

PTHB Board

Wed 21 May 2025, 09:30 - 15:00

Agenda

09:30 - 09:30

0 min

1. PRELIMINARY MATTERS

 Board_Agenda_21May25 FINAL.pdf (4 pages)

1.1. Welcome and apologies for absence

Chair

1.2. Declarations of interest

All

 Board_1.2_Register of Interests Board Members 2024-25Feb.pdf (4 pages)

1.3. Board Action Log

Chair

 Board_1.3_Action Log May25.pdf (1 pages)

1.4. Experience Stories

1.4.1. Radiography

1.5. Questions to Board from the public

Director of Corporate Governance

1.6. Update from the:

1.6.1. Chair

Chair

 Board_1.6a_Chair's Report to Board May 2025.pdf (6 pages)

1.6.2. Vice-Chair

Vice-Chair

 Board_1.6b_VC Report May25.pdf (3 pages)

1.6.3. Chief Executive

Chief Executive

 Board_1.6c_CEO Board Report.pdf (5 pages)

1.7. Assurance Reports of the Board's Committees

Committee Chairs / Chief Executive

 Board_1.7_Committee Chair Reports_May2025.pdf (7 pages)

 Board_1.7a_AppA_AAAI for ARAC 13May2025.pdf (1 pages)

 Board_1.7b_AppB_Charitable Funds Chairs Report May25.pdf (3 pages)

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- Board_1.7c_AppC_AAAI_D&P_Chairs Report_01May2025.pdf (5 pages)
- Board_1.7d_AppD_Chairs AAAI for PEQS April 25.pdf (3 pages)
- Board_1.7e_App_E_PPPH_AAAI Report_19May2025_verbal.pdf (1 pages)
- Board_1.7f_AppF_AAAI_W&C_Chairs Report13 March 2025.pdf (3 pages)
- Board_1.7g_AppG_EC Chair's Assurance Report MAY25.pdf (9 pages)

1.7.1.

09:30 - 09:30 **2. CONSENT AGENDA BUSINESS**
0 min

09:30 - 09:30 **3. ITEMS FOR APPROVAL/RATIFICATION/DECISION**
0 min

3.1. Annual Delivery Plan 2025/26

Executive Director of Planning, Performance and Commissioning

- Board_3.1_Annual Delivery Plan Cover Paper.pdf (5 pages)
- Board_3.1a_Delivery Plan 2025-2026 master version.pdf (63 pages)

3.2. Integrated Quality and Performance Framework

Executive Director of Planning, Performance and Commissioning

- Board_3.2_IQPF Cover Paper.pdf (6 pages)
- Board_3.2a_AppA_IQPF 2526 Board May 2025.pdf (39 pages)

3.3. Director of Corporate Governance Report

Director of Corporate Governance

- Board_3.3_DCG report.pdf (4 pages)
- Board_3.3a_Consent agenda protocol_May 2025.pdf (4 pages)
- Board_3.3b_PTHB Protocol for In-Committee meetings - V1 April 2025.pdf (5 pages)
- Board_3.3c_Work Programme 2025-26.pdf (3 pages)

3.3.1. Committee Terms of Reference

Director of Corporate Governance

- Board_3.3.1_Committee Terms of Reference Review.pdf (7 pages)
- Board_3.3.1a_AppA_Audit Risk and Assurance Committee Terms of Reference May 2025.pdf (13 pages)
- Board_3.3.1b_AppB - Delivery and Performance Committee Terms of Reference May 2025.pdf (12 pages)
- Board_3.3.1c_AppC - Patient Experience Quality and Safety Committee Terms of Reference May 2025.pdf (12 pages)
- Board_3.3.1d_AppD - Planning, Partnerships and Population Health Committee Terms of Reference May 2025.pdf (11 pages)
- Board_3.3.1e_AppE - Remuneration and Terms of Service Committee Terms of Reference May 2025.pdf (8 pages)
- Board_3.3.1f_AppF- People and Culture Committee Terms of Reference May 2025.pdf (12 pages)
- Board_3.3.1g_App G_Charitable Funds Committee ToR May 2025.pdf (12 pages)
- Board_3.3.1h_App H_Executive Committee ToR.pdf (11 pages)

3.3.2. Policies and Written Control Documents

Director of Corporate Governance

- Board_3.3.2_Policies and Written Control Document cover paper.pdf (6 pages)
- Board_3.3.2a_Appendix 1 - Management of Policies and Other Written Control Document (1).pdf (23 pages)
- Board_3.3.2b_Appendix 2 - Approval Routes and Authority Levels Procedures.pdf (1 pages)

3.4. Strategic Risk and Risk Appetite Register

Director of Corporate Governance

Patterson, Liz
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 Board_3.4_Strategic Risk Register and Risk Appetite Statement.pdf (14 pages)

3.5. Health and Safety Annual Report

Executive Director of People and Culture

 Board_3.5_Health and Safety Annual Report (Q4 - 2024-25).pdf (30 pages)

3.6. Welsh Language Annual Report

Executive Director of People and Culture

 Board_3.6_Cover Paper- WL Annual Report 2024.pdf (3 pages)

 Board_3.6a_Welsh Language Annual Report 2024.pdf (32 pages)

3.7. Minutes of the Previous Meeting held on 26 March 2025

Chair

 Board_3.7_Minutes 26MAR2025_Draft.pdf (20 pages)

09:30 - 09:30 0 min

4. ITEMS FOR BOARD ASSURANCE

4.1. Escalation and Intervention Status Level 4

Chief Executive

 Board_4.1_Escalation PPT.pdf (12 pages)

 Board_4.1a_Annex 1_PTHB Level 4 escalation framework - April 2025.pdf (10 pages)

4.2. Financial Performance: 2025/26 - Month 01

Executive Director of Finance, Capital and Support Services

 Board_4.2_Financial Performance Report Mth 01 Summary.pdf (4 pages)

4.3. Integrated Quality and Performance Report: 2024/25 - Month 12

Executive Director of Planning, Performance and Commissioning / All Directors

 Board_4.3_Month12_IQPR Cover.pdf (9 pages)

 Board_4.3a_IPR_24-25_Month 12.pdf (50 pages)

4.4. Annual Delivery Plan 2024/25 - Quarter 4 Performance Report

Executive Director of Planning, Performance and Commissioning

 Board_4.4_Q4 Delivery Plan Cover Paper.pdf (9 pages)

 Board_4.4a_Annual Delivery Plan 2024-25 year end progress.pdf (62 pages)

4.5. Better Together - Transformation / Route Map to Sustainability

Executive Director of People and Culture

 Board_4.5_Better Together Update May 2025.pdf (7 pages)

4.6. Temporary Service Change (MIU and Ready to Go Home Units)

Executive Medical Director

 Board_4.6_TSC Assurance Paper April 2025.pdf (11 pages)

4.7. Speaking Up Safely and Raising Concerns Report

Executive Director of People and Culture

Patterson, Liz
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- Board_4.7_Speaking Up Safely Framework Report.pdf (9 pages)
- Board_4.7a_Appendix B PTHB Process for managing concerns raised.pdf (1 pages)
- Board_4.7b_Appendix C EIA Speaking Up Safely.pdf (10 pages)

4.8. Report of the Chief Executive of Llais

Llais Regional Director

- Board_4.8_RD Report May 2025.pdf (10 pages)

09:30 - 09:30 5. CONSENT AGENDA

0 min

5.1. Assurance Reports of the Board's Joint Committees

Chief Executive

- Board_5.1_Joint Committee Reports_May25.pdf (2 pages)
- Board_5.1a_App1_Highlight Report - JCC 18 March 2025.pdf (7 pages)
- Board_5.1b_App2_MWJC Update report April 2025.pdf (14 pages)

5.2. Assurance Report of the Board's Partnership Arrangements

Chief Executive

- Board_5.2_Summary of Partnership Board Activity May 25.pdf (3 pages)
- Board_5.2a_App1_SSPC Assurance Report 25 March 2025.pdf (6 pages)

5.3. Assurance Report of the Board's Local Partnership Forum

Executive Director of People and Culture

- Board_5.3_Assurance Report of Boards Advisory Group May 2025.pdf (2 pages)
- Board_5.3a_Chairs report_LPF_08 April 2025.pdf (4 pages)

5.4. Committee Annual Reports

Director of Corporate Governance

- Board_5.4_Committee Annual Reports.pdf (3 pages)
- Board_5.4a_ARAC Committee Annual Report_2024-25.pdf (9 pages)
- Board_5.4b_D&P Committee Annual Report_2024-25.pdf (11 pages)
- Board_5.4d_PPPH Committee Annual Report_2024-25.pdf (10 pages)
- Board_5.4c_PEQS Committee Annual Report 2024-25.pdf (13 pages)

5.5. Committee Work Programmes

Director of Corporate Governance

- Board_5.5a_ARAC Work Programme 2025-26.pdf (1 pages)
- Board_5.5b_D&P Work Programme 2025-26.pdf (1 pages)
- Board_5.5c_PEQS Work Programme 2025-26.pdf (1 pages)
- Board_5.5d_PPPH Work Programme 2025-26.pdf (1 pages)
- Board_5.5e_W&C Work Programme 2025-26.pdf (1 pages)

5.6. Partnership Governance Framework

Director of Corporate Governance

- Board_5.6_Partnership Governance and Assurance Framework.pdf (6 pages)
- Board_5.6a_PTHB Partnership Governance and Assurance Framework PPPH Committee May 2025.pdf (50 pages)

5.7. External Audit Reports

Director of Corporate Governance

Patterson, Liz
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5.8. Glossary

 Board_5.8_Glossary.pdf (5 pages)

09:30 - 09:30 **6. OTHER MATTERS**
0 min

6.1. Any Other Urgent Business

Chair

6.2. Close

6.3. Date of the Next Meeting: 26 March 2025

09:30 - 09:30 **7. CONFIDENTIAL MATTERS**
0 min

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

Chair

7.1. Welcome and apologies for absence

Chair

7.2. Declarations of interest

All

7.3. Minutes from the In-Committee meetings held on 26 March 2025 and Action Log

Chair

7.4. Chief Executive Briefing

Chief Executive

OOH Update

7.5. Covid-19 Public Inquiry preparation update

Director of Corporate Governance

7.6. Any other urgent business

7.7. Close

Patterson, Liz
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**POWYS TEACHING HEALTH BOARD
BOARD MEETING
WEDNESDAY 21 MAY 2025
09:30 – 14.35
Via Teams
CHAIR: Dr Carl Cooper**



**GIG
CYMRU
NHS
WALES**

**Bwrdd Iechyd
Addysgu Powys
Powys Teaching
Health Board**

AGENDA

1: PRELIMINARY MATTERS

09.30	1.1	Welcome and Apologies for Absence	Verbal	Chair
	1.2	Declarations of Interest	Verbal	All
	1.3	Board Action Log	Attached	Chair
09.40	1.4	Staff and Patient Experience Story: Radiography	Presentation	Executive Director of Allied Health Professions, Health Science and Digital
	1.5	Questions to Board from the public:	Verbal	Director of Corporate Governance
10.00	1.6	Update from the: a) Chair b) Vice Chair c) Chief Executive	Attached Attached Attached	Chair Vice-Chair Chief Executive
10.20	1.7	Assurance Reports of the Board's Committees	Attached	Committee Chairs Chief Executive

2: CONSENT AGENDA BUSINESS

The Chair will ask if there are any items from the Consent Agenda (Item 5) that Board Members wish to bring forward to the main agenda.

3: ITEMS FOR APPROVAL/RATIFICATION/DECISION

10.45	3.1	Annual Delivery Plan 2025/26	Attached	Executive Director of Planning, Performance and Commissioning
11.15	BREAK 15 minutes			
11.30	3.2	Integrated Quality and Performance Framework	Attached	Executive Director of Planning, Performance and Commissioning
11.45	3.3	Director of Corporate Governance Report	Attached	Director of Corporate Governance
	3.3.1	Committee Terms of Reference	Attached	Director of Corporate Governance
	3.3.2	Policies and Written Control Documents	Attached	Director of Corporate Governance
12.00	3.4	Strategic Risk and Risk Appetite Statement	Attached	Director of Corporate Governance

12.10	3.5	Health and Safety Annual Report	Attached	Executive Director of People and Culture
12.20 10 mins	3.6	Welsh Language Annual Report	Attached	Executive Director of People and Culture
12.30	3.7	Minutes of Previous Meeting held on 26 March 2025	Attached	Chair
4: ITEMS FOR BOARD ASSURANCE				
12.35	4.1	Escalation and Intervention Status: Level 4	Presentation	Chief Executive
12.50	4.2	Financial Performance: 2025-26 month 01	Attached	Executive Director of Finance, Capital and Support Services
13.05	LUNCH 30 minutes			
13.35	4.3	Integrated Quality and Performance Report 2024/25 month 12	Attached	Executive Director of Planning, Performance and Commissioning /All Directors
13.55	4.4	Annual Delivery Plan 2024/25 Quarter 4 performance	Attached	Executive Director of Planning, Performance and Commissioning
14.05	4.5	Better Together – Transformation / Route map to Sustainability	Attached	Executive Director People and Culture
14.25	4.6	Temporary Service Change (MIU and Ready to Go Home Units)	Attached	Executive Medical Director
14.35	4.7	Speaking Up Safely and Raising Concerns Report	Attached	Executive Director of People and Culture
14.45	4.8	Report of the Chief Officer of Llais	Attached	Llais Regional Director
5: CONSENT AGENDA				
Patterson, Liz 20/05/2025 15:22:19	5.1	Assurance Report of the Board's Joint Committees Purpose: Assurance	Attached	Chief Executive
	5.2	Assurance Report of the Board's Partnership Arrangements Purpose: Assurance	Attached	Chief Executive
	5.3	Assurance Report of the Board's Local Partnership Forum • LPF (08 April) Purpose: Assurance	Attached	Executive Director of People and Culture

	5.4	Committee Annual Reports Purpose: Assurance	Attached	Director of Corporate Governance
	5.5	Committee Work Programmes Purpose: Assurance	Attached	Director of Corporate Governance
	5.6	Partnership Governance Framework Purpose: Assurance	Attached	Director of Corporate Governance
	5.7	External Audit Reports: - Structured Assessment - The Annual Audit 2024 for PTHB - Audit Wales Purpose: Assurance	Attached	Director of Corporate Governance
	5.8	Glossary Purpose: Information	Attached	

6: OTHER MATTERS

14.50	6.2	Any Other Urgent Business	Verbal	Chair
	6.3	Close		
	6.4	Date of the Next Meeting: 25 June 2025 via Teams (Annual Report and Accounts)		

7. The Chair, with advice from the Director of Corporate Governance, has determined that the following items include confidential or commercially sensitive information which is not in the public interest to discuss in an open meeting at this time. The Board is asked to take this advice into account when considering the following motion to exclude the public from this part of the meeting:

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

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

Time	Item	Title	Attached / Oral	Presenter
15.00	7.1	Welcome and Apologies for Absence	Verbal	Chair
	7.2	Declarations of Interest	Verbal	All
	7.3	Minutes of Previous In-Committee Meeting held on 26 March 2025 and Action Log	Attached	Chair
15.05	7.4	Chief Executive Briefing	Verbal	Chief Executive
15.15	7.5	Covid-19 Public Inquiry update	Attached	Director of Corporate Governance
	7.6	Any other urgent business	Verbal	Chair

15.20	7.7	Close		

MESSAGE TO THE PUBLIC:
Powys Teaching Health Board is committed to openness and transparency and conducts as much of its business as possible in a session that members of the public are normally welcome to attend and observe. At present Board meetings are held virtually and livestreamed. Members of the public are able to view the livestream or view the uploaded copy of the meeting on demand.

Patterson Liz
20/05/2025 15:22:19

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 Subsidiory 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		

		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	Current	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								

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		

Board Action Log																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																						

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Agenda item: 1.6a

BOARD MEETING		DATE: 21 MAY 2025	
Subject:	CHAIR's REPORT		
Approved and presented by:	Carl Cooper, Powys Teaching Health Board (PTHB) Chair		
Prepared by:	Carl Cooper, PTHB Chair		
Other Committees and meetings considered at:	N/A		
PURPOSE:			
To bring to the Board's attention key points for awareness from the Chair of Powys Teaching Health Board, since the previous Board meeting in March 2-25.			
RECOMMENDATION(S):			
It is recommended that the Board RECEIVES this report.			
Approve/Take Assurance		Discuss	Note
N		Y	N

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:		
1. Focus on Wellbeing	Y	The Chair's report covers a broad range of activities.
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	

Patterson, Liz
20/05/2025 15:22:18
Chair's Report

CHAIR'S REPORT:

Board Membership

I am pleased to report that the Cabinet Secretary has extended Mick Giannasi's fixed-term, direct appointment until September 2025. We are working with the Public Appointments team in Welsh Government to implement arrangements for the recruitment of a substantive Independent Member. In the meantime we continue to benefit from Mick's significant knowledge, experience, skills and expertise.

Escalation, Assurance and Accountability

We have further clarified the Board's role in owning and overseeing matters relating to our level 4 escalation for finance, strategy and planning (see chart in appendix 1). Ultimately, responsibility and accountability lies with the whole board. However, distinctive scrutiny also takes place within a number of our committees. These committees will be an important source of assurance to the board as regards their particular areas of focus. Importantly, this is closely aligned with our 2025-2026 plan and our Better Together route-map to sustainability, both of which are mapped against our de-escalation criteria. These formal arrangements are also supported by informal meetings, discussions and sessions such as our Board Development Days and our frequent Quad meetings involving CEO, deputy CEO, Vice Chair and Chair supported by our Director of Corporate Governance.

It is also important to reiterate that we remain in routine monitoring (level 1) for all other domains of the NHS Wales Intervention and Escalation Framework Arrangements.

Listening and Learning

The Board continues to prioritise engaging with patients and staff members in order that we may hear directly about people's experiences. Alongside the data and information we receive in many reports, the lived experience of people helps to paint a holistic picture of reality within Powys Teach Health Board and Powys.

Each monthly board development session includes an opportunity to engage with different, operational colleagues. Since the January 2025 Board meeting, we have spent time considering the finding of the NHS Wales Staff Survey. It was encouraging to note the relatively high response rate from PTHB staff colleagues, and the many positive and affirming results and comments about working in and for Powys Teaching Health Board. Nonetheless, we are not complacent, and actions are being pursued regarding the learning from the survey about how we can further improve things. We are also aware that we still need to support and encourage a higher response rate in subsequent surveys.

The Vice Chair and my 'Out and About' programme of visits continues apace. However, due to the demands of other requirements e.g. PADR (Performance Appraisal Development Review) meetings and Welsh Government conferences, it

has not been possible for me to undertake visits since the last Board meetings. I look forward to getting out and about again over the next weeks. We are also reviewing the nature, structure and content of this programme to better align with national expectations of 'Board Walkarounds'.

Performance and Development Reviews (PADRs) – Independent Members

I have been pleased to meet with all Independent Member colleagues over recent weeks to conduct annual PADR conversations. Once again, I am struck by the impressive breadth, depth and mix of skills, knowledge and experience we have in our Board. This is brought to bear on our business in ways that continue to strengthen, develop and improve the effectiveness of the Board. We will use the information from PADR conversations to build on this over the next year. I take this opportunity to thank all Independent Member colleagues for their diligence, commitment and dedication.

Strategic Contacts and Involvement

Since the March Board meeting there have been several key strategic meetings held at the request and invitation of the Cabinet Secretary and Welsh Government. A summary is set out below:

Cabinet Secretary's Priorities

The Cabinet Secretary invited NHS senior leaders from across Wales to a gathering on 07 March to set out his priorities for 2025-2026. The Chief Executive and I along with other members of the Board attended the event. It is expected that these priorities be adopted as we deliver our plan for this year. We are giving detailed consideration to our implementation and delivery plans in the light of the Cabinet Secretary's requirements.

The priorities focus on 5 key areas:

1. Prevention
2. Primary and Community Care
3. Digital transformation
4. Regional working
5. Leadership

He also set out how he will enable greater public transparency and accountability for Health Boards.

Ministerial Advisory Group – Performance and Productivity

The previous Cabinet Secretary set up a Ministerial Advisory Group (MAG) to explore how NHS Wales could improve its performance and productivity, specifically as regards cancer care, planned care, emergency and urgent care and diagnostics. Senior NHS leaders were invited to an event on 29 April to receive the final report of the MAG and to learn about its findings, the Chief Executive and I attended the event. There are 29 recommendations to be implemented over the next year. Welsh Government has accepted all the recommendations, most

fully and a small number partially. Essentially, the MAG has identified a number of levers it states should be pulled to maximum effect:

- A focus on using evidence-based standards and taking out unwarranted variation
- A strong and empowered clinical leadership voice
- Transparency of data and a commitment to “improving in public”
- Sharper accountability and performance management
- A reduction in bureaucracy and more effective operational management
- A narrowing of targets, and
- Aligning financial flows with performance priorities

We are considering the implications of these recommendations for our activity and delivery plans.

Digital Summit

Welsh Government invited key and senior NHS Wales personnel to a Digital Summit held on 08 April. The Minister for Mental Health and Wellbeing, whose portfolio of responsibilities includes digital, gave the introductory address. She emphasised the essential importance of adopting a *digital by default* approach, and ensuring a ‘Once for Wales’ way of working. The presentations during the conference focussed on:

- NHS Wales App – launched 09 April
- Maternity App – developed in Aneurin Bevan University Health Board.
- Connecting Care – a successor to Welsh Community Care Information System (WCCIS) whereby health and social care personnel and services would populate and have access to a shared client record.
- Mental Health Electronic Patient Record – developed in Betsi Cadwaladr University Health Board.

Reference was also made to the new, national digital governance arrangements under the umbrella of the Digital, Data and Technology (DDaT) Board.

Annual Plan 2025-2026

As a Board, we have spent time in shared consideration of Welsh Government’s response to our plan for 2025-2026. This was set out in a letter to our Accountable Officer, our CEO. More information can be found in the wider Board agenda. We fully accept our responsibility to manage within the constraints our limited finances as we seek to provide the best possible, timely health services for and with the people of Powys.

Regional Working

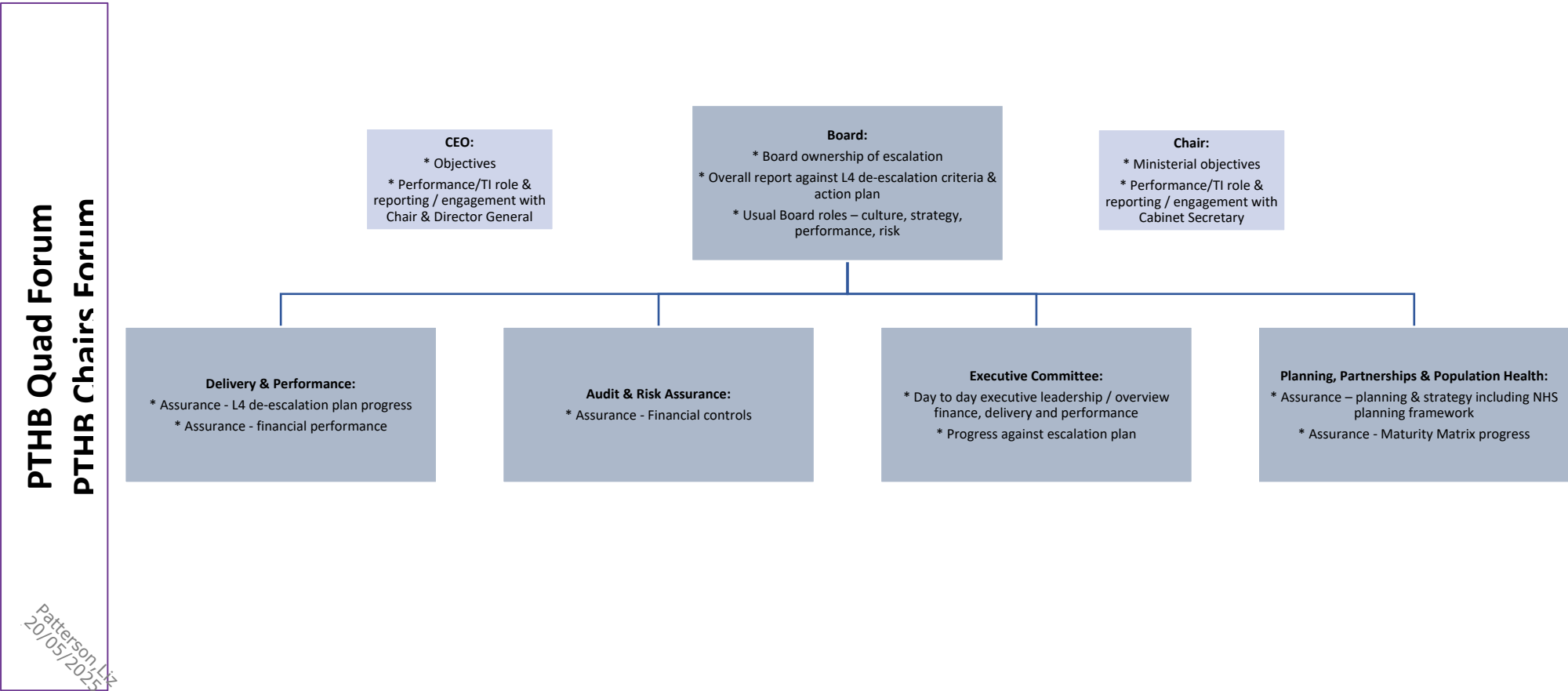
The Cabinet Secretary has written to respective Health Boards setting out his expectations for regional working. He has directed Hywel Dda and Swansea Bay to continue the South-West Regional Board, and has directed Cardiff & Vale, Aneurin Bevan and Cwm Taf Morgannwg to establish the South-East Regional Board. In both cases there is a requirement to include Powys Teaching Health

Board as an associate member. Given that Betsi Cadwaladr serves the whole of North Wales, it is considered a region on its own.

Powys County Council Leadership

It has been announced that Cllr. James Gibson-Watt, the leader of Powys County Council (PCC), intends to step down at the Council's AGM. The person to be nominated as his successor has been identified as Cllr. Jake Berriman. I take this opportunity to thank James for his contribution as leader. It has been a pleasure to work alongside him. I have particularly appreciated his unswerving commitment to partnership and collaboration in the service of our population. Our partnership with PCC is very important and I look forward to building on James' legacy with his successor whom I assure of my and our ready cooperation and support as they take up office.

Appendix One – Governance response for Level 4 Escalation Status



PTHB Quad Forum
PTHR Chairs Forum

Patterson LK
20/05/2025 15:22:19



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Agenda item: 1.6b

BOARD MEETING		DATE: 21 MAY 2025	
Subject:	VICE CHAIR’S REPORT		
Approved and presented by:	Kirsty Williams, PTHB Vice Chair		
Prepared by:	Kirsty Williams, PTHB Vice Chair		
Other Committees and meetings considered at:	N/A		
PURPOSE:			
To bring to the Board’s attention key points for awareness from the Vice Chair of Powys Teaching Health Board, since the previous Board meeting in March 2025.			
RECOMMENDATION(S):			
It is recommended that the Board RECEIVES this report.			
Approve/Take Assurance		Discuss	Note
x		✓	x

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:		
1. Focus on Wellbeing	Y	The Vice Chair's report covers a broad range of activities.
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	

Patterson, Liz
20/05/2025 15:22:19
Vice Chair's Report

VICE CHAIR'S REPORT

Mental Health

The Welsh Government has recently launched its new Mental Health Strategy & Delivery plan. Earlier this month I attended an online briefing on the contents of the strategy and to hear from professionals in Canada who have already begun to implement a similar approach. I was pleased to note that service developments in PTHB including our single point of entry are very much in line with Welsh Government expectations. Elaine Lorton will deliver a session at our Board Development meeting in July.

The Power of Discharge Committee also met in this period and a full report will be given at the next Patient Experience, Quality and Safety Committee (PEQS). The members have formally asked the Health Board to undertake a recruitment exercise for new Hospital Managers and this is being actioned.

The Live Well Mental Health Partnership met. Items for discussion included the development of the peer led Recovery College which was warmly welcomed by service user representatives.

Veterans Champion

The PTHB Armed Forces and Veterans Forum held its latest meeting at the end of March. Issues discussed included whether "Fit to Farm" model of delivering health messages and basic checks in livestock markets could be adapted to better support Ex-forces members of our community.

Listening to Staff, Patients & Visits

During this period, I have undertaken a number of visits that have enabled me to engage with both staff and people who use our services.

- Alongside Steve Elliot (Independent Member), I visited Clywedog Ward in Llandrindod Wells Hospital. It was very positive to see works being undertaken to improve the outdoor environment and to meet a staff member who spoke very positively about the support offered to her to further her skills and qualifications. Staffing overall continued to be a challenge, however.
- On a separate occasion I visited the X-ray department to find out more about the impact of the new equipment on staff and patients. Feedback from staff was extremely positive, they felt proud to be able to offer their patients state of the art technology that improved efficiency and quality. The patients I spoke to also spoke highly of the service they had received, this included individuals who were visiting the area, who compared it very favourably to services in their home area.

- The Patient Experience, Quality and Safety (PEQS) Committee recently held a face-to-face meeting at the new facilities in Machynlleth Hospital. Following the meeting Jennifer Owen Adams (Independent Member) and I visited the ward and met with staff. We received positive feedback about the difference our overseas educated nurses had brought to staffing stability and continuity of care for patients. However long lengths of stay due to a lack of Elderly Mental Health beds in the community was raised. Some staff also expressed frustration with the condition of the external areas and the difficulty in patients being able to access outdoor spaces.

Equality Diversity & Inclusion

Welsh Government are once again running their “Aspiring Board Member Programme”, one of the health elements of their Anti-Racism Plan. I am delighted to be PTHB’s main sponsor for the programme and recently attended an introductory workshop with Welsh Government officials and fellow sponsors. I look forward to meeting the programme participant who has been matched to PTHB and know that all Board members will welcome them to Powys and ensure their experience is a positive one.



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Agenda item: 1.5c

BOARD MEETING		DATE: 21 May 2025
Subject:	CHIEF EXECUTIVE REPORT	
Approved and presented by:	Hayley Thomas, Chief Executive	
Prepared by:	Director of Corporate Governance with contribution from other colleagues	
Other Committees and meetings considered at:	Elements of this report may have been considered at various committees or meetings prior to being presented.	
PURPOSE:		
This report is intended to keep the Board up to date with key developments at a national and local level.		
It sets out for the Board areas of work being progressed and achievements that are being made, which may not be subject to consideration by a Committee of the Board or may not be directly reported to the Board through other Board reports.		
The report specifically covers:		
• Level 4 Escalation and Intervention Arrangements • Better Together (Transformation) • Health Protection ◦ Exercise Solarius ◦ Spring Covid vaccination Campaign • EMRTS Judicial Review • Service Change Engagement and Consultation • PTHB Staff Excellence Awards • External Recognition for PTHB staff		
RECOMMENDATION(S):		
The Board is asked to RECEIVE the report and DISCUSS any key issues.		
Approve/Take Assurance	Discuss	Note
N	Y	N

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:

1. Focus on Wellbeing	Y	The CEO report covers a board spectrum of updates that impact on a number, if not all wellbeing objectives.
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	

CEO REPORT:

Level 4 Escalation and Intervention Arrangements

The first meeting with Level 4 Escalation Board meeting took place with Welsh Government on the 29 April 2025. A full report is provided within the Board agenda for 21 May 2025 including the agreed governance structure.

Better Together

Powys Teaching Health Board is calling on all Powys residents, patients and service users to share their views on the future of health services.

The 'Better Together' programme is working across the county to find ways to keep delivering quality services that best meet the needs of the people of Powys.

Our ambition is that Powys residents receive safe, quality and reliable health care services. We want to make the very best use of the resources we have whilst ensuring above all that patient care and safety is at the forefront of everything we do. In recent years the county and its population has experienced lots of changes. Communities are getting older, and as they age, more people are living with two or more health conditions. The legacy of the COVID-19 pandemic still affects services, with rising demand for treatments and growing waiting lists. Large increases in the cost of fuel, food and other bills have had an impact, too.

Better Together pledges to work with local people, our staff and stakeholder organisations, to develop a plan that meets the needs of Powys communities over the next 10 to 25 years.

This plan will help PTHB respond to changes in illnesses and treatment and invest more into preventing ill health. It will also look for ways to build a sustainable workforce, and to improve building and facilities so they can meet our needs into the future.

Members of the public are invited take part and share their views, visit the [Better Together website](#) to watch or listen to the summary case for change video or to read the summary or full case for change documents. If you need a paper copy, want an Easy Read version, or to sign-up to receive regular updates on Better Together, please:

- call us on 01874 442 917
- email powys.engagement@wales.nhs.uk
- write to us at Better Together, Powys Teaching Health Board, Glasbury House, Bronllys Hospital, Bronllys, Powys LD3 0LY.

This first phase of Better Together seeks views by 25 May, but there will be plenty more opportunities to get involved.

HEALTH PROTECTION

Exercise Solarius

The Health Board participated, in an all-Wales exercise in April, to exercise multi-agency pandemic response arrangements and plans at Local Resilience Forum (regional) level. The Executive Director of Public Health Chaired the Dyfed Powys Resilience multi-agency group which involved active participation from all tier 1 organisations across the region. The Exercise was designed as a precursor to inform the development of an UK planned exercise in Autumn 2025 which aims to assess elements of the UK's preparedness, capabilities, and response arrangements in the context of a pandemic arising from a novel infectious disease.

Spring Covid Vaccination Programme

The Spring Covid Vaccination Programme commenced early April with the aim to protect those at greatest risk from respiratory viruses. All care homes for older adults have been visited and vaccination offered, and further 'mop-up' visits will continue until the end of the campaign delivery by 30th June 2025. The programme will be delivered by the Health Board Vaccination Team, at main vaccination centres at Bronllys and Newtown and outreach clinics to increase access to eligible population groups.

EMERGENCY MEDICAL RETRIEVAL AND TRANSFER SERVICE (EMRTS) - Judicial Review update

As I have reported previously, a judicial review was granted in relation to EMRTS. A two day hearing took place in Cardiff Crown Court on the 22 and 23 January, a further day of the hearing took place on the 7 February 2025. The judgement is awaited, I will update the Board when the judgement has been received.

SERVICE CHANGE ENGAGEMENT AND CONSULTATION

Later this month, Hywel Dda University Health Board is due to commence a period of formal consultation on their Clinical Services Plan. This plan covers nine key areas where HDUHB has identified potential fragility: Critical Care, Dermatology, Emergency General Surgery, Endoscopy, Ophthalmology, Orthopaedics, Radiology, Stroke, and Urology.

HDUHB is the main provider of acute hospital services for several Powys communities. This includes pathways of care for residents of north west Powys to Bronglais General Hospital in Aberystwyth.

PTHB is therefore working with HDUHB to ensure that information about their proposals is shared with Powys communities who use HDUHB services so that they can find out more and have their say.

More information, including a dedicated web pages to provide more information about the consultation, is due to be published on 29 May on the HDUHB website: [Clinical services plan - Hywel Dda University Health Board](#)

STAFF EXCELLENCE AWARDS

Since our last Board meeting, nominations for our PTHB Staff Excellence Awards 2025 have closed. Over 140 nominations were received, and judging is under way.

The awards provide an important opportunity to celebrate success and achievement across Powys, both within the health board and in partnership with communities and partner organisations. Awards will be presented in eight categories:

- PTHB Supportive Colleague
- PTHB Team of the Year
- Quality and Excellence in Practice
- Rising Star
- Partnership and Working Together
- Great Place to Work
- Improving Health in Powys
- Leadership and Taking Responsibility

Shortlisted finalists in each of our eight categories are due to be announced by early June, with celebration events taking place later this summer. Details are being finalised, and invitations will be issued to Board members to join these events.

EXTERNAL RECOGNITION FOR PTHB STAFF

We're proud to share that the Waiting Well Service team has been recognised at the National 3Ps Awards, held on Thursday 20th March 2025. This event celebrated the work happening across Welsh health boards in delivering the outcomes of the 3Ps Policy - Promote, Prevent and Prepare for planned care.

The team were highly commended for Patient Focus, presented by the Cabinet Secretary for Health and Social Care. This recognition reflects the teams unwavering dedication for putting patients at the heart of everything they do. Huge congratulations to: Abi Henderson, Project Officer; Julie Searle, Nurse Call Handler; Mihaela Raees, Nurse Call Handler; Rachel Hughes, Clinical Lead.

Good luck on 9 June to the PTHB dental service who have been shortlisted for the UK antibiotic guardian awards for Improving the Appropriateness of Antimicrobial Prescribing in Dental Practice.

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Agenda item: 1.7

BOARD		DATE: 21 May 2025
Subject:	BOARD COMMITTEES: CHAIRS ASSURANCE REPORTS	
Approved and presented by:	Director of Corporate Governance / Board Secretary Committee Chairs	
Prepared by:	Interim Head of Corporate Governance	
Other Committees and meetings considered at:	The content of each of the reports has been subject to the consideration of the relevant Board Committee Chair.	
PURPOSE:		
The purpose of this report is to provide the Board with an update on the work of the Board Committees.		
RECOMMENDATION(S):		
The Board is asked to: RECEIVE the summary assurance reports appended to this covering paper taking ASSURANCE that Board Committees are fulfilling their roles and reporting accordingly to the Board.		
Approve/Take Assurance	Discuss	Note
Y	Y	

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:		
1. Focus on Wellbeing	Y	The Committee Chairs reports cover a range of areas across the wellbeing objectives.
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:

ASSURANCE REPORTS FROM COMMITTEE CHAIRS

The following Chair's Assurance Reports with links to committee agendas and papers are appended for the information of the Board:

Audit, Risk and Assurance Committee:

- The Committee Chair's report of the meeting held on 13 May 2025 is attached at Appendix A.

Charitable Funds Committee

- The Committee Chair's report of the meetings held on 17 March 2025 is attached at Appendix B.

Delivery and Performance Committee:

- The Committee Chair's report of the meeting held on 01 May 2025 is attached at Appendix C.

Patient Experience, Quality and Safety Committee:

- The Committee Chair's report of the meetings held on 29 April 2025 is attached at Appendix D.

Planning Partnership and Public Health Committee:

- The Committee Chair's report of the meeting held on 19 May 2025 is attached at Appendix E and includes the RPB delivery update.

Workforce and Culture Committee:

- The Committee Chair's report of the meeting held on 13 March 2025 is attached at Appendix F.

Executive Committee:

- The Committee Chair's report of the meetings held from 19 March to 07 May 2025 is attached at Appendix G.

Escalation and Information to the Board

A summary of the position of items escalated/communicated to Board from the Committees is outlined below to support the Board in keeping track of these items. Whilst items are reported to the Board at each meeting, the table below includes the latest update for ease of reference. Historic updates are included as **Appendix One**.

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Meeting	Escalated Matter	Date Escalated	Purpose of Escalation	Latest Update
PEQS	Concerns regarding internal capacity constraints in respect of the use of Civica in relation to patient experience	July 2023	For Board awareness, no specific action requested	PEQS 30 April 2025: received an update within the Integrated Quality Report on Patient Experience – Civica. Item remains escalated.
	Infection Prevention and Control	July 2023 (In-Committee)	For Board awareness, no specific action requested	PEQS 30 April 2025: 45 of the 47 improvement actions had been completed. The remaining two were due for completion within the next few weeks. The Executive Committee recommended Infection Prevention and Control be de-escalated. Item is de-escalated.
PEQS - transferred from D&P	Neurodiversity Services – has been placed into level 3 local escalation	Oct 2024	For Board awareness, no specific action requested	PEQS 30 April 2025: Progress had been made although challenges remained. (see PEQS Chair's Report to Board). Item remains escalated.
W&C	Availability of Regional Investment Funding	Mar 2025	For Board awareness	W&C have not met since this was last reported to Board Item remains escalated.
D&P	Organisational Status	Feb 2025	For Board awareness	D&P 01 May 2025: D&P heard that the first Level 4 Escalation meeting with Welsh Government had taken

				place where the escalation framework and support package were discussed. Item remains escalated.

NEXT STEPS:
Further updates from the Chairs of the Board Committees will be received at the Board meeting scheduled for 30 July 2025

IMPACT ASSESSMENT – NOT REQUIRED
This section must be completed for all strategic organisational decisions including approval of health board policies.

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Appendix One – reporting history to the Board

Meeting	Escalated matter	Update
PEQS 25 April 2023	Concerns regarding internal capacity constraints in respect of the use of Civica in relation to patient experience	PEQS 24 Oct 2023: - received an update within the Integrated Quality Report on Patient Experience – Civica (see PEQS Chair’s Report to Board) PEQS 23 Jan 2024: - received an update within the Integrated Quality Report on Patient Experience – Civica. Noting the system continues to evolve and become established with feedback used to improve the system. Successes and opportunities were outlined along with ongoing priorities. PEQS 16 April 2024: - received an update within the Integrated Quality Report – in relation to the Patient Experience Stories, recording equipment has been purchased but limited administrative support available to support the production of patient stories. PEQS 30 July 2024: - A plan is in place to increase capacity and the Patient Experience Framework will be brought to PEQS in November 2024 when this escalation to Board will be reviewed. PEQS 07 Nov 2024: - A presentation on the ‘Peoples Experience Framework’ was brought to Committee. The Draft People’s Experience Framework will be brought to PEQS in February 2025.

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		PEQS 11 February 2025: This work is tied to the imminently expected publication of the Wales Patient Experience Framework.
PEQS 4 July 2023	Infection Prevention and Control (Reported to Board IC July 2023)	PEQS 24 Oct 2023: - received an update within the Integrated Quality Report on progress on the Infection Prevention and Control Improvement Plan which will be repeated on an agreed timeframe, and - agreed the Board level statement on Infection Prevention and Control (see PEQS Chair's Report to Board) PEQS 23 Jan 2024: - received an update within the Integrated Quality Report on progress on the Infection Prevention and Control Improvement Plan which outlined that 60% of activities were complete, 19% were making good progress, 2% were behind schedule and 19% were on track. The priorities for Quarter 4 were outlined to Committee PEQS 16 April 2024: Action plan is nearing completion and all actions are on track PEQS 30 July 2024: - Progress has been made (see PEQS Chair's Report to Board) but this matter remains escalated to Board. PEQS 07 Nov 2024: - Progress has been made (see PEQS Chair's Report to Board). PEQS 11 February 2025:

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		Majority of actions completed or completion is imminent. Expect to receive a report recommending de-escalation to April meeting of PEQS
PEQS (transferred from Delivery and Performance Committee) 22 October 2024	Neurodiversity Services	D&P 22 Oct 2024: - This service has been placed into local escalation by the Executive Committee. D&P have transferred oversight of this service to PEQS to enable a focus on quality as well as performance. PEQS 07 Nov 2024: - PEQS received this item noting the recent local escalation recognising the change of status and opportunity to focus on improvements to the service. An update will be received at the February 2025 meeting. PEQS 11 February 2025: - Received the action plan and a progress report – took assurance that the IQPF escalation mechanism is providing robust oversight
W&C March 2025	Availability of Regional Investment Funding	W&C 13 Mar 2025: RIF funding currently supports a number of work streams across Powys is subject to review by the Regional Partnership Board (RPB). Should funding be discontinued there would be implications for the deliverability of Better Together Agenda. W&C to monitor and alert Board of any fundamental changes.
D&P February 2025	Organisational Status	D&P 06 March 2025: Monitoring report received and assurance taken that PTHB continues to report as required in relation to its organisational escalation status

Reporting Committee:	Audit, Risk and Assurance Committee
Committee Chair	Stephen Elliot
Date of last meeting:	13 May 2025
Paper prepared by:	Corporate Governance Business Officer
KEY DECISIONS / MATTERS CONSIDERED BY THE COMMITTEE	
The Board is asked to NOTE that the following matters were discussed at the meeting held on 13 May 2025. A full report has not been provided to the May Board meeting due to the proximity of dates to the Committee meeting, a full report will be available at the Board meeting in July 2025. • PTHB Draft Accountability Report and Financial Accounts • Internal Audit Progress Report • Internal Audit Reports (Primary Care GMS Unified Contract, Pharmacy Stores, Business Continuity Planning, Risk Management, Information Governance, Llandrindod Phase 2, Partnership Governance) • Draft Head of Internal Audit Opinion • External Audit Progress Report and Annual Report • External Audit Report: Structured Assessment • Counter Fraud Update (Annual Report and Investigations) • Single Tender Waivers (including extensions to contracts) • Losses and Special Payments Annual Report • Information Governance Records Management and Annual Report • Annual Review of Committee Effectiveness • Review of Committee Terms of Reference • Post Payment Verification Year End • Welsh Health Circular Tracker • Committee Annual Report The papers from this meeting can be accessed at: Agenda and Papers-ARAC-13-may-2025/	
NEXT MEETING: 17 June 2025 at 10:30 via Microsoft Teams (Annual Accounts).	

Patterson, Liz
20/05/2025 15:22:19

Reporting Committee:	Charitable Funds Committee
Committee Chair	Carl Cooper
Date of meeting:	17 March 2025
Paper prepared by:	Senior Administrator – Corporate Governance

KEY DECISIONS / MATTERS CONSIDERED BY THE COMMITTEE

The Board is asked to NOTE the following matters were discussed and resolved at the Charitable Funds Committee (CFC) on 17 March 2025. The papers from this meeting can be accessed at: [Charitable Funds Committee - Powys Teaching Health Board \(nhs.wales\)](#)

Vestibular Assessment Progress Pathway

The Committee received a progress update on the application to establish vestibular pathway. The Committee took ASSURANCE that progress had been made with the vestibular pathway.

Powys General Purposes and Local Funds bids for approval

The Charity Manager presented the following bids to the Committee for approval:

- **LF61-202501 Ready to Go Home Unit (£8,937.60)**

The application is a request for 20 new patient chairs - 14 beds on the ward, the additional six chairs are for the Patient Day room. The Committee SUPPORTED the application

- **Welsh National Opera Funding Renewal (£8,000.00)**

The Committee noted the programme had run for two years with an equal sharing of cost across all Health Boards in Wales, although a breakdown of the number of Powys patients who had participated in the project was not available.

The Committee AGREED to SUPPORT in principle and DELEGATED authorisation to the Chair, subject to receipt of a breakdown of the number of Powys Patients who had accessed the project, the impact to those patients and the clarification on how the project managed interdependencies in terms of financial sources of income.

Projects approved under Delegated Authority

The Committee received a summary of the expenditure approved under Delegated Authority between 01 December 2024 and 06 March 2025

The Committee DISCUSSED and RATIFIED the expenditure

Proposed Charity Team Operational Budget

The Committee received an overview of possible expenses identified by the Charity Team for the 2025/2026 financial year.

The Committee APPROVED the proposed Charity Team Operational Budget.

Charity Dashboard

The Committee received the Charity Dashboard which provided the headline figures for the Charity's activities over the past year, an analysis of applications and a further breakdown of how the applications were submitted and the amount of funding approved monthly.

The Committee NOTED the Charity Dashboard

Financial Report

The Committee received the financial report which outlined the committed funds. Total expenditure to January 2025 was £144k with an income of £226k. The cash bank balance was approximately £700k, this was expected to be nearer to £500k by year end.

The Committee SUPPORTED the financial report.

Investment Manager Report

The Committee noted the level of the investment portfolio with fund advisors Brewin Dolphin had remained broadly consistent. The current valuation of £3.61m outweighed the actual investment of £2.84m. The capital value had increased by £800k, plus the Health Board had received approximately £100k in dividends.

The Committee RECEIVED and took ASSURANCE of the Investment Manager report.

Charitable Funds Committee Effectiveness Review – 2024/25

The Committee noted this was the first set of data, so no comparisons could be made. Overall, the scores had been positive with three areas requiring further consideration which would be included in the Governance Action Plan.

The Committee RECEIVED the Charitable Funds Effectiveness Review.

Expenditure Strategy Session discussion outcomes

The Committee noted the output from the strategy session in February.

One of the challenges was the facilitation of quicker completion of the aspects of the goods and services they were looking to fund.

A number of fundraising campaigns had been launched to help drive income to allow targets to be set to run those campaigns on an annual cycle.

The Committee NOTED the Expenditure Strategy Session Update

May’s Miles Campaign

The Committee noted a new campaign to be launched in May, initially to support the health and wellbeing of the staff and the community. Fundraising had been tagged onto this campaign, but it was not the primary focus.

The Committee NOTED the May’s Miles Campaign

Communication and Website

The Committee received a brief update on key activities since the previous meeting.

The Committee NOTED the Communication and Website Update.

DATE OF NEXT COMMITTEE MEETING

16 June 2025

Reporting Committee:	Delivery and Performance Committee
Committee Chair	Ronnie Alexander
Date of last meetings:	01 May 2025
Paper prepared by:	Corporate Governance Officer
KEY DECISIONS / MATTERS CONSIDERED BY THE COMMITTEE	
1. SITUATION/BACKGROUND This report had been prepared to provide Board Members with a summary of the key issues considered by the Delivery and Performance Committee meeting on 01 May 2025. Key highlights from the meeting are reported in Section 3. 2. PURPOSE The Purpose and Role of the Delivery and Performance Committee is set out in Schedule 4 (pages 42 – 52) of Standing Orders. 3. HIGHLIGHT REPORT (Links to agenda and reports: Delivery & Performance Committee 01May2025)	
Alert / Escalate	ORGANISATIONAL STATUS (NHS WALES ESCALATION FRAMEWORK) ENHANCED MONITORING REPORT Work had progressed to understand the de-escalation framework and criteria as per the action plan provided by Welsh Government. The framework and support packages were discussed at the first level 4 escalation meeting with Welsh Government and work had progressed to map the Board structure and Sub Committees to ensure they are aligned to respond to the escalation framework. The Board continued to work against the Integrated Quality Performance framework and have strengthened elements of commissioning. The planning maturity matrix was approved in December 2024 and continues to be monitored by the Planning, Partnerships and Population Health (PPPH) Committee. An update report would be provided to Delivery and Performance members at the next meeting. The Committee RECEIVED the Organisational Status Level 4 Monitoring report.
Advise	Nothing to report from this meeting.

Assure

FINANCE PERFORMANCE REPORT MONTH 12

An overview of the month 12 report was provided, and the following key areas were highlighted:

- An additional £7.178m of Welsh Government funding had been allocated in month 08 and the financial plan for 2024/25 had been revised from a £22.948m deficit to £15.770m position;
- At month 12, there was a £15.753m overspend against the revised planned year to date deficit of £15.770m giving the Health Board an operational overspend of £0.017m;
- The position excludes an unexpected £5m invoice from Wye Valley NHS Trust (WVT). The basis for the invoice and its value had been refuted;
- Significant pressures continue across Continuing Health Care, Provider pay, Agency spend and Commissioning of Healthcare services. These had been offset due to reduced expenditure on prescribing, Dental and other non-pay expenditure.
- Powys continues to be an outlier within the NHS Wales as agency spend average at 9.2% of total pay in month 11 against the Wales average of 2.7%.
- Additional funding of £5.7 for contracting with English NHS and £0.650 for Specialised Services had helped mitigate the overspend in year.

The Committee:

- RECEIVED the financial report and took assurance that the organisation has effective financial monitoring and reporting mechanisms in place.
- NOTED that, subject to audit, it is reported that the Health Board has achieved the 2024/25 financial plan of a £15.8m deficit.
- NOTED the underlying deficit is assessed as deteriorating by £2.0m to £32.6m.

INTEGRATED QUALITY AND PERFORMANCE REPORT MONTH 11

An overview on the latest performance position against the NHS Wales Performance Framework 2024/25 was provided and the following key themes were highlighted:

- Referral to treatment (RTT) compliance remains positive;
- Planned Care: Long waits remain challenging. The impact of the additional planned care funding released to Welsh providers, continues to be monitored;
- Emergency Care: Powys provider Minor Injuries Units (MIU) services performed well, meeting the 4-hour target

- Shrewsbury and Telford Hospital NHS Trust (SATH) data had been unavailable since July-24 following reporting challenges and this is expected to be in place in Q1 2025/26.
- Primary Mental Health Services assessments undertaken and had achieved planned improvement against both National targets. The service had been de-escalated.

The Committee DISCUSSED the report and were ASSURED that the Health Board has appropriate systems in place to monitor performance and respond to relevant issues.

Q3 ANNUAL DELIVERY PROGRESS REPORT

The report provided members with an update of the progress made against the Integrated plan year end to March 2025. Detail on the progress made with delivery of the actions and priorities in the Plan as reported at the end of the year.

The Committee CONSIDERED the report ahead of submission to the Board and took ASSURANCE that there is a process in place for monitoring progress against plan.

IN REACH FRAGILITY SIX MONTHLY UPDATE

The committee were provided with a verbal update on the planned review of JAG which is scheduled in November 2025 with a key focus around clinical leadership. All Service Level Agreements (SLAs) which are under performing are under review with Providers. The Planned care Transformation Programme would seek to improve sustainable services, referral optimisation and digital support around referrals.

The Committee RECEIVED the In-reach Fragility six monthly update.

HEALTH AND SAFETY ANNUAL REPORT

Committee members received an overview of the Health Board's compliance with statutory health and safety requirements. The key areas of performance, areas for improvement and progress made throughout the year were highlighted.

The Committee RECEIVED report and ENDORSED the report for onward submission to the Board in May 2025.

COMMITTEE RISK REGISTER

Members were advised that the Board had approved the Risk Management Framework in March 2025 and work was underway to create a Strategic Risk Register and Organisational Risk Register which would be brought to Board in May 2025.

	ANNUAL ASSESSMENT OF COMMITTEE EFFECTIVENESS The report outlined the results of the Committee Effectiveness review. The Corporate Governance team would seek to develop an action plan to ensure that feedback from the Committee effectiveness reviews were addressed individually and as a collective. The Chairs Forum would monitor progress throughout the year. The Committee NOTED the Annual Assessment of Committee Effectiveness and suggested actions for improvement. REVIEW TERMS OF REFERENCE Noting the Organisational status of Level 4 escalation, attention was drawn to the time allocated to the committee to the need to ensure sufficient time is given to review and scrutinise financial performance and to seek assurance as required. The Committee agreed to following amendments: • To retain Finance within the committee and amended title to 'Finance and Performance Committee'; • To review the balance of agendas to allow focus and deep dives as required and extension to the meeting if needed; • Assurance in regard to the performance management of Digital is removed, to be transferred to the Audit, Risk and Assurance Committee. • Assurance in regard to Health and Safety arrangements to be transferred into Delivery and Performance Committee which historically sat within Workforce and Culture Committee. • Continue to strengthen Primary Care and its components within the Delivery and Performance Committee. The Committee: • ENDORSED the proposed amendments to the Terms of Reference subject to the amendments listed above; • AGREED 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.
Inform	The Committee RECEIVED the following items for assurance and information. • Committee Annual Report; • Internal Audit Reports: -Community Cardiology -Patient Flow and Discharge Management -Pharmacy Sores -Primary Care GMS Unified Contract

	• The Joint Commissioning Committee Planning and Performance Highlight report. • PTHB Glossary for Information.
NEXT MEETING: 26 June 2025 via Microsoft Teams	

Patterson Liz
20/05/2025 15:22:19



Reporting Committee:	Patient Experience, Quality and Safety Committee
Committee Chair	Kirsty Williams
Date of last meetings:	29 April 2025
Paper prepared by:	Head of Corporate Governance
KEY DECISIONS / MATTERS CONSIDERED BY THE COMMITTEE	
1. SITUATION/BACKGROUND	
This report had been prepared to provide Board Members with a summary of the key issues considered by the Patient Experience, Quality and Safety Committee (PEQS) at its meeting on 29 April 2025. Key highlights from the meeting are reported in Section 3.	
2. PURPOSE	
The Purpose and Role of the PEQS Committee is set out in Schedule 4 (pages 15 – 30) of Standing Orders.	
3. HIGHLIGHT REPORT	
Links to agenda and reports: 29 April 2025 - Powys Teaching Health Board	
Alert / Escalate	• Mental Health Services – was entered into local escalation earlier in 2024, Executive Committee de-escalated the service from local escalation on 16 October 2024 from which PEQS took assurance. PEQS received a presentation of Mental Health and Learning Disabilities staff experience of escalation and it was agreed a further monitoring report on post escalation performance would be received at the October meeting of PEQS. This matter remains escalated to Board and PEQS will continue to provide updates • Neurodiversity Services – This service was placed under local escalation (level 3) by Executive Committee on 02 October 2024. PEQS received an update on actions taken to address the issues that had led to escalation and were advised that whilst good progress was being with funding from Welsh Government enabling an



	improvement in wait times. The Executive Committee had committed to additional temporary funding to maintain the improved position but the situation needed to be resolved in the longer term. PEQS noted the position remains challenging and requested details of funding arrangements to be included in the next report to Committee. This matter is escalated to Board and PEQS will continue to provide updates • Civica – patient experience system – PEQS heard that the draft People’s Experience Framework had now been issued by Welsh Government and an assessment against the framework was underway. The adoption of the Peoples Experience Framework would be brought to Board in due course. This matter remains escalated to Board and PEQS will continue to provide updates • Infection Prevention and Control – PEQS heard that 45 of the 47 improvement actions had been completed and the remaining two actions would be completed imminently. The Executive Committee had de-escalated this matter and PEQS recommend that this matter is de-escalated from Board.
Advise	• The PEQS Committee Annual Report 2024/25 was APPROVED. • The PEQS Work Programme 2025/26 was APPROVED
Assure	• Integrated Quality Report The Committee 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 A series of improvements to the Integrated Quality Report were proposed including key performance indicators and updates on quality from service groups for inclusion in future reports • Annual Clinical Audit Programme The Committee RECEIVED and APPROVED the Clinical Audit Plan 2025/26. • Monitor Health Board Actions of Joint Inspection of Child Protection Arrangements



	The Committee took ASSURANCE from the progress made in progressing the health board specific actions within the JICPA. • Annual Assessment of Committee Effectiveness The Committee RECEIVED a presentation on the outcome of the Committee Effectiveness review and noted the improvements to the Integrated Quality Report which had been proposed as identified above. • Review of Terms of Reference The Committee ENDORSED the proposed amendments to the Terms of Reference subject to the amendments listed above and AGREED 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. • Committee Risk Register The Committee heard that following approval of the Board Assurance Framework in March work was underway to create a Strategic Risk Register and Organisational Risk Register.
Inform	• The Patient Flow and Discharge Management Internal Audit Report and the Additional Learning Needs Legislation Internal Audit Report were shared for information having previously been reported at the Audit, Risk and Assurance Committee (ARAC) in March 2025. • The Audit Wales report on Cancer Services was shared for information. • The Joint Commissioning Committee Quality Patient Safety Committee Highlight Report from the meeting held on 18 March 2025 was shared for information. • The 2025 PEQS Work Programme was received and APPROVED
NEXT MEETING: 31 July 2025	

Patterson, Liz
20/05/2025 15:22:19



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Reporting Committee:	PLANNING, PARTNERSHIP AND POPULATION HEALTH COMMITTEE
Committee Chair	Simon Wright
Date of last meeting:	19 May 2025
Paper prepared by:	Corporate Governance Business Officer
KEY DECISIONS / MATTERS CONSIDERED BY THE COMMITTEE	
The Board is asked to NOTE that the following matters are scheduled to be discussed at the meeting held on 19 May 2025 (the Committee has not met at the time of the release of this paper). A full report will be available at the Board meeting in July 2025. • Strategic Change Report and Engagement Report • Whole Systems approach to prevention of Obesity • Primary Care Cluster Reporting against delivery 2024/2025 • Partnership Governance and Assurance Framework • Adult Weight Management Pathway update • Health Child Wales Programme – Health Visiting Programme • Committee Risk Register • Annual Assessment of Committee Effectiveness • Review Terms of Reference • Internal Audit Report: Additional Learning Needs Legislation • NWSSP Performance Report • Joint Commissioning Committee Planning, Performance & Finance Sub Committee Highlight Report The papers from this meeting can be accessed at: Planning, Partnership and Population Health Committee - Powys Teaching Health Board.	
DATE OF NEXT COMMITTEE MEETING	
14 August 2025 at 10:00 via Microsoft Teams.	

Patterson, Liz
20/05/2025 15:22:19



Reporting Committee:	Workforce and Culture Committee
Committee Chair	Jennifer Owen-Adams
Date of last meetings:	13 March 2025
Paper prepared by:	Corporate Governance Officer
KEY DECISIONS / MATTERS CONSIDERED BY THE COMMITTEE	
1. SITUATION/BACKGROUND	
This report had been prepared to provide Board Members with a summary of the key issues considered by the Workforce and Culture Committee meeting on 13 March 2025. Key highlights from the meeting are reported in Section 3.	
2. PURPOSE	
The Purpose and Role of the Workforce and Culture Committee is set out in Schedule 4 (pages 31 – 41) of <u>Standing Orders</u>.	
3. HIGHLIGHT REPORT	
(Links to agenda and reports: Workforce and Culture Committee - Powys Teaching Health Board)	
Alert / Escalate	External Funding – The RIF funding which currently supports a number of work streams across Powys is subject to review by the Regional Partnership Board (RPB). Should funding be discontinued there would be implications for the deliverability of the Transformation Better Together Agenda. The Workforce and Culture Committee agreed to monitor this closely and will alert the Board of any fundamental changes that arise. Progress of work across Workforce and Culture Committee – Committee members recognised the very good work being undertaken across the Health Board in terms of progress and positive direction of travel in relation to Workforce performance across a number of services.
Advise	Nothing to report from this meeting.



Assure

• **Workforce and Performance Report**

The Committee **RECEIVED** the Workforce Performance Report and were **ASSURED** that the organisation has appropriate mechanisms in place to record and monitor workforce data.

• **NHS STAFF SURVEY**

Powys had the highest response rates of Health Boards with a response rate of 30%. The majority of scores across the survey had increased with all questions against a number of themes higher than the NHS Wales average scores.

The Committee **RECEIVED** and **NOTED** the NHS Staff Survey.

• **Director of People and Culture Report (including Staff Bank Service update and Theme 2 – a Great Place to Work)**

The Committee **RECEIVED** the report as an update on priorities within the Workforce section of the Integrated Plan for Q4 2024/25 and were **ASSURED** against delivery of those priorities.

• **Theme 4 – Welsh Language, Equality, Diversity and Inclusion**

The Committee received a presentation on the Strategic Equality Plan which sets out priorities over a five-year period with particular focus on Age, Sensory Loss and Neurodiversity as areas identified by staff and public consultation. The Committee was provided with an overview of the key activities delivered in 2024/2025.

The Anti Racism Plan had been approved by Board in January 2025 and had been referred to the Workforce and Culture Committee for clarification of some issues which were provided during the meeting.

The Committee **RECEIVED** the Equality and Welsh Language Update and took **ASSURANCE** that actions were being implemented.

• **Committee Risk Register (CRR)**

The Committee **RECEIVED** and **NOTED** the risk register update.



	• Annual Assessment Of Committee Effectiveness The Committee were provided a summary of the Annual Committee Effectiveness Survey. The Committee DISCUSSED the summary of the Committee Effectiveness survey and areas for action and improvement. • Review Committee Terms Of Reference The Committee RECEIVED the Committee Terms of Reference. • ENDORSED the proposed amendments. • AGREED that the Chair of the Committee and Director of Corporate Governance would finalise the revised Terms of Reference for approval to the Board in May.
Inform	The Committee RECEIVED the Committee Work Programme for 2024/2025. Members RECEIVED the Staff Retention and Board and Committee Structure/Effectiveness Internal Audit Reports for information.
NEXT MEETING: 03 June 2025 via Microsoft Teams	

Patterson, Liz
20/05/2025 15:22:19

Reporting Committee:	Executive Committee
Committee Chair	Hayley Thomas, Chief Executive
Date of last meeting:	7 May 2025
Paper prepared by:	Director of Corporate Governance and Corporate Business Manager
KEY DECISIONS AND MATTERS CONSIDERED BY THE COMMITTEE	
The Executive Committee is chaired by the Chief Executive with all members of the Executive team acting as members of the Committee. The Committee meets within In-Committee sessions due to the practical nature of the day-to-day management and operations of the organisation. I am pleased to provide the Board with a summary of the matters considered by the Executive Committee when it met on 19 March, 2 April, 16 April, 23 April, 30 April and 7 May 2025. Meetings following these dates will be reported to the Board in May 2025.	

Patterson, Liz
20/05/2025 15:22:16

Report of the Executive Committee Chair

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Alert/ Advise/ Assure/ Inform	Topic	Purpose	Additional Comments	Onward to Committee /Board	Date of Executive Committee
Alert	Nothing to report.				
Advise	Nothing to report – all content captured in either assure or inform sections below.				
Assure	Better Together Update	Assurance	The Committee discussed the Impact and Deliverability Assessment undertaken. Discussion took place, but approval not given to the option for alignment of the mental health and community models – further discussion and assurance were required. The Committee APPROVED: - Acceleration of the Community Model Work and indicative timelines. - The Communication and Engagement Option 3 and resource plan. - Agreed the resource considerations and principles. The Committee acknowledged the impacts and risks identified and agreed steps required to mitigate.	Board Development and Board	19.03.2025
	Finance Performance Report (Month 11)	Assurance	The Committee received the update and took assurance that the organisation has effective financial monitoring and reporting mechanisms in place. It was noted, from the forecast that the Health Board will achieve the financial plan of £15.8M deficit.	Board	19.03.2025
	Integrated Quality & Performance Report (IQPR) (Month 10)	Assurance	The Month 10 IQPR was received and the content of the report discussed; the Committee took assurance that the appropriate systems were in place to monitor performance and respond to relevant issues.	Board	19.03.2025

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	Neurodevelopment Service Escalation Oversight Update	Assurance	The Committee received the monthly escalation oversight update – the contents of the report were discussed.	PEQS Committee	19.03.2025
	Corporate Risk Register	Assurance	The Committee reviewed the Corporate Risk Register and noted that work was underway to develop the 2025/26 Strategic Risk Register in accordance with the Risk Management Framework.	Board	19.03.2025
	National Power Outage (NPO) Planning and Pandemic Preparedness	Assurance	The Committee received an update on the current status of internal planning for the risk of a pandemic and a national power outage scenario. The Committee took assurance that work is in progress to ensure the organisation has an appropriate emergency response plan.		19.03.2025
	Staff Survey Briefing	Assurance	The Committee received the staff survey highlights and agreed to discuss the activity, communications and engagement at a future meeting.	W&C Committee	19.03.2025
	SBAR: EPMA	Assurance	It was noted that the ePMA project was progressing at pace from pre-implementation to full implementation. It was noted that formal confirmation of funding had not been received, the project progressing according to plan. The Committee took assurance from the update.		02.04.2025
	Partnership Governance and Assurance Framework	Approval	The Committee discussed and approved the Framework (subject to final comments).	PPPH Committee and Board	02.04.2025
	Quarter 4 Integrated Plan Progress Report		The Committee received the update and it was agreed for the report to be strengthened in its narrative, but noted that good progress is being made in relation to the plan.	D&P Committee	16.04.2025

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	Infection Prevention & Control Improvement Plan (2023-25) Update		The Committee received an updated position at the end of year two of the IPC improvement plan. The report highlighted the progress made and sought for de-escalation and for future reporting to be included in the Integrated Quality Report and annual assurance report. The Committee took assurance from progress and achievements and recommended the plan can be de-escalated.	PEQS Committee	16.04.2025
	Integrated Quality Report	Assurance	The Committee received an update report and took assurance that Quality and Safety is appropriately monitored and continued actions are in place to further develop monitoring and reporting.	PEQS Committee	16.04.2025
	Better Together Portfolio Update	Assurance	The Committee noted the monthly update from the Better Together portfolio; it was noted that good progress against the Case for Change and due to publication to the public on 28 April.		23.04.2025
	Integrated Quality & Performance Report (IQPR) (Month 11)	Assurance	The Committee discussed and took assurance on the month 11 IQPR report.	D&P Committee	23.04.2025
	Q4 Integrated Plan Progress Update	Assurance	The Committee considered the report, discussed and strengthened areas ahead of consideration at D&P Committee. The Committee took assurance that there is a process in place for monitoring progress against plan.	D&P Committee and Board	23.04.2025
	Neurodevelopment Services Escalation Oversight Update	Assurance	The Committee took assurance that the implementation of the escalation oversight mechanism is providing robust oversight of the quality improvement and risk mitigation work being undertaken within this service.	PEQS Committee	23.04.2025

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	Health and Safety Annual Report	Assurance	The Committee considered the report and reviewed for the purposes of assurance the performance, training and incident information.	D&P Committee and Board	23.04.2025
	Financial Performance Report (Month 12)	Assurance	The Committee received and took assurance from the report. It was noted that, subject to Audit, it is reported that the Health Board has achieved the 2024/25 financial plan of a £15.8M deficit; and that the underlying deficit is assessed as deteriorating by £2.0M to £32.6M.	D&P Committee and Board	30.04.2025
	Strategic Change Report	Assurance	The Committee discussed this report and noted that next steps involve reviewing the best way to present information to the Committee, ensuring clarity and alignment with governance requirements. The planning team would refine the approach, maintaining good practice whilst streamlining reporting for efficiency and relevance.	PPPH Committee	30.04.2025
	Whole System Approach: Healthy Weight in Powys	Assurance	The Committee took assurance about progress made on implementing a whole system approach to the prevention of overweight and obesity in Powys targeting 'Children, Families and Access to Healthy Food' which is funded through a short-term grant of £104k until March 2026. It was not that in Powys, the percentage of 4-5-year-olds living with overweight or obesity has seen a decrease from 28.1% in 2019 to 22% in 2023. The Committee also noted that over 50% adults report as being overweight or obese, with rates highest in the most deprived areas.	PPPH Committee	30.04.2025
	Speaking Up Safely Framework Actions Closure Report	Assurance	The Committee received and took assurance from the report that detailed actions defined under section 6 of the Speaking Up Safely framework have been undertaken and approved the closure of the actions and transfer the work into business as usual operations.	Board	30.04.2025

Report of the Executive Committee Chair

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	Digital First Assurance Report		The Committee took assurance that work is progressing and delivering against the second year of the Digital Strategic Framework. The Digital Programme updates and challenges were noted. It was requested for a further discussion on the replacement of WCCIS.		30.04.2025
	Welsh Health Circulars and Ministerial Directions Tracking Report	Assurance	The Committee received and took assurance on the position relating to the Welsh Health Circulars and Ministerial Directions. It was noted that the position would be included within the Health Board's Annual Report 2024/25.	ARA Committee	07.05.2025
	Temporary Service Change Assurance Report	Assurance	The Committee received the update on progress to date and took assurance in relation to the delivery of the mitigation plan.	Board	07.05.2025
	Primary Care Cluster Reporting Against Delivery 2024/25	Assurance	The Committee received the Primary Care Cluster reporting and took assurance that a monitoring approach is in place ensuring appropriate performance reporting against cluster plans.	PPPH Committee	07.05.2025
	UK Covid-19 Public Inquiry Progress Report Q4 2024/25 and Forward Look	Assurance and Approval	The Committee received an update on organisational preparedness for, and responses to, the UK Covid-19 Public Inquiry and WG Special Purposes Committee. Assurance was received and approved that the dedicated programme management arrangements will return to business as usual processes.	Board	07.05.2025
Inform	Delivery Model Continuing Health Care for Children	Approval	The Committee discussed and approved the preferred method to deliver Continuing Healthcare for Children in Powys.		19.03.2025

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	Continuing Health Care and Funded Care (Interim) Inflationary Uplifts for 2025/26	Approval	The Committee agreed in principle the Funded Nursing Care inflationary uplift subject to benchmarking to be undertaken.		19.03.2025
	Nationally Reportable Incidents Report	Assurance	The Committee received an update regarding open Nationally Reportable (NRI) and Duty of Candour incidents.	PEQS Committee	19.03.2025
	Storm Darragh Internal Debrief	Approval	The Committee approved the 'response to Storm Darragh internal debrief' which had identified 15 recommendations and aims to strengthen future internal major incident responses arrangements and to feedback identified learning into multi-agency debriefs.		19.03.2025
	Educational Commissioning	Approval	The Committee approved the Education Commissioning Templates and all associated data enabling submission to HEIW by 31 March 2025.		19.03.2025
	Continuing Health Care and Funded Care (interim) inflationary uplifts for 2025/26	Approval	The CHC/FNC paper had been updated following previous discussion at the Committee on 19 March; at that meeting the FNC uplift was agreed and the CHC Uplift was agreed in principle subject to benchmarking information being provided in relation to other Health Board uplift rates. The Committee noted the update where the FNC rates for Powys were approved, outside of the meeting, on the 25 March 2025.		02.04.2025
	Gender Identity Service	Approval	The Committee did not approve the business case and requested for the report to be reviewed and further discussions to take place and report to be rescheduled for the Committee's decision.		02.04.2025

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Appendix G

	Flow Hub and Transfer Co-ordinators Presentation	Information	The Committee received a presentation which provided a greater level of assurance and information on the flow hub project.		02.04.2025
	Case for Change	Approval	The Committee formally recorded the discussion and approval of the Case for Change at its Informal Executives Committee on the 9 April 2025.		16.04.2025
	Better Together – Acceleration of Community Model: Mental Health Scope	Approval	The Committee discussed and agreed the scope for the accelerated approach – acknowledging that the focus on older adults in the community is appropriate, especially given persistently high acuity and care demands.		16.04.2025
	Primary Care Optometry Eye Health Needs Assessment	Approval and Assurance	The Committee approved that the assessment fulfilled the health board requirements and took assurance that the comprehensive review of current and future ocular conditions had been considered for the future provision of primary care eye care services.		16.04.2025
	Radiological Information Systems Procurement (RISP) Update	Approval	The Committee received an update on the emerging risks relating to the full implementation of the RISP rollout. The Committee noted and discussed the contents of the report and approved the favoured option.		16.04.2025
	Update on Overseas Nurses Programme	Information	An update was received on the risks identified in a previous briefing paper, and an overview given of the current risks associated with the ongoing programme. The Committee noted the update for information.		16.04.2025
	Annual Update of the Integrated Quality and Performance	Approval	The updated framework was discussed and considered. It was requested for urgent action to finalise the framework for consideration at the Board meeting on 21 May.	Board	30.04.2025

Report of the Executive Committee Chair

Board Meeting
21 May 2025
Agenda Item 1.7g
Appendix G

	Framework 2025/26				
	Mental Capacity Act 2005; Deprivation of Liberty Safeguards	Approval	The report outlined service provision gaps and the internal audit findings, which highlight limited assurance. The case for change is critical to meeting statutory responsibilities, assessing current demand and addressing risks, particularly delays in documentation approval. The Committee discussed and did not approve the financial investment of the preferred option. It was requested for the report to be strengthened and rescheduled to be reconsidered at this committee.		30.04.2025
	Cross Border Project Update	Information	The Committee received an update report and noted the risks identified that had been raised during the pathology workstream system testing phase; the delays have impacted the target completion timescale by six weeks.		30.04.2025

ITEMS TO BE ESCALATED TO THE BOARD

A large number of topics from this report are reported either to the full Board or one of its other Committees.

There are no specific topics to escalate that have not already been reported to or addressed by the Board or a Board Committee.

NEXT MEETING

The Executive Committee generally meets fortnightly with additional meetings held if urgent matters arise. The Committee will continue to report to the Board.



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Agenda item: 3.1

PTHB Board		21 May 2025	
Subject:	Integrated Plan: Annual Delivery Plan 2025-26		
Approved and presented by:	Executive Director of Planning, Performance & Commissioning		
Prepared by:	Assistant Director of Planning/Planning Managers		
Other Committees and meetings considered at:	Executive Committee		
PURPOSE:			
This report provides the Board with the Annual Delivery Plan 2025-2026, following approval of the Annual Plan 2025/26 by the PTHB Board as submitted to Welsh Government in March 2025.			
RECOMMENDATION(S):			
The Board are asked to NOTE the report and take ASSURANCE that this forms the basis of the quarterly review, monitoring and reporting cycle of progress against plan.			
Approve/Take Assurance		Discuss	Note
Y		N	Y

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:		
1. Focus on Wellbeing	Y	The annual delivery plan covers all wellbeing objectives.
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	

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EXECUTIVE SUMMARY:

This report provides the Board with the Annual Delivery Plan 2025/26.

- The Annual Plan 2025/26 was approved by PTHB Board at its meeting on the 26th March 2025 and submitted to Welsh Government on 31st March 2025. This is the second year of the five-year plan submitted in 2024/25.
- The Annual Delivery Plan is an important 'baseline' document, fully aligned to the original submission of the PTHB Plan, with no material changes made to Strategic Priorities, Deliverables or Milestones.
- Executive lead allocation against areas of delivery have been made in line with the Executive roles and portfolios.
- Delivery confidence assessments have been made by each Executive lead and are included; these will be revisited quarterly as part of the review and monitoring of progress against plan.
- It should be noted that feedback has been received from Welsh Government in relation to the PTHB Annual Plan and additional requirements have been communicated in several correspondences – this may result in changes to the Delivery Plan which will be transacted as required part of the quarterly change management, review and monitoring process.

BACKGROUND

Scope and Purpose of the Annual Delivery Plan

This report provides the Board with the Annual Delivery Plan 2025-2026, following approval of the Annual Plan 2025/26 by the PTHB Board as submitted to Welsh Government in March 2025. This is the second year of delivery of the Five Year Integrated Plan 2024 – 2029.

The Annual Delivery Plan is therefore an important 'baseline' document, fully aligned to the original submission of the PTHB Plan, with no material changes made to Strategic Priorities, Deliverables or Milestones.

The attached Delivery Plan forms the basis for the quarterly review, monitoring and reporting of progress against plan and is therefore an important component in the organisation's strategic planning and assurance approach.

Continuous improvements have been made to the format and utility of the Delivery Plan and the associated monitoring processes. This has been built into the design and content of the attached Delivery Plan. This is intended to produce a consistent and meaningful overview across a complex and multi-dimensional plan.

Executive Leadership for respective areas of accountability and delivery

The allocation of Executive Leads has been made in line with Executive roles and portfolios.

Delivery Confidence Assessments

Delivery Confidence assessments have been made by each Executive Lead for their respective areas of accountability and delivery portfolios.

These are compiled into the attached Delivery Plan and provide a baseline assessment; these will be reviewed by Executive leads as part of the quarterly review and monitoring of progress against plan.

The assessments are predominantly medium and high confidence of delivery. There are eight rated as 'low' confidence. These are:

- GP Out of Hours provision /commissioning with Swansea Bay University Health Board
- Implementation of Dental Collaborative
- Development of Endoscopy / colorectal pathways
- Some components of Mental Health Transformation (noting that reprioritisation is due to acceleration of Older Adult Mental Health work)
- Further development of Trusted Assessment
- Information Sharing agreements (inc. Cross Border)
- Digital Skills and Confidence Training
- Further development of the Marches Forward Partnership

The majority of areas are rated low due to interdependences with other organisations or bodies with elements of the actions being outside PTHB control. These will be reviewed with the aim of improving delivery confidence throughout the year and change control if necessary will be undertaken through the quarterly review process.

Potential changes following feedback from Welsh Government

As per normal practice, Welsh Government provide feedback to NHS organisations on their Plans. A letter was received from the Director General Health, Social Care & Early Years / NHS Wales Chief Executive on 11th April advising that the PTHB Annual Plan is unsupportable and unacceptable. Further work is required on:

- Improving upon and derisking the financial position
- Further developing and detailing the options and choices available to the organisation that could be considered in order to deliver to the target control total
- Increasing confidence in delivery of the savings plan

- Ensuring that your commissioning arrangements and in house services are in line with the Cabinet Secretary's strategic objectives.

The PTHB Integrated Plan responded to the original NHS Wales Planning Framework 2025-28, Technical Planning Guidance and the Supporting Governance arrangements. This remains in place and therefore the consideration of the above items will be made in the context of the wider framework which encompassed the complex and multiple legislative and policy requirements for the health board.

An Accountable Officer has been sent back to Welsh Government responding to the addition request for information. At this time, the Board approved Annual Plan remains unchanged and the organisation continues to plan and take action to deliver the Annual Plan as agreed at the March 2025 Board meeting. More specific details will be provided to the July 2025 Board meeting.

It is possible that changes may need to be made to the Annual Delivery Plan. The quarterly monitoring and review process includes a change request process which can be used for this purpose, ensuring both the appropriate rigour and discipline required to track and deliver progress against the plan, alongside an element of agility and flexibility to respond to changing requirements.

Review, monitoring and assurance

The Annual Delivery Plan enables Quarterly reports of progress against this plan to be produced, moderated through Executive Committee and considered at Delivery and Performance Committee.

The Delivery Plan has been aligned to the Executive Director portfolios and Executive lead sign off of progress reporting will be maintained. This will ensure that quarterly monitoring reflects the appraisal carried out within Directorates and is given as part of the Lead Executive's accountability for their portfolio and strategic priorities.

The quarterly monitoring and assurance process includes a 'change request' process which is based on proposals of change made by each individual Executive lead and then subject to collective moderation at the Executive Committee. This enables a consideration of the balance of delivery both within individual Executive portfolios and across the plan as a whole.

The consideration of the quarterly reports at Delivery and Performance Committee and subsequently at PTHB Board therefore ensures a clear line of accountability and visibility, including tracking and assuring any variances to the plan.

This provides both rigour in reporting, and an element of agility in delivery, to respond to changing requirements or risks. This is an important component in a complex planning and delivery environment.

The quarterly reports are submitted to Welsh Government as a record of progress against the PTHB Integrated Plan. They are also used to provide information at key performance meetings including the IQPD (Integrated Quality, Performance and Delivery Meetings) and JET (Joint Executive Team Meetings).

NEXT STEPS:

The Annual Delivery Plan will be used as the basis for the quarterly review, monitoring and assurance of progress against plan, as detailed in the body of this paper.

IMPACT ASSESSMENT – NOT REQUIRED FOR THIS REPORT



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Integrated Plan Delivery Plan 2025-26

BRAGG Key

Blue - Complete

Red - Behind schedule

Amber - At risk/issues present

Green - On track

Grey – Not due yet

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Plan on a page 2025 > 2026

Quality is the golden thread across the whole plan, underpinned by the Quality Standards Of Safe, Timely, Effective, Efficient, Equitable and Person-Centred care (STEEEP)

Logic Map

showing the link between Key Drivers, Objectives, Priorities and

CRITICAL ACTIONS

Key Drivers

(aligned with escalation status and de-escalation criteria)

> RISK

Addressing performance/quality/delivery/corporate risk

> RECOVERY

Addressing the drivers of the financial deficit, optimising efficiency and productivity

> SUSTAINABILITY

Delivering 'A Healthy Caring Powys' (Health and Care Strategy) through the Better Together Programme

CRITICAL ACTIONS

in the Delivery Plan 2025 - 26



A whole system approach to wellbeing & prevention

1. Whole system Prevention across the life course
2. Health Protection Response including Vaccination
3. Women, Family and Children's health

CRITICAL ACTION:

- Neurodevelopment Services for Children & Young People



A responsive community based model of care

4. Enhanced Primary & Community Care

CRITICAL ACTION:

- Community Model

CRITICAL ACTION:

- GP Out of Hours

5. Planned Care and Diagnostics

CRITICAL ACTIONS:

- Performance & Delivery
- Referral Optimisation

6. Complex and Continuing Healthcare

CRITICAL ACTION:

- External support for further improvement to develop a new model



Effective care across the Big Four

7. Major Conditions

CRITICAL ACTION:

- High Value High Impact Pathways: Diabetes (2025/26)

8. Mental Health

CRITICAL ACTION:

- Transformation Programme



Sustainable and resilient health care

9. Community Hospital Model and Rural Regional Centre

CRITICAL ACTION:

- Optimising inpatient pathways and bed use

10. Improve System Resilience

CRITICAL ACTION:

- Six Goals Plan – further development of Hub

11. Commissioning for Value

CRITICAL ACTION:

- Strategic and Tactical Commissioning Framework

Wellbeing Objectives

Strategic Priorities

Enablers



WORKFORCE FUTURES

CRITICAL ACTION:

- Workforce Transformation



DIGITAL FIRST

CRITICAL ACTIONS:

- Cybersecurity
- WCCIS Replacement



INNOVATIVE ENVIRONMENTS



TRANSFORMING IN PARTNERSHIP

CRITICAL ACTION:

- RPB Prioritisation for greatest system impact



Focus on Wellbeing

Strategic Priority 1: Whole system Prevention across the life course Executive Director of Public Health

Intended Outcome/ Impact

Population and system outcomes (longer term impacts):

- A joined-up preventative approach, helping to create conditions to be well and healthier for longer, addressing health inequalities
- Reducing preventable mortality and ill health
- Contribute to preventing a rise in childhood (under 5s) obesity rates by 2030
- Delivery against National programme requirements for smoking cessation and healthy weights
- Delivery against NHS Wales Performance Framework for health improvement related measures

Progress against key actions and milestones

Key Areas of Delivery	Key Deliverables	Lead Executive	Status				Year End Delivery Confidence Assessment
			Q1	Q2	Q3	Q4	Initial
1.1) Work with partners to develop and commence implementation of a population health strategic framework for Powys (subject to funding)	1.1.1) Commence implementation of a whole system population-level prevention framework (subject to funding) Q4	ED PH	Select				Medium
	1.1.2) Population Health Strategic Framework presented and discussed at PTHB Board Q1						
	1.1.3) Framework consultation activities held with PTHB stakeholders to co-produce and prioritise areas of focus Q2						
	1.1.4) Framework governance and funding arrangements agreed Q3						
	1.1.5) Review of new return on investment publications to be undertaken Q3						

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1.2) Delivery of health board-led population level health improvement programmes, ensuring an equity focus	1.2.1) Implement the Powys Whole System Approach to Healthy Weights action plan Q1-Q4		Select				High
	1.2.2) Develop and implement a proactive promotion and engagement plan, to support smokers to quit through accessible and equitable services in the community Q1-Q4						
	1.2.3) Work with partners to prepare for pending legislation on tobacco and vaping Q3						
	1.2.4) Refresh and update the Powys Tobacco Control Delivery Plan to align with national plan (when published) Q4						
	1.2.5) Deliver Making Every Contact Count training Q1						

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Focus on Wellbeing

Strategic Priority 2: Health Protection Response including Vaccination Executive Director of Public Health

Intended Outcome/ Impact

Population and system outcomes (longer term impacts):

- Reducing preventable mortality and ill health, contributing to addressing health inequalities
- Preventing infections and avoidable harm including responding to incidents/outbreaks
- System impacts include prevention of avoidable healthcare utilisation and treatments including hospital admissions and GP consultations
- Delivery against national frameworks and requirements for vaccination, immunisation and screening, inequities in uptake are narrowed
- Wider impacts on decreasing GP consultations, treatment and hospital admissions and incidents/outbreaks

Progress against key actions and milestones

Key Areas of Delivery	Key Deliverables	Lead Executive	Status				Year End Delivery Confidence Assessment
			Q1	Q2	Q3	Q4	
2.1) Ensure emergency preparedness and organisation resilience and compliance against Civil Contingencies Act	2.1.1) Review of civil contingency response plans - including participation in training and exercises Q1-Q4	ED PH	Select				High
2.2) Provide Health Protection response to all hazards in line with Communicable Disease Outbreak Plan for Wales	2.2.1) Deliver proactive and reactive health protection to protect the population and vulnerable groups from communicable disease Q1-Q4		Select				Medium
2.3) Implement respiratory vaccination programme in line with Welsh Government directives, narrowing inequities and maximising uptake in all groups	2.3.1) Plan and deliver annual respiratory vaccination programmes Q1, Q3, Q4		Select				High

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	2.3.2) Plan and deliver central contracting of Influenza vaccine Q3					
2.4) Implement immunisation schedule in line with National Immunisation Framework and Welsh Health Circulars, narrowing inequities and maximising uptake in all groups	2.4.1) Plan and deliver vaccination programmes Q1-Q4		Select			High
	2.4.2) Plan for changes to childhood routine immunisation schedule (MMR2) Q4					
	2.5.1) Deliver Making Every Contact Count training (includes screening) Q1 (recorded in 1.2.5)		Select			High
2.5) Promote uptake of national screening programmes in partnership with Welsh Government and Public Health Wales	2.5.2) Ensure PTHB is represented in planning for proposed lung cancer screening in Wales Q1-Q4					
	2.5.3) Annual assurance update to committee regarding adult screening programme performance in Powys delivered by Public Health Wales Q4					

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Focus on Wellbeing

Strategic Priority 3: Women, Family and Children's health Executive Lead - Executive Director of Nursing, Quality, Women and Family Health

Intended Outcome/ Impact

Population and system outcomes:

- Improved outcomes for children, young people, women and families through holistic care tailored to their needs and earlier targeted interventions for those in need of support, with equitable access to services and improved citizen experience
- Contributing to addressing health inequalities
- Delivery against NHS Wales Performance Framework – in particular improvement in access to Neurodevelopment services for children and young people

Progress against key actions and milestones

Key Areas of Delivery	Key Deliverables	Lead Executive	Status				Year End Delivery Confidence Assessment
			Q1	Q2	Q3	Q4	Initial
3.1) Develop, design and implement a Children's Neurodevelopment (ND) service that is family and child centred in line with national standards CRITICAL ACTION	3.1.1) Embed and sustain improvements in the Children's ND Improvement Plan Q1	ED NQW&FH	Select				High
	3.1.2) Ensure a clear delivery model is in place aligned to demand and capacity modelling along with population need and mapping for future prevalence Q2						
	3.1.3) Ensure a robust workforce model is in place Q2						
3.2) Implementation of Welsh Government Strategy for Women's Health	3.2.1) Develop, design and commence implementation of the Powys Women's Health Plan, including scoping the Women's Health Hub model for Powys (dependent on Welsh Government funding) informed by the All-Wales Strategy and Plan for Women's Health Q1-Q4		Select				High
3.3) Implement a robust and safe Children's Continuing Health Care (CHC) service	3.3.1) Implement PTHB Children's Continuing Health Care service with a robust workforce plan Q1-Q3		Select				High

3.4) Commence intention to become a UNICEF Baby Friendly Organisation	3.4.1) Undertake commitment of intent with UNICEF Baby Friendly Initiative UK Q1		Select				High
	3.4.2) Completion of Stage 1 Accreditation Q3						

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Early Help and Support

Strategic Priority 4: Enhanced Primary & Community Care Executive Lead - Executive Director of Primary Care, Community and Mental Health, Executive Medical Director

Intended Outcome/ Impact

Population and system outcomes (longer term impacts):

- Work in this area will contribute to the development of a sustainable model of care longer term, particularly in relation to the enhanced community care developments
- Longer term, this will create a value based approach across all services, optimising use of resources for greatest impact and outcomes
- Improving equity of access and supporting the shift to a preventive approach, contributing to addressing health inequalities
- Delivery against NHS Wales Performance Framework for measures relating to community and primary care
- Delivery against People's Experience Framework in relation to patient and carer reported outcomes and experience
- Ensures implementation of the WG Hospital Pharmacy review recommendations

Specific improvements in services and pathways including:

- Those relating to the community model i.e. Integrated Community Teams
- GP Out of Hours service provision
- Co-ordination of the last year of life
- Coherent and engaged cluster groups across Powys working together to provide quality and timely services for patients closer to home
- Committed primary care workforce working to top of competencies leading to resilient sustainable and engaged primary care services
- Primary care services operating in line with contracts and regulations with focus on clinical activity

Progress against key actions and milestones

Key Areas of Delivery	Key Deliverables	Lead Executive	Status				Year End Delivery Confidence Assessment
			Q1	Q2	Q3	Q4	Initial
4.1) Enhanced Community Care Model Develop and implement a new Enhanced Community Care	4.1.1) Carry out a strategic assessment of community provision including delivery of MDTs, Community Resource Team/Virtual Ward, Directed Supplementary Service (DSS), outcomes, variation, best practice and opportunities Q1	ED PCC & MH	Select				High

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model incorporating Frailty, Virtual Ward and Hospital @ Home in a Powys context and the development of Integrated Community Teams CRITICAL ACTION	4.1.2) Complete a strategic assessment of the existing community based MDTs in Powys to learn from existing good practice and identify opportunities (linked to similar work in Mental Health) Q1					High
	4.1.3) Design a new model for Enhanced Community Care with stakeholders Q1					High
	4.1.4) Develop and agree with partners (primary care, social care and third sector) the workforce scope and geographical structure Q1					Medium
	4.1.5) Check, challenge and test the proposed model through engagement with staff, stakeholders and partners Q2					Medium
	4.1.6) Commence implementation of the integrated community model across all localities in Powys Q4					Medium
4.2) GP Out of Hours (OOH) CRITICAL ACTION	4.2.1) Extend the Shropdoc contract to sustain existing services subject to the assessment of delivery Q1	Select				Medium
	4.2.2) Re-tender for an Out Of Hours service provision Q2-Q3					Medium
	4.2.3) Resolve and commission SBUHB to deliver for Ystradgynlais Q1					Low
4.3) Last Year of Life Improve coordination for Powys patients	4.3.1) Finalise the model to improve the coordination of the Last Year of Life Q1-Q2	Select				Medium
	4.3.2) Implement the new model through a phased approach with partners Q3-Q4					
4.4) Fracture Liaison Improve access to Fracture Liaison Services for Powys patients	4.4.1) Subject to approval, recruit to new posts to better coordinate access to Fracture Liaison Services for Powys patients Q1-Q2	Select				High
	4.4.2) Work with partners in primary care and acute care to improve the performance of the core Fracture Liaison Service Q3-Q4					

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4.5) Falls Response Design and deliver a community-based falls response service in a Powys context	4.5.1) Scope and design a community-based falls response service with partners that meets the needs of a rural population Q1-Q2	Select				Medium				
	4.5.2) Implement the phased delivery of the community-based falls response service Q3-Q4									
4.6) Cluster Development Develop a robust planning and delivery framework at a cluster and collaborative level, capable to deliver at scale for the population	4.6.1) Cluster and Collaborative Lead engagement and maturity development Q1-Q4					Select				High
	4.6.2) Develop Powys-wide Cluster reporting, governance and engagement with Regional Partnership Board Executive Q1-Q4									High
	4.6.3) Implementation of Dental Collaborative (pending national negotiation outcome) Q2-Q4									Low
	4.6.4) Develop the Professional Nursing Collaborative Q2-Q4									Medium
	4.6.5) Develop the Optometry Collaborative Q1-Q4									High
	4.6.6) Continue to identify services best delivered at cluster or pan-cluster level Q1-Q4									High
	4.6.7) Develop Accelerated Cluster Development delivery programme with focus on streamlining, outcomes and benefits realisation to support ‘shift left’ Q1									High
4.7) General Medical Services (GMS) Ensure an equitable, robust and sustainable model of core GMS across Powys to enable broader primary and community development	4.7.1) GMS Practice Sustainability analysis, review, and action planning Q2	Select				High				
	4.7.2) Monitor GMS provision in mid cluster, and if appropriate scope alternative models to support patient access Q1-Q4					High				
	4.7.3) Access Standards analysis, review and action planning Q1					High				
	4.7.4) Unified Contract Assurance Framework assurance and outcome management Q2-Q4					High				
	4.7.5) Quality Improvement Framework – project analysis and action planning Q1-Q2					High				

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	4.7.6) Supplementary Service audit review, analysis and feedback Q2-Q3						High
4.8) Optometry Ensure continued growth of community optometric services to enable a wider range of eye care services to be delivered within Powys	4.8.1) Systematic tracking of core hour provision Q2		Select				High
	4.8.2) Support and track access in relation to IPOS (Independent Prescribing Optometrists) Q1						High
	4.8.3) Implement Special School Primary Eyecare (SPECS) pathway following national agreement Q3						Medium
	4.8.4) Implement pathways with outreach Ophthalmology Services, clusters and Optometry practices for Glaucoma and Medical Retina pathways Q1-Q2						Medium
	4.8.5) Support and track access to specialist services in relation to Welsh Government Optometry Services (WGOS4) (Medical Retina and Glaucoma) and WGOS 5 Q1-Q4						High
4.9) Dental Services Grow capacity and sustainability of dental, orthodontic and special care dentistry services across Powys	4.9.1) Maintain urgent access in General and Community Dental Service to balance demand and capacity Q1		Select				Medium
	4.9.2) Welsh Enhanced Recruitment Offer enhanced offer for Dental Foundation dentists Q1-Q4						High
	4.9.3) Continue to transfer patients from the Dental Access Portal to salaried General Dental Practitioner (GDP) in line with contract reform Q1						High
	4.9.4) Development of remote specialist in special care post Q1-Q4						Medium
	4.9.5) Develop IV sedation service in the Community Dental Service Q4						High
	4.9.6) Enhance specialist services within Community Dental Service by developing consultant led restorative and paediatrics Q4						High

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	4.9.7) Utilization of digital technology to improve efficiency and patient experience Q4					Medium
	4.9.8) Formalise special care dentistry pathways with external providers for special care patients who are unable to be treated safely in Powys Q4					Medium
	4.9.9) Systematic review and contractual change to enhance capacity for dental & orthodontic care Q1-Q4					High
4.10) Primary & Community Care Academy Develop educational offer across primary and community services to ensure improving leadership, collaborative, administrative and clinical skills	4.10.1) Continue to support the new to General Practice Nursing foundation programme Q1-Q4		Select			High
	4.10.2) Develop workshops to support Primary Care Nursing & Allied Health Professionals to access advanced and extended practice skills Q1 & Q4					High
	4.10.3) Deliver scenario-based training for non-clinical staff in primary care Q2-Q4					High
	4.10.4) Develop cluster & collaborate lead workshops Q2					High
	4.10.5) Provide a range of training for Practice Managers to upskill and improve sustainability and business continuity Q1-Q4					High
	4.10.6) Expand range of training for clinical support workers in primary care Q1-Q4					High
4.11) Medicines Management/Pharmacy: Optimising Medicines Use	4.11.1) Improve Prescribing Efficiency: Implement the 10 Medicines priorities identified by Value and Sustainability Board Q1-Q4	EMD	Select			High
	4.11.2) Implement the roll out of Bluteq Q1-Q4					Medium
	4.11.3) Support Deprescribing: working with frailty teams, promote polypharmacy reviews, develop deprescribing pathways for patients on unnecessary or potentially harmful medications, particularly in elderly and multimorbid patients Q1-Q4					Medium

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4.12) Enhancing Patient Safety & Medicines Governance	4.12.1) Improve Medicines Safety Culture: Promote reporting and learning from medication incidents to reduce avoidable harm Q1-Q4		Select				Medium
	4.12.2) Deliver improvement in antimicrobial prescribing Q1-Q4						
	4.12.3) Deliver improvement in opiate prescribing Q1-Q4						
	4.12.4) Deliver improvement in gabapentin prescribing Q1-Q4						
	4.12.5) Provision of pharmacy professional support for Mental Health wards and service Q2-Q4						
4.13) Expanding Community Pharmacy & Primary Care Integration	4.13.1) Develop Community Pharmacy Services: Expand services including needle and syringe exchange, blood borne virus testing, minor ailment consultations Q1-Q4		Select				High
	4.13.2) Implement Electronic Prescribing and Medicines Administration (ePMA) Q2-Q4						
	4.13.3) Implement Electronic Prescribing System Q1-Q4						
4.14) Workforce Development & Sustainability	4.14.1) Increase pharmacy work based training places to support new schools of pharmacy and collaboration with HEIW Q2		Select				Medium
	4.14.2) Support for development of portfolio roles Q1-Q4		Select				High
	4.14.3) Support Continuing Professional Development (CPD): Focus on supporting development of Independent Prescribers Q1-Q4		Select				High
4.15) Public Health & Preventative Medicine	4.15.1) Expand Vaccination & Public Health Roles: Strengthen pharmacy-led vaccination programmes, smoking cessation, and weight management Q1-Q4		Select				Medium

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	4.15.2) Support for roll out of self-administration of medicines Q1-Q4		Select				High

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Early Help and Support

Strategic Priority 5: Planned Care and Diagnostics Executive Lead - Executive Director of Planning, Performance, and Commissioning, Executive Director of Allied Health Professions, Health Sciences and Digital

Intended Outcome/ Impact

Population and system outcomes (longer term impacts):

- Work in this area will contribute to the development of a sustainable model of care longer term, particularly in relation to planned care
- Longer term, this will create a value based approach across all services, optimising use of resources for greatest impact and outcomes
- Improving equity of access and supporting the shift to a preventive approach, contributing to addressing health inequalities
- Delivery against NHS Wales Performance Framework including access measures for Referral to Treatment (RTT) and Diagnostics
- Delivery against People's Experience Framework in relation to patient and carer reported outcomes and experience

Specific improvements in services and pathways including:

- Improved resilience and utilisation of provider services capacity where appropriate
- Facilitate coordination of services across sectors to deliver more holistic and joined up pathways of care.
- Delivery of outcomes in line with GIRFT recommendations
- Recovery of access times and waiting lists
- Reduction in RTT waiting times for patients requiring planned surgery or diagnostic tests
- Delivery of service closer to patients home reducing unnecessary travel and number of appointments

Progress against key actions and milestones

Key Areas of Delivery	Key Deliverables	Lead Executive	Status				Year End Delivery Confidence Assessment
			Q1	Q2	Q3	Q4	Initial
5.1) Delivery of prioritised strategic planned care improvements	5.1.1) Implementation of Clinically led referral optimisation model for Planned Care (Ophthalmology and Orthopaedics) – joint work across Transformation, Operational teams, Commissioning and Digital CRITICAL ACTION Q1-Q3	ED PP&C	Select				High
	5.1.2) Strategic assessment of provided and commissioned planned care Q4						

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	5.1.3) Development and delivery of consolidated priority speciality delivery plan Q2-Q4				
	5.1.4) Review and implementation of plan for in-reach provision Q3				
	5.1.5) Continued development of Planned Care Quality & Safety Framework Q1-Q4				
	5.1.6) Development of 3Ps Waiting Well Service, business case for recurrent funding Q2-Q4				
	5.1.7) Continued participation and response to National Planned Care Programme Q1-Q4				
5.2) Pathway Development Muscular Skeletal / Orthopaedics	5.2.1) Implementation of MSK/orthopaedic pathways transformation business case, service development in line with Orthopaedic Optimisation Framework Q1-Q4		Select		High
5.3) Eyecare (ophthalmology)	5.3.1) Develop business case for ophthalmology pathway transformation Q1-Q4		Select		High
	5.3.2) Service development in line with Ophthalmology Optimisation Framework Q1-Q4				
	5.3.3) Scope opportunity for eyecare surgical hub in Powys Q1-Q4				
5.4) Continue the development/transformation of Endoscopy/Colorectal pathways in Powys	5.4.1) Cost plan for appointment of lead via SLA or speciality sessions pan Powys Q2		Select		Low
	5.4.2) Development of Endoscopy service in line with National Plan including work to maintain and scope opportunity to improve against JAG standards Q1-Q4				
5.5) Develop pre-operative pathways of care	5.5.1) Development of environment at Brecon Hospital for preoperative assessment Q3		Select		High
	5.5.2) Plan for collaboration with Primary Care to enable whole system approach Q2				
	5.5.3) Development of specialist workforce to deliver peri operative care Q4				

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5.6) Theatres: Development of key day case pathways	5.6.1) Development of theatre dashboard in line with national programme Q3		Select				High
	5.6.2) Implementation of all day lists ophthalmology/orthopaedics 2025/26 Q4						
	5.6.3) Anaesthetics specialty lead for PTHB resourced from SLA underperformance Q2						
	5.6.4) Digitalisation – costed proposal for theatre management system Q1						
	5.6.5) Review of day case procedures to identify opportunities for repatriation Q2						
5.7) Outpatients: Develop a single management system and oversight	5.7.1) Development of Outpatients in core specialities aligned to Planned Care optimisation frameworks with focus on discharge pathways SOS/PIFU, digital and MDT development Q1-Q4		Select				High
	5.7.2) Develop business case and delivery model for clinical room booking system Q1-Q4						
5.8) Diagnostics transformation	5.8.1) Strategic assessment and implementation of plan for diagnostics Q2-Q4		Select				Medium
5.9) Point of Care Testing (POCT) Improved assurance and governance	5.9.1) Add all connectable devices to WPOCT Q1-Q2	ED AHPHS&D	Select				High
	5.9.2) Expand POCT in support of clinical pathway development and governance Q1-Q4						
	5.9.3) Monitor Internal Quality Control (IQC) & External Quality Assurance (EQA) Q2-Q3						
	5.9.4) Establish model for working with Primary Care Q1-Q2						
	5.9.5) Review and develop existing POCT provision and governance: Develop QA Compliance framework including audits and KPIs for all devices in use Q2						
	5.9.6) Monitor training and develop collaborative model with Suppliers and Clinical Education teams for all POCT devices currently in use Q1-Q4						

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	5.9.7) Identify further opportunities for POCT within PTHB Q2-Q4						
	5.9.8) Identify opportunities in primary & community care Q2						

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Early Help and Support

Strategic Priority 6: Complex and Continuing Healthcare Executive Lead - Executive Director of Primary Care, Community and Mental Health

Intended Outcome/ Impact

Population and system outcomes (longer term impacts):

- Delivery of, and compliance with, the National Framework for NHS Continuing Healthcare
- Clear arrangements in place with other NHS organisations, independent or voluntary sector partners to ensure effective operation of the Framework
- Implement improvements recommended by external support including finance, audit and national targets
- Delivery against National Framework for NHS Continuing Healthcare

Specific improvements in services and pathways including:

- Improved process for CHC applications and understanding of trends within PTHB through work with NHS Executive
- Governance arrangements for NHS Continuing Healthcare eligibility processes and commissioning NHS Continuing Healthcare packages
- System in place to record assessments undertaken and their outcomes, and the costs of NHS Continuing Healthcare packages
- Implementing and maintaining good practice; ensuring that quality standards are met and sustained

Progress against key actions and milestones

Key Areas of Delivery	Key Deliverables	Lead Executive	Status				Year End Delivery Confidence Assessment
			Q1	Q2	Q3	Q4	
6.1) External expertise will be commissioned to fully appraise any further improvements and develop a new model CRITICAL ACTION	6.1.1) Expertise commissioned and appraisal completed Q1-Q2	ED PCC&MH	Select				Medium
	6.1.2) Outputs of appraisal used to inform further improvement plan Q2						
6.2) Systematic review of high growth commissioned activity – cost and volume, to determine further improvement activity	6.2.1) Review of private providers, specifically for adult mental health needs Q1		Select				Medium
	6.2.2) Review of high growth activity – specifically Learning Disability and Elderly Mentally Infirm (EMI) Q1-Q2						

	6.2.3) Design of alternative opportunities for care provision which offers sustainability, value and experience Q3-Q4					
6.3) Improve Health Board processes to support effective and efficient commissioning	6.3.1) Process scrutiny of diverse funding applications - Number of Continuing Healthcare (CHC) & Funded Healthcare (FNC) applications approved at Panel Q1-Q4	Select				High
	6.3.2) Chase details of individual patients to evidence eligibility for care - Number of Fast Track and Joint/Section 117 applications approved at Panel Q1-Q4					
	6.3.3) Progress patient flow from hospital - Number of Reviews undertaken on time Q1-Q4					
	6.3.4) Monitor care setting availability daily to secure care provision and match with patient need - Patient need is matched with care setting availability in the community Q1-Q4					
6.4) Develop robust mechanism for capturing data and processing information in order to support better commissioning and care	6.4.1) Maintaining over 85% of reviews within time Q1-Q4	Select				High
	6.4.2) Clear analysis of changes and trends which supports planning for Years 3-5 Q3-Q4					
6.5) Progress Retrospective CHC Claims	6.5.1) Complete Retrospective Claims within mandatory timescale to divert from interest on payments Q1-Q4	Select				High
6.6) Enhance complex care commissioning against regional and national standards	6.6.1) NHS Executive work with Hywel Dda UHB - To benchmark and gain understanding of trends within PTHB Q1	Select				High
	6.6.2) Work with Public Health - Learn from the outcomes of public health demographics Q1					
	6.6.3) Internal Audit Action Plan - Implement Internal Audit Action Plan responses Q1-Q2					
	6.6.4) Value & sustainability – to ensure learning and delivery against the 7 national recommendations Q1-Q4					

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Tackling The Big Four

Strategic Priority 7: Major conditions (Cancer, Respiratory, Circulatory, Cardiac, Stroke, Diabetes) Executive Lead - Executive Medical Director / Executive Director of Allied Health Professions, Health Sciences and Digital / Executive Director of Nursing, Quality, Women and Family Health / Executive Director of Planning, Performance and Commissioning

Intended Outcome/ Impact

Population and system outcomes (longer term impacts):

- Work in this area will contribute to the development of a sustainable model of care longer term, particularly in relation to planned care
- Longer term, this will create a value based approach across all services, optimising use of resources for greatest impact and outcomes
- Improving equity of access and supporting the shift to a preventive approach, contributing to addressing health inequalities
- Delivery against NHS Wales Performance Framework including access measures for Referral to Treatment (RTT) and Diagnostics
- Delivery against People's Experience Framework in relation to patient and carer reported outcomes and experience

Specific improvements in services and pathways including:

- Improved resilience and utilisation of provider services capacity where appropriate
- Facilitate coordination of services across sectors to deliver more holistic and joined up pathways of care.
- Delivery of outcomes in line with GIRFT recommendations
- Recovery of access times and waiting lists
- Reduction in RTT waiting times for patients requiring planned surgery or diagnostic tests
- Delivery of service closer to patients home reducing unnecessary travel and number of appointments

Progress against key actions and milestones

Key Areas of Delivery	Key Deliverables	Lead Executive	Status				Year End Delivery Confidence Assessment
			Q1	Q2	Q3	Q4	Initial
7.1) Deliver improvements in High Value High Impact pathways (Diabetes) CRITICAL ACTION	7.1.1) Implement improvements in the High Value High Impact pathways aligned to Value & Sustainability Board priorities – Diabetes Q1-Q4	ED PCC&MH	Select				Medium
	7.1.2) Review the outcomes in Powys of existing Diabetes care and pathways Q1						Medium

	7.1.3) Scope the potential to provide elements of the hybrid closed loop pathway closer to home Q1-Q2						High
	7.1.4) Further Faster review in reach general medical endocrinology (Links to eye care referral management diabetic retinopathy pathway) Q2						High
	7.1.5) Develop cluster model to enhance the 8 care process outcomes Q2-Q3						Medium
	7.1.6) Implement changes to the hybrid closed loop pathway Q3-Q4						High
	7.1.7) Implement enhanced primary & community Diabetes pathway Q4						Medium
7.2) Cancer	7.2.1) Delivery against Cancer Improvement plan Q1-Q4	EMD	Select				High
	7.2.2) Continue to work with Commissioned Service Providers to identify areas of the suspected Cancer pathway which could be improved Q1-Q4						
	7.2.3) Work with the Cancer Network to implement innovations to support earlier diagnosis and reduce waiting times Q1-Q4						
	7.2.4) Continue the Improving the Cancer Journey Programme Phase 2 Q1-Q4						
	7.2.5) Annual review of the PTHB Cancer Improvement Plan Q1-Q4						
7.3) Respiratory	7.3.1) Further Faster review of in reach respiratory provision Q2	ED AHPHS&D	Select				High
	7.3.2) Pilot remote monitoring of clinically appropriate Powys patients with respiratory conditions Q1-Q4						
	7.3.3) Evaluate the impact of the remote monitoring of Powys patients with respiratory conditions and confirm the next steps Q4						
7.4) Cardiac	7.4.1) Further Faster review of in reach cardiology consultants Q2	ED PCC&MH	Select				Medium
	7.4.2) Develop sustainable solutions and county wide options for echocardiology & baseline against standards Q3						

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	7.4.3) Rheumatology – scope opportunities for Multi-Disciplinary Team (MDT) different approach with medicines management Q4						
7.5) Stroke	7.5.1) Continue to work with commissioned service providers to ensure neighbouring Health Board and NHS Trust plans appropriately reflect provider responsibilities to Powys residents (including Hereford and Worcestershire Stroke Service Changes) Q1-Q4	ED PP&C	Select				Medium
	7.5.2) Ensure clinical engagement on the National Stroke Programme (including future option for current temporary changes in place at Cwm Taf Morgannwg University Health Board) Q1-Q4						

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Tackling The Big Four

Strategic Priority 8: Mental Health Executive Lead - Executive Director of Primary Care, Community and Mental Health

Intended Outcome/ Impact

Population and system outcomes (longer term impacts):

- A shift to prevention of major conditions, contributing to addressing health inequalities and equity of access
- Improved support for those living with major conditions and associated with that, more effective and higher value use of healthcare
- Delivery against NHS Wales Performance Framework including access measures for Referral to Treatment (RTT) and Diagnostics
- Delivery against People's Experience Framework in relation to patient and carer reported outcomes and experience
- Delivery of outcomes in line with condition specific requirements i.e. single cancer pathway, quality statements, GIRFT recommendations

Service and Pathway improvements:

- Delivery of principles of prehabilitation to rehabilitation
- Enhanced coordination of services across sectors to deliver more holistic care for people living with major conditions in Powys
- Improved resilience and utilisation of provider services capacity where appropriate
- Improved value based evidence (outcomes, variation, cost, programme budgeting and high cost user data) to guide pathway improvements, to drive system efficiency and improve clinical outcomes and patient experience

Progress against key actions and milestones

Key Areas of Delivery	Key Deliverables	Lead Executive	Status				Year End Delivery Confidence Assessment
			Q1	Q2	Q3	Q4	Initial
8.1) Mental Health Transformation Programme CRITICAL ACTION	Community Model Re-Design for Mental Health Services	ED PCC&MH	Select				High
	8.1.1) Complete strategic assessment of community based MDTs and identify opportunities Q1						
	8.1.2) Continue transformation of front door building on Single Point of Access aligned to 111(2) Q1-Q4						High
	8.1.3) Implement electronic GP referral to SPOA Q2						Medium
	8.1.4) Undertake demand and capacity modelling (health and care) Q1-Q2						Low

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	8.1.5) Redefine core offer / care and treatment pathways with new recovery focused model Q3-Q4					Medium
	8.1.6) Design community model to deliver core offer, aligned to wider community model Q3-Q4					Medium
	8.1.7) Develop phased implementation plan Q4					Medium
	8.1.8) Rescope Sanctuary model in above context, in North Powys Q2-Q3					Low
	8.1.9) Align teams to address co-morbidities and complex needs across health and care Q3					Low
	8.1.10) Align specialist teams (including Complex Emotional Needs service) Pan Powys Q3-Q4					Low
	8.1.11) Leverage digital opportunities e.g. access to information, virtual appointments, data collection and reporting Q1-Q4					Medium
	Acute Inpatient Model of Care					High
	8.1.12) Further planning and design following recommendations of Supportive Assessment by NHS Executive in March 2025 Q1					High
	8.1.13) Consideration of optimum bed / ward configuration in line with Strategic Priority 9 (which includes period of engagement for any proposed redesign and service change) Q1-Q4					Low
	Older Adult Mental Health Services					High
	8.1.14) Clinical review of existing model and demand / capacity analysis (linked to work above) Q1					High
8.2) Suicide and Self Harm Prevention & Postvention	8.1.15) Service improvement learning from Phase 1 Dementia Home Treatment Team (Design / implementation of model part of wider work noted above) Q1-Q2					High
	8.2.1) Deliver the Suicide and Self Harm Prevention Strategy 2024-2034 with particular focus on: - Developing the pathways for people who self-harm - Further aligning crisis support with the Single Point of Access	Select				High

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	○ Promoting the provision of specialist postvention support ○ Ongoing suicide surveillance and rapid response to suspected suicides Work with partners to implement strategy, building resilience of communities and responding to learning Q1-Q4						

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Strategic Priority 9: Community Hospital Model and Rural Regional Centres Executive Lead - Executive Director of Primary Care, Community and Mental Health

Intended Outcome/ Impact

Population and system outcomes (longer term impacts):

- Work in this area will contribute to the development of a sustainable model of care longer term, particularly in relation to infrastructure
- Longer term, this will create a value based approach across the use of the estate, optimising use of resources for greatest impact and outcomes
- Improving equity of access and supporting the shift to a use of resource for the greatest impact, contributing to addressing health inequalities
- Improve stakeholder understanding of the challenges and changes needed in the system as a result of continued engagement
- Lead to greater co-production of the design and delivery of the model of care
- Enable risk stratification and improved intelligence about population need
- Environments in which care is delivered are also important for delivery against the People's Experience Framework/ patient and carer reported outcomes and experience / quality of care across all six domains of the framework

Specific improvements in services and pathways including:

- Improved resilience and utilisation of provider services capacity where appropriate
- Enabling progression against the local Health and Care Strategy and Cabinet Secretary priority to further enhance community capacity
- Improved patient flow, reduction in delayed transfers and reduced length of stay
- Reduction in emergency activity / admission avoidance where appropriate
- Increased activity in relation to preventative and wellbeing interventions
- Optimised utilisation of community based care
- Improved co-ordination of care including end / last year of life
- Improved join up of physical and cognitive frailty approach
- Prevention of deconditioning

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Progress against key actions and milestones

Key Areas of Delivery	Key Deliverables	Lead Executive	Status				Year End Delivery Confidence Assessment
			Q1	Q2	Q3	Q4	Initial
9.1) Optimising inpatient care and bed utilisation CRITICAL ACTION	Colocation by clinical need 9.1.1) Complete the evaluation of Temporary Service Changes (Ready to Go Home Units and Rehabilitation Units) with learning to be considered in developing future models of care (as part of SP4 Community Model) Q1	ED PCC&MH	Select				High
	9.1.2) Implement recommendations including any rostering improvements (reflected in Workforce Futures and as part of SP4 Community Model) Q2-Q4						
9.2) Review and develop the Community Hospital, Community Wellbeing Hub and Rural Regional Centre model across all service groups including ongoing development of the North Powys Wellbeing Programme	9.2.1) Develop and engage with public, staff and stakeholders on the Case for Change and emerging solutions to respond to the issues identified including development of the SOC/ OBC for Phase 1 for the North Powys Wellbeing Programme Q1		Select				High
	9.2.2) Engage with public, staff and stakeholders on the development of options to improve quality of services and make better use of resource Q2						
	9.2.3) Commence formal consultation on the options (if required) Q3						
	9.2.4) Confirm the new model Q4						

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Strategic Priority 10: System Resilience Executive Lead - Executive Director of Primary Care, Community and Mental Health

Intended Outcome/ Impact

Population and system outcomes (longer term impacts):

- System resilience is a key priority given the challenges and constraints placed on the health board by system pressures – the PTHB Six Goals plan is a component of delivery to improve system efficiency and flow (locally and in neighbouring systems)
- Improving system effectiveness and efficiency (locally and across all neighbouring systems) is key to achieving the longer term shift to a prevention based model of care and associated shift to value based use of resources for population health
- Supporting delivery across the NHS Wales People's Experience Framework and Six Domains of Quality

Specific improvements in services and pathways including:

- Delivery against National Six Goals Urgent and Emergency Care Programme requirements
- As a provider, continued excellence in performance of urgent care services (i.e. Minor injuries measures)
- Improved patient flow, reduction in delayed transfers and reduced length of stay as a provider and in relation to PTHB role in wider systems
- Improvements in performance in key areas of high impact and value – notably Discharge to Recover and Assess
- Reduction in emergency activity / admission avoidance where appropriate
- Increased efficiency of bed base utilisation – greater value based approach to care to improve outcomes and experience

Progress against key actions and milestones

Key Areas of Delivery	Key Deliverables	Lead Executive	Status				Year End Delivery Confidence Assessment
			Q1	Q2	Q3	Q4	Initial
10.1) Refine the Integrated Flow Hub to develop a sustainable model that enhances system-wide coordination and patient flow	10.1.1) Scope and define the role and priorities of the Integrated Flow Hub, including the development of a resource plan Q1	ED PCC&MH	Select				High
	10.1.2) Subject to scoping, secure necessary resourcing including workforce and digital technologies for effective and sustainable implementation Q2						

CRITICAL ACTION	10.1.3) Implement a revised approach to the Integrated Flow Hub, ensuring alignment with identified role and priorities Q3					
	10.1.4) Assess the effectiveness and impact of the revised Integrated Flow Hub, identifying lessons learned and opportunities to support long-term sustainability Q4					
10.2) Improved approach to Pathways of Care Delays (POCD) through escalation and tracking and working in partnership to deliver the recommendations of the Newton Europe diagnostic report.	10.2.1) Reduce the number of service users experiencing Pathways of Care Delays (POCDs) through escalation and tracking Q1-Q4	Select				High
	10.2.2) Reduce the number of super-stranded patients through escalation and tracking Q1-Q4					
	10.2.3) Work in partnership with PCC to improve social care delays through the recommendations of the Newton Europe diagnostic report Q1-Q4					
	10.2.4) Reduce the total number of days delayed due to Pathways of Care delays Q1-Q4					
10.3) Evaluation and Next Step relating to Temporary Service Changes	10.3.1) Evaluate temporary service changes for Minor Injury Units Q1	Select				High
	10.3.2) Based on evaluation, recommendation to be made to PTHB Board meeting in July regarding next steps for Minor Injury Units Q2					
10.4) Enhance the provision of PTHB Urgent Care Services	10.4.1) Conduct a review of current clinical practices and processes to establish key insights to inform the transformation of Urgent Care services Q2	Select				High
	10.4.2) Establish a clear framework and criteria to optimise access and streamline processes Q3					
	10.4.3) Review and scope key clinical pathways to improve the delivery of Urgent Care and inform future service design Q3					
	10.4.4) Advance pathway development - define vision for the future service Q4					
10.5) Further develop PTHB's utilisation of the Optimal Hospital Flow Framework and	10.5.1) Develop R2G and D2RA Information and Performance dashboards Q1	Select				High
	10.5.2) Monitor and review data outputs and identify barriers Q2					

associated tools, with a focus on D2RA and Red2Green	10.5.3) Scope and assess means to address identified barriers Q3		Select				Low
	10.5.4) Develop targeted action plan to address identified barriers 4						
10.6) Further strengthening the approach to Trusted Assessment	10.6.1) Pilot of Trusted Assessment approach Q1		Select				Low
	10.6.2) Review outcomes of the pilot Q2						
	10.6.3) Scoping of next steps Q3						
	10.6.4) Implementation of Trusted Assessment Q4						
10.7) Enhance and expand the use of the Digital Patient Flow System: Powys DigiFLO	10.7.1) Scope the expansion of Powys DigiFLO onto Mental Health Wards Q1		Select				High
	10.7.2) Rollout of Powys DigiFLO to Mental Health Wards Q2						
	10.7.3) Embed Powys DigiFLO into standard practice for Mental Health Q3						
	10.7.4) Refine based on lessons learned from Mental Health implementation Q4						
	10.7.5) Embed all DigiFLO processes into Business as Usual Q4						

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Strategic Priority 11: Commissioning for Value Executive Lead - Executive Director of Planning, Performance and Commissioning

Intended Outcome/ Impact

The Commissioning for Value work programme aims to review services PTHB provides and those services it commissions to ensure that:

- Resources are used wisely to get the best possible outcomes (individual, service, organisation and community) and experience for the population.
- We understand what matters to the population, with an evidence-base for effective interventions, unwarranted variation, outcomes, costs and value.
- Focus on quality outcomes, experience and cost to help ensure that resources are allocated and managed to have the greatest positive impact.
- Discharge commissioning within available resources considering need; resource allocation; service review and gap analysis; demand and capacity.
- Achieve NHS Wales enabling actions including productivity and efficiency measures, and evidence base compliance.
- Robust service specifications underpinning contracted activity levels.
- Focus on resource allocation and management to have the greatest positive impact and on the systems in processes to deliver value.
- A citizen centred approach, putting patients, safety, outcomes and experience as well as safeguarding above all other considerations.
- Development of an annual commissioning and contracting work programme which will support PTHB sustainability and recovery.
- Supporting and driving forward the Better Together Portfolio and sustainable model of care, including Planned Care and Community Model.
- Integrated approach to performance, commissioning and contracting and business intelligence for secondary and specialised services.
- Ensuring local commissioning takes into account NHS Wales and NHS England performance and outcomes frameworks/ productivity and efficiency
- Responding to PTHB accountability conditions and escalation status of Level Four, delivering against associated action plan.
- Working closely with NHS England Integrated Care Boards to align commissioning approaches and reviewing contract design.
- Working with the Joint Commissioning Committee (JCC) as a preferred partner to assess options for pathway and referral optimisation

Progress against key actions and milestones

Key Areas of Delivery	Key Deliverables	Lead Executive	Status				Year End Delivery Confidence Assessment
			Q1	Q2	Q3	Q4	Initial
11.1) Commissioning development Framework CRITICAL ACTION	11.1.1) Develop Strategic Commissioning Framework for tactical commissioning and contracting for 2025/26 based on population health and evidence based practice to improve outcomes and value for population, in context of escalation and plan status. Includes underpinning work on reducing variation and	ED PP&C	Select				High

	implementing national INNU policies and supporting referral optimisation and coordination of Last year of Life Q1				
11.2) Pathway development/redesign Through the application of the PTHB commissioning cycle, Identify and redesign/recommission 2 pathways through clinically led Commissioning Approach; including gynaecology and General Medicine	11.2.1) Establish and secure clinical leadership Q1	Select			Medium
	11.2.2) Review of population need, current and intended outcomes Q2				
	11.2.3) Review existing service provision, undertake gap analysis in context of identified need and relevant national benchmarking data (including evidence base) Q2				
	11.2.4) Determine current provider/commissioner budget, performance and contract frameworks for each pathway Q2				
	11.2.5) Develop proposed service specifications Q2				
	11.2.6) Detail proposed clinical pathways and models of care based on the service specifications Q3				
	11.2.7) Translate clinical pathways and models of care into final specification (including tender documentation if service to be procured) Q3				
	11.2.8) Plan demand and capacity requirements to ensure timely, effective and equitable delivery of the pathway Q3				
	11.2.9) Develop pathway implementation plans Q4				
	11.2.10) Develop performance monitoring and assurance framework Q4				
11.3) Specialised services Work with JCC as a preferred partner to analyse and scope opportunities to improve value; take forward JCC Transformation priorities 2025-26	11.3.1) Establish with JCC preferred partner arrangement Q1	Select			Medium
	11.3.2) Scope opportunities for pathway and referral optimisation (linking to the Critical action set out in SP5) – Q1-Q4				
	11.3.3) Develop implementation plan for identified options – Q1-Q4				
11.4) Develop Fragile Service Risk Assessment methodology	11.4.1) Using national work, agreed methodology to review existing in-reach services and determine options for future commissioning arrangements Q1				Medium

to guide strategic commissioning of in reach						
11.5) Strengthen Integrated Quality and Performance Framework for PTHB as both provider and commissioner	11.5.1) Revised IQPF reflects NHS Wales Planning and Performance Frameworks for 2025-26; revised PTHB internal performance monitoring structure; and revised commissioned service quality and performance review mechanisms Q1		Select			High
11.6) Agree first phase outcomes of Third Sector Review, focussing on admission avoidance, timely discharge and end of life care	11.6.1) Establish review group, clinical and managerial leadership Q2		Select			High
	11.6.2) Updated service specifications and agreement of SLAS with providers Q2-Q3					
	11.6.3) Develop KPI's and agree new reporting metrics Q2					
	11.6.4) Review of Provider Selection Regime and National Commissioning Framework for Hospices, Mental Health and other third sector services in support of future commissioning approach Q4					
	11.6.5) Review opportunities for reallocation of funding streams Q2-Q3					

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Workforce Futures

Strategic Priority: Transformation and Sustainability Executive Lead – Executive Director of People and Culture

Intended Outcome/ Impact

- Meeting Welsh Government 30% agency reduction spend target
- Zero agency spend on Agency Healthcare Support Worker, Admin & Clerical, and Estates & Ancillaries
- Reduction in Whole Time Equivalent vacancies
- Increase workforce pipeline routes
- Restorative supervision Trained clinical managers
- Sustainable workforce model with associated reduction in vacancies, agency usage and a greater pipeline of potential recruits
- Home grown capability in rural healthcare, with associated improvements in patient care and experience

Progress against key actions and milestones

Key Areas of Delivery	Key Deliverables	Lead Executive	Status				Year End Delivery Confidence Assessment
			Q1	Q2	Q3	Q4	Initial
12.1) Transformation skills and development Focused on targeted support for transformation, including leadership, change management, training and capability for transformation and new ways of working CRITICAL ACTION	12.1.1) Working with the Transformation and Improvement team, assess and prioritise the development of transformation and improvement training, skills and capacity at all levels of the organisation Q1-Q4	ED P&C	Select				Medium
12.2) Variable pay: On board a further 3 cohorts of internationally trained Adult	12.2.1) Successful on-boarding of cohorts of Internationally Educated Nurses (IENs) and Medics Q1-Q4		Select				Medium

Nurses, Mental Health Nurses and 2 Medics					
12.3) Undertake targeted recruitment to Bank, prioritising services with variable pay spend	12.3.1) Increased recruitment to Bank Q4	Select			High
12.4) Introduce arrangements to temporarily realign establishments to remove the use of Healthcare Support Workers (HCSW) agency staff	12.4.1) Increase in temporary/fixed term HCSWs to remove HCSW agency use Q2	Select			High
	12.4.2) Cease Healthcare Support Worker, Admin & Clerical, and Estates & Ancillary agency use by September 2025 Q2	Select			Medium
12.5) Ensure Executive approval to enhance vacancy controls	12.5.1) All vacancies are reviewed by Executives to support in year savings through delayed recruitment Q1-Q4	Select			High
12.6) Enhanced monitoring of clinical vacancies to ensure timely advertising of posts that would otherwise attract variable pay	12.6.1) All clinical vacancies attracting variable pay are advertised Q1-Q4	Select			High
12.7) Work with clinical and operational directorates, ensure staffing models are reviewed where appropriate to recognise ongoing national work relating to health care support worker roles and the Nurse Associate role	12.7.1) Schedule of reviews operationalised Q1-Q4	Select			High
12.8) Ensure that local job descriptions are reviewed in line with changes to the national agenda for change profiles	12.8.1) Develop a timetable of activity to ensure that local job descriptions are reviewed in line with changes to the national agenda for change profiles Q1-Q4	Select			High
12.9) Pipeline: Launch the third cohort of the Aspiring Nurse Programme with HEIW and University partners	12.9.1) Evaluate impact and Return on Investment (ROI) of pipeline workforce Q2-Q4	Select			High
	12.9.2) Advertise, recruit and onboard 15 aspiring nurses Q1-Q3				

12.10) Continue to deliver and evaluate the Academy Career and Education Enterprise Scheme (ACEES) with Powys County Council Education service	12.10.1) Provide an ACEES offer to schools Q2-Q4		Select				Medium
	12.10.2) Evaluate impact of programme 2024/25 Q1						
12.11) Students: Train registered Nursing staff as Practice Assessors and Supervisors to support Students on placement	12.11.1) Number of registered nurses that have received the Practice Assessors/ Practice Supervisors training Q1-Q4		Select				High
12.12) Train eligible registered nurses in restorative supervision	12.12.1) Number of registered nurses trained in restorative supervision Q1-Q4		Select				High

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Workforce Futures

Strategic Priority: A Great Place to Work Executive Lead – Executive Director of People and Culture

Intended Outcome/ Impact

- Turnover percentage in terms of retention
- A great place to work, with positive organisational and team climates, high levels of staff satisfaction, engagement and wellbeing
- Associated improvements in recruitment and retention and reductions in workplace absences
- Staff are able to raise concerns and speak up safely

Progress against key actions and milestones

Key Areas of Delivery	Key Deliverables	Lead Executive	Status				Year End Delivery Confidence Assessment
			Q1	Q2	Q3	Q4	Initial
13.1) Continue to address actions within the HEIW Nurse Retention Plan	13.1.1) Pilot 'Stay Conversations' template Q2	ED P&C	Select				High
	13.1.2) Develop a leavers toolkit, to include exit interview guidance Q3						
13.2) Embed Speaking up Safely framework	13.2.1) Promote the SUS routes; quarterly SUS steering group to monitor impact Q1&Q4		Select				High
	13.2.2) Evaluate Vivup SUS offer Q2						
13.3) Promote the findings and themes emerging from the 2024 NHS staff survey	13.3.1) Communicate 2024 findings and themes - “you said we have/ did” model Q1-Q2		Select				High
13.4) Undertake 2025 NHS staff survey	13.4.1) Promote 2025 NHS staff survey retaining a 30% or higher return Q3		Select				High
13.5) Development: Deliver B6 and 7 (expanding to 8A) Clinical Leadership Immersive Programme (CLIP)	13.5.1) Run monthly CLIP programmes Q1-Q4		Select				Medium

13.6) Develop a one-day CLIP for B5's	13.6.1) Pilot and then implement a 1 day CLIP programme Q1-Q4		Select				Medium
13.7) Support HEIW to Scale up PTHBs CLIP programme pan Wales	13.7.1) Run monthly CLIP sessions for HEIW ** subject to RIF funding Q1&Q2		Select				Medium
13.8) Integrate the Managers Charter within the existing managers programme	13.8.1) Number of Managers programmes held /participants Q1-Q2		Select				High
13.9) Evaluate Reverse mentoring pilot	13.9.1) Evaluate the first reverse mentoring cohort and promote 2 nd round Q1-Q2		Select				Medium
13.10) Develop a People strategy	13.10.1) Create a people strategy with feedback from staff that describes structures, systems, skills, behaviour, leadership, and culture Q4		Select				Medium

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Workforce Futures

Strategic Priority: Employee Health and Wellbeing Executive Lead – Executive Director of People and Culture

Intended Outcome/ Impact

- Reduction in sickness absence, whole time equivalent turnover and recruitment & retentions / grievances, self and Management Occupational Health referrals relating to Sickness, Depression, and Anxiety (SAD)
- Staff report positively about their health and wellbeing at work, feel supported and have access to wellbeing initiatives that meet their needs
- Managers are able to utilise workforce policy, guidance and wellbeing initiatives to support staff to remain in/return to work

Progress against key actions and milestones

Key Areas of Delivery	Key Deliverables	Lead Executive	Status				Year End Delivery Confidence Assessment
			Q1	Q2	Q3	Q4	Initial
14.1) Provide access to a range of wellbeing initiatives which support the health of the workforce	14.1.1) Deliver wellbeing roadshows across the county ** subject to RIF funding Q1-Q4	ED P&C	Select				High
	14.1.2) Promote the Employee assistance platform offers Q1-Q4		Select				High
	14.1.3) Develop and promote the offer for working carers Q1-Q4		Select				Medium
14.2) Deliver the Compassionate Leadership model to underpin approach to staff wellbeing	14.2.1) Deliver monthly Compassionate leadership intro sessions for both Health and Care staff ** subject to RIF funding Q1-Q4		Select				Medium
14.3) Provide a range of offers that deliver on the HEIW Staff Health and Wellbeing Framework (SHWF)	14.3.1) Complete Match and Gap of PTHBS Wellbeing plan/ staff experience framework against HEIW's SHWF Q1		Select				Medium
	14.3.2) Develop plan and implementation for addressing the gaps Q1-Q2						
14.4) Targeted Support for managers to reduce short term	14.4.1) Pilot and evaluate a mindfulness / wellbeing programme of offers to support return to work /stay in work ** subject to RIF funding Q1		Select				High

absence through Managing attendance at work policy						
14.5) Introduce regular case reviews for all long-term absentees	14.5.1) Rolling programme of case reviews in place Q4		Select			High
14.6) Develop capability of managers on Managing Attendance	14.6.1) Rolling programme of capability improvement Q4		Select			High
14.7) Re- tender Occupational Health Employee Assistance Platform (EAP)	14.7.1) Write tender specification and go out to the market Q1-Q2		Select			High
	14.7.2) Award and implement EAP Q2-Q3					

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Workforce Futures

Strategic Priority: Equalities and Welsh Language Executive Lead – Executive Director of People and Culture

Intended Outcome/ Impact

- Performance – Strategic Equality Plan/ Workforce Race Equality Standard plan
- The health board is dynamic in promoting and achieving equality as an employer and employees report positive experiences and support
- The health board takes a pro-active wider role as an anchor institution, leveraging its importance in the Foundational Economy
- There is an 'Equality Friendly' culture with a well-trained workforce and effective utilisation of assistive technology, translation and interpretation

Progress against key actions and milestones

Key Areas of Delivery	Key Deliverables	Lead Executive	Status				Year End Delivery Confidence Assessment
			Q1	Q2	Q3	Q4	Initial
15.1) Continue the implementation of the objectives set out in the Strategic Equality Plan (SEP)	15.1.1) Achievements set out with the SEP are met Q4	ED P&C	Select				High
15.2) Explore certification / kite mark schemes and accreditation e.g. Diverse Cymru Competence scheme; hate crime charter	15.2.1) Exploration completed and implemented plan in place Q3		Select				High
15.3) Develop and implement policy and approach to sexual safety in the workplace, linking with National programmes	15.3.1) Policy implemented and promoted, monitoring in place Q1		Select				High
15.4) Implement updated Anti racism plan which includes actions relating to recommendations arising from the WRES report	15.4.1) Achievements set out within the Plan are met Q1-Q4		Select				High
	15.4.2) Half yearly updates against the Anti Racism action Plan Q2&Q4						

15.5) Continue to rollout the Gender awareness training	15.5.1) Number of cohorts and participants Q2&Q4		Select				High
15.6) Development of a reasonable adjustment guidance for staff and a reasonable adjustment passport	15.6.1) Guidance issued and passport in place Q4		Select				High
15.7) Monitor and evaluate the usage and impact of the Welsh Language Vacancy Assessment Tool	15.7.1) Review compliance of use of tool. Consider improvement target if required Q2&Q4		Select				High
15.8) Monitor the use and uptake of Online translation, including exploration of sign live within primary care services	15.8.1) Sign live introduced within Primary Care settings Q4		Select				High
	15.8.2) Continued utilisation of online translation Q1-Q4						

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Digital First

Strategic Priority: Leadership and Planning for Digital Executive Lead - Executive Director of Allied Health Professions, Health Sciences and Digital

Intended Outcome / Impact

- Staff and patients will improve their digital skills and confidence, enabling them to adopt technology and use systems effectively. This will foster a culture of continuous learning and adaptation, which is crucial for successful digital transformation.
- Embedding accountable digital clinical leadership will ensure that digital initiatives are aligned with clinical priorities and that there is accountability for the outcomes of these initiatives. This approach will improve the quality and safety of care.
- Implementing AI-driven clinical decision support systems will assist healthcare providers in diagnosing and treating patients, leading to better clinical outcomes.
- The creation and implementation of dashboards to track efficiency metrics will support the Business Efficiencies programme to reduce waste. This initiative will provide real-time insights into various operational metrics, enabling the organisation to identify inefficiencies and areas for improvement quickly. Increasing the use of virtual consultations across services for follow-ups by 10% will significantly improve accessibility and convenience for patients, reducing the need for in-person visits and allowing for more flexible care options as we redesign the digital model of care.
- Developing predictive analytics models will help anticipate patient needs and optimise resource allocation. This could involve using historical data to predict patient admissions, identify high-risk patients, and improve care management. Expanding the use of natural language processing (NLP) will extract valuable insights from unstructured data, such as clinical notes and patient feedback. This can help identify trends, improve patient care, and streamline administrative processes
- Overall, these efforts will lead to a more digitally competent workforce, improved care quality and safety, increased operational efficiency, and a culture of innovation within the organisation.

Progress against key actions and milestones

Key Areas of Delivery	Key Deliverables	Lead Executive	Status				Year End Delivery Confidence Assessment
			Q1	Q2	Q3	Q4	Initial
16.1) DSF Strategic Theme - Leadership, Partnership and Alliances	16.1.1) To ensure digital transformation is a continuous focus at the highest levels of leadership plan two Digital Board Awareness Sessions in year Q1	ED AHPHS&D	Select				Medium

Schedule Board Development sessions to embed digital thinking at the leadership level CRITICAL ACTION	16.1.2) Schedule and present a Cyber/Information Governance Awareness Board Session Q2					
	16.1.3) Schedule and present a Big Data Management Awareness Board Session Q4					
16.2) DSF Strategic Theme - Enabling Efficiency and Effectiveness Embed Accountable Digital Clinical Leadership to improve quality and safety of care, and efficiency of Health Board assets	16.2.1) Embed accountable Digital Clinical Leadership to improve quality and safety of care, & efficiency of Health Board information and assets Q1-Q4	Select				Medium
	16.2.2) Monitor attendance by stakeholders at the Digital Clinical Transformation Board and assess for increase in use of digital adoption Q1-Q4					
	16.2.3) In collaboration with services, create and implement dashboards to track efficiency metrics such as unused licenses, highest printing and franking users. This will optimise resources and reduce waste Q2					
	16.2.4) Collect patient feedback on the access to digital tools and services Q3					
	16.2.5) Increasing use of Virtual Consultations for Follow Ups by 10% to improve accessibility and convenience with more flexible care options Q4					
16.3) DSF Strategic Theme - Citizen Centred Care and Support Patient Health Care Pathway Mapping and encouraged use of the NHS Wales	16.3.1) Identify two priority pathways that must improve current waiting times, reduce duplication and inefficiency in administrative tasks in line with the Business Efficiencies priorities Q2	Select				Medium
	16.3.2) Collaborate across identified services to map those pathways identified and identify any gaps in the NHS Wales App and NHS App that will impact patients Q3					
	16.3.3) Create an improvement plan in collaboration with services with a view to standardising processes and documentation, reduce data collection and input duplication and support the design of new requirements Q4					
	16.3.4) Aim to achieve a reduction in referral processing times, within 12 months through an integrated digital referral system for identified priority services Q4					
	16.4.1) Information Sharing agreements in place across providers and commissioners Q3	Select				Low

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16.4) DSF Strategic Theme - Leadership, Partnership and Alliances System Integration with providers and commissioners in NHS Wales and NHS England, with robust Data Sharing Agreements	16.4.2) Collectively continue to deliver digital transformation to support sharing of information and standardisation across pathways, with cross border providers Q1-Q4					
16.5) DSF Strategic Theme - Leadership, Partnership and Alliances Develop a Supportive and Inclusive Digital Training Function to improve Digital Skills and Confidence for staff and patients to adopt technology and use systems effectively	16.5.1) To support all staff to adopt technology and use systems effectively create a business case to support Digital Skills and Confidence training which must include patient engagement, and supporting partners such as Workforce and Development, Health Education in Wales Q2 16.5.2) Increase the number of Clinical Safety Officer Training sessions and increase digital confidence Q4	Select				Low
16.6) DSF Strategic Theme - Enabling Efficiency and Effectiveness Workforce Planning for Digital and Clinical Informatics services through a Demand and Capacity exercise to support Digital Transformation across the organisation	16.6.1) Conduct a Demand and Capacity exercise to identify workforce needs for Digital Transformation and Enablement, considering current and future business as usual activities and prioritising programmes to support transformation, efficiency, safety, and quality Q1-Q2	Select				Medium
16.7) DSF Strategic Theme - Infrastructure and Security CRITICAL ACTION Cyber and Infrastructure	16.7.1) Complete the Cyber Assurance Framework (CAF) and establish a process for reducing the cyber risk and managing the incidents in a timely manner Q1-Q4	Select				Medium
16.8) DSF Strategic Theme - Big Data and Artificial Intelligence Put the use of data, insight and analytics, used safely and securely, at the core of the health and care system	16.8.1) Creation of clear project plans and actions to adopt innovative approaches to improving patient care and reducing waiting times or improving administrative processes using Artificial Intelligence and Robotic Process Automation technology, prioritising technologies that have undergone successful assessments by partners (robust case studies) Q1-Q4	Select				Medium

16.9) Strategic Theme - Leadership, Partnership and Alliances DSF National Programme Alignment Electronic Prescribing Maternity system and app Radiology Information System Connected Care (WCCIS), Mental Health and Community Health Solution replacement connected to Primary Care CRITICAL ACTION Deploy with industry partners, proven clinical systems such as for Maternity, Mental Health and Community Health Systems, electronic care records and medical technologies	16.9.1) Commence the implementation of Electronic Prescribing Medicines Management to meet the Welsh Gov Milestone Funding agreement Q2		Select				Low
	16.9.2) Submit the Digital Maternity Solution Business Case for internal Approval Q1						
	16.9.3) Radiology Information System Programme Upgrade Go Live Q4						
	16.9.4) Draft the Community Care solution replacement (WCCIS) Business Case, ready for submission for internal approval Q3						
	16.9.5) Collaborate with Betsi Cadwaladr University Health Board on the specification requirements for procuring a new Mental Health Solution Q3						
	16.9.6) Complete a full WPAS review to evidence Data Quality, duplication and gaps in functionality, as part of the whole system review Q4						
	16.9.7) Commence a Referral Management System review in collaboration with Primary Care and Services from a System application perspective i.e. findings to evidence if referrals are made electronically and consistently Q4						

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Innovative Environments

Strategic Priority: Strategic Capital Executive Lead - Associate Director of Estates, Facilities and Support Services

Intended Outcome/ Impact

- Delivery of Capital Programme enhancements to the estate including compliance improvements
- Strategic Capital Programme progressed to support delivery of 'A Healthy Caring Powys' and PTHB Integrated Plan / Strategic Priorities
- Programme of works to address urgent compliance risks and infrastructure improvements
- Underpinning Better Together and Routemap to Sustainability change programmes
- Capital delivery is monitored against time, cost and quality for each project
- Fit for purpose estate – reduces backlog maintenance and improves building energy performance
- Improved environmental benefits for patients, staff and visitors

Progress against key actions and milestones

Key Areas of Delivery	Key Deliverables	Lead Executive	Status				Year End Delivery Confidence Assessment
			Q1	Q2	Q3	Q4	Initial
17.1) North Powys Wellbeing Programme	17.1.1) Develop Strategic Outline Case / Outline Business Case for funding in support of an integrated health, care and wellbeing hub (phase 1) Q3	AD EF&SS	Select				High
17.2) Llandrindod Wells Rural Regional Centre	17.2.1) Business Case submission in format as outlined by Welsh Government as part of endorsed Programme Business Case Q3		Select				High
17.3) Discretionary Capital Programme including Targeted Estates Funding (TEF) etc	17.3.1) Discretionary Capital Programme (circa 25 projects) Q1-Q4		Select				High
	17.3.2) Secure funding and deliver projects within TEF categories; Decarbonisation, Infrastructure, Fire, Decontamination, Infection Prevention Control & Mental Health Q4						
17.4) Development of RPB Strategic Capital Plan, project pipeline	17.4.1) Health and Social Care, Integration and Rebalancing Capital Fund (IRCF); capital project programme Q1		Select				High

17.5) Llanfair Caereinion GP Practice and community hub	17.5.1) Identify project delivery and procurement pathway, secure funding and site and progress development of the project with commencement of construction phase Q1-Q4		Select				Medium

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Innovative Environments

Strategic Priority: Environmental Management and Decarbonisation Executive Lead - Associate Director of Estates, Facilities and Support Services

Intended Outcome/ Impact

- Delivery of Capital Programme enhancements to the estate including compliance improvements
- Strategic Capital Programme progressed to support delivery of 'A Healthy Caring Powys' and PTHB Integrated Plan / Strategic Priorities
- Programme of works to address urgent compliance risks and infrastructure improvements
- Underpinning Better Together Portfolio
- Creating enhancements to workplace making working environments more comfortable
- Supporting workforces transition to low carbon solutions
- Green space management and biodiversity plans will deliver on social and green prescribing to help delivery of care
- Public Service Board coordination of response to climate change and development of climate adaptation.
- 12.6% scope 1 & 2 carbon emissions reduction
- Electricity reduction across the programme
- Gas reduction across the programme
- Revenue savings from reduced energy consumption (revenue available direct to health board post 'invest to save' payback)
- Improved air quality and energy network capacity from reduced consumption

Progress against key actions and milestones

Key Areas of Delivery	Key Deliverables	Lead Executive	Status				Year End Delivery Confidence Assessment
			Q1	Q2	Q3	Q4	Initial
18.1) Environmental Management System accreditation	18.1.1) Maintain external accreditation to ISO14001 standards Q2	AD EF&SS	Select				High
18.2) Decarbonisation	18.2.1) Decarbonisation Strategic Delivery Plan – actions as set out by WG for 2025/2026 Q1-Q4		Select				High
18.3) Biodiversity	18.3.1) Enhancement and protection of biodiversity including community group engagement. Publication of statutory 3-yr Biodiversity Report. Development of Biodiversity Plan Q4		Select				High

18.4) Energy Efficiency	18.4.1) Implementation of energy efficiency interventions pan-Powys: Re:fit programme / Invest to Save Q2		Select				High

Innovative Environments

Strategic Priority: Estates and Facilities Executive Lead - Associate Director of Estates, Facilities and Support Services

Intended Outcome/ Impact

- Fit for purpose estate – reduces backlog maintenance and improves building energy performance
- Improved environments benefits patients, staff and visitors
- Identify and explore any potential savings on revenue and productivity
- Investigate collaborative working options
- Reduce revenue spend
- Improve service delivery
- Upskill existing workforce
- Improve productivity
- Ensure a more streamlined self-sufficient service
- Enhance cost effectiveness and resilience, reduce reliance on contractors and outside providers. Look at upskilling of existing staff to improve cross over work streams and joint working

Progress against key actions and milestones

Key Areas of Delivery	Key Deliverables	Lead Executive	Status				Year End Delivery Confidence Assessment
			Q1	Q2	Q3	Q4	Initial
19.1) Develop synergies between Estates and Facilities work streams	19.1.1) Identify and develop joint working synergies and efficiencies for Estates and Facilities department Q4	AD EF&SS	Select				High

19.2) Facilities to implement the Symbiotix system for auditing and monitoring of assurance for catering and cleaning	19.2.1) Improved Assurance and the monitoring of quality Q3		Select				High
	19.2.2) Improve data collection for cleaning and catering standards Q3						
19.3) Implementation of all Wales Cleaning Standards	19.3.1) Improved cleaning standards which are measured and matched across Wales Q3		Select				High

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Transforming in Partnership

Strategic Priority: Partnership Development Executive Lead- Executive Director of Planning, Performance and Commissioning / Director of Strategic Improvement and Transformation, Executive Director of Public Health

Intended Outcome/ Impact

- Collaboration across partners in Powys is central to delivery of a whole system approach to prevention for the population of Powys
- The work on a wider Mid Wales basis and other regional / national footprints have the potential to leverage improvement at greater scale and value
- Surveillance of Strategic Changes within and outside Powys provides intelligence which assists with the appraisal of risk and opportunity

Progress against key actions and milestones

Key Areas of Delivery	Key Deliverables	Lead Executive	Status				Year End Delivery Confidence Assessment
			Q1	Q2	Q3	Q4	Initial
20.1) Work with the Regional Partnership Board to prioritise the greatest system issues and impacts i.e. pathways of care delays and prevention of inappropriate admission to hospital, using the recommendations of the Newton Europe diagnostic report CRITICAL ACTION	20.1.1) Strengthened prioritisation and utilisation of RIF funded delivery to target greatest system pressures Q4	ED PP&C	Select				Medium
	20.1.2) Agreement on RPB support for Ready to Go Home Units subject to the PTHB Board decision in July 2025 Q2						
20.2) Work with the Regional Partnership Board (RPB) to develop, agree and implement a shared approach to partnership development	20.2.1) Work with the Regional Partnership Board to develop and agree a framework for partnership development Q1		Select				High
	20.2.2) Work with the Regional Partnership Board to implement the agreed partnership development framework Q4						
20.3) Work with the RPB to implement the findings and learning from the Evaluation, Prioritisation and Assurance	20.3.1) Work with the Regional Partnership Board to ensure strengthened implementation plans, risk management plans and exit plans for the time-limited Regional Integration Fund (fund ending 2027) Q1		Select				Medium

Framework and agree the arrangements for the next round	20.3.2) Work with the Regional Partnership Board to ensure the Evaluation, Prioritisation and Assurance approach is applied to new proposals and planning for the subsequent financial year (2026/27) Q4					
20.4) Work with the PSB to implement the PSB Wellbeing Plan	20.4.1) Lead the Powys Healthy Weights Strategic Steering Group to implement the Powys whole system approach to healthy weights action plan Q1-Q4	ED PH	Select			Medium
20.5) Align partnership planning across the Powys region for health and wellbeing, via development and delivery of PSB Wellbeing Plan, RPB Area Plan (Health and Care Strategy) and Mid Wales Joint committee work programme	20.5.1) Annual cycle of delivery via respective Partnership arrangements Q1-Q4	ED PP&C	Select			High
20.6) Work with the Marches Forward Partnership to develop and implement a plan to address shared priorities	20.6.1) Work with the health group to influence other Marches Forward Partnership programmes to implement a population health and preventative approach -including within external funding bids Q4		Select			Low
	20.6.2) Work with the Marches Forward Partnership and key decision makers to assess the viability of a prevention at scale proposal involving external funding and to agree the way forward Q1					
20.7) Systematic tracking and surveillance of external Strategic Change programmes and developments with a potential impact on healthcare for Powys residents	20.7.1) Annual cycle with quarterly production of Stocktakes Q1-Q4		Select			High
20.8) Embed Research & Innovation as a key enabler of change across the organisation	20.8.1) Delivery of RIC Hub workplan in partnership through the RPB with a focus on supporting and enabling progress of Better Together including the Business Efficiencies programme Q1-Q4	DSI&T	Select			Medium

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Transforming in Partnership

Strategic Priority: Governance incorporating Corporate Business, Information Governance & Records Management Executive Lead - Director of Corporate Governance / Board Secretary

Intended Outcome/ Impact

As an enabling function, these activities support the achievement of wider finance, performance, quality and population outcome indicators through support across the organisations Strategic Priorities. Contribution to the achievement of the health board's Strategic Priorities is tracked through the quarterly engagement and communication delivery and assurance report.

Enabling contribution across all health board outcomes (as agreed/prioritised) Specifically:

- Critical contribution to effective organisational governance; decisive and effective decision making supported by assurance, oversight and effective management of risks
- Appropriately skilled, trained and informed Board
- Excellent Board and Executive administration and governance advice and support
- Provide pro-active assurance to the Board and key stakeholders of on-going alignment with relevant legislation and legislation; ensuring all staff have sufficient knowledge and training to comply with governance and data protection legislation
- Ensure consistent awareness and education communications deliver a single corporate message around information governance and records management issues
- Effective engagement to aid in implementation of robust measures to protect digital data and ensure up to date protections and compliance with data protection legislation, contribute to the transition from paper based to electronic management systems
- A streamlined records management system that ensures proper creation, storage, retention and disposal of both digital and paper health records
- Increased trust and confidence from stakeholders, including clients, partners and regulatory bodies in the health board's governance and data handling practices
- Efficient and effective corporate business systems and processes
- Effective collaboration with key stakeholders to facilitate secure and compliant information sharing
- Contribution to staff engagement, great place to work, recruitment and retention

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Progress against key actions and milestones

Key Areas of Delivery	Key Deliverables	Lead Executive	Status				Year End Delivery Confidence Assessment
			Q1	Q2	Q3	Q4	Initial
21.1) Further develop and implement the Board Assurance Framework	21.1.1) Board Assurance Framework (BAF) is an integrated part of every Board meeting and informing the Boards (and Committees) work programme Q1-Q4	DCG	Select				Medium
21.2) Design Board and Committee work plans ensuring alignment to the organisational strategic plan, Board Assurance Framework and Corporate Risk Register	21.2.1) Board and Committee work plans are agreed Q1		Select				High
	21.2.2) Work plans delivered Q4						
	21.2.3) Evaluation of work plans (Q4 into 2026/27 Q1) Q1-Q4						
21.3) Design & deliver a Board Development programme that supports the Board in fulfilling its role	21.3.1) Board development programme x10 sessions; board briefings x12 sessions reflecting the needs of the Board Q1-Q4		Select				High
21.4) Review the Boards Risk Management Framework further embedding effective risk management	21.4.1) Risk management framework reviewed Q1		Select				High
	21.4.2) Fully implemented (Q4) Q1-Q4						
21.5) Ensure corporate business systems maximising efficiency and effectiveness	21.5.1) High quality corporate business systems and support in place across all corporate portfolios Q1-Q4		Select				Medium
21.6) Information Governance and Records Management Strategy	21.6.1) Finalise strategy including improvement plan Q1-Q2		Select				High
21.7) Develop the PTHB elements of the NHS Wales Information	21.7.1) Engagement with Service leads to progress identified actions to improve compliance in readiness for next submission Q1-Q4		Select				High

Governance Toolkit – Improvement Plan 2025/26						
21.8) Develop a communications/awareness plan	21.8.1) Develop and deliver a plan that co-ordinates the communication/training and awareness plan which includes a review of effectiveness Q1-Q4		Select			High
21.9) Records Management – Align and strengthen the Storage of Archive Health Records against legislation	21.9.1) Identify the resourcing strategy to support the effective on-going management to store archive health records over 4 designated facilities Q1-Q4		Select			High
21.10) Ensure effective Information Governance and Records Management systems and processes are implemented to maintain and improve legislative compliance	21.10.1) Reduction in number of data and Information Governance breaches Q1-Q4		Select			High
	21.10.2) Successful completion of regulatory audits with no major non compliance issues Q1-Q4					

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Transforming in Partnership

Strategic Priority: Engagement, Communication and Corporate Affairs Executive Lead - Director of Corporate Governance / Board Secretary

Intended Outcome/ Impact

Enabling contribution across all health board outcomes (as agreed/prioritised). Specifically:

- Better informed public and stakeholders
- Better engagement and alignment between organisational goals and wider community/economy assets and skills
- Compliance with key legislation and guidance relation to communication, engagement, service change, accessibility, Welsh Language etc.
- Help to “Ensure the people of Wales have a strong voice to inform the ongoing development of an effective, joined up health and social care system” (A Healthier Wales Refresh, December 2024)
- Effective stakeholder relations and corporate affairs both to inform and to supportive achievement of organisational goals on behalf of the people of Powys
- Effective and compliant operation of the Powys Health Charity in line with agreed strategy

Progress against key actions and milestones

Key Areas of Delivery	Key Deliverables	Lead Executive	Status				Year End Delivery Confidence Assessment
			Q1	Q2	Q3	Q4	Initial
22.1) Design and delivery of a programme of marketing and communication	22.1.1) Design and deliver annual programme of communication and marketing activity focusing on those issues offering greatest strategic benefit and/or management of principal risks Q1-Q4	DCG	Select				High
22.2) Design and delivery of a programme of continuous engagement	22.2.1) Design and deliver compliant programmes of continuous engagement as well as targeted engagement and/or consultation reflecting the strategic requirements of the health board (e.g. Better Together), local partnerships (e.g. Sustainable Powys), regional programmes (e.g. cross-border / commissioned service changes) and national programmes (e.g. all Wales, specialised services) Q1-Q4		Select				Medium

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22.3) Delivery of shared PSB/RPB Engagement and Participation Plan priorities	22.3.1) Continue to embed shared approach to coproduction across RPB and PSB partners including through the development and implementation of the Coproduction Journey Tracker Q1-Q4		Select				Medium
22.4) Ensure effective corporate affairs systems and processes that support the organisation to achieve its goals	22.4.1) Undertake quarterly review and update of principal stakeholder map, including specifically readiness for Senedd Reform 2026 Q1-Q4		Select				High
22.5) Ensure effective and appropriate contribution to COVID learning through the UK COVID Inquiry and Senedd Special Purpose Committee	22.5.1) Continue organisational learning including proactive and reactive engagement with the UK COVID Inquiry and the Senedd Special Purpose Committee Q1-Q4		Select				Medium
22.6) Development and delivery of the Powys Health Charity strategy	22.6.1) Conclude delivery of current Powys Health Charity Strategy and develop and agree Powys Health Charity Strategy 2026-29 Q1-Q4		Select				Medium

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Powys Teaching
Health Board

Agenda item: 3.2

BOARD		21 st May 2025	
Subject:	Approval of the Annual Update of the Integrated Quality & Performance Framework – 2025/26		
Approved and presented by:	Nicola Johnson, Executive Director of Planning, Performance and Commissioning		
Prepared by:	Assistant Director of Performance and Commissioning, Head of Performance, and Performance Support Officer		
Other Committees and meetings considered at:	Executive Committee - 30 th April 2025 and 14 th May 2025.		
PURPOSE:			
The PTHB Integrated Performance Framework (IPF) was approved in September 2022 and following the introduction of the Duty of Quality an updated version including additional detail regarding a Quality and Performance Escalation Process was approved in March 2024; the IPF was consequently renamed the Integrated Quality and Performance Framework (IQPF).			
The annual review of the IQPF has been undertaken as planned with a revised IQPF presented to and approved by the Executive Committee on the 14 th May 2025 which included learning from the first round of Integrated Quality and Performance Group (IQPG) meetings; strengthening of the arrangements for performance management, monitoring and oversight of commissioned services; and increased focus on quality.			
RECOMMENDATION(S):			
The Board is asked to:			
1. APPROVE the updated IQPF for implementation within the Health Board.			
Approve/Take Assurance		Discuss	Note
Y		Y	Y

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ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:		
1. Focus on Wellbeing	Y	The IQPF covers all wellbeing objectives.
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	

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EXECUTIVE SUMMARY

Powys Teaching Health Board (PTHB) is responsible for planning, providing and commissioning healthcare services to improve the health and wellbeing of the people of Powys.

The current Integrated Quality and Performance Framework (IQPF), which was approved in 2024, describes the mechanisms by which the Board discharges its duty to scrutinise and assure the performance of the organisation in line with the strategic objectives; and most importantly the delivery of quality, patient centred services. The IQPF is reviewed on an annual basis to ensure that it continues to provide a robust and effective quality and performance management approach focused on continuous improvement.

The IQPF has been updated to reflect the learning from 2024-25 including the first round of IQPGs; to reflect the proposed Strategic Commissioning Framework (SCF), which is currently in development with the aim to present for Board for approval in July 2025; and requirements of the NHS Wales Planning and Performance Frameworks for 2025-26.

The original IPF (2021) superseded the Health Board's previous Commissioning Assurance Framework but the commissioning performance arrangements were less well developed in the subsequent documents. The management, monitoring and oversight of the performance and quality of commissioned services has been strengthened in this version and the arrangements will be implemented from May 2025 as a matter of urgency.

This report asks the members of the Board to approve the updated IQPF for implementation within the Health Board.

DETAILED BACKGROUND AND ASSESSMENT

IQPF 2025/26

The IQPF 2025/26 ([see Appendix One](#)) includes the following updates:

- 1) Section 1 – Purpose updated to reflect:
 - a) NHS Wales Planning Framework 2025-28.
 - b) NHS Wales Performance Framework 2025-26 and Enabling Actions.
 - c) Requirement to deliver the Annual Plan 2025-26 (particularly with regard to commissioning performance and oversight).
 - d) PTHB Draft Structured Assessment 2024-25.
 - e) Regional Partnership Board Area Plan / Health and Care Strategy 'A Healthy Caring Powys' and Public Services Board Wellbeing Plan.
 - f) Feedback from Executive, Deputy and Assistant Director colleagues.
- 2) Section 3 – Components of the Framework
 - a) Additional principle of 'Focus on Data' included to recognise that performance management requires a focus on data input, data quality and data analysis to effectively detect poor and best practice to enable changes and improvements to patient care to be undertaken.

3) Section 4 – Roles and Responsibilities

- a) Increased detail and links to the Health Board PADR process and how continuous development and improvement through individual PADR, supports the achievement of strategic priorities and critical actions to deliver the Health Board joint Strategy and Annual Plan.

4) Section 5 – Performance Monitoring and Reporting

- a) 5.1 Coverage of the IQPF – Quality, Safety and Patient Experience domain updated to reflect working within the principles of the PTHB Quality Management System.
- b) 5.2 Planning for Performance Delivery – enhanced to reflect the fundamental importance of the alignment between the Annual Plan, Directorate Plans, Team Plans and PADR.
- c) 5.3.3 Additional detail included on the PTHB Quality Management System approach to improving the quality of healthcare and outcomes for the population of Powys, including the floor to Board reporting governance processes and structures.
- d) 5.4 Oversight and Accountability – removal of Welsh Government External Oversight; PEQs – removal of Quality Outcomes Framework and replaced with Integrated Quality Report; Progress against plan added for Operational Directorates and Directorate/Team coverage.
- e) 5.5 Management and Monitoring – additional clarity and detail on the meeting arrangements central to the effectiveness of the IQPR namely:
 - i. 5.5.1 PADR meetings.
 - ii. 5.5.2 Team Performance Reviews.
 - iii. 5.5.3 Directorate IQPG meetings
 - Detail included on directorates and updated process and frequency of the Directorate Integrated Quality and Performance Group meetings.
 - Reference to principles of PTHB Quality Management System.
 - iv. 5.5.4 Local Performance Intelligence and Assurance Arrangements - Reference to principles of PTHB Quality Management System.
- f) 5.6 Commissioned Services Oversight
 - i. The establishment of an Executive led Commissioning Oversight and Assurance Group (COAG).
 - ii. Updated and strengthened description of the Contract Quality and Performance Review Meeting (CQPRM) process (change of frequency of meetings and reporting /escalation to COAG).
 - iii. A Commissioned Services Performance Report to be presented to the Executive Committee on a monthly basis.

- iv. Strengthening of the Commissioned Services Performance Reporting to Delivery and Performance Committee and the Board on a quarterly basis.
- v. Recognition of effective alignment/interdependency of IQPF and proposed draft Strategic Commissioning Framework (SCF).

5) Section 6 – System of Reporting, Review, Escalation and Assurance

- a) Increased detail on the Integrated Quality and Performance reporting structure both within PTHB and to Welsh Government.

6) Section 8 – Commissioned Services Escalation

- a) New detail on how the escalation framework within the IQPF is applied to provide effective oversight and assurance on commissioned services performance and delivery.

7) Appendix A – Supporting Information

- a) Detail included on the proposed draft Strategic Commissioning Framework (SCF) and the alignment and interdependency with the IQPF.

NEXT STEPS:

- Review of IQPF implementation in Autumn 2025.
- Strategic Commissioning Framework to be finalised and presented to Board in July for approval.

IMPACT ASSESSMENT

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

QUALITY:

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

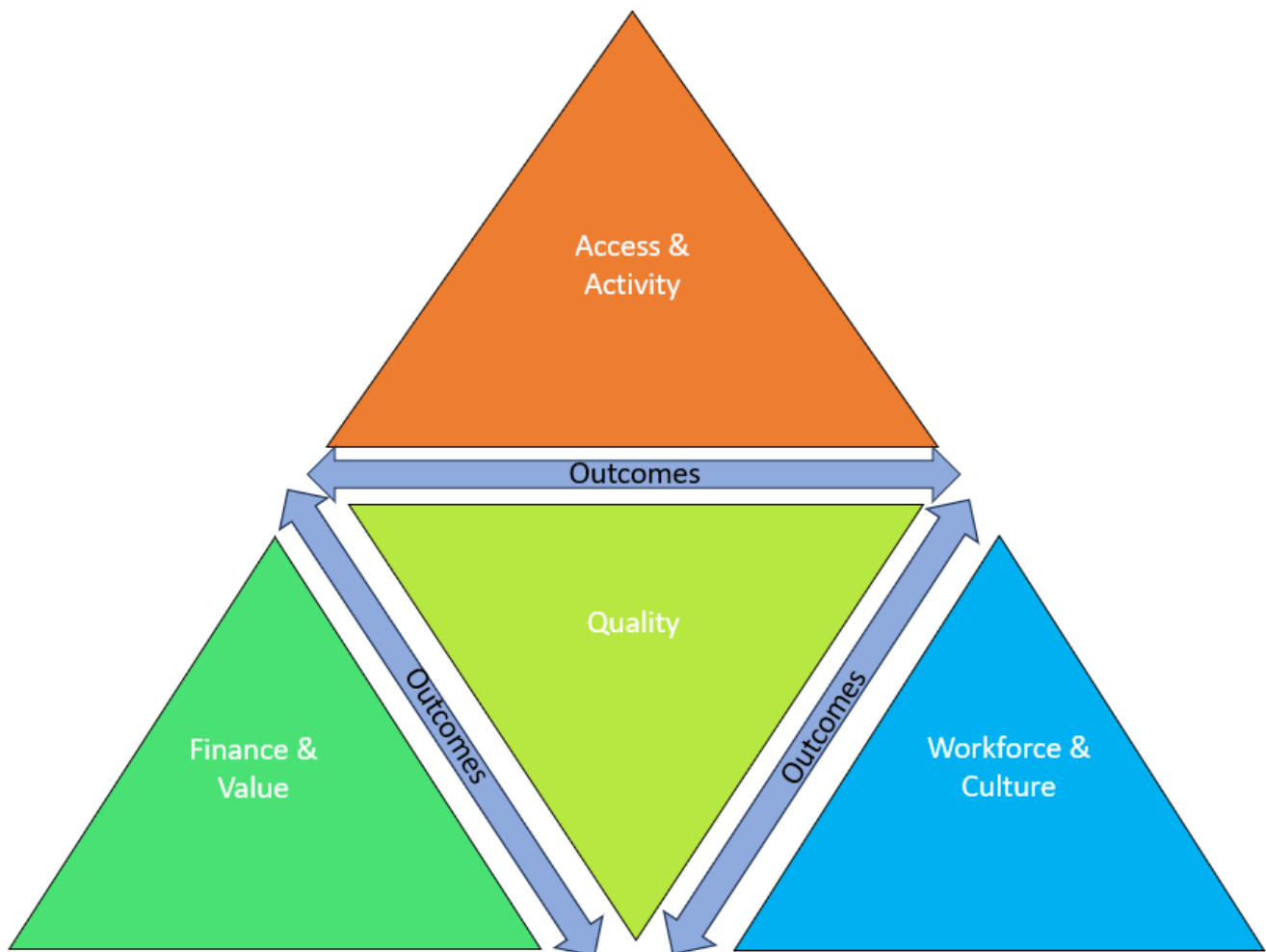
EQUALITY:

	No impact	Negative	Positive	Both
Age	X			
Disability	X			
Gender reassignment	X			
Marriage / civil partnership	X			
Pregnancy / maternity	X			

Race	X				
Religion or Belief	X				
Gender	X				
Sexual Orientation	X				
Welsh Language	X				
Socio-economic status	X				
Social exclusion	X				
Carers	X				
RISK ASSESSMENT:					
	Very Low (0-3)	Low (4-8)	Moderate (9-12)	High (15-25)	
Clinical	X				
Financial	X				
Corporate	X				
Operational	X				
Reputational	X				

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Powys Teaching Health Board **Integrated Quality & Performance** **Framework** **2025/26 – 2026/27**



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Document Control

Document Author:	Executive Director of Planning, Performance and Commissioning Executive Director of Nursing, Quality, Women and Family Health Assistant Director of Performance and Commissioning Assistant Director of Quality Head of Performance Head of Commissioning
Document Owner:	Executive Director of Planning, Performance and Commissioning Executive Director of Nursing, Quality, Women and Family Health
Document Type:	Framework
Approval:	Executive Committee Delivery and Performance Committee Board
Frequency of Review:	12 monthly
For Use By:	Internal use for Health Board

Version History and Control

Version	Author	Date	Reason and Changes
Draft v1	Ffion Ansari	19/04/17	First draft
Draft v2	Ffion Ansari	19/05/17	Revision following discussion with DP&P, CEO, Asst. Dir. Commissioning
Draft v3	Ffion Ansari	01/06/2017	Minor amendments following discussion with Dir. Governance & Corporate Affairs
Draft v4	Ffion Ansari	02/06/2017	Comments of DP&P 17/06/2017 included
Draft v5	Ffion Ansari	16/06/2017	Feedback of D&P Group included in for revised draft
Draft v6	Ffion Ansari	20/07/2017	Revised structure to reflect comments of CEO, Medical Director and

Version	Author	Date	Reason and Changes
			further comments from Planning & Performance Team
Final Draft v7	Ffion Ansari	01/09/2017	Updated following final review by Delivery and Performance Group on 09/08/17
Final Version v8	Ffion Ansari	14/09/17	Additional content on Benchmarking included following Finance Planning & Performance Committee 12/19/17
2022 New Integrated Performance Framework Draft version 1	Stephen Powell	15/09/2022	First Draft – updating the previous Improving Performance Framework and incorporating the previous Commissioning Assurance Framework
2022 New Integrated Performance Framework Draft version 2	Stephen Powell	23/09/2022	Updated to reflect comments received at Executive Director session held 22/9/22
2024 Integrated Quality & Performance Framework	Chris Moss Zoe Ashman	4/03/2024	Updated to reflect increased focus on Duty of Quality
2025/26 Integrated Quality & Performance Framework	Nicola Johnson Chris Moss Simon McLellan Tracey Gwyther Claire Roche	24/04/2025	Updated to reflect proposed draft Strategic Commissioning Framework and revised IQPG structure and process. Updated to provide increased focus on quality focus including reference to Health Board Quality Management System.
2025/26 Integrated Quality and Performance Framework	Chris Moss Simon McLellan	1/5/2025	Updated to reflect feedback provided from Executive Team 30/4/2025.

Powys THB Integrated Quality & Performance Framework

2025/26 - 2026/27

1. Purpose

- 1.1 Powys Teaching Health Board (PTHB) is responsible for planning, providing and commissioning healthcare services to improve the health and wellbeing of the people of Powys. The Board has the key responsibilities of setting the strategic direction for the Health Board and scrutinising and assuring the organisation's performance. The purpose of the Integrated Quality and Performance Framework (IQPF) is to support the Board to discharge these duties effectively and that quality and performance are seen as everyone's business with a 'ward to Board' culture of transparency and continuous improvement.

The overall aim is to ensure that the best possible health and wellbeing outcomes are achieved for Powys residents. To achieve this the health board strategically integrates various components to enhance quality and performance while aligning with the vision of "A Healthier Wales" and ensuring we are guided to comply with all our statutory duties including:

NHS Wales Planning Framework

The NHS Wales Planning Framework which is issued annually provides a structured approach and guidance for Health Boards to meet the statutory planning duty in NHS Wales. It also includes the key performance measures and in 2025/26 also included a set of 'Enabling Actions' for productivity and efficiency.

The Health Board produces an Integrated Plan each year which demonstrates the delivery of our Wellbeing Objectives as outlined in the agreed Health and Care Strategy 'A Healthy, Caring Powys', responds to the organisation's strategic risks, the NHS Wales Planning and Performance Frameworks in the context of the financial settlement in the annual Allocation Letter.

Health organisations, including PTHB, are required to complete an MDS (Minimum Data Set) comprising service, financial, and workforce information and to submit it each year with the Integrated Plan. The MDS provides

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assurance on the robustness of plans and ensures alignment with statutory duties and ministerial targets.

NHS Wales Duty of Quality

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

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

Welsh NHS Performance Framework (including Cabinet Secretary Enabling Actions)

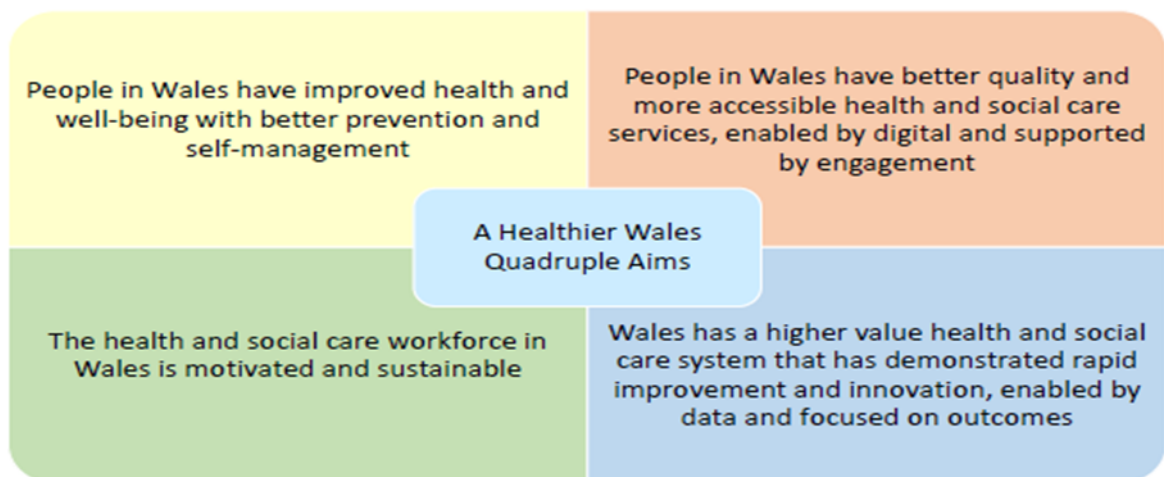
The NHS Wales Performance Framework provides a structured approach to measuring and reporting performance in healthcare.

It sets expectations for health boards to report progress against key corporate-level information, service delivery, and their role in supporting the wider NHS system.

Strategic Alignment

PTHB's plan takes a whole-system approach, recognizing collaboration with partners, including the third sector, primary care contractors, social care colleagues, and other healthcare providers across Wales and England.

By integrating these frameworks, PTHB aims to balance quality, performance, and financial duties, ultimately working towards the Welsh Government's vision of "A Healthier Wales" and improved patient outcomes.



In summary, PTHB's Integrated Quality & Performance Framework (IQPF) combines these elements to drive continuous improvement, enhance service

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delivery, and promote better health for the people of Powys. The framework uses accessible information that allows the Board, Executives, and other essential personnel to comprehend, monitor, and evaluate the organization's performance. It facilitates timely intervention when quality or performance falls short of established targets and encourages ongoing enhancements in service delivery.

- 1.2 The regular measurement and comparison of actual performance against target requirements and appropriate benchmarks allows us to take proactive and proportionate actions in challenging situations. By doing so, we drive continuous improvement in service delivery for the benefit of our population's health and well-being.

To achieve this effectively, we need timely and accurate information while maintaining confidentiality. Quality and performance management are everyone's responsibility. Positive performance management supports service improvement, strengthens planning, and facilitates effective problem-solving without stifling innovation.

- 1.3 Our existing quality, performance, and planning arrangements provide a solid foundation for managing quality and performance effectively. This revised framework aligns and emphasises the principles of the Duty of Quality, aiming for a significant improvement in informed performance management. It fosters a culture of positive performance improvement, supports the Annual Plan, manages risks, and assures the Board of successful delivery.

Improving and managing quality of care along with performance is everyone's business, positive performance management will enable service improvement, strengthen planning and risk management whilst facilitating effective problem solving to support delivery without stifling innovation and change. The quality, performance management and planning arrangements in place have developed a solid foundation for effectively managing performance as evidenced through the recent Structured Assessment.

This revision of the framework seeks to ensure alignment with the principles of Duty of Quality to facilitate a step change in quality informed performance improvement and management. This will build on the foundations in place to create a culture of quality focussed positive performance improvement which supports the delivery of the Annual Plan, manages risks effectively and provides assurance to the Board on delivery.

This revision of the framework has considered the following inputs:

- NHS Wales Planning Framework 2025-28
- NHS Wales Performance Framework 2025/26 and Enabling Actions

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- Requirement to deliver the Annual Plan 2025/26 (particularly with regard to commissioning performance and oversight)
- PTHB Draft Structured Assessment 2024/25
- Regional Partnership Board Area Plan / Health and Care Strategy 'A Healthy Caring Powys' and Public Services Board Wellbeing Plan
- Feedback from Executive, Deputy and Assistant Director colleagues

1.4 The objective of this framework is to ensure that information is available which enables the Board and other key personnel to understand, monitor and assess the organisation's performance, enabling appropriate action to be taken when performance against set targets deteriorates, and support and promote continuous improvement in service delivery.

1.5 The IQPF is a contributor to the Board Assurance Framework (BAF). This will ensure there is sufficient, continuous and reliable assurance on the management of the major risks to the delivery of strategic objectives and most importantly to the delivery of quality, patient centred services.

1.6 Ultimately the IQPF aims to report holistically at individual, service, directorate, or organisation level the performance of the resources deployed, and the outcomes being delivered. Overall quality and performance will be assessed via intelligence gathered across key domains including access & activity; finance & value; workforce & culture; and quality, safety & patient experience outcomes and performance indicators. Ultimately, the framework assesses quality and performance across key domains, including access, finance, workforce, culture, safety, and patient experience.

2. Scope

2.1 The IQPF applies to all responsibilities of the Health Board. The scope therefore includes all NHS services the Health Board provides and those commissioned in County and out of County. The IQPF also supersedes the previous Commissioning Assurance Framework and now incorporates those key elements.

The Framework includes is to:

- Definition of roles and responsibilities for managing and improving performance;
- Description of the structures required to deliver robust quality care, performance management and improvement;
- Description of clear accountability and oversight with lines of responsibility;
- Processes of a quality management system which will support quality improvement, quality planning and quality control through proactive problem solving and risk management.

The delivery and commissioning of services may change over time. The areas where the IQPF apply in order to provide the Board with the oversight of quality and performance are shown below. This is not an exhaustive list.

Areas of Application	
Commissioned Services	Community, Mental Health & Secondary Care providers – England and Wales
	Joint Commissioning Committee (JCC)
	Emergency Services and out of hours care providers.
	Voluntary Sector
	Care Home Placements or Packages of Care funded by the Health Board through Continuing Healthcare or Funded Nursing Care
PTHB Provided Services	Primary Care including GMS, GDS, GOS, GPS
	Maternity Services
	Community Service Group
	Women and Childrens Services
	Mental Health and Learning Disabilities
	Corporate Departments including support services

The IQPF is not intended to:

- Exhaustively measure all aspects of organisational and commissioning performance.
- Replace or duplicate the role of Health Inspectorate Wales, Care Inspectorate Wales and for services based in England the Care Quality Commission.
- Replace or duplicate the JCC's own Performance Management Framework and arrangements.

3. Components of the Framework

3.1 Guiding Principles

The following principles underpin the framework:

- **Culture of Innovation and Improvement:** These arrangements are intended to support the development of a culture of continuous performance improvement and innovation embedded in all aspects of organisational activity and delivered for the benefit of patients. This will be supported by clear objectives at all levels which drive a culture of high performance and accountability, supported by the Personal Appraisal and Development Review (PADR) process. Good performance will be recognised, and staff supported and engaged with to enable an understanding of expectations. At directorate level, the Framework for Improving Performance should also be used as a driver for cultural change and engagement. Services which are identified as under-performing will be offered the tools and resources to improve performance and responsible individuals will be supported to make improvements. Areas of excellence will be promoted for wider sharing, learning and celebration.

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- **Transparency:** Agreed performance objectives will be clear and performance measures transparent. Expectations and accountabilities will be clearly set out for individuals, directorates and teams through agreed plans, quality performance targets and measures, with clear escalation arrangements in place to manage non-delivery..
- **Integrated:** The quality performance management approach will be integrated, action orientated and focussed on delivering improved performance. Quality and performance will be considered from multiple perspectives taking into consideration, national targets and measures, local targets and measures, financial and workforce performance, benchmarking and delivery of actions against planned milestones.
- **Proportionality and Balance:** Quality and performance management arrangements will seek to ensure that interventions and actions are proportionate to the scale of the quality or performance risk and that a balance between challenge and support is maintained. The framework will also endeavour to balance the burden of reporting with the assurance requirements necessary for the Board.
- **Accountability:** Quality and performance management arrangements will ensure that all parties are clear where lines of accountability lie with processes in place to manage escalation of poor performance or non-delivery against plan. This will be supported by the Integrated Quality and Performance Groups (IQPG) meetings with Directorates to oversee, review and challenge quality, delivery and performance.
- **Empowerment and Delegation:** The structure within which employees work will nurture a culture of collaborative working where solving problems at a local level is the norm and a culture of mutual support is adopted in order to optimise delivery. Higher performance will earn greater levels of delegated authority. Conversely, there will be greater levels of performance management intervention in underperforming areas.
- **Promoting excellence and quality:** Ensuring service provision meets the "Fundamentals of Care" and NHS Wales's Health and Social Care Quality and Engagement Act (2020) requirements re Duty of Quality and Duty of Candour.
- **Focussed on outcomes:** PTHB will use nationally reported clinical outcomes and develop other outcome-based measures for provided and commissioned services to measure and drive improvement over time.
- **Focus on data:** Effective performance management requires utilisation and ownership of data (both quantitative and qualitative) to monitor,

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assess, and improve organisational performance with the goal of ensuring high quality care.

Data input and data quality is a vital part of performance management in providing the right information for analysis to effectively monitor service performance, inform strategic decisions, evaluate effectiveness of interventions, analyse efficiency, identify trends and patterns, evaluate impact of service changes, support workforce planning and to identify and address patient safety concerns such as adverse events or errors in care.

- **Evolve over time:** The IQPF is based on what can be measured now and will be updated as time progresses to reflect either new data becoming available or a change to regulatory or national oversight measures. In line with the improvement-based approach PTHB will review the IQPF annually, considering learning within and without the organisation on a continuous basis.

4. Roles and Responsibilities

Quality and performance improvement are everyone's business in PTHB. A key element of PTHB's quality and performance management arrangements is ensuring that individuals and teams are aware of their personal accountability for the delivery of improvements in quality and performance across both directly provided and commissioned services.

The Board's Wellbeing Objectives and Enabling Objectives as laid out in the joint Strategy 'A Healthy, Caring Powys' are cascaded through the Annual Plan and Directorate Plans. These and inform Strategic Priorities and Critical Actions for all teams and individuals throughout the organisation, and quarterly monitoring and reporting is carried out against the Activities and Deliverables in the Plan. Supporting this is the continuous development and improvement of individual Performance Assessment and Development Reviews (PADR) as set out in the organisations' [PADR process](#).

Whilst it is everyone's role to improve quality and performance, the Board drives a culture of quality and performance by providing a clear vision together with health board aims, objectives and priorities by holding the Executive Team to account for the delivery of the Annual Plan 2025/26 including the agreed performance measures and trajectories. Effective performance improvement requires defined roles and responsibilities and clear ownership of measures. A summary of these roles and responsibilities is as follows:

4.1 Board

The Board has overall responsibility for the implementation of the IQPF. The Board's role is to set the strategic direction and to scrutinise and assure the performance of the organisation. It provides leadership and direction to the organisation and will agree the health board's Strategy including the vision, Wellbeing Objectives, Enabling Objectives, Strategic Priorities and Critical Actions

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through approval of the Annual Plan and will undertake continuous assessment of its performance. The IQPF outlines the framework and processes to provide the evidence to support the Board in undertake its duties with regard to performance, safety and delivery against these Objectives, Priorities and Actions. The Board will delegate scrutiny and assurance to its Sub-Committees as appropriate.

4.2 Chief Executive Officer

The Chief Executive Officer is accountable for the management of the organisation including ensuring that the quality and performance of services are achieved in line with the Annual Plan within available resources. The Chief Executive will ensure remedial action is taken where there are areas of challenge and all opportunities for improvement are taken and chairs the six-monthly IQPG Directorate reviews.

The Chief Executive has delegated responsibility for the detailed operation of the IQPF to the Executive Director of Planning, Performance and Commissioning. To discharge this responsibility, they will work with the Executive Directors, particularly with the Director of Nursing and Quality, to ensure effective quality, performance management and improvement arrangements are in place across the health board.

4.3 Executive Team

The Executive Team, through the Executive Committee provides a forum for Executive Directors to discuss matters of strategic or operational significance prior to onward transmission or cascade, where appropriate, to the Board or other appropriate committees. The Executive Team also decides, given evidence from IQPGs or directly from directorate or corporate teams, whether any deviation from required performance is material in relation to the health board's escalation process (described in section 6).

4.4 Executive Directors

Each Executive Director is responsible for supporting the development of strategic and organisational plans including the Annual Plan and in the development and implementation of their own Directorate Plan ensuring all plans are informed by evidence, are achievable and challenging with particular reference to their areas of responsibility and/or expertise. Each Director also has responsibility for supporting the analysis and reporting of quality and performance for their areas of responsibility through the structures set out in the IQPF including participating in IQPGs and leading the IQPG for their Directorate.

- The [Executive Director of Primary Care, Community and Mental Health](#) is accountable for a significant proportion of operational delivery across the Health Board. Through using this framework, they are responsible for ensuring that operational services have appropriate internal oversight arrangements in place.

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- The **Executive Director of Nursing, Quality, Women and Family Health** ensures that the required levels of quality management and nursing performance are in place through the IQPF and ensures that delivery against the Quality Outcomes Framework is embedded into this process. They work closely with the Executive Medical Director, Executive Director of Public Health and Executive Director of Allied Health Professionals, Health Science and Digital to ensure that all aspects of quality are monitored and managed; and that clinical executive leadership is provided to each IQPG review.
- The **Executive Director of People and Culture** is responsible for ensuring that affordable and appropriate workforce planning is in place along with robust arrangements for reviewing the performance of all staff on an individual basis through the PADR Policy. They work closely with the Executive Medical Director, Executive Director of Nursing, Quality, Women and Family Health and the Executive Director of Allied Health Professionals, Health Science and Digital who have individual responsibilities for ensuring clinically qualified staff have appraisals which deliver their professional standards.
 - The **Director of Improvement and Transformation** is responsible for the Innovation and Improvement, Transformation and Value and North Powys Wellbeing Programme teams within the organisation and key regional and national links in relation to these areas. These teams collectively enable delivery of identified improvement and transformation activities across the organisation, this includes delivery of the Better Together Portfolio to shape the future of safe, quality health services for Powys.
- The **Executive Director of Public Health** is responsible for ensuring that robust plans are in place to secure improvement in population health and well-being and to protect the health of the local community. They contribute to the clinical Executive oversight of quality and performance at each IQPG review.
- The **Executive Medical Director** ensures that the required levels of medical performance and relevant quality areas are in place through the IQPF. They contribute to the clinical Executive oversight of quality and performance at each IQPG review.
- The **Executive Director of Allied Health Professionals, Health Science and Digital** ensures that the health board has the required digital systems, IT infrastructure, reporting, and analysis to provide high quality support to the health boards staff at all levels which will underpin the national and local requirements of the IQPF and linked processes. They will also ensure that levels of therapy and health science performance and relevant quality areas are in place through the IQPF. They contribute to the clinical Executive oversight of quality and performance at each IQPG review.

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- The **Executive Director of Finance, Capital and Support Services (DoF) and Deputy Chief Executive** is responsible for ensuring there is an effective system of internal control and financial governance and there is a financial strategy and Annual Plan and budget plan established for the organisation which integrates with the workforce and service plans. As part of delivery and monitoring and reporting, the DoF will ensure there are mechanisms established to provide financial information, analytics and insight into this performance framework.
- The **Director of Corporate Governance** is responsible for advising on the process and system of reporting/escalation to the Committees and the Board in line with the IQPF and is responsible for the health board's corporate governance framework. Internal and external communication also forms part of the portfolio.

Each Director holds accountability for the performance of the area for which they have delegated authority within their Job Description and in the Scheme of Delegation.

- The **Executive Director of Planning, Performance and Commissioning (DPPC)** has the delegated responsibility for developing the Annual Plan and ensuring that the Board effectively sets the strategic direction through that mechanism.

The DPPC is also responsible for the agreement and effective performance management of the Long Term Agreements with commissioned service providers and ensuring that arrangements are in place for performance management of in-reach Service Level Agreements and contracts with the Third sector providers, with quality being a key domain of all of these arrangements.

The DPPC has delegated responsibility for the development and implementation of performance management and has delegated responsibility for preparing, implementing, and updating the IQPF as well as:

- Ensuring a culture of openness, transparency, continuous improvement and learning is in place for performance management;
- Ensuring that robust systems are in place for the performance management and assurance of national, local and internal targets;
- Preparing the Integrated Quality and Performance Report giving assurance to the Board on performance;
- Preparing the Quarterly Progress Against Plan reports, giving assurance to the Board on delivery against the Annual Plan
- Facilitating performance reporting to the Delivery and Performance Committee, including exception reporting of improved or poor performance;

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- Ensuring that plans to address poor performance are developed and implemented and that the Escalation Process outlined in section 7 is used effectively where required;
- Ensuring that governance arrangements to support quality and performance management are in place, robust and effective; Ensuring that all aspects of the health board's responsibilities are reflected within the framework, including the balance of provider and commissioned services is adequately reflected.

4.5 Senior Leaders and Managers

Senior leaders and managers across the organisation have responsibility for developing and managing the implementation of their Team Plans aligned to and in support of their Directorate Plans and the Annual Plan and the regular undertaking of Personal Appraisal and Development Reviews. They are also responsible for promoting a culture of quality and performance management and improvement, participating in the development of strategic plans, and supporting the reporting of performance and delivery.

4.6 All Staff

Every employee contributes towards quality and performance improvement and management by being encouraged and supported to identify improvement opportunities and to take the required action. It is important that staff own the data and information on their activity and understand how that translates to the corporate performance of the organisation, taking positive personal action and responsibility to improve their own practice and performance.

All staff have a responsibility to contribute to planning and performance improvement through their Personal Appraisal and Development Review process.

4.7 Performance Management – A Patient Perspective

A patient centred approach to care involves engaging patients and their families in decision making, giving them greater responsibility for their own health. Patients must be given adequate information on timescales, anticipated process, and their own responsibilities to assist the health board to provide efficient and effective treatment. Patients will be empowered through this information provided by national or local information systems to question and monitor their own progress against targets.

5. Performance Monitoring and Reporting

In order that the health board can robustly assess performance across all aspects of service and delivery it is vital that the IQPF supports an integrated approach to monitoring and reporting. A monthly Integrated Quality and Performance Report will be produced as well as a monthly commissioned services report to provide an integrated performance update across each provider the health board commissions from. Both of these reports will be presented on a monthly basis to the Executive Team and at each Board meeting and will ensure read across to the Health Board Integrated Quality Report that is presented to the Patient Experience

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and Quality Committee. Quarterly Progress Against Plan reports will also be provided, giving assurance to the Board on delivery against the Annual Plan.

A dashboard will be created that will feature overall performance information which will give greater insight into the services residents are receiving out of county versus the resources deployed.

To enable an integrated approach to be used to assess quality and performance, the framework sets out the necessary domains and attributes of performance management and reporting processes.

The domains below set out the areas which inform assurance processes, and which must be considered and evaluated within the framework of organisational performance.

5.1 Coverage of the Integrated Quality and Performance Framework

The attributes identified describe the necessary elements or reporting required to enable the effective implementation of the IQPF .

Domains	Description
Access to Care and Timeliness	Assurance on timely and appropriate access to health care services to achieve the best health outcomes within agreed targets.
Quality, Safety and Patient Experience	Assurance against national and locally set quality and safety measures of care ensuring services are:  Assurance through listening and responding to patient and carer feedback along with complaints and concerns and the development of PROMS and PREMS. Work within the principles of the Health Board Quality Management System (see section 5.3)

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Domains	Description
Finance & Value	Assurance that services are improving efficiency and productivity and financial plans are being delivered. Prudent or Value-Based health care approach.
Workforce and Culture	Assurance that the organisation has a motivated and sustainable workforce that is well-trained and the capacity and capability to provide quality services.

Attributes of the Integrated Quality and Performance Reporting Framework

Attribute	Description
Link to Wellbeing Objectives/ Strategic Priorities and Critical Actions (Progress Against Plan)	Clear links to Wellbeing Objectives, Enabling Objectives and Strategic Priorities to ensure delivery of plans and support prioritisation processes.
Exception Reporting	Reporting of improving, poor or challenging performance through effective and comprehensive exception reporting.
Scorecard Reporting	Supporting enhanced understanding of organisational performance through a high-level overview.
Qualitative & Quantitative	A mix of quantitative indicators and data supported by concise qualitative contextual information providing insight into influences on performance.
Timely Information	Consistently updating information and managing the timeliness of information to ensure up to date analysis of performance and resolution of issues.
Managing Risk	Using risk registers and assurance frameworks (corporate and local) to inform performance improvement decisions.
Analytics	Looking beyond results to interpret and communicate meaningful patterns in data.
Forecasting	Predicting future positions and anticipating risks through forecasting.
Benchmarking	Contextualising performance through comparison to best practice and peers and identifying areas for improvement.
Targets / Measures	Setting challenging, achievable, and meaningful targets to monitor performance, celebrate improvement and reinforce purpose linked to strategic direction.
Performance Trajectories	Indicating expected timescales of delivery and to enable regular monitoring of performance.
Performance Against Targets	Using status scales to effectively communicate performance against plan/target/trajectory.

Attribute	Description
Targeted Performance Improvement Planning	Clear action plans in place to ensure mitigating actions and performance recovery is delivered.
Responsibility & Accountability	Accountable leads identified for actions to ensure delivery.
Escalation & De-escalation	Review 'performance hotspots' to identify escalation/de-escalation action Focus on accountability through management intervention identifying and agreeing actions, consequences, tolerances and incentives where appropriate.

5.2 Planning for Performance Delivery

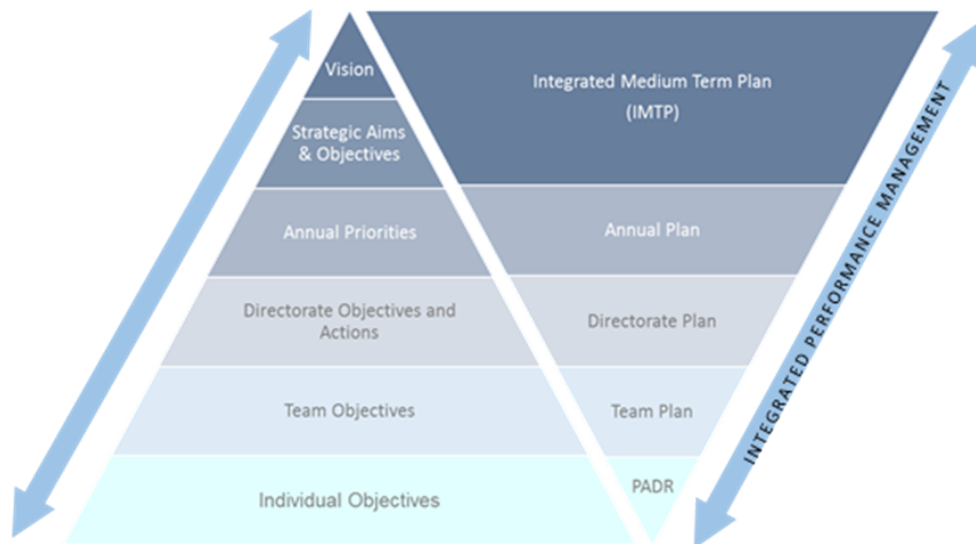
Fundamental to robust performance management and improvement is alignment with the strategic planning cycle and processes. Developing robust plans will ensure a clear focus on delivery and a framework for prioritising resources. Coherent plans with clear alignment between the Annual Plan, Directorate Plans, Team Plans and Personal Appraisal and Development Reviews help to ensure that individuals and teams are aware of their personal accountability for the delivery of improvements in service and performance.

At every level of the organisation stemming from the Chair and Chief Executive Officer, staff will need to be involved in the process of agreeing plans, objectives, performance measures and targets to ensure ownership of the process and as a core component of the pay progression process. This means that performance improvements and objectives must be assessed, as stretching but achievable. These will reflect the Board's strategic objectives, translated into operational and individual objectives. Recognising that the workforce is key to delivery, the Health Board will reflect and incorporate learning on the deployment of planning and performance management across the organisation to ensure continued improvement.

The figure below describes an alignment of plans to personal objectives and the relation to the Integrated Quality and Performance Framework.

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5.3 Performance Reporting and Assurance Measuring Performance

The use of targets, measures, indicators and trajectories and their deployment across the organisation is a key part of implementing the Framework for Improving Performance. All means of measuring performance should facilitate organisational understanding of performance and delivery and therefore should have the following characteristics:

- Relevant
- Able to avoid perverse incentives
- Clear accountability
- Well defined
- Timely
- Reliable
- Comparable
- Verifiable

Performance measures will be agreed at various levels in the organisation. These include specifically Board, Board Committees, Directorate, Team, and an individual level. Performance measures will include the following:

Performance Measure	Description
NHS Wales Performance Framework	Through the specific measures of the NHS Wales Performance Framework the health board is measured on the delivery of services and processes that contribute towards the goals of the Public Health Outcomes Framework for Wales, and ultimately the national indicators of the Wellbeing of Future Generations Act as well as its contribution to meeting the Social Services and Wellbeing Act requirements.
NHS Wales Planning Minimum Data Set (MDS)	This data set introduced to measure against key areas of primary care, mental health, cancer care, unscheduled care, planned care and includes forecasts and actual in revenue and workforce planning.
Progress Against Plan	The Annual Plan will be agreed locally through Board approval, including Wellbeing Objectives, Enabling

Performance Measure	Description
	Objectives and Strategic Priorities. and Progress against Activities and Deliverables will be reported quarterly.
Local Measures	Further local measures may be agreed at a Directorate/Team level to support the delivery of Directorate and Team Plans. Work is also underway as part of the Better Together Portfolio on a Benefits Realisation Framework which will strengthen the oversight and scrutiny of the impacts and outcomes of transformation activity.
Primary Care Performance	Primary care is at the heart of the vision for health services in PTHB. It is necessary that primary care performance systems and measures within the National Oversight Framework (NOF), the Quality & Outcomes Framework (QOF) and locally agreed key performance indicators are aligned to the overarching health board Framework for Improving Performance.
Performance Trajectories	Performance trajectories are set internally or worked through collaboratively with providers where appropriate against targets and measures, to demonstrate schedule for delivery and to enable the monitoring of improvement throughout the year. Trajectories against national measures, MDS measures and key priority areas are agreed through Board approval of the Annual Plan and are to be monitored at committee level with additional trajectories set, agreed and monitored by Directorates/Teams as appropriate.
Social Services National Outcomes Framework	The Social Services Outcomes Framework applies to outcomes for people in need of care and support and carers in need of support. While this outcomes framework is directly linked to performance within social services it should be considered as part of the broader framework for delivery, and it therefore forms a key part of the whole system outcomes framework the health board aims to develop.

5.3.1 Business and Performance Intelligence

Business and performance intelligence will play a central role in providing both assurance to the Board, and critical intelligence to leaders and managers, teams and individuals throughout the organisation to focus improvement efforts. The development of this core organisational functionality will continue to receive focus as information capabilities across the range of areas of the health board continue to mature. The provision of effective business intelligence (data and information) and performance intelligence (context and rigour) will be key to ensuring that the organisation has a clear and consistent picture of performance and further work

will take place in assuring the organisation of the integrity of the intelligence it places reliance upon. The relevant Board Committee will have delegated responsibility to ensure that the integrity of data and information is protected ensuring valid, accurate, complete, and timely data and information is available for use within the organisation.

5.3.2 Benchmarking

Benchmarking performance will be a key component of improving service delivery. Using robust benchmarking will enable the contextualisation of performance through comparison to best practice and peers and will aid in the identification of areas for improvement. Benchmarking will be appropriately applied using comparisons internally, across Wales, across the U.K. or internationally as possible and applicable and strengthening the health board's ability to establish benchmarking across performance areas will be a key action. Benchmarking will utilise systems and national group examples such as CHKS, NHS benchmarking project Wales, NHS benchmarking club, Model system (English providers only, Get it right first time (GIRFT).

5.3.3 PTHB Quality Management System

The Duty of quality requires NHS bodies to establish effective quality management systems to improve the quality of healthcare services and improve outcomes for people in Wales. The four components of a Quality Management System are Quality Planning, Quality Control, Quality Assurance, Quality Improvement. These are reflected in the PTHB Quality Management System approach:

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Principles

Patient focus; Evidence based decision making; Population and Stakeholder Engagement; Clear Vision and Purpose; Leadership and Organisational Culture & Values; Education and Training; Internal Audit; Documentation Management; Information Management; Process Management; Procurement Management; Health and Safety Management; Risk Management; Environmental Management; Legal and Regulatory Compliance; Human Resources; KPI's

Domain	Narrative
Quality Planning	- Understanding population need & design of services, policies, structures, systems to meet those needs. - Quality Control and Quality Assurance need to feed into Quality Planning. - Reflect government strategies and targets. - When services are assessed, reviewed and undergo service change, quality impact assessments will be undertaken, considering the 6 domains of quality (STEEEP) and the five enablers of Leadership, Culture & Valuing People, Data, Learning Improvement & Research, and Whole Systems Perspective. Population data and public health intelligence will support and inform our planning.
Quality Control	- Processes in place to monitor performance in real time & take action when required standards not met. - Control processes owned by those directly providing the service with skills and permission to address performance issues within their control. - Quantitative and qualitative measures with appropriate escalation measures. - We monitor the quality and safety of our services through key sources of intelligence. This includes patient safety and nationally reportable incidents (incident management framework), near misses, patient feedback through surveys and local intelligence gathering, patient concerns and complaints. In partnership with the third sector and Llais, we also triangulate their sources of information. Other sources of key intelligence to monitor and assess services include clinical audit, NWSSP internal audits, HIW inspections and reviews by the Wales Audit Office.
Quality Improvement	- Model for Improvement - Cycles of experimentation informed by ongoing reflection using both quantitative and qualitative data. - Practical iterative tests of change to learn, implement and scale improvements in quality of services and patient outcomes - Intelligence that we gather through our quality controls inform our priorities for improvement and subsequently our strategic transformation. Our Transformation team are central to this deployment; however, improvement and transformation is seen as a key role for all our staff in PTHB.
Quality Assurance	- Verify that quality control is maintained, and that performance is evaluated. - 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. - We deploy floor to Board reporting via our quality governance processes and structures. The Integrated Quality Report (IQR) presented to the Patient Experience and Quality Committee (PEQs) is the mechanism through which the Quality domain of the IQPF is reported to the Board. - The service groups QUAILS (Quality Assurance, Learning and Improvement Groups) within service areas (e.g. Mental Health, Community Services, Women and Family) deploy quality control and improvement locally and report through the IQR to the Executive Committee, PEQs and Board. - Similarly, the Patient Experience Steering Group, Safeguarding Strategic Group and Infection Prevention Control Steering Group report to Board via the IQR.

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5.4 Oversight and Accountability

Performance and quality of care assurance reporting is undertaken at every level throughout the Health Board, from individual performance appraisals through to Directorate Performance Reviews. The reporting arrangements will be proportionate and regular to ensure an effective process for monitoring performance, achievements and non-delivery and agree actions and ongoing review to ensure corrective action where necessary.

Performance should be managed and resolved at the appropriate level of accountability and authority. The identification of areas of performance that require attention and escalation will be based on informed analysis of performance, considering local context, local and national targets, delivery trajectories, quality and safety, progress against Health Board plans, finance, benchmarking and risk management.

The structure of reporting, escalation and assurance is described below, this will require refinement and updating as the process evolves:

It is important that there is clarity on the standard and minimum level of oversight. The table below sets out the "base" position for performance meetings. The application of any external or internal escalation level will modify the base position as set out below:

Level	Mechanisms	Frequency	Coverage
Board <i>Internal Scrutiny</i>	Board	Bi-monthly	- Quarterly Outcomes (life course) Report - Integrated Quality and Performance Report - Quarterly Progress against Plan report
	Patient Experience Quality Safety Committee (PEQS)	Quarterly	Integrated Quality Report
	Delivery and Performance Committee (D&P)	Bi-monthly	- Integrated Quality and Performance Report - Quarterly Progress against Plan report - Outcomes Framework - Finance Report
	Workforce & Culture	Quarterly	Workforce Report
Executive <i>Executive oversight</i>	Executive Committee	Fortnightly	Monthly focus on performance delivery by exception
Operational Directorates <i>Accountability & Assurance</i>	Integrated Quality and Performance Group review (detail below)	Quarterly	- Access and Activity - Quality, Safety and Patient Experience - Finance and Value - Workforce - Progress against plan

Level	Mechanisms	Frequency	Coverage
Corporate Teams <i>Accountability & Assurance</i>	Integrated Quality and Performance Group review (below)	Quarterly/Six Monthly	- Quality & Safety - Finance and Value - Delivery - Workforce - Progress against Plan
Commissioned Providers <i>Accountability and Assurance</i>	Contract Quality and Performance Review Meetings.	Monthly/Bi-monthly/Quarterly	- Access and Activity - Quality, Safety and Patient Experience - Finance and Value - Workforce
	Commissioning Oversight and Assurance Group.	Monthly	
Directorate/ Team <i>Collective Responsibility</i>	Internal governance tailored to directorate/ team	Monthly	- Quality & Safety - Finance - Delivery - Workforce - Progress against plan
Individual	PADR	Quarterly	Delivery against objectives
Personal contribution	One to Ones	Monthly	Delivery against objectives
	Appraisals and validation	Annual	Setting and Delivery against objectives

5.5 Management and Monitoring

Central to the effectiveness of the IQPF is clarity on where the “business of performance” is undertaken. Details of the meetings arrangements are set out below.

5.5.1 Personal Appraisal and Development Review meetings

Performance Appraisal and Development Reviews (PADR) are protected quality time for staff and their manager to have a meaningful conversation so that staff know what is expected of them and they understand how their contribution helps the organisation achieve its vision, aims and objectives and helps to deliver the best possible care and services for the people of Powys. They are therefore the principal process of the deployment of planning and performance management and improvement across the workforce.

Regular and meaningful conversations and meetings should be used to set individual objectives and review progress, rewarding and recognising good performance.

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Performance and attainment of satisfactory appraisal ratings at year end appraisal are linked to pay progression, therefore it is important that individual objectives are agreed, are reasonable in number, clear, challenging and measurable.

It is both the employee and manager's responsibility to ensure they have an appraisal meeting scheduled for six weeks before an increment date with regular reviews in place.

It is also the responsibility of all staff and managers to plan and prepare for their appraisals.

5.5.2 Team Performance Reviews

Teams should regularly review their performance against their team plan using this to inform personal objective setting and the directorate Integrated Quality and Performance reviews.

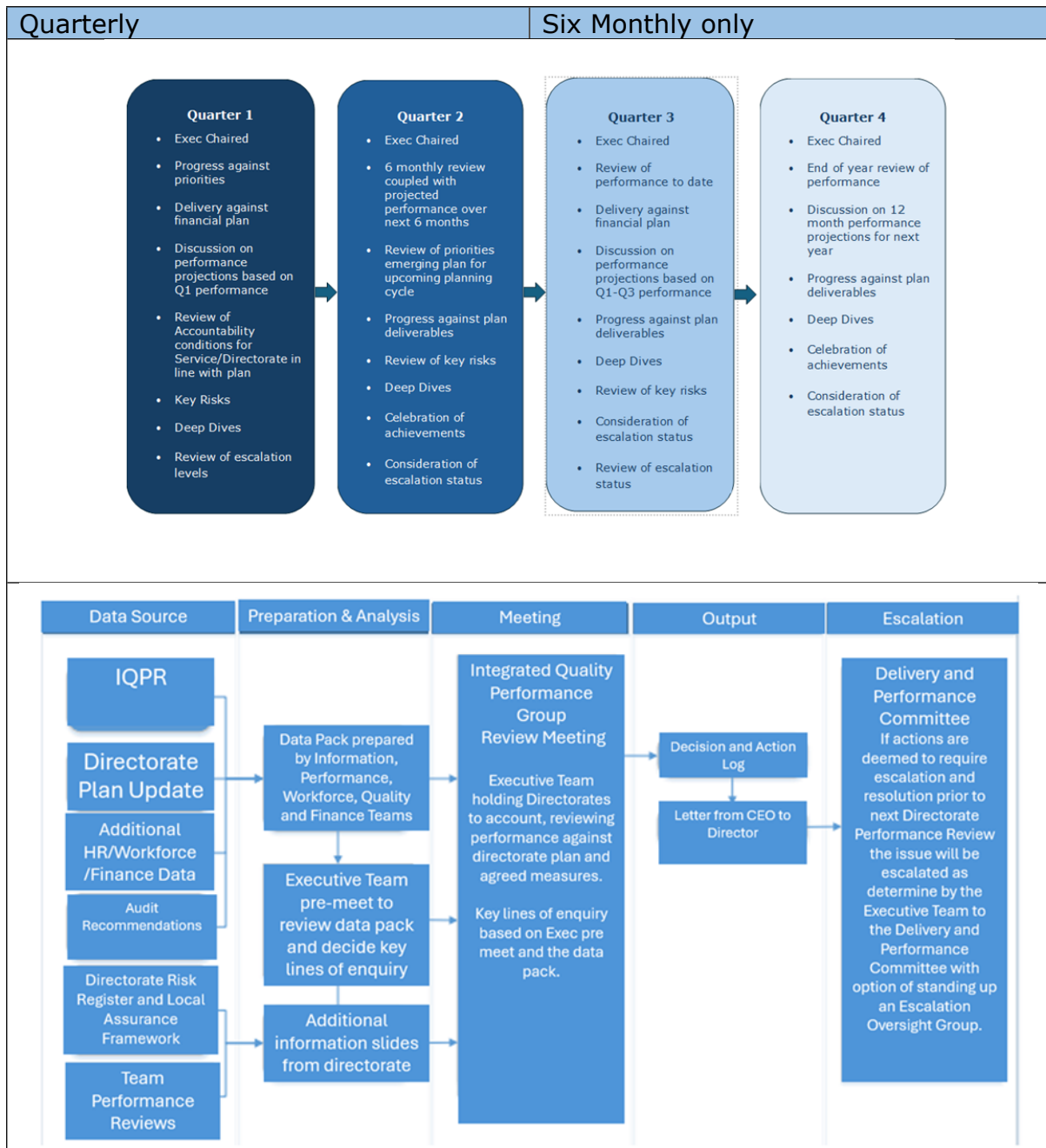
5.5.3 Directorate Integrated Quality and Performance Group (IQPG) Meetings

This IQPF applies to the whole organisation with Integrated Quality and Performance Group Meetings being held on a Quarterly and Six Monthly basis to review areas of their portfolio as agreed in the scheme of delegation:

Quarterly	Six Monthly only
• Planning, Performance and Commissioning • Medical • Primary, Community Care and Mental Health • Nursing, Quality, Women and Family Health • Digital	• Public Health • Corporate Governance • Allied Health Professions and Health Sciences • Finance, Estates and Support Services • People and Culture • Transformation and Improvement
For the <u>quarterly IQPG meeting</u> the following features will apply: • Chaired by Clinical Director (MD/EDoAHP/EDoNM). • Vice Chair Director with lead for Performance (EDPPC). • Representation from operational colleagues as appropriate. • Representation from Deputy / Assistant Director of Finance, Workforce, Quality, Planning, Performance and Commissioning, Improvement and Transformation, and Business Partners. • Other members can be co-opted to cover areas of specialist expertise should this be determined to be helpful.	The <u>six monthly IQPG meeting</u> will cover a broader agenda and so involve a wider representation: • Full Executive Team present. • Where necessary, deep dives into key areas of challenged quality, performance and finance will be requested in advance and considered within the meeting agenda. This meeting will also consider progress against specific actions set out in the Health Board plan. These reviews will also include specific consideration of the highest rated risks along with mitigating actions to manage these. • The review will consider the key performance indicators (working



Quarterly	Six Monthly only
The meeting will be a focused meeting and will concentrate on a subset of key quality, performance and financial metrics as required by the health board plan; this will be done by exception. Should separate, more detailed finance (or other) discussions be required, these will be agreed through the assurance review process using the escalation options. These reviews will also include specific consideration of the highest rated risks along with mitigating actions to manage these. There is a clear expectation that the reviews will build on historical reporting to look ahead on a rolling quarterly basis and define the critical actions to ensure performance is delivered and where relevant recovered from any position of variance. The review will consider the content of the Service Performance report/ performance dashboard and will be supported by agreed action notes for each session. The quarter 2 and quarter 4 meetings will serve as <u>six-monthly</u> performance reviews, with quarter 4 functioning as a review of the year, providing an opportunity to fully celebrate and recognise the successes and achievements of the Directorate and enable a discussion on delivery plans for the year ahead.	towards a standard performance dashboard by area/service) and will be supported by agreed action notes and a formal letter from the chair of the meeting.
<u>IQPG meeting structure</u>	



The IQPG meetings will enable the Executive Team to hold Directorates to account for delivery against plan and agreed performance management and improvement measures and support the development of integrated plans, by:

- Reviewing directorate performance against directorate plan (i.e. their directorate delivery of Annual Plan) and agreed performance measures and trajectories.
- Ensuring directorate performance management and review is integrated, thus considering all perspectives i.e. Quality & Safety (referencing the principles of the PTHB Quality Management System as described in

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section 5.3); Patient Experience; Access & Activity; People & Organisational Development; Finance; and Governance.

- Investigating and challenging areas of non-delivery and ensuring improvement plans are in place.
- Exploring learning opportunities and areas of best practice.
- Identifying requirements for additional support and guidance in managing delivery and developing plans.
- Ensuring a culture of high performance and continuous improvement.

5.5.4 Local Performance Intelligence and Assurance Arrangements

In conjunction with each Operational Directorate and Corporate Directorates the Performance Team, supported by the Information Team, will look to implement local performance reporting and management systems which will include, as a minimum, the following areas of discussion on a minimum of a monthly basis through Directorate Management Team meeting structures and report into the above quarterly and six monthly performance review structure:

- Quality and safety meeting through which risk, clinical governance, patient experience, health & safety performance be reviewed (referencing the principles of the PTHB Quality Management System as described in section 5.3).
- Performance meeting to include reporting on Key Performance Indicators (KPIs), projections and agreed local action to include activity compared to plan, (e.g. delayed pathways of care, length of stay and urgent and emergency attendance).
- Workforce key performance data on attendance, turnover, mandatory training compliance and attrition.
- Monthly financial position review (key drivers of the financial position to be discussed in detail).
- Monthly savings review to assure in-year plans and build a pipeline of future savings opportunities.

5.6. Commissioned Services Oversight

The Health Board commissioning arrangements are extremely complex and include agreements with health providers in NHS Wales and NHS England for the provision of non-specialist services for the Powys population.

5.6.1 Commissioning Oversight and Assurance Group (COAG)

The COAG provides a formal forum for internal oversight and escalation for the performance monitoring of commissioned non-specialist services, informed and supported by the Contract, Quality, Performance and Resource meeting (CQPRM) process with reference to the PTHB IQPF; PTHB proposed draft Strategic Commissioning Framework (SCF); NHS Wales Planning Guidance and Performance Framework; and NHS England Annual Priorities and Operational Planning guidance.

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The Group, which will be chaired by the Executive Director of Planning, Performance and Commissioning, will provide oversight of the performance of commissioned service providers against the four domains of the IQPF:

- Analysis of relevant data including demand and capacity of service, NHS Wales and NHS England Performance Framework adherence, workforce availability/cost, trends, areas of concern, and opportunities for improvement.
- Receive updates, from CQPRMs, to feed into the Health Board Integrated Quality and Performance Report and Commissioned Services Performance Report (the latter to be presented to the Executive Committee on a monthly basis).
- Identify and discuss specific challenges and issues that impact the performance of services. This process will underpin the IQPF exception and escalation process.
- Review and monitor action plans that address the identified challenges and outline the steps required for mitigation/improvement. These plans should be specific, measurable, achievable, relevant, and time-bound (SMART) to ensure effective implementation with progress against timelines of recovery / improvement.
- Update and maintain the commissioning services risk register, reviewing and validating the risk score/impact and feed into overarching corporate risk register
- Determine requirement for further internal escalation and enact these as required

5.6.2 Contract, Quality, Performance and Resource (CQPRM) meetings

Provides a mechanism to oversee the arrangements for performance monitoring of PTHB Commissioned Services with reference to the PTHB IQPF; PTHB proposed draft Strategic Commissioning Framework (SCF); NHS Wales Planning Guidance and Performance Framework; and NHS England Annual Priorities and Operational Planning guidance.

The CQPRM will ensure that:

- PTHB and Provider resources are used wisely to get the best possible outcomes (individual, service, organisation and community) and experience for the population we serve.
- The evidence base for which interventions are most effective, looking at unwarranted variation in services, outcomes and costs, and measuring the impact actions are having on improving experience and outcomes of individuals and populations and the use of resources.

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- There is focus on quality outcomes, experience and cost to help ensure that resources are allocated and managed to have the greatest positive impact.
- There is clear, consistent strategic direction, strong leadership and transparent lines of accountability.
- At all levels there is a person centred approach, putting patients, patient safety and experience as well as safeguarding above all other considerations.
- The right systems and processes are in place to deliver from a patient's perspective – safe, timely, efficient, effective and equitable services.
- There is good team working, non-hierarchical collaboration and partnership working to provide the best possible health and wellbeing outcomes. Risks and issues are actively identified and robustly managed at all levels.
- Relationships with commissioned service providers ensure that decisions are based upon valid, accurate, complete and timely data and information.

The frequency of CQPRMs will be dependent on the circumstances, performance and range of risks identified for each contract with NHS Wales, NHS England, private sector commissioned service providers.

Within these meetings, assurance on compliance will be sought and information reviewed in line with the contract requirements to ensure national standards for performance, quality, patient experience and finance are met as detailed within the NHS Wales and NHS England Performance and Delivery Frameworks.

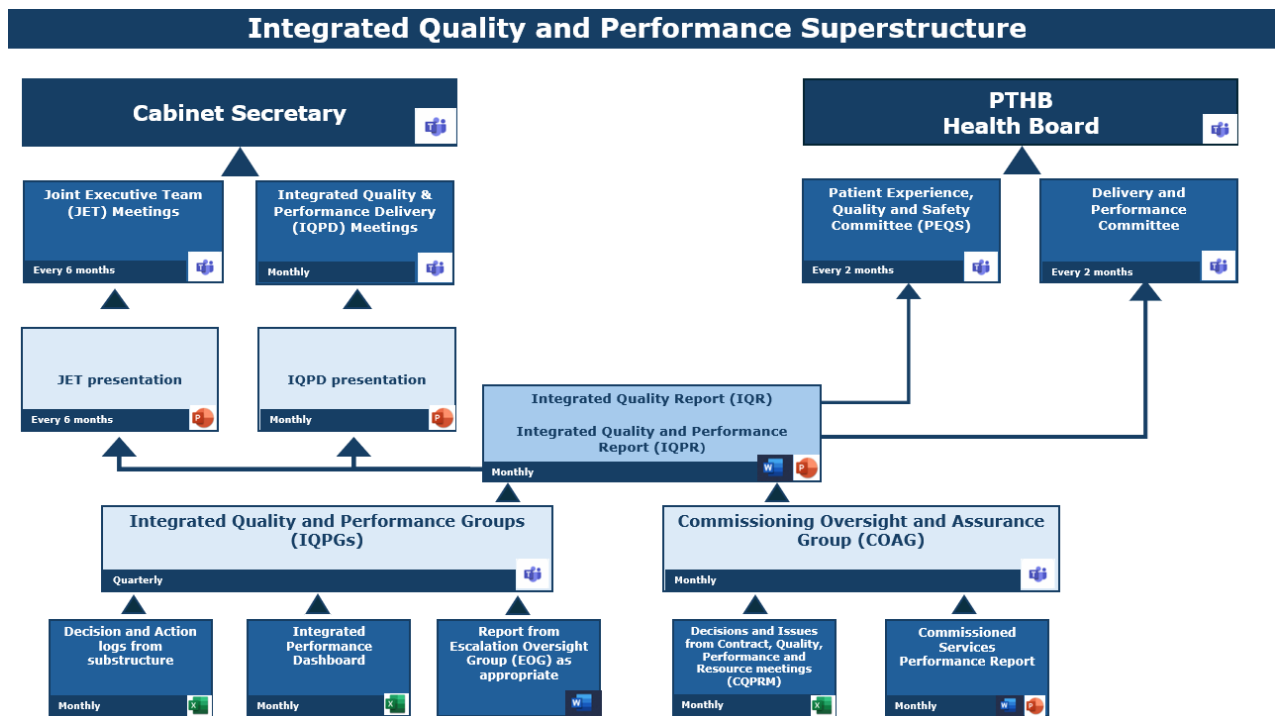
The core membership of the CQPRM, which will be chaired by the Assistant Director of Performance and Commissioning / Head of Commissioning shall comprise officers from Commissioning, Quality, Finance, Information, Performance, Workforce and Service Group colleagues (as appropriate) from PTHB and commissioned service providers.

6. System of Reporting, Review, Escalation and Assurance

It is the expectation that the Integrated Quality and Performance Group review meetings at both clinical service group and corporate level will report to the Executive Committee. The CQPRMs will report to the COAG which will then report to the Executive Committee. Reports and issues by exception will be received by the Delivery and Performance Committee / PEQ Committee for assurance and scrutiny as appropriate, ultimately then reporting to Board. The illustration below sets out the high-level approach to performance oversight:

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7. Provider Services Escalation Arrangements

- 7.1 The operationalisation of the IQPF is predicated on the principle that, wherever possible, issues should be resolved at individual, team, Operational Directorate or Corporate Directorate level and that Operational Directorates and Corporate Directorates should work collaboratively and be mutually supportive in line with Health Board values. This means escalation within provider services should be very much the exception and that, where it is necessary, proportionate, and appropriate support and intervention takes place at the earliest opportunity to ensure performance remains on track to achieve our objectives.
- 7.2 The purpose of escalation is two-fold. It is to ensure oversight at the appropriate levels of authority in order to provide assurance to the Board that performance and delivery is being robustly managed and poor performance addressed. Secondly, escalation serves to highlight issues where solutions require intervention and or support from higher levels of authority within the organisation. Individual thresholds for escalation should be determined on a case-by-case basis for services or measures based on an assessment of risk including confidence in associated controls and assurance.

Identification of performance issues for escalation will be based upon the nature and seriousness of the performance concern. De-escalation will occur through the delivery of management intervention, through the delivery of actions, consequences, tolerances, incentives.

This system of escalation reporting and review is designed to provide assurance through to Committees of the Board and the Board on the quality

and safety of services, access to care, improvement, and delivery against the Annual Plan.

- 7.3** First line intervention in relation to matters such as unresolved problems and persistent non-achievement of targets will be a dialogue between relevant Operational Directors and Corporate Directors to understand the reasons for this. Arrangements will then be agreed to either improve performance or better manage the risk and progress monitored.
- 7.4** Second line intervention will be to the Executive Team via the Integrated Quality and Performance Group meetings to understand the reasons for the failure to deliver and agree recovery actions with support to do this where necessary. The Executive Team will receive monthly performance updates as routine and where services are escalated, where appropriate, will also receive targeted monthly updates.
- 7.5** Progress will be monitored at regular review meetings, with the frequency being determined based on the particular circumstances.
- 7.6** There will be times when Operational Directorate or corporate team performance and delivery is triggering cause for concern with no evidence of sustained improvement. In such circumstances an escalation process will apply in line with the performance triggers as per the NHS Wales Quality and Delivery Framework. Escalation will be considered against 4 domains (Access & Activity; Finance & Value; Quality; Workforce & Culture) and 3 levels of escalation.
- 7.7** Escalation status for Operational Directorates and Corporate Departments will be reviewed monthly based on month end reporting against the key deliverables in the Health Board plan. The Executive Team will receive a monthly overview report which will assist in the determination of escalation and will also draw in other relevant matters as necessary. For clarity this will include elements of the following areas as relevant to the Operational Directorates or Corporate Directorate (other aspects will be added as required):
- Quality and safety matters e.g. Health Inspectorate Wales (HIW) inspections, never events
 - External reviews
 - Infection control
 - Patient experience
 - Any matters of public health
 - Performance against Plan deliverables
 - Financial performance
 - Unscheduled care delivery
 - Planned care delivery (OP, IP/DC, diagnostics, therapy)
 - Activity measures
 - Workforce matters, training, PADRs, revalidation
 - Cancer access

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- Primary care access
- Immunisation and Vaccination

7.8 The levels of the framework, triggers and escalation response are set out below. Broad triggers are described as a level of judgement that will need to be used about escalation decisions. However, the intention will be to maintain all Operational Directorates and Corporate Departments as low down the escalation framework as possible. Consideration will be made, as the IQPF beds in, on increasing the breadth of the benefits of earned autonomy which could include fewer performance meetings, changes in financial delegations, lighter touch Vacancy and Non Pay Control measures as examples. This will be considered as part of the development of the IQPF.

Escalation level	Performance Trigger	Action expected	Monitoring and support
Level 1: Normal arrangements (consider earned autonomy)	Local delivery of agreed objectives and performance, finance ambitions in line with agreed trajectories. No exceptions or quality concerns. Sound governance arrangements in place. Performance within expected targets.	No escalation action. Could result in freedom from some of monitoring mechanisms and meetings.	Main monitoring through base performance review process.
Level 2a	Failure to achieve / maintain delivery in more than 1 key deliverable / area of performance. Sustained deterioration on 1 or more domain.	Correspondence to Clinical service area/corporate dept on reasons for escalation – areas of concern, expected response and confirm any enhanced monitoring. Recovery plan to be developed that address issues to be recovered/improved.	Options include: • Internal support as required (QI/VBHC/planning – issue dependent). • Consideration of compliance with Professional clinical codes and standards and proportionate response.

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Escalation level	Performance Trigger	Action expected	Monitoring and support
	This can include: • Failure to deliver on an NHS Performance Framework target or local target trajectory. • A deviation or departure from the normal or expected course of action signifying specific condition or event that requires attention or further action to address the deviation. • Failure of quality standard.	Depending on issue – change in frequency of and focus of standard meeting and consideration of increasing frequency. Reported through to Executive Committee.	• Consideration of compliance with managerial code of practice. • Internal peer review. • Executive support (directly or from other teams). • Consider need for bespoke response. Minimum monthly updates to Executive Committee.
Level 2b (Financial)	Specially for finance: Where Corporate Directorate or Clinical Service Area level budget is overspending by more than £0.5m Year to date or £1m forecast.	Identified through monthly financial reporting	CEO to call a special 'Budget Review Meeting' of all Executive Directors and the Divisional or Directorate budget holder (up to 3 team members may attend in support). Agreed action plan established: – monitored through financial reporting arrangements. – Review period established if plan failing.
Level 3	Serious concerns on	Correspondence to service area/corporate dept on reasons for	Actions could include: - Independent review of

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Escalation level	Performance Trigger	Action expected	Monitoring and support
	quality and governance. Continued and consistent failure to meet agreed performance improvements and trajectories across a number of objectives. Clear articulation of reasons for escalation and criteria for escalation. This can include: • Where a performance matter (exception) does not meet target and hits criteria for higher level of resolution, decision making or further action. • Any measure that continues to fail a health board submitted trajectory as part of the Ministerial Priority measures.	escalation – areas of concern, expected response and confirm any enhanced monitoring. Service Area or corporate directorate demonstrating recognition of issues and commitment to improve. Improvement/recovery plan required to address issues identified. Reported through to executive and relevant committee.	service/corporate department effectiveness. - Temporary or permanent change in leadership arrangements. - Consideration of compliance with Professional codes and standards and proportionate response. - Deployment of appropriate HR policies e.g. Capability policy. - Weekly/fortnightly meetings with CEO and/or relevant execs to track progress against improvement actions (which directly related to de-escalation criteria). Minimum monthly updates to executive and relevant committee.

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Escalation level	Performance Trigger	Action expected	Monitoring and support
	• Performance recovery is failing to improve or maintain performance. • Any significant failure of quality standard.		

7.9 These arrangements act as a framework and may need to be flexed to respond to the specific circumstances and context.

7.10 In areas where performance does not improve the Executive Team will agree the support options available. The final decision on support options will rest with the Chief Executive Officer.

7.11 Reporting of escalation levels and associated actions to recover performance will be to the Executive Team and to both the Delivery and Performance Committee and the Quality and Safety Committee as determined by the performance challenges faced.

8. Commissioned Services Escalation

8.1 For PTHB Commissioned Services, the escalation framework as detailed in Section 7 will be referenced to ensure oversight to provide assurance to the Board that commissioned services performance and delivery is being robustly managed and poor performance addressed.

8.2 Identification of performance issues for escalation will be based upon the nature and seriousness of the performance concern. De-escalation will occur through the delivery of management intervention, through the delivery of actions, consequences, tolerances, incentives.

8.3 Performance will be monitored through regular CQPRM meetings with the frequency of these meetings being determined based on the particular circumstances.

8.4 There will be times when a commissioned service provider performance and delivery is triggering cause for concern with no evidence of sustained improvement. In such circumstances an escalation process will apply in line with the performance triggers as per the NHS Wales Quality and Delivery Framework. Escalation will be considered against 4 domains (Access &

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Activity; Finance & Value; Quality; Workforce & Culture) and 3 levels of escalation.

- 8.5 Intervention in relation to matters such as unresolved problems and persistent non-achievement of targets will be as per the Disputes and Arbitration process detailed within the Long Term Agreements (LTAs).

9. Implementation

The implementation of the IQPF will continue with the revised framework implemented from 1st April 2025. The implementation plan will be managed via the Delivery and Performance Committee as will any infrastructure reporting changes required as a result of the implementation of this revised framework.

10. Feedback

Key to continuous improvement, learning and development is effective feedback. The reporting and escalation process set out in the framework should be accompanied by feedback on actions taken, outcomes and learning.

11. Review of the IQPF

This IQPF will be approved by the Board. It will be reviewed annually by the Delivery and Performance Committee who will make recommendations for refresh when deemed necessary or in three years whichever comes first.

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Appendix A: Supporting Information

A.1 NHS Wales Escalation and Intervention Arrangements

The IQPF sits within the broader performance management arrangements of NHS Wales. The IQPF assists the health board in fulfilling its duties to maintain appropriate governance arrangements to ensure it is operating effectively and delivering quality and safe care to patients. The framework also supports the health board to provide accurate and timely responses to requests for information from Welsh Government and enables cooperation with action taken under the collective arrangements of the [NHS Wales Escalation and Intervention Arrangements](#) where necessary.

A.2 Board Assurance Framework

Performance management is a major part of PTHB's assurance arrangements and an important component of its overall system of internal control. Performance reports and review meetings generate valuable information for an assurance framework and so performance reporting and the Board Assurance Framework are strongly aligned. Performance reports will detail known performance issues and the planned corrective action. These, in turn, will be reflected in the assurance framework within the descriptions of gaps in control. Similarly, the results of performance reporting will be used to regularly review the effectiveness of internal controls and inform integrated planning processes.

A.3 Proposed Draft Strategic Commissioning Framework

The effective alignment and interdependency of the Health Board Integrated Quality Performance Framework and the proposed draft Strategic Commissioning Framework (currently being finalised- hyperlink to be inserted once completed) is vital and will facilitate a more robust understanding of achievements, risks and issues to delivery, highlighting issues of capacity, resource and prioritisation. This will enable the Annual Plan, Directorate Plans and Team Plans to be evidence based, challenging and achievable.

A.4 Performance and Outcomes Frameworks

There are three key National Outcome Frameworks which need to be considered within the Framework for Integrated Performance; The NHS Wales Performance Framework, the Public Health Outcomes Framework and the Social Services Outcomes Framework. These frameworks set out the population and process outcomes to be delivered through both health and social care. The health board and Powys County Council will work to develop a coherent whole system performance outcomes framework; aligning these three frameworks and other performance frameworks to enable more efficient and effective performance

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management and improvement across health and care. Further detail of the three frameworks is provided below.

A.5 Wellbeing of Future Generations Act (2015)

The Wellbeing of Future Generations Act sets a legal requirement on Welsh Ministers to set national indicators for the purpose of measuring progress towards the achievement of the national wellbeing goals. Other performance management and indicator frameworks should be viewed in the context of the Wellbeing of Future Generations Act.

A.6 NHS Wales Planning and Performance Frameworks (including Cabinet Secretary Enabling Actions)

Organisational delivery measured against the annual NHS Wales Performance Framework evidences the delivery of services and processes which contribute to the goals of the Public Health Outcomes Framework for Wales and ultimately the national indicators of the Wellbeing of Future Generations Act. The Powys THB IQPF to support the health board in providing assurance to the Welsh Government that it is delivering against priorities and driving up standards through reporting against the delivery framework measures.

Performance reporting within the health board will be aligned to its Annual Plan and therefore to the agreed aims and strategic objectives. However, the alignment to the NHS delivery domains will be maintained through the comprehensive reporting against the measures within the national delivery framework.

A.7 Public Health Outcomes Framework

While not a performance management framework, the Public Health Outcomes Framework enables a greater understanding of the impact of individual behaviours, public services, programmes and policies on health and wellbeing in Wales. The framework was developed within the context of the other national outcomes framework and more particularly underpins the national indicator for the wellbeing of Future Generations Act, providing a detailed range of measures that reflect the wider determinants that influence health and wellbeing. Accordingly, the Public Health Outcomes Framework will likely be integral to the development and monitoring of the Powys Public Service Board's Wellbeing Plan and the Health and Care Strategy for Powys.

A.8 Social Services Outcomes Framework

The Social Services Outcomes Framework was developed to fulfil the requirements of the Social Services and Wellbeing Act (2014). The outcomes framework sets the national direction to promote the wellbeing of people who need care and support and carers who need support in Wales, it describes the important national wellbeing outcomes that people who need care and support and carers who need support should expect to lead fulfilled lives and it also provides greater transparency on whether services are improving wellbeing outcomes for those people who need care and support and carers who need support.

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A.9 Health and Social Care (Quality and Engagement) (Wales) Bill / Act

To include associated performance measures as they become operable within the Welsh NHS including Duty of Quality and Duty of Candour.

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Agenda item: 3.3

BOARD		26 March 2025
Subject:	Director of Corporate Governance Report	
Approved and presented by:	Director of Corporate Governance / Board Secretary	
Prepared by:	Director of Corporate Governance / Board Secretary	
Other Committees and meetings considered at:	The changes to the PTHB Standing Orders were considered by the Audit and Risk Assurance Committee (11 March 2025) and recommended to the Board.	
PURPOSE:		
The paper provides a series of updates to the Board linked to: • Board activity since the last meeting held on the 26 March 2025 • Application of the Common Seal • Board and Committee Effectiveness reviews • The Consent Agenda Protocol • The Protocol for In-Committee meetings.		
RECOMMENDATION(S):		
The BOARD is asked to: • RECEIVE the Director of Corporate Governance report. • RATIFY the application of the Common Seal applied on one occasion since 26 March 2025 and receive ASSURANCE that the action was taken in accordance with Section 9 of the Standing Orders. • Take ASSURANCE the Board and Committee Effectiveness reviews have been undertaken for 2024/25; • APPROVE the Consent Agenda Protocol; • APPROVE the Protocol for In-Committee meetings; • APPROVE the Boards annual work programme for 2025/26 noting it will change according to business need throughout the year.		
Approve/Take Assurance	Discuss	Note
Y	N	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	N	

5. Develop Workforce Futures	N	
6. Promote Innovative Environments	N	
7. Put Digital First	N	
8. Transforming in Partnership	Y	

EXECUTIVE SUMMARY:

Board Activity since the last in routine meeting public meeting held on the 26 March 2025.

In-Committee meetings

The Board aims to conduct as much of its business in public as possible. There are occasions where the Board will need to meet In-Committee (in private session) to discuss matters that are confidential at the time of meeting.

The Board have not held any In-Committee meetings since the last scheduled meeting on the 26 March 2025.

Additional In-Public Board meetings

The Board have not held any additional In-Public meetings since the last scheduled meeting on the 26 March 2025.

Board Development Sessions

The Board holds informal Board Development sessions on a monthly basis. The focus of Board Development sessions centre around four key themes:

1. Developing the (Board) team
2. Developing the Organisation
3. Engaging with the Organisation
4. Engaging with Strategic Partners

The Board held Board Development sessions on the 10 April and 8 May 2025.

Application of the Common Seal

In accordance with Section 9 of the Standing Orders, the Powys Teaching Health Board Common Seal may be affixed and entered onto the Register of Sealing when the entry is signed by the Chair and the Chief Executive and is witnessed by the Director of Corporate Governance / Board Secretary.

Affixing of the Common Seal has taken place on one occasion since the last report to the Board. This was taken in accordance with Section 9 of the Standing Orders. The document has been authorised and signed by the Chair and Chief Executive then sealed by the Director of Corporate Governance / Board Secretary. Contrary to the Standing Orders the documents were not signed in the presence of the Director of Corporate Governance/Board Secretary due to the modern working environment of remote working and application of

electronic signatures. Additional steps to check the confirm the authenticity of signatures are taken.

The affixing of the Common Seal has been applied on one occasion as follows:

Purpose	Document / Purpose
Deed of surrender for Health and Care Research Wales (hosted body) to exit the Castlebridge facility/venue	Deed of surrender

Board and Committee Effectiveness Reviews

Committee effectiveness reviews are a helpful and recognised component of good governance. They provide opportunity for reflection and then planned action in response to feedback, data and information.

Reviews have been undertaken for the following Committees:

- Audit and Risk Assurance (ARAC)
- Delivery and Performance (D&P)
- Patient Experience, Quality and Safety (PEQS)
- Planning, Partnerships and Population Health (PPPH)
- Workforce & Culture (W&C)
- Local Partnership Forum (LPF)

The same approach of review has not been used for Executive Committee, due to the frequency and format of the meetings, a standing agenda item is in place seeking feedback and adjustments made throughout the year.

A review and reflection discussion has also taken place within the Remuneration and Terms of Service Committee and a formal questionnaire evaluation will take place in 2025/26.

Each review includes an online questionnaire of structured questions for Committee members and attendees to complete in the following areas:

- Composition and establishment
- Effective functioning
- Assurance
- General comments (including what is going well, what could be improved, learning and development)

All Committee Effectiveness review results have been presented to each Committee and discussed at a full meeting of each Committee. The key actions from effectiveness reviews will be incorporated into a governance action plan, this will also include actions relating to the governance of the Board more broadly, including the outcome of the Boards own effectiveness review – scheduled for the 5 June 2025.

Consent Agenda Protocol

The Consent Agenda protocol was introduced in March 2024 and was subject to a 12-month review. The Corporate Governance team and PTHB Chairs Forum have reviewed the protocol and recommend it to Board for approval.

Minimal change has been made, the review period has been extended to two years.

Protocol for In-Committee meetings

In accordance with Powys Teaching Health Boards Standing Orders (SOs), the Board holds its formal Board meetings in public. The SOs provide, at paragraph 7.5.2, the basis to meet and discuss relevant items in private. This is sometimes known as an 'in-committee Board meeting'. The legal basis of this section of the SOs is The Public Bodies Act (Admission to Meetings) Act 1960, section 1 (2).

There will be occasions when aspects of the organisation's business is considered more appropriate for in-committee session; this could be for many reasons.

A protocol has been developed to guide how the Board and its Committees determine in-Committee agenda items and the different rationales that apply to business considered within in-committee sessions.

The PTHB Chairs Forum has reviewed the draft and provided comments that have been incorporated.

Board Annual Work Programme

In line with the organisations Standing Orders and good governance practice, the Boards annual work programme has been developed and is attached to the paper. The plan has been developed taking into account the Boards Standing Orders and scheme of delegation, the Strategic (and previous Corporate risk register), topical and relevant matters identified by the executive team and Committee Chairs through Committee work plans and the carry forward of relevant annual requirements of the Board.

The work programme will continue to be provided at each meeting of the Board, progress against the plan will be tracked and relevant adjustments made throughout the year to ensure the Boards fulfils its responsibilities.

NEXT STEPS:

The Director of Corporate Governance will continue to provide a relevant report to the Board at each meeting.

IMPACT ASSESSMENT – NOT REQUIRED FOR THIS REPORT

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



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Consent Agenda Protocol

May 2025

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- A consent agenda is a Board/Committee meeting practice that groups business and reports into one agenda item
- The consent agenda contains items that are
 - routine
 - non-contentious; and
 - do not require an important decision from the Board/Committee
- Items included within the consent agenda may be for:
 - approval
 - assurance
 - information

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How Does the Consent Agenda Work?

- The Chair, with advice from the Director of Corporate Governance, decides which items to place on the consent agenda
- The agenda and associated documents are distributed in time for Board members to read and review, 5-7 days before the meeting
- Members are asked to notify the Director of Corporate Governance 24-48 hours before the meeting if they wish to bring any consent agenda items onto the main agenda
- At the beginning of the meeting, the Chair will ask all members again if any of the consent agenda items should be moved onto the agenda
- If a member requests that an item be moved, it will be moved. Any reason is sufficient to move an item.
- Once the item has been moved, the Chair will decide to take up the matter immediately or move it to a relevant part of the agenda
- When there are no items to be moved, the Chair or Director of Corporate Governance reads out loud the remaining consent items
 - On hearing no objections, the Chair can confirm that the items on the consent agenda have been accepted (either for approval, assurance or information)
- The full text of the resolutions, reports, and recommendations that were accepted as part of the consent agenda will be included in the minutes of the meeting.

- The consent agenda is designed to help us with the efficient management of our meetings
- All consent items will be routine, non-contentious and not require significant decision
- Any member can raise any report/topic from the consent agenda onto the main agenda
- Transparency and accountability remains fully in place, our responsibilities remain and therefore:
 - Consent items will be distributed 5-7 days in advance of the meeting
 - All consent items should be read in the same way as all other papers
- The use of the consent agenda was monitored and reviewed following the initial 12 months of operation (enacted March 2024, reviewed April 2025).
- The Board will continue to monitor the use of the consent agenda and will review this Protocol at least every two years going forward (April 2027).

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PROTOCOL FOR RESERVING MATTERS TO AN IN- COMMITTEE BOARD (and Committee) MEETING

**April 2025
Version 1 (DRAFT)**

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Introduction

In accordance with Powys Teaching Health Boards Standing Orders (SOs), the Board holds its formal Board meetings in public. The SOs provide, at paragraph 7.5.2, the basis to meet and discuss relevant items in private. This is sometimes known as an 'in-committee Board meeting'. The legal basis of this section of the SOs is The Public Bodies Act (Admission to Meetings) Act 1960, section 1 (2).

There will be occasions when aspects of the organisation's business are considered more appropriate for in-committee session; this could be for many reasons. This protocol identifies the different rationales that apply to business considered within in-committee sessions.

We are able to identify some issues in advance, however on some occasions this is not possible. In determining which matters should be reserved for private consideration, the Board may consider whether the information to be discussed would be exempt from disclosure under the Freedom of Information Act (FOI) 2000.

Powys Teaching Health Board's Values and Transparency

The Board is strongly committed to the Health Board being a value-driven organisation, rooted in the seven principles of public life ('the Nolan principles'), including openness, integrity and accountability. The Codes of Conduct and Accountability for NHS Boards and the Code of Conduct for NHS Managers Directions 2006 reinforce the seven principles of public life and focus on the crucial public service values which must underpin the work of the health service.

Our values are **'trust, respect, integrity, working together, kindness and caring, equality and fairness'**. The Board operates on the basis that transparency and openness are at the heart of its governance and decision-making approach; and that Board members debate everything in the public unless there is a specific reason not to do so.

Factors to consider when reserving a matter for an in-committee meeting

In deciding whether to reserve a matter for the In-Committee Board and

Committee agenda, there are a number of factors to consider, including:

- Whether the item or materials include personal data;
- Is there confidential or commercial sensitivity;
- Would the item undermine public confidence or cause undue concern or potential harm to the public;
- Are there reputational issues to consider – either for the Health Board or other individuals, partners or stakeholders;
- Are the documents in draft for future publication;
- Does the item include legal advice, is it legally confidential or is it subject to legal privilege;
- Could the matter be prejudicial to the conduct of affairs;
- Is the disclosure of the matter inhibited by law.

The list is not exhaustive and sets out examples of key considerations. The Board and its Committees may consider papers in draft form within an in-committee session, before taking the final version to meetings in public.

The following categories will generally be used for each agenda item on the In-Committee Minutes:

- Investigations into conduct of employees or Board systems
- Drafts of documents
- Discussion of issues likely to inhibit the free and frank provision of advice
- Information containing the personal data of any living person
- Information provided in confidence from another person or organisation
- Legally privileged
- Commercially sensitive
- Disclosures prohibited by law
- Undue concern or harm to the public, for example a health protection update
- Minutes of in-committee meetings / subgroup meetings - subject matter confidential

Management of Board meetings held in-committee

When the Board comes together for formal meetings, the in public Board agendas sets out the majority of the business under consideration. Board papers will include a formal rationale for taking any item in-committee session. Powys Teaching Health Board publishes the agenda for both in public and in-committee meetings on the website. Confidential papers relating to the in-confidence items are only circulated to Members of the Board or Committee. It may also be that some matters held in public

session have documents which may be withheld from public availability until such time as it is in final form and published, for example a draft report.

There may be occasions when the Board needs to convene within an in-committee session, without public notice, to consider urgent business associated with its legal and statutory roles.

Decision to consider items In-Committee session

The Chair, with advice from the Director of Corporate Governance/Board Secretary and where required the Chief Executive and/or lead Executive Officer, will decide whether an item should be considered in-committee in accordance with this Protocol. The Chair may also seek advice from any other member of staff or professional advisor, including the designated Data Protection Officer for the organisation.

Should a Board member disagree with the motion to hold a discussion in private this should be raised at least 24 hours prior to the meeting wherever possible to allow for discussion with the Chair (of the Board or relevant Committee) and Director of Corporate Governance/Board Secretary with the purpose of reaching a reasonable consensus. If an objection is raised at the time of the meeting, the meeting will be postponed allowing for the appropriate discussions to take place.

The reporting of items considered In-Committee session

The Chair of the Board will produce a summary report (via their Committee Chairs assurance report to the Board) of any items taken in-committee session and include this on the agenda for the next Board meeting in public session.

Review of this protocol and Feedback

The Board will review this protocol annually, to ensure that it continues to meet the needs of the organisation and remains consistent with the spirit of Regulations and Standing Orders. The Director of Corporate Governance/Board Secretary will maintain a log of items considered in-committee and will produce an analysis to inform the annual review.

We welcome any feedback about this Protocol and are happy to respond to any queries in relation to it. Please email the Director of Corporate Governance/Board Secretary at:

powysdirectorate.corporategovernance@wales.nhs.uk

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Board 2025-26									
Theme	Item Title	21/05/2025	25 June 2025 (Annual Accounts)	30/07/2025	24/09/2025	08/10/2025	26/11/2025	28/01/2026	25/03/2026
Governance	Minutes of previous meeting	✓	✓	✓	✓		✓	✓	✓
Governance	Declaration of Interests	✓	✓	✓	✓		✓	✓	✓
Listening and Learning	Patient Experience Story	✓		✓	✓		✓	✓	✓
Listening and Learning	Staff Experience Story	✓		✓	✓		✓	✓	✓
Governance	Update from Chair (inclu PSOW in Sept update)	✓		✓	✓		✓	✓	✓
Governance	Update from Vice-Chair	✓		✓	✓		✓	✓	✓
Governance	Update from Chief Executive	✓		✓	✓		✓	✓	✓
Governance	Assurance Reports of Board Committees	✓		✓	✓		✓	✓	✓
Governance	Board Action Log	✓		✓	✓		✓	✓	✓
Risk	Strategic Risk Register	✓		✓	✓		✓	✓	✓
Risk	Risk Appetite	✓							✓
Risk	Review of Risk Management arrangements						✓		
Governance	Assurance Reports of Board Partnership Arrangements	✓		✓	✓		✓	✓	✓
Governance	Assurance Reports of Joint Committees	✓		✓	✓		✓	✓	✓
Governance	Assurance Report of Local Partnership Forum	✓		✓			✓	✓	✓
Governance	Committee Terms of Reference	✓							✓
Governance	Committee Work Plans	✓							✓
Governance	Board Work Programme	✓							
Governance	Standing Orders (as needed)								
Governance	Scheme of Delegation (as needed)								
Governance	Common Seal (as needed)								
Governance	Committee Membership Annual Review			✓					
Governance	Annual Assessment of Committee and Board Effectiveness	✓							
Governance	Committee Annual Reports	✓							
Governance	Socio-economic duty assurance report			✓					✓
Governance	Speaking Up Safely and Raising Concerns Report	✓							
Governance	Board Assurance Framework	✓					✓		
Governance	BAF Dashboard	✓		✓	✓		✓	✓	✓
Governance	Structured Assessment							✓	
Governance	Review of Consent Agenda Protocol	✓							
Governance	Escalation and Intervention Status update	✓					✓		✓
Planning	Integrated Plan Approach to development						✓		
Planning	Draft Integrated Plan							✓	
Planning	Integrated Plan 2025/26								✓
Planning & Finance	Annual Delivery Plan 2025/26 including budget allocation and framework	✓							✓
Performance	Annual Delivery plan - by quarter	✓			✓		✓		✓

Performance	Primary Care Summary Report				✓				✓
Planning	Winter Planning/Resilience						✓		
	Winter vaccination programme				✓				
Partnerships	RPB Annual Report				✓				
Partnerships	RPB Delivery (6 monthly update) Date TBC								✓
Partnerships	PSB Wellbeing Plan (Future Generations Act). Next due 2027								
Partnerships	Partnership Governance Framework	✓					✓		
Population Health	Annual Report of Director of Public Health	✗			✓				
Performance	Integrated Performance & Quality Report	✓		✓	✓		✓	✓	✓
Finance	Approach to the Annual Accounts								
Finance	Annual Report and Financial Statements		✓						
Finance	Financial Performance	✓		✓	✓		✓	✓	✓
Finance	Charitable Funds Annual Accounts and Report							✓	
Finance	Approve contracts and financial delegations above the CEOs limit (as needed)								
Partnerships	Llais Regional Director Report	✓		✓	✓		✓	✓	✓
Equality, Diversity & Inclusion	Equality, Diversity and Inclusion Annual Report 2024/25			✓					
Equality, Diversity & Inclusion	Strategic Equality Report				✓				
Equality, Diversity & Inclusion	Welsh Language Annual Report			✓					
Compliance	Safeguarding Annual Report				✓				
Listening and Learning	Patient Experience Approach				✓				
Compliance	Wellbeing of Future Generations Act Report			✓					
Civil Contingencies	Major Incident and Emergency Response Plan			✓					
Civil Contingencies	Civil Contingencies Annual Report			✓					
Planning	Corporate Business Continuity Plan			✓					
Capital and Estates	Health and Safety Annual Report	✓		✓					
Capital and Estates	Capital and Estates Strategy								✓
	Therapies and Health Sciences Annual Update								
Digital	Digital Strategic Framework annual update				✓				
Transformation / Change	Temporary Service Changes	✓		✓					
Workforce	Nurse Staffing Levels				✓				
	Better Together Case for Change	✓		✓		✓			
Governance	Annual summary of petitions received under Petitions Protocol				✓				
Governance	Standards of Behaviour Policy (Next due March 2027)								
	Duty of Quality Annual Report				✓				

IN-COMMITTEE	CRR (IC risks)	✓		✓	✓		✓	✓	✓
	Minutes of previous IC meeting	✓			✓		✓	✓	✓
	RaTS Committee Annual Report			✓					
	COVID-19 Public Inquiry preparation and readiness update	✓		✓					
	Emergency Response and Planning self assessment			✓					
	Out of Hours Contract			✓	✓				✓
Key									
Date to be confirmed									
Item to be confirmed									
Item deferred									
Item brought forward									
Due to Committee									
Find Exec Cttee date									
Added to draft agenda									

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Agenda item: 3.3.1

Board		Date of meeting: 21 May 2025	
Subject:	Board 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:	Audit, Risk and Assurance Committee – 13 May 2025 Charitable Funds Committee – 2 December 2024 Delivery and Performance Committee – 1 May 2025 Patient Experience, Quality and Safety Committee – 29 April 2025 Remuneration and Terms of Service Committee – 26 March 2025 Workforce and Culture Committee – 13 March 2025		
PURPOSE:			
The purpose of this paper is for the Board to consider and approve the proposed revisions to the Terms of Reference of Board’s Committees.			
RECOMMENDATION(S):			
The Committee is asked to:			
• RECIEVE the proposed amendments to the Terms of Reference • NOTE that all Committees have reviewed and endorsed the proposed amendments as referenced above (with the exception of the PPPH Committee who meet on the 19 May 2025), and • APPROVE the proposed revisions to the Terms of Reference.			
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	

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 for the Health Board's Committees as approved by the Board in May 2024 can be found here: pthb.nhs.wales/about-us/the-board/1/standing-orders-schedule-4/

Each Committee of the Board has received, reviewed and endorsed the proposed updates to their Terms of Reference. In advance of this the Corporate Governance Team met with Committee Chairs and Executive Leads for each Committee to undertake a detailed review of the Terms of Reference to identify and consider proposed amendments.

The following general updates have been proposed for each Committee:

Section of Terms of Reference	Updates
4 – Membership	Section 4.1 'Members' has been standardised as Chair, Vice Chair and 2 Independent Members. Additional IM's can be added as required. Section 4.2 'In Attendance' has been reviewed for each Committee to include only those Executive Directors who are Executive Lead(s) or are expected to attend each meeting. All other Executive Directors will continue to receive an invitation to relevant Committee meetings but will be expected to attend under section 4.3 based upon the content of the agenda for each meeting. (Not Applicable to Executive Committee) Section 4.3 recognition of the invitation extended to representatives from Llais on an observer basis (not Applicable to Executive Committee or Remuneration and Terms of Service Committee)
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 and that all Terms of Reference are aligned in terms of format and standard content.

The Board reviewed and approved the Terms of Reference for the Committees in May 2024, a summary of the material changes for each Committee as of May 2025 is included below, full Terms of Reference for each Committee are appended as listed below and will be published to the website as part of the Health Board’s Standing Orders when approved.

- Audit, Risk and Assurance Committee (Appendix A)
- Delivery and Performance Committee (Appendix B)
- Patient Experience, Quality and Safety Committee (Appendix C)
- Planning, Partnerships and Population Health Committee (Appendix D)
- Remuneration and Terms of Service Committee (Appendix E)
- Workforce and Culture Committee (Appendix F)

It is suggested that the Board considers **the following proposals:**

Audit, Risk and Assurance Committee	
Section of Terms of Reference	Updates
3 – Delegated Powers and Authority	Assurance in regard to the performance management of digital and information management and technology (IM&T) systems is removed, to be transferred to the Committee (previously Delivery and Performance Committee). Increased clarity on the role of the Committee in relation to the oversight of the system of risk and assurance.
Delivery and Performance Committee	
Section of Terms of Reference	Updates
3 – Delegated Powers and Authority	Assurance in regard to the performance management of digital and information management and technology (IM&T) systems is removed, to be transferred to the Audit, Risk and Assurance Committee.

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	Assurance in regard to Health and Safety arrangements for employees, patients, members of the public, volunteers, contractors etc. to be included as a holistic item, transferred from the Workforce and Culture Committee and Patient Experience, Quality and Safety Committee who previously considered Staff Health and Safety and Patient Safety respectively.
Patient Experience, Quality and Safety Committee	
Section of Terms of Reference	Updates
3 – Delegated Powers and Authority	Updated to reference the Integrated Quality and Performance Framework and Peoples Experience Framework and to specifically reference the role in terms of patients experience in Primary Care. Updated to include receipt of the Medical Appliances Annual Report.
Planning, Partnerships and Population Health Committee	
Section of Terms of Reference	Updates
2 – Purpose	Removal of specific reference to quality and safety of services, to avoid overlap with the role of the Patient Experience, Quality and Safety Committee and in recognition of the Committee's role in all strategies, strategic framework and plans. Clarity that the Committee's purpose in respect of assuring plans and arrangements for key partnerships is not to scrutinise or review as there is no mechanism to support this, the role if the Committee is to receive and consider alignment. Sole Committee for seeking assurance in regard to Wellbeing of Future Generations Act (Wales) 2015 (previously also included in the Workforce and Culture ToR).

3 – Delegated Powers and Authority	Inclusion of specific reference to the key transformation programmes such as the Better Together Portfolio Board.
Remuneration and Terms of Service Committee	
Section of Terms of Reference	Updates
	No material changes
Workforce and Culture Committee	
Section of Terms of Reference	Updates
1 - Introduction	It is proposed that the Committee title is updated to 'People and Culture Committee' to reflect the organisations current structure
3 – Delegated Powers and Authority	Removal of arrangements for compliance with Health and Safety Regulations and Fire Safety Standards as transferred to Delivery and Performance Committee. Inclusion of specific reference to the Better Together Portfolio in regard to assurance on the implementation of the Health Board's transformation workstreams relevant to people, organisational development or any other areas within the Committees remit.

Charitable Funds Committee

The Terms of Reference for the Charitable Funds Committee were not included in the May 2024 review but were reviewed and endorsed by the Committee in December 2024. The Terms of Referenced are appended as Appendix G with a summary table also included below:

Charitable Funds Committee	
Section of Terms of Reference	Updates

2 – Purpose	Scope and Duties have been incorporated to align with other Terms of Reference
4 – Delegated Powers and Authority	4.7 Committee Programme of Work incorporated to align with other Terms of Reference.
6 – Committee Meetings	6.4 Openness and Transparency incorporated to align with other Terms of Reference.

Executive Committee

The Executive Committee is constituted by the Board and is the executive decision-making committee of the organisation, chaired by the Chief Executive as Accountable Officer. The Executive Committee is responsible for ensuring the effective and efficient operational co-ordination of all functions of the organisation, and thus supporting the Chief Executive to discharge the responsibilities delegated to the Accountable Officer. Due to its unique nature the Terms of Reference of the Committee differ slightly in their format and standard content. A review of the Committee's sub-groups is currently underway (Appendix 1 of the Committee Terms of Reference), the agreed structure will be confirmed to the Board via the appropriate Executive Committee Chair's Report.

A summary of the proposed amendments to the Executive Committee Terms of Reference is provided below, and the full Terms of Reference are appended (Appendix H):

Executive Committee	
Section of Terms of Reference	Updates
3 – Delegated Powers and Authority	Clarification that sub-groups will report to the Executive Committee who in turn will report relevant items to the Health Board's Board and other Committees as appropriate.
4 - Membership	Clarification that membership is constituted by Executive Directors, with other Directors recognised as regular attendees.

NEXT STEPS:

When approved the revised Terms of Reference will be adopted into Schedule 4 of the Health Board's Standing Orders and published to the Health Board's

internet as such. The Corporate Governance Team will enact any required to changes to Committee titles, agendas or work programmes in readiness for the forthcoming cycle of meetings.

The Terms of Reference of the Board's Advisory Fora are currently under review or development and will be brought forward in July 2025 for approval.

APPENDICES

- a.** Audit, Risk and Assurance Committee Terms of Reference
- b.** Delivery and Performance Committee Terms of Reference
- c.** Patient Experience, Quality and Safety Committee Terms of Reference
- d.** Planning, Partnerships and Population Health Committee Terms of Reference
- e.** Remuneration and Terms of Service Committee Terms of Reference
- f.** People and Culture Committee Terms of Reference
- g.** Charitable Funds Committee Terms of Reference
- h.** Executive Committee Terms of Reference

Audit, Risk and Assurance Committee

Terms of Reference & Operating Arrangements

Draft May 2025

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1. INTRODUCTION

- 1.1 Section 2 of Powys Teaching Health Board's (referred to in this document as 'PTHB' or the 'health board') Standing Orders provides that:

"The Board may and, where directed by the Welsh Government must, appoint Committees of the THB 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 all its business extends equally to the work carried out on its behalf by committees".

- 1.2 The Board has established a committee to be known as the **Audit, Risk and Assurance** (referred to throughout this document as 'the Committee'). The Committee has been established in order to enable the scrutiny and review of matters related to audit, financial accounting, assurance and risk management, to a level of depth and detail not possible in Board meetings. The Terms of Reference and operating arrangements set by the Board in respect of this committee are provided below.

2. PURPOSE

- 2.1 The purpose of the Committee is to support the Board and Accounting Officer by reviewing the comprehensiveness and reliability of assurances on governance, risk management, the control environment and the integrity of financial statements and the annual report by:

- independently monitoring, reviewing and reporting to the Board on the processes of governance, risk management and internal control in accordance with the standards of good governance determined for the NHS in Wales;
- advising the Board and the Accountable Officer on where, and how, its system of assurance may be strengthened and developed further;
- Maintaining an appropriate financial focus demonstrated through robust financial reporting and maintenance of sound systems of internal control; and

- Working with the other committees of the Board to provide assurance that governance and risk managements arrangements are adequate and part of an embedded Board Assurance Framework that is 'fit for purpose'.

3. DELEGATED POWERS AND AUTHORITY

3.1 The Audit, Risk and Assurance Committee will advise the Board and Accountable Officer on:

- the design, operation and effectiveness of strategic processes for risk management, internal control and corporate governance across the whole of the organisation's activities;
- the Annual Accountability Report, which includes the Annual Governance Statement;
- the accounting policies, the accounts, and the annual report of the organisation, including the process for review of the accounts prior to submission for audit, levels of error identified, and management's letter of representation to the external auditors;
- the planned activity and results of internal and external audit;
- adequacy of management response to issues identified by audit activity, including external audit's management letter;
- assurances relating to the management of risk and corporate governance requirements for the organisation;
- systems for financial reporting to the Board (including those of budgetary control);
- proposals for tendering for the purchase of audit and non-audit services from contractors who provide audit services; and
- anti-fraud policies, whistle-blowing processes, and arrangements for special investigations.

The Audit, Risk and Assurance Committee will also periodically review its own effectiveness and report the results of that review to the Board.

3.2 The Committee's workplan will include:

A report regarding the system of risk and assurance in operation within the Health Board, this may include:

- any significant changes to the organisations framework for managing risk
 - any significant changes to the organisations framework for managing board assurance
 - progress updates in relation to the ongoing development and integration of risk and assurance systems and processes
 - a progress report from the Head of Internal Audit summarising:
 - work performed (and a comparison with work planned);
 - key issues emerging from the work of internal audit;
 - management response to audit recommendations;
 - changes to the agreed internal audit plan; and
 - any resourcing issues affecting the delivery of the objectives of internal audit
 - a progress report (written/verbal) from the External Audit representative summarising work done and emerging findings (this may include, where relevant to the organisation, aspects of the wider work carried out by the Wales Audit Office, for example, Value for Money reports and good practice findings)
 - management assurance reports
 - reports (where appropriate) on action taken within the Board's Scheme of Delegation as regards:
 - use of single tender waivers
 - extensions of contracts:
 - writing off of losses; or
 - the making of special payments
 - A report summarising progress in the implementation of audit recommendations, together with a copy of the Audit Recommendations Tracker
- and when appropriate the Committee will be provided with:
- proposals for the terms of reference of internal audit / the internal audit charter
 - the internal audit strategy

- the Head of Internal Audit's Annual Opinion and Report
- quality assurance reports on the internal audit function
- the draft accounts of the organisation
- the draft Annual Accountability Report which includes the Annual Governance Statement
- a report on any changes to accounting policies
- external Audit's management letter
- a report on any proposals to tender for audit functions
- a report on co-operation between internal and external audit
- the organisation's Risk Management strategy and Board Assurance Framework
- regular reporting on Information Governance arrangements to ensure compliance with statutory obligations in relation to data protection legislation, national frameworks and good practice,
- periodic reporting on Post Payment Verification Audits
- periodic reporting on financial controls
- periodic reporting on declarations of interest and gifts and hospitality; and
- annual review of the Board's Standing Orders and Standing Financial Instructions, monitoring compliance and reporting any proposed changes to the Board for consideration and approval.
- assurance reporting regarding arrangements for the performance management of digital and information management and technology (IM&T) systems including:
 - the monitoring of digital related objectives and priorities as set out in the Board's Integrated Plan; and
 - the monitoring of the annual business plan for IM&T.

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3.3 In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of good governance, risk management and internal control, together with indicators of their effectiveness.

3.4 The Committee's programme of work will also be designed to provide assurance that:

- there is an effective internal audit function that meets the standards set for the provision of internal audit in the NHS in Wales and provides appropriate independent assurance to the Board and the Accountable Officer through the Committee;
- there is an effective counter fraud service that meets the standards set for the provision of counter fraud in the NHS in Wales and provides appropriate assurance to the Board and the Accountable Officer through the Committee;
- there is an effective clinical audit and quality improvement function that meets the standards set for the NHS in Wales and provides appropriate assurance to the Board and the Accountable Officer through the Patient Experience, Quality & Safety Committee;
- there are effective arrangements in place to secure active, ongoing assurance from management with regard to their responsibilities and accountabilities, whether directly to the Board and the Accountable Officer or through the work of the Board's committees;
- the work carried out by key sources of external assurance, in particular, but not limited to the health board's external auditors, is appropriately planned and co-ordinated and that the results of external assurance activity complements and informs (but does not replace) internal assurance activity;
- the work carried out by the whole range of external review bodies is brought to the attention of the Board, and that the organisation is aware of the need to comply with related standards and recommendations of these review bodies, and the risks of failing to comply; and

- the results of audit and assurance work specific to the health boards, and the implications of the findings of wider audit and assurance activity relevant to the Health Boards's operations, are appropriately considered and acted upon to secure the ongoing development and improvement of the organisations governance arrangements.

Authority

3.5 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. It 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, subcommittee or group set up by the Board to assist it in the delivery of its functions.

3.6 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

3.7 The Head of Internal Audit and the Engagement Partner/Audit Manager of External Audit shall have unrestricted and confidential access to the Chair of the Audit Committee.

3.8 The Committee will meet with Internal and External Auditors and the nominated Local Counter Fraud Specialist without the presence of officials on at least one occasion each year.

3.9 The Chair of the Committee shall have reasonable access to Executive Directors and other relevant senior staff.

Sub Committees

3.10 The Committee may, subject to the approval of the LHB Board, establish sub committees or task and finish groups to carry out on its behalf specific aspects of Committee business.

4. MEMBERSHIP

Members

4.1 Membership will comprise:

Chair	Independent Member of the Board
Vice Chair	Independent Member of the Board
Members	Independent Member of the Board x 2

Additional Independent Members of the Board may be appointed if required.

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 members of the Executive Team will be regular attendees:

- The Accountable Officer
- Executive Director of Finance, Capital and Support Services
- Director of Corporate Governance / Board Secretary

Other attendees will be:

- Head of Internal Audit
- Local Counter Fraud Specialist
- Representative of the Auditor General/External Audit

4.3 By invitation: The Committee Chair may extend invitations to attend committee meetings to the following:

- other Executive Directors not listed above;
- other Senior Managers
- 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 and

- representatives from Llais on an observer basis.

Secretariat

- 4.4 The secretariat for the Committee will be provided by the Corporate Governance Team.

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.

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- 5.1 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

- 5.2 The Chair of the Committee shall determine the timing and frequency of meetings, which shall be held no less than four times a year, and in line with the Health Board's annual plan of Board Business.
- 5.3 The Chair of the Committee may call additional meetings if urgent business is required to be taken forward between scheduled meetings.

Openness and Transparency

- 5.2 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

- 5.5 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 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

- 5.6 Committee meetings will be held via virtual means unless otherwise specified.

Should a meeting be held in person this will be agreed by the Chair and confirmed in advance by the Director of Corporate Governance/Board Secretary. In-person meeting arrangements will be co-ordinated and communicated 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, it retains overall responsibility and accountability for the audit and assurance. 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, through its Chair and members, shall 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
- appropriate escalation of concerns.

in doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.

6.3 The Committee shall embed the Health Board's agreed Values and Behaviours, as set out in the Board's Values and Behaviours Framework and Standards of Behaviour Policy, 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 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, on behalf of the Board, 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.

APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

- 8.1 The requirements for the conduct of business as set out in PTHB's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:
- Quorum
 - Issue of Committee papers (some papers are confidential)

9. CHAIR'S ACTION ON URGENT MATTERS

- 9.1 There may, occasionally, be circumstances where decisions which would normally be made by the Committee need to be taken between scheduled meetings, and it is not practicable to call a meeting of the Committee. In these circumstances, the Chair of the Committee, supported by the Director of Corporate Governance / 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 Director of Corporate Governance / 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.

Delivery and Performance Committee

Terms of Reference & Operating Arrangements

Draft May 2025

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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 In-line with Standing Orders and the Board's Scheme of Delegation and Reservation of Powers, the Health Board has established a committee to be known as the **Delivery and Performance 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 set out below.

2. PURPOSE

- 2.1 The scope of the Committee extends to the full range of PTHB responsibilities. This encompasses the delivery and performance management of all directly provided and commissioned services. The purpose of the Committee is 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. In doing so, the Committee will seek assurance that there is ongoing development of an improving performance culture which continuously strives for excellence and focuses on improvement in all aspects of the health board's business, in line with the Board's Framework for Improving Performance.

ADVICE

- 2.2 The Committee will provide accurate, evidence based (where possible) and timely advice to the Board and its committees in respect of the ongoing development of an improving performance culture which continuously strives for excellence and focuses on

improvement in all aspects of the Health Board's business, in line with the Board's Framework for Improving Performance.

2.3 **ASSURANCE**

In respect of the achievement of the Boards' strategic aims, objectives and priorities, the Committee will seek assurances:

- a. on timely and appropriate access to health care services to achieve the best health outcomes within agreed targets, for directly provided and commissioned services;
- b. on performance against national and locally set quality and safety measures of care together with compliance to legislative requirements ensuring services are safe, personal, effective and continuously improving;
- c. that services are improving efficiency and productivity, and financial plans are being delivered;
- d. risks are suitably identified, mitigated and residual risks controlled, and corrective actions are taken as required to sustain or improve performance.

3. DELEGATED POWERS AND AUTHORITY

3.1 With regard to specific powers delegated to it by the Board, the Committee will play a key role in monitoring the achievement of the Board's strategic aims, objectives and priorities and will:

A. Seek assurance that arrangements for **financial management** and **financial performance** are sufficient, effective and robust, including:

- the allocation of revenue budgets, based on allocation of funding and other forecast income;
- the monitoring of financial performance against revenue budgets and statutory financial duties;
- the monitoring of performance against capital budgets;
- the monitoring of progress against savings plans, cost improvement programmes and implementation of the efficiency framework;
- the monitoring of budget expenditure variance and the corrective actions being taken to improve performance;
- the monitoring of activity and financial information for external contracts to ensure performance within specified contract terms, conditions and quality thresholds;
- the monitoring of arrangements to ensure efficiency, productivity and value for money;

- the monitoring of delivery against the agreed Discretionary Capital Programme; and
- the adequacy of standing financial instructions, including the application of capital and estates controls.

B. Seek assurance that arrangements for the **performance management** and **accountability** of **directly provided** and **commissioned services** are sufficient, effective and robust, including:

- the ongoing implementation of the Board's Framework for Improving Performance, enabling appropriate action to be taken when performance against set targets deteriorates, and support and promote continuous improvement in service delivery;
- the monitoring of performance information against the Board's Well-being and Enabling Objectives and associated outcomes;
- the monitoring of performance information against National Outcome Frameworks, including the NHS Wales Outcomes Framework, the Public Health Outcomes Framework and the Social Services Outcomes Framework, developed in-line with the Wellbeing of Future Generations Act and the Social Services Wellbeing Act;
- the monitoring of performance information across directly provided services including outpatients, theatres, community and inpatient services, mental health and LD, women and children's services;
- the monitoring of performance information across commissioned services including Primary Care, outpatients, community and inpatient services, mental health, women and children's services, NHS Wales Joint Commissioning Committee and NHS Wales Shared Services Partnership;
- the monitoring of poor performance through effective and comprehensive exception reporting, including trajectories for improved performance; and
- the review of performance through comparison to best practice and peers and identifying areas for improvement.

C. Seek assurance that arrangements for **information management** are sufficient, effective and robust, including:

- the monitoring of information related objectives and priorities as set out in the Board's IMTP and Annual Plan;

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D. Seek assurance that arrangements for the **Health and Safety** of all employees and of those who may be affected by work-related activities, such as patients, members of the public, volunteers, contractors etc. are sufficient, effective and robust

E. Seek assurance that arrangements for the **performance management of capital, estates and support services related standards and systems** are sufficient, effective and robust, including:

- the monitoring of capital and estates related objectives and priorities as set out in the Board's IMTP and Annual Plan;
- the monitoring of compliance with Health Technical Memorandums;
- the monitoring of progress in delivery Board-approved capital business cases and programmes of work.
-

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 Management of Policies and Other Written Control Documents Policy 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 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. It 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.

Committee Programme of Work

- 3.9 Each year the Board will determine the Committee's priorities for its annual programme of work, based on the Board's Assurance Framework and 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 Members of the Board x2

Additional Independent Members of the Board may be appointed if required.

The Committee may also co-opt additional independent 'external'

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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 Finance, Capital and Support Services (Joint Officer Lead)
- Executive Director of Commissioning, Performance and Planning (Joint Officer Lead)
- Executive Director of People and Culture
- Executive Director of Primary Care, Community and Mental Health
- Executive Director of Therapies and Health Sciences

4.3 By invitation:

The Committee Chair extends an invitation to the PTHB Chair and Chief Executive to attend committee meetings.

The Committee Chair will extend invitations to attend committee meetings, dependent upon the nature of business, to the following:

- other Executive Directors not listed above;
- other Senior Managers and
- other officials from within or outside the organisation to attend all or part of a meeting to assist it with its discussions on any particular matter.

Secretariat

4.5 The secretariat for the Committee will be provided by the Corporate Governance Team.

Member Appointments

4.6 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.

4.7 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.

4.8 Terms and conditions of appointment, (including any remuneration and reimbursement) in respect of co-opted independent external

Delivery and Performance Committee:

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members are determined by the Board, based upon the recommendation of the Chair of PTHB.

Support to Committee Members

- 4.9 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 no less than six 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 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.

Should a meeting be held in person this will be agreed by the Chair and confirmed in advance by the Director of Corporate Governance/Board Secretary. In-person meeting arrangements will be co-ordinated and communicated 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 delivery and performance. 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.

6.3 The Committee shall embed the Health Board's agreed Values and Behaviours, as set out in the Board's Values and Behaviours Framework, through the conduct of its business.

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

Delivery and Performance Committee:

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- 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 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.

7.2 The Board may also require the Committee Chair to report upon the Committee's activities at public meetings, e.g., Annual General Meeting, or to community partners and other stakeholders, where this is considered appropriate, e.g., where the committee's assurance role relates to a joint or shared responsibility.

7.3 The 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.

7.4 The Committee shall provide a written annual report to the Board on its activities. The report will also record the results of the Committee's self-assessment and evaluation.

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

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

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 Director of Corporate Governance/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 Director of Corporate Governance/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 Director of Corporate Governance will report any changes to the Board, for approval.
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Patient Experience, Quality and Safety Committee

Terms of Reference & Operating Arrangements

Draft May 2025

Patterson, Liz
20/05/2025 14:22:19

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.

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 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 Framework;
 - 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;
 - 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; receipt of the Medical Appliances Annual Report;
 - 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.

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- 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 and Scheme of Delegation and Reservation of Powers.
- 3.3 The Committee will seek assurances on the management of strategic risks delegated to the Committee by the Board, via the 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. It may seek any relevant information from any:
- employee (and all employees are directed to cooperate with any reasonable request made by the Committee); and
 - any other committee, sub committee or group set up by the Board to assist it in the delivery of its functions.
- 3.5 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary (subject to the Board's procurement, budgetary and any other applicable standing requirements).

Access

- 3.6 The Head of Internal Audit shall have unrestricted and confidential access to the Chair of the Committee.
- 3.7 The Chair of the Committee shall have reasonable access to Executive Directors and other relevant senior staff.

Sub Committees

- 3.8 The Committee may, subject to the approval of the Board, establish sub committees or task and finish groups to carry out on its behalf specific aspects of Committee business.
- 3.9 The Committee has established a sub-committee, named the

Mental Health Act Power of Discharge Group. The purpose of this group is to review and monitor how the operation of the delegated functions under Section 23 of the Mental Health Act 1983 are being exercised. This group will report through to the Patient Experience, Quality & Safety Committee providing assurance in-line with its agreed Terms of Reference.

Committee Programme of Work

3.10 Each year the Board will determine the Committee's priorities for its annual programme of work, based on the Board's Assurance Framework and 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 Members of the Board x2

Additional Independent members of the Board may be appointed if required.

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
- 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 and
- representatives from Llais on an observer basis

Secretariat

4.4 The secretariat for the Committee will be provided by the Corporate Governance Team.

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 no less than 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 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.

Should a meeting be held in person this will be agreed by the Chair and confirmed in advance by the Director of Corporate Governance/Board Secretary. In-person meeting arrangements will

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be co-ordinated and communicated 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 patient experience, quality and safety. 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, through its Chair and members, shall 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
- appropriate escalation of concerns.

in doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.

6.3 The Committee shall embed the Health Board's agreed Values and Behaviours, as set out in the Board's Values and Behaviours Framework, through the conduct of its business.

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

- report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes verbal updates on activity, and the submission of 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

- 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 Director of Corporate Governance / 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 Director of Corporate Governance / 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 or Director of Corporate Governance will report any changes to the Board, for approval.
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Planning, Partnerships & Population Health Committee

Terms of Reference & Operating Arrangements

Draft May 2025

Planning, Partnerships & Population Health
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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 In-line with Standing Orders and the Board's Scheme of Delegation and Reservation of Powers, the Health Board has established a committee to be known as the **Planning, Partnerships and Population Health 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 set out below.

2. PURPOSE

- 2.1 The scope of the Committee extends to all areas of Planning, Partnership Working and Population Health, across the full breadth of the Health Board's responsibilities.

2.2 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:

- strategy, strategic frameworks and plans consistent with the board's overall strategic direction;
- business cases and service planning proposals;
- the alignment of supporting and enabling strategies, including workforce, capital, estates digital;
- the implications for service planning arising from strategies and plans developed through the Joint Committees of the

- Board or other strategic partnerships, collaborations or working arrangements approved by the Board; and
- the Health Board's priorities and plans to improve population health and wellbeing.

2.3 **ASSURANCE**

In respect of the achievement of the Boards' strategic aims, objectives and priorities, the Committee will seek assurances:

- that Health Board planning arrangements are appropriately designed and operating effectively to monitor the provision of high quality, safe healthcare and services across the whole of the Health Board's responsibilities (directly provided and commissioned);
- plans and arrangements for the following matters are received and appropriately aligned:
 - (i) Joint committee and partnership planning;
 - (ii) Engagement and communication; and
 - (iii) Civil Contingencies and Business Continuity;
- that partnership governance and partnership working is effective and successful; and
- that those arrangements in place to improve population health and wellbeing are robust and effective and delivering intended outcomes.

3. DELEGATED POWERS AND AUTHORITY

3.1 With regard to specific powers delegated to it by the Board, the Committee will play a key role in the development of the Health Board's aims, objectives and priorities, and in doing so will:

Strategic Planning

- Seek assurance that the Health Board's Planning Framework is robust and fit for purpose, including the approach to developing the Integrated Plan and Annual Plan
- Seek assurance that the health board has sufficient enabling plans to support the achievement of strategic objectives including oversight of key organisational transformation programmes such as the Better Together Portfolio
- Seek assurance that the Health Board's arrangements for engagement and consultation in respect of service change matters are robust and effective;

- d) Seek assurance that national and regional planning guidance is used to inform the development of strategic plans;
- e) Seek assurance on the process for the development of the Board's Capital Discretionary Programme and Capital Business Cases;
- f) Seek assurance that the Health Board's Strategic Commissioning Framework is robust and fit for purpose;
- g) Seek assurance on the effectiveness of the Health Board's Civil Contingency Plans and Major Incident Planning;
- h) Seek assurance that plans respond to the Wellbeing of Future Generations Act (Wales) 2015; and
- i) Seek assurance that the Health Board's plans give due regard to the Socio-economic Duty for Wales.

Partnership Working

- a) receive the strategies and plans developed in partnership with key strategic partners including the Regional Partnership Board
- b) monitor work undertaken with partner organisations and stakeholders to influence the provision of services to meet current and future population need
- c) seek assurance that partnership governance and partnership working is effective and successful.

Population Health

- a) consider population health needs assessments and other key information that underpins the strategic planning process to ensure the robustness and best fit of developing plans;
- b) consider plans for whole-system pathway development and re-design;
- c) seek assurance on the adequacy of programmes to promote healthy lifestyles to the Powys population;
- d) seek assurance on the work of the Health Board to reduce health inequalities.

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 and Scheme of Delegation and Reservation of Powers.

- 3.3 The Committee will seek assurances on the management of strategic risks delegated to the Committee by the Board, via the 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.
- 3.4 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.

Committee Programme of Work

- 3.9 Each year the Board will determine the Committee's priorities for its annual programme of work, based on the Board's Assurance Framework and 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	Independent Member of the Board
Vice Chair	Independent Member of the Board
Members	Independent Members of the Board x2

Additional Independent Members of the Board may be appointed if required.

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 Planning, Performance and Commissioning (Joint Officer Lead)
- Executive Director of Public Health (Joint Officer Lead)

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
- 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 and
- representatives from Llais on an observer basis

Secretariat

- 4.4 The secretariat for the Committee will be provided by the Corporate Governance Team.

Member Appointments

- 4.4 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.
- 4.5 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.
- 4.6 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

- 4.6 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 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.

Should a meeting be held in person this will be agreed by the Chair and confirmed in advance Director of Corporate Governance/Board Secretary. In-person meeting arrangements will be co-ordinated and communicated 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.

6.3 The Committee shall embed the Health Board's agreed Values and Behaviours, as set out in the Board's Values and Behaviours Framework, through the conduct of its business.

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

- report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes verbal updates on activity, and the submission of Committee minutes and written reports;
- bring to the Board's specific attention any significant matters under consideration by the Committee;
- ensure appropriate escalation arrangements are in place to alert the Chair of PTHB, Chief Executive or Chairs of other relevant committees/groups of any urgent/critical matters that may affect the operation and/or reputation of the Health Board.

7.2 The Board may also require the Committee Chair to report upon the Committee's activities at public meetings, e.g., Annual General Meeting, or to community partners and other stakeholders, where this is considered appropriate, e.g., where the committee's assurance role relates to a joint or shared responsibility.

7.3 The 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.

7.4 The Committee shall provide a written annual report to the Board on its activities. The report will also record the results of the Committee's self-assessment and evaluation.

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

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

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 Director of Corporate Governance / 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 Director of Corporate Governance / 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 or Director of Corporate Governance will report any changes to the Board, for approval.



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Powys Teaching
Health Board

Remuneration and Terms of Service Committee

Terms of Reference & Operating Arrangements

Draft May 2025

Patterson, Liz
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1. INTRODUCTION

- 1.1 Section 2 of Powys Teaching Health Board's (referred to throughout this document as PTHB or the health board) Standing Orders provides that

"The Board may and, where directed by the Welsh Government must, appoint Committees of the THB 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 all its business extends equally to the work carried out on its behalf by committees".

- 1.2 In line with Standing Orders and PTHB's Scheme of Delegation, the Board has established a committee to be known as the **Remuneration and Terms of Service Committee** (referred to throughout this document as 'the Committee'). The Committee has been established in order to enable the scrutiny and review of matters related to remuneration and terms of service to a level of depth and detail not possible in Board meetings. The detailed Terms of Reference and operating arrangements set by the Board in respect of this Committee are detailed below.

2. PURPOSE

- 2.1 The purpose of the Committee is to:

- a) provide **assurance** to the Board in relation to the health board's arrangements for the remuneration and terms of service, including contractual arrangements, for all staff, in accordance with the requirements and standards determined for the NHS in Wales;
- b) provide **advice** to the Board on remuneration and terms of service for the Chief Executive, Executive Directors and other senior staff within the framework set by the Welsh Government; and
- c) perform certain, specific functions as delegated by the Board and listed below.

3. DELEGATED POWERS AND AUTHORITY

3.1 With regard to the specific powers delegated to it by the Board, the Committee will advise the Board in relation to:

- a) remuneration and terms of service for the Chief Executive, Executive Directors and other Very Senior Managers (VSMs) not covered by Agenda for Change; ensuring that the policies on remuneration and terms of service as determined from time to time by the Welsh Government are applied consistently;
- b) the performance management system in place for those in the positions mentioned above and its application seeking assurance that relevant objectives are set and monitored;
- c) proposals to make additional payments to consultants;
- d) proposals regarding termination arrangements, ensuring the proper calculation and scrutiny of termination payments in accordance with the relevant Welsh Government guidance;
- e) consider and approve Voluntary Early Release Scheme (VERS) applications and severance payments in line with Standing Orders and extant Welsh Government guidance; and

Authority

3.2 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. It 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.

3.3 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).

3.4 The Committee will develop for the Board's approval a scheme of delegated decision making, which will be appended to these terms of reference, which outlines those decisions the Committee is

authorised to take on behalf of the Board.

Access

3.5 The Head of Internal Audit shall have unrestricted and confidential access to the Chair of the Committee.

3.6 The Chair of the Committee shall have reasonable access to Executive Directors and other relevant senior staff.

Sub Committees

3.7 The Committee may, subject to the approval of the Health Board, establish sub committees or task and finish groups to carry out on its behalf specific aspects of Committee business.

4. MEMBERSHIP

Members

4.1 Membership will comprise:

Chair	Chair of the Board
Vice Chair	Vice Chair of the Board
Members	Independent Members x 3, to include the Chair of the Audit, Risk and Assurance Committee and the Chair of the People and Culture Committee.

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 members of the Executive Team will be regular attendees:

- the Chief Executive
- Executive Director of People and Culture
- Director of Corporate Governance / Board Secretary

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4.3 By invitation: The Committee Chair may extend invitations to attend committee meetings to the following:

- other Executive Directors; and
- other officials from within or outside the organisation to attend all or part of a meeting to assist it with its discussions on any particular matter.

Secretariat

4.4 The secretariat for the Committee will be provided by the Corporate Governance Team.

Member Appointments

4.5 The membership of the Committee shall be determined by the Board, based on section 4.1 above and 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.

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 organisational development for committee members as part of the health board's overall OD programme developed by the Executive Director of People and Culture.

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5. COMMITTEE MEETINGS

Quorum

- 5.1 At least **three** members must be present to ensure the quorum of the Committee, one of whom should be the Committee Chair or Vice Chair.
- 5.2 Where members are unable to attend a meeting and there is a likelihood that the Committee will not be quorate, the Chair can invite another independent member of the board to become a temporary member of the Committee.

Frequency of Meetings

- 5.3 The Chair of the Committee shall determine the timing and frequency of meetings, which shall be held no less than 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.

Withdrawal of individuals in attendance

- 5.4 The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of a particular matter.

Other meeting arrangements

- 5.5 Committee meetings will be held via virtual means unless otherwise specified.

Should a meeting be held in person this will be agreed by the Chair and confirmed in advance by the Director of Corporate Governance/Board Secretary. In-person meeting arrangements will be co-ordinated and communicated 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, it retains overall responsibility and accountability for the remuneration and terms of service agenda. 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, through its Chair and members, shall work closely with the Board's other committees, joint and sub committees and groups to provide advice and assurance to the Board through the:

- joint planning and co-ordination of Board and Committee business;
- sharing of appropriate information; and
- appropriate escalation of concerns.

in doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.

6.3 The Committee shall embed the Health Board's agreed Values and Behaviours, as set out in the Board's Values and Behaviours Framework, through the conduct of its business.

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

- report formally and on a timely basis to the Board on the Committee's activities, in a manner agreed by the Board;
- 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, on behalf of the Board 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
 - Committee will not hold meetings in public

9. CHAIR'S ACTION ON URGENT MATTERS

- 9.1 There may, occasionally, be circumstances where decisions which would normally be made by the Committee need to be taken between scheduled meetings, and it is not practicable to call a meeting of the Committee. In these circumstances, the Chair of the Committee, supported by the Director of Corporate Governance/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 or Director of Corporate Governance will report any changes to the Board, for approval.

People and Culture Committee

Terms of Reference & Operating Arrangements

Draft May 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 In-line with Standing Orders and the Board's Scheme of Delegation and Reservation of Powers, the Health Board has established a committee to be known as the **People and Culture 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 set out below.

2. PURPOSE

- 2.1 The role of the People and Culture Committee is to advise the Board on all matters relating to staff and workforce planning of the Health Board and enhance the environment that supports and values staff in order to engage the talent and nurture the leadership capability of individuals and teams working together to drive the desired culture throughout the health service to deliver safer better healthcare.
- 2.2 The Committee will provide advice and assurance to the Board in relation to the direction and delivery of the organisational development and other related strategies to drive continuous improvement and to achieve the objectives of the Health Board's Strategies and Strategic Plans.

3. DELEGATED POWERS AND AUTHORITY

- 3.1 The Committee will, in respect of its provision of advice and assurance to the Board:

People and Culture Committee:

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21 May 2025
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Appendix F

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Culture and Values:

- a) Oversee a credible process for assessing, measuring and reporting on the “culture of the organisation” on a consistent basis over time.
- b) Oversee the coherence and comprehensiveness of the ways in which the Health Board engages with staff and with staff voices, including the staff survey, and report on the intelligence gathered, and its implications.
- c) Oversee the development of a person-centred open and learning culture that is caring and compassionate, which nurtures talent and inspires innovation and excellence.
- d) Seek assurance that there is positive progress on equality and diversity, including shaping and setting direction, monitoring progress and promoting understanding inside and outside the Health Board.
- e) Promote staff engagement and partnership working.
- f) Seek assurance that the organisation adopts a consistent working environment which promotes staff well-being, where people feel safe and are able to raise concerns, and where bullying and harassment are visibly and effectively addressed.
- g) Support the enhancement of collaborative working relationships across the Health Board between professions and other stakeholders including representative bodies and regulators to improve culture.

Organisational Development & Capacity:

- a) Seek assurance on the implementation of the Board’s Organisational Development Strategic Framework; Seek assurance that the systems, processes and plans used by the Health Board have integrity and are fit for purpose in the following areas:
 - strategic approach to growing the capacity of the workforce;
 - analysis and use of sound workforce, employment and demographic intelligence;
 - the planning of current and future workforce capacity;
 - effective recruitment and retention;
 - new models of care and roles;
 - agile working;
 - identification of urgent capacity problems and their resolution
 - continuous development of personal and professional skills;
 - talent management
- b) Seek assurance on the Health Board’s plans for ensuring the development of leadership and management capacity, including the Health Board’s approach to succession planning;

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- c) Seek assurance that workforce and organisational development plans, including those developed with strategic partners, are informed by the Sustainable Development Principle as defined by the Well-being of Future Generations (Wales) Act 2015.

Performance Reporting:

- a) Seek assurances that governance (including risk management) arrangements are appropriately designed and operating effectively to ensure the provision of high quality, legal and safe workforce practices, processes and procedures.
- b) Scrutinise workforce and organisational development performance issues and key performance indicators and the associated plans to deliver against these requirements, achieved by establishing a succinct set of key performance and progress measures (in the form a performance dashboard) relating to the full purpose and function of the Committee, including:
 - The Health Board's strategic priorities relating to people;
 - organisational culture;
 - strategies to promote and protect staff Health & Wellbeing;
 - workforce utilisation and sustainability;
 - recruitment, retention and absence management strategies;
 - strategic communications;
 - workforce planning;
 - plans regarding staff recruitment, retention and remuneration;
 - succession planning and talent management;
 - staff appraisal and performance management;
 - Training, development and education; and
 - Management & leadership capacity programmes.
- c) Seek assurance on the implementation of those strategic plans developed in partnership which related to workforce and culture, including the Workforce Futures Strategic Framework.
- d) Seek assurance on the implementation of the Health Board's transformation workstreams such as the Better Together Portfolio Board relevant to people, organisational development or any other areas within the Committees remit;
- e) Ensure there is an effective system in place to consider and respond in a timely manner to workforce and organisational development performance audits received across the organisation and an effective system in place to monitor progress on actions resulting from such audits.
- f) Monitor and scrutinise relevant internal and external audit reports, management responses to action plans.

- 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 and Scheme of Delegation and Reservation of Powers.
- 3.3 The Committee will seek assurances on the management of strategic risks delegated to the Committee by the Board, via the Strategic Risk Register.

Statutory Compliance:

- 3.4 Seek assurance, on behalf of the Board, that current statutory and regulatory compliance and reporting requirements are met, including:
- Equality & Diversity Legislation
 - Welsh Language Standards
 - Consultation on Organisational Change
 - Mandatory and Statutory Training

Authority

- 3.5 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.
- 3.6 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

- 3.7 The Head of Internal Audit shall have unrestricted and confidential access to the Chair of the Committee.
- 3.8 The Chair of the Committee shall have reasonable access to Executive Directors and other relevant senior staff.

Sub Committees

- 3.9 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.

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 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	Independent Member of the Board
Vice Chair	Independent Member of the Board
Members	Independent Members of the Board x 2

Additional Independent Members of the Board may be appointed if required.

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 People and Culture (Officer Lead)
- Executive Director of Commissioning, Performance and Planning
- Executive Director of Finance, Capital & Support Services
- Executive Director of Primary Care, Community and Mental Health
- Executive Director of Allied Health Professions, Health Science and Digital

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
- 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 and
- representatives from Llais on an observer basis.

Secretariat

4.4 The secretariat for the Committee will be provided by the Corporate Governance Team.

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 no less than 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

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- to be discussed in private (see point 5.6);
- meetings to 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 (item 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 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.

Should a meeting be held in person this will be agreed by the Chair and confirmed in advance by the Director of Corporate Governance/Board Secretary. In-person meeting arrangements will be co-ordinated and communicated 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 people and culture. 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.

- 6.3 The Committee shall embed the Health Board's agreed Values and Behaviours, as set out in the Board's Values and Behaviours Framework, through the conduct of its business.

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

- report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes verbal updates on activity, and the submission of 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.

7.2 The Board may also require the Committee Chair to report upon the Committee's activities at public meetings, e.g., Annual General Meeting, or to community partners and other stakeholders, where this is considered appropriate, e.g., where the committee's assurance role relates to a joint or shared responsibility.

7.3 The 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.

7.4 The Committee shall provide a written annual report to the Board on its activities. The report will also record the results of the Committee's self-assessment and evaluation.

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

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

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 Director of Corporate Governance/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 or Director of Corporate Governance will report any changes to the Board, for approval.
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Powys Teaching
Health Board

Charitable Funds Committee

Terms of Reference & Operating Arrangements

Draft May 2025

Patterson, Liz
20/05/2025 15:22

1. INTRODUCTION

- 1.1 Section 2 of Powys Teaching Health Board's (referred to throughout this document as PTHB or the health board) Standing Orders 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 all its business extends equally to the work carried out on its behalf by committees".
- 1.2 In line with Standing Orders and PTHB's Scheme of Delegation, the Board has established a committee to be known as the **Charitable Funds Committee** (referred to throughout this document as 'the Committee'). The detailed Terms of Reference and operating arrangements set by the Board in respect of this Committee are detailed below.

2. PURPOSE

- 2.1 The purpose of the Committee is to:
- Oversee the strategic direction and development of PTHB's Charity;
 - make and monitor arrangements for the control and management of the Charity's Funds, within the budget, priorities and spending criteria determined by the Board and consistent with the legislative framework; and
 - provide assurance to the Board, in its role as corporate trustee, of the charitable funds held and administered by the Health Board.
- 2.2 The Charitable Funds Committee shall:
- Oversee the strategic direction and development of the PTHB Charity, including its annual programme of work; branding and promotion and fundraising activities.
 - operate within the budget, priorities and spending criteria determined by the health board, and should be consistent with

the requirements of the Charities Act 2022 (or any modification of these acts) to apply the charitable funds in accordance with its respective governing documents.

- devise, implement and approve appropriate procedures and policies to ensure that fundraising and accounting systems are robust, donations received are coded as instructed and that all expenditure is reasonable, clinically and ethically appropriate.
- ensure that the health board's policies and procedures for charitable funds investments are followed.
- make decisions involving the sound investment of charitable funds in a way that both preserves their value and produces a proper return consistent with prudent investment and ensuring compliance with:
 - ✓ Trustee Act 2000
 - ✓ The Charities Act 2022
 - ✓ Terms of the fund's governing documents
- receive at least twice a year reports for ratification from the Executive Director of Finance, Capital and Support Services the investment decisions and action taken through delegated powers upon the advice of the health board's investment adviser.
- oversee and monitor the functions performed by the Executive Director of Finance, Capital and Support Services as defined in the health board's Standing Financial Instructions.
- monitor the progress of Charitable Appeal Funds where these are in place and considered to be material.
- monitor and review the Health Board's scheme of delegation for Charitable Funds expenditure and to set and reflect in Financial Procedures the approved delegated limits for expenditure from Charitable Funds.

3. DELEGATED POWERS AND DUTIES OF THE EXECUTIVE DIRECTOR OF FINANCE, CAPITAL AND SUPPORT SERVICES

- 3.1 The Executive Director of Finance, Capital and Support Services has prime responsibility for the health board's Charitable Funds as defined in the health board's Standing Financial Instructions. The specific powers, duties and

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responsibilities delegated to the Executive Director of Finance, Capital and Support Services are:

- The administration of all existing charitable funds;
- To identify any new charity that may be created (of which the health board is trustee) and to deal with any legal steps that may be required to formalise the trusts of any such charity;
- Provide guidelines with respect to donations, legacies and bequests, fundraising and trading income;
- Responsibility for the management of investment of funds held on trust;
- Ensure appropriate banking services are available to the health board; and
- Prepare reports to the Health Board's Board including the Annual Accounts.

3. DELEGATED POWERS AND AUTHORITY

4.1 The Committee is responsible for:

- Overseeing the day-to-day management of the investments of the charitable funds in accordance with the investment strategy set down from time to time by the Trustees, and in accordance with the requirements of the health board's Standing Financial Instructions.
- The appointment of an Investment Manager (where appropriate) to advise it on investment matters and may delegate day-to-day management of some or all of the investments to that Investment Manager. The Investment Manager, if appointed, must actively manage the charitable fund on behalf of Trustees. In exercising this power the Committee must ensure that:
 - ✓ The scope of the power delegated is clearly set out in writing and communicated with the person or persons who will exercise it;
 - ✓ There are in place adequate internal controls and procedures which will ensure that the power is being exercised properly and prudently;

- ✓ The performance of the person or persons exercising the delegated power is regularly reviewed;
 - ✓ Where an investment manager is appointed, that the person is regulated under the Financial Services Act 1986;
 - ✓ Acquisitions or disposal of a material nature outside the terms of agreement must always have written authority of the Committee or the Chair of the Committee in conjunction with the Executive Director of Finance, Capital and Support Services.
- Ensuring that the banking arrangements for the charitable funds should be kept entirely distinct from the health board's NHS funds.
 - Ensuring that arrangements are in place to maintain current account balances at minimum operational levels consistent with meeting expenditure obligations, the balance of funds being invested in interest bearing deposit accounts.
 - The amount to be invested or redeemed from the sale of investments shall have regard to the requirements for immediate and future expenditure commitments.
 - The operation of an investment pool when this is considered appropriate to the charity in accordance with charity law and the directions and guidance of the Charity Commission. The Committee shall propose the basis to the Board of PTHB for applying accrued income to individual funds in line with charity law and Charity Commission guidance.
 - Obtaining appropriate professional advice to support its investment activities.
 - Regularly reviewing investments to see if other opportunities or investment services offer a better return.
 - Reviewing alternative sources of funding to donations and legacies which could provide the Committee with additional leverage and access to additional funds.
 - By giving reasonable notice, require the attendance of any of the officers or employees and auditors of the Board at any meeting.

Authority

- 4.2 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. It 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.
- 3.3 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, in accordance with the Board's procurement, budgetary and other requirements.

Access

- 3.4 The Head of Internal Audit shall have unrestricted and confidential access to the Chair of the Committee.
- 3.5 The Chair of the Committee shall have reasonable access to Executive Directors and other relevant senior staff.

Sub Committees

- 3.6 The Committee may, subject to the approval of the Health Board's Board, establish sub committees or task and finish groups to carry out on its behalf specific aspects of Committee business.

Committee Programme of Work

- 4.7 Each year the Board will determine the Committee's priorities for its annual programme of work, based on the Board's Assurance Framework and Corporate Risk Register. This approach will ensure that the Committee's focus is directed to the areas of greatest assurance needs. This will therefore mean that these Terms of Reference are provided as a

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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	Independent Member of the Board
Vice Chair	Independent Member of the Board
Members	Independent Members of the Board x 1, Executive Director of Finance, Capital and Support Services and one nominated Executive Director

Attendees

5.2 In attendance

- Director of Corporate Governance/Board Secretary
- Charity Manager
- Head of Financial Services

Secretariat

5.3 The secretariat for the Committee will be provided by the Corporate Governance Team.

5.4 Member Appointments

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.

- 5.5 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.
- 5.6 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

- 5.7 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 organisational development (OD) for committee members as part of the Health Board's overall development

5. COMMITTEE MEETINGS

Quorum

- 6.1 At least **three** members must be present to ensure the quorum of the Committee. Of these three, two must be independent members (one of whom is the Chair or Vice Chair and one must be the Executive Director of Finance, Capital and Support Services, or nominated representative).
- 6.2 Where members notify the Committee Chair or Committee Secretariat that they are unable to attend a meeting, and there is a danger that the Committee will not be quorate the Chair

can invite another independent member to become a temporary member of the Committee.

Frequency of Meetings

- 6.3 The Chair of the Committee in agreement with Committee Members, shall determine the timing and frequency of meetings. However, meetings shall be held no less than four times a year, and in line with the health board's annual plan of Board Business. However, additional meetings will be called in agreement with the Chair of the Committee if urgent business is required to be taken forward between scheduled meetings.

Openness and Transparency

- 6.4 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

- 6.5** 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 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.

7. RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

- 7.1 Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for the Charitable Funds agenda. The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.
- 7.2 The Committee, through its Chair and members, shall work closely with the Board's other committees, joint and sub committees and groups to provide advice and assurance to the Board through the:
- joint planning and co-ordination of Board and Committee business;
 - sharing of appropriate information; and

- appropriate escalation of concerns.

in doing so, contributing 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.

- 7.3 The Committee shall embed the health board's corporate standards, priorities and requirements, e.g., equality and human rights through the conduct of its business.

8. REPORTING AND ASSURANCE ARRANGEMENTS

- 8.1 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 written reports;
 - bring to the Board's specific attention any significant matters under consideration by the Committee;
 - ensure appropriate escalation arrangements are in place to alert the Chair of PTHB, Chief Executive or Chairs of other relevant committees/groups of any urgent/critical matters that may affect the operation and/or reputation of the Health Board.
- 8.2 The Board may also require the Committee Chair to report upon the Committee's activities at public meetings, e.g., Annual General Meeting, or to community partners and other stakeholders, where this is considered appropriate, e.g., where the committee's assurance role relates to a joint or shared responsibility.
- 8.3 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.
- 8.4 The Committee shall provide a written annual report to the Board on its activities. The report will also record the results of the Committee's self-assessment and evaluation.

9. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

9.1 The requirements for the conduct of business as set out in PTHB's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum
- Issue of Committee papers
- The Committee will not hold its meetings in public

10. CHAIR'S ACTION ON URGENT MATTERS

10.1 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 Director of Corporate Governance/Board Secretary as appropriate, may deal with the matter on behalf of the Committee - after first consulting with at least one other Independent Members of the Committee and the Executive Director of Finance, Capital and Support Services. The Director of Corporate Governance/Board Secretary must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.

10.2 Chair's action may not be taken where the Chair has a personal or business interest in the urgent matter requiring a decision.

11. REVIEW

11.1 These Terms of Reference shall be reviewed annually by the Committee. The Committee Chair or Director of Corporate Governance will report any changes to the Board, for approval.

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Executive Committee

Terms of Reference & Operating Arrangements

Draft May 2025

Patterson, Liz
20/05/2025 16:22:19

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 In line with Standing Orders and the Board's Scheme of Delegation and Reservation of Powers, the Health Board has established a committee to be known as the **Executive 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 set out below.

2 PURPOSE

- 2.1 The Executive Committee has been constituted by the Board and is the executive decision-making committee of the organisation, chaired by the Chief Executive as Accountable Officer.
- 2.2 The Accountable Officer is responsible for the overall organisation, management and staffing of the Health Board. This includes its arrangements related to quality, safety and standards of care, as well as matters of finance, together with any other aspect relevant to the conduct of the Health Board's business, such as partnership responsibilities, in pursuance of the strategic directions set by the Health Board's Board, and in accordance with its statutory responsibilities and the Strategic Objectives approved by the Health Board.
- 2.3 The Executive Committee is responsible for ensuring the effective and efficient operational co-ordination of all functions of the organisation, and thus supporting the Chief Executive to discharge the responsibilities delegated to the Accountable Officer.

3 DELEGATED POWERS AND AUTHORITY

3.1 The key responsibilities of the Executive Committee are outlined below:

- a) To provide the Board with advice and assurance concerning all aspects of setting and delivering the strategic direction for the Board, and the delivery of its associated strategies and plans;
- b) To support and advise the Board and its Committees in exercising its key functions:
 - To set strategy and shape culture;
 - To make and take decisions;
 - Taking and providing assurance;
 - Setting risk appetite and overseeing corporate risks;
- c) To lead delivery of the Board's strategies and plans aligned to national plans and policy requirements;
- d) To ensure effective operational management of the Health Board, enabling critical issues to be anticipated, discussed and action plans agreed and impact monitored and reported;
- e) To ensure that there is appropriate integration, connection and liaison between individual services, between clinical and corporate functions and between strategic and operational matters both inside the organisation and for the Health Board in partnership;
- f) To ensure the organisation remains fit for purpose by continuously reviewing effectiveness and efficiency of the organisational structure and support functions and also the Health Board's participation in partnership mechanisms;
- g) To provide a forum for key policy and strategic areas to be debated and refined before they are discussed formally with the Board and/or responsible committees and/or approved depending on the delegated powers of the Committee;
- h) To support individual directors to deliver their delegated responsibilities by providing a forum for briefing, exchange of information, mutual support, resolution of issues and achievement of agreement;

- i) To make management decisions on issues within the remit of the Executive Committee, in-line with the Board's Scheme of Delegation, Framework of Reservation of Powers/Decisions and Authorisation Matrix.

3.1.1 With regard to the specific powers delegated to it by the Board, the Committee's programme of work will include:

- a) Leading and overseeing the Health Board's planning and performance to achieve and deliver NHS Wales' requirements for planning e.g. quarterly and annual plans and also local planning and objectives/priorities approved by the Health Board;
- b) Taking forward actions arising from national and local objectives and performance requirements, developing integrated performance reporting and managing the delivery of action plans and reporting against their progress;
- c) Agreeing and monitoring the delivery of action plans and directing where further action is required to improve performance, by holding services and functions to account for required improvements and reporting against progress;
- d) Agreeing business cases for service developments, improvements and investments in line with the Scheme of Delegation as agreed by the Board.
- e) Reviewing the capital programme prior to consideration by the relevant Health Board Committee and approval by the Board;
- f) Developing, directing and monitoring the delivery of the Health Board's key sub strategies and plans including ensuring the responsibilities for improving the health and wellbeing of the population of Powys, as well as service delivery are included in these plans and programmes of work.
- g) Monitoring financial performance to ensure that the Health Board's meets its statutory duties;
- h) Ensuring the effective management of monitoring requirements of Welsh Government and other regulators;
- i) Implementing and managing the structures, processes and responsibilities for identifying and managing the key risks facing the organisation and its partnerships; informing discussions and reporting to the Audit, Risk and Assurance Committee, other relevant committees and the Board;

- j) Keeping the operational effectiveness of policies and procedures under review; approval of a policy framework and operational arrangements for the organisation and approval of policies not reserved for Board approval or a designated committee of the Board;
- k) Providing advice and assurance to the Committees of the Board and/or the Board on matters related to quality, safety, standards, planning, commissioning, service level agreements, partnership arrangements and change management initiatives;
- l) Ensuring staff are kept up to date and actively engaged with regard to Health Board wide and partnership issues and matters;
- m) Acting as the forum in which Directors and senior managers can formally raise concerns and issues for discussion, making decisions on these issues and matters;
- n) Ensuring there is an effective business planning process in place for the Health Board, which will include the formulation of business frameworks, sequencing and prioritisation of business flows and acting as an effective mechanism through which reporting is co-ordinated and agreed to the Health Board and its committees in line with the Health Board's Board Assurance Framework arrangements.

Authority

3.3 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 and in line with information governance legislation and requirements.

3.4 The Committee may seek any relevant information from any:

- employee (and all employees are directed to co-operate 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).

Sub Committees & Working Groups

- 3.6 The Committee may, subject to the approval of the Accountable Officer, establish sub-committees or task and finish groups to carry out on its behalf specific aspects of Committee business and responsibilities. Sub groups will report to the Executive Committee who in turn will report relevant items to the health boards Board and other committees.
- 3.7 The Committee has established to assist with the discharging of its responsibilities, a series of sub-committees and groups. It is recognised that these groups will have cross-cutting and connected portfolios and will receive their direction via the Executive Committee. The Executive Committee will act as the locus for the co-ordination of the direction and business of these sub-committees and groups. The Executive Committee will agree integrated annual work programmes for these groups and will receive regular reports on progress to inform reporting to the Board and its committees. Programmes of work for these groups/sub-committees will be adjusted as required and aligned to the overall annual programme of business of the Executive Committee.

The current sub groups of the Executive Committee (January 2025) are shown in appendix 1.

Other Groups or response structures may be established, as required, in response to emerging priorities or emergency situations as they throughout the year.

4 MEMBERSHIP

Members

- 4.1 Membership will comprise:
- Chair
 - Chief Executive Officer (Accountable Officer)
 - Vice Chair
 - Deputy Chief Executive Officer
 - Executive Directors
 - Executive Director of Finance, Capital and Support Services (Vice Chair)
 - Executive Director of People & Culture
 - Executive Medical Director
 - Executive Director of Nursing, Quality, Women and Family Health

- Executive Director of Public Health
- Executive Director of Allied Health Professions, Health Sciences and Digital
- Executive Director of Primary Care, Community and Mental Health
- Executive Director of Planning, Performance and Commissioning

Attendees

4.2 In attendance: The following members will be standing/regular attendees:

- Director of Corporate Governance / Board Secretary
- Director of Improvement and Transformation
- Associate Director of Capital, Estates and Property;
- Corporate Business Manager / minute taker

4.3 By invitation: The Committee Chair may invite other officers, staff or officials (from within or outside the organisation) to attend all or part of a meeting to assist the Committee in discharging its responsibilities on any particular matter.

Secretariat

4.4 The secretariat for the Committee will be provided by the Corporate Governance Directorate via the Director of Corporate Governance.

5 COMMITTEE MEETINGS

Quorum

5.1 At least four full members must be present to ensure the quorum of the Committee, one of whom must be the Committee Chair or Vice Chair.

5.2 Where members are unable to attend a meeting, a nominated deputy should be asked to attend. Deputies will not count towards the quorum where decisions are required.

Frequency of Meetings

- 5.3 The Chair of the Committee, supported by the Director of Corporate Governance, shall determine the timing and frequency of meetings, which shall be held no less than **monthly**. This will be in line with an agreed programme of annual business for the Committee, which will be agreed each year and will be regularly reviewed (at least for each six month period, ideally quarterly).
- 5.4 The Chair of the Committee may call additional meetings if required to be taken forward between scheduled meetings.
- 5.5 Meetings can be held either in person or through electronic means.

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 and Accountable Officer retain overall responsibility and accountability for all matters relating to the operations of the organisation.
- 6.2 The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.
- 6.3 The Committee will work closely with the Board's other committees, joint and sub committees and groups to provide advice, performance updates and assurance to the Board through the:
- joint planning and co-ordination of Board and Committee business;
 - sharing of appropriate information; and
 - applicable escalation of concerns.

In doing so, this will contribute to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall assurance framework arrangements.

- 6.4 The Committee shall embed the Health Board's corporate standards, strategic objectives, well-being objectives, priorities and requirements, e.g., equality and human rights through the conduct of its business.

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

- report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes verbal updates on activity, and the submission of Committee minutes and written reports;
- bring to the Board's specific attention any significant matters under consideration by the Committee;
- ensure appropriate escalation arrangements are in place to alert the Chair of PTHB, Chief Executive or Chairs of other relevant committees/groups of any urgent/critical matters that may affect the operation and/or reputation of the Health Board.

7.2 The Board may also require the Committee Chair to report upon the Committee's activities at public meetings, e.g. Annual General Meeting, or to community partners and other stakeholders, where this is considered appropriate, e.g. where the committee's assurance role relates to a joint or shared responsibility.

7.3 The Director of Corporate Governance, on behalf of the Board shall oversee a process of regular and rigorous self assessment and evaluation of the Committee's performance and operation.

7.4 The Committee shall provide a written annual report to the Board on its activities. The report will also record the results of the Committee's self-assessment and evaluation.

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

8.1 The requirements and standards for the conduct of business as set out in PTHB's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum

- Issue of papers
- Committee meetings will not be held in public, however, to ensure public accountability, the Chief Executive, as the Committee Chair, shall report formally, regularly and on a timely basis to the Board on the Committee's activities.

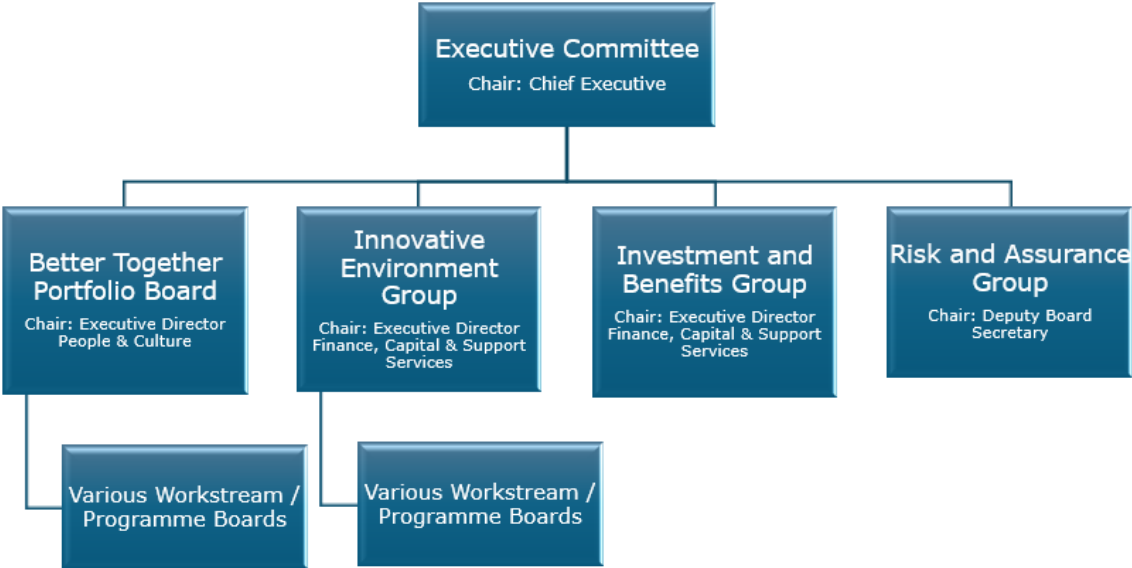
9. REVIEW

9.1 These Terms of Reference shall be reviewed annually by the Committee. The Director of Corporate Governance will report any changes to the Board, for approval.

Patterson, Liz
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Appendix 1 Executive Committee Sub Group Details

The following sub committees / working groups are directly accountable to the Executive Committee:



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Agenda Item: 3.3.2

Board		21 MAY 2025
Subject:	Project to review the Management of Policies and Other Written Control Documents	
Approved and Presented by:	Helen Bushell, Director of Corporate Governance / Board Secretary	
Prepared by:	COVID-19 Inquiry Programme Manager	
Other Committees and meetings considered at:	Executive Committee – 14 May 2025 who supported the paper to the Board	

PURPOSE:

This paper proposes a revised way of working for the management and approval of policies and other written control documents across the organisation. Setting out the framework and structures to support the organisation in the control and oversight of its policies and other written control documents.

The approval of this document is retained by the Board as per the scheme of delegation within the PTHB Standing Orders.

RECOMMENDATION:

The Board is asked to:

- **APPROVE** the Management of Policies and Other Written Control Documents.

Approval/Ratification/Decision	Discussion	Information
✓	x	x

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

Strategic Objectives:	1. Focus of Wellbeing	
	2. Provide Early Help and Support	✓

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

OVERVIEW:

In January 2024 a small project team was established to review how Powys Teaching Health Board (PTHB) manages its policies and other written control documents across the organisation. The aims of this project was to:

- Review and update the Management of Policies, Procedures and Other Written Control Documents Policy and Procedure
- Develop robust process of policy creation, approval route and review
- Redesign control and responsibilities of the Procedures and Other Written Control documents
- Develop robust process of directorate creation, approval route and review of Procedures and Other Written Control documents for which they are responsible
- Develop a user-friendly toolkit to support the creation, approval and review of Policies, Procedures and Other Written Control documents
- Design an appropriate communication mechanism for informing employees of Policy launch, Policy updates and Policy impact
- Develop an effective Policy reporting mechanism assurance process to inform the organisation of compliance
- Develop mechanisms to improve Policy, and Other Written Control document accessibility

The 'document set' consisting of policies and other written control documents within PTHB, communicates the standards and expectations both of those working within and for PTHB, and the customers and patients of PTHB. These documents play a vital part in explaining and understanding what we do, what we're expected to do and why we do what we do at PTHB.

The redesigned policy and the proposed revised supporting procedures follow an 8-step continuous cycle across the life of a document, starting with the

appropriate identification of the right document to convey the communication, expectations and standards to be met.



Document Life Cycle

This project, consulting with Assistant Directors across the organisation, has produced a *Management of Policies and Other Written Control Document*; and supporting procedures - the *Procedure for Managing Policies*; and the *Procedure for Managing Written Control Documents*.

Appropriate document Approval Pathways have been developed with the inclusion of a Clinical Policy Review Group and a Corporate Policy Review Group to help support authors and compliance to the new way of working as well as providing assurance to the Executive team that correct process is being followed.

Working with each of the Directorates, *current* and *proposed new* Approval Pathways have been discussed and agreed for both policies and other written control documents.

The supporting documents within the document management toolkit have been reproduced to reflect this proposed way of working.

A new simplified version of a document management system has been built and will be used by the Corporate Governance team and demonstrated on its use at the point of training and handover with Directorate teams.

This project is now ready to go live within PTHB.

Roles & Responsibilities

Each Directorate will identify someone who can be designated as the Directorate/Department Policy Lead (dependant on the number of differing

specialisms within the Directorate) as a point of contact for the Corporate Governance team. The Directorate/Department Policy Lead would also be a point of contact within the Directorate to provide support and guidance within the Directorate to authors of Policies or other Written Control Documents on style and structure as well as the correct Approval route for the document. This project recognises that not all Directorates will be ready as a result of resource or capacity to adopt this new way of working at project launch. The project is rolled out at an appropriate pace with Corporate Governance retaining management of other written control documents for those Directorates that cannot implement this proposed new practice at this time.

Redefined Approval Levels

The project proposes to build on what we know to be the existing approval routes and levels of authorities for documents giving clear sight and delegation of these responsibilities where it is appropriate to do so.

Depending on the document type and the business authority responsibilities, the approval levels would fall to the following levels across the organisation:

- the Directorate Senior Management Team or Professional Groups,
- the Responsible Executive,
- the appropriate Policy Review Group
- the Executive Committee,
- an appropriate Board Committee and,
- the PTHB Board

It is recognised that specific Policies are for Board Committee Approval only, or Executive Committee Approval only. The proposed renewed level of Approval for all other Policies and other Written Control Documents is at Appendix 2.

Policy Review Groups

As previously mentioned and building on previous behaviours and the format and operation of the existing Workforce Policy Review Group (WPRG), this project proposes the introduction of a Clinical Policy Review Group (CIPRG) and a Corporate Policy Review Group (CoPRG).

Each group will have the responsibility for the oversight of policies and other written control documents for their area of responsibility:

- WPRG - people policies
- CIPRG - clinical and medical policies and,
- CoPRG - policies on how the organisation is run

Membership will be drawn from the directorates and appropriate employee representation groups at an appropriate level to make decisions and approve documents for which they have delegated authority.

Terms of Reference have been written for these groups and these have been shared with Assistant Directors for consultation. These documents are now ready for sharing at the inaugural meeting of these groups for further review and then implementation.

Virtual Policy Review Group

This project has also engaged with organisation wide specialist roles to agree and develop a Virtual Policy Review Group.

All authors of policies will seek consultation and engagement with this group for the purposes of ensuring compliance and consideration of any additional matters is drawn to the attention of the members of the 'virtual' policy review group and their area of specialism.

Whilst identification of the membership of this group continues, and your feedback and consideration toward the appropriate make-up of the group is to be sought, key contributors identified so far are:

- Welsh Language & Equalities Lead
- Senior Health & Safety Officer
- Information Governance & Records Management lead
- Corporate Governance
- Safeguarding Lead

Document Management Control

This project proposes that all Policies and Strategies will continue to be centrally managed and stored by the Corporate Governance team as the Policies are central to the organisations core values and standards, our expected commitments and deliverables. They convey what we do and what we intend to do for our employees, our customers and our community.

As a result of proposing this concept with Policies and Strategies, it is therefore proposed that the management of other Written Control Documents is shared across the organisation, placing the relevant documents under the control of the appropriate Executive/Director and their team. If there is a shared document across Directorates, then the responsibility will sit with the lead author and their Directorate. The purpose of this is to enhance the responsibility and accountability of the appropriate Directorate for these documents.

Publication and Communication

It is paramount that staff are made aware of new and reviewed policies as soon as is practical following approval, especially when new ways of working or any changes impact upon a role. It is also important for the organisation to provide appropriate mechanisms for the communication and raising of awareness and knowledge of new and reviewed policies making this communication accessible to all employees.

The redesign of the policy document structure and proposed content has been in support of such a communication. The completion of an accurate and succinct "Scope" for all policies (new or reviewed) and the accurate and detailed completion of the "Version Control" section for reviewed policies will be the substance from which a communication can be developed. Providing the concise detail of what the policy is about and where appropriate what has changed, will provide the consistency in the content for what is communicated about our policies.

Consulting with the Communications team we have identified a mechanism that will support the consistent and timely communication of all new and reviewed policies:

- Monthly article within Powys Announcements informing readers of all new and reviewed policies from the previous month. The Article will provide the detail captured from the Scope and Version Control sections of the policy as well as the provision of a link to the policy
- The introduction of a Management Team Brief for the organisation will also benefit the improved way of communicating new and reviewed policies. This method of communication to the managers in our organisation will include the sharing of information about new and reviewed policies, again providing the detail captured from the Scope and Version Control sections of the policy as well as the provision of a link to the policy for managers to share across their teams
- Regular reporting to the Executive Committee will continue to provide the detail and assurance of upward reporting.

Appendices:

Appendix 1 – Management of Policies and Other Written Control Document

Appendix 2 – Approval Routes and Authority Levels

Management of Policies and Other Written Control Documents

Document Reference No:	PTHB / CGP 004
Version No:	7
Publication Date:	Date published on Corporate Governance SharePoint dd/mm/yyyy
Review Date:	30 months from Publication date dd/mm/yyyy
Expiry Date:	36 months from Publication date dd/mm/yyyy
Author:	Charity Manager / COVID-19 Inquiry Programme Manager
Document Owner:	Director of Corporate Governance/Board Secretary
Accountable Executive:	Director of Corporate Governance/Board Secretary
Approved By:	PTHB Board
Approved Date:	Date policy approved dd/mm/yyyy
Document Type:	Policy
Scope:	All PTHB employees

Powys Teaching Health Board is the operational name of Powys Teaching Local Health Board
Bwrdd Iechyd Addysgu Powys yw enw gweithredol Bwrdd Iechyd Lleol Addysgu Powys

To ensure that you are always using the latest version of this corporate policy,
please refer to the version on the Corporate Governance SharePoint site

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Policies & Written Control Documents

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1. Scope

This policy sets out the standards to be met for the development and publication of all Powys Teaching Health Board policies and other written control documents.

This policy applies to all staff employed by the health board who have the responsibility for the development, review, approval, dissemination and management of policy and other written control documents.

2. Policy Statement

To ensure Powys Teaching Health Board (PTHB) delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, PTHB will develop and describe its “ways of working” in policies, procedures, guidelines and other written control documents.

All PTHB policies and other written control documents will be written in plain language so that all staff, stakeholders and where appropriate, our patients and the people we serve are clear about what is expected. Our documents will be aligned to the values and behaviours of the organisation, contribute to staff engagement and meet the characteristics of being a teaching health board.

It will be possible to find these documents on our internal SharePoint site [Policies & Written Control Documents - Policies, Procedures and other Written Control Documents - All Documents \(sharepoint.com\)](#) or, where appropriate, the PTHB Internet site.

It is the aspiration of PTHB that policies will be translated and available in Welsh. This will be a developing progressive target, to be achieved when policies are reviewed and renewed, commencing from the date of publication of this policy. It is the aim that all new PTHB policies, after the date of publication of this policy, will be translated and made available in Welsh.

Other relevant written control documents will be translated and available in Welsh where required by legislation and for any other approved reason.

All PTHB policies and other written control documents will be written and developed with the focus of preventing and reducing fraud, bribery and corruption to an absolute minimum within the Health Board. Any concerns regarding fraud, bribery or corruption arising from the development of a policy or other written control document, contact

should be made with PTHB Local Counter Fraud Specialist Team for advice and guidance. The LCFS Team can be contacted via email: Powys.CounterFraudTeam@wales.nhs.uk / Tel: 01874 712419.

PTHB recognises the importance of sound records management and information governance arrangements for both clinical and corporate records. All PTHB policies and other written control documents will be written, stored, and archived securely in accordance with relevant Records Management or Information Governance regulatory requirements IGP 017, IGP 018, and IGP 019 which can be accessed here: [Policies & Written Control Documents - IGP - Information Governance - All Documents \(sharepoint.com\)](#)

Any corporate wide documents beyond their three-year lifespan will remain extant until reviewed.

Some policies and other written control documents are adopted by PTHB. Where this is the case, PTHB will complete and place the PTHB facing pages at the front of the document adopting the remainder of the document as a PTHB document, accepting that the style and structure are different from PTHB documents. The content of these documents is not under the control of PTHB and they similarly remain extant, until the point of replacement. Should you have any questions regarding the adoption of another document then please contact the Corporate Governance team pthb.policy.management@wales.nhs.uk

3. Aim

The aim of this policy is to provide assurance that a structure and process for the development or review, approval, dissemination and management of policies and other written control documents is in place to support document owners and authors in ensuring that their documents are in line with current practice.

See Appendix 1 for an overview of the process for the development or review of a new or existing policy or other written control document with an example of the timeline for this process

4. Objective

To ensure consistency in the format, consultation, approval, dissemination and application of the organisation's policies and other written control documents, these documents will be:

- produced using the document templates found within the Corporate

Governance Policies and Other Written Control Document toolkit
[Policies & Written Control Documents - Written Control Document Toolkit - All Documents \(sharepoint.com\)](#)

- developed and reviewed when required and in a timely manner;
- owned – each document will have an Owner - a Senior Manager or Policy Lead, who has responsibility for making sure that it is regularly reviewed and kept up to date;
- subject to Equality Impact Assessments where required [CGP 009 Equality Impact Assessment Policy.pdf](#)
- appropriately consulted on and co-produced where required;
- considered and approved at the appropriate level within PTHB
- appropriately communicated and accessible to staff and stakeholders
- supported by appropriate learning, education and development where required; and
- available to the public in line with Freedom of Information Act requirements and our Publication Scheme

This Policy is supported by the **Procedure of Managing Policies** [Written Control Document Toolkit](#) and the **Procedure for Managing Other Written Control Documents** [Written Control Document Toolkit](#). Please refer to these Procedures for further information on how to develop, review and approve a policy or other written control document.

To assist the development of new or the review of existing policies or other written control documents a suite of advisory documents and templates is available within the Corporate Governance Policies and Other Written Control Document toolkit [Written Control Document Toolkit](#)

5. Monitoring Compliance, Audit & Review

No policy, or other written control document can be approved unless the processes set out in the supporting Procedure documents have been followed.

All approved policies will be made accessible through the Corporate Governance SharePoint site and all other approved written control documents will be available via the appropriate Directorates SharePoint site or accessibly through a link from the Corporate Governance SharePoint page.

Internal audit will assess the effectiveness of and compliance with this policy and of all Powys Teaching Health Board policies on a periodic

basis.

This document will be reviewed every three years or earlier should audit results or changes to legislation / practice within the health board indicate otherwise.

Appendix 1: Policy and Other Written Control Document Flowchart and Example timeline



Version Control

Version	Summary of Changes/Amendments	Issue Date
1	Initial Issue	Oct 2003
2	Reviewed following change from Trust to Local Health Board	Jan 2004
3	Reviewed and updated following Organisational changes	Jun 2009
4	Reviewed and further minor updates made following departmental changes	Aug 2010
5	Interim adjustments pending confirmation of organisation restructure	Aug 2013
6	Full review and update undertaken to meet Internal Audit recommendations and organisational restructure. Clarification of responsibilities and approval routes.	Dec 2014
7	Full review and update extracting procedural elements into separate supporting documents, revising the required response for Equality Impact Assessment, revising Engagement & Consultation required response, revising and updating approval process	Aug 2024

Engagement & Consultation

Key Individuals/Groups Consulted in the development of this document

Role Designation	Date	Name of Reviewer
Trade Unions	08/05/2024	Unison Branch Secretary
WOD	07/05/2024	Head of Workforce
	02/05/2024	Service Lead for Welsh Language and Equalities
	13/05/2024	Senior Health & Safety Officer
Corporate Governance	01/05/2024	Deputy Director (Engagement and Communication)
	20/05/2024	Head of Information Governance, Records & Data Protection
Finance	13/05/2024	Assistant Director of Support Services
Nursing	14/05/2024	Assistant Director Nursing -

		Safeguarding
	15/05/2024	Deputy Director of Nursing
	20/05/2024	Chief Technology Officer
Mental Health	13/06/2024	Assistant Director of Mental Health and Learning Disabilities Services
Medicine	14/05/2024	Chief Pharmacist
Assistant Directors	22/04/2024	Assistant Directors Community email

Policy Approval Pathway

Name	When	Why
Corporate Governance SMT	TBC	Final review for recommendation for approval
PTHB Executive Directors	TBC	Recommended for approval
PTHB Board	TBC	Recommended for approval

Task & Finish Group Members

Name	Job Title
Rhiannon Davies	Business & Governance Officer
Susan Wilcox	Senior Administrator/Personal Assistant
Martin O'Brien	Covid-19 Inquiry Programme Manager

Equality Impact Assessment

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken Make reference to where the mitigation is included in the document, as appropriate
Age For most purposes, the main categories are: • under 18; • between 18 and 65; and • over 65	N / A		
Persons with a disability as defined in the Equality Act 2010 Those with physical impairments, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes	N / A		

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People of different genders: Consider men, women, people undergoing gender reassignment NB Gender-reassignment is anyone who proposes to, starts, is going through or who has completed a process to change his or her gender with or without going through any medical	N / A		
How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken Make reference to where the mitigation is included in the document, as appropriate
procedures. Sometimes referred to as Trans or Transgender			
People who are married or who have a civil partner.	N / A		

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Women who are expecting a baby, who are on a break from work after having a baby, or who are breastfeeding. They are protected for 26 weeks after having a baby whether or not they are on maternity leave.	N / A		
People of a minority race, nationality, colour, culture or ethnic origin including non-English speakers, gypsies/travellers, migrant workers	N / A		

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How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken Make reference to where the mitigation is included in the document, as appropriate
People with a religion or belief or with no religion or belief. The term 'religion' includes a religious or philosophical belief	N / A		
People who are attracted to other people of: - the opposite sex (heterosexual); - the same sex (lesbian or gay); - both sexes (bisexual)	N / A		

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People who communicate using the Welsh language in terms of correspondence, information leaflets, or service plans and design Well-being Goal – A Wales of vibrant culture and thriving Welsh language	The aim of this policy and all PTHB policies is that they are to be translated and available in Welsh prior to publication. This aim will be monitored across the cycle of this project and when policies are reviewed for publication		Work with the Welsh Language Lead to monitor the effectiveness of this aim and to ensure as a minimum all mandatory policy documents are translated and available in Welsh

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How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken Make reference to where the mitigation is included in the document, as appropriate
People according to their income related group: Consider people on low income, economically inactive, unemployed/workless, people who are unable to work due to ill-health	N / A		
People according to where they live: Consider people living in areas known to exhibit poor economic and/or health indicators, people unable to access services and facilities. This also may include wifi poverty, travel poverty and fuel poverty.	N / A		
Consider any other groups and risk factors relevant to this strategy, policy, plan, procedure and/or service	N / A		

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How will the strategy, policy, plan, procedure and/or service impact on the health and well-being of our population and help address inequalities in health?

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Questions in this section relate to the impact on the overall health of individual people and on the impact on our population. Specific alignment with the 7 goals of the Well-being of Future Generations (Wales) Act 2015 is included against the relevant sections.

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
People being able to access the service offered: Consider access for those living in areas of deprivation and/or those experiencing health inequalities Well-being Goal - A more equal Wales	N/A		

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People being able to improve /maintain healthy lifestyles: Consider the impact on healthy lifestyles, including healthy eating, being active, no smoking /smoking cessation, reducing the harm caused by alcohol and /or non-prescribed drugs plus access to services that support disease prevention (eg immunisation and vaccination, falls prevention). Also consider impact on access to supportive services including smoking cessation services, weight management services etc Well-being Goal – A healthier Wales	N / A		

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate
			Make reference to where the mitigation is included in the document, as appropriate

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People in terms of their income and employment status: Consider the impact on the availability and accessibility of work, paid/ unpaid employment, wage levels, job security, working conditions Well-being Goal – A prosperous Wales	N / A		

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How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
People in terms of their use of the physical environment: Consider the impact on the availability and accessibility of transport, healthy food, leisure activities, green spaces; of the design of the built environment on the physical and mental health of patients, staff and visitors; on air quality, exposure to pollutants; safety of neighbourhoods, exposure to crime; road safety and preventing injuries/accidents; quality and safety of play areas and open spaces Well-being Goal – A resilient Wales	N / A		

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People in terms of social and community influences on their health:	N / A		

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
Consider the impact on family organisation and roles; social support and social networks; neighbourliness and sense of belonging; social isolation; peer pressure; community identity; cultural and spiritual ethos Well-being Goal – A Wales of cohesive communities	N / A		

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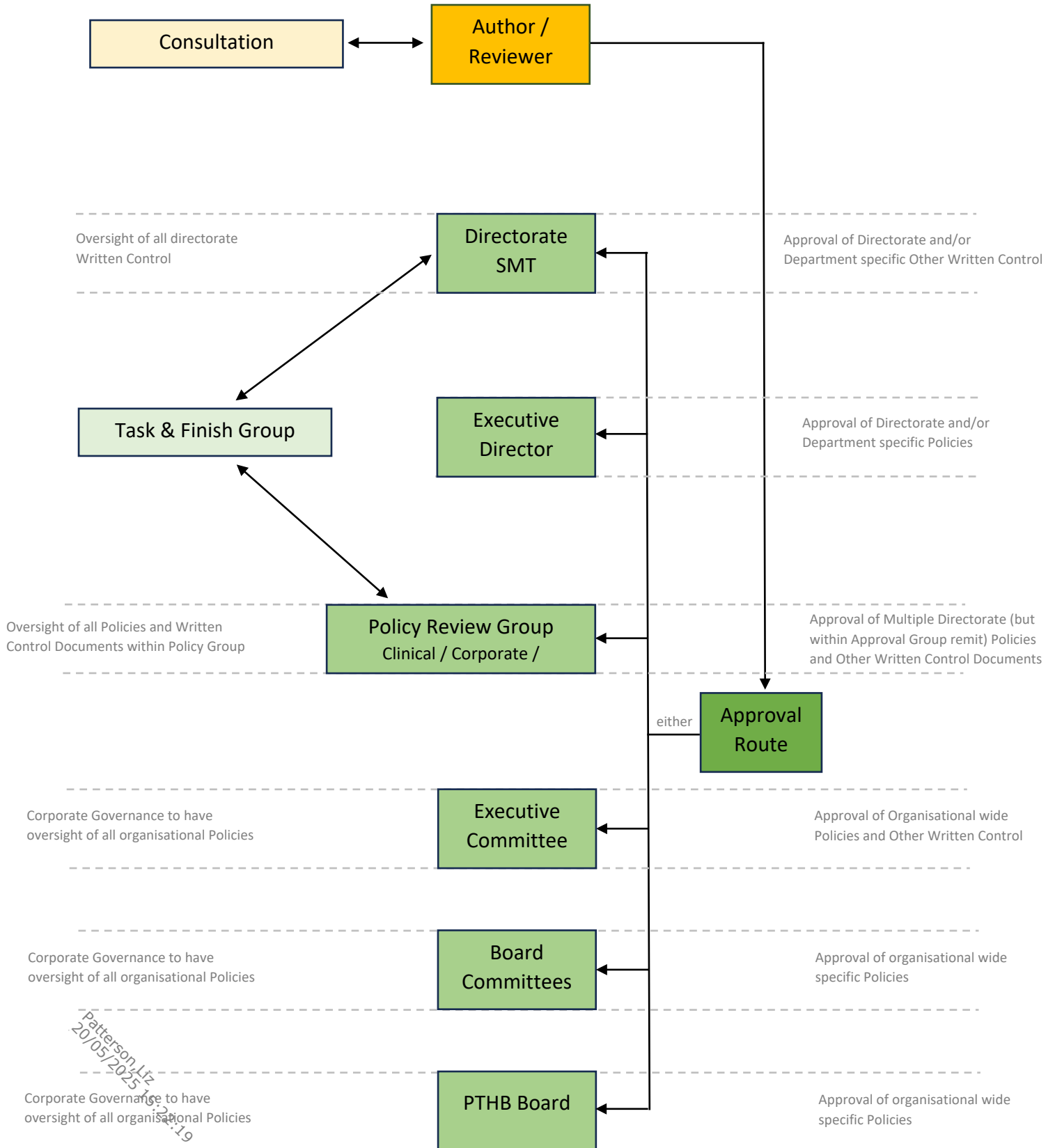
People in terms of macro-economic, environmental and sustainability factors: Consider the impact of government policies; gross domestic product; economic development; biological diversity; climate	N / A		

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How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
Well-being Goal – A globally responsible Wales	N / A		

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Proposed Approval Routes and Authority Levels





GIG
CYMRU
NHS
WALES

Bwrdd Iechyd
Addysgu Powys
Powys Teaching
Health Board

Agenda item: 6.4

Executive Committee		14 MAY 2024	
Subject:	Strategic Risk Development and Risk Appetite		
Approved and presented by:	Helen Bushell, Director of Corporate Governance		
Prepared by:	Deputy Board Secretary		
Other Committees and meetings considered at:	Board Development – 8 May 2025 Executive Committee – 14 May 2025 who endorsed the report.		
Appendices :	Appendix A – Strategic Risk Areas Appendix B – Draft Risk Descriptors Appendix C – Risk Appetite Statement		
PURPOSE:			
This report provides the Board with the proposed risks for the constitution of the Strategic Risk Register, which has been developed to align to the revised Risk Management Framework (RMF) and Annual Plan as approved by the Board in March 2025. Strategic risks form part of the Board’s Assurance Framework (BAF) and provides a summary of the significant risks to the delivery of the health board’s strategic objectives. The report also provides the proposed revisions to the Board’s risk appetite statement.			
RECOMMENDATION(S):			
The Board is asked to: • RECEIVE and APPROVE the newly developed strategic risks descriptors included at Appendix 1 taking ASSURANCE that it is a complete and a true reflection of the Health Board’s current strategic risks • RECEIVE and APPROVE the recommendations regarding the actions to close the previous Corporate Risk register taking ASSURANCE that the risks contained in the previous risk register will be appropriately managed going forward. • RECEIVE and APPROVE the revised Board’s risk appetite statement.			
Approve/Take Assurance		Discuss	Note
X			

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:

1. Focus on Wellbeing	Y	The corporate risks are a reflection of the significant risks to the delivery of the health board's strategic objectives and therefore underpin all wellbeing objectives.
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	

BACKGROUND

The Health Boards Strategic Risks are those risk that's represent an issue that has the potential to hinder achievement of one or more of the health board's strategic priorities; these risks can broadly be separated into 'cross-cutting risks', those risks underpin the achievement of several or all of the strategic priorities or wellbeing objectives and risk to the strategic priorities, which are relevant to one or two of the strategic priorities outlined in the Health Board's Annual Plan. The Board and Executive Committee have undertaken a series of development sessions regarding Strategic Risk since the approval of the RMF and Annual Plan by the Board in March 2026 and have identified key areas of risk as detailed within this paper.

Alongside this, following engagement at a Board Development session in April 2025 the Board proposed updates to its Risk Appetite Statement which is appended to this paper for review and approval.

DEVELOPMENT OF STRATEGIC RISKS

The Board and Executive Committee have undertaken a series of development sessions regarding Strategic Risk since the approval of the RMF and Annual Plan by the Board in March 2026, as a result the below areas have been identified as the key strategic risk areas:

Risks to Strategic Objectives

- Commissioning
- Primary Care
- Provider capacity
- Enabling the shift to prevention
- Service fragility
- Continuing Health Care (CHC) stabilisation

Cross-cutting Risks

- Financial Balance
- Estate
- Workforce
- Public Confidence
- Digital
- Incident Response/Emergency Preparedness

- Transformation

This is further outlined in the graphic provided in Appendix A.

Draft risk descriptors have been developed for each of the areas the detail of the which are included in Appendix B.

CLOSURE OF THE CORPORATE RISK REGISTER

It is proposed that the Corporate Risk Register which operated under the previous RMF is formally closed, as it will be replaced by the aforementioned Strategic Risk Register, owned by the Board and an Organisational Risk Register (ORR), focused on significant and cross-organisation operational risk, owned by the Executive Committee but reported regularly to the Board for oversight. Both registers will be co-ordinated by the Corporate Governance Team.

The following actions are proposed to ensure the appropriate ongoing management of legacy risks recorded within the Corporate Risk Register upon closure.

De-escalate: De-escalate the risk to the new Organisational Risk Register, or appropriate Directorate Risk Register

Update: Retain the essence of the risk but review the wording, scope etc

Maintain: Carry the same risk forward unchanged to the new SRR

CRR Ref and Summary	Proposed Action:
CRR 001 (Financial forecast – in-year delivery)	De-escalate for management within the ORR by the Executive Committee
CRR 002 (Financial resources)	Update, retain the essence of the risk on the SRR but update descriptor to reflect the need to achieve financial sustainability
CRR 003 (Resource allocation)	Update, retain the essence of the risk on the SRR but update descriptor to focus the risk descriptor transformation rather than resources.
CRR 004 (Provided Services Demand)	Maintained, direct transfer to SRR
CRR 005 (Commissioned Services Demand)	Maintained, direct transfer to SRR
CRR 006 (Workforce)	Maintained, direct transfer to SRR

CRR 007 (Primary Care)	Maintained, direct transfer to SRR
CRR 008 (Cyber-attack)	De-escalate for management within the ORR by the Executive Committee, subsumed by broader Incident Response/Emergency Preparedness risk at strategic level.
CRR 007 (Estate)	Maintained, direct transfer to SRR
CRR010 (Public Health Emergency)	De-escalate for management within the ORR by the Executive Committee, subsumed by broader Incident Response/Emergency Preparedness risk at strategic level.
CRR011 (Power Outage)	De-escalate for management within the ORR by the Executive Committee, subsumed by broader Incident Response/Emergency Preparedness risk at strategic level.
CRR012 (National Digital Programmes)	De-escalate for management within the ORR by the Executive Committee, subsumed by broader Digital risk at strategic level.

The Board is asked to consider and APPROVE the above recommendations.

RISK APPETITE

The Board last revised its risk appetite in May 2024 in the context of significant and complex challenges and opportunities. In early 2025 the Board has spent some informal time reflecting on the appetite statement.

Below is a summary of the proposed changes to the Boards risk appetite statement:

Risk Category	May 2024 Appetite	Proposed new Appetite
Safety	Averse	Averse
Quality	Minimal	Minimal
Regulation & Compliance	Cautious	Cautious
Reputation & Public Confidence	Open	Open
Performance and Service Sustainability	Cautious	Open
Financial Sustainability	Open	Cautious

Workforce	Cautious	Cautious
Reputation & Public Confidence	Open	Open
Partnerships	Open	Open
Innovation & Strategic Change	Open	Eager

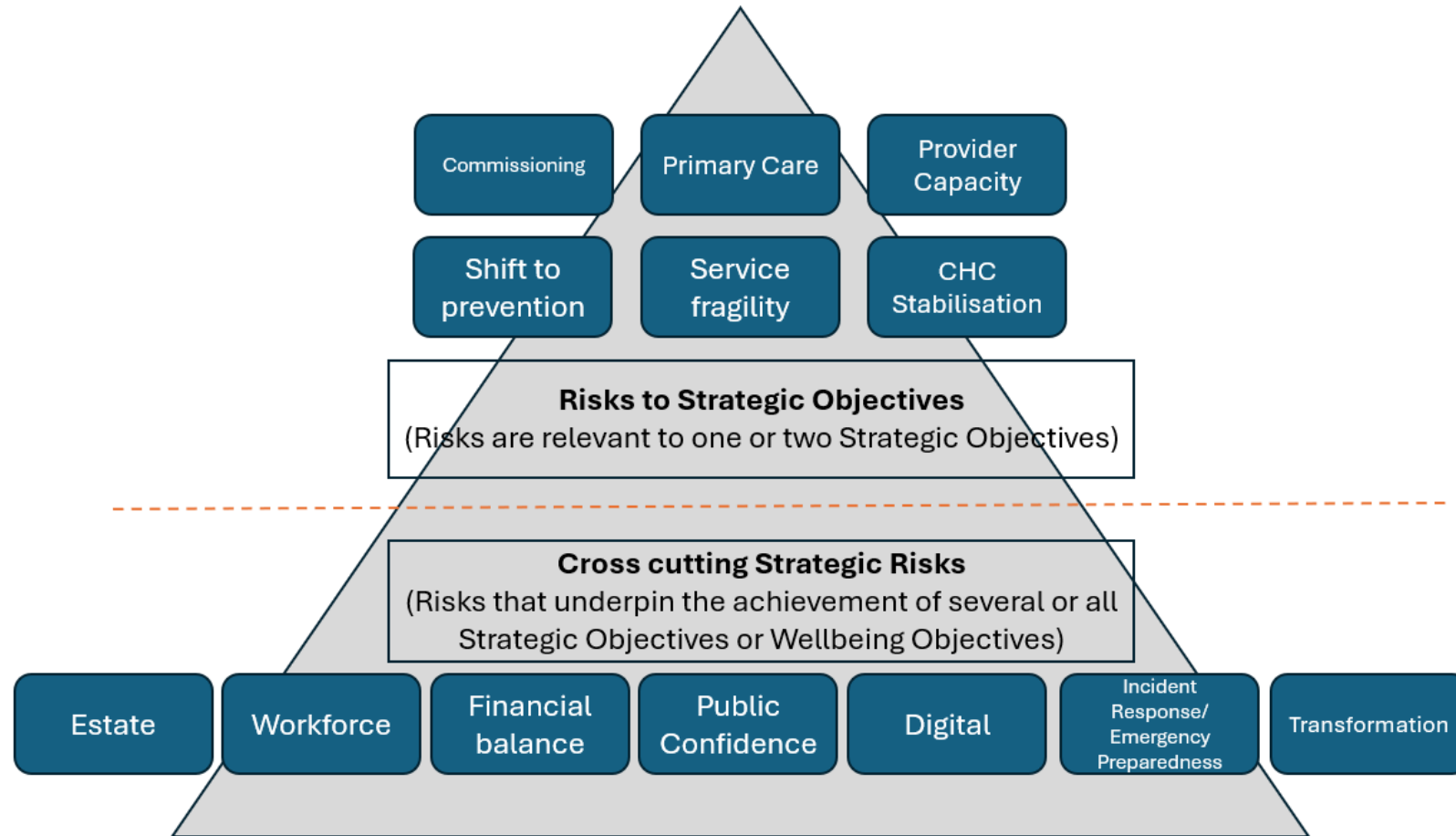
The full revised risk appetite statement is attached as Appendix C for consideration.

NEXT STEPS:

Key next steps include:

- The Board at its July meeting will receive a full copy of the new risk register together with a developed Board Assurance matrix reflecting assurance levels and gaps in control
- Board Committees will receive the full risk templates that fall within the committee's remit from July 2025 to enable their role in seeking assurance about effective risk management to be undertaken, on behalf of the Board
- The Audit and Risk Assurance Committee will continue to seek assurance in relation to the organisations overall system of control, including risk management and continue to report to the Board
- The Executive Committee will continue to review the Strategic Risk Register ahead of each Board meeting (more frequently if needed), and will undertake work in partnership with Directorates and Services to develop the Organisational Risk Register.
- Senior Risk Owners will continue to actively manage risks, as per the Strategic Risk Register and Board agreed risk appetite, on a day to day operational basis.

Appendix 1 - Strategic Risk Areas



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Appendix 2 – Draft Risk Descriptors

Theme and Strategic Priority Reference	There is a risk that the Health Board ...
Financial balance	is unable to achieve its duty to achieve financial breakeven (and therefore sustainability)
Provider capacity	is unable to respond to the demand for PTHB directly provided services
Commissioning	is unable to respond to the demand for commissioned services
Continuing Health Care Stabilisation	is unable to stabilise the growing cost implications of Continuing Health Care
Shift to prevention	is unable to shift to a prevention focused health care system
System resilience	is unable to deliver integrated, resilient health and care services
Estate	provides care in some areas that is compromised due to the health board's estate being not fit for purpose
Incident Response/Emergency Preparedness	is unable to respond effectively to a major incident or emergency
Transformation	is unable to successfully deliver and realise the benefits of transformation

Digital	has inadequate digital infrastructure and systems to deliver safe, high-quality services
Primary Care	's demand for primary care services is higher than the capacity available.
Workforce	is unable to recruit and retain an appropriate workforce and therefore is unable , to consistently sustain high quality services.
Public confidence	is unable to instil confidence in regard to service delivery and transformation in staff, patients, stakeholders and community.

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Appendix C – Risk Appetite Statement



RISK APPETITE STATEMENT – MAY 2025

The Board recognises that risk is inherent in the provision and commissioning of healthcare services, and therefore a defined approach is necessary to articulate risk context, ensuring that the organisation understands and is aware of the risks it is prepared to accept in the pursuit of its aims and objectives. **The Health Board will continue its open and transparent approach to risk management.**

The Board places fundamental importance on the delivery of its strategic objectives and its relationships with its patients, the public and strategic partners in achieving delivery of the ten-year Health and Care Strategy: 'A Healthy, Caring Powys'.

The Health Board should make a strategic choice about the style, shape and quality of risk management and should lead the assessment and management of opportunity and risk. The Board should determine and continuously assess the nature and extent of the principal risks that the organisation is exposed to and is willing to take to achieve its objectives - its risk appetite – and ensure that planning and decision-making reflects this assessment. Effective risk management should support informed decision-making in line with this risk appetite, ensure confidence in the response to risks and ensure transparency over the principal risks faced and how these are managed.

The Board will seek to balance all categories of risk appetite, in reality complex decisions contain components that fall across the range of risk categories, for example financial sustainability, performance and service sustain ability and workforce could all be contained within any one decision.

The risk appetite statement should be read in conjunction with the Health Boards Risk Management Framework which can be found here – [PTHB Risk Management Framework March 2025](#)

The Board has adopted the following Risk Appetite Matrix:

Risk Appetite	Description
Averse	Avoidance of risk and uncertainty in achievement of key deliverables or initiatives is key objective. Activities

Risk Appetite	Description
	undertaken will only be those considered to carry very limited or virtually no inherent risk.
Minimal	Preference for very safe business delivery options that have a low degree of inherent risk with the potential for benefit/return not a key driver. Activities will only be undertaken where they have a low degree of inherent risk.
Cautious	Preference for safe options that have low degree of inherent risk and only limited potential for benefit. Willing to tolerate a degree of risk in selecting which activities to undertake to achieve key deliverables or initiatives, where we have identified scope to achieve significant benefit and/or realise an opportunity. Activities undertaken may carry a high degree of inherent risk that is deemed controllable to a large extent.
Open	Willing to consider all options and choose one most likely to result in successful delivery while providing an acceptable level of benefit. Seek to achieve a balance between a high likelihood of successful delivery and a high degree of benefit and value for money. Activities themselves may potentially carry, or contribute to, a high degree of residual risk.
Eager	Eager to be innovative and to choose options based on maximising opportunities and potential higher benefit even if those activities carry a very high residual risk.

The Board is not open to risks that materially impact on the quality or safety of services the Health Board provides or commissions; or risks that could result in the organisation being non-compliant with UK law, healthcare legislation, or any of the applicable regulatory frameworks in which we operate.

The Board has greatest appetite to pursue innovation and challenge current working practices and financial risk in terms of its willingness to take opportunities where positive gains can be anticipated, within the constraints of the regulatory environment.

The health board's risk appetite has been defined following consideration of organisational risks, issues and consequences. Appetite levels will vary, in some areas our risk tolerance may be cautious in others we may be eager for risk and are willing to carry risk in the pursuit of important strategic objectives. The health board will always aim to operate organisational activities at the levels defined below. Where activities are projected to exceed the defined levels, this will be escalated through the appropriate governance mechanisms to the Board for ratification.

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Risk Category	Description
APPETITE FOR RISK: Averse	
Safety	We consider the safety of patients and staff to be paramount and core to our ability to operate and carry out the day-to-day activities of the organisation. We have a low appetite to risks that result in, or are the cause of, incidents of avoidable harm to our patients or staff. We will not accept risks, nor any incidents or circumstances which may compromise the safety of any staff members and patients or contradict our values i.e., unprofessional conduct, underperformance, bullying or an individual's competence to perform roles or tasks safely nor any incident or circumstances which may compromise the safety of any staff members or group.
APPETITE FOR RISK: Minimal	
Quality	The provision of high-quality services is of the utmost importance for the health board. The Board acknowledges that in order to achieve individual patient care, treatment and therapeutic goals there may be occasions when a low level of risk must be accepted. Where such occasions arise, we will support our staff to work in collaboration with those who use our services, to develop appropriate and safe care plans. We therefore have a low appetite for risks which may compromise the Duty of Quality and/or the quality of the care we deliver / could result in poor quality care, non-compliance with standards of clinical or professional practice or poor clinical interventions. Our service is underpinned by clinical and professional excellence and any risks which impact on quality could adversely affect outcomes and experiences of our patients, service users and communities.
APPETITE FOR RISK: Cautious	
Regulation & Compliance	We are cautious when it comes to compliance and regulatory requirements. Where the laws, regulations and standards are about the delivery of safe, high quality care, or the health and safety of the staff and public, we will make every effort to meet regulator expectations and comply with laws, regulations and standards that those regulators have set, unless there is strong evidence or argument to challenge them.
Workforce	The Health Board is committed to recruit and retain staff that meet the high-quality standards of the organisation and will provide on-going development to ensure all staff

Risk Category	Description
	reach their full potential. This key driver supports our values and objectives to maximise the potential of our staff to implement initiatives and procedures that seek to inspire staff and support transformational change whilst ensuring it remains a safe place to work. Our work will continue to be undertaken in partnership with our Trade Union colleagues.
Financial Sustainability	We recognise we have been entrusted with public funds and must remain financially viable. We will make the best use of our resources for patients and staff ensuring maximum value is achieved. Risks associated with investment or increased expenditure will only be considered when linked to delivery of core patient services supporting innovation and strategic change and/or legal or regulatory compliance. We will not accept risks that leave us open to fraud or breaches of our Standing Financial Instructions.
APPETITE FOR RISK: Open	
Performance and Service Sustainability	We have a low-moderate risk appetite for risks which may affect our performance and service sustainability. We are prepared to accept managed risks to our portfolio of services if they are consistent with the achievement of patient/donor safety and quality improvements as long as patient/donor safety, quality care and effective outcomes are maintained. Whilst these will both be at the fore of our operations; we recognise there may be unprecedented challenges (such as Covid-19, workforce availability and limited resources) which may result in lower performance levels and unsustainable service delivery for a short period of time. We will also consider impacts on both short and long term performance and service sustainability in our decision making.
Reputation & Public Confidence	We will maintain high standards of conduct, ethics and professionalism at all times, championing our Values and Behaviours Framework, and will not accept risks or circumstances that could unduly damage the public's confidence in the organisation. Our reputation for integrity and competence should not be compromised with the people of Powys, Partners, Stakeholders and Welsh Government. Our communication and engagement will remain open and transparent.

Risk Category	Description
	In light of the challenging environment related to public sector funding, we have a more open appetite for risks that may impact on the reputation of the Health Board when these arise as a result of the Health Board taking opportunities to improve the quality and safety of services, within the constraints of the regulatory and financial environment.
Partnerships	The Health Board is committed to working with its stakeholder organisations to bring value and opportunity across current and future services through system-wide partnership. We are open to developing partnerships with organisations that are responsible and have the right set of values, maintaining the required level of compliance with our statutory duties at a local, regional and national level . We therefore have a high risk appetite for partnerships which may support and benefit the patients in our care. For example, the Health Board has a high appetite for risks associated with innovation and partnership with the third sector, industry and academia in order to realise the provision of new models of care, new service delivery options, new technologies, efficiency gains and improvements in clinical practice. However, the Health Board will balance the opportunities with the capacity and capability to deliver such opportunities and is confident that there will be no adverse impact on the safety and quality of the services provided.
APPETITE FOR RISK: Eager	
Innovation & Strategic Change	We wish to maximise opportunities for developing and growing our services by encouraging entrepreneurial activity and by being creative and pro-active in seeking new initiatives, consistent with the strategic direction set out in the Integrated Plan, whilst respecting and abiding by our statutory obligations. We will consider risks associated with innovation, research and development to enable the integration of care, development of new models of care and improvements in clinical practice that could support the delivery of our person and patient centred values and approach. We will only take risks when we have the capacity and capability to manage them, and are confident that there will be no adverse impact on the safety and quality of the services we provide or commission.

Risk Category	Description

This Statement will be regularly reviewed and modified so that any changes to the organisation’s strategy, objectives or our capacity to manage risk are properly reflected. It will be communicated throughout the organisation in order to embed sound risk management and to ensure risks are properly identified and managed.

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Health Board

Agenda item: 3.5

BOARD		Date: 01 May 2025
Subject:	Health & Safety Q4/Annual Report 2024-25	
Approved and presented by:	Debra Wood-Lawson, Executive Director People & Culture	
Prepared by:	Deputy Director People & Culture Senior Health & Safety Officer	
Other Committees and meetings considered at:	Executive Committee – 23 April 2025 who supported the paper Delivery and Performance Committee – 01 May 2025 who recommended the report to the Board.	
PURPOSE:		
The Annual Health and Safety report presents a comprehensive overview of performance during Quarter 4, alongside a full-year summary covering the financial period from 1 April 2024 to 31 March 2025.		
The purpose of this report is to provide the Board with assurance on the Health Board’s compliance with statutory health and safety requirements. It also highlights key are of performance, areas for improvement, and summarises the key activities and progress made throughout the year.		
RECOMMENDATION(S):		
Board is asked to:		
• APPROVE the Health and Safety Annual report.		
Take Assurance	Discuss	Note
Y	Y	N

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:		
1. Focus on Wellbeing	Y	The continued investment in H&S across the health board and training of staff, is critical to ensuring a proactive approach and positive H&S culture, and ultimately the safety and wellbeing of its employees.
2. Provide Early Help and Support	Y	
3. Tackle the Big Four	N	
4. Enable Joined up Care	N	
5. Develop Workforce Futures	Y	

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

EXECUTIVE SUMMARY:

This report presents a detailed update on Health and Safety performance for Quarter 4 and provides a year-end overview for the financial year 2024/2025. It outlines key trends and developments in accident and incident reporting, highlights areas of significant risk, and provides an update on training compliance and delivery. The report also reflects on the progress made in implementing internal audit recommendations and enhancing governance arrangements across the Health Board.

Governance and Policy Development

Significant progress has been achieved in response to the findings of the Internal Audit review, which concluded with an overall assurance rating of *Reasonable*. Actions to address the audit recommendations have been effectively progressed, demonstrating a strengthened commitment to continuous improvement and robust governance in Health and Safety.

All Health and Safety policies remain current, reflecting the Health Board’s proactive approach to policy management. In addition, a comprehensive review of the Corporate Health and Safety Policy is currently underway. This review aims to ensure continued alignment with best practice and health board needs. The revised policy is scheduled for completion and formal approval in Quarter 1 of 2025/2026, alongside updated Terms of Reference and membership proposals for the Health and Safety Group. As part of wider governance reforms, the Group will be formally established as a sub-committee of the Executive Committee, enhancing its visibility and strategic oversight.

Accident and Incident Reporting

During 2024/2025, there has been a slight increase in the number of RIDDOR-reportable incidents compared to the previous year. However, analysis indicates no recurring underlying causes, and importantly, no enforcement action has been taken by the Health and Safety Executive (HSE). This suggests that while incidents have occurred, they have been appropriately managed, with effective responses in place.

Similarly, there has been a modest rise in the total number of reported accidents and incidents across the health board. Despite this increase, overall figures remain relatively low and consistent with previous years, indicating a stable risk profile across the Health Board.

Violence and Aggression

One area of heightened concern during the reporting period has been the increase in incidents which fall under violence and aggression. A total of 70 more incidents were reported compared to 2023/2024, with the majority of the increase linked to cases of inappropriate behaviour and verbal assault, such as swearing or threatening language. While this trend is concerning and underscores the continued importance of protecting

staff, it is reassuring that the number of incidents involving physical assault (i.e., physical contact) has decreased by 21% compared to the previous year.

Efforts to address this challenge are ongoing. The Prevention and Management of Violence and Aggression (PMVA) Adviser is actively rolling out targeted training on de-escalation techniques and personal safety. These sessions are designed to support staff in managing challenging behaviours and reducing the frequency and severity of incidents. The reduction in physical assaults suggests early signs of impact, and this remains a strategic priority for the Health Board moving forward.

Training Delivery and Compliance

Training compliance across core Health and Safety subjects has remained relatively stable throughout the year. There have been slight, but encouraging, improvements in manual handling training rates, reflecting positive engagement from services and staff. However, there has been a slight decline in compliance levels for PMVA training, particularly in relation to Module D. To address this, a programme of targeted engagement and support will be rolled out during 2025/2026, working closely with service areas to monitor compliance levels and provide additional opportunities for staff to complete mandatory training. The Health Board remains committed to ensuring that all staff are equipped with the necessary skills and knowledge to work safely and confidently in their respective environments.

As part of the review of the corporate Health and Safety policy a risk-based approach is being adopted to identify those supervisors/managers who should form part of a wider training offer for managers.

ASSESSMENT & CURRENT SITUATION:

Internal Audit:

An Internal audit was conducted in November 2023 and reported back in December 2023.

Purpose: The overall objective of the audit was to review and assess the adequacy of the processes in place within the Health Board to ensure compliance with Health & Safety legislation.

The internal audit provided an overall rating of Reasonable Assurance but identified health and safety training as limited assurance, due to the challenges in delivering the training as outlined in the Health and Safety Policy, which due to challenges with workforce vacancies may be unsustainable.

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Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Objectives	Assurance
1 The Health Board has health and safety policies in place which comply with the requirements of health and safety legislation. The policies are accessible to staff	Substantial
2 Training requirements and needs have been identified for staff. Training is undertaken and up to date	Limited
3 The health board has an appropriate structure to manage health and safety responsibilities and governance arrangements are in place for the regular monitoring and reporting of health and safety matters	Reasonable
4 Health & Safety risks are appropriately assessed and there is an up-to-date health and safety risk register in place	Substantial

It is expected that following the review and approval of the health board's corporate H&S policy HSP-001, which is currently in progress, all outstanding items from the 2023 Audit will have been completed, this includes the items below:

Health and Safety Governance:

Health and Safety Governance and reporting streams are currently being reviewed and discussed by Senior Management from Corporate Governance, People and Culture and Estates. This is to ensure where responsibilities sit within other departments, these are aligned and report through the correct mechanisms and committees for scrutiny. Once agreed, this will be included in the reviewed and updated Health and Safety Policy.

Standard Operating Procedures (SOP) & Other Procedures / Guidance:

In the last 12 months the H&S team have developed and implemented an SOP for the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). This document is designed to assist and guide Managers and Supervisors in

identifying and understanding the types of incidents need to be reported to the HSE in line with the Regulations.

Policies

The current H&S policy position is as follows:

Number	Policy Title	Status
PTHB- HSP001	Health & Safety Policy	Under Review
PTHB - HSP002	Health and Safety Local Implementation Procedure	Current
PTHB - HSP003	Manual Handling Policy	Current
PTHB - HSP004	Hand Arm Vibration	Current
PTHB - HSP005	Violence and Aggression Policy	Current
PTHB - HSP006	Lone Working Policy & Procedure	Current
PTHB - HSP007	Display Screen Equipment Policy (DSE)	Current
PTHB - HSP008	Management of Contractors	Current
PTHB - HSP010	New and Expectant Persons and New Mothers Policy	Current
PTHB - HSP011	Stress Management Policy (Wellbeing in the Workplace)	Current
PTHB - HSP012	The Control of Risks at Work to Young Persons Policy and Procedure	Current
PTHB - HSP013	Control of Substances Hazardous to Health (COSHH) Policy & Procedure	Current
PTHB - HSP018	First Aid at Work Policy	Current
PTHB - HSP025	Personal Protective Equipment Policy	Current

All H&S policies were updated in Q2 of 2024/25 to reflect the changes in portfolio and structure that have taken place in the last twelve months. Which involved the Health and Safety team moving from the Support Services Directorate to the People and Culture Directorate.

Policies due for their 3-year review and updated in 2024/25, included:

- HSP008 – The Management of Contractors Policy
- HSP018 – First Aid at Work Policy
- HSP001 – The health board's Health and Safety Policy

Both the Management of Contractors (HSP008) and First Aid at Work (HSP018) policies have been reviewed, revised and approved at HSG. These are now live via both the corporate policy pages and H&S pages of the intranet. The main Health and Safety Policy (HSP001) is still under review. This is due to the outstanding audit items identified above which have taken time to resolve and also to encompass the new Terms of Reference of the Health and Safety Group.

Health and Safety Executive Activity

The Health and Safety Executive (HSE) aim to influence change and help health boards manage risks at work. This includes:

- Providing advice, information, and guidance
- Raising awareness in workplaces by influencing and engaging
- Operating permissions and licensing activities in major hazard industries
- Conducting targeted inspections and investigations
- Taking enforcement action to prevent harm and hold those who break the law to account.

The Current Enforcement Record for PTHB since 2019

Type of HSE Enforcement Action	2019	2020	2021	2022	2023	2024/25 Q1	2024/25 Q2	2024/25 Q3	2024/25 Q4
Prosecution									
Prohibition Notice									
Improvement Notice									
Fee for Intervention (FFI)									

There has been no enforcement action by the Health and Safety Executive in the financial year 2024/25.

Previous Interventions by the HSE.

HSE Interventions	Reason
2019	HSE Letter of Contravention in relation to the prevention and management of violence & aggression and Manual Handling. This resulted in Fee for Intervention (FFI).

2019	HSE Improvement Notices associated with Legionella. This resulted in Fee for Intervention (FFI).
2021	HSE Improvement Notices associated with Hand Arm Vibration (HAVS). This resulted in Fee for Intervention (FFI).
2022	PTHB Prosecution by the HSE in relation to Hand Arm Vibration.

Ionising Radiation

The Powys Teaching Health Board (PTHB) Radiology service operates in collaboration with Radiation Protection Adviser's (RPA) and Medical Physics Expert's (MPE) who are appointed in writing from the Director of Therapies and Health Science (DOTHS) as per the Ionising Radiation safety policy Rad 002. The annual update from the Radiation Lead is as follows:

A combined briefing summarizing the key points from both the Radiography Service Exception Report (Q4 2025) and the RPC Executive Annual Report (2024), focusing on the 12-month period leading into Q1 2025:

1. Capital Equipment Replacement:

- £1.7 million programme to replace digital X-ray equipment has progressed significantly.
 - Phase 1 (Welshpool, Llandrindod, Ystradgynlais) completed.
 - Phase 2 to complete early 2025; Brecon is the final site, set to go live 24th April 2025.
- All new equipment is IRMER compliant and underwent critical examination by Medical Physics before going live.
- Standardised QA programmes for new machines have been drafted; final ratification expected 17th April 2025.

2. Radiation Incidents & Risk Management:

- Six radiation-related Datix incidents were recorded in Q4 2025; two were formally reportable to Medical Physics:
 - Common issues: wrong patient ID, decontamination lapse, wrong laterality, and repeated exposure.
 - None exceeded radiation dose thresholds; all were contained and reviewed with learning reflections and team discussions.

- A reportable incident in Brecon (Oct 2024) was escalated to HIW but deemed not clinically significant. Awaiting formal closure confirmation from HIW.

3. Compliance & Training:

- IRMER updates being integrated:
 - RAD 004 is being rewritten to reflect the Oct 2024 IRMER update.
- All staff have undergone application training on the new equipment.
- Annual entitlement to refer under IRMER confirmed for NMRs.
- Safety documentation and H&S files are current.
- Radiation safety training and RPS updates delivered (Oct–Nov 2024); now included in the Electronic Staff Record (ESR).

4. RPA & QA Monitoring:

- Regular QA testing and equipment audits carried out:
 - Dose audits flagged some imaging for further review; suggested local Diagnostic Reference Levels (DRLs).
 - Environmental radiation monitoring across all sites showed no safety concerns.
 - QC strategies pending for new ultrasound and image reporting workstations (Welshpool/Cardiology).

5. Radon Monitoring:

- All PTHB sites remain under the 300 Bq/m³ safety limit.
- A 5-year maintenance contract with RPW Radon Wales is active.
- Estates teams received training; Knighton Hospital may need future mitigation depending on usage.

6. PACS/RIS Implementation:

- Scheduled go-live: April 2025.
- Risk: Philips will not migrate 3 years of historical data.
 - Workaround: 18-month migration under review to maintain continuity of care.

7. Governance & Risks:

- 12 risks managed locally; five were escalated, most now resolved.
Ongoing issue: obstetric ultrasound staffing.

- SOPs for consent, clinical audits, and QA ratified and stored centrally on SharePoint.

Next Steps & Actions (as of early 2025)

- Ratify QA standardisation and RAD 004 update.
- Complete installation and compliance approval of final radiography sites (Brecon, Newtown).
- Address historical data gap for PACS/RIS.
- Continue staff training and monitor radon levels and imaging dose compliance.

Asbestos

Given the age and historical development of the Powys Teaching Health Board estate, asbestos-containing materials (ACMs) are present across a number of our buildings and facilities. The management of asbestos compliance is overseen by the Estates team, with dedicated responsibility held by the appointed Asbestos Manager.

Compliance is monitored through established procedures and is reported annually to the Board via the Innovative Environment Group. This is done through the formal submission of the Annual Asbestos Report, which outlines key findings, actions taken, and the current status of asbestos management across the estate. A copy of the most recent report is included as **Appendix 1** for reference.

Work-Related Stress

To proactively support staff wellbeing, the Health and Safety team has implemented a comprehensive **Stress Management Policy (HSP-011)**, which is complemented by a practical **Stress Management and Wellbeing Toolkit**. These resources, along with additional guidance and information, are readily accessible through the Health and Safety intranet site. Ongoing support is also available via the **Occupational Health Department** and the **People and Culture Directorate**.

During the year, the People and Culture Directorate undertook a detailed analysis of workforce absence data to identify any patterns or areas requiring additional interventions related to stress. The findings were presented to both the **Executive Committee** and the **Health and Safety Group**. While stress, anxiety, and depression continue to be the leading reasons recorded in ESR for staff absence, the review did not reveal any significant trends or hotspots requiring action beyond the current support measures in place.

Accidents and Incidents

The data is taken from the Once for Wales - Datix system and can be subject to change where the reporting of accidents and incidents is delayed.

For Note - The slips trips and falls being reported within this report do not include patients falls which are reviewed by a patient fall group.

General Incidents/Accident Data - Q4 January - March 2025

		Jan 2025	Feb 2025	Mar 2025	Total
Accident, Injury	Burns or scalds	0	1	0	1
	Contact with needles or medical sharps	0	0	2	2
	Contact with object or animal	1	0	2	3
	Contact with or exposure to hazardous substance	1	0	0	1
	Entrapment / Drawn in	0	0	0	0
	Manual Handling - Non patient/service user handling	2	0	1	3
	Manual Handling - Patient/service user handling	4	1	1	6
	Patient injury	0	0	0	0
	Road traffic collision	0	0	0	0
	Slip, trip or fall	4	1	1	6
	Struck against or by an object	2	1	1	4
	Total	14	4	8	26
Equipment, Devices	Manual Handling - Equipment	0	0	0	0
	Manual Handling - Patient/service user handling	0	0	0	0
	Medical devices	0	1	0	1
	Non-medical equipment	1	2	2	5
	Total	1	3	2	9
Total		15	7	10	32

General Incidents/Accident Data - Q4 Trends and Themes

There has been a very slight increase in accidents and incidents in Q4 compared to those reported in Q3. A total of 28 or were reported in Q3 and 32 have been reported in Q4, an increase of 4 incidents. These numbers remain generally low with a total of 60 reported the last two quarters, in comparison to Q1 and Q2 there were a total of 59 accidents and incidents were reported, a difference of one.

The top four categories in Q4 include:

- Slips, trips and falls (6)
- Manual handling – patient and service user handling (6)
- Non-medical equipment (5)
- Struck against or by and object (4)

Slips, trips and falls – this category continues to be in the top reported categories each quarter, increasing from five reported in Q3 to six reported in Q4. None of the six in this period were reportable to the HSE. The slips, trips and falls are the result of various factors, including:

- Community Nursing – An employee was returning to their car when they slipped and fell on the drive injuring their back, head and arm.

- Community Nursing – An employee slipped on a loose brick on the exterior steps causing a sprained ankle and grazing to the wrist.
- Community Nursing – An employee at leg club while delivering care tripped on the lino causing them to fall onto their left knee and then land on their coccyx.
- Brecon Hospital – An employee was carrying notes while ascending a staircase, tripped causing the employee to fall, injuring their head, elbow and leg.
- Newtown Hospital – Employee tripped due to defective carpet under their desk, this defect has been reported on several occasions since 2018, and no action has been taken to address the situation. The office was re-arranged so the defect wasn't in an accessible position then it was moved back to the original configuration again posing a hazard to the workstation user.
- Bronllys Hospital – Trip and fall on level surface, due to hole hidden under the grass being walked on to visit the electrical switch room.

Manual handling – patient and service user handling – In Q4 the following patient and service user handling incidents were reported:

- Llandrindod Hospital (Theatre) – Employee aggravated an existing knee condition when manoeuvring a wheelchair with patient.
- Llandrindod Hospital – While assisting to move a patient the employee injured their back.
- Brecon Hospital (Therapies) – While assisting with the transferring and exercising of a patient aggravated an existing back condition.
- Brecon Hospital – Employee experienced pain of the neck, shoulders and lumbar spine after delivering care to a bariatric patient, on a defective bed that could not be raised.
- Community – Employee while delivering care in the community injured their lower back.
- Bronllys Hospital – Employee assisted a patient to the floor who suddenly fell and then had to support the patient on the floor for some time while waiting for assistance, this resulted in them aggravating an existing back condition. This incident was reported to the HSE as an over 7-day injury.

General Incidents/Accident Data - Year 1st April 2024 - 31st March 2025.

		Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Total
Accident, Injury	Burns or scalds	0	0	1	2	0	0	1	0	1	0	1	0	6
	Contact with needles or medical sharps	0	0	2	2	0	0	1	2	1	0	0	2	10
	Contact with object or animal	2	0	1	1	1	0	2	1	1	1	0	2	12
	Contact with or exposure to hazardous substance	0	1	0	1	0	0	0	0	0	1	0	0	3
	Entrapment / Drawn in	0	0	0	0	0	0	0	0	0	0	0	0	0
	Manual Handling - Non patient/service user handling	0	0	0	1	2	0	0	2	0	2	0	1	8
	Manual Handling - Patient/service user handling	2	0	0	1	1	1	2	0	0	4	1	1	13
	Patient injury	0	0	0	0	0	0	0	0	0	0	0	0	0
	Road traffic collision	1	0	0	0	0	1	1	0	2	0	0	0	5
	Slip, trip or fall	3	2	1	6	2	2	2	2	1	4	1	1	27
	Struck against or by an object	0	2	1	0	0	0	1	2	1	2	1	1	11
	Total	8	5	6	14	6	4	10	9	7	14	4	8	95
Equipment/ Devices	Manual Handling – Equipment	0	0	0	0	0	0	0	0	0	0	0	0	0
	Manual Handling - Patient/service user handling	0	0	1	0	0	0	0	0	0	0	0	0	1
	Medical devices	1	0	1	0	2	0	0	0	2	0	1	0	7
	Non-medical equipment	3	0	2	1	0	4	0	1	0	1	2	2	16
	Total	4	0	4	1	2	4	0	1	2	1	3	2	24
Total		12	5	10	15	8	8	10	10	9	15	7	10	119

Annual Trends and Themes from the Accident and Incident data

In the last 12-months a total of 119 reported general accidents and incidents were reported across the health board. This compared to the year 2023/24 where there was a total of 109 is an increase in 10 reported general accidents and incidents.

The top five categories over the last twelve months are as follows:

- Slips, Trips and Falls – 27, which is an increase of 8 incidents on the previous year.
- Manual Handling (patient/service user) – 13, which is an increase of 4 incidents on the previous year.
- Contact with Object or Animal – 12, which is an increase of 3 incidents on the previous year.
- Struck Against or by and Object – 11, which is a reduction of 2 incidents on the previous year.
- Non-medical Equipment -16, which is a reduction of 2 incidents on the previous year.

V&A Incident Data Q4 January – March 2025

	Jan	Feb	March	Total
Abduction	0	0	0	0
Absconding or missing patient/service user	1	4	2	7
Aggressive/threatening behaviour	7	7	5	19
Anti-social behaviour	0	1	0	1
Equality and diversity policy / guidelines	0	0	0	0
Harassment	0	0	0	0
Inappropriate behaviour / attitude	2	2	8	12
Inappropriate use of social media	0	0	0	0
Indecent exposure	0	0	0	0
Patient clinically challenging behaviour	0	0	0	0
Physical assault (physical contact)	8	3	6	17
Privacy and dignity for the patient	0	0	0	0
Protest	0	0	0	0
Restrictive practices	4	2	8	14
Self-harm / self-injurious behaviour	6	5	3	14
Sexual (inappropriate) behaviour	2	2	0	4
Sexual assault	0	0	0	0
Smoking	0	0	1	1
Verbal assault (gender/sexual orientation)	0	0	1	1
Verbal assault (racial abuse)	1	0	1	2
Verbal assault (swearing etc.)	0	1	1	2
Total	31	27	36	94

Data shows that Q4 saw a slight reduction across most categories in overall reporting of incidents compared to the 3 previous quarters. Although overall numbers reduced there were no discernible changes in the pattern for the categories where incidents were occurring.

Aggressive/Threatening Behaviour remains the highest reported category accounting for 20% of overall reported incidents. However, there was a reduction of 41% in the actual number of incidents of Aggressive/threatening behaviour reported compared to Q3.

Physical assault also saw lower reporting numbers compared to Q3 and follows the overall reduction in the number of incidents reported for this category across the year.

V&A Incident Data - Financial Year 1st April 2024 - 31st March 2025.

For the year 2024/25 - **477** Reports were made under the category of Behaviour (including Violence and Aggression).

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	Apr 2	May 2	Jun 2	Jul 2	Aug 2	Sep 2	Oct 2	Nov 2	Dec 2	Jan 2	Feb	Mar	Total	23/24
Abduction	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Absconding or missing patient/service	3	3	2	1	5	2	3	1	4	1	4	2	31	13
Aggressive/threatening behaviour	13	16	10	12	11	8	12	14	6	7	7	5	121	117
Anti social behaviour	1	0	2	1	0	0	2	0	1	0	1	0	8	11
Equality and diversity policy / guideline	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Harassment	0	1	2	0	4	2	4	0	2	0	0	0	15	4
Inappropriate behaviour / attitude	6	3	5	8	9	5	9	8	8	2	2	8	73	36
Inappropriate use of social media	0	0	0	0	0	1	0	1	1	0	0	0	3	2
Indecent exposure	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Patient clinically challenging behaviour	0	1	0	3	3	0	0	0	1	0	0	0	8	14
Physical assault (physical contact)	5	2	3	6	4	13	6	9	10	8	3	6	75	94
Privacy and dignity for the patient	0	0	0	0	0	0	1	0	0	0	0	0	1	0
Protest	0	0	0	0	0	0	1	0	0	0	0	0	1	0
Restrictive practices	3	4	12	3	5	1	3	3	2	4	2	8	50	54
Self-harm / self-injurious behaviour	1	2	2	1	2	1	5	8	15	6	5	3	51	43
Sexual (inappropriate) behaviour	0	0	0	0	1	0	4	0	0	2	2	0	9	4
Sexual assault	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Smoking	0	0	1	0	0	0	0	0	0	0	0	1	2	3
Verbal assault (gender/sexual orientation)	0	1	0	0	0	0	0	0	0	0	0	1	2	2
Verbal assault (racial abuse)	0	0	0	0	0	0	0	1	0	1	0	1	3	3
Verbal assault (swearing etc.)	4	4	2	1	3	1	1	4	2	0	1	1	24	5
Total	36	37	41	36	47	34	51	49	52	31	27	36	477	407

In 2024/25 we saw an increase of **17.2%** (70 incidents) in the overall number of incidents reported compared to the previous year. The overall number however remain relatively low.

Increased reports were seen in the following categories:

- Absconding/missing patients – (Increase from 13 to 31)
- Harassment – (Increase from 4 to 15)
- Inappropriate behaviour / attitude (Increase from 36 to 73)
- Verbal assault (swearing) – (Increase from 5 to 24)
- Self-harm – (Small increase from 43 to 51)

Decreased reports were shown for

- Physical assault – (Decrease from 94 to 75)

The 2 categories that contain the largest number of Datix are

- i) Aggressive / Threatening behaviour; and
- ii) Inappropriate behaviour / attitude.

While it is pleasing to see a reduction in the numbers of physical assaults, which is likely linked to improved de-escalation techniques and distraction, many of these incidents would still be reportable as they would often include an element of intimidation, threats and verbal abuse.

Of the 31 reports of absconding / missing patients:

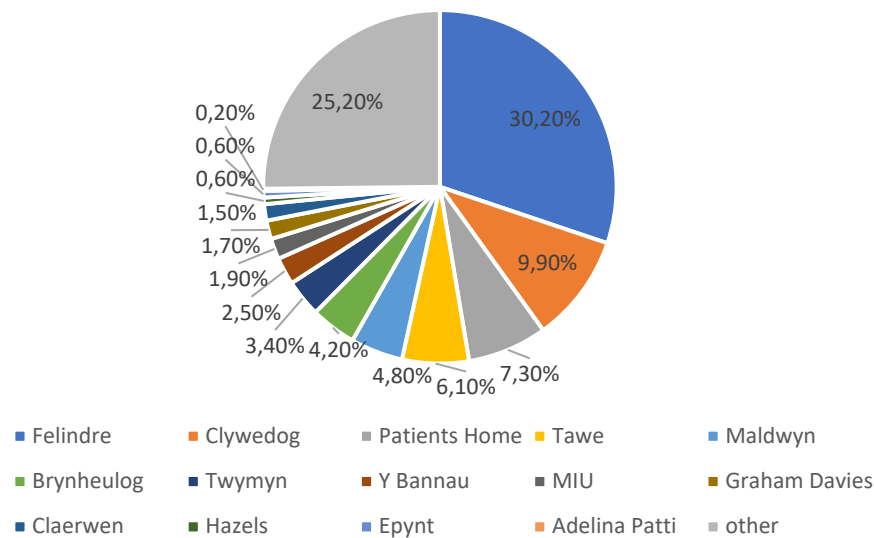
- 9 were from Felindre, 5 from 1 female attempting to leave through window and once escaping over the roof; others including patients failing to return.
- 9 Reports were from Y Bannau where disorientated patients were using push door release and fire exits to leave, 5 reports were related to 1 male.
- Other reports including missing people who were service users but not formal patients and patients who were late returning from relative visits.

Ward	Q1	Q2	Q3	Q4	Total	%
Felindre	28	24	59	33	144	30.2%
Clywedog	3	25	14	5	47	9.9%
Patients Home	11	8	11	5	35	7.3%
Tawe	5	11	2	11	29	6.1%
Maldwyn	10	2	7	4	23	4.8%
Brynheulog	8	5	3	4	20	4.2%
Twymyn	3	9	3	1	16	3.4%
Y Bannau	2	6	2	2	12	2.5%
MIU	5	2	1	1	9	1.9%
Graham Davies	3	1	3	1	8	1.7%
Claerwen	3	1	3	0	7	1.5%
Hazels	0	1	0	2	3	0.6%
Epynt	3	0	0	0	3	0.6%
Adelina Patti	0	0	1	0	1	0.2%
Other	30	22	43	25	120	25.2%
Totals	114	117	152	94	477	

Figures have been recorded across the health board and of the 477 Datix reports made in 2024/25:

- 46% were from the 3 MH Wards
- 7% were from patient homes
- 19% were recorded from general wards
- 25% were recorded from unspecified areas which may be related to wards or incorrectly recorded i.e. some Incidents reported as in site grounds have been related to Felindre patients.

V & A Report locations



Unfortunately, 25% of records were not recorded under specific locations and were recorded under:

- Outpatients
- Clinical Areas
- Non-clinical Areas
- Site grounds
- Residential/ Nursing homes

This may therefore affect some of the data.

2024/25 Data. Discrepancies

Datix Data - Unfortunately Datix records are not always accurately recorded; although category changes are often made by the V & A Advisor at monthly reviews no other data including location would be changed for example:

Of the 152 reports in Q3, 59 (38.8%) were recorded from Felindre, however manual manipulation of data shows this to have been 64 (42%) which demonstrates that some Datix reports related to Felindre may have been recorded away from the ward. 8 reports were also recorded from the Hazels however only 2 of these were recorded under that location.

** It is important that staff try to record reports under the correct location instead of non-clinical (31); clinical (26) and site grounds (13) which equated to 70 of the 477 reports (14.7%).

Overview

Report numbers can be largely affected by individuals on the wards, between December and February one patient on Felindre was attached to at least 25 Datix reports, they then left the ward but soon returned and a further 7 Datix reports were submitted for in March, this relates to over 20% of Felindre's reports in this year.

Violence and aggression incident data shows that violent and aggressive incidents are happening across the health board and are not just related to MH inpatient wards. Data has identified that 7% of incidents have occurred in patient homes, where staff are often attending as lone workers and 19% recorded from general wards where currently staff only receive E-Learning training.

Going forward it is important that Datix reports are checked before submission, to ensure that categories and locations are correct, so data is accurate. It is also important that services and wards undertake a V&A training needs analysis, to assess based on risk the levels of PMVA training their staff require, to ensure we can better equip our employees to safely deal with these types of situations where they manifest themselves.

Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR)

RIDDOR Incidents Reported by Category

RIDDOR Category	2019	2020	2021	2022	2023	2024 Q1	2024 Q2	2024 Q3	2024 Q4	Total
Specified Injury			1	3	1		1			6
Specified Injury (Public)		1		2			3			6
Over 7-day Injury	4	2	7	4	5	3		2	1	28
Occupational Disease		4	3	3		1	1			12
Dangerous Occurrence					1	1				2
Fatality										0
Total	4	7	11	12	7	5	5	2	1	54

RIDDOR Incidents Reported by Accident Category

Accident Category	2019	2020	2021	2022	2023	2024 Q1	2024 Q2	2024 Q3	2024 Q4	Total
Slips, Trips & Falls	3	1	3	3		1	3			14
Physical Assault	1			1	3		1			6
Manual Handling		1	3	1	1	2		1	1	10
Burns / Scalds										0
Struck by Object			2	1				1		4
Struck Against		1								1
Falls From Height				2						2
Occupational Disease		4	3	3		1	1			12
Needle Stick										0
Electric Shock				1						1
Another Kind of Accident					2					2
Release of a Chemical					1	1				2
Totals	4	7	11	12	7	5	5	2	1	54

RIDDOR - Q4 and year end 2024/25

Q4 - There has only been one RIDDOR reported incident, this relates to people moving and handling – where a patient fell on the ward and during the fall was supported by a member of staff during causing a sprain to the employees back leading to an over 7-day injury. This was investigated by the line manager and advice provided by H&S.

The total number of reported incidents to the Health and Safety Executive in the year 2024/25 was thirteen. Six of which were classified as an over a 7-day injury, this is where the injured person was not able to work or carry out their role without adjustments, for a period of seven consecutive days or more following the injury. Four incidents were reported in the category of specified injury, and included three bone fractures due to slips, trips, falls and one loss of consciousness due to a slip trip or fall.

H&S - Accident / Incident Investigations

The H&S team continually provided advice and support to departments and managers during their investigations of accidents, incidents throughout the year and have undertaken one formal investigation into a RIDDOR reported accident which occurred in July 2024.

This investigation related to an incident where a member of the Estates Department slipped while cutting back foliage on a raised bank to the rear of one the hospitals. The member of staff fell onto the stationary blade of the hedge cutter they were using, resulting in a laceration to two fingers which required emergency intervention at a district general hospital and then surgery to repair tendons in one finger. A report with the findings of the investigation, long with recommendations has been issued to the Estates Department and H&S are awaiting confirmation the recommendations have been implemented. The findings of the investigation, included:

- Issues with the allocation and supervision of work activities / tasks, especially where these are of a higher risk.
- Issues where the generic risk assessments for the task did not cover the equipment being used and access to the risk assessments by the operative on-site proved to be a potential issue.
- Issues with Training and competence to undertake the task safely or in the safe use of grounds maintenance equipment.
- There was no evidence that there was a toolbox talk in place for grounds maintenance work, or the correct equipment identification, selection and safe use is demonstrated or discussed.

- The Personal Protective Equipment (PPE) toolbox talk required updating to cover the need to ensure PPE is risk assessed and to ensure it is fit for the intended purpose.

During the investigation it was also noted that the HAVS tag fitted to the hedge cutter by and external company via plastic cable tie, had been fitted at the base of the front handle. This handle is a safety cut out device, which when released by the operator immediately stops the blades from operating. The positioning and fixing of this tag had the potential for the tag to move around the handle preventing the safety cut out operating correctly. Luckily in this instance this wasn't the case, and safety cut out worked correctly, and the injured person only made contact with a stationary blade. Had the blade continued to operate the injury would have been significantly more serious.

The Estates department were advised to check all equipment and tag fitting, to ensure there were no further instances of incorrect fitting and to ensure the company who fitted the tags were made aware of their error and potential implications of their actions.

Training

During 2025/26 the following training has been delivered via the Health and Safety team, either by the in-house resource, or by external providers.

Health and Safety Training Delivered:

- 3-day IOSH Managing Safely, delivered by an external provider.
- The Level 1 Health and Safety e-learning package which is mandatory for all staff continues to be delivered via ESR.
- All new starters attend Corporate Induction which includes a section on H&S – this includes - H&S Responsibilities, V&A, Manual Handling, Fire Safety, Lone working, Driving for work, DSE assessments and Datix reporting.
- Patient Handling and Object Handling
- Manual Handling for Managers
- PMVA 4-day Foundation and 1-day refresher courses.
- Breakaway Training.
- Personal Safety & De-escalation Training.
- Med Gas training for Porters.
- Hand Arm Vibration Training.
- Face Fit testing – online presentations.

IOSH Managing Safely

Two pilot courses were run with NPTC, and although very successful with good evaluation outcomes, less than 20 employees were able to attend.

Due to the withdrawal of Welsh Government funding, any further courses that are booked with NPTC will now be charged at a rate of £185 per person, with a minimum of 8 persons per course.

As part of the review and update of the corporate Health and Safety Policy, the health and safety training requirements for employees will be reviewed and will be updated to reflect a deliverable and achievable program of training for managers, relevant to their levels of responsibility and the risks within their service.

It is recognised that given the number of managers and supervisors across the health board, it will be a significant undertaking to achieve the training identified in the policy within a short timeframe. Therefore, to ensure training is prioritised, the H&S team will be conducting risk-based training needs analysis, specifically for health and safety training. This will allow for more structured and planned programme, with a view to achieving compliance within the 3-year term of the updated H&S Policy.

As part of this training review, the H&S team have been investigating various options for training delivery, with a view to try and reduce the impact on services, especially where staff backfilling can be challenging. One of which included utilising an in-house health and safety course, currently being developed by Cwm Taff Health Board, as an alternative to IOSH Managing Safely.

This course has been in development for around two years, and it is hoped once ready will be a more flexible option to the IOSH Managing Safely course, also with the hope in the future it can be accredited. The course is currently still not ready for launch and when it is, it will need to be assessed to ensure it is fit for the needs of PTHB.

Statutory and Mandatory Training rates for Manual Handling & PMVA.

Training compliance rates are reported through several Groups and Committees within the Health Board. The key challenge remains the same as previous years, which continues to be widely reported and this is the ability for departments to release staff to attend training, although these challenges are not supported by factual evidence or data.

The table below shows compliance for the financial year 2024/25, with an increase in compliance in 3 of the 5 categories with only a drop in compliance in both V&A categories, Module B (Online) and Module D. Module D in Q2 of the year had shown an increase of 10% on Q1, but over the twelve-month compliance in this module has dropped by 5.03%.

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Competence Name	Assignment Count	Required	Achieved	Compliance %	Situation Against 2023/24
070 LOCAL Manual Handling for Managers - No Renewal	220	220	169	76.82%	Up 01.17%
NHS CSTF Moving and Handling - Level 1 - 2 Years	855	855	755	88.30%	Up 04.89%
NHS CSTF Moving and Handling - Level 2 - 2 Years	1607	1607	1275	78.22%	Up 01:03%
NHS CSTF Violence and Aggression (Wales) - Module B - 3 Years	2143	2143	1976	92.21%	Down 01.20%
NHS MAND Violence & Aggression Module D - 1 Year	75	75	38	76%	Up 25.33%

**** Module D performance has be under reported previously due to ESR records for 19 staff who have completed their training not being updated. This is being looked into.**

Manual Handling Training

The manual handling training is delivered in line with the All-Wales NHS Passport scheme and the standards contained therein, this is currently version 3, 2020.

The All-Wales NHS Manual Handling Training Passport and Information Scheme (Passport Scheme) was developed by the All-Wales NHS Manual Handling Group. It was originally launched in 2003 with endorsement from the Welsh Government, NHS Wales and the Health and Safety Executive.

Moving and Handling training is currently planned and booked on a three-monthly basis. This has been reduced from booking six months in advance, to allow more flexibility to meet the demands of the health board, including delivery of training to bank staff and the new cohorts of internationally educated nurses.

People handling training can only be delivered in two venues, Llanidloes and Bronllys, where the equipment is provided in dedicated training rooms. It was hoped that this would expand in 2024 to a facility in Llandrindod, but this has not come to fruition. As has been well documented and communicated previously, due to block booking of the two dedicated training facilities, this has an impact on manual handling delivery and the available spaces that can be offered.

Going forward during the next 12 months the H&S team are going to trail the use of manual handling assessors in the workplace, a model current used by several health boards in Wales. This method would see staff being assessed within their work environment at the point of their two-year refresher, being assessed in a "live" setting

by trained workplace assessor from within their department. The assessors will be trained and supported by the Manual Handling Trainer/Advisor. With this model staff will only need to return to the classroom every 4 years for formal training, this is unless they fail their workplace assessment.

Moving to this model will potentially free up both training space availability and reduce the need for staff to leave the workplace to attend training. The trail is to take place in both the Therapies and X-ray departments in the first instance and will be evaluated over the next 12 to 24 months. If successful it will be a model that can be rolled out across the health board.

Manual Handling Course Deliver 2024/25.

Moving & Handling Course Breakdown – 1 st April 2024 – 31 st March 2025		
Course	Number of courses	Number attended
1 Day Refresher	50	377
2 Day Foundation	53	346
Object/Load	97	549
Managers Module G	16	66
Pool Evacuation	8	52
Totals	224	1429

Each of the manual handling courses is expected to take 8 candidates, so the offering for the financial year as identified in the table above was 224 courses, delivering 1792 training places, with an attendance of 1429, giving an overall attendance of 80%.

Prevention Management of Violence & Aggression Training (PMVA)

PMVA training is currently being delivered by Aneurin Bevan Health Board under an SLA, this includes.

- The 4-day PMVA Foundation Course
- The 1-Day PMVA Refresher Course

A one-day breakaway course along with a personal safety and de-escalation course are being delivered in-house by the PTHB V&A Trainer/Advisor, with training delivered both on-demand and via scheduled courses.

In Q4 a four-day Foundation course had to be run internally additional to the offering by ABUHB, this was due to extra demand to train bank staff.

PMVA Course Deliver 2024/25

PMVA Courses Breakdown - 1st April 2024 – 31st March 2025		
Course	Number of courses	Number attended
4 Day Foundation (ABUHB)	16	26
1 Day Refresher (ABUHB)	52	63
4 Day Foundation (PTHB)	1	8
1 Day Refresher (PTHB)	0	0
1 Day Breakaway	9	53
Personal Safety & De-escalation	14	130
Totals	92	280

Courses Delivered to PTHB by ABUHB

The PMVA course delivery by ABUHB is expected to take 3 candidates but this can vary depending on availability.

The above offering for the 12-month period included 16 four-day foundation courses with a total of 44 training places offered to PTHB and a booked attendance of 26 employees. AB are currently only charging for actual attendance.

There were also 52 one-day refresher courses run by ABUHB, with an offering of 192 training places to PTHB. The attendance of PTHB employees on these courses was 63.

Courses Delivered by PTHB

One 4-day foundation course was run internally by PTHB, utilising our internal trainer supported by an external trainer. This course was to cover a recent increase to Bank staff and for new starters. This course supported 12 training spaces of which 8 attended, an attendance rate of 67%.

PMVA Module D Compliance -

Compliance rates in relation to the Module D training course detailed above are as follows:

Of the 78 Staff listed on ESR requiring Module D PMVA Training, 57 are compliant = 73%. However, there are an additional 23 employees that have completed the training and are now compliant, including Bank staff, CAMHS, some which it is believed should be recorded on ESR as substantive ward staff. This is currently being cross referenced with ESR.

Therefore, of the 101 staff recorded as having completed Module D PMVA Training – 80 are compliant = 79.2%

Non-Compliance – There are currently 21 employees showing as not compliant, including:

- 7 from Tawe Ward
- 8 from Clywedog Ward
- 6 from Felindre Ward

These include employees currently off sick, on maternity leave or have since changed roles where PMVA is no longer required but is still showing against their ESR record. 3 members of staff did not pass their refresher course. Further work is being undertaken in consultation with the staff members and their trade unions to consider options including redeployment to roles where PMVA is not required.

Breakaway training

Breakaway training is run internally with 9 courses were run in the twelve-month period, an offering of 72 spaces (8 per course) and 53 employees attending, an attendance rate of 74%.

Personal Safety & De-escalation Training

This course is run internally with 14 courses being run in the last twelve months, and 130 places available and 130 employees attending, and attendance rate of 100%

Hand Arm Vibration Training

In line with the health board's HAVS Policy and training strategy, the following training was delivered during the last financial year:

Level 3 HAVS Awareness Training –

The level 3 training is delivered by the H&S team, either face to face or online via Teams presentation. This year staff from the works and estates department were due their 3 yearly refresher training in line with the policy and training strategy. This was delivered over several sessions in Q1 and Q2 and included several new members of staff. Level 3 training can be arranged to meet the needs and demands of the services when new employees join the health board.

Level 2 HAVS Awareness Training –

At this time there are no employees having been assessed as requiring the level 2 training. Even though the course has been created, there have been significant difficulties getting the course converted into a format to make it available on-demand via ESR. This will be revised in the next financial year to see if this can be progressed.

Level 1 HAVS Awareness Training –

This level of training is delivered by trained department HAVS Leads, via a Toolbox Talk along with the HSE Document INDG 296 and the staff requiring this training are predominantly in Support Services department. At the refresher point of April 2024 there were approximately 150 plus employees who required training across the county.

The information in the tables below has been provided by the service and demonstrate Support Services staff HAVS compliance South and North.

Compliance South

Location	Staff to Attend	Training Completed	Percentage complete
Ystradgynlais	20	16	80%
Brecon	21	15	71%
Bronllys	23	14	61%
Llandrindod Wells	33	22	67%
Totals	97	67	69%

We are advised there are a number of staff in the South on long term sick at present which is potentially resulting in lower compliance than expected. Further toolbox talks are to be run at the end of April 2025.

Compliance North

Location	Staff to Attend	Training Completed	Percentage complete
Llanidloes	17	17	100%
Newtown	16	15	94%
Machynlleth	17	14	82%
Welshpool	17	17	100%
Totals	67	63	94%

We are advised those who have not completed the training in the North are mainly new starters who are scheduled to complete this training by the end of April.

Face Fit Testing

Staff attendance at the online presentations has been sporadic and some sessions have been delivered with as few as one or two attendees. As can be seen in the table below 243 members of staff attended the 35 sessions, giving an average of attendance of 7 persons per session. Moving forward, and to try and maximise the use of the limited resources, arrangements have been made to replace the face-to-face delivery of the presentation on line, which will be recorded on ESR.

The practical testing sessions have predominantly been taking place at three hubs across the county: Llanidloes, Builth Wells and Bronllys. Testing has also been facilitated on site at four further locations, as listed in the table below.

The tables below indicate both the number of online presentations and practical testing sessions delivered in 2024/25 by the team.

Number of Online Presentations Delivered	Number of Persons Attended	Average Attendees Per Session
35	243	7

Number of Test Days	Location	Appointments Available	Appointments Used	Appointments Un-used
7	Bronllys	112	78	34
8	Builth Wells	128	61	83
9	Llanidloes	144	68	76
2	Ystradgynlais	32	22	10
1	Llandrindod Wells	16	6	10
2	Newtown	32	15	17
2	Welshpool	32	27	5
Totals				
<u>31</u> Test Days	<u>7</u> Test Locations	<u>496</u> Available Appointments	<u>277</u> Appointment Used	<u>235</u> Appointments un-used

A total of 31 face fit testing days were offered during the financial year 2024/25, each of the days was able to deliver 16 test appointments, a total of 496 appointments offered, with a total of 277 appointments attended, this equates to a 56% attendance rate.

Staff who are Face fit tested have this recorded on ESR. However, there is not a comprehensive risk assessment to show who requires testing to enable compliance levels to be reported. Discussion with the Infection, Prevention and Control manager and Public Health are on-going to find a resolution to this. Notably though MIUs were identified as amongst our highest risk areas and compliance in these teams has been 100%.

Health and Safety – Corporate Web Pages

A key element of the role of the health and safety function is to communicate and support managers and local teams in understanding health and safety and raising their awareness in the subject along with their roles and responsibilities.

One of the methods deployed to do this, is through the use of the H&S team's web pages, SharePoint and Powys Announcements. With safety critical issues communicated in safety alerts.

Updates to the corporate health and safety web pages this year include sections on:

- Workplace Inspections – A guide to carrying out workplace inspections along with downloadable inspection templates.
- The Safe Use of Bedrails – Information in the safe use of bedrails.
- Shift Workers -Information for those who are carrying out shift work.
- Bullying – Information on tackling bullying and harassment in the workplace.
- A new Seven Minute Briefing – A quarterly briefing issued by the H&S team, communicating seven bite sized topical H&S messages in each edition.
- Manager and Supervisor Health and Safety Responsibilities – A comprehensive guide for managers and supervisors in relation to their health and safety responsibilities and duties.
- Department Health and Safety File Guidance – A comprehensive guide on putting together a departmental health and safety file.
- Working at Height – a guide to working at height including a video toolbox talk, along with ladder safety awareness for step ladders/extension ladders, ladder inspections and safe working from height.

Staff Side Engagement and Support

During this year staff side have undertaken various workplace inspections, but these have not been in collaboration with the H&S team. It has been recognised that when these inspections are submitted to the employer there is often little response to the findings of the report and actions go un-managed.

To address this situation, the H&S team have developed a process for the employer to manage workplace inspections conducted by staff side. In order to ensure the employer responds appropriately and where actions and recommendations are identified, these are captured, actioned, progressed and tracked to completion where required, with feedback to staff side.

A paper was tabled at the Q3 H&S Group meeting in January 2025, recommending a process for implementation, the proposal was supported and approved. Work is currently being undertaken to formalise the process and recommendations within the paper and move the process forward for implementation.

Workplace Inspections

Powys Teaching Health Board has adopted HSG65 - Managing for Health and Safety, as its H&S Management System, which involves the process of Plan, Do, Check, Act. Premises inspections are part of the "Check" section of the cycle and an active method of monitoring health and safety performance.

The H&S team have a section on the website in relation to workplace inspections and have downloadable templates for Site Co-ordinators, Department Managers and others to use.

The need to conduct inspection has been communicated at various meeting and through the web pages, but to date there has been little evidence any inspection have been undertaken, except those done by the Trade Union Reps.

The failure to undertake regular workplace safety inspections poses a significant risk to the health board. The implementation of regular workplace inspected is a proactive way in ensuring hazards are identified at the earliest opportunity, so risk mitigation can be implemented before they result in injury or harm. The H&S team will review the current process in the next financial year, to see how this can be progressed, ensuring proactive programme of workplace inspections are undertaken.

Corporate Health and Safety Risks

In the financial year 2024/2025 - There were no Health and Safety Risks for the Health and Safety team to escalate to the Health and Safety Group and Corporate Risk Register.

Risks held on local Directorate Risk Registers are reviewed by the Directorate Management teams on a regular basis and those pertaining to health and safety should be escalated to the Health and Safety Group as required for review by the service manager.

NEXT STEPS:

Looking Ahead – 2025-26

1. To finalise the review and update of the Health and Safety Policy (HSP001) and submit this policy for approval at the Q1 meeting in July 2025. This will encompass the final pieces of work currently being done in relation to:

- Health and Safety Governance.
- Health and Safety Training.
- The Terms of Reference for the re-formed Health and Safety Committee.

2. To progress and update the current face fit testing booking progress and implement an online video presentation accessed and recorded on ESR. Which will also require an update of the face fit testing web page and information on the intranet. It is envisaged this will be completed in Q1/Q2.

3. Undertake a 3-yearly review and update of the following policies:

- Stress Management Policy – to be reviewed in period Q2.
- Manual Handling Policy – to be reviewed in period Q3.
- Violence & Aggression Policy – to be reviewed in period Q3.

4. To begin rolling out health and safety Training in accordance with the Training needs analysis and approved H&S Policy.

5. Undertake an interim review of the new manual handling workplace assessor's project – to be reviewed in period Q4.

6. To identify and undertake audits and inspections for the financial year 2025/26 based on the health board's data and current HSE focus areas.

7. Review the current audit and inspection process and identify an electronic version – to be review in period Q4.

The H&S team continue to be committed to ensuring a positive health and safety culture is embedded across the health board. It is hoped that following the training needs analysis, targeted health and safety training will be rolled out on a risk-based approach for managers and supervisors. Attending this training will support and give them the knowledge to discharge their health and safety responsibilities in accordance with their job roles. It will also help to foster and encourage a positive safety culture across the health board.

Some progress has been made in trying to reduce non-attendance at both face fit testing and the various training sessions delivered by the H&S team, including Manual Handling and PMVA, but there is more work to do on this, which we will continue in the next year.

It is hoped by changing the process for face fit testing this will improve the situation significantly although there are still issues around the capacity to deliver sessions due to the limited number of testers and availability of suitable rooms to carry out the testing. It is also hoped that a move to workplace assessors for manual handling will improve the situation, although this project may take longer to achieve results.

IMPACT ASSESSMENT

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

QUALITY:

	No impact	Negative	Positive	Both	
Safe				x	Good H&S is critical to the safe day to day running of the health board and helps to a safety culture for patients, staff and visitors.
Timely				x	
Effective				x	
Efficient				x	
Equitable				x	
Person Centred				x	
Workforce				x	
Leadership				x	
Culture				x	
Information				x	
Learn, Improve, Research				x	
Whole Systems Approach				x	

EQUALITY:

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

RISK ASSESSMENT:

	Level of risk identified				
	Very Low (0-3)	Low (4-8)	Moderate (9-12)	High (15-25)	
Clinical			x		A lack of H&S compliance within the health board presents a significant risk, through un-safe situations and circumstances leading to the injury to employees, visitors, patients and contractors. This in turn has a significant potential to lead to regulatory intervention by the Health and Safety Executive (HSE). This could have a significant impact, both in sanctions and fines for failing to comply with criminal law along with reputationally. There will also potentially be further financial impact where civil claims are made for injury/damage along with lost time.
Financial			x		
Corporate			x		
Operational			x		
Reputational			x		

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Agenda item: 3.6

BOARD		Meeting date: 21 MAY 2025	
Subject:	Welsh Language Standards Annual Monitoring Report		
Approved and presented by:	Debra Wood-Lawson, Executive Director of People and Culture		
Prepared by:	Vicky Malcomson, Head of People: Business Partnering & EDI		
Other Committees and meetings considered at:	Executive Committee – 14 May 2025		
PURPOSE:			
The purpose of the report is to request approval for publication of the Welsh language standards annual monitoring report.			
RECOMMENDATION(S):			
The Board is asked to APPROVE the Welsh Language Standards Annual Monitoring Report. Subject to approval, the report will be made available in both Welsh and English and made available to the public by publishing on the Health Health’s website.			
Approve/Take Assurance		Discuss	Note
Y		N	N

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:		
1. Focus on Wellbeing	Y	NHS Wales organisations have specific annual reporting requirements concerning the Welsh language, which are set out by the Welsh Language (Wales) Measure 2011 and the Welsh Language Standards issued by the Welsh Language Commissioner.
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:

In line with the requirements of the Welsh Language Standards, all health boards must produce an annual report that demonstrates how the organisation has complied with applicable standards during the reporting year. Appendix 1 contains the draft report for Powys Teaching Health Board, covering April 2024 to March 2025. In line with reporting requirements, the report outlines:

- A summary of how **each standard has been met** and any challenges in meeting the standards: Outlined in part 2 of the report
- Details of **training provided to staff and promotion** of the Welsh language: Included throughout part 1 of the report.
- Number and nature of **complaints received** regarding non-compliance: During 2024-25 no formal complaints have been received by the health board (see part 2 of the report). However, the health board was issued a compliance notice (Ref: CS1124) in March 2023 by the Welsh Commissioners officer in relation to its compliance with Welsh language telephone standards. In response, various actions, including staff training, were undertaken during 2023-24 and 2024-25 to improve compliance. However, delays in telephony system upgrades, intended to allow callers to choose their preferred language, meant the new system could not be implemented as planned in 2024-25. The upgrades are now expected to be completed in early 2025-26.
- Information on staff **Welsh language skills**: Outlined in part 1 of the report.

The report also outlines the steps taken by the health board to implement the Welsh Language Standards throughout 2024-25. This includes improvements made in the following key areas:

- Introduction of a new vacancy assessment service and a review of the way we advertise vacancies in Welsh.
- Continued rollout of Welsh for Managers training.
- Promotion of training opportunities.
- Improvements to processes around the uploading of documents to the website.
- Increased translation activity

Overall, the health board continues to work to ensure compliance with the Standards, an update against each of the standards is embedded within the report (part 2). The health board performs particularly well in areas such as communications and social media, and in areas where systems are managed centrally (e.g. recruitment processes such as offering contracts, assessing prospective applicants' Welsh language skills and inviting them to apply in Welsh / use the Welsh language at interview).

Our Welsh in Healthcare Strategy sets out our priorities and targets over the coming five-year period in terms of improving the Welsh language skills of our workforce, which in turn will improve our ability to comply with the standards.

The 'Proposed Actions during 2025-26' captured in part 2 of the report suggests further avenues of work during the next financial year. These include:

- Ensure that the delayed telephony system is established as soon as possible and that the relevant teams have the appropriate level of Welsh language skills to enable compliance with standards 8, 9 and 10.
- Explore the use of AI tools to increase internal Translation capacity to improve compliance with standards 82 and 107.
- Continue to promote the use of the Welsh Language Vacancy Skills Assessment including escalation where necessary to ensure roles are being appropriately assessed as per standard 106.
- In line with guidance published by the Welsh Language Commissioner, develop appropriate policy approaches to standards 24 and 78.

NEXT STEPS:

Subject to approval, the report will be made available in both Welsh and English and made available to the public.

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Welsh Language Standards Annual Monitoring Report 2024-2025

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Foreword

I am proud to present Powys Teaching Health Board's Welsh Language Standards Annual Report, which reflects our ongoing commitment to promoting and embedding the Welsh language in our services.

One of the standout achievements this year has been the remarkable surge in staff engagement with Welsh language training. We have seen a record number of colleagues completing courses, demonstrating a growing enthusiasm and dedication to enhancing our bilingual capabilities. This surge not only highlights the increasing importance placed on Welsh language skills within our workforce but also supports our wider goal of offering high-quality bilingual services to the people of Powys.

I am deeply encouraged by this progress and would like to thank all of our staff for their dedication to learning and embracing the Welsh language. We remain committed to fostering a bilingual environment and look forward to further advancing our Welsh language initiatives in the coming year.

Hayley Thomas

Chief Executive Officer

We are pleased to present the Welsh Language Standards Annual Report for Powys Teaching Health Board, outlining our progress and commitment to promoting the Welsh language in our services and workplace. Over the past year, we have taken meaningful steps to strengthen our bilingual capabilities, ensuring that the Welsh language is treated no less favourably than English in all aspects of our operations.

A key development during this reporting period has been the refinement of the Welsh language requirements within our job advertisements. We have updated the wording to provide clearer, more consistent messaging about the importance of Welsh language skills in different roles, helping applicants better understand expectations and supporting our goal of growing a bilingual workforce.

To support this further, we introduced a new Vacancy Assessment App. This tool allows recruiting managers to assess the linguistic needs of each post more effectively, ensuring that decisions about Welsh language requirements are appropriate, evidence-based, and aligned with the Standards. The app has improved the consistency and transparency of our recruitment processes and has been positively received across the organisation.

Training and development have also been a strong focus this year. We are proud to report a record number of staff completing Welsh language training courses. This surge in engagement highlights the growing interest among our workforce in

learning and using Welsh, as well as the success of our efforts to promote and facilitate training opportunities.

Together, these achievements reflect our continued commitment to embedding the Welsh Language Standards across Powys Teaching Health Board. We are building on this foundation to further enhance our bilingual services and support the Welsh Government's vision of a million Welsh speakers by 2050.

Debra Wood-Lawson

Executive Director for People and Culture

Executive Lead for Welsh Language and Equality.

Executive Summary

This report outlines the steps taken by Powys Teaching Health Board (PTHB) to implement the Welsh Language Standards.

It provides details on the progress made throughout 2024-2025. This includes improvements made in the following key areas:

- Introduction of a new vacancy assessment service.
- Continued rollout of Welsh for Managers training.
- Promotion of training opportunities.
- Improvements to processes around the uploading of documents to the website.
- Review of the way we advertise vacancies in Welsh.

Overall, the health board continues to work to ensure compliance with the Standards. Systems are in place to ensure most of the standards are met in most circumstances. The health board performs particularly well in areas such as communications and social media, and in areas where systems are managed centrally (e.g. recruitment processes such as offering contracts, assessing prospective applicants' Welsh language skills and inviting them to apply in Welsh / use the Welsh language at interview).

Further information on the above alongside a detailed account of the health board's compliance against each of the Standards can be found in Part 2 of this report.

Background

PTHB along with other Health Boards and Trusts in Wales must comply with a set of Standards as outlined in [The Welsh Language Standards \(No. 7\) Regulations 2018](#).

Although it is the Welsh Ministers who specify the standards, it is for the Commissioner to determine which standards apply to a specific body. In November 2018, the Commissioner issued a compliance notice to PTHB which outlined the standards with which it must comply and the date by when it must be compliant. A copy of PTHB's compliance notice can be found [here](#).

Included in these Standards is the requirement for PTHB to monitor the implementation of the Standards and produce an Annual Report (this document) which provides details of how the health board has complied with the Standards.

All staff must take responsibility for implementing the Standards across PTHB. Service Leads will monitor compliance within their own service areas and will report progress to the Service Improvement Manager for Welsh Language who will provide advice and support around the implementation of the Standards accordingly. At the end of each financial year, the Service Improvement Manager for Welsh Language will draft an annual report which will be presented to the Executive Lead for Welsh Language and approved by the Executive Committee and the Board before being published on the health board's website.

The *More than Just Words* framework for the Welsh Language in Health and Social Care sits alongside the Standards and outlines how the health and social care sectors in Wales will improve their ability to provide their services in Welsh, organised around the principle of the Active Offer – the idea that it is service providers' responsibility to offer service users the opportunity to use Welsh without being asked.

Part 1: 2024-25 in Review

Overview

2024-25 has been the first year since the introduction of our new Welsh in Healthcare Strategy and efforts this year have been directed at processes intended to increase the level of Welsh language skills within our workforce.

Welsh Language Vacancy Assessment Tool

During 2023-24, the health board developed and introduced PTHB Welsh Language Vacancy Assessment tool. This enables the user to carry out an assessment of the appropriate level of Welsh language skills to assign to a new vacancy, facilitating compliance with Standards 106 and 117. Previous systems used to assess vacancies have been trust-based and did not record outcomes; this system now allows managers to be held accountable for their decision. Designed locally, similar systems based on PTHB's model have been introduced in other NHS Wales organisations.



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Vacancy Welsh Language Requirement Assesment

This tool allows you to assess the Welsh language requirements of a vacancy.

It will help you decide whether Welsh language skills need to be an Essential or Desirable criteria for a vacancy, and if so what level is required.

You must carry out this assessment before your vacancy will be approved by the Workforce team.

Begin

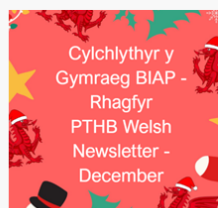
Internal Communications

The Health Board continues to run internal communications campaigns to promote understanding of the Standards and the More than Just Words framework as well as promoting opportunities for training around Welsh and encouraging staff to take part in events like Dydd Miwsig Cymru the Welsh Language Commissioner's the #DefnyddiaDyGymraeg campaign to promote the use of Welsh internally.



#DefnyddiaDyGymraeg

O nawr hyd at yr 11eg o Ragfyr bydd ymgyrch Comisiynydd y Gymraeg '#DefnyddiaDyGymraeg' yn rhedeg sy'n annog pobl i ddefnyddio'u Cymraeg ym mhob rhan o'u bywydau ac yn annog sefydliadau i hyrwyddo eu gwasanaethau Cymraeg. Bydd amryw o sesiynau ar-le...



Cylchlythyr y Gymraeg / Welsh Newsletter

Cliciwch yma i weld ein cylchlythyr ar gyfer mis Rhagfyr! Click here to see our December newsletter!

Changes to Wording around Welsh in Job Advertisements and Descriptions

Drawing on anecdotal accounts from some staff who had joined the organisation from outside Wales who indicated that standard wordings used in Job Advertisements were unclear and potentially discouraged applications, we have changed the wordings used across PTHB to make it clear that Welsh skills are an

essential minimum criterion for certain roles whilst also highlighting local learning opportunities for other staff. The new wording for Welsh Desirable roles (which represent the majority of advertised vacancies at PTHB) continues to make it clear that Welsh skills are valued, whilst reframing Welsh as a positive reason to apply for a role in Powys - because PTHB will offer training and language-learning opportunities to those interested in development – rather than a reason not to apply for those who are currently without skills.

Powys Teaching Health Board Presence at Eisteddfodau



It was exciting to see Powys hosting the 2024 Urdd Eisteddfod in Meifod, and PTHB, in partnership with Powys Council, had a presence on the Maes throughout the week, promoting careers in healthcare as well as some of our public health campaigning in Welsh. PTHB staff also attended the NHS Wales stands at the 2024 National Eisteddfod in Pontypridd.

Welsh in Healthcare for Managers Training

This training module was introduced during 2023-24 as a part of the Powys Teaching Health Board Managers’ Training Program. A total of 24 staff with leadership responsibility attended four sessions over the course of the year.

The course covers such subjects as:

Model good behavior

- Use whatever Welsh skills you have
- Begin / end meetings with Welsh greetings
- Be proactive in allowing staff to use their Welsh
- Promote internal processes in Welsh
- Do you know who the Welsh speakers are on your team?
- Consider setting personal and team objectives around Welsh and the Active Offer.

Do you have any good internal processes you'd like to share?



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- The moral and cultural reasons why providing services in Welsh is a necessary part of good clinical practice, touching on subjects such as Cultural Anxiety, as well as outlining the legislative and strategic requirements.
- How to appropriately consider the Welsh language in recruitment.
- How to access translation and interpretation services and why you need them.

The Welsh in Healthcare for managers training module is a cornerstone of our strategy for compliance with the Standards and *More than Just Words*, helping to ensure the standards become 'business as usual' across the health board.

Recruitment: Applications & Interviews

Examples of interview questions to ask:

- How would you respond if you received a telephone call from someone speaking in Welsh?
- How do you think our department can support compliance with the Welsh language Standards / patients who wish to use Welsh?

Do any of you have any questions regarding recruitment?




Investigation into Compliance with Standards 8-10

The health board received notification of an investigation by the Commissioner (Ref: CS1124) on 28th March 2023 into these standards relating to answering telephone calls in Welsh. During 2023-24 and 2024-25 various actions were carried out to improve compliance including training sessions for call handling staff. These actions were all originally scheduled to be completed during 2024-25, unfortunately a delay to the installation of new telephony upgrades (allowing incoming callers to choose their language when contacting the health board), it was not possible to introduce the new system during 2024-25 as originally intended. It is now anticipated that these upgrades will be completed during the first months of 2025-26.

Investigation into Compliance with Standards 39 and 41

The health board received notification of the Commissioner's investigation (Ref: CS1205) on 23rd October 2023 into the compliance of the health board with these two standards, which relate to the Website. Internal investigations by the PTHB Communications team found that instances of non-compliance largely related to a small number of individual teams consistently uploading content. A new process was developed and introduced and compliance has improved significantly; the Commissioner's investigation was thus closed.

Welsh Language Service Leads Steering Group

This group has continued to meet during the year, providing an opportunity for staff to discuss and share issues relating to compliance with the standards as well as consulting on strategies and developments. The group provides an opportunity for staff to share updates or best practice and to feedback on developments such as the vacancy assessment app.

Welsh Language Awareness Training

The Welsh Language Awareness ESR module has been a mandatory online training session for all staff; it has been now been completed by **94.7%** of staff, an increase of 4.7% from last year.

Welsh Translation Service

A total of 597,111 words were translated internally during 2024-25, an increase of 25.4% on 2023-24. Internal analyses have shown demonstrable financial savings since the introduction of this service in 2021, with an additional benefit from the use of Translation Memory software. The use of this software likely explains the significant year-on-year gains: as the content stored in the translation memory grows, the system becomes increasingly powerful. However, the main benefits have been related to efficiency and effectiveness, eg.

- Improved experience from the point of view of staff, with greater input on the finished product and the ability to consult with the translator in real time.
- Greatly improved turnaround times.
- Improved consistency of terminology.

Strategy for Welsh in Healthcare

Published in 2023-24, our Strategy for Welsh in Healthcare 2024-2029 incorporates the requirement to develop a Five-Year Plan to increase our ability to provide Clinical Consultations in Welsh in accordance with Welsh Language Standard 110 as well as the Workforce Strategy required by *More than Just Words*, and provide overall direction and targets for the development of our bilingual workforce. The document is available on the PTHB website and sets out how we plan to develop our Welsh language capacity as an organisation over the next five years.



Strategy for Welsh in Healthcare 2024-2029

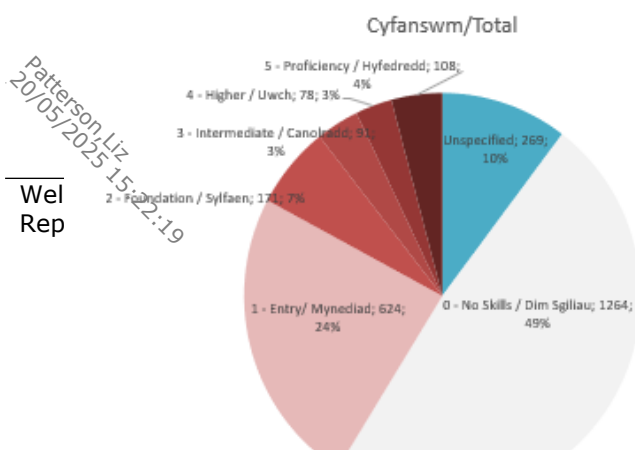
Incorporating:

- 1) A **five year** plan to increase the health board's ability to carry out a clinical consultation in Welsh (Welsh Language Standard 110);
- 2) a targeted Welsh language training and workforce strategy under the *More than Just Words* Framework.

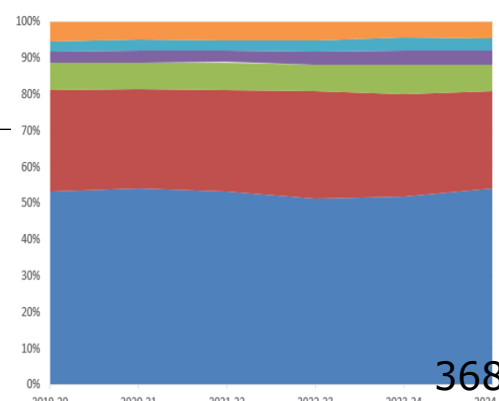
Mae'r ddogfen hon ar gael yn y Gymraeg.

Welsh Language Skill Levels at PTHB

As of 31st March 2025, the 2,605 staff at PTHB staff indicated that their ability to speak Welsh was as follows:



e 9 of 32



(Unknown not shown in above graph)

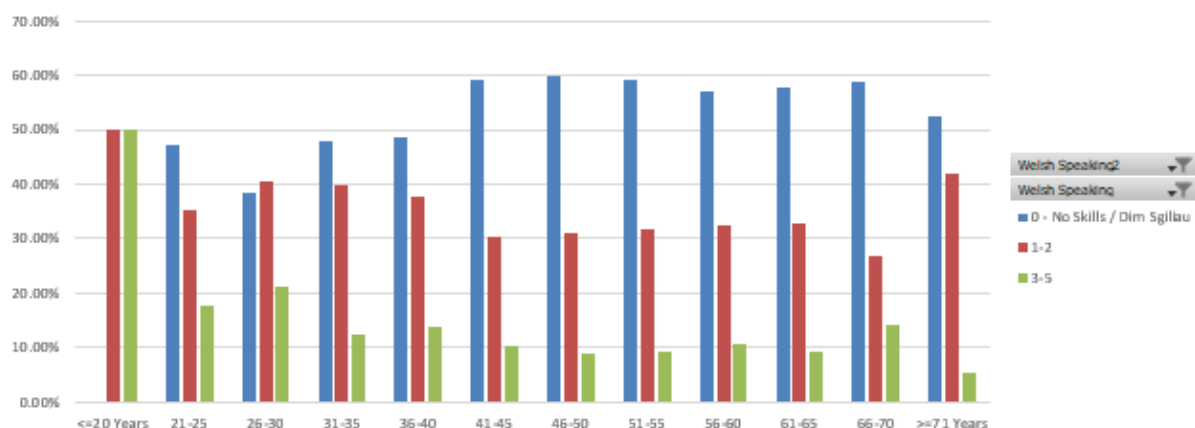
Welsh Language Skills by Year (Proportion and Numbers)

Year	Unknown	Level 0	Level 1	Level 2	Level 3	Level 4	Level 5	TOTAL
2022-23	317	1,140	654	161	79	69	115	2,535
2023-24	306	1,148	625	178	91	77	97	2,522
2024-25	269	1,265	624	171	91	78	108	2,605

The number of staff in each group has remained broadly similar in previous years. Whilst the proportion and absolute number of staff with advanced Welsh skills (levels 3+) has increased to its highest yet recorded, this is offset by a slight fall in lower levels (1&2) and growth in the staff body overall, meaning the percentage with any level of Welsh language skills has slightly reduced.

Welsh Language Skills by Age (Unknowns Removed)

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As in previous years, breaking down Welsh language skills by age shows higher levels of Welsh language skills generally amongst younger employees. Staff with no skills at all are in the minority in all age groups below 40 and in the majority in all groups above 40.

This data has been broken down by base (for the 9 main PTHB hospital sites) and is provided within appendix 1 (note that not all PTHB staff are shown in the following graphs as some are based in other locations). The distribution of Welsh skills amongst PTHB staff is uneven, with two sites (Ystradgynlais and Bro Dyfi (Machynlleth) hospitals) showing significantly higher levels of staff skills than other sites. This is in line the 2021 census which showed that the proportion locally varies from as low as 7% in Knighton and Presteigne to as high as 33% in Ystradgynlais and 48% in Machynlleth.

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Part 2: Compliance with the Welsh Language Standards

In addition to the examples provided above, the following provide details of steps PTHB has taken to ensure or improve compliance with the Welsh Language Standards during 2024-25:

Service Delivery Standards

Standards	Situation as of 2024-25	Proposed Actions during 2025-26
Standards 1-7 relating to correspondence sent by the health board	As per the standards and our internal PTHB policy, we have continued to proactively ensure standard correspondence is sent out bilingually as a matter of course. Regarding non-standard correspondence, the requirement to deal with this locally on a case-by-case basis is promoted via induction, language awareness courses and internal departmental action plans. A considerable quantity of communication with the health board takes place over social media, which is managed by the communications team who have a Welsh speaker in post able to ensure that any correspondence received using that platform can be addressed in Welsh without recourse to translation.	Continue to ensure that correspondence is proactively translated as required, and to promote compliance with these standards via induction, language awareness courses and internal departmental action plans. Steps to increase Welsh language skills via the vacancy assessment app and training prioritisation should improve the health board's ability to quickly respond to Welsh correspondence.
Standards 8 – 20 relating to telephone	During 2023-24 PTHB received notification of an investigation into a failure to comply with standards 8, 9,	Ensure the new system is put in place and operational as soon as

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calls made and received by the health board	and 10. The investigation was carried out and found a lack of compliance; and PTHB was tasked with developing and carrying out an action plan to ensure compliance in the future. The majority of the action associated with this investigation were carried out during 2023-24 and the original intention was that this would be completed during 2024-25. The outstanding action involved the of procurement of a replacement for the health board's decades-old telephony system. Unfortunately work on this was delayed; it is now expected to be completed during the early months of 2025-26.	possible during 2025-26, and that Patient Services teams have the appropriate level of skills in place to ensure compliance.
Standards 20-22CH relating to meetings that are not open to the public	This requirement is promoted on an ongoing basis and individual teams have implemented processes as per their individual requirements. The Manager's Resource and Guidance document includes information on holding meetings with members of the public. Where Welsh speaking staff are not available to attend meetings, staff have access to interpretation services who can assist, and details of the approved interpretation services are available to staff on the intranet and have been promoted to staff. The new Welsh in Healthcare for Managers training session covers the requirements of these standards and ensures managers are aware of the need to proactively offer persons invited to meetings the opportunity to use the Welsh language.	Continue to monitor compliance levels and feedback.

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Standards 23-25 relating to in-patients and case conferences	In-patient language choice can be recorded via several channels across PTHB. Our WPAS and WCCIS electronic systems both have capacity to record patient language choice. Many of our service user referral forms also asks patients for their preferred language choice, and case conferences are routinely carried out with the assistance of interpretation.	Ensure any new systems are developed in line with these requirements, including any national systems to which PTHB contributes. PTHB will develop a policy approach to comply with Standard 24.
Standards 26-32 relating to meetings and events that are open to the public	The requirement to ask the public if they would like to use Welsh at our meetings is outlined in guidance documentation on holding meetings and events. Uptake of this offer is rare, e.g. Participants at the AGM of the board were invited to use Welsh in questions, and all information provided was in Welsh; however, no questions in Welsh were received. The 'Welsh Language – Communication and Marketing' procedural guidelines which includes information on how to comply with the Standards when arranging meetings which are open to the public continues to be promoted to managers and staff within their teams; the new Welsh in Healthcare for Managers training session covers the requirements of these standards and ensures managers are aware of the need to proactively offer persons invited to meetings the opportunity to use the Welsh language.	Continue to monitor compliance levels and feedback.
Standards 33-38 relating to publicity and advertising, displaying material in public,	Periodic site visits have been carried out of the 9 main hospital sites, assessing compliance with a range of standards including those related to signage, information displays and documents or leaflets.	Continue to visit sites to assess compliance and escalate issues.

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producing and publishing document and forms.

(Standards 47-49 relating to signage; also, Standards 111 – 113 relating to signage)

Fixed signage has been bilingual as a matter of course long before the introduction of the Welsh Language Standards, and no examples of non-compliance were found with regards fixed signage.

Large quantities of documents, signage and public information is routinely published in Welsh and/or bilingually within the health board. The images in this section show some of the materials published during 2024-25.



Patterson Liz
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Mural in Physiotherapy dept., Brecon Hospital

Temporary signage and information displays remain somewhat inconsistent and prominence has been given to these standards in the Welsh in Healthcare for Managers training. We have seen an improvement since 2023-24 with

a greater proportion of signage now displayed bilingually.



It should be noted that a significant proportion of information posters on display in PTHB sites come from sources which do not have Welsh language standards and provide information in English only; for example, UK charities such as The Alzheimer's Society, or small local voluntary or charity groups. In line with the Code of Practice for the Welsh Language Standards (No. 7) published by the Welsh Language Commissioner, displaying this information does not

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	consist of a breach of the standards, where PTHB (or another organisation which has received a Welsh Language Standards Compliance Notice) did not produce the information in the first place.	
Standards 39-46 relating to the health board's website, apps and social media	Following the introduction of a new system during 2023-24 compliance has improved and to the best of our current knowledge, the PTHB website and main social media channels are operated in full compliance with the standards.	Continue to ensure compliance remains high.
Standards 47-49 relating to signage	<i>See Standards 33-38 above.</i>	<i>See Standards 33-38 above.</i>
Standards 50-53 relating to receiving visitors	A sign has been provided to each reception area in the health board (where there was not already a sign present), inviting visitors to use the Welsh language (Standard 52); badges/lanyards were also widely also distributed to Welsh speaking staff (Standard 53). During 2024-25, all Welsh speaking staff at PTHB were directly contacted via email and offered a <i>Iaith Gwaith</i> or <i>Dysgwr</i> (learner) lanyard. 77 individual lanyards have been distributed, and the ability to have the logo embroidered into a uniform has also been widely advertised.	Once the new telephony system is installed and functioning it will be possible to offer a telephone reception service (as per the Welsh Language Commissioner's code of practice) at all reception areas.
Standards 54-59 relating to grants, tenders and procurement	PTHB remains compliant with these standards as per NHS Wales standard procurement and practice.	Continue to ensure compliance.

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Standards 60-62 relating to the organisation's corporate image	PTHB's corporate identity is wholly bilingual, with the Welsh appearing above the English in our logo.	Continue to ensure compliance.
Standard 63 relating to education courses offered by the health board	Managers are informed of this standard as part of the Welsh in Healthcare for Managers training program.	Continue to ensure compliance.
Standard 64 relating to public address systems	As of 31 st March 2025, there are currently no public address systems in operation within PTHB.	N/A
Standards 65-68 relating to primary care	As per Standard 65, a dedicated area of the website exists to provide the public with information on primary care services able to offer some or all services in Welsh. The "Iaith Gwaith" logo enables providers to identify that they are able to offer services in Welsh:	Ensure this section of the website remains current by annually prompting providers to review the information to ensure it is kept up to date.

List of GP Practices in Powys

Use the table below to find all GP Practices in Powys. Click on a practice to find more details.

Find your local NHS service

Show entries Search:

[Previous](#) [1](#) [2](#) [3](#) [Next](#)

Code	Name	Address	Town	Postcode	Telephone	Fax
W96001	Montgomery Medical Practice	Well Street, Montgomery	Powys	SY15 6PF	01686 668217	
W96001a	Ladywell Surgery	St Davids House, New Road	Newtown	SY16 1RB	01686 623791	01686 629215
W96002	Pengorof Surgery	Gorof Road, Ystradgynlais	Powys	SA9 1DS	01639 843221, 01639 843221	01639 846920, 01639 846920
W96002a	Abercrave Surgery	Heol Tawe, Abercrave	Swansea	SA9 1TJ		
W96002b	Ystalyfera Surgery (Swansea)	Wern Road, Ystalyfera	Swansea	SA9 2LX		
W96003	Ty Henry Vaughan	Bridge Street, Brecon	Powys	LD3 8AH	01874 622121	01874 623742
W96003a	Sennybridge Health Centre	Defynnog Road, Sennybridge	Brecon	LD3 8RU	01874 636559	
W96004	Wylcwm Street Surgery	Wylcwm Street, Knighton	Powys	LD7 1AD	01547 528523	01547 529347

The PTHB in-house translation service continues to be offered to primary care providers as per Standard 66 along with the opportunity to order badges / lanyards with the 'Iaith Gwaith' logo free of charge.

Policy Making Standards

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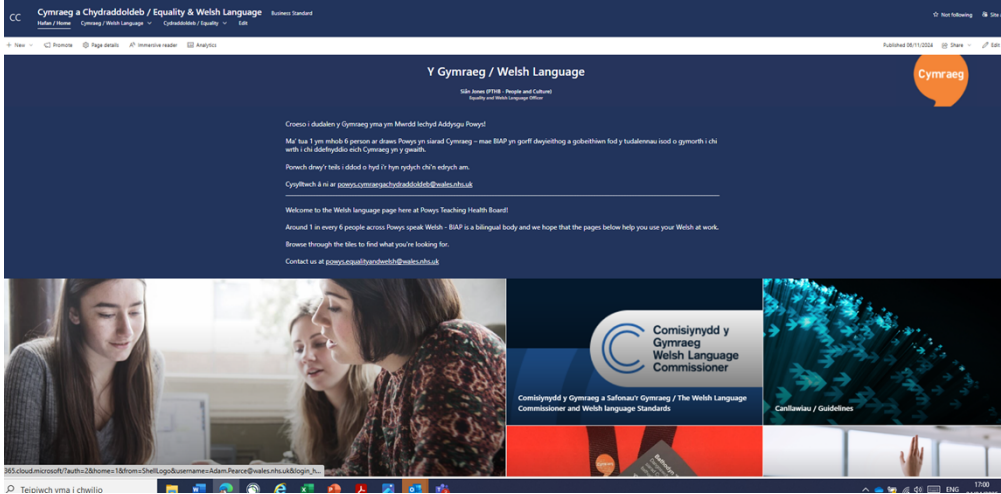
Standards 69 – 78A relating to policy making decisions	A planned review of the Health Board’s EIA process was removed from our plans due to the expectation that an All-Wales EIA process may be introduced, which would incorporate these standards.  http://pthb.nhs.wales What do I need to consider? (5/6) Welsh Language The Policy or Project must should not have negative effects and ideally will have positive effects on 1) Opportunities to use the Welsh Language 2) Treating the Welsh Language less favourably than English <i>Questions to ask:</i> What provision have you made for Welsh? Will Welsh versions be distributed with English materials? Will it be easier for people to receive services in Welsh? If the service is new, how will you offer it in Welsh? 11 Equality Impact Assessment Training Nevertheless, the health board’s existing EIA procedure remains in place and has led to changes to projects/policies including, within our <i>Speaking Up Safely</i> framework, making the right to make raise internal concerns in Welsh explicit and making the page in question available in Welsh.	PTHB will participate in any All-Wales EIA project and ensure that the requirements of the standards are incorporated into any such work. Continue to record positive changes made to improve Welsh language access and provision of services. PTHB will develop a policy approach to Standard 78 on Primary Care decisions.

Operational Standards

Standard 79 relating to a policy on the internal use of the Welsh language	Powys Teaching Health Board’s Welsh Language in the Workplace policy meets the requirements of this standard. It is promoted via induction and the Welsh in Healthcare for Managers training session.  WELSH LANGUAGE IN THE WORKPLACE POLICY <table><tr><td>Document Reference No:</td><td colspan="2">PTHB /HR 109</td></tr><tr><td>Version No:</td><td colspan="2">1</td></tr><tr><td>Issue Date:</td><td colspan="2">July 2023</td></tr><tr><td>Review Date:</td><td colspan="2">July 2026</td></tr><tr><td>Author:</td><td colspan="2">Service Improvement Manager for Equality and Welsh Language</td></tr><tr><td>Document Owner:</td><td colspan="2">Service Improvement Manager for Equality and Welsh Language</td></tr><tr><td>Accountable Executive:</td><td colspan="2">Director of Workforce and Organisational Development</td></tr><tr><td>Approved By:</td><td colspan="2">Executive Committee</td></tr><tr><td>Approval Date:</td><td colspan="2">12 July 2023</td></tr><tr><td>Document Type:</td><td>Policy</td><td>Non-clinical</td></tr><tr><td>Scope:</td><td colspan="2">PTHB-wide</td></tr></table> The latest approved version of this document is online. If the review date has passed please contact the Author for advice. Powys Teaching Health Board is the operational name of Powys Teaching Local Health Board Bwrdd Iechyd Addysgu Powys yw enw gweithredol Bwrdd Iechyd Lleol Addysgu Powys	Document Reference No:	PTHB /HR 109		Version No:	1		Issue Date:	July 2023		Review Date:	July 2026		Author:	Service Improvement Manager for Equality and Welsh Language		Document Owner:	Service Improvement Manager for Equality and Welsh Language		Accountable Executive:	Director of Workforce and Organisational Development		Approved By:	Executive Committee		Approval Date:	12 July 2023		Document Type:	Policy	Non-clinical	Scope:	PTHB-wide		Continue to promote the Welsh in the Workplace Policy.
Document Reference No:	PTHB /HR 109																																		
Version No:	1																																		
Issue Date:	July 2023																																		
Review Date:	July 2026																																		
Author:	Service Improvement Manager for Equality and Welsh Language																																		
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Approved By:	Executive Committee																																		
Approval Date:	12 July 2023																																		
Document Type:	Policy	Non-clinical																																	
Scope:	PTHB-wide																																		
Standards 80 – 81 relating to employment documents	Contracts (Standard 80) are standardised and automatically provided bilingually through the TRAC system. Other Employment documents have been made available in Welsh on the Health Board intranet; awareness of these is promoted via																																		

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	induction and the Welsh in Healthcare for managers training session.	
Standard 82 - relating to operational policies	A process has been put in place to ensure policies relevant to this standard are made available in Welsh, and where changes are made, these are flagged. Most of the policies covered by Standard 82 are published bilingually already due to being All-Wales policies. Any local policies will be translated in line with the existing review processes and will be ongoing throughout 2024-25.	Explore the potential of AI to increase translation capacity to reduce the translation backlog.
Standards 83-88 - relating to disciplinary, grievance and other internal processes.	All these requirements continue to be met via the existing relevant all-Wales and PTHB policies; awareness of these is promoted via induction and the Welsh in Healthcare for managers training session.	Continue to ensure all policies reflect these requirements.
Standard 89 relating to bilingual computer software interfaces	Cysgliad and Welsh interfaces for Windows, Office and ESR remain available to staff. Details on accessing these are available on the health board staff intranet, and awareness of these is promoted via induction and the Welsh in Healthcare for managers training session.	Continue to promote these via staff induction and training/awareness sessions.

Standards 90 – 95 relating to the intranet	Our intranet has been designed from the start to be wholly compliant with the Standards related to the intranet (to the extent that the architecture allows). The Welsh versions of intranet pages (where they exist) can be accessed by clicking 'Welsh' on the languages tab:  As well as the pages relating to the use of Welsh at work (see above), the homepage of the intranet is available in Welsh as are pages relating to OD and clinical education (Training) and all other sites as specified by the Standard 81.	Continue to monitor the intranet to ensure compliance continues as the intranet grows.
Standards 96 – 101 relating to staff Welsh language skills and training	See the section above for staff skills reporting responsibilities. PTHB have continued to promote and, where appropriate, financially support learning of Welsh in line with the standards.	Continue to promote existing and new training options to staff across PTHB to maintain this level of engagement.

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	PTHB maintains a strong working partnership with Dysgu Cymraeg and Coleg Cambria to provide Welsh learning opportunities to staff. During 2024-25: - a total of 17 individuals from the health board took part in the <i>Codi Hyder</i> Confidence Raising scheme. - 12 individuals took part in the <i>Cwrs Croeso</i> introductory learning scheme with Dysgu Cymraeg. - 4 completed online self-directed courses with Dysgu Cymraeg. - 1 individual attended a week's residential course. - 1 individual completed a <i>Gloywi Iaith</i> course. - 2 other individuals took part in Dysgu Cymraeg schemes with the health board's support. - 1 individual undertook a course of self-directed study through <i>Say Something in Welsh</i>. This combined total of 38 confirmed courses is a new high for PTHB.	
Standards 102-103 relating to Welsh language awareness training	The online More than Just Words: Welsh Language Awareness module was introduced in December 2022. As of March 2025, a total of 94.7% of all PTHB staff had undertaken this mandatory training module (an increase of 4.7% since 2023-24).	Continue to monitor and encourage completion of the mandatory training module.
Standards 104-105 relating to identifying Welsh speaking staff	Badges and lanyards to identify Welsh speaking staff and Welsh learners are available to all staff, which can also be embroidered into clinical staff uniforms. During 2024-25, all Welsh speaking staff at PTHB were directly contacted via email and offered a <i>Iaith Gwaith</i> or <i>Dysgwr</i> (learner) lanyard, with 77 distributed during the course of the financial year.	

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	This enables patients to readily identify Welsh speaking staff and increases their confidence in the health board's ability to provide services in Welsh. Bilingual email signature templates are available on the Welsh language resource intranet page and in the Managers Guidance and Resource document.	
Standards 106 – 109 relating to recruitment	During the later part of 2024-25 a new electronic assessment process was introduced to ensure that vacancies are appropriately assessed for their Welsh language requirements. Whilst this system has been useful in standardising the approach it has revealed that only a minority of managers are utilising it, with the number of roles assessed being quite small. The health board's policy is that all vacancies have the Welsh language requirement specified, and are advertised in Welsh as well as English as per Standards 106 and 106A; as a matter of course applicants to all vacancies are invited to apply in Welsh. 107A a-c are all provided in Welsh as a matter of standard practice. The health board does not currently translate all job descriptions (107A ch) due to financial and capacity constraints. During 2024-2025 PTHB advertised 849 vacancies: 8 posts were advertised with Welsh language skills as essential (an increase from 1 in 2023-24). 824 posts were advertised with Welsh language skills as desirable. 17 posts were advertised with Welsh language skills as not required.	Ensure greater uptake of the Welsh language skills assessment tool for vacancies during 2024-25. Continue to ensure Welsh essential vacancies on programs like apprenticeships and aspiring nursing programs are a fixture in 2025-26. Explore the potential of AI to increase translation capacity to potentially enable longstanding issues e.g. Job Descriptions to be addressed.

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	Examples of roles advertised with Welsh language skills as essential included - Complaints and Public Services Ombudsman for Wales Case Co-ordinator - Academy Skills Educator - Aspiring Nursing Program - Apprenticeships Program Whilst the total number of posts advertised as Welsh essential remains a very small fraction of the total (<1%) this represents a significant increase on previous years, with the range of teams represented also being higher.	
Standards 110-110A relating to a plan for bilingual clinical consultations	Our Strategy for Welsh in Healthcare 2024-2029 was designed to meet the requirements of this strategy. This comprehensive document incorporates the requirement to develop a Five-Year Plan to increase our ability to provide Clinical Consultations in Welsh in accordance with Welsh Language Standard 110 as well as the Workforce Strategy required by More than Just Words, and provide overall direction and targets for the development of our bilingual workforce. The document is available on the PTHB website and sets out how we plan to develop our Welsh language capacity as an organisation over the next five years.	Ensure the Welsh in Healthcare Strategy is embedded and promoted across the health board.
Standards 111 – 113 relating to signage	(See Standards 33-38 above).	(See Standards 33-38 above).
Standard 114 – relating to	This standard is not applicable to PTHB as there are not recorded workplace announcement systems in place on our sites.	N/A

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recorded workplace messages.		

Record Keeping and Supplementary Standards

Standard 115 - relating to complaints.	During 2024-2025 PTHB received no formal complaints in relation to the our compliance with the Welsh Language Standards. PTHB continues to follow the conditions set out in NHS Wales 'Putting Things Right' policy, which include information on dealing with complaints made in Welsh and relating to Welsh language provision. Copies of these documents can be found here. Two informal contacts were made concerning our compliance with the Welsh language standards. - One related to the provision of services on an interactive screen at a Primary Care setting within the Health Board in such a way that treated the Welsh language less favourably than English. Although as this was not a managed practice and the Standards therefore did not directly apply, the concern was able to be resolved and the issue addressed. - Another related to standards in relation to the advertising of roles and on our telephone lines, though no details were provided that would have enabled the health board to	N/A

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	investigate further. These standards are either the subject of ongoing compliance (see Standards 8-10 above) or a case where the health board has made a deliberate decision on its compliance position (see Standard 107 above).	
Standards 116-121 relating to Record keeping and supplementary matters.	For Standard 116, see 'current Welsh Language Skill levels at PTHB' above. For Standard 117, see under Standard 106.	N/A

Moving Forward: Priorities for 2025-26

Our new Strategy for Welsh in Healthcare sets out our priorities and targets over the coming five-year period in terms of improving the Welsh language skills of our workforce, which in turn will improve our ability to comply with the standards.

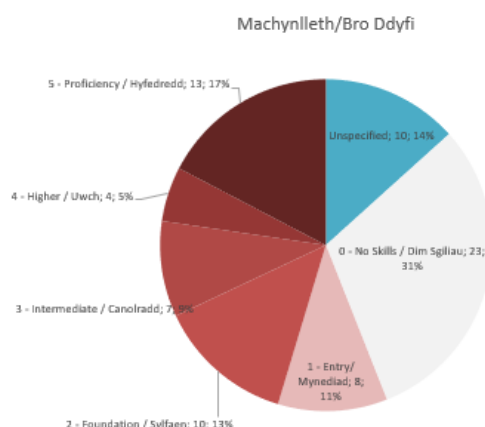
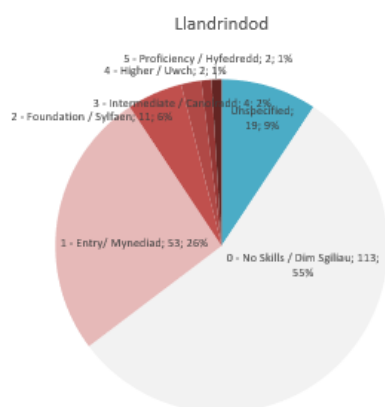
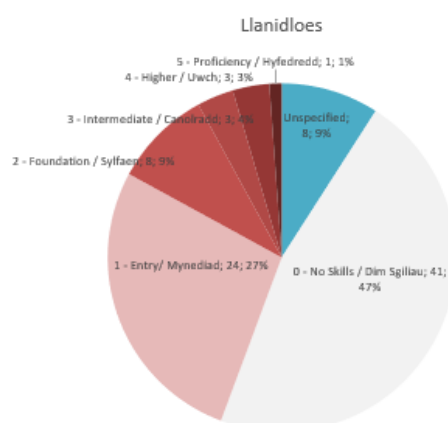
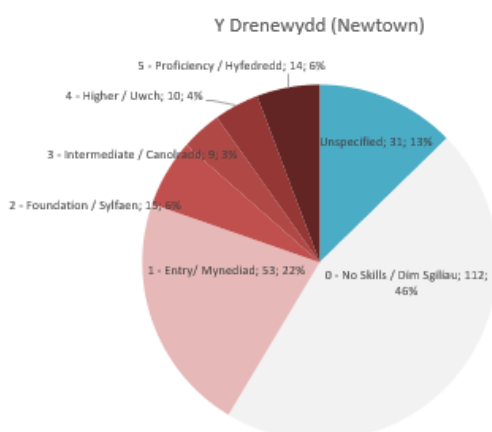
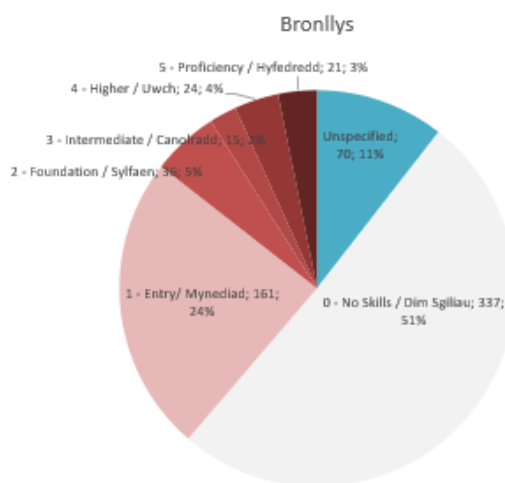
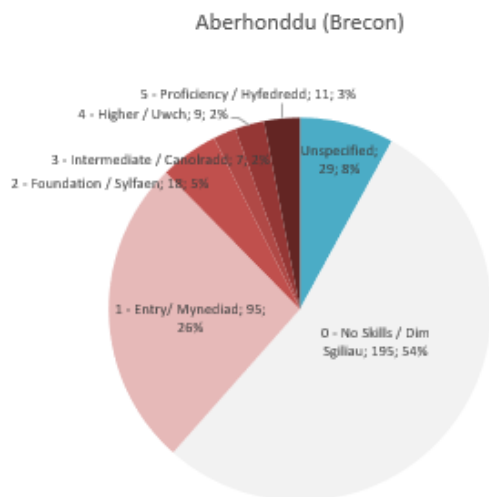
The 'Proposed Actions during 2025-26' column in the above section suggests further avenues of work during the next financial year. These include:

- Ensure that the delayed telephony system is established as soon as possible and that the relevant teams have the appropriate level of Welsh language skills to enable compliance with standards 8, 9 and 10.
- Explore the use of AI tools to increase internal Translation capacity to improve compliance with standards 82 and 107.
- Continue to promote the use of the Welsh Language Vacancy Skills Assessment including escalation where necessary to ensure roles are being appropriately assessed as per standard 106.
- In line with guidance published by the Welsh Language Commissioner, develop appropriate policy approaches to standards 24 and 78.

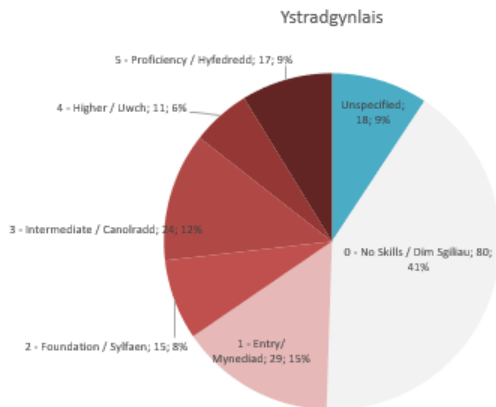
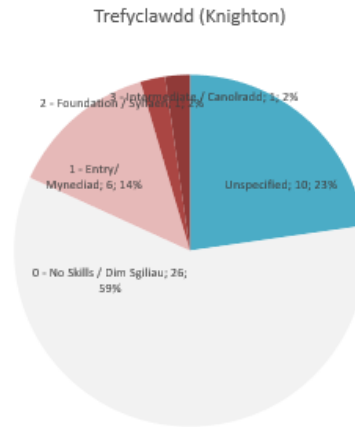
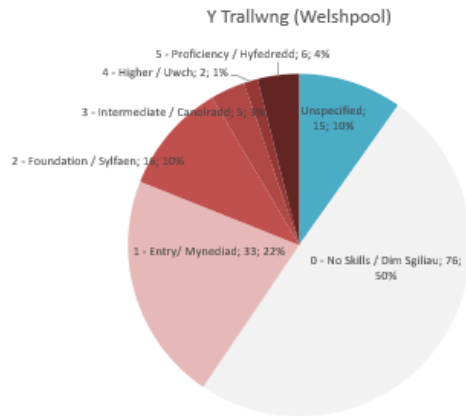
For further information on the details of this report and for further information on PTHB's implementation of the Welsh Language Standards, please contact the Equality and Welsh Language team by emailing powys.equalityandwelsh@wales.nhs.uk.

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Appendix 1: Welsh Language Skill Levels at PTHB by Base



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GIG
CYMRU
NHS
WALES

Bwrdd Iechyd
Addysgu Powys
Powys Teaching
Health Board

BOARD

UNCONFIRMED

MINUTES OF THE MEETING HELD ON 26 MARCH 2025 AT 09:30

HELD IN THE BOARD ROOM, GLASBURY HOUSE, BRONLLYS HOSPITAL

MEMBERS		
Carl Cooper	CC	Chair
Hayley Thomas	HT	Chief Executive Officer
Ronnie Alexander	RA	Independent Member (General)
Mererid Bowley	MB	Executive Director of Public Health
Steve Elliot	SE	Independent Member (Finance)
Mick Giannasi	MG	Independent Member (General)
Pete Hopgood	PH	Executive Director of Finance, Capital and Support Services / Deputy Chief Executive
Nicola Johnson	NJ	Executive Director of Planning, Performance and Commissioning
Rhobert Lewis	RL	Independent Member (General)
Elaine Lorton	EL	Executive Director of Primary Care, Community and Mental Health
Cathie Poynton	CP	Independent Member (Trade Union)
Claire Roche	CR	Executive Director of Nursing, Quality, Women and Family Health
Ian Thomas	IT	Independent Member (General)
Kirsty Williams	KWi	Independent Member Vice-Chair
Kate Wright	KW	Executive Medical Director
Simon Wright	SW	Independent Member (University)
IN ATTENDANCE		
Katie Blackburn	KB	Regional Director Llais
Helen Bushell	HB	Director of Corporate Governance / Board Secretary
Lucie Cornish	LC	Director of Improvement and Transformation
Nina Davies	ND	Associate Member (Director of Social Services, Powys County Council)
Hayley Hughes	HH	Corporate Business Manager (Minutes)
Mark McIntyre	MM	Deputy Director People and Culture
Liz Patterson	LP	Head of Corporate Governance (meeting support)
APOLOGIES FOR ABSENCE:		
Claire Madsen	CM	Executive Director of Allied Health Professions, Health Science and Digital
Debra Wood-Lawson	DWL	Executive Director of People and Culture
Jennifer Owen Adams	JOA	Independent Member (Third Sector)
Chris Walsh	CW	Independent Member (Local Authority)

1. PRELIMINARY MATTERS
1.1 WELCOME AND APOLOGIES FOR ABSENCE (PTHB/24/193)
The Chair (CC) welcomed everyone to the meeting. Apologies for absence were received as recorded above. The Chair explained that this was a meeting held in public rather than a public meeting and as such, only Board Members, Health Board officers and those playing a formal role in the meeting would be participating. The meeting was held in person and livestreamed. A recording will be uploaded after the meeting.
1.2 DECLARATIONS OF INTEREST (PTHB/24/194)
No interests were declared in addition to those already declared within the published register. It was acknowledged that the register of interests had been included within the agenda for reference.
1.3 BOARD ACTION LOG (PTHB/24/195)
The action log was presented, and the following were noted: - PTHB/24/167a; 167b; 167c: Anti-Racism Plan – These three actions are transferred to the Workforce and Culture Committee and will be reported back through to Board via the Committee Chair report. - PTHB/24/131: People’s Experience Framework – this had been considered at the Patient Experience, Quality and Safety Committee where timelines for the national framework were awaiting release. The target date was revised to May 2025. The Board REVIEWED and ACCEPTED the action log.
1.4 QUESTIONS TO THE BOARD FROM THE PUBLIC (PTHB/24/196)
CC advised that no questions from the public had been received.
1.5 UPDATES FROM: (PTHB/24/197)
REPORT FROM THE CHAIR CC presented the report and invited any questions. CC noted that RL had been appointed for a further 4-year term as an Independent Member. <i>Is it your view, as Chair, that Welsh Government (WG) understand and accept that the way the Health Board achieves the control target will have a considerable impact on the services that will be able to be delivered in the future?</i> CC advised that consistent and clear communication had been received from WG regarding the need to meet statutory duties. He emphasised that, while fulfilling these duties is critical, a balanced approach is required. WG has communicated that, as a minimum, the target control total must be achieved, which may necessitate making difficult decisions and it is essential the Board be prepared to make these decisions when needed. HT reiterated that the Health Board is in Level 4 escalation and correspondence with WG has consistently highlighted the requirement to meet the target control total. The Board must review the plan, considering available resources, commissioning, and provider responsibilities, while balancing quality, performance, and financial duties in making difficult decisions. REPORT FROM THE VICE CHAIR KWi presented the report outlining a recent visit to Ystradgynlais hospital working alongside the catering and domestic teams and highlighted the crucial work they

undertake in order to keep patients safe and the importance they play in the organisation.

In relation to the Power of Discharge Committee are you confident the improvements are being achieved, and in a reasonable, timely manner?

KWi noted that senior staff in the mental health services have recognised the issues, and some mitigations have been implemented to drive improvements using a consistent form based on a national framework. KWi has been liaising with ND at Powys County Council regarding the matter and this will be monitored at the Power of Discharge Committee, to ensure the form is used consistently.

REPORT FROM THE CHIEF EXECUTIVE

HT presented the report and drew attention to the following matters:

- Vaccination Programme Update: an important programme, protecting people, communities and workforce. Further work to be undertaken, both locally and national to address behavioural change in order to increase uptake.
- Charter for Families Bereaved by Public Tragedy: the Health Board has recently signed the Charter.
- 2024 NHS Wales Staff Survey: 30% of staff completed the 2024 staff survey. A more detailed assessment and action plan will be brought to the Workforce and Culture Committee and Board.

What are the barriers for staff responding to the staff survey and what is being done to improve the response rate?

MM advised that performance is improved compared to previous periods. However, feedback from staff side and wider colleagues indicates survey fatigue. More activity is planned to demonstrate the importance of the survey and ensure that managers are aware of performance and interest and are actively addressing concerns raised.

What are the implications of signing up to the 'Charter for Families Bereaved by Public Tragedy' for the Health Board? How will the challenges be addressed?

MB advised of the principles set out by the Charter. Plans will be tested, and the duty of candour will be rolled out as part of the response, with lessons learned from previous events; an emphasis on giving confidence to staff and raising the profile. HT agreed to bring back detailed assurance and information to the Planning, Partnerships and Population Health Committee.

Action: Executive Director Public Health

Against the vaccination target rate of 75%, 50.1% was achieved. Is there a progressive and persistent pattern of Did Not Attend (DNA) rates and does that mean vaccination staff are not usefully employed and/or vaccine wastage?

HT responded that discussion had taken place at the National Leadership Board, where strong concerns about not meeting vaccination targets were expressed. Key topics included learning from other areas, the need for behavioural change support and equity issues and further actions to increase uptake were discussed.

MB reported a steady decline in vaccine uptake both locally and across Wales, with around 50% uptake in the Autumn programme. Uptake decreases as age profile lowers, though it remains higher in the clinically vulnerable groups. MB provided

assurance around the booking process and factoring in the DNA rates across cohorts. The Health Board has increased the outreach programme to seven areas, alongside insight work by Public Health Wales to target communities with lower uptake. Vaccine wastage is being managed centrally through a co-ordinated process with NHS Executive, with daily and weekly stock monitoring. MB also advised that flu vaccines will also be moving to a centrally co-ordinated system.

The Board **RECEIVED** and **NOTED** the Reports of the Chair, Vice Chair and Chief Executive.

1.6 ASSURANCE REPORTS OF THE BOARD'S COMMITTEES (PTHB/24/198)

The following Chairs' Assurance Reports were received:

Audit, Risk and Assurance Committee

SE presented the item which provided an overview of matters considered by the Committee on 11 March 2025. Attention was drawn to the following matters:

- The Committee approved the Internal Audit Plan for 2025/26.
- The Committee approved the Counter Fraud Work Plan 2025/26.
- The Audit Process and Reporting Handbook were approved, seeking to support internal audit. Further consideration to be given to extend to colleagues involved in clinical audits.
- Three internal audit reports received, all with Reasonable Assurance. Noted there was a further 12 2024/25 reports to be considered at this Committee in May and June.
- The Committee took assurance that effective financial controls are in place across the organisation.

Charitable Funds Committee

CC presented the item which provided an overview of matters considered by the Committee on 17 March 2025.

Delivery and Performance Committee

RA presented the item which provided an overview of matters considered by the Committee on the 6 February 2025.

The Committee has escalated to Board its concerns on the pace of progress from Welsh Government relating to Level 4 escalation, is there an update?

HT informed that a schedule of meetings will be established, with a scrutiny meeting already held to discuss the plan. Work will continue to strengthen reporting, particularly in the Level 4 escalation meetings, and updates will be brought forward as they occur.

CC drew attention to a point of clarity on page five of the report: Capital and Estates Compliance Report which should state "...funding with £40M of funding available for Powys to bid for....".

Patient Experience Quality and Safety Committee

KW presented the item which provided an overview of matters considered by the Committee on the 11 February 2025. Attention was drawn to the following matters:

2025-03-17 15:22:19

- The Committee continues to have concerns regarding the development of a comprehensive way to receive patient experience feedback.
- The Committee received a report on Infection, Prevention & Control which advised that 24 actions were completed and remaining actions to be completed within the planned timeframe. The Committee expect to receive a report to allow de-escalation of that concern and thanked colleagues for driving improvement in this area.
- The Committee received the Medicines Management Report and the Annual Report of Controlled Drugs. KWi expressed gratitude for the contribution of the previous Chief Pharmacist.

How are manual feedback loops being captured, and how are these adding value to patient experience?

CR advised that a Patient Experience Steering Group is already established with representatives from various departments. The group gathers quadrant reports from local teams engaging with service users, and this information is incorporated into the Integrated Quality Report that comes through to Board. CR emphasised the need for a more systematic approach to collecting and using patient feedback to drive service improvements. Additionally, the process of appointing a patient experience role is underway to help develop the framework for improving patient experience.

RA suggested a mechanism for patient feedback outside Minor Injury Units as an example, which CR would look into further.

Planning, Partnerships and Population Health Committee

RL presented the item which provided an overview of matters considered by the Committee on the 4 February 2025. Attention was drawn to the following matters:

- The Strategic Change Report was received and concentrated on the enforced move of stroke services in the Cwm Taf area. NJ noted that these are temporary changes at present and the Health Board remains engaged with the process of developing the permanent model.
- The Committee had received an update on the Transformation Programme and expressed concern regarding the capacity of the Health Board and partner organisations to support this programme.

Workforce and Culture Committee

HB (in JOAs absence) presented the item which provided an overview of matters considered by the Committee on the 13 March 2025. Attention was drawn to the following matters:

- The Committee Alerted Board in relation to RIF funding; currently there was some risk to the availability of RIF funding which would impact workstreams and will be closely monitored by the Executive Cttee.
- A recognition of the positive improvement in relation to workforce performance statistics.

Executive Committee

HT presented the item which provided an overview of matters considered by the Committee on the 8 January, 15 January, 22 January, 5 February, 19 February and 5 March 2025. No issues to alert or advise the Board were recorded.

Joint Delivery and Partnership and Planning, Partnerships and Population Health In-Committee

RL advised that this joint meeting had been convened to scrutinise the Draft Annual Plan and financial assessment. The joint meeting was assured the Plan had been developed in line with the Powys Health and Care Strategy, the NHS Planning Framework and was aligned to the draft Level 4 de-escalation criteria.

The Board **RECEIVED** and **NOTED** all the Committee Reports recognising the key assurance role the Committees have in supporting the Board in its work.

2. CONSENT AGENDA BUSINESS

There were no requests to consider any items from the Consent Agenda.

3. ITEMS FOR APPROVAL/RATIFICATION/DECISION

3.1 APPROVAL OF INTEGRATED PLAN 2025/26 (PTHB/24/199)

HT introduced the paper recommending the Final PTHB Annual Plan 2025/26 to the Board for approval. A presentation was provided by HT, PH and NJ which outlined the oversight and direction of the planning process, the alignment with the Health Board's Strategy, the NHS Wales Planning and Performance Frameworks and the draft De-escalation Criteria. It was stated that the Plan included the Health Board's delivery and improvement actions across the full breadth of the organisation with particular focus on the critical actions to address the key themes of risk, recovery and sustainability. It was noted that the Plan included options and choices to deliver the Health Board's strategic priorities and manage the key strategic, quality and performance risks in alignment with the development of the Better Together portfolio to move towards sustainability. It was noted that this, in turn, underpinned the financial options for improvement on the baseline financial assessment working towards meeting Welsh Government's direction for all health boards to meet their Target Control Total in 2025/26. It was noted that the Plan has been discussed with WG, most recently through the formal Scrutiny meeting, and there will be ongoing dialogue and scrutiny to support delivery of the Plan (including through the Joint Executive Team and Level 4 Escalation meetings in 2025/26).

HT noted that, in the current financial plan, no savings have been assumed from the recent review of adult social care commissioned by the County Council. Additionally, while a £0.5M improvement target has been set for Continuing Health Care, the Plan has accounted for the expected growth in demand and inflation in healthcare costs. There is much more detailed work behind the presentation.

HT recorded her gratitude to colleagues for the hard work in developing the 2025/26 Annual Plan.

CC echoed the thanks for the skilled and professional work that had gone into the developing the Annual Plan and reminded the Board of its ownership of the plan, which has been steered in shape and content in the various Board development sessions.

The Chair invited the following observations:

ND (Associate Member)

- There are risks in the 2025/26 budget plan, noting the difficult decisions that will need to be made.

- Joint working between the Health Board and the County Council will be important, especially in key areas.
- A concern regarding the increasing spend on Continuing Health Care (CHC), which noted a budget increase and the growing impact of an aging population.
- Efficiency targets were discussed, assurance was sought on how they would be achieved without negatively affecting patients.
- Clarity was sought on how the £5M target relating to hospital flow and adult care was determined.
- RIF funding should be targeted at higher priorities, with a focus on areas with the greatest need.
- The importance of prevention and innovation in partnership funding was noted.
- Reference was made to the ongoing adult social care diagnostic work, expected to conclude in the coming weeks with implementation in 2025/26 and savings projected for 2026/27. Collaboration with the Health Board on this work is crucial with a focus on working together to ensure successful implementation and outcomes in this area.

KB (Regional Director Liaison)

- Noted the concerns on commissioning times and NHS Wales targets, appreciating the challenges faced by the Health Board and other public sector bodies financially. There is an ongoing issue of patients waiting for services and the significant negative impact on patients, families and carers. The proposal could be seen as 'levelling down' aspirations rather than improving waiting times and whilst the target aligns with Welsh standards, it still means a 104-week wait which may disadvantage many individuals and concerned with the challenge of supporting individuals and communities whilst they wait for access to services. The decision might offer a short-term solution but could have significant long-term consequences for patients and the health system.

Independent Members asked the following questions for assurance:

What is the risk to the Health Board as an organisation, and reputationally, if one or more of these critical actions fails?

HT emphasised that the focus of the plan is on overall organisational delivery, rather than specific individual actions, including balancing day-to-day operations with the capacity to drive change. HT stated that the plan has been designed based on the organisation's best assessment of what is realistically achievable with a focus on deliverability. The plan includes necessary actions to maintain financial stability, while acknowledging the presence of high-risk elements within the overall strategy.

NJ stated that the executive team have had extensive discussions around balancing ambition with deliverability and focusing on recovery and sustainability, addressing strategic and service risks. Mental Health Transformation was highlighted as a critical action (recognising the significant role the Health Board has in providing primary and secondary mental health services, as well as commissioning tertiary care). The Plan outlines actions for the next year while also setting the foundation for future transformation.

Does the English provider commissioning proposal require a service change consultation? What is the level of confidence in its deliverability, and how advanced are discussions with English providers? What is the plan if clinicians in England say no, and how will we address the potential impact on the plan's deliverability, given the significant work still needed?

NJ advised that the planning assumes that activity levels will meet ministerial measures. Clear conversations have been held with WG on financial and quality criteria. The focus is on balancing quality with financial duties. The proposed changes are not considered a service change, as service will remain in the same place and patient access to clinical services will continue. The Plan does not require formal engagement or consultation on service change. Discussions with providers are ongoing to assess deliverability, with meetings commencing tomorrow to validate assumptions; the intent is to give providers more time for planning and ensure that commissioning and strategic consequences are managed effectively, including clinical prioritisation and balance of risk. The plan will not affect patients under 18 or those prioritised by clinicians as urgent or cancer patients.

KW stated that the issue will require ongoing discussion with the Board, as it affects medium-term expectations for health services. There is existing inequity in waiting times across the system and the goal is to improve assurance through more planning and dialogue with service providers. Referral management will be a key part of the plan to streamline referrals and ultimately improve care and outcomes.

When will the financial plan for 2025/26 be finalised, as the underlying deficit and agreed actions to reduce it are currently unclear, with figures ranging from £38.4 million to £60 million?

PH acknowledged the scale of the financial challenge, noting the process for refining this will continue. Clarity on the financial position will be provided on an ongoing basis with a longer-term process in place to ensure targets are met.

PH referred to NDs query on the CHC saving. The £5M target related to social care and CHC efficiency is linked to an increase in funding, with a £5M uplift planned to cover price inflation and additional growth. The savings target for CHC is lower than other areas, linked to a national programme of work. The inefficiencies resulting from delayed transfers of care are estimated as £18M, thus any improvement in reducing delays will lead to financial benefits. This target is part of a broader strategy that includes repurposing funding and improving efficiency through reduced length of stay in hospitals. It will be critical for the Health Board and the Local Authority to work together to identify efficiencies.

Given the absence of discussion regarding the reprioritisation of RIF at the Regional Partnership Board (RPB) level, what risk is associated with this aspect of the plan? What alternatives have been considered for the savings target, and what would the consequences be for services, particularly primary care, if the decision to follow WGs guidance on commissioning only within the available budget is not made?

HT stated that in terms of resource allocation, the Health Board faces a significant challenge balancing spending across various services, especially with 30-40% of the budget dedicated to commissioning services. Protecting one part of the healthcare pathway over another could have severe consequences, particularly in

primary and community care, which sees the highest number of patient contacts. Some cost saving options, such as stopping premium rate cover, agency allocations, or halting variable pay for surgeries, have been discounted due to the severe impact they would have on service delivery.

Assurance is sought around the resources available for primary and community care and whether the resources that have been allocated will allow the actions to be fulfilled in the plan?

HT and MB gave assurance that the focus for this financial year has been on protecting primary care delivery, while the future model, Better Together, will allow for further collaboration with the Local Authority. The growing demand for secondary care, driven by an aging population, makes it crucial to shift towards prevention and a healthier population. The plan includes a prevention strand, but more attention will be needed on improving healthy life expectancy and managing health conditions in primary care to reduce the overall burden on the system.

CR recognised that the Board was facing a difficult choice and felt it important to highlight the focus on quality and prevention within the plan. Critical actions, such as reducing length of stay and improving care transfers, addressing quality issues and an aim to prevent long term health decline would be required. The plan also emphasises a person-centred approach, particularly in developing services for children and families. The Health Board is committed to ensuring long term sustainability and the overall wellbeing of the population.

The Board:

- **RECOGNISED** that, as supported at the Board's In-Committee meeting in January 2025, the Accountable Officer informed Welsh Government of the Board's inability, at this time, to develop a three-year plan that meets the statutory break-even duty and, therefore, an Annual Plan has been developed for 2025/26 in line with the NHS Wales Planning Framework.
- **RECOGNISED** the plan seeks to balance all statutory and other duties placed on the Board to deliver health services and improve the health and wellbeing of our local population and reduce health inequalities.
- Took **ASSURANCE** that the Annual Plan delivers the Health Board's agreed Strategy 'A Healthy, Caring Powys', complies with the NHS Wales Planning Framework and meets the draft Level 4 Welsh Government Escalation and Intervention Framework De-Escalation Criteria.
- **NOTED** that the Annual Plan includes the financial plan and options to achieve an end of year forecast nearer to the Target Control Total, which involve a number of areas including provider and commissioner performance.
- **RECOGNISED** that further work will continue, both locally and nationally, on options to improve the financial plan position;
- **RECOGNISED** that, in approving the plan, there are aspects that are subject to further discussion and decision, for example the possible 4% increase for the Joint Commissioning Committee. An oral update will be given during the Board meeting.
- **APPROVED** the Annual Plan 2025/26 and its associated deficit financial plan, **NOTING** the plan's underlying deficit of £38.4m with agreed actions

identified to reduce this deficit to a potential £16m for submission to Welsh Government in line with the national deadline of 31 March 2025.

- **DELEGATED** the final sign-off of the plan to the Chief Executive and Chair acknowledging that minor amendments will be made prior to submission to Welsh Government.

LC left the meeting.

3.2 DISCRETIONARY CAPITAL PROGRAMME 2025/26 AND 2026/27 (PTHB/24/200)

PH presented the Discretionary Capital Programme 2025-27, providing an update on the general capital funding status, including risks and opportunities. PH advised that the report title should state 2025/26-2026/27. PH brought the below key items to the Board's attention:

- Discretionary Capital had been uplifted to £2.7M, to reflect the current and projected allocation of WG.
- Ongoing support had been provided for the Re:Fit programme.
- The Health Board has been successful in £3.525M targeted estates funding from WG.

Independent Members asked the following questions for assurance:

Where does the Health Board stand with risk and project prioritisation, given that some assets are overdue maintenance? Is the Health Board using funding effectively, not just replacing things but addressing the root issues. Will the Re:Fit investment significantly improve the overall position?

PH advised that focus is on maintaining estates in the best possible way, noting there is a backlog maintenance programme and slippage is being used to maintain the estate. The Innovative Environments Group oversees elements of the programme, ensuring everything is aligned and the organisation is making the best use of resources. The Re:Fit programme is aimed at continuous improvement.

Is there provision in the Capital Programme for Digital?

PH advised there is a separate funding stream for digital where the Health Board has been successful in accessing funding, with a nominal amount included in the plan for equipment refresh.

Is attention paid to value for money when undertaking capital works? A recent visit to Spa Road highlighted the use of seemingly high cost radiator values. How is the proportion of work delivered in-house versus contracted managed?

PH advised that the team works to maximise funding, ensuring the best value and price. All external contractors are managed under procurement roles. A Board Briefing on Capital and Estates was imminent where such matters could be explored.

Will the Health Board's Capital team have capacity to deliver works with vacant positions?

PH advised that the team continuously assess capacity against requirements, filling vacancies as they arise, and considering additional resource needs, noting that project funding and capacity are always under review.

HT emphasised the need to balance strategic goals and secure support for the capital team, acknowledging efficiency targets and the need to flex the workforce to meet peak demands within constrained capital availability.

The Board **APPROVED** the Discretionary Capital Programme, 2025/2026–2026/27.

3.3 DIRECTOR OF CORPORATE GOVERNANCE REPORT (PTHB/24/201)

HB presented the report to the Board and brought key items to the Board's attention:

- Board activity since the last meeting held on the 29 January 2025 was outlined.
- Work is underway to constitute the HealthCare Professional Forum Advisory Group.
- The Common Seal has been applied on one occasion.
- Scheme of Delegation proposal to increase the Charitable Funds Committee level to £10,000 for non-contentious items.
- Board Committee Terms of Reference and the Executive Scheme of Delegation are currently under review and will be presented to the Board in May 2025.

The Board:

- **RECEIVED** the Director of Corporate Governance report.
- **RATIFIED** the application of the Common Seal applied on one occasion since 29 January 2025 and received **ASSURANCE** that the action was taken in accordance with Section 9 of the Standing Orders.
- **APPROVED** the changes to the PTHB Standing Orders;
- **APPROVED** the change to the Scheme of Delegation for the financial delegation in relation to Charitable Funds applications.

3.4 STANDARDS OF BEHAVIOUR FRAMEWORK POLICY AND PROCESSES (PTHB/24/202)

HB presented an amended Standards of Behaviour Framework Policy to the Board, noting the strengthened mechanisms in place for the deployment of the policy in relation to Declaration of Interests and Gifts and Hospitality. HB brought key items to the Board's attention:

- Standards of Behaviour policy is a Board retained policy that has been reviewed in detail and recommended by the Executive Committee to the Board.
- A number of amendments have been suggested to strengthen and streamline how declarations of interests are recorded, aligned to best practice. It was suggested that all employees record their declarations using the existing Electronic Staff Record (ESR) Management System.

How will implementation and compliance be monitored?

HB advised that regular reports will be considered at the Executive Committee and the Audit, Risk and Assurance Committee. Declarations of interest will be monitored against staffing lists.

How will the of this policy and process be communicated to staff?

HB advised that policy updates are regular items at the Chief Executive staff briefing sessions and that an ongoing training programme will be rolled out with 'how-to' guides produced.

The Board **APPROVED** the proposed amendments to the Standards of Behaviour Policy and implementation across the organisation.

3.5 RISK MANAGEMENT FRAMEWORK (PTHB/24/203)

HB presented the updated Risk Management Framework and brought the below key items to the Board's attention:

- Key change proposed is the closure of the current Corporate Risk Register, to be replaced with a Strategic Risk Register, owned by the Board.
- An Organisational Risk Register, focused on significant and cross-organisation operational risk will be owned by the Executive Committee.
- Creation of an additional risk register will allow greater focus on the risks to the Health Board's strategic objectives at Board level, as well as more dynamic escalation, oversight and management of significant, cross-organisational operational risks by the Executive Team.
- A programme of training will be implemented and local risk registers moved onto the Datix IT system.

Independent Members asked the following questions for assurance:

What assurance can be given that there will be no 'grey areas' between the strategic and operational risks.

HB advised that the framework supports escalation between risk register tiers and is supported by training, ensuring parity in risk assessment. The process focusses on the principles that determine the escalation of risks with the importance of moderation highlighted. Good progress has been made, particularly in the previous year, but continued development and maturity of the process are needed especially at the Board and Executive levels.

What mechanism will be put in place to ensure a dynamic, whole system approach is happening?

HB advised that the Risk and Assurance Group, chaired by the Deputy Board Secretary, supplements the Committee and is attended by all Assistant and Deputy Directors. This group is a key mechanism for risk management. Additionally, an annual internal audit is conducted, assessing the corporate system and performing dip tests on at least two service areas each year, with different areas reviewed annually.

As a Board, how would we assure the risk to effectiveness is either eradicated or mitigated?

HB advised that the Audit, Risk and Assurance Committee will receive a specific session on risk assurance in terms of risk management and explore that in detail.

The Board **APPROVED** the revised Risk Management Framework.

3.6 MINUTES OF PREVIOUS MEETING HELD ON 29 JANUARY 2025 (PTHB/24/204)

The minutes of the meeting held on the 19 January 2025 were **AGREED** as an accurate record.

4. ITEMS FOR BOARD ASSURANCE

4.1 FINANCIAL PERFORMANCE: MONTH 11 – 2024/25 (PTHB/24/205)

PH updated the Board on the financial performance report for period 11 and brought the following key items to the Boards attention:

- At month 11, there is a £14.479M overspend against the revised planned year to date deficit of £14.457M, an operational overspend of £0.022M.
- Year-end forecast remains in line with the adjusted plan of a deficit £15.770M.
- £7.743M capital resource has been spent and is on track to deliver by year-end.
- Key expenditure areas include provider services, locum/agency spend, commissioning of healthcare services, delayed transfers of care.
- Mental Health private provider forecast overspend has increased and is subject to urgent focus.
- Continuing Health Care remains overspent.

Independent Members asked the following questions for assurance:

Is there a specific reason for increased agency usage in February?

EL noted a significant increase in agency use, largely due to staff sickness and higher acuity in the system. A framework has been implemented, and a rapid review is underway. The recent step-up in agency usage had not previously been escalated and a deep dive will be conducted to identify further actions needed.

It appears that contracts with English providers had not been agreed in month 11, is there clarity around that?

NJ highlighted challenges, particularly around Wye Valley NHS Trust (WVT), noting these have been resolved successfully along with Shrewsbury and Telford Hospitals NHS Trust (SaTH). Formal agreements were signed late in the year and NJ is communicating with providers and collaborating with Integrated Care Boards on performance management. SaTH's data repository issues will continue into quarter one, with agreements in progress on how these will be managed including close monitoring.

This is the first time that private providers have been drawn out specifically in the report, with nearly £4M spend against a budget of £1M. To what extent is this due to capacity or acuity of packages?

EL advised that closure of beds in Powys services led to increased use of private providers, which had not been identified until the last six weeks. A deep dive is currently underway, with a significant number of patients being repatriated back into Powys services. A Complex and Continuing Care Programme Board has been established, and additional support is expected for the complex care review, which has already shown a reduction in reliance on private provision; and lessons learned have resulted in application of different procedures to ensure this is not repeated.

KW noted that whilst nursing agency use is stable, staff in mental health services are facing fragilities, with sickness affecting a small team, noting that recruitment has had some success and improvement is expected.

MM clarified that the reported increase in agency use is due to delays in submitting rosters, not an actual increase in agency staff and efforts are being made to work with services to ensure accurate reporting of agency use. It was agreed the

Delivery and Performance Committee will receive an assurance report on this for review.

Action: Executive Director of Primary Care, Community and Mental Health.

Independent Members asked the following questions for assurance:

Will the deep dive into agency staff also consider unintended consequences; in relation to the process for requests and whether it can be streamlined?

EL advised that a new process had been implemented with the aim of reviewing how requests are made and the reasoning behind them. Feedback will be provided on necessary actions or improvements along with a timeline for the process.

Would using a standard contract with an agency, where the nurses are trained to common standards be a possibility for the Health Board?

EL emphasised the importance of learning from other areas and the single biggest area to stabilise would be substantive recruitment.

MM highlighted the use of automated systems, prioritising the bank staff for shifts and offering a digitised platform to make it easier for people to take up shifts. There are fast-track processes in place, through the number of pre-employment training requirements can cause delays in onboarding.

What lessons from this financial year can be taken forward?

HT discussed the importance of incorporating learning into quarter one discussions and ensuring timely decision-making on arrangements. It was agreed that this will be a substantive focus at both the Delivery and Performance Committee and Board Development.

Action: Director of Corporate Governance.

The Board:

- **RECEIVED** the financial report and took **ASSURANCE** that the organisation has effective financial monitoring and reporting mechanisms in place.
- **NOTED** that it is forecast that the Health Board will achieve the financial plan of a £15.8m deficit. However, the underlying deficit is assessed as £30.6m.

4.2 INTEGRATED QUALITY AND PERFORMANCE REPORT 2024/25: MONTH 10 (PTHB/24/206)

NJ presented the Integrated Quality and Performance Report providing an update on the latest available performance position up until the end of January 2025 (month 10) and drew attention to the following matters:

- Diagnostics show an improved picture.
- An improvement in Cancer pathway performance.
- There is fragility in mental health measures, particularly 1A and 1B. Performance improved in month 11 which will be seen in the next report to Board.
- Psychological therapy waiting times compliance improved.
- Neurodevelopmental services, for month 10, showed no improvement in performance, but performance improved in month 11 which will be seen in the next report to Board.
- Performance for Minor Injury Units remains good and forms part of the ongoing evaluation of Temporary Service Change.

- Variability of waits remains, but the Health Board is in close dialogue with Robert Jones Agnes Hunt regarding their trajectories.
- Stroke performance to be included in future reports.

Independent Members asked the following questions for assurance:

Regarding the tracking of the ongoing effectiveness of the additional planned care funding (commissioned services), what are the benefits for Powys residents?

NJ advised that funding is centrally deployed to providers, but the latest report indicated that three health boards will not meet the 104-week wait target, affecting some Powys patients. WG has requested further assurance from those providers regarding next year's trajectories.

The improvement in Children's neurodevelopment services is noted, including that the internal waiting list has now been removed. Can assurance be given that the service designed alongside the standards, is effective and impactful?

KWi noted the progress was as a result of additional funding received in 2024/25. Further funding was, as yet, unconfirmed.

CR noted that the service has gained a much better understanding of the capacity, and by improving pathways and standards, the aim is to reduce demand. A triage approach was introduced to ensure appropriate referral resulting in a reduction in the acceptance rate from 99% to 70%. The focus is on ensuring children are seen in a timely manner or referred to a more appropriate pathway. Whilst there is still progress to be made, significant effort has been put into building a foundation to sustain those improvements.

KW noted the improvements resulted from additional funding being made available and the continuation of this additional resource was, yet unconfirmed.

HB left the meeting.

SG joined the meeting.

Independent Members asked the following questions for assurance:

Why have endoscopy and echocardiograms pathways waiting times increased?

EL noted that a large number of people are going through those pathways, with a few specific complex cases contributing to longer waiting times.

KW noted that more complex cases will require commissioned services, which are outside the Health Board's control.

The Board:

- **DISCUSSED** the content of this report; and
- Took **ASSURANCE** that the Health Board has appropriate systems in place to monitor performance and respond to relevant issues.

4.3 ANNUAL DELIVERY PLAN 2024/25 QUARTER 3 (PTHB/24/207)

NJ provided the Board with an update of the progress made against the Integrated Plan for the Quarter 3 period (October to December 2024) noting the following:

- Good assurance of delivery of the 2024/25 Annual Plan.

- Those actions that were RAG rated red at quarter 3, have detailed reasons for any delay included at page 4 of the report.

Independent Members asked the following questions for assurance:

Is a 26% deficit in the outturn plan a reasonable position? Are there any lessons that can be learnt?

NJ noted the key question is balancing deliverability, testing the planning for 2025/26, noting there were challenges with national digital programmes and dependencies on national funding that did not come through. Reflecting on performance in other health boards, around 20% flexibility in-year seems typical, and this learning will be incorporated into future planning.

Regarding digital transformation, there seems to have been a series of national delays, how is that being managed?

HT advised that a recent review of the national digital programmes has led to the development of a new digital transformation initiative for Wales. The Terms of Reference have been created, with Chief Executives expected to attend, providing a broader understanding. In terms of deliverability, a Q3 progress report is available, and a delivery confidence aspect will be included in the Q4 report. Lessons learned will be assessed at the end of the financial year, with the new national oversight arrangement expected to improve capacity and delivery.

The Board **CONSIDERED** the report ahead of submission to Welsh Government and took **ASSURANCE** that there is a process in place for monitoring progress against plan.

4.4 ASSURANCE REPORT FOR TEMPORARY SERVICE CHANGES TO MINOR INJURY UNITS AND COLOCATION UNITS (PTHB/24/208)

KW updated the Board on the evaluation and monitoring of the temporary service changes and updates against the Mitigation plan for Temporary Service Changes as agreed at Board on 10 October 2024:

- All expected monitoring and evaluation are underway.
- All mitigation is in place and ongoing. The Temporary Service Change Programme Board will continue to monitor, and a report will be brought to Board in July 2025 for further discussion and decision making.
- Minor Injury Units (MIU). There were no unexpected closures as a result of the changes, noting the radiology replacement project has been progressing at the same time and no additional risks have been identified.
- Some stakeholder feedback on clinical communication on transfer has been received and will be helpful in refining the model.

KB advised Llais had not received any complaints to the MIU changes and a report following patient feedback at Llanidloes and Bronllys hospitals is being prepared.

The Board:

- RECEIVED** the update on progress to date including the evaluation and monitoring plan.
- Took **ASSURANCE** in relation to the mitigation plan.

ND left the meeting.

4.5 CORPORATE RISK REGISTER (PTHB/24/209)

SG provided the Board with the March 2025 version of the Corporate Risk Register and the following changes were proposed:

- CRR001 (Financial Forecast) – Risk score decreases from 20 (L5 x I4) to (L3 x I4) 12, due to the expectation that the Health Board will now achieve its planned deficit.
- CRR007 (Primary Care) – Risk score increases from 16 (L4 x I4) to (L4 x I5) 20, due to Termination of Shropdoc OOH contract 31/03/25; Practice Sustainability applications for support being prepared for Llanfyllin, Knighton and Presteigne practice; Dental access in mid cluster affected currently (Llandrindod Wells & Knighton) and Orthodontic waiting list.

It was noted that no other changes are proposed, but development of the Strategic Risk Register will be undertaken in light of the earlier approved Risk Management Framework for presentation to Board in May.

It was requested that future reports include a summary of key changes from the previous report.

Action: Director of Corporate Governance.

The Board:

- **REVIEWED** the March 2025 Corporate Risk Register update, included at Appendix 1 (noting details of Risks 008/011 and 012 are provided in Board In-Committee papers item 7.5), ensuring that it is a complete and a true reflection of the health board's current high-level risks
- Took **ASSURANCE** on the controls and assurances to manage strategic risks and there are actions to address any identified gaps
- **NOTED** that work is underway to develop the 2025/26 Strategic Risk Register in accordance with the revised Risk Management Framework and Integrated Plan subject to Board approval (subject to a separate paper) by the Board on 26 March 2025.

4.6 REPORT OF THE REGIONAL DIRECTOR OF LLAIS (PTHB/24/210)

KB presented the Regional Directors report to the Board and drew attention to the following matters:

- Three national projects had been undertaken this year including reporting on care close to home, unpaid carers and travel time. These reports will be published imminently.
- The Emergency Care, Urgent Care and ED report had received a lot of coverage.
- Llais was planning to host a Health and Social Care Summit, to consider planning for the future and priorities going forward.

It was acknowledged by Board members that Llais is a valuable source of feedback, particularly in relation to the emergency care report, aligning with community concerns. The importance was noted in understanding patient experiences, and even though Emergency Departments are not directly under this Health Board's control, they are a funded service. KB confirmed that there are good relationships with border hospitals but noted capacity constraints that prevented deeper engagement.

The Board reflected on the significance of the findings and questioned how they could be used positively and for findings to be integrated into current work and inform future actions. The challenges related to the Joint Health and Social Care Plan were noted and members were reassured that work was underway to join efforts across various initiatives, including the Sustainable Powys and Better Together programmes with community engagement.

CC questioned how the report could spur immediate action, with HT indicating that existing mechanisms would drive the necessary improvements. The need to review the scope of the work was discussed and the need to ensure it is reported to the most appropriate Committee. It was suggested to use a Board Development session to highlight changes and action items moving forward.

Action: Chief Executive, Director of Corporate Governance.

The Board **NOTED** the report.

5. CONSENT AGENDA

The below reports were taken under the Consent Agenda and recommendations supported:

- **FOR ASSURANCE:** Assurance Report of the Board’s Joint Committees
- **FOR ASSURANCE:** Assurance report of the Board’s Partnership Arrangements.
- **FOR ASSURANCE:** Assurance report of the Board’s Local Partnership Forum (20 January 2025-written).
- Board Work Programme 2024-25.
- **FOR INFORMATION:** Glossary.

6. OTHER MATTERS

6.1 ANY OTHER URGENT BUSINESS (PTHB/24/211)

No other urgent business was raised.

6.2 DATE OF NEXT MEETING (PTHB/24/212)

The next meeting is scheduled for Wednesday 21 May 2025.

Meeting closed 14:21

The Chair, with advice from the Director of Corporate Governance, has determined that the following items include confidential or commercially sensitive information which is not in the public interest to discuss in an open meeting at this time. The Board is asked to take this advice into account when considering the following motion to exclude the public from this part of the meeting:

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

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

PRESENT

Carl Cooper	CC	Chair
Hayley Thomas	HT	Chief Executive Officer
Ronnie Alexander	RA	Independent Member (General)
Mererid Bowley	MB	Executive Director of Public Health
Steve Elliot	SE	Independent Member (Finance)

Mick Giannasi	MG	Independent Member (General)
Pete Hopgood	PH	Executive Director of Finance, Capital and Support Services / Deputy Chief Executive
Nichola Johnson	NJ	Executive Director of Planning, Performance and Commissioning
Rhobert Lewis	RL	Independent Member (General)
Elaine Lorton	EL	Executive Director of Planning, Performance and Commissioning
Claire Madsen	CM	Executive Director of Allied Health Professions, Health Science and Digital
Cathie Poynton	CP	Independent Member (Trade Union)
Claire Roche	CR	Executive Director of Nursing, Quality, Women and Family Health
Ian Thomas	IT	Independent Member (General)
Kirsty Williams	KWi	Independent Member Vice-Chair (to 15.30)
Kate Wright	KW	Executive Medical Director
Simon Wright	SW	Independent Member (University)
IN ATTENDANCE		
Helen Bushell	HB	Director of Corporate Governance / Board Secretary
Lucie Cornish	LC	Director of Improvement and Transformation
Mark McIntyre	MM	Deputy Director People and Culture
Liz Patterson	LP	Head of Corporate Governance (meeting support)
APOLOGIES FOR ABSENCE:		
Jennifer Owen Adams	JOA	Independent Member (Third Sector)
Chris Walsh	CW	Independent Member (Local Authority)
Debra Wood-Lawson	DWL	Executive Director of People and Culture
7. CONFIDENTIAL MATTERS		
The following motion was passed: 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.		
7.1 WELCOME AND APOLOGIES FOR ABSENCE (PTHB IC/24/213)		
The Chair welcomed everyone to the meeting. Apologies for absence were noted as above.		
7.2 DECLARATIONS OF INTEREST (PTHB IC/24/214)		
No interests were declared in addition to those already declared within the published register.		
7.3 MINUTES OF PREVIOUS IN-COMMITTEE MEETINGS AND ACTION LOG (PTHB IC/24/215)		
The minutes of the In-Committee meetings held on 29 January and 06 March 2025 were CONFIRMED as an accurate record. It was confirmed there were no outstanding Board In-Committee actions.		
7.4 NORTH POWYS WELLBEING PROGRAMME (PTHB IC/24/216)		

Rationale for item being held in private: Issues, the discussion of which in public would be likely to prejudice the effective conduct of public affairs.

The Board:

- **NOTED** the assessment of potential impact if Phases 2 and 3 funding is delayed or not forthcoming – for Phase 2 this will result in the Health Board not being able to re-configure existing community hospital services (subject to consultation) to deliver safe, efficient and sustainable service models for Powys.
- **ENDORSED** the recommendations associated with mitigating actions outlined in the contingency plan should Phases 2 and 3 funding be delayed or not forthcoming.
- **NOTED** the position with the RIF resource plan and ongoing support to continue to progress phase 2 work and to undertake further service planning work test the viability and achievability of proposed service developments in Phase 3.
- **NOTED** the risks associated with delivery of Phase 1.
- Confirmed **ACCEPTANCE** of the £971,270 IRCF funding from Welsh Government and approval to proceed with an integrated Strategic Outline Case/Outline Business Case (SOC/OBC) for Phase 1 of the multi-agency campus.

7.5 CHIEF EXECUTIVE UPDATE (PTHB IC/24/217)

HT updated the Board on the EMRTS Judicial Review and GP Out of Hours provision.

7.6 IN-COMMITTEE CORPORATE RISK REGISTER (PTHB IC/24/218)

Rationale for item being held in private: Information relating to the financial and business affairs of the organisation that were confidential and legally privileged.

The Board

- **REVIEWED** the **March 2025** Corporate Risk Register update in respect of In-Committee risks, ensuring that it is a complete and a true reflection of the Health Board's current high-level risks
- Took **ASSURANCE** on the controls and assurance to manage strategic risks and there are actions to address any identified gaps.

7.8 ANY OTHER BUSINESS (PTHB IC/24/)

There was no other business.

Meeting closed 16:04

Patterson, Liz
20/05/2025 15:22:19

Escalation and Intervention Arrangements

PTHB Board– 21 March 2025 Item 4.1

Patterson, Liz
20/05/2025 15:22:19

Escalation and Intervention Arrangements (Board) 21 May 2025

Subject:	Escalation and Intervention Arrangements
Approved and Presented by:	Chief Executive
Prepared by:	Director of Corporate Governance/Board Secretary Executive Director Planning, Performance and Commissioning
Purpose:	This document provides an update against the Welsh Government escalation and intervention arrangements for Powys Teaching Health Board.
Recommendations:	The Board is asked to: • RECEIVE the report • NOTE the escalation framework in place (appendix 1) • Take ASSURANCE that appropriate mechanisms are in place to monitor and report to the Board (and its Committees) • APPROVE the governance arrangements in place to support escalation status (slide 8) • NOTE the procurement specification for external support will be approved by the Chair and Chief Executive
Executive Summary	The Welsh Government Escalation and Intervention Arrangements has five levels of escalation 1. Routine arrangements 2. Area of concern (new level) 3. Enhanced monitoring 4. Targeted intervention 5. Special measures The the framework has six escalation domains and can be viewed here - NHS Oversight, Assurance, Escalation and Intervention Framework (gov.wales) PTHB's status increased from Enhanced Monitoring (Level 3) Finance, Strategy to Targeted Intervention on the 5 November 2024 having previously been in Enhanced Monitoring since September 2023. PTHB remains in routine monitoring for all other domains.
Appendices:	Appendix 1 – PTHB Level 4 Escalation Framework (issued by Welsh Government)

NHS Wales Escalation and Intervention Arrangements

- Welsh Government Escalation and Intervention Arrangements – Five levels of escalation
 1. Routine arrangements
 2. Area of concern (new level)
 3. Enhanced monitoring
 4. Targeted intervention
 5. Special measures
- Six escalation domains
- [NHS Oversight, Assurance, Escalation and Intervention Framework \(gov.wales\)](https://gov.wales/nhs-oversight-assurance-escalation-and-intervention-framework)



- PTHB's status **increased** from Level 3 to Level 4 for Finance, Strategy and Planning on the 5 November 2024 having been in Level 3 since July 2023
- Increased status due to worsening financial position.

Patterson, Liz
20/05/2025 15:22:19

NHS Wales Escalation and Intervention Arrangements

Arrangements pre-Escalation to Level 3 and 4	Level 4 Arrangements – additional
Quarterly IQPD (Integrated Quality and Performance Delivery) meetings (instead of monthly)	Monthly IQPD (Integrated Quality and Performance Delivery) meetings (instead of quarterly)
- Bi-annual Joint Executive Meetings (JET) with Welsh Government (standard) - Escalation status forms part of these meetings	Planning professionals leads meeting with Welsh Government – monthly
Standard monthly reporting and financial monitoring returns	Finance professionals leads meeting with Welsh Government – monthly
Tri-partite meetings bi-annually (ore more as needed) to review each organisations arrangements (WG, Audit Wales, HIW) – standard (PTHB not involved)	Quarterly Level 4 Escalation Meetings (chaired by WG Director General / NHS Wales CEO)

Roles and Responsibilities

Welsh Government

- Support a formal structure for reviewing and reporting progress.
- Signpost relevant best practice guidance and frameworks.
- Act as a critical friend and sounding board on existing practices and new developments.
- Review and provide feedback on developed products.
- Undertake and share relevant analysis and deep dives of national data.
- Enable shared approaches to key national issues across Welsh NHS organisations and promote shared learning.
- Direct the NHS Executive or make alternative arrangements to provide targeted support to areas of concern to help the health board to improve their progress against programme objectives.
- Work with the health board on critical enablers relating to regional planning, clinical services redesign, infrastructure (digital and buildings).

PTHB

- Appoint an SRO (designated point of contact) to lead the health board's response to the escalation.
- Ensure Board ownership and oversight with a clear governance structure, ensure that the Board is appraised of the escalation plan and evidence regular progress updates to the Board on progress against de-escalation criteria.
- To produce a level 4 action plan in response to the areas of concern and commit sufficient resources to ensure that the plan deliverables are achieved.
- Provide quarterly progress reports and evidence against the escalation plan to Welsh Government.
- Strengthen the formal review mechanisms to support urgency in delivering confidence and improvement to the financial position.

Strategy and Planning

- Submission of a balanced and credible three-year medium-term plan or acceptable annual plan in line with the current planning framework
- Board clarity on the strategic vision for the organisation
- Evidence of a clear roadmap and implementation of the health board's clinical services plan
- Welsh Government's confidence in delivery based on an assessment against an agreed planning maturity matrix
- Delivery of commitments set out within the health board's plan, particularly in relation to the ministerial priorities, delivery expectations and enabling actions

Finance

- Demonstrate that there is robust financial governance and a robust financial control environment in place with risks minimised
- Substantial progress to be made in delivering the level 4 action plan including actions to improve the organisation's understanding of the existing deficit and key drivers and development and realisation of opportunities
- Annual plan developed with Board approval demonstrating a substantial financial improvement trajectory and delivering as a minimum the target control total

- The escalation and related interventions detailed within the finance action plan have been designed to support the health board to demonstrate actions and evidence in line with the key objective areas
- Support categorised into green, amber and red areas, with green the priority to action
- Four green actions are as follows:

Commissioning and contracting expertise

Required to provide capacity to the health board to review contracting mechanism, process and approach and to improve process and controls of entering and monitoring commissioned contracts within resources available.

CHC clinical and operational expertise

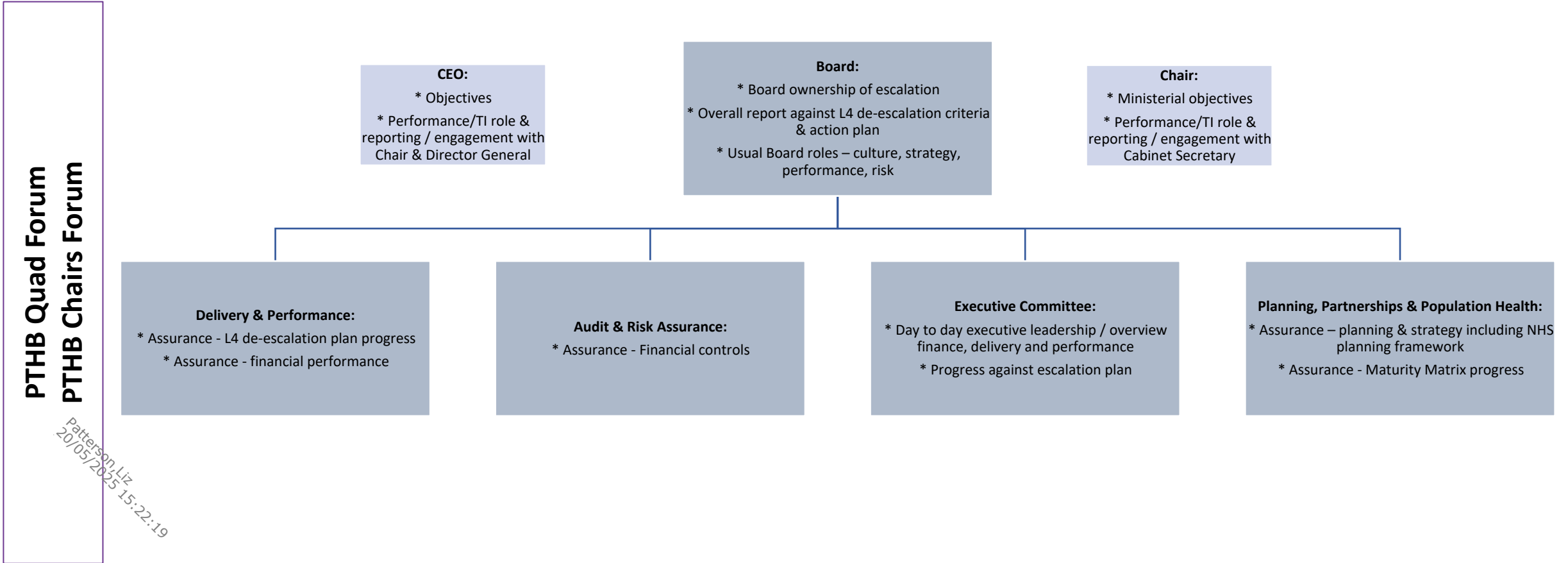
Required to enhance capacity and review the process and pathways underpinning CHC and FNC and support the development of sustainable solutions.

External planning and transformation capacity and expertise

To support the health board in developing and delivering an integrated plan for 2025/26, including effective stakeholder engagement, identification of rapid turnaround actions to support delivery of target control total, and support the longer-term through development of a clear route map to balance, including a focus on opportunities to strengthen planning capability.

Audit expertise - Additional internal audit days required to review the controls and processes within key risk areas that have not been recently reviewed and in key areas such as workforce (e.g. bank and agency)

Approach to Managing Level 4 Escalation



Approach to Managing Escalation – Governance

- Whole Board ownership
- Health Board Senior Responsible Officer confirmed - Executive Director Planning, Performance & Commissioning
- Building on effective governance foundations (routine monitoring) with
 - Board governance reviewed and enhanced
 - Executive governance reviewed and enhanced
- Finance and Integrated Quality and Performance Reporting enhanced
- Drivers of deficit well understood and Annual Plan responds to them as 'critical actions'
- Draft De-Escalation Criteria responded to throughout the Annual Plan planning process and final product
- Board approved the submitted 2025/26 Annual Plan in March 2025
 - Additional scrutiny in place ahead of full Board consideration (and approval) of revised 2025/26 annual plan
 - Better Together (transformation programme) a critical action, public engagement went live 28 April 2025
 - Continued work on de-risking the Plan and driving towards financial improvement with submission of AO letter on 12th May at a point in time
- Action Plan in place for Finance, agreed with WG Director of Planning that the HB will use the Planning Maturity matrix as the framework for developing an evidence log for Strategy and Planning
- Staff/organisation communication
- Partnership with Powys County Council – leadership structure reviewed and enhanced.

Approach to Managing Escalation – Planning & Strategy

- Integrated Quality and Performance Framework (includes internal escalation framework) reviewed annually. Commissioning elements strengthened in 2025/26 arrangements
- Performance delivery scrutinised and assured by the Executive Committee, Delivery and Performance Committee (D&P) and Board
- Good level of internal audit assurance on Planning process and monitoring of Delivery Plan
- Planning Maturity Matrix approved by Board in November 2024, monitored via PPPH Committee. Awaiting WG feedback, using as an active tool within the HB
-
- Transformation Portfolio Board and programme management arrangements established and underway, supporting key elements of Annual Plan delivery. Reports to Executive Committee which is a formal Sub-Committee of the Board. Overseen by PPPH
- Approach to the development of Better Together agreed by the Board as three Chapters (phases). Timeline for first Chapter (Community and Frailty Model) included in Annual Plan – up to March 2026
- Level 4 Escalation external capacity and expertise to be secured for planning and transformation including stakeholder engagement, identification of rapid turnaround actions and support the development of the routemap to balance – included as 'Green' element of the support package.

Approach to Managing Escalation – Finance

- Grip and Control report to Audit & Risk Assurance Committee on key control actions
- Scheme of Delegation and Standing Financial Instructions
- Budgetary Control and Savings (delegation and scrutiny).
- Focussed groups (Executive Director led)
 - Variable Pay
 - CHC
 - Prescribing
- Non-Pay Scrutiny Group
- Workforce Vacancy Control and Fixed Term posts processes
- Investment and Benefits Group
- Enhanced financial reporting to budget holders, executives and Board/Committees
- Executive sign off for agency booking process
- Executive Director Financial Performance Meetings and Monthly Performance Review process
- Board understanding and ownership re the options and choices to deliver financial improvement
- Internal escalation process (for service areas) linked to financial performance (as part of the IQPF)

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Dashboard – PTHB Roles and Responsibilities

Criteria	Status	Evidence (at 21 May 2025)
Appoint an SRO (designated point of contact) to lead the health board's response to the escalation.		Executive Director Planning, Performance and Commissioning confirmed as SRO
Ensure Board ownership and oversight with a clear governance structure, ensure that the Board is appraised of the escalation plan and evidence regular progress updates to the Board on progress against de-escalation criteria.		- Regular Board reporting (via D&P Chair's report) since Autumn 2023 - Several Board Development sessions including WG attendance in Dec 2024 - Formal paper to Board – 21 March 2025 with escalation framework included - Committee reports to every Board as per the escalation governance arrangements (slide 8)
To produce a level 4 action plan in response to the areas of concern and commit sufficient resources to ensure that the plan deliverables are achieved.		- Previous Enhanced Monitoring action plans delivered - Planning Maturity Matrix – feedback awaited from WG and will be used to develop evidence log for Strategy and Planning - Draft Finance action plan in place following escalation meeting, further details will now be populated - Action plan will be reported to D&P and Board (bi-monthly monitoring to D&P, bi-annual reporting to Board)
Provide quarterly progress reports and evidence against the escalation plan to Welsh Government.		- Update provided at meeting 1 (29 April 2025) - Mechanisms in place to ensure updates provided at each quarterly meeting - Procurement specification in development for external support
Strengthen the formal review mechanisms to support urgency in delivering confidence and improvement to the financial position.		- Board approved annual plan (March 2025) - Enhanced financial reporting - Series of internal controls continue from 2024/25 - Revised IQPF due for Board consideration – 21 May 2025

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Introduction

Following an assessment against the NHS Wales oversight and escalation framework in November 2024, the current escalation level of Powys Teaching Health Board is level 4 for finance, strategy and planning.

Level 4 (targeted intervention) is the second highest level of escalation within the NHS oversight and escalation framework. It is applied when organisations have serious problems and where there are concerns that they cannot make the necessary improvements without external support.

At this level of escalation, the Welsh Government will take and co-ordinate action and direct intervention to support the health board to strengthen its capability and capacity to drive improvement. It consists of a set of interventions designed to remedy the problems within a reasonable timeframe. The interventions will normally be undertaken by the NHS Wales Executive directed by Welsh Government. If appropriate, external support will be agreed with the organisation.

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Escalation history

In September 2023, Powys Teaching Health Board was escalated to enhanced monitoring for finance, strategy and planning as the health board was unable to produce an approvable balanced three-year plan in accordance with the direction given by Welsh Ministers and the NHS Planning Framework, which could be considered for approval under section 175(2A) of the NHS (Wales) Act 2006 ("the 2006 Act"). On 22 January 2024, the Minister for Health and Social Services confirmed the escalation status of Powys Teaching Health Board would remain as being in **enhanced monitoring for finance, strategy and planning**.

In November 2024, the health board was escalated to **level 4 for finance, strategy and planning** following a widening financial deficit.

Patterson, Liz
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NHS Wales oversight and escalation framework

The NHS Wales oversight and escalation framework sets out the process by which the Welsh Government maintains oversight of NHS bodies and gains assurance across the system. It describes the escalation, de-escalation and intervention process, the five levels of escalation and the domains against which each health board will be assessed - [NHS oversight and escalation framework](#).

Interventions will be:

- Collaborative – we will seek to minimise duplication by working collaboratively with other national committees, groups and programmes.
- Collective – we will maximise shared knowledge by sharing common approaches, tools, guidance.
- Impact focussed - we will examine and seek assurance and evidence how organisations are obtaining assurance over delivery and impact of actions.
- Be undertaken with openness; transparency; and mutual trust and respect between the health board, Welsh Government, and the NHS Executive.

Whilst in escalation:

- Normal performance management arrangements will continue through the Integrated Quality, Planning and Delivery Board (IQPD) and Joint Executive Team (JET) meetings.
- There will be quarterly escalation meetings chaired by the Director General of the Health and Social Services Group / Chief Executive NHS Wales.
- Finance, strategy and planning level 4 touchpoint meetings will be agreed with the NHS Executive - these will examine progress made against the action log, review evidence and agree outputs for inclusion at the Welsh Government led escalation meetings.

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Roles and responsibilities

Welsh Government

1. Support a formal structure for reviewing and reporting progress.
2. Signpost relevant best practice guidance and frameworks.
3. Act as a critical friend and sounding board on existing practices and new developments.
4. Review and provide feedback on developed products.
5. Undertake and share relevant analysis and deep dives of national data.
6. Enable shared approaches to key national issues across Welsh NHS organisations and promote shared learning.
7. Direct the NHS Executive or make alternative arrangements to provide targeted support to areas of concern to help the health board to improve their progress against programme objectives.
8. Work with the health board on critical enablers relating to regional planning, clinical services redesign, infrastructure (digital and buildings).

Powys Teaching Health Board

1. Appoint an SRO (designated point of contact) to lead the health board's response to the escalation.
2. Ensure Board ownership and oversight with a clear governance structure, ensure that the Board is appraised of the escalation plan and evidence regular progress updates to the Board on progress against de-escalation criteria.
3. To produce a level 4 action plan in response to the areas of concern and commit sufficient resources to ensure that the plan deliverables are achieved.
4. Provide quarterly progress reports and evidence against the escalation plan to Welsh Government.
5. Strengthen the formal review mechanisms to support urgency in delivering confidence and improvement to the financial position.

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Finance intervention

In 2024/25, Powys submitted a financial plan with a £24.9m deficit, which was subsequently revised to £22.9m by the Board in response to a request from Welsh Government to further strengthen the delivery priorities and address the financial position.

The in-year operational overspend has been driven by cost pressures presenting within continuing healthcare (CHC), commissioned services and use of temporary workforce solutions.

In March 2025, the Board approved the health board's annual plan and associated financial deficit plan for 2025/26, which included a planned deficit of £38.4m deficit before additional actions, with a set of further options and actions to potentially reduce this deficit to £16m.

The finance intervention and focus whilst in level 4 covers the following areas and the health board will be required to action and demonstrate:

Financial governance and control environment

- The financial governance framework at the health board is robust in both design and implementation, including a self-assessment against best practice frameworks.
- The financial committee structure is clearly articulated and actively addresses key risks.
- Financial controls at the health board are robust in both design and implementation.
- The finance function has the necessary capacity and capability to support the needs of the wider organisation.
- Financial reports include the analysis and narrative explanation required to enable management and Board to discharge their duties.
- Integrated reports provide the Board with a clear understanding of the interlink between financial performance and operational performance including the organisation's productivity and efficiency.
- Budgets are set with alignment to the plan and budget management is effective, with budget holders held to account for delivering their financial plans.
- As a result of the above, it has developed and is delivering an action plan to improve the financial governance and financial control environment.

Understanding the existing deficit and key drivers

- There is a clear understanding of the cost drivers and investment decisions responsible for the growth in deficit across the organisation, including an explicit breakdown by key service area and cost driver.
- There is a clear and robust process for challenging underlying deficits reported at local divisional levels.
- There is a clear understanding and management of the reasons for, and the drivers of the underlying deficit and increasing cost pressures reported within commissioned services.
- The drivers responsible for the cost growth and high cost base within CHC and NHS-funded nursing care (FNC) are understood and managed.

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- The drivers responsible for cost growth and high cost base within prescribing are understood and managed. The cost drivers and investment decisions responsible for the growth in workforce costs are well understood, alongside workforce capacity constraints and clear development actions to support a sustainable workforce.
- As a result of the above there are triangulated approaches to identify and deliver actions to improve efficiency and maximise the sustainable use of resources.

Development and realisation of opportunities

- National opportunities identified through the Value and Sustainability Board are translated into local savings schemes.
- Value based health care (VBHC) principles have been embedded across the organisation and VBHC plans are delivered.
- All prior year investments have been reviewed to assess whether the planned benefits have been delivered.
- There is a clear process for the development and delivery of strategic opportunities to support the health board's sustainability.

Clear financial plan and strategy

- There is an integrated plan that will deliver the target control total of a £12m deficit in 2025/26 at a minimum and demonstrates greater progress towards delivery and efficiency of services within available resources and a route to delivering the break-even duty.
- There is a clear engagement plan to communicate the necessity for financial improvement across the organisation.

Delivery of plan

- Delivery of financial performance for 2025/26 in line with the financial plan and demonstrates progress towards delivering the break-even duty by reducing the value of the underlying deficit.
- Delivering target in-year and full-year effect savings and progressing the transformational schemes necessary to support future financial sustainability.
- Demonstrate that in-year choices are identified and taken early to mitigate any emerging pressures.
- Has clear performance management processes in place to manage the delivery of emerging variations within commissioning contracts and to take appropriate risk-based choices to address budgetary pressures.

De-escalation criteria

1. Demonstrate that there is robust financial governance and a robust financial control environment in place with risks minimised.
2. Substantial progress to be made in delivering the level 4 action plan including actions to improve the organisation's understanding of the existing deficit and key drivers and development and realisation of opportunities.
3. Annual plan developed with Board approval demonstrating a substantial financial improvement trajectory and delivering as a minimum the target control total.

Patterson, Liz
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Strategy and planning intervention

The strategy and planning intervention and focus whilst in level 4 covers the following areas and the health board will be required to action and demonstrate areas as highlighted below:

Submission and delivery of an approvable plan

- Improved integrated planning evident across the organisation to develop an approvable IMTP, providing a route map towards the health board's longer-term ambition.
- If the health board is unable to submit a balanced IMTP for 2025/28 as is the statutory requirement, the health board will be expected to very clearly set out a credible plan which will deliver the target control total of a £12m deficit in 2025/26 as a minimum.
- Make good progress in delivering the ministerial priorities, delivery expectations, enabling actions (as set out in the NHS Wales Planning framework 2025-28), accountability criteria and the level 4 requirements.

Strategic planning and transformation

- Demonstrate how the clinical strategy and plan are driving decision-making across the organisation.
- Board approval of timeline and strategic approach for route map to sustainability.
- Board-level alignment between strategic direction for transformation of service model and financial obligations.

De-escalation criteria

1. Submission of a balanced and credible three-year medium-term plan or acceptable annual plan in line with the current planning framework.
2. Board clarity on the strategic vision for the organisation.
3. Evidence of a clear roadmap and implementation of the health board's clinical services plan.
4. Welsh Government's confidence in delivery based on an assessment against an agreed planning maturity matrix.
5. Delivery of commitments set out within the health board's plan, particularly in relation to the ministerial priorities, delivery expectations and enabling actions.

Patterson, Liz
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Support required

The escalation and related interventions detailed within the finance action plan (Annex A) have been designed to support the health board to demonstrate actions and evidence in line with the key objective areas.

The NHS Executive Financial Planning and Delivery team will work with the health board to support delivery of actions and products detailed within the action plan to gain a clear assessment of the financial governance arrangements in place, key financial challenges (diagnosis), opportunities for improvement and to gain an understanding of plans and actions for improvement.

The health board's cumulative and current position is driven by challenges in key resource areas; commissioning (in particular with England); CHC, including the associated impact of provider configuration and capacity; prescribing and workforce.

The escalation framework and action plan identify ten priority areas and recommendations for potential additional support. In taking forward these actions, officials consider that the health board does not have sufficient capacity and capability to deliver the actions required to address this challenge.

The intervention therefore is a combination of sufficient capacity from an external partner to provide additional support to the organisation, alongside securing specific expertise in key areas such as commissioning.

The likely delivery model will require procuring additional capacity from a third party, and also secure appropriate specialist expertise for commissioning and CHC in particular.

The health board will therefore procure and commission this support directly, ensuring that this additional support operates closely with and responds to the direction of the NHS Executive in an oversight capacity, and within the requirements of the agreed level 4 action plan.

The priority areas for intervention have been identified through the level 4 action plan and are set out below in priority order categorised:

- Green - support required and action needed to commission this support at pace
- Amber - support required but at a later stage once a clear diagnosis is undertaken
- Red - support required but a longer-term requirement post immediate priorities to deliver improvement

Green

1. Commissioning and contracting expertise required to provide capacity to the health board to review contracting mechanism, process and approach and to improve process and controls of entering and monitoring commissioned contracts within resources available.
2. CHC clinical and operational expertise required to enhance capacity and review the process and pathways underpinning CHC and FNC and support the development of sustainable solutions.

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3. External planning and transformation capacity and expertise to support the health board in developing and delivering an integrated plan for 2025/26, including effective stakeholder engagement, identification of rapid turnaround actions to support delivery of target control total, and support the longer-term through development of a clear route map to balance, including a focus on opportunities to strengthen planning capability.
4. Audit expertise - Additional internal audit days required to review the controls and processes within key risk areas that have not been recently reviewed and in key areas such as workforce (e.g. bank and agency)

Amber

1. Pharmacy expertise to assist the health board to assess drivers of growth, mitigate growth through opportunities and review prescribing behaviours.
2. Workforce planning expertise and capacity to establish workforce solutions and strategy to reduce the demand for agency in a rural area and support longer-term sustainability.
3. Operational HR expertise to strengthen capacity and support the establishment and implementation of robust engagement and appointment controls.

Red

1. Board and committee partnering expertise - External party / consultant support to lead a Board self-assessment, assessment of committee, governance and control effectiveness and change process.
2. Finance function and business partnering expertise providing an external review of the strategy, capacity, roles and delivery of the finance function to include support for identification and implementation of a change process.
3. WViHC expertise providing engagement and input to local team.
4. Communication expertise - support on establishing best practice for engagement and communication within and externally to the health board.

Patterson, Liz
20/05/2025 15:22:19

Powys THB Finance Department

Financial Performance Report – Month 1 Summary

Board

Period 01 (April 2025)
FY 2025/26

Date Meeting: 21 May 2025

Patterson, Liz
20/05/2025 15:22:19

Introduction

Subject:	FINANCIAL PERFORMANCE REPORT FOR MONTH 01 OF FY 2025/26
Approved & Presented by:	Pete Hopgood, Executive Director of Finance, Estates & Support Services
Prepared by:	Deputy Director of Finance
Other Committees and meetings considered at:	Executive Committee – 14 May 2025
PURPOSE:	
This paper provides an update on the March (Month 12) Financial Position for 2025/26.	
RECOMMENDATION:	
The Board is asked to: RECEIVE the financial report and take ASSURANCE that the organisation has effective financial monitoring and reporting mechanisms in place.	

Patterson, Liz
20/05/2025 15:22:19

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

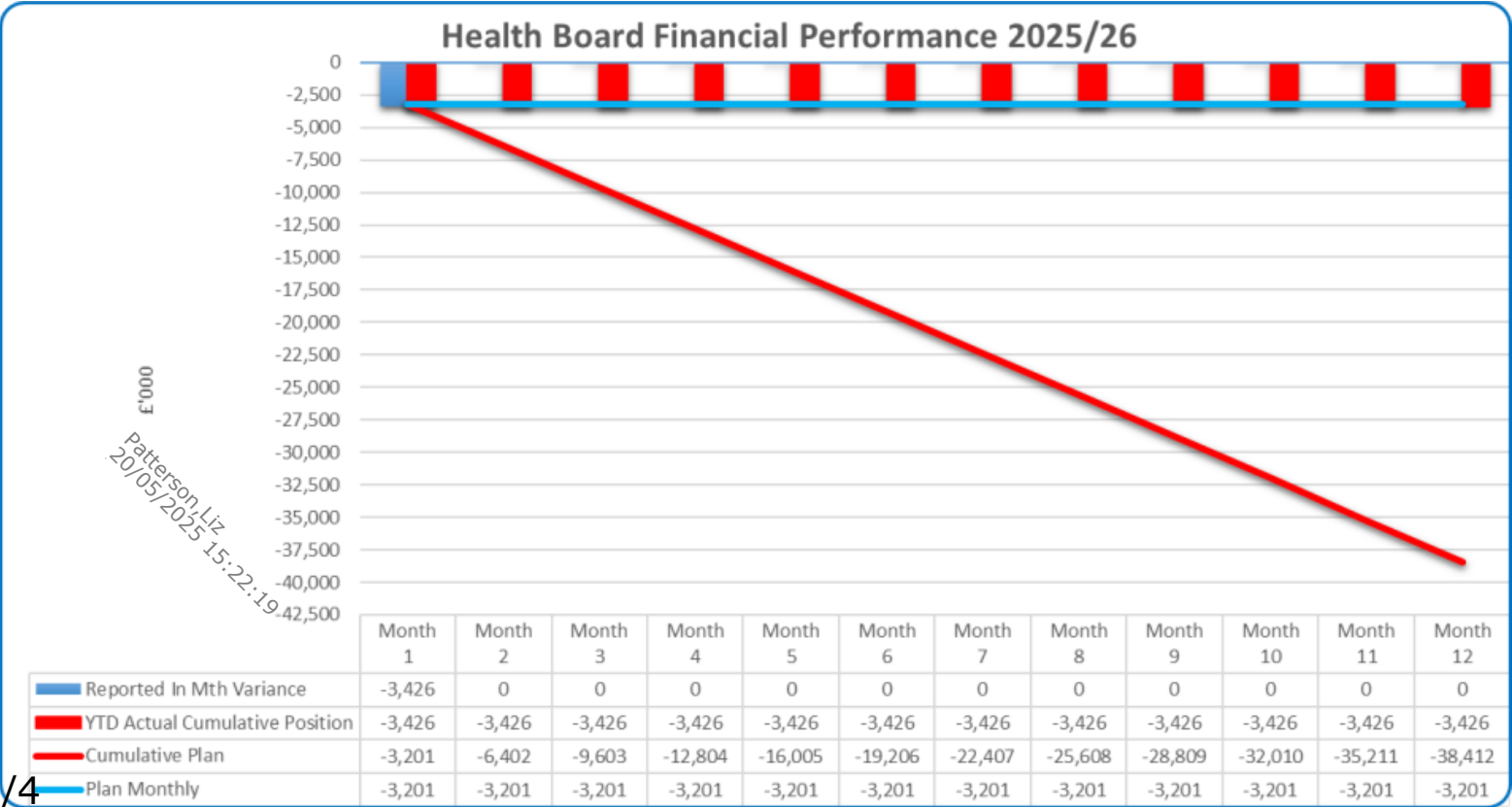
Approval/Assurance/Decision	Discussion	Information
2/4 ✓	✓	435/819

Revenue			
Financial KPIs : To ensure that net operating costs do not exceed the revenue resource limit set by WG	Plan £'000	Actual £'000	Trend
Reported in-month financial position – (deficit)/surplus	-3,201	-3,426	↓
Reported Year To Date financial position – (deficit)/surplus	-3,201	-3,426	↓
Year end – (deficit)/surplus	-38,412	-38,412	↓

The 2025/26 Annual Plan submitted to Welsh Government in March was for a £38.4m deficit with an ambition for further actions to reduce the deficit to £16.0m in line with financial performance in 2024/25.

At month 01, there is a £3.426m overspend against the planned year to date deficit of £3.201m giving the Health Board an operational overspend of £0.225m.

The capital resource limit for 2025/26 is currently £5.941m. Capital expenditure will be reported from month 2 onwards.



Overall Summary of Variances £'000s

Table B Categories	Budget YTD	Actual YTD	Operational Variance YTD
01 - Revenue Resource Limit	(36,384)	(36,384)	0
02 - Capital Donations	(11)	(11)	0
03 - Other Income	(660)	(734)	(74)
Total Income	(37,054)	(37,129)	(74)
05 - Primary Care - (excluding Drugs)	4,025	3,961	(64)
06 - Primary care - Drugs & Appliances	2,923	2,923	0
07 - Provided services -Pay	9,836	10,024	187
08 - Provided Services - Non Pay	1,986	2,083	97
09 - Secondary care - Drugs	116	119	3
10 - Healthcare Services - Other NHS Bodies	16,158	16,158	0
12 - Continuing Care and FNC	3,386	3,301	(85)
13 - Other Private & Voluntary Sector	569	731	161
14 - Joint Financing & Other	812	812	(0)
15 - DEL Depreciation etc	430	430	0
16 - AME Depreciation etc	12	12	0
18 - Profit\Loss Disposal of Assets	0	0	0
Total Costs	40,256	40,555	300
Reported Position	3,201	3,426	225

At Month 01 there is a £3.426m overspend against the planned deficit of £3.201m giving the Health Board an operational overspend of £0.225m.

The financial reporting is limited at month 1, due to the timing lag on receiving supporting information connected with the Commissioning of Healthcare Services from other NHS Bodies, Prescribing and Primary Care activity.

The £0.210m net variance across provider services (pay, non-pay and income) is due to underachievement of savings at the beginning of the year / agency and locum use.

Other private and voluntary sector is overspent due to the cost and number of acute mental health placements with private providers.



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Addysgu Powys
Powys Teaching
Health Board

Agenda item: 4.3

BOARD		21 May 2025	
Subject:	Powys Teaching Health Board Integrated Quality & Performance Report Scorecard – Month 12 (March 2025)		
Presented by:	Nicola Johnson, Executive Director of Planning, Performance and Commissioning		
Approved by:	Executive Director of Planning, Performance and Commissioning Assistant Director of Performance and Commissioning		
Prepared by:	Head of Performance Administrative Officer, Integrated Performance		
Other Committees and meetings considered at:	Executive Committee – 14 May 2025 who supported the paper to the Board.		
PURPOSE:			
This Integrated Quality & Performance Report (IQPR) provides an update on the latest available performance position for Powys Teaching Health Board against the NHS Wales Performance Framework 2024/25 containing information up until the end of March 2025 (month 12).			
RECOMMENDATION(S):			
The Board is asked to:			
• DISCUSS the content of this report; and • TAKE ASSURANCE that the Health Board has appropriate systems in place to monitor performance and respond to relevant issues.			
Approve/Take Assurance		Discuss	Note
Y		Y	Y

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:		
1. Focus on Wellbeing	Y	Use this space to provide a brief narrative explanation of alignment with the health board's wellbeing objectives including reference to our strategic priorities. This can include reference to the Board Assurance Framework.
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	

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SUMMARY:

This report provides The Board with the latest performance information to highlight performance achievements and challenges. This is provided as an exception and escalation version for month 12 2024/25 with narrative only included for those measures that are internally escalated to level 3 for performance or are unable to meet their National target or Powys Health Board trajectory target for ministerial priorities.

Summary for Month 12

Provider services

Planned care:

- Diagnostic waits reported 79 breaches in March, performance has remained the same as February. Most breaches involve echocardiograms (69 pathways), endoscopy (4 pathways), and non-obstetric ultrasound (6 pathways).

The health board is not achieving its ministerial priority trajectory although complexity around clinical practice change has increased echo cardiogram demand significantly. An operational review of capacity is being undertaken with additional clinics being undertaken in PTHB Community Cardiology service. A full evaluation of the service is to be undertaken to inform future for the service coverage to be expanded to mid and south Powys.

- Referral to treatment (RTT) compliance remains positive :
 - 104-week waits: 0 pathways – **End of year ministerial priority achieved.**
 - 52-week outpatient waits: 0 pathways - **End of year ministerial priority achieved.**
 - 52-week treatment waits: achieved target with improved performance reporting 6 breaches in March compared to 9 in February
- Therapies waits remain robust with no patient pathways waiting longer than 14 weeks.
- Provider cancer pathway performance for outpatients and diagnostics remains robust with key diagnostics (endoscopy) being carried out within target. In March service demand increased with 58 new single cancer pathways reported. Downgrades within 28 days performance has improved to 60.6% but remains challenged by numerous factors including acute centre diagnostics and reporting delays.

- Overall performance broadly continues to improve aligned to national requirements and ministerial priorities. Challenges remain with in-reach capacity fragility, and complex diagnostic delays affecting specialties including Ophthalmology, ENT, and Orthopaedics. Insourced capacity remains in place to boost activity especially for the key urgent and urgent suspected cancer pathways through quarter 4 and into 2025/26.

Mental Health:

- Under-18s: Compliance achieved in March for assessments, interventions, and care treatment plans (CTP).
- For Adults:
 - Assessments: Performance shows an increasing trend since August now reporting 98.0% against the target of 80%. This measure has now achieved the planned recovery trajectory and has been de-escalated. It is expected that with the recent recruitment of 3 whole time equivalent mental health practitioners and agency mental health practitioner's performance improvement will be sustained.
 - Interventions: Although the overall performance has improved, there has been a slight decline in performance in March at 93.7% compared to 96.2% in February. This remains significantly above the target of 80%.
 - CTP compliance: Performance has not achieved target or trajectory since July 2024 and has fallen slightly in March to 81.9%. Performance has been impacted by sickness absence especially in North Powys and ongoing challenges with social services capacity to undertake office duties. Since the month 11 IQPR validation and resubmission has been undertaken for 2024/25 financial year, it should be noted that data continues to be retrospectively updated back to April 2024 due to caseload validation with system updates altering the percentage compliance. Following the completion of Care and Treatment Plan audit an action plan has been developed with initiation of training response in Q1 2025/26. Further actions include focussed work and system improvements which include Outpatient Clinics revised to accommodate CTP reviews and compliance data with out-of-date reviews now added as standard Multi-Disciplinary Team (MDT) agenda item. Performance is expected to report an improvement to circa 90% by the end of April 2025.

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- Psychological therapy waiting times did not meet target with a reported performance of 71.3% in March (target: 80%). Performance has been impacted by fixed term staff contracts finishing in Q4 2024/25, a recruitment freeze and ongoing long-standing challenges. Development and implementation of focused waiting list recovery plan include a review of allocation process, job plans, demand & capacity work, caseload management and review of service core offer. The service remain confident that these key actions will result in an improved position predicted close to or at target by the end Q1 2025/26.

Neurodevelopmental Services:

- There has been a slight improvement in performance against the nationally reported measure (26 week wait to assessment) reported in March (29.9% compliance).
- Backlog and internal waits addressed, and patients will be taken from referral to assessment waiting list from March 2025.
- No patients waited over 104 weeks on the referral to assessment list at the end of March 2025.
- Internal Executive oversight (Level 3) remains in place.
- Activity levels in Q4 higher than planned with long waiting patients seen.

Emergency Care:

- Powys provider Minor Injuries Units (MIU) services performed very well, meeting the 4-hour target (100% compliance) and reporting median waits of 4 minutes for triage and 5 minutes for senior clinician assessment. This will be kept under review as the temporary service changes progress through the evaluation and monitoring reporting.

Commissioned services

Planned care:

- In Wales long waits remain at the end of 2024/25 but there has been significant improvement for Powys residents. Hywel Dda University Health Board (UHB) & Swansea Bay UHB reported no Powys resident pathways waited over 2 years (104 weeks) for treatment at the end of March 2025, and all providers have reported their numbers falling as compliance improves. The picture is the same for those Powys resident pathways waiting over 52 weeks for a new outpatient appointment, again both Hywel Dda and Swansea Bay are compliant against this measure with zero pathways over 52 weeks at the end of March.

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- For English providers, the February position is more mixed, Wye Valley NHS Trust have improved waiting time compliance with only 5 PTHB responsible pathways waiting over 76 weeks, whilst Shrewsbury and Telford NHS Trust (SaTH) although reporting zero PTHB responsible pathways over 104 weeks is reporting special cause concern e.g., a growing total volume of pathways for each lower wait band (capacity is not meeting demand pressures). Finally, as a commissioned provider, Robert Jones and Agnes Hunt reported 39 PTHB responsible pathways waiting over 104 weeks in February.

Cancer Pathways:

- Cancer treatment pathways for Powys responsible patients have not met the 75% target throughout 2024/25 with March reporting 59% compliance for the 62-day SCP pathway. For those patients who attended English commissioned services the compliance equity was varied, for example Wye Valley NHS Trust broadly reported compliance higher than the English average and consistently outperformed SaTH whose performance often did not meet or exceed the English average.

Commissioned Emergency Care:

- Welsh Ambulance Service NHS Trust (WAST) 8-minute response times to RED calls remained poor throughout 2024/25 and did not achieve the target in any given month. March performance fell to a reported 47.0% with median emergency response times also increasing to 1hr and 17 minutes.
- No commissioned service meets the required national 4 or 12hr targets for their A&E departments. However Welsh emergency department performance for Powys residents is better than the English counterparts, though significant delays persist, especially in ambulance handovers. It should be noted that The Shrewsbury and Telford Hospital NHS Trust (SATH) data has not been available since August-24 following reporting challenges which are due to be resolved in Q1 2025/26.

Month 12 measures by escalation level

There are a total of 50 reportable measures, with 4 reported at level 3 as follows:

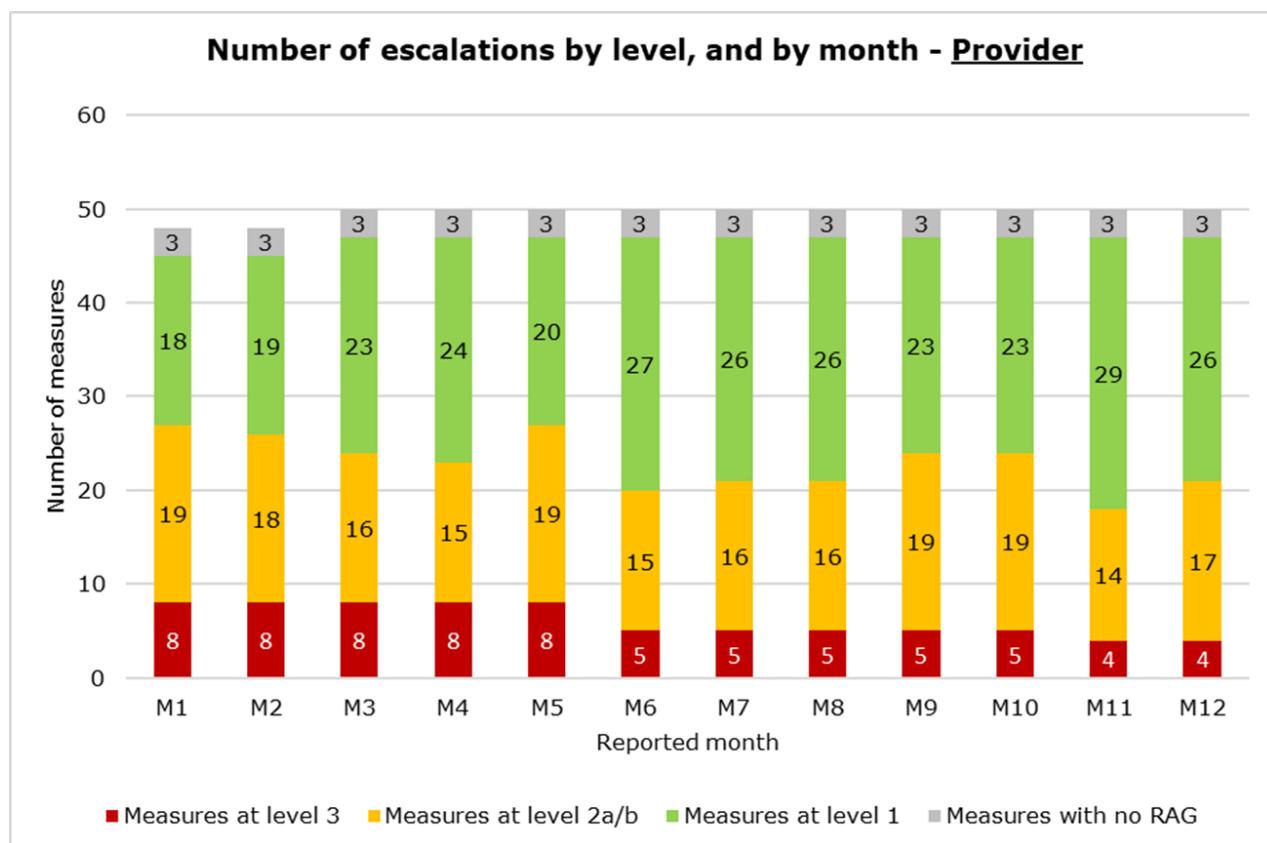
- Percentage of patients offered an index colonoscopy procedure within 4 weeks of booking their Specialist Screening Practitioner assessment appointment.
- Number of patients waiting more than 8 weeks for a specified diagnostic.
- Number of patients waiting for a follow-up (FUP) outpatient appointment who are delayed by over 100% due to data quality issues.

- Percentage of children and young people waiting less than 26 weeks to start an ADHD or ASD neurodevelopment assessment.

A further 17 measures are rated at level 2a, and 29 are achieving level 1 compliance e.g., no issues reported. To note, measure 1 "Percentage of adult smokers who make a quit attempt via smoking cessation services" is rated as level 1, although not compliant in Q3 and remains on track for meeting respective end of year performance target (cumulative annual target).

A further 3 health care acquired infections (HCAI) measures are currently non-rated with ongoing discussions between the Nursing Directorate and Welsh Government on integration into the national targets.

The following provides the relative performance of the Health Board against the NHS Performance Framework that is applicable to the provider e.g., no commissioned or local measures are accounted for even if they are listed within the below exception/escalation reports or other areas of the IQPR.



Key performance indicators 2024/25 (Health Board submitted trajectories)

For the March 2025 snapshot the Health Board reports compliance on 5 of 6 Powys applicable submitted key performance indicator trajectories. The measures unable to meet trajectory are:

- Patients waiting over 8 weeks for a diagnostic, the trajectory of zero not being achieved, with 79 pathway breaches reported.

Please note that for the below tables scoring is colour and icon coded dependant on compliance of trajectory and national target:

- Value cell shading is red/green and denotes compliance to health board submitted trajectory as a key performance indicator.
- Value cell icon either green tick  or red cross  denotes compliance against the NHS Performance Framework target (mental health improvement trajectory targets match the NHS performance targets bar two with slight variation as noted in table).

Ministerial Priority Measures			Baseline	Month												
Measure	NHS Performance Target	KPI Improvement Target			Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Number of patients waiting more than 52 weeks for a new outpatient appointment	Zero	40% reduction by end of September 2024 Zero by March 2025	0	Performance trajectory	55	65	55	45	20	8	5	0	0	0	0	0
				Actual	0	0	0	1	1	0	0	0	0	0	0	0
Number of patients waiting more than 104 weeks for referral to treatment	Zero	Zero end of December 2024	1	Performance trajectory	0	0	0	0	0	0	0	0	0	0	0	0
				Actual	0	1	2	3	3	0	0	0	0	0	0	0
Number of patients waiting over 8 weeks for a specified diagnostic	Zero	95% to be zero by December 2024	116	Performance trajectory	230	200	150	75	30	0	0	0	0	0	0	0
				Actual	140	171	157	155	140	124	107	83	84	70	79	79
Number of patients who spend 12 hours or more in all major and minor emergency care facilities from arrival until admission, transfer or discharge	Zero	20% reduction by September 2024 Further 20% reduction by March 2025	0	Performance trajectory	0	0	0	0	0	0	0	0	0	0	0	0
				Actual	0	0	0	0	0	0	0	0	0	0	0	0
Percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS for people age under 18 years	80%	80% by December 2024	97.7%	Performance trajectory	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%
				Actual	80.0%	86.5%	83.7%	93.1%	90.0%	87.5%	92.1%	89.2%	92.9%	86.7%	91.2%	91.7%
Percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS for adults age 18 years and over	80%	80% by December 2024	91.1%	Performance trajectory	85.6%	85.6%	85.6%	85.6%	85.6%	85.6%	85.6%	85.6%	85.6%	85.6%	85.6%	85.6%
				Actual	95.2%	95.3%	93.0%	95.10%	87.50%	91.7%	92.3%	98.3%	95.6%	79.0%	96.2%	93.7%

Of the key mental health improvement trajectories submitted by the health board, 6 of the 9 performance orientated measures have achieved the health board trajectory in February. Non-compliant to trajectory/target measures include:

- Percentage of children and young people waiting less than 26 weeks to start an ADHD or ASD neurodevelopment assessment. The measure reported and slightly improved 29.9% (Mar-25) against a target of 80% and the health board set trajectory of 45% for the same period.
- Percentage of health board residents in receipt of secondary mental health services who have a valid care and treatment plan for adults 18 years and over. Performance fell slightly but did not meet the 90% national target and health board set trajectory for March. It should also be noted that retrospective validation and resubmission has contributed to minor adjustments of the reported performance back to April 2024.
- Percentage of patients waiting less than 26 weeks to start a psychological therapy in Specialist Adult Mental Health. Again, measure performance improved but does not meet the 80% national target or 95% health board set trajectory.

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Age Group	Policy Lead Priority Measures			Month											
	Measure	Target		Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Under 18s	Mental Health Measure Part 1a - % of mental health assessments undertaken within (up to and including) 28 days from the date of receipt of referral	80%	Performance trajectory	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%
			Actual	98.0%	98.1%	100.0%	94.6%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	Mental Health Measure Part 1b - % of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS	80% by December 2024 (80% monthly is NHS Performance Framework Target)	Performance trajectory	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%
			Actual	80.0%	86.5%	83.7%	93.1%	90.0%	87.5%	92.1%	89.2%	92.9%	86.7%	91.2%	91.7%
	Mental Health Measure Part 2 - % of health board residents in receipt of secondary mental health services who have a valid care and treatment plan	90%	Performance trajectory	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%
			Actual	94.1%	93.9%	90.8%	91.0%	93.6%	94.9%	94.9%	97.8%	94.8%	96.3%	95.7%	97.4%
	Neurodevelopmental - % of children and young people waiting less than 26 weeks to start an ADHS or ASD neurodevelopment assessment	80%	Performance trajectory	45.0%	45.0%	45.0%	45.0%	45.0%	45.0%	45.0%	45.0%	45.0%	45.0%	45.0%	45.0%
			Actual	45.4%	45.8%	39.6%	42.0%	37.2%	34.3%	30.9%	30.5%	27.3%	24.4%	25.9%	29.9%
	SCAMHS - % of patients waiting less than 28 days for a first appointment for sCAMHS	80%	Performance trajectory	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%
			Actual	98.0%	92.7%	93.8%	100.0%	100.0%	100.0%	100.0%	100.0%	97.1%	100.0%	100.0%	100.0%
18 years and over	Mental Health Measure Part 1a - % of mental health assessments undertaken within (up to and including) 28 days from the date of receipt of referral	80%	Performance trajectory	70.0%	70.0%	70.0%	75.0%	75.0%	75.0%	75.0%	75.0%	80.0%	80.0%	80.0%	80.0%
			Actual	44.1%	54.1%	69.2%	74.0%	45.3%	46.7%	58.7%	71.4%	78.7%	58.0%	85.5%	98.0%
	Mental Health Measure Part 1b - % of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS	80% by December 2024 (80% monthly is NHS Performance Framework Target)	Performance trajectory	86%	86%	86%	86%	86%	86%	86%	86%	86%	86%	86%	86%
			Actual	95.2%	95.3%	93.0%	95.1%	87.5%	91.7%	92.3%	98.3%	95.6%	79.0%	96.2%	93.7%
	Mental Health Measure Part 2 - % of health board residents in receipt of secondary mental health services who have a valid care and treatment plan	90%	Performance trajectory	80%	83%	86%	88%	90%	90%	90%	90%	90%	90%	90%	90%
			Actual	89.5%	89.6%	90.5%	90.7%	89.7%	89.0%	89.9%	86.3%	81.7%	82.1%	82.5%	81.9%
	Psychological Therapies - % of patients waiting less than 26 weeks to start a psychological therapy in Specialist Adult Mental Health	80%	Performance trajectory	80.0%	83.0%	85.0%	88.0%	90.0%	93.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%
			Actual	75.1%	69.4%	75.2%	76.9%	78.7%	79.9%	72.9%	67.0%	63.1%	66.4%	68.2%	71.3%

NEXT STEPS:

- 2025/26 Performance Framework is now available with IQPR reporting format and local measures to be reviewed and update prior to the 2025/26 framework reporting.
- Enabling Actions for 2025/26 released April 2025 – metric reporting to be confirmed by Welsh Government Performance, the schedule has been revised, and an update will be provided before June 2025.

IMPACT ASSESSMENT - NOT REQUIRED FOR THIS REPORT

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Powys Teaching Health Board

Integrated Quality & Performance Report

Month 12

Updated on 15/05/2025

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Delivery Area	Report section
	Introduction
	Executive Summary
Provider National Focus (NHS Performance Framework)	Level 3 Performance Challenges
	Level 2a/2b Performance Challenges
	Level 1 Achievements
	Quadruple Aim 1
	Quadruple Aim 2
	Quadruple Aim 3
	Quadruple Aim 4
Provider/Commissioned service assurance	Provider Cancer & Quality & Safety
	Planned & Emergency Care Inc. Cancer
	Key health board trajectories

Background of the IQPR

What is the Integrated Quality & Performance Report (IQPR)

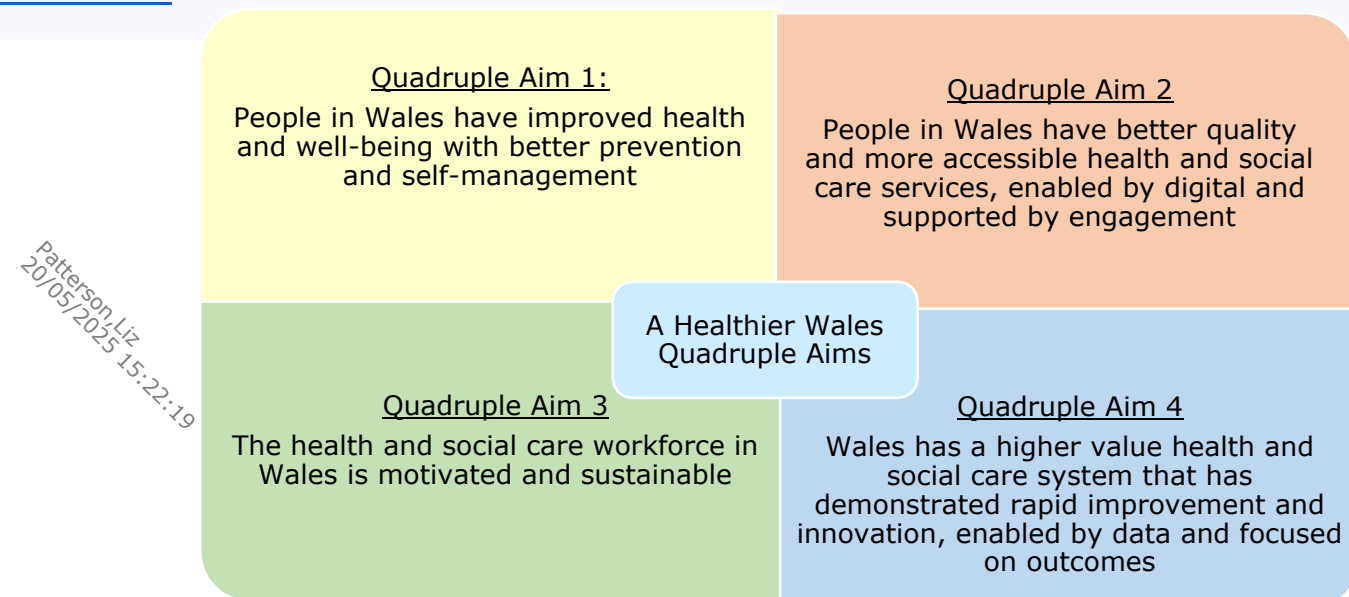
This report is a key part of the health boards Integrated Quality and Performance Framework (IQPF) designed to drive improvement in health board performance and health outcomes for those patients that Powys is responsible for.

The IQPR uses key NHS Performance Framework measures updated for 2024/25 which include Ministerial priorities and other timely local measures to provide robust assessment of the health boards performance as both a provider and commissioner of care focusing on key challenge and success.

This process utilises both quantitative and qualitative measurements which are backed by statistical process, business rules, and narrative provided by leads of the service area. The IQPR will continue to be developed with further inclusion of key measures.

What is the NHS Performance Framework?

The NHS Performance Framework is a key measurement tool for “A Healthier Wales” outcomes, The NHS Wales Quadruple Aim Outcomes are a set of four interconnected goals or aims that aim to guide and improve healthcare services in Wales. These aims were developed to enhance the quality of care, patient experience, and staff well-being within the National Health Service (NHS) in Wales. Link to the [NHS Wales performance framework 2024 to 2025 | GOV.WALES](https://gov.wales/nhs-wales-performance-framework-2024-to-2025)



What is the Integrated Quality and Performance Framework (IQPF) in Powys?

The Integrated Quality & Performance Framework (IQPF) aims to report holistically at service, directorate or organisation level the performance of the resources deployed, and the outcomes being delivered. Overall performance assessed via intelligence gathered across key domains including activity, finance, workforce, quality, safety, outcomes and performance indicators.

The IQPF is a revision of the 2023/24 Integrated Performance Framework with a greater focus on quality, it remains undergoing phased implementation across the health board.

Key for the framework is the system review, reporting, escalation and assurance process that aligns especially to the NHS Performance measures and any priority trajectories. In the provider Integrated Quality & Performance Group meetings will address key challenges and provide a robust forum for support and escalation to Executive leads and provide actions and recovery trajectories for escalated metrics.

As part of the operationalisation of the IQPF there is an expected element of exception or escalation either in a clinical or corporate service area triggering cause for concern. In such circumstances the Clinical Service Area or corporate team may be put into an escalation arrangement. Escalation will be considered against 4 domains (Access & Activity; Finance & Value; Quality; Workforce & Culture) and 3 levels of escalation. The levels of the framework, triggers and escalation response are set out below.

1. Level 1 : Normal e.g., earned autonomy meeting key objectives
2. Level 2a : Failure to achieve / maintain delivery
3. Level 2b : Specific for financial overspend by more than £0.5m per year
4. Level 3 : Serious concerns on quality, governance, ongoing failure to achieve key priority metrics.
5. De-escalation : Challenge rectified, requirement change, or senior committee decision.

[Link to escalation descriptor slide](#)

PTHB Integrated Quality & Performance Framework Escalation Framework 2024/25

Please note that this framework replaces the 23/24 business reporting rules as used within the Integrated Performance Framework and report.



Escalation level	Trigger	Action expected	Monitoring and support
Level 1 (No concerns)	- Local delivery of agreed objectives and performance, finance ambitions in line with agreed trajectories. - No exceptions or quality concerns. - Sound governance arrangements in place. - Performance within expected targets either national or local	- No escalation action. - Could result in frequency adjustment for some monitoring mechanisms and meetings including IQPG.	Main monitoring through base performance review process. Key measures bi-annually in IQPR to the Board.
Level 2a (Exception)	- Failure to achieve / maintain delivery in more than 1 key deliverable / area of performance. - Sustained deterioration on 1 or more domain. This can include: - Failure to deliver on an NHS Performance Framework target or local target trajectory. - A deviation or departure from the normal or expected course of action signifying specific condition or event that requires attention or further action to address the deviation. - Failure of quality standard. - Where SPC methodology notes variance of concern.	- Correspondence to Clinical service area/corporate dept on reasons for escalation – areas of concern, expected response and confirm any enhanced monitoring. - Recovery plan to be developed that address issues to be recovered/improved. - Depending on issue – change in frequency of and focus of standard meeting and consideration of increasing frequency including IQPG. - Reported through to Executive Committee. - Monthly reporting where appropriate via IQPR as an exception to performance.	Options include: - IQPG engagement monthly with Executive - Internal support as required (QI/vbhc/planning – issue dependent). - Consideration of compliance with Professional clinical codes and standards and proportionate response. - Consideration of compliance with managerial code of practice. - Internal peer review. - Executive support (directly or from other teams). - Consider need for bespoke response. - Minimum monthly updates to Executive Committee.
Level 2b (Exception)	Specially for finance: Where Corporate Directorate or Clinical Service Area level budget is overspending by more than £0.5m Year to date or £1m forecast.	Identified through monthly financial reporting	CEO to call a special 'Budget Review Meeting' of all Executive Directors and the Divisional or Directorate budget holder (up to 3 team members may attend in support). Agreed action plan established: - Monitored through financial reporting arrangements. - Review period established if plan failing.
Level 3 (Escalation)	- Serious concerns on quality and governance. - Continued and consistent failure to meet agreed performance improvements and trajectories across a number of objectives. - Clear articulation of reasons for escalation and criteria for escalation. This can include: - Where a performance matter (exception) does not meet target and hits criteria for higher level of resolution, decision making or further action. - Any measure that continues to fail a health board submitted trajectory as part of the Ministerial Priority measures. - Performance recovery is failing to improve or maintain performance. - Any significant failure of quality standard. - Where IQPG deems that a service or measured outcome requires escalation resulting from identified challenge or significant concern.	- Correspondence to service area/corporate dept on reasons for escalation – areas of concern, expected response and confirm any enhanced monitoring. - Service Area or corporate directorate demonstrating recognition of issues and commitment to improve. - Improvement/recovery plan required to address issues identified. - Reported through to executive and relevant committee. - Escalated frequency of IQPG meetings and resultant remedial action plan completion. - Challenge review on appropriate shift to the Escalations Oversight Group (EOG). - Monthly reporting where appropriate via IQPR as an exception to performance.	Actions could include: - Escalation Oversight Group (EOG) - Independent review of service/corporate department effectiveness. - Deployment of appropriate HR policies e.g. Capability policy. - Weekly/fortnightly meetings with CEO and/or relevant execs to track progress against improvement actions (which directly related to de-escalation criteria). - Consideration of compliance with Professional clinical codes and standards and proportionate response. - Consideration of compliance with managerial code of practice. - Suspension or revision of service provision. De-escalation: The appropriate outcome for a challenge to be de-escalated. Either challenge has been rectified, requirement has changed, or via senior committee decision. A level 3 escalation may return to any previous lower level of escalation dependant on the remaining challenge and required monitoring.

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Summary of Performance Provider – Month 12

Provider

Planned care:

- Diagnostic waits reported 79 breaches in March, performance has remained the same as February. Most breaches involve echocardiograms (69 pathways), endoscopy (4 pathways), and non-obstetric ultrasound (6 pathways). The health board is not achieving its ministerial priority trajectory although complexity around clinical practice change has increased echo cardiogram demand significantly. An operational review of capacity is being undertaken with additional clinics being undertaken in PTHB Community Cardiology service. A full evaluation of the service is to be undertaken to inform future for the service coverage to be expanded to mid and south Powys.
- Referral to treatment (RTT) compliance remains positive :
 - 104-week waits: 0 pathways – **End of year ministerial priority achieved.**
 - 52-week outpatient waits: 0 pathways - **End of year ministerial priority achieved.**
 - 52-week treatment waits: achieved target with improved performance reporting 6 breaches in March compared to 9 in February
- Therapies waits remain robust with no patient pathways waiting longer than 14 weeks.
- Provider cancer pathway performance for outpatients and diagnostics remains robust with key diagnostics (endoscopy) being carried out within target. In March service demand increased with 58 new single cancer pathways reported. Downgrades within 28 days performance has improved to 60.6% but remains challenged by numerous factors including acute centre diagnostics and reporting delays.
- Overall performance broadly continues to improve aligned to national requirements and ministerial priorities. Challenges remain with in-reach capacity fragility, and complex diagnostic delays affecting specialties including Ophthalmology, ENT, and Orthopaedics. Insourced capacity remains in place to boost activity especially for the key urgent and urgent suspected cancer pathways through quarter 4 and into 2025/26.

Mental Health:

- Under-18s: Compliance achieved in March for assessments, interventions, and care treatment plans (CTP).
- For Adults:
 - Assessments: Performance shows an increasing trend since August now reporting 98.0% against the target of 80%. This measure has now achieved the planned recovery trajectory and has been de-escalated. It is expected that with the recent recruitment of 3 whole time equivalent mental health practitioners and agency mental health practitioner's performance improvement will be sustained.
 - Interventions: Although the overall performance has improved, there has been a slight decline in performance in March at 93.7% compared to 96.2% in February. This remains significantly above the target of 80%.
 - CTP compliance: Performance has not achieved target or trajectory since July 2024 and has fallen slightly in March to 81.9%. Performance has been impacted by sickness absence especially in North Powys and ongoing challenges with social services capacity to undertake office duties. Since the month 11 IQPR validation and resubmission has been undertaken for 2024/25 financial year, it should be noted that data continues to be retrospectively updated back to April 2024 due to caseload validation with system updates altering the percentage compliance. Following the completion of Care and Treatment Plan audit an action plan has been developed with initiation of training response in Q1 2025/26. Further actions include focussed work and system improvements which include Outpatient Clinics revised to accommodate CTP reviews and compliance data with out-of-date reviews now added as standard Multi-Disciplinary Team (MDT) agenda item. Performance is expected to report an improvement to circa 90% by the end of April 2025.
 - Psychological therapy waiting times did not meet target with a reported performance of 71.3% in March (target: 80%). Performance has been impacted by fixed term staff contracts finishing in Q4 2024/25, a recruitment freeze and ongoing long-standing challenges. Development and implementation of focused waiting list recovery plan include a review of allocation process, job plans, demand & capacity work, caseload management and review of service core offer. The service remain confident that these key actions will result in an improved position predicted close to or at target by the end Q1 2025/26.

Neurodevelopmental Services:

- There has been a slight improvement in performance against the nationally reported measure (26 week wait to assessment) reported in March (29.9% compliance).
- Backlog and internal waits addressed, and patients will be taken from referral to assessment waiting list from March 2025.
- No patients waited over 104 weeks on the referral to assessment list at the end of March 2025.
- Internal Executive oversight (Level 3) remains in place.
- Activity levels in Q4 higher than planned with long waiting patients seen.

Emergency Care:

- Powys provider Minor Injuries Units (MIU) services performed very well, meeting the 4-hour target (100% compliance) and reporting median waits of 4 minutes for triage and 5 minutes for senior clinician assessment. This will be kept under review as the temporary service changes progress through the evaluation and monitoring reporting.

Commissioned services

Planned care:

- In Wales long waits remain at the end of 2024/25 but there has been significant improvement for Powys residents. Hywel Dda University Health Board (UHB) & Swansea Bay UHB reported no Powys resident pathways waited over 2 years (104 weeks) for treatment at the end of March 2025, and all providers have reported their numbers falling as compliance improves. The picture is the same for those Powys resident pathways waiting over 52 weeks for a new outpatient appointment, again both Hywel Dda and Swansea Bay are compliant against this measure with zero pathways over 52 weeks at the end of March.
- For English providers, the February position is more mixed, Wye Valley NHS Trust have improved waiting time compliance with only 5 PTHB responsible pathways waiting over 76 weeks, whilst Shrewsbury and Telford NHS Trust (SaTH) although reporting zero PTHB responsible pathways over 104 weeks is reporting special cause concern e.g., a growing total volume of pathways for each lower wait band (capacity is not meeting demand pressures). Finally, as a commissioned provider, Robert Jones and Agnes Hunt reported 39 PTHB responsible pathways waiting over 104 weeks in February.

Cancer Pathways:

- Cancer treatment pathways for Powys responsible patients have not met the 75% target through out 2024/25 with March reporting 59% compliance for the 62-day SCP pathway. For those patients who attended English commissioned services the compliance equity was varied, for example Wye Valley NHS Trust broadly reported compliance higher than the English average and consistently outperformed SaTH whose performance often did not meet or exceed the English average.

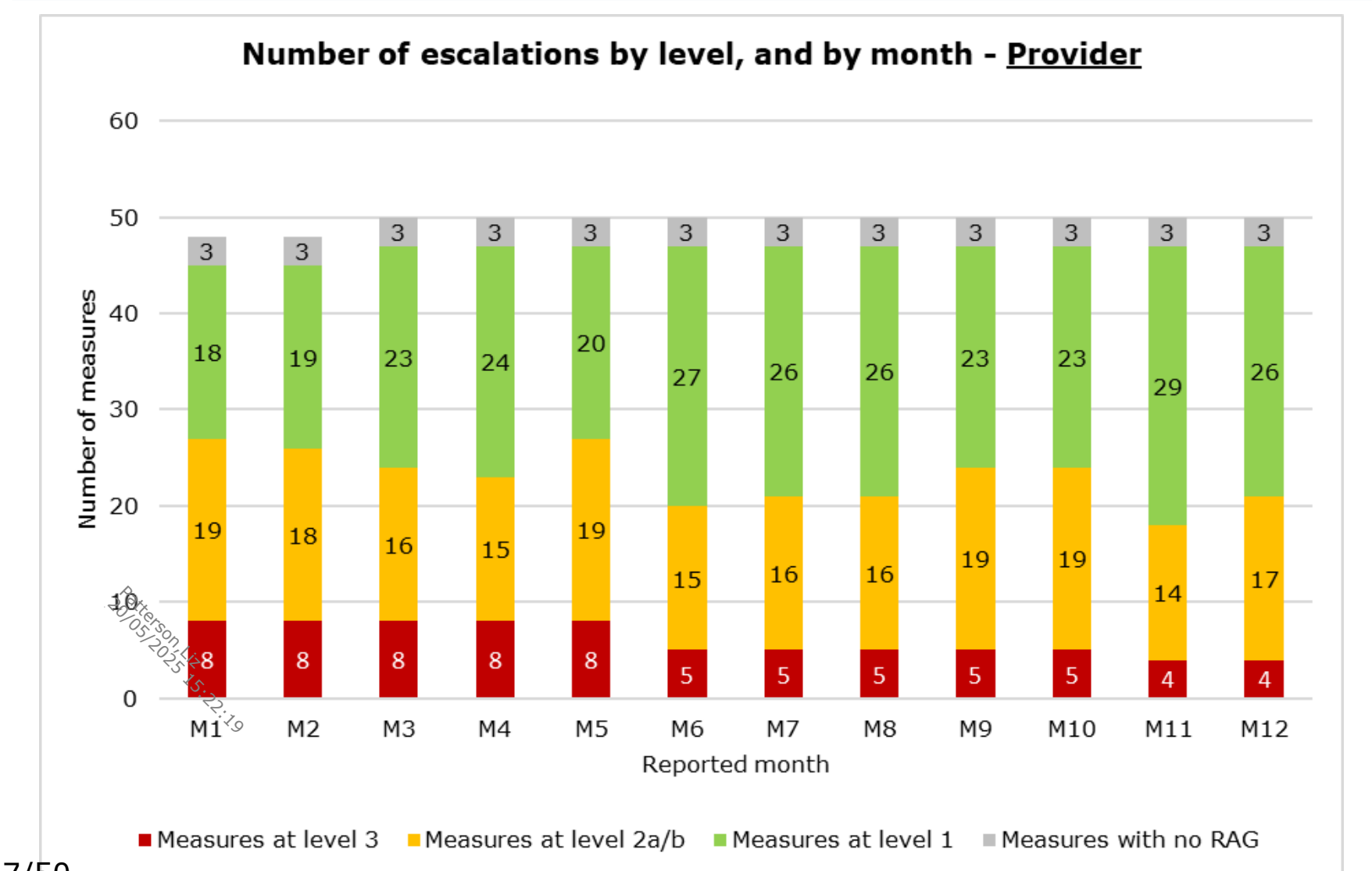
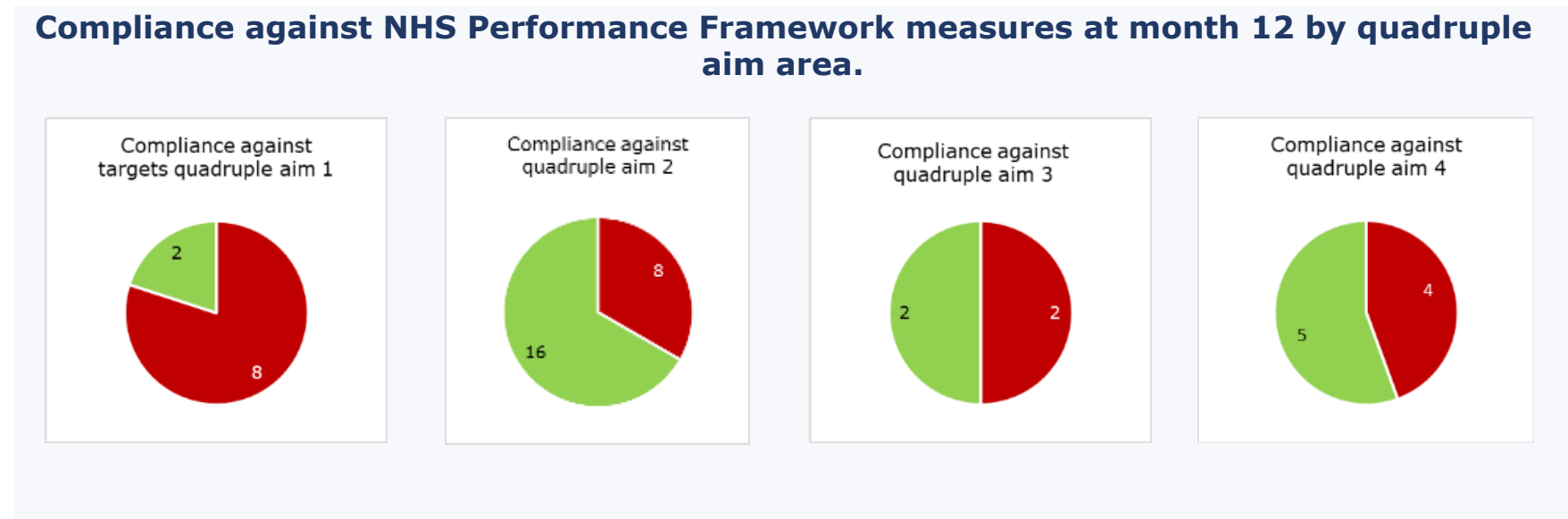
Commissioned Emergency Care:

- Welsh Ambulance Service NHS Trust (WAST) 8-minute response times to RED calls remained poor throughout 2024/25 and did not achieve the target in any given month. March performance fell to a reported 47.0% with median emergency response times also increasing to 1hr and 17 minutes.
- No commissioned service meets the required national 4 or 12hr targets for their A&E departments. However Welsh emergency department performance for Powys residents is better than the English counterparts, though significant delays persist, especially in ambulance handovers. It should be noted that The Shrewsbury and Telford Hospital NHS Trust (SATH) data has not been available since August-24 following reporting challenges which are due to be resolved in Q1 2025/26.

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Visual summary of performance at month 12 (March 2025)

Only measures with a compliance rating e.g., compliant (green), non-compliant (red) are included within the quadruple aims compliance pie charts.
No commissioned metrics are included within graphs below.
No non-RAG rated measures are included.



- 50 quantitative measures as a provider are reportable of the 52 total in the NHS Performance Framework with the inclusion from June of median emergency unit wait times.
- This graph provides the relative performance of the health board against the NHS Performance Framework that is applicable to the provider e.g., no commissioned or local measures are accounted for even if they are listed within the below exception/escalation reports or other areas of the IQPR.
- It should also be noted however that any measure can have its escalation level raised or lowered by senior agreement for example serious concerns can result in a level 3 escalation, even if performance meets national target e.g., the escalation rating can override compliance against national target.
- Measures with no RAG rating are those with either insufficient data to determine compliance e.g. 12-month reduction trends (normally new metrics), and those where PTHB reports but has no national target as a non-acute provider.

Serious concerns on quality and governance or continued and consistent failure to meet agreed performance improvements and trajectories.

No.	Measure description, target, performance and other information								Reason for escalation level	Key Performance Drivers	Key Actions
8	Percentage of patients offered an index colonoscopy procedure within 4 weeks of booking their Specialist Screening Practitioner assessment appointment								Escalated by Powys Performance team for historic and current poor target compliance	- In-reach consultant unavailable during Q1, Q3, Q4 due to unplanned circumstances, backfill provided by in-source provider. - Insource re-procurement process with Shared Services delays. - BSW Nurse capacity re-allocated by Bowel Screening Wales to support regional pressures.	- Agreed joint appointment of band 7 screening practitioner with CTMUHB, this role is now out for recruitment with plans to have staff member in place end of March 2025. - Insource capacity utilised for both screening and symptomatic service. - Performance team engaged with Public Health Wales to check methodology for the provider of this measure, Powys residents have screening colonoscopies carried out in both provider and commissioned services.
	Period	Feb-25	Target	90%	Actual	8.3%	SPC icon				
26	Number of patients waiting more than 8 weeks for a specified diagnostic								This metric has been escalated due to ongoing service pressure and non-compliance against the national target and Powys Teaching Health Board Ministerial priority set performance improvement trajectory.	- Key challenge within Echo-cardiograms because of in-reach fragility of ABUHB. Patients are also now sent straight to test by consultant prior to first outpatient appointment significantly increasing demand. - Endoscopy challenged primarily through in-reach service capacity in South Powys. Increased demand and urgency. - NOUS challenge linked to North Powys in-reach from BCUHB.	Cardiology in-reach service escalated via CQPRM with ABUHB. Operational review of capacity ongoing with additional clinics being undertaken within the PTHB Community Cardiology service. Full evaluation of Community Cardiology Service to be undertaken in March 2025. Expected business case for service to be expanded to mid and south Powys in Q1 2025. Key use of agency to support NOUS.
	Period	Mar-25	Target	0	Actual	79	SPC icon				
31	Number of patients waiting for a follow-up (FUP) outpatient appointment who are delayed by over 100%								FUP pathways recording and reporting was escalated in Q4 2021/22 following service identified significant accuracy challenge in the reporting of pathway time banding. Resulting reporting checks by the Powys Data Intelligence team highlighted a significant quantity of un-reported pathways and local reporting was aligned to the National WPAS team's process. Although accuracy of reporting has improved significantly this measure with remain escalated until suitably resolved with Executive signoff.	- Service pressure and demand to prioritise urgent and cancer pathways reducing FUP capacity. - Ongoing data quality and validation challenges including patient administration system problems which are being resolved working with national team.	- SOS & PIFU reporting has now been resolved with the National Digital Team, improved local reporting identified and commenced to support national work stream. - New action plan including standard operating procedure for validation, new validation report and work with services to meet escalation recommendations Q1 2025/26.
	Period	Mar-25	Target	< same month pre. year	Actual	1318	SPC icon				
34	Percentage of children and young people waiting less than 26 weeks to start an ADHD or ASD neurodevelopment assessment								- Escalation triggered following poor and ongoing service performance challenges including pathway delays, demand pressures, and service processes. - Health board concerns required Executive led internal escalation oversight group (EOG).	- From April 2022 the ND service has been in receipt of non-recurrent funding via the Regional Partnership Board's (RPB) Revenue Integration Fund (RIF) (2022-27) plus Welsh Government Neurodivergence monies (2022-25), all of which is supporting temporary staff to address the RTT and waiting list backlog. - Internal backlog completed and children appointed from RTA list since 01/03/25 - Priority to manage waits to retain <104weeks. - KPI's in place to ensure timely management of open pathways, number of appointments required along with experiential information.	- Robust scheduling in place with the utilisation of joint appointments. - Demand and capacity data to inform business case to support substantive structure. - Improvement plan in place aligned to HB escalation process, all actions on track for completion. - TNA completed and training arranged within Q1 2025/26.
	Period	Mar-25	Target	80%	Actual	29.9%	SPC icon				

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Failure to achieve / maintain delivery in more than 1 key deliverable / area of performance, or deterioration of performance over time.

No.	Measure description, target, performance and other information								Reason for escalation level	Key Performance Drivers	Key Actions
2	Percentage of adult smokers who made a quit attempt via smoking cessation services who are CO-validated as quit at 4 weeks								Measure not meeting target	Many clients are choosing telephone support, so it is challenging to obtain validated CO reading (rather than self-report). The rurality of Powys, transport issues etc make it challenging for some clients to meet face to face to undertake CO monitoring, preferring to self-validate their successful quit.	- Drop-in CO validation clinics in Welshpool and Brecon. - Local pharmacies offering CO validation to community clients in Newtown. - Pregnant smokers are offered their own personal CO monitor to validate progress through their quit attempt. The sonography team also offer CO validation at routine scan appointments to pregnant women who have quit smoking.
	Period	Q3 2024/25	Target	40% Annual target	Actual	14.7%	SPC icon	N/A			
3	Percentage of people who have been referred to health board services who have completed treatment for substance misuse (drugs/alcohol)								Measure not meeting target	- Interpretation of the target varies across Wales. PTHB have focussed service to concentrate on harm reduction and enabling service users to take control on reducing the harm of substance misuse therefore, this does not always include complete abstinence, and clients may access the service for a significant length of time. - South Powys Dual Diagnosis worker role remains vacant. - Lack of full time Clinical Lead role for Area Planning Board (APB).	- Area Planning Board (APB) Commissioning Manager currently drafting an APB Action Plan encompassing recommendations and focus points from Health Inspectorate Wales (HIW) review. The APB has reviewed its structure and improved performance management through development of subgroups. - PTHB have created a Harm Reduction Co-ordinator role which was appointed to in 2023 who continues to provide liaison with the provider.
	Period	Q3 2024/25	Target	4 Quarter Improvement Trend	Actual	65.5%	SPC icon	N/A			
4	Percentage of children who are up to date with the scheduled vaccinations by age 5								Measure not meeting target	Data on uptake is sourced nationally from the Child Health System whilst vaccination is undertaken by GP Practices and recorded on their information system. Children moving into the area from countries outside of the UK, and challenges to record accurate vaccination history in Primary Care & Child Health.	- Enhanced COVER surveillance continues, focussing on pre-school age (up-to-date by age 4) - Primary Care SOP developed to ensure timely return of Childhood Immunisation clinic lists from Primary Care to Child Health Department
	Period	Q3 2024/25	Target	95%	Actual	91.6%	SPC icon	N/A			
5	Percentage of children receiving the Human Papillomavirus (HPV) vaccination by the age of 15								Measure not meeting target	Obtaining signed parental consent forms can be challenging when vaccinating in schools.	Vaccination promotion in schools in an appropriate way and through the curriculum where possible. A new HPV toolkit has been released and is being promoted in schools
	Period	Q3 2024/25	Target	90%	Actual	76.5%	SPC icon	N/A			
6	Percentage uptake of the influenza vaccination amongst adults aged 65 years and over								Measure not meeting target	Adult flu vaccine is offered through GP Practices, all community pharmacies and additionally through Vaccination Centres (latter from Jan 24). Data on uptake is taken from GP Practice data which does not automatically include vaccinations given by pharmacy and therefore reliant on the timely input into the GP data system.	- GP led clinics organised across Powys for eligible residents by GP Practices. - Pharmacy flu clinics also available in many communities across Powys. - Public Health Wales led communication campaign, supported by local communications team through health board channels, amplified through local networks.
	Period	Mar-25	Target	75%	Actual	69.2%	SPC icon	N/A			
7	Percentage uptake of the COVID-19 vaccination for those eligible								Measure not meeting target, performance below previous year at same time point. Autumn booster started from October 2024.	- Vaccine fatigue anecdotally reported across Wales which is reflected in uptake rates. - Data on COVID-19 Vaccination uptake is sourced from Public Health Wales (PHW) surveillance data, which is based on total eligible population. This does not consider those who have opted out of vaccination, and therefore cannot be included for a vaccination	- Thorough cleansing of priority groups over the summer to ensure denominators are more accurate going into the Autumn Booster Campaign. - Ongoing work to support care homes with completing the correct paperwork for vaccination prior to vaccination teams visiting care homes in the Autumn Campaign. - Increase local clinics to offer more access to vaccinations in targeted communities, utilising PTHBs community hospitals. - Hybrid approach to GP clinics, with the vaccination team undertaking booking and call handling, with the GP practice delivering clinics.
	Period	Feb-25	Target	75%	Actual	50.6%	SPC icon	N/A			

Level 2 - Performance Challenges

Failure to achieve / maintain delivery in more than 1 key deliverable / area of performance, or deterioration of performance over time.

No.	Measure description, target, performance and other information								Reason for escalation level	Key Performance Drivers	Key Actions
13	Percentage of the primary care dental services (GDS) contract value delivered (for courses of treatment for new, new urgent and historic patients)								Measure not meeting target	Regulatory limitations impacts on the health board's ability to action recurrent contract reductions; therefore the release of cash to improve access in other areas of Powys is limited. Contractors are reluctant to commit to permanent contract reductions.	- Mid-year contract review meetings completed with all eligible UDA practices and 100% of Contract Reform Practices. - Non recurrent adjustments have taken place through the year, implemented for underperforming practices through mutual agreement (if agreed) and also non recurrent contract increases have been made where appropriate. - Contract performance date is monitored on an individual contract basis monthly via the GDS monitoring group. - Year-end forecasting in place and reviewed/updated monthly. - Year end visits are planned, commencing in July when final 24/25 data is published on 30th June 2025. All practices will receive an end of year visit
	Period	Mar-25	Target	A month on month increase towards a minimum of 30% contract value delivered by 30 September 2024 and 100% by 31 March 2025	Actual	75.0%	SPC icon				
14	Number of consultations delivered through the Pharmacist Independent Prescribing Service (PIPS)								Measure not meeting target	Identifying mentors to support trainee Pharmacist Independent Prescribers (PIP) is a limiting factor – many struggle to identify a suitable, willing mentor.	The health board is continuing to work with contractors and Welsh Government to promote Pharmacist Independent Prescribers.
	Period	Mar-25	Target	Increase compared to the same month in the previous year	Actual	511	SPC icon				
19	Percentage of emergency responses to red calls arriving within (up to and including) 8 minutes								Measure not meeting target	This is a commissioned service by the health board, as such Powys has limited actions available to resolve issues. Handover delays more than 15 minutes continue to be a challenge with lengthy handover delays continuing to be experienced at most DGHs. Delayed discharges - for patients declared medically fit for discharge (MFFD) the number occupying hospital beds slowing system flow.	All hospital providers running A&E services have been asked to improve flow so that ambulance turnaround times can be improved. All Wales urgent care system escalation calls being held daily (often more than once per day). Health Boards asked to review Local Options Frameworks. Most Health Boards who run acute services have now deployed elements of this service resilience option.
	Period	Mar-25	Target	65%	Actual	47.0%	SPC icon				
20	Median emergency response time to amber calls								Measure not meeting target	- Demand for urgent care services continues to increase including calls to 999 ambulance services. - Handover delays at A&E sites are increasing the time ambulance crews are spent static as opposed to quick turnaround times.	- All hospital providers running A&E services have been asked to improve flow so that ambulance turnaround times can be improved. - All Wales urgent care system escalation calls being held daily (often more than once per day).
	Period	Mar-25	Target	12-month reduction target	Actual	01:17:33	SPC icon				
35	Percentage of patients waiting less than 26 weeks to start a psychological therapy in Specialist Adult Mental Health								Measure not meeting target	The recent dip in performance has been principally attributed to: - Fixed term contracts ending for 4 staff in Jan/Feb 2025 - Recruitment pause/freeze from Nov/Dec 2024 causing delay in the replacement of staff through recruitment. - This deterioration in performance has been caused by short term pressures compounded by longer term service fragility.	Addressing acute challenges: - The unfreeze of psychology posts has occurred which means that recruitment is underway 2 x CBT practitioners undergoing induction Addressing longstanding challenges - Engagement with HEIW and Doctoral Training Programmes to address qualified psychology pipeline - Exploring how to expand provision of psychological interventions across community and acute mental health teams - Diversification of the psychological workforce
	Period	Mar-25	Target	80%	Actual	71.3%	SPC icon				
36	Percentage of sickness absence rate of staff								Measure does not meet target but continues to report special cause improvement throughout 2024/25.	- In the last 12 months there a continued reduction in the rolling sickness absence rate, with a minor increase in the last 5 months. - Anxiety, Stress & Depression continues to be the top reason, followed by other musculoskeletal.	- The People and Culture Business Partners team (P&C BP) are monitoring absences prompts in ESR and following these up with managers to ensure policy is followed. - All long-term absence cases over 6 months are reviewed with managers to ensure all actions are up to date in line with the Managing Attendance at Work policy.
	Period	Mar-25	Target	80%	Actual	5.3%	SPC icon				

Level 2 - Performance Challenges

Failure to achieve / maintain delivery in more than 1 key deliverable / area of performance, or deterioration of performance over time.

No.	Measure description, target, performance and other information								Reason for escalation level	Key Performance Drivers	Key Actions
39	Percentage headcount by organisation who have had a Personal Appraisal and Development Review (PADR)/medical appraisal in the previous 12 months (excl. doctors and dentists in training)								Measure not meeting target but reporting special cause improvement throughout 2024/25.	Over the last 24 months, the health board have seen a sustained improvement in PADR Compliance. However, directorates continue to report that a combination of staff absence, vacancies and operational pressures has continued to have an impact in the delivery of PADRs.	- Workforce & OD Business Partners team continue to discuss compliance at senior management meetings within services. - Low compliance is addressed with individual managers and signposting to guidance also takes place
	Period	Mar-25	Target	85%	Actual	82.0%	SPC icon				
42	Percentage of calls ended following WAST telephone assessment (Hear and Treat)								This measure as of April 2024 was not achieving the target of 17%, however no data has been received since this period.	This is a commissioned service by the health board, as such Powys has limited actions available to resolve issues.	Regular meetings are carried out between the health board and WAST, these meeting cover performance, patient experience, incidents and resultant investigations, clinical indicators and staff safety.
	Period	Apr-24	Target	17% or more	Actual	10.3%	SPC icon				
45	Percentage of health board residents in receipt of secondary mental health services who have a valid care and treatment plan for adults 18 years and over								Measure not meeting target.	- Team Lead sickness has improved, and some individual teams have been targeted to improve their compliance which should see improvement in next reporting period. - The service continues to be significantly affected by Social Services inability to undertake their share of Office Duty, which places additional demand on NHS staff. In order to mitigate and align to work to modernise and streamline services the new triage and assessment service was launched in September. Phase 2 is currently being rolled out, but this has impacted on Community Mental Health Team (CMHT) capacity as they are holding additional pressures whilst assessments are moved from teams to the SPOA.	- Joint modelling work in the developing Transformation agenda for MH has seen positive developments with Adult Social Care and consideration of Powys County Council's responsibilities in Community Mental Health Teams (CMHT). Workshops are ongoing for a PTHB/PCC Mental Health Senior Leadership Team to define future operating model. - Continue to advertise vacant positions. - An enhanced reminder system has been put in place to advise staff of when CTPs are due to be out of compliance with support from data Team and local administrators. This aligns with the standard operating procedure (SOP) has been put in place to standardise data collection pan Powys with review meetings regularly undertaken to check consistency.
	Period	Mar-25	Target	90%	Actual	81.9%	SPC icon				
46	Number of service user feedback experience responses completed and recorded on CIVICA								Measure not meeting target.	- Limited resource to support proactive management of CIVICA experience questionnaires to realise the full potential of the system. - Limited analysis of 'People's Experience' responses to inform service improvements or service successes due to no 'aligned resource' to support. - There is no lead in place currently in the Health Board for patient experience.	- Support to run the CIVICA system in the health board continues to be provided by the Quality & Safety (Q&S) team. - The Patient Experience Lead post has been advertised with interviews planned for 1st May 2025
	Period	Feb-25	Target	65%	Actual	376	SPC icon				
51	Percentage of ophthalmology R1 patients who attended within their clinical target date (+25%)								Measure not meeting target.	- National fragility impacting in-reach capacity for ophthalmology. - National staffing recruitment (including local impact) challenge reducing capacity including sickness absence, vacancies for theatre staffing, and industrial PTHB service is reliant on Wye Valley NHS Trust (WVT) for in-reach capacity (it is key for service). - Ongoing demand and capacity challenge resulting from inaccuracies with follow-up (FUP) reporting impacting service planning assumptions. - National Digital Eye Care roll-out delay, pending national decisions.	- Working with WVT & Rural Health Care Academy to formalise training opportunities in DGH, extending OP role to include eye care scrub for potential future clean room developments in PTHB. - Exploring charity funding for purchase of equipment to support repatriation of cataract pathway. - Work with community optometry on contract reform and transformation opportunities. - Escalated weekly waiting list meetings carried out in March with Executive leads to support waiting list management.
	Period	Mar-25	Target	12-month improvement trend towards national target of 95%	Actual	68.2%	SPC icon				

Level 1 – No concerns

Local delivery of agreed objectives and performance, finance ambitions in line with agreed trajectories.

No.	Measure description	Period	Target	Actual	SPC icon
*1	Percentage of adult smokers who make a quit attempt via smoking cessation services	Q3 2024/25	5% cumulative annual target	3.96%	N/A
9	Percentage of well babies completing the hearing screening programme within 4 weeks	Jan-25	90%	90.4%	
10	Percentage of eligible new-born babies who have a conclusive bloodspot screening result by day 17 of life	Jan-25	95%	98.8%	
11	Percentage of GP practices that have achieved all standards set out in the National Access Standards for In-hours	2023/24	100%	100%	N/A
12	Percentage of patients (aged 12+) with diabetes who received all 8 NICE recommended care processes	Mar-25	Improvement compared to the same month in the previous year	50.5%	
15	Percentage of Local Primary Mental Health Support Service (LMPHSS) assessments undertaken within (up to and including) 28 days from the date of receipt of referral for people aged <u>under 18 years</u>	Mar-25	80%	100%	
16	Percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by Local Primary Mental Health Support Service (LMPHSS) for people aged <u>under 18 years</u>	Mar-25	80%	91.7%	
17	Percentage of Local Primary Mental Health Support Service (LMPHSS) assessments undertaken within (up to and including) 28 days from the date of receipt of referral for people aged <u>18 and over</u>	Mar-25	80%	98.0%	
18	Percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by Local Primary Mental Health Support Service (LMPHSS) for people aged <u>18 and over</u>	Mar-25	80%	93.7%	
21	Median time from arrival at an emergency department to triage by a clinician	Mar-25	15 minutes or less	4	N/A
22	Median time from arrival at an emergency department to assessment by a senior clinical decision maker	Mar-25	60 minute or less	4	N/A
23	Percentage of patients who spend less than 4 hours in all major and minor emergency care facilities from arrival until admission, transfer or discharge	Mar-25	Improvement compared to the same month in the previous year, towards the national target of 95%	100%	
24	Number of patients who spend 12 hours or more in all hospital major and minor emergency care facilities from arrival until admission, transfer or discharge	Mar-25	Reduction compared to the same month in the previous year, towards the national target of zero	0	
27	Percentage of children (aged under 18 years) waiting 14 weeks or less for a specified Allied Health Professional therapy	Mar-25	100%	100%	

*Measure 1 - Percentage of adult smokers who make a quit attempt via smoking cessation services. This measure although noncompliant in Q1 & Q2 against annual target is on trajectory to achieve 5% target by March 2025. As such the measure is meeting local delivery of agreed objectives and performance.

Level 1 – No concerns

Local delivery of agreed objectives and performance, finance ambitions in line with agreed trajectories.

No.	Measure description	Period	Target	Actual	SPC icon
28	Number of therapy breaches 14+ weeks (all ages)	Mar-25	0	0	
29	Number of patients (adult hearing aids only) waiting more than 14 weeks	Mar-25	0	0	
30	Number of patients waiting more than 52 weeks for a new outpatient appointment	Mar-25	0	0	
32	Number of patients waiting more than 104 weeks for referral to treatment	Mar-25	0	0	
33	Number of patients waiting more than 52 weeks for referral to treatment	Mar-25	Month on month reduction towards the national target of zero by 30 June 2025	6	
37	Turnover rate for nurse and midwifery registered staff leaving NHS Wales	Dec-24	Rolling 12-month reduction against a baseline of 2019/20	8.8%	
38	Agency spend as a percentage of the total pay bill	Mar-25	12-month reduction	4.1%	
40	Percentage of episodes clinically coded within one reporting month post episode discharge end date	Jan-25	Maintain the 95% target or demonstrate a 12-month improvement trend	100%	
41	Percentage of all classifications' coding errors corrected by the next monthly reporting submission following identification	Feb-25	90%	100%	
43	Number of pathways of care delayed discharges	Mar-25	12 month reduction trend	53	
44	Percentage of health board residents in receipt of secondary mental health services who have a valid care and treatment plan for people aged under 18 years	Mar-25	90%	97.4%	
54	Number of patient safety incidents that remain open 90 days or more	Mar-25	12 month reduction trend	12	

Non-RAG rated measures – Powys as a provider is not nationally benchmarked for infection control measures, as such they are not allocated a RAG rating.

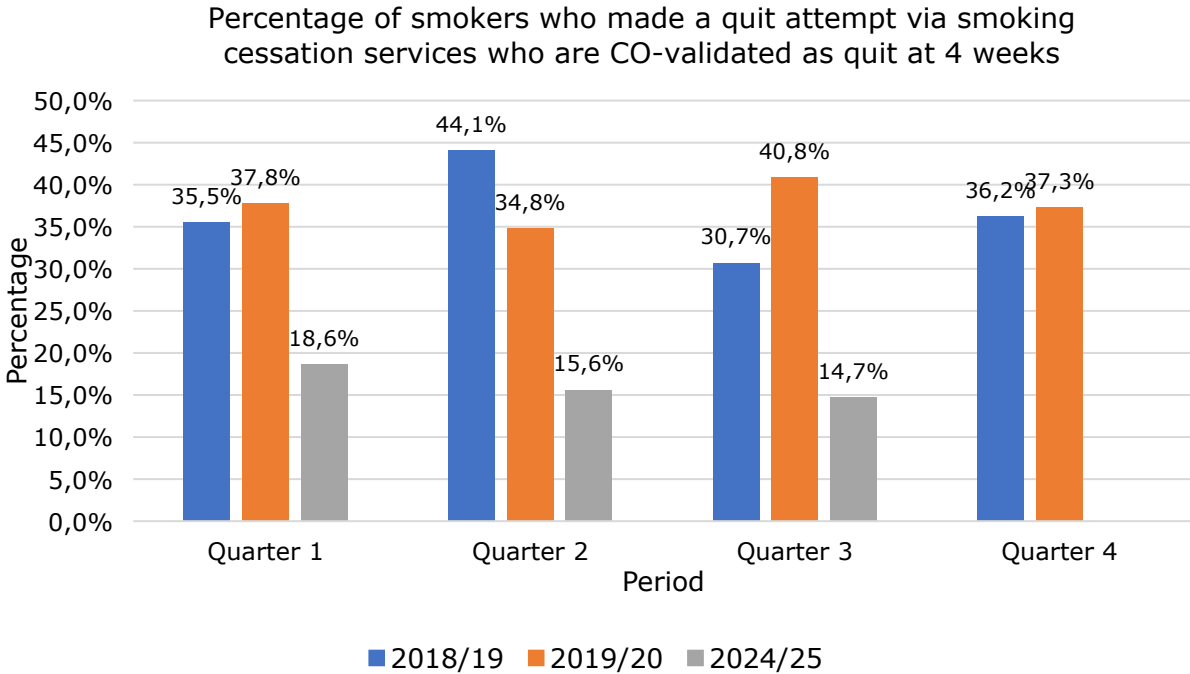
47, 48, 49	Cumulative number of laboratory confirmed bacteraemia cases: Klebsiella sp and; Pseudomonas aeruginosa	Mar-25	No national target for PTHB as a non-acute provider.	0	N/A
	Cumulative rate of laboratory confirmed bacteraemia cases per 100,000 population: E.coli and; S.aureus (MRSA and MSSA)	Mar-25		2.98	
	Cumulative rate of laboratory confirmed bacteraemia cases per 100,000 population: C.Difficile	Mar-25		15.68	

Access & ActivityNHS Performance Measure – 2

Smoking - Percentage of adult smokers who made a quit attempt via smoking cessation services who are CO-validated as quit at 4 weeks

Executive lead	Executive Director of Public Health	Officer lead	Principal Public Health Practitioner

Latest available	Q3 2024/25	Status of measure	Level 2a
Reported performance	14.7%	Benchmark position (Wales)	5 th (17.0%)
Target	40% annual target		
SPC assurance rating	Not applicable		
Measure type	NHSPF	Quality of measure data	Good
Data source of measure	PTHB Public Health		
Recover by?			



What the data tells us

- By end of Q3 2024/25 14.7% of treated smokers were CO validated as quit at 4 weeks. In addition, 50% self-reported as having quit at 4 weeks. In total, therefore, two-thirds of treated smokers had quit at 4 weeks.

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Challenges

Many clients are choosing telephone support, so it is challenging to obtain validated CO reading (rather than self-report). The rurality of Powys, transport issues etc make it challenging for some clients to meet face to face to undertake CO monitoring, preferring to self-validate their successful quit.

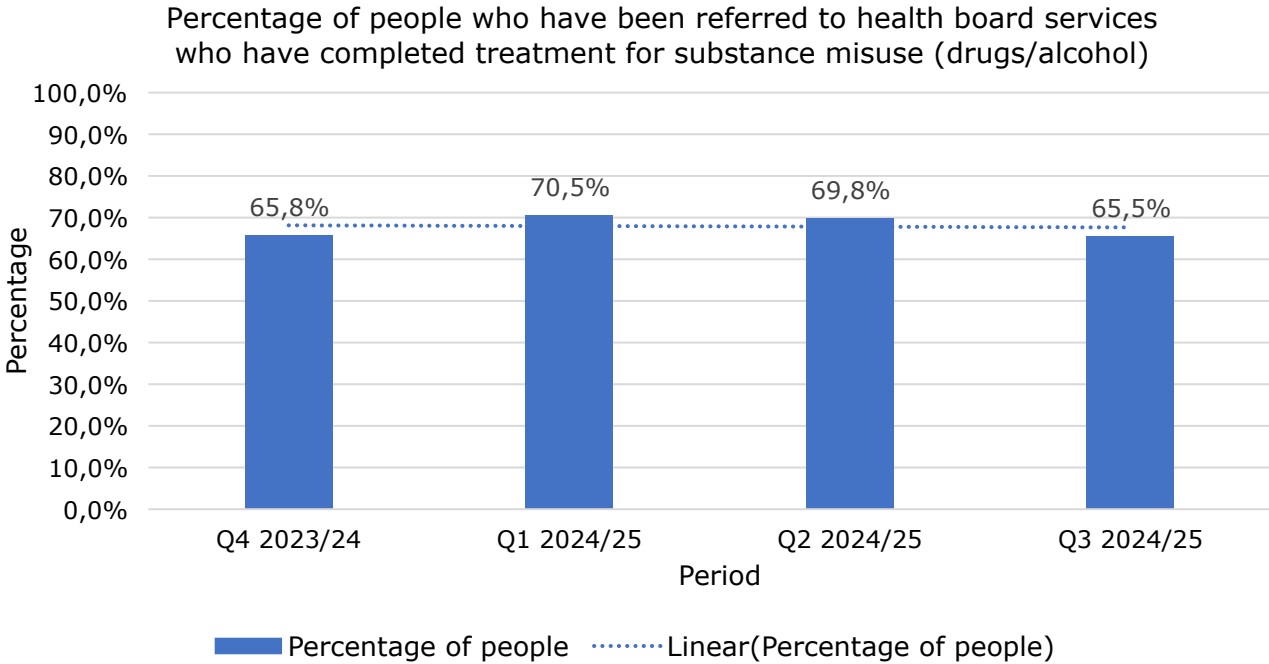
Actions & Mitigations

- Drop-in CO validation clinics are offered in Welshpool and Brecon to allow clients accessing telephone support to CO validate their successful quits.
- 2 local pharmacies in Newtown work in partnership with Smoking Cessation team to offer CO validation to community clients.
- Pregnant smokers are offered their own personal CO monitor to validate progress through their quit attempt. The sonography team also offer CO validation at routine scan appointments to pregnant women who have quit smoking.

Substance Misuse - Percentage of people who have been referred to health board services who have completed treatment for substance misuse (drugs or alcohol)

Executive lead	Interim Executive Director of Primary Care, Community and Mental Health	Officer lead	Assistant Director of Mental Health

Latest available	Q3 2024/25	Status of measure	Level 2a
Reported performance	65.5%	Benchmark position (Wales)	3 rd (56.2%)
Target	4 quarter improvement trend		
SPC assurance rating	Not currently applicable		
Measure type	NHSPF	Quality of measure data	Good
Data source of measure	Welsh Government Scorecard		
Recover by?			



What the data tells us
- Performance has broadly maintained over the last 12 months with 65.6% in Q3 2023/24 and 65.5% reported in Q3 2024/25. - The health board benchmarked 3rd in Wales with an All-Wales position of 56.2% for Q3 2024/25

Challenges
- Interpretation of the target varies across Wales. PTHB have focussed service to concentrate on harm reduction and enabling service users to take control on reducing the harm of substance misuse therefore, this does not always include complete abstinence, and clients may access the service for a significant length of time. - South Powys Dual Diagnosis worker role remains vacant. - Lack of full time Clinical Lead role for Area Planning Board (APB).

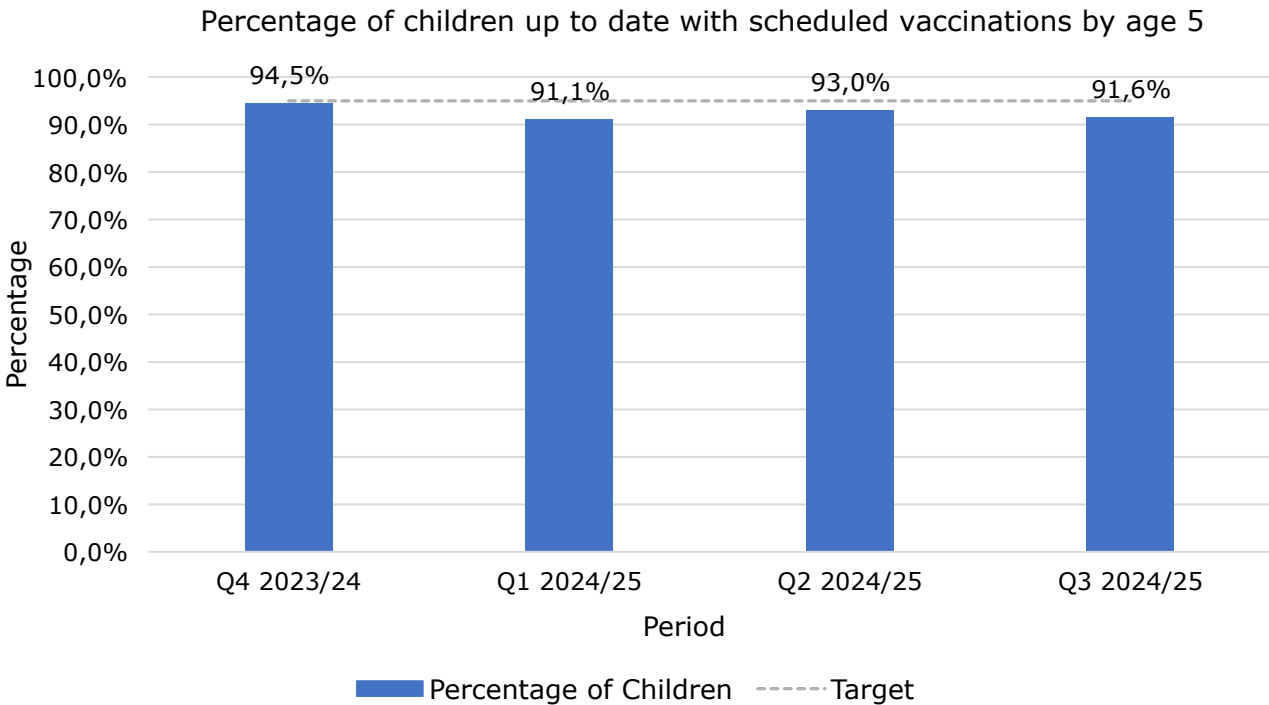
Actions & Mitigations
- Area Planning Board (APB) Commissioning Manager currently drafting an APB Action Plan encompassing recommendations and focus points from Health Inspectorate Wales (HIW) review. The APB has reviewed its structure and improved performance management through development of subgroups. - PTHB have created a Harm Reduction Co-ordinator role which was appointed to in 2023 who continues to provide liaison with the provider. - The recently retendered contract for drugs and alcohol community treatment service has a new emphasis is on client outcomes and holistic support. - Regular commissioning monitoring meetings with provider in place to monitor community demand. - Complex Needs portfolio – agreed that Powys County Council (PCC) lead and will co-ordinate partnership meeting in the next quarter. Ongoing Live Well – Mental Health Partnership Priority. - Recruitment campaign for remaining vacant Dual Diagnosis post. - Agreed that PTHB will utilise ringfenced substance misuse funding to establish a Clinical Lead Post that will oversee Harm Reduction and Dual Diagnosis and will enhance clinical governance arrangements. - Substance Harm reduction plan is established in line with area need. - An APB co-production Planner is in place for 2025-26. - A full clinical audit has been completed of the kaleidoscope services - An analysis of Needle exchange provision has been completed - A series of Stigma videos’ have been completed

Access & ActivityNHS Performance Measure – 4

Vaccinations - Percentage of children who are up to date with the scheduled vaccinations by age 5 ('4 in 1' preschool booster, the Hib/MenC booster and the second MMR dose)

Executive lead	Executive Director of Public Health	Officer lead	Head of Service: Public Health Programmes & Services

Latest available	Q3 2024/25	Status of measure	Level 2a
Reported performance	91.6%	Benchmark position (Wales)	1 st (88.1%)
Target	95%		
SPC assurance rating	Not currently applicable		
Measure type	NHSPF	Quality of measure data	Average
Data source of measure	Welsh Government Scorecard		
Recover by?	Q3 2024/25		



What the data tells us

- Although reported uptake performance for Q3 (91.6%) remains just below target (95%), uptake in Powys is the highest in Wales with the All-Wales benchmark reported as 88.1%.

Challenges

- Data on uptake is sourced nationally from the Child Health System whilst vaccination is undertaken by GP Practices and recorded on their information system. The Child Health System and GP database are not electronically linked, therefore frequent data cleansing is required to ensure that the information flow into the Child Health System is accurate and reflects immunisation status for Powys residents.
- Children moving into the area from countries outside of the UK, and challenges to record accurate vaccination history in Primary Care & Child Health.

Actions & Mitigations

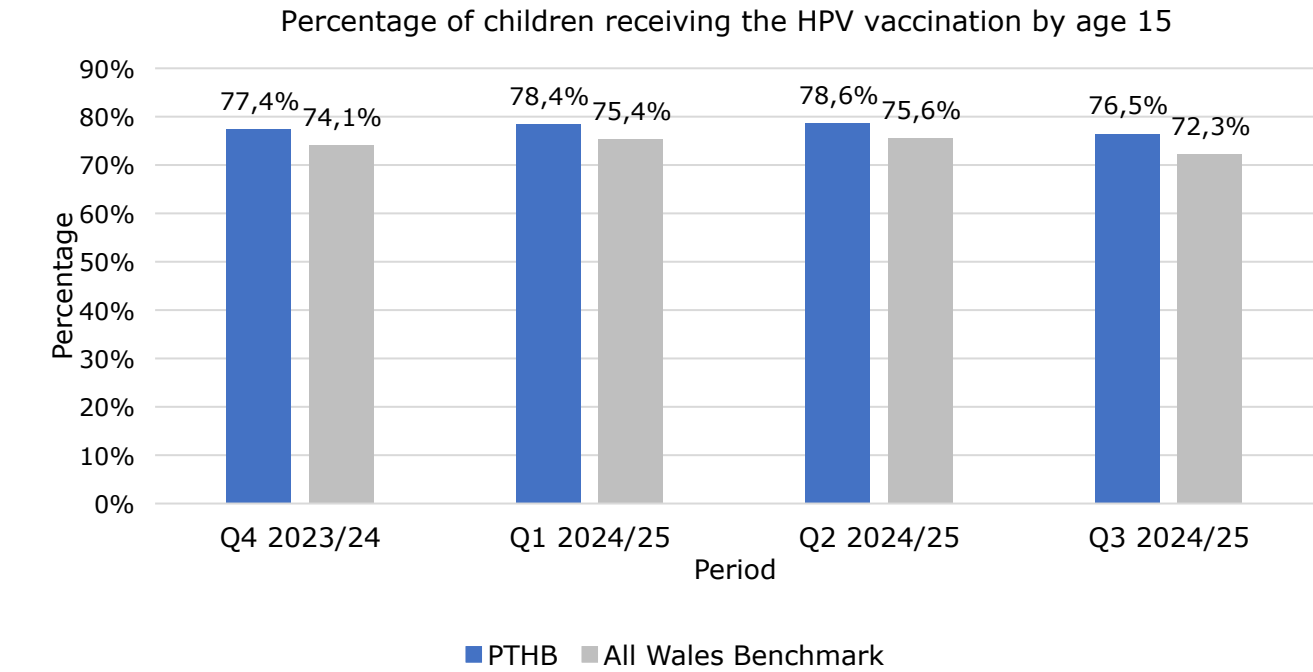
- Enhanced COVER surveillance continues which includes:
 - Data cleansing
 - Enhanced monitoring of practice queues lists
 - Enhanced monitoring of key childhood vaccinations (6 in 1 and MMR).
- Support being provided to Health Visitors to follow up preschool children who have missed routine vaccinations – Standard Operating Procedure (SOP) ratified and in use.
- Ongoing support provided for Primary Care with queues list monitoring and prompting to review lists. Encouraging GPs to offer unscheduled vaccinations for missed vaccinations. SOPs have been developed for both scheduled and unscheduled immunisations to improve the accuracy of data recorded by Primary Care and shared with Child Health System.
- MMR Catch-up completed and the Health Board achieved the WHC target of reaching over 90% for 2 MMR vaccines in both primary and secondary schools.
- There is national work exploring improving vaccine uptake and information sharing for children who transfer in from outside the UK.
- National changes to the digital infrastructure underway, led by DHCW, to improve data transfer between GP practices and CYPRiS (the child health record database).
- The All-Wales data collection Child Health Immunisation Process Standards (CHIPS) pathway is currently being updated.

Access & ActivityNHS Performance Measure – 5

Vaccinations - Percentage of children receiving the Human Papillomavirus (HPV) vaccination by the age of 15

Executive lead	Executive Director of Public Health	Officer lead	Consultant in Public Health

Latest available	Q3 2024/25	Status of measure	Level 2a
Reported performance	76.5%	Benchmark position (Wales)	3 rd (72.3%)
Target	90%		
SPC assurance rating	Not currently applicable		
Measure type	NHSPF	Quality of measure data	Good
Data source of measure	Welsh Government Scorecard		
Recover by?	TBC		



What the data tells us

- Reported uptake declined slightly in Q3 2024/25 but is expected to be higher when the annual HPV programme is operational in schools during the Summer Term (ie Q1 2025/26).

Liz Patterson

20/05/2025 15:22:19

Challenges

- Obtaining signed parental consent forms can be challenging when vaccinating in schools.

Actions & Mitigations

- Vaccination promotion in schools in an appropriate way and through the curriculum where possible. A new HPV toolkit has been released and is being promoted in schools.
- Review implementation of the NICE guidelines (NG218) Vaccine uptake in the general population particularly recommendations 1.3.24 to 1.3.39 in subsection - Vaccinations for school-aged children and young people to ensure these are being implemented, where appropriate.
- Delivery of HPV vaccination consent forms will be via E-Consent, with the aim of increasing the return rate of consent.

Access & Activity

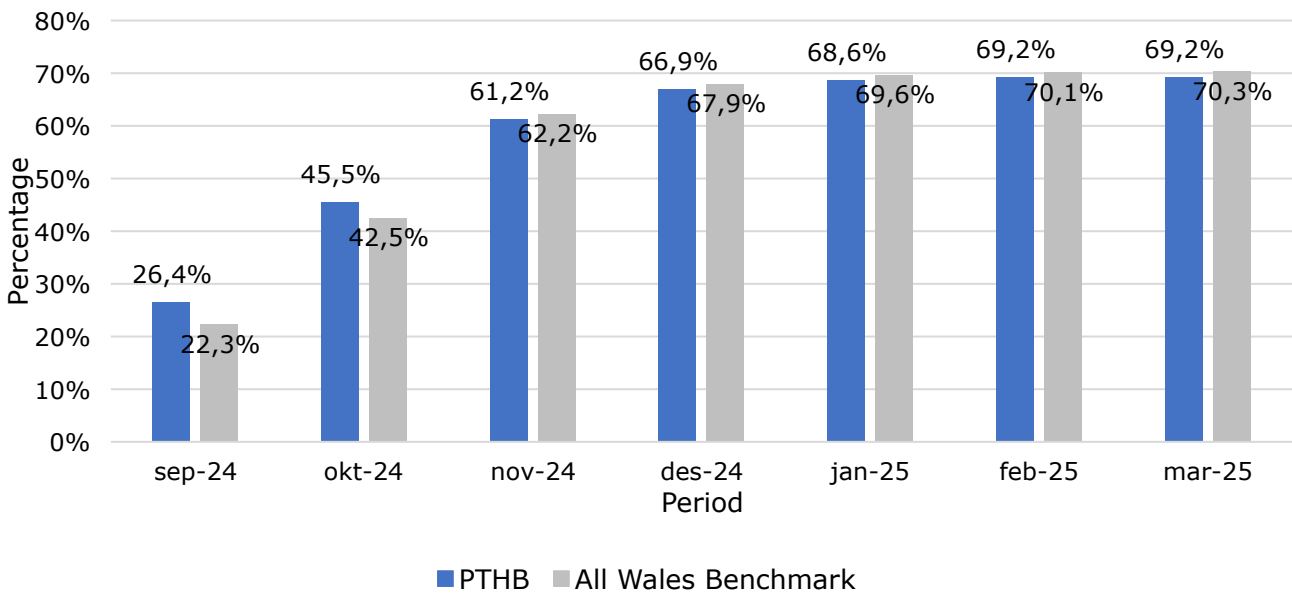
NHS Performance Measure – 6

Vaccinations - Percentage uptake of the influenza vaccination amongst adults aged 65 years and over

Executive lead	Executive Director of Public Health	Officer lead	Head of Service: Public Health Programmes & Services

Latest available	Mar-25	Status of measure	Level 2a
Reported performance	69.2%	Benchmark position (Wales)	5 th (70.3%)
Target	75%		
SPC assurance rating	Not applicable (season cumulative measure)		
Measure type	NHSPF	Quality of measure data	
Data source of measure	Welsh Government Scorecard		
Recover by?	Not applicable 23/24 season of vaccination has finished		

Percentage uptake of the influenza vaccination amongst adults aged 65 years and over



What the data tells us

- To note this is a cumulative measure and will only be updated during active influenza vaccination period.
- PTHB did not meet the 75% target, vaccine fatigue is being anecdotally reported across Wales. However, two practices in Powys did reach the 75% target

Challenges

- Vaccine fatigue anecdotally reported across Wales which is reflected in uptake rates.
- Adult flu vaccine is offered through GP Practices and community pharmacies across Powys
- Data on uptake is taken from GP Practice data which does not automatically include data for vaccinations given by pharmacy. This data needs to be manually inputted by GP Practices so therefore incomplete data and underreporting of uptake.
- Adult flu commencing later this season, October 2024, to ensure 2–3-year-olds targeted first. Vaccinating adults in October, however, does allow the older population to be appropriately protected in the peak season of flu.
- Difficulty in identifying and targeting unvaccinated patients due to flu vaccines being recorded on GP systems

Actions & Mitigations

- Actions implemented:
- GP led clinics organised across Powys for eligible residents by GP Practices.
 - Pharmacy flu clinics also available in many communities across Powys.
 - Public Health Wales led communication campaign, supported by local communications team through health board channels, amplified through local networks.
 - Additional targeted support provided to GP Practices to increase uptake
 - Continued monitoring of uptake, and engaging with GPs to encourage further sessions
 - Opportunistic vaccination of eligible population through vaccination centres
 - Mapping out of remaining flu stock across Powys and signposting patients to where appropriate stock is available
 - Drop-in clinics offered from December 2024 for the remainder of the campaign- advertised weekly via PTHB social media channels
 - Communications issued through local advertising methods- i.e. local newspapers, local beacon and PAVO newsletter
 - Public Health Practitioner is conducting a “lessons learned” session with primary care contractors with the highest uptake of influenza vaccination to enable sharing of ideas to increase vaccination uptake across Powys.

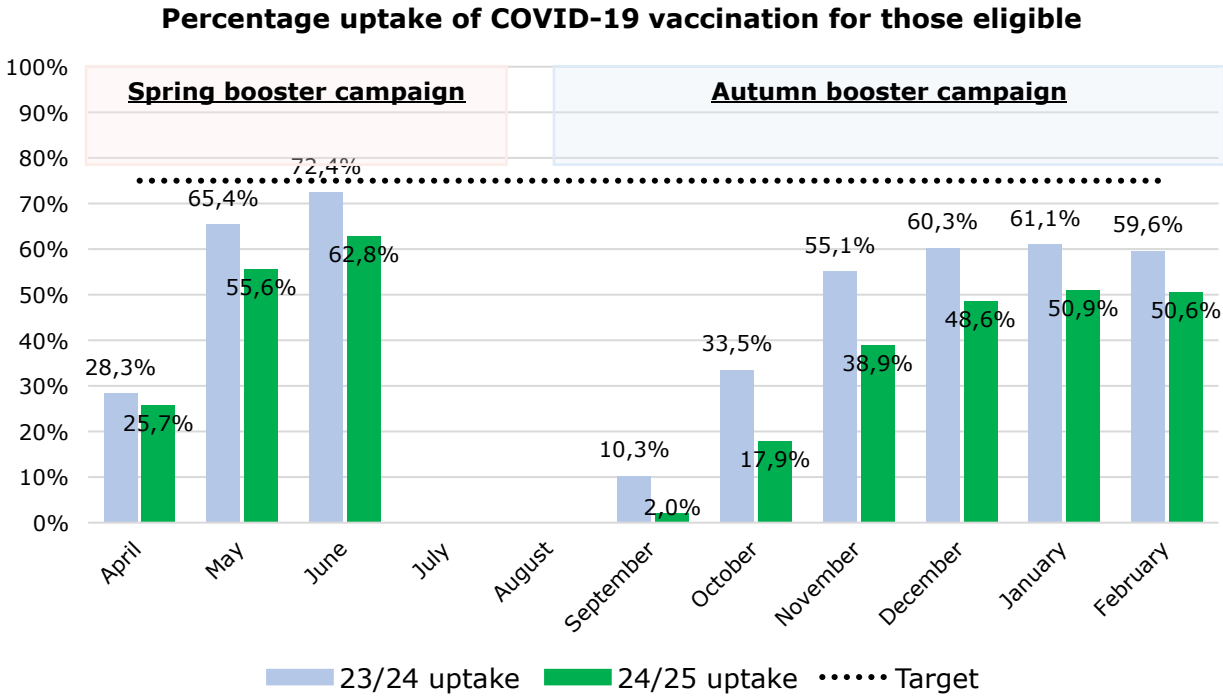
Vaccinations - Percentage uptake of the COVID-19 vaccination for those eligible - Spring and Autumn Booster 2024: All eligible people

Executive lead	Executive Director of Public Health	Officer lead	Head of Service: Public Health Programmes & Services

Latest available	Feb-25	Status of measure	Level 2a
Reported performance	50.6%	Benchmark position (Wales)	1 st (46.7%)
Target	75%		
SPC assurance rating	Not applicable (season cumulative measure)		
Measure type	NHSPF	Quality of measure data	Average
Data source of measure	Welsh Government Scorecard		
Recover by?			

Challenges

- Vaccine fatigue anecdotally reported across Wales which is reflected in uptake rates.
- Data on COVID-19 Vaccination uptake is sourced from Public Health Wales (PHW) surveillance data, which is based on total eligible population. This does not consider those who have opted out of vaccination, and therefore cannot be included for a vaccination
- Universal offer of Covid-19 for eligible populations, no longer a need for patients to have received any previous doses prior to being invited.
- Denominator now includes those who have previously chosen not to come forward for a Covid-19 vaccination.



Actions & Mitigations

- Thorough cleansing of priority groups over the summer to ensure denominators are more accurate going into the Autumn Booster Campaign.
- Ongoing work to support care homes with completing the correct paperwork for vaccination prior to vaccination teams visiting care homes in the Autumn Campaign.
- Increase local clinics to offer more access to vaccinations in targeted communities, utilising PTHBs community hospitals.
- Hybrid approach to GP clinics, with the vaccination team undertaking booking and call handling, with the GP practice delivering clinics.
- Drop-in clinics offered from December 2024 for the remainder of the campaign- advertised weekly via PTHB social media channels
- During the Spring 2025 Campaign data to be collected on why patients are cancelling appointments, to help make improvements to the COVID-19 vaccination services in the future.

What the data tells us

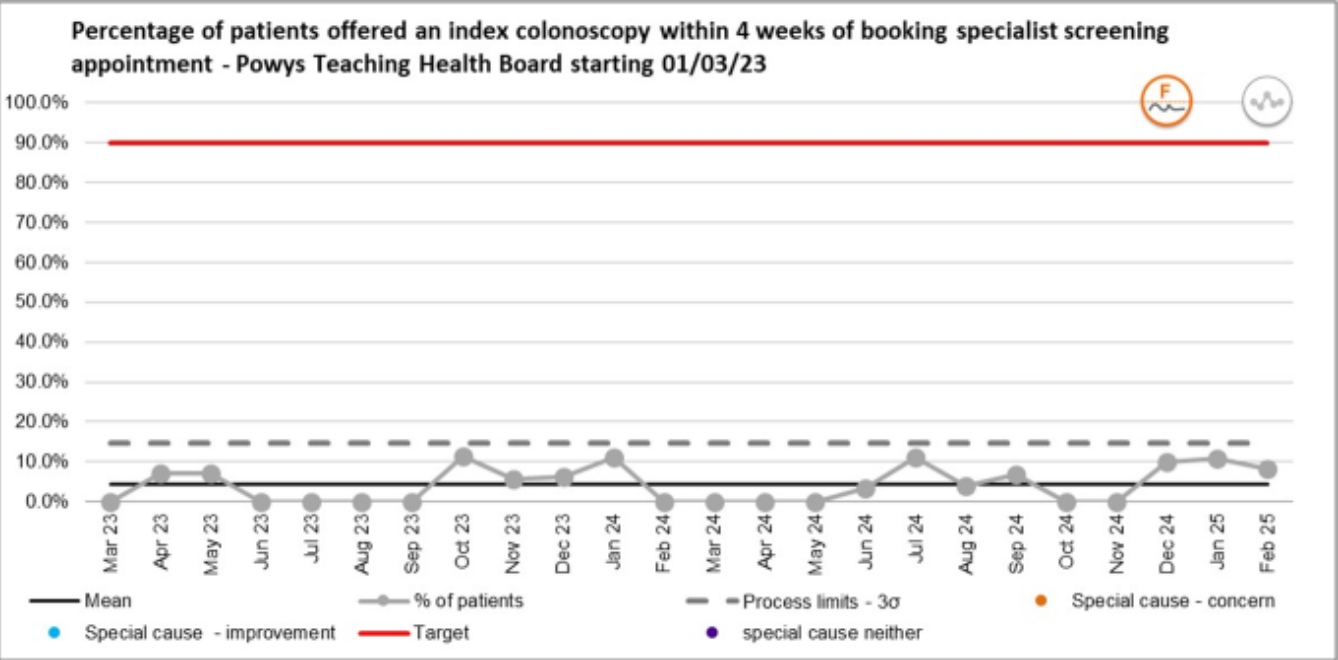
Autumn Vaccination campaign

- Autumn vaccination programme officially began 1 October 2024, although a small number of Powys citizens were vaccinated outside of Powys during September 2024.
- Uptake in the Autumn Campaign has reduced from the 2023/24 campaign. This reduction has been mirrored across all Health Boards in Wales and vaccine fatigue is being reported across all Health Boards.

Screening - Percentage of patients offered an index colonoscopy procedure within 4 weeks of booking their Specialist Screening Practitioner assessment appointment

Executive lead	Executive Director of Primary Care, Community and Mental Health	Officer lead	Assistant Director Community Services

Latest available	Feb-25	Status of measure	Level 3
Reported performance	8.3%	Benchmark position (Wales)	3 rd (15.2%)*
Target	90%		
SPC assurance rating	Common cause variation		
Measure type	NHSPF	Quality of measure data	Average
Data source of measure	PHW compliance report		
Recover by?	Timescale requested from Public Health Wales		



What the data tells us

- Powys performance against this measure is challenged reporting 8.3% in February 2025, All Wales performance is also challenged against this measure.
- Due to poor performance compliance this metric has been escalated by the Powys Performance team to level 3 for enhanced monitoring.
- Methodology of measure is currently under scrutiny with Public Health Wales.

Challenges

- In-reach consultant unavailable during Q1, Q3/4 due to unplanned circumstances, backfill provided by in-source provider.
- Key issues across Wales are linked to the capacity of Endoscopy and the ability to offer diagnostics in a timely manner against target.
- Service extremely fragile with in-source requirement to continue meeting current demand due to national shortage of colorectal capacity and acute care provider pressures including recent business continuity challenges for CTMUHB.
- Further expansion of national FIT test criteria from October is anticipated to increase demand.
- Current insourcing arrangements will end in Feb 25, awaiting re-procurement process.
- As a large area Powys residents will attend diagnostics following positive screening results outside of PTHB including cross border in English facilities.
- Powys is commissioned to carry out Bowel Screening Wales (BSW) activity within its diagnostic/day case units, patients also access services commissioned from bordering DGH.
- National staff resource has been re-directed to support CTMUHB which impacts on the capacity for PTHB service with resultant increase in wait times.

Actions & Mitigations

- Positive assurance review during Q3 with Public Health Wales, complimented in terms of service development and access times improvement.
- Increased number of patients being assessed and screened in PTHB; the service is also repatriating patients from CTMUHB pathways.
- Agreed joint appointment of band 7 screening practitioner with CTMUHB, this role is now out for recruitment with plans to have staff member in place circa Q4.
- Regular meetings between local operational leads and the Bowel Screening Wales (BSW) team.
- Requested capacity for symptomatic and screening from commissioned health providers via the Contract Quality Performance Review Meeting (CQPRM)
- In-source capacity utilised for both screening and symptomatic service.
- Continue with regional planning discussions around endoscopy which in turn supports bowel screening.
- Successfully recruited two band 6 bowel screening specialist nurses.
- Work ongoing with regional partners around the provision of sustainable services going forward.
- Powys physical capacity (treatment rooms) offered as part of mutual aid for regional solutions further discussions with Associate Director Regional Delivery NHS Exec Feb 25 to progress.

Primary Care - Percentage of the primary care dental services (GDS) contract value delivered (for courses of treatment for new, new urgent and historic patients)

Executive lead	Executive Director of Primary Care, Community and Mental Health	Officer lead	Assistant Director of Primary Care

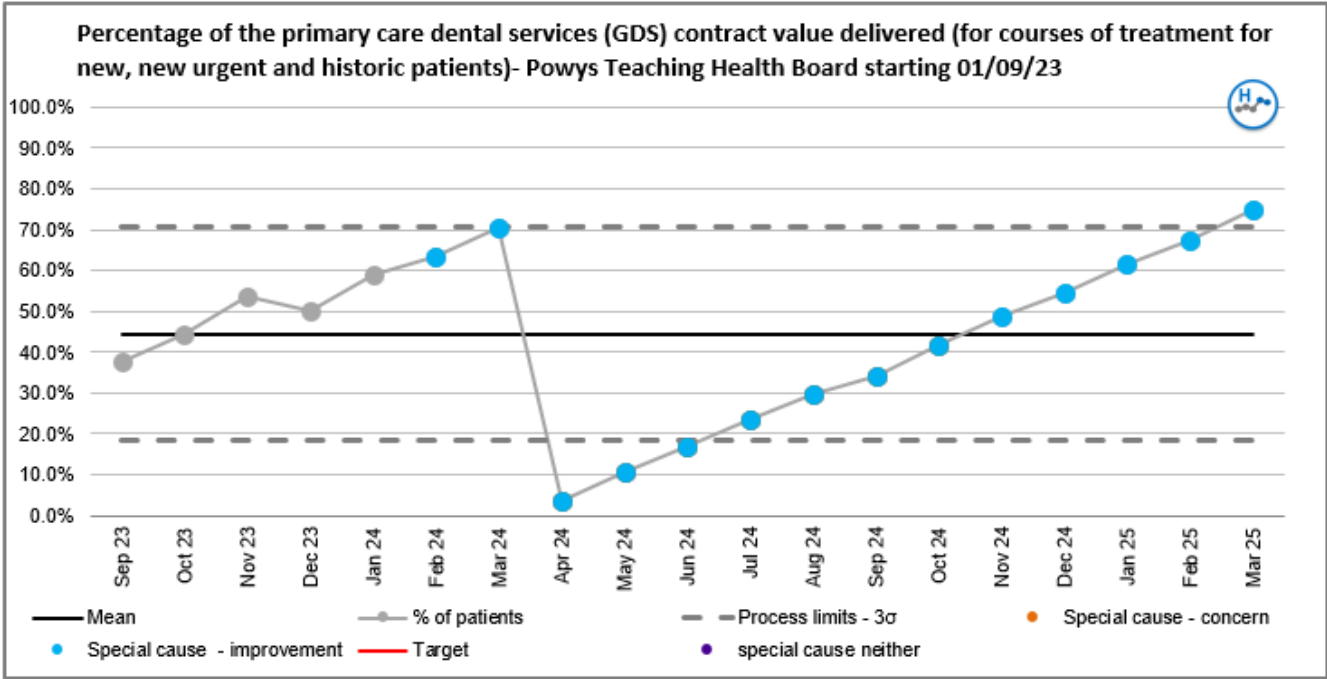
Latest available	Mar-25	Status of measure	Level 2a
Reported performance	75.0%	Benchmark position (Wales)	5 th (70.1%)
Target	Deliver 30% contract value by Sep-24 and 100% by Mar-25		
SPC assurance rating	Special cause improvement		
Measure type	NHSPF	Quality of measure data	Average
Data source of measure	NHSBSA		
Recover by?			

Challenges

- Regulatory limitations impacts on the health board's ability to action recurrent contract reductions; therefore, the release of cash to improve access in other areas of Powys is limited. Contractors are reluctant to commit to permanent contract reductions.

Actions & Mitigations

- Mid-year contract review meetings completed with all eligible UDA practices and 100% of Contract Reform Practices.
- Non recurrent adjustments have taken place through the year, implemented for underperforming practices through mutual agreement (if agreed) and also non recurrent contract increases have been made where appropriate.
- Contract performance date is monitored on an individual contract basis monthly via the GDS monitoring group.
- Year-end forecasting in place and reviewed/updated monthly.
- Year-end visits are planned, commencing in July when final 24/25 data is published on 30th June 2025. All practices will receive an end of year visit



What the data tells us

- Data provided by the NHS Business Services Authority (NHSBSA) This metric applies to Contract Reform practices only. 23% of practices are still working to the UDA model contract, therefore, this data is not capturing this cohort to represent a true access position.
- only reports against Units of Dental Activity (UDA) and does not include a significant element of contracts under "contract reform" e.g., not a complete picture of compliance for dental practices in PTHB.
- March reports 75.0% and therefore does not meet the target of 100% by March 2025 although shows continual improvement.

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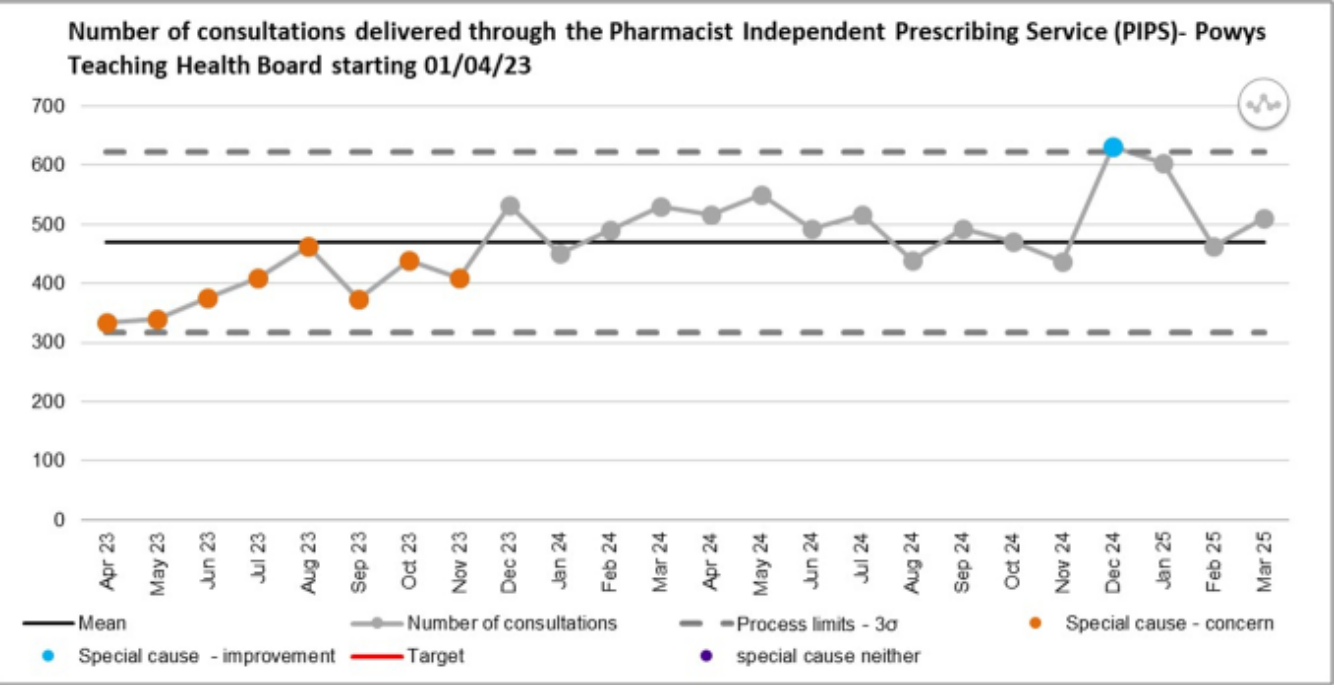


Access & Activity	NHS Performance Measure – 14	Frequency - Monthly

Primary Care - Number of consultations delivered through the Pharmacist Independent Prescribing Service (PIPS)

Executive lead	Executive Medical Director	Officer lead	Chief Pharmacist

Latest available	Mar-25	Status of measure	Level 2a
Reported performance	511	Benchmark position (Wales)	7 th (16,820)*
Target	Increase compared to the same month in the previous year.		
SPC assurance rating	Common cause variation		
Measure type	NHSPF	Quality of measure data	Average
Data source of measure	Welsh Government Scorecard		
Recover by?			



Challenges

- Identifying mentors to support trainee Pharmacist Independent Prescribers (PIP) is a limiting factor – many struggle to identify a suitable, willing mentor.

Actions & Mitigations

We now have 8 Pharmacies with active Pharmacist Independent Prescribers:

- Llanidloes Pharmacy
- Llanwrtyd Wells Pharmacy
- Primrose Pharmacy – Talgarth
- RM Jones – Hay on Wye
- RJ Davies – Lower Cwmtwrch
- JG and RJ Davies – Ystradgynlais
- Well Pharmacy, Brecon
- Boots the Chemist – Builth Wells

The health board is continuing to work with contractors and Welsh Government to promote Pharmacist Independent Prescribers.

What the data tells us

- This was a new measure for the 2023/24 NHS Performance Framework. PIPS is the first UK nationally commissioned community pharmacy prescribing service with the aim to increase access to services that should relieve pressure across the NHS including common ailment services, emergency medicine supply, influenza vaccinations, and emergency, bridging and quick start contraception.
- Performance against the measure shows PTHB is non-compliant (i.e. showing a decrease in consultations compared to the same month in the previous year): 511 consultations were delivered in March 2025 compared to 531 consultations in March 2024. This difference is largely due to one particularly active contractor (delivered 72% of all consultations in 24/25) reducing their output in order to concentrate on the purchase of more pharmacies in Powys. All other contractors increased consultations for the same timeframe.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2023/24	334	339	375	410	463	374	439	409	532	451	491	531
2024/25	517	551	492	517	440	492	471	438	632	604	462	511

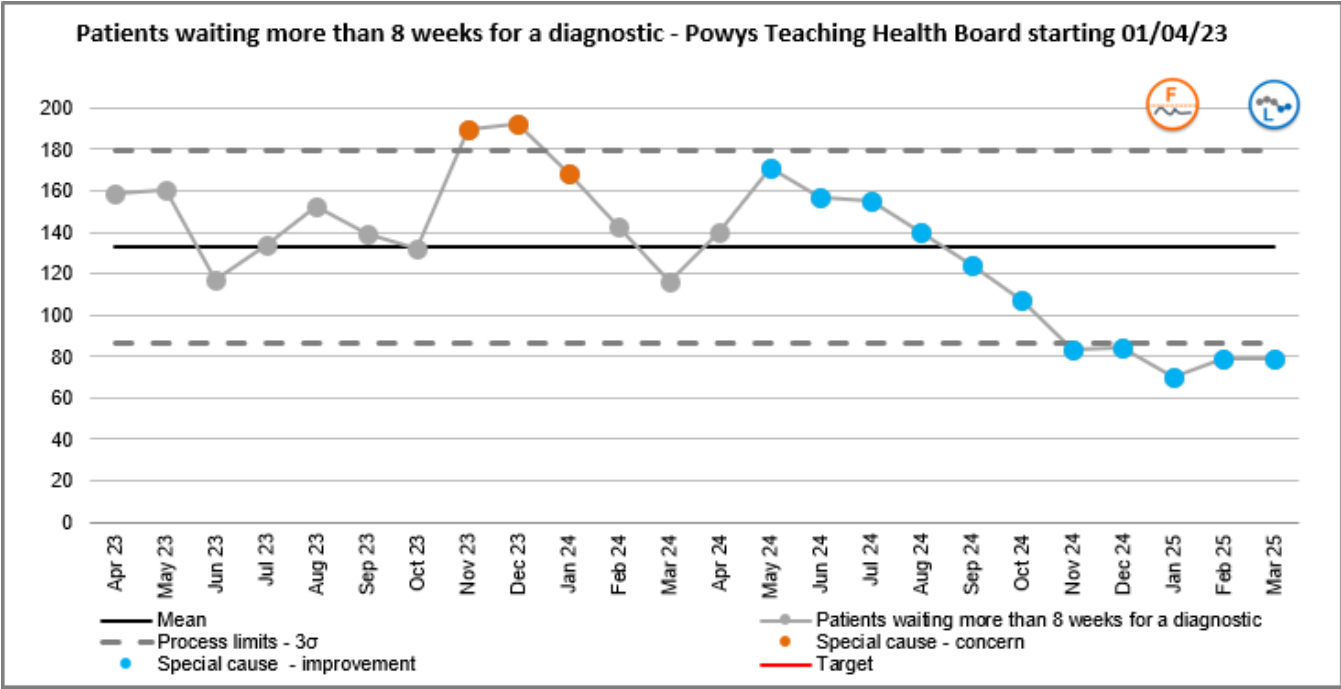
Healthier Wales Quadruple Aim 2: People in Wales have better quality and more accessible health and social care services, enabled by digital and supported by engagement



Planned Care & Cancer - Number of patients waiting more than 8 weeks for a specified diagnostic

Executive lead	Executive Director of Primary Care, Community and Mental Health	Officer lead	Assistant Director of Community Service Group

Latest available	Mar-25	Status of measure	Level 3
Reported performance	79	Benchmark position (Wales)	1 st (37,352)*
Target	Zero		
SPC assurance rating	Special cause improvement		
Measure type	NHSPF	Quality of measure data	Average
Data source of measure	PTHB Data Engineering and Analytics		
Recover by?	TBC 2024/25		



Diagnostic’s performance by sub service				
Service	Sub service	Total Waiting	Pathway breaches	% waiting over 8 weeks
Cardiology	Echo Cardiogram	122	69	57%
Diagnostic Endoscopy	Colonoscopy	16	1	6%
Diagnostic Endoscopy	Cystoscopy	10	0	0%
Diagnostic Endoscopy	Flexible Sigmoidoscopy	10	3	30%
Diagnostic Endoscopy	Gastroscopy	18	0	0%
Radiology - Consultant Referral	Non-Obstetric Ultrasound	18	2	11%
Radiology - GP referral	Non-Obstetric Ultrasound	449	4	1%

What the data tells us

- This measure includes various diagnostic provisions, echo cardiograms, endoscopy, and non-obstetric ultrasound.
- The health board has reported 79 breaches in March 2025, 69 breaches are for Cardiology (Echo Cardiograms), 4 within Endoscopy and 6 reported for Non-Obstetric Ultrasound.
 - This measure remains **escalated** due to ongoing service pressure and non-compliance against Welsh Government key performance indicator target and trajectory.
 - The diagnostic measure has not achieved the end of year target for 2024/25 of zero, although significant improvements were made in year.

Detailed narrative of challenges, actions and mitigations by sub service on the next slide

Healthier Wales Quadruple Aim 2: People in Wales have better quality and more accessible health and social care services, enabled by digital and supported by engagement



Access & Activity	NHS Performance Measure – 26	Frequency - Monthly

Planned Care & Cancer - Number of patients waiting more than 8 weeks for a specified diagnostic

Executive lead	Executive Director of Primary Care, Community and Mental Health				Officer lead	Assistant Director of Community Service Group		
Cardiology - Challenges	No. of breaches	69	Diagnostic Endoscopy - Challenges	No. of breaches	4	Non-Obstetric Ultrasound - Challenges	No. of breaches	6
- Cardiology (Echo Cardiogram scans) remain under pressure in South Powys, due to in reach fragility of Aneurin Bevan University consultant services and increasing echo cardiogram demand, following change in clinical practice where patients are sent straight to test by consultant prior to outpatient appointment. - National shortage of clinical physiologists has resulted in whole system fragility, acute care providers also require insource arrangements to manage demand and reduce delays. - National waiting times for echo-cardiograms have increased and remain high in acute providers.			- National shortage of Endoscopists particularly colorectal. - National increase in urgent suspected cancer referrals with resultant diagnostic demand increase. - All health care providers are utilising insource to help negate increased demand challenges. - In-reach clinician fragility resulting from the above points including further business continuity challenges in Cwm Taf Morgannwg UHB (CTMUHB). CTMUHB currently have challenges in succession planning (as per national challenge), ongoing fragile workforce reliant on locums and insourcing which impacts on in-reach service capacity and reliability with resulting short notice cancellations. - JAG 5 Year Assurance accreditation status to be reassessed Q3 2025/26 requires speciality medical leadership to progress. - General surgery capacity does not meet demand, routine and urgent pathways wait longer as Urgent Suspected Cancer is prioritised. - Colonoscopy capacity is insufficient without supplementary insourcing. - Delays in District General Hospitals (DGH diagnostics, especially Histology/Pathology risk timeliness of pathways including urgent suspected cancer pathways. - Insource capacity available until Q4, procurement process in progress.			- Increase in demand. - Recruitment challenges.		
Cardiology - Actions & Mitigations			Diagnostic Endoscopy - Actions & Mitigations			Non-Obstetric Ultrasound - Actions & Mitigations		
- Improved patient information and advice and support with aims to reduce patient "Did not attend" (DNA). - Use of PTHB employed echo-cardiogram technician to support cardiology. - Working with in-reach to review capacity due to changes in clinical practice (escalated via CQPRM). - Development of clinical waiting list validation within in reach clinical team: On-going. - Capital bid in place for a new echo cardiogram scanner for Brecon War Memorial Hospital from Q4 2024/25. - Escalated via CQPRM, capacity shortfall escalated as part of insourcing proposal, insourcing currently being progressed. - Operational review of capacity ongoing with additional clinics being undertaken within the PTHB Community Cardiology service. - Full evaluation of Community Cardiology Service to be undertaken. Future plans for service to be expanded to mid and south Powys. Patterson, Liz 20/05/2025 15:22:19			- Significant service transformation including strengthening of team leadership and staff development to maximise service efficiency. - Bid to Welsh Government Cancer Transformation fund for development of PTHB colorectal multi-disciplinary team (MDT) approach in Q3, successful in round 1 to progress to full business case. - Service have escalated the CTMUHB in-reach fragility, and diagnostic challenges for histology & pathology (this is currently reported as a very high risk for the health board). Proposal for capacity and contingency planning awaiting finalisation. - Start of sponge capsule (cytosponge) from 2nd October 2023 in PTHB as enhanced diagnostic improving patient experience and reducing demand on staffing resource. Feedback so far has been excellent from both staff and patients. - Ongoing Executive level discussions around service sustainability and joint work with CTMUHB from February 2024, ongoing. Alongside ongoing discussions with CTM for permanent clinical lead role. - Rolling programme of clinical and administrative waiting list validation. - Additional in-sourcing capacity requested but awaiting financial package confirmation to allow utilisation. - Working at Regional level to support service sustainability offering estate capacity endoscopy suite as part of regional solution mutual aid. - Appointment colorectal specialty lead on a locum being progressed. - Review of standard operating procedures (SOP's) and related documentation completed.			- Use of agency for breaching patients. - Demand and Capacity workstream to assess system efficiency and implement improvements. - Continuous monitoring of waiting list. - Recruited a development post with a view to complete preceptorship 2025/26		

Healthier Wales Quadruple Aim 2: People in Wales have better quality and more accessible health and social care services, enabled by digital and supported by engagement



Access & Activity

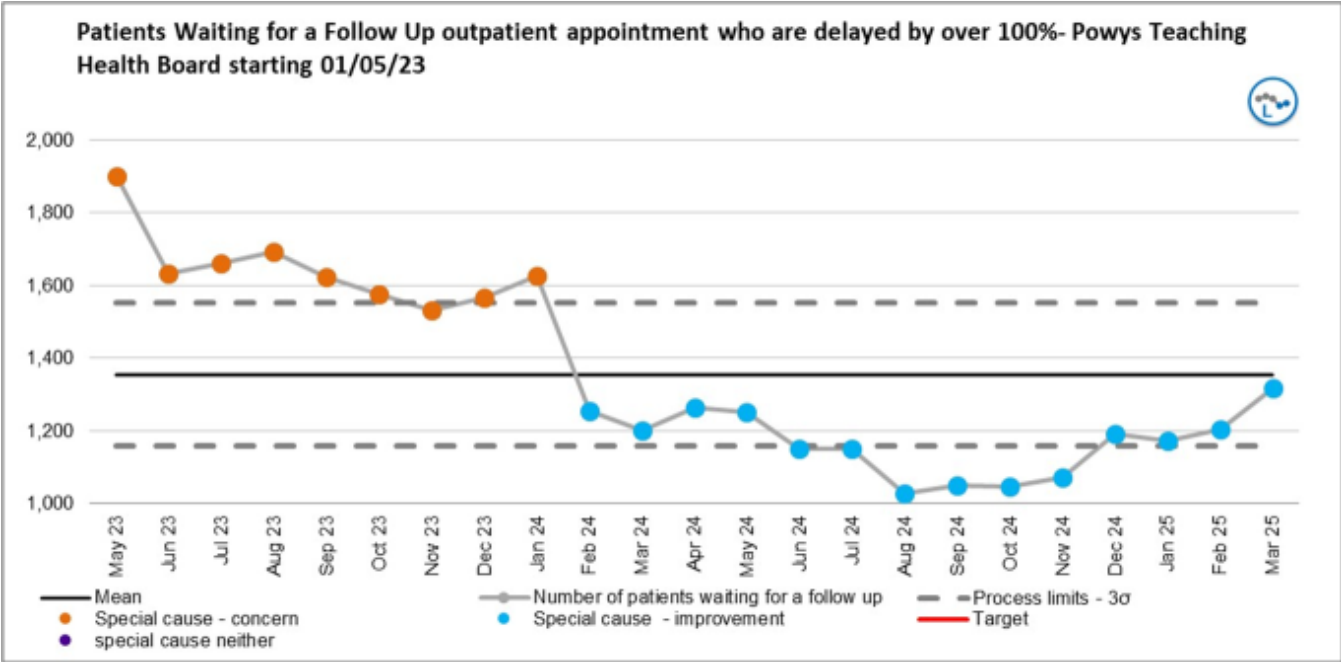
NHS Performance Measure – 31

Frequency - Monthly

Planned Care & Cancer - Number of patients waiting for a follow-up outpatient appointment who are delayed by over 100%

Executive lead	Executive Director of Primary Care, Community and Mental Health	Officer lead	Assistant Director of Community Service Group

Latest available	Mar-25	Status of measure	Level 3
Reported performance	1318	Benchmark position (Wales)	1 st (245,579)
Target	Reduction compared to the same month in the previous year		
SPC assurance rating	Special cause improvement		
Measure type	NHSPF	Quality of measure data	Poor
Data source of measure	PTHB Data & Business Intelligence reporting		
Recover by?	TBC		



Challenges

- Service capacity pressure prioritising urgent, and urgent suspected cancer pathways, which in turn places pressure of compliance on routine and FUP pathways.
- Clinical leadership to support in reach clinicians to adopt see on symptoms (SOS)/patient-initiated follow-up (PIFU) pathways.
- Reporting challenges, capacity to support development of data, work is wider than just reportable follow-ups including specialist nursing teams etc.
- Ongoing challenges with patient administration system – ongoing investigation with Digital applications and operational team.

Actions & Mitigations

- Revised approach with the aim to de-escalate by the end of Q1 2025/26. Further actions include but are not limited to;
 - Cleansing small number of new outstanding records.
 - PTHB wide standardised service operating procedure for validation to be developed and implemented
 - New PowerBI reports to be developed supporting operational teams to improve future validation.
 - New local reporting metrics.
- SOS & PIFU reporting has now been resolved with the National Digital Team, improved local reporting identified and commenced to support national work stream.
- Operational services continue to support the validation of records and provide challenge identification for the D&BI team to investigate.
- Enhanced clinical support for consultants in outpatients to maximise SOS & PIFU opportunities.
- Support from National Clinical Implementation Networks to move clinical practice in terms of SOS/PIFU.
- Plan under development for national implementation of discharge protocols which will require MDT resource and specialty leadership.

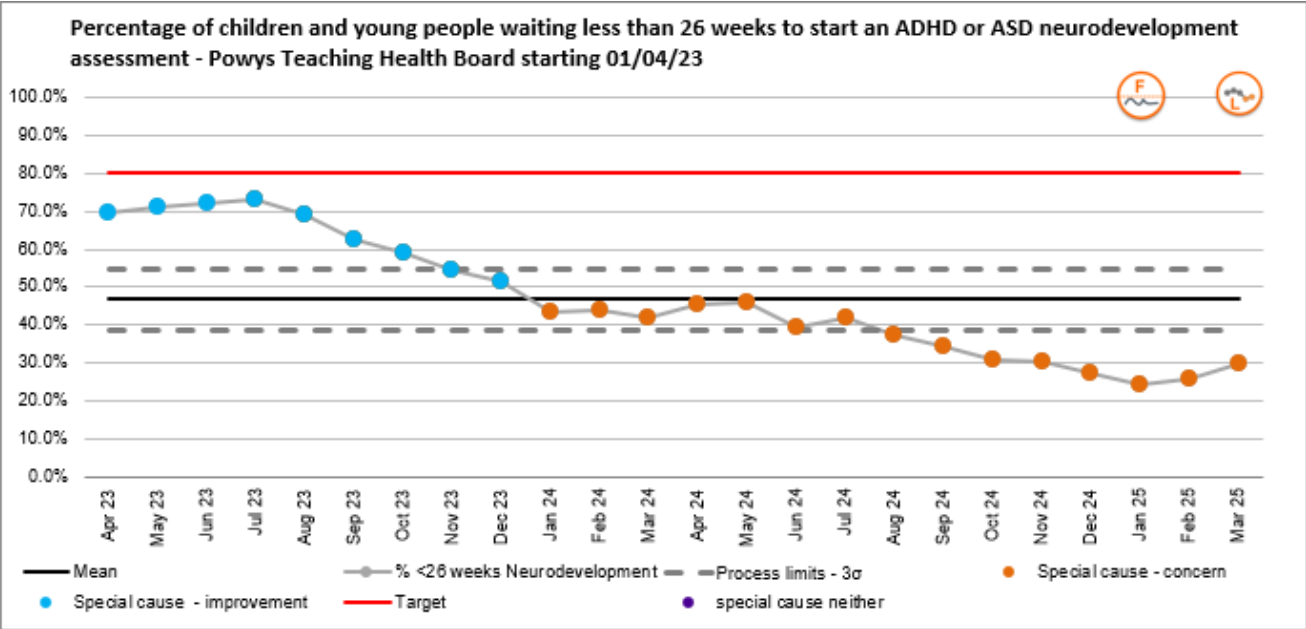
What the data tells us

- In March 1318 FUP’s were reported as overdue by 100% or over, this is more than the equivalent period in March 2024 (1202).
- FUP pathways recording and reporting was escalated in Q4 2021/22 following service identified significant accuracy challenge in the reporting of pathway time banding. Resulting reporting checks by the Powys Data Intelligence team highlighted a significant quantity of un-reported pathways and local reporting was aligned to the National WPAS team's process. The measure will remain escalated until both Executive and Service leads are provided assurance on data quality and achievement of performance.

Mental Health including CAMHS - Percentage of children and young people waiting less than 26 weeks to start an ADHD or ASD neurodevelopment assessment (ND)

Executive lead	Executive Director of Nursing, Quality, Women and Family Health	Officer lead	Assistant Director of Womens and Childrens

Latest available	Mar-25	Status of measure	Level 3
Reported performance	29.9%	Benchmark position (Wales)	3 rd (21.0%)*
Target	80%		
SPC assurance rating	Special cause concern		
Measure type	NHSPF	Quality of measure data	Good
Data source of measure	PTHB Data Engineering and Analytics		
Recover by?	Linked to business case approval		



What the data tells us

Please note that unlike normal referral to treatment pathways for planned care this metric measures the time from referral to first assessment appointment, this assessment may then take a significant engagement time to provide a diagnosis and future care plan.

- Performance for ND remains at level 3 escalation following ongoing and challenging performance. Of the 1112 pathways reporting in the March snapshot 29.9% wait less than 26 weeks for their first assessment.
- Performance remains flagged as special cause concern, but small improvements to performance have been noted over the last 2 months. The service is currently at the highest level of escalation within the Integrated Quality and Performance Framework and is undertaking Executive engagement via the internal Escalation Oversight Group.
- PTHB continues to benchmark positively against the All-Wales position however this reflects the system challenge in Wales rather than good performance locally.

Challenges

- From April 2022 the ND service has been in receipt of non-recurrent funding via the Regional Partnership Board's (RPB) Revenue Integration Fund (RIF) (2022-27) plus Welsh Government Neurodivergence monies (2022-25), all of which is supporting temporary staff to address the RTT and waiting list backlog.
- The measures pathway to assessment time will continue to worsen whilst those in the 'Assessments in progress' (Internal waiting list) backlog are addressed.
- Given the consistent national increase in referral demand since June 2021, ND waiting lists have increased exponentially and the service has been unable to meet the demand with the current model.
- Inability to recruit additional ND skilled workforce within timeframe, funded by the WG 24/25 waiting list initiative monies outlined below

Actions & Mitigations

- Waiting list management aligned to longest wait from RTA commenced in March 2025 as internal waiting list had been addressed and concluded.
- KPI's in place to ensure quality service is in place.
- Robust scheduling in place with the utilisation of joint appointments.
- Commencements of improved clinic scheduling inclusive of weekend offering.
- Pan Powys model for waiting time pathways rather than the previous geographically led process which resulted in regional variance in patient's pathway wait times.
- Child centred model with partners in education, social care and 3rd sector being mapped – care around the child and family/carer.
- Commissioned co-production partnership model with the Parent and Carers Voices Forum, programme of work commenced in September 2024.
- Business efficiencies being addressed within the administrative processes.
- Robust communication plan in place for parents/carers; letters to be sent to families when a child is accepted to the waiting list along with progress updates.
- Implementation of mail envoy.
- Procurement and Implementation of dictate IT.
- Multi Disciplinary Team (MDT) panel and decisions implemented and embedded within the structure.
- Recruitment of additional team members 3.6wte to support ND assessments, to commence end of January 2025.
- Funding support 2025/26 agreed in anticipation of business case and MDT model.

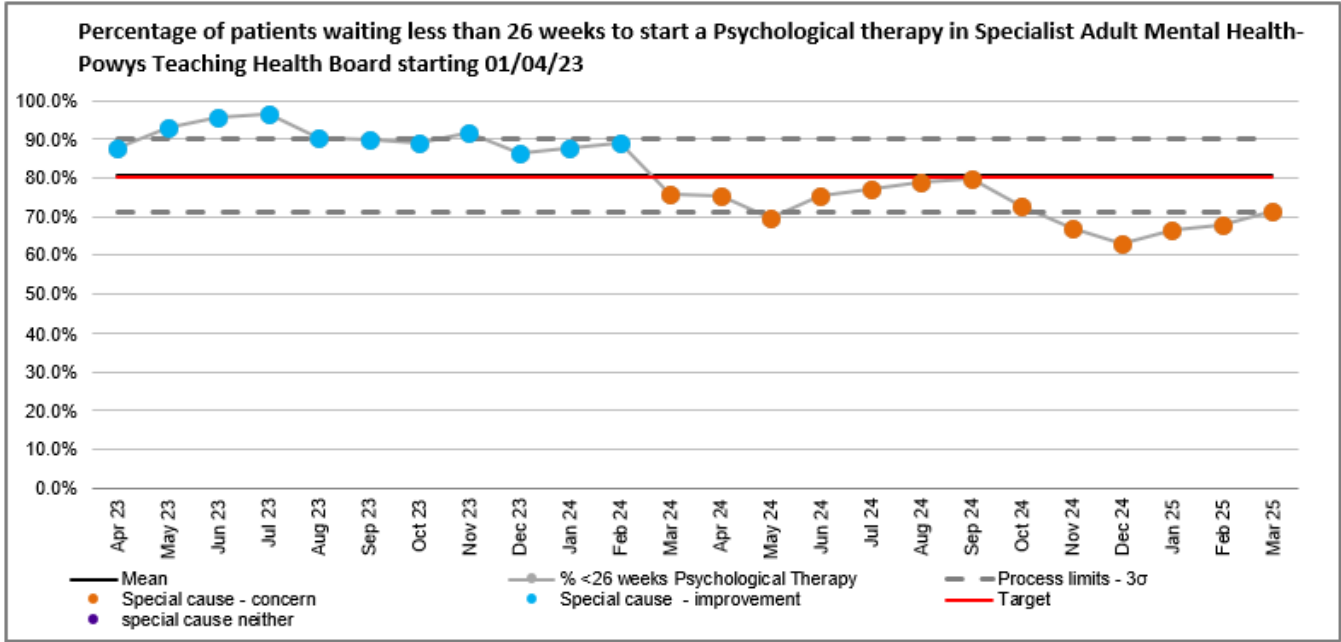
Healthier Wales Quadruple Aim 2: People in Wales have better quality and more accessible health and social care services, enabled by digital and supported by engagement



Mental Health, including CAMHS - Percentage of patients waiting less than 26 weeks to start a psychological therapy in Specialist Adult & Older Adult Mental Health

Executive lead	Executive Director of Primary Care, Community and Mental Health	Officer lead	Assistant Director of Mental Health

Latest available	Mar-25	Status of measure	Level 2a
Reported performance	71.3%	Benchmark position (Wales)	2 nd (57.3%)*
Target	80%		
SPC assurance rating	Special cause concern		
Measure type	NHSPF	Quality of measure data	Average
Data source of measure	PTHB Data Engineering and Analytics		
Recover by?			



What the data tells us

- Performance improves slightly in March to 71.3%, but the measure continues to report special cause concern remaining at level 2a escalation.
- Powys benchmarked positively in February and ranked 2nd with the All-Wales position of 57.3% for the same period.

Patterson, Liz
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Challenges

Longstanding challenges contributing to current fragility:

- Psychological interventions delivered by small team with very little psychological therapy provision across wider secondary mental health workforce (incl. CMHTs, CRHTTs, and Acute Settings).
- Challenges recruiting qualified psychologists and psychological therapists

The recent dip in performance has been principally attributed to:

- Fixed term contracts ending for 4 staff in Jan/Feb 2025
- Recruitment pause/freeze from Nov/Dec 2024 causing delay in the replacement of staff through recruitment.
- This deterioration in performance has been caused by short term pressures compounded by longer term service fragility.

Actions & Mitigations

Addressing longstanding challenges

- Engagement with HEIW and Doctoral Training Programmes to address qualified psychology pipeline
- Exploring how to expand provision of psychological interventions across community and acute mental health teams
- Diversification of the psychological workforce

Addressing acute challenges:

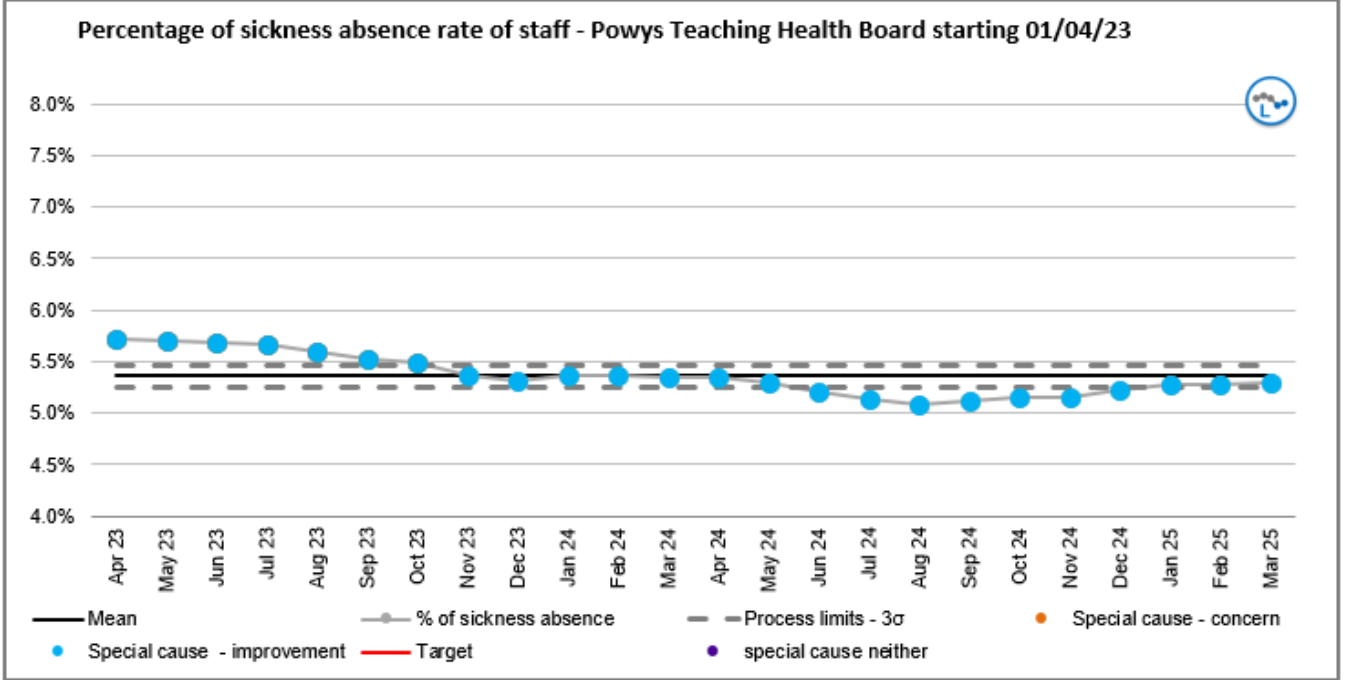
- The unfreeze of psychology posts has occurred which means that recruitment is underway
- 2 x CBT practitioners undergoing induction
- 2 x trauma practitioners undergoing pre-employment checks
- Successful recruitment of qualified psychologist and assistant psychologists into OA Psychology
- Shortlisting for qualified psychologist post in adult mental health
- Ongoing engagement of 2 x psychological therapy locums whilst substantive staff are recruited and inducted
- Development and implementation of focused waiting list recovery plan incl. review of allocation process, job plans, demand & capacity, caseload management and review of service core offer

There is high confidence that the robust recovery plan and successes in recruitment as part of this will see an increase in performance over the coming months.

Percentage of sickness absence rate of staff

Executive lead	Executive Director of People and Culture		Deputy Director of People and Culture

Latest available	Mar-25	Status of measure	Level 2a
Reported performance	5.29%	Benchmark position (Wales)	5 th (6.3%) (Jan-25)
Target	12-month reduction trend		
SPC assurance rating	Special cause improvement		
Measure type	NHSPF	Quality of measure data	Good
Data source of measure	PTHB Workforce		
Recover by?			



What the data tells us

- The rolling 12-month sickness absence rate is reported as 5.29% for March 2025
- The organisation benchmarks positively when compared with the All-Wales position of 6.3% (Jan 2025).
- Variation is special cause – improvement.

28/50

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Challenges

- In the last 12 months there a continued reduction in the rolling sickness absence rate, with a minor increase in the last 5 months.
- Anxiety, Stress & Depression continues to be the top reason, followed by other musculoskeletal.

Sickness absence rates are highest in the following staffing groups:

- Additional Clinical Services – 7.09%
- Estates & Ancillary – 6.70%
- Nursing & Midwifery – 6.16%.

Actions & Mitigations

- The People and Culture Business Partners team (P&C BP) are monitoring absences prompts in ESR and following these up with managers to ensure policy is followed.
- Sickness absence is monitored via directorate Senior Management Team (SMT) meetings and escalated to Assistant Directors (AD’s) where necessary.
- All long-term absence cases over 6 months are reviewed with managers to ensure all actions are up to date in line with the Managing Attendance at Work policy.
- The managers training programme covers the managing attendance at work policy and manager responsibilities in detail.
- The P&C BP team undertake absence monitoring to enable more efficient targeted interventions in directorates. This has included delivery of several bespoke sessions to directorates.
- A focussed deep dive into absence relating to anxiety, stress and depression took place in October to better understand trends within this area and enable more focussed interventions where possible. Since the review in October and subsequent actions anxiety, stress and depression related absence has reduced by approximately 7 WTE.
- P&C are recruiting Mindfulness practitioners onto the bank and will use their skills alongside the wellbeing and experience lead and Human Resource Business Partners to develop some bespoke training offers for our staff that on off sick or receiving counselling support (with their consent).
- There has been an increase in the numbers (103) of staff signing up to VIVUPS YourCare app where they can monitor their wellbeing and access additional support resources.

Workforce

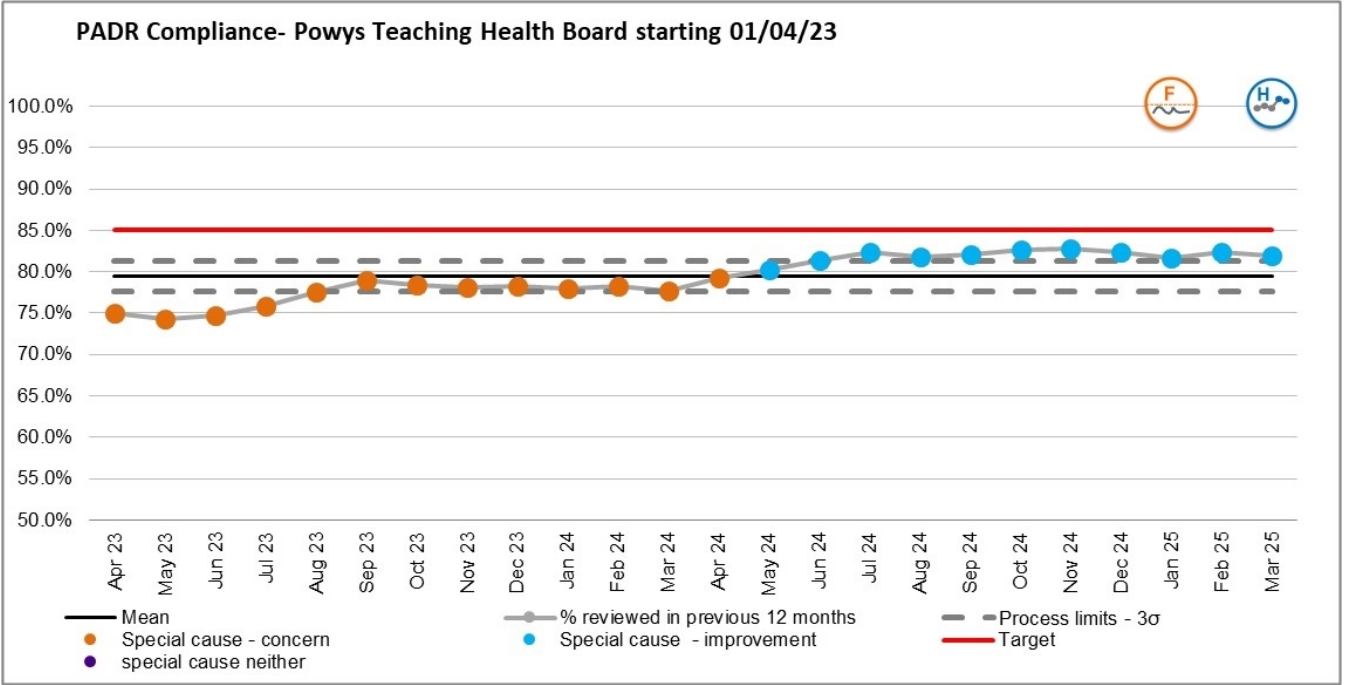
NHS Performance Measure – 39

Frequency - Monthly

Percentage headcount by organisation who have had a Personal Appraisal and Development Review (PADR)/medical appraisal in the previous 12 months (excluding doctors and dentists in training)

Executive lead	Executive Director of People and Culture	Officer lead	Deputy Director of People and Culture

Latest available	Mar-25	Status of measure	Level 2a
Reported performance	82.0%	Benchmark position (Wales)	5th (77.1%) (Jan-25)
Target	85%		
SPC assurance rating	Special cause improvement		
Measure type	NHSPF	Quality of measure data	Good
Data source of measure	PTHB Workforce & OD team		
Recover by?	Plan under development 2024/25		



Challenges

- Over the last 24 months, the health board have seen a sustained improvement in PADR Compliance. However, directorates continue to report that a combination of staff absence, vacancies and operational pressures has continued to have an impact in the delivery of PADRs.

Actions & Mitigations

- The People and Culture Business Partners team (P&C BP) team review the monthly PADR compliance report and provide focussed intervention to managers that have compliance less than 85%.
- The P&C BP team continue to discuss compliance at senior management meetings within services, escalating to Assistant Directors areas of concern as required.
- Targeted work is underway in directorates with sustained low compliance

What the data tells us

- PTHB PADR compliance is reported at 82% for March 2025, performance continues to remain above average but is below national target.
- The last benchmark available for Wales in January showed PTHB benchmarking 5th out of 13 organisations

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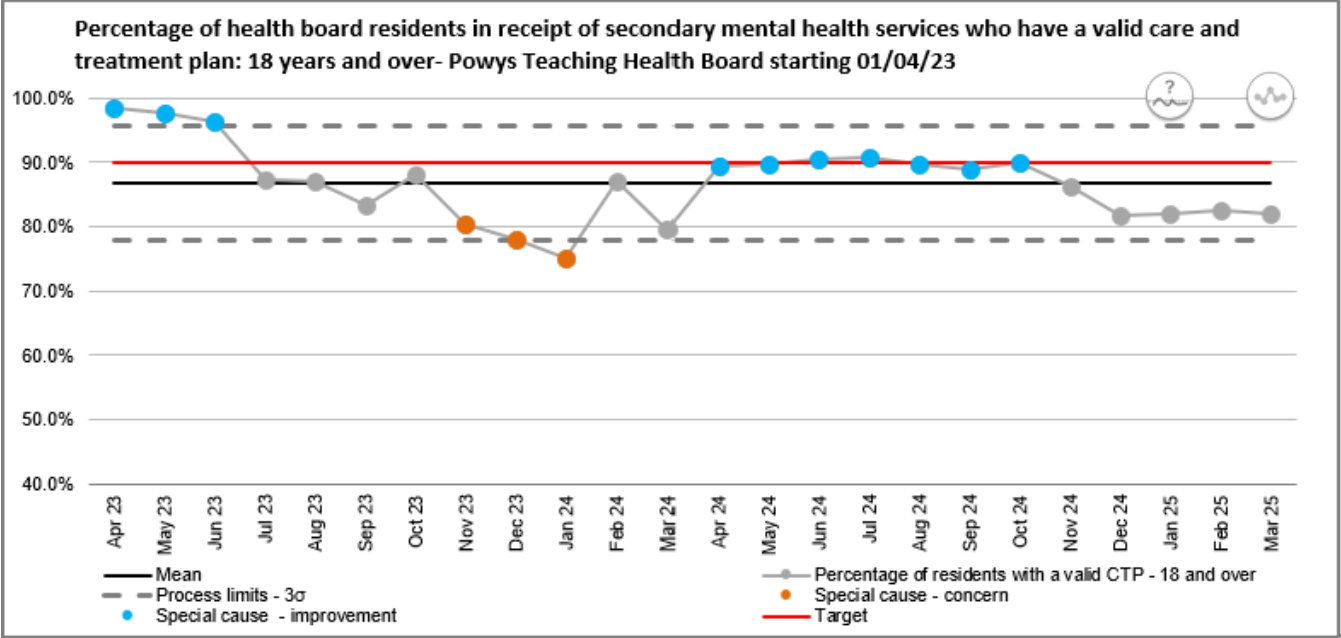


Quality, safety, effectiveness, and experienceNHS Performance Measure – 45Frequency - Monthly

Mental Health, including CAMHS - Percentage of health board residents in receipt of secondary mental health services who have a valid care and treatment plan (CTP) for adults 18 years and over

Executive lead	Executive Director of Primary Care, Community and Mental Health	Officer lead	Assistant Director of Mental Health

Latest available	Mar-25	Status of measure	Level 2a
Reported performance	81.9%	Benchmark position (Wales)	5 th (77.2%)*
Target	90%		
SPC assurance rating	Common cause variation		
Measure type	NHSPF	Quality of measure data	Average
Data source of measure	PTHB Mental Health submission proforma		
Recover by?	Q4 2024/25		



Challenges

- Team Lead sickness has improved, and some individual teams have been targeted to improve their compliance which should see improvement in next reporting period.
- The service continues to be significantly affected by Social Services inability to undertake their share of Office Duty, which places additional demand on NHS staff. In order to mitigate and align to work to modernise and streamline services the new triage and assessment service was launched in September. Phase 2 is currently being rolled out, but this has impacted on Community Mental Health Team (CMHT) capacity as they are holding additional pressures whilst assessments are moved from teams to the SPOA.
- Long term sick has significantly affected Newtown CMHT with one member of staff having 10 out of date CTPs as a result - protected time and admin support has been provided to support the completion of CTPs following phased return.

Actions & Mitigations

- Joint modelling work in the developing Transformation agenda for MH has seen positive developments with Adult Social Care and consideration of Powys County Council’s responsibilities in Community Mental Health Teams (CMHT). Workshops are ongoing for a PTHB/PCC Mental Health Senior Leadership Team to define future operating model.
- Continue to advertise vacant positions.
- An enhanced reminder system has been put in place to advise staff of when CTPs are due to be out of compliance with support from data Team and local administrators. This aligns with the standard operating procedure (SOP) has been put in place to standardise data collection pan Powys with review meetings regularly undertaken to check consistency.
- There has recently been some success in recruitment which will remove agency locums from community provision ensuring longevity and consistency in caseload with direct impact on CTP measure.
- Currently investigating a ‘MH Measure’ data recording area of WCCIS to replace and centralise current means of data collection.
- The triage and assessment service when phase 2 is rolled out, will have a positive impact in reducing the pressures within CMHTs enabling more time for C&T Planning.
- Mental Health & Learning Disabilities division have brought in capacity to undertake a whole service CTP audit. This has been completed and reported to with improvement plan in place.
- Focussed work is being undertaken striving for improvement for next reporting period as follows.
 - Out Patients Clinics have been revised to accommodate CTP reviews
 - Compliance data and out of date reviews have been added as standard MDT agenda item
- Ystradgynlais CMHT were lowest performing team but following targeted work in last two months have now increased to + 80% since the last submission.
- It is anticipated that performance will be at the 90% mark for April’s submission.

What the data tells us

- Adult and older CTP compliance has measured at 81.9% and reports common cause variation.
- PTHB benchmarked 5th against an All-Wales position of 77.2% in February.
- Data challenge around retrospective updates in CTP performance.

Healthier Wales Quadruple Aim 4: Wales has a higher value health and social care system that has demonstrated rapid improvement and innovation and enabled by data and focused on outcomes



Quality, safety, effectiveness, and experience NHS Performance Measure – 46 Frequency - Monthly

Number of patient experience surveys completed and recorded on CIVICA

Executive lead	Executive Director of Nursing, Quality, Women and Family Health	Officer lead	Assistant Director Quality & Safety

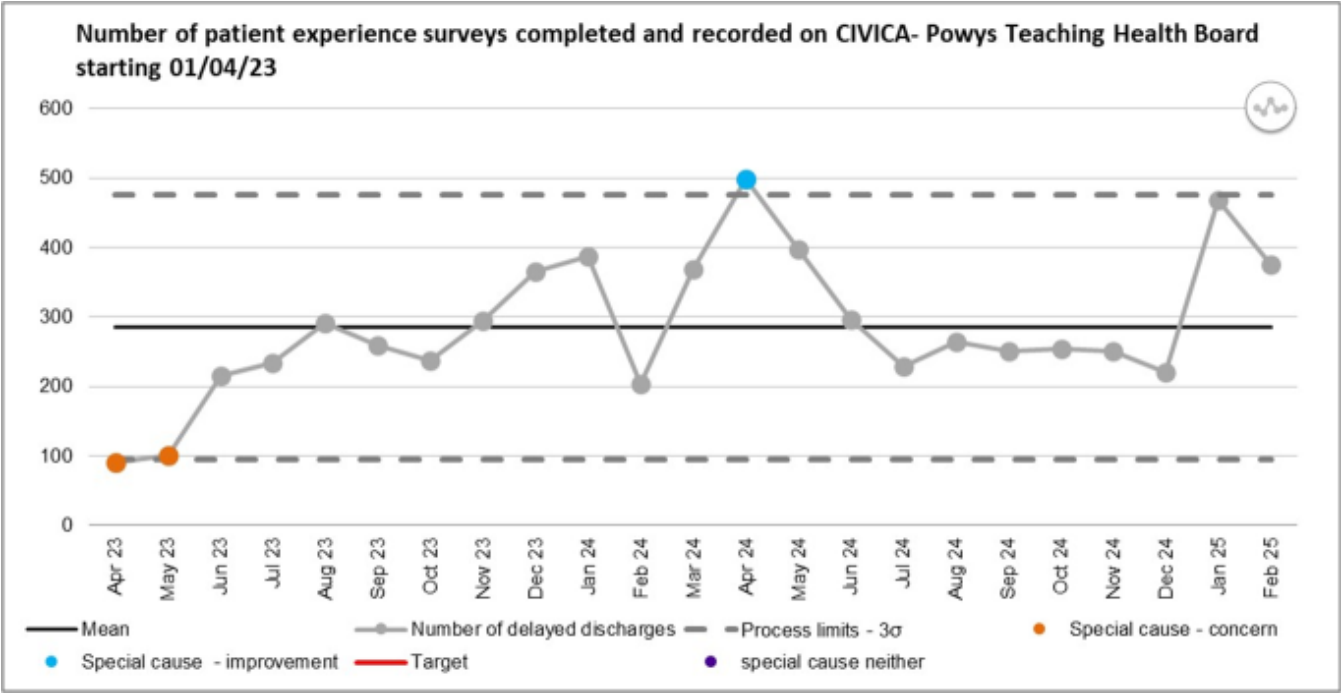
Latest available	Feb-25	Status of measure	Level 2a
Reported performance	376	Benchmark position (Wales)	9th (23,903)
Target	Month on month improvement		
SPC assurance rating	Common cause variation		
Measure type	NHSPF	Quality of measure data	Average
Data source of measure	PTHB Quality and Safety team		
Recover by?			

Challenges

- Limited resource to support proactive management of CIVICA experience questionnaires to realise the full potential of the system.
- Limited analysis of 'People's Experience' responses to inform service improvements or service successes due to no 'aligned resource' to support.
- There is no lead in place currently in the Health Board for patient experience.

Actions & Mitigations

- 1814 responses received during Q4, of which 776 were received via SMS.
- 81 Surveys available in the CIVIC system with 1 in development.
- Support to run the CIVICA system in the health board continues to be provided by the Quality & Safety (Q&S) team.
- The Patient Experience Lead post has been advertised with interviews planned for 1st May 2025
- A paper to Executive Committee (Q1 25/26) is being drafted to discuss the way forward with the People's Experience Framework and the new People's Experience Survey.



What the data tells us

- Reported experience surveys have declined February 2025 with 376 surveys completed and recorded on CIVICA compared to 469 in January 2025.
- It should be noted that the number of recorded surveys is a snapshot and when re-assessed the number of completed and recorded surveys increases significantly for the same time period.

Healthier Wales Quadruple Aim 4: Wales has a higher value health and social care system that has demonstrated rapid improvement and innovation and enabled by data and focused on outcomes

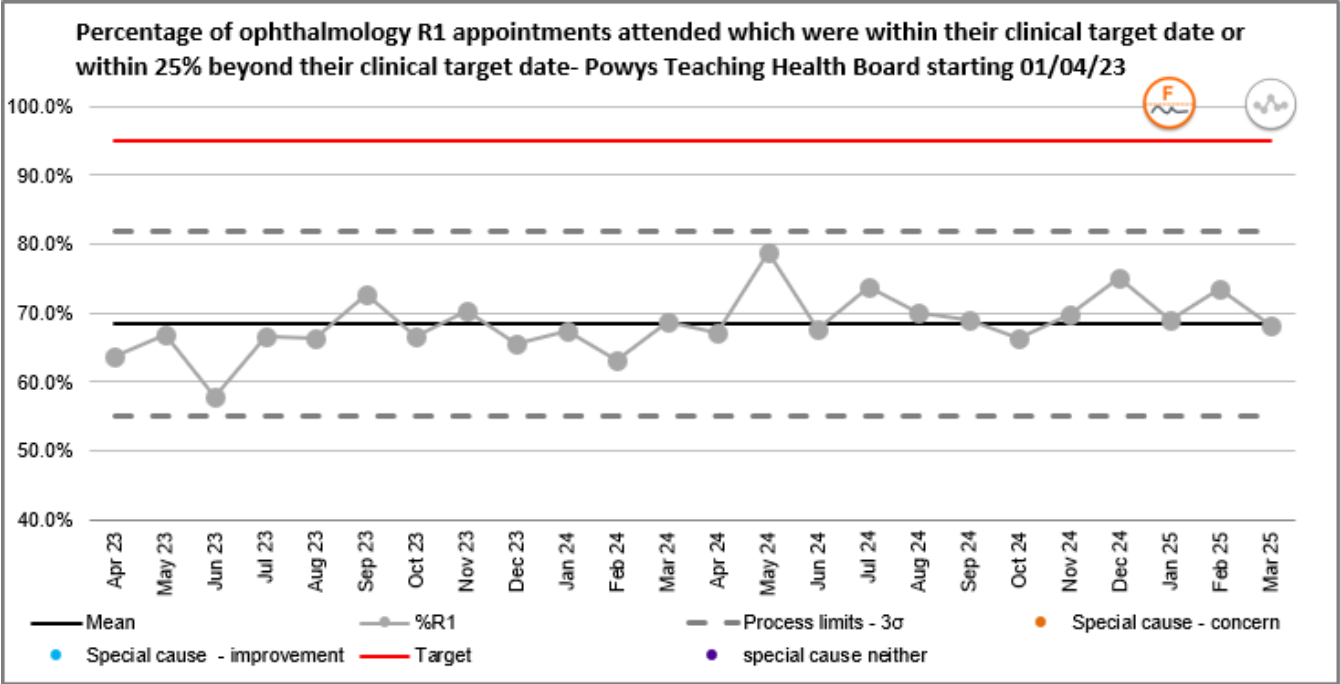


Access & Activity NHS Performance Measure – 51 Frequency - Monthly

Planned Care and Cancer - Percentage of ophthalmology R1 appointments attended which were within their clinical target date or within 25% beyond their clinical target date

Executive lead	Executive Director of Primary Care, Community and Mental Health	Officer lead	Assistant Director of Community Service Group

Latest available	Mar-25	Status of measure	Level 2a
Reported performance	68.2%	Benchmark position (Wales)	1 st (62.5%)
Target	12-month improvement trend towards national target of 95%		
SPC assurance rating	Common cause variation		
Measure type	NHSPF	Quality of measure data	Average
Data source of measure	PTHB Data Engineering and Analytics		
Recover by?	Plan to be developed 2024/25		



Challenges

- National fragility impacting in-reach capacity for ophthalmology.
- National staffing recruitment (including local impact) challenge reducing capacity including sickness absence, vacancies for theatre staffing, and industrial PTHB service is reliant on Wye Valley NHS Trust (WVT) for in-reach capacity (it is key for service). However, WVT remains impacted industrial actions during Q4 23/24 which had a significant impact on eyecare.
- Ongoing demand and capacity challenge resulting from inaccuracies with follow-up (FUP) reporting impacting service planning assumptions.
- National Digital Eye Care roll-out delay, pending national decisions.

Actions & Mitigations

- Working with WVT & Rural Health Care Academy to formalise training opportunities in DGH, extending OP role to include eye care scrub for potential future clean room developments in PTHB.
- Exploring charity funding for purchase of equipment to support repatriation of cataract pathway.
- Work with community optometry on contract reform and transformation opportunities.
- Escalated weekly waiting list meetings carried out in March with Executive leads to support waiting list management.
- Planned care bids to national planned care fund in March 2024 – outcome pending
- Enhancing staffing – including first non-registrant Ophthalmic health care scientist in the UK (supporting MDT development), and work with Rural Health Care Academy on career pathways for eye care in PTHB has resulted in trainee Eye care developmental post recruitment.
- Wet Age-related macular degeneration (AMD) service has been extended into mid Powys, embedded as service model for Llandrindod/Brecon Hospitals. PTHB 1st nurse eye care injector trained, plans in place for 2nd PTHB injector training (complete 2023/24).
- Service SOPs in place utilising best practice from Birmingham and Midland Eye Centre.
- Local Safety Standard for Invasive Procedures (LOCSIPs) in place for Eye Care & other outpatient department specialities first HB in Wales.
- Failsafe officer in place for WET AMD aligning fail safe duties within general ophthalmology.

What the data tells us

- The health boards performance for the measure in March is 68.2% attending within clinical target date (or within 25% beyond). PTHB has continued to benchmark positively against the All Wales benchmark (62.5%) and ranks 1st in March 2025.

Provider Service Assurance

PTHB information on key provider elements e.g., local measures, quality specific and provider cancer pathway assurance..

Healthier Wales Quadruple Aim 2: People in Wales have better quality and more accessible health and social care services, enabled by digital and supported by engagement

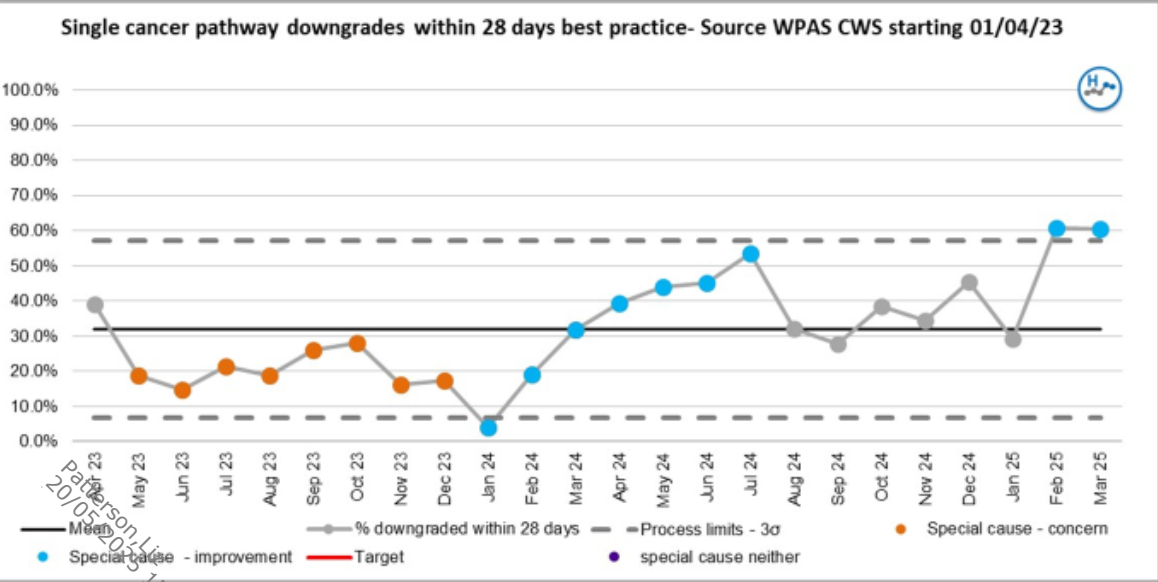
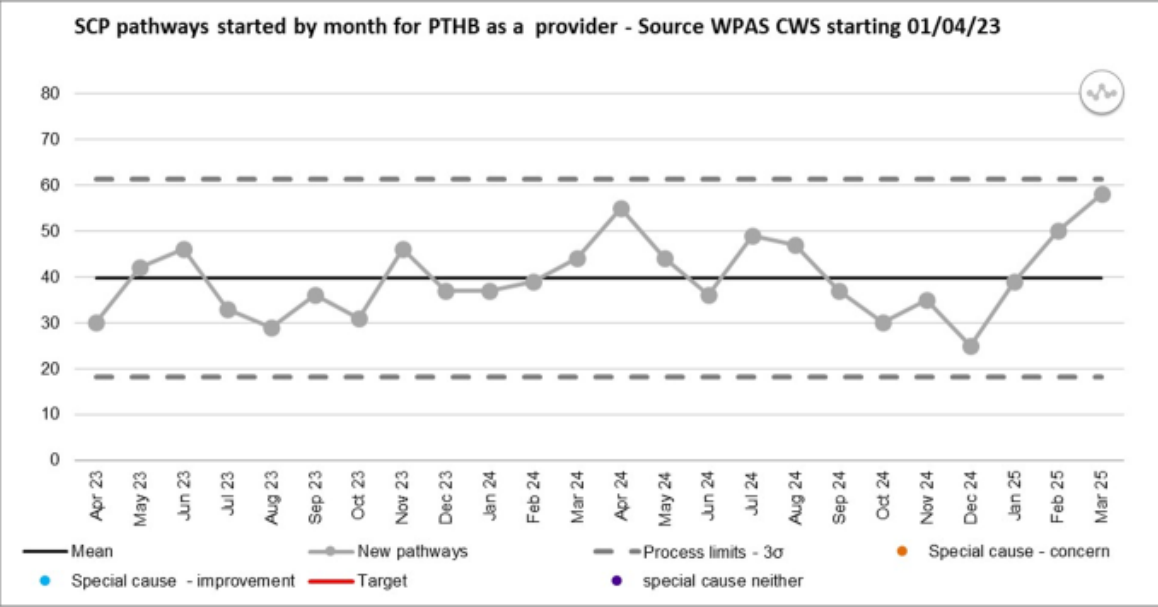


Access & Activity	Local Measure	Frequency - Monthly

Planned Care & Cancer – Powys provider cancer pathways additions and downgrade performance against 28-day NICE guidance of best practice.

Executive lead	Executive Director of Primary Care, Community and Mental Health	Officer lead	Assistant Director of Community Service Group

Latest available	Mar-25	Status of measure	Level 2a
Measure type	Local measure	Quality of measure data	Good
Data source of measure	PTHB Data Engineering and Analytics		



What the data tells us

- Powys has reported 58 new pathways in March 2025 with the majority via primary care, this is the second month where referral numbers are above average.
- The health board has reported improved compliance to 60.6%% for downgrades within 28 days, the last 2 months have reported compliance above the upper control line.
- PTHB meets the straight to diagnostic test 12-month improvement trend in January, however this measure and its compliance will be volatile because of small numbers.
- It should be noted that complex diagnostics are carried out within acute care providers although the patient remains tracked by PTHB, these delays remain a challenge for provider pathway compliance.

Challenges

PTHB predominately provides outpatient and diagnostic pathways for upper & lower gastrointestinal suspicions, as such key challenges reflect General Surgery constraints;

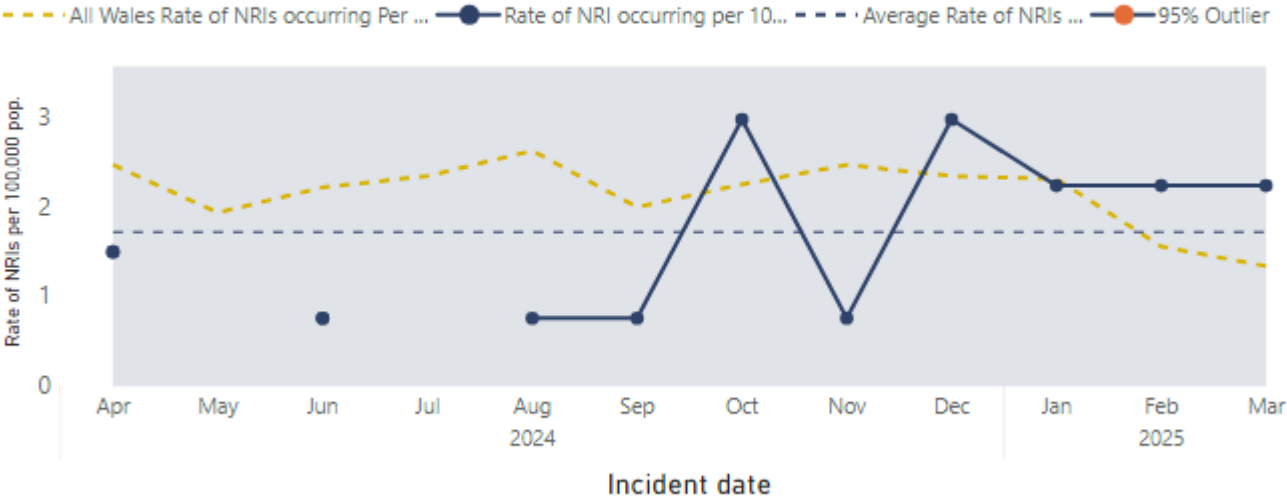
- National shortage of Endoscopists particularly colorectal.
- National increase in urgent suspected cancer referrals with resultant diagnostic demand increase.
- In-reach clinician fragility resulting from the above points including further business continuity challenges in Cwm Taf Morgannwg UHB (CTMUHB). CTMUHB currently have challenges in succession planning (as per national challenge), ongoing fragile workforce reliant on locums and insourcing which impacts on in-reach service capacity and reliability with resulting short notice cancellations.
- Delays in DGH diagnostics, Histology/Pathology risk timeliness of pathways including USC.
- Complex pathways across providers with referral triage and access criteria challenges.

Actions & Mitigations

- Significant service transformation including strengthening of team leadership and staff development to maximise service efficiency.
- Bid to Welsh Government Cancer Transformation fund for development of PTHB colorectal multi-disciplinary team (MDT) approach in Q3.
- Service have escalated the CTMUHB in-reach fragility, and diagnostic challenges for histology & pathology (this is currently reported as a very high risk for the health board). Proposal for capacity and contingency planning awaiting finalisation.
- Start of sponge capsule (cytosponge) from 2nd October 2023 in PTHB as enhanced diagnostic improving patient experience and reducing demand on staffing resource. Feedback so far has been excellent from both staff and patients.
- Enhanced administrative cancer tracking in place with substantive post appointment March 2024.
- Work with Welsh Government and DHCW reporting team ongoing to assess validation of records submitted, the methodology and its appropriateness for PTHB pathways as reported nationally.
- Working at Regional level to support service sustainability offering estate capacity endoscopy suite as part of regional solution mutual aid.
- Assistant Medical Director Planned Care role is now confirmed as permanent position.
- Appointed colorectal specialty lead on a locum basis.
- Successful recruitment to PTHB developmental specialist nurse roles for bowel screening service, completed in Mar 24.
- Rolling programme of clinical and administrative waiting list validation.
- Utilising Waiting Well Service to provide clinical support to cancer tracking.

Source National SCP dataset	Target	2024-04	2024-05	2024-06	2024-07	2024-08	2024-09	2024-10	2024-11	2024-12	2025-01	2025-02	2025-03
% of patients who are sent straight to test	12 month improvement trend	53.3%	31.8%	20.8%	42.9%	42.9%	28.6%	23.1%	26.3%	33.3%	45.5%	58.3%	73.3%

PT HB rate of NRIs occurring (by incident date) per 100,000 populatio...



Other Indicators	Date updated	Reported position
Patient safety notice/alerts compliance	06/01/2025	100%
National reportable incident rate per 100k pop	March 2025	2.23 per 100k
% Complaints settled within 30 days (month received)	February 2025	100%
Reported never events	09/04/2025	Zero
Mortality Rate Rolling 12 months	March 2025	5.83%

What the data tells us

- PTHB reports a higher than All-Wales rate for incidents in March with 2.23 per 100k population vs the All-Wales rate of 1.33 per 100k.
- Performance for complaints settled within 30 days by month received achieved 100% above the 75% target for February 2025.
- PTHB is 100% compliant with all current patient safety notices or alerts.
- Zero never events have been reported.
- Powys reported 5.83% rolling 12 mortality rate for March 2025, this slightly higher than the equivalent period last year that reported 5.78%. PTHB’s mortality rate is significantly higher than the All-Wales average of 1.7% but this due to the nature of service provision e.g., we are a community provider focused on end-of-life care and support with limited admissions (denominator) rather than an acute health board who carry out high numbers of elective admissions for planned care and operations.

Challenges

- Historic NRI investigations requiring joint review have prevented closure within time frame.
- The Health Board has a small pool of experienced, incident investigators to draw on for investigation completion.
- Two incidents pending police investigation have prevented reporting within time frame.

Actions & Mitigations

- Quality and Safety Team undertaking a review of incident investigation training.
- Mental Health have recruited an external incident investigator to review historic outstanding NRI investigations to coach to closure.
- Quality and Safety Team reviewing the Incident Management Framework to provide robust process on the completion of investigations and the accompanying action plan to prevent delay of closure.

Commissioned Service Assurance

PTHB information on key commissioned e.g., services not provided in county. This includes planned, urgent and cancer care as examples.

Healthier Wales Quadruple Aim 2: People in Wales have better quality and more accessible health and social care services, enabled by digital and supported by engagement



Planned Care & Cancer – Welsh Commissioned Referral to treatment (RTT)

Executive lead	Interim Executive Director of Planning, Performance and Commissioning	Officer lead	Assistant Director of Performance and Commissioning

Latest available	Mar-25	Status of measure	Level 3
Measure type	Commissioned	Quality of measure data	Good
Data source of measure	DCHW		

	Mar-25	No. long waits by cohort, with latest SPC variance						Total pathways Waiting
Welsh Providers	% of Powys residents < 26 weeks for treatment	All pathways waiting over 36 weeks.		All pathways waiting over 52 weeks.		All pathways waiting over 104 weeks.		
Aneurin Bevan Local Health Board	63.1%	684		387		6		2719
Betsi Cadwaladr University Local Health Board	49.0%	259		142		23		678
Cardiff & Vale University Local Health Board	45.4%	174		103		9		399
Cwm Taf Morgannwg University Local Health Board	54.8%	310		174		3		897
Hywel Dda Local Health Board	58.7%	440		238		0		1526
Swansea Bay University Local Health Board	56.0%	609		332		0		1946
Total	57.6%	2476		1376		41		8165

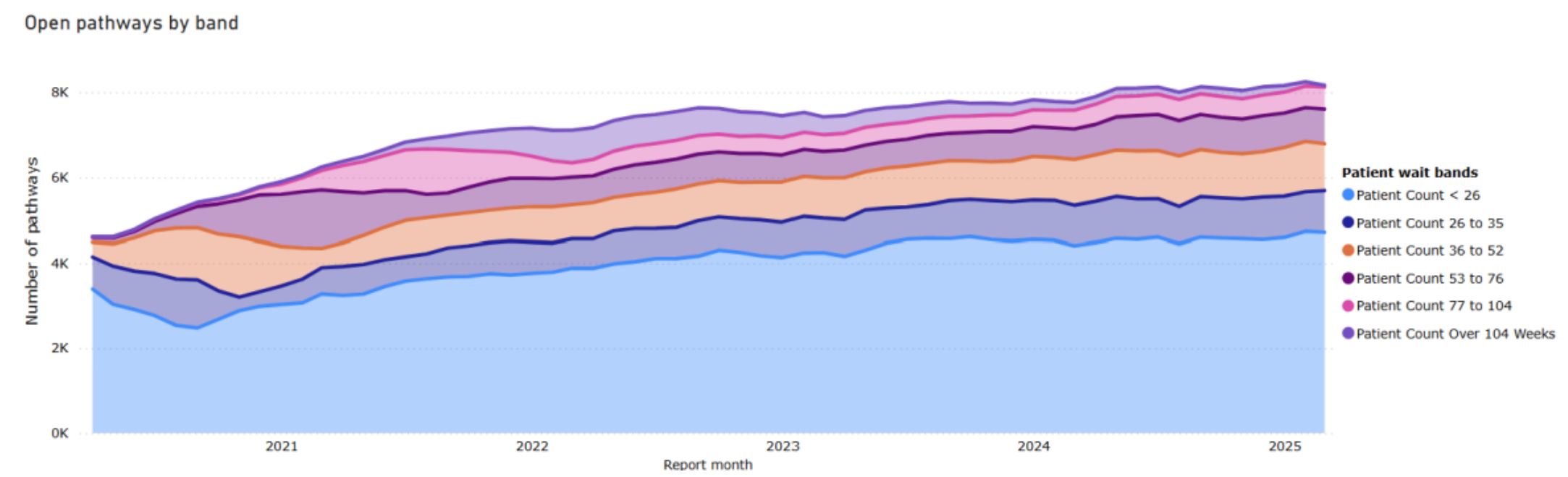
What the data tells us

- Powys residents in Welsh acute care providers have continued to see very long waits fall, however the waiting list as a total broadly shows limited growth with increased challenge in key providers being represented in as special cause concern for those waiting over 36 weeks.
- As of March, 324 patient pathways waited over 52 weeks for a new outpatient appointment, Swansea Bay University Health Board and Hywel Dda Local Health Board are compliant with zero breaches.

Provider	Patients waiting > 104 weeks
ABUHB	6 (6 T&O)
BCUHB	23 (1 General Surgery, 2 Gynaecology, 3 Ophthalmology, 6 ENT, 6 Oral Surgery, 3 Orthodontics, 1 Urology and 1 Pain Management)
C&VUHB	9 (1 General Surgery, 3 T&O, 1 Gynaecology, 1 Urology and 3 Ophthalmology)
CTMUHB	3 (3 T&O)

RTT open pathway waiting list snapshots by month and band of wait for combined Welsh providers excl. PTHB

Source DHCW



Challenges

- May 2024 Cabinet Secretary detailed required areas for improvement across Planned Care:
 - 40% reduction in number of patients waiting over 52 weeks for new outpatient appointment by September 2024; zero by March 2025.
 - Zero patients waiting more than 104 weeks for referral to treatment by end of December 2024.
 - Number of patients waiting more than 8 weeks for a specified diagnostic: 95% to be zero by December 2024.
- Welsh acute care providers continue to experience ongoing challenges due to increased demand and service sustainability issues.
- Powys residents who can have their pathways within the Powys as a provider have the quickest reported care, and with English acute health trusts providing more timely access for residents in the North & East of the county. Those residents living in southwest health economy wait the longest.
- Long wait pressure by treatment specialty remains within General Surgery, Trauma & Orthopaedics, ENT, and Ophthalmology.

Actions & Mitigations

- Welsh including Powys provider services, have mobilised additional capacity including insourcing, outsourcing, increase usage of additional payments for clinical activity.
- Ongoing repatriation scoping workstream for Powys residents who may be able to have treatment/care within PTHB or alternative provider.
- Continued to engage on a regular basis with all commissioned providers via contracting, quality and performance meetings. These meetings are used to discuss challenges and highlight key concerns but primarily to support the best possible care for Powys responsible patients within current health contracts. Also note progress against GIRFT pathway and case mix recommendations are discussed and noted.
- Health Boards have received additional funding to ensure patients waiting over 104 weeks are treated during 2023/24, the majority of PTHB patients in this cohort are sitting with commissioned providers.
- PTHB developed productive pathways for planned care with actions including referral management, effective clinically led pathways, implementation of GIRFT recommendations, theatre utilisation improvement.
- All Welsh providers have been formally contacted to request confirmation of when those patients waiting > 104 weeks will be seen.

Planned Care & Cancer – English Commissioned Referral to treatment (RTT) patients waiting more than 52 weeks for referral to treatment

Executive lead	Interim Executive Director of Planning, Performance and Commissioning	Officer lead	Assistant Director of Performance and Commissioning

Latest available	Feb-25	Status of measure	Level 3
Measure type	Commissioned	Quality of measure data	Good
Data source of measure	DCHW		

RTT open pathway waiting list snapshots by month and band of wait for combined English providers
Source DHCW

	Feb-25	No. long waits by cohort, with latest SPC variance						Total pathways Waiting
English Providers	% of Powys residents < 26 weeks for treatment	All pathways waiting over 36 weeks.		All pathways waiting over 52 weeks.		All pathways waiting over 104 weeks.		
English Other	72.7%	39		6		0		267
Robert Jones & Agnes Hunt Orthopaedic & District Trust	52.9%	1262		653		39		3701
Shrewsbury & Telford Hospital NHS Trust	56.9%	1432		440		0		4907
Wye Valley Trust	70.0%	576		128		0		3411
Total	59.7%	3309		1227		39		12286

What the data tells us

- Powys residents in English acute commissioned service providers continue to see generally faster access for treatment.
- English providers still report an improved position when compared to waiting pathways in Wales except for Robert Jones and Agnes Hunt.
- Robert Jones and Agnes Hunt show ongoing and growing challenge over all long wait measures.

Challenges

- English acute care providers continue to experience ongoing challenges due to increased demand and service sustainability issues.
- Powys residents who can have their pathways within the Powys as a provider have the quickest reported care, and with English acute health trusts providing more timely access for residents in the North & East of the county. Those residents living in southwest health economy wait the longest.
- Long wait pressure by treatment specialty remains within General Surgery, Trauma & Orthopaedics, ENT, and Ophthalmology.
- NHS England 2024/25 priorities:
 - Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%.
 - Eliminate waits of over 65 weeks for elective care as soon as possible and by September 2024 at the latest (except where patients choose to wait longer or in specific specialties).
- SATH reviewed and updated their patient administration system during Q1 2024/25, this has unfortunately been challenged with system problems and waiting list including outpatient and inpatient data disrupted, the health board are awaiting confirmation on the resolution of this challenge.

Actions & Mitigations

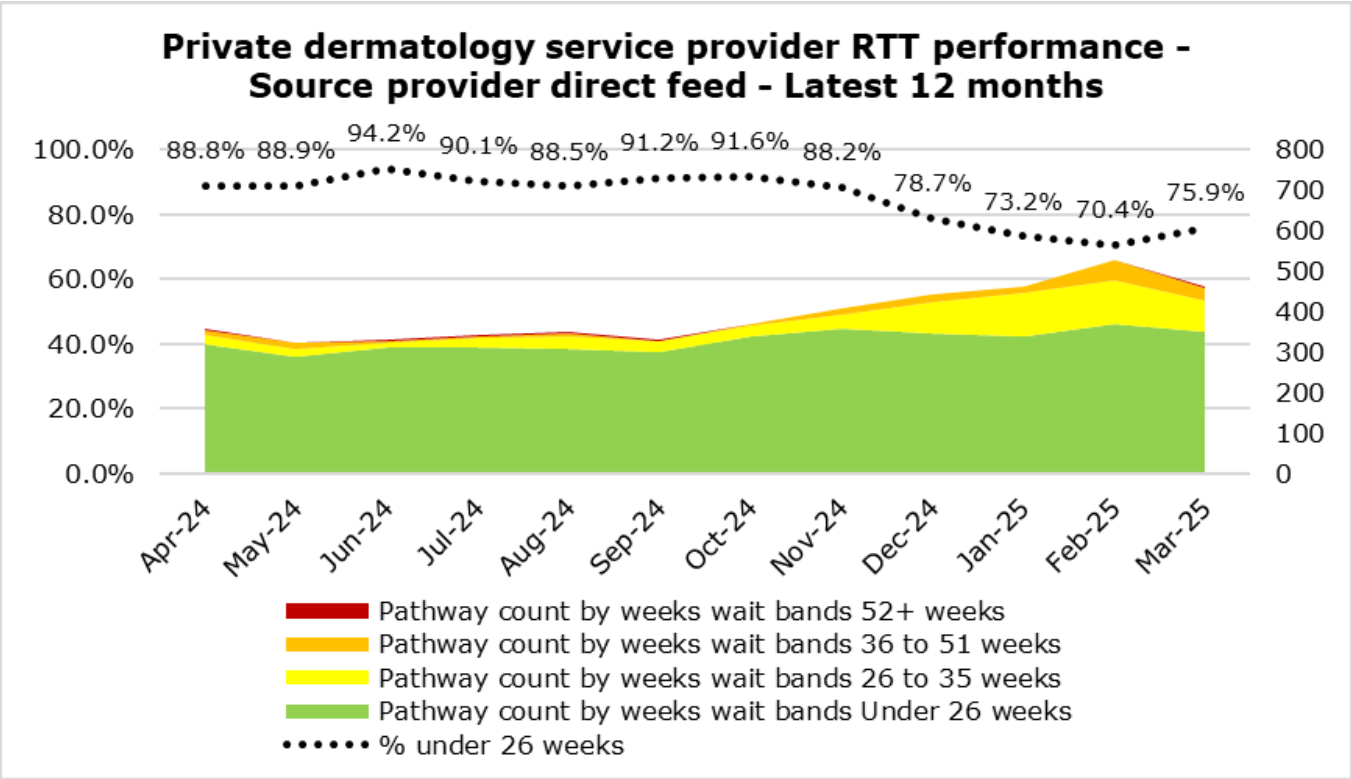
- English providers have mobilised additional capacity including insourcing, outsourcing, increase usage of additional payments for clinical activity.
- Ongoing repatriation scoping workstream for Powys residents who may be able to have treatment/care within PTHB or alternative provider.
- Continued to engage on a regular basis with all commissioned providers via contracting, quality and performance meetings. These meetings are used to discuss challenges and highlight key concerns but primarily to support the best possible care for Powys responsible patients within current health contracts. Also note progress against GIRFT pathway and case mix recommendations are discussed and noted.
- PTHB developed productive pathways for planned care with actions including referral management, effective clinically led pathways, implementation of GIRFT recommendations, theatre utilisation improvement.

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Referral to Treatment - Private dermatology service provider

Executive lead	Interim Executive Director of Planning, Performance and Commissioning	Officer lead	Assistant Director of Performance and Commissioning

Latest available	Mar-25	Status of measure	Level 2a
Measure type	Commissioned	Quality of measure data	Good
Data source of measure	DCHW		



Snapshot month	% under 26 weeks	Pathway count by weeks wait bands				Total Waiting
		Under 26 weeks	26 to 35 weeks	36 to 51 weeks	52+ weeks	
Nov-23	81.8%	320	47	21	3	391
Dec-23	82.5%	325	45	18	6	394
Jan-24	84.1%	348	51	12	3	414
Feb-24	83.9%	348	56	9	2	415
Mar-24	86.2%	324	37	13	2	376
Apr-24	88.8%	318	25	13	2	358
May-24	88.9%	288	20	14	2	324
Jun-24	94.2%	311	12	6	1	330
Jul-24	90.1%	310	24	6	4	344
Aug-24	88.5%	309	30	7	3	349
Sep-24	91.2%	301	26	2	1	330
Oct-24	91.6%	339	25	6	0	370
Nov-24	88.2%	359	33	15	0	407
Dec-24	78.7%	348	76	18	0	442
Jan-25	73.2%	338	109	15	0	462
Feb-25	70.4%	371	105	50	1	527
Mar-25	75.9%	349	80	30	1	460

Challenges

- Limited number of patients continue to wait over 52 weeks.
- Reduced NHS contract capacity for routine (Wye Valley NHS Trust). Currently exploring alternative providers including capacity commissioned from private provider

Actions & Mitigations

- Private provider requested to confirm mitigating actions for patients waiting 52 weeks and over.
- Scoping exercise being undertaken to identify additional capacity requirements (routine).

What the data tells us

- 75.9 % of patients wait under 26 weeks for treatment in March 2025 which is an improvement compared to February 2025 however there has been an increase in patients waiting over 36 weeks, there are 31 patients waiting over 36 weeks for treatment in March 2025.

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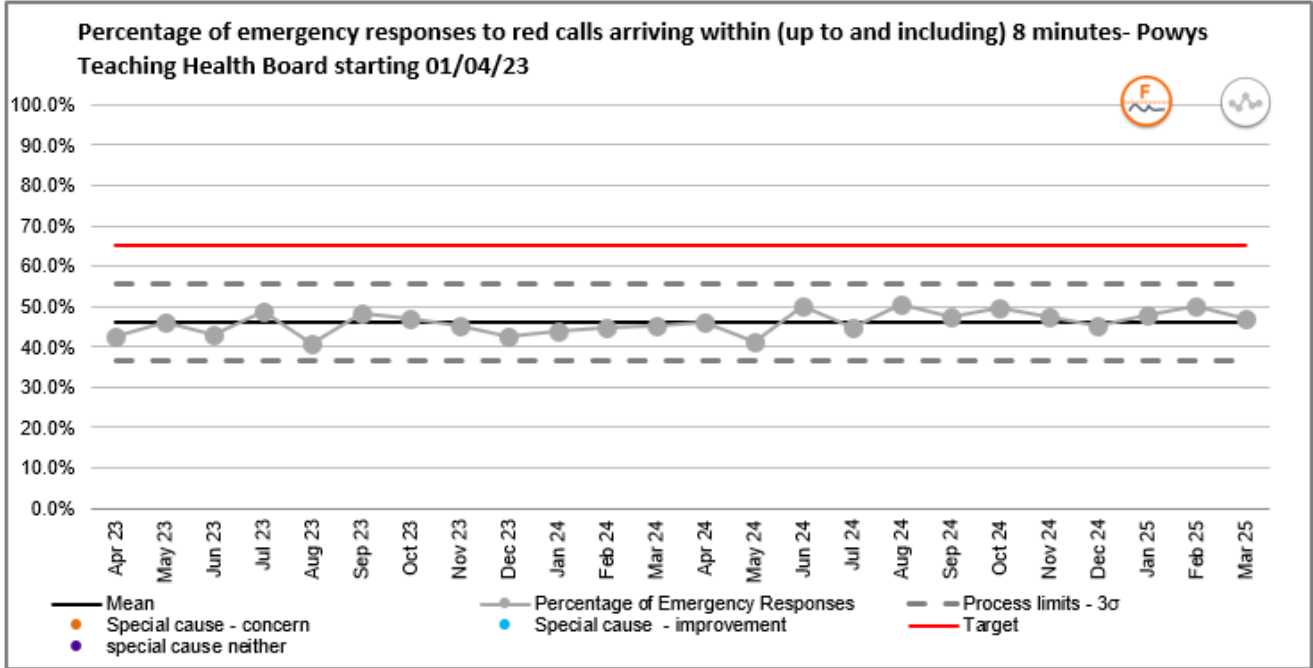
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Urgent & Emergency Care - Percentage of emergency responses to red calls arriving within (up to and including) 8 minutes within Powys

Executive lead	Executive Director of Planning, Performance and Commissioning	Officer lead	Assistant Director of Performance and Commissioning

Latest available	Mar-25	Status of measure	Level 2a
Reported performance	47.0%	Benchmark position (Wales)	7th (50.3%)
Target	65%		
SPC assurance rating	Common cause variation		
Measure type	NHSPF	Quality of measure data	Good
Data source of measure	WAST		
Recover by?	Commissioned provider, unable to provide recovery estimate.		



Challenges

- This is a commissioned service by the health board, as such Powys has limited actions available to resolve issues.
- Handover delays more than 15 minutes continue to be a challenge with lengthy handover delays continuing to be experienced at most DGHs.
- Delayed discharges - for patients declared medically fit for discharge (MFFD) the number occupying hospital beds slowing system flow.
- Temporary relocation of stroke services from Prince Charles Hospital (PCH) to Royal Glamorgan Hospital (RGH) from 6th January may impact on stroke conveyances.

Actions & Mitigations

- All hospital providers running A&E services have been asked to improve flow so that ambulance turnaround times can be improved.
- All Wales urgent care system escalation calls being held daily (often more than once per day).
- Health Boards asked to review Local Options Frameworks. Most Health Boards who run acute services have now deployed elements of this service resilience option.
- Action has been taken to improve 'return to footprint' by Powys crews to increase capacity for calls in county.
- New national dashboard ongoing development to provide improved intelligence around challenge and hotspots.
- Wider system calls being held daily with the aim to improve overall system flow.
- Engagement with the Ambulance Service to develop actions to reduce handover delays, including enhancement of current in-county pathways to reduce admission.
- Regular meetings are carried out between the health board and WAST, these meeting cover performance, patient experience, incidents and resultant investigations, clinical indicators and staff safety.
- Work ongoing with Joint Commissioning Committee Emergency Ambulance Services and WAST colleagues to develop improvement plan for Powys.
- Urgent and Emergency Care Programme work ongoing within Powys,- falls work has resulted in 15% reduction in WAST attendances to falls in Care Homes in Q1 2024/25.
- PCH will continue to provide emergency assessment and treatment for Stroke patients, temporary changes mean that ambulance service will convey with stroke or suspected stroke patients to alternative hospital to PCH (number of patients likely to be affected reviewed to assist this change).

What the data tells us

- The reported performance in March has shown a slight decrease in performance to 47.0% compliance for the 8-minute emergency response target for red calls.
- Performance remains common cause variation.
- The performance data supports that without a significant intervention to system the commissioned WAST service will not achieve the national target of 65.0%.
- PTHB ranks 7th and the All-Wales position is 50.3%

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Urgent & Emergency Care - Median emergency response time to amber calls

Executive lead	Executive Director of Planning, Performance and Commissioning	Officer lead	Assistant Director of Performance and Commissioning

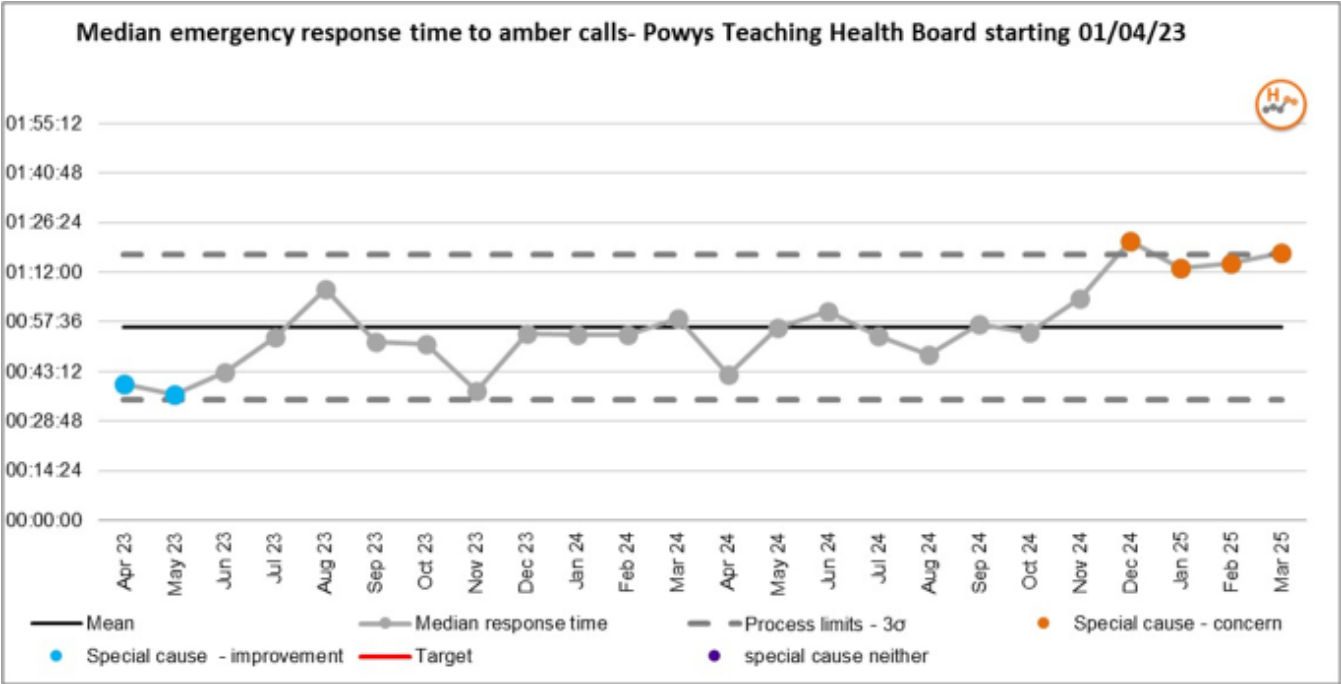
Latest available	Mar-25	Status of measure	Level 2a
Reported performance	01:17:33	Benchmark position (Wales)	1 st (01:55:57)
Target	12-month reduction target		
SPC assurance rating	Special cause concern		
Measure type	NHSPF	Quality of measure data	Good
Data source of measure	WAST		
Recover by?	Commissioned provider, unable to provide recovery estimate.		

Challenges

- Demand for urgent care services continues to increase including calls to 999 ambulance services.
- Handover delays at A&E sites are increasing the time ambulance crews are spent static as opposed to quick turnaround times.
- Delayed discharges - for patients declared medically fit for discharge (MFFD) the number occupying hospital beds slowing system flow.
- Noticeable shift in demand acuity away from red to Amber 1.

Actions & Mitigations

- All hospital providers running A&E services have been asked to improve flow so that ambulance turnaround times can be improved.
- All Wales urgent care system escalation calls being held daily (often more than once per day).
- Health Boards asked to review Local Options Frameworks. Most Health Boards who run acute services have now deployed elements of this service resilience option.
- Action has been taken to improve 'return to footprint' by Powys crews to increase capacity for calls in county.
- Wider system calls being held daily with the aim to improve overall system flow.
- Engagement with the Ambulance Service to develop actions to reduce handover delays (ICAP), including enhancement of current in-county pathways to reduce admission.
- Work ongoing with Joint Commissioning Committee Emergency Ambulance Services and WAST colleagues to develop improvement plan for Powys.



What the data tells us

- Median amber response times have reported a decrease in performance in March 2025 with response times increasing to 01:17:33
- PTHB ranks 1st in Wales with the All-Wales average at 01:55:57

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Access & ActivityNHS Performance Measure – 21 & 22Frequency - Monthly

Urgent & Emergency Care – Powys residents - Median time from arrival at an emergency department to triage by a clinician

Urgent & Emergency Care – Powys residents - Median time from arrival at an emergency department to assessment by a clinical decision maker

Executive lead	Executive Director of Planning, Performance and Commissioning	Officer lead	Assistant Director of Performance and Commissioning

Latest available	Mar-25	Status of measure	Level 2a
Target	Median wait to triage = 15 minutes or less Median wait to senior clinical decision = 60 minutes or less		
Measure type	Commissioned	Quality of measure data	Average
Data source of measure	DHCW EDDS		

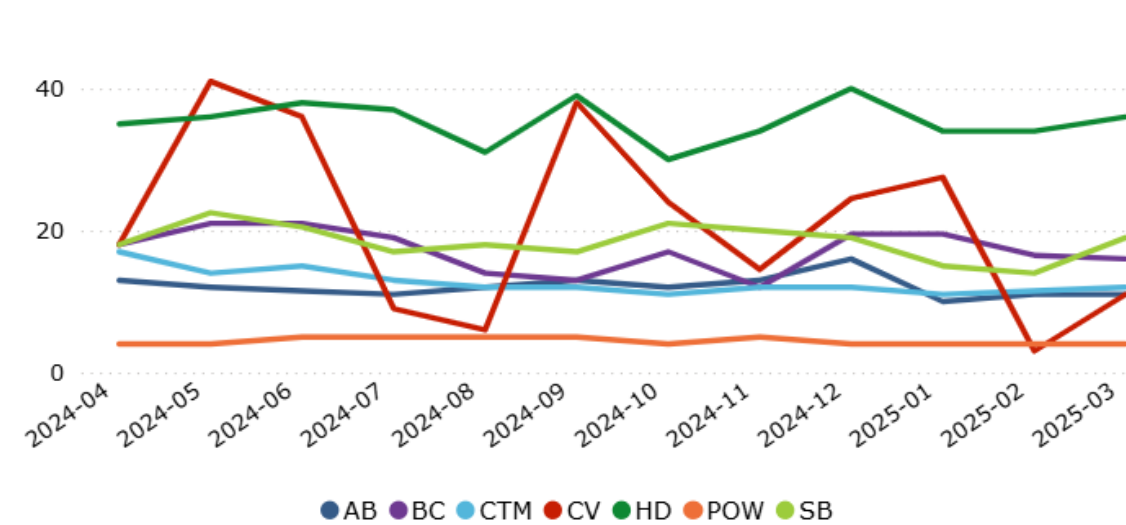
What the data tells us

- Access to median emergency departments data for Powys residents has been made available from June 2024 with access provided to the data via the DHCW. This data is currently being used for Information with analysis development to drive assurance conversations with commissioned service providers.
- The data is currently only available for Welsh providers.

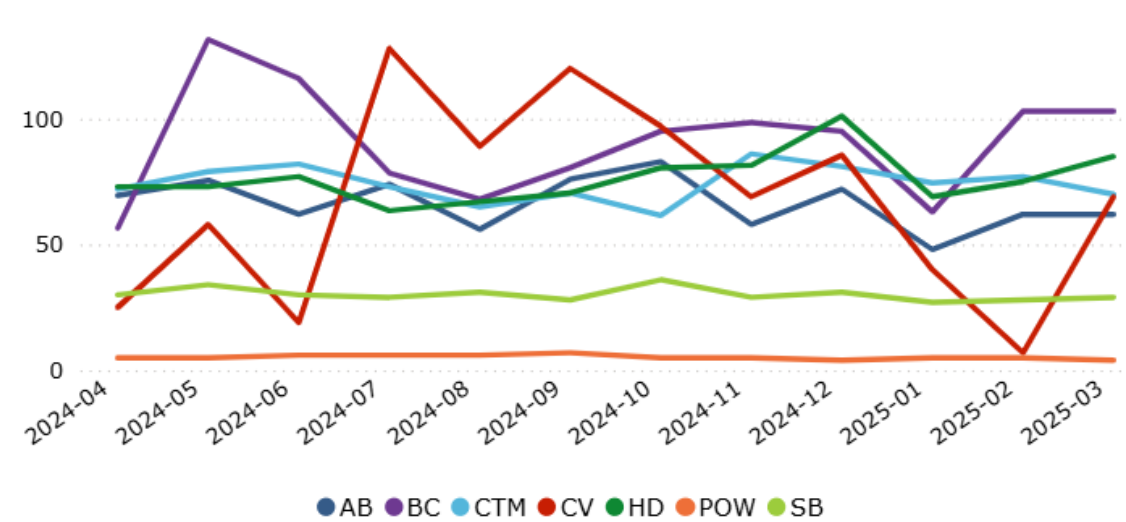
Actions & Mitigations

- Development of the data set to provide further analysis measures for Powys residents.
- Engagement with commissioned services via CQPRM meetings and sharing resident view findings with key services.

Median Wait from Arrival to Triage (minutes)



Median Wait from Arrival to Clinician (minutes)



The data in the below table should be used for guidance only and cannot provide an equity of access review without significant data quality risk (caveat). The cohort of Powys residents of which their median wait is calculated is considerably smaller than the over number of patients attending the unit. These low numbers will result in potentially significant variation for the health boards overall calculated median wait.

Mar-25 -Source Welsh Government monthly scorecard.				
Emergency access provider	Median wait to triage – Powys resident - minutes	Median wait to triage – All patients attending - minutes	Median wait to senior clinical decision – Powys resident - minutes	Median wait to senior clinical decision – All patients attending - minutes
ABUHB	11	18	62	144
BCUHB	16	22	103	136
CTMUHB	12	13	70	73
C&VUHB	11	8	69	64
HDUHB	36	29	85	76
SBUHB	19	24	29	25

Urgent & Emergency Care - Percentage of patients who spend less than 4 hours in all major and minor emergency care (i.e. A&E) facilities from arrival until admission, transfer or discharge

Urgent & Emergency Care - Number of patients who spend 12 hours or more in all hospital major and minor emergency care facilities from arrival until admission, transfer, or discharge

Executive lead	Interim Executive Director of Planning, Performance and Commissioning	Officer lead	Assistant Director of Performance and Commissioning

Latest available	Mar-25	Status of measure	Level 2a
Target	Improvement compared to the same month in the previous year, towards the national target of 95%.		
Measure type	Commissioned	Quality of measure data	Average
Data source of measure	DHCW EDDS		

What the data tells us

Welsh Emergency Access (A&E) providers

- Powys residents have seen a slight increase to 65.3% for those waiting under 4 hrs in Welsh units.
- Number of patients reported waiting over 12 hrs was 131 for March 2025

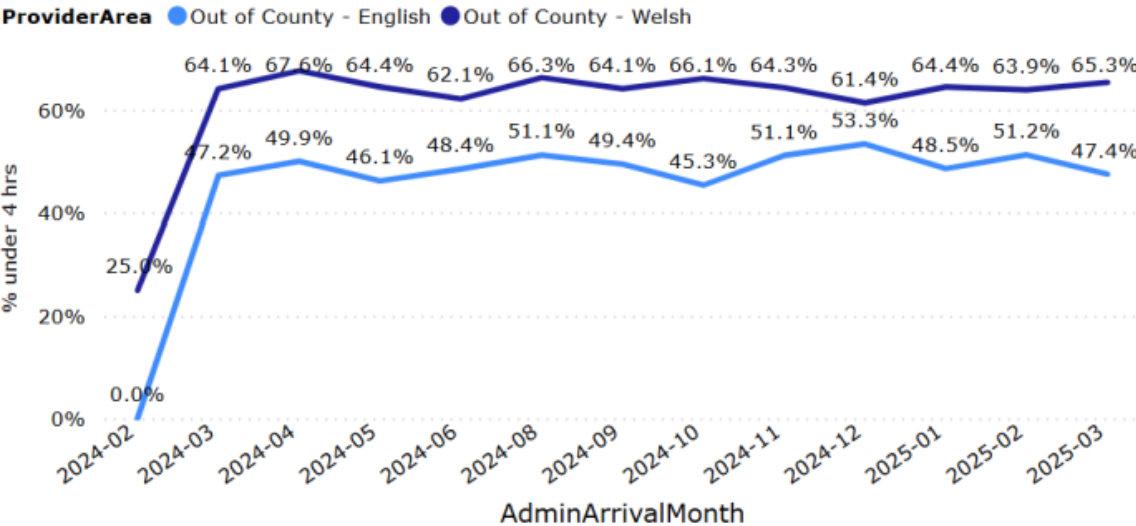
English Emergency Access (A&E) providers

- It should be noted that the English information is not complete, Shrewsbury and Telford NHS Trust data has not been available since August 2024.
- PTHB residents attending English emergency units see the longest wait with 47.4% reported as waiting less than 4hrs in their units.
- Of the reported health board 140 patients were reported waiting over 12hrs (predominately Wye Valley NHS Trust).

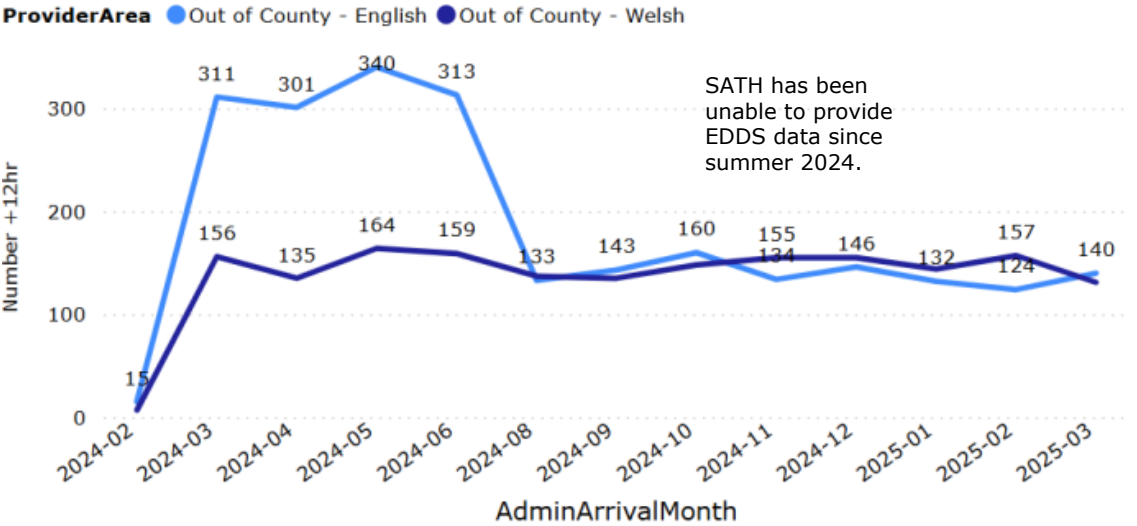
Data Quality

- Information on emergency department waits can be delayed especially from English providers, this results in retrospective updates of performance which will be noticeable between reporting month although minor.

Percentage of patients who spend less than 4 hours in all major and minor emergency care



Number of patients who spend 12 hours or more in all hospital major and minor emergency care facilities



Challenges

- More Powys residents flow into emergency units in England than Wales, where the greatest compliance pressures occur.
- Handover times of ambulances are poor at key sites in Wales & England with patients waiting a considerable period before being admitted to A&E.
- Providers experiencing challenges of increased demand, over occupancy in departments, long waits for inpatient beds, delay in discharge of clinically optimised patients.
- Ongoing data challenges with SATH in 2024/25, SATH are unable to provide the data from August onwards.

Actions & Mitigations

- PTHB as provider to continue to progress Urgent and Emergency Care plans within context of Better Together (including falls prevention pathway, frailty models, enhanced care in the community and Same Day Urgent Care).
- Work ongoing with Joint Commissioning Committee Emergency Ambulance Services and WAST colleagues to develop improvement plan for Powys.
- Urgent and Emergency Care Programme work ongoing within Powys,- falls work has resulted in 15% reduction in WAST attendances to falls in Care Homes in Q1 2024/25.

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Planned Care & Cancer – Percentage of patients starting their first definitive cancer treatment within 62 days from point of suspicion (regardless of the referral route)

Executive lead	Interim Executive Director of Planning, Performance and Commissioning				Officer lead	Assistant Director of Performance and Commissioning			

Latest available	Mar-25	Status of measure	Level 3
Measure type	Commissioned	Quality of measure data	Average
Data source of measure	DHCW		

Welsh Provider Cancer Performance Per SCP 62 Day Target (75%) - Last 12 Months

HealthBoard	2024-04	2024-05	2024-06	2024-07	2024-08	2024-09	2024-10	2024-11	2024-12	2025-01	2025-02	2025-03
Aneurin Bevan UHB												
Pathways With Treatment	18	10	11	18	16	11	9	13	16	15	16	16
Treated Within 62 Days	11	5	9	10	10	7	8	7	9	11	9	11
Breaching 62 Day Target	7	5	2	8	6	4	1	6	7	4	7	5
% Treated Within Target	61%	50%	82%	56%	63%	64%	89%	54%	56%	73%	56%	69%
Betsi Cadwaladr UHB												
Pathways With Treatment				4	1	1	1	3	2		1	
Treated Within 62 Days							1	3	2			
Breaching 62 Day Target				4	1	1					1	
% Treated Within Target				0%	0%	0%	100%	100%	100%		0%	
Cardiff And Vale UHB												
Pathways With Treatment					1				1	1		
Treated Within 62 Days					1					1		
Breaching 62 Day Target									1			
% Treated Within Target					100%				0%	100%		
Cwm Taf Morgannwg UHB												
Pathways With Treatment	4	4	3	4	7	6	5	3	9	4	3	5
Treated Within 62 Days	1	1	1	1	4	2	4		4	1	1	1
Breaching 62 Day Target	3	3	2	3	3	4	1	3	5	3	2	4
% Treated Within Target	25%	25%	33%	25%	57%	33%	80%	0%	44%	25%	33%	20%
Hywel Dda UHB												
Pathways With Treatment	9	8	8	8	8	8	5	7	7	9	7	6
Treated Within 62 Days	3	3	5	6	6	5	2	6	2	6	5	3
Breaching 62 Day Target	6	5	3	2	2	3	3	1	5	3	2	3
% Treated Within Target	33%	38%	63%	75%	75%	63%	40%	86%	29%	67%	71%	50%
Swansea Bay UHB												
Pathways With Treatment	8	7	11	10	14	7	11	9	11	11	4	7
Treated Within 62 Days	6	6	5	8	8	5	7	5	8	6	1	5
Breaching 62 Day Target	2	1	6	2	6	2	4	4	3	5	3	2
% Treated Within Target	75%	86%	45%	80%	57%	71%	64%	56%	73%	55%	25%	71%
Pathways With Treatment	39	29	33	44	47	33	31	35	46	40	31	34
Treated Within 62 Days	21	15	20	25	29	19	22	21	25	25	16	20
Breaching 62 Day Target	18	14	13	19	18	14	9	14	21	15	15	14
% Treated Within Target	54%	52%	61%	57%	62%	58%	71%	60%	54%	63%	52%	59%

What the data tells us

- At the end of March, the provisional position reported a at total of 313 pathways were closed for Powys residents across all Welsh providers including PTHB. Of these 279 were downgrades or patients whose pathway closed due to being reported deceased (all reasons). The remaining 34 pathways were closed with the commencement of definitive treatment. 14 patients breached the 62 days target with the longest wait reported as 190 days in Cwm Taf Morgannwg UHB for a Lower GI pathway.
- Reported performance for March has improved slightly to 59% (20 of 34 pathways being treated within the 62-day target) against the 75% target.
- 57% of 184 pathway breaches (provisional) for 2024/25 were within the primary tumour types of Lower Gastrointestinal (57 breaches) and Urological (47 breaches).

Data quality for reporting - please note that the SCP data provided within the IQPR is preliminary as the reported position is reviewed, finalised and validated at the end of every completed quarter. This validation by submitting health boards often results in limited changes included added/removed pathways or adjustment of waiting times. These changes will be fully reflected in the IQPR when available.

Challenges

- The key challenges for Powys residents in cancer pathways for Welsh commissioned services remain predominately capacity, including but not limited to, diagnostic test and reporting capacity especially within imaging, endoscopy and pathology, and surgical capacity meeting the <62-day target. There is also a limited number of breaches resulting from patient-initiated delay e.g., holidays etc.
- Consistency of receiving completed pathway reports/reviews for Powys residents whose treatment pathway has exceeded targets
- In May 2024 following limited improvement the Cabinet Secretary confirmed incremental improvement goals for the SCP pathway (regardless of the referral route) with providers expected to achieve 60% performance by December 2024, and 70% performance by March 2025 – **these goals have not been achieved for Powys residents.**

Actions & Mitigations

- Ongoing quarterly review with commissioners for very long waits e.g., where days are beyond 146 days. Q3 & Q4 review is now underway, and no pathways reviewed for Q1 and Q2 by the commissioned services were flagged as resultant harm.
- SCP performance reviewed regularly through CQPRM process and reported through PTHB Integrated Quality & Performance Report, which highlights variation across providers in NHS Wales and NHS England.
- New digital report for enhanced assurance utilising key elements of national workstream but with Powys resident's focus.
- SCP performance discussion monthly with Welsh Government and the NHS Executive team.

Healthier Wales Quadruple Aim 2: People in Wales have better quality and more accessible health and social care services, enabled by digital and supported by engagement



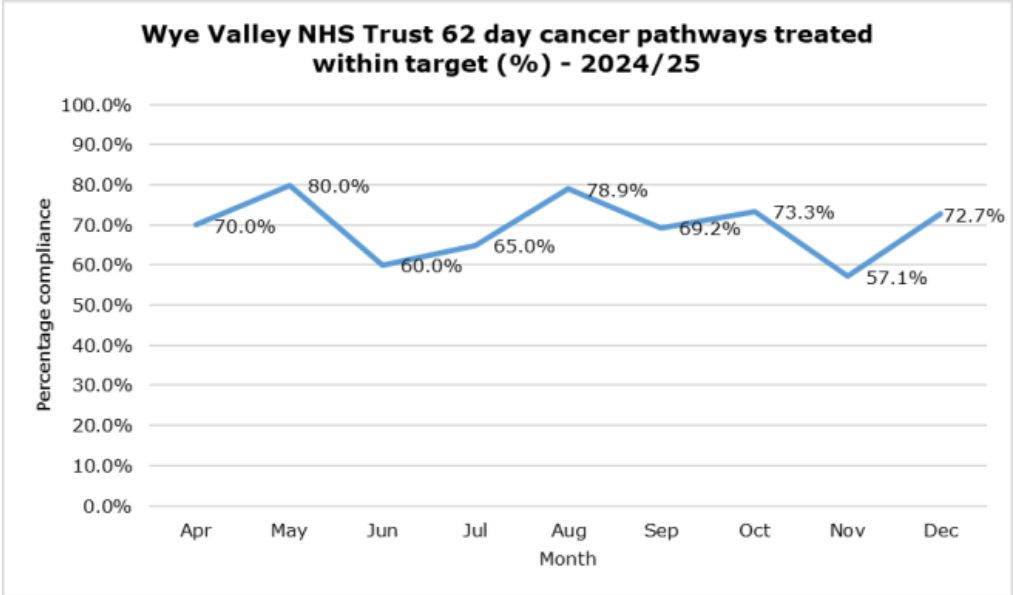
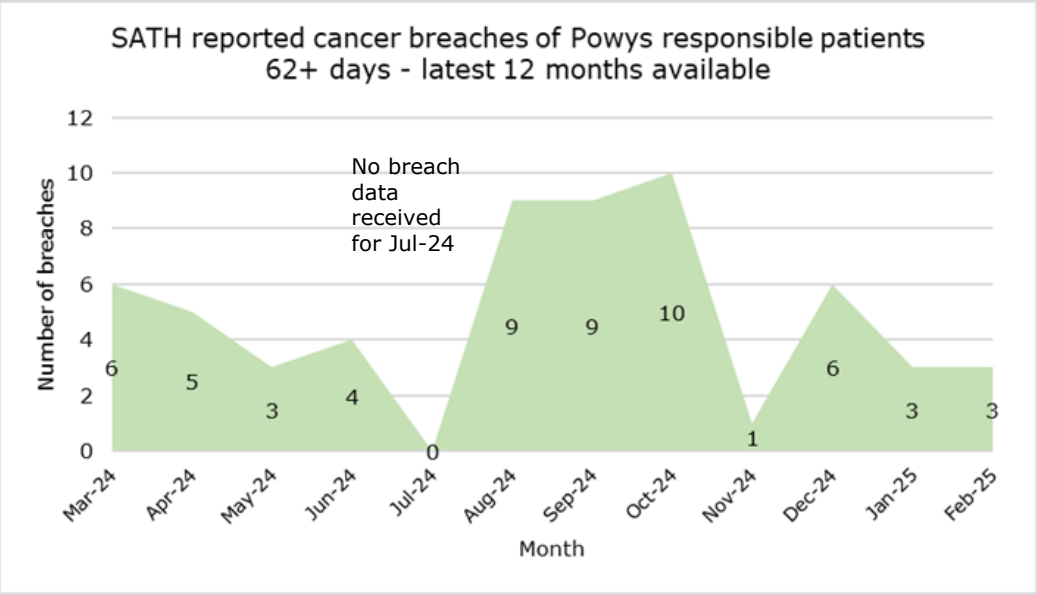
Planned Care & Cancer – Percentage of patients starting their first definitive cancer treatment within 62 days from point of suspicion (regardless of the referral route)

Executive lead	Interim Executive Director of Planning, Performance and Commissioning	Officer lead	Assistant Director of Performance and Commissioning

Latest available	Feb-25	Status of measure	Level 3
Measure type	Commissioned	Quality of measure data	Average
Data source of measure	Manual Provider Feeds, and NHS England reporting.		

NHS England Cancer Measures, and target

- 28-day FDS = Four Week (28 days) Wait from Urgent Referral to Patient Told they have Cancer, or Cancer is Definitively Excluded (target 75%)
- 31-day DTT = One Month (31-day) Wait from a Decision To Treat/Earliest Clinically Appropriate Date to First or Subsequent Treatment of Cancer (target 96%)
- 62-day USC = Two Month (62-day) Wait from an Urgent Suspected Cancer or Breast Symptomatic Referral, or Urgent Screening Referral, or Consultant Upgrade to a First Definitive Treatment for Cancer (target 85%)



Powys key provider cancer waiting times standards NHS England - All patients e.g., including non-Powys residents (table 1)

Feb-25	SATH	WVT	All English Providers	Target
28-day FDS	65.1%	82.9%	80.2%	75%
31-day DTT	93.7%	95.2%	91.8%	96%
62-day USC	54.7%	67.3%	67.0%	85%

[Statistics » Cancer Waiting Times \(england.nhs.uk\)](#)

What the data tells us

Powys residents attending English providers are measured in line with key NHS England cancer targets. The closest match to the Welsh Single Cancer Pathway measure is that of the Two Month (62-day) Wait from an Urgent Suspected Cancer or Breast Symptomatic Referral, or Urgent Screening Referral, or Consultant Upgrade to a First Definitive Treatment for Cancer. As a commissioner PTHB uses this key measure to gauge the compliance of our resident care in England.

- Shrewsbury and Telford NHS Trust (SATH) report 3 breaches in February for a Powys residents, all were reported waiting longer than 104 days. Key reasons for breach included complex diagnostic pathways and limited elective capacity. Breaches were across a range of tumour type pathways.
- SATH’s overall compliance (all patients not just Powys residents) is below average for England in February except for 31-day DTT (table 1).
- Wye Valley NHS Trust (WVT) performance reported in December was 72.7% for Powys residents. It should be noted that only eleven Powys accountable residents were reported as requiring treatment in December.
- WVT overall compliance for February reports higher performance for all measures against the English average, the Trust has seen compliance against 62-day USC fall in February for all patients.

Challenges

- Capacity challenges for outpatients, complex diagnostics are all listed as challenges within received breach reports, however several breaches are linked to patient choice slowing the pathway.
- SATH fragility specifically with Oral and Maxi facial capacity due to medical vacancies/sickness.
- NHS England 2024/25 priorities:
 - Improve performance against the headline 62-day standard to **70% by March 2025**.
 - Improve performance against the 28-day Faster Diagnosis Standard to **77% by March 2025 towards the 80% ambition by March 2026**.

Actions & Mitigations

- SCP performance reviewed regularly through CQPRM process and reported through PTHB Integrated Quality & Performance Report, which highlights variation across providers in NHS Wales and NHS England.
- Re-commenced engagement with NHS Digital England to access the central Cancer Waits Information system for Powys responsible patient information to provide enhanced overarching assurance on pathways.
- SATH outsourcing/redirecting referrals where possible, utilising mutual aid where available and actively triaging all referrals to focus on cancer and treat accordingly (impact on routine waiters).

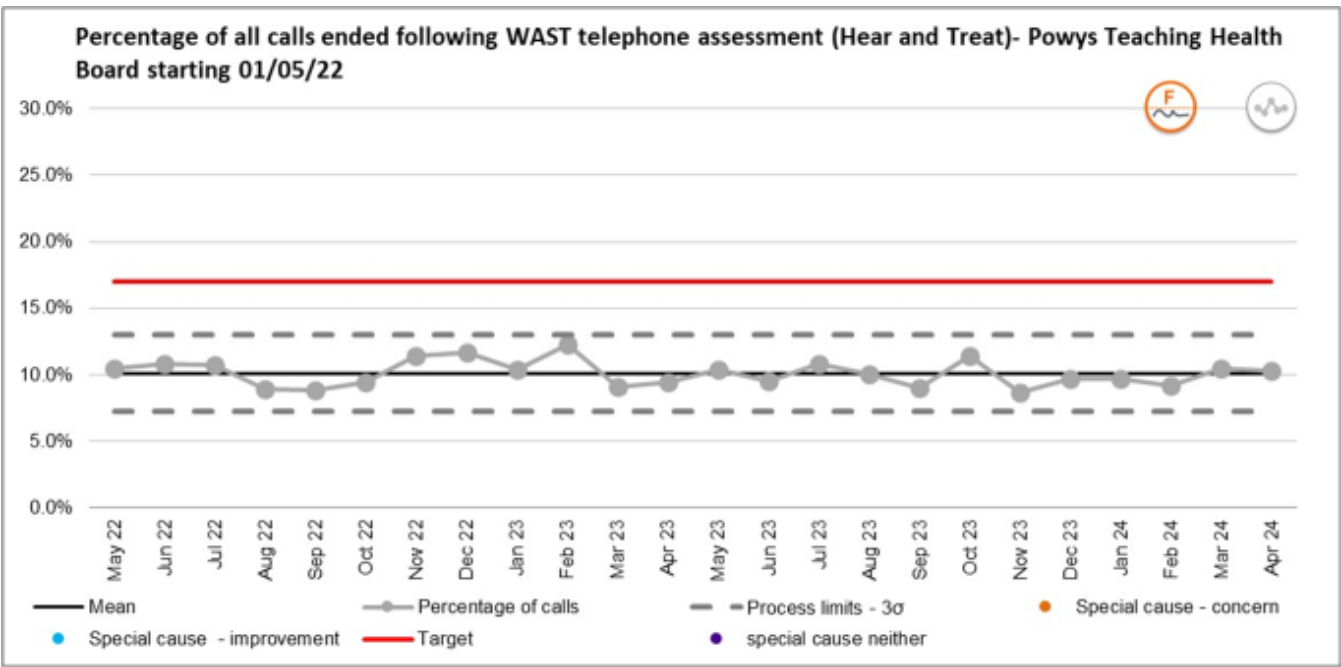
Healthier Wales Quadruple Aim 4: Wales has a higher value health and social care system that has demonstrated rapid improvement and innovation and enabled by data and focused on outcomes



Urgent and Emergency Care - Percentage of calls ended following WAST telephone assessment (Hear and Treat)

Executive lead	Interim Executive Director of Planning, Performance, and Commissioning	Officer lead	Assistant Director of Performance and Commissioning

Latest available	Apr-24	Status of measure	Level 2a
Reported performance	10.3%	Benchmark position (Wales)	7 th (15.2%)
Target	17% or more		
SPC assurance rating	Common cause variation		
Measure type	NHSPF	Quality of measure data	Poor
Data source of measure	Welsh Government Scorecard		
Recover by?			



What the data tells us

- Powys has not met the national target in April with 10.3% reported against the 17% target. It should be noted that the health board area ranks 7th against the All-Wales position of 15.2% for April 2024.
- Poor assurance of compliance in 2024/25 with no further data received around compliance post April 2024.

Challenges

- In April 2024, the Welsh Ambulance Service University NHS Trust implemented a new 111 system for call handing and clinical assessment. The data and reporting for this system has been developed at pace, and some metrics are still being finalised and awaiting sign-off. An issue has also been identified when aggregating 111 call records to Health Board level to support the AQI reporting. This issue is being actively worked on, with mitigations already in place, however, until full validation and sign-off which is planned for January 2025 this information will not be available.

Actions & Mitigations

- Regular meetings are carried out between the health board and WAST, these meeting cover performance, patient experience, incidents and resultant investigations, clinical indicators and staff safety.
- Work ongoing with Joint Commissioning Committee Emergency Ambulance Services colleagues to develop improvement plan for Powys.

PTHB Integrated Quality & Performance Framework Escalation Framework 2024/25

Please note that this framework replaces the 23/24 business reporting rules as used within the Integrated Performance Framework and report.



Escalation level	Trigger	Action expected	Monitoring and support
Level 1 (No concerns)	- Local delivery of agreed objectives and performance, finance ambitions in line with agreed trajectories. - No exceptions or quality concerns. - Sound governance arrangements in place. - Performance within expected targets either national or local	- No escalation action. - Could result in frequency adjustment for some monitoring mechanisms and meetings including IQPG.	Main monitoring through base performance review process. Key measures bi-annually in IQPR to the Board.
Level 2a (Exception)	- Failure to achieve / maintain delivery in more than 1 key deliverable / area of performance. - Sustained deterioration on 1 or more domain. This can include: - Failure to deliver on an NHS Performance Framework target or local target trajectory. - A deviation or departure from the normal or expected course of action signifying specific condition or event that requires attention or further action to address the deviation. - Failure of quality standard. - Where SPC methodology notes variance of concern.	- Correspondence to Clinical service area/corporate dept on reasons for escalation – areas of concern, expected response and confirm any enhanced monitoring. - Recovery plan to be developed that address issues to be recovered/improved. - Depending on issue – change in frequency of and focus of standard meeting and consideration of increasing frequency including IQPG. - Reported through to Executive Committee. - Monthly reporting where appropriate via IQPR as an exception to performance.	Options include: - IQPG engagement monthly with Executive - Internal support as required (QI/vbhc/planning – issue dependent). - Consideration of compliance with Professional clinical codes and standards and proportionate response. - Consideration of compliance with managerial code of practice. - Internal peer review. - Executive support (directly or from other teams). - Consider need for bespoke response. - Minimum monthly updates to Executive Committee.
Level 2b (Exception)	Specially for finance: Where Corporate Directorate or Clinical Service Area level budget is overspending by more than £0.5m Year to date or £1m forecast.	Identified through monthly financial reporting	CEO to call a special ‘Budget Review Meeting’ of all Executive Directors and the Divisional or Directorate budget holder (up to 3 team members may attend in support). Agreed action plan established: - Monitored through financial reporting arrangements. - Review period established if plan failing.
Level 3 (Escalation)	- Serious concerns on quality and governance. - Continued and consistent failure to meet agreed performance improvements and trajectories across a number of objectives. - Clear articulation of reasons for escalation and criteria for escalation. This can include: - Where a performance matter (exception) does not meet target and hits criteria for higher level of resolution, decision making or further action. - Any measure that continues to fail a health board submitted trajectory as part of the Ministerial Priority measures. - Performance recovery is failing to improve or maintain performance. - Any significant failure of quality standard. - Where IQPG deems that a service or measured outcome requires escalation resulting from identified challenge or significant concern.	- Correspondence to service area/corporate dept on reasons for escalation – areas of concern, expected response and confirm any enhanced monitoring. - Service Area or corporate directorate demonstrating recognition of issues and commitment to improve. - Improvement/recovery plan required to address issues identified. - Reported through to executive and relevant committee. - Escalated frequency of IQPG meetings and resultant remedial action plan completion. - Challenge review on appropriate shift to the Escalations Oversight Group (EOG). - Monthly reporting where appropriate via IQPR as an exception to performance.	Actions could include: - Escalation Oversight Group (EOG) - Independent review of service/corporate department effectiveness. - Deployment of appropriate HR policies e.g. Capability policy. - Weekly/fortnightly meetings with CEO and/or relevant execs to track progress against improvement actions (which directly related to de-escalation criteria). - Consideration of compliance with Professional clinical codes and standards and proportionate response. - Consideration of compliance with managerial code of practice. - Suspension or revision of service provision. De-escalation: The appropriate outcome for a challenge to be de-escalated. Either challenge has been rectified, requirement has changed, or via senior committee decision. A level 3 escalation may return to any previous lower level of escalation dependant on the remaining challenge and required monitoring.

Patterson, Liz
20/05/2025 15:22:19

PTHB Integrated Quality & Performance Framework: Duty of Quality Measures and Enablers



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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.

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At the start of 2024/25 financial year NHS Executive wrote to all health boards and trusts setting out a requirement for improved waiting times, this to drive improvements in patient care and experience. Five areas were highlighted, and minimum access targets provided. As a health board PTHB provided trajectories to meet or exceed these minimum planned care targets to achieve the targets.

- The below table contains submission trajectories and is colour and icon coded dependant on compliance, please note that:
- Value cell shading red/green, this denotes compliance to health board submitted trajectory as a key performance indicator
 - Value cell icon either green tick  or red cross  denotes compliance against the NHS Performance Framework target.

Ministerial Priority Measures			Baseline		Month											
Measure	NHS Performance Target	KPI Improvement Target	Mar-24		Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Number of patients waiting more than 52 weeks for a new outpatient appointment	Zero	40% reduction by end of September 2024 Zero by March 2025	0	Performance trajectory	55	65	55	45	20	8	5	0	0	0	0	0
				Actual	 0	 0	 0	 1	 1	 0	 0	 0	 0	 0	 0	 0
Number of patients waiting more than 104 weeks for referral to treatment	Zero	Zero end of December 2024	1	Performance trajectory	0	0	0	0	0	0	0	0	0	0	0	0
				Actual	 0	 1	 2	 3	 3	 0	 0	 0	 0	 0	 0	 0
Number of patients waiting over 8 weeks for a specified diagnostic	Zero	95% to be zero by December 2024	116	Performance trajectory	230	200	150	75	30	0	0	0	0	0	0	0
				Actual	 140	 171	 157	 155	 140	 124	 107	 83	 84	 70	 79	 79
Number of patients who spend 12 hours or more in all major and minor emergency care facilities from arrival until admission, transfer or discharge	Zero	20% reduction by September 2024 Further 20% reduction by March 2025	0	Performance trajectory	0	0	0	0	0	0	0	0	0	0	0	0
				Actual	 0	 0	 0	 0	 0	 0	 0	 0	 0	 0	 0	 0
Percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS for people age under 18 years	80%	80% by December 2024	97.7%	Performance trajectory	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%
				Actual	 80.0%	 86.5%	 83.7%	 93.1%	 90.0%	 87.5%	 92.1%	 89.2%	 92.9%	 86.7%	 91.2%	 91.7%
Percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS for adults age 18 years and over	80%	80% by December 2024	91.1%	Performance trajectory	85.6%	85.6%	85.6%	85.6%	85.6%	85.6%	85.6%	85.6%	85.6%	85.6%	85.6%	85.6%
				Actual	 95.2%	 95.3%	 93.0%	 95.10%	 87.50%	 91.7%	 92.3%	 98.3%	 95.6%	 79.0%	 96.2%	 93.7%

At the start of 2024/25 financial year Welsh Government policy and performance leads requested trajectories to support internal NHS Wales delivery assurance process for the operational delivery of mental health performance, forming part of routine mental health touchpoint meetings with Health Board colleagues as well as Integrated Quality, Planning and Delivery meetings between Health Boards, Welsh Government and the NHS Executive.

- The below table contains key elements for the submitted trajectories and is colour and icon coded dependant on compliance, please note that:
- Value cell shading red/green, this denotes compliance to health board submitted trajectory as a key mental health performance indicator
 - Value cell icon either green tick  or red cross  denotes compliance against the NHS Performance Framework target.

Age Group	Policy Lead Priority Measures			Month											
	Measure	Target		Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Under 18's	Mental Health Measure Part 1a - % of mental health assessments undertaken within (up to and including) 28 days from the date of receipt of referral	80%	Performance trajectory	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%
			Actual	 98.0%	 98.1%	 100.0%	 94.6%	 100.0%	 100.0%	 100.0%	 100.0%	 100.0%	 100.0%	 100.0%	 100.0%
	Mental Health Measure Part 1b - % of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS	80% by December 2024 (80% monthly is NHS Performance Framework Target)	Performance trajectory	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%
			Actual	 80.0%	 86.5%	 83.7%	 93.1%	 90.0%	 87.5%	 92.1%	 89.2%	 92.9%	 86.7%	 91.2%	 91.7%
	Mental Health Measure Part 2 - % of health board residents in receipt of secondary mental health services who have a valid care and treatment plan	90%	Performance trajectory	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%
			Actual	 94.1%	 93.9%	 90.8%	 91.0%	 93.6%	 94.9%	 94.9%	 97.8%	 94.8%	 96.3%	 95.7%	 97.4%
	Neurodevelopmental - % of children and young people waiting less than 26 weeks to start an ADHS or ASD neurodevelopment assessment	80%	Performance trajectory	45.0%	45.0%	45.0%	45.0%	45.0%	45.0%	45.0%	45.0%	45.0%	45.0%	45.0%	45.0%
			Actual	 45.4%	 45.8%	 39.6%	 42.0%	 37.2%	 34.3%	 30.9%	 30.5%	 27.3%	 24.4%	 25.9%	 29.9%
18 years and over	Mental Health Measure Part 1a - % of mental health assessments undertaken within (up to and including) 28 days from the date of receipt of referral	80%	Performance trajectory	70.0%	70.0%	70.0%	75.0%	75.0%	75.0%	75.0%	75.0%	80.0%	80.0%	80.0%	80.0%
			Actual	 44.1%	 54.1%	 69.2%	 74.0%	 45.3%	 46.7%	 58.7%	 71.4%	 78.7%	 58.0%	 85.5%	 98.0%
	Mental Health Measure Part 1b - % of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS	80% by December 2024 (80% monthly is NHS Performance Framework Target)	Performance trajectory	86%	86%	86%	86%	86%	86%	86%	86%	86%	86%	86%	86%
			Actual	 95.2%	 95.3%	 93.0%	 95.1%	 87.5%	 91.7%	 92.3%	 98.3%	 95.6%	 79.0%	 96.2%	 93.7%
	Mental Health Measure Part 2 - % of health board residents in receipt of secondary mental health services who have a valid care and treatment plan	90%	Performance trajectory	80%	83%	86%	88%	90%	90%	90%	90%	90%	90%	90%	90%
			Actual	 89.5%	 89.6%	 90.5%	 90.7%	 89.7%	 89.0%	 89.9%	 86.3%	 81.7%	 82.1%	 82.5%	 81.9%
	Psychological Therapies - % of patients waiting less than 26 weeks to start a psychological therapy in Specialist Adult Mental Health	80%	Performance trajectory	80.0%	83.0%	85.0%	88.0%	90.0%	93.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%
			Actual	 75.1%	 69.4%	 75.2%	 76.9%	 78.7%	 79.9%	 72.9%	 67.0%	 63.1%	 66.4%	 68.2%	 71.3%



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Agenda item: 4.4

Board		21 May 2025	
Subject:	Progress Against the Integrated Plan (Delivery Plan 2024-2029) end of year report January to March 2025		
Approved and presented by:	Executive Director of Planning, Performance & Commissioning		
Prepared by:	Assistant Director of Planning/Planning Managers		
Other Committees and meetings considered at:	Executive Committee 16 April 2025 Informal Executive Committee 23 April 2025 Delivery and Performance Committee 01 May 2025 – who supported the report to the Board.		
PURPOSE:			
This report provides the Board with an update of the progress made against the Integrated Plan as an end of year report January to March 2025. Following consideration at this meeting it will be submitted to Welsh Government as a formal report of Progress against Plan for Quarter 4. It will also feed into the PTHB Annual Report 2024-2025.			
RECOMMENDATION(S):			
The Board are asked to: CONSIDER the report ahead of submission to Welsh Government and take ASSURANCE that there is a process in place for monitoring progress against plan.			
Approve/Take Assurance		Discuss	Note
Y		Y	N

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:		
1. Focus on Wellbeing	Y	Use this space to provide a brief narrative explanation of alignment with the health board's wellbeing objectives including reference to our strategic priorities. This can include reference to the Board Assurance Framework.
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:

This report provides the Board with an update of the progress made against the Integrated Plan for the year end (January-March 2025). This is the output of the reviews carried out by each Executive Lead on their respective areas.

This information is particularly important at year end as part of the review and appraisal of progress against plan that contributes to the Annual Report 2024/25 (which will give a fuller picture of achievements and learning from the year, and how this has informed the forward plan and planning practice going forward).

Once considered and approved by the Board this will then be submitted to Welsh Government as a formal report of Progress against Plan for the year end.

This is an important component of the health board’s assurance and performance management regime. This is particularly relevant in the context of the Health Board’s escalation status of ‘Level 4’ for strategy, finance and planning. Improvements have been made continuously to this report to enable sufficiently detailed yet concise reporting of the PTHB Integrated Plan.

BACKGROUND

This report provides the Board with an update of the progress made against the Integrated Plan for the Quarter 4 period (January to March 2025).

1) Development of Progress Report against Plan

Each of the 27 Strategic Priorities set out within the Integrated Plan have been reviewed and a commentary provided by Executive Leads on key achievements and challenges, where required for Quarter 4.

An additional explanation including mitigating action is also included where any items are **RAG** rated as Red. Executive leads were also asked to reassess their delivery confidence ratings with current confidence levels compared to that of the start of the year. Improvements have been made continuously to this report to enable sufficiently detailed yet concise reporting of progress against the PTHB Integrated Plan.

This is an important component of the Health Board’s monitoring, assurance and performance management regime. This is particularly relevant in the context of the Health Board’s escalation status of ‘Targeted Intervention’ for strategy, finance and planning.

Executive Lead sign off has been maintained, to ensure that the report reflects the appraisal carried out within Directorates and is given as part of the Executive Leads accountability for their portfolio and strategic priorities.

The information provided in this report is also part of the wider review and appraisal of progress and performance across the year, as part of the production of the Annual Report 2024 – 2025, which is currently being drafted. This latter document will give a fuller picture of achievements and learning from the year, and how this has informed the forward plan and planning practice going forward.

2)Progress Summary at Q4

The report shows the progress made with delivery of the actions and priorities in the Plan as reported at the end of the year.

Of the 215 key deliverables identified for completion in 2024/25, 149 have been completed (Blue), this represents 72% of the plan as being complete, as at year end. The remaining key deliverables have been categorised as behind schedule (26) or at risk (31) representing 28% of the plan. A number of these have been identified as key areas to inform the Annual Plan 2025/26 which is year 2 of the Health Board's 5-year plan.

Achievements in 2024/25

- Enhanced coordination for those in Powys who are most frail, or at risk of frailty. There has been an enhanced focus on the end of life, with improved care planning and streamlined clinical pathways for example those for the management of Cellulitis and Urinary Tract Infections.
- Referral management for those with musculoskeletal conditions, enhancing patient care and service efficiency. This initiative is implementing evidence and value-based interventions including clinical review and triage, specialised leadership for Orthopaedics, and the joint appointment of an Orthopaedic Consultant for Upper Limb services.
- Major investment in modernising diagnostic services and enhancing patient care, through the X-Ray replacement programme. Welshpool, Llandrindod Wells and Ystradgynlais have successfully re-opened with state-of-the-art equipment.
- Successful implementation of the Single Point of Access for Mental Health as part of '111 Press 2'. This marks a major achievement in improving access to care and is a transformative step in enhancing mental health support and access.
- The Children and Adolescent Mental Health Services Crisis Hub is now fully operational, providing a dedicated, purpose-built sanctuary for children and young people experiencing mental health distress. The alignment of Rapid Response and Outreach with Crisis Response has also improved out-of-hours support.

Powys is the first region in Wales to establish a pathway integrating a jointly operated Integrated Autism Service (IAS) alongside a newly developed Attention Deficit Hyperactivity Disorder (ADHD) service.

Further work is also in train to address long waits in neurodevelopment services following a comprehensive appraisal of the challenges and opportunities.

- The successful Phase 1 implementation of Powys 'DigiFLO' is a major advancement in digital patient flow management across Powys community hospitals.
- A focus on delays in pathways of care has seen a 13% decrease in the last quarter, reflecting improvements in tracking and co-ordinating responses to patient flow.
- Approval of Digital Maternity Cymru business case, with programme progressing to implementation stage, anticipated completion by end March 2026.
- Completion of the Maternity Assurance and Safety Improvement Plan.
- Neurodevelopmental strategic action plan in place, informed by co-production and multi-agency collaboration shaped by future demand aligned to best practice.
- Patient Story agenda progressing with the recruitment of a Peoples Experience lead expected in June 2025
- Work underway to complete the People Experience Maturity Matrix following the release of the Peoples Experience Framework
- Effective delivery of all health board-led population level health improvement programmes
- Successful implementation of the Outpatient Transformation Plan, supporting service modernisation and improved patient experience
- Expanded availability and utilisation of Point of Care Testing across Powys, enhancing timely diagnostics
- Ongoing implementation and annual evaluation of the 'Improving Cancer journey' in Powys
- Strengthened strategic workforce planning capabilities through enhanced managerial knowledge and skills development
- Effective onboarding and development of new recruits through the Aspiring Nure Programme
- On going delivery of the National Nurse Retention Plan
- Implementation of Full the Speaking Up Safely framework
- Completion of the Virtual Consultation project, resulting in an award directed to Attend Anywhere to ensure ongoing business continuity.

- Approval of the Electronic Prescribing and Medicines Administration (EPMA) business case, with the programme now progressing into the implementation stage
- Implementing the technology to support Telephony Welsh Language functionality, enhancing bilingual service provision within the health board
- Reduction in the length of stay in Community Hospitals achieved since December 2024
- Successful roll out of PROMs in the Mental Health acute inpatient settings
- As part of the Mental Health Network, PTHB hosted a Mental Health Knowledge Exchange event that received outstanding feedback from attendees. The event showcased the triage and assessment project, along with the implementation of the Mental Health Single Point of Access (SPOA). It served as a precursor to a three-day international knowledge exchange held in Cardiff, where Powys was recognised as a leader in the development and delivery of the Mental Health SPOA.

Items Behind Schedule

Further analysis has identified the items below as behind schedule.

The table below shows the areas of delivery with a RAG rating of red at year end and an explanation for the reason for delay/action for recovery.

The main areas relate to specific schemes in Community Services and Planned Care, the Major Conditions Plan and Mental Health (which is being reviewed as part of the reshaping of the Transformation Programme), and some Digital schemes due to the interdependency with national programmes. There are also items that have been rolled over into the new year.

Strategic Priority	Area of delivery	Deliverables	Reason for delay / action for recovery	Delivery confidence assessment at Q3
Early Help and Support				
Improve Access to Primary and Community Care	General Medical Services	Engagement with patients and stakeholders on perception and experience of access Q4	This deliverable was paused due to the implementation of the national Access T&F Review Group	Low
	Optometry	Pre-registration Optometrist between primary and secondary care in Cluster(s) Q2	Recruitment and supervision challenges	Low
		School vision and eyecare access	School Vision will sit under the Womens Family and Children	Low

		improvements Q2	services going forward and become part of the school's programme	
	Dental	Increase capacity of Llandrindod Wells contract Q2	Issues within the practice, practice is open but offering very limited GDS offer via a Dental Therapist	Medium
Design and Deliver a phased Frailty and Community Model	Improve coordination of the Last Year of Life	Commence implementation including liaison with out of county providers Q3-Q4	As outlined in Q3, the liaison work with out of county providers has not taken place	Low
Deliver the Planned Care & Diagnostic Programme	GIRFT Recommendations	Seek Consultant Urologist sessions to scope community urology service Q2-Q4	PTHB were unsuccessful in the Planned Care Transformation fund for speciality consultant sessions	Low
	Key Strategic Relationships	Recruitment for jointly funded or regional post Q3	Plans to recruit a jointly funded post through the delivery of the MSK Triage solution has been reviewed, the posts would be better managed through a Service Level Agreement	High
		Evaluation of jointly funded or regional post Q4	As Above	Medium
	Referral Management Solutions	Subject to approval implementation of interface triage solution for Orthopaedic Referrals; Evaluation Q3-Q4	Recruitment for key roles are currently being progressed, with the band 7 physiotherapist in its second week of advert. The band 8a physiotherapist job has been approved through the job matching panel and scheduled to go out to advert imminently. The band 6 physiotherapist role has been approved and advertised with interviews scheduled. The workspace for the 2 Band 3 admin roles has been confirmed as Newtown. The initial mapping design document for single point of access for Orthopaedic referral management has been	High

			drafted and discussed with the clinical and admin teams for ratification. This has been taken into Q1-Q2 2025/26 Deliverables.	
		Develop referral management solution for dentistry in relation to oral cancer Q2	Scoping of opportunities in dental to be taken forward in Annual Plan 2025/26	Low
Tackling the Big Four				
Develop and Deliver a Major Conditions Plan	Development of a Transformative Major Conditions Plan	Development of <u>a phased major conditions transformation plan</u> to develop: a less siloed approach; streamline appointments, diagnostics, assessments, care and treatment plans, reviews and polypharmacy; and to improve co-ordination in the last year of life Q1- Q3 development of the plan	An SRO was not identified for the work programme and it has therefore been unable to progress as planned	Low
Deliver the Mental Health Transformation Programme	Transformation of Adult and Community Model Phase 1 (includes alignment of Duty and Assessment Model)	Refining the baseline. Refining the modelling for the new model. Continuous engagement Q1	This work has been rescheduled for Q1-Q2 2025-26 as part of the Community model redesign work	High
		Public engagement and consultation Q2	Public engagement and consultation has not been required.	High
		Phase 1 implementation Q4	Implementation into Q1 2025-26, potentially aligned with accelerated work for the Mental Health Community Model.	High
Workforces Futures				
A Great Place to Work	Develop a Pilot for Tier 2	Develop the Tier 2 programme Q2	This has been delayed to Q1 2025/26	Medium
Digital First				
Citizen centred care and support	Improve awareness and access to their digital appointment	Introduce patient portal for managing appointments Q4	Issues with cyber assurance, exploring alternative solutions	Low

Leadership, Partnership and Alliances	Continue engagement with NHS England to improve clinical cross border pathways	Improve data flows of clinical information into our All Wales architecture to support delivery of care Q2	The Cross border programme has been escalated the time for completion has slipped to May 2025.	Low
	Scope requirements for Integrated Shared Care Record	Enable front line staff to access digital clinical information across multiple disciplines Q4	Reliant on the Connected Care National Programme which is not progressing as expected.	Low
Enabling Efficiency and effectiveness	Whole system application review to standardise digital system access and improve efficiencies	Ensuring the system gaps are fully understood to meet the needs of the health board and standardise the approach to recording Q2	This internal work has slowed down due to conflicting priorities and waiting for the direction nationally and the application roadmap for national all Wales solutions	Low
	Finalise cross border clinical records sharing project	Improve data flows of clinical information into our All Wales architecture to support delivery of care Q2	This has slipped due to Digital Health and Care Wales (DHCW) and Testing activities	Low
	Review replacement of WCCIS	Implement a replacement community system that supports the delivery and recording of patient care Q4 (NB - Change in Timescale from Q1-Q4)	Connected Care programme and WCCIS replacement has not progressed. There is no confirmation of WG funding, and the National Business Case has not been re-submitted following comment from key stakeholders	Low
Infrastructure and Security	Continue to improve cyber security posture	Replace and update Firewall authentication technology across the Health Board and migrate applications Q4	This could not progress due to not being able to receipt the equipment needed. This will move to FY 25/2026	Low
Big Data and Artificial Intelligence	Accelerate use of Robotic Processing Automation	Plan and deliver a 'RPA Framework' and Operating Model across the HB Q4	This has not progressed due to capacity and resource	Low
	Adopt Machine learning toolkit (predictive analysis on current data sets)	Design and deliver a framework to adopt Machine Learning models Q3	This has not progressed as expected due to resource and capacity constraints	Low
Innovative Environments				

Property	Integrated Hubs/Agile Working	Develop Spa Road, Llandrindod Wells as Integrated Hub Q3	Confidence of agreement and future creation of Integrated Hub is high for within 2025-26	Medium

Following feedback and discussions at the Delivery and Performance Committee, further analysis has been conducted to understand the reasons behind the non-delivery of the Q4 action: *Engagement with patients and stakeholders on perception and experience of access*. In response, Executive Leads have requested that, as part of the formal change control process, an additional deliverable be incorporated into the 2025/2026 Delivery Plan. This will ensure the outstanding work is appropriately captured and progressed within the year.

3) Conclusion

This report provides the Board with an update of the progress made against the Integrated Plan for the end of year 2024/25 (January to March 2025.)

Following consideration at this Board meeting this report will be provided to Welsh Government as a formal report of Progress against Plan in line with national reporting requirements.

The information provided in this report is also part of the wider review and appraisal of progress and performance across the year, as part of the production of the Annual Report 2024 – 2025, which is currently being drafted. This latter document will give a fuller picture of achievements and learning from the year, and how this has informed the forward plan and planning practice going forward.

NEXT STEPS:

Following consideration at this Board meeting, this report will be provided to Welsh Government as a formal report of Progress against Plan for Quarter 4 - year end, in line with national reporting requirements.

It will also feed into the PTHB Annual Report 2024-2025.

IMPACT ASSESSMENT

Not required

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GIG
CYMRU
NHS
WALES

Bwrdd Iechyd
Addysgu Powys
Powys Teaching
Health Board

Integrated Plan Progress Report

Quarter 4 2024/ 2025

January to March 2025

BRAGG Key

Blue - Complete

Red - Behind schedule

Amber - At risk/issues present

Green - On track

Grey - Not due yet

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PLAN ON A PAGE 2024 - 2029



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NHS WALES

Iswydd Iechyd
Addysgu Powys
Powys Teaching
Health Board

Plan on a page 2024 - 2029



OUR FUTURE VISION
FOCUS ON INEQUALITIES & PEOPLE WITH COMPLEX NEEDS
IMPROVE HEALTH AND WELLBEING
WE WILL PUT THE PEOPLE OF POWYS FIRST

TO 2027 AND BEYOND





Better Together for a Sustainable Model of Care

Whole System Approach to Wellbeing & Prevention

- Develop a whole system prevention plan *across the life course*
- Deliver a Health Protection response *including Vaccination*

Faster, effective diagnosis and treatment

- Improve access to Primary and Community Care
- Design and Deliver a phased Frailty and Community Model
- Deliver the Planned Care and Diagnostics Programme

Working together across Major Conditions, Physical and Mental Health

- Develop and deliver a Major Conditions Plan *respiratory & circulatory health (cardiac, diabetes, stroke) and cancer*
- Deliver the Mental Health Transformation Programme

Home first and back home fitter and faster

- Improve pathways of care *focused on system flow*
- Deliver the Six Goals Plan for Urgent and Emergency Care *focusing on what works for the Powys population*



Quality is the golden thread across the whole plan

- Underpinned by the Quality Standards: Safe, Timely, Effective, Efficient, Equitable, Person-Centred (STEEEP)
 - Delivery of Duty of Quality and Duty of Candour Action Plans
- Interdependencies across the plan in relation to a Value based approach and effective Governance

WG TEMPLATE
Primary & Community Care

WG TEMPLATE
Enhanced Care in the Community (Pathways of Care)

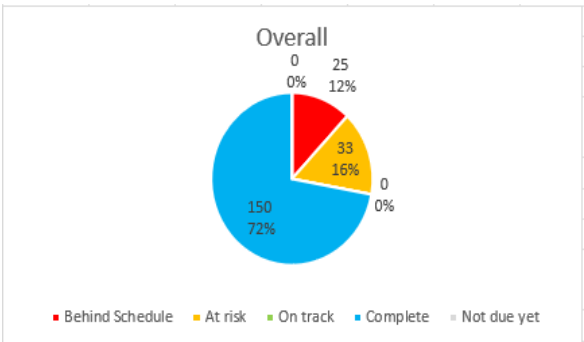
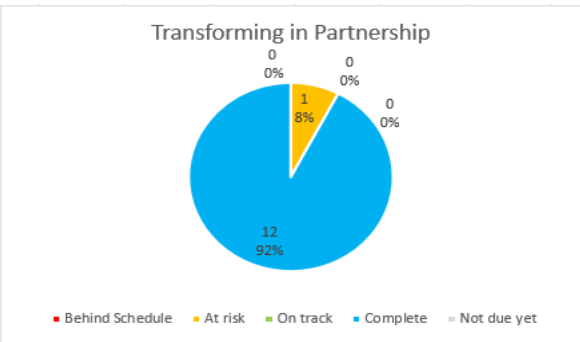
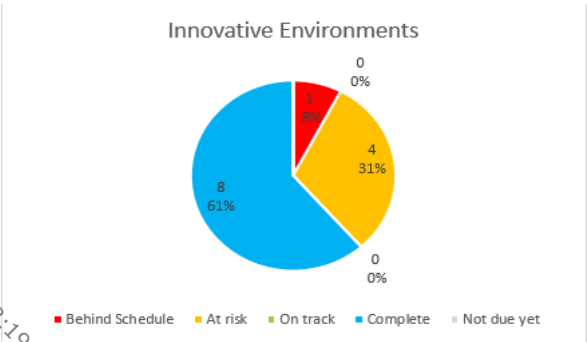
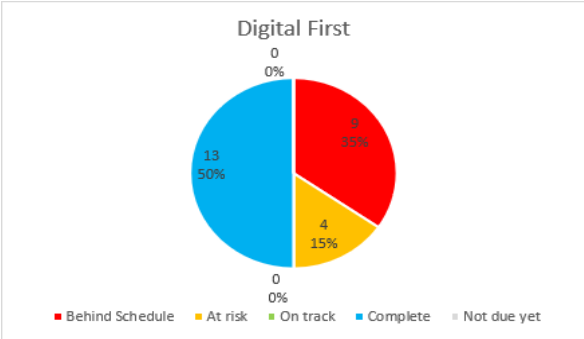
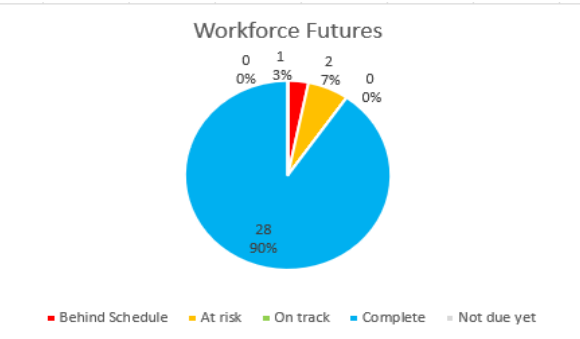
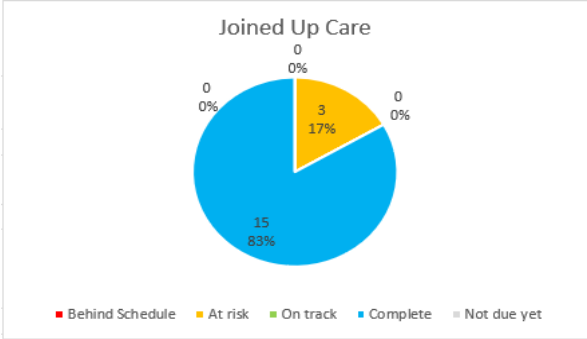
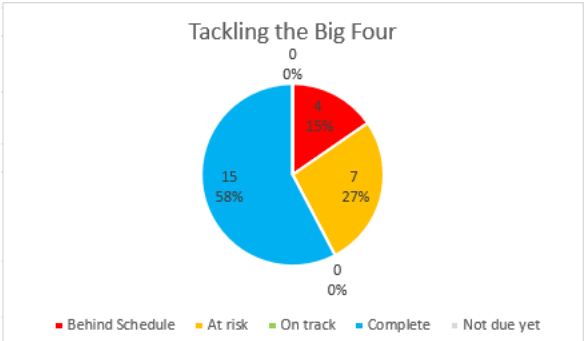
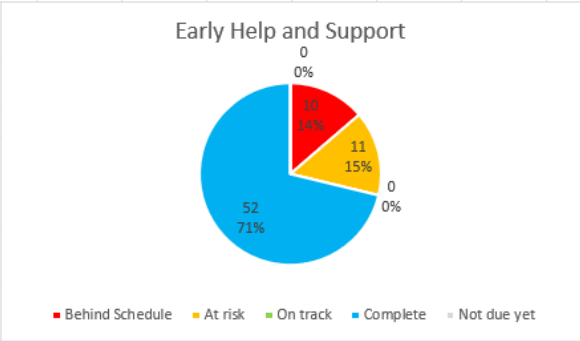
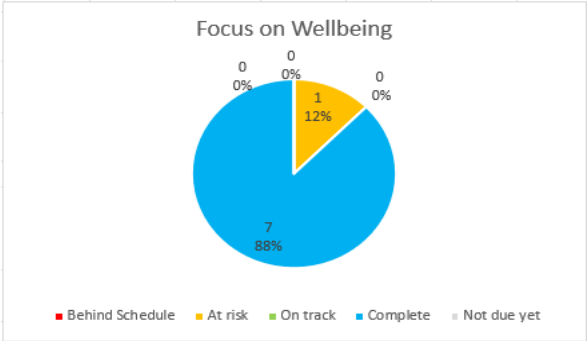
WG TEMPLATE
Planned Care & Cancer

WG TEMPLATE
Mental Health

WG TEMPLATE
Urgent and Emergency Care / Six Goals



CONSOLIDATED YEAR TO DATE SUMMARY



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Role:	Acronym
Chief Executive Officer	CEO
Deputy Chief Executive Officer	DCEO
Executive Director of Primary Care, Community and Mental Health	ED PCC&MH
Executive Director of Finance, Capital and Support Services	ED FC&SS
Executive Director of People and Culture	ED P&C
Executive Director of Public Health	ED PH
Executive Director of Nursing, Quality, Women and Family Health	ED NQW&FH
Executive Director of Allied Health Professions, Health Sciences and Digital	ED AHPHS&D
Executive Medical Director	EMD
Executive Director of Planning, Performance and Commissioning	ED PP&C
Director of Corporate Governance / Board Secretary	DCG
Director of Strategic Improvement and Transformation	DSI&T
Associate Director of Estates, Facilities and Support Services	ADEF&SS

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Focus on Wellbeing

Strategic Priority 1: Develop a whole system prevention plan across the life course

Executive Lead – Executive Director of Public Health

Intended Outcome/ Impact

- A vision for a joined-up preventative approach is developed
- Conditions are being created that support people to maintain a healthy weight
- Work towards meeting national smoking cessation targets

Commentary on Progress in this Quarter:

- **1.1)** A whole system approach framework for prevention has been developed, setting the foundation for further promotion and engagement with partners in 2025/26 to 'shift left'.
- **1.2)** Powys Whole System Approach to Healthy Weights Action Plan continues to be implemented through partnership working, including:
 - Powys Breastfeeding Welcome Scheme was launched in August 2024 with the health board and Powys County Council. To date, 226 settings across Powys have registered.
 - Introduction to Solid Foods ('weaning') training has been updated and provided to staff, along with resources updated for parents.
 - The Powys Gold Standard Healthy Snack Award has been developed and promoted to early years' settings, alongside the provision of training sessions and individualised support. To date, 7 settings have been successful in achieving the award.
- **1.3)** Smoking cessation work is focusing on building on earlier successes and embedding work to improve awareness of and access to services, including:
 - Providing individualised support to community pharmacy staff to build their confidence in delivering support to smokers.
 - Engagement being undertaken with professionals to improve identification of smokers and to ensure embedding of referral pathways and NRT protocols, so that smokers are signposted/referred to the specialist support available to quit. A focus has been on Midwifery to increase CO monitoring and referral rates of pregnant smokers.
 - Continuously promoting the range of services available through a communication and engagement plan, which has included the launch and extensive distribution of a regular Powys Smokefree newsletter. Q3 data showed 4% of smokers made a quit attempt through smoking cessation services, therefore on track to achieve 5% target by year end.

Commentary on red rated actions: N/A

Progress against key actions and milestones														
Key Areas of Delivery		Key Deliverables		Lead Executive	Status				Year End Delivery Confidence Assessment					
					Q1	Q2	Q3	Q4	0	Q1	Q2	Q3	Q4	
Work with partners to develop a whole system approach to address common modifiable risk factors		1.1) Framework for whole system approach developed Q4		ED PH				Blue	M	M	M	M	High	
Delivery of health board-led population level health improvement programmes		1.2) Implement the Powys Whole System Approach to Healthy Weights action plan, working in partnership Q1-Q4			Green	Green	Green	Blue	H	H	H	H	High	
		1.3) Improve awareness of and access to NHS Stop Smoking services Q1-Q4			Green	Green	Green	Blue	H	H	H	H	High	
Formal change request (Please tick as applicable and provide explanation below)														
Change in Scope	N/A	Change in Timescale	N/A											
Executive Director Sign Off		Mererid Bowley (Executive Director of Public Health)												

Strategic Priority 2: Deliver a Health Protection response, including vaccination

Executive Lead – Executive Director of Public Health

Intended Outcome/ Impact

- PTHB is able to provide a local health protection response that aligns with the Communicable Disease Outbreak Plan for Wales
- Eligible Powys population is offered vaccination, narrowing the uptake in inequities between groups

- Screening uptake rates are above targets

Commentary on Progress in this Quarter:

- Revised Major Incident and Emergency Response Plan and Corporate Business Continuity Plan approved by PTHB Board in July 2024.
- Revised Pandemic Framework was approved by the Executive Committee in May 2024; this forms part of an interim review until updated national pandemic strategy and guidance is published.
- Revised Severe Weather Arrangements approved by the PTHB Executive Team in January 2025.
- Regular internal and external communications tests have taken place, at local and regional levels.
- Operational major incident response walkthroughs across hospital sites with Minor Injury Units, and a number of operational walkthroughs of the Health Board's pathway for patients with suspected Mpox took place during 2024.
- The Health Board responded to a Welsh Ambulance Service Trust (WAST) 'major incident declared' notification for the Talerddig train collision on 21st October 2024. Lessons identified following the response have been submitted and approved at Executive Committee.
- The Health Board continues to be engaged in national emergency planning, resilience and response preparedness activities that have taken place with multi-agency partners within the Dyfed Powys Local Resilience Forum and at a national level, this includes engagement in a range of planning, training and exercising activities.
- The Health Board has participated in a number of multi-agency coordination group meetings that have been activated during 2024/2025, including its response to Storm Darragh, December 2024.
- **2.2) Health Protection** responses made for incidents and outbreaks to prevent spread and control spread of infections including ARIs, Scabies, diarrhoea and vomiting. Other work included supporting care homes around winter preparedness, and Hepatitis B and C elimination.
- **2.3) Vaccination programmes** were planned and delivered in line with national directives/guidance. Uptake continuously monitored to guide mitigating actions. For influenza, engagement occurred with GPs to encourage further vaccination sessions; Public Health Wales led communication campaign was supported by local communications team through health board channels, amplified through local networks. To improve access, more local clinics were scheduled using community hospitals; also hybrid approach adopted with support provided for booking and call handling by Vaccination Team to GP practices to deliver vaccination clinics.
 - Covid-19 2024 autumn campaign started in October and, by the end of February 2025, 728 care home residents were vaccinated (uptake of 82.73%); over 29,000 doses administered in the rest of the eligible population achieving an uptake of 51.4% (highest in Wales). Despite the mitigating actions, uptake in the autumn campaign has reduced significantly from the 2023/24 campaign, reflecting a national trend in vaccine uptake reduction being reported.
 - Flu vaccination programme as at end February: Uptake in 2 and 3 year olds of 53.1% (highest in Wales); 65 year olds and over uptake of 69.2% (4th in Wales); clinical risk group uptake 40.9% (highest in Wales). Staff vaccination uptake of 38.6%.
 - MMR Catch-up programme completed and the health board achieved the national target of reaching over 90% for 2 MMR vaccines in both primary and secondary schools.

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- New RSV vaccination programme planned and developed and commenced September 2024 with maternal programme and older adult routine programme, followed by older adult catch up campaign running January to August 2025.

Commentary on red rated actions: N/A

Progress against key actions and milestones

Key Areas of Delivery	Key Deliverables	Lead Executive	BRAG ('not due' already greyed out)				Year End Delivery Confidence Assessment				
			Q1	Q2	Q3	Q4	0	Q1	Q2	Q3	Q4
Ensure PTHB emergency preparedness and organisation resilience and compliance against Civil Contingencies Act	2.1) Review of civil contingency response plans. Implement required actions, including participation in training and exercises Q1-Q4	ED PH	Green	Green	Green	Blue	H	H	H	H	High
Provide Health Protection response to all hazards in line with Communicable Disease Outbreak Plan for Wales	2.2) Continue transition to a regional health protection service to enable a local response to health protection threats and contribute to Health Protection, Framework, in partnership with Powys County Council and Public Health Wales Q3				Amber	Amber	M	M	M	M	High
Implement respiratory vaccination programme in line with Welsh Government directives	2.3) Plan and deliver respiratory vaccination programmes Q1, Q3, Q4		Green		Green	Blue	H	M	H	H	High
Implement immunisation schedule in line with National Immunisation Framework and Welsh Health Circulars	2.4) Plan and deliver vaccination programmes Q4					Blue	H	M	M	H	High
Promote uptake of national screening programmes in partnership with Public Health Wales	2.5) Analyse data published and develop and implement action plan Q4					Blue	H	H	H	H	High

Formal change request (Please tick as applicable and provide explanation below)			
Change in Scope	N/A	Change in Timescale	N/A
Executive Director Sign Off	Mererid Bowley (Executive Director of Public Health)		

Early Help and Support
Strategic Priority 3: Improve Access to Primary and Community Care
Executive Leads - Executive Director of Primary Care, Community and Mental Health / Executive Medical Director /Executive Director of Nursing, Quality, Women and Family Health
Intended Outcome/ Impact - Improved outcomes through earlier, targeted interventions for those in need of support - Quality, timely services provided closer to home - Resilient and sustainable rural primary and community care services that meet the needs of the Powys population
Commentary on Progress in this Quarter: 3.19) – Optometry - Welsh General Ophthalmic Service (WGOS) 4 glaucoma filtering launched in February 25. Admin, IG and digital concerns have all progressed to move forward glaucoma monitoring. High probability that WGOS 4 Glaucoma Monitoring/ Medical Retina Filtering/ Medical Retina Monitoring will all launch in Q1 25/26 3.37) The Digital Maternity Cymru business case has been submitted to Welsh Government for consideration following Health Board approval. 3.38) The workforce plan has been commenced in Children’s Nursing and the final interim senior post is within the job evaluation process. The Workforce plan for Maternity Services will be address by the Director of Midwifery 3.41) Following significant improvements within the Neurodevelopment delivery model, further transformation of wider Children’s services is required inclusive of Community Paediatrics to ensure a sustainable model for the future.

Commentary on red rated actions:

- **3.9 General Medical Services)** – This deliverable was paused due to the implementation of the national Access T&F Review Group. National review continues to inform the national and local approach. Request to remove as a key deliverable for 24/25.
- **3.14 Optometry)** – Cluster projects to support a pre-registration Optometrists have been reviewed and ceased. Recruitment and supervision challenges, alongside potential issues with indemnity has proven challenging. Furthermore, the changing recruitments of the Optometry pre-registration year to a Clinical Learning In Practice (CLIP) period has changed the requirements of the initial proposals. Academy supporting with future workforce plans, alongside Health Education and Improvement Wales (HEIW), looking towards longer-term sustainability and including Optical Assistants and Dispensing Opticians, alongside Optometrists.
- **3.16 Optometry)** - School Vision services sits under W&C Directorate. Previously included in Optometry due to scoping a COVID catch up programme. Request to remove as routine service via W&C back in place as part of the school's programme
- **3.21 Dental)** – The Dentist currently suspended; however practice is open but offering a very limited GDS offer via a Dental Therapist

Progress against key actions and milestones

Key Areas of Delivery	Key Deliverables	Lead Executive	BRAG ('not due' already greyed out)				Year End Delivery Confidence Assessment				
			Q1	Q2	Q3	Q4	0	Q1	Q2	Q3	Q4
Accelerated Cluster Development	3.1) Collaborative engagement and develop maturity Q1-Q4	ED PCC&MH	Amber	Amber	Green	Blue	H	M	M	H	High
	3.2) Continue to develop reporting and governance arrangements with RPB Executive (Pan Cluster Planning Group) Q3				Amber	Amber	H	H	H	M	Medium
	3.3) Implementation of Dental Collaborative (pending national negotiation outcome) Q2			Amber	Amber	Amber	M	M	L	L	Low
	3.4) Develop the Professional Nursing Collaborative Q2			Red	Amber	Amber	H	H	M	M	Low
	3.5) Develop the Optometry Collaborative Q1		Green	Blue	Blue	Blue	H	H	M	H	High
	3.6) Continue to identify services best delivered at cluster or pan-cluster level Q4					Amber	H	H	H	H	Medium

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General Medical Services	3.7) Annual Programme of Primary and Community Care Academy – training and support for all contractors; identifying funding opportunities; support for GMS (General Medical Services) PLT (Protected Learning Time); evaluation Q1		Green	Blue	Blue	Blue	H	H	H	H	High
	3.8) GMS Practice Sustainability analysis, review, and action planning Q2			Green	Blue	Blue	H	H	H	H	High
	3.9) Engagement with patients and stakeholders on perception and experience of access Q4					Red	H	H	H	L	Low
	3.10) Development of workforce model in line with Strategic Programme for Primary Care/ Primary Care Strategic Workforce Plan & PTHB Frailty and Community Model Q3				Green	Blue	H	H	H	M	High
	3.11) Roll out multi-professional workforce tool Q3				Amber	Blue	M	M	M	M	High
Optometry	3.12) Systematic tracking of core hour provision Q2			Green	Blue	Blue	H	H	H	H	High
	3.13) Support and track access in relation to IPOS (Independent Prescribing Optometrists) Q1		Green	Green	Green	Blue	H	H	H	H	High
	3.14) Pre-registration Optometrist between primary and secondary care in Cluster(s) Q2			Red	Red	Red	M	M	M	L	Low
	3.15) Establish inter-practice referral for urgent cases Q1		Blue	Blue	Blue	Blue	M	H	H	H	High
	3.16) School vision and eyecare access improvements Q2			Red	Red	Red	L	L	L	L	Low
	~~3.17) Scope Special School Primary Care Eyecare Q1~~		Red	Red	Red		L	L	L	L	Low
	3.18) Publicise occupational health services offer Q1		Red	Blue	Blue	Blue	M	H	H	H	High
	3.19) Implement pathways with outreach Ophthalmology Services, clusters and Optometry practices for Glaucoma and Medical Retina pathways Q1-Q2		Amber	Green	Green	Blue	M	M	M	M	Medium
Dental	3.20) Maintain urgent access in General and Community Dental Service to balance of demand and capacity Q1	ED PCC&MH	Green	Green	Green	Amber	H	H	H	H	Medium
	3.21) Increase capacity of Llandrindod Wells contract Q2			Blue	Blue	Red	H	M	H	M	Low

	3.22) Secure future dental access in Newtown Q2			Green	Green	Blue	M	L	H	H	Medium
	3.23) Rural enhancement offer for Foundation Dentists Q4					Blue	L	L	L	M	High
	3.24) Continue to transfer patients from the dental waiting list to salaried General Dental Practitioner (GDP) in line with contract reform Q1		Blue	Blue	Blue	Blue	H	H	H	H	High
	3.25) Undertake dental waiting list cleansing to support accurate waiting list numbers Q1		Green	Blue	Blue	Blue	H	H	H	H	High
	3.26) Recruit additional dental officer for sedation by end of Year 1 Q4					Blue	M	M	M	L	High
	3.27) Rescope mobile dental services in areas with limited or no access Q1		Blue	Blue	Blue	Blue	H	H	H	H	High
	3.28) Develop undergraduate dental therapy placement programme with Cardiff Dental School Q4					Blue	M	M	M	L	High
Community Pharmacy	3.29) Further development of Assurance Framework; Annual programme of contract monitoring – and targeted visits (50% of pharmacies in Year 1); implement contract breach process by year end Q4	EMD				Blue	H	H	H	H	High
	3.30) Ensure access and monitor provision of Clinical Community Pharmacy Service (CCPS) and “additional pharmacy services”. Q1-Q4 Ongoing (monthly)		Green	Green	Green	Blue	H	H	H	H	High
	3.31) Review and update of service specifications for locally commissioned services Q4					Blue	H	H	H	H	High
	3.32) Review pharmacy ‘rota services’ to ensure that they are delivering value to our population Q4					Amber	H	M	M	L	Low
	3.33) Work with Welsh Government to address challenges that are unique to Powys (e.g. implementation of 56-day prescribing in dispensing practices) Q4					Amber	L	L	L	L	Low

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	3.34) Work with contractors to improve the quality of Datix reporting and ensure that learning is shared as appropriate Q1-Q4 Ongoing		Green	Green	Green	Blue	H	H	H	H	High
	3.35) Continue to encourage Pharmacists to train as independent pharmacist prescriber (IPPs) and monitor provision of IPP services across Powys Q1-Q4 Ongoing		Green	Green	Green	Blue	H	H	H	H	High
Women & Children’s - Maternity	3.36) Delivery of the Maternity Assurance and Safety Improvement Plan Q1-4	ED NQW&FH	Blue	Blue	Blue	Blue	H	H	H	H	High
	3.37) Implementation of Digital Maternity Cymru (DMC) appropriate to PTHB Q1-4		Amber	Amber	Amber	Blue	M	M	M	M	High
	3.38) Review workforce and implement the revised workforce review Q1-4		Green	Green	Amber	Amber	H	M	M	M	Medium
	3.39) Implementation of Health Inspectorate Wales recommendations including birth centre environments Q1-4		Green	Green	Green	Blue	M	L	L	L	Medium
Women & Children’s – Women’s Health	3.40) Assessment and local delivery of All Wales policy and plan requirements, adapted to PTHB context		Green	Green	Green	Blue	M	M	M	M	Medium
	Implement plans for Women’s Health and Sexual Health Improvement; HIV and All Wales Women’s Health Implementation Group Priorities Q1-4										
Women & Children’s – Pathway Development	3.41) Implementation of key service / pathway developments: - Develop and deliver Community Paediatric Remodel action plan - Implementation of the multi agency Neurodevelopment Strategic Action Plan for Powys - Develop an Additional Learning Needs Strategy for Powys including partnership delivery plan Q1-4			Amber	Amber	Amber	Blue	M	H	H	H
Formal change request (Please tick as applicable and provide explanation below)											
Change in Scope	N/A	Change in Timescale	N/A								

Change in Scope and Timescale

- 3.17 - Special School Primary Care Eyecare (SPEC) is dependent upon national clinical pathways, led by national clinical leads and has been assigned lower priority versus other clinical pathways. Scope of service has not been communicated to HBs so cannot progress this action. No indication this pathway is imminent during 24/25 – request to remove as a key deliverable for 24/25. Change request approved at Executive Committee 22.01.2025.

Executive Director Sign Off

Elaine Lorton (Executive Director of Primary Care, Community and Mental Health)

Kate Wright (Executive Medical Director)

Claire Roche (Executive Director of Nursing, Quality, Women and Family Health)

Strategic Priority 4 - Design and Deliver a phased Frailty and Community Model

Executive Lead - Executive Director of Primary Care, Community and Mental Health

Intended Outcome/ Impact

- A sustainable approach to frailty and community care, improving equity of access
- Risk stratification of the population to deliver effective support for those with greatest need and at greatest risk of ill health
- Joined up support for physical and cognitive frailty and improved co-ordination at end of life particularly the last year of life
- Associated reduction in emergency admissions/ prevention of avoidable deterioration in health such as deconditioning and fractures

Commentary on Progress in this Quarter:

- **4.1) Continuous Engagement in sharing the challenge and understanding Discovery findings; shaping and refining ideas Q1-4:** Building on the previous joint Better Together / Sustainable Powys sessions back in February and March 2024, further joint sessions between PTHB and Powys County Council were held with Town and Community Councils in Q3 and the final one took place in Newtown in Q4 (it was previously delayed due to bad weather). The health board has also developed its Case for Change document during Q4 which was shared with staff for their feedback between 13/02/2025 and 09/03/2025, with an updated Case for Change document due to be published for further engagement with patients, the public and wider stakeholders in Spring 2025.
- **4.4) Minimum 12 Week Consultation for areas of significant service change Q3-4:** As outlined in 4.1) above, the health board has also developed its Case for Change document during Q4 which was shared with staff for their feedback between 13/02/2025 and 09/03/2025, with an updated Case for Change document due to be published for further engagement with patients, the public and wider stakeholders in Spring 2025. Work to identify the steps to consultation have been developed in readiness for 2025/26.

- 4.7) Review access to Fracture Liaison Service Q3-Q4:** The Task & Finish Group has remained in place to finalise the business case, including the preferred option to improvement patient outcomes, experience and cost through ensuring better access to Fracture Liaison Services for Powys patients. Work has continued with national colleagues to understanding if resource may be available to help support the development of a PTHB service to support access to Fracture Liaison Services for Powys patients.
- 4.8) Implement National Community Nursing Framework in Powys Q1-Q4:** Following the self-assessment against elements of the Community Nursing Standards in Q2, the resultant action plan continues to be implemented to prioritise the areas where further development is needed, recognising what can be successfully and safely delivered in a rural county.
- 4.13) Review the impact of the PTHB-element of the National Cellulitis Improvement Programme Q4:** The individual commenced in post on 01/11/2024 in the National Cellulitis Improvement Programme in the national team, with links to the local PTHB Lymphoedema & Cellulitis Team established and being developed operationally. Recognising the short period of time, work has taken place to identify the impact and benefits delivered to date, with positive signs. It is proposed a fuller evaluation will take place towards the end of 2025/26 to inform the next steps.

Commentary on red rated actions:

- 4.10) Commence implementation including liaison with out of county providers Q3-Q4:** As outlined in Q3, the liaison work with out of county providers has not taken place. It was anticipated that the National Service Specification for Palliative and End of Life Care in Wales would be finalised towards the end of 2024/25, however the recent consultation by the NHS Wales Executive on the draft service specification has been delayed. Similarly, the nationally-led Joint Commissioning Committee work to look at a different commissioning model for hospice services has not yet been finalised. Whilst awaiting these national pieces of work, PTHB has been able to roll out a revised Treatment Escalation process in the community in Powys, including related training for staff and the development of a patient-information leaflet which will be published in Q1 2025/26.

Progress against key actions and milestones												
Key Areas of Delivery	Key Deliverables	Lead Executive	BRAG ('not due' already greyed out)				Year End Delivery Confidence Assessment					
			Q1	Q2	Q3	Q4	0	Q1	Q2	Q3	Q4	
Continue development of tiered community model	4.1) Continuous Engagement in sharing the challenge and understanding Discovery findings; shaping and refining ideas Q1-4	ED PCC&MH	Green	Green	Green	Blue	H	H	H	H	High	

	4.2) Next phase of design including configuration of tiered community model, outpatient, daycase and admitted patient care Q2-3		Green	Amber	Amber	M	M	H	H	High
	4.3) Identification of service development Q3			Amber	Amber	M	M	M	H	High
	4.4) Minimum 12 Week Consultation for areas of significant service change Q3-4			Green	Blue	M	M	M	M	Medium
Continue to implement Frailty Model, including optimisation and join up for frailty of memory	4.5) Develop Frailty scoring Q1-Q3		Green	Amber	Blue	Blue	M	M	M	High
	4.6) Develop the approach to Comprehensive Geriatric Assessment and care planning Q1-Q3		Green	Green	Blue	Blue	M	M	M	High
	4.7) Review access to Fracture Liaison Service Q3-Q4				Green	Blue	H	H	H	High
	4.8) Implement National Community Nursing Framework in Powys Q1-Q4		Green	Green	Amber	Amber	M	M	M	Medium
Improve coordination of the Last Year of Life	4.9) Finalise approach to planning for the Last Year of Life with major conditions Q1-Q2		Green	Blue	Blue	Blue	H	H	H	High
	4.10) Commence implementation including liaison with out of county providers Q3-Q4				Red	Red	M	M	M	L
Review and refine the Community Hospital model	~~Scope an improved approach to cognitive impairment on general wards Q1-Q2 see change in box below~~		Green	Red			M	M	L	Select
	~~Pilot the approach Q3-Q4~~						M	M	L	Select
Support Admission Avoidance	4.11) Subject to approval, support the National Cellulitis Improvement Programme with a Powys-related post Q1-Q3		Green	Green	Blue	Blue	H	H	H	High
	4.12) Scope phase 1 Urinary Tract Infection (UTI) pathway transformation and commence implementation Q2-Q3			Green	Blue	Blue	H	H	H	High
	4.13) Review the impact of the PTHB-element of the National Cellulitis Improvement Programme Q4					Blue	H	H	H	High

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Formal change request (Please tick as applicable and provide explanation below)			
Change in Scope	N/A	Change in Timescale	N/A
Change in Timescale			
Review and refine the community hospital model – due to the Temporary Service Change to co-locate patients this area of delivery has been reprioritised. Change request approved in Quarter 2.			
Executive Director Sign Off	Elaine Lorton (Executive Director of Primary Care, Community and Mental Health)		

Strategic Priority 5 - Deliver the Planned Care & Diagnostics Programme	
Executive Leads – Executive Director of Primary Care, Community and Mental Health / Executive Director of Planning, Performance and Commissioning / Executive Director of Allied Health Professions, Health Sciences and Digital	
Intended Outcome/ Impact	
- As many patients treated in Powys as possible – delivery of Rural Regional Centres and North Powys Wellbeing Programme - Improved resilience of provider services and greater utilisation of provider services capacity/ system assets - Getting It Right First Time is the default method of operation with associated improvements in quality, governance and assurance	
Commentary on Progress in this Quarter: 5.1) - The GIRFT implement support sessions are complete for Ophthalmology, Orthopaedics, General Surgery, Gynaecology and Urology. GIRFT has now been replaced by optimisation frameworks which will be launched at the end of March 2025 and recommendations delivered through a long-term plan. 5.13) - Work is ongoing to increase clinic capacity, with weekly sessions now being held in Brecon and Llandrindod Wells. There is ongoing discussion with neighbouring health boards for the development of nurse led WET AMD service in North Powys and discussions around pre assessment and biometric pathways for cataract patients. Work will continue as part of the 2025/26 long term delivery planning.	

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- **5.15)** - Virtual appointments are part of clinic templates across Orthopaedics/ENT/Colorectal/Urology/Rheumatology specialities. Discharge is the preferred patient outcome, but Patient Initiated Follow Ups and SOS pathways are well established. For advice patients have access to the Waiting Well Programme. This work will continue into 2025/26 delivery planning. Work will continue as part of the 2025/26 long term delivery planning.
- **5.18)** - Phase 1 complete -Ystradgynlais, Welshpool and Llandrindod have completed the x-ray replacement phase and now back fully operational, Phase 2 - Newtown x-ray equipment has been delivered and expected to be installed and fully operational by 31st March. There is a delay on the Brecon delivery of the x-ray equipment but is on track to be installed before the end of March, but it will not go live until April 18th which will then see phase 2 complete.
- **5.20)** – Point Of Care Testing (POCT) co-Ordinator supporting the following areas on adding POCT into their clinical pathways: Mental Health Pochi for FBC in Clozapine monitoring: Living Well Service - metabolic function monitoring for GLP-1 prescribing pathway: Women & Childrens - All Wales NEWTT2 pathway for neonates: MIU - T&F for MIU development. Opportunities identified with South Cluster on CRP pathway to improve the pathway and relationship with Primary Care. Internal Audit underway around Medical Devices Contract Monitoring.

Commentary on red rated actions:

- **5.2) Seek Consultant Urologist sessions:** PTHB were unsuccessful in the Planned Care Transformation fund for speciality consultant sessions resulting in PTHB not being able to progress with Consultant Urologist sessions.
- **5.4) & 5.5)** - Plans to recruit a jointly funded post through the delivery of the MSK Triage solution has been reviewed, the posts would be better managed through a Service Level Agreement.
- **5.9)** - Recruitment for key roles are currently being progressed, with the band 7 physiotherapist in its second week of advert. The band 8a physiotherapist job has been approved through the job matching panel and scheduled to go out to advert imminently. The band 6 physiotherapist role has been approved and advertised with interviews scheduled. The workspace for the 2 Band 3 admin roles has been confirmed as Newtown. The initial mapping design document for single point of access for Orthopaedic referral management has been drafted and discussed with the clinical and admin teams for ratification. This has been taken into Q1-Q2 2025/26 Deliverables.
- **5.11) Dental:** The proposal to purchase high quality cameras to allow good clinical photography in Dental service is currently paused until the outcome and evaluation is complete for the Dermatology pilot. Dermatology pilot was evaluated as successful - scoping of opportunities in dental to be taken forward in Annual Plan 2025/26.

Progress against key actions and milestones

Key Areas of Delivery	Key Deliverables	Lead Executive	BRAG ('not due' already greyed out)				Year End Delivery Confidence Assessment				
			Q1	Q2	Q3	Q4	0	Q1	Q2	Q3	Q4

GIRFT Recommendations	5.1) Continue implementation of GIRFT recommendations for General Surgery, Orthopaedics and Ophthalmology to include repatriation of low complexity day cases Q1-Q4	ED PCC&MH ED PP&C	Green	Green	Green	Blue	H	H	H	H	High
	5.2) Seek Consultant Urologist sessions to scope community urology service Q2-Q4			Red	Red	Red	M	L	L	L	Low
Key Strategic Relationships	5.3) Explore Opportunities for jointly funded or regional post Q1		Blue	Blue	Blue	Blue	H	H	H	H	High
	5.4) Recruitment for jointly funded or regional post Q3				Amber	Red	H	M	M	H	Medium
	5.5) Evaluation of jointly funded or regional post Q4					Red	H	M	M	M	Medium
Referral Management Solutions	5.6) Scope a (Provider) interface triage pilot for Orthopaedic Referrals Q1		Blue	Blue	Blue	Blue	H	H	H	H	High
	5.7) Pilot interface triage solution for Orthopaedic Referrals Q2			Blue	Blue	Blue	H	H	H	H	High
	5.8) Evaluate interface triage solution for Orthopaedic Referrals and any associated Business Case through the Investment Benefit Group Q3				Blue	Blue	H	H	H	H	High
	5.9) Subject to approval implementation of interface triage solution for Orthopaedic Referrals; Evaluation Q3-Q4				Green	Red	H	H	H	H	Select
	5.10) Scope a referral management solution for Dermatology; Pilot subject to any associated Business Case support; Evaluate; begin phased roll-out Q1		Blue	Blue	Blue	Blue	H	H	H	H	High
	5.11) Develop referral management solution for dentistry in relation to oral cancer Q2			Red	Red	Red	H	M	L	L	Low

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Improve Value in Key Specialities	5.13) Continued implementation of Wet Age-Related Macular Degeneration (AMD) and Cataracts improvement plan in alignment with GIRFT Q1-Q4	ED PCC&MH ED PP&C	Green	Green	Green	Blue	H	H	H	H	High
Implement the Outpatient Transformation Plan	5.14) Appoint permanent Assistant Medical Director for Planned Care Q1		Blue	Blue	Blue	Blue	M	H	H	H	High
	5.15) Continued implementation of outpatient transformation plan (virtual appointments, access to advice and guidance, modernisation of follow ups including see on symptoms) Q1-Q4		Green	Green	Green	Blue	M	M	H	H	High
Radiology Provision across Powys (enabling implementation of RISP)	5.16) Submit capital business case for replacement of X-ray equipment to enable implementation of RISP Q1		Blue	Blue	Blue	Blue	M	H	H	H	High
	5.17) Review x-ray provision across Powys as part of work on sustainable model Q1	ED AHPHS&D	Blue	Blue	Blue	Blue	H	H	H	H	High
	5.18) Develop x-ray implementation plan and implement phase 1 Q2-Q4			Green	Green	Blue	M	L	H	H	High
Enhance the provision of Point of Care Testing throughout Powys	5.19) Review and develop existing POCT provision and governance: Establish QA Compliance framework, analyse asset registry, monitoring initiation and training development Q1-Q2	ED PCC&MH	Green	Blue	Blue	Blue	H	H	H	H	High
	5.20) Expand availability of POCT provision in support of clinical pathway development and governance: identify opportunities in primary & community care, prepare for internal audit Q3-Q4	ED PP&C			Amber	Blue	M	M	M	M	High
	5.21) Identify ongoing funding for the POCT Co-ordinator role Q3-Q4				Blue	Blue	M	M	M	H	High
Formal change request (Please tick as applicable and provide explanation below)											
Change in Scope	N/A	Change in Timescale	N/A								

Executive Director Sign Off	Elaine Lorton (Executive Director of Primary Care, Community and Mental Health) Nicola Johnson (Executive Director of Planning, Performance and Commissioning) Claire Madsen (Executive Director of Allied Health Professions, Health Sciences and Digital)

Tackling the Big Four

Strategic Priority 6 - Develop and Deliver a Major Conditions Plan

Executive Leads - Director of Strategic Improvement and Transformation / Executive Medical Director / Executive Director of Allied Health Professions, Health Sciences and Digital / Executive Director of Planning, Performance and Commissioning / Executive Director of Primary Care, Community and Mental Health

Intended Outcome/ Impact

- A shift to prevention to improve population health and reduce the burden of ill health, with smarter approaches to segment and target those at risk
- Optimising the key pathways of care to improve equity of access and patient experience
- Joined up care across physical and mental health; effective management of long term conditions and a core approach to rehabilitation
- Greater co-ordination of care to improved efficiency, performance and outcomes

Commentary on Progress in this Quarter:

- **6.2) Map and develop key optimal pathways for Diabetes:** Mapping of the existing diabetes pathway took place to support a presentation to the Directors of Finance Value Leadership Group on 31/01/2025. Work commenced in Q4 on a business case to scope whether clinics for Powys patients living with diabetes who have hybrid closed loop pumps could be provided closer to home, with the aim of the business case being finalised in 2025/26.
- **6.9) Single Cancer Pathway (SCP):** The Cancer Performance of providers continues to be reviewed regularly and any learning for improvement of pathways is shared. However, in spite of this, due to capacity constraints in commissioned services, the SCP is performance is still challenged.

Commentary on red rated actions:

- **6.1) Development of a phased major conditions transformation plan:** An SRO was not identified for the work programme and it has therefore been unable to progress as planned. Progress has however been made in the background with a focus on High-cost user data modelling which has identified co-morbidities as an

area of higher spend based on patients with more than one condition. Work around how outcomes and experience for Powys patients living with comorbidities in the community can be improved will be taken forwards in 2025/26 and development and delivery of the integrated community model.

Progress against key actions and milestones

Key Areas of Delivery	Key Deliverables	Lead Executive	BRAG ('not due' already greyed out)				Year End Delivery Confidence Assessment				
			Q1	Q2	Q3	Q4	0	Q1	Q2	Q3	Q4
Development of a transformative Major Conditions Plan	6.1) <u>Development of a phased major conditions transformation plan</u>	DSI&T	Amber	Red	Red	Red	H	H	L	L	Low
	to develop: a less siloed approach; streamline appointments, diagnostics, assessments, care and treatment plans, reviews and polypharmacy; and to improve co-ordination in the last year of life Q1- Q3 development of the plan										
Optimal Pathways	6.2) <u>Map and develop key optimal pathways for Diabetes</u> (in liaison with national Value and Sustainability Work)	ED PCC&MH		Amber	Amber	Amber	M	M	L	L	Low
	Q2 confirm baseline and gap analysis Q3-Q4 first phase improvement										
<u>Stroke</u>	6.3) Review National Prescribing indicators in primary care for Atrial Fibrillation; explore improvements Q3	ED PP&C EMD			Amber	Amber	H		H	M	Medium
	6.4) PTHB Clinical engagement in key Strategic Programmes for Stroke (Wales and England particularly Herefordshire & Worcestershire) Q3	DPPP&C EMD			Green	Blue			H	H	High
	6.5) Incorporation of guidelines for stroke rehabilitation Q3	ED AHPHS&D			Green	Blue			H	H	High

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<u>Diabetes</u>	6.6) Delivery of All Wales Diabetes Prevention Programme (AWDPP) Q1-Q4	ED PH	Green	Green	Green	Blue	H				H	Select
<u>Cardiac</u>	6.7) Community cardiology Q4	ED PCC&MH / ED PP&C				Amber	H			M		Medium
<u>Cancer</u> Cancer Improvement Plan	6.8) Deliver the PTHB Cancer Improvement Plan Q1- Q4	EMD	Green	Amber	Amber	Amber	M	M	M	M		Medium
Single Cancer Pathway	6.9) Review variation of Single Cancer Pathway performance across secondary care providers and reduction of backlog of those waiting over 62 days for first definitive cancer treatment Q1 – Q4	EMD	Red	Red	Red	Amber	L	L	L	L		Low
Implement improving Cancer Journey	6.10) Implement Improving Cancer Journey Programme Phase 2 Q1-Q4	EMD	Green	Green	Green	Blue	H	H	H	H		High
	6.11) Annual review of PTHB Cancer Improvement Plan and update for 2024-25 at year end Q4					Blue	H	H	H	H		High
<u>Respiratory</u> Ensure equitable and standardised MDT services across the whole of PTHB	6.12) Continue to explore options for medical cover across PTHB Q1-Q3	ED PCC&MH	Amber	Amber	Amber	Amber	M	M	M	M		Medium
	6.13) Provide support to Primary Care to implement Asthma plans for the asthma population Q2-Q4			Green	Green	Blue	M	M	M	M		High
Formal change request (Please tick as applicable and provide explanation below)												
Change in Scope	N/A	Change in Timescale	N/A									
Q3 Change in Executive Lead												

6.2) Map and develop key optimal pathways for Diabetes – Change request to remove DSI&T and transfer to ED PCC&MH. Change request approved at Executive Committee 22.01.2025.

6.6) Delivery of All Wales Diabetes Prevention Programme (AWDPP) Q1-Q4 – Change request to remove DSI&T as Exec Lead. Change request approved at Executive Committee 22.01.2025.

Executive Director Sign Off

Lucie Cornish (Director of Strategic Improvement and Transformation)

Kate Wright (Executive Medical Director)

Claire Madsen (Executive Director of Allied Health Professions, Health Sciences and Digital)

Nicola Johnson (Executive Director of Planning, Performance and Commissioning)

Elaine Lorton (Executive Director of Primary Care, Community and Mental Health)

Tackling the Big Four

Strategic Priority 7 - Deliver the Mental Health Transformation Programme

Executive Lead – Executive Director of Primary Care, Community and Mental Health

Intended Outcome/ Impact

- Delivery of equitable and quality mental health care that meets the needs of the population
- Increased efficiency and integration of services to improve sustainability and user experience with clear navigation, access and referral
- Improved co-ordination and care planning with reduction in avoidable urgent and emergency attendances and out of county care

Commentary on Progress in this Quarter:

- **7.3) Workforce design and further consultation Q3:** The alignment of Powys Dementia Home Treatment Teams to create a sustainable pan-Powys team, improving equity and consistency across Powys is progressing, (though progress affected by staff sickness). A proposed pan-Powys DHTT pathway, refined staff model and working pattern have been drafted and are due for signoff via Mental Health SMT and Transformation Programme Board. A meeting is in place to review proposed operational process with digital team colleagues to ensure best use of available electronic systems and reporting functionality. A task & finish group is in place to

review outcome measures and work with the Information team to develop a DHTT BI dashboard. OD are advising regarding required organisational change process during Q1 25-26, with new operational policy planned to be rolled out late Q1.

- Following preliminary transformation work with partners including North Powys Wellbeing Programme, PTHB Mental Health Services, Social Care and 3rd Sector colleagues, the redesign of the Mental Health community model for Powys has progressed during Q4. The redesign aims to ensure the provision of equitable, quality care, in line with national strategies, that meets the needs of the Powys population. This work has been identified as a priority for the 2025-26 integrated Plan, linked to the Community Model for physical health and will also include the phase 3 work for Mental Health Single Point of Access (SPOA). Following a joint workshop in January 2025, including Social Care and NHS Executive colleagues, a draft vision, outline model and principles for the Mental Health community model have been drafted. All or part of the community model will be accelerated within Q1-Q2 2025-26, linked to the community model for physical health, which will also inform work around the inpatient model (bedded care) for Powys.
- **7.5)** Refine baseline including urgent referral information. Continuous engagement. Scope expansion of “front door” role including development to align other referral processes. Q1: Scoping for Single point of access (SPOA) phases 1 & 2 was completed during Q2.
- **7.6)** Develop phased delivery plan Q2: Delivery plan developed in Q2.
- **7.7)** Phase 1 implementation including administrative single point of access Q3, & **7.8)** Phase 2 implementation including commencing development of referral routes for Secondary Care referrals Q4: The Mental Health Single Point of Access (SPOA) phase 1 (refinement of previous email administration hub) and phase 2 (implementation of Triage team), went live successfully in Q2, utilising WG ‘pump prime funding’ from the ‘Six goals’ project. Following a successful business case submission to the Investment Benefit Group (IBG) in Q4, for continued funding, preparation work is underway to develop a holistic assessment (phase 3), close to ‘the front door’. A joint workshop with PCC Social Care took place in January to scope the Assessment phase (phase 3), which identified the opportunity for Social Care to link to the MH Services ‘front door’. This workshop also highlighted the integration required of the SPOA within the MH Community model. Q4 has seen the Single Point of Access (SPOA) process refinement activities and staffing challenges, despite which scoping work has continued, which will now progress alongside development of the MH Community Model, linked with the Physical Health Community Model, (which may be accelerated for Q1-2 2025-26, pending Executive Committee decision).
- **7.9)** Engagement with children and young people, families, and carers (i) Workforce design Q1: A Child and Adolescent Health Services (CAMHS) Crisis Hub is now fully operational, providing access to sanctuary for children in a safe, friendly, built for purpose environment.
- **7.10)** Recruitment Q2, & **7.11)** Implementation of rapid response and outreach service Q3-Q4: A new Rapid response & Outreach Team (RRO) has been recruited with working hours aligned to the adults CRHTs, enabling a greater out of hours (OOH) for CYP. The Hub uses a multidisciplinary team (MDT) approach to supporting young people and their families in mental health distress. Engagement with families is ongoing with young people supporting the ongoing development of the project. This facility is increasingly diverting children and young people from attending A&E, or acute mental health wards, whilst offering intensive home treatment and assertive outreach service. Numbers of appointments/ contacts are increasing month on month, with a 25% reduction in average monthly Welsh emergency department attendances (0-17yr olds), throughout 2024/25 from an average of 7.2 attendances per month in 2023/24 to 5.4 attendances per month in 2024/25 from April – August, (6 Goals for Urgent & Emergency Care 2021-2026). This successful project is yet to secure 2025/26 funding.

- **7.19)** A revised pathway for neurodiversity pathway Q1-Q4: This deliverable has to date been led within the MH Learning Disabilities and Neurodiversity Teams. Powys is the first region in Wales to now have an ND pathway which includes a jointly operated Integrated Autism Service (IAS) working alongside a new ADHD service. New working practices have been embedded, with the pathway undergoing service evaluation and further development. Sustainability work is underway due to fragility of current specialist workforce comprised of temporary seconded posts. This service remains a priority going forwards.

Commentary on red rated actions:

- **7.1) Refining the baseline. Refining the modelling for the new model.** Continuous engagement Q1: 2023/24 MH Baseline data approved by MH Senior Team 16/3/25 and will be taken forward to MH Transformation Board 25.4.25. Preliminary modelling work was ongoing throughout Q3, undertaken by North Powys Wellbeing Team. A meeting between MH Senior Management Team and external modelling resource in January 2025 determined that scoping and vision was required for MH services prior to further modelling work. This work has been rescheduled for Q1-Q2 2025-26 as part of the Community model redesign work.
- **7.2) Public engagement and consultation Q2:** Public engagement and consultation has not been required.
- **7.4) Dementia Home Treatment Team (DHTT):** Resource has been diverted due to staff absences. Also, as part of organisational change process, this project will include a 4- week staff consultation, taking implementation into Q1 2025-26, potentially aligned with accelerated work for the Mental Health Community Model.

Progress against key actions and milestones

Key Areas of Delivery	Key Deliverables	Lead Executive	BRAG ('not due' already greyed out)				Year End Delivery Confidence Assessment				
			Q1	Q2	Q3	Q4	0	Q1	Q2	Q3	Q4
Transformation of Adult and Community Model Phase 1 (includes alignment of Duty and Assessment Model)	7.1) Refining the baseline. Refining the modelling for the new model. Continuous engagement Q1	ED PCC&MH	Amber	Red	Red	Red	H	M	M	H	High
	7.2) Public engagement and consultation Q2			Amber	Red	Red	M	H	M	H	Low
	7.3) Workforce design and further consultation Q3				Blue	Blue	M	M	M	H	High
	7.4) Phase 1 implementation Q4					Red	M	M	M	H	Low
	7.5) Scope model. Refine baseline including urgent referral information. Continuous engagement. Scope expansion of "front		Green	Blue	Blue	Blue	M	H	M	H	High

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Expand capacity to extend single point of access including Next Phase of Development offer alignment with 111P2 for Duty and Assessment Model	door” role including development to align other referral processes. Q1	ED PCC&MH											
	7.6) Develop phased delivery plan Q2			Blue	Blue	Blue	M	H	H	H	High		
	7.7) Phase 1 implementation including administrative single point of access Q3				Blue	Blue	M	M	H	H	High		
	7.8) Phase 2 implementation including commencing development of referral routes for Secondary Care referrals Q4					Blue	M	M	H	H	High		
Ensure access to provision for sanctuary for children	7.9) Engagement with children and young people, families, and carers		Blue	Blue	Blue	Blue	H	H	H	H	High		
	(i) Workforce design Q1												
	7.10) (ii) Recruitment Q2			Blue	Blue	Blue	M	H	H	H	High		
	7.11) (iii) Implementation of rapid response and outreach service Q3-Q4				Green	Blue	M	H	H	M	High		
Develop access to provision for sanctuary for adults	~~7.12) i) Through collaboration with stakeholders, staff and partners, design a sustainable model for a highly rural setting Q3-4~~				Red		M	M	M	L	Select		
	7.13) (ii) Assess impact of right care, right person				Amber	Amber	H	H	H	H	Low		
	7.14) Q3 Year 2 Phased Delivery Plan												
	7.15) Continuous engagement Q1-Q4		Green	Red	Red		M	H	L	L	Select		
Take forward the next phase of work to enable access to a step-down solution for those with complex needs	~~7.16) Explore and develop advisory options appraisal Q1~~		Red	Red	Red		L	L	L	L	Select		
	~~7.17) Design and workforce planning Q2~~			Red	Red		M	L	L	L	Select		
	~~7.18) Preparation for procurement Q3-Q4~~				Red		M	L	L	L	Select		

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Next phase of neurodiversity pathway development		7.19) A revised pathway for neurodiversity pathway Q1-Q4				Amber	Blue	Blue	Blue	H	L	M	H	High
Formal change request (Please tick as applicable and provide explanation below)														
Change in Scope	N/A	Change in Timescale	N/A											
Change in Timescale														
7.12) Develop access to provision for sanctuary for adults: This programme has been suspended due to lack of evidence for rural areas. It is not a current priority for 2024/2025. Change request approved at Executive Committee 22.01.2025. 7.15 – 7.18) Step-down solution: This project was paused and is not a current priority. Change request approved at Executive Committee 22.01.2025.														
Executive Director Sign Off		Elaine Lorton (Executive Director of Primary Care, Community and Mental Health)												

Joined Up Care	
Strategic Priority 8 – Improve pathways of care focused on system flow	
Executive Lead - Executive Director of Primary Care, Community and Mental Health	
Intended Outcome/ Impact - People Home Fitter and Faster - Co-ordinated and effective pathways of care which deliver an efficient flow across health and care systems - Associated elimination of pathways of care delays and reduction in avoidable bed utilisation / average length of stay	
Commentary on Progress in this Quarter: 8.4) Review and refine Digital Patient Flow System, begin to strengthen beyond minimum viable product Q4: The review and refinement of the Digital Patient Flow System has been achieved, with the basic functionality performing well. Recent developments have focused on enhancing user-friendliness, improving operational utility, and introducing 'quality of life' improvements for users. Further enhancements are planned to continue into FY 2025/26 8.5) Reduce the number of service users experiencing Pathways of Care Delays (POCDs) through escalation and tracking Q1-Q4: Total numbers of Pathways of Care Delays have increased in Q4. Number of POCDs within recent 3-month data (Dec '24 – Feb '25) demonstrate a 9% increase compared with the 3-month prior (176	

[Sep-Nov]: 192 [Dec-Feb]) and a 15% increase when compared with the same period in the previous year (167 [2023]: 192 [2024]). Assessment Issues and Care Home Placement arrangements remain the highest contributing causes, making up 49% and 18% of total POCDs for this period respectively. However, the February position does represent a 25% decrease compared with the March 2024 baseline established as part of national monitoring and intervention (74 [Mar '24]: 56 [Feb '25]). The total number of days delayed as a result of Pathways of Care Delays has reduced (2308 [Avg. Dec-Feb]) representing 14% decrease when compared with the 3-month prior (2693 [Avg. Sep-Nov]: 2308 [Avg. Dec-Feb]) and a 15% decrease compared to the March 2024 baseline (2710 [Mar]: 2308 [Avg. Dec-Feb]) To reduce the number of service users experiencing Pathways of Care Delays, a Pathway of Care Delay Action Plan remains in place. Implementation is monitored through the POCD sub-group which reports into Care Action Committee. Efforts to continue to reduce the number of service users experiencing Pathways of Care Delays (POCDs) through escalation and tracking are planned to continue into FY 2025/26.

- **8.6) Reduce the number of super-stranded patients through escalation and tracking Q1-Q4:** The number of super-stranded patients has remained stable (12 [Dec '24]: 12 [Feb '25]). However, this continues to represent a 20% when compared with the previous Q4 baseline (12 [Feb '25]: 15 [Q4,23/24]). This will continue to be monitored through the Power BI dashboard to enhance monitoring of super-stranded patients, as well as monitoring through the POCD sub-group which reports into Care Action Committee. Efforts to continue to reduce the number of super-stranded through escalation and tracking are planned to continue into FY 2025/26.
- **8.8) Consider Expansion of Discharge Liaison Officer Q3-Q4:** Recruitment for the Mid Powys DLO role, funded through the Six Goals for Urgent and Emergency Care, was initially unsuccessful. The post was subsequently readvertised, and interviews are scheduled for the final week of Q4. Recruitment is now anticipated early in Q1.
- **8.9) Reduce average length of stay throughout Powys, through escalation and tracking Q1-Q4:** Average length of stay has remained stable (42.80 [Dec '24]: 42.84 [Feb '25]). However, this represents a 22% reduction when compared with the same period of the previous year (54.88 [Feb '24]: 42.84 [Feb '25]). Efforts to continue to reduce the average length of stay throughout Powys, through escalation and tracking are planned to continue into FY 2025/26.

Commentary on red rated actions: N/A

Progress against key actions and milestones

Key Areas of Delivery	Key Deliverables	Lead Executive	BRAG ('not due' already greyed out)				Year End Delivery Confidence Assessment				
			Q1	Q2	Q3	Q4	0	Q1	Q2	Q3	Q4
Implement a Digital Patient Flow System	8.1) Complete test and pilot phases of newly developed Digital Patient Flow System Q1	ED AHPHS& D	Blue	Blue	Blue	Blue	H	H	H	H	High
	8.2) Launch and roll-out of Digital Patient Flow System Q2			Blue	Blue	Blue	H	H	H	H	High
	8.3) Embed Digital Patient Flow System into standard practice and broaden user operability Q3				Amber	Blue	H	H	H	H	High

	8.4) Review and refine Digital Patient Flow System, begin to strengthen beyond minimum viable product Q4					Blue	H	H	H	H	High
Improved Approach to Pathways of Care Delays (POCD)	8.5) Reduce the number of service users experiencing Pathways of Care Delays (POCDs) through escalation and tracking Q1-Q4	ED PCC&MH	Green	Amber	Amber	Amber	H	H	M	M	Medium
	8.6) Reduce the number of super-stranded patients through escalation and tracking Q1-Q4		Green	Amber	Green	Blue	H	H	M	M	Medium
Improved Approach to Supporting People to Leave Hospital Fitter and Faster	8.7) Embed discharge liaison officer posts throughout Powys Q1-Q2		Green	Blue	Blue	Blue	H	H	H	H	High
	8.8) Consider Expansion of Discharge Liaison Officer Q3-Q4				Amber	Blue	H	H	H	H	High
	8.9) Reduce average length of stay throughout Powys, through escalation and tracking Q1-Q4		Green	Amber	Green	Blue	H	H	M	M	Medium

Formal change request (Please tick as applicable and provide explanation below)

Change in Scope	N/A	Change in Timescale	N/A

Executive Director Sign Off	Claire Madsen (Executive Director of Allied Health Professions, Health Sciences and Digital) Elaine Lorton (Executive Director of Primary Care, Community and Mental Health)

Strategic Priority 9 – Deliver the Six Goals Plan for Urgent and Emergency Care focusing on what works for the Powys population

Executive Lead - Executive Director of Primary Care, Community and Mental Health / Executive Director of Allied Health Professions, Health Sciences and Digital

Intended Outcome/ Impact

- People home fitter and faster
- A co-ordinated and evidence based Urgent and Emergency Care offer across complex health and care systems used by the Powys population

- Effective and efficient locally provided services including optimised minor injuries provision and bed utilisation to ensure patient flow

Commentary on Progress in this Quarter:

- **9.2) Broadening the knowledge and skills of MIU staff in Powys Q1-Q4:** The training needs analysis led by the Urgent and Emergency Care Clinical Transformation Lead is ongoing. Other scheduled training remains on track, with no further changes to planned timelines. Overall, progress towards broadening the knowledge and skills of MIU staff remains on schedule, with efforts to continue to broaden the knowledge and skills of Minor Injuries Unit (MIU) staff planned to continue into FY 2025/26.
- **9.6) Review of SOP and operational model including PROMS to inform the way forward Q4:** System challenges have prevented the implementation of an optimised model at the Glan Irfon site, with further work is needed to enhance collaborative working with partners. Work is underway to enhance partnership working and move toward a more optimal model for delivery of care. However, the scope of the expansion of Therapy Led Rehabilitation throughout PTHB has expanded in-year through the implementation of Rehabilitation Units as part of the Colocation Temporary Service Changes. These changes have introduced a new SOP, aligned to the 2023 Community Rehabilitation Standards to establish clear guidelines and procedures that promote high-quality rehabilitation care, including supporting patients to: maintain and improve function, compensate for lost function, prevent or slow the loss of function, self-manage their condition and maintain a better quality of life. New PROMS have been developed and introduced to support the evaluation of these changes, with efforts to continue to expand Therapy Led Rehabilitation are planned to continue into FY 2025/26, through the evaluation of the Rehabilitation Units as part of the Colocation Temporary Service Change evaluation.
- **9.8) Improve data quality and confidence of D2RA Measure reporting Q3-4:** There have been positive improvements in data quality and confidence for D2RA Measure reporting throughout Q4, with compliance trends showing steady progress. Measure 1, allocation within one day of admission, improved from 0% in January to 24% in February and 44% to mid-March. Measure 2, allocation at the point of Clinical Optimisation, increased from 50% in January to 66% in February and 83% to mid-March. Measure 3, allocation at the point of discharge, rose from 33% in January to 38% in February and 72% to mid-March.
- **9.9) Expansion of dedicated pathway capacity Q1-4:** The existing reablement service has been redesigned to create a more integrated and effective community rehabilitation service that aligns with the Allied Health Professional (AHP) Rehabilitation Standards. This transformation includes the development of two clearly defined pathways, enabling Powys Teaching Health Board (PTHB) and PCC to ensure individuals are triaged and placed on the appropriate Discharge to Recover then Assess (D2RA) pathway in a timely manner, aligning with the objectives of Goal 6: Six Goals for Urgent and Emergency Care. The refreshed service model will offer a robust PTHB community rehabilitation provision, delivered by a suitably skilled workforce, with well-established step-up and step-down pathways for individuals requiring support at home. It fosters a culture of rehabilitation and positive risk-taking and strengthens collaboration between PTHB and Powys County Council (PCC) through clearly defined service criteria, reducing duplication and inefficiency. The PCC Enablement Service will focus on rightsizing care packages and promoting enablement, helping to reduce dependency on long-term domiciliary care. Through the delivery of timely care, these services it will support to prevent deconditioning and ensure pathways are used appropriately, improving outcomes for individuals across Powys.

Commentary on red rated actions: N/A

Progress against key actions and milestones

Key Areas of Delivery		Key Deliverables	Lead Executive	BRAG ('not due' already greyed out)				Year End Delivery Confidence Assessment 0 = Original				
				Q1	Q2	Q3	Q4	0	Q1	Q2	Q3	Q4
Implement Enhanced Community Care Phase One, including the Rapid Response in the community	9.1) Scope the need for a Rapid Response service Q1	ED PCC&MH	Amber	Amber	Amber	Amber	H	H	H	H	High	
	9.2) Broadening the knowledge and skills of MIU staff in Powys Q1-Q4		Green	Green	Green	Blue	H	H	H	H	High	
Expand Therapy Led Rehabilitation	9.3) Embed new Standard Operating Procedure (SOP) and Key Performance Indicators (KPIs) for Therapy Led Rehabilitation at Mid-Powys Intermediate Care Centre (Glan Irfon) Q1	ED AHPS&D	Blue	Blue	Blue	Blue	H	H	H	H	High	
	9.4) Enhance partnership and collaboration to ensure targeted patient referral and access, as well as appropriate service utilisation Q2			Blue	Blue	Blue	H	H	H	H	High	
	9.5) Implement optimised model as part of winter response strategy Q3				Amber	Amber	H	H	H	M	Medium	
	9.6) Review of SOP and operational model including PROMS to inform the way forward Q4					Blue	H	H	H	H	High	
Enhance and expand D2RA Pathway utilisation	9.7) Commence monthly aggregate reporting of D2RA Measures Q1-Q3	ED PCC&MH	Green	Green	Blue	Blue	M	H	H	H	High	
	9.8) Improve data quality and confidence of D2RA Measure reporting Q3-4				Green	Blue	H	H	H	H	High	
	9.9) Expansion of dedicated pathway capacity Q1-4		Green	Green	Green	Blue	M	M	M	H	High	
Formal change request (Please tick as applicable and provide explanation below)												
Change in Scope	N/A	Change in Timescale	N/A									
Executive Director Sign Off		Claire Madsen (Executive Director of Allied Health Professions, Health Sciences and Digital)										

Workforce Futures

Strategic Priority 10: Transformation and Sustainability

Executive Lead – Executive Director of People and Culture

Intended Outcome/ Impact

- Strategic workforce planning with creative, innovative and effective approaches
- Sustainable workforce model with associated reduction in vacancies, agency usage and a greater pipeline of potential recruits
- Home grown capability in rural healthcare, with associated improvements in patient care and experience

Commentary on Progress in this Quarter:

- **10.1)** The People & Culture (P&C) Directorate deployed an intensive piece of work to roll out workforce planning training to senior managers and leaders earlier last year to ensure there was adequate support available for developing the skills and capabilities of our staff to drive the development and delivery of strategic workforce plans. Workforce planning (WFP) training is available for managers to access through multiple modalities, such as 1-hour information and awareness session, through to more detailed training accessed via online or face to face classroom-based training. The P&C Business Partnering team have undertaken a gap analysis to understand who has undertaken the training to date and who, from those identified as a senior leader who should attend, has yet to complete the training. Targeted discussions with Assistant Directors have taken place with an identified list of senior managers to prioritise in relation to training delivery. 39 senior managers have completed the full training to date with leadership teams from across Mental Health, Women’s & Childrens, Digital and Corporate Nursing receiving the 1-Hour awareness sessions. Our training approach has continued to develop based around service needs and has included the development of a bespoke awareness session and more recently, targeted practical follow up sessions to explore the 6-step toolkit in more detail.
- **10.2)** During this financial year 2024/25, we have recruited 3 cohorts (6 x Registered Nurses per cohort) of Adult Field Internationally Educated Nurses (IENs). The first cohort joined Newtown hospital in Aug 2024, the 2nd cohort joined the team in Machynlleth hospital in November 2024, and the third cohort joined Brecon hospital in February 2025. This most recent cohort in Brecon are currently undergoing OSCE training and due to take their OSCE exam on 25th March. An additional 6 Registered Mental Health IENs are also due to arrive before the end of the 2024/25 financial year and join and subsequently join PTHB. Two of these RMNs are already in country and currently undergoing OSCE training in Swansea Bay University Health Board (SBUHB), due to take their OSCE exam on

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18th Mar and then move to Llandrindod Wells to work in Llandrindod Wells hospital. The remaining four RMNs travel to Wales on 20th March will and undertake their OSCE training in SBUHB and are scheduled to take their OSCE exam on 24th April. Thereafter, two will go to Ystradgynlais hospital, and the other two to Bronllys hospital to join the Mental Health teams.

- 10.5/10.6) Aspiring Nurse Programme:** Our newest cohort (Sept 2024) of Aspiring Nurses saw the recruitment and onboarding of 19 new recruits and they are now well into the first year of their learning pathway. Of the original 19 recruited, 4 have unfortunately withdrawn from the course due to personal circumstances. Currently, there are 12 working in the adult general wards and 3 in the Mental Health Wards. This cohort will complete the first year of the course with Llandrillo College, and if successful, will progress onto Year 2 of the degree programme with the Open University. The September 2023 cohort of 17 Aspiring Nurses all progressed successfully into year 2 last September and are now studying full time with Bangor University. They are currently undertaking full time academic study and clinical placements. HEIW have confirmed that they are committed to supporting PTHB with the ongoing success of the Aspiring Nurse Programme with further ongoing funding. Recruitment to the September 2025 cohort will begin in May 2025 with onboarding planned for August 2025. There is a current bank recruitment campaign ongoing, encouraging potential aspiring nurse applicants to join our Temporary Staffing Unit to build knowledge and experience that will help to support their applications to the programme.

Commentary on red rated actions: N/A

Progress against key actions and milestones

Key Areas of Delivery	Key Deliverables	Lead Executive	BRAG ('not due' already greyed out)				Year End Delivery Confidence Assessment				
			Q1	Q2	Q3	Q4	0	Q1	Q2	Q3	Q4
Grow the knowledge and capabilities of managers to develop strategic workforce plans aligned to the Accelerated Model of Care	10.1) Cohort of managers (who are required to) who have completed training Q2 & Q4	ED P&C		Green		Blue	H	M	M	H	High
On board a further 3 cohorts of internationally trained Adult Nurses targeting areas with high variable pay spend	10.2) On board Cohorts 1, 2 and 3 for 24/25 Q2 & Q4			Green		Blue	H	H	H	H	High
	10.3) Scope opportunities from national programmes for international recruitment for Mental Health Q3				Green	Blue	H	H	H	H	High

Explore the potential to recruit internationally trained Mental Health Nurses and Medics										
Launch a second cohort of the Aspiring Nurse Programme with HEIW and University partners (improving access for Powys based pre-registered students to the Nurse Degree Programme)	10.4) Agreed plans and funding arrangements in partnership with HEIW and FE/ HEI providers Q2		Blue	Blue	Blue	H	H	H	H	High
	10.5) Report on the recruitment rates of the programme Q4				Blue	H	H	H	H	High
	10.6) Ensuring there is an opportunity for a Welsh essential recruitment offer Q4				Blue	H	H	H	H	High
Generate interest from the younger generation in a rural health and care career through the Academy Career and Education Enterprise Scheme (ACEES)	10.7) Evaluate the Academy Careers and Education Enterprise Scheme (ACEEs) and develop plans for 2024/25 academic year Q1	Blue	Blue	Blue	Blue	H	H	H	H	High
	10.8) Report on the development plans for 2024/25 academic year Q3			Blue	Blue	H	H	H	H	High

Formal change request (Please tick as applicable and provide explanation below)

Change in Scope	N/A	Change in Timescale	N/A

Executive Director Sign Off	Debra Wood Lawson (Executive Director of People and Culture)

Strategic Priority 11: A Great Place to work

Executive Lead – Executive Director of People and Culture

Intended Outcome/ Impact

- The health board is a great place to work, with positive organisational and team climates, high levels of staff satisfaction, engagement and wellbeing
- Associated improvements in recruitment and retention and reductions in workplace absences

- Staff are able to raise concerns and speak up safely and there is clarity on standards of behaviour and role expectations

Commentary on Progress in this Quarter:

- 11.6)** Embed the Speaking Up Safely framework. The thirteen actions within the speaking up safely framework have been reviewed and completed, or transferred into business-as-usual operations, with an ongoing commitment by PTHB continue to develop a culture of speaking up safely. This has included the provision of the 'Our Voice' portal as a mechanism for people to speak up, and the formation of a quarterly Speaking Up Safely Steering Group who will review any current data, hear from the experiences of those who have spoken up, understand barriers and also agree further organisational actions to be undertaken. The roll out of Speaking Up Safely development sessions has also started with 9 attendees on the first formal session following the previous pilots.
- A review paper to be agreed by Executive Committee that closes the initial action plan and transfers the requirements set out in the Speaking Up Safely Framework to business-as-usual, has been produced and will be approved in Q1 2025/26.

Commentary on red rated actions:

- 11.8)** A pilot tier 2 programme has been developed but due to service pressures and uncertainty around resource funding to deliver, this has been delayed to Q1 2025/26.

Progress against key actions and milestones

Key Areas of Delivery	Key Deliverables	Lead Executive	BRAG ('not due' already greyed out)				Year End Delivery Confidence Assessment 0 = Original				
			Q1	Q2	Q3	Q4	0	Q1	Q2	Q3	Q4
Deliver the actions set out in the national Nurse Retention Plan	11.1) Complete the nurse retention self-assessment tool Q1	ED P&C	Blue	Blue	Blue	Blue	H	H	H	H	High
	11.2) Undertake a gap analysis and deep dive of data and intelligence, to understand retention and priorities Q2			Blue	Blue	Blue	H	H	H	H	High
Ensure a clear mechanism for staff to raise concerns and support a culture of psychological safety, so staff feel able to speak up.	11.3) Introduce the Speaking Up Safely 'Your Voice' Portal on staff intranet Q1		Blue	Blue	Blue	Blue	H	H	H	H	High
	11.4) Introduce team activities/briefings Q2			Amber	Blue	Blue	H	H	H	H	High

		11.5) Refresh the Chat2Change plan Q2				Green	Blue	Blue	H	H	H	H	High
		11.6) Embed the Speaking Up Safely Framework Q4						Blue	H	H	H	H	High
Roll out Tier 1 of clinical leadership programme		11.7) Deliver the Tier 1 programme at a rate of 1 course per month Q1-2			Blue	Blue	Blue	Blue	H	H	H	H	High
Develop a pilot for Tier 2		11.8) Develop the Tier 2 programme Q2				Amber	Amber	Red	H	H	M	M	High
		11.9) Pilot Tier 2 programme Q3					Amber	Blue	H	M	M	M	High
Design a Charter with leadership expectations of managers responsibilities in setting standards of behaviour, engaging with staff and creating a great place to work		11.10) Develop draft Charter and resources for consultation and feedback Q1			Blue	Blue	Blue	Blue	H	H	H	H	High
		11.11) Consult with Executive team, Trade Unions and Chat2Change group Q2				Blue	Blue	Blue	H	H	H	H	High
		11.12) Launch Charter Q3					Blue	Blue	H	H	H	H	High
Formal change request (Please tick as applicable and provide explanation below)													
Change in Scope	N/A	Change in Timescale	N/A										
Executive Director Sign Off	Debra Wood Lawson (Executive Director of People and Culture)												

Strategic Priority 12: Employee Health and Wellbeing

Executive Lead – Executive Director of People and Culture

Intended Outcome/ Impact

- Staff report positively about their health and wellbeing at work, feel supported and have access to wellbeing initiatives that meet their needs

- Staff across the organisation demonstrate compassionate leadership in their everyday work
- Managers are able to utilise workforce policy and guidance to support staff to remain in/return to work

Commentary on Progress in this Quarter:

- **12.1)** Wellbeing Roadshows. Roadshows have been undertaken across 14 sites including all of the main hospitals. 356 staff were engaged with out of a potential 436 available on those days (81%). Further Road Runs have been undertaken to visit the smaller sites with 141 staff engaged with so far.
- **12.2)** Compassionate Leadership. Within Q4 5 Introduction to Compassionate Leadership Behaviour sessions were run, 3 open to all and 2 specifically to capture those attending CLIP. In total 46 attendees completed this activity.
- **12.3 & 4)** Working in partnership, a reviewed managing attendance at work toolkit was developed and launched aimed at providing a range of supporting information to assist in managing attendance, this has included reviewing our approaches in relation to temporary redeployments and the development of a “my health passport” to assist in discussions regarding reasonable adjustments. We have an active and ongoing offer of training to support managers in the deployment of policy and have continued to undertake targeted work in relation to our interventions, which also includes support to long term absence over 6 months or complex cases. This is reflected in the health board sickness absence performance which demonstrates a sustained reduction in sickness absence levels.
- **12.5)** Team Climate. Due to service demands no large service area undertook the Team Climate Survey. However, the Integrated Autism Service did complete it as part of Team Intervention work.

Commentary on red rated actions: N/A

Progress against key actions and milestones

Key Areas of Delivery	Key Deliverables	Lead Executive	BRAG ('not due' already greyed out)				Year End Delivery Confidence Assessment				
			Q1	Q2	Q3	Q4	0	Q1	Q2	Q3	Q4
Regular access to wellbeing roadshows and initiatives which support health	12.1) Undertake a series of wellbeing roadshows across the county Q4	ED P&C				Blue	H	H	H	H	High
Embed Compassionate Leadership model to underpin approach to staff wellbeing	12.2) Deliver two Compassionate Leadership courses per month Q1-Q4 Quarterly Update		Green	Green	Green	Blue	H	H	H	H	High

Develop the capability of managers in relation to Managing Attendance at work policy to support staff to return to work or stay in work	12.3) Review and republication of the managing attendance at work toolkit Q1		Blue	Blue	Blue	Blue	H	H	H	H	High
	12.4) Delivery of targeted / bespoke sessions to managers Q1-Q4 Ongoing		Green	Green	Green	Blue	H	H	H	H	High
Undertake regular Team Climate surveys and feedback to service managers to identify ways they can support the wellbeing of their staff	12.5) Undertake surveys targeting one service per quarter Q1-Q4 Quarterly Update		Green	Amber	Green	Blue	H	H	H	H	High

Formal change request (Please tick as applicable and provide explanation below)

Change in Scope N/A **Change in Timescale** N/A

Executive Director Sign Off Debra Wood Lawson (Executive Director of People and Culture)

Strategic Priority 13: Equalities and Welsh Language

Executive Lead – Executive Director of People and Culture

Intended Outcome/ Impact

- The health board is dynamic in promoting and achieving equality as an employer and employees report positive experiences and support
- The health board takes a pro-active wider role as an anchor institution in the community, leveraging its importance in the Foundational Economy
- There is an 'Equality Friendly' culture with a well trained workforce and effective utilisation of assistive technology, translation and interpretation

Commentary on Progress in this Quarter:

13.3) This activity is partially complete, an audit of all main hospital sites has been undertaken to assess the current assistive hearing technology available and its utilisation. This identified that whilst most sites had at least some technology available it was underutilised and/or people were unaware of how to use, with only one site making good use. As a result of this assessment, training is going to be delivered in relation to the use of the equipment however, we were unable to schedule this in Q4 due to availability and we anticipate this will take place in Q1 2025.

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- **13.4)** This project has been completed with the exception of the delivery of the training associated with the equipment. This was not able to be scheduled within Q4 due to availability of the Outpatients teams. The training day has been scheduled for 2nd May.
- **13.5)** This information will be included in the Directors report to the next People and Culture Committee meeting.

Commentary on red rated actions: N/A

Progress against key actions and milestones

Key Areas of Delivery	Key Deliverables	Lead Executive	BRAG ('not due' already greyed out)				Year End Delivery Confidence Assessment				
			Q1	Q2	Q3	Q4	0	Q1	Q2	Q3	Q4
Continue the rollout of the Gender Awareness programme	13.1) Updates on Gender Awareness provided in Equality Annual Report Q4	ED P&C				Blue	H	H	H	H	High
Integration of Welsh Language into the wider Managers' Training Programme	13.2) Continuous programme of training Q4					Blue	H	H	H	H	High
Commence the implementation of the objectives set out in the Strategic Equality Plan	13.3) Achieve workplace certifications for Age-Friendly Employer, Disability Confident and Hate Crime Charter Q4					Amber		H	M	L	High
	13.4) Sensory loss work: deployment of assistive technologies & Sign Live Q4					Amber	H	H	M	M	High
Continue to monitor the use and uptake of Online translation to reduce costs and improve access to BSL and foreign language interpretation	13.5) Provide an update in relation to the use of online translation Q2-Q4			Green	Green	Blue	H	H	H	H	High
Begin work on the new Welsh in Healthcare Strategy including the introduction of the new Welsh Language recruitment assessment system.	13.6) System designed and functionality finalised Q1		Green	Green	Green	Blue	H	H	H	H	High

Formal change request (Please tick as applicable and provide explanation below)			
Change in Scope	N/A	Change in Timescale	N/A
Executive Director Sign Off Debra Wood Lawson (Executive Director of People and Culture)			

Digital First

Strategic Priority 14: Citizen centred care and support

Executive Lead - Executive Director of Allied Health Professions, Health Sciences and Digital

Intended Outcome/ Impact

- Efficient and effective digital approaches used to improved citizen centred care and support – with improved patient engagement, access and control
- Digital enables patients and service users to take an active part in their own health & wellbeing
- Greater communication at all points of access and delivery in a rural healthcare system

Commentary on Progress in this Quarter:

- 14.2)** We have been engaged with the NHS Wales app team to work with them in prioritising cross border pathways, however there more to do in facilitating wider uptake from GP Clusters to register patients in Powys on the NHS Wales App
- 14.3)** Virtual Consultation has completed with an award directed to Attend Anywhere to ensure Business Continuity.

Commentary on red rated actions:

- 14.1)** Due to the supplier not meeting the cyber assurance requirements for the patient portal, we can not proceed and will seek to look at an alternative supplier/solution

Progress against key actions and milestones

Key Areas of Delivery			Key Deliverables			Lead Executive	BRAG ('not due' already greyed out)				Year End Delivery Confidence Assessment				
							Q1	Q2	Q3	Q4	0	Q1	Q2	Q3	Q4
Improve awareness and access to their digital appointment			14.1) Introduce patient portal for managing appointments Q4			ED AHPHS& D				Red	H	H	L	L	Low
Improve awareness of and access to the NHS Wales App			14.2) Support the development of the NHS Wales App to include Cross Border pathway Q4							Amber	M	M	L	L	Low
Transition to an alternative virtual consultation platform			14.3) Provide a replacement virtual consultation platform across Powys Q3						Green	Blue	H	H	M	H	High
Formal change request (Please tick as applicable and provide explanation below)															
Change in Scope		N/A	Change in Timescale		N/A										
Executive Director Sign Off			Claire Madsen (Executive Director of Allied Health Professions, Health Sciences and Digital)												

Strategic Priority 15: Leadership, Partnership and Alliances

Executive Lead - Executive Director of Allied Health Professions, Health Sciences and Digital

Intended Outcome/ Impact

- Digital First supports leadership and partnership planning and decision making
- Well led Digital Teams providing excellent services and support for staff and patients, to support and improve the delivery of care
- Increased efficiency and optimisation of system use to reduce administrative and repetitive tasks

Commentary on Progress in this Quarter:

- **15.1)** the Target Operating Model was completed with the transition of the S33 ICT Schedule to PTHB. This model of IT Service and support is complete and will continue to be evaluated as part of continuous service improvement
- **15.4)** Draft Business Case complete to implement a Training Function, next steps are to take the case through IBG

Commentary on red rated actions:

- **15.2)** The Cross border programme has been escalated to Executive level, the time for completion has slipped to May 2025.
- **15.3)** Reliant on the Connected Care National Programme which is not progressing as expected. The programme is changing in scope from a Mental Health, Social Care and Community Care replacement to defining an Integrated Shared Care Record. This has created a risk for our WCCIS system, which is contracted with the supplier until 2027 however the platform will be unsupported by Microsoft in 2026

Progress against key actions and milestones

Key Areas of Delivery	Key Deliverables	Lead Executive	BRAG ('not due' already greyed out)				Year End Delivery Confidence Assessment				
			Q1	Q2	Q3	Q4	0	Q1	Q2	Q3	Q4
Transition of ICT Service Support; Digital Clinical partnership with Experience Level Agreements (XLA)	15.1) Target Operating Model Implementation Q3	ED AHPHS& D			Blue	Blue	H	H	M	H	High
Continue engagement with NHS England to improve clinical cross border pathways	15.2) Improve data flows of clinical information into our All Wales architecture to support delivery of care Q2			Red	Red	Red	L	L	L	L	Low
Scope requirements for Integrated Shared Care Record	15.3) Enable front line staff to access digital clinical information across multiple disciplines Q4					Red	M	M	M	L	Low
Provide opportunities to improve Digital literacy across the HB	15.4) Upskill, train and support staff to improve confidence in using digital systems Q4					Amber	H	H	H	L	Medium

Formal change request (Please tick as applicable and provide explanation below)

Change in Scope	N/A	Change in Timescale	N/A
Executive Director Sign Off	Claire Madsen (Executive Director of Allied Health Professions, Health Sciences and Digital)		

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Strategic Priority 16: Enabling Efficiency and effectiveness

Executive Lead - Executive Director of Allied Health Professions, Health Sciences and Digital

Intended Outcome/ Impact

- Improved efficiency and streamlining – to support decision making and delivery of safe and timely care
- Improved staff / user and patient experience; greater engagement and associated improvements in healthcare system utilisation (e.g. Reduced DNAs)
- Centralised maintenance and a reduction in the carbon footprint

Commentary on Progress in this Quarter:

- 16.2) and 16.3) Electronic Prescribing and Medicines Administration (EPMA) case has moved to the implementation phase following successful approval of the business case

Commentary on red rated actions:

- 16.1) This internal work has slowed down due to conflicting priorities and waiting for the direction nationally and the application roadmap for national all Wales solutions
- 16.4) This has slipped due to Digital Health and Care Wales (DHCW) and Testing activities
- 16.5) Connected Care programme and WCCIS replacement has not progressed. There is no confirmation of WG funding, and the National Business Case has not been re-submitted following comment from key stakeholders

Progress against key actions and milestones

Key Areas of Delivery	Key Deliverables	Lead Executive	BRAG ('not due' already greyed out)				Year End Delivery Confidence Assessment				
			Q1	Q2	Q3	Q4	0	Q1	Q2	Q3	Q4
Whole system application review to standardise digital	16.1) Ensuring the system gaps are fully understood to meet the needs of the health board and standardise the approach to recording Q2	ED AHPHS&D		Amber	Red	Red	M	M	M	L	Low

Strategic Priority 17: Infrastructure and security

Executive Lead - Executive Director of Allied Health Professions, Health Sciences and Digital

Intended Outcome/ Impact

- Improved reliability and supportability of digital infrastructure
- Reduce and where possible remove single points of failure in the digital estate; reduce likelihood of single component outages
- Improved cyber security posture

Commentary on Progress in this Quarter:

- 17.1) Substantial progress has and continues to be made to upgrade core infrastructure across the Health Board
- 17.2) The Telephony Welsh Language functionality will be configured and completed before the year end
- 17.3) Resilience improvements are completed and will continue to be monitored
- 17.5) This has made substantial progress and is on track for completion

Commentary on red rated actions:

- 17.4) This could not progress due to not being able to receipt the equipment needed. This will move to FY 25/2026

Progress against key actions and milestones												
Key Areas of Delivery	Key Deliverables	Lead Executive	BRAG ('not due' already greyed out)				Year End Delivery Confidence Assessment					
			Q1	Q2	Q3	Q4	0	Q1	Q2	Q3	Q4	
Improve network Connectivity and reliability	17.1) Upgraded core infrastructure across all areas in the Health Board Q4	ED AHPHS&D	Amber	Green	Green	Blue	M	L	M	M		Medium
Improve telephony and collaboration tools	17.2) Procure and implement new telephony system Q4		Amber	Green	Blue	Blue	M	H	H	M		High
Improve application availability and resiliency	17.3) Implement enterprise level availability technologies to support resilience across the Health Board Q2			Blue	Blue	Blue	M	L	H	H		High

Continue to improve cyber security posture	17.4) Replace and update Firewall authentication technology across the Health Board and migrate applications Q4		Red	Red	Red	Red	M	L	H	L	Low
Align and upgrade legacy operating systems	17.5) Removal of legacy and unsupported operating systems to support resilience Q3				Green	Blue	H	M	H	H	High

Formal change request (Please tick as applicable and provide explanation below)

Change in Scope	N/A	Change in Timescale	N/A

Executive Director Sign Off Claire Madsen (Executive Director of Allied Health Professions, Health Sciences and Digital)

Strategic Priority 18: Big Data and Artificial Intelligence

Executive Lead - Executive Director of Allied Health Professions, Health Sciences and Digital

Intended Outcome/ Impact

- Increased access, quality and trust in health and care data available in near real time, promoting complete transparency of data
- Data collected consistently, cutting down manual/paper processes and releasing administration time
- 'Cloud first' approach with robust, advanced and secure reporting solutions; use of Data Platform Machine Learning and predictive modelling

Commentary on Progress in this Quarter:

- 18.1)** This work is progressing well and will be ongoing as more dashboards are made available to meet the changing needs of the organisation
- 18.3)** Complete and data sets continue to transfer from Ifor to the new platform
- 18.4)** This is progressing, and needs user acceptance testing for ease of use
- 18.5)** This is scheduled to complete by the end of the FY
- 18.7)** This is being prioritised in collaboration with the clinical informatics function

Commentary on red rated actions:

- 18.6)** This has not progressed due to capacity and resource

- **18.8)** This has not progressed as expected due to resource and capacity constraints

Progress against key actions and milestones

Key Areas of Delivery	Key Deliverables	Lead Executive	BRAG ('not due' already greyed out)				Year End Delivery Confidence Assessment				
			Q1	Q2	Q3	Q4	0	Q1	Q2	Q3	Q4
Onboard services to new Business Intelligence platform and adopt single source of truth for data	18.1) Provide the necessary tools to allow staff to access a 'Data Self-Service' to review a single source of data Q3	ED AHPHS&D			Green	Blue	M	M	M	H	High
Creation of a Health & Care Data Platform	18.2) Develop and implement a secure & robust Platform Q3				Red		M	M	M	L	Low
Modernise data processes	18.3) Plan and deliver a data collection framework Q2			Blue	Blue	Blue	M	M	H	H	High
Introduce a Data Catalog to enable users to discover, understand, and use the data they need to make informed decisions	18.4) Create a Data Catalog that is accessible by the entire Health Board Q2			Amber	Amber	Amber	M	M	H	M	Medium
Migration of legacy reports and data processes from IFOR to the cloud	18.5) Commence transition from the IFOR Reporting platform to a cloud hosted platform Q3, Q4				Green	Blue	M	M	H	H	High
Accelerate use of Robotic Processing Automation	18.6) Plan and deliver a 'RPA Framework' and Operating Model across the HB Q4	ED AHPHS&D				Red	H	H	H	L	Low
Improve the accuracy, completeness, of data quality using advanced technologies and best practices	18.7) Identify required resource and approach to improve Data Quality Q4					Amber	H	H	H	L	Medium
Adopt Machine learning toolkit (predictive analysis on current data sets)	18.8) Design and deliver a framework to adopt Machine Learning models Q3				Red	Red	H	H	M	L	Low

Formal change request (Please tick as applicable and provide explanation below)			
Change in Scope	N/A	Change in Timescale	N/A
<u>Change in Timescale</u>			
Develop and implement a secure & robust Platform Q3 – currently on hold due to other priorities and system replacement within Powys Council Social Care Services (procurement complete and contract awarded) - will need to move to 2025/26. Change request approved at Executive Committee 22.01.2025.			
Executive Director Sign Off	Claire Madsen (Executive Director of Allied Health Professions, Health Sciences and Digital)		

Innovative Environments

Strategic Priority 19: Strategic Capital

Executive Lead - Associate Director of Estates, Facilities and Support Services

Intended Outcome/ Impact

- Delivery of Capital Programme enhancements to the estate including compliance improvements
- Strategic capital programme progressed to support delivery of 'A Healthy Caring Powys' and PTHB Integrated Plan / Strategic Priorities
- Programme of works to address urgent compliance risks and infrastructure improvements

Commentary on Progress in this Quarter:

- **19.1) North Powys Wellbeing Programme:** phased approach has been agreed to progress the Integrated Hub element as phase 1. Application for funding for fees to progress SOC/OBC business case submitted to IRCF. Presented at panel in February awaiting approval.
- **19.2) Llandrindod Wells Rural Regional Centre:** £3M funding obtained to undertake part of Phase 2 programme which includes replacement windows, roofs, external access improvements and refurbishment of Westdene accommodation unit. This phase of the work is on track for completion within financial year. Business case for remaining phases will be developed in 2025/26
- **19.3) Discretionary Programme / EFAB:** progressing well with largest overall programme of activity for many years but some resource gaps in Capital team.

Commentary on red rated actions: N/A

Progress against key actions and milestones

Key Areas of Delivery	Key Deliverables	Lead Executive	BRAG ('not due' already greyed out)				Year End Delivery Confidence Assessment				
			Q1	Q2	Q3	Q4	0	Q1	Q2	Q3	Q4
North Powys Wellbeing Programme	19.1) Outline Business Case Development for campus Q2	ADEF&S S		Amber	Amber	Amber	L	M	M	M	Medium
Llandrindod Wells Rural Regional Centre	19.2) Business Case submission in format as outlined by Welsh Government as part of endorsed Programme Business Case Q3	ADEF&S S			Amber	Amber	L	M	H	M	Medium
Discretionary Capital Programme including Estates Funding Advisory Board (EFAB), etc.	19.3) Discretionary Capital Programme (circa 25 projects) Q1-Q4		Amber	Green	Green	Blue	H	M	M	M	High
	19.4) EFAB Brecon Fire Q4					Blue	H	H	H	M	High
	19.5) EFAB Machynlleth Fire Q4					Blue	H	H	H	H	High
	19.6) Building Management Systems Ystradgynlais Q4					Amber	H	H	H	H	Medium
	19.7) Waste Compounds pan-Powys Q4					Blue	H	H	H	H	High
Development of Strategic Capital Plan, project pipeline	19.8) Health and Social Care, Integration and Rebalancing Capital Fund (IRCF); capital project programme Q2			Green	Blue	Blue	H	M	H	H	High

Formal change request (Please tick as applicable and provide explanation below)

Change in Scope	N/A	Change in Timescale	N/A

Change in Scope and Timescale

- 19.1) North Powys: scope now changed to phased approach with submission of SOC/OBC for Integrated Hub / Front Door element only in Q3 2025/26. Change request approved at Executive Committee 22.01.2025.
- 19.2) Llandrindod: Welsh Government Capital Prioritisation Process has put business case submissions on hold. Progression in year of £3M element of larger Phase 2 programme. Change request approved at Executive Committee 22.01.2025.

Executive Director Sign Off	Wayne Tannahill (Associate Director of Estates, Facilities and Support Services)

Strategic Priority 20: Estates Strategy

Executive Lead - Associate Director of Estates, Facilities and Support Services

Intended Outcome/ Impact

- Structured plan for future estate development / health and care needs

Commentary on Progress in this Quarter:

- 20.1)** Work continues to be aligned and dependant on Better Together outcomes – specific ‘Site Review’ task and finish group has been set up under Better Together with work ongoing and incorporating consideration of Regional Partnership Board IRCF Integrated Hubs as part of activity.

Commentary on red rated actions: N/A

Progress against key actions and milestones

Key Areas of Delivery	Key Deliverables	Lead Executive	BRAG ('not due' already greyed out)				Year End Delivery Confidence Assessment				
			Q1	Q2	Q3	Q4	0	Q1	Q2	Q3	Q4
Draft Estates Strategy	20.1) Estates Strategy; initial draft for review Q1	ADEF&SS	Amber	Amber	Amber	Amber	M	M	M	M	Medium

Formal change request (Please tick as applicable and provide explanation below)

Change in Scope	N/A	Change in Timescale	N/A

Change in Scope and Timescale

					Q1	Q2	Q3	Q4	0	Q1	Q2	Q3	Q4	
Decarbonisation		21.1) Decarbonisation Strategic Delivery Plan – actions as set out for 2024/2025 Q1-Q4			ADEF&SS	Green	Green	Green	Blue	H	H	H	H	High
Biodiversity		21.2) Enhancement and protection of biodiversity including community group engagement Q1-Q4				Green	Green	Green	Blue	H	H	H	H	High
Energy efficiency		21.3) Implementation of energy efficiency interventions pan-Powys: Re:fit programme / Invest to Save Q4							Blue	M	M	H	H	High
Formal change request (Please tick as applicable and provide explanation below)														
Change in Scope	N/A	Change in Timescale	N/A											
Executive Director Sign Off		Wayne Tannahill (Associate Director of Estates, Facilities and Support Services)												

Strategic Priority 22: Property											
Executive Lead - Associate Director of Estates, Facilities and Support Services											
Intended Outcome/ Impact											
Integrated Working in agile environments to maximise space efficiency											
Commentary on Progress in this Quarter: N/A Commentary on red rated actions: 22.1) Detailed design and study work has been completed to identify the space requirements for a Council-led team’s co-location within the building to create an Integrated Hub. Revenue-costed plans have been developed and shared with the Council leads but delay in Council approval has led to programme slipping past Q3 and subsequent Q4 deadlines. However, confidence of agreement and future creation of Integrated Hub is high for within 2025-26.											

Progress against key actions and milestones														
Key Actions		Key Milestones			Lead Executive	BRAG ('not due' already greyed out)				Year End Delivery Confidence Assessment 0 = Original				
						Q1	Q2	Q3	Q4	0	Q1	Q2	Q3	Q4
Integrated Hubs / Agile Working		22.1) Develop Spa Road, Llandrindod Wells as Integrated Hub Q3			ADEF&SS			Amber	Red	H	M	M	M	Low
Formal change request (Please tick as applicable and provide explanation below)														
Change in Scope		N/A	Change in Timescale		N/A									
Executive Director Sign Off		Wayne Tannahill (Associate Director of Estates, Facilities and Support Services)												

Transforming in Partnership													
Strategic Priority 23: Key Strategic Partnerships													
Executive Leads - Executive Director of Public Health / Director of Corporate Governance / Board Secretary / Executive Director of Planning, Performance and Commissioning													
Intended Outcome/ Impact													
- Whole system approach to health and wellbeing to leverage benefit of collaborative working for population of Powys (and wider region as appropriate) - Whole system value and effectiveness – best use of public purse for population - Effective partnership governance and oversight													
Commentary on Progress in this Quarter:													

- **23.1)** A Partnership Assurance and Governance Framework has been developed in line with the agreed revised timeframe (development Quarter 4 and operationalisation Q1 2025/26). The Framework sets out the purpose and legislative background; a classification of statutory partnerships and “partnerships by choice” and “partnership” as a way of working. For the 14 main partnerships and Joint Committees involving PTHB it sets out for each - the partnership type, legislation and delegation, terms of reference, key subgroups, leadership (including the designated PTHB lead), budget, plan, existing assurance arrangements, reporting process and cycle, key issues. It recommends a regular highlight report to the PPPH Committee as part of operationalisation in 25/26 and a process for keeping the schedule of partnerships up to date. (In addition, the development and implementation of an Evaluation, Prioritisation and Assurance Framework for the RPB was completed in Q3 and applied to existing revenue funding - in order to help inform RPB decision making in January 2025.)

Commentary on red rated actions: N/A

Progress against key actions and milestones

Key Actions	Key Milestones	Lead Executive	BRAG ('not due' already greyed out)				Year End Delivery Confidence Assessment				
			Q1	Q2	Q3	Q4	0	Q1	Q2	Q3	Q4
PTHB Partnership Assurance and Governance Framework to be developed	23.1) Framework to be developed by Q4, operationalised in Q1 of 25/26.	DCG/ ED PP&C			Red	Blue	M	M	L	L	High

Formal change request (Please tick as applicable and provide explanation below)

Change in Scope	N/A	Change in Timescale	N/A

Change in Timescale

23.1) Framework to be developed, agreed and operationalised Q3 – Timescale change to Q4. Change request approved at Executive Committee 22.01.2025.

Executive Director Sign Off

Helen Bushell (Director of Corporate Governance / Board Secretary)

Nicola Johnson (Executive Director of Planning, Performance and Commissioning)

Strategic Priority 24: Commissioning, Performance, Planning

Executive Lead - Executive Director of Planning, Performance and Commissioning

- Intended Outcome/ Impact
- Integrated commissioning, performance and planning delivering ‘A Healthy Caring Powys’ and the PTHB Integrated Plan
 - Effective mechanisms in place for strategic planning, commissioning assurance and performance management
 - Supporting value, effectiveness, efficiency, quality and resilience of provider and commissioned services for Powys residents

Commentary on Progress in this Quarter:

- 24.3)** Portfolio of commissioning and performance activity as noted - at risk in terms of NHSW providers not delivering required RTT and cancer performance; and due to financial pressures mainly in NHSE providers and Specialised Services.

Commentary on red rated actions: N/A

Progress against key actions and milestones

Key Actions	Key Milestones	Lead Executive	BRAG ('not due' already greyed out)				Year End Delivery Confidence Assessment				
			Q1	Q2	Q3	Q4	0	Q1	Q2	Q3	Q4
Delivery of Annual Strategic Planning Cycle	24.1) Quarterly Reporting cycle (progress against plan and strategic change) Q1-Q3	ED PP&C	Green	Green	Green	Blue	H	H	H	H	High
	24.2) Annual Plan Review & Development Q3-Q4				Green	Blue	H	H	H	H	High
Delivery of Immediate / Short / Medium and Long Term Commissioning and Performance Work Programme	24.3) Portfolio of commissioning and performance activity as noted Q1-Q4		Green	Green	Amber	Amber	H	H	H	H	Low

Formal change request (Please tick as applicable and provide explanation below)

Change in Scope	N/A	Change in Timescale	N/A

Executive Director Sign Off	Nicola Johnson (Executive Director of Planning, Performance and Commissioning)

Strategic Priority 25: Governance

Executive Lead - Director of Corporate Governance / Board Secretary

Intended Outcome/ Impact

- Decisive and effective decision making supported by assurance, oversight and effective management of risks
- Appropriately skilled, trained and informed Board
- Excellent Board and Executive administration and governance advice and support

Commentary on Progress in this Quarter:

- **25.1) Board Assurance Framework** – Framework is in place, core risk element of the framework in place. Next phase of assurance dashboards in development.
- **25.2) Board and Committee plans** -delivered, all scheduled committees and Boards delivered with additional meetings also supported. Work plans fully monitored.
- **25.3)** Board Development programme fully delivered
- **25.4)** Risk Management Framework revised and approved by Board in March 2025
- **25.5)** Corporate business systems continue to mature across the team

Commentary on red rated actions: N/A

Progress against key actions and milestones

Key Actions	Key Milestones	Lead Executive	BRAG ('not due' already greyed out)				Year End Delivery Confidence Assessment			
							0 = Original			
			Q1	Q2	Q3	Q4	0	Q1	Q2	Q3

Board Assurance Framework	25.1) Board Assurance Framework (BAF) is an integrated part of every Board meeting Q1	DCG	Green	Green	Amber	Blue	H	H	M	M	High
Board and Committee work plans aligned to the plans Board Assurance Framework and Corporate Risk Register	25.2) Board and Committee work plans are agreed, delivered and evaluated. Q1-Q4		Green	Green	Green	Blue	H	H	H	H	High
Board Development programme that underpins the High Performing Board programme	25.3) Board development programme x6 sessions; board briefings x12 sessions Q1-Q4		Green	Green	Green	Blue	H	H	H	H	High
Review Boards Risk Management Framework further embedding effective risk management	25.4) Risk management framework reviewed and fully implemented Q4	DCG				Blue	H	H	L	M	High
Corporate business systems maximising efficiency and effectiveness	25.5) Corporate business systems clearly defined and in place Q1		Green	Green	Green	Blue	H	H	H	H	High

Formal change request (Please tick as applicable and provide explanation below)

Change in Scope	N/A	Change in Timescale	N/A

Executive Director Sign Off Helen Bushell (Director of Corporate Governance / Board Secretary)

Strategic Priority 26: Effective systems and delivery of engagement and communication

Executive Lead - Director of Corporate Governance / Board Secretary

Intended Outcome/ Impact

- Clear and effective communication and engagement between the health board and the population it serves
- Communication activity supports strategic priorities and focuses on the management of principal risks
- Increased coherency across partners with a shared approach to public voice and insight to drive positive change

Commentary on Progress in this Quarter:

Whilst recognising that the key actions within this ongoing objective relate to ongoing programmes of engagement, communication, and co-production, the specific actions identified for 2024/2025 are on schedule and work is under way to develop the priority programme for 2025/26. The focus of work has remained under ongoing review and reprioritisation particularly to reflect emerging requirement relating to the development of the future shape of safe and sustainable health services.

- Focus support for the consideration of potential areas of in-year cost improvement including in relation to the potential waiting list measures which were subsequently discounted at a meeting in public of the Board in January 2025.
- Continued engagement and communication support for temporary service changes implemented during Q3.
- Establishment of a new co-production journey tracker through the Powys Engagement and Insight Network (a joint sub-group of the Public Services Board and Regional Partnership Board) as well as preparatory work towards the Q3 and Q4 People and Communities Insight Report.
- Promotion of flu and COVID vaccination has continued to be a key focus during Q4, alongside wider winter response. Further adverse weather events have required significant reactive comms support to reduce risk and impact for the organisation and for communities.
- Planning and delivery of the Better Together programme including delivery of a focused phase of staff engagement during February & March 2025, and planning towards a phase of patient, public and stakeholder engagement expected early in Q1 2025/26 to help shape the future of safe, quality health services for Powys.
- Launch of the 2025 Staff Excellence Awards Commentary on red rated actions

Commentary on red rated actions: N/A

Progress against key actions and milestones

Key Actions	Key Milestones	Lead Executive	BRAG ('not due' already greyed out)				Year End Delivery Confidence Assessment				
			Q1	Q2	Q3	Q4	0	Q1	Q2	Q3	Q4
Design and delivery of a programme of marketing and communication	26.1) Design and deliver annual programme of communication and marketing activity focusing on those issues offer the most strategic benefit and management of principal risks Q1-Q4	DCG	Green	Green	Green	Blue	H	H	H	H	High
Design and delivery of a programme of continuous and targeted engagement	26.2) Design and deliver compliant programmes of engagement and/or consultation reflecting the requirements of the health board (e.g. Better Together), local partnerships (e.g. Sustainable Powys), regional programmes (e.g. cross-border / commissioning changes)		Amber	Green	Green	Blue	H	H	H	H	High

	and national programmes (e.g. all-Wales and specialised services). Q1-Q4													
Delivery of shared PSB/RPB Engagement and Participation Plan priorities	26.3) Design and deliver a shared approach to coproduction across public sector partners in the Regional Partnership Board and Public Services Board Q1-Q4		Green	Green	Green	Blue	H	H	H	H	High			
Formal change request (Please tick as applicable and provide explanation below)														
Change in Scope	N/A	Change in Timescale	N/A											
Executive Director Sign Off	Helen Bushell (Director of Corporate Governance / Board Secretary)													

Strategic Priority 27: Quality and Safety														
Executive Lead - Executive Director of Nursing, Quality, Women and Family Health														
Intended Outcome/ Impact														
• Delivery of Quality care that meets the needs of the Powys population • A mature and effective approach to quality embedded throughout the organisation														
Commentary on Progress in this Quarter:														
• 27.1) The IQR and IQPD reporting framework provides updates on the progress and implementation of the Duty of Quality, this is in readiness for the updated regulation expected late 2025, a scoping exercise is underway to establish the impact this will have PTHB Corporate Q&S Services. • Patient stories agenda has progressed with resource to recruit to a Patient Experience Lead and to implement the new Peoples Experience Framework.														
Commentary on red rated actions: N/A														
Progress against key actions and milestones														

Key Actions	Key Milestones	Lead Executive	BRAG ('not due' already greyed out)				Year End Delivery Confidence Assessment				
			Q1	Q2	Q3	Q4	0	Q1	Q2	Q3	Q4
Year 2 Maturity Plan (building on Year 1 of Duty of Quality and Candour Implementation Plan)	27.1) Duty of Quality and Candour Maturity Plan Q1-Q4	ED NQW&FH	Green	Green	Green	Blue	H	H	H	H	High
Formal change request (Please tick as applicable and provide explanation below)											
Change in Scope	N/A	Change in Timescale	N/A								
Executive Director Sign Off		Claire Roche (Executive Director of Nursing, Quality, Women and Family Health)									

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Addysgu Powys
Powys Teaching
Health Board

Agenda item: 4.5

Board		21 May 2025
Subject:	Better Together Portfolio Update	
Approved and presented by:	Debra Wood-Lawson, Executive Director of People & Culture; Lucie Cornish, Director of Improvement & Transformation	
Prepared by:	Director of Improvement & Transformation; Deputy Director of Engagement, Communication & Corporate Governance	
Other Committees and meetings considered at:	Executive Committee - 15 May 2025 who supported the paper	
PURPOSE:		
To provide an update to the Board on the progress and next steps of the Better Together Transformation portfolio		
RECOMMENDATION(S):		
The Board is asked to:		
- NOTE and TAKE ASSURANCE on the progress made in relation to the delivery of Better Together. - ENDORSE the strategic direction and proposed timetable, recognising alignment with Health Board strategy, national policy and legal duties, including the Duty of Quality. - NOTE the planned forward activity. - NOTE the risks identified and mitigating actions in place.		
Approve/Take Assurance	Discuss	Note
Y	Y	Y

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:		
1. Focus on Wellbeing	Y	The Better Together Portfolio is aligned with all Health & Care strategy objectives.
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:

This report provides a strategic update on the progress of Better Together - the Health Board's transformation route map to ensure sustainable, high-quality, and person-centred care across the county. It outlines thematic focus areas, programme milestones, engagement activity and next steps as the health board moves from engagement toward formal option development and consultation.

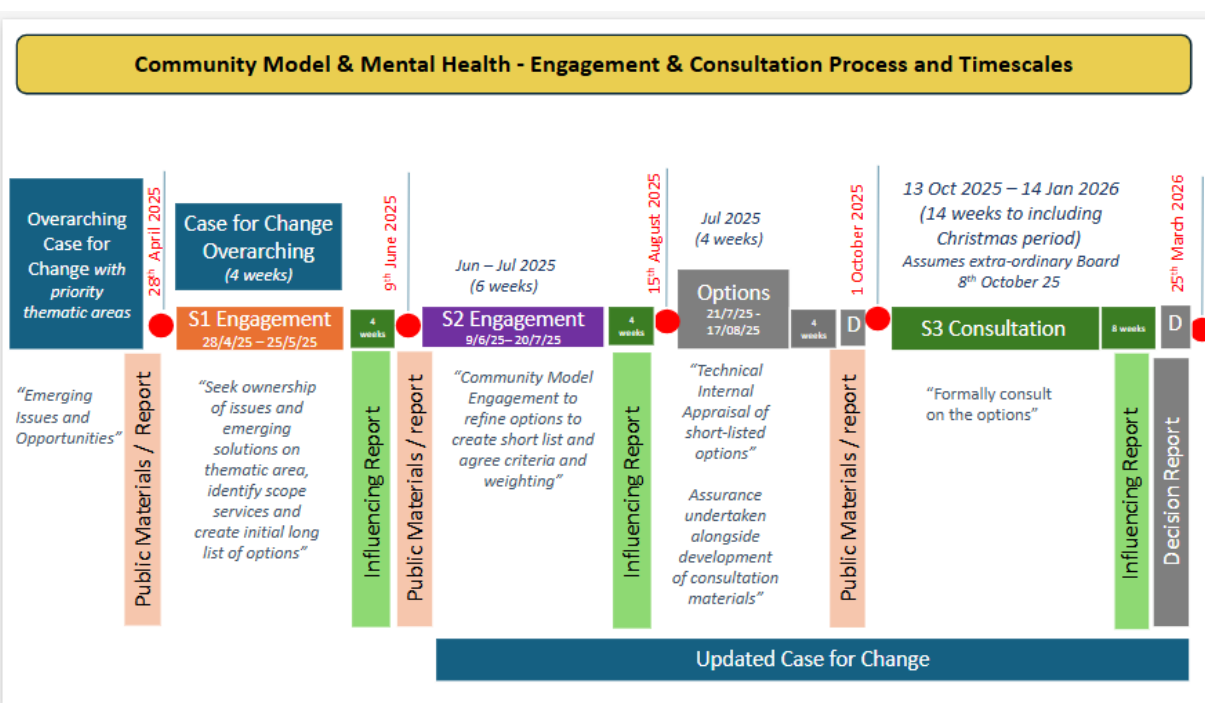
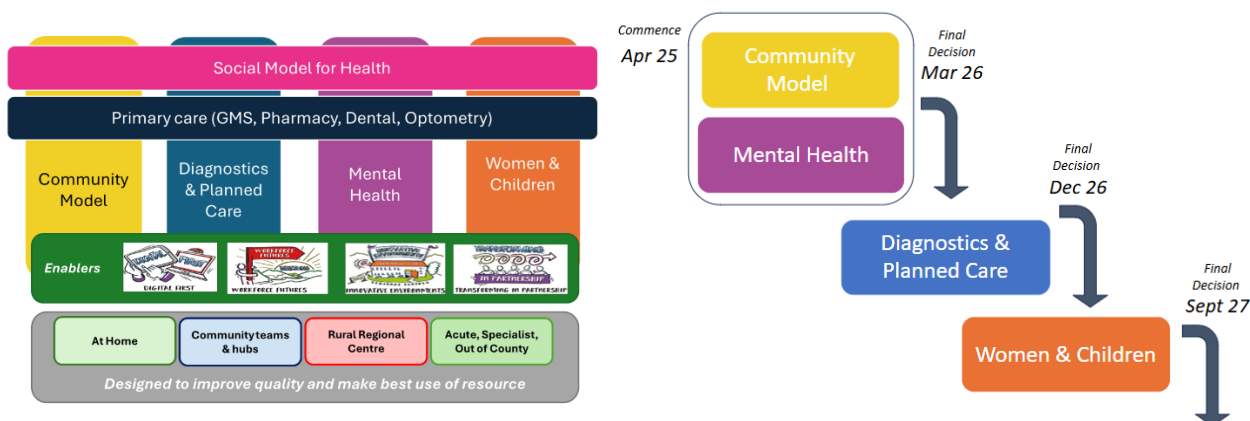
SITUATION

Better Together responds to an urgent and well-evidenced case for change. Health and care services in Powys face increasing pressure from a growing elderly population, rising incidence of complex multimorbidity, ageing infrastructure, workforce challenges, and escalating financial constraints. There is clear alignment with local and national strategy, including *A Healthier Wales* and the *NHS in 10+ Years* (Orford) report, in recognising that "no change is not an option."

The transformation portfolio aims to redesign models of care to deliver safe, sustainable services aligned to population needs, with a stronger focus on prevention, earlier intervention, and integration across physical health, mental health, primary care, and the third sector.

The design approach is shown in the diagram below including thematic areas of focus. Phasing of the thematic areas is also described below along with the Engagement and Consultation process and timescale for the Community and Adult Mental Health models. Recognising the importance of delivering action towards a sustainable future model for healthcare in Powys, the timeline has been developed to enable engagement, consultation and any decision making to take place on the Community and Adult Mental Health models ahead of the 2026 Senedd election period.

Patterson, Liz
20/05/2025 15:22:19



BACKGROUND

The Health Board has an approved Health and Care strategy, 'A Healthier Powys', which sets out our vision for health and care services across Powys. This remains our direction of travel and work has been undertaken to deliver the strategy through the Renewal, Accelerated Sustainable Model (ASM) and Better Together Transformation & Value programmes.

The ASM Discovery Phase informed the Better Together Programme structure which has been in place and delivering against the FY 2024/25 Integrated Plan. It was recognised that this plan does not go far enough to deliver the level of strategic change committed to in the Health & Care Strategy and required to address the case for change.

To address this, a Directorate of Improvement & Transformation was established in October 2024, and the existing programme structure and its delivery mechanisms were reviewed. Since establishment of the new Directorate, the Health Board has gone into Escalation & Monitoring Level 4 (Targeted Intervention) for Finance, Strategy and Planning. Evidence of a clear roadmap and implementation of the health board's Clinical Services Plan is included in Welsh Government de-escalation criteria.

A revised transformation structure was agreed in December 2024 with a transition to the Better Together Portfolio from January 2025. This provides a clear delivery mechanism and governance framework (Appendix 1). Portfolio deliverables form part of the FY2025/26 Integrated Plan.

ASSESSMENT

This section provides an overview of progress since transition to the new structure.

Portfolio Progress and Engagement Milestones

- An overarching **Case for Change** and summary version have been produced. Thematic chapters to support the development of options are in the final stages of completion. These documents will be updated throughout the process.
- Acceleration of **Community** and **Adult Mental Health** models has been agreed and is underway. Clinically and Operationally led Programme Boards and workstreams are in place.
- A comprehensive **Organisational Development, Engagement & Communications (ODEC)** plan is in place, incorporating lessons learned from previous service changes.
- **Stage 1 Public Engagement** launched on **28th April 2025** and runs until **25th May 2025**, centred around the Case for Change and asking our communities for their views on our strengths, weaknesses, opportunities and threats (see Appendix 2).
- Staff engagement activities have included hospital walkabouts, workshops, and targeted leadership development to build internal understanding and ownership of the transformation.
- **Engagement support**, including independent assurance and facilitation for consultation events, is being procured to ensure a robust and inclusive process.
- A **Primary Care workshop** was held in March 2025 and plans for ongoing collaboration across the portfolio are being implemented.
- A structured **workshop series** is underway including system partners to shape the future vision, emerging principles and models, taking a data driven approach.

- The first **deliberative event**—a 'check and challenge' session—will take place on **3rd June 2025** to review feedback from stage 1 public engagement and further discuss the issues and opportunities within the case for change. The workshop will also share and test initial thinking on the future vision and emerging principles to improve patient outcomes for community services and mental health services and readiness for Stage 2 public engagement which will commence from **9th June 2025**.
- The portfolio is currently **on track** to deliver against the approved timeline.

Risks

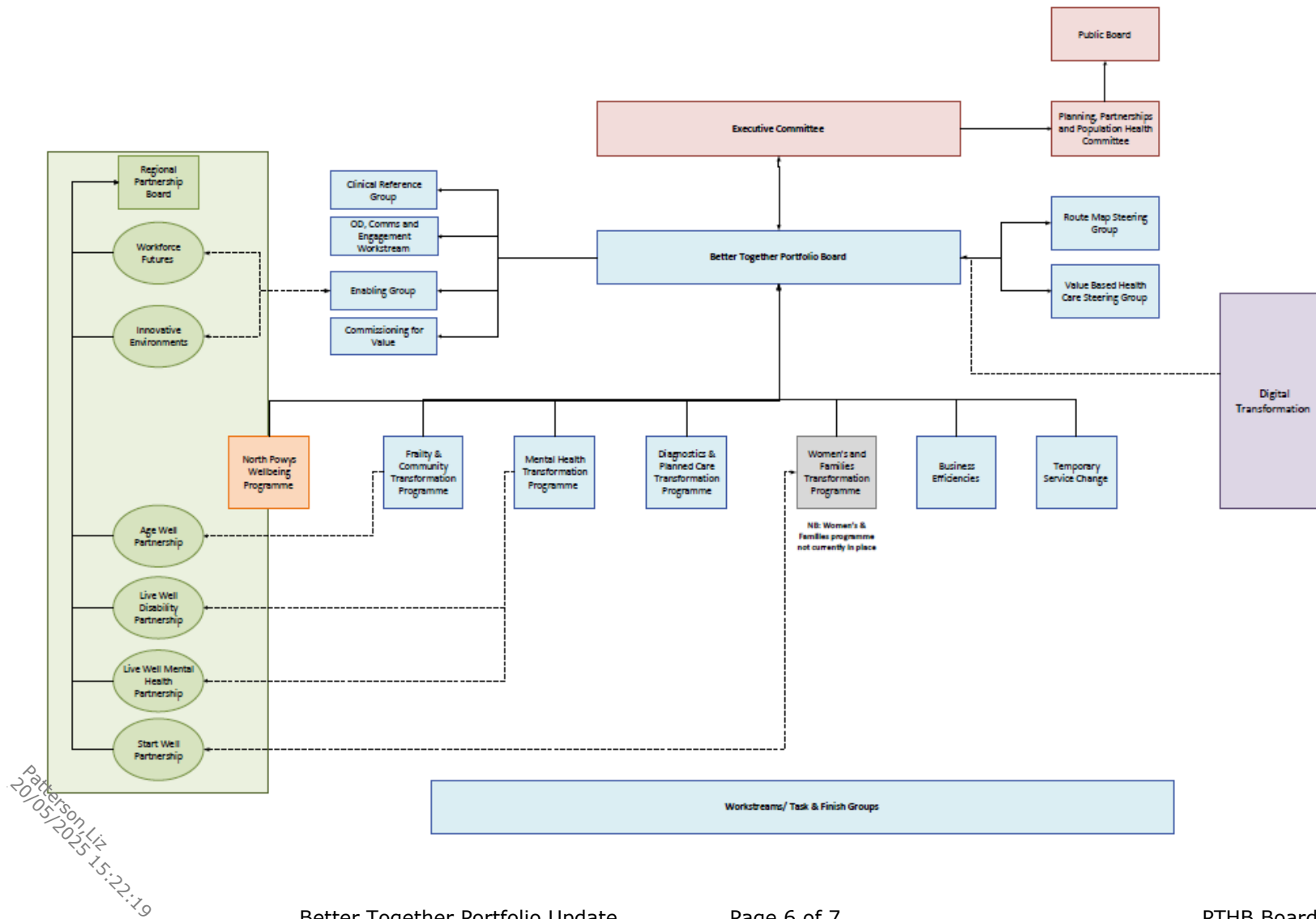
A portfolio risk register is in place. The most significant risks identified for the present phase are the capacity, cognition and capability across the organisation and partner organisations to deliver Better Together, additional high rated risks (16+ before mitigation) are organisational and public readiness for change and the delivery timeline. Actions are being taken to mitigate these risks through the identification, release and/or recruitment of capacity to support key areas, particularly clinical and engagement expertise. The ODEC plan for both internal and external communication and engagement provides mitigation to the risk identified for readiness for change. Phasing of delivery for Better Together seeks to provide mitigation against the timeline. Risks will be monitored closely through the Portfolio Board.

Next Steps

Key next steps are as follows:

- **Workshops** will continue to be delivered through May to shape principles and models to inform Stage 2 public engagement.
- **Stage 2 Public Engagement** begins **9th June 2025**, running for 8 weeks, focusing on the Community and Adult Mental Health models.
- **Option development, appraisal and shortlisting** will take place over summer, supported by feedback from public engagement, impact assessments and financial/workforce modelling.
- A full **public consultation** is scheduled from **13th October 2025 to 14th January 2026**, subject to Board approval of materials and assurance processes.

Appendix 1 – Better Together Portfolio structure



Appendix 2 – Better Together Public Engagement April/May 2025

Public engagement on the Better Together Case for Change is taking place from 28 April to 25 May 2025.

The key elements of the engagement plan include:

- Engagement website established in Cymraeg (www.dweudeichdweudpowys.cymru/gwella-gydan-gilydd-gwanwyn25) and English (www.haveyoursaypowys.wales/better-together-spring25)
- Summary Case for Change available in Cymraeg, English, Easy Read, accessible web format for screen readers and other adaptive software, and video versions
- Detailed Case for Change available in Cymraeg and English
- Publicity materials including posters and flyers available to signpost people to the engagement (example right)
- Opportunity to request printed engagement materials by phone or email, and to respond in writing
- Printed information packs available in local libraries across the county
- Digital distribution of engagement materials to key stakeholders

Alongside the suite of engagement materials:

- An ongoing programme of qualitative engagement has been taking place across the county, visiting a range of local groups to gather insights and feedback across a broad spectrum of equality protected characteristics and other socio-demographic factors.
- Attendance at a range of events and meetings including PAVO Locality Forums, Town & Community Councillor events organised by Powys County Council.
- Ongoing staff engagement including through Staff Briefings and PTHB Team Focus.





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Agenda item: 4.6

BOARD		21 May 2025	
Subject:	Assurance Report for Temporary Service Changes to Minor Injury Units and Colocation Units (Ready To Go Home & Rehabilitation)		
Approved and presented by:	Executive Medical Director		
Prepared by:	Assistant Director Innovation & Improvement		
Other Committees and meetings considered at:	Executive Committee - 07 May 2025 who supported to the paper to the Board.		
PURPOSE:			
This paper provides assurance to the PTHB Board in relation to the evaluation and monitoring of the temporary service changes and updates against the Mitigation plan for Temporary Service Changes as agreed at Board on 10 October 2024.			
RECOMMENDATION(S):			
The Board is asked: - To RECEIVE the update on progress to date including the evaluation and monitoring plan - Take ASSURANCE in relation to the delivery of the mitigation plan			
Approve/Take Assurance		Discuss	Note
Y		Y	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	Y	
6. Promote Innovative Environments	Y	
7. Put Digital First	Y	
8. Transforming in Partnership	Y	
EXECUTIVE SUMMARY:		

To receive an assurance update on the progress of the Temporary Service Changes approved by the Board on 10 October 2024, including the Evaluation and Mitigation plans. The approved Temporary Service Changes are as follows:

- Minor Injury Unit Services in Brecon and Llandrindod Wells to open from 8am to 8pm.
- The implementation of "Ready To Go Home" units in Llanidloes and Bronllys with a strengthened role for Brecon and Newtown to provide community inpatient rehabilitation.

EVALUATION MONITORING AND MITIGATION PLAN DELIVERY:

1.1 Background

At a meeting of the Board on 24 July 2024, the Health Board considered the significant challenges to the quality and sustainability of health services in Powys, and specifically to a number of operational proposals for improving quality and value on a temporary basis.

On 10 October 2024 the Board approved:

- The implementation of temporary changes to Minor Injury Unit (MIU) Services in Brecon and Llandrindod Wells to open from 8am to 8pm for a six-month period
- The implementation of temporary changes to the community hospital model with Llanidloes and Bronllys as "Ready To Go Home" units and with a strengthened role for Brecon and Newtown to provide community inpatient rehabilitation for a six-month period.

This is the third assurance update report to be presented.

1.2 Operational status

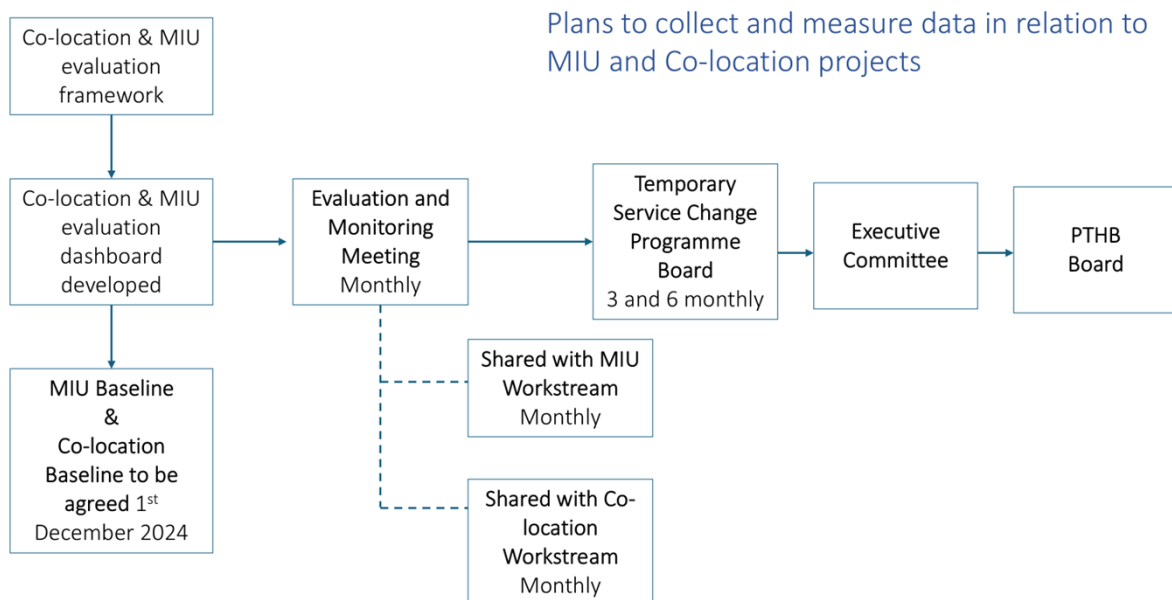
MIU changes went live on 18 November 2024

Ready to Go units went live on 2 December 2024

1.3 Monitoring against the Evaluation Frameworks

A **Temporary Service Change Evaluation & Monitoring Group** has been established overseen by the Research, Innovation & Improvement Team. This group is responsible for the active monitoring against the agreed measures, with evaluation and monitoring reported at least monthly through the Temporary Service Change Programme Board from January in line with revised governance following the establishment of the Better Together Portfolio Board.

The Evaluation and Monitoring group will ensure that benefits are captured and that any adverse impacts are identified. It will ensure that triggers to consider stop/pause of temporary changes are identified and reported promptly.



In addition to the agreed Monitoring and Evaluation Framework measures, arrangements are in place to collect the following at the 3-month and 6-month points to contribute to mid-point and summative review:

- Primary Care, Third Sector and Social Care feedback on the model
- PTHB Staff Experience of those directly impacted by the changes
- Service User/patient stories

All expected Monitoring and Evaluation activity has taken place as set out in the agreed Monitoring and Evaluation Frameworks.

1.4 Progress on Development and Delivery of the Mitigation Plan

In preparation for the Board consideration on 10 October 2024, an integrated impact assessment was undertaken. This summarises the detailed consideration that has taken place of the potential impact of these proposals across a range of quality, equality and wider strategic factors. The summative quality assessment that was undertaken in preparedness for the approval of the temporary service changes is that these changes will deliver an overall quality benefit, as there are high potential positive impacts that outweigh downside impacts with clear potential for sufficiency of mitigation.

As part of the identification of the potential impacts of the two temporary service changes proportionate mitigations were described in the paper to Board on 10 October 2024. A Mitigation Plan has been developed and progress against these will be monitored and reported.

The attached Mitigation Plan Tracking documents which can be found at **Appendix 1** provides a summary of the current position and next steps.

To note, all mitigations are on track.

1.5 Reporting Timeline

Evaluation and Monitoring will be reported through the Temporary Change Programme Board and updates to Board as set out below. In the absence of any trigger to make changes to the models, detail will be reported to board at the end of the process.

Timeline in summary:

Report 1 - Board Update Report including: Assurance on change implementation and progress Reporting and evaluation timeline and process	29 January 2025
Report 2 - Board Assurance Report Submission of information from workstream leads; updates against mitigation together with any significant positive or adverse issues to highlight, any additional risks identified and anything to specifically highlight on comms, stakeholder engagement/management.	26 March 2025
Report 3 - Board Assurance Report	21 May 2025
Report 4 – 6 Month Evaluation Report with considerations for next steps	30 July 2025

1.7 Steps to be taken at the end of the 6-month temporary period

- The Temporary Service Changes will be monitored monthly through the Evaluation and Monitoring Group.
- During June 2025 there will be a full evaluation of both changes against the evaluation framework utilising the qualitative and quantitative information gathered during the 6-month period.
- The workstream leads will assess the changes against agreed decision-making criteria. These are based on the evaluation framework, benefits and mitigation agreed by Board in October 2024.

- Recommendations based on the evaluation will be considered by Strategic Change Programme Board and Executive Committee before being presented to Board on 30 July 2025

Decision making criteria have been agreed with each workstream based on the benefits and mitigation set out in the Board paper in October 2024. These will be used, together with the full evaluation of the temporary service changes, to make recommendations to the Board in July 2025.

1.8 Any significant positive or adverse issues to highlight since last report

Nothing to report.

1.9 Any additional risks identified

Nothing to report.

1.10 Anything to specifically highlight on comms, stakeholder engagement /management

Nothing to report.

NEXT STEPS:

Evaluation and monitoring will continue as outlined in the plan. Approval is sought for onward presentation of this report to Board on 26 March 2025

A six Month Evaluation Report with considerations for next steps will be presented to Board 30 July 2025.

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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	
Safe	X				Review and approval of this paper does not impact on quality standards as this paper provides an update on work under way to continue to develop and deliver the mitigation plan for the Temporary Service Changes agreed on 14th October 2024.
Timely	X				
Effective	X				
Efficient	X				
Equitable	X				
Person Centred	X				
Workforce	X				
Leadership	X				
Culture	X				
Information	X				
Learn, Improve, Research	X				
Whole Systems Approach	X				

EQUALITY:

	No impact	Negative	Positive	Both	
Age	x				Review and approval of this paper does not impact on equality protected characteristics or Welsh Language as this paper provides an update on work under way to continue to develop and deliver the mitigation plan for the Temporary Service Changes agreed on 14th October 2024.
Disability	x				
Gender reassignment	x				
Marriage / civil partnership	x				
Pregnancy / maternity	x				
Race	x				
Religion or Belief	x				
Gender	x				
Sexual Orientation	x				
Welsh Language	x				
Socio-economic status	x				
Social exclusion	x				
Carers	x				

RISK ASSESSMENT:

	Level of risk identified				
	Very Low (0-3)	Low (4-8)	Moderate (9-12)	High (15-25)	
Clinical	X				Review and approval of this paper does not have further risk impact beyond the key impacts identified in the paper to the Board on 14th October 2024.
Financial	X				
Corporate	X				
Operational	X				
Reputational	X				

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Appendix 2:



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Minor Injury Unit Services in Brecon and Llandrindod Wells to open from 8am to 8pm Mitigation Plan Tracking

Updated based on discussion and review at:

MIU Temporary Service Change Workstream	16 th April 2025
Temporary Service Change Programme Board	29 th April 2025
Executive Committee	7 th May 2025
Presented to PTHB Board	21 st May 2025

Action	Responsibility	Timeline	Updates with date
A marketing campaign would raise awareness of the revised opening hours if approved (Health Board already requires regular cascade to promote short notice changes to opening hours).	Deputy Director Coms & Engagement	By December 2024 and ongoing	Publicity campaign in place via digital channels with regular updates.
The marketing campaign would include awareness of alternatives to MIU including more detailed information about which facility to access for given conditions and clinical advice from 111.	Deputy Director Coms & Engagement	By December 2024 and ongoing	Publicity campaign in place via digital channels with regular updates.

Relevant directories of service including NHS 111 Wales Online directory would be updated to provide consistent information regarding the current service offer.	Assistant Director CSG		Complete A process for this is already in place. WAST updated with any service changes.
There would be continued promotion of Phone First for all MIU attendances (this will help MIU attenders know whether MIU is open or closed, and signpost to alternatives).	Deputy Director Coms & Engagement	By December 2024 and ongoing	Publicity campaign in place via digital channels with regular updates.
There would be new visible signage at hospital entrances to signpost to alternative services.	Deputy Director Coms & Engagement	December 2024	Complete
The need for the Health Board to issue frequent messaging to raise awareness of short notice changes to MIU overnight opening times would significantly reduce, also reducing confusion and uncertainty for patients.	Deputy Director Coms & Engagement	By December 2024 and ongoing	Weekly social media posts advertising opening hours remain in place as part of publicity campaign above, but there has been no requirement to raise awareness of short notice closures since the temporary changes were introduced.

Complete	
On Track	
Delayed, plan in place to recover	
Off Track	

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Co-location Mitigation Plan Tracking

Updated based on discussion and review at:

Co-location Temporary Service Change Workstream	24 th April 2025
Strategic Change Programme Board	29th April 2025
Executive Committee	7th May 2025
Presented to PTHB Board	21st May 2025

The implementation of temporary changes to community hospital model with Llanidloes and Bronllys as “Ready To Go Home” units and Brecon and Newtown as Rehabilitation Units

Action	Responsibility	Timeline	Updates with date
Model supports strategic ambition in Health & Care Strategy and Integrated Plan	Assistant Director CSG	Complete	Complete That the change was in line with strategic aims was part of the assessment for ‘go live’
Model supports delivery of NHS Wales Rehabilitation Framework	Assistant Director CSG	Ongoing	Rehabilitation outcomes will be collected as part of the evaluation.
Expand information and signposting for all Units including travel information and wider social support	Assistant Director CSG	By December 2024 and ongoing	Included in comms documentations – leaflets, patient information etc.

Risk of adverse impact for some patients from isolation	Assistant Director CSG	March 24	Availability of tablet for virtual communication between family and patient Focus on prevention of deconditioning and activity to provide stimulation Explore expansion of activity availability on unit to support ward team
Risk of adverse impact for some families & unpaid/informal carers for travel costs	Assistant Director CSG Comms team	Complete	Flexible visiting times will be maintained and strengthened Placement in nearest RTGHU to usual place of residence Promotion of benefits for RTGHU including reduction of deconditioning leading to lower levels of long-term need and potential reduction in Length of stay Engagement with PCC for continued focus on public transport routes between market towns. Development of leaflet and posters for public education
Risk to some Welsh speaking patients placed in locations with reduced local uptake of Welsh language		Complete	Existing policies in place to ensure Welsh Language compliance Availability of translation services
SOPs will clarify criteria-led admission	Assistant Director CSG	Complete	Complete and signed off.
Explainer leaflet for patients and families using RTGH and Rehabilitation Unit	Deputy Director Engagement and Workstream / Lead Nurse	Complete	Complete Leaflets in place. Printed copies are available on the wards and digital copies available from the PTHB website
Raise public awareness of role of the RTGH and rehabilitation units	Deputy Director Engagement	Complete	Dedicated leaflets created for RTGH and rehabilitation units:

	and Communication		Dedicated web content to provide information about temporary model Video explainer from Nurse Director Direct mail to stakeholders. Posters up on walls in the appropriate areas. Information about RTGH Units including patient leaflet: Ready To Go Home Units - Powys Teaching Health Board Information about Rehabilitation Units including patient leaflet: Inpatient Rehabilitation Units - Powys Teaching Health Board
No reduction in bed numbers (155) – need to confirm to give assurance	Assistant Director CSG	By December 2024 and ongoing	No change - December 2024
No change to medical cover	Assistant Director CSG	December 2024 and ongoing	No change - December 2024

Complete	
On Track	
Delayed, plan in place to recover	
Off Track	

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Agenda item: 4.7

BOARD		21 MAY 2025
Subject:	Speaking Up Safely Framework Actions Closure Report	
Approved and presented by:	Debra Wood-Lawson, Executive Director for People and Culture	
Prepared by:	Head of Organisational Development	
Other Committees and meetings considered at:	Informal Executive Committee earlier in 2025 Executive Committee - 30 April 2025 who took assurance and confirmed the project can be embedded into business as usual activity.	
PURPOSE:		
The purpose of this paper is to assure the Board that actions defined under section 6 of the Speaking Up Safely framework have been undertaken, and to confirm the Executive Committee’s approval for the closure of the actions and transfer the work into business-as-usual operations.		
RECOMMENDATION(S):		
The Board is asked to: Take ASSURANCE that PTHB has met its obligations in meeting the specific requirements set out in section 6 of the national SUS Framework, and Welsh Health Circular 2023/036.		
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	N	
3. Tackle the Big Four	N	
4. Enable Joined up Care	N	
5. Develop Workforce Futures	Y	
6. Promote Innovative Environments	N	
7. Put Digital First	N	
8. Transforming in Partnership	N	

EXECUTIVE SUMMARY:

Background

Speaking Up Safely – A Framework for the NHS in Wales (SUS Framework) was published in September 2023. Welsh Health Circular 2023/036 placed a requirement on NHS organisations to undertake a self-assessment against Section 6 of the document and provide an action plan to overcome any gaps. PTHB's plan was submitted to Welsh Government by the October 2023 deadline and included the formation of a strategic working group to ensure that the plan was implemented. The group has met monthly and includes a wide range of membership including Staff Side representatives.

Purpose

Provide assurance to the Board that PTHB has met its obligations in meeting the specific requirements set out in section 6 of the national SUS Framework, and Welsh Health Circular 2023/036.

The paper outlines how the principles of a speaking up safely culture will continue to be embedded and the mechanisms that are in place which ensures any occurrences of staff speaking up will be heard and resolved in a manner that represents the best intentions of the framework.

DETAILED REPORT

References/Appendices

- A. Speaking Up Safely – A Framework for the NHS in Wales 2023 – available here - [NHS Wales speaking up safely framework | GOV.WALES](#)
- B. Our Voice Portal – PTHB SharePoint intranet pages (Internal link: [Our Voice](#))
- C. PTHB process and timelines for managing concerns raised through the NHS Wales Procedure for Staff to Raise Concerns (paper 4.7a)
- D. Equalities Impact Assessment (paper 4.7b)

Speaking Up Safely Framework - Section 6 Review

The Speaking Up Safely Working Group (SUSWG) first met in December 2023 with the aim of implementing the PTHB action plan, with the following membership:

- Chair - Deputy Director of Workforce and Organisational Development (now People and Culture)
- Project Lead –Head of Organisational Development
- Assistant Director for Quality and Safety
- Assistant Director of Organisational Development
- Deputy Director of Corporate Governance and Communications

- Assistant Director of Digital Transformation
- Deputy Director of Nursing
- Assistant Director of Nursing - Safeguarding
- Head of Equalities and Welsh Language
- Independent Member Staff Side
- Representative Unison
- Associate Director of Estates (as Chair of Chat to Change)
- Organisational Development Practitioner (as project lead for Chat to Change)

The action plan was based on the 13 requirements set out in Section 6 of the SUS Framework and described the activity that would take place in PTHB to develop both the processes and culture to enable staff to be able to speak up.

Below are each of the defined actions within the SUS Framework, and how PTHB has met each of the actions, or where they will be monitored for the long-term as part of business-as-usual arrangements.

Action A – Appoint an Independent Member/Non-Executive Director as Speaking Up Safely Champion as well as an Executive Lead.

Status: Closed

The Chair of the Board has been appointed as the Independent Member Champion with the Director of People and Culture as the Executive Lead.

Action B – Ensure adequate investment that provides sufficient resource to support the continuous development of the organisational Speaking Up Safely approach and associated cultural change.

Status: Closed

The topic of investment was discussed within the working group, taking into account the current financial position of the Health Board. The decision was to undertake this work within our existing resources, utilising the group membership to drive the work primarily through People and Culture Directorate and Communications and Engagement Team.

An assessment of the current numbers of concerns that are raised through the various channels did not lead to the decision that specific, paid Speaking Up Safely Guardians were required, although as the culture is embedded, this may be reassessed in the future.

Action C – Embed Speaking Up Safely in the functions of a board committee, which can be an existing committee, to support the champion/lead for speaking up in terms of guiding the organisation's approach. Membership of the committee should consist of a range of key

stakeholders, including (but not limited to) some of those identified in Section 4.

Status: Closed

Speaking Up Safely is part of the Executive Director for People and Culture's report in the People and Culture Committee's regular agenda, and on an annual basis as a requirement within the SUS Framework. Specific elements of the national staff survey relating to speaking up, as well as any data and themes around concerns inform the the work of the group and identification of future actions.

Action D - Ensure that clear and easy to follow processes are in place to allow individuals to raise concerns (including anonymously). The NHS Wales Procedure for Staff to Raise Concerns is a necessary minimum standard but is not in itself sufficient for facilitating and supporting a Speak Up Safely culture.

Status: Transferred to Business-as-Usual

The implementation programme for Speaking Up Safely has identified that there are multiple formal and informal routes for staff to raise concerns, depending on their specific nature. Therefore the 'Our Voice' portal was created on the intranet (with mirror pages for staff on the external web) to have a single place for staff to if they wanted to raise a concern formally. The pages capture elements such as DATIX, the Safeguarding Portal, and People and Culture policies, as well as providing information and a form to complete under the NHS Wales Procedure for Staff to Raise Concerns. The flowchart utilised in the SUS Framework (appended) is also published to help provide clarity.

In addition, PTHB has commissioned VIVup as its EAP provider to host a trial whistleblowing service for 12 months. This will provide an external point of contact to triage concerns and allocate them to the right senior person within the organisation.

The 'Our Voice' portal also has the opportunity to raise a concern directly to the Speaking Up Safely Group, with a process in place for the Deputy Director of People and Culture to triage any concerns and raise them directly with the most relevant senior manager (outlined at Annex F), and tracked by the OD team to ensure resolution.

Action E - Identify those groups which experience the most barriers when speaking up and ensure that processes are inclusive and equitable.

Status: Closed and Transferred to Business-as-Usual

An Equalities Impact Assessment has been undertaken by the Equalities and Welsh Language Officer as part of the implementation of the approach. The

approach includes trying to ensure that the means to raise concerns are not just digital, or just advertised digitally. The Equalities Impact Assessment appended to this paper.

Relevant aspects to speaking up from the Welsh Race Equality Standards reporting is included in the annual report to Workforce and Culture Committee.

Action F - Ensure that the response mechanism/process is continuously monitored, clear and timely.

Status: Transferred to Business-as-Usual

Concerns raised through the existing mechanisms such as DATIX, the Safeguarding Portal, or the People and Culture Directorate re already monitored with response expectations defined.

Concerns raised through the NHS Wales Procedure for Staff to Raise Concerns, and the VIVup Whistleblowing approach, are outlined in the organisational policy on Raising Concerns. Concerns comes into a monitored email inbox within the People and Culture Directorate and allocated to the most appropriate senior leader within the organisation. Progress towards resolution is monitored within the People and Culture Administrative team, with outcomes and timescales reported into the Speaking Up Safely Steering Group.

Action G - Ensure that individuals speaking up do not suffer detriment as a result of raising concerns.

Status: Transferred to Business-as-Usual

This element will be monitored through the Speaking Up Safely Steering Group. There will be opportunity for those who have raised concerns, as well as those from groups who are identified as commonly facing barriers to speaking up, to be invited to provide feedback on their experiences.

Where workforce processes are utilised as part of the investigation and resolution of the concern, and detrimental effect will be monitored under the ongoing activity associated with avoidable harm in HR processes.

Action H - Undertake regular reviews of responses, as well as of the leadership and governance arrangements in place, and provide regular reports to the appropriate committee.

Status: Transferred to Business-as-Usual

Regular reviews of responses and governance arrangements is a standing agenda item for the Speaking Up Safely Steering Group. A full, annual report is provided to People and Culture Committee, that includes qualitative and quantitative

information about the numbers, themes and stories raised over the period through the raising concerns mechanisms.

Action I - Ensure that arrangements are in place to monitor concerns/issued raised against the protected characteristics of the Equality Act 2010 and the implementation of any learning as a result of this.

Status: Transferred to Business-as-Usual

Monitoring of concerns that fall under this category is a standing agenda item for the Speaking Up Safely Steering Group, with data reported annually to the Workforce and Culture Committee.

Action J - Request feedback from all individuals who have spoken up and evaluate the feedback received (consider inviting a sample of individuals who have spoken up to attend committees and Board meetings to discuss experiences and share learning).

Status: Transferred to Business-as-Usual

Any individual who has raised a concern through either the VIVup whistleblowing service, or through the internal approach for NHS Wales Staff to Raise Concerns, is contacted following the resolution of their concern for feedback. This feedback is reported to the Speaking Up Safely Steering Group at each meeting and themes presented to the Workforce and Culture Committee annually.

Action K - Fully implement the All-Wales branding/messaging for Speaking Up Safely.

Status: Closed

All-Wales Branding has been utilised on posters and communications where appropriate. However, the approach for PTHB has been to drive engagement with the 'Our Voice' portal as a mechanism for staff to engage with the organisation and be heard. This is not limited to times when people wish to speak up about an issue, but also includes staff surveys etc.

Action L - Continuously/consistently promote and raise awareness of speaking up and listening/responding as a pro-social/desirable behaviour.

Status: Transferred to Business-as-Usual

The approach has been regularly promoted through posters, the Chat to Change network, the organisation's cascade briefing, and when promoted related activity such as the NHS Staff Survey.

A training course has been rolled out in January 2025 (with limited uptake so far) that invites individuals in teams to understand psychological safety and the approach to speaking up in PTHB. The intent is to provide the participant with a simple toolkit of discussions to have in their own teams to help create a culture of speaking up, whilst also raising awareness of the formal mechanisms.

Action M - Ensure that appropriate training to deliver a Speaking Up Safely culture is rolled out to leaders, managers and staff throughout the organisation, as part of leadership and management development arrangements.

Status: Transferred to Business-as-Usual

In addition to the training course detailed above, speaking up safely has been specifically included within the Manager's programme, corporate induction, and as a theme within the Clinical Leadership Immersive Programme (CLIP).

Recommendations

The Speaking Up Safely Work Group recommended that the actions required within the SUS Framework are closed and that the group develops into the Speaking Up Safely Steering Group with oversight of the business-as-usual actions. Executive Committee confirmed this recommendation.

Speaking Up Safely Steering Group

The Speaking Up Safely Steering Group will consist of senior leaders from across the organisation, meeting on a quarterly basis. The primary function of the group is to assess the progress towards a speaking up safely culture and recommend additional activity that needs to take place to achieve this. The group will utilise data from the annual national staff survey, as well as data received through Datix, safeguarding, and workforce mechanisms to identify areas of the organisation that may require intervention.

The group will review the activity around concerns raised during the previous quarter, as well as invite feedback from staff members who have raised concerns, as well as invite staff from groups that face the greatest barriers to being able to speak up.

The group will on an annual basis prepare a report for the Workforce and Culture Committee, providing assurance around the organisations progress to improving a psychologically safe culture.

Work is being undertaken nationally to establish more a more centralised approach to embedding a culture of speaking up across NHS Wales. The group will monitor and respond to these developments.

NEXT STEPS:

Next Steps

1. Formally close the reporting to Welsh Government around the 13 actions within the Speaking Up Safely framework
2. Establish the Speaking Up Safely Steering Group

IMPACT ASSESSMENT

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

QUALITY:

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

EQUALITY:

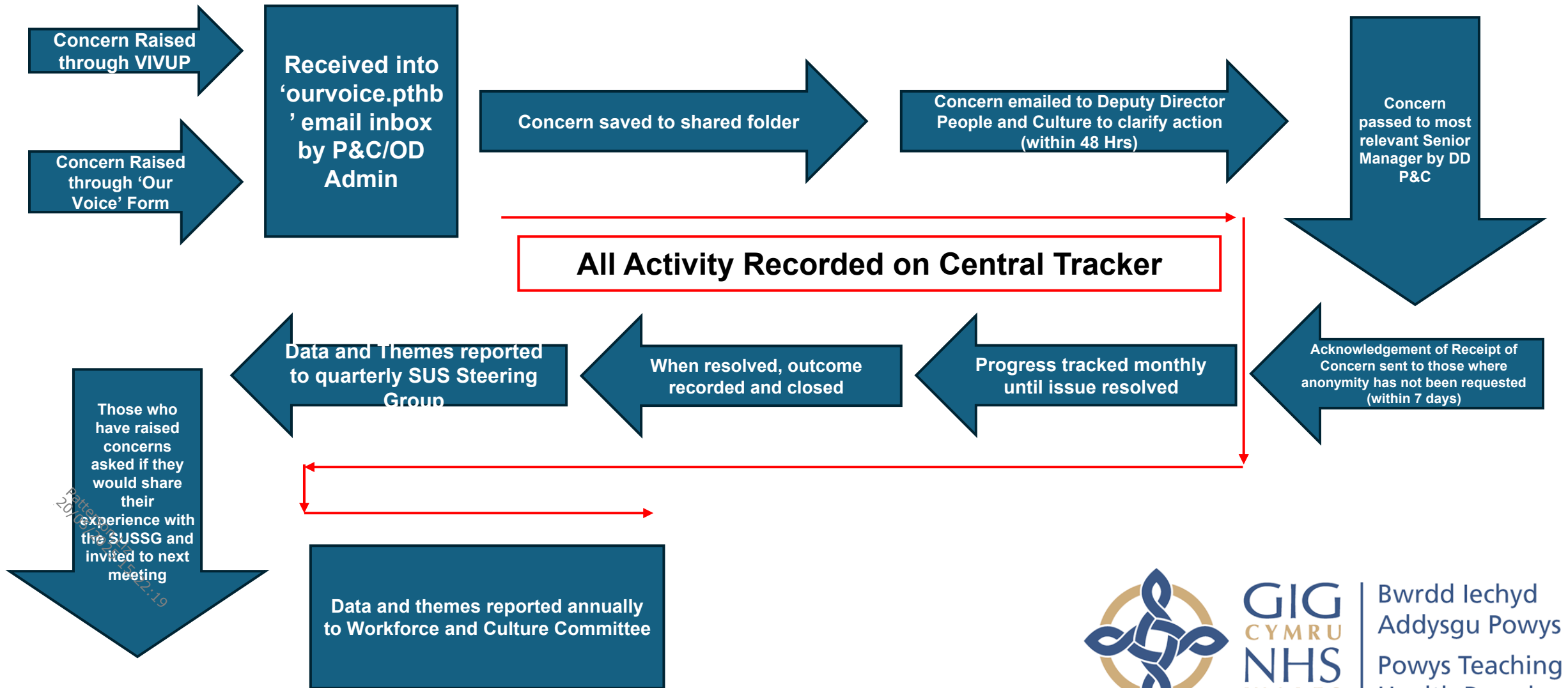
	No impact	Negative	Positive	Both	
Age	X				An Equality Impact Assessment must be undertaken for all reports requesting approval, ratification or decision in line with health board Equality Impact Assessment policies and procedures (CGP009). In this space you should provide supporting narrative to explain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

RISK ASSESSMENT:

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

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

Process flow for managing concerns raised through VIVUP or the Raising Concerns MS Form on the Our Voice Portal



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Equality Impact Assessment Template

<u>For:</u>	Speaking Up Safely
<u>Date form completed:</u>	24-6-2024
<u>Name of Completer</u>	<i>Adam Pearce</i>

Any organisation providing a public function is subject to the general duty under the Equality Act 2020.

In summary, those subject to the general equality duty must have had due regard to the need to:

- a) Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Equality Act.
- b) Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it.
- c) Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

Equality Impact Assessments **must** be carried out for all new policies, strategies, service plans, new services and service change proposals.

Introduction

Having effective arrangements which enable staff to speak up (also referred to as 'raising a concern') helps to protect patients, the public and the NHS workforce, as well as helping to improve our population's experience of healthcare. It is essential to ensure that all individuals have a voice, are listened to, and receive a timely and appropriate response.

This Framework will support organisations to create that culture; one where individuals feel safe and able to speak up about anything that gets in the way of delivering safe, high-quality care or which negatively affects their experience. This includes, but is not limited to, matters related to patient safety, safe staffing, the quality of care, bullying and harassment (and cultures which enable this), as well as financial malpractice or fraud.

To support this, leaders and managers need to be willing to listen, and to be open to constructive challenge. Speaking up and bringing these issues into the open is a brave and vulnerable thing to do, and therefore should be welcomed and seen as an opportunity to listen, learn and improve. This is the Framework that organisations, departments and teams are required to follow in order to establish and sustain a culture where no individual will suffer victimisation or detrimental

Equality Impact Assessment Template

treatment as a result of speaking up, and where organisations learn and improve as a result of listening and responding to concerns raised.

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Equality Impact Assessment Template

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken
All Protected Characteristics	The framework is designed to facilitate and thereby encourage staff to raise concerns they may have. These could include the treatment of themselves or others and therefore could include cases of discrimination or harassment of any kind, or any other kinds of inequality. The considerations in this row relate to all protected characteristics. The following rows consider only additional considerations specific to individual characteristics.	Ensure that the framework are set up in such a way as 1) to make it clear to staff that it can be used to express such concerns, and 2) that it is suitably equipped with the expertise to address such concerns and achieve positive outcomes. Specific Consdierations: Recommendation 1: Should “discrimination or unfair treatment” be included as a category under “nature of concern”? Recommendation 2: Given the framework provides opportunity for individuals to	Make reference to where the mitigation is included in the document, as appropriate There is representation from the PTHB Equality Team on the Speaking up Safely Working Group who triage concerns raised through the framework. This is clearly indicated in the procedure description.

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		feed back on the framework itself, would it be useful to gather equality data to see whether the experience of the framework by different groups varies?	
Age For most purposes, the main categories are: • under 18; • between 18 and 65; and • over 65	At present the online pages requests that staff fill an online form and provides this as the default option. This may discourage staff less comfortable with online options, or without workplace access to sharepoint/the intranet.	Recommendation 3: Give consideration to providing alternative means of raising concerns, or making such means more clear as options. Recommendation 4: Consider non-online means of promoting the framework (e.g. posters).	
Persons with a disability as defined in the Equality Act 2010 Those with physical impairments, learning disability, sensory loss or impairment, mental health	At present the online pages requests that staff fill an online form and provides this as the default option. This may discourage staff less comfortable with online options, or without	Give consideration to providing alternative means of raising concerns, or making such means more clear as options.	

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conditions, long-term medical conditions such as diabetes	workplace access to sharepoint/the intranet.	Consider non-online means of promoting the framework (e.g. posters).	
People of different genders: Consider men, women, people undergoing gender reassignment NB Gender-reassignment is anyone who proposes to, starts, is going through or who has completed a process to change his or her gender with or without going through any medical procedures. Sometimes referred to as Trans or Transgender	None identified.		
People who are married or who have a civil partner.	None identified.		
Women who are expecting a baby, who are on a break from	If a pregnant member of staff had a concern to raise whilst on	Give consideration to providing alternative means of raising	

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work after having a baby, or who are breastfeeding. They are protected for 26 weeks after having a baby whether or not they are on maternity leave.	maternity leave (for example, regarding their treatment whilst on maternity leave), how would they access the framework without necessarily having sharepoint access?	concerns, or making such means more clear as options. Consider non-online means of promoting the framework (e.g. posters).	
People of a different race, nationality, colour, culture or ethnic origin including non-English speakers, gypsies/travellers, migrant workers	The PTHB framework materials do not specifically acknowledge the potential of concerns related to race and the experience of racial discrimination.	Recommendation 5: In the interests of providing actively anti-racist leadership, the acknowledgment of the potential for racial discrimination could be made explicit rather than implicit within the framework materials.	
People with a religion or belief or with no religion or belief. The term 'religion' includes a religious or philosophical belief	None identified.		

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People who are attracted to other people of: - the opposite sex (heterosexual); - the same sex (lesbian or gay); - both sexes (bisexual)	None identified.		
People who communicate using the Welsh language in terms of correspondence, information leaflets, or service plans and design Well-being Goal – A Wales of vibrant culture and thriving Welsh language	Welsh Language Standard 83 You must allow and state in any document that you have that sets out your procedures for making complaints that each member of staff may - (a) make a complaint to you in Welsh, and (b) respond to a complaint made about him or about her in Welsh; and you must also inform each member of staff of that right. And possibly also Welsh Language Standard 84	Recommendation 6: The framework materials / pages could be made available in Welsh and the ability to raise concerns in Welsh made explicit. Recommendation 7: Make framework sharepoint pages available in Welsh.	

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	If you receive a complaint from a member of staff or a complaint about a member of staff, and a meeting is required with that member of staff, you must - (a) offer to conduct the meeting in Welsh or, if necessary, provide a translation service from Welsh to English for that purpose; and (b) if the member of staff wishes for the meeting to be conducted in Welsh, conduct the meeting in Welsh or, if necessary, with the assistance of a simultaneous or consecutive translation service from Welsh to English. _____ ... would seem to relate to this framework. They are not acknowledged in the PTHB framework materials, though local policies sitting under the framework do acknowledge these requirements.		

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	It may be advantageous also to offer the framework materials in Welsh.		
People according to their income related group: Consider people on low income, economically inactive, unemployed/workless, people who are unable to work due to ill-health	At present the online pages requests that staff fill an online form and provides this as the default option. This may discourage staff without workplace access to sharepoint/the intranet, who are likely to be in lower pay bands.	Give consideration to providing alternative means of raising concerns, or making such means more clear as options. Consider non-online means of promoting the framework (e.g. posters).	
People according to where they live: Consider people living in areas known to exhibit poor economic and/or health indicators, people unable to access services and facilities. This also may include wifi poverty, travel poverty and fuel poverty.	None identified.		
Consider any other groups and risk factors relevant to	None identified.		

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this strategy, policy, plan, procedure and/or service			

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Region:	Powys
Report:	Regional Directors Report
Period Covered:	19 March 2025 to 13 May 2025
Author:	Katie Blackburn
Status:	For Information
Date:	21 May 2025

Local/ Regional Update – Engagement:

April	Crotchet & Cuppas	Newtown
	Men's Shed	Newtown
	Newtown Medical Practice	Newtown
	Visual Impairment Group	Newtown
	Ladywell Surgery	Newtown
	Llais Local Coffee Morning	Newtown
	MIND Mum's Matter	Newtown
May	Llanfyllin Public Forum	Llanfyllin
	Epynt Ward	Brecon

Llais Local, Newtown – Initial Observations

Group/event/activity name	Newtown Crochet and Cuppas Community Group
Working well	● RJAH Hospital praised for good care. ● Bronglais Hospital's cancer unit highly rated.
Needs improvement	● NHS dental access is extremely limited, with some individuals being forced to go private. Those registered

	with My Dentist are experiencing app cancellations due to only one dentist in position. Minors not being seen. • Transport Issues for Medical Appointments • Long Waiting Times for Appointments & Treatment • Ambulance Response Delays & Emergency Care Issues. • Poor Hospital & A&E Experiences - Complaints about staff attitude, lack of urgency, and poor treatment in hospitals. Patients left waiting too long for emergency care. Concerns over inadequate screening of ambulance calls. • Issues with Disability & Accessibility - Lack of disabled access to NHS dentists. • Concerns over long distance to access follow up appointments that could be done over the phone (discussing results for example). A 2 hr round trip for a 15-minute appointment is very wearing.
Group/event/activity name	Men's Shed
Working well	Several praised kind staff in specific services (e.g. physios, nurses, memory clinic). Shed seen as key source of peer support.
Needs improvement	Long waits (e.g. CMHT, OT), disjointed follow-up, inaccessible communication
Group/event/activity name	Newtown Medical Practice
Working well	Prescription Process is well organised
Needs improvement	• Access & Transportation Issues – Access to out of town appointments is very difficult for patient to reach due to geography and access to public transport. • Long Wait Times for Appointments to see a GP – Reports of waits up to 5 weeks.

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	• Loss of local services - Disappointment about the permanent closure of the Newtown leg clinic; it hasn't reopened post-Covid and affects accessibility and health outcomes.
Group/event/activity name	Ladywell Surgery
Working well	• Positive experience with home adaptations from Powys County Council. • Positive experience with Ladywell Surgery. • excellent mental health support.
Needs improvement	Access to Dentistry, including: - having to travel to Oswestry for dental care. - unable to access an NHS dentist in Newtown for self and diabetic father. Mental Health Services - good and poor experiences • Mentions that inadequate housing is negatively impacting mental health. Physical Disability & Adaptations • Positive experience with home adaptations from Powys County Council. • Long wait (2 years) for a wet room; praises the occupational therapist's efforts. Accessibility Issues (e.g., parking, town design) • Disabled access and parking are poor due to new town design; now must collect prescriptions from a different pharmacy.
Group/event/activity name	Newtown Pop Up Coffee Shop
Working well	• Praise for community transport services. • Positive mentions of Rekindle and CAMHS.

	• Praise for Ladywell Surgery. • Triage system working well.
Needs improvement	Access to NHS Dentistry in Newtown • Multiple complaints about being removed from lists without reason. • Long gaps between appointments. • No availability or forced to go private. • Concerns about age discrimination. • Inaccessibility due to poor public transport for medical needs. Transport Issues (Buses & Patient Transport) • Poor bus service to Shrewsbury Hospital. • Concerns about requiring changes of transport service in Welshpool. Cross-border Healthcare & Communication Between Welsh and English Services • Poor coordination between Welsh and English hospitals. • Duplicate scans due to inaccessible records. • Delays in care due to lack of communication. Poor Communication & Continuity of Care • Between GPs, hospitals, and social services. • Lack of access to medical records. • Insufficient information sharing. • Fragmented services and patients having to repeat their stories. Social Services & Mental Health Support • Lack of continuity with social workers.

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	• Inadequate mental health services for people with learning disabilities or psychosis. • Long wait times and insufficient aftercare. Extended Waiting Times for Treatment • Delays in surgery referrals. • Hip replacements – long waiting times. • Concerns that delays could be life-threatening. Air Ambulance Concerns • Concerns about losing the Wales Air Ambulance. • Importance of local emergency services in rural areas. Wellbeing Hub / Health Infrastructure Planning • Requests for diagnostic centres in Newtown. • Need for better community information about the hub. Lack of Male-Focused Domestic Abuse Support • A deeply personal story highlighting gaps in support for male abuse victims. • Need for awareness, targeted funding, and support resources. Parking Issues at Medical Facilities • Limited parking availability at both Newtown Medical Centre and hospitals. Staffing Issues at Local Practices • Struggles to recruit doctors in Newtown.
	Group/event/activity name
	MIND Mums Matter
	Working well
	Credu Service

	• High praise was given for Credu bringing back the phone line for carers, they have been very helpful for a carer of a paediatric. Sexual Health Services • Newtown sexual health services praised;
Needs improvement	GP Access Specialist Access NHS Dental Care • No one able to access Dental Care Access free NHS dental care before or after birth. • lived here 6 years and not seen a dentist. • had to travel to Shrewsbury for child's dental appointment. Neurodevelopmental Health - ADHD • Unable to access a referral for daughter. Maternity & Postnatal Care NHS 111 Service: • Frustrating repetition – same issue has to be explained three times during the process. Financial Support & Benefits: • Full-time carer cannot claim because husband lacks a formal diagnosis. Have not been offered any advice on how to advance the issue.

What we've heard in Powys:

Health Issues

Access to GP Services - Long waits for non-urgent appointments, delisting from GP lists after mental health incidents, difficulty getting through triage systems.

Access to NHS Dental Services - Long waits for appointments, deregistration without notice, lack of local provision forcing long travel or private care.

Access to Mental Health Services - Long waits for assessments, poor communication, gaps between children's and adult services, lack of flexible and consistent care.

Poor Communication by Health and Social Care Services - Families not kept informed about changes in care; patients left uncertain about complaints processes; missing follow-up after complaints.

Ambulance & Hospital Stays – We keep hearing about long ambulance waits, challenges with follow-up care, and people being stuck in hospital because the right support isn't in place for them to go home.

Social Care Issues:

Discharge Delays and Care Package Provision - Delays organising social care support after hospital discharge; lack of communication about when support would start.

Delays in Assessments – Social care assessments are taking too long, leaving people without the support they need.

Support for Carers – Unpaid carers are finding it tough. There's a real need for clearer guidance and financial support.

Poor Communication by Health and Social Care Services - Families not kept informed about changes in care; patients left uncertain about complaints processes; missing follow-up after complaints.

National Updates:

Listening to parents: Llais publishes report on maternity experiences in Swansea Bay

<https://www.llaiswales.org/news-and-reports/news/listening-parents-llais-publishes-report-maternity-experiences-swanea-bay>

Llais response to the NHS Wales Performance and Productivity Review and Welsh Government Action Plan

<https://www.llaiswales.org/sites/default/files/2025-05/Llais%20response%20to%20the%20NHS%20Wales%20Performance%20and%20Productivity%20Review%20and%20Welsh%20Government%20Action%20Plan.pdf>

Llais: New NHS Wales targets are welcome; most importantly change must be felt by people and communities quickly

<https://www.llaiswales.org/news-and-reports/news/llais-new-nhs-wales-targets-are-welcome-most-importantly-change-must-be-felt>

Advocacy:

Total no. new cases opened	12
Total no. cases closed	2
Total no. open advocacy cases	116

Emergent themes from complaints:

- Being appointed a Care Co-ordinator (MH)
- Lack of Social Work support
- Having to travel cross-border for orthodontic treatment
- Patients being transferred to England for Mental Health admissions
- Poor follow up care in private hospital when NHS care has been outsourced
- Waiting list for T&O surgery

Regional Ambassador – Dr. Rajan Madhok

Dr. Rajan Madhok has recently been nominated as the Regional Ambassador for Powys.

Having lived in South Denbighshire since 2018, Rajan has a fondness for the Welsh culture and began learning Welsh recently.

Before retiring he was a public health doctor, working in senior medical management positions in the NHS in England.

During his active career, Rajan's main interest was in patient centric health care especially patient and worker safety and academic medicine.

Amongst many other positions in the past Rajan was the Chairman of British Association of Physicians of Indian Origin and a Council member of the General Medical Council.

He is currently a trustee of some voluntary organisations, and a Non-executive director on the Board of Wirral University Teaching Hospitals NHS Foundation Trust.

Rajan is passionate about public engagement, leadership development and on promoting reflective practice. He is pleased to be part of the important work that Llais is going to deliver for the people of Wales.

Katie Blackburn

Regional Director – Llais Powys

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