Patient Experience, Quality and Safety Committee

Thu 23 October 2025, 09:30 - 12:30

Agenda

09:30 - 09:30
0 min

1. PRELIMINARY MATTERS

PEQS_ Agenda_23OCT2025 FINAL.pdf (2 pages)

1.1. Welcome and Apologies

1.2. Declarations of Interest

PEQS_1.2_Declarations of Interest Oct25.pdf (3 pages)

09:30 - 09:30
0 min

2. CONSENT AGENDA BUSINESS

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

09:30 - 09:30
0 min

3. ITEMS FOR APPROVAL / DECISION / RATIFICATION

3.1. Minutes of the previous meeting: 31 July 2025

PEQS_3.1_Minutes 2025-07-31 PEQS unconfirmed.pdf (14 pages)

3.2. Committee Action Log

PEQS_3.2_Action Log Oct25.pdf (1 pages)

09:30 - 09:30
0 min

4. ESCALATED ITEMS

4.1. Children's Neurodiversity Services

PEQS_4.1_ND Services.pdf (6 pages)

4.2. Patient Experience Framework - update

PEQS_4.2_Peoples Experience Framework.pdf (7 pages)

09:30 - 09:30
0 min

5. ITEMS FOR ASSURANCE

5.1. Integrated Quality Report

PEQS_5.1_Integrated Quality Report October 2025.pdf (22 pages)
PEQS_5.1a_App1_PAVO Powys Third Sector Report July 2025 - Patient Experiences.docx.pdf (11 pages)
PEQS_5.1b_App2_SWC Regulation 28.pdf Edward Funnell pdf.pdf (4 pages)
PEQS_5.1c_App4_Llais Written Summary Submission to the Health and Social Care Committee.pdf (40 pages)
PEQS_5.1d_App5_Annual Letter 2024-25 - Powys Teaching Health Board_Redacted.pdf (10 pages)
PEQS_5.1e_App6_Annual letter response 2024_25.Michelle Morris.pdf (2 pages)

5.2. Maternity Assurance Report

PEQS_5.2_Maternity Assurance Report.pdf (15 pages)

5.3. Patient Experience - dental quality

PEQS_5.3_GDS Quality and Safety Report FINAL.pdf (8 pages)

5.4. Clinical Audit - update

PEQS_5.4_Update for the Clinical Audit Programme 2025-26.pdf (21 pages)

5.5. Medicines Management Annual Report 2024/25

PEQS_5.5_Medicines Management cover paper.pdf (2 pages)
PEQS_5.5a_Medicines Management and Pharmacy Annual Report 2024-2025.pdf (30 pages)

5.6. Medical Devices and Point of Care Testing Annual Report 2024/25

PEQS_5.6_Med Devices POCT Annual Report 24_25 FINAL.pdf (30 pages)

5.7. Committee Risk Register

PEQS_5.7_Committee Risk Register.pdf (3 pages)
PEQS_5.7a_Appendix A - Committee Risk Register.pdf (22 pages)

09:30 - 09:30
0 min

6. ITEMS FOR DISCUSSION

There are no items for discussion

09:30 - 09:30
0 min

7. CONSENT AGENDA

7.1. Internal Audit Reports:

7.1.1. Duty of Candour (Reasonable Assurance)

PEQS_7.1_Duty of Candour Final Internal Audit Report.pdf (13 pages)

7.2. Work Programme

PEQS_7.2_Work Programme Oct25.pdf (1 pages)

7.3. Glossary

PEQS_7.3_Glossary.pdf (5 pages)

09:30 - 09:30
0 min

8. OTHER MATTERS

8.1. Any Other Urgent Business

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

8.3. Committee reflections

8.4. Date of the Next Meeting: 05 February 2026

8.5. Confidential Items

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

8.6. Welcome and Apologies

8.7. Declarations of Interest

8.8. Minutes of the In-Committee meeting held on 31 July 2025

8.9.

POWYS TEACHING HEALTH BOARD
PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE

THURSDAY 23 OCTOBER 2025
09.30 – 12.30
VIA MICROSOFT TEAMS

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

AGENDA				
Time	**Item**	**Title**	**Attached/Oral**	**Presenter**
	1	**PRELIMINARY MATTERS**		
09.30	1.1	Welcome and apologies	Verbal	Chair
	1.2	Declarations of interest	Verbal	All
	2	**CONSENT AGENDA BUSINESS**		
The Chair will ask if there are any items from the Consent Agenda (Item 7) that Committee Members wish to bring forward to the main agenda.				
	3	**ITEMS FOR APPROVAL / DECISION / RATIFICATION**		
09.35	3.1	Minutes of previous meeting: • 31 July 2025	Attached	Chair
	3.2	Committee Action Log	Attached	Chair
	4	**ESCALATED ITEMS**		
09.45	4.1	Children's Neurodiversity Services	Attached	Executive Director of Planning, Performance and Commissioning
10.15	4.2	People Experience Framework - update	Attached	Executive Director of Nursing, Quality, Women and Family Health
	5	**ITEMS FOR ASSURANCE**		
10.25	5.1	Integrated Quality Report	Attached	Executive Director of Nursing, Quality, Women and Family Health
10.55	5.2	Maternity Assurance Report	Attached	Executive Director of Nursing, Quality, Women and Family Health
11.10	5.3	Patient Experience – Dental Quality including: Action 'How quality is measured in general and community dental services'	Attached	Executive Director Primary, Community Care and Mental Health
11.25	**COMFORT BREAK (10 minutes)**			
11.35	5.4	Clinical Audit: • 2024/25 update on outstanding items • 2025/26 progress report	Attached	Executive Medical Director
11.50	5.5	Medicines Management Annual Report 2024/25	Attached	Executive Medical Director

12.05	5.6	Medical Devices and Point of Care Testing Annual Report 2024/25	Attached	Executive Director Allied Health Professions, Health Science and Digital
12.15	5.7	Committee Risk Register	Attached	Director of Corporate Governance
	6	**ITEMS FOR DISCUSSION**		
		There are no items for discussion		
	7	**CONSENT AGENDA**		
	7.1	Internal Audit Report: • Duty of Candour *(Reasonable Assurance)* **Purpose**: Information	Attached	Director of Corporate Governance
	7.2	Work programme **Purpose**: Information	Attached	Director of Corporate Governance
	7.3	Glossary **Purpose**: Information	Attached	Director of Corporate Governance
	8	**OTHER MATTERS**		
12.20	8.1	Any Other Urgent Business	Verbal	Chair
	8.2	Items to be brought to the attention of the Board and/or other Committees	Verbal	Chair
	8.3	Committee Reflections	Verbal	Chair
	8.4	Date of the next meeting: 05 February 2026		

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

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

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

12.25	8.6	Welcome and Apologies	Verbal	Chair
	8.7	Declaration of Interest	Verbal	Chair
	8.8	Minutes of In-Committee meeting held on 31 July 2025	Attached	Director of Corporate Governance
12.30	Close			

POWYS TEACHING HEALTH BOARD - REGISTER OF DECLARATION OF INTERESTS 2025-26

Updated: October 2025

Position	Name	Interest Category	Interest Situation	Relevant Dates from	Relevant Dates to	Description of Declaration	Comment	Date Returned
INDEPENDENT MEMBERS								
PTHB Chair	**Carl Cooper**	Indirect Interests	Loyalty Interests	2018	Ongoing	Sole Trader, Mandy Williams, Consulting	NIL	29/05/2025
		Indirect Interests	Loyalty Interests	2025	Ongoing	Family member is an employee of Cardiff & Value University Health Board (non Director).	Nil	
Vice Chair	**Kirsty Williams**	Non Finanical personal interests	Loyalty Interests	Feb-25	Current	Co Director of Samaritans Powys	None	22/04/2025.
		Non Finanical personal interests	Loyalty Interests	Nov-22	Current	Director of ILEP Ltd a subsiduary of Cardiff University	None	Left the Health Board on 30 September 2025
		Indirect Interests	Outside Employment	Feb-24	Ongoing	Commissioner for South Wales Fire and Rescue	Ministerial Appointment	
		Non Finanical personal interests	Loyalty Interests	2024	Current	Vice Chair of Brecknock YFC Board of Management	NIL	
Independent Member (General)	**Rhobert Lewis**	Non Financial professional interests	Outside Employment	Nov-21	Current	Chair NPTC Group of Colleges	NIL	30/05/2025
		Indirect Interests	Outside Employment	Nov-21	Current	External member Cross-party STEMM Group Welsh Government	NIL	
Independent Member (Trade Union)	**Cathie Poynton**	NIL	NIL	NIL	NIL	NIL	NIL	01/05/2025
Independent Member (finance)	**Steve Elliot**	Non Financial professional interests	Outside Employment	04/02/2024	Current	Spouse Directorship of Oshi's World Private Limited Company and a Trustee of Oshi's World Charity	NIL	17/04/2025
Independent Member (General)	**Ronnie Alexander**	Indirect Interests	Outside Employment	01/10/2018	Current	Lay Observer to HEIW Participation in ARCPs and Pharmacy Advisory Board	Small half-day or daily payment dependant on booking availability	15/05/2025
		Indirect Interests	Outside Employment	2012	Current	Partner-Director of RA and CJ Consulting Limited	Dividend Payment only	
		Indirect Interests	Outside Employment	2017	Current	Member of Finance, Risk and Audit Committee Hafod/Hendre Housing Association	Remunerated	
		Indirect Interests	Outside Employment	Mar-21	Current to Dec-27	Independent Monitoring Authority (IMA) – Non Executive Director	Remunerated	
		Indirect Interests	Shareholdings and other ownership interests	2012	Current	Director of RA and CJ Consulting Limited	Dividend Payment only	
Independent Member (University)	**Simon Wright**	Financial Interests	Outside Employment	2015	Current	Personal: Academic Registrar, Cardiff University-Various Healthcare Programmes	Salaried Employment	18/06/2025
		Indirect Interests	Loyalty Interests	2001	Current	Sister: Senior Operational Manager, Milestone Trust, Bristol	Salaried Employment	
		Indirect Interests	Loyalty Interests	2021	Current	Spouse: District Nurse, Cardiff and Vale UHB	Salaried Employment	
Independent Member (Third Sector)	**Jennifer Owen Adams**	Non Financial professional interests	Loyalty Interests	Jun-16	Ongoing	Member (not a NED) of Glas Cymru the holding company of Dwr Cymru/Welsh Water	None	10/06/2025
		Non Financial professional interests	Loyalty Interests	07.02.2025	09.02.2028	PAVO-Vice Chair	None	
		Non Financial professional interests	Loyalty Interests	01.09.2024	01.06.2028	Coopted Member of PAVO	None	

		Non Financial professional interests	Loyalty Interests	Jul-05	Ongoing	Chair Public Services Board Scrutiny Committee	None	
		Non Financial professional interests	Loyalty Interests	2013	Ongoing	Brother - Senior Manager Freedom Leisure (Lead responsibility for Swansea and South Powys).	NIL	
Independent Member (Local Authority)	**Christopher Walsh**	Non Financial professional interests	Loyalty Interests			Member of Community Speed Watch Group Member of Society Genealogists Associate Member of the Association of Genealogists and Registered Archivists	NIL	19/06/2025
		Financial Interests	Shareholdings and other ownership interests		Ongoing	Sole Trader/Owner of Celebratory Gifts Heraldic Names Sole Trader/Owner:CTW Genealogy Research and Owner:Property in the County of Powys	NIL	
		Non Financial professional interests	Loyalty Interests		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	
		Non Financial professional interests	Loyalty Interests		Ongoing	•Member of Royal College of Nursing •Registered Member of Nursing and Midwifery Council	NIL	
		Non Financial professional interests	Loyalty Interests		Ongoing	Labour Party member	NIL	
Independent Member (Capital)	**Michael Giannai**	Indirect Interests	Loyalty Interests	2019	Current	Chair of the Board of Social Care Wales (Welsh Government Sponsored Body).	Remunerated	01/04/2025
Independent Member	**Ian Thomas**	Non Financial Personal Interests	Outside Employment	Apr-23	01/03/2024	Worked with a team of consultants as an independent associate in the past. I worked alongside HICO from April 2023 to March 2024. I was self employed during this time as a sole trader. I have not worked with HICO since this time and have withdrawn my associate status	NIL	09/04/2025
EXECUTIVE MEMBERS								
Chief Executive Officer	**Hayley Thomas**	NIL	NIL	NIL	NIL	NIL	NIL	30/05/2025
Executive Director of Finance, Capital and Support Services	**Pete Hopgood**	Non Financial Interests	Loyalty Interests	18/06/2018	Ongoing	Partner is Finance Manager working in SBUHB	Not Relevant	22/05/2025
Executive Director of Allied Health Professions, Health Science and Digital	**Claire Madsen**	Financial Interests	Outside Employment	07-Jan-19	Current	Occasional Lecturer for University of West of England.	Hourly rate	02/06/2025
		Non Financial professional interests	Loyalty Interests	10-Jun-05	Current	Member of the The Chartered Society of Physiotherapy	NIL	
Executive Director of Nursing, Quality, Women and Family Health	**Claire Roche**	Non Financial Professional Interests	Outside Employment	2018	Current	Member of the Royal College of Nursing	NIL	10/06/2025 Left the Health Board on 10 October 2025
		Non Financial Professional Interests	Outside Employment	1994	Current	Member of the Royal College of Midwifery		
Executive Medical Director	**Kate Wright**	Non-Finanical professional Interest	Outside Employment	01-Aug-91	Current	Member of the British Medical Association	NIL	10/06/2025
Executive Director of People and Culture	**Debra Wood Lawson**	Indirect Interests	Outside Employment	01-Nov-24	Current	Non Executive Board Director - Cadarn Housing Group Limited (Powys is a zonal partner)	Remunerated	29/05/2025
			Outside Employment	01-Sep-25	Current	Relative employee and training in Aneurin Bevan Univeristy Health Board (non Director)	NIL	

Executive Director of Public Health	**Mererid Bowley**	Non-Finanical professional Interest	Loyalty Interest	NIL	NIL	Member of Faculty of Public Health	Previously declared on annual Declaration of Interest form issued by corporate team since commencement of role. (Transferring recording of	14/05/2025
		Financial Interest	Shareholdings and other Ownership interests	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	Previously annually since start of employment through completion of declarations of interest form issued by corporate team annually.	
Director of Corporate Governance/ Board Secretary	**Helen Bushell**	Non-Finanical professional Interest	Outside Employment	Nov-21	Current	Self - School Governor – Langynwyd primary school (Bridgend)	Not remunerated	18/06/2025
		Indirect Interests	Outside Employment	Aug-16	Current	Partner is the Chair of a Housing Association who provide social housing across a large geographical area (including Powys).	Remunerated part time role, 2-4 days per month	
		Indirect Interests	Outside Employment	Jul-24	Oct-24	Partner is listed on the Bank for PTHB - working occasionally for the organisation by dual agreement.	Paid per hour/day of work	
		Indirect Interests	Outside Employment	Sep-22	Current	Parnter - Public Appointment - Youth Work strategy and implementation Board - Oct 22 - Sept 24	Remunerated 2-4 days per month	
Director of Strategic Improvement and Transformation	**Lucie Cornish**	Nil	Nil	Nil	Nil	Nil	Nil	13/11/2024
Executive Director of Planning, Performance & Commissioning	**Nicola Johnson**	Nil	Nil	Nil	Nil	Nil	Nil	30/05/2025
Executive Director of Primary, Community Care and Mental Health	**Elaine Lorton**	Financial Interests	Outside Employment	Apr-24	Current	Independent Member – ateb - housing Association	Remunerated	30/05/2025
		Non Financial professional interests	Outside Employment	Nov-19	Current	Chair of the Board - Wet Wales Care and Repair	Voluntary	
		Indirect Interests	Outside Employment	Mar-23	Current	Family Member is an employee of Hywel Dda University Health Board (non Director)	Nil	
		Indirect Interests	Outside Employment	Sep-23	Current	Family Member employee of Aneurin Bevan Univeristy Health Board (non Director)	Nil	

PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE

UNCONFIRMED MINUTES OF THE MEETING HELD ON 31 JULY 2025 at 09:30 VIA MICROSOFT TEAMS

MEMBERS		
Kirsty Williams	KWi	Vice Chair (Committee Chair)
Mick Giannasi	MG	Independent Member (General)
Jennifer Owen Adams	JOA	Independent Member (Third Sector)
IN ATTENDANCE		
Zoe Ashman	ZA	Interim Assistant Director Women & Children
Helen Bushell	HB	Director of Corporate Governance / Board Secretary
Tracey Coombe	TC	Llais (until 10.30)
Carl Cooper	CC	Chair of PTHB Board
Amanda Edwards	AE	Assistant Director Innovation and Improvement
Nilufa Hossain	NH	Assistant Medical Director Quality and Safety and Clinical Governance
Elaine Lorton	EL	Executive Director of Primary Care, Community and Mental Health
Claire Madsen	CM	Executive Director of Allied Health Professionals, Health Sciences and Digital (from 11.21)
Chris Moss	CM	Executive Director of Planning, Performance and Commissioning (for Item 4.1)
Claire Roche	CR	Executive Director of Nursing, Quality, Women and Family Health
Heidi Sinclair	HS	Head of Quality and Safety
Aime Symes	AS	Director of Midwifery, Women and Family Health
Hayley Thomas	HT	Chief Executive
Jayne Wheeler-Sexton	JWS	Assistant Director Safeguarding (to 10.18)
Kate Wright	KW	Executive Medical Director
APOLOGIES FOR ABSENCE:		
Katie Blackburn	KB	Regional Director of Llais
Nicola Johnson	NJ	Executive Director Planning, Performance and Commissioning
Ian Thomas	IA	Independent Member (General)
Chris Walsh	CW	Independent Member (Local Authority)
Simon Wright	SW	Independent Member (University)

1. PRELIMINARY MATTERS
1.1 WELCOME AND APOLOGIES (PEQS/25/28)
The Chair welcomed everyone to the meeting. Apologies for absence were received as recorded above. The newly appointed Director of Midwifery, Women and Family Health (AS) was welcomed to the meeting.
1.2 DECLARATIONS OF INTEREST (PEQS/25/29)
No declarations of interests were received in addition to those already recorded on the register.
1.3 PATIENT STORY (PEQS/25/30)
ZA read out 'Our Birth in Powys', the story of Emily, Luke and Baby Eswen which KWi noted drew attention to the challenges and unpredictability faced by a Midwife led service in a rural community. Thanks were expressed to the family for sharing their story.
2. CONSENT AGENDA BUSINESS
The Chair asked Members if they wished to bring forward any items from the Consent agenda to the main agenda. No items were raised by Committee Members.
3. ITEMS FOR APPROVAL / DECISION / RATIFICATION
3.1 MINUTES OF PREVIOUS MEETING (PEQS/25/31)
The minutes of the meeting held on 29 April 2025 were **CONFIRMED** as an accurate record.
3.2 COMMITTEE ACTION LOG (PEQS/25/32)
HB outlined that the Action Log recorded updates with the following information provided: • PEQS/24/83c (a report on General Dental Services to be presented to the Committee in July) – request to defer to October 2025 • PEQS/24/83 (Transition of Care Annual Report) – request to defer to October 2025. The change of dates were accepted, with KWi noting that be no further extension requests would be accepted in relation to the Transitions of Care Annual Report. CR gave an assurance that this item would be presented to the October meeting. Verbal updates were given for the following items: • PEQS/24/52b (a review of the Integrated Quality and Performance Framework) This had been presented to Board in May and was therefore COMPLETE • PEQS/25/08 (details of funding for Neurodevelopmental Services). To be considered after item 4.1 on the agenda • PEQS/24/11a (key performance indicators to be included relating to Nationally Reportable indicators in the Integrated Quality Report). It was confirmed these are included in the Integrated Quality Report and was therefore COMPLETE • PEQS/25/11b (Powys specific data from the Medical Examiner Service to be included in the Integrated Quality Report). KW confirmed that this data had not

been available for the July meeting and requested a date change to October. Item DEFERRED

- PEQS/25/12 (Clinical Audit Programme to include detail on assurance routes for reporting). KW advised Clinical Audit is evolving rapidly and this would be addressed in more detail in the July 2026 Clinical Audit Programme. A date change to July 2026 was requested. Item DEFERRED.
- PEQS/25/15 (updates from Service Groups to be included in the Integrated Quality Report). The Integrated Quality Report includes updates from Service Groups. Item COMPLETE

Independent Members asked the following questions for assurance:
There appears to be an unusually high number of open actions for this Committee, what is the reason for this?
KWi advised that the Committee receive a number of actions from other Committees to monitor, and have requested additional information on a number of areas. It may be timely to reflect on the appropriateness of the additional requests.

HB confirmed that this Committee along with Finance and Performance Committee carry the heaviest loads and this is being analysed and will be considered in the Chairs' Forum.

3.3 SAFEGUARDING ANNUAL REPORT (PEQS/25/33)

JWS presented the report which provided a comprehensive overview of safeguarding activity at local, regional, and national levels, highlighting achievements, challenges, and priorities.

Independent Members asked the following questions for assurance:
Are the safeguarding team making internal changes to manage increasing complexity and volume without additional resources?
JWS advised the safeguarding team had matured significantly over the past five years. Although no additional resources had been allocated, the team had been redesigned to better meet increasing demands. Succession planning and staff development had been prioritised, and team members had been exposed to regional and national safeguarding networks. This approach had enabled delegation of responsibilities and enhanced resilience within the team.

Were there any changes planned for 2025–26 that differed from previous years to improve agility and expertise?
JWS advised that the team had planned to use data trends, such as the rise in neglect, to shape future safeguarding priorities. A pilot of a neglect toolkit in collaboration with the local authority had been initiated to address emerging needs. The team had also focused on building resilience through safeguarding supervision and cross-organisational exposure.

Was there a different or more innovative way to deliver Level 3 safeguarding training to improve compliance?
JWS advised the safeguarding team had recognised the need for more creative approaches to training. They had proposed using podcasts, YouTube videos, and

newsletters to support learning. Staff were encouraged to reflect on their practice and use daily experiences to demonstrate compliance, moving beyond traditional training sessions.

How was the safeguarding team addressing the challenge of low compliance in Adult Level 3 safeguarding training?
JWS advised that whilst child safeguarding training had reached over 75% compliance, adult safeguarding remained at 49%. The team had identified that half of the non-compliant staff had completed the training but had not finalised their e-passports. This insight had guided targeted follow-up and support.

How was the safeguarding team managing differences in "Was Not Brought" policies across Welsh and English borders?
JWS confirmed that the newly launched "Was Not Brought" guidance was a Welsh national document, and Health Board had contributed significantly to its development. Whilst the guidance did not apply to across the border in England, the team had maintained strong links with English safeguarding boards and held regular meetings to share learning and address cross-border issues.

How was the safeguarding team supporting staff when referrals were rejected?
JWS noted staff were encouraged to escalate concerns through internal processes. The safeguarding team had committed to supporting such challenges and had maintained open communication with the local authority to ensure mutual understanding of thresholds.

The Patient Experience, Quality and Safety Committee **APPROVED** the Annual Safeguarding Report for 2024/25.

JWS left the meeting 10.18

3.4 DUTY OF QUALITY ANNUAL REPORT (PEQS/25/34)

CR presented the report which demonstrated the Health Boards maturity in deploying and reporting on its duty of quality. It reflected how quality is embedded across the organisation, not only annually but also through the quarterly Patient Experience, Quality and Safety Committee updates.

TC left the meeting 10.28

Independent Members asked the following questions for assurance:
Are the charts on page 18 of the report duplicates?
ZA confirmed this would be checked and amended if necessary, prior to publication of the final report.

Is there sufficient context for patient experience data in relation to the 1,147 responses received?
CR noted that the People's Experience Framework would support maturity in this area.

How will improvements in mental health services be sustained following escalation?
CR and HT explained that the IQPF and Executive oversight mechanisms were designed to ensure sustainability, with plans to revisit lessons learned one year after de-escalation.

How is learning from duty of candour incidents shared across the organisation?
CR highlighted the importance of systematic learning and referenced the 'SHARE' (Speak up, Hear, Act, Respect and Empower) initiative as a visual tool to support this effort.

What is the People's Experience Framework and how will it be used?
CR explained that a self-assessment was underway across all services to identify strengths and gaps. The framework would support systematic engagement and learning from patient experiences.

How will community engagement be improved?
CR confirmed that this was a priority and would be embedded within the People's Experience Framework and the Integrated Quality Report going forward.

The Duty of Quality Annual Report 2024/25 was **APPROVED**.

3.5 MENTAL HEALTH SERVICES ACT HOSPITAL MANAGERS POWER OF DISCHARGE GROUP TERMS OF REFERENCE (PEQS/25/35)

KWi introduced the report advising minor clarifications and amendments had been suggested to the Terms of Reference.

Independent Members asked the following question for assurance:
Given the importance of the decisions being made to both the individual and society does a mechanism existed to review, test, and ensure consistency and equality across different discharge panels?
KWi suggested the inclusion of reference to a commitment to organisational learning within the Terms of Reference and EL undertook to examine how to enable the organisation to provide assurance of the appropriateness and consistency of panel decisions.

The Committee **DISCUSSED** and **APPROVED** revised Terms of Reference and Operating Arrangements for the Mental Health Act Power of Discharge Group, as sub-Group of the Patient Experience, Quality and Safety Committee, subject to the inclusion of reference to organisational learning as outlined above.

3.6 COMMITTEE GOVERNANCE ACTION PLAN (PEQS/25/36)

HB introduced the report outlining that the Committee Governance Action Plan was presented for approval, following recent discussions within the Committee and at Board level. It focused on two priority areas, patient voice and organisational learning, rather than attempting to document every action. The plan would be monitored through the Chairs' Forum and embedded into the agenda to ensure implementation.

The Committee **RECEIVED** the Committee Continuous Development Plan 2025-26 and took **ASSURANCE** that the implementation of continuous development actions will be monitored throughout the year as a key principle of good corporate governance.

4. ESCALATED ITEMS

4.1 CHILDREN'S NEURODIVERSITY SERVICES (PEQS/25/37)

CMo joined the meeting 10.47

CMo presented the report advising that the Executive Team had acknowledged the substantial progress made in the Children and Young People Neurodevelopmental Service but clarified that the service remained under Level 2A escalation. This decision aligned with the annual planning cycle, where it had been agreed to maintain current performance rather than pursue further improvement, allowing for strategic engagement with national funding discussions.

Independent Members asked the following questions for assurance:
What does "no change to maturity assessment" mean, and how could the Committee be assured that internal processes were sufficiently mature and sustainable?
CR advised that the maturity assessment was not an exact science but a cautious self-evaluation. Although there had been significant improvements in systems and processes, cultural transformation required more time. The internal escalation process was designed to address specific remedial actions rather than deliver widespread transformation. Overestimating maturity would be premature and that the service was still in the midst of cultural development.

Is it correct that the standard waiting time for a neurodevelopmental assessment was two years?
CMo confirmed that the two-year (104-week) wait was the minimum standard set by Welsh Government across Wales. The service was actively working to reduce this through phase two of the improvement programme, supported by a business case submitted to the Investment and Benefits Group. Improvement trajectories were being developed to assess capacity needs and reduce waiting times.

Was there any information available regarding the quality of interactions with children and young people who had been seen, beyond the numerical data?
KWi noted the request for this information to be included in future reporting.
Action: Executive Director of Planning, Performance and Commissioning

What methods are being used to triangulate the self-assessment process underpinning the maturity matrices. Was there any peer review or external challenge involved to ensure that the assessments were not solely based on internal perceptions?
CR responded that the team had been liaising with the national NHS Performance and Improvement team, which provided an opportunity for external challenge and peer review. This engagement was intended to act as a critical friend to support the robustness of the self-assessment process. KW added that internal peer review had also been strengthened, with decisions now being made through a multidisciplinary team format, which had not previously been the case.

It is noted that the maturity matrix had not shifted, is this due to capacity issues? Have the service got the right staffing levels and personnel in place, or is this yet to be resolved?
CR confirmed that capacity remained a key issue and was central to the business case being developed. The aim was to secure continued financial support and investment to stabilise the team, moving away from reliance on temporary or fixed-term funding.

KW added that rising demand had made it difficult to assess actual capacity needs, but recent work had improved confidence in the systems and processes, helping to clarify future capacity requirements.
HT also noted that funding and capacity were part of ongoing national discussions and that all health boards were facing similar challenges.

The improvements in triage and the reduction in acceptance rates are welcomed. Can assurance be given that children who genuinely needed services are not being excluded?
CR explained that the Health Board was working in partnership with the local authority and education system to ensure that children not requiring medical intervention still received appropriate support or signposting. This collaborative approach was essential for meeting the diverse needs of children and families.

The Committee:

1. Took **ASSURANCE** that the implementation of the IQPF Escalation Oversight mechanism is providing robust oversight of the quality improvement and risk mitigation work being undertaken within Neurodevelopmental Services.
2. **NOTED** and **DISCUSSED** the contents of the report and including the progress made on the implementation plan, and updated maturity assessment.
3. Took **ASSURANCE** from the ongoing monitoring and evaluation mechanisms in place as part of IQPF.
4. **NOTED** that the recommendation that the service is de-escalated to Level 2a was approved by the Executive Committee on 23 July 2025.

CMo left the meeting 11.16

4.2 PEOPLE EXPERIENCE FRAMEWORK UPDATE (PEQS/25/38)

KWi noted this item was escalated to the Board, however, would be considered under item 5.1 Integrated Quality Report and confirmed this item would remain as an escalated item.

5.ITEMS FOR ASSURANCE

5.1 INTEGRATED QUALITY REPORT (PEQS/25/39)

CM joined the meeting 11.21

CR introduced the report which covers April to June (Quarter 1) and drew attention to the following areas:

- Compliance is recorded as above 75% in responding to concerns, with recent improvements.
- Graph 2 shows an average response time of 29 days for formal concerns; other Welsh organisations respond faster, highlighting a need for improvement in timeliness.
- Graph 3 indicates strong early resolution performance, with only one concern reopened in the past 14 months.
- Section 2.3 discusses duty of candour cases, noting a slight decrease compared to the same period last year, with 29 cases currently open and emerging themes identified.
- Section 2.5 presents incident data by severity, but many incidents lack a severity value. This is flagged as a key issue.
- Three internal audit reports are referenced:
    - One on quality and safety governance, which received reasonable assurance and offered recommendations for improving the report format.

    - One on the people's experience framework, introducing the SHARE initiative and plans for a network of champions.
    - One on Mattresses which received Limited Assurance. An action plan is in place to address the findings which will be monitored via the clinical service group to completion and ongoing monitoring
- The report includes service updates from women's and children's services, community services, and mental health.
- Two key matters for the attention of the Committee:
    - The issue of incidents with no attributed severity value.
    - A planned organisation wide self-assessment using existing resources and promoting collective ownership.

Independent Members asked the following questions for assurance:
Is the breakdown of data by individual groups significant, should it be a cause for concern?
CR advised that the breakdown marked the beginning of a shift towards collective ownership across service areas. The integrated quality report was primarily authored by the quality and safety team, but the goal was for relevant sections to be owned by respective service groups. This would be achieved through improved reporting structures and maturity in data handling.

Is the organisation gaining full value from Civica and is the data was being used effectively to drive improvements? Why is the June data missing?
ZA explained that although Civica had been implemented earlier, the organisation had only recently appointed a People's Experience Lead who was now actively interrogating the data and sharing feedback with services. The People's Experience Framework was being developed, and improvements were expected in the coming months.

What problem the organisation was trying to solve regarding incidents recorded with no value?
CR clarified that the issue was being flagged to alert the committee (not for immediate action) as all incidents should be recorded with a harm value, whether no harm, low, moderate, or severe. HS was managing the improvement process, and updates were being provided to teams regularly. The matter was a priority and would be tracked through integrated quality and performance group
HS advised that this would be reported to the Committee via the quarterly Integrated Quality Report.

What progress is being made in reducing antimicrobial usage? Should the organisation be acting more urgently given the potential risks.?
KW explained that an Antimicrobial Stewardship Pharmacist had been appointed and was actively implementing measures to improve prescribing practices. The issue was complex but expressed confidence that improvements would be seen as the Pharmacist's plan was put into action.

Can the organisation sustain its improved performance in responding to complaints?
CR responded that although there had been a slight dip below the 75% compliance target earlier in the year, this was due to small numbers and the disproportionate

impact of complex cases. Performance had improved steadily over the past three and a half years and that benchmarking response times against other organisations was helping to maintain focus and drive further improvement.

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.

5.2 COMMITTEE RISK REGISTER (PEQS/25/40)

HB presented the report which was based on the newly developed Strategic Risk Register considered at Board on 30 July 2025. Two risks are assigned to the Committee relating to Commissioning and Provider Services.

Independent Members asked the following question for assurance:
How will the newly introduced risk register be applied in practice within Committee settings? How might it influence agenda planning, paper content, and scrutiny responsibilities, and how could Independent Members effectively enact the register in their roles?
HB advised that risk management was both a technical and cultural process. The Risk Register served as a central tool to consolidate direction, actions, and assurances, enabling transparent tracking and reporting. Its value lay in how senior leaders actively managed risks day-to-day. The Risk Register would inform agenda and work programme planning, with assurance drawn from a range of reports.

Might a Board Development session on the risk register be useful for Independent Members?
HB supported the idea of a Board Development session.
Action: Director of Corporate Governance

The Committee is asked to:
- **RECEIVED** the corporate risks within the committee's remit
- **DISCUSSED** any relevant issues and
- took **ASSURANCE** that risks are being managed in line with the Risk Management Framework.

5.3 UPDATE ON JAG (JOINT ADVISORY GROUP ON GASTROENTESTINAL ENDOSCOPY) ACCREDITATION (PEQS/25/41)

EL updated the Committee on the status of JAG accreditation for endoscopy services. The accreditation had been lost in November 2024 due to a lack of appropriate medical leadership, previously provided via a Service Level Agreement with Cwm Taf Morgannwg UHB, which did not meet JAG standards. A local consultant had since been appointed in June to fulfil the leadership role, with plans underway to transition this into a substantive post. The service continued to perform well, with no breaches beyond eight weeks and positive feedback from a recent assessment of bowel screening. A re-accreditation visit was scheduled for November 2025, and the team remained optimistic about a successful outcome.

5.4 MONITOR IMPLEMENTATION OF MANAGEMENT ACTIONS FOR DEPRIVATIONS OF LIBERTY STANDARDS INTERNAL AUDIT REPORT (PEQS/25/42)

CR presented the report noting that the Internal Audit report which had been brought to the Committee due to limited assurance rating, included six recommendations. One of the actions has already been completed, while the remaining five are partially complete, primarily due to dependencies on the business case and the appointment of the DoLS coordinator, both of which are now progressing. All actions are in place and advancing, even though some timelines have shifted.

Independent Members asked the following question for assurance:
When are the partially completed actions likely to be completed?
CR advised that as soon as the appointed individuals started in post the actions could be completed, and this was likely to be within the next two months.

The Committee took **ASSURANCE** on the progress made within the Action Plan aligned to the Limited Internal Audit report on Deprivation of Liberty Safeguards.

5.5 CLINICAL AUDIT PROGRAMME ANNUAL REPORT 2024/25 (PEQS/25/43)

KW presented the report noting that the majority of the audits had been completed with a few withdrawn, paused or rolled forward. The Powys Audit Hour had proved successful and would continue to take place. Clinical audit was evolving, and a formal review was planned before the next planning round to clarify which audits were clinical and subject to this reporting process and what other routes were available to report on non-clinical audits. HB would be asked to advise with governance arrangements.

CM advised that the incomplete audits in audiology and podiatry resulted from severe staffing challenges which were being addressed. A decision had been taken to prioritise national audits.

Independent Members asked the following questions for assurance:
Has the impact of the Powys Audit Hour been evaluated?
KW acknowledged that formal evaluation had not taken place but would be considered, potentially led by the Learning from Experience Group. Informally, shared feedback had been positive, with benefit being seen in bringing together small, and sometimes siloed staff groups.

Why has the Adult Community Mental Health Team audit been deferred to 2025/26?
KW and EL advised that for those items which noted a deferral it would be necessary to bring an update on the Clinical Audit Programme to Committee.
Action: Executive Medical Director

What has led to the deferrals?
EL advised that there were two elements to this matter, firstly were the audits being undertaken as business as usual, and secondly the collation of the report to Committee. There had been some confusion as to what was required for the report. This was being addressed and should improve going forward.

The Committee took **ASSURANCE** that the 2024-25 Clinical Audit programme has been delivered subject to the updates to be provided via the action above.

5.6 INFECTION PREVENTION AND CONTROL (IPC) ANNUAL ASSURANCE REPORT (PEQS/25/44)

CR presented the report highlighting its increased maturity and key achievements for 2024–25, including progress on the IPC improvement plan and a reduction in C. difficile infection rates. The MEG audit system was outlined as a valuable tool for IPC audits and noted the inclusion of antimicrobial stewardship and decontamination as core IPC functions. There is a need to expand IPC's reach across services including primary care and dental.

Despite capacity challenges, the IPC team's efforts were praised, and the IPC steering group were formally thanked, especially Estates and Facilities colleagues, for their proactive support in maintaining environmental cleanliness.

Independent Members asked the following questions for assurance:
Do the Executive Team feel satisfied with the maturity of the culture across the health board, specifically, whether all staff, from clinical to support roles, were consistently prioritising IPC in their daily work?
CR responded that while there is more assurance now than two years ago, due to the IPC improvement plan and strengthened monitoring mechanisms, achieving a widespread culture of collective ownership remains an ongoing challenge. Recent audits showed areas for improvement, such as environmental cleanliness and mattress hygiene, and there was a need for timely tracking and leadership development within clinical areas to sustain progress.

Having seen through this meeting occasional pockets of non-compliance (such as the mattress audit), what can be done at a strategic level to foster a culture of compliance, and personal responsibility?
CR advised that the team has recently discussed how to improve visibility and accountability, including conducting unannounced joint visits where they reviewed note keeping, medicines management, IPC practices, and spoke directly with patients. There was a need to avoid a culture of fear, instead promoting readiness and local ownership. Building a culture of compliance is a shared leadership responsibility across the organisation and requires a more proactive, strategic approach.

HT emphasised the importance of addressing compliance culture across the organisation, referencing the mattress audit as a signal of broader issues. The need for clear leadership roles and accountability at all levels was highlighted. Targeted conversations are underway to reinforce this. It is important to identify compliance hotspots and patterns across sites. Ongoing work to strengthen professionalism and standards was taking place and there was a need to provide further assurance to committees.

CM acknowledged the need to be able to rely on staff to meet the required standards and as clinical and professional leads to set the appropriate standards. A standardised checklist is being devised to use for visits in consultation with the unions.

The Committee took **ASSURANCE** from the contents of the Infection, Prevention and Control annual report that the Health Board is fulfilling its responsibilities.

5.7 ELECTRONIC PRESCRIBING AND MEDICINES ADMINISTRATION (EPMA) SYSTEM UPDATE (PEQS/25/45)

KW presented the report outlining the project was progressing well. It has been difficult to quantify monetary benefits, but the quality improvements were significant and are expected to enhance services, particularly in areas like antimicrobial stewardship, prescribing visibility, and polypharmacy management. The project is seen as a key enabler for other initiatives, generating excitement across teams. However, challenges include staff turnover, largely due to late confirmation of Welsh Government funding, resulting in reliance on fixed-term contracts. Despite this, all roles are currently filled. From next year, the project will transition to business-as-usual funding, supported by an Investments and Benefits Group case. A minor correction was noted in the rollout chart. December should not show a gap, and a continuous rollout is planned to accelerate progress. Training is underway over the summer, with rollout to inpatient wards starting in Q3, followed by outpatient areas in the next phase.

Independent Members asked the following questions for assurance:
What will happen to the project when the funding ceases in March 2026?
KW advised that the project was designed to support inpatient rollout, and additional funding would be sought to support outpatient rollout.

Has a baseline been measured to enable benefits realisation to be calculated?
KW highlighted that a substantial amount of work was done for the original business case submitted to Welsh Government, including financial efficiency modelling. Although the projected monetary benefits appear low, there is a strong belief that the actual impact will be greater.

CM confirmed that a benefits realisation documentation process was part of the original submission and measuring will take place once the system is in place.

HT added that given this was a national programme, there would be an overall evaluation from a national perspective.

The Committee:
1. Took **ASSURANCE** from the progress made
2. **NOTED** the upcoming milestones and intended benefits.

6. ITEMS FOR DISCUSSION

There were no items for discussion

7. CONSENT AGENDA

7.1 INTERNAL AUDIT REPORTS (PEQS/25/46)

The Committee **RECEIVED** the following Internal Audit Reports

- Pharmacy Stores (Reasonable)
- Quality, Safety and Governance (Reasonable Assurance)
- Business Continuity Planning (Substantial Assurance)
- Risk Management (Reasonable Assurance)
- Mattresses Final Report (Limited Assurance)

which had been received by the Audit, Risk and Assurance Committee on 13 May, 17 June and 08 July 2025.

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

7.3 JOINT COMMISSIONING COMMITTEE QUALITY PATIENT SAFETY COMMITTEE (PEQS/25/47)

The Committee **RECEIVED** the Joint Commissioning Committee Quality Patient Safety Committee Highlight Report from the meeting held on 20 May 2025.

7.3 WORK PROGRAMME (PEQS/25/48)

The Work Programme was **RECEIVED.**

8. OTHER MATTERS

8.1 ANY OTHER URGENT BUSINESS (PEQS/25/49)

There were no items of any other business.

8.2 ITEMS TO BE BROUGHT TO THE ATTENTION OF THE BOARD AND/OR OTHER COMMITTEES (PEQS/25/50)

It was noted that the Chair would provide updates on those items escalated to Board including the de-escalation of Neurodevelopmental Services to level 2a.

8.3 COMMITTEE REFLECTION (PEQS/25/51)

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

- KWi noted this was CR's last meeting and thanked her for the visible progress that had been made during her time with the Health Board.
- CC noted that this was KWi's last meeting and thanked her for fostering an environment of robust scrutiny as Chair of the Committee.
- Having the meeting the day following July Board was not sustainable. The summer 2026 Committee date to be reviewed.
-

8.4 DATE OF NEXT MEETING (PEQS/25/52)

The date of the next meeting is scheduled on 23 October 2025 via Microsoft Teams.
Meeting closed 12.50.

8.5. CONFIDENTIAL MATTERS

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		
Kirsty Williams	KWi	Vice Chair (Committee Chair)
Mick Giannasi	MG	Independent Member (General)
Jennifer Owen Adams	JOA	Independent Member (Third Sector)
IN ATTENDANCE		
Zoe Ashman	ZA	Interim Assistant Director Women & Children
Carl Cooper	CC	Chair of PTHB Board
Amanda Edwards	AE	Assistant Director Innovation and Improvement

Paul Hanna	PH	Head of Mental Health Nursing
Nilufa Hossain	NH	Assistant Medical Director Quality and Safety and Clinical Governance
Elaine Lorton	EL	Executive Director of Primary Care, Community and Mental Health
Louisa Kerr	LK	Assistant Director Mental Health and Learning Disabilities
Claire Madsen	CM	Executive Director of Allied Health Professionals, Health Sciences and Digital
Claire Roche	CR	Executive Director of Nursing, Quality, Women and Family Health
Hayley Thomas	HT	Chief Executive
Kate Wright	KW	Executive Medical Director
APOLOGIES FOR ABSENCE:		
Helen Bushell	HB	Director of Corporate Governance / Board Secretary
Ian Thomas	IA	Independent Member (General)
Chris Walsh	CW	Independent Member (Local Authority)
Simon Wright	SW	Independent Member

8.6 WELCOME AND APOLOGIES FOR ABSENCE (PEQS IC/25/53)

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

8.7 DECLARATIONS OF INTEREST (PEQS IC/23/54)

No interests were declared in addition to those already declared within the published register.

KWi noted she was a Co-Director of Powys Samaritans which was recorded in her declaration.

8.8 MINUTES OF THE IN-COMMITTEE MEETING HELD ON 29 APRIL 2025 (PEQS IC/25/55)

The minutes of the In-Committee meeting held on 29 April 2025 were **APPROVED**.

8.9 BRIEFING ON SUICIDES (PEQS IC/25/56)

Rationale for item being held in private: Contains matters for which the discussion public would be likely to prejudice the effective conduct of public affairs.

That Committee **NOTED** the contents of this report and took **ASSURANCE** from the mechanisms in place on a multi-agency basis to work collaboratively to deliver suicide prevention and postvention activity.

8.10 ANY OTHER BUSINESS (PEQS IC/25/57)

There was no other business.

Meeting closed at 13.33

Liz Patterson
RAG Status:

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

Patient Experience, Quality and Safety Committee

Meeting Date	Item Reference	Lead	Meeting Item Title	Details of Action	Update on Progress	Original target date	Revised Target Date	RAG status
OPEN ACTIONS FOR REVIEW								
11-Feb-25	PEQS/24/83	Executive Director of Nursing, Quality, Women and Family Health	Transition of Care Annual Report	Transition of Care Annual Report to be brought to July meeting where a review of the frequency of monitoring will take place	**Update 31.07.202:** the Annual Report has not been completed - a request to defer to October meeting **Update 23.10.2025:** due to staff change and resource prioritisation, the report has been drafted but not completed. - change request made to Feb 2026	Jul-25	Oct-25	At risk
30-Apr-25	PEQS/25/14	Executive Director of Primary, Community Care and Mental Health.	Staff Experience of Mental Health and Learning Disability Services in escalation	To receive an assurance report on post escalation monitoring after one year	**Update 31.07.2025** Not yet due **Update 23.10.2025:** Agenda prioritised for October, item added to work programme for Feb 2026. Date change requested	Oct-25		At risk
30-Apr-25	PEQS/25/08	Executive Director of Planning, Performance and Commissioning	Children's Service Neurodiversity	Details regarding funding for service to be included in the next update to Committee	**Update 31.07.2025** A verbal update will be given at the meeting **Update 23.10.2025:** further work is required in this area, date change requested to next meeting in Feb 2026	Jul-25	Feb-26	At risk
31-Jul-25	PEQS/25/37	Executive Director of Planning, Performance and Commissioning	Children's Service Neurodiversity	Information to be provided on the quality of assessments in addition to the quantative information provided	**Update 23.10.2025**: verbal update to be provided within the agenda item	Oct-25		On track
OPEN ACTIONS - IN PROGRESS BUT NOT YET DUE OR ARE ONGOING - (23 OCTOBER 2025) - NONE								
OPEN ACTIONS - IN PROGRESS BUT NOT YET DUE								
30-Apr-25	PEQS/25/12	Executive Medical Director	Clinical Audit Programme	The Annual Clinical Audit Report to include detail on assurance routes for reporting	**Update 31.07.2025** Clinical Audit is rapidly evolving and this action will be addressed in more detail in the July 2026 Plan	Jul-25	Jul-26	On track
ACTIONS RECOMMENDED FOR CLOSURE (MEETING 23 OCTOBER 2025)								
07-Nov-24	PEQS/24/52b	Executive Director of Nursing, Quality, Women and Family Health	Mental Health Services Update	A review of the Integrated Quality and Performance Framework be brought to a future meeting of PEQS	**Update 11.02.25**: The has been scheduled to be completed by 30 April 2025 **Update 31.07.2025** presented to Board in May 2025.	Jul-25		Completed
05-Dec-24	D&P/24/083c	Executive Director of Primary, Community Care and Mental Health.	Primary Care: GDS	It was agreed that a report would be considered at the Patient Experience, Quality and Safety Committee in the near future to fully understand how quality is measured from a general and community dental perspective.	**Transferred to PEQS Committee** **Update 11.02.25:** Item will be added to the 2025/26 work programme, date to be confirmed - in meeting date agreed as July 2025 **Update 31.07.25:** Request defer to October to ensure an even spread of primary care assurance over the year **Update 23.10.2025:** Agenda item on October 25 PEQS Committee	Jul-25	Oct-25	Completed
14-Jan-25	ARAC/24/075	Executive Director of Nursing, Quality, Women and Family Health	Items to be brought to the attention of other Committees	Deprivation of Liberty Safeguards to be transferred to PEQS for monitoring progress against recommendations	**Transferred to PEQS Committee** **Update 11.02.25:** Item added to work programme for 2025/26. The internal audit report has been shared for information within the agenda and papers for the 11.02.25 meeting DCG undertook to confirm date for this to be considered with EDNQWFH **-** agreed as July 2025 **Update 31.07.2025:** monitoring report included at agenda item 5.5. Committee to agree future monitoring arrangements **Update 23.10.2025:** Update agaionst audit actions provided to ARAC in October, update scheduled to PEQS Committee in Feb 2026.	Jul-25		Completed
30-Apr-25	PEQS/25/11a	Executive Director of Nursing, Quality, Women and Family Health	Integrated Quality Report	Key performance indicators relating to investigating Nationally Reportable Incidents to be included in the next Integrated Quality Report	**Update 31.07.2025** included in the Integrated Quality Report	Jul-25		Completed
30-Apr-25	PEQS/25/15	Executive Director of Nursing, Quality, Women and Family Health	Annual Assessment of Committee Effectiveness	To include updates from services groups in the next Integrated Quality Report	**Update 31.07.2025** updates from the service groups are included in the Integrated Quality Report	Jul-25		Completed
30-Apr-25	PEQS/25/11b	Executive Medical Director	Integrated Quality Report	Powys specific data from the Medical Examiner Service to be included in the next Integrated Quality Report	**Update 31.07.2025** The data was unavailble for the July meeting and would be brought to October Committee **Update 23.10.2025:**This information is included in the Integrated Quality Report for presentation to October PEQS meeting	Jul-25	Oct-25	Completed
31-Jul-25	PEQS/25/43	Executive Medical Director	Clinical Audit Annual Report	An update on the clinical audits that had been deferred from the 2024/25 Clinical Audit Programme	**Update 23.10.2025**: Included within agenda item on October PEQS Committee meeting	Oct-25		Completed
31-Jul-25	PEQS/25/40	Director of Corporate Governance	Committee Risk Register	A request for a Board Development session on the risk register	**Update 23.10.2025**: Scheduled into the Board Development programme for Jan 2026.	Oct-25		Completed

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 4.1

PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE	**23 October 2025**
Subject:	Integrated Quality & Performance Framework – Children & Young People Neurodevelopmental Services Escalation Oversight Group
Approved and presented by:	Nicola Johnson, Executive Director of Planning, Performance and Commissioning
Prepared by:	Executive Director for Nursing, Quality, Women and Family Health Director of Midwifery, Women and Family Health Head of Children Public Health Nursing and Paediatric Services Deputy Director of Performance and Commissioning
Other Committees and meetings considered at:	Executive Committee 2nd October 2024; 13th November 2024; 11th December 2024; 5th February 2025; 19th March 2025 and 23rd April 2025; 23rd July 2025; 15th October 2025. Patient Experience, Quality and Safety Committee 7th Nov 2024, 11th Feb 2025; 29th April 2025; 31st July 2025.

PURPOSE:

Within the context of the Powys Teaching Health Board (PTHB) Integrated Quality and Performance Framework (IQPF), in October 2024 the Executive Committee agreed that Children and Young People's (CYP) Neurodevelopmental Services be placed into PTHB's internal 'escalated' status. An Escalation Oversight Group (EOG) has been established.

The purpose of this paper is to provide the Patient Experience, Quality and Safety (PEQS) Committee with an update on current progress.

RECOMMENDATION(S):

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

1. **TAKE ASSURANCE** that the implementation of the IQPF Escalation Oversight mechanism is providing robust oversight of the quality improvement and risk mitigation work being undertaken within Neurodevelopmental Services.
2. **NOTE** and **DISCUSS** the contents of the report and including the progress made on the implementation plan, and updated maturity assessment.

3. **TAKE ASSURANCE** that ongoing monitoring and evaluation mechanisms are in place as part of the Integrated Quality and Performance Framework.		
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

In October 2024, the Executive Committee agreed that, within the context of the Health Board IQPF, CYP Neurodevelopmental Services in PTHB be placed into an escalated (internal within the Health Board) status.

Escalation is considered against the 4 IQPF domains and 3 levels of escalation. An EOG has been established, which describes the process of escalation, de-escalation, and intervention process; the levels of escalation; and the four domains of the IQPF against which each service in escalation will be assessed. Services can be in escalation for any or all of these four domains. PTHB CYP Neurodevelopmental services had been placed in escalation level 3 of the IQPF escalation framework.

This paper provides an update on current progress and escalation status.

DETAILED BACKGROUND AND ASSESSMENT

Background

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

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

- National Institute for Health and Care Excellence (NICE) guidelines.
- Welsh Government delivery of Neurodevelopmental service standards.

- Wales Code of Practice on the Delivery of Autism Servies (Sept 2021).

In October 2024, the Executive Committee agreed that, within the context of the Health Board IQPF, CYP Neurodevelopmental Services in PTHB be placed into an escalated (internal within the Health Board) status, level 3.

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.

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

- Continued and consistent failure to meet agreed performance improvements, including failure to deliver Ministerial Priority measure.
- Performance for Neurodevelopmental assessment continues to fall outside of the lower control limit, with performance flagged as special cause concern due to consecutive decreasing trend.

As per the IQPF, an Escalation Oversight Group (EOG) for CYP Neurodevelopmental Services was established with the first meeting held on 29th October 2024. The group is chaired by the Executive Director of Planning, Performance and Commissioning with membership drawn from Executive Directors, Women and Children's Services and Corporate Directorates.

The aim of the EOG is to:

- Provide assurance to the Health Board on the provision of safe and high-quality care to the population we serve.

- Support an ethos of continuous quality improvement, listening, learning, and acting, seeking continual improvement in communication and openness within and across Health Board to enable positive outcomes and shared learning.

- Provide support to the PTHB service placed in escalation and establish a robust monitoring process to gain assurance of improvements being realised and to establish where progress is not being made, ensuring remedial action and/or escalation to the Executive Team.

- Support and enable the service placed in escalation to make improvements and to provide assurance against the four domains of the IQPF.

Progress to date

In response to being placed in level 3, the CYP Neurodevelopmental service developed a Phase 1 Improvement Plan with actions identified to address the long-term commitment in addressing performance requirements in:

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

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

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

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

The service undertook an assessment of progress against the performance escalation triggers, noting that considerable progress had been made with the continued delivery of the implementation plan. Consequently, at the meeting held on the 23rd of July 2025, the Executive Committee agreed the recommendation of EOG that the CYP Neurodevelopmental service was not ready to be fully de-escalated but that the Escalation level is decreased to escalation Level 2a:

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.

The most recent meeting of the CYP Neurodevelopmental Service EOG was held on the 30th of September 2025 with the following progress update noted:

- 2 actions from initial implementation plan reflected in updated implementation plan (Appendix One).

- Business Case developed and to be presented to the Health Board Investment and Benefits Group (IBG) seeking recurrent financial investment

to deliver a sustainable, robust service which is compliant with both Welsh Government standards and NICE; and which will deliver timely assessments, pre and post diagnostic support.

- Concern regarding predictability of long term demand and therefore WTE requirements of the team.

- New model roll out November clinics (Validated Assessment Tools).

- Risks identified:
  - Required increase in diagnostician oversight of diagnostic outcomes.
  - Cost pressure with implementation of Validated tools (£23k – to be included within Business Case).
  - Referral demand may reduce in the long term: review of service to ensure that post diagnostic support instigated when demand reduction allows and identified of excess resource managed through organisational change.

- Performance
  - Referral management pathway change in January 2025 with families and referrers signposted for wider support opportunities.
  - Expected impact of role of out multi-agency early help and support, single point of access (SPOA) panel. Anticipated that referrals will be reviewed in the SPOA and directed accordingly with those to be accepted through diagnostic assessment waiting list pulled through to referrals for the team.
  - Waiting list – total of 931 CYP waiting for first appointment; 237 (26-51 weeks), 496 (52-103 weeks), 16 (>104 weeks).

NDWaitBand	2025-04	2025-05	2025-06	2025-07	2025-08	2025-09
0 to 11 weeks	169	117	105	146	110	88
12 to 17 weeks	49	69	60	43	32	49
18 to 25 weeks	107	69	65	71	68	45
26 to 35 weeks	82	122	122	91	72	85
36 to 51 weeks	201	179	151	130	158	152
52 to 103 weeks	498	501	518	529	501	496
104 weeks and over	5	4	2	20	22	16
Total	**1111**	**1061**	**1023**	**1030**	**963**	**931**

Trajectory for remainder of 2025/26, based on total planned capacity, is to deliver:

	Neurodevelopment (ASD and ADHD)	Census Date									
		30/06/2025	31/07/2025	31/08/2025	30/09/2025	31/10/2025	30/11/2025	31/12/2025	31/01/2026	28/02/2026	31/03/2026
	Activity Date Range	01/06-30/06	01/07 - 31/08	01/08 - 31/08	01/09 - 30/09	01/10 - 31/10	01/11 - 30/11	01/12 - 31/12	01/01 - 31/01	01/02 - 28/02	01/03 - 31/03
Trajectory	Volume waiting 183 days and over up to and including 364 days (26-51 weeks)- Profiled	274	274	274	274	274	274	274	274	274	274
	Volume waiting 364 days and over up to and including 729 days (52 weeks - 103 weeks, 1-2 years) - Profiled	518	505	492	479	466	453	440	427	414	401
	Volume waiting 730 days and over up to and including 1094 days (104 - 155 weeks/ 2-3 years) - Profiled	2	0	0	0	0	0	0	0	0	0
	Volume waiting 1095 days and over up to and including 1459 days (156-207 weeks/ 3-4 years) - Profiled	0	0	0	0	0	0	0	0	0	0
	Volume waiting 1460 days and over (>=208 weeks/ 4 years) - Profiled	0	0	0	0	0	0	0	0	0	0
	Volume waiting Over 182 Days (26 Weeks) - Profiled	794	0	766	753	740	727	714	701	688	675
	Total Planned Core Activity	32	32	32	32	32	32	32	32	32	32
	Planned Additional Activity	32	32	32	32	32	32	32	32	32	32
	Total Planned Activity (Core + Additional)	64	64	64	64	64	64	64	64	64	64

- 'Was Not Brought' and 'Could Not Attend' increases primarily due to summer holidays for families.
- Joint appointment model complex due to clusters of absence, annual leave and long term sickness.
- Focus of team on follow up appointment management.

Next steps

As part of the EOG process, an Integrated Quality and Performance Assessment Framework (IQPAF) self-assessment tool has been developed to be used for a self-assessment of service maturity, seeking to answer three key questions:

1. How safe and effective are services?
2. How person centred are services?
3. How well led and effectively managed are services?

The service has previously completed a baseline assessment in November 2024, and an assessment review in March 2025, which have been presented to PEQs. A further assessment review will be undertaken in November and presented to PEQs.

A Conditions for Sustainability self-assessment tool has also been developed as part of the EOG process, designed to be used for self-assessment of the service against a number of domains identified as essential for a sustainable service. The service has previously undertaken an assessment review in April 2025 which was presented to PEQs. A further assessment review will be undertaken in November and presented to PEQs.

Ongoing Executive scrutiny and oversight of the service escalation and improvement will remain in place via the EOG, which will continue to oversee the implementation updated service remodel implementation plan and continued progress against the IQPAF and Conditions for Sustainability.

Regular progress reports will continue to be presented to future meetings of both the Executive Committee (monthly) and PEQs (at each meeting).

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 4.2

PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE	**23 OCTOBER 2025**
Subject:	**People's Experience Update Paper – October 2025**
Approved and presented by:	Paul Hooton, Executive Director of Nursing, Quality, Women and Family Health
Prepared by:	Claire Roche, Executive Director of Nursing, Quality, Women and Family Health (until 03/10/25) Assistant Director of Quality and Safety Head of Quality and Safety People's Experience Lead
Other Committees and meetings considered at:	Executive Committee - 01 October 2025

PURPOSE:

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

RECOMMENDATION(S):

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

- **RECEIVE** the report and take **ASSURANCE** that progress is being made regarding the implementation of the People's Experience Framework including appropriate monitoring and reporting.
- Take **ASSURANCE** that continued actions are in place to further develop People's Experience implementation, monitoring, and reporting.
- **NOTE** the development of a People's Experience Framework, scheduled to be completed by end of Q3 2025/26.

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	N	
4. Enable Joined up Care	Y	

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

EXECUTIVE SUMMARY:

The Welsh Government's People's Experience Framework (PEF) was launched in April 2025. The Framework contains several elements that health boards must implement.

OVERVIEW

1. Situation.

Following consultation with Welsh Government, the People's Experience Framework was launched in April 2025, placing a requirement on Health Boards to ensure implementation and monitoring of the required elements of the Framework. In June 2025 following the launch, Powys Teaching Health Board (PTHB) recruited a People's Experience Lead.

2. Background.

Prior to the implementation of the PEF, the Health Board did not have a strategy for patient experience. The Equality team previously had responsibility for supporting the production of patient stories, until July 2023 when the portfolio was transferred to the Executive Director of Nursing Women and Family Health. Without a dedicated resource for patient experience, services and teams were encouraged to obtain and provide patient stories for Board and Committees, whilst also obtaining feedback from engagement events with Llais and updates from PAVO.

The role of People's Experience lead was successfully recruited to during Q1 2025/26, this role enables robust leadership and development of the workplan aligned to the People's Experience Framework.

The launch of the Framework contains several required elements, aligned to the Listening and Learning Tree (**Picture 1**) which all health boards will need to enact.
Picture 1.

These will include:

- The completion of a self-assessment tool aligned to the PEF.
- Implementation of the People's Experience Survey (PES).
- The Framework encompasses legislation, including Putting Things Right, Duty of Candour and collaborative partnerships with Llais, independent advocacy, Public Services Ombudsman for Wales.
- A change of language – people as opposed to patients.
- Introduction of a requirement to build experience measures into contractual arrangements such as commissioned services (this aligns with the NHS England Friend and Family test)

3. Assessment.

The People's Experience Survey (PES) has been launched, and services are being encouraged to use this method of survey as first choice. Where bespoke surveys are necessary, the 5 core questions and equality monitoring questions are being included.

All services have been asked to undertake a self-assessment against the Framework to further understand how they currently capture feedback and people's experience. All responses were to be submitted by 19 September 2025. An implementation plan and People's Experience strategy are being developed to demonstrate how the Health Board aim to meet the requirements of the Framework. This is anticipated to be completed during Q3.

A range of promotional materials and a new People's Experience logo (**Picture 2**) have been developed, this enables staff and patients to recognise the Health Board's commitment to incorporating a person's experience and feedback. Enabling services to learn from service user's experiences both negative and

positive thus informing improvements where required. This is accessible to staff via the Health Board intranet.

Picture 2

Priorities

- Ensure CIVICA (system to capture feedback) structures and hierarchy for reporting are up to date.
- Review the use of SMS (text messaging) as it is recognised this comes with a cost but does significantly improve response rates.
- Review the use of CIVICA for compliments to ensure a uniformed approach is prioritised.
- Development of a People's Choice Award across the health board where patients can nominate individual members of staff or teams who have delivered exceptional, quality patient care.

<u>Experience Measures within Commissioning Framework</u>
All commissioned services have been approached through the Contract Quality Performance and Review Meeting (CQPRM) to inform them of the requirements under the Framework. A number of health boards are now providing monthly updates regarding concerns, patient safety incidents and patient feedback, which will now be reported in the Integrated Quality Report and Integrated Quality Planning and Delivery (IQPD).

<u>Patient Stories</u>
Patient stories are being encouraged at every opportunity and training has been undertaken in the Quality and Safety Team for Digital Storytelling. A rolling programme of patient stories is in place for stories to be presented to the Board going forward.

<u>People's Experience Steering Group</u>
The purpose of the People's Experience stakeholder and steering groups are being reviewed to ensure membership is appropriate and services are represented. Terms of Reference has been drafted.

NEXT STEPS:
The implementation plan along with self-assessment outcome will continue to be reported through PEQS Committee on a quarterly basis.

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				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.
Financial	X				
Corporate	X				
Operational	X				
Reputational	x				

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 5.1

Patient Experience & Quality Committee	**26 October 2025**
Subject:	**Integrated Quality Report: Quarter**
Approved and presented by:	Paul Hooton, Executive Director Nursing, Quality, Women & Family Health
Prepared by:	Assistant Director Quality & Safety Head of Quality and Safety
Other Committees and meetings considered at:	Executive Committee - 15 October 2025.

PURPOSE:

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

RECOMMENDATION(S):

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

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

Approve/Take Assurance	Discuss	Note
N	Y	Y

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:		
1. Focus on Wellbeing	N	
2. Provide Early Help and Support	N	
3. Tackle the Big Four	N	
4. Enable Joined up Care	Y	
5. Develop Workforce Futures	N	
6. Promote Innovative Environments	N	
7. Put Digital First	N	
8. Transforming in Partnership	N	

EXECUTIVE SUMMARY:

1 Background

The purpose of this report is to provide the Executive Committee with an update on the quality and safety agenda for Powys Teaching Health Board (PTHB). **Due to the date of submission, the data for Q2 is incomplete, Q2 data will therefore also be included within Q3 reporting period.**

2 Specific matters for consideration by this meeting (Assessment)

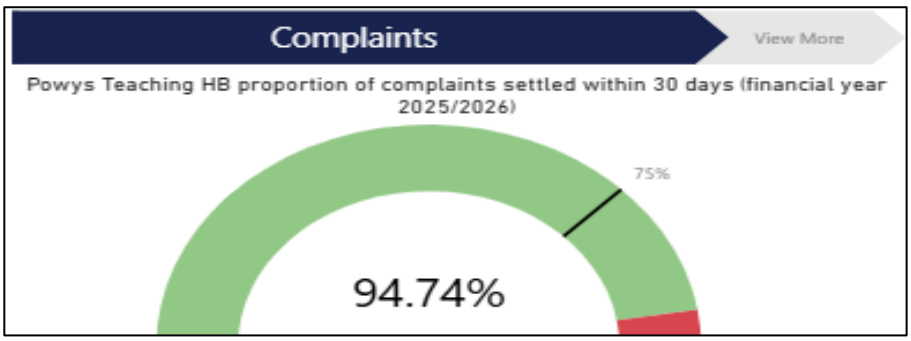
2.1 Once for Wales(OFW) Content Management System (RLDatix)

The RLDatix system – Risk Register

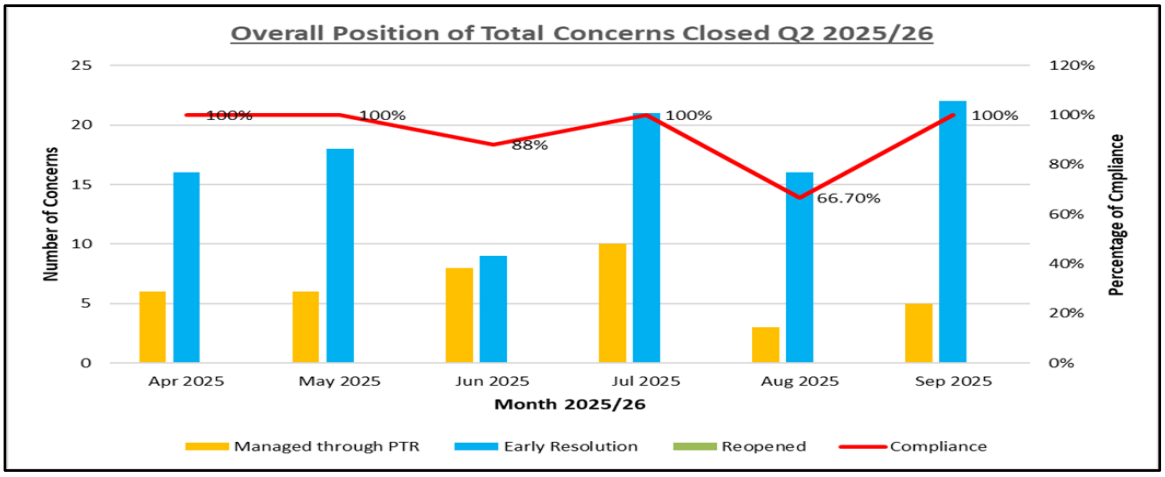
- Due to capacity in Corporate Governance Risk, rollout of the risk register has been slower than anticipated. This will continue during Q3 & Q4 to ensure all services and departments utilize the digital system.
- PTHB met with the OFW team on 29 August 2025 to explore the support available from the national team; training resources have been provided for use.

2.2 Putting Things Right – Concerns

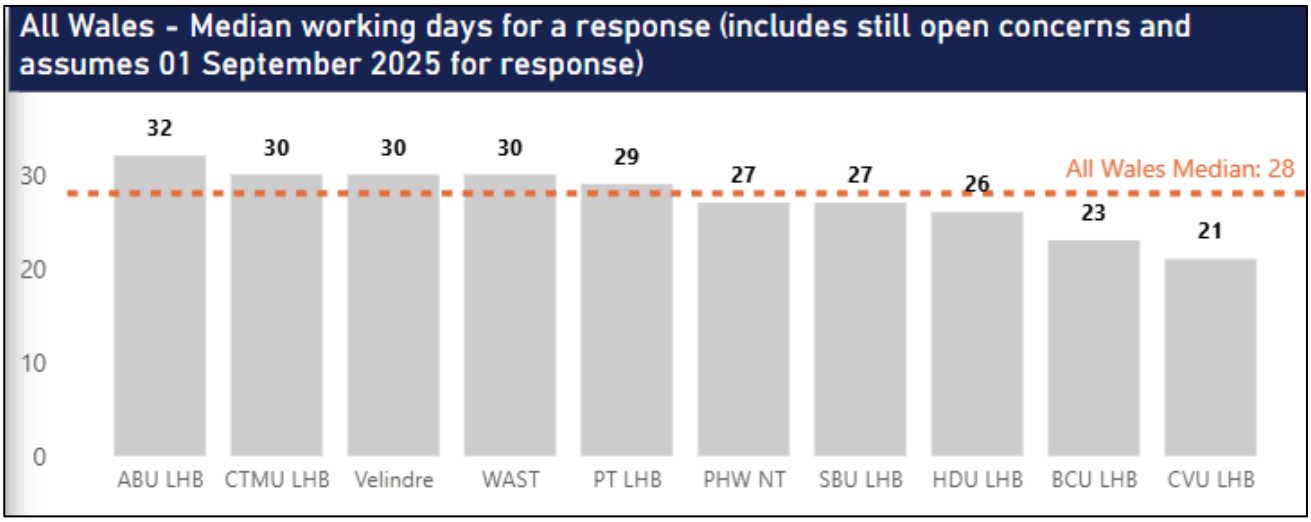
The management of concerns compliance within 30 working to date for 2025/26 compliance (**Graph 1)** is 94.7%. Despite the continued compliance with 30day response an area of focus is the mean response time of 29 working days, with a primary focus on the sign off process as the main area for improvement **(Graph 3)**.



Graph 2 – Complaints compliance Response Rate – Datix Source.



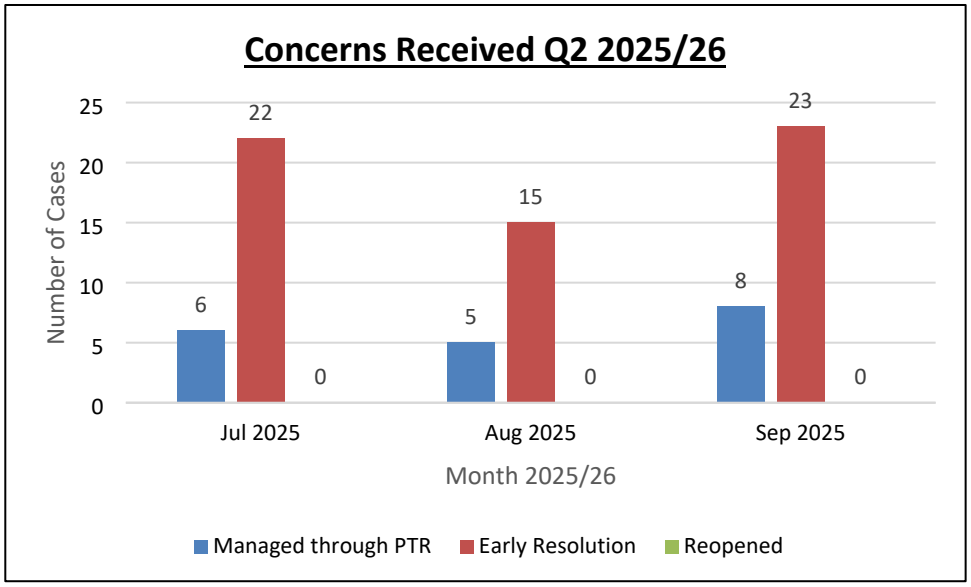
Graph 3 – All Wales Median Working days for Concerns Response – Source Beacons Dashboard as of 01/09/2025



To date Q2 2025/26, 11 formal concerns have been raised through PTR. Issues identified:

- Clinical Treatment & Assessment.
- Appointments.
- Access.
- Patient care.

Graph 4 – New Concerns Received Q2 2025/26 (updated 03/10/2025)

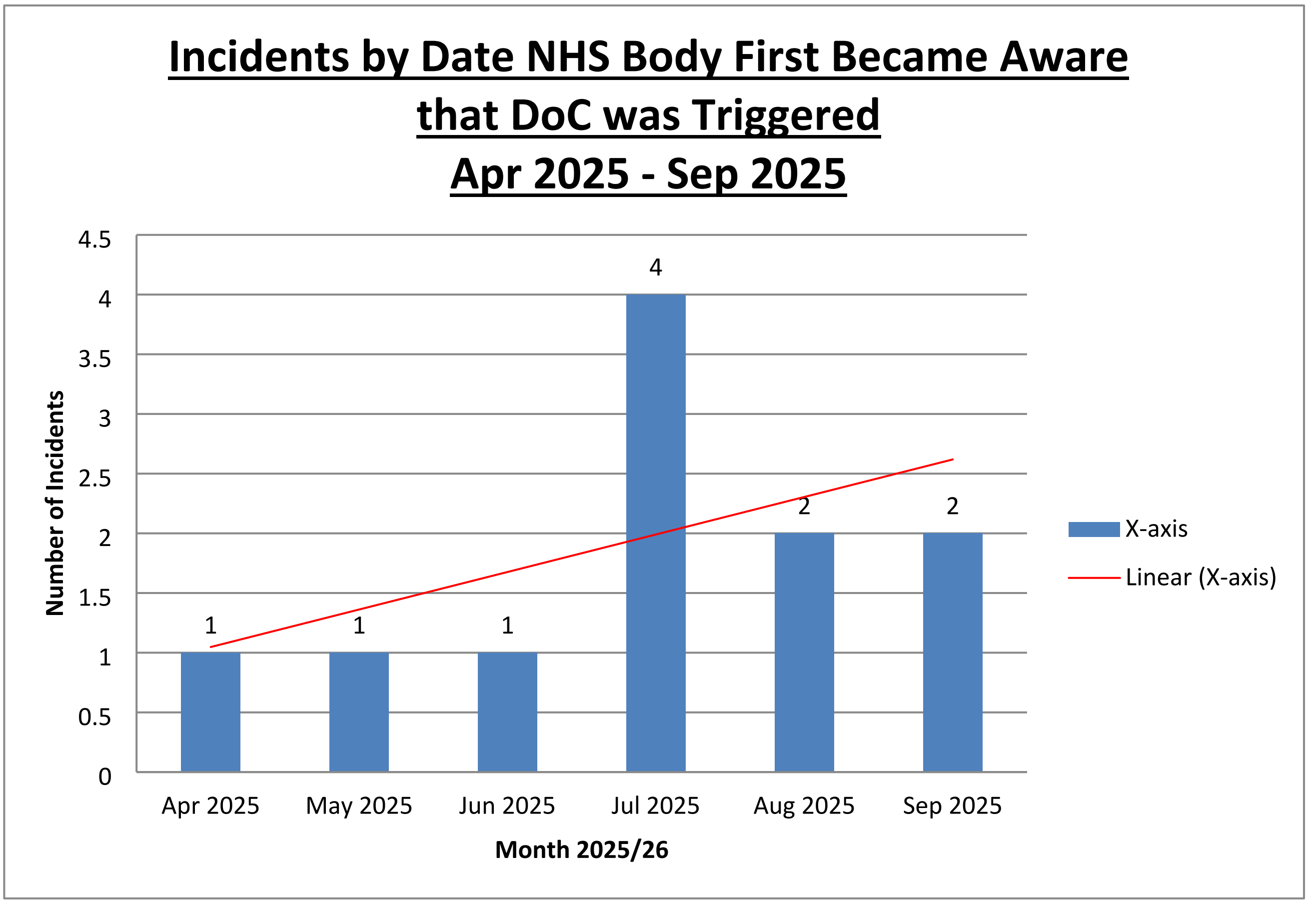


The current PTR regulations are under review by Welsh Government, and it is anticipated that the new regulations will be released in February 2026, in readiness for implementation on 1 April 2026. A PowerPoint presentation was presented at Executive Committee on 9 July 2025 advising of the proposed changes and potential impact to services.

2.3 Duty of Candour (DoC)

There have been 8 Duty of Candour cases during Q2 2025/26; this is a marked reduction on same period in 2024/25 (13 cases). This reduction is felt to be due to a robust rapid review process and proportionate reporting in line with the national reporting criteria. This is attributed to colleagues increased awareness and understanding of the requirements of the Act.

Graph 5 – Date DoC was triggered in the Organisation (03/10/2025 – Datix)



There are currently 24 open DoC case in various stages of investigation. Of the 8 DOC cases triggered in Q2, no themes were identified.

8 DOC cases have triggered redress.

It is anticipated within the new PTR regulations that more robust and timely management of DoC cases will be required, this is likely to be in line with 30 working day PTR responses currently. The teams are therefore being supported to review their processes to ensure more timely and proportionate investigations.

2.4 Claims, Redress & Clinical Negligence Position

Redress
11 confirmed cases.

At the point in which we make an admission of Qualifying Liability (that there is both breach of duty, and as a result we have caused harm), a Learning from Events Report (LFER) must be completed. This LFER is then submitted to the Welsh Risk Pool (WRP) for them to review and consider whether the health board has provided sufficient learning from an incident or concern to mitigate against reoccurrence. Once this learning has been approved, and at the conclusion of a case, we can apply for reimbursement of monies paid.

We are currently 100% compliant with WRP LFER processes with no penalties.

Clinical Negligence
9 confirmed cases.

Personal Injury
<5 confirmed cases.

General Medicine Practice Indemnity (GMPI) Claims
<5 confirmed cases.

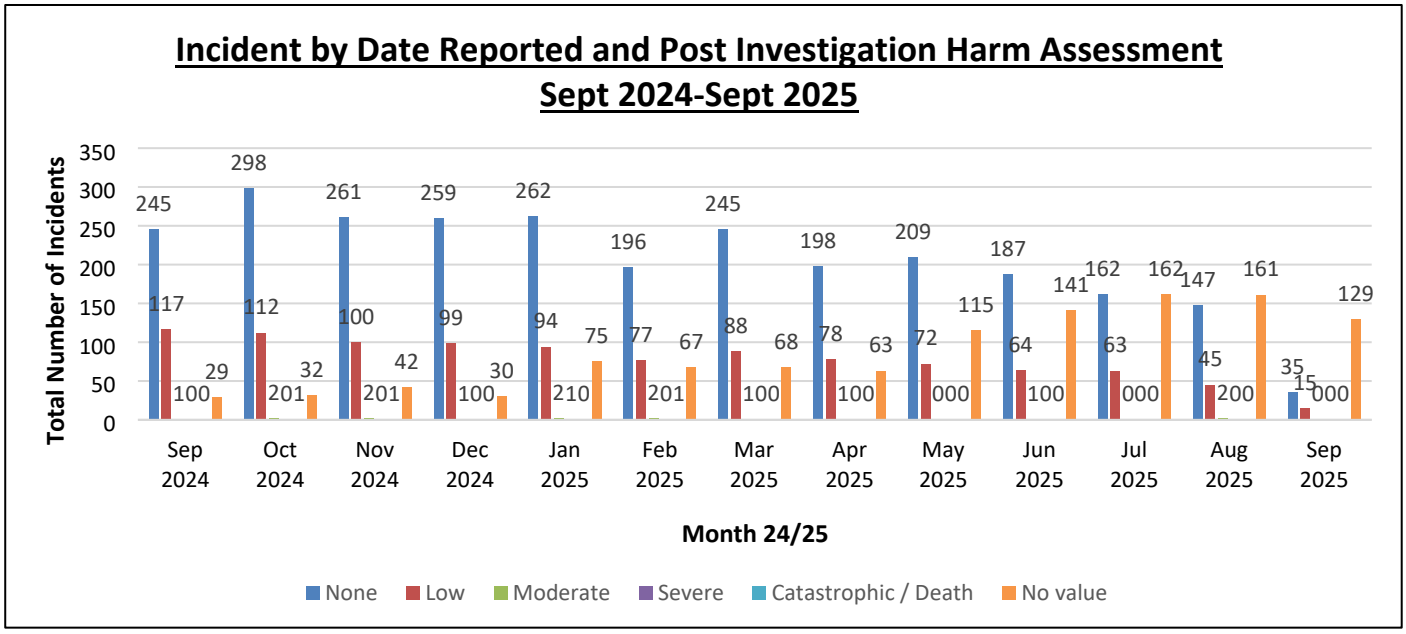
Upon the conclusion of a claim and all payments have been made, we are required to submit a Case Management Report to the WRP within 4 months of the final payment being made to support reimbursement ; currently 100% compliant with this process.

Inquests
19 confirmed inquests.
2 inquests listed for November 2025 in which staff have been called to attend to give evidence in person and 1 inquest listed for January 2026.

2.5 Incident Management

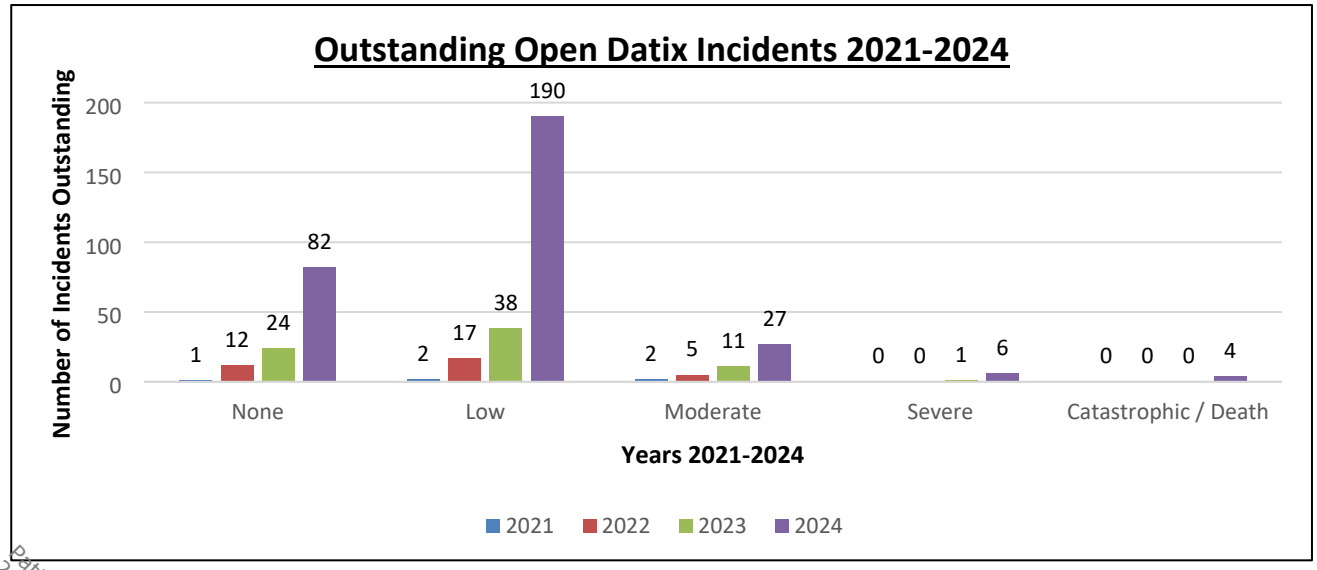
Graph 6 demonstrates stability in reporting across the year, and that most incidents are reported as low or no harm. A no value reporting category has been noted in Q1 and continues to be under review. No value incidents are those where the investigation is partially investigated or incomplete. There has been a gradual rise of no value incidents from May 2025. During Q2 a total of **221 'no value'** incidents have been closed, and this continues to be a priority for CSGs.

Graph 6 Incidents Reported by Post Level of Harm April 2024-Jun 2025

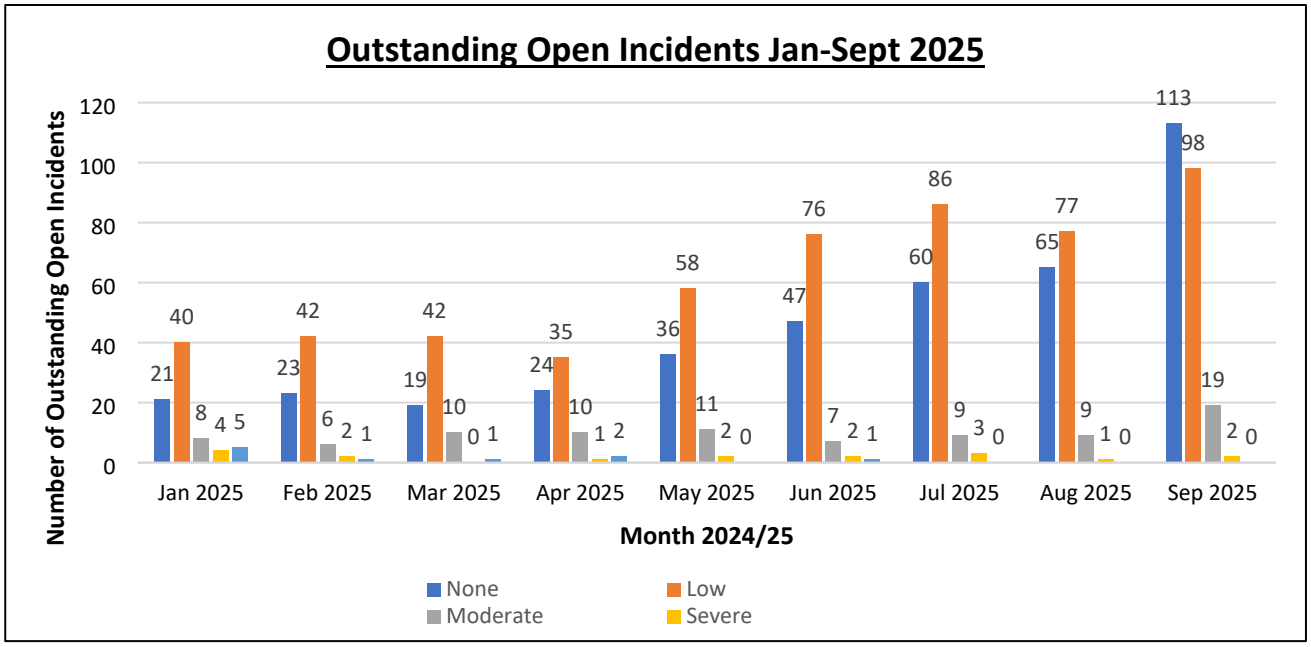


While reporting of incidents remains stable across the Health Board, it is visible in **Graphs 7-9** that the closure of incidents remains challenging across all care service areas. All 'none' and 'low' harm incidents must be reviewed and closed within 7 days (unless the level of harm is changed at the interim manager's review). **Graph 7** indicates that there is still **119** 'none', **247** 'low' harm incidents still open (and not investigated) between 2021-2024. Moderate incidents must be reviewed within 5 days to enable the consideration of whether Duty of Candour should be triggered. Duty of Candour was implemented in 2023. Since this time **Graph 7** indicates that **38** 'moderate', **7** 'severe' and **4** 'Catastrophic/Death' remain open from 2023-2024.

Graph 7: Data source Datix 09/10/2025

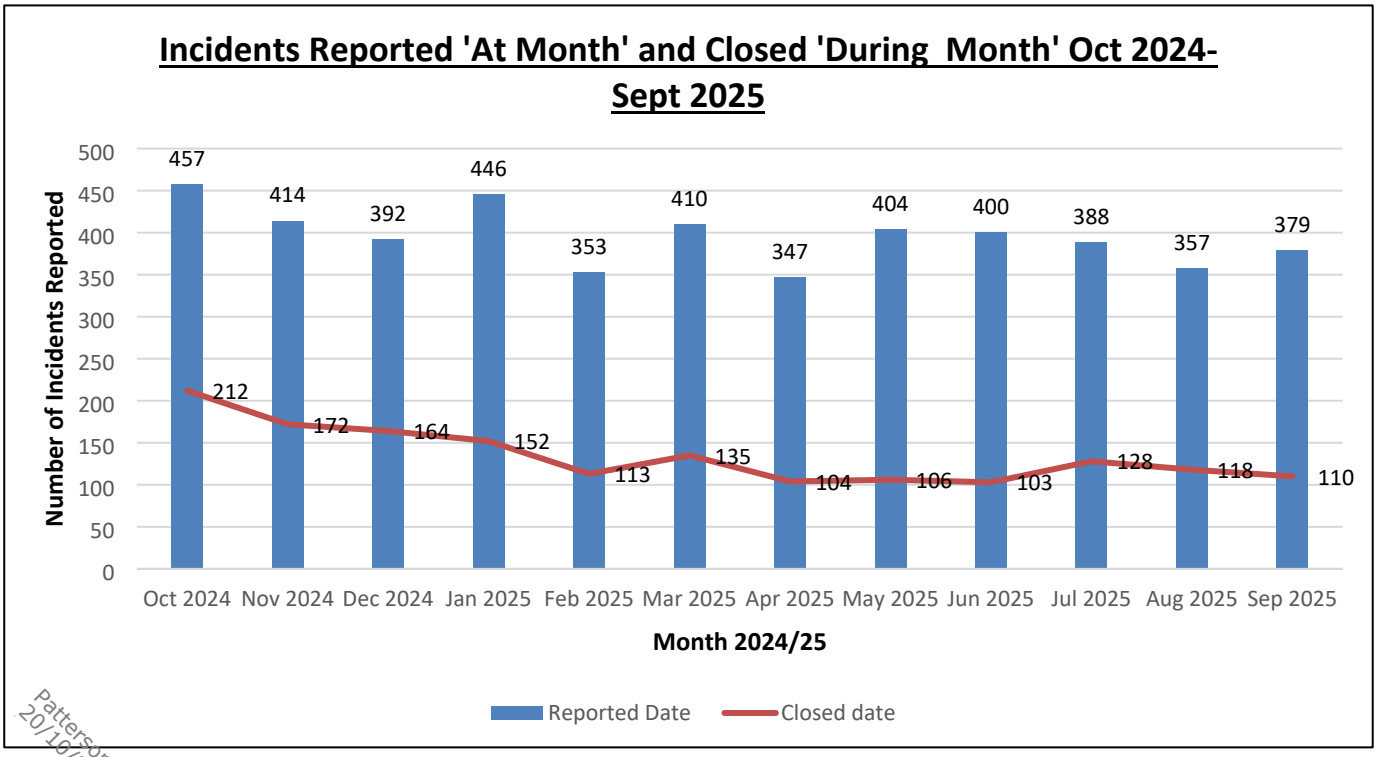


Graph 8 – Data source Datix 09/10/2025



Graph 8 demonstrates the outstanding incidents reported between January and September 2025. In total **408** 'none' and **554** 'low' incidents have been reported that have not been reviewed and closed within 7 days. Across the year to date there remain **89** 'moderate' incidents, **17** 'severe' and **10** 'catastrophic/death' incidents that remain open.

Graph 9 – Data source Datix 09/10/2025



Graph 9 demonstrates that there are on average **395** incidents reported across the Health Board on a monthly basis. On average, the closure rate for 'at month' incidents is **135** per month. This is a 'at month' closure compliance rate of **34%**.

The Quality and Safety team provide regular updates for Datix training for reporters and managers where reporting time frames are emphasised. Heads of Service are also sent a weekly report providing the position on moderate incidents and going forward it will include service position on 'at month' data compliance.

2.6 Early Warning Notifications (previously No surprises notifications)

No Early Warning Notifications have been submitted during Q2 2025/2026.

2.7 Nationally Reportable Incidents

The current position for open Nationally Reportable Incidents (NRI's):

- 16 Open – 7 awaiting closure
- 13 Closed (During Q2)
- 5 Downgraded

Improved timeliness of investigations is a focus for 2025/26 as 87% of open investigations remain open for >90 working days with the average completion time of 181 days, slight improvement on Q1 of 190days (All-Wales median is 132days) This can be attributed to complex mental health cases which are anticipated to be completed by 120days. Investigation timeliness requires an improvement to ensure outcomes are shared with families and learning consolidated.

Table 10 Shows that the average length of time between the NRI notification and the investigation being shared with the Executive Lead for consideration and approval is 162 days. Incidents at 0 are investigations yet to be completed.

Table 10

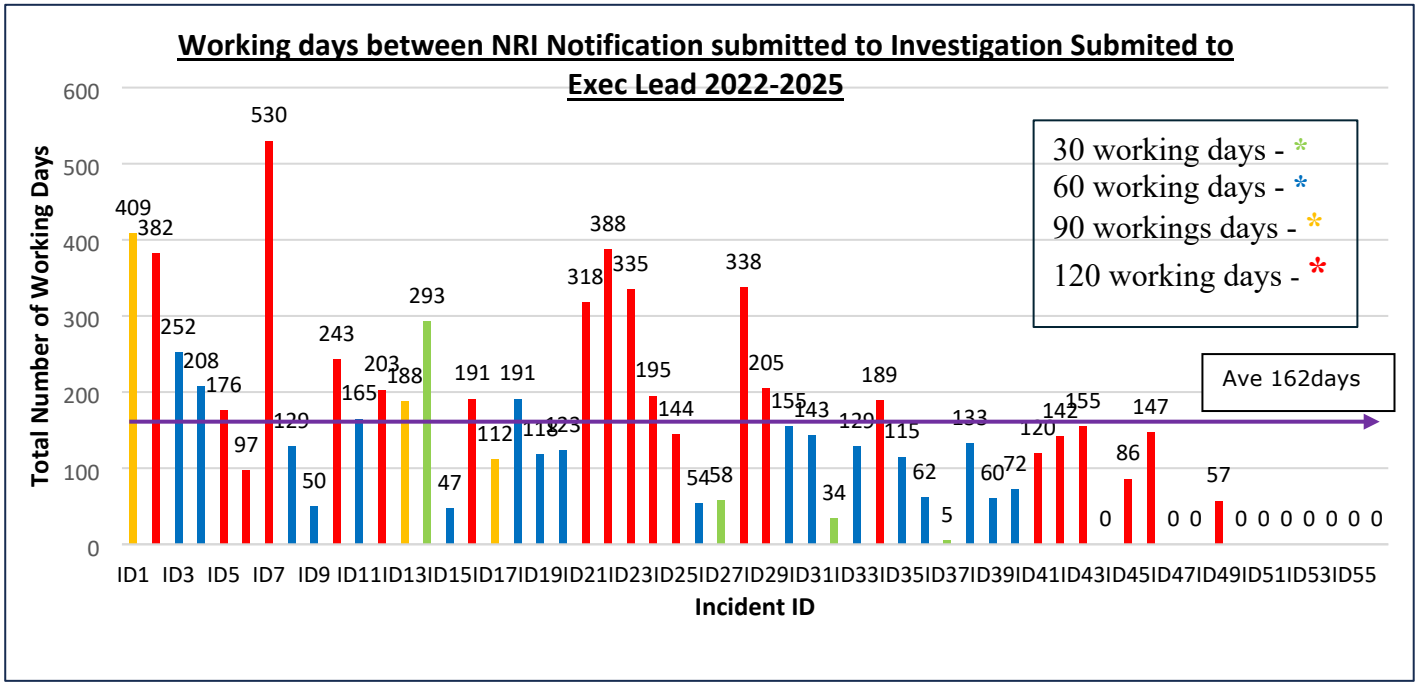
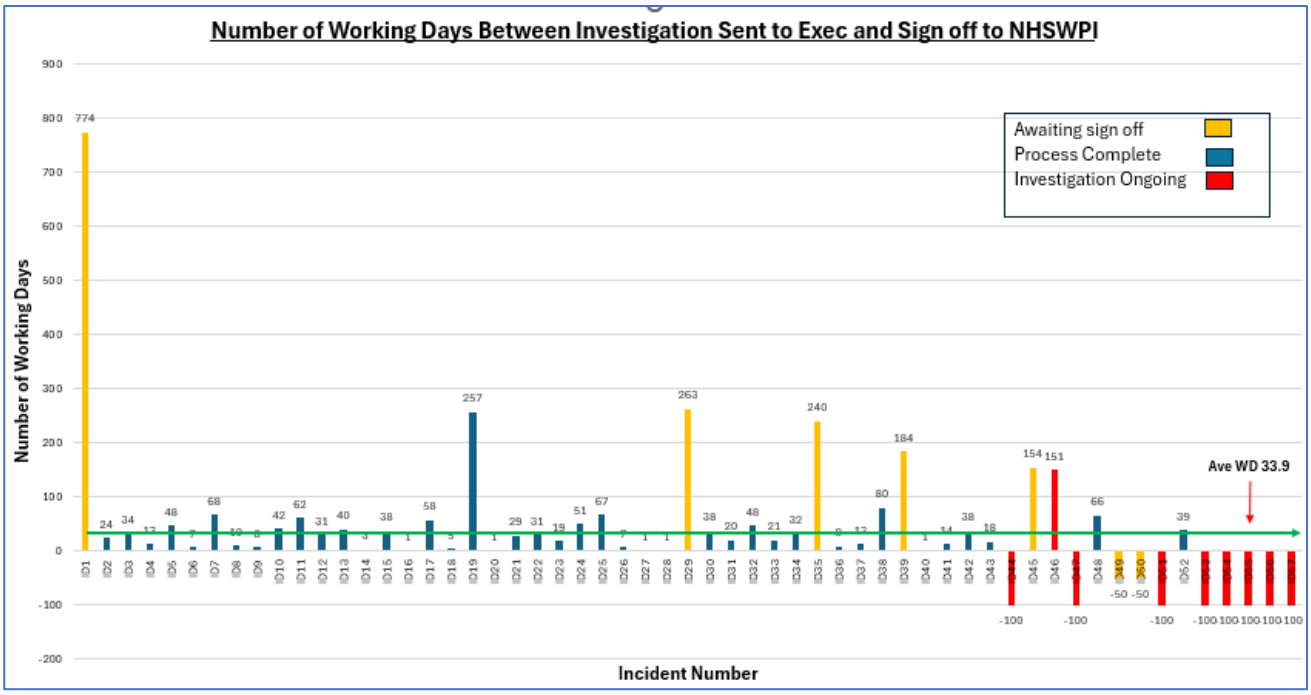


Table 11 Shows the number of working days between submission of the investigation to the Exec Lead before signoff and submission to the NHSWPI. The average working days taken to complete this process is 33.9 working days. It is important to note the average of the five cases still awaiting sign off is 323 working days.
During this period a number of factors should be considered to impact sign off:

- Robustness of information received and requirement for further clarity or information.
- Further investigative or analysis required.

Table 11



3. People's Experience will be addressed in a bespoke paper for this committee.

3.4 Llais Activity

Llais published a written submission to the Health and Social Care Committee (June 2025, Appendix 4) Llais Written Summary Submission to the Health and Social Care Committee.pdf which highlights where efforts have been made with engagement and the priorities going forward.
In August 2025 Llais met with the Health Board to communicate their findings from engagement sessions with Crickhowell (July 2025) and Newtown (April 2025) and the reports will be published in due course. Llais undertook a Wellbeing event in Knighton on 14/09/2025 and their Public Board Meeting will take place 24/09/2025.

3.5 PAVO

PAVO submitted their Third Sector Report for Q1 to the People's Experience Strategic Group in August 2025 (**Appendix 1)**.

This report underscores the importance of continued partnership working to address systemic barriers and improve patient experience across Powys.

4. Infection Prevention and Control (IP&C)

PTHB has had Zero bed days lost due to IP&C concerns during the reporting period — a strong indicator of effective infection control practices and proactive management across the Health Board.

Learning from post-infection reviews continues to be actively embedded into routine procedures, supporting a culture of continuous improvement and organisational learning.

The IP&C team remains engaged in key national workstreams, contributing expertise and aligning local practice with broader strategic developments.

Collaborative relationships with commissioned services remain strong, enabling effective monitoring of infection rates and shared learning related to Powys patients.

Table 12 PTHB Infection Rates – Q1 25/26

Reduction expectation number	Domain	Cases reported (April – August 2025/26)	Cases reported (April – August 2024/25) Comparison
E. coli bacteraemia			
1.	2025/26 reduction expectations currently awaiting final sign-off from Welsh Government	1 cases reported (**increase in 1 on previous FY**)	0 cases reported
P. aeruginosa bacteraemia			
2.	2025/26 reduction expectations currently awaiting final sign-off from Welsh Government	0 cases reported (**equivalent to previous FY**)	0 cases reported
Klebsiella spp. Bacteraemia			
3.	2025/26 reduction expectations currently awaiting final sign-off from Welsh Government	0 cases reported (**equivalent to previous FY**)	0 cases reported
Clostridioides difficile			
4.	2025/26 reduction expectations currently	8 cases reported	15 cases reported

	awaiting final sign-off from Welsh Government	(**decrease in 7 on previous FY**)	
Staphylococcus aureus bacteraemia			
5.	2025/26 reduction expectations currently awaiting final sign-off from Welsh Government	1 case reported (**equivalent to previous FY**)	1 case reported

5. Public Service Ombudsman for Wales (PSOW) Annual Report and Accounts 2024/25

The PSOW Annual Report and Accounts for 2024/25 were received by the Health Board on 14/08/2025 and can be found via Turning the page - Annual Report and Accounts 2024/25 (**Appendix 5**). The report identifies that PSOW received 20 complaints relating to PTHB, and intervened in 24% of cases which is in line with Welsh average. PSOW closed 25 – some complaints were carried over from the previous year. During 24/25 the health board complied with 33% recommendations made in the agreed timeframe.

A response has been provided to PSOW following the receipt of the annual report and letter, the actions required are;

- Improve compliance with recommendations agreed.
- Share Duty of Candour and Quality Report 2024/25 (Completed).
- Present annual letter to the Board on 26th November 2026 (Scheduled).

5 Health and Social Care Inspections Regulatory Recommendations

Of the 47 recommendations made by HIW 7 actions remain outstanding with 1 overdue but being addressed; for assurance there are no actions outstanding that cause a risk to patient or staff safety.

Graph 13 Summary of Outstanding actions by inspection/national review as at 16/10/2025

Year/ Reference No	Inspection Title	Recommendations Made / Actions	Recommendations / Actions Complete	Recommendations / Actions Overdue (agreed timescale)	Actions underway	Recommendations / Actions Not Yet Due
232405	HIW National Review of CAMHS	20	17		1	1
242509	HIW Inspection Clywedog Ward	17	16		1	
252601	HIW Unannounced Inpsection Felindre Ward - Immediate Assurance Improvement Plan	3	3			
252601	HIW Unannounced Inpsection Felindre Ward - full Improvement Plan	7	5		2	
252602	HIW Inspection Ystradgynlais Community Mental Health					
		47	41	0	4	1

5.1 Health Inspectorate Wales Inspections

In addition, HIW undertook an unannounced inspection of Llandrindod Wells Minor Injuries Unit 19 and 20 August 2025 resulting in 3 immediate improvement actions which were all completed within a week. The Report and any further improvement plan is awaited.

HIW will undertake a planned inspection of Ystradgynlais Community Mental Health Team on 16 and 17 September 2025. 1 immediate improvement action was made and has been actioned on the same day. The final report is awaited.

6. Bereavement Framework

Objectives of the Nation Bereavement Framework (NBF):

- Development and Roll-out of Bereavement Pathways - A dedicated pathway is currently being designed with Maternity Services, tailored specifically to Powys Teaching Health Board (PTHB).
- Engagement with Bereaved Individuals - Visits to hospital sites across Powys have commenced and will continue throughout September and October. Feedback is being actively used to shape and improve bereavement services.
- Out-of-Hours Support - Current gaps in out-of-hours, weekend, and bank holiday provision are being addressed. Awaiting delivery of 'Out of Hours Bereavement Support' booklet which is scheduled for roll-out before the end of 2025.

Success during Q2 2025/2026:

- Support for Families - Ongoing collaboration with Maternity Services is focused on strengthening support for women and families who have experienced baby loss. Two members of staff have volunteered to act as bereavement champions. An action plan has been developed to monitor and progress identified priorities.
- Raising Awareness - Planning is underway for Baby Loss Awareness Week, which will help raise awareness and engagement across Powys.
- Feedback and Improvement - It has been one year since the Bereavement questionnaires were introduced. Following a review and feedback from bereaved families, updates have been made to improve their effectiveness.
- Stakeholder Engagement - A bereavement stakeholder group has been established, with the first meeting scheduled for 20th October.

Medical Examiner

- The June 2025 data for Powys Teaching Health Board indicates that overall Medical Certificate of Cause of Death (MCCD) completion times remain in line with the Wales average. However, two process stages are performing slower than national benchmarks:
  - **Death → Notes Received**: 2.0 days (vs 1.7 days)
  - **Notification → ME Scrutiny**: 2.5 days (vs 1.1 days)

A Task and Finish Group has been established to review delays, agree actions and provide assurance. Quarterly updates will be submitted to the Medical Director to confirm that targets are being met.

A step has been added to the MR process following the receipt of the ME reports. Governance Leads within the HB will be responsible for ensuring that services provide feedback in relation to any actions and learning for their areas, supporting continuous improvement.

7. Prevention of Future Deaths Order

PTHB received a Regulation 28 Prevention of Future Deaths notice from HM Coroner on 09/09/2025 (**Appendix 2)** for a case heard in Coroner's Court in July 2025. Matters of concern resulting in the notice are as follows:

- There was a lack of appreciation of the need for the deceased to see a podiatrist as recommended by a Tissue Viability Nurse. The referral was not followed up or actioned.
- There was an identifiable lack of knowledge on the part of the nursing staff to understand the reason for referral to a podiatrist and the possible interventions a podiatrist could undertake in respect of pressure wound damage, particularly in patients with circulatory problems.
- There was an identifiable lack of knowledge on the importance of following the recommendations of the Tissue Viability Nurse in respect of the type of dressings to be administered and the importance of ensuring such steps were followed as opposed to using an alternative and, on the evidence, an inappropriate dressing.

The Health Board response and Action plan has been shared with the His Majesty's Coroner on 14 October 2025.

8. Acute Deterioration Workstream

Following the national workstream in July 2025 to progress the implementation of Early Warning Scores (NEWS2) across healthcare settings in Wales by 30/09/2025, PTHB has undergone consultation of the new NEWS2 document. Distribution of the document to all services is complete, with planned implementation for 26/09/25. All staff are to complete the ESR NEWS2 online training and NEWS2 champions will be established across directorates to support rollout.

9. Quality & Safety Reports: Provided Services

9.1 Women and Children's Services

Concerns

Q2 2025/26

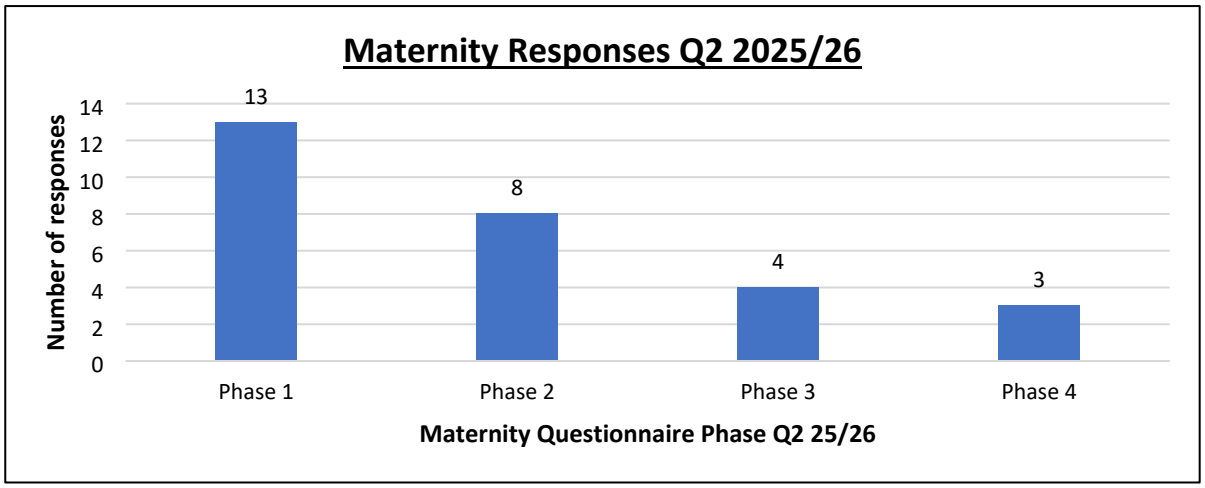
Formal concerns <5

Early resolution 17

Positive Feedback
Q2 2025/26, Total 8 regarding the following services:

- Children's community Nursing.
- Childrens Learning Disabilities.
- School Nursing

Graph 14 Maternity CIVICA Responses Q2 25/26



Successes

- Powys maternity is one of three trial sites to launch the All-Wales perinatal experience measures (questionnaires) through Civica on 01/04/2025. The feedback from certain questions will feed into the national dashboard enabling monitoring and comparison across Wales.
- Vaccinations for RSV / Pertussis / Flu are provided by midwives as part of their role for all women in Powys who are pregnant.
- Midwifery triage is working well for normal working hours, and an audit is ongoing on the out of hours triage system.

Learning

- Learning posters continue to be shared with staff across maternity for incidental learning that is picked up through the month.
- Where challenges arise in contacting families to make appointments, appointment letters should be sent to the home address.
- Information leaflets have been updated to make families aware of the different options available for local anaesthesia prior to paediatric blood tests.
- Learning to strengthen IG compliance has been disseminated in the Neurodevelopmental service including the adoption of a 5-point check when compiling records to include Name, DOB, address, WCCIS and NHS number.

Incidents

- There have been no incidents in Women & Children's Services that have met the threshold for Duty of Candour during Q2.
- There have been no NRIs in Women & Children's Services during Q2.

Key Priorities for Q3
Sexual Health & Womens Health
Consider service provision pan-Powys in line with Womens Health Strategy (women's hubs).

Public Health Nursing
Ensure all contacts in line with Healthy Child Wales Programme are recorded within CYPRiS (National recording platform).
Ensure responsibilities are met for the ALN act consistently

Community Children's Nursing
Recruit to key posts to enable repatriation of Children's Continuing Care by Q3 thereby improving governance and quality and cost effectiveness of the service.

Neurodevelopmental Service
Advance Business Case through IBG and agree sustainable funded service to meet population need.
Continue with the Parental co – production group and regular staff engagement sessions to ensure continued development of a sustainable service.

Commissioned Services (Maternity)
- Maternity services have regular structured meeting with commissioned services to share learning and understand any local challenges which may impact Powys women.

9.3 Community Service Group (CSG) Integrated Quality Report Quarter 2 2025

CSG Concerns Q2 2025
Formal Concern 10
Early Resolution 20

Areas of good practice
- Prompt and responsive concern management
- Within District Nursing, the formulation and usage of the SBAR-P (P means pressure) within the documentation has improved the consideration of patient's pressure damage risk at every patient contact.

3 points of learning
- Patient assessments and record keeping within Podiatry.
- Maintain clear and sensitive communication with service users, including informing them of telephone line availability and response times, to ensure they know when support is accessible.

- The importance of the administration role to support the audiology service following multiple enquiries received.

CSG open Duty of Candour & NRI Cases Q2

Open NRI Incidents <5
Open Duty of Candour Incidents <5

3 points of good practice

- District Nursing teams are managing a high complexity of patients well in the community utilising the wider multi-disciplinary team.
- Falls Review huddles demonstrate completion of Multi Factorial Risk Assessments in a timely manner and post inpatient falls.
- Thematic analysis of pressure damage, and combination with the overarching audit and action plan. Improved attendance at pressure scrutiny panel for shared learning opportunities.

3 points of learning

- The importance of thorough risk assessments. Ensuring that all assessments are completed at the start of a care pathway and revisited when clinically indicated to identify the need for pressure-redistributing equipment and offloading advice.
- Proactive measures: Recognising the potential risks associated with medical devices, such as splints, and taking proactive measures to mitigate these risks.
- Ensuring documentation is robust and complete.

CSG Key priorities for Q3

- A review of the Standard Operating Procedure of Glan Irfon Unit is being undertaken alongside therapy colleagues, Care staff and District Nurses to ensure that there is a collaborative and holistic approach to the residents in our care.
- To improve training figures across specific roles in relation to managing pressure damage risk and associated complexities.
- Within Radiology to explore the introduction of a flexible booking option, to enable service users to confirm or request changes by phone or online.

9.4 – Mental Health

Concerns and Early Resolution

Formal Concerns <5

Early Resolutions 11

Trends and themes

- Communication issues linked to patient/service users' appointment.
- Inpatient care.
- Clinical assessment, diagnosis and referral pathways.

3 points of Learning

- Formalised process in place to monitor referrals and assessment outcomes via weekly MDT meeting
- Implementing a buddy cover system for staff sickness.
- The Psychology Service is committed to embedding trauma-informed care across all aspects of the service.

Incidents Q2 2025/26

Duty of Candour <5
NRI Incidents reported 0

Trends and themes.

- No themes have been identified in Q2

NRI/ DoC Learning

- Training for staff on incident reporting.
- Review of medication management policy and training.
- An audit of section 117 process.
- A review operational of CMHT policy.

Key Priorities – September & October (MHLD Services)

- National Collaboration & Co-Production
  Continued engagement with the RCRP National Partnership Group and delivery through the Patient Experience Framework and co-production events.

- Policy Development
  The CPAG group meets monthly to progress MHLD policy work, aligned with service action plans and progressing at pace.

- Learning & Development
  A monthly Learning & Development group ensures shared learning across MHLD services, supported by regular patient experience reporting.

10. Contract Quality Performance Review Meeting (CQPRM) – Commissioning

Through the CQPRM meetings the following **quality themes** (Q2 2025/26) have been discussed.

Across commissioned services, several quality challenges persist, particularly in urgent care, diagnostics, outpatient follow-ups, and safeguarding. Themes include reported increases in medication errors, patient falls, and poor cleaning standards, alongside fragile staffing in A&E and high-risk outpatient delays. One organisation has highlighted concerns in their Trust Board Reports around cancer performance, ED crowding, and

complaints timeliness, while another has highlighted long waits for Welsh patients and RTT non-compliance.

Regarding patient safety incidents, one health board has reported complications and low-harm incidents decreased, but 'no-harm' incidents rose. Clinical staff appraisal rates dropped, and safeguarding audits revealed gaps in documentation and external liaison.

Actions taken include governance de-escalation insourcing, and mobile diagnostics, harm reviews, and consultant transfers, and safeguarding audit follow-ups.

Key priorities, as a result of these themes going forward being undertaken by commissioned providers include:

- Strengthening workforce resilience and reducing reliance on agency staff.
- Sustaining improvements in diagnostics and RTT trajectories.
- Enhancing safeguarding documentation and inter-agency coordination.
- Addressing cleaning standards and incident trends to mitigate safety risks.
- Maintaining high patient experience while improving feedback participation and clinical governance.

PTHB Actions:

- Maintaining focus on the relevant areas of concern via the CQPRM with oversight of any additional internal action plans, implementation, and learning.
- Continue to work with commissioned partners to develop PROMS and PREMS data sharing in line with the People's Experience Framework and this will evolve in reporting through Q3/4 2025/26.

Concerns Monitoring

Following the changes to planned activity regarding Powys patients provided by NHS England, the health board have received 31 concerns which have been managed as enquiries.

There have been no incidents of associated harm or nationally reported incidents associated with the changes made.

11. Duty of Candour – Internal Audit Report 25/26 (ARA Agenda 5.2)

During August and September NWSSP completed an internal audit on Duty of Candour for PTHB **(Appendix 3)**. This was presented in the Audit, Risk and Assurance Committee on 07/10/2025 and will be presented. The Health Board achieved reasonable assurance in all areas and are currently working through the associated action plan which include the following areas:

- The Incident Management Framework requires review.
- Increased awareness and compliance of Duty of Candour training in PTHB

- Consistent reporting, escalation and documentation of the Duty of Candour process.
- Consistent reporting of the Duty of Candour position to clinical service groups.

Table 15 – Assurance position - Duty of Candour – Internal Audit Report 25/26

Scope & Assurance Summary Objectives The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.		Related Findings	Assurance
1	Clearly defined procedures are in place for the management of Duty of Candour cases, which are in line with Welsh Government guidance and include the roles and responsibilities for identifying, investigating and monitoring cases.	1	**Reasonable**
2	Health Board wide training and ongoing support is in place to help staff meet their Duty of Candour responsibilities.	2	**Reasonable**
3	Cases are consistently managed in accordance with the defined procedures to ensure that the Health Board complies with the Duty of Candour.	3,4	**Reasonable**
4	Timely monitoring and reporting arrangements are in place at appropriate levels within the Health Board, which include lessons learnt and contribute to a system of continuous improvement.	5	**Reasonable**

NEXT STEPS:

Key Matters for Board/Committee

1. **Rollout of the RL Datix Risk Register**
   ACTION taken: Additional focus and support is being provided by the Once For Wales Team, who are creating a training package. They will also be supporting the development/building of service hierarchy.

2. **Ensure the required support and resource is available to support the implementation of the People's Experience Framework.**
   ACTION taken: Following the release of the People's Experience Framework by Welsh Government, services are now required to complete the self-assessment for their area. This is a request to be completed by 19/09/2025.

3. **Implementation of NEWS2**
   Action taken: PTHB NEWS2 chart ratified and printed and disseminated to all service areas. Ward Champions to be identified and staff are to complete the ESR NEWS2 online training package. Monitoring of ESR training is to be completed.

Appendix 1	PAVO - Third Sector Report - Q1 July 2025
Appendix 2	Prevention of Future Death Order – September 2025
Appendix 3 (see Item 7.1)	Duty of Candour – Internal Audit Report 25/26
Appendix 4	Llais Written Summary Submission to the Health and Social Care Committee
Appendix 5	PSOW - Turning the page - Annual Report and Accounts 2024/25
Appendix 6	PTHB reply to PSOW letter in appendix 5.

IMPACT ASSESSMENT – NOT REQUIRED FOR THIS REPORT

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

QUALITY:

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

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				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.
Financial	X				
Corporate	X				
Operational	X				
Reputational	X				

Patient Experience Steering Group - July 2025

	PAVO Patient Experience Steering Group Report Quarter 1 (April - June 2025)
Paper submitted by	John Williams - Senior Officer Health Engagement Information and Participation
Purpose of Paper	Information gathered via engagement with Powys population to inform Patient Experience Steering Group and other relevant partnership groups
Action/Decision required	For information/action
Acronyms and abbreviations	PAVO - Powys Association of Voluntary Organisations PTHB - Powys Teaching Health Board SaTH - Shrewsbury and Telford NHS Trust PCC Powys County Council PPC - Powys Patients Council WG - Welsh Government OPF - Older People's Forum IMHA - Independent Mental Health Advocate Community Transport Association TSTN - Third Sector Transport Network PLWC - Person Living With Cancer OT - Occupational Therapist

RAG rating

Red	Causing Concern over a significant period of time
Amber	In the process of being addressed
Green	Addressed or proceeding to plan

Felindre Ward Patients Council

PAVO Mental Health Participation Officer - Alice Dolan and Service Reps John Lilley & Rhydian Parry attend and support the facilitation of Patient's Council on Felindre Ward, Bronllys Hospital. The Ward Manager attends the meeting in order to address concerns raised.

Examples of issues raised in Q1

Issue	Detail	Action to date
WIFI	Very slow Wifi at the far end of the gents corridor. (April)	The PPC, in collaboration with PTHB IT services, was able to get the issue sorted within a week. The speedy turnaround is credited to the Felindre internet access working group that concluded last year but is still fostering positive working relationships.
Staff Attitudes	1. Feeling ignored by all staff, from doctors to nurses (June 2025) 2.Sometimes the nurses can shout and be rude (May 2025) 3. I went to the nurse with a physical health concern & wanted to make an appointment with the gp. The nurse ignored me and just gave me a leaflet. (April 2025)	Reporting from Q1 shows that 1⁄3 of all issues raised to the PPC was to do with negative attitudes presented by staff on Felindre Ward. Staff are often described as dismissive & rude, patients are reporting that they feel ignored. In conversation with ward management in May this was highlighted as a concern. The belief is that the high level of acuity intersected with the vast range in acuity is putting added pressure on both staff and patients alike. To combat this mgmt. are looking for funding to allow for staff to have 4 hours weekly (8x30mins sessions) supervision sessions with an outside agency. The hopes that this will promote reflective practice & foster positive relations between those on ward.
Outdoor access	We're only allowed outside for 15 mins every hour. (May 2025)	Following an incident, patient access to the garden was limited to 15 minutes per hour due to the need for staff supervision. Ward management acknowledged this was not

		ideal, particularly given the rising temperatures. By 18 June, full access was reinstated with a staff member stationed in the area. However, this arrangement is not sustainable long-term, as staffing levels may not always support continuous supervision.
Noise On Ward	1. Can the door for the men's corridor be kept closed (June 2025) 2. The doors are constantly slamming, is there anyway that we can put noise dampeners on them?	Patients often complain about the high level of noise that is ever present on the ward. Primarily, the constant banging of the doors and doors to the patient corridors being left open overnight. To combat this mgmt. are looking into installing door dampeners and automatic closers.

Older People Forum Engagement

Andrew Davies, PAVO Health & Wellbeing Participation Officer has been carrying out engagement across Powys with Older People to listen to their concerns.

Concerns raised are reported to the relevant department or lead officer and they are reported to the Older People's Forum meeting where Senior Officers from PCC & PTHB are present.

Issue	Detail	Action to date
GP	Issues in multiple locations throughout Powys in accessing GP appointments through the new systems	Via reports to Age Well
Fall Alarm Systems	My fall alarm has stopped working since switching over to a digital phone system. The engineer is supposed to come tomorrow.	Reported to services - resolved
Cross border communication	I can't see why Powys GP and Hereford hospital can't talk to each other. Every time I go there, it is an issue with my notes not being sent from one or the other.	Reported to Age Well
GPs and Transport	The GP practice in Talgarth is shared with Hay, but there is no public transport, so if	Reported to Age Well -ongoing issue

	you need an emergency appointment on the wrong day, you can't get there.	
Centralised Call System, Bronllys Hospital	The centralised call system at Bronllys is not working. I have tried calling on four separate days and at different times, and each time, no one has answered, which leads me to believe the phones are not manned.	PAVO to liaise with PTHB
Pharmacy	Talgarth Pharmacy is fantastic.	compliment
Other comments	I have lived here for 8 years and have seen a decline in the health services and transport provision.	Noted - fyi

Items reported via PAVO **Community Connector Service**

Issue	**Detail**	**Action to date**
NEPT Transport	Transports cancelled at short notice - difficulty for person to get to hospital Patient called PAVO at 3.30pm 09/07/25. He had just received a call from NEPT cancelling transport booked 2 weeks previously to take him from Machynlleth area down to Morriston Hospital for 7.00am for surgery on 10/07/25. This gave him less than 15 hours notice to arrange transport.	Escalated to David Farnsworth, Assistant Director, Community Services and PTHB Commissioning Lead

Items raised via **PAVO MacMillan Cancer Connector** Penny Tanner

Issue	**Detail**	**Action to date**
DWP requesting information from a person in palliative care.	DWP contacted Person Living With Cancer (PLWC), asking for random transactions on bank statements and requesting the statements, which means PLWC has to travel to banks which are 35/40 miles away. The person is on chemotherapy and says it's stressful.	Reported to ICJ Team / Signposted to Powys Money Advice Team, whom person has been in contact/
Cancer Wellbeing Services in Powys	1 PLWC felt it was too far to travel for treatment, and one said services seem to be in Llandrindod Wells and Shrewsbury.	Reported to ICJ Team

	Another PLWC said that they would participate in more wellbeing sessions if nearer. Another PLWC shared that no transport to wellbeing / support groups in Powys, with Shropshire services closer for PLWC	
NEPT	PLWC missed two appointments due to no transport and no clear guidance on when to ring. Another PLWC said they spent 4 hours trying to get in contact. Once booked they were then told the transport may be cancelled. They shared the stress this causes them.	Reported to ICJ Team
Appointments at SaTH	Appointments booked for 8am or late evening in winter. PLWC unable to drive and NEPT say unable to book transport at the times.	Reported to ICJ Team / Signposted to PALS and referred to LLAIS
Communication between Hereford Hospital and Powys GP	PABC would like practical support and said 'disappointed by the situation' referring to the communication.	Reported to ICJ Team / Signposted to CNS and The Bracken Trust.
Prescription for pain relief at Boots Pharmacy	Pharmacist asked to collect the next day at 5pm. PABC said they couldn't wait that long and they said the Pharmacist said 'Do you know how many prescriptions I have in a day? Yours is just one'. PLWC required morphine for pain relief.	Reported to ICJ Team
GP Appointments in Llandrindod Wells	PLWC said they don't get to see GP in person. Telephone calls only.	Reported to ICJ Team
Clinical and treatment appointments	PLWC travelled to Llanelli for clinical appointments, chemo at Bronglais. Both in one week was a lot. Another 80 year old PLWC in the Mid, travelling 3 hours each way to South Wales.	Reported to ICJ Team.
Mobility Lease Car	PLWC has received a letter to say it is coming to an end and said 'It is another thing that can knock you down again'.	Reported to ICJ Team

Signed off from CNS	PLWC said signed off from Breast CNS team 2.5 years ago, but having tablets and has questions	Reported to ICJ Team. Signposted to The Bracken Trust and offered to support to find CNS
Recovery	PLWC says they can't afford time off work and are not receiving any financial support. PLWC diagnosed in 2022 with bowel cancer, had 7 days off work to recover. Using holidays up to recover.	Reported to ICJ Team. Referral made to Powys Money Advice Team and Clinical Team.
CNS	PLWC had diagnosis for 3 years and unaware of CNS Another PLWC unaware who CNS is	Reported to ICJ Team.
Referral to services in Powys from SaTH	80 year old PLWC was inpatient at RSH in December with pneumonia and sepsis and advised would have an OT referral for physio following discharge, but not heard anything and due for operation soon.	Reported to ICJ Team. Referral to Community Therapy Team and iCAN.
PLWC lost with in system at SatH.	PLWC referred to SaTH by GP, but not advised why. Chased after ¾ weeks and Shrewsbury said they were too busy and PLWC could attend a mobile unit in Telford Industrial Estate. They said he would have to be referred to Shrewsbury. PLWC went private and was seen the next day, operated on within a week. Advised to have follow up treatment at Shrewsbury with NHS and start within 2 weeks. PLWC said Shrewsbury Hospital had lost him in the system and it took 2 weeks to find his referral. It is now 6 weeks post op and PLWC given a date to start in 3 weeks.	Reported to ICJ Team.
OT wait times	OT wait times as of 29th April: Newtown - medium triaged is 8 weeks, high triage is 1 week and urgent is 24 hours. Welshpool - Medium triage is 3-4 weeks, high is a week and urgent is 24 hours.	Reported to ICJ Team. Followed up with one PLWC and after 8 weeks still not contacted.
Transport from SaTHl following discharge and childcare.	PLWC, who is a single mother, was told that she needed to be admitted to hospital (RSH) and she said she had to make own way. PLWC said that she has used train, bus and taxi. On hospital discharge from RSH, PLWC said that she was told that she was fit enough to find her own way home.	Reported to ICJ Team. Signposted to Credu for emergency planning support and Powys Money Advice Team for travel costs.

	Client shared how it felt when people, who lived in Shrewsbury were being discharged and having transport arranged for them. PLWC paid for a taxi. PLWC shared the challenge of childcare and what she will do in future.	
ASSIST	PLWC, given an expectancy of 2-6 months, was initially referred to ASSIST by daughter in February, prior to diagnosis. Following diagnosis in April, another referral was put in for Care Needs Assessment and support provided by Palliative Care Nurses. CC chased ASSIST and advised awaiting allocation of social worker and that it would be 'stepped up'.	Reported to ICJ Team. ICJ Community Connector contacted ASSIST and updated Palliative Care Nurse. Referral made to Red Cross who have supported in the interim.
PIP reviews	PLWC said they applied for review in January and in May were still not reviewed. PLWC is unwilling to spend money on practical support.	Reported to ICJ Team. Supported by Pobl. Signposted to Llais.
Defibrillator not charged	A defibrillator in south Powys was not charged so it was unable to be used in an emergency, while waiting for an ambulance.	Reported to ICJ Team. Contacted the venue out of Duty of Care and they had contacted the Circuit for future information and maintenance guidance.
PALS at SaTH	PLWC said PALS are not getting in touch. ICJ Community Connector left a message asking them to call me and sent an email - No reply after 2 months.	Reported to ICJ Team
Parking at Hereford Hospital	PLWC said parking at Hereford Hospital is an issue and said that he was told that lots of people miss their appointments because they can't park and can't walk that far. PLWC shared how he felt this would have an impact on the NHS. PLWC said the queue to park at the hospital backs up to the main road.	Reported to ICJ Team
Cancer Treatment at SaTH	Delay of hours for treatment at RSH	Reported to ICJ Team.

Welsh Health Service	PLWC said bad experience	Reported to ICJ Team
Llandrindod Medical Centre	PLWC shared his experience of Llandrindod Medical Centre and said 'Not good'. PLWC said prescriptions were delivered with medication that isn't suitable for diabetics and that he went to the GP in January asking for a PSA test. The GP gave him antibiotics. PLWC said he pushed for an appointment and said he had to say 'It is my legal right to have a PSA test' and they did one. PLWC said it took from January to May to get a PSA test.	Reported to ICJ Team.
Respite and carers assessment	82 year old PABC looking for respite and carers assessment referred to ASSIST. PABC said she received a letter, which said that ASSIST weren't taking on new referrals, due to being inundated. PABC shared with CC, 'tired everyday'.	Reported to ICJ Team. ICJ Community Connector contacted Credu to check the referral received.
Medical assistance	PABC overwhelmed and unsure who to contact for support with PLWC and cleaning bags (on kidneys). Said when they have contacted Urology CNS at Hereford Hospital, unable to get hold of.	Reported to ICJ Team. Signposted to ASSIST and referred to OT
COMPLIMENTS		
Nurse at Llandrindod Medical Practice and Diabetes Nurse.	PLWC said 'Been brilliant'	Feb back to ICJ Team.
Nurse at Llanidloes Medical Practice	PLWC said a nurse at Llanidloes medical practice started ball rolling for services to support.	Feedback to ICJ Team
Mid Wife in South Powys	Praise to a Mid Wife, Sam Woods in south Powys who PABC said that when she told her that her mother had been diagnosed with cancer ' she took me under her wing'.	Fed back to ICJ Team.
Communication with Hereford & Cheltenham Hospitals	PLWC said communication between Hereford and Cheltenham Hospitals are good.	Fed back to ICJ Team

PAVO 3rd Sector Community Transport Network facilitated by Claire Sterry, PAVO

Organisation	Issue	Detail	Action to date
Third Sector Transport Network	Networks and Influencing	• Having the networks join up was useful (Volunteer Involvers Network & TSTN). • Service users to meet and discuss services and give feedback. • Work with other services for the benefit of users, not against. • Working together can cost less than each partner trying to work alone. • Improve employment opportunities to create better networks. • Links with statutory partners will be beneficial to supporting networks.	Issues will be actioned - our priority for this quarter is demonstrating the impact of CT services across Powys .
Patterson,Liz 20/10/2025 16:46:21	Expansion and Diversity of Services	• Open to all ages regardless of disability or age ○ locations based means restricted access • Linked network.	Issues will be actioned - our priority for this quarter is demonstrating the impact of CT services across Powys .

		• Understanding of different services. • Operating at capacity. • Who is delivering MiDAS training - can we map? • How can services help in instances such as bus breakdown?	
	Working Together	• Developing a map to show what areas of Powys are covered and what areas aren't covered. • Partial shared pool of volunteers to share volunteer availability. • Potential app or other strategy to make contact with volunteers easier	Issues will be actioned - our priority for this quarter is demonstrating the impact of CT services across Powys . We will be setting up a smaller network of CT providers that will meet quarterly. A map will be produced of areas covered by CT services in Powys.

Feedback from last quarter report

NEPT	Issues last and this quarter	Escalated to David Farnsworth
Patient Council Issues	Please see this report for update on current progress	See report (page 2)
Transport	Of the 56 people consulted in Q4, 27% said transport in Powys is still an issue for older people, with people stating that. *"I rely on buses, but they don't connect, so long waits, no Sunday service at all, so I can't get out at all",* and "*Transport is the biggest issue for me, along with isolation.*	Transport continues to be a county wide issue
GP	Residents are still having issues accessing GP appointments	National GP issue also being raised by Llais
NHS	Some people are finding that services are being moved, and without the transport network, they struggle to make appointments.	Continue to share comments via reports and Age Well meetings - **raised again this quarter**

Prescriptions	information on changes to services and support are not getting through to residents	Reported via Age Well - **continue to raise**

Reported compiled by the Health, Wellbeing & Partnership Team - PAVO
July 2025

GRAEME HUGHES

HIS MAJESTY'S SENIOR CORONER

SOUTH WALES CENTRAL CORONER AREA

CORONER'S OFFICE
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ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **The Chief Executive of Powys Teaching Hospital Board**
1	**CORONER** I am **Andrew Morse, HMC for the Coroner Area of South Wales Central.**
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 10 May 2023 I commenced an investigation into the death of Edward John FUNNELL. The investigation concluded at the end of the inquest 10/07/2025. The conclusion of the

	inquest was Natural Causes. **1a Ischaemic left foot** **1b Peripheral Vascular Disease** **1c** **II Congestive Cardiac Failure, Chronic Kidney Disease, Ischaemic Heart Disease, Atrial Fibrilation**
4	**CIRCUMSTANCES OF THE DEATH** These were recorded as :- Mr Edward John Funnell died on 29th April 2023 at Ystradgynlais Community Hospital. Mr Funnell was admitted to Hereford Hospital on 16th December 2022 for an orthopaedic procedure. During his time at Hereford Hospital he developed a pressure ulcer on his left heel. Mr Funnell was not fit to be discharged home. He was transferred to Llanidloes War Memorial Hospital on 11th January 2023 until admission to Bronglais Hospital and transfer onwards to Morriston Hospital on 19th February 2023. During his time at Llanidloes the pressure ulcer worsened, and he developed an ischaemic left leg. On admission to Morriston Hospital he decided against surgery to amputate his ischaemic left leg and received palliative care at Ystradynlais Hospital from 24th February 2023 until his death. On balance it cannot be said that missed opportunities to treat and escalate the care of the worsening heel ulcer and signs of ischaemia in the left leg contributed to his death. A finding of natural causes was made. During the course of the inquest extensive evidence was heard in respect of the wound dressings and interventions of nursing and Tissue Viability specialists during the deceased's time at Bronglais Hospital.
5	**<u>CORONER'S CONCERNS</u>** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. a. There was a lack of appreciation of the need for the deceased to see a podiatrist as recommended by a Tissue Viability Nurse. The referral was not followed up or actioned. b. There was an identifiable lack of knowledge on the part of the nursing staff to understand the reason for referral to a podiatrist and the possible interventions a

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	podiatrist could undertake in respect of pressure wound damage, particularly in patients with circulatory problems. c. There was an identifiable lack of knowledge on the importance of following the recommendations of the Tissue Viability Nurse in respect of the type of dressings to be administered and the importance of ensuring such steps were followed as opposed to using an alternative and, on the evidence, an inappropriate dressing.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 28th October 2025. I, the Coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to family who may find it useful or of interest. I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. She may send a copy of this report to any person who she believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
	2 September 2025 **SIGNED:**  Patterson,Liz 20/10/2025 16:46:21

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LLAIS

Eich llais chi mewn iechyd a gofal | Your voice in health and social care

Llais Written Submission to the Health and Social Care Committee

June 2025

Contents

Llais Written Submission to the Health and Social Care Committee

Llais is the independent statutory body established in April 2023 by the Welsh Government to strengthen the public voice in health and social care.

This submission outlines how we have laid strong foundations in our early development and are building momentum in our engagement, influence and impact. It highlights where we have focused and will be focusing in the future.

The submission is structured around five key themes, each aligned with our statutory functions and values: volunteers, we have made significant strides in building a robust framework that supports our mission.

1. **Establishing a trusted, people-centred organisation** – how we have structured Llais as a national body with independence and integrity, including how we work with others across the health and social care system.

2. **Amplifying the voices of people and their communities across health and social care** – our work to listen to, engage with and represent all people and communities living in Wales.

3. **Delivering independent complaints advocacy** – our complaints advocacy function and how this complements the other parts of our work.

4. **Turning insight into influence and impact** – how we are developing insight functions and systems that drive impact, including data, evidence and introduction of our customer relationship management (CRM) system.

5. **Looking Ahead: maturity, collaboration and impact** – our priorities and what's next.

1. Establishing a trusted, people-centred organisation

Llais is the Citizens Voice Body for Health and Social Care in Wales, established in April 2023 under the Health and Social Care (Quality and Engagement) (Wales) Act 2020, to ***represent the interests of the public in respect of health and social services.***

We replaced the former Community Health Councils (CHCs) and continue to build on their proud legacy, drawing on their deep-rooted connection with communities and commitment to people's voice in healthcare.

Our remit now includes social care, requiring new approaches, but that ethos of standing alongside people and challenging constructively remains central to our organisation.

As an independent statutory body, we ensure the voices of people and communities are heard, without fear or favour, and help shape services across Wales. Our independence is both a safeguard and a strength. It reinforces our credibility, fosters trust, and enables us to challenge constructively and represent people with integrity.

We have a legal duty to seek people's views on health and social care services, represent those views to NHS bodies, local authorities and others, and support individuals in making complaints when things go wrong. These responsibilities ensure real experiences shape how services are planned, delivered, and improved.

Llais is accountable to Welsh Ministers through a common governance framework designed to support and enable our independence. This includes the Framework Document and our annual Remit Letter, which set out expectations for our role, performance, and relationship with the Welsh Government.

Our sponsoring Minister is the Cabinet Secretary for Social Justice, Trefnydd and Chief Whip, to whom our Chair is directly accountable for the performance of the Board.

Our Chief Executive Officer, Alyson Thomas, is the Accounting Officer for

1. Establishing a trusted, people-centred organisation

Llais and is responsible for the organisation's leadership, day-to-day operations, and financial stewardship.

We are governed by a Board comprising a non-executive chair and non-executive deputy chair, and 6 additional non-executive members. All these roles are appointed via the Public Appointments processes in Wales. Our Chief Executive is the only executive member of the Board.

The Board is also joined by a non-voting, associate member, who brings a staff perspective to the Board. Together, they provide strategic direction, assurance and oversight. Further details including the supporting structures of the organisation are available in our Organisational Relationship Map.

The current members of the Llais Board are:

Professor Medwin Hughes	Chair
Grace Quantock	Deputy Chair
Alyson Thomas	Chief Executive
Bamidele Adenipekun	Non executive member
Jack Evershed	Non executive member
Karen Lewis	Non executive member
Dr Rajan Madhok	Non executive member
Jason Smith	Non executive member
Vacancy	Non executive member
Mwoyo Makuto	Associate Member (non-voting)

Building a trusted, people-centred organisation through listening and partnership

Since launching in April 2023, Llais has worked to build a trusted national organisation rooted in the views and experiences of people across Wales. In our first 100 days, we listened to communities, staff, and partners to understand what people want from us.

People told us they want:

- A strong, independent voice that champions their experiences and views
- More opportunities to shape their services, especially when things change
- An organisation that is visible, accessible, and inclusive of all communities
- Help to navigate systems and provide support when things go wrong.
- Evidence that their voice makes a difference.

These messages shaped everything we've built: our vision, mission, strategic priorities, and ways of working. They also informed our 2024–2027 Strategic Plan, Annual Business Plans, behaviours framework, and ways of working.

Our Mission is to listen and make people's voices count in health and social care.

1. Building a trusted, people-centred organisation through listening and partnership

Our 5 strategic priorities (2024–2027)

We play a unique role: we are not a regulator, but an independent voice for people, working in partnership with health and social care services to drive change.

We've already worked with over a 1,000 organisations and community groups and built strong partnerships with Healthcare Inspectorate Wales, Care Inspectorate Wales, the NHS Executive, Local Authorities, the Public Services Ombudsman for Wales, Social Care Wales, the Commissioners' offices and many others. These partnerships support shared learning and joint approaches to improving care.

Our work alongside a wide range of third sector organisations, both nationally and locally, helps to make sure our work is informed by, and connected to, communities who experience the greatest barriers to being heard.

Internal culture and workforce development

The staff from the former Community Health Council movement transferred to Llais from the NHS under TUPE-style arrangements, helping to bring continuity of local knowledge, relationships, and experience across all regions of Wales.

Moving to a single independent organisation with a broader remit has meant big changes, including:

- Building new corporate arrangements from scratch (e.g. finance, HR, IT)
- Developing our own organisational values and behavioural standards, supporting a common cultur.
- Developing consistent ways of working across Wales.
- Expanding our focus to include social care.

We've made progress but have also faced challenges, such as:

- Creating, evaluating and recruiting to new, unique roles
- Equipping our people, through learning and development to deliver on our wider remit as a stand alone public body
- Long-term sickness and stretched teams
- The need for new digital systems and infrastructure
- Operating in a challenging financial landscape, alongside the rest of the public and third sectors in Wales.

Our teams are based in 10 locations across Wales, with strong links into regional and local networks. Llais has 107 funded staff posts (with 17 currently vacant) and 164 active volunteers. We continue to adapt as we learn more about where we can have the biggest impact.

Board structure and public accountability

Our diverse Board provides strategic direction, challenge, and accountability. Board meetings are held publicly across the 7 regions of Wales. This helps to make our governance and decision-making visible and rooted in local communities.

We publish all meeting details, papers, and links in advance, and actively encourage members of the public to attend and submit questions. In addition to making our Board papers bilingual, we are exploring using artificial intelligence to make our meetings and materials more accessible and inclusive, so that more people can engage with and understand our work.

1. Building a trusted, people-centred organisation through listening and partnership

We're strengthening our Board through:

- Ongoing recruitment
- A placement through the Aspiring Board Members Programme to improve diversity, as part of our commitment to the Antiracist Wales Action Plan
- Adding expertise in areas like digital and finance.

We've added independent members to our Audit and Risk Assurance Committee (ARAC) with expertise in digital, cyber, and finance to fill the experience gaps of our current members.

While some executive and non-executive member vacancies have taken time to fill, this remains a key focus, and we anticipate a fully constituted Board shortly.

Governance and financial assurance

We are committed to using Welsh public money effectively, transparently, and responsibly to maximise our impact.

Our governance framework has been developed in line with ***Managing Welsh Public Money***, supported by a published Framework Document, Standing Orders, Scheme of Delegation, and other key governance and control documents.

1. Building a trusted, people-centred organisation through listening and partnership

Our governance model includes:

- Our Board
- An active Audit and Risk Assurance Committee, and a Workforce, Remuneration and Terms of Service Committee, chaired by non-executive members of the Board
- Clear frameworks, structures and decision-making processes for financial control, risk management, performance monitoring, and compliance
- A published schedule of Board papers and documents.

We have procured an internal audit service from NHS Wales Shared Services Partnership. During 2023-2025 the internal audits programme gave us a reasonable assurance assessment. A recent audit on budgetary control and financial management received a substantial assurance assessment.

Audit Wales independently audited our 2023/2024 Annual Report and Accounts. The Auditor General for Wales issued an unqualified opinion and had nothing to report under the ongoing going concern sections.

This provides strong assurance of our governance and financial controls.

For Llais, governance is not just compliance; it enables impact, trust, and value for the people of Wales.

2. Amplifying the voices of people and their communities across health and social care

National Voice and strategic impact

Since we were established, over **70,000 people** have engaged with us through events, surveys, and community based outreach activities. We don't just listen – **we act on what we hear**.

We have a statutory right introduced by ***the*** Act to make **representations** when services are not meeting people's needs. NHS and local authorities must consider these and tell us what action they've taken.

Since our establishment, we have made over 800 representations across a range of issues, including access to NHS dental services, maternity care, and hospital discharge. We prioritise representations that reflect widespread concern or where action is urgently needed to improve people's experiences.

In 2025, we'll introduce **new standards** to improve how we make and follow up on representations. We know it's not enough to raise issues – people want to see what's changed.

In the future, we believe there is scope to work more closely with NHS Performance and Improvement to track and follow up responses to representations, helping to ensure that people's voices continue to shape better services, not just in principle, but in practice.

Hearing from people while they use services

We have also followed the Code of Practice on Access to Premises to visit settings where health and social services are provided to hear from people receiving those services. Since April 2023, we have done this **261 times** (213 health, 26 social care, 22 both health and social care).

2. Amplifying the voices of people and their communities across health and social care

We want to increase the number of social care settings we visit. However, several additional aspects must be considered when visiting some care settings to ensure that everyone has a chance to have their voice heard safely. This requires the development of our staff and volunteers, and our ways of working. We are working with partners such as Age Cymru, Care inspectorate Wales, and Social Care Wales on this area of development.

2. Amplifying the voices of people and their communities across health and social care.

What we're hearing from people

Across our engagement work, the most common concerns we hear from people include:

- Access to primary care: hard to get appointments, poor communication
- Mental health and neurodevelopmental care: delays and gaps
- Emergency care: long waits, overcrowding, ambulance delays
- Waiting times for treatment: especially for orthopaedics, gynaecology, hearing, and eye care
- Maternity services: inconsistent experiences and postnatal support
- Hospital discharge: rushed processes, poor support for carers
- Transport: major barriers to accessing services in rural areas
- System coordination: people feel passed around with little joined-up care.

Emerging themes

Concerns are growing around gender identity care, neurodivergent-friendly services, dental access, and involving carers more meaningfully.

People have also told us what works well:

- Dedicated staff
- Clear communication
- Joined-up care in some areas
- Community-based support and new mobile services

When people have told us that things are working well, we have driven change by sharing the things that work for people with other services.

2. Amplifying the voices of people and their communities across health and social care.

Local and regional engagement

Our engagement model is built from the ground up. We follow the National Principles for Public Engagement in Wales to guide our engagement, and we connect with people locally, regionally, and nationally through:

- Llais Locals: in-depth engagement in local communities
- Regional Public Fora: bringing people and partners together to talk about challenges and ideas in health and social care
- Regional Partnership Boards: our regional teams participate in all 7 Regional Partnership Boards across Wales, bringing people's lived experience directly into integrated planning for health and social care
- Thematic projects in each region, including on cancer care, school nursing, dementia, and carers' experiences.

Our National Insights and Engagement Team supported the local team to speak to over 500 people about their experiences of maternity and neonatal services provided by Swansea Bay University Health Board. The stories we heard revealed both compassionate care and areas of deep concern. We shared these insights in a major report, contributing to the ongoing Independent Review and influencing local and national action.

Our report, discussed by the Cabinet Secretary for Health and Social Care in the Senedd, shows how lived experience can and must shape safer, more compassionate care.

2. Amplifying the voices of people and their communities across health and social care.

National-level engagement and campaigns

On an All-Wales basis, we have driven our ***National Conversation*** at events such as the **Royal Welsh Show, National Eisteddfod, Pride Cymru**, and **Minority Ethnic Communities Fair**.

Examples of national work include:

Our all-Wales project on Getting urgent and emergency healthcare was sparked by concerns from local communities and partners about corridor care and system pressures. We heard from more than 700 people through visits, an online survey, and focus groups.

We teamed up with the Bevan Commission and the Institute for Health Improvement to launch the "Silly Rules" campaign. This asked staff and the public which rules or processes get in the way of better care. We heard from over 780 people as part of the Silly Rules campaign. The findings will be published in Summer 2025.

2. Amplifying the voices of people and their communities across health and social care.

Supporting public voice in service change

When health or social care services want to make changes to their services, it's important that the people and communities that may be affected are involved from the start.

Unlike under the former Community Health Councils model, Llais is not required to get actively involved in every proposed change to health and social care services. Under the current requirements, duty to engage and involve people lies directly on NHS bodies and local authorities.

We've been involved in hundreds of service changes since April 2023. We get actively involved where people's voices need to be heard.

Where appropriate, we make representations based on what we hear and support people to raise their own concerns. This supports our strategic priority to push for services that meet everyone's needs.

Examples:

Emergency Medical Retrieval and Transfer Service review: We worked closely with those leading the service change to extend the arrangements for engaging with people so more people could have their say at key stages. We also challenged aspects of public engagement and the clarity of information being shared because meaningful involvement can't happen without clear and open communication.

Laugharne GP service: We worked alongside the community to ensure their voices were heard and considered as part of the decision-making process.

This short video captures that journey from the perspectives of those directly affected, showing how meaningful involvement can shape the future of services: Laugharne Surgery

2. Amplifying the voices of people and their communities across health and social care.

Influencing policy

We have shared what we hear with policy makers and others when they're seeking views on plans or proposals for health and social care in Wales.

We've responded to **38 national consultations** and submitted evidence to inquiries on key issues like:

- GP services
- Cross-border care
- Hospital discharge
- Neurodivergent code of practice
- Emergency and dental care
- Data justice and the use of personal data.

We also publish **position statements** rooted in public experience.

Dentistry: Dental care crisis in Wales: Llais calls for urgent action to ensure fair access for all

New NHS Wales targets: New NHS Wales targets are welcome; most importantly change must be felt by people and communities quickly

These help ensure that people's voices contribute to national conversations and influence decisions that affect them.

2. Amplifying the voices of people and their communities across health and social care.

Reaching underrepresented voices

As part of our commitment to equity and inclusion, we've worked with a wide range of organisations, including local authorities, community groups, statutory bodies, and equality organisations, to reach people whose voices are often underrepresented in health and social care conversations.

- Minority ethnic communities
- Deaf communities
- Young people
- Carers
- Gypsy, Roma and Traveller communities.

We use **community-led videos**, events, and partnerships to ensure voices are heard in ways that are respectful, accessible, and culturally appropriate.

We've also taken part in national and local events including the Creating an Anti-Racist Wales Summit, the Minority Ethnic Communities Health Fair, and regional 'Chai and Chat' conversations, helping us to hear from people directly in settings that feel accessible and welcoming.

We collaborated with partners working with black communities about their mental health to understand people's experiences and amplify their voices. See this short video.

We also co-produced a second video with young people, focused on mental health services.

2. Amplifying the voices of people and their communities across health and social care.

Understanding who we hear from

We're improving how we record and understand equality, diversity and inclusion data – working with Healthcare Inspectorate Wales and Care Inspectorate Wales, and updating our Customer Relationnship Management (CRM) system to spot gaps so we can better target our outreach activities.

In 2025/2026, we're prioritising the integration of diversity fields into our CRM system, helping us track who we're engaging with, where gaps remain, and what action is needed to ensure everyone's voice is heard and understood.

Digital inclusion

In support of our strategic priority to help people and services to use technology in ways that work for them we have focused on digital Inclusion by joining the Digital Inclusion Alliance Wales, signing the digital inclusion charter, partnering with Digital Health and Care Wales on a Patient and Public Experience group to share people's views on the NHS Wales App design and development, and supported Welsh Government discussions around possible MedTech, AI, and Minimum Digital Living Standards in the future.

Volunteering with Llais

Our volunteer network plays a vital role in helping us reach more people and build trusted local connections across our communities.

We launched a new Volunteering Strategy in 2024. Since April 2023:

- **315** volunteers have supported our work
- **8,750+ hours** of volunteer time has been given
- New and flexible opportunities have been introduced to suit people's time and skills.

These videos featuring our volunteers offer a glimpse into what it's like to be part of Llais and the difference they help make: What it's like to Volunteer with Llais

2. Amplifying the voices of people and their communities across health and social care.

Awareness and visibility

Llais has a statutory duty to promote awareness of our functions and ensure people across Wales know how to access our services. This duty is also placed on NHS bodies and Local Authorities, recognising the shared responsibility to make sure people understand their rights and how their voices can influence health and social care services. We're raising awareness through:

- Posters, leaflets, and outreach
- Social media and media coverage (186 media story mentions in 2024–2025)
- Partnerships and paid campaigns (e.g., bus ads, radio)
- A growing digital presence (website visits, e-newsletters).

This mix of channels has helped us build recognition of Llais as the citizens voice body in Wales, while making it easier for people to share their experiences, take part in projects, and seek help through our complaints advocacy service.

We're reviewing our approach to make sure we reach **younger, rural, and digitally excluded people**.

2. Amplifying the voices of people and their communities across health and social care.

Our commitment to Welsh Language

We have taken steps to ensure we are compliant with our statutory duties relating to the Welsh Language Standards, and we are actively supporting the Welsh Government's ambition for a bilingual nation through Cymraeg 2050 and the More Than Just Words framework.

- We completed an internal self-assessment against the Welsh Language Standards and developed an action plan to improve how we meet and exceed our duties.
- We offer bilingual services across our channels and support Welsh language use in our teams. Over 40% of our staff can speak and understand spoken Welsh, and we're encouraging more staff to learn.
- We have reviewed our recruitment approach and are taking steps to strengthen our Welsh language presence and culture.
- We established an internal Welsh Language Working Group, made up of staff and volunteers who speak or are learning Welsh. The group shares ideas on how we can actively promote the Welsh language in our day-to-day work, foster a bilingual culture across Llais, and build confidence among colleagues to use more Welsh in their roles.

2. Amplifying the voices of people and their communities across health and social care.

People's Stories

We're sharing more real-life stories to bring people's experiences to life and highlight what needs to change. This will grow in the year ahead.

Over the past year, we have begun to share more of these powerful insights, including Frank and Anne's story about navigating dementia services, or Ally John's story about getting help for her son's mental health. We want to build on this approach, creating more opportunities for people to share their experiences in ways that are accessible, meaningful, and impactful. This will be a growing part of our engagement, advocacy, and influencing work in the year ahead.

3. Delivering independent complaints advocacy

Our Approach

Helping people raise concerns when care goes wrong is a key part of our role.

Our complaints advocacy service:

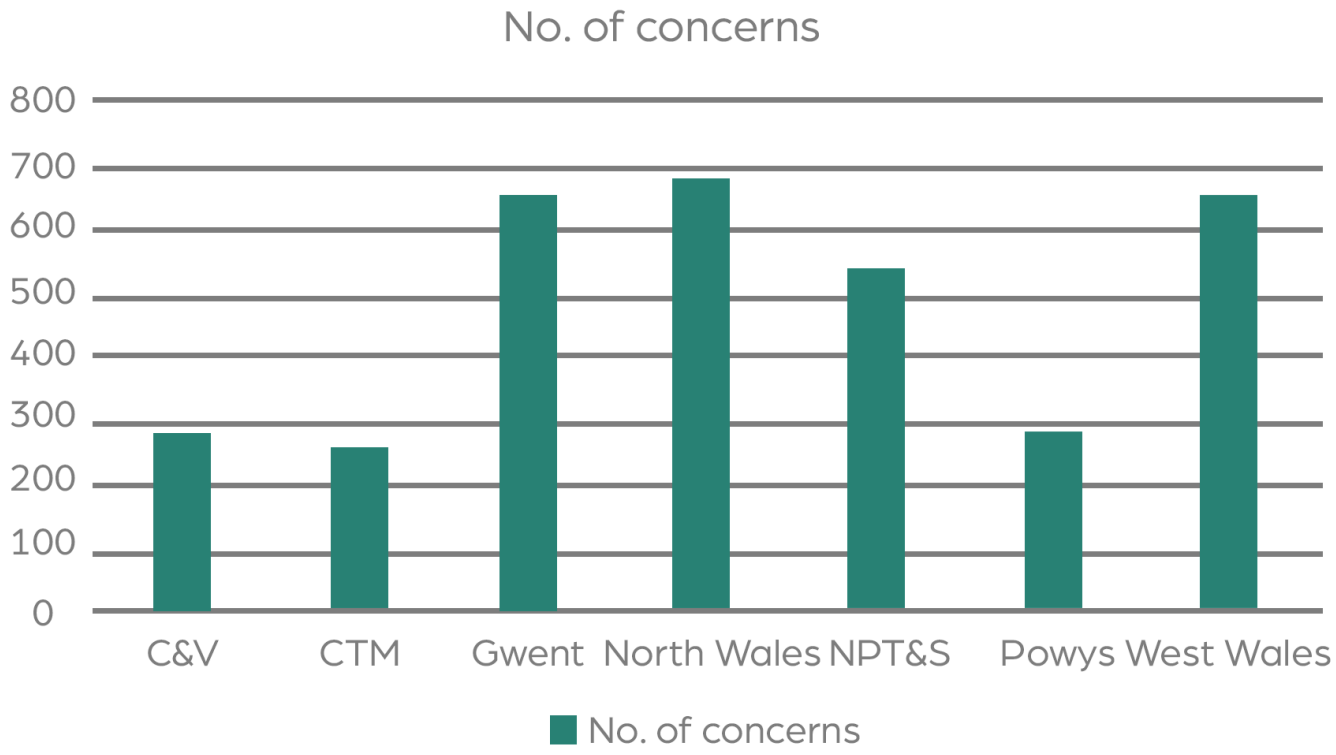
- Explain how NHS and social care complaints processes work
- Help and support people to voice their concerns through writing letters, completing forms, and attending meetings
- Offers flexible support that fits individual needs
- Work in a confidential, trauma-informed, and person-centred way.

Demand and Regional Variation

Since April 2023, we've handled:

- 6,343 enquiries and complaints
    - 2,973 individual enquiries
    - 3,370 complaints advocacy cases (2,550 health | 820 social care).

Demand for our complaints advocacy service is highest in our Gwent, North Wales, and West Wales regions. While some of this reflects the size of the population in these regions, we're exploring this further to see whether this also reflects awareness, service issues, or both.



The concerns people raise

The concerns people raise often reflect deep-rooted challenges across both health and social care systems.

In healthcare, common issues include:

- Long waits for access to GP appointments and specialist referrals
- Missed or delayed diagnoses, sometimes with serious consequences
- Unsafe hospital discharge planning
- Breakdowns in communication, between services and with individuals
- Distressing maternity and emergency care experiences
- Lack of clear complaints guidance
- Emotional toll on individuals and families.

In social care, concerns include:

- Inadequate support in care homes, especially at end-of-life
- Confusing or uncoordinated services
- Discrimination and lack of trust, including claims of being misrepresented or coerced by services
- Long waits for children's mental health support
- Gaps in help for adults with mental health needs
- Emotional distress caused by trying to secure safe, compassionate, and consistent care.

Rising Complexity and Our Response

We are supporting more **complex, multi-agency cases**, including people with additional communication needs.

To support this work and respond to the rising complexity:

- We created a **Head of Complaints Advocacy** role to lead service improvements. This work programme is designed to ensure our team has the right knowledge, tools, and support to meet the rising complexity of the issues we're seeing, while also delivering a high-quality, compassionate service for the people we support.

- We launched a **specialist cancer complaints advocate**, in partnership with **Tenovus**, to support people with cancer to raise their concerns.

Broadening access to our service

We are developing a clearer understanding of where our referrals for complaints advocacy services come from. We promote our service through:

- Community settings (libraries, health events, support groups)
- Referrals from engagement events
- Accessible materials in plain language
- Statutory and community partners.

There are **limits to who we can support**, due to statutory rules. For example:

- We can support NHS complaints from children and young people – but **not those under social care**
- We can support people **self-funding care in regulated social services** – but **not people self-funding private healthcare**.

These boundaries can be confusing for the public and staff. We're raising this with Welsh Government and partners to support clearer access and responsibility across the system for addressing concerns.

Using Advocacy Insights to Improve Services

Our complaints advocacy work often reveals wider issues in the system. We are working to link individual advocacy cases to broader service improvement and policy change.

3. Delivering independent complaints advocacy

Examples:

- A complaint in Powys about gender service access led to services being delivered locally via GPs

- A complaint about a GP-related medical emergency led to staff training and a review of local protocols.

These examples show how personal advocacy can drive systemic improvement, and why we are committed to deepening the connections between our complaints advocacy work, our insights, and our influence.

Building strong systems behind powerful stories

From the beginning, we knew that **people's stories alone aren't enough** – we also need the right systems and evidence to back them up.

We're continuing to develop the right tools, processes, and learning to:

- Listen well
- Record what we hear
- Analyse it clearly
- Use it to influence decisions across health and social care.

We've introduced a **national Customer Relationship Management (CRM)** system to track and analyse all our engagement, advocacy, and representation work. It helps us see:

- What people across Wales are telling us
- Where the biggest concerns are
- How we're responding.

Although the system is still in development, we're:

- **Training staff** and building shared standards
- Running **data quality checks** and **"super user" groups**
- Supporting teams to use it well and confidently.

Building this system takes time, specialist expertise, and ongoing staff input. We're balancing this carefully with the need to continue our **frontline activity**.

We're also ensuring that the CRM system is:

- Safe and secure
- Built around **clear data governance**
- Fully compliant with privacy and permissions standards.

Using insight to influence services

We are increasingly combining quantitative and qualitative insight to tell a fuller story. This includes:

- Thematic analysis of recurring concerns (e.g. GP access, maternity care)
- Complaints advocacy insights feeding into wider representations
- Case studies and video stories to highlight lived experience
- Regional differences reflected in both local and national engagement.

We're also working with NHS Wales **Performance and Improvement** to:

Better understand what data the public wants to see (e.g. wait times, outcomes).

Explore **joint data-sharing** through the People Experience Framework.

We're now looking to mirror this work in **social care**, where data systems are less developed. We've started early conversations with Social Care Wales, Care Inspectorate Wales, and others to improve how people's experiences are captured and used.

Growing our insight function

Our next steps include:

Improving how we **categorise/group and describe issues** in the CRM system.

Enabling **trend analysis** and linking engagement, complaints advocacy, and action.

Creating **tailored reports** for NHS, local authorities, and government.

Exploring more routine, public sharing of insight so people can see how their voice is making a difference.

By combining real life experiences, expressed in people's own words with wider data and embedding responsible data handling throughout our work, we want to further strengthen the power of people's voices in informing and influencing the design, development and continuous improvement of health and social care services for everyone in Wales.

Our focus for the future

As Llais moves forward, our goal is to **strengthen how we support people's voices to be heard**, especially those who are often under-represented. We want to:

- Make public involvement more meaningful and inclusive
- Develop smarter systems and stronger evidence
- Build deeper partnerships across health and social care
- Invest in our people, tools, and leadership.

National engagement projects – voice into influence

We're focusing on 2 major All-Wales engagement projects this year. They represent a step-change in how we listen to and work with people across Wales:

1. Rights, Expectations and Responsibilities

A national conversation on what people should expect from health and care services. It explores:

- People's rights
- Their expectations
- Shared responsibilities between the public and services.

This will result in a practical framework for improving how services communicate, listen, and act.

2. Getting care and support through Integrated Community Care Hubs

We'll be hearing from people using local joined-up services to understand:

- Access and availability
- Digital options
- How smoothly care is coordinated.

We want these insights to help shape future planning and service improvement.

Later in 2025, we'll also host our first **Voices for Change summit**, a national event to:

- Share lived experiences
- Present our project findings
- Bring people and decision-makers together to influence service design and delivery improvement.

Strengthening community power and local voice

At the same time, we are focusing on building stronger communities through the way we engage with people and support their active involvement in their health and social care services. We're building long-term relationships with groups such as:

- Carers' forums
- GP patient groups
- Mental health service users.

We're embedding **equity and anti-racism** into all national engagement and ensuring our volunteers help gather local feedback in meaningful ways.

We are also improving how we track **diversity data** to help us make sure we are hearing from everyone.

Expanding our role in digital and data

People want **clear data** on how their services are performing.

That's why we are:

- Investing in our **CRM system** and analytics
- Combining complaints, advocacy, and survey feedback to give a fuller picture
- Working with NHS Performance & Improvement to share useful data in ways people understand and can use.

5. Looking ahead: maturity, collaboration and impact

We want to better understand what people want to know, how they want to see it, and how best to provide it at national and local levels.

Growing our reach in social care

We want to deepen our focus on supporting people to have a stronger voice in social care. While our role spans both sectors, our legacy and systems are more established in health, so we are now sustainably and purposefully expanding our understanding and reach in social care. This year:

- Each region will hold **listening events in 2025–2026**
- We'll host **regional Health and Social Care Summits**
- Nationally, we're partnering with organisations like Social Care Wales and ADSS Cymru to increase our visibility and influence.

Strengthening accountability and service improvement

Following the introduction of the duties of quality and candour for the NHS in Wales, we will be focusing on using what we hear from people to understand whether and how these duties are making a real, meaningful difference in people's experience of NHS care.

This is part of our commitment to working with NHS and social care organisations to support their learning, shine a light on gaps, and use our independent voice to call for improvement.

We are the host organisation for the **Maternity and Neonatal Voice Partnership (MNVP) Cymru**, which supports a network of local voices helping shape maternity care across Wales. This is a **new model** for Llais, and we will use what we learn from this to think about whether there is scope to extend this to other areas in the future.

We are working to make our feedback loops stronger, so people can see how their voice made a difference, whether locally or nationally. We want people to see what happens when they speak up. That's why we're introducing more:

- Digital stories
- Interactive summaries
- Community updates, tailored to local areas.

We want to do more to routinely share our insights and work together with partners like the **Older People's Commissioner** and **Children's Commissioner** to help amplify people's voices and influence wider policy to make the biggest difference by using our collective resources to best effect.

5. Looking ahead: maturity, collaboration and impact

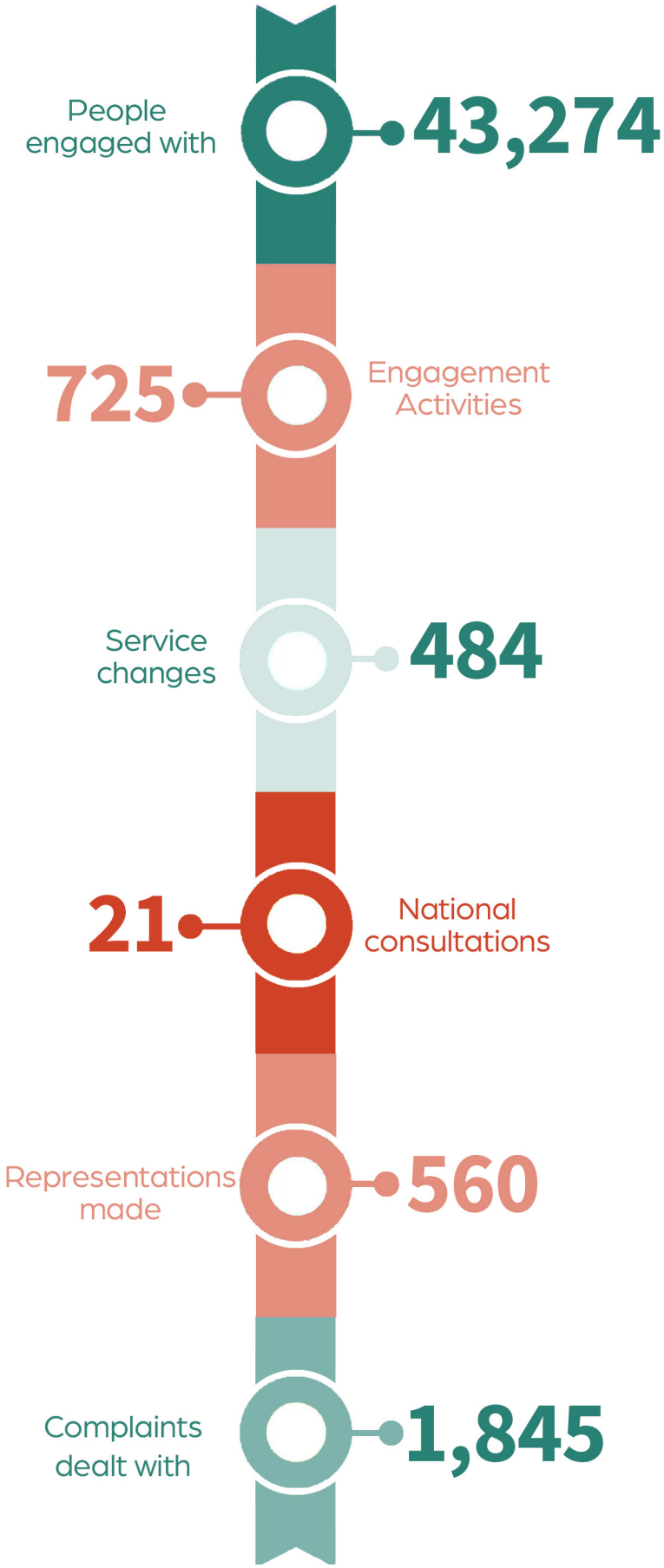
Measuring our impact

We are developing better ways to track:

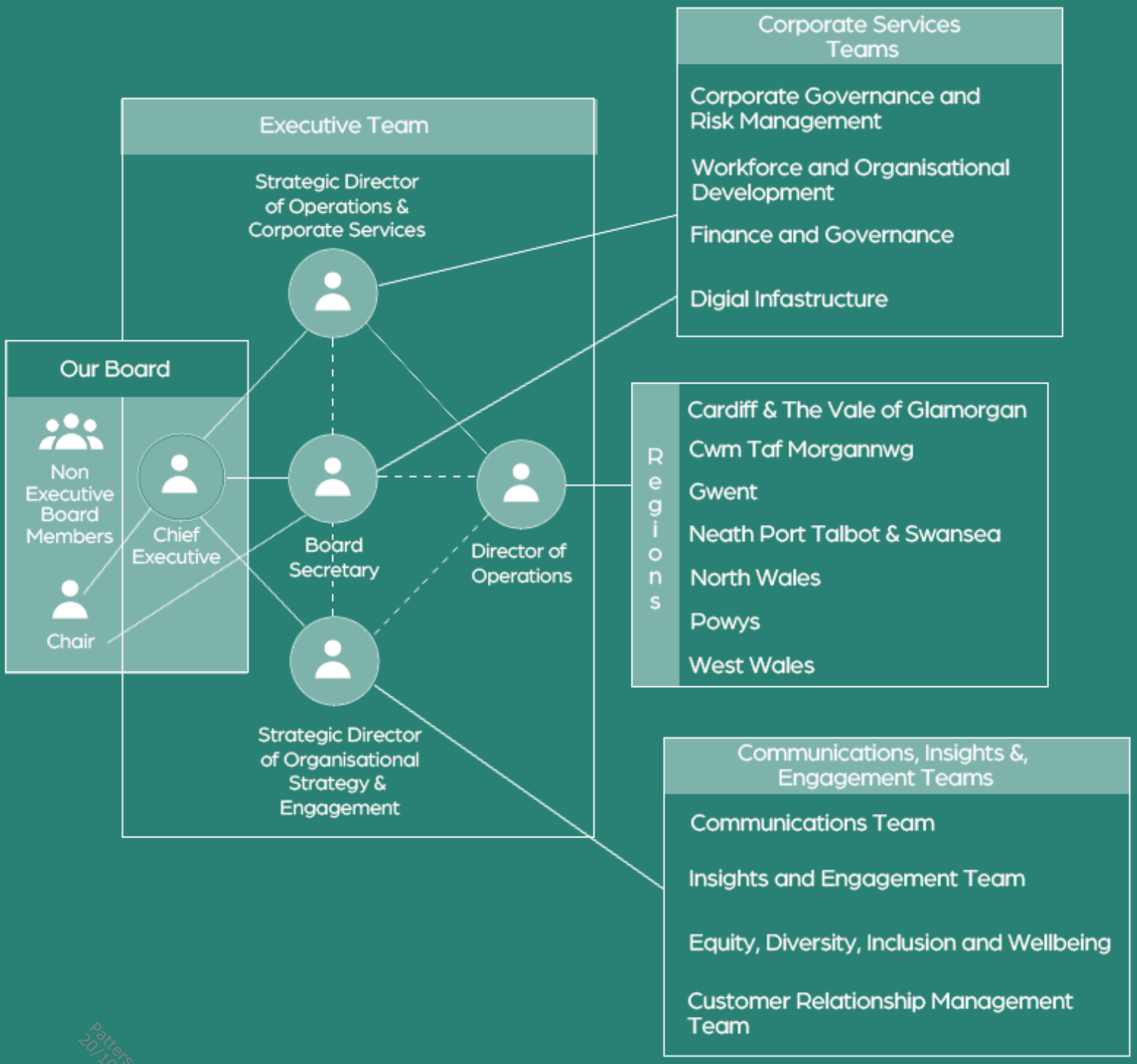
- **Reach**: How many people we engage
- **Influence**: Where we are shaping decisions
- **Outcomes**: What changes as a result.

We will use both quantitative indicators (e.g., engagement levels, response rates) and qualitative methods (e.g., case studies, co-produced evaluation) to assess how well we are meeting our purpose.

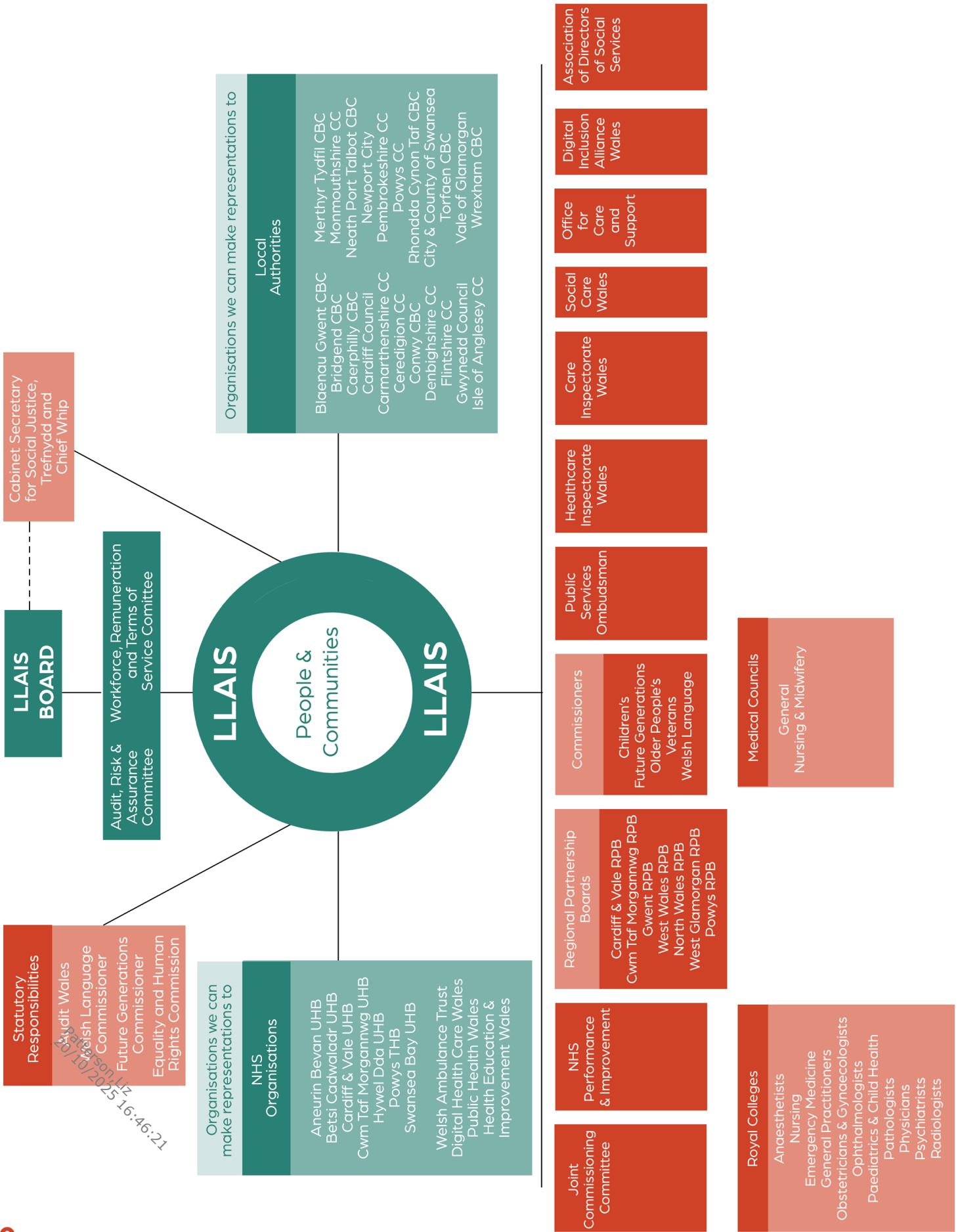
Appendix 1: Our year in numbers:



Appendix 2: Llais governance



Appendix 3: Llais relationship map



Ombwdsmon
Ombudsman
Cymru · Wales

Ask for: Communications
01656 641150
caseinfo@ombudsman.wales

Date: 30 September 2025

PERSONAL & CONFIDENTIAL
Carl Cooper
Powys Teaching Health Board

By email only
carl.cooper@wales.nhs.uk
hayley.thomas@wales.nhs.uk
[redacted]

Dear Carl Cooper

Annual Letter 2024-25

Role of PSOW

As you know, our role as the Public Services Ombudsman for Wales is to consider complaints about public services, to investigate alleged breaches of the councillor Code of Conduct, to set standards for complaints handling by public bodies and to drive improvement in complaints handling and learning from complaints. We also undertake investigations into public services on own initiative.

Purpose of letter

Through this letter, we want to give you an update on our work, share key trends in complaints about local government in Wales and highlight any particular issues for your organisation, together with actions I would like your organisation to take.

Complaints about public services

This letter, as always, coincides with the publication of our Annual Report. Again, we saw an increase in the number of people contacting us about public services. Since 2019-20, the volume of new complaints about public services reaching our office has increased by 44%.

We also closed a record number of complaints about public services – 5% more than last year. This year, we intervened (found that something has gone wrong, and recommended how to put things right) in 18% of complaints that we closed. Positively, this year we resolved many more complaints early on. 87% of our interventions this year involved Early Resolution, compared to 70% in 2023-24.

ombwdsmon.cymru
holwch@ombwdsmon.cymru
0300 790 0203
1 Ffordd yr Hen Gae, CF 35 5LJ
Rydym yn hapus i dderbyn ac ymateb i ohebiaeth yn y Gymraeg.

ombudsman.wales
ask@ombudsman.wales
0300 790 0203
1 Ffordd yr Hen Gae, CF 35 5LJ
We are happy to accept and respond to correspondence in Welsh.

We understand that people who come to us want their complaints resolved as quickly as possible and we are committed to dealing with them in a timely manner.

Overall, we assessed incoming complaints, or intervened with an Early Resolution, within an average of 4 weeks; well within our target of 6 weeks. We have also reduced the time it takes us to complete an average investigation, from 64 weeks in 2023-24, to 53 weeks this year.

During 2024-25, we received 949 complaints about health boards. This is an increase of only 1% since last year, and shows that the rate of increase in health board complaints is still slowing down. Still, we are now receiving 26% more complaints about health boards than in 2019-20.

Predictably, most complaints about health boards concern health services. By far, the most common area of these complaints is clinical treatment in hospital. In addition, about 16% of complaints about health boards related to complaint handling. This was a welcome drop from 18% the year before.

We intervened in 27% of health board complaints that we closed – compared to 31% last year.

In 2024-25, we received 20 complaints about Powys Teaching Health Board and closed 25 – some complaints were carried over from the previous year. Powys Teaching Health Board's intervention rate was 24%. You can find detailed information on complaints about your organisation that we handled this year can be found in the appendices.

We made 16 recommendations to your organisation during the year. To ensure that our investigations and reports drive improvement, we follow up compliance with the recommendations agreed with your organisation. In 2024-25, 12 recommendations were due. 33% of the recommendations due was complied with in the timescale agreed. Recommendations and timescales for complying with recommendations are always agreed with the public body concerned before being finalised, and we therefore expect organisations to comply within the timescales agreed.

Supporting improvement of public services

We continued our work on supporting improvement in public services.

During 2024-25, we concluded our second wider own initiative investigation which looked into unpaid carers' needs assessments in Wales. We considered whether 4 local councils – Caerphilly, Ceredigion, Flintshire and Neath Port Talbot - undertook carers' assessments in line with their statutory obligations.

We published the report on this investigation in October 2024. We found that only 2.8% of people in those council areas who identified as carers had received a needs assessment. In addition, only 1.5% had received a proper support plan following their assessment. Many carers were also not aware of their rights with regard to assessments and support services that might be available to them.

We identified some areas of good practice by the councils we investigated. However, we also made several recommendations including to:

- improve recording practices
- improve how information is shared with carers
- offer staff refresher training on carers' rights
- collaborate better with the healthcare sector.

We invited the other local councils in Wales to make similar improvements.

As we did in the case of our first own initiative investigation, we have been actively monitoring how organisations' have been complying with our recommendations.

We are planning to review compliance with the recommendations and any other impacts of the report in October 2025.

Currently 54 organisations across Wales operate our model complaints policy. This includes all local councils, all health boards and now most housing associations - representing about 85% of the complaints which we receive.

Our offer of free complaints handling training has remained popular and we provided a further 52 training sessions to public bodies across Wales during the year. This brings the total to 550 training sessions and 10,000 people, since 2020.

We have continued our work to publish complaints statistics, gathered from public bodies, with data published twice a year. We expect to publish the data on complaints handled by local councils in Wales during 2024-25 in the Autumn. This data allows us to see information with greater context – for example, during 2024-25, 6.13% of complaints made to NHS bodies went on to be referred to us.

Finally, this year we also published 1 thematic report, which included as case studies complaints about health boards:

- 'Equality Matters' (January 2025): a thematic report on inclusion and accessibility across public services.

This report includes general recommendations for public service providers, drawing on lessons learned from our casework.

Action we would like your organisation to take

Further to this letter can I ask that your organisation takes the following actions:

- Present my Annual Letter to the Board at the next available opportunity and notify me of when these meetings will take place.

- Consider the data in this letter, alongside your own data, to understand more about your performance on complaints, including any patterns or trends and your organisation's compliance with recommendations made by my office.

- Provide my office with a copy of the Health Board's Annual Report for 2024-25 on the Duty of Candour and Quality.

- Inform me of the outcome of the Board's considerations and proposed actions on the above matters at your earliest opportunity.

I would like to thank you, and your officers, for your continued openness and engagement with my office.

Yours sincerely

Michelle Morris

Michelle Morris
Public Services Ombudsman

Cc. Hayley Thomas, Chief Executive, Powys Teaching Health Board
[redacted]

Information Sheet

Appendix A shows the number of complaints received by PSOW for all health boards in 2024-25. These complaints are contextualised by the population of each authority.

Appendix B shows the categorisation of each complaint received, and what proportion of received complaints represents for the Health Board.

Appendix C shows intervention rates for all health boards in 2024-25. An intervention is categorised by either an upheld complaint (either public interest or non-public interest), an early resolution, or a voluntary settlement.

Appendix D shows outcomes of the complaints which PSOW closed for the Health Board in 2024-25. This table shows both the volume, and the proportion that each outcome represents for the Health Board.

Appendix E shows the compliance performance of each health board.

Appendix A – Complaints received (overview)

Health Board	Complaints Received	Population	Received per 1,000 residents
Aneurin Bevan University Health Board	178	595412	0.30
Betsi Cadwaladr University Health Board	236	691991	0.34
Cardiff and Vale University Health Board	149	518269	0.29
Cwm Taf Morgannwg University Health Board	102	446514	0.23
Hywel Dda University Health Board	130	388139	0.33
Powys Teaching Health Board	20	134439	0.15
Swansea Bay University Health Board	134	389640	0.34
Welsh Ambulance Services University NHS Trust	24	-	-
Total	**973**	**3164404**	**0.28**

Appendix B – Complaints received (by organisation)

Powys Teaching Health Board	Complaints Received	% Share
Admissions/discharge and transfer procedures	0	
Adult Mental Health	2	10%
Ambulance Services	0	
Appointment procedures (including outpatients)	0	
Care Homes	0	
Child and Adolescent Mental Health	1	5%
Clinical treatment in hospital	7	35%
Clinical treatment outside hospital; Dentist	0	
Clinical treatment outside hospital; GP	0	
Clinical treatment outside hospital; Other	0	
Clinical treatment outside hospital; Physiotherapist	0	
Complaints Handling	0	
Confidentiality	1	5%
Continuing care	3	15%
De-Registration	1	5%
Disclosure of personal information / data loss	0	
Funding	0	
Gender Identity Funding	0	
Health	3	15%
Housing	0	
Medical records/standards of record-keeping	0	
Medication > Prescription dispensing	2	10%
Non-medical services	0	
Nosocomial (Framework)	0	
Other	0	
Out of Hours GP care	0	
Patient list issues	0	
Poor/No communication or failure to provide information	0	
Prisoner Care	0	
Referral to treatment time	0	
Rudeness/inconsiderate behaviour/staff attitude	0	
Various Other	0	
Total	**20**	

Appendix C – Cases with PSOW intervention (overview)

Health Board	No. of interventions	No. of closures	% of interventions
Aneurin Bevan University Health Board	50	176	28%
Betsi Cadwaladr University Health Board	64	227	28%
Cardiff and Vale University Health Board	27	154	18%
Cwm Taf Morgannwg University Health Board	36	104	35%
Hywel Dda University Health Board	43	131	33%
Powys Teaching Health Board	6	25	24%
Swansea Bay University Health Board	33	136	24%
Welsh Ambulance Services University NHS Trust	4	29	14%
Total	**263**	**982**	**27%**

Appendix D – Complaint outcomes (by organisation) (* denotes intervention)

Powys Teaching Health Board	Complaint Outcomes	% Share
Complaint investigation discontinued (with early resolution at assessment stages)*	0	
Complaint investigation discontinued (without settlement)	0	
Decision not to investigate complaint	8	32%
Early resolution*	5	20%
Matter out of jurisdiction	5	20%
Non-public interest report issued: complaint not upheld	1	4%
Non-public interest report issued: complaint upheld*	1	4%
Non-public interest report issued: complaint upheld with early resolution at assessment stage*	0	
Premature	5	20%
Public interest report issued: complaint upheld*	0	
Public Interest report issued: complaint upheld with early resolution at assessment stage*	0	
Special Interest Report*	0	
Voluntary settlement*	0	
Total	**25**	

Appendix E – Compliance performance comparison

Health Board	Number of recommendations made on complaints closed in 2024-25	Number of recommendations falling due in 2024-25	% of recommendations, complied with in line with agreed target date
Aneurin Bevan University Health Board	136	160	66%
Betsi Cadwaladr University Health Board	196	210	65%
Cardiff and Vale University Health Board	72	96	70%
Cwm Taf Morgannwg University Health Board	101	118	42%
Hywel Dda University Health Board	137	140	89%
Powys Teaching Health Board	16	12	33%
Swansea Bay University Health Board	86	86	64%
Welsh Ambulance Services University NHS Trust	18	6	33%

Dr Carl Cooper, Cadeirydd / Chair
E-bost / Email: carl.cooper@wales.nhs.uk

Hayley Thomas, Y Prif Weithredwr / Chief Executive
E-bost / Email: hayley.thomas@wales.nhs.uk

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

08 October 2025

Michelle Morris
Public Services Ombudsman for Wales
By email: caseinfo@ombudsman.wales

Dear Michelle Morris,

Re: Annual Letter 2024–25

Thank you for your Annual Letter dated 30 September 2025, and for the constructive feedback and insights it provides on the trends in complaints and our performance within Powys Teaching Health Board (PTHB). I also extend my thanks to you and your office for your continued engagement and support in helping us strengthen our complaints handling processes and ensure that we deliver the best possible services for our population.

We acknowledge the findings outlined in your letter, in particular:

- **Complaint volumes and intervention rates:** We note that PTHB received 20 complaints during 2024–25 and that our intervention rate stood at 24%, which is broadly in line with the Welsh average. We also recognise that clinical treatment in hospital remains the most common area of complaint and are taking steps to ensure that learning from these cases informs service improvement.

- **Compliance with recommendations:** We are concerned by the reported compliance rate of 33% with recommendations due in 2024–25. We accept that this performance is below the standard we expect of ourselves and are taking immediate action to strengthen our internal monitoring and escalation processes to ensure that agreed recommendations are implemented within the timescales set.

Pencadlys
Tŷ Glasbury, Ysbyty Bronllys,
Aberhonddu, Powys LD3 0LU
Ffôn: 01874 712730

CYFLOGWR YSTYRIOL MINDFUL EMPLOYER

Headquarters
Glasbury House, Bronllys Hospital
Brecon, Powys LD3 0LU
Tel: 01874 712730

- **Duty of Candour and Quality Report:** In line with your request, we have provided your office with a copy of the Health Board's 2024–25 Quality Annual Report with this letter.

- **Board consideration of the Annual Letter:** Your letter will be presented to the next formal meeting of the Board, scheduled for 26th November 2025. A record of the Board's discussion, along with the proposed actions, will be shared with your office following that meeting.

For information, we are also undertaking a review of complaint themes and patterns, drawing on both our internal data and the insights from your office, to identify areas where we can drive further improvement. This work will be supported by additional staff training and refreshed reporting arrangements to ensure greater transparency and accountability.

Finally, I want to reiterate our commitment to transparency, candour, and learning from complaints. We value the role your office plays in supporting continuous improvement and look forward to building on our positive relationship.

Yours sincerely,

Dr Carl Cooper
Cadeirydd | Chair

cc Hayley Thomas, Chief Executive, PTHB
Simon Wright, Chair, Patient Experience, Quality & Safety Committee, PTHB

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

Agenda item: 5.2

Patient Experience, Quality and Safety Committee	**DATE: 23 OCTOBER 2025**
Subject:	**Maternity Services Assurance Report**
Approved and presented by:	Paul Hooton, Executive Director of Nursing, Women and Family Health
Prepared by:	Director of Midwifery, Women and Family Health
Other Committees and meetings considered at:	Executive Committee - 15 October 2025

PURPOSE:

This paper provides assurance to the Patient Experience, Quality and Safety Committee on the safety and quality of maternity services within Powys Teaching Health Board, in the context of national scrutiny and recent independent review findings. It outlines the service's position against the independent review into maternity services at Swansea Bay UHB and corresponding recommendations, supporting scrutiny, challenge, and continuous improvement in line with both local and national expectations.

RECOMMENDATION(S):

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

- Take **ASSURANCE** on the assessment and actions identified against the Swansea Bay maternity report.
- **NOTE** a wider update will be provided in February 2026 relating to maternity services for Powys patients, including an update on the national assessment work currently taking place.

Approve/Take Assurance	Discuss	Note
Y	Y	Y

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:		
1. Focus on Wellbeing	Y	This paper provides assurance regarding the strategic priority 3 – Women and Family Health.
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	N	

EXECUTIVE SUMMARY:

Since 2016, maternity services across Wales have been under increasing scrutiny, driven by the national ambition to reduce stillbirths, neonatal deaths, and intrapartum brain injuries by 2025. More recently, an Independent Maternity Services Review at Swansea Bay University Health Board, prompted system-wide reflection and improvement across Welsh Health Boards.

Commissioned by Welsh Government, and led by NHS Performance and Improvement, a comprehensive, All-Wales Maternity and Neonatal Assurance Assessment is currently underway, to evaluate the safety and quality of care provided in maternity and neonatal services across Wales. It is expected that the findings of this assessment will be published in December 2025.

This paper provides assurance to the Patient Experience, Quality and Safety Committee on the safety and quality of maternity services within Powys Teaching Health Board (PTHB), aligning with both local priorities and national expectations. The paper outlines the service position against the recommendations set out in the Swansea Bay report. The paper also outlines current progress relating to the Maternity and Neonatal Assurance Assessment.

This paper is submitted for scrutiny, challenge and oversight at Committee, supporting PTHB's commitment to continuous improvement and the delivery of safe, high-quality maternity care.

Given that the routine reporting of the quality and safety of maternity services is undertaken through the Integrated Quality and Performance Framework, allowing for both internal and external scrutiny and oversight, this paper will not duplicate this function.

POSITION SUMMARY:

The Swansea Bay report sets out 10 recommendations, specific to the organisation. These have been translated into the maternity service at PTHB, enabling self-assessment, gap analysis and key quality improvement plans. The progress summary and assurance scoring of the 10 recommendations is outlined in Appendix 1. This section summarises PTHB position against each of the 10 recommendations.

1. Single Point of Access for Triage

Create a unified triage system for all women to ensure timely and consistent access to maternity care.

Local Provision:

The Birmingham Symptom-specific Obstetric Triage System (BSOTS) is a nationally recognised, standardised triage model that uses symptom-based

algorithms and colour-coded urgency ratings to prioritise maternity care needs and improve safety and consistency in clinical decision-making.

BSOTS uses a **four-tier traffic light system** to prioritise clinical urgency:

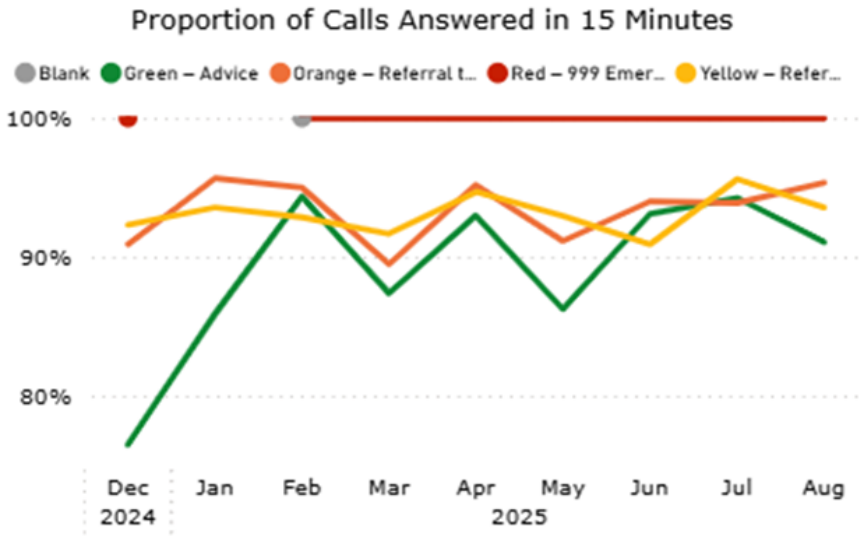
Colour	Urgency Level	Action Required
Red	Emergency	Immediate action required. Often involves calling 999 or urgent medical review.
Orange	Priority	Referral to a District General Hospital (DGH) or urgent assessment by senior clinician.
Yellow	Further Assessment	Local care required, typically within a set timeframe.
Green	Advice Only	Non-urgent; standardised advice given, no immediate clinical action needed.

Locally, implementation of BSOTS now allows a clinically recognised system for prioritising and directing women for assessment within appropriate, clinically indicated timeframes and settings. A dedicated midwife call handler is assigned during weekday daytime shifts to review and respond to these calls. Each case is tracked using a digital triage board that records arrival time, presenting concern, colour rating, and expected review time. Midwives are responsible for ensuring timely follow-up and may escalate the triage category if clinical judgement indicates increased urgency. In the absence of a local obstetric unit, women graded as green or yellow are managed by midwives within local services.

For assurance purposes, monthly audits of calls are conducted to monitor response times and referral appropriateness, extracting and disseminating learning, ensuring safe and consistent care within the community setting.

Collection, review and reporting of data provides a level of assurance that calls are responded to in a timely manner, although this should be improved and further improvement mechanisms are being developed with 95% of calls being answered within 15 mins across September 2025.

Audit shows a small number of events where cases should have been referred to an Obstetric Unit but have been seen by midwives locally. This presents risk and although there have been no incidents or unintended outcomes as a result, further learning is currently underway and this impacts assurance overall.



Improvements in-progress:

- Data collection to ensure red calls are not delayed when coming through switchboard in current telephone system
- Data collection to ensure thematic learning is extracted with regard to midwifery assessment of women who should have been directed to DGH with direct examples noted – to disseminate and reduce recurrence
- Revision of communication to women to support non-triage calls (e.g. change of appointment) to come through routine, non-urgent telephone mechanisms

Commissioned Services:

There are currently no mechanisms in place to gain assurance from commissioned services. Standardised assurance report templates for maternity IQPD are currently being drafted.

National Action:

A centralised, All Wales, telephone triage system, intended for hosting by WAST, is currently in development. We will ensure colleagues from PTHB maternity services attend to ensure service representation.

2. Senior Clinical Oversight

Ensure consistent care delivery with direct involvement and oversight from senior clinical staff.

Local Provision:

The specific requirements of this recommendation are related to Obstetric, Neonatal, ITU and Paediatric Radiology clinical care. There is no local action required for midwifery care.

Commissioned Services:

There are currently no mechanisms in place to gain assurance from commissioned services. Standardised assurance report templates for maternity IQPD are currently being drafted.

3. Maternity Early Warning Scores (MEWS)

Implement MEWS to improve early detection of clinical deterioration and enhance patient safety.

Local Provision:

Recently published MEWs charts are designed for use and implementation in acute settings. Audit identified that implementation in the routine community setting would significantly increase transfers and admissions of women who were otherwise clinically well. The Maternity Network advises against use in routine community midwifery care except where:

- Women feel or appear unwell
- Women with observations that score on the routine MEWs chart
- Women are experiencing an obstetric emergency

Improvements in-progress:

A small team in PTHB have been granted a research award to develop a MEWs chart for national adoption into the community setting, with completion anticipated the end of the financial year.

4. Improve Investigations Quality

Strengthen the rigour and transparency of incident investigations to support learning and accountability.

Local Provision:

The health board implemented the Incident Management Framework in July 2023; this is currently being reviewed and updated following 2 years of learning. Investigations and compliance in relation to timeframes and quality is monitored and reported through the IQPF.

Improvements in-progress:

Taking on board reflections from the past 2 years, proposed changes have been drafted, enhancing rigour and externality out of department oversight. Proposals are being presented at Executive Committee in November.

5. Compassionate, Trauma-Informed Care

Embed compassionate practices and trauma-informed approaches throughout maternity and neonatal services.

Local Provision:

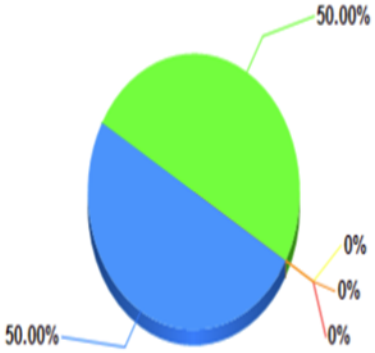
All women who are Powys resident or birth in Powys can access birth reflections from 4 weeks postnatal onwards or in a pregnancy after 12 weeks. Locally, five midwives and four health visitors support the reflections service, with four midwives trained in the 'Rewind' technique for trauma symptoms. Women can self-refer or be referred by someone and it is open to women and partners. The service sees small numbers of referrals and the feedback is largely positive.

Question 3: The service helped me cope/deal with the issues I shared

Available Answers	Responses	Score (%)
Strongly agree	2	50.00%
Agree	2	50.00%
Neither agree nor disagree	0	0.00%
Disagree	0	0.00%
Strongly disagree	0	0.00%
Total	4	100%

View Demographic Report

Create new action



Improvement:

Local improvement is focused on strengthening how service user feedback is gathered and shared with staff. While an annual report was previously used to highlight key themes and data, this has not been produced in recent years and should be reinstated. Although service uptake has been limited, further steps are being considered, including proactively contacting previous service users to invite feedback. Many women value the opportunity to reflect on their care, and some return during subsequent pregnancies to discuss personalised care planning. Drawing on lived experience, the service can influence priority areas for improvement and development.

Data is currently tracked via Excel and this needs to progress to a dashboard. Further work is required to break down by theme as by provider so that where cases arise outside of PTHB, we can work with providers to enhance services and seek assurance.

Commissioned Services:

The local service offers birth reflections to women who have birthed out of county, recognising the importance regardless of provider boundaries. Each contact is tailored to the individual, with referrals made to commissioned Health Boards or Trusts where specific clinical queries arise. Common themes include poor communication, lack of control, and not feeling heard.

National Action:

There is a traumatic stress Wales group that are looking at things around PNMH and trauma including birth trauma, and we look forward to more nationally led improvements that we will commit to embed.

6. Governance Enhancements

Improve governance structures to ensure robust oversight, challenge, and learning from safety issues.

The actions in this recommendation extend to include:

- There should be a complete review of governance processes and Board reporting across maternity and neonatal services, including escalation processes, and the structure and terms of reference for all relevant committees. A direct line of sight of maternity and neonatal services through the governance structure is required. This involves definitively ironing out duplication, clear reporting lines and ensuring appropriate clinical representation at key meetings.
- A maternity 'real time monitoring' report must be available to the Board at each meeting. The performance and quality indicators should be supported by qualitative feedback.

Local Provision:

The local governance arrangements are established, although would benefit from further improvement to align with the principles of the recommendations and to ensure that Board have appropriate oversight of the service. The Director of Midwifery, Women and Family Health has been undertaking an observational based assessment to inform improved structures.

Improvements in-progress:

The service is actively reviewing its approach to monitoring, investigating, and responding to incidents across all levels of harm. Existing systems are being further developed to support shared ownership of incident responses, including the presentation of evidence, and timely and collaborative closure. A locally tailored framework is currently in development to formalise this process and ensure consistency, transparency, and accountability across the service.

The current maternity dashboard, although recently developed, provides partial assurance and actionable insight. Further development will facilitate improved benchmarking against national targets or performance, strengthening its presentation in a way that readily identifies trends, successes, or areas of concern. Further improvement work will ensure the dashboard evolves into a robust tool that supports effective oversight, enables early intervention, and aligns with national safety and quality expectations.

Commissioned Services:

Quarterly meetings are well established with all commissioned services. The agenda is currently under review to further strengthen the assurance required. A revised agenda is currently being reviewed with one key provider, and once drafted will be circulated across all commissioned services to ensure an improved standardised assurance mechanism is established.

Furthermore, national work is underway to standardise assurance report templates for maternity IQPD, with these currently being drafted. As these are shared at a national level, it will become possible to extract assurance on commissioned services through review of those slides.

7. Fetal Monitoring Training

Mandate attendance for all maternity staff in fetal monitoring training to ensure consistent clinical standards.

Local Provision:

The training in relation to fetal monitoring is limited to intermittent auscultation elements only, since the service has permanently withdrawn CTG monitoring. The current training provision is externally provided, and compliance (Sept 24 – Sept 25) has been reported as 85%. A national target of 95% compliance has recently been announced, and the service will deliver this compliance by the next period end, in Sept 26. An annual training plan is in place to ensure that compliance has an upward trend herein, and committee should take assurance that current levels are above 85% and the service is safe to deliver this clinical aspect of maternity care.

8. Induction of Labour (IOL) Process

Develop a clear and prioritised booking system for women undergoing induction of labour.

Local Provision:

In relation to Recommendation 8 of the Independent Maternity Services Review, it is important to note that Powys Teaching Health Board (PTHB) does not provide local induction of labour (IOL) services. As such, no direct assurance is required from within the local service provision.

Commissioned Services:

There remains a critical need to strengthen assurance mechanisms with our commissioned providers to ensure safe, timely, and equitable access to IOL for Powys residents. Work is underway to establish robust reporting and oversight arrangements that reflect the expectations set out in national guidance.

9. Policy and Procedure Review

Review and revise all maternity and neonatal policies to ensure consistency and alignment with best practice.

Local Provision:

The maternity service keeps a database of all policies, guidelines and SOPs, enabling oversight of expiry dates and allowing management of the same. Monthly, new or amended policies are reported to the Maternity PAG, and further approval granted through the recently instated health board wide policies committee, chaired by the EDoN.

National, All-Wales policies and guidelines have a well-structured process and the service will continue to commit to PTHB representation to ensure the nuances of the local maternity service and population needs are heard, considered and factored into national policy.

Improvements required:
In order to meaningfully achieve the required level of assurance, the Swansea Bay Report recommends a review of maternity policies, including those that are in-date. This should be undertaken to ensure they are all fit for purpose, and to ensure that the auditable standards of each policy are set to provide meaningful assurance and that these are fully embedded. This review will be undertaken with a priority focus on key policies and guidelines thought to bear the most impact on safety, and will be undertaken over a 6 month period, reporting locally into the Women's and Children's Quality and Performance meeting.

10. Wider Engagement Plan

Establish a comprehensive engagement strategy to involve women, families, and communities in service improvement.

Local Provision:
The service has launched all applicable surveys through the CIVICA text messaging service, supported by Welsh Government. This provides intelligence and insight but comes with some limitation. Current limitations restrict us from being able to determine where responses relate to commissioned services and this can skew results to an unknown extent. Furthermore, there is no current mechanism for identifying patients who report very poor or poor experiences, limiting opportunity to identify causation and take learning, and limiting opportunities for us to work with them to resolve concerns.

Improvements required:
The CIVICA service provision has been initiated by Welsh Government and the Director of Midwifery, Womens and Family Health is committed to feeding back on the challenges experienced and to try and solution some of those.

Commissioned Services:
CIVICA data will be reported within IQPD reports which are shared for maternity services and therefore we can see data from Welsh providers. This is limited at present as 4 Health Boards are yet to launch CIVICA for maternity. Assurance from our English Providers is gathered through the annual CQC Maternity (service user) Survey.

Maternity Assessment:

The Welsh Government has commissioned NHS Wales Performance and Improvement to undertake a comprehensive, forward-looking assurance assessment of perinatal (maternity and neonatal) services across Wales. Overseen by an independent chair and expert panel, the assessment aims to provide real-time assurance to the Cabinet Secretary for Health and Social Services on whether services are delivering safe, high-quality, and compassionate care, and whether learning from previous reviews, including the Swansea Bay Independent Review, has been effectively embedded.

The Director of Midwifery, Women and Family Health has been attending the NHSPI Health Board Liaison Group and representing the health board. The assessment will encompass a multi-method approach including desktop analysis of data, stakeholder engagement, and triangulation of evidence. The voices and experiences of women, parents, and families are central to the process.

The key point to know is that there is a Maternity 'Self-Assessment' that requires completion by the service leads and a number of Executive colleagues with Independent Member opinion also sought. This is due to be returned to NHSPI by the 31st October and meeting dates are being secured to allow timely completion of this assessment.

Additionally, the service anticipates a 15 Steps approach across its sites, involving a walk-through of the service by a multidisciplinary team, using 15 key questions or "steps" that focus on first impressions, safety, dignity, communication, and responsiveness. The approach is designed to highlight strengths and areas for improvement from the perspective of service users, and encourages staff and leaders to reflect on the patient journey, fostering a culture of continuous improvement and patient-centred care.

NEXT STEPS:

Committee is asked to note partial assurance given some priority key actions, although be assured that this is in progress and on track with plans in place to achieve full assurance within the next 3-6 months.

The maternity assessment will likely identify other areas of focus and the service will keep board abreast of findings and outcomes from this as and when they become known.

APPENDIX 1 - PTHB Progress against recommendations from SBUHB Report

Recommendation	Local Provision	Improvements in Progress / Required	Commissioned Services	National Action	Assurance Status
1. Single Point of Access for Triage	BSOTS triage system implemented; midwife call handler assigned; digital triage board used; monthly audits conducted.	Improve data collection for red calls; extract thematic learning; revise communication for non-triage calls.	No current assurance mechanisms; standardised IQPD report templates in draft.	All-Wales centralised telephone triage system in development (WAST).	Assurance largely limited
2. Senior Clinical Oversight	No local action required for midwifery care (applies to Obstetric, Neonatal, ITU, Paediatric Radiology).	N/A	No current assurance mechanisms; All-Wales standardised IQPD report templates in draft.		Assurance largely reasonable
3. Maternity Early Warning Scores (MEWS)	MEWS charts not used routinely in community; only for unwell women or emergencies and have been implemented	Research award to develop community MEWS chart for national adoption (completion by year end).	No current assurance that this has been rolled out – checking with network.		Assurance largely reasonable
4. Improve Investigations Quality	Incident management framework implemented (July 2023); under review	Enhance rigour, external oversight, and challenge; learning from investigations to	Further work required to work in partnership with commissioned services when		Assurance largely reasonable

	after 2 years of learning.	inform changes; to be discussed at Exec committee Nov 2025.	undertaking reviews of PTHB patients.		
5. Compassionate, Trauma-Informed Care	Birth reflections offered to all Powys residents in and out of county births; 5 midwives, 4 health visitors involved; 'Rewind' technique available; Excel tracking.	Reinstate annual report; improve feedback sharing; proactively contact previous service users; dashboard development needed.	Referrals to equivalent services for out-of-county births; common themes: communication, control, being heard.	Traumatic Stress Wales group working on national improvements.	Assurance largely substantial
6. Governance Enhancements	Governance arrangements established; observational assessment underway; Director of Midwifery leading review.	Develop shared ownership systems for incident response; local framework in development; dashboard improvement required.	Quarterly meetings with providers; agenda template in review; standardised IQPD templates in draft.		Assurance largely reasonable
7. Fetal Monitoring Training	Training limited to intermittent auscultation; CTG monitoring withdrawn; external training provision; 85% compliance (target 95% by Sept 2026).	Increase compliance to meet national target.	N/A		Assurance largely substantial

8. Induction of Labour (IOL) Process	No local IOL provision; no direct assurance required.	Strengthen assurance with commissioned providers for safe, timely, equitable IOL access; robust reporting and oversight in development.	Assurance sought from commissioned providers.		Assurance largely reasonable
9. Policy and Procedure Review	Database of policies, guidelines, SOPs; monthly reporting to PAG; approval via health board committee.	Review all policies for fitness and assurance; priority focus on safety-impacting policies; 6-month review period.	PTHB representation in national policy development.		Assurance largely reasonable
10. Wider Engagement Plan	CIVICA surveys launched; feedback via text messaging; limitations in provider attribution and poor experience identification.	Feedback challenges being addressed; Director of Midwifery committed to improvement; consider proactive engagement with service users.	CIVICA data in IQPD reports; annual CQC survey for English providers; 4 Welsh HBs yet to launch CIVICA for maternity.		Assurance largely substantial

KEY:

Control Assurance
Based on what evidence?
GREEN: Assurance largely substantial
AMBER: Assurance largely reasonable
RED: Assurance largely limited
GREY: Insufficient assurance available

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					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					
Effective					
Efficient					
Equitable					
Person Centred					
Workforce					
Leadership					
Culture					
Information					
Learn, Improve, Research					
Whole Systems Approach					

EQUALITY:

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

RISK ASSESSMENT:

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

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 5.3

Patient Experience, Quality & Safety Committee	**DATE: 23 October 2025**
Subject:	**Quality and Safety in General Dental Services**
Approved and presented by:	Elaine Lorton, Executive Director of Primary, Community Care & Mental Health
Prepared by:	Assistant Director of Primary Care & Associate Dental Director
Other Committees and meetings considered at:	Executive Committee - 15 October 2025

PURPOSE:

To provide assurance that systems and clinical governance processes are in place to monitor primary care dentistry.

RECOMMENDATION(S):

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

- **RECEIVE** the report that has been requested by the Committee.
- Take **ASSURANCE** that systems and clinical governance processes are in place to monitor primary care dentistry.

Approve/Take Assurance	Discuss	Note
Y	Y	Y

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

EXECUTIVE SUMMARY:

This paper offers assurance around the processes in place regarding the monitoring of quality and safety across general dental services.

This report does not duplicate, but adds further detail regarding quality and safety assurance detailed in the General Dental Services (GDS) Commissioning Assurance Framework (CAF). The 2024/25 GDS CAF was presented to Executive Committee on 15/10/25 and then onto Finance & Performance Committee on 21/10/25.

There are several systems in place to monitor the quality of NHS dentistry in Powys, which is primarily undertaken by the GDS Monitoring Group, which reviews all aspects of contract performance, quality & safety and escalates findings to executive level where necessary.

GDS Monitoring Group oversight of Quality and Safety Monitoring Processes includes:

- General Dental Council registration and Dental Performer List compliance – both a mandatory requirement to undertake NHS dentistry.
- Primary Care Performer List Review Group – executive input into ongoing concerns.
- Health Inspectorate Wales – private regulator who share intelligence with PTHB for practices providing both private and NHS dentistry.
- PTHB Quality & Safety Team - Concerns team input provides intelligence and oversight around 'Putting things Right,' clinical incidents and Duty of Candour.
- Quality Assurance Scheme – Contractor self-audit on clinical governance processes.
- Annual Contract Reviews – Includes physical inspections and document checks with Contractors.
- Clinical Record Card Reviews – Undertaken by the NHS Business Services Authority.
- Patient Satisfaction Surveys (NHSBSA and CIVICA) - Providing feedback and insight on patient experience.
- PTHB Dental Helpline – Offers patient support and gathers soft intelligence of potential future issues.
- PTHB Medicines Management Team – Monitors dental prescribing data.

DETAILED BACKGROUND AND ASSESSMENT:

The assurance on the quality of NHS dentistry across Powys is summative and takes place throughout a contractual year through various assurance checks. The

responsibility of this sits with the PTHB General Dental Service (GDS) Monitoring Group which meets monthly to oversee contractual performance of the contracts, with a subgroup that meets bi-monthly, focussing specifically on quality and safety.

The GDS Monitoring Group is a pan Powys forum which has specific responsibility for

- co-ordinating the management, monitoring, and development of dental services to support the delivery of general dental services across Powys.
- monitoring the quality of dental services being delivered within contractual and regulatory requirements, including Dental Performer List requirements.
- offering general dental services across Powys within the recurrent financial allocation provided by Welsh Government.

The remit of the Group encompasses all contracting issues, access, quality and safety, finance & activity, patient experience, governance, and performer list compliance.

Membership of the group includes clinical, contractual and finance representation. Additional members are co-opted onto the Group as necessary, which may include for example Consultant in Dental Public Health, Clinical Policy Advisor from the Dental Reference Service and Health Inspectorate Wales representation.

MONITORING ARRANGEMENTS AND ASSURANCES

PTHB General dental services are monitored through comprehensive data collection and analysis as part of a wider all Wales monitoring system with additional local monitoring systems in place.

Assurance around quality and safety can relate to regulatory requirements and also non contractual levers. When the GDS Monitoring Group identifies areas of concern it agrees whether to 'step up' or 'step down' escalation to executive level.

Quality of care is intrinsically linked to dental performer performance and therefore both qualitative and quantitative data is continually reviewed. This is pulled together in an annual GDS Commissioning Assurance Framework (CAF) report, presented to Finance & Performance Committee.

The complex nature of the dental contract means that areas often overlap and impact on each other, for example a large contract value with an inadequate workforce can cause a performer to be overwhelmed leading to a reduction in quality.

General Dental Council registration and revalidation

General Dental Council (GDC) is the UK's independent regulatory body for dental professionals. Registration is mandatory for dentists, dental hygienists, dental therapists, dental nurses and other Dental Care Professionals who want to practice in the UK. Registration with the GDC ensures patient safety by upholding standards of conduct, performance, and ethics in the dental profession and that only qualified professionals practice dentistry. Registration helps maintain public trust and confidence in the dental profession. The GDC investigates concerns about the treatment or conduct of dental professionals and liaises with the health board accordingly.

Dentist revalidation is a five-year cycle involving annual renewal steps and a final declaration to the GDC requiring verifiable Continuing Professional Development (CPD), submission of a Personal Development Plan and a declaration of meeting the GDC's standards. The Revalidation process ensures dentists remain fit to practise by demonstrating competence and meeting standards for patient care. Dental Care Professionals are required to comply with these standards also. Failing to renew can lead to removal from the UK register, making it illegal to practise and there are processes in place for the GDC to inform the Health Board, should this happen. The Medical Director is professionally responsible for all NHS dentists working in Powys.

Dental Performers List (DPL)
Dental Performers List Regulations in Wales are governed by the National Health Services (Performers Lists) Wales Regulations 2004, which mandate that dentists providing NHS primary dental services must be on a Health Boards list (in addition to the GDC register). Inclusion requires an enhanced DBS disclosure and clinical references. NHSWSSP administers the lists on behalf of Health Boards, with the responsibility of the Powys DPL sitting with the Medical Director.

The regulations outline grounds for inclusion and removal, and dentists are subject to ongoing requirements to maintain their inclusion. The lists ensure that only qualified practitioners providing safe and effective NHS dental services are included. Dentists remain on the list contingent on meeting expected requirements as detailed in the Performer List regulations. Prior to entry onto the list, any ongoing or previous investigations must be declared, and relevant intelligence is shared across UK NHS Services. Following the completion of satisfactory checks a dentist is issued with a Performer Number.

The regulations and associated guidance provide grounds for refusal to admit or removal from a list, including failure to meet requirements or concerns about a performer's performance. Under specific circumstances, a performer may be nationally disqualified, meaning they are prohibited from inclusion in performers lists across Wales.

The PTHB DPL includes dentists whose main practice base is within Powys, although some may be listed under neighbouring Health Boards. A dentist may only be listed on one Welsh Performers List at any given time. Once approved, they are eligible to work at any NHS dental practice across Wales. The Performers List Regulations provide the Health Board with the legal authority to manage and act on concerns relating to clinical or professional standards.

To work as a dentist within PTHB, individuals must first obtain a Wales Dental Performer Number. Following a dentists inclusion on the Welsh Performers List, the contractor must submit a request to add the performer to the contract. Once this process is completed, the dentist is authorised to submit claims for NHS courses of treatment against the individual contract against which they are listed.

An annual performer validation exercise is undertaken for each contract, during which the PTHB Primary Care Team reviews the list of performers associated with each practice. This involves cross-referencing data to identify performers currently recorded as working under the contracts. The compiled list is then sent to the practice for confirmation of accuracy. Additionally, discussions regarding performer activity and staffing are held during end-of-year review meetings with practices.

In addition, NWSSP conducts periodic data cleansing exercises to identify dental performers who have not submitted activity against a contract for an extended period. In such cases, NWSSP contacts the PTHB Primary Care Team to confirm whether the performer should remain linked to the contract or be removed.

Primary Care Performer List Review Group with executive leadership meets to review all Dental Performer Concerns. This Group gathers assurance and provides direction regarding performer concerns across all independent contractors.

Framework for The Management of Performance Concerns, a national Framework which outlines the process for Health Boards to identify, manage and support Performers when performance concerns arise. The Framework provides guidance in a uniform and consistent approach and interpretation in dealing with performance concerns including Screening Panels and Performer List Panels. The Health Boards is responsible for assessing and arranging appropriate and proportionate action in response to concerns raised.

NHSBSA
The NHSBSA produces a variety of reports tailored to the need of PTHB. These include:

- high-level data reports, which can be targeted or random,
- provider self-audit reports and

- clinical record card reviews.

For example, if a contract is suspected of not carrying certain treatments, a report can be requested to examine activity relating to that intervention. Intelligence leading to such a request could be, for example, due to inappropriate referrals to secondary/specialist dental services.

Activity Data
All NHS dental activity undertaken by Practices is submitted to the NHS Business Services Authority (NHSBSA) via the FP17W form, which captures patient demographics and clinical treatments undertaken. PTHB has access to this data and it enables benchmarking at both local and national levels. The data can be analysed by contract and at individual dental performer level including other Dental Care Professionals such as Dental Therapists and Hygienists, working under NHS contracts. The NHSBSA employs statisticians and Clinical Policy Advisors to interpret and report on this data back to the health board.

Clinical Record Card Reviews are carried out by the NHSBSA Clinical Policy Advisors, which requires the contractor to submit full clinical documentation, including patient notes, radiographs, laboratory prescriptions and other supporting materials. The clinical review assesses both clinical quality and probity including concerns around inappropriate mixing of NHS and private treatments.

Following issue of the NHSBSA report, the PTHB Associate Dental Director along with the Primary Care contracting team will analyse the findings and take action as appropriate through the GDS Monitoring Group. The reports often contain a summary of recommendations and must be interpreted holistically. For example, a contract may show a higher-than-average activity in a particular treatment area, which could be justified by the higher-than-average demographics of the local population.

As the Clinical Policy Advisor is a co-opted member of the GDS Monitoring Group, they contribute to the oversight of contractual and clinical standards across Powys.

Patient Satisfaction
The (NHSBSA) conducts patient satisfaction surveys for dental services. Patients are randomly selected to receive a voluntary questionnaire regarding their dental experience. The purpose of the survey is to assess experience and the quality of NHS dental care provided. The health board has access to this information and supports dialogue with contractors.

Health Inspectorate Wales
Health Inspectorate Wales are responsible for private dentistry in Wales; however, practices often provide both NHS and private dentistry, and therefore HIW share information with the health board. HIW review practices on a 5-year rolling cycle which includes a physical review of the premises.

Quality Assurance Scheme
All NHS dental contractors must complete an annual Quality Assurance Scheme (QAS) self-audit. This is an electronic submission to ensure all practices maintain high standards across a wide range of operational and clinical areas. The QAS covers Infection, Prevention and Control (IPC), Health & Safety Compliance, equipment maintenance, safeguarding, clinical governance and workforce training. The GDS Monitoring Group review the audits and addresses issues in a proportionate and appropriate basis, noting that some areas of noncompliance carry a higher risk than others.

Annual Contract Reviews
Primarily a contract process but also addresses various quality and safety assurances. This includes three items from each practices QAS submission randomly selected for validation. This could include verification of documentation such as autoclave service records, sharps injury protocols and fire safety risk assessments. These checks are undertaken by the PTHB Primary Care Team and the Associate Dental Director.

In addition, discussions also take place regarding findings from Clinical Record Card Reviews, however additional separate meetings are held with Performers following NHSBSA report findings.

Duty of Candour
Dental teams must adhere to the Duty of Candour if the threshold is met. Whilst Datix is encouraged for incident reporting the ability for electronic submission is limited due to lack of access to NHS email addresses for contractors. Practices must maintain internal concerns procedures that align with the 'Putting Things Right' framework. PTHB assurance on compliance is received via the QAS.

CURRENT PTHB QUALITY AND SAFETY UPDATE:

Five practices have been subject to recent record card review scrutiny so far in 2025/26, completed by the NHS Business Services Authority. The reviews have been linked to both quality and probity flags that require further analysis. Discussions are ongoing with practices. Various outcomes are anticipated which may include repeat record card reviews, agreed action plans, involvement of Counter Fraud or may proceed to more formal measures and invoke a Dental Performers List formal process.

Two performers have been subject to conditions on registration with involvement from the General Dental Council.

NEXT STEPS:

1) GDS monitoring Group to monitor existing concerns and continue to link in with Performers as appropriate.

2) To continue with existing assurance processes to ensure that NHS Dental Services are being delivered from a qualitative and quantitative perspective.

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

IMPACT ASSESSMENT
Not required

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Powys Teaching Health Board

Agenda item: 5.4

PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE	**23 OCTOBER 2025**
Subject:	**Update on the 2025-2026 Clinical Audit Programme**
Approved and presented by:	Kate Wright, Executive Medical Director
Prepared by:	Prepared by the individual services and collated by Safety and Quality Improvement Manager
Other Committees and meetings considered at:	Executive Committee – 16 October 2025

PURPOSE:

The purpose of this paper is to provide an update on the 2025/26 clinical audit plan and the 11 outstanding audits from 2024/25.

RECOMMENDATION(S):

The Patient Experience Quality and Safety Committee is asked to:

- **RECEIVE** the clinical audit plan for both 2025/26 (mid year update) and for the 11 outstanding audits from 2024/25
- Take **ASSURANCE** that a clinical audit plan is in place, **NOTING** an end of year report will be provided in early 2026/27.

Approve/Take Assurance	Discuss	Note
N	Y	Y

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:		
1. Focus on Wellbeing	Y	Clinical audit impacts on all clinical areas of the health board and therefore a wide nu8mber of 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	

SUMMARY:

2025/26 Clinical Audit Plan

The Executive Committee and then Patient Experience Quality and Safety (PEQS) Committee considered the clinical audit programme for 2025/26 in April 2025 resulting in it being approved by PEQS. This report provides an update against delivery at the mid year point. The report also provides an update on the 11 clinical audits from 2024/25 that were not reported in the end of year update in April 2025.

In-year changes to 2025/2026 audit programme.

The audit programme has continued on schedule. Two additional audits have been added by the Therapies services.

The Surgery and Endoscopy Service is undertaking work on the Association for Perioperative Practices (AfPP) audits for theatres (highlighted in yellow), these are currently undergoing a full review with a view to either removing them due to their duplication of information in other audits conducted or amalgamating them into a more logical approach which will in turn, lead to the development of new audits.

Audits from the 2024/2025 program that were incomplete at the end of that audit period.

Service area	Audit	Status
Mental health	- Adult CMHT MDT Audit.	Audit added to 2025-26 program and completed.
Medicines Management	Allergy status reporting in PTHB community hospitals	Audit delayed awaiting the introduction of the in-patient ePMA rollout. Status: Still awaiting rollout of system, now expected January 2026.
	completion of Venous thromboembolism (VTE) risk assessment	Audit delayed awaiting the introduction of the in-patient ePMA rollout. Status: Still awaiting rollout of system, now expected January 2026.
	The Valproate prescribing Audit of compliance with NatPSA/2023/013/MHRA was delayed awaiting a national digital solution via DHCW	Audit still delayed due to lack of a national digital solution. PTHB Chief Pharmacist is following up to establish likely timeframes.

Paediatrics	Monitoring of children with Down's syndrome.	Still awaiting development of a national system to support this audit, timescales not known at this point.
Surgery and Endoscopy	Post colonoscopy cancer detection rate	The results of the audit were reported to, and discussed by, the Endoscopy Users and Audit Group (EUAG) in July 2025.
Podiatry	Shockwave Audit	Data collected but not yet formally reported.
	Taxonomic Classification	Audit formally abandoned due to having insufficient staff resources to complete.
Therapies	The Implementation of a Falls Therapy Practitioner	These audits have been folded into the work of the newly established falls panel.
	Multi-factorial Falls Assessment	
	Adherence to clinical supervision policy	Completed as part of a wider piece of work

NEXT STEPS:

The Patient Experience Quality and Safety Committee will receive an end of year report for the 2025/26 clinical audit programme in early 2026/27.

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		No decision requested from the Committee
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				No decision requested from the Committee
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					No decision requested from the Committee
Financial					
Corporate					
Operational					
Reputational					

Community Services Group Surgery and Endoscopy					
Driver	**Audit Title**	**Expected End Date**	**Service**	**Lead**	**Status**
Local Audits for Service Improvement	Staff Survey	Quarter 4	Theatre and Endoscopy	Theatre / Endoscopy Lead	Not Yet Due
Service Evaluation	Hand hygiene Audits	Quarter 4	Theatre and Endoscopy	Theatre / Endoscopy Lead	Not Yet Due
Service Evaluation	Legal and ethical audit	Quarter 1	Theatre	Theatre Lead	Audit Paused whilst review is undertaken to streamline quality processes
Service Evaluation	Data protection and GDPR	Quarter 1	Theatre	Theatre Lead	Audit Paused whilst review is undertaken to streamline quality processes
Service Evaluation	Management/Human Resources	Quarter 1	Theatre	Theatre Lead	Audit Paused whilst review is undertaken to streamline quality processes
Service Evaluation	Education	Quarter 1	Theatre	Theatre Lead	Audit Paused whilst review is undertaken to streamline quality processes
Service Evaluation	Five Steps to Safer Surgery	Quarter 1	Theatre	Theatre Lead	Audit Paused whilst review is undertaken to streamline quality processes
Service Evaluation	Managing Perioperative Normothermia	Quarter 1	Theatre	Theatre Lead	Audit Paused whilst review is undertaken to streamline quality processes
Service Evaluation	Medical devices audit	Quarter 1 Quarter 4	Theatre	Theatre Lead	Q1 audit completed
Service Evaluation	Risk Management (Organisational and Environmental)	Quarter 2	Theatre	Theatre Lead	Audit Paused whilst review is undertaken to streamline quality processes
Service Evaluation	Decontamination	Quarter 2	Theatre	Theatre Lead	Audit Paused whilst review is undertaken to

					streamline quality processes
Service Evaluation	Specimen Management	Quarter 2	Theatre	Theatre Lead	Audit Paused whilst review is undertaken to streamline quality processes
Service Evaluation	Tourniquets	Quarter 2	Theatre	Theatre Lead	Audit Paused whilst review is undertaken to streamline quality processes
Service Evaluation	Use and Handling of Surgical Instruments	Quarter 2	Theatre	Theatre Lead	Audit Paused whilst review is undertaken to streamline quality processes
Service Evaluation	Preoperative care for Patients with Dementia	Quarter 2	Theatre	Theatre Lead	Audit Paused whilst review is undertaken to streamline quality processes
Service Evaluation	Anaesthesia	Quarter 3	Theatre	Theatre Lead	Audit Paused whilst review is undertaken to streamline quality processes
Local Audits for Service Improvement	Surgical record keeping audit & consent	Quarter 3	Theatre	Theatre Lead	Not Yet Due
Service Evaluation	Post anaesthetic Care	Quarter 3	Theatre	Theatre Lead	Audit Paused whilst review is undertaken to streamline quality processes
Service Evaluation	Electrosurgery	Quarter 3	Theatre	Theatre Lead	Audit Paused whilst review is undertaken to streamline quality processes
Service Evaluation	Fluid Management	Quarter 3	Theatre	Theatre Lead	Audit Paused whilst review is undertaken to streamline quality processes
Service Evaluation	Surgical patient story	Quarter 4	Theatre	Theatre Lead	Not Yet Due
Service Evaluation	Pre assessment and Specific Day Case Requirements	Quarter 4	Theatre	Theatre Lead	Audit Paused whilst review is undertaken to streamline quality processes
Service Evaluation	Audit of prosthesis verification data	Quarter 4	Theatre	Theatre Lead	Not Yet Due
Service Evaluation	Intraoperative Care	Quarter 4	Theatre	Theatre Lead	Audit Paused whilst review is undertaken to streamline quality processes
Service Evaluation	Accountable Items, Swab, Instrument and Sharps Count	Quarter 4	Theatre	Theatre Lead	Audit Paused whilst review is undertaken to streamline quality processes
Service Evaluation	Infection Control	Quarter 4	Theatre	IPC	Reported by Infection Control

Service Evaluation	NEWS audit	Quarter 4	Theatre	Quality & safety lead Clinician/Planned care manager	Not Yet Due
Service Evaluation	Foreign body aspiration during intubation, advanced airway management or ventilation	Quarter 4	Theatre	Planned care manager	Not Yet Due
Service Evaluation	Individual endoscopists KPIs	Quarter 1 Quarter 3	Endoscopy	Endoscopy Clinical Lead	Q1 audit completed
Service Evaluation	Gastric ulcers rescoped within 12 weeks	Quarter 2 Quarter 4	Endoscopy	Endoscopy coordinator & Data/ Audit Support	Q2 audit completed
Service Evaluation	Post colonoscopy colorectal cancer rate	Quarter 4	Endoscopy	Endoscopy Clinical lead	Not Yet Due
Service Evaluation	Patient satisfaction survey	Quarter 4	Endoscopy	Data/ Audit Support	Not Yet Due
Service Evaluation	Patient story	Quarter 1 Quarter 3	Endoscopy	Endoscopy Coordinator	Q1 audit completed
Service Evaluation	Endoscopist satisfaction survey	Quarter 4	Endoscopy	Endoscopy Coordinator	Not Yet Due
Service Evaluation	Vetting and validation of endoscopy referrals	Quarter 4	Endoscopy	Clinical lead Endoscopy	Not Yet Due
Service Evaluation	Environmental audit Process Improvement Tool (PIT) Llandrindod Wells /Brecon	Quarter 2	Endoscopy	Infection Prevention and Control	Not Yet Due
Welsh Government National Audit Programme	Bowel Screening Wales User Experience Survey Results	Quarter 4	Endoscopy	Bowel Screening Wales	Not Yet Due
Local Audits for Service Improvement	Record Keeping/Consent	Quarter 3	Endoscopy	Endoscopy Coordinator	Not Yet Due
Service Evaluation	Annual planning & productivity report	Quarter 3	Endoscopy	Planned Care Manager	Not Yet Due
Service Evaluation	Scope traceability	Quarter 4	Endoscopy	Endoscopy Coordinator	Not Yet Due
Local Audits for Service Improvement	Inclusion/exclusion criteria audit	Quarter 2 Quarter 4	Endoscopy	Endoscopy Coordinator	Q2 audit underway
Local Audits for Service Improvement	Bowel Screening Wales pathology reporting audit	Quarter 3	Endoscopy	Business Support Manager Planned Care	Not Yet Due
Local Audits for Service Improvement	Pain / Comfort Audit	Quarter 2 Quarter 4	Endoscopy	Endoscopy Coordinator	Q2 audit completed
Local Audits for Service Improvement	Single cancer pathway process	Quarter 4	Endoscopy	Planned care manager	Not Yet Due

Local Audits for Service Improvement	Audit of open access referrals into our service	Quarter 4	Endoscopy	Planned care manager	Not Yet Due
Local Audits for Service Improvement	Audit for Endoscopy Screening assessment	Quarter 4	Endoscopy	Planned care manager	Not Yet Due
Local Audits for Service Improvement	Additional Audit: PGD 0083C (Supply of Moviprep for Bowel Screening)	6 months prior to expiry of PGD operational from 11/06/25 -10/06/28	Endoscopy	Endoscopy Coordinator	Quarter 1 Completed
Local Audits for Service Improvement	Additional Audit: PGD 0149A (Administration of Adrenaline in Endoscopy)	6 months prior to expiry of PGD operational from 01/08/25 -12/06/28	Endoscopy	Endoscopy Coordinator	Quarter 1 Completed
Service Evaluation	Medical devices audit	Quarter 1 Quarter 4	Endoscopy	Endoscopy Coordinator	Quarter 1 Completed

Therapies and Health Science					
Driver	Audit Title	**Expected End Date**	**Service**	**Lead**	**Status**
Audits performed for accreditation schemes	Compliance with Standard operating procedures	Quarter 3	Radiography	Head of Radiography	Underway, to be reported at Radiation Protection Committee Oct. 25
Audits performed for accreditation schemes	Pregnancy Status	Quarter 3	Radiography	Head of Radiography	Underway, to be reported at Radiation Protection Committee Oct. 25

Audits performed for accreditation schemes	Correct use of radiographic markers	Quarter 3	Radiography	Head of Radiography	Underway, to be reported at Radiation Protection Committee Oct. 25
Audits performed for accreditation schemes	Non Medical Referrals (NMR) Audit of NMR compliance	Quarter 3	Radiography	Head of Radiography	Underway, to be reported at Radiation Protection Committee Oct. 25
Audits performed for accreditation schemes	Reject analysis	Quarter 3	Radiography	Head of Radiography	Underway, to be reported at Radiation Protection Committee Oct. 25
Audits performed for accreditation schemes	Radiographer commenting audit	Quarter 3	Radiography	Head of Radiography	Underway, to be reported at Radiation Protection Committee Oct. 25
Audits performed for accreditation schemes	QA plain film and NOUS / Midwife Sonography	Quarter 3	Radiography	Head of Radiography	Underway, to be reported at Radiation Protection Committee Oct. 25
Local Audits for Service Improvement	QA reporting Audit	Quarter 3	Radiography	Head of Radiography	Underway, to be reported at Radiation Protection Committee Oct. 25
Audits performed for accreditation schemes	Monthly Clinispet/Clinel Wipes Audit	Quarter 3	Radiography	Head of Radiography	Underway, to be reported at Radiation Protection Committee Oct. 25
Audits performed for accreditation schemes	Sonography Service Audit	Quarter 1	Radiography	Clinical Governance Lead for Sonography	Underway, to be reported at Radiation Protection Committee Oct. 25
Audits performed for accreditation schemes	Reporting Radiography Service Audit	Quarter 3	Radiography	Head of Radiography	Underway, to be reported at Radiation Protection Committee Oct. 25
Other National Audit & Service Evaluation	The Sentinel Stroke National Audit Programme	Quarter 4	All AHPs	Consultant Therapist for Stroke	Not Yet Due
Audits performed for accreditation schemes	Red Dot	Quarter 4	Radiography	Head of Radiography	Not Yet Due
Local Audits for service improvement	Therapy Outcome Measures Audit	Quarter 4	Speech and Language Therapy	Head of Speech and Language Therapy	Underway

Other National Audits	National Diabetes Foot Care Audit	TBC National	Podiatry	Head of Podiatry	All Wales meeting arranged: study underway
Other National Audits	Parkinsons AHP	TBC National	Therapies & Health Sciences	SLT	Study underway: data to be submitted 31/10/25
Other National Audits	Adult Audiology Standards	TBC National	Audiology	Professional Head of Audiology	Not Yet Due
Service Evaluation	RCOT proforma on 'focusing on occupation' and 'your professional rationale'	Quarter 4	OT	Professional Head of OT	Audit complete. data to be presented at OT professional forum Sept 2025 & action plan agreed.
National Audit	Additional Audit: NRAP (National Respiratory Audit Programme for England and Wales) PR data	Quarter 4	Respiratory	Respiratory Lead	Study underway
Service Evaluation	Additional Audit: Sleep outcome audit -number of patients sent out of area following a sleep appointment in our service.	Quarter 4	Respiratory	Lead Respiratory Physiologist	Study underway

Community Dentistry					
Driver	Audit Title	**Expected End Date**	**Service**	**Lead**	**Status**
Local Audits for Service Improvement	Patient Experience Audit	May 2025	Community Dentistry	Tesni Jones	Audit on hold
Other National Audit	WHTM01-05	Sept 2025	Community Dentistry	Rachael Anwyl	Delayed but now underway
Local Audits for Service Improvement	Written Consent to treatment audit	Dec 2025	Community Dentistry	Lloyd Bovensiepen	Not Yet Due
Local Audits for Service Improvement	Compliance with Acorn and Fluoride Application for GDS patients	Sept 2025	Community Dentistry	Evelyn Gough	Audit delayed

Local Audits for Service Improvement	Antimicrobial Stewardship	Jan 2026	Community Dentistry	Lloyd Bovensiepen	Not Yet Due
Local Audits for Service Improvement	Patient engagement and outcomes of treatment visits	Feb 2026	Community Dentistry	TBC	Not Yet Due
Local Audits for Service Improvement	Radiography grading - Annual subjective image quality ratings of dental radiographs in the Community Dental Service	Continuous yearly run chart	Community Dentistry	Warren Tolley/ Catherine Adams	Ongoing data collected

Unscheduled Care					
Driver	Audit Title	**Expected End Date**	**Service**	**Lead**	**Status**
Local Audits for Service Improvement	Missed Fractures Audit	Quarter 4 2025	Unscheduled Care	Senior Manager	Audit Completed
Local Audits for Service Improvement	Mattress audit	Quarter 4 2025	Unscheduled Care	Senior Manager	Not yet due
Local Audits for Service Improvement	Hand Hygiene Audit	Quarter 4 2025	Unscheduled Care	Senior Manager	Audit Completed
Local Audits for Service Improvement	Primary Care Attenders – removed as reported in BI	TBC	Unscheduled Care	Senior Manager	Audit Completed
Local Audits for Service Improvement	Paramedic/downgrade ambulance audit – Removed as reported in BI	TBC	Unscheduled Care	Senior Manager	Audit Completed
Local Audits for Service Improvement	PGD Audit	Quarter 4 2025	Unscheduled Care	Senior Manager	Not yet due
Local Audits for Service Improvement	Paeds under five audit – scrutiny of every attender under five	Quarter 4 2025	Unscheduled Care	Senior Manager	Not yet due
Local Audits for Service Improvement	Ask & Act – Audit tool for RE Enquiry for Domestic Abuse in MIU	Quarter 4 2025	Unscheduled Care	Senior Manager	Not yet due

Medical Directorate					
Medicines Management					
Driver	Audit Title	**Expected End Date**	**Service**	**Lead**	**Status**
Local Audits for Service Improvement	4C antimicrobial prescribing in primary care.	Quarter 3 2025/26	The Antimicrobial Stewardship (AMS) Pharmacist recruited October 2024 will take the lead on this audit moving forward.	Chief Pharmacist Emlyn Pritchard/Amie Bain	Not Yet Due
Local Audits for Service Improvement	"Start Smart then Focus" audit for antimicrobial prescribing in community hospitals	Quarter 4 2025/6		Amie Bain	Not Yet Due
Local Audits for Service Improvement	Community Pharmacy Rota Services The aim of this audit is to establish how much current rota services are used for their intended purpose.	Quarter 3 2025/26		Chief Pharmacist Emlyn Pritchard/Gail Brown	Not Yet Due
Local Audits for Service Improvement	Blueteq assurance audit A random sample of 10 patients will be selected and their clinical notes will be checked to ensure that they meet the criteria for treatment.	Quarter 4 2025/26		Chief Pharmacist Claire Jones	Not Yet Due
Local Audits for Service Improvement	Controlled Drugs Management in clinical areas across PTHB.	Quarter 4 2025/26		Controlled Drugs Accountable Officer Jayne Price/Internal Audit	Not Yet Due

Corporate Functions					
Resuscitation					
Driver	Audit Title	**Expected End Date**	**Service**	**Lead**	**Status**
Other National Audit	Completion of DNACPR	Q4 2025	Resuscitation	Resuscitation Officer	Not Yet Due
Infection Prevention and Control					
Local Audits for Service Improvement	Organisational IPS Environmental Audit	Q4 2025	IPC Staff	IPC Lead	Not Yet Due
Local Audits for Service Improvement	IPS Environmental Audit (More frequent/smaller)	Quarterly	IPC Staff	IPC Lead	Now Reported Elsewhere
Local Audits for Service Improvement	Mental Health Ward Environmental Audit	Q4 2025	Ward Staff	IPC Lead	Not Yet Due
Local Audits for Service Improvement	Hand Hygiene	Quarterly	Ward Staff	IPC Lead	Now Reported Elsewhere Not Yet Due

Mental Health and Learning Disabilities					
Mental Health					
Driver	Audit Title	**Expected End Date**	**Service**	**Lead**	**Status**
Audits in response to identified Risk	Audit of Environmental Ligature Risk Assessment	Quarter 2	All Mental Health Units	Senior Nurse - Inpatient Matron role	Quarter 2 – Inpatient complete. Division has community audit plan in development with majority of community

					team environment audits for anti-ligature.
Audits in response to Identified Risk	Audit of WARRN risk assessments	Quarter 4	All Mental Health Units	Consultant Nurse/Governance Lead	Complete. To be reported 10th November with 3 week turn around and will be peer reviewed
Audits in response to Identified Risk	Audit of Security Risk Assessment	Quarter 2	All Mental Health and LD Units	Head of MH Operations	Complete To be reported 10th November with 3 week turn around will be peer reviewed.
Local Audits for Service Improvement	Audit of Care and Treatment plans	Quarter 2	All Mental Health Units	CTP Lead/Governance Lead	Complete To be reported 10th November with 3 week turn around will be peer reviewed.
National Programme Audit	NCISH Suicide audit	Quarter 2	All Mental Health Units	Suicide and SH Prevention Lead	Data provided to NCISH quarterly.
National Programme Audit	National review of schizophrenia audit	Quarter 4	All Mental Health Units	Clinical Director MH&LD	Engage with audit when required, no suitable patient contact as yet.
Local Audits for Service Improvement	Inpatient Physical health monitoring audits	Quarter 2	Ward units	Clinical Director MH&LD	Complete. New diagnosis EIP Inpatient physical health monitoring project
Local Audits for Service Improvement	RCP/NICE quality standards for inpatient care	Quarter 2	Ward units	Senior Nurse - Inpatient Matron role	Delayed to Q4 to put in line with National timescales.
Local Audits for Service Improvement	Medicine management audit	Quarter 2	All Mental Health & LD Units	Service Managers and Ward Managers	Completed.
Local Audits for Service Improvement	Hand hygiene/Matress audits	Quarter 2	Ward units	Ward Managers	Completed. (Ward monthly audit plan)
Local Audits for Service Improvement	Record Keeping	Quarter 2	All Mental Health Units	Team Leads/Ward Managers/IG	Completed. Now working with IG on consistent template to standardise approach
Local Audits for Service Improvement	DNAs	Quarter 2	All Mental Health Units	Business and Performance Manager	Collected and reviewed

Local Audits for Service Improvement	Multi-factorial Falls Risk Assessment Audit (Inpatients)	Quarter 2	Ward units	Service Managers and Ward Managers	Falls panel in place
Local Audits for Service Improvement	Welsh Language Active Offer Audits	Quarter 3	All Mental Health & LD Units	TBC	n/a
Local Audits for Service Improvement	WNB	TBC	CAMHS	CAMHS Operational Lead	Audit complete. final report in production.
Local Audits for Service Improvement	Early Intervention in Psychosis	Quarter 3	CAMHS	CAMHS Operational Lead	Completed
Local Audits for Service Improvement	Outcome Measure Audit	Quarter 3	CAMHS	CAMHS Operational Lead	Completed
Local Audits for Service Improvement	LPMHSS Pathway Audit	Quarter 3	Community Based	Service Manager LPMHSS/Psychology	Completed
Local Audits for Service Improvement	Policy Audit	TBC	All Mental Health & LD Units	CPAG	Underway
Local Audits for Service Improvement	Community Medical Caseload and Admin	Quarter 2	All Mental Health Units	Clinical Director MH&LD	Underway
Local Audits for Service Improvement	S117 Audit	Quarter 2	All Mental Health Units	Head of MH Operations	Underway -significant work involved in creating baseline
Local Audits for Service Improvement	MH Act Compliance	Quarter 3	All Mental Health Units	HoMH Nursing	3 HIW inspections – CTO process – positive compliance. Monthly scrutiny of papers. Annual Report for POD and Exec Committee
Local Audits for Service Improvement	Adult & Older Adult CMHT MDT Audit	Quarter 3	Community Based	Head of MH Operations	Quarter 3/4 Community SOP produced 2024/25. To be audited. Introducing a peer review process starting with Brecon Q3.
Local Audits for Service Improvement	Epilepsy audit	Quarter 2	All LD	Head of LD	Due Q4
Local Audits for Service Improvement	Liaison data audit	Quarter 2	All LD	Head of LD	Complete
Local Audits for Service Improvement	Champion training audit	Quarter 2	All LD	Head of LD	Complete
Local Audits for Service Improvement	Anti-psychotic and physical health audit	Quarter 3	All Mental Health & LD Units	Consultant Psychiatrist/Head of SOAD	First phase of audit implemented (for South Powys)

					To be extended to other medications. This is creating standardised template to be used across Powys. CAMHS also completed
Local Audits for Service Improvement	H&S audit doors/alarms/ radio functions	Quarter 2	Ward Based	Service Managers and Ward Managers	Completed. part of monthly ward audits
Local Audits for Service Improvement	Medical Devices audit	Quarter 2	All Mental Health & LD Units	Service Managers and Team Managers	Completed. Undertaken in Jan and June each year
Local Audits for Service Improvement	Environmental audit/ cleanliness/risks	Quarter 2	All Mental Health & LD Units	Service Managers and Team Managers	Completed. part of monthly ward audits
Local Audits for Service Improvement	Fire risk audit drills/points/equipment	Quarter 2	All Mental Health & LD Units	Service Managers and Team Managers	Completed. – corporately supported
Audits in response to Identified Risk	Therapeutic observations audit	Quarter 3	All Mental Health & LD Units	Service Managers and Ward Managers	Completed. Op policy ratified by SMT in summer 25 – will form part of future audit plan. However, obs levels and decision making is reviewed weekly as is bed management and other processes
Audits in response to Identified Risk	WCCIS and V4 MHM forms audit	Quarter 3	All Mental Health & LD Units	Service Managers and Ward Managers	Quarter 3 – as above CTP, to be reviewed Nov 10th 2025
Audits in response to Identified Risk	Advocacy audit	Quarter 3	All Mental Health & LD Units	Head of LD	Due Q4
Audits in response to Identified Risk	Discharge letters audit from in-patient services.	Quarter 3	All Mental Health & LD Units	Clinical Director MH&LD	Completed. Remedial action required. However, supportive assessment reviewed this in May 2025.
Audits in response to Identified Risk	Escorting patients off hospital grounds	Quarter 3	All Mental Health & LD Units	Service Managers and Ward Managers	Completed. Section 17 leave policy development and audit template produced. CPAG in Dec 25.
Audits in response to Identified Risk	Educational audit	Quarter 3	All Mental Health & LD Units	Service Managers and Team Managers	Capacity to take students and mentors reviewed every 12

					months. Date to be confirmed.
Audits in response to Identified Risk	CRHTT audit of CTP/WARRN & 72 hour f2f assessments	Quarter 3	All Mental Health & LD Units	Service Managers and Team Managers	CRHTT policy now ratified. Audit template developed deadline of Q4
Audits in response to Identified Risk	Older adult CMHT discharge audit	Quarter 3	All Mental Health & LD Units	Service Managers and Team Managers	Completed. Remedial action required. However, supportive assessment reviewed this in May 2025.
Audits in response to Identified Risk	s136 audit	Quarter 3	All Mental Health & LD Units	Clinical Director MH&LD	Internal audit and partner review in MHAA operational group. Audit of both required. Ongoing process of review – rapid reviews and longitudinal ongoing.

Women and Children's Service

Midwifery

Driver	Audit Title	Expected End Date	Service	Lead	Status
Local Audit for Service Improvement	All Wales Handheld Maternity Records	July 2025	Maternity	Clinical Supervisor for Midwives	Rolling
Service evaluation	Maternity Triage Process Review	October 2025	Maternity	MatNeo Champion	Completed initial audit and implementation of change, but further audit required.

Local Audit following change to policy or procedure	VTE Guideline	November 2025	Maternity	Clinical Supervisors for Midwives	In progress
Local Audit following change to policy or procedure	Spontaneous Rupture of Membranes Guideline	April 2025	Maternity	Consultant Midwife	Completed
Local Audit for Service Improvement	Perinatal Mental Health Birth Management Planning	December 2025	Maternity	Perinatal Mental Health	Not Yet Due
Local Audit for Service Improvement	Intrapartum Transfers from Powys to DGH *(Business as usual)*	June 2025	Maternity	Consultant Midwife	Rolling – completed monthly as they arise and learning shared
Local Audit for Service Improvement	Clinical Information Sharing Caseload *(Business as usual)*	March 2026	Maternity	Clinical Supervisors/Consultant Midwife	Not Yet Due
Children's Nursing Leadership Team					
Local Audit for Service Improvement	Transition	Q2 &Q4	Children's Services	SD	Q2 complete Q4 not yet due
Local Audit for Service Improvement	Children's Continuing Care	Q4	Children's Services	SD	Not Yet Due
Children's Public Health nursing (Health Visiting & Flying Start)					
Local Audit for Service Improvement	Routine Enquiry (Quarterly)	Q3	Generic HV& Flying Start	WD/Delegate	Not Yet Due
Local Audit for Service Improvement	Record Keeping	Annual	Generic HV& Flying Start	WD/Delegate	Rolling
Local Audit for Service Improvement	Was Not Brought	Monthly	Generic HV& Flying Start	WD/Delegate	Rolling with QI implemented based on findings
Local Audit for Service Improvement	Welsh Levels of Care	Quarterly	Generic HV& Flying Start	WD/Delegate	Rolling
Local Audit for Service Improvement	Implementation of Guideline: Health Visiting Caseload cleanse	6monthly	Generic HV& Flying Start	WD/Delegate	In progress
Local Audit for Service Improvement	Cypris Data Compliance	6 monthly	Generic HV& Flying Start	WD/Delegate	In progress
School Nursing and Immunisation Team					

Local Audit for Service Improvement	Was Not Brought	Monthly	School Nursing/Imms	WD/Delegate	Rolling with QI implemented based on findings
Local Audit for Service Improvement	Flu Immunisation Uptake	Following programme	Immunisation Team	WD/Delegate	Rolling
Local Audit for Service Improvement	DTP MenACWY Imms Uptake	Following programme	Immunisation Team	WD/Delegate	Rolling
Local Audit for Service Improvement	HPV Immunisation uptake	Following programme	Immunisation Team	WD/Delegate	Rolling
Local Audit for Service Improvement	E-Consent	Following each Imms programme	Immunisation Team	WD/Delegate	Rolling
Local Audit for Service Improvement	Level 1 Continence Delivery	Quarterly	School Nursing	WD/Delegate	Rolling – QI required and not yet delivered
Local Audit for Service Improvement	Record Keeping	Q4	SN/Imms	WD/Delegate	Not Yet Due
Local Audit for Service Improvement	Handwashing	Q4	SN/Imms	WD/Delegate	Not Yet Due
Local Audit for Service Improvement	ANTT (Immunisation nurses)	Q4	Immunisation team	WD/Delegate	Not Yet Due
	Safeguarding Caseloads	Quarterly	School Nursing Team	WD/Delegate	Rolling
Community Paediatrics					
National Audit	National Audiology Audit	Q3	Comm Paeds	RL	Not Yet Due
Local Audit for Service Improvement	ADHD Medications	Q2	Comm Paeds	RL	Not Yet Delivered
Local Audit for Service Improvement	Downs Syndrome Audit	Q4	Comm Paeds	IP	Not Yet Due
Local Audit for Service Improvement	CPIP +Register review	Q4	Comm Paeds	LA/RL	Not Yet Due
Local Audit for Service Improvement	Record Keeping	Q3	Comm Paeds	SD/LA	Not Yet Due
Children's Community Nursing					

Local Audit for Service Improvement	Was not brought	Monthly	CCNS	CD/Delegate	Monthly
Local Audit for Service Improvement	Record keeping	Quarter 4	CCNS	CD/Delegate	Not Yet Due
Local Audit for Service Improvement	ANTT	Quarter 4	CCNS	CD/Delegate	Not Yet Due
Local Audit for Service Improvement	Paediatric Continence	Quarter 4	CCNS	CD/Delegate	Not Yet Due
Local Audit for Service Improvement	Paediatric Epilepsy	Quarter 4	CCNS	CD/Delegate	Not Yet Due
Neuro Development Team					
Local Audit for Service Improvement	Introduction of caseload management	Monthly	ND	CD/Delegate	Being implemented from Q3
Local Audit for Service Improvement	Average length of open assessment pathways	Monthly	ND	CD/Delegate	Rolling
Local Audit for Service Improvement	Record Keeping	Quarterly	ND	CD/Delegate	Rolling
Local Audit for Service Improvement	Was Not Brought	Monthly	ND	CD/Delegate	Rolling

Audit Driver Key:

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

Progress Key:

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

Agenda item: 5.5

PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE	DATE: 23 OCTOBER 2025
Subject:	**Medicines Management and Pharmacy Annual Report 2024/25**
Approved and presented by:	Kate Wright, Executive Medical Director
Prepared by:	Chief Pharmacist
Other Committees and meetings considered at:	Executive Committee - 15 October 2025 who endorsed the report to the Committee.

PURPOSE:

The Medicines Management and Pharmacy Annual Report aims to provide an understanding of the roles and responsibilities of the Medicines Management / Pharmacy Team (MMT), the scope of the work undertaken, and the progress made during 2024/25. The report also outlines key medicines management / pharmacy challenges facing the team and the wider Health Board.

RECOMMENDATION(S):

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

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

Approve/Take Assurance	Discuss	Note
Y	Y	N

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:	
1. Focus on Wellbeing	N
2. Provide Early Help and Support	Y
3. Tackle the Big Four	Y
4. Enable Joined up Care	Y
5. Develop Workforce Futures	Y
6. Promote Innovative Environments	N
7. Put Digital First	Y
8. Transforming in Partnership	N

EXECUTIVE SUMMARY:
This report attached outlines the scope of the work undertaken by the Medicines Management Team (MMT), highlights the progress made between October 2024 and September 2025, raises awareness of the challenges and discusses the plans for the next 12 months.

IMPACT ASSESSMENT
Not required for this report.

Medicines Management and Pharmacy Annual Report 2024 -25

1. Foreword

As Chief Pharmacist, I am pleased to present the Medicines Management and Pharmacy Annual Report for 2024–25. Medicines remain the most common therapeutic intervention and one of the highest areas of NHS expenditure. The safe, effective and efficient use of medicines is therefore central to patient outcomes, financial stewardship and the statutory duties of the Board.

This report provides assurance to the Board on the governance of medicines, the progress made by the Medicines Management and Pharmacy Team and outlines our future priorities. It also highlights the impact our work has on patient safety, experience and value for money across Powys.

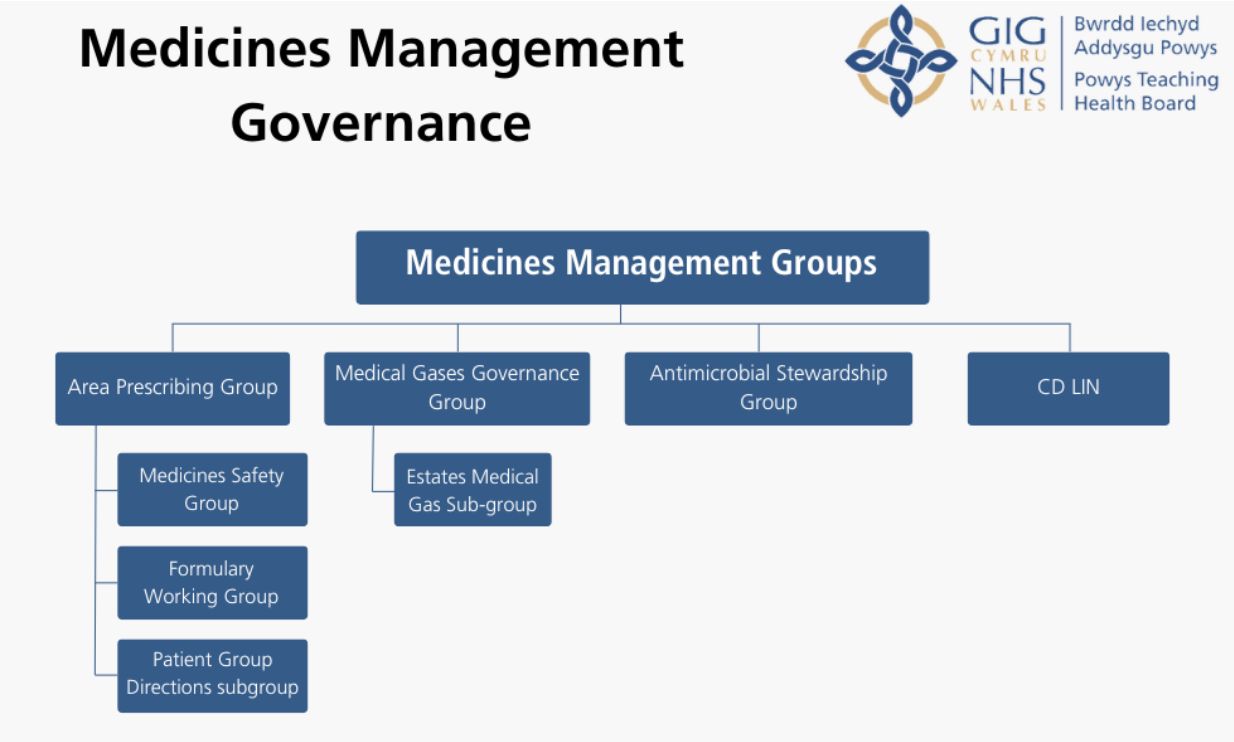
2. Introduction

The Medicines Management and Pharmacy Service plays a critical role across the 2,000 square miles of Powys. Medicines account for around 10% of the Health Board's budget and carry high clinical and financial responsibility. The team works across community, primary care, hospitals and with commissioned providers to ensure that patients receive the right medicines at the right time, with the best possible outcomes.

This report aligns with the Health and Care Quality Standards and reflects our contribution to the statutory Duty of Quality, Duty of Candour and wider national strategies.

3. Medicines Governance

Strong governance underpins our work. The Chief Pharmacist is the Board's statutory lead for medicines. Medicines governance is overseen through the Area Prescribing Group and its sub-groups, including the Medicines Safety Group, Formulary Working Group and Patient Group Direction sub-group. Regular reporting ensures transparency, accountability and continuous learning.



Safe and Secure Management of Medicines

Medicines are used throughout the health board, and their safe and secure handling is essential to protect patients.

The Chief Pharmacist sets the overall framework and policy standards, ensuring that medicines are managed in line with legislation and best practice. This role also involves raising awareness of the risks associated with poor medicines management and how these risks can affect patient and public safety.

Operational leaders are responsible for making sure that the organisation's medicines requirements are built into local procedures and plans. Everyone who handles medicines must be competent, legally entitled, appropriately trained, and authorised to do so.

The Medicines Management Team (MMT) applies four core governance principles to guide its work:

Establish assurance arrangements – be clear about what we do and why.

Ensure capacity and capability – train staff and provide the right resources.

Seek assurance – demonstrate that we do what we say.

Continually improve – review and refine our practice.

Embedding responsibility for medicines safety is a key priority for the MMT. The team promotes a culture of evaluation, learning, and continuous improvement so that medicines safety is seen as everyone's responsibility.

The Pharmacy Team regularly audits critical processes, including controlled drug stock checks, expiry date monitoring, stock rotation, temperature control, and key management. Where issues are identified, remedial action is taken promptly and escalated where required.

Temperature Monitoring and Vaccine Management

Routine temperature monitoring of medicines storage is firmly embedded across PTHB, with thermometers and data loggers in use in all clinical areas. Because of the age of the estate, ambient temperature breaches are not uncommon, especially in the summer. The Pharmacy Team provides rapid support whenever cold chain incidents occur.

During 2024/25, a comprehensive audit of vaccine management in GP practices delivered significant improvements. Within a year, reported vaccine wastage fell by £21,000, equating to 544 fewer wasted doses, and the number of reported incidents reduced from 74 to 52. These results were achieved through tighter stock control, enhanced staff training, and proactive monitoring of vaccine orders. Practices received targeted feedback, and early intervention by the team prevented inappropriate use of RSV vaccines, ensuring patients received the right vaccine at the right time.

Impact: Powys is now recognised nationally for leading improvements in vaccine safety and stewardship. By reducing waste, safeguarding stock, and strengthening governance, the Medicines Management Team has delivered better value for the NHS while protecting patient safety.

Transforming Medicines Safety: ePMA Project Highlights

The introduction of Electronic Prescribing and Medicines Administration (ePMA) is one of NHS Wales' top digital priorities and marks a major step towards safer, smarter medicines use in Powys Teaching Health Board.

ePMA will replace paper drug charts and handwritten prescriptions with a fully digital system, giving doctors, nurses and pharmacists real-time access to essential information. This will help prevent errors, speed up medicines administration, and support safer prescribing across all inpatient settings.

Pharmacy professionals have been central to driving the programme:

- The Principal Pharmacist led on clinical strategy, digital safety and procurement, acting as Clinical Safety Officer and ensuring the system meets both local needs and national standards.
- The Senior Pharmacy Technician mapped medicines workflows across inpatient, outpatient and community settings—including cross-border care—and developed the project's Benefits Realisation Plan.
- The Principal Pharmacist also chaired the All-Wales ePMA Technical and Clinical Assurance Group (Aug 2024–Aug 2025).
- Pharmacy staff worked with colleagues across Wales and England using the same system, sharing learning from previous implementations.
- Pharmacy professionals completed the medicines configuration and validation for ePMA, building a system tailored to the needs of both patients and staff.

Key achievements so far include:

- End-to-end mapping of prescribing and administration processes.
- Baseline data collection to demonstrate expected improvements in safety, efficiency and clinician time.
- User testing and selection of digital hardware to ensure the best fit for ward teams.
- Establishing a new clinical governance framework for digital prescribing in Powys.
- Delivering the evidence base that underpinned the Board-approved ePMA Business Case (July 2024).

Benefits of ePMA will include:

- Fewer medication errors and reduced patient harm.
- Secure, web-based access to prescribing records anytime and anywhere.
- Thousands of clinical hours released each year through the removal of paper processes.
- Complete, auditable and real-time data to support clinical decisions.
- Faster, safer care with fewer delays and more consistent standards.

The system is now in its final configuration and testing phase, with Phase 1 go-live planned for early 2026.

Primary Care Decision Support Software

In 2024/25, two clinical decision support systems were used in GP practices across Powys: ScriptSwitch (5 practices) and FDB OptimiseRx (10 practices). These systems support clinicians to improve the safety, effectiveness and value of prescribing.

When a prescription is entered, the system can generate either an information message (highlighting safety or cost issues) or a switch (suggesting an alternative medicine that is safer or better value, but clinically equivalent).

Impact: These tools are helping Powys clinicians make prescribing safer and more cost-effective, supporting both patient care and financial stewardship of NHS resources.

Decision Support Software	Total Information Messages	Total Switches Offered	Switches Accepted	Savings Realised*
ScriptSwitch	17,448	13,211	2,504 (19% acceptance rate)	£43,869
OptimiseRx	26,730	29,014	4,434 (15.3% acceptance rate)	£239,992

Immunisation and vaccination

Pharmacy involvement in the health board's national immunisation and vaccination programmes has strengthened governance of vaccine safety. The Medicines Management Team (MMT) now oversees vaccines from the point of delivery to the point of administration, ensuring safe handling at every stage. The team also leads work to prevent and reduce vaccine waste.

The range and volume of vaccines managed by the MMT continues to expand and will increase further as the National Immunisation Framework for Wales is implemented.

Influenza vaccination

From the 2025–26 flu season, Welsh Government has taken on **central procurement** of flu vaccines for all eligible groups. This replaces the previous model where GP practices and community pharmacies placed individual orders with manufacturers. The new approach will streamline the process, improve supply reliability, and strengthen oversight of vaccine distribution across Wales.

Eligibility criteria and vaccine recommendations remain the same as in 2024–25, covering:

- Children aged 2 and 3 years, and school-aged children.
- People aged 6 months to 64 years in clinical risk groups.
- Adults aged 65 and over.
- Pregnant women, carers, and frontline health and care workers.
- Individuals with specific needs such as learning disabilities or homelessness.

By moving to central procurement, the programme is expected to deliver greater efficiency and equity, ensuring that all eligible people in Powys and across Wales have timely access to flu vaccination.

Covid-19 treatments

Vaccination remains the most effective protection against COVID-19. However, some vulnerable people can receive antiviral or monoclonal antibody treatments if they contract COVID-19 and are at high risk of severe illness.

Until April 2025, the Medicines Management Team (MMT) was responsible for receiving referrals from NHS 111, triaging patients, and supplying treatment under national Patient Group Directions (PGDs). First-line treatment with Paxlovid® was collected or delivered to patients across Powys, while second-line treatment with intravenous sotrovimab was administered in Minor Injury Units (MIUs) by trained nurses.

During 2024/25, the MMT triaged 93 patients for COVID-19 treatments:

- 39 patients (42%) received Paxlovid®.
- 15 patients (16%) received IV sotrovimab.
- 24 patients (26%) were ineligible.
- 15 patients (16%) declined treatment.
- The remainder were either not Powys patients, not contactable, or were offered advice and guidance.

This activity was supported by a bank nurse appointed early in 2024/25 and by the hospital pharmacy team for inpatients.

From April 2025, following national changes to the General Medical Services (GMS) contract, responsibility for first-line COVID-19 treatment moved to primary care clinicians. At the same time, NICE revised the eligibility criteria, restricting treatment to only the highest-risk patients because broader use was no longer considered cost-effective (each course costs £829).

The MMT has since led the development of a new pathway enabling primary care clinicians to refer patients for IV sotrovimab when Paxlovid® is unsuitable. Training and resources, prepared by the antimicrobial stewardship pharmacist, have been shared with primary care clinicians and community services teams, including MIU staff and district nurses.

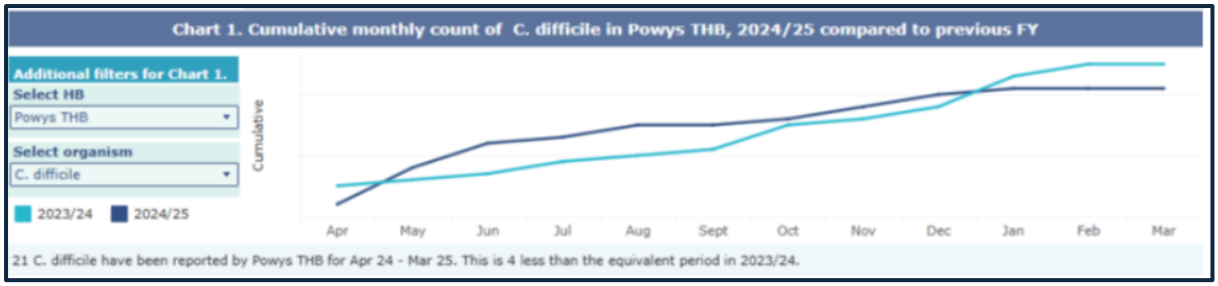
Impact: This careful transition has safeguarded patient access to COVID-19 therapies while shifting responsibility into primary care. By providing clear pathways, training and governance oversight, the MMT has ensured that Powys residents continue to receive timely and appropriate treatment, avoided unnecessary costs, and strengthened the system's resilience to future waves of infection.

Antimicrobial Stewardship (AMS)

Antimicrobial resistance (AMR) remains a major global threat, recognised by the World Health Organization as one of the top ten public health risks worldwide. To address this, Welsh Government published **antimicrobial improvement goals** in 2024, to be achieved by 2029.

Measure	Target	Progress March 2025
Primary care total antibiotic prescribing Metric: Antibacterial DDDs per STAR-PU	Quarterly reduction of 5% against a Q4 2019/20 baseline of 2,373	Q4 2024/5 = 2,407 Increase of 1.4% **Target not met**
Primary care broad-spectrum (4C) antibiotic prescribing Metric: 4C antibacterial DDDs per 1,000 patients	Maintain performance levels within lower quartile (threshold 34.9) or show reduction towards the quartile below	Q4 2023/4 = 74.03 Q4 2024/5 = 56.79 **Decrease of 23%**
Primary Care Watch + Reserve prescribing Source: HARP, Local data Metric: Total primary care antibiotic prescribing from the “Access”, “Watch” and “Reserve” categories of the WHO Essential Medicines List AWaRe Index	70% of total antimicrobials prescribed from the “Access” category	70.4% **Target met**

Alongside these measures, the Health Board has seen a reduction in **Clostridium difficile infections**, with 21 cases reported in 2024/25 – four fewer than the same period in 2022/23.



Key activities in 2024/25 included:

- Recruitment of a dedicated Antimicrobial Stewardship Pharmacist (Oct 2024), bringing Powys in line with other Welsh health boards.
- Delivery of protected learning time sessions for primary care clinicians (Feb–Mar 2025).

- Development of prescribing resources, including one-page guideline summaries and treatment duration posters.
- Launch of live dashboards to allow clinicians to track and benchmark antimicrobial prescribing.
- Migration of antimicrobial guidelines from MicroGuide to the new Eolas platform.
- Delivery of AMR and AMS awareness sessions through induction, preceptorship, nurse/pharmacy training, and wellbeing roadshows.
- Hospital audit of guideline adherence with direct feedback to ward teams.
- Ongoing clinical support for primary care clinicians and hospital staff.
- Co-ordination of public health campaigns, including World Antimicrobial Awareness Week.
- Joint reviews with Infection Prevention and Control teams for every C. difficile case, with recommendations to prevent recurrence.
- Planning with community services for an Outpatient Parenteral Antimicrobial Therapy (OPAT) service.
- Updating the formulary to include new therapies, e.g. Pylera®.
- Delivery of the AMS Improvement Plan, accelerating progress towards national goals.

Impact: With the appointment of a dedicated AMS Pharmacist, Powys now has the leadership capacity to deliver a robust stewardship programme. Regular audit, education, feedback and strengthened governance are improving prescribing practice, reducing the risk of healthcare-associated infections, and aligning Powys with national antimicrobial standards.

Next steps for 2025/26:

- Embed national and local policy directives into all Powys processes to provide assurance on meeting AMR standards.
- Monitor and report progress against AMR improvement goals, recommending further actions where necessary.

Patient Group Directions (PGDs)

Most medicines should be prescribed for individual patients. However, in some circumstances Patient Group Directions (PGDs) allow healthcare professionals to supply or administer specified medicines to pre-defined groups of patients without a prescription. PGDs are only used where they improve patient care without compromising safety.

At Powys Teaching Health Board, PGDs are managed by the Medicines Management Team (MMT) under robust governance arrangements. Oversight is provided by the PGD Sub-Group, which meets monthly as part of the Area Prescribing Group.

Activity in 2024/25:

- 58 PGDs were developed or reviewed.
- A total of 67 PGDs are now in use across the health board, with a further 31 in community pharmacies.
- All PGDs are published on the health board website for ease of access.
- Development of each PGD involves a multidisciplinary team including a doctor or dentist, a pharmacist, and a representative of the professional group expected to use the PGD.

Governance and audit:
The MMT audits the use of PGDs to ensure they are being applied safely and appropriately. Audits consider:

- Frequency of use of individual PGDs.
- How staff access the most up-to-date versions.
- Whether staff are authorised and competent to use PGDs.
- Registration and training status of staff.
- Record-keeping practices.

These audits have highlighted areas for improvement, including PGDs that may no longer be required, and circumstances where non-medical prescribing should be prioritised instead of continued reliance on PGDs.

Protocols:
Where legislation allows, a medicine protocol may be developed instead of a PGD. Protocols are used for medicines that do not require a prescription (General Sales List or Pharmacy medicines) and support the safe and timely care of pre-defined patient groups. Four such protocols were developed or reviewed in 2024/25.

Impact: The PGD programme provides a safe and effective mechanism for delivering medicines in specific circumstances. By maintaining strict governance, auditing use, and promoting alternatives such as non-medical prescribing where appropriate, Powys continues to ensure that PGDs support patient care without undermining safety.

4. Learning from Experience & Patient Safety

Improving medicines safety remains a top priority. During 2024/25 we enhanced incident reporting, strengthened use of Datix and Yellow Card submissions, and developed thematic learning from medication-related incidents. Medicines shortages and antimicrobial resistance were significant challenges, addressed through proactive engagement with clinicians and patients.

Examples of improvement include:
• Development of a Medicines Safety Champion network across clinical teams.
• Introduction of targeted safety alerts (e.g. warfarin–tramadol interaction).
• Increased use of the ‘Medicines Matters’ newsletter and safety huddles to share learning in clinical teams.

Medicines Safety Leadership

The Medication Safety Officer (MSO) role is embedded in the Medicines Management Team to drive learning, improvement and assurance around medicines safety. Acting as the organisational link with the MHRA, Welsh Government and the national MSO Network, the MSO ensures timely action on national safety alerts, supports incident reporting, and leads local improvement initiatives.

The MSO chairs the Medicines Safety Group (MSG), a sub-group of the Area Prescribing Group, which meets monthly to oversee safe use of medicines across PTHB. The group provides assurance to the Board, promotes a culture of safety, reviews and learns from incidents, and coordinates quality improvement initiatives.

During 2024/25 the MSO expanded the medicines safety team, engaging pharmacy technicians, nurses and other healthcare professionals as “medicines champions” within every clinical service. A network of champions is being established to share learning and strengthen practice across Powys. The MSG also set up a dedicated sub-group to lead implementation of new valproate safety regulations, with a live Action and Improvement Plan now in place.

Impact: Medicines safety leadership has been strengthened through clear governance, wider staff engagement, and proactive response to national priorities, ensuring lessons are learned and risks minimised across the health board.

Datix

Medicines related incidents are reported via the Once For Wales Concerns Management System (Datix). The Head of Community Services Pharmacy is notified of all incidents involving medicines and, where necessary, support is provided by the MMT to investigate and share learning.

During 2024/25 further work was undertaken with the health board's Safety Systems and Information Co-ordinator to develop routine reports from the Datix system, extracting information on the themes associated with the incidents, to help identify the priority areas that need to be address.

Within the health board 238 medicines related incidents were reported via Datix, along with an additional 123 incidents reported via community pharmacy.

Common themes from the health board reported incidents included:

- Delayed administration (including critical medicines)
- Incorrect medication
- Incorrect dose
- Incorrect frequency
- Incorrect time of administration
- Omitted medicines

The health board's Medicines Management Nurse plays an active role in supporting clinical staff to learn from medicines incidents and now produces a quarterly newsletter 'Medicines Matters' which shares learning from Datix reports. 'Specials' are also produced to communicate specific areas where incident reporting appears to be on the rise. The Medicines Management nurse regularly participates in 'safety huddles' relating to medicines incidents which have caused harm or had the potential to cause harm to patients and works alongside ward managers to investigate medication incidents. The Medicines Management Nurse also provides support, supervision and education to registered nurses/registered mental health nurses involved in medicines incidents.

During 2025/26 further work will be undertaken to improve the quality of Datix reports, encourage wider reporting of medicines related incidents, refine the reports extracted from Datix and to ensure that processes are in place to support widespread learning from the incidents.

5. Patient & Community Experience

Community pharmacies across Powys continue to provide essential services including the Common Ailments Service, contraception, emergency supply, influenza vaccination and needle exchange. These services improve access, reduce pressure on general practice, and support national priorities such as smoking cessation and antimicrobial stewardship.

Community Pharmacy

Community pharmacies play a vital role in communities across Powys. As providers of NHS services, they contribute directly to improving the health and wellbeing of the people, both by ensuring they get the medicines they need to keep themselves well and by providing an alternative to other NHS services for a range of health and advice needs.

There are 23 community pharmacies in Powys, providing care closer to home, often without an appointment, taking pressure of other parts of the NHS and releasing time for other services to deliver the care only they can provide.

In April 2022, substantial reforms to the way the NHS contracted with community pharmacies were introduced, encouraging the provision of clinical services and promoting integration with other primary care contractors, the NHS and social care. The reforms described in Presgripsiwn Newydd published in December 2021 have been the catalyst for transformation in community pharmacy. Building on the traditional strengths and values of the sector to ensure the continued safe dispensing of prescribed medicines, pharmacies now deliver clinical services more consistently and in greater number than ever before. This has been instrumental in reshaping the way that many people access NHS services in Wales.

Implementing the Welsh Government 56-Day Prescribing Directive

Welsh Government guidance encourages health boards to move from 28-day to 56-day prescribing intervals, where clinically appropriate, to improve patient convenience, reduce medicines waste and release dispensing capacity within community pharmacy.

Powys Teaching Health Board has made strong progress in implementing this directive. Many patients whose prescriptions are dispensed by community pharmacies are now on 56-day prescribing intervals, helping to release capacity for pharmacy teams to focus on the delivery and expansion of clinical services such as the Common Ailments Service, contraception service and independent prescribing.

Engagement continues with dispensing GP practices to explore how this approach can be adopted more widely while maintaining financial viability and safeguarding patient access to medicines. The health board remains committed to maximising the benefits of 56-day prescribing across Powys to support a more sustainable and patient-centred approach to medicines supply.

Clinical Community Pharmacy Service (CCPS)

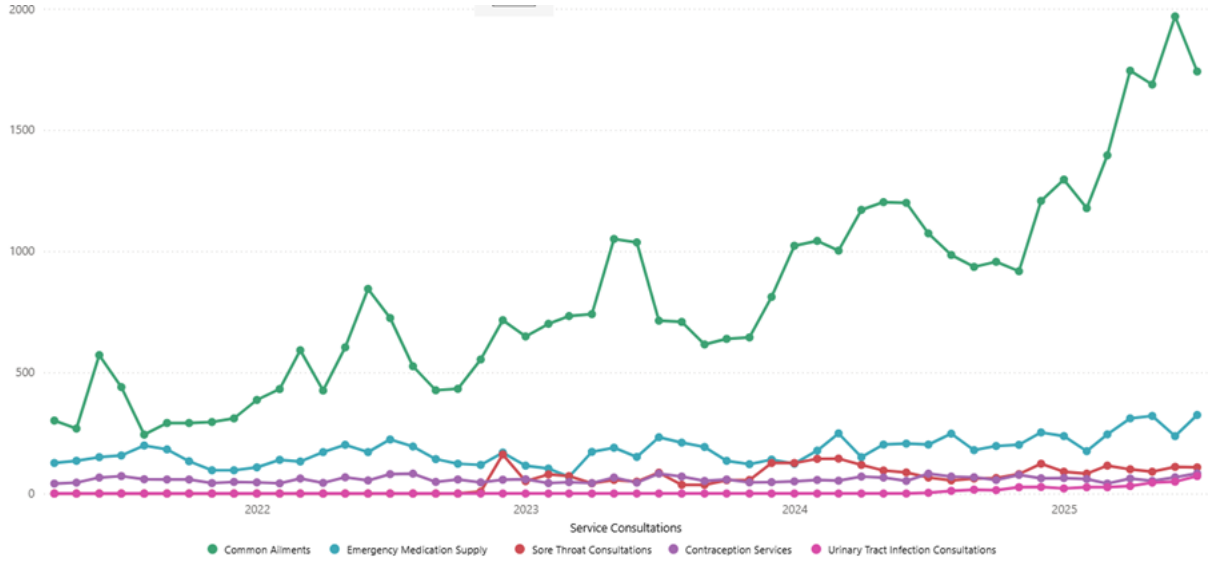
In April 2022 a new National Directed Service, the Clinical Community Pharmacy Service (CCPS) was introduced in Wales. The service originally incorporated four existing services: Common Ailments Service (CAS), Emergency Contraception Service, Emergency Medicines Supply (EMS) Service, Seasonal Flu Vaccination Service.

Several changes have been made to the service over the years and from 1st October 2025 the service will consist of 5 mandatory elements:

- Common Ailments Service (CAS)
- Contraception Services (Emergency Contraception and QuickStart Contraception)
- Emergency Medicines Supply (EMS) service
- CAS – Management of Sore Throat (as of April 2025)
- CAS – Management of Urinary Tract Infection (as of October 2025)

All 23 community pharmacies in Powys are commissioned to provide the CCPS and must deliver all mandatory component services to qualify for payment.

The graph below demonstrates that, overall, CCPS consultations in Powys community pharmacies have risen steadily over time, with common ailments showing the most significant and rapid growth compared to other services.



Common Ailments Services (CAS)

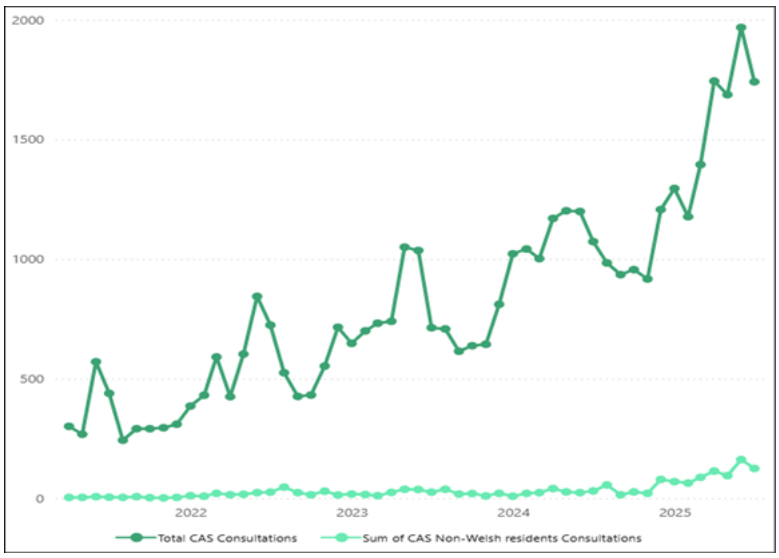
The Common Ailments Service provides advice and treatment to people who have minor illnesses. It is offered by every community pharmacy contractor in Powys and it covers 28 different conditions, from acne to warts and verruca's.

The service can be accessed by anyone, including tourists, as long as they plan to stay in Wales for at least 24 hours after visiting the pharmacist.

During 2024/25, 13,510 CAS consultations were undertaken in community pharmacies across Powys. This represents a 35% increase in consultations compared to 2023/24.

90% of consultations were for Powys residents, 3.2% were for people living outside Powys but within Wales, 3% lived on the border and 2.3% lived in England.

The graph below shows a significant increase in total CAS consultations from 2022 to 2025, reaching nearly 2,000 by 2025, while consultations involving non-Welsh residents remained low and relatively stable throughout the same period.



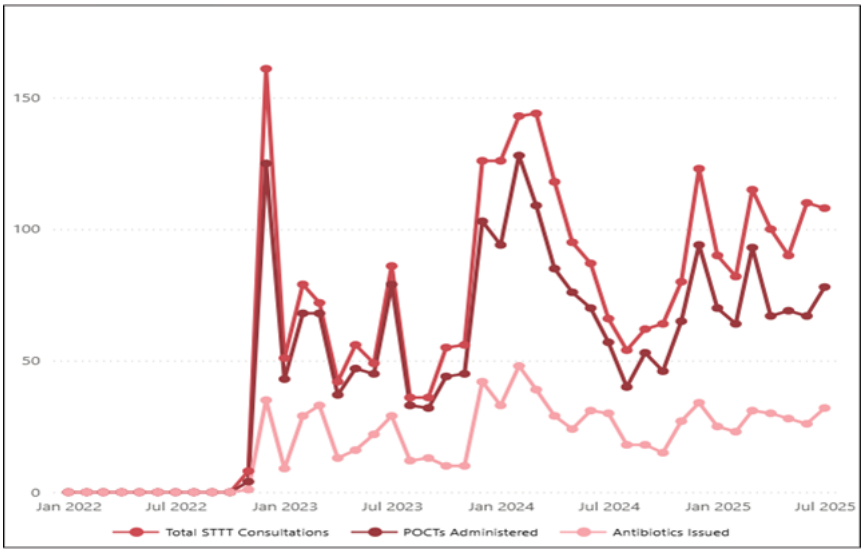
The Medicines Management Team continues to monitor provision of the Common Ailments Service and shares service data with contractors.

CAS - Management of Sore Throat

This service was formally known as the Sore Throat Test and Treat (STTT) service. It became a mandatory element of the CCPS on 1st April 2025 and provides eligible patients with access to clinical assessment and the provision of advice and appropriate medication when presenting with symptoms of acute sore throat.

During 2024/25, 1,036 STTT consultations were undertaken in community pharmacies across Powys. 813 point of care tests were carried out and 305 courses of antibiotics supplied. This represents an 8.5% increase in consultations compared to 2023/24.

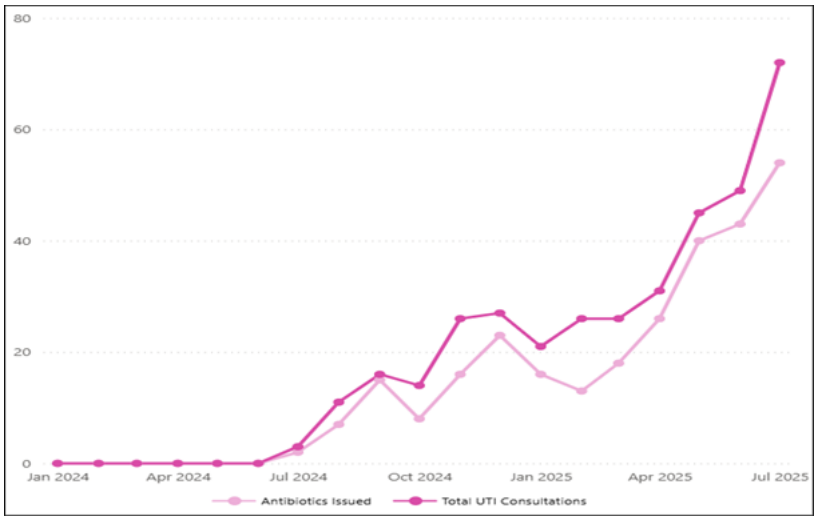
The graph below shows a steady increase in STTT consultations from January 2022 to July 2025, with noticeable seasonal fluctuations—activity typically peaking in winter months.



CAS – Management of Urinary Tract Infection (UTI)

The Urinary Tract Infection service offers eligible patients access to a clinical assessment, expert advice, and, where appropriate, the supply of medication for symptoms of a lower UTI. The service will become a mandatory element of the CCPS in October 2025. Ahead of this, the Medicines Management team has supported contractors to successfully accredit to provide the service from 1st October, ensuring readiness and consistent delivery across Powys.

During 2024/25, 170 UTI consultations were carried in community pharmacies across Powys with 118 courses of antibiotics supplied.



The graph above shows a steady increase in UTI Consultations and Antibiotics Issued from January 2024 to July 2025, with a notable spike beginning around April 2025 in preparation for its mandatory inclusion in the CCPS from October 2025.

Contraception Services

All community pharmacies in Powys provide access to emergency hormonal contraception. In 2024/25, there were 768 consultations, a 16.5% increase on the previous year.

From February 2025, legislation was updated to allow pharmacy technicians to deliver contraception services under a Patient Group Direction (PGD) as part of the Clinical Community Pharmacy Service. This development is expected to expand capacity and improve access across Wales.

Emergency Medicines Supply Service (EMS)

The EMS allows community pharmacy contractors to supply previously prescribed medicines to patients, via the NHS, where, for example, a patient may have run out of their medicine, or they may have lost their medication or left it at home if they are on holiday in Wales. The service is available if the patient is unable to obtain a prescription before their next dose is due.

During 2024/25, 2,491 emergency supplies were made by community pharmacy contractors in Powys. This represents an 19% increase on the number of supplies made during 2023/24. The table below shows the reasons why access to the EMS service was required.

Reason for Supply	No. Consultations	%
Not ordered in time	1042	56%
On holiday and medication forgotten	613	16%
Prescription not available in the GP practice for collection	483	14%
Lost or misplaced medicine	254	10%
Not able to collect from usual pharmacy	76	3%
Other	21	1%
(blank)	2	0%
Total	2491	100%

Although EMS should not be routinely accessed by residents during surgery hours (Monday-Friday 9am-5pm), 34% of EMS consultations for patients registered with a GP in Powys were carried out during surgery hours. Clear outliers have been identified, and the MMT will work collaboratively with relevant stakeholders to investigate and resolve any underlying causes or service delivery concerns.

Pharmacist Independent Prescribing Service (PIPS)

Eight community pharmacy sites across Powys offered a prescribing service to the local population during 2024/25. Patients were able to access treatment for an extended range of common conditions that might otherwise have required treatment from a GP surgery - including upper and lower respiratory infections, urinary tract infections and impetigo.

The MMT is continuing to work with contractors and Welsh Government to support the national ambition to have an independent prescribing pharmacist in every pharmacy in

Wales. Another four pharmacies are expected to start delivering prescribing services in Powys during 2025/26.

Discharge Medicines Review (DMR) Service

The DMR Service is available in all Powys community pharmacies. Its purpose is to improve patient safety after discharge from hospital or another care setting by:

- Reducing the risk of medication errors and adverse drug events.
- Improving communication between healthcare professionals, patients and carers.
- Reconciling the medicines a patient leaves hospital with those prescribed in primary care.

During 2024/25, pharmacies in Powys completed 213 DMRs.

Delivery rates remain lower than in other parts of Wales. A key reason is that many Powys patients are admitted to hospitals in England, where discharge information is not standardised in the same way as in Wales. The Medicines Management Team (MMT) is working with both Powys pharmacy contractors and English acute providers to improve the sharing of discharge information so Powys patients treated across the border also benefit.

Impact: DMRs are an important safeguard for patients moving between hospital and primary care. Strengthening cross-border information-sharing is essential to improving delivery rates and patient safety in Powys.

Influenza vaccination

In 2024/25, 3,867 flu vaccinations were administered in Powys community pharmacies under a PGD – a 13.4% decrease compared to the previous year.

From 2025/26, pharmacies will benefit from Welsh Government's move to central procurement of flu vaccines and the introduction of the Welsh Immunisation System (WIS) for recording vaccinations. These changes should support more efficient delivery and better oversight of the programme.

Impact: Despite a fall in uptake, community pharmacies remain a key access point for flu vaccination. New national systems are expected to support contractors and improve uptake in 2025/26.

Needle and Syringe Supply Programmes

In 2023/24, eight pharmacies provided sterile injecting equipment under the Level 1A Needle Exchange Service. They supported 563 transactions for 152 unique clients.

In 2024/25, the service was successfully extended to more rural areas, with 13 pharmacies now commissioned across Powys, including Presteigne, Rhayader and Machynlleth. This expansion increased reach and activity: 846 transactions were recorded for 167 unique clients, a 50% increase compared to the previous year.

In addition, three pharmacies were commissioned to provide the Level 3 Naloxone Supply Service, giving injecting drug users, their families and peers access to potentially life-saving treatment for opioid overdose.

Plans are in place to expand naloxone supply to all pharmacies offering needle exchange. However, this is on hold pending a national review and update of the service specification.

Impact: Extending needle and naloxone services has improved access to harm reduction and lifesaving interventions across Powys, especially in rural areas. National guidance will shape the next stage of expansion.

5. Person Centred Care

Self-administration

Supporting patients to manage their own medicines during a hospital stay promotes independence, builds confidence and reduces the risk of deconditioning. It also prepares patients for a safer, smoother discharge.

In 2024/25, the Pharmacy Team extended access to self-administration, with implementation on Llewellyn Ward (Bronllys Hospital) and training provided for nursing staff on Claerwen Ward (Llandrindod Wells Hospital). Patients are supported through two levels: supervised administration (Level 2) and independent administration from bedside lockers (Level 3), with all patients starting at Level 2 before progressing as appropriate.

The Pharmacy Team leads training and works with multidisciplinary teams to assess patient suitability. While workforce challenges limited full roll-out, the team remains committed to expanding self-administration across all PTHB hospital sites in 2025/26.

Impact: More patients are being supported to take control of their own medicines in hospital, improving safety, independence and readiness for discharge.

Medicines Management Support to Care Homes and Domiciliary Care

During 2024/25 the MMT provided support to 40 care homes, all of which received at least one physical visit. Visits were prioritised according to need (e.g. if the home had had a medicine related incident or if a medicine related safeguarding concern had been raised) and requests for support. The MMT supported care homes to review all processes including ordering, storage, administration and disposal of medicines and offered support and guidance based on best practice.

The MMT works closely with Powys County Council and social care agencies and regularly supports investigations into incidents involving medicines.

During 2024/25, a joint medicines policy was agreed with Powys County Council for the administration of medicines within domiciliary care settings.

6. Workforce & Partnerships

Recruitment and retention remain a challenge across pharmacy, particularly in rural areas. During 2024/25 we strengthened our workforce through pharmacy technician roles, ILM leadership training, and participation in the HEIW workforce plan. Partnerships with GP practices, care homes, Public Health Wales and national pharmacy networks underpin our ability to deliver safe, sustainable services.

Clinical Pharmacy Services

The health board's clinical pharmacy team is managed by the Head of Community Services Medicines Management. Services are provided to all PTHB sites (Brecon, Bronllys, Llandrindod Wells, Llanidloes, Machynlleth, Newtown, Welshpool and Ystradgynlais, community teams and limited support to Knighton and Glan Irfon) by pharmacists, pharmacy technicians, medicines management nurses and assistant technical officers.

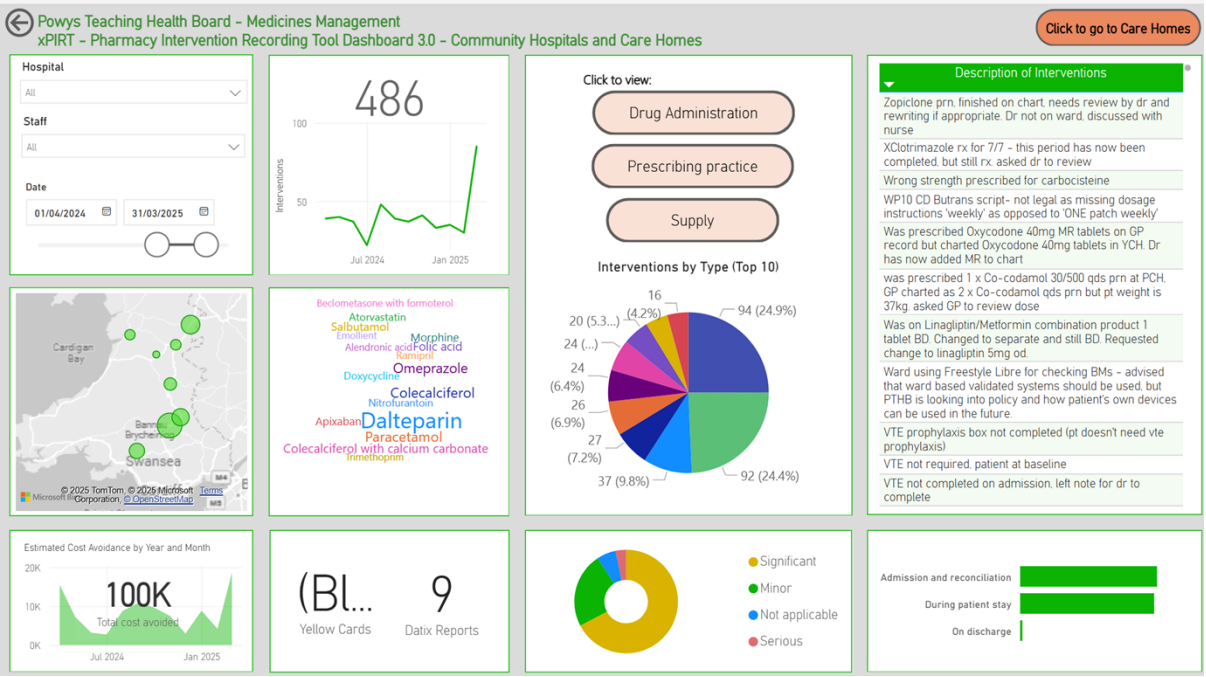
Our clinical pharmacy service ensures that the use of medication is both safe and appropriate, and that patients receive the best possible care. The service provided by the team includes, but is not limited to:

- Clinical advice and support to health care professionals
- Medication history taking
- Medicines reconciliation
- Managing medicines via MTeD
- Ensuring the safe and secure management of medicines
- Attending multidisciplinary team meetings
- Dispensing at ward level
- Accuracy checking dispensed items
- Medication chart review
- Storage temperature compliance
- Ensuring that medicines alerts/recalls are actioned and advising on shortages
- Supporting self-administration
- Patient/carer counselling
- Management of patients own drugs
- Mentoring and supervising support staff and students
- Discharge planning (including liaison with primary care, care homes; assembling and checking TTOs)
- Medicines ordering, stocklist review
- Monitoring formulary compliance and ensuring that prescribing is evidence based and cost-effective

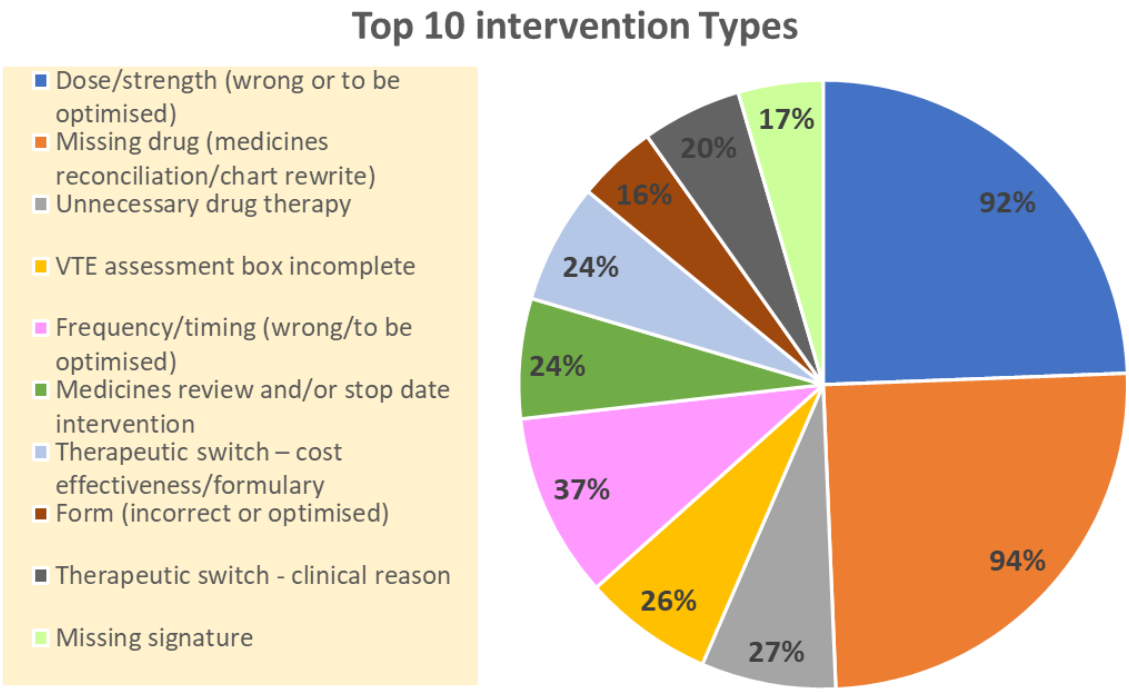
Hospital admissions data and patient acuity is used to guide the frequency of clinical pharmacy support to each hospital site. There is a pharmacy presence on each of our hospital sites at least twice a week and the team provide remote support when they are not physically present on the site.

Pharmacy Intervention Reporting Tool

Interventions undertaken by the Clinical Pharmacy team are recorded on the Pharmacy Intervention tool with analysis through a Power BI dashboard. 486 interventions were recorded during 2024/25.



The chart below shows the top 10 intervention categories and the percentage of interventions recorded against each category.



The Power BI dashboard allows interventions to be analysed to identify areas where further work may be required e.g. development of prescribing guidelines and the information gathered is used during hospital training or review sessions.

During 2024/25, dalteparin remained the most frequently queried medicine, mainly around correct use for VTE prevention and dose adjustments for weight, renal function, and clinical

indication. In response, VTE prophylaxis guidance is being developed, with a planned switch to enoxaparin.

Other recurring themes included improving weight-based dosing of paracetamol, identifying opportunities to deprescribe omeprazole, and optimising anticoagulant use through appropriate dosing and formulary adherence.

Reviewing antimicrobial use has been a frequent intervention, including appropriate management of UTI and wound infections. Firstly, assuring that use is indicated and where it is that the choice of antimicrobial is in line with PTHB Eolas guidance and that appropriate course lengths are used.

Impact: Ward/department level reports are provided from the Power BI dashboard and analysed within the pharmacy team and with clinical teams to capture themes, share learning and enhance guidance.

Non-medical prescribing

Several groups of healthcare professionals, beyond doctors and dentists, can train to prescribe medicines within their area of practice. These are known collectively as Non-Medical Prescribers (NMPs).

- Independent Prescribers are responsible for assessing patients (with new or existing conditions) and making prescribing decisions.
- Supplementary Prescribers work in partnership with a doctor or dentist to deliver care according to an agreed management plan.

Eligible professions include nurses, pharmacists, physiotherapists, optometrists, podiatrists, paramedics, therapeutic radiographers, and (for supplementary prescribing only) dietitians.

Benefits of NMPs:

- Faster access to treatment for patients.
- Reduced waiting times and greater choice.
- Better use of professional skills across the workforce.

Governance

The Medicines Management Team (MMT) leads on governance for non-medical prescribing (NMP), including training access, maintaining the prescriber database, and assuring safe practice.

During 2023/24, service managers were asked to embed NMP requirements in Service Development Plans, and a clear process was agreed to allocate training places based on service need.

In October 2023, Health Education and Improvement Wales (HEIW) introduced new all-Wales standards for assuring prescriber competence. Welsh Government requires these to be implemented by March 2026. PTHB has nominated the Chief Pharmacist as senior lead, with the NMP Lead developing a local implementation plan in partnership with HEIW.

Qualified prescribers	Total 2025
Community Practitioner Nurse Prescribers (CPNPs)*	55
Independent NMPs/PTHB	47
INMP / Primary care staff	10
INMP/Pharmacist	5
INMP / Optometrist	6

*CPNPs include district nurses, health visitors, community nurses and school nurses. They may prescribe from a limited list (the Nurse Prescribers' Formulary). In Powys, most CPNPs are health visitors or district nurses.

Independent NMPs work across a wide range of services including mental health, respiratory, cardiology, minor injuries, diabetes, learning disabilities, sexual health and palliative care.

In addition, we have some qualified prescribers who are not currently active. The MMT is working with these clinicians to understand barriers and support them back into prescribing practice where appropriate.

Next Steps

- Ensure all job descriptions clearly state prescribing expectations where required.
- Review and update each NMP's scope of practice annually.
- Continue supporting training and appraisal in line with national standards.

Impact: Strengthening non-medical prescribing in Powys increases flexibility, reduces pressure on medical staff, and improves patient access to timely treatment. Implementation of the national standards will give the Board assurance that prescribing by NMPs is safe, competent and consistent with all-Wales policy.

7. Value and Efficiency

The Medicines Management Team plays a central role in financial stewardship. The efficiency plan delivered savings across primary care, high-cost drugs and biosimilar switches. Decision support software (OptimiseRx and ScriptSwitch) provided over £283,000 in savings in 2024/25. Our work also supported the decarbonisation agenda, with measurable reductions in inhaler-related carbon footprint.

Efficiency Plan

During 2024/25 the MMT developed a comprehensive efficiency plan covering primary care prescribing, secondary care prescribing (commissioned services) and medicines costs associated with PTHB provider services.

The plan was broad and included all of the national value and sustainability priorities, along with locally identified priorities.

The national value and sustainability priorities for 2024/25 included:

- Maximising biosimilar use of adalimumab, etanercept, infliximab and ranibizumab; including preferential use of lowest acquisition cost biosimilars;
- Switching to generic use of abiraterone, apixaban, lanreotide, lenalidomide, teriflunomide, and sugammadex in secondary care;
- In primary care:
    - Preferential use of DOACs apixaban and rivaroxaban
    - Preferential use of sitagliptin as DPP4 of choice
    - Reduction in prescribing of WG basket of branded products
    - Reduction in prescribing of medicines on WG ‘low value’ list
    - Audit of procurement and cold chain process of NHS-procured vaccines
    - Restricting prescribing of bath and shower emollients
    - Selection of dry eye preparations in accordance with local formularies

At the end of the financial year the team had exceeded its efficiency target and delivered £2.7M of prescribing efficiencies.

Increasing cost pressures on the PTHB prescribing budgets during this period make delivery of efficiencies imperative to financial sustainability and maintaining access to new technologies recommended by NICE Guidance.

In primary care the majority of cost pressures came from:

- Drug Tariff price increases and Concession prices
- Increased prescribing of SGLT2 inhibitor drugs following NICE guidance recommendations
- Increases in more expensive inhaler products supporting the decarbonisation agenda/National Prescribing Indicator
- Increased use of interstitial blood glucose monitoring devices which reflects Health Technology Wales (HTW) guidance, that has widened access beyond the criteria set by NICE in England.

- Increased prescribing of sacubitril/valsartan following NICE guidance recommendations
- HRT – increased use (high profile celebrity promotion) and additional costs resulting from significant national shortages

High-cost drug management & Blueteq

Blueteq is a web-based system designed to strengthen both clinical and financial governance of high-cost medicines. It ensures that these medicines are prescribed in line with mandated guidance from the All-Wales Medicines Strategy Group (AWMSG) and NICE, while also giving patients faster access to approved treatments.

Governance and implementation:

- Roll-out is being overseen by the All Wales Blueteq Steering Group, with project management support from the All-Wales Therapeutics and Toxicology Centre (AWTTC).
- During 2024/25, following DPIA approval, PTHB was the first health board to start using Blueteq - with St Michael's Clinic (dermatology) in Shrewsbury, before wider roll out across English providers and further adoption across Welsh health boards.
- PTHB are leading on development of the All-Wales Blueteq forms for dermatology and are highly involved in supporting other health boards in the development of forms for other therapeutic areas.

Future benefits:
Blueteq will replace the current paper-based process for high-cost drug applications in Powys. The new system will:

- Provide real-time assurance that prescribing decisions follow national guidance.
- Improve the accuracy of monitoring and reporting on high-cost medicines.
- Strengthen audit trails and financial forecasting.
- Enhance transparency and reduce delays in patient access to treatment.

Impact: The move to Blueteq will give the Board much stronger assurance over the governance of high-cost medicines, ensuring both safe prescribing and prudent financial management, while supporting patients to receive the right medicines quickly and consistently.

National Prescribing Indicators

Since 2003, the All-Wales Medicines Strategy Group (AWMSG) has developed and endorsed National Prescribing Indicators (NPIs) to promote safe, effective and cost-efficient prescribing. These indicators allow health boards, primary care clusters, GP practices and individual prescribers to benchmark their performance against an agreed national standard.

For 2022–2025, the NPIs focus on four priority areas:

- Analgesics – including opioids, tramadol, gabapentin and pregabalin.
- Anticoagulants – for patients with atrial fibrillation.
- Antimicrobial stewardship – reducing overall antibiotic prescribing and specifically targeting the “4C” antibiotics: co-amoxiclav, cephalosporins, fluoroquinolones and clindamycin.
- Decarbonisation of inhalers – supporting a shift towards lower-carbon inhaler use and safe disposal.

These are supported by additional indicators covering:

- Safety – prescribing safety measures, hypnotics and anxiolytics, and reporting of Yellow Cards (adverse drug reactions).
- Efficiency – use of best-value biological medicines and reducing low-value prescribing.

How performance is measured:
Achievement thresholds are based on the prescribing rates of the best-performing 25% of practices in Wales (quarter 3, previous financial year). Targets are therefore relative rather than fixed, encouraging ongoing improvement rather than absolute numbers.

Local approach in Powys:

The Health Board operates a Prescribing Incentive Scheme, rewarding practices for improving performance against selected national priorities.

Practices receive monthly reports showing their performance on each indicator and how they compare to peers.

The Medicines Management Team discusses NPIs during annual practice visits and holds targeted conversations with practices facing specific challenges.

Impact: NPIs provide a structured, evidence-based way to improve the quality, safety and sustainability of prescribing in Powys. Through regular reporting, incentives and hands-on support, the Health Board can demonstrate assurance that prescribing practice is aligned to national priorities and contributes to better outcomes for patients.

Summary of overall HB position against the national prescribing indicators

The table below shows the extent to which practices in each health board met the target or indicator thresholds by quarter ending March 2025:

- The figure in the cell is the number of practices in each health board meeting the target or indicator threshold.
- The percentage figure and cell colour represent the proportion of practices in each health board meeting the target or indicator threshold.

The target for antibacterial items per 1,000 STAR-PUs is by health board, therefore a tick demonstrates achievement.

Health boards/practices achieving the indicator targets/thresholds – Quarter ending March 2025

Indicator Description	Aneurin Bevan	Betsi Cadwaladr	Cardiff and Vale	Cwm Taf Morgannwg	Hywel Dda	Powys	Swansea Bay
Opioid burden Total OME Per 1,000 Patients	18 26%	27 28%	40 73%	6 14%	9 19%	3 19%	9 20%
High Strength Opioid burden Total OME Per 1,000 Patients	19 28%	22 23%	27 49%	6 14%	6 13%	6 38%	16 36%
Tramadol DDDs per 1,000 patients	24 35%	24 25%	32 58%	8 18%	15 32%	7 44%	14 32%
Gabapentin and pregabalin DDDs per 1,000 patients	20 29%	21 22%	32 58%	2 5%	15 32%	2 13%	13 30%
Antibacterial items per 1,000 STAR-PUs	✓	✗	✓	✓	✓	✗	✓
4C antibacterial items per 1,000 patients	18 26%	47 49%	20 36%	15 34%	13 28%	2 13%	30 68%
DPIs and SMIs as a percentage of all inhalers	33 49%	21 22%	40 73%	21 48%	42 89%	4 25%	20 45%
Hypnotics and anxiolytics ADQs per 1,000 STAR-PUs	20 29%	26 27%	37 67%	8 18%	8 17%	8 50%	13 30%
Low Value for Prescribing (UDG) spend (£) per 1,000 patients	2 3%	35 36%	17 31%	4 9%	4 9%	4 25%	7 16%

Percentage of practices meeting threshold 0% 100%

It should be noted that the threshold targets are established in the December quarter of the preceding year and is based on the best performing quartile of all GP practices in Wales. Therefore, at the baseline only 25% of practices in Wales will be achieving the threshold target.

This information needs to be seen in the context of the trends in prescribing performance. AWTTC develop quarterly prescribing reports for health boards in Wales. These give the health board's ranking and progress regarding a series of measures in relation to the others.

The Medicines Management Team will continue to focus on these priority areas during 2025/26, and the reports provided to primary care will be refined to allow more interactive comparison at national, health board, cluster and practice level.

8. Future Developments

The year ahead presents an ambitious programme of work for the Medicines Management Team, building on the foundations laid in 2024/25. Our priorities for 2025/26 focus on delivering safer, smarter, and more sustainable medicines use across Powys:

- **Digital Transformation – ePMA implementation**
  The launch of the Electronic Prescribing and Medicines Administration (ePMA) system will be a landmark change, replacing paper-based prescribing with a fully digital process. This will reduce errors, save clinician time, and provide real-time data to improve safety and efficiency across inpatient care. Go-live is expected in early 2026, but the focus for 2025/26 will be on system build, testing, and preparing staff for the transition.
- **Expanding Pharmacist Prescribing**
  Welsh Government's ambition is for every community pharmacy to have an independent prescribing pharmacist. This will allow pharmacists to provide direct treatment for a wider range of conditions, improving access and reducing pressure on GP services. Work will also focus on ensuring pharmacists in managed sectors (such as hospitals and community services) can use these skills to their full potential, supported by clear governance and training.
- **Driving Safer, Greener Prescribing**
  Antimicrobial stewardship will remain a core priority, reducing unnecessary antibiotic use and tackling the global threat of antimicrobial resistance. Alongside this, the team will accelerate work on the decarbonisation agenda, with a particular focus on inhaler prescribing and disposal, supporting both patient health and the environment.
- **Strengthening Medicines Governance**
  Targeted work will be undertaken in areas of heightened clinical risk, including mental health services and the safe management of medical gases. New governance processes will provide assurance that medicines in these high-risk settings are being used safely, effectively and prudently.
- **Promoting Patient Independence**
  The roll-out of self-administration of medicines across Powys community hospitals will continue. This initiative empowers patients to take greater responsibility for their treatment, reduces deconditioning during hospital stays, and supports smoother, safer discharge planning.

These developments represent more than operational improvements. They demonstrate a commitment to modernising pharmacy services, reducing harm, enhancing patient experience, and ensuring Powys is aligned with national ambitions for digital innovation, prescribing practice, and sustainability.

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

Agenda item: 5.6

Patient Experience, Quality & Safety Committee	**Date: 23 October 2025**
Subject:	Medical Devices and Point of Care Testing Annual Report 2024 - 2025
Approved and presented by:	Claire Madsen, Executive Director for Allied Health Professions, Health Sciences and Digital
Prepared by:	Medical Devices Manager Point of Care Testing Co-ordinator
Other Committees and meetings considered at:	Executive Committee - 01 October 2025 who endorsed the report to the Committee.

PURPOSE:

This paper provides an overview of the Medical Devices and Point of Care Testing Service, its background to the organisation and its ambitions for 2025 – 2026. The report sets out how the service has performed over the past year, with highlights of the key achievements and a review of the challenges and risks.

RECOMMENDATION(S):

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

- **RECEIVE** the report and take **ASSURANCE** that the necessary responsibilities in relation to Medical Devices and Point of Care Testing are being met.

Approve/Take Assurance	Discuss	Information
✓	x	x

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:		
1. Focus on Wellbeing	✓	
2. Provide Early Help and Support	✓	
3. Tackle the Big Four	✓	
4. Enable Joined up Care	✓	
5. Develop Workforce Futures	✓	
6. Promote Innovative Environments	✓	
7. Put Digital First	✓	
8. Transforming in Partnership	✓	

EXECUTIVE SUMMARY:

This paper has been prepared for information and approval. It provides an overview of the Medical Devices and Point of Care Testing Service, its background to the organisation and its ambitions for 2025-2026. The report sets out how the service has performed over the past year, with highlights of the key achievements and a review of the challenges and risks.

Key achievements include the permanent appointment of a Point of Care Testing Coordinator that has led to improved governance and development opportunities; progress against internal audit recommendations and medical devices being added to the Community Equipment Service catalogue to enable prompt and efficient prescribing of key items of equipment to patients in the community. In addition, the procurement and awarding of the maintenance contract to a new provider, with the contract due to commence 01 April 2025. This is following a contract period of 3 years with previous provider which has proved to be challenging, as highlighted later in the report.

The Health Board has entered a joint contract with Cwm Taf Morgannwg University Health Board to procure dual Glucose/Ketone meters from Nova Biomedical. This collaboration has enabled the replacement of outdated glucose and ketone testing meters across both community and inpatient services. The new meters will support improved point-of-care testing, ensuring consistency, accuracy, and enhanced patient safety throughout our services. This has enabled the health board to come in line with other health boards in Wales in terms of model of machine and governance.

Hot topics for 2024/2025 or the health board include:

- following Welsh Government funding of over £1 million for replacement radiography equipment, new equipment has been purchased and is in place and up and running.
- development of a long-term replacement programme for high value equipment has commenced with further development planned for next year
- new process for reusing walking aids to reduce cost and waste implemented in August 2024
- and a procurement exercise for main maintenance contract which is due for renewal from 1st April 2025
- Improvements in the process for access to bariatric equipment for inpatient wards
- Opportunities for savings across all aspects of medical device and point of care testing management
- POCT involvement in clinical pathway expansion as part of the MIU service development

Compliance with statutory and legal requirements is always a priority for the health board. Focused work has been undertaken on the management of

Liquid Nitrogen Gas, which is used for minor dermatological procedures, ensuring robust governance is in place to achieve compliance with regulations.

The health board is required to ensure compliance with the Medical Device Regulations (MDR), which have been recently updated. The health board has fully engaged in a national group to monitor progress and contributed to a national preparedness survey which is reported to Welsh Government.

A review of bariatric equipment provision (equipment specifically designed to accommodate individuals with higher weight capacities or larger body sizes) has identified improvements are required. A planned approach to ensure inpatient staff can access suitable equipment in a timely manner will prevent any delays in patients being admitted to Powys hospitals and ensure patient experience is not compromised through inappropriate equipment. This work is being progressed by Medical Device Manager in conjunction with Head of Nursing, Community Service Group, and NWSSP Procurement following an options appraisal and decision made to progress with implementation of a formal rental arrangement.

A review of wheelchair provision has identified improvements are required in terms of availability and maintenance of appropriate chairs. Recommendations have been made.

DETAILED BACKGROUND AND ASSESSMENT:

A detailed background and assessment has been provided in the main Annual Report document below.

NEXT STEPS:

The health board will continue to work towards achieving the priorities listed in the report for 2025/2026.

POWYS TEACHING HEALTH BOARD
MEDICAL DEVICES AND POINT OF CARE TESTING ANNUAL REPORT
1st April 2024 - 31st March 2025

Contents

Background

Powys Teaching Health Boards (PTHB) Medical Devices and Point of Care Testing (POCT) Service ensures practicable steps are taken to make sure all risks associated with the acquisition, management and use of medical devices are minimised to protect and safeguard the interest of service users, carers, and staff. Medical Devices and equipment represent a substantial health board asset and have a significant impact on patient care.

The term "medical devices" covers a broad range of products and can be defined as; "*an instrument, apparatus, appliance, material, or healthcare product, (except medicines) used for, or by a patient or service user*". The associated consumables are not the responsibility of the Medical Device Team, these sit as the responsibility of the operational service groups.

Based on the Medicines and Healthcare products Regulatory Agency (MHRA) definition, a Point of Care Testing device can be defined as "*any device or piece of equipment that analyses or measures a sample taken from a patient in the clinical setting rather than the sample being collected and then sent off to a laboratory for analysis".*

Powys Teaching Health Board must ensure that medical devices and POCT equipment meet appropriate standards of safety, quality, and performance, complying with all the relevant directives set out by the MHRA. It is the responsibility of the organisation and all employees to contribute to the provision of safe and secure use of all medical devices for service users, carers, and staff.

Introduction

This Annual Report describes the Health Board's Medical Device and Point of Care Testing activities undertaken, for the Financial Year commencing the 1st of April 2024 to 31st of March 2025.

The report covers the following activities that PTHB has undertaken during this period, to make improvements to the Health Board's Medical Devices and Point of Care Testing Service provision:

- Governance Arrangements
- Risk Assessment and Management
- Partnership Working
- Environment and Sustainability
- Assurance
- Key Priorities for April 2025 to March 2026

Governance Arrangements

Medical Device and Point of Care Testing Team

The overall responsibility for Medical Devices and Point of Care Testing sits with the Chief Executive.

The Chief Executive has delegated the responsibility and leadership for Medical Devices and Point of Care Testing to the Executive Director of Allied Health Professions, Health Science and Digital, who has delegated its management to the Deputy Director of Allied Health Professions and Health Science.

This role is supported by a full-time Medical Device Manager, full-time Point of Care Testing Coordinator and part-time Senior Administrator. The Medical Devices Manager takes responsibility for ensuring that PTHB is compliant with all aspects of Medical Device management and works in collaboration with internal and external service leads, Welsh Government, other NHS organisations and external multiagency partners, to help facilitate a comprehensive integrated approach across the organisation.

Acknowledging the requirement for a governance and reporting framework for Point of Care Testing to enable development in this area, a Band 7 Point of Care Testing Coordinator has been in post since January 2024, funded through the Six Goals for Urgent and Emergency Care Programme. The post holder is a Specialist Biomedical Scientist with both clinical and technical expertise and scientific qualifications. The post, in conjunction with a formal Service Level Agreement with Aneurin Bevan University Health Board, has enabled a much-needed Governance and Assurance framework to support the development of Point of Care Testing in Powys.

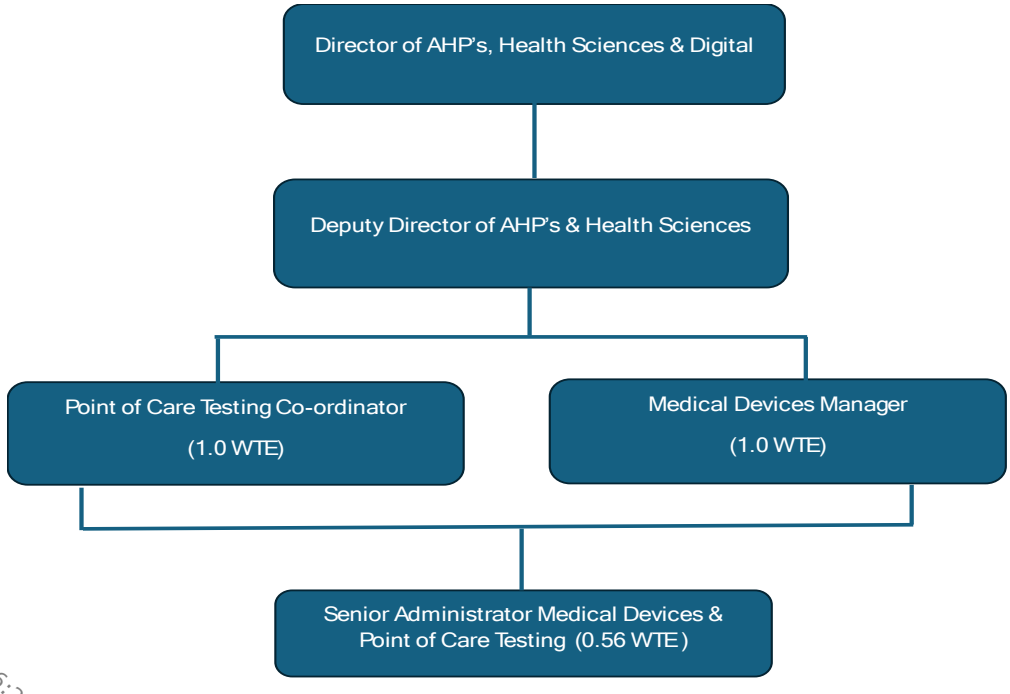


Diagram 1 – Medical Devices and Point of Care Testing Management Structure

Medical Equipment and Devices Internal Audit, October 2021

		Trend
Reasonable 	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.	 2017/18

Image 1 - Medical Equipment and Devices Internal Audit, October 2021 Report Classification

An Internal Audit was carried out in July 2021 with the final report being issued in October 2021. The overall rating of Reasonable Assurance was awarded, a significant improvement on previous audits. Reasonable Assurance reflects the fact that a policy and procedures are in place, but improvements are required in some areas to ensure that controls are being consistently complied with. The key matters requiring management attention have been outlined in an action plan and regularly reviewed and updated through the Medical Device and Point of Care Testing Group. Compliance against the recommendations is also formally reported through internal audit monitoring processes led by the Corporate Governance Team.

Significant improvements have been made against the recommendations, with several fully completed, however, the speed of progress against the remaining recommendations has been limited by capacity of the team. Outstanding actions continue to be closely monitored and full details of these can be referenced in Appendix A.

Recommendation Area	Status
Purchase of New Equipment	**Complete**
Inventory Records	**Complete**
Loaned Equipment	**Complete**
Storage of Medical Equipment Devices & Equipment	**Complete**
Staff Training Recorded on ESR.	**Elements Outstanding** Training offered by Clinical Education and Resuscitation Officer is all booked through ESR. It is anticipated that a robust model will be implemented for high-risk items by end of

	2025/2026. This will be dependent on resource and capacity but once embedded the model will be rolled out across all service areas and devices. **Complete for POCT** All POCT training now offered and recorded via ESR
Contract Monitoring	**Elements outstanding** Progress is being made against this recommendation. Improved processes have positively impacted on contract monitoring, Financial Year cost savings and opportunities to strengthen processes. Limitations within the medical devices team and challenges with the main contract provider continue to be a barrier to continuous improvement against this recommendation.
Point of Care Testing	**Complete** Point of Care Testing Coordinator commenced in post January 2024 was made substantive in March 2025 is making significant process in terms of strengthening processes and governance for existing POCT. Blood Gas & INR devices are now configured for compulsory IQC and registered for EQA. Glucose devices will also be when installation across the health board is completed, bringing all POCT devices in line with PTHB Management of Point of Care Testing Policy.

Table 1 - Medical Equipment and Devices Internal Audit, October 2021 Summary of Recommendation Areas

Risk Assessment and Management

The Medical Devices and Point of Care Testing Service risk registers are reviewed and updated monthly, those risks (over 12) are reported into the Directorate risk register. During the timeframe for this report the team had 3 risks (over 12) on the overarching risk register.

The risks identified on the Therapies & Health Sciences directorate risk register include:

- Capacity within the team
- Equipment Maintenance - contract monitoring, key performance indicators, staff training

- Acquisition of medical devices – procurement practices, preferred equipment list, review, and digitisation of EDOF process (Equipment and Device Ordering Form)

Previously there were ongoing challenges related to the management of Liquid Nitrogen Gas in terms of ownership and responsibility. Liquid Nitrogen is formally identified as a Medical Device and is used in Outpatient areas of the Health Board for minor dermatological procedures. Following the identification of an operational lead, the situation has improved.

Incidents

Incidents are reported into the Medical Device and Point of Care Testing Group where key themes and trends are also identified. Learning from incidents is a key contributor to continuous quality improvement. The Medical Device Manager and POCT Coordinator are automatically informed of any related incidents, although this relies on accuracy of reporting. Through the Medical Device and Point of Care Testing Group, awareness has been raised of the importance in selecting correct categories when reporting an incident into Datix. This is to ensure incidents are not missed by relevant personnel in order for appropriate actions and learning to be achieved. Collaboration with key services, including Medicines Management and Estates, has taken place to continue this improvement work.

During this reporting period, there have been a total of 58 incidents reported. These fall into subcategories as listed below. Analysis of these figures does not show any trends or themes of concern relating to specific equipment type or service.

Category	Quantity
Failure of Medical Device	19
Other	15
Medical Device User Error	4
Accidental Damage/Loss	7
Lack of Availability of Medical Device consumables	1
Lack of Availability of Medical Device	8
Poorly Maintained Device	1
Expired Equipment	3

Table 2 – Incidents Reported by Category (*Data Source: Datix*)

Medical Devices Audit

Specific months have been set for completion of the medical devices audit, these are January and June. Having set months has had a positive impact on the number of services completing the audit. The audit covers key areas of medical device management. For example, maintenance; asset tracking;

storage; training; infection control and decontamination. Transferring the audit tool into MS Forms has also resulted in an increase in uptake. Audit outcomes are reported and monitored through the Medical Device and Point of Care Testing Group. The Medical Device and Point of Care Testing Team provide support to teams who are identified through their audit process that improvements are required. Further improvements are being implemented to support services with increasing their uptake further. During this reporting period, an audit month occurred in June 2024 with an uptake of 85 and January 2025 when 112 responses were received from services. The results were overall positive, with a few areas identified as requiring some additional support from the Medical Device and Point of Care Testing Team. The number and types of queries received from services by the team during each audit month suggested the audit was having a positive impact. Audit outcomes are shared with Medical Device and Point of Care Testing Group to ensure learning is shared widely. Learning from incidents is a key contributor to continuous quality improvement and is always a priority for the team.

Medical Device Training

The Management of Medical Devices policy requires operational managers to ensure that staff are suitably trained and competent to use all medical devices and equipment depending on their role, and to document evidence of training taking place which must be recorded on the Electronic Staff Record *(*ESR*).*

The Medical Equipment and Devices Internal Audit, October 2021 gave Limited Assurance in terms of staff training and therefore for staff that are expected to operate and use medical devices.

As reported in the Annual Report for 2023/2024, high risk items would be the focus but would be dependent on resource and capacity but once embedded the model will be rolled out across all service areas and devices, where applicable. Collaborative work between Medical Devices and Clinical Education has identified what immediate actions were required to achieve this.

Progress has included implementation of infusion pump training by the Clinical Education Team and training in how to use a defibrillator (model specific) provided by Resuscitation Officer during Basic Life Support (BSL) Training. This is in readiness for implementation of replacement defibrillators planned for Q2 2025. Syringe Driver training is scheduled to be fully implemented in Q3 of 2025. Whilst significant progress has been made in this area, continued improvement is required in all aspects of medical device training. Currently the health board cannot be assured that all staff are both trained and competent in the use of devices they are expected to operate.

The new contract for dual glucose/ketone meters included monthly in-person training sessions delivered by the supplier, Nova Biomedical. Installation of the new meters was triggered when more than 75% of staff had completed

the required training in that service area. To support ongoing training needs from 2025/26 onwards, it is anticipated that members of the Clinical Education team will complete 'train the trainer' sessions, enabling them to deliver glucose meter training across the health board as needed, supplementing the supplier-led sessions.

Support and engagement from the Clinical Education Team in progressing training in these key areas has been key to successful implementation of training that was not previously in place.

Medical Devices Regulations (MDR)

Following the United Kingdom's departure from the European Union, the updated Medical Devices Regulations are in the process of being updated. It is anticipated that EU MDR will implement new requirements for services within health institutions who are considered to manufacture and / or modify medical devices. This activity was previously unregulated. The Medical Devices and Point of Care Testing Manager, along with clinical representation, attend a *Health Education and Improvement Wales* (*HEIW*) led national MDR group which has been tasked with reviewing information and assessing Health Board readiness for the change in regulations which will have legal implications on organisations. Whilst the MHRA continue to make key decisions, health boards in Wales completed a preparedness survey against the new EU MDR which has been reported to Welsh Government.

Partnership Working

Medical Devices Replacement Programme

The Medical Devices Replacement Programme is regularly discussed at the Medical Device and Point of Care Testing Group.

During 2024/2025 a pilot commenced in theatre and endoscopy, a service with high value equipment. Validation of key items of equipment has been undertaken which will enable progression to the next phase of populating equipment age and value. This will support with identifying expected replacement dates and estimated costs. Once the pilot is complete and the model evaluated, the approach will be rolled out across other high value equipment areas including dental and outpatients.

It is recognised that further work is needed in this area with the relevant service areas. The Medical Device Manager has close links with Capital Control Group to ensure any opportunity for funding is secured and allocated through a fair prioritisation process. Prior to medical equipment requests for Capital Funding being presented to the Capital Control Group, they go through the Capital Funding Prioritisation Group where a formal evaluation process takes place. Prioritisation in this way supports the Capital Control Group in allocating funding accordingly.

During the Financial Year 2024/2025, in addition to £1.089M Welsh Government funding for the upgrade of x-ray equipment, the health board was also successful in obtaining end of year monies from Welsh Government which enabled £1.012M of equipment to be purchased across the organisation. This includes essential equipment for ophthalmology clinics and theatre procedures, replacement defibrillators, dental x-rays, bladder scanners, washer disinfectors and decontamination units. Appendix 2 shows the distribution of this equipment across the health board. This funding is essential to support replacement of key items of equipment required to deliver services across the health board. The prioritisation process, which is now fully embedded is key to this end of year funding, to ensure the health board is able to submit a detailed list of equipment when requested by WG. Timeframes and lead times are dependent on the funding being awarded and the health board being able to deliver within the Financial Year.

Links have continued to be strengthened with Charitable Fund and League of Friends colleagues. This has led to vast improvements, particularly in relation to the governance arrangements to support the correct acquisition of equipment purchased through these routes and also raised awareness of funding options available to service leads.

Radiology Informatics System Procurement (RISP)

Following approval by Welsh Government of over £1 million for replacement radiography equipment in PTHB to support delivery of the RISP programme, the project team is diving this forward to implementation phase.

Clinical Education

The Medical Devices Manager and Point of Care Testing Coordinator and representatives from the Clinical Education Team continue to have regular meetings. This relationship is key to developing a robust training programme for all staff expected to operate medical devices and Point of Care Testing equipment. It is anticipated that the coordinated HB induction days such as the HCSWs, or Aspiring Nurses program will include Glucose/Ketone meter training from 2025/26.

Community Equipment Contract and Medical Devices

The Medical Devices Manager has worked closely with the Head of Therapies and the Strategic Commissioning Manager in Powys County Council to identify medical devices which are suitable for distribution via the Community Equipment Service. These items include nebulisers, suction machines and cough assists and are now available for clinicians to prescribe for patients. Issuing medical devices in this way will ensure that the Health Board is assured that those items are readily available for patients, ensuring a prompt response when requests are made. Additional assurance is also achieved in terms of tracking, maintenance and servicing. These key relationships continue to strengthen enabling improved assurance processes, reporting on

activity and compliance into the Medical Device and Point of Care Testing Group on a quarterly basis.

Environment & Sustainability

The Medical Device Manager, Point of Care Testing Coordinator and the Environment and Sustainability Team work very closely. Collaboratively, improvements have been put in place to support the acquisition and disposal of medical devices ensuring environmental and sustainability factors are always considered. Discussions are in place to implement a Medical Device and Point of Care Testing Action plan to support the Health Boards work in relation to ISO 140001. This will become a priority for 2025/2026.

The Health Board is part of an all-Wales contract with an on-line auction company. This company collects and disposes of equipment that is no longer required by the Health Board. This process generates substantial income for the Health Board with a total of £18,000 during Financial Year 2024/2025. Please note this total includes non-medical equipment. This process not only provides some income generation for the Health Board but also ensures items are disposed of in a responsible way. The Medical Device Manager is certified Carbon Literate, along with other members of the AHP and Health Science Directorate.

The contract with the current provider is due to end during Financial Year 2024/2025 for which a formal procurement exercise has commenced, led by colleagues in NWSSP Procurement.

Assurance

POCT Governance

As a discipline, Point of Care Testing is regulated under ISO 15189:2022 standards, aligning it closely with laboratory science. Following a detailed review of current practices against these standards, the POCT Coordinator has identified several Standard Operating Procedures (SOPs) and policies within Powys Teaching Health Board (PTHB) that require updating.

Work is ongoing to address any significant omissions and ensure all documentation reflects the latest regulatory requirements. This process will provide assurance that staff across the health board are equipped with accurate, up-to-date guidance to safely and competently perform POCT, ultimately supporting high standards of patient care and safety.

Below is the outline of the Key Areas that have been successfully delivered in 2024/25

Strategic Priority 5			
Key Areas of Delivery	**Key Deliverables**	**Timescale**	**Intended Outcome/ Impact**

Enhance the provision of Point of Care Testing throughout Powys	Review and develop existing POCT provision and governance: Establish QA Compliance framework, analyse asset registry, monitoring initiation and training development	Q1-Q2	Improved assurance and governance
	Expand availability of POCT provision in support of clinical pathway development and governance: Financial Year opportunities in primary & community care, prepare for internal audit	Q3-Q4	Improved access to Point of Care Testing
	Financial Year ongoing funding for the POCT Coordinator role	Q3-Q4	Ensure continuity for future development & expansion of POCT

Table 3 – POCT PTHB Strategic Priorities for 2024-25 (from IMTP 24-29)

Medical Device Alerts

Collaborative working between the Quality and Safety Team and Medical Device Team, along with Service Groups has seen vast improvements in the way the Health Board manages and responds to Medical Device Alerts. A review of alerts management and implementation of new processes has enabled prompt engagement with key stakeholders to ensure action is taken as quickly as possible. Compliance against the alerts is reported through the Medical Device and Point of Care Testing Group. Processes have also been strengthened between the Health Board and NHS Wales Shared Services Partnership (NWSSP) Procurement, this supports the way in which alerts are managed and provides additional assurance that any impacted products are identified, and appropriate action taken.

There were 6 alerts received into the Health Board during this reporting period. Whilst there was one alert with an outstanding action at the end of the reporting period, at the time of writing all actions were complete.

Number of alerts received	Number not Applicable to PTHB	Number Closed	Number with actions outstanding
6	1	5	1

Table 4 - Medical Device Alerts received within the reporting period.

Internal Audit - Mattresses

Following a disappointing mattress audit in December 2023, an improvement plan was put in place. To obtain assurance that improvements are being made an Internal Audit by NWSSP has been commissioned. An audit brief was agreed by Executive Director of Allied Health Professionals, Health Sciences and Digital Services on 20th March 2025. Field work is scheduled to

be undertaken during March/April 2025 with the Final Report expected to be presented at Audit Committee in May 2025.

Internal Audit - Mattresses

NWSSP Internal Audit of Contract Management audit brief agreed by Executive Director of Finance, Capital and Support Services in October 2024. Field work undertaken in October/November 2024 with the Final Report expected to presented to Audit Committee in May 2025.

Contracts

Contract monitoring is a key aspect of Medical Device and Point of Care Testing management. Contracts can include all-Wales purchasing contracts through which the Health Board benefits from reduced costs, and maintenance contracts for maintenance and repair of equipment. As of 1st of April 2022, the main maintenance contract for medical devices was awarded to a new provider on a 3-year tenure. Throughout the duration of the contract issues and challenges arose. These were raised with the provider and NWSSP Procurement and worked through collaboratively. These issues include unexpected costs associated with wasted visits and user damage including inappropriate charges amount to £30,000.

The contract covers many general medical devices, excluding specialist items such as beds, hoists, dental and x-ray equipment for example. These specialist items are covered by separate contracts. Following the issuing of a Contract Improvement Notice, an action plan was developed to monitor progress against the areas requiring improvement. Contract Review meetings held in conjunction with NWSSP Procurement colleagues were held to monitor this progress.

During 2024/2025 the health board made the decision not to extend the contract. Options were explored and the decision to retender made. The service specification was refreshed and thorough tender process followed, led by NWSSP Procurement. The contract was awarded to a new provider with the contract due to commence 1st April 2025 for a 2-year tenure.

Improved engagement and input from support services including finance and procurement has enabled improved processes. However, limited capacity within the Medical Device and Point of Care Testing team continues to impact on the ability to robustly monitor contracts.

Complaints & Patient Feedback

The service is pleased to report there have been no complaints reported in relation to medical devices and Point of Care Testing during the reporting period. However, the Medical Devices Team has listened and taken on board comments made regarding disposal methods for walking aids. A collaborative approach, both internally and externally with neighbouring health boards, has

enabled the development of an improved process. A Standard Operating Procedure for "Maintenance, Inspection and Refurbishment of Walking Aids to be Re-issued" has been developed to enable patients to return walking aids to their local hospital, regardless of where they were issued which was not previously permitted. The change also sees the implementation of a re-issuing process, rather than the previous process of disposal of the equipment. Not only does this process offer a far more convenient option for Powys residents but also ensures the Health Board is acting responsibly in relation to environment and sustainability factors. Whilst these items are generally low value items, the financial benefits to re-issuing such equipment will be significant. This Standard Operating Procedure was implemented on 1st August 2024.

Lessons & Good Practice

Medical Devices and Point of Care Service Testing Group receives quarterly reports from all service areas, which are reviewed and used to formulate lessons learnt and good practice for sharing across the Health Board. In addition to these formal reports, ad hoc sharing of good practice is also something the team encourage.

SharePoint Site Development Update

Significant work has been undertaken to ensure that all relevant documentation and guidance is now available on the SharePoint site. This enhancement provides staff with streamlined access to procedures, policies, and other essential, up-to-date resources.
Ongoing improvements include the progressive upload of medical device User Manuals, further supporting clinical teams in their day-to-day operations.
Looking ahead to 2025/26, this initiative will be expanded with the transition from static Word-based documents to interactive, live Microsoft Forms where appropriate. This will enable more efficient data and information collection from clinical areas, enhancing both usability and responsiveness.

Freedom of Information Requests

During 2024/2025 there were 10 Freedom of Information requests made with regards to Medical Devices. Of these, 3 breached the timeframe for replies because of either collation of information from other areas and/or limited capacity within the team to respond in a timely manner.

Month of Request	Request Subject	Requestor Type	Time taken (days)
May 24	Patient Monitoring systems on wards	Company	16 Days
May 24	Use and Procurement of spirometry medical devices	Company	12 Days

May 24	Electronic Patient Record (EPR) and Medical Device Integration (MDI)	Company	1 Day
July 24	Peripherally Inserted Central Catheters (PICC)	Company	1 Day
August 24	How many hospitals have Ceiling Track Hoists and Mobile Hoists	Company	2 Days
November 24	Gamma camera (Nuclear Medicine Imaging System) and SPECT/CT systems installed.	Company	1 Day
November 24	Inventory management, and disposal practices for medical equipment, with particular attention to environmental impact and sustainability efforts.	Company	17 Days
December 24	How many hospitals have Ceiling Track Hoists and Mobile Hoists (additional question: who maintains, repairs and services hoists)	Company	1 Day
January 25	Full list of diagnostic imaging and radiography equipment	Company	1 Day
March 25	Ambulatory ECG Monitors	Company	1 Day

Table 5 – Freedom of Information requests made during 2024/2025 (Data Source: Medical Device & Point of Care Testing Team)

Medical Devices and Point of Care Testing Priorities 2025/26

Point of Care Testing

The clinical delivery risks associated with limited governance of Point of Care Testing across PTHB, are fully documented and monitored via the directorate internal audits and risk register. While these gaps in policy, SOPs etc. are being actively addressed by the POCT Coordinator through a structured review and update process, the POCT Coordinator role was only on a fixed term until September 2025. Capacity within MD & POCT meant that these risks could reappear and even worsen after that date.

However, after the successful submission of a business case to the Internal Business Group (IBG) in Q3 of 24/25 the post was made substantive in March 2025. The IBG case also included the phased appointment of 1x WTE Band 4 and 1x WTE Band 3 over the next 3 years 2025-27 which should enable the POCT department to fully deliver on the goals set out in the Integrated Medium-Term Plan (IMTP) 2024–2029, particularly in relation to innovation, service expansion, and long-term sustainability.

	Key Deliverables
5.9) Point of Care Testing (POCT) Improved assurance and governance	5.9.1) Add all connectable devices to WPOCT
	5.9.2) Expand POCT in support of clinical pathway development and governance
	5.9.3) Monitor Internal Quality Control (IQC) & External Quality Assurance (EQA)
	5.9.4) Establish model for working with Primary Care
	5.9.5) Review and develop existing POCT provision and governance: Develop QA Compliance framework including audits and KPIs for all devices in use
	5.9.6) Monitor training and develop collaborative model with Suppliers and Clinical Education teams for all POCT devices currently in use
	5.9.7) Identify further opportunities for POCT within PTHB
	5.9.8) Identify opportunities in primary & community care

Table 6 – POCT Delivery plan for 2025-26 as aligned with PTHB Strategic Priorities Integrated Medium Term Plan 2024/29

POCT is a cornerstone of Strategic Priority 5: Deliver the Planned Care and Diagnostics Program. The above key areas have been identified as a priority for 2025/26.

Point of Care Testing (POCT) IT Solution – All-Wales Contract Update

Powys Teaching Health Board continues to participate in the All-Wales contract for the implementation of the Welsh Point of Care Testing (WPOCT) IT solution. This system facilitates the direct electronic transfer of test results from networked POCT devices into the Welsh Clinical Portal, supporting timely clinical decision-making and improved patient care.

Although the Health Board contributes annually to the funding of this solution, full organisational implementation has not yet been achieved. Progress has been steady; however, the planned completion by the end of Q4 2024/25 was not met due to unresolved technical issues currently under investigation by the supplier (Siemens).

The POCT team remains actively engaged with national stakeholders and the supplier to resolve these issues. Implementation efforts will continue into 2025/26, with this work recognised as a key priority for enhancing POCT service delivery and digital integration across the Health Board.

Antimicrobial Resistance (AMR) – Supporting good Stewardship

As part of their role on the National Strategy Board and Delivery Group for Point of Care Testing (POCT), the POCT coordinator has been leading PTHB's involvement in the national rollout of C-Reactive Protein (CRP) testing across Primary Care and Community Pharmacies. This important initiative is ongoing and will offer surgeries and pharmacies the opportunity to provide POCT CRP testing free of charge. POCT CRP testing is a NICE approved diagnostic tool that can support clinicians in deciding whether to give antibiotics in certain conditions, thus supporting good Antimicrobial Stewardship in Primary Care.

This work forms part of a Welsh Government collaborative project with the University of Oxford, aiming to tackle antimicrobial resistance in Wales by reducing unnecessary antibiotic use in cases of Lower Respiratory Tract Infections (LRTIs) and exacerbations of COPD.

Environment and Sustainability

The Medical Device and Point of Care Testing Team are committed to supporting the health board with ISO 14001 Environmental Management Systems accreditation. The standard provides a framework for organisations to manage and improve their environmental performance. An action plan will be developed to monitor progress for relevant areas against the standard within the team. The Medical Device Manager or Point of Care Testing Coordinator will continue to represent the team on the health board Environment and Sustainability Group.

Business Continuity

A Business Impact Assessment has been undertaken, and the service is compliant with the Health Boards requirements. Given the single points of dependency for both Medical Device and Point of Care Testing, there remains ongoing challenges during times of absence. Whilst cross cover is possible to some degree, there will always be limitations in technical and expert knowledge. A review of the Business Impact Assessment is planned for the end of December 2025 in line with the Health Boards Business Continuity process.

Information Communication and Technology (ICT)

Progress has been made in that the Medical Device and Point of Care Testing Audit is now digitalised in the form of MS Forms. Opportunities continue to be identified for further digitalisation with plans to move the Equipment and Device Ordering Form (EDOF) asset registering form into (MDF3) into a digital format. This will create a much more user-friendly version for staff

completing the document. It will also create efficiencies within the Medical Device & Point of Care Testing Team.

e-Quip Asset Management System

e-Quip Asset Management System is used by the Health Board to manage medical devices. Following a lengthy project implementation phase the system is now embedded. Robust processes have been implemented to support the success of the system. It is essential that service groups adhere to these processes and ensure they are compliant with all elements of medical devices and Point of Care Testing management. Validation exercises continue to be undertaken, in conjunction with services to ensure processes continue to be embedded. As previously referenced, a pilot in Theatre & Endoscopy includes key staff having access to the system to support with replacement planning. Further work will be undertaken working in partnership with main maintenance provider to align assets on the contract with data held in e-Quip. All POCT Devices will be managed in e-Quip by the POCT Coordinator and Senior Administrator.

Contracts

The new main maintenance contract commencing on 1st April 2025 provides the health board the opportunity to make improvements in the way the contract operates. For example, the adoption of the hub model, where equipment is sent to the Medical Devices hub for repairs rather than engineers driving around the county will offer a far more efficient service. Not only will this ensure equipment is out of use for minimal amount of time but also reduce the carbon footprint of engineers through reduced travel.

The team constantly explores opportunities for cost savings within maintenance contracts. Scrutiny of costs is a key role undertaken by the team with a £30,000 saving identified through inappropriate charges applied by current provider. These were challenged and accepted. Had the team not undertaken this scrutiny the £30,000 would have been incorrectly paid.

There is potential to reduce costs with the provider of maintenance for plinths and physiotherapy equipment. By reducing the site visits to one per year, a saving of £1,500 would be achieved. This is a priority for the team to put in place during the contract renewal process for 205/2026.

POCT Contracts

International Normalise Ratio (INR) Testing

PTHB was the final Health Board to enter into contract under the All-Wales INR Testing Agreement, with its current contract set to expire in 2027. It has been agreed at a national level that all other Health Boards will extend their existing contracts to align with PTHB's timeline. This coordinated approach will enable all Health Boards to participate in a unified tendering process for INR testing devices and dosing software during 2026/27.

Glucose/Ketone Testing

The existing glucose meters were discontinued by the supplier, Abbott, and the contract expired in July 2024. Since then, the Health Board (HB) has been purchasing consumables off-contract due to the supplier's proposed terms being highly unfavourable and not cost-effective.

As Abbott will no longer support the current devices, it is imperative that the new contract with Nova Biomedical is implemented without delay. Preparations, including technical setup and staff training progressed smoothly and reached the implementation trigger point by the end of Q3.

The District Nursing (DN) teams went live in Q4 of 2024/25, with 160 meters switched over at that time. The new contract enables all District Nurses to have their own meter for the first time, supporting more efficient workflows and safer, patient-centred care.

Implementation of the new IT-connected meters in inpatient areas is anticipated to follow in May 2025, once Wi-Fi and technical issues have been resolved.

PTHB Preceptorship Study Day

The Medical Device Manager and Point of Care Testing Coordinator will be engaging with the PTHB Preceptorship Study Day in March 2026 to promote awareness of medical device management and Point of Care Testing. This engagement will be invaluable in ensuring users of equipment are aware of their responsibilities, ensuring both patient and staff safety is not compromised.

Bariatric Equipment

The health board has experienced challenges with access to bariatric equipment for inpatient wards. This has sometimes led to delayed admissions as suitable equipment has not been available in time to accept patients. The Medical Device Manager has engaged with the Assistant Director for Community Service Group and Head of Nursing. The response to an SBAR was that a formal rental arrangement would be the preferred option to ensure such equipment could be accessed in a timely manner. NHS Wales Shared Services Partnership Procurement Services (NWSSP) are now engaged along with Supply chain, exploring potential suppliers. It is anticipated this formal arrangement will be in place by the end of Financial Year 2025/2026.

Wheelchair Provision and Maintenance

Reports from some service areas have identified that some sites have a lack of wheelchair provision which has impacted on patient experience and increased risks to patient safety. For example, lack of wheelchair availability has prevented attendance at an outpatient appointment. A review of wheelchair provision has identified a gap in responsibility, management and

maintenance service. A review of wheelchair inventory is required in conjunction with replacement programme and maintenance. This will be a priority for the team in 2025/2026 in conjunction with support services, therapy and nursing colleagues.

In addition to the elements of training already discussed in the report, the health board is in discussions with the current maintenance provider for beds and mattresses. They offer, at no cost, ward specific training in the use of bed and mattresses to ensure staff are fully aware of all functions of the equipment and how to ensure the equipment is utilised to its full potential. It is anticipated this will be in place during the early part of 2025/2026.

In response to National Patient Safety Alert in 2023 regarding bed rails, Swansea Bay University Health Board are developing an e-learning module of Risks associated with medical beds, bed rails, bed grab handles and lateral turning devices. It is anticipated the health board, along with all other Welsh health boards, will adopt this onto ESR for staff to access. Timescales are uncertain but it is anticipated this will be in place during 2025 for staff to access.

Future Annual Reports

As the development and expansion of the Point of Care Testing (POCT) service continues, it is recommended that, from 2025/26 onwards, the annual report be submitted as two separate documents—one for Medical Devices and one for POCT. This approach will better reflect the distinct nature and progress of each service.

Appendix A – Medical Equipment and Devices Internal Audit, October 2021 -

Progress Against Outstanding Actions

Matter Arising 1 - Purchase of New Equipment (Operating effectiveness)	Status
• A process should be developed to ensure that the Preferred Equipment list is maintained and kept up to date by adding and removing items as necessary. • The EDOF form should include a field to confirm that NWSSP have been involved in the purchase, or an explanation as to why not. • The Medical Devices team should ensure that all EDOF's are fully completed prior to processing.	**Complete**
Matter Arising 2 - Inventory Records (Operating effectiveness)	**Status**
Management should consider alternative methods of populating the e-Quip system in addition to the current process of requesting information from ward or departmental staff. These could include: • Using item data from maintenance schedules to populate the e-Quip system, then forwarding e-Quip Inventory records to each site for verification. • Nominated e-Quip 'champions' at each site with access to input data directly to the e-Quip system. • Undertaking site visits. • Sending out e-Quip inventory reports to each site on a half yearly basis for updating. • Financial Year additional staff resources on a temporary basis to help populate the e-Quip system.	**Complete**
Matter Arising 3 - Loaned Equipment (Operating effectiveness)	**Status**
All staff should be reminded of the requirement to ensure indemnity forms signed by the patient are completed for all items loaned to patients.	**Complete**

Matter Arising 4 - Storage of Medical Equipment Devices & Equipment (Operating effectiveness)	Status
Management at the Llanidloes Hospital should be asked to review their storage areas within the Graham Davies Ward at Llanidloes Hospital with a view to providing a single, secure storage facility for medical devices and equipment. A general reminder should be issued to all sites within the Health Board of the requirement to ensure that all medical devices and equipment are stored in a safe, secure location when not in use.	**Complete**

Matter Arising 5 - Staff Training (Operating effectiveness)	Status
a) The Local Responsible Officers at each ward / department should ensure that all training received by staff in respect of medical devices and equipment is recorded in ESR.	**a) Progress is being made against this recommendation.** Training offered by Clinical Education and Resuscitation Officer is all booked through ESR. It is anticipated that a robust model will be implemented for high-risk items by end of 2025/2026. This will be dependent on resource and capacity, but once embedded the model will be rolled out across all service areas and devices. Complete for POCT All POCT training now offered and recorded via ESR

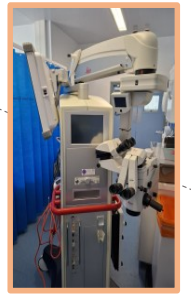
b) The manufacturer's instructions for all medical devices and equipment should be scanned and stored together electronically in accordance with the requirements of the Policy for the Management of Medical Devices and Equipment. This may be achieved by developing a central repository for manufacturer's instructions that is accessed via the Medical Devices pages of the intranet, rather than being done by individual wards and departments.	**b) Complete**
Matter Arising 6 - Contract Monitoring (Control design)	**Status**
The Health Board should introduce suitable monitoring arrangements for all contracts associated with the provision and maintenance of medical devices and equipment. This should include the development of key performance indicators (KPI's) and targets for each contract. These could for example include: • Actual expenditure against expected expenditure / annual contract value • The number / percentage of medical devices and equipment serviced each month / quarter (Planned Preventative Maintenance Contracts) • Quality - the number of staff and patient complaints received, number resolved / unresolved, time taken to resolve. • Call out response times (for responsive, unplanned maintenance) Performance should preferably be monitored on a regular basis and reported to the Medical Devices Group.	**Progress is being made against this recommendation.** Improved processes have positively impacted on contract monitoring, Financial Year cost savings and opportunities to strengthen processes. Limitations within the medical devices team and challenges with the main contract provider continue to be a barrier to continuous improvement against this recommendation.
Matter Arising 7 - Point of Care Testing (Operating effectiveness)	**Status**
7.1) Staff and independent contractors across the HB responsible for undertaking POCT should be reminded to ensure that all Internal Quality Control (IQC) checks and External Quality Assessments (EQA's) are recorded in accordance with the requirements of the Management of Point of Care Testing Policy.	**7.1 Complete** Point of Care Testing Coordinator commenced in post January 2024 was made substantive in March 2025 is making significant process in terms of

7.2) Staff and independent contractors across the HB responsible for the management of medical devices and equipment and undertaking POCT should be reminded of the requirement to periodically complete the Medical Devices Audit Form, in accordance with the Management of Point of Care Testing Policy and the Management of Medical Devices and Equipment Policy. The Management of POCT policy should be updated to include an indicative timescale for undertaking self-audits and completing the Medical Devices Audit Form. A link to the Medical Devices Audit Form should also be added to the Management of Medical Devices and Equipment Policy. 7.3) A Standard Operating Procedure (SOP) should be drawn up for all medical devices and equipment used in POCT, in accordance with the Management of Point of Care Testing Policy.	strengthening processes and governance for existing POCT. Blood Gas & INR devices are now configured for compulsory IQC and registered for EQA. Glucose devices will also be when installation across the health board is completed, bringing all POCT devices in line with PTHB Management of Point of Care Testing Policy. **7.2 Complete**. Medical Device Audit fully embedded with increased uptake since adopting MS Forms method for completion. 7.3 Complete SOPs for POCT equipment are being updated in Clinical SOPs by Clinical Leads and user manuals will be available on the POCT intranet pages when live 25/26

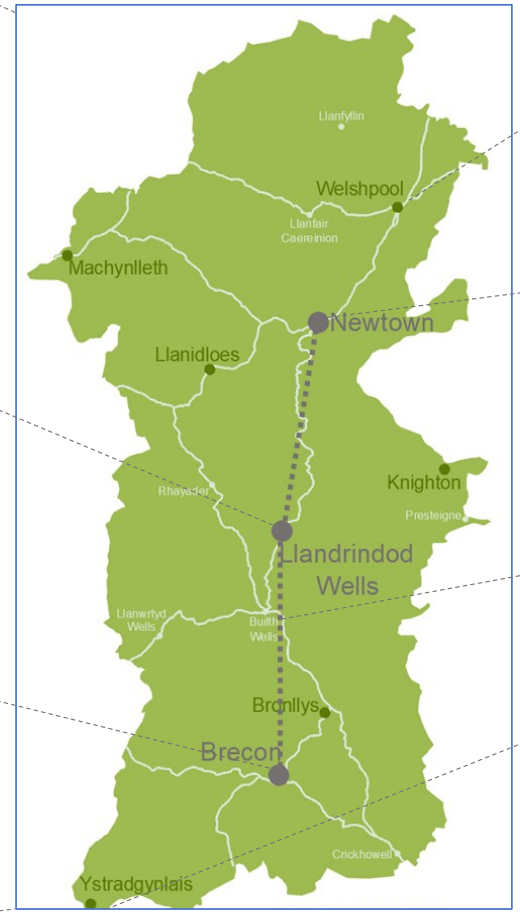
Appendix B: 2024/25 - Equipment Purchased through Capital Funding

Pan Powys	
Dental Departments	Washer Disinfectors
Various Wards / Departments	Defibrillators
X-Ray Departments	Digital X-Ray Equipment

Llandrindod Wells	
Theatre	Ophthalmic Surgical Microscope
Dental X-Ray	X-Ray equipment
Theatre	Phacoemulsification System
Ultrasound	Ultrasound Scanner
Ultrasound	Decontamination Unit (Trophon)



Brecon Hospital	
Theatre	Ophthalmic Microscope
Cardiac Services	Ultrasound
Ultrasound	Decontamination Unit (Trophon)
Theatre	Phacoemulsification System
Theatre	Fluid Management System



Welshpool Hospital	
Outpatients	Visual Field Analyser
Ultrasound	Decontamination Unit (Trophon)

Newtown Hospital	
Ultrasound	Ultrasound Scanner
Ultrasound	Decontamination Unit (Trophon)
Dental X-Ray	Dental X-Ray Equipment

Builth/Rhayader Distrct Nursing Team	
District Nursing	Bladder Scanner

Ystradgynlais Hospital	
Ultrasound	Ultrasound Scanner
Ultrasound	Decontamination Unit (Trophon)

Impact Assessment

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

QUALITY:

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

EQUALITY:

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	
Financial		X		
Corporate		X		
Operational			X	
Reputational		x		

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 5.7

Patient Experience, Quality and Safety Committee	**Date: October 2025**
Subject:	**Committee Risk Register**
Approved and presented by:	Helen Bushell, Director of Corporate Governance
Prepared by:	Deputy Board Secretary
Other Committees and meetings considered at:	Board Development – 08 May 2025 Executive Committee – 14 May 2025 Board – 21 May 2025 PEQS – 31 July 2025
Appendices :	Appendix A – Committee Risk Register

PURPOSE:

The purpose of the Committee Risk Register is to draw together relevant risks for the Committee from the Strategic Risk Register (SRR), to provide a summary of the significant risks to delivery of the health board's strategic objectives.

This copy of the Committee Risk Register is based upon the SRR adopted by the Board on 30 July 2025.

RECOMMENDATION(S):

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

- **RECEIVE** the corporate risks within the committee's remit
- **DISCUSS** any relevant issues and
- take **ASSURANCE** that risks are being managed in line with the Risk Management Framework.

Approve/Take Assurance	Discuss	Note
Y	Y	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	

COMMITTEE RISK REGISTER

The Committee has routinely received a Committee Risk Register which draws together relevant risks from the Corporate Risk Register (CRR) to provide a summary of the significant risks to the Health Board's within the Committee's remit.

This copy of the Committee Risk Register is based upon the adopted by the Board on 30 July 2025 and was previously presented to the Committee on 31 July 2025.

The Committee Risk Register is attached at **Appendix A.**

NEXT STEPS:

The Committee will continue to seek assurance on the ongoing development and management of patient experience, quality and safety risks as set out above.

The next Strategic Risk Register update is due to the Board on 26 November 2025.

Committee Risk Register

Patient Experience, Quality and Safety Committee

October 2025

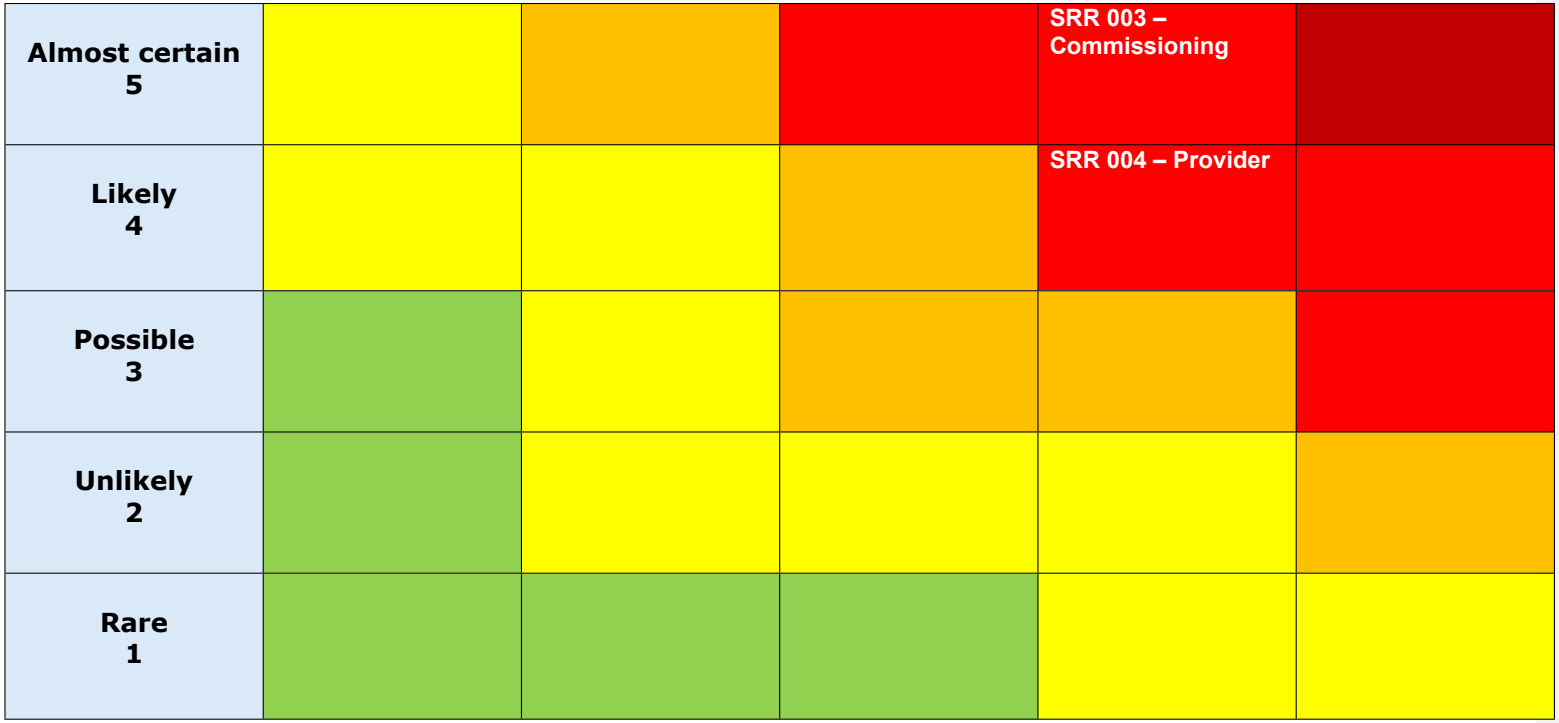
STRATEGIC RISK DASHBOARD – JULY 2025

Risk Lead	Risk ID	Risk Category	Risk Description There is a risk that:	SCORE (Likelihood x Impact)	Trend	Board Risk Appetite	At Target ✓/×	Lead Board Committee	Link to Strategic Priorities:
EDPP&C	SRR 003	**Performance and Service Sustainability**	The Health Board is unable to respond to the demand for commissioned services	**5 x 4 = 20**	➔	Open	×	Patient Experience, Quality and Safety	SP 11 and WBO 8
EDPCCMH	SRR 004	**Performance and Service Sustainability**	The Health Board is unable to respond to the demand for provided services.	**4 x 4 = 16**	➔	Open	×	Patient Experience, Quality and Safety	Several SPs and WBOs 4 and 8

KEY:

Executive Lead	
EDPP&C	Executive Director of Planning, Performance and Commissioning
EDPCCMH	Executive Director of Primary Care, Community and Mental Health
Trend	
*	**New risk**
➔	**Risk score unchanged since last report**
↓	**Risk score decreased since last report**
↑	**Risk score increased since last report**

RISK HEAT MAP – JULY 2025



LIKELIHOOD X IMPACT	Insignificant 1	Minor 2	Moderate 3	Major 4	Catastrophic 5

SRR 003	There is a risk that the Health Board is unable to respond to the demand for commissioned services	
Current Risk Score: **20**	**Risk rating detail:** (likelihood x impact) Current: L5 x I4 = 20 Inherent: L5 x I4 = 20 Target: L3 x I4 = 12	**Risk Category:** Performance and Service Sustainability **Boards Risk Appetite:** **Open**
Executive Lead: Executive Director of Planning, Performance & Commissioning		**Assuring Committee:** Patient Experience, Quality & Safety Committee

Latest review date: July 2025

Added to register:

July 2024

Link to Strategic Priorities and Wellbeing Objectives:

SP 11 and WBO 8

Cause of risk and rationale for current score:

- Increase in demand, inequality of access, complexity of patient needs, or failure to respond to demand pressures
- Planned care recovery continuing to accelerate in NHSE.
- High volumes of patients waiting > 52 weeks and > 104 weeks in NHS Wales. Cabinet Secretary expectations to improve waiting times in NHS Wales.
- The risk relates to the Timely, Equitable, Effective and Patient Experience elements of the Duty of Quality.

Risk materialising could result in:

- Poorer outcomes and experience for the citizens of Powys
- Difficulty in balancing performance and financial plan

Controls (What has been implemented to manage the risk?)		Sources of Assurance	Level of Assurance	Highest Assurance provided to:
7.1	For Planned Care Services - Regular review of demand pressures by looking at referral levels into services	Referral data into services from commissioning data sets and supplementary reports received from commissioned providers. Low assurance currently due to robustness of referral data. Exploring alternative data	Limited	Executive Director

		sources (e.g. activity) whilst working through improved data set for GP referrals.		
7.2	For Urgent & Emergency Services – Regular review of demand pressure by reviewing attendance rates and emergency inpatient volumes	Attendance data into services from commissioning data sets and supplementary reports received from commissioned providers	Reasonable	Executive Director
7.3	Using demand data to plan to commission sufficient service provision for all services provided out of county, noting the need to agree a balanced finance and performance position as part of the IMTP process	Demand, activity and financial information from commissioning datasets used to inform contract plans	Reasonable	Executive Director
7.4	Reviewing where services do not meet clinical and operational standards	Various data sources including operational & performance data.	Limited	Executive Director
7.5	Improving the outcomes and experience data capture to inform future reporting on commissioned services to the Finance and Performance Committee and Board as well as future planning	Various data sources including operational & performance data. Qualitative information from QMS, PROMS & PREMS reporting, concerns, NRIs, clinical audit, regulatory inspections	Limited	Executive Director

Mitigating Actions (What more will we do?)

Action	Lead	Action update	Deadline	Action on Target

<u>Planned Care</u> ▪ Continue regular meetings with commissioned service providers. ▪ Secure performance improvement trajectories from providers. ▪ Insourcing contract extended to offer Powys residents experiencing long waits in commissioned service providers in NHS Wales to be treated in Powys. ▪ Ongoing scrutiny and oversight through CQPR meetings with escalation through Integrated Quality and Performance Report. ▪ Continuing to work to obtain robust data for referrals from NHSW and NHSE GPs for Powys residents.	Executive Director of Planning, Performance and Commissioning (supported by DPCCMH)	Performance Trajectories and details on harm reviews for Powys residents requested from commissioned service providers in NHS England and NHS Wales to understand expected performance 2025/26 and to be reviewed and discussed through CQPRMs. Planned Care Insourced provision tender exercise delayed. Mitigating actions put in place to ensure continuity of service provision whilst tender exercise undertaken. Paper presented to Executive Committee for decision. Established Commissioning Oversight and Assurance Group (COAG), chaired by Exec DPPC, to provide a forum for internal oversight and escalation of performance monitoring of commissioned non-specialist services.	April 2025 and ongoing	On track

▪ Cancer	MD (supported by DPPC)	Added to this version of the risk register. Actions to be agreed. Cancer Working Group chaired by Medical Director. CQPRMs and COAG cover all specialties with commissioned providers.	TBA	TBC
<u>Urgent and Emergency Care</u> ▪ CQPRMS cover all specialties with commissioned providers including UEC. ▪ Continued work on 6 Goals plan to reduce admissions and secure timely discharge. ▪ Strengthening arrangements for admissions to community beds in NHSE. ▪ Continue series of regular meetings with WAST and commissioned service providers. ▪ Continue commissioning of ambulance services in partnership through the Joint Commissiong Committee	DPPC (supported by DPCCMH)	CQPRMS and COAG cover all specialties including urgent and emergency care. Historically had regular meetings (ICAP and Q&S) with Health Boards and WAST to cover performance, patient experience, incidents and resultant investigations, clinical indicators. Several recent ICAP meetings have been cancelled. Regular attendance at CCLG and sub- committee structure. New governance structure being developed by the JCC	April 2025 and ongoing	On track

Commented [NJ1]: Can we put anything in about revived cancer Working Group?

Commented [NJ2R1]: Also COAG will cover all specialities

▪ Secure performance improvement trajectories and improvement plans from providers.		with establishment of Ambulance Services and 111 Collaborative Commissioning Integration Group. Terms of Reference awaited. Standing agenda item in CQPRMs to review improvement plans, patient experience, and patient harm.		
<u>All indicators</u> There are some performance indicators that continue to fail the operational standard e.g. Single Cancer Pathway, 4 Hour ED waits. The Health Board will develop a suite of indicator sub-sets to determine if any improvement is being made towards achievement of the overall target.	DPPC	Integrated Quality and Performance Framework (IQPF) has been reviewed and refreshed for 2025/26. As part of the IQPF, the Integrated Quality and Performance Report will continue to provide information across the NHS Wales Performance Framework measures including Cancer and 4 hour ED waits.	April 2025 and ongoing	On track
Additional information:				
Rationale for current score: **<u>Planned Care</u>** **NHS Wales** • Latest validated position to month 1 (April 2025):				

	Apr-25	No. long waits by cohort, with latest SPC variance						Total pathways Waiting	Stage 1 pathways over 52 weeks	
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	62.4%	708		398		7		2712	154	
Betsi Cadwaladr University Local Health Board	47.8%	285		172		33		689	89	
Cardiff & Vale University Local Health Board	43.7%	177		111		12		387	46	
Cwm Taf Morgannwg University Local Health Board	53.0%	327		189		3		920	91	
Hywel Dda Local Health Board	59.3%	449		238		7		1533	0	
Swansea Bay University Local Health Board	56.3%	610		317		0		1956	0	
Total	57.2%	**2556**		**1425**		**62**		**8197**	**380**	

- Swansea Bay UHB and Hywel Dda UHB continue to meet the stage 1 waits target reporting zero pathways over 52 weeks for Powys residents. However, the overall position in Wales increases in pathways over 52 weeks with Aneurin Bevan UHB and Cwm Taf Morgannwg UHB reporting special cause concern.
- Only Swansea Bay UHB remains compliant in April reporting no pathways over 104 weeks. All other providers bar Cardiff and Vale UHB continue to report special cause improvement. But the overall number increases from 41 in March to 62 in April 2025.

Challenges

- NHS Wales Planning and Performance Frameworks 2025/26:
  - No patients waiting over 104 weeks for referral to treatment.
  - No patients waiting over 52 weeks for new outpatient appointment.
  - No patients waiting over 8 weeks for specified diagnostics.
- 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.
- 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.

NHS England

- Latest validated position month 12 (March 2025):

English Providers	Mar-25 % of Powys residents < 26 weeks for treatment	No. long waits by cohort, with latest SPC variance: All pathways waiting over 36 weeks.	All pathways waiting over 52 weeks.	All pathways waiting over 104 weeks.	Total pathways Waiting
English Other	69.4%	41	6	0	252
The Robert Jones and Agnes Hunt Orthopaedic Hospital	52.0%	1307	660	40	3755
The Shrewsbury and Telford Hospital NHS Trust	60.2%	1316	371	0	4815
Wye Valley NHS Trust	70.1%	571	113	0	3430
Total	59.7%	**3235**	**1150**	**40**	**12252**

- Powys residents in England have consistently waited less time for treatment except for Robert Jones & Agnes Orthopaedic Hospital NHS Foundation Trust (RJAH), all wait bands are reporting special cause concern at an aggregated level.
- **Wye Valley NHS Trust (WVT)** reports the best performance of all Powys commissioned providers with 70.1% of pathways waiting under 26 weeks for treatment, 113 wait over 52 and of these 4 pathways wait between 77 and 104 weeks for Ophthalmology and respiratory medicine. WVT is the only English provider to consistently report special cause improvement for all key wait bands.
- **The Shrewsbury & Telford Hospital NHS Trust (SATH)** reports a more challenged position with all key wait bands reporting special cause concern e.g., the total numbers of waiters in these bands is increasing. The key challenged specialties for long waiting pathways in SATH are Ophthalmology and Oral Surgery which make up 24 of the total 27 pathways between 77 and 104 weeks.
- **The Robert Jones and Agnes Hunt Orthopaedic Hospital (RJAH)** remains the most challenged English provider for long waits the SPC chart (right) shows a growing trend of very long waiters and with all key wait bands are reporting special cause concern. Historically RJAH has always been challenged by complex spinal pathways but in March of the 40 total breaches 16 are for Knee & Sports Injuries, 12 are complex spinal, 10 reported for Arthroplasty pathways, and 2 in upper/lower limb. The longest wait for a complex spinal pathway awaiting specialist unit was reported by the provider at 307 weeks.

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.

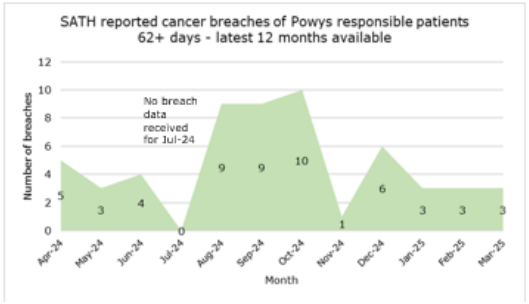
- Work ongoing with NHSE providers, primarily RJAH, SaTH and WVT, re PTHB Commissioning Intentions 2025/26, commissioning to NHS Wales treatment targets.

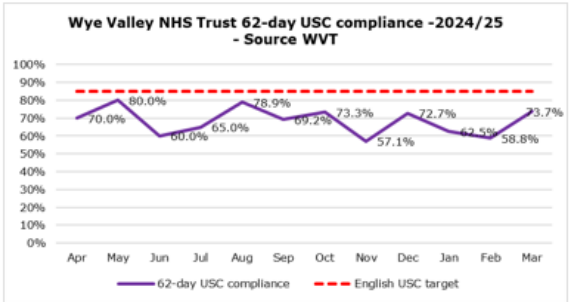
Cancer

- Cancer performance remains poor against the 62 day targets in both English and Welsh commissioned services.

Welsh Provider Cancer Performance Per SCP 62 Day Target - Last 12 Months

HealthBoard	2024-05	2024-06	2024-07	2024-08	2024-09	2024-10	2024-11	2024-12	2025-01	2025-02	2025-03	2025-04
Aneurin Bevan UHB												
Pathways With Treatment	10	11	18	16	11	9	13	16	15	16	16	8
Treated Within 62 Days	5	9	10	10	7	8	7	9	11	9	11	4
Breaching 62 Day Target	5	2	8	6	4	1	6	7	4	7	5	4
% Treated Within Target	50%	82%	56%	63%	64%	89%	54%	56%	73%	56%	69%	50%
Betsi Cadwaladr UHB												
Pathways With Treatment			4	1	1	1	3	2		1		3
Treated Within 62 Days						1	3	2				2
Breaching 62 Day Target			4	1	1					1		1
% Treated Within Target			0%	0%	0%	100%	100%	100%		0%		67%
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	3	4	7	6	5	3	9	4	3	5	3
Treated Within 62 Days	1	1	1	4	2	4		4	1	1	1	
Breaching 62 Day Target	3	2	3	3	4	1	3	5	3	2	4	3
% Treated Within Target	25%	33%	25%	57%	33%	80%	0%	44%	25%	33%	20%	0%
Hywel Dda UHB												
Pathways With Treatment	8	8	8	8	8	5	7	7	9	7	6	9
Treated Within 62 Days	3	5	6	6	5	2	6	2	6	5	3	4
Breaching 62 Day Target	5	3	2	2	3	3	1	5	3	2	3	5
% Treated Within Target	38%	63%	75%	75%	63%	40%	86%	29%	67%	71%	50%	44%
Swansea Bay UHB												
Pathways With Treatment	7	11	10	14	7	11	9	11	11	4	7	6
Treated Within 62 Days	6	5	8	8	5	7	5	8	6	1	5	
Breaching 62 Day Target	1	6	2	6	2	4	4	3	5	3	2	6
% Treated Within Target	86%	45%	80%	57%	71%	64%	56%	73%	55%	25%	71%	0%
Pathways With Treatment	**29**	**33**	**44**	**47**	**33**	**31**	**35**	**46**	**40**	**31**	**34**	**29**
Treated Within 62 Days	**15**	**20**	**25**	**29**	**19**	**22**	**21**	**25**	**25**	**16**	**20**	**10**
Breaching 62 Day Target	**14**	**13**	**19**	**18**	**14**	**9**	**14**	**21**	**15**	**15**	**14**	**19**
% Treated Within Target	**52%**	**61%**	**57%**	**62%**	**58%**	**71%**	**60%**	**54%**	**63%**	**52%**	**59%**	**34%**





Powys key provider provisional cancer waiting times standards NHS England - All patients e.g., including non-Powys residents (table 1)

Mar-25	SATH	WVT	All English Providers	Target
28-day FDS	62.5%	76.9%	78.9%	75%
31-day DTT	96.6%	91.1%	91.4%	96%
62-day USC	66.6%	69.3%	71.4%	85%

Urgent and Emergency Care (latest position April 2025)

Welsh Emergency Access (A&E) providers

- Powys residents have seen a slight increase to 66.3% for those waiting under 4 hrs in Welsh units.
- Number of patients reported waiting over 12 hrs was 124 for April 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 consistently from Q1 2024/25.
- PTHB residents attending English emergency units see the longest wait with 47.4% reported in March 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).

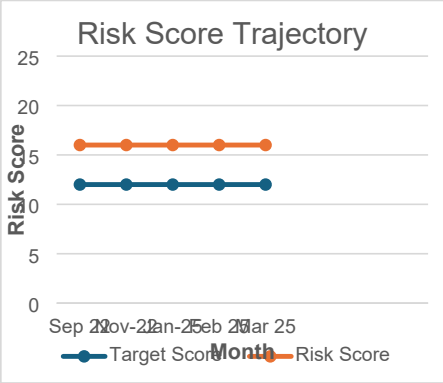
Data Quality

- 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.

Update including impact of actions to date on current risk score:

Improved performance experienced within NHS England commissioned service providers; expected improvement in NHS Wales expected following issue of additional planned care monies in 2025/26, and national procurement process for outpatients and treatments.

Continued inequity of access for PTHB residents accessing NHSW services in comparison with NHSE.
Associated organisational risks (ORR):
• Organisational Risk Register under development Q2 2025/26.

SRR 004	There is a risk that the Health Board is unable to respond to the demand for provided services	
Current Risk Score: **16**	**Risk rating detail:** (likelihood x impact) Current: L4 x I4 = 16 Inherent: L4 x I4 = 16 Target: L3 x I4 = 12	**Risk Category:** Performance and Service Sustainability **Boards Risk Appetite:** **Open**
Executive Lead: Executive Director of Primary Care, Community and Mental Health (PCCMH)		**Assuring Committee:** Patient Experience, Quality & Safety Committee
Latest review date: July 2025 **Added to register:** July 2024 **Link to Strategic Priorities and Wellbeing Objectives:** Several SPs and WBO 4 and 8	 **No change to risk score although additional control and migration added.**	**Cause of risk:** • Increase in demand, inequality of access, complexity of patient needs, or failure to respond to demand pressures. **Risk materialising would result in:** • Poorer outcomes and experience for the citizens of Powys • Increased system pressure across urgent and emergency care pathways. • Reduced efficiency in patient flow and bed utilisation • Inability to meet national performance targets and ministerial priorities.

Controls (What has been implemented to manage the risk?)		Sources of Assurance	Level of Assurance	Highest Assurance provided to:
7.1	For Planned Care Services - Regular review of demand pressures by looking at referral levels into services. Reviewing all in-reach SLA with partner organisations to achieve a more sustainable offer. Maximising insourcing offer to ensure optimal performance standards are achieved. Implement as many Optimisation frameworks and 5 Goals for Planned Care as appropriate for a community-based provider	• Referral data into services from commissioning data sets and supplementary reports received from commissioned providers Best practice guidance from GIRFT and Welsh Government / NHS Exec	Reasonable	Finance & Performance
7.2	For Urgent & Emergency Services – Regular review of demand pressure by reviewing attendance rates and emergency inpatient volumes	Attendance data into services from commissioning data sets and supplementary reports received from commissioned providers	Reasonable	Finance & Performance
7.3	All services - using demand data to plan to provide the correct level of services provision for all services provided in county	Demand, activity and financial information from commissioning datasets used to inform contract plans	Reasonable	Finance & Performance
7.4	Reviewing where services do not meet clinical and operational standards	Various data sources including operational & performance data.	Reasonable	Finance & Performance
7.5	Constantly reviewing staffing level and the amount of agency staff being used. Additional control procedures in place to the reliance on agency staff (particularly higher cost agency providers) and deliver expected cessation.	Various workforce and financial reports recording agency usage at ward and service level	Reasonable	Finance & Performance

7.6	Improving the outcomes and experience data capture to inform future planning	Various data sources including operational & performance data. Qualitative information from PROMS & PREMS reporting, clinical audit, regulatory inspections	Reasonable	Finance & Performance
7.7	Development and implementation of integrated system coordination mechanisms—including the Integrated Flow Hub, daily discharge huddles, Trusted Assessment processes, and the expansion of Powys DigiFLO—to enhance system resilience and operational efficiency. This control supports delivery of the PTHB Six Goals for Urgent and Emergency Care, contributes to the NHS Wales People's Experience Framework, and enables a shift toward a prevention-based, value-driven model of care.	Task & Finish Group reports, baseline assessment against National SPoA Framework, operational data (Package of Care Delays, PoCD), pilot evaluations and implementation monitoring reports	Reasonable	Finance & Performance

Mitigating Actions (What more will we do?)

Action	Lead	Action update	Deadline	Action on Target
<u>Planned Care</u> ▪ Continue series of regular meetings with service providers ▪ Monitor and manage delivery against performance improvement trajectories for our own services. ▪ Medinet contract extended to offer Powys residents experiencing long waits in commissioned service providers in NHS Wales to be treated in Powys. Work being progressed to	Executive Director PCCMH	Performance Trajectories being routinely monitored and managed.	September 2026	On track

issue a tender for insourced provision in 2025/26. Ongoing scrutiny and oversight through CQPR meetings with escalation through Integrated Performance Report.				
<u>General Service Sustainability & Future Models of Care</u> The health board is currently reviewing models of care as part of its five-year plan but also in response the staffing and financial challenges. ▪ A number of service reviews are being undertaken with several 'cases for change' having been approved by the Health Board and stakeholders.	Executive Director PCCMH	The first two cases for change were approved by the Board in October 2024, with overall case for change now available for second phase engagement.	September 2025	On track
There are some performance indicators that continue to fail the operational standard e.g. Neuro-developmental target. The Health Board will develop a suite of indicator sub-sets to determine if any improvement is being made towards achievement of the overall target.	Executive Director PCCMH	A number of sub-indicator performance targets have been identified. These have been built into the IQPR and actions in train to further reduce risk	December 2025	On track
Operationalise and expand integrated system coordination mechanisms—including the Integrated Flow Hub, daily discharge huddles, Trusted Assessment processes, and DigiFLO rollout—to	Executive Director PCCMH	Flow Hub: model scoped, and roles identified; launch planned for September 2025.	March 2026	On Track

mitigate delays, improve patient flow, and support timely discharge across the system.		PoCD: Daily tracking and escalation in place; delays reduced by 6%. Daily 'huddle' to review patients in place. DigiFlo: Implemented on community hospital wards, expansion into MH has been scoped with rollout expected in Q2. Trusted Assessment: Pilot completed in collaboration with PCC with early findings indicating positive impact.		

Additional information:

Rationale for current score:

Planned Care

- NHS Wales Ministerial standards
- Whilst services generally perform well against access targets, the fragility of some of the in-reach SLAs creates inherent operational risk to delivery.

Inpatient Beds

- At present capacity is part staffed by continued reliance upon agency staff. This is not a sustainable or affordable model.
- On any given day, over 40% of our beds can be occupied by patients that are clinically optimised and ready for discharge. They are delayed due to a lack of capacity in onward parts of the pathway. Elongated lengths of stay can have a detrimental impact to the long term needs for patients, and an increase to overall rehabilitation needs

Primary Care

- There are some recruitment challenges for staffing in primary care.
- Dental access and capacity required does not currently meet demand.

Minor Injury Units

- Powys MIUs continue to performance well, in May (latest validated available) reported 100% compliance against 4 hour target and no patients waiting longer than 12 hours.

Mental Health

Elements of the service are currently in internal performance and scrutiny escalation
Associated organisational risks (ORR):
Organisational Risk Register under development Q2 2025/26.

Duty of Candour

Final Internal Audit Report

2025/26

Powys Teaching Health Board

Reasonable Assurance

Contents

Review Reference	PTH-2526-22
Fieldwork	June – August 2025
Executive Sign Off	September 2025
Audit Committee	October 2025
Executive Lead	Claire Roche, Executive Director of Nursing, Quality, Women and Family Health
Audit Team	Ian Virgill, Head of Internal Audit
	Lucy Jugessur, Deputy Head of Internal Audit

Patterson,Liz
20/10/2025 16:46:21

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

Executive Summary

Purpose

Our audit review in relation to the Duty of Candour arrangements was completed in line with the 2025/26 Internal Audit Plan for Powys Teaching Health Board (the 'Health Board').

Legislation in relation to the Duty of Candour was introduced in April 2023 as part of the Health & Social Care (Quality and Engagement) (Wales) Act 2020 along with the Duty of Quality.

Duty of Candour means that NHS organisations have a duty to be open and honest with the service users they are providing healthcare for. If things go wrong, and harm has occurred, they must recognise this and communicate with the service user. This builds upon the principles of the 'Putting Things Right Regulations' already in place within NHS Wales, with an overall objective of ensuring that when a person receives healthcare services, that they are dealt with in an open an honest way by their care provider. The Duty ensures that NHS organisations are clear about avoiding any potential culture of blame and supports those where mistakes and errors have been made.

Where Duty of Candour incidents are identified they should be investigated by the relevant NHS organisation within the required timeframes to understand what happened, to provide the service user with truthful information and an apology, and to identify areas for improvement and lessons to be learnt.

The relevant lead for this review is the Executive Director of Nursing, Quality, Women and Family Health.

Overview

We have concluded reasonable assurance on this area. The key matters requiring management attention include:

- The Integrated Management Framework does not state responsibility, accountability and reporting structures in respect of Duty of Candour.
- There is a lack of awareness of Duty of Candour training which is not being monitored, and the Duty of Candour SharePoint page is not being promoted effectively.
- There is inconsistent recording and supporting documentation of changes made to Duty of Candour incident assessment severity levels and Rapid Review Meetings being undertaken.
- There is inconsistent recording within Duty of Candour Datix case files of 'in person' notification dates and retention of 'written notification' letters.
- There is an absence of regular Duty of Candour reports to Clinical Service Group management and Governance Leads to support local scrutiny and oversight of Duty of Candour case activity.

Full details of matters arising are within the Findings & Agreed Action Plan. We also identified the following opportunities for enhancement that do not impact the overall opinion and are highlighted for management information:

- The Integrated Management Framework and the Datix User Guide, which details case recording and management, are currently not available on the Duty of Candour SharePoint page.

Scope & Assurance Summary

	Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)	Related Findings	Assurance
1	Clearly defined procedures are in place for the management of Duty of Candour cases, which are in line with Welsh Government guidance and include the roles and responsibilities for identifying, investigating and monitoring cases.	1	**Reasonable**
2	Health Board wide training and ongoing support is in place to help staff meet their Duty of Candour responsibilities.	2	**Reasonable**
3	Cases are consistently managed in accordance with the defined procedures to ensure that the Health Board complies with the Duty of Candour.	3,4	**Reasonable**
4	Timely monitoring and reporting arrangements are in place at appropriate levels within the Health Board, which include lessons learnt and contribute to a system of continuous improvement.	5	**Reasonable**

Management Actions

1 High Priority

4 Medium Priority

Themes

Risk Types

Legal & Regulatory Non-Compliance

Quality or Safety Issues

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Findings & Agreed Action Plan

Objective 1: Clearly defined procedures are in place for the management of Duty of Candour cases, which are in line with Welsh Government guidance and include the roles and responsibilities for identifying, investigating and monitoring cases.	Reasonable

Overview / Summary of Observations

Duty of Candour (DoC) procedures are incorporated within the Health Board Incident Management Framework (IMF), rather than detailed in a separate DoC Policy and Procedure. The IMF document is current in content; however, it does not indicate which Health Board management group or Committee is responsible for its sign off.

Our formal comparison of the Welsh Government Guidance and the IMF found that both documents align regarding the key requirements and processes in respect of Duty of Candour. Both also highlight the significance of honesty, reporting, and internal review when addressing incidents of this type. The Health Board has a dedicated DoC page on the Quality and Safety SharePoint pages. However, the Incident Management Framework and the Welsh Government Guidance is not currently available on this site and as such there is a risk of limited management and staff awareness of its existence and statutory content as a result.

We also note that the Health Board's Duty of Candour processes are available via the Feedback and Concerns pages of the Health Board's internet site for the public to access.

	Key Findings	Risk & Impact	Agreed Management Action
1	<u>Incident Management Framework</u> We note that whilst the Incident Management Framework (IMF) is current, it does not state which Health Board Group/Committee is responsible for its sign off. The IMF provides a high level overview of key staff and their responsibilities for the operation and management of Duty of Candour but does not specify which roles within the Health Board are accountable for this. In the absence of a dedicated Duty of Candour policy, it may be important to define clear responsibilities for relevant roles. Furthermore, the Framework lacks detail regarding lines of accountability within the Health Board and does not outline a formal organisational structure for the monitoring or reporting of Duty of Candour at the Clinical Service Group, Committee, and Board levels. We also identified discrepancies within the IMF regarding the specified timeframes for conducting Rapid Incident Review Meetings (RIRM) as references are made to both 72-hour and 48-hour intervals.	Non-compliance with legislation if guidance is unclear and staff are unaware of their responsibilities.	**Agreed Action:** The Incident Management Framework will define and document the specific Health Board / Committee responsible for the sign-off of the IMF. This will be included in the document to ensure accountability and clarity. The IMF will define and document clear responsibilities for relevant roles within the Health Board for identifying, investigating, and monitoring Duty of Candour cases. A detailed organisational structure will be developed and included within the Framework that outlines the lines of accountability for monitoring and reporting Duty of Candour. This will specify the roles and responsibilities at the Clinical Service Group, Committee, and Board levels. The IMF will be amended to show the correct timeframe for conducting the RIRMs. **Expected Evidence of Implementation:** The IMF is in the final phases of a review, where all recommendations have been implemented in the new version

			and once ratified will be published on the Q&S SharePoint and cascaded through the Health Board.
		High Priority	**Officer: Heidi Sinclair**
	Theme: Policies & Procedures	Control Operation	**Target Implementation Date: 31/10/2025**

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20/10/2025 16:46:21

Objective 2: Health Board wide training and ongoing support is in place to help staff meet their Duty of Candour responsibilities.	Reasonable

Overview / Summary of Observations

The Duty of Candour (DoC) page on the Quality and Safety SharePoint page offers training resources, including a Datix reporting video, staff leaflets explaining Duty of Candour, and an ESR e-Learning package that comprises three training modules.

Despite being in place since March 2023, the SharePoint page has seen minimal visits and there have been no recent awareness campaigns in respect of DoC. Uptake of both the ESR e-Learning package and the Datix Manager training remains low across clinical and nursing departments. Additionally, there has been no monitoring of training participation to fully assess and address gaps in uptake.

The Quality and Safety management team has noted the value of collaborating with the Clinical Education department to compare current ESR training with future face-to-face or Teams-based Duty of Candour training for staff. Staff are also able to access one-to-one Datix coaching on Duty of Candour cases on an ad hoc or request basis. The review and possible enhancement of training materials was discussed at the Quality & Safety team meeting in August 2025; however, information regarding the outcome and the timeline for implementing changes is not currently available.

	Key Findings	Risk & Impact	Agreed Management Action
2	<u>Absence of Duty of Candour Awareness Exercises</u> At the time of our review, the Duty of Candour SharePoint page had been viewed 452 times since its launch in March 2023. Additionally, no recent awareness exercises to promote Duty of Candour as a statutory requirement and also that of the SharePoint site have been undertaken within the Health Board during April 2024 to July 2025. <u>Duty of Candour Training</u> The Duty of Candour E-Learning course can be accessed through the ESR system. From March 2023 to July 2025, only 285 Health Board staff had completed the training. Additionally, we reviewed the attendance log for Health Board managers who completed Datix training, which covers Duty of Candour incident management. In 2024/25, only 44 managers attended including: • 29 from Nursing or Midwifery • 7 were Admin & Clerical • 5 Allied Health Professionals	Non-compliance with legislation if guidance is unclear and staff are unaware of their responsibilities.	**Agreed Action:** Periodic exercises will be introduced to increase awareness and promotion of the Duty of Candour process and also signposting of the Duty of Candour SharePoint site. The Quality and Safety team will work with Clinical Education to review and enhance Duty of Candour training. Additional exercises may be implemented so all relevant staff gain the required statutory knowledge and understand reporting and investigation processes. The team will also identify staff who would benefit from this training. <u>Monitoring of Duty of Candour training uptake within the Health Board</u> Processes will be put in place to track and address gaps in Duty of Candour training across all Clinical Service Groups.

	• 3 Other • 0 from medical staff. Since clinical and nursing managers are responsible for these duties, such low participation poses a risk to effective management of Duty of Candour. <u>Monitoring of Duty of Candour training uptake within the Health Board</u> There is currently no monitoring of Duty of Candour training gaps within the Health Board, though discussions with Clinical Education are planned.		**Expected Evidence of Implementation:** Q&S team have implemented a tracker to support services with completion of DOC investigations within KPI time frames. [Completed] Q&S will be working with Clinical Education and the Communications Team to develop a series of online tutorials to support services through the completion of DOC investigations and the final response letter. The People's Experience Lead and Head of Quality and Safety have implemented training for DoC into internal training, including: Health Board Induction, Preceptorship and the Aspire training courses. Signposting to the online DOC ESR training will be frequently shared via SharePoint and the Health Board intranet newsfeed.
		Medium Priority	**Officer: Heidi Sinclair** **Target Implementation Date: 30/11/2025**
	Theme: Training & Development	Control Operation	

Objective 3: Cases are consistently managed in accordance with the defined procedures to ensure that the Health Board complies with the Duty of Candour.	Reasonable

Overview / Summary of Observations

All staff are responsible for reporting incidents within the Datix system as they occur, including recording an initial assessment of the level of harm. We were informed that it is the responsibility of the Governance Leads to review incidents daily and ensure appropriate investigators are assigned. Within the Health Board, these three Governance Leads, are also responsible for adjusting the harm level according to their assessments, coordinating and leading the Rapid Incident Review Meeting (RIRM) for incidents classified as moderate or higher within 72 hours and ensuring that meeting minutes are accurately documented and uploaded to Datix.

A DoC incident is triggered when harm is classified as moderate or higher and the Health Board is identified as a contributor. The Health Board must notify the service user or their representative in person (by phone, video call, or face-to-face) then follow up with a written letter within 5 working days confirming the details of the notification.

We conducted sample testing to verify that cases are managed consistently with established procedures, and that the Health Board meets the Duty of Candour requirements. A Datix DoC activity report was provided, outlining incidents during 2024/2025 that led to adverse outcomes. This analysis focused on cases where the Health Board was not identified as a contributing factor, therefore not initiating the Duty of Candour procedures. Eight cases were found, and for the four cases reviewed, all decisions were appropriately ratified, managed, and documented in Datix as required.

Further testing was undertaken to examine incidents that triggered a Duty of Candour over a six-month period from January to June 2025. During this time, 1,775 incidents were reported. Of these, 521 were classified as 'low' harm and 814 as 'none' during the Manager's Interim harm assessment, resulting in a total of 1,335 cases (the remaining 440 cases were either left blank (401) or categorised as Moderate or above (39)). At the Post Investigation stage, 92% (1,224 cases) maintained the same harm level. From the other 111 cases, 110 remained under investigation, and one was reclassified from low to moderate harm. These findings suggest that managers' initial harm assessments are generally consistent and accurate.

Using the same Datix report we reviewed 9 out of 27 cases that triggered a DoC and found existing processes for updating harm levels were generally followed. However, key information from RIRM is not routinely recorded in DoC files. We also identified inconsistences in documenting trigger dates, ‘in person’ notifications and evidence of issuing written notification within 5 working days.

Key Findings		Risk & Impact	Agreed Management Action
3	Changes to level of harm and Duty of Candour Rapid Review Meetings: Recording and retention of information on Datix A sample of 9 out of 27 DoC cases between January and June 2025 were selected. Our testing identified that: • All nine sampled cases had their severity ratings changed in Datix by appropriate staff; two were downgraded however during the final investigation stage with no documented justification or narrative. Rapid Incident Review Meeting (RIRM) Eight out of nine sampled cases had no documentary evidence retained within Datix to support the RIRM meetings. A questionnaire was distributed to CSG Governance Leads. The Mental Health CSG reported that rapid reviews are not routinely completed for all DoC incidents; however, they are conducted in cases involving a death. The Community CSG has implemented a process flow chart, which indicates that a RIRM should occur within 5 working days, though this is not consistent with the IMF timeframe. For Women and Children, a patient safety huddle may be convened between the governance lead, HoM, DoM, and Quality and Safety team as required. This indicates inconsistencies in the application of RIRM across all CSGs.	Patient harm or poor patient experience if there is a lack of monitoring and oversight to ensure lessons are learnt.	**Agreed Action:** Any changes to assessment severity levels will be recorded in Datix with an accompanying narrative explaining the reason for the change to the harm level. This documentation will be maintained for each phase. A copy of the Rapid Incident Review Meeting (RIRM) TOR will be distributed to relevant staff to emphasise the importance of conducting RIRM meetings within 72 hours of the initial report for incidents classified as moderate harm or above. Additionally, the TOR will be revised to highlight the requirement for documenting and recording of these meetings, ensuring that supporting evidence is maintained in Datix to confirm their completion. **Expected Evidence of Implementation:** Recommendations have been built into the IMF. The HOQ&S will meet with the Governance Leads of the Care Service Groups and emphasis the necessity to document changes to the assessment of severity levels during the RIRM and investigation process. They will also be reminded to use the TOR during the process. The TOR will be shared again on the Q&S SharePoint page.
		Medium Priority	**Officer: Heidi Sinclair** **Target Implementation Date: 30/11/2025**
	Theme: Information, Data Quality & Data Accuracy	Control Operation	
4	Recording of Duty of Candour Communication on Datix A Datix report was requested to incorporate the five working day key performance indicators, which showed that there had been 102 DOC-triggered incidents since its introduction in April 2023. The report found six cases with missing 'in person' notification dates in Datix with three dating back to 2024. Additionally, five cases all prior to 2025 had incident notification dates preceding their DoC trigger dates. Further detailed analysis was performed by selecting ten current DoC cases to assess the key processes in the Health Board's	Patient harm or poor patient experience if there is a lack of monitoring and oversight to ensure lessons are learnt.	**Agreed Action:** Key staff will be reminded of the importance of ensuring that • All 'in person' notification dates are recorded promptly in Datix. • All cases have documented narratives within the progress notes confirming the 'in person' initial date. • Copies of all 'written notification' letters are retained in the documents section of Datix. A review of the IMF will also be carried out to ensure that these requirements are documented within it for transparency.

	IMF. One case however had to be removed from our sample due to it being under external investigation and not subject to Duty of Candour requirements. Our findings highlighted: • All nine cases showed evidence that the service user/respondent was kept updated on the issue's progress. • The 'written notification' letter was not retained in Datix for three of the nine cases. (One respondent requested not to receive this correspondence or updates). • Although all nine cases had an initial date entered in the DoC section of Datix, five lacked documented narratives in the progress notes.		Periodic audits will be undertaken to verify compliance with these key stages and feedback will be provided to staff of any non-compliance. **Expected Evidence of Implementation:** Updated IMF to include documentation requirements. KPI reports will now be run in line with the Integrated Quality Report and a selection of DOC cases will be audited for monitoring to include documentations requirements.
		Medium Priority	**Officer: Heidi Sinclair** **Target Implementation Date: 31/10/202**
	Theme: Information, Data Quality & Data Accuracy	Control Operation	

Objective 4: Timely monitoring and reporting arrangements are in place at appropriate levels within the Health Board, which include lessons learnt and contribute to a system of continuous improvement.	Reasonable

Overview / Summary of Observations

We were informed that weekly updates on moderate and above incidents were previously distributed to Clinical Service Group Management, Directors, and Executives. However, this practice discontinued as of June 2025. Governance leads and heads of service currently have access to dashboards within Datix for monitoring concerns, incidents, and duty of candour cases, although the frequency of dashboard usage remains unclear. As stated in Key Finding 1, it is essential that clear monitoring and reporting arrangements are embedded within the reporting structure to support ongoing oversight and continuous improvement.

It was indicated that Clinical Service Groups conduct quality and assurance meetings to address concerns, incidents, and nationally reportable events, with escalation to the Executive Committee as necessary. However, this process could not be substantiated during the course of the audit.

Duty of candour activity data and associated lessons learned outcomes are included in the Integrated Quality Report (IQR), which is submitted bi-monthly to the Patient Experience and Quality Safety (PEQS) Group. Additionally, the PEQS Committee Chair provides a quarterly copy of the IQR to the Board. In addition, any significant Duty of Candour issues that require escalation are reported to the Board on an exception basis.

A review of Board Papers and relevant PEQS Committee Chair Highlight Reports from March to July 2025 found no Duty of Candour issues reported. Duty of Candour activities, lessons learned, and improvement outcomes are referenced in the Health Board's Annual Report for 2024/25, as well as in the annual Duty of Quality Report for 2024/25 which is submitted to the Welsh Government.

Key Findings		Risk & Impact	Agreed Management Action
5	<u>Monitoring and reporting arrangements</u> Weekly Datix DoC reports were historically sent to CSG Service Managers and Governance Leads for review within quality meetings covering concerns, incidents, and NRIs. These reports detailed cases under review, investigation, and closure. However, distribution of the weekly reports ceased in mid-June 2025 due to uncertainty over their value, and also whether the data provided to CSG management teams was having any direct effect. Governance leads and heads of service have access to dashboards within Datix for monitoring concerns, incidents, and duty of candour cases; however, the frequency with which these dashboards are used has not been determined. A questionnaire was distributed to CSG Governance Leads, which indicated that Mental Health and Women & Children's CSGs conduct weekly safety or PTR meetings and provide monthly reports to their Quality Assurance (QA) Group or Senior	Patient harm or poor patient experience if there is a lack of monitoring and oversight to ensure lessons are learnt	**Agreed Action:** Meetings will be scheduled with CSG management teams, and their Governance Leads to determine whether the weekly DoC reports are necessary. If required, these discussions will also establish the specific data types to be included to ensure the reports provide meaningful information. Additional analysis will also be conducted to identify current users of the Datix DoC dashboard and determine whether it is being used to support case incident review and decision-making. A standardised review process will be established to manage cases designated as 'blank,' ensuring that all cases are evaluated within the prescribed timeframes. These steps will be included into the reporting structure that has been discussed under Key Finding 1.

	Management Team (SMT); however, this information could not be independently verified during the audit. Based on the testing conducted under objective 3, it was identified that interim harm assessments by managers were 'blank' in 401 out of 1,775 incidents, including: • Seven classified as Severe; • 15 as Moderate; and • Two as Catastrophic. These incidents should have undergone assessment with the corresponding harm levels confirmed. The Quality & Safety team meets with CSGs every two weeks to review DoC and NRI cases but cannot address unresolved cases due to limited capacity. This suggests that CSG's case monitoring needs a thorough review and that checks on 'blank' cases have been insufficient.		**Expected Evidence of Implementation:** Meeting minutes from Governance Lead meeting in October. This will discuss dashboard access and usage and management under DOC KPIs. Audit to include review process
	Theme: Reporting	**Medium Priority** Control Design	**Officer: Heidi Sinclair** **Target Implementation Date: 31/10/2025**

Appendix A

Assurance Opinion

 **Substantial**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
 **Reasonable**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
 **Limited**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
 **Unsatisfactory**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
 **Advisory**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Findings

Priority	Explanation
High	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
Medium	Some risk to achievement of a system objective. Minor weakness in system design OR limited non-compliance.

Website: [Audit & Assurance Services - NHS Wales Shared Services Partnership]

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The report is based on the review work undertaken and is not necessarily a complete statement of all weaknesses that exist or potential improvements. Whilst every care has been taken to ensure that the information provided in this report is as accurate as possible, no complete guarantee or warranty can be given with regard to the advice and information contained.

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with management of the Powys Teaching Health Board. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Public Sector Internal Audit Standards

Audit work undertaken by NHS Wales Audit and Assurance Services conforms with the International Standards for the Professional Practice of Internal Auditing and associated Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

Patient Experience, Quality and Safety Committee 2025-26

Theme	Item Title	April 29/04/2025	July 31/07/2025	October 23/10/2025	February 05/02/2026	Rationale
Governance	Minutes of previous meeting	✓	✓	✓	✓	
Governance	Declaration of Interests	✓	✓	✓	✓	
Governance	Action Log	✓	✓	✓	✓	
Governance	Committee Risk Register	✓	✓	✓	✓	
Governance	Annual Work Programme	✓				
Governance	Committee Work Programme (updated through year)		✓	✓	✓	
Governance	Items to be brought to the attention of the Board and/or other Committees	✓	✓	✓	✓	
Governance	Annual Assessment of Committee Effectiveness	✓				
Governance	Committee Governance Action Plan		✓		✓	
Governance	Committee Annual Report	✓				
Governance	Review of Terms of Reference PEQS	✓				
	Review of Terms of Reference Power of Discharge Group		✓			
Quality	Integrated Quality Report to include:	✓	✓	✓	✓	
	Once for Wales Content Management System	✓				
	Putting Things Right - Concerns	✓				
	Duty of Candour	✓				
	Claims, Redress and Clinical Negligence Position	✓				
	Incident Management	✓				
	Early Warning Notifications	✓				
	Nationally Reportable Incidents	✓				
	Mental Health Review of Suicides	✓				
	Welsh Risk Pool Assurance Report	✓				
	Peoples Experience - Civica	✓				
	Llais Activity	✓				
	Infection Prevention and Control	✓				
	Health Inspectorat Wales Inspections	✓				
	PAVO reports	✓				
	Bereavement Framework	✓				
	Venous Thrombiembolism Scroping Review	✓				
	Strengthening Safeguarding in Health Review	✓				
	QUAILS reports from Service Groups		✓			
	PSOW Annual Letter (within IQR - when received)			✓		
	National Programmes and Initiatives		✓	✓	✓	
Quality	High vacancy/high agency use in relation to the quality and sustainability of services					
	Integrated Quality and Performance Framework		✓			
Research, Development and Improvement	Quality based improvement / learning					
Research, Development and Improvement	Research, Development and Innovation					
Patient Experience	Patient Experience Framework		☒	✓		Update paper provided, Framework itself due Feb 2026
	Patient Story	✓	✓		✓	
Primary Care	Patient Experience in Primary Care		☒	☒	✓	Will form part of patient experience framework.
Primary Care	Primary Care - dental quality			✓		
MH Compliance	MH Power of Discharge Annual Report including MH compliance with legislation and update				✓	
Clincial Audit	Annual Programme Clinical Audit	✓	✓			
	Progress Report Clinical Audit			✓		
Audit Reports	Any Internal Audit/Wales Audit reports received - for information	✓	✓	✓	✓	
Medicines Management	Annual Report of Accountable Officer for Controlled Drugs				✓	
Annual Reports	Medicines Management Annual Report			✓		
	Safeguarding Annual Report		✓			
	Duty of Quality Annual Report		✓			
	Annual Report Medical Devices and Point of Care Testing			✓		
	Transition of Care Annual Report		☒	☒	✓	Delayed due to staff change and resource pressures
Infection Prevention and Control	IPC Annual Assurance Report		✓			
	IPC progress/focus				✓	
Comms and Engagement	Comms and Engagement Report for PEQS					No longer required
Other	Monitor Health Board actions of Child Pratice Review		✓			
	Monitor Health Board actions of JICPA	✓				
	Corporate Parenting Charter				✓	
	Staff experience of MH&LD Services in escalation	✓				
	Staff experience of ND Services in escalation (post escalation)					
	AW Cancer services report and WG response	✓				
	JCC Quality Safety and Outcomes Sub-Committee Hightlight Report	✓	✓			
	EPMA SBAR		✓			
	Maternity Assurance Report			✓	✓	
Actions						
	Monitor implementation of management actions for DoLS IA report	✓	✓		✓	
	Six-monthly update on Antimicrobrial resistance		✓		✓	
	How quality is measure in general and community dental services	✓		✓		
	Quality elements in JAG to regain accreditation				✓	
Escalated Items:						
	IP&C	✓				IPC de-escalated April 2025
	Civica (Patient Experience - see above)	✓	✓	✓	✓	
	Neurodiversity (referred from D&P Oct 2024)	✓	✓	✓	✓	
In Committee						
	Briefing on suicides	✓	✓			

KEY
Added to draft agenda
Date to be confirmed
Item deferred
Item brought forward
Going to Board
Due to Committee
Find Exec Cttee date
transferred to another committee
Date/Item to be confirmed

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Powys Teaching Health Board Glossary (Last updated October 25)

Acronym	
ADoECP	Associate Director of Estates, Capital & Property
CEO	Chief Executive Officer
DCG	Director of Corporate Governance
DIT	Director of Improvement & Transformation
EMD	Executive Medical Director
ED PH	Executive Director of Public Health
ED P&C	Executive Director of People and Culture
ED PP&C	Executive Director of Planning, Performance and Commissioning
ED FCSS	Executive Director of Finance, Capital & Support Services
ED AHPHSD	Executive Director of Allied Health Professions, Health Sciences and Digital
ED NQW&FH	Executive Director of Nursing, Quality, Women and Family Health
EDPCCMH	Executive Director of Primary Care, Community & Mental Health
ABUHB	Aneurin Bevan University Health Board
AFC	Agenda for Change
AGW	The Auditor General for Wales
AHPs	Allied Health Professionals
ALN	Additional Learning Needs
AO	Accountable Officer
ARAC	Audit, Risk and Assurance Committee
ASM	Accelerated Sustainable Model
AR	Audit Recommendations
APB	Area Planning Board
BAF	Board Assurance Framework
BCUHB	Betsi Cadwaladr University Health Board
BMA	British Medical Association
CAAP	Clinical associate in applied psychology
CAMHS	Child and Adolescent Mental Health Services
CCN	Childrens Community Nursing
CEMT	Chief Executive Management Team
CHC	Continuing Health Care
CIW	Care Inspectorate for Wales
CLIP	Collaborative Learning in Practice
CNO	Chief Nursing Officer

CPD	Continued Professional Development
CPR	Child Practice Review
CRR	Corporate Risk Register
CSP	Clinical Service Plan
CTMUHB	Cwm Taff Morgannwg University Health Board
CV	Curriculum Vitae
CVUHB	Cardiff and Vale University Health Board
CWMPAS	Mid and West Wales Regional Safeguarding Adults Board
CYSUR	Mid and West Wales Regional Safeguarding Children Board
CTC	Care Transfer Co-ordinator
CCOMG	Complex Care Operational Management Group
DATIX	Incident Management System
D&P	Delivery and Performance Committee
DCG	Delivery Co-ordination Group
DGH	District General Hospital
DHCW	Digital Health and Care Wales
DNA	Did not Attend
DNACPR	Do Not Attempt Cardio-Pulmonary Resuscitation
DPA	Data Protection Act
DToC	Delayed Transfer of Care
D2RA	Discharge to Recover and Assess
DST	Decision Support Tool
EASC	Emergency Ambulance Services Committee
EOG	Executive Oversight Group
EOY	End of Year
EMRTS	Emergency Medical Retrieval & Transfer Service
EPMA	Electronic Prescribing and Medicines Administration
ESR	Electronic Staff Record
EMI	Elderly Mentally Infirm
FBC	Full Business Case
FOI	Freedom of Information
FFT	Friends and Family Test
FTE	Full Time Equivalent
F&P	Finance and Performance Committee
GDS	General Dental Services
GIRFT	Getting It Right First Time
GMC	General Medical Council
GMS	General Medical Services
GP	General Practitioner
GNCC	General Nursing Complex Care Team

H&S	Health and Safety
HCA	Health Care Assistant
HCS	Health and Care Standards
HCSW	Health Care Support Worker
HDUHB	Hywel Dda University Health Board
HEIW	Health Education and Improvement Wales
HIW	Healthcare Inspectorate Wales
HP	Health Protection
HPF	Healthcare Professionals Forum
ICF	Integrated Care Funding
IEN	Internationally Educated Nurse
IG	Information Governance
IM	Independent Members
IMTP	Integrated Medium Term Plan
IP&C	Infection Prevention and Control
IQPF	Integrated Quality Performance Framework
IQPG	Integrated Quality & Performance Group
IQPR	Integrated Quality Performance Report
IT	Information Technology
JAG	Joint Advisory Group (on Gastrointestinal Endoscopy)
JCC	Joint Commissioning Committee
JD	Job Description
JET	Joint Executive Team
JIPCA	Joint Inspection of Child Protection Arrangements
JLT	Joint Leadership Team (PTHB and PCC)
JR	Judicial Review
KPI	Key Performance Indicator
LoF	League of Friends
LA	Local Authority
LHB	Learning Health Board
LMC	Local Medical Committee
LPF	Local Partnership Forum
LRF	Local Resilience Forum
LTA	Long Term Agreement
MD	Ministerial Direction
MDTs	Multi-Disciplinary Teams
MEG	Medical E-Governance System
MEG	Main Expenditure Group
MH	Mental Health
MHD	Mental Health & Learning Disability

MIU	Minor Injury Unit
MOU	Memorandum of Understanding
MOA	Memorandum of Agreement
MSK	Musculoskeletal
MV	Mass Vaccination
NHSE	National Health Service England
NHS	National Health Service
NHSWE	NHS Wales Executive
NICE	National Institute of Health and Clinical Excellence
NRI	Nationally Reportable Incidents
NWSSP	NHS Wales Shared Services Partnership
NNA	Nursing Needs Assessment
OBC	Outline Business Case
OCP	Organisational Change Process
OOC	Out of County
OOH	Out of Hours
OSCE	Objective Structured Clinical Examination
OT	Occupational Therapy
PA	Physician Associate
PADR	Personal Appraisal Development Review
PAVO	Powys Association of Voluntary Organisations
PCC	Powys County Council
PEQS	Patient Experience, Quality and Safety Committee
PHE	Public Health England
PHW	Public Health Wales
PPPH	Planning, Partnerships and Population Health Committee
PSB	Public Service Board
PSOW	Public Services Ombudsman for Wales
PTHB	Powys Teaching Health Board
PTR	Putting Things Right
P&C	People and Culture Committee
QA	Quality Assurance
RaTS	Remuneration and Terms of Service Committee
RCN	Royal College of Nursing
RIIC	Research, Innovation & Improvement Coordination
RIF	Regional Investment Fund
RISP	Radiology Information System Procurement
RJAH	Robert Jones and Agnes Hunt
RN	Registered Nurse
RPB	Regional Partnership Board

RTT	Referral to Treatment
RTS	Routemap To Sustainability
Q1 Q2 Q3 Q4	Quarter 1 (April, May, June), Quarter 2 (July, August, September), Quarter 3 (October, November, December), Quarter 4 (January, February, March)
QSEG	Quality, Safety and Experience Group
SAR	Subject Access Request
SAS	Specialty and Specialist
SBAR	Situation, Background, Assessment, Recommendation
SBUHB	Swansea Bay University Health Board
SDEC	Same Day Emergency Care
SLA	Service Level Agreement
SOC	Strategy Outline Case
SOP	Standard Operating Procedure
SaTH	Shrewsbury and Telford Hospital NHS Trust
SPB	Strategic Programme Board
SRO	Senior Responsible Owner
TI	Targeted Intervention
ToR	Terms of Reference
TRAC	Online Recruitment Management System
T&V	Transformation & Value
VERS	Voluntary Early Release Scheme
WAST	Welsh Ambulance Services NHS Trust
W&C	Workforce and Culture Committee
WCCIS	Welsh Community Care Information System
WG	Welsh Government
WHC	Welsh Health Circular
WHSSC	Welsh Health Specialised Service Committee
WNB	Was Not Brought
WOD	Workforce and Organisational Development
WPAS	Welsh Patient Administration System
WPOCT	Welsh Point of Care Test System
WTE	Whole Time Equivalent
WVT	Wye Valley Trust
YTD	Year to Date