and users of systems. This is to ensure investment and a phased approach to improving digital systems, with the aim of seamless communication and reducing the risk of ineffective safeguarding communication within and across organisations. This should include a focus on but not limited to: -

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- Robust digital systems for referrals and other important safeguarding related information and feedback, between health and social care.

- Access for health professionals to Child Protection registers, Looked After children information and other important safety alerts on a need-to-know basis.
- Harmonisation of different data bases working incrementally towards a single patient record.
- Digital systems must also be able to communicate effectively and transfer information appropriately between different NHS departments and teams in relation to safeguarding related information and risks.
- NHS organisations have reciprocal arrangements between health and social care for relevant safeguarding information sharing. Systems for performance monitoring of safeguarding arrangements must also be made efficient and effective.
- Ensure there are effective digital systems in place for monitoring and reporting of Safeguarding performance and timely identification of areas needing improvement and provide assurance on safeguarding effectiveness.

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16. Appendices

Appendix 1. Review Terms of Reference

20240122 - ToR Safegurading 2023 I

20240110 - Letter from CNO to EDoNs

Appendix 2. Steering Group Terms of Reference

Safeguarding Steering Group ToR

Appendix 3. Stakeholders Interviewed

Safeguarding Interview Results.pd

Appendix 4. NHS Wales Safeguarding Network

NHS WALES SAFEGUARDING NET

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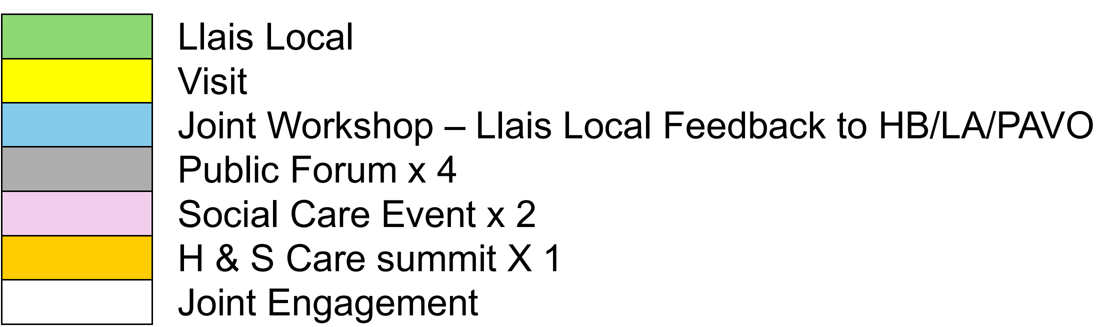
Llais Powys

Engagement Planning 2025/26

Key



Month	Engagement Type	Locality	Comments / Update
April 2025 1st – 11th April	Newtown Llais Local 1st – 11th April	Newtown	
	Visit – Newtown Medical Practice	Newtown	
May 2025 Early	Llanfyllin Public Forum	Llanfyllin	
June 2025	Social Care Public Forum	Ystradgynlais	

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June 2025	Joint Workshop – Llais Local Feedback to HB/LA/PAVO	Newtown	
July 2025 1st July – 11th July	Llais Local Crickhowell	Crickhowell	
July 21 – 24 July	Royal Welsh Show	Builth Wells	
August 2025	Llanfair Caereinion Public Forum	Llanfair Caereinion	
September 2025	Health & Social Care Summit	Llandrindod Wells	
September 2025	Joint Workshop – Llais Local Feedback to HB/LA/PAVO	Crickhowell	
October 2025 1st – 15th October	Knighton and Presteigne Llais Local	Knighton & Presteigne	
December 2025	Joint Workshop – Llais Local Feedback to HB/LA/PAVO	Knighton and Presteigne	
February 2026 2nd – 13th Feb	Llais Local Llanfyllin 2nd – 13th Feb	Llanfyllin	
March 2026	Joint Workshop – Llais Local Feedback to HB/LA/PAVO	Llanfyllin	
March 2026	Social Care Public Forum	Welshpool	

Notes:

- Llais Local (our choice of number)
- Public Forum x 4
- Health & Social Care Summit x 1
- Regional Project (our choice of number)
- Social Care Event x 2
- All Wales Projects x 2
- Visits (our choice of number)

- Royal Welsh Show

Recruiting Volunteers – Regional Operations Manager is developing a plan to work with communities to recruit volunteers. The focus will initially be on the areas where we have no volunteers. This is likely to reach localities down the western side of the county.

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Agenda item: 5.2

Patient Experience, Quality and Safety Committee		**29 April 2025**
Subject:	2025-2026 Clinical Audit Programme	
Approved and presented by:	Kate Wright, Executive Medical Director	
Prepared by:	Prepared by the individual services and collated by Safety and Quality Improvement Manager	
Other Committees and meetings considered at:	Executive Committee - 16 April 2025 who endorsed the paper.	

PURPOSE:

The purpose of this paper is to present the PTHB clinical audit plan for 2025-2026

RECOMMENDATION(S):

The Patient Experience Quality and Safety Committee is asked to:

- **RECEIVE** and **APPROVE** the clinical audit plan 2024-2025.

Approve/Take Assurance	Discuss	Note
Y	N	N

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:		
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	N	
8. Transforming in Partnership	N	

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EXECUTIVE SUMMARY:
This paper presents the PTHB clinical audit programme for 2025-26 for consideration and approval.

HEADING:

Clinical Audit, the systematic review of actual performance against expected standards, remains an important benchmarking tool in determining the level of our clinical standards and is an important tool in guiding continuous quality improvement.

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 2025/26 which incorporates the following:

- High volume basic activities which require a high level of compliance.
- Concerns identified during investigations of Nationally Reportable Incidents or complaints.
- New policies or changes to existing policy / practice to confirm new practice is established.
- The prioritisation of new and repeat clinical audit projects based on recognised clinical risk.
- Clinical audits required to confirm that practice has improved where concern had been raised.

The plan was developed and approved by the 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 2025/26 can be found in Appendix A.

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.

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Any national audits that are continuing as part of a multi-year audit plan are included in this program and any others will be added to the Clinical Audit program once known.

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.

New developments for 2025/26.

Introduction of the Medical e-Governance (MEG) Clinical audit software
The MEG Clinical audit software is currently used to record data in support of a number of infection control audits.

Audit of the completion of Do Not Attempt Cardio-Pulmonary Resuscitation forms
The appointment of a full-time Resuscitation Officer means that Powys will undertake an audit of the completion of DNACPR forms in accordance with the latest All-Wales resuscitation policy.

The Powys Audit Hour
The Powys Audit hour, a forum for presenting clinical audits and sharing of learning was successfully introduced last year. This will be further developed over the coming year.

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Community Services Group					
Surgery and Endoscopy					
Driver	**Audit Title**	**Start Date**	**Service**	**Lead**	**End Date**
Local Audits for Service Improvement	Staff Survey	Annual	Theatre and Endoscopy	Theatre / Endoscopy Lead	Quarter 4
Service Evaluation	Hand hygiene Audits	Monthly	Theatre and Endoscopy	Theatre / Endoscopy Lead	Quarter 4
Service Evaluation	Legal and ethical audit	Annual	Theatre	Theatre Lead	Quarter 1
Service Evaluation	Data protection and GDPR	Annual	Theatre	Theatre Lead	Quarter 1
Service Evaluation	Management/Human Resources	Annual	Theatre	Theatre Lead	Quarter 1
Service Evaluation	Education	Annual	Theatre	Theatre Lead	Quarter 1
Service Evaluation	Five Steps to Safer Surgery	Annual	Theatre	Theatre Lead	Quarter 1
Service Evaluation	Managing Perioperative Normothermia	Annual	Theatre	Theatre Lead	Quarter 1
Service Evaluation	Medical devices audit	Bi yearly	Theatre	Theatre Lead	Quarter 1 Quarter 4

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Service Evaluation	Risk Management (Organisational and Environmental)	Annual	Theatre	Theatre Lead	Quarter 2
Service Evaluation	Decontamination	Annual	Theatre	Theatre Lead	Quarter 2
Service Evaluation	Specimen Management	Annual	Theatre	Theatre Lead	Quarter 2
Service Evaluation	Tourniquets	Annual	Theatre	Theatre Lead	Quarter 2
Service Evaluation	Use and Handling of Surgical Instruments	Annual	Theatre	Theatre Lead	Quarter 2
Service Evaluation	Preoperative care for Patients with Dementia	Annual	Theatre	Theatre Lead	Quarter 2
Service Evaluation	Anaesthesia	Annual	Theatre	Theatre Lead	Quarter 3
Local Audits for Service Improvement	Surgical record keeping audit & consent	Annual	Theatre	Theatre Lead	Quarter 3
Service Evaluation	Post anaesthetic Care	Annual	Theatre	Theatre Lead	Quarter 3
Service Evaluation	Electrosurgery	Annual	Theatre	Theatre Lead	Quarter 3
Service Evaluation	Fluid Management	Annual	Theatre	Theatre Lead	Quarter 3
Service Evaluation	Surgical patient story	Annual	Theatre	Theatre Lead	Quarter 4
Service Evaluation	Pre assessment and Specific Day Case Requirements	Annual	Theatre	Theatre Lead	Quarter 4

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Service Evaluation	Audit of prosthesis verification data	Annual	Theatre	Theatre Lead	Quarter 4
Service Evaluation	Intraoperative Care	Annual	Theatre	Theatre Lead	Quarter 4
Service Evaluation	Accountable Items, Swab, Instrument and Sharps Count	Annual	Theatre	Theatre Lead	Quarter 4
Service Evaluation	Infection Control	Annual	Theatre	IPC	Quarter 4
Service Evaluation	NEWS audit	Annual	Theatre	Quality & safety lead Clinician/Planned care manager	Quarter 4
Service Evaluation	Foreign body aspiration during intubation, advanced airway management or ventilation	Annual	Theatre	Planned care manager	Quarter 4
Service Evaluation	Individual endoscopists KPIs	6 monthly	Endoscopy	Endoscopy Clinical Lead	Quarter 1 Quarter 3
Service Evaluation	Electrosurgery	Annual	Theatre	Theatre Lead	Quarter 3
Service Evaluation	Fluid Management	Annual	Theatre	Theatre Lead	Quarter 3
Service Evaluation	Surgical patient story	Annual	Theatre	Theatre Lead	Quarter 4
Service Evaluation	Pre assessment and Specific Day Case Requirements	Annual	Theatre	Theatre Lead	Quarter 4
Service Evaluation	Audit of prosthesis verification data	Annual	Theatre	Theatre Lead	Quarter 4

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Service Evaluation	Intraoperative Care	Annual	Theatre	Theatre Lead	Quarter 4
Service Evaluation	Gastric ulcers rescoped within 12 weeks	6 monthly	Endoscopy	Endoscopy coordinator & Data/ Audit Support	Quarter 2 Quarter 4
Service Evaluation	Post colonoscopy colorectal cancer rate	As and when reported	Endoscopy	Endoscopy Clinical lead	Quarter 4
Service Evaluation	Patient satisfaction survey	Annual	Endoscopy	Data/ Audit Support	Quarter 4
Service Evaluation	Patient story	6 monthly	Endoscopy	Endoscopy Coordinator	Quarter 1 Quarter 3
Service Evaluation	Endoscopist satisfaction survey	Annual	Endoscopy	Endoscopy Coordinator	Quarter 4
Service Evaluation	Vetting and validation of endoscopy referrals	Annual	Endoscopy	Clinical lead Endoscopy	Quarter 4
Service Evaluation	Environmental audit Process Improvement Tool (PIT) Llandrindod Wells /Brecon	Annual	Endoscopy	Infection Prevention and Control	Quarter 2
Service Evaluation	Gastric ulcers rescoped within 12 weeks	6 monthly	Endoscopy	Endoscopy coordinator & Data/ Audit Support	Quarter 2 Quarter 4

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Welsh Government National Audit Programme	Bowel Screening Wales User Experience Survey Results	Annual	Endoscopy	Bowel Screening Wales	Quarter 4
Local Audits for Service Improvement	Record Keeping/Consent	Annual	Endoscopy	Endoscopy Coordinator	Quarter 3
Service Evaluation	Annual planning & productivity report	Annual	Endoscopy	Planned Care Manager	Quarter 3
Service Evaluation	Scope traceability	Annual	Endoscopy	Endoscopy Coordinator	Quarter 4
Local Audits for Service Improvement	Inclusion/exclusion criteria audit	6 monthly	Endoscopy	Endoscopy Coordinator	Quarter 2 Quarter 4
Local Audits for Service Improvement	Bowel Screening Wales pathology reporting audit	Annual	Endoscopy	Business Support Manager Planned Care	Quarter 3
Local Audits for Service Improvement	Pain / Comfort Audit	6 monthly	Endoscopy	Endoscopy Coordinator	Quarter 2 Quarter 4
Local Audits for Service Improvement	Single cancer pathway process	Annual	Endoscopy	Planned care manager	Quarter 4
Local Audits for Service Improvement	Audit of open access referrals into our service	Annual	Endoscopy	Planned care manager	Quarter 4

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Local Audits for Service Improvement	Audit for Endoscopy Screening assessment	Annual	Endoscopy	Planned care manager	Quarter 4
Service Evaluation	Medical devices audit	Bi yearly	Endoscopy	Endoscopy Coordinator	Quarter 1 Quarter 4

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

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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	
Audits performed for accreditation schemes	Reporting Radiography Service Audit	Quarter 1	Radiography	Head of Radiography	Quarter 3
Other National Audit & Service Evaluation	The Sentinel Stroke National Audit Programme	Quarter 1 - Monthly	All AHPs	Consultant Therapist for Stroke	Quarter 4
Audits performed for accreditation schemes	Red Dot	Quarter 3	Radiography	Head of Radiography	Quarter 4

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Local Audits for service improvement	Therapy Outcome Measures Audit	Quarter 1	Speech and Language Therapy	Head of Speech and Language Therapy	Quarter 4
Local Audits for service improvement	Correct use of radiographic markers	Quarter 4	Radiography	Head of Radiography	Quarter 4
Local Audits for service improvement	MIU NMR Audit for appropriate referrals	Quarter 4	Radiography	Head of Radiography	Quarter 1
Other National Audits	National Diabetes Foot Care Audit	TBC National	Podiatry	Head of Podiatry	TBC National
Other National Audits	SNAPP	TBC National	Therapies & Health Sciences	Consultant Therapist - Stroke	TBC National
Other National Audits	Parkinsons AHP	TBC National	Therapies & Health Sciences	SLT	TBC National
Other National Audits	Adult Audiology Standards	TBC National	Audiology	Professional Head of Audiology	TBC National
Service Evaluation	RCOT proforma on 'focusing on occupation' and 'your professional rationale'	Quarter 1	OT	Professional Head of OT	Quarter 4
Service Evaluation	MSK Transformation Business Case	Quarter 4	Physio	Professional Head of Physio / Consultant MSK	Quarter 1

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Community Dentistry					
Driver	Audit Title	Start Date	Service	Lead	End Date
Local Audits for Service Improvement	Patient Experience Audit	April 2025	Community Dentistry	Tesni Jones	May 2025
Other National Audit	WHTM01-05	July 2025	Community Dentistry	Rachael Anwyl	Sept 2025
Local Audits for Service Improvement	Written Consent to treatment audit	Dec 2025	Community Dentistry	Lloyd Bovensiepen	Dec 2025
Local Audits for Service Improvement	Compliance with Acorn and Fluoride Application for GDS patients	Sept 25	Community Dentistry	Evelyn Gough	Sept 2025
Local Audits for Service Improvement	Antimicrobial Stewardship	Dec 2025	Community Dentistry	Lloyd Bovensiepen	Jan 2026
Local Audits for Service Improvement	Patient engagement and outcomes of treatment visits	Jan 2026	Community Dentistry	TBC	Feb 2026
Local Audits for Service Improvement	Radiography grading - Annual subjective image quality ratings of dental radiographs in the Community Dental Service	Continuous yearly run chart	Community Dentistry	Warren Tolley/ Catherine Adams	Continuous yearly run chart

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Unscheduled Care (updated Feb 2025)

Driver	Audit Title	Start Date	Service	Lead	End Date
Local Audits for Service Improvement	Missed Fractures Audit	Quarterly Quarter 1	Unscheduled Care	Senior Manager	Quarter 4 2025
Local Audits for Service Improvement	Mattress audit	Quarterly Quarter 1	Unscheduled Care	Senior Manager	Quarter 4 2025
Local Audits for Service Improvement	Hand Hygiene Audit	Quarterly Quarter 1	Unscheduled Care	Senior Manager	Quarter 4 2025
Local Audits for Service Improvement	Primary Care Attenders – removed as reported in BI	Biennial 2023	Unscheduled Care	Senior Manager	
Local Audits for Service Improvement	Paramedic/downgrade ambulance audit – Removed as reported in BI	Biennial 2023	Unscheduled Care	Senior Manager	
Local Audits for Service Improvement	PGD Audit	Monthly	Unscheduled Care	Senior Manager	Quarter 4 2025
Local Audits for Service Improvement	Paeds under five audit – scrutiny of every attender under five	Biennial 2024	Unscheduled Care	Senior Manager	Quarter 4 2025
Local Audits for Service Improvement	Ask & Act – Audit tool for RE Enquiry for Domestic Abuse in MIU	Quarterly Quarter 1	Unscheduled Care	Senior Manager	Quarter 4 2025

Medical Directorate

Medicines Management

Driver	Audit Title	Start Date	Service	Lead	End Date
Local Audits for Service Improvement	**4C antimicrobial prescribing in primary care.**	Quarter 2 2025/26	The Antimicrobial Stewardship (AMS) Pharmacist recruited October 2024 will take	Chief Pharmacist Emlyn Pritchard/Amie Bain	Quarter 3 2025/26

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			the lead on this audit moving forward.		
Local Audits for Service Improvement	**"Start Smart then Focus"** audit for antimicrobial prescribing in community hospitals	Quarter 1 2025/6		Amie Bain	Quarter 4 2025/6
Local Audits for Service Improvement	**Community Pharmacy Rota Services** The aim of this audit is to establish how much current rota services are used for their intended purpose.	Quarter 2 2025/26		Chief Pharmacist Emlyn Pritchard/Gail Brown	Quarter 3 2025/26
Local Audits for Service Improvement	**Blueteq assurance audit** A random sample of 10 patients will be selected and their clinical notes will be checked to ensure that they meet the criteria for treatment.	Quarter 3 2025/26		Chief Pharmacist Claire Jones	Quarter 4 2025/26
Local Audits for Service Improvement	**Controlled Drugs Management in clinical areas across PTHB.**	Quarter 4 2025/26		Controlled Drugs Accountable Officer Jayne Price/Internal Audit	Quarter 4 2025/26

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Corporate Functions

Resuscitation

Driver	Audit Title	Start Date	Service	Lead	End Date
Other National Audit	Completion of DNACPR	Q3 2025	Resuscitation	Resuscitation Officer	Q4 2025

Infection Prevention and Control

Driver	Audit Title	Start Date	Service	Lead	End Date
Local Audits for Service Improvement	Organisational IPS Environmental Audit	Annually	IPC Staff	IPC Lead	Q4 2025
Local Audits for Service Improvement	IPS Environmental Audit (More frequent/smaller)	Quarterly	IPC Staff	IPC Lead	Quarterly
Local Audits for Service Improvement	Mental Health Ward Environmental Audit	Annually	Ward Staff	IPC Lead	Q4 2025
Local Audits for Service Improvement	Hand Hygiene	Quarterly	Ward Staff	IPC Lead	Quarterly

Mental Health and Learning Disabilities

Mental Health

Driver	Audit Title	Start Date	Service	Lead	End Date
Audits in response to Identified Risk	Audit of Environmental Ligature Risk Assessment	Quarter 1	All Mental Health Units	Senior Nurse - Inpatient Matron role	Quarter 2

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Audits in response to Identified Risk	Audit of WARRN risk assessments	Quarter 4	All Mental Health Units	Consultant Nurse/Governance Lead	
Audits in response to Identified Risk	Audit of Security Risk Assessment	Quarter 2	All Mental Health and LD Units	Head of MH Operations	
Local Audits for Service Improvement	Audit of Care and Treatment plans	Quarter 2	All Mental Health Units	CTP Lead/Governance Lead	
National Programme Audit	NCISH Suicide audit	Quarter 2	All Mental Health Units	Suicide and SH Prevention Lead	
National Programme Audit	National review of schizophrenia audit	Quarter 4	All Mental Health Units	Clinical Director MH&LD	
Local Audits for Service Improvement	Inpatient Physical health monitoring audits	Quarter 1	Ward units	Clinical Director MH&LD	Quarter 2
Local Audits for Service Improvement	RCP/NICE quality standards for inpatient care	Quarter 1	Ward units	Senior Nurse - Inpatient Matron role	Quarter 2
Local Audits for Service Improvement	Medicine management audit	Quarter 1	All Mental Health & LD Units	Service Managers and Ward Managers	Quarter 2
Local Audits for Service Improvement	Hand hygiene/Matress audits	Quarter 1	Ward units	Ward Managers	Quarter 2
Local Audits for Service Improvement	Record Keeping	Quarter 1	All Mental Health Units	Team Leads/Ward Managers/IG	Quarter 2
Local Audits for Service Improvement	DNAs	Quarter 1	All Mental Health Units	Business and Performance Manager	Quarter 2
Local Audits for Service Improvement	Multi-factorial Falls Risk Assessment Audit (Inpatients)	Quarter 1	Ward units	Service Managers and Ward Managers	Quarter 2

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Local Audits for Service Improvement	Welsh Language Active Offer Audits	Quarter 3	All Mental Health & LD Units	TBC	
Local Audits for Service Improvement	WNB	TBC	CAMHS	CAMHS Operational Lead	
Local Audits for Service Improvement	Early Intervention in Psychosis	Quarter 2	CAMHS	CAMHS Operational Lead	Quarter 3
Local Audits for Service Improvement	Outcome Measure Audit	Quarter 2	CAMHS	CAMHS Operational Lead	Quarter 3
Local Audits for Service Improvement	LPMHSS Pathway Audit	Quarter 2	Community Based	Service Manager LPMHSS/Psychology	Quarter 3
Local Audits for Service Improvement	Policy Audit	TBC	All Mental Health & LD Units	CPAG	
Local Audits for Service Improvement	Community Medical Caseload and Admin	Quarter 1	All Mental Health Units	Clinical Director MH&LD	Quarter 2
Local Audits for Service Improvement	S117 Audit	Quarter 1	All Mental Health Units	Head of MH Operations	Quarter 2
Local Audits for Service Improvement	MH Act Compliance	Quarter 2	All Mental Health Units	HoMH Nursing	Quarter 3
Local Audits for Service Improvement	Adult & Older Adult CMHT MDT Audit	Quarter 2	Community Based	Head of MH Operations	Quarter 3
Local Audits for Service Improvement	Epilepsy audit	Quarter 1	All LD	Head of LD	Quarter 2
Local Audits for Service Improvement	Liaison data audit	Quarter 1	All LD	Head of LD	Quarter 2
Local Audits for Service Improvement	Champion training audit	Quarter 1	All LD	Head of LD	Quarter 2
Local Audits for Service Improvement	Anti-psychotic and physical health audit	Quarter 2	All Mental Health & LD Units	Consultant Psychiatrist/Head of SOAD	Quarter 3

Local Audits for Service Improvement	H&S audit doors/alarms/ radio functions	Quarter 1	Ward Based	Service Managers and Ward Managers	Quarter 2
Local Audits for Service Improvement	Medical Devices audit	Quarter 1	All Mental Health & LD Units	Service Managers and Team Managers	Quarter 2
Local Audits for Service Improvement	Environmental audit/ cleanliness/risks	Quarter 1	All Mental Health & LD Units	Service Managers and Team Managers	Quarter 2
Local Audits for Service Improvement	Fire risk audit drills/points/equipment	Quarter 1	All Mental Health & LD Units	Service Managers and Team Managers	Quarter 2
Audits in response to Identified Risk	Therapeutic observations audit	Quarter 2	All Mental Health & LD Units	Service Managers and Ward Managers	Quarter 3
Audits in response to Identified Risk	WCCIS and V4 MHM forms audit	Quarter 2	All Mental Health & LD Units	Service Managers and Ward Managers	Quarter 3
Audits in response to Identified Risk	Advocacy audit	Quarter 2	All Mental Health & LD Units	Head of LD	Quarter 3
Audits in response to Identified Risk	Discharge letters audit from in-patient services.	Quarter 2	All Mental Health & LD Units	Clinical Director MH&LD	Quarter 3
Audits in response to Identified Risk	Escorting patients off hospital grounds	Quarter 2	All Mental Health & LD Units	Service Managers and Ward Managers	Quarter 3
Audits in response to Identified Risk	Educational audit	Quarter 2	All Mental Health & LD Units	Service Managers and Team Managers	Quarter 3
Audits in response to Identified Risk	CRHTT audit of CTP/WARRN & 72 hour f2f assessments	Quarter 2	All Mental Health & LD Units	Service Managers and Team Managers	Quarter 3
Audits in response to Identified Risk	Older adult CMHT discharge audit	Quarter 2	All Mental Health & LD Units	Service Managers and Team Managers	Quarter 3
Audits in response to Identified Risk	s136 audit	Quarter 2	All Mental Health & LD Units	Clinical Director MH&LD	Quarter 3

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Women and Children's Service					
Midwifery					
Driver	Audit Title	Start Date	Service	Lead	End Date
Local Audit for Service Improvement	All Wales Handheld Maternity Records	Rolling	Maternity	Clinical Supervisor for Midwives	July 2025
Service evaluation	Maternity Triage Process Review		Maternity	MatNeo Champion	October 2025
Local Audit following change to policy or procedure	VTE Guideline		Maternity	Clinical Supervisors for Midwives	November 2025
Local Audit following change to policy or procedure	Spontaneous Rupture of Membranes Guideline		Maternity	Consultant Midwife	April 2025
Local Audit for Service Improvement	Perinatal Mental Health Birth Management Planning		Maternity	Perinatal Mental Health	December 2025
Local Audit for Service Improvement	Intrapartum Transfers from Powys to DGH *(Business as usual)*		Maternity	Consultant Midwife	June 2025
Local Audit for Service Improvement	Clinical Information Sharing Caseload *(Business as usual)*		Maternity	Clinical Supervisors/Consultant Midwife	March 2026
Children's Nursing Leadership Team					
Local Audit for Service Improvement	Transition	Q2 &Q4	Children's Services	SD	6 monthly
Local Audit for Service Improvement	Children's Continuing Care	Q4	Children's Services	SD	Q4
Children's Public Health nursing (Health Visiting & Flying Start)					
Local Audit for Service Improvement	Routine Enquiry (Quarterly)	Q1	Generic HV& Flying Start	WD/Delegate	Q3

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Local Audit for Service Improvement	Record Keeping	Annual	Generic HV& Flying Start	WD/Delegate	Record Keeping
Local Audit for Service Improvement	Was Not Brought	Monthly	Generic HV& Flying Start	WD/Delegate	Monthly
Local Audit for Service Improvement	Welsh Levels of Care	Quarterly	Generic HV& Flying Start	WD/Delegate	Quarterly
Local Audit for Service Improvement	Implementation of Guideline: Health Visiting Caseload cleanse	6monthly	Generic HV& Flying Start	WD/Delegate	6monthly
Local Audit for Service Improvement	Cypris Data Compliance	6 monthly	Generic HV& Flying Start	WD/Delegate	6 monthly
School Nursing and Immunisation Team					
Local Audit for Service Improvement	Was Not Brought	Monthly	School Nursing/Imms	WD/Delegate	Monthly
Local Audit for Service Improvement	Flu Immunisation Uptake	Following programme	Immunisation Team	WD/Delegate	
Local Audit for Service Improvement	DTP MenACWY Imms Uptake	Following programme	Immunisation Team	WD/Delegate	
Local Audit for Service Improvement	HPV Immunisation uptake	Following programme	Immunisation Team	WD/Delegate	
Local Audit for Service Improvement	E-Consent	Following each Imms programme	Immunisation Team	WD/Delegate	
Local Audit for Service Improvement	Level 1 Continence Delivery	Quarterly	School Nursing	WD/Delegate	Quarterly
Local Audit for Service Improvement	Record Keeping	Annual	SN/Imms	WD/Delegate	Q4
Local Audit for Service Improvement	Handwashing	Annual	SN/Imms	WD/Delegate	Q4

Local Audit for Service Improvement	ANTT (Immunisation nurses)	Annual	Immunisation team	WD/Delegate	Q4
	Safeguarding Caseloads	Quarterly	School Nursing Team	WD/Delegate	Quarterly
Community Paediatrics					
National Audit	National Audiology Audit	Q2	Comm Paeds	RL	Q3
Local Audit for Service Improvement	ADHD Medications	Q1	Comm Paeds	RL	Q2
Local Audit for Service Improvement	Downs Syndrome Audit	Q3	Comm Paeds	IP	Q4
Local Audit for Service Improvement	CPIP +Register review	Q4	Comm Paeds	LA/RL	Q4
Local Audit for Service Improvement	Record Keeping	Q2	Comm Paeds	SD/LA	Q3
Children's Community Nursing					
Local Audit for Service Improvement	Was not brought	Monthly	CCNS	CD/Delegate	Monthly
Local Audit for Service Improvement	Record keeping	Annual	CCNS	CD/Delegate	Quarter 4
Local Audit for Service Improvement	ANTT	Annual	CCNS	CD/Delegate	Quarter 4
Local Audit for Service Improvement	Paediatric Continence	Annual	CCNS	CD/Delegate	Quarter 4
Local Audit for Service Improvement	Paediatric Epilepsy	Annual	CCNS	CD/Delegate	Quarter 4
Neuro Development Team					
Local Audit for Service Improvement	Introduction of caseload management	Monthly	ND	CD/Delegate	Monthly
Local Audit for Service Improvement	Average length of open assessment pathways	Monthly	ND	CD/Delegate	Monthly

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Local Audit for Service Improvement	Record Keeping	Quarterly	ND	CD/Delegate	Quarterly
Local Audit for Service Improvement	Was Not Brought	Monthly	ND	CD/Delegate	Monthly

Audit Driver Key:

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

Progress Key:

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

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IMPACT ASSESSMENT					
This section must be completed for all strategic organisational decisions including approval of health board policies.					
QUALITY:					
	No impact	Negative	Positive	Both	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.
Safe					
Timely					
Effective					
Efficient					
Equitable					
Person Centred					
Workforce					
Leadership					
Culture					
Information					
Learn, Improve, Research					
Whole Systems Approach					
EQUALITY:					
	No impact	Negative	Positive	Both	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.
Age					
Disability					
Gender reassignment					
Marriage / civil partnership					
Pregnancy / maternity					
Race					
Religion or Belief					
Gender					
Sexual Orientation					
Welsh Language					
Socio-economic status					
Social exclusion					
Carers					

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

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Agenda item: 5.3

Patient Experience and Quality Committee	**29 April 2025**
Subject:	**Joint Inspection of Child Protection Arrangements (JICPA) Update**
Approved and presented by:	Claire Roche Executive Director of Nursing, Quality, Womens and Family Health
Prepared by:	Assistant Director of Nursing, Safeguarding
Other Committees and meetings considered at:	Executive Committee - 16 April 2025

PURPOSE:

To update the Patient Experience and Quality Committee on the Joint Inspection of Child Protection Arrangements (JICPA) actions for PTHB.

RECOMMENDATION(S):

The Patient Experience Quality and Safety Committee are asked to:

1. Take **ASSURANCE** from the progress made in progressing the health board specific actions within the JICPA.

Approve/Take Assurance	Discuss	Note
Y	Y	N

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:		
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	

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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) conducted 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 eleven 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 240130-Powys-JICPA-en.pdf

Strengths and areas for improvement were identified for the partnership and individual agencies. A whole system improvement plan which identified multi agency and individual agency actions was submitted by the Head of Childrens Services for Powys County Council to CIW.

The whole system improvement plan has been monitored within Powys Local Multi-Agency Safeguarding Operation Group which reports quarterly to the Mid and West Wales Regional Safeguarding Board.

The JICPA identified four specific actions for PTHB which were translated into a PTHB improvement plan and managed within PTHB Safeguarding Operational Group with oversight by PTHB Safeguarding Strategic Group.

All the improvements identified have been completed.

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).

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Improvement Required	Actions	By when	By whom	Status
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 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	May 24	SGT	Completed

All actions completed. Safeguarding Level 3 training compliance will continue to be reported on and monitored using the new reporting template into the Strategic Safeguarding Group. Compliance at the time of completing this report is 75%. Each service area is committed to continuing to support their staff to prioritise achieving compliance.

In addition to the agreed actions, PTHB Safeguarding Team are working with the NHS Wales National Safeguarding Services to take forward an All-Wales Safeguarding Level 3 Learning Record. This will ensure a consistent approach to evidencing Safeguarding Level 3 competencies across NHS Wales.

Improvement No 2
The Health Board's safeguarding Team needs 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	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

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supervision trigger list and for its use to become custom and practice.	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

All actions completed. In addition to the agreed actions PTHB Safeguarding Team are working with Powys County Council Children Services to design and develop and Multi Agency Safeguarding Supervision Process. This process will enable facilitated multi agency supervision sessions with practitioners who are working with children at risk of harm and listed on Powys Children Services Child Protection Register. Certain criteria will be set that must initiate Multi Agency Supervision, for example, periods of child protection registration that exceed 15 months, repeat child protection registrations, cases where there is drift, no progress in managing/reducing risks, professional disagreement and majority decisions regarding child protection registration. An anticipated launch date is Q2 2025-26

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	Reference the risks within the Safeguarding Risk Register and work with Service Groups to put strategies in place to mitigate the risk	Aug 24	Safeguarding Team and service groups	Completed
	Reference this work within PTHB's 2024/25 Safeguarding Maturity Matrix	June 24	Safeguarding Team	Completed

All actions completed. The Safeguarding Risk Register and Safeguarding Maturity Matrix have both been updated. The current Risk Score is 12, mitigations include;

- **I.** A representative from the Safeguarding Team invited to commissioning pre meetings where issues can be noted, raised and addressed. Safeguarding will be consulted when safeguarding statements within contracts require updating.
- **II.** Health staff have, when required to, access to Welsh Clinical Portal where they can review health information from other Welsh Health Boards.
- **III.** Significant Event Chronology Standard Operating Process updated and recirculated to practitioners.

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IV. Section added to WCCIS to enable health practitioners to list services children are open too.

V. Practitioners encouraged, reminded and supported to be professionally curious. Professional Curiosity Training available to practitioners.

VI. Children Not Brought to appointments Policy in place, services working with children in the Health Board undertake monthly audits of children not brought to appointments. The Safeguarding Team are engaged in a national piece of work led by the NHS Wales National Safeguarding Service to develop an All Wales Was Not Brought Guidance.

VII. PTHB Safeguarding Team supported the establishment of an NHS England Safeguarding and NHS Wales Safeguarding six monthly Connection Forum. The aim of the Forum is to provide support, advice and share learning between NHS England and NHS Wales, whereby they share boarders. The purpose of the Forum is to;

1. provide leadership for the commissioning process in relation to the Safeguarding agenda with a regional and integrated care system context.
2. understand, discuss and act on factors that affect the successful delivery of the safeguarding programme and projects within it.
3. broker relationships with stakeholders internally and externally.
4. discuss cross-border issues and share learning.

VIII. In March 2025 PTHB Safeguarding Team launched Pick up the Phone Campaign, an electronic poster encouraging staff to go **back to basics, Pick Up the Phone and have a conversation** with colleagues across Health Boards in Wales and our borders and with our partner agencies. The idea for this came from NHS England running the Campaign and gave consent for us to use and adapt.

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	Completed
	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	Completed
	Continue quarterly review of staff's use of significant event tracker	April 24	SGT	Completed

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All actions completed. The issues raised by staff relates to general recording and locating information within health systems as practitioners create individual records for each service. This is not unique to PTHB. In September 2023, a CIW Rapid National Review of Child Protection Arrangements in Wales recommended Welsh Government consider a single child record which will support processes and has been highlighted with national reviews Full report - Rapid Review of Child Protection Arrangements FINAL FOR PUBLICATION

In March 2025, the **Safeguarding in Health Review** commissioned by Welsh Government to review of the effectiveness of safeguarding arrangements in NHS Wales was published. One of the improvements within the report is for Welsh Government to explore the development and implementation of a Digital Tracking System to track actions from reviews, inspections, and reports at both organisational and national levels in NHS Wales. This three-year digital programme will involve key statutory partners and address the need for improved information sharing between agencies.

The Health Board is exploring a new system to replace WCCIS, this will provide opportunity for practitioners to be consulted on the requirements for a new system. Safeguarding is engaged in the work.

Many of the mitigating Actions within Improvement No 3 also apply to Improvement No 4

NEXT STEPS:

1. Service Groups will continue to report safeguarding training compliance at the PTHB Strategic Safeguarding Group
2. PTHB to engage in the national workstreams to implement the recommendations within Safeguarding in Health Review
3. Clinical Teams to engage in workshops regarding what is required from the new IT system being commissioned.

IMPACT ASSESSMENT
Not applicable

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Subject:	Committee Effectiveness – Patient Experience, Quality and Safety Committee
Approved and Presented by:	Helen Bushell, Director of Corporate Governance/Board Secretary
Author:	Deputy Board Secretary
Purpose:	This presentation provides a summary of the responses received to the Committee Effectiveness questionnaire and is provided to stimulate discussion within the Committee to support the identification of what works well, learning and actions for improvement.
Recommendations:	The Committee is asked to: • **DISCUSS** the summary of the Committee Effectiveness survey and any areas for action/improvement.
Executive Summary:	Each Committee of the Board is required to assess its effectiveness at the end of each year and to report its views to the Board on how governance arrangements might be improved. This is a key principle of good corporate governance which demonstrates a committee's understanding of its remit and oversight responsibility and a culture of continuous improvement. The approach for 2024/25 contains a questionnaire followed by discussion at the Committee meeting. The Committee effectiveness questionnaire focuses on the critical themes of: (i) composition and establishment, (ii) effective functioning, (iii) assurance and (iv) leadership and culture.

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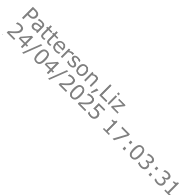
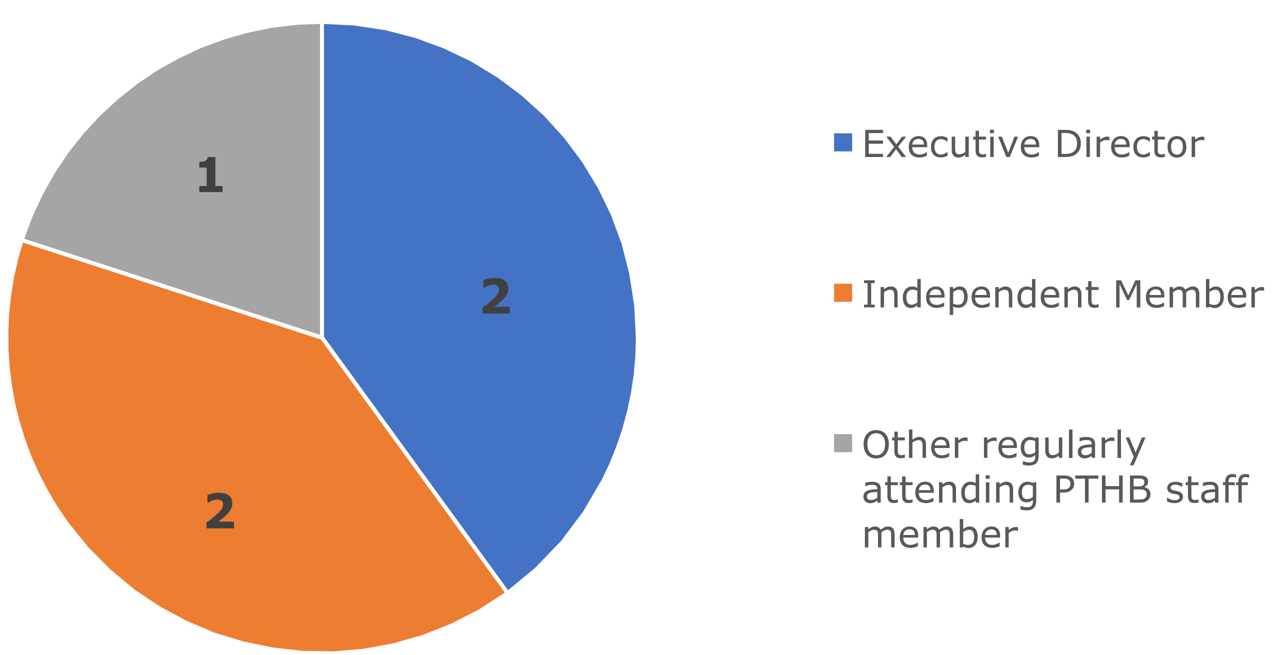
Section 1 – Response Rate





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5 responses in total

Section 2 – Composition and Establishment

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Section 2 - Composition and Establishment					
Question	Strongly Agree	Agree	Unsure	Disagree	Strongly disagree
The Committee understands its role:.	**3** 60%	**2** 40%	0	0	0
The Committee's annual work plan and subsequent agendas enable it to effectively deliver the relevant areas of its Terms of Reference: .	**2** 40%	**3** 60%	0	0	0
The Committee has the membership, authority and resources to perform its role effectively: .	**3** 60%	**2** 40%	0	0	0
The right people attend meetings of the Committee to enable it to fulfil its role effectively: .	**3** 60%	**2** 40%	0	0	0
Committee members have the collective skills and experience required to fulfil the terms of reference and advise and assure the Board.	**3** 60%	**2** 40%	0	0	0

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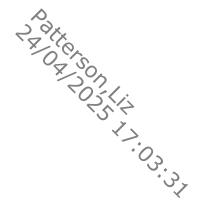
KEY THEMES:

- **Attendance/Membership**

Comments:

- The only challenge is when some IMs are unable to attend meetings; there is added pressure on those who do attend to provide sufficient scrutiny and challenge.
- The depth/detail/subject matter of some of the papers can be/are sometimes outside the expertise of some committee members; trying to find the right balance between asking questions to establish meaning/understanding and asking questions which scrutinise/challenge from a point of knowledge/experience is sometimes tricky.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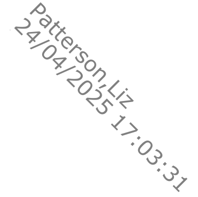
Section 3 – Effective Functioning



Overview of ratings – Effective Functioning

Section 3 - Effective Functioning					
Question	Strongly Agree	Agree	Sometimes	Disagree	Strongly disagree
Meeting arrangements (frequency, time allocation) allow members individually and collectively to contribute to effective scrutiny and challenge:.	**5** 100%	0	0	0	0
Committee meetings are conducted professionally and managed effectively with issues getting the appropriate time and attention proportionate to their importance:.	**5** 100%	0	0	0	0
Committee papers are of a reasonable length, good quality and provide the appropriate level of information to enable the Committee to fulfil its role: .	**2** 40%	**3** 60%	0	0	0
Papers are distributed in a timely manner, sufficient for members and attendees to adequately read, understand and scrutinise their content: .	**2** 40%	**3** 60%	0	0	0
There is good monitoring of matters arising and agreed actions to support the Committee in its role:.	**2** 40%	**3** 60%	0	0	0
Reports to the Board cover all key issues discussed at Committee. The Board takes due regard of the Committee's views (i.e. recommendations, escalated items, sharing of good practice) and shares feedb	**5** 100%	0	0	0	0

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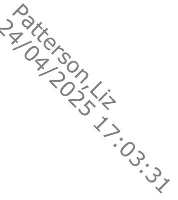
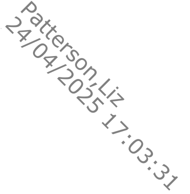
- There were no comments to share for this section



Section 4 – Assurance



Overview of ratings – Assurance

Section 4 - Assurance					
Question	Strongly Agree	Agree	Sometimes	Disagree	Strongly disagree
The Committee receives advice and assurance on key issues which clearly sets out the analysis of the situation, key risks and what is required of the Committee to allow the Committee to discharge its	**2** 40%	**3** 60%	0	0	0
Information received is sufficiently balanced in terms of evidence (assurance) and professional opinion (reassurance):.	**2** 40%	**3** 60%	0	0	0
The Committee receives timely reports on the work of external regulatory and inspection bodies and other independent sources of assurance: .	**1** 20%	**4** 80%	0	0	0
The Committee receives regular and sufficient evidence that the organisation is learning and improving:.	**2** 40%	**2** 40%	**1** 20%	0	0
The Committee receives the assurance (quantity, quality and timeliness) it needs to fulfil its role effectively:.	**2** 40%	**3** 60%	0	0	0
The mechanism for providing onwards assurance to the Board is effective:.	**4** 80%	**1** 20%	0	0	0

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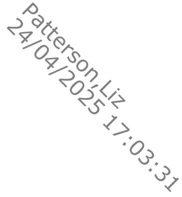
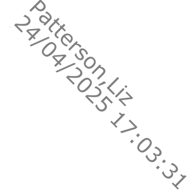
Comments:

- not sure the extent to which the committee receives 'regular' and 'sufficient' evidence that the org is learning (are examples of that Maternity Services review, Mental Health services?). Not sure we're improving fast enough, are not comprehensive enough the way we collect and collate patient feedback - could PEQS do more to push for that?



Section 5 – Leadership and Culture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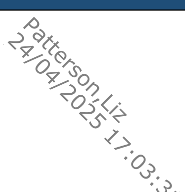
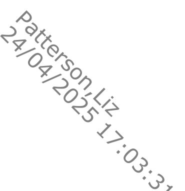
Section 5 - Leadership and Culture					
Question	Strongly Agree	Agree	Sometimes/Unsure	Disagree	Strongly disagree
In meetings, contributions from members and other attendees are encouraged, open debate is welcomed, and all contributions are listened to and respected: .	**5** 100%	0	0	0	0
The Committee environment is one in which members can provide supportive but critical challenge on key/sensitive issues: .	**5** 100%	0	0	0	0
The Chair summarises discussions well, captures the main points that have been made and clarifies how the Committee will progress the item under discussion: .	**4** 80%	**1** 20%	0	0	0
Committee members routinely probe the facts, challenge assumptions and identify the advantages and disadvantages of proposals:	**4** 80%	**1** 20%	0	0	0



Section 5 - Leadership and Culture					
Question	Strongly Agree	Agree	Sometimes/Unsure	Disagree	Strongly disagree
There is an effective relationship between Committee members and Executive colleagues:.	**5** 100%	0	0	0	0
Matters considered by the Committee are improved/strengthened as a result of the Committees involvement and/or feedback:.	**3** 60%	**2** 40%	0	0	0
The Committee is conducted in a manner consistent with the values of PTHB:	**5** 100%	0	0	0	0
The Committee is conducted in a manner consistent with the principles of compassionate leadership: .	**5** 100%	0	0	0	0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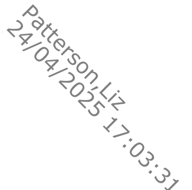
Comments:

- I have a sense that the Committee's feedback/involvement does add value to the matters discussed by the committee - but sometimes that depends on who's present and the quality of the input from committee members.
- I think adding value it's a great thing to look out for in any of the sub committees and Board - and something I will take away with me as learning objective i.e....did my contribution today add value to the items discussed? did it shift the dial at all? Is there evidence that matters are better BECAUSE of what was discussed- a point which is relevant to all sub committees and main Board...the 'so what' question!



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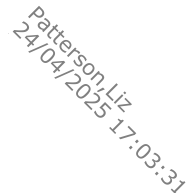
Section 6 – General Comments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In what areas do you think the Committee is doing well?
Identifying areas of good practice along with areas where further information may be required to be assured.
Scrutiny is robust but respectful. The Committee follows through on issues well. We hear from a range of voices and papers are generally well written. Meetings are productive.
Chairing and leadership; meeting culture; forensic focus on patients- we never go 'off track'.
Strong, constructive but supportive scrutiny
Culture of openness and challenge facilitates culture of learning and improvement Non exec level attendance is positive (and could be encouraged more to help develop staff and improve understanding of HB governance structures)

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In what areas do you think the Committee could improve and how?
It would be good to hear from other agencies to triangulate information. I believe there is still more to do in demonstrating that we are a learning organization and greater attention paid to risk. Still don't feel we have cracked patient voice.
No improvement areas come to mind- I see this committee as a model of quality which i try to take with me to other committees in my role as either committee member or Chair. Really like the 'out and about' development; one which I plan to replicate.
We need to balance planning our agenda with being agile to respond to issues that arise
More detail could be taken on assurance from service groups (i.e. they more directly present detail of Q&S issues within their service groups)

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What training/other development activity would support the Committee in its role?
Ongoing risk training would be welcome and more development around quality improvement.
Might be good to have an 1hr Deep Dive into PEQS - its mandate, key highlights (what has improved as result of PEQS) and our focus for next 12-18 months (?) at a Board Devt sessions (same could be said for all sub committees) - that would help reinforce learning and expectations of current PEQS members, help others have a better understanding of what we do and help all of us 'join the dots' in our heads about how the work of each of the subcommittees aligns/augments.
perhaps a session to describe the governance arrangements for service groups and their Q&S arrangements

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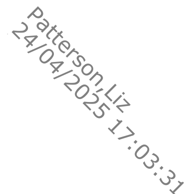
What areas should the Committee focus on in the future (incl. areas to be looked at more or less frequently)?
Focus should be on risk areas. Would like more focus on patient experience.
maintaining/pushing harder on patient experience, quality and safety focus in Better Together. More focus on seeking assurance around our Mental Health Services- are we doing enough on that? Could/should we push harder? Primary Care- how can we/ought we to drive/facilitate improvements in patient experience at our GP surgeries? Do we have a mandate there?
Patient experience framework / patient experience
See above - more detail form service groups. Should we also seek to take assurance on Q&S /incidents /learning from commissioned services /CQPRM processes?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Please feel free to expand on your answers above or make any other comments under this heading:2
PEQS is a very high performing committee - unquestionably. I'd be interested to know what aspects of patient experience, quality and safety we DON'T talk about. There may not be any ...do we cover it all? just reflecting on how do we know we're discussing the right priorities at the right time - I assume/trust we are, given the way the committee work programmes and agendas are developed..but always good to have a 'sense' check..how much horizon scanning do we do? If we were to stand back a little, what would be the top 3 things that PEQS should be addressing in order to be assured and drive improvements in patient experience, quality and safety. Given the temporary service changes agreed at last Board meeting, what is PEQS' role in providing assurance to the Board and public that patient experience, quality and safety is a priority for us.
Really effective committee, well done everyone

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Overall Summary

- A very positive review, scoring/ratings strong across all sections with no negative scores
- Some specific areas to consider for focus:
  - Membership/Attendance
  - Patient Experience/Patient Voice
  - Organisational Learning
  - Assurance from Service Groups
  - Risk based/agile Committee approach

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Next Steps

Next Steps

Actions	Timescale
1. Share content of the Effectiveness questionnaire with Committee	29 April 2025
2. Receive feedback from the Committee, discuss any actions / improvements	29 April 2025
3. Develop action plan, in partnership with Committee Chair, for Committee oversight based on Committee survey and contributions	Next Committee meeting (24 July 2025)
4. Committee feedback and key actions will be incorporated into summary report with other Committees' feedback and shared with the Board	By end May 2025
5. Committee forward plan for 2025/26 is in development and will form part of the Committee meeting (reviewed at each meeting)	Next Committee meeting (24 July 2025)
6. PTHB Chairs Forum will continue to develop an overarching role in committee focus areas and work plans	Ongoing

- Does the Committee collectively recognise the feedback?
- Are there any further reflections?
- Any areas of specific focus / priority to address?

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Agenda item: 5.6

Patient Experience, Quality and Safety Committee	**29 April 2025**
Subject:	Patient Experience, Quality and Safety Committee Terms of Reference
Approved and presented by:	Helen Bushell, Director of Corporate Governance and Board Secretary
Prepared by:	Deputy Board Secretary
Other Committees and meetings considered at:	N/A

PURPOSE:

The purpose of this paper is for the Committee to consider the Terms of Reference of the Patient Experience, Quality and Safety Committee in order to ensure that they remain fit for purpose.

RECOMMENDATION(S):

The Committee is asked to:

- **ENDORSE** the proposed amendments to the Terms of Reference
- **IDENTIFY** any further potential amendments
- **AGREE** that the Chair of the Committee and Director of Corporate Governance will finalise the revised Terms of Reference for presentation to the Board in May 2025 for approval.

Approve/Take Assurance	Discuss	Note
Y	Y	

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:		
1. Focus on Wellbeing		Commitment to good governance is a key element of Transforming in Partnership.
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	Y	

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EXECUTIVE SUMMARY:

Under the Standing Orders of the Health Board, Board Committees are required to review their Terms of Reference on an annual basis.

The existing Terms of Reference (May 2024) for the Patient Experience, Quality and Safety Committee with proposed changes tracked are attached as Appendix A.

Any suggested changes will need to be recommended to the Board for approval.

The Chair of the Committee and Director of Corporate Governance will take forward any recommendations and/or final amendments to the Board in May 2025 to take effect into 2025/26.

It is suggested that the Committee considers **the following proposals**:

Section of Terms of Reference	Updates
3 – Delegated Powers and Authority	• Updates to reference the Integrated Quality and Performance Framework/quality management system and Peoples Experience Framework • Patient experience in primary care has been added
5 - Committee meetings	The modern practice of holding meetings virtually has been reflected, including clarification in regard to arrangements for in-person meetings
Tidying up	The document has undergone general tidying up to ensure correct job titles etc. are reflected

NEXT STEPS:

The Chair of the Committee and Director of Corporate Governance will take forward any recommendations to the Board in May 2025 to take effect into 2025/26.

APPENDICES

a. Patient Experience, Quality and Safety Committee Terms of Reference (Draft April 2025 – using track changes to highlighted proposed changes)

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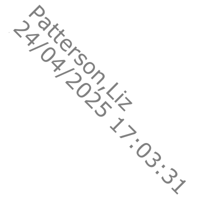
Patient Experience, Quality and Safety Committee

Terms of Reference & Operating Arrangements

Draft April 2025



1. INTRODUCTION

1.1 Section 2 of the Standing Orders of the Powys Teaching Health Board (referred to throughout this document as 'PTHB', the Board' or the 'Health Board') provides that:

"*The Board may and, where directed by the Welsh Government must, appoint Committees of the Health Board either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of its business extends equally to the work carried out on its behalf by committees*".

1.2 The Health Board has established a committee to be known as the **Patient Experience, Quality and Safety Committee** (referred to throughout this document as 'the Committee'). The Terms of Reference and operating arrangements set by the Board in respect of this committee are provided below.

2. PURPOSE

2.1 The scope of the Committee extends to the full range of PTHB responsibilities. This encompasses all areas of patient experience, quality and safety relating to patients, carers and service users, within directly provided services and commissioned services. The Committee will embrace the Health and Care Quality Standards as the Framework in which it will fulfil its purpose:

- Safe
- Effective
- Timely
- Person Centred
- Efficient
- Equitable

2.1 ADVICE
The Committee will provide accurate, evidence based (where possible) and timely advice to the Board and its committees in respect of the development of the following matters, consistent with the Board's overall strategic direction

- Citizen Experience; and
- Quality and Safety of directly provided and commissioned services.

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2.2 ASSURANCE

In respect of the achievement of the Boards' strategic aims, objectives and priorities, the Committee will seek assurances on:

a) The robustness of the Board's Clinical Quality Framework;
b) the experience of patients, citizens and carers ensuring continuous learning;
c) the provision of high quality, safe and effective healthcare within directly provided and commissioned services;
d) the effectiveness of arrangements in place to support Research and Innovation and
e) compliance with mental health legislation, including the Mental Health Act 1983 (amended 2007) and the Mental Capacity Act 2005.

3 DELEGATED POWERS AND AUTHORITY

3.1 With regard to the powers delegated to it by the Board, the Committee will:

a) Seek assurance that the Health Board's has relevant total quality management frameworks in place (via the Integrated Quality and Performance Framework and other associated plans) to ensure quality is central to health board activity, is aligned to national standards and is **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 PlanFramework;
- patient experience in primary care; 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;

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- the commissioning assurance arrangements in place to ensure efficient, effective, timely, dignified and safe delivery of commissioned services;
- the arrangements in place to undertake, review and act on clinical audit activity which responds to national and local priorities;
- the recommendations made by internal and external review bodies, ensuring where appropriate, that action is taken in response;
- the arrangements in place to ensure that there are robust infection, prevention and control measures in place in all settings;
- the development of the board's Duty of Quality Annual Report; and
- performance against key quality focussed performance indicators and metrics.

d) Seek assurance on the arrangements in place to support **Improvement and Innovation**, including:
   - an overview of the research and development activity within the organisation;
   - alignment with the national objectives published by Health and Care Research Wales (HCRW);
   - an overview of the quality improvement activity within the organisation.

e) Seek assurance that arrangements for **compliance with mental health legislation** are sufficient, effective and robust, including:
   - the Mental Health Act 1983 Code of Practice for Wales and associated regulations;
   - the Mental Capacity Act 2005 Code of Practice and associated regulations;
   - the Mental Capacity Act 2005 Deprivation of Liberty Safeguards Code of Practice and associated regulations; and
   - the Mental Health Measure (Wales) 2010.

3.2 The Committee will consider and recommend to the Board for approval those policies reserved for the Board and delegated to this Committee for review, in-line with the Board's Management of Policies and Other Written Control Documents Policy ~~Policy Management Framework~~ and Scheme of Delegation and Reservation of Powers.

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3.3 The Committee will seek assurances on the management of strategic risks delegated to the Committee by the Board, via the ~~Corporate~~ Strategic Risk Register.

Authority

3.4 The Committee is authorised by the Board to investigate or have investigated any activity within its terms of reference. In doing so, the Committee shall have the right to inspect any books, records or documents of the Health Board relevant to the Committee's remit and ensuring patient/client and staff confidentiality, as appropriate.

The Committee may seek any relevant information from any:

- employee (and all employees are directed to cooperate with any reasonable request made by the Committee); and
- any other committee, sub committee or group set up by the Board to assist it in the delivery of its functions.

3.5 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary (subject to the Board's procurement, budgetary and any other applicable standing requirements).

Access

3.6 The Head of Internal Audit shall have unrestricted and confidential access to the Chair of the Committee.

3.7 The Chair of the Committee shall have reasonable access to Executive Directors and other relevant senior staff.

Sub Committees

3.8 The Committee may, subject to the approval of the Board, establish sub committees or task and finish groups to carry out on its behalf specific aspects of Committee business.

3.9 The Committee has established a sub-committee, named the **Mental Health Act Power of Discharge Group.** The purpose of this group is to review and monitor how the operation of the delegated functions under Section 23 of the Mental Health Act 1983 are being exercised. This group will report through to the Patient Experience, Quality & Safety Committee providing assurance in-line with its agreed Terms of Reference.

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Committee Programme of Work

3.10 Each year the Board will determine the Committee's priorities for its

annual programme of work, based on the Board's Assurance Framework and ~~Corporate~~ Strategic Risk Register. This approach will ensure that the Committee's focus is directed to the areas of greatest assurance needs. This will therefore mean that these Terms of Reference are provided as a framework for the Committee's annual programme of work and is not an exhaustive list for full coverage.
This approach recognises that the Committee's programme of work will be dynamic and flexible to meet the needs of the Board throughout the year.

4 MEMBERSHIP

Members

4.1 Membership will comprise:

Chair	Vice Chair of the Board
Vice Chair	Independent Member of the Board
Members	Independent ~~Membera~~ Members of the Board x3

The Committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise.

Attendees

4.2 In attendance: The following Executive Directors of the Board will be regular attendees:

- Executive Director of Nursing, Quality, Women and Family Health (Officer Lead)
- Executive Director of Allied Health Professions, Health Science and Digital
- Executive Medical Director
- Executive Director of Public Health
- Executive Director of Primary Care, Community and Mental Health

4.3 By invitation:
The Committee Chair extends an invitation to the PTHB Chair and Chief Executive to attend committee meetings.

The Committee Chair will extend invitations to attend committee meetings, dependent upon the nature of business, to the following:

- other Executive Directors not listed above;
- other Senior Managers and
- other officials from within or outside the organisation to attend all or part of a meeting to assist it with its discussions on any particular matter.

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Secretariat

4.4 The Corporate Governance Team will provide secretariat services to the Committee.

Member Appointments

4.5 The membership of the Committee shall be determined by the Board, based on the recommendation of the Chair of PTHB - taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government.

4.6 Members shall be appointed to hold office for a period of one year at a time, up to a maximum of their term of office. During this time a member may resign or be removed by the Board.

4.7 Terms and conditions of appointment, (including any remuneration and reimbursement) in respect of co-opted independent external members are determined by the Board, based upon the recommendation of the Chair of PTHB.

Support to Committee Members

4.8 The Director of Corporate Governance / Board Secretary, on behalf of the Committee Chair, shall:

- arrange the provision of advice and support to committee members on any aspect related to the conduct of their role; and
- ensure the provision of a programme of development for committee members as part of the Board's overall Development Programme.

5 COMMITTEE MEETINGS

Quorum

5.1 At least **three** members must be present to ensure the quorum of the Committee, one of whom should be the Committee Chair or Vice Chair.

5.2 Where members are unable to attend a meeting and there is a likelihood that the Committee will not be quorate, the Chair can invite another independent member of the board to become a temporary member of the Committee.

Frequency of Meetings

5.3 The Chair of the Committee shall determine the timing and frequency of meetings, which shall be held four times a year, and in line with the Health Board's annual plan of Board Business.

5.4 The Chair of the Committee may call additional meetings if urgent business is required to be taken forward between scheduled meetings.

Openness and Transparency

5.5 Section 3.1 of PTHB Standings Orders confirms the Board's commitment to openness and transparency in the conduct of all its business and extends equally to the work carried out on its behalf by Committees. The Board requires, wherever possible, meetings to be held in public. The Committee will:

- hold meetings in public, other than where a matter is required to be discussed in private (see point 5.6);
- meetings may be held virtually with opportunities extended to the public to observe meetings held virtually on request;
- issue an annual programme of meetings (including timings and venues) and its annual programme of business;
- publish agendas and papers on the Health Board's website in advance of meetings;
- ensure the provision of agendas and minutes in English and Welsh and upon request in accessible formats, such as Braille, large print, and easy read;
- where appropriate items may be included as 'consent' items (items that do not require discussion or debate either because they are routine or have already been unanimously agreed. A Consent Agenda allows the Committee to approve all these items together without discussion which can free up the meeting for more substantial discussion. When using a Consent Agenda, the Chair will invite members to request a discussion on any item on the Consent Agenda. If a request is made this item will move onto the Main Agenda for discussion); and
- through PTHB's website, promote information on how attendees can notify the Health Board of any access needs sufficiently in advance of a proposed meeting, e.g., interpretation or translation arrangements, in accordance with legislative requirements such as the Equality Act 2010 and Welsh Language Standards 2018.

Withdrawal of individuals in attendance

5.6 There may be circumstances where it would not be in the public interest to discuss a matter in public, e.g., business that relates to a confidential matter. In such cases the Chair (advised by the Director of Corporate Governance / Board Secretary where appropriate) shall

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schedule these issues accordingly and require that any observers withdraw from the meeting. In doing so, the Committee shall resolve:

That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960 (c.67).

In these circumstances, when the Committee is not meeting in public session it shall operate in private session, formally reporting any decisions taken to the next meeting of the Committee in public session.

Other meeting arrangements

5.7 Committee meetings will be held via virtual means unless otherwise specified.

5.8 Should a meeting be held in person this will be confirmed in advance by the Chair and Director of Corporate Governance/Board Secretary. In-person meeting arrangements will be co-ordinated and communicated in advance by the Corporate Governance Team.

6. RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

6.1 Although the Board has delegated authority to the Committee for the exercise of certain functions (as set out within these terms of reference), the Board retains overall responsibility and accountability for all matters relating to performance and resources.

The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.

6.2 The Committee will work closely with the Board's other committees, joint and sub committees and groups to provide advice and assurance to the Board through the:

- joint planning and co-ordination of Board and Committee business (holding joint meetings where appropriate);
- sharing of appropriate information; and
- applicable escalation of concerns. in doing so, this contributes to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.

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The Committee shall embed the Health Board's agreed Values and Behaviours, as set out in the Board's Values and Behaviours Framework, through the conduct of its business.

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

- report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes verbal updates on activity, and the submission of ~~Committee minutes and~~ written assurance reports;
- bring to the Board's specific attention any significant matters under consideration by the Committee;
- ensure appropriate escalation arrangements are in place to alert the Chair of PTHB, Chief Executive or Chairs of other relevant committees/groups of any urgent/critical matters that may affect the operation and/or reputation of the Health Board.

The Board may also require the Committee Chair to report upon the Committee's activities at public meetings, e.g., Annual General Meeting, or to community partners and other stakeholders, where this is considered appropriate, e.g., where the committee's assurance role relates to a joint or shared responsibility.

7.2 The Director of Corporate Governance / Board Secretary shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation including that of further committees established.

7.3 The Committee shall provide a written annual report to the Board on its activities. The report will also record the results of the Committee's self-assessment and evaluation.

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

8.1 The requirements for the conduct of business as set out in PTHB's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum

9. CHAIR'S ACTION ON URGENT MATTERS

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9.1 There may, occasionally, be circumstances where decisions which would normally be made by the Committee need to be taken between scheduled meetings, and it is not practicable to call a

meeting of the Committee. In these circumstances, the Chair of the Committee, supported by the Board Secretary as appropriate, may deal with the matter on behalf of the Committee - after first consulting with at least two other Independent Members of the Committee. The Board Secretary must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.

9.2 Chair's action may not be taken where the Chair has a personal or business interest in the urgent matter requiring a decision.

10. REVIEW

10.1 These Terms of Reference shall be reviewed annually by the Committee. The Committee Chair will report any changes to the Board for ratification.

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Patient Flow and Discharge Management

Final Internal Audit Report 2024/25

Powys Teaching Health Board

Review Reference	PTH-2425-06
Fieldwork	October 2024 – January 2025
Executive Sign Off	27th February 2025
Audit Committee	March 2025
Executive Lead	Elaine Lorton, Executive Director of Operations, Community and Mental Health.
Distribution	David Farnsworth, Assistant Director Community Services Group. Claudia O'Shea, Senior Manager USC Christina Thomas, Senior Manager USC
Audit Team	Ian Virgill, Head of Internal Audit Liz Vincent, Principal Auditor

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GIG CYMRU NHS WALES | Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

Executive Summary

Purpose

The overall objective of the audit was to review the current controls and systems around patient flow, reducing discharge delays and work of the Complex Care and Unscheduled Care Team.

Overview

Providing safe, timely and effective discharge for every person who attends hospital is essential, however due to the ageing demographic and an increasing number of older patients being admitted, the complexity of the discharge planning has increased.

The Welsh Governments (WG) 'Hospital Discharge Guidance' issued in September 2024 sets out guidance on Hospital Discharge standards for health, social care, third and independent sector partners in Wales. The principles and processes that support effective discharge are set out in the Discharge to Recover then Assess (D2RA) Pathways Guidance. All patients with a decision to admit to hospital should be assessed and provisionally allocated to one of four pathways.

The national 'Six Goals for Urgent and Emergency Care Programme' sets out the expectations for the Health Boards and their partners for the delivery of the right care, in the right place, first time for physical and mental health. It outlines six goals to help achieve the best possible clinical outcomes, value and experience for patients and staff involved in the delivery of care. The goals include:

Goal 5 – Optimal hospital care and discharge practice from the point of admission.

Goal 6 – Home first approach and reduce the risk of readmission.

We have concluded **Reasonable** assurance on this area. The significant matters requiring management attention include:

- The Community Hospital Discharge policy is outdated and requires revision to align with the Welsh Government's 'Hospital Discharge Guidance' released in September 2024.
- Staff members are required to retake the D2RA training course to guarantee full compliance and to ensure that their records are updated in the ESR system.
- Staff members comprehension of Red2Green (R2G) days did not completely align with the guidance provided by Welsh Government. Additionally, the recording of R2G days within the DigiFLO whiteboards indicated that the wards included in the sample were not effectively updating or utilising the R2G feature.
- We were unable to locate adequate evidence within the current systems to explain the rationale behind the decision regarding the D2RA Pathway.
- A Clinical frailty Score for patients over 65 does not form part of the patient assessment on admission to the Community Hospitals.
- The remaining six key findings are operational in nature and include the utilisation of DigiFLO whiteboards, use of Inpatient Notes within WNCR, and delays in setting an estimated date of discharge.

Full details of matters arising are detailed within the Findings & Agreed Action Plan. The following opportunities for enhancement have been identified that do not impact the overall opinion and are highlighted for management information:

- Pharmacy are not always in attendance at MDT meetings.
- User Access Guidance for the Patient Flow List has been prepared and is currently under review by the Local Authority for approval. Once finalised, it needs to be included as an Appendix to the Integrated Patient Flow SOP.
- A comprehensive reporting structure detailing the hierarchy and communication flow concerning discharge management would be beneficial.
- Identifying the attendees of meetings proved challenging due to the absence of this being documented.
- There were limited instances of delays in the identification of a Powys Plan pathway for patients in the Wye Valley Trust.

Scope & Assurance Summary

	Objectives	Related Findings	Assurance
1	The Health Board has up to date policies and procedures in place for discharge management that reflect the requirements of the Welsh Government's Hospital Discharge Guidance and the D2RA Pathways Guidance.	1,2	**Reasonable**
2	Relevant staff within the Health Board are aware of the policies and procedures in place and have received appropriate training where required.	3	**Reasonable**
3	Processes and resources are in place to support timely discharge of patients from the Health Board's Community Hospitals, including allocation to a specified D2RA pathway discharge stream and identification of an Expected Discharge Date (EDD) at the point of admission.	4,5,6,7,8,9,10,11	**Limited**
4	The Health Board has processes and resources in place to work with local teams in provider Health Boards and Trusts to support the timely discharge and / or repatriation of Powys residents.	10,11	**Reasonable**
5	Data is collated, reviewed and analysed to demonstrate the effectiveness of the discharge management arrangements and support compliance with the key principles of the guidance, and actions are taken to address areas of poor performance and low/non-compliance.		**Substantial**
6	Robust governance arrangements are in place to ensure timely and effective monitoring and oversight of discharge management, including effective co-ordination with local authorities and the third sector.		**Substantial**

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Findings & Agreed Action Plan

Objective 1: The Health Board has up to date policies and procedures in place for discharge management that reflect the requirements of the Welsh Government's Hospital Discharge Guidance and the D2RA Pathways Guidance.	**Reasonable**

Overview / Summary of Observations

There are three established policies and procedures governing Patient Flow and discharge management: the 'Community Hospital Discharge Policy & Procedures', the 'Management of Reluctant Discharge procedure', and the 'Integrated Patient Flow Standard Operating Procedure' (SOP). The Management of Reluctant Discharge procedure was released in June 2024, aligning with the WG guidance. However, the Integrated Patient Flow SOP, issued in July 2024, has become outdated due to recent changes in certain processes. Additionally, it is important to note that the Community Hospital Discharge Policy is out of date, with its last review occurring in January 2018.

	Key Findings	Risk & Impact	Agreed Management Action
1	**Out of date 'Community Hospital Discharge Policy & Procedures'.** The Health Boards 'Community Hospital Discharge Policy & Procedures' (GNP042) is outdated and does not include the specific requirements and processes that are detailed in the September 2024 WG hospital discharge guidance. The WG document is key to patient flow and sets out the guidance on Hospitals Discharge standards for health, social care, third and independent sector partners in Wales. The update to the Health Board's Hospital Discharge Policy & Procedures will need to incorporate all the necessary elements of the guidance to ensure the delivery of optimal outcomes is fully addressed. For example, D2RA, SAFER, REDtoGREEN and Prevent Deconditioning. Including a 'Planning your Discharge' Letter as an appendix to the Policy would also be advantageous	If detailed policy and procedures are not in place, the principles set out in the WG guidance may not be adhered to.	**Agreed Action:** Develop an updated 'Community Hospital Discharge Policy & Procedures', incorporating all relevant information from the September 2024 WG hospital discharge guidance. Once the Policy has been developed, staff will be made aware of its existence, and it will made accessible to staff via the intranet pages.
			Expected Evidence of Implementation: March 2025 GNP 042 Community Hospital - revision in process of being uploaded to intranet Minutes of Bi Monthly Operations - Minutes of approval for the above in CSG ops
		High Priority	**Officer:** Claudia O'Shea **Target Implementation Date:** 1/4/25
	Theme: Policies & Procedures	Control Design	

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2	**Update the Integrated Patient Flow SOP.** The Integrated Patient Flow SOP (GNP 088) documents the overarching approach adopted by the Health Board and Powys County Council (PCC) to ensure appropriate flow of Powys residents, both in the Community Hospitals and bordering District General Hospitals. The procedure references the WG Six Goals for Urgent and Emergency Care (with a hyperlink to the relevant document on page 8) and also mentions the D2RA model and Hospital Discharge Guidance. However, the hyperlink for the D2RA pathway incorrectly directs to the Six Goals Policy, whereas it would be more appropriate to link the 'Delivering optimal outcomes and experience for people in hospital'. The link to the Hospital Discharge Policy also needs to be updated once the Policy has been developed. This SOP is primarily operational in nature, emphasising governance, reporting on Pathways of Care Delays and Census, as well as system escalations. Recent modifications to several of these processes have occurred and the policy requires an update to align with the new Patient Flow List which was introduced on 21st October 2024. Additionally, it should include the new Ready to Go units and the governance related to user access for SharePoint.	Incorrect details in the SOP could compromise compliance with the principles established in the WG guidance. **Medium Priority**	**Agreed Action:** Revise the Standard Operating Procedure to incorporate the recent modifications to several processes and verify that all links are functioning properly. **Expected Evidence of Implementation:** Revision and publication of SOP **Officer:** Senior Nurse Patient Flow **Target Implementation Date:** 1/4/25
	Theme: Policies & Procedures	Control Operation	

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Objective 2: Relevant staff within the Health Board are aware of the policies and procedures in place and have received appropriate training where required.	Reasonable

Overview / Summary of Observations

Meetings were conducted with the Discharge Coordinator and the Nurses in Charge of both Y Bannau Ward and Epynt Ward. During these discussions, they demonstrated their familiarity with the location of the Discharge Policies and provided explanations regarding the D2RA concept.

D2RA videos are available on the intranet, and staff have undergone training provided by the national team. To promote awareness of this training, posters have been placed in the wards, and a dedicated SharePoint page for D2RA and Optimal Hospital Flow has been established. This page features the latest Welsh Government Hospital Discharge Guidance and the Management of Reluctant Discharge/Transfer of Care document. It also guides staff to the D2RA training modules that were incorporated into the ESR system in June 2023.

	Key Findings	Risk & Impact	Agreed Management Action
3	**Compliance with D2RA module within ESR** A request for a list of staff who have completed the D2RA course revealed that only one individual had done so. The USC Senior Manager clarified that some staff completed the training before the D2RA module was launched on ESR. Consequently, a request has been sent to all staff to retake the course to ensure their records are updated in ESR. There is no specific deadline for retaking this module, but discharge remains a regular agenda item in their internal meetings. Furthermore, bi-monthly meetings are held with Ward Staff. Although this training is not formally structured, it includes updates on policies and encourages discussions about the impact of these changes on patient care.	Insufficiently updated records could lead to incomplete training documentation, which may have implications for compliance.	**Agreed Action:** Establish a specific timeframe for staff to retake the course, ensuring accountability and timely compliance. Monitor training progress and follow up with staff who have not yet completed the module. Consider using the existing bi-monthly meetings to emphasise the importance of the training, address questions, and provide support for those retaking the course. **Expected Evidence of Implementation:** ESR Monitoring in place with minuted bi monthly meetings with training as a standard agenda. To discuss and agree timeframes with HoN & Clinical Service Managers
		Medium Priority	**Officer:** Clinical Service Managers **Target Implementation Date:** Quarter 3 2025
	Theme: Training & Development	Control Design	

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Objective 3: Processes and resources are in place to support timely discharge of patients from the Health Board’s Community Hospitals, including allocation to a specified D2RA pathway discharge stream and identification of an Expected Discharge Date (EDD) at the point of admission.	Limited

Overview / Summary of Observations

The WG Hospital Discharge guidance offers detailed insights into the tasks, standards, and expectations applicable to different teams and departments. In our audit review, we assessed the processes in place at the ward level at Y Bannau and Epynt Ward at Brecon War Memorial Hospital to evaluate whether the Health Board had established appropriate practices for the effective implementation of the D2RA Pathways.

We were informed that early morning and afternoon huddles are not conducted on the wards, however, a handover occurs prior to the commencement of each shift. The handover notes do not contain any reference to the D2RA pathway for the patient, nor do the action notes specify whether the patient is classified as a red or green day.

Multi-disciplinary Team (MDT) meetings are conducted weekly in each of the wards included in the sample testing. For the 12 patients reviewed, the attendees at these meetings were considered appropriate. However, there was no evidence of Pharmacy attendance at any of the MDTs, which could potentially lead to delays in the administration of take-home medications.

WG guidance states that in order to minimise any delays to recovery and discharge the Red2Green (R2G) process must be adopted at all times. Although we can evidence the recording of R2G on the manual whiteboards and the DigiFLO whiteboards, staffs’ comprehension of R2G days did not completely align with the guidance provided by Welsh Government.

The decision around how the D2RA Pathway was decided, and how the rationale is conveyed from ward to a discharge co-ordination hub is unclear. Also evidencing how the family/ careers have been informed of this decision is also uncertain.

The organisation employs three methods for documenting electronic data related to Patient Flow; The Welsh Nursing Care Record (WNCR), the DigiFLO whiteboards and the Patient Flow Microsoft List database, which is managed by the Local Authority and is accessible to various staff members at USC Powys.

Before conducting our ward visits, we extracted the essential principles from the Welsh Government guidance and evaluated them against the patients in our sample. A number of issues were identified, which have been highlighted under key findings 7,8, 10 and 11.

Further testing was conducted on patients with complex discharge needs to determine whether their discharge was manged efficiently and promptly. Identifying the locations of blockages within the process was difficult due to the notes in Patient Flow. There was frequently a lack of clarity regarding when the assessments were sent to the Complex Care Team, if the documentation was returned for further information and when panel approval was obtained.

	Key Findings	Risk & Impact	Agreed Management Action
4	**Red2Green Process** The R2G standard has been integrated into the DigiFLO application and by default, all patients are categorised as red, requiring staff to manually update their status to green each day. Staff members comprehension of R2G days did not completely align with the guidance provided by Welsh Government.	Government guidance not adhered to in relation to managing patient discharge and hospital flow.	**Agreed Action:** Provide clear, step-by-step guidance for staff to fully understand the "Red2 Green Process" and how to correctly apply it using both the manual and electronic whiteboards. Conduct refresher training sessions for staff to ensure they fully understand the process. Incorporate the D2RA pathway and R2G standard to the handover documentation.

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	All patients listed on the DigiFLO Whiteboards for Y Bannau Ward and Epynt Ward were indicated as having a red day. This suggests that staff may not be adequately updating or using the R2G feature on the DigiFLO application. Furthermore, the manual boards are showing discrepancies, with some patients recorded as having a Green Day, leading to inconsistent reporting. It was also noted that the handover notes prepared before each shift currently lack references to the D2RA pathway and do not specify whether the patient is categorised as a red or green day. Integrating this information into the handover notes, can ensure that all staff members are well-informed and can effectively contribute to maintaining the appropriate pathway, promoting an increase in green days.	**High Priority**	**Expected Evidence of Implementation:** Concordance with boards and compliance of D2RA R2G demonstrated with reporting nationally **Officer:** Clinical Change Manager (Unscheduled Care)
	Theme: Quality, Safety & Patient Experience	Control Design	**Target Implementation Date:** Quarter 3 2025
5	**How the D2RA Pathway is decided and communicated** The Hospital Discharge guidance from WG emphasises there must be simple, robust and responsive local processes to enable the definitive pathway decision and rationale to be accurately conveyed from the ward to a discharge co-ordination hub, to ensure that safe and appropriate onward care and assessment can be arranged via the appropriate D2RA Pathway. Furthermore, once the decision of the definitive discharge pathway has been agreed, the patient and their family or unpaid carer and existing care providers must be informed and be provided with details of the decision. We could not find sufficient evidence within the existing systems to clarify how the decision regarding the D2RA Pathway was made. Additionally, the communication of this rationale from the ward to the discharge coordination hub remains unclear. It is also uncertain how families and caregivers have been informed about this decision.	Government guidance not adhered to in relation to managing patient discharge and hospital flow. **Medium Priority**	**Agreed Action:** Establish a standardised procedure for recording the decision-making process related to the D2RA Pathway, ensuring that the rationale and supporting evidence are clearly outlined. Additionally, document how families and caregivers have been informed about these decisions within the appropriate systems. **Expected Evidence of Implementation:** D2RA pathways recorded on Digiflow with HB wide compliance which feeds into national reporting Documentation on WNCR to reflect family discussions **Officer:** Clinical Change Manager (Unscheduled Care)
	Theme: Information, Data Quality & Data Accuracy	Control Design	**Target Implementation Date:** Quarter 3 2025

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6	**Utilisation of DigiFLO whiteboards** The DigiFLO whiteboard app can be installed on phones, tablets, laptops, and large screens, with nine wards currently equipped. It replicates manual whiteboard processes but faces information governance challenges, particularly maintaining an audit trail to track changes. Currently, large screens are accessible to all staff, but generic accounts only allow display access. Modifications require logging in with individual identification on a computer. Future plans include tap-to-login or PIN systems to enable broader access, including bank and agency staff. The current utilisation of the DigiFLO whiteboards is mixed with some departments still relying on manual whiteboards, as observed during the audit of the two wards.	Government guidance not adhered to in relation to managing patient discharge and hospital flow.	**Agreed Action:** Conduct targeted training and engagement sessions for departments still relying on manual whiteboards to demonstrate the benefits of the electronic whiteboard and address barriers to adoption. Expedite the implementation of a secure tap-to-login or PIN-based system to ensure accurate tracking of user actions while improving accessibility for all staff, including temporary personnel.
			Expected Evidence of Implementation: Utilization flow boards for all wards with user access, log ins, ability to audit data and bank and agency staff to access removing barriers to access. Ability to confirm access to all with IG barriers resolved for usability and visibility.
		Medium Priority	**Officer:** Clinical Change Manager (Unscheduled Care) **Target Implementation Date:** Quarter 3 2025
	Theme: Information, Data Quality & Data Accuracy	Control Operation	
7	**Clinical Frailty Score** The suggested standards outlined in the WG operational guidance for delivering optimal outcomes and experience for people in hospital states that patients aged 65 and over must have a clinical frailty score (CFS) on arrival into urgent care and those that are frail must have rapid access to comprehensive geriatric assessment (CGA) and rehabilitation. Currently this is not a requirement within WNCR, and it does not form part of the patient assessment on admission to the Community Hospital. Although the DigiFLO app includes a section for recording this information, it is currently underutilised. We have been notified that a new national deconditioning score is being developed, which will monitor deconditioning over time based on the length of stay. The DigiFLO whiteboards will be updated accordingly once this new score is implemented.	Government guidance not adhered to in relation to managing patient discharge and hospital flow.	**Agreed Action:** Utilise the DigiFLO system to document the clinical frailty scores of patients aged 65 and above. It may be beneficial to incorporate this procedure into the admission pack.
			Expected Evidence of Implementation: Clinical frailty scores as part of the output and recording function for DigiFlow.
		Medium Priority	**Officer:** Clinical Change Manager (Unscheduled Care) **Target Implementation Date:** Quarter 4 2026
	Theme: Information, Data Quality & Data Accuracy	Control Design	

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No.	Finding	Risk	Recommendation / Action

8	**Use of Inpatient Notes within WNCR**
	
	Within WNCR, there is a dedicated section for Inpatient Notes that allows users to select a 'note type' when updating entries, depending on the contributor or content being added. Available options include MDT Review, and Discharge discussions. The admission details and the estimated Date of Discharge (EDD) is also recorded in the system.
	
	As part of the sample testing, we examined the Nursing Notes and although it provided insights into patient mobility, nutrition, and assistance needs, the information could better align with the Hospital Discharge guidance. The notes should include indicators of whether a patient is experiencing a red or green day and the rationale behind this, thereby demonstrating that the R2G framework has been considered and discussed. Currently, the information provided is limited.
	
	Furthermore, the discharge discussion notes section within the Inpatient notes is infrequently utilised, with only three instances identified out of twelve.
	
	As highlighted in key findings 5 and 11, fully utilising WNCR to record all key information would enhance documentation practices and establish a more comprehensive audit trail.
		Government guidance not adhered to in relation to managing patient discharge and hospital flow.	**Agreed Action:**
			
			Establish a step-by-step guidance on what should be recorded within the Inpatient Notes under each specific 'note type' so that the information recorded is better aligned with the Hospital Discharge Guidance. The guidance should cover the following:
			• Highlight the key elements of the guidance that must be reflected in the Nursing Notes (e.g., indicators of R2G days, rationale for observations).
			• MDT Review Notes to include how the decision regarding the D2RA Pathway was made and communicated to patient and family. (Key Finding 5)
			• Enhance Discharge Discussion Notes by including key information, such as:
			  ○ What was discussed with the patient or their family, including discussions around EDD. (Key finding 10)
			  ○ Date the 'Planning your Discharge' Letter was issued and to whom it was issued. (Key Finding 11)
			
			After the guidance has been established, inform staff about its availability.

			Expected Evidence of Implementation: Update of WNCR user notes for guidance on the above completion (CNO Informatics) will need discussion with national team who control WNCR inputs. Implementation and monitoring of completion with Community Service Managers of PTHB Community Hospitals if above agreed.
		Medium Priority	**Officer:** Emma McGowan, Chief Nursing Information Officer **Target Implementation Date:** Quarter 3 Scoping & implementing into WNCR / Quarter 4 to implement into practice
	Theme: Information, Data Quality & Data Accuracy	Control Operation	
9	**Patients with complex needs** Patients categorised under Pathway 3 present complex needs. Those who are either CO or Discharge Ready and require Nursing Care must undergo a DST assessment or a PAN assessment by the appropriate ward. The findings should be sent to the Complex Care Team for review and submitted to the panel as needed.	Government guidance not adhered to in relation to managing patient discharge and hospital flow.	**Agreed Action:** Improve documentation practices by implementing a standardised template or clear guidelines for recording and tracking key dates, such as when assessments are forwarded to the Complex Care Team and when panel approvals are granted. This will enhance transparency and traceability and help to identify themes and trends.

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	We reviewed 24 patients on Pathway 3 and identified that four had a length of stay exceeding 100 days. Two of the four assessment documents for these patients took longer than 30 days to be completed and forwarded to the Complex Care Teams, with one extending up to 60 days. Additionally, we examined the time from the decision to assess the patient (when patient is CO) to the testing date (18/12/24). All four assessments exceeded 90 days, and two patients have been discharge ready since October 2024. Determining the locations of blockages within the process proved challenging based on the notes in Patient Flow. It was often unclear when the assessments were forwarded to the Complex Care Team or when they received panel approval. Accurately documenting these dates will enable management to determine whether delays originate from the wards or the Complex Care Teams. The Health Board, however, has recognised existing quality issues with the documentation sent to the Complex Care Team, and training needs have been identified to address these concerns.		Explore alternative systems like DigiFLO or WNCR for recording and tracking key dates, as access to Patient Flow is limited to specific staff members. Conduct targeted training sessions for Ward staff to address quality issues in the documentation submitted to the Complex Care Team.
			Expected Evidence of Implementation:
		Medium Priority	**Officer:** Clinical Change Manager (Unscheduled Care) – DigiFlow Quarter 3 2025 **Rhian Price Evans –** CHC Training Quarter 2 2025 **Target Implementation Date:** As above
	Theme: Training & Development	Control Operation	

Objective 4: The Health Board has processes and resources in place to work with local teams in provider Health Boards and Trusts to support the timely discharge and / or repatriation of Powys residents.

Reasonable

Overview / Summary of Observations

Wye Valley Trust (WVT) use three methods for documenting electronic data relating to Patient Flow. These methods include the Wye Valley system, the daily live list, which is an Excel document, and the Patient Flow list. A daily live report is generated from the Wye Valley system, capturing all patients registered with a GP in Powys. This information is then exported into the Excel document.

An email is distributed to recipients from Powys Teaching Health Board and Wye Valley, including senior managers, nursing staff, and members of their Care Transfer Coordinators (CTC) team. This communication outlines patients awaiting assessment from a local authority standpoint, highlights individuals who may qualify for the 'Ready to Go' unit, and specifies which patients are palliative and set for discharge today and tomorrow. The email also includes the 'daily live list' for information. This procedure offers a thorough overview of forthcoming discharges and incoming patients. This process is repeated again in the afternoon to ensure that all individuals are informed of any updates.

The Estimated Discharge Date (EDD) is determined during the Multidisciplinary Team (MDT) meetings, which occur daily, and in certain wards, twice a day. While the objective is to establish this date within 24 hours of a patient's admission, the decision is often influenced by the patient's complexity and can sometimes delay the outcome or they provide a preliminary estimate, which may evolve as the patient's journey progresses.

The D2RA care pathways are not implemented in WVT; however, a comparable pathway system is in place for each patient. For instance, Pathway 0 is designated for those returning home, while Pathway 1 caters to reablement or those with slightly elevated needs. Pathway 2 involves admission to a community hospital, and Pathway 3 addresses more complex cases.

The CTC attend daily meetings with social workers and a coordinator from the local authority, which is kept small for efficiency. During the meeting, each participant provides updates. The LA coordinator meets with brokerage beforehand to gather information on assessments and discharge dates. If a discharge date is set, the CTC will inform the ward and arrange the transfer home or to a nursing home by 4:00 PM. Additionally, the CTCs will coordinate transport and provide contact numbers for handovers, whether nurse-to-nurse or doctor-to-doctor. Any changes to the patient journey is documented on all three systems. Alongside the daily meetings, a Delay in Transfer of Care (DTOC) meeting is held every Tuesday. This meeting brings together all CTCs and local authorities, providing a platform for Senior Managers to participate and present challenges.

A sample of the 'daily live lists' was received and evaluated. However, we were unable to compare this data with the Patient Flow List, as the Patient Flow List is a live system, making retrospective analysis impossible.

	Key Findings (Relating to Objectives 3 and 4)	Risk & Impact	Agreed Management Action
10	**Estimated Date of Discharge (EDD)** **Powys Community Hospitals** As part of the sample testing, we compared the EDD recorded on the manual whiteboard to those documented in the WNCR. We identified three instances within Epynt Ward where the dates did not align. Additionally, we examined the interval between the admission date and the date when the original EDD was established. Across both wards, we discovered six cases where the EDD was set more than seven days post-admission, with the longest delay being 51 days.	Government guidance not adhered to in relation to managing patient discharge and hospital flow.	**Agreed Action:** Clear guidance on the management and recording of EDD needs to be established. Each patient should have an agreed-upon EDD confirmed during their initial Multidisciplinary Team (MDT) meeting or within 24 hours of admission, which must be documented and communicated to the patient and their family or caregivers. Any discussions or modifications regarding the EDD should occur and be recorded prior to the expiration of the original EDD.

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It is common for the EDD to be adjusted based on changes in patient needs and their progress in rehabilitation. Out of 12 patients, five had their EDDs modified from the original dates. Notably, for two of the five, the amendments recorded in WNCR occurred after the original EDD had lapsed, with one instance being 38 days later.

It is essential that the EDD is discussed with both the patient and their family; however, we were unable to locate any documentation of such discussions in the In-Patient notes under the MDT Review, or discharge discussion records. (key finding 8).

WVT

We tested a sample of 38 patients, 12 had an estimated discharge date (EDD) set within 24 hours of admission. The remaining 26 patients did not have an EDD within that timeframe, with 8 patients still lacking an EDD after 4 days, and one patient waiting up to 7 days.

While 68% of patients did not receive an EDD within 24 hours of admission, we recognise that there may be valid reasons or factors contributing to this situation. For instance,

- There are currently two CTCs operational. If one is absent from the office, the inclusion of the EDD in the daily live list may be affected by the volume of new admissions and overall workload. Although the EDD has been identified in the WVT system, the CTCs have not yet had the opportunity to update the list accordingly.
- There may be instances when WVT are at full capacity upon the admission of a Powys patient, resulting in them being allocated a bed within the boarding bays. Consequently, the CTCs will not be informed of this patient until they visit the wards, as the patient is not officially assigned a 'bed'.
- Delays in receiving MRI results, especially for stroke patients, can hinder timely decision-making regarding the expected EDD.

The CTC team is aware of these delays in the process and is actively working to enhance the situation.

Expected Evidence of Implementation:

EDD guidance recording to be reflected in Digiflow SOP & recorded as a reporting output measure.

WVT evidence, all WVT pts have an EDD with an improved system to identify PTHB pts regardless of bed allocation.

	Medium Priority	**Officer: Officer:** Clinical Change Manager (Unscheduled Care) – DigiFlow / Chistina Thomas WVT
Theme: Information, Data Quality & Data Accuracy	Control Design	**Target Implementation Date:** Clinical Change Manager (Unscheduled Care) – DigiFlow – Quarter 2 2025 / Chistina Thomas WVT – Quarter 3 2025

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11	**'Planning your Discharge' Letter** Individuals and their families or unpaid carers must be fully informed of the next steps at all stages of the inpatient stay and involved in the discharge planning process. The Welsh Government Hospital Discharge guidance includes a template for a 'Planning your Discharge' letter, which should be provided to patients. This letter emphasises that discharge planning should already be in progress and outlines the importance of facilitating a quick and safe discharge to enhance the patient's recovery. **Powys Community Hospitals** Our sample testing identified only one instance out of twelve where the system recorded that this letter had been issued. The WG guidance does not specify the appropriate timing for issuing the letter. It is therefore important for the Health Board to decide whether the letter should be provided after the patient's initial MDT review or included as part of the admission pack. Additionally, it would be beneficial to document the issue of the discharge letter in the Discharge Discussions section of the WNCR. (Key Finding 9) **WVT** During discussions with the CTC, it was observed that they do not provide a 'Planning your Discharge' letter to patients and caregivers. The CTC acknowledged that the letter was discontinued due to the outdated policy. However, they expressed their willingness to resume issuing and documenting the letter once the new policy, which incorporates the standard letter, is implemented.	Government guidance not adhered to in relation to managing patient discharge and hospital flow.	**Agreed Action:** Ensure that a 'Planning your Discharge' Letter is issued to each patient. Establish clear guidance on when the letter should be issued. Ensure that the issue of the letter is documented within WNCR system, as highlighted in key finding 9.
			Expected Evidence of Implementation: March 2025 for letter and issuing as part of PTHB Discharge Policy.
		Medium Priority	**Officer:** Senior Manager Unscheduled Care & Community Service Managers
	Theme: Information, Data Quality & Data Accuracy	Control Operation	**Target Implementation Date:** Quarter 2 2025

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Objective 5: Data is collated, reviewed and analysed to demonstrate the effectiveness of the discharge management arrangements and support compliance with the key principles of the guidance, and actions are taken to address areas of poor performance and low/non-compliance.	**Substantial**

Overview / Summary of Observations

The Integrated Patient Flow SOP is in place to guide this process. The primary data source is obtained from the Patient Flow list, which contains real-time patient information and tracks critical milestones for all admissions throughout their inpatient journey. It also tracks the Pathway of Care Delay (POCD) codes associated with each patient who has been classified as Clinically Optimised, and has exceeded 48 hours without being discharged.

The allocation of POCD codes to patients occurs on Census day during a meeting with the USC Senior Management team and the Local Authority Hospital Patient Transfer Manager. A Joint Validation meeting follows to confirm codes linked to delays, with validation finalised and approved within three days.

After the census submission, the national team will provide a spreadsheet to the Health Board and a dashboard that illustrates the organisation's performance in relation to the national targets. Themes and trends from the census reports, previously reviewed by the now-dissolved Strategic Oversight Group (SOG), are monitored by the POCD Action Plan working group, which meets quarterly. The Management Team uses the dashboard to track delay progress. The Senior Management Group has noted a reporting gap since the SOG's disbandment.

For 2024/25 the Care Action Committee has agreed the following ministerial targets of:

- 15% reduction in total Delays
- 20% reduction in total days delayed
- 20% reduction in delays due to an assessment reason code

In October, the Health Board reported a 21% decrease compared to their baseline for the 15% target reduction in total delays. Additionally, there was a 19% reduction against the 20% target for total days delayed, and a significant 43% reduction in delays attributed to an assessment reason code, surpassing the 20% reduction goal.

Every quarter, the Health Board is required to submit a POCD action plan. This plan outlines their top 1-5 key actions, details their initiatives related to the POCD reason codes, and assesses their progress towards meeting ministerial targets. The WG reviews the plan and offers feedback on the Health Board's latest submission. In August 2024, the WG acknowledged several positive aspects of the July POCD action plan but recommended that the Health Board include in their October submission the progress made during the second quarter to tackle capacity issues resulting from funding decisions. Additionally, they requested more detailed information regarding engagement with the regional Mental Health and Learning Disabilities lead.

A review of the October POCD Action Plan submissions indicates that the Health Board has supplied WG with further information on capacity issues. However, they could not advance engagement with the regional Mental Health and Learning Disabilities leads due to the Strategic Oversight Group being stepped down.

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Objective 6: Robust governance arrangements are in place to ensure timely and effective monitoring and oversight of discharge management, including effective co-ordination with local authorities and the third sector.	Substantial

Overview / Summary of Observations

To ensure that there is effective monitoring and oversight of discharge management within the Health Board, Unscheduled Care has established several meetings. These involve executive-led groups, representatives from Powys County Council, and third sector organisations, all collaborating alongside health professionals.

Patient Flow meetings primarily focus on reviewing district general hospitals, community hospitals extended length of stay, whereas the Daily Flow meetings are held to discuss safe care practices, which are escalated to organisational management and reported to the Delivery Coordination Group as needed. Alongside the daily meetings, the team has established the Delivery Co-location Group, tasked with monitoring the advancements of the temporary colocation modifications. Furthermore, they engage in the National Call to communicate the operational pressure levels of the Health Boards to the National Team.

In addition to these meetings, there is the bi-weekly Care Action Committee (CAC), formed in November to tackle the 50-day Integrated Care Winter Challenge initiated by the Welsh Government. This committee has taken the place of the SOG. After reviewing the information presented at the CAC, we are assured that the data previously discussed at the SOG is now being addressed within the CAC.

The POCD Action Plan working group convenes on a quarterly basis, prior to the submission of the updated action plan to Welsh Government. There is a Bimonthly Community Service Group Operational Meeting, which receives updates from each service. It was noted that the Terms of Reference for this meeting was incomplete and remained in draft form. Between April and July 2024, the Lead of Unscheduled Care participated in only one out of three scheduled meetings. Additionally, the meeting in October did not occur, and no subsequent meetings were communicated during the audit.

Before the disbandment of the USC SOG, a monthly highlight report was prepared for the Joint Executive Committee. This report included any unresolved operational issues that could impact service delivery. However, we could not determine whether this practice has continued or if the committee still convenes, as we were unable to obtain evidence of any recent meetings.

It has been noted that while several meetings are recorded in the Integrated Patient Flow Standard Operating Procedure, a comprehensive reporting structure detailing the hierarchy and communication flow concerning discharge management would be beneficial. Additionally, identifying the attendees of these meetings proved challenging due to the absence of this being documented.

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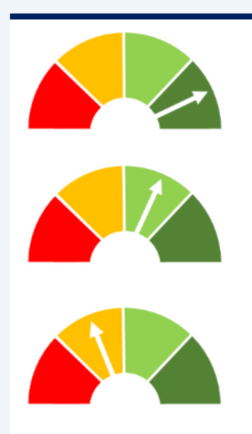
Appendix A

Assurance Opinion



Rating	Description
Substantial	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
Reasonable	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
Limited	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
Unsatisfactory	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
Advisory	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 Findings

Priority	Explanation
High	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
Medium	Some risk to achievement of a system objective. Minor weakness in system design OR limited non-compliance.

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The report is based on the review work undertaken and is not necessarily a complete statement of all weaknesses that exist or potential improvements. Whilst every care has been taken to ensure that the information provided in this report is as accurate as possible, no complete guarantee or warranty can be given with regard to the advice and information contained.

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 management of the 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.

Public Sector Internal Audit Standards

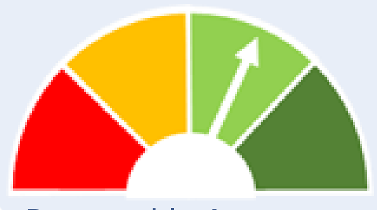
Audit work undertaken by NHS Wales Audit and Assurance Services conforms with the International Standards for the Professional Practice of Internal Auditing and associated Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

Additional Learning Needs Legislation

Final Internal Audit Report

2024/25

Powys Teaching Health Board



Reasonable Assurance

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Review Reference	PTH-2425-19
Fieldwork	December 2024 – February 2025
Executive Sign Off	27th February 2025
Audit Committee	March 2025
Executive Lead	Claire Roche, Director of Midwifery, Women and Family Health
Audit Team	Ian Virgill, Head of Internal Audit Warren Alexander, Principal Auditor

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Executive Summary

Purpose

Our review of the Additional Learning Needs Legislation was completed in line with the 2024/25 Internal Audit Plan for the Powys Teaching Health Board (PTHB, the 'Health Board').

The additional learning needs (ALN) system supports children and young people aged 0 to 25 in Wales with ALN and replaces the special educational learning needs (SEN) system. The ALN system is being implemented over a four-year period, which concludes in August 2025.

The ALN legislative framework was created by the Additional Learning Needs and Education Tribunal (Wales) Act 2018 (the ALNET Act, ALN Act), the Additional Learning Needs Code for Wales 2021 (the ALN Code) and regulations made under the Act.

The Act became lawful from 2021, but implementation is being phased in over a four-year period. In accordance with Section 61 of the Act, Local Health Boards must have a Designated Education Clinical Lead Officer (DECLO) for co-ordinating the Board's functions in relation to children and young people with ALN.

Chapter 9 of the ALN Code details their specific roles and responsibilities. The Act also continues the existence of the Special Educational Needs Tribunal for Wales, which hears and decides appeals and applications in relation to children and young people who have or may have ALN but renames it the Education Tribunal for Wales.

Overview

We have concluded **reasonable** assurance on this area. The matters requiring management attention include:

- Collaborative Governance arrangements for the partnership are insufficiently robust.
- Whilst training exercises have taken place, currently there is no formal training programme in relation to ALN operating within PTHB.
- The partnership's Work Plan has not been subject to adequate monitoring or scrutiny.
- Data validation processes are ongoing with respect to the case management system and therefore assurances cannot yet be placed on the accuracy of data contained within it.

Full details of matters arising are detailed within the Findings & Agreed Action Plan. The following opportunities for enhancement have been identified that do not impact the overall opinion and are highlighted for management information:

- The Terms of Reference belonging to the ALN Integrated Steering Group (AISG) lists attendees from all partner organisations. Agendas and action logs are produced but records of attendees have not been maintained.
- A multi-agency Strategic Plan has been produced by Powys County Council (PCC) on behalf of the partnership, but there is no evidence that PTHB was involved in the process. Efforts should be made to ensure that the Health Board is able to demonstrate its input to the ALN and Inclusion Strategic Plan where possible.
- Outcome monitoring procedures are yet to be developed. The establishment of effective outcome monitoring procedures should be raised with the ALN Integrated Steering Group.
- Performance monitoring procedures are yet to be developed. Performance monitoring procedures should be defined in consultation with the Women and Children's Quality and Performance Group.
- A Standard Operating Procedure has been produced in respect of the Health Board's Duties in relation to the ALN Tribunals process; the document has been submitted to the AISG for approval / ratification but has not yet been approved.

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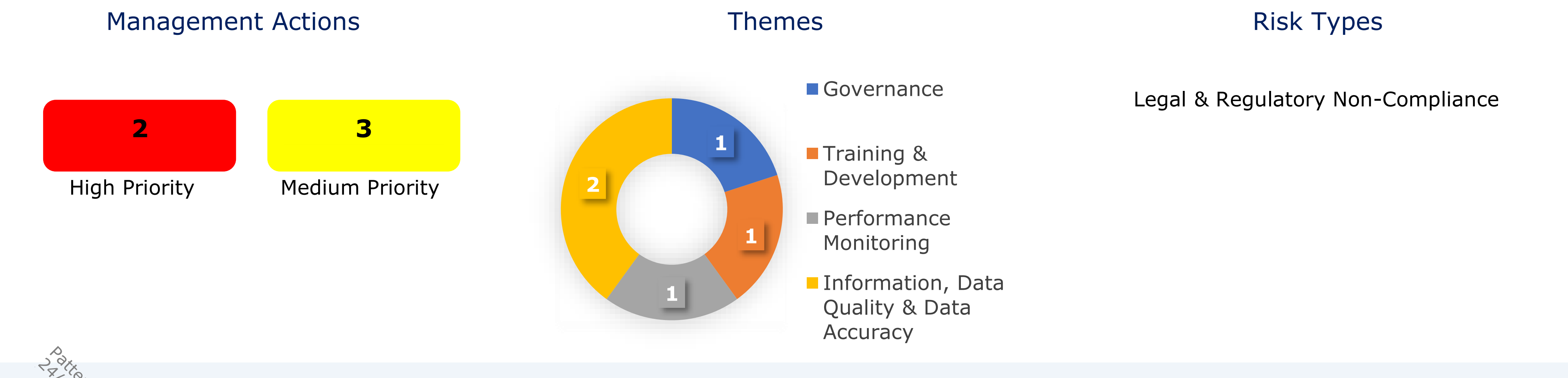
Scope & Assurance Summary

Objectives	The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.	Related Findings	Assurance
1	Sufficient progress is being made to implement the ALN Act through developing strategies, policies and procedures, and delivery plans.	1	**Reasonable**
2	There is sufficient training and engagement with staff.	2	**Limited**
3	Arrangements are in place to ensure effective multi-agency working between the health board, local authorities, and other partner organisations who cohesively engage and communicate with the public and service users.	3	**Limited**
4	There is an efficient and consistent system for recording and managing ALN requests, referrals, and notifications along with monitoring outcomes.	4, 5	**Reasonable**
5	There are robust quality assurance measures in place to demonstrate compliance with the ALN Act.	4	**Reasonable**
6	There are appropriate mechanisms for dealing with complaints, disputes, and appeals to the Tribunal.		**Substantial**
7	Appropriate governance framework is in place to provide oversight of compliance with the ALN Act including that the statutory roles and responsibilities of the Designated Educational Clinical Lead Officer (DECLO) are being met.		**Substantial**



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Findings & Agreed Action Plan

Objective 1: Sufficient progress is being made to implement the ALN Act through developing strategies, policies and procedures, and delivery plans.	**Reasonable**

An ALN Integrated Steering Group has been established in partnership with Powys County Council and Neath Port-Talbot Group of Colleges. A Strategic Plan and a Strategic Priorities Work plan in relation to the partnership have been produced.

A Standard Operating Procedure has been produced in relation to the Health Board's duties under the ALN Act for the purposes of providing guidance to staff.

No current staffing or capacity issues have been reported, although the potential exists for future increases in demands upon the service as the legislation becomes more established.

Governance arrangements have been documented in relation to the partnership insofar as senior representatives of each partner organisation are listed in the AISG Terms of Reference, but a lack of accountability was indicated with respect to actions contained in the work plan and this may have a detrimental impact on the effectiveness of the group. Clearly documented governance and escalation arrangements exist within PTHB, but the means by which the partnership itself is subject to overall scrutiny have not been clearly defined. **(Key Finding 1).**

	Key Findings	Risk & Impact	Agreed Management Action
1	**Governance Arrangements** Responsible individuals have been designated within each partner organisation but robust collaborative working governance arrangements are yet to be established.	Failure to comply with legislation resulting in a reputational risk, additional Welsh Government scrutiny, wasted financial and staff resource.	**Agreed Action:** An agenda item will be raised at the ALN Integrated Steering Group with the intention of establishing more clearly defined governance arrangements in respect of the partnership working arrangements. It will be requested that the newly established governance arrangements are employed to ensure that the strategic plan and actions listed within the work plan are subject to a documented approvals process and that monitoring procedures are established in order to address outstanding actions.
			Expected Evidence of Implementation: ALN Integrated Steering Group Minutes. Updated TORs to reflect updated Governance arrangements.
		Medium Priority	**Officer:** Assistant Director for Women and Children's Services / Director of Midwifery, Women and Family Health
	Theme: Governance	Control Design	**Date:** September 2025

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Objective 2: There is sufficient training and engagement with staff.	**Limited**

Several guidance documents, including detailed procedure notes, flowcharts and presentations have been produced in order to provide information to Health Board staff in relation to the requirements of the ALN Act. Emphasis is placed on the procedures Health Board staff must follow in order to ensure compliance with the Act.

Training materials are available, and we were informed by the DECLO that some training exercises have taken place in order to provide Health Board staff with information about their responsibilities under the new legislation. An audit of staff knowledge and confidence has been carried out but it does not appear that any actions have been implemented. A training schedule has not been established, and training records have not always been maintained. **(Key Finding 2).**

	Key Findings	Risk & Impact	Agreed Management Action
2	**Training** The DECLO has undertaken some training initiatives and offers individual assistance to colleagues who require guidance in relation to ALN issues but a formal or regular training programme is not currently in place.		**Agreed Action:** Training initiatives will be revisited; a training schedule will be produced, informed by existing or refreshed data about staff knowledge and confidence, and details of training availability will be made available to relevant staff. Records will then be maintained of attendance at completed training.
			Expected Evidence of Implementation: Training schedule. Training records.
		High Priority	**Officer**: Designated Education Clinical Lead Officer / Assistant Director for Women and Children's Services
	Theme: Training & Development	Control Design	**Date:** September 2025

Objective 3: Arrangements are in place to ensure effective multi-agency working between the health board, local authorities, and other partner organisations who cohesively engage and communicate with the public and service users.	**Limited**

Partnership arrangements have been established with relevant stakeholders in the ALN Integrated Steering Group, and some collaborative work has taken place in relation to a joint 'Strategic Priorities Plan'. Outcomes in the plan were appropriate, but in some cases were found to lack clarity in that intended actions have not always been documented. Target dates either have not been listed, are ambiguously defined, or have elapsed. **(Key Finding 3).**

Each partner's operational case management responsibilities are clearly defined and protocols for communicating with service users have been documented.

An 'ALN and Inclusion Strategic Plan 2024-2030' has been produced, although this was led by Powys County Council with only limited input from the Health Board.

	Key Findings	Risk & Impact	Agreed Management Action
3	**Strategic Priorities Plan Monitoring** A plan is in place, and whilst listed outcomes were appropriate, some were found to be unclear in terms of the means by which they are to be achieved. Target dates either have not been listed, are ambiguously defined, or have elapsed.	Ineffective arrangements resulting in wasted resources, failure to deliver strategic objectives, poor service user experience, and additional scrutiny from Welsh Government.	**Agreed Action:** Monitoring procedures in relation to the partnership's Strategic Priorities Plan will be reviewed and it will be ensured that regular reports are made at an appropriately senior level, with reference to the reviewed governance arrangements specified in Key Finding 1. **Expected Evidence of Implementation:** Work Plan progress reports.
		High Priority	**Officer:** Assistant Director for Women and Children's Services / Director of Midwifery, Women and Family Health
	Theme: Performance Monitoring	Control Design	**Date:** September 2025

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Objective 4: There is an efficient and consistent system for recording and managing ALN requests, referrals, and notifications along with monitoring outcomes.	**Reasonable**

A case management system 'ALN App' has been developed and is currently in the later stages of implementation. Once fully implemented, this will enable ALN requests and referrals to be recorded accurately, and for relevant data to be captured and made available to stakeholders such as the DECLO. However, there have been implementation issues surrounding the system, principally relating to ensuring all relevant data is input where necessary. Efforts are currently underway to ensure that all relevant data is captured within the system and a framework for monitoring compliance data is being implemented. **(Key Finding 4).**

It is also of note that data regarding the Health Board's duty (under Section 64 of the ALN Act) to notify the parents / carers of a preschool child and the responsible Local Authority in cases where the Health Board identifies that the child is likely to have ALN is not currently available. The system through which such notifications take place and the dataset associated with this are being finalised. **(Key Finding 5)**

Access arrangements to 'Tyfu', a system administered by PCC which contains service users' Individual Development Plans (IDPs) have been established for Health Board staff. Guidance is available to staff who are responsible for contributing to the IDPs.

Case outcomes are evaluated on an individual basis as part of the wider ALN processes but monitoring procedures in order to identify themes and trends in this area are yet to be developed.

	Key Findings	Risk & Impact	Agreed Management Action
4	**Data Validation** Data validation exercises are being undertaken but assurances cannot yet be made with respect to the completeness of data contained in the ALN App.	The health board does not comply with its statutory responsibilities resulting in children failing to access the support that they need leading to poor outcomes.	**Agreed Action:** Data validation exercises will continue and regular compliance reports will be made to the Planning, Partnerships and Population Health Committee.
			Expected Evidence of Implementation: Reports to the Planning, Partnerships and Population Health Committee.
		Medium Priority	**Officer: Assistant Director for Women and Children's Services / Director of Midwifery, Women and Family Health**
	Theme: Information, Data Quality & Data Accuracy	Control Design	**Date: December 2025**

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5	**Section 64 Notifications** The system by which notifications of suspected cases where additional learning needs have been identified and are issued to parents / carers and the Local Authority is yet to be established.	The health board does not comply with its statutory responsibilities resulting in children failing to access the support that they need leading to poor outcomes.	**Agreed Action:** The system will be finalised and validated. Progress reports will be made in the ALN Update to the PPPH Committee. **Expected Evidence of Implementation:** Reports to the Planning, Partnerships and Population Health Committee.
		Medium Priority	**Officer:** Assistant Director for Women and Children's Services / Director of Midwifery, Women and Family Health **Date:** December 2025
	Theme: Information, Data Quality & Data Accuracy	Control Design	

Objective 5: There are robust quality assurance measures in place to demonstrate compliance with the ALN Act.	**Reasonable**

Higher level performance monitoring and quality assurance procedures across the partnership are still being developed. This is being addressed by the ALN Integrated Steering Group.

The principal risks to the Health Board relate to compliance in areas directly under its control; the dashboard of the case management system incorporates key parameters in relation to the Health Board's compliance with the requirements of the ALN Act in order to expedite monitoring processes.

The dashboard is regularly monitored by the DECLO, and whilst there have been some inconsistencies during the implementation stage of the new systems (Finding 4), monitoring activities and investigations into inconsistencies have been taking place in order to ensure that data is being captured correctly.

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Objective 6: There are appropriate mechanisms for dealing with complaints, disputes, and appeals to the Tribunal. | **Substantial**

The 'Putting Things Right' process is in place to manage complaints in relation to the Health Board's ALN provision, which would be received by the same means as other Health Board complaints. Details of the process are available on the PTHB website.

A procedure has been established to ensure the DECLO will be notified of any complaints relating to the Health Board's ALN provision, the details will then be reviewed to ensure there are no compliance issues which relate to the ALN legislation. The DECLO would provide input only where concerns with potential compliance issues are identified.

No specific concerns relating to the exercise of the Health Board's functions under the ALN Act have been received. The anticipated volume of complaints is limited and will be dealt with on a case-by-case basis through the standard Putting Things Right process and including oversight by the DECLO.

The ALN Act provides for children, their parents and young people to challenge decisions about ALN, ALP and related matters by way of appeal to the Tribunal.

Information in relation to the tribunal process is not routinely provided to service users and details in relation to it have not been included in the contents of the Additional Learning Needs homepage of the PTHB website. This would instead be provided to complainants during the course of the complaints process. This is an intentional policy decision in order to reduce the likelihood of service users referring complaints to the Tribunal service prematurely. There are other provisions within the ALN Code which make recommendations intended to [avoid the] 'more formal and burdensome route' of a Tribunal.

Appeals to Tribunal are made against the education body, not against the Health Board. Even in cases where the concerns relate to NHS provisions, the appeal would be raised against the education body.

PTHB have previously been involved in tribunals and a Tribunals Standard Operating Procedure ('NHS Participation in Appeals to Education Tribunal Wales: Standard Operating Procedure') has been produced to improve the process for PTHB's involvement though this has not yet been formally ratified through the AISG.

Objective 7: Appropriate governance framework is in place to provide oversight of compliance with the ALN Act including that the statutory roles and responsibilities of the Designated Educational Clinical Lead Officer (DECLO) are being met. | **Substantial**

Governance arrangements within PTHB in relation to ALN are satisfactory. Oversight is provided by the Women's and Children's Quality and Performance Group and the Planning, Partnerships and Population Health Committee. Detailed reports have been provided at appropriate intervals during the implementation stages of ALN.

The risks relating to ALN are periodically reviewed by the Planning, Partnerships and Population Health Committee. Senior Executives, including the CEO of the Health Board have provided input into the reporting process.

The DECLO possesses all of the requirements for the role as specified by the ALN Code, and there is a documented escalation procedure within PTHB which is also compliant with the code.

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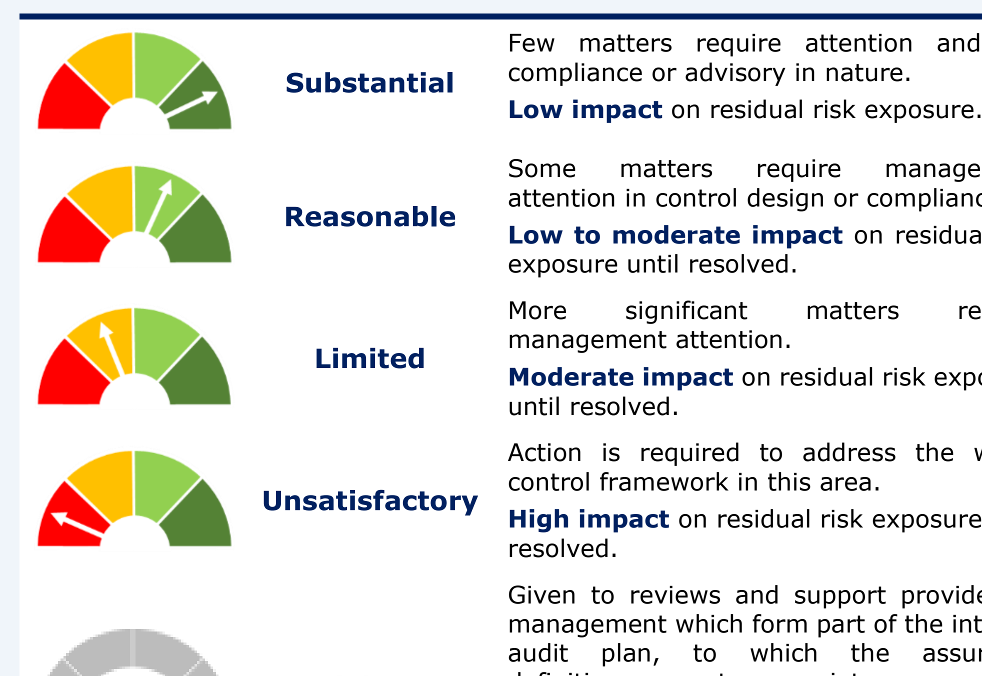
Appendix A

Assurance Opinion



Opinion	Description
Substantial	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
Reasonable	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
Limited	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
Unsatisfactory	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
Advisory	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 Findings

Priority	Explanation
High	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
Medium	Some risk to achievement of a system objective. Minor weakness in system design OR limited non-compliance.

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Website: Audit & Assurance Services - NHS Wales Shared Services Partnership

Cancer Services in Wales:

A review of the strategic approach to improving the timeliness of diagnosis and treatment

January 2025

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Mae'r ddogfen hon hefyd ar gael yn Gymraeg.

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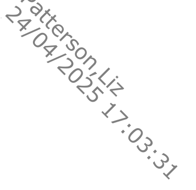
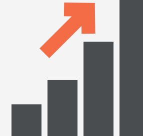


Key facts

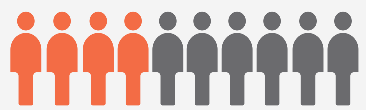
Exhibit 1: key facts

Cancer is the **leading cause of death** in Wales

Wales has the **second highest** cancer mortality in the UK. The UK has one of the highest cancer mortality rates of all OECD countries



Five-year cancer survival has improved. **62%** of people diagnosed with cancer between 2016-2022 survived at five years compared to **54%** of people diagnosed between 2002-2006



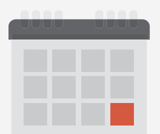
4 in 10 annual cancer cases in Wales could be prevented

At £719 million in 2022-23, spending on cancer services was the **third highest area of NHS spending** after mental health and trauma and orthopaedics

Real terms spending on cancer services has **increased by 54%** from 2009-10 to 2022-23

Since August 2020, no health board has met the overall target that **75%** of patients should start their first definitive treatment within **62 days** of first suspicion of cancer

From August 2023 to August 2024, between **53%** and **61%** of patients started treatment within **62 days**



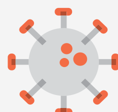
In 2021, **24%** of cancer patients were diagnosed at stage 4 and **18%** at stage 3

Survival decreases as stage advances for all cancer types

Bowel screening eligibility has expanded in stages since October 2021. It now includes people aged **50 to 74** and uses a more sensitive test.

From July 2023 to July 2024, just **21%** of bowel screening participants referred to their health board for a colonoscopy were offered the procedure within 4 weeks against a standard of **90%**

Breast and cervical screening uptake were **below standard**



Non-melanoma skin cancer, bowel, female breast, lung and prostate cancers are the most **common cancers** in Wales

Source: Audit Wales

Notes: *Welsh Government data: NHS Expenditure by programme budget category and year, 'cancer and tumours', on StatsWales

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Key messages

Context

1 One in two people in the UK born after 1960 will be diagnosed with some form of cancer during their lifetime[1]. Many people go on to survive cancer and lead healthy lives. Early diagnosis and timely treatment are key to survival for most cancers.

2 Services to detect, diagnose and treat cancers and to support cancer patients are provided by many public and third sector organisations. Some services, notably Systemic Anti-Cancer Therapy[2] and radiotherapy, mostly serve cancer patients. However, much of the outpatient, diagnostic and surgical capacity needed for cancer patients is part of the wider planned care system.

3 The Welsh Government is responsible for setting the vision and targets for health care and for the allocation of funding. It sets out a range of expectations for the NHS Executive, including supporting improvement in cancer services, through an annual remit letter. The National Strategic Clinical Network for Cancer[3] is part of the NHS Executive and brings together clinicians and health professionals to support improvement. Health boards are responsible for providing high quality care to patients and meeting performance targets. **Appendix 1** explains roles and responsibilities for cancer services and key elements of the strategic approach.

4 Our work has examined the coherence of the national arrangements to drive improvements in cancer services in Wales. The report includes an overview of NHS Wales' performance in providing cancer diagnosis and treatment and offers views on the prospects for improvement, including through prevention. The report does not comment on the performance of individual NHS bodies as this will be examined as part of the Auditor General's 2025 programme of local audit work at those bodies. **Appendix 3** provides more detail about our work.

1 Cancer Research UK.

2 Systemic Anti-Cancer Therapy includes chemotherapy, immunotherapy and hormonal therapy.

3 Called the Wales Cancer Network at the time. We refer to the Network as the 'Cancer Network' throughout the report for ease of reference.

Overall conclusions

5 Overall, we found that despite increased investment, there is a continuing failure to meet the national performance targets for cancer with a minority of patients facing unacceptably long waits for diagnosis and/ or treatment. Cancer outcomes in Wales have improved over recent years but are still poor compared to other countries. Stronger and clearer national leadership is urgently needed to help drive the necessary improvements in the timeliness and sustainability of cancer diagnosis and treatment.

Key findings

Performance and resources

6 Demand from suspected cancer patients is increasing ahead of the NHS' ability to meet it. As a result, the waiting list for diagnosis and treatment is growing. Our indicative modelling shows that without a significant increase in activity to diagnose and treat patients, the waiting list will not return to pre-pandemic levels.

7 The national target that 75% of cancer patients should start their first definitive treatment within 62 days of first suspicion has not been met by any of Wales' health boards since August 2020. Performance deteriorated following the pandemic and has been stable since early 2022 with between 52% and 61% of patients starting their treatment within the target time. Waiting times for some cancer types are particularly long with some patients waiting over 100 days for treatment[4]. There are also growing waits between diagnosis and the start of treatment.

8 A significant minority of people are being picked up with late-stage cancer which impacts their likelihood of survival. In 2021, patients diagnosed with cancers of the gall bladder, pancreas and lung were more likely than patients with other types of cancers to be diagnosed at stage four (74%, 52% and 48% of patients).

9 Screening plays a vital role in early detection. While the standard for uptake of bowel screening is being achieved, this is not the case for breast and cervical screening programmes.

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4 See **Exhibit 8.**

10 Patient outcomes have improved over time. But Wales has the second highest cancer mortality rate in the UK after Scotland. The UK itself has a worse rate than many OECD countries. Mortality rates in Wales are significantly worse for people living in deprived areas and the gap between the most and least deprived is growing.

11 Real terms spending on cancer care over the last 13 years has grown considerably more than the overall increase in real terms NHS spending. However, this increase does not necessarily translate into extra activity as there are a range of inflationary cost pressures, including costs of drugs and new treatments. There are also challenges around capacity – including gaps in the workforce and concerns about a shortage of modern scanning equipment.

Strategic direction

12 The Welsh Government has set out its high-level strategic vision for cancer services in its 2021 Quality Statement for Cancer. In February 2023, at the request of the then Minister for Health and Social Care, the Cancer Network published a three-year Cancer Improvement Plan as a collated NHS response to the Quality Statement. The NHS Executive is developing a National Cancer Recovery Programme as part of the wider national approach to transforming planned care. The Welsh Government has also launched a 'Cancer: Improving Outcomes' initiative through its Life Sciences Hub aimed fostering innovation and collaboration between the NHS and industry.

13 Whilst these various developments demonstrate a clear national commitment to improve cancer services, their collective efficacy is undermined by a lack of clarity over the status of the three-year Cancer Improvement Plan. Welsh Government officials were clear that the Plan was not their document but rather the collated response of the NHS to the Quality Statement.

14 However, NHS and third sector bodies are confused about the Cancer Improvement Plan's status and what, if anything, they should be doing to implement it. Many were also confused about the links between the Improvement Plan, the National Cancer Recovery Programme and the Cancer: Improving Outcomes initiative.

15 There is similar confusion about the split of leadership and accountability between the Welsh Government and the NHS Executive and about roles within the NHS Executive. Overall, we identified a consensus, including within the Welsh Government and the NHS Executive, that the arrangements were not yet providing the strong leadership needed to drive system-wide improvement in cancer services.

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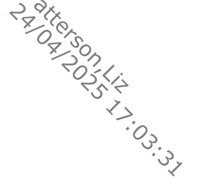
16 We identified examples of important Welsh Government investment to improve cancer services and broader planned care including rapid diagnostic centres and a new cancer centre for Velindre NHS Trust. However, the pace at which some new developments are taken forward can be slow, in areas such as digital cellular pathology and lung cancer screening.

17 There is also a risk that the Welsh Government may not get a good return on its £3.4 million investment in a National Imaging Academy. The Academy is training more radiologists to address workforce shortages, but some NHS bodies have not been able to create jobs for newly qualified people.

18 The Welsh Government relies heavily on its performance management arrangements to oversee and drive improvement. However, these arrangements are focussed predominantly on the 62-day timeliness target, which only covers part of the patient pathway. The Welsh Government told us it also focuses on delivery of National Optimised Pathways, although at the time of drafting the NHS Executive was still developing plans for monitoring compliance with those pathways.

19 The Welsh Government's Quality Statement does not set out any specific expectations in respect of cancer prevention despite around 38% of cancers being preventable. Whilst there are other Welsh Government strategies and frameworks aimed at encouraging healthier lifestyles these do not constitute a coherent policy framework for population health and disease prevention.

20 Data and digital are two other key areas for improvement. We identified inaccuracies in national data and a need for more consistent national data that helps track delivery across the patient pathway. Work is underway to replace the previous outdated cancer information system. However, progress has been slow, and services continue to rely on fragmented digital systems that consume time and carry risks to patient safety.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The Welsh Government's Quality Statement, the identification of nationally optimised pathways and the publication of a Cancer Improvement Plan are all examples of a clear commitment to secure high quality cancer care for the people of Wales.

However, despite this and increased investment over recent years, too many people are experiencing unacceptably long waits for cancer diagnosis and treatment. Variations in performance and outcomes persist within and between health bodies in Wales, and insufficient attention is being placed on prevention of the lifestyle factors that can cause cancer and other major health conditions.

The arrangements for the national leadership and oversight of cancer services in Wales need to be clarified and strengthened as a matter of urgency. This must include a clear statement on the status of the NHS Wales Cancer Improvement Plan and how the Welsh Government and NHS Executive expect it to be used, alongside other programmes and initiatives, to shape the improvements which are needed in cancer services in Wales.

Adrian Crompton
Auditor General for Wales

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Recommendations

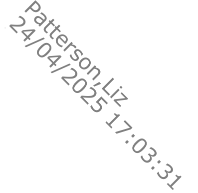
Exhibit 2: recommendations

Setting out a coherent, long-term strategic approach for cancer in Wales, supported by clear system leadership and informed oversight

R1 The Welsh Government should publicly clarify the status of the Cancer Improvement Plan and its links to the National Cancer Recovery Programme and the Cancer: Improving Outcomes initiative. As part of this the Welsh Government should clarify how it intends to hold NHS bodies to account for delivery of the Cancer Improvement Plan.

R2 The Welsh Government should set out a coherent model for system leadership in respect of cancer services that clarifies its own role and that of the NHS Executive and sets out how it will bring on board clinicians and other key stakeholders to build a common view of cancer service performance, quality and opportunities for improvement.

R3 The Welsh Government should review its oversight and performance framework in respect of cancer services to focus on a broader range of issues, including a more explicit alignment to the ambitions and quality attributes set out in the Quality Statement for Cancer.



Developing the strategic approach to population health improvement and disease prevention

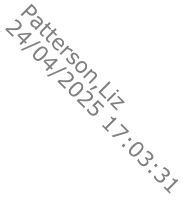
R4 The Welsh Government should develop a more coherent approach to population health improvement by setting out how it intends to use its Science Evidence Advice: NHS in 10+ Years to harness the opportunities associated with prevention to reduce the incidence of cancer and other major conditions.

Exploiting specific opportunities for improvement

R5 The Welsh Government should work with Public Health Wales to accelerate decision making for a national lung screening programme. It should clarify as soon as possible whether it will fund national lung screening for Wales and the timescale for implementing such a programme.

R6 As part of a wider approach to encourage greater regional working between health boards, the Welsh Government and the NHS Executive should work with the service to understand and help address any key barriers to delivering regional services. This should include working with DHCW to identify digital solutions to support shared waiting lists for cancer diagnosis and treatment, where it is appropriate to do so.

R7 The Welsh Government should work with the NHS Executive, HEIW and other NHS bodies to ensure there are employment opportunities for radiologists who have been trained in the National Imaging Academy.



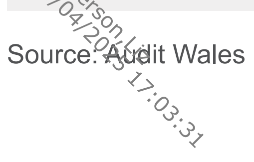
Improving Data and Digital

R8 The Welsh Government should clarify national roles and responsibilities for monitoring and ensuring compliance with its data standards including how it will hold NHS bodies to account for poor compliance.

R9 The Welsh Government should work with the NHS Executive (particularly the Cancer Network), DHCW and Public Health Wales NHS Trust to develop a more comprehensive set of publicly available data on cancer services, which as a minimum should include:

- the number of people currently waiting for cancer diagnosis or treatment (open pathway data).
- performance against the 62-day target for the health board providing diagnosis and treatment and health board of residence, including people living Powys Teaching Health Board area.
- performance across the patient pathways including timeliness of diagnostic reporting across different tumour sites; timeliness from the decision to treat a patient to the start of that treatment (including surgery, radiotherapy and Systemic Anti-Cancer Therapy); and diagnosis and treatment of recurrent disease. Performance information should be provided at cancer sub-tumour level where possible.
- timeliness of diagnosis and treatment for patients referred from the breast and cervical screening programmes.
- accurate information on equity of access, including ethnicity of cancer patients as well as the experiences of different patient groups (this should include children and young people).

R10 The Welsh Government should work with DHCW and NHS England to share regular and consistent data on the timeliness of diagnosis and treatment for Welsh cancer patients treated by NHS England.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Source: Audit Wales

Performance and resources

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1.1 This part of the report looks at how well services to diagnose and treat cancer are performing, including against national targets. It considers performance in the wider context of demand, financial and capacity pressures.

What we looked for

We looked for evidence that the NHS is sustainably meeting demand to diagnose and treat cancer; whether it is meeting the national performance targets for timeliness of cancer diagnosis and treatment; and for evidence that outcomes for cancer patients are improving and compare well internationally.

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Demand is increasing ahead of the NHS's ability to meet it and the waiting list for diagnosis and/ or treatment is growing

The number of people referred for suspected cancer has continued to rise following a sharp drop during the pandemic

1.2 Suspected cancer referrals create demand for NHS services even though the vast majority of those referrals (over 84%[5]) go on to find out that they do not have cancer. Around 80% of patients with suspected cancer are referred by GPs. However, because they are far less likely than those coming from other routes[6] to actually have cancer, those referred by GPs only make up around 54% of patients who go on to start treatment.

1.3 The number of suspected cancer referrals increased by 14% from June 2019 to August 2024 (**Exhibit 3**); equivalent to around 3% growth each year. Referrals have increased after a drop at the start of the pandemic. The highest numbers of referrals in August 2024 were for skin (excluding basal cell carcinoma[7]) and lower gastrointestinal cancers (17% and 15% of referrals respectively).

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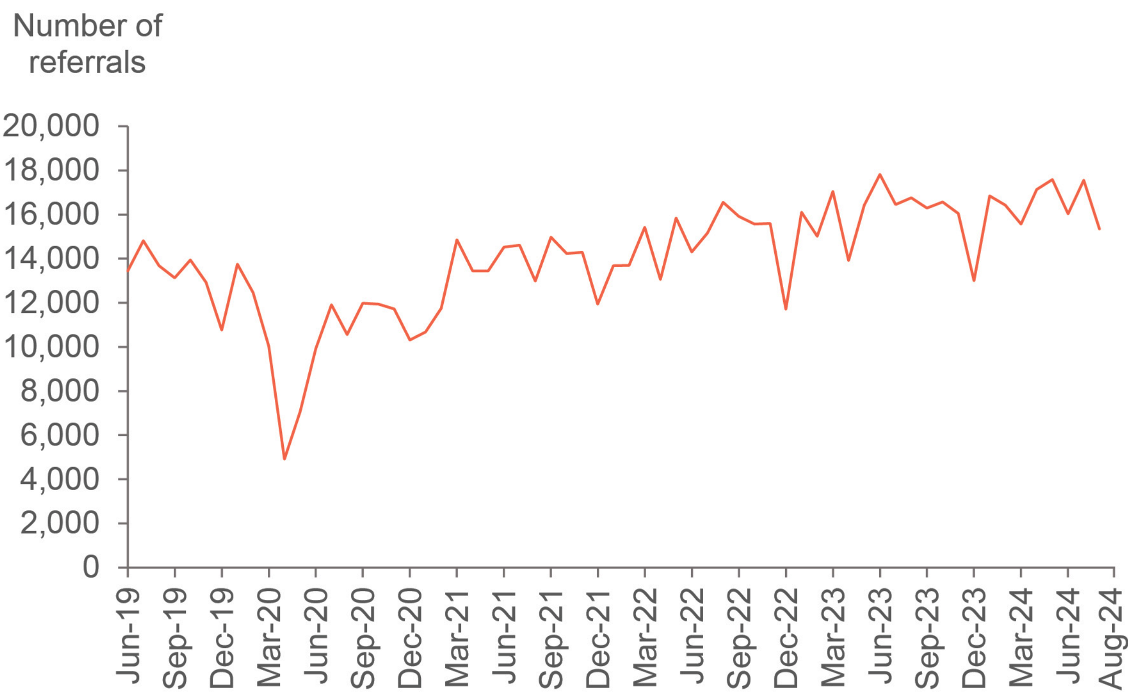
5 Since November 2020.

6 Other routes include screening services, emergency departments, and other secondary care professionals.

7 Basal cell carcinoma is the most common type of skin cancer and less likely than other skin cancers to spread to other parts of the body. NHS Wales does not refer suspected basal cell carcinomas via the suspected cancer pathway unless there is a concern that delayed investigation may cause significant impact to the patient in line with NICE Guidance NG12, last updated October 2023.

Exhibit 3: urgent suspected cancer referrals, June 2019 – August 2024



Source: DHCW, Suspected Cancer Pathway – Open Pathways Dataset, on StatsWales.

Note: data from June 2019 to November 2021 is based on experimental analysis on StatsWales and may not be directly comparable to the validated data from December 2021 onwards.

1.4 The number of newly diagnosed cancer patients has also increased over time (by 22% from 2002 to 2021) (see **Appendix 2, Exhibit 26**). Numbers fell in 2020, probably because fewer people accessed healthcare during the pandemic. Numbers of newly diagnosed cancers increased in 2021 but have not yet returned to pre-pandemic levels. The Welsh Cancer Intelligence and Surveillance Unit (WCISU)[8] has not yet published clinical cancer registry data beyond 2021.

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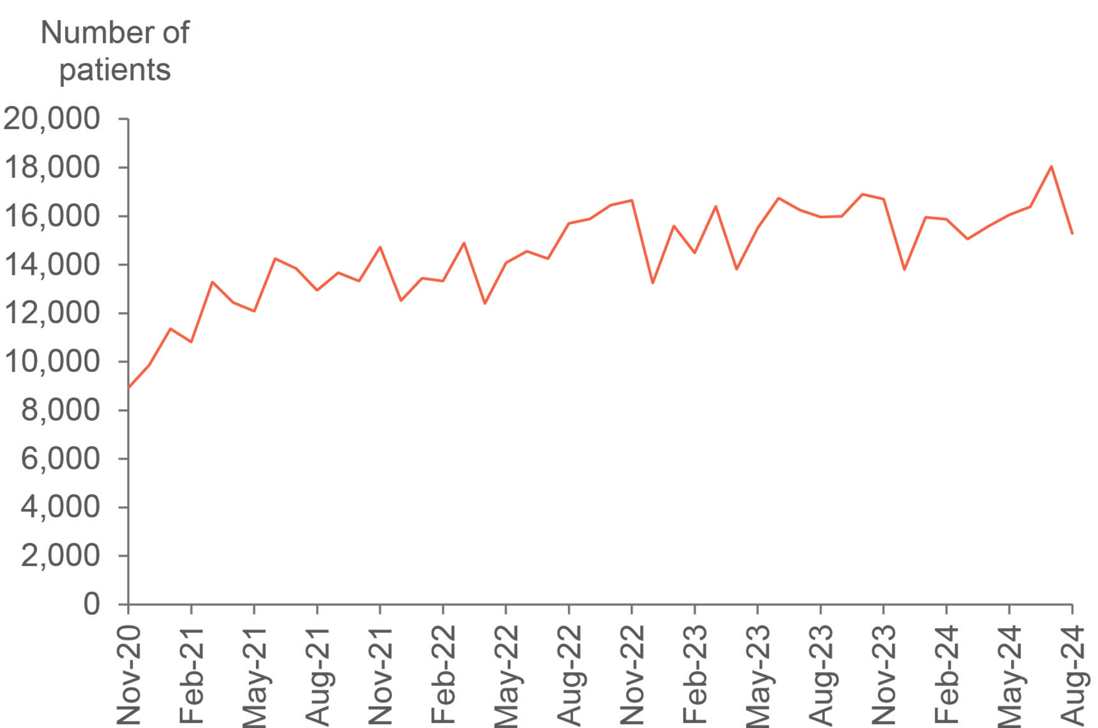
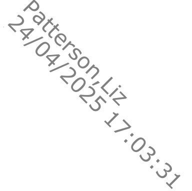
8 WCISU is part of the Public Health Wales NHS Trust.

The sharp increase in activity after the pandemic seems to have levelled off

1.5 Activity to diagnose and treat suspected cancer patients[9] has increased since the pandemic but seems to be levelling off. The overall number of pathways closed – including those who were told they do not have cancer and those who started treatment – has increased since November 2020 (**Exhibit 4a**). There is no comparable historic data to show how overall activity levels compare with pre-pandemic levels. However, the number of patients starting treatment for cancer increased quickly after a drop at the start of the pandemic and exceeded pre-pandemic figures by March 2021 (**Exhibit 4b**). The number of patients starting treatment appears to have to broadly levelled out from November 2022.

Exhibit 4a: all closed pathways November 2020 – August 2024

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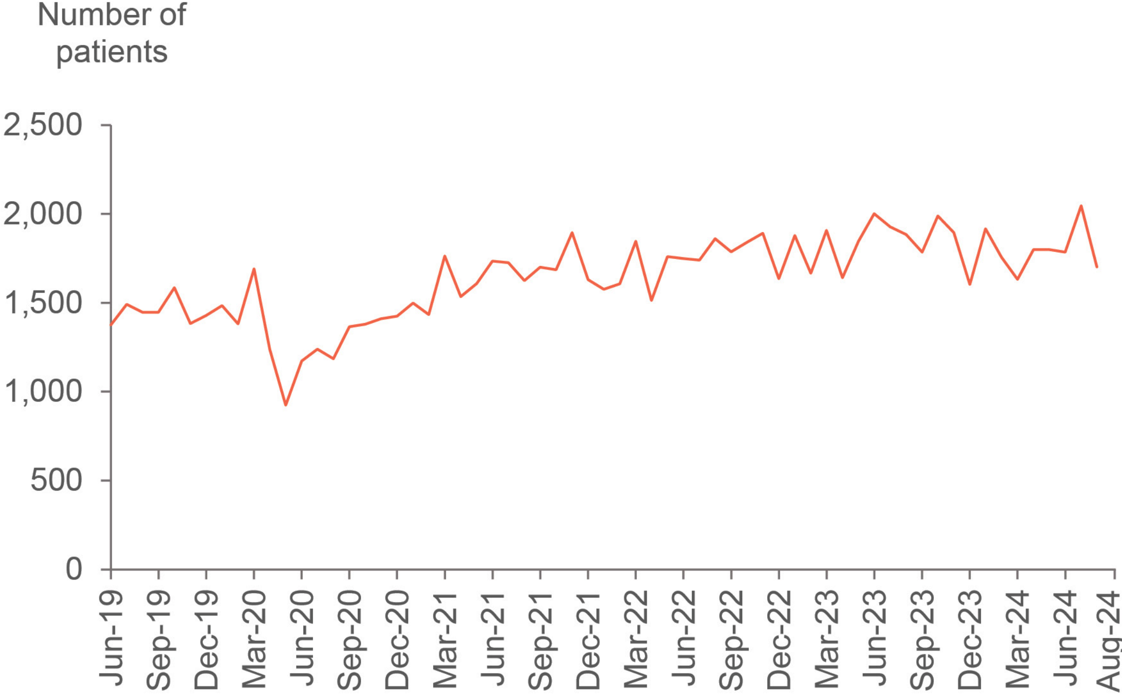
9 As measured by pathways closed.

Exhibit 4b: pathways closed due to patient starting first treatment, June 2019 – August 2024



Source: DHCW, Suspected Cancer Pathway – Closed Pathways Dataset, on StatsWales.

1.6 The available data understates the amount of activity because it only includes activity to the point of first treatment. Many people will need multiple episodes of care after they start their first treatment. It is likely that the amount of activity after first starting treatment is growing with the increasing complexity of new treatments, particularly in immunotherapy. The three cancer centres in Wales[10] hold information on the timeliness of access to radiotherapy and Systemic Anti-Cancer Therapy. However, inconsistencies in the way some of the data is collected means it cannot currently provide any insight on national trends or comparative timeliness of ongoing treatment across Wales.

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10 In north Wales, southwest Wales, and south Wales. The centres are managed individually by Betsi Cadwaladr University Health Board, Swansea Bay University Health Board and Velindre NHS Trust.

The numbers of patients awaiting diagnosis or treatment is growing and our analysis suggests the NHS needs to further increase activity if it is to reduce the backlog and sustainably meet demand

1.7 As part of its vision for quality cancer care, the Welsh Government wants to see the waiting list volume return to pre-pandemic levels. It has also set a target that 80% of cancer patients start treatment within 62-days by March 2026. However, the waiting list for diagnosis and/ or treatment has continued to increase, and it is difficult to see how that target will be achieved (**Exhibit 5**). Our indicative modelling shows that the list will continue to grow based on recent trends of demand and activity. It is clear that without a significant increase in activity to diagnose and treat more patients the waiting list is unlikely to return to previous levels.

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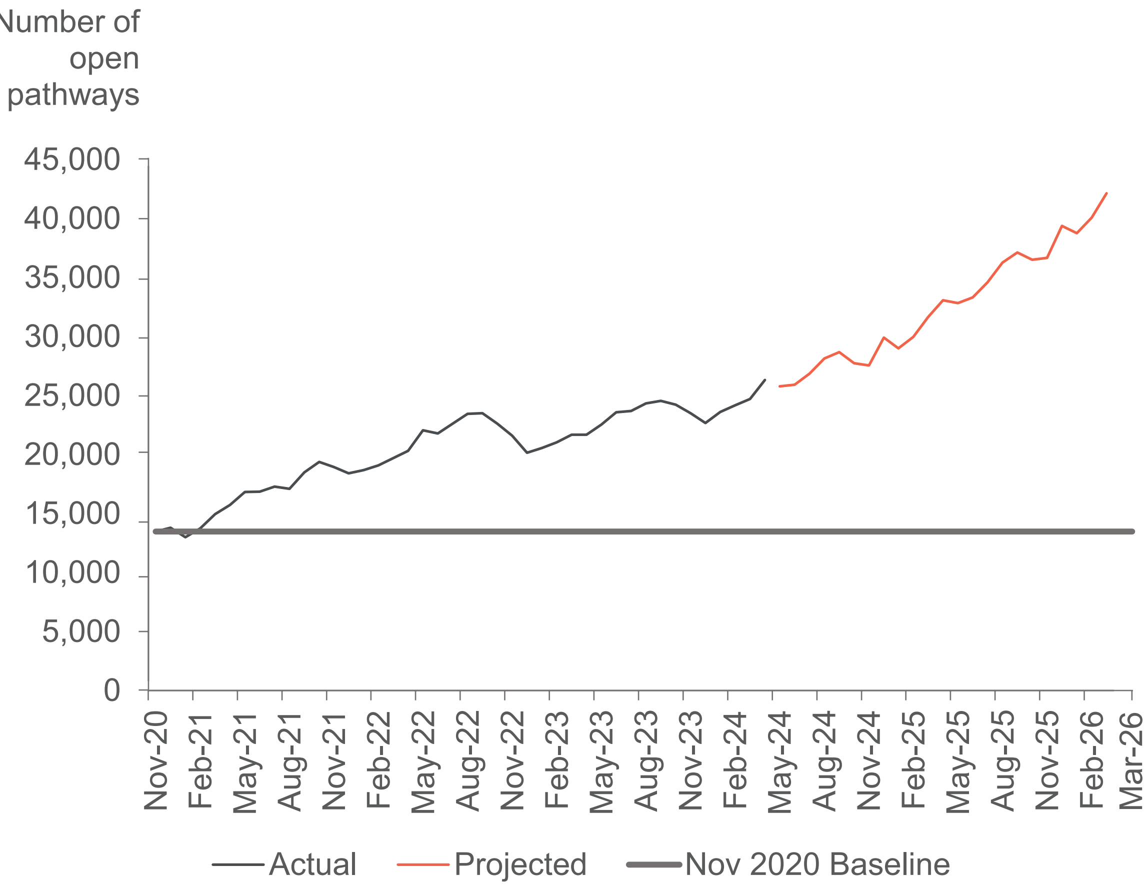
Exhibit 5: actual and modelled numbers of open suspected cancer pathways to March 2026



Source: Audit Wales analysis of DHCW data, open suspected cancer pathways at month end

Note: Patients may have more than one pathway if they are waiting for diagnosis or treatment for more than one cancer.

Our projection assumed demand, as measured by referrals, increases by 3% a year in line with recent trends and that activity increases by 1% a year.

1.8 Much of the capacity the NHS uses to diagnose and treat cancer patients is also used for other non-cancer patient pathways. Achieving the political and policy ambitions to improve access to both cancer and wider planned care within the system's existing capacity will therefore be challenging. Priorities on cancer care will need to be balanced with other planned care priorities. A consideration of how existing capacity can be better used or expanded will also be needed.

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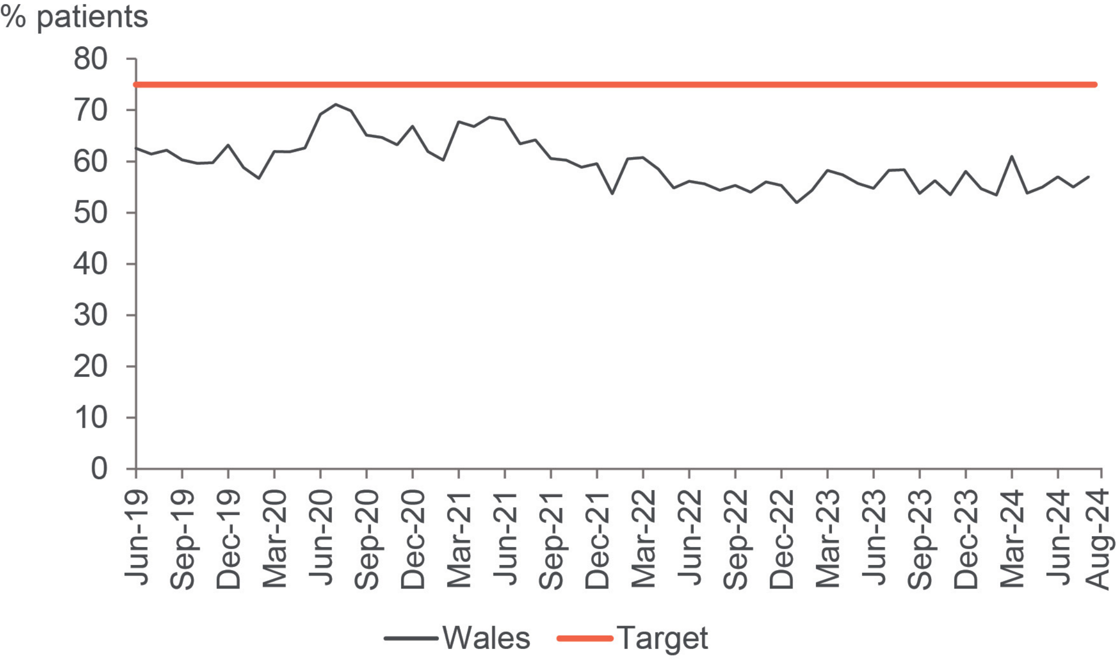
The NHS in Wales is continuing to miss the national performance target for cancer treatment

While the majority of patients start their treatment within 62 days, performance is well short of the national target of 75%

1.9 The Welsh Government started implementing its Suspected Cancer Pathway in June 2019, with a target that 75% of cancer patients should start their first definitive treatment within 62 days of the first suspicion of cancer[11]. No health board has met the overall 75% target since August 2020 although performance has been better for some individual tumour sites (**paragraphs 1.10 and 1.11**). During the summer of 2020, referrals were lower and health boards were prioritising urgent and cancer care over other patients due to the pandemic. Since then, despite some month on month variations, performance has stayed between 52 and 61% (**Exhibit 6**).

Exhibit 6: performance against the 62-day Suspected Cancer Pathway Target, June 2019 – August 2024

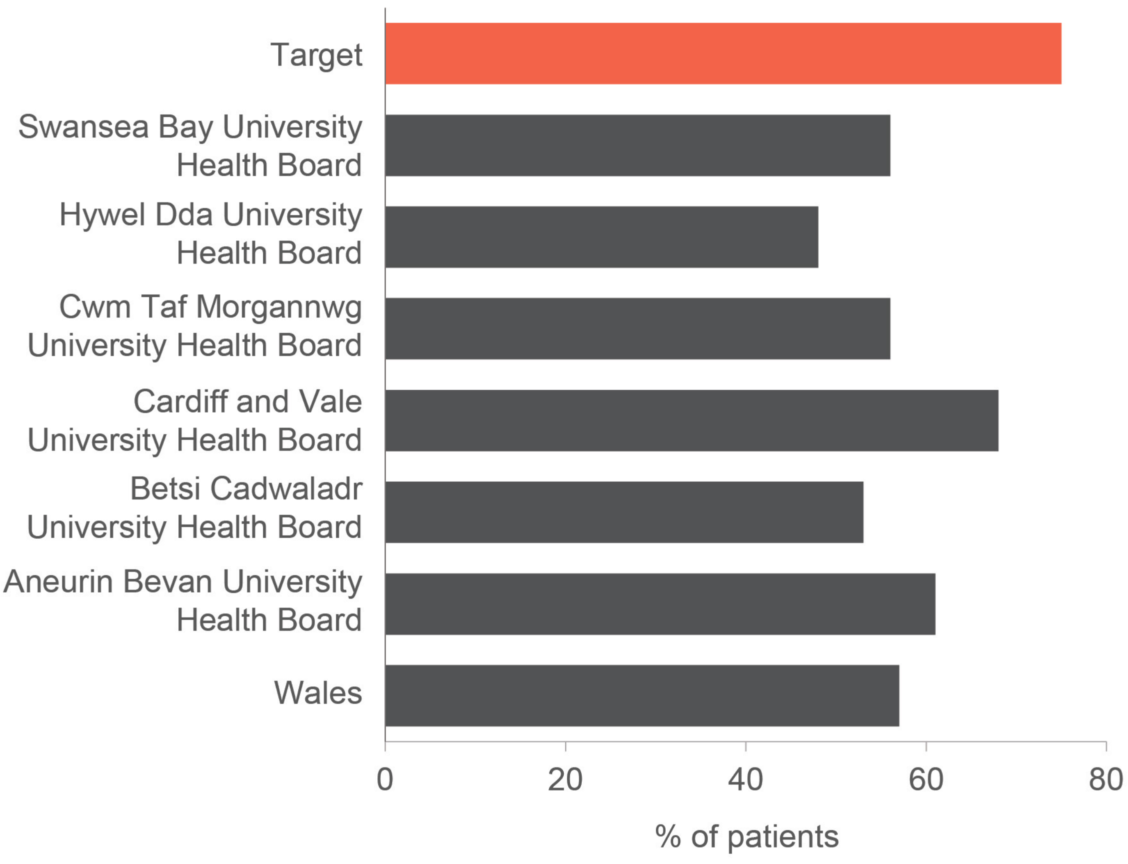


Source: DHCW, Suspected Cancer Pathway – Closed Pathways Dataset, on StatsWales.

11 Some data on performance against the target is available from June 2019 and the Welsh Government officially required health boards to report against the target from February 2021.

1.10 There is considerable variation and fluctuation in performance against the target by health board area. In August 2024, Cardiff and Vale University Health Board was closest to meeting the target at 68%, and Hywel Dda University Health Board was the worst performer at 48% (**Exhibit 7**). Health board performance has fluctuated considerably since 2019 (see **Appendix 2, Exhibits 27a to f**).

Exhibit 7: health board performance against the 62-day Suspected Cancer Pathway Target, August 2024



Source: DHCW, Suspected Cancer Pathway – Closed Pathways dataset, on StatsWales.

Note: StatsWales publishes data for residents of each health board unless they are treated by NHS England. Residents of Powys Teaching Health Board treated by other Welsh health boards are included in that health boards' figures. StatsWales does not distinguish between residents of Powys and residents of the health board they are treated by.

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Time to start treatment varies by type of cancer and some patients can face unacceptably long waits

1.11 Waiting times vary depending on the site of the cancer. Waiting times for skin cancer, excluding basal cell carcinoma (BCC) have been consistently above the 75% target, aside from a brief dip in November 2023. However, waiting times for other tumour sites have rarely been at or above the target at an all-Wales level[12]. Waiting times for gynaecological, lower gastrointestinal and urological cancers, and sarcoma are particularly poor with less than half of patients starting their first treatment within 62 days of first suspicion in August 2024 (**Exhibit 8**). Performance may vary within the sub-tumour sites[13] for these cancers but there is no nationally available information to understand performance by sub-tumour site (**recommendation 9**).

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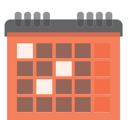
12 Performance for breast and lung cancers briefly met the target in June 2021 but has deteriorated since. Brain and central nervous system and haematological cancers, acute leukaemia and sarcoma have all met the target at various points from November 2020 to June 2024 but represent low numbers of patients.

13 For instance, cervical and ovarian cancers are both gynaecological sub tumour sites.

Exhibit 8: performance against the Suspected Cancer Pathway target, median and 75th percentile waits for gynaecological, lower gastrointestinal, skin, and urological cancers, and sarcoma, and August 2024

	Performance against the 75% target	 Median waiting times	75th percentile waiting times
Skin (excluding BCC)	80%	35 days	61 days
Sarcoma	20%	No data	No data
Urological	40%	86 days	132 days
Gynaecological	35%	83 days	115 days
Lower gastrointestinal	45%	70 days	106 days

Source: DHCW, Suspected Cancer Pathway – Closed Pathways Dataset on StatsWales (data on performance against the 75% target) and DHCW data on the Suspected Cancer Dashboard (data on median and 75th percentile waits).

Note: Median waiting time is point where half the people have had their treatment and the other half are still waiting. The 75th percentile represents the time when 75% of people have had their treatment but 25% are still waiting.

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While diagnostic waits are getting shorter, waits between diagnosis and starting treatment are getting longer

1.12 Health board, NHS Executive and Welsh Government officials told us that delays at diagnostic stage are one of the main reasons for poor performance against the 62-day cancer target. Median waits from first suspicion of cancer to first diagnostic test have fallen from 20 days in February 2021 to 16 in August 2024. Depending on the type of cancer, patients usually face another wait between having a diagnostic test and finding out whether they have cancer (diagnosis). Median waits from first suspicion to actual diagnosis increased from 26 days in February 2021 to 36 in January 2022 but fell to 27 in August 2024[14].

1.13 Our analysis[15] points to problems between diagnosis and starting treatment. Between February 2021 and August 2024, median waits from diagnosis to treatment increased by 38% from 21 days to 29. Waits between diagnosis and treatment vary between tumour sites, with patients with lower gastrointestinal and breast cancers waiting longer than those with other cancer types in August 2024[16] (**Exhibit 9**).

1.14 There are also considerable variations in waits at other stages of the pathway across tumour sites. For instance, in August 2024, the median wait for urological cancers was 16 days from first suspicion to diagnostic test, 49 days from first suspicion to diagnosis, and 86 days from first suspicion to the start of treatment. By comparison, the median wait for skin cancers was 41 days from first suspicion to diagnostic test and 34 days from first suspicion to diagnosis, and 35 days from first suspicion to the start of treatment (**Exhibit 9**).

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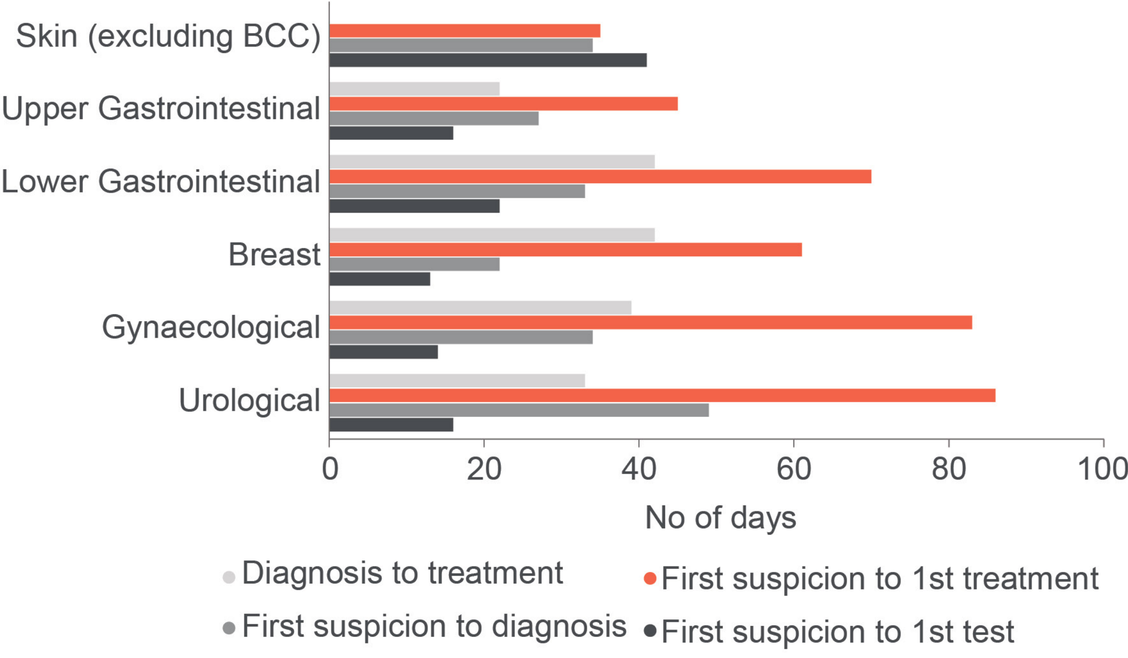
14 **Appendix 2, Exhibit 28** gives median waits from first suspicion to diagnosis over time.

15 Of DHCW data from the Suspected Cancer Pathway Dashboard. DHCW only publishes median waits for the tumour sites included in **Exhibit 9.**

16 The Welsh Government does not publish median waits for all tumour sites.

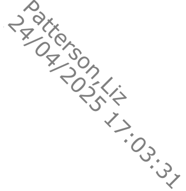
Exhibit 9: median wait from first suspicion of cancer to first test, diagnosis and starting first treatment, August 2024



Source: DHCW data from the Suspected Cancer Pathway Dashboard

A significant minority of people are being picked up with late-stage cancer which impacts their likelihood of survival

1.15 Survival decreases as stage at diagnosis advances for all cancer types[17]. In 2021, 24% of cancer patients were diagnosed at stage four and 18% at stage 3 (**Exhibit 10**). The increase in the proportion of cancer patients diagnosed at stage 1 between 2011 and 2021 corresponds with a fall in patients diagnosed at stage 2 and patients whose stage is unknown at diagnosis. With the exception of an increase in 2020, the proportion of cancer patients diagnosed at stage 4 has ranged between 19% and 24% during the same period. Positively, the overall proportion of cancer patients whose stage at diagnosis was 'unknown' has significantly decreased since 2011.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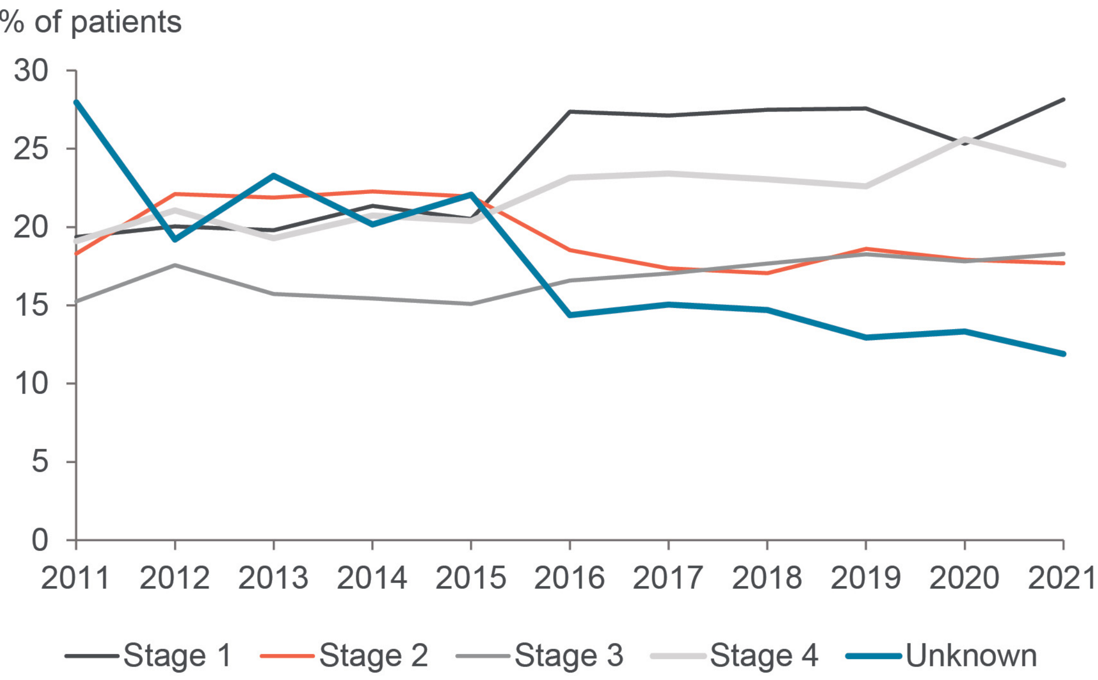
17 WCISU, Cancer Survival in Welsh Residents Diagnosed Between 2002 and 2020, November 2023.

Exhibit 10: proportion of cancer patients by stage at diagnosis, 2011 to 2021

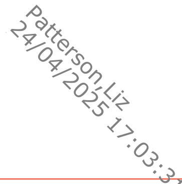


Source: WCISU cancer incidence data

Note: Our analysis is based on WCISU cancer incidence data which does not include 'non-stageable' cancer, non-melanoma skin cancer, and some rare cancer types.

1.16 Some cancers are more likely than others to be diagnosed at a late stage, particularly asymptomatic cancers. In 2021, patients with gall bladder, pancreatic, and lung cancer were more likely than other cancer patients to be diagnosed at stage four[18]. 48% of lung cancer patients were diagnosed at stage four in 2021 (1,175 people). To illustrate the importance of early diagnosis, five-year survival for lung cancer diagnosed during 2016-2020 is 55% at stage one, 30% at stage two, 13% at stage three, and just 3% at stage four[19].

1.17 Although the numbers are relatively small, the number of people whose suspected cancer was identified via emergency departments has increased by over 40% from October 2021 to April 2024 (**Exhibit 11**).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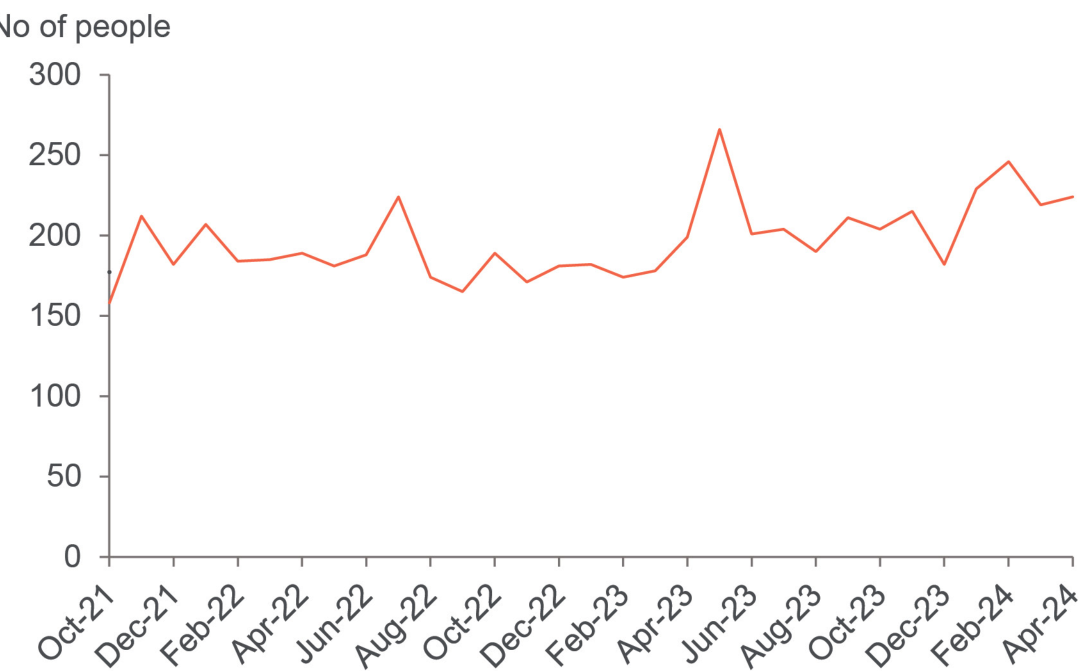
18 74% of patients with gall bladder cancer and 52% of patients with pancreatic cancer were diagnosed at stage 4 in 2021.

19 WCISU, Cancer Survival in Welsh Residents Diagnosed between 2002 and 2020, November 2023.

Exhibit 11: number of urgent suspected cancer referrals via emergency departments from October 2021 to April 2024.



Source: Audit Wales analysis of DHCW Suspected Cancer Pathway Data – closed pathways by source of suspicion.

1.18 Research by the International Cancer Benchmarking Partnership[20] found that countries with higher rates of cancer diagnosis after emergency presentation had poorer survival rates[21]. It explained that Wales and Scotland have some of the highest rates amongst comparable countries. Our own analysis found that suspected cancer patients referred from emergency departments were more likely than those referred via other routes to die before being diagnosed or starting treatment[22]. While some caution is needed due to the small numbers, there is an upwards trend in patients referred from emergency departments dying before treatment or diagnosis.

20 The Partnership brings together international clinicians, policymakers and researchers to identify best practice and support improved cancer outcomes for patients.

21 Abd Elkader, Alv, R; Barclay, M; Johnson, S; McPhail, S; Swann, R, Risk Factors and Prognostic Implications of Diagnosis of Cancer Within 30 Days After and Emergency Admission (Emergency Presentation): An International Cancer Benchmarking Partnership Population-Based Study, 2022.

22 Based on our analysis of on our analysis of DHCW Suspected Cancer Pathway Data. In April 2024, 4% of suspected cancer patients referred from an emergency department died before starting treatment or finding out they did not have cancer compared to 1% of all suspected cancer referrals.

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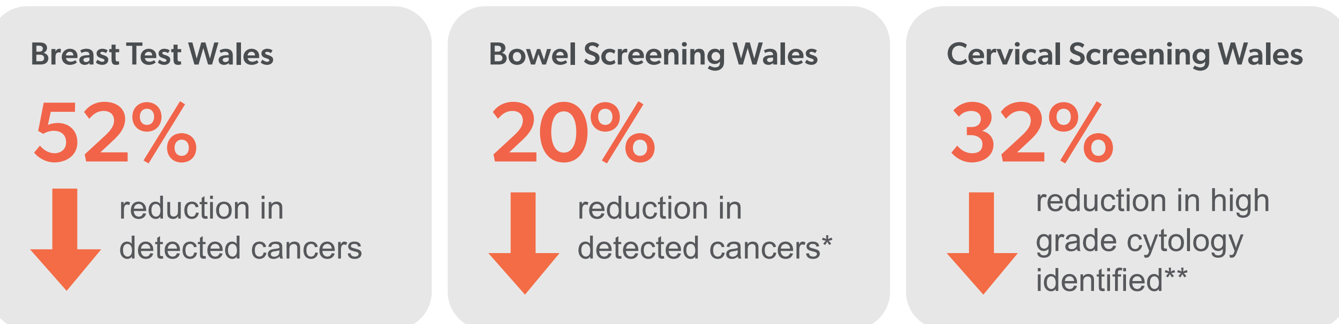
There is scope to increase uptake of screening to detect cancers earlier

1.19 Screening plays a vital role in early detection. Public Health Wales NHS Trust (PHW) runs Wales's three cancer screening programmes: Breast Test Wales, Bowel Screening Wales and Cervical Screening Wales. The Trust estimates that brief pauses to its screening programmes[23] at the start of the pandemic reduced the number of detected cancers in 2021 compared to previous years (**Exhibit 12**).

Exhibit 12: reduction in cancers detected via screening, from April 2020 to March 2021 compared to the previous year



Source: PHW, Update on Population Based Screening Programmes in Wales to the Quality, Safety and Improvement Committee, June 2021

Note: * from April 2020 to February 2021.

**abnormal cells with the potential to develop into cervical cancer.

1.20 Whilst bowel screening is achieving its uptake standards, there are opportunities to increase screening uptake for the breast and cervical screening programmes which were both below the standard in August and April 2024 respectively (**Exhibit 13**). In 2022, the Trust reported differences in screening uptake for all three programmes depending on age, the health board area people live in, and whether the area is deprived or not[24]. It is working to address inequity in screening uptake via its Screening Equity Strategy but has not published a progress report on screening equity since June 2022.

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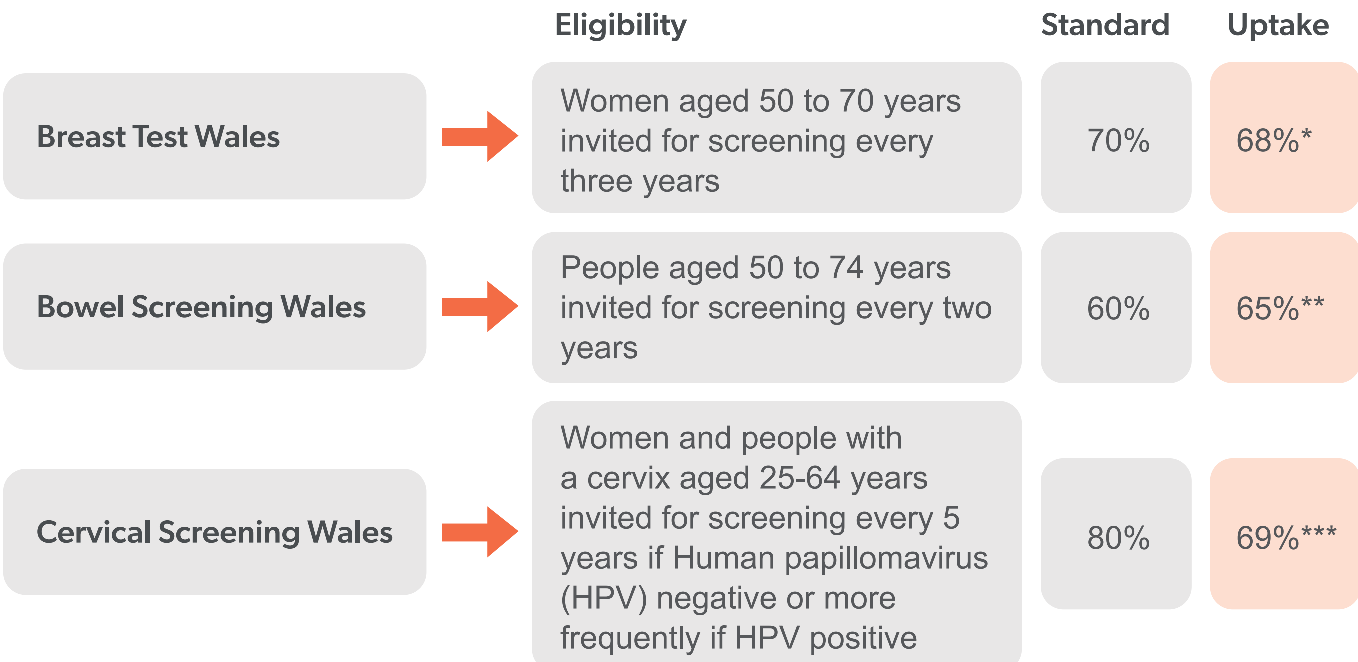
23 Audit Wales, A Review of Arrangements to Recover Screening Services at Public Health Wales NHS Trust, August 2023, provides more information the pause and recovery screening services including performance measures, eligibility and coverage standards for each programme.

24 Public Health Wales NHS Trust, Screening Division Inequities Report 2020-21, June 2022.

Exhibit 13: screening coverage against target, April and August 2024



	Eligibility	Standard	Uptake
Breast Test Wales	Women aged 50 to 70 years invited for screening every three years	70%	68%*
Bowel Screening Wales	People aged 50 to 74 years invited for screening every two years	60%	65%**
Cervical Screening Wales	Women and people with a cervix aged 25-64 years invited for screening every 5 years if Human papillomavirus (HPV) negative or more frequently if HPV positive	80%	69%***

Source: Audit Wales, based on information and wording from PHW, October 2024.

Note:

*Rolling annual rate at August 2024
**Average over the previous year at August 2024
***Age appropriate coverage at April 2024

1.21 Referrals from breast and bowel screening programmes were amongst the most likely to go on to start cancer treatment (92% and 28% respectively in 2023-24 compared to 12% overall)[25]. However, there is no national data on the timeliness of subsequent cancer diagnosis and treatment for people referred from breast or cervical screening. From July 2023 to July 2024, just 21% of eligible people referred from bowel screening were offered a colonoscopy by the relevant health board within four weeks of phoning to book[26]. The target is 90%. Waiting times for colonoscopies varied between health boards from four to 14 weeks.

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25 Based on our analysis of DHCW Suspected Cancer Pathway Data. We have excluded cervical screening referrals from our analysis due to low numbers. Less than 5 people are referred with suspected cancer following cervical screening each month.

26 Public Health Wales NHS Trust, October 2024.

Survey data suggests that patients are generally satisfied with their cancer care, though the latest survey pre-dates the recent decline in performance

1.22 Data on patient experience is collected via the annual Wales Cancer Patient Experience Survey commissioned by the Cancer Network and Macmillan Cancer Support. The most recent data is from 2021 and pre-dates the downturn in performance against the 62-day target.

1.23 The vast majority of cancer patients who responded to the survey rate their overall care highly. The average rating for overall care was 9 out of 10 across Wales, based on 5,859 responses. The positive results reflect the hard work and compassionate care of the many staff working across the NHS to care for and support cancer patients. 87% of respondents said that the different professionals treating and caring for them worked well together to give them the best possible care either 'always' or 'most of the time'. The survey does not ask patients how they felt about the overall length of time they waited from first suspicion to starting treatment.

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Outcomes for cancer patients are generally improving but lag behind comparable countries and are worse for people living in deprived areas

1.24 Cancer is the leading cause of death[27] in Wales, accounting for 25% of all deaths in 2022. Lung, bowel, and prostate cancer account for the largest proportions of cancer deaths[28]. The number of cancer deaths has increased from 8,295 in 2002 to 9,154 in 2022 and is projected to increase by 27% by 2040 (based on 2021 levels)[29]. The rise in cancer deaths is primarily explained by the changing age structure of the population. The age standardised rate[30] of cancer deaths has generally decreased since 2011 although there was a slight increase in 2022 (**Exhibit 14**).

1.25 The cancer death rate in Wales compares poorly to other UK nations and internationally[31]. Wales has had the second highest age standardised cancer death rate in the UK almost consistently since 2010 (**Exhibit 14**). The OECD compared age standardised cancer death rates in 2023, based on 2021 data. It placed the UK 35th out of 45 countries[32].

27 In 2022, 24% of deaths were caused by diseases of the circulatory system, 12% by diseases of the respiratory system, 10% by dementia and Alzheimer's, and 29% by other causes.

28 WCISU cancer mortality data.

29 National Strategic Clinical Network for Cancer, A Cancer Improvement Plan for NHS Wales 2023-26, 2023.

30 Deaths per 100,000 of the population taking account of differences in the age structure of different parts of Wales.

31 Many factors affect cancer incomes including the relative wealth and spending on healthcare in each country, underlying population health, and deprivation.

32 OECD, Health At A Glance 2023: OECD Indicators, OECD, 2023.

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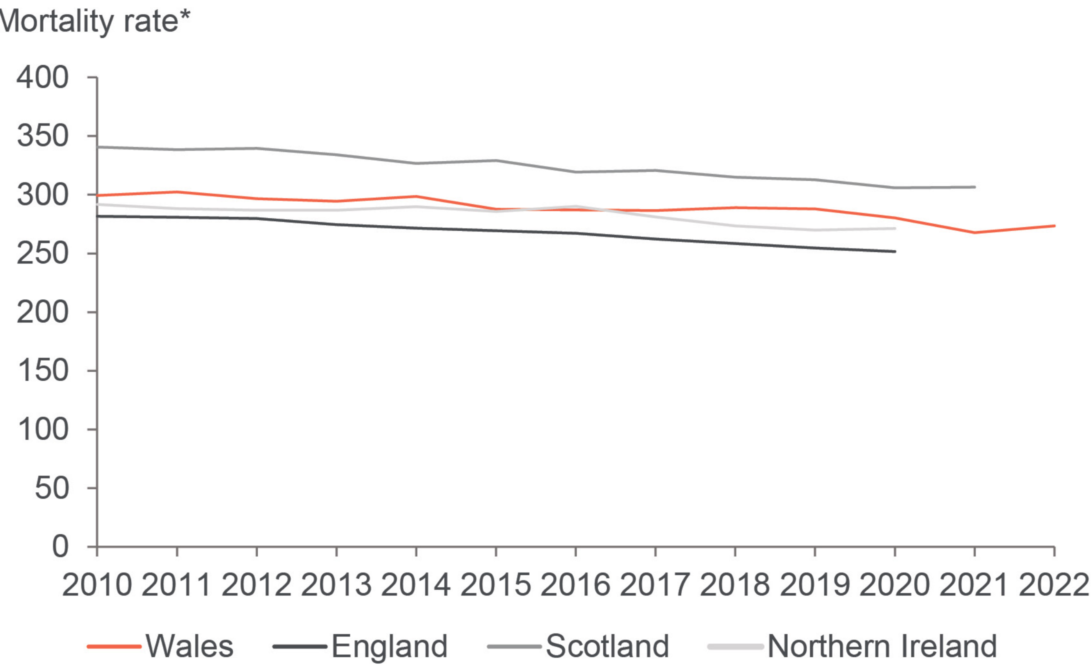
Exhibit 14: age standardised cancer mortality rates in UK countries (excluding non-melanoma skin cancer), 2010 to 2022

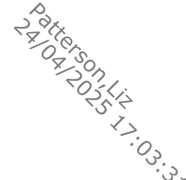


Source: WCISU cancer mortality data

Note: *per 100,000, adjusted to reflect the age of the population

1.26 Cancer survival[33] improved between 2002 and 2020. 54% of patients diagnosed with cancer from 2002-2006 survived their cancer at five years compared to 62% of patients diagnosed between 2016 and 2020. There is not yet data available to track the impact of the pandemic on survival rates. Differences in data collection methods makes it difficult to compare overall survival figures across UK countries.

1.27 There is a significant deprivation gap in survival rates. While 69% of cancer patients living in the most affluent parts of Wales survive cancer at five years, that falls to 51% for those in the most deprived areas (**Exhibit 15**). Worryingly, the deprivation gap has widened from a difference of 16 percentage points for people diagnosed between 2002-06 to 18 percentage points for people diagnosed between 2016-20.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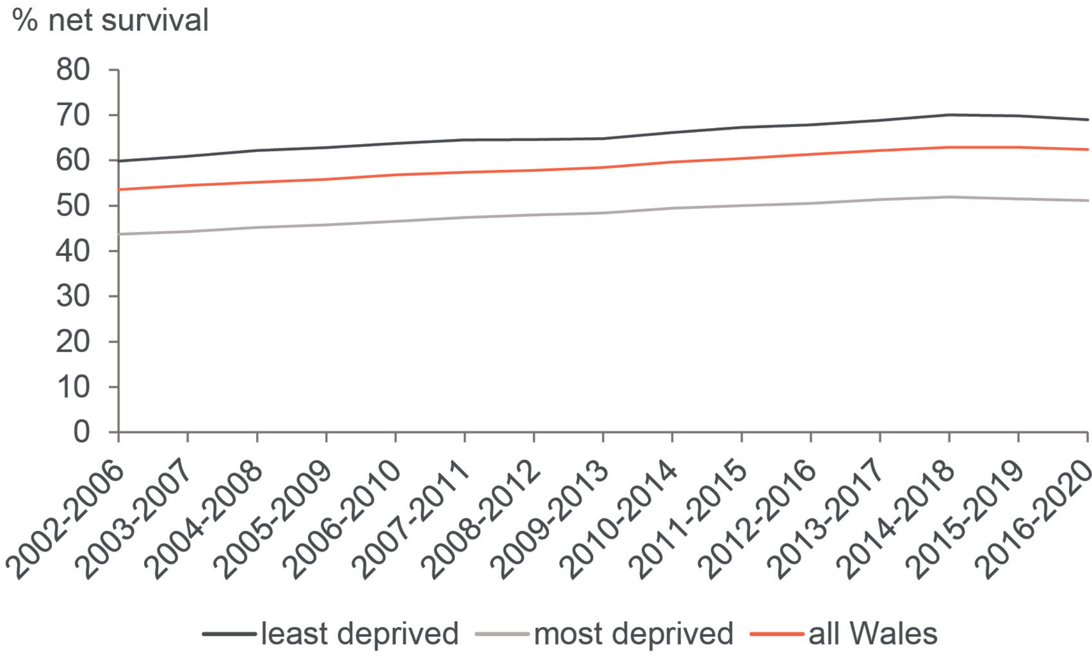
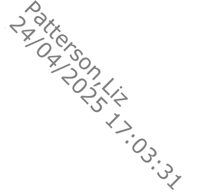
33 Cancer mortality figures show the number of deaths where cancer was the underlying cause whilst survival figures show how many people who have had cancer are still alive after a certain period of time so it takes several years for accurate data to be published.

Exhibit 15: percentage unstandardised rolling net survival at five years comparing most and least deprived areas with the all Wales figure for patients diagnosed in the periods 2002-2006 to 2016-20 (excluding non-melanoma skin cancer).



Source: WCISU cancer survival data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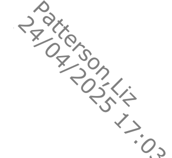
Spending on services to diagnose, treat and support cancer patients has risen faster than overall NHS spending but there are gaps in staffing capacity

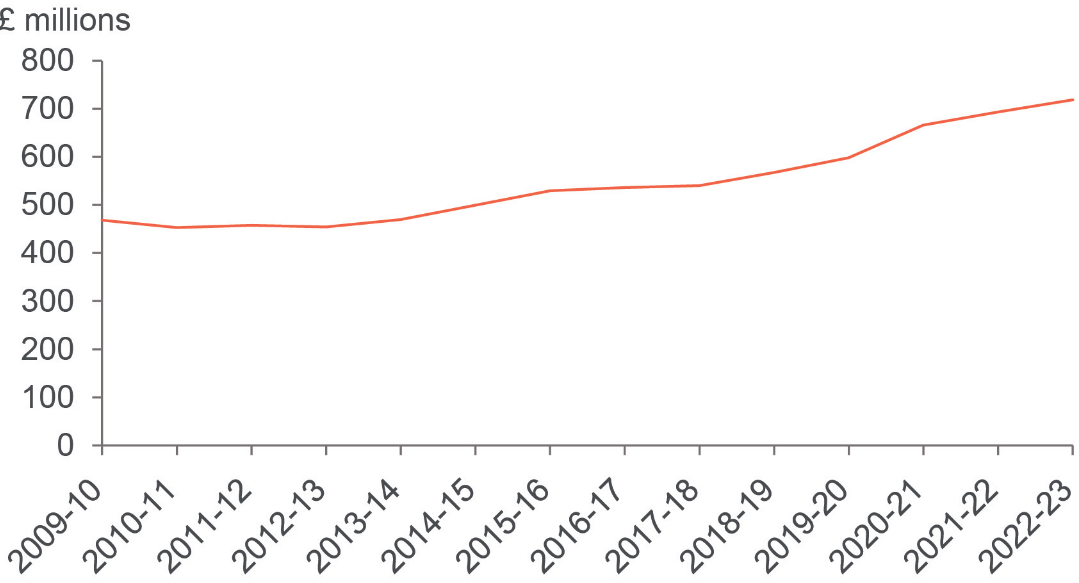
Real terms spending on services to diagnose, treat and support cancer patients has grown more than overall growth in NHS Wales spending but there are significant cost pressures on those services

1.28 Real terms spending on services to diagnose, treat and support cancer patients increased by 54% from just over £450 million in 2009-10 to almost £720 million in 2022-23 (**Exhibit 16**). This increase is considerably greater than the overall 33% real terms growth in NHS Wales spending[34]. As a proportion of overall NHS spending, spending on services to diagnose, treat and support cancer patients has increased slightly from 7% in 2009-10 to 8% in 2022-23. Increased spending does not necessarily translate to additional capacity or activity. There are lots of cost pressures on services including rising workforce costs associated with pay growth and the use of agency staff; rising costs of existing drugs; new drugs and new technologies to improve treatment.



34 Based on revenue spending in the Welsh Government's NHS expenditure by programme budget category data on StatsWales for consistency with cancer spending figures. The NHS Finances Data Tool on our website is based on published Welsh Government budgets and gives a slightly different figure.

Exhibit 16: real terms NHS spending on cancer, 2009-10 to 2022-23



Source: Welsh Government, NHS Expenditure by programme budget category and year, 'cancer and tumours', on StatsWales.

Note: Real terms figures are adjusted to take account of inflation. We used HM Treasury GDP deflators at market prices and money for 2022-23, March 2024.

The Welsh Government confirmed that this data is based on NHS Wales patient activity costs including staff, consumables, medicines and overhead costs such as estates, catering, HR and finance costs.

1.29 In 2022-23 NHS Wales spent £230 per head of the population on services to diagnose, treat and support cancer patients[35]. Spend per head ranged from £206 in Cardiff and Vale to £270 in Swansea Bay University Health Board. An examination of the reasons behind differing spending figures across health board areas was outside the scope of this review but it is likely to reflect different local models of care and population factors including demography and deprivation.

1.30 Despite improvements in cancer waiting times being one of the key priorities for NHS Wales, the prospects for spending on services to diagnose, treat and support cancer patients are uncertain. UK public finances are under pressure. NHS bodies in Wales are already under financial strain, with six out of seven health boards overspending in 2023-24 and most projecting deficits for 2024-25. It is unclear whether they will be able to prioritise services for urgent suspected cancer patients to increase activity sufficiently to meet demand and reduce waiting times. Health boards are also under pressure to prioritise other parts of the system where performance is poor, including long waits for unscheduled care and for planned care.

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35 There is no comparable data from other UK or comparable countries.

Workforce capacity is a significant challenge and there is an absence of information on the availability and condition of equipment

1.31 Despite spending increases, workforce capacity remains a significant challenge and workforce shortages are reducing service capacity[36]. HEIW's Education and Training Plan 2025-26[37] describes 'significant national shortages and longstanding gaps' in specialist professional roles impacting diagnostics, cancer, emergency care and mental health. It highlights particular shortages in dermatologists, clinical oncologists, consultant urology surgeons, and histopathologists. It cites pressure from increasingly complex cancer reporting and the evolving field of geonomics on histopathology, and demand from cancer patients on urology.

1.32 The Royal College of Radiologists describes shortfalls of 34% and 12% in the radiology and clinical oncology workforces, likely to deteriorate to 38% and 28% respectively by 2028[38]. We also heard that there are shortages of medical physicists, specialist and district nurses, and in the geonomics, Systemic Anti-Cancer Therapy and radiotherapy workforce.

1.33 HEIW set out its plans to address workforce shortages in its Education and Training Plan and Integrated Medium-Term Plan 2024-27. In line with its commitment in the Cancer Improvement Plan, HEIW has published its workforce plans for pharmacy and for geonomics, and intends to publish its plan for nursing in early 2025. The Ten-Year Workforce Strategy for Health and Social Care 2020 sets out the broader strategic approach.

1.34 As well as sufficient staff, NHS Wales needs sufficient equipment to deliver timely and effective diagnosis and treatment. The NHS Executive is building up a picture of capacity associated with the age and availability diagnostic imaging equipment including the age and availability of equipment. We heard anecdotal evidence that Wales has fewer imaging machines than comparable countries, and that some machines are old and prone to breaking down. Whilst it was beyond the scope of this review examine those claims, we did hear that limitations in access to diagnostic equipment are putting pressure on staff, affecting recruitment and retention, and restricting HEIW's ability to offer training places for diagnostic students[39].

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36 Audit Wales, Workforce Data Briefing, 2023, sets out broad workforce issues, with many affecting services for cancer patients where services are not specific to cancer patients (such as diagnostics and surgery).

37 The Plan sets out commissioning and training recommendations for the health professional workforce in Wales.

38 Royal College of Radiologists, Radiology Workforce Census 2023, June 2024.

39 It is exploring using simulated training environment as an alternative.

Strategic direction

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2.1 This part of the report looks at national strategic direction and leadership to improve cancer care in Wales. **Appendix 1** explains key elements of the strategic approach and broad roles and responsibilities for cancer services.

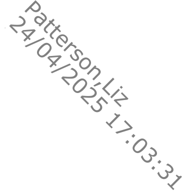
What we looked for

We looked for evidence of a clear strategic direction for improving cancer outcomes and services, and for reducing demand for cancer services by preventing cancer occurring in the first place. We also looked for evidence of appropriate and clear leadership structures to direct, oversee and support improvement and tackle barriers at a national level.

There is a lack of clarity on the status of the Cancer Improvement Plan and how it aligns with other cancer improvement initiatives

The Cancer Improvement Plan has not been sufficiently integrated into the wider strategic approach for improving cancer services

2.2 The Welsh Government set out its vision of what 'good' cancer services should look like in the Quality Statement for Cancer (2021). The Statement is generally high-level but is underpinned by tumour specific national optimal pathways. The pathways set out what should happen at different stages of the patient journey according to professional guidance. The Welsh Government instructed health boards to start embedding the pathways by September 2022[40]. When it published the Statement, the Welsh Government said that the Cancer Network would develop a rolling, three-year plan to achieve the national vision.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40 Via Welsh Health Circular (2022) (021).

Exhibit 17: vision set out in the Quality Statement for Cancer

The Cancer Quality Statement sets out that its ultimate aim is to improve population survival and reduce cancer mortality rates. It identifies key areas for action:

- that cancer is effectively prevented where possible,
- that cases of cancer are detected at earlier more treatable stages,
- that complex treatment pathways are optimised, while throughout people are properly supported and co-produce their care.

The statement sets out a series of attributes, indicating what good quality care looks like, under six headings:

- Equitable
- Safe
- Effective
- Efficient
- Person centred
- Timely

Source: Welsh Government Quality Statement for Cancer, 2021.

2.3 In 2023, the Network published A Cancer Improvement Plan for Wales 2023-26 (the Plan) at the request of then Minister for Health and Social Services. The Plan encompasses a broad range of cross-sector actions to improve cancer patient outcomes and reduce health inequalities. It's three year horizon was deliberately aligned to local health board planning cycles. However, this means the Plan lacks focus on longer-term actions to build sustainable cancer services. It also lacks detail on prevention, palliative and end-of-life care, and on services for children and young people and does not cover the full range of ambitions in the Quality Statement.

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2.4 The then Minister used the Plan to set the new expectation that by March 2026, 80% of patients would start their first treatment within 62 days. The Minister announced publication of the Plan in an oral statement, describing it as a collective NHS Wales approach to delivering the policy intentions in the Quality Statement for Cancer. The Welsh Government told us that it is not a Welsh Government Plan. It considers that it does not require a national plan to implement the Quality Statement because health boards and trusts are responsible for implementing the vision through their own local plans.

2.5 Nonetheless, the Plan exists at the request of the Minister and many of its actions require national direction and leadership to support successful implementation. This would include consideration of the funding needed to support the Plan's actions and using national planning and performance management frameworks to clarify requirements around the Plan's delivery (**recommendation 1**).

2.6 The Cancer Improvement Plan commits the Welsh Government to monitoring delivery of the Plan through its existing performance arrangements. However, during our fieldwork, Welsh Government officials told us that such monitoring was not taking place. Since then, at the then Minister's request, the Cancer Network has collated a retrospective progress 'update' on delivery of the Plan. However, the Welsh Government is not routinely monitoring implementation in line with its commitment in the Cancer Improvement Plan.

New national initiatives to improve cancer services have merit but stakeholders are confused about how they link to the Cancer Improvement Plan

2.7 Since publication of the Plan in 2023, the Welsh Government and NHS Executive have set up new programmes aiming to improve cancer services (**Exhibit 18**). While there are merits in each programme, stakeholders are unclear about how they align with the Cancer Improvement Plan.

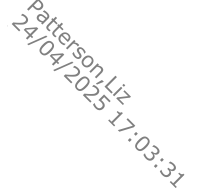


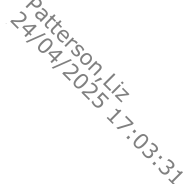
Exhibit 18: new programmes to improve cancer services

Programme	Description
Cancer: Improving Outcomes initiative	The Welsh Government commissioned Life Science Hub Wales to develop the initiative, which is aimed at focusing innovation on key problem areas and removing the barriers to delivering innovation at pace.
National Cancer Recovery Programme	The NHS Executive set up the programme, which is aimed at reducing long waits to achieve a target that 80% of suspected cancer patients start treatment within 62 days by 31st March 2026.

Source: Audit Wales.

2.8 The NHS Executive is currently finalising arrangements for its National Cancer Recovery Programme. The Programme focuses on five specific tumour sites[41] with some cross-cutting actions to improve more general services to diagnose and treat cancer patients. Rather than large-scale, whole-system transformation, the Programme aims to improve performance and improve compliance with the National Optimal Pathways within existing budgets.

2.9 The Welsh Government has repurposed Cancer Network funding to provide £2 million per annum for 2024-25 to 2026-27 for the NHS Executive to implement the Programme. Around half of this funding will pay for staff costs in line with the Programme aims around encouraging improvement within existing budgets. NHS Executive officials told us that the Programme may identify improvement opportunities which would then be costed and developed into business cases for additional Welsh Government funding.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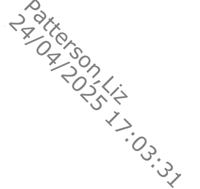
41 Breast, gynaecological, lower gastrointestinal, skin, and urological cancers.

Many NHS bodies and third sector partners are confused about the strategic direction

2.10 NHS and third sector organisations told us they are confused about the strategic direction for cancer services in Wales. Some all-Wales NHS bodies have embraced the commitments in the Plan (for example **paragraph 1.33**). Others have rejected actions attributed to their organisation and saw some actions in the Plan as irrelevant (for example **paragraph 2.37**).

2.11 Health boards have developed local initiatives to improve diagnosis, treatment and support for cancer patients but it is not clear how they link to the Cancer Improvement Plan. During our fieldwork it was apparent that NHS bodies were not clear about the status of the Plan and how it should be shaping their activities. NHS and third sector bodies told us that the development of the new initiatives and programmes so soon after the publication of the Cancer Improvement Plan has increased their confusion about the strategic direction.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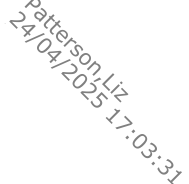
National leadership, decision-making and oversight arrangements are not effective and there is an over-reliance on narrow performance management

There is a lack of clarity as to who is responsible and accountable for driving system wide improvement to cancer services

2.12 The Welsh Government established the NHS Executive to drive improvements in the quality and safety of care. It brings together existing improvement organisations to better coordinate and drive improvements to the quality and safety of care[42]. However, officials in NHS bodies and third sector representatives we interviewed, were confused about the differing roles of the Welsh Government and NHS Executive. We also heard that there was confusion about the different roles and functions within the NHS Executive. At the time of our review, three NHS Executive functions had responsibility for driving cancer improvement:

- the Strategic Planned Care Programme had responsibility for supporting improvement in the timeliness of cancer diagnosis and treatment;
- the Performance Assurance Directorate provided direct support to NHS bodies to improve cancer performance; and
- the Cancer Network worked with clinicians, health professionals, and third sector and patient representative organisations to improve outcomes and care for cancer patients.

2.13 We found a general consensus, including within the Welsh Government and NHS Executive, that the Executive is not yet providing the intended strong leadership to drive improvement. Many NHS and third sector bodies described arrangements after the establishment of the Executive as a 'step backwards' or 'worse than ever.'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42 The NHS Wales Delivery Unit, the NHS Wales Finance Delivery Unit, the NHS Wales Health Collaborative; and Improvement Cymru.

2.14 Stakeholders raised various concerns about the national leadership and accountability arrangements for cancer services including:

- the Cancer Network lacking the authority to make decisions and commit the level of resources needed to secure change;
- lack of integration of the Cancer Network within the NHS Executive's leadership and with the wider NHS, and gaps in arrangements to share frontline insight from clinicians;
- third sector bodies are struggling to know who to engage with and how to share important intelligence and more generally feeling under-appreciated for the extensive support they provide to the system[43] and individuals and their families (**recommendation 2**);
- overlap and duplication between the cancer recovery work carried out by the Strategic Planned Care Programme and the intervention work led by the Performance Assurance Directorate; and
- lack of communication between the Welsh Government and NHS Executive to assess whether funding for additional capacity is being allocated to areas of greatest need.

2.15 Since our fieldwork the NHS Executive has established a Network Clinical Leadership Group to support closer working between clinicians and wider NHS Executive senior leadership. Whilst this is a positive development, wider action is needed to strengthen national leadership arrangements. The gaps, lack of clarity and duplication described above have led to a situation where many stakeholders from inside and outside of the NHS told us: 'we don't know who is in charge' (**recommendation 2**). The Senedd Health and Social Care Committee's report on gynaecological cancers[44] raised similar concerns and called on the Welsh Government to be 'more accountable' for driving improved cancer services.

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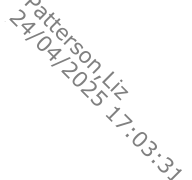
43 The third sector has a wealth of knowledge and insight and provides funding for some services in Wales (such as the Teenage Cancer Trust cancer ward in Cardiff). We also found examples of third sector organisations attracting private sector funding to drive innovation, and developing data resources which are now used by NHS Wales.

44 Welsh Health and Social Care Committee, Unheard: Women's Journey through Gynaecological Cancer, December 2023.

National decision-making and leadership arrangements are not sufficiently robust to systematically identify and prioritise opportunities to improve cancer services

2.16 Cancer treatment is an area of significant innovation, with opportunities to improve outcomes and efficiency. We identified examples of Welsh Government investment and decision making to improve cancer and planned care. For instance, it has worked with health boards and the NHS Executive to introduce rapid diagnostic centres; supported improvements to the bowel screening programme and is funding a new cancer centre for Velindre NHS Trust[45].

2.17 However, the Welsh Government recognises that it lacks a robust approach to identifying, assessing and prioritising such opportunities. Current arrangements need strengthening to ensure there is sufficient capacity to assess and prioritise initiatives for funding. Arrangements should address gaps in decision making structures to prioritise investment in areas such as digital, workforce and diagnostics (**recommendation 2**). **Exhibit 19** sets out two areas of opportunity to improve efficiency and outcomes, where decision making has been slow.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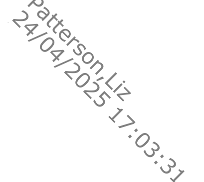
45 We are conducting a separate examination of decision-making relating to the development of the new Velindre Cancer Centre. We aim to publish that report in 2025.

Exhibit 19: potential innovations where decision making has been slow

Programme	Description
Digital cellular pathology	During our review, NHS bodies and third sector organisations cited frustration with the speed of national decision making on the use of digital cellular pathology. Betsi Cadwaladr University Health Board was a pioneer of the approach and transformed its pathology service in 2014. Laboratories could scan and upload images onto digital systems to be analysed remotely rather than transporting samples between locations. Alongside a broader transformation programme*, the approach dramatically improved the timeliness of pathology results and helped the health board recruit and retain staff because it facilitated flexible working arrangements. The National Pathology Programme has been working with the Welsh Government and health boards to develop a consistent all-Wales approach to digital cellular pathology since 2019. Despite general consensus on the benefits of the approach, progress has been restricted by uncertainty about who would fund modern scanning equipment and digital storage. Health boards have been reluctant to commit funds without clarity on the Welsh Government's financial contribution. Despite investing in other aspects of digital cellular pathology, at the time of our review, the Welsh Government was not clear about whether it would fund the equipment and storage to establish an all-Wales approach. The National Pathology Programme was still working with health boards to agree a business case share ongoing annual costs of around £3 million for the scanning equipment and storage. Wales now lags behind the rest of the UK for digital cellular pathology capacity, making it a less attractive employment option for newly qualitied pathologists in an already competitive market.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Programme	Description
Lung Screening	In 2019, the Cancer Network started exploring evidence on the effectiveness lung screening. It concluded that screening could increase the percentage of cancers identified at an early stage and had the potential to reduce lung cancer mortality by 20%. The work informed a pilot lung health check programme in Cwm Taf Morgannwg University Health Board, which started in 2022 and was funded by third sector organisations and private industry. The UK National Screening Committee recommended that UK nations develop targeted lung screening for people aged 55-74 years with a history of smoking in June 2022. Despite an endorsement from the Wales Screening Committee in November 2022, the Welsh Government did not task PHW with developing options for a national programme until July 2023. The Welsh Government has asked PHW to provide interim proposals on a national lung screening programme by May 2025. If PHW meets the 2025 deadline, it will have taken three years from the UK National Screening Committee's recommendation just to develop interim proposals. Finalising proposals and implementing a national programme would take more time after this point (**recommendation 5**).

Source: Audit Wales.

Note: *The digital cellular pathology approach was part of a wider transformation programme including combining regional services into a single Betsi Cadwaladr University Health Board Cellular Pathology Service.

2.18 We also heard concerns about the Welsh Government's ability to secure the benefits from its investment in capacity and new ways of working. In particular, stakeholders frequently cited an incoherent approach that has seen the Welsh Government invest in the training and recruitment of radiologists only for many to be unable to find work in NHS Wales (**Exhibit 20**).

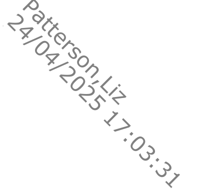

Exhibit 20: investment in training and radiologists

A National Imaging Academy opened in 2019, as a result of the Welsh Government providing £3.4 million to HEIW to establish the facility to help meet identified workforce gaps in respect of radiologists and imaging professionals.

However, many of the newly qualified radiologists are leaving Wales because, despite workforce gaps there are no jobs for them. Some health boards told us that financial pressures have led to recruitment freezes which limited their ability to recruit diagnostic staff. We also heard that weaknesses in health board workforce planning including projections of future need and slow recruitment processes were part of the problem*.

The NHS Executive's National Diagnostics Implementation Plan** contains a weak commitment to work with HEIW to 'advocate' for commitment to employment from health boards when requesting training numbers. It is unclear what role the Welsh Government intends to play in ensuring the benefits of its investment in training the future workforce are not lost to Wales (**recommendation 7**).

Source: Audit Wales

Notes:

* Our review of workforce planning made specific recommendations to health boards to improve workforce planning. Individual reports for each NHS body are available on our website www.Audit.Wales.

** NHS Executive, National Diagnostic Implementation Plan 2023-25.

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2.19 Regional working across health board areas can help to share capacity and bolster fragile services. Health boards are developing regional approaches in some areas that can increase capacity in the system[46]. The NHS Executive is also developing plans for two regional diagnostic hubs in South Wales to provide additional shared diagnostic capacity for the region. However, the overall pace of regional collaboration is slow. Whilst there is a clear onus on health boards to take forward regional working, there is also a need for national leadership and co-ordination from the Welsh Government and the NHS Executive. In that regard the recent creation of a dedicated senior role within the NHS Executive to support regional working is a welcome development. However, success will also depend on action to tackle barriers to regional working such as a lack of integration between digital systems making it difficult to share waiting lists across health boards[47] (**recommendation 6**).

Welsh Government oversight is narrowly focussed on the 62-day target

2.20 The Welsh Government's NHS Performance Framework (2024-25) sets out the measures (but not the targets) against which NHS bodies are accountable. The 62-day measure is the main cancer specific measure. There is a measure on the timeliness of colonoscopy for bowel screening referrals (**paragraph 1.21**) but no measures for breast or cervical screening referrals. Previous performance frameworks[48] included coverage measures for all three cancer screening programmes. There is also a measure for uptake of the human papillomavirus (HPV) vaccine (**paragraph 2.24**).

2.21 The Performance Framework does not include any measures on cancer incidence, mortality and survival rates. It does not clearly link to the six quality attributes set out in the Quality Statement for Cancer and the Framework makes no reference to compliance with the National Optimal Pathways that underpin the Quality Statement. While the Welsh Government has made the NHS Executive responsible for monitoring compliance with the pathways it is still developing methods for doing so.

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46 Including developing regional approaches to diagnostics and treatment in North, Southeast and Southwest Wales using Welsh Government planned care recovery funding.

47 Welsh Health and Social Care Committee, Unheard: Women's Journey through Gynaecological Cancer, December 2023.

48 NHS Wales Performance Framework 2022-23.

2.22 There is a well-established framework for oversight of NHS bodies' planning and performance through activities such as scrutiny of NHS bodies' annual or medium-term plans, monthly Integrated Quality, Planning and Delivery meetings and twice yearly Joint Executive Team meetings between Welsh Government, the NHS Executive and individual NHS bodies. In addition, monthly cancer performance meetings provide a specific focus on the diagnosis and treatment of cancer patients. Collectively this represents a significant volume of performance management activity and includes positive developments around collaboration and information sharing between the Welsh Government and NHS Executive. However, the focus is largely on short-term delivery of the 62-day cancer performance target, rather than broader system change and wider delivery of the vision in the Quality Statement (**recommendation 3**).

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The strategic approach lacks a coherent focus on cancer prevention, and is undermined by gaps in data and fragmented digital services

There is no coherent strategic approach to prevention, even though many cancers are preventable and doing so could save lives and reduce demand for NHS services

2.23 The Cancer Improvement Plan states that 38% of cancers each year in Wales are preventable. There are considerable opportunities to tackle lifestyle factors which increase the risks of some cancers. Many of the lifestyle risk factors for cancer are similar across major conditions accounting for the majority of planned and emergency care in the UK. Data from PHW's Public Health Outcomes Framework[49] showed that in 2022-23, 13% of adults in Wales smoked; 17% drank more alcohol than recommended guidelines[50]; and only 36% of working age adults were a healthy weight[51].

2.24 There are also opportunities associated with increasing the uptake of the human papillomavirus (HPV) vaccine. Since its introduction in 2008, the vaccine has reduced cancer rates by almost 90% in women in their 20s and is expected to save hundreds of lives a year in the UK[52]. PHW reported that 74% of children in school year 9 during 2023-24 had the vaccine. There was considerable variation in uptake ranging from 60% in Cardiff and Vale University Health Board to 88% in Swansea Bay. Changes in eligibility for the vaccine make it difficult to compare changes in uptake over time[53].

49 Public Health Wales NHS Trust Observatory, Public Health Outcomes Framework.

50 Based on adults who reported drinking over 14 units of alcohol per week.

51 Smoking and alcohol consumption data uses age standardised rates to account for differences in age structures of different parts of Wales. Data on healthy weight is age specific.

52 Public Health Wales NHS Trust: immunisation and vaccines.

53 Public Health Wales, Vaccine Uptake in Children in Wales, Quarterly Report January to March 2024, May 2024.

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2.25 The World Health Organisation states that prevention offers the most cost-effective long-term strategy for managing cancer[54]. The Welsh Government's Science Evidence Advice[55] agrees that there are considerable opportunities to reduce the burden of disease on the NHS by preventing cancer and other major conditions. It identifies scope for long-term financial savings and calls for 'drastic action' to address increases in lifestyle risk factors, making many suggestions to reshape services around prevention.

2.26 The Welsh Government's NHS Planning Framework 2024-27 refers health boards to the Science Evidence Advice, explaining that it expects to see evidence of prevention in health boards plans. However, the Welsh Government does not go further in encouraging and leading health boards to develop local preventative initiatives.

2.27 Preventing cancer would also reduce demand on NHS capacity. **Exhibit 21** sets in crude terms what impact a 10%, 20% and 38% reduction in cancer cases could have, based on 2022-23 activity levels. The potential annual financial savings from the reduction in bed days would be in the order of £8.2 million to £31.4 million[56]. There could also be significant savings from reducing outpatient appointments and drugs costs. However, there would also be costs associated with activity to prevent cancer.

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54 World Health Organisation, Health Topics – Cancer Prevention.

55 Welsh Government, Science Evidence Advice – NHS in 10+ Years – An Examination of the Projected Impact of Long-Term Conditions and Risk Factors in Wales', September 2023.

56 Savings calculation based on £500 per day cost of an NHS bed in Wales.

Exhibit 21: potential capacity gains associated with preventing cancer occurring in the first place based on 2022-23 activity

2022-23	**90,532** finished consultant episodes	**84,583** admission episodes	**164,971** bed days	**10,864** regular attenders*
-10%	**81,479** finished consultant episodes (9,053 reduction)	**76,125** admission episodes (8,458 reduction)	**148,474** bed days (16,497 reduction)	**9,778** regular attenders (1,086 reduction)
-20%	**72,426** finished consultant episodes (18,106 reduction)	**67,666** admission episodes (16,917 reduction)	**131,977** bed days (32,994 reduction)	**8,691** regular attenders (2,173 reduction)
-38%	**56,130** finished consultant episodes (34,402 reduction)	**52,441** admission episodes (32,142 reduction)	**102,282** bed days (62,689 reduction)	**6,736** regular attenders (4,128 reduction)

Source: Audit Wales analysis of DHCW data from the Patient Episode Database for Wales, Headline Figures and Primary Diagnosis Datasets, Welsh Providers

Note:

*Our analysis is indicative of potential capacity gains based on averages. We calculated potential gains associated with a 38% reduction in activity based on the assertion in the Cancer Improvement Plan that 38% of cancers each year are preventable.

*Regular attenders are patients who are admitted to hospital on a regular basis to receive treatment.

2.28 Despite compelling evidence and it being a long-standing ambition, the Welsh Government has yet to translate broader aims on prevention into more concrete and cohesive policy approaches aimed at shifting the balance of care towards prevention (**recommendation 4**). In particular:

- it has never set out a clear, over-arching strategic approach to achieving this shift across the many public sector bodies whose priorities, choices and behaviours would need to change;
- it has a piecemeal approach with individual strategies on healthy weight and tobacco control[57] but no plan related to the health impacts of alcohol use; and
- the Future Generations Commissioner, amongst others, criticised the Welsh Government for cutting its preventative health improvement budgets in 2024-25[58].

There are gaps in the availability and quality of data to understand how well cancer care is being provided

2.29 Good quality data is essential for the planning, delivery and improvement of cancer care. The NHS Executive has improved the timeliness and accessibility of performance data in an unpublished interactive dashboard used by health boards, the Executive, and the Welsh Government. DHCW publishes a different Suspected Cancer Pathway Dashboard with less detailed information[59].

2.30 However, there are gaps in published data right across the patient pathway (**Exhibit 22**). The Welsh Government publishes data on 'closed' pathways showing how many patients were treated within 62 days but does not publish 'open' pathway waits to show how many patients are currently waiting for treatment.

2.31 Much of the available data focusses narrowly on the period between referral and diagnosis or first treatment. There is no national data on the activity and timeliness leading up to a referral. There is also no available data on activity after the first treatment starts (see **paragraph 1.6**), including follow-up tests, ongoing treatment and access to palliative and end-of-life care (**recommendation 9**).

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57 Welsh Government, Healthy Weight Healthy Wales, 2019 and Welsh Government, A Smoke Free Wales – Our Long-term Tobacco Control Strategy, 2022.

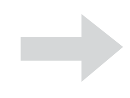
58 The budget for health improvement and healthy living reduced by £3.8 million bringing the total budget to £10.8 million; the substance misuse action plan fund by £2.5 million bringing the total budget to £47.5 million); and the health promotion budget fell by £710,000 to £12.2 million.

59 DHCW's dashboard uses data which has been validated to identify errors but the internal NHS Executive dashboard is unvalidated performance data.

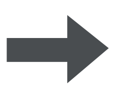
Exhibit 22: gaps in data at different stages of the cancer pathway

First suspicion to first definitive treatment

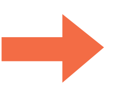
First suspicion of cancer

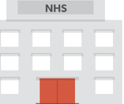


First appointment



First diagnostic test





First definitive treatment

Information to understand how many times patients had to visit a GP before being referred

Waiting times for urgent suspected cancer referrals made via screening programmes

More timely information on stage / severity at diagnosis and waiting times by stage

Better information to understand potential delays between diagnosis and treatment such as:

Waiting times between the test and a decision to treat the patient

Waiting times for the patient to receive their test results

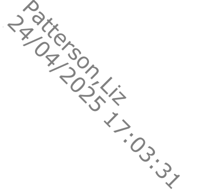
Waiting times for subsequent diagnostic tests

Waiting times for subsequent treatment and follow up appointments

Waiting times for radiotherapy and Systemic Anti-Cancer Treatment

Information on demand for and access to palliative and end of life care

Source: Audit Wales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2.32 There is very limited data to track progress against the ambitions in the Quality Statement. Against the overarching ambition of prevention and early detection, we found limited information on the causes of growing demand that can be used to prevent or detect cancer early amongst those most at risk. For instance, little is known about why some people are presenting at a more advanced stage, or as an emergency. There is also limited information about the demographic profile and location of people with unhealthy lifestyles. A new project led by WCISU has the potential to improve national intelligence on cancer risk factors. It will link Cancer Registry data to Census 2021 information via the SAIL databank to explore the influence of factors like ethnicity, income and educational status on cancer outcomes[60].

2.33 There is also very limited information to understand how equitable cancer support services are. For example:

- the Welsh Government requires heath boards to record the ethnicity of cancer patients[61] but compliance is extremely low. We were unable to analyse waiting list and timeliness trends by ethnicity because over two thirds of the pathways had no information on patient ethnicity.
- DHCW reports performance against the 62-day target by sex but there is little information to understand patient experience and outcomes by sex. The Senedd inquiry into gynaecological cancers found that women can experience many barriers to accessing cancer treatment but there is little information to understand how many women are affected[62].
- there is insufficient public data to understand potential differences in the timeliness of cancer diagnosis and treatment across Wales, particularly for people living in Powys. Timeliness data for Powys residents treated by other Welsh health boards is included in data for those health boards. The data is not disaggregated to show timeliness for Powys residents or the residents of the health board providing treatment[63]. There is also a lack of data on Welsh patients from any health board who are treated by NHS England (**recommendation 10**).
- there is also little information to understand equity of provision for children and young people. DHCW groups all data for under 30-year-olds together in the Suspected Cancer Dashboard data whereas other patients are grouped ten-year age bands. Under 16-year-olds are excluded from the Macmillan cancer patient experience survey.

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60 The project aims to report its findings in late 2024.

61 Under Data Standards Change Notices from 2020 onwards (DCSN 2020/21 and DSCN 23/45). The Notices mandate compliance with data standards.

62 Welsh Parliament Health and Social Care Committee, Unheard: Women's Journey Through Gynaecological Cancer, December 2023.

63 Other published NHS Wales data does include distinct health board 'residence' and 'provider' performance data. For instance the Referral for Treatment data on StatsWales.

2.34 There are problems with the quality of some of the available data. WCISU officials told us Wales is a year behind England in publishing Cancer Registry data because a high volume of errors in the source data is creating extra work for its staff. NHS bodies told us that poor compliance with data standards by NHS staff inputting patient information is creating data errors. We found that there is confusion around who is responsible for improving compliance (**recommendation 8**). We have not specifically reviewed data quality as part of this review but have uncovered several inaccuracies in published data and bespoke analysis provided by DHCW.

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Digital systems are fragmented and progress implementing the new cancer information system has been slow

2.35 Progress in updating the core digital system for cancer patients has been extremely slow. The previous system (Canisc) was constructed using a programming language in 1997 which Microsoft stopped supporting in 2014. Following our 2018 report on NHS Wales informatics systems[64], the Senedd Public Accounts Committee inquiry raised serious concerns about slow progress replacing Canisc[65]. It took a further five years to implement the first phase of the new cancer information system. DHCW told us that the pandemic has added to delays. The Welsh Government has recently confirmed funding for the second phase of the programme, aimed at improving integration and digital processes and dealing with requests for specific changes from individual NHS bodies.

2.36 More broadly, NHS bodies told us that lack of integrated digital systems is consuming valuable staff time because they are using manual 'workarounds' to transfer patients across the different patient administration systems. The process is frustrating staff and diverting their time from seeing patients. It also carries risks to patient safety because details could be transferred incorrectly or not at all. DHCW is responsible for delivering national digital systems for NHS Wales but not their local configuration. DHCW described considerable barriers to getting those systems to join up. In particular, there are numerous examples of NHS bodies either procuring their own digital systems rather than using the national products, or adapting the national products which limits interoperability.

2.37 The Cancer Improvement Plan committed PHW, the Cancer Network and DHCW to developing a cancer version of the national Digital and Data Strategy for Wales by the end of June 2023. No such plan had been created at the time of our review and we found confusion about the commitment to create one in the first place. DHCW told us there is no need to create a separate digital cancer plan because the overarching Digital and Data Strategy sets out the system wide approach to improve digital provision.

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64 Wales Audit Office, Informatics Systems in NHS Wales, 2018.

65 National Assembly for Wales Public Accounts Committee, Informatics Systems in NHS Wales, 2018.

Appendices

1 Strategic context

2 Additional data analysis

3 About our work

1 Strategic context

Exhibit 23: broad roles and responsibilities for cancer services in Wales

Welsh Government

Sets priorities for the NHS Executive and health bodies

NHS Executive | **National Strategic Clinical Network for Cancer** (formerly the Wales Cancer Network)

Leading and supporting improvement of cancer services

NHS bodies responsible for delivering cancer services

Health Boards	Velindre NHS Trust	Public Health Wales NHS Trust
Responsible for the health of their resident population including health improvement, providing cancer services* and end-of-life and palliative care	Responsible for providing cancer services** in South East Wales and specialised blood services across Wales	Responsible for improving health and wellbeing, reducing health inequalities, providing cancer screening services, and the cancer registry (WCISU)

NHS bodies supporting NHS Wales***

Digital Health and Care Wales	NHS Wales Shared Services Partnership	Health Education and Improvement Wales
Responsible for providing digital solutions to support cancer services	Provides support functions and services to NHS Wales	Responsible for supporting the development of the health and care workforce

Bodies supporting cancer patients and their families including:
The social care sector; third sector; local authorities; and patient groups

Source: Audit Wales

Note:

*Including diagnostic tests; treatment; and support and advice for patients. The level and type of services provided differs between health boards because some services are provided by other healthcare providers. For instance, Powys Teaching Health Board provides some diagnostic services but commissions other cancer services from other NHS providers in England and Wales.

**Including chemotherapy; radiotherapy; and support and advice for patients.
***There are also organisations and groups responsible for research, development and innovation including: Geonomics Partnership Wales; Health and Care Research Wales; Life Sciences Hub Wales; and the Wales Cancer Research Centre.

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Exhibit 24: key elements of the strategic approach to cancer services in Wales

Programme for Government

Ministerial priorities

Health and Social Care (Quality and Engagement) (Wales) Act 2020

A Healthier Wales: Plan for Health and Social Care

Set the Welsh Government's vision for health and social care:

NHS Planning Framework
Planning guidance and principles for NHS bodies

NHS Performance Framework
Sets performance measures for NHS bodies

National Clinical Framework
Principles for planning and delivery of clinical services

Quality Statement for Cancer 2022
The national vision for cancer services

National Optimum Pathways
Guidelines for each stage of patient pathways depending on tumour site

Integrated Medium Term Plans

Wales Cancer Network: Cancer Improvement Plan 2023
A collective plan for NHS Wales to improve services for cancer patients

NHS Executive: National Cancer Recovery Programme 2024
National programme to improve cancer services

Life Sciences Hub Wales: Cancer: Improving Outcomes Initiative
A Welsh Government commissioned programme, aimed at delivering innovation at pace.

Broader Welsh Government Strategy including:

Diagnostics, Recovery and Transformation Strategy for Wales 2023-25

Digital and Data Strategy for Health and Social Care in Wales 2023

National Workforce Implementation Plan: Addressing NHS Wales Workforce Challenges 2023 and A Healthier Wales: Our Workforce Strategy for the Health and Social Care Workforce, 2020 (commissioned by the Welsh Government from Health Education and Improvement Wales)

Healthy Weight, Healthy Wales, 2019 including a 2022 to 2024 delivery plan

A smoke-free Wales: Long-term tobacco control strategy, 2022 including a 2022 to 2024 delivery plan

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Source: Audit Wales

2 Additional data analysis

Data on demand for cancer services

Exhibit 25: Patients who were treated by source of suspicion, monthly average across 2023-24

Source of suspicion / referral	% overall suspected cancer referrals	% of patients starting treatment as a proportion of referrals by source of suspicion
GP	**80%** (12,635 people)	**8% of GP referrals** (975 people)
Internal secondary care	**10%** (1,570 people)	**17% of internal secondary care referrals** (266 people)
Following a diagnostic test	**6%** (911 people)	**37% of referrals following a diagnostic test** (341 people)
Bowel screening	**1%** (120 people)	**28% of bowel screening referrals** (33 people)
Breast screening	**1%** (106 people)	**92% of breast screening referrals** (98 people)
Cervical screening	**<1%***	**50% of cervical screening referrals***
Emergency department	**1%** (214 people)	**38% of emergency department referrals** (81 people)
Other primary care professional	**1%** (120 people)	**5% of referrals from other primary care professionals***
Other health professional	**<1%** (66 people)	**15% of referrals from other health professionals***
Consultant from another health board	**<1%** (38 people)	**21% of referrals from external consultants***

Source: Audit Wales analysis of DHCW Suspected Cancer Pathway Data – closed pathways by source of suspicion.

Note: A small number of patient pathways did not have data on the source of suspicion / referral.

*Where there are 10 people or less.

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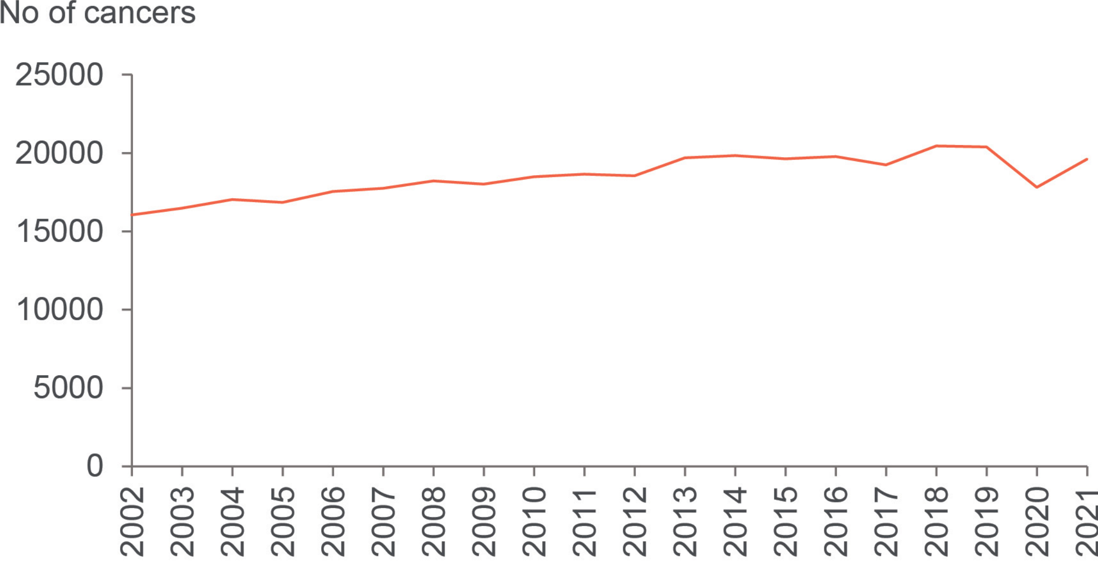
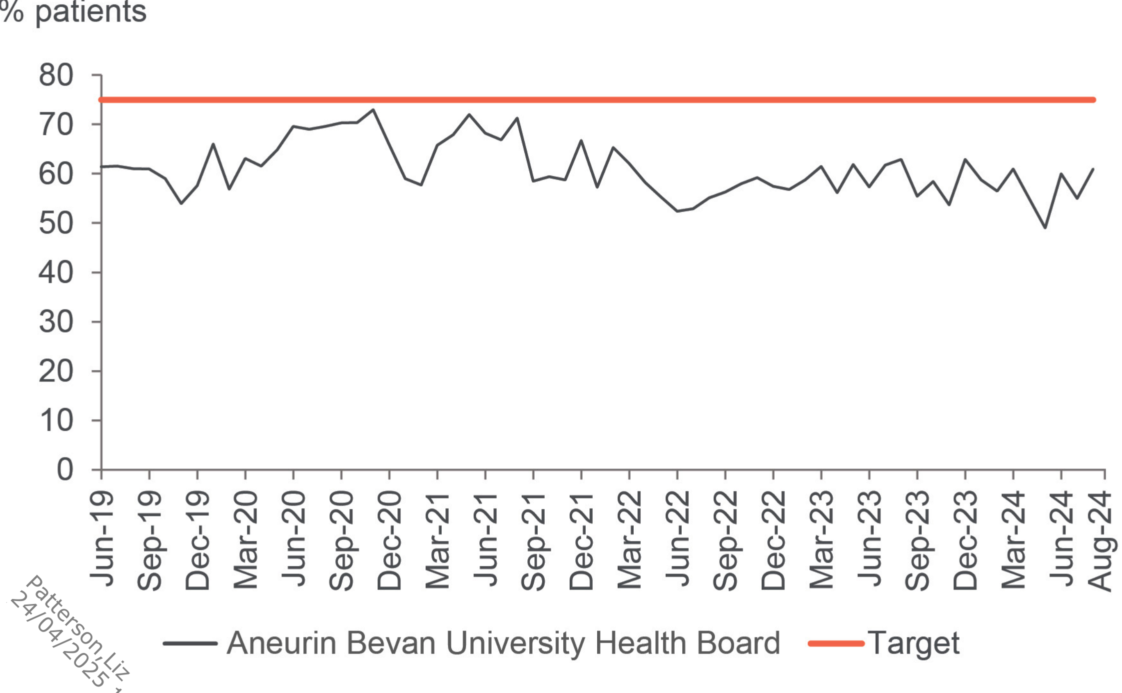
Exhibit 26: number of newly diagnosed cancers in Wales (excluding non-melanoma skin cancer), 2002-2021



Source: WCISU cancer incidence data

Exhibit 27a: performance against the 62-day target by Aneurin Bevan University Health Board, June 2019 to August 2024



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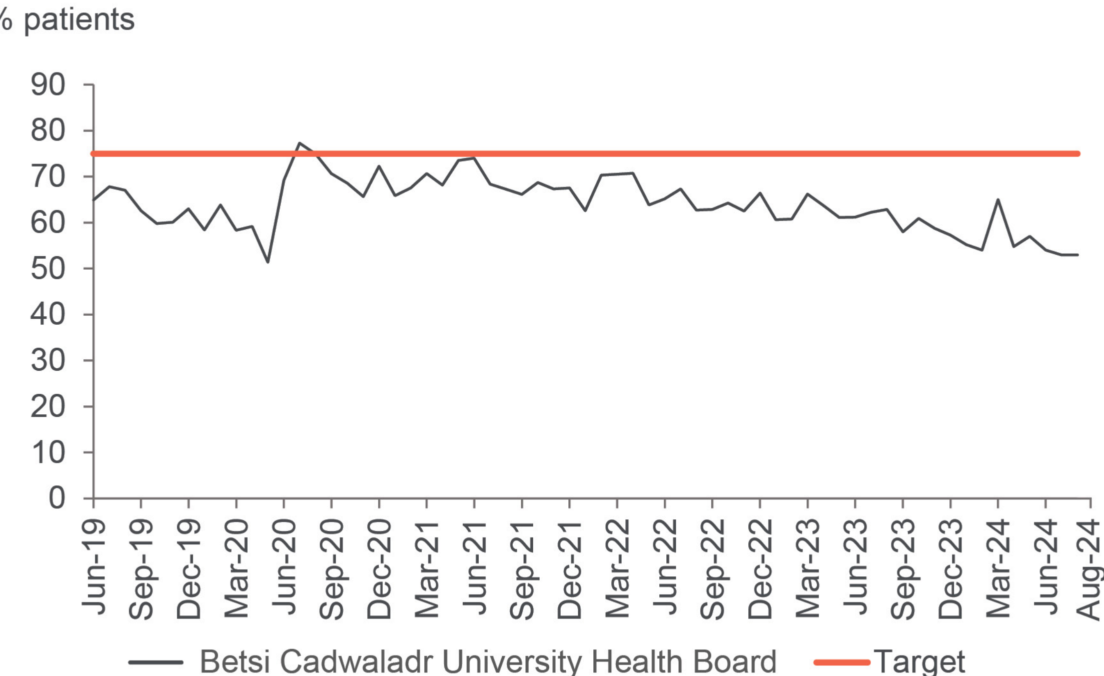
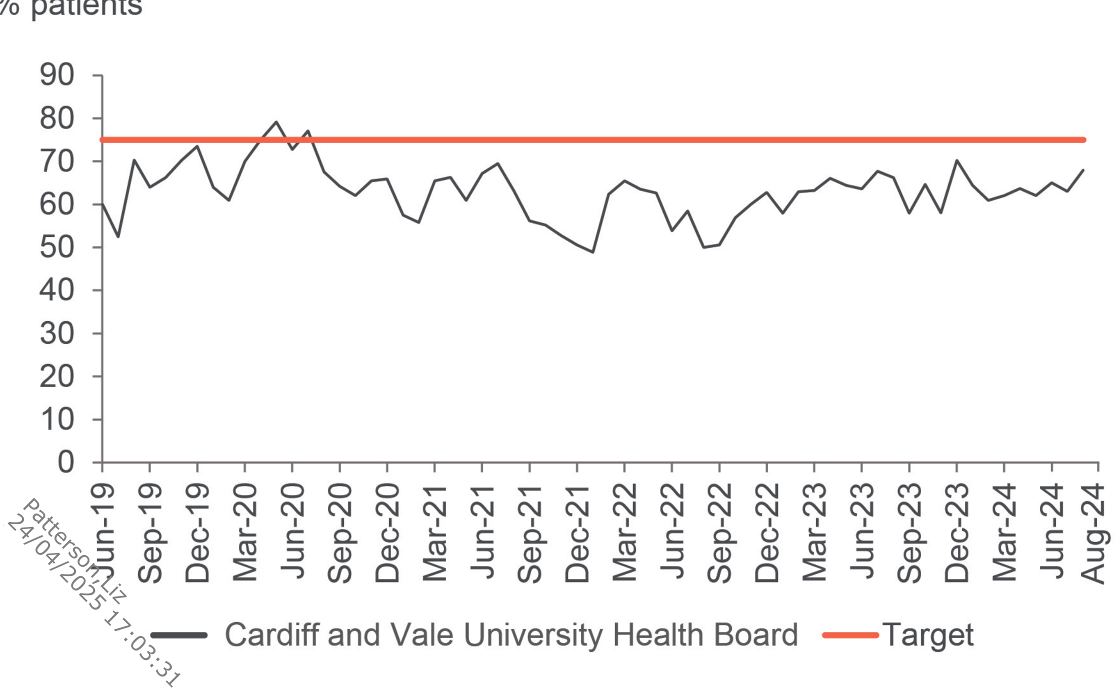
Source: DHCW, Suspected Cancer Pathway – Closed Pathways dataset, on StatsWales.

Exhibit 27b: performance against the 62-day target by Betsi Cadwalladr University Health Board, June 2019 to August 2024



Source: DHCW, Suspected Cancer Pathway – Closed Pathways, on StatsWales.

Exhibit 27c: performance against the 62-day target by Cardiff and Vale University Health Board, June 2019 to August 2024



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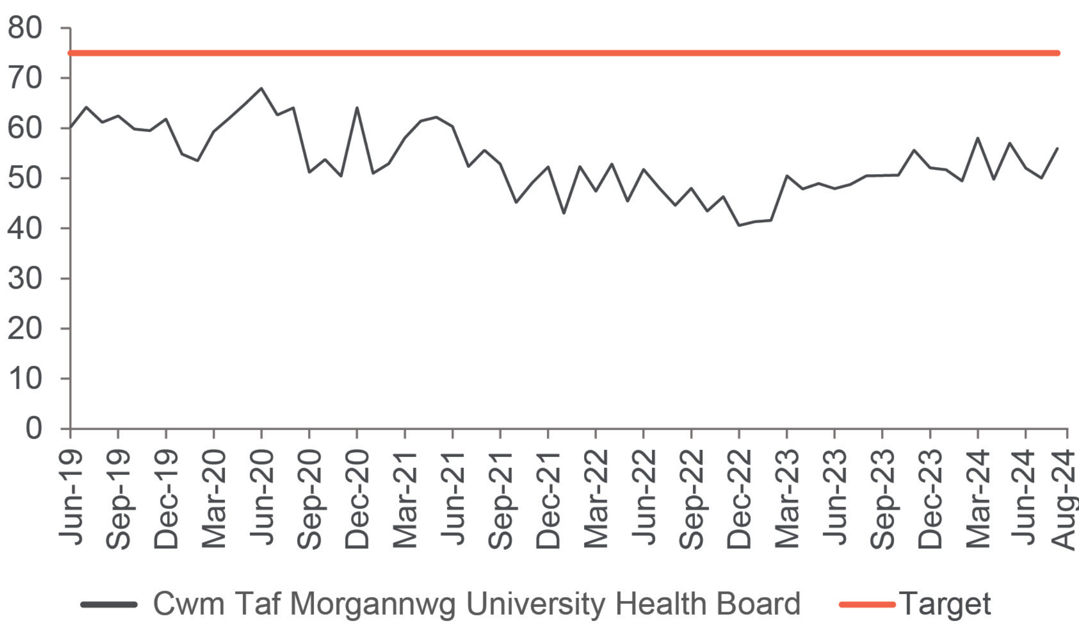
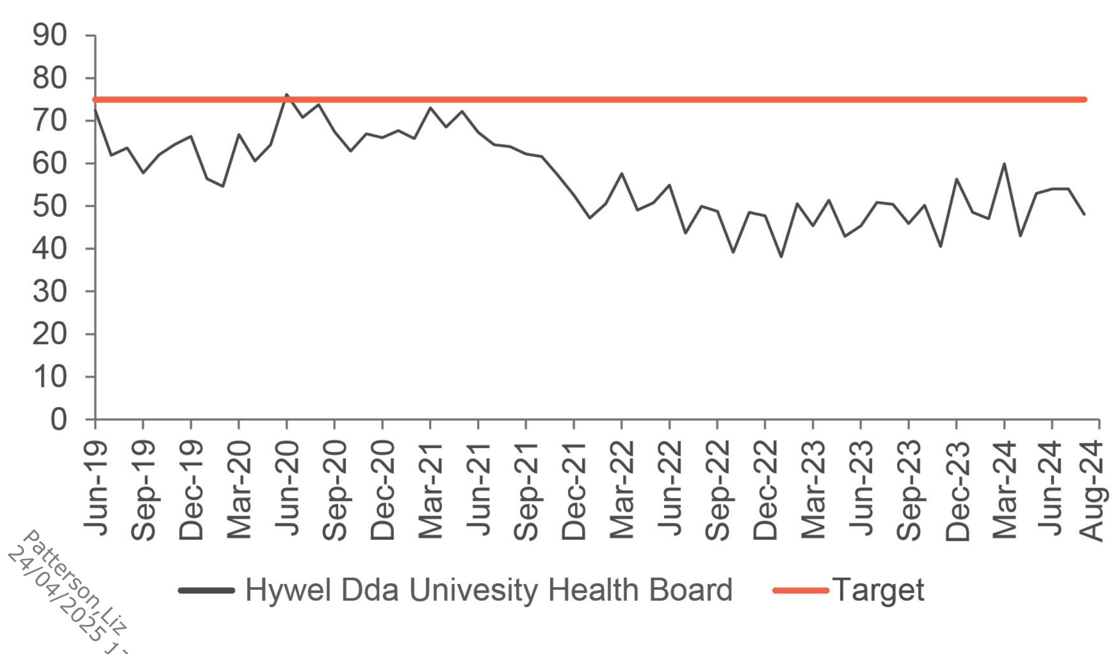
Source: DHCW, Suspected Cancer Pathway – Closed Pathways dataset, On StatsWales.

Exhibit 27d: performance against the 62-day target by Cwm Taf Bro Morgannwg University Health Board, June 2019 to August 2024



Source: DHCW, Suspected Cancer Pathway – Closed Pathways dataset, on StatsWales.

Exhibit 27e: performance against the 62-day target by Hywel Dda University Health Board, June 2019 to August 2024



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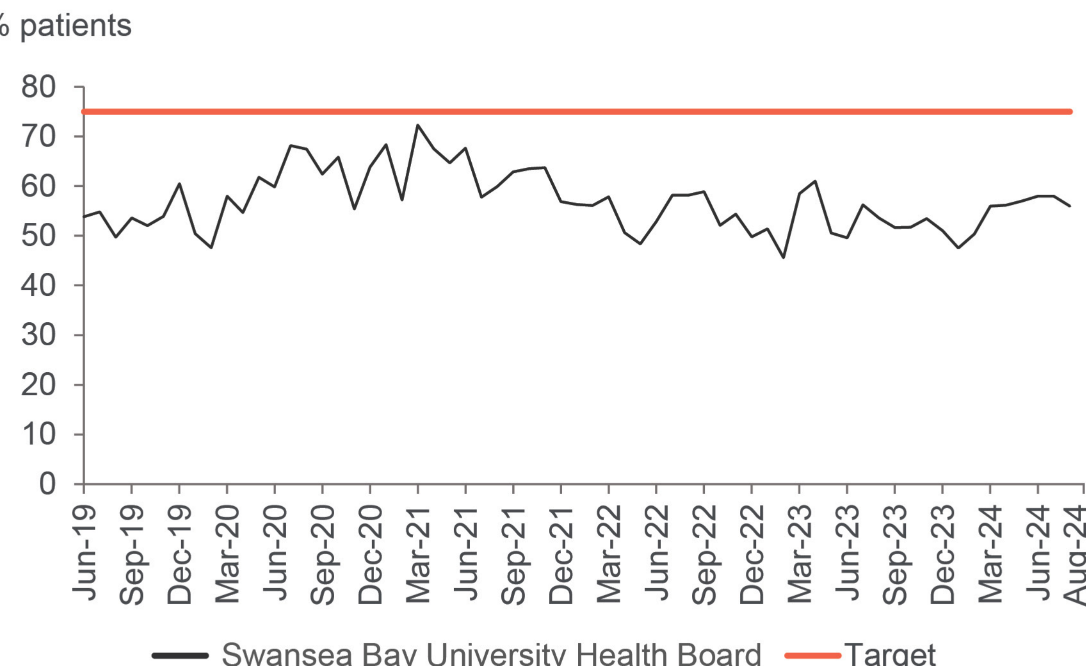
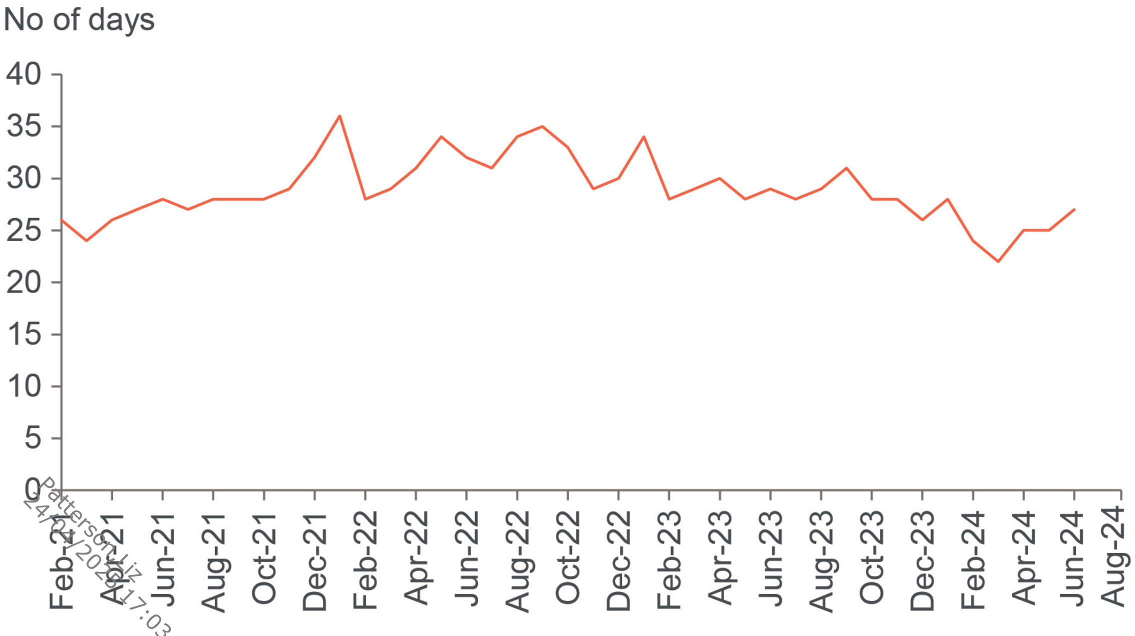
Source: DHCW, Suspected Cancer Pathway – Closed Pathways dataset, on StatsWales.

Exhibit 27f: performance against the 62-day target by Swansea Bay University Health Board, June 2019 to August 2024



Source: DHCW, Suspected Cancer Pathway – Closed Pathways dataset, on StatsWales.

Exhibit 28: median waits from first suspicion to diagnosis, February 2021 to August 2024



Source: DHCW data from the Suspected Cancer Pathway Dashboard

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3 About our work

Audit question, scope and criteria

We chose to focus on the national strategic approach to improving the timeliness of cancer diagnosis and treatment because we identified significant systemic challenges facing cancer services during our scoping. This review focuses on the Welsh Government and NHS Executive (and its National Strategic Clinical Network for Cancer) as system leaders, recognising that health boards and trusts have responsibility for the operational delivery of different aspects of cancer services. We will consider the merits of further work focusing on NHS bodies' approach to delivering cancer services in our 2025-26 work programme.

We developed our audit criteria based on learning from our previous audits of planned care[66] and local health audit work, analysis of key strategic documents[67], and research from relevant organisations on the challenges associated with cancer services in Wales.

66 Audit Wales, NHS Wales Waiting Times for Elective Care in Wales, 2015; Audit Wales, 10 Opportunities for Resetting and Restarting the NHS Planned Care System, 2020; and Audit Wales, Tackling the Planned Care Backlog in Wales, 2022.

67 Including Welsh Government, A Healthier Wales – a Long Term Plan for Health and Social Care, 2021; Welsh Government, Our Programme for Transforming and Modernising Planned Care and Reducing Waiting Lists in Wales, 2022, Welsh Government, The Quality Statement for Cancer, 2022, Welsh Government, Diagnostics Recovery and Transformation Strategy for Wales 2023 to 2025; and the National Strategic Clinical Network for Cancer, A Cancer Improvement Plan for NHS Wales 2023-26, 2023.

Audit methods

Document review

We reviewed relevant documentation including:

- documents setting out the national strategic approach. Key documents include the Quality Statement for Cancer, Cancer Improvement Plan, the Diagnostic Recovery and Transformation Strategy, National Clinical Framework, National Optimal Pathways and NHS planning and performance frameworks
- documents relating to the NHS Executive's national cancer recovery programme
- individual NHS body plans setting out their approach to delivering cancer services, and relevant board and committee papers on cancer performance
- papers from the Welsh Government's performance management meetings
- Public Health Wales NHS Trust information on the delivery of population screening servicesinformation on cancer data and population health including reports from the Welsh Cancer Surveillance and Intelligence Unit and the Welsh Government's Science Evidence Advice[68]
- the Senedd Health and Social Care Committee's report on its inquiry on gynaecological cancers[69] and supporting evidence

Semi-structured interviews

We interviewed officials from the following organisations:

- the Welsh Government;
- the NHS Executive including its National Strategic Clinical Network for Cancer;
- a sample of health boards including officials from Betsi Cadwaladr, Hywel Dda and Swansea Bay University Health Boards, and Powys Teach Health Board;
- officials from other NHS bodies including Digital Health and Care Wales, Health Education and Improvement Wales, Public Health Wales and Velindre NHS Trusts; and
- we also met with officials from the NHS Executive, Cardiff and Vale, Hywel Dda and Swansea Bay University Health Boards to inform our scoping.

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68 Welsh Government, Science Evidence Advice – NHS in 10+ Years – An Examination of the Projected Impact of Long-Term Conditions and Risk Factors in Wales', September 2023.

69 Welsh Parliament Health and Social Care Committee, Unheard: Women's Journey Through Gynaecological Cancer, December 2023.

Workshop with third sector representatives

We held a workshop with representatives from the third sector on 1st May 2024 organised by the Wales Cancer Alliance[70]. We asked participants for their views of the strengths and weaknesses of the national strategic approach and invited further written responses with more detail on the same topic. We conducted follow-up interviews with some organisations for clarification where necessary. Representatives from the organisations below took part in the workshop:

- ALK Positive UK
- Association of the British Pharmaceutical Industry
- Blood Cancer UK
- Bowel Cancer UK
- Breast Cancer Now
- Cancer Research UK
- Fair Treatment for the Women of Wales
- Leukaemia Care
- MacMillan Cancer Support
- Marie Curie
- Prostate Cancer UK
- Royal College of Pathologists
- Royal College of Paediatrics and Child Health
- Royal College of Physicians
- Tenovus Cancer Care
- Young Lives vs Cancer
- We established an expert panel to inform our understanding of the systemic barriers to the timeliness of cancer diagnosis and treatment and provide critical challenge on our findings. The panel included representatives from Marie Curie, the Association of the British Pharmaceutical Industry, the Royal College of Physicians, and the Wales Cancer Alliance.

70 A coalition of charities working to prevent cancer, improve care, fund research and influence policy in Wales.

Data analysis

We reviewed data from different sources including:

- DHCW published data on open and closed cancer pathways, on StatsWales;
- DHCW published data on hospital admissions. We also requested data on discharge destinations of cancer patients admitted to hospital;
- we requested data from the Suspected Cancer Pathway dataset managed by DHCW that is not published elsewhere. We analysed data on performance against the Suspected Cancer Pathway target by ethnicity; source of suspicion ; and closed pathways by whether patients started treatment for cancer, were downgraded for not having cancer, or died before being downgraded or starting treatment; and
- Welsh Cancer Surveillance and Intelligence Unit data on cancer incidence, mortality and survival.

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Audit Wales
1 Capital Quarter (ground & first)
Tyndall Street
Cardiff CF10 4BZ

Tel: 029 2032 0500

Textphone: 029 2032 0660

E-mail: info@audit.wales

Website: www.audit.wales

We welcome correspondence and telephone calls in Welsh and English.

Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

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Management response form

Report title: Cancer Services in Wales: A review of the strategic approach to improving the timeliness of diagnosis and treatment

Completion date: 14/01/25

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
R1	The Welsh Government should publicly clarify the status of the Cancer Improvement Plan and its links to the National Cancer Recovery Programme and the Cancer: Improving Outcomes initiative. As part of this the Welsh Government should clarify how it intends to hold NHS bodies to account for delivery of the Cancer Improvement Plan.	Accept. The Welsh Government will update the Quality Statement for Cancer to clarify the respective roles of the Cancer Recovery Programme, Cancer improvement Plan, and other important national work streams such as the Making it Happen initiative. This will include a description of accountability arrangements.	End quarter 1 2025-26	Sue Tranka Chief Nursing Officer
R2	The Welsh Government should set out a coherent model for system leadership in respect of cancer services that clarifies its own role and that of the NHS Executive and sets out how it will bring on board clinicians and other key stakeholders to build a common view of	Accept. The Welsh Government is in the process of finalising a revised governance and leadership model for cancer service development. This will include the introduction of a National Cancer Leadership Board	End quarter 4 2024-25	Nick Wood Deputy Chief Executive, NHS Wales

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Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
	cancer service performance, quality and opportunities for improvement.	that will coordinate or lead on national actions. The NHS Executive will provide the clinical, third sector, and private sector input to its work. This model will continue to develop in response to the feedback of those directly involved and those involved through related leadership groups. These arrangements will be described in the updated Quality Statement for Cancer.		
R3	The Welsh Government should review its oversight and performance framework in respect of cancer services to focus on a broader range of issues, including a more explicit alignment to the ambitions and quality attributes set out in the Quality Statement for Cancer.	Accept. The NHS Performance Framework only includes the top-level strategic metrics for the NHS; it does not include all the metrics that are routinely applied in accountability processes. There are a broader set of metrics which sit outside the Framework. This includes component waits in the cancer pathway, access to treatment measures, data on care quality and outcome, screening and immunisation uptake, and patient outcomes. The broader set of metrics	End quarter 1 2025-26	Jeremy Griffith Director of Operations

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Ref	Recommendation	**Management response** Please set out here relevant commentary on the planned actions in response to the recommendations	**Completion date** Please set out by when the planned actions will be complete	**Responsible officer (title)**
		are used as part of routine accountability process as required. The updated Quality Statement for Cancer will include additional detail to explain how cancer service delivery will be measured.		
R4	The Welsh Government should develop a more coherent approach to population health improvement by setting out how it intends to use its Science Evidence Advice: NHS in 10+ Years to harness the opportunities associated with prevention to reduce the incidence of cancer and other major conditions.	The Welsh Government pursues an evidence-led approach to prevention and to reducing population-level risk for cancer and major conditions. There are established programmes for smoking prevention through the Smoke Free Wales Strategy and Tobacco Control Delivery Plan (with additional supportive legislation imminent) and on tackling overweight and obesity, through the Healthy Weight Healthy Wales strategy and delivery plan, including through the facilitation of physical activity. These programmes are under constant review and development as new evidence and technologies emerge. The NHS Planning Framework for 2025-28 has population health and prevention as one of the five	Establishment of preventing ill-health advisory group by end quarter 1 2025-26	Sioned Rees Director for Public Health Protection

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Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
		priority areas and this will support a further drive and focus on primary, secondary and tertiary prevention interventions in the plans of NHS organisations. We are also in the process of establishing a preventing ill-health advisory group under the Chief Medical Officer to support and harness opportunities to implement sustainable, evidence informed policies that focus on preventing ill-health and related inequalities. The initial focus will be on securing and measuring funding of ill-health prevention, strengthening the current architecture, progressing work on data, and supporting the cross-government role in prevention of ill-health. The establishment of this group will assist in providing sustained engagement and a coherent, coordinated approach to the development of appropriate policy and system responses.		

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Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
R5	The Welsh Government should work with Public Health Wales to accelerate decision making for a national lung screening programme. It should clarify as soon as possible whether it will fund national lung screening for Wales and the timescale for implementing such a programme.	Accept. The Welsh Government has asked Public Health Wales to accelerate its work on scoping lung screening to permit a decision by Welsh Ministers on its introduction and funding. Public Health Wales is due to provide an interim report by end of March and a final report by end of September to permit Welsh Ministers to make a decision on introducing a national lung screening programme.	End quarter 2 2025-26	Sioned Rees Director for Public Health Protection
R6	As part of a wider approach to encourage greater regional working between health boards, the Welsh Government and the NHS Executive should work with the service to understand and help address any key barriers to delivering regional services. This should include working with DHCW to identify digital solutions to support shared waiting lists for	Accept. The Welsh Government will work with NHS organisations to support regional working for services, where appropriate, to address service fragility. This will include working with Digital Health and Care Wales on the development of digital solutions to permit shared waiting lists.	Ongoing	Mike Emery Chief Digital Officer

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Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
	cancer diagnosis and treatment, where it is appropriate to do so.			
R7	The Welsh Government should work with the NHS Executive, HEIW and other NHS bodies to ensure there are employment opportunities for radiologists who have been trained in the National Imaging Academy.	Accept. The Welsh Government will work with health boards in Wales, which are responsible for planning their workforce, to enable employment of Imaging Academy graduates in line with local or regional workforce needs.	Quarter 2 2025-26	Helen Arthur Director of Workforce and Government Business
R8	The Welsh Government should clarify national roles and responsibilities for monitoring and ensuring compliance with its data standards including how it will hold NHS bodies to account for poor compliance.	Accept. Digital Health and Care Wales develop and design data standards, including minimum data sets for NHS Wales. DHCW advises the Welsh Government on what should be included and how they should be collected. Only the Welsh Government can mandate	Quarter 3 2025-26	Mike Emery Chief Digital Officer

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Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
		requirements through national policy, planning guidance or Welsh Health Circulars. To ensure compliance, the Welsh Government expects organisations to audit themselves against the standards and DHCW to deliver a quality assurance and review process. Regulatory bodies such as Audit Wales and Healthcare Inspectorate Wales also have a role in auditing organisations against national standards. DHCW and regulatory bodies should report to the Welsh Government any significant failure to comply with national data requirements, so that these can be addressed with NHS organisations through accountability processes and meetings.		
R9	The Welsh Government should work with the NHS Executive (particularly the Cancer Network), DHCW and Public Health Wales NHS Trust to develop a more comprehensive set of publicly available data on cancer services, which as a minimum should include:	Accept in principle. The Welsh Government will develop a cancer data road map to improve the available data on cancer service delivery for use by the NHS, the Welsh Government, and the public. However, it may not be	Quarter 3 2025-26	Mike Emery Chief Digital Officer

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Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
	• the number of people currently waiting for cancer diagnosis or treatment (open pathway data); • Performance against the 62-day target for the health board providing diagnosis and treatment and health board of residence, including people living Powys Teaching Health Board area; • Performance across the patient pathways including timeliness of diagnostic reporting across different tumour sites; timeliness from the decision to treat a patient to the start of that treatment (including surgery, radiotherapy and Systemic Anti-Cancer Therapy); and diagnosis and treatment of recurrent disease. Performance information should be provided at cancer sub-tumour level where possible; • Timeliness of diagnosis and treatment for patients referred from the breast and cervical screening programmes; and	possible to provide all of this data to the public for reasons of data accuracy, reporting burden on NHS services, and patient confidentiality. In addition, the barriers to providing data on treatment in England must first be understood before commitments can be made to publishing this data, but we support the principle of doing so, subject to their further analysis.		

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Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
	• accurate information on equity of access, including ethnicity of cancer patients as well as the experiences of different patient groups (this should include children and young people).			
R10	The Welsh Government should work with DHCW and NHS England to share regular and consistent data on the timeliness of diagnosis and treatment for Welsh cancer patients treated by NHS England.	Accept. The Welsh Government will work with health boards, NHS England, and Digital Health and Care Wales to ensure relevant data on the diagnosis and treatment of Welsh residents seen in England is appropriately shared.	Quarter 4 2025-26	Mike Emery Chief Digital Officer

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Agenda Item
5.2.2

Joint Commissioning Committee

Quality Safety and Outcomes Sub-Committee Highlight Report

Dyddiad y Cyfarfod / Date of Meeting	18/03/2025
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Helen Tyler, Head of Corporate Governance
Cyflwynydd yr Adroddiad / Report Presenter	Susan Elsmore, Lay Member
Noddwr yr Adroddiad / Report Sponsor	Carole Bell, Director of Nursing and Quality

Pwrpas yr Adroddiad / Report Purpose	For Noting Choose an item.

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
N/A		Choose an item.

1. SITUATION/BACKGROUND

This report had been prepared to provide a summary of the key issues considered by the Joint Commissioning Committee Quality, Safety and Outcomes sub-committee at its meeting on 3 February 2025.

Key highlights from the meeting are reported in Section 3.

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2. PURPOSE

The Purpose and Role of the Joint Committee and the sub-committees are set out in Paragraphs 2.18 and 2.20 of the JCC Standing Orders.

The Quality and Safety Outcomes Committee Terms of Reference can be found here.

3. HIGHLIGHT REPORT

(Links to reports highlighted February 2025 – NHS Wales JCC QSO)

RAG Rating	Highlight
Alert / Escalate	• The Chair and Members expressed concern in relation to the risks and pace of resolution for Neonatal and Paediatric Services. Before escalating this formally to the JCC a specific update on the strategic approach and progress from the escalation process will be brought to the March 2025 QSO meeting for further discussion. Members discussed potential inequity of access and how this would be reported. It was agreed that where such inequities were identified these could be highlighted and addressed within the Director reports. This will form part of the Commissioning Approach for the JCC which will be developed over the coming months as part of the next phase of the formation work and organisational development.
Advise	• The Chair welcomed members and attendees to the first JCC QSO meeting. The Terms of Reference and Forward Work Plan were presented. Members noted the inclusion of a HB CEO as a member rather than an attendee. Further work on the forward work plan will be undertaken to ensure a comprehensive approach to reporting. The reporting of patient experience was queried and members were assured that outcomes reporting would be included within the directors' commissioning reports and the overarching incident and concerns reports. A suggestion was made to broaden the scope of the concerns report to include patient experience to meet the reporting requirements for the duty of Candor and duty of Quality. • Members discussed the reporting mechanisms into Health Boards (HBs), with the Director of Nursing suggesting the reinstatement of the Quality Newsletter to share information with HBs, as this highlighted good practice and service improvements. This would be in addition to a highlight report for inclusion on HBs' Quality and Safety Agendas and the Joint Commissioning Committee (JCC) public meeting Agenda.

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RAG Rating	Highlight
	• The Director of Commissioning for Specialised Services provided updates on various specialist services, including improvements in workforce for paediatric and neonatal services, progress in plastic surgery wait times, and the status of the major trauma network data system. Members raised concerns in relation to neonatal and paediatric services as highlighted above. • The Director of Nursing presented the Director of Commissioning for Ambulance Services and 111 report and provided updates in relation to ongoing emergency ambulance pressures, including a critical incident declared by the Welsh Ambulance Service. The commissioning team has been working closely with health board colleagues to address these pressures and develop improvement plans. The quality and safety dashboard, which includes high-level reports on quality domains was highlighted. An update on ambulance measures review was provided which aims to align quality patient outcomes with ambulance performance targets. Members raised concerns over bundle compliance and it was noted that compliance for ST-elevation myocardial infarction (STEMI) was under 70%. A request was made for adding immediate release red and amber data to this report for future meetings. • The Director for Mental Health and Vulnerable Groups report was presented and members noted in relation to framework services quality ratings, that some units, including St. Andrews in Northampton, faced staffing and medication challenges, which may lead to safety concerns. Action plans have been implemented to address these issues. Staffing issues at Rampton High Secure Hospital and one patient waiting for many months for admission was highlighted as an issue within High Secure Services. The JCC Director for Mental Health will write to the Director of Specialised Commissioning in England highlighting concerns with Broadmoor Hospital not being accessible to Welsh patients. Capacity issues at Caswell were also noted. Members received an update on the review of gender assessment clinics in England and plans to open satellite clinics in Wales. An update on children and young people's gender services and the commissioning of beds in a new perinatal unit in North Wales was also provided.

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RAG Rating	Highlight
Assure	• Members were informed about the Risk approach and noted that by March 2025, risks related to quality and safety will be reported to this sub-committee for review and assurance. Members requested additional information for the March 2025 meeting on the following items: • Specific update on the qualitative information regarding the review of long waiters for plastic surgery (south Wales). • An update on the resolution of the radioactive isotope production issue at Cardiff University and its impact on South Wales patients. • There were gaps in the Ambulance and 111 reporting data around percentages of patients kept at home rather than transferred to hospitals and further information was requested; and • Mental Health –a detailed update on the commissioning framework for secure services including staff training and experience to be provided. A discussion around concerns and incident reporting led to the Director of Nursing and Lay Member agreeing to meet and progress some work on this outside of the meeting.
Inform	• A presentation was shared which focused on the Microprocessor Knee (MPK) Service at Cardiff Artificial Limb and Appliance Service (ALAS). The presentation highlighted the benefits of MPKs, such as improved mobility, less pain, and increased confidence among users. The presentation included quotes from patient impact statements, emphasising the positive changes in their lives due to the MPK. • A patient story was also received, and the patient highlighted the benefits in improved mobility, reduced falls and overall quality of life along with the improved emotional and mental wellbeing. • Members received an update on incidents and concerns across the range of JCC commissioned services. A summary of the open incidents and complaints was provided and members noted that work was underway to improve reporting on complaints and concerns. • Members received an update on regulatory activity, including recent changes in representation and ongoing work with the NHS executive and Welsh Government.
Appendices	None

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4. ASSESSMENT

Objectives / Strategy	
Dolen i Amcan (au) Strategol CBC **Link to JCC Strategic Objectives(s)**	Improve Equity and Population Health
	Ensure Quality
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / **Link to Wellbeing of Future Generations Act – Wellbeing Goals** *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A More Equal Wales
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Whole-systems Perspective
	If more than one applies please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Person Centred
	If more than one applies please list below: Equitable
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

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Impact Assessment

<table>
<tr><td rowspan="2">Ansawdd
Ydych chi wedi ymgymryd â Sgrinio Asesiad o’r Effaith ar Ansawdd? /
Quality
Have you undertaken a Quality Impact Assessment Screening?</td><td>Yes: ☐</td><td>No: ☒</td></tr>
<tr><td>Outcome:</td><td>If no, please include rationale below:
N/A</td></tr>
<tr><td rowspan="2">Cydraddoldeb
Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /
Equality
Have you undertaken an Equality Impact Assessment Screening?</td><td>Yes: ☒</td><td>No: ☒</td></tr>
<tr><td>Outcome for Equality (delete as appropriate):
POSITIVE/NEUTRAL/NEGATIVE

Outcome for Welsh Language (delete as appropriate):
POSITIVE/NEUTRAL/NEGATIVE</td><td>If no, please include rationale below:
N/A</td></tr>
<tr><td>Cyfreithiol / Legal</td><td colspan="2">There are no specific legal implications related to the activity outlined in this report.</td></tr>
<tr><td>Enw da / Reputational</td><td colspan="2">There is no direct impact on the reputation of the Joint Committee as a result of the activity outlined in this report.</td></tr>
<tr><td>Effaith Adnoddau
(Pobl /Ariannol) /
Resource Impact
(People / Financial)</td><td colspan="2">There is no direct impact on resources as a result of the activity outlined in this report.</td></tr>
</table>

5. RECOMMENDATIONS

The Joint Committee is asked to:

- **Note** the highlights outlined in Section 3 of this report.

Powys Teaching Health Board Glossary (april 25)

Acronym	
ADoECP	Associate Director of Estates, Capital & Property
CEO	Chief Executive Officer
DCG	Director of Corporate Governance
DIT	Director of Improvement & Transformation
EMD	Executive Medical Director
ED PH	Executive Director of Public Health
ED P&C	Executive Director of People and Culture
ED PP&C	Executive Director of Planning, Performance and Commissioning
ED FCSS	Executive Director of Finance, Capital & Support Services
ED AHPHSD	Executive Director of Allied Health Professions, Health Sciences and Digital
ED NQW&FH	Executive Director of Nursing, Quality, Women and Family Health
EDPCCMH	Executive Director of Primary Care, Community & Mental Health
ABUHB	Aneurin Bevan University Health Board
AFC	Agenda for Change
AGW	The Auditor General for Wales
AHPs	Allied Health Professionals
ALN	Additional Learning Needs
AO	Accountable Officer
ARAC	Audit, Risk and Assurance Committee
ASM	Accelerated Sustainable Model
AR	Audit Recommendations
BAF	Board Assurance Framework
BCUHB	Betsi Cadwaladr University Health Board
BMA	British Medical Association
CAAP	Clinical Associate in Applied Psychology
CAMHS	Child and Adolescent Mental Health Services
CCN	Childrens Community Nursing
CEMT	Chief Executive Management Team
CHC	Continuing Health Care
CIW	Care Inspectorate for Wales
CLIP	Collaborative Learning in Practice
CNO	Chief Nursing Officer
CPD	Continued Professional Development

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CPR	Child Practice Review
CRR	Corporate Risk Register
CSP	Clinical Service Plan
CTMUHB	Cwm Taff Morgannwg University Health Board
CV	Curriculum Vitae
CVUHB	Cardiff and Vale University Health Board
CWMPAS	Mid and West Wales Regional Safeguarding Adults Board
CYSUR	Mid and West Wales Regional Safeguarding Children Board
CTC	Care Transfer Co-ordinator
CCOMG	Complex Care Operational Management Group
DATIX	Incident Management System
D&P	Delivery and Performance Committee
DCG	Delivery Co-ordination Group
DGH	District General Hospital
DHCW	Digital Health and Care Wales
DNA	Did not Attend
DNACPR	Do Not Attempt Cardio-Pulmonary Resuscitation
DPA	Data Protection Act
DToC	Delayed Transfer of Care
D2RA	Discharge to Recover and Assess
DST	Decision Support Tool
EASC	Emergency Ambulance Services Committee
EOG	Executive Oversight Group
EOY	End of Year
EMRTS	Emergency Medical Retrieval & Transfer Service
EPMA	Electronic Prescribing and Medicines Administration
ESR	Electronic Staff Record
EMI	Elderly Mentally Infirm
FBC	Full Business Case
FOI	Freedom of Information
FFT	Friends and Family Test
FTE	Full Time Equivalent
GDS	General Dental Services
GIRFT	Getting It Right First Time
GMC	General Medical Council
GMS	General Medical Services
GP	General Practitioner
GNCC	General Nursing Complex Care Team
H&S	Health and Safety

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HCA	Health Care Assistant
HCS	Health and Care Standards
HCSW	Health Care Support Worker
HDUHB	Hywel Dda University Health Board
HEIW	Health Education and Improvement Wales
HIW	Healthcare Inspectorate Wales
HP	Health Protection
HPF	Healthcare Professionals Forum
ICF	Integrated Care Funding
IEN	Internationally Educated Nurse
IG	Information Governance
IM	Independent Members
IMTP	Integrated Medium Term Plan
IP&C	Infection Prevention and Control
IQPF	Integrated Quality Performance Framework
IQPG	Integrated Quality & Performance Group
IQPR	Integrated Quality Performance Report
IT	Information Technology
JAG	Joint Advisory Group (on Gastrointestinal Endoscopy)
JCC	Joint Commissioning Committee
JD	Job Description
JET	Joint Executive Team
JIPCA	Joint Inspection of Child Protection Arrangements
JLT	Joint Leadership Team (PTHB and PCC)
JR	Judicial Review
KPI	Key Performance Indicator
LoF	League of Friends
LA	Local Authority
LHB	Learning Health Board
LMC	Local Medical Committee
LPF	Local Partnership Forum
LRF	Local Resilience Forum
LTA	Long Term Agreement
MD	Ministerial Direction
MDTs	Multi-Disciplinary Teams
MEG	Medical E-Governance System
MEG	Main Expenditure Group
MH	Mental Health
MHD	Mental Health & Learning Disability
MIU	Minor Injury Unit

MOU	Memorandum of Understanding
MOA	Memorandum of Agreement
MSK	Musculoskeletal
MV	Mass Vaccination
NHSE	National Health Service England
NHS	National Health Service
NHSWE	NHS Wales Executive
NICE	National Institute of Health and Clinical Excellence
NRI	Nationally Reportable Incidents
NWSSP	NHS Wales Shared Services Partnership
NNA	Nursing Needs Assessment
OBC	Outline Business Case
OCP	Organisational Change Process
OOC	Out of County
OOH	Out of Hours
OSCE	Objective Structured Clinical Examination
OT	Occupational Therapy
PA	Physician Associate
PADR	Personal Appraisal Development Review
PAVO	Powys Association of Voluntary Organisations
PCC	Powys County Council
PEQS	Patient Experience, Quality and Safety Committee
PHE	Public Health England
PHW	Public Health Wales
PPPH	Planning, Partnerships and Population Health Committee
PSB	Public Service Board
PSOW	Public Services Ombudsman for Wales
PTHB	Powys Teaching Health Board
PTR	Putting Things Right
QA	Quality Assurance
RaTS	Remuneration and Terms of Service Committee
RCN	Royal College of Nursing
RIIC	Research, Innovation & Improvement Coordination
RIF	Regional Investment Fund
RISP	Radiology Information System Procurement
RJAH	Robert Jones and Agnes Hunt
RN	Registered Nurse
RPB	Regional Partnership Board
RTT	Referral to Treatment
RTS	Routemap To Sustainability

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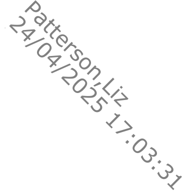
Q1 Q2 Q3 Q4	Quarter 1 (April, May, June), Quarter 2 (July, August, September), Quarter 3 (October, November, December), Quarter 4 (January, February, March)
QSEG	Quality, Safety and Experience Group
SAR	Subject Access Request
SAS	Specialty and Specialist
SBAR	Situation, Background, Assessment, Recommendation
SBUHB	Swansea Bay University Health Board
SDEC	Same Day Emergency Care
SLA	Service Level Agreement
SOC	Strategy Outline Case
SOP	Standard Operating Procedure
SaTH	Shrewsbury and Telford Hospital NHS Trust
SPB	Strategic Programme Board
SRO	Senior Responsible Owner
TI	Targeted Intervention
ToR	Terms of Reference
TRAC	Online Recruitment Management System
T&V	Transformation & Value
VERS	Voluntary Early Release Scheme
WAST	Welsh Ambulance Services NHS Trust
W&C	Workforce and Culture Committee
WCCIS	Welsh Community Care Information System
WG	Welsh Government
WHC	Welsh Health Circular
WHSSC	Welsh Health Specialised Service Committee
WNB	Was Not Brought
WOD	Workforce and Organisational Development
WPAS	Welsh Patient Administration System
WPOCT	Welsh Point of Care Test System
WTE	Whole Time Equivalent
WVT	Wye Valley Trust
YTD	Year to Date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