Patient Experience, Quality and Safety Committee

Thu 31 July 2025, 09:30 - 12:30

Agenda

09:30 - 09:30
0 min

1. PRELIMINARY MATTERS

PEQS_ Agenda_31JUL2025 FINAL.pdf (3 pages)

1.1. Welcome and Apologies

1.2. Declarations of Interest

PEQS_1.2_Board Members Declaration Of Interests summary 2025-26_June 2025.pdf (3 pages)

1.3. Patient Story

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: 29 April 2025

PEQS_3.1_Minutes 2025-04-30 PEQS unconfirmed.pdf (11 pages)

3.2. Committee Action Log

PEQS_3.2_Action Log July 2025.pdf (1 pages)

3.3. Safeguarding Annual Report

PEQS_3.3_PTHB Safeguarding Annual Report 2024-25.pdf (4 pages)
PEQS_3.3a_PTHB Safeguarding Annual Report 2024 - 2025 (2).pdf (72 pages)

3.4. Duty of Quality Annual Report

PEQS_3.4_Duty of Quality cover paper.pdf (2 pages)
PEQS_3.4a_PTHB Annual Duty of Quality Report 2024-2025.pdf (42 pages)

3.5. Mental Health Services Act Hospital Managers Power Of Discharge Group Terms of Reference

PEQS_3.5_MH Act Hospital Managers PoDCG cover paper.pdf (2 pages)
PEQS_3.5a_PODG_Terms of Reference_Feb25_Draft.pdf (5 pages)

3.6. Committee Governance Action Plan

PEQS_3.6_Effectiveness Continuous Development Plan 2025-26.pdf (6 pages)

09:30 - 09:30
0 min

4. ESCALATED ITEMS

4.1. Children's Neurodiversity Services

- PEQS_4.1_ND PEQS 31 July 2025.pdf (7 pages)
- PEQS_4.1d_Appendix Four.pdf (1 pages)
- PEQS_4.1b_Appendix Two.pdf (8 pages)
- PEQS_4.1c_Appendix Three.pdf (5 pages)

4.2. People Experience Framework update

(within IQR)

09:30 - 09:30
0 min

5. ITEMS FOR ASSURANCE

5.1. Integrated Quality Report

- PEQS_5.1_Integrated Quality Report July 2025 - Q1 25-26.pdf (24 pages)
- PEQS_5.1a_ Antimicrobial stewardship summary report July 2025.pdf (5 pages)
- PEQS_5.1b_RD Report May 2025.pdf (10 pages)

5.2. Committee Risk Register

- PEQS_5.2_Committee Risk Register Update July 2025.pdf (4 pages)
- PEQS_5.2a_Appendix A - Committee Risk Register July 2025.pdf (20 pages)

5.3. Update on JAG accreditation

5.4. Monitor implementation of management actions for Deprivation of Liberty Standards Internal Audit report

- PEQS_5.4_MCA DoLS Internal Audit Update.pdf (5 pages)
- PEQS_5.4a_Internal Audit Report DoLS.pdf (17 pages)

5.5. Clinical Audit Programme Annual Report 2024/25

- PEQS_5.5_24 25 Clinical Audit Paper.pdf (21 pages)

5.6. Infection Prevention and Control Annual Assurance Report

- PEQS_5.6_IPC annual report cover paper.pdf (2 pages)
- PEQS_5.6a_PTHB IPC Annual Report 2024-25 - final.pdf (27 pages)

5.7. Electronic Prescribing and Medicines Administration (ePMA) system update

- PEQS_5.7_ePMA update.pdf (7 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. Pharmacy Stores

PEQS_7.1a_Pharmacy Stores Final Internal Audit Report.pdf (9 pages)

7.1.2. Quality, Safety and Governance

PEQS_7.1b__Quality Safety Governance Final Audit Report.pdf (8 pages)

7.1.3. Business Continuity Planning

PEQS_7.1c_BCP Final Internal Audit Report.pdf (7 pages)

7.1.4. Risk Management

PEQS_7.1d_Risk Management Final Internal Audit Report.pdf (9 pages)

7.1.5. Mattresses

PEQS_7.1e_Mattresses Final Internal Audit Report.pdf (10 pages)

7.2. Joint Commissioning Committee – Quality Safety and Outcomes Sub-Committee Highlight Report 20 May 2025

PEQS_7.2_QSO Highlight Report March 2025.pdf (8 pages)

7.3. Work Programme

PEQS_3.2_Work Programme July 2025.pdf (1 pages)

7.4. Glossary

PEQS_7.4_Powys Teaching Health Board 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: 23 October 2025

8.5. Confidential Items

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

8.6. Welcome and Apologies

8.7. Declarations of Interest

8.8. Minutes of the In-Committee meeting held on 29 April 2025

8.9. Report on unexpected deaths

POWYS TEACHING HEALTH BOARD
PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE

THURSDAY 31 JULY 2025
09.30 – 13.15
Via Microsoft Teams

AGENDA				
Time	**Item**	**Title**	**Attached / Verbal**	**Presenter**
	1	**PRELIMINARY MATTERS**		
09.30	1.1	Welcome and apologies	Verbal	Chair
	1.2	Declarations of interest • 2025/26 Register of Interests	Verbal	All
09.35	1.3	Patient Story	Attached	Executive Director of Nursing, Quality, Women and Family Health
	2	**CONSENT AGENDA BUSINESS**		
The Chair will ask if there are any items from the Consent Agenda (Item 7) that Committee Members wish to bring forward to the main agenda.				
	3	**ITEMS FOR APPROVAL / DECISION / RATIFICATION**		
09.50	3.1	Minutes of previous meeting: • 29 April 2025	Attached	Chair
09.55	3.2	Committee Action Log	Attached	Chair
10.00	3.3	Safeguarding Annual Report	Attached	Executive Director of Nursing, Quality, Women and Family Health
10.10	3.4	Duty of Quality Annual Report	Attached	Executive Director of Nursing, Quality, Women and Family Health
10.20	3.5	Mental Health Services Act Hospital Managers Power Of Discharge Group Terms of Reference	Attached	Director of Corporate Governance
10.25	3.6	Committee Governance Action Plan	Attached	Director of Corporate Governance
	4	**ESCALATED ITEMS**		
10.30	4.1	Children's Neurodiversity Services (to include details of funding (Action PEQS/25/08)	Attached	Executive Director of Planning, Performance and Commissioning
	4.2	People Experience Framework update (within IQR)	Verbal	Executive Director of Nursing, Quality, Women and Family Health
10.45		**COMFORT BREAK 15 MINUTES**		

	5	**ITEMS FOR ASSURANCE**		
11.00	5.1	Integrated Quality Report including: • Update on review of Integrated Quality and Performance Framework (Action PEQS24/52b) • QUAILS reports (Action PEQS/25/15) • National Programmes and initiatives • KPIs re NRIs (Action PEQS25/11a) • Powys specific data from Medical Examiner service • Six-monthly update on Antimicrobial resistance (Action PPPH/24/12)	Attached	Executive Director of Nursing, Quality, Women and Family Health
12.00	5.2	Committee Risk Register	Attached	Director of Corporate Governance
12.05	5.3	Update on JAG accreditation (Action D&P/24/86a)	Verbal	Executive Director of Primary, Community Care and Mental Health
12.10	5.4	Monitor implementation of management actions for Deprivation of Liberty Standards Internal Audit report (Action ARAC/24/75)	Attached	Executive Director of Nursing, Quality, Women and Family Health
12.15	5.5	Clinical Audit Programme Annual Report 2024/25 – to include detail on assurance routes for reporting (Action PEQS25/11b)	Attached	Executive Medical Director
12.25	5.6	Infection Prevention and Control Annual Assurance Report	Attached	Executive Director of Nursing, Quality, Women and Family Health
12.35	5.7	Electronic Prescribing and Medicines Administration (ePMA) system update	Attached	Executive Medical Director
	6	**ITEMS FOR DISCUSSION**		
		There are no items for discussion		
	7	**CONSENT AGENDA**		
	7.1	Internal Audit Reports: • Pharmacy Stores (Reasonable) • Quality, Safety and Governance (Reasonable Assurance)	Attached	Director of Corporate Governance

		• Business Continuity Planning (Substantial Assurance) • Risk Management (Reasonable Assurance) • Mattresses Final Report (Limited Assurance) **Purpose**: Information		
	7.2	Joint Commissioning Committee – Quality Safety and Outcomes Sub-Committee Highlight Report 20 May 2025 **Purpose**: Assurance	Attached	Director of Corporate Governance
	7.3	Work Programme **Purpose**: Information	Attached	Director of Corporate Governance
	7.4	Glossary **Purpose**: Information	Attached	Director of Corporate Governance
	8	**OTHER MATTERS**		
	8.1	Any Other Urgent Business	Oral	Chair
	8.2	Items to be brought to the attention of the Board and/or other Committees	Verbal	Chair
	8.3	Committee Reflections	Verbal	Chair
12.45	8.4	Date of the next meeting: 23 October 2025 via Teams		

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

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

"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"

12.50	8.6	Welcome and Apologies	Verbal	Chair
	8.7	Declaration of Interest	Verbal	Chair
	8.8	Minutes of the In-Committee meeting held on 29 April 2025	Attached	Chair
	8.9	Report on unexpected deaths	Attached	Executive Director of Nursing, Quality, Women and Family Health/Executive Director Primary, Community Care and Mental Health
13.15	Close			

POWYS TEACHING HEALTH BOARD - REGISTER OF DECLARATION OF INTERESTS 2025-26								Updated: June 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	
		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	£2500.00 per annum	
		Indirect Interests	Outside Employment	Mar-21	Current to Dec-27	Independent Monitoring Authority (IMA) – Non Executive Director	£7500.00 per annum	
		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 Owneer: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	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
		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
		Non Financial professional Interests	Hospitality	19-Nov-24	20/11/2024	Attended digital conference which was funded by the hosting organiser (Health Strategy Forum).	An opportunity to meet with other NHS senior leaders and consider opportunities for use digital innovation in transforming Health care.	

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28/07/2025 15:02:22

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)	NIL	29/05/2025
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	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	School Governor – Langynwyd primary school (Bridgend)	Not remunerated	18/06/2025
		Indirect Interests	Outside Employment	Aug-16	Current	My 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	My 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	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	£2,960 Per Annum	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	Nil	

PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE

UNCONFIRMED MINUTES OF THE MEETING HELD ON 29 APRIL 2025 at 09:00 THE BOARD ROOM, MACHYNLLETH HOSPTIAL AND VIA MICROSOFT TEAMS

MEMBERS		
Kirsty Williams	KWi	Vice Chair (Committee Chair)
Jennifer Owen Adams	JOA	Independent Member (Third Sector)
Ian Thomas	IA	Independent Member (General)
IN ATTENDANCE		
Zoe Ashman	ZA	Interim Assistant Director Women & Children
Katie Blackburn	KB	Regional Director of Llais
Helen Bushell	HB	Director of Corporate Governance / Board Secretary
Susan Dinsdale	SD	Head of Nursing for Children
Amanda Edwards	AE	Assistant Director Innovation and Improvement
Nicola Johnson	NJ	Executive Director of Planning, Performance and Commissioning (for Item 4.1)
Louisa Kerr	LK	Assistant Director Mental Health (for Item 5.4)
Elaine Lorton	EL	Executive Director of Primary Care, Community and Mental Health
Claire Madsen	CM	Executive Director of Allied Health Professionals, Health Sciences and Digital
Claire Roche	CR	Executive Director of Nursing, Quality, Women and Family Health
Heidi Sinclair	HS	Head of Quality and Safety
Kate Wright	KW	Executive Medical Director
APOLOGIES FOR ABSENCE:		
Carl Cooper	CC	Chair of PTHB Board
Hayley Thomas	HT	Chief Executive
Simon Wright	SW	Independent Member

1. PRELIMINARY MATTERS

1.1 WELCOME AND APOLOGIES (PEQS/25/01)

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

1.2 DECLARATIONS OF INTEREST (PEQS/25/02)

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

1.3 PATIENT STORY (PEQS/25/03)

A recording of the experience of two parents accessing neurodiversity assessments and services was shared with the Committee. The patient story linked to a later item on the agenda on neurodiversity services in escalation and KWi expressed gratitude to the participants for sharing their experiences.

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/25/04)

The minutes of the meeting held on 11 February 2025 were **CONFIRMED** as an accurate record.

3.2 COMMITTEE ACTION LOG (PEQS/25/05)

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

- PEQS/24/52b 'Mental Health Services update - A review of the Integrated Quality and Performance Framework'. EL suggested this action should be split into two with one action relating to the ongoing monitoring of Mental Health Services post escalation (timescale to be agreed after the Item 5.4 Staff experience of Mental Health and Learning Disabilities service in escalation), and one action relating to the review of the Integrated Quality and Performance Framework to be brought to the July meeting of the Committee.

Action: Director of Corporate Governance

The remaining actions were noted as either not yet due or completed.

3.3 COMMITTEE ANNUAL WORK PROGRAMME 2025/26 (PEQS/25/06)

HB presented the work programme which had been created based on the terms of reference, risk registers and other sources of information. It was noted that the work programme would remain flexible throughout the year to accommodate any matters that arose.

Members asked the following questions for assurance:
How will cross cutting issues such as Better Together be routed through Committees?
HB advised that the Joint Chair's Forum had a role to play in deciding where cross-cutting matters were placed. It was likely that the Better Together programme would be considered at the Board rather than at Committee level.

Is there a formal process for moving items between Committee Work Programmes?
HB advised that the Committees work collaboratively and items that have been referred to another Committee are recorded in the minutes and tracked via the action log.

CM requested the addition of an Annual Report on Medical Devices and ad hoc audits to be included on the Annual Work Programme.

KWi suggested that consideration should be given as to whether this should be included in the Terms of Reference for the Committee.
Action: Director of Corporate Governance

The Committee **APPROVED** the Committee Work Programme for 2025/2026.

3.4 COMMITTEE ANNUAL REPORT (PEQS/25/07)

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

NJ joined the meeting 09.35

4. ESCALATED ITEMS

4.1 CHILDREN'S NEURODIVERSITY SERVICES (PEQS/25/08)

NJ presented the report which provided an outline on progress at six months in relation to escalation status. Attention was drawn to the following areas:

- The service model had been redesigned and modernised and service standards were now met
- All apart from one of the actions identified in September had been completed. The remaining action was now underway
- Additional funding from Welsh Government had enabled the service to reduce waits to under 2 years
- Since March 2025 the internal wait list has been cleared
- The 2025/26 plan is to maintain the 2 year wait list enabled by a commitment from the Executive team to maintain temporary staffing levels
- It will be necessary to demonstrate sustained improvement before de-escalation can be considered

CR noted that whilst a considerable amount of progress had been made challenges remained.

Members asked the following questions for assurance:
Has turnover of workforce contributed to the problems in this service?
ZA advised that workforce turnover had not been a contributing factor. There was a small core workforce supplemented by temporary staff funded by Welsh Government which had enabled the service to be transformed.

KW noted the common theme expressed in the patient story that communications needed to be improved, and now the service has been reorganised it will be possible to provide better communications with patients.

ZA advised that it was now possible to share with patients the number they are on the list and confirm that they will be seen within two years. There are currently around 1,100 children on the list, and these will be seen in turn rather than cases being expedited.

Does the Health Board have the resources to meet the demand in this service?

CR advised that time limited funding had been received from Welsh Government to improve the service. This had ceased, and it was the responsibility of the Health Board to put in place sustainable arrangements.

Are there opportunities for the third sector to provide support which would enable the Health Board to focus on core provision?
CR advised it had been necessary to get the foundations of the service right and then work with colleagues in the local authority to provide support that is not medicalised. The service is only seeing those children that need to be assessed, and where assessment is not appropriate the family are signposted to appropriate services.

Feedback from staff highlights this has been a particularly challenging period. What support is in place for staff?
SD advised the team were on a firebreak week ensuring all the processes are working correctly with opportunities to feedback difficulties. Training and supervision are priorities.

EL noted it was necessary to look after the well-being of the senior leadership team in addition to the operational team

Thanks were expressed to the team for the work undertaken to improve the service.

KWi requested that the next update include details regarding the funding for the service.
Action: Executive Director of Planning, Performance and Commissioning

The Committee:

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

NJ left the meeting 10.00

4.2 CIVICA – PATIENT EXPERIENCE SYSTEM (PEQS/25/09)

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.

4.3 INFECTION PREVENTION CONTROL (PEQS/25/10)

CR presented the report advising Infection Prevention and Control was an area of concern two years ago. A gap analysis was undertaken and a two-year improvement plan developed. 45 of the 47 improvement actions have been completed with the remaining two actions due for completion in the next few weeks. Thanks were expressed to the Infection, Prevention and Control teams along with associated teams who have facilitated the improvements. The Executive Committee have recommended Infection Prevention and Control be de-escalated.

Members asked the following questions for assurance:
What assurance can be given that the improvements documented will be sustained after de-escalation?
CR advised that a sustainable workforce had been put in place with a number of roles which facilitated career progression, along with a Nurse Consultant. The audit

arrangements have been strengthened which will enable regular monitoring. Infection Prevention and Control performance will be reported to the Committee via the Integrated Quality Report.

The Committee:

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

5.ITEMS FOR ASSURANCE

5.1 INTEGRATED QUALITY REPORT (PEQS/25/11)

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

- Year-end compliance for response to concerns under Putting Things Right was 80% against a 75% target of a response within 30 days, although the Q4 figure was 71%. The Health Board are starting to use the Beacons dashboard to compare compliance against other Health Boards. The Health Board are taking 30 days to respond compared to some other Health Boards who respond in less than 20 days and the opportunity to respond more quickly whilst ensuring a quality response is the intention.
- Over half of Nationally Reported Incidents (NRIs) remain open for more than 90 days (in part due to complexity of pathways and a small investigation team). Whilst recognising the improvements in response times, the Beacons dashboard has identified areas where more improvement can be made
- The Welsh Risk Pool assessment identified six areas of substantial assurance with one area of reasonable assurance which included two red items (investigation outcomes to be recorded on DATIX, and Key Performance Indicators are needed for managing incident reporting)
- Duty of Candour incidents are increasing which is welcome as it demonstrates colleagues developing confidence in handling these matters
- The Peoples Experience Framework has been recently published by Welsh Government. The Health Board are now undertaking a self-assessment against the framework. A Patient Experience Lead is being recruited to facilitate co-ordination and reporting on patient experience.
- The Safeguarding in Health report has been published and a Safeguarding in Health assurance group will be created to increase the focus on safeguarding from a health perspective in response to a series of recent Child Practice Reviews

KW drew attention to recent changes which extended the work of Medical Examiners from initially reviewing deaths in secondary care and community hospitals to reviewing all deaths since September 2024. The process is well developed, however, there have been delays in the system nationally due to a quick roll out. These delays are being addressed nationally. The Health Board have a low number of referrals compared to other Health Boards and no significant concerns have been raised. The arrangements will enable whole system learning.

Members asked the following questions for assurance:
What has been the impact of resourcing the Patient Experience Lead, will other work cease to enable this work to be undertaken, and how does this link with the work that Llais produces?

CR noted that the proposals for patient experience, along with proposed changes to the Putting Things Right arrangements related to the Cabinet Secretary's aim to improve openness and transparency in health. Resource is a concern, and the impact of the proposed changes will need to be understood. The Health Board work closely with Llais whose Regional Director is a member of the Patient Experience Framework Steering Group to ensure maximum opportunities for information triangulation.

HB advised that Patient Experience was a matter escalated to Board by the Committee and the adoption of the Peoples Experience Framework will be a Board matter. Llais will be invited to a Board Development session in the summer to examine working arrangements in relation to patient experience between both organisations.

HS advised that the self-assessment against the People's Experience Framework was partially completed, and presentations are in preparation for Executive Committee on the revised Putting Things Right guidance to then share with teams across the Health Board.

KB confirmed that good sharing arrangements were already in place between the Health Board and Llais and stressed that there should be a rounded view of experience as there was on occasion a focus on negative experiences.

Is it known why some other Health Boards are able to respond more quickly to concerns than Powys?
CR advised that whilst benchmarking data was available there were questions such as, were concerns all recorded in the same way or did some Health Boards include minor concerns managed elsewhere under an early resolution process which could lead to differences in response times.

How will improvement in investigating NRIs be undertaken?
CR advised that this linked to the production of Key Performance Indicators which would be set and monitored as an outcome from the Welsh Risk Pools report. This will be included in the next Integrated Quality Report.
Action: Executive Director of Nursing, Quality, Women and Family Health

Is Powys specific data not available from the Medical Examiner service?
KW advised that Powys specific data was just becoming available and would be included in the next Integrated Quality Report.
Action: Executive Medical Director

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 ANNUAL CLINICAL AUDIT PROGRAMME (PEQS/25/12)

KW presented the report advising that each service areas draws up an audit plan. These focus on areas including perceived risk, where new processes have been put in place, where there have been incidents and where improvement is needed. This is collated into a Clinical Audit Programme and triangulation has been undertaken with input from senior colleagues. A quarterly Audit Hour has been introduced which will strengthen learning across the organisation.

Members asked the following questions for assurance:
What is done with the information gained by the audits?
KW advised that the information was examined in the Service Groups with any concerns being escalated as necessary.

HB suggested that the Annual Report on Clinical Audit should contain detail on assurance routes for reporting.
Action: Executive Medical Director

KWi noted consideration is being given to how the Committee hear from the service groups via the Integrated Quality Report

The Committee:
1. **RECEIVED** and **APPROVED** the Clinical Audit Plan 2025/26

5.3 MONITOR HEALTH BOARD ACTIONS OF JOINT INSPECTION OF CHILD PROTECTION ARRANGEMENTS (PEQS/25/13)

CR presented the Report noting the Joint Inspection of Child Protection Arrangements (JICPA) had taken place in autumn 2023 with the report published in February 2024.l The Mid and West Regional Safeguarding Board monitored implementation of the action plan for all partners. In relation to Health Board actions, it was confirmed that all actions had been completed, however, attention was drawn to the continued difficulty in reaching 85% compliance for Level 3 safeguarding which is currently recording 75% compliance having risen from 59% compliance.

Members asked the following questions for assurance:
Why is it difficult to reach 85% compliance for Level 3 Safeguarding training?
CR explained that Level 3 safeguarding is delivered face to face, and difficulties arise in releasing staff from operational duties. This is a problem faced across Wales and is not specific to the Health Board.

How is the Health Board assured that information sharing across the complex pathways attended by Powys patients in place to ensure safe practice?
CM confirmed that Wales was some way off having seamless digital information sharing with local authorities commissioning their own separate systems. There will need to be an overarching connecting care approach which includes the ability to identify and escalate concerns identified in different organisations.

The Committee:
- Took **ASSURANCE** from the progress made in progressing the health board specific actions within the JICPA.

LK joined the meeting 10.55

5.4 STAFF EXPERIENCE OF MENTAL HEALTH AND LEARNING DISABILITY SERVICES IN ESCALATION (PEQS/25/14)

EL introduced the item noting that Mental Health and Learning Disability Services had been the first service subject to local escalation under the Integrated Quality and Performance Framework in March 2024.

LK gave a presentation noting weekly escalation oversight meetings had taken place, a maturity matrix and conditions of sustainability were established, with the service was de-escalated in October 2024. Attention was to the following areas:

- A number of helpful procedural matters had been identified,
- After initial anxiety staff felt well supported, but were challenged by additional asks, in particular in relation to two serious incidents when the escalation pace did not change,
- Senior Leadership Team found a level of resilience which was not expected but a significant amount of out of hours working was required resulting in some burnout and low immunity
- There were mixed views on whether the timing for de-escalation was right or too soon, but it is recognised the service is stronger and safer as a result of significant effort. It had been expected that de-escalation would feel like an achievement, but it felt like business as usual with sustaining the position whilst balancing operational issues remaining a challenge.

CR welcomed the feedback which helped colleagues understand the experience of escalation. The experience of a team previously under local escalation included a sense of fear and failure and the organisation needed to address this within the framework. Identifying the correct time to de-escalate was important as there is a sense of safety whilst in escalation.

EL observed that as an Executive Director who joined the organisation whilst the service in the process of de-escalation there was still a level of focus and pressure on the team and the impact will be long lasting.

KW noted that there had been significant improvements in the service but there remained more to do. A lesson learnt had been for services to ask for help as soon as difficulties are identified rather than waiting for problems to be noticed.

Members asked the following questions for assurance:
Is this a good example of compassionate leadership?
LK confirmed that being in escalation from a service perspective compassionate leadership had been felt. However, capacity remained a challenge which influenced the degree to which compassion was experienced.

KWi observed that when Velindre Ward had been visited by the Chair and Vice-Chair the staff had described management as an umbrella protecting staff from the stress of escalation.

When would be appropriate to receive an assurance report on post-escalation monitoring?
LK suggested that the autumn meeting would be appropriate as the service would be one year post escalation.
Action: Executive Director Primary Care, Community and Mental Health

LK left the meeting 11.25

5.5 ANNUAL ASSESSMENT OF COMMITTEE EFFECTIVENESS (PEQS/25/15)

HB presented the report outlining the results of the Committee Effectiveness review.

CR welcomed the feedback and noted that updates from service groups including Women's and Children's, Mental Health and Community Services would be included in the next Integrated Quality Report.
Action: Executive Director of Nursing, Quality, Women and Family Health

Members asked the following questions for assurance:
How content are the Committee that the improvement agenda is being sufficiently challenged?
CR was of the view that the Committee are impactful and had seen improvements, however, they may be an opportunity to challenge the other committees to see the duty of quality as central to work across the board.

5.6 REVIEW OF TERMS OF REFERENCE (PEQS/25/16)

HB presented the report noting the following items to be amended:

- The addition of Medical Appliances Annual Report
- Remove Clinical Quality Framework and add Integrated Quality and Performance Framework

Action: Director of Corporate Governance

The Committee:

- **ENDORSED** the proposed amendments to the Terms of Reference subject to the amendments listed above,
- **AGREED** that the Chair of the Committee and Director of Corporate Governance will finalise the revised Terms of Reference for presentation to the Board in May 2025 for approval.

5.7 COMMITTEE RISK REGISTER (PEQS/25/17)

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

6. ITEMS FOR DISCUSSION

There were no items for discussion

7. CONSENT AGENDA

7.1 INTERNAL AUDIT REPORTS (PEQS/25/18)

The Committee **RECEIVED** the Internal Audit Report on Patient Flow and Discharge Management, and Additional Learning Needs Legislation which had been received by the Audit, Risk and Assurance Committee on 11 March 2025. These internal audits had reported Reasonable Assurance.

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

The Joint Commissioning Committee Quality Patient Safety Committee Summary Reports 03 February 2025 was received.

7.2 AUDIT WALES (PEQS/25/18)

The Committee **RECEIVED** the Audit Wales report on Cancer Services.

7.3 JOINT COMMISSIONING COMMITTEE QUALITY PATIENT SAFETY COMMITTEE (PEQS/25/20)

The Committee **RECEIVED** the Joint Commissioning Committee Quality Patient Safety Committee Highlight Report from the meeting held on 18 March 2025.

8. OTHER MATTERS

8.1 ANY OTHER URGENT BUSINESS (PEQS/25/21)

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/25/22)

It was noted that the Chair would provide updates on those items escalated to Board including the de-escalation of Infection Prevention and Control.

8.3 COMMITTEE REFLECTION (PEQS/25/23)

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

- Holding the meeting in person was welcomed
- It was challenging to Chair a hybrid meeting
- The sharing of presentations in advance was welcomed
- There was a real attention, focus and honest commitment to the agenda and welcoming of colleagues attending to share information
- A positive experience from those joining virtually

8.4 DATE OF NEXT MEETING (PEQS/25/24)

The date of the next meeting is scheduled on 31 July 2025 via Microsoft Teams.
Meeting closed 12.20

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)
Jennifer Owen Adams	JOA	Independent Member (Third Sector)
Ian Thomas	IA	Independent Member (General)
IN ATTENDANCE		
Zoe Ashman	ZA	Interim Assistant Director Women & Children
Helen Bushell	HB	Director of Corporate Governance / Board Secretary
Susan Dinsdale	SD	Head of Nursing for Children
Amanda Edwards	AE	Assistant Director Innovation and Improvement
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

Claire Roche	CR	Executive Director of Nursing, Quality, Women and Family Health
Heidi Sinclair	HS	Head of Quality and Safety
Kate Wright	KW	Executive Medical Director
APOLOGIES FOR ABSENCE:		
Carl Cooper	CC	Chair of PTHB Board
Hayley Thomas	HT	Chief Executive
Simon Wright	SW	Independent Member

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

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

8.7 DECLARATIONS OF INTEREST (PEQS IC/23/26)

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

8.8 BRIEFING ON SUICIDES (PEQS IC/25/27)

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

The Committee RECEIVED a briefing on recent unexpected deaths.

Meeting closed at 12.38

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 - NONE								
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	Jul-25	Oct-25	At risk
11-Feb-25	PEQS/24/83	Executive Director of Nursing, Quality, Women and Family	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	Jul-25	Oct-25	At risk
OPEN ACTIONS - IN PROGRESS BUT NOT YET DUE OR ARE ONGOING - NONE FOR THIS MEETING (31 JULY 2025)								
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	Oct-25		On track
OPEN ACTIONS - IN PROGRESS BUT NOT YET DUE								
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	Jul-25		On track
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 A verbal update will be given at the meeting	Jul-25		On track
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	Jul-25		On track
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** A verbal update will be given at the meeting	Jul-25		On track
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** A verbal update will be given at the meeting	Jul-25		On track
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** A verbal update will be given at the meeting	Jul-25		On track
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** A verbal update will be given at the meeting	Jul-25		On track
ACTIONS RECOMMENDED FOR CLOSURE (MEETING 31 JULY 2025)								
30-Apr-25	PEQS/25/05	Director of Corporate Governance	Action Log	To consider splitting PEQS/24/52b into two separate actions	**Update 31.07.25:** This is not necessary as action PEQS/24/52b relates solely to the review of the Integrated Framework which happened to be raised under the Mental Health Services update	Jul-25		Completed
30-Apr-25	PEQS/25/06	Director of Corporate Governance	Committee Work Programme	To consider if an Annual Report on Medical Devices and ad hoc audits should be included in the Committee Work Programme	**Update 31.07.25:** This has been added to the Committee Work Programme	Jul-25		Completed
30-Apr-25	PEQS/25/16	Director of Corporate Governance	Review of Terms of Reference	Addition of Medical Appliances Annual Report, removal of Clinical Quality Framework and addition of Integrated Quality and Performance Framework to the work programme	**Update 31.07.25:** The Committee Work Programme has been amended to reflect this	Jul-25		Completed
14-Nov-24	PPPH/24/012	Executive Director of Nursing, Quality, Women and Family Health	Antibiotic Resistance	Antibiotic Resistance is of Public Health significance, clarity as what frequency would committee expect to see report updates would be confirmed in February 2025	**02.02.2025 update** - The Director of Nursing, Quality, Womens and Family Health confirmed that reporting would be placed at the PEQS Committee given its remit: Item will be scheduled into the 2025/26 work programme. During meeting proposed a provisional six month schedule (MD to confirm) **Update 31.07.2025:** included as an appendix to the Integrated Quality Report and noted on the	Feb-25	Jul-25	Completed
30-Apr-25	PEQS-IC/25/15	Executive Director of Nursing, Quality, Women and Family Health	Briefing on suicides	A report on unexpected deaths to be brought to the July meeting of the Committee	**Update 31.07.2025** This is included in the In-Committee agenda for the July meeting of the Committee	Jul-25		Completed
05-Dec-24	D&P/24/086a	Executive Medical Director / Executive Director Primary, Community Care and Mental Health	In-reach Fragility	It was agreed that an update report regarding JAG accreditation would be considered to the Patient Experience, Quality and Safety Committee to reflect on quality elements to provide further assurance on what is being done to regain the accreditation.	**Transfered to PEQS Committee.** **11.02.25 update** - scheduled to July 2025 meeting. PPPH and D&P are considering a JAG accreditation update w/c 3 Feb 2025 **Update 31.07.2025:** A verbal update will be given at the July meeting agenda item 5.3	Jul-25		Completed
CLOSED ACTIONS								
16/04/2024	PEQS/24/10	DCG	Committee Annual Report	Consider including on the work programme an item on areas with high vacancy/high agency use in relation to the quality and sustainability of services	**30.07.24 update** - discussion planned with Chair and lead executive to explore and determine work programme **11.02.25 update:** Item will be scheduled into the 2025/26 work programme **29.04.25 update:** scheduled into work programme for July 2025. Action recommended for closure on that basis	Feb-25	Timescales TBC within 2025/26	Completed

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

Agenda item: 3.3

PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE	**31 July 2025**
Subject:	Powys Teaching Health Board Safeguarding Annual Report 2024-2025
Approved and presented by:	Claire Roche Executive Director of Nursing, Quality, Womens and Family Health
Prepared by:	Jayne Wheeler Sexton Assistant Director of Nursing, Safeguarding
Other Committees and meetings considered at:	Executive Committee 23 July – who endorsed the report to the Committee.

PURPOSE:

To present to Patient Experience, Quality and Safety Committee the Powys Teaching Health Board's Safeguarding Annual Report for 2024-2025.

RECOMMENDATION(S):

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

- **APPROVE** the Annual Safeguarding Report for 2024/25.

Approve/Take Assurance	Discuss	Note
Y	Y	N

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

EXECUTIVE SUMMARY:

PTHB Safeguarding Annual Report presents the key areas of development and achievement which have supported the Health Board to meet its statutory responsibilities for safeguarding during 2024/25. The report is aligned to the Standards of the Safeguarding Maturity Matrix (SMM); a self-assessment tool which addresses the interdependent strands regarding safeguarding; service quality improvement, compliance against agreed standards and learning from incidents and reviews.

Improvements within each of the SMM Standards are highlighted throughout the Annual Report and demonstrates the vast and varied safeguarding and public protection agenda.

The Safeguarding Team have been both visible and accessible across the Health Board driving change and improvements throughout 2024/25.

Introduction

NHS Wales has an essential role in ensuring that all adults and children receive the care, support and services they need to promote a healthy, safer and fairer Wales, however measuring the effectiveness of health services and their contribution to safeguarding adults and children is difficult and complex. Powys Teaching Health Board is committed to ensuring safeguarding is part of its core business. The Health Board recognises that safeguarding children and adults at risk is a shared responsibility that requires all our employees to have the competencies to safeguard people and be able to develop strong and effective joint working relationships with our partner agencies and colleagues. Our vision is that Powys residents live their lives free from violence, abuse, neglect and exploitation. The Health Board will promote the United Nations Convention on the Rights of the Child, Human Rights and the United Nations principles for Older Persons in all its work.

The Safeguarding Annual Report outlines, with some examples, how the safeguarding service is performing and innovating to deliver an accessible, research led service. It provides an update on safeguarding practice improvements and challenges during 2024/25 and identifies safeguarding priorities for 2025/26. The Safeguarding Team continues to build on what has already been achieved to ensure PTHB and all contracted services, fully meet their statutory responsibilities for preventing harm, and to act in a

timely way on concerns raised about the welfare of people who reside, work or visit Powys.

Key Achievements

- Completion of the JICPA and Child Practice Review action plans.
- Safeguarding Management app went Live
- Strong multi agency partnership working to safeguard people, from operational teams through to various safeguarding boards.
- Multiple workstreams which co-produce multi agency safeguarding training and guidance
- Completion of the National Safeguarding Review which will drive improvements and raise safeguarding to be more visable
- Safeguarding Team is accessible, with contact into the Safeguarding HUB at its highest since the HUB established
- Successful delivery of childhood injury training
- PREVENT training mandated for specific staff groups
- Voice of children looked after key in driving forward a service that listens and acts on what they tell us

Challenges Identified

- The vast and varied safeguarding landscape
- The complexity of the safeguarding concerns raised, and the subsequent level of support required by the Safeguarding Team
- Variability in safeguarding Level 3 compliance
- Limited Assurance MCA DoLS audit
- Repeated themes noted within National Safeguarding Reviews

Key Safeguarding Themes

- Neglect and Emotional Harm: Remain high among referrals for children and adults.
- Self-neglect and Domestic Abuse: Ongoing key themes in adult safeguarding referrals.
- Highest level of safeguarding reports recorded since Health Board data has been collected.
- Increase in the number of children on Powys Child Protection Register
- Process in how we Learn from safeguarding reviews is changing

Safeguarding Priorities for 2025/26

i.	Engage in the National Strengthening Safeguarding Review Implementation Programme and all four subgroups (commissioned by CNO & WG)
ii.	Roll out new updated PREVENT Guidance and monitor mandatory Compliance
iii.	Implement the Multi Agency Safeguarding Supervision Model with our statutory partners
iv.	Participate in a Regional Neglect Tool Kit Pilot with Health Visitors and School Nurses
v.	Review the Level 3 Safeguarding Training Passport, considering merging adult and child passport and developing/designing an electronic Safeguarding Workbook.
vi.	The Corporate Parenting Charter has been signed by PTHB. The principles now need embedded across the HB
vii.	Extend the reach of the safeguarding service using Pod Casts
viii.	Roll out the National Childrens Looked After and Carers Surveys via CIVICA
ix.	Progress the MCA Internal Audit management action plan

IMPACT ASSESSMENT
Not required

Powys Teaching Health Board Safeguarding Annual Report 2024 - 2025

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Powys Teaching Health Board

Contents

Foreword

I am delighted to present Powys Teaching Health Boards Safeguarding Annual Report for 2024-25

The Annual Report illustrates the Health Boards commitment to Safeguarding and supports our maturing safeguarding journey in strengthening and embedding our safeguarding processes, building and maintaining a confident and competent workforce, ensuring safeguarding support and advice is available to all our staff, building and maintaining key multiagency partnerships and embracing the Health Boards overarching learning culture, by sharing safeguarding messages and learning with a focus on quality improvement.

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

I wish to thank all our dedicated staff, our supportive partners, the Executive Team and the Board who continue to work so positively with us to make Powys Teaching Health Board a safer place to work and Powys a safer place to live.

Claire Roche

Executive Director of Nursing, Quality, Women & Family Health

Introduction

Powys Teaching Health Board (PTHB) is responsible for providing health care for approximately 133,600 people living throughout Powys, this includes health services both provided by and commissioned on behalf of PTHB. The Health Board employs around 2,500 staff which include over 500 bank staff. Care is delivered across a network of services and practitioners. The geography and rurality can make access to some services a challenge and requires the Health Board to be innovative and creative to ensure Powys residents have timely access to high quality services to meet their needs. PTHB is uniquely positioned as Powys accounts for a quarter of the land mass in Wales and borders several other Welsh and English Health Boards and Trusts.

Powys Teaching Health Board is committed to;

- ensuring safeguarding is part of its core business. The Health Board recognises that safeguarding children and adults at risk is a complex and shared responsibility that requires all employees and contracted services to have the competencies to safeguard our patients, families and communities and develop strong, effective joint working relationships with partner agencies and colleagues.

- being a trusted, safe organisation where all children and adults at risk of harm, abuse or neglect are safeguarded by staff who feel empowered, valued and supported. Working collaboratively and innovatively with our patients and their families to ensure the best support and outcome is achieved.

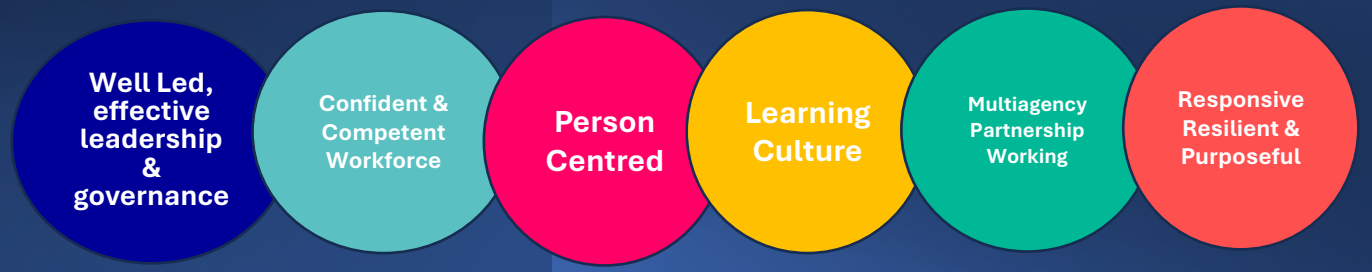
- supporting people's lives while protecting their right to live in safety, free from bullying, harassment, abuse, discrimination, exploitation, avoidable harm, and neglect. Staff will share concerns quickly and appropriately; the Health Board will learn and improve when something goes wrong.

- working in partnership to support the strategic priorities of the Mid and West Wales Safeguarding Board, the Violence Against Women, Domestic Abuse and Sexual Violence Board and the National Safeguarding Network.

- each year review how the Health Board is performing against the Safeguarding Maturity Matrix Standards and review qualitative and quantitative data to drive discussions regarding the delivery of safe, timely, effective, efficient, equitable and person-centred health care in the context of a learning culture, with the overall aim of improving the quality of safeguarding in PTHB, leading to improved outcomes for the people who live, work and visit Powys.

- provide excellent care at the heart of the community, listening to children and adults must be central to the delivery of care. Safeguarding will be guided by the Health Boards values, alongside the relevant safeguarding legislation.

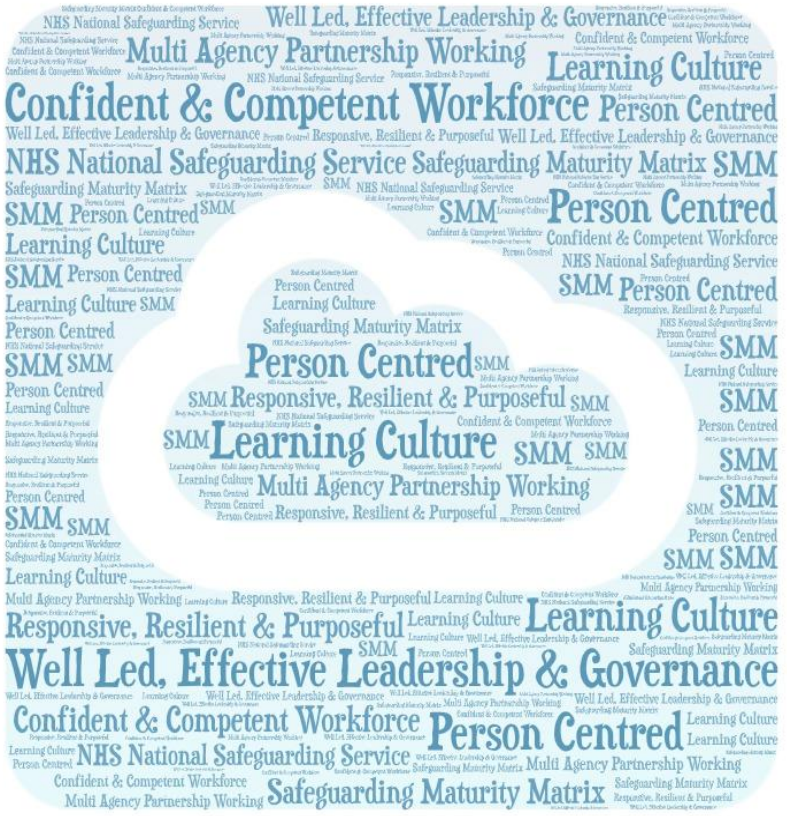
NHS Wales Safeguarding Maturity Matrix



NHS Wales has an essential role in ensuring that all adults and children receive the care, support and services they need to promote a healthier, safer and fairer Wales, however, measuring the effectiveness of health services and their contribution to safeguarding adults and children is difficult and complex. The Safeguarding Maturity Matrix (SMM) is a self-assessment tool which enables scrutiny of the effectiveness, innovation, quality, learning and risks within safeguarding. There are 6 Standards within the assessment tool;

Powys Teaching Health Board's SMM self-assessment & improvement plan is completed annually and returned to the National Safeguarding Service, where it contributes to a National Safeguarding Report to the Chief Nursing Officer in Welsh Government. Capturing a national overview of safeguarding helps drive improvement, horizon scan, informs the NHS Wales National Safeguarding Service key priorities, annual plan, and shares best practice.

Powys Teaching Health Board's 2024-25 Safeguarding Maturity Matrix Improvement Plan has been reported on quarterly to PTHB Safeguarding Strategic Group. Most of the actions have been completed, any that remain incomplete will be carried over into 2025-26



SMM Standard; Well Led- Effective Leadership & Governance

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

Well Led, Effective Leadership & Governance

Within this section;

Governance and Lines of Accountability

Powys Teaching Health Board Safeguarding Strategic Group Governance

Safeguarding Quality Assurance

Safeguarding Legislation and Drivers

PTHB Safeguarding Polices, Protocols & Guidance Documents

Inspections and Audits

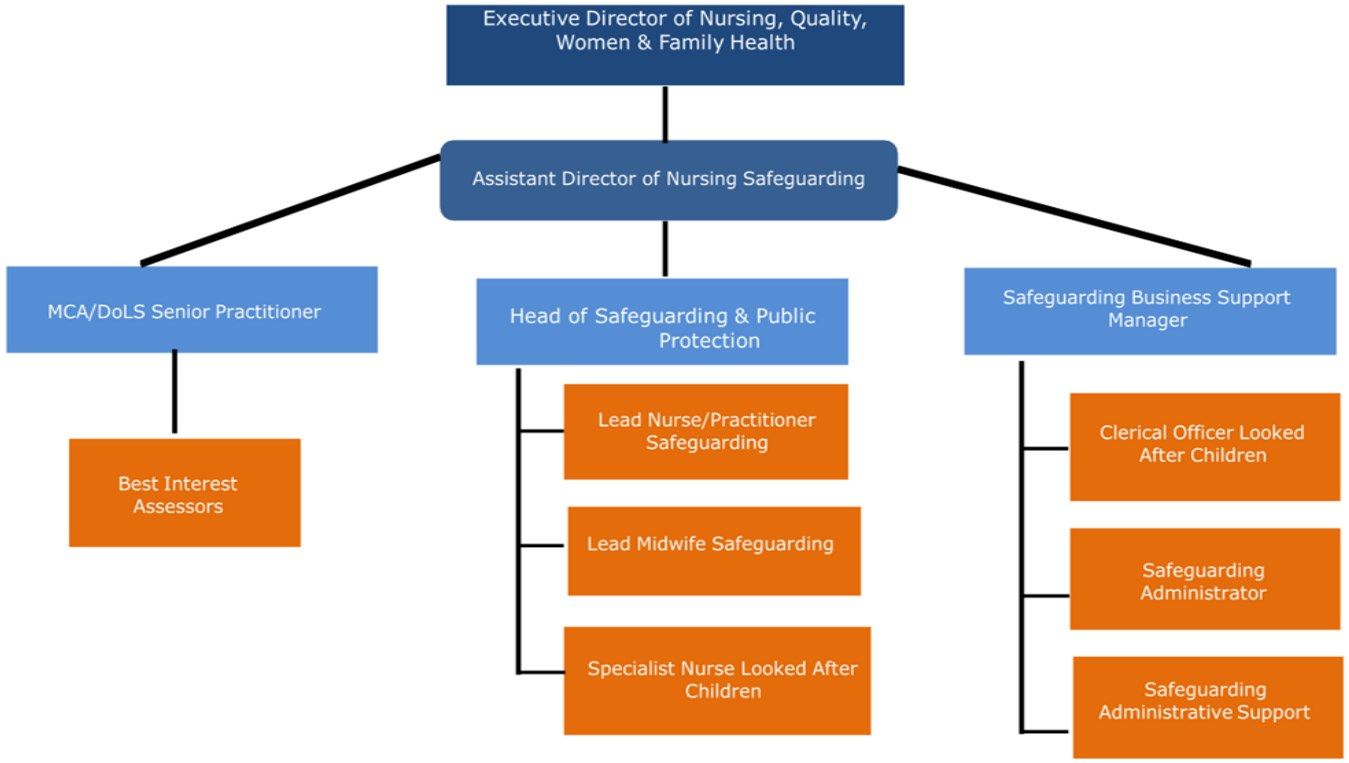
Strengthening Safeguarding Health Review

Governance & Lines of Accountability

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

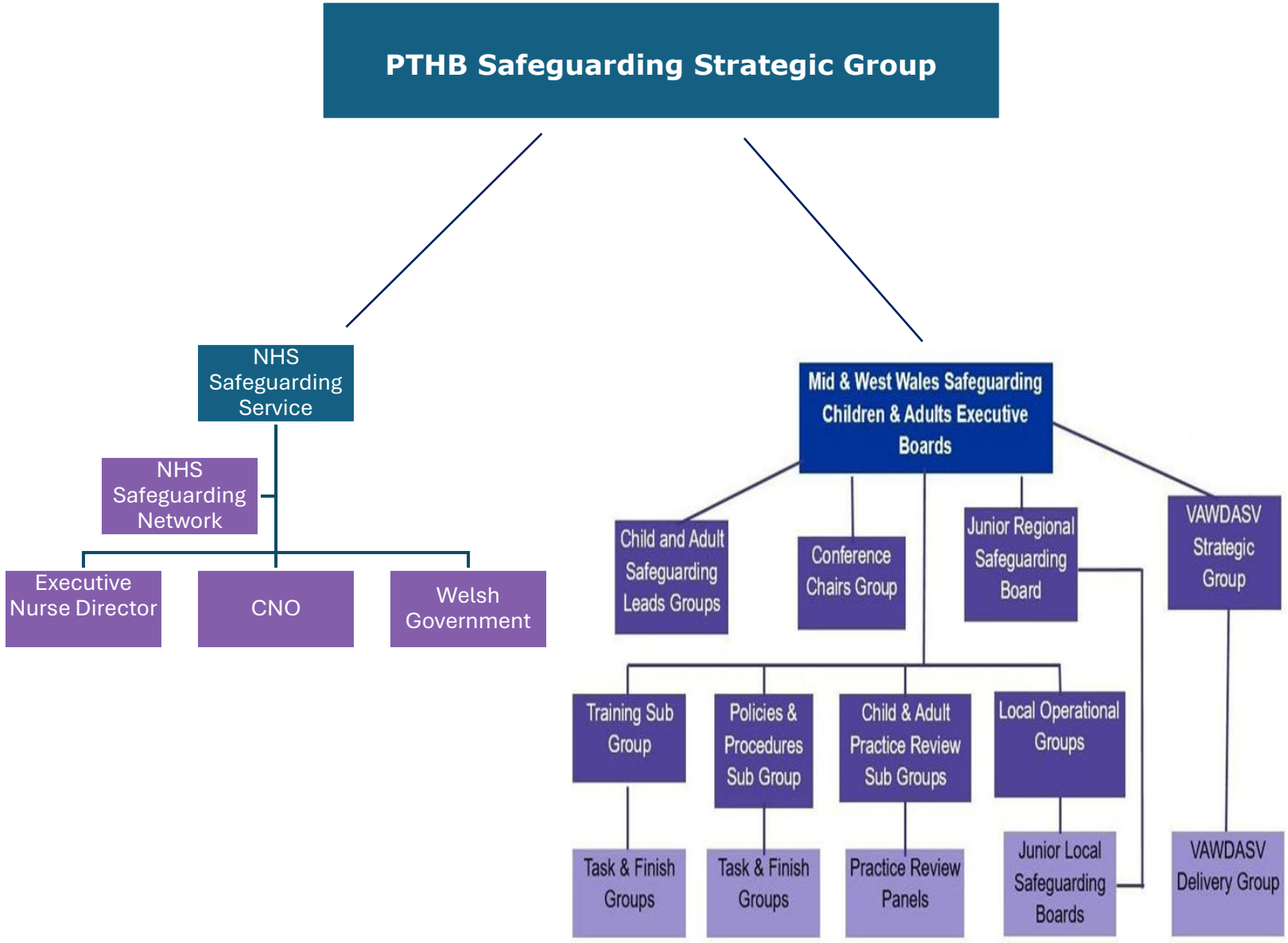
PTHB Governance Reporting Structure

Powys Teaching Health Board Safeguarding Team Structure



Powys Teaching Health Board Safeguarding Strategic Group

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



Safeguarding Quality Assurance PTHB Safeguarding Management Application Goes Live

The implementation of the Safeguarding Management App has resulted in notable improved operational efficiency and effectiveness across key activities including safeguarding quality, assurance and accountability. By optimising workflows and reducing manual intervention to produce metrics to monitor and evaluate the effectiveness of safeguarding practices the team can now focus on more strategic and value-driven tasks enhancing overall quality using the outputs of the App

Prior to the introduction of the App, several processes required significant manual effort and extended time commitments to produce safeguarding metrics. The revised approach has streamlined these tasks, reducing the complexity and margin for error while allowing for quicker execution. Areas of improvement include:

Administrative Processes: Routine tasks that previously required multiple steps have been simplified, leading to faster completion and reduced administrative overhead

Data Management: Improved data handling processes now allow for more efficient collection, analysis, and reporting, minimising the time spent on repetitive tasks.

Decision-Making: The reduction of time spent on routine activities facilitates faster access to information, supporting quicker and more informed decisions.

Impact on Operational Efficiency

The time savings achieved have led to several tangible benefits, including:

1. **Increased Capacity:** With less time spent on manual processes, the team can allocate more resources to complex or high-priority work.
2. **Improved Accuracy:** Automation reduces the likelihood of errors, enhancing the quality and reliability of outputs.
3. **Enhanced Responsiveness:** Faster processing times allow for quicker responses to internal and external requests.

These efficiencies contribute to a more agile and responsive operational environment, ultimately supporting better service delivery and long-term sustainability.

Continued monitoring and refinement will ensure that these measures remain effective and can be further enhanced to meet evolving organisational needs.

Safeguarding Quality Assurance

Quarterly Safeguarding Team Audits, Reviews and Spot Checks

During each quarter throughout 2024-25 the safeguarding team completed quarterly audits, reviews or spot checks. The outcome of this activity informs what is working well and where improvements, developments or changes can be made. The Audits, reviews and spot checks include;

- Themes from Supervision
- Mental Capacity Audit
- DoLS Audit
- Significant Event Chronology
- Routine Enquiry in Health Visiting
- Routine Enquiry in Midwifery
- Quality Assure LAC Health Assessments
- Multi Agency Risk Assessment Conference Information Request
- Training Evaluation
- Safeguarding Advice Tracker
- Practitioners Feedback about Safeguarding Services
- Children Looked After & Foster Carer Feedback
- Safer Sleep Audit
- Routine Enquiry in MIU

Safeguarding Legislation and Drivers

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

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

PTHB Safeguarding Polices, Protocols & Guidance Documents

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

- SGP051 Significant Event Chronology SOP
- SGP011 Child Protection Medical Policy
- SGP012 Looked After Children Guidance for Health Professionals
- SGP034 PREVENT Policy
- SGP035 Child Exploitation Guidance
- SGP036 Safeguarding Policy
- SGP041 Managing Allegations of Abuse & Neglect
- SGP042 Deprivation of Liberty Safeguards Policy & Procedure
- SGP002 – Safeguarding Supervision Protocol
- SGP049 Mental Capacity Act
- SGP047 Policy for Children & Adults who "Was Not Brought" to health appointments

Inspections and Audits: NWSSP NHS Internal Audit and Assurance of MCA DoLS

In January 2025 PTHB received the NHS Wales Internal Audit of MCA DoLS which gave overall limited assurance. The audit determined key matters arising and recommended three high priority actions and three medium priority actions.

The matters requiring management attention include:

- Review of the DoLS Policy;
- Ensuring appropriate on-going provision of training around the Managing Authority responsibilities;
- Contractor supplied Best Interest Assessors should have their qualifications confirmed periodically;
- Establishing a sustainable approach for the future delivery of the DoLS Supervisory Body role;
- Improvement to the process and timeliness for authorisation of DoLS applications; and
- Case tracking and Management Information could be improved with qualitative data as well as quantitative.

The outcome from the audit was as expected. Following a previous MCA DoLS gap analysis undertaken in 2024, interim measures were put in place, however, not sustainable. In response to the audit and gap analysis, a business case to support the development of a Supervisory Body is progressing through the Health Boards Investment Benefit Group (Business case approved by Executive Committee in early 2025/2026), Executive support for the business case will enable the identified improvement work to commence in 2025/26

Limited

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved

Assurance summary[1]

Objectives		Assurance
1	Policy and procedure documentation	Reasonable
2	Training and Accreditation	Reasonable
3	Process Operation	Limited
4	Reporting	Limited

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

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

The scope of the JICPA was to review:

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

The final JICPA Report was published on 1st February 2024 Powys JICPA Report - Final.pdf

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

The JICPA identified four specific actions for PTHB which have been managed within the Safeguarding Operational Group with quarterly progress provided into PTHB Safeguarding Strategic Group.

During 2024-25 all the improvements identified have been completed.

Inspections and Audits: Mid & West Wales Child Practice Review – CYSUR 3 2021 Update

On the 14th of March 2024, Mid and West Safeguarding Board published the Concise Child Practice Review on their website. The review made 9 recommendations for the Mid and West Wales Safeguarding Board partner agencies, 4 of the recommendations were specific for Powys Teaching Health Board. The recommendations were translated into an Action Plan which was approved by the Mid and West Wales Safeguarding Board in May 2024.

The Action Plan has been monitored within the Health Board's Safeguarding Practice Improvement Group, which reports to the Safeguarding Strategic Group. Regionally, PTHB have provided quarterly progress reports on all actions at both the Multi-Agency Regional Safeguarding Operational Group the Mid and West Wales Safeguarding Board.

During 2024-25 all the improvements identified have been completed.

Examples of the Improvements Implemented from both the JICPA & the Child Practice Review include:

- ❖ Review and focus on Safeguarding Children Level 3 Training compliance – compliance as of March 2025 when compared to the same period in 23/24 has improved from 59% to 77%
- ❖ PTHB Safeguarding Team, Powys County Council Children Services & Education colleagues have designed and developed and a Multi Agency Safeguarding Supervision Process. This process will enable facilitated multi agency supervision sessions with practitioners who are working with children at risk of harm and are listed on Powys Children Services Child Protection Register. Certain set criteria must initiate Multi Agency Supervision, for example, periods of child protection registration that exceed 15 months, repeat child protection registrations, cases where there is drift, no progress in managing/reducing risks, professional disagreement and majority decisions regarding child protection registration.
- ❖ Practitioners encouraged, reminded and supported to be professionally curious. Professional Curiosity Training available to practitioners.
- ❖ Children Not Brought to appointments Policy in place, children services in the Health Board undertake monthly audits of children not brought to appointments. The Safeguarding Team are engaged in a national piece of work being led by the NHS Wales National Safeguarding Service to develop an All Wales Was Not Brought Guidance.
- ❖ Audit of multi agency responses to child protection case conferences
- ❖ Ongoing review of how the voices of children are captured and heard within safeguarding activity
- ❖ PTHB Safeguarding Team have supported the establishment of NHS England Safeguarding and NHS Wales Safeguarding six monthly Connection Forum. The aim of the Forum is to provide support, advice and share learning between NHS England and NHS Wales, whereby they share boarders. The purpose of the Forum is:
  - To provide leadership for the commissioning process in relation to the Safeguarding agenda with a regional and integrated care system context.
  - To understand, discuss and act on factors that affect the successful delivery of the safeguarding programme and projects within it.
  - To broker relationships with stakeholders internally and externally.
  - To discuss cross-boarder issues and share learning.

Examples of the Improvements Implemented from both the JICPA & the Child Practice Review include:

In March 2025 PTHB Safeguarding Team launched Pick up the Phone Campaign, an electronic poster encouraging staff to go **back to basics! Pick Up the Phone and have a conversation** with colleagues across Health Boards in Wales and our borders and with our partner agencies. The idea for this came from NHS England running the Campaign and gave consent for us to use and adapt.

Pick Up the Phone Campaign

Over many years various Regional Safeguarding Adult and Child Practice Reviews, National Safeguarding Reviews and Joint Inspections consistently highlight similar themes and areas for improvement across many services. These themes include practitioners working in silos, not sharing timely, relevant and proportionate information and not having professional curiosity.

To support and remind staff across the Health Board of these key findings, PTHB Safeguarding Team designed an electronic poster encouraging staff to go **back to basics! Pick Up the Phone and have a conversation** with colleagues across Health Boards in Wales and our borders and with our partner agencies.

The Poster Campaign was launched in March 2025 on Powys Teaching Health Boards socials including Facebook, Powys Announcements and the Health Boards Safeguarding Intranet Page News Feed, it has been sent to all safeguarding strategic and operational group members for onwards sharing, our Primary Care Academy and Primary Care Services.

The Safeguarding Team will highlight the **Pick Up the Phone** message at all opportunities including safeguarding supervision, training and while attending Service Group team meetings.

Themes from Safeguarding Practice Reviews in Wales are telling us that practitioners should speak to each other, share information and be professionally curious.
Let's go back to basics & have a conversation

PICK UP THE PHONE

to colleagues across Health Boards in Wales & our borders & our partner agencies

MWWSB Adult Practice Reviews
MWWSB Child Practice Reviews
Myth Busting Information Sharing
Professional Curiosity Bitesize
Was Not Brought Animation
CIW Rapid Review of Child Protection

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Remember! Doing the Basic Things Well Helps Keep People Safe

Examples of the Improvements Implemented from both the JICPA & the Child Practice Review include:

- A referral Pathway for Powys children into a National Paediatric Lymphoedema Service already existed, the service is hosted by Swansea Bay University Health Board (SBUHB). A Standard Operating Process (SOP) has been developed which sets out improved communication, monitoring and documentation processes both internally and between Powys Teaching Health Board and the National Lymphoedema Service.
- Challenges were also identified as the National Service follows SBUHB's *Was Not Brought* process which is different to PTHB's. The new SOP addresses this issue. The development of a National *Was not Brought Guidance* will alleviate this issue.
- Primary Care are represented at PTHB Safeguarding Strategic Group with clear communication pathways to share learning which includes the Primary Care Academy.
- A whole system approach to healthy weight is one of three priority objectives within Powys Wellbeing Plan. The Powys Well-being Plan - Powys County Council
- Powys Teaching Health Board, Powys Children Service and Integrated Disability Service (IDS) have worked together to develop pathways and improve coordination and collaboration which includes

IDS reviewed its Early Help and closure processes. IDS & social care case closure process updates all health professionals open to a child, and in IDS details of when a child may need additional support at transition points, alongside details of how to re-refer into social care services

Health and IDS are providing increased information to children and families about charitable organisations, both have updated their web pages to contain more information

IDS and Adult social care have a transition pathway for children open to IDS which health professional's attend

A review of the triage process to take place. Community paediatric triage is in place and has an MDT health presence

Health have recruited to a specific home-schooled nurse role to support home educated children.

IDS updated the disability register form and it's available on new web pages

Strengthening Safeguarding in Health Review

The **Safeguarding in Health Review** was commissioned by Welsh Government to review of the effectiveness of safeguarding arrangements in NHS Wales, thus ensuring that the Welsh Government (the CNO, Director General/Chief Executive NHS Wales and Ministers) have sufficient, meaningful assurance that the NHS in Wales is delivering against its statutory safeguarding duties. The Strengthening Safeguarding in Health Review final report was received in January 2025

Background

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

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

Findings

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

The review provides well-informed insights including structural adjustments and other modifications that may be necessary to improve systems and practices within NHS Wales.

A Safeguarding in Health Oversight Group has been established to take forward to the recommendations.

Strengthening Safeguarding in Health Review

Agreed recommendations which will be taken forward in 2025/26

Safeguarding Quality & Safety/learning Framework: Establish a robust system for continuous learning and improvement in safeguarding arrangements in health. This framework will include mechanisms for sharing best practices, learning from incidents, and ensuring that all staff are adequately trained and supported in their safeguarding roles managing and overseeing safeguarding practices within NHS Wales.

Quality Statement & Safeguarding Metrics: Provide clear guidelines on safeguarding objectives and expected outcomes and develop metrics to monitor and evaluate the effectiveness of safeguarding practices. The Quality Statement & Safeguarding Metrics will provide a clear and concise description of what good quality safeguarding should look like within NHS Wales. This statement will be accompanied by a set of metrics that can be used to monitor and evaluate the effectiveness of safeguarding practices, providing early warning signals for any issues.

Safeguarding Quality, Assurance & Accountability Framework: Ensure that safeguarding practices are effectively implemented, monitored, and evaluated for continuous improvement. Framework focuses on ensuring that safeguarding practices are not only implemented effectively but also monitored and evaluated for continuous improvement. This framework will include mechanisms for accountability and assurance, ensuring that health boards and trusts are held responsible for their safeguarding duties reporting to IQPD and JET meetings

Digital Tracking: System to track actions from reviews, inspections, and reports at both organizational and national levels in NHS Wales. This three-year digital programme will involve key statutory partners and address the need for improved information sharing between agencies.

SMM Standard; Confident and competent Workforce

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

Confident & Competent Workforce

Within this section;

Safeguarding Supervision, Advice and Support

NHS Wales National Safeguarding Service (NSS)

Safeguarding Training and Development

Safeguarding Processes

Safeguarding Supervision, Advice & Support

Any situation where there are concerns about the safety of a child or adult is unlikely to be simple and will involve making sense of complex and often contradictory information. Managing uncertainty and risk has implications for working with emotions as well as enabling reflection and practical application of skills. Safeguarding supervision and support are essential to the delivery of system-wide quality services that are safe, effective, person-centred, timely, efficient, equitable and occur within a learning culture.

The Intercollegiate Document for Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff 2019 and the Intercollegiate Document, Adult Safeguarding: Roles and Competencies for Health Care Staff 2024 state that all health staff should have access to and participate in safeguarding supervision and/or peer review which should be as appropriate to role.

Safeguarding Supervision should support to;

- **Avoid** – Avoid Drift
- **Keep** – Keep Focus
- **Address** – Address the emotional impact of work
- **Maintain** – Maintain a degree of objectivity
- **Challenge** – challenge fixed views
- **Test and assess** – Test and assess the evidence base

Types of Safeguarding Supervision available to PTHB staff include;

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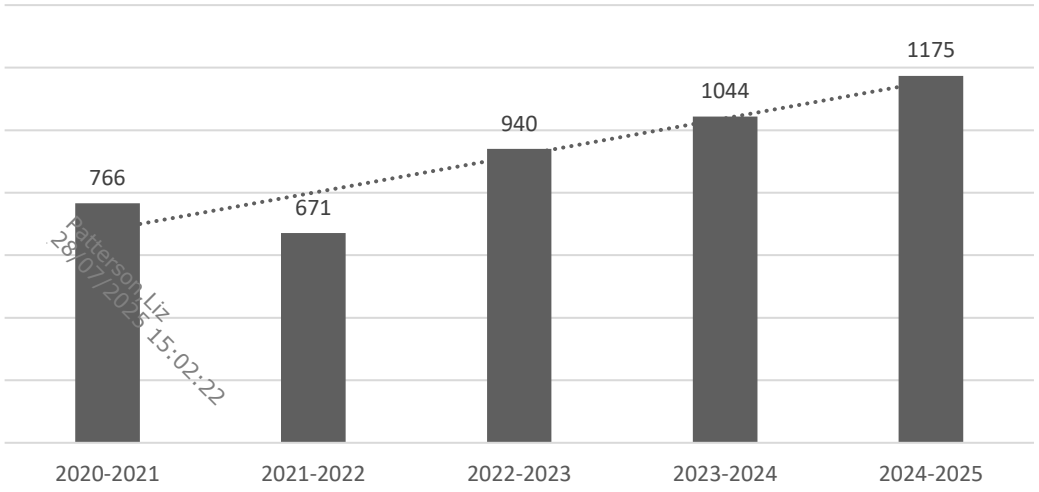
- Immediate Telephone Supervision
- Individual Case Supervision
- Group Supervision
- Debrief
- Peer Review for Paediatricians

Safeguarding Supervision, Advice & Support

Staff should be able to raise concerns and feel supported in their safeguarding role. Effective safeguarding supervision is important in promoting good standards of practice and to support individual staff members; it should assist in ensuring health practitioners are competent and confident and provides a safe environment for challenging practice

PTHB Safeguarding Hub is available to give supervision, advice, support and guidance Monday to Friday 9am to 5pm. During 2024-25, **1,175** calls were received into the Safeguarding HUB, this is a 53% increase since the HUB was introduced in 2021. Safeguarding Lead Practitioners managing the HUB also attended **451** Strategy Discussions with the Local Authority and Police Colleagues.

Calls to PTHB Safeguarding Hub 2025-25



A variety of Health Board staff contacted the Safeguarding HUB during 2024-25 with concerns requiring supervision, advice & support, regarding all types of issues and concerns

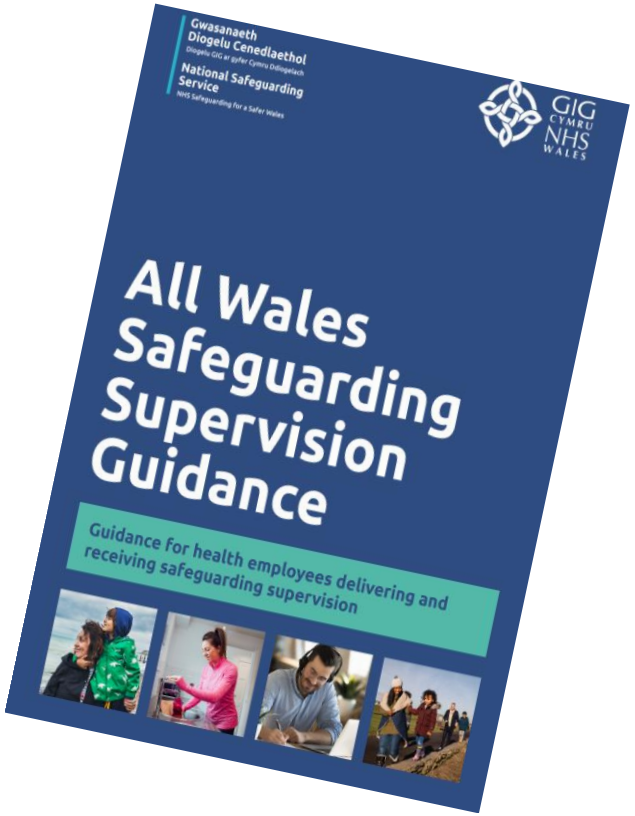
NHS Wales National Safeguarding Service (NSS)

All Wales Safeguarding Supervision Guidance

Launched by the NSS in Collaboration with NHS Wales Heads of Safeguarding

In the context of the changing safeguarding landscape because of the pandemic, the cost-of-living crisis and other global factors, there has been an increase in the numbers of children and adults in the UK referred to local authorities. This has presented as additional and sustained increases in safeguarding workload, including the complexity of cases. In managing such intensity and change, NHS organization's require resilient health care systems (Behrens et al 2022). The All-Wales Safeguarding Supervision guidance identifies what good quality safeguarding supervision looks like and how it can support the development of resilient practitioners.

The negative emotional impact of safeguarding work has been recognised for many years (Ferguson 2005; Newman and Vasey, 2020) in that, where a worker's emotional responses cause increased anxiety, this may lead to an approach whereby the worker manages anxiety by opting for simple explanations and solutions to presenting situations (Wallbank and Wonnacott, 2015). This presents significant concerns when addressing and responding to complexity within safeguarding. In this context, the complexity of safeguarding scenarios may cause practitioners to feel overwhelmed and decisions difficult to make; conversely, they may strive to respond without optimal professional curiosity. Both approaches can lead to ineffective analysis and decision making.



PTHB have aligned the Supervision Standard Operating Process inline with this guidance

Safeguarding Supervision, Advice & Support

PTHB Safeguarding Team, Powys County Council Children Services and Education colleagues have designed and developed a Multi Agency Safeguarding Supervision Process. This process will enable facilitated multi agency supervision sessions with practitioners who are working with children at risk of harm and are listed on Powys Children Services Child Protection Register and a certain set of criteria has been met. The Guidance will be promoted and its use and outcomes monitored during 2025-26

Purpose of Multi Agency Supervision

The purpose of this guidance is to provide a framework for reflection using the Multi-Agency Supervision model.

The aim of Multi-Agency Supervision is not about accessing additional funding/services, it works on the principles of encouraging multi-agency reflection to enhance relationships and the effectiveness of plans, thereby improving outcomes for children.

Multi-agency supervision will provide practitioners working with the family the time and space to review the case including the current plan and give them the opportunity to reflect and consider if there are alternative options that may help the case move forward. This may include exploration of what is going well and ensuring that all risks are identified and addressed.

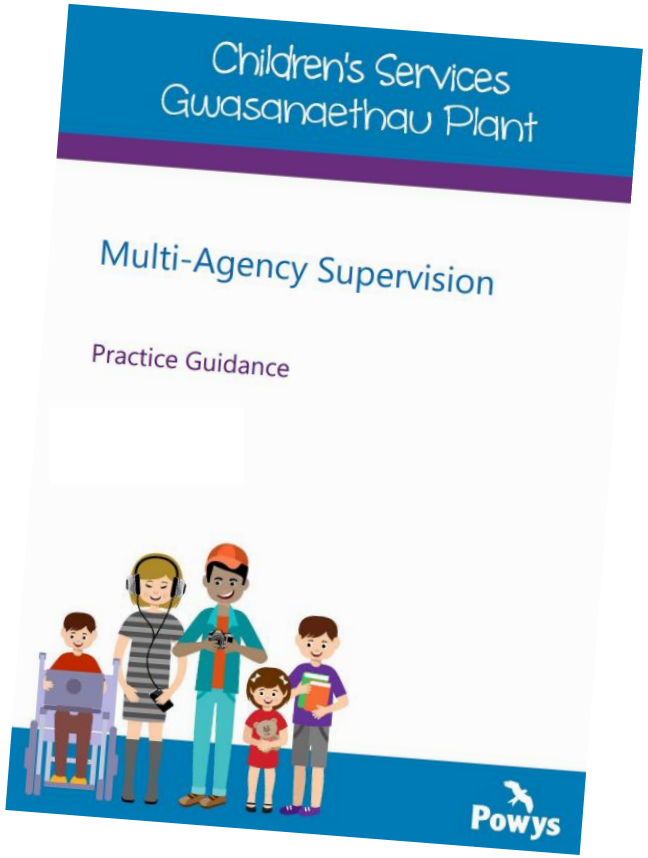
Multi-agency supervision will only be provided when the case status meets the required criteria and will support staff to inform decision making and strengthen how we can work with children and families to address need and risk.

Multi-agency supervision sessions are facilitated by lead practitioners from Children's Services, Powys Teaching Health Board (PTHB) & Education

Criteria

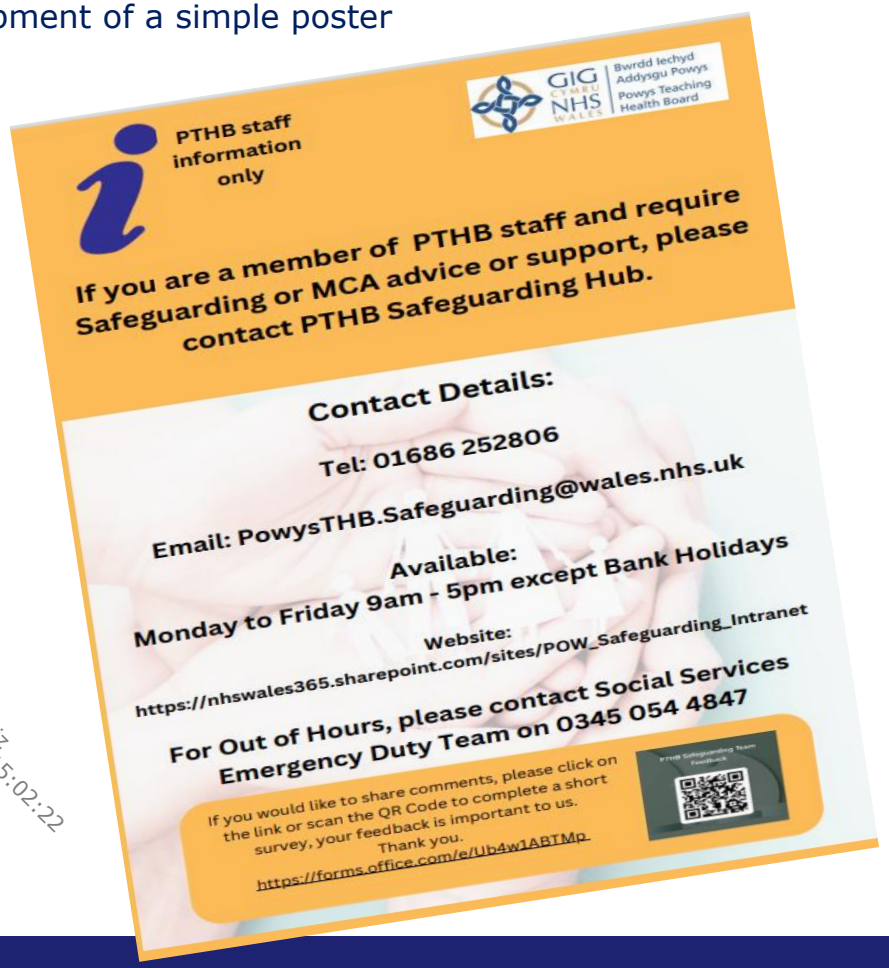
A Multi-Agency Supervision can be requested if the following criteria are met:

- **The child is subject to their second period of child protection registration**
- **Cases where there are regular split decisions amongst core group members**
- **Complex cases with evidence of drift**
- **Cases where Child Protection planning is not coming together and practitioners feel 'stuck' as how best to proceed**
- **The child has been subject to an extended period of registration in excess of 18 months**
- **Cases where there is evidence of disguised compliance or challenges engaging the family.**



Safeguarding Supervision, Advice & Support

Following the Safeguarding Leads visiting clinical area's it was noted there was no visible, easy to read information to guide staff about contacting the Safeguarding Hub, this led to the development of a simple poster



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The Safeguarding Team always welcome feedback on the service we offer across the Health Board. Limited responses are received via the QR Code

What we do well?

Supportive and clear information and guidance
Signpost
Support offered via hub is helpful
Always on hand and approachable

What could we do better?

A break in between the 2-hour supervision session
Access to safeguarding hub on the weekend

Safeguarding Training & Development

Powys Teaching Health Board has a responsibility to support our employees develop knowledge, skills and the competencies to perform effectively in their role and know how to respond & report to safeguarding concerns in line with local and national polices and processes
During 2024-2025 the Safeguarding Team delivered a variety of training sessions over MS Teams
Additional multi agency training is circulated across PTHB via Training Tuesday, with additional learning resources available on PTHB Safeguarding Intranet Page: **Safeguarding & Public Protection - Home (sharepoint.com)**

Safeguarding training compliance is reported quarterly to both the Strategic & Operational Safeguarding Groups. During the year work has been undertaken to review training packages & PTHB's competency ppassport, review and realign ESR and put a system in place to send reminders to staff regarding non-compliance with an escalation pathway to managers. This work has taken longer than anticipated, it has been completed with the consultation and cooperation of managers and leads. Improvement has been seen with Children Level 3, however, Adults Level 3 remains below the target of 85%. Work continues to achieve compliance

	Target	Q1	Q2	Q3	Q4
Safeguarding Adults Level 1	85%	88.49%	90.49%	90.82%	91.26%
Safeguarding Adults Level 2	85%	93.13%	93.74%	90.03%	91.94%
Safeguarding Adults Level 3	85%	42.15%	40.34%	45.42%	47.46%
Safeguarding Adults Level 4	85%	83.33%	83.33%	83.33%	83.33%
Safeguarding Children Level 1	85%	88.41%	90.29%	90.73%	90.66%
Safeguarding Children Level 2	85%	92.50%	92.87%	92.84%	93.30%
Safeguarding Children Level 3	85%	64.57%	66.07%	67.43%	76.74%
Safeguarding Children Level 4	85%	83.33%	83.33%	83.33%	71.43%
VAWDASV Group 1	85%	85.89%	87.31%	87.28%	88.46%
VAWDASV Ask & Act Group 2	85%	69.68%	71.23%	71.13%	71.29%

Training Delivered by the Safeguarding Team in 2024-25 & Feedback Themes

3 Level 3 children training to 42 staff

6 Level 3 adult training to 236 staff

12 Ask & Act training to 379 staff

4 Childhood Injury training to 58 staff

6 Mental Capacity Act Level 3 to 29 staff

Safeguarding Training & Development

Local, Regional and National Developments in 2024–25 include

- The Intercollegiate Document (ICD) rewrite for *Safeguarding Adults: Roles & Competencies for Healthcare Staff* was launched. **Adults ICD**.
- The Royal College of General Practitioners have published a **Safeguarding Standards for General Practice** document on 1st October 2024, with changed training requirements, no longer based on hours but instead based on the principles of adult learning.
- PTHB Safeguarding team are working with Primary Care Academy to support with safeguarding training within primary care. Dates planned to deliver training at Protected Learning Sessions which includes PTHB Named Doctor for Safeguarding delivering training on Childhood Injuries
- Development of the Safeguarding and Public Protection page on PTHB Internet page **Safeguarding & Public Protection - Powys Teaching Health Board (nhs.wales)**
- Safeguarding Leads have a programme whereby they attend team meetings twice a year
- Quarterly Mid & West Wales Safeguarding Board Newsletters :https://www.cysur.wales/newsletter/ one of which contains a piece on the work of PTHB Children Looked After Specialist Nurses
- National Safeguarding Week provided an opportunity for multi agency partners to come together where they were able to network, reflect, learn and consider how regionally we continue to keep people safe from harm
- PREVENT Awareness mandatory training agreed for PTHB practitioners providing care to children/adults at risk of being radicalised

Safeguarding Process

Safe Recruitment
Allegations Made Against Staff in a Position of Trust
Resolution of professional Differences
Pressure Care
Falls

Safe Recruitment

Powys Teaching Health Board recognises the importance of pre-employment disclosure checks on newly appointed employees and those who change position within the Health Board, in accordance with the relevant legislation and codes of practice. There is a Disclosure and Barring Service Policy and Procedure in place which sets out the process for DBS. Recruitment data is reported to the Safeguarding Strategic Group quarterly. HR 019 Disclosure and Barring Service Policy and Procedure V5 Review Date June 2025.pdf

Allegations Made Against Staff in a Position of Trust

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

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

Resolution of Professional Differences

Mid & West Wales Safeguarding Board Multi Agency Protocol for the Resolution of Professional Differences. media_bjpprbqn_resolution-of-professional-differences-protocol-approved-20230124 (1).pdf

Pressure Care

PTHB has a policy in place to support the prevention & management of pressure damage. The policy objective is to ensure appropriate care & management is provided to individuals at risk of or to those who have sustained pressure damage. All pressure damage found must be reported via RL Datix clinical incident reporting system. PTHB Pressure Damage Scrutiny Group meet monthly, a member of the safeguarding team attends the panel. GNP 026 Prevention and Management of Pressure Damage.pdf

Falls

PTHB has a policy in place for reducing & managing in patient falls which sets out a systematic process for the prevention & management of inpatient falls. Policy aims to; 1.Reduce preventable fall in hospital by providing an evidence based, patient centred approach to reducing the risk of harm & promoting patient safety. 2. Heighten awareness & knowledge to staff & carers on the prevention & causes of falls, slips & trips. 3. Provide guidance for the action to be taken when a patient has fallen.

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

Person Centred

SMM Standard; Person Centred

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

Within this section;

Safeguarding Children

Child Protection Register

Child Protection Medicals

Childhood Injuries Training

Child Exploitation

Looked After Children

PRUDiC (Procedural Response to Unexpected Death in Childhood)

Safeguarding Adults

Mental Capacity Act 2005

Pressure Ulcers

Inpatient Falls

Immediate Rapid Response

Public Protection and Offender Management

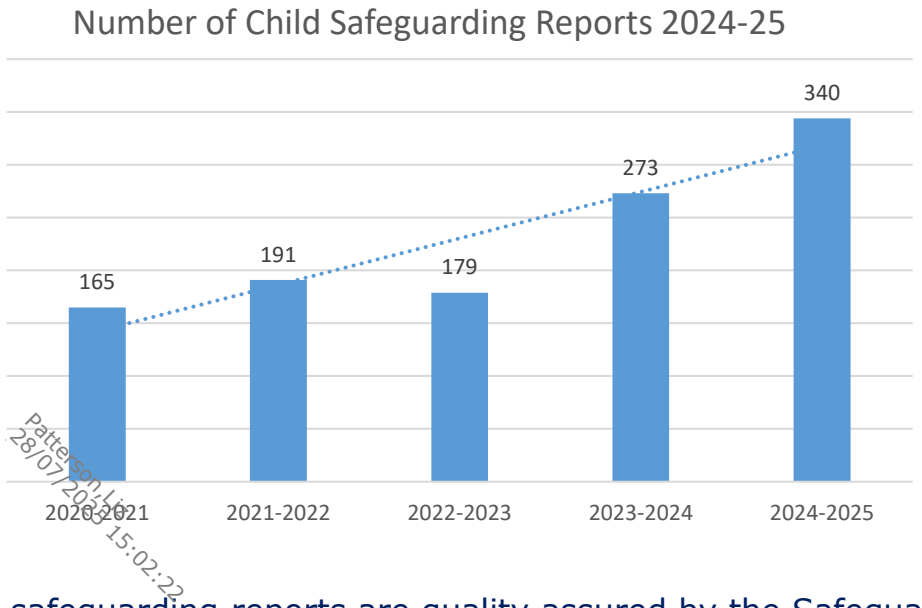
Violence Against Women, Domestic Abuse & Sexual Violence (VAWDASV)

Safeguarding Children

In accordance with the Social Services and Well-being (Wales) Act 2014 and the Children Act 1989/2004, the Health Board has a statutory duty to report a child who is (a) experiencing or is at risk of abuse, neglect or other kinds of harm, and (b) has needs for care and support .

340 Safeguarding reports were made by PTHB staff in 2024-25. This has more than doubled over the last 5 years. This rise may be due to several factors including improved data collection and reporting, a more visible and accessible Safeguarding Team including access to the Safeguarding HUB. Post pandemic reports increased when children & family's re engaged with services and the impact of the cost-of-living crisis.

30% of safeguarding reports were for concerns about Neglect



All safeguarding reports are quality assured by the Safeguarding Team

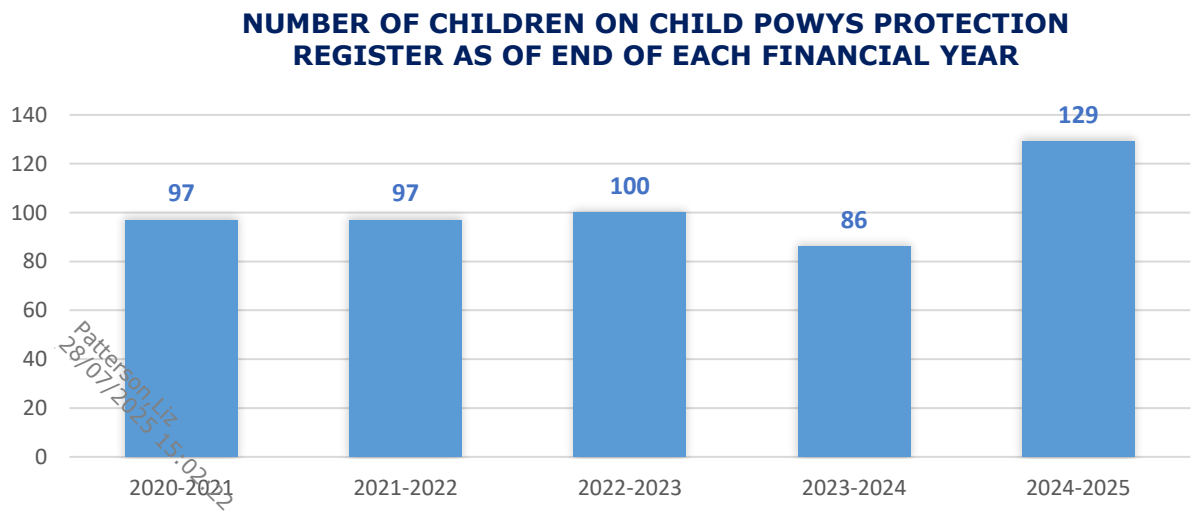
Living a life that is free from harm and abuse is a basic right for every child within Wales

Child Protection Register

When a child protection case conference concludes a child/ren are suffering or likely to suffer significant harm from abuse and /or neglect, their name is added to the Local Authority's Child Protection Register. This is always a multi agency decision. The Safeguarding Team receive daily updates from Powys Local Authority of all children whose names have been added to or removed from Powys Local Authority Child Protection Register. This information is shared with practitioners, GP'S and Shrop Doc

Child Protection Register

The number of children on Powys Children Protection Register children with care and support and protection plans was 129 as of 31.03.25. There has been a significant increase in the past 12 months which is being monitored within the local multi professional safeguarding group. When benchmarked against the most recently published Welsh data, the number of Powys children on the CPR per 10k population is just below that of the National Average.



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

The highest category of registration as of the 31.03.25 was Emotional or Psychological Abuse

Child Protection Medical Data

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

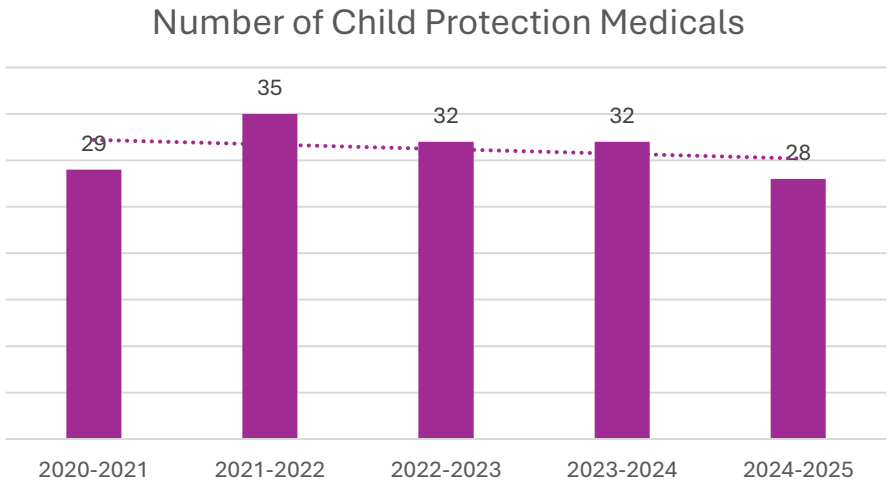
A PTHB Safeguarding Lead Practitioner attends most strategy discussions and will contribute to the decision making. This is supported by PTHB's Named Dr for Child Protection

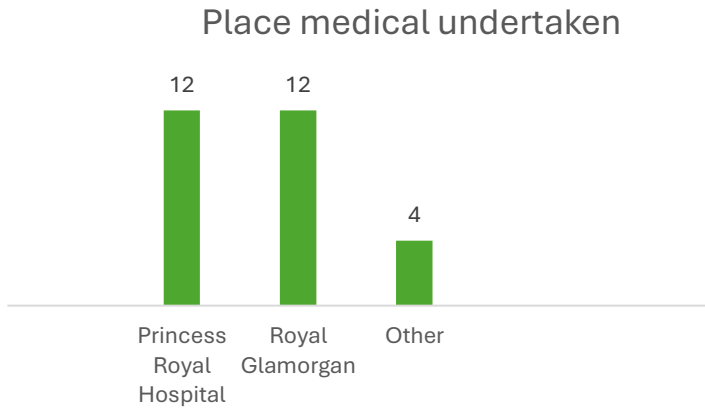
PTHB have a Child Protection Medical Pathway in place and commission medicals dependent on where the child resides and the type of medical required

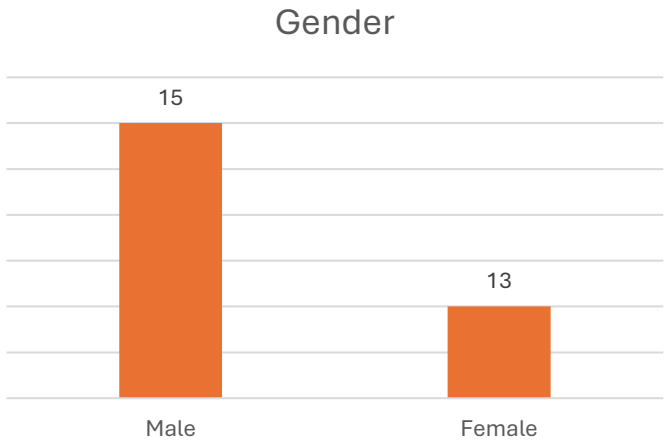
Throughout 2024-2025 there were 28 Child Protection Medicals undertaken on Powys Children. This is comparable to the numbers undertaken each year since 2020. 15 were male and 13 female. 17 were under 5 years of age and 11 aged between 5 and 17 years. 24 of the 28 medicals undertaken were due to concerns regarding physical abuse, followed by 4 for other reasons.

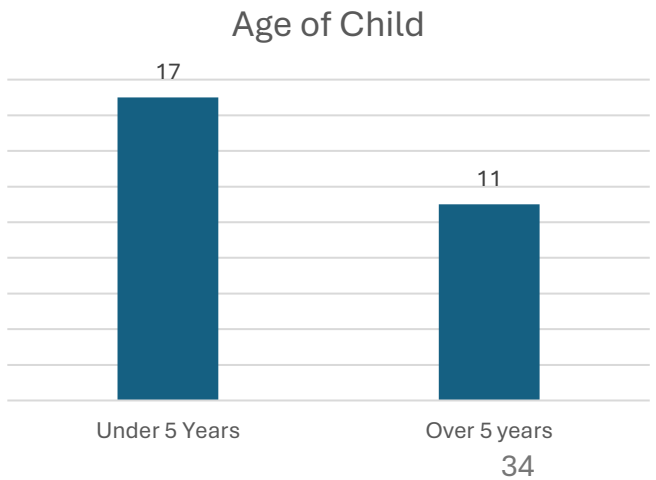
PTHB Named Doctor for Child Protection attends Child Protection Peer Review

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









Childhood Injuries Training

National reviews have indicated that practitioners have sometimes underestimated the significance of the presence of bruising or minor injuries in children, especially those who are not independently mobile. It is important to recognise that minor injuries can be an indicator or precursor to significant injuries or death of a child. Early recognition and action in such cases is key to preventing further injuries

Throughout the year PTHB Named Dr for Child Protection has planned and delivered multi- agency training on Childhood Injuries.

A Childhood Injury 7-minute briefing has been developed to support the training.

Sessions have been attended by frontline health practitioners, social workers, education staff and police officers

The training has received positive feedback.

Further sessions are planned for 2025-26

Childhood Injury & PA_ 7 MB_ final 2024

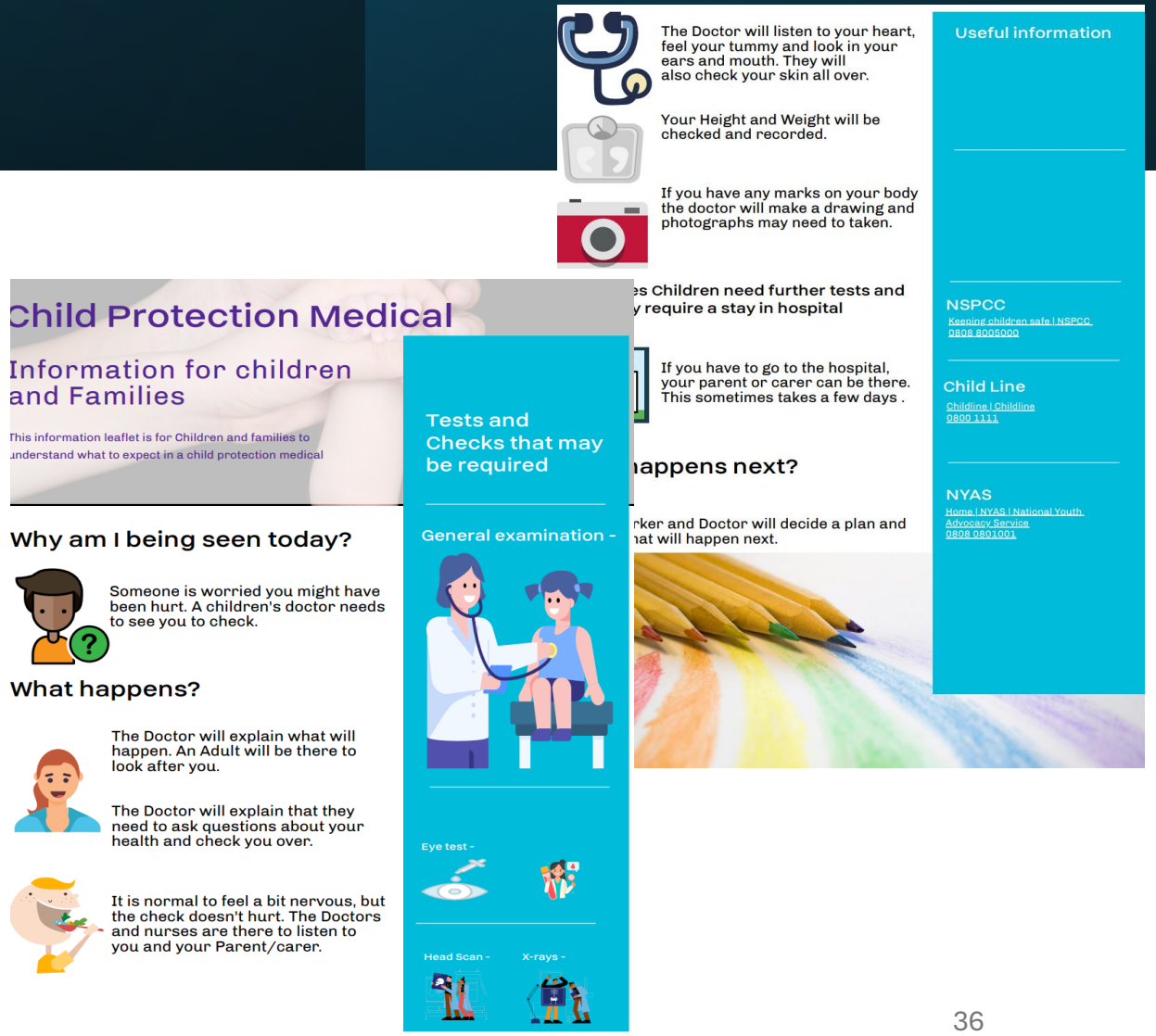
Development of All Wales Child Protection Medical Proforma & Child Protection Medical Leaflets

A national Royal College of Paediatric Child Health (RCPCH) audit of child protection medical assessments identified areas for improvement around consent and provided recommendations to our partner agencies.

In response to the audit the Wales Lead Doctors for Safeguarding (WLDS) group:

- redesigned and develop a Once for Wales Child Protection medical proforma with an improved section on consent and included a *Preliminary Paediatric Opinion* sheet to improve clarity and reduce ambiguity in recommendations to partner agencies.
- designed an All-Wales Child & Family & Guardians Child Protection Medical information leaflet which should be used to inform consent.
- Wrote a Standard Operating Procedure (SOP) for Child Protection Medical Assessments

All were launched by the National Safeguarding Network in Spring 2025



Child Exploitation

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

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

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

A PTHB Safeguarding Lead attends all MACE meetings

During 2024-25, 25 children were referred into the NRM (National Referral Mechanism) process

Children Looked After

Children Looked After (CLA) are children up to the age of 18 for whom the Local Authority is providing accommodation or care for a period of more than 24 hours (Children Act 1989). Children who are looked after are amongst the most socially excluded groups in our society and have been found to have significantly increased health needs in comparison with children from comparable socio-economic backgrounds (Sampeys 2015)

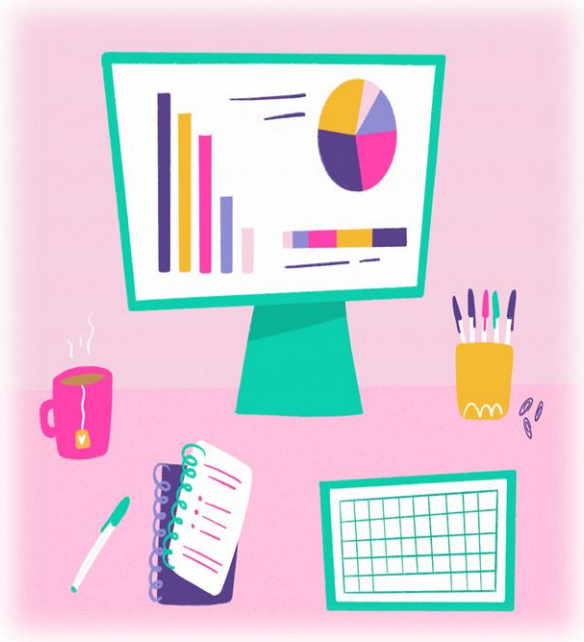
Improving the health of children who are looked after is a multi-agency responsibility involving local authorities and health agencies. PTHB have a duty to comply with the statutory legislation: Part 6, Social Services & Wellbeing (Wales) Act 2014 – Looked After & Accommodated Children

Throughout 2024-2025 PTHB Clinical Nurse Specialist for Children Looked After and Health Visitors continued to work flexibly around the needs of the child, offering advice and support to both children, foster carers and professionals. This includes completing CLA health assessments, attending LAC reviews, pathway planning for 16+children and strategy meetings. The views of the children are captured during their statutory health assessment and help to shape the child's Health Plan

Children Looked After Performance Data

Children Looked After (CLA) are children up to the age of 18 for whom the Local Authority is providing accommodation or care for a period of more than 24 hours (Children Act 1989). Children who are looked after are amongst the most socially excluded group in our society and have been found to have significantly increased health needs in comparison with children from comparable socio-economic backgrounds (Sampeys 2015)

- *354 CLA* Health Assessments completed by Powys Looked After Children Clinical Nurse Specialists & Health Visitors
- all assessments aim to capture the voice of the child, all assessments undergo a Quality Assurance process.
- *85%* were completed within statutory timescales, delays were mainly due to accommodating the needs of the children and Foster carers availability. There has been a significant improvement in receiving timely consent for Powys Local Authority
- *271* Health Assessments were with children from Powys
- *83* Health Assessments were with children from other Local Authorities placed in Powys
- 62 were completed by another Health Boards Child Looked After Team
- 100% of children were registered with a GP prior to the CLA health assessment
- *15* Unaccompanied Asylum Seeker Children (UASC) are being supported by PTHB CLA Team.



Luck/Lwc event at the Senedd 12 November 2024: Voices of the care experience children and young people to showcase their thoughts and feelings to produce an insightful exhibition & recommendations

The girls from the HOPE girls' rights group, who were the primary contributors, agreed on five key recommendations:

1. Training for Foster carers. We would like training to include therapeutic techniques and Mental Health First Aid training to better equip Foster Carers to deal with the often-complex emotions and ways that young people express themselves.

2. Being able to participate in packing our own belongings. We would like there to be mechanisms in place to enable us to pack our own belongings. Whether this be helping a social worker/foster carer or writing a list of the belongings we expect to see in our new home.

3. Belongings should be packed in bags and suitcases not black bags. We would like there to be a commitment from government that all children and young people in care should have appropriate bags and suitcases to move their belongings.

4. Participation in our care. We would like to be included in our own care meetings. We would like the guidance to be stronger on what should happen to include us in our own care. Guidance is weak, we need more.

5. Emotional Literacy and therapeutic support. We would like to see more group therapeutic work happening in school and better emotional literacy sessions for all children and young people. We want Wales to be a country where all children have the words to describe how they are feeling and express themselves prior to anything traumatic happening to them.

Work is underway within the Local Authority to address the recommendations made by the girls, this includes the development of a Participation Champion Group managed by Powys Local Authority and stopping the use of carrier/black bags for possessions – all children now have a suitable bag.

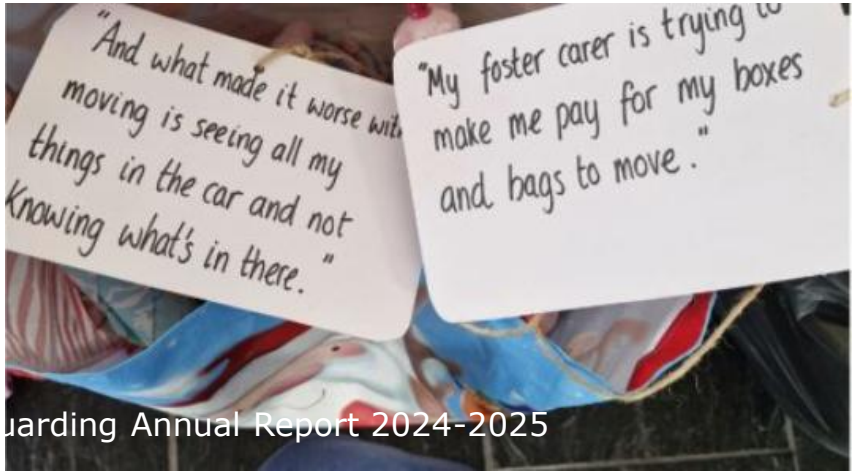
Care Experienced Children: Art, Poetry & Quotes from the LUCK Event

The event was attended by Helen Wear Children's Looked After Clinical Nurse Specialist in Powys Teaching Health Board; Helen writes:

The Childrens Commissioner for Wales invited groups from around Wales into a foster carer's 'home', we were then asked to wear headphones to hear the voices of care experienced children.

As we walked through the 'homes' the children described their experiences of placement moves and unfamiliar surroundings. We saw and heard how the children felt and saw themselves by seeing their belongings piled up in black bags, drawers full of deeply personal belongings with no safe place for them to be kept, and some of their property being lost

The emotions and feelings of the care experienced children was evident, some had produced very powerful art, poetry and quotes to express themselves



My social worker has seen my bras! That just hit me then, my social worker has seen my bras!"

"You should be asked before your stuff is packed"

"Social workers and foster carers might not see the importance of your stuff"

Children Looked After Launch of National Questionnaire

Listening for Change

As part of the identified need to develop person experience feedback within safeguarding for shaping services and triangulation of data, a national survey has been developed with stakeholders and crucially with care experienced young people supported by Voices From Care Cymru – a national organisation dedicated to upholding the rights of care experienced children and young people.

Developing a Person-Centred Service

The survey will be used to seek feedback in relation to the statutory health assessments of looked after children and their carers. The aim is to establish a person-centred service, using real time data to drive service improvement that includes what matters to looked after children and their carers, and ensure that the voice of vulnerable children and young people is integral to service provision. The survey will permit standardised responses on satisfaction of service delivery as well as identification of wellbeing themes and trends, access to services and quality improvement.

Surveys

Three surveys have been designed for children and for carers. Questions focus on the core values including dignity, respect, safety and if the children and young people feel involved in decisions made in respect of their health, that they feel valued and safe and that they have had information shared with them in an age-appropriate format. There is also a free text box to suggest improvements. The survey has been built using the CIVICA platform and surveys are available currently in both English and Welsh. Future developments may include providing the surveys in other languages, easy read format and British sign language

Next Steps

Every Child Looked After and their carer will be given the opportunity to complete the survey via a QR code following their statutory health assessment. PTHB will be responsible for collating and analysing their own data and reporting back key indicators to the National Children Looked After Steering Group, a subgroup of the National Safeguarding Network. This will allow themes to be analysed at both a Health Board and national level allowing for specific local and national service developments.

The survey went live in April 2025

PTHB has a process in place to share the QR Code and monitor responses

Removing Profit from Children's Care

Health and Social Care (Wales) 2025 Bill received Royal Assent in March 2025

The new law, passed by the Senedd, will improve services for children, families and disabled people. Wales is the first UK nation to legislate to **end private profit in children's residential and foster care**. Care for looked after children will only be provided by the public sector, charitable or not-for-profit organisations in the future. This will ensure that money going into the system is reinvested into children's welfare, rather than taken as profit for shareholders.

Four key takeaways

- From 1 April 2026 a new law will start to come into force in Wales, this will eventually stop all children's homes and fostering services in Wales from making private profit.
- The law will be phased in to minimise any disruption to children and carers and make sure that it achieves its intended benefits
- WG will be working with local councils, care providers, agencies, trade unions and children's groups as the changes are introduced. WG want to support any affected providers and their employees in making decisions that are right for them.
- WG will work with the sector including looked after children, to manage the changes in a smooth and seamless manner.

Patterson,Liz 28/07/2025 15:02:22

Llywodraeth Cymru
Welsh Government

Procedural Response to Unexpected Death in Childhood (PRUDiC)

phw.nhs.wales/services-and-teams/national-safeguarding-service/safeguarding-latest-guidance/specific-group-guidance/prudic-pdf/

PRUDiC sets a minimum standard for a response to unexpected deaths in infancy and childhood. It describes the process of multi agency communication, collaborative action and information sharing following the unexpected death of a child.

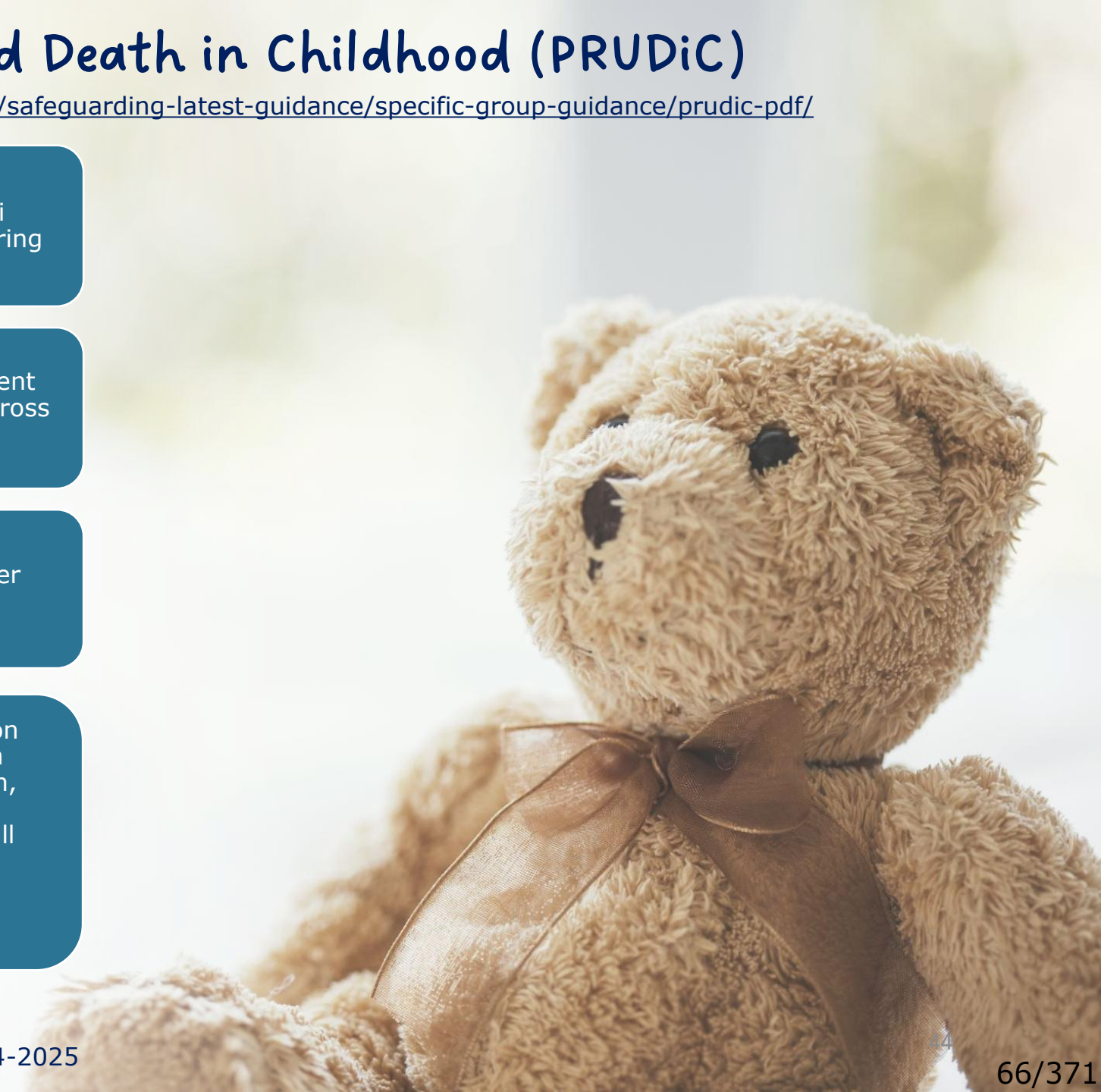
The aim of the PRUDiC is to ensure this response is safe, consistent and sensitive to those concerned, and that there is uniformity across Wales in the multi-agency response to unexpected child deaths

During 2024-25, all unexpected child deaths were managed under the PRUDiC Procedure.

To accompany the revised PRUDIC guidance, national information leaflets for both professionals & families have been developed in consultation with parents with lived experience, alongside health, education representatives, this process has supported the information to be clear and compassionately communicated to all those affected by the death of a child

PRUDiC Information for Families Leaflet

PRUDiC Information for Professionals Leaflet

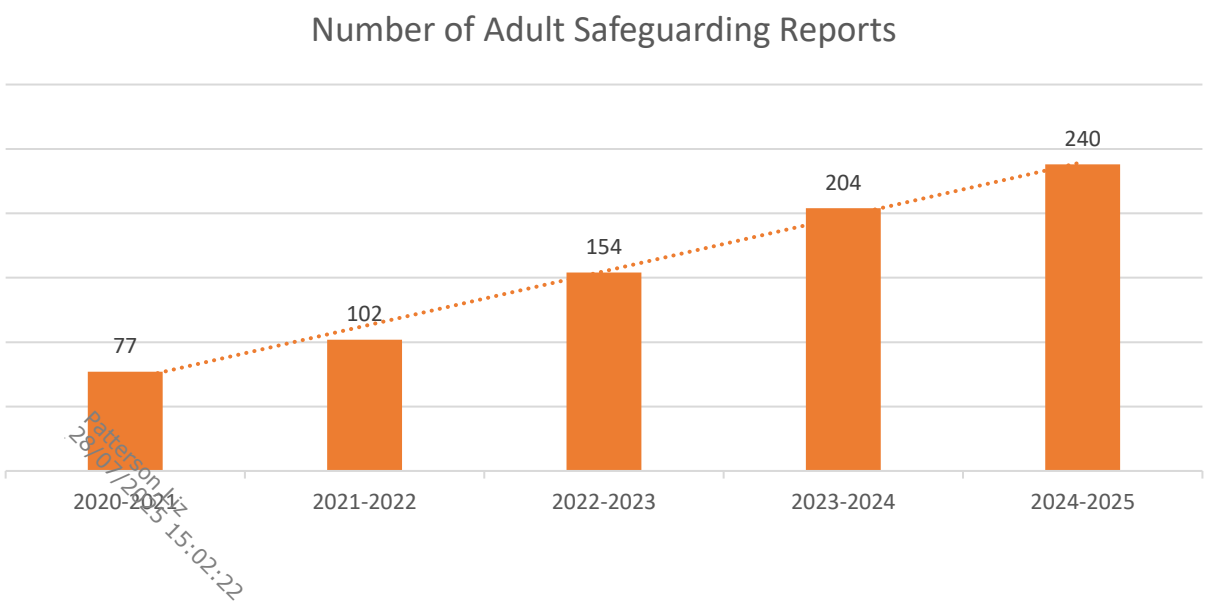


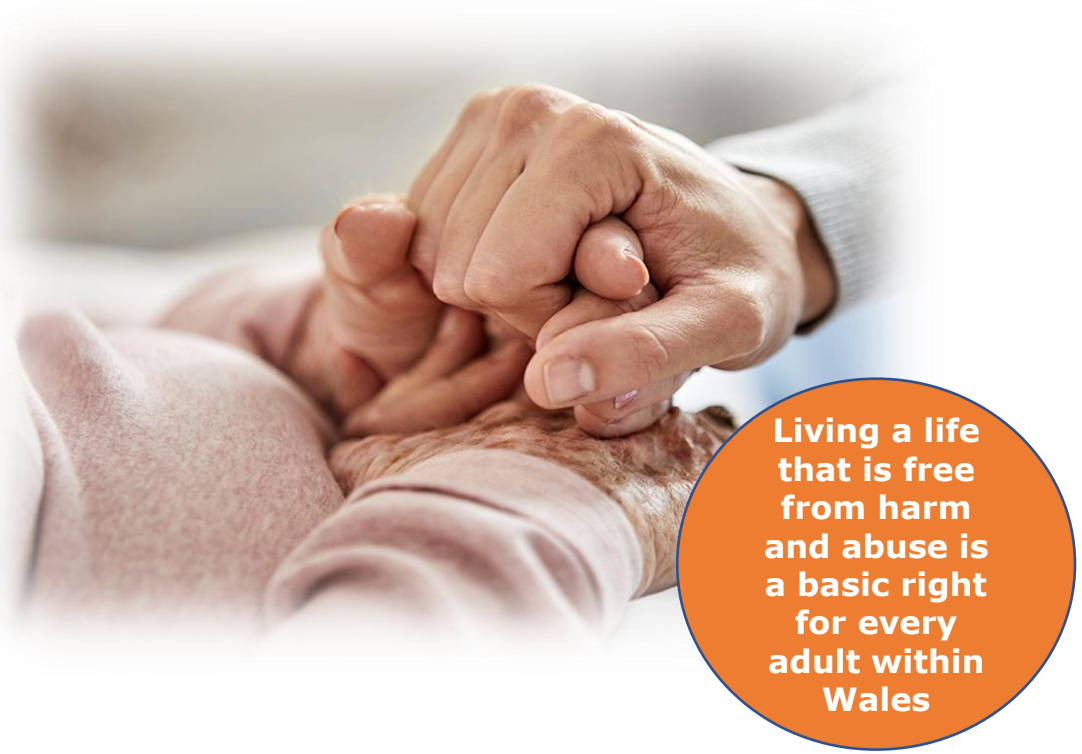
Safeguarding Adults

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

240 Safeguarding reports were made by PTHB staff in 2024-2025. This has year on year increased over the last 5 years. This rise may be due to several factors including improved data collection and reporting, a more visible and accessible Safeguarding team including the Safeguarding HUB. Post pandemic reports increased when adults and family's re engaged with services and the impact of the cost-of-living crisis.

32% of reports were for concerns about Neglect followed by 14% for concerns relating to domestic abuse





All safeguarding reports are quality assured by the Safeguarding Team

The Mental Capacity Act 2005 (MCA)

MCA provides safeguards for people lacking capacity for specific decisions at the time they need to take them. It puts the individual who lacks capacity at the centre of decision making and stresses the importance to support individual's make their own decisions. The MCA identifies the steps required to assess capacity and what is required to determine best interests.

The MCA also recognises adults with capacity have the right to make decisions that others may regard as unwise, for example refusing medical treatment. Within the MCA 2005 are the Deprivation of Liberty Safeguards (MCA DoLS).

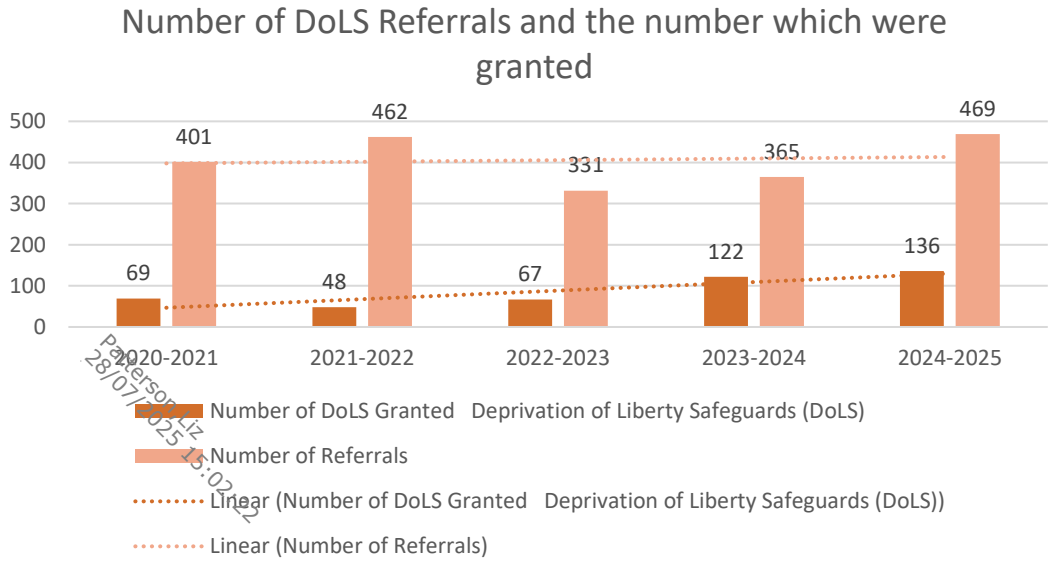
MCA DoLS provides a legal process to authorise an adult who meets the criteria, who may become, or are being deprived of their liberty in a care home or hospital setting. These safeguards are for people who lack capacity to decide where they need to reside to receive treatment and/or care and need to be deprived of their liberty, in their best interests.

By following this process, authorisation of a deprivation of liberty can be achieved. This will ensure that the managing authority is Human Rights Act compliant having identified an interference with article 5.

The Mental Capacity (Amendment) Act 2019 has not been implemented. No further updates are available and preparatory work has ceased.

MCA Performance and Activity

The number of DoLS applications have fluctuated since 2020 with 2024-25 seeing the highest number of referrals at **469** in the past 5 years. The total figure is the lowest in Wales, however when applications are viewed per 100,000 adult population, Powys have the third highest. In addition, PTHB has the highest number of applications received from outside Wales due to the number of services commissioned from England, other Health Boards do not have to manage this level. Powys has an ageing community and 88% of applications are received from people aged over 65. PTHB must be prepared for higher numbers of applications in future years.

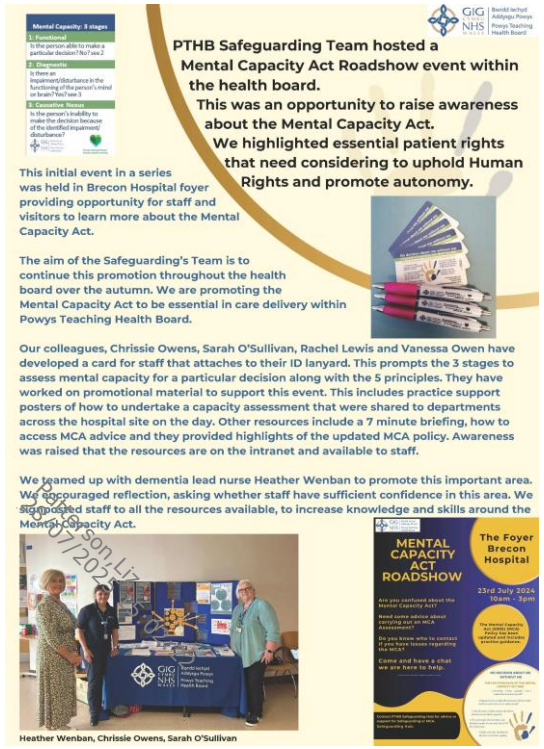


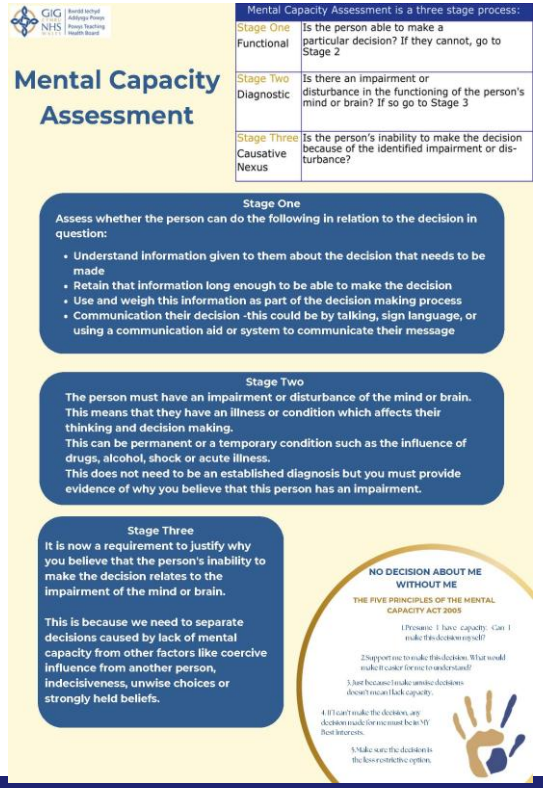
PTHB Deprivation of Liberty Safeguards (DoLS) Activity 2024-25

	Q1	Q2	Q3	Q4
No. of referrals for the period	86	100	149	134
No. granted	31	42	30	33
No. allocated to external BIA's	37	48	22	54
No. allocated to internal BIA's	22	16	19	26
No. withdrawn/not granted	54	65	105	89
No. of standard/renewal referrals for the period	8	10	5	11
No. of urgent referrals for the period	77	89	99	123
No. objecting	22	21	26	48
Total outstanding applications	33	35	40	22

MCA Roadshow 2024/25

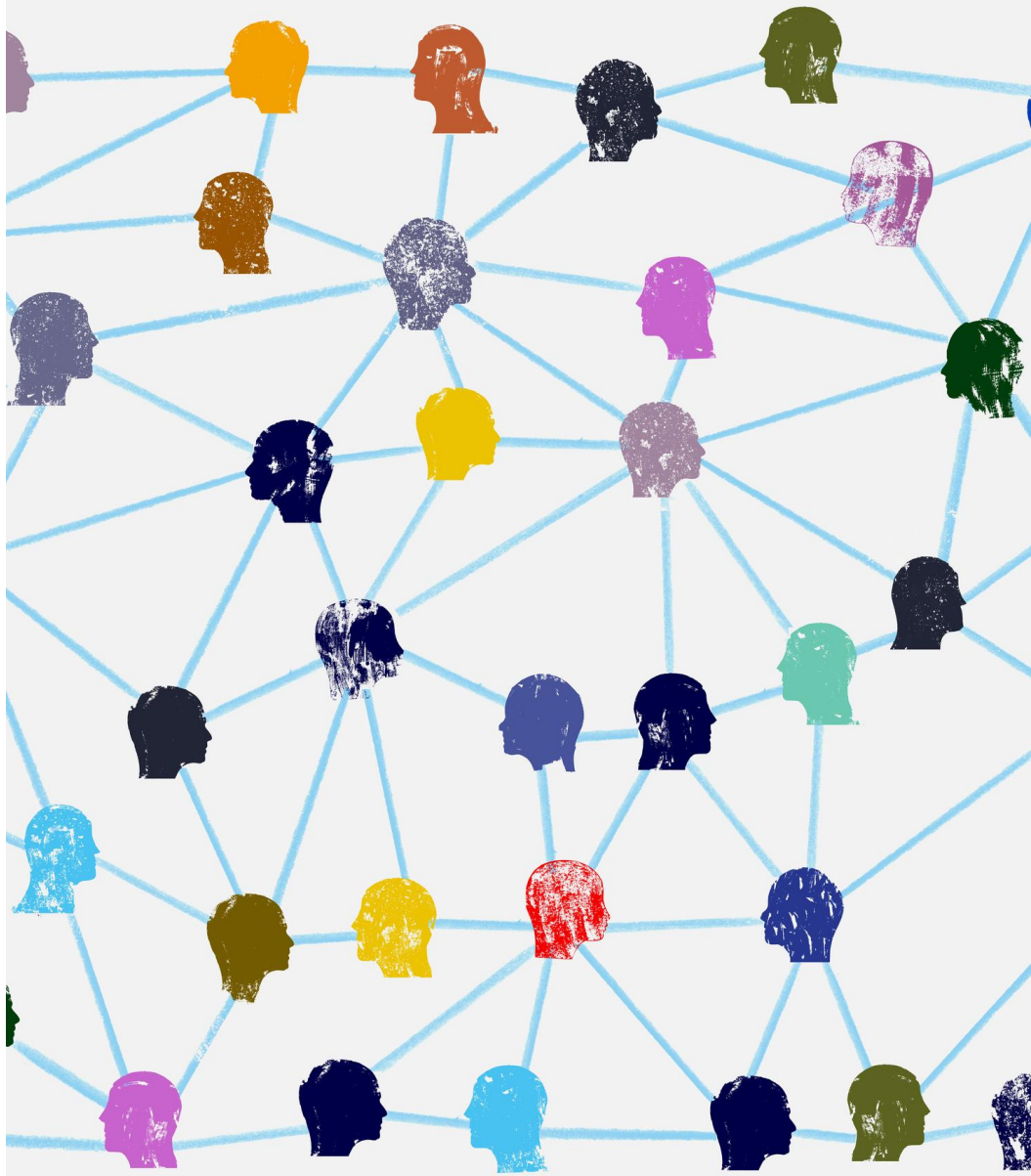
The roadshow has completed its tour of PTHB hospital sites, promoting the MCA, resources, MCA policy, and Safeguarding Hub. At each site, service and teams were linked in with, resources, asked questioned and engaged in conversation to promote the Mental Capacity Act. There was also useful networking of those already skilled around the MCA.





NHS Wales Safeguarding Network MCA Improvement Group has achieved:

- Quarterly meeting's which link MCA professionals from NHS Wales together, to seek clarification and share learning across the network
- Developed an All Wales MCA Leads TEAMS channel to share information and facilitate work streams
- Updated online MCA level 1 & 2 training and continue to work on developing MCA level 3 training with view to have an All-Wales agreement for use across NHS Wales with accompanying guidance on who should receive this training and its frequency
- Updated joint DoLS form 1/1a which is being piloted in Health Boards
- Engaged with Welsh Government to raise ongoing challenges regarding the lack of guidance following the halting of Liberty Protection Safeguards
- Reviewed the data requirements for MCA DoLS and offer advise on an improved national data set
- Scoped, design, develop and pilot of an All Wales Recording of a Capacity Assessment form



In Patient Falls Review Huddles

During October 2024, a new process for reviewing all in-patient falls commenced, for each fall a huddle is convened. In attendance is the Ward Manager, Community Service Manager, and Governance Lead, this aim is to met within 72 hours of the fall. All huddles are transcribed to ensure openness and transparency.

A review of all huddles in the 6 months the process has been in place has drawn out themes for learning and identified good practice

Between October to March 2024-26; 228 falls were reviewed; 6 falls were deemed as avoidable where no injuries were sustained from these falls. 5 injuries sustained from in-patient falls that were deemed as unavoidable, no omissions in the care were identified.

Themes from Review
learning
The need to improve recording of a lying & standing blood pressure, by Mid December 2024, questions prompting lying/standing blood pressure were added to clinical paperwork, which has been successful in aiding this procedure to be embedded within clinical practice. Over a 6-month period there was quarter a 36% drop in this being a learning outcome for the falls being reviewed.

Non updating a post fall clinical note saw an 11% increase into quarter 4, this prompted targeted work to improve this practice.
Ensuring that relatives are informed of falls and documenting this discussion.
When patients have an unwitnessed fall and take anti-coagulant medication, it is good practice to transfer for a clinical review in a District General Hospital. When this is not advised by a Clinician for a valid reason, we must ensure that clinicians document this clearly in patient records.

Good Practice
Falls review huddles are ensuring that in-patient falls are reviewed timely and learning identified at the point of the fall. This learning is disseminated to all staff to support the sharing of best practice and improve patient safety and care.
Embedding the recording of lying & standing blood pressure into clinical practice as part of falls assessment.

Hospital-Acquired Pressure Ulcer

Pressure Ulcer Review Panels are held monthly and include representation for the safeguarding team. All grade 3 and above pressure ulcers are reviewed and a determination agreed. Learning themes are gathered and presented as a quarterly report which is disseminated to all teams. If avoidable pressure ulcers are deemed as moderate harm, then they are managed via the Duty of Candour/Nationally Reportable Incident (NRI) process.

- During 2024-25 there were 3 moderate harm avoidable pressure ulcers which triggered the Duty of Candour process.
- A further 3 avoidable pressure ulcers that have been reported as a National Reportable Incident.

Learning themes

- to ensure patient pressure ulcer prevention risk assessments and care planning are completed in a timely manner
- to ensure that all patient wounds are regularly photographed
- to have a consistent knowledge base across all staff around the grading and identifying of pressure ulcers
- to have a consistent approach to identifying patients in last year of life to provide anticipatory pressure relieving equipment
- to improve documenting the advice, information, literature and conversations with patients/family/carers around pressure ulcer prevention
- to improve timely Datix reporting within 24 hours
- to ensure capacity assessments are undertaken where there are concerns a patient lacks mental capacity

Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV) Honor Base Violence, Female Genital Mutilation, Sexual Exploitation, Criminal Exploitation, Human Trafficking, Modern Slavery

VAWDASV is a major public health problem in Wales and globally, it is a violation of human rights and has far reaching consequences for families, children, communities and society.

All forms of violence and abuse are unacceptable, anyone who experiences violence against women, domestic abuse and sexual violence deserves an effective and timely response from all public services, who must work together in a consistent and cohesive way, together we can make progress towards achieving a Wales that is free from violence against women, domestic abuse and sexual violence

1:4 women & 1:6 men in the UK are victims of some form of domestic abuse.

2 women are killed a week but each week a further 10 are thought to take their own lives due to domestic abuse.

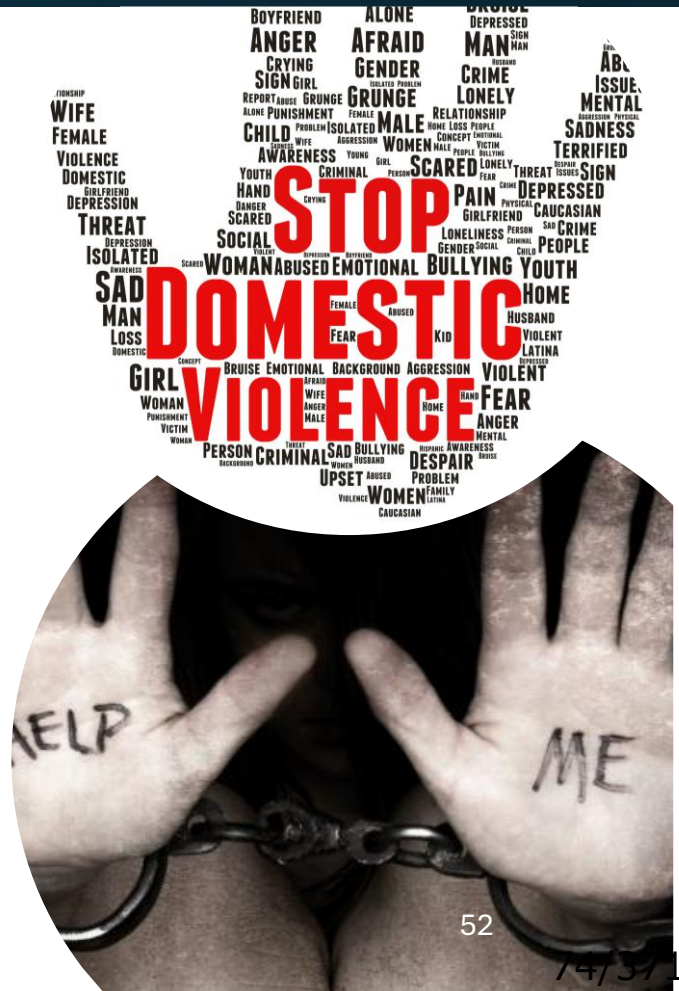
Modern Slavery is the illegal exploitation of people for personal or commercial gain.

Modern Slavery affects over 16,000 people in the UK a 33% increase since 2021.

Modern Slavery in Wales is on the rise. In 2016 123 referrals of potential victims of slavery were reported. This is an 8.2% increase on the previous year and represents 3.2% of all UK referrals.

Men, women and children may be forced into slavery which includes forced prostitution, child trafficking, criminal & sexual exploitation, domestic servitude, forced labour organ harvesting

Female genital mutilation (FGM) is a procedure where the female genitals are deliberately cut or injured or changed for no medical reason.



PTHB Domestic Abuse Data: PTHB Safeguarding Team:

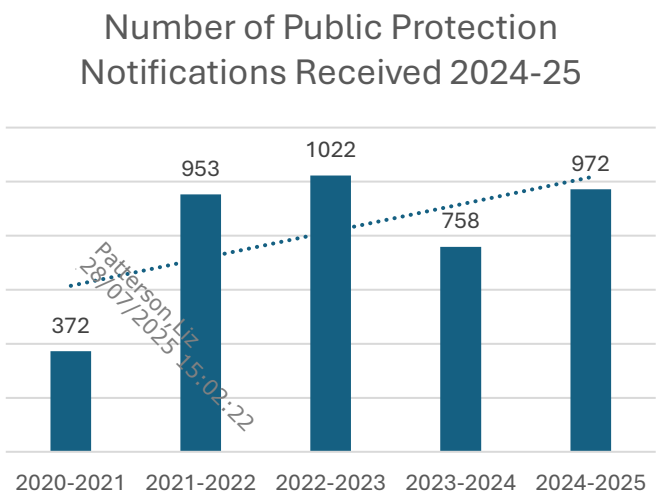
receives daily **Public Protection Notifications** from Dyfed Powys Police following a report of Domestic Abuse when an individual involved is pregnant or there are children associated with the victim or perpetrator

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

Domestic Abuse Multi Agency Risk Assessment Conferences (MARAC) are victim focused conferences where agencies share information on the highest risk victims of all types of abuse. A safety plan for each victim is developed.

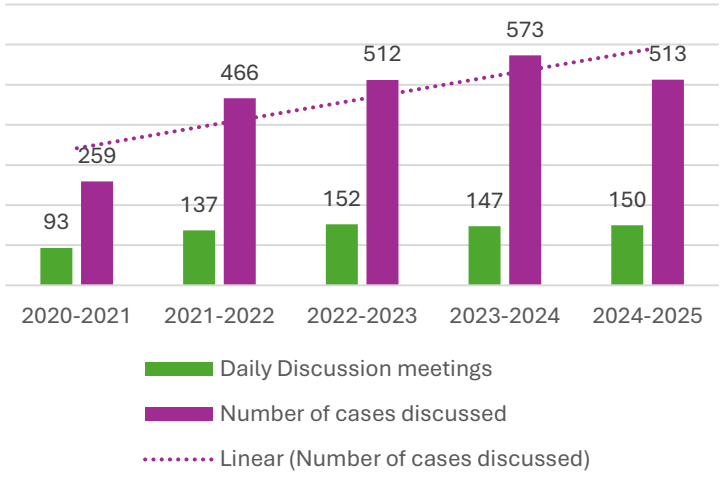
During 2024-25 there were **972** Public Protection Notifications received into PTHB Safeguarding Hub from the Police which were shared with the appropriate GP, Health Visitor & School Nurse Hub and Midwifery

Trend: this is an increase of **28%** from 2023-2024



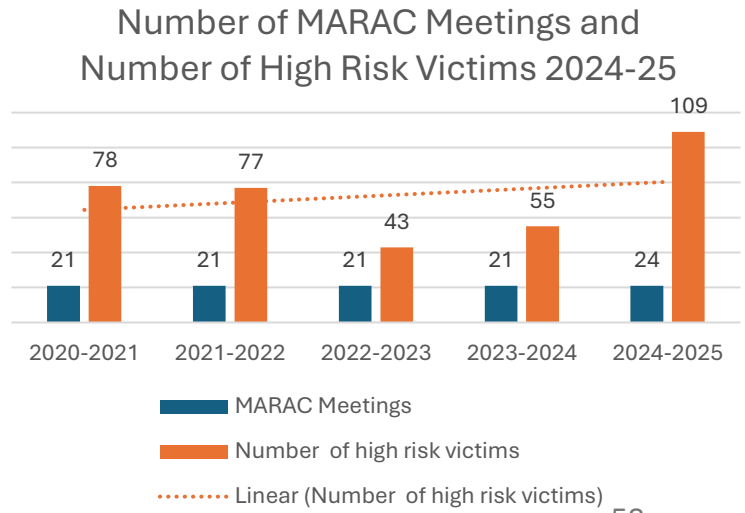
During 2024-25 there were **513** cases discussed at Domestic Discussions. PTHB Safeguarding Hub contributed to DD

Trend: this is a decrease of victims discussed of **10%** from 2024-2025



During 2024-25 there were **109** high risk victims. PTHB Safeguarding Leads attended all MARAC's

Trend: this is an increase of victims discussed of **98%** from 2024-2025. This is likely to be due to some agencies not attending DD resulting in victims progressing to MARAC, this is being addressed regionally



The Menopause and Domestic Abuse

Learning from a Domestic Homicide Review in a neighboring Health Board highlighted a link between domestic abuse and the menopause. The Review highlighted Menopause Research from Nuffield Health (2017) found that approximately 13 million women in the U.K are either peri- or post-menopausal, approximately two-thirds of whom say there is a general lack of support and understanding regarding menopause The British Menopause Society (2017) found that 50% of women said their menopause symptoms had impacted their home life. Where their partners were surveyed, a third of partners reported conflicts arising because they lacked understanding of what their partners were going through

National statistics (2020) suggest nearly four in ten (39%) women killed by men in the UK are in the 36-55 age range (Femicide Census, 2020). This means they are potentially at a stage of perimenopause or menopause. Where menopause and domestic abuse have been explored in tandem, researchers have found that experience of emotional abuse within the context of domestic abuse may heighten menopause symptoms.

Why is this significant?

Menopause related health appointments offer opportunity with women who may not otherwise disclose or identify their experiences as domestic abuse: • Ask about domestic abuse and/or relationships in all menopause related appointments. • Consider additional barriers midlife and older women face to disclosing domestic abuse. • Use follow up appointments to build trust, encourage disclosure and offer support • Signpost to appropriate specialist services, including those for older women and services run by and for Black and minoritised women

With this knowledge, PTHB Safeguarding Team

- ❖ adapted the Menopause and Domestic Abuse 7MB which has been shared with staff
- ❖ Linked with Occupational Health to ensure pathway to DA support services are shared on our menopause information for staff and ensued viv up have up to date information on local support services

Process for the Immediate Rapid Response to Incidents of Suspected Suicide

Regional Guidance sets out arrangements to provide a rapid, multi-agency response to managing the consequences and impact of suspected incidents of suicide for children and adults across the Mid and West Wales region and is complementary and supportive of, but does not replace, other protocols and processes, i.e. Wales Safeguarding Procedures, Procedural Response to Unexpected Deaths in Childhood (PRUDIC), Emergency Planning Processes and Critical Incidents in Schools

The impact of a suicide can be far-reaching, both within a family and within friendships and communities. Mid and West Wales is not unique in Wales within the context of known rising levels of suicide in recent years, both for children and adults across the region. Any unexpected death can cause a “ripple effect” spanning long periods of time. Individuals and groups can all be impacted by an unexpected death and as a result, some of those individuals can be vulnerable to experiencing harm or even death as a result. This can include but is not limited to, immediate and extended family members, peers and members of the community.

The role and purpose the Rapid Response Model is to quickly identify those most vulnerable and who are likely to be significantly impacted by the death. This provides agencies and practitioners with an opportunity to identify what support, and services may need to be provided to those effected, to prevent further harm or death.

The Immediate Rapid Response Model ***is not*** a forum that seeks to understand the sequence of events, missed opportunities or what lessons we can learn from practice. Many other regional forums and processes exist that provide platforms to explore these issues, it is important the meeting stays within the parameters of its primary purpose and function. The chair of the meeting has a critical role in ensuring the discussion remains focussed and within boundaries.

During 2024-25, 20 suspected suicides have been managed using the Rapid Response model. PTHB are represented by the Safeguarding Team and Suicide Prevention, Harm Reduction Team. Resources are available to support the bereaved and promote post vention work.

guidance-for-a-rapid-response-to-incidents-of-suspected-suicide.pdf (updated January 2025)

Public Protection and Offender Management

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

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

Statutory Agencies have worked together under the new **Serious Violence Duty (SVD) 2023** to deliver the Mid and West Wales Serious Violence Strategy and plan Link

Contest is the UK's overarching response to Terrorism CONTEST 3.0 (publishing.service.gov.uk), its aim is to reduce the risk to the UK, overseas interests and UK Citizens from terrorism. CONTEST provides a strategic framework of four work strands known as the 4 P's:

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

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

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

PREVENT training is not mandatory in Wales, however, PTHB have mandated PREVENT awareness for groups of practitioners who are most likely to provide health care to children and/or adults who are vulnerable to radicalisation.

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

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

SMM Standard; Learning Culture

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

Learning Culture

Within this section;

Incident Management System and Processes

Management of Learning from Reviews

Themes and Learning from the Reviews during 2024 - 2025

Single Unified Safeguarding Review (SUSR)

Incident management system and Process

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

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

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

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

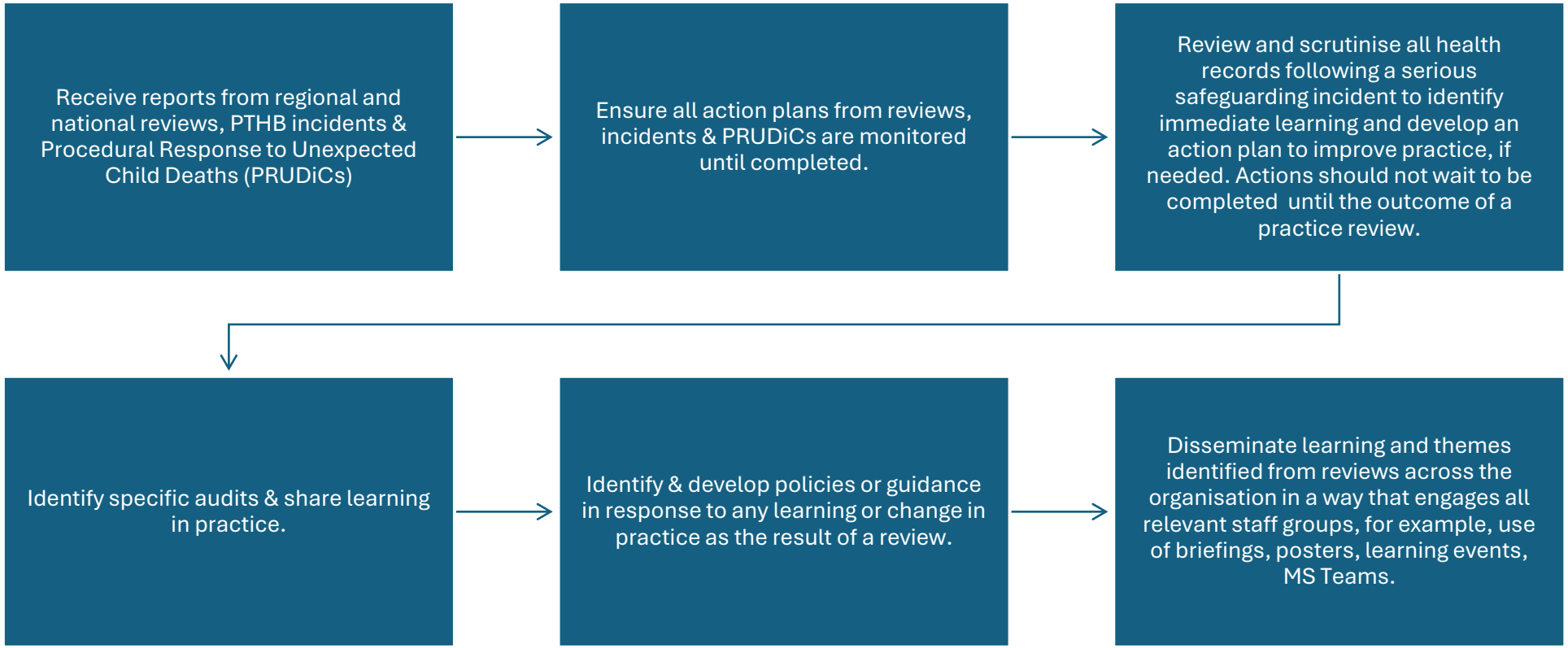
The IMF follows the principles of a " Just Culture" guide, ensuring that all processes avoid blame in the investigation process. The IMF also explores human factors and psychological safety to ensure that staff are supported to engage throughout the process (including with safeguarding, practice reviews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

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

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

Management of Learning from Reviews in PTHB

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



Themes and Learning from the Multi Agency Reviews during 2024 - 2025

Themes and Learning

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

How the Themes and Learning is shared

- Training Packs updated
- Use of short Videos
- Safeguarding attend Service Group/Team meetings
- 7 minute briefings
- Safeguarding Newsletter
- Safeguarding Intranet Page
- Safeguarding Newsfeed
- Promote Regional Training Opportunities and Events
- Strategic & Operational Safeguarding Groups
- Supervision, Avice and Support Conversations
- Safeguarding Week

SUSR
Single Unified Safeguarding Review

On the 1st October 2024, the SUSR was launched

SUSR Statutory Guidance :
single-unified-safeguarding-review-statutory-guidance.pdf

Single Unified Safeguarding Review statutory guidance: easy read (gov.wales)

SUSR: Single Unified Safeguarding Review

The Single Unified Safeguarding Review (SUSR) is a single review process incorporating all safeguarding reviews in Wales. The SUSR was launched on the 1st of October 2024, following 4 years of substantial cross-sector collaboration with partners including Safeguarding Boards, Community Safety Partnerships, the Home Office, Police and Crime Commissioners, Health and third sector organisations. Wales is the first country in the UK to take this new approach to safeguarding reviews. The SUSR process will be reviewed after 12 months to ensure that any changes required to improve the process are made

The SUSR will remove the need for multiple reviews when any life is lost or is significantly impacted through abuse, neglect, or violence.

The SUSR framework replaces the Adult and Child Practice Review Guidance and must be used alongside current DHR Guidance and introduces Mental Health Homicide reviews and Offensive Weapon Homicide reviews into one single, proportionate and rigorous process

Combining Adult Practice, Child Practice, Mental Health Homicide, Domestic Homicide and Offensive Weapon Homicide reviews into one process will prevent the need for families to take part in multiple, often onerous and traumatising reviews & ensure the subject and family are at the heart of the process

The process allows multi-agency review teams to quickly identify learning; build a greater understanding of what happened during an incident and provide a clear action plan to improve services.

The SUSR will support learning throughout Wales. Central to this being achieved is the development of the Wales Safeguarding Repository. This digital repository stores all reviews and can be interrogated using social science and machine learning to extract learning, thematic information and good practice which can be used to deliver positive change in practice & prevent future harm

SUSR: Single Unified Safeguarding Review: PTHB Process

SUSR Presentation shared at Safeguarding Strategic and Operational Groups

Communicate formal launch of the SUSR across the HB when this occurs

The SUSR guidance & Referral Form is available on PTHB Safeguarding Intranet page

All referrals for a SUSR must be discussed with PTHB Head of Safeguarding

PTHB Head of Safeguarding will share the referral with partner agencies, to gather their information prior to submitting the referral to the M&WWSB Practice Review Subgroup for their consideration. (PTHB represented on this group)

PTHB employees will not be able to be a Reviewer or Chair on a PTHB review, PTHB will however have to provide the most appropriate panel members, one of which must be a member of the Safeguarding Team.

The PTHB panel member must be able to have access to all relevant health records, be able to complete and analyse a health chronology, be able to participate in all panel meetings and have the knowledge and confidence to challenge and seek clarity on points / areas of uncertainly within the multiagency timeline

Training materials to support reviews have been developed and will be available to practitioners involved in Reviews

SMM Standard; Multi Agency Partnership working

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

Multiagency Partnership Working

Within this section;

Mid and West Wales Safeguarding Board

VAWDASV Strategic Group

NHS Wales Safeguarding Network

National Safeguarding Week

Multi Agency Partnerships: Working in Collaboration

Mid & West Wales Safeguarding Board

The Mid and West Wales Regional Safeguarding Board (Children and Adults) was established to meet the requirements of the Social Services and Well-being (Wales) Act 2014 and is a key Vehicle for agreeing how statutory agencies will cooperate to safeguard and promote the welfare of children and adults at risk, and for ensuring the effectiveness of those agencies both regionally and at a local level.
The regional purpose is to coordinate the strategic direction, collaboration, consistency and improvement of practice across the region. The local purpose is to coordinate local practice, and work towards ensuring effectiveness of safeguarding local arrangements.

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

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

The Boards priorities for 2024-25 were set during the annual board development day, these are themed into 4 main areas;

❖Develop a culture of collaboration and innovation across the partnership, which promotes a safe, skilled and resilient workforce
❖Measure, evidence and understand the impact of this Board's work on professional practice, and how this improves outcomes for children and adults at risk
❖Undertake systemic analysis of organisational performance and change to better understand its impact on children and adults at risk.
❖Continue to influence and contribute to the national strategic agenda to support improvements in safeguarding legislation, guidance and policy

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

The VAWDASV Strategic Group is a multiagency collaboration that is driving forward the requirements of the VAWDASV Act, including the implementation of the new Mid and West Wales Violence Against Women, Domestic Abuse and Sexual Violence Strategy 2023-27 media_20gh4vhu_mww-vawdasv-strategy-2023-28-final.pdf.

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

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

The 6 Priorities of the Strategy are;

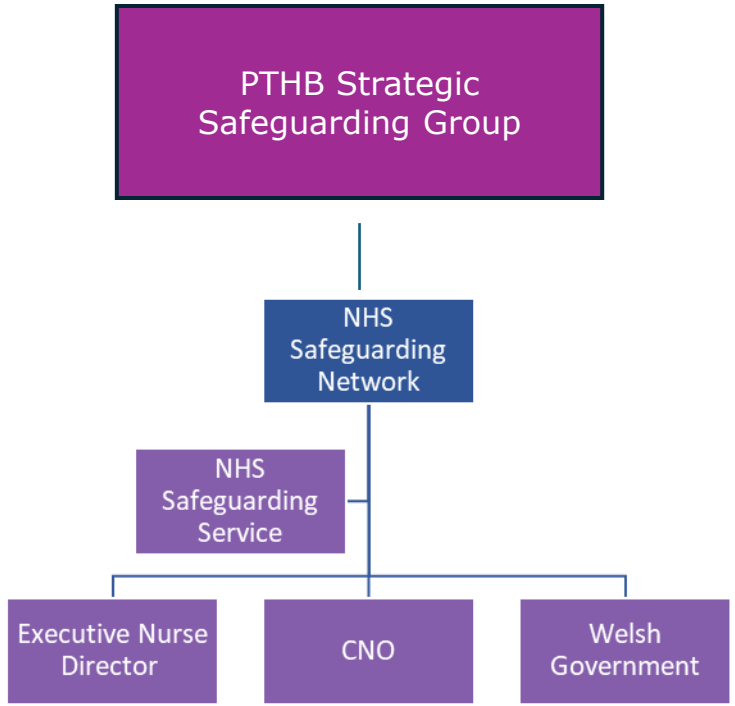
1. Challenge public attitudes towards violence against women, domestic abuse and sexual violence across the Welsh population through awareness raising and a space for public discussion with the aim to decrease its occurrence.
2. Increase awareness in children, young people and adults of the importance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

GIG CYMRU | NHS WALES
DIOGELU RHWYDWAITH | SAFEGUARDING NETWORK

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

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

To enable this work and to deliver against a yearly work plan, strong partnerships are key. Powys Teaching Health Board are represented at the Safeguarding Network and actively contribute to the networks workplan



The Safeguarding Network Priorities for 2024-25 are;

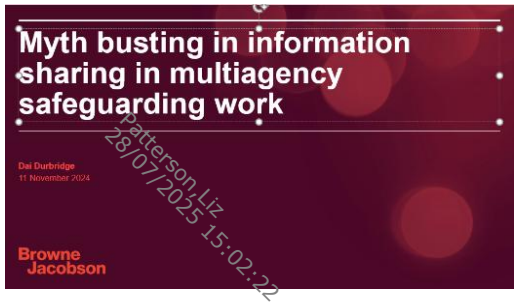
National Safeguarding Week: November 2024

National Safeguarding Week took place this year from 11 to 15 November 2024, with the theme of "The Right Help, at the Right Time". Under this broad heading a wide-ranging programme was designed in response to some of the safeguarding themes and issues that have emerged across the Mid and West Wales region in the last year.

Throughout the week both in-person and online events were held, in the form of conferences and webinars that sought to raise awareness and highlight issues that currently affect children and adults at risk. These included:

Regional Conference: Right Help at the Right Time.

The flagship event for the week was a Regional Conference: Right Help at the Right Time. This in-person event was hosted by Ceredigion Local Authority and held at the Medrus Conference Centre, Aberystwyth University. It included workshops that covered a variety of themes and offered a breadth of engaging content focussing on trauma informed practice using virtual reality, trauma recovery model: sequencing in practice & developing services to meet family's needs.

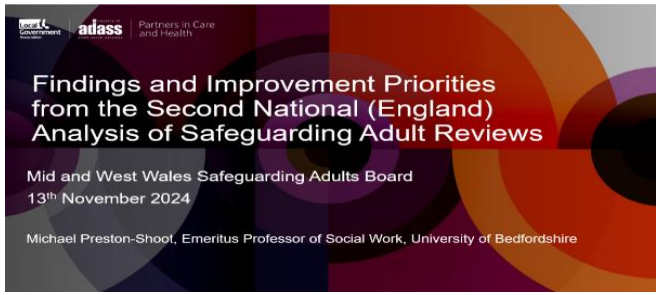


The session offered engaging training on information sharing with a particular focus on data protection legislation within the content of safeguarding. The webinar also explored the barriers to information sharing, with a focus on the grey areas where there are worries and emerging concerns. The webinar also focused on some of the myths surrounding consent.

Several related resources are online to support further learning
https://cysur.wales/resource-hub/information-sharing/

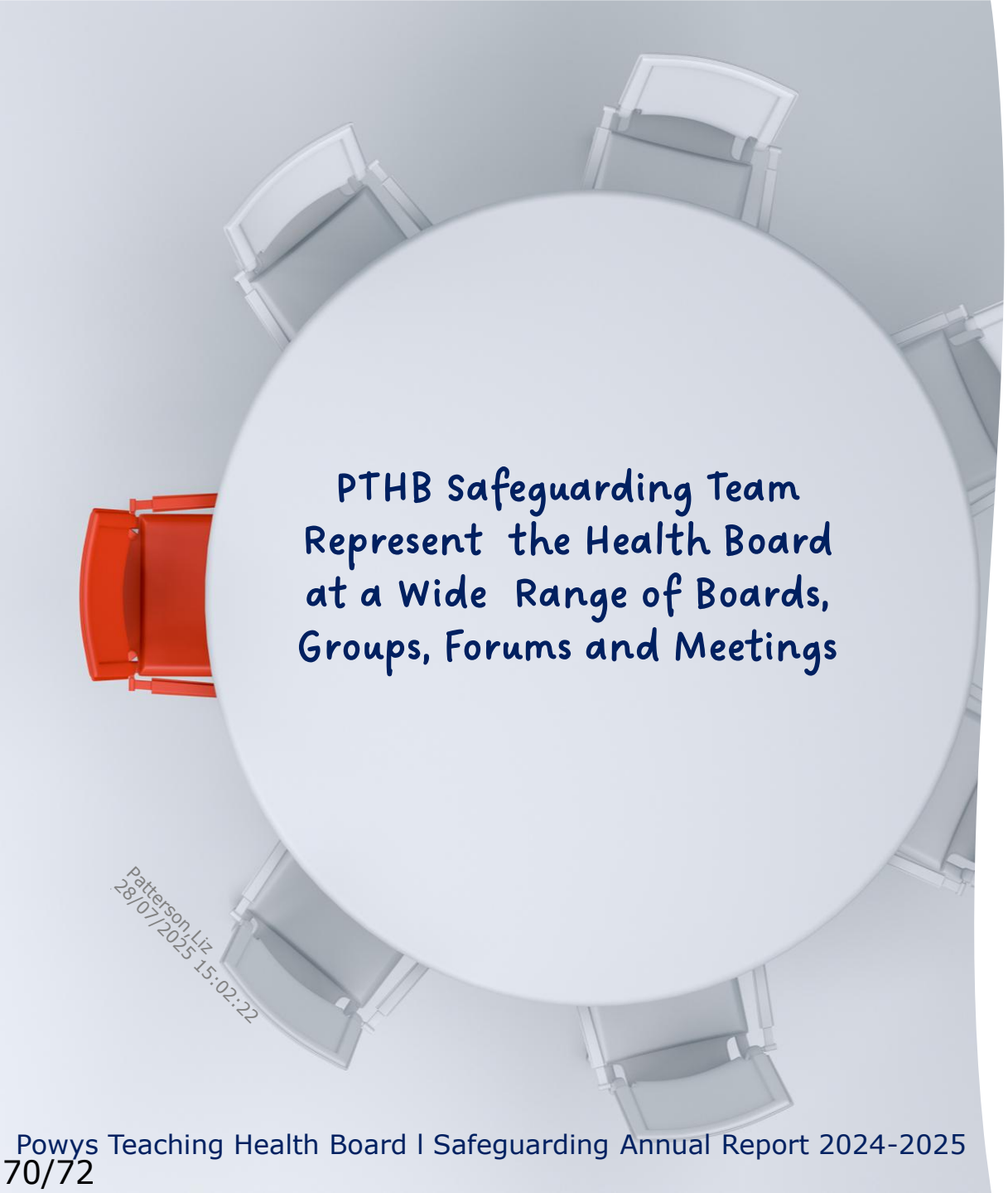
This event was facilitated by Dr Donna Peach and Dr Holly Gordon. This regional webinar presented participants with key themes and messages from Child Practice Reviews undertaken in Mid and West Wales in recent years. It also considered key finding from recent national multi-agency inspection reports undertaken in Wales and considered the implications for multi-agency practitioners and managers in their roles of safeguarding children

This regional webinar drew on learning from 652 safeguarding adult reviews in England, identifying learning about the process of commissioning, undertaking and completing reviews. The webinar presented quantitative and qualitative findings about effective safeguarding practice and shortcomings and allowed participants to consider the relevance of the findings of the review, in respect of adult safeguarding practice in Wales. The event was facilitated by Professor Michael Preston-Shoot



Additional webinars were offered these included:

- **Understanding Spina Bifida and Hydocephalus,** hosted by SHINE Cymru. This event offered an introduction to spina bifida and hydrocephalus with a case study approach to address the theme of the 'right help at the right time'.
- **Safeguarding Transgender Young People from Exploitation**, was hosted by the Children's Society. This event explored how barriers in society, can lead to us failing to protect trans and non-binary young people from exploitation and harm, and what we can do to overcome these in our practice and in our systems.
- **Listen up, Speak up Workshop,** was hosted by NSPCC. This session highlighted the NSPCC's free listen up, speak up, workshops. This training help attendees understand how to listen and speak up on behalf of children & empowers the attendee to support children in their communities.
- **Talk PANTS campaign,** was hosted by NSPCC. This session highlighted the NSPCC's Talk PANTS campaign, which is aimed at education professionals, teachers, early years practitioners and those with caring responsibilities for children aged 3-11, to have simple and age-appropriate conversations, that can help them keep children safe from sexual abuse.



National Meetings

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

Local Meetings

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

Regional Meetings

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

Health Board

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

SMM Standard; Responsive, Resilient and Purposeful

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

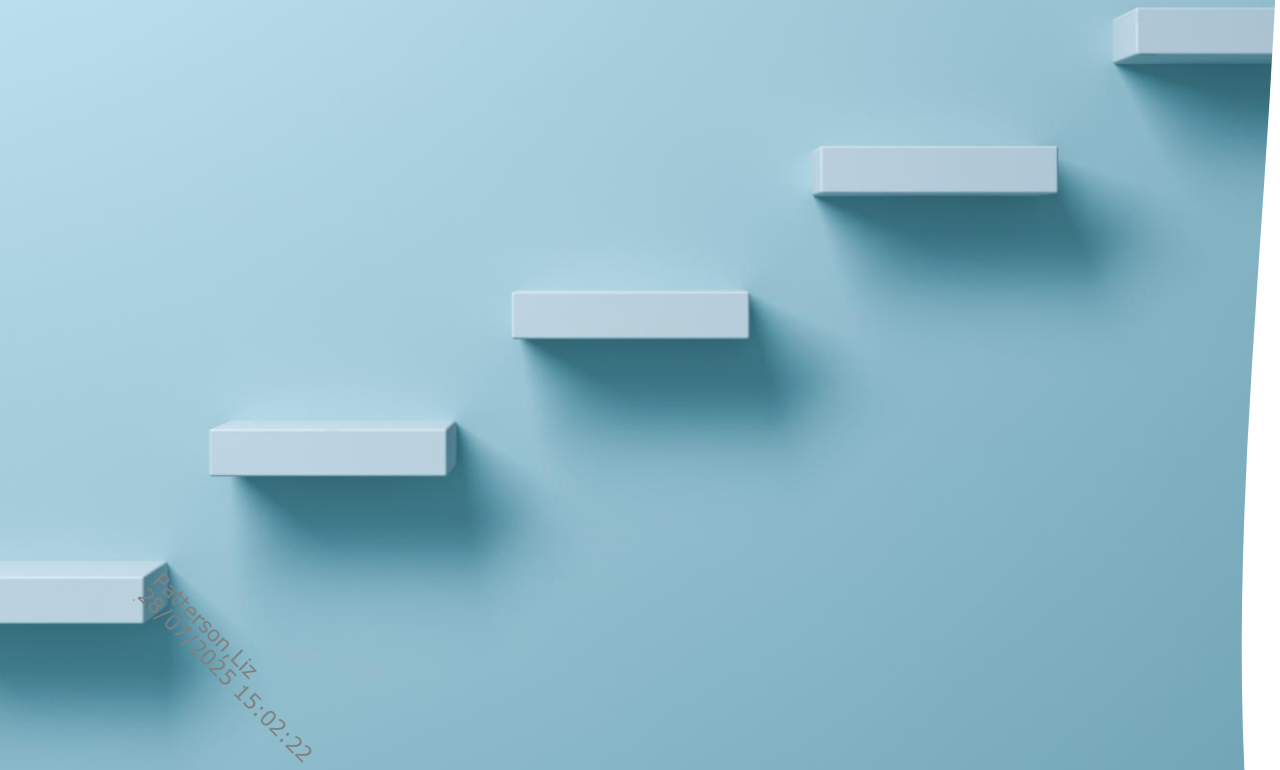
Work is ongoing within the Safeguarding Team to build resilience and succession plan;

Opportunities are being given to all members of the Safeguarding Team to develop and enhance their interest in specific specialised area's and share their advanced knowledge across the team.

Regular Safeguarding Supervision is available to all the Safeguarding Team which builds strategies when dealing with complex, emotive and challenging cases.

As the safeguarding landscape continues to grow, there is a large volume of work locally, regionally and nationally, this gives opportunity for the whole team to experience safeguarding at a strategic level, working through new developments into the operational space. This also allows for networking across Wales, forming strong connections for support, sharing of ideas and collaboration.

Powys Teaching Health Board Safeguarding Priorities 2025-26



- Engage in the National Strengthening Safeguarding Review Implementation Programme and all 4 subgroups (commissioned by CNO & WG)
- Roll out new updated PREVENT Guidance and monitor mandatory Compliance
- Implement the Multi Agency Safeguarding Supervision Model with our statutory partners
- Participate in a Regional Neglect Tool Kit Pilot with Health Visitors and School Nurses
- Review the Level 3 Safeguarding Training Passport, considering merging adult and child passport and developing/designing an electronic Safeguarding Workbook. To use the same format for an e-newsletter
- The Corporate Parenting Charter has been signed by the HB. The principles now need embedded across the HB
- Extend the reach of the safeguarding service using Pod Casts
- Roll out the National Childrens Looked After and Carers Surveys via CIVICA
- Implement the MCA audit assurance management plan

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 3.4

PATIENT EXPERIENCE QUALITY AND SAFETY	**DATE: 31 JULY 2025**
Subject:	**Duty of Quality Annual Report 2024-2025**
Approved and presented by:	Claire Roche, Executive Director of Nursing, Quality, Women and Family Health
Prepared by:	Service Development Officer
Other Committees and meetings considered at:	Executive Committee - 09 July 2025 who recommend the report to the Committee.

PURPOSE:

To provide an updated position on services across the Health Board concerning the areas with the Duty of Quality.

RECOMMENDATION(S):

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

- **APPROVE** the Duty of Quality Annual Report which evidences progress and areas for improvement for 2024-2025.

Approve/Take Assurance	Discuss	Note
Y	Y	N

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

EXECUTIVE SUMMARY:

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

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

- Ensure that all strategic decisions are made through the lens of improving the quality of services and patient outcomes.
- Exercise their functions in a way that considers how they improve quality and outcomes on an on-going basis.
- Actively monitor progress on the improvement of quality services and patient outcomes and routinely share information on this progress with population.
- Strengthen governance arrangements by reporting annually on the steps taken to comply with the Duty and assess the extent of improvements in outcomes.
- Ensure that NHS organisations are operating an interlinked Quality Management System.
- Create a quality culture within organisations.

DETAILED BACKGROUND AND ASSESSMENT:

Following the implementation of the Health and Social Care (Quality and Engagement) (Wales) Act 2020, which came into force in April 2023, it is a requirement for health boards to publish an annual quality report.

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

NEXT STEPS:

Publication of the Annual Duty of Quality Report.

IMPACT ASSESSMENT

Not required.

Annual Duty of Quality Report 2024-2025

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

Contents

1.0 Foreword

Powys Teaching Health Board has a whole range of responsibilities for healthcare for the people of Powys, both as a provider and as a commissioner of services.

To ensure that our services are person-centered, timely, safe, effective, efficient and equitable, in line with the quality standards, we have a statutory Duty of Quality as set out in the Health and Social Care (Quality and Engagement) (Wales) Act 2020.

We are pleased to present the Health Board's Duty of Quality Annual Report for 2024/25. We hope this report provides you with an overview of what we have been doing over the last year to improve quality oversight and infrastructure across Powys and share the improvements we have made.

This year has seen us mature our Quality Management System through our Integrated Quality and Performance Framework. Our local escalation framework supports us to have robust *Quality Assurance* and *Quality Control* mechanisms, the way we plan our services is underpinned by a golden thread of quality, ensuring that we deploy *Quality Planning* and learning from concerns, incidents and listening to our population informs our priorities for *Quality Improvement.*

These are challenging times for public services and we as a Health Board will need to transform to ensure that we meet the needs of our population. As we embark on our transformation Programme of *Better Together,* we will ensure that quality impact assessments guide our decision making.

Our Duty of Quality underpins our intention to be a listening, learning Organisation; a place that is psychologically safe to work in and where services are open and transparent.

Claire Roche, Executive Director of Nursing, Quality, Women and Family Health

2.0 Introduction

This Duty of Quality Annual Report for 2024–2025 outlines Powys Teaching Health Board's ongoing commitment to improving the quality of services and the health outcomes of our population. It reflects the progress made over the past year in delivering safe, effective, and person-centred care in line with our statutory responsibilities under the Duty of Quality.
The Duty of Quality, which applies to all NHS bodies and Ministers in Wales, requires that all functions relating to health services are exercised with a consistent focus on improving quality and securing better outcomes. This obligation aligns with the five ways of working set out in the Well-being of Future Generations (Wales) Act 2015 and contributes to the overarching goal of achieving a healthier Wales.

This report demonstrates how Powys Teaching Health Board has embedded the Duty of Quality across its operations. Specifically, it highlights how:

- All strategic decisions are made through the lens of improving service quality and patient outcomes.
- Functions are discharged in a way that continually seeks improvements in quality and outcomes.
- Actively monitor progress, sharing regular updates with the population to maintain transparency and accountability.
- Strengthen the governance arrangements by reporting annually on our actions and evaluating the extent of improvement achieved.
- Maintain an interconnected Quality Management System across the organisation.
- Foster a culture of quality that is integral to everything we do.

The Annual Report describes how the Health Board are meeting the responsibilities under the Duty of Quality and continuously working towards delivering high-quality, equitable healthcare for the people of Powys.

3.0 Quality Governance

As an NHS Wales organisation, Powys Teaching Health Board operates within a clearly defined framework of quality standards. These expectations are articulated through key strategic and legislative documents, including:

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

The Health Boards commitment to continuous improvement and organisational learning is underpinned by these guiding frameworks. Embedding the legislative requirements from 2023-2024, has been strengthened further the Quality Governance Framework. The *Health and Social Care (Quality and Engagement) (Wales) Act 2020* introduced enhanced responsibilities for all health and care organisations in Wales. Central to this legislation are the Duty of Quality, the Duty of Candour, and the establishment of the Citizen Voice Body. Together, these elements reinforce a culture of openness, transparency, and meaningful citizen engagement across the Health Board.

Embedding the Duty of Candour has been fundamental to fostering an organisational culture grounded in honesty and accountability. This

approach ensures the Health Board is transparent with service users and communities when care does not meet expectations or results in harm. Importantly, the Duty of Candour also serves as a catalyst for system-wide learning and service improvement, driving innovation and responsiveness.

The existing Quality Governance structure has remained robust throughout the year. The Patient Experience, Quality and Safety Committee continues to receive assurance reports and monitor escalated risks relating to patient experience, service quality, and safety.

Key components of the Health Board's Quality Governance arrangements include:

- The Integrated Quality and Performance Framework
- The *Putting Things Right* framework, encompassing Concerns, Incidents, Redress, and Clinical Negligence
- Clinical Audit programmes
- Data and benchmarking through CHKS and other healthcare intelligence tools
- Independent external reviews, such as *Getting It Right First Time*
- Professional supervision and regulatory compliance
- Organisational development initiatives and staff engagement surveys
- Strategic relationships and escalation pathways involving bodies such as Healthcare Inspectorate Wales and the Welsh Risk Pool.

Maintaining Focus on Quality in 2024/2025

In 2024-2025, the focus on quality has been sustained through several targeted activities:

- Enhancing the reporting and interpretation of quality metrics, supported by the rollout of the Integrated Quality Performance Framework (IQPF)
- Embedding our local escalation framework as part of the IQPF.
- Reporting progress from services across the Health Board through the Integrated Quality, Planning and Delivery Meeting (IQPD)
- Ongoing oversight of the Medical Examiner Service, particularly following service model changes introduced in September 2024
- Delivery of quarterly Integrated Quality Reports to provide a holistic view of performance, outcomes, and areas for improvement
- Quarterly reporting on the Duty of Candour and Nationally Reportable Incidents, including insights and learning drawn from these events.

The Health Board has continued to strengthen its formal response to concerns, guided by the *NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011* — widely recognised as the *Putting Things Right* framework. This process ensures that concerns are addressed in a timely, open, and constructive manner.

The Health Boards learning culture continues to evolve. Learning from concerns is now systematically captured and applied to improve services. The establishment of a Health Board-wide Learning Repository represents a significant advancement, enabling all staff to access

shared lessons from incidents and concerns. This system is supporting the embedding of learning into everyday practice and reinforcing a cycle of continuous quality improvement.

3.1 Health and Care Standards

The Health and Care Quality Standards replace the 2015 Health and Care Standards as set out in W HC/2023/013.The inclusion of quality directly aligns the standards with the Duty of Quality in healthcare | GOV.WALES introduced in April 2023 through the Health and Social Care (Quality and Engagement) (Wales) Act: summary | GOV.WALES. The standards set out the expectations for both provider and commissioned services and are aligned to the Health Board's Quality Management System and cross referenced as part of committee reporting, with associated risks and escalation raised.
Decisions should be based on the 12 Health and Care Quality Standards 2023:

The Duty of Quality Annual Report presents the progress made across the Health Board over the last 12 months. The report encompasses how the 12 Quality Standards are used across the Health Board, which helps deliver against the 6 quality domains. Safe, Timely, Effective, Efficient, Equitable and Person-centered (STEEP) care which are delivered through: Leadership, Workforce, Culture and Valuing People, Information, Learning, improvement and research and a Whole systems approach.

4.0 Learning from Experience Group – 2024/25 Update

The Learning from Experience Group continues to foster improvement across services. In 2024–2025, the group focused on several key areas:

Key Areas of Learning

- Do Not Attempt CPR (DNACPR) Policy:
  - Reviewed the newly published All Wales DNACPR policy to ensure consistent application across services.
- Medical Examiner Service:
  - Reflected on insights from the rollout of the Medical Examiner service to enhance the review process of patient deaths.
- Clinical Audits and Reflections:
  - Analysed findings from clinical audits and reflective practices to improve patient care.
- Quality Improvement in Mental Health:
  - Recognized and promoted successful practices within Mental Health services for adoption across other teams.

Ongoing and Future Work

- Enhancing Staff Induction:
  - Strengthening staff induction programs by integrating key learnings from past experiences.
- Improving Information Sharing:
  - Utilizing tools like 7-minute briefings for efficient knowledge dissemination.
  - Developing online forums to broaden the reach of shared learning resources.
- Upcoming Initiatives for 2025:
  - Inviting the antimicrobial pharmacist to share valuable insights.
  - Exploring the application of these learnings across primary care and community teams.

4.1 Engagement and Consultation

Engagement Work Key Themes

The Health Board has an ongoing programme of engagement in place, which includes close working relationships with Llais. This programme enables the Health Board to understand "what matters" to the people of Powys to help shape its plans and priorities for the people it serves.

Some of the key strands during 2024 and into 2025 included:

- Work with the Bevan Commission through a conversation with the public about the future model of health and care in Wales
- Ongoing engagement as part of the Better Together programme
- Focused engagement on a series of proposals for temporary change to health services, during which feedback was gathered about the specific proposals for temporary change as well as on wider opportunities and challenges for healthcare
- Listening and learning with Llais through their Llais Local Engagement
- Listening and learning with Powys Association of Voluntary Organisations through their Locality Networks

The key themes we heard during 2024 have been drawn together into an annual engagement report which informs the Health Board's Annual Plan. The key themes are summarised below.

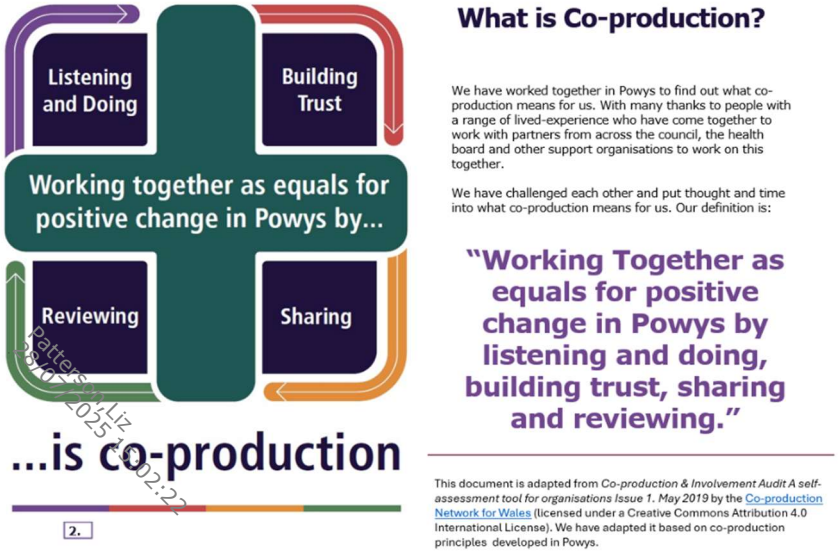
As well as work carried out directly by the Health Board, the Health Board works together as part of the Powys Engagement and Insight Network. This group is a sub-committee of both the Powys Regional Partnership and the Powys Public Service Board and brings together leads on engagement and insight from partner organisations to support a citizen-focused approach to engagement. Co-chaired by Powys Teaching Health Board (PTHB) and Powys Association of Voluntary Organisations (PAVO), a key focus for this group during 2024/25 was the development of a shared model of co-production to support a consistent approach that is increasingly embedded in organisational practice and decision-making. This has included the development of a Co-production Journey Tracker which is a simple tool to help services, groups and organisations find out where they are on their co-production journey. It can help to highlight strengths and support or training needs. This work has been informed and shaped by user voices who are central to this work.

The network is now developing six-monthly Community Insight reports to draw together findings from community engagement undertaken by all partner organisations, so that we can learn and share from each other's work and use this to drive our individual and collective organisational ambition on behalf of the people of Powys.

Towards the end of 2024-2025, a new phase of work on the Better Together programme commenced (Better Together: Shaping the future of safe, quality health services for Powys. | Have Your Say Powys). This programme aims to develop a shared understanding of the "case for change" based on the expert advice of health and care staff, and the needs and experience of the people of Powys. Initial engagement with health and care staff took place during February and March, with a period of engagement with the public commencing shortly after in April 2025. This will continue through the coming months, with an initial focus on developing options for the future of safe, quality community and adult mental health services for Powys.

In addition to Better Together work, other key engagement priorities for 2025/26 include:

- Review and evaluation of the temporary changes implemented in December 2024, with recommendations for the next steps due in July 2025.
- Engagement and consultation in relation to services in neighbouring counties that are accessed by Powys residents (e.g., forthcoming consultation by Hywel Dda University Health Board on their Clinical Services Plan).
- Continued engagement with Llais to hear patient and public voices.
- Further strengthening and embedding of the model for Co-Production including through participation in Co-production Champions Training in partnership with the Co-production Network for Wales.
- Aligning the Health Board's approach to community insight with the wider aspirations of the newly published People's Experience Framework.



Temporary Service Changes

The challenges facing the NHS

The NHS across the UK, and locally in Powys, faces a number of challenges to maintain quality, safety, outcomes and financial sustainability for patients and communities. Waiting times for planned care increased during the COVID pandemic and remained high. Inflationary pressures affect the whole of the public sector, increasing the costs of service-delivery. More people are living longer with multiple health conditions, and there are pressures on staffing, including that the proportion of people of working age is reducing. Powys Teaching Health Board therefore took some immediate steps to help maintain quality services within available resources. Following a series of events involving engagement with staff, and consultation with stakeholders and the public, the following temporary changes have been implemented:

- The implementation of temporary changes to Minor Injury Unit Services in Brecon and Llandrindod Wells is to open from 8am to 8pm for a six-month period, with evaluation and monitoring in place as set out in the Monitoring and Evaluation Framework.
- The implementation of temporary changes to community hospital model with Llanidloes and Bronllys as "Ready to Go Home" units and with a strengthened role for Brecon & Newtown to provide community inpatient rehabilitation for a six-month period, with evaluation and monitoring in place as set out in the Monitoring and Evaluation Framework.

The next steps will be: The Board will receive an evaluation of the temporary service changes and agree the way forward.

Engagement 2024 - Key Themes

Bevan Commission

1. Prevention, Early Intervention and Lifestyle
2. Shared Responsibility
3. Wider Determinants of Health
4. Communication
5. Services and Support
6. Workforce
7. Demographic

Background:

In autumn 2023, the Bevan Commission hosted a series of conversations – one in each Health Board area – to discuss the challenges facing the Welsh health and social care sector.

Seventeen people attended the Powys event in Brecon on 3 October 2023, and around 100 Powys residents completed an online survey.

Analysis of the key factors affecting the health and wellbeing of people and communities across the Powys locality were listed under seven themes.

Better Together

1. Access to services/Coordination of care
2. Communication/ Education/Information
3. Current/Future Services
4. Data/Evidence/ Research
5. Mental Health
6. Our ageing population
7. Relationships/ Partnerships
8. The prevention agenda
9. The role our communities play in supporting health and well-being
10. Workforce
11. Travel and transport in our rural county

Better Together Background:

In February and March 2024 the health board hosted workshops in the 13 Powys localities to start a conversation about the future of health services including the key challenges facing health in the county. Data and plans around key models of care like mental health, frailty, planned care were shared. Participant views and health care concerns were captured. 11 themes were identified.

Note: A model on Mental Health, workforce challenges and our ageing population were topics introduced as part of the workshop sessions with conversations ensuing so are listed as key themes.

Temporary Service Change

1. Travel and transport in our rural county
2. Communication/ Education/Information
3. Workforce
4. Access to services/coordination of care
5. Current/Future services (downgrading)
6. Workforce
7. Mental health (impact of changes on patients)
8. Civic pride in local community hospitals
9. Equality and wellbeing impacts
10. Engagement and Listening

Background:

During the Summer 2024 engagement took place on proposals for PTHB services including inpatient wards and MIUs. We we heard directly from nearly 800 voices in addition to thousands of interested individuals through online events, public meetings, visits to online engagement platforms and petitions.

Some of the engagement feedback echoed the key themes captured from the Better Together engagement. Some was more pertinent to the proposals. We also asked a question about the key themes and what respondents felt was missing in terms of health provision. Above are the key themes that respondents fed back.

Wider Issues (TSC survey)

1.Travel and transport in our rural county
2.Access to services/coordination of care
3.Our ageing population
4. The prevention agenda
5. Workforce
6. Relationships/ Partnerships
7. Communications/ Education/Information
8. Engagement and Listening
9.The Bigger Picture
10.Care Closer to home
11.Collaboration
12.Equity of Care for all

Llais Local Engagement

1.Access to services/ coordination of care
2.Travel and transport in our rural county
3. Communication/ Information/Education
4. Mental Health
5. Primary care
6. Current/Future services
7. Our Ageing Population
8. Civic pride in our local community hospitals
9. Praise for PTHB
10. The Bigger Picture

Llais Powys has 3 Priorities

- Care and support closer to home
- Getting good care wherever you live in Powys
- Supporting carers

Llais Powys Region has launched a programme of locality-based engagement across the county, visiting each of the 13 Powys localities in turn to gather insights from citizens' experience of health and care.

PAVO Locality Networks

- Transport to health & social opportunities
- Access to Primary health services
- Access to Dental
- Lack of Day Opportunities
- Social Isolation & Loneliness
- Financial concerns for individuals
- Changes to benefits for the elderly
- Access to appropriate housing
- Cross Border health access
- Financial concerns for 3rd sector due to lack of access to core funding and increase in NI contributions
- Lack of volunteers available

PAVO hosts 13 locality networks capturing views from the voluntary sector. They seek views on gaps which feed into the Social Value Forum and funding.

5.0 Bereavement Care and Medical Examiner Service

5.1 Bereavement Care

Following the Welsh Government directive, a survey of Bereavement Care in Powys was conducted which showed several gaps in the directive, Bereavement Care to the residents of Powys and therefore the Powys Teaching Health Board's Bereavement Service was established 2nd April 2024.

In 2019, the Marie Curie Palliative Care Research Centre, Cardiff University, and the Wales Cancer Research Centre, funded by the End of Life Care Board in Wales, undertook a Bereavement Scoping Survey in Wales.

The survey identified that the amount of bereavement support available varied significantly across Wales. The findings identified gaps in the provision of adult and children and young people bereavement services, in particular following the loss of children, infants and in pregnancy, pregnancy loss and stillbirth.

The National Framework for the Delivery of Bereavement Care in Wales, published in October 2021 sets out how in Wales we can respond to those who are facing, or have experienced, a bereavement.

The **framework** includes core principles, minimum **bereavement** care standards and a range of actions to support regional and local planning.

Its vision is for Wales to **be a place where everyone has equitable access to high quality bereavement care**

This framework seeks to set out how in Wales we can respond to those who are facing, or have experienced, a bereavement. Good bereavement support should be something available to everyone who needs it.

They said ....

We did ...

They Said:

- Health Boards are to report progress on implementation plans, including local needs assessments and collaboration with bereavement support providers.
- Implement Immediate Support Pathway for sudden and unexpected deaths in individuals up to age 25.
- Provide bereavement support to patients and families, including those affected by nosocomial COVID-19 incidents.
- Enhance support for individuals with Protected Characteristics.
- Gather feedback on the impact of bereavement support services.

We Did:

- Ongoing engagement with external support organisations.
- Delivery of bereavement training (Child Bereavement, Grief First Aid, Baby Loss).
- PRUDIC applied following unexpected child or young person deaths.
- Bereavement midwife support provided for baby loss; meetings underway to enhance maternity bereavement support and establish a mothers' group.
- Strong links established with hospices in north and south Powys.
- Bereavement resources (packs, posters, leaflets) distributed across the Health Board, in English and Welsh.
- Bereavement information is available on the Health Board website.
- Bereavement questionnaire launched via CIVICA and shared through social media, websites, and GP QR codes.
- Regular bereavement roads shows to begin countywide from end of May.
- Medical Examiner process in place, with learning shared via mortality review panels and internal learning platforms

5.2 Medical Examiner Service

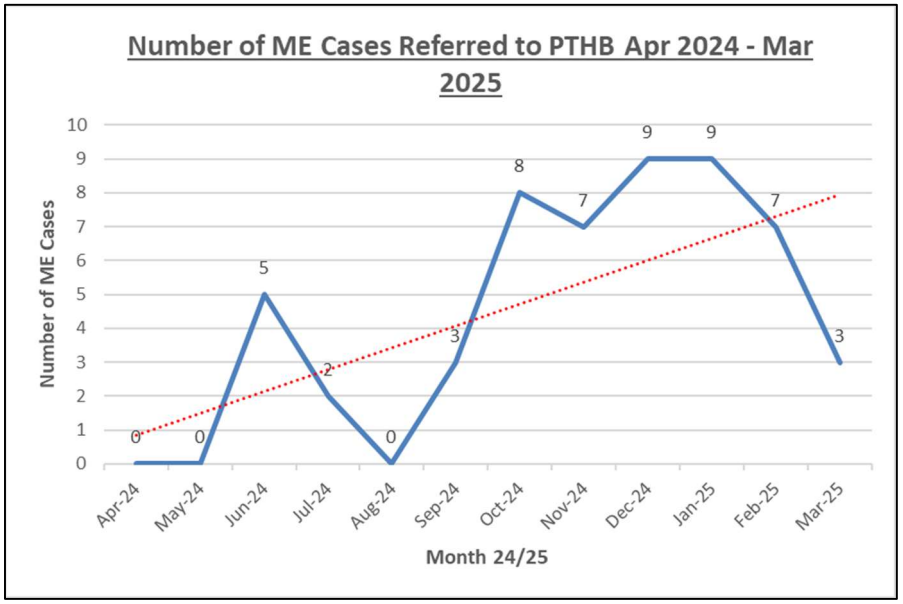
In line with government requirements, Powys Teaching Health Board is working closely with the Medical Examiner Service. The medical examiner is a senior doctor not involved in the care of the patient, who provides an independent scrutiny of each death. This service allows the cause of death to be more accurately identified, and the circumstances surrounding the death to be more objectively assessed.

The medical examiner's officers contact the deceased's family in the days following the death. They will discuss with them the cause of death and listen to their views on the care provided. They can answer any questions the family may have about the cause of death and the circumstances of the death.

For further details about the service please access the link below:

Medical Examiner Service - NHS Wales Shared Services Partnership

ME referrals 2024 - 2025:
Since the changes to the ME service on 9 September 2024, there has been a marked increase in the number of reports received by the Health Board. The data indicates that the number of reports has nearly doubled compared to previous months.



Care Provided by Other Health Boards
Some of the issues raised in Medical Examiner (ME) reports relate to care delivered by other Health Boards. As Powys Teaching Health Board commission services for residents, we receive these reports, even when the care was provided elsewhere. In such cases, those Health Boards are responsible for addressing any concerns.

Care in Nursing Homes
Of the 53 ME referrals received, 12 involved Nursing Homes, which are managed by the Local Authority. Any concerns are shared with them to ensure appropriate follow-up and learning.

6.0 Mental Health Services Update – De-escalation and Improvement Progress

Since March 2024, Powys Teaching Health Board's (PTHB) Mental Health Services have been under internal escalation (Level 2a) to address several areas for improvement. Following the implementation of a focused Improvement Plan and strong progress across priority areas, the Executive Committee agreed to de-escalate internal escalation status from 16 October 2024. This decision reflects the Mental Health and Learning Disabilities Service's commitment to learning, improvement, and providing safe, effective care.

Key Improvements Made

- **Patient Safety**: Overdue incident reports reduced from around 480 to 67, with reviews now happening on time.
- **Care & Treatment**: Audits have been completed across teams, and targeted training plans are now in place.
- **Training & Development**: A full workforce training needs analysis has been completed, with future plans mapped out.
- **Governance**: Team leadership structures and clinical governance have been strengthened.
- **Workforce Stability**: Recruitment challenges have been addressed, including full staffing on Tawe Ward.

Ongoing Positive Developments

- As part of the All-Wales Strategy for Mental Health, PTHB is **piloting suicide risk assessment training** in Wales.
- Leading a **Community of Practice for Community Mental Health Teams**.
- Actively engaged with the national **NHS Patient Safety Programme**.
- **New team bases** for Adult and Older Adult CMHTs in Newtown and Llandrindod Wells are underway.
- The **Single Point of Access (SPOA)** model continues to develop and improve.
- It is hoped that the new Care and Treatment Plan (CTP) Lead role will be sustained to continue to support teams across Powys with Bi-monthly CTP audits.

Powys Teaching Health Board remains committed to maintaining these improvements as part of everyday practice, ensuring high standards of care and support for people across Powys.

7.0 Duty of Candour

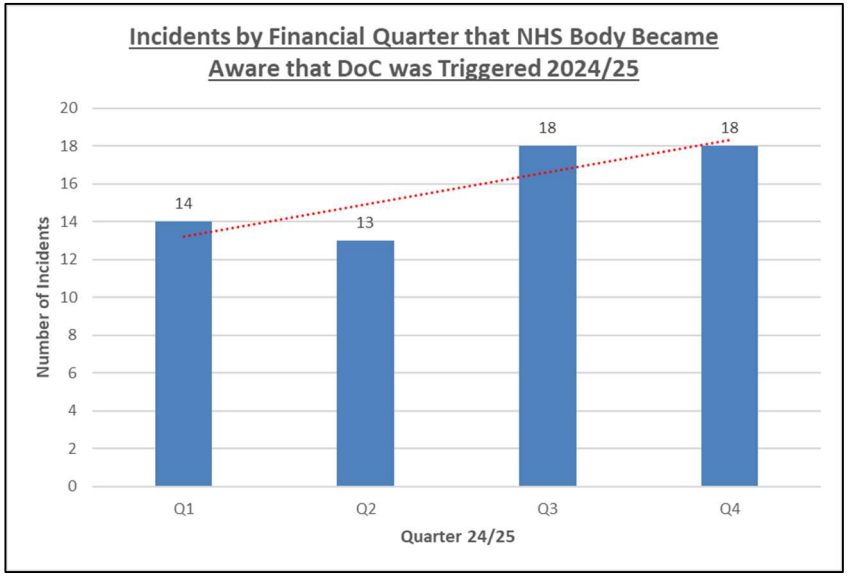
The Duty of Candour is a legal requirement for NHS bodies in Wales to be open and honest with service users receiving care and treatment. The duty stems from the Health and Social (Quality and Engagement) (Wales) Act (2020) and became operational from 1 April 2023.

Powys Teaching Health Board strives to provide high quality, safe and compassionate care to all service users. However, even when staff do their best, service users may sometimes experience harm. That is why the Duty of Candour was introduced.

The Health Board's goal is to create a culture of trust and openness, so that service users feel confident in the care they receive.

To follow Duty of Candour the Health Board will:

1. As soon as we know that Duty of Candour applies, contact the person affected or someone acting on their behalf. This will be done in person, either by phone, video call, or face to face.
2. During this conversation, say sorry, explain what it knows so far, offer support, outline what will happen next, and give contact details for further help.
3. Within five working days, send a letter confirming what was discussed
4. Carry out an investigation to understand what happened, why it happened, and how the Health Board can stop it from happening again.
5. This process will follow the NHS Wales Putting Things Right procedure (Putting Things Right Leaflet).



In 2024/2025, Duty of Candour was triggered 63 times and several areas for improvement were identified to ensure safer, more inclusive, and effective care across services. Key themes include:

1. Inclusive Communication and Access
Interpretation services must be offered when English is not a person's first language.
Family members should not be used as interpreters.
Electronic tablets have been placed in all birth centres to support access to interpreter services.

2. Safe Maternity and Antenatal Care
Staff reminded to carry out full antenatal assessments and to follow guidance when women report contact with infections.
Missed vaccinations due to medicine shortages highlighted the need for weekly stock checks in birth centres.

3. Falls Prevention and Enhanced Care
Staff are reminded of their responsibility to maintain 1:1 care to reduce fall risks.
Training and expectations for staff providing enhanced care have been reinforced.
Post-fall observations and risk assessments must be completed and updated as needed.

4. Medication Safety
Medication ward rounds must be completed in a dedicated space with no interruptions to reduce errors.
Mental health wards will review medication administration errors in team meetings to support learning.

5. Administrative Accuracy
Letters and reports are double-checked before posting to avoid communication errors, especially within the Integrated Autism Service.

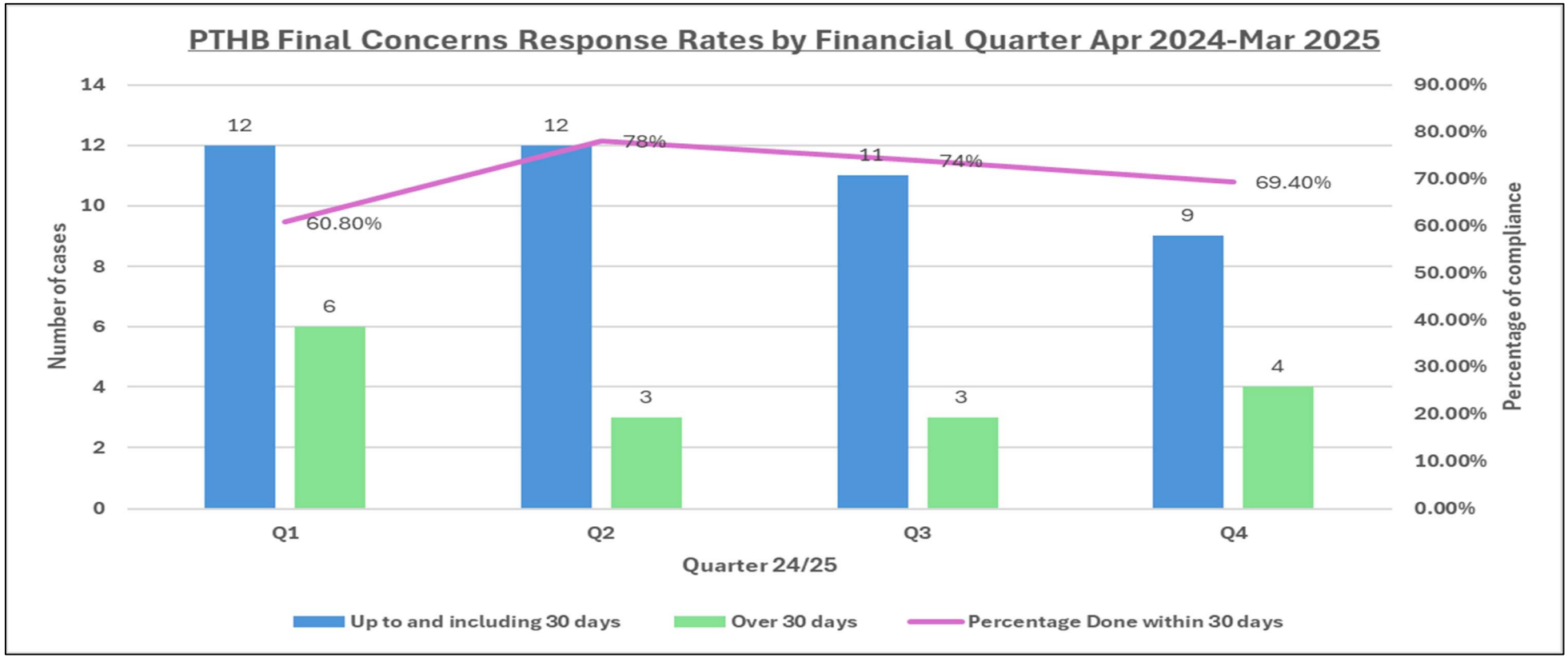
6. Staff Training and Planning
Staff must complete agency inductions and comply with mandatory training.
Nurse leaders must ensure staff are appropriately allocated to duties during each shift.

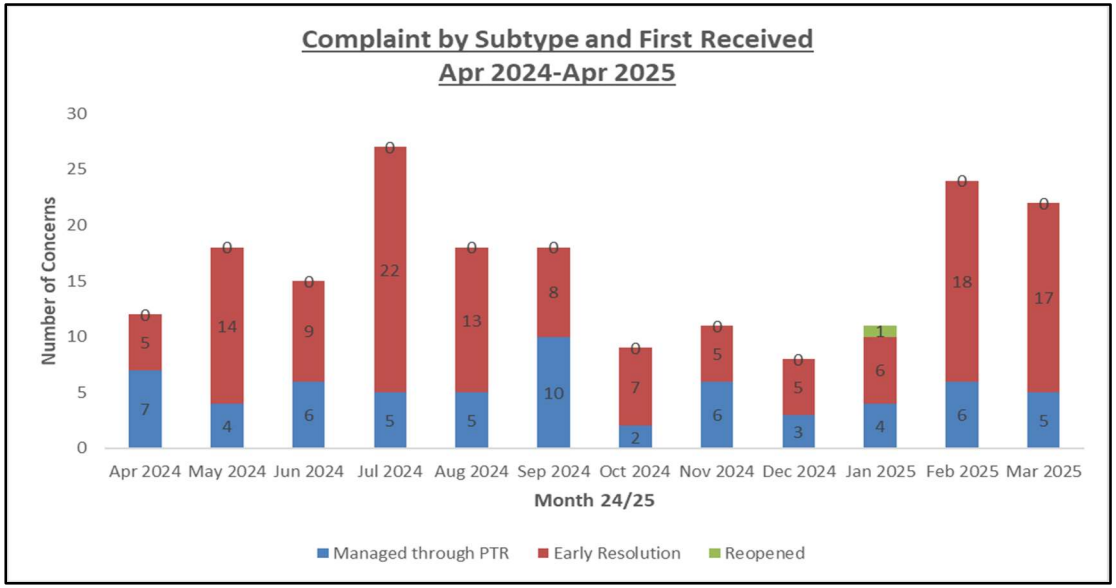
7. Improved Patient Assessment and Risk Management
All patients must have a full risk assessment on admission.
Deprivation of Liberty Assessments and documentation must be up to date and audited.

8. Clinical Pathway and Emergency Care Improvements
Pathways from Minor Injury Units to hospitals are being reviewed.
Continued focus on the management of deteriorating patients, including pain management and response to sepsis.

8.0 Putting Things Right (PTR) – Concerns Management

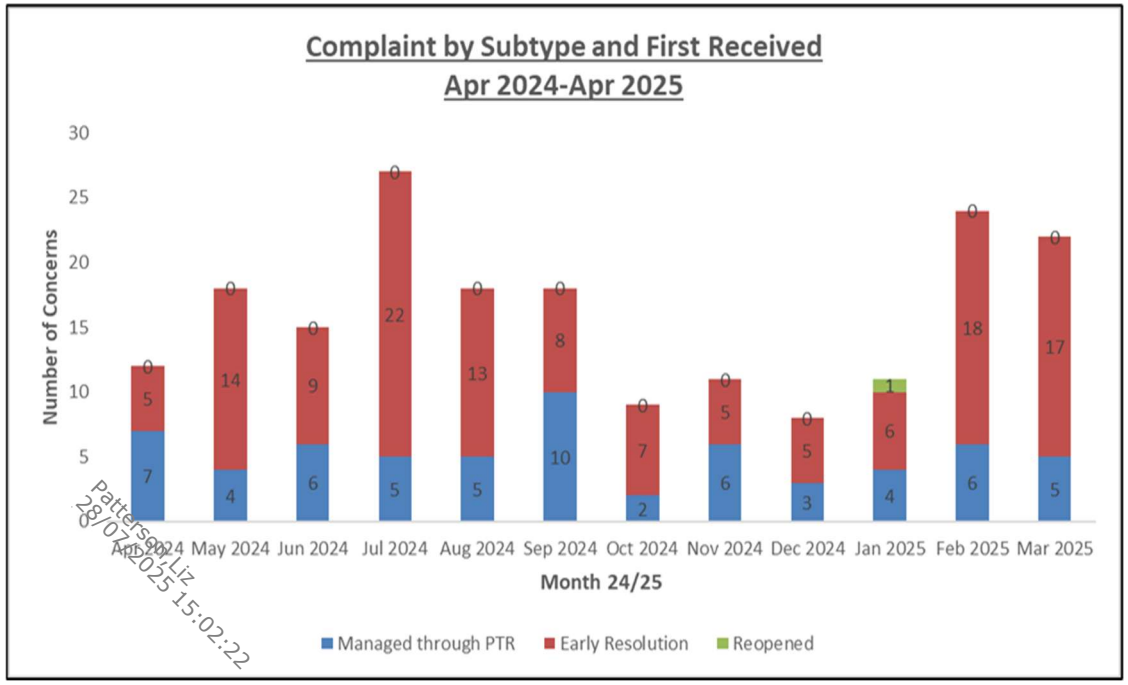
At the end of 2024/25, Powys Teaching Health Board (PTHB) reported a 70.5% compliance rate for responding to concerns within 30 working days, which is slightly under the national average of 75%. While this is positive, the organisation faced challenges when managing complex cases involving multiple Health Boards or Trusts, which impacted overall performance.





Key Trends:

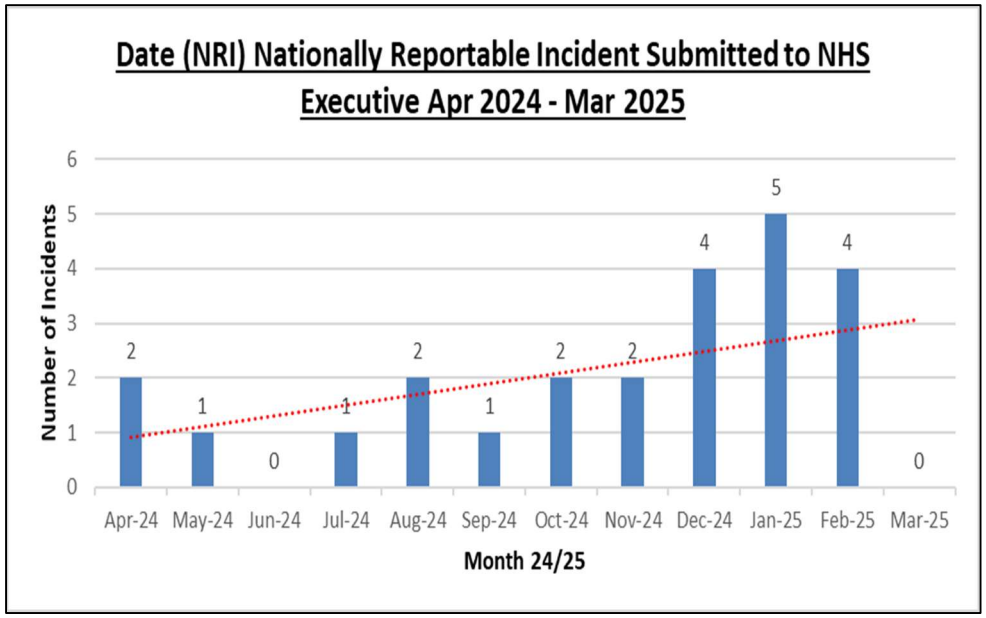
- Most concerns are resolved through Early Resolution, suggesting effective front-line handling.
- PTR managed complaints remained relatively stable, averaging 5 to 7 per month.
- A single concern was reopened in January 2025, indicating mostly satisfactory outcomes.



Key Themes:

- Clinical & assessment.
- Attitude & behaviour of staff.
- Availability of rehabilitation equipment.
- Communication with relatives/family/next of kin.
- Discharge issues
- Appointments cancellations and delays in planned care.
- Delays with prescribed medication
- Access to Orthodontist services outside of Powys.
- Access to Dental services across Powys

9.0 Nationally Reportable Incidents (NRIs)



Serious incidents are reported to the NHS Performance and Improvement (Formally NHSE) if they meet the reporting criteria for Nationally Reportable Incidents. During 2024/25 PTHB reported a total of 24 incidents from all services across the Health Board.

PTHB on average took 190 days to complete NRI investigations, complicated by:

- Capacity of services to complete investigations
- Delays in obtaining information from commissioned organisations involved in patient safety incidents.

Focus for 2025/26 will be to improve:

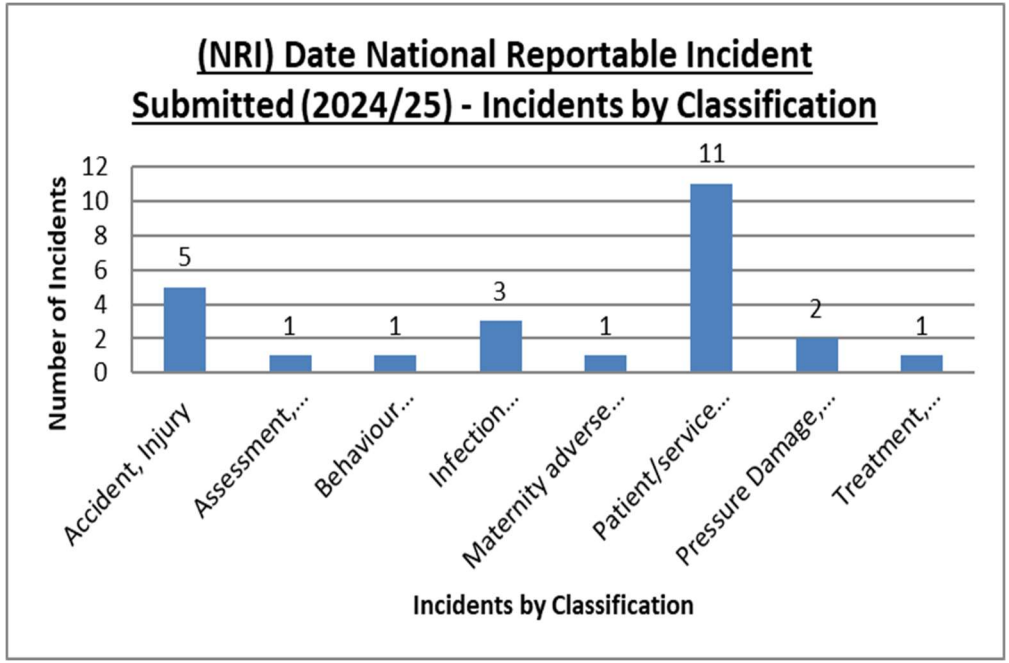
- Staff training on investigations
- Staff support during incident management
- Timely reporting on investigation outcomes to families and the NHS Performance and Improvement.

Themes from NRI incidents throughout the year included:

- Accident and injury
- Assessment
- Behaviour
- Hospital acquired infection
- Maternity adverse event.
- Unexpected death of an individual known to mental health services in the 12 months prior to death.
- Treatment

All incidents were robustly investigated, resulting in action plans and learning events for services.

All NRI incidents are automatically treated as Duty of Candour events requiring engagement with patients and their families, ensuring their contribution and opportunity to ask questions in Health Board investigations, post incident support and timely updates on outcomes and next steps.



10.0 Patient experience

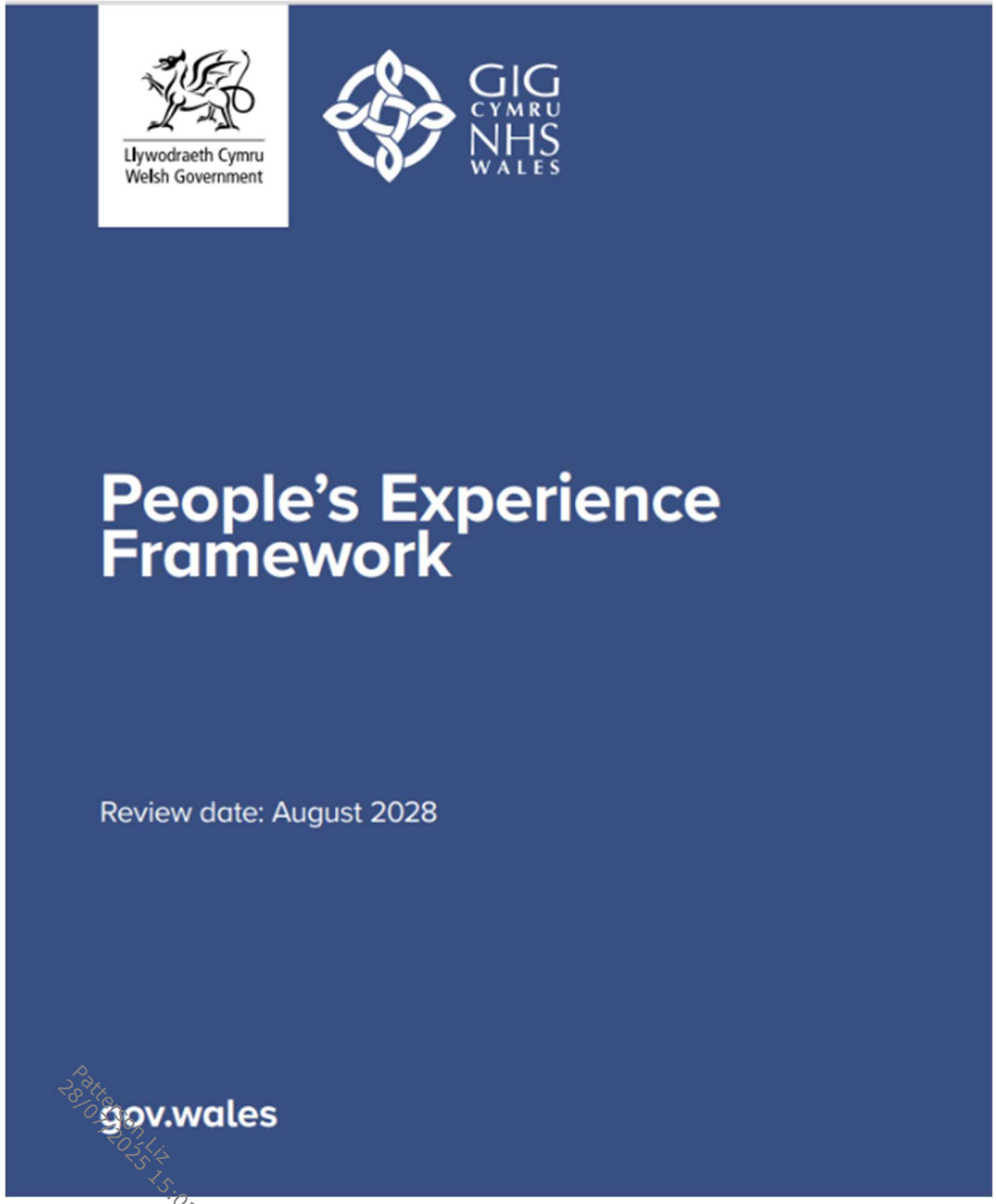
Receiving real-time feedback from patients/carers/family, whether positive or negative, supports continual improvement in the services provided, including commissioned services thus ensuring service decisions are made including those thoughts and experiences.

Since 2022, when the Health Board implemented the CIVICA Patient Experience Survey System, services have been able to use the feedback received to:

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

Results from the CIVICA patient experience survey system for the Your NHS Experience Survey during 2024 to 2025÷

A total of 1147 Your NHS Experience Survey responses were received (1 April 2024 to 31 March 2025)			
	87.47% scored their experience as "Excellent" (5 and above)		70.57% stated they always felt cared for
	70.82% felt they were always listened to		74.03% said that the time they waited was either shorter than expected or about right
	40.82 % felt they always had assistance when they needed it		68.37% always understood what was happening with their care
	71.19% said explanations were always given in a way they could understand		68.50% always felt they were involved as much as they wanted to be in decisions about their care



In April 2025, Welsh Government launched the People Experience Framework (People's experience framework: guidance for NHS Wales | GOV.WALES).

The aim of the framework is to "empower organisations to evaluate their current position and to develop an ambitious improvement plan for people's experience through a Value lens".

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

As part of the framework, there has been a refresh of the Your NHS Experience Survey which will change to the People's Experience Survey from April 2025

10.1 Patient Stories

Patient stories are an invaluable method of bringing the patients voice to the center of healthcare planning and improvement. The Framework focuses on understanding what matters to people – their needs, values, and experiences. Patient stories highlight these personal experiences in a powerful and relatable way, helping Health Boards to see care through the eyes of the people that use it.

They help Health Boards to understand the care they provide from a patient's point of view, something that data alone is unable to capture. Real experiences help us to understand what works well and which areas need improvement, they give the patient a voice and remind staff why their work matters, while supporting a patient-centered approach to care. Sharing patient stories reinforces the importance of compassion, communication and continuous improvement in healthcare delivery.

10.2 Powys Maternity Service

Powys maternity services use several ways to gain feedback to improve performance. Social media is utilised to share birth stories, feedback, and public health messaging as well as advertising antenatal classes. The reach of social media is monitored monthly and continues to grow.

Learning from feedback is shared through 'you said / we did/listened posters'. An example of you said/we did is:

You Said:
Some of you were disappointed with the lack of continuity at times in your care, you reported that sometimes care has felt dis-jointed.
Some of you noted that there were periods of time where it was evident we were short staffed and some of you felt that this impacted on you developing a trusting relationship or that the midwife did not fully understand your needs.

We Listened:
We are sorry that we have had some periods of sick leave within the maternity team. When this happens, your care will need to be picked up by another member of the team to ensure that you are seen at the appropriate points in your pregnancy or postnatal care. We are sorry that sometimes this means you will see different midwives. In 2025, we have been completing some philosophy and physiology training with all midwives. In the sessions we talk about the evidence supporting continuity models of care. All staff will have attended by June 2025.

We have also re-established the 'buddy system' within each team. You should expect to have a named midwife and a 2nd 'buddy' midwife who you will also meet during your care. This means two people should review your care plan and get to know you in the hope that if your named midwife is not available the 'buddy' would try to see you. Wherever possible we aim to have a handover of care if needed so that any important information is handed over to a new midwife.

Sometimes postnatal care visits may need to happen when your named midwife or 'buddy' are not working. We are committed to ensuring continuity with a different midwife should this happen.

Patient Experience

- Powys maternity is one of three trial sites for the launch of the All-Wales Perinatal Experience Measures (questionnaires) through the Patient Experience Survey System (CIVICA) which will launch on 1st April 2025. These will replace the Powys Teaching Health Board surveys.
- The changes will mean that women who birth outside of Powys will not receive a survey from Powys to ask for feedback related to labour care out of Powys as this feedback will be obtained by the hospital they birth in if in Wales. The service is considering how best to obtain feedback form women who give birth in England. The feedback from core questions will feed into the national dashboard enabling monitoring and comparison across Wales.

Birth stories

Social media continues to be utilised with a consistent rise in views and subscribers to the pages. Birth Stories are shared on these pages, promoting births in Powys with 15 birth stories submitted over a 14-month period.

The service proactively contacts families who have been transferred from home or a birth centre, with an opportunity to provide feedback about their experience.

10.3 Children's Neurodevelopment Service

Gwasanaeth Niwroddatblygiadol Plant
Children's Neurodevelopmental Service

The Children and Young People (CYP) Neurodevelopment Service was launched the 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 Neurodevelopmental pathway and its standards now offer CYP diagnostic assessment for both Autism 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.

A transformation program of work commenced during 2024/25 to review the whole service provision. This aligned to the implementation of Co-production activity facilitated by Parents and Carers Voices in Wales to ensure service were informed by service users and their experiences. The co-production activity has included partners in Powys County Council Education department to ensure the child remains the focus of all services and is at the heart of any service developments.

Additional in-year funding was received from Welsh Government during Quarter 3 2024/25 to address the longest waits which were >4 years at that time. The funding enabled the team to provide additional capacity along with procured activity which resulted in the longest wait reducing to 2 years.

Continue transformation and service redesign will continue into 2025/26 to ensure a sustainable need-led service for children is in place and able to meet demand aligned to a whole system approach.

10.4 Child and Adolescent Mental Health Services – CAMHS

Supporting Children and Young People in Powys

Several key achievements and improvements have been made in CAMHS services across Powys during 2024-2025. There includes a focus on mental health crisis support, parenting programmes, and the impact of training for staff to ensure families receive the right help, at the right time, in the right way.

The CAMHS Crisis Service was launched in March 2024. This service offers fast and flexible mental health support for children and young people in crisis. Children and young people receive the help they need at home or in the community, potentially avoiding attending A&E or staying in hospital.

What we did	What changed	What people said
Offered 304 mental health assessments during 2024-2025. Support contacts grew each month, from 68 in April 2024 to 372 by February 2025.	A&E visits for mental health support by children and young people dropped by 21% (Sep–Nov) and 27% (Apr–Nov) compared to 2023-2024.	Families reported they felt safer and more involved in decisions. With easier access through 111, children and young people receive quicker care, avoiding hospital trips unless absolutely necessary.

Parenting Support – Helping Families Thrive

CAMHS parenting practitioner supports parents and a carers by working closely with local services and schools to identify where help is needed most. This includes running programmes for parents and carers of children with autism and helping families build stronger, more positive relationships.

Autism Parenting Programme Results (Sept–Dec 2024):	What changed	What parents said
Offered 5 parenting groups 32 parents joined, 26 of whom completed the full course (81%)	Children and young people stress scores dropped (average score fell from 23.9 to 19.2) 30% of children and young people scored below the level considered a concern after the course	"My confidence has grown. I enjoy parenting again." "We feel more connected as a family." "I wish we had found this support sooner."

CAMHS Staff Training – Building Knowledge and Confidence

Feedback from Training Participants:

Staff found that the most useful part of the training was hearing real-life examples, engaging with the trainers, and peer discussions. The training also meant that staff felt more confident and better equipped to support families

Looking Ahead

During 2025-2026 the CAMHS service will be looking to:

- Expand the CAMHS Crisis Service so more young people can benefit
- Build stronger parenting support with even better access
- Continue improving our training to meet staff needs

Together, Powys CAMHS are working to make Powys a place where children, young people, and families feel supported, valued, and heard.

10.5 Outpatients and Waiting Well

Outpatient Services across Powys Teaching Health Board have embedded the CIVICA Patient Experience Survey System to collect feedback relating to one-to-one appointments. Service users are able to provide feedback via QR codes and through the use of iPads which are available in each outpatient unit. The surveys consistently show that service users feel listened to, that they can make joint care decisions and that their care reflects what is important to them.

The feedback is reviewed monthly and shared with the team via email and at service audit days. Feedback has influenced service development across the Health Board using the "You said" "We did" proforma.

"You said"

It would be good to have the ability to get a hot drink, especially when there is a longer wait in clinics.

"We did"

Collaborative working approach with hotel facilities staff has resulted in the installation of hot drinks machines across the sites, enabling patients and families who attend the hospital to access hot drinks.

Learning from patient feedback led to the development of an Outpatient Learning Disability Care Bundle in collaboration with the Learning Disability team and the Paul Ridd Foundation. This Outpatient Care Bundle is the first of its type in Wales and enables staff to work with patients who have additional needs to plan their clinic visits, ensuring all needs are met, improving patient and family experiences. Feedback from service users has been extremely positive.

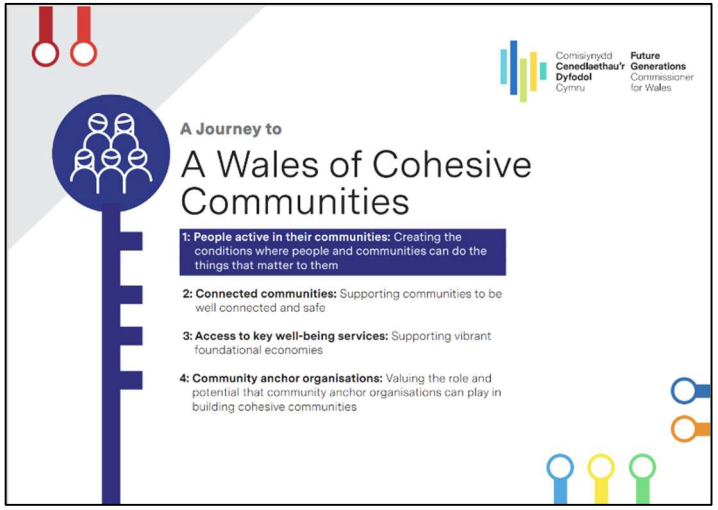
"My daughter has learning difficulties and autism. Staff and consultant very caring, explained everything to her in a way she understood and treated her like an individual, most people just speak to me. Wonderful experience and as a family very appreciative of care provided."

In 2023 the Outpatient Team across Powys Teaching Health Board embedded a pre appointment triage phone call with service users. The aim of these phone calls is to develop relationships prior to clinic appointments. This has enabled staff to identify service users who require additional support during their appointment and to plan their visit in accordance with their needs. These conversations have promoted the development of the nurse-service user relationship and has fostered joint decision making. This service has also led to a reduction in the clinic DNA (did not attend) rate to 3.8%.

"I felt that I was listened to and was given plenty of time for my appointment. The staff were extremely friendly and caring towards me. I was given a lot of options and information about my care."

10.6 Powys Living Well Service (PLWS)

The digital team in the Powys Living Well Service won the "Cohesive Communities Wales Award" at the first NHS Wales Sustainability Awards in 2024 for their partnerships with Powys County Council Libraries and Accessibility Powys. The partnership work, under the title of "Breaking Down Barriers - Supporting people to access digital healthcare in rural Powys" involves providing digital support to service users across Powys ranging from reassurance and coaching on using technology through to arranging loans of iPads from a local library or even providing individual support within their home. In all cases, their approach seeks to reduce the stigma attached to requesting support. All support provided is free to access and is available to anyone engaging with the Health Board, regardless of their health condition or socio-economic situation.



The service was also shortlisted in the "Healthier Wales Award" category at the NHS Wales Sustainability Awards in the "Person Centred Care" category at the 2024 NHS Wales Awards, for their work in delivering a co-produced service to support people in Powys experiencing long-term health conditions. Over 95% of people using the service state that they feel involved in the decisions about their care, leading to a better experience and better outcomes. By taking a Digital First approach, the service has reduced the typical waiting time for first appointments by 50% and driven a significant reduction in their environmental impact by reducing the need for travel and the volume of materials being printed, whilst delivering accessible and person-centred care.

10.7 Therapies and Health Care Sciences

Therapies and Healthcare Science Services capture patient feedback using questionnaires on Civica (Patient Experience Survey System). The response rate was initially low in all services, so in March 2025, Muscular Skeletal Physiotherapy (MSK) implemented a text message when patients were discharged from the service with a link to the patient experience questionnaire to capture their feedback. This had a significant impact on the number of responses received.

The responses received during 2024-2025 showed 95.76% would recommend the service to others and 89% were either satisfied or very satisfied that the service met their needs.

Some positive feedback on the MSK Physiotherapy service included:

"The physiotherapist has really helped my mobility, and I was shown and helped by being shown all the best exercises" and

"My physiotherapist was all that you could wish for. He listened carefully and was specific / clear when giving instructions."

A new Frailty Allied Health Professionals service was implemented during 2024-2025. This service supports people staying well at home, early discharge from hospital and helps to prevent unnecessary hospital admissions. The service has received a number of positive comments, examples include:

…. was excellent during the visit to our home today. Explained how the services were available and has arranged a further visit next week. It was nice to have someone who listened and was sympathetic to my wife's problems. Thank you.

…A very nice young lady she helped with choices on what pieces of equipment would be to my advantage. 10 out of 10.

…Practitioner was lovely and very caring really appreciated the service

…Today has been helpful. I was not sure what this would be about, and I was a bit anxious, but you put me at ease right away. I would recommend this service it has been wonderful.

In April 2024 the Orthotic service transferred to the Therapies Hub to support their appointments and arrangement of appliances. Their Did Not Attend (DNA) rate in 23/24 was 10.45%. Following the introduction of text reminders for appointments DNAs have significantly reduced to 5.25% in 24/25 as patients have the option to cancel their appointments if required and the Therapies Hub are able to utilise cancelled slots. This has improved service efficiency, and several positive compliments have been received including:

A patient's daughter called into the Therapies Hub today and explained to another member of the team that the patient had sadly passed away at the weekend. She wanted to express her gratitude and thank the member of staff personally for their help with her father's appointments in such a kind and helpful manner.

Following the successful implementation of an online form for Audiology service users to request replacement batteries and tubes, Lymphoedema have implemented a similar form for patients to request additional prescribed garments. Feedback from the Service Lead has noted that the form is working well. This not only makes it easier for patients to request new prescriptions, but it also helps staff and the service to handle demand more effectively and efficiently.

Speech and Language Therapy (SLT) have implemented national Therapy Outcome Measures (TOMS) which review impairment, activity, participation, wellbeing and carer wellbeing. This has been supported by the Royal College of Speech and Language Therapy with an online tool (ROOT) to help the service capture the data. From the data collected to date for the adult SLT service, 58% have improved in their impairment score, 55% in their activity scores, 43% in their participation and 43% improved in their wellbeing.

10.8 Dementia

The All-Wales Dementia Care Pathway of Standards superseded the previous Dementia Action Plan for Wales in 2022. The Standards were developed with over 1800 people in Wales to establish what people believe will make a positive difference to dementia care in Wales. Powys Teaching Health Board have worked collaboratively with Powys County Council and third sector partners to embed the standards and improve dementia care in Powys (Dementia Care - NHS Wales Executive).

Four task groups were developed to progress the requirements of the Dementia Care Pathways of Standards with their focus being on community engagement, memory services including learning disabilities, the Dementia Friendly Hospital Charter and workforce and organisational development.

The outcomes of the task groups have meant that:

- Engagement projects in an identified community established what good dementia care meant to that community. The group also engaged with communities across Powys to develop a job description for a new Dementia Navigator role which will commence in May 2025.

- Memory services saw an increase in diagnostic rates and a reduction in waiting times for a diagnosis of dementia. Prevention and intervention programs have also commenced to support families following diagnosis. The feedback from people who have attended these services has been very positive and teams are working to ensure there is a consistent offer across Powys.

- The Dementia Friendly Hospital Charter focused on developing dementia friendly environments with wards being decorated in dementia friendly colour schemes to support orientation. Bronllys Hospital Outpatient's Department was decorated in a colour scheme to support living with dementia who have commented about the positive effect this has had when visiting outpatient clinics. Plans are in place to replicate the improvements in all outpatient department and ward corridors.

  Meaningful activities on the wards enhance their admission and keep people active and involved during their stay and reduce the risk of de-conditioning and prolonged admission.

- The workforce group has focused on dementia training and has seen dementia awareness training for staff mandated in eight departments across the Health Board. Powys Teaching Health Board have also worked in partnership with local authority colleagues to develop a digital training resource in a dementia e-book, which will give staff the skills they need to support people living with dementia. This will be rolled out in 2025-2026.

At a national level, Powys Teaching Health Board are involved in developing the next Dementia Action Plan for Wales with the NHS Executive team, this is due to be launched late in 2025 or spring 2026.

Improvements to Bronllys Outpatient Department:

As part of the Dementia Friendly Hospital Charter work, the Health Board is looking at the environment that people living with dementia may come into contact with. This started in early 2024 with the refurbishment of the outpatient's corridor at Bronllys Hospital. This new environment scheme will be rolled out to all Powys Teaching Health Board ward and outpatient corridors during 2025-2026.

The Dementia Friendly Hospital Charter requires that "*the environment is comfortable, empowering and promotes independence. Hospital planning and maintenance incorporates dementia friendly areas and there is support from all departments to design, achieve and upkeep them.*"
Principles of the environmental section of the charter include:

- People living with dementia and staff work together.
- Signage, symbols, and markers support navigation and are consistent throughout a region's hospitals.
- Adaptations are made to support people living with dementia.
- The environment helps people to see, hear and communicate better and promote independence.

Colour schemes also support people who are neurodivergent and living with a visual impairment.

11.0 Safeguarding

Powys Teaching Health Board is committed to ensuring safeguarding is part of its core business. The Health Board recognises that safeguarding children and adults at risk is a shared responsibility that requires all our employees to have the competencies to safeguard people, and can develop strong, effective joint working relationships with our partner agencies and colleagues.
Our vision is that Powys residents live their lives free from violence, abuse, neglect, and exploitation. The Health Board will promote the United Nations Convention on the Rights of the Child, Human Rights, and the United Nations Principles for Older Persons in all its work.

Measuring the effectiveness of health services and their contribution to safeguarding adults and children is difficult and complex. Annually, Powys Teaching Health Boards Safeguarding Service coordinates the completion of an NHS Wales Safeguarding Maturity Matrix (SMM) self-assessment which enables scrutiny of the effectiveness, innovation, quality, learning and risks within safeguarding and leads to the development of a safeguarding improvement plan. There are 6 Standards within the assessment tool:

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

Powys Teaching Health Board's SMM self-assessment & improvement plan is shared with the National Safeguarding Service, where it contributes to a National Safeguarding Report to the Chief Nursing Officer in Welsh Government. Capturing a national overview of safeguarding helps drive improvement, horizon scan, informs the NHS Wales National Safeguarding Service key priorities and shares best practice.

Powys Teaching Health Board's 2024-2025 Safeguarding Maturity Matrix Improvement Plan has been reported on quarterly to the Health Boards Safeguarding Strategic Group. Most of the actions have been completed, any that remain open will be reviewed and where applicable, carried forward into 2025-2026.

12.0 Recommendations from External Reviews and Inspection

Health Inspectorate Wales

During 2024-2025 Health Inspectorate Wales (HIW) undertook 2 inspections of services at Clywedog Ward, Llandrindod Wells Hospital Team Llandrindod Wells County War Memorial Hospital | Healthcare Inspectorate Wales and Newtown Community Mental Health Newtown Community Mental Health Team | Healthcare Inspectorate Wales

Clywedog Ward

Health Inspectorate Wales recommended that the service could improve in the following areas:

• Ensure structured therapeutic activity provided for service users
• The environment of care issues are addressed.

HIW reported service was responsive to patient worries with opportunities for patients and their relatives to provide feedback and raise any concerns.

Overall, HIW found the ward environment to be calm and quiet, with positive and respectful interactions between staff and patients noted. All patients that we spoke with agreed that staff treated them with dignity and respect. However, the ward lacked environmental stimuli.

Newtown Community Mental Health Team

Health Inspectorate Wales recommend that the service could improve in the following areas:

- Ensure a person centred and empowering approach to the provision of care and support is fully embedded across the service and that care documentation consistently reflects service users' views on how they wish to be cared for
- Ensure all service users and their carers are aware of how to access support and advice outside of normal office opening hours
- Ensure service users are offered the option of receiving service through the medium of Welsh and that this is consistently recorded within care notes
- Update the Community Mental Health Team (CMHT) web page to ensure the information reflects the CMHT's current address and contact details.

They also reported that the service did well in the following areas:

- Single point of access to services
- Service users' involvement in the assessment and care planning process
- Availability of health promotion material to include smoking cessation advice and support

Overall service users spoken with during the inspection were generally satisfied with the care and support that they received. They felt listened to and that their views and wishes were considered during the care planning process. Service users reported generally satisfactory experiences when accessing services and that they were involved in the assessment and care planning process. The report did note that care documentation did not always reflect the person-centered planning and provision, and service users' views were not always consistently recorded within care treatment plans.

Welsh Risk Pool

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

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

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

NOTES

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

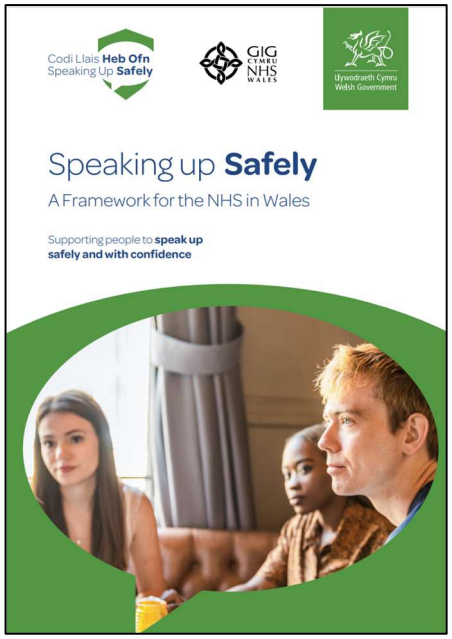
Through embedding of further processes, outlined in the existing recommendations to monitor compliance with incident management principles, the Health Board can expect to increase assurance in this area also.

The review found that there were still challenges in the timely closure of National Reportable Incidents (NRI) and Duty of Candour (DoC incidents, however, the quality of the outcomes had improved. The Assessment noted recommendations from the previous review which had not been addressed. The overall Assessment noted positive, sustained changes in practice. Putting Things Right (PTR) was considered to be led by the small Corporate Quality and Safety Team to a high standard, with several areas of exemplar practice identified.

Ten recommendations were made (including three previous recommendations to be completed), which have been incorporated into a Health Board action.

13.0 Speaking up Safely Framework

The Speaking up Safely Framework was circulated to NHS Wales Chief Executives at the end of August 2023. The purpose was to support Health Boards to reflect on their quality and safety systems. The Framework was in response to high-profile cases, which served as a stark reminder of the requirement to ensure that everyone working in the NHS feel safe and confident to speak up about anything that gets in the way of delivering safe, high-quality care.



In response, the Health Board established a working group to carry out the internal action plan which was created to meet the thirteen requirements in the Speaking Up Safely Framework. Over the past twelve months most actions have been completed and there remains a clear commitment to the ongoing development of a culture where staff feel safe to raise concerns. The actions through the last year have been:

- Development of the 'Our Voice' portal as a single place where staff can raise concerns.
- Development and delivery of a specific Speaking up Safely training session to provide a toolkit of discussions that can take place in team meetings.
- A clear process for any concerns raised to be considered and managed by the most appropriate senior manager.
- The creation of the Speaking Up Safely Steering Group which meets quarterly to understand trends of concerns raised, understand any barriers to raise concern and direct further actions to continuously improve the culture.
- Annual reporting through to the Workforce and Culture Committee to assure progress.

Speaking up Safely: A Framework for the NHS in Wales

14.0 Commissioned Services

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

Powys Teaching Health Board is responsible for planning, providing, and commissioning healthcare services to improve the health and wellbeing of the people of Powys. To ensure that the best possible health and wellbeing outcomes are achieved for Powys residents and that services are provided to the necessary standards, the Health Board sets out in its framework for improving quality and performance processes to provide assurance on the comprehensive implementation of its Integrated Medium-Term Plan (IMTP).

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

The IQPF applies to all activities in all parts of the Health Board. The scope therefore includes all services the Health Board provides and those commissioned in County and out of County.

The key purpose of the framework is to:

- Define roles and responsibilities for managing and improving performance.
- Describe the structures required to deliver robust quality care, performance management and improvement.
- Set out the processes of a quality management system which will support quality improvement, quality planning and quality control through proactive problem solving and risk management.

In order that the Health Board can robustly assess performance across all aspects of service and delivery it is vital that an integrated approach is adopted with a focus on the necessary attributes and coverage requirements of performance management and reporting processes.

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

Coverage	Description
Core Areas	
Access to Care and Timeliness	Assurance of timely and appropriate access to health care services to achieve the best health outcomes within agreed targets.
Quality, Safety and Patient Experience	Assurance against national and locally set quality and safety measures of care ensuring services are safe, personal, effective and continuously improving. Assurance through listening and responding to patient and carer feedback along with complaints and concerns and the development of Patient Reported Outcomes Measure (PROMS) and Patient Reported Experience Measures (PREMS).
Finance & Value	Assurance that services are improving efficiency and productivity, and financial plans are being delivered. Prudent or value-based health care approach.
Workforce and Culture	Assurance that PTHB has a motivated and sustainable workforce that is well-trained.

Attributes of the Framework for Improving Performance

Attribute	Description
Link to Aims & Strategic Objectives	Clear links to strategic aims, objectives, and annual priorities to ensure delivery of plans and support prioritisation processes.
Exception Reporting	Reporting of poor or challenging performance through effective and comprehensive exception reporting.
Scorecard Reporting	Supporting enhanced understanding of organisational performance through a high-level overview.
Qualitative & Quantitative	A mix of quantitative indicators and data supported by concise qualitative contextual information providing insight into influences on performance.
Timely Information	Consistently updating information and managing the timeliness of information to ensure up to date analysis of performance and resolution of issues.
Managing Risk	Using risk registers and assurance frameworks (corporate and local) to inform performance improvement decisions.
Analytics	Looking beyond results to interpret and communicate meaningful patterns in data.
Forecasting	Predicting future positions and anticipating risks through forecasting.
Benchmarking	Contextualising performance through comparison to best practice and peers and identifying areas for improvement.
Targets / Measures	Setting challenging, achievable, and meaningful targets to monitor performance, celebrate improvement and reinforce purpose linked to strategic direction.
Performance Trajectories	Indicating expected timescales of delivery and to enable regular monitoring of performance.
Performance Against Targets	Using status scales to effectively communicate performance against plan/target/trajectory.
Targeted Performance Improvement Planning	Clear action plans in place to ensure mitigating actions and performance recovery are delivered.
Responsibility & Accountability	Accountable leads identified for actions to ensure delivery.
Escalation & De-escalation	Review escalations pulling out "performance hotspots". Focus upon accountability through management intervention - actions, consequences, tolerances, incentives

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

Quality Planning

- Understanding population need & design of services, policies, structures, systems to meet those needs.
- Quality Control and Quality Assurance need to feed into Quality Planning.
- Reflect government strategies and targets.

Quality Control

- Processes in place to monitor performance in real time & take action when required standards not met.
- Control processes owned by those directly providing the service with skills and permission to address performance issues within their control.
- Quantitative and qualitative measures with appropriate escalation measures.

Quality Improvement

- Cycles of experimentation informed by ongoing reflection using both quantitative and qualitative data.
- Practical iterative tests of change to learn, implement and scale improvements in quality of services and patient outcomes

Quality Assurance

- Verify that quality control is maintained and that performance is evaluated.
- Effective structures, systems and standards to provide clear line of sight across the Health Board to give assurance internally and externally to stakeholders, that desired improvements to services and population outcomes are being achieved and sustained

Performance and Assurance via Commissioning Oversight Assurance Group (COAG) and Contract Quality, Performance and Review Meetings (CQPRMs)

For the services PTHB commissions (contracts) from external NHS service providers, the Commissioning Oversight and Assurance Group (COAG) and the Contract Quality, Performance and Review Meetings held internally and with the commissioned providers, ensure there are mechanisms in place to oversee the arrangements for the contractual performance monitoring of PTHB Commissioned Services, including focus on quality outcomes and patient experience.

PTHB works collaboratively with their Commissioned Service providers to review:

- Analysis of relevant data including demand and capacity of service, NHS Wales and NHS England Performance Framework adherence, workforce availability/cost, trends, areas of concern, and opportunities for improvement
- Identification and discussion on specific challenges and issues that impact the performance of services.
- Review and monitoring of action plans that address the identified challenges and outline the steps required for improvement.
- Integrated performance updates across each provider the Health Board commissions from, which gives greater insight into the services residents are receiving out of county.

All elements of the information provided, reported and reviewed through the CQPRM meetings will be utilised within organisational performance management processes to help inform the future delivery and development of services by PTHB.

15.0 Overseas Nurse Recruitment

"We have noticed that community hospital nursing is different in quite a few ways to my home. In community hospitals, surgery would be taking place, for example hysterectomies and c-sections whereas here I notice we are providing care to a lot more people with dementia."
Overseas Nurse

"We've had a warm welcome from the local community – this area is a nice, safe place to live; a calm and quiet area."
Overseas Nurse

Over the last few years, Powys Teaching Health Board, along with other Welsh Health Boards have been recruiting nurses from overseas, specifically from India.

In 2024 Powys Teaching Health Board successfully recruited Adult Nurses and Medics.

A further cohort has been recruited, undertaking their training in February and March of 2025. This latest cohort, who will be based in Brecon War Memorial Hospital completed their training and have received their Nursing and Midwifery Council personal identification number (PIN) number.

The nurses are employed on a permanent basis providing continuity of high-quality patient care.

The program sits alongside the Health Board's work to attract local young people into the health and care sectors. This latter work is done in partnership with Powys County Council (under the flag of the Powys Regional Partnership Board) through the Powys Health, Care and Social Care Academy, which currently has sites in Bronllys and Llandrindod Wells and is looking to open in Newtown in the coming years.

"We feel very lucky to have had our six internationally educated nurses join our team. They are all truly lovely and a perfect fit with our team and they have all worked so hard to pass their OSCE's. We are very proud to have them."
Ward Manager

"Overseas colleagues join us in PTHB community hospitals. They bring a wealth of nursing knowledge and expertise, and every cohort allows continued support to our existing overseas nurses which will support retention of these valued staff members"
Community Services Manager

16.0 Future Developments

Digital transformation set to improve hospital care for patients in Powys

Powys Teaching Health Board has been working through 2024-2025 to lay the groundwork for a new and exciting digital transformation. This will be a significant step forward towards a safer and more efficient prescribing and medicines administration in hospitals. Further work will be undertaken in 2025-2026 to complete the implementation of this system.

The Health Board has chosen Better as its technology partner to support delivery of the electronic Prescribing and Medicines Administration (ePMA), which will revolutionise medicines management within the Health Board's community hospitals and other healthcare settings.

This new digital system will streamline prescribing by replacing the use of paper in hospitals and freeing up time for clinicians. ePMA will help to ensure that information is captured accurately, is up to date and readily available, reducing the risk of medication errors and improve patient care.

The implementation of ePMA in Wales is a key part of the national Digital Medicines Programme led by Digital Health and Care Wales (DHCW) and supported and funded by Welsh Government.

Looking Forward Quality Priorities 2025/2026

The following priorities reflect the issues and learning of the Health Board during 2024/25 through collaboration with services across the Health Board, under the auspices of the Health Boards Quality Management System and the Integrated Medium-Term Plan (IMTP). The IMTP sets out the key priorities of the organisation and how these will be achieved. The four main priority themes are:

- Strengthening our Quality Management System
- Improving the Health Board quality performance position
- Improving feedback opportunities and learning events from patient experience
- Continued improvements to patient safety

Strengthening our Quality Management Approach
How we will improve our performance

- Ensure that all safety reviews are completed in line with the NHS Wales policy on patient safety and management and the Health Board Incident Management Framework.
- Ensure that all service users and their relatives are afforded timely opportunity to contribute their experience to patient safety reviews.

- Ensure that feedback is provided to all staff throughout an incident review.
- Strengthen the quality and safety structure at service level to include a review of training provision and quality metrics that inform performance and culture of patient safety management.
- Continue to evolve and improve the Integrated Quality Report to Board.

How improvements will be measured and monitored

- In 2025-2026 undertake a review of the Incident Management Framework and associated training to ensure it remains commensurate with Welsh Government legislation.
- By December 2025, audit patient safety investigations to ensure consistency with staff and family engagement and feedback.
- The staff survey results on quality and safety structures, knowledge and implementation.

Improving the Health Board quality performance position
How we will improve our performance

- Continue to evolve and improve our use of performance monitoring IT platforms to improve patient outcomes.
- Continued implementation of the Bereavement Assurance Framework and the People's Experience Framework.
- Reviewing the Health Boards quality assurance process for responses to concerns and patient safety incidents under the auspices of Putting Things Right and Duty of Candour.
- Improving reporting performance on Nationally Reportable Incidents.
- Improving Concerns response times within 30 working days.

How improvements will be measured and monitored

- Use of performance data to inform the Board through bi-monthly updates on Duty or Candour and Nationally Reported Incidents.
- Quarterly updates on the People's Experience Framework, engagement with services and patients and feedback through CIVICA, via the People's Experience Steering Group.
- Bi-annually reporting to the Welsh Government on continued progress and priority actions on the Bereavement Assurance Framework.
- By December 2025 a review of quality assurance processes will be undertaken to improve response times for concerns and incidents under the Duty of Candour and Putting Things Right

Improving feedback opportunities and learning events from patient experience
How we will improve our performance

- Embedding and implementing the People's Experience Framework across the Health Board
- Engaging with stakeholders for people's experience to evolve and mature the Health Board's position on obtaining feedback and documenting patient stories.
- Improve the Health Board's use of SMS messages for obtaining feedback across all services.
- Maturing the Health Board repository for organisation-wide learning from experience.

- Obtain and present more patient stories to aid service improvement.

How improvements will be measured and monitored

- Completion of the People's Experience Framework self-assessment to create an action plan for implementation of the Framework.
- Creation of a Health Board strategy to implement the People's Experience Framework through collaboration with staff and key-stakeholders by September 2025.
- Auditing the use of SMS messages across all services to target areas of improvement.
- Supporting services in acquiring patient stories in a digital format for sharing and presenting to the Board.
- Continued engagement with our community to understand and hear opinions on service developments and people's experiences.
- Quarterly comparisons on the percentage of patient feedback received and themes identified.

Continued Improvements to Patient Safety

How we will improve our performance

- Review training to ensure all staff are equipped to manage and investigate patient safety incidents to the best of their ability.
- Audit of incident management across the Health Board.
- Thematic reviews of patient safety incidents to target areas for improvement.
- Continued rollout of Dementia friendly environments.

How improvements will be measured and monitored

- Thematic reviews will be reported through the quarterly Integrated Quality Report to the Board.
- There will be a weekly audit and communication to all services of patient safety incidents, ensuring the timely investigation and where necessary escalation, in line with Duty of Candour reporting.
- Ensure that Incident management training is accessible online by September 2025.
- To ensure that all historical patient safety NRI investigations (pre-2025) are closed by November 2025.
- Monthly reporting of patient safety incidents through IQPF.

Conclusion

Over the past 12 months, the Health Board has demonstrated its unwavering commitment to providing excellent patient care through a strong focus on collaboration and continuous service improvement. These achievements have only been possible through the power of co-production, working alongside dedicated staff, valued stakeholders, and the communities of Powys.

The health board is proud of what has been achieved, not just in the progress made, but in how it has been made: through shared effort, open dialogue, and a deep commitment to doing what is right for the Powys communities. This includes the Health Board's ability to listen, adapt, and learn from experience. This approach ensures that services are responsive, inclusive, and truly centered around the needs of those the Health Board serve.

As the Health Board looks ahead, it remains dedicated to building on this momentum, continuing the journey with partners and communities,

delivering a real and lasting impact for the people of Powys, and sharing future achievements in the coming year.

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 3.5

PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE	**31 JULY 2025**
Subject:	**Mental Health Act Hospital Managers Power of Discharge Group Terms of Reference and Operating Arrangements**
Approved and presented by:	Helen Bushell, Director of Corporate Governance
Prepared by:	Head of Corporate Governance
Other Committees and meetings considered at:	N/A

PURPOSE:

The purpose of this paper is to request approval of 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.

RECOMMENDATION(S):

The Patient Experience, Quality and Safety Committee asked to:

- **DISCUSS** and **APPROVE** 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.

Approve/Take Assurance	Discuss	Note
Y	Y	N

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

EXECUTIVE SUMMARY:

The purpose of the Mental Health Act Power of Discharge Group is to review and monitor how the operation of the delegated functions under Section 23 of the Mental Health Act 1983 are being exercised.

The Terms of Reference and Operating Arrangements for the Mental Health Act Power of Discharge Group were last reviewed in April 2021. A review was undertaken by the Assistant Director of Mental Health and Learning Disabilities and Deputy Board Secretary in spring 2025. No material changes have been made to the content of the Terms of Reference, though the format, layout and references to individuals and governance bodies have been updated to align with current organisational structures and standards. The revised draft is attached at **Appendix A**.

NEXT STEPS:

On approval of the revised terms of reference and operating arrangements Board will be advised that Schedule 4 of Standing Orders (Committee Arrangements – Terms of Reference) will be amended and the website updated.

MENTAL HEALTH ACT HOSPITAL MANAGERS POWER OF DISCHARGE GROUP

Terms of Reference & Operating Arrangements

REVISED DRAFT FOR PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE

April 2025

1. INTRODUCTION

1.1 Powys Teaching Health Board (PTHB) is required under the Mental Health Act (MHA) Code of Practice (para 37.8) to develop a scheme of delegation for the duties identified by the MHA legislation. PTHB has taken a decision to delegate the power of discharge under the MHA to the 'Power of Discharge Group'.

1.2 The Power of Discharge Group (PODG) is a Sub-Group of the PTHB Patient Experience, Quality & Safety Committee which is directly accountable to the PTHB Board. The Chair of the PODG must be a member of the Patient Experience, Quality & Safety Committee and will for assurance purposes make regular reports to the Patient Experience, Quality & Safety Committee on the work of the PODG.

1.3 The PODG will comprise MHA Hospital Managers who have been independently appointed. The MHA Hospital Managers sit as panels of three or more in order to exercise their power of discharge as detailed in the MHA Code of Practice. The decisions made by the panels are binding and therefore are not required to be ratified by the Patient Experience, Quality & Safety Committee or by the Health Board. However, the procedures and behaviours adopted by the panel are subject to scrutiny and as such the MHA Hospital Managers are accountable to the Board via the Patient Experience, Quality & Safety Committee.

2. REQUIREMENTS OF THE MHA

2.1 The primary purpose of the 1983 Act is to ensure that compulsory measures can be taken, where necessary and justified, to ensure that people who suffer from a mental disorder get the care and treatment they need. Because these provisions place people under compulsion (for example to receive treatment) the 1983 Act also contains a number of safeguards. These include, for example, a right to apply for discharge to the MHA Hospital Managers. MHA Hospital Managers have a central role in operating the provisions of the Act and as detailed above the Health Board has made the decision to delegate this responsibility to the PODG, and assurance will be provided to the Board through monitoring by the Patient Experience, Quality & Safety Committee.

3. PURPOSE

3.1 The purpose of the PODG is to:

- Consider all relevant issues for MHA Hospital Managers to undertake their role in accordance with PTHB and legislative requirements.

- Receive activity monitoring reports on the use of the Mental Health Act.
- Ensure that discharge panels are acting in a fair and reasonable manner and exercised lawfully.
- Consider updates regarding recommendations made during panel hearings.
- Discuss and agree training for MHA Hospital Managers.
- Receive professional advice to support the discharge of the MHA Hospital Manager Role.
- Provide a forum for consideration of any matter impacting on the decision making for discharge of patients detained under the Mental Health Act.
- Receive development/discussion sessions to improve overall knowledge of services.

3.2 The PODG will, in respect of its provision of advice to the Patient Experience, Quality & Safety Committee, comment specifically upon:

- Processes in place to support discharge panels.
- Advise on issues arising from discharge panels and appeals of an unusual or contentious nature.
- Discuss any impact of legislative changes on role of MHA Hospital Managers.
- Highlight any impact of service changes on the ability to undertake the MHA Hospital Manager role effectively.

3.3 To achieve this, the Patient Experience, Quality & Safety Committee shall provide assurance to the Board that:

- MHA Hospital Managers are effectively equipped and trained to undertake their role.
- PTHB provides appropriate support to ensure the Discharge Panels operate effectively.
- PTHB is aware of the impact of any legislative or service changes impacting on the Discharge panel's considerations and recommendations

4. MEMBERSHIP

4.1 The membership of the PODG is as follows: -

Chair	Independent Member (who must be a member of the Patient Experience, Quality & Safety Committee)
Members	All of the Mental Health Act Managers appointed by PTHB

By invitation	The Committee Chair may invite: any other PTHB officials and/or any others from within or outside the organisation

The invitees may be asked to attend all or part of a meeting to assist it with its discussions on any particular matter.

4.2 Secretariat

The secretariat for the PODG will be via the Mental Health Act Administration Team.

4.3 Member Appointments

The membership of the Committee shall be determined by the Patient Experience, Quality & Safety Committee, based on the recommendation of the PODG Chair and the membership of the PODG will be reviewed annually.

5. SUPPORT

5.1 The PODG will receive support from the Mental Health Act Administration Department.

6. MEETINGS

6.1 Quorum

A Quorum of a third of the whole number, including the Independent Member of the Health Board as Chair of the PODG.

6.2 Frequency of Meetings

Meetings shall be held no less than four times a year or more frequently if deemed necessary by the chair of the PODG.

6.3 Other meeting arrangements

Meetings will be held via digital means (Microsoft Teams) as standard. Should the Group wish to meet in person, this will be confirmed in advance by the Chair and organised by the Mental Health Act Administration Department.

7. RELATIONSHIP AND ACCOUNTABILITIES

7.1 The PODG is directly accountable to the Health Board for its performance in exercising the functions set out in these terms of reference. The accountability is achieved by the appointment of a PODG chair who must be included in the membership of the Patient Experience, Quality & Safety Committee. Accountability will also be achieved by the submission of six-monthly Mental Health Compliance reports to the Patient Experience, Quality & Safety Committee acting on behalf of the Board. The Patient Experience, Quality & Safety Committee will also provide assurance reports to the Board, which will include information relating to its monitoring role of the PODG.

8. REPORTING AND ASSURANCE ARRANGEMENTS

8.1 The PODG Chair shall:

- report formally, regularly and on a timely basis to the Patient Experience, Quality & Safety Committee on the PODG's activities. This includes verbal updates on activity and written reports throughout the year;
- bring to the Patient Experience, Quality & Safety Committee's Chair specific attention any significant matters needing their consideration.
- ensure appropriate escalation arrangements are in place to alert the PTHB Chair, Vice Chair, Chief Executive (Accountable Officer) or Chairs of other relevant committees of any urgent/critical matters that may affect the operation and/or reputation of the PTHB.

9. REVIEW

9.1 The PODG terms of reference shall be reviewed annually by the Patient Experience, Quality & Safety Committee.

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 3.6

Patient Experience, Quality and Safety Committee	**Date: 31 July 2025**
Subject:	**Committee Effectiveness: Continuous Development Plan 2025-26**
Approved and presented by:	Helen Bushell, Director of Corporate Governance
Prepared by:	Deputy Board Secretary
Other Committees and meetings considered at:	N/A
Appendices :	Appendix A – PEQS Continuous Development Plan 2025-26

PURPOSE:

This report provides the Committee with a plan for continuous development, based upon the matters identified for actions within the 2024-25 annual review of Committee effectiveness.

The plan comprises of actions arising from and relevant to all Committees (Cross Committee Action Plan) and those actions which are specific to the Patient Experience, Quality and Safety Committee.

RECOMMENDATION(S):

The Committee is asked to:

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

Approve/Take Assurance	Discuss	Note
x		

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:		
1. Focus on Wellbeing	Y	A commitment to good governance and robust corporate systems are a key enabler of all of our 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 EFFECTIVENESS

Each Committee of the Board is required to assess its effectiveness at the end of each year and to report its views to the Board on how governance arrangements might be improved. This is a key principle of good corporate governance which demonstrates a committee's understanding of its remit and oversight responsibility and a culture of continuous development.

The approach for 2024/25 comprised of a a questionnaire followed by discussion at the Committee. The Committee effectiveness questionnaire focused on the critical themes of:

(i) composition and establishment
(ii) effective functioning
(iii) assurance and
(iv) leadership and culture

The findings of the Patient Experience, Quality and Safety Committee review were received and discussed by the Committee on 29 April 2025, and subsequently the findings of all Committees were combined and reported to the Chair's Forum and the Board.

A key aspect of the effectiveness review is the formulation of actions based upon identified opportunities for continuous development as part of the process.
The Corporate Governance team has undertaken a thematic review of all Committee Effectiveness review findings both holistically for all Committees and for each Committee individually and has pulled out the key actions to enable continuous development for implementation throughout 2025-26.

Actions have been identified as either Cross-Committee actions (development opportunities/actions arising identified by and/or relevant to all Committees of the Board) or Committee specific actions, identified by and/or relevant to a single Committee.

Implementation of the Continuous Development Plan 2025-26 (Appendix A) will be monitored by the Corporate Governance team, and will return to the Committee periodically for assurance.

NEXT STEPS:
The Corporate Governance Team will continue to monitor implementation and will provide a further update on progress to the meeting on the Committee 5 February 2026.

Appendix A – PEQS Continuous Development Plan 2025-26

Committee Effectiveness: Continuous Development Plan 2025–2026

Patient Experience, Quality and Safety Committee

Cross-Committee Action Plan (actions relevant to all Committees)

Theme	Action	Owner	Timeline	Status	Comments
Membership	Review and confirm committee membership	DCG / PTHB Chair	Q1	Complete	New Committee Membership confirmed as of May 2025
Assurance to Board (Quality Assurance: QMS)	Develop a standardised reporting template for clear upwards assurance	Governance Team	Q2	Complete	Alert, Advice, Assurance, Inform (AAAI) Reports have been introduced for all Committees for reporting to the Board from March 2025 (having been piloted during 2024/25). This template will be reviewed and matured in readiness for September Board.
Organisational Learning (Quality Learning: QMS)	Schedule opportunity to actively consider evidence of learning and improvement in each Committee	Governance Team	Q3	Not yet started	
Committee Agenda Focus	Apply risk-based approach to	DCG/Committee Chairs	Q1	Underway	Prioritisation is already undertaken as part of the agenda setting

(Quality Planning: QMS)	planning agendas, prioritising high-risk/high-impact items				process, but check in will be integrated to consider the associated risk and impact of items
Training & Induction	Develop induction information and training needs analysis for each Committee	Governance Team	Q4	Underway	ARAC induction pilot scheduled for September 2025, other Committees tbc.
Integration of Risk	Incorporate risk lens in committee discussions and papers	Governance Team	Ongoing	Not yet started	

Committee-Specific Action Plan

Patient Experience, Quality and Safety Committee

Theme	Action	Owner	Timeline	Status	Comment
Patient Voice	Formalise patient experience as a substantive, consistent agenda item	Governance Team/Chair of Committee	Q2	In progress	
Organisational learning	Strengthen feedthrough from incident reviews/actions taken to Committee. (Quality Learning: QMS)	EDoNQW&FH	Q3	Not yet started	

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 4.1

PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE	**31 JULY 2025**
Subject:	Integrated Quality & Performance Framework – CYP Neurodevelopmental Services Escalation Oversight Group
Approved and presented by:	Nicola Johnson, Executive Director of Planning, Performance and Commissioning
Prepared by:	Executive Director for Nursing, Quality, Women and Family Health Director of Midwifery, Women and Family Head of Children Public Health Nursing and Paediatric Services Assistant Director of Quality and Safety 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. Patient Experience, Quality and Safety Committee 7th Nov 2024, 11th Feb 2025; 29th April 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** from the ongoing monitoring and evaluation mechanisms in place as part of IQPF.

4. **NOTE** that the recommendation that the service is de-escalated to Level 2a was approved by the Executive Committee on 23rd July.

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 have 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 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 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.

In response to being placed in level 3, the CYP Neurodevelopmental service developed a Phase 1 Improvement Plan (**Appendix One** – background papers) 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.

Progress to date

The CYP ND service, in implementing the Phase 1 Improvement Plan, has achieved considerable progress:

- All 8 Welsh Government standards met within current service delivery model.

- All improvement plan actions bar 2 achieved (remainder are being addressed to support increase of consultant capacity and sustainable funding plans). The EOG has agreed for the 2 remaining actions to be reflected in the Phase 2 ND remodel improvement plan.

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

Area of Improvement	Current position
Continued and consistent failure to meet agreed performance improvements, including failure to deliver Ministerial Priority measure.	• All children previously managed on list have been seen for a first clinical appointment. • Appropriate management of RTA since March 2025 with children being seen for first clinical appointment triggering removal from RTA. • All appointments from 1/3/25 from RTA for clinical assessment – first time this has occurred for > 2 years. • Currently holding performance at 2-year wait. • Implementation of MDT triage and complex case discussion February 2025, noting acceptance rate reduced from 99% to 70%. More scrutiny regarding threshold for acceptance. • KPI's in place to support quality outcome measures: Length of open pathway, number of appointments within pathway, timely completion of screening tools, DNA rate, experiential measures within CIVICA, weeks from referral to first appointment. • PTHB approach and transformation was commended as good practice by NHS Executive and WG colleagues during monitoring meetings in line with accelerated programme. • PTHB collaborating and learning from neighbouring Health Boards regarding Triage and digital tools to support assessment.
Performance for Neurodevelopmental assessment continues to fall outside of the lower control limit, with performance flagged as special cause concern due to consecutive decreasing trend.	
Challenge on RTT backlog not resolved as expected.	

	• £236,000 NDIP funding to eliminate > 2-year waits. • % of <26-week waits have been decreasing – historically, this is because of climbing waiting lists and increasing longest waits - more recently this is mainly due to the successful improvements made to the triage process and a reduction of children going on to the waiting list. • 1094 children on waiting list. • 321 open assessments. • DNA rate 2% (follow ups), 5% (new appointments). • Monitoring and managing the closure of open pathways remains a priority.

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

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

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

- Additional investment required to support transformation and sustainability.

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

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

The IQPAF process will see an increase in maturity of the service group having developed a formal capability programme to build skills across clinical and non-clinical colleagues; build service wide skills in application of modern quality improvement methods; aligned with culture where improvement work is becoming integrated into day-to-day work.

The EOG group recognise that implementation of the Phase 1 Improvement Plan (**Appendix One** – background papers) has been completed bar 2 remaining actions having been progressed to a satisfactory degree with clear plans in place to embed the ongoing continuous improvement work.

Next Steps

The agreed IQPF lays out the Escalation Framework for the Health Board (see **Appendix Four**). Noting the progress made and the continued delivery of the implementation plan with evidenced progress, the EOG recommended that the CYP Neurodevelopmental service was not ready to be fully de-escalated but that the Escalation level is decreased to Level 2a, and the Executive Committee agreed this on 23rd July 2025. This is on the following basis:

Performance Escalation Triggers	Current position
Continued and consistent failure to meet agreed performance improvements, including failure to deliver Ministerial Priority measure. Performance for Neurodevelopmental assessment continues to fall outside of the lower control limit, with performance flagged as special cause concern due to consecutive decreasing trend. Challenge on RTT backlog not resolved as expected.	• RTA management in line with guidance. • Currently holding performance at 2-year wait. • KPI's in place to support quality outcome measures. • Triage process in place and reduced acceptance rate. • PTHB approach and transformation commended as good practice by NHS Performance and Improvement. • All children previously managed on list have been seen for a first clinical appointment.
Integrated Quality and Performance Framework (IQPAF) Self-Assessment.	• Noted Early Progress being maintained in Safe and Effective Care domain; Results being maintained in Quality of Patient and Family Experience, and Quality of Leadership and Management domains.
Conditions for Sustainability Assessment	• Noted assessment undertaken by the service: ▪ Achievement of All Wales Standards within current service model. ▪ Improved governance. ▪ Substantive clinical leadership structure in place, business case

	being developed to sustain this structure. ▪ Clear KPI's in place. ▪ Clinical support structure in place to support culture of psychological safety. ▪ Clear vision and strategy in place. ▪ Alignment to PTHB Quality Management System approach.

It was agreed that ongoing Executive scrutiny and oversight of the service Escalation and improvement will remain in place via the EOG, which will meet on a monthly basis to oversee the implementation of the Phase 2 service remodel implementation plan and continued progress against the IQPAF and Conditions for Sustainability.

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

PTHB Integrated Quality & Performance Framework Escalation Framework 2024/25

Please note that this framework replaces the 23/24 business reporting rules as used within the Integrated Performance Framework and report.

Escalation level	Trigger	Action expected	Monitoring and support
Level 1 (No concerns)	• Local delivery of agreed objectives and performance, finance ambitions in line with agreed trajectories. • No exceptions or quality concerns. • Sound governance arrangements in place. • Performance within expected targets either national or local	• No escalation action. • Could result in frequency adjustment for some monitoring mechanisms and meetings including IQPG.	Main monitoring through base performance review process. Key measures bi-annually in IQPR to the Board.
Level 2a (Exception)	• Failure to achieve / maintain delivery in more than 1 key deliverable / area of performance. • Sustained deterioration on 1 or more domain. **This can include:** • Failure to deliver on an NHS Performance Framework target or local target trajectory. • A deviation or departure from the normal or expected course of action signifying specific condition or event that requires attention or further action to address the deviation. • Failure of quality standard. • Where SPC methodology notes variance of concern.	• Correspondence to Clinical service area/corporate dept on reasons for escalation – areas of concern, expected response and confirm any enhanced monitoring. • Recovery plan to be developed that address issues to be recovered/improved. • Depending on issue – change in frequency of and focus of standard meeting and consideration of increasing frequency including IQPG. • Reported through to Executive Committee. • Monthly reporting where appropriate via IQPR as an exception to performance.	**Options include:** • IQPG engagement monthly with Executive • Internal support as required (QI/vbhc/planning – issue dependent). • Consideration of compliance with Professional clinical codes and standards and proportionate response. • Consideration of compliance with managerial code of practice. • Internal peer review. • Executive support (directly or from other teams). • Consider need for bespoke response. • Minimum monthly updates to Executive Committee.
Level 2b (Exception)	**Specially for finance:** • Where Corporate Directorate or Clinical Service Area level budget is overspending by more than £0.5m Year to date or £1m forecast.	Identified through monthly financial reporting	CEO to call a special 'Budget Review Meeting' of all Executive Directors and the Divisional or Directorate budget holder (up to 3 team members may attend in support). **Agreed action plan established:** • Monitored through financial reporting arrangements. • Review period established if plan failing.
Level 3 (Escalation)	• Serious concerns on quality and governance. • Continued and consistent failure to meet agreed performance improvements and trajectories across a number of objectives. • Clear articulation of reasons for escalation and criteria for escalation. **This can include:** • Where a performance matter (exception) does not meet target and hits criteria for higher level of resolution, decision making or further action. • Any measure that continues to fail a health board submitted trajectory as part of the Ministerial Priority measures. • Performance recovery is failing to improve or maintain performance. • Any significant failure of quality standard. • Where IQPG deems that a service or measured outcome requires escalation resulting from identified challenge or significant concern.	• Correspondence to service area/corporate dept on reasons for escalation – areas of concern, expected response and confirm any enhanced monitoring. • Service Area or corporate directorate demonstrating recognition of issues and commitment to improve. • Improvement/recovery plan required to address issues identified. • Reported through to executive and relevant committee. • Escalated frequency of IQPG meetings and resultant remedial action plan completion. • Challenge review on appropriate shift to the Escalations Oversight Group (EOG). • Monthly reporting where appropriate via IQPR as an exception to performance.	**Actions could include:** • Escalation Oversight Group (EOG) • Independent review of service/corporate department effectiveness. • Deployment of appropriate HR policies e.g. Capability policy. • Weekly/fortnightly meetings with CEO and/or relevant execs to track progress against improvement actions (which directly related to de-escalation criteria). • Consideration of compliance with Professional clinical codes and standards and proportionate response. • Consideration of compliance with managerial code of practice. • Suspension or revision of service provision. **De-escalation:** The appropriate outcome for a challenge to be de-escalated. Either challenge has been rectified, requirement has changed, or via senior committee decision. A level 3 escalation may return to any previous lower level of escalation dependant on the remaining challenge and required monitoring.

POWYS TEACHING HEALTH BOARD INTEGRATED QUALITY AND PERFORMANCE FRAMEWORK: ASSESSMENT FRAMEWORK (IQPAF)

Introduction

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

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

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

Purpose

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

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

The secondary purposes are to:

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

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

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

These three questions will be considered within the context of:

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

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

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

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

Process

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

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

1. Directorate SMT review service against the Maturity Matrix.
2. Challenge session via Escalation Oversight Group.
3. Challenge Session with Executive Team.
4. Submit final assessment for Executive/Board assurance.

A visual representation of the process in shown below:

1 - Directorate Review against Maturity Matrix

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

2. Challenge Session via Escalation Oversight Group

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

3. Challenge Session with the Executive Team

This would be a session where the service senior leadership would present the assessment and expect to be challenged on this by the Executive Team.

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

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

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

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

Assessment Areas – Scope

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

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

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

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

Examples of information sources are:

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

Assessment Template

Date	12/3/25
Assessment	Neurodevelopmental Disorder Services

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

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

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

Appendix Three: Conditions for Sustainability Assessment (April 2025)

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

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

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

WG 8 Standards

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

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

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

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

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

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

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

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

Agenda item: 5.1

Patient Experience & Quality Committee	**31 JULY 2025**
Subject:	**Integrated Quality Report: Quarter 2**
Approved and presented by:	Claire Roche, Executive Director Nursing, Quality, Women & Family Health
Prepared by:	Zoe Ashman, Assistant Director Quality & Safety Heidi Sinclair, Head of Quality and Safety
Other Committees and meetings considered at:	Executive Committee - 23 July 2025 who supported the paper to the Committee.

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 Executive 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).

2 Specific matters for consideration by this meeting (Assessment)

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

The RLDatix system – Risk Register

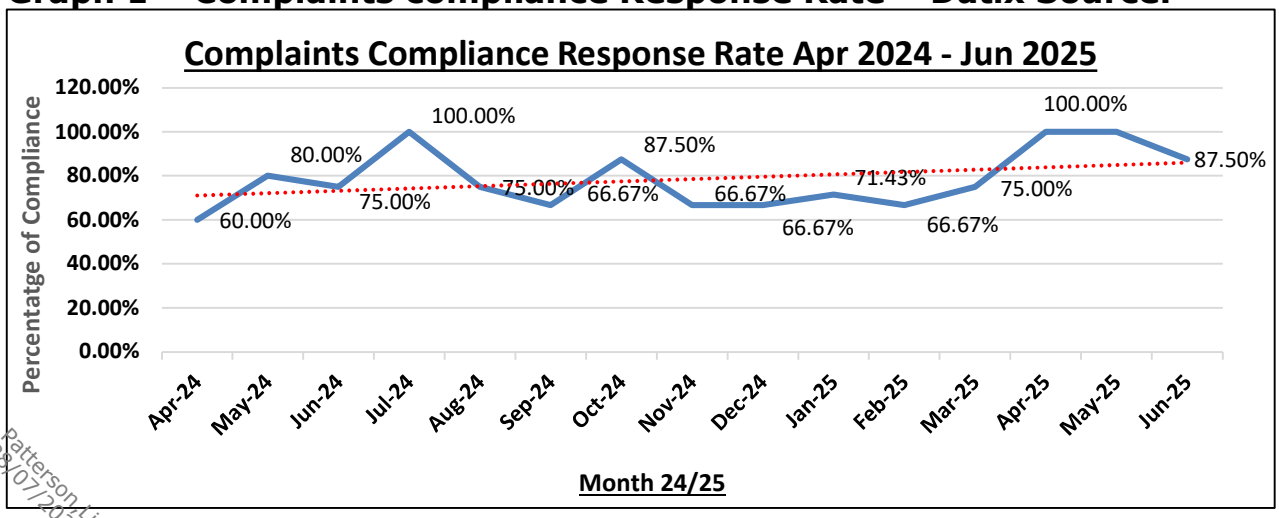
- Work has been undertaken in partnership with OFW to update digital forms and align to PTHB Risk Management Framework.
- Engagement currently underway with the Community Service Groups to develop a bespoke sub-hierarchy using the location and service functionality
- Current engagement with Powys Assistant Directors to complete an options appraisal and identify an appropriate window of opportunity to roll out risk register uptake, with current focus on volunteer areas.
- Recruitment of x1 WTE Corporate Governance Risk and Assurance Officer for 12 weeks via the bank to support the integration of RM Datix and other key risk associated tasks which have been unsupported due to sickness absence, anticipated commencement August 2025.

2.2 Putting Things Right – Concerns

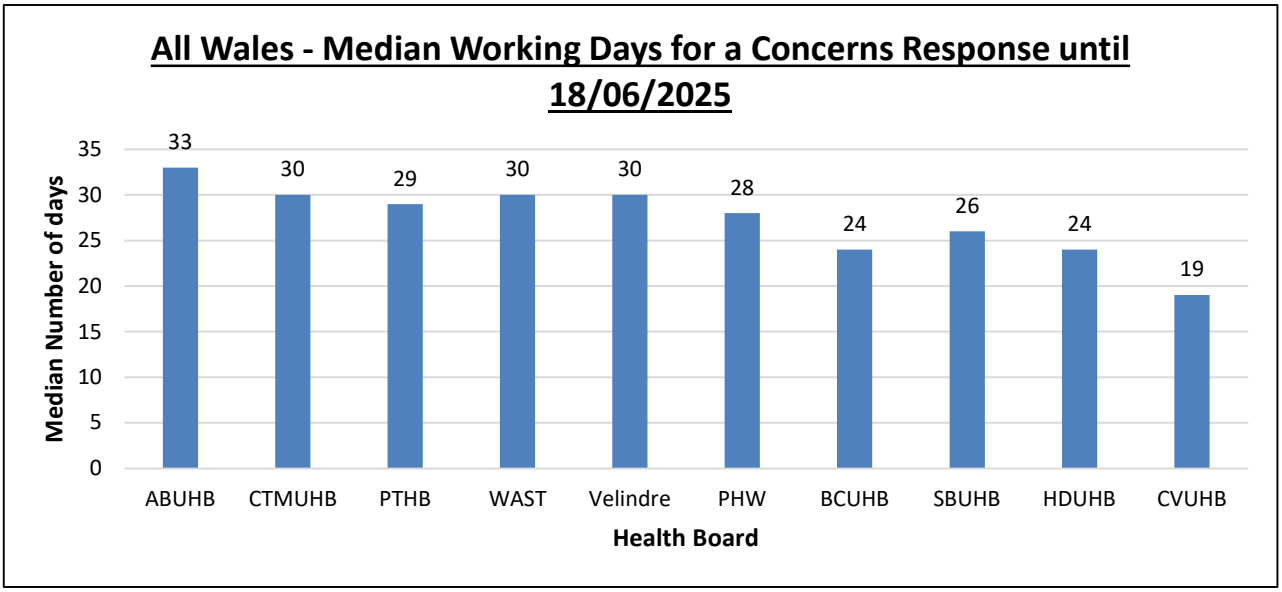
The management of concerns compliance within 30 working days for 2024/25 was 73% in comparison 85% during 2023/24.

Q1 (2025/26) compliance is 95%**(Graph 1).** There is a focus on reducing the mean response time of 30working days, with a primary focus on the sign off process as the main area for improvement **(GRAPH 2)**.

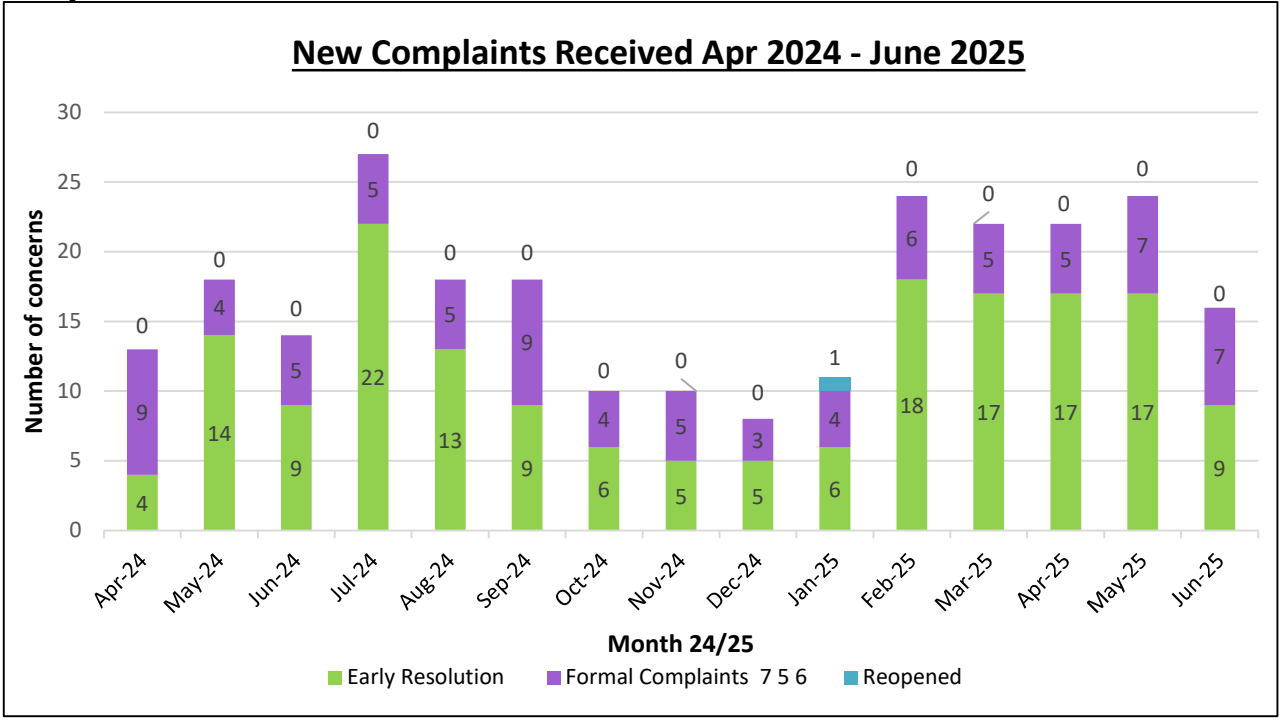
Graph 1 – Complaints compliance Response Rate – Datix Source.



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



Graph 3 – New Concerns Received 2024/25



During Q1 2025/26, 19 formal concerns have been raised through PTR. Themes include:

- Clinical & assessment.
- Attitude & behaviour
- Waiting times
- Referral management
- Complex Pathway

Following the changes to planned activity regarding Powys patients provided by NHS England, the concerns team will monitor concerns received to address any challenges or themes proactively.

The current PTR regulations are under review with Welsh Government, and it is anticipated that the new regulations will be released in February 2026, in readiness for implementation in April 2026. A PowerPoint presentation was presented at Executive Committee on 09/07/2025 advising of the proposed changes and potential impact to services.

2.3 Duty of Candour (DoC)

There have been <5 Duty of Candour cases during Q1 2025/26; is a marked reduction on same period in 2024/25. This reduction is felt to be due to a robust rapid review process and proportionate reporting inline with the national reporting criteria. This is attributed to colleagues increased awareness and understanding of the requirements of the Act.

To note the implementation of Duty of Candour has had no impact on the number of Redress cases to date.

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

- Avoidable falls
- Medicines administration
- Pathways of care
- Avoidable pressure damage.

2.4 Claims, Redress & Clinical Negligence Position

Redress
8 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, with one LFER due for submission for review by September 2025.

Clinical Negligence
10 confirmed cases.

Personal Injury
<5 confirmed cases.

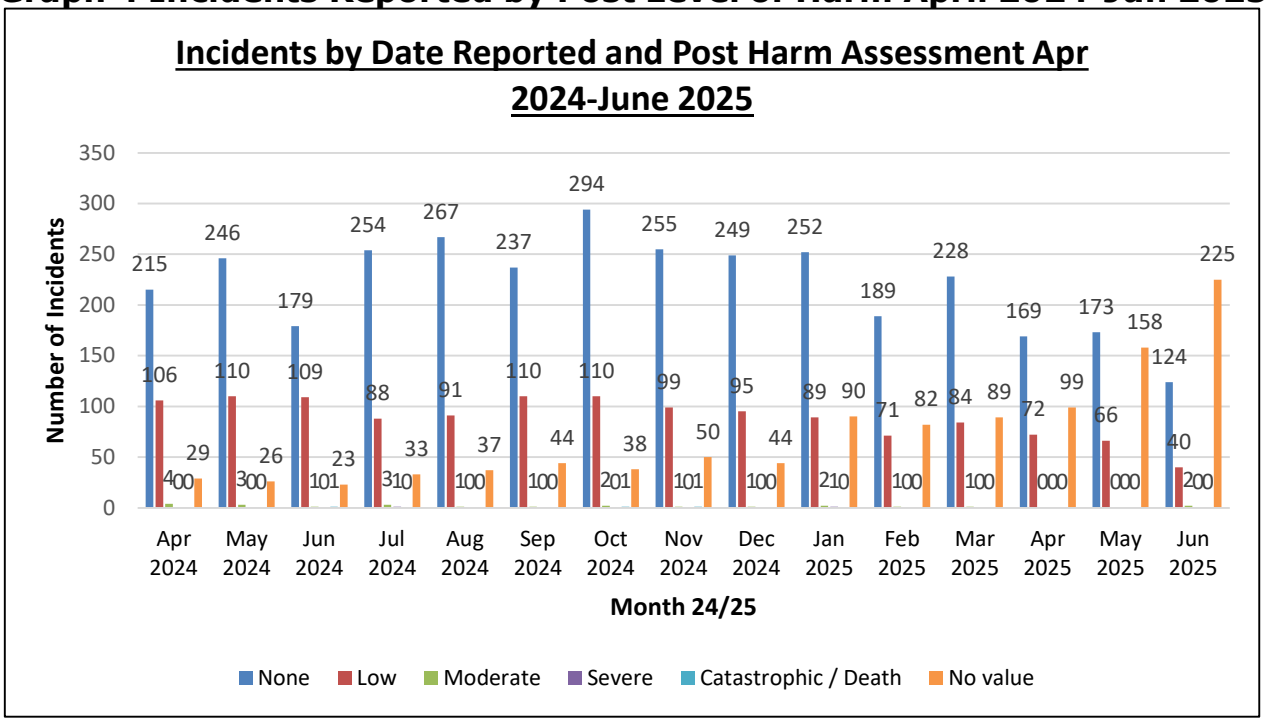
General Medicine Practice Indemnity (GMPI) Claims
<5 confirmed cases.

Inquests
23 confirmed inquests.
6 inquests listed for 2025.

2.5 Incident Management

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

Graph 4 Incidents Reported by Post Level of Harm April 2024-Jun 2025

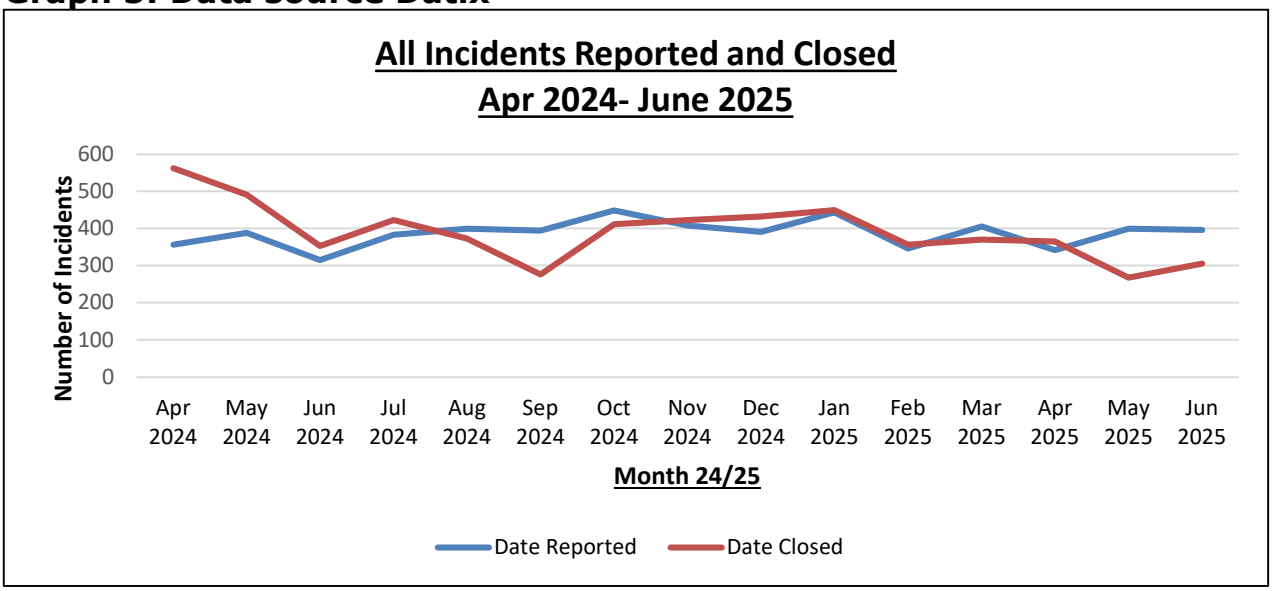


Graph 4 demonstrates stability in reporting across the year, and that most incidents are reported as low or no harm. A no value reporting category has been noted and currently under review to avoid this in future and also further understand this category; resolution anticipated during Q2 2025/26.

This area remains a point of improvement across the Health Board. It is visible in **Graph 5** below that the number of incidents closed has mirrored the live position of reporting during Q4, following proactive and supportive measures which continue with incident position emails to service leads on a weekly basis,

with particular emphasis on moderate and above incidents that trigger Duty of Candour.

Graph 5: Data source Datix



2.6 Early Warning Notifications (previously No surprises notifications)

<5 Early Warning Notifications have been submitted during Q1 2025/2026.

2.7 Nationally Reportable Incidents

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

Current NRI Position

- Open 18 – 7 awaiting closure
- Closed 12

Improved timeliness of investigations is a focus for 2025/26 as 55.2% of investigations remain open for >90 working days with the average completion time of 181days, slight improvement on Q3 of 190days (All-Wales median is 132days). This can be attributed to complex mental health cases which are anticipated to be completed by 120days. With the consideration of the most complex cases, investigation timeliness requires improvement to ensure investigations are shared with families and learning consolidated.

2.8 Audit
2024/25 Internal Audit Report: Quality & Safety Governance (Duty of Quality) for Powys Teaching Health Board (7.1b Consent Agenda)

Between February and May 2025 an audit was undertaken by NWSSP Audit and Assurance services to review the Health Board's arrangements for quality

monitoring and reporting through the Integrated Quality Report, as part of ensuring compliance with the Duty of Quality. The following highlights can be found in the main report:

Overall Assurance: Reasonable
The audit reviewed the Integrated Quality Report (IQR) processes and how well the Health Board is meeting the Duty of Quality under the Health and Social Care (Quality and Engagement) Wales Act 2020.

Key Strengths

- The Integrated Quality Report (IQR) is in place and used to report on quality and safety to key governance committees.
- Timeliness: Reports are compiled and submitted on schedule, supporting consistent governance oversight.
- Governance Forums: Effective engagement with Executive and PEQS Committees, including escalation where necessary (e.g. Mental Health service review).
- Quarterly rhythm is in place with contributions from across nursing, redress, concerns, and data teams.

Key Areas for Improvement (All Medium Priority)

- Updating the IQR Format
- Ongoing development is needed to reflect new legislative and strategic changes (e.g. People's Experience Framework, Duty of Candour).
- Actions scheduled for completion by September 2025.
- Data Clarity and Accuracy
- Issues found in CIVICA survey graphs: some data lacked timeframes, and system-generated errors affected colour coding of results.
- Target for addressing these is July 2025.
- Clarity on Impact
- Some IQR indicators lacked clear links to quality improvement outcomes (e.g. no year-to-date trends provided).

Future reports will include this analysis to better demonstrate performance and impact.

Table 6 is the overall assurance from NWSSP Audit and Assurance services in their Assurance Report

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	The structure and content of the Health Board's Integrated Quality Report allows for effective reporting and monitoring of key areas of quality and improvement	1	Reasonable
2	Robust systems and processes are in place to capture and validate the data required to populate the Integrated Quality Report	1,2	Reasonable
3	The Integrated Quality Report is completed within required timescales to allow for timely submission to the relevant governance forums		Substantial
4	The Integrated Quality Report is submitted to appropriate groups and / or committees and is subject to effective review so that areas of poor performance are identified and addressed	3	Reasonable

Conclusion

The audit concludes that while reasonable assurance can be given, ongoing improvements are needed to:

- Ensure clarity and accuracy of data,
- Better demonstrate quality improvement over time, and
- Keep pace with evolving quality and governance frameworks.

Committee can take assurance that systems are in place but should expect enhanced reporting as part of the scheduled improvements.

2024/25 Mattresses Audit

Purpose

The overall objective of the audit was to review the processes and controls in place across the Health Board to ensure that mattresses are subject to appropriate checks and maintenance.

All equipment that is used in the delivery of patient care possesses a potential infection risk directly to the patient utilising the equipment and a potential cross-infection risk if the equipment is not properly checked and decontaminated.

All Powys Health Board staff have a duty to safeguard patients and in doing so must ensure that equipment being used for patient care is appropriately decontaminated and checked to ensure its safe use.

The Health Board should prevent as far as reasonably practicable the risk of Healthcare Associated Infections to patients. The Health Board must therefore ensure that equipment, such as mattresses are appropriately checked and maintained to ensure they are fit for patient use.

Overview

Limited Assurance was noted as the outcome of the audit associated with significant matters requiring management attention include:

- Limited awareness of the Health Board's Mattress Policy and a lack of specific training provision for staff on the cleaning and assessment of mattresses;

- No process in place on the wards for confirming monthly compliance with the Health Board's policy on the cleaning of mattresses;
- Monthly mattress audits are not being consistently completed by all wards across the Health Board;
- No confirmation that actions are being taken to address issues identified through mattress audits;
- Completed mattress audits are retained on individual wards and not currently held centrally;
- Information was missing or incomplete within a number of the mattress audits reviewed; and
- There is no central monitoring or reporting arrangements in place for mattresses.

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	There are appropriate and up to date policies and / or procedures in place that set out the required processes for the cleaning, decontamination, maintenance and audit of mattresses.	-	Substantial
2	There is staff awareness and promotion of the policies / procedures and staff have undertaken / received appropriate levels of training.	1	Limited
3	Cleaning, decontamination and maintenance of mattresses is being undertaken in accordance with the stated policies / procedures.	2	Reasonable
4	Regular mattress audits are undertaken across the Health Board, with results reported and remedial action taken to address any issues identified.	3, 4, 5, 6	Limited
5	There are appropriate governance, monitoring and reporting arrangements in place for mattresses.	7	Limited

Conclusion

Immediate action plan in place to ensure the areas of highest priority are addressed. Improved governance & monitoring through clinical service group Quality & Safety Governance structures will review progress to completion and continued monitoring.

3. People's Experience

3.1 CIVICA

Your NHS Experience survey has been replaced by the People's Experience Survey (PES) and is currently available for all patients that have accessed healthcare and for staff to add compliments from patients.

Table 7 New Civica Surveys – Total Responses Received Apr-June 25/26

Start Date: 2025-04-01 00:00:00 End Date: 2025-06-30 23:59:59

Month	Surveys			Responses				Targeted Contacts	
	Number of Surveys with New Responses	Surveys with New Targeted Responses	Surveys with New Passive Responses	Total New Responses	# of New Targeted Responses	# of New Passive Responses	# of Responses in Welsh	# of Contacts by SMS	# of Contacts by IVR
Jun-25	1	0	1	26	0	26	0	0	0
May-25	1	1	1	289	265	24	0	1958	0
Apr-25	1	1	1	241	218	23	0	1970	0

Targeted responses are those collected via SMS, IVR and Email. Passive responses are those collected via all other delivery methods such as QR codes and survey links

The above table demonstrates the number of new surveys added to Civica, the total number of responses received and number of contacts via SMS.

It is unclear why there was such a dramatic drop in June however it is known that there can be a delay in responses uploading to Civica.

It has been agreed that all compliments, concerns and feedback provided to staff, either verbally or cards/gifts, will be logged via Datix, allowing Civica to be used solely for patients to provide their feedback.

Work is also required to assess the accessibility of providing feedback, it is noted that Therapies department have success with the use of SMS to provide direct links to surveys. The use of SMS will be explored further.

Graph 8 below sourced from Civica provides an overview of responses to the PES by service area; work is underway to rationalise the service available to select. It is hoped this will improve the ability of the responder to complete, along with addressing the unmapped responses which currently account for a large amount (n473) in graph 8 below.

Graph 8 – Heatmap responses to PES by Service Area – Q1 25/26

Start Date: 01/04/2025 12:00:00 AM End Date: 30/06/2025 11:59:59 PM

Services	Site	Location							
Services	Responses	2 - How would you rate your overall experience?	6 - Were you able to communicate in your preferred language?	7 - Was the time you waited:	8 - Did you feel well cared for?	9 - Were you treated with dignity and respect?	10 - Did you feel that you were listened to?	11 - Were you involved as much as you wanted to be in decisions about your care?	12 - Were things explained to you in a way you could understand?	Overall
		People's Experience Survey (PES)	People's Experience Survey (PES)	People's Experience Survey (PES)	People's Experience Survey (PES)	People's Experience Survey (PES)	People's Experience Survey (PES)	People's Experience Survey (PES)	People's Experience Survey (PES)	
Community: e.g. your home, mobile unit, public place	3	83	100	42	89	89	67	89	89	81
Dental Practice	1	0	100	50	0	0	33	33	0	27
Feedback	12	65	100	68	73	77	83	70	80	77
General Practice (GP)	17	25	100	47	41	48	37	41	56	47
Hospital site other than a Powys Hospital	4	50	92	13	67	67	67	56	67	59
Hospitals and services outside Powys	4	25	100	25	22	67	50	56	78	52
Other services not on a hospital site: e.g. mental health, Glan Irfon	3	8	100	50	0	33	0	0	0	26
Pharmacy	2	0	100	0	0	0	0	67	50	27
Powys Services	22	89	100	72	90	95	89	90	92	90
School	1	0	-	-	-	-	-	-	-	0
Unmapped	473	84	99	61	87	94	88	88	92	87
	Overall	80	99	60	85	92	85	86	90	85
	Benchmarks	85	85	85	85	85	85	85	85	

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With the recruitment of the People's Experience Lead feedback both negative and positive will be routinely shared with services with actions for improvement monitored within the People's Experience Group quarterly.

CIVICA - Accessible information

Nationally, we are awaiting a new Accessible Information Framework to be released, however we currently obtain feedback to ensure a person's preferred language is used. Further work will be undertaken when the new framework is available. Grid below demonstrates that 97.12% of responders are ALWAYS able to communicate in their preferred language.

Available Answers	Responses	Score (%)
Always	472	97.12%
Usually	11	2.26%
Sometimes	2	0.41%
Never	1	0.21%
Total	486	100%

3.2 Patient Stories

All service areas are encouraged to actively support creation of people's story creation. Maternity and Neurodevelopment Services have both produced stories, while Mental Health have produced Good News Stories from patients at their Learning and Development Forum.

3.3 People's Experience Framework (PEF) Update

The People's Experience Framework has been developed into an action plan both for the Lead and as a self-assessment toolkit for PTHB services to use to benchmark their own current feedback and engagement with patients and staff.

A new SHARE logo (see below) has been developed that encompasses what the role aims to achieve through the implementation of the Framework that will allow both staff and patients the means to share their experiences more widely.

Next steps include:

- Continuing with initial engagement with services.
- A review of the current use of Civica and how accessible it is for staff and patients to share their compliments will be undertaken to acknowledge and celebrate service areas more widely.
- Scoping feasibility of a People's Experience network of champions in service areas.
- This offer will include training, tools and resources to encourage feedback, no matter how small, at every opportunity and embed a culture of accountability and participation where we listen, share and learn together.

Image 11

3.4 Llais Activity

Llais published a Regional Director Report (May 2025)(**Appendix 4**), these are shared with services to ensure experiential themes are used to inform service change and improvements. The Health Board continues proactive communication and meets with Llais to ensure strengthened partnership relationships across health and social care.

4. Infection Prevention and Control (IP&C)

Progress continues against the Welsh Government's healthcare-associated infection (HCAI) reduction targets as outlined in WHC-2024-038. As part of the response, post-infection reviews have been completed for all community and hospital-onset cases, ensuring that learning is captured where appropriate. There is ongoing collaborative work with the Antimicrobial Stewardship (AMS) Pharmacist to implement a robust and effective electronic data capture process from Primary Care Services, which will support enhanced surveillance and timely reporting.

Importantly, no beds were closed due to IP&C-related issues during this reporting period(Q1 2025/26), indicating that the management of these incidents was timely and effective. Following a recent Executive-level review, the IP&C Improvement Plan has now been de-escalated and is no longer under direct Executive oversight. However, completion of outstanding actions from the plan is ongoing, including work on Aseptic Non-Touch Technique (ANTT) and management of Multi-Drug-Resistant Organisms (MDROs).

Table 12 PTHB Infection Rates – Q1 25/26

Reduction expectation number	Domain	Current HB rates 2025/26 (April – June)	HB rates 2024/25 (April – June)
E. coli bacteraemia			
1.	Health boards to have fewer overall cases of E-coli Bacteraemia compared to 2023/24	0 Cases reported	0 cases reported
2.	Health boards to have 10% fewer hospital onset cases of E-coli bacteraemia compared to 2023/24	0 Cases reported	0 cases reported
P. aeruginosa bacteraemia			
3.	Health boards to have fewer overall cases of P. aeruginosa bacteraemia compared to 2024/25	0 cases reported	0 cases reported
4.	Health boards to have 10% fewer hospital onset cases of P. aeruginosa bacteraemia compared to 2024/25	0 cases reported	0 cases reported
Klebsiella spp. Bacteraemia			
5.	Health boards to have fewer overall cases of Klebsiella spp. bacteraemia compared to 2024/25	0 cases reported	0 cases reported
6.	Health boards to have 20% fewer hospital onset cases compared to 2024/25	0 cases reported	0 cases reported
Clostridioides difficile			
7.	All health boards to have fewer hospital onset C.difficile cases	<5 hospital onset cases	<5 hospital onset cases

	than they had in the 2024/25 FY		
8.	All health boards should have no more community onset cases than in 24/25	5 community onset cases	8 community onset cases
Staphylococcus aureus bacteraemia			
9.	All health boards to have fewer hospital onset MRSA and MSSA bacteraemia than they had in the 2024/25 FY	0 hospital onset MSSA case	0 hospital onset case

4.1 Antimicrobial Stewardship Progress Report Summary July 2025

Background

Antimicrobial resistance (AMR) is a critical global health threat. Powys Teaching Health Board (PTHB) has implemented a system-wide AMS programme since October 2024, led by a dedicated Antimicrobial Pharmacist. The AMS Group meets quarterly and oversees progress against national targets.

Table 13 Key National Goals & PTHB Progress – 2025/26

Goal	Target	PTHB Status
1. Reduce primary care antimicrobial use by 10% (vs 2019/20)	234.55 items/1000 STAR-PU	262.5 (+0.72%) – Only HB in Wales with increased use
2. 75% of RTI antibiotics as 5-day courses by 2028	75%	53.2% overall – Progressing but below target
3. 70% of antibiotics from Access category by 2029/30	70%	70.4% overall, 68.4% in GP in-hours
4. Reduce 4C antibiotic use (target: 5.65 items/1000 patients)	5.65	9.31 – Highest in Wales, but improving

Highlights & Actions Taken

1. Primary Care Prescribing
   - Increased prescribing driven by GP in-hours (+8.1%).
   - Actions: Dashboard launched, education sessions held, audits underway, targets embedded in contracts and incentive schemes.
2. Optimising Duration

- Improved compliance with 5-day courses, especially for amoxicillin.
- Actions: Dashboard visibility, updated guidelines, audits, and educational posters.

3. Access Antibiotics
   - Target met overall, but GP in-hours slightly below.
   - Actions: Surveillance dashboards, updated guidelines, award-winning dental audit.
4. 4C Antibiotics
   - Highest use in Wales, but recent reductions noted.
   - Actions: Practice-level audits, allergy de-labelling pilot, C. difficile case reviews, and prescribing checklists.

Conclusion
While PTHB demonstrates strong governance and engagement in AMS, urgent focus is needed on reducing overall antimicrobial use and 4C prescribing. Continued education, audit, and system-wide collaboration are key to achieving national targets.

5 Health and Social Care Inspections Regulatory Recommendations

5.1 Health Inspectorate Wales Inspections

During Q4 2024/25 it was reported to committee that 23 outstanding HIW actions were being addressed. Since this time, 18 actions have been completed with the following actions working towards completion,

- Brynheulog Ward continues to make progress toward full compliance with Duty of Candour training, which currently stands at 56.25%, with the aim of reaching 100% by the end of July 2025.
- In relation to the CAMHS National Review, 12 actions have now been completed, with a further five underway and three not yet due for implementation.
- At Clywedog Ward, Llandrindod Wells Hospital, the improvement plan following the Healthcare Inspectorate Wales (HIW) inspection was received on 26 March 2025. Of the 17 actions identified, 15 have been completed.

For assurance there are no actions outstanding that cause a risk to patient or staff safety.

In addition, HIW has recently undertaken an unannounced inspection of Felindre Ward, resulting in three immediate assurance actions (These are highlighted in the MH aspect of this report).

Graph 14 Summary of Outstanding actions by inspection/national review as at 04/07/2025

Year/ Reference No	Inspection Title	Recommendations Made / Actions	Recommendations / Actions Complete	Recommendations / Actions Overdue (agreed timescale)	Actions underway	Recommendations / Actions Not Yet Due
232404	HIW Inspection of Brynheulog Ward	15	14	1		
232405	HIW National Review of CAMHS	20	12		5	3
242502	HIW National Review DNACPR - further updates requested	16	15	1		
242509	HIW Inspection Clywedog Ward	17	15			2
252601	HIW Unannounced Inpsection Felindre Ward	3		2	1	
		71	56	4	6	5

6 PAVO

No reports provided for reporting period.

7 Bereavement Framework

Objectives of the National Bereavement Framework (NBF) are being addressed, assurance can be provided on the following:

- The assessment of the local population's bereavement needs, including for people with protected characteristics.
- Bereavement Training Package on ESR is being piloted in Powys THB, if successful will be rolled out as an 'All Wales' training package.
- The roll-out of bereavement pathways, particularly in Children's Services, CAMHS and bereavement midwifery care.
- Engagement with bereaved individuals through bereavement roadshows and how their feedback is being used to improve services – roadshows are planned for 2025.
- Plans or pilot models to address the current lack of out-of-hours, weekend, and bank holiday support. An 'Out of Hours Bereavement Support Booklet' has been created and is currently being published, this will be disseminated throughout PTHB.

Successes during Q1 2025/26:

- Grief 1st Aid Training – 9 members of staff have successfully completed training to become Grief 1st Aiders and are now equipped to provide compassionate support to colleagues experiencing bereavement. Since the initiative was launched during June 2025 and support has already been provided to staff members.
- The second of two Child Bereavement Training sessions took place on 05/06/2025, with 18 members of staff in attendance. Across both sessions, a total of 35 staff members participated, enhancing their understanding and confidence in supporting children and families through Bereavement.
- Upcoming "Navigating Grief" Event – October 2025 - Plans are currently underway to host a *Navigating Grief* event in October 2025. The full-day programme will feature a series of workshops, lived experience accounts, patient stories, and guest speakers, offering a comprehensive exploration of the grief journey from end of life through the first year of bereavement.

Medical Examiner

- Mortality review – The Health Board continues to receive Medical Examiner reports at an average rate of 7 each month. 22 cases were forwarded in Q1 with the following themes:

    - Issues around verification of death
    - Issues with DNACPR form
    - Concerns regarding the lack of nursing cover overnight in the community and the differences in support across the region due to differing Health Board initiates.

Graph 15 – PTHB Number of ME referrals Jan-Jun 2025

8. Quality & Safety Reports: Provided Services

8.1 Health Board Commissioning for Care Homes: Strategic Overview

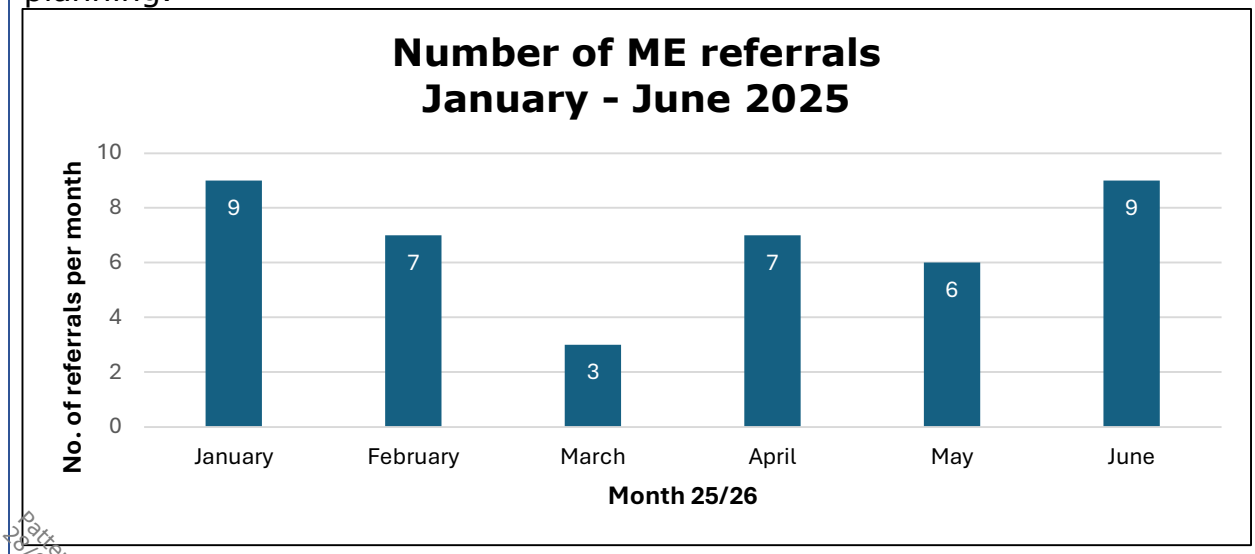
Powys Teaching Health Board commissions care for more individuals in care homes than in local community hospital beds. Given the scale of the care home sector, this carries significant governance implications.

The **All-Wales Care Home Framework** sets the standard for equitable access to primary and community health services for care home residents, aligning care homes with broader community services. Care homes are key partners in delivering integrated, person-centred care that prioritises quality of life.

Key Health Board Actions:

Strategic Planning

PTHB uses the Framework to guide service development, prioritising equitable access for care home residents and embedding their needs into wider service planning.



Operational Delivery

Complex Care Nurses work in partnership with the Local Authority to monitor, review, and support care homes. Over 85% of reviews are now completed within target timescales. These reviews focus on the *lived experience* of residents, ensuring care is guided by personal goals and preferences.
Primary and community services—including diabetes, mental health, respiratory, and therapies—are made accessible to care home residents, supported by clear referral routes and training offers. "In-reach" training strengthens collaboration and promotes consistent approaches to Advance and Future Care Plans, including DNACPR.

Partnership and Oversight
The Health Board participates in the Joint Inter-agency Monitoring Panel with the Local Authority, addressing Escalating Concerns and supporting joint commissioning. Care homes are engaged through regular contact, a named nurse system, and timely sharing of national and local guidance.

Quality and Resident Focus
Information from care home visits informs continuous improvement, with a strong emphasis on resident experience. Reviews centre on residents' aspirations and daily quality of life, aligning with the Framework's focus on individual outcomes and independence.

This approach ensures the Health Board delivers consistent, high-quality care in collaboration with care homes, with governance, service delivery, and planning aligned to the needs and rights of residents.

8.2 Women and Children's Services
Concerns
Q3 2024/25
Formal Concerns <5
Early Resolution 9

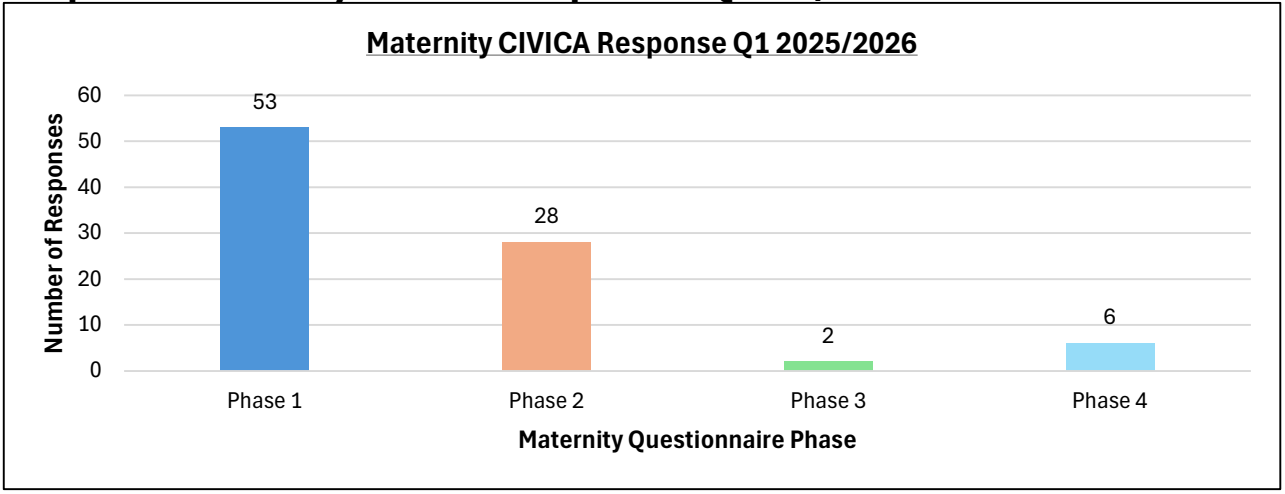
Q4 2024/25
Formal concerns <5
Early resolution 15

Q1 2025/26
Formal concerns 5
Early resolution 22

Positive Feedback
Q1 2025/26, Total 15 regarding the following services:

- Children's community Nursing.
- Paediatric continence.
- Childrens Learning Disabilities.

Graph 18 Maternity CIVICA Responses Q1 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.
- School Nursing has gone live with E-Consent for school-aged vaccinations, there has been a positive reaction by staff, schools and those providing consent.
- Health Visiting will be piloting a blended approach of Generic and Flying Start services from 1/09/2025 to ensure an equitable service is delivered across Newtown.
- Routine Enquiry audit for Q3 2024 demonstrated a significant improvement to routine enquiry documentation.
- The ROM Plus®Test has been introduced into Powys Maternity for women with suspected Rupture of Membranes (ROM). They can now be tested at home or in a birth centre rather than needing to be referred to hospital. This improves efficiency, reduces time and travel, upskills staff and reduces in unnecessary intervention.

Learning

- 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.
- If a woman has a CO reading of less than 4 at booking it should be repeated at 28 weeks and 36 weeks if no other risk factors are present.
- 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.

- Following incidental learning highlighted in a review recent midwives have been advised that women with a history of genital herpes who are midwifery-led care should be referred for review by an obstetrician in line with guidance from BASSH and RCOG.

Incidents

- There have been no incidents in Women & Children's Services that have met the threshold for Duty of Candour during Q1.
- There have been no NRIs in Women & Children's Services during Q1.

Key Priorities for Q2

Maternity
Work in collaboration with Director of Midwifery & Family to develop a strategic workforce plan that includes adapting the on-call period.

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)
The independent review of maternity and neonatal services at Swansea Bay University Health Board report was published on 15 June 2025.

The independent review was commissioned by Swansea Bay University Health Board in December 2023 to provide assurance about the services delivered and to identify opportunities for service improvement. The review has been overseen by an independent oversight panel which has played a key role in providing assurance about all aspects of the review and ensuring the review was delivered in line with the terms of reference.

Swansea Bay maternity support group has also published its family led review into Swansea Bay maternity services with over 50 families contributing to the report. It highlighted their experiences as well as perceived failures in the escalation and oversight process of a number of statutory bodies including Welsh Government**.**

There are common themes running throughout both reports related to poor communication and advice; trauma and fear; women and families feeling ignored; about a lack of compassion and care; informed decision making; access to care; and birth partner separation. They both highlight unacceptable patient and family experiences, cultural issues, staffing, training and resource issues, environmental and safety concerns. These reflect the experiences which women expressed in the recent Llais report.

As a result of the issues highlighted in the family led report and the independent review report, and the ongoing concerns raised, the minister raised the escalation level of Swansea Bay University Health Board's maternity and neonatal services to level four.

As announced in May 2025, the minister has commissioned NHS Performance and Improvement to undertake an all-Wales assurance assessment of maternity and neonatal services. This commenced in June 2025 and will be independently chaired. It will take account of the findings of the recent reviews of maternity and neonatal services across the UK, including in Swansea Bay.

The full report is hyperlinked here Review of our maternity and neonatal services - Swansea Bay University Health Board – (and is available as an attachment electronically on request)

Maternity services in Powys will review current processes and all learning from the SBUHB report and address any shortfalls identified in Powys immediately. To note there are no Powys residents impacted by the review in SBUHB directly.

8.3 Community Service Group (CSG) Integrated Quality Report Quarter 1 2025

Concerns
Q1 2025/26
Formal Concern 19
Early Resolution 9

Points of good practice

- Planned care receive support from the Waiting Well team to ensure the patient, allowing clinical staff to focus on clinical priorities.
- Prompt response to concerns and enquiries.

Learning

- Concerns received relating to waiting times of appointments.
- Communication surrounding appropriate use of services within PTHB (MIU attendance).
- Effective communication with people who identify as neurodivergent.

Incidents Q1 2025/26

Open NRI Incidents <5

Open Duty of Candour Incidents <5

Points of good practice

- Falls huddle in place for all inpatient falls.
- Excellent clinical management of 'walk in' patients attending OPD with unexpected clinical symptoms.
- Appropriate use of WHO checklist in theatre.

Learning

- Pressure damage classification and management
- Correct usage of bedrails in the inpatient setting
- Focus needed regarding timely investigation of datix incidents

CSG Key priorities for Q2

- Implementation of monthly education and joint review of incidents to plan enhanced learning opportunities for staff
- Monthly review of Duty of Candour training and process implementation

8.4 – Mental Health

Concerns and Early Resolution

Trends and themes

- Communication issues linked to patient/service users' appointment.
- Inpatient care.

Learning

- All concerns have been dealt with in a timely manner.
- Positive feedback from students within Older Adult and Adult services has been taken forward to support the learning experience of students.
- Effective information sharing with external agencies.

Service users/family/carer feedback

Civica reports provided monthly are shared with all teams and this includes compliment data which is captured in the PTR reports.

Incident Q1 2025/26
Duty of Candour <5
NRI Incidents reported 6

Trends and themes.

- Increased activity in Violence and Aggression to include physical assault.
- There has been a slight increase in falls for Older Adult services during Q1.

Learning

- Continued review of use of agency staff within wards and the community teams.
- An assault pathway has been updated and developed to support teams on reporting to 101 in line with the V&A operational policy.
- Continued training and understanding of Duty of Candour processes.
- Ensure an MDT review and agreement is in place prior to discharge.
- Partner agencies should be invited to join an MDT meetings/ discussion.
- Documentation must comprehensively detail decision on care planning.

External Assurance Visits
HIW completed an unannounced visit to Felindre Ward, Bronllys Hospital during 10-12 June 2025, final report not yet received.

The three areas of immediate improvement were identified by HIW, these have been addressed:

- Access to ILS training for all staff.
- Review of management and risk register for controlled drugs.
- A review of all care plans ensuring that all patients have care plans for physical and mental health needs.

NEXT STEPS:

Key Matters for Board/Committee

1. **Addressing open incidents with no value**
   ACTION taken: Additional focus and support is being provided by the Head of Quality and Safety and Datix Administrator along with Governance Leads to ensure service address these incidents. Reports continue to be sent out on a weekly basis drawing attention to the heads of service regarding the timely management of incidents

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

Appendix 1 Item 5.1a	Antimicrobial Stewardship Progress Report Summary July 2025
Appendix 2 Item 7.1b	Quality & Safety Governance (Duty of Quality) Final Internal Audit Report 2024/25
Appendix 3 Item 7.2	Joint Commissioning Committee: Quality Safety and Outcomes Sub-Committee Highlight Report
Appendix 4 Item 5.1b	Llais Regional Director Report 21 May 2025
Appendix 5 Item 5.1c	The Independent Review of Maternity and Neonatal Services at Swansea Bay University Health Board

IMPACT ASSESSMENT – NOT REQUIRED FOR THIS REPORT
Not required

Antimicrobial Stewardship Progress Report Summary July 2025

Background

Antimicrobial resistance (AMR) is a significant and growing problem that renders our antibiotics ineffective, making infections difficult or impossible to treat. AMR is cited by WHO as one of the top 10 global public health threats, and is included on the UK National Risk Register.

Factors that contribute to AMR include the inappropriate use of antimicrobials in both human and animal medicine, in plants and crops and unintentional exposure, for example through environmental contamination and food.

The NHS has a key role to play in tackling AMR and all NHS organisations are required to support the implementation of antimicrobial stewardship (AMS) interventions. Powys Teaching Health Board recruited an Antimicrobial Pharmacist in October 2024 to co-ordinate an AMS programme with the aim of managing a whole-system approach to tackling AMR.

The health board has established an Antimicrobial Stewardship (AMS) Group, with representation from across the system. This meets quarterly and provides highlight reports to the health board's IP&C Group, chaired by the Executive Director of Nursing.

An Antimicrobial Stewardship Improvement Plan is in place and is regularly reviewed by the AMS Group. AMS is integrated into educational programmes delivered at the health board, including on the corporate induction, preceptorship programmes and nurse prescribers and student programmes.

AMR Improvement Goals

AMR & HCAI improvement goals reflect the UK's National Action Plan (NAP) and are supported by the Welsh Health Circular (WHC) 2024/038 and AWTTC National Prescribing Indicators (NPI):

Goal	Measure	Drivers
Reduce overall antimicrobial consumption in primary care by 10% against 2019/20 baseline by 2029/30	DDDs per 1000 STAR-PU Items per 1000 STAR-PU	NAP Target 4a 2024-9 WHC 11a 2024 NPI 2025-8
Reduce overall antimicrobial consumption in secondary care by 5% against 2019/20 baseline by 2029/30	***NB: Unable to measure at PTHB therefore not included***	NAP Target 4a 2024-9 WHC 11b 2024 NPI 2025-8
75% of antibiotics prescribed for RTIs are 5-day courses (compared to 7) by 2028	% of 5-day prescriptions for amoxicillin, doxycycline and clarithromycin vs 7 days	NPI 2025-8
70% of total antibiotics used from Access category (preferred, narrow-spectrum agents) by 2029/30	% antibiotic use (in DDDs)	NAP Target 4b WHC 12
Maintain levels of 4C antimicrobials (cephalosporins, clindamycin, co-amoxiclav, quinolones) within lower quartile or show reduction towards quartile below	Items per 1000 patients	NPI 2025-8

PTHB Progress for the above goals is described below:

1. Reducing overall antimicrobial consumption in primary care

PTHB is the second lowest consumer of antimicrobials compared to other Health Boards in Wales, but is the only Health Board that is showing **increased consumption**:

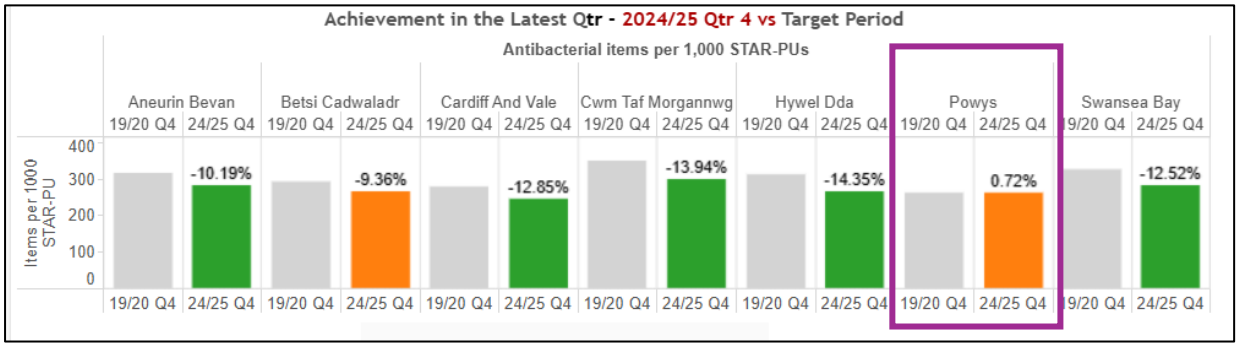


Figure 1: Change in total volume of antimicrobials prescribed in Health Boards

Table 1: PTHB Progress on reducing total antimicrobial items per 1000 STAR-PU

Baseline value 2019/20 Q4	Target 2024/5 Q4	Actual value 2024/5 Q4	Target % change	Actual % change
260.6	234.55	262.5	- 10%	**+0.72%**

The data includes all primary care prescribing (e.g. including GP in/out of hours, dental and pharmacist prescribers.). The greatest increase is seen in **GP in-hours prescribing** (8.1% vs 3% increase total PTHB primary care at the end of 2023/4).

Plan and Progress
- PTHB Prescribing Indicators Dashboard live and shared with practices to allow data visibility on total antimicrobial prescribing. This allows for benchmarking and follow-up with practices regarding sub-optimal prescribing. - PTHB Antibiotic guidelines (hosted on Eolas) outlines when antibiotics not recommended (e.g. acute otitis media), as well as appropriate selection and duration. - Practice Education Sessions undertaken at PTHB Protected Learning Time addressing overprescribing and evidence for when no benefit seen from antibiotics. - AMS pharmacist working with outlying practices to undertake audits on long-term antibiotic use, total antimicrobial prescribing and high-prescribing infections (e.g. UTI) - Target included in contract assurance - Target included in Medicines Management Incentive Scheme (MMIS) - SLA practices working with AMS pharmacist - All Wales Backup prescribing guide hosted on Eolas platform and discussed with practices.

2. Optimising Antimicrobial Durations

PTHB has recently made significant progress with optimal course durations (5 vs 5 or 7 days) in Wales, and is no longer in an outlying position.

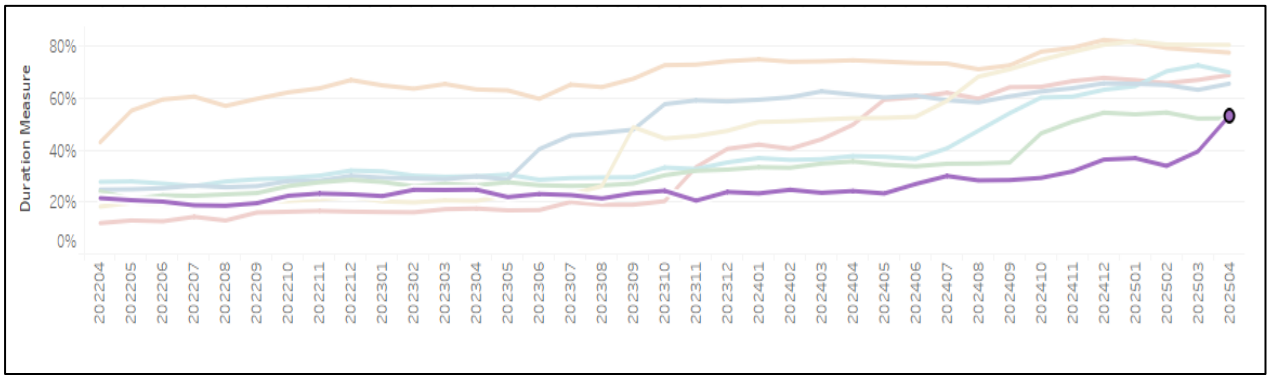


Figure 2: Percentage of amoxicillin, clarithromycin and doxycycline prescriptions issued as 5-day courses vs 5 plus 7-day courses in Health Boards (PTHB is purple).

Table 2: PTHB progress on achieving NPI target of optimising RTI prescribing

Antibiotic	Target % 5-day prescription	Actual value % 5-day prescription
Amoxicillin 500mg capsules	75%	**63.6%**
Doxycycline 100mg capsules	75%	**43.7%**
Clarithromycin 500mg tablets	75%	**38.8%**
Combined RTI antibiotics	75%	**53.2%**

Plan and Progress
- Prescribing Indicators Dashboard live and shared with practices to allow data visibility on course lengths of all three measured antibiotics. - Practice Education Sessions undertaken at PTHB Protected Learning Time addressing course length - Posters produced and given to practices to outline course lengths for common infections - Antimicrobial guidelines on Eolas updated and publicised (increase in users from 101 to 192 members since April 2025) containing information on recommended durations - Target included in MMIS supported by cough/bronchitis audit conducted by medicines management team in Summer 2025 - Community Hospital antimicrobial guideline adherence audit conducted in February 2025 and results fed back to ward managers, pharmacy teams, and community hospital learning forum

3. Access Category Antimicrobials

Access antimicrobials are preferred narrow-spectrum agents that are associated with less harm. PTHB are currently meeting the 70% target for "Access" antibiotic use as a health board (combined primary and secondary care data). For GP in-hours, however, this reduces to **68.4%.**

This figure is lower than expected compared to other health boards, as PTHB does not have a district general hospital to account for the volumes of non-"Access" antibiotic use (such as IV Tazocin). This may be explained by PTHB's high use of oral broad-spectrum antibiotics (see section 4.)

Figure 3: Proportion of Access, Watch and Reserve antibiotics as a proportion of total antibiotics prescribed in Health Boards.

Table 3: PTHB progress on proportion of antibiotics prescribed from the "Access" group

Target % Access group	Actual value % Access group
70%	**70.4%**

Plan and Progress
- PTHB BNF Analysis dashboard created by Medicines Management Team for surveillance of Access, Watch and Reserve prescribing to highlight and address non-"Access" prescribing with prescribers. - Surveillance for hospital IV prescribing via MS forms completed by pharmacy team, pending EMPA implementation to allow for better surveillance. - Antibiotic guidelines (Eolas) updated to recommend access antibiotics wherever appropriate, in preference to broad-spectrum/more toxic antibiotics. - Community Hospital antimicrobial guideline adherence audit conducted in February 2025 and results fed back to ward managers, pharmacy teams, and community hospital learning forum - PTHB Community Dental team audit demonstrated significant improvements in antimicrobial prescribing and won a commendation at the 2025 UK National Antibiotic Guardian Awards.

4. Reduce 4C Antimicrobials

The 4C antimicrobials are broad-spectrum agents associated with increased multi-drug resistance, as well as the most common antibiotics implicated in *C. difficile* infection and MRSA bacteraemia.

PTHB is the highest prescriber of 4Cs in Wales, but has recently made good progress to reduce their use in Q4 2024/5:

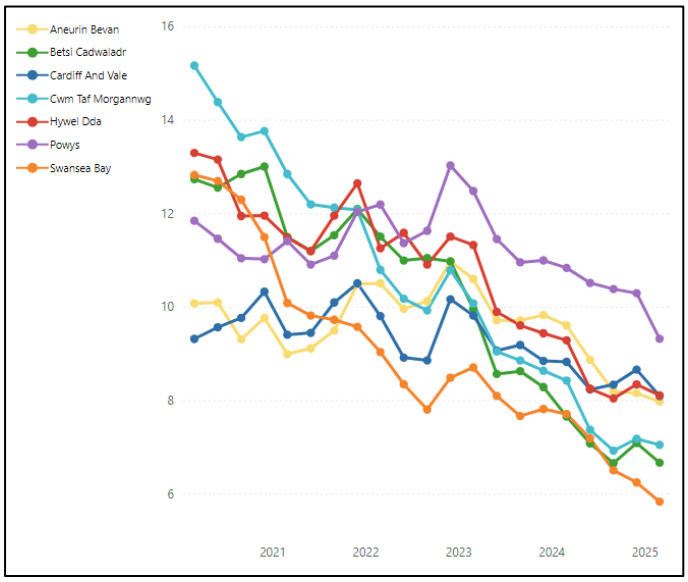


Figure 4: 4C antibiotic prescribing in items/1000 patients in Health Boards

Table 4: PTHB Progress on meeting the NPI on 4C broad-spectrum antimicrobial prescribing

Target number of 4C items/1000 patients 2024/5 Q4	Actual value of 4C items/1000 patients 2024/5 Q4
5.65	**9.31**

Plan and Progress
- Prescribing Indicators Dashboard live and shared with practices to allow data visibility and benchmarking, as well as follow-up with practices, with breakdown of individual 4C prescribing, as well as overall 4C prescribing. - Health-board wide 4C prescribing audit undertaken in Q1 2025/6 and individual practice reports discussed with practices. HB-report to be shared at the Antimicrobial Stewardship Group in Q3 2025/6. - History-based penicillin allergy delabelling pilot project as part of national workplan to be undertaken by AMS pharmacist in 2025/6, then rolled-out to other practices. - All cases of c. difficile infection are reviewed and learning is shared collaboratively with IPC, AMS pharmacist and ward teams. - Data visualisation and learning in primary care following community acquired/identified C diff infections requires further work. - Target in the MMIS - Target reflected in contract assurance - Fluroquinolone prescribing checklist written and hosted on Eolas

Region:	**Powys**
Report:	**Regional Directors Report**
Period Covered:	**19 March 2025 to 13 May 2025**
Author:	**Katie Blackburn**
Status:	**For Information**
Date:	**21 May 2025**

Local/ Regional Update – Engagement:

April	Crotchet & Cuppas	Newtown
	Men's Shed	Newtown
	Newtown Medical Practice	Newtown
	Visual Impairment Group	Newtown
	Ladywell Surgery	Newtown
	Llais Local Coffee Morning	Newtown
	MIND Mum's Matter	Newtown
May	Llanfyllin Public Forum	Llanfyllin
	Epynt Ward	Brecon

Llais Local, Newtown – Initial Observations

Group/event/activity name	Newtown Crochet and Cuppas Community Group
Working well	● RJAH Hospital praised for good care. ● Bronglais Hospital's cancer unit highly rated.
Needs improvement	● NHS dental access is extremely limited, with some individuals being forced to go private. Those registered

	with My Dentist are experiencing app cancellations due to only one dentist in position. Minors not being seen. ● Transport Issues for Medical Appointments ● Long Waiting Times for Appointments & Treatment ● Ambulance Response Delays & Emergency Care Issues. ● Poor Hospital & A&E Experiences - Complaints about staff attitude, lack of urgency, and poor treatment in hospitals. Patients left waiting too long for emergency care. Concerns over inadequate screening of ambulance calls. ● Issues with Disability & Accessibility - Lack of disabled access to NHS dentists. ● Concerns over long distance to access follow up appointments that could be done over the phone (discussing results for example). A 2 hr round trip for a 15-minute appointment is very wearing.
Group/event/activity name	**Men's Shed**
Working well	Several praised kind staff in specific services (e.g. physios, nurses, memory clinic). Shed seen as key source of peer support.
Needs improvement	Long waits (e.g. CMHT, OT), disjointed follow-up, inaccessible communication
Group/event/activity name	**Newtown Medical Practice**
Working well	Prescription Process is well organised
Needs improvement	● Access & Transportation Issues – Access to out of town appointments is very difficult for patient to reach due to geography and access to public transport. ● Long Wait Times for Appointments to see a GP – Reports of waits up to 5 weeks.

	● Loss of local services - Disappointment about the permanent closure of the Newtown leg clinic; it hasn't reopened post-Covid and affects accessibility and health outcomes.
Group/event/activity name	**Ladywell Surgery**
Working well	● Positive experience with home adaptations from Powys County Council. ● Positive experience with Ladywell Surgery. ● excellent mental health support.
Needs improvement	**Access to Dentistry, including**: - having to travel to Oswestry for dental care. - unable to access an NHS dentist in Newtown for self and diabetic father. **Mental Health Services - good and poor experiences** ● Mentions that inadequate housing is negatively impacting mental health. **Physical Disability & Adaptations** ● Positive experience with home adaptations from Powys County Council. ● Long wait (2 years) for a wet room; praises the occupational therapist's efforts. **Accessibility Issues** (e.g., parking, town design) ● Disabled access and parking are poor due to new town design; now must collect prescriptions from a different pharmacy.
Group/event/activity name	**Newtown Pop Up Coffee Shop**
Working well	● Praise for community transport services. ● Positive mentions of Rekindle and CAMHS.

	● Praise for Ladywell Surgery. ● Triage system working well.
Needs improvement	**Access to NHS Dentistry in Newtown** ● Multiple complaints about being removed from lists without reason. ● Long gaps between appointments. ●No availability or forced to go private. ●Concerns about age discrimination. ● Inaccessibility due to poor public transport for medical needs. **Transport Issues (Buses & Patient Transport)** ●Poor bus service to Shrewsbury Hospital. ●Concerns about requiring changes of transport service in Welshpool. **Cross-border Healthcare & Communication Between Welsh and English Services** ● Poor coordination between Welsh and English hospitals. ●Duplicate scans due to inaccessible records. ●Delays in care due to lack of communication. **Poor Communication & Continuity of Care** ●Between GPs, hospitals, and social services. ●Lack of access to medical records. ●insufficient information sharing. ●Fragmented services and patients having to repeat their stories. **Social Services & Mental Health Support** ●Lack of continuity with social workers.

	●Inadequate mental health services for people with learning disabilities or psychosis. ●Long wait times and insufficient aftercare. **Extended Waiting Times for Treatment** ●Delays in surgery referrals. ● Hip replacements – long waiting times. ●Concerns that delays could be life-threatening. **Air Ambulance Concerns** ●Concerns about losing the Wales Air Ambulance. ●Importance of local emergency services in rural areas. **Wellbeing Hub / Health Infrastructure Planning** ●Requests for diagnostic centres in Newtown. ●Need for better community information about the hub. **Lack of Male-Focused Domestic Abuse Support** ●A deeply personal story highlighting gaps in support for male abuse victims. ●Need for awareness, targeted funding, and support resources. **Parking Issues at Medical Facilities** ●Limited parking availability at both Newtown Medical Centre and hospitals. **Staffing Issues at Local Practices** ●Struggles to recruit doctors in Newtown.
Group/event/activity name	**MIND Mums Matter**
Working well	**Credu Service**

	● High praise was given for Credu bringing back the phone line for carers, they have been very helpful for a carer of a paediatric. **Sexual Health Services** ● Newtown sexual health services praised;
Needs improvement	**GP Access** **Specialist Access** **NHS Dental Care** ● No one able to access Dental Care Access free NHS dental care before or after birth. ● lived here 6 years and not seen a dentist. ● had to travel to Shrewsbury for child's dental appointment. **Neurodevelopmental Health - ADHD** ● Unable to access a referral for daughter. **Maternity & Postnatal Care** **NHS 111 Service:** ● Frustrating repetition – same issue has to be explained three times during the process. **Financial Support & Benefits:** ● Full-time carer cannot claim because husband lacks a formal diagnosis. Have not been offered any advice on how to advance the issue.

What we've heard in Powys:

Health Issues

Access to GP Services - Long waits for non-urgent appointments, delisting from GP lists after mental health incidents, difficulty getting through triage systems.

Access to NHS Dental Services - Long waits for appointments, deregistration without notice, lack of local provision forcing long travel or private care.

Access to Mental Health Services - Long waits for assessments, poor communication, gaps between children's and adult services, lack of flexible and consistent care.

Poor Communication by Health and Social Care Services - Families not kept informed about changes in care; patients left uncertain about complaints processes; missing follow-up after complaints.

Ambulance & Hospital Stays – We keep hearing about long ambulance waits, challenges with follow-up care, and people being stuck in hospital because the right support isn't in place for them to go home.

Social Care Issues:

Discharge Delays and Care Package Provision - Delays organising social care support after hospital discharge; lack of communication about when support would start.

Delays in Assessments – Social care assessments are taking too long, leaving people without the support they need.

Support for Carers – Unpaid carers are finding it tough. There's a real need for clearer guidance and financial support.

Poor Communication by Health and Social Care Services - Families not kept informed about changes in care; patients left uncertain about complaints processes; missing follow-up after complaints.

National Updates:

Listening to parents: Llais publishes report on maternity experiences in Swansea Bay

https://www.llaiswales.org/news-and-reports/news/listening-parents-llais-publishes-report-maternity-experiences-swansea-bay

Llais response to the NHS Wales Performance and Productivity Review and Welsh Government Action Plan

https://www.llaiswales.org/sites/default/files/2025-05/Llais%20response%20to%20the%20NHS%20Wales%20Performance%20and%20Productivity%20Review%20and%20Welsh%20Government%20Action%20Plan.pdf

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

https://www.llaiswales.org/news-and-reports/news/llais-new-nhs-wales-targets-are-welcome-most-importantly-change-must-be-felt

Advocacy:

Total no. new cases opened	12
Total no. cases closed	2
Total no. open advocacy cases	116

Emergent themes from complaints:

- Being appointed a Care Co-ordinator (MH)
- Lack of Social Work support
- Having to travel cross-border for orthodontic treatment
- Patients being transferred to England for Mental Health admissions
- Poor follow up care in private hospital when NHS care has been outsourced
- Waiting list for T&O surgery

Regional Ambassador – Dr. Rajan Madhok

Dr. Rajan Madhok has recently been nominated as the Regional Ambassador for Powys.

Having lived in South Denbighshire since 2018, Rajan has a fondness for the Welsh culture and began learning Welsh recently.

Before retiring he was a public health doctor, working in senior medical management positions in the NHS in England.

During his active career, Rajan's main interest was in patient centric health care especially patient and worker safety and academic medicine.

Amongst many other positions in the past Rajan was the Chairman of British Association of Physicians of Indian Origin and a Council member of the General Medical Council.

He is currently a trustee of some voluntary organisations, and a Non-executive director on the Board of Wirral University Teaching Hospitals NHS Foundation Trust.

Rajan is passionate about public engagement, leadership development and on promoting reflective practice. He is pleased to be part of the important work that Llais is going to deliver for the people of Wales.

Katie Blackburn

Regional Director – Llais Powys

13 May 2025

Agenda item: 5.2

Patient Experience, Quality and Safety Committee	Date: 31 July 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 – 8 May 2025 Executive Committee – 14 May 2025 Board – 21 May 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 newly developed 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 newly developed SRR to be considered by the Board on 30 July 2025.

RECOMMENDATION(S):

The 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	

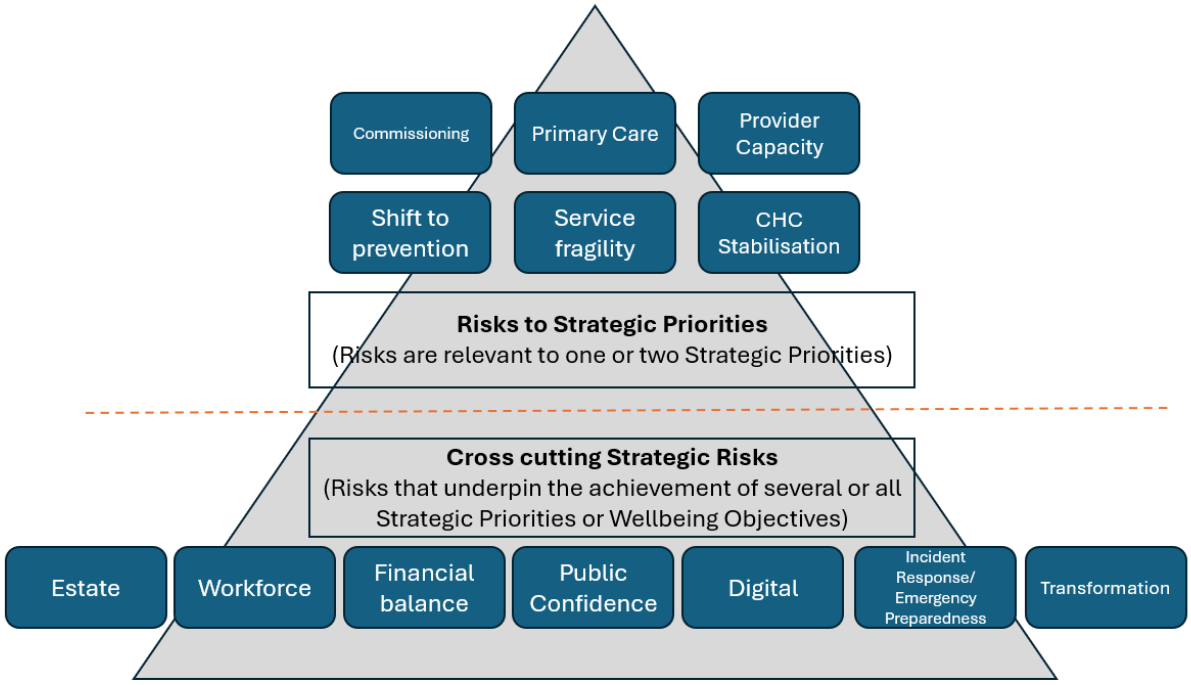
REVISED COMMITTEE RISK REGISTER

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.

In March 2025 the Board approved a revised Risk Management Framework (RMF), The key fundamental change within the revised framework was the closure of the Corporate Risk Register (CRR), to be replaced with a Strategic Risk Register (SRR), owned by the Board and an Organisational Risk Register (ORR), focused on significant and cross-organisation operational risk, owned by the Executive Committee.

In the weeks following on from the approval of the revised RMF the Corporate Governance Team has been working closely with the Board, individual Executive Directors and Assistant and Deputy Directors to develop the new SRR.

On 21 May 2025, an update on progress was reported to the Board which provided a summary of the identified risks to the delivery of the Health Boards Strategic Priorities and their associated risk descriptors. It was noted that some of these risks had been identified as 'cross-cutting' (underpinning the achievement of several or all Strategic Priorities or Wellbeing Objectives) and risks to Strategic Priorities which were relevant to one or two of the Strategic Priorities identified within the Health Board's Integrated Plan. An overview of this update is provided below:



The proposals were supported by the Board on 21 May 2025 and the Board is due to receive a fully developed SRR on 30 July 2025.

Whilst in development the following risks have been identified as falling within the Patient Experience, Quality and Safety Committee's remit for scrutiny and oversight on behalf of the Board:

Risk Reference and Title	Description	Current Score (Draft): likelihood x impact
SRR 003 – **Commissioning**	the Health Board is unable to respond to the demand for commissioned services.	**L5 x I4 = 20**
SRR 004 – **Provider**	the Health Board is unable to respond to the demand for provided services.	**L4 x I4 = 16**

Following review by the Directorate of Primary, Community Care and Mental Health it was found that there was a large degree of duplication between the following risks supported by the Board on 21 May 2025:

Summary	Risk description
Provider	There is a risk that the Health Board is unable to respond to the demand for provided services

System Resilience	There is a risk that the Health Board is unable to deliver integrated, resilient health and care services

The proposed system resilience risk has therefore been integrated into SRR 004 (Provider).

Committee Risk Register is attached at **Appendix A.**

NEXT STEPS:

The newly developed Strategic Risk Register will be presented to the Board on 30 July 2025.

The Committee will continue to seek assurance on the ongoing development and management of patient experience, quality and safety risks as set out above.

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

Committee Risk Register

Patient Experience, Quality and Safety Committee

July 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

Almost certain 5				SRR 003 – Commissioning	
Likely 4				SRR 004 – Provider	
Possible 3					
Unlikely 2					
Rare 1					
LIKELIHOOD X IMPACT	**Insignificant 1**	**Minor 2**	**Moderate 3**	**Major 4**	**Catastrophic 5**

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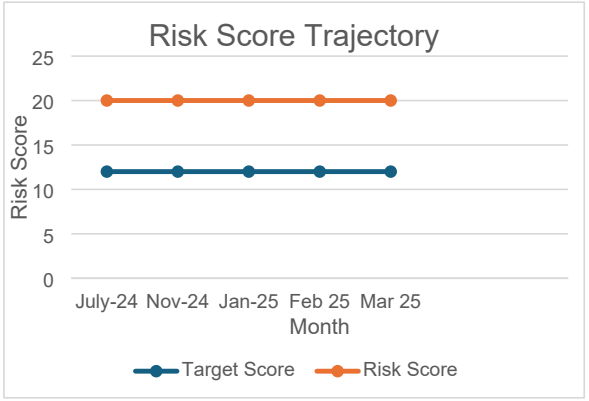
SRR 003	There is a risk that the Health Board is unable to respond to the demand for commissioned services	
Current Risk Score: **20**	**Risk rating detail:** (likelihood x impact) Current: L5 x I4 = 20 Inherent: L5 x I4 = 20 Target: L3 x I4 = 12	**Risk Category:** Performance and Service Sustainability **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 sources (e.g. activity) whilst working through improved data set for GP referrals.	Limited	Executive Director
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	Various data sources including operational & performance data. Qualitative information	Limited	Executive Director

	Finance and Performance Committee and Board as well as future planning	from QMS, PROMS & PREMS reporting, concerns, NRIs, clinical audit, regulatory inspections		

Mitigating Actions (What more will we do?)				
Action	**Lead**	**Action update**	**Deadline**	**Action on Target**
Planned Care ▪ 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.	April 2025 and ongoing	On track

		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.		
▪ 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.	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	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

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▪ Continue series of regular meetings with WAST and commissioned service providers. ▪ Continue commissioning of ambulance services in partnership through the Joint Commissiong Committee ▪ Secure performance improvement trajectories and improvement plans from providers.		recent ICAP meetings have been cancelled. Regular attendance at CCLG and sub- committee structure. New governance structure being developed by the JCC 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:

Planned Care

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	H	398		7	L	2712	154	H
Betsi Cadwaladr University Local Health Board	47.8%	285		172		33	L	689	89	
Cardiff & Vale University Local Health Board	43.7%	177	H	111	H	12		387	46	
Cwm Taf Morgannwg University Local Health Board	53.0%	327	H	189	H	3	L	920	91	H
Hywel Dda Local Health Board	59.3%	449	L	238	L	7	L	1533	0	L
Swansea Bay University Local Health Board	56.3%	610		317		0	L	1956	0	L
Total	57.2%	**2556**	H	**1425**		**62**	L	**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):

	Mar-25	No. long waits by cohort, with latest SPC variance						Total pathways Waiting
English Providers	% of Powys residents < 26 weeks for treatment	All pathways waiting over 36 weeks.		All pathways waiting over 52 weeks.		All pathways waiting over 104 weeks.		
English Other	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.

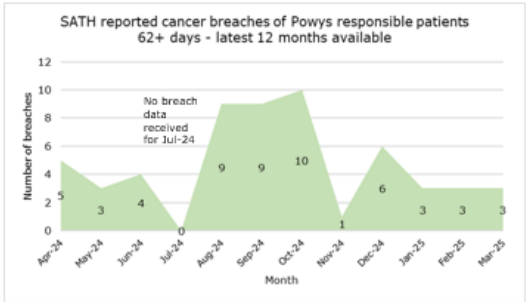
- Work ongoing with NHSE providers, primarily RJAH, SaTH and WVT, re PTHB Commissioning Intentions 2025/26, commissioning to NHS Wales treatment targets.

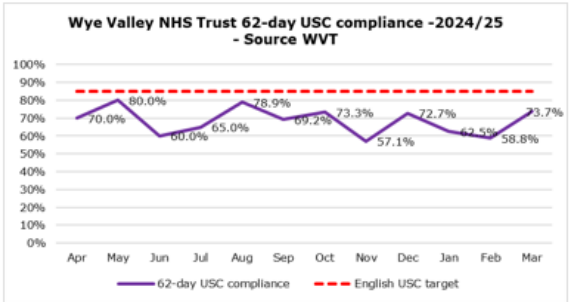
Cancer

- 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).

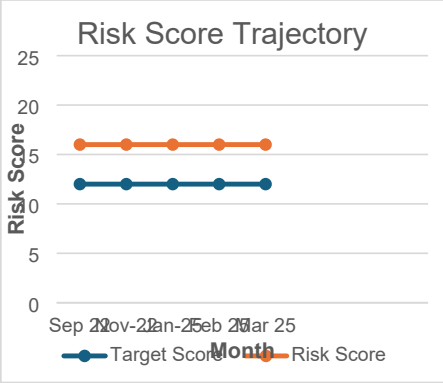
Data Quality

- 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 issue a tender for insourced provision in 2025/26. Ongoing scrutiny and oversight through CQPR meetings with escalation through Integrated Performance Report.	Executive Director PCCMH	Performance Trajectories being routinely monitored and managed.	September 2026	On track

<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 mitigate delays, improve patient flow, and support timely discharge across the system.	Executive Director PCCMH	Flow Hub: model scoped, and roles identified; launch planned for September 2025. 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.	March 2026	On Track

		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.

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 5.4

PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE	**DATE 31 July 2025**
Subject:	Deprivation of Liberty Safeguards (DOLS) Internal Audit Report – Monitoring of Matters Arising
Approved and presented by:	Claire Roche Executive Director of Nursing, Quality, Women and Family Health
Prepared by:	Assistant Director of Nursing, Safeguarding Mental Capacity Senior Practitioner, Safeguarding
Other Committees and meetings considered at:	Executive Committee 09 July 2025 – who took assurance from the progress report recognising some dates have not been fully met as yet for operational management reasons.

PURPOSE:

To update the Patient Experience, Quality and Safety Committee on the matters arising from the NHS Wales Internal report for DoLS in January 2025.

RECOMMENDATION(S):

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

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

Approve/Take Assurance	Discuss	Note
Y	N	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	Y	
4. Enable Joined up Care	Y	
5. Develop Workforce Futures	N	
6. Promote Innovative Environments	N	
7. Put Digital First	N	
8. Transforming in Partnership	N	

EXECUTIVE SUMMARY:

In January 2025 PTHB received the NHS Wales Internal Audit of MCA DoLS **(Appendix 1)** which gave overall limited assurance. The audit determined key matters arising and recommended three high priority actions and three medium priority actions. The outcome from the audit was as expected.

The recommendations and required actions have been translated into an action plan. Monitoring of the action plan is achieved through the MCA Operational Group which reports to the Strategic Safeguarding Group.

AUDIT SUMMARY

The Health Board has statutory responsibilities from the Mental Capacity Act Deprivation of Liberty Safeguards (MCA DoLS), which requires PTHB to be a Supervisory Body and Managing Authority with prescribed responsibilities, to ensure that correct legal procedure is undertaken to authorise a patient who is being deprived of their liberty and cannot consent for this.

An MCA gap/analysis paper presented to the Executive Board in March 2024 highlighted significant risks for both the Health Board and patients and recommended action to strengthen PTHB Supervisory Body. These risks were captured on the risk register, interim mitigations have been taken; however, these are not sustainable and require a permanent solution.

The Internal NHS MCA DoLS audit reported in January 2025 and returned limited assurance. The report recommended 3 High priority actions and 3 medium priority actions.

In response to audit and the previous gap analysis undertaken, a business case to support the development of a Supervisory Body was presented and approved at PTHB Executive Committee in May 2025, enabling the identified improvement work to commence.

Management Action Plan

Recommendation 1	**Priority**
The DoLS policy should be reviewed and brought up to date as necessary with a date of the next review noted in line with any appropriate Health Board guidance on Policy documentation maintenance. The updated policy should include reporting requirements, including frequency, content, to whom, and format (spreadsheet, table, dashboard etc).	Medium
Agreed Management Action	**Target Date**
PTHB DoLS policy requires updating. **Update; partially completed**	June 2025

The content of an updated DoLS Policy was dependent on the outcome of business case. Now the business case has been achieved, updating of the DoLS policy has commenced and will include reporting requirements.	

Recommendation 2	**Priority**
The Health Board has effective arrangements in place for providing training to nursing staff on the wards relating to DoLS processes. However, there is currently no on-going cycle of DoLS training in place that is directed towards the Managing Authority responsibilities. This gap in training is linked to the current lack of a DoLS co-ordinator post within the Health Board. Once the DoLS co-ordinator post is in place, training on the DoLS Managing Authority responsibilities should be developed along with a plan for on-going delivery.	Medium
Agreed Management Action	**Target Date**
A business case will need to be made for the role of DoLS co-ordinator. A training needs analysis will be undertaken to determine required cycle of training. Identified training to be offered to the Managing Authority. **Update; partially completed** Business case agreed for DoLS co-ordinator role. Recruitment commenced; interviews planned for July 2025 Task & Finish group initiated to undertake a training needs analysis of MCA DoLS. Each PTHB ward offered a session on Managing Authority Responsibilities & PTHB process, 6 wards completed to date, with remaining to be arranged. DoLS Co-ordinator, when recruited, will take the lead for on-going sessions alongside outcome from T&F work on training.	September 2025

Recommendation 3	**Priority**
Action First are commissioned to provide BIA assessments when the demand rises above a level that can be managed by the Health Board staff. The Health Board DoLS team should create a process to ensure that any staff provided by Action First are fully qualified and that any certification requirements for the role are up to date.	Medium
Agreed Management Action	**Target Date**
Safeguarding Team to ensure they have a process to maintain evidence of correct qualifications from external assessors. To ensure that procurement amend the contract as required. **Update; Action completed** Safeguarding Business manager has a process in place that monitors evidence that external assessors have correct qualifications. Procurement advice implemented with agency.	February 2025

Recommendation 4	**Priority**
There remains a gap in the provision of a dedicated DoLS Supervisory Body role within PTHB, that provides oversight and co-ordination of the process and decision-making required. This is a gap that has been identified to PTHB Executive team The Health Board should ensure that arrangements are put in place as soon as possible to allow for the on-going provision of the DoLS Supervisory Body Role.	High
Agreed Management Action	**Target Date**
A business case will need to be made for the role of DoLS co-ordinator, administration and Best Interest Assessors. Depending on outcome of business case, recruitment into positions will be required. **Update; partially completed** Business case agreed for DoLS co-ordinator role. Recruitment commenced; interviews planned for July 2025 Recruitment for Best Interest Assessor due to go live in coming week. Administration provision is in place and a service level agreement is being progressed with Powys County Council.	June 2025

Recommendation 5	Priority
Delays are currently being experienced in obtaining timely sign-off of DoLS applications. The DoLS Signatories element of the process is reliant on senior staff agreeing to be part of a DoLS Signatory rota which is challenging to maintain due to being additional to normal duties. The DoLS Co-ordinator role would help to reduce this pressure and ensure timely scrutiny and sign-off of DoLS applications. The Health Board must ensure that all DoLS applications are reviewed and signed off in a timely manner.	High
Agreed Management Action	**Target Date**
A business case will need to be made for the role of DoLS co-ordinator This role will include to sign off the applications and review the current signatories process and manage the signatory's rota. **Update; partially completed** Business case agreed for DoLS co-ordinator role. Recruitment commenced; interviews planned for July 2025 This role will develop the current authorisation process and will serve as a signatory alongside the rota of signatories. Additional 5 signories identified, trained and on the rota.	June 2025

Recommendation 6	Priority
Management reports should be developed to record ongoing performance against the target dates. These should then be reported to an appropriate group and / or Committee with actions identified to improve performance where required. The case tracker spreadsheet could be developed to track and monitor progress on a case-by-case basis to confirm whether the target dates are being achieved and facilitate qualitative reporting, not just quantitative. Ideally a shared system should be used to enable all authorised users at least read access to live case data	High
Agreed Management Action	
A case tracker spreadsheet will be updated and accessible in real time for PTHB Supervisory Body. A Dols Co-ordinator role will need to be in place to provide the challenge and scrutiny. Performance will be reported into PTHB Strategic Safeguarding Group. **Update; partially completed** A case tracker spreadsheet has been updated and accessible to PTHB Supervisory Body in real time. Action completed Feb 2025. DoLS co-ordinator role, when recruited, will provide the required challenge and scrutiny. Performance will be reported into PTHB Strategic Safeguarding Group and MCA Operational group from Q1 of 2025/26. KPI's and data requirements have been identified and agreed between PCC and PTHB.	June 2025

NEXT STEPS:

- On-going implementation and monitoring of the Improvement Plan to the MCA Operational and Practice Improvement Group and Strategic Safeguarding Group

Appendix 1 NHS Internal Audit MCA DoLS January 2025

IMPACT ASSESSMENT

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

QUALITY:

	No impact	Negative	Positive	Both	
Safe					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					

Deprivation of Liberty Safeguards
Final Internal Audit Report

January 2025

Powys Teaching Health Board

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

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

Contents

Review reference:	PTHB-2425-10
Report status:	Final
Fieldwork commencement:	11 September 2024
Fieldwork completion:	06 November 2024
Debrief meeting:	26 November 2024
Draft report issued:	08 November 2024 & 10 December 2024
Management response received:	23 December 2024
Final report issued:	30 December 2024
Auditors:	Ian Virgil Head of Internal Audit John Cundy Principal Auditor
Executive sign-off:	Claire Roche Executive Director of Nursing, Quality, Women and Family Health
Distribution:	Jayne Wheeler Sexton, Assistant Director Nursing - Safeguarding Rachel Lewis, Safeguarding Business Support Manager Michelle Lewis, Senior Practitioner for Mental Capacity
Committee:	Audit Risk & Assurance Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

Acknowledgement
NHS Wales Audit and Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Executive Summary

Purpose

The overall objective of the audit was to review the controls and processes in place for the control, operation and reporting of the Deprivation of Liberty Safeguards (DoLS) as operated by the Health Board.

Overview:

We have issued Limited assurance on this area.

We note that following a period of difficulty for the DoLS process due to staff shortages within PTHB and PCC the situation is now improved but is not sustainable going forward. Clarity is required over the future provision of the DoLS Supervisory Body role and there are issues around capacity and delays in key stages of the DoLS application process.

The matters requiring management attention include:

- Review of the DoLS Policy;
- Ensuring appropriate on-going provision of training around the Managing Authority responsibilities;
- Contractor supplied Best Interest Assessors should have their qualifications confirmed periodically;
- Establishing a sustainable approach for the future delivery of the DoLS Supervisory Body role;
- Improvement to the process and timeliness for authorisation of DoLS applications; and
- Case tracking and Management Information could be improved with qualitative data as well as quantitative.

Report Opinion

Limited

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved

Assurance summary[1]

Objectives		Assurance
1	Policy and procedure documentation	Reasonable
2	Training and Accreditation	Reasonable
3	Process Operation	Limited
4	Reporting	Limited

[1]The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	Policy and process document	1	Design	Medium
2	Provision of Training on Managing Authority Responsibilities	2	Design	Medium
3	BIA contractor qualification	2	Design	Medium
4	Provision of DoLS Supervisory Body role	3	Design	High
5	Authorisation of DoLS Applications	3 & 4	Operation	High
6	Case tracking	4	Operation	High

1. Introduction

1.1 Our audit of the Deprivation of Liberty Safeguards (DoLS) policy and procedures was undertaken in line with the 2024/25 Internal Audit Plan for Powys Teaching Health Board ('the Health Board').

1.2 The Deprivation of Liberty Safeguards (DoLS) are an amendment to the Mental Capacity Act 2005 (the 'Act'), and provides protection for vulnerable people, in care homes or hospitals who lack capacity to consent to the care or treatment they need. In 2014, following a Supreme Court ruling, the law in relation to DoLS changed, meaning the Act applied to far more people than it had previously, with the number of people subject to DoLS increasing significantly.

1.3 In 2019 the law was changed with an amended Mental Capacity Act (2019) (MCA). The MCA (amendment) 2019 was to put in place new legislation, the publication of a new code, and regulations under Liberty Protection Safeguards (LPS). These changes were originally scheduled to replace the DoLS legislation and procedures from 1 October 2020. However, in April 2023 the Department of Health and Social Care announced the implementation of the Liberty Protection Safeguards (LPS), the Mental Capacity (Amendment) Act 2019, would be delayed "beyond the life of this Parliament" (therefore beyond Autumn 2024). As such, the existing 2009 amendment from the Mental capacity Act (2005), with its codes of practice, policies, rules and regulations are still extant.

1.4 Our review looked at the current processes for DoLS applications to ensure they are managed in accordance with the DoLS Code of Practice, Welsh Government guidance and Health Board procedures.

1.5 The potential risks considered for this review were as follows:

- Policies, procedures and responsibilities relating to DoLS are not clear resulting in non-compliance with regulations.
- DoLS applications are not logged and actioned promptly causing delays in assessments, patient's clinical needs not being met, and possible patient harm.
- Information used for monitoring DoLS applications is not up to date, accurate or complete and action is not taken to address backlogs, causing reputational damage to the Health Board and the risk of financial penalties.

2. Detailed Audit Findings

Objective 1: The Health Board policies and procedures covering DoLS are consistent with Welsh Government requirements and accepted best practice; properly implemented, and fully and consistently applied.

2.1 The Health Board's intranet contains copies of all the extant DoLS policies and documents. The Powys County Council (PCC) website also linked to publicly available documentation on DoLS and contact details for the PCC DoLS team.

2.2 The Health Board policy documents, 'SGP 042 Deprivation of Liberty Safeguards Policy and Procedure' and 'SGP 050 SOP for Deprivation of Liberty Safeguards Signatory' are clear and concise documents. They are easy to read and understand and an excellent source of information on the Health Board's DoLS process.

2.3 There is an issue with the policy review date having passed, but this was explained at the outset of the audit as being due to the ongoing delay and indecision around the potential implementation of the Liberty Protection Safeguards (LPS). We further noted there is nothing in the Health Board's Policies on the requirements for reporting the DoLS position, though we have confirmed this does happen (As noted under Objective 4). **See Matter Arising 1**

Conclusion:

2.4 We have identified a matter arising regarding the Health Board DoLS Policy and Procedure documentation. We have provided **Reasonable** A**ssurance** for this objective.

Objective 2: Staff and external contractors directly involved in DoLS operations are trained, with role specific certification and accreditation where necessary.

2.5 The DoLS policy mandates a DoLS training requirement and that staff with key roles in the process are correctly certified and that the certifications are in-date.

2.6 The Health Board utilise nationally available DoLS awareness courses on ESR. (Awareness is for all staff). The courses are for level one and level two. ESR management information supplied shows 83.7% of staff have completed the level one course and 90.37% have completed the level two course. Both courses remain accessible from ESR.

2.7 The DoLS process is commenced by a registered nurse who completes a form 1 to start the process. Level 3 training on the MCA has been offered to registered nurses. The next series of courses are at differing locations in Powys in November 2024 and targeted at registered staff working on Adult wards, Community staff e.g. District Nurses, Therapies or Complex Care Nurses.

2.8 The Health Board does not currently have an on-going cycle of DoLS training directed towards the Managing Authority responsibilities. This gap in training is linked to the current lack of a DoLS co-ordinator post within the Health Board, which is further noted under objective 3. **See Matter Arising 2**

2.9 A key role in the DoLS process is the Best Interest Assessor (BIA). We noted that the Health Board has a robust process to ensure that its directly employed BIA are appropriately qualified when initially appointed and that any certifications are maintained throughout employment.

2.10 There is a third-party supplier of BIA personnel, Action First, contracted to provide additional BIA on a case-by-case basis as required. At the time of the audit, we were unable to confirm what processes the Health Board has in place to ensure BIA provided by Action First are appropriately qualified. **See Matter Arising 3**

Conclusion:

2.11 The DoLS and MCA training and certification requirements for the key ward staff likely to be involved in the DoLS process are well understood within the Health Board and systems are in place to deliver. There is however a need for delivery of training on the DoLS Managing Authority responsibilities. There is also an area where work should potentially be done to confirm contractor staff are also appropriately trained and qualified. We have provided **Reasonable Assurance** for this objective.

Objective 3: An appropriate functioning operational system is in place to control all aspects of DoLS applications. This should ensure actions are appropriately logged and completed within mandated timescales with completed documentation authorised by responsible and accountable people where necessary

2.12 The primary operational control of the Health Board DoLS process is provided by a DoLS Administration Team. This team is employed by Powys County Council (PCC), their services are commissioned by the Health Board. The team's responsibilities are clearly defined in the SGP042 DoLS Policy. This means that the DoLS managing authority is the ward where the patient is situated; the supervising authority is PTHB with PCC DoLS providing the administration team. The Health Board remain the Supervisory Body for PTHB but do not have a post within PTHB to undertake this role. **See Matter Arising 4**

2.13 The PCC team's DoLS application receipt and control processes are well documented and are well understood and operated effectively. They maintain a case tracker spreadsheet that contains a full and comprehensive record of all key information for the managing of a DoLS case for each patient. It supports date and deadline monitoring and effectively gives PTHB a full report on every DoLS case they are administering for them, and at what stage of the process it is at. As stated above, PTHB do not have a role responsible to oversee this and ensure the required monitoring and subsequent action is achieved. In addition, the DoLS Signatories element of the process is reliant on senior staff agreeing to be part of a DoLS Signatory rota which is challenging to maintain due to being additional to normal duties and increased difficulties fulfilling this rota and maintaining timely responses are identified. **See Matter Arising 5**

2.14 We spoke to the ward sister or leading staff nurse at three hospital locations across the health board. They all confirmed they have staff who are trained to level 3 MCA and qualified to complete the form 1 when necessary. They are aware of the guidance available to them and that they can contact the safeguarding team if they need any assistance. They did note that there is sometimes a reluctance by staff to start this process, even when qualified. There was also universal concern over the time the process can take. (objective 4 includes a comment and recommendation on qualitative information on case management).

2.15 It was acknowledged at the commencement of the audit that staff changes and shortages in both the Health Board and PCC DoLS teams had a negative effect on

the process operation. Individuals left and recruitment for replacements took a long time, leaving both teams short of key personnel. There has been additional administration recruited until March 25. This is an interim measure to ensure essential DoLS Supervisory Body processes are achieved to an acceptable level. This is managed by the MCA Senior Practitioner working outside of her role with subsequent gaps identified in the delivery of PTHB Supervisory Body, and is not sustainable. PTHB has a significant gap in the delivery of PTHB Supervisory Body function and any improvements are temporary until March 2025 and a permanent solution is required as raised to PTHB executives. **See Matter Arising 4**

2.16 As part of their management oversight the Health Board's Safeguarding Team carried out a MCA gap analysis including DoLS. Which identified the following:

- critical omissions in documentation;
- No resource for a rolling training programme of DoLS awareness training;
- Non-Compliance with requirements resulting in patients deprived of their liberty without authorisation;
- Demand exceeds capacity; and
- No process for court protection work.

2.17 The analysis findings were presented to the Health Board executive team and Senior Safeguarding Group in March 2024 with three options to address the situation. This resulted in the development of an approved improvement plan and a risk register. The improvement plan is in spreadsheet format with actions, owners, timeframe, RAG status and update information present. At the time of our audit, plan delivery is ongoing with several of the objectives completed; the plan has been updated with a 2024-25 version which is now in operation. The mitigations identified are not permanent at this current stage whilst there is no PTHB Supervisory Body practitioner, additional BIA, or administration.

2.18 We noted the safeguarding risk on the risk register and that it has been managed and reviewed in line with the risk management policy. We also noted that the process problems occurred when key staff left from both the Health Board and PCC DoLS teams.

2.19 A case tracking spreadsheet is produced by the PCC admin team to facilitate progress monitoring of the Health Board DoLS cases. This has been changed to allow PTHB to now access this spreadsheet in real time since October 2024.

2.20 The only target dates in the DoLS guidance relate to completion within 28 days for a standard application and 7 days (extendable by 7) for an urgent (unplanned)one. The Health Board is not currently meeting these targets as 77% of urgent applications were not completed within 7 days and 68% were not completed within 14 days. For the standard applications only 50% were completed within 28 days but the numbers are small because the majority of applications are urgent. As this spreadsheet is a new development it should be developed further and refined to facilitate target date tracking on a case-by-case basis. **See Matter Arising 4.**

2.21 We reviewed the assessment and decision documents for a sample of cases both granted, and not granted. All decisions were correctly and appropriately signed and

recorded. The assessments looked complete and well documented in a manner that a lay person could follow and understand the rationale behind the decision. All the decisions, forms 5 and 6 were signed electronically (Docu-sign) by an appropriately authorised signatory.

Conclusion:

2.22 The current arrangements for managing the DoLS process are not sustainable going forward due to the lack of a dedicated resource to provide the DoLS Supervisory Body role. There is also a lack of management review to ensure that DoLS applications are processed in line with required timescales. We have provided **Limited Assurance** for this objective.

Objective 4: The Health Board maintains up to date, accurate and complete data on DoLS operational activity, and uses this to produce relevant management information on the volume and quality of DoLS casework

2.23 We have under objective 3 reviewed the tracker spreadsheet in use since April 2024 and consider that has a complete record of the data on individual DoLS cases and consider it is sufficient to meet the requirements of the objective at this time.

2.24 The PCC DoLS admin team supply numerical information on a monthly and quarterly basis to the Health Board which identifies the volumes of cases at the various stages of the process. We note that the reports seen are quantitative only, there is no qualitative information e.g % target date achievement. We further note that review of the tracker spreadsheet highlights that there is currently a considerable delay in the appointment of BIA for urgent and non-urgent DoLS applications. **See Matter Arising 4**

2.25 The Welsh Government require an annual return on the DoLS position from all Health Boards, councils, and bodies that operate a DoLS system. They specify the format, content requirements and due date.

2.26 The Health Boards last return was prepared and submitted by the PCC DoLS admin team, on time and in the correct format.

Conclusion:

2.27 Although reporting on DoLS is currently limited and quantitative we note that it is compliant with Welsh government requirements, and the opportunities for improving reporting have only recently become available. However, scrutiny of the DoLS data is required on a consistent and reliable basis to ensure the quality of the work and timely challenge of identified gaps. We have provided **Limited Assurance** for this objective.

Appendix A: Management Action Plan

Matter Arising 1: Policy and process document (Design)	**Impact**
There is an issue with the October 2022 review date for the Health Board's DoLS policy having passed. Although this was explained at the outset of the audit as initially being due to the UK Government delay and indecision with any potential implementation of the Liberty Protection Safeguards (LPS), which were effectively 'abandoned' in April 2023. Currently, the DoLS policy is unable to reflect updates within its policy until PTHB determine its Supervisory Body Role, following the Local Authority notice that they cannot continue their role of DoLS Co-ordination. This remains an identified gap within PTHB. The Policy should still be formally reviewed and updated where required. We also noted that there is nothing in the Health Board's Policies on the requirements for reporting the DoLS position, though we have confirmed this does happen, and also note that the WG policy does not include reporting either.	Potential risk of: • Guidance fails to keep up with legislative changes. • Out of date guidance loses credibility with its users or causes time loss as they search for an up to date version.

Recommendations		**Priority**
1	The DoLS policy should be reviewed and brought up to date as necessary with a date of the next review noted in line with any appropriate Health Board guidance on Policy documentation maintenance. The updated policy should include reporting requirements, including frequency, content, to whom, and format (spreadsheet, table, dashboard etc).	**Medium**

Agreed Management Action		**Target Date**	**Responsible Officer**
1	Update DoLS policy.	June 2025	Jayne Wheeler Sexton

Matter Arising 2: Provision of Training on Managing Authority Responsibilities (Design)	**Impact**
The Health Board has effective arrangements in place for providing training to nursing staff on the wards relating to DoLS processes. However, there is currently no on-going cycle of DoLS training in place that is directed towards the Managing Authority responsibilities. This gap in training is linked to the current lack of a DoLS co-ordinator post within the Health Board, which is noted under matter arising 4.	Potential risk of: • Inappropriate actions being undertaken by untrained staff.

Recommendations		**Priority**
2	Once the DoLS co-ordinator post is in place, training on the DoLS Managing Authority responsibilities should be developed along with a plan for on-going delivery.	**Medium**

Agreed Management Action		**Target Date**	**Responsible Officer**
2	A business case will need to be made for the role of DoLS co-ordinator.	March 2025	Jayne Wheeler Sexton
	A training needs analysis will be undertaken to determine required cycle of training.	July 2025	Jayne Wheeler Sexton
	Identified training put into place for the Managing Authority.	September 2025	Jayne Wheeler Sexton

Matter Arising 3: BIA Contractor Qualification (Design)			**Impact**
Action First are contracted to the Health Board to provide BIA personnel when the demand rises above a level that can be managed by the Health Board Staff. The Health Board have been unable to confirm what/if any process exists to ensure the Action First staff are fully qualified and currently certified to fulfil the role.			Potential risk of: • Unqualified staff working on NHS patients
Recommendations			**Priority**
3	The Health Board DoLS team should create a process to ensure that any staff provided by Action First are fully qualified and that any certification requirements for the role are up to date.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
3	Safeguarding Team to ensure they have a process to maintain evidence of correct qualifications from external assessors. To ensure that procurement amend the contract as required.	Feb 2025	Jayne Wheeler Sexton

Matter Arising 4: Provision of DoLS Supervisory Body role (Design)	**Impact**
The DoLS process previously failed to operate correctly when key personnel left the Health Board. The current interim measure has allowed additional administration for PCC to support the DoLS process using Welsh Government grant money. The MCA Senior Practitioner is also stepping outside of her role to undertake some responsibilities required in the DoLS Co-ordination responsibility. However, there remains a gap in the provision of a dedicated DoLS Supervisory Body role within PTHB, that provides oversight and co-ordination of the process and decision-making required. This is a gap that has been identified to PTHB Executive team	Potential risk of: • Process failure due to key staff leaving.

Recommendations		**Priority**
4	The Health Board should ensure that arrangements are put in place as soon as possible to allow for the on-going provision of the DoLS Supervisory Body Role.	**High**

Agreed Management Action		**Target Date**	**Responsible Officer**
4	A business case will need to be made for the role of DoLS co-ordinator, administration and Best Interest Assessors.	March 2025	Jayne Wheeler Sexton
	Depending on outcome of business case, recruitment into positions will be required.	June 2025	Jayne Wheeler Sexton

Matter Arising 5: Authorisation of DoLS Applications (Operation)	**Impact**
Delays are currently being experienced in obtaining timely sign-off of DoLS applications. The DoLS Signatories element of the process is reliant on senior staff agreeing to be part of a DoLS Signatory rota which is challenging to maintain due to being additional to the MCA Senior Practitioners normal duties. The DoLS Co-ordinator role would help to reduce this pressure and ensure timely scrutiny and sign-off of DoLS applications.	Potential risk of: • Unqualified staff working on NHS patients

Recommendations		**Priority**
5	The Health Board must ensure that all DoLS applications are reviewed and signed-off in a timely manner.	**High**

Agreed Management Action		**Target Date**	**Responsible Officer**
5	A business case will need to be made for the role of DoLS co-ordinator, This role will include to sign off the applications and review the current signatories process and manage the signatory's rota.	March 2025 June 2025	Jayne Wheeler Sexton Jayne Wheeler sexton

Matter Arising 6: Case tracking (Operation)	**Impact**
The DoLS applications have timescales for completion, being within 28 days for a standard application and 7 days (extendable by 7) for an urgent (unplanned) one. To date the Health Board has not monitored or reported whether or not the target dates have been achieved. The case tracking spreadsheet updated by the DoLS Admin team, is available to PTHB in real time since October 2024 and prior to this the spreadsheet was shared for the purpose of the audit from April 2024. This identifies within that time frame for the standard applications the target date was not achieved in 50% of cases. For urgent applications, 77% were not completed within the 7 day time limit and 68% were not completed within the 14-day extended. We were informed by the MCA Senior Practitioner that the current demand of application's are above what the Health Board can provide with the number of BIA's available and that the procurement of Action First is dependent on WG grant money being available for this.	Potential risk of: • Failure to achieve DoLS case target dates • People within PTHB are deprived of their liberty without legal authorisation for this.

Recommendations		**Priority**
6	Management reports should be developed to record ongoing performance against the target dates. These should then be reported to an appropriate group and / or Committee with actions identified to improve performance where required. *The case tracker spreadsheet could be developed to track and monitor progress on a case-by-case basis to confirm whether or not the target dates are being achieved and facilitate qualitative reporting, not just quantitative. Ideally a shared system should be used to enable all authorised users at least read access to live case data.*	**High**

Agreed Management Action		Target Date	Responsible Officer
6	The case tracker spreadsheet will be updated and accessible in real time for PTHB Supervisory Body.	March 2025	Jayne Wheeler Sexton
	A Dols Co-ordinator role will need to be in place to provide the challenge and scrutiny.	June 2025	Jayne Wheeler Sexton
	Performance will be reported into PTHB Strategic Safeguarding Group.	June 2025	Jayne Wheeler Sexton

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**Unsatisfactory assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

* Unless a more appropriate timescale is identified/agreed at the assignment.

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Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 5.5

Patient Experience, Quality and Safety Committee	**31 July 2025**
Subject:	**2024-2025 Clinical Audit Programme Closure Report**
Approved and presented by:	Dr Kate Wright, Medical Director
Prepared by:	Safety and Quality Improvement Manager from submissions provided by the operational teams.
Other Committees and meetings considered at:	Executive Committee - July 2025

PURPOSE:

The purpose of this paper is to inform the Patient Experience, Quality, and Safety Committee of the closure of the 2024-2025 Clinical Audit programme.

RECOMMENDATION(S):

The 2024-2025 Clinical Audit programme was accepted by the Patient Experience, Quality, and Safety Committee in April 2024. The programme identified 160 audits that the services within Powys intended to undertake in the fiscal year 2024-2025.

The Committee us asked to take **ASSURANCE** that the 2024-25 Clinical Audit programme has been delivered and is presented for closure.

Approve/Take Assurance	Discuss	Note
Y	N	Y

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:

This paper presents the closure report for the 2024-2025 clinical audit programme.

HEADING:

2024-25 Programme Summary

The 2024-2025 Clinical Audit programme was accepted by the Patient Experience, Quality and Safety Committee in April 2024. The programme identified 160 audits that the services within Powys intended to undertake in the fiscal year 2024-2025.

This paper serves as the closure report for that Clinical Audit program.

Audits listed on the 2024-2025 audit program	153
Audits added to the program during the year	7
Audits withdrawn from the program during the year	15
Audits where the introduction of new data capture systems obviated the need for the audit	12
Audits stood down because service intended to be audited was not introduced	1
Audits delayed in whole or in part to period 2025-2026	11
Completed audits (includes 2 audits still underway and partially complete)	121

Powys Audit Hour

In November Powys held its first Audit Hour. An MDT presentation by video link where three members of staff presented their audits.

The first audit presented was a systematic review of potential ligature point risks in a Mental Health unit that ensured that they were either removed or mitigated against, thereby reducing the risk that a client might self-harm.

The second presentation was a great example of how clinical audit can improve cost management. By identifying seven process weaknesses in Primary Care that lead to vaccine doses being wasted the audit led to a significant reduction of nearly 70% in the volume of doses being lost.

The third presentation focussed on the clinically effective practice around the use of antibiotics. The audit showed that antibiotics were frequently prescribed in situations where there was no clear clinical need. Over-prescription is a concern in a world where we are increasingly faced with drug resistant microbes and feeding best practice back to staff can help reduce this problem.

These three audits told a strong story in the various uses of clinical audit, showing its success as a safety exercise, a cost reduction measure, and an improvement to clinical effectiveness.

The audits hour was well received by attendees and was seen as an excellent forum for sharing of learning and ideas. Further sessions will be planned for 25/26.

Spotlight on:

This section of the report is an opportunity to focus on one particular audit. For this report the spotlight is on the Prescribing of 4C antimicrobials in Primary Care.

The 4C antimicrobials (cephalosporins, ciprofloxacin, co-amoxiclav and clindamycin) is the term used to collectively refer to four classes of broad-spectrum antibiotics.

Whilst these drugs can be highly effective in combating infections, their powerful broad spectrum activity means that they can seriously disrupt a person's gut bacteria. The destruction of the person's normal gut flora may then in turn leave them vulnerable to infection with *Clostridioides difficile.*

The audit was undertaken by the Medicines Management team because the data suggested that Powys GPs are prescribing 4C antibiotics at a *per capita* rate that is the highest observed in Wales and stands at twice the recommended National Prescribing Indicator level.

The audit reviewed 512 prescriptions issued by 10 GP practices. In 56% of cases the prescribing of the drug was clearly justified by the issued guidelines on presenting conditions.

In 70% of these cases the most appropriate antibiotic was the one prescribed to the patient, for example prescribing cefalexin for pyelonephritis. However, it was noted that this was a significant improvement over the 43% observed in the previous audit.

Just 33% of cases where the correct drug was prescribed also had the correct guidance details given on the dose and the length of the course of treatment. Although low this is an improvement over the previous audits figure of 19%.

Following the audit, individual feedback was given to the practices especially where a trend of poorer practice had been identified. For example, prescribers were encouraged to replace the use of cefalexin with a more narrow-spectrum antibiotic such as pivmecillinam. The audit is scheduled to be repeated in the 2025-2026 program.

The antimicrobial pharmacist is working closely with practices and the wider community services to continue to audit, feedback, promote good practice and to embed best practice. Whilst practice is improving, there is still much work to do.

NEXT STEPS:

Future planning and reporting of clinical audit

Service groups are encouraged to monitor clinical audits through their quality governance groups. For example the Mental Health team has audit as an agenda item for their monthly QUAILS meeting and theatres have a mechanism for reporting audits through scorecards and IPR. It may be proposed that service groups bring clinical audit reports through their own reporting to the Integrated Quality Report. As systems such as MEG and dashboards are being introduced across service groups to help coordinate and record audits, a review of reporting will be undertaken as part of planning for the next clinical audit plan. A summary plan will be brought in future updates for agreement.

IMPACT ASSESSMENT
Not required

Community Services Group					
Unscheduled Care					
Driver	Audit Title	End Date	Service	Lead	Status
Local Audits for Service Improvement	Missed Fractures Audit	Quarter 4 2024/25	Unscheduled Care	Senior Manager	COMPLETED
Local Audits for Service Improvement	Routine enquiry audit	Quarter 4 2024/25	Unscheduled Care	Senior Manager	COMPLETED
Local Audits for Service Improvement	Hand Hygiene Audit	Quarter 4 2024/25	Unscheduled Care	Senior Manager	COMPLETED
Local Audits for Service Improvement	Adherence to clinical supervision policy	Quarter 4 2024/25	Unscheduled Care	Senior Manager	COMPLETED
Local Audits for Service Improvement	Paramedic/downgrade ambulance audit	Quarter 4 2024/25	Unscheduled Care	Senior Manager	COMPLETED
Local Audits for Service Improvement	PGD Audit	Quarter 4 2024/25	Unscheduled Care	Senior Manager	COMPLETED
Local Audits for Service Improvement	Paeds under five audit – scrutiny of every attender under five	Quarter 4 2024/25	Unscheduled Care	Senior Manager	Audit no longer required. Data now reported on IFOR

Nursing (Ward and Community)					
Driver	Audit Title	End Date		Lead	Status
Local Audits for Service Improvement	Health & Care Monitoring Tool (Includes Hand hygiene audits & Patient surveys, ward cleaning)	Quarter 4 2024/25	Nursing (Wards)	Ward Managers	COMPLETED

Local Audits for Service Improvement	NEWS Audit	Quarter 4 2024/25	Nursing (Wards)	Ward Managers	COMPLETED
Local Audits for Service Improvement	Wristband Audit	Quarter 4 2024/25	Nursing (Wards)	Ward Managers	COMPLETED
Local Audits for Service Improvement	Dols Audit	Quarter 4 2024/25	Nursing (Wards)	Ward Managers	COMPLETED
Local Audits for Service Improvement	Environmental Audit	Quarter 4 2024/25	Nursing (Wards)	Ward Managers	COMPLETED
Local Audits for Service Improvement	Welsh Language Audit	Quarter 4 2024/25	Nursing (Wards)	Ward Managers	COMPLETED
Local Audits for Service Improvement	DNACPR Audit	Quarter 4 2024/25	Nursing (Wards)	Ward Managers	COMPLETED
Local Audits for Service Improvement	Multi-factorial Falls Risk Assessment Audit (Inpatients)	Quarter 4 2024/25		Ward Managers	Not completed. Quarterly falls panels themes reports available. Due to restart MFRA audit Q2 2025.

Specialist Nursing					
Driver	Audit Title	End Date		Lead	Status
Other National Audit & Service Evaluation	Parkinson's UK National Audit	Quarter 4 2024/25	Specialist Nursing – Parkinson's Disease	Parkinson's Disease ANP	COMPLETED
Local Audits for Service Improvement	Pressure Damage Audit	Quarter 4 2024/25	Specialist Nursing – Tissue Viability Nurse	Senior Nurses	COMPLETED
Service Evaluation	Clinic PREM Data	Quarter 4 2024/25	Specialist Nursing - Continence	Continence Service Manager	COMPLETED
Service Evaluation	Prescribing Data	Quarter 4 2024/25	Specialist Nursing - Continence	Continence Service Manager	COMPLETED
Service Evaluation	Transition Clinic PREM Data	Quarter 4 2024/25	Specialist Nursing - Continence	Continence Service Manager	Audit stood down as no clinics actually held.

Service Evaluation	Pad PREM	Quarter 4 2024/25	Specialist Nursing - Continence	Continence Service Manager	COMPLETED
Service Evaluation	COBWEB PREM	Quarter 4 2024/25	Specialist Nursing - Continence	Continence Service Manager	COMPLETED
Service Evaluation	CIVICA/PREMS clinic data	Quarter 4 2024/25	Specialist Nursing – Cardiology	Cardiology Team Lead	Ongoing. Reviewed monthly
Other National Audit & Service Evaluation	National Audit of Cardiac rehab/PROMS	Quarter 4 2024/25	Specialist Nursing – Cardiology	Cardiology Team Lead	Annual report published
Service Evaluation	CROMS data	Quarter 4 2024/25	Specialist Nursing – Cardiology	Cardiology Team Lead	Reported bi-monthly in governance meetings
Local Audits for Service Improvement	Quality Assurance Audits for ECHO scans at neighbouring DGH.	Quarter 4 2024/25	Specialist Nursing – Cardiology	Cardiology Team Lead	Link with Wolverhampton ongoing

Surgery and Endoscopy					
Driver	**Audit Title**	End Date	**Service**	**Lead**	Status
Service Evaluation	Surgical Performance/DNA/Cancellation data	Quarter 4 2024/25	Theatre	Theatre Lead	Data collection automated theatre BI dashboard reported via IPR/National Planned Care Programme
Service Evaluation	Monthly Surgical Utilisation data	Quarter 4 2024/25	Theatre	Theatre Lead	Data collection automated theatre BI dashboard reported via IPR/National Planned Care Programme

Service Evaluation	Surgical Site Infection data	Quarter 4 2024/25	Theatre	Theatre Lead	Audit no longer required following agreement at IPC group.
Service Evaluation	Surgical incidents	Quarter 4 2024/25	Theatre	Theatre Lead	Automated via datix reporting/IPR reporting
Service Evaluation	Hand hygiene Audits	Quarter 4 2024/25	Theatre	Theatre staff	COMPLETED
Service Evaluation	Bi weekly C4C audit	Quarter 4 2024/25	Theatre	Facilities	Audit no longer required. All cleanliness/ environmental information held by facilities and planned care data is reported into IPC
Service Evaluation	Legal and ethical audit	Quarter 2 2024/25	Theatre	Theatre Lead	COMPLETED
Service Evaluation	Data protection and GDPR	Quarter 2 2024/25	Theatre	Theatre Lead	COMPLETED
Service Evaluation	Management/Human Resources	Quarter 2 2024/25	Theatre	Theatre Lead	COMPLETED
Service Evaluation	Education	Quarter 2 2024/25	Theatre	Theatre Lead	COMPLETED
Service Evaluation	Five Steps to Safer Surgery	Quarter 2 2024/25	Theatre	Theatre Lead	COMPLETED
Service Evaluation	Managing Perioperative Normothermia	Quarter 2 2024/25	Theatre	Theatre Lead	COMPLETED
Service Evaluation	Risk Management (Organisational and Environmental)	Quarter 2 2024/25	Theatre	Theatre Lead	COMPLETED
Service Evaluation	Decontamination	Quarter 2 2024/25	Theatre	Theatre Lead	COMPLETED
Service Evaluation	Specimen Management	Quarter 2 2024/25	Theatre	Theatre Lead	COMPLETED

Service Evaluation	Tourniquets	Quarter 2 2025	Theatre	Theatre Lead	COMPLETED
Service Evaluation	Use and Handling of Surgical Instruments	Quarter 2 2024/25	Theatre	Theatre Lead	COMPLETED
Service Evaluation	Preoperative care for Patients with Dementia	Quarter 3 2024/25	Theatre	Theatre Lead	COMPLETED
Service Evaluation	Anaesthesia	Quarter 3 2024/25	Theatre	Theatre Lead	COMPLETED
Service Evaluation	Surgical record keeping audit & consent	Quarter 3 2024/25	Theatre	Theatre Lead	COMPLETED
Service Evaluation	Post anaesthetic Care	Quarter 3 2024/25	Theatre	Theatre Lead	COMPLETED
Service Evaluation	Surgical Patient Satisfaction audit	Quarter 3 2024/25	Theatre	Theatre Lead	COMPLETED
Service Evaluation	Electrosurgery	Quarter 3 2024/25	Theatre	Theatre Lead	COMPLETED
Service Evaluation	Fluid Management	Quarter 3 2024/25	Theatre	Theatre Lead	COMPLETED
Service Evaluation	Foreign body aspiration during intubation, advanced airway management or ventilation	Quarter 3 2024/25	Theatre	Theatre Lead	COMPLETED
Service Evaluation	Surgical patient story	Quarter 3 2024/25	Theatre	Theatre Lead	Withdrawn
Service Evaluation	Pre assessment and Specific Day Case Requirements	Quarter 4 2024/25	Theatre	Theatre Lead	COMPLETED
Service Evaluation	Audit of prosthesis verification data	Quarter 4 2024/25	Theatre	Theatre Lead	COMPLETED
Service Evaluation	Intraoperative Care	Quarter 4 2024/25	Theatre	Theatre Lead	COMPLETED
Local Audits for Service Improvement	Staff Satisfaction	Quarter 4 2024/25	Theatre	Theatre Lead	Withdrawn
Service Evaluation	Accountable Items, Swab, Instrument and Sharps Count	Quarter 4 2024/25	Theatre	Theatre Lead	COMPLETED
Service Evaluation	Infection Control PIT	Quarter 4 2024/25	Theatre	Theatre Lead	Additional audit COMPLETED
Local Audits for Service Improvement	NEWS Audit	Quarter 4 2024/25	Theatre	Theatre Lead	Additional audit COMPLETED

Service Evaluation	Individual Endoscopist KPI's	Quarter 3 2024/25	Endoscopy	Clinical Lead Endoscopy	COMPLETED
Service Evaluation	Gastric ulcers rescoped within 12 weeks	Quarter 4 2024/25	Endoscopy	Endoscopy coordinator & Data/Audit Support	COMPLETED
Service Evaluation	Post colonoscopy colorectal cancer rate Links established with Cwm Taf Morgannwg University Health Board MDT. If we are made aware – root cause analysis carried out	TBC	Endoscopy	Clinical Lead Endoscopy	Audit Completed not reported however data has been reviewed and will be reported to EUAG for Quarter 1 25/26
Service Evaluation	Patient Satisfaction survey	Quarter 4 2024/25	Endoscopy	Endoscopy coordinator & Data/Audit Support	COMPLETED
Service Evaluation	Staff survey	Quarter 4 2024/25	Endoscopy	Endoscopy coordinator & Data/Audit Support	Withdrawn
Service Evaluation	Endoscopist satisfaction survey	Quarter 4 2024/25	Endoscopy	Clinical Lead Endoscopy	COMPLETED
Service Evaluation	Endoscopy Performance e.g DNA cancellations no of procedures late start early finishes	Quarter 4 2024/25	Endoscopy	Data/Audit Support	Data collection automated BI dashboard reported via IPR/National Planned Care Programme
Other National Audit Programme	Bowel Screening Wales User Experience Survey results	Quarter 4 2024/25	Endoscopy	Clinical Lead Endoscopy	COMPLETED
Local Audits for Service Improvement	Record Keeping	Quarter 4 2024/25	Endoscopy	Clinical Lead Endoscopy	COMPLETED
Service Evaluation	Annual planning & productivity report	Quarter 4 2024/25	Endoscopy	Clinical Lead Endoscopy	COMPLETED
Service Evaluation	Scope traceability	Currently underway	Endoscopy	Endoscopy Coordinator	COMPLETED
Local Audits for Service Improvement	Inclusion/exclusion criteria audit	Quarter 2 &4 2024/25	Endoscopy	Endoscopy coordinator	Additional Audit COMPLETED
Other National Audit Programme	Bowel Screening Wales pathology reporting audit	Quarter 3 2024/25	Endoscopy	Bowel Screening Wales	Additional Audit COMPLETED

Therapies and Health Science					
Driver	Audit Title	End Date	Service	Lead	Status
Audits performed for accreditation schemes	Compliance with Standard operating procedures	Quarter 3	Radiography	Head of Radiography	COMPLETE
Audits performed for accreditation schemes	Pregnancy Status	Quarter 3	Radiography	Head of Radiography	COMPLETE
Audits performed for accreditation schemes	Correct use of radiographic markers	Quarter 3	Radiography	Head of Radiography	COMPLETE
Audits performed for accreditation schemes	Non Medical Referrals (NMR) Audit of NMR compliance	Quarter 3	Radiography	Head of Radiography	COMPLETE
Audits performed for accreditation schemes	Reject analysis	Quarter 3	Radiography	Head of Radiography	COMPLETE
Audits performed for accreditation schemes	Radiographer commenting audit	Quarter 3	Radiography	Head of Radiography	COMPLETE
Audits performed for accreditation schemes	QA plain film and NOUS / Midwife Sonography	Quarter 3	Radiography	Head of Radiography	COMPLETE
Local Audits for service improvement	QA reporting Audit	Quarter 3	Radiography	Head of Radiography	COMPLETE
Audits performed for accreditation schemes	Monthly Clinispet/Clinel Wipes Audit	Quarter 3	Radiography	Head of Radiography	COMPLETE
Audits performed for accreditation schemes	Sonography Service Audit	Quarter 3	Radiography	Clinical Governance Lead for Sonography	COMPLETE
Audits performed for accreditation schemes	Reporting Radiography Service Audit	Quarter 3	Radiography	Head of Radiography	COMPLETE
Audits performed for accreditation schemes	MIU NMR Audit for appropriate referrals	Quarter 4	Radiography	Head of Radiography	COMPLETE
Audits performed for accreditation schemes	Red Dot Audit	Quarter 4	Radiography	Head of Radiography	COMPLETE
Local Audits for service improvement	Caseload Management	Quarter 3	All AHP and HS	All HOS	COMPLETE
Local Audits for service improvement	Clinical Records audit focusing on consent, goal planning	Quarter 4	Occupational Therapy	Head of OT	COMPLETE

Local Audits for service improvement	Clinical Records audit focusing on consent, goal planning	Quarter 4	SALT	Head of SALT	COMPLETE
Service Evaluation	Quarterly Wax Management	Quarter 4	Audiology	Head of Audiology	Audit Withdrawn due to Professional Head vacancy
Local Audits for Service Improvement	audiology Inappropriate referrals	Quarter 3	Audiology	Head of Audiology	Audit Withdrawn due to Professional Head vacancy
Service Evaluation	waiting times/compliance with target	Quarter 3	Audiology	Head of Audiology	Audit Withdrawn – new standard implemented from April 2025
Service Evaluation	Inpatient Nutrition Frailty	Quarter 3	Dietetics	Head of Dietetics	COMPLETE
Welsh Government National Audit Programme	Quality Standards Tinnitus Service	Quarter 4	Audiology	Head of Audiology	COMPLETED AS NATIONAL AUDIT
Other National Audits	National Diabetes Foot Care Audit	TBC National	Podiatry	Head of Podiatry	Waiting for National
Local Audits for Service Improvement	Taxonomy compliance audit	Quarter 4	Podiatry	Head of Podiatry	Delayed to 2025/26
Local Audits for Service Improvement	Patient Notes	TBC	Podiatry	Head of Podiatry	Audit Withdrawn due to capacity challenges and fragility of service

Local Audits for Service Improvement	Nail Surgery Consent and Dressing Audit	Quarter 4	Podiatry	Head of Podiatry	COMPLETE
Service Evaluation	Shockwave Podiatry	Quarter 3	Podiatry	Head of Podiatry	Delayed to 2025/26
Local Audits for Service Improvement	Implementation of Falls Therapy Practitioner	Quarter 4	Community Therapies	Senior Therapist	Delayed to 2025/26
Local Audits for Service Improvement	Implementation of MFA - Falls	Quarter 4	Community Therapies	Senior Therapist	Delayed to 2025/26
Service Evaluation	FCP Evaluation - North	Quarter 3	Physiotherapy	Consultant Physio	COMPLETE
Service Evaluation	GTPS Shockwave	Quarter 3	Physiotherapy	Head of Physiotherapy	UNDERWAY
Local Audits for Service Improvement	Therapy Outcome Measures Audit	Quarter 4	Speech and Language therapy	Head of Speech and Language therapy	COMPLETE
Other National Audits	National Audit Programme Lymphodema	Quarter 4	Lymphoedema	Team Lead for Lymphoedema services	COMPLETE
Other National Audits	SNAPP Audit	TBC Nationally	Therapies	Head of Service	Delayed due to new national standards
Local Audits following change to policy or procedure	Adherence to clinical supervision policy	Quarter 4	Therapies	Head of Service	Delayed to 2025/26

[Text Wrapping Break]

Primary Care Group

GP Services

Driver	Audit Title	End Date	Service	Lead	Status
Local Audits for Service Improvement	Safety of Lithium Therapy	April 2025	GP Surgery	GP Surgery Staff	COMPLETE
Local Audits for Service Improvement	Care Home Medical Services	April 2025	GP Surgery	GP Surgery Staff	COMPLETE
Local Audits for Service Improvement	Community Resource Team Audit	April 2025	GP Surgery	GP Surgery Staff	COMPLETE

Community Dentistry

Driver	Audit Title	End Date	Service	Lead	Status
Local Audits for Service Improvement	Clinical Record Keeping Audit	TBC	Community Dentistry	TBC	COMPLETE
Other National Audit	WHTM01-05 Equipment decontamination audit	TBC	Community Dentistry	Rachel Anwyl	COMPLETE
Local Audits for Service Improvement	Written Consent to treatment audit	TBC	Community Dentistry	TBC	COMPLETE
Local Audits for Service Improvement	Compliance with Acorn and Fluoride application for GDS patients	TBC	Community Dentistry	Heidi Thomas	Merged with audit below
Local Audits for Service Improvement	Acorn and contract reform compliance (GDS)	Sept 2024	Community Dentistry	Eva Gough	COMPLETE
Local Audits for Service Improvement	Antimicrobial Stewardship	Sept 2024	Community Dentistry	Warren Tolley	COMPLETE

Medical Directorate					
Medicines Management					
Driver	Audit Title	End Date	Service	Lead	Status
Identified Risk – Powys has the highest per capita 4C antibiotic prescribing in Wales	4C antimicrobial prescribing in primary care	Quarter 3 2024/25	Medicines Management	Medicines Management Staff	COMPLETE
Identified Risk	Allergy status reporting in PTHB community hospitals	Quarter 3 2024/25	Medicines Management	Medicines Management Team	Audit delayed until inpatient ePMA rollout
Identified Risk	The completion of Venous thromboembolism (VTE) risk assessments	Quarter 3 2024/25	Medicines Management	Medicines Management Team	Audit delayed until inpatient ePMA rollout
Identified Risk	Valproate prescribing Audit of compliance with NatPSA/2023/013/MHRA	Quarter 3 2024/25	Medicines Management	Medicines Management Team	Audit delayed awaiting a national digital solution via DHCW

Nursing Directorate (Corporate Functions)					
Safeguarding					
Driver	Audit Title	End Date	Service	Lead	Status
Other National Audit Programme	Safeguarding maturity matrix self-assessment audit	Sept 24	Safeguarding	Asst. Director of Safeguarding and Public Protection	COMPLETED
Local Audits for Service Improvement	Quality of child protection case conference reports audit	Dec 24	Safeguarding	Asst. Director of Safeguarding and Public Protection	COMPLETED

Mental Health and Learning Disabilities					
Mental Health					
Driver	Audit Title	End Date	Service	Lead	Status
Identified Risk – patients may suffer harm if these assessments are not correctly completed	Audit of Environmental Ligature risk assessments	Quarter 4 2024/25	Mental Health Service	Mental Health Service Staff	COMPLETED
Identified Risk – patients may suffer harm if these assessments are not correctly completed	Audit of WARRN risk assessments	Quarter 4 2024/25	Mental Health Service	Mental Health Service Staff	COMPLETED
Identified Risk – patients may suffer harm if these assessments are not correctly completed	Audit of Security Risk Assessment	Quarter 4 2024/25	Mental Health and Learning Disabilities Service	MH&LD staff	COMPLETED for inpatients. Community patient audit planned for 2025/26

Local Audits for Service Improvement	Audit of Care and treatment plans	Quarter 4 2024/25	Mental Health Service	Mental Health Service Staff	COMPLETED
Welsh Government National Audit Programme	NCISH Suicide audit	Quarter 4 2024/25	Mental Health Service	Mental Health Service Staff	COMPLETED
Welsh Government National Audit Programme	National review of schizophrenia audit	Quarter 4 2024/25	Mental Health Service	Mental Health Service Staff	COMPLETED
Local Audits for Service Improvement	In patient Physical health monitoring audits	Quarter 4 2024/25	Mental Health Service	Mental Health Service Staff	COMPLETED
Local Audits for Service Improvement	RCP/NICE quality standards for inpatient care	Quarter 4 2024/25	Mental Health Service	Mental Health Service Staff	Audit Withdrawn
Local Audits for Service Improvement	Medicine management audit	Quarter 4 2024/25	Mental Health Service	Mental Health Service Staff	COMPLETED
Local Audits for Service Improvement	Hand Hygiene Audit	Reported quarterly	In-patient service	Ward Managers	COMPLETED
Local Audits for Service Improvement	Record Keeping Audit	Quarter 4 2024/25	Mental Health Service	Team Leads	COMPLETED
Local Audits for Service Improvement	Did Not Attend Appointment Audit	Quarter 4 2024/25	Mental Health Service	Performance Manager	COMPLETED
Local Audits for Service Improvement	Falls Risk Assessment Audit	Reported quarterly	In-patient service	Ward Managers	COMPLETED
Local Audits for Service Improvement	Welsh Language Active Offer Audit	Quarter 4 2024/25	Mental Health Service with Workforce Colleagues		Audit Withdrawn
Local Audits for Service Improvement	(Child) Was Not Brought to Appointment Audit	Reported quarterly	CAMHS service	CAMHS staff	COMPLETED
Welsh Government National Audit Programme	Early Intervention in Psychosis Audit	TBC Nationally	CAMHS service	CAMHS staff	COMPLETED
Local Audits for Service Improvement	Outcome Measures Audit	Quarter 4 2024/25	CAMHS service	CAMHS staff	COMPLETED
Local Audits for Service Improvement	LPMHSS Audit	Quarter 4 2024/25	Local Primary Mental Health Support Service (LPMHSS)	Service Manager	COMPLETED

Local Audits for Service Improvement	Policy Audit	Quarter 4 2024/25	Mental Health and Learning Disabilities Service	MH&LD staff	COMPLETED
Local Audits for Service Improvement	Community Medical Caseload Audit	Quarter 4 2024/25	Mental Health Service	Mental Health Service Staff	Underway
Local Audits for Service Improvement	Section 177 Audit	Quarter 4 2024/25	Mental Health Service	Mental Health Service Staff	Audit Withdrawn
Local Audits for Service Improvement	Mental Health Act Compliance Audit	Quarter 4 2024/25	Mental Health Service	Mental Health Service Staff	COMPLETED
Local Audits for Service Improvement	Adult CMHT MDT Audit	Quarter 4 2024/25	Mental Health Service	Mental Health Service Staff	Delayed to 2025/26 program
Local Audits for Service Improvement	Integrated Autism Audit	Quarter 4 2024/25	Mental Health Service	MH&LD staff	Additional audit COMPLETED
Local Audits for Service Improvement	Peri-natal audit	Quarter 4 2024/25	Mental Health Service	Mental Health Service Staff	Additional audit COMPLETED
Local Audits for Service Improvement	Learning Disability services.	Quarter 4 2024/25	Mental Health and Learning Disabilities Service	Head of Learning Disability Services.	Additional audit COMPLETED

[Text Wrapping Break]

Women and Children's Service					
Midwifery					
Driver	Audit Title	End Date	Service	Lead	Status
Local Audits for Service Improvement	Antenatal Contacts – HCWP (Health Visiting)	Quarter 1	Health Visiting	Assistant Head of Public Health Nursing	Audit withdrawn due to lack of capacity
Identified Risk	Was Not Brought - School Nursing.	TBC	Health Visiting	Assistant Head of Public Health Nursing	Now reported routinely at Quality and Performance meeting
Local Audits for Service Improvement	DTP/MenACWY Uptake	Quarter 1	Health Visiting	Assistant Head of Public Health Nursing	COMPLETED
Local Audits for Service Improvement	ChatHealth	Quarter 1	Health Visiting	Assistant Head of Public Health Nursing	COMPLETED
Local Audits for Service Improvement	Health Visiting & School Nursing CIVICA Audit	Quarter 1	Health Visiting	Assistant Head of Public Health Nursing	Now reported routinely at Quality and Performance meeting
Local Audits for Service Improvement	Health Visiting CNN Audit	Quarter 1	Health Visiting	Assistant Head of Public Health Nursing	Now reported routinely at Quality and Performance meeting
Local Audits for Service Improvement	Routine Enquiry (Health Visiting)	Quarter 1	Health Visiting	Assistant Head of Public Health Nursing	COMPLETED
Local Audits for Service Improvement	HPV vaccine Uptake	Quarter 2	Health Visiting	Assistant Head of Public Health Nursing	Withdrawn

Local Audits for Service Improvement	Flu vaccine Uptake	Quarter 2	Health Visiting	Assistant Head of Public Health Nursing	COMPLETED
Local Audit for service improvement	Health Visiting CNN Audit	Quarter 2	Health Visiting	Assistant Head of Public Health Nursing	Now reported routinely at Quality and Performance meeting
Local Audits for Service Improvement	Health Visiting and School Nursing CIVICA Audit	Quarter 2	Health Visiting	Assistant Head of Public Health Nursing	Now reported routinely at Quality and Performance meeting
Local Audits for Service Improvement	Routine Enquiry (Health Visiting)	Quarter 4	Health Visiting	Assistant Head of Public Health Nursing	COMPLETED
Local Audits for Service Improvement	Health Visiting & School Nursing CIVICA Audit	Quarter 3	Health Visiting	Assistant Head of Public Health Nursing	COMPLETED
Local Audit for Service Improvement	Recording Keeping – Sexual Health Services	Quarter 1	Sexual Health	Sexual Health Clinical Lead	COMPLETED
Local Audit for Service Improvement	Routine Enquiry – (Sexual Health)	Quarter 3	Sexual Health	Sexual Health Clinical Lead	COMPLETED
Local Audit for Service Improvement	All Wales Handheld Maternity Records	Quarter 2	Maternity	Clinical Supervisor of Midwives	COMPLETED
Local Audit for Service Improvement	Intrapartum Transfers from Powys to DGH	Quarter 2	Maternity	Research Midwife Consultant Midwife	COMPLETED
Local Audit for Service Improvement	Clinical Information Sharing Caseload	Quarter 2	Maternity	Consultant Midwife	COMPLETED
Local Audit for Service Improvement	Record keeping – WCCIS Clinical Assessment form	Quarter 3	Maternity	Endometriosis Clinical Nurse Specialist	COMPLETED
Local Audit for Service Improvement	ADHD medication monitoring audited against NICE guidelines/new SOP	Quarter 4	Community Paediatrician	Paediatrics	COMPLETED

Local Audit for Service Improvement	Monitoring for Children and YP with Down Syndrome	Quarter 3	Community Paediatrician	Paediatrics	Delayed awaiting the national development of an audit platform
Local Audit for Service Improvement	Children and YP with Cerebral Palsy – monitoring including hips (CPIPs), timely diagnosis. And review	Quarter 4	Community Paediatrician and Physio CPIP lead	Paediatrics	Audit withdrawn due to lack of capacity

[Text Wrapping Break]

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

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

Agenda item: 5.6

PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE	**31 JULY 2025**
Subject:	**Infection, Prevention and Control Annual Report 2024-25**
Approved and presented by:	Claire Roche, Executive Director Nursing, Quality, Women and Family Health
Prepared by:	
Other Committees and meetings considered at:	Infection, Prevention and Control Committee - 05.08.2025 Executive Committee - 23.07.2025 who supported the report to the Committee.

PURPOSE:

To provide the annual Infection Prevention and Control report, providing assurance on statutory compliance, performance against national standards, and local infection control priorities. The report also highlights the key risks, achievements, challenges and areas for improvement across Powys Teaching Health Board.

RECOMMENDATION(S):

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

- Take **ASSURANCE** from the contents of the Infection, Prevention and Control annual report that the Health Board is fulfilling its responsibilities

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	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:
The IPC annual report outlines activity, assurance, and outcomes in infection prevention and control across the Health Board for 2024/25.
DETAILED BACKGROUND AND ASSESSMENT
A comprehensive background and full assessment are provided in the attached report for further detail.

IMPACT ASSESSMENT – NOT REQUIRED FOR THIS REPORT

Powys Teaching Health Board

Infection Prevention and Control (IP&C) Annual Report 2024/25

Table of Contents

Foreword

This 2024/25 Infection, Prevention and Control Annual Report looks back on the years activity, achievements and challenges and looks forward to the future direction in Infection Prevention and Control.

This was a pivotal year in progressing the second-year requirements of the Improvement Plan, leading to Infection Prevention and Control (IP&C) no longer being escalated in the Health Board.

The Health Board maintains a zero-tolerance stance towards Healthcare Associated Infections (HCAIs) and is committed to continuous learning from any occurrence to drive improvements and standards that enhance patient care and safety across the Health Board.

The continued progress made in 2024/25 will support further improvement as we progress into 2025/26. These improvements are due to the commitment, dedication and expertise from the Infection Prevention and Control team and the continued support and efforts from all our staff and colleagues in driving continuous improvements in Infection Prevention and Control.

Claire Roche

Executive Director of Nursing, Quality, Women & Family Health

1.Introduction

This Infection Prevention and Control Annual Report for the year ending 2024/25 provides a detailed overview of Powys Teaching Health Board's ongoing commitment in maintaining and developing a robust system to safeguard against infections. Healthcare Associated Infections (HCAIs) can cause significant harm to patients and the cost to patients and families can be incalculable. Organisationally, HCAIs cause significant disruption, generate an increased financial burden to the service and create complex logistical and patient management issues.

Powys THB recognises that effectively preventing and controlling HCAI's is crucial to providing safe and effective care to our patients and is dedicated to fostering public trust in the services it provides, with rigorous Infection Prevention and Control measures being fundamental to this commitment, both in our role as a provider and a commissioner.

The Health Board maintains a zero-tolerance stance towards Healthcare Associated Infections (HCAIs) and is committed to learning from any occurrence to drive improvements that enhance patient care and safety across the Health Board. Robust Infection Prevention and Control standards, and the process by which they are implemented across an organisation can be seen as a key quality indicator of how an organisation is performing to ensure safe and effective care and services.

This report outlines how Powys Teaching Health Board complies with the requirements of the Code of Practice for the Reduction of Healthcare Associated Infections and reflects upon the progress made over the past year and identifies priority areas of work required to ensure the delivery of continuous improvements in care that safely and effectively meets the needs of the patient.

Key Achievements

There have been a several notable achievements in 2024/25, some of which are highlighted below:

- Despite significant challenges within the IP&C resource the team have continued to successfully develop, implement and maintain additional policies, processes, and standard operating procedures fundamental to Infection Control and related activity across the organisation.
- Significant progress has been made in completing the second-year requirements of the Improvement Plan, leading to IP&C no longer being an escalated matter in the Health Board. However, two areas of work identified in the Improvement Plan remain outstanding, specifically:
    - Aseptic Non-Touch Technique (ANTT) provision and compliance in Powys Teaching Health Board and the availability of Multi Drug Resistant Organism management (MDRO) guidance and processes which will be completed in the coming 12 months.
- The Health Board has continued to record zero cases of MRSA bacteraemia since 2013/14.
- The Health Board has been successful in recruiting a specialist Antimicrobial Pharmacist, which has resulted in an Antimicrobial Stewardship Improvement plan.
- Following successful procurement of an electronic audit tool, MEG is now operational within PTHB which will significantly enhance audit activity and management of related outcomes. A robust and comprehensive IP&C audit schedule is now operational within PTHB, and further investment will significantly develop the systems capability.
- Compliance for mandatory and statutory IP&C training levels one and two have continued to increase over the year, with end of year compliance for Level one >90% and level two >85%.

Key Challenges

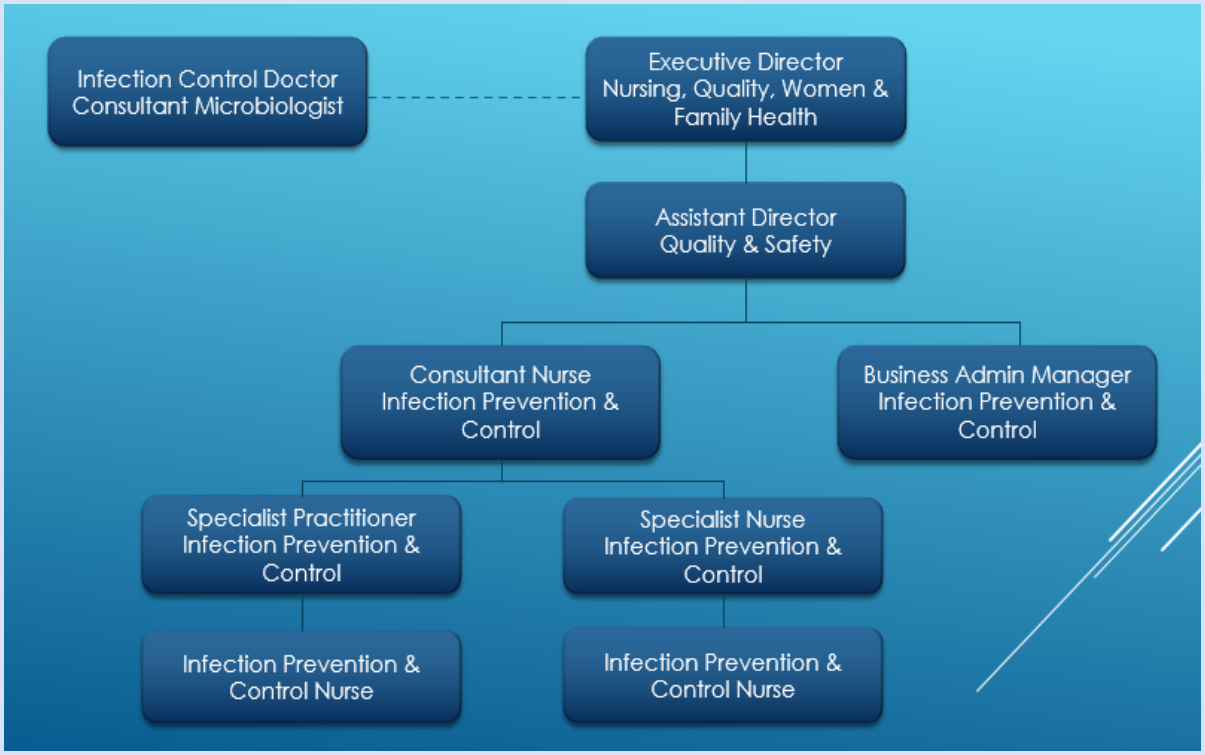
Numerous key challenges were identified during 2024/25, and some are expected to persist as we move into 2025/26 forming a significant proportion of the IP&C Workplan over the next financial year:

- Lack of team capacity has impacted the ability to fully complete the Improvement plan; the completion of two areas of work remains outstanding are ANTT and MDRO Management which will require completion within the next financial year.
- Engagement with proactive work has been sporadic and planned Quality Improvement Initiatives have stalled due to team capacity and the need to prioritise activities.
- Specialist IP&C support for primary care, such as GP surgeries, is not routinely available due to resource limitations. Clarity regarding commissioning is required and robust IP&C provision reflective of the commissioned provision.
- Having made some initial progress with evaluating decontamination services and activity across the Health Board in 2023/24, constraints on the team throughout 2024/25 regarding capacity, has meant that this portfolio of work slowed considerably and remains challenging.
- Environmental Cleanliness across the organisation has presented challenges which are detailed further on in the report.
- Maintaining effective IP&C standards poses a challenge within an increasingly ageing estate portfolio.

2.Infection Prevention and Control Structure

Infection Prevention and Control sits within the Quality and Safety function, with the Executive Director of Nursing, Quality, Women & Family Health holding delegated responsibility for Infection Prevention and Control and Decontamination across Powys Teaching Health Board.

The current organisational structure of the Infection Prevention and Control team is illustrated below:



3. Primary Responsibilities of the Infection Prevention and Control Team

The Infection Prevention and Control team consists of Nurses and Allied Health Professionals, with the expertise to provide support which spans the whole of the Health Board. The team are supported by an Infection Control Doctor/Consultant Microbiologist

The team are responsible for:

Providing expert advice, guidance and support to all services and departments within Powys Teaching Health Board	Surveillance, audit, and management of Healthcare Associated Infections across the Health Board.	Education, training, and support across the organisation to provide safe environments of care for service users.
Ensuring policies, process and procedures are up-to-date and in-line with best practice and current clinical standards and guidelines.	Liaising with internal and external groups, agencies and stakeholders to ensure appropriate infection control guidance is issued and followed.	Representation of Health Board's interest in relation to IP&C matters on local, regional and national meetings.

4. IP&C Reporting Structure

Infection Prevention and Control activities are reported within the Health Board, to the quarterly Infection Prevention and Control Committee, which is chaired by the Executive Director of Nursing, Quality, Women & Family Health. Onward reporting is to the Patient Experience, Quality and Safety (PEQS) Committee and to the Board.

5. Groups

The Infection Prevention and Control team actively participate and are members of various groups and committees across Powys Teaching Health Board, providing expertise which significantly contributes to enhancing patient safety across the Health Board.

Group	Meeting Frequency
Antimicrobial Stewardship Group	Quarterly
Water Safety Group	Quarterly
Ventilation Safety Group	Quarterly
Prevention and Response Oversight Group	Monthly
Waste & Recycling User Group	Quarterly
Linen User Group	Quarterly
Environmental & Sustainability Group	Quarterly
Medical Devices/PoC Testing Group	Quarterly
Health & Safety Group Meeting	Quarterly
All-Wales Healthcare Associated Infection Delivery Board	Quarterly
All-Wales Decontamination Group	Quarterly
Womens & Children Health & Safety Group	Quarterly
Ultrasound Governance Group	Quarterly
Decontamination Safety Group	Bi-annually

6. IP&C improvement plan

In May 2023, the IP&C team conducted a comprehensive GAP analysis of Infection Prevention and Control services across the Health Board, leading to the development of an organisational improvement plan. The plan was evaluated against the nine standards, as set out in the 2014 Code of Practice for the Prevention and Control of Healthcare Associated Infections, and subsequently reviewed and approved by the Patient Experience, Quality & Safety Committee (PEQS).

2024/25 saw year two of the action plan come to fruition and after a considerable amount of work by the Infection Prevention and Control team in conjunction with colleagues across the Health Board, the improvement plan is now almost complete, and Infection Prevention and Control is no longer considered an escalated matter within the Health Board.

The remaining outstanding actions from year two will be completed in 2025/26 and include:

- The implementation of ANTT provision and compliance mechanisms across all clinical areas of the Health Board. Aseptic technique is a critical clinical competency that is paramount to patient safety. Aseptic Non-Touch Technique (ANTT) is a specific type of aseptic technique with a unique theoretical and practice framework and its use is advocated across Wales by Public Health Wales, supported by Welsh Government. A detailed SBAR has been completed, and collaboration has commenced between clinical services and clinical education to effectively and sustainably implement ANTT in PTHB with the long-term aim of achieving bronze accreditation as a minimum standard to clearly demonstrate the level of excellence achieved within the Health Board.
- Increasing antimicrobial resistance is hindering the effective treatment of infections and consequently Multi Drug Resistant Organisms are increasing challenging our ability to manage them. Clear guidance is required for PTHB staff. Work is underway in producing guidance which will include admission screening, management and requirements of active and contact cases, including the risk assessing process.

7. Policies/Procedures/Standard Operating Procedures

In addition to the suite of policies that were implemented as part of the Infection Prevention and Control improvement plan in year one, two additional policies were developed in 2024/25.

Policy/Standard Operating Procedure Title	Issue Date
IP&C 053 Policy on Transmissible Spongiform Encephalopathy (Creutzfeld-Jakob Disease)	Due to be ratified at IP&C Committee – August 2025
IP&C 004 Decontamination of Reusable Medical and Surgical Devices	Due to be ratified at IP&C Committee – August 2025
SOP IP&C-001 Results Standard Operating Procedure	June 2025

8. Rates of Healthcare Associated Infections (Welsh Government Reduction Targets)

Annual reduction targets for Healthcare Associated Infections and Antimicrobial Prescribing are set by Welsh Government. However, due to the relative size of Powys Teaching Health Board, and the patient population, in comparison to other Health Boards within Wales, we consistently fall below these targets and are not benchmarked against other Health Boards, specifically from an Infection Prevention and Control perspective.

The improvement goals set out for the NHS for 2024/25, target Health Boards with having fewer HCAIs than in the previous financial year.

Clostridioides Difficile (CDI)

The Health Board has observed an overall decrease in CDI cases in 2024/25. Rates of CDI for 2024/25 were twenty-one, a decrease of four cases compared to the same period in 2023/24. Generally, Wales continues to see increasing rates of CDI and the proportion of non-inpatient cases has

not reduced for a decade. Powys, conversely, has seen a decrease in community acquired cases (*non-inpatient*) and a small increase to in-patient cases (13 and 8 respectively as at the end of 2024/25). An overview of the rates of CDI can be seen in the graph below:

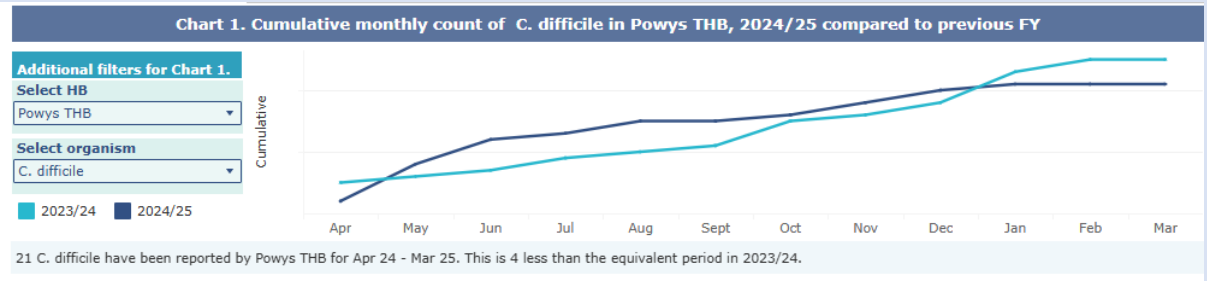


Table 2. Monthly count and rate of C. difficile in Powys THB, 2024/25

	Total count	CO* count	HO** count	% HO***	Total rate per 1,000 hospital ..	Total rate per 100,000 popula.
2024/25	**21**	**13**	**8**	**38%**	**15.18**	**15.68**
April 2024	2	0	2	100%	20.00	18.17
May 2024	6	5	1	17%	50.00	52.76
June 2024	4	3	1	25%	34.48	36.35
July 2024	1	1	0	0%	10.10	8.79
August 2024	2	2	0	0%	19.61	17.59
September 2024	0	0	0	0%	0.00	0.00
October 2024	1	1	0	0%	8.47	8.79
November 2024	2	0	2	100%	16.95	18.17
December 2024	2	1	1	50%	15.75	17.59
January 2025	1	0	1	100%	7.75	8.79
February 2025	0	0	0	0%	0.00	0.00
March 2025	0	0	0	0%	0.00	0.00

Source: Public Health Wales

As part of the Health Board's commitment to tackling the burden of infection, cases of CDI are investigated via a process of post infection review (PIR) where learning is identified and best practice shared. These reviews combine the expertise of colleagues from across the organisation.

Common Themes from Clostridiodies Difficille (CDI) post infection reviews:

- Prescribing of broad-spectrum antibiotics continues to be a concern in Powys. Powys has the highest use of the 4C antibiotics in Wales, the current prescribing rate is 59% higher than the Welsh National Prescribing Indicator target (10.4 vs 5.65 items/1000 patients) with slower improvement being seen compared to other Health Boards in Wales. Data gathered from review tools are used to support feedback to community practices.
- For the period 2023/24 we saw that some General Practices were not following guidance for first line treatment for CDI however, for

2024/25 evidence received through post infection review processes shows this practice is improving.

- Ward processes in identification of symptomatic patients which may lead to delays in implementing IP&C precautions such as Isolation and sampling.
- Decontamination of patient equipment continues to be sub-standard which has been identified via multiple Infection Prevention and Control audits and ward visits, despite significant IP&C intervention and support.
- Decontamination of the Environment. Cleaning and disinfection protocols are crucial in preventing the spread of CDI. C Difficile (C Diff) spores are resistant to many common disinfectants and can survive on surfaces for extended periods. Environmental Cleaning issues have been identified on several IP&C audits and seen during ward visits. Additionally, Powys Teaching Health Board are still not able to undertake HPV (Hydrogen Peroxide Vapour) cleaning which is widely researched as a highly effective method of terminal disinfection that eradicates C Diff spores from surfaces.

Actions to address learning:

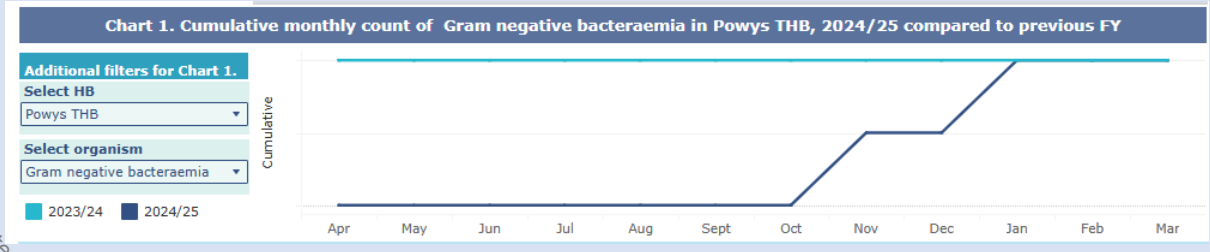
- An Antimicrobial Stewardship Improvement Plan is in place which is managed and overseen by the Antimicrobial Pharmacist.
- Monthly monitoring of primary care prescribing data by medicines management; General Practices receive monthly key performance indicator reports which include several antimicrobial KPIs; prescribing data is routinely discussed during General Practice visits; where prescribing concerns are identified, targeted discussions take place; Eolas App (formally Microguide) is promoted to all clinicians.
- 4C antimicrobial prescribing audits are undertaken by medicines management in primary care in practices who have agreed to participate.
- The Antimicrobial Stewardship Group has a standing agenda item on primary care antimicrobial prescribing.
- CDIs associated with antimicrobial prescribing are used to highlight the risks and to share learning with clinicians.
- Significant work has been undertaken by the IP&C team to streamline our primary care Post Infection Review (PIR) process to make gathering and analysing data easier. A digital PIR form has been devised by the team which is a quick and simple means of gathering

information. The digital platform is equipped with prescribing applications and C diff patient information resources along with business intelligence capabilities to withdraw data sets. The piloting of the form has been delayed due to the release of The All-Wales C Difficile Framework which recommends an All-Wales Approach for post infection reviewing of C difficile cases. This work along with aligning the health Board with the other elements of the All-Wales C difficile Framework will require significant IP&C resource in the next financial year.

- Equipment and environmental cleanliness are being addressed through the development of an Environmental Cleanliness Standards Group to provide assurance that learning from post infection review processes and IP&C audits is taken forward.
- Workforce training pertaining to C Difficile requires strengthening within the 25/26 by routinely embedding an annual training plan into the IP&C training programme.
- The availability of C Difficile resources; Patient Information Leaflets, Public Health Wales (PHW) literature to be accessible to staff and utilised.
- Re visit the availability of isolation provision within clinical areas in South Powys, to comply with requirements under Section 6 of the Code of Practice for the prevention and Control of Healthcare Associated Infections.

Gram negative blood stream infections (E.coli, klebsiella and pseudomonas aeruginosa)

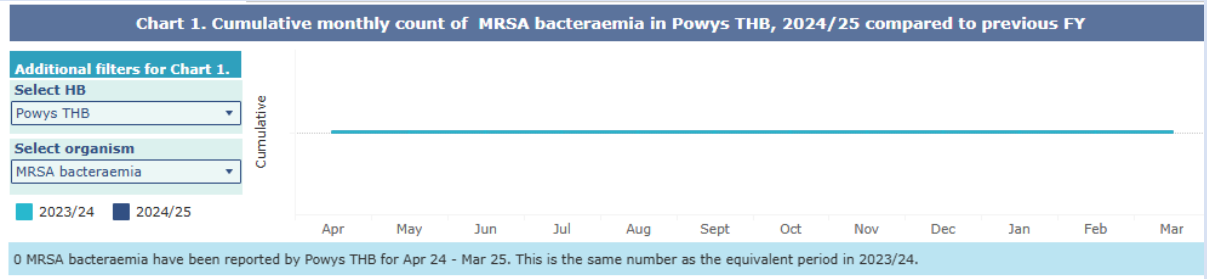
The Health Board observed two cases of gram-negative bacteraemia (E.coli), which is the same as the equivalent period in 2023/24.



Source: Public Health Wales

Methicillin-resistant Staphylococcus aureus Bacteraemia (MRSA)

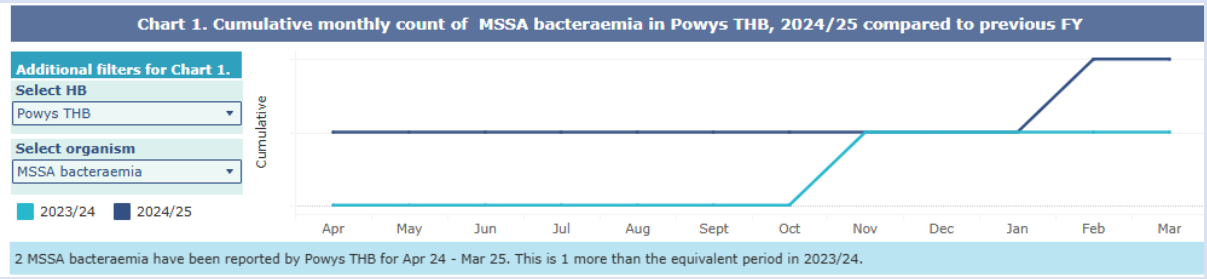
The Health Board has continued to observe zero cases of MRSA bacteraemia, with the last case of MRSA bacteraemia reported in 2013-14.



Source: Public Health Wales

Methicillin-Sensitive Staphylococcus aureus Bacteraemia (MSSA)

The Health Board has observed two cases of MSSA bacteraemia, which is an increase of one on the previous year.



Source: Public Health Wales

Acute Respiratory Infections

COVID-19

PTHB re-introduced mandatory mask wearing in early January 2025 due to the high prevalence of acute respiratory infections in our communities, the increase in hospital admissions and clinical presentations being seen in various settings. The measure was a key component in the Infection Prevention and Control Strategy, which was essential to safeguard patient safety and minimise healthcare associated infections. This action also aligned with the World Health Organisation (WHO) recommendation that

universal mask wearing should be undertaken in healthcare organisations when periods of high community transmission rates are observed. One COVID-19 outbreak was recorded during Q3 and two further periods of increased incidence were identified but contained to prevent significant onward transmission.

Influenza

The Health Board observed an Influenza A outbreak, which resulted in the closure of a ward in December 2024 requiring the completion of a National Reportable Incident (NRI). An outbreak review meeting was convened to identify areas of learning and good practice. Transmission had occurred despite prompt isolation of patients, a current programme of vaccination and appropriate use of PPE. Transmission of the virus during the asymptomatic phase was discussed. Messaging was reinforced to the workforce around not attending work with respiratory illness and encouraging the uptake of vaccinations.

The learning identified continues to be taken forward by the Infection Prevention and Control team through ad hoc training sessions and 'making every contact count' (MECC) principles.

Norovirus

No norovirus outbreaks we recorded during the period 2024/25. A small number of sporadic, unlinked cases occurred early in the year but no onward transmission was associated.

9. Infection Prevention and Control Audits

Annual IP&C audits were undertaken in PTHB using the Infection Prevention Society (IPS) audit tools, which are evidence based and utilised nationally, for standard environmental audits. The audits were undertaken using MEG, an intuitive, cloud based digital quality management system which will support and help monitor and measure care quality, drive improvement and support quality assurance in the health board. The implementation of MEG has required significant resource from the IP&C team and although the system is in its infancy, structured plans and developments are underway to mature the system to reach its full potential, this includes onboarding

the workforce to MEG which is essential for the system to be fully operational.

Following this year's audits, notable practices and improvements were identified which are outlined below.

Notable practice:

- IP&C Team welcomed on the wards and supported if queries arose.
- Improved relationships with the IP&C team.
- Staff responsive to the offer of IP&C education and training.
- Appropriate levels of Patient Protective Equipment (PPE) available on wards.
- Significant improvements in IP&C practices and requirements seen in some clinical areas in comparison with last year's audit findings.

Areas for improvement:

- Environmental cleanliness: numerous areas fell below the acceptable standard for environmental cleanliness. Governance regarding environmental cleaning standards was incomplete or absent.
- Patient equipment cleanliness: equipment seen in several clinical areas was visibly soiled or contaminated. Cleaning schedules were sporadic and not reflective of the equipment seen.
- Compliance with governance surrounding decontamination of equipment and devices
- Compliance with the All-Wales uniform policy. Standards of compliance varied across the health board and bare below the elbow was variable.
- Appropriate use of PPE: inappropriate glove use and inadequate PPE usage when needed.
- Chemical Compliance: despite significant IP&C investment over the last 12 months concerns remain regarding product use, storage, make-up and documentation standards.
- Sharps Safety: poor compliance noted i.e., sharps boxes not always labelled appropriately, overfilled and contaminated.
- Mattress Checking: policy compliance re checking absent in some clinical areas.
- Age of estates, which can indirectly influence Infection Prevention and Control standards.

IP&C resource is required to ensure ongoing collaborative working with colleagues across the Health Board to progress the areas identified for improvement.

Initiatives are underway and will be strengthened in the next financial year to support the continuing drive for improvement, including:

- The development of a comprehensive Audit Plan to be undertaken by IP&C. In addition to the IPS Environmental audits undertaken 5 key observation audits focusing on the key areas of concern (Sharps, Mattress, All Wales Uniform, Cleanliness) will now be undertaken to validate compliance with clinical procedures.
- Robust methods of detailed audit feedback. This involves utilising MEG to its full potential to develop Audit Action Plans with key areas of improvement noted and subsequent assurance of change. Embedding MEG into everyday practice ensuring understanding of the system and its requirements is essential.
- A programme of training has been developed and is now underway; this will require further investment to explore and develop a more comprehensive programme of training. In the interim individual IP&C audit action plans have been created for all clinical areas
- As a response to the Environmental Cleanliness issues identified with the audit schedule a Facilities Improvement Plan to be established in 2025/26.
- Re-establish a dedicated group that focuses on environmental cleaning standards and decontamination of clinical equipment.
- A planned program of collaborative visits to all in-patient premises with Works and Estates colleagues to identify and address minor works requirements.
- A national campaign on appropriate glove usage is in development as a collaborative piece of work with other stakeholders such as the Environment and Sustainability Team and the 'Bright Ideas' Team.

10. Environmental Cleanliness

PTHB recognises the importance of maintaining clean environments, especially in areas identified as requiring a critical level of cleanliness.

The Support Services Department is primarily responsible for maintaining hygiene and cleanliness standards across the Health Board's environment, encompassing clinical, nonclinical, and public spaces, as well as any

additional facilities acquired by the Health Board for healthcare purposes. Relevant department staff also carry out additional cleaning duties where they are responsible for cleaning specific equipment.

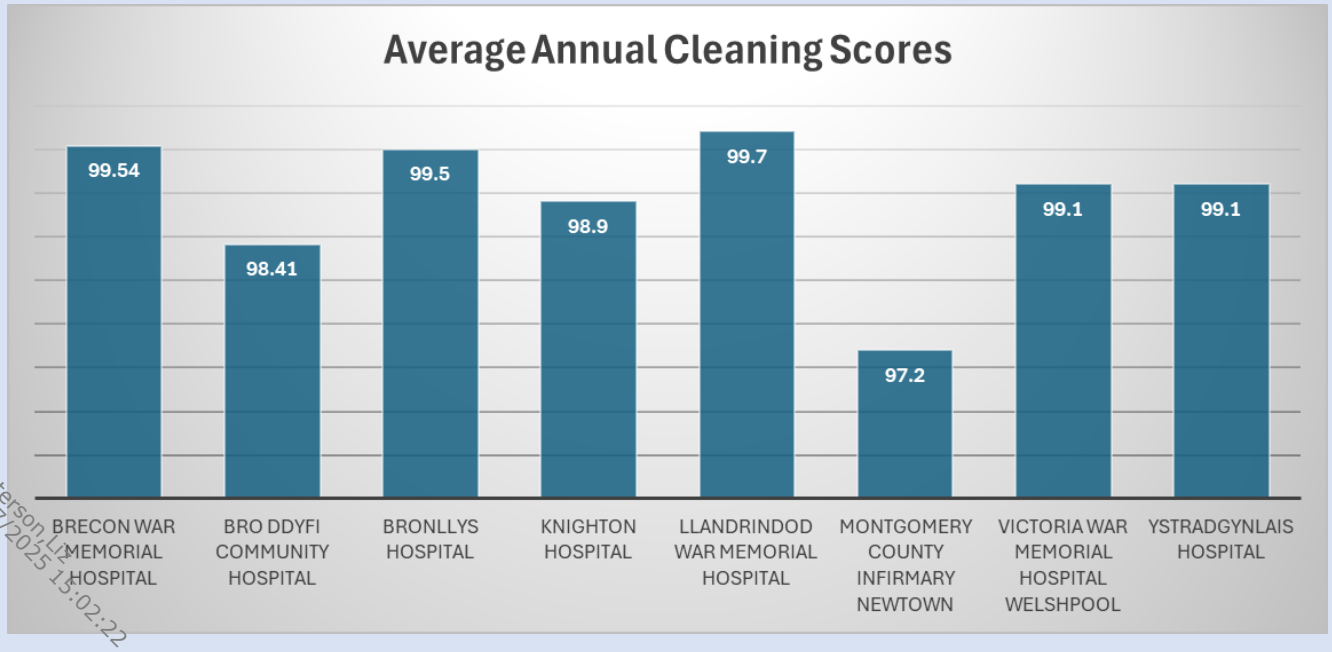
The Health Board's Environmental Cleanliness Standards Operating Procedure applies to all sites within the Health Board and all employees. It informs the correct processes for assuring high cleanliness standards through the inclusion of method statements which give detail on procedure, frequency and responsibility and includes nursing staff as well as Support Services.

Given the importance of maintaining cleanliness standards the Facilities Department can provide monthly assurance reports on several key performance areas to demonstrate and monitor the effectiveness of environmental cleanliness across PTHB sites. These reports include:

- Monthly average cleaning scores by risk level and area.
- Number of cleaning audits completed by risk level and area.
- Number of failing elements by element type, site, and area risk level.

Reporting capability has changed over the last 12 months with the transition from the MiCAD cleanliness monitoring software to Synbiotix which is reported to have the capability to provide more meaningful reporting and performance dashboards.

Average Scores for Reporting Period:



Following the IP&C environmental audits, numerous improvement mechanisms have been introduced over the last 12 months and will continue into 2025/26, to support the Cleaning Service Standards. These include:

- Close communication with Facilities colleagues over reactive and operation cleaning matters.
- Improvement in Audit Feedback Mechanisms.
- Plans to undertake joint auditing processes- to validate audit findings due to variations in Monthly data reporting by environmental cleanliness teams in comparison to IP&C audit and observational findings.
- Collaboration pertaining to Facilities Improvement Plan
- Collaboration in re-establishing Environmental Cleanliness Group.
- Work has been undertaken and will continue to develop regarding obtaining HPV cleaning provision within the Health Board to provide enhanced disinfection in areas exposed to infectious agents.
- The availability of specific IP&C Training for facilities staff.

The anticipated introduction of the new National Standards for Environmental Cleanliness is expected imminently and will form further collaborative workstreams over the next 12 months.

11. Internal Audit

Following the conclusion of the Internal Audit in Q4 2023/24, where reasonable assurance was given, the recommendations laid out in the management action plan have all been realised and completed actions reported through the IP&C Committee. Furthermore, the two-year Infection Prevention and Control Improvement is no longer an escalated matter.

As part of the 2024/25 internal audit programme, a review was undertaken to assess whether mattresses are appropriately checked and maintained. Overall, limited assurance was concluded, with key areas for improvement identified, including increasing staff awareness and providing enhanced training in mattress checking, cleaning and assessment. The IP&C team is actively working with service areas to strengthen assurance, supported by

detailed audits now embedded within the MEG electronic auditing system and the development of a robust training programme aligned with the mattress policy. Strengthening this area will remain a strategic priority for the team during 2025/26.

12. Decontamination

Despite significant disruption to the IP&C team's staffing capacity throughout 2024/25, efforts have focused on addressing the key issues identified in 2023-24 Annual Institute of Healthcare Engineering and Estate Management (IHEEM) audit by NHS Wales Shared Services Partnership (NWSSP), and providing strategic support to services.

Key initiatives within the decontamination portfolio include:

An action plan was developed following the Institute of Healthcare, Engineering and Estate Management (IHEEM) audit in 2024 and recommendations have now been achieved, most notably the procurement and launch of an electronic traceability system that has been a standing recommendation for over 5 years.

The action plan was used as supporting evidence to demonstrate the Health Board's commitment to decontamination during the most recent IHEEM Audit in 2025 by NHS Wales Shared Services Partnership on behalf of NHS Wales Executive and Bowel Screening teams.

The results of the audit provided Amber/Green assurance when measured against the Joint Advisory Group on Gastrointestinal Endoscopy (JAG) standards for decontamination services.

Following an in-depth analysis looking at usage of equipment, incidents and utilisation of Endoscopy spaces by the Senior Clinician for Theatres and Endoscopy, it was decided to temporarily decommission the Endoscope Washer Disinfectors (EWD) at the Llandrindod site. This has brought with it a financial benefit owing to the underuse of the equipment and associated costs of servicing, validation and consumables.

The Theatre team have also realised a saving through conversion to single use nasoendoscopes which negates the need for resource heavy decontamination processes.

The Dental Service has initiated a trial for centralisation of decontamination processes which is the gold standard for decontamination of reusable

instruments. With input and support from the IP&C team, work has begun to set up a single-site trial for a defined period, commissioning services from a neighbouring Health Board, the pilot is due to start in June 2025.

Moving into 2025-26, the team is committed to focusing on:

- Promoting continued engagement for the decontamination safety group, which takes place bi-annually and includes members who are key to driving improvements in decontamination. This group reports to the quarterly Infection Prevention and Control group, chaired by the Executive Director of Nursing, Quality, Women & Family Health.
- Strengthen partnerships with commissioned providers, who deliver decontamination/sterile services to the Health Board.
- Continue to work with Community Dental Services to further strengthen frameworks.
- Engage with community practices who undertake minor surgery within their premises to promote Essential Quality Requirements around decontamination procedures.
- Continue to ensure robust process for decontamination of re-usable medical devices are in place, including ultrasound machines.
- Ensure a structured annual audit programme across the Health Board, which will include an audit of commissioned service providers.
- Ensure robust contingency plans are in place for decontamination services across the Health Board

13. Commissioning Arrangements

Powys Teaching Health Board commissions care within Wales and across the border in England. The team have continued to foster relationships with counterparts in England, engaging in meetings, including attending post infection reviews where Powys patients have been impacted. This collaboration provides assurance to the Health Board that likely causes of HCAIs have been explored and any lessons learned are adopted by the commissioning organisation. As we move into 2025/26 the IP&C team will continue to work on strengthening these relationships and report learning via the IP&C Committee.

Historically, the commissioning of laboratory services across the border in England has presented challenges in the timely notification of results, as

they did not feed into the ICNET Clinical Surveillance platform that is utilised Wales-wide.

This led to communication gaps to the Infection Prevention and Control team, which has on occasions impacted the prompt management actions from the team. Significant efforts have seen integration of one of the laboratories into the ICNET system, meaning results are now available as they are authorised and reported. However, efforts continue to mirror this activity with a second English laboratory in 2025/26 as the challenges remain evident with current process' without integration to the ICNET system. These steps will enhance coordination between and within organisations and will streamline the flow of information via one source, ensuring more accurate and complete data.

14. Antimicrobial Stewardship

Antimicrobial resistance (AMR) has been identified as one of the most pressing global challenges. The World Health Organisation (WHO) has declared it as one of the top 10 global public health threats along with the UK Government acknowledging the issue on the national risk register.

AMR arises when the organisms that cause infection evolve ways to survive treatment. Once standard treatments are ineffective, it is easier for infections to persist and spread.

Although resistance occurs naturally, the inappropriate use of antimicrobials in both human and animal medicine, in plants and crops and unintentional exposure, for example through environmental contamination and food, is rapidly accelerating the pace at which it develops and spreads.

The NHS has a key role to play in tackling AMR and all NHS organisations are required to support the implementation of antimicrobial stewardship (AMS) interventions. In October 2024 Powys Teaching Health Board recruited an Antimicrobial Pharmacist to help support AMS efforts.

An important part of AMS is reducing the use of broad-spectrum antibiotic use, when narrow spectrum antibiotics remain appropriate alternatives. Broad-spectrum ("4C") antibiotics are associated with increased side-effects, including *C. difficile* and multi-drug-resistant infections, and should be reserved for use in limited, specific indications, as per national and local guidance. Powys has the highest use of the 4C antibiotics in Wales, the

current prescribing rate is 59% higher than the Welsh National Prescribing Indicator target (10.4 vs 5.65 items/1000 patients) with little improvement being seen compared to other Health Boards in Wales.

WHC 2024/038 sets out the AMR & HCAI improvement goals for 2024/25. The goals reflect the UK's 20-year vision to tackle antimicrobial resistance which involves a commitment to reduce overall antimicrobial prescribing by 10% against performance in baseline year 2019/20, and to achieve a minimum of 70% of total antimicrobials being from the 'access' category (i.e. narrow-spectrum). Powys Teaching Health Board has the highest deviation from the target and was the only health board to increase its consumption in 2023/24, however it is currently within target with respect to access antimicrobials (70.4%).

National prescribing indicators are also set to encourage antimicrobial stewardship, including percentage of antibiotics prescribed for Respiratory Tract Infection (RTI) as a 5-day course (vs 7) and reduction in 4C prescribing. The Health Board is currently the outlier in both indicators, being the highest prescribers of both course length and 4C antimicrobials.

The Health Board has established an Antimicrobial Stewardship (AMS) Group, chaired by the Chief Pharmacist. This meets quarterly and provides highlight reports to the Health Board's IP&C Group, chaired by the Executive Director of Nursing, Quality, Women & Family Health.

An Antimicrobial Stewardship Improvement Plan is in place and is regularly reviewed by the Medicines Management Team and the AMS Group.

The Pharmacy/Medicines Management Team routinely monitors primary care antimicrobial prescribing and practices are provided with quarterly antimicrobial KPI's, via an interactive dashboard, covering:

- Total antimicrobial prescribing (items per 1,000 STAR-PU)
- 4C antimicrobials (items per 1,000 patients)
- Co-amoxiclav (items per 1,000 patients)
- Cephalosporins (items per 1,000 patients)
- Quinolones (items per 1,000 patients)
- Silver dressings (cost per 1,000 patients)
- Amoxicillin course length (5-day course length as a proportion of vs 5+7-day courses)
- Clarithromycin course length (5-day course length as a proportion of vs 5+7-day courses)

- Doxycycline course length (5-day course length as a proportion of vs 5+7-day courses)
- Amoxicillin 250mg capsules (items per 1,000 patients)
- Trimethoprim prescribing as a proportion of UTI antimicrobials

Antimicrobial prescribing is discussed at every practice meeting, and the antimicrobial pharmacist is working with individual practices and prescribers to implement interventions to improve prescribing (e.g. targeted audit and feedback, access to guidelines, resources and education).

In the absence of an electronic prescribing system, the Pharmacy Team has limited ability to monitor antimicrobial prescribing in Powys Community Hospitals. This ability will change with the implementation of electronic prescribing and medicines administration (ePMA) in 2025/26. Snapshot audits of antimicrobial guideline adherence are undertaken by the antimicrobial pharmacist, which help identify areas for targeted improvement to be actioned by the ward teams.

The Medicines Management Team has commissioned access to the Eolas App (formally Microguide) to improve access to the Health Board's antimicrobial prescribing guidelines. The antimicrobial pharmacist is continually updating and expanding these guidelines to meet the needs of end-users.

Primary care audits have been undertaken to get a better understanding of 4C antimicrobial prescribing, although not all practices agreed to participate in these audits. The antimicrobial pharmacist is also working with interested practices to identify those with inappropriate penicillin allergies in primary care, to help further reduce the use of broad-spectrum antibiotics.

Collaboratively the Health Board's Infection Prevention and Control and Medicines Management teams diligently review all cases of CDI, including those in Primary Care. Review meetings with these teams and the ward are arranged as soon as a CDI case is identified in the community hospital, to review management and provide advice. Where sub-optimal prescribing is identified by pharmacy teams in post-infection reviews, these are followed up with the prescribers. However, a robust process and tool for data collection and reporting, particularly with respect to primary care cases, is required to ensure appropriate, relevant and timely learning from events.

15. IP&C Priority Workplan Plan 2025-2026

As we move into 2025-2026 the IP&C Team will continue to focus on providing a service that supports our clinical teams to deliver safe care. Infection Control will continue to be a high priority for the Health Board and the IP&C team have set out an ambitious but flexible plan of work.

Key areas of work for 2025-2026 include:

- Comprehensive Audit Schedule
- Developing MEG
- Completion of the two outstanding Improvement Plan actions; ANTT and MDRO work.
- IP&C Training Provision.
- C Difficile Framework Alignment.
- Improving Practice and competence.
- Strengthening governance and assurance.

16. Conclusion

2024-2025 presented challenges for the IP&C team as we continually strive to reduce Healthcare associated infections, which has remained a priority for the Health Board, ensuring our patients, staff and the public are kept safe. Despite the challenges numerous successes can be celebrated. HCAI rates remained stable, infection prevention and control were removed from escalation.

The report demonstrates the continued commitment of the Health Board and shows service improvement through the leadership of a dedicated and committed IP&C team. All employees have a responsibility in infection prevention and control and the successes achieved over the last year have only been possible with the commitment and collaboration of other services across the Health Board. Throughout 2025-2026 the IP&C team will continue to strengthen and support close working relationships and will strive to maintain high standards within Infection Prevention and Control.

PTHB remains committed to preventing and reducing and reducing the incidence and risks associated with Healthcare Associated Infections and recognises that we can do more by continually working collaboratively

together with colleagues, patients, service users and carers to develop and implement a wide range of IP&C strategies and initiatives to deliver safe care in our ambition to have zero tolerance to avoidable infections.

Agenda item: 5.7

PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE	31 JULY 2025
Subject:	**Electronic Prescribing and Medicines Administration (ePMA) system update**
Approved and presented by:	Kate Wright, Executive Medical Director
Prepared by:	Head of Digital Programmes Chief Nursing Information Officer
Other Committees and meetings considered at:	Executive Committee - 09 July 2025

PURPOSE:

To update the executive committee on the progress and timelines for the Electronic Prescribing and Medicines Administration (ePMA) system implementation.

RECOMMENDATION(S):

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

1. Take **ASSURANCE** from the progress made
2. **NOTE** the upcoming milestones and intended benefits.

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	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:

The purpose of this paper is to provide the Patient Experience, Quality and Safety Committee with an update on progress with the Electronic Prescribing and Medicines Administration (ePMA) system implementation in Powys, providing assurance on the continued work taking place to maintain quality and patient safety.

HEADING:

A key component of Welsh Government's A Healthier Wales policy is the investment and use of digital technology to improve patient care.

The introduction of an ePMA system is intended to enhance the quality of care and safety of patients in PTHB through the best possible use and management of medicines.

Replacing paper medicine charts/prescriptions with an ePMA, will make the entire process safer, easier and more efficient. Health professionals will have information at their fingertips to inform vital clinical decisions. Paper drug charts will disappear from the end of bed and digitising the process will mean patients spend less time waiting for medication before they leave hospital.

It will enable easy access to information for clinical decision-making and support the use of technology to free up more time for healthcare professionals to care for patients. It will reduce delays in obtaining medication, enhance patient safety, improve patient experience and satisfaction, strengthen medicines governance and make documentation and communication processes more efficient and effective, both within the Health Board and the wider NHS. This will lead to better healthcare outcomes and contribute to a reduction in the average length of stay for patients.

Powys Teaching Health Boards ePMA project is focused on implementing an ePMA solution for community hospital in-patient services in phase 1 by March 2026. Phase 2 will undertake expansion to other clinical areas, including outpatients and additional service settings, subject to evaluation and strategic priorities commencing April 2026.

Progress update

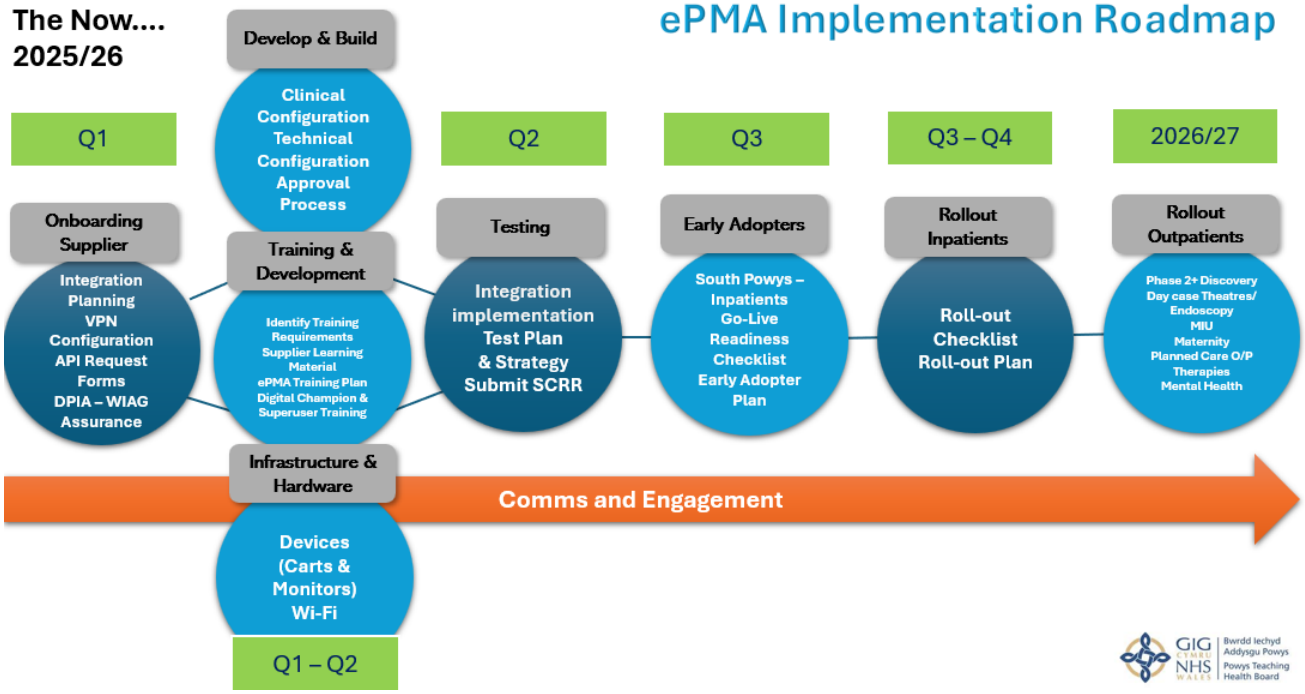
- Access has been granted to the development environment
- Wi-fi coverage is complete at the remaining hospital sites; Llanidloes and Newtown
- A draft training plan framework has been developed to ensure staff are competent and confident in using the new ePMA system, supporting a

smooth transition and maintaining patient safety throughout the implementation.
- Integration planning with Digital Health and Care Wales (DHCW) ongoing
- Recruitment complete
- Funding letter received from Welsh Government for 2025/26
- Configuration spreadsheets have been shared with the supplier, representing a significant and complex undertaking that involved both technical and clinical expertise
- Mobile computerised medication carts have been purchased to enable staff to administer medication safely at the bedside for phase 1
- Phase 2 Discovery work in progress
- Working collaboratively with neighbouring health boards who are further advanced in the project for shared learning.
- Rollout plan drafted – see below
- Virtual Private Network (VPN) established between Powys and the supplier (private tunnel for data exchange which provides enhanced privacy and security when accessing the internet)

Planned work

- Create training material. This will include an e-learning package with embedded assessment questions to ensure understanding and safety, alongside Quick Reference Guides (QRGs) and short instructional videos covering key tasks and functions.
- User Acceptance Testing (UAT) to be undertaken to ensure the system functions as intended and meets the clinical and operational requirements prior to go-live
- Working in collaboration with the Temporary Staffing Unit to ensure that all agency staff have completed the required ePMA training prior to commencing clinical duties, thereby supporting safe practice and continuity of care.
- Develop policies and standard operating procedures to support the new ways of working and ensure consistency and safety in the use of the new ePMA system and associated processes
- Develop a business continuity process to ensure safe and effective prescribing and medicines administration can continue in the event of system downtime or technical failure

The roadmap below provides a visual of the key deliverables and timelines expected over the next 12+ months.



The planned work outlines clear steps to ensure successful implementation and integration across inpatient wards in Powys during 2025/26, and outpatient areas post March 2026.

Intended Benefits

The main benefits of implementing an ePMA system are highlighted below:

Current issue	ePMA Benefit
Illegible, handwritten medicine charts	Clear, legible text no longer requiring clarification.
Information missing from medicine charts	ePMA system will mandate the completion of information. Will contribute to a reduction in administration errors.
Time spent rewriting paper medicine charts	ePMA system will eliminate need to rewrite charts, also reducing the risk of transcription errors.
Patient details missing or handwritten	ePMA system will pull information from WPAS in a clear, legible text.
Allergy information missing or incomplete	ePMA system will integrate with SMR to create true allergy status. ePMA system will mandate the completion of allergy status before allowing users to access the prescribing function.

Time spent looking for paper medicine charts	ePMA system will give staff digital access to medicine charts. Will also reduce time taken for medication administration rounds.
Blank boxes on paper medicine charts	ePMA system will digitally record administration and highlight when this has not occurred.
Lack of decision support tool at the point of prescribing	Inbuilt decision support tool available at the point of prescribing with ePMA system. Will also link to BNF, drug interaction databases NICE guidance, yellow card reporting etc. Will contribute to a reduction in prescribing errors.
Poor compliance with Antimicrobial Stewardship	ePMA system will mandate the completion of indication, course duration, review date and if Microbiology guidance was sought, and link to Microguide.
Poor compliance with VTE documentation	ePMA system will mandate the completion of VTE assessment before allowing users to access the prescribing function.
Correct prescribing of VTE	ePMA system will link to formulary choices and can link to clinical patient information such as weight and creatinine clearance.
Medication administration	ePMA system will provide clear, legible charts with links to administration information (BNF, SPC, Medusa) which is auditable.
Time taken transcribing medicines onto MTeD	ePMA system will auto-populate MTeD medicine list. Reduces risk of transcribing errors.
Availability of data	ePMA system will give a wealth of data, available in real time that provides full audit trail and allows for work and resource prioritisation.
Medicine chart not available when in use	ePMA system will give staff digital access to medicine chart, which can be viewed by multiple staff. As it is a digital system the chart can also be viewed remotely, which will provide staff with better efficiencies in their working practices.
Environmental burden of printing paper charts	Digital medicine charts will eliminate the need to obtain printed charts for use.
Financial burden of purchasing paper charts	No need to purchase paper medicine charts with ePMA system.
Prescribing of non-formulary items	ePMA system can be configured to PTHB formulary and tightly control non-formulary prescribing. System can be audited to identify any non-formulary prescribing.

Patients accessing timely medicines	Patients no longer must wait for prescribers to come to the ward to prescribe as they can access the ePMA system remotely.

Current Risks

The primary high-level risks currently involve securing BAU resources to complete phase 2, maintaining support for the transition from paper to digital, and ensuring that comprehensive training materials are prepared for early adoption.

Risk Number	Description of Risk	Severity (RAG)	Mitigating Actions
R64	There is a risk that key project personnel might leave the organisation due to fixed term contracts ending March 2026; prior to implementation of Phase 1	15	BAU Business Case to be submitted to IBG then executive committee for financial approval.
R67	Risk of Phase 2 not being implemented because BAU resources not yet agreed for 26/27 onwards	15	BAU Business Case to be submitted to IBG then executive committee for financial approval.
R69	The timeframe available to train all super users and develop the necessary training materials ahead of go-live is extremely limited, with a deadline of mid-August	20	Requested the go-live date be pushed back to allow adequate time for preparation. Training sessions from Better Meds have been scheduled to begin as soon as our configuration is available in the system.

Conclusion

The ePMA project is progressing well, with significant milestones achieved during the pre-implementation phase and now transitioning into the configuration phase, however there is a **risk** around maintaining clinical and technical resource post March 2026 for continued support, sustainability and service development. A business case is being submitted to IBG during July for ratification.

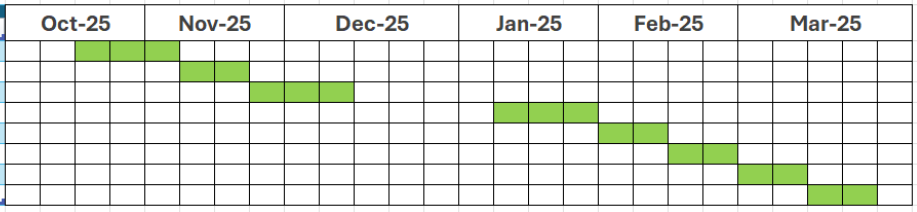
The current focus is on ensuring configuration, testing and training are completed in preparation for early adoption commencing quarter three. This digital transformation is intended to enhance patient safety, improve workflow efficiency, and advance the quality of healthcare we deliver in Powys.

Rollout Plan

ePMA Rollout Plan 2025-2026

Location	Start	End	Weeks
Brecon	20/10/2025	07/11/2025	3
Ystrad	10/11/2025	21/11/2025	2
Bronllys	24/11/2025	12/12/2025	3
Llandod	12/01/2026	30/01/2026	3
Llanidloes	02/02/2026	13/02/2026	2
Newtown	16/02/2026	28/02/2026	2
Welshpool	02/03/2026	13/03/2026	2
Machynlleth	16/03/2026	27/03/2026	2

Proposed



NEXT STEPS:

Relevant reports will continue to be provided to the Executive Committee.

IMPACT ASSESSMENT

Not required

Pharmacy Stores

Final Internal Audit Report 2024/25

Powys Teaching Health Board

Reasonable Assurance

Contents

Review Reference	PTHB-2425-04
Fieldwork	February – March 2025
Executive Sign Off	9th April 2025
Audit Committee	May 2025
Executive Lead	Kate Wright, Executive Medical Director
Audit Team	Ian Virgil, Head of Internal Audit
	Geoffrey Woolley, Principal Internal Auditor

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Executive Summary

Purpose

The overall scope of the audit was to review the policies and procedures in place regarding the Pharmacy Stores.

Overview

Appropriate storage and management arrangements are necessary to ensure that the quality of medicines/vaccines is maintained and so prevent potential harm to patients.

The current arrangements and procedures for the ordering, receipt, storage and distribution of medicines/vaccines were established during the Covid-19 Pandemic in response to the emergency situation.

The Main Pharmacy Store, which was the focus of our review, is situated in Hafren ward on the Bronllys site. This then delivers vaccines into wards, departments and vaccination centres across the Health Board.

We have concluded **Reasonable** assurance on this area. The matters requiring management attention include:

- A lack of supporting documentation for the ordering, receipt and distribution of vaccine stock;
- Inadequate and / or incomplete recording of information within the stock management spreadsheets; and
- Inadequate stock reconciliation procedures, including a lack of book to physical stock reconciliations.

Full details of matters arising are detailed within the Findings & Agreed Action Plan. The following opportunities for enhancement have been identified that do not impact the overall opinion and are highlighted for management information:

- While each vaccine spreadsheet is broadly similar in structure, they have been set up separately and are not identical templates.
- A separate spreadsheet should be set up for each annual vaccination programme.

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	Appropriate and up to date written policies/procedures are in place which have been communicated to all staff required to follow them.	-	**Substantial**
2	The written policies/procedures are being followed correctly and ensure that medicines/vaccines are being ordered, received, stored and distributed appropriately.	1, 2, 3	**Limited**
3	Medicines/vaccines are being managed correctly and safely in accordance with recognised pharmacy standards, Health & Safety requirements and other relevant regulations.	-	**Substantial**

Management Actions

3	0
High Priority	Medium Priority

Themes

Risk Types

Public Perception & Reputational Risk

Choose an item.

Patterson,Liz
28/07/2025 15:02:22

Findings & Agreed Action Plan

Objective 1: Appropriate and up to date written policies/procedures are in place which have been communicated to all staff required to follow them.	**Substantial**

Overview / Summary of Observations

Appropriate and up to date policies and procedures are in place for Pharmacy Stores which are available on the Health Board's intranet and public website.

A log is maintained which records when the written policies/procedures were last read in full by staff required to follow them.

'Good Distribution Practice' training is also provided to staff for which an accompanying test must be passed. Both had been completed by the Pharmacy Stores staff within the preceding year.

Objective 2: The written policies/procedures are being followed correctly and ensure that medicines/vaccines are being ordered, received, stored and distributed appropriately.	**Limited**

Overview / Summary of Observations

Pharmacy Stores manages the vaccine stock for each of the three core vaccination programmes i.e. Covid-19, Flu and RSV (Respiratory Syncytial Virus).

Vaccine stock is managed using a series of spreadsheets, with a separate spreadsheet set up for each vaccination programme. Each spreadsheet comprises a series of detailed worksheets which record a comprehensive range of relevant information for orders, receipts, storage and distributions.

Ordered

The types of vaccines ordered reflect central guidance, they are ordered from known suppliers, and the quantities ordered reflect known requirements. Vaccine orders are completed by the Senior Pharmacy Technician, Vaccinations/Therapies & Pharmacy Stores which is a key aspect of the role.

Received

When vaccines are delivered to Pharmacy Stores, the items received are checked for consistency with the order and any quantity or quality issues would be immediately followed up with the supplier.

Full receipt details, including batch reference and expiry date, are recorded against the order on the vaccination order worksheet. In addition, Pharmacy Stores is required to record vaccine receipts online on the Welsh Immunisation System (WIS).

However, copies of orders and delivery notes are not being consistently retained so we were not able to fully validate these processes for all the orders sampled.

Stored

Pharmacy Stores is made up of three rooms. The main room is a preparation area where receipts are checked and distributions are prepared and the other two rooms hold nine large fridges. Access is restricted by a locked door.

The fridges are medical grade with digital temperature displays which are designed to store vaccines within the required +2°C to +8°C range, plus cool packs used to maintain vaccine temperature during distribution. They have glass doors so their content can be viewed without having to open the door.

The high and low temperatures for each fridge are checked and recorded daily on the online Welsh Immunisation System (WIS). If any are outside the required range, then comments should also be added. We checked a sample of temperatures recorded on WIS and confirmed that they were within the required range.

We visited Pharmacy Stores and confirmed that the fridges were operating correctly within the required temperature range and had unique identifier reference numbers attached. Furthermore, each had a label attached confirming it had been calibrated in May 2024 and this was scheduled to be repeated in May 2025.

However, at peak times of the year, some vaccine is initially held at a neighbouring Health Board's hospital prior to being drawn down to Pharmacy Stores. We were informed that this is due to a lack of current available fridge space and therefore, Pharmacy Stores has proposed upgrading to a large capacity walk in cold storage unit. A paper regarding this was produced for wider consideration, and the issue has been added to the department's risk register.

The Health Board has appropriate procedures regarding the use of quarantine stock where special conditions need to be put in place e.g. reduced expiry date where the required temperature range has been exceeded for a limited period. Furthermore, there has been no vaccine wastage which required recording online on WIS.

Distributed

Vaccines are distributed using specialised vaccine carriers which the Health Board has in a variety of sizes.

Vaccination distributions reflect known appointments scheduled at the vaccination centres (Bronllys and Newtown), to whose records Pharmacy Stores has access, or requests from District Nurses, Maternity Services or School Nurses.

Most distributions occur via an NHS Shared Services driver who collects and distributes vaccines, plus District Nurses occasionally collect vaccines personally.

A vaccination delivery template has been developed which records a comprehensive set of information. It accompanies each vaccination distribution and, following sign off by the recipient, the completed version should be returned to Pharmacy Stores for retention. However, these were not present for the majority of deliveries we sampled.

Vaccine distributions are packed in insulated cool boxes along with cool packs which should maintain the required temperature for up to eight hours. Furthermore, most are transferred in temperature controlled vans.

The vaccination centres have medical grade fridges identical to those in Pharmacy Stores and so can hold surplus stock for the next vaccination session.

Distributions to District Nurses and wards comprise individual vials which have been taken from a full box so that excess stock is not distributed.

Again, we were not able to fully validate the delivery processes for all our sample as copies of requests and delivery notes are not consistently retained.

Key Findings		Risk & Impact	Agreed Management Action
1	**Lack of supporting documentation.** We tested a sample of 8 vaccine orders and 25 distributions and noted the following: • 8/8 supporting orders were not available; • 7/8 supporting delivery notes for orders were not available; • 14/25 supporting requests for distribution were not available; and • 13/25 supporting delivery notes for distribution were not available.	Inadequate support for Pharmacy Stores stock movements.	**Agreed Action:** Supporting documentation will be retained and appropriately filed for all Pharmacy Stores stock orders and movements so that the accuracy of the details recorded can be fully justified.
			Expected Evidence of Implementation: Supporting documentation is readily available for all Pharmacy Stores stock movements.
		High Priority	**Officer:** Senior Pharmacy Technician, Vaccinations/Therapies & Pharmacy Stores.
	Theme: Information, Data Quality & Data Accuracy	Control Operation	**Target Implementation Date:** Complete, already implemented.
2	**Inadequate recording of information.** While the worksheets have a comprehensive set of columns to record relevant information, a small proportion of the cells were empty or had not been completed. We also noted the following issues: • 1/8 receipts showed differences between the supporting delivery note and the vaccine receipts worksheet; • 3/8 receipts were not correctly shown on the stock check worksheet; • Where WIS records were available, as they are only available for three months, while for 2/8 receipts the stock check worksheet was consistent with WIS, only one of these was also consistent with the receipt tested; • Only 9/12 stock check worksheet balances were consistent with WIS; • The stock check worksheet only includes figures, formulae are not used to carry forward and calculate balances.	Inadequate control of Pharmacy Stores stock.	**Agreed Action:** The Pharmacy Stores stock records will be reviewed and amended so that they accurately record all stock movements and balances held and are consistent with movement supporting documentation and the online Welsh Immunisation System (WIS).

	Furthermore, the figures shown occasionally do not cast correctly; • 11/12 supporting delivery notes had differences compared to the distribution worksheet, one supporting delivery note's file name was incorrect and one supporting delivery note was incorrectly filed; • 7/25 transaction movements were not correctly shown in the stock check worksheet and of the 18 transaction movements that were correctly shown, 3 did not clearly show the breakdown; and • For 13/25 transaction movements which indicated that they included pack down separated vials, information was not correctly shown in the pack down worksheets.		**Expected Evidence of Implementation:** The Pharmacy Stores stock records accurately record all stock movements and balances held and are consistent with movement supporting documentation and the online Welsh Immunisation System (WIS).
		High Priority	**Officer:** Senior Pharmacy Technician, Vaccinations/Therapies & Pharmacy Stores. **Target Implementation Date:** Complete, already implemented.
	Theme: Information, Data Quality & Data Accuracy	Control Design	
3	**Inadequate stock reconciliation procedures.** While daily and weekly stock checks are performed, they do not include book to physical stock check reconciliations to confirm the accuracy or otherwise of the records. The stock check worksheet closing balance does not show the split between pack down separated vials and non pack down full box balances. The stock check worksheet does not include the earliest expiry date against the closing balance to ensure that any expiry date issues are promptly highlighted.	Incorrectly recorded Pharmacy Stores stock balances.	**Agreed Action:** Daily and weekly book to physical stock check reconciliations will be performed, with the book and physical stock balances clearly stated along with a reconciliation of the difference between them and the name of the person who completed the stock check. The stock check worksheet closing balances will show the split between pack down separated vials and non pack down full box balances. The stock check worksheet will include the earliest expiry date against the closing balance.
			Expected Evidence of Implementation: Records of completed monthly stock check reconciliations.
	Patterson,Liz 28/07/2025 15:02:22	**High Priority**	**Officer:** Senior Pharmacy Technician, Vaccinations/Therapies & Pharmacy Stores. **Target Implementation Date:** Complete, already implemented.
	Theme: Information, Data Quality & Data Accuracy	Control Design	

Objective 3: Medicines/vaccines are being managed correctly and safely in accordance with recognised pharmacy standards, Health & Safety requirements and other relevant regulations.	**Substantial**

Overview / Summary of Observations

The Senior Pharmacy Technician, Vaccinations/Therapies & Pharmacy Stores is the Health Board's designated person responsible for identifying standards and regulations to be complied with in relation to Pharmacy Stores. They have a high level of pharmacy knowledge and experience and are supported by a Pharmacy Technician who also has an appropriate level of pharmacy knowledge and experience.

In relation to Pharmacy Stores, the most significant risks that medicines/vaccines are not being managed in accordance with recognised pharmacy standards, Health & Safety requirements and other relevant regulations are:

- Deterioration of vaccines due to inadequate temperature control:

  The fridges are temperature controlled medical grade with daily temperature checks which were calibrated in May 2024 and are due to be repeated in May 2025.

- Manufacturer product recall:

  The batch references for vaccine stock are on the packaging and recorded in the vaccine programme spreadsheets and on the Welsh Immunisation System (WIS). Therefore, the implications of any recall can be immediately identified and appropriate action taken.

- Quarantine stock:

  Pharmacy Stores staff have confirmed that any such stock would be recorded, and a label attached and advice, confirmed in writing, would be obtained from the manufacturer regarding what action should be taken. However, it was also stated that this is generally not a problem in Pharmacy Stores but is more likely to occur at vaccination locations where the vaccine storage is being repeatedly opened and closed.

Furthermore, no vaccine wastage has been recorded by Pharmacy Stores on the Welsh Immunisation System (WIS) in the preceding three months for which records were available, and we have been assured that this is correct.

We have been informed that the Health Board does not hold an MHRA (Medicines and Healthcare products Regulatory Agency) licence as this is only required by manufacturers / distributers and so is not applicable as the Health Board is merely a user which obtains the vaccines for its own use.

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.

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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 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.

Website: [Audit & Assurance Services - NHS Wales Shared Services Partnership]

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Audit and Assurance Services

Quality & Safety Governance (Duty of Quality)

Final Internal Audit Report

2024/25

Powys Teaching Health Board

Reasonable Assurance

Contents

Review Reference	PTHB-2425-09
Fieldwork	February - May 2025
Executive Sign Off	June 2025
Audit Committee	June 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

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Audit and Assurance Services

Executive Summary

Purpose

Review of the Health Board's arrangements for quality monitoring and reporting through the Integrated Quality Report, as part of ensuring compliance with the Duty of Quality.

Overview

The Welsh Government's 'A Healthier Wales' plan sets out the long-term future vision of a whole system approach to health and social care, one which is focussed on health and wellbeing, and on preventing illness. The Duty of Quality is part of the Health and Social Care (Quality and Engagement) Wales Act 2020, and alongside the Duty of Candour, supports the ambitions within a Healthier Wales. The Duty of Quality (the 'Duty') came into force on 1 April 2023 and affects all NHS Wales organisations, including non-clinical settings. The Duty aims to improve the quality of services and improve the health outcomes for people in Wales. The Duty focuses on four key elements:

- Health and Care Quality Standards;
- Quality-driven decision making;
- Quality Management System; and
- Quality Reporting.

The Duty of Quality compels NHS organisations to:

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

The Integrated Quality Report was introduced to provide an overview of the Quality & Safety agenda across the Health Board and provide assurance that Quality and Safety is appropriately monitored and reported.

We have concluded **Reasonable** assurance on this area. The matters requiring management attention include:

- Timely update of the structure and content of the Health Board's Integrated Quality Report (IQR).
- Ensuring full accuracy of the indicators included within the IQR prior to publishing for the committees.
- Clarity on impact of information within the IQR.

Full details of matters arising are detailed within the Findings & Agreed Action Plan.

Scope & Assurance Summary

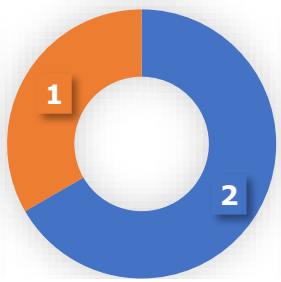
Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)		Related Findings	Assurance
1	The structure and content of the Health Board's Integrated Quality Report allows for effective reporting and monitoring of key areas of quality and improvement	1	**Reasonable**
2	Robust systems and processes are in place to capture and validate the data required to populate the Integrated Quality Report	1,2	**Reasonable**
3	The Integrated Quality Report is completed within required timescales to allow for timely submission to the relevant governance forums		**Substantial**
4	The Integrated Quality Report is submitted to appropriate groups and / or committees and is subject to effective review so that areas of poor performance are identified and addressed	3	**Reasonable**

Management Actions

0 High Priority

3 Medium Priority

Themes



- Information, Data Quality & Data Accuracy
- performance Monitoring

Risk Types

Legal & Regulatory Non-Compliance

Quality or Safety Issues

Quality or Safety Issues

Choose an item.

Patterson,Liz
28/07/2025 15:02:22

Findings & Agreed Action Plan

Objective 1: The structure and content of the Health Board's Integrated Quality Report allows for effective reporting and monitoring of key areas of quality and improvement	**Reasonable**

Overview

The purpose of the Integrated Quality Report (IQR) is to provide an overview of the Quality and Safety agenda across the Health Board.

There is on-going work on the report to ensure the organisation is able to demonstrate how they are maintaining the Duty of Quality (DoQ).

At the time the DoQ became live, there was no template provided on an All-Wales basis or centrally for reporting against the requirements of the DoQ. However, the Health Board initiated and developed the IQR for this purpose. The IQR's current template has been in use since 2023.

The IQR was developed using the knowledge and skills of the Quality and Safety team. The IQR also takes into consideration the Health and Care Quality standards and further items are included based on key areas the Board wants to be reported.

There are standard and non-standard items currently being reported through the IQR. Non-standard items may be reported depending on what the Health Board deems important at the time, influenced by the changes in risks and regulations and the need to reflect key areas of Quality. The report highlights information on areas such as Putting Things Right (PTR), Infection, Prevention & Control, RLDatix, Incident reporting, Incident management, Patient's experience framework and Welsh Risk Pool assurance report, which is currently being developed.

We note that whilst there is work ongoing to further develop the robustness of the IQR, the current format and content allows for effective reporting and monitoring.

	Key Findings	Risk & Impact	Agreed Management Action
1	<u>On going changes to the Integrated Quality Report.</u> We note that work is already underway and ongoing regarding the presentation of the IQR and future changes that may be required as a result of new/ updated legislation and frameworks the Health Board has to comply with. The IQR is an evolving report responsive to changes relevant to the Duty of Quality and the organisation. For instance, over time the IQR has evolved with the addition of the bereavement framework. There will also be some upcoming changes that will affect the reporting structure of the IQR as a result of the Welsh Government People's Experience Framework and changes regarding the Duty of Candour and how targets are going to be met.	Legal & Regulatory Non-Compliance Inaccurate and / or incomplete quality information	People's Experience Framework paper to Executive Team in q2 PTR changes to be taken to Exec Team 18 June **Expected Evidence of Implementation:** Updated Integrated Quality Report with required changes.
		Medium Priority	**Officer:** Heidi Sinclair, Head of Quality & Safety **Target Implementation Date:** 30 September 2025
	Theme: Information, Data Quality & Data Accuracy	Control Design	

Objective 2: Robust systems and processes are in place to capture and validate the data required to populate the Integrated Quality Report	**Reasonable**

Overview

The IQR is produced every quarter. The Quarter three IQR presented at the Executive Committee in January 2025 and the PEQs in February 2025 was used for our review. The Head of Quality & Safety is responsible for the preparation of the IQR and is supported by the datix administrator, concerns manager and redress co-ordinator. The datix administrator runs the report at the beginning of each month to have the most accurate information.

Five areas were selected for review within the IQR to ensure systems and processes are in place to capture and validate the data. Some exceptions were found regarding 1 of the 5 areas sampled. The areas selected were:

- Claims, Redress & Clinical Negligence- The primary system is datix where a report is downloaded and used to populate the relevant data within the IQR. As this is a live system, the reported figures could not be fully validated due to the timing difference. However, we were able to confirm the reasonableness of the reported figures.
- The Early Warning Notifications (EWN)- The data as stated within the IQR was validated to the datix exported download.
- Nationally Reportable Incidents - There has been a recent change in the use of the NRI table that was presented in the February 2025, Quarter 3 IQR. Due to the timing of this change in process, we have not validated the previously mentioned information but accept that it was reasonable.
- Civica - This is a patient service survey done on a service-by-service basis. The survey is done via SMS, use of QR codes on posters and iPad. The system cannot be manually influenced.
- Infection Prevention and Control- The action plan includes the relevant fields (link to DoQ, recommendation, action required, target dates, key leads), with RAG ratings stating the position of the actions of the plan and evidence update. The action plan highlights 2 ongoing actions remaining, as reported within the IQR.

Before publication, the information within the IQR is quality assured by the Head of Quality & Safety and is reviewed by the Assistant Directors of Nursing and Quality, before final review and sign-off by the Executive Director of Nursing, Quality, Women & Family Health.

	Key Findings	Risk & Impact	Agreed Management Action
2	**CIVICA review outcome** 85% is the benchmark set for positive responses on an all-Wales basis and is used to determine the position of any outcome. The benchmark does not relate to the number of respondents but the positivity of the response irrespective of the size/ number of	Inaccurate and / or incomplete quality information	The quarter dates will be displayed in the relevant graphs.

	people responding. The table which has the collated result used for benchmarking does not state its metric is in percentages. We also note that graph 9 was completed by only one person in Dec 2024. A part of the table under graph 8 should also have shown a red or amber highlight for the overall satisfaction level but was showing as all green. However, the Datix Administrator explained that this is a system error and this function cannot be manipulated, and no form of adjustment can be made to it.		**Expected Evidence of Implementation:** Information within the IQR completely and accurately reported.
	Graphs 10 & 11, 12 & 13 and 14 did not state the period of coverage, and the Datix Administrator was also unable to determine the period the data within the graphs related to.	**Medium Priority**	**Officer:** Heidi Sinclair, Head of Quality & Safety **Target Implementation Date:** 31 July 2025
	Theme: Information, Data Quality & Data Accuracy	Control Operation	

Objective 3: The Integrated Quality Report is completed within required timescales to allow for timely submission to the relevant governance forums — **Substantial**

Overview

There are arrangements in place to ensure the timely compilation of the IQR for reporting to the relevant governance forum. The Executive committee receives and reviews the IQR prior to its formal presentation to the quarterly Patient Experience, Quality & Safety (PEQS) committee meetings. The rhythm and timing are set such that the IQR is available to be presented at each of the PEQS meetings.

We confirmed that the 2024/25 Quarter two and three IQR reports were timely presented at the respective Executive committee and PEQS committee meetings.

The Nursing business support officer maintains a copy of the reporting timetable for the financial year 2024/25.

Staff responsible for providing the information for inclusion within the IQR are aware of the deadlines for submission.

Objective 4: The Integrated Quality Report is submitted to appropriate groups and / or committees and is subject to effective review so that areas of poor performance are identified and addressed	**Reasonable**

Overview

As noted under objective 3, the quarterly IQR is presented to the Executive Committee and PEQS Committee for review.

Our review of the committee papers evidenced that discussions are held on the content of the IQR and actions are put in place, as noted within the minutes of the meetings and action notes.

As an example of this, there were concerns highlighted around incidents within Mental Health which led to a service review and subsequent internal escalation of the service. An escalation report has since been provided via the IQR process with updates on required actions included. Mental Health has an action log and they provide up to date information on this to the PEQS Committee.

The committees keep a log and from time-to-time request updates within an agreed timeline as evidenced within the meeting action notes. However, it can be difficult to follow through or monitor information being reported if an overview from previous periods is not available.

Key Findings		Risk & Impact	Agreed Management Action
3	**Clarity on Impact of Information within the IQR** The information on IP&C Claims, Redress & Clinical Negligence, and Early warnings notifications reported in the IQR are extracted from datix. These were some of the sampled areas we reviewed as a part of our testing under objective two. The purpose of the IQR is to provide the Executive Committee and PEQS Committee with an overview of the Quality and Safety agenda across the Health Board. However, we noted that the relevance of some of the figures highlighted within the report was sometimes unclear, specifically on how they enable the Health Board to demonstrate that quality has been improved through the monitoring of the figures over time via the IQR.	Ineffective oversight and monitoring	Year to date analysis of Performance will be included within the IQR where this is applicable. **Expected Evidence of Implementation:** Copies of IQR with year to date analysis included.
	Theme: Performance Monitoring	**Medium Priority** Control Operation	**Officer:** Heidi Sinclair, Head of Quality & Safety **Target Implementation Date:** 31 July 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.

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Website: [Audit & Assurance Services - NHS Wales Shared Services Partnership]

Business Continuity Planning

Final Internal Audit Report

2024/25

Powys Teaching Health Board

Substantial Assurance

Contents

Review Reference	PTH-2425-23
Fieldwork	March - April 2025
Executive Sign Off	April 2025
Audit Committee	May 2025
Executive Lead	Executive Director of Public Health
	Executive Director of Primary, Community Care and Mental Health
Audit Team	Ian Virgill, Head of Internal Audit
	Ken Hughes, Audit Manager

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Shared Services Partnership
Audit and Assurance Services

Executive Summary

Purpose

The purpose of this review was to establish if the Health Board had appropriate arrangements in place to ensure effective business continuity across all areas and services.

Overview

NHS organisations and providers of NHS funded care must take reasonable steps to ensure that in the event of a service interruption, essential services will be maintained and normal services restored as soon as possible. As a Category 1 responder with key emergency response duties under the Civil Contingencies Act (2004), the Health Board is required to ensure that it has robust plans in place for emergency preparedness, resilience and response. An audit of Business Continuity Planning was undertaken in 2023/24, focusing on arrangements at a corporate level. This audit considered the effectiveness of Business Continuity Planning arrangements at an operational level.

We have concluded **Substantial Assurance** on this area. The matters requiring management attention include:

- The key contact details were missing and / or out of date for some service BCP's
- Testing of service area BCP's was not being undertaken in accordance with BCP policy and guidance

Full details of the matters arising are detailed within the Findings & Agreed Action Plan.

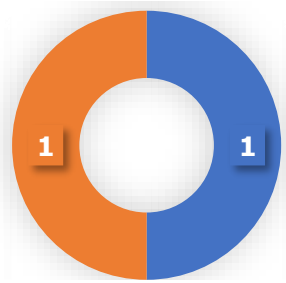
Scope & Assurance Summary

Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)		Related Findings	Assurance
1	There are appropriate operational business continuity plans and supporting processes in place, which cover all of the Health Board's critical operations.	1	**Reasonable**
2	Relevant operational staff are aware of business continuity plans and the actions required during an incident.	-	**Substantial**
3	Appropriate command structure and communications are in place in the event of a continuity event occurring.	-	**Substantial**
4	The Health Board has processes in place for testing operational plans and incorporating lessons learned from recent events.	2	**Reasonable**

Management Actions

0	2
High Priority	Medium Priority

Themes



Risk Types

Quality or Safety Issues

Legal & Regulatory Non-Compliance

Choose an item.

Choose an item.

Patterson,Liz
28/07/2025 15:02:22

Findings & Agreed Action Plan

Objective 1: There are appropriate operational business continuity plans and supporting processes in place, which cover all of the Health Board's critical operations.	**Reasonable**

Overview / Summary of Observations

The Business Continuity Management Policy requires the Health Board to publish a Corporate Business Continuity Plan (BCP), supporting service level BCP's and threat specific BCP's such as for severe weather or a pandemic. Service areas are required to complete a high-level Business Impact Assessment (BIA), and this is reviewed annually. The last review was completed in June 2024. The BIA assesses and prioritises services into four categories: Critical; Core; Reduced or Suspended. Only those areas that identify 'critical' services within their BIA are required to then develop a BCP. A separate BCP is required for each critical service identified. A BCP template has been developed as part of the BCP toolkit, and this is available on the PTHB intranet / SharePoint site.

The results of the most recent BIA's undertaken by each service area have been published within the Corporate BCP. Testing confirmed that all service areas had completed the BIA, and all directorates that had identified critical services had developed a BCP for each of the critical services identified, and that these BCP's were in line with the toolkit template. However key contact and staff details were missing or out of date for some plans.

	Key Findings	Risk & Impact	Agreed Management Action
1	**Completeness of Service Area BCP's** Review of the six Service Area BCP's identified that whilst all followed the toolkit template, the contact names and telephone numbers of key staff had not been included in three of the six plans. In addition, one 'document owner' and three other key contacts could not be found on Outlook which suggests they may have left the organisation, and several other key contacts had moved on to new job roles and no longer had any BCP responsibilities. Three document owners were recorded by job title but were not named.	BCP's do not contain up to date contact details of key staff causing delays in implementing BCP actions.	**Agreed Action:** The key contact names and telephone numbers will be updated for all 6 BCP's. A process will be developed to ensure all staff contact names and telephone numbers are kept up to date. **Expected Evidence of Implementation:** Updated BCP's.
		Medium Priority	**Officers:** Assistant Director Community Services Group Assistant Director of Mental Health & Learning Disabilities Services
	Theme: Information, Data Quality & Data Accuracy	Control Operation	**Target Implementation Date:** 30 June 2025

Objective 2: Relevant operational staff are aware of business continuity plans and the actions required during an incident.	**Substantial**

Overview / Summary of Observations

The directorate BCP leads are responsible for communicating the results of their Business Impact Assessments and, where developed, Business Continuity Plans to all relevant staff within their service areas. This includes all actions required during an incident. A copy of each service area BCP is also held by the Civil Contingencies manager, and a copy is held securely on Resilience Direct, a UK wide secure web platform hosted by the Cabinet Office.

The Civil Contingencies and Emergency Planning section of the PTHB SharePoint site highlights a number of training courses for staff that are delivered by the Civil Contingencies Manager, and a link to an E-learning package 'An Introduction to Emergencies' that is accessed via ESR. The training has been developed to inform and prepare staff to support the Health Board in discharging its responsibilities. The ESR training is not mandatory, but all staff are encouraged to complete the course. The training commenced in 2022/23 and to date 100 staff have completed the training. A Civil Contingencies Training and Education Plan is maintained by the Civil Contingencies Manager, and this sets out the training requirements for all staff and management groups with BCP responsibilities.

Objective 3: Appropriate command structure and communications are in place in the event of a continuity event occurring.	**Substantial**

Overview / Summary of Observations

The command structure is set out in the Corporate Business Continuity Plan and the Major Incident and Emergency Response Plan and applies to all BCP activity at all levels. The command structure is based on a three-tiered Gold (Strategic) / Silver (Tactical) / Bronze (Operational) structure. There are four levels of response as documented in the Escalation and Response process. Level 1 is the lowest level incident and will result in the implementation of localised business continuity arrangements. Level 2 will require the Gold on-call to be notified (for information) in addition to the implementation of the local BCP. For incidents assessed as level 3 or 4 the Gold on-call and Executive Lead will be notified of the incident. The Gold on-call will then determine the level of response that is required. For a Level 3 incident a Silver Business Continuity Management Group (BCMG) will be established. For a Level 4 incident the Gold on-call will liaise with the Chief Executive Officer to determine if an internal Gold Command is required. These arrangements were tested during our previous review of BCP and were given a substantial assurance opinion.

The Civil Contingencies Emergency Response and Business Continuity Training Plan includes a requirement to carry out a Communications Exercise every 6 months, and our review confirmed this is being done with WAST on a regular basis. The Major incident and Emergency Response Plan contains a section on Liaising with the Media and the use of social media to put messages out directly into the public domain. This states that the Local Resilience Forum Media Cell will usually take the lead in joint agency co-ordination of media information. The Corporate BCP also requires a Communications Lead to be appointed to the internal Silver Business Continuity Management Group (BCMG) to ensure effective communications are put in place in the event of a Level 3 or Level 4 incident.

Objective 4: The Health Board has processes in place for testing operational plans and incorporating lessons learned from recent events.	**Reasonable**

Overview / Summary of Observations

The Business Continuity Plan template within the BCP toolkit requires the document author to undertake an exercise on an annual basis to test the plan. The testing requirements of BCP's is documented in more detail in the Civil Contingencies Training Plan. A debrief template is included as part of the Business Continuity Plan for completion following a business continuity event. Once completed, a post incident Report is completed and submitted to the Executive Committee for scrutiny and approval. The BCP template is part of the Business Continuity Toolkit that is available to all staff on the Civil Contingencies section of SharePoint.

To date no planned testing of the six operational BCP's in place has been undertaken, although we were informed that both Community Services Group BCP's had been effectively tested during live incidents. A full debrief was also undertaken following Storm Darragh during which the Inpatient BCP was implemented. Following the debrief an incident report with 22 recommendations was prepared and submitted to the Executive Committee for approval on the 5th March 2025. However, we have not received details of any completed or planned testing from either directorate relating to the BCP's they have developed.

A full review was undertaken following the Covid 19 pandemic, and this has resulted in the updating of the PTHB Pandemic Framework for responding to new and emerging pandemics. We were informed that the lessons learned from the Storm Darragh debrief will be incorporated into future BCP plans and guidance.

Key Findings		Risk & Impact	Agreed Management Action
2	**Testing of BCP's** Service area BCP's should be tested annually in accordance with the Health Board's BCP guidance. The two Community Services Group BCP's had been tested during live incidents, but no planned testing exercises had been carried out. Information on testing for the four Mental Health BCP's was requested but no information was provided in relation to any completed or planned testing. Patterson,Liz 28/07/2025 15:02:22	Without appropriate testing, plans may be ineffective, and staff may not be adequately informed and practiced.	**Agreed Action:** Annual tests of all service area BCPs will be scheduled and undertaken with subsequent completion of the debrief template and post incident report. Where testing is effectively undertaken via live incidents, full supporting documentation will be retained. **Expected Evidence of Implementation:** Copies of annual tests, debriefs and post incident reports for all service area BCPs.
		Medium Priority	**Officers:** Assistant Director Community Services Group Assistant Director of Mental Health & Learning Disabilities Services **Target Implementation Date:** 31 July 2025
	Theme: Lessons Learnt	Control Operation	

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.
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Risk Management & Assurance

Final Internal Audit Report

2024/25

Powys Teaching Health Board

Reasonable Assurance

Contents

Review Reference	PTHB-2425-01
Fieldwork	February - March 2025
Executive Sign Off	April 2025
Audit Committee	May 2025
Executive Lead	Helen Bushell, Director of Corporate Governance
Audit Team	Ian Virgil, Head of Internal Audit
	Lucy Jugessur, Deputy Head of Internal Audit

Patterson.Liz 28/07/2025 15:02:22

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Partneriaeth Cydwasanaethau

Gwasanaethau Archwilio a Sicrwydd

Shared Services Partnership

Audit and Assurance Services

Executive Summary

Purpose

The purpose of this review was to assess the effectiveness of the procedures for identification, management and reporting of strategic and key operational risks and to also review the risk management arrangements in the People & Culture Directorate and the Mental Health & Learning Disability Service.

Overview

The Health Board is committed to the principles of good governance and recognises the importance of effective risk management as a fundamental element of the Health Board's governance and system of internal controls. The Board is committed to having a risk management culture that underpins and supports the business of the Health Board; providing and securing high quality care in a safe environment, that is complying with legal and regulatory requirements, meeting objectives and promoting its values.

At the time of our review the Health Board was undertaking substantial changes to its risk management framework. As well as continuing to develop the use of the Datix Cloud software to record and manage its key risks, the Health Board was revising its overall approach in the recognition that the Board Assurance Framework (BAF) is undergoing further development and also that there is too large a gap between the risks contained in the Corporate Risk Register and those that are managed at Directorate and Service level. The Health Board is therefore developing a sub-component of the BAF that will sit alongside a new Strategic Risk Register, which will replace the current Corporate Risk Register. An Organisational Risk Register is also to be introduced to sit in between the Strategic Risk Register and those at a Directorate level.

The key current concern is therefore development of the BAF, but as stated above this is currently being addressed. Notwithstanding this concern, the reporting of the current key risks through the Board and its sub-committees is working effectively. Given that the known areas of weakness are the subject of documented plans (i.e. the documentation of a BAF, and the introduction of both a Strategic and Organisational Risk Register), we have not raised findings in these areas, and we have concluded reasonable assurance overall. The only matter requiring management attention, over and above the detailed work already underway, is the need to ensure that Directorates and Services have a consistent and accurate approach to recording their risks. The implementation of the DatixCloudIQ system should largely address this but we recommend that this is supported by updated training and guidance.

Full details of matters arising are detailed within the Findings & Agreed Action Plan.

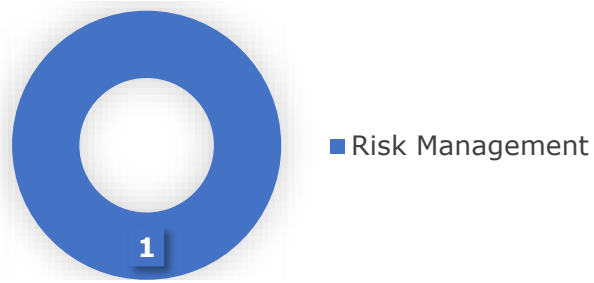
Scope & Assurance Summary

Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)		Related Findings	Assurance
1	There is appropriate guidance in place which is up to date and accessible to all staff.	-	**Reasonable**
2	There is an appropriate risk management structure in place within the organisation and resources are identified to ensure that risks are identified and managed.	-	**Substantial**
3	There are appropriate processes in place for reviewing, monitoring and reporting of risks. Risks are escalated when appropriate.	1	**Reasonable**
4	There is a Board Assurance framework in place that is subject to regular review and monitoring to the Board.	-	**Reasonable**
5	The audit will identify the progress of implementing the internal audit recommendations raised in the 2023/24 audit of Risk Management (PHTB-2324-01).	-	**Reasonable**

Management Actions

0	1
High Priority	Medium Priority

Themes



Risk Types

Financial Loss

Legal & Regulatory Non-Compliance

Choose an item.

Choose an item.

Patterson,Liz
28/07/2025 15:02:22

Findings & Agreed Action Plan

Objective 1: There is appropriate guidance in place which is up to date and accessible to all staff.	**Reasonable**

Overview / Summary of Observations

The Risk Management Framework has been updated and was approved by the Health Board in March 2025. Although the previous version of the Framework was overdue for review, it remained relevant to the existing arrangements for risk management. The Risk Management Toolkit will now also need to be updated to reflect the changes made in the Framework. The updated Toolkit is planned to be presented to the July 2025 meeting of the Audit, Risk and Assurance Committee for approval. There is therefore sufficient and current documentation available to managers and staff across the Health Board to provide appropriate guidance in the management of risk. We have allocated a rating of reasonable to this objective but not raised a specific finding as the Health Board has plans in place to update the Risk Management Toolkit.

Objective 2: There is an appropriate risk management structure in place within the organisation and resources are identified to ensure that risks are identified and managed.	**Substantial**

Overview / Summary of Observations

The Director of Corporate Governance is the nominated Director lead for risk management across the organisation. As the planned changes to the approach are implemented the Board will own the Strategic Risk Register and the Organisational Risk Register will be owned by the Executive Committee. Each Executive Director is responsible for identifying a 'Risk Champion' within their relevant directorate to attend the Risk and Assurance Group, a sub-group of the Executive Committee. The Risk and Assurance Group (RAG) provides the opportunity to collectively review Directorate Risk Registers, discussing any subsequent urgent, emerging or materialising risks, identifying potential thematic risks arising across Directorates and recommending potential actions for management and/or mitigation where appropriate. The RAG has been in existence for some time but did not meet between November 2023 and July 2024. However, it now appears to be back on a quarterly meeting cycle, albeit that ensuring full attendance remains a challenge.

Objective 3: There are appropriate processes in place for reviewing, monitoring and reporting of risks. Risks are escalated when appropriate.	**Reasonable**

Overview / Summary of Observations

There is evidence of appropriate review, management, and monitoring of risks at the Board and also with the Board sub-Committees regularly reviewing the risks allocated to them, supported by detailed information from the central risk team. There is also a procedure in place for the escalation of Directorate risks to the Corporate Risk Register, although to date very few risks appear to have been accepted for escalation, but the new procedures proposed for risk management, with the introduction of the Organisational Risk Register, may make this more likely in future. At a Directorate and Service level there is again evidence of appropriate review and updating of Risk Registers albeit that some contain inaccuracies and inconsistencies in their completion. It is hoped that a revised standard approach across the Health Board, populated within the Datix Cloud system, should help to address the issues noted.

Key Findings		Risk & Impact	Agreed Management Action
1	**Directorate Risk Registers** Review of the Risk Register for People & Culture, and Mental Health & Learning Disabilities Service, identified that whilst both bore evidence of regular review and update, there were some minor errors and inconsistencies in completion. A number of these related to the calculation and rating of the score which should be addressed by the move to the Datix system. One recurring issue was that the column for actions already taken often included actions that appeared to be on-going. Patterson,Liz 28/07/2025 15:12:22	Risks are not accurately recorded in terms of their overall priority and there may be confusion over whether controls are in place.	**Agreed Action:** The Health Board will ensure that appropriate guidance and training is provided to all relevant staff to accompany the revised risk management framework and the implementation of the DatixCloudIQ system. The Health Board will also review the "what has been done to manage the risk to date" field and instead consider "what existing measures are already in place to control the risk" to help to avoid the issue of partially completed actions being included in this field, which currently may give a false assurance that the risk is being effectively managed. **Expected Evidence of Implementation:** Updated guidance and training material.
	Theme: Risk Management	**Medium Priority** Control Operation	**Officer:** Deputy Board Secretary **Target Implementation Date:** November 2025

Objective 4: There is a Board Assurance framework in place that is subject to regular review and monitoring to the Board.	**Reasonable**

Overview / Summary of Observations

The Health Board has a BAF framework in place which was approved by the Board in May 2024, and is in the process of producing the strategic risk dashboard as a subcomponent of the BAF. This will be accompanied by a Strategic Risk Register drawn from the strategic priorities outlined in the Strategic Plan for 2025/26. The intention is for a populated Strategic Risk Register to be presented to the May 2025 Health Board meeting. The BAF dashboards will be developed alongside the Strategic Risk Register and will focus on the assurances in place for the strategic risks that have been identified. Whilst the Strategic Risk Register will be reviewed at all Board meetings, the BAF is expected to be reviewed on a twice-yearly basis. We have allocated a rating of reasonable for this objective as whilst there is a BAF framework in place, there is still a need to develop the risk dashboard as a subcomponent of the BAF. However, we acknowledge that plans are in place to complete this task and for that reason we have not raised a formal finding, but the ongoing action from the 2023/24 audit is noted within Appendix A.

Objective 5: The audit will identify the progress of implementing the internal audit recommendations raised in the 2023/24 audit of Risk Management (PHTB-2324-01).	**Reasonable**

Overview / Summary of Observations

Detail on the position with each of the recommendations from the 2023/24 report is provided in Appendix A. Progress has been made with all of the recommendations although four remain on-going at the current time.

Appendix A

Ref	Recommendation	Management Response	Audit Update (March 2025)
1	The Risk Management Framework and Risk Management Toolkit should be reviewed in accordance with their stated version control requirements to ensure that their content is current, and in alignment with organisational strategic objectives.	The Risk Management Framework and Risk Management Toolkit will be revised as recommended. **Deputy Board Secretary 30 September 2024**	The Risk Management Framework has been updated and was signed off by the Board in March 2025. The Risk Management Toolkit will be updated in the coming months. **On-going**
2	Promotion of risk management should be undertaken to ensure that all Health Board staff are aware of their roles and responsibilities, and a rolling programme of risk management training introduced to maximise their understanding and application of the contents of the Risk Management Toolkit.	A programme of risk management training and awareness will be developed and roll out will commence by 30 October 2024. **Deputy Board Secretary 31 October 2024**	Training has been provided in-year but it is recognised that an effective programme of training and support will be essential for the effective implementation of the revised framework. Implementation will be supported by a suite of training, guidance and support which is currently under development by the Corporate Governance Team. This will include a revised Risk Management Toolkit, which will return to the Audit, Risk and Assurance Committee on 8 July 2025 for approval. **On-going**
3	Formal Processes should be established within the Medicines Management department, and Medical Directors Office to ensure regular review and formal reporting of their respective risk registers, and their collegiate risk issues as a whole.	Medicines Management/Pharmacy service leads to ensure that all Medicines Management/Pharmacy risks are reviewed on a monthly basis and that the risk register is updated as appropriate, initialled and dated. **Head of Primary Care Medicines Management; Head of Community Services Medicines Management; Senior Pharmacist High-Cost Drugs/Formulary 30 June 2024** Risk register to be a quarterly standing agenda item on the senior pharmacist meeting agenda. **Chief Pharmacist 30 June 2024**	Review of the Medicines Management Risk Register demonstrates that this was last reviewed on the 30th January 2025. Subsequent to this date the Chief Pharmacist left the organisation on the 14th of February and currently the position has not been filled. Regular review of the register will recommence once a new Chief Pharmacist is in post. **Complete** Monthly meetings were in place between the Chief Pharmacist and Medical Director to review Medicines Management/Pharmacy Risk Register and will recommence when a new Chief Pharmacist is appointed. Risk is also discussed at Senior Pharmacists' meeting. **Complete**

Appendix A

		Formal quarterly meeting between Medical Director and Chief Pharmacist in place to go through Medicines Management/Pharmacy Risk Register to ensure that risks are escalated to RAG as appropriate. **Medical Director/Chief Pharmacist 31 August 2024**	Risks scoring ≥ 12 escalated to the Risk and Assurance Group. This was evidenced by the submission of two risks for potential escalation to the Corporate Risk Register at the September 2024 meeting of the Executive Committee. This included the recommendation from the RAG on their consideration of these risks. **Complete**
4	All risks stated on the Women & Children risk register should be reviewed in accordance with a prescribed review timescale that is commensurate to the level of risk scoring. Risks should also be supported by a brief narrative to state action to be undertaken to mitigate each risk, a proposed timescale for completion if practicable, and an action progress update provided during each review undertaken.	Risk registers will be reviewed and updated within the monthly Women & Children Quality & Performance meeting, to ensure timely updates and escalation as required. **Assistant Director, Women & Children 31 July 2024**	The risk register live link is placed on the Women and Children Senior Leadership Team and Quality and Performance monthly meeting where each department produces a report which also highlights any risks for concerns. **Complete**
5	All Directorate/departmental risk management leads should be reminded that key risks that are scored 12 and above should be submitted to the RAG for discussion, with a further view for potential escalation onto the Corporate risk register.	Requests for directorate risks have been issued and incorporated onto the Risk and Assurance Group agenda for the scheduled meeting on the 18 July 2024 and will be a standing item thereafter. **Director of Corporate Governance 30 June 2024**	Review of the Risk & Assurance Group meeting notes suggest that this has been occurring but not on a consistent basis. However, the change in risk management arrangements, with the implementation of an Organisational Risk Register, is likely to make it easier for Directorate risks to be considered for escalation as appropriate and this is reinforced by the updated Risk Management Framework. **On-going**
6	Ongoing action should be taken to ensure that the BAF is populated as detailed within the covering paper presented to the May 2024 Board meeting. Furthermore, the BAF should then be subject to ongoing progress reporting to the Audit Risk & Assurance Committee and the Board.	The development of the BAF forms part of the scheduled work programme and forms part of the Board work programme for the Boards meeting on the 25 September 2024. **Director of Corporate Governance 30 September 2024**	Although work has been taken forward on the design of the BAF and how it will work in practice, it is still to be actually populated. The plan is for the Strategic Risk Register to be presented to the May Board meeting with the BAF then going to the July meeting. **Ongoing**

Appendix B

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.
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Mattresses

Final Internal Audit Report

2024/25

Powys Teaching Health Board

Limited Assurance

Contents

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Fieldwork	April - June 2024
Executive Sign Off	June 2025
Audit Committee	July 2025
Executive Lead	Claire Madsen, Executive Director of Allied Health Professions, Health Sciences & Digital
Audit Team	Ian Virgil, Head of Internal Audit
	Geoffrey Woolley, Principal Internal Auditor

Patterson,Liz
28/07/2025 15:02:22

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

Executive Summary

Purpose

The overall objective of the audit was to review the processes and controls in place across the Health Board to ensure that mattresses are subject to appropriate checks and maintenance.

All equipment that is used in the delivery of patient care possesses a potential infection risk directly to the patient utilising the equipment and a potential cross-infection risk if the equipment is not properly checked and decontaminated.

All Powys Health Board staff have a duty to safeguard patients and in doing so must ensure that equipment being used for patient care is appropriately decontaminated and checked to ensure its safe use.

The Health Board should prevent as far as reasonably practicable the risk of Healthcare Associated Infections to patients. The Health Board must therefore ensure that equipment, such as mattresses are appropriately checked and maintained to ensure they are fit for patient use.

Overview

We have concluded **limited** assurance on this area. The significant matters requiring management attention include:

- There is limited awareness of the Health Board's Mattress Policy and a lack of specific training provision for staff on the cleaning and assessment of mattresses;
- There is currently no process in place on the wards for confirming monthly compliance with the Health Board's policy on the cleaning of mattresses;
- Monthly mattress audits are not being consistently completed by all wards across the Health Board;
- No confirmation that actions are being taken to address issues identified through mattress audits;
- Completed mattress audits are retained on individual wards and not currently held centrally;
- Information was missing or incomplete within a number of the mattress audits reviewed; and
- There is no central monitoring or reporting arrangements in place for mattresses.

Full details of matters arising are detailed within the Findings & Agreed Action Plan.

Scope & Assurance Summary

The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

	Objectives	Related Findings	Assurance
1	There are appropriate and up to date policies and / or procedures in place that set out the required processes for the cleaning, decontamination, maintenance and audit of mattresses.	-	**Substantial**
2	There is staff awareness and promotion of the policies / procedures and staff have undertaken / received appropriate levels of training.	1	**Limited**
3	Cleaning, decontamination and maintenance of mattresses is being undertaken in accordance with the stated policies / procedures.	2	**Reasonable**
4	Regular mattress audits are undertaken across the Health Board, with results reported and remedial action taken to address any issues identified.	3, 4, 5, 6	**Limited**
5	There are appropriate governance, monitoring and reporting arrangements in place for mattresses.	7	**Limited**

Management Actions

5	2
High Priority	Medium Priority

Themes

Risk Types

Quality or Safety Issues

Patterson,Liz
28/07/2025 15:02:22

Findings & Agreed Action Plan

Objective 1: There are appropriate and up to date policies and / or procedures in place that set out the required processes for the cleaning, decontamination, maintenance and audit of mattresses.	**Substantial**

Overview / Summary of Observations

The Health Board Policy IPC 052 'Policy for the checking, replacement and auditing on mattresses, trolleys and cushions' (the "Policy") sets out the required processes for cleaning, decontamination, maintenance and audit of mattresses.

The Policy was issued in February 2024 with review due by February 2027. It was formally approved by the Infection Prevention and Control Committee in January 2024.

Objective 2: There is staff awareness and promotion of the policies / procedures and staff have undertaken / received appropriate levels of training.	**Limited**

Overview / Summary of Observations

The Health Board's Policy states that all employees should be familiar with it and understand their roles and responsibilities under it. Furthermore, it states that staff should receive appropriate training, which it expands as being mandatory training Infection Prevention and Control (IPC) level 1 and 2 as appropriate.

As part of the audit, we met with the two Community Services Managers (CSM), and staff from the following four sampled wards:

- Y Bannau ward – South Region;
- Adelina Patti ward – South Region;
- Brynheulog ward – North Region; and
- Maldwyn ward – North Region.

Our discussions with two CSMs and the ward staff indicates that while staff have general knowledge regarding how to clean and assess a mattress, most have limited, if any, awareness of the Policy.

In addition, our discussions indicated that whilst the relevant staff are shown how to carry out cleaning of mattresses, they do not receive any further specific training. We were also informed that IPC level 1 and 2 mandatory training only covers general Infection Prevention and Control issues, requirements and guidance and does not specifically address the cleaning of mattresses.

Furthermore, while the ESR system records all staff mandatory training undertaken, no register is maintained which records who has received specific training on the mattress policy and how this compares with those staff undertaking the work.

We were informed by the Professional Head of Nursing that training was provided to relevant staff between June 2023 and May 2024, around the time the Policy was introduced. However, no evidence was available to verify the training and the numbers of staff who received it.

Key Findings		Risk & Impact	Agreed Management Action
1	**Lack of awareness and specific training on the Health Board's Mattress Policy.** Limited specific training on the Health Board's mattress policy has been provided and so most staff have limited awareness of its requirements. Furthermore, no register is maintained which records who has received specific training and how this compares with those staff undertaking the work.	Non-compliance with the policy requirements.	**Agreed Action:** Specific training on the Health Board's Mattress Policy will be provided to all staff required to implement its requirements and a mattress training register will be developed to ensure that all staff undertaking the work are covered. **Expected Evidence of Implementation:** A mattress training register is in place which lists all staff undertaking work on mattresses and indicates when training was last completed.
		High Priority	**Officer:** Linzi Shone **Target Implementation Date:** 30/07/25
	Theme: Training & Development	Control Design	

Patterson,Liz
28/07/2025 15:02:22

Objective 3: Cleaning, decontamination and maintenance of mattresses is being undertaken in accordance with the stated policies / procedures.	**Reasonable**

Overview / Summary of Observations

We discussed the cleaning, decontamination and maintenance of mattress arrangements in place with staff in each of the four sampled wards. In summary, the following was noted:

- There was variation between wards in the staff who undertook the work, being domestic, healthcare assistant and nursing staff;
- Thorough deep cleans and checks were undertaken following patient discharge before arrival of the next patient; and
- Daily quick cleans and checks were undertaken with any issues quickly dealt with.

However, while these discussions confirm that staff have general knowledge regarding how to clean and assess a mattress, as noted under the previous objective, most staff have limited, if any, awareness of the Policy. Therefore, the activities undertaken may not fully comply with the detailed requirements set out in the Policy.

Key Findings		Risk & Impact	Agreed Management Action
2	**No monthly confirmation of compliance with the Health Board's policy.** There is currently no process in place whereby the ward leads confirm at the end of each month that cleaning, decontamination and maintenance of mattresses has been undertaken in accordance with the Health Board's policy. There is also no periodic review undertaken by the CSMs to check completion and follow up on any issues where necessary.	Non-compliance with the policy requirements.	**Agreed Action:** A system will be implemented to record monthly confirmation from the ward leads that cleaning, decontamination and maintenance of mattresses has been undertaken in accordance with the Health Board's policy. The records will be reviewed by the Community Services Managers and followed up where necessary. A summary of these declarations will also be incorporated into the reporting arrangements under Finding 7.
			Expected Evidence of Implementation: Records of monthly confirmations from each of the ward leads.
		Medium Priority	**Officer:** Zoe Client / Donna Jones / Paul Sussex **Target Implementation Date:** 31/08/25
	Theme: Governance	Control Design	

Objective 4: Regular mattress audits are undertaken across the Health Board, with results reported and remedial action taken to address any issues identified.	**Limited**

Overview / Summary of Observations

We requested the previous twelve months' mattress audits for each of the four wards in the North and four wards in the South regions. These had to be obtained from the individual wards are they are not available centrally on Teams or SharePoint.

We reviewed each of the mattress audits provided. In summary:

- There was a clear division between the two regions. In the North region, there was a generally good level of compliance with three wards having completed monthly audits for the whole period and one ward having completed monthly audits for two thirds of the time. However, in the South region there was a poor level of compliance with only a couple of monthly audits completed for two of the wards and no monthly audits for the other two wards.
- Multiple issues and areas for improvement were also identified following review of the audits that had been completed. These are detailed in the findings below.

	Key Findings	**Risk & Impact**	**Agreed Management Action**
3	**Monthly mattress audits not completed by all wards.** As detailed above, monthly mattress audits are not being completed by all wards. Furthermore, the audit templates in the mattress policy were not consistently used.	Mattress issues may not be promptly identified.	**Agreed Action:** All staff will be reminded that monthly mattress audits should be completed using the audit templates in the mattress policy. Monitoring of compliance will be incorporated into the reporting arrangements under Finding 7. **Expected Evidence of Implementation:** Copies of completed monthly audits for all wards.
		High Priority	**Officer:** Linzi Shone **Target Implementation Date:** 30/07/25
	Theme: Quality, Safety & Patient Experience	Control Operation	
4	**Confirmation that actions are taken to address issues identified.** Where issues were identified in the mattress audits that we reviewed, there was generally no confirmation whether action had been taken to rectify the issues and if so, when it occurred. We also noted that there is currently no register in place that records the mattress audits and details any issues identified and the actions taken to address them.	Mattress issues may not be promptly rectified.	**Agreed Action:** A mattress audit register will be maintained which summarises issues identified through the mattress audits and when and how they have been rectified. The mattress audit register will be reviewed monthly by the CSMs and issues followed up where necessary. **Expected Evidence of Implementation:**

			Copy of the mattress audit register with details of issues identified and actions taken included.
		High Priority	**Officer:** Zoe Client / Donna Jones / Paul Sussex **Target Implementation Date:** 30/07/25
	Theme: Reporting	Control Design	
5	**Retention of completed mattress audits.** Completed mattress audits are generally retained on the individual wards. They are not held centrally and are not therefore available for review or oversight. We were informed that a mattress audit Teams channel had been set-up but has not been fully implemented and is not therefore fully operational.	Mattress audits may not be readily available to everyone who need access to them.	**Agreed Action:** All mattress audits will be retained centrally, either on the Teams channel or SharePoint so that they are readily available to all staff who need access to them.
			Expected Evidence of Implementation: Copies of the mattress audits retained centrally on Teams or SharePoint.
		Medium Priority	**Officer:** Zoe Client / Donna Jones / Paul Sussex **Target Implementation Date:** 31/08/25
	Theme: Information, Data Quality & Data Accuracy	Control Design	
6	**Missing mattress audit information.** Mattress identifier numbers and identifiable signatures were often missing on the mattress audits we reviewed. On some of the audits we also noted that there was no information recorded for a number of the mattresses, and the reasons for the omissions were not indicated.	Incomplete mattress checks and inadequate traceability.	**Agreed Action:** Staff will be reminded to ensure that all required information is included for all mattresses as part of every audit.
			Expected Evidence of Implementation: Copies of audits with all required information included.
		High Priority	**Officer:** Zoe Client / Donna Jones / Paul Sussex **Target Implementation Date:** 30/08/25
	Theme: Quality, Safety & Patient Experience	Control Operation	

Objective 5: There are appropriate governance, monitoring and reporting arrangements in place for mattresses.	**Limited**

Overview / Summary of Observations

Our discussions with the CSMs identified that mattresses are periodically discussed within some locality and ward meetings. For example, the North and Mid Powys ward managers meetings held in 2024/25 included discussions on mattress policy, replacement and auditing as part of the Governance and Assurance agenda.

However, regular central monitoring and reporting arrangements are not currently in place for mattresses.

	Key Findings	Risk & Impact	Agreed Management Action
7	**No central monitoring and reporting arrangements are in place.** As highlighted under the previous objectives, there is currently no central register of all mattresses in place, and no process for recording compliance with cleaning requirements or the completion of monthly mattress audits. As a result, there is also no central monitoring or reporting of information relating to mattresses. The information that should be captured and reported would be expected to include the following: • Details of all mattresses on each ward; • Confirmation of compliance with cleaning and maintenance requirements; • The number of mattress audits undertaken; • The number of issues identified analysed by category; and • The length of time taken to resolve the issues identified analysed into appropriate time bands. Furthermore, the report should include previously reported results so that comparison and trends can be identified and drawn out. This information should be regularly reported to appropriate Groups within the Localities and Service Group. There should also be a clear mechanism for escalating any serious issues identified through the reports up to an appropriate Committee of the Board.	Lack of corporate oversight.	**Agreed Action:** A system which captures the information suggested, will be put in place for mattresses along with appropriate reporting within the Localities. A clear mechanism for escalation of serious issues will also be established. **Expected Evidence of Implementation:** Copies of reports generated from the implemented system. Agendas and minutes from Locality and Service Group meetings confirming receipt and review of the repots.
		High Priority	**Officer:** Linzi Shone **Target Implementation Date:** 30/09/2026
	Theme: Governance	Control Design	

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 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.

Agenda Item
6.2.1

Joint Commissioning Committee

Quality Safety and Outcomes Sub-Committee Highlight Report

Dyddiad y Cyfarfod / Date of Meeting	20/05/2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Maxine Evans, Interim Corporate Governance Officer
Cyflwynydd yr Adroddiad / Report Presenter	Mandy Rayani, Lay Member
Noddwr yr Adroddiad / Report Sponsor	Carole Bell, Director of Nursing and Quality

Pwrpas yr Adroddiad / Report Purpose	For Noting Choose an item.

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
N/A		Choose an item.

1. SITUATION/BACKGROUND

This report had been prepared to provide a summary of the key issues considered by the Joint Commissioning Committee Quality, Safety and Outcomes sub-committee at its meeting on 31 March 2025.

Key highlights from the meeting are reported in Section 3.

2. PURPOSE

The Purpose and Role of the Joint Committee and the sub-committees are set out in Paragraphs 2.18 and 2.20 of the JCC Standing Orders.

The Quality and Safety Outcomes Committee Terms of Reference can be found here.

3. HIGHLIGHT REPORT

RAG Rating	Highlight
Alert / Escalate	• Members commented on the importance of developing a video tour for the Mother and Baby Unit and agreed to highlight this in the Chairs report, and to provide feedback to the HB that provides this service.
Advise	• Members were advised that further work was being undertaken on the Quality Newsletter to align it with the JCC communications strategy. This was close to being completed and will be referred to as a Quality Bulletin. • Members received an update on the escalation status of the Paediatric Critical Care Unit (PCCU) and the Neonatal Intensive Care Unit (NICCU) at the Children's Hospital for Wales. The following points were noted: ○ Improvements in the governance structure including key appointments and regular meetings to ensure clearer oversight and accountability. ○ Introduction of a dashboard to accurately capture activity and cot availability. ○ Key improvements demonstrated in neonatal mortality and national benchmarking in areas such as retinopathy, prematurity screening and infection rates. ○ Positive feedback from patient and families highlighting the improvements in care and the importance of ongoing work to maintain these improvements. ○ Clear expectations and requirements for de-escalation improved understanding of what was being asked and once established the service was able to provide the necessary information and assurance. • Members received the Welsh Kidney Network (WKN) report which provided a briefing on the current Quality and Patient Safety issues within the WKN commissioned services. The following points were noted: ○ Oxa 48 e-coli infection identified on a kidney ward and the challenges related to this outbreak. Although this primarily affects kidney patients, it may become a broader infection control concern. It was noted that the environment had been a contributing factor. An

RAG Rating	Highlight
	infection prevention and control meeting is arranged to discuss and agree a consistent approach across Wales. ○ The WKN meetings with the three providers of BCUHB, CVUHB and SBUHB and how the wider JCC will be made aware and kept informed of this issue. This would be highlighted in the QSO Chairs report to the JCC. ○ The diversity of dialysis providers and whether this poses any challenges in terms of applying a uniform approach to protocols and standards. It was confirmed that the renal community work very closely, sharing clinical input and that infection prevention and control issues are driven by the clinical teams within the renal centres. • The Director of Commissioning for Specialised Services provided updates on various specialist services including: ○ The continued challenges in engagement with Salford Royal Hospital obesity services. This will continue to be escalated. Meanwhile, additional capacity has been secured in South Wales. ○ Improvements in plastic surgery waiting times, the data for March 2025 was still pending, but the target of 104 weeks is likely to be achieved. There was insufficient capacity to make any significant in-roads into achieving 52 weeks targets. ○ Prostate-Specific Membrane Antigen (PSMA) due to the ongoing production challenges with Positron Emission Tomography Imaging Centre (PETIC) in CVUHB. A clinical update was provided advising that undertaking clinical revalidation with all the PMSA PET requests has been agreed with a view to shared decision making, noting that these scans were not mandated according to NICE guidance, therefore, the suggested triage involves categorising patients into high, intermediate, and lower risk groups. This positive progress was welcomed. ○ South Wales Specialist Auditory Implant Device Service and the continued lack of progress. This will form part of a broader conversation however there was an action plan in place and the requirements were more visible. • A report for the Commissioning for Ambulance and 111 services was received. The quality and safety dashboard, which includes high-level reports on quality domains was highlighted. In addition: ○ The establishment of a new clinically led 'National Ambulance Patient Handover Improvement Implementation Group.' The work of this group will be

RAG Rating	Highlight
	a key enabler in supporting the JCC in reducing its emergency ambulance services associated risks around utilisation of capacity. ○ The new ambulance performance framework and introduction of new categories was noted which included a purple category for incidents of cardiac and respiratory arrest. ○ High rate of 111 call abandonments and whether the service can cope with demand. The JCC has yet to assess whether it provides sufficient or effective call handling and clinical capacity as a formal strategic demand and capacity review of the 111 system has not yet been conducted. A detailed analysis of the GDPR breaches within the Ambulance and 111 report was requested to understand the causes. ○ A deep dive on Ambulance services, including a patient story, was scheduled for June 2025 where several issues can be addressed. • The Director for Mental Health and Vulnerable Groups report was presented. The following points were highlighted: ○ Improvements in High Secure services through the introduction of positive interaction program (PIP) at Ashworth, reducing long-term segregation numbers, noting that Broadmoor and Rampton were implementing similar strategies. ○ Environmental issues at Caswell Medium Secure Unit and Ty Llewellyn, including lack of seclusion facilities. SBUHB has appointed an independent assessor to undertake an independent review of their mental health services. The JCC needs to stay cited on the work of this review to help with informing strategic commissioning decisions. ○ Inpatient numbers have risen within eating disorder services. Noting ongoing discussions to enhance gatekeeping processes. ○ Plans for two newly commissioned perinatal beds for North Wales patients located in Chester, by October 2025.
Assure	• Members heard a story from a patient's specific experience of the Tonna Mother and Baby Unit stating the challenges she faced as a mother with physical health disabilities. It was noted that the Unit worked hard to address the environment and accessibility issues and the staff's willingness to listen and adapt. To minimise anxiety for patients, the Unit is now planning to produce booklets with

RAG Rating	Highlight
	photographs of the unit and to introduce phone calls between staff and patients prior to admission to discuss and prepare for their stay. A video tour was also planned, however due to resources this has not been possible. The Chair thanked her for her sharing her personal story and wished her well for the future. • Members received the risk register as at 31 January 2025, highlighting the risks relating to the Quality Safety and Outcomes assigned for monitoring and scrutiny purposes. The following areas were highlighted: ○ Cardiac Device Services, the Chair inquired whether this risk was specific to North Wales or if it represented a broader issue concerning engagement within the service. It was clarified that the service was safe, and the engagement issues relate to the provider. The risk was likely to be resolved by the next meeting. ○ Paediatric Intensive Care Beds and Neonatal Infection Control which had been covered in the earlier presentation. Whilst these remain on the Risk Register as risks scoring 20, these should also be updated by the time of the next meeting. It was noted however there appeared to be some underlying issues that could be related to the environment. The infections rates appeared to be higher than national averages despite good compliance with infection control measures. ○ Neurosurgery Sustainability, noting that this risk had been de-escalated from 16 to 8. It was queried if this was premature as the funding had been allocated but the overall sustainability of the service was dependent on successful recruitment. The matter around when a risk is mitigated from a commissioner perspective and becomes a provider risk/issue was discussed. It was suggested that this topic could be addressed in a JCC strategy session since the JCC still needed to conclude their discussions around risk appetite. ○ C&VUHB Neurosciences Staffing issues/level was queried as the description around the risk being addressed by the rehabilitation strategy was due for consideration by the JCC in Quarter three 2024/2025 but this has now passed. It was agreed to review this outside of the meeting and provide an update at the next meeting.
Inform	• The forward plan of business for the next twelve months was presented noting that it was a work in progress and would be used to support Agenda planning for future meetings.

RAG Rating	Highlight
	• A report outlining recent incidents and concerns reported to the JCC from provider and commissioned services covering the period January 2025 – February 2025 was received. • An update on the Regulator Report (Healthcare Inspectorate Wales (HIW) / Care Quality Commission (CQC) regulatory activity was provided noting the ongoing collaboration with HIW to improve reporting and assurance processes.
Appendices	None

4. ASSESSMENT

Objectives / Strategy	
Dolen i Amcan (au) Strategol CBC Link to JCC Strategic Objectives(s)	Improve Equity and Population Health Ensure Quality
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A More Equal Wales
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Whole-systems Perspective If more than one applies please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality**	Person Centred If more than one applies please list below: Equitable

(*Duty of Quality Statutory Guidance (gov.wales)*)	
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: N/A
Cydraddoldeb *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /* **Equality** *Have you undertaken an Equality Impact Assessment Screening?*	Yes: ☒	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE	If no, please include rationale below: N/A
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Joint Committee as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

5. RECOMMENDATIONS

The Joint Committee is asked to:

- **Note** the highlights outlined in Section 3 of this report.

Patient Experience, Quality and Safety Committee 2025-26					
Theme	**Item Title**	**April 29/04/2025**	**July 31/07/2025**	**October 23/10/2025**	**February 05/02/2026**
Governance	Minutes of previous meeting	✓	✓	✓	✓
Governance	Declaration of Interests	✓	✓	✓	✓
Governance	Action Log	✓	✓	✓	✓
Governance	Committee Risk Register	✓	✓	✓	✓
Governance	Annual Work Programme	✓			
Governance	Committee Work Programme (updated through year)		✓	✓	✓
Governance	Items to be brought to the attention of the Board and/or other Committees	✓	✓	✓	✓
Governance	Annual Assessment of Committee Effectiveness	✓			
Governance	Committee 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		☒	✓	
	Patient Story	✓	✓	✓	✓
	Patient Experience in 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		☒	✓	
Infection Prevention and Control	IPC Annual Assurance Report		✓		
	IPC progress/focus				✓
Comms and Engagement	Comms and Engagement Report for PEQS			✓	
Other	Monitor Health Board actions of Child Pratice Review		✓		
	Monitor Health Board actions of JICPA	✓			
	Corporate Parenting Charter				✓
	Staff experience of MH&LD Services in escalation	✓			
	Staff experience of ND Services in escalation			✓	
	AW Cancer services report and WG response	✓			
	JCC Quality Safety and Outcomes Sub-Committee Hightlight Report	✓	✓		
	EPMA SBAR		✓		
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	✓			
	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					

Powys Teaching Health Board Glossary (juli 25)

Acronym	
ADoECP	Associate Director of Estates, Capital & Property
CEO	Chief Executive Officer
DCG	Director of Corporate Governance
DIT	Director of Improvement & Transformation
EMD	Executive Medical Director
ED PH	Executive Director of Public Health
ED P&C	Executive Director of People and Culture
ED PP&C	Executive Director of Planning, Performance and Commissioning
ED FCSS	Executive Director of Finance, Capital & Support Services
ED AHPHSD	Executive Director of Allied Health Professions, Health Sciences and Digital
ED NQW&FH	Executive Director of Nursing, Quality, Women and Family Health
EDPCCMH	Executive Director of Primary Care, Community & Mental Health
ABUHB	Aneurin Bevan University Health Board
AFC	Agenda for Change
AGW	The Auditor General for Wales
AHPs	Allied Health Professionals
ALN	Additional Learning Needs
AO	Accountable Officer
ARAC	Audit, Risk and Assurance Committee
ASM	Accelerated Sustainable Model
AR	Audit Recommendations
BAF	Board Assurance Framework
BCUHB	Betsi Cadwaladr University Health Board
BMA	British Medical Association
CAAP	Clinical associate in applied psychology
CAMHS	Child and Adolescent Mental Health Services
CCN	Childrens Community Nursing
CEMT	Chief Executive Management Team
CHC	Continuing Health Care
CIW	Care Inspectorate for Wales
CLIP	Collaborative Learning in Practice
CNO	Chief Nursing Officer
CPD	Continued Professional Development

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